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Births: Preliminary Data for 1999

Use Teen Pregnancy

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Abstract

Objectives—This report presents preliminary data for 1999 on births in the United States. U.S. data on births are shown by age, race, and Hispanic origin of mother. Data on marital status, prenatal care, cesarean delivery, and low birthweight are also presented.

Methods—Data in this report are based on more than a 97-percent sample of births for 1999. The records are weighted to independent control counts of births received in State vital statistics offices in 1999. Comparisons are made with 1998 final data.

Results—The crude birth rate in 1999 was 14.6 per 1,000 population, a slight decline from 1998 (14.6), returning to the level observed in 1997. However, the fertility rate, which is limited to women aged 15–44 years, was 65.8 in 1999, a slight increase over the rate for 1998 (65.6). The birth rate for teenagers continued to decline for 1998–99, dropping 3 percent to 49.6 births per 1,000 females aged 15–19 years. The 1999 rate for teenagers is 20 percent lower than the recent high point in 1991. The rate for young teenagers 15–17 years fell 6 percent, and the rate for teenagers 18–19 years declined 2 percent. Since 1991, rates have fallen 26 percent for teenagers 15–17 years, and 15 percent for teenagers 18–19 years. Birth rates for women aged 20–24 years declined slightly between 1998 and 1999 whereas the rate for women aged 25–29 years rose 2 percent. Birth rates for women in their thirties and forties continued their long increase. Rates for women in their thirties increased 2 to 3 percent and were the highest in three decades. The birth rate for women aged 40–44 years was the highest level reported since 1970. The birth rate for unmarried women in 1999 was 43.9 per 1,000, 1 percent lower than in 1998 and 6 percent lower than the peak level reported for 1994 (46.9). However, the number of births to unmarried women was up about 1 percent due to the continued increase in the number of unmarried women of childbearing age. The rate of prenatal care utilization continued to improve. The total cesarean rate increased 4 percent between 1998 and 1999 and continued a 3-year rise. The low birthweight rate remained unchanged at 7.6 percent.

Keywords: births • vital statistics

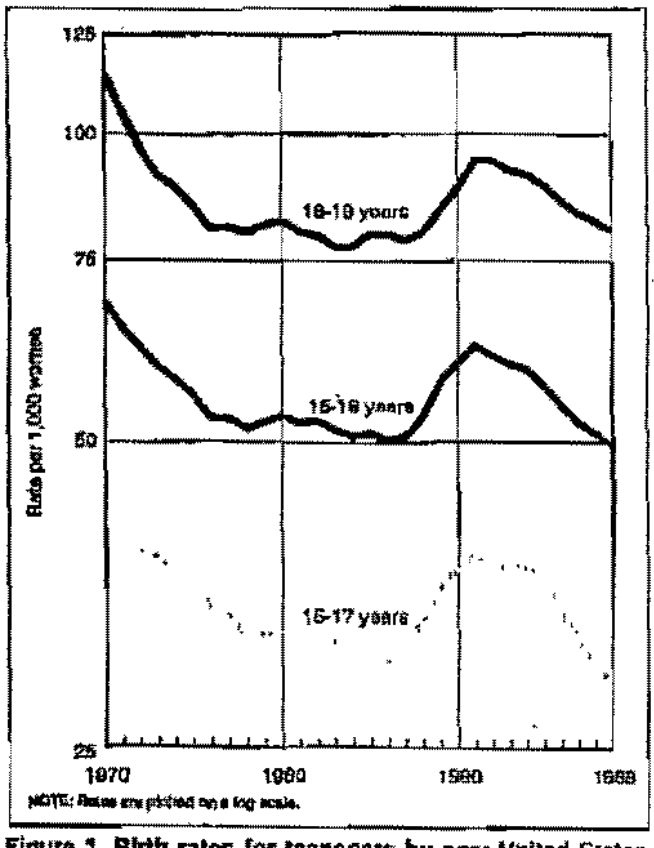

Figure 1. Birth rates for teenagers by age: United States, 1970–99

Introduction

This report presents preliminary data on births based on a substantial proportion of vital records for births occurring in 1999. Previous reports in the preliminary series have included data for both

births and deaths. This report includes data on births only; preliminary 1999 mortality data will be published separately. The preliminary report series, which is published annually by NCHS, includes detailed tabulations from the preliminary natality file. This report is the eighth in the series and shows preliminary birth data for 1999. Trends shown in the preliminary reports for 1985–98 births for most measures were confirmed by the final statistics for each year (1–4).

Sources and methods

The preliminary data in this series are based on records of births that occurred during 1999 and were received and had undergone quality control by NCHS as of May 10, 2000. This represents over 97 percent of the births that occurred in the United States during this 12-month period.

To produce the preliminary estimates shown in this report, records in the file were weighted using independent control counts of births by State of occurrence. Preliminary estimates are subject to sampling variation as well as random variation.

In addition to national and State estimates of total births and birth rates, this report includes preliminary statistics on births by age, live-birth order, marital status, race, Hispanic origin, and selected maternal and infant health characteristics: receipt of prenatal care, cesarean delivery, and low birthweight.

Race and Hispanic origin are reported as separate items on the birth certificate. Therefore, births shown by race may be of Hispanic or non-Hispanic origin, and births of Hispanic origin may be of any race. All tabulations in this report show data separately for the non-Hispanic white population as well as for the white population as a whole. Although the overwhelming majority of Hispanic-origin births (approximately 97 percent) are to white women, there are notable differences in childbearing patterns between Hispanic and non-Hispanic white women. About one in five white births are to Hispanic women. For this preliminary report, data are not shown separately for non-Hispanic black persons because the great majority (more than 95 percent) of black births are to non-Hispanic persons and, thus, the difference in the statistics for the two groups are minimal (1). The report "Births: Final Data for 1998," show data for these groups separately.

State-specific preliminary data are shown only for those States and areas for which at least 75 percent of the records for 1999 were received and had undergone quality control by May 10, 2000 (i.e., were processed). (See Technical notes.) All States met this requirement in 1999. The proportion of records processed is shown by State in table I in the Technical notes. Detailed information on the nature, sources, and qualifications of the preliminary data is given in the Technical notes.

Results

Trends in numbers and rates

The number of births (preliminary) in the United States was 3,957,629 in 1999, a less than 1-percent increase over the final number for 1998 (3,941,553) (table A). All of the increase in the total number was due to increases for Asian or Pacific Islander and Hispanic mothers. The number of births for non-Hispanic white, black, and American Indian mothers declined between 1998 and 1999. The crude birth rate in 1999 was 14.6, a slight decline from 1998 (14.6), returning to the level observed in 1997. The rates in 1999 and 1997 were the lowest in two decades. The *fertility rate* relates births to the population at risk of giving birth (women aged 15–44 years) and is thus more indicative of changes in fertility behavior than is the crude birth rate. The rate was 65.6 in 1999, a slight increase over the rate for 1998 (65.6). This was the second consecutive increase in the fertility rate after dropping each year during 1990–97 (see tables 1–4 for birth, birth rates, and fertility rates). The majority of States, 29, and the District of Columbia had declines in their crude birth rates between 1998 and 1999 while 12 States had increases and 10 were unchanged. In contrast, fertility rates increased for 33 States, declined for 13 States and the District of Columbia, and were unchanged in 4 States.

Table A. Total births and percent of births with selected demographic and health characteristics, by race and Hispanic origin of mother: United States, final 1998 and preliminary 1999

[Figures for 1999 are based on weighted data rounded to the nearest individual]

Characteristic	All races[1]		White, total[2]		White, non-Hispanic		Black[2]		Hispanic[3]	
	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
					Number					
Births	3,957,629	3,941,553	3,130,100	3,118,727	2,348,538	2,361,462	606,720	609,802	762,364	734,661
					Percent					
Births to mothers under 20 years	12.2	12.5	10.8	11.1	8.2	8.4	20.6	21.5	16.7	16.9
Births to unmarried mothers	33.0	32.8	26.7	26.1	22.0	21.9	68.8	69.1	42.1	41.6
Low birthweight[4]	7.5	7.5	6.8	6.8	6.6	6.6	13.1	13.0	6.4	6.4
Very low birthweight[5]	1.45	1.45	1.15	1.15	1.15	1.15	3.13	3.08	1.13	1.16
Births delivered by cesarean	22.9	21.2	21.8	21.0	22.1	21.2	23.1	22.4	21.2	20.6
Prenatal care beginning in first trimester	83.2	82.6	85.1	84.8	88.4	87.9	74.9	73.3	74.5	74.3
Prenatal care beginning in third trimester or no care	3.8	3.9	3.2	3.3	2.8	2.4	6.7	7.0	6.3	6.3

[1] Includes races other than white and black.
[2] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[3] Includes all persons of Hispanic origin of any race; see Technical notes.
[4] Birthweight of less than 2,500 grams (5 pounds 8 ounces).
[5] Birthweight of less than 1,500 grams (3 pounds 4 ounces).

The fertility rate in 1999 for Hispanic women (101.8) was 76 percent higher than for non-Hispanic white women (57.9), the group with the lowest rate. Rates for black women (70.2), American Indian women (69.4), and Asian or Pacific Islander women (65.7) were much lower than for Hispanic women but moderately higher than for non-Hispanic white women. Fertility rates in 1999 for black and American Indian women both declined compared with 1998, by 1 and 2 percent, respectively. The rate for non-Hispanic white women increased slightly between 1998 and 1999. The 1999 rate for Asian and Pacific Islander women increased 3 percent compared with 1998, but was still the second lowest fertility rate since these data were first collected in 1980. For Hispanic women, the fertility rate was about 1 percent higher in 1999 than in 1998, the first increase in this rate since 1992. However, the 1999 fertility rate for Hispanic women was still the second lowest rate since national data became available for this group in 1989 (1). Births to Hispanic women comprised 19 percent of all births in the United States in 1999, the same percent as in 1998, but much higher than in 1989 (14 percent).

The birth rate for teenagers in 1999 was 49.6 per 1,000 births to women aged 15–19 years, a 3-percent decline compared with the rate for 1998 (51.1), and 20 percent lower than the recent high point in 1991 (62.1) (table B, table 1, and figure 1). The 1999 rate for teenagers is at an all-time low. The rate for the youngest teenage group, **10–14 years**, fell slightly between 1998 (1.0 per 1,000 women 10–14 years of age) and 1999 (0.9). The number of births to women aged 10–14 years fell 4 percent between 1998 and 1999 (from 9,462 to 9,048), to the lowest number in 30 years. **Rates for teenagers 15–17 and 18–19 years** continued their steady decline since the early 1990's. Compared with 1998, the 1999 rate for teenagers 15–17 years (28.7) declined 6 percent whereas the rate for teenagers 18–19 years (80.2) declined 2 percent. Between 1991 and 1999 there was a 26-percent drop in the birth rate for teenagers 15–17 years and a 15-percent drop in the rate for teenagers 18–19 years.

Birth rates for 15–19 year-olds by race and Hispanic origin show that all groups continued their declines into 1999. The largest declines between 1998 and 1999 were for American Indian teenagers (6 percent, with a 1999 rate of 67.7 per 1,000), followed by a 5-percent drop among black (81.1), and a 3-percent decline for non-Hispanic white teenagers (34.1). The birth rate for Hispanic teenagers declined by less than 1 percent, to 93.1, remaining substantially higher than that of other groups. Between 1991 and 1999, rates for teenagers dropped most steeply for black women (30 percent) with the smallest decline observed for Hispanic women (13 percent). Due to these trends, rates for Hispanic teenagers have been higher than for black teenagers for each year 1994–98.

Birth rates for women in their twenties in 1999, the ages at which rates are typically the highest, were 111.0 per 1,000 for women aged 20–24 years and 117.8 for women aged 25–29 years (table 1). The 1999 rate for women aged 20–24 years was slightly lower than in 1998 (111.2) whereas the rate for women aged 25–29 years increased 2 percent, from 115.9 in 1998. The rate for women aged 20–24 years was down slightly for non-Hispanic white and Hispanic women and declined 2 percent for American Indian mothers. In contrast, the rate for black women aged 20–24 years was unchanged whereas it rose 2 percent for Asian or Pacific Islander women. Except for American Indian women, all groups experienced increases in the rate for women aged 25–29 years. All of the increases in the rate between 1998 and 1999 were less than 2 percent except for a 6-percent increase in the rate for Asian or Pacific Islander women. The decline for American Indian women was less than 1 percent.

The birth rates for women in their thirties continued to increase. For women aged 30–34 years, the rate in 1999 (89.6) was 3 percent higher than the 1998 rate (87.4) whereas the 1999 rate for women aged

Table B. Birth rates for women aged 15–19 years, by age, race, and Hispanic origin: United States, final 1990–98 and preliminary 1999, and percent change in rates, 1991–99

(Rates per 1,000 women in specified group)

Age, race, and Hispanic origin of mother	1999	1998	1997	1996	1995	1994	1993	1992	1991	1990	Percent change 1991–99
15–19 years											
All races[1]	49.6	51.1	52.3	54.4	56.8	58.9	59.6	60.7	62.1	59.9	–20.1
White, total[2]	44.6	45.4	46.3	48.1	50.1	51.1	51.1	51.8	52.8	50.6	–15.7
White, non-Hispanic	34.1	35.2	36.0	37.6	39.3	40.4	40.7	41.7	43.4	42.5	–21.4
Black, total[2]	81.1	85.4	88.2	91.4	98.1	104.6	109.6	112.4	115.9	112.8	–29.8
Hispanic[3]	93.1	93.6	97.4	101.8	106.7	107.7	106.9	107.1	106.7	108.3	–12.7
15–17 years											
All races[1]	28.7	30.4	32.1	33.8	35.0	37.6	37.8	37.6	38.7	37.5	–25.8
White, total[2]	24.0	25.9	27.1	28.4	30.0	30.7	30.3	30.1	30.7	29.5	–19.2
White, non-Hispanic	17.1	18.4	19.4	20.6	22.0	22.8	22.7	22.7	23.6	23.2	–27.5
Black, total[2]	62.1	66.8	69.9	64.7	69.7	76.3	79.8	81.3	84.1	82.3	–38.0
Hispanic[3]	61.2	62.3	66.3	69.9	72.9	74.0	71.7	71.4	70.6	69.9	–13.3
18–19 years											
All races[1]	80.2	82.0	83.6	85.9	88.1	91.6	92.1	94.5	94.4	96.8	–15.0
White, total[2]	73.4	74.6	75.9	78.4	81.2	82.1	82.1	83.8	83.5	78.8	–12.1
White, non-Hispanic	59.0	60.6	61.9	63.7	66.1	67.4	67.7	69.8	70.5	66.6	–16.3
Black, total[2]	122.9	126.9	130.1	132.5	137.1	148.3	151.9	157.9	158.8	152.9	–22.6
Hispanic[3]	130.0	140.1	144.3	151.1	157.9	158.0	159.1	159.7	156.6	147.7	–11.6

[1]Includes races other than white and black.
[2]Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[3]Includes all persons of Hispanic origin of any race; see Technical notes.

35–38 years (38.3) was 2 percent higher than the comparable rate in 1998 (37.4). The birth rates for women in their thirties were the highest in about three decades. The birth rate for women aged 40–44 years increased slightly between 1998 (7.3) and 1999 (7.4) and was the highest in almost two decades.

The birth rate for women aged 45–54 years remained at 0.4 per 1,000 in 1999 but the number of births to these women increased 14 percent between 1998 (3,782) and 1999 (4,330). All of the increase in the number of births can be attributed to the increase in the population of these women.

Due to the continued decline in teenage birth rates along with increases for most groups aged 20 years and over, the percent of all births to women under the age of 20 declined to 12.2 percent compared with 12.5 percent in 1998 (table A). The percent of teenage births varies tremendously by State, from 6.9 in Massachusetts to 18.7 in Mississippi (table 5).

The first birth rate increased slightly between 1998 (26.4 first births per 1,000 women aged 15–44 years) and 1999 (26.5) (table 3). This was the first increase in this rate since 1990 (5). The first birth rate for teenagers, however, continued to decline to the lowest level recorded since 1986. The first birth rate for teenagers was 39.9 in 1999, a 3-percent decline compared with 1998 (39.8).

The total fertility rate (TFR) indicates the number of births that a hypothetical group of 1,000 women would have if they experienced throughout their childbearing years the age-specific birth rates observed in a given year. The TFR for 1999 was 2,075.0, a 1-percent increase over 1998 (2,059.5) and the highest TFR since 1990. TFR's increased between 1998 and 1999 for the following groups—from 2,041.0 to 2,063.0 overall for white women, from 1,837.0 to 1,853.5 for non-Hispanic white women, from 1,867.5 to 1,930.5 for Asian or Pacific Islander women, and from 2,947.5 to 2,978.0 for Hispanic women. TFR's declined between 1998 and 1999 for black women (from 2,171.0 to 2,149.0) and for American Indian women (from 2,090.5 to 2,049.5) (tabular data not shown).

The number (preliminary) of births to unmarried women for 1999 was 1,304,594, about 1 percent higher than in 1998 (1,293,567) (table C). The number for 1999 is the highest ever reported in the United States, and the increase is due mostly to the continued increase in the number of unmarried women of childbearing age (up 4 percent since 1997) (6). The birth rate for unmarried women declined about 1 percent in 1999 to 43.9 births per 1,000 unmarried women aged 15–44 years, compared with 44.3 in 1998; the 1999 rate was 5 percent lower than its highest level, 46.9 in 1994 (1).

The proportion of all births to unmarried women in 1999 increased to 33.0 percent, compared with 32.8 percent in 1998. This proportion has been relatively stable since 1994, ranging from 32.2 to 33.0 percent. The proportion for all white births increased from 26.3 to 26.7 percent, for non-Hispanic white births from 21.9 to 22.0 percent, and for Hispanic births from 41.6 to 42.1 percent. The proportion declined slightly for black births from 68.1 to 68.8 percent.

The number (preliminary) of births to unmarried teenagers (total under age 20 years) was 2 percent lower in 1999 than in 1998 (table C). The numbers declined 5 percent for births to teenagers under 15 years and for births to teenagers 15–17 years. Births to older unmarried teenagers, 18–19 years, rose by about 1 percent.

Despite the decline in the total number of births to unmarried teenagers, the percent of all teenage births that occurred to unmarried

Table C. Number and percent of births to unmarried women, all ages and women under 20 years: United States, final 1998 and preliminary 1999

(Figures for 1999 are based on weighted data rounded to the nearest individual)

Age of mother	Number		Percent	
	1999	1998	1999	1998
All ages	1,304,594	1,293,567	33.0	32.8
Under 20 years	382,655	390,005	78.9	78.9
Under 15 years	8,724	9,137	98.4	98.5
15–19 years	373,931	380,868	78.6	78.5
15–17 years	143,318	151,557	87.6	87.6
18–19 years	230,613	229,311	73.0	73.6

teenagers was unchanged in 1999 (78.9 percent) compared with 1998. Slight increases in the percent unmarried were found for each teenage subgroup, 15–19 years, even for the 15–17 age group, which reported fewer nonmarital births. The percent unmarried increased slightly for births to teenagers 15–17 years because total births to these teenagers declined even more than nonmarital births. Birth rates for unmarried teenagers for 1999 are not yet available; see Technical notes.

The procedures for reporting mother's marital status did not change in any State between 1998 and 1999 (See table 5 for State data). Connecticut added a direct question on marital status to the birth certificate in June 1998. Previously, Connecticut inferred the mother's marital status from information on the birth certificate (see Technical notes). Because the change in Connecticut was implemented in June 1998 and because Connecticut accounts for only 1 percent of U.S. births, the change has had essentially no impact on the national data or the trends for 1998–99. For 1998 and 1999, birth data on marital status for all but two States are based on a direct question on each State's birth certificate or electronic birth registration system (see Technical notes).

The proportion of low birthweight births (LBW) (less than 2,500 grams) was 7.6 percent for 1999, unchanged from the previous year. A gradual upward trend in LBW has been observed since the mid-1980's; during the 1990's, LBW has risen from 7.0 percent (1). See tables A and 7 for 1998 and 1999 data. The percent of births born very low birthweight (VLBW) remained unchanged at 1.45 percent. VLBW has also risen slowly over the last two decades.

The percent LBW was essentially the same for 1998–99 for births to non-Hispanic white (6.6 percent), black (13.1 percent), and Hispanic women (6.4 percent). For the 1990's, LBW rose among non-Hispanic white births, declined among black births, and remained fairly stable among Hispanic births.

The rate of cesarean delivery increased 4 percent between 1998 and 1999, from 21.2 per 100 births to 22.0 (tables A and B). This was the third consecutive increase in the cesarean rate after steady declines between 1989–96 (figure 2). The rate of primary cesarean delivery increased for the second consecutive year and was 4 percent higher in 1999 (15.9 per 100 births to women with no previous cesarean) than in 1998 (14.8). The rate of vaginal births after previous cesarean delivery (VBAC) fell 11 percent between 1998 and 1999 (from 26.3 per 100 births to women with a previous cesarean to 23.4) and has declined 17 percent since 1996. Between 1989 and 1996 the rate had risen 50 percent (1).

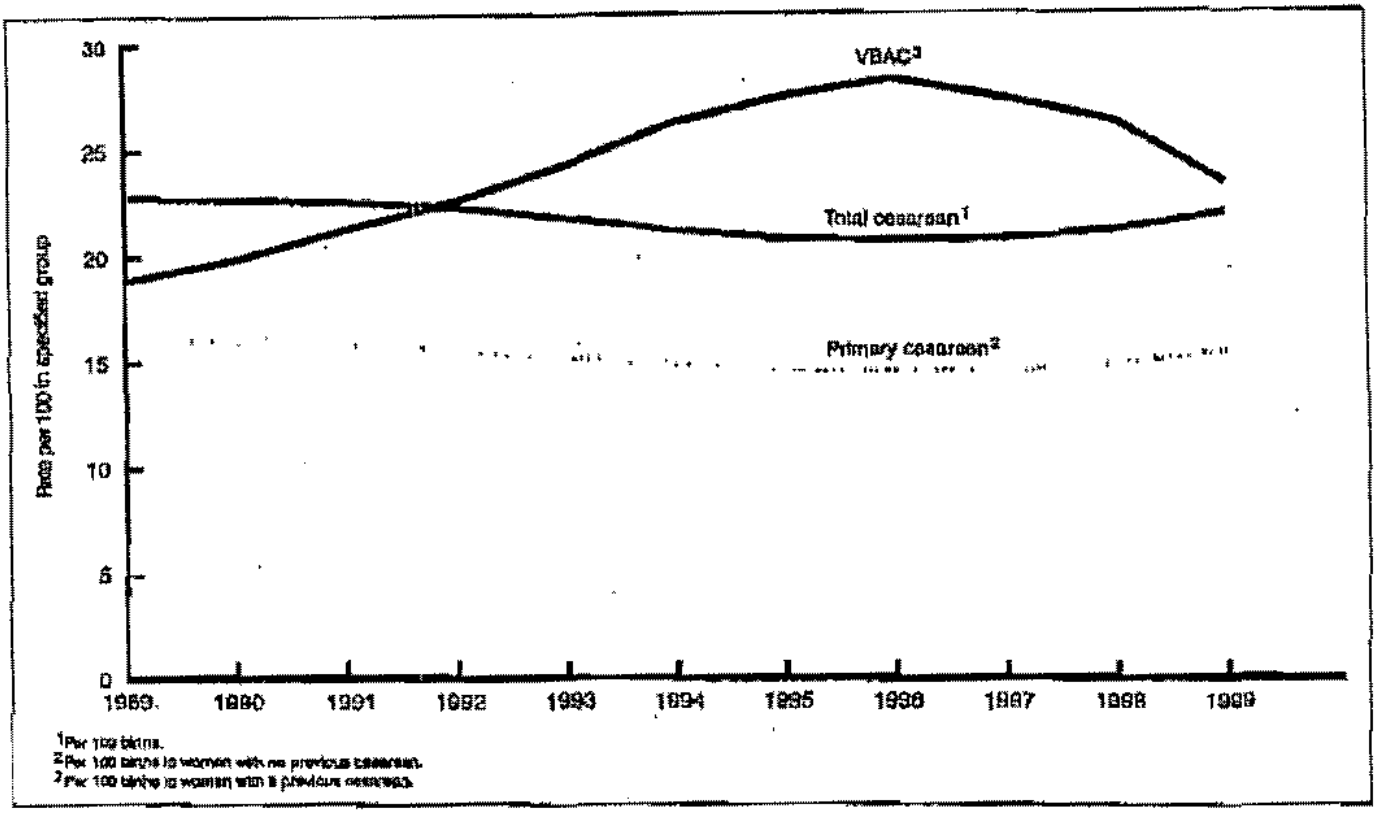

Figure 2. Total and primary cesarean rate and vaginal birth after previous cesarean (VBAC) rate: United States, 1989–99

Cesarean rates increase with maternal age, from 15.0 for women under age 20 years to 34.7 for women aged 40–54 years. All age groups experienced increases in cesarean rates between 1998 and 1999, with the percent increases ranging between 3 and 5 percent. The percent increases for older mothers were slightly greater than for their younger counterparts (tabular data not shown).

Cesarean rates by race and Hispanic origin show that all groups experienced increases between 1998 and 1999 (table B). The percent increase in the rate was 4 percent for non-Hispanic white women, and 3 percent each for black and Hispanic women. The rate in 1999 continued to be the highest for black women (23.1 per 100 births), lowest for Hispanic women (21.2) and intermediate for non-Hispanic white women (22.1).

Cesarean rates vary tremendously by State, from 14.8 in Alaska to 27.3 in Mississippi. The vast majority of States—45 and the District of Columbia—experienced increases in their rates between 1998 and 1999 whereas only 2 States declined (Delaware and Montana) and 3 States were unchanged (New Mexico, Utah, and Vermont).

VBAC rates varied from a low of 11.3 in Louisiana to a high of 36.2 in New Hampshire. Rates declined between 1998 and 1999 for 46 States, with 29 States having declines of greater than 10 percent. VBAC rates increased for the District of Columbia, Montana, North Dakota, South Dakota, and Utah (tabular data not shown).

The percent of women beginning **prenatal care in the first trimester of pregnancy** rose slightly for 1999 to 83.2 percent, compared with 82.8 percent for 1998. This measure of prenatal care has shown steady progress during the 1990's, rising 10 percent since 1989 (from 75.6 percent) (1). The percent of women with late (care beginning in the 3rd trimester of pregnancy) or no care declined slightly from 3.9 to 3.8 percent for 1998–99. The proportion late or no care has dropped from 6.4 percent during the decade. (See tables A and B for 1998 and 1999 data.)

For the current year, improvement in prenatal care initiation was observed for each of the racial and ethnic groups: non-Hispanic white, black, and Hispanic women. During the 1990's, first trimester care has risen 7 percent among non-Hispanic white women (from 82.7 to 88.4 percent), 24 percent among black women (from 60.0 to 74.0 percent) and 25 percent among women of Hispanic origin (from 59.5 to 74.5 percent).

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List of detailed tables

Table 1. Births and birth rates, by age, race and Hispanic origin of mother: United States, final 1998 and preliminary 1999

[Data for 1999 are based on a continuous file of records received from the States. Figures for 1999 are based on weighted data rounded to the nearest individual, so categories may not add to totals]

Age and race/Hispanic origin	1998		1999	
	Number	Rate	Number	Rate
All races				
Total [1]	3,957,826	66.8	3,941,853	65.5
10-14 years	9,049	0.9	9,462	1.0
15-19 years	475,749	48.8	464,695	61.1
15-17 years	183,656	29.7	179,731	30.4
18-19 years	312,189	80.2	311,664	82.0
20-24 years	961,207	111.0	966,122	111.2
25-29 years	1,076,350	117.8	1,083,015	115.8
30-34 years	882,478	89.8	889,385	87.4
35-39 years	433,703	38.3	424,890	37.4
40-44 years	83,878	7.4	81,827	7.3
45-54 years [2]	4,190	0.4	3,762	0.4
White, total [3]				
Total [1]	3,130,100	66.9	3,116,727	64.6
10-14 years	4,723	0.6	4,801	0.6
15-19 years	337,323	44.6	340,584	45.4
15-17 years	111,481	24.8	110,523	25.0
18-19 years	225,842	73.4	224,971	74.8
20-24 years	747,717	106.8	732,864	107.2
25-29 years	870,566	121.1	860,696	119.1
30-34 years	729,957	93.2	757,532	90.5
35-39 years	366,646	38.7	349,709	37.8
40-44 years	67,225	7.3	65,485	7.2
45-54 years [2]	3,599	0.4	3,064	0.4
White, non-Hispanic				
Total [1]	2,349,830	57.9	2,361,462	57.7
10-14 years	2,046	0.3	2,132	0.3
15-19 years	215,223	34.1	219,369	35.2
15-17 years	63,559	17.1	66,819	18.4
18-19 years	148,664	58.8	150,553	60.6
20-24 years	515,036	90.1	511,101	90.7
25-29 years	695,015	111.3	678,227	109.7
30-34 years	601,670	90.4	603,838	88.0
35-39 years	284,585	37.3	291,202	38.4
40-44 years	55,037	6.8	53,460	6.7
45-54 years [2]	2,602	0.4	2,369	0.4
Black, total [3]				
Total [1]	633,720	70.2	606,802	71.0
10-14 years	3,951	2.6	4,288	2.9
15-19 years	121,262	61.1	120,937	65.4
15-17 years	46,979	53.1	50,103	58.5
18-19 years	74,283	122.0	70,834	126.5
20-24 years	183,483	141.8	180,068	141.8
25-29 years	139,179	102.2	139,302	101.8
30-34 years	91,590	64.6	83,785	64.7
35-39 years	47,244	30.7	46,557	30.6
40-44 years	9,052	6.5	9,466	6.7
45-54 years [2]	417	0.3	348	0.3
American Indian, total [3,4]				
Total [1]	40,015	69.4	40,272	70.7
10-14 years	203	1.7	197	1.8
15-19 years	7,005	67.7	8,251	72.1
15-17 years	2,080	41.3	3,187	44.4
18-19 years	4,925	110.4	5,034	116.4
20-24 years	13,203	135.9	13,048	139.3
25-29 years	9,549	101.4	9,529	102.2
30-34 years	5,695	64.3	5,833	66.3
35-39 years	2,972	30.6	2,795	29.2
40-44 years	613	7.0	595	6.4
45-54 years [2]	25	0.4	19	*

See footnotes at end of table.

Table 1. Births and birth rates, by age, race and Hispanic origin of mother: United States, final 1998 and preliminary 1999 -Con.

[Data for 1999 are based on a continuous file of records received from the States. Figures for 1999 are based on weighted data rounded to the nearest individual, so categories may not add to totals]

Age and race/Hispanic origin	1999		1998	
	Number	Rate	Number	Rate
Asian or Pacific Islander, total [3]				
Total [1]	180,993	66.7	172,652	64.0
10-14 years	142	0.4	175	0.4
15-19 years	9,255	22.8	9,063	23.1
15-17 years	3,119	12.8	3,338	13.8
18-19 years	6,135	36.8	5,725	36.3
20-24 years	27,304	70.4	26,324	68.8
25-29 years	56,040	116.3	53,491	110.4
30-34 years	65,220	109.2	62,116	105.1
35-39 years	27,182	54.6	25,539	52.8
40-44 years	5,472	11.5	5,491	12.0
45-54 years [2]	379	0.9	361	0.9
Hispanic [5]				
Total [1]	762,364	101.5	734,681	101.1
10-14 years	2,721	1.0	2,716	2.1
15-19 years	124,382	93.1	121,388	93.6
15-17 years	48,127	81.2	48,234	82.3
18-19 years	76,228	139.0	73,154	140.1
20-24 years	230,881	178.3	223,113	176.4
25-29 years	203,366	162.6	196,012	160.2
30-34 years	131,134	102.1	125,702	98.8
35-39 years	67,020	49.2	64,186	44.9
40-44 years	11,930	10.7	11,056	10.6
45-54 years [2]	519	0.8	479	0.6

* Figure does not meet standards of reliability or precision.
1 The total number includes births to women of all ages, 10-54 years. The rate shown for all ages is the fertility rate, which is defined as the total number of births, regardless of age of mother, per 1,000 women aged 15-44 years.
2 The number of births shown is the total for women aged 45-54 years. The birth rate is computed by relating the number of births to women aged 45-54 years to women aged 45-49 years, because most of the births in this group are to women aged 45-49.
3 Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are also included in the data for each race group, according to the mother's reported race. See Technical notes.
4 Includes births to Aleuts and Eskimos.
5 Includes all persons of Hispanic origin of any race; see Technical notes.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical notes.

Table 2. Live births by age of mother, live-birth order, and race and Hispanic origin of mother: United States, preliminary 1999

[Data are based on a continuous file of records received from the States. Figures are based on weighted data rounded to the nearest individual, so categories may not add to totals]

Live-birth order and race/Hispanic origin of mother	All ages	Age of mother							
		Under 15 years	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-54 years
All races	3,957,539	9,049	475,745	991,207	1,078,350	882,478	433,793	82,875	4,330
1st child	1,687,971	8,618	370,749	448,102	382,762	255,327	88,688	17,577	1,061
2d child	1,385,974	169	86,458	336,720	373,667	322,390	141,268	23,116	987
3d child	662,380	8	14,543	137,232	194,879	168,292	101,359	17,200	767
4th child and over	413,012	1	2,148	52,782	112,283	126,464	93,376	24,488	1,496
Not stated	18,491	62	2,750	4,391	4,559	4,005	2,205	491	37
White, total [1]	3,130,100	4,723	337,323	747,217	879,686	738,067	356,648	67,228	3,666
1st child	1,281,393	4,607	266,489	355,369	328,833	211,398	78,472	14,810	935
2d child	1,034,704	72	67,139	260,979	306,448	271,040	116,283	18,850	813
3d child	516,212	3	3,481	88,764	165,646	156,369	84,531	13,627	610
4th child and over	302,888	-	1,038	30,636	78,224	87,815	74,464	19,451	1,158
Not stated	14,903	41	2,166	3,469	3,535	5,331	1,918	390	30
White, non-Hispanic	2,349,536	2,049	213,223	515,628	665,018	601,878	294,585	56,037	2,924
1st child	972,697	2,017	174,829	266,239	270,788	184,899	70,065	12,960	809
2d child	796,235	22	32,840	177,880	237,628	228,658	100,916	16,543	728
3d child	373,019	-	4,218	81,562	126,704	119,719	68,667	11,322	610
4th child and over	189,202	-	459	17,484	47,774	65,180	53,486	13,852	857
Not stated	6,383	6	677	1,831	2,124	2,217	1,242	289	19
Black, total [1]	606,720	3,881	121,262	193,483	198,175	91,696	47,244	8,682	417
1st child	228,478	3,588	88,745	71,573	34,848	18,726	8,315	1,641	86
2d child	179,729	88	26,369	68,670	44,331	20,842	13,482	2,267	97
3d child	106,375	4	5,856	35,744	31,135	20,759	10,918	2,061	70
4th child and over	89,820	1	1,020	19,878	28,453	22,153	14,304	3,626	184
Not stated	2,617	21	479	715	807	418	216	87	5
American Indian, total [1,2]	40,615	203	7,805	13,203	8,649	6,695	2,822	813	26
1st child	14,395	203	6,036	4,997	1,949	882	354	84	4
2d child	10,804	-	1,540	4,881	2,721	1,329	839	96	8
3d child	7,003	-	269	2,414	2,585	1,287	563	113	2
4th child and over	7,622	-	36	1,143	2,462	2,203	1,346	337	12
Not stated	193	-	41	58	44	24	20	4	-
Asian or Pacific Islander, total [1]	180,893	142	9,255	27,304	68,040	65,225	27,182	6,473	379
1st child	83,705	141	7,480	19,264	29,634	21,418	7,444	1,365	77
2d child	60,836	-	1,416	7,497	17,387	21,498	10,864	1,818	79
3d child	22,780	1	285	2,311	6,773	7,897	5,067	1,176	68
4th child and over	13,063	-	50	1,103	3,134	4,100	3,283	1,088	147
Not stated	509	-	34	149	273	233	104	26	7
Hispanic [3]	782,364	2,721	124,352	230,881	203,399	131,134	57,926	11,430	519
1st child	282,284	2,633	93,664	98,810	53,337	23,868	8,041	1,435	76
2d child	232,267	52	24,412	82,612	70,370	36,630	14,058	2,176	80
3d child	140,047	3	4,256	35,040	48,555	35,721	14,878	2,412	66
4th child and over	102,218	-	577	13,139	30,169	32,222	20,385	5,360	274
Not stated	4,550	33	1,145	1,480	979	693	269	48	3

- Quantity zero.
[1] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[2] Includes births to Aleuts and Eskimos.
[3] Includes all persons of Hispanic origin of any race; see Technical notes.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical notes.

Table 3. Birth rates by age of mother, live-birth order, and race and Hispanic origin of mother: United States, preliminary 1999

[Data are based on a continuous file of records received from the States. Rates per 1,000 women in specified age and racial group]

Live-birth order and race/Hispanic origin of mother	15-44 years [1]	Age of mother							
		10-14 years	15-19 years	20-24 years	25-29 years	30-34 years	35-39 years	40-44 years	45-49 years [2]
All races	65.8	0.9	46.6	111.6	117.8	69.6	36.3	7.4	0.6
1st child	29.6	0.8	35.8	60.9	43.1	25.0	6.5	1.6	0.1
2d child	21.5	0.0	9.0	36.6	41.0	32.5	12.5	2.1	0.1
3d child	10.8	*	1.6	15.6	21.4	18.0	9.0	1.6	0.1
4th child and over	5.9	*	0.2	8.0	12.3	13.6	6.5	2.2	0.2
White, total [3]	65.0	0.8	44.5	109.5	121.1	93.2	38.7	7.3	0.4
1st child	29.3	0.6	35.7	51.0	45.0	28.7	6.7	1.5	0.1
2d child	21.6	0.5	7.8	37.5	43.1	34.3	12.7	2.1	0.1
3d child	10.8	*	1.1	13.8	21.7	19.8	8.2	1.6	0.1
4th child and over	6.3	*	0.1	4.4	10.8	12.4	6.1	2.1	0.1
White, non-Hispanic	57.9	0.3	34.1	90.1	111.3	89.4	37.3	6.8	0.4
1st child	24.0	0.3	28.1	44.8	45.4	27.8	6.6	1.6	0.1
2d child	19.7	0.0	5.3	31.2	39.8	34.7	12.6	2.1	0.1
3d child	9.2	*	0.7	10.8	17.9	19.0	8.7	1.4	0.1
4th child and over	4.9	*	0.1	3.1	8.1	9.8	6.8	1.7	0.1
Black, total [3]	70.2	2.8	81.1	141.8	102.2	64.5	30.7	6.6	0.3
1st child	26.8	2.6	69.6	52.7	26.5	14.0	5.4	1.1	0.1
2d child	20.8	0.1	17.0	48.3	32.7	20.2	8.6	1.6	0.1
3d child	12.4	*	3.8	28.3	23.0	14.7	7.1	1.4	0.1
4th child and over	10.4	*	0.7	14.8	21.0	15.7	9.3	2.5	0.2
American Indian, total [3,4]	49.4	1.7	67.7	136.9	101.4	64.3	30.6	7.0	0.4
1st child	25.1	1.7	62.0	61.1	30.8	19.9	5.8	0.7	*
2d child	16.0	*	13.3	48.7	29.0	15.0	6.8	1.1	*
3d child	12.2	*	8.2	26.1	25.4	14.4	8.1	1.3	*
4th child and over	10.1	*	0.3	11.9	26.2	25.0	14.6	3.8	*
Asian or Pacific Islander, total [3]	65.7	0.4	22.8	70.4	116.3	109.3	54.6	11.5	0.9
1st child	30.5	0.4	18.5	42.2	51.8	42.5	16.0	2.9	0.2
2d child	22.1	*	3.5	18.4	38.3	42.7	23.1	3.8	0.2
3d child	8.3	*	0.7	8.0	17.5	16.7	10.8	2.5	0.2
4th child and over	4.7	*	0.1	2.8	8.5	8.3	6.8	2.3	0.4
Hispanic [5]	101.6	2.0	83.1	176.9	162.8	102.1	40.2	10.7	0.8
1st child	37.9	2.0	71.5	76.9	42.8	19.7	6.7	1.3	0.1
2d child	31.2	0.0	10.5	64.2	66.5	30.1	11.3	2.8	0.1
3d child	18.9	*	1.2	27.2	32.0	27.8	11.9	2.3	0.1
4th child and over	13.7	*	0.4	10.2	24.2	35.3	16.3	6.0	0.3

0.0 Quantity more than zero but less than 0.05.
* Figure does not meet standards of reliability or precision.
1 The rate shown is the fertility rate, which is defined as the total number of births, regardless of age of mother, per 1,000 women aged 15-44 years.
2 The birth rate for ages 45-49 years is computed by relating births to women aged 45-54 years to women aged 45-49 years, because most of the births in this group are to women aged 45-49.
3 Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
4 Includes births in Alaska and Oklahoma.
5 Includes all persons of Hispanic origin of any race; see Technical notes.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical notes.

Table 4. Live births by race and Hispanic origin of mother: United States, each State, and territory, preliminary 1999, and birth and fertility rates, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the States. Birth rates are total births per 1,000 total population; fertility rates are total births per 1,000 women aged 15–44 years. Figures for 1999 are based on weighted data rounded to the nearest individual, so categories may not add to totals]

Area	Number							Birth rate		Fertility rate	
	All races	White, total [1]	White, non-Hispanic	Black [1]	American Indian [1,2]	Asian or Pacific Islander [1]	Hispanic [3]	1999	1998	1999	1998
United States [4]	3,957,629	3,130,160	2,349,636	606,720	46,015	180,883	762,364	14.6	14.6	65.8	65.6
Alabama	62,123	41,728	40,182	19,771	156	466	1,606	14.2	14.3	63.3	63.2
Alaska	9,863	6,629	6,063	480	2,486	479	666	16.1	16.2	74.3	73.1
Arizona	81,226	71,126	38,299	2,603	6,398	1,999	31,646	17.0	16.8	81.1	79.2
Arkansas	38,532	28,476	26,521	7,717	241	398	1,873	14.4	14.6	67.6	67.6
California	519,229	420,188	172,319	36,681	3,262	58,748	249,247	15.9	16.0	69.4	70.7
Colorado	62,161	56,706	40,700	2,903	646	1,910	16,264	15.3	15.0	69.7	67.2
Connecticut	43,471	36,502	29,420	6,514	61	1,673	8,541	13.2	13.4	62.1	61.3
Delaware	10,975	7,879	6,895	2,858	34	276	853	14.2	14.2	61.7	61.2
District of Columbia	7,523	1,867	1,411	5,552	6	169	760	14.5	14.7	69.8	69.8
Florida	197,014	146,883	105,370	46,085	863	4,493	41,487	13.0	13.1	66.1	66.1
Georgia	126,744	81,140	59,857	42,113	222	3,268	10,566	16.3	16.0	66.8	67.2
Hawaii	17,047	4,931	3,347	460	232	12,384	2,411	14.4	14.7	69.9	69.6
Idaho	19,871	18,211	16,809	77	299	283	2,357	16.9	16.8	73.2	72.3
Illinois	183,174	146,835	103,986	34,264	209	6,907	35,942	15.0	15.2	68.1	68.3
Indiana	88,010	75,448	70,885	8,923	114	1,166	4,384	14.5	14.4	65.2	64.3
Iowa	37,641	35,348	33,249	1,169	205	523	1,844	13.1	13.0	62.2	61.4
Kansas	38,789	34,811	30,055	2,868	367	961	4,276	14.5	14.8	67.5	67.1
Kentucky	54,344	48,747	47,607	4,959	101	536	937	13.7	13.8	61.4	61.6
Louisiana	66,913	38,438	36,818	27,225	324	866	1,527	15.3	15.3	67.5	68.7
Maine	13,816	13,241	12,446	106	99	169	135	10.8	11.0	49.4	49.7
Maryland	72,257	44,266	42,520	24,568	108	3,147	4,106	14.0	14.0	69.6	69.1
Massachusetts	80,866	68,216	60,787	8,282	162	4,336	9,784	13.1	13.2	58.5	58.6
Michigan	133,562	106,283	81,806	24,057	702	3,509	6,232	13.6	13.6	60.7	60.4
Minnesota	65,958	57,491	50,965	4,034	1,161	3,260	3,298	13.8	13.9	62.8	61.8
Mississippi	42,694	22,668	22,134	19,417	226	383	449	15.4	15.6	67.0	66.3
Missouri	76,352	62,231	59,336	11,253	332	1,236	2,262	13.8	13.9	62.9	62.9
Montana	10,786	9,357	8,974	35	1,098	97	316	12.2	12.3	59.8	59.0
Nebraska	23,607	21,727	18,821	1,281	426	474	2,273	14.3	14.2	66.8	66.2
Nevada	29,357	24,075	16,573	2,923	438	1,722	8,287	16.2	16.4	76.3	77.2
New Hampshire	14,071	13,607	12,780	139	28	247	287	11.7	12.2	61.0	62.3
New Jersey	114,087	84,103	66,259	21,386	193	8,417	21,048	14.0	14.1	64.6	64.3
New Mexico	27,306	22,791	9,148	497	3,407	370	13,773	15.6	15.7	71.8	72.2
New York	268,412	186,129	126,312	53,798	896	17,789	53,269	14.2	14.2	64.3	63.9
North Carolina	113,800	81,332	71,662	28,440	1,578	2,448	9,819	14.9	14.9	67.8	68.6
North Dakota	7,637	6,742	6,493	66	730	78	121	12.1	12.4	57.3	58.3
Ohio	160,292	129,636	122,980	21,020	281	2,355	3,371	13.4	13.6	60.6	61.2
Oklahoma	48,064	36,926	34,178	4,849	4,807	870	3,915	14.8	14.9	69.8	69.9
Oregon	45,206	41,410	34,251	805	709	2,189	8,802	13.6	13.5	64.8	64.7
Pennsylvania	145,497	121,065	113,733	20,608	336	3,488	7,191	13.1	13.2	57.4	58.0
Rhode Island	12,356	10,796	7,400	837	149	444	1,858	12.9	12.7	57.1	57.5
South Carolina	54,884	34,947	33,333	19,103	166	734	1,721	14.2	14.6	62.2	61.5
South Dakota	10,523	8,569	8,504	80	1,564	101	170	14.4	13.9	67.7	66.1
Tennessee	77,839	59,988	57,607	18,537	142	1,162	2,434	14.2	14.0	63.5	63.1
Texas	348,774	297,150	140,456	36,883	805	8,934	166,207	17.3	17.3	77.1	76.2
Utah	49,289	44,033	38,645	270	818	1,367	6,428	21.7	21.8	99.1	91.4
Vermont	6,565	6,468	6,297	43	19	45	39	11.1	11.1	49.2	49.1
Virginia	85,839	58,198	52,097	22,498	183	4,958	6,528	13.8	13.8	68.7	69.1
Washington	79,003	68,227	55,137	3,383	1,891	9,121	10,950	13.8	14.0	62.1	62.3
West Virginia	20,784	18,828	18,710	762	19	174	86	11.6	11.5	54.8	53.7
Wisconsin	68,216	58,777	54,853	6,509	971	1,980	4,044	13.0	12.9	59.4	58.5
Wyoming	6,135	5,745	5,230	73	268	49	539	12.8	13.0	60.8	60.8
Puerto Rico	58,571	54,858	—	3,016	—	—	—	16.3	16.7	65.2	66.8
Virgin Islands	1,868	303	89	1,295	66	6	288	14.0	15.2	64.2	69.8
Guam	4,915	316	294	61	2	3,848	46	28.4	29.0	129.1	130.6
American Samoa	—	—	—	—	—	—	—	—	27.2	—	124.8
Northern Marianas	—	—	—	—	—	—	—	—	21.9	—	86.0

— Data not available.
[1] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[2] Includes births to Aleuts and Eskimos.
[3] Includes all persons of Hispanic origin of any race; see Technical notes.
[4] Excludes data for live territories.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further statistics, see Technical notes.

Table 5. Percent of live births to mothers under 20 years of age by race and Hispanic origin of mother: United States, each State and territory, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the States]

Area	All races [1]		White, total [2]		White, non-Hispanic		Black, total [2]		Hispanic [3]	
	1998	1999	1999	1998	1999	1998	1999	1998	1999	1998
United States [4]	12.2	12.6	10.9	11.1	9.2	9.4	20.6	21.6	16.7	16.9
Alabama	16.2	17.1	13.0	13.3	12.7	13.3	23.6	26.2	17.0	14.2
Alaska	11.5	11.2	8.5	8.8	8.6	8.7	17.4	13.5	11.1	12.0
Arizona	14.9	15.1	14.4	14.6	10.0	10.1	22.5	23.2	20.1	20.7
Arkansas	17.9	18.5	15.3	15.5	15.2	15.9	27.5	28.4	16.8	16.9
California	11.1	11.4	11.6	11.7	6.5	6.9	18.2	18.8	16.0	16.2
Colorado	11.8	12.1	11.8	11.7	8.1	8.2	19.5	20.5	20.5	21.4
Connecticut	8.0	8.5	7.0	7.0	4.2	4.1	16.0	17.5	21.1	21.6
Delaware	13.3	13.1	10.0	9.6	9.3	8.8	23.5	24.9	15.6	17.0
District of Columbia	14.8	16.3	2.6	5.7	*	1.5	19.7	19.3	13.4	12.6
Florida	12.8	13.2	10.8	10.9	10.1	10.4	20.0	21.5	12.7	12.5
Georgia	14.6	15.0	11.8	12.0	11.6	11.7	20.4	21.4	16.2	15.0
Hawaii	10.4	10.7	5.1	5.0	4.4	4.1	8.6	8.1	16.9	16.7
Idaho	13.2	12.8	12.1	12.7	11.0	11.7	*	*	19.8	20.3
Illinois	12.0	12.4	8.4	8.5	7.3	7.5	24.0	25.5	15.4	15.7
Indiana	13.2	13.6	12.0	12.5	11.7	12.3	24.0	25.6	16.5	16.2
Iowa	10.5	10.6	10.2	10.2	9.2	9.7	24.5	25.3	18.0	18.2
Kansas	12.6	12.6	11.9	11.7	11.0	10.8	25.1	25.3	18.8	18.8
Kentucky	15.0	16.4	14.4	14.9	14.3	14.7	22.6	24.6	16.6	12.5
Louisiana	17.8	18.6	12.0	12.9	12.7	12.9	26.0	26.5	10.8	12.4
Maine	9.7	9.8	9.7	9.7	9.3	9.5	*	*	15.6	*
Maryland	10.3	10.2	7.0	7.0	6.8	6.8	17.3	17.2	11.4	10.9
Massachusetts	8.0	7.2	6.3	6.8	4.5	4.9	13.0	14.0	19.7	20.5
Michigan	11.1	11.6	9.2	9.6	8.2	8.7	20.1	21.0	18.4	18.5
Minnesota	8.5	8.6	7.0	7.1	6.8	6.8	19.4	21.2	18.1	17.9
Mississippi	18.7	20.0	14.1	14.1	14.1	14.1	28.8	27.3	14.4	16.1
Missouri	13.5	13.8	11.9	12.1	11.7	12.0	23.1	23.9	16.0	16.8
Montana	11.7	12.3	10.2	10.7	9.9	10.4	*	*	17.3	21.4
Nebraska	10.6	10.6	9.4	9.7	8.8	8.7	26.6	23.0	16.8	16.9
Nevada	13.1	13.1	12.6	12.7	10.4	10.6	22.3	20.1	16.1	16.7
New Hampshire	7.1	7.7	7.2	7.7	6.9	7.4	*	*	14.9	16.4
New Jersey	7.3	7.7	5.6	5.7	3.2	3.2	16.3	16.1	14.3	14.6
New Mexico	17.9	18.2	16.9	16.2	11.3	11.7	21.4	24.0	22.5	23.0
New York	8.6	8.8	7.6	7.7	5.2	5.3	14.2	14.5	14.1	14.7
North Carolina	13.5	14.0	11.0	11.1	10.2	10.4	20.9	22.0	16.6	17.1
North Dakota	8.3	8.8	6.0	6.3	7.7	6.0	*	*	17.4	14.6
Ohio	12.6	13.0	11.0	11.1	10.8	10.9	23.4	24.4	18.3	19.8
Oklahoma	16.2	16.3	14.8	14.7	14.4	14.2	23.5	23.5	19.0	20.3
Oregon	12.0	12.5	12.3	12.4	11.2	11.5	20.8	21.4	17.5	17.3
Pennsylvania	10.3	10.3	8.4	8.6	7.5	7.5	22.1	22.3	23.3	24.1
Rhode Island	9.7	10.6	8.8	9.0	7.1	7.9	15.4	16.9	16.3	18.8
South Carolina	15.8	16.0	12.1	12.0	11.8	11.9	23.0	23.5	17.4	13.6
South Dakota	11.3	12.0	8.7	9.5	8.6	9.5	*	*	14.8	16.3
Tennessee	15.4	15.8	13.4	13.8	13.3	13.4	23.1	24.7	16.3	18.0
Texas	16.9	18.1	15.5	15.6	11.1	11.3	21.6	22.4	19.6	19.6
Utah	9.3	9.8	9.1	9.7	8.0	8.5	20.4	19.8	17.0	19.0
Vermont	8.5	7.9	8.5	7.9	8.4	7.7	*	*	*	*
Virginia	10.6	10.8	8.2	8.4	7.9	8.1	19.5	19.7	11.9	11.2
Washington	10.8	10.9	10.8	10.7	9.4	9.6	19.6	19.5	17.8	17.7
West Virginia	14.8	15.7	14.5	15.4	14.5	15.4	24.8	25.3	22.9	*
Wisconsin	10.7	10.5	8.4	8.1	7.7	7.4	28.0	28.3	19.2	19.4
Wyoming	13.5	14.2	13.5	15.5	13.2	15.0	*	*	19.4	24.0
Puerto Rico	19.9	20.5	19.8	20.3	—	—	20.9	22.9	—	—
Virgin Islands	16.3	17.8	16.6	19.9	*	*	16.5	17.6	19.1	25.2
Guam	14.5	14.2	6.8	8.2	7.3	*	*	*	*	*
American Samoa	—	7.5	—	*	—	—	—	*	—	—
Northern Marianas	—	11.1	—	*	—	—	—	*	—	—

* Figure does not meet standards of reliability or the state.
— Data not available.
† Includes races other than white and black.
[2] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical Notes.
[3] Includes all persons of Hispanic origin of any race; see Technical Notes.
[4] Excludes data for Louisiana.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical Notes.

Table 6. Percent of live births to unmarried mothers by race and Hispanic origin of mother: United States, each State and territory, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the States]

Area	All races [1]		White, total [2]		White, non-Hispanic		Black, total [2]		Hispanic [3]	
	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
United States [4]	33.0	32.8	26.7	26.5	22.0	21.9	68.9	68.1	42.1	41.8
Alabama	33.3	34.1	17.2	17.5	16.9	17.1	67.9	69.3	26.6	25.0
Alaska	33.1	31.1	23.0	21.8	22.7	21.3	46.9	39.7	31.5	28.6
Arizona	35.7	36.4	36.0	35.5	24.8	24.9	63.5	62.9	50.4	49.7
Arkansas	36.2	36.0	24.7	24.1	24.0	23.6	74.6	74.4	35.0	34.0
California	32.8	32.8	32.7	32.5	20.7	21.4	62.0	61.9	41.3	40.7
Colorado	26.4	25.5	24.1	24.1	18.4	18.5	64.5	64.5	39.8	39.8
Connecticut	26.9	31.2	24.2	26.0	18.8	19.4	68.8	69.7	62.6	64.1
Delaware	38.9	37.1	28.0	25.9	25.4	23.4	72.8	72.8	51.4	48.1
District of Columbia	61.7	62.9	14.2	23.3	5.2	5.2	77.2	78.0	64.9	69.7
Florida	37.8	36.8	29.0	27.9	26.1	25.7	67.1	67.1	37.3	34.7
Georgia	36.8	36.2	21.9	20.7	20.0	19.6	68.7	67.1	36.4	32.3
Hawaii	32.7	31.6	17.8	16.6	16.6	14.6	24.8	22.1	45.4	45.4
Idaho	21.6	22.0	21.1	21.3	19.7	19.8	41.6	40.2	31.3	32.1
Illinois	34.1	34.1	24.9	24.2	19.3	19.2	77.1	77.8	40.8	38.4
Indiana	34.6	33.8	29.5	28.4	28.6	27.7	77.0	77.2	46.4	42.2
Iowa	27.6	27.2	26.0	25.8	25.2	24.9	71.2	72.3	40.2	41.0
Kansas	28.9	27.8	25.4	24.4	23.7	22.7	68.1	69.0	39.6	39.7
Kentucky	30.3	30.1	26.1	26.1	26.0	26.0	73.0	71.5	31.8	28.8
Louisiana	44.8	44.8	26.1	26.4	24.9	24.2	73.8	74.2	30.7	31.9
Maine	31.3	30.5	31.1	30.3	30.5	30.1	49.1	49.6	35.0	32.8
Maryland	34.9	34.4	21.6	21.4	19.8	19.9	62.0	61.7	43.6	37.5
Massachusetts	28.0	28.1	23.1	22.9	18.7	18.9	59.3	58.4	61.3	60.0
Michigan	33.1	33.9	24.5	25.1	22.6	23.4	72.7	74.7	41.4	42.0
Minnesota	25.9	25.5	23.3	22.1	21.5	21.5	61.5	65.5	47.2	47.8
Mississippi	46.0	45.4	21.0	20.4	20.7	20.2	75.4	76.5	33.3	31.0
Missouri	34.1	34.1	28.7	28.5	28.2	28.1	76.5	77.0	39.6	37.8
Montana	29.7	28.9	24.3	26.1	23.8	24.4	*	60.0	36.8	39.6
Nebraska	28.5	28.2	32.7	23.1	23.5	21.1	69.8	68.9	40.8	39.3
Nevada	35.7	35.0	33.2	32.6	26.8	27.9	69.0	68.1	41.4	41.2
New Hampshire	24.2	24.1	24.3	24.0	23.6	23.5	37.4	44.8	40.9	37.0
New Jersey	28.2	28.3	21.1	20.6	12.8	12.8	64.0	65.6	60.6	49.0
New Mexico	46.0	44.0	41.3	40.0	26.8	25.7	63.3	60.8	51.2	50.2
New York	36.5	34.8	29.4	27.5	19.1	17.5	67.9	66.3	60.0	57.9
North Carolina	33.2	32.5	21.5	20.8	19.1	18.8	66.4	66.7	41.7	40.7
North Dakota	27.6	27.0	23.8	22.4	22.6	22.1	36.7	28.7	53.9	39.8
Ohio	34.0	34.0	27.4	26.8	25.9	25.2	76.1	76.7	47.7	46.1
Oklahoma	32.9	33.2	27.0	27.3	26.0	26.5	70.5	69.1	38.4	36.6
Oregon	30.4	29.7	29.0	28.8	26.0	27.2	63.0	65.4	38.8	36.3
Pennsylvania	32.9	32.8	25.6	25.7	23.6	23.8	77.7	77.6	61.8	61.1
Rhode Island	33.3	33.9	29.9	30.6	24.6	24.8	64.8	66.4	66.2	67.2
South Carolina	36.9	36.6	22.3	22.1	21.8	21.6	70.6	69.8	37.1	35.6
South Dakota	31.8	32.0	23.6	23.2	23.4	22.9	36.0	37.8	34.3	42.6
Tennessee	34.6	34.6	24.3	24.1	23.7	23.7	73.9	73.8	37.8	37.5
Texas	31.0	31.5	27.5	27.8	20.9	20.0	62.9	63.0	34.8	35.1
Utah	16.7	17.1	16.0	16.3	12.9	13.6	51.1	10.3	37.7	38.6
Vermont	29.8	26.9	28.8	27.9	28.7	27.9	66.0	*	*	*
Virginia	28.8	29.8	20.8	20.1	18.8	18.7	62.4	63.6	37.6	36.4
Washington	26.5	27.8	25.1	25.4	23.2	24.5	50.6	54.4	38.3	38.3
West Virginia	31.7	32.4	30.3	30.8	30.1	30.8	77.7	78.7	38.6	52.5
Wisconsin	28.2	28.5	23.2	22.4	21.8	21.0	83.8	82.1	43.6	44.9
Wyoming	29.1	29.4	27.2	27.9	26.5	26.5	64.1	60.0	40.2	42.8
Puerto Rico	47.9	47.0	46.6	45.7	—	—	61.4	62.7	—	—
Virgin Islands	67.1	69.8	51.3	57.4	26.3	42.1	73.4	74.3	66.8	69.8
Guam	55.9	54.2	20.2	19.3	18.9	18.2	40.5	*	*	*
American Samoa	—	34.2	—	*	—	—	—	*	—	—
Northern Marianas	—	46.5	—	*	—	—	—	*	—	—

* Figure does not meet standards of reliability or precision.
— Data not available.
1 Includes races other than white and black.
2 Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
3 Includes all persons of Hispanic origin of any race; see Technical notes.
4 Excludes data for the territories.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical notes.

