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CURRENT ISSUES RELATING
TO PREGNANCY AND PARENTING

FEBRUARY/MARCH 2002

SIECUS

R E P O R T

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Tamara Kreinin, M.H.S.A.

President and CEO

Monica Rodriguez

Director of Information and Education

Mac Edwards

Editor

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All article, review, advertising, and publication inquiries and submissions should be addressed to:

Mac Edwards, Editor

SIECUS Report

130 West 42nd Street, Suite 350

New York, NY 10036-7802

phone 212/819-9770 fax 212/819-9776

Web Site: www.siecus.org

E-mail: medwards@siecus.org

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CALL FOR SUBMISSIONS: SEXUALITY EDUCATION IN AMERICA

The *SIECUS Report* is seeking articles on “Sexuality Education in America” for its August/September issue. We are particularly interested in articles relating to implementation of both abstinence-only-until-marriage and comprehensive sexuality education programs in public schools. Deadline for submissions is June 5.

PREGNANCY ISSUES COVER DIVERSE SUBJECTS: GAY ADOPTION, UNWANTED BABIES, AND RACISM

Mac Edwards

My life partner Reggie and I have two very close gay friends who have been together for over 15 years and who have just adopted a baby Vietnamese boy—the first, they hope, of many children.

Since the state in which they reside does not allow gays to adopt, one friend adopted the baby that they call their own. Because they are not expecting the state to change its position on gay adoptions anytime soon, they are planning to move to a state that will allow both of them to adopt their baby and their future children.

It is a pleasure to see and feel the love that these men have for their newborn child. It is also a pleasure to see the love their parents have for their new grandson. We are proud to be a part of their lives.

On a related subject, we are happy to include in this *SIECUS Report* on “Current Issues Relating to Pregnancy and Parenting” an article on the announcement by the American Academy of Pediatrics (AAP) that it supports adoption by gays. Of particular significance, the AAP report says that “the key factor in healthy child development has more to do with the quality of relationships within a family than with the particular family structure.” It goes on to say that “children are better adjusted when their parents report greater relationship satisfaction, higher levels of love, and lower inter-parental conflict regardless of their parents’ sexual orientation.”

I have seen personal evidence of this with my friends. I am very much encouraged that the American Academy of Pediatrics has come out in support of gay adoptions.

NEW INFORMATION

This issue of the *SIECUS Report* is filled with other new information related to pregnancy and parenting.

To update you, we have included charts relating to state-by-state action on five subjects: (1) substance abuse by pregnant women, (2) infertility insurance coverage, (3) Medicaid family planning waivers, (4) minors’ access to prenatal care, (5) “safe surrender” of infants, (6) human cloning, and (7) gay and lesbian adoption.

We have also developed a new *SIECUS* Fact Sheet on *Teenage Pregnancy, Birth, and Abortion* that provides numerous statistics proving that teenage pregnancy is an endemic

public health issue in the United States despite the decline in pregnancies, births, and abortion rates over the past decade.

NEW ANALYSES

Many articles in this issue of the *SIECUS Report* also provide new analyses on a number of important subjects.

Carol Cassell, the director of Critical Pathways in Albuquerque, NM, examines the causes and consequences of parenthood and school achievement on both the teenage mother and her children in her article “Let It Shine: Promoting School Success and Life Aspirations to Prevent School-Age Parenthood.” She also provides recommendations for preventing adolescent childbearing through programs that help young people overcome obstacles to school success and offer support for their life goals.

Next, Stacy Weibley, *SIECUS* senior public policy associate, writes in her article “States Implement ‘Safe Surrender’ Laws for People Who Give Up Their Babies” that never has the media brought to our attention as it has in recent years the number of infants abandoned by distraught parents, many of them children themselves. She explains how this publicity has created a wave of laws that allows troubled parents to safely and anonymously surrender their child to a third party.

Then, Tracy Weitz, project director for the Center for Reproductive Health, Research, and Policy at the University of California at San Francisco, writes in her article “Asian Pacific Islander Subpopulations: A True Look at Teen Pregnancy” that Asian Pacific Islander (API) subpopulations are often ignored by public health campaigns, policymakers, and community services programs. She writes about her organization’s collaborative project which informs policymakers of the need to provide resources to support teen pregnancy prevention efforts in the API subpopulation communities.

Next, Jodie Levin-Epstein, senior policy analyst on reproductive health at the Center for Law and Social Policy (CLASP) in Washington, DC, writes about the reauthorization of welfare reform in Washington. In her article, she urges legislators involved in the reauthorization process of the TANF program—Temporary Assistance to Needy Families—to support proven teenage pregnancy-prevention programs and to take a serious look at what’s wrong with the restrictive

abstinence-only-until-marriage education currently funded by the federal government.

Finally, Assata Zerai, assistant professor in the Sociology Department, and Rae Banks, assistant professor in African American Studies, both at Syracuse University in Syracuse, NY, write in their article “African American Mothers and Substance Abuse: Punishment over Treatment?” that African American mothers who are addicted to drugs—particularly crack—are often punished rather than treated for their addictions. The authors propose that the United States must take a serious look at the subject of gender, race, and class subordination if it wants to develop healthful and affirming policies to help these women become substance-free mothers.

PUBLIC POLICIES

President Bush has made no secret in recent months of his support of the federal government’s funding for abstinence-only-until-marriage education programs that do little to educate teenagers about pregnancy prevention.

As readers will see in the article “Bush Administration Releases 2003 Budget Proposal” by Bill Smith, SIECUS public policy director, the President’s main goals are the promotion of marriage regardless of circumstances and an insistence upon abstinence for everyone else.

To provide an alternative to abstinence-only-until-marriage education, three members of the U.S. Congress—Reps. Barbara Lee (D-CA), Lynn Woolsey (D-CA), and James Greenwood (R-PA)—are the lead sponsors of the Family Life Education Act (HR3469), which proposes allocation of \$100 million per year to sexuality education programs that teach scientifically sound programs that include both abstinence and contraception.

Such a law will help to reduce unwanted pregnancies, unwanted births, and abortions through information and education.

MORE THAN PREGNANCY

As we developed this