Table 7. Percent low birthweight by race and Hispanic origin of mother: United States, each State and territory, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the states. Low birthweight is less than 2,500 grams]

Area	All races [1]		White, total [2]		White, non-Hispanic		Black, total [2]		Hispanic [3]	
	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
United States [4]	7.8	7.8	6.8	6.8	6.0	6.8	13.1	13.0	6.4	6.4
Alabama	9.3	9.3	7.8	7.3	7.3	7.4	13.8	13.3	6.6	5.9
Alaska	5.8	6.0	5.3	5.8	5.2	5.6	10.7	10.6	6.6	5.4
Arizona	7.0	6.8	6.7	6.6	6.5	6.6	12.3	12.2	7.0	6.8
Arkansas	8.8	8.9	7.4	7.5	7.5	7.6	13.0	13.0	5.8	6.8
California	6.1	6.2	5.8	5.7	5.8	5.8	11.6	11.6	6.5	6.5
Colorado	6.3	6.5	6.0	6.3	6.0	6.3	12.7	13.3	6.2	6.4
Connecticut	7.6	7.9	6.8	7.0	6.3	6.5	13.2	13.3	9.0	9.7
Delaware	8.6	8.4	6.9	6.2	6.8	6.1	13.7	14.6	6.2	7.7
District of Columbia	13.1	13.1	6.2	5.9	6.7	5.7	15.3	15.6	6.1	6.9
Florida	8.2	8.1	6.9	6.8	7.1	6.8	12.2	12.2	6.4	6.5
Georgia	8.7	8.5	6.7	6.4	6.6	6.6	12.7	12.7	5.8	5.3
Hawaii	7.6	7.5	6.6	6.2	6.2	6.2	9.6	10.7	7.9	7.7
Idaho	6.2	6.6	6.1	6.0	6.1	5.9	*	*	6.0	6.6
Illinois	8.0	8.0	6.6	6.4	6.5	6.6	14.2	14.2	6.4	6.3
Indiana	7.9	7.9	7.2	7.2	7.3	7.3	12.9	13.6	6.7	6.6
Iowa	6.2	6.4	5.9	6.3	5.9	6.2	12.7	12.9	5.6	6.1
Kansas	7.1	7.0	6.7	6.6	6.6	6.6	12.1	13.0	6.2	6.6
Kentucky	8.2	8.1	7.6	7.6	7.6	7.6	13.6	13.5	6.5	6.9
Louisiana	10.0	10.1	6.9	7.0	7.0	7.0	14.4	14.6	6.3	7.3
Maine	6.0	5.9	6.0	5.9	6.1	6.0	*	*	*	*
Maryland	9.0	8.7	6.7	6.4	6.7	6.4	13.6	13.9	7.2	6.1
Massachusetts	7.1	6.9	6.5	6.5	6.4	6.3	10.6	10.2	6.2	7.6
Michigan	8.1	7.9	6.6	6.4	6.5	6.5	14.7	13.5	6.5	6.6
Minnesota	6.1	6.5	5.6	5.4	5.7	5.6	11.0	11.0	6.0	5.7
Mississippi	10.3	10.1	7.4	7.2	7.4	7.3	13.5	13.7	6.3	*
Missouri	7.7	7.8	6.7	6.7	6.7	6.7	13.7	14.0	5.8	5.3
Montana	5.8	7.5	5.8	6.8	6.5	6.5	*	*	*	7.4
Nebraska	6.7	6.6	6.4	6.2	6.4	6.1	12.6	12.3	6.7	6.6
Nevada	7.6	7.8	7.1	6.8	7.5	7.3	12.2	13.3	6.1	6.8
New Hampshire	6.2	6.7	6.2	6.6	6.2	6.5	*	*	7.3	*
New Jersey	8.1	8.0	6.8	6.7	6.7	6.4	13.0	13.3	7.1	7.4
New Mexico	7.7	7.6	7.7	7.7	7.7	8.1	12.4	11.4	7.6	7.6
New York	7.6	7.8	6.7	6.7	6.6	6.3	11.7	11.9	7.5	7.8
North Carolina	8.9	9.5	7.2	7.0	7.3	7.1	13.7	13.9	6.4	6.2
North Dakota	6.2	6.5	6.2	6.5	6.3	6.6	*	*	*	*
Ohio	7.7	7.7	6.8	6.7	6.7	6.7	13.4	13.2	7.3	7.2
Oklahoma	7.4	7.2	7.1	6.8	7.2	6.9	11.6	12.6	6.0	6.0
Oregon	5.4	5.4	5.3	5.2	5.3	5.1	10.7	9.8	5.2	5.8
Pennsylvania	7.8	7.8	6.7	6.8	6.6	6.4	14.3	13.6	6.1	6.4
Rhode Island	7.3	7.2	6.8	7.1	6.7	6.8	11.1	11.4	7.1	7.8
South Carolina	9.8	9.5	7.2	7.1	7.5	7.1	14.7	14.9	6.5	5.8
South Dakota	5.9	6.5	6.0	5.7	5.9	5.7	*	*	*	*
Tennessee	9.2	9.1	7.8	7.8	7.8	7.8	14.1	14.3	6.8	6.8
Texas	7.3	7.4	6.8	6.7	6.6	6.7	13.6	12.5	6.6	6.7
Utah	6.8	6.7	6.7	6.8	6.7	6.8	13.2	14.6	6.7	7.2
Vermont	6.7	6.8	6.7	6.8	6.6	6.6	*	*	*	*
Virginia	7.8	7.9	6.4	6.4	6.5	6.4	11.9	12.7	6.9	6.6
Washington	6.8	6.7	6.6	6.4	6.4	6.3	10.3	10.1	6.3	6.7
West Virginia	8.0	8.0	7.9	7.8	7.8	7.9	12.9	13.4	*	*
Wisconsin	6.7	6.6	6.0	6.7	6.0	6.8	13.4	13.9	6.1	6.6
Wyoming	6.4	6.9	6.1	6.8	6.4	6.8	*	*	6.7	7.5
Puerto Rico	11.5	10.9	11.5	11.0	—	—	11.6	10.5	—	—
Virgin Islands	10.0	8.2	10.9	*	*	*	10.1	10.3	13.0	*
Guam	7.9	7.8	*	8.1	*	*	*	*	*	*
American Samoa	—	3.0	—	*	—	—	—	*	—	—
Northern Marianas	—	6.6	—	*	—	—	—	*	—	—

* Figure does not meet standards of reliability or precision.
— Data not available.
[1] Includes races other than white and black.
[2] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[3] Includes all persons of Hispanic origin of any race; see Technical notes.
[4] Excludes data for the territories.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical notes.

Table 5. Percent of live births by cesarean delivery by race and Hispanic origin of mother: United States, each State and territory, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the states]

Area	All races [1]		White, total [2]		White, non-Hispanic		Black, total [2]		Hispanic [3]	
	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
United States [4]	22.9	21.2	21.9	21.0	22.1	21.2	23.1	22.4	21.2	20.5
Alabama	24.6	24.0	25.4	24.7	25.6	24.8	23.6	22.9	25.4	20.7
Alaska	14.8	14.7	15.9	15.5	15.7	15.4	15.2	15.0	17.2	17.6
Arizona	17.8	17.0	17.8	17.2	18.2	18.3	19.6	20.1	18.2	15.8
Arkansas	25.4	24.6	24.9	24.7	25.3	25.0	27.8	26.1	19.2	20.6
California	22.7	21.7	22.8	21.6	23.5	22.5	25.8	24.8	21.9	20.9
Colorado	17.3	16.4	17.3	16.4	17.9	16.7	19.2	16.9	15.8	15.7
Connecticut	21.0	20.1	21.0	20.1	21.1	20.4	21.6	20.6	19.1	16.7
Delaware	23.0	23.2	23.2	22.7	23.6	23.3	22.6	24.8	20.9	18.2
District of Columbia	22.2	20.6	22.1	17.8	23.9	21.3	22.3	22.1	12.6	12.2
Florida	23.8	22.4	24.3	22.9	23.4	22.1	22.5	21.2	25.4	24.9
Georgia	21.7	20.8	21.8	20.7	22.2	21.3	22.4	21.6	16.7	15.1
Hawaii	17.5	15.6	18.7	16.8	18.6	16.4	17.4	16.7	15.9	17.1
Idaho	17.3	15.7	17.1	15.6	17.6	16.5	*	*	18.0	16.5
Illinois	20.1	19.4	20.1	19.4	20.9	20.3	20.2	19.5	17.8	16.8
Indiana	20.6	20.6	20.6	20.6	20.8	20.8	20.6	18.8	19.8	20.3
Iowa	19.6	19.6	20.0	19.7	20.0	19.7	19.8	19.9	19.6	19.6
Kansas	21.2	19.6	21.3	19.5	21.4	19.7	21.3	20.6	20.2	17.2
Kentucky	23.3	22.8	23.4	22.9	23.4	22.8	23.1	22.0	22.0	17.9
Louisiana	26.8	26.0	27.4	26.8	27.4	26.8	26.0	25.1	26.9	26.4
Maine	21.5	19.7	21.6	19.6	21.6	19.8	20.3	25.1	28.1	22.1
Maryland	23.2	21.3	22.8	20.7	22.8	21.0	24.7	22.5	19.7	17.9
Massachusetts	22.4	20.6	22.4	21.1	22.7	21.6	23.7	21.6	20.4	17.8
Michigan	21.0	20.6	21.1	20.6	21.4	20.7	20.4	20.9	16.5	19.5
Minnesota	18.9	18.0	19.4	18.4	19.6	18.8	18.6	17.2	17.6	17.4
Mississippi	27.3	27.0	28.1	27.9	28.5	28.0	26.4	26.0	20.6	24.9
Missouri	21.7	20.6	22.1	20.7	22.2	20.8	19.9	20.0	19.2	19.3
Montana	18.6	18.9	18.4	18.5	18.5	18.6	*	*	21.3	21.7
Nebraska	22.0	20.6	22.2	20.7	22.6	21.0	20.4	21.6	19.5	18.3
Nevada	21.8	21.4	21.3	20.6	22.6	22.1	26.6	25.7	19.2	18.6
New Hampshire	19.9	18.5	19.9	18.5	20.0	18.5	26.4	17.2	21.1	18.0
New Jersey	26.2	25.4	26.2	25.6	26.3	25.4	26.5	25.5	26.4	26.5
New Mexico	18.4	18.4	18.5	18.5	17.4	17.7	18.9	20.5	18.3	18.1
New York	23.8	22.9	23.6	22.9	24.3	23.5	24.3	23.5	22.7	22.0
North Carolina	22.7	21.5	23.5	21.3	22.9	21.8	23.0	22.3	18.1	18.5
North Dakota	19.5	19.4	19.6	19.2	19.8	19.8	*	25.0	18.2	30.3
Ohio	19.2	18.8	19.3	18.9	19.3	18.9	19.0	19.0	19.4	17.9
Oklahoma	24.2	22.8	24.1	22.8	24.5	22.8	24.6	24.2	21.5	20.2
Oregon	16.4	17.8	16.5	17.6	16.5	17.8	16.3	21.6	17.7	16.6
Pennsylvania	20.7	19.8	21.0	19.8	21.1	19.9	16.7	19.3	18.2	16.1
Rhode Island	20.8	19.5	20.9	19.9	21.3	21.3	20.9	18.4	20.5	18.7
South Carolina	24.2	23.4	24.3	23.5	24.6	23.8	24.1	23.4	18.8	19.4
South Dakota	22.3	21.5	22.5	21.5	22.7	21.5	*	29.8	19.1	27.0
Tennessee	24.0	22.6	24.2	22.9	24.3	22.7	23.8	23.0	20.4	18.3
Texas	23.6	23.5	23.6	23.3	24.8	24.1	26.5	26.1	22.5	22.7
Utah	16.0	16.0	16.0	15.9	15.7	15.9	20.4	23.5	17.7	16.4
Vermont	18.5	18.5	18.5	18.5	18.5	18.7	*	*	*	*
Virginia	21.7	21.2	21.9	20.8	21.8	21.1	22.0	22.5	19.3	17.9
Washington	18.6	17.9	18.7	17.7	18.8	17.8	22.4	22.7	17.7	17.2
West Virginia	24.7	24.1	24.6	24.1	24.8	24.1	27.3	23.3	25.5	21.5
Wisconsin	17.0	16.0	17.5	16.5	17.5	16.5	12.7	14.1	16.2	16.4
Wyoming	19.6	19.5	19.5	19.4	19.6	19.2	*	*	18.7	19.5
Puerto Rico	37.0	35.1	36.0	35.4	—	—	36.1	30.7	—	—
Virgin Islands	22.7	22.7	28.1	27.0	28.3	28.1	21.4	21.5	27.6	24.0
Guam	19.8	14.7	18.1	20.8	19.0	20.6	*	*	*	*
American Samoa	—	—	—	—	—	—	—	—	—	—
Northern Mariana	**	17.1	—	*	—	—	—	*	—	—

* Figure does not meet standards of reliability or precision.
— Data not available.
[1] Includes races other than white and black.
[2] Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race; see Technical notes.
[3] Includes all persons of Hispanic origin of any race; see Technical notes.
[4] Excludes data for the territories.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the rates and further discussion, see Technical notes.

Table 8. Percent of mothers receiving prenatal care in first trimester of pregnancy by race and Hispanic origin of mother: United States, each State and territory, final 1998 and preliminary 1999

[By place of residence. Data are based on a continuous file of records received from the States]

Area	All races [1]		White, total [2]		White, non-Hispanic		Black, total [2]		Hispanic [3]	
	1999	1998	1999	1998	1999	1998	1999	1998	1999	1998
United States [4]	83.2	82.9	85.1	84.8	88.4	87.9	74.0	73.3	74.8	74.3
Alabama	83.2	82.4	88.0	88.3	90.0	89.1	71.4	70.1	80.5	82.6
Alaska	79.3	81.4	82.2	83.5	82.2	85.7	83.6	82.3	78.8	81.3
Arizona	76.0	76.1	75.7	76.0	88.0	84.7	73.7	73.4	85.1	84.7
Arkansas	78.1	77.8	81.8	80.7	83.1	82.0	68.4	67.5	63.7	61.8
California	83.6	82.4	83.6	82.4	88.2	88.2	81.2	79.5	78.7	78.1
Colorado	81.7	82.2	82.0	82.7	86.4	87.9	75.4	75.6	88.0	89.5
Connecticut	89.3	88.0	90.5	89.3	93.0	91.3	81.2	79.0	78.1	75.2
Delaware	83.7	83.4	86.6	86.4	88.3	88.2	75.4	74.2	71.7	68.7
District of Columbia	74.0	72.0	87.4	84.8	90.9	91.0	88.9	86.9	84.2	89.5
Florida	83.9	83.6	87.1	85.9	88.1	88.8	79.6	72.5	81.3	81.9
Georgia	87.3	86.4	90.4	89.0	91.9	91.4	81.5	79.4	79.7	79.2
Hawaii	85.7	85.4	91.0	90.2	91.6	90.9	91.2	91.5	83.8	83.6
Idaho	80.5	78.7	80.7	78.1	82.9	81.7	74.7	80.1	84.8	81.5
Illinois	82.6	82.7	85.4	85.7	89.9	89.7	70.0	70.1	72.4	73.7
Indiana	80.0	79.9	81.7	81.9	82.8	82.8	66.1	65.9	83.8	84.7
Iowa	87.7	87.3	88.3	87.9	89.2	89.0	74.8	74.8	71.2	73.0
Kansas	85.8	85.8	86.7	86.7	89.2	89.2	77.0	78.1	88.1	88.1
Kentucky	86.0	86.4	87.5	87.3	87.8	87.5	78.4	76.5	71.7	73.8
Louisiana	82.8	82.2	89.7	89.4	89.9	89.5	73.2	72.1	86.8	86.3
Maine	89.2	88.8	89.5	89.1	89.7	89.3	83.0	85.0	86.2	77.9
Maryland	87.0	87.5	91.5	91.5	92.4	92.3	78.0	80.3	81.4	82.3
Massachusetts	89.4	89.5	90.9	90.9	92.2	92.3	78.8	80.1	79.0	79.2
Michigan	84.0	84.2	87.0	87.1	88.8	88.4	68.9	71.1	72.0	72.8
Minnesota	84.5	84.5	87.1	87.1	89.1	87.9	66.3	69.7	82.1	83.8
Mississippi	81.6	80.8	89.1	89.3	89.4	89.6	72.0	70.3	75.1	73.9
Missouri	87.1	88.1	89.1	89.3	89.6	89.8	78.3	74.6	77.6	77.7
Montana	83.9	82.3	85.8	84.5	86.1	84.9	65.7	77.3	76.0	76.6
Nebraska	84.4	83.9	85.4	84.9	87.3	86.9	73.7	71.0	88.9	88.8
Nevada	75.2	74.6	75.6	75.3	83.2	82.5	68.6	68.3	82.0	82.2
New Hampshire	90.7	89.7	91.0	90.8	91.4	90.0	72.9	76.9	80.1	78.4
New Jersey	81.7	81.8	85.5	85.6	89.6	89.8	66.0	65.1	70.3	71.0
New Mexico	86.8	87.8	88.0	89.1	73.6	76.1	82.5	80.8	84.4	84.8
New York	81.0	81.3	84.2	84.4	88.1	88.2	71.0	70.8	71.8	72.1
North Carolina	86.6	84.8	85.4	83.1	81.1	80.3	78.1	76.2	88.7	89.5
North Dakota	88.3	85.6	88.5	87.3	88.6	87.7	72.1	75.8	81.7	73.0
Ohio	86.5	86.5	88.2	87.8	88.5	87.9	79.1	79.3	77.7	77.4
Oklahoma	80.6	78.6	82.7	80.7	83.9	81.8	73.2	69.7	88.0	88.3
Oregon	80.8	80.2	81.2	80.4	83.8	82.8	76.1	79.4	86.6	87.2
Pennsylvania	85.1	84.8	87.5	87.3	89.4	89.2	71.1	70.8	74.1	72.4
Rhode Island	91.8	89.7	92.7	90.9	93.8	92.1	83.6	79.3	86.3	82.4
South Carolina	80.8	81.4	86.9	87.3	87.2	88.0	70.8	71.9	81.1	85.9
South Dakota	85.4	82.7	87.0	86.8	87.4	86.8	74.2	75.3	68.8	74.3
Tennessee	84.3	84.1	87.0	87.3	87.9	88.1	74.8	72.7	84.0	84.8
Texas	79.3	79.3	79.4	79.8	87.3	86.9	76.5	76.7	72.2	72.7
Utah	90.5	92.1	91.8	92.9	94.6	95.3	84.3	84.7	83.1	84.9
Vermont	88.0	87.4	88.0	87.8	89.9	87.6	81.5	*	82.8	85.3
Virginia	85.3	85.2	88.8	88.8	90.2	90.2	74.4	74.4	74.9	73.2
Washington	83.0	83.0	83.9	83.8	86.1	86.5	76.5	77.1	71.5	71.0
West Virginia	85.1	83.7	85.8	84.2	85.7	84.2	70.8	70.2	88.8	84.0
Wisconsin	84.1	84.3	86.6	87.0	87.7	88.0	68.1	67.6	70.8	71.9
Wyoming	83.0	81.3	83.4	82.2	84.3	83.4	78.6	87.3	74.8	70.2
Puerto Rico	77.9	78.6	78.7	79.4	—	—	88.5	70.6	—	—
Virgin Islands	58.5	58.3	63.8	60.5	73.7	79.6	58.1	58.6	57.4	55.0
Guam	62.1	53.0	87.2	86.0	90.8	85.8	76.5	61.8	70.3	63.7
American Samoa	—	—	—	—	—	—	—	—	—	—
Northern Marianas	—	26.3	—	*	—	—	—	*	—	—

* Figure does not meet standards of reliability or precision.
— Data not available.
1 Includes races other than white and black.
2 Race and Hispanic origin are reported separately on the birth certificate. Data for persons of Hispanic origin are included in the data for each race group according to the mother's reported race. See Technical Notes.
3 Includes all persons of Hispanic origin of any race. See Technical Notes.
4 Excludes data for the territories.

NOTE: Data are subject to sampling and/or random variation. For information on the relative standard errors of the data and further discussion, see Technical Notes.

Technical notes

Nature and sources of data

Preliminary data for 1999 are based on a substantial proportion of vital records for that year. The data for 1999 are based on a continuous receipt and processing of statistical records through May 10, 2000, by the National Center for Health Statistics (NCHS). NCHS receives the data from the States' vital registration systems through the Vital Statistics Cooperative Program. In this report, U.S. totals include only events occurring within the 50 States and the District of Columbia. Data for Puerto Rico, the Virgin Islands, and Guam are included in tables showing data by State, but are not included in U.S. totals. Tables by State generally show entries for American Samoa and the Northern Marianas, but preliminary data for these areas were not available by May 10, 2000, and are not presented in this report. Final data for 1998 for these areas are presented where available.

For 1999, individual records of births are weighted to independent counts of vital events occurring in each State. These State-specific counts serve as control totals and are the basis for the record weights in the preliminary file. If the number of records in the preliminary file is greater than the count received from the State, the State-specific number of records in the preliminary file is used instead and the weight is set at 1.0.

Each birth record has one weight specific to the State where the birth occurred. Table I shows the percent completeness of the preliminary file for each event by place of occurrence. The percent completeness is obtained by dividing the number of records in the preliminary file by the control total and multiplying by 100. Although data by place of occurrence are used to compute the weights, all data in this report are tabulated by place of residence.

For selected variables in the natality file, unknown or not-stated values are imputed. The percent not stated in the natality files was less than 1 percent for birthweight and method of delivery and 2.7 percent for month prenatal care began. Detailed information on reporting completeness and imputation procedures may be found in *Technical Appendix of the Vital Statistics of the United States: Natality* (7).

Race and Hispanic origin are reported separately on the birth certificate. Therefore, data shown by race include persons of Hispanic or non-Hispanic origin, and data for Hispanic origin include persons of any race. In this report, births of Hispanic origin are included in the totals for each race group—white, black, American Indian, and Asian or Pacific Islander—according to the mother's race as reported on the birth certificate. Data shown for Hispanic persons include all persons of Hispanic origin of any race. In 1999, approximately 97 percent of Hispanic-origin births were to white women. Data are shown separately for non-Hispanic white women because there are substantial differences in childbearing patterns between Hispanic and non-Hispanic white women. More than 1 in 5 white births were to Hispanic women in 1999.

From 1964 to 1996, mother's age was edited for ages 10–49 years: births reported to occur to mothers younger than age 10 or older than 49 years had age imputed according to the same race and total birth order (total of live births and total deaths). Beginning in 1997, age of mother is edited for ages 10–54 years. A review and verification of unedited birth data for 1985 showed that the vast majority of births reported as occurring to women aged 50 years and over were to women aged 50–54 years. The numbers of births to women aged 50–54 years

Table I. Total count of records and percent completeness of preliminary file of live births: United States, each State and territory, preliminary 1999

(By place of occurrence)

Area	Live births	
	Count of records	Percent completeness
United States[1]	3,884,473	97.5
Alabama	61,341	100.0
Alaska	9,848	100.0
Arizona	81,288	74.6
Arkansas	35,591	98.8
California	518,883	100.0
Colorado	62,382	100.0
Connecticut	43,401	94.0
Delaware	11,306	100.0
District of Columbia	14,660	100.0
Florida	197,155	100.0
Georgia	127,818	100.0
Hawaii	17,091	100.0
Idaho	18,414	100.0
Illinois	179,300	99.7
Indiana	86,351	99.6
Iowa	37,690	100.0
Kansas	38,244	100.0
Kentucky	52,850	97.6
Louisiana	67,824	99.8
Maine	13,303	100.0
Maryland	67,852	92.7
Massachusetts	81,839	100.0
Michigan	132,319	100.0
Minnesota	68,784	99.9
Mississippi	41,757	99.8
Missouri	77,300	99.9
Montana	10,761	98.7
Nebraska	24,210	100.0
Nevada	38,894	100.0
New Hampshire	13,718	100.0
New Jersey	111,048	90.4
New Mexico	26,886	100.0
New York	259,981	98.4
New York excluding New York City	136,224	97.0
New York City	123,757	100.0
North Carolina	114,894	100.0
North Dakota	8,879	100.0
Ohio	152,816	85.3
Oklahoma	47,936	97.5
Oregon	46,109	100.0
Pennsylvania	146,936	97.3
Rhode Island	13,223	97.7
South Carolina	62,646	99.9
South Dakota	10,573	100.0
Tennessee	83,002	100.0
Texas	360,593	98.0
Utah	47,266	100.0
Vermont	6,216	99.4
Virginia	92,303	99.9
Washington	79,075	100.0
West Virginia	21,389	100.0
Wisconsin	67,199	100.0
Wyoming	5,769	100.0
Puerto Rico	59,626	99.9
Virgin Islands	1,773	100.0
Guam	4,038	82.0
American Samoa	---	---
Northern Marianas	---	---

--- Data not available.
[1] Excludes data for Puerto Rico, Virgin Islands, Guam, American Samoa, and Northern Marianas.

NOTE: Percent completeness = $\frac{\text{Number of records in preliminary file}}{\text{Count of records}} \times 100$

are too small for computing age-specific birth rates and have been included with births to women aged 45–49 years for computing birth rates.

National estimates of births to unmarried women are based on two methods of determining marital status. For 1998 and 1999, birth certificates in 49 States and the District of Columbia included a direct question about mother's marital status; in Nevada the direct question is part of the electronic birth registration process but does not appear on certified or paper copies of the birth certificate. The question in most States is: "Mother married? (At birth, conception, or any time between) (Yes or no)."

Marital status is inferred in Michigan and New York (both New York City and the balance of the State). A birth is inferred as nonmarital if the father's name is missing from the birth certificate or if a paternity acknowledgment was filed.

Since June 1998, marital status has been reported in Connecticut based on a direct question on the birth certificate. Previously, marital status was inferred for Connecticut births on the basis of one of these factors: a paternity acknowledgment was filed, the father's name is missing, or the parent's and child's surnames were different. The impact of the change was to reduce the numbers and proportions of births to unmarried women in the State. During the first half of 1998, 33.4 percent of Connecticut births were nonmarital; during the second half, 29.1 percent were nonmarital. The inferential procedures evidently had resulted in overstatement of births to unmarried women because of the reliance on the comparison of the parent's and child's surnames. Many births were erroneously inferred as nonmarital because the surnames did not match or because the parents and/or child had a hyphenated surname. With the adoption of a direct question on marital status, data on nonmarital births for Connecticut are much more accurate since mid-1998 than in previous years.

The birth rate for unmarried women for 1999 is estimated on the basis of population distributions by marital status provided by the U.S. Bureau of the Census as of March 1999 (6) applied to the national population estimates as of July 1 (8) . The nonmarital birth rate shown here for 1999 thus differs from those published by NCHS in the annual final reports, which are based on populations estimated from 3-year averages of the marital status distributions, rather than a single year as shown here (1–4,9). Population estimates for a single year are not an adequate basis for computing age-specific birth rates for unmarried women—these rates are available only in the final reports.

Computing rates and percents

Rates are on an annual basis per 1,000 estimated population residing in the specified area as of July 1, 1999, and July 1, 1998, and are based on populations furnished by the U.S. Bureau of the Census (8,10). Rates by State are computed on the basis of populations on July 1, 1999, and July 1, 1998 (11,12).

For calculating birth rates, age and race of mother are imputed if they are not stated (0.02 percent and 0.2 percent, respectively, for 1999). In computing birth rates by live-birth order, births with live birth order not stated are distributed in proportion to stated data. Births with marital status not reported (0.1 percent for 1999) are included with births to married mothers. Percents were computed using only events for which the characteristic is reported. The "Not stated" category is subtracted from the total before the percent is computed for birthweight, prenatal care, and method of delivery. Birth rates for the Hispanic population are based only on events to persons reported as Hispanic. Rates for non-Hispanic white persons are based on the sum of all white events reported as non-Hispanic and white events with origin not stated. Hispanic origin is not imputed if it is not reported.

An asterisk indicates that the figure does not meet standards of reliability or precision. In this report, three sets of criteria determine whether a figure meets those standards.

- The State-specific sample is complete enough to provide reliable estimates. For example, a criterion of at least 75 percent of a State's records for the 12-month period is used as a basis for providing State-specific estimates (see table I).
- Reporting for any particular variable is at least 80 percent complete. In this report, no data were suppressed based on this criterion.
- A rate or percent is based on at least 20 births in the numerator or denominator.

Rates based on fewer than 20 births have a relative standard error (RSE) of about 23 percent or more and, therefore, are considered highly variable. However, some birth rates (based on data files that are less than 100-percent complete and based on 20–31 births) may have RSE's of 23 percent or more but are still shown instead of asterisks. As a result, caution should be exercised in analyzing rates based on 20–31 events. Additional information on random variation in numbers of events, rates, ratios, and percents may be found in "Reliability of estimates."

Reliability of estimates

Because the preliminary estimates of births in this report are based on files that may not be complete, they are subject to sampling variability. The notion of the sample is reflected in the record weights that are used to adjust record counts to independent control totals. The lack of completeness of the vital statistics files is due to delays in receiving and processing the live birth records.

In addition, the natality file is subject to nonsampling errors or biases. Records that were delayed and were not included in this report are assumed to have the same characteristics as the records that were included in this report. Seasonal bias may occur because file completeness is greater during the early part than during the later part of the 12-month period for which the data are processed and tabulated.

Even if the number of vital events in this report were 100 percent complete and not subject to sampling variability, it might be affected by random variation. Thus, when the number of events is small and the probability of such an event is small, considerable caution must be observed in interpreting the data. Such infrequent events may be assumed to follow a Poisson probability distribution. The first column of table II shows the estimated RSE's of a file that is nearly 100 percent complete. The estimated RSE's of the 1998 final data, the preliminary 1999 control totals, and the preliminary 1999 data (based on nearly 100 percent of a file) are shown in the first column of table II.

Data based on a sample, that is, where the file is less than 100 percent complete, are affected by sampling variation as well as by random variation. The estimated RSE's in columns 2–6 of table II for various levels of file completeness are measures of the sampling errors and the random errors of the estimates. The estimated RSE's in table II were computed using this formula:

Table II. Relative standard errors for preliminary number of live births by percent of file completeness

[Relative standard errors are expressed as a percent of the estimate]

Estimated number of live births	Percent of file completeness					
	100	95	90	80	70	60
	Relative standard error (percent)					
1	100.0	102.6	105.4	111.8	119.5	129.1
5	44.7	46.0	47.1	50.0	53.5	57.7
10	31.6	32.4	33.3	35.4	37.8	40.8
20	22.4	22.9	23.6	25.0	26.7	28.9
30	18.3	18.7	19.2	20.4	21.8	23.6
40	15.8	16.2	16.7	17.7	18.9	20.4
50	14.1	14.5	14.9	15.8	16.9	18.3
60	12.9	13.2	13.6	14.4	15.4	16.7
70	12.0	12.3	12.6	13.4	14.3	15.4
80	11.2	11.5	11.8	12.5	13.4	14.4
90	10.6	10.8	11.1	11.8	12.6	13.6
100	10.0	10.3	10.5	11.2	12.0	12.9
200	7.1	7.3	7.5	7.9	8.5	9.1
300	5.8	5.9	6.1	6.5	6.9	7.5
400	5.0	5.1	5.3	5.6	6.0	6.5
500	4.5	4.6	4.7	5.0	5.3	5.8
600	4.1	4.2	4.3	4.6	4.8	5.3
700	3.8	3.9	4.0	4.2	4.5	4.8
800	3.6	3.6	3.7	4.0	4.2	4.6
900	3.3	3.4	3.5	3.7	4.0	4.3
1,000	3.2	3.2	3.3	3.5	3.8	4.1
2,000	2.2	2.3	2.4	2.5	2.7	2.9
5,000	1.4	1.5	1.5	1.6	1.7	1.8
10,000	1.0	1.0	1.1	1.1	1.2	1.3
20,000	0.7	0.7	0.7	0.8	0.8	0.9
50,000	0.4	0.5	0.5	0.5	0.5	0.5
100,000	0.3	0.3	0.3	0.4	0.4	0.4
200,000	0.2	0.2	0.2	0.2	0.3	0.3
500,000	0.1	0.1	0.1	0.2	0.2	0.2
1,000,000	0.1	0.1	0.1	0.1	0.1	0.1
2,000,000	0.1	0.1	0.1	0.1	0.1	0.1
4,000,000	0.1	0.1	0.1	0.1	0.1	0.1

$$RSE = 100 \sqrt{\frac{1}{X} + \frac{(1-f)}{fX\left(N - \frac{1}{f}\right)}}$$

where

- f = the sampling fraction or the percent of file completeness/100 from table I.
- X = the estimated number of live births.
- N = the total count of live births for the United States or any State. (The RSE's shown in table II are based on N = 4,000,000. If N is smaller, the RSE's may be slightly smaller than those shown.)

RSE's may be used to compute 95-percent confidence intervals for the number of events (X), for a rate (R), or for a percent (P) and to compute statistical tests concerning the equality of two rates (R_1 and R_2) or two percents (P_1 and P_2).

For the number of live births, the 95-percent confidence interval may be computed as follows:

$$\text{Lower limit: } X_1 - 1.96 * X_1 * \frac{RSE(X_1)}{100}$$

$$\text{Upper limit: } X_1 + 1.96 * X_1 * \frac{RSE(X_1)}{100}$$

As a hypothetical example, assume the number of births, X_1, is 70 from a file with 80-percent completeness. Then

$$\text{Lower limit: } 70 - 1.96 * 70 * \frac{13.4}{100} = 51.6$$

$$\text{Upper limit: } 70 + 1.96 * 70 * \frac{13.4}{100} = 88.4$$

This means that the chances are 95 times out of 100 that the confidence interval (51.6–88.4) will cover the "true" number of births.

For rates based on population estimates in the denominator, the 95-percent confidence interval may be computed as follows:

$$\text{Lower limit: } R_1 - 1.96 * R_1 * \frac{RSE(R_1)}{100}$$

$$\text{Upper limit: } R_1 + 1.96 * R_1 * \frac{RSE(R_1)}{100}$$

As a hypothetical example, assume the birth rate, R_1, is 20.0, which is based on 70 births from a file with 80-percent completeness.

$$\text{Lower limit: } 20.0 - 1.96 * 20.0 * \frac{13.4}{100} = 14.7$$

$$\text{Upper limit: } 20.0 + 1.96 * 20.0 * \frac{13.4}{100} = 25.3$$

This means that the chances are 95 times out of 100 that the confidence interval (14.7–25.3) will cover the "true" rate.

For testing the equality of two rates, R_1 and R_2, the following z-test may be used to define a significance test statistic:

$$z = \frac{R_1 - R_2}{\sqrt{R_1^2\left[\frac{RSE(R_1)}{100}\right]^2 + R_2^2\left[\frac{RSE(R_2)}{100}\right]^2}}$$

The two-tailed 0.05 critical value for a z statistic is 1.96. Therefore, if $|z| \geq 1.96$, the difference is significant at the 0.05 level. If $|z| < 1.96$, then the difference would be considered not statistically significant at the 0.05 level.

As a hypothetical example, assume R_1 is the same as the above example for the current 12-month period and that R_2, 15.0, is based on 50 births occurring in the prior 12-month period (which implies that the file is approximately 100 percent complete for R_2). The z-test may be determined as follows:

$$z = \frac{20.0 - 15.0}{\sqrt{(20.0)^2\left[\frac{13.4}{100}\right]^2 + (15.0)^2\left[\frac{14.1}{100}\right]^2}} = 1.46$$

Because $|z| < 1.96$, there is not a statistically significant difference between the two rates at the 0.05 level of significance.

Contents

Acknowledgments

This report was prepared in the Division of Vital Statistics under the general direction of Mary Anne Freedman, Director, Division of Vital Statistics; Stephanie J. Ventura, Acting Chief, Reproductive Statistics Branch (RSB); and Nahoson F. Pace, Chief, Systems, Programming, and Statistical Resources Branch (SPSRB). Joyce Arbouine, Thomas D. Dunn, David Johnson, Gail Purr, Margit Sharma, and Steven Sinlash of SPSRB provided computer programming support and statistical tables. Melissa M. Park of RSB provided content review. Staff of the Data Acquisition and Evaluation Branch carried out quality evaluation and acceptance procedures for the State data on which this report is based, and were responsible for receipt and processing of the basic data files. This report was edited by Demetrius V. Miller, typeset by Jacqueline M. Davis, and graphics were produced by Jamila Ogburn of the Publications Branch, Division of Data Services.

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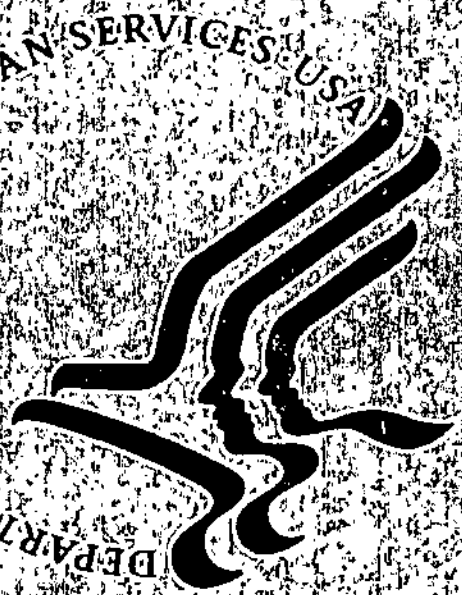
A National Strategy to Prevent Teen Pregnancy

ANNUAL REPORT *1999-2000*



U.S. Department of Health and Human Services

2000

Introduction

In this 1999-2000 Annual Report, after three years of a National Strategy to Prevent Teen Pregnancy, the U.S. Department of Health and Human Services (HHS) is pleased to report that teen pregnancy and birth rates in this country have declined to record low levels. Trends throughout the 1990s have shown a steady reduction in teen birth rates that is now significant for all 50 states. Rates have declined for all adolescent age groups, for all racial and ethnic groups, and for both first and second births to teens. Clearly we are reaping the benefits of this Administration's strong commitment to our National Strategy and renewed efforts by states, localities, private organizations, parents, and youth.

Although we have come far, we have a considerable distance still to go. U.S. teen pregnancy rates remain among the highest in the industrialized world, and birth rates for Hispanic and black teens continue to be substantially higher than those for non-Hispanic white and Asian or Pacific Island youth. We must remain steadfast in our intention to reduce teen pregnancy.

Yet, while we must not underestimate the need to continue our prevention efforts, the facts are enormously promising. For example:

- **Earlier Trends Reversed.** By the end of 1999, a record low U.S. birth rate for teens aged 15-17 reversed the 27 percent increase in teen birth rates recorded in the 1980s.
- **Lowest Rate in Three Decades for Youngest Teens.** The youngest group, aged 10-14, showed the lowest birth rates since 1967, as well as a sharp decline in number of births. The latter decline occurred despite the fact that the population of girls in this age group actually increased during this time period.
- **Black Teens Show Greatest Reductions.** Throughout the 1990s, black teens have had the largest declines in teen childbearing rates of any group.

The Department issued the National Strategy to Prevent Teen Pregnancy in January 1997, in response to a call from the President and Congress to develop a comprehensive strategy to address the problem of adolescent pregnancy. The request was to demonstrate a cohesive approach to the challenges of teen pregnancy prevention, in general, and specifically, to provide assurance that at least 25 percent of communities in the United States have teen pregnancy prevention programs in operation. The latter requirement is mandated by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

The Strategy relies on some basic principles of teen pregnancy prevention, listed below, and on the support and integration of pregnancy prevention efforts with other positive youth development activities in local communities.

Trends in Teen Births and Pregnancies

At the end of the third year of our National Strategy to Prevent Teen Pregnancy, the news continues to be good - and getting better: Teen birth rates are still steadily declining, according to the latest data compiled from the Department's National Center for Health Statistics (NCHS). These declines cut across ages (both younger and older adolescents), states, races and ethnic groups; moreover, fewer teenagers are having second children.

Last year's report provided analyses through 1998 based on preliminary birth data.[1] This year we are happy to report that the preliminary results were validated with publication of the final data file for 1998, suggesting that the decade of the 1990s has been one of real success in reducing teen birth rates.[2] Moreover, rates continued to decline in 1999 based on preliminary data.[3] Our nation continues to move toward improving prevention efforts for this most vulnerable population.

Trends and variations in teen birth rates are based on information reported on the birth certificates of all babies born in the United States, provided to the National Center for Health Statistics (NCHS) by the state health departments through the Vital Statistics Cooperative Program. NCHS and the states share costs for collecting and processing the data. The most recent analyses were based on more than 97 percent of all U.S. births through 1999. More information on the collection and reporting of teen birth data is presented in Appendix I.

Teen Birth Rates Continue to Fall. Both national and state-level teen birth rates have fallen steadily since 1991. For teenagers aged 15-19, the birth rate dropped 20 percent, from 62.1 births per 1,000 in 1991 to 49.6 in 1999, a record low. As of 1997, 49 states had declines that were statistically significant (Rhode Island's decline was the exception), as noted in last year's Report to Congress. However, this year we are happy to report that through 1998, all 50 states had reductions in their teen birth rates that were statistically significant.[2]

The 1990s: A Decade of Declining Teen Birth Rates. The NCHS figures show that from 1991 through the end of 1998, teen birth rates dropped 20 percent or more in 13 states, as well as in the District of Columbia and the Virgin Islands. In five of these states, teen birth rates declined by more than 25 percent.

Record Lows Reverse Earlier Trends. A U.S. record low birth rate for younger teens (aged 15-17) by the end of 1999 essentially reversed the 27 percent increase in teen birth rates that occurred in the late 1980s.[2-5] Birth rates fell more for younger than for older teenagers. Rates differ substantially by age: in 1999, the rate for older teens (aged 18-19) was 80.2 per 1,000 women, more than two-and-a-half times the rate of 28.7 per 1,000 for the younger teens. The U.S. birth rate for teenagers aged 15-19 declined 3 percent from 1998 (when the rate was 51.1

percent in the 1990s. Because these second teen births are associated with the most adverse outcomes for the mothers and their children, this finding is particularly encouraging.

First Births to Teens Falling Since 1994. About four-fifths of births to teenagers are first births, accounting for 78 percent of teen births in 1998. After little change in the first-birth rate for childless teens from 1991 to 1994 (when the rate hovered around 50 per 1,000), this rate then declined 13 percent between 1994 and 1998 (to 43 per 1,000).

Declining Teen Pregnancy Rates. The estimated teen *pregnancy* rate (as differentiated from the *birth* rate, reported above) for 1996 is 99 pregnancies per 1,000 women aged 15-19, down 15 percent since 1991 (116) and the lowest level recorded since Federal data collection begin in 1976.[6] The decline in the 1990's reverses the 11-percent rise from 1986 to 1991. (The most recent year for which *pregnancy* rates are available is 1996.) Between 1991 and 1996, *pregnancy* rates fell 15 and 12 percent, respectively, for teenagers 15-17 and 18-19 years. Rates have fallen for non-Hispanic white, non-Hispanic black, and Hispanic teenagers.[6]

[1] Martin JA, Smith BL, Mathews TJ, Ventura SJ. Births and Deaths: Preliminary Data for 1998. *National Vital Statistics Reports*; Vol. 47, No. 25. Hyattsville, Maryland: National Center for Health Statistics. 1999.

[2] Ventura SJ, Martin JA, Curtin SC, Mathews TJ, Park MM. Births: Final Data for 1998. *National Vital Statistics Reports*; Vol. 48, No. 3. Hyattsville, Maryland: National Center for Health Statistics. 2000.

[3] Curtin SC, Martin JA., Births: Preliminary Data for 1999. (National Vital Statistics Reports), Vol. 48, No. 14. Hyattsville, Maryland: National Center for Health Statistics, 2000.

[4] Ventura SJ, Mathews TJ, Curtin SC. Declines in Teenage Birth Rates, 1991-97: National and State Patterns. *National Vital Statistics Reports*, Vol. 47, No. 12. Hyattsville, Maryland: National Center for Health Statistics. 1998.

[5] Ventura SJ, Curtin SC, Mathews TJ. Variations in Teenage Birth Rates, 1991-98: National and State Trends. *National Vital Statistics Reports*, Vol. 48, No. 6. Hyattsville, Maryland: National Center for Health Statistics. 2000.

[6] Ventura SJ, Mosher WD, Curtin SC, Abma JC, Henshaw S. Trends in Pregnancies and Pregnancy Rates by Outcome: Estimates for the United States, 1976-96. Vital and Health Statistics; Series 21, No. 56. Hyattsville, Maryland: National Center for Health Statistics. 2000.

Building Partnerships

Partnership building is gaining momentum across the country, as local communities work together toward building more sustainable supports for children, youth and families. From the start, partnership building has been a cornerstone of the Department's National Strategy to Prevent Teen Pregnancy. Out of these coalitions and collaborations, prevention efforts can be created with the resources and contribution of all key stakeholders in a community. Because research tells us that youth reared in the most supportive, nurturing environments are least likely to engage in behavior that leads to teen pregnancy, this building of sustainable partnerships for youth development is key to reducing the teen birth rate.

HHS partnerships involve national, state, and local organizations; schools; health and social service organizations; community-based organizations; business; religious institutions; tribes and tribal organizations; federal, state, and local governments; parents and other family members; and teens themselves. At HHS, we recognize that building these partnerships is not a simple task, that it takes considerable time, energy, effort, and commitment. Continuing energy and commitment are necessary to sustain these partnerships over time. The payoff in the integration of services, pooling of resources, and the building of community is significant, given the considerable challenges that must be addressed -- some common and some unique to each community. Barriers to collaboration include differences in racial, ethnic, linguistic, religious, class and/or educational backgrounds. Collaboration can best be accomplished when partners are able to align on a common goal.

The following highlight and update HHS' efforts to build and strengthen partnerships in communities across the country this past year.

Get Organized: A Guide to Preventing Teen Pregnancy. This three-volume guide for states and communities to use in their fight against teen pregnancy was developed in partnership with the National Campaign to Prevent Teen Pregnancy -- a private nonprofit, nonpartisan organization formed in response to the President's 1995 State of the Union challenge to parents and leaders across the country to come together in a national effort to reduce teen pregnancy. In October 1999, HHS Secretary Donna Shalala and Campaign President Isabel Sawhill announced the release of this comprehensive guide. The Secretary noted that although the teen pregnancy rate is declining, four out of 10 girls become pregnant before they are 20 years old, with some girls having multiple births during their teen years. She emphasized the critical importance of promoting prevention and providing guidance to young people.

"Get Organized" stresses a long-term, localized approach to teen pregnancy prevention, with careful evaluation plans built into prevention efforts. Chapters in the Guide cover: "Promising Approaches", "Involving Teen Boys and Young Men", "Involving Parents", "Involving the Faith Community", "Involving Health Care Professionals", and "Involving the Business Community." Other chapters address issues that often challenge community leaders in their efforts to prevent teen pregnancy such as: how to conduct a community needs assessment, how to raise funds for prevention programs, how to create an effective teen pregnancy prevention message, and how to move forward in the face of conflict.

minutes at the site. Another component of this effort is "Girl Neighborhood Power! Building Bright Futures for Success," described in the "Supporting Promising Approaches" chapter of this document.

Joint Work Group on School-Based Teen Pregnancy Prevention. The Centers for Disease Control and Prevention's Division of Adolescent and School Health supports nine national associations in their work helping state and local education staff, health policy makers; school administrators, maternal and child health professionals, school health professionals, and other school personnel prevent teen pregnancies. The nine national, non-governmental organizations are the American Association of Maternal and Child Health Programs, American School Health Association, American Association of School Administrators,* Association of State and Territorial Health Officials, Council of Chief State School Officers, National Association of State Boards of Education, National Conference of State Legislatures, National Education Association, and the National School Boards Association.

After two years of gathering information about the needs of their respective groups, Joint Work Group members are coordinating efforts to motivate and assist these groups in developing and implementing school-based teen pregnancy prevention policies and programs. This year, the Joint Work Group will provide on-site, customized technical assistance for three competitively selected states that convene teams composed of state and local education and health policymakers, administrators, and other school personnel. Technical assistance will include development, implementation, or expansion of state action plans to build team members' capacity to address school-based teen pregnancy prevention policies and programs, and to develop partnerships with local communities. Technical assistance activities include support for:

- Funding and resources for teen pregnancy prevention.
- Partnerships among schools, communities and families.
- Collaboration between state and local organizations.
- Schools, youth development, and teen pregnancy prevention.
- Evaluating the impact of teen pregnancy on academic achievement.
- Developing social marketing strategies.
- Evaluating teen pregnancy prevention programs and policies.

Note: * The American Association of School Administrators was previously funded by CDC; however, this organization no longer receives funding.

In the year following technical assistance training, the Joint Work Group will compile reports to be shared with state team leaders and will communicate with state leaders to discuss progress and identify additional needs. Technical assistance activities will be expanded to additional states in subsequent years.

The Centers for Disease Control and Prevention (CDC) Community Coalition Partnership Programs for the Prevention of Teen Pregnancy. With support from and in partnership with CDC, 13 communities with high rates of teen pregnancy are working to reduce these rates. The 13 demonstration projects began in 1995. Currently in the second phase, these coalitions of local

Supporting Promising Approaches

HHS has continued to ensure that at least 25 percent of communities have teen pregnancy prevention programs in place -- as mandated by section 905 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996.

In FY 1999, at least 35 percent of communities had teen pregnancy prevention programs in place. This is a conservative estimate because it represents only HHS funded programs that flow directly to communities. HHS also supports other teen pregnancy prevention efforts through its various state block grant programs. For example, two of the purposes of Temporary Assistance for Needy Families (TANF; which replaced Aid to Families with Dependent Children, AFDC) are to prevent out-of-wedlock pregnancies and to encourage the formation and maintenance of two-parent families. In support of these goals, states may use TANF funds for a wide variety of teen pregnancy prevention programs, serving both welfare recipients and the general population. In addition, there are numerous activities supported by funding sources outside of HHS.

Abstinence Education

Abstinence education is funded by the Department through two programs. In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) created a program entitled the Abstinence Education Grant Program, funded under Section 510 of Title V of the Social Security Act. The grants funded under this program must meet specific criteria defined in the legislation. In addition, the Department has been funding abstinence education through its Adolescent Family Life Program (AFL) since 1981.

Abstinence Education Grant Program. The HHS Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB) is responsible for the administration of the Abstinence Education Grant Program (Section 510 of Title V of the Social Security Act). The law provides for a mandatory annual appropriation of $50 million for each fiscal year (FY), 1998 through 2002. Annual submission of a State application and an annual report are required prior to allocation of funds. Fifty-three States and Territories received Abstinence Education Grant funding in Year 1 of the program (FY 1998), and fifty-two States and Territories received funding in Year 2 (FY 1999). (California, subsequently decided to return both FY 1998 and FY 1999 Abstinence Education Grant funding.) Fifty-three States and Territories received FY 2000 Abstinence Education Grant funding. The final annual reports for the FY 1999 Abstinence Education Grants and the Year 4 (FY 2001) applications were to have been submitted to MCHB by mid-July 2000.

In April 2000, MCHB completed an annual program summary for FY 1999. Key findings reported by States and Territories are summarized below.

- Most frequently funded activities were: community-based projects (44 States/Territories); program evaluations (40); technical assistance and training (37); program monitoring (37); state media campaigns (31); and advisory councils/steering committees (25).

Community Coalition Partnership Program for the Prevention of Teen Pregnancy. Since 1995, the Centers for Disease Control and Prevention (CDC) has supported demonstration projects in 13 communities with high rates of teen pregnancy (Boston, Chicago, Jacksonville, Kansas City, Milwaukee, Oklahoma City, Orlando, Philadelphia, Pittsburgh, Rochester, San Antonio, San Bernardino, and Yakima, WA).

Eleven of these communities are actively working with Latino and other minority youth and neighborhoods, as part of their overall plan to prevent teen pregnancy. Phase II of the demonstration began in 1997 and continues for five years. In this phase, coalitions of local public and private agencies and organizations, leaders, and residents are working to implement their action plans, field test promising interventions, build toward financial and programmatic sustainability of their programs, conduct site-specific evaluations, and participate in cross-site evaluations.

Each of the 13 demonstration communities have continued their efforts to develop and strengthen, neighborhood coalitions. They continue to mobilize and organize community resources in support of comprehensive, effective and sustainable programs for the prevention of initial and repeat teen pregnancies. The communities are pursuing a wide variety of strategies to provide health, education, employment, recreation and other youth development services, programs and opportunities for youth and their families.

Girl Neighborhood Power! Building Bright Futures for Success (GNP). This five-year national demonstration program, forms part of the Department's *Girl Power!* effort (see "The Girl Power! Campaign" in the "Building Partnerships" chapter of this document). Administered by the Maternal and Child Health Bureau, Health Resources and Services Administration, the program began in October 1997 and is funded through a cooperative agreement among several agencies within the Department. Girl Neighborhood Power! major goals are: (1) promoting the health and well-being of girls between the ages of nine and fourteen years; (2) preventing the onset of health risk behaviors among girls during their adolescence; (3) encouraging connectedness between girls and the communities in which they live and supporting the growth of the girls' citizenship; (4) developing leadership skills in girls; and (5) fostering communities' and neighborhoods' investments in their youth. Four community partners and one national leadership consortium are funded through this initiative: Crispus Attucks Association, York, Pennsylvania; Girls Incorporated, Memphis, Tennessee; the City of Madison, Wisconsin; Youth and Family Services, Incorporated, Rapid City, South Dakota; and the national leadership consortium, housed at Healthy Mothers, Healthy Babies Coalition, Incorporated, Alexandria, Virginia. Community organizations are required to serve a minimum of four low-income neighborhoods, to demonstrate local commitment through a broad-based coalition of community agencies and parents, and to provide creative programming for the positive development of participating girls. Program elements must include: community service; journal-keeping; before and after school activities; career development; health education, and mentoring. Prevention of teen pregnancy and substance abuse are goals for all four projects. Each grantee receives $200,000 in Federal support, and is expected to match this amount by an additional 25 percent each year beginning in Project Year II.

Youth Development

In recent years, recognition has grown of the critical importance of primary and secondary prevention of youth risk behavior, through youth development approaches targeting all youth, and particularly high-risk youth.

existing youth development and adult mentoring programs as incentives to draw young men into reproductive health and family planning education activities, the mix of program types has now become more comprehensive. In addition to the community based models, a number of projects are based on a clinical model that provides comprehensive health care services, including reproductive health and family planning on site, and many are school based (using established curricula such as **Wise Guys**), on site, and offer referrals for reproductive health and family planning services and specialized counseling.

Promoting Male Involvement in Pregnancy Prevention: Federal, State and Local Strategies. The Department has sponsored several meetings to identify innovative male involvement strategies that might be shared with a larger audience. Specific strategies designed to inform and collaborate with stakeholders and other community based partners include creative use of the media and social marketing, regional and state forums and summits, peer-to-peer networking opportunities, and technical assistance. The goal is to promote and support a view of boys and men as responsible members of families.

Welfare Reform

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 created the Temporary Assistance for Needy Families (TANF), replacing the former Aid to Families with Dependent Children (AFDC). Two of the primary goals of TANF are preventing out-of-wedlock pregnancies and encouraging the formation and maintenance of two-parent families; consequently, TANF funds may be used to support teen pregnancy prevention efforts. TANF also requires unmarried minor parents to stay in school and live at home, or in an adult-supervised setting in order to receive assistance. The law supports the creation of Second Chance Homes, which provide teen parents with skills to become good role models and providers of their children, giving them guidance in parenting and in avoiding repeat pregnancies. The Administration's FY 2001 budget includes $25 million to Second Chance Homes. In addition, HHS' other programs are working together to look at welfare reform in the context of their programmatic activities.

Bonus to Reward Decrease in Illegitimacy Ratio. Welfare reform included an incentive for states to reduce the incidence of out-of-wedlock childbearing and encourage the development of new approaches to pregnancy prevention. Awards for the first year of the Bonus to Reward Decrease in Illegitimacy Ratio were announced in September 1999. Alabama, the District of Columbia, California, Massachusetts and Michigan all received awards of $20 million each. The decrease in the ratio of out-of-wedlock to total births ranged from 5.7 percent in California to 1.5 percent in Massachusetts. This provision is targeted toward all women, not just teenage mothers; however, in measuring state decreases in out-of-wedlock births, this measure would also include births among unmarried teens. Consistent with the purpose of TANF, the funds can be used to support a wide variety of programs extending beyond needy families.

Guide to States: Helping Families Achieve Self-Sufficiency. The Administration for Children and Families has developed a guide for states entitled Helping Families Achieve Self-Sufficiency. This guide offers suggestions on how best to use TANF funds for services to children and families (including teen pregnancy prevention efforts). The guide can be found at: **http://www.acf.dhhs.gov/programs/ofa/funds2.htm**

Research and Evaluation Activities

The Department continues to support research and evaluation related to the prevention of teen pregnancy. This commitment includes investment in the creation and maintenance of data sets, long-term research to follow trends in important areas, and the design and evaluation of preventive interventions.

The data sets used to conduct research in the area of teen pregnancy are vital to the Department's mission to prevent teen pregnancy. The Department continues to invest resources to gather and maintain high-quality, comprehensive data. These data serve as a critical foundation for the information we now have with regard to teen pregnancy, and for the information we will need in the future. A brief description of each data set is included in Appendix IV.

The Department also continues to fund Sociometrics, a small business, to archive data sets and make them available for other researchers to use for specific purposes. In addition, Sociometrics maintains a collection of teen pregnancy prevention programs that are in a "ready to use" format, including teachers' guides, student information and evaluation tools.

Research and Evaluation Activities

The Department's research and evaluation activities cover a wide spectrum of topics including adolescent patterns of sexual behavior, intent to become pregnant, the impact of the media on adolescents, and attitudes toward and feelings about sexuality, relationships, contraceptive use, pregnancy and childbearing. These efforts are wide-ranging, and include areas such as HIV prevention, which often enhances teen pregnancy prevention. The Department strives to fund studies that address the needs of adolescents from a myriad of backgrounds including youth in high-risk situations, such as those in foster care, in resource-poor inner cities, and those who are homeless or living in fragile families. Research funding is also spent designing, implementing and evaluating pregnancy prevention programs, so that resources may be used to replicate programs that are demonstrably effective. The Department's efforts include newly funded projects, ongoing research, and the publication of final reports and research findings. The following is an overview of the Department's activities in the past year.

National Survey of Family Growth. In December of 1999, the National Center for Health Statistics (NCHS) awarded a contract to the Institute for Social Research of the University of Michigan (ISR-UM) to conduct Cycles 6, 7, and 8 of the National Survey of Family Growth (NSFG). The Pretest/Pilot Study for the NSFG will be conducted in FY 2001. The study will test a number of ways to improve the quality of data on sexual activity, pregnancy, and parenting, using interviews with 600 males and 600 females. In FY 2002, 19,000 men and women, including 4,500 male and female teenagers, will be interviewed. This study, which will greatly improve the reliability of data on teen sexual activity and pregnancy, as well as our knowledge of how consistently both teens and adults use contraception, will be available in FY 2003 (Cycle 6). The Department is also looking toward the future with the goal of conducting two new cycles in 2005 and 2008. These cycles have the potential to include even larger samples, interviews of prisoners and the military, and biomarkers to test for sexually transmitted diseases. DHHS is currently seeking funding to fulfill these ambitious plans.

There are two major study components. To measure the effectiveness of targeted abstinence-only education initiatives, the study relies on an experimental design that compares program participants with a comparable group of youth not offered abstinence-only education. To examine strategies for creating systemic change through more comprehensive community initiatives, the study will monitor key aspects of program implementation and operation, and track community and school indicators of youth behaviors and outcomes. Please see the following web site for more information: **http://www.mathematica-mpr.com/abstinence.htm**

Girl Neighborhood Power! (GNP) Evaluation. During the last year, the national leadership consortium has sub-contracted with a social science research organization to develop a plan for a national evaluation which will supplement individual evaluation efforts initiated in local partners' sites. It has also begun planning a site development guide to facilitate the replication of the GNP model in additional communities. During the current year, three sites received supplemental funding to deepen the level of collaborative activities in their communities on behalf of girls aged 9-14.

Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs. This long-awaited document, finalized in 1999, examines existing evaluations of positive youth development programs and summarizes the state of the field. Funded by the Assistant Secretary for Planning and Evaluation (ASPE), the report is also known as the Positive Youth Development Project. The project reviewed 77 programs located in community, school, and family settings, or in a combination of these settings. The review concluded that prevention of youth problem behaviors and positive youth behavior outcomes can result from a wide range of youth development approaches. Authors of the report are with the Social Development Research Group at the University of Washington. The report can be found at **http://aspe.hhs.gov/hsp/PositiveYouthDev99/index.htm/**

Update on Ongoing Projects

Detailed descriptions of the following projects may be found in last year's report (**http://aspe.hhs.gov/hsp/hspyoung.htm#teenpreg**). These ongoing projects include:

Adolescent Sexual Activity. NICHD and NCHS continue to support research that tracks adolescent sexual activity. Please see the following web sites for more information: **http://www.cdc.gov/nchs/NSFG.htm** and **http://www.cdc.gov/nchs.births.htm** and http://www.nichd.nih.gov/about/cpr/dbs/supported.htm.

(**See also**: Ventura SJ, Mosher WD, Curtin SC, Abma JC, Henshaw S. Trends in Pregnancies and Pregnancy Rates by Outcome: Estimates for the United States, 1976-96. Vital and Health Statistics; Series 21, No. 56. Hyattsville, Maryland: National Center for Health Statistics. 2000.)

Young Women's First Intercourse. NCHS supports ongoing research that explores the feelings that adolescent girls have about their sexual experiences, specifically first intercourse. Please see the following web site for more information: **http://www.cdc.gov/nchs/NSFG.htm.**

Contraceptive Use. NCHS also continues to investigate trends in contraceptive use among young people. Please see the following web site for more information: **http://www.cdc.gov/nchs/NSFG.htm.**

APPENDIX I

National Vital Statistics Reports
From the CENTERS FOR DISEASE CONTROL AND PREVENTION
National Center for Health Statistics
National Vital Statistics System

Volume 48, Number 6 April 24, 2000

Variations in Teenage Birth Rates, 1991–98: National and State Trends

by Stephanie J. Ventura, M.A.; Sally C. Curtin, M.A.; and T. J. Mathews, M.S; Division of Vital Statistics

Abstract

Objectives—This report presents national birth rates for teenagers for 1991–98 and the percent change, 1991–98. State-specific teenage birth rates by age, race, and Hispanic origin for 1991 and 1998 and the percent change, 1991 to 1998, are also presented.

Methods—Tabular and graphical descriptions of the trends in teenage birth rates for the Nation and each State, by age group, race, and Hispanic origin of the mother, are discussed.

Results—Birth rates for teenagers 15–19 years declined nationally between 1991 and 1998 for all age and race and Hispanic origin populations, with the steepest declines recorded for black teenagers. State-specific rates fell significantly in all States for ages 15–19 years; declines ranged from 10 to 38 percent. In general, rates by State fell more for younger than for older teenagers, ranging by State from 10 to 46 percent for ages 15–17 years. Statistically significant reductions for older teenagers ranged from 3 to 39 percent. Reductions by State were largest for black teenagers 15–19 years, with rates falling 30 percent or more in 15 States. Among the factors accounting for these declines are decreased sexual activity, increases in condom use, and the adoption of the implant and injectable contraceptives.

Keywords: teenage fertility • State-specific birth rates • race and Hispanic origin • teenage pregnancy

Introduction

The birth rate for U.S. teenagers in 1998 was 51.1 live births per 1,000 women aged 15–19 years, 2 percent lower than in 1997, and 18 percent lower than in 1991 when it reached its recent peak (**table 1 and figure 1**). The 1998 rate is close to the 1986 record low of 50.2 (1, 2).

The number of births to women aged 15–19 years increased only slightly to 484,895 in 1998, compared with 483,220 in 1997; the 1998 total was still 7 percent lower than the recent high in 1990 of 521,826. The 3-percent increase in the number of teenage females in the population between 1997 and 1998 accounts entirely for the modest rise in the number of births (3).

The major shift in teenage childbearing patterns over the last half century has been the general decline in the birth rate whereas the proportion of teenage births that occur to unmarried women has risen steeply (**figure 1**).

Details of trends and variations in teenage pregnancy and childbearing in the 1990's, including some discussion of the health consequences and the demographic and behavioral changes accounting for the recent trends, have been published in recent reports (1, 2, 4). This report updates the findings through 1998 for national and State data.

Teenage birth and pregnancy rates fall

When data on live births are combined with information for induced abortions and fetal losses, we are able to compute pregnancy rates. The most recent year for which teenage pregnancy rates can be computed is 1996, because information on abortions and fetal losses is not as current as information on live births. The estimated teenage pregnancy rate in 1996 was 98.7 pregnancies (the sum of live births, induced abortions, and fetal losses) per 1,000 women aged 15–19, down 15 percent from its high point of 116.5 in 1991 (4). A consistent series of pregnancy rates for teenagers is available since 1976; the 1996 rate is lower than in any year since 1976. The rate for young teenagers 15–17 years fell 16 percent from its recent peak (80.3 per 1,000 in 1990) to 67.8 in 1996, while the rate for older teenagers dropped 12 percent from its recent peak in 1991 (167.2) to 146.4 in 1996.

Acknowledgments

This report was prepared in the Reproductive Statistics Branch (RSB) of the Division of Vital Statistics (DVS). Janet Gutierrez and Melissa Park of RSB provided content review. The report was edited by Demarius V. Miller, typeset by Jacqueline M. Davis, and graphics were produced by Jamila Ogburn of the Publications Branch, Division of Data Services.

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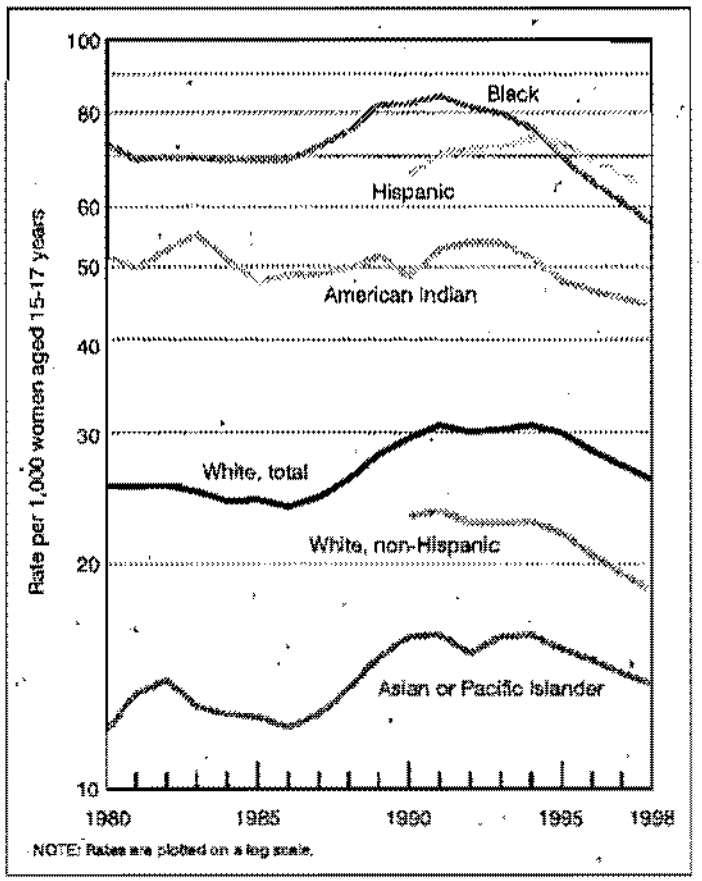

Figure 2. Birth rate for teenagers 15–17 years by race and Hispanic origin: United States, 1980–98

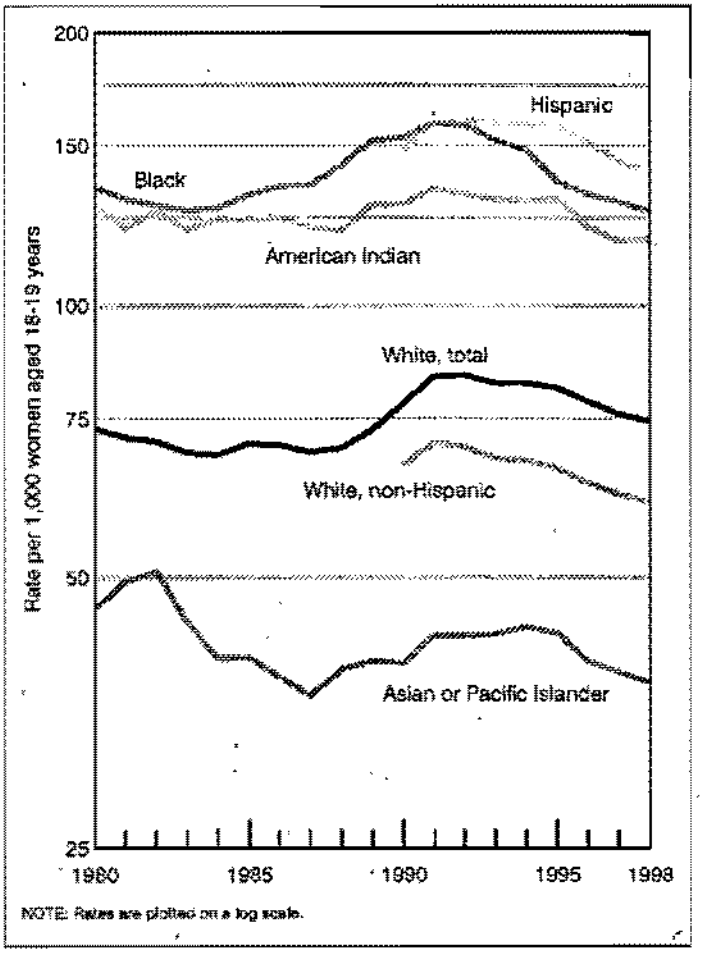

Figure 3. Birth rate for teenagers 18–19 years by race and Hispanic origin: United States, 1980–98

Moreover, unlike smoking rates for older women that have declined steadily in the 1990's, smoking by pregnant teenagers has increased since 1994 (2, 6). As a consequence of these and other factors, including less adequate weight gain during pregnancy, infants born to teenagers are at elevated risk of low birthweight, of preterm birth, and of dying in the first year of life (2, 7).

Teenage birth rates vary greatly by State

Birth rates vary substantially by State and territory. In 1998 the State rates per 1,000 women aged 15–19 years ranged from 24.4 (Vermont) to 73.0 (Mississippi) (**tables 2, 3, and figure 5**). The rate for the District of Columbia was 86.7; the highest rate reported was for Guam (104.8).

As previously reported, differences in overall rates by State reflect in part the differences in the composition of the teenage populations of the States by race and Hispanic origin (1, 5, 6). This report includes, for the first time, birth rates for 1991 and 1998 for American Indian and API teenagers 15–19 years for all States for which these rates could be reliably computed (**table 4**). Rates within States are generally much higher for Hispanic and black teenagers than for non-Hispanic white, American Indian, and API teenagers. This pattern is found in 1998 for all but 10 States for which reliable rates could be computed (table 4). Therefore, States with relatively high proportions of Hispanic and/or black teenagers would be expected to have higher overall teenage birth rates. These compositional differences should be kept in mind when comparing teenage birth rates across States (8).

Rates by State decline for younger and older teenagers

Between 1991 and 1998, birth rates for teenagers 15–19 years fell in all States, the District of Columbia, and the Virgin Islands, with statistically significant reductions in all areas except Puerto Rico and Guam, which increased (**table 2 and figure 6**). Declines exceeded 20 percent in 13 States and the District of Columbia.

Birth rates for teenage subgroups also vary greatly by State and territory. Rates for teenagers 15–17 years fell significantly in all States except Wyoming. Changes in the Virgin Islands and Guam were not significant; the rate increased in Puerto Rico. Declines exceeded 20 percent in 25 States and the District of Columbia. The rates for the District of Columbia, Maine, Michigan, and Vermont declined at least 30 percent.

State-specific rates for older teenagers 18–19 years also fell but not as steeply as for younger teenagers. Statistically significant reductions were reported for all but four States and Puerto Rico. Changes in Rhode Island and Guam were not significant. Rates fell significantly by 20 percent or more in seven States and the Virgin Islands.

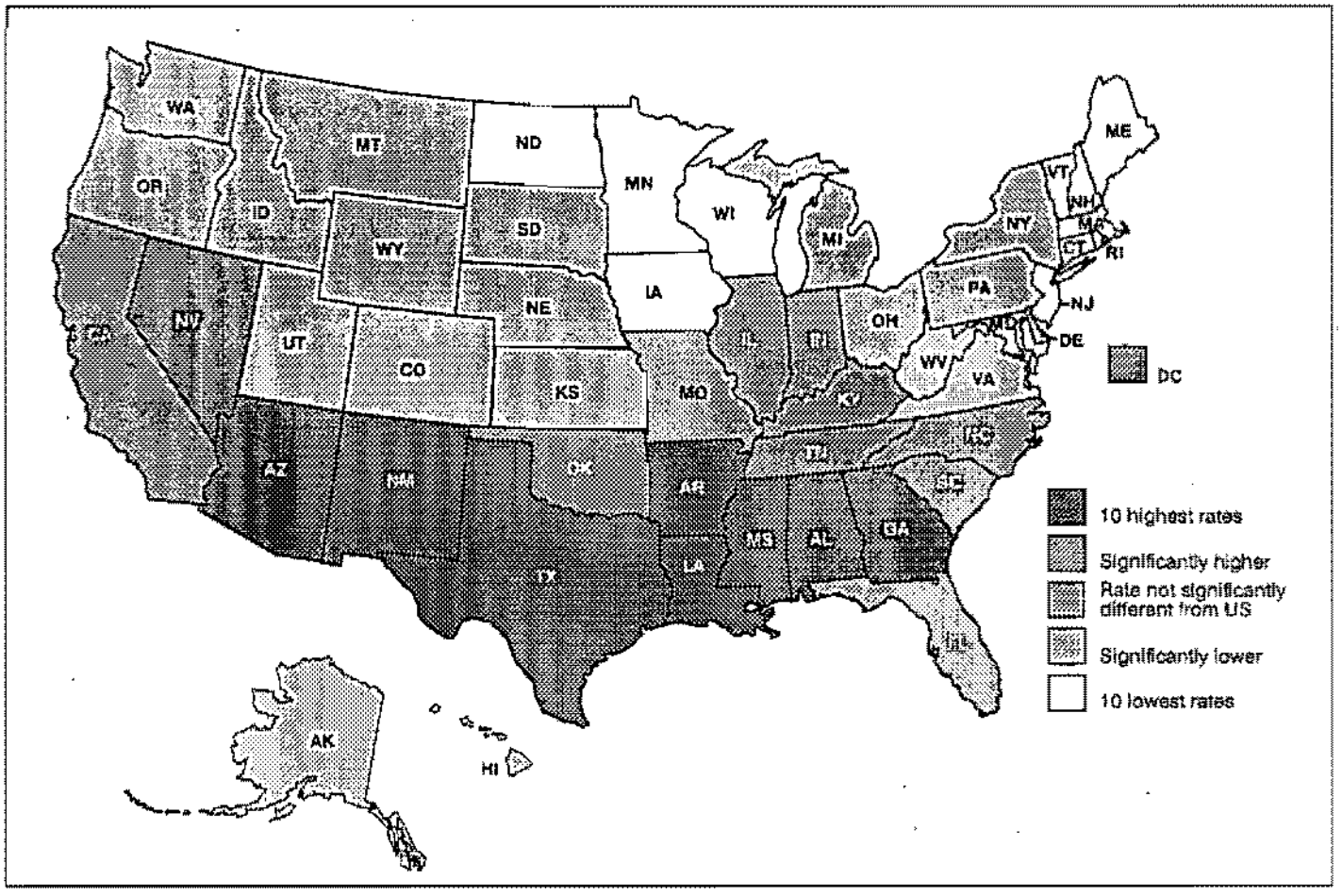

Figure 5. Birth rates for teenagers 15–19 years by State, 1998

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List of detailed tables

Table 1. Births for women under 20 years, by age, race, and Hispanic origin of mother: United States, 1998, and birth rates, 1990–98, and percent change in rates, 1991–98

[Rates per 1,000 women in specified group]

Age and race and Hispanic origin of mother	Number of births, 1998	Birth rates									Percent change in rates, 1991–98
		1998	1997	1996	1995	1994	1993	1992	1991	1990	
10–14 years											
Total	9,462	1.0	1.1	1.2	1.3	1.4	1.4	1.4	1.4	1.4	–28.6
White, total	4,801	0.6	0.7	0.8	0.8	0.8	0.8	0.8	0.8	0.7	–25.0
Non-Hispanic white	2,132	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.5	–40.0
Black	4,289	2.9	3.3	3.6	4.2	4.6	4.6	4.7	4.8	4.9	–39.6
American Indian[1]	197	1.6	1.7	1.7	1.8	1.9	1.4	1.6	1.6	1.6	0.0
Asian or Pacific Islander	175	0.4	0.5	0.6	0.7	0.7	0.6	0.7	0.8	0.7	–50.0
Hispanic[2]	2,716	2.1	2.3	2.5	2.7	2.7	2.7	2.6	2.4	2.4	–12.5
15–19 years											
Total	484,895	51.1	52.3	54.4	56.8	58.9	59.6	60.7	62.1	59.9	–17.7
White, total	340,694	45.4	46.3	48.1	50.1	51.1	51.1	51.8	52.6	50.8	–14.0
Non-Hispanic white	219,169	35.2	36.0	37.6	39.3	40.4	40.7	41.7	43.4	42.5	–18.9
Black	126,937	85.4	88.2	91.4	96.1	104.5	106.6	112.4	115.5	112.8	–26.1
American Indian[1]	8,201	72.1	71.8	73.9	78.0	80.8	83.1	84.4	85.0	81.1	–15.2
Asian or Pacific Islander	9,063	23.1	23.7	24.8	26.1	27.1	27.0	29.6	27.4	26.4	–15.7
Hispanic[2]	121,388	93.6	97.4	101.5	106.7	107.7	106.8	107.1	106.7	100.3	–12.3
18–17 years											
Total	173,231	30.4	32.1	33.8	36.0	37.6	37.6	37.6	38.7	37.5	–21.4
White, total	116,623	25.9	27.1	28.4	30.0	30.7	30.3	30.1	30.7	29.5	–15.6
Non-Hispanic white	66,619	18.4	19.4	20.6	22.0	22.6	22.7	22.7	23.6	23.2	–22.0
Black	50,103	56.6	60.8	64.7	69.7	76.3	79.6	81.3	84.1	82.3	–32.5
American Indian[1]	3,167	44.4	45.3	46.4	47.9	51.3	53.7	53.8	52.7	48.5	–15.7
Asian or Pacific Islander	3,338	13.8	14.3	14.9	15.4	16.1	16.0	15.2	16.1	16.0	–14.3
Hispanic[2]	48,234	62.3	66.3	69.0	72.9	74.0	71.7	71.4	70.6	65.9	–11.8
18–19 years											
Total	311,664	82.0	83.5	86.0	89.1	91.5	92.1	94.5	94.4	88.6	–13.1
White, total	224,071	74.5	75.9	78.4	81.2	82.1	82.1	83.8	83.5	78.0	–10.7
Non-Hispanic white	150,550	60.6	61.9	63.7	66.1	67.4	67.7	69.8	70.5	66.6	–14.0
Black	79,534	126.9	130.1	132.5	137.1	148.3	151.9	157.9	158.6	152.9	–20.0
American Indian[1]	5,034	118.4	117.6	122.3	130.7	130.9	130.7	132.6	134.2	129.3	–11.8
Asian or Pacific Islander	6,725	38.3	39.3	40.4	43.4	44.1	43.3	43.1	43.1	40.2	–11.1
Hispanic[2]	73,154	140.1	144.3	151.1	157.9	158.0	159.1	159.7	158.5	147.7	–11.6

[1]Includes births to Aleuts and Eskimos.
[2]Includes all persons of Hispanic origin of any race.

Table 3. Birth rates for teenagers 15–19 years, by age and race and Hispanic origin: United States and each State, 1998

(Rates are births per 1,000 women in specified group)

State	15–19 years					15–17 years					18–19 years				
		White					White					White			
	All	Total	Non-Hispanic	Black	Hispanic[1]	All	Total	Non-Hispanic	Black	Hispanic[1]	All	Total	Non-Hispanic	Black	Hispanic[1]
United States	51.1	45.4	35.2	86.4	93.6	30.4	25.9	18.4	56.8	62.3	82.0	74.6	60.6	126.9	140.1
Alabama	65.5	53.8	52.9	88.6	99.9	40.7	30.5	29.7	61.9	72.8	100.4	88.1	87.0	123.3	*
Alaska	42.4	31.9	30.5	49.3	65.0	24.8	16.5	15.1	*	*	68.6	54.8	53.3	*	*
Arizona	70.5	70.4	41.3	76.4	124.7	45.2	45.2	22.9	50.3	87.9	108.2	107.4	68.8	114.0	177.5
Arkansas	70.8	62.2	60.3	99.6	110.7	41.4	32.7	31.4	71.5	68.4	114.0	106.6	104.0	137.8	170.8
California	53.5	58.1	27.7	64.0	87.1	33.4	36.5	14.4	40.0	58.1	83.4	89.7	47.5	97.4	129.0
Colorado	48.7	47.4	30.6	76.3	113.8	29.0	28.1	15.5	48.3	77.2	79.0	77.2	53.5	118.8	171.9
Connecticut	35.8	30.5	17.1	77.3	117.7	21.4	17.6	8.1	51.5	79.4	58.6	51.0	31.5	116.4	179.0
Delaware	53.9	39.0	34.2	104.0	112.1	33.9	22.9	19.7	69.9	*	81.7	60.5	53.5	152.8	*
District of Columbia	86.7	20.9	5.4	141.7	*	65.5	25.9	*	79.9	*	110.8	18.8	4.8	300.6	*
Florida	55.5	46.5	41.8	88.1	80.8	33.3	26.1	22.2	59.1	38.9	90.8	79.1	73.8	132.5	92.9
Georgia	66.4	54.7	50.1	87.0	127.5	40.3	30.7	27.9	59.4	78.9	102.5	90.9	84.0	126.0	197.7
Hawaii	45.7	17.2	14.2	34.7	96.0	29.5	6.9	4.7	*	79.3	67.3	29.8	25.8	*	117.8
Idaho	44.8	44.8	39.8	*	101.3	24.5	24.3	19.5	*	72.8	73.1	73.0	65.9	*	140.0
Illinois	53.2	40.7	28.7	113.7	100.8	32.7	22.7	14.6	80.3	63.1	85.0	68.8	50.5	165.3	159.5
Indiana	53.3	48.0	46.0	102.9	99.7	28.9	24.9	23.5	65.1	52.1	89.5	82.2	79.3	160.8	158.0
Iowa	36.2	33.5	31.5	93.4	106.8	18.6	17.4	16.2	59.3	63.7	60.3	57.8	54.6	139.4	174.5
Kansas	47.0	43.3	38.1	96.6	106.7	24.8	22.0	18.4	57.3	65.4	81.1	76.0	68.2	154.9	171.2
Kentucky	57.0	54.1	53.9	89.1	69.5	31.5	29.3	29.2	56.0	*	94.2	90.6	90.4	133.0	*
Louisiana	65.4	45.4	45.8	95.8	32.9	40.4	23.8	24.0	67.0	15.3	100.6	77.1	77.8	133.7	55.0
Maine	30.4	30.0	29.9	*	*	14.9	14.6	14.5	*	*	54.5	54.2	54.1	*	*
Maryland	43.1	29.6	27.6	73.5	52.6	26.4	15.9	14.6	50.1	32.0	69.2	51.2	48.2	109.6	82.0
Massachusetts	30.8	27.5	19.9	71.3	106.3	16.2	15.4	9.7	45.4	72.1	49.5	45.5	35.1	114.7	161.0
Michigan	42.6	34.6	32.1	84.6	87.9	23.9	18.0	16.4	55.0	52.7	70.9	59.8	56.0	128.6	140.8
Minnesota	30.6	24.5	21.9	115.4	130.2	16.5	12.1	10.3	74.3	86.5	52.7	43.8	40.0	181.4	197.8
Mississippi	73.0	53.7	53.4	96.1	*	47.2	30.3	30.1	67.1	*	110.3	86.5	88.2	134.3	*
Missouri	51.2	44.2	43.2	97.6	81.7	28.6	23.1	22.4	64.7	52.3	85.7	76.4	75.2	148.9	122.1
Montana	37.1	31.6	30.4	*	*	19.8	16.0	15.0	*	*	63.3	54.9	53.4	*	*
Nebraska	37.0	33.7	29.4	81.9	99.3	20.5	18.0	14.9	55.5	64.3	61.6	57.0	50.8	125.0	154.9
Nevada	65.7	65.1	46.4	81.3	117.2	38.2	37.4	24.3	53.4	75.9	108.5	108.7	82.2	124.9	177.5
New Hampshire	27.1	27.2	26.7	*	*	13.1	13.0	12.6	*	*	50.0	50.5	49.8	*	*
New Jersey	34.6	25.6	13.6	80.4	76.2	20.2	14.2	6.6	52.0	47.6	56.9	43.3	24.8	120.9	117.5
New Mexico	69.0	69.7	39.5	57.1	93.0	44.2	44.8	20.1	41.3	64.6	107.5	107.9	70.1	*	136.6
New York	38.5	33.9	21.6	61.4	75.2	22.4	19.2	10.9	37.8	46.9	62.4	55.1	37.0	98.4	118.2
North Carolina	61.0	50.6	44.4	84.7	198.6	36.2	27.7	24.4	56.2	107.5	98.5	85.6	75.1	125.5	341.8
North Dakota	30.4	24.6	24.0	*	*	16.1	11.6	11.3	*	*	52.5	44.2	43.2	*	*
Ohio	48.1	40.6	39.6	96.8	83.1	26.7	21.0	20.3	63.6	50.8	80.3	70.1	68.7	145.5	130.8
Oklahoma	61.6	56.0	52.2	85.0	110.5	35.0	30.2	27.0	55.4	76.8	102.6	95.8	90.8	124.6	164.4
Oregon	47.4	46.9	40.2	72.2	113.9	26.3	25.7	21.0	49.1	73.4	80.0	79.5	69.9	105.4	174.5
Pennsylvania	36.9	29.3	25.7	98.8	114.7	21.8	16.1	13.4	66.4	60.2	60.2	49.5	44.7	150.9	169.7
Rhode Island	41.0	36.9	27.3	74.2	129.1	24.4	21.4	14.6	44.1	79.6	65.8	60.0	45.8	*	*
South Carolina	60.4	48.2	47.2	80.3	80.8	39.6	29.3	28.6	56.3	53.5	89.8	74.7	73.4	114.5	*
South Dakota	38.5	28.7	28.3	*	*	19.6	13.3	12.9	*	*	66.0	50.1	49.7	*	*
Tennessee	64.3	55.0	53.8	96.9	113.9	37.7	29.6	28.9	68.0	66.4	103.4	92.7	90.9	141.8	*
Texas	70.9	71.4	43.4	80.7	106.3	45.2	45.5	23.3	52.1	73.4	109.3	110.2	73.5	121.3	156.0
Utah	40.9	40.1	33.7	*	120.4	22.2	21.8	16.8	*	83.5	65.6	64.3	55.9	*	169.1

See footnotes at end of table.

Table 4. Birth rates for teenagers age 15–19 years, by race and Hispanic origin: United States and each State, 1991 and 1998, and percent change, 1991–98

[Rates are births per 1,000 women in specified group]

State	Non-Hispanic white			Black			American Indian			Asian or Pacific Islander			Hispanic		
	1991	1998	Percent change 1991–98	1991	1998	Percent change 1991–98	1991	1998	Percent change 1991–98	1991	1998	Percent change 1991–98	1991	1998	Percent change 1991–98
United States	43.4	35.2	–18.9	115.5	85.4	–26.1	85.0	72.1	–15.2	27.4	23.1	–15.7	106.7	93.6	–12.3
Alabama	56.4	52.9	–6.2	111.0	88.6	–20.2	*	*	*	*	18.7	*	*	99.9	*
Alaska	50.8	30.5	–40.0	*	49.3	*	115.3	77.3	–33.0	*	40.3	*	*	65.0	*
Arizona	53.5	41.3	–22.8	126.7	76.4	–39.7	103.9	83.4	–19.7	27.8	21.3	**–23.4	131.1	124.7	–4.9
Arkansas	66.8	60.3	–9.7	127.3	99.6	–21.8	*	*	*	*	*	*	*	110.7	*
California	42.9	27.7	–35.4	98.7	64.0	–35.2	50.9	47.0	**–7.7	27.9	20.0	–28.3	122.4	87.1	–28.8
Colorado	40.2	30.6	–23.9	122.3	76.3	–37.6	76.3	76.4	**0.1	35.5	26.4	**–25.6	118.7	113.8	**–4.1
Connecticut	20.4	17.1	–16.2	98.4	77.3	–21.4	*	*	*	19.1	13.2	**–30.9	131.9	117.7	–10.8
Delaware	37.5	34.2	**–8.8	134.0	104.0	–22.4	*	*	*	*	*	*	*	112.1	*
District of Columbia	10.2	5.4	**–47.1	135.3	141.7	**4.7	*	*	*	*	*	*	*	*	*
Florida	50.6	41.8	–17.4	132.4	88.1	–33.5	61.5	62.1	**1.0	15.8	19.2	**21.5	60.5	60.8	**0.5
Georgia	54.7	50.1	–8.4	118.4	87.0	–26.5	*	*	*	28.1	19.3	**–31.3	90.5	127.5	40.9
Hawaii	37.9	14.2	–62.5	*	34.7	*	*	*	*	64.7	58.4	–9.7	116.9	96.9	–17.2
Idaho	48.9	38.8	–20.7	*	*	*	*	*	*	*	*	*	124.9	101.3	–18.9
Illinois	36.9	28.7	–22.2	146.1	113.7	–22.2	*	39.1	*	12.7	9.5	–25.2	103.4	100.8	**–2.5
Indiana	53.0	46.0	–13.2	126.6	102.9	–18.7	*	*	*	13.9	18.9	**36.0	64.4	99.7	54.8
Iowa	39.5	31.5	–20.3	138.1	93.4	–32.4	*	*	*	32.9	28.2	**–14.3	80.9	106.6	31.8
Kansas	46.8	38.1	–18.6	131.4	96.6	–26.5	*	68.4	*	38.6	30.3	**–21.5	96.1	106.7	**8.8
Kentucky	64.8	53.9	–16.8	117.6	89.1	–24.2	*	*	*	*	*	*	*	69.5	*
Louisiana	52.7	45.8	–13.1	117.5	95.8	–18.5	*	84.5	*	19.2	23.4	**21.9	24.8	32.9	**32.7
Maine	43.3	29.9	–30.9	*	*	*	*	*	*	*	*	*	*	*	*
Maryland	36.2	27.6	–23.8	96.9	73.5	–24.1	*	*	*	12.1	10.4	**–14.0	44.2	52.6	19.0
Massachusetts	25.3	19.9	–21.3	95.7	71.3	–25.5	*	*	*	30.6	21.8	–29.4	129.8	106.3	–18.1
Michigan	41.1	32.1	–21.9	130.1	84.6	–35.0	*	47.2	*	19.4	20.7	**6.7	90.3	87.9	**–2.7
Minnesota	29.2	21.9	–25.0	156.3	115.4	–26.2	144.2	92.5	–35.9	70.7	69.8	**–1.3	100.9	130.2	29.0
Mississippi	59.1	53.4	–9.6	117.6	95.1	–19.1	*	*	*	*	*	*	*	*	*
Missouri	51.3	43.2	–15.8	146.3	97.6	–33.3	*	*	*	19.6	20.4	**4.1	67.4	81.7	21.2
Montana	38.7	30.4	–21.4	*	*	*	131.8	90.6	–31.1	*	*	*	*	*	*
Nebraska	34.7	29.4	–15.3	130.3	81.9	–37.1	*	*	*	*	*	*	99.8	99.3	**–0.5
Nevada	60.4	46.4	–23.2	138.4	81.3	–41.3	*	64.2	*	42.8	47.3	**10.5	114.1	117.2	**2.7
New Hampshire	---	26.7	---	*	*	*	*	*	*	*	*	*	*	*	*
New Jersey	18.2	13.6	–25.3	103.3	80.4	–22.2	*	*	*	7.3	6.8	**–6.8	85.1	76.2	–10.5
New Mexico	50.9	39.6	–22.2	100.8	57.1	–43.4	91.8	74.0	–19.4	*	*	*	101.0	93.0	–7.9
New York	26.3	21.6	–17.9	76.7	61.4	–19.9	29.9	35.2	**17.7	10.7	11.1	**3.7	85.4	75.2	–11.9
North Carolina	52.5	44.4	–15.4	110.9	84.7	–23.6	97.5	94.1	**–3.5	33.2	52.5	58.1	104.0	198.6	91.0
North Dakota	28.8	24.0	–16.7	*	*	*	143.2	110.0	–23.2	*	*	*	*	*	*
Ohio	48.9	39.6	–19.0	134.7	96.8	–28.1	*	*	*	15.2	20.9	**37.5	83.1	83.1	**0.0
Oklahoma	61.5	52.2	–15.1	132.0	85.0	–35.6	90.2	85.8	**–4.9	36.5	27.5	**–24.7	91.7	110.6	20.6
Oregon	49.2	40.2	–18.3	113.1	72.2	–36.2	84.5	82.3	**–2.6	21.5	29.5	**37.2	131.4	113.9	–13.3
Pennsylvania	33.1	25.7	–22.4	132.5	98.8	–25.4	*	*	*	18.9	14.8	**–21.7	130.1	114.7	–11.8
Rhode Island	33.5	27.3	–18.5	120.6	74.2	–38.5	*	*	*	*	57.1	*	109.2	129.1	**18.2

See footnotes at end of table.

Technical notes

Data shown in this report for 1998 and earlier years are based on 100 percent of the birth certificates registered in all States and the District of Columbia. More than 99 percent of births occurring in this country are registered. Tabulations by State also include Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Marianas. However, totals shown for the United States do not include these areas.

Tabulations by race and Hispanic origin of mother are based on this information as reported on the birth certificate. Race and Hispanic origin are reported as separate items on the birth certificate. Although the overwhelming majority of Hispanic births (97 percent) are to white women, there are substantial differences in teenage childbearing patterns between Hispanic and non-Hispanic white women. Therefore, data are shown separately for these groups.

Population data for computing birth rates were provided by the U.S. Bureau of the Census (3, 5). Rates by State shown here may differ from rates computed on the basis of other population estimates. State rates are based on mother's place of residence. Population estimates by race and Hispanic origin are not available for the territories. Data are not available for American Samoa and the Northern Marianas for 1991, because birth data were not collected.

Rates were not computed if there were fewer than 20 births in the numerator or fewer than 1,000 women in the specified group in the denominator. In tables 1–4, an asterisk is shown in place of the rate.

Additional detailed information on the tabulation of birth data by race, random variation, and relative standard error is provided in earlier reports (2,13).

APPENDIX II:

Measuring the Proportion of Communities with Teen Pregnancy Prevention Programs

Record declines in the teen birth rate, and further decline in the teen pregnancy rate, suggest that the numerous public- and private-sector efforts across the country to prevent teen pregnancy are having a positive impact. Measuring all factors that help adolescents postpone premature sexual activity and avoid pregnancy is difficult, however, since individual, family, and community characteristics are all influential. Nevertheless, measuring the proportion of communities that have at least one teen pregnancy prevention program in place (estimated by dividing the number of such communities by the number of communities in the United States) provides a rough sense of how many communities are responding to this problem with specific, targeted prevention efforts. In FY 1999, at least 35 percent of communities had HHS supported teen pregnancy prevention and related programs compared with 34 percent in FY 1998. This proportion represents about 1677 communities across the country.

To develop a sound, albeit conservative, estimate of this proportion, the estimate includes only those programs supported by HHS through funds that flow directly to communities. HHS supported programs which include teen pregnancy prevention services as a component are diverse, ranging from comprehensive health and social services to substance abuse treatment and HIV prevention education. In this report, the number of teen pregnancy prevention programs funded by HHS includes those programs funded in the year FY 1999 (including the latest year for which complete information on grants awarded is available).

To determine the number of communities with at least one program, the location of each program was identified based on the site of the services provided and/or the location of the grant recipient. A community with more than one program was counted only once. The estimate excludes HHS funding provided directly to states (e.g., Medicaid, Maternal and Child Health Block Grant, TANF) which states may use to fund activities in multiple communities. Since there is no single standard definition for community in the United States, the estimate uses a definition of community based on areas identified by the Commerce Department's Bureau of the Census. This definition includes all incorporated places with a population of 10,000 individuals or more (2,673) and all counties where, excluding these incorporated places, the remaining population reaches 10,000 or more (2,079), for a total of 4,752 communities. Under this definition, for example, Montgomery County, Maryland would consist of four communities, including three incorporated places of 10,000 or more inhabitants (Gaithersburg, Rockville, and Takoma Park) and one community representing the balance of the county's population, which exceeds 10,000.

APPENDIX III

The Department of Health and Human Services supports a variety of efforts to help communities develop comprehensive teen pregnancy prevention strategies that reflect five principles: parental and adult involvement, abstinence and personal responsibility, clear strategies for the future, community involvement, and a sustained commitment.

HHS Programs

Girl Neighborhood Power! - Building Bright Futures for Success is challenging America's communities to become active partners in assisting 9- to 14-year-old girls to successfully navigate adolescence and achieve maximum potential. The initiative, administered by HRSA, strives to combine several elements including strong "no use" messages about tobacco, alcohol, and illicit drugs with an emphasis on physical activity, nutrition, abstinence, mental health, social development, and future careers.

The Center for Disease Control and Prevention's Community Coalition Partnership Program for the Prevention of Teen Pregnancy has supported demonstration grants for the prevention of teen pregnancies since 1995. Coalitions of local and public and private agencies and organizations in communities with high rates of teen pregnancy have been working over the last two years to develop community action plans, coordinate efforts to reduce teen pregnancy, identify gaps in current programs and services, target existing resources, and design evaluation plans. CDC awarded approximately $250,000 per year for two years to 13 communities in 11 states to help these communities mobilize and organize their resources. For FY 1998, a total of $13.7 million was made available to help the 13 community coalition partnerships implement their action plans and evaluate their impact, as well as to support related data collection, evaluation, and dissemination activities.

State Children's Health Insurance Program (SCHIP) was established by the Balanced Budget Act of 1997 under Title XXI of the Social Security Act. This program, administered by the Health Care Financing Administration (HCFA), enables states to provide health insurance coverage to uninsured targeted low-income children. States have the opportunity to involve communities as they design and implement their SCHIP programs so that the new programs, including teen pregnancy prevention programs, may be an additional avenue to provide services to adolescents at risk.

The Independent Living Program, run by the Administration for Children and Families, provides funds to states to support activities ranging from educational programs to programs that help young people who are making the transition from foster care to independent living to avoid early parenthood. This program supports activities in all 50 states and the District of Columbia.

Youth Programs including Runaway and Homeless Youth Programs, Transitional Living Programs, and the Youth Sports Program, address a wide range of risk factors for teen pregnancy. Together, these programs operate in 500 communities in 50 states and the District of Columbia.

Healthy Start, administered by HRSA, has 62 projects to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided (including state prenatal hotlines), thousands of teenagers participate in prevention programs exclusively designed for adolescents. The programs encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.

Maternal and Child Health Services Block Grant (Title V) funds support a variety of adolescent health programs in 59 states and jurisdictions, including adolescent pregnancy prevention programs, state adolescent health coordinators, family planning, technical assistance, and other prevention services.

The Adolescent Family Life Program (AFL), created in 1981, supports research into the causes and consequences of adolescent pregnancy; demonstration projects that provide health, education, and social services to pregnant and parenting adolescents, their children, male partners, and families; and programs aimed at promoting abstinence among pre-adolescents and adolescents as the most effective way of preventing adolescent pregnancies, sexually transmitted diseases, and HIV/AIDS. In FY 1999, the AFL program funded 89 projects in 34 states and the District of Columbia. AFL is administered by the Office of Population Affairs.

Empowerment Zones and Enterprise Communities in 105 rural and urban areas in 43 states and the District of Columbia have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.

Health Education in Schools supports the efforts of every state and territorial education agency to implement local school health programs to prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

APPENDIX IV:
HHS Funded Data Sets

National Survey of Family Growth. The National Survey of Family Growth (NSFG), conducted by the National Center for Health Statistics (NCHS), is based on personal interviews with a national sample of women 15-44 years of age in the United States. Its main function is to collect data on factors affecting pregnancy and child bearing. Please see **http://www.cdc.gov/nchs/nsfg.htm** for more information.

National Survey of Adolescent Males. The National Survey of Adolescent Males (NSAM), conducted by the Urban Institute and supported by the National Institute of Child Health and Human Development (NICHD), provides data exclusively on teenage males ages 15-19, specifically their contraceptive and sexual behavior. This data set complements the data on teenage females which is available from the NSFG. Please see **http://silk.nih.gov/silk/DBSB/nsam.htm** for more information.

National Longitudinal Study of Adolescent Health. The National Longitudinal Study of Adolescent Health (Add Health), conducted by the Carolina Population Center, University of North Carolina and supported by the NICHD and seventeen other federal agencies, is a school based study of adolescents in grades 7 to12 which provides information on physical, mental, and emotional health status, and health behaviors, including sexual behavior and contraceptive use. It provides the first comprehensive view of the health and health behaviors of adolescents and the antecedents personal, interpersonal, familial, and environmental of these outcomes. This study will follow-up with these young people in to their late teens and early 20s. Please see **http://www.cpc.unc.edu/addhealth/** for more information.

Youth Risk Behavior Surveillance System. The Youth Risk Behavior Surveillance System (YRBSS), established by the Centers for Disease Control and Prevention (CDC), monitors the prevalence of youth behaviors that most influence health. This national school-based survey focuses on priority healthrisk behaviors established during youth that result in the most significant mortality, morbidity, disability, and social problems during both youth and adulthood. Please see **http://www.cdc.gov/nccdphp/dash/yrbs/ov.htm** for more information.

PRESIDENT CLINTON PRAISES OUR NATION'S PROGRESS IN ACHIEVING THE LOWEST TEEN BIRTH RATES ON RECORD

New Actions to Help More Communities Launch Second Chance Homes for Teen Parents

Saturday, August 12, 2000

Today in his weekly radio address, President Clinton will highlight that our efforts to reduce teen pregnancy are working – teen birth rates have declined for the eighth year in a row to the lowest level ever recorded. He will also challenge the nation to build on this historic progress by continuing to working together to help even more young people make responsible choices and delay parenting until they are financially and emotionally ready. Despite this encouraging trend in birth rates, we still have much to do – there are nearly half a million babies born to teenagers every year, of which about 100,000 are repeat births. To help break this cycle, the President will direct the Secretaries of Health and Human Services and Housing and Urban Development to help community- and faith-based organizations acquire vacant or foreclosed property and access existing resources to establish or expand second chance homes.

Making Historic Progress in Reducing Teen Births. This week, the Centers for Disease Control and Prevention released preliminary 1999 data confirming that we continue to make impressive strides in addressing one of the most important social problems facing our nation. The birth rate for 15 to 19 year olds dropped three percent last year and 20 percent from the most recent peak in 1991, and is now at the lowest level since tracking began 60 years ago. This has had a dramatic impact: if teen birth rates had remained at the 1991 level, 120,000 more babies would have been born to teen parents last year. These improvements are seen among younger and older teens, married and unmarried teens, all states, and all racial and ethnic groups. The sharpest decline last year was a six percent drop in the birth rate for American Indian teenagers. And, since 1991, the African American teen birth rate has decreased by 30 percent. At the same time, our latest data show that teen pregnancy and abortion rates are also continuing to fall.

Taking Action to Create More Second Chance Homes. President Clinton has long supported second chance homes, an innovative approach to help teen parents who cannot live at home. These adult-supervised living arrangements offer parenting skills, job counseling, education and other referrals that help reduce repeat pregnancies and improve the prospects for young mothers and their children, and many also involve young fathers in parenting and employment activities. Early evidence shows that teen parents in second chance homes are less likely to have repeat pregnancies, and more likely to immunize their children, complete high school, and become self-sufficient. The welfare reform law, signed by the President in 1996, required unmarried minor parents to stay in school and live at home or in a supervised setting, and encouraged states to create supervised, supportive housing programs such as second chance homes.

To continue these efforts to promote responsibility and self-sufficiency among teen parents, the President will direct the Secretaries of HHS and HUD to work together to help communities open second chance homes. Through this Executive Memorandum, we will make it easier for community- and faith-based groups to access vacant or foreclosed property, provide a blueprint for communities on how to create second chance homes, and provide a roadmap to federal and

state resources they can tap to get second chance homes up and running. This will help replicate this innovative model in more communities across America.

Implementing a Comprehensive Strategy for Reducing Teen Pregnancy. The Clinton-Gore Administration has supported a variety of innovative and promising teen pregnancy prevention strategies. The National Campaign to Prevent Teen Pregnancy, a private nonprofit organization formed in response to the President's 1995 State of the Union challenge, has worked with all sectors of society to share promising strategies and send the right message to our children.

This week, HHS transmitted to Congress the third annual report on the National Strategy to Prevent Teen Pregnancy, first announced by the President in 1997. This report highlights efforts to promote abstinence and personal responsibility, provide more teens with mentors and access to college or jobs, and develop local prevention strategies reaching out to both girls and boys. It also documents that at least a third of all communities now have HHS-funded teen pregnancy prevention activities – exceeding the goal of 25 percent set in the 1996 welfare reform law – and describes strong partnerships with states, communities, families, religious leaders, the media, and teens themselves that have contributed to the historic progress we have achieved.

These efforts are critical because teen parents and their children face tremendous challenges. Nearly 80 percent of single teen mothers end up on welfare and only one-third receive a high school diploma or GED, while their children are at greater risk of low birth weight, abuse and neglect. Down the line, their daughters are more likely to become teen moms themselves and their sons are more likely to become involved in the criminal justice system.

Building on a Strong Record of Promoting Opportunity and Responsibility. Since taking office, the Clinton-Gore Administration has sent a clear message to young women and young men alike: don't get pregnant or father a child until you are ready to take on the responsibility of parenthood. At the same time, the President and Vice President have worked hard to provide positive alternatives for young people through education and training, community service, after-school opportunities, and record job growth. Today, fewer teens are becoming parents, teen unemployment is the lowest since 1969, millions of parents have moved from welfare to work and child support collections have reached a record of nearly $16 billion - double the collections in 1992.

To build on our progress in promoting responsibility and breaking the cycle of dependency, the President will urge Congress to work with him in a bipartisan manner to take action on key budget initiatives: providing $25 million for "second chance homes;" ensuring that more child support goes to families; and investing $255 million for the Fathers Work/Families Win initiative to help 40,000 low-income fathers and 40,000 low-income families work and support their children. Despite the clear bipartisan support for second chance homes, Congress has yet to provide any funding.

For Immediate Release
Tuesday, August 8, 2000

CDC/NCHS Press Office
(301) 458-4800

New CDC Birth Report Shows Teen Birth Rates Continue to Drop

Report Also Covers Key Aspects of Maternal and Infant Health

The birth rate for teenagers declined 3 percent between 1998 and 1999, to reach a rate of 49.6 births per 1,000 women ages 15-19 –the lowest rate in the 60 years data on teen births have been recorded. The teen birth rate is down 20 percent from the most recent high in 1991, according to a new report from CDC=s National Center for Health Statistics.

The preliminary report also found a drop in the number of births to unmarried teens, record high levels of women receiving early prenatal care, a rise in the cesarean delivery rate, and no improvement in the percent of infants born at low birthweight. The report presents data for the nation as well as key indicators by state.

During the 1990s, teen birth rates declined among white, black, American Indian, Asian or Pacific Islander and Hispanic women aged 15-19, with the largest decline a 30-percent drop among black teens. Hispanic teens reported the smallest decline of 13 percent. Between 1998 and 1999, the sharpest decline (6 percent) was for American Indian teenagers followed closely by a 5 percent drop for black teens.

"In the last few years, we've made remarkable progress in reducing the teen birth rate,@ said HHS Secretary Donna E. Shalala. AParents, local communities, government and teens themselves have all been part of writing this success story. Everyone benefits when teens postpone pregnancy until they are ready to assume the responsibility and appreciate the wonder of raising children,@ she said.

The drop in teen births was more pronounced among young teens ages 15-17, who registered a decline of 6 percent between 1998 and 1999. In addition, the number of births for the youngest teenage group, ages 10-14, dropped by 4 percent to the lowest level in 30 years.

The total number of births in the United States rose again in 1999 to about 3,958,000 and the fertility rate for women aged 15-44 also increased slightly. Birth rates for women aged 20-24 declined slightly between 1998 and 1999 while the rate for women aged 25-29 was up slightly. Birth rates for women in their thirties and forties continued to increase, with rates for women in their thirties the highest in three decades.

The report also shows that prenatal care continues to improve, with a slight increase in the percent of women who received early prenatal care, up from 82.8 percent in 1998 to 83.2 percent in 1999. This measure of prenatal care has shown steady progress during the 1990s, rising 10 percent since 1989. The increase in early prenatal care was most notable for black women and Hispanic women, with an increase of approximately 25 percent over the past decade.

"Prenatal care – the earlier, the better – means healthier mothers and babies," said CDC Director Dr. Jeffrey Koplan. "In prenatal visits, women and their health care providers can focus on the healthy habits and preventive services that are so important to mothers and infants," he said.

The percent of infants born at low birth weight (7.6 percent) in 1999 was unchanged from the previous year. There has been a gradual upward trend in the percent of infants born at low birth weight since the mid-1980s.

The birth rate for unmarried women in 1999 was 1 percent lower than the previous year; however, the number of births to unmarried women was up about 1 percent due to the continued increase in the number of unmarried women of childbearing age. The number of births to unmarried teenagers was 2 percent lower in 1999 than in 1998.

The annual report, which also covers trends in health issues related to births, shows that cesarean delivery rates were up for the third year in a row in 1999, reversing a steady decline between 1989 and 1995. The rate of cesarean delivery increased by 4 percent from 1998 and 1999, up from 21.2 per 100 live births in 1998 to a 1999 rate of 22.0, continuing increases first noted in 1997.

The rise in the total cesarean rate was primarily fueled by an increase in cesareans to women who had not previously had one - up 4 percent between 1998 and 1999. Another factor contributing to the rise in the total cesarean rate was the marked decline in the rate of VBAC (vaginal birth after cesarean), down 11 percent in the last year and 17 percent since 1996. The rise in the total cesarean rate was widespread - increases were observed among woman of all ages and races and in 45 of the 50 states. However, the preliminary report does not include data on maternal risk factors – which will be available later in the final data for 1999 – to fully evaluate the factors involved in the increase.

ABirths: Preliminary Data for 1999@ is based on birth records filed in state vital statistics offices and reported to CDC through the National Vital Statistics System. The report is available to view or download on the CDC/NCHS website at

Teen Birth and Pregnancy Rates
8/7/2000

Revised

Births Per 1,000 Teens (15-19)	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
All teens	62.1	60.7	59.6	58.9	56.8	54.4	52.3	51.1	49.6	-20.1%	-15.8%	-2.9%
Hispanic teens	106.7	107.1	106.8	107.7	106.7	101.8	97.4	93.6	93.1	-12.7%	-13.6%	-0.5%
Black teens	118.9	116.0	112.2	107.7	99.3	94.2	90.8	85.4	81.1	-29.8%	-24.7%	-5.0%
White Teens	43.4	41.7	40.7	40.4	39.3	37.6	36.0	35.2	34.1	-21.4%	-15.6%	-3.1%
American Indian	85.0	84.4	83.1	80.8	78.0	73.9	71.8	72.1	67.7	-20.4%	-16.2%	-6.1%
Asian /Pacific Islander	27.4	26.6	27.0	27.1	26.1	24.6	23.7	23.1	22.6	-17.5%	-16.6%	-2.2%

Source: "Births: Preliminary Data for 1999," National Vital Statistics Reports, August 8, 2000, NCHS, CDC.

Pregnancy Per 1,000 Teens (15-19)	1991	1992	1993	1994	1995	1996	% change 1991-1996	% change 1994-1996	% change 1995-1996
All teens	116.5	112.8	110.4	107.6	102.7	98.7	-15.3%	-8.3%	-3.9%
Hispanic teens	164.6	167.8	166.1	167.2	162.8	157.1	-4.6%	-6.1%	-3.5%
Black teens	221.7	217.3	211.7	201.2	184.4	177.8	-4.6%	-11.6%	-3.6%
White teens	84.7	79.3	76.9	74.5	71.6	68.1	-19.6%	-8.6%	-4.9%

Source: "Trends in Pregnancies and Pregnancy Rates by Outcomes," Vital Health and Statistics Reports, February 2000, NCHS, CDC.
Note that there is a lag in reporting pregnancy data because it combines birthrate, abortion and miscarriage data. Pregnancy data for unmarried women is not available for specific age groups.

Number and Percent of Births to Unmarried Teens (15-19)	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
Number (thousands)	357.5	353.9	357.4	381.5	375.7	373.3	376.1	380.9	373.8	+4.6%	-2.0%	-1.9%
Percent of teen births to unmarried teens	68.8%	70.0%	71.3%	75.5%	75.2%	75.9%	78.2%	78.6%	78.6%	+9.8 pctg. pts	+3.1 pctg. pts	No change

Source: "Births: Preliminary Data for 1999," National Vital Statistics Reports, August 8, 2000, NCHS, CDC. "Births: Final Data for 1998," National Vital Statistics Reports, March 28, 2000, NCHS, CDC.

Teen Birth and Pregnancy Rates Revised
8/7/2000

Births Per 1,000 Teens (15-19) by Race/Ethnicity	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1998	% change 1994-1998	% change 1998-1998
Unmarried teens	44.8	44.6	44.5	46.4	44.4	42.9	42.2	41.5	N/A	-7.4%	-10.6%	-1.7%
Hispanic unmarried teens	72.4	72.9	74.6	82.6	78.7	74.5	75.2	73.9	N/A	+2.1%	-10.5%	-1.7%
Black unmarried teens	108.5	105.9	102.4	100.9	92.8	89.2	86.4	83.4	N/A	-23.1%	-17.4%	-3.5%
White unmarried teens	N/A	N/A	N/A	28.1	27.7	27.0	25.9	25.7	N/A	N/A	-8.6%	-0.8%

Source: "Births: Final Data for 1998," National Vital Statistics Reports, March 28, 2000, NCHS, CDC.

N/A: Until 1994, data on non-Hispanic white unmarried teens was available only during the decennial census; also birth rates for unmarried teenagers for 1999 are not yet available.

Highlights of trends:

- Teen birth and pregnancy rates for all groups of teens have continued a steady decline since 1991 and have reached historic lows. The birth rate for 15-19 year olds is now the lowest it has been since we began collecting data on teen births 60 years ago.
- Teen birth rates declined more quickly from 1998-1999 than from 1997-1998, showing that the rate of improvement in teen birth rates is not slowing despite prolonged declines.
- The largest declines in teen birth rates since 1991 occurred among black teens. The second largest declines were seen among American Indian teens, who had the largest decrease (6%) in the past year.
- Teen pregnancies are at a record low, declining for all groups (though at a bit slower rate for Hispanic girls) according to our most recent data (1996). Data released by CDC's in Mortality and Morbidity Weekly Report (7/14/00) found that this decline continued in 1997 (see endnote below).
- The *absolute number* of births to unmarried teens has increased from 1991, but decreased about 2 percent from 1998 to 1999.
- The *percentage* of all teen births to unmarried teens has risen over the 1990s by almost 10%, driven by a faster decline in married teen births than in unmarried teen births.
- The *rate* of births per 1,000 unmarried teens has declined by more than 7% during the same period.
- Among unmarried teens, the birth rate remains highest for black teens as of 1998.

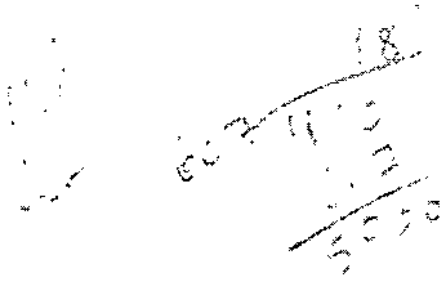
[*] Note: This chart does not include the recently released data from CDC's July 14, 2000 Morbidity and Mortality Weekly Report (MMWR) including teen pregnancy rates for 1997; because the MMWR report used a different methodology to calculate teen pregnancy, this data is not comparable with the data put out by NCHS. However, this data does indicate that there was a decline of 7.8 percent in pregnancy rates for teen 15-19 from 1995 to 1997.

STATEMENT BY THE PRESIDENT ON TEEN BIRTH TRENDS
August 8, 2000 – Draft as of 8:20 pm

Today the Center for Disease Control and Prevention released preliminary FY 1999 data showing that teen birth rates have dropped by three percent in the past year and by 20 percent since the most recent peak in 1991 – the lowest birth rate for 15-19 year olds in the 60 years for which such data have been recorded. This information confirms that we continue to make impressive strides in addressing one of the most important social problems facing our nation. By enacting welfare reform in 1996, taking executive action to require young mothers to stay in school or lose welfare payments, cracking down on child support enforcement, and launching a National Campaign to Prevent Teen Pregnancy, the Clinton-Gore Administration has sent a clear message to young women and young men alike: don't get pregnant or father a child until you are ready to take on the responsibility of parenthood. These trends cut across both younger and older teens, all racial and ethnic groups, and all states --the sharpest decline last year was a six percent drop in the birth rate for American Indian teenagers and since 1991, the African American teen birth rate has decreased by 30 percent. The number of births to unmarried teenagers also dropped in the past year.

In partnership with states communities, families, religious leaders, and teens themselves, my Administration has promoted innovative teen pregnancy prevention strategies that have contributed to the historic progress we are now witnessing. In 1995 I challenged parents and leaders all across this country to join together to reduce teen pregnancy, and in response, the National Campaign to Prevent Teen Pregnancy has made a tremendous difference by helping to identify what works and engaging every part of our society – including the media – in an effort to send the right message to our children.

I applaud this encouraging news showing that, together, we are helping more young people make responsible choices and delay parenting until they are financially and emotionally ready. However, we still have much to do and I urge all sectors of society to continue their efforts to reduce teen pregnancy even further. To build on our progress in breaking the cycle of dependency, I call on Congress to enact my budget initiative to provide $25 million to support "second chance homes". These adult-supervised, supportive living arrangements for teen parents who cannot live at home offer parenting skills, job counseling, education and other referrals that help reduce repeat pregnancies and improve the prospects for young mothers and their children.



8/7/00

TALKING POINTS ON ADMINISTRATION ACTIONS TO REDUCE TEEN PREGNANCY – August 7, 2000

- Since 1993, the Administration has supported innovative and promising teen pregnancy prevention strategies, including working with boys and young men on pregnancy prevention.

- In 1995, the National Campaign to Prevent Teen Pregnancy, a private nonprofit organization, was formed in response to the President's State of the Union challenge to "parents and leaders all across this country to join together in a national campaign against teen pregnancy." They pledged to reduce the teen pregnancy rate by one-third over a decade (1996 – 2005).

- In May 1996, the President took executive action requiring young mothers to stay in school or lose welfare payments.

- In August 1996, the President signed the welfare reform law, which put into place significant components of the President's comprehensive effort to reduce teen pregnancy, including:
  - A requirement that unmarried minor parents must stay in school and live at home or in a supervised setting, such as "second chance homes"; and
  - $50 million a year in new funding for state abstinence education activities.

- In 1997, the President announced the National Strategy to Prevent Teen Pregnancy, which seeks to engage parents and other adults as mentors to youth; educate young people about abstinence and personal responsibility; provide teens with clear connections and pathways to college or jobs; develop comprehensive local strategies including public and private partners, and commit to supporting young people over time. The Department of Health and Human Services has taken the lead on building partnerships, supporting promising approaching and sponsoring research and evaluation to work towards the goals outlined in the National Strategy.

- In April 1999, Vice President Gore announced positive new teen birth trends and h roundtable discussion highlighting promising local teen pregnancy preve[illegible] ef[illegible]

- The Administration has strengthened child support enforcement and cracked down on absent parents through a range of tough and effective tools, with dramatic results. Final FY 1999 figures show child support collections increased another 10 percent in the past year, reaching a record of nearly $16 billion - double the collections in 1992.

- To build on our progress in breaking the cycle of dependency, the Administration's FY 2001 budget includes $25 million to support adult-supervised, supportive living arrangements, often called second chance homes, for unmarried teen parents and their children who cannot live at home or with other relatives. States will be able to use these Social Services Block Grant (SSBG) funds to support services provided by faith-based and community-based organizations.

Final 08/10/00 11:15 pm
John Pollack

PRESIDENT WILLIAM JEFFERSON CLINTON
RADIO ADDRESS ON DECLINING TEEN BIRTH RATES
WASHINGTON, DC
AUGUST 12, 2000

Good morning. These are good times for America. Our economy is stronger than it has ever been. And all across our country, Americans of every age and background are working together to strengthen the fabric of our communities.

Today I want to talk about the remarkable progress our society has made in the last eight years. Crime is at a 25-year low. The welfare rolls are the smallest in 30 years. And a new report from the Centers for Disease Control shows that teen birth rates have fallen for the eighth year in a row. We now have the lowest teen birth rate in 60 years.

That is a remarkable achievement. Consider this: if the teen birth rate had stayed the same as its peak in 1991, teen mothers would have given birth to another 120,000 babies last year.

That drop is wonderful news, and further proof that, together, we can make real progress on social problems that people once said were beyond our reach. This is a tribute to community and religious groups. Teachers and families and, of course, teens themselves.

From the start of our administration, we have endeavored to restore the sense that responsibility and opportunity are the foundation of a strong American community. Five years ago, we called upon parents and community leaders to launch a National Campaign to Prevent Teen Pregnancy.

The next year, we worked across party lines to enact landmark welfare reform, which requires unmarried minor parents to stay in school and live under adult supervision. We also demanded that fathers live up to their obligations, and have doubled child support collections. We have increased counseling, promoted abstinence and paired children with mentors, documenting our achievements in a report to Congress this week.

Despite this progress, we know that too many of America's children are still having children. As friends and neighbors, we need to reach out and help these young people learn and grow.

Today, I am taking action to promote one innovative approach we know will work. It's called "Second Chance Homes" -- an idea that Al Gore and I have long supported, and which was championed early on by Senators Kent Conrad and Joe Lieberman. These homes provide teenage moms and their babies with an environment that is safe, supportive and supervised. The

teens get the help they need to finish school. They learn how to care for their children and manage a budget. Some homes also work with teenage fathers.

Experts say mothers in these homes are less likely to have another baby or go on welfare, and they're more likely to get an education and find a job. I read of one New Hampshire mom who got pregnant at 14, and soon was estranged from her family with no place to live. With the help of a Second Chance Home, she got back on her feet, trained at a community college, and has left welfare to become a proud working mom.

Second Chance Homes are a good idea that enjoy bipartisan support. I have already asked Congress to provide $25 million to start more across the country, and I hope they will work with me to give mothers and babies hope for a better future.

Still, many families can't wait for Congress to act. That's why, today, I am directing the Secretaries of Health and Human Services and Housing and Urban Development to work together to help communities across America open Second Chance Homes. First, we will make it easier for communities and faith-based groups to acquire vacant or foreclosed property to create these homes for teenage mothers. Second, we will provide communities a blueprint for how to create a Second Chance Home, and a road map of federal and state resources they can tap to get one up and running.

We extend this helping hand to these families because it's the right thing to do, and because over time it will help bring the teen birth rate down even more. With these steps, we will do still more to make welfare what it was meant to be: a second chance, not a way of life.

Working together, in a spirit of progress, we can help everybody make the most of their own lives.

Thanks for listening.

Teen Birth/Second Chance Homes
Q & A
August 11, 2000 -- Draft

Q: What is this new data on teen birth rates and what does it tell us?

A: The new report from CDC contains preliminary data for 1999 that shows we continue to make impressive strides in addressing one of the most important social problems facing our nations. It reports that teen birth rates (for 15-19 year olds) have declined by 20 percent from 1991 to 1999, bringing them to the lowest level ever recorded in the 60 years that this data has been collected. Moreover, these gains span all ages, racial and ethnic groups, and every state. It is the eighth year in a row that the teen birth rate has declined.

These encouraging trends confirm that this Administration's strategy to prevent teen pregnancy is working. By enacting welfare reform in 1996, taking executive action to require young mothers to stay in school or lose welfare payments, cracking down on child support enforcement, and launching a National Campaign to Prevent Teen Pregnancy, the Clinton-Gore Administration has sent a clear message to young women and young men alike: don't get pregnant or father a child until you are ready to take on the responsibility of parenthood. Working in partnership with states, communities, families, religious leaders, the media, and teens themselves, we have promoted innovative teen pregnancy prevention strategies that have contributed to the historic progress we witness today.

Background
By any measure, we are making real progress. The overall teen birth rate (births per 1,000 teens ages 15-19) dropped 3 % between 1998 and 1999, 20 percent since its most recent peak in 1991, and is now the lowest level ever recorded. The absolute number of teen births has also declined by 8 percent since 1991, from 520,000 to 476,000. The percent of all births that are to teens has also declined slightly since 1991, from 12.7% to 12% (trends in teen births have generally followed birth trends for all women, but the number of teen births has gone down faster than the overall number of births). Of the 476,000 births to teens between 15 and 19, just over 100,000 were repeat births.

Q: How did you calculate that 120,000 more babies would have been born to teen mother if the rate had stayed at the same level as 1991?

A: In 1991, the teen birth rate was 62.1 teen births for every 1,000 girls ages 15-19 (520,975 teen births and 8,389,295 girls in this age group). After falling for eight years, the 1999 teen birth rate was 49.6 (475,745 teen births and 9,596,926 girls in this age group). If the rate had stayed at 62.1 in 1999, there would have been 595,969 births (9,596,926/1,000 x 62.1). This would have been 120,224 more babies than the 475,745 actually born to teens in 1999. [Since the 8/8 NCHS report didn't include population figures, we used Census Bureau numbers that are very close to the figures NCHS reflects in previous reports].

Q: Is this improvement in the teen birth rate because there are more abortions?

A: No. Birth and abortion rates among teenagers have both declined, reflecting the overall decline in the teen pregnancy rate. In fact, the abortion rate has dropped more than the birth rate. From 1991 to 1996 (the latest year for which we have data), the abortion rate for teenagers dropped over 22 percent, while the teen birth rate fell 12 percent in that same time (and 20 percent from 1991 to 1999).

Q: What steps has the Administration taken to reduce teen pregnancy?

A: Since 1993, the Clinton-Gore Administration has supported innovative and promising teen pregnancy prevention strategies, including working with boys and young men on pregnancy prevention strategies. The National Campaign to Prevent Teen Pregnancy, a private nonprofit organization, was formed in response to the President's 1995 State of the Union address. In his 1996 book *Between Hope And History*, President Clinton emphasized the importance of reducing teen pregnancy and called for funding for Second Chance Homes. In May 1996, the President took executive action requiring young mothers to stay in school or lose welfare payments. In addition, significant components of the Administration's comprehensive effort to reduce teen pregnancy became law when the President signed the welfare reform law in 1996. The law requires unmarried minor parents to stay in school and live at home or in a supervised setting; encourages "second chance homes" to provide teen parents with the skills and support they need; and provides $50 million a year in new federal funding for state abstinence education activities. In 1997, the President announced a National Strategy to Prevent Teen Pregnancy, which already has succeeded in ensuring that HHS-supported programs reach at least one-third of all communities in the United States. In April 1999, Vice President Gore announced positive new teen birth trends and led a roundtable discussion highlighting promising local teen pregnancy prevention efforts. Finally, to build on our progress in breaking the cycle of dependency, the Administration's FY 2001 budget includes $25 million to support adult-supervised, supportive living arrangements (second chance homes) for unmarried teen parents and their children who can't live at home or with other relatives.

Q: How is this decline in teen pregnancy rates distributed across racial and ethnic groups? Are some groups showing a faster rate of decline than others?

A: Black teens have had the greatest decline in teen birth rates (30%) since 1991. In this past year, American Indian teen birth rates fell more than other racial/ethnic groups, dropping by 6 percent. Hispanic teen birth rates have also fallen since 1994, but at a slower rate than for other populations and are now the highest of any group.

Births Per 1,000 Teens (15-19)	1991	1994	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
All teens	62.1	58.9	51.1	49.6	-20.1%	-15.8%	-2.9%
Hispanic teens	106.7	107.7	93.6	93.1	-12.7%	-13.6%	-0.5%
Black teens	118.9	107.7	85.4	81.1	-29.8%	-24.7%	-5.0%
White Teens	43.4	40.4	35.2	34.1	-21.4%	-15.6%	-3.1%
American Indian	85.0	80.8	72.1	67.7	-20.4%	-16.2%	-6.1%
Asian /Pacific Islander	27.4	27.1	23.1	22.6	-17.5%	-16.6%	-2.2%

Q: What is the difference between teen birth rates and teen pregnancy rates?

A: Teen *birth* rates refer only to pregnancies that result in live births; teen *pregnancy* rates include all pregnancies, whether the result is live birth, abortion, miscarriage, or still birth. Today's release includes preliminary 1999 data for teen *births*. There is a significant lag in reporting pregnancy data because it combines data on births, abortions and miscarriages.

Both teen birth rates and teen pregnancy rates have shown impressive and steady declines over the 1990s. Teen birth rates, as reported by CDC today, have declined by 20 percent since 1991 and by three percent from 1998 to 1999, bringing them to the lowest level ever recorded. According to the most recent comparable data on teen pregnancy, published by CDC in February 2000, teen pregnancy rates fell 15 percent from 1991 to 1996 and dropped four percent from 1995 to 1996, also an historic low. NOTE: In July 2000, CDC published 1997 teen pregnancy rate data indicating a decline of 7.8 percent from 1995 to 1997. However, this report used a different methodology than previous reports and cannot be compared to the historical data.

Q: What is happening to out-of-wedlock teen births?

A: Between 1998 and 1999, the total number of births to unmarried teens dropped by 2%. At the same time, the percent of teen births that are to unmarried teens stabilized in the past year after increasing steadily over the past decade. It is also extremely encouraging that, according to the latest available data, the teen out-of-wedlock birth rate dropped in 1998 for the fourth year in a row, to 41.5 births per 1,000 unmarried teens aged 15-19,

down 11 percent from its high in 1994. This rate is the most significant indicator as it controls for population changes; however, the 1999 rate won't be available until later in the year.

Q: Does the Administration support abstinence as the main strategy to prevent teen pregnancy?

A: The Administration supports abstinence education as one important part of our National Strategy to Prevent Teen Pregnancy. HHS funds a variety of teen pregnancy prevention efforts, including abstinence education, family planning, and other community-based efforts, in over a third or 1,600 communities in the United States. Research shows that there's no one single solution to preventing teen pregnancy, and we believe decisions about program choices should be made at the community level. It is unacceptable for young teens to be having sex and having children and we must do everything we can to prevent that.

Q: What abstinence education programs does the federal government fund?

A: The 1996 welfare law set up a new program for abstinence education to be funded through state maternal and child health agencies. The program provides states $50 million a year to promote sexual abstinence until marriage. When state matching funds are included, the program is expected to spend more than $400 million over five years. The federal law forbids any of the programs receiving grants from discussing contraception except to stress failure rates. The required message is that abstinence is the only sure way to avoid pregnancy or sexually transmitted diseases.

Q: Why does the teen birth rate in our country exceed those in other industrialized countries?

A: Despite the historic progress we've made in reducing teen births and teen pregnancies, it's clear that more needs to be done. It is very difficult to make comparisons across countries, given the complicated social, cultural and economic differences. Teen pregnancy is just one of many high-risk behaviors among youth, including drug use and violence. During most of the 1980s and 1990s, we have seen in the United States a growing tendency toward high-risk behaviors of all kinds among youth. During this Administration we are finally reversing these trends.

Q: What report did HHS send to Congress this week?

A: As required by the 1996 welfare reform law, HHS transmitted an annual progress report on implementing the National Strategy to Prevent Teen Pregnancy, which was issued in 1997. This report summarizes the promising trends in teen births and teen pregnancies, describes a wide range of promising approaches, partnerships, and research that are underway, and documents that at least 35% of communities in America had HHS-funded

teen pregnancy prevention programs in place – well above the goal of 25% set in the welfare reform law.

Q: How many places have second chance homes?

A: Massachusetts and New Mexico were among the first states to provide state funding for second chance homes, and at least five states now have a statewide Second Chance Homes initiative (MA, NM, RI, NC, TX). A number of communities have opened such homes, some of which are operated with public funds; others with private sources. The best estimate is that there are about 50 second chance homes operating around the country.

Q: What are second chance homes do and what do we know about their success?

A: For teen parents who cannot live with their own parents or other relatives, second chance homes provide a supportive, adult-supervised living arrangements. They typically offer parenting skills, job counseling, education and other referrals to help reduce repeat pregnancies and improve the prospects for young mothers and their children. Where appropriate, these programs also reach out to involve young fathers in responsible parenting, and to help reconnect teens with their own parents. An early evaluation of the second chance homes program in Massachusetts has demonstrated that second chance homes can reduce the number of repeat pregnancies. Moreover, this study showed that mothers served by second chance homes were more likely to become self-sufficient, complete high school and to keep their children's immunizations up to date. With approximately 100,000 repeat pregnancies each year, we must do all that we can to help improve the prospects for teen parents and their children.

Q: What do you hope to accomplish with the executive memorandum?

A: The President will direct the Secretaries of HHS and HUD to work together to help more communities open second chance homes. Through this Executive Memorandum, we will make it easier for community- and faith-based groups to access vacant or foreclosed property, provide a blueprint for communities on how to create second chance homes, and provide a roadmap to federal and state resources they can tap to get second chance homes up and running. The President's budget proposed $25 million for second chance homes, and we urge Congress to work with us to fund this initiative this year.

While continuing to push for a dedicated funding stream, there are number of existing federal funding streams that can be used to support second chance homes. However, HHS funding sources such as TANF, SSBG, and CSBG cannot be used for capital or construction costs. Therefore, it is important to help communities understand the HUD resources available to purchase or renovate the actual facility. This blueprint will help community groups understand the various funding options and the agencies will provide coordinated technical assistance about how to leverage these resources. For example, HUD's Good Neighbor Initiative offers HUD foreclosed properties at deeply discounted prices to, among others, nonprofit organizations and local governments. The program

includes HUD's Dollar Homes Initiative, which offers local governments an opportunity to purchase HUD-owned homes for just $1 each to help create housing for families in need and to revitalize neighborhoods. HUD also offers community-based nonprofit organizations the opportunity to purchase HUD homes at discounts of up to 30% of the appraised value. With this discount, local nonprofit organizations invest in property rehabilitation and resale to first-time homebuyers and low- and moderate-income families. Each year, more than 500 local nonprofit organizations partner with HUD in this program to rebuild their communities. Through the McKinney Act, surplus government property is made available to non-profit groups that administer homeless services – in many situations, teen mothers in need of a second chance home are considered homeless.

Q: What did the Administration propose in the budget for second chance homes?

A: The Administration's FY 2001 budget proposed $1.775 billion for the Social Services Block Grant (SSBG), $75 million more than the authorized level for FY 2001. We proposed using $25 million of this proposed increase for second chance homes. However, we are willing to consider alternative funding sources as well. Despite bipartisan interest in the second chance homes model, States and a wide range of advocates are concerned about diverting SSBG funds which are already under considerable pressure.

Q: If the President is such a supporter of second chance homes, why is the Administration's proposal on second chance homes so modest?

A: In this era of balanced budgets, the President is seeking a responsible increase in appropriations to ensure that some dedicated funding is available to foster the creation of more second chance homes, and

Background: Governor Bush has pushed second chance maternity homes in Texas; there is now a $1.6 million appropriation of TANF block grant funds for these programs, but they are still in the early implementation phase. In his campaign, has called for a block grant to the states for second chance maternity homes. Senator Moynihan proposed $40 million for second chance homes in the Enhancing Family Life Act of 1999 (S. 208). When he was campaigning, Bill Bradley proposed $300 million as part of his $10 billion youth poverty agenda.

Teen Birth and Pregnancy Rates
Rev. 8/8/2000

Number and Percent of Births to Teens (15-19)	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
Number (thousands)	519.6	505.4	501.1	505.5	499.9	491.6	483.2	484.9	475.7	-8.4%	-5.9%	-1.9%
Percent of all births to teens	12.65%	12.42%	12.78%	12.82%	12.64%	12.45%	12.45%	12.3%	12.03%	-.6 pctg pts	-.7 pctg pts	-.2 pctg pts

Source: "Births: Preliminary Data for 1999," National Vital Statistics Reports, August 8, 2000, NCHS, CDC; "Births: Final data for 1998," National Vital Statistics Reports, March 28, 2000; "Declines in Teenage Birth Rates1991-1997: National and State Patterns." National Vital Statistics Reports, December 17, 1998.

Births Per 1,000 Teens (15-19) by Race/Ethnicity	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
All teens	62.1	60.7	59.6	58.9	56.8	54.4	52.3	51.1	49.6	-20.1%	-15.8%	-2.9%
Hispanic teens	106.7	107.1	106.8	107.7	106.7	101.8	97.4	93.6	93.1	-12.7%	-13.6%	-0.5%
Black teens	118.9	116.0	112.2	107.7	99.3	94.2	90.8	85.4	81.1	-29.8%	-24.7%	-5.0%
White Teens	43.4	41.7	40.7	40.4	39.3	37.6	36.0	35.2	34.1	-21.4%	-15.6%	-3.1%
American Indian	85.0	84.4	83.1	80.8	78.0	73.9	71.8	72.1	67.7	-20.4%	-16.2%	-6.1%
Asian /Pacific Islander	27.4	26.6	27.0	27.1	26.1	24.6	23.7	23.1	22.6	-17.5%	-16.6%	-2.2%

Source: "Births: Preliminary Data for 1999," National Vital Statistics Reports, August 8, 2000, NCHS, CDC.

18.7% Since 92

Pregnancy Per 1,000 Teens (15-19)	1991	1992	1993	1994	1995	1996	% change 1991-1996	% change 1994-1996	% change 1995-1996
All teens	116.5	112.8	110.4	107.6	102.7	98.7	-15.3%	-8.3%	-3.9%
Hispanic teens	164.6	167.8	166.1	167.2	162.8	157.1	-4.6%	-6.1%	-3.5%
Black teens	221.7	217.3	211.7	201.2	184.4	177.8	-4.6%	-11.6%	-3.6%
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Source: "Trends in Pregnancies and Pregnancy Rates by Outcomes," Vital Health and Statistics Reports, February 2000, NCHS, CDC.
Note that there is a lag in reporting pregnancy data because it combines birthrate, abortion and miscarriage data. Pregnancy data for unmarried women is not available for specific age groups.[1]

[1] Note: This chart does not include data from CDC's July 14, 2000 Morbidity and Mortality Weekly Report (MMWR) including teen pregnancy rates for 1997, because the MMWR report used a different methodology to calculate teen pregnancy, this data is not comparable with the data put out by NCHS. However, this data does indicate that there was a decline of 7.8 percent in pregnancy rates for teen 15-19 from 1995 to 1997.

Teen Birth and Pregnancy Rates
Rev. 8/8/2000

Number and Percent of Births to Unmarried Teens (15-19)	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1999	% change 1994-1999	% change 1998-1999
Number (thousands)	357.5	353.9	357.4	381.5	375.7	373.3	376.1	380.9	373.8	+4.6%	-2.0%	-1.9%
Percent of teen births to unmarried teens	68.8%	70.0%	71.3%	75.5%	75.2%	75.9%	78.2%	78.6%	78.6%	+9.8 pctg. pts	+3.1 pctg. pts	No change

Source: "Births: Preliminary Data for 1999," National Vital Statistics Reports, August 8, 2000, NCHS, CDC. "Births: Final Data for 1998," National Vital Statistics Reports, March 28, 2000, NCHS, CDC.

Births Per 1,000 Unmarried Teens (15-19) by Race/Ethnicity	1991	1992	1993	1994	1995	1996	1997	1998	1999	% change 1991-1998	% change 1994-1998	% change 1998-1998
Unmarried teens	44.8	44.6	44.5	46.4	44.4	42.9	42.2	41.5	N/A	-7.4%	-10.6%	-1.7%
Hispanic unmarried teens	72.4	72.9	74.6	82.6	78.7	74.5	75.2	73.9	N/A	+2.1%	-10.5%	-1.7%
Black unmarried teens	108.5	105.9	102.4	100.9	92.8	89.2	86.4	83.4	N/A	-23.1%	-17.4%	-3.5%
White unmarried teens	N/A	N/A	N/A	28.1	27.7	27.0	25.9	25.7	N/A	N/A	-8.6%	-0.8%

Source: "Births: Final Data for 1998," National Vital Statistics Reports, March 28, 2000, NCHS, CDC.
N/A: Until 1994, data on non-Hispanic white unmarried teens was available only during the decennial census; also birth rates for unmarried teenagers for 1999 are not yet available.

Highlights of trends:

- Teen birth and pregnancy rates for all groups of teens have continued a steady decline since 1991 and have reached historic lows. The birth rate for 15-19 year olds is now the lowest it has been since we began collecting data on teen births 60 years ago.
- Teen birth rates declined more quickly from 1998-99 than from 1997-98, showing that the rate of improvement in teen birth rates is not slowing despite prolonged declines.
- The largest declines in teen birth rates since 1991 occurred among black teens. American Indian teens had the largest decrease (6%) in the past year.
- Teen pregnancies are at a record low, declining for all groups (though at a bit slower rate for Hispanic girls) according to our most recent data (1996). Data released by CDC's in Mortality and Morbidity Weekly Report (7/14/00) found that this decline continued in 1997 (see footnote above).
- The *absolute number* of births to unmarried teens has increased from 1991, but decreased about 2 percent from 1998 to 1999.
- The *percentage* of all teen births to unmarried teens has risen over the 1990s by almost 10%, driven by a faster decline in married teen births than in unmarried teen births; however, this percentage leveled off between 1998 and 1999.
- The *rate* of births per 1,000 unmarried teens has declined by more than 7% during the same period.
- Among unmarried teens, the birth rate remains highest for black teens as of 1998.

WF - Teen Pregnancy

Report Shows Children's Well-Being Is Improving

By Dale Russakoff
Washington Post Staff Writer

A1

The federal government's most comprehensive gauge of children's well-being shows child poverty, child mortality, teenage pregnancy and juvenile violence at their lowest rates in 20 years, officials announced yesterday. Teenage pregnancy, the new report shows, has reached its lowest rate since the government began collecting statistics.

The annual compilation of voluminous, child-related statistics gathered by federal agencies also documented wide disparities by race and income—with white, affluent youth far ahead of their counterparts—although measures of distress declined in all groups.

Despite the progress, the United States remains well behind the rest of the industrialized world and even some Third World countries in some categories, according to U.S. and international studies.

The performance of all ethnic groups in school has not improved, and there has been no decrease in binge drinking, smoking and drug use.

"The good news is that so many indicators are improving, and keep improving," said Duane Alexander, a physician who directs the National Institute of Child Health and Human Development. "But even with teenage pregnancy, which just reached the lowest level ever recorded in this country, we have the highest rate in the industrialized world."

The report, "America's Children: Key National Indicators of Well-Being," compiled by the Federal Interagency Forum on Child and Family Statistics, reflects intensifying national attention to what is now the largest generation of children in American history. At 70.2 million in 1999, the number of Americans under 18 is now larger than it was at the peak of the baby boom in 1964, although it is a much smaller proportion of the total U.S. population.

Release of the data prompted widely divergent views of their implications for the future of children and the nation.

President Clinton, addressing the NAACP at its national convention in Baltimore, called the report "very good news." But the Children's Defense Fund, which champions low-income families, emphasized that child poverty is no lower today than in 1980—before the crack cocaine epidemic, recessions and AIDS devastated inner cities.

"To have the 1980 child poverty rate in a time of record, sustained prosperity has to be viewed as a failure," said Susanne Martinez, the group's senior vice president for policy. "We should not be bragging about that."

Douglas Besharov, a social policy analyst for the American Enterprise Institute, said the gains reflect important economic and behavioral changes.

"The people who said a strong economy would redirect a lot of these trends were right," he said. "But the folks who said our problems were problems of choice—meaning that people could clean up their acts and behave more 'virtuously'—turned out to be right also."

The improvements were only incrementally better than last year's results, but reflected steady gains over five or more years in most categories.

Analysts of all persuasions said improved conditions could foster a healthier and less dependent generation, reducing pressures on schools, social welfare agencies and the health care system. But persistent racial and economic disparities threaten to skew the benefits, they added.

For example, the report shows that infant mortality has declined nationally from 10.9 infant deaths for every 1,000 live births in 1983 to 7.2 in preliminary data from 1998, the latest year available. But among blacks, the rate is 13.7, or more than twice as high as among whites and Hispanics, the report shows.

But the United States lags behind more than 20 countries in infant mortality, including Singapore, Hong Kong, Israel, Northern Ireland and most of Europe. Similarly, while the rate of firearms deaths of U.S. adolescents has declined markedly since its peak in 1994, it still dwarfs the rate in Israel and New Zealand.

Among Americans aged 18 and 19, the rate is 27 per 100,000, while in England it is 0.3, according to Lois Fingerhut of the National Center for Health Statistics at the U.S. Centers for Disease Control and Prevention.

"It's not good news no matter how one looks at it on an international scale," said Kenneth Schoendorf, who heads the health statistics center's branch on child health.

The poverty rate for children dropped to the lowest level since 1980—18 percent in 1998, the most recent year for which statistics are available—continuing a five-year decline since it peaked in 1993, the report shows. But the rate among black children is 36 percent and 34 percent among Hispanic children, a marked contrast to the white child poverty rate of 10 percent.

Among industrialized countries, according to a recent UNICEF report on child poverty, the United States has the second-highest percentage of children living in households with incomes below 50 percent of the national median. Mexico's rate was 26 percent, the United States, 22.4 percent. Sweden was the lowest with 2.6 percent.

Perhaps the most unqualified successes came in child immunization and decreased teenage pregnancy. Based on 1998 data, the pregnancy rate dropped to 30.4 births nationally for every 1,000 females between ages 15 and 17. It peaked at 38.7 in 1991.

The drop was most dramatic among black teens—from 84.1 in 1991 to 56.8 in 1998. Hispanic teenagers have the highest birthrate, at 62.3 per 1,000 girls ages 15 to 17, down from a peak of 74 per thousand.

The persistence of binge drinking, drug use and cigarette smoking disturbed child advocates. "We have a war on drugs, but alcohol remains the number one drug in cost to kids—killing kids, destroying the potential of kids," said Enoch Gordis, director of the National Institute on Alcohol Abuse and Alcoholism.

Similarly, lagging educational performance and a slight increase in dropout rates prompted concern, with school reformers seizing on the report to call for structural changes such as more charter schools and stricter adherence to new standards.

"Everyone always agreed that it's not a good idea to have young children dying or having babies, but it's taken over a decade of pushing and shoving to persuade people we have a crisis in public schools," said Jeanne Allen, president of the Center for School Reform.

Rebecca Maynard, an economist at Princeton University who specializes in educational research and policy, emphasized that it would take many years for improved economic and social conditions to change school achievement.

"Educational outcomes will show greatest improvements for youths who experience improved environments from a young age," she said.

The Washington Post
Friday, July 14, 2000

China Threatens Arms Control Collapse

Top Negotiator Says Missile Defense Puts Treaties at Risk

By John Pomfret
Washington Post Foreign Service

BEIJING, July 13—China's top arms control negotiator warned today that U.S. deployment of a national missile defense system would risk collapsing the whole architecture of China's arms control and nonproliferation agreements with the West.

Sha Zukang, director general of the Foreign Ministry's department of arms control and disarmament, also stressed that the sale of U.S. technology to Taiwan for a smaller-scope theater missile defense system would "lead to serious confrontation" because it would be tantamount to restoring a military alliance between Taipei and Washington.

"This is of supreme national interest," Sha said in an interview. "It will be defended at any cost."

Sha's warnings marked an escalation of China's war of words against the plan to protect U.S. territory and U.S. troops abroad from missile attack. China had previously indicated it might expand its nuclear forces to compensate for the proposed U.S. defense system, but Sha broaded the possible consequences to include a renunciation of previous undertakings barring nuclear or chemical weapons proliferation and nuclear testing.

"I have spent the most valuable and important part of my life, 16 years, on these issues," said Sha, a veteran diplomat who led China's team in the Comprehensive Test Ban Treaty negotiations and is considered the most knowledgeable and vocal Chinese official on this issue. "Now all of these achievements are at risk."

Sha made his comments as Defense Secretary William S. Cohen wrapped up his first trip to China in almost three years. While Cohen was upbeat about his visit, on the subject of the national missile defense system, he acknowledged: "I don't know if our differences . . . have been narrowed."

Sha predicted that if President Clinton or his successor decides to go ahead with the U.S. plan to protect itself from missile attacks, it would backfire and create enormous security headaches for the United States.

"Instead of enhancing your security, your security policy will be further compromised," he said. "The United States will play the role of a fire brigade. Rushing from one place to another to extinguish fires."

He rejected U.S. assurances that the plan is not aimed at China but rather at what Washington regards as unpredictable and hostile "states of concern," such as North Korea, Iran and Iraq. "That doesn't matter, the consequences are still terrible for us," he said.

Asked if China would reconsider its commitment to nuclear disarmament and a halt in sensitive weapons sales, he responded: "To say the least, our enthusiasm and our participation in all of those regimes, particularly in cooperating with the United States, our mood, let me say, would be severely dampened."

China has already taken practical steps to block U.S.-backed disarmament proposals because of the missile defense issue. In Geneva, Beijing's delegation to the Conference on Disarmament is holding up talks on a treaty to stop production of fissile material, said Bates Gill, a China security specialist at the Brookings Institution. China instead wants the conference to focus on a treaty to limit or control space-based weapons systems, which could be part of an expanded, multi-tiered missile defense scheme.

When asked if a decision to deploy missile defenses would also affect China's existing arms control treaties, Sha used a similar formulation: "To say the least, it would seriously dampen our interest. . . . We have not reached a stage to say we will forget our commitments . . . yet." But he added that China would link its attitude toward nonproliferation and modernization of its nuclear forces to the success of the national missile defense program.

"It is too early to say what we will do," he said. "All I can say is that China will do everything possible to ensure its security, and the measures it will take will be in proportion to the success" of national missile defense.

While Sha's comments seemed calculated to affect the debate in the United States, they nonetheless could have serious consequences, because the United States already has accused China of extensive proliferation. It is widely believed China supplied Pakistan with at least the design for a nuclear weapon; Pakistan detonated a nuclear device in 1998. China has also sold missiles or missile technology to Pakistan, Iran and Libya, and ballistic missiles to Saudi Arabia.

The idea behind missile defense is to shoot down incoming missiles. The United States is considering deploying the beginning of a limited national shield system within its borders, as well as other, more limited systems outside the United States to protect its troops abroad and its allies.

Currently, for instance, the United States and Japan are working together on constructing a theater missile defense program for northeast Asia.

The technology and the politics surrounding the systems are equally complex. So far, the United States has conducted three intercept tests of the proposed missile defense system, two of which have failed. In addition, going ahead with a national system would necessitate amending the 1972 Anti-Ballistic Missile Treaty signed with the former Soviet Union.

That treaty banned construction of missile defense systems and was, Sha said, the "cornerstone" of arms control agreements during the Cold War. Citing the treaty, Russia has strongly opposed national missile defense, as have several European countries.

China has opposed both national and theater missile defense, for different reasons.

China, which first detonated a nuclear device in 1964, has never tried to match U.S. or Russian nuclear arsenals, preferring to keep a small number of strategic weapons for defense. China is believed to possess around 20 rockets that can deliver a single warhead, and it is working on a multiple warhead delivery system.

An effective national missile defense, Sha said, would risk negating China's limited arsenal and upending the "strategic stability" that ensures deterrence around the world.

Beijing fears theater missile defense, which would cover a more limited area, because the People's Liberation Army is strong in missiles but weak almost everywhere else. Removing China's strategic and conventional missile threat in the Asian theater—particularly as regards Taiwan—would cripple its plans to regain what it feels to be its rightful place in regional security.

Sha said exporting theater missile defense technology specifically to Taiwan would also constitute a belligerent act on the part of the United States and would mark the first step in resumption of a U.S. military alliance with Taipei. That alliance was abrogated in the 1970s as a condition for the historic rapprochement between Washington and Beijing.

"Wear our cap for a moment," he said. "Imagine we are pumping arms to one of your states and supporting their independence. How would America feel about it?"

China regards Taiwan as a renegade province and believes U.S. high-tech weapons exports to the island democracy of 22 million people encourage Taiwan's government to avoid unification with China.

Although most of the Clinton administration's diplomacy on missile defenses thus far has concentrated on mitigating the responses from Russia and Europe, the Democratic Party defense intelligentsia is almost unanimous in arguing that the impact on relations with China would be the strongest negative fallout on national security.

John Deutch, Harold Brown and William Perry, all former senior U.S. security officials, have argued publicly that China can be expected to increase its arsenal and drop cooperation on arms control and nonproliferation. That, in turn, could spur India, which also detonated a nuclear device in 1998, and then Pakistan, to do the same, they have warned.

The Washington Post
Friday, July 14, 2000

THE PRESIDENT HAS SEEN
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THE WHITE HOUSE

WASHINGTON

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Podesta

January 14, 2000

Bruce
Per our conversation
Await for call

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed
Cynthia Rice

SUBJECT: Second Chance Homes

We understand Jane Fonda would like to talk to you about second chance homes. Ms. Fonda has been very involved in teen pregnancy prevention efforts, and is the founder of the Georgia Campaign for Adolescent Pregnancy Prevention.

Background on Second Chance Homes

As you know, the 1996 welfare law included a provision you championed to require unmarried minor parents to attend school and live with a parent, guardian or adult relative in order to receive TANF, unless these options are not available or appropriate. For teens unable to live at home or with relatives, states must provide access to an adult-supervised and supportive living arrangement such as a second chance home. States can use TANF funds to pay for these homes.

To date, several states (including Massachusetts, Nevada, New Mexico, Rhode Island, and Texas) have statewide second chance homes programs, and at least 16 states have local programs. Rough estimates show that current programs are serving about 1,000 teen mothers each year.

What More We Can Do

This fall, we began to consult with experts about what more we could do to encourage second chance homes. (One of these experts, Kathleen Sylvester, formerly of the Progressive Policy Institute, has also been working with Fonda, which may have prompted this call.) Fonda may be calling to urge you to do more in general on second chance homes; or she may be urging you specifically to include new funding in your budget.

In general, we do not think funding is an obstacle to the expansion of second chance homes. States currently have $4.2 billion in unobligated TANF funds, or 11 percent of the total awarded, that they could devote to these efforts. Thus, we did not recommend to you any new spending in the FY 2001 budget.

However, there are several very helpful steps we believe we could take by executive action, and once the budget is completed, we were planning to work with HHS and HUD to develop such a package, which we believe could include:

1. Issue HHS guidance to states making clear how they can use TANF and other federal funds for second chance homes. In our experience, guidance like this often spurs action by providing reassurance to state budget officials and fodder for state advocates.

2. Direct HUD to make certain surplus properties available, at a 50 percent discount, to nonprofit groups that want to purchase them to create second chance homes. Since TANF funds cannot be used to purchase property, this action would provide another way to subsidize such purchases. (It is not necessary to purchase property in order to run a second chance home, of course – TANF funds may be used to rent property for such homes – but this action would provide additional options.)

3. Direct HHS to use existing evaluation funds to research the impact and effectiveness of these programs. We believe more states and communities will be willing to put homes in place if there is more concrete evidence of their effectiveness in helping teen parents become self-sufficient and prevent additional out-of-wedlock births.

Note that we have not yet vetted these ideas with the agencies, but plan to very shortly.

Support for Second Chance Homes

There is widespread political support for second chance homes. Senator Moynihan and Senator Bradley have both proposed new funding for second chance homes (Moynihan at $45 million a year and Bradley at $300 million a year). Governor Bush, as part of his faith-based platform, said he would provide a block grant to states (amount unspecified) for pilot maternity homes.

Teen-Age Birth Rate in U.S. Falls Again

Trend Spans Ethnic Groups and Geographic Areas, Report Finds

By MARC LACEY

WASHINGTON, Oct. 26 — The nation's teen-age birth rate fell again last year to a near-record low, Federal health officials said today, continuing an encouraging trend that spans ethnic groups, geographical areas and ages.

Officials of the National Center for Health Statistics said high school girls 15 to 17 years of age had the lowest birth rate in 40 years. For younger girls, ages 10 to 14, the rate was the lowest level since 1969. African-American teen-agers recorded the lowest birth rate since 1960, when such data were first gathered, and the rate among Hispanic women also dropped precipitously, officials said.

"There has definitely been a decline in sexual activity among teen-agers, both boys and girls," said Stephanie J. Ventura, the Government demographer who wrote the report. "There is also more consistent use of birth control, especially condoms. Finally, you have to look at the widespread attention this subject has gotten."

The positive trend showed up across the country, with 10 states and the District of Columbia recording declines of more than 20 percent. Vermont and Alaska had the biggest declines, while Rhode Island, Arkansas and Puerto Rico recorded the smallest. But even with the lower numbers across the country, health officials said they still saw far too many unintended births.

Babies were crying at the Hart Infant Center not far from the Capitol, and Betty Lightfoot, the director, was not sure she had heard the news correctly. Teen-age pregnancies were really down for the seventh straight year? she asked. The teen-age birth rate here really fell 20 percent from 1991 to 1997?

"If that's so, it's great," Ms. Lightfoot said. "But our day care for teen mothers is still full. We still have a maximum of 10 here and a maximum of 20 at another site. Girls are still having babies."

Ms. Lightfoot cares for three babies who were all born to one 17-year-old girl. The young mother drops her children off at the center in the morning and goes to high school classes during the day. And she is pregnant with her fourth child.

"It's still a problem," said Ms. Lightfoot, who was herself a mother at the age of 14.

Health officials agree. Despite the decline, they said, teen-age birth rates in the United States still far exceed those in other industrialized countries. The statistics also show that the proportion of unmarried teen-agers giving birth continued to increase in 1998, to 78.8 percent of teen-agers from 78.2 percent in 1997.

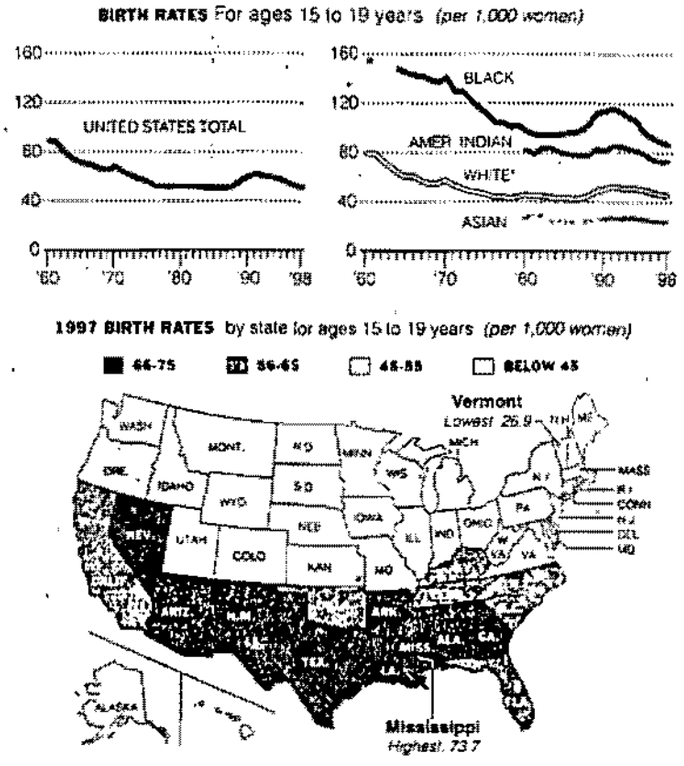
"To get to where the rest of the developed world is, we have a lot of work to do," said Kristin Moore of Child Trends, a research and advocacy group in Washington. "Our lowest state has a rate equal to about the highest rate in the developed world."

Ms. Ventura said the teen-age birth rate in the United States was in the same league with the Philippines, Indonesia, Thailand and Turkey. She said Japan, France, Germany and Britain had teen-age birth rates that were significantly smaller than those in the United States.

KEEPING TRACK

Fewer Births to Teen-Agers

Birth rates for teen-agers have continued to decline in recent years.



Source: National Center for Health Statistics

*Includes those who are Hispanic

The New York Times

Sarah Brown, director of the National Campaign to Prevent Teen Pregnancy, an advocacy group in Washington, was attending a conference today on teen-age pregnancy in South Carolina. Mrs. Brown said in a telephone interview that one person at the conference reported that an 8-year-old girl and a 9-year-old girl had recently became mothers.

"The principal challenge among those of us working in the field is to avoid a sense of complacency," Mrs. Brown said. "This new data is terrific news, but we still remain the industrialized country with the highest degree of teen pregnancy and abortion. And even if we don't compare ourselves to other countries, we still have too many girls giving birth."

Despite a decline, the U.S. still does poorer than its peers in a crucial area.

The birth rates among minority girls are falling particularly fast, the report found. But the birth rates for Hispanic and African-American teen-agers were still considerably higher than those for whites.

"Even though the decreases have been remarkable in our community, we still have a higher rate of unintended pregnancies and abortions than white women," said Shelia Clark, public policy associate at the National Black Women's Health Project. "We still have to work on issues of poverty. We have to work on education. This is not a dead issue."

How to get the numbers to decline ever further remains the challenge. Miss Clark points to opportunity as one answer.

"When you give people in general — and African-Americans in particular — increased access to education and employment, you increase their quality of life and reduce the number of unintended pregnancies," she said.

In the district's schools, officials have health centers in the high schools to distribute condoms and educate students on sex. There are also child care centers to allow teen-age mothers to continue their studies, and a program called Teen Moms Take Charge to teach prenatal care and prevent more births.

Ms. Lightfoot, who sees the young mothers drop off their children in her center every day, also tries to use her own experience as a teen-age mother to educate them.

"It was hard for me," said Ms. Lightfoot, who is 42. "It was like one minute I had a doll and then the next minute I had a real baby. I share everything I've gone through. How I had to put everything in my life off. Maybe one day they'll listen."

Anxious Wife Tried to Call Golfer During Fatal Flight

By MATTHEW L. WALD

WASHINGTON, Oct. 26 — Payne Stewart's wife, Tracey, was one of the millions of people transfixed by television reports on Monday about his Learjet flying uncontrolled across the United States, and she tried to call him on his cellular phone, a family member said.

"She tried to ring Payne on his cell phone, but she couldn't raise him," said Mike Ferguson, a brother of Mrs. Stewart, whose husband, the golf champion, died with five others in the plane, which crashed in South Dakota.

As investigators began a tedious search for clues, the electronic age added a twist to the old-fashioned tragedy of a plane crash: an advertisement offering the doomed plane for sale was still posted today on the Web page of the operator, Sunjet Aviation. The plane had a new interior installed in July 1998, including a compact disc sound system and "medium gray carpet w/gray accents."

"The aircraft is in premium condition inside and out," the advertisement said.

Crash investigators said today that the Learjet, which flew 1,400 miles before it crashed near Mina, S.D., had buried itself deep in the soft mud, promising a laborious task. The plane apparently hit the ground at a high angle, creating a compact field of debris, and Robert T. Francis, the vice chairman of the National Transportation Safety Board, speaking near the site, said it would take time to recover the pieces in a way that preserved all possible information.

Mr. Francis said investigators would pay special attention to the seals around the doors and windows, among other parts. Asked about identifying parts in the wreckage, he said, "I was amazed this morning, standing at the side of the pit out there, that the folks from Lear could say, 'That's the horizontal stabilizer; that's part of the aileron.' "

According to the Federal Aviation Administration, the two pilots stopped responding to air-traffic controllers some time after reaching 37,000 feet, and Air Force jets called out to chase the Lear found that its windows were fogged. The plane's mechanical systems kept working, including the autopilot and a radio beacon that faithfully broadcast the flight's identity and altitude.

The Lear, which can carry up to eight passengers, had a cockpit voice recorder, but it had not been found by this evening. Even if it is found, the recorder is unlikely to have any voices on it, because the plane flew for four hours. The recorder's tape is only 30 minutes long, and newer conversations record over earlier ones.

As is the case with most corporate jets, this one did not carry a flight data recorder. Mr. Francis said this evening that investigators had picked up wreckage, including human remains from the area around the crater created by the crash, and would begin work in the crater itself on Wednesday.

He also said that Air Force planes had shot video the Lear at the end of its flight but that the quality was not good enough to make it useful.

South Dakota officials said they would order tests on the human remains but that there was no specific test to determine if the two pilots and four passengers had been knocked out or killed by a lack of air. Loss of cabin pressure is one possible cause of the accident. Smoke in the cockpit is another, and that can be determined from blood tests, as well as from evidence in the wreckage.

Investigators were also interviewing the pilots of military chase planes, and asked if any member of the public had made a videotape of the crash.

Meanwhile, other investigators were poring over maintenance records of the plane, which was built in 1976 and had made about 7,500 flights. One question was whether the operators had complied with an order from the Federal Aviation Administration in November 1995 to replace the valve that controls the flow of air out of the cabin. The valve, under the co-pilot's seat, is one place where a cabin pressure problem could develop, if that is what happened to this plane. The aviation agency ordered planes using the valve not to fly above 41,000 feet until the repair was done, and to do the work within 18 months.

David M. Franson, a spokesman for Lear, a subsidiary of Bombardier Inc., said the order, which amounts to a recall, began when Allied Signal Aerospace, which supplied the environmental control system, found a defect in the manufacturing process. It was not set off by a failure, he said.

SERVICE FOR STEWART

The PGA Tour has modified its championship tournament to accommodate a service for Payne Stewart. SportsWednesday, page A29.

Books of The Times: Weekdays

WR-
Teen
Pregnancy

Steady drop in teen birth rate has many 'proud parents'

From one segment of the population in which "Mom, I'm pregnant" almost always constitutes bad news, there's great news: Teen pregnancy has declined for the seventh year in a row.

The proportion of teens having sex and those having abortions also has been declining. And this massive behavioral reversal has interest groups patting themselves on the back.

For every 100 girls age 15-17, three had babies in 1997. That's a 17% drop since 1991, according to new government data.

Obviously, there's more room for progress: 50% of girls having sex in their teens is a far cry from the 29% who'd done so in 1970. Yet the trend in decreasing teen births looks durable: It crosses regional and racial lines. All states have seen the birth rate among teens drop. And the seven-year, 24% drop among black teen-age girls, to seven births per 100 girls, is the most dramatic.

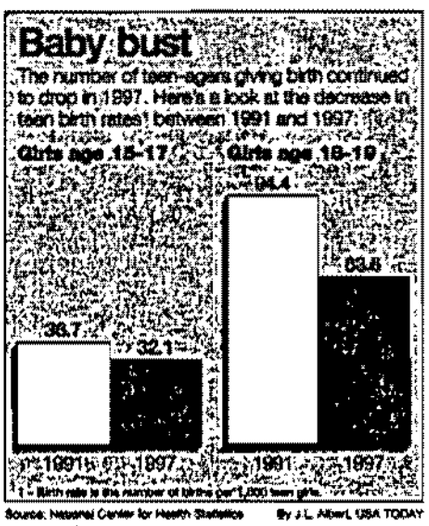
So where do the fewer babies come from?

Interest groups are quick to explain these new facts of life. Planned Parenthood credits "increased and improved use of contraceptive methods." National Right to Life applauds the abortion drop, "due to the pro-life movement's educational and legislative efforts."

Some credit is given to abstinence education, now being pushed by more than 60 state and local organizations. Even popular music groups such as TLC and the Spice Girls advocate sexual self-respect.

Then there's welfare reform, now two-and-a-half years old, which makes would-be teenage parents think twice about having babies the government is less eager to support. And teens themselves are quick to stress that awareness of AIDS and sexually transmitted diseases, pushed in the classrooms and even on MTV, can act as an effective cold shower.

Or at least an incentive to use protection. An earlier government survey showed two-thirds of women now use condoms the first time they have sex, up from 18% in the 1970s.



There's truth in all these explanations for teen birth rates. Success does, after all, have a thousand fathers. But perhaps there's also a common theme at work. Call it fear of the consequences.

The rules of welfare reform require even teen parents to accept greater financial responsibility for babies. And AIDS education has taught many teens a fear of disease.

One fear that doesn't come up among interest groups' hot buttons, though, is that of getting hurt — for example, by having sex before one is old enough to foresee weak commitment. Maybe that's a lesson for parents to work on.

The bottom line is that among all the educating and advocating, something's being done right. And increasingly, it's keeping kids focused on kids' stuff, not kids of their own.

Today's debate: Nonviolent drug offenders

Treatment in lieu of jail works

OUR VIEW **Ariz. probation program saves money, begs imitation.**

By late 1996, Arizona voters were fed up with nickle-and-dime drug abusers sitting on their duffs in state prisons and jails at taxpayer expense. So they approved a proposition making Arizona the first (and so far only) state to require that people convicted of nonviolent drug offenses be given probation and treatment rather than a prison sentence.

After one full year in practice, the proposition's excellent results have begun attracting interest from both state and federal lawmakers, and no wonder. If nothing else, the idea is a demonstrated money-saver.

According to Arizona Supreme Court estimates, taxpayers saved $2.5 million in the first year alone by not jailing 2,622 first- and second-time offenders. Makes sense. The Arizona slammer costs $50 per person a day; probation and treatment cost $30. Bonus: 70% of those in mandatory programs made at least one payment against the cost of their treatment.

In another study, the state's Auditor General documented a correlation between mandatory treatment and probation outcomes. About 85% of those in mandatory programs also successfully completed their probation, which means they didn't commit a new crime, abscond, test positive for drugs or have some other problem. When treatment is not required, success is less than 60%.

This is terrific news for Arizona, which houses a record 26,000 convicts in its prisons and jails. But it's also good news for the rest of the country, where the war on drugs has jammed state and federal prisons with hundreds of thousands of drug offenders, each of them doing their time at a cost to taxpayers of $20,000 per inmate per year in state prisons; $23,000 in federal ones. Plainly, the potential savings of keeping low-level drug offenders out of prison are pronounced.

No one wants traffickers and violent drug offenders to skate. And that's not happening in Arizona. But as the studies indicate, there are more effective solutions for the tens of thousands of small-fry users than ordering up a stretch in an overcrowded slammer.

Programs that keep drug users free and in treatment are a hard sell for lawmakers who believe that (a) drug use should be punished and (b) treatment is a luxury. Yet Arizona demonstrates how narrow that view really is. Users who receive treatment, even under court order, are less likely to commit new crimes. This, in turn, produces additional savings and security.

Fact is, drug abuse and drug-related crime are a bipartisan epidemic. Likewise, the inadequacy of lock-'em-up strategies is a nonpartisan fact.

Against that, why shouldn't Arizona keep convicted users out of jails and in treatment? Why doesn't every state?

Don't claim victory yet

OPPOSING VIEW **Success only proved if inmates do not return to crime.**

By Robert L. Maginnis

I commend Arizona's efforts to treat drug-addicted criminals. But let's wait to see what happens to these felons after treatment and probation, before declaring victory.

America has a serious, drug-related prison crisis. The inmate population is expected to rise to 2.1 million by 2002. A growing number of these inmates were drug offenders. Annual prison costs are a staggering $38 billion.

The prison problem reflects our drug-soaked society. In 1997, nearly three-quarters of all arrestees tested in 35 cities nationwide had drugs in their system at the time of arrest.

As street-drug prices decline, social costs climb. Thus, as per-gram costs for hard drugs have dropped 50% since 1988, a government study estimates the social costs of illegal drugs are at least $98 billion annually and rising.

Voters want something done. A recent Family Research Council poll found that 48% of voters give a high priority to prison-based substance-abuse treatment to reduce crime.

Most arrested drug offenders never go to jail. Of those who do, few are ever treated. Without drug treatment while in prison, most drug offenders quickly return to bad habits, earning them more hard time. In addition, most probation and parole programs are largely ineffective because they are underfunded.

Arizona, with its adequately funded parole and treatment program, may provide a model for dealing with nonviolent drug offenders with no prior record. But in many cases, drug offenders charged with a variety of crimes, including violent ones, plea-bargain their sentences down to only probation. It is not yet known whether Arizona's probation and treatment candidates would be more likely to return to their old ways because no hard time had been served.

Since the late 1980s, the Delaware Corrections Department has run both institutional and transitional drug treatment programs. Although their results are among the best, they don't reach the lofty heights promised but not yet proved by Arizona.

Drug treatment and other alternatives to incarceration for nonviolent drug offenders should be tested. Only programs that truly reduce recidivism and prison costs while punishing offenders fairly should be embraced.

Robert Maginnis is senior director for national security at Family Research Council.

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Brookings
November 1998 ■ no. 38

Teen Pregnancy Prevention: Welfare Reform's Missing Component

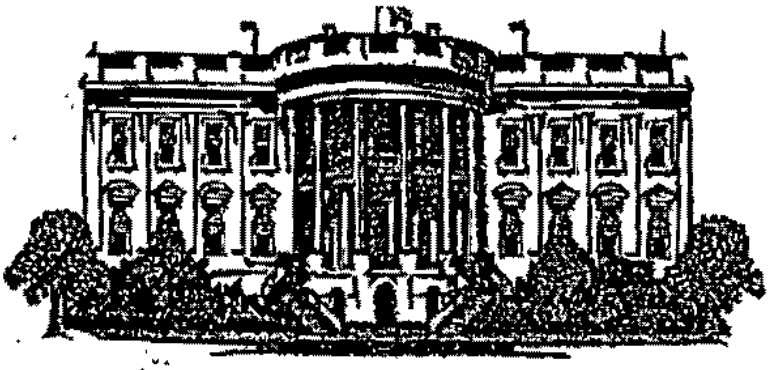
Welfare reform is being widely heralded as a success. But without attention to teen pregnancy and its corollary, single-parent homes, the reform's victories may be fleeting. In the last decade, teen pregnancy rates have declined somewhat, but remain twice those of other industrialized nations. Unless this underlying situation is addressed, child poverty and other social problems are likely to increase.

Educating teens about the consequences of early sex while continuing to make contraceptives available can go some way toward solving the problem. So, too, can after-school or mentoring programs and holding young men accountable for their actions. But to really effect change, what is needed is a broader campaign to strengthen social norms against early sex and out-of-wedlock pregnancy.

Isabel V. Sawhill

Two years after the enactment of welfare reform, the new law is being hailed as a great success. Caseloads have declined by one-third since the law was signed, and with fewer individuals to support, the states are flush with money. A strong economy interacting with tougher welfare rules and more support for the working poor is helping to turn welfare checks into paychecks. But the welfare system is like a revolving door. In good times, more people move off the rolls than come on and caseloads decline. But in bad times, exactly the reverse can occur. The only way to permanently reduce poverty and its associated expense is to stem the longer-term trends, such as more out-of-wedlock childbearing, that have historically pushed child poverty and caseloads up. Unless the states invest their surplus funds in programs aimed at *preventing* poverty, success may be short-lived or purchased at the expense of the children it was designed to help. If every recipient who finds a job is replaced by a younger sister ill-prepared to support a family, the immutability of the revolving door will once again prevail.

Common and Uncommon Sense from the Brookings Institution



THE WHITE HOUSE

WR - Teen Pregnancy

Domestic Policy Council

DATE: 9/17

FACSIMILE FOR: Bruce/Elena

FAX: 6 2878
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FACSIMILE FROM: Andrea Kane

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NUMBER OF PAGES (INCLUDING COVER): 5

COMMENTS: Here's 1st few pgs of HHS Report on Teen Pregnancy. I'll send over full rept if you're interested.

A NATIONAL STRATEGY TO PREVENT TEEN PREGNANCY

ANNUAL REPORT 1997-98

U.S. Department of Health and Human Services

June 1998

Table of Contents

Introduction

Despite the recent decline in the teen birth rates, teen pregnancy remains a significant problem in this country. It is a problem that impacts nearly every community. Thus, the responsibility to solve this problem lies with all of us, including families, communities, and young people themselves.

The President and Congress called on HHS to develop a National Strategy to address this serious challenge and to assure that at least 25 percent of communities in this country have teen pregnancy prevention programs in place--as mandated under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The Department responded to this call by releasing a National Strategy to Prevent Teen Pregnancy in January of 1997. This Strategy presented a comprehensive new plan to prevent teen pregnancies in the United States by strengthening, integrating, and supporting teen pregnancy prevention and other youth-related activities in communities across this country.

The Department is required by this law to report to the Congress by June 30th of each year on progress made with the Strategy. This represents our first Report to the Congress on the National Strategy to Prevent Teen Pregnancy. In this document, we also report that in FY 1997, HHS funded teen pregnancy prevention programs in at least 31% of the communities in the country. This is a conservative number as it only includes HHS funds that flow directly to the communities.

Good News. Statistics and data demonstrate some encouraging trends:

- From 1991 through 1996, HHS reported that teen birth rates declined for white, black, American Indian, Asian or Pacific Islander and Hispanic women ages 15-19.
- The birth rate for black teens demonstrated the largest decline—down a fifth from 1991 to 1996—reaching the lowest birth rate ever reported for blacks.
- Teen birth rates have decreased in every state.
- The teen pregnancy rate has also declined by 8 percent from 1991 to 1994.

Our Charge and the Work Ahead. While these data indicate that concerted efforts to reduce teen pregnancy may be succeeding, we still have a long way to go. The Federal government, the private sector, parents and other caring adults are all helping send the same message:

Don't become a parent until you are truly ready to support a child.

Key Principles. In implementing this National Strategy, we have adhered to and advanced the five principles highlighted in the January 1997 report. According to research and experience, these five principles are essential to community efforts.

The Five Principles

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

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

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

4. Public and private-sector partners throughout communities—including parents, schools, business, media, health and human service providers, and religious organizations—must work together to develop comprehensive strategies.

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

Reporting Our Progress. We hope that this annual report—and those that follow—will provide useful information on the efforts of the Department of Health and Human Services. We also hope to complement the efforts of others, such as those of the non-profit National Campaign to Prevent Teen Pregnancy, individual states and communities, foundations, other non-governmental entities, parents, youth, and other caring adults.

WR Teen Pregnancy

December 20, 1996

NOTE TO RAHM EMANUEL AND BRUCE REED:

As you know, the welfare law requires the Department to establish a national strategy to reduce teen pregnancy by January 1, and to assure that 25 percent of communities have teen pregnancy prevention programs in place. Attached is a draft of the strategy, which still has some holes. The news here is that we have a strategy that builds on our previous efforts and incorporates a strong abstinence message, and that we have new state-by-state teen birth data (to be included).

Rich and I would like to send this to interested members of Congress on January 2nd and put out an HHS press release. Rahm and I also talked about putting out a statement from the President to accompany the report, which I'd be happy to draft. I think if we wait to put this out in a larger event with the President after he returns from vacation, we risk being criticized for not following Congress's mandate and missing the January 1 deadline.

Please give me a call on Monday to discuss this further. I'll be out the rest of the week.

Thanks,

Melissa

THE NATIONAL STRATEGY

I. Enhance The National Response To Reduce Out-Of-Wedlock Teen Pregnancies

A. Strengthen Teen Pregnancy Prevention in Communities

Teen pregnancy is a problem that affects nearly every community. The responsibility to solve this problem lies with all of us, including families, communities, and young people themselves. In calling for a national campaign, Congress has recognized the critical importance of assuring that every community, large or small, urban or rural, is working to find solutions to this problem.

HHS-supported programs that include teen pregnancy prevention are just a part of the myriad and diverse teen pregnancy prevention efforts located in communities across the country. However, HHS plays an important leadership role in sponsoring innovative and promising strategies tailored to the unique needs of individual communities. For example, HHS-supported programs that include teen pregnancy prevention alone reach [27-52 percent – note: still working on this] of communities in the United States. (See Appendix I for an overview of HHS teen pregnancy prevention activities and the methodology used to make this count). **[add more discussion, caveats]**

Nevertheless, more can be done by every community to reduce out-of-wedlock teen pregnancies. As part of the national strategy, we will use new resources to strengthen, integrate, and support additional teen pregnancy prevention and youth development activities in communities across the country. Further, we will work with our partners to identify additional promising efforts and disseminate information about them to other communities.

B. Increase Opportunities Through Welfare Reform

The welfare law signed by President Clinton on August 22, 1996 calls for additional efforts to prevent out-of-wedlock teenage pregnancies and to assure that communities engage in local efforts to prevent teenage pregnancy. These additional efforts are a critical component of our national strategy. As President Clinton has said, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future."

Abstinence Education. The new welfare law provides $50 million a year in new funding for state abstinence education activities, beginning in FY 1998. States will be able to target these funds to high-risk groups, such as teenage boys and girls most likely to have children out-of-wedlock. These new funds will be available through the Maternal and Child Health Block Grant, starting in FY 1998.

Regs?

Teen Parents. Under the new welfare law, unmarried minor parents will be required to stay in school and live at home, or in an adult-supervised setting in order to receive assistance. The law also supports the creation of second chance homes for teen parents and their children who might be at risk of abuse if they remained in their own homes. Second chance homes will provide teen parents with the skills they need to become good role models and providers for their children, giving them guidance in parenting, child development, family budgeting, and proper health and nutrition, and in avoiding repeat pregnancies. Through our national strategy, the Department will work with states to gather information on Second Chance Homes and help to disseminate this information, as well as lessons learned, to states and communities across the country. **(Check again with ACF on language).**

Directive?

A National Strategy to Prevent Teen Pregnancy

Despite the recent decline in the teen birth rate, teen pregnancy remains a significant problem in this country. Each year, 200,000 teenagers aged 17 and younger have children. Their babies are often low-birth weight and have disproportionately high infant mortality rates. They are also far more likely to be poor. Approximately 80 percent of the children born to teenage parents who dropped out of high school and did not marry are poor. In contrast, just 8 percent of children born to married high school graduates aged 20 or older are poor.

The U.S. Department of Health and Human Services (HHS) has responded to a call from the President and Congress for a national strategy to reduce out-of-wedlock teen pregnancies and to a directive, under the new welfare law, to assure that at least 25 percent of communities in this country have teen pregnancy programs in place.

Building on our previous work on this area, our national strategy is designed to:

I. Enhance the national response to reduce out-of-wedlock teen pregnancies.

II. Support and encourage adolescents to remain abstinent.

Our national strategy will build on existing public and private-sector efforts and initiatives in the new welfare law by helping to provide the tools needed to develop more strategic and targeted approaches to reducing out-of-wedlock teen pregnancies. It will strengthen ongoing efforts across the nation by supporting promising approaches; building partnerships; improving data collection, research, and evaluation; and disseminating information on innovative and effective practices.

This strategy will also send the strongest possible message to teens that postponing sexual activity, staying in school, and preparing for work are the right things to do. In particular, our new Girl Power! campaign will engage the Department's teen pregnancy prevention programs in efforts to promote abstinence among 9 to 14-year-old girls. **(add another sentence to describe Girl Power! here? (ASL edit)**

KEY PRINCIPLES

As we move forward in implementing the national strategy, we will adhere to the following five principles that research and experience tell us are key to promising community efforts:

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

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

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

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

B.S.

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

Incentives for States. Under the new welfare law, HHS will award a bonus to the five states in the country that have the largest decrease in out-of-wedlock births while also having abortion rates lower than in 1995. The bonus will equal $20 million per state if five states qualify, and $25 million per state if fewer states qualify. HHS will work with these states to capture lessons learned and to disseminate that information to all interested parties.

Rules*

The Toughest Possible Child Support Enforcement. Through tougher child support enforcement, we will send the strongest possible message to young girls and boys that they should not have children until they are ready to provide for them. The new welfare law includes the child support enforcement measures President Clinton proposed in 1994 -- the most sweeping crackdown on non-paying parents in history. The new measures include: streamlined efforts to name the father in every case; employer reporting of new hires to locate non-paying parents who move from job to job; uniform interstate child support laws; computerized state-wide collections to speed up payments; and tough new penalties, like drivers' license revocation, for parents who fail to pay.

Studies

C. Support Promising Approaches

The five principles of promising strategies described above are reflected in the teen pregnancy prevention programs HHS supports, including the major demonstration programs of the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA). Additional funding for these programs in FY 1997 will enable communities across the county to expand their teen pregnancy prevention efforts.

The Community Coalition Partnership Program for the Prevention of Teen Pregnancy is one of HHS's most comprehensive and innovative teen pregnancy prevention programs. The CDC launched the program in 1995 by awarding grants to 13 communities in 11 states with high rates of teen pregnancy. The funds will be used to strengthen existing community-wide coalitions and develop community action plans. The next phase begins in FY 1997 when the 13 community coalitions will receive a total of $13.7 million for implementation of the action plans, evaluation of their impact, and other related activities.

The Adolescent Family Life Program (AFL), created in 1981, supports demonstration projects, approximately one-third of which provide abstinence-focused educational services to prevent early unintended pregnancies, sexually-transmitted diseases, and HIV/AIDS. Most projects provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families, with a major emphasis on preventing repeat pregnancies among adolescents. In FY 1996, the AFL program funded projects in 14 states, which will be continued in FY 1997. An additional $7.6 million in new funding will be used to enable smaller communities to develop and implement about 40 abstinence-based education programs and about 60 larger prevention demonstration projects, following the abstinence education definition in the welfare law. **(Lisa -- Ask Tom about last sentence)**

D. Build Partnerships

Building partnerships among all concerned citizens is essential to the success of the national strategy. Tackling the complex problem of reducing out-of-wedlock teen pregnancies will require a comprehensive, focused, and sustained effort from all sectors of society. Increasing both organized and individual efforts to address this problem will not be effective, however, if efforts continue to be fragmented and uncoordinated. By building partnerships among national, state, and local organizations; schools; businesses; religious institutions; federal, state and local governments; tribes; parents; and teenage girls and boys, we will be able to unite in our efforts to send a strong message of abstinence and personal responsibility to young people and to provide them with opportunities for the future.

HHS will initiate a broad partnership-building process to implement the national strategy and to solicit nationwide commitment and involvement in the goal of reducing out-of-wedlock teen pregnancies. The feedback from this process will allow us to refine the national strategy as well as to improve our ongoing efforts. In addition to the partners described above, we look forward to working with other federal agencies and with the National Campaign to Prevent Teen Pregnancy, a private-sector group that responded to President Clinton's challenge on this issue.

The strategy will also include a partnership effort with federal, state, and community organizations that work on behalf of teenagers with disabilities. Teens with learning disabilities, mental retardation, mental illness, and physical disabilities present a unique set of challenges in reducing out of wedlock pregnancies. Recent data indicate that approximately 40 percent of teenagers with disabilities leaving teen special education will become parents within 3-5 years; of those, the vast majority are single parents, living alone with the child. As with the general population of teenagers, early intervention is key. Mainstream programs can be highly effective, but the unique characteristics of teenagers with disabilities also must be taken into account in developing and implementing these programs. As part of the national strategy, HHS will work to address the special challenges in preventing out-of-wedlock teen pregnancies among young women with disabilities. The strategy will address issues such as program access, the need for targeted materials, and opportunities for education and skills-building to give teens with disabilities a positive future and a better chance of avoiding teen pregnancy.

E. Improve Data Collection, Research, and Evaluation

Data collection, research, and evaluation are all critical for understanding the magnitude, trends, and causes of teen pregnancies; for developing targeted teen pregnancy prevention strategies; and for assessing how well these strategies work, whether on a local, state, or national level. As part of the national strategy, HHS will work to strengthen each of these important activities.

Data Collection and Surveillance. National statistics on teen birth patterns, including state-by-state data, are now available nearly a full year earlier than in prior years, a result of a more timely approach to collecting, compiling, and publishing vital statistics data. The new system builds on advances in computer and communications technology as well as the CDC's National Center for Health Statistics' (NCHS) long-standing collaboration with state vital statistics offices. Preliminary teen birth rates from the new system for 1995 were published in October 1996 and future statistics will be reported semiannually. (See Appendix II: **New Data ?**). The CDC also provides consultation to states and local areas to enable them to compute estimates of teen pregnancy and other related indicators. ?

The upcoming release in 1997 of the new National Longitudinal Study of Adolescent Health (ADD HEALTH), a comprehensive study of adolescent health funded by HHS' National Institute of Child Health and Human Development (NICHD) and other HHS agencies, will provide an opportunity to increase our knowledge about risky behaviors and resiliency factors in adolescents and about environmental influences, including parents, siblings, peers, schools, neighborhoods, and communities. The National Survey of Adolescent Males, also supported by NICHD and other HHS agencies, and the 1995 cycle of the National Survey of Family Growth conducted by NCHS with other HHS support, will also provide relevant information on the behavior of young men and women.

Research and Evaluation. While promising approaches to reduce teenage pregnancy have been identified, a comprehensive review of teen pregnancy programs funded by HHS and conducted by Child Trends, Inc. indicates that most interventions have not been rigorously evaluated to assess their impact or to identify the components that contribute to program success or failure. Using our demonstration programs, we will work with our partners to increase our understanding of what works and what doesn't. For example, the CDC's Community Coalition Partnership Program for the Prevention of Teen Pregnancy is helping each community to incorporate evaluation into its teen pregnancy prevention strategy.

The Child Trends report also indicates that further research is needed in a number of areas of normal adolescent development, including why certain adolescents, including those with disabilities, **(check this)** engage in high-risk behaviors, why some adolescents are able to negotiate safely to adulthood, and what factors influence adolescent sexual behavior, including media influences and cultural norms. In addition to its own research studies, such as ADD Health, and demonstration projects, HHS will provide information from its new survey data that will help researchers answer these questions.

F. Disseminate Information on Innovative and Effective Practices

Sharing information about promising and successful approaches is critical to the replication and expansion of teen pregnancy prevention efforts across the country. Policy makers, program administrators, tax payers, media producers, community leaders, parents, and teenage boys and girls all need to know about the approaches most likely to be successful in preventing teen pregnancy.

HHS will continue to work with its partners to highlight innovative practices at the federal, state, and local levels and to disseminate new research and evaluation findings. Ongoing efforts include outreach to 105 Empowerment Zones and Enterprise Communities to encourage and help them to include teenage pregnancy prevention in their community development strategies. The Department will also disseminate new information on the developmental needs of youth and on the use of broad-based activities to help teenagers avoid risky behaviors leading to teen pregnancy. In addition, HHS currently supports a variety of resource centers, clearinghouses, and toll-free hotlines at both the state and national level that provide information and technical assistance to state and community-based health, social service, and youth-serving agencies. (See Appendix III: Program Contacts and other Resources).

II. Support and Encourage Adolescents to Remain Abstinent

To reach adolescent populations at risk for premature sexual activity and pregnancy, we must develop comprehensive efforts specifically tailored to the unique needs, interests, and challenges of each group, including targeted messages that work. Although the national strategy must send the strongest possible message to all teens that postponing sexual activity, staying in school, and preparing to work are the right things to do, the research shows that girls and boys experience some aspects of early adolescence in different ways, because they encounter different social, cultural, physiological and psychological challenges. Therefore, different approaches will be required to meet the unique needs of different adolescent populations, including disabled teens who are at increased risk of pregnancy. As a result, an important component of the national strategy will be to determine the best ways to reach different groups of young boys and girls.

The national strategy will place a special emphasis on encouraging abstinence among 9-to 14-year-old girls. The research tells us that this a critical age for reinforcing self confidence and positive values and attitudes among girls. In 1997, HHS will use its new Girl Power! campaign to address premature sexual activity among girls aged 9-14, promoting a strong abstinence message. The Girl Power! campaign, launched in November, 1996, is a multi-phased, national public education campaign designed to galvanize parents, schools, communities, religious organizations, health care providers, and other caring adults to make regular sustained efforts to reinforce girls' self-confidence, by providing them with positive messages, meaningful opportunities, and accurate information on a variety of key health issues. The Girl Power! abstinence education initiative includes: engaging all HHS teen pregnancy prevention and related youth programs in sustained efforts to promote abstinence among 9 to 14-year-old girls, and developing and implementing a national media campaign to involve parents and caring adults in sending a strong abstinence message across the country.

The national strategy will also focus on boys and young men. Significantly less is known about decision-making behavior of boys around motivations for abstinence, sexual activity, and fatherhood. Through the national strategy, HHS will increase our understanding of the factors related to boys' remaining abstinent. The Department will work on effective prevention strategies, particularly those promoting abstinence, for boys. This will include working with the Administration's Fatherhood Initiative to ensure that men, including pre-teen and teenage boys, receive the education and support necessary to postpone fatherhood until they are emotionally and financially capable of supporting children. The strategy will also build on existing Departmental efforts, such as the Title X Family Planning Adolescent Male Initiative and other Title X funding (? -- **ask Tom**) to support male-oriented community-based organizations in promoting responsible behavior among teenage boys. The Department will work with national youth-serving organizations to use their networks to promote activities that encourage abstinence among girls and boys.

APPENDIX I: HHS ACTIVITIES

The Department of Health and Human Services supports a variety of efforts to help communities develop comprehensive teen pregnancy prevention strategies that reflect five principles: parental and adult involvement; abstinence; clear strategies for the future; community involvement; and a sustained commitment. We estimate that, through our support, at least __ percent of communities across the country already have promising teen pregnancy prevention programs in place. (See note below). Our national strategy will build upon, strengthen, and expand these promising efforts to assure that every community in the country is working to reduce out-of-wedlock teen pregnancies.

- **The Community Coalition Partnership Program for the Prevention of Teen Pregnancy** is one of HHS's most comprehensive and innovative teen pregnancy prevention programs. In 1995, the Centers for Disease Control and Prevention awarded grants to community-wide coalitions in communities with high rates of teen pregnancy. CDC awarded approximately $250,000 per year for two years to 13 communities in 11 states to help these communities mobilize and organize their resources to support effective and sustainable teen pregnancy prevention programs. The next phase begins in FY 1997 when the 13 community coalitions will receive a total of $13.7 million for implementation of the action plans, evaluation of their impact, and other related activities.

- **The Adolescent Family Life Program (AFL)**, created in 1981, supports demonstration projects, approximately one-third of which provide abstinence-focused educational services to prevent early unintended pregnancies, sexually-transmitted diseases, and HIV/AIDS. Most projects provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families, with a major emphasis on preventing repeat pregnancies among adolescents. In FY 1996, the AFL program funded 17 projects in 14 states, which will be continued in FY 1997. An additional $7.6 million in new funding will be used to enable smaller communities to develop and implement about 40 abstinence-based education programs and about 60 larger prevention demonstration projects, following the abstinence education definition in the welfare law.

- **Reproductive Health and Family Planning Services** (under Title X of the Public Health Service Act) are provided to nearly 5 million persons each year, nearly one third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients. To address male involvement in preventing unintended pregnancy, the Title X Family Planning Program will supplement existing community-based programs to develop effective approaches for providing family planning education and services to males.

- **Healthy Schools, Healthy Communities,** a Health Resources and Services Administration program created in 1994, has established school-based health centers in 27 communities in 20 states and the District of Columbia to serve the health and education needs of children and youth at high risk for poor health, teenage pregnancy, and other problems.

- **Federal/State Partnerships**, including **the Maternal and Child Health Block Grant** and **the Social Services Block Grant** (authorized by Titles V and XX of the Social Security Act, respectively), include support for adolescent pregnancy prevention programs, state adolescent health coordinators, state prenatal care hotlines, family planning, school health, and other prevention services. These programs operate in all 50 states, the District if Columbia, and eight territories in 610 school-based or school-linked settings.

- **The Community Services Block Grant**, which operates in all 50 states, the District of Columbia, and the territories, enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services.

- **The Preventive Health and Health Services Block Grant** (under Title XIX of the Public Health Service Act) provides resources to 49 States for services to the general population, including health education, risk reduction and public health nursing.

- **The Independent Living Program**, run by the Administration for Children and Families, provides funds to states to support activities ranging from educational programs to programs that help young people avoid early parenthood. This program supports activities in __ communities in ___ states.

- **Youth Programs** including Runaway and Homeless Youth Programs, the High Risk Youth Program, and National Youth Sports Program, address a wide range of risk factors for teen pregnancy. These programs operate in __ communities in __ states.

- **The Community Schools Program** was created by the 1994 Violent Crime Control and Law Enforcement Act to support activities for youth in high-risk communities during non-school hours. Funds are awarded to public-private partnerships of community-based organizations to provide a broad spectrum of supervised extracurricular and academic programs after-school and during evenings, weekends and school vacations. Grantees also train teachers, administrators, social workers, guidance counselors, parent and school volunteers to provide concurrent social services for at-risk students. The Administration for Children and Families awarded $10.15 million in grants to 54 communities in 1996 under this program.

- **Healthy Start** has 22 demonstration projects operating in 25 states to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.

- **Empowerment Zones and Enterprise Communities** in 105 rural and urban areas in 43 states and the District of Columbia have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.

- **Health education in schools** supports the efforts of every state and territorial education agency to implement school health programs to prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

- **Community and migrant health centers**, including family and neighborhood health centers, operate in 1647 sites in 643 communities in all 50 states, the District of Columbia, and six territories. The centers provide primary and specialized health and related services to medically underserved adolescents. Some centers include special hours or clinics for adolescent patients.

- **Indian Health Service** provides a full range of medical services for American Indians and Alaska Natives. IHS has a special emphasis on youth substance abuse, child abuse and women's health care, and supports projects targeted at preventing teenage pregnancy.

- **Drug treatment and prevention programs** include services to prevent first-time and repeat births among teenagers. Sixty-five residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services in ___ communities in ___ states. In addition, 13 grant demonstration projects offer interventions and outreach to female adolescents ages 12-20 who are at risk for alcohol, tobacco, and other drug use; physical and sexual abuse; and pregnancy.

- **Health Care and Promotion** under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- **The Medicaid program** funds family planning services at an enhanced match rate for states. The federal government pays 90 percent of the cost related to a state's provision of family planning services while the state funds the remaining 10 percent. The enhanced match encourages states to fund generous family planning programs which include patient counseling and education concerning pregnancy prevention and reproductive health. The Medicaid program also collaborates with state Medicaid agencies to support and publicize state efforts and lessons learned in providing teen pregnancy prevention services, including services provided through school-based health clinics.

Evaluation and Research

HHS has conducted research, surveillance, demonstrations, and evaluations on an ongoing basis to gather and provide information and technical assistance on the magnitude and causes of teenage pregnancy and on prevention programs and approaches that work, including:

- "**Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood**" is a two-volume comprehensive review by HHS of the most recent literature on teen sexual behavior, pregnancy and parenthood and the effectiveness of teen pregnancy prevention programs.

- As part of its **Youth Risk Behavior Surveillance System**, CDC helps states monitor critical health risk behaviors among teenagers, including sexual risk behaviors that result in HIV infection, other STDs, and teen pregnancy. In 1995, 40 states and territories and 16 large cities collected comparable data

- The upcoming release in 1997 of the new National Longitudinal Study of Adolescent Health (ADD HEALTH), a comprehensive study of adolescent health funded by HHS' National Institute of Child Health and Human Development (NICHD) and other HHS agencies, will provide an opportunity to increase our knowledge about risky behaviors and resiliency factors in adolescents and about environmental influences, including parents, siblings, peers, schools, neighborhoods, and communities. The National Survey of Adolescent Males, also supported by NICHD and other HHS agencies, and the 1995 cycle of the National Survey of Family Growth conducted by NCHS with other HHS support, will also provide relevant information on the behavior of young men and women.

NOTE:

The estimate of the number of HHS programs in communities is based on a broad definition of teen pregnancy prevention programs that include comprehensive health and social services delivered to children and adolescents as well as other related efforts, such as substance abuse treatment or school health education or HIV prevention. **(NOTE: Goal here is to get to 25 percent with the tightest def'n of teen pregnancy prevention programs).**

The number of teen pregnancy programs funded by HHS includes those funded in FY 1995 (the latest year for which complete information on grants awarded is available), **as well as new programs funded in FY 1996 (e.g., community schools).** Programs were sorted by community (as defined by the program) based on the site of services and/or the grant recipient. If multiple programs were funded in a single community (e.g., Detroit, Michigan) they were only counted as one program in one community. Programs funded only at the state level were counted as being funded in one community, recognizing that many state-level funded programs fund services or activities at the community level (e.g., block grants and Medicaid).

The number of communities was based on a Census Bureau count from 1990, which identified 2700 cities and other urban and incorporated areas with a population of 10,000 or more. The resulting proportion is a rough and conservative estimate of the number of HHS teen pregnancy prevention and related programs in communities.

APPENDIX II: TEEN BIRTH DATA

[Insert December 19, 1996 Data]

In October 1996, the National Center for Health Statistics (NCHS) inaugurated a new statistical series designed to provide more timely release of national and state-level birth statistics. The October release included births for 1995 and U.S. birth rates for teenagers 15-19 years old. The data covered all races and white, black, American Indian, Asian or Pacific Islander, and Hispanic subgroups. The October report also provided data on the percent of all births occurring to teenagers in each state, by race and Hispanic origin. Other state-level birth data available from the preliminary report include births to unmarried mothers, low birthweight, prenatal care beginning in the first trimester, and births by cesarean delivery. These data will provide state and local health officials a quick and timely first-look at trends in these important measures of their community's health status. NCHS will publish data from the new statistical series on a semi-annual basis. The next report will be issued in April 1997, and will cover the period July 1995-July 1996. The Center is working to shorten the release time for future issues of the preliminary data report.

After NCHS completes final processing of birth data for a given year, additional, more-detailed statistical tabulations can be produced. In December 1996, NCHS published a report of state-level birth rates for teenagers, included in this appendix (2). The report includes data for teenage subgroups 15-19, 15-17, and 18-19 years, and by race and Hispanic origin of the mother. The report describes the recent declines in U.S. birth rates for teenagers and the extent to which rates in individual states have also declined. The December report focuses on the period 1990-94. NCHS expects to update this report with rates for 1995 in late spring of 1997.

Reports showing state-level data in conjunction with national statistics can be very useful for state and local public health and other officials as they monitor trends in their states and compare their own states with their neighbors. The rates in NCHS' teen birth rate report can help to assess the extent to which programs to reduce teenage pregnancy are succeeding. To assist in the comparison of state-level data, the December report includes maps of teen birth rates, showing the various levels of the rates as well as the 1991-94 trend in the rates. The authors also note that some of the differences in overall rates by state reflect differences in the composition of the teenage populations by race and Hispanic origin, since birth rates for Hispanic and black teenagers are more than double the rates for non-Hispanic white teenagers. To examine state variations while controlling for population differences in race and ethnicity, the report includes standardized birth rates for each state. The standardized rates for many states with high Hispanic or black populations are lower than the actual rates.

[ASPE/CDC – anything to add on Surveillance Data?]

(1) Rosenberg HM, Ventura SJ, Maurer JD, Heuser RL, Freedman MA. Births and Deaths: United States, 1995. *Monthly Vital Statistics Report*, Vol. 45, No. 3, Supplement 2. Hyattsville, Maryland: National Center for Health Statistics. 1996.
(2) Ventura SJ, Clarke SC, Mathews TJ. Recent Declines in Teenage Birth Rates in the United States: Variations by State, 1990-94. *Monthly Vital Statistics Report*, Vol. 45, No. 5, Supplement. Hyattsville, Maryland: National Center for Health Statistics. 1996.

APPENDIX III: PROGRAM CONTACTS AND OTHER RESOURCES

HHS Programs

Centers for Disease Control and Prevention
Community Partnership Programs for the Prevention of Teen Pregnancy
For Information Call: 404-639-3286

Office of Population Affairs
Adolescent Family Life Program and the Title X Family Planning Program
For Information Call: 301-594-4000

Health Resources and Services Administration
Healthy Start, Community and Migrant Health Centers,
Healthy Schools, Healthy Communities, and Maternal and Child Health Block Grant
For Information Call: 301-443-3376

Administration for Children and Families
Youth Programs (Runaway and Homeless Youth, Community Schools, etc.)
For Information Call: 202-401-9215

Substance Abuse and Mental Health Services Administration
Drug Treatment and Prevention Programs
For Information Call: 301-443-8956

Health Care Financing Administration
Medicaid Bureau
For Information Call: 410-786-3393

Enterprise Zones/Economic Communities
For Information Call: ____

National Institute for Child Health and Human Development
ADD HEALTH and the National Survey of Adolescent Males
For Information Call: 301-496-5133

National Center for Health Statistics
National Survey of Family Growth and Monthly/Semi-Annual Vital Statistics Reports
For Information Call: 301-436-7551

Hotlines and Referral Numbers

AIDS/HIV
800-342-AIDS (English); 800-344-SIDA (Spanish)

Sexually Transmitted Diseases
800-227-8922

Research Reports

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

Trends in the Well-Being of America's Children and Youth. A 1996 report written by Child Trends, Inc. for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services. Copies available by faxing requests to Child Trends at 202-362-5533 or ASPE at 202-690-5514. Also available at the Internet address http://aspe.os.dhhs.gov

The Report to Congress on Out-of-Wedlock Childbearing. A 1995 report prepared by the Department of Health and Human Services and university researchers that provides a comprehensive overview of nonmarital childbearing among women of all ages. Copies available from the ____(?)

The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. A 1995 report by the Institute of Medicine. Copies available from the National Academy Press at 800-624-6242.

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

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

Wk - Teen Pregnancy

Following is a brief summary of the key findings from the National Campaign To Prevent Teen Pregnancy draft report, "Whatever Happened to Childhood.?" to be published in two to four weeks.

The report aptly illustrates teen pregnancy as a social crisis that continues to break down family, community and common culture. The message the report sends is twofold: 1) although we are making some progress, there is much more work to do and we must not let our attention stray from this critical national issue and, 2) despite consistent community-based efforts, the evidence has not born out a simple solution to the problem so we must continue to be creative, innovative and persistent in our efforts.

Of the many community experiments around the country, the report states, most have exhibited mixed outcomes, and no one program stands out as having produced clear, replicable results. Community approaches include sex education aimed at delaying sexual activity and reducing the number of sexual partners and using birth control; abstinence only programs; support for community-based family planning services; comprehensive approaches stresses components from each approach and; programs dedicated to nurturing and guiding young people.

In addition to these conclusions, the report also presents some interesting observations that may have future policy implications.

First, the vast majority (85 percent) of pregnancies among teens are not fully planned *or* unintended. Rather they result from teens' ambivalence about pregnancy, accidents, their confusion about preventing pregnancy, and sometimes their failure to make any clear decision about sexual activity.

Second, many communities do not address the problem at all because the conflict over which approach to use can become so intense and destructive to the community that a community decides to do nothing at all. Therefore, the report states, a new and emerging approach to teen pregnancy prevention is community conflict resolution. The report lays out an excellent example of this approach at work. In 1990, the rural community of Tillamook County, Oregon had the highest teen pregnancy rate in the state but fought bitterly over a solution, including the Board of Education voting down several proposals. Finally, the County decided to embrace a new ethic of "unity of purpose, diversity of means," allowing various segments of the community to develop their own intensive initiatives, from creating a church-based abstinence program to improving access to family planning programs. By 1994, the county teen pregnancy rate had dropped by 70 percent, becoming the lowest in the state. *This story bares out research by Dr. Kristen Moore that says teen pregnancy programs that send mixed messages to teens actually work because the teen will be exposed to all messages and will take what works for her or him, whether it be abstinence, birth control, or self-esteem raising.*

Third, although the teen birth rate has decreased in the past few years, the number of births to teens increased in 1993 and 1994, reflecting an overall increase in the U.S. teen population. Because the number of teens is expected to increase further, so will the number of pregnancies and births, perhaps increasing by 26 percent by the year 2010 unless rates are reduced.

The report tells its story using mostly previously released data that remain relevant. Following are facts from the report worth reviewing.

- Every year in this country, over 1 million teenagers become pregnant and four in 10 girls become pregnant as least once before turning 20.

- The pregnancy rate increased among all girls age 15-19 by 23 percent between 1972 and 1990 from 95 to 117 pregnancies per 1,000 women, and then declined to 112 per 1,000 women in 1992 (the year for which the most recent data is available). At the same time, the pregnancy rate among sexually experienced girls decreased 19 percent, largely due to increased use of contraception.

- By 1991, the teen birth rate had reached 62 births per 1,000 women aged 15-19, its highest point in the past two decades. Since then, that rate has fallen slowly to 57 births per 1,000 women in 1995.

- The encouraging recent decline in the U.S. teen birth rate is counterbalanced by a negative trend: today, nearly three-quarters of teen births are to unmarried teens, while as recently as 1960, only 50 percent were. Today, teen mothers make up the largest group (48 percent) of all first births to unmarried women.

- Birth rates are higher among African-American and Hispanic teens than among white teens

- While most pregnant teens are 18 or 19 years old, about 40 percent are 17 or younger and about half of all pregnant teens ages 15-19 are white.

- Many of the fathers of children born to teen mothers are older -- nearly 40 percent of those young men who impregnate a minor teen (under 18) are 20 years old or older.

- More than half of the teen pregnancies result in a birth (1/3 end in abortion and 14 percent in miscarriage) and of those who give birth most keep their

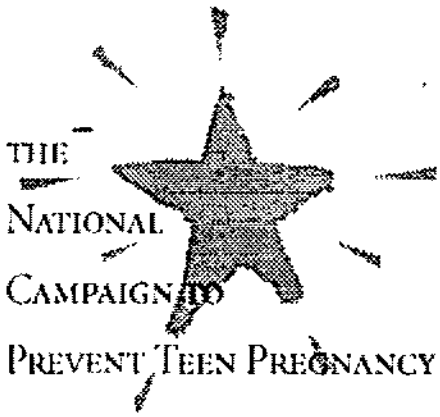
child rather than put it up for adoption.

Early parenting limits a young mother's likelihood of completing high school -- less than one-third of teens who begin their families before age 18 ever complete high school.

When compared to children of older mothers, children of teen mothers have more health problems, do much worse in school, live in home environments of lower quality, suffer higher rates of abuse and neglect, and are more likely to become teen mothers themselves.

WR-Teen Pregnancy

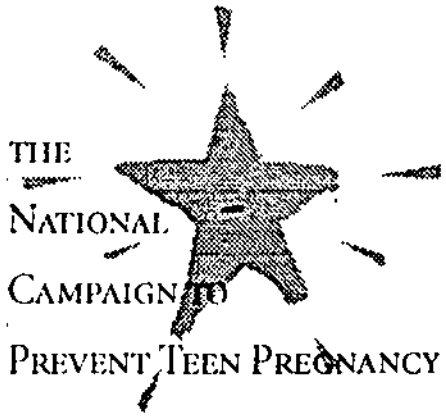
DRAFT



Whatever Happened to Childhood?

The Problem of Teen Pregnancy in the United States

A report from the National Campaign to Prevent Teen Pregnancy



Whatever Happened to Childhood?

The Problem of Teen Pregnancy in the United States

A report from the National Campaign to Prevent Teen Pregnancy

May 1997

the National Campaign to Prevent Teen Pregnancy

Founded in 1996, the National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan initiative supported entirely by private donations. The Campaign's mission is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. The Campaign's goal is to reduce the teen pregnancy rate by one-third by the year 2005.

The Campaign's strategy has five primary components: taking a strong stand against teen pregnancy and attracting new and powerful voices to this issue; enlisting the help of the media; supporting and stimulating state and local action; leading a national discussion about the role of religion, culture, and public values in an effort to build common ground; and making sure that everyone's efforts are based on the best facts and research available.

For more information, write to the National Campaign to Prevent Teen Pregnancy, 2100 M Street, NW, Suite 300, Washington, DC 20037.

Suggested Citation:

National Campaign to Prevent Teen Pregnancy. (1997). *Whatever Happened to Childhood? The Problem of Teen Pregnancy in the United States*. Washington, DC: Author.

Preface

Most Americans consider teen pregnancy a national crisis. When President Clinton identified it as the nation's most serious social problem in his 1995 State of the Union Address and challenged us all to combat it, his words resonated strongly with the public.[1] Only his call for a middle-class tax break garnered greater approval.[2]

In fact, Americans see teen pregnancy as a powerful marker of a society gone astray — a clear and compelling example of how our families, communities, and common culture are under siege. When asked what sign of the current social crisis troubles them the most, 90 percent of surveyed adults named threats to family cohesiveness. The number one symptom they identified of the erosion of family cohesiveness? The spread of teen pregnancy.[3]

Widespread recognition that teen pregnancy is a problem, however, is not the same as a full appreciation of the problem's magnitude and consequences. This statement by the National Campaign to Prevent Teen Pregnancy seeks to provide the basic facts on teen pregnancy and to describe what program evaluation tells us about the effectiveness of various community-level programs developed in the last 20 years to reduce teen pregnancy or related outcomes. It concludes with the campaign's views about where to go from here at both the local and national levels.

In the aggregate, this statement paints a sobering picture that should worry all Americans. Simply put, far too many teenage girls in this country find their own childhoods curtailed by pregnancy and parenthood. This hurts not only the girls themselves but also the children they bear and the communities in which they live. Although it is true that teen pregnancy is an old problem, it takes on new urgency in today's society. Now more than ever, the adolescent years must be devoted to education and to building the skills needed to hold a decent job and compete in an increasingly competitive economy — tasks that pregnancy and parenthood can derail all too easily. Moreover, it is increasingly clear the earliest years of life are especially important; babies and toddlers need the very best care and stimulation possible in order to ensure their own growth and development. Although many teens try valiantly to be good parents, most are themselves still growing up and frequently lack the maturity, patience, and perspective that being a parent requires.

Although we know we need to reduce teen pregnancy, we know far less than we should about how to accomplish this at the community level. Unfortunately, the years of hard work spent developing and running prevention programs have not been matched by equal commitment to evaluating the impact of these programs or building on early sign of success. As a consequence, we have some good ideas and promising leads around the country, but we are far from having even a handful of

tried and true interventions to apply nationwide. In the face of such limited information, both community and national leaders need to encourage innovation and creativity, to continue refining programs that look promising, and to make new investments in high-quality program evolution.

Bearing a child and being a parent are among the most important responsibilities of life. The National Campaign to Prevent Teen Pregnancy hopes that this statement of the teen pregnancy problem will deepen the resolve of us all to take on this issue with new energy and determination. Our shared goal should be to ensure that all children are welcomed into the world by adult parents committed to providing their children with the resources needed to help them grow into responsible adults — a task requiring years of dedication. Failing to reach this goal casts a cold shadow not only on our present time but on future generations as well.

Acknowledgments

The National Campaign expresses special appreciation to Kristin Moore, Ph.D., President of Child Trends and Chair of the Campaign's Task Force on Effective Programs and Research, and to Rebecca Maynard, Ph.D., Professor in the Graduate School of Education at the University of Pennsylvania and a member of the Campaign's Task Force on Effective Programs and Research, both of whom provided technical review of this statement, and to Jamie Tullman of the Campaign's staff who assembled the data. Although some of the figures presented here derive from analyses conducted by the National Campaign itself, many draw heavily on the publications of the Alan Guttmacher Institute and on the Robin Hood Foundation's report, *Kids Having Kids*, released in 1996. We would especially like to thank the Alan Guttmacher Institute for allowing us to include their newly computed state-by-state teen pregnancy rates from 1992. The summary of program evaluation is from *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*, a report by Douglas Kirby, Ph.D., commissioned by the National Campaign's Task Force on Effective Programs and Research and released in March 1997. The Campaign extends its appreciation to all of these individuals and organizations for their steady commitment to producing accurate and credible information on this important topic.

How Big Is the Problem?

The teen pregnancy numbers are alarming. Every year in this country, almost one million teenagers become pregnant.[4] In fact, approximately four in ten girls become pregnant at least once before turning 20 years old (Figure 1).[5] As a consequence, the teen pregnancy and teen birth rates in the United States are the highest of any industrialized country — nearly twice as great as the next highest nation, Great Britain (Figure 2).[6] And, unlike 30 years ago, fully 76 percent of births to teenage mothers are now out-of-wedlock.[7]

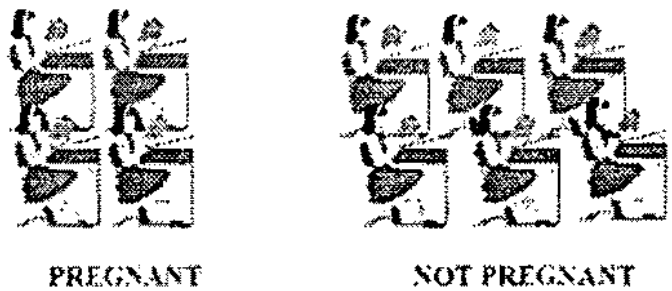


Figure 1: Approximately 4 in 10 girls become pregnant at least once before age 20

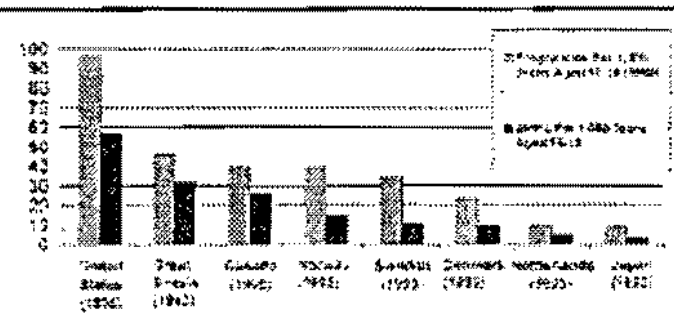


Figure 2: U.S. teen pregnancy and birth rates are very high

Teen pregnancy and childbearing go hand-in-hand with high levels of risk for all of those involved, particularly the teenage mother and her child. Often unprepared for the responsibilities and demands of childrearing, teenage parents face many obstacles that are made more difficult by their lower levels of education and lack of job skills. Teen mothers are likely to have a second birth relatively soon, which can further impede their ability to finish school or embark on a steady work life. The obstacles faced by teen mothers obviously affect their children who often inherit a legacy of poverty and social disadvantage.

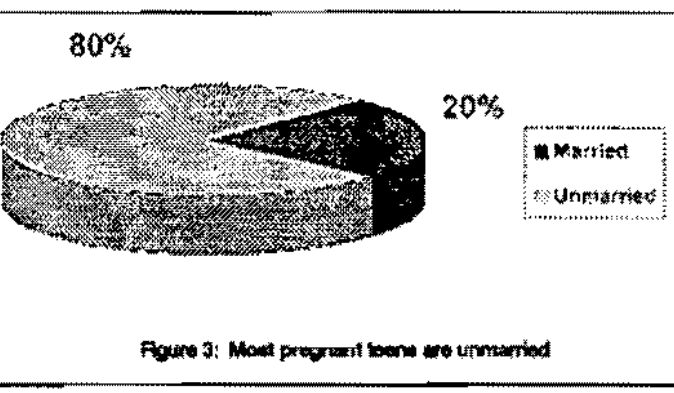


Figure 3: Most pregnant teens are unmarried

Who Are the Pregnant Teens?

Some of the characteristics of pregnant teens are surprising. While most pregnant teens are 18 or 19 years old, about 40 percent are 17 or younger.[8] About half of all pregnant teens aged 15-19 are white.[9] Nearly all are unmarried (Figure 3).[10]

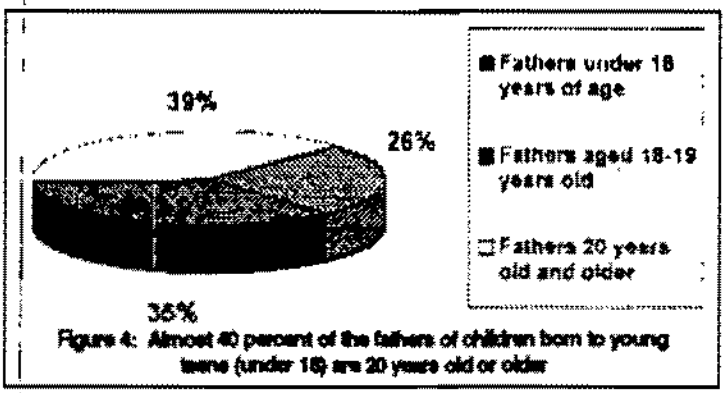


Figure 4: Almost 40 percent of the fathers of children born to young teens (under 18) are 20 years old or older

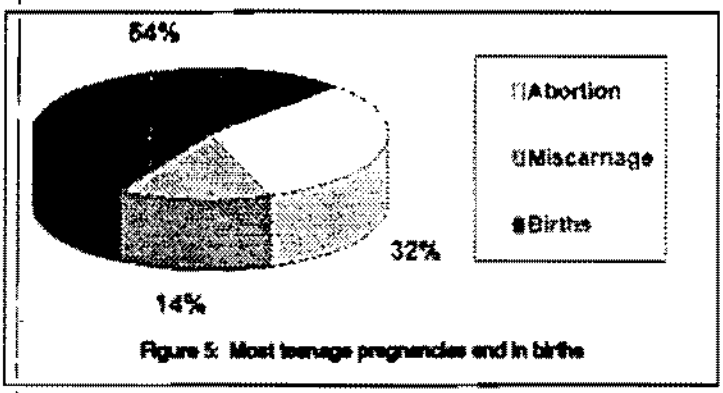


Figure 5: Most teenage pregnancies end in births

Many of the fathers of children born to teen mothers are older — nearly 40 percent of those young men who impregnate a minor teen (under 18) are 20 years old or older (Figure 4).[11]

The vast majority (85 percent) of pregnancies among teens are not fully planned or intended.[12] Rather, they result from accidents or teens' ambivalence about pregnancy, their confusion about preventing it, and sometimes their failure to make any clear decisions about abstinence, sexual activity, or contraception one way or another. With so many teen pregnancies unintended, it is not surprising that one-third of them end in abortion. Another 14 percent end in miscarriage. More than half end in birth, and almost all of these young mothers choose to keep their children rather than put them up for adoption (Figure 5).[13] While the fact that so few of the one million teen pregnancies annually in the United States are intended is indeed troubling, it does suggest that there are real opportunities to help teens prevent pregnancies that they themselves do not intend.

Trends in Rates of Teen Pregnancy, Teen Births, and Out-of-Wedlock Births

The most recent news on teen pregnancy and birth rates is somewhat encouraging. In the early 1990s, both pregnancy and birth rates dropped. However, this very recent development follows a much longer period during which the teen pregnancy problem worsened and a growing proportion of teen births occurred outside of marriage.

Teen Pregnancy Rate

Reflecting the dramatic rise in the proportion of teenagers who have had sexual intercourse, the pregnancy rate among all girls aged 15-19 increased 23 percent between 1972 and 1990, from 95 to 117 pregnancies per 1,000 women, and then declined to 112 per 1,000 in 1992, the most recent year for which data are available (Figure 6).[14] At the same time, the pregnancy rate among sexually experienced girls *decreased* 19 percent (Figure 7)[15] — largely due to increased use of contraception among this group.

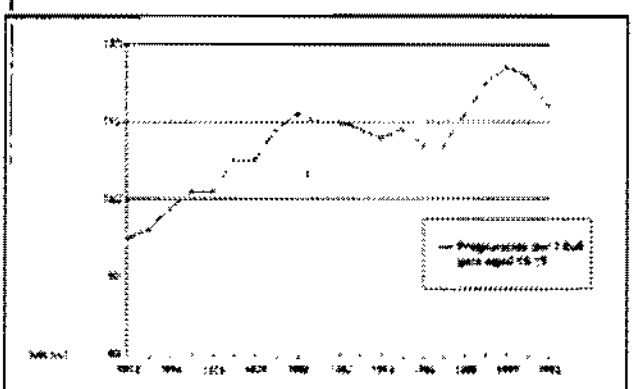


Figure 6: The teen pregnancy rate rose 23 percent between 1972 and 1990, then fell slightly

States vary enormously in their levels of teenage pregnancy from rates as low as 59 per 1,000 in North Dakota to as high as 159 per 1,000 in California (Figure 8).[16] This range reflects a variety of social, economic, and demographic factors but also suggests that some states and communities may have lessons to teach about combating teenage pregnancy.

Teen Birth Rate

The teen birth rate (as distinct from the pregnancy rate) dropped 45 percent between 1955 and 1986 and then began climbing again in 1987.[17] By 1991, the teen birth rate reached 62 births per 1,000 women aged 15-19, its highest point in the past two decades. Since then, the rate has slowly fallen to 57 births per 1,000 women in 1995 (Figure 9).[18] The recent decrease reflects a leveling off of teen sexual activity as well as the increased number of teens using contraception effectively.[19] While this steady decline in the teen birth rate over the last four years is very encouraging, the U.S. rate remains much higher than in other industrialized democracies (Figure 2).

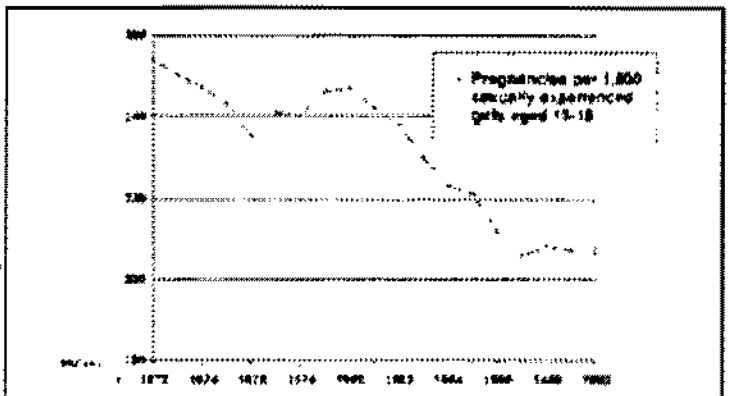


Figure 7: The pregnancy rate among sexually experienced teen girls has declined

As with teen pregnancy rates, there is substantial variation across the states in teenage birth rates. Several states have achieved rates almost as low as that of other industrialized nations, including Minnesota (34 per 1,000 females aged 15 to 19), New Hampshire (30), North Dakota (35), and Vermont (33). However, other states — Mississippi, for example — have rates nearly three times as high (Figure 10).[20]

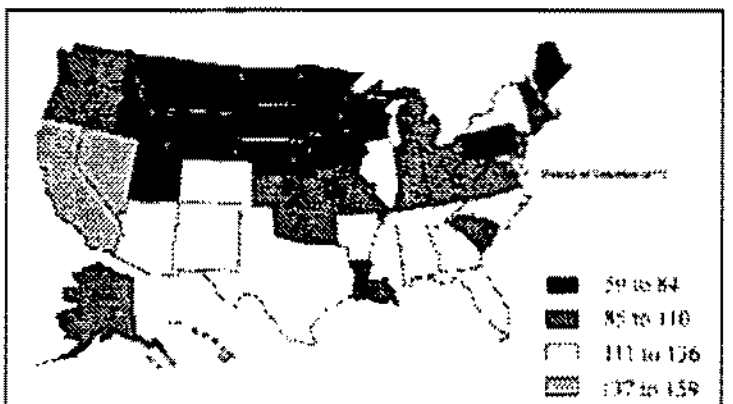


Figure 8: Teen pregnancy rates vary widely from state to state

Out-of-Wedlock Births

The encouraging recent decline in the U.S. teen birth rate is counterbalanced by another trend that has elicited much public concern: today, nearly three-quarters of teen births are to *unmarried* teens, while as recently as 1960 only 15 percent were (Figure 11).[21] This trend is especially ominous when one considers the hardships faced by single-parent families. It reflects, among other things, a marked decline in marriage after pregnancy is confirmed — so-called "shotgun marriages" — along with greater social acceptance of nonmarital childbearing in general. As is true for many social trends, teens mirror the behavior of the adults around them. More adult women are bearing children out-of-wedlock as well. In fact, only 30 percent of all out-of-wedlock births in the United States are to teenagers (Figure 12).[22] Nonetheless, nearly half of nonmarital *first births* occur to teens. Therefore, the teen years are frequently a time when unmarried families are first formed — a fact that provides a strong rationale for focusing on teens in any broad effort to reduce out-of-wedlock childbearing. Today, teen mothers make up the largest single group (48 percent) of all first births to unmarried women.[23]

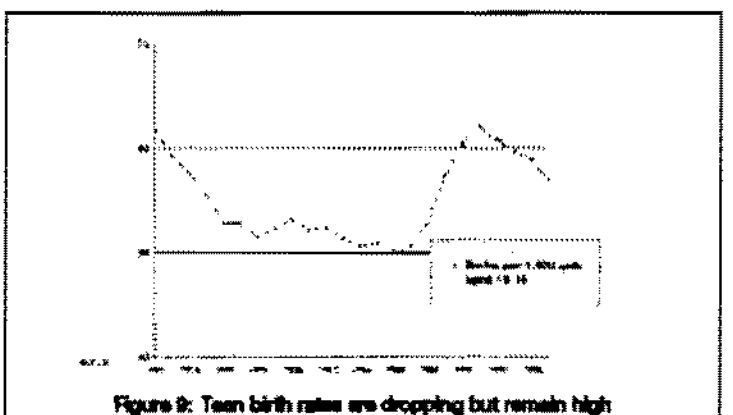


Figure 9: Teen birth rates are dropping but remain high

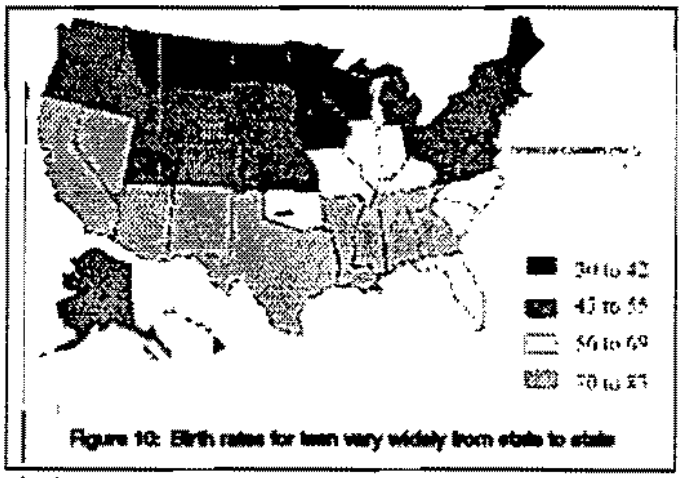


Figure 10: Birth rates for teen vary widely from state to state

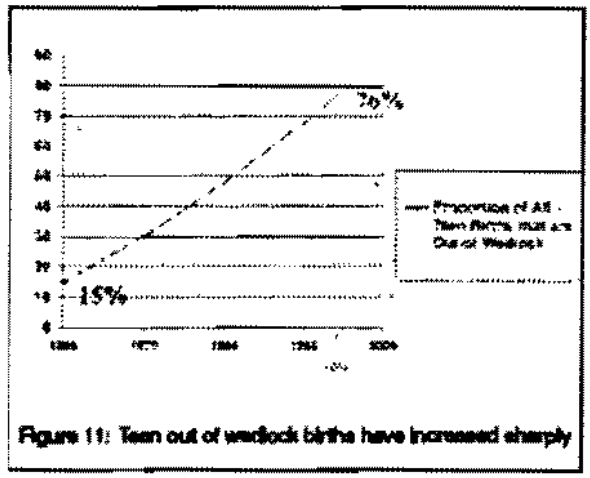


Figure 11: Teen out of wedlock births have increased sharply

What Lies Behind These Trends?

Changes in teen pregnancy and teen birth rates do not happen in a vacuum, of course. Underlying these changes have been shifts in marriage patterns, sexual norms, contraceptive practices, the availability of abortion, and the size and composition of the teenage population.

Teen Sexual Activity and Marriage Rates

Although many teens are not sexually active, more teens are having sex today than in previous decades. In 1970, 35 percent of young women and 55 percent of young men reported having had sex by age 18. By 1988, those numbers had risen to 56 percent for young women and 73 percent for young men (Figure 13).[24]

At the same time that teens are more sexually active, they are less likely to be married. Men and women today marry, on average, three to four years later than did their counterparts in the 1950s. By 1990, the average age at first marriage was 26 for men and 24 for women.[25] As a result of later marriage and earlier sexual activity, teens today begin having sex roughly eight years before marriage — about 10 years for men and seven years for women. The average gap between first intercourse and marriage is especially wide for African-Americans (about 12 years for women and 19 years for men).[26] Hispanics are the most likely to marry in their teenage years.[27]

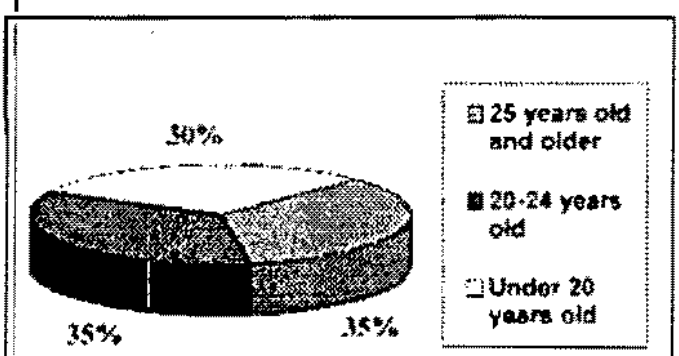


Figure 12: Only 30 percent of all out-of-wedlock births are to teenagers

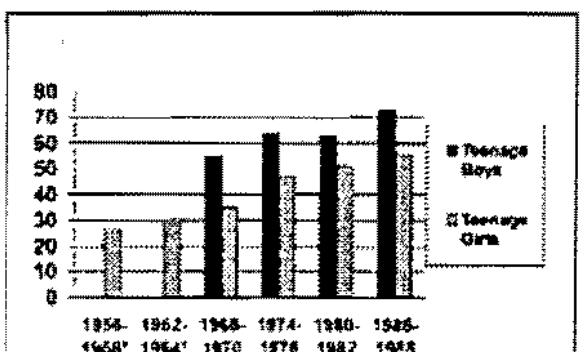


Figure 13: Sexual activity among teens has increased

Teenage Abortion Rates

In the years immediately following the national legalization of abortion in 1973, teen abortion rates increased considerably but then remained relatively stable until the late 1980s, despite the fact that a greater proportion of teenage women were becoming sexually active. Since 1990, abortion rates among teens have declined because fewer teens are becoming pregnant, and, in recent years, fewer pregnant teens have chosen to have an abortion (Figure 14). Today, one-third of teenage pregnancies end in abortion, and teens account for roughly one-quarter of all abortions performed annually.[28]

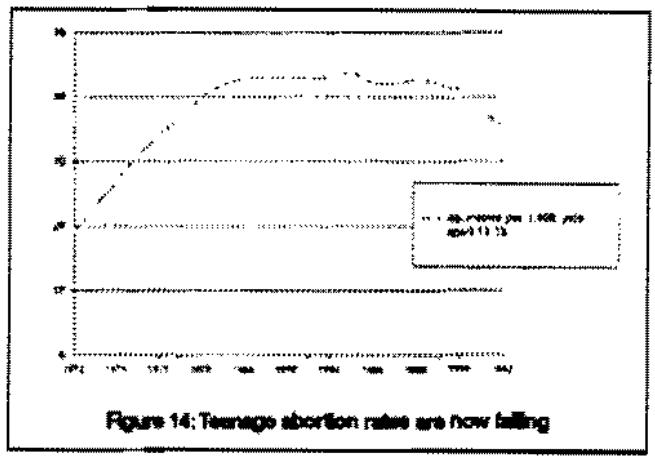


Figure 14: Teenage abortion rates are now falling

These trends indicate that the increased availability of abortion since 1973 has been one factor keeping teen birth rates from rising. Now that pregnancy rates are declining, abortion rates have declined as well. Indeed, preventing teen pregnancy appeals to many because it can result in fewer abortions.

Contraceptive Use

Contraceptive use among sexually active teens has increased. Two-thirds of teens use some method of contraception (usually a condom) the first time they have sex. Teen contraceptive use at first intercourse rose from 48 percent to 65 percent during the 1980s, almost entirely because of a doubling in condom use, partly due to fear of AIDS (Figure 15).[29] Higher rates of contraceptive use have partially offset the potential increase in pregnancy resulting from increased teen sexual activity.

It is important to note, however, that successful use of most contraceptive methods requires both motivation and a constancy of attention and action that is sometimes difficult for even married adults to maintain, let alone teenagers and others who are not in stable and long-term relationships.[30] For example, among young women aged 15-19 relying upon oral contraception as their main form of birth control, only about 40 percent took a pill every day.[31] Similarly, among women relying upon condoms as their primary method of contraception, only 35 percent of 15- to 17-year-olds and 31 percent of 18- to 19-year-olds used a condom during every act of intercourse.[32] The consequences of less-than-perfect or infrequent contraceptive use are serious. A sexually active teen who does not use contraception at all, for instance, has a 90 percent chance of pregnancy within one year.[33]

When teens are asked why they do not use contraception, they often say they did not expect or plan to have sex and thus were not prepared. Far less frequently do they say that they can't afford birth control, don't know where to get it, can't get it, or don't know how to use it.[34]

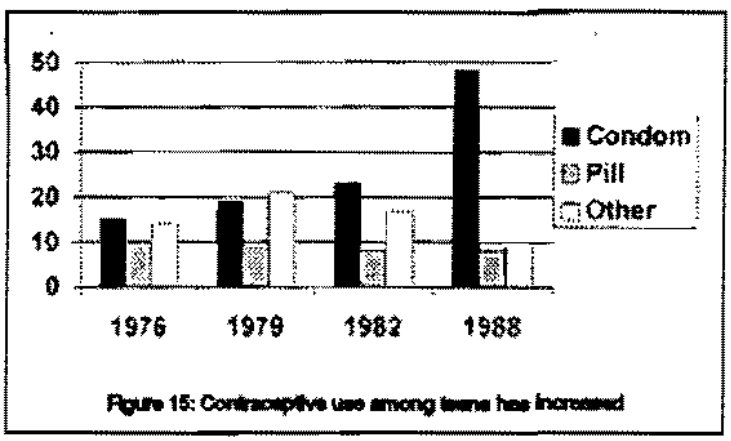


Figure 15: Contraceptive use among teens has increased

Although the teen pregnancy rate increased during the 1970s and 1980s despite a major concurrent increase in contraceptive use, that does not mean

that increased reliance on contraceptives hasn't made a difference. If teenagers had not improved their contraceptive practices over this period, the teen pregnancy rate would have been almost 40 percent higher.[35] However, better use of contraceptives couldn't keep pace with the greater tendency of teens to engage in sex, and the result is that the pregnancy rate continued rising instead of falling. Some have argued that making contraception more accessible to teens contributed to the relaxation of social restrictions on teen sexual behavior, thereby *encouraging* such activity. Whether the latter is true or not, these data suggest that more contraception *by itself* is unlikely to solve the teen pregnancy problem completely.

Size of the Teenage Population

Although the teen birth *rate* has decreased in the past few years, the *number* of births to teens increased in 1993 and 1994, reflecting an overall increase in the U.S. teen population. Because the number of teens is expected to increase further, so will the number of pregnancies and births unless rates are reduced. Between 1995 and 2010, the number of girls aged 15-19 will increase by 2.2 million.[36] If current fertility rates remain the same, we will see a 26 percent increase in the number of pregnancies and births among teenagers.[37]

Birth Rates by Race and Ethnicity

Birth rates are higher among African-American and Hispanic teens than among white teens. In 1994, the birth rate for Hispanic teens was 108 births and for African-American teens was 105 births per 1,000 women aged 15-19. For non-Hispanic whites, the birth rate for 1994 was 40 births per 1,000 women aged 15-19.[38]

Increases in birth rates among teenagers in the late 1980s may be partly attributable to increases in the population of Hispanic teens, who have high fertility rates. For example, between 1980 and 1990, the number of Hispanic teens increased 30 percent, while the number of non-Hispanic white teens decreased 23 percent.[39]

What Are the Consequences of Teen Pregnancy?

Teenage childbearing is associated with adverse consequences for teenage mothers and particularly for their children. However, most of the negative consequences for teen mothers — some say all — are due to the disadvantaged situations in which many of these girls already live. In other words, it is not as if all teen mothers were doing well *before* giving birth and then sank into poverty and social disorganization only as a result of having a child. Researchers are continuing to sort out the extent to which poor outcomes for teen mothers are due to the timing of the birth versus characteristics of the mother that were present even before she became pregnant. However, most experts agree that, although the disadvantaged backgrounds of most teen mothers account for many of the burdens that these young women shoulder, having a baby during adolescence only makes matters worse.

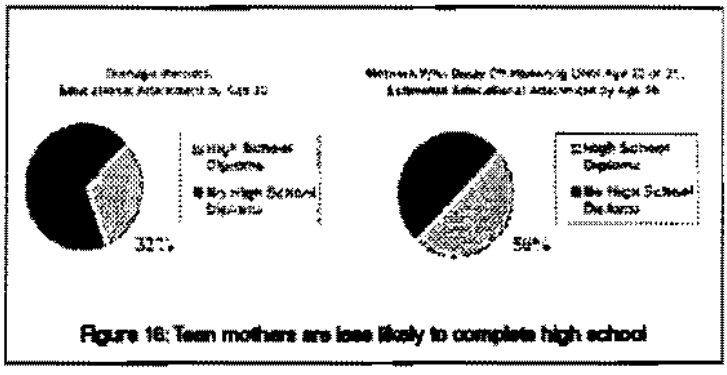


Figure 16: Teen mothers are less likely to complete high school

Thus, when compared to similarly situated women who delay childbearing until age 20 or 21, adolescent mothers and their children experience a number of adverse social and economic consequences. For

instance, early parenting limits a young mother's likelihood of completing the high school and postsecondary education necessary to qualify for a well-paying job. Less than one-third of teens who begin their families before age 18 ever complete high school. If they delay childbearing until age 20 or 21, the odds of high school graduation for these young mothers increases to 50 percent (Figure 16).[40]

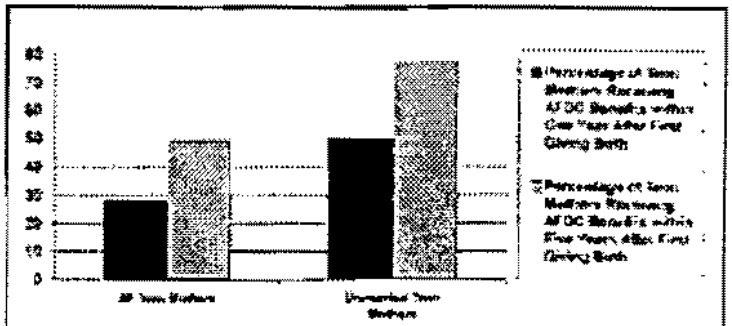


Figure 17: Many teen mothers end up on welfare, especially if they are unmarried

Teen mothers spend more of their young adult years as single parents than do women who delay childbearing, which means that their children spend much of their young lives with only one parent.[41] Children who grow up in single-parent homes are disadvantaged in many ways. For example, when compared with similarly situated children who grow up with two parents, children in one-parent families are twice as likely to drop out of high school, 2.5 times as likely to become teen mothers, and 1.4 times as likely to be both out of school and out of work.[42] Even after adjusting for a variety of relevant social and economic differences, children in single-parent homes have lower grade point averages, lower college aspirations, and poorer attendance records. As adults, they have higher rates of divorce.[43]

Adolescent mothers also have more children, on average, than women who delay childbearing, which makes it more difficult for them and their children to escape a life of poverty.[44] About one-fourth of teenage mothers have a second child within 24 months of the first birth; this percentage is even higher for younger teen mothers than for older ones.[45] As a result, adolescent mothers must stretch their limited incomes to support more children.[46]

Many young mothers end up on welfare (Figure 17). Data show that almost half of all teenage mothers and over three-fourths of *unmarried* teen mothers began receiving Aid to Families with Dependent Children (AFDC) within five years of the birth of their first child.[47] In addition, 52 percent of *all* mothers on AFDC had their first child as a teenager.[48]

Conversely, the fathers of children born to teenage mothers bear relatively little of the measurable costs of adolescent childbearing, although anecdotal evidence suggests some fathers bear emotional or other costs that have not been well-studied. Nearly 80 percent of these fathers do not marry the young mothers of their first children, and, on average, these absent fathers pay less than $800 annually for child support. Otherwise, the measurable effects for the fathers are limited to somewhat lower education levels and to modest earnings losses — on the order of 10 to 15 percent annually.[49]

By far, the greatest harm is borne by the children of teen mothers. In fact, the difficulties experienced by these children begin before birth and continue into adulthood. For example, the children of teen mothers (particularly mothers under 18) are more likely to be born prematurely and at low birthweight (Figure 18).[50] Low birthweight (less than five-and-a-half pounds) raises the probabilities of infant death, blindness, deafness, chronic respiratory problems, mental retardation, mental illness, and

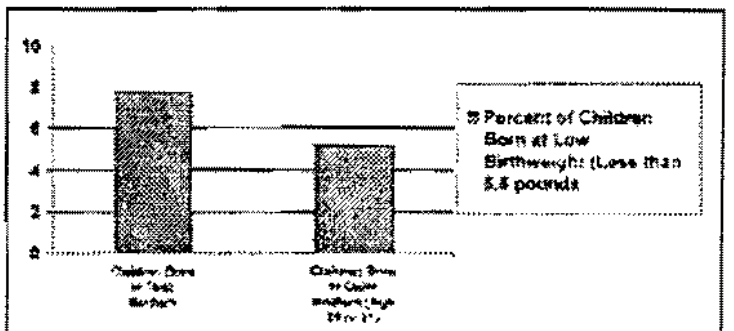


Figure 18: The children of teen mothers have lower birthweights

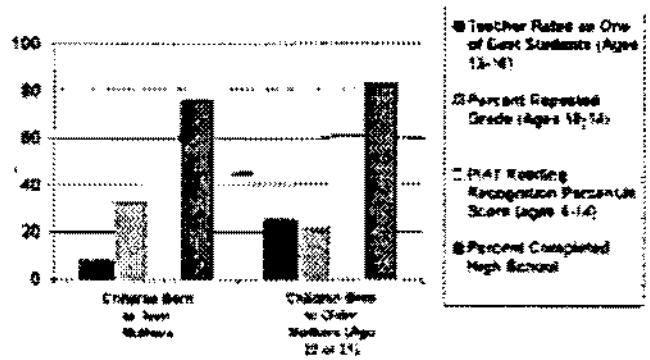


Figure 19: The children of teen mothers have poorer school performance

cerebral palsy. In addition, low birthweight doubles the chance that a child will later be diagnosed as having dyslexia, hyperactivity, or another disability.[51]

Despite having more health problems than the children of older mothers, the children of teen mothers receive less medical care and treatment. In his or her first 14 years, the average child of a teen mother visits a physician or other medical provider an average of 3.8 times per year, compared with 4.3 times per year for the children of later childbearers.[52]

Children of teen mothers also do much worse in school than those born to older parents. They are 50 percent more likely to repeat a grade, they perform much worse on standardized tests of performance, and ultimately they are less likely to complete high school than if their mothers had delayed childbearing (Figure 19).[53]

Children born to teen mothers are also at higher risk because their mothers — and often their fathers as well — are typically too young to master the demanding job of being parents. Still growing and developing themselves, teen mothers are often unable to provide the kind of environment that infants and very young children require for optimal development. Recent research, for example, has clarified the critical importance of early cognitive stimulation for adequate brain development.[54]

Measured against national norms, the children of adolescent parents live in homes that are of poorer overall quality (e.g. poorer physical conditions, less parent-child interaction, and fewer educationally stimulating resources in the home). These limitations are reflected in poorer academic performance by the children, less attention given to their health problems, and higher rates of behavior problems.[55]

The children of teen parents also suffer higher rates of abuse and neglect than would occur if their mothers had delayed childbearing (Figure 20). There are 110 reported incidents of abuse and neglect per 1,000 families headed by a young teen mother. If mothers delay childbearing until their early twenties, the rate drops by half — to 51 incidents per 1,000 families. Similarly, rates of foster care placement are significantly higher for children whose mothers are under 18. In fact, over half of foster care placements of children with young mothers could be averted simply by delaying childbearing a few years, thereby saving taxpayers nearly $1 billion annually in foster care costs alone.[56]

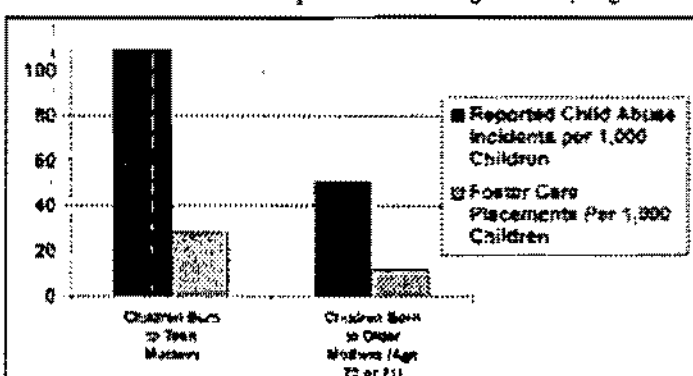


Figure 20: The children of teen mothers are at greater risk of abuse and neglect

Adolescent childbearing contributes to the high rates of economic inactivity among young adults and of crime among young men, as well as to a repetitive cycle of teen parenting. Young adult children of teen mothers are 30 percent more likely to be neither working nor going to school. The sons of teen

mothers are 13 percent more likely to end up in prison. And, the teen daughters are 22 percent more likely to become teen mothers themselves.[57]

Taxpayers pay a high price for teen childbearing. A recent study found that, after controlling for differences between teen mothers and mothers aged 20 or 21 when they had their first child, teen childbearing costs taxpayers $6.9 billion each year — $2,831 a year per teen mother (Figure 21).[58]

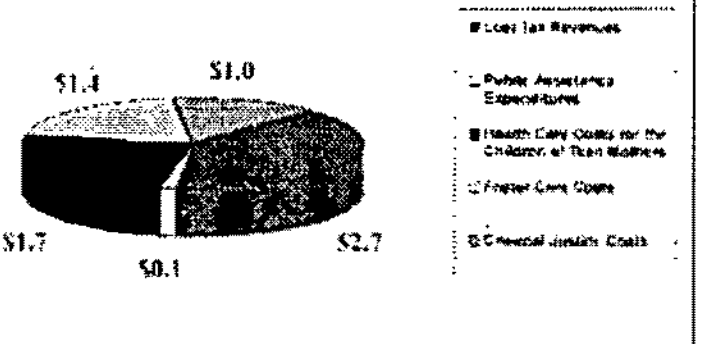


Figure 21: Taxpayers pay a high price for teen childbearing

What Should Be Done?

The serious consequences of teen pregnancy have caught the attention of many groups and individuals around the country, and their hard work in recent years is undoubtedly one of the reasons that the nation may be turning the corner on teen pregnancy. What can be learned from all the efforts now underway, and what are the obvious next steps? In other words, what should be done?

Along with many other groups and individuals, the National Campaign has asked itself this critical question and talked extensively with leaders both at the national level and in states and communities. We have made numerous visits around the country, including site visits to eight diverse areas. We have listened to teens themselves and to their parents. And finally, we have looked at what research reveals about a few carefully evaluated programs designed to reduce teen pregnancy.60 This information — some of it based on research, some on experience, and some of it simple common sense — suggests that action is required both at the community level and at the national level as well.

The Basic Messages

Most fundamentally, the nation needs to embrace the basic social norm that the teenage years are for education and growing up, not pregnancy and parenthood. One of the reasons the United States has such high levels of teen pregnancy and childbearing is that the consensus that "teen pregnancy is not OK" is less robust than many imagine. There has been a sea change in attitudes and behavior over the past few decades with the result that teen sexual activity and out-of-wedlock births are now commonplace. Partly as a result, not all young people — and not even all adults — place a high priority on avoiding teen pregnancy. When asked why they became pregnant, many teenage girls respond, "it just sort of happened," a response that is consistent with research showing clearly that unless motivation is strong to avoid pregnancy, it can happen all too easily.61 Adults need to speak directly to teens about this issue, providing guidance in accordance with their own values and encouraging teens to make much clearer choices about when to become sexually active and how to handle the responsibilities that such a decision entails.

In communicating this basic message, the consequences of teen pregnancy should be emphasized. As the data summarized above show, teen pregnancy and childbearing impose significant costs, both economic and personal, and place major burdens on families and communities. Teenage pregnancy and childbearing are not in anyone's best interest, least of all the children born to teenaged mothers. Keeping these consequences squarely before the public can help motivate both adolescents and adults to take action to reduce teen pregnancy.

We also need to recognize that, especially for those at highest risk, reducing teen pregnancy often requires that better, more attractive options be on hand. In a community characterized by poor schools, insufficient adult attention and guidance, limited jobs, and few recreational opportunities, early pregnancy and childbearing can sometimes seem the most appealing life course available. Babies, after all, can bring purpose and joy to life, even in the most stressful circumstances, and early family formation is sometimes a more reasonable choice than it seems. We need to give teens ample reasons not to become pregnant or cause a pregnancy by pointing them toward a better future.

Research Findings on the Major Approaches to Reducing Teen Pregnancy

Many communities have been hard at work in recent years to reduce teen pregnancy, and it is important to understand what research teaches about these efforts in order to craft future plans. A recent research review commissioned by the National Campaign summarized available data on the major approaches currently being taken to reducing adolescent pregnancy.62 This review and other studies suggest the following:

1. Although their impact is modest, some sex education programs (but not all) can help to delay the initiation of sex, reduce the number of sexual partners, or increase the use of contraception. It is important to add, however, that many school districts do not use the few curricula that have been shown to be somewhat effective; many courses are too short or begin too late or are taught by teachers who are poorly trained in this area or have been given mediocre teaching materials. And, in many such classes, little time is spent on talking about responsible relationships, how to cope with peer pressure, or other such factors. As a consequence, sex education in its current form is unlikely to make a major dent on teen pregnancy, although there may be other education-related reasons to support such classes.

2. Another approach currently being taken to reducing teen pregnancy is enrolling teenagers in programs that focus on the importance of abstinence from sexual intercourse until adulthood, sometimes until marriage. Either these programs do not discuss contraception or they briefly discuss the failure of contraceptives to provide complete protection against pregnancy and sexually transmitted diseases. Even though these "abstinence-only" programs may be appropriate for many youths, especially junior high and middle school youths, there does not currently exist any credible scientific research demonstrating that they have actually delayed the onset of sexual intercourse or reduced any other measure of sexual activity. Thus, although some of these programs appear promising — especially those that emphasize peer support, adult mentoring, and sustained attention — it is not yet known whether they delay intercourse. In short, the jury is still out, and more research is needed to understand the effects of these programs.

3. The third major approach communities typically rely on to reduce teen pregnancy is to support family planning services for sexually active teenagers. Family planning clinics or family planning services within other settings such as schools can ease access to contraception. However, because contraceptives — condoms in particular — are widely available in stores, it is not clear that access per se is the issue. On the other hand, large numbers of sexually active teenage girls attend family planning clinics or visit private physicians where they obtain contraceptives that are more effective than those sold over-the-counter and where they often are counseled about how to use contraception effectively and about other related matters. All else being equal, these special family planning services should logically reduce the pregnancy rates of those youth who use them. However, the few studies that have examined the impact of subsidized family planning services upon pregnancy or birth rates have produced mixed results and are very limited methodologically.

We also know that even teens who do attend family planning clinics are often inconsistent users of contraception, as noted above, and often fail to return for follow-up visits or to use the methods they have chosen properly. A few studies suggest that improving clinic protocols and practices, community outreach, and ease of clinic access can increase adolescents' use of medical providers or improve their contraceptive use.

4. The fourth strategy that some communities employ is a comprehensive approach that stitches together several different components. These programs typically combine a strong educational element, clear messages about the importance of postponing sex and/or avoiding pregnancy, access to contraception (sometimes through clinics based in or near schools), and an additional component such as a community-wide media campaign or an active parent group. A few such programs have been shown to increase the use of contraceptives and decrease pregnancy rates. These programs can be expensive and are often quite labor-intensive, and, because few have a stable funding base, they can be hard to sustain financially.

5. Finally, some (although not all) programs dedicated to nurturing and guiding young people — often called youth development programs — can help to decrease teen pregnancy, even if these programs have little specific focus on sexual behavior. Like comprehensive programs, these too can be hard to sustain for all the same reasons.

The bottom line is that there are no clear answers at the community-level to reducing teen pregnancy. We have some clues about promising approaches but no single proven method guaranteed to produce large results. In particular, those few interventions that show some positive signs of benefit have rarely been tried elsewhere in the country or even somewhere else in the same state or community. Without such replication, it is hard to determine the impact of any particular approach.

Community Innovation

Given that research offers no clear answers, what should communities do? Field experience, common sense, and expert opinion can all help to chart a course. The guiding theme should be innovation and creativity. Building on the lessons gleaned from research, experience, and local preferences, communities should be open to new ideas and willing to try new approaches.

Many communities, for example, are encouraging parents to talk more with their children and teenagers about love and sex (and how to tell the difference) and to be clearer about expected standards of behavior. Some communities are focusing on afterschool programs and recreational opportunities to fill the hours in which many teens are unsupervised while their parents are at work; others are beginning to see job training, community service, and more general efforts to develop work-related skills in a new light — as an important part of preventing teen pregnancy. A few are trying to put many separate approaches together into integrated, comprehensive programs. And many communities now understand the importance of peer pressure and are using teens as peer educators or encouraging the formation of peer groups in which teens support one another in a decision to remain abstinent. At the same time, because so many teens are already sexually active, other communities are redoubling their efforts to make family planning services for sexually active teens more accessible and more effective.

Many are also recognizing that caring and focused attention from adults — whether as parents, friends, mentors, or leaders — can have a transforming effect on teens. Thus, interest in mentoring programs and in finding the volunteers to fill them is increasing nationwide. In a similar vein, many

are trying to engage faith communities in helping teens pass safely through adolescence, avoiding not only pregnancy and parenthood, but also drug use, delinquency, and other risks. Community initiatives also increasingly target men and boys in recognition that girls alone do not cause teen pregnancy. And many now realize that interventions must begin early — in junior high school and even before. Years of research in child and adolescent development have clarified that many basic values and attitudes with great relevance to sexual risk-taking are formed in childhood. Waiting until high school can often be too late.

The National Campaign supports all such innovation and creativity. It is important to add, however, that a concerted effort must be made by these programs and those funding them to assess their effects on teen pregnancy and other outcomes so that others can learn from the experience.

Managing Conflict

Visits by the National Campaign to many states and communities have revealed that those who want to work on preventing teen pregnancy often find themselves mired in conflict. People often differ in their views about why teens become pregnant or cause pregnancy and about what to do. The most obvious example of the tensions is the current struggle over whether a strong abstinence message is preferable to a focus on access to contraception for sexually active teens. Although some seek to combine these two strategies, others see them as incompatible. Adults also disagree over whether parental consent should be required before minors gain access to health care services, including contraception, and over the content of school-based sex education.

In fact, conflict over these issues is sometimes so intense that communities are unable to do anything at all. The ensuing paralysis means, among other things, that teen pregnancy remains unattended. Accordingly, it is critical that communities consider explicitly how to manage these conflicts, remembering, as we often say at the National Campaign, that "while the adults are arguing, the kids are getting pregnant." One way through these differences is for all sides to embrace a new ethic of "unity of purpose, diversity of means." This perspective stresses the importance of reducing teen pregnancy but allows each group to take action in its own arena and in its own way without opposition. It also tacitly recognizes that America is an increasingly diverse country requiring respect and tolerance for differing points of view.

Tillamook County, Oregon, offers an important insight about managing differences. When in 1990 state data showed that this rural county of 23,000 citizens had one of the highest teen pregnancy rates in the state, the county health department proposed creating a school-based clinic, provoking intense community conflict. The proposal was defeated by the school board, but the community agreed that something had to be done. They decided the only consensus they needed was that the teen pregnancy rate must drop. Various segments of the community developed intensive initiatives — ranging from creating new church-based abstinence education programs, to improving access to family planning clinics, to expanding YMCA programs for girls — and agreed not to fight each other's efforts. By 1994, the county teen pregnancy rate had dropped by 70 percent, becoming the lowest in the state.

National Leadership

Even if communities find the energy to address teen pregnancy in intense and creative ways, they shouldn't be expected to do it alone. The problem of teen pregnancy is as much one of the overall culture as it is a lack of community programs, and of national as well as local policies. Thus, it

would be naive to think that the problem can be solved only by a network of individual community projects. Most programs, in truth, reach only a limited number of individuals, many are poorly funded and their status is often fragile. Accordingly, leaders of the nation's major institutions must become as deeply involved in finding solutions to this problem as are those already hard at work in communities.

Several sectors have a key role, the media most of all. The power of television, movies, radio, and the print media to shape opinion and influence behavior is beyond doubt. This pervasive force must be harnessed to the task of reducing teen pregnancy, as it has been to other important social issues. In particular, the media need to incorporate a variety of messages consistent with a pregnancy-free adolescence into their myriad products — messages carried by characters that are credible to the targeted audiences. The National Campaign is encouraged that a number of media leaders have already answered our call for doing so, but much more needs to be done.

Major national leaders in all sectors need to speak out about the problem of teen pregnancy and the importance of bringing the rates down. Celebrities can be effective in communicating such ideas as can political leaders and other powerful and widely respected voices. In particular, such leaders can help those at the community level to feel part of a larger national movement. In this regard, the National Campaign is pleased to have the strong support of President Clinton and of two Congressional advisory panels, one in the House under the leadership of Rep. Nita Lowey (D-NY) and Rep. Mike Castle (R-DE) and one in the Senate under the leadership of Sen. Joe Lieberman (D-CT) and Sen. Olympia Snowe (R-ME). These and other leaders can be especially effective in honoring local initiatives and giving them national visibility. Such recognition can help motivate continued work at the community level — work that is usually hard, frequently unappreciated, and often invisible.

A new ethic of tolerance and respect also requires national leadership. It is a hollow and hypocritical message to ask communities to manage their differences if national leaders will not do so as well. Accordingly, current efforts underway by many groups to revitalize the quality of civic life and discourse have direct relevance to preventing teen pregnancy. If leaders at the national level can model new ways of resolving differences — or at least of managing differences in a way that doesn't impede action — then communities may find it easier to move forward as well.

At a more practical level, national leadership is needed to help the many disparate state and community groups working in this area to share ideas and information among themselves. Local activists are eager for current information on the extent of the teen pregnancy problem, on what other colleagues are doing, on what research says about the impact of particular programs or school curricula, and on how best to mobilize their own neighbors and sustain their interest. The risk of isolation is ever present, and leadership is needed to build a national movement from many separate parts.

And finally, communities need help in garnering adequate public and private support for both new program initiatives and for program evaluation. As noted earlier, too few programs have been carefully evaluated, which has greatly limited the ability of communities to know how best to intervene to reduce teen pregnancy. All those who care about preventing teen pregnancy must be encouraged to fund strong and well-managed programs, and then to ask the difficult (and often expensive) questions about their impact on pregnancy rates. Without such commitments, our ability to reduce adolescent pregnancy significantly is seriously impaired.

Conclusion

Despite the good news of the slight decline in teen birth rates over the past four years, the rates of teen pregnancy and teen births in the United States remain far higher than those in any other industrialized nation. The costs of today's teen pregnancies will be borne most heavily by tomorrow's children, who will grow up in circumstances less than they deserve and less than they need to become responsible, competent adults.

Much concern has been voiced about this nation's lagging rate of economic growth and widening income disparities. But too little attention has been paid to the way in which children's very early family environments affect both trends — and to the difficulties and expense of helping children overcome early disadvantages. In 1990, 45 percent of all first births in the United States were to mothers who were either teenagers, unwed, or lacking a high school degree.[63] The high proportion of children starting out their lives in such circumstances has strong implications for the nation's future competitiveness and social cohesiveness. Until more is done to ensure that as many children as possible begin life with parents who are ready to nurture and care for them, progress on these other fronts will be difficult at best — and perhaps impossible.

The National Campaign challenges all who are worried about these larger economic and social issues to join with us in finding and evaluating effective strategies to prevent teen pregnancy, to strengthen families in the process, and thereby to provide a better life for all our children.

Endnotes

1. A 1987 *USA Today* poll found that 72 percent of adults believe that the growth in teen pregnancies is a very important problem. [Poll conducted by the Gordon S. Black Corporation and cited in Princeton Survey Research Associates, "A Review of Public Opinion About Teen Pregnancy," a report prepared for the National Campaign to Prevent Teen Pregnancy, Princeton, NJ: Author, September 1996.] Teens themselves agree. According to a 1997 *Parade* magazine survey, 66 percent of girls aged 12 to 19 said pregnancy among unmarried teens was a problem in their community, and 87 percent believed that something more must be done to prevent pregnancy [Chassler, S., "Teenage Girls Talk About Teen Pregnancy," *Parade*, 4-5, February 2, 1997].
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3. Yankelovich, D., "The Public's Views About the Current 'Moral Crisis,'" A special DYG SCAN Study, New York: Author, May 12, 1995.
4. Approximately 10 percent of all 15- to 19-year-old females and 20 percent of sexually active teen females become pregnant in a year.
5. National Campaign to Prevent Teen Pregnancy analysis of Henshaw, S.K., *U.S. Teenage Pregnancy Statistics*, New York: Alan Guttmacher Institute, May 1996; Forrest, J.D., *Proportion of U.S. Women Ever Pregnant Before Age 20*, New York: Alan Guttmacher Institute, 1986, unpublished. Note: This is an estimate based in part on assumptions about the number of repeat pregnancies among teens that can occur either because of multiple abortions (including miscarriages) or because of multiple births, or because of some combination of the two. As new or better data become available, the Campaign intends to update this estimate.
6. McElroy, S.W., & Moore, K.A., "Trends over Time in Teenage Pregnancy and Childbearing: The Critical Changes," in R.A. Maynard (ed.), *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy* (pp. 23-53), Washington, DC: The Urban Institute Press, 1997; Rosenberg, H.M., et al., "Births and Deaths: United States, 1995," *Monthly Vital Statistics Report*, 45(3), Suppl. 2, 1-40, October 4, 1996; and the Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994, Figure 55, p. 76.
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11. Alan Guttmacher Institute tabulations of data from the 1988 National Maternal and Infant Healthy Survey, 1993; Alan Guttmacher Institute tabulations of data from the 1987 AGI Abortion Patient Survey, 1993; and Henshaw, S.K., "Abortion Trends in 1987 and 1988: Age and Race," *Family Planning Perspectives*, 24, 85-86, 1992, Table 1, p. 86. All three in the Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994.
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15. The 1990 pregnancy rate among sexually experienced women aged 15-19 was 207 per 1,000. Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994, Figure 30, p. 41.
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17. From 90.5 births per 1,000 women aged 15-19 in 1955 to 50.2 in 1986.

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19. While the proportion of young people who are sexually active has continued to climb, the rate of increase has slowed since the 1980s.

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24. In the mid-1950s, only 27 percent of young women reported having had sex by their 18th birthday (comparable data for men is not available for that time period). Data on women adapted by the Alan Guttmacher Institute from tabulations by S.L. Hofferth of data from the 1982 National Survey of Family Growth; data on men adapted by the Alan Guttmacher Institute from tabulations by K. Tanfer of data from the 1991 National Survey of Men. Both in the Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994.

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31. Forty percent of 15- to 17-year-olds and 41 percent of 18- to 19-year-olds took a pill every day. Tabulations by D. Oakley of data from University of Michigan longitudinal survey of initial clients at three family planning clinics near Detroit, February 1987-April 1989, in the Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994, Figure 26g, p. 36. See also Oakley, D., Serrika, S., & Bogue, E.L., "Oral Contraceptive Pill Use After an Initial Visit to the Family Planning Clinic," *Family Planning Perspectives*, 23, 150-154, 1991.

32. Tabulations by D. Oakley of data from the University of Michigan longitudinal survey of initial clients at three family planning clinics near Detroit, February 1987-April 1989, in the Alan Guttmacher Institute, *Sex and America's Teenagers*, New York: Author, 1994, Figure 25, p. 35.

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35. This estimate is based on multiplying the 1972 rate of pregnancies among sexually active teens by the 1988 rate of sexual activity among all teens to obtain the pregnancy rate that teens would have experienced in 1988 if there had been no change in contraceptive behavior. The resulting estimate is a 15.4 percent pregnancy rate — 4.3 percent (or almost 40 percent) higher than the actual rate of 11.1 percent for that year.

36. U.S. Department of Health and Human Services, *Report to Congress on Out-of-Wedlock Childbearing*, Washington, DC: Author, September 1995, Table III-1.

37. National Campaign to Prevent Teen Pregnancy analysis of Henshaw, S.K., "U.S. Teenage Pregnancy Statistics," New York: Alan Guttmacher Institute, May, 1996; and U.S. Department of Health and Human Services, *Report to Congress on Out-of-Wedlock Childbearing*, Washington, DC: Author, September 1995, Table III-1.

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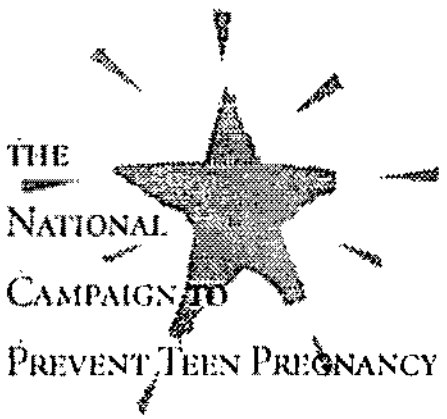

Founded in 1996, the National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan initiative supported entirely by private donations. The Campaign's mission is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. The Campaign's goal is to reduce the teen pregnancy rate by one-third by the year 2005.

The Campaign's strategy has five primary components: taking a strong stand against teen pregnancy and attracting new and powerful voices to this issue; enlisting the help of the media; supporting and stimulating state and local action; leading a national discussion about the role of religion, culture, and public values in an effort to build common ground; and making sure that everyone's efforts are based on the best facts and research available.

The National Campaign to
Prevent Teen Pregnancy
1776 I Street, NW, Suite 200
Washington, DC 20006

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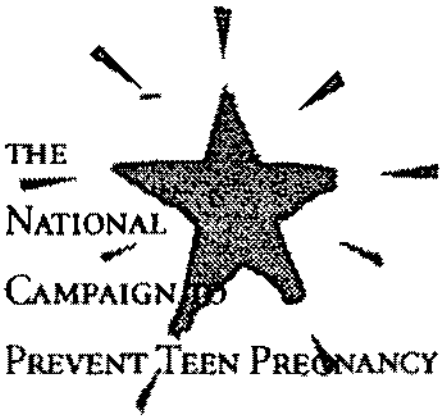
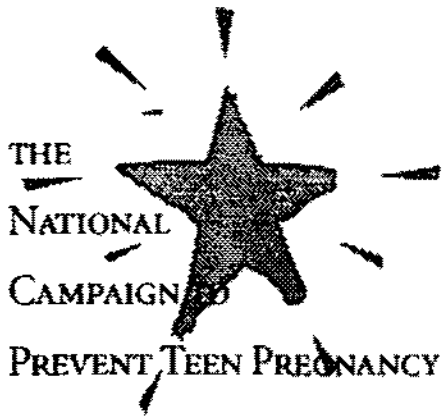


THE NATIONAL CAMPAIGN TO PREVENT TEEN PREGNANCY

Snapshots from the Front Line

Lessons About Teen Pregnancy Prevention from States and Communities

A report from the National Campaign to Prevent Teen Pregnancy



THE
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Lessons About Teen Pregnancy Prevention from States and Communities

A report from the National Campaign to Prevent Teen Pregnancy

May 1997

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The National Campaign to Prevent Teen Pregnancy

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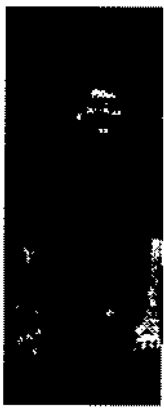
For more information, write to the National Campaign to Prevent Teen Pregnancy, 2100 M Street, NW, Suite 300, Washington, DC 20037.

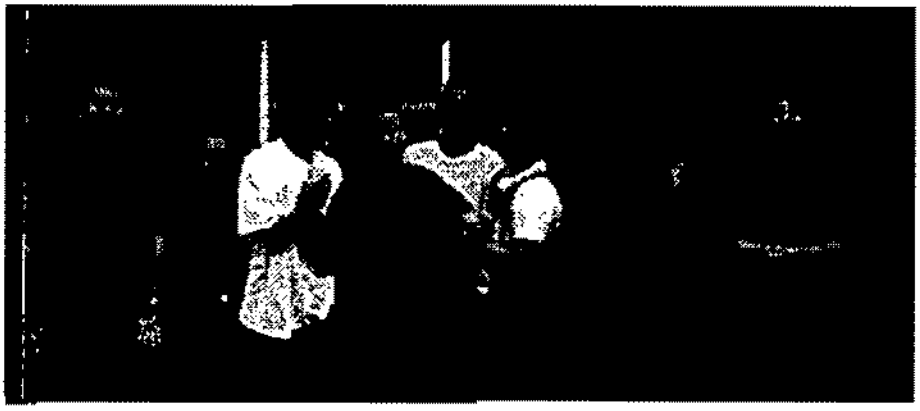
Preface



At its founding board meeting in February 1996, the leaders of the new National Campaign to Prevent Teen Pregnancy defined "supporting and stimulating state and local action to prevent teen pregnancy" as one of the organization's primary goals. They recognized that the real work of preventing teen pregnancy happens not in Washington, DC, but on the front-line — in states and communities across the nation where many people are working hard to help teens have the best futures possible.

From its inception, the National Campaign was determined to make site visits to communities across the nation both to learn from state and local experts and to catalyze and support their efforts. This report offers snapshots of what the Campaign has learned from visits to Arkansas, Illinois, Louisiana, New Jersey, New York, Oregon, Texas, and Virginia over the past year. It is not a comprehensive guide to state and local action, but we believe it offers a sense of the spirit of innovation in communities, as well as of the continued challenges faced by those committed to preventing teen pregnancy.

In two and three-day site visits to urban, suburban, and rural communities, Campaign officials and staff met with community leaders,



Andrew Lewis (left), a family life educator in Austin, Texas, and participants in Austin's teen pregnancy prevention program for boys welcomed visitors from the National Campaign

members of state and local teen pregnancy prevention coalitions, state and local policymakers, service providers, youth workers, and, of course, teens themselves. From prayer breakfasts to teen forums, from community health centers to state- or community-wide meetings, Campaign representatives participated in events that were as diverse as the variety of communities interested in making a difference.

These site visits have been more than just learning opportunities for the Campaign; they have also aided the host communities. In some locales, a visit by the National Campaign helped reenergize participants in a state or local coalition. In one state, the Campaign offered detailed assistance to a team charged with developing a coordinated state plan to prevent teen pregnancy. And often the Campaign has been able to link particular community initiatives to similar efforts in other states.

The National Campaign applauds the efforts of the states and local communities described in this report, as well as similar work happening all over the nation. We look forward to continuing to learn from and support the work of people on the front-lines of the campaign to prevent teen pregnancy.

"So, what's wrong with teen pregnancy? I don't think it's so bad."

— a teenage boy in Texas

What the Campaign Has Learned:

NO1 We must strengthen the consensus nationwide that adolescence is a time for education and growing up, not pregnancy and childbearing.

The Campaign site visits have confirmed that most people recognize the seriousness of the problem of teen pregnancy. However, we've also learned not to overestimate the consensus on this issue. Not all young people — and not even all adults — place a high priority on avoiding or reducing teen pregnancy. In fact, we have met with many groups who feel that more teens get pregnant as a result of their and society's ambivalence about whether teen pregnancy is "OK" than most adults realize. Some teens even seek to become pregnant and have children. This sense was made clear to us when, halfway through a youth forum in Austin, Texas, a young man asked pointedly, "So, what's wrong with teen pregnancy? I don't think it's so bad."

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Teens conducting a role-playing exercise in Tillamook, Oregon

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Real differences in values among adults can impede action to prevent teen pregnancy.

In many communities, people of good faith disagree strongly about particular strategies to prevent teen pregnancy, especially when values about teen sexuality are at issue. Sometimes these conflicts stymie a community's ability to do anything at all. Tillamook County, Oregon, made a deep impression on the Campaign because it was able to find a way to move forward in the face of value conflicts. The essence of their approach was to take action in an atmosphere of tolerance, with all sides "agreeing to disagree."

When in 1990 state data showed that this rural county of 23,000 citizens had one of the highest teen pregnancy rates in the state, the county health department proposed creating a school-based clinic that would provide contraception, provoking intense community conflict. The proposal was defeated by the school board, but the community agreed that something had to be done. They decided the only consensus they needed was that the teen pregnancy rate must drop. Various segments of the community developed intensive initiatives — ranging from creating new church-based abstinence education programs, to improving access to family planning clinics, to expanding YMCA programs for girls — and agreed not to fight each other's efforts. By 1994, the county teen pregnancy rate had dropped by 70 percent, becoming the lowest in the state.

NO3

Many communities are moving away from brief, one-dimensional prevention programs in favor of adopting intensive prevention strategies that have many components.

Motivated by high rates of repeat teen pregnancies, community leaders in the upstate New York town of Cortland formed the Zero Adolescent Pregnancy (ZAP) coalition in 1991 to put in place a diverse set of activities, including:

- Training teens to be peer educators in schools and the community.
- Offering parent training classes to increase their knowledge and communication skills.
- Training clergy and religious education leaders to provide sexuality education in their faith communities.
- Encouraging all youth to postpone sexual intercourse.
- Providing teachers with graduate training in such abstinence-based curricula as "Postponing Sexual Involvement."
- Providing free-of-charge birth control services to high school-aged teens who are sexually active.
- Working with the media to create community awareness and enlisting teens to create, film, and edit public service announcements to be shown in the schools and on local TV.
- Publishing a quarterly newsletter.

After a few years of these efforts, Cortland's teen pregnancy rate had dropped by 25 percent to the county's lowest level in 20 years. Research supports the idea that such complex programs offer real promise for preventing teen pregnancy (Kirby, 1997). Because teen pregnancy is caused by many factors, from poverty to teens' feelings of inadequacy, from a lack of caring adults to a change in social norms, prevention programs must employ many approaches simultaneously. Moreover, leaders in every state and community we visited said preventing teen pregnancy means giving teens reasons not to become pregnant or cause a pregnancy. A youth worker in Chicago said, "We're trying to make pregnancy only one of 15 attractive options, rather than one of two." Her program focuses on jobs, education, career planning, and self-development.

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"We're trying to make pregnancy only one of 15 attractive options, rather than one of two."

— a youth worker in Chicago

Two teen participants at a New Beginnings conference in Richmond, Virginia

Many local groups working to reduce teen pregnancy seek the meaningful involvement of young people in program planning and development.

№4

The Richmond, Virginia, Community Collaborative for Youth considers teens as equal partners. Teens serve as full members of the steering committee, and a youth development committee trains youths to participate as decision makers.

In Cortland, teens are involved with designing programs and services. For instance, when the community recently opened a teen clinic, teens advised that information about clinic services on posters had to be visible from a distance so that teens could see it without obviously (and embarrassingly) looking at it.

In New Jersey, *SEX, etc.*, a newsletter written for teens, by teens, reaches 60,000 New Jersey high school students. Funded by foundation grants and overseen by the Network for Family Life Education at Rutgers, teen reporters have covered such topics as "Let's Wait Awhile: This Teen Couple Saves Sex for Marriage," "Straight Skinny from the Opposite Sex," and "Doing Drugs: Not All It's Cracked Up to Be."

Oregon Governor John Kitzhaber greets National Campaign President Isabel Sawhill

No 5

Involving powerful state and local leaders can make a real difference. Whether in the state house or local church, key leaders can be especially successful at bringing in new people and funds. They increase the public visibility of promising programs and can encourage community involvement.

In 1995 the Richmond (Virginia) City Council and the city's new assistant manager jointly established teen pregnancy prevention as a primary goal. Together they developed public-private partnerships, increased city funding for prevention programs, and expanded a family life education program.

Oregon has had long-standing commitment from public officials to preventing teen pregnancy. The 1991 "Oregon Benchmarks" identified teen pregnancy as a major indicator of quality of life. In 1994, Governor Barbara Roberts identified teenage pregnancy as her top priority issue. Current Governor John Kitzhaber and his wife, Sharon Kitzhaber, who met with Campaign leaders to exchange ideas about promising prevention strategies, have begun a statewide effort to stimulate state and local initiatives to reduce teen pregnancy, targeting teens aged 10 to 17.

In Arkansas, several state legislators have joined together to introduce legislation creating an ambitious statewide initiative to reduce teen pregnancy. Campaign staff encouraged such efforts at meetings with the Governor, the Lt. Governer, and other state leaders, including state Senator Jay Bradford, a member of the Campaigns State and Local Action Task Force.

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Baltimore's Edwards Blair speaks to a group of teen boys in Richmond, Virginia

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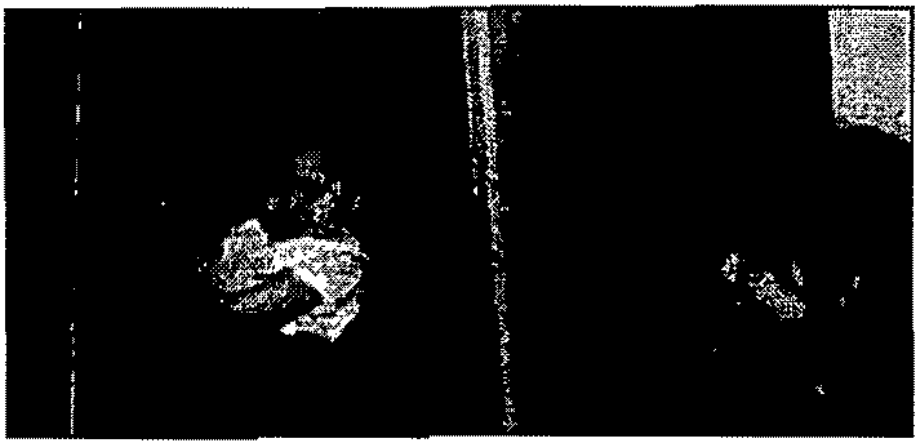
Involving boys and men in prevention efforts is critical. In the past two years, new initiatives have surfaced around the country to focus prevention efforts on adolescent boys that involve adult men as leaders and role models.

At Inwood House in New York City, "not-yet fathers" are deterred from unprotected sex by learning of the struggles faced by young men participating in the Young Fathers Program. Boys aged 9-10 hear a strong message from the young fathers about delaying fatherhood — that teen years are for learning and having fun rather than struggling to provide for children.

In Austin, Texas, a three-year federal grant helped the state health department place special emphasis on male involvement in teen pregnancy prevention, and a broad public/private coalition on male involvement was developed. The state, which is sponsoring a fourth statewide male involvement conference this year, has been successful in including "unlikely partners" — like law enforcement officers — in prevention efforts focused on boys and men.

A Newark, New Jersey, prevention program for young fathers and not-yet fathers seeks to expand life options for at-risk young men by increasing their employment opportunities through counseling, education, and job referrals.

Male involvement initiatives should not be just program add-ons but must be integrated into every aspect of teen pregnancy prevention. The National Campaign is publishing a report in mid-1997 on ways to involve boys and men in these efforts, based upon a roundtable meeting co-sponsored by the Campaign and the Family Impact Seminar.



National Campaign Hits Close to Home: Girls Visit Arkansas

NO7

Caring and focused attention from adults — as parents, friends, mentors, and leaders — can have a transforming effect on teens.

Communities everywhere are worried about who is minding the six- to eighteen-year-olds when they are not in school. In a society in which parents in both single- and two-parent families must work, kids of all ages are often unsupervised during afternoon and evening hours. We know that kids who have access to afterschool activities that involve close relationships with caring adults are less likely to be involved in risky behaviors. The Illinois Caucus for Adolescent Health has had a state bill introduced to create a task force that will collect information on the status of recreational activities for children and teens.

In Texas, the East Austin Youth Charter works with neighborhood groups — churches, schools, businesses, and other youth-serving organizations — to promote adult involvement with teens, including youth employment and enrichment activities during non-school hours.

In Arkansas, abstinence educators view their work as a character-building movement in which the values of self-respect, self-control, and personal responsibility are modeled and shared by adults with teens who then act as role models for their peers — creating a cascading effect of adult caring.

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"While adults are arguing, kids are getting pregnant."

— a national teen pregnancy prevention leader

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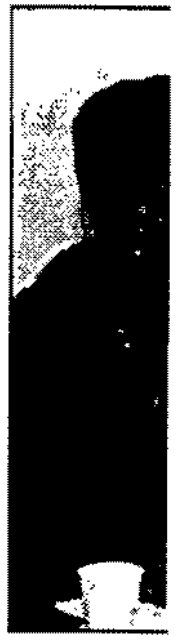
States are seeking to harness the power of the media to reduce teen pregnancy, often through public service announcements.

States and communities that have developed media initiatives have learned to follow several important steps: determine the goal, identify target audiences, conduct research on the targeted audiences (using pollsters and focus groups), and include teens in the message development process. National Campaign staff participated in a day-long retreat sponsored by the Oregon Department of Human Resources. Participants reviewed videos from several states and discussed focus groups and message development with a pollster who will help develop messages and design an overall plan for outreach.

The Network For Family Life Education in New Jersey learned a valuable lesson about the importance of teen involvement in planning media campaigns in the mid-1980s when they undertook a statewide campaign geared to teen pregnancy prevention, which attracted nearly one million dollars in free space on billboards, kiosks, and buses. Once the posters were out, Project Director Susan Wilson was summoned to Plainfield High School by angry teens who wanted to express how insulted they were by them. They were adamant that teens must be involved in creating media messages in order for them to be acceptable and effective.

These experiences and others have given the National Campaign a strong sense of the value — and limitations — of media campaigns focused on teen pregnancy prevention. In June 1997, the Campaign is hosting a conference to help states learn from the experiences of others how to develop media campaigns that focus on prevention. The key theme of the meeting will reflect another lesson from the field — that a media campaign should be only one part of a more comprehensive prevention plan that includes community action and local services as well.

In Cortland, NY (from left to right), Andrea Rankin, director of the Justice Center for Reproductive Health, spearheads the ZAP Coalition. ZAPella, the teen pregnancy prevention superhero, Valery Lapham, a ZAP peer educator, and the National Campaign's Tamara Kreinin.



The National C

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It is easy to start a coalition to prevent teen pregnancy; the challenge is to sustain it.

In 1995, after four years of steadily decreasing teen pregnancy rates, Tillamook, Oregon, saw the rates starting to creep back up, which reminded the community of the necessity of continued vigilance in prevention efforts. And in Cortland, New York, coalition leaders confronted a paradox: their very success in reducing teen pregnancy rates by 25 percent over several years made maintaining the momentum of the initiative difficult. Because the county's teen pregnancy rate dropped so precipitously, Cortland became ineligible for state prevention funds. The coalition soon understood the need to create new gimmicks and strategies to keep people interested. For instance, a local teen peer educator created ZAPella, a female "superhero" who talks to kids about self-esteem and self-respect at schools, community events, and churches. While these efforts have helped reduce the teen pregnancy rates in Cortland, community leaders acknowledge that maintaining the energy necessary to keep all these activities going is difficult. With constant turnover in the teen population — a new group enters adolescence every year — findings ways to sustain commitment is essential.

Well-organized communities often find assistance from outside valuable in reenergizing their coalitions and programs. People have told us that sometimes even a simple visit from the National Campaign can be a boost for burned-out community workers and volunteers.

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The National Campaign's Phyllis Wolfe with Robert Johnson, MD, at a school-based youth services program at Plainfield High School in Plainfield, New Jersey.

State and local leaders are eager to know "what works" in teen pregnancy prevention..

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The Campaign has been struck by the growing understanding throughout the nation that preventing teen pregnancy requires more than simple messages like "just say no" or "use a condom." States and communities are full of creative people coming up with innovative strategies to help teens avoid pregnancy. These same people are looking for better information on what has worked elsewhere.

The Campaign is committed to helping communities do the very best job possible — to learn from others and, particularly, to understand what research can teach about effective approaches to prevention. Toward that end, the Campaign's recent report, *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*, summarizes an enormous amount of information about how to help and what to do next. Two versions of this report are available from the Campaign: a brief summary and the full review.

Conclusion

The National Campaign will continue to travel to communities across the nation — to learn, to help where we can, and to celebrate the hard work being done to prevent teen pregnancy. As we learn of specific needs in states and communities, the Campaign acts to meet them where possible. In early 1997, for example, the Campaign developed a well-regarded Welfare Reform Resource Packet to help states and communities implement the teen pregnancy provisions of the recent federal welfare legislation. We also developed a list of ideas for celebrating May as Teen Pregnancy Prevention Month. And, in response to great demand, the Campaign will host a training meeting on developing state-based media campaigns this summer.

In a similar spirit, the Campaign's Task Force on State and Local Action is currently cataloguing state and community efforts in a more orderly way and is gathering information on resources available to states and communities from national organizations. We will release this information in the coming year.

We remain committed to visiting the front line — it's always a rich experience, always worth the effort, and it always infuses the National Campaign with new energy.

Reference

Kirby, D. (1997). *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy.

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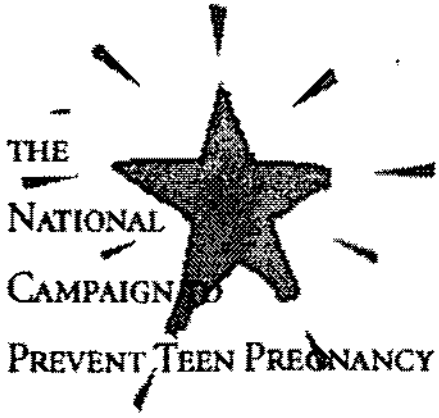

Founded in 1996, the National Campaign to Prevent Teen Pregnancy is a nonprofit, nonpartisan initiative supported entirely by private donations. The Campaign's mission is to prevent teen pregnancy by supporting values and stimulating actions that are consistent with a pregnancy-free adolescence. The Campaign's goal is to reduce the teen pregnancy rate by one-third by the year 2005.

The Campaign's strategy has five primary components: taking a strong stand against teen pregnancy and attracting new and powerful voices to this issue; enlisting the help of the media; supporting and stimulating state and local action; leading a national discussion about the role of religion, culture, and public values in an effort to build common ground; and making sure that everyone's efforts are based on the best facts and research available.

The National Campaign to
Prevent Teen Pregnancy
2100 M Street, NW, Suite 300
Washington, DC 20037

- **IL Breast Cancer Hospitalization:** Last week, the IL State House sent the Senate a measure guaranteeing at least four days in the hospital for women who undergo mastectomies to treat breast cancer. The House passed the measure 112-0 and vowed to revisit the broader issue of managed care regulation.

- **Medicare Choices Demonstration:** HHS is in the final stages of implementing the Medicare Choices Demonstration, a demonstration designed to give Medicare beneficiaries expanded choices among types of managed care plans and test new ways to pay for managed care. Implementation will begin by January 1, 1997. Three of the initial 6 sites are located in Philadelphia, PA; others are located in Houston, TX, Orlando, FL, and Charlottesville, VA.

- **Temporary Assistance to Needy Families (TANF):** On December 13, Temporary Assistance to Needy Families (TANF) plans for NY and UT were certified complete, bringing the total number of certified plans to 20. As of December 17, plans have been submitted by 38 states, the DC and one tribe. Plans were previously certified complete for: AL, SD, NE, CA, KS, MS, TX, KY, VT, NH, WI, MI, FL, AZ, OH, OK, OR, and IN.

- **Domestic Violence:** On October 3, you launched National Domestic Violence Awareness Report month by strongly encouraging states to implement the Family Violence Amendment of the new welfare law. You also issued a directive to HHS and the DOJ to consult with states and other partners and to develop guidance and technical assistance on this issue. On January 3, the two agencies will submit a progress report to you.

Teen Pregnancy: The new welfare law requires Secretary Shalala to establish and implement a strategy by January 1, 1997 to prevent out-of-wedlock teen pregnancies and to assure that at least 25 percent of communities have teen pregnancy prevention programs in place. Secretary Shalala will submit a report to the Congress on this strategy by January 1, 1997.

- **NBC *Today* Show:** On December 15, Christopher Reeve visited NIH, meeting with Director Varus and other researchers on the issue of spinal cord injury research. Portions of his visit will appear in an upcoming segment on NBC's *Today* on December 23.

wh-Teen Pregnancy

A National Strategy to Prevent Teen Pregnancy

U.S. Department of Health
and Human Services

January 1997

A National Strategy to Prevent Teen Pregnancy

Despite the recent decline in the teen birth rate, teen pregnancy remains a significant problem in this country. Most teen pregnancies are unintended. Each year, about 200,000 teens aged 17 and younger have children. Their babies are often low birth weight and have disproportionately high infant mortality rates. They are also far more likely to be poor. About 80 percent of the children born to unmarried teenagers who dropped out of high school are poor. In contrast, just 8 percent of children born to married high school graduates aged 20 or older are poor.

The U.S. Department of Health and Human Services (HHS) has responded to a call from the President and Congress for a national strategy to prevent out-of-wedlock teen pregnancies and to a directive, under the new welfare law, to assure that at least 25 percent of communities in this country have teen pregnancy prevention programs in place.

Building on our previous work in this area, our national strategy is designed to:

I. Strengthen the national response to prevent out-of-wedlock teen pregnancies.

II. Support and encourage adolescents to remain abstinent.

Our national strategy will build on existing public and private-sector efforts and on initiatives in the new welfare law by helping to provide the tools needed to develop more strategic and targeted approaches to preventing out-of-wedlock teen pregnancies. It will strengthen ongoing efforts across the nation by increasing opportunities through welfare reform; supporting promising approaches; building partnerships; improving data collection, research, and evaluation; and disseminating information on innovative and effective practices.

This strategy will also send the strongest possible message to teens that postponing sexual activity, staying in school, and preparing for work are the right things to do. In particular, our new Girl Power! public education campaign will engage the Department's teen pregnancy prevention programs in efforts to promote abstinence among 9- to 14-year-old girls.

KEY PRINCIPLES

As we move forward in implementing the national strategy, we will adhere to and promote the five principles that research and experience tell us are key to promising community efforts:

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

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

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

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

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

THE NATIONAL STRATEGY

I. Strengthen The National Response To Prevent Out-Of-Wedlock Teen Pregnancies

Teen pregnancy is a problem that impacts nearly every community. The responsibility to solve this problem lies with all of us, including families, communities, and young people themselves. In calling for a national strategy, Congress has recognized the critical importance of assuring that every community, large or small, urban or rural, is working to find solutions to this problem.

As part of the national strategy, we will use new resources to strengthen, integrate, and support additional teen pregnancy prevention and other youth-related activities in communities across the country. Further, we will work with our partners to identify additional promising efforts and disseminate information about them to other communities.

A. Increase Opportunities Through Welfare Reform

The welfare law signed by President Clinton on August 22, 1996 calls for additional efforts to prevent out-of-wedlock teenage pregnancies and to assure that communities engage in local efforts to prevent teenage pregnancy. These additional efforts are a critical component of our national strategy. As President Clinton has said, "Nobody should get pregnant or father a child who isn't prepared to raise the child, love the child, and take responsibility for the child's future." HHS will work with the states to provide guidance, to capture lessons learned from these welfare reform initiatives, to identify successful and innovative strategies, and to disseminate that information to all interested parties.

Personal Responsibility for Minor Parents. Under the new welfare law, unmarried minor parents will be required to stay in school and live at home, or in an adult-supervised setting, in order to receive assistance. The law also supports the creation of Second Chance Homes for teen parents and their children who might be at risk of abuse if they remained in their own homes. Second Chance Homes are expected to provide teen parents with the skills they need to become good role models and providers for their children, giving them guidance in parenting, child development, family budgeting, and proper health and nutrition, and in avoiding repeat pregnancies.

Abstinence Education. The new welfare law provides $50 million a year in new funding for state abstinence education activities, beginning in FY 1998. States will be able to target these funds to high-risk groups, such as teenage boys and girls most likely to have children out-of-wedlock. These new funds will be available through the Maternal and Child Health Block Grant.

Incentives for States. Under the new welfare law, HHS will award a bonus to as many as five states in the country that have the largest decrease in out-of-wedlock births while also having abortion rates lower than in 1995. The bonus will equal $20 million per state if five states qualify, and $25 million per state if fewer states qualify.

The Toughest Possible Child Support Enforcement. Through tougher child support enforcement we will send the strongest possible message to young girls and boys that parenthood brings responsibilities and obligations and that they should not have children until they are ready to provide for them. The new welfare law includes the child support enforcement measures President Clinton proposed in 1994 – the most sweeping crackdown on non-paying parents in history. The new measures include: streamlined efforts to name the father in every case; employer reporting of new hires to locate non-paying parents who move from job to job; uniform interstate child support laws; computerized state-wide collections to speed up payments; and tough new penalties, like drivers' license revocation, for parents who fail to pay.

B. Support Promising Approaches

HHS-supported programs that include teen pregnancy prevention are just a part of the myriad and diverse teen pregnancy prevention efforts located in communities across the country. However, HHS plays an important leadership role in sponsoring innovative and promising strategies tailored to the unique needs of individual communities. Excluding HHS-funded programs that reach communities through states (e.g., Medicaid and the Maternal and Child Health Block Grant), HHS-supported programs that include teen pregnancy prevention reach an estimated 30 percent of communities in the United States. This represents about 1,410 communities across the country that receive funding from HHS. (See Appendix I: HHS Activities for overview of HHS teen pregnancy prevention activities and the methodology used to develop this estimate).

The five principles of promising strategies described above are reflected in the teen pregnancy prevention programs HHS supports, including the key demonstration programs of the Centers for Disease Control and Prevention (CDC) and the Office of Population Affairs (OPA). Additional funding for these programs in FY 1997 will enable communities across the country to expand their teen pregnancy prevention efforts.

The Community Coalition Partnership Program for the Prevention of Teen Pregnancy is one of HHS's most comprehensive and innovative teen pregnancy prevention programs. The CDC launched the program in 1995 by awarding grants to 13 communities with high rates of teen pregnancy located in 11 states. The funds have been used to strengthen existing community-wide coalitions and to develop community action plans. The next phase begins in FY 1997 when a total of $13.7 million is available to help the 13 community coalition partnerships implement their action plans and evaluate their impact, as well as to support related data collection, evaluation, and dissemination activities.

The Adolescent Family Life Program (AFL), created in 1981, supports demonstration projects, approximately one-third of which currently provide abstinence-focused educational services to prevent early unintended pregnancies, sexually transmitted diseases, and HIV/AIDS. Most projects provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families, with a major emphasis on preventing repeat pregnancies among adolescents. In FY 1996, the AFL program funded 17 projects in 14 states, which will be continued in FY 1997. An additional $7.6 million in new funding will be used to enable smaller communities to develop and implement about 40 abstinence-based education programs and about 60 larger prevention demonstration projects, following the abstinence education definition in the welfare law.

C. Build Partnerships

Building partnerships among all concerned citizens is essential to preventing teen pregnancy, which President Clinton has described as "our most serious social problem." Tackling this problem will require a comprehensive, focused, and sustained effort from all sectors of society. Therefore, HHS will initiate a broad partnership-building process to implement the national strategy and to solicit nationwide commitment and involvement in the goal of preventing out-of-wedlock teen pregnancies. The feedback from this process will allow us to refine the national strategy as well as to improve our ongoing efforts. By building partnerships among national, state, and local organizations; schools; health and social services; businesses; religious institutions; federal, state and local governments; tribes and tribal organizations; parents; and adolescents, we will be able to unite in our efforts to send a strong message of abstinence and personal responsibility to young people and to provide them with opportunities for the future.

An important partner in this effort will be the National Campaign to Prevent Teen Pregnancy. In his January 1995 State of the Union Address, President Clinton challenged "parents and leaders all across this country to join together in a national campaign against teen pregnancy to make a difference." A group of prominent Americans responded to that challenge, forming the National Campaign to Prevent Teen Pregnancy ("Campaign"). The President has pledged the help of the Executive Branch in this non-partisan, private-sector effort.

The mission of the Campaign is to prevent teen pregnancy by supporting the values and stimulating actions that are consistent with a pregnancy-free adolescence. The Campaign is designed to support the efforts of local communities and to make sure that local community efforts are based on research about what works. The Campaign is helping to build partnerships with the media, the business sector, and others, and HHS looks forward to working with the Campaign in implementing the national strategy.

The strategy will also include a partnership effort with federal, state, and community organizations that work on behalf of teenagers with disabilities. Teens with learning disabilities, mental retardation, mental illness, and physical disabilities present a unique set of challenges in preventing out-of-wedlock pregnancies. Mainstream programs can be highly effective, but the unique characteristics of teenagers with disabilities also must be taken into account in developing and implementing these programs. As part of the national strategy, HHS will work to address the special challenges in preventing out-of-wedlock teen pregnancies among young men and women with disabilities. The strategy will address issues such as program access, the need for targeted materials, and opportunities for education and skills-building to give teens with disabilities a positive future and a better chance of avoiding teen pregnancy.

D. Improve Data Collection, Research, and Evaluation

Data collection, research, and evaluation are all critical for contributing to our understanding of the magnitude, trends, and causes of teen pregnancies and births; for developing targeted teen pregnancy prevention strategies; and for assessing how well these strategies work, whether on a local, state, or national level. As part of the national strategy, HHS will work to strengthen each of these important activities.

Data Collection and Surveillance. National statistics on teen birth patterns, including state-by-state data, are now available nearly a full year earlier than in prior years, a result of a more timely approach to collecting, compiling, and publishing vital statistics data. The new system builds on advances in computer and communications technology as well as the CDC's National Center for Health Statistics' (NCHS) long-standing collaboration with state vital statistics offices. Preliminary teen birth rates from the new system for 1995 were published in October 1996 and future statistics will be reported semiannually. (See Appendix II: Teen Birth Data). The CDC also provides consultation to states and local areas to enable them to compute estimates of teen pregnancy and other related indicators.

The upcoming release in 1997 of the new National Longitudinal Study of Adolescent Health (Add HEALTH), a comprehensive study of adolescent health funded by HHS' National Institute of Child Health and Human Development (NICHD) and other HHS agencies, will provide an opportunity to increase our knowledge about risky behaviors and resiliency factors in adolescents and about environmental influences, including parents, siblings, peers, schools, neighborhoods, and communities. The National Survey of Adolescent Males, supported by NICHD, OPA, and other HHS agencies, and the 1995 cycle of the National Survey of Family Growth, conducted by NCHS with other HHS support, will also provide relevant information on the behavior of young men and women.

Research and Evaluation. While promising approaches to reduce teenage pregnancy have been identified, a comprehensive review of teen pregnancy programs funded by HHS and conducted by Child Trends, Inc. indicates that most interventions have not been rigorously evaluated to assess their impact or to identify the components that contribute to program success or failure. Using our demonstration programs, we will work with our partners to increase our understanding of what works and what does not. For example, the CDC's Community Coalition Partnership Program for the Prevention of Teen Pregnancy is helping each community to incorporate evaluation into its teen pregnancy prevention strategy. In addition, the National Institutes of Health is sponsoring research on interventions to prevent teen pregnancy.

The Child Trends report also indicates that further research is needed in a number of areas of normal adolescent development, including why certain adolescents engage in high-risk behaviors, why some adolescents are able to negotiate safely to adulthood, and what factors influence adolescent sexual behavior, including media influences and cultural norms. In addition to its own research studies and demonstration projects, HHS will provide information from its new survey data, (e.g., Add HEALTH), to help researchers answer these questions.

E. Disseminate Information on Innovative and Effective Practices

Sharing information about promising and successful approaches is critical to the replication and expansion of teen pregnancy prevention efforts across the country. Policy makers, program administrators, tax payers, media producers, community leaders, parents, and adolescents all need to know about the approaches most likely to be successful in preventing teen pregnancy.

HHS will continue to work with its partners to highlight innovative practices at the federal, state, and local levels and to disseminate new research and evaluation findings. For example, at a White House press conference in June, HHS released "Preventing Teen Pregnancy: Promoting Promising Strategies: A Guide for Communities" highlighting five teen pregnancy programs that evaluation shows to be promising. (See Appendix III: Promising Strategies). Ongoing efforts include outreach to 105 Empowerment Zones and Enterprise Communities to encourage and help them to include teenage pregnancy prevention in their community development strategies. The Department will also disseminate new information on the developmental needs of youth and on the use of broad-based activities to help teenagers avoid risky behaviors leading to teen pregnancy. In addition, HHS currently supports a variety of resource centers, clearinghouses, and toll-free hotlines at both the state and national level that provide information and technical assistance to state and community-based health, social service, and youth-serving agencies. (See Appendix IV: Program Contacts and Other Resources).

II. Support and Encourage Adolescents to Remain Abstinent

To reach adolescent populations at risk for premature sexual activity and pregnancy, we must develop comprehensive efforts specifically tailored to the unique needs, interests, and challenges of each group, including targeted messages that work. Although the national strategy must send the strongest possible message to all teens that postponing sexual activity, staying in school, and preparing to work are the right things to do, the research shows that girls and boys experience some aspects of early adolescence in different ways, because they encounter different social, cultural, physiological and psychological challenges. Therefore, different approaches will be required to meet the unique needs of different adolescent populations, including disabled teens who are at increased risk of pregnancy. As a result, an important component of the national strategy will be to determine the best ways to reach different groups of young boys and girls.

The national strategy will place a special emphasis on encouraging abstinence among 9- to 14-year-old girls. The research tells us that this a critical age for reinforcing self confidence and positive values and attitudes among girls. In 1997, HHS will use its new Girl Power! campaign to address premature sexual activity among girls aged 9-14, promoting a strong abstinence message. The Girl Power! campaign, launched in November, 1996, is a multi-phased, national public education campaign designed to galvanize parents, schools, communities, religious organizations, health care providers, and other caring adults to make regular sustained efforts to reinforce girls' self-confidence, by providing them with positive messages, meaningful opportunities, and accurate information on a variety of key health issues. The Girl Power! abstinence education initiative includes: engaging all HHS teen pregnancy prevention and related youth programs in sustained efforts to promote abstinence among 9- to 14-year-old girls, and developing and implementing a national media campaign to involve parents and caring adults in sending a strong abstinence message across the country.

The national strategy will also focus on boys and young men. Significantly less is known about the decision-making behavior of boys around motivations for abstinence, sexual activity, and fatherhood. Through the national strategy, HHS will increase our understanding of these factors and work to develop effective prevention strategies, particularly those promoting abstinence, for boys. These efforts will include working with the Administration's Fatherhood Initiative to ensure that men, including pre-teen and teenage boys, receive the education and support necessary to postpone fatherhood until they are emotionally and financially capable of supporting children. The strategy will also build on existing Departmental efforts, such as the Title X Family Planning Adolescent Male Initiative and other Title X-funded projects to support male-oriented community-based organizations in promoting responsible behavior among teenage boys.

Finally, the Department will work with national youth-serving organizations to use their networks to promote activities that encourage abstinence among girls and boys. With their important efforts in stimulating parental and community involvement, these programs will help provide the sustained commitment necessary to help prevent teen pregnancy.

APPENDIX I: HHS ACTIVITIES

The Department of Health and Human Services supports a variety of efforts to help communities develop comprehensive teen pregnancy prevention strategies that reflect five principles: parental and adult involvement, abstinence, clear strategies for the future, community involvement, and a sustained commitment. We estimate that, through our support, at least 30 percent of communities across the country already have teen pregnancy prevention programs in place. This estimate will differ from a simple count of the number of communities served by the following programs due to overlapping sites and other factors (see note below for methodology). Our national strategy will build upon, strengthen, and expand the most promising efforts to assure that every community in the country is working to prevent out-of-wedlock teen pregnancies.

HHS Programs

- **The Community Coalition Partnership Program for the Prevention of Teen Pregnancy** is one of HHS's most comprehensive and innovative teen pregnancy prevention programs. In 1995, the Centers for Disease Control and Prevention awarded grants to community-wide coalitions in communities with high rates of teen pregnancy. CDC awarded approximately $250,000 per year for two years to 13 communities in 11 states to help these communities mobilize and organize their resources to support effective and sustainable teen pregnancy prevention programs. The next phase begins in FY 1997 when a total of $13.7 million is available to help the 13 community coalition partnerships implement their action plans and evaluate their impact, as well as to support related data collection, evaluation, and dissemination activities.

- **The Adolescent Family Life Program (AFL)**, created in 1981, supports demonstration projects, approximately one-third of which currently provide abstinence-focused educational services to prevent early unintended pregnancies, sexually transmitted diseases, and HIV/AIDS. Most projects provide comprehensive and innovative health, education, and social services to pregnant and parenting adolescents, their infants, male partners, and their families, with a major emphasis on preventing repeat pregnancies among adolescents. In FY 1996, the AFL program funded 17 projects in 14 states, which will be continued in FY 1997. An additional $7.6 million in new funding will be used to enable smaller communities to develop and implement about 40 abstinence-based education programs and about 60 larger prevention demonstration projects, following the abstinence education definition in the welfare law.

- **Reproductive Health and Family Planning Services** (under Title X of the Public Health Service Act) are provided to nearly 5 million persons each year, nearly one third of whom are under 20 years of age. Abstinence counseling and education are an important part of the Title X service protocol for adolescent clients. To address male involvement in preventing unintended pregnancy, the Title X Family Planning Program will supplement existing community-based programs to develop effective approaches for providing family planning education and services to males.

- **Healthy Schools, Healthy Communities,** a Health Resources and Services Administration program created in 1994, has established school-based health centers in 27 communities in 20 states and the District of Columbia to serve the health and education needs of children and youth at high risk for poor health, teenage pregnancy, and other problems.

- **The Social Services Block Grant (SSBG)** (under Title XX of the Social Security Act) provides funding to prevent, reduce, or eliminate dependency; achieve or maintain self-sufficiency; prevent neglect, abuse, or exploitation of children and adults; prevent or reduce inappropriate institutional care; and provide admission or referral for institutional care when other forms of care are inappropriate. SSBG Grants are made directly to the 50 states, the District of Columbia, and Puerto Rico. Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands to fund social services tailored to meet the needs of individuals and families residing within that jurisdiction.

- **The Community Services Block Grant,** which operates in all 50 states, the District of Columbia, and the territories, enables local community agencies to provide low-income populations, including youth at risk, with job counseling, summer youth employment, GED instruction, crisis hotlines, information and referral to health care, and other services.

- **The Independent Living Program,** run by the Administration for Children and Families, provides funds to states to support activities ranging from educational programs to programs that help young people who are making the transition from foster care to independent living to avoid early parenthood. This program supports activities in all 50 states and the District of Columbia.

- **Youth Programs** including Runaway and Homeless Youth Programs, Transitional Living Programs, and the Youth Sports Program, address a wide range of risk factors for teen pregnancy. Together, these programs operate in 620 communities in 50 states and the District of Columbia.

- **The Community Schools Program** was created by the 1994 Violent Crime Control and Law Enforcement Act to support activities during non-school hours for youth in high-risk communities. Funds are awarded to public-private partnerships of community-based organizations to provide a broad spectrum of supervised extracurricular and academic programs after-school and during evenings, weekends and school vacations. Grantees also train teachers, administrators, social workers, guidance counselors, and parent and school volunteers to provide concurrent social services for at-risk students. The Administration for Children and Families awarded $10.15 million in grants to 54 communities in 1997 under this program.

- **Healthy Start** has 22 demonstration projects operating in 25 states (one project operates in three states) to reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants, and their families. Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for adolescents that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem.

- **Maternal and Child Health Services Block Grant** (Title V) funds support a variety of adolescent pregnancy prevention activities in 59 states and jurisdictions that include adolescent pregnancy prevention programs, state adolescent health coordinators, state prenatal hotlines, family planning, technical assistance, and other prevention services. Approximately 85 percent of the block grant funds are distributed under a formula which requires a match by the states. More than $1 billion is generated under this federal-state partnership. Through the block grants, approximately 610 school-based and school-linked centers are supported. In addition, the Maternal and Child Health Bureau administers a program of discretionary grants using 15 percent of the Block Grant appropriation. In FY 1995-96, the Bureau awarded approximately 144 discretionary grants to support adolescent health programs each of which impacts directly or indirectly on the problems of teen pregnancy.

- **Empowerment Zones and Enterprise Communities** in 105 rural and urban areas in 43 states and the District of Columbia have been awarded grants to stimulate economic and human development and to coordinate and expand support services. As they implement their strategic plans, some sites are including a focus on teenage pregnancy prevention and youth development.

- **Health education in schools** supports the efforts of every state and territorial education agency to implement school health programs to prevent the spread of HIV and sexually transmitted diseases (STDs). Assistance is also provided to 13 states to build an infrastructure for school health programs. Efforts are targeted at preventing early sexual activity, STDs, HIV, drug and alcohol abuse, tobacco use, and injuries.

- **Community and migrant health centers**, including family and neighborhood health centers, operate in 1,647 sites in 643 communities in all 50 states, the District of Columbia, and six territories. The centers provide primary and specialized health and related services to medically-underserved adolescents. Some centers include special hours or clinics for adolescent patients.

- **Indian Health Service (IHS)** provides a full range of medical services for American Indians and Alaska Natives. IHS supports projects targeted at preventing teenage pregnancy, and its prevention and treatment programs also have a special emphasis on youth substance abuse, child abuse, and women's health care.

- **Drug treatment and prevention programs** include services to prevent first time and repeat pregnancies among teenagers. One hundred twenty-two residential substance abuse treatment programs for pregnant and postpartum women, as well as women with dependent children, receive support to provide family planning, education, and counseling services in 39 States, the District of Columbia, and the Virgin Islands. Also, 25 programs to prevent substance use and other adverse life outcomes serve high-risk female teens in 13 States and the District of Columbia.

- **Health Care and Promotion** under Medicaid provides Medicaid-eligible adolescents under age 21 with access to a comprehensive range of preventive, primary, and specialty services within its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

- **The Medicaid program** also funds family planning services at an enhanced match rate for states. The federal government pays 90 percent of state expenditures for Medicaid family planning services, while the state funds the remaining 10 percent. The enhanced match encourages states to fund family planning programs which include patient counseling and education concerning pregnancy prevention and reproductive health.

Evaluation and Research

HHS has conducted research, surveillance, demonstrations, and evaluations on an ongoing basis to gather and provide information and technical assistance on the magnitude, trends, and causes of teenage pregnancy and on prevention programs and approaches that work, including:

- "**Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood**" is a two-volume comprehensive review completed for HHS by Child Trends, Inc. in June, 1995 of the most recent literature on teen sexual behavior, pregnancy and parenthood and the effectiveness of teen pregnancy prevention programs.

- As part of its **Youth Risk Behavior Surveillance System**, CDC helps states monitor critical health risk behaviors among teenagers, including sexual risk behaviors that result in HIV infection, other STDs, and teen pregnancy. In 1995, 40 states and territories and 16 large cities collected comparable data.

- The upcoming release in 1997 of the new **National Longitudinal Study of Adolescent Health (Add HEALTH)**, a comprehensive study of adolescent health funded by HHS' National Institute of Child Health and Human Development (NICHD) of the National Institutes of Health and other HHS agencies, will provide an opportunity to increase our knowledge about risky behaviors and resiliency factors in adolescents and about environmental influences, including parents, siblings, peers, schools, neighborhoods, and communities. The **National Survey of Adolescent Males**, supported by NICHD, OPA and other HHS agencies, and the 1995 cycle of the **National Survey of Family Growth** conducted by NCHS with other HHS support, will also provide relevant information on the behavior of young men and women.

- National Institutes of Health also conducts research and evaluation studies of promising interventions, including the "Adolescent Pregnancy Prevention Program", "Preventing Problem Behavior Among Middle School Students" program, and the "Research on Sexually Transmitted Diseases, Violence, and Pregnancy Prevention" (RSVPP) project.

NOTE:

Measuring the Proportion of Communities with Teen Pregnancy Prevention Programs

Recent declines in the teen birth rate, and indications of further declines in the teen pregnancy rate, suggest that the numerous public- and private-sector efforts across the country to prevent teen pregnancy are having a positive impact. Measuring all the factors that help adolescents postpone premature sexual activity and avoid pregnancy is difficult, however, since individual, family, and community characteristics are all influential. Nevertheless, measuring the proportion of communities that have at least one teen pregnancy prevention program in place (estimated by dividing the number of such communities by the number of communities in the United States) provides a rough sense of how many communities are responding to this problem with specific, targeted prevention efforts.

To develop a sound, albeit conservative, estimate of the proportion of communities with teen pregnancy prevention programs, the estimate includes only those programs supported by HHS. HHS-supported programs that include teen pregnancy prevention services as a component are diverse, ranging from comprehensive health and social services to substance abuse treatment and HIV prevention education. The number of teen pregnancy prevention programs funded by HHS includes those programs funded in FY 1995 (the latest year for which complete information on grants awarded is available).

To determine how many communities have at least one program, the location of each program was identified based on the site of the services provided and/or the location of the grant recipient. Any individual community with more than one program was counted only once. The estimate excludes HHS funding provided directly to states (e.g., Medicaid, Maternal and Child Health Block Grant) which states may use to fund activities in multiple communities.

Since there is no single standard definition for community in the United States, the estimate uses a definition of community based on areas identified by the Commerce Department's Bureau of the Census. This definition includes all incorporated places with a population of 10,000 individuals or more (2,673) and all counties where, excluding these incorporated places, the remaining population reaches 10,000 or more (2,079), for a total of 4,752 communities. Under this definition, for example, Montgomery County, Maryland would consist of four communities, including three incorporated places of 10,000 or more inhabitants (Gaithersburg, Rockville, and Takoma Park) and one community representing the balance of the county's population, which exceeds 10,000.

Using the above calculations, the resulting estimate of the proportion of communities in the United States with HHS-supported teen pregnancy prevention and related programs is at least 30 percent. This proportion represents about 1,410 communities across the country.

APPENDIX II: TEEN BIRTH DATA

In October 1996, the National Center for Health Statistics (NCHS) inaugurated a new statistical series designed to provide more timely release of national and state-level birth statistics (1). These data will provide state and local health officials with a timely first-look at trends in these important measures of their community's health status. NCHS will publish data from the new statistical series on a semi-annual basis. The next report will be issued in early spring of 1997, and will cover the period July 1995-July 1996.

The October release included births for 1995 and U.S. birth rates for teenagers 15-19 years old. The data covered "all races" and white, black, American Indian, Asian or Pacific Islander, and Hispanic subgroups. The October report also provided data on the percent of all births occurring to teenagers in each state, by race and Hispanic origin. Other state-level birth data available from the preliminary report include births to unmarried mothers, low birth weight, prenatal care beginning in the first trimester, and births by cesarean delivery.

After NCHS completes final processing of birth data for a given year, additional, more-detailed statistical tabulations can be produced. In December 1996, NCHS published a report of state-level birth rates for teenagers which is included in this appendix (2). The report includes data for teenage subgroups 15-19, 15-17, and 18-19 years, and by race and Hispanic origin of the mother. The report describes the recent declines in U.S. birth rates for teenagers and the extent to which rates in individual states have also declined. The December report focuses on the period 1990-94. NCHS expects to update this report with rates for 1995 in late spring of 1997.

Reports showing state-level data in conjunction with national statistics can be very useful for state and local public health and other officials as they monitor trends in their states and compare them with trends in neighboring states. In addition, the rates in NCHS' teen birth rate report can help to assess the extent to which programs to reduce teenage pregnancy are succeeding. To assist in the comparison of state-level data, the December report includes maps of teen birth rates, showing the various levels of the rates as well as the 1991-94 trend in the rates.

The authors also note that some of the differences in overall rates by state reflect differences in the composition of the teenage populations by race and Hispanic origin, since birth rates for Hispanic and black teenagers are more than double the rates for non-Hispanic white teenagers. To examine state variations while controlling for population differences in race and ethnicity, the report includes standardized birth rates for each state. The standardized rates for many states with high Hispanic or black populations are lower than the actual rates.

Note on Teen Pregnancy Data:

HHS has published national estimates of teenage pregnancy for the years 1976-92. National data on teen pregnancy are updated on a regular basis as soon as the required data on births and estimates for abortions and fetal losses can be assembled for a given year. National rates for 1993 and 1994 are expected to be available in 1997. State-level teen pregnancy statistics have been published for 1980 and 1990-92. Updates of state rates for 1993 and 1994 are anticipated for 1997.

(1) Rosenberg HM, Ventura SJ, Maurer JD, Heuser RL, Freedman MA. Births and Deaths: United States, 1995. *Monthly Vital Statistics Report*, Vol. 45, No. 3, Supplement 2. Hyattsville, Maryland: National Center for Health Statistics. 1996.

(2) Ventura SJ, Clarke SC, Mathews TJ. Recent Declines in Teenage Birth Rates in the United States: Variations by State, 1990-94. *Monthly Vital Statistics Report*, Vol. 45, No. 5, Supplement. Hyattsville, Maryland: National Center for Health Statistics. 1996.

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Recent Declines in Teenage Birth Rates in the United States: Variations by State, 1990–94

by Stephanie J. Ventura, A.M.; Sally C. Clarke, M.A.; and T. J. Mathews, M.S., Division of Vital Statistics

Abstract

Objectives—This report presents teenage birth rates by State for 1990–94. Rates for the United States for 1970–94 are shown to put the State changes in perspective. U.S. rates for 1990–94 are shown by race and Hispanic origin of mother and for teenage subgroups 15–17 and 18–19 years as well as for teenagers 15–19 years. Also presented in the same detail are birth rates by mother's State of residence for 1994, and birth rates for teenage subgroups by State for 1990–94.

Methods—Descriptive tabulations of birth rates for teenagers for the United States and by State are presented and explained.

Results—After increasing from 1990 to 1991, birth rates declined for American teenagers during the years 1991–94; rates fell 3 percent each for teenagers 15–17 and 18–19 years. Preliminary data indicate that the birth rate for teenagers 15–19 years continued to decline in 1995, with a total decline of about 8 percent during the 1991–95 period. The largest declines were reported for black teenagers, with smaller declines measured for non-Hispanic white teenagers. Rates for Hispanic teenagers increased slightly. Declines from 1991 to 1994 were reported for the majority of the States.

Keywords: Teenage fertility • State-based birth rates • Fertility trends • Teenage pregnancy

Introduction

This report presents national and State-level data on teenage birth rates for 1990–94. The early 1990's have witnessed a slow but steady decline in birth rates for teenagers. Rates have declined steadily for black teenagers and for teenage subgroups 15–17 and 18–19 years; rates for white teenagers have generally declined while changes in rates for Hispanic teenagers have been less consistent. The data in this report show the patterns in teenage birth rates by State and the extent to which the recent national declines are shared by all States. Teenage childbearing continues to be an important social issue because studies have shown that teenage mothers are more likely to be poorly educated and more likely to face lifetime poverty.

Although birth rates for teenagers were substantially higher in the early 1970's than in recent years, most teenagers giving birth in the earlier period were married, whereas most teenagers giving birth recently are unmarried.

The birth rate for married teenagers was about 13 percent lower in 1994 than in 1970 (388 per 1,000 married women aged 15–19 compared with 444). Moreover, the proportion of 15–19-year-olds who were married was less than 5 percent in 1994 compared with 14 percent in 1970. In contrast to the change in childbearing by married teenagers, the rate for unmarried teenagers has risen virtually without interruption, although the pace of increase has slowed considerably since 1991. For

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unmarried teenagers 15–19 years, the rate doubled from 22 births per 1,000 in 1970 to 46 in 1994. The rate for younger teens aged 15–17 years rose from 17 to 32 per 1,000, while the rate for older teens rose from 33 to 70 per 1,000 unmarried women aged 18–19 years. As a consequence of these trends in marriage and childbearing among teenagers, the proportion of all teenaged births occurring to unmarried teenagers has risen dramatically during this period. For teenagers 15–19 years, the proportion rose from 30 percent in 1970 to 76 percent in 1994 (shown in table A). The percent unmarried nearly doubled for young teenagers 15–17 years and more than tripled for older teenagers 18–19 years.

The vast majority of teenage childbearing is unintended. Data on teenage pregnancy trends (including information on induced abortions and fetal losses as well as live births) in the 1990's are more limited than are data on live births. The data in this report provide some information on the extent to which efforts to reduce teenage pregnancy are succeeding.

State-level birth rates for unmarried teenagers can be computed only in census years when the necessary population data are available. Rates for unmarried teenagers by State have been published for 1980 and 1990 (1–2). In addition, rates for teenagers under 15 years of age are not shown in this report because the numbers of births are relatively small, 12,901 for the entire United States in 1994. Thus, the numbers are too small to compute reliable rates for many States.

Methods

Data shown in this report are based on 100 percent of the birth certificates registered in all States and the District of Columbia. More than 99 percent of births occurring in this country are registered.

Table A. Percent of teen births to unmarried teenagers

Year	15–19 years	15–17 years	18–19 years
1994	76	84	70
1990	67	78	61
1985	58	71	51
1980	48	62	40
1975	38	51	30
1970	30	43	22

Population data for computing birth rates were provided by the U.S. Bureau of the Census (3,4). Tables showing data by State provide information for the 50 States and the District of Columbia. Rates are not shown for Puerto Rico, the Virgin Islands, and Guam, because the population data by age needed to compute teenage birth rates are not available for these areas. State rates are based on mother's place of residence.

All tabulations are by race and Hispanic origin of mother as reported on the birth certificate. Race and ethnicity differentials in rates for teenagers may reflect differences in income, education, access to health care, and health care coverage. Additional information on the computation of birth rates, population denominators, and statistical significance is presented in the Technical notes.

Results and discussion

There were 505,488 live births to teenagers 15–19 years in 1994 resulting in a birth rate of 58.9 per 1,000 women aged 15–19 years (table 1). The birth rate for teenagers fell steadily from 1970 (68.3) to 1976 (52.8), a 22-percent decline, fluctuated modestly over the next 10 years reaching a low of 50.2 in 1986, increased considerably—by 24 percent— from 1986 to 1991 (62.1) and then declined steadily from 1991 to 1994, by 5 percent overall, to its current level (table 1 and figure 1). Preliminary data indicate that the U.S. teenage birth rate declined again in 1995 to 56.9 per 1,000, 3 percent lower than in 1994 (5).

The birth rate for teenagers aged 18–19 years was 91.5 in 1994, more than twice the rate for teenagers 15–17 years (37.6). The trend in the birth rates for teenagers 15–17 years and teenagers 18–19 years had essentially the same pattern during the 1970–94 period, but the disparity between the rates for the two age groups diminished somewhat because the rate for older teenagers in 1994 was much lower than in 1970, while rates for younger teenagers were essentially the same in 1970 and 1994.

Table 2 shows teenage birth rates for each year, 1990–94, for each State and the District of Columbia. In 1994, birth rates for teenagers 15–19 years ranged from a high of 114.7 in the District of Columbia to a low of 30.1 in New Hampshire. In general, the 10 States with the highest rates in 1994 were located in the South or West while the 10 States with the lowest rates were in the Northeast and Midwest (figure 2). The same regional variation in birth rates was also evident for the more detailed age groups of 15–17 and 18–19 years.

The majority of States had lower birth rates for teenagers in 1994 than in 1991, the year with the recent high point. The State with the largest decline was Maine (18 percent), followed by Vermont and Alaska (16 percent), Idaho (14 percent), and Montana (12 percent). About

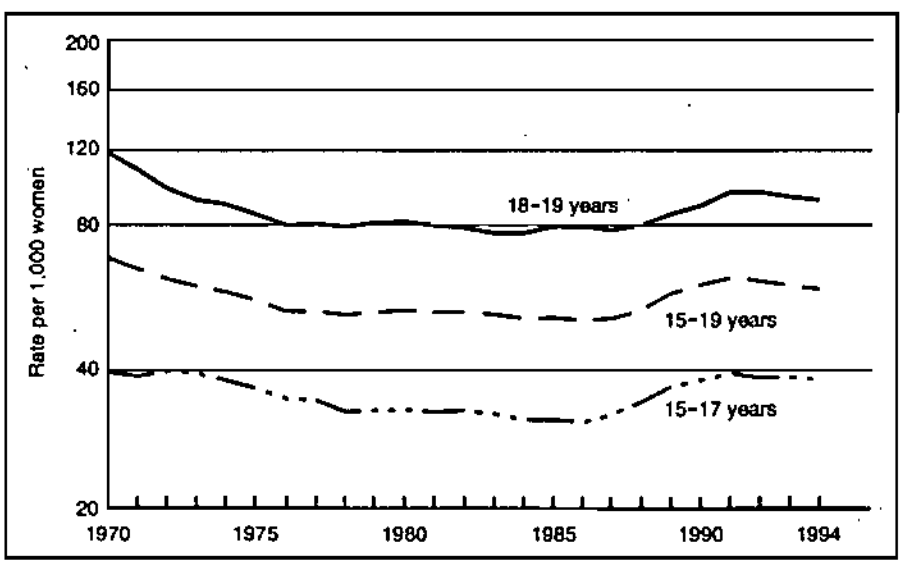

Figure 1. Birth rates for teenagers, by age: United States, 1970–94

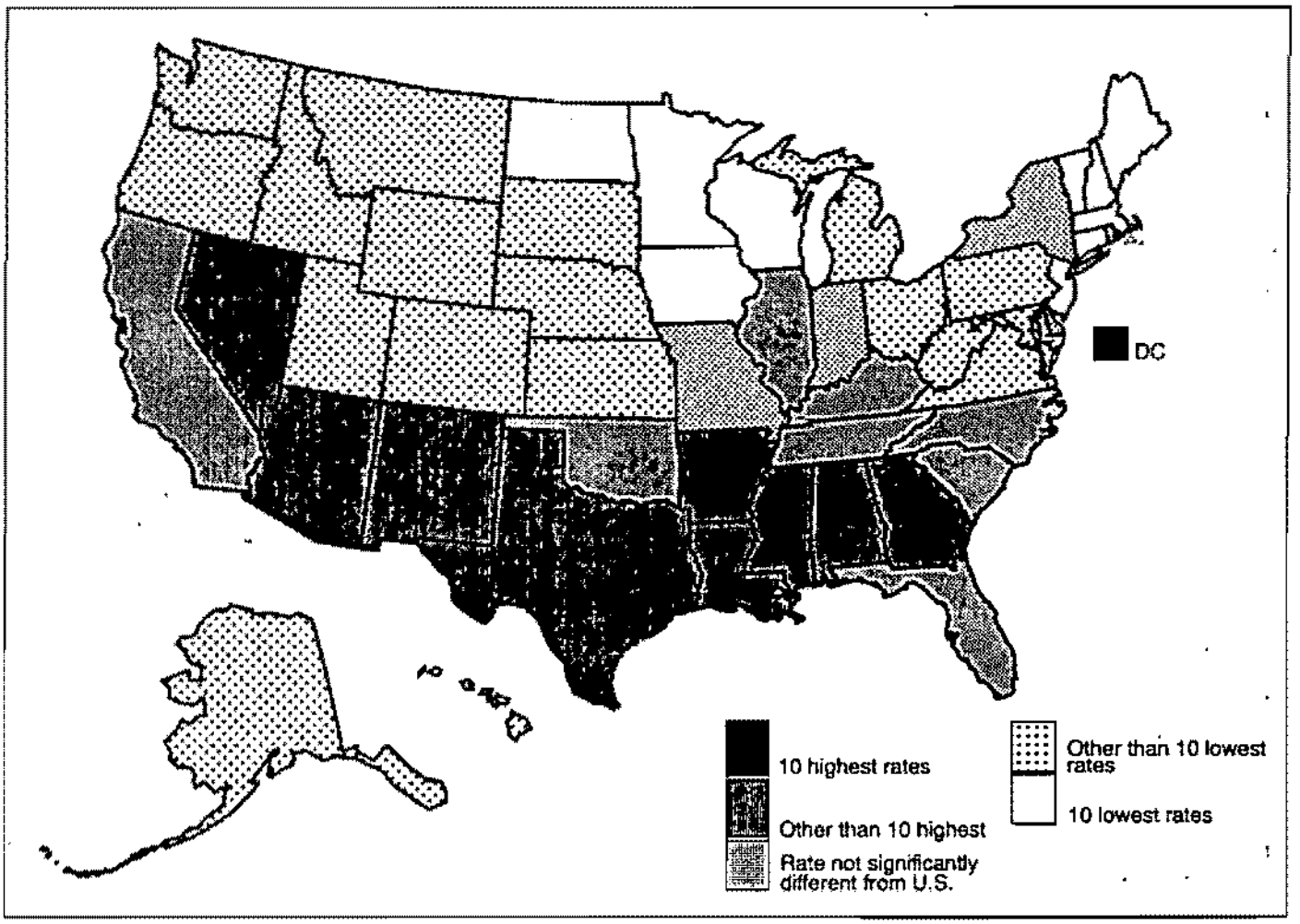

Figure 2. Teenage birth rates by State, 1994

half of the States had declines of between 5 and 11 percent while the teenage birth rate for 13 States and the District of Columbia was not significantly different in 1994 than in 1991 (figure 3). In general, many States with the lowest rates in 1994 experienced the largest declines. For the more detailed age groups 15–17 and 18–19 years, the majority of States had declines in rates for both age groups for the 1991–94 period (table 2). Many changes in rates for detailed age groups, especially 15–17 years, are not statistically significant because the numbers of births are small.

Birth rates for black and Hispanic teenagers 15–19 years were very similar, 104.5 and 107.7, respectively, and were about two and a half times the rate for non-Hispanic white teenagers, 40.4 (table 3). This pattern has been observed for many years (2,6). The rate for black teenagers fell sharply during the 1991–94 period, by 10 percent, from 115.5 to 104.5 per 1,000. The rate for non-Hispanic white teenagers declined 7 percent, from 43.4 to 40.4 per 1,000, and the rate for Hispanic teenagers rose 1 percent, from 106.7 to 107.7. The disparity between the rate for non-Hispanic white teenagers and the rates for black and Hispanic teenagers was observed for both 15–17 year olds and 18–19 year olds (table 3 and figure 4).

The pattern of lower birth rates for non-Hispanic white than for black and Hispanic teenagers was evident in almost every State in which there were sufficient data to compute birth rates for all groups (table 4). The birth rate for non-Hispanic white teenagers 15–19 years varied between 63.1 in Arkansas and 15.3 in the District of Columbia; the rate for black teenagers varied between 142.3 in Wisconsin and 66.4 in New Mexico; the rate for Hispanic teenagers varied between 159.6 in North Carolina and 49.3 in Louisiana. These relationships within racial and Hispanic subgroups have been noted for several years (1,2,7).

With few exceptions, birth rates for teenagers 18–19 years were at least double the rates for younger teenagers 15–17 years. This pattern was observed for all races combined as well as for racial and Hispanic origin subgroups. In the age group 15–17 years, rates were higher for black and Hispanic teenagers than for non-Hispanic white teenagers. Among the areas for which birth rates could be reliably computed for black teenagers 15–17 years, rates were highest in the District of Columbia, Illinois, and Wisconsin (105–107 per 1,000 women) and lowest in New Mexico, New York, and Washington (51–52 per 1,000). Birth rates for Hispanic teenagers 15–17 years were computed for 35 States. Rates were highest in Connecticut and Massachusetts (101 per 1,000) and lowest in Louisiana and Maryland (28–34 per 1,000). Birth rates for non-Hispanic white teenagers 15–17 years

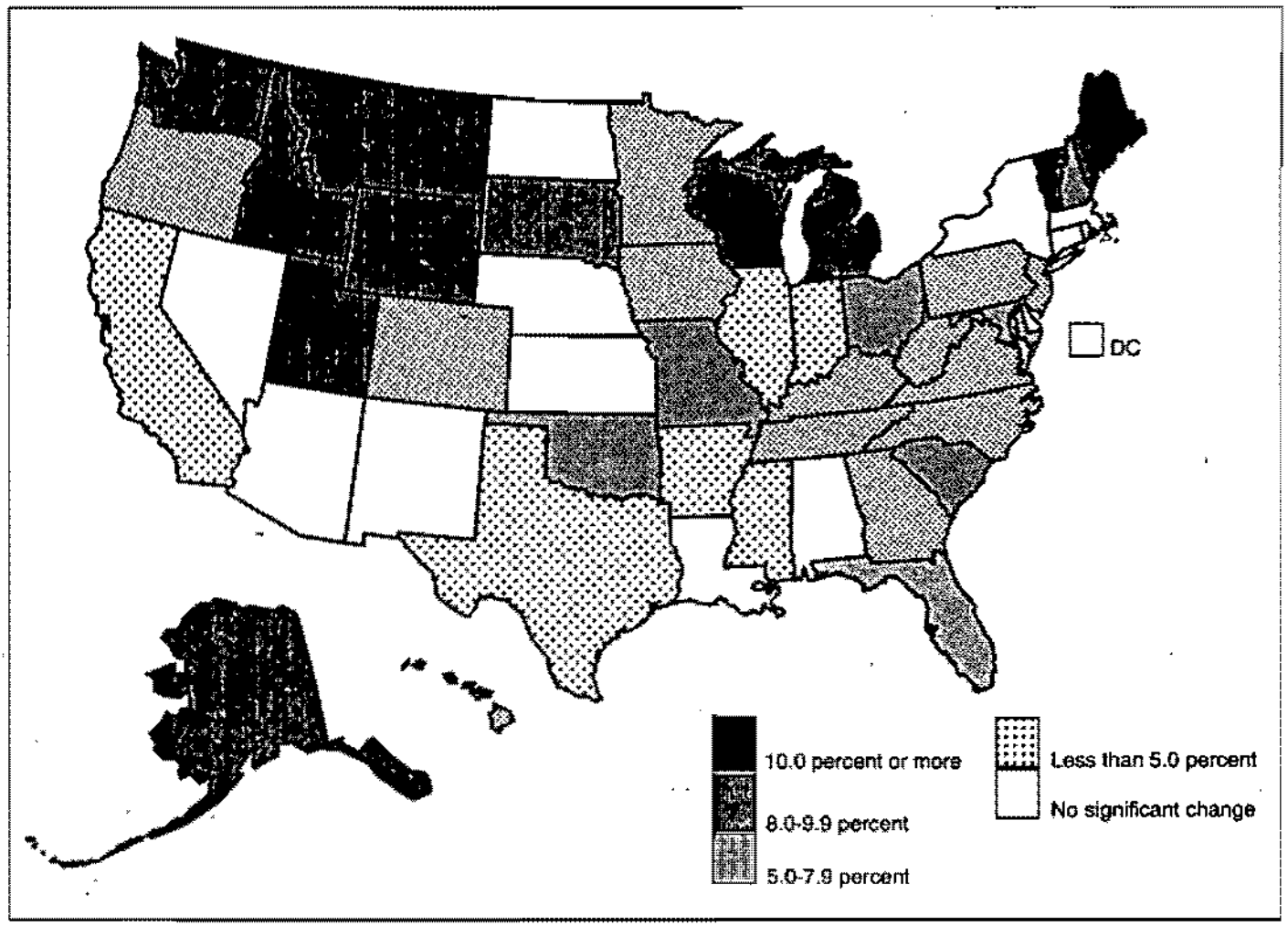

Figure 3. Percent decline in teenage birth rates by State, 1991–94

were substantially lower than for black or Hispanic teenagers; rates were highest in Alabama, Arkansas, Kentucky, and Mississippi (35–37 per 1,000) and lowest in Hawaii and New Jersey (8–10 per 1,000).

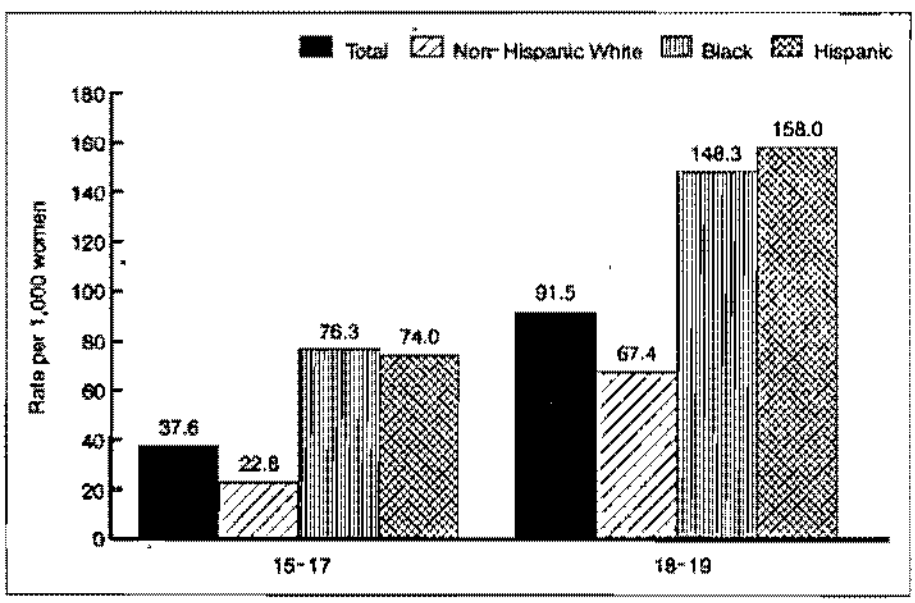

Figure 4. Birth rates by race and ethnicity for mothers 15–17 and 18–19 years of age: United States, 1994

Patterns were similar for older teenagers; rates were higher for Hispanic and black teenagers than for non-Hispanic white teenagers. Among the 31 States for which birth rates for Hispanic teenagers were computed, rates ranged from 80 to 100 per 1,000 women aged 18–19 years in Florida and Louisiana to 234–275 per 1,000 in Georgia and North Carolina. The variation in rates for black teenagers 18–19 years was narrower, with a range of 105 per 1,000 in New York to 193–200 per 1,000 in Illinois and Wisconsin. Rates were substantially lower for non-Hispanic white teenagers 18–19 years, ranging from 29 to 33 per 1,000 (New Jersey and Connecticut) to 98–101 (Arkansas, Kentucky, and Tennessee).

Some of the differences in overall rates by State reflect differences in the composition of the teenage populations by race and Hispanic origin. Given that birth rates for Hispanic, and black

teenagers are more than double the rates for non-Hispanic white teenagers, States with relatively high proportions of Hispanic and/or black teenagers in their populations would be expected to have higher overall teenage birth rates. This is in fact the case. Birth rates standardized for differences in population composition by race and ethnicity control for these compositional differences (table 5). The standard population used was the distribution of all U.S. teenagers by race and Hispanic origin (see Technical notes).

For example, the standardized teenage birth rate for California for 1994 was 56.5, considerably below the actual rate of 71.3. This difference results from the relatively lower proportion of Hispanics in the U.S. population compared with the California population. The most dramatic example of the compositional effect was for the District of Columbia. The standardized rate, 43.9, was well below the actual rate of 114.7, reflecting the much lower proportion of black women in the U.S. population compared with the District of Columbia. For many States, the standardized rate was often higher than the actual rate. An example is Minnesota, with a standardized rate of 54.3 compared with the actual rate of 34.4. Compared with the U.S. teenage population, Minnesota has substantially fewer Hispanic and black teenagers.

When State rates are examined separately by race and Hispanic origin, certain geographic patterns emerge. For example, 15 of the 17 highest rates for non-Hispanic white teenagers were generally in the South. Conversely, 16 of the 18 lowest rates were in the Northeast, Middle Atlantic, and Midwest. Of the 15 highest rates for black teenagers, 13 were in the Middle Atlantic and Midwest States. There was no consistent pattern in the States with the lowest rates for black teenagers. Although the Hispanic population is highly concentrated geographically, with more than 60 percent of all births occurring to residents of California and Texas, birth rates for Hispanic teenagers for those States were not among the highest. There was no apparent pattern in the States with high and low rates for Hispanic teenagers.

Although birth rates have fallen for teenagers in the 1990's, nonetheless the rates reported for 1994 are still as high or higher than they were two decades earlier (figure 1). Despite the drop in the rate for teenagers 15–17 years, the number of births for this age group increased by 2 percent in 1994, a reflection of the 3-percent increase in the number of teenagers from 1993 to 1994 (3). Population projections show that the number of women in this age group will continue to rise over the next several years (8). Thus, without larger declines in the birth rate for this age group, the number of births to young teenagers can be expected to continue to increase.

The number of births to older teenagers 18–19 years changed very little between 1993 and 1994, because the 1-percent decline in the birth *rate* was matched by a 1-percent increase in the *number of women* in that age group (1). The number of teenagers 18–19 years is projected to continue to increase over the next several years (8). In order for the number of births to decline, the birth rate will have to decline further to compensate for the increasing number of women.

The rates in this report can be useful in assessing the extent to which programs to reduce teenage pregnancy are succeeding. Comprehensive assessment, however, requires that data on legal induced abortion and fetal loss be combined with the live-birth data to produce teenage pregnancy rates. State-level pregnancy rates have been published for 1990–92 (7,9). For the period 1991–92, State teenage pregnancy rates declined significantly, by 2 to 15 percent, in 31 of the 42 reporting areas for which age-specific abortion data were available. The U.S. rate for women aged 15–19 years declined 3 percent from 1991 to 1992, from 115.0 pregnancies per 1,000 women aged 15–19 years to 111.1 per 1,000 (10–13). More recently, preliminary abortion statistics indicate a continued decline in abortions and abortion rates for teenagers (14). This coupled with the declines in teenage birth rates in 1993 and 1994 suggest that the declines in teenage pregnancy rates have continued.

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Table 1. Births and birth rates for teenagers 15–19 years, by age and race of mother: United States, 1970–94

(Birth rates per 1,000 women in specified group)

Year	All races[1]			White			Black		
	Total	15–17 years	18–19 years	Total	15–17 years	18–19 years	Total	15–17 years	18–19 years
	Number of births								
1994	505,488	185,169	310,319	348,081	126,388	221,693	140,968	52,563	78,405
1993	501,093	190,535	310,558	341,817	121,309	220,508	143,153	63,156	79,997
1992	505,415	187,549	317,866	342,739	118,786	223,953	146,800	63,002	83,798
1991	519,577	188,226	331,351	352,359	118,809	233,550	150,956	63,571	87,385
1990	521,826	183,327	338,499	354,482	114,934	239,548	151,613	62,881	88,732
1989	506,503	181,044	325,459	340,472	111,736	228,736	150,698	63,832	86,867
1988	478,353	176,624	301,729	323,630	109,739	214,091	140,608	61,856	78,752
1987	462,312	172,591	289,721	315,464	108,592	206,872	134,050	59,361	74,689
1986	461,905	168,572	293,333	317,970	107,177	210,793	131,594	57,003	74,591
1985	467,485	167,789	299,696	324,590	107,993	216,597	130,857	55,656	75,201
1984	469,582	166,744	302,838	326,301	106,782	219,519	131,497	55,932	75,565
1983	489,286	172,673	316,613	343,199	111,163	232,036	133,953	57,332	76,621
1982	513,758	181,162	332,596	363,742	117,644	246,098	137,456	59,362	78,094
1981	527,392	187,397	339,995	375,432	122,561	252,871	140,344	60,944	79,400
1980	552,161	198,222	353,939	393,564	129,341	264,223	147,378	65,069	82,309
1979	549,472	200,137	349,335	383,807	127,970	255,837	152,605	67,728	85,077
1978	543,407	202,661	340,746	380,060	130,957	249,103	151,001	67,317	83,684
1977	559,154	213,788	345,366	392,183	138,223	253,960	155,190	71,182	84,008
1976	558,744	215,493	343,251	393,275	139,901	253,374	153,936	71,429	82,507
1975	582,238	227,270	354,968	410,129	148,344	261,785	161,044	74,946	86,098
1974	595,449	234,177	361,272	420,152	152,257	267,895	164,430	77,947	86,483
1973	604,096	238,403	365,693	424,833	153,416	271,417	168,773	81,156	87,615
1972	616,280	236,641	379,639	433,956	150,897	283,059	172,349	82,217	90,132
1971	627,942	226,296	401,644	446,726	143,806	302,920	171,684	79,238	92,446
1970	644,708	223,590	421,118	460,606	143,646	319,962	171,826	76,682	94,944
	Birth rate								
1994	58.9	37.6	91.5	51.1	30.7	82.1	104.5	76.3	148.3
1993	59.6	37.8	92.1	51.1	30.3	82.1	106.6	79.8	151.9
1992	60.7	37.8	94.5	51.8	30.1	83.8	112.4	81.3	157.9
1991	62.1	38.7	94.4	52.8	30.7	83.5	115.5	84.1	158.6
1990	59.9	37.5	88.6	50.8	29.5	78.0	112.6	82.3	152.9
1989	57.3	36.4	84.2	47.9	28.1	72.9	111.5	81.9	151.9
1988	53.0	33.6	79.9	44.4	26.0	69.6	102.7	75.7	142.7
1987	50.6	31.7	78.5	42.5	24.6	68.9	97.6	72.1	135.8
1986	50.2	30.5	79.6	42.3	23.8	70.1	95.8	69.3	135.1
1985	51.0	31.0	79.6	43.3	24.4	70.4	95.4	69.3	132.4
1984	50.6	31.0	77.4	42.9	24.3	69.4	94.1	69.2	128.1
1983	51.4	31.8	77.4	43.9	25.0	68.8	93.9	69.6	127.1
1982	52.4	32.3	79.4	45.0	25.5	70.8	94.3	69.7	128.9
1981	52.2	32.0	80.0	44.9	25.4	71.5	94.5	69.3	131.0
1980	53.0	32.5	82.1	45.4	25.5	73.2	97.6	72.5	135.1
1979	52.3	32.3	81.3	43.7	24.7	71.0	101.7	75.7	140.4
1978	51.5	32.2	79.8	42.9	24.9	69.4	100.9	75.0	139.7
1977	52.8	33.9	80.9	44.1	26.1	70.5	104.7	79.6	142.9
1976	52.8	34.1	80.5	44.1	26.3	70.2	104.9	80.3	142.5
1975	55.6	36.1	85.0	46.4	28.0	74.0	111.8	85.6	152.4
1974	57.5	37.3	88.7	47.9	28.7	77.3	116.5	90.0	158.7
1973	59.3	38.5	91.2	49.0	29.2	79.3	123.1	96.0	166.6
1972	61.7	39.0	96.9	51.0	29.3	84.3	129.8	99.5	179.5
1971	64.5	38.2	105.3	53.6	28.5	92.3	134.5	99.4	192.6
1970	68.3	38.8	114.7	57.4	29.2	101.5	140.7	101.4	204.9

[1]Includes races other than white and black.

NOTE: Figures for 1970–79 are by race of child. See Technical notes.

Table 2. Birth rates for teenagers 15–19 years by age: United States and each State, 1990–94

[Rates per 1,000 women in specified group]

State	15–19 years					15–17 years					18–19 years				
	1994	1993	1992	1991	1990	1994	1993	1992	1991	1990	1994	1993	1992	1991	1990
United States	58.9	59.6	60.7	62.1	59.9	37.6	37.6	37.8	38.7	37.5	81.5	82.1	84.5	84.4	83.5
Alabama	72.2	70.5	72.5	73.9	71.0	50.8	48.2	46.3	47.7	47.4	103.4	102.3	109.9	109.5	101.4
Alaska	55.2	56.9	63.9	65.4	65.3	32.3	33.4	34.5	35.3	31.2	90.0	91.5	108.6	111.7	120.0
Arizona	78.7	79.8	81.7	80.7	75.5	50.2	49.6	51.2	51.4	47.7	123.5	126.4	128.3	122.6	111.6
Arkansas	76.3	73.9	75.5	79.8	80.1	48.8	45.9	46.8	49.4	50.4	117.1	114.7	117.1	122.8	120.7
California	71.2	72.7	74.0	74.7	70.6	45.5	46.4	46.1	46.9	44.6	110.8	112.3	116.0	113.6	104.3
Colorado	54.3	55.2	58.4	58.2	54.5	34.3	34.9	36.7	35.3	33.1	85.7	86.6	91.5	91.4	82.9
Connecticut	40.3	39.2	39.4	40.4	38.8	28.9	26.4	25.9	26.3	26.4	58.2	58.4	59.3	59.4	53.9
Delaware	60.2	59.7	59.6	61.1	54.5	44.6	39.2	43.8	40.3	38.4	82.9	89.4	82.0	87.1	71.4
District of Columbia	114.7	128.8	116.1	114.4	93.1	87.9	102.1	88.6	102.8	88.4	151.0	162.8	148.1	125.5	96.7
Florida	64.4	64.8	66.3	68.8	69.1	42.4	42.1	42.2	44.0	44.9	96.3	96.6	101.6	102.9	100.6
Georgia	71.7	73.0	74.5	76.3	75.5	48.5	48.9	48.4	50.6	50.1	107.4	108.4	111.6	110.9	108.5
Hawaii	53.5	53.0	53.5	58.7	61.2	31.7	29.7	31.5	34.7	32.5	83.6	85.0	83.1	91.5	102.0
Idaho	46.6	50.7	51.7	53.9	50.6	27.0	29.4	28.5	29.3	26.3	76.4	83.2	87.8	90.6	84.8
Illinois	62.8	63.0	63.6	64.8	62.9	41.1	41.4	40.3	40.6	40.1	96.7	96.1	98.7	99.1	93.3
Indiana	57.9	58.6	58.7	60.5	58.6	34.9	34.4	34.6	35.2	35.3	92.4	94.0	93.7	95.2	87.6
Iowa	39.7	41.1	40.8	42.6	40.5	22.7	23.1	21.0	22.8	20.4	66.5	69.3	72.3	71.5	65.7
Kansas	53.5	55.7	55.7	55.4	56.1	30.3	31.0	30.3	29.4	30.4	90.1	94.3	95.6	94.1	89.9
Kentucky	64.5	64.0	64.7	66.9	67.6	39.7	39.6	38.8	42.6	40.8	102.1	100.2	103.0	105.5	103.0
Louisiana	74.7	76.1	76.5	76.1	74.2	51.3	52.6	52.4	51.1	49.5	109.6	110.9	112.2	111.4	106.9
Maine	35.5	37.1	39.8	43.5	43.0	16.1	20.0	21.2	23.8	23.3	62.8	62.8	66.6	70.1	68.8
Maryland	49.7	50.1	50.7	54.3	53.2	32.5	33.8	32.8	35.2	33.5	76.5	74.5	76.6	79.8	78.4
Massachusetts	37.2	37.9	38.0	37.8	35.1	23.7	23.6	24.7	25.2	23.7	57.3	58.1	56.0	52.9	47.0
Michigan	52.1	53.2	56.5	59.0	59.0	31.6	32.8	33.6	35.5	36.0	83.8	83.6	89.8	91.1	88.8
Minnesota	34.4	35.0	36.0	37.3	36.3	18.8	20.4	20.6	20.7	19.9	57.9	57.8	60.0	61.4	57.6
Mississippi	83.0	83.3	84.2	85.6	81.0	58.2	57.6	59.1	60.1	57.5	120.2	121.2	120.6	120.4	111.0
Missouri	59.0	59.8	63.2	64.5	62.8	35.4	36.6	36.2	38.7	39.3	96.2	95.2	100.8	100.7	93.0
Montana	41.2	45.7	46.2	46.7	48.4	22.1	26.5	25.8	23.6	24.0	72.1	76.3	78.3	83.0	85.8
Nebraska	42.8	40.5	41.1	42.4	42.3	24.2	22.7	22.6	23.6	23.0	70.8	66.8	68.5	69.2	68.0
Nevada	73.6	73.4	71.4	75.3	73.3	46.6	44.9	42.7	43.9	42.5	116.2	117.1	113.9	119.1	115.1
New Hampshire	30.1	30.7	31.3	33.3	33.0	14.5	14.7	14.8	17.1	17.1	55.2	55.0	54.4	53.9	51.3
New Jersey	39.3	38.1	39.2	41.6	40.5	25.6	25.1	24.4	26.3	24.4	60.6	57.6	61.0	62.9	62.4
New Mexico	77.4	81.1	80.3	79.8	78.2	51.7	53.6	51.5	50.0	46.9	116.4	123.7	124.1	124.4	124.2
New York	45.8	45.7	45.3	46.0	43.6	29.8	29.8	29.0	29.1	27.5	70.1	69.4	69.3	69.0	63.4
North Carolina	66.3	66.8	69.5	70.5	67.6	43.5	42.9	43.8	46.2	44.9	100.3	101.4	105.6	101.7	94.4
North Dakota	34.6	36.8	37.3	35.5	35.4	15.4	17.6	17.8	18.1	15.6	65.5	67.4	68.3	62.4	62.3
Ohio	55.0	56.8	58.0	60.5	57.9	33.7	34.8	34.9	36.2	34.3	87.4	89.2	91.5	93.8	88.1
Oklahoma	65.9	68.6	69.9	72.1	66.8	40.5	40.5	41.1	41.7	38.8	104.9	111.2	113.3	115.6	104.3
Oregon	50.7	51.2	53.2	54.9	54.6	30.1	30.2	30.3	31.3	30.7	83.5	84.4	89.6	90.7	87.9
Pennsylvania	43.8	44.3	45.2	46.9	44.9	28.0	28.4	28.7	29.2	28.4	66.0	68.0	68.9	70.5	64.9
Rhode Island	47.7	49.8	47.5	45.4	43.9	32.2	33.5	29.7	30.1	31.6	71.5	73.5	72.1	63.6	55.7
South Carolina	66.5	66.0	70.3	72.9	71.3	45.7	43.6	45.8	48.0	47.0	96.9	97.8	104.6	105.4	101.4
South Dakota	42.8	44.3	48.3	47.5	46.8	23.0	24.9	26.8	26.3	23.9	74.1	74.7	81.9	79.2	78.7
Tennessee	71.0	70.2	71.4	75.2	72.3	43.2	43.4	44.6	47.8	45.0	113.5	109.7	109.5	112.1	107.3
Texas	77.6	78.1	78.9	78.9	75.3	51.8	51.3	51.1	50.4	48.0	116.4	117.6	120.2	119.3	112.2
Utah	42.7	44.5	46.3	48.2	46.5	24.9	25.7	26.1	27.0	26.3	70.4	74.0	78.4	79.8	78.7
Vermont	33.0	35.2	35.6	39.2	34.0	16.5	17.0	17.3	21.3	19.5	58.7	62.6	62.0	62.0	49.6
Virginia	50.7	49.6	51.8	53.5	52.9	31.2	30.6	31.0	31.8	32.1	78.8	76.7	80.1	81.2	77.7
Washington	48.2	50.2	50.9	53.7	53.1	28.5	29.3	30.6	31.0	29.6	78.9	82.2	81.5	86.5	84.4
West Virginia	54.3	55.6	56.0	57.8	57.3	32.5	33.5	32.4	32.4	33.0	87.0	88.2	90.7	93.2	89.9
Wisconsin	38.8	41.1	42.1	43.7	42.6	23.0	23.9	23.9	24.8	24.2	63.6	67.5	70.1	71.2	66.1
Wyoming	48.2	49.6	49.6	54.2	56.3	24.9	26.9	24.8	26.4	29.7	86.4	86.0	89.8	98.6	96.1

NOTES: Rates for 1990–92 were previously published. 1991–92 (ages 15–19 only): CDC. "State-Specific Pregnancy and Birth Rates Among Teenagers—United States, 1991–1992." MMWR 44(37):677–84. 1995. 1990: Clarke SC, Ventura SJ. Birth and Fertility Rates for States: United States, 1990. National Center for Health Statistics. Vital Health Stat 21(52). 1994.

Table 3. Birth rates for teenagers 15–19 years by age, race, and Hispanic origin of mother: United States, 1990–94

[Rates per 1,000 women in specified group]

Year	15–19 years			15–17 years			18–19 years		
	Hispanic[1]	Non-Hispanic White	Black	Hispanic[1]	Non-Hispanic White	Black	Hispanic[1]	Non-Hispanic White	Black
1994	107.7	40.4	104.5	74.0	22.8	76.3	158.0	67.4	148.3
1993	106.8	40.7	106.6	71.7	22.7	79.8	159.1	67.7	151.9
1992[2]	107.1	41.7	112.4	71.4	22.7	81.3	159.7	69.8	157.9
1991[2]	106.7	43.4	115.5	70.6	23.6	84.1	158.5	70.5	158.6
1990[3]	100.3	42.5	112.8	65.9	23.2	82.3	147.7	66.6	152.9

[1]Persons of Hispanic origin may be of any race; see Technical notes.

[2]Rates estimated for the United States; based on information for 49 States and the District of Columbia, which reported Hispanic origin on the birth certificate; information was not reported for New Hampshire; see Technical notes.

[3]Rates computed for the total of 49 States and the District of Columbia, which reported Hispanic origin on the birth certificate in 1990; this information was not reported by Oklahoma and New Hampshire. See Technical notes.

Table 4. Birth rates for teenagers 15–19 years by age and race/Hispanic origin: United States and each State, 1994

[Rates per 1,000 women in specified group]

State	15–19 years					15–17 years					18–19 years				
		White					White					White			
	All races[1]	Total	Non-Hispanic	Black	Hispanic[2]	All races[1]	Total	Non-Hispanic	Black	Hispanic[2]	All races[1]	Total	Non-Hispanic	Black	Hispanic[2]
United States	56.9	51.1	40.4	104.5	107.7	37.6	30.7	22.8	76.3	74.0	91.5	82.1	67.4	148.3	158.0
Alabama	72.2	55.1	54.6	108.1	71.8	50.8	35.2	35.1	82.8	*	103.4	83.7	83.2	145.8	*
Alaska	55.2	44.5	43.4	79.3	*	32.3	24.8	24.3	*	*	90.0	74.0	71.9	*	*
Arizona	78.7	77.3	49.2	99.7	136.3	50.2	49.4	28.3	64.9	94.2	123.5	120.9	82.0	154.3	201.2
Arkansas	76.3	64.1	63.1	120.2	118.4	48.9	37.6	37.2	88.2	*	117.1	102.9	101.1	169.5	*
California	71.3	76.6	38.1	89.2	118.4	45.5	48.8	21.4	58.9	79.7	110.8	119.0	64.5	137.3	175.1
Colorado	54.3	52.0	38.2	96.6	109.3	34.3	33.1	21.3	61.0	81.8	85.7	81.6	64.5	154.5	152.4
Connecticut	40.3	33.0	20.1	93.6	125.0	28.9	22.9	11.7	72.2	101.4	58.2	48.6	33.1	128.9	162.9
Delaware	60.2	43.0	38.4	115.4	*	44.6	29.5	26.2	92.2	*	82.9	62.6	56.1	160.6	*
District of Columbia	114.7	16.9	15.3	138.5	96.7	87.9	10.7	*	107.0	*	151.0	25.5	*	180.5	*
Florida	64.4	51.5	46.9	113.1	68.2	42.4	31.0	27.0	84.0	46.5	98.3	82.5	77.4	159.3	99.9
Georgia	71.7	54.1	51.5	106.9	133.6	48.5	32.5	31.3	79.4	68.4	107.4	86.6	81.9	150.6	233.7
Hawaii	53.5	33.0	29.8	*	107.7	31.7	13.5	9.5	*	70.1	83.6	59.4	57.8	*	160.6
Idaho	46.6	46.2	40.6	*	117.8	27.0	26.9	22.6	*	82.7	76.4	75.5	68.1	*	171.3
Illinois	62.8	46.2	34.3	139.1	112.6	41.1	26.8	16.6	105.4	71.5	96.7	76.4	58.3	182.7	175.5
Indiana	57.9	51.8	50.6	115.3	82.2	34.9	29.4	28.7	85.5	52.7	92.4	85.3	83.9	160.2	125.8
Iowa	39.7	37.5	36.2	117.4	96.9	22.7	21.0	20.0	87.1	63.8	66.5	63.8	61.9	*	*
Kansas	53.5	48.7	44.9	116.4	106.9	30.3	26.3	23.5	82.6	69.4	90.1	84.1	78.7	171.7	164.8
Kentucky	64.5	60.4	60.3	113.5	*	39.7	35.6	35.6	85.7	*	102.1	97.8	97.5	159.0	*
Louisiana	74.7	49.2	49.6	115.3	49.3	51.3	28.8	29.1	86.7	27.9	109.6	79.3	79.9	156.8	80.3
Maine	35.5	35.0	35.0	*	*	18.1	17.7	17.6	*	*	62.8	62.1	62.1	*	*
Maryland	49.7	32.4	31.5	89.3	62.0	32.5	18.0	17.4	64.5	34.0	76.5	54.5	53.2	128.4	104.9
Massachusetts	37.2	32.6	23.5	90.5	132.9	23.7	20.5	13.0	60.2	101.0	57.3	50.6	38.9	136.1	180.3
Michigan	52.1	39.7	37.8	110.2	65.3	31.6	21.9	20.4	78.1	59.2	83.8	67.8	64.9	158.9	127.2
Minnesota	34.4	28.5	26.9	132.3	98.9	19.8	15.1	14.0	99.3	62.4	57.9	50.4	47.9	185.9	156.6
Mississippi	83.0	56.6	56.7	114.4	*	58.2	34.5	34.6	85.6	*	120.2	89.1	89.3	156.0	*
Missouri	59.0	49.1	48.7	123.1	65.4	35.4	26.3	26.0	92.7	40.1	96.2	84.8	84.3	171.1	106.0
Montana	41.2	34.7	34.0	*	*	22.1	18.0	17.5	*	*	72.1	61.4	60.3	*	*
Nebraska	42.8	37.9	34.5	119.3	110.6	24.2	20.7	18.0	83.7	78.6	70.8	63.5	59.2	173.8	*
Nevada	73.6	71.1	55.4	111.3	138.3	46.6	43.4	31.4	81.3	95.7	116.2	114.7	93.4	159.0	204.5
New Hampshire	30.1	30.1	29.6	*	*	14.5	14.3	13.9	*	*	55.2	55.4	54.7	*	*
New Jersey	39.3	27.2	16.5	99.7	81.1	25.6	16.0	8.2	71.8	55.7	60.6	44.2	29.2	144.0	120.3
New Mexico	77.4	76.2	43.7	66.4	102.4	51.7	51.7	24.5	50.6	74.1	118.4	115.0	74.5	*	146.6
New York	45.8	39.8	26.4	73.0	81.1	29.8	24.6	14.7	52.3	56.1	70.1	62.7	44.0	104.5	118.6
North Carolina	66.3	52.3	50.0	98.5	159.6	43.5	30.8	29.5	72.5	87.3	100.3	84.3	80.4	137.9	275.1
North Dakota	34.6	29.2	28.7	*	*	15.4	11.9	11.7	*	*	55.5	57.0	56.0	*	*
Ohio	55.0	46.1	45.2	116.1	83.6	33.7	26.3	25.6	83.3	54.2	87.4	76.1	74.9	167.5	129.2
Oklahoma	65.9	59.0	57.1	105.5	87.1	40.5	34.5	33.1	73.3	58.0	104.9	96.0	93.5	157.1	132.0
Oregon	50.7	49.8	43.8	101.6	136.8	30.1	29.2	24.9	68.1	93.5	83.5	82.5	73.9	*	204.3
Pennsylvania	43.8	34.0	30.5	118.1	129.3	28.0	19.6	16.7	90.6	97.3	68.0	56.0	51.5	161.9	180.1
Rhode Island	47.7	41.3	31.7	120.4	136.8	32.2	27.1	20.2	87.9	98.4	71.5	63.0	49.2	*	*
South Carolina	66.5	50.3	49.9	92.1	68.4	45.7	31.0	30.9	66.4	*	96.9	78.3	77.6	127.0	*
South Dakota	42.8	33.0	32.3	*	*	23.0	16.0	15.6	*	*	74.1	59.7	58.4	*	*
Tennessee	71.0	58.8	56.5	119.8	79.5	43.2	32.7	32.6	84.2	41.9	113.5	96.3	97.8	176.3	*
Texas	77.6	75.7	47.7	100.4	113.6	51.8	49.6	27.4	72.8	80.8	116.4	114.6	78.7	143.9	161.4
Utah	42.7	42.0	38.6	*	96.9	24.9	24.5	21.9	*	66.9	70.4	69.1	64.7	*	141.9
Vermont	33.0	33.2	33.4	*	*	16.5	16.5	16.5	*	*	58.7	59.1	59.6	*	*
Virginia	50.7	40.7	38.8	87.9	79.4	31.2	23.1	21.6	59.7	50.1	76.6	65.7	62.9	129.9	122.2
Washington	48.2	47.2	40.5	90.9	125.6	26.5	27.1	22.5	52.4	83.0	76.9	76.3	68.4	128.1	192.0
West Virginia	54.3	53.7	53.6	80.7	*	32.5	31.6	31.7	60.4	*	87.0	86.7	86.9	*	*
Wisconsin	38.8	28.8	26.5	142.3	92.6	23.0	15.2	13.5	105.7	66.8	63.6	50.1	47.0	199.7	131.3
Wyoming	48.2	47.6	45.4	*	74.9	24.9	24.1	22.2	*	*	86.4	86.1	83.4	*	*

* Figure does not meet standards of reliability or precision; based on fewer than 20 births or fewer than 1,000 women in specified group.

[1] Includes races other than white and black.

[2] Persons of Hispanic origin may be of any race.

Table 5. Birth rates for teenagers 15–19 years—Actual and standardized: United States and each State, 1994

[Rates per 1,000 women aged 15–19 years]

	Actual rate	Standardized rate[1]	Percent difference
United States	58.9	58.9	...
Alabama	72.2	63.6	–12.0
Alaska	55.2	55.4	0.2
Arizona	78.7	71.1	–9.7
Arkansas	76.3	78.0	2.3
California	71.3	56.5	–20.7
Colorado	54.3	56.9	4.8
Connecticut	40.3	45.1	11.8
Delaware	60.2	62.7	4.2
District of Columbia	114.7	43.9	–61.7
Florida	64.4	59.2	–8.1
Georgia	71.7	68.9	–3.8
Hawaii	53.5	44.6	–16.5
Idaho	46.6	55.1	18.3
Illinois	62.8	59.0	–5.6
Indiana	57.9	63.2	9.1
Iowa	39.7	57.0	43.8
Kansas	53.5	63.7	19.1
Kentucky	64.5	67.5	4.7
Louisiana	74.7	58.9	–21.1
Maine	35.5	42.1	18.4
Maryland	49.7	42.9	–13.7
Massachusetts	37.2	47.8	28.5
Michigan	52.1	54.8	5.3
Minnesota	34.4	54.3	58.1
Mississippi	83.0	62.2	–25.0
Missouri	59.0	61.5	4.1
Montana	41.2	43.8	6.4
Nebraska	42.8	60.2	40.6
Nevada	73.6	75.1	2.0
New Hampshire	30.1	35.6	18.0
New Jersey	39.3	37.2	–5.4
New Mexico	77.4	59.4	–23.3
New York	45.8	41.3	–9.8
North Carolina	66.3	72.2	9.0
North Dakota	34.6	41.7	20.7
Ohio	55.0	59.8	8.7
Oklahoma	65.9	69.5	5.5
Oregon	50.7	65.0	28.1
Pennsylvania	43.8	56.2	28.5
Rhode Island	47.7	64.2	34.6
South Carolina	66.5	58.0	–12.8
South Dakota	42.6	45.7	6.9
Tennessee	71.0	69.5	–2.0
Texas	77.6	63.5	–18.2
Utah	42.7	52.4	22.6
Vermont	33.0	32.3	–2.2
Virginia	59.7	59.1	–1.2
Washington	48.2	57.9	20.1
West Virginia	54.3	52.3	–3.6
Wisconsin	38.6	55.2	42.2
Wyoming	48.2	49.1	1.9

... Category not applicable

[1]Standardized by direct standardization with distribution of the U.S. population of women aged 15–19 years by race and Hispanic origin for 1994 as standard population; see Technical notes.

Technical notes

Sources of data

Data shown in this report for 1994 are based on 100 percent of the birth certificates in all States and the District of Columbia. The data are provided to the National Center for Health Statistics (NCHS) through the Vital Statistics Cooperative Program (VSCP).

Race

Beginning with the 1989 data year, NCHS is tabulating its birth data primarily by race of the mother. In 1988 and prior years, births were tabulated by the race of the child, which was determined from the race of the parents as entered on the birth certificate.

Trend data by race shown in this report are by race of mother for all years beginning with the 1980 data year. The factors influencing the decision to tabulate births by race of the mother have been discussed in detail in a previous report (15). They include the recent revision of the birth certificate, effective with the 1989 data year, which includes many more health questions that are directly associated with the mother in addition to many other items on the birth certificate for more than two decades. In all these instances, it is more appropriate to tabulate births by the mother's race. A second factor has been the increasing incidence of interracial parentage. In 1994, 4.4 percent of births were to parents of different races compared with just 1.7 percent in 1974. The third factor influencing the decision to tabulate births by race of mother is the growing proportion of births with race of father not stated, 16 percent in 1994 compared with 9 percent in 1974. This reflects the increase in the proportion of births to unmarried women; in many such cases, no information is reported on the father. These births are already assigned the race of the mother because there is no alternative.

Birth rates for American Indian teenagers and Asian or Pacific Islander teenagers are not included in this report. These two population groups are relatively small and tend to be highly concentrated geographically, which makes it possible to compute meaningful rates for only a few States.

Hispanic origin

Hispanic origin of the mother is reported and tabulated independently of race. Thus persons of Hispanic origin may be of any race. In 1994, 91 percent of women of Hispanic origin were reported as white (1).

Population denominators

Birth rates for 1991–94 shown in this report are based on populations estimated as of July 1 for each year; rates for 1990 are based on populations enumerated as of April 1, 1990. The population estimates have been published by the U.S. Bureau of the Census (1,2) and are based on the 1990 census counts by race and age that were modified to be consistent with Office of Management and Budget racial categories and historical categories for birth data, and in the case of age, to reflect age as of the census reference date. The modification procedures are described in detail in a census report (16).

In computing birth and fertility rates for the Hispanic population, births with origin of mother not stated are included with non-Hispanic births rather than being distributed. Thus, rates for the U.S. Hispanic population are underestimates of the true rates to the extent that the births with origin not stated (1.1 percent) were actually to Hispanic mothers. The origin of the mother was imputed for population counts when it was not stated. The effect on the rates is believed to be small.

Computation of rates

Rates were not computed if there were fewer than 20 births in the numerator or fewer than 1,000 women in the specified group in the denominator. An asterisk is shown in place of the rate.

Rates by Hispanic origin shown in table 3 for 1990 are based on a reporting area consisting of 48 States and the District of Columbia that reported Hispanic origin on the birth certificate in 1990. Data were not available for Oklahoma and New Hampshire; it is estimated that 99.6 percent of the Hispanic population lived in the reporting area (17). Rates for 1991–92 are based on all States except New Hampshire. It is estimated that more than 99.9 percent of the U.S. Hispanic population lived in the reporting area. Beginning in 1993, Hispanic origin was reported by all States. Given that more than 99 percent of the Hispanic origin population lived in the reporting area for 1990–92, the addition of Oklahoma and New Hampshire should not have affected the trends in the birth rates (17).

To eliminate the effect of differences among States in the distributions of the populations by race and Hispanic origin on the State birth rates, standardized birth rates were computed for 1994. The direct method of standardization was used. The 1994 distribution of the U.S. population of women aged 15–19 years by race and Hispanic origin was used as the standard population in this procedure.

Random variation and relative standard error

Although the birth data in this report for births since 1985 are not subject to sampling error, they may be affected by random variation in the number of births involved. When the number of events is small (perhaps less than 100) and the probability of such an event is small, considerable caution must be observed in interpreting the data. Events of rare nature may be assumed to follow a Poisson probability distribution. For this distribution, a simple approximation may be used to estimate the error as follows:

If N is the number of births and R is the corresponding rate, the chances are 19 in 20 that

1. The "true" number of events lies between

$$N - 2\sqrt{N} \text{ and } N + 2\sqrt{N}$$

2. The "true" rate lies between

$$R - 2\frac{R}{\sqrt{N}} \text{ and } R + 2\frac{R}{\sqrt{N}}$$

If the rate R_1 corresponding to N_1 events is compared to the rate R_2 corresponding to N_2 events, the difference between the two rates may be regarded as statistically significant if it exceeds

$$2\sqrt{\frac{R_1^2}{N_1} + \frac{R_2^2}{N_2}}$$

For example, the teenage birth rate for Maine for 1994 was 35.5 births per

1,000 women 15–19 years of age and this rate was based on 1,459 recorded births. Given prevailing conditions, the chances are 19 in 20 that the "true" or underlying birth rate for Maine lies between 33.6 and 37.4 per 1,000 women 15–19 years of age. The 1991 teenage birth rate for Maine was 43.5 based on 1,805 recorded births. The difference between the rates is 8.0, which is more than twice the standard error of the difference

$$\sqrt{\frac{(35.5)^2}{1459} + \frac{(43.5)^2}{1805}}$$

of the two rates that is computed to be 2.8. From this, it is concluded that the difference between the teenage birth rate in 1991 and 1994 is statistically significant.

Contents

Suggested citation

Ventura SJ, Clarke SC, Mathews TJ. Recent declines in teenage birth rates in the United States: Variations by State, 1990–94. Monthly vital statistics report; vol 45 no 5, supp. Hyattsville, Maryland: National Center for Health Statistics. 1996.

DEPARTMENT OF
HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics
6525 Belcrest Road
Hyattsville, Maryland 20782

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7-0039 (12/96)

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APPENDIX III: PROMISING STRATEGIES

NOTE: Descriptions of the following five programs are excerpted from "Preventing Teen Pregnancy: Promoting Promising Strategies: A Guide for Communities," a report by HHS released at a White House press conference on June 13, 1996.

CHILDREN'S AID SOCIETY'S ADOLESCENT PREGNANCY PREVENTION PROGRAMS

Approach: Comprehensive, Multi-Faceted

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

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

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

Population Served: Youth ages 10 through 20

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

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

TEEN OUTREACH PROGRAM

Approach: Life Options

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

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

Location: Nationwide and in Canada, mostly located in schools

Population Served: Youth ages 11 through 19

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

POSTPONING SEXUAL INVOLVEMENT

Approach: Abstinence and Delayed Sexual Initiation

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

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

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

Population Served: Youth ages 13 to 14

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

I HAVE A FUTURE

Approach: Life Options and Opportunity Development

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

Goals of the Program:

- Developing a replicable community-based, life-enhancement program that promotes a significant reduction in the incidence of early pregnancy and child bearing among high-risk adolescents;

- Improving knowledge, attitudes and behaviors related to personal health and human sexuality; and,

- Enhancing the ability of high-risk adolescents to overcome environmental barriers to attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility.

Location: Public housing projects in Nashville, TN

Population Served: Youth ages 10 through 17

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

QUANTUM OPPORTUNITIES PROGRAM

Approach: Life Options and Opportunity Development

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

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

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

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

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

Population Served: Students entering the 9th grade

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

APPENDIX IV: PROGRAM CONTACTS AND OTHER RESOURCES

HHS Programs

Centers for Disease Control and Prevention
Community Partnership Programs for the Prevention of Teen Pregnancy
For information call: 404-639-3286

Office of Population Affairs
Adolescent Family Life Program and the Title X Family Planning Program
For information call: 301-594-4000

Health Resources and Services Administration
Healthy Start; Community and Migrant Health Centers;
Healthy Schools, Healthy Communities; and Maternal and Child Health Block Grant
For information call: 301-443-3376

Administration for Children and Families
Youth Programs (Runaway and Homeless Youth, Community Schools, etc.)
For information call: 202-401-9215

Substance Abuse and Mental Health Services Administration
Drug Treatment and Prevention Programs
For information call: 301-443-8956

Health Care Financing Administration
Medicaid Bureau
For information call: 410-786-3393

Enterprise Zones/Economic Communities
For information call: 202-401-3951

National Institute of Child Health and Human Development
Add HEALTH and the National Survey of Adolescent Males
For information call: 301-496-5133

National Center for Health Statistics
National Survey of Family Growth and Monthly/Semi-Annual Vital Statistics Reports
For information call: 301-436-7551

Hotlines and Referral Numbers

National AIDS Hotline (CDC)
1-800-342-AIDS (English)
1-800-344-SIDA (Spanish)
1-800-243-7889 (TDD)

Sexually Transmitted Diseases Hotline (CDC)
1-800-227-8922

Office of Population Affairs Clearinghouse (OPA)
301-654-6190
301-215-7731 (to order by facsimile)

National Center On Child Abuse and Neglect (ACF)
703-385-7565 or 800-394-3366

National Clearinghouse on Families and Youth (ACF)
301-608-8098
301-608-8721 (to order by facsimile)

National Clearinghouse on Alcohol and Drug Information (SAMHSA)
1-800-729-6686 (English)
1-800-487-4889 (TDD)

HHS On-Line

HHS Home Page
Access to consumer information on a variety of issues and links to specific HHS agencies.
http://www.os.dhhs.gov

YouthInfo
Latest information on America's teenagers including reports and publications, resources for parents, statistical profiles, and links to related federal and private organization websites.
http://youth.os.dhhs.gov

Girl Power!
Materials, information, and products for girls, parents, and caring adults.
http://www.health.org/gpower

Research Reports

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

Trends in the Well-Being of America's Children and Youth. A 1996 report written by Child Trends, Inc. for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services. Copies available by faxing requests to Child Trends at 202-362-5533 or ASPE at 202-690-5514. Also available at the Internet address http://aspe.os.dhhs.gov

Report to Congress on Out-of-Wedlock Childbearing. A 1995 report prepared by the U.S. Department of Health and Human Services and university researchers that provides a comprehensive overview of nonmarital childbearing among women of all ages. Copies available by faxing requests to ASPE at 202-690-5514 or to Stephanie Ventura, NCHS, at 301-436-7066 (DHHS Pub. No. (PHS) 95-1257). Also available at the Internet address http://www.cdc.gov/nchswww/products/pubs/pubd/other/miscpub/miscpub.htm

The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families. A 1995 report by the Institute of Medicine. Copies available from the National Academy Press at 800-624-6242.

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

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

WR - Teen Pregnancy Bruce Dear Per SBA for e-mail for your review

June 18, 1996

Senator Daniel Patrick Moynihan
United States Senate
Washington, D.C.

Dear Senator Moynihan:

Your note of May 13 on welfare reform and teen pregnancy makes some important points as always.

We are making progress pursuing a "quiet revolution" in the states on welfare reform. We are learning a lot from these state experiments, and I am pleased that we are continuing to approve them. I still believe we need to reshape the national system, however, and will continue to try to work with the Congress to implement real national reform that promotes work and supports people moving from dependence to independence.

On teen pregnancy, the data from 1992 and 1993 do show minimal movement in the right direction. I could not agree with you more that this is no reason to declare victory and move on to other issues. It is cause only to redouble our effort to address the problem. I am pleased that the National Campaign to Prevent Teen Pregnancy has been established and that Tom Kean has agreed to chair it. I am also hopeful that my proposal for $30 million in Fiscal Year 1997 for community based prevention programs and for evaluation of those efforts will be approved so that we can truly get a better handle on what works and what does not.

As always, thank you for your kind words and for sharing your thoughts.

Sincerely,

Eliz - let's get this done by COB this Fri. at latest

JUN 3 1996 CLR

THE WHITE HOUSE
WASHINGTON

June 3, 1996

MEMORANDUM FOR CAROL RASCO

FROM: **SUSAN BROPHY**
LEGISLATIVE AFFAIRS

SUBJECT: **PRESIDENTIAL CORRESPONDENCE**

Enclosed please find a copy of the letter that was sent to the President from Sen. Daniel P. Moynihan (D-NY).

The President has requested that he see and sign every letter going to Capitol Hill. We did not want to fully answer the issues addressed in the Representative's letter without advice from your department; therefore, I am requesting that your office draft a response and return it to Chris Walker (Room 102-East Wing).

Thank you very much for your assistance in this matter. If you have any questions, please feel free to call Chris at 456-7500.

Enclosure

Daniel Patrick Moynihan
New York

United States Senate
Washington, D. C.

May 13, 1996

Dear Mr. President,

I have read your Penn State address with great joy.

> ...[I]n the past three years, by executive actions, we've been working on what the New York Times called a "quiet revolution on welfare." We've cut red tape for 37 states and now let 75 percent of the people in this country on welfare be a part of welfare reform experiments with little fanfare and no new legislation. We've done things like impose time limits and require work. And we've worked much harder to enforce the national government's role in child support enforcement across national lines.

These were the goals of the Family Support Act of 1988 which you helped so much to enact. It has taken time to show results: nothing unusual. What is unusual is that careful research is beginning to show results. Surely it is no time to turn this national issue over to the States, as the current Senate Republican proposal would do.

It would appear to me that the right course is the one you are taking, as described in this morning's Times editorial: Mr. Clinton Toughens Welfare Rules. We can build on the 1988 legislation in the next Congress.

One small point. HHS has been putting it about that, as you stated Saturday, "the teen pregnancy rate has even started to go down a bit." Possibly. The latest data are 1993; I see no real change. We are not at the rate of the boomer decades, but are up from 1980. The real issue, of course, is the illegitimacy ratio. This has risen every year since 1957 when it was 138.9 births per 1000 live births. By 1993, it was 713.3.

Respectfully,

The President
The White House
Washington, DC 20500

WR
Teen
Pregnancy

THE WHITE HOUSE

WASHINGTON

January 17, 1996

MEMORANDUM TO DON BAER
VICKI RADD

FROM: Jeremy Ben-Ami

SUBJECT: Teen Pregnancy/State of Union Rollout.

Attached is a memo on the current status of the National Campaign to Reduce Teenage Pregnancy as well as the current draft of the status report on the administration's record on the issue that we would like to release.

We can put together an event for the President with the Campaign's leaders with a little lead time, if it fits into the rollout from the speech.

If we do not schedule something for the first week or two, we will plan on rescheduling the release of Dr. Foster's position and this report for the week of January 29th -- so that we can get this over with.

Please let me know as soon as you know what you want us to do.

cc: Carol Rasco
Mike McCurry
Rahm Emanuel
Bruce Reed
Michael Waldman
Janet Abrams
Debbie Fine
Deborah Both

January 16, 1996

MEMORANDUM FOR CAROL RASCO AND JEREMY BEN-AMI

FROM: Janet Abrams

RE: Teen Pregnancy Initiative

The leadership council for the national private-sector campaign is taking shape. As of today, the following individuals have agreed to serve:

- Whoopi Goldberg
- Andrew Young
- Hugh Price, Urban League
- Charlotte Beers, Ogilvy & Mather
- David Hamburg, Carnegie Corporation
- Nancy Kassebaum
- Kay Graham
- Belle Sawhill

Others likely to sign on include:

- Jane Fonda
- C. Everett Koop
- Tom Kean
- Warren Rudman
- Gloria Estefan
- Judy McGrath, MTV

A meeting is being held on January 30 at the Carnegie Corporation in NYC to move forward with planning the campaign. All individuals who attended the White House event in October have been invited, plus a number of others.

I will update you as soon as we receive additional information. Thanks.

DRAFT

THE CLINTON ADMINISTRATION RECORD ON REDUCING TEEN PREGNANCY

A Summary Report

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

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

> *Responsible Behavior:* Personal responsibility has been a central part of the President's message to young people, as he has urged them not to become parents before they are adults, have finished school, and are ready to support their children. He has supported policies that embody this principle, including abstinence-based curricula, welfare reforms that discourage early parenting and require young mothers to live at home and stay in school, and tough new child support enforcement provisions that drive home the responsibility of parenthood to young men.
>
> *Opportunities for Youth:* Teen pregnancy cannot be addressed in isolation from the wide range of other problems confronting youth, their families, their communities and their schools. Much of the Administration's social and economic agenda, ranging from education to crime prevention to empowerment zones, is designed to provide increased opportunities for young people and to give them something to say 'yes' to. If our youth do not have access to education, health services, jobs, or safe places to go after school and on weekends, they will not have a chance to make the right choices.

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

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

The Facts About Teen Pregnancy

A NATIONAL EPIDEMIC

- Every year, about 1 million American teenagers become pregnant -- that's approximately 11% of women ages 15-19.

- From the 1950s through the early 1980s, the rate of births to teens decreased steadily. However, in 1986, that trend reversed, and over the period 1986-91, the rate grew by 24%. Recent news has been somewhat positive: From 1991 to 1993, the national rate declined by 4%.

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

TREND TOWARDS OUT-OF-WEDLOCK CHILDBEARING

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

INTERNATIONAL COMPARISONS

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

ROLE OF ADULT MALES

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

COSTS TO THE CHILDREN

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

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

COSTS TO SOCIETY

- In 1990, slightly more than half of all mothers receiving Aid to Families and Dependent Children (AFDC) first had children as teenagers. And 43% of the long-term welfare recipients are women who gave birth at or before age 17.

- More than three-fourths of all unmarried teen mothers receive welfare (AFDC) at some point during the 5 years following the birth of their child.

Research and Evaluation: Learning What Works to Prevent Teen Pregnancy

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

- Comprehensive Study: In June of 1995, the Department of Health and Human Services issued, **"Beginning Too Soon: Adolescent Sexual Behavior, Pregnancy, and Parenthood,"** a two volume report containing a comprehensive and exhaustive review of the most recent research literature on teenage sexual behavior, pregnancy and parenthood and on effectiveness of teenage pregnancy prevention programs. This report was produced by Child Trends, Inc. with funding from the Department of Health and Human Services, and is now available on the Internet at http://aspe.os.dhhs.gov/hsp/cyphome.htm.

- State Data: In September 1995, HHS reported **state-level teenage pregnancy data** for 1991 and 1992. This marks the first time that HHS is able to report state-level teen pregnancy data. Updating trends on a state-by-state basis regularly provides more information for making effective policy decisions and enables us to see where we need to target our resources.

- Family Planning and Adolescent Family Life : HHS funds, as part of Family Planning and Adolescent Family Life programs, research projects and studies that focus on **adolescent sexual behavior.** Goals of these studies range from developing strategies to improve services to sexually active adolescents who are at-risk for contraceptive non-compliance and young women who visit family planning clinics, to learning more about: precursors and results of pregnancy and birth among adolescent males, the factors that influence teen attitudes toward sexual behavior, and the consequences for teen mothers who decide to parent as compared to those who place their children for adoption.

- New Mothers' Study: HHS funds The New Mothers' Study and has expanded its original scope to provide support for a 5-year follow-up to look at longer term outcomes, including employment and welfare dependency. *The Study focuses on research and analysis of a study in Memphis, Tennessee, where a sample of first-time, low-income, pregnant women received weekly visits from a nurse. Approximately 65% of the research sample were 18 or younger at enrollment. Early findings indicate that there were **significantly fewer repeat pregnancies** within two years following the birth of the child for those women who received home visits. It was originally started in 1988, and is also supported by other government agencies and private foundations.*

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

Reaching Into Our Communities And Promoting Partnerships to Prevent Teen Pregnancy

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

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

- Adolescent Family Life Program: In September of 1995, HHS's Adolescent Family Life Program awarded 15 grants totaling $4.2 million dollars for comprehensive demonstration programs aimed at preventing early teenage sexual activity and reducing teenage pregnancies. These programs feature innovative ways to **emphasize abstinence as the best way to prevent adolescent pregnancy** and to encourage the involvement of parents in these discussions with their children.

- Community Coalition Partnership Programs for Prevention of Teen Pregnancy: In September of 1995, Centers for Disease Control and Prevention launched the new Community Coalition Partnership Programs for Prevention of Teen Pregnancy by awarding 13 grants totalling $6.5 million over two years. These grants enable communities to develop plans for implementing and evaluating **community-wide interventions** that are innovative, comprehensive and sustainable. In addition, these demonstrations include an evaluation component.

- Healthy Schools/Healthy Communities: In 1994, the Administration started the new Healthy Schools/Healthy Communities program -- funding 27 **new school-based health centers** in 20 states and the District of Columbia. These centers provide for the health services and education needs of children and teenagers at high risk for poor health, teenage pregnancy, and other problems. A comprehensive evaluation of this program is currently being conducted.

- The Corporation for National Service: Created under the Clinton Administration in 1993, the Corporation for National Service supports over 50 teen pregnancy programs in 20 states across the country -- working both to **prevent teen pregnancy and to assist teen parents.** National service participants provide case management, mentor pregnant teens, sponsor health fairs, teach parenting skills to teen parents, make presentations on teen pregnancy prevention to school-age youth, help youth access health care, provide referrals to health care providers, and develop social supports for teen parents. *National service programs are operated with members of AmeriCorps, Learn and Serve America, and the National Senior Service Corps, who work collaboratively with school districts, universities, churches, health departments, national non-profits, and community-based organizations.*

- Healthy Start Program: HHS continues to support the Healthy Start Program, which has demonstration projects underway in 22 communities nationwide to **reduce infant mortality in the highest-risk areas and to improve the health and well-being of women, infants and their families.** Among a broad array of services provided, thousands of teenagers participate in prevention programs exclusively designed for them that encourage healthy lifestyles, youth empowerment, sexual responsibility, conflict resolution, goal setting, and the enhancement of self-esteem. A comprehensive evaluation is ongoing and results are expected in 1997.

- The Home Visiting Services Demonstration: In September 1994, HHS launched this new grant program that is currently operating in three sites. Under the demonstration, paraprofessional home visitors provide first-time teenage parents on welfare with instruction and supportive guidance related to family planning, parenting skills, health care for themselves and their children, and child support. The visitors also facilitate the teenagers' participation in the required education and employment-related activities.

Promoting Personal Responsibility Among Young People

President Clinton has made personal responsibility a central part of his message to young people, striving to prevent both first and repeat pregnancies for young mothers and fathers. Estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child. To prevent welfare dependency, teenagers must get the message that staying in school, postponing sexual activity, and preparing to work are the right things to do.

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

Welfare Reform: The President's welfare reform proposals incorporate a clear message to minor parents seeking assistance: to get help, you have to live with a responsible adult, you have to stay in school, and you have to be committed to supporting yourself and your children after high school. Welfare reform proposals passed by the House and the Senate have adopted the President's proposal requiring unmarried teen mothers to live at home with an adult family member in order to qualify for assistance. The pending legislation would also allow states grants to establish "Second Chance" homes, or adult-supervised group homes, as alternative living situations to help teen parents break the cycle of welfare dependency.

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

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

State Welfare Reform Demonstrations: The Administration has approved State Welfare Reform Demonstrations that include various provisions affecting minor parents. 12 states have authority to implement provisions linking AFDC benefits to the school attendance of minor parents. Nine states have received waiver authority to require minor parents to live with their parents or guardians or in an adult-supervised setting. A comprehensive evaluation will be conducted for each of these demonstrations.

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

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

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

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

LEARNING MORE ABOUT YOUTH AT-RISK

- National Adolescent Health Survey: Teens have been a significantly understudied sector of the population. In 1994, the National Institutes of Health began funding a new 5-year study known as Add Health, the first comprehensive study of the determinants of adolescent health. Using a national sample of 7th through 12th graders, Add Health examines the personal, familial, peer-related and community related influences on health behavior, taking a more **comprehensive look at the health of our nation's teenagers** in order to provide a better understanding of the complex forces that promote good health for our young people and those factors that put youth at risk.

- Preventing Youth Violence in Public Housing: This year, HUD and CDC have awarded a $550,000 grant to collect and develop information on youth violence prevention research. The intent is to disseminate existing information on successful programs to Indian and Public Housing authorities so that they can make more informed choices about prevention programs, which offer alternative services and activities for youth that can play a major role in preventing teen pregnancy as well.

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

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

- Review for Practitioners: *Family Life, Delinquency, and Crime: A Policymaker's Guide--Research Summary,* was completed in May of 1994 by the Department of Justice. Its findings indicate that **family is one of the most powerful socializing forces for young people,** and can therefore seriously impact children's behavior.

- Parenting Initiative: The Department of Justice completed research work in 1993 under a grant to the University of Utah and the Pacific Institute for Research and Evaluation. This four-year major parenting initiative resulted in a document entitled *Effective Parenting Strategies for Families of High-Risk Youth (December 1993),* which identified a representative group of 25 programs as potentially the most promising. The research findings underscore the **importance of a family-focused approach to prevention and intervention of youthful problem behavior.**

EXPANDING OPPORTUNITIES FOR YOUTH AT-RISK

- SafeFutures: In September 1995, the Department of Justice created the SafeFutures Program, a five-year program which will provide approximately $8 million per year to six jurisdictions for a comprehensive and coordinated **delinquency prevention and intervention program for at-risk and delinquent youth.** Several programmatic components allow the four cities, one rural jurisdiction and one tribal government, to address teen pregnancy and receive support for specific counseling and education services. These include support for family strengthening activities, mentoring, specific services to at-risk and delinquent females, and general delinquency prevention activities.

- High Risk Youth Demonstration: HHS supports the High Risk Youth Demonstration program, which funds **innovative and effective model programs for preventing alcohol and drug use among high-risk youth.** One component of the program targets the specific needs of females from 12 to 20 whose use of substances often occurs with special factors (e.g. sexual abuse and domestic violence) that underlie or contribute to women's addictive problems. Every component of the program is evaluated.

- School Health Programs: The CDC has established a national framework to support school health programs that are locally determined and consistent with community values. Programs in all 50 states and 18 major cities are designed to help young people avoid those risk behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancies. CDC's Youth Risk Surveillance System provides information about the prevalence of behaviors practiced by youth that put their health at risk, and states, cities, and CDC use this information to more effectively target and evaluate school health programs.

- Youth Development Initiative: Started in 1994 under the Departments of Veterans Affairs and Housing and Urban Development, the purpose of this initiative is to address the problem of violence in low-income communities by providing young people aged 13 to 25, with access to education and employment opportunities and supportive services. Offering these positive alternatives and services to youth to reduce violence are shown to be effective for affecting other teen behavior as well, such as sexual behavior that could lead to teen pregnancy.

- Youth Fair Chance: In July 1994, the Department of Labor implemented the Youth Fair Chance program, funding seventeen sites. Youth Fair Chance is a community-based program that targets money directly into **high poverty areas where youth problems are greatest**. Working in cooperation with local service providers, these sites use in- and out-of-school components to provide a variety of services that focus on youth problems, like teen pregnancy, unemployment, drug and gang involvement, and dropping out of school. Some of the sites utilize AmeriCorps volunteers.

- The Community Schools Youth Services and Supervision Grant: Through this new program established in 1994 under the Crime Bill, HHS provides matching grants to communities with significant poverty and juvenile delinquency for **after-school, weekend and summer recreation and education programs**. The program includes an evaluation component.

- Family Planning: In the face of strong opposition, the President has proposed budget increases for the federal Family Planning Program each year and successfully maintained the program. Among other reproductive health and education services, this program makes family planning information and contraception available to millions of women who might not otherwise get reproductive health care.

- 4-H Youth Development Program and Children, Youth and Families at Risk Initiative: The Department of Agriculture, through the Cooperative Extension System, funds these important initiatives serving young people. These programs work with communities to implement effective research-based programs which address a broad range of issues and needs, including teen pregnancy, child abuse, infant mortality, community crime and violence, and child care.

- Safe and Drug-Free School Act: Passed in 1994, this act responds to the continuing crisis of violence and drugs in our schools by **supporting comprehensive school-and community-based drug abuse and violence prevention programs**. Local school districts in high need areas are coordinating violence and drug prevention programs with comprehensive school health education programs.

- Comprehensive Services for Teenage Parents on Welfare: In 1994, HHS funded these grants, which supported development of programs providing **comprehensive services to meet the personal, physical and social needs of teenage parents,** as well as aiding the cognitive, physical and emotional development of their children. They were implemented in conjunction with mandatory participation requirements for education and employment-related activities.

LIFELONG LEARNING: INVESTING IN OUR YOUNG PEOPLE

> *"We can do all these things -- put our economic house in order, expand world trade, target the jobs of the future, guarantee equal opportunity -- but if we're honest, we'll admit that this strategy still cannot work unless we also give our people the education, training, and skills they need to seize the opportunities of tomorrow."* **President Clinton; January 25, 1994**

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

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

EMPOWERING COMMUNITIES TO SOLVE PROBLEMS

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

Promoting Personal Responsibility Among Young People

[NOTE:SECTION TO BE UPDATED AS WELFARE REFORM DEBATE EVOLVES]

President Clinton has made personal responsibility a central part of his message to young people, striving to prevent both first and repeat pregnancies for young mothers and fathers. Estimates indicate that over half the mothers who receive Aid to Families with Dependent Children were teenagers when they had their first child. To prevent welfare dependency, teenagers must get the message that staying in school, postponing sexual activity, and preparing to work are the right things to do.

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

Welfare Reform: The President's welfare reform proposals incorporate a clear message to minor parents seeking assistance: to get help, you have to live with a responsible adult, you have to stay in school, and you have to be committed to supporting yourself and your children after high school. Welfare reform proposals passed by the House and the Senate have adopted the President's proposal requiring unmarried teen mothers to live at home with an adult family member in order to qualify for assistance. The pending legislation would also allow states grants to establish "Second Chance" homes, or adult-supervised group homes, as alternative living situations to help teen parents break the cycle of welfare dependency.

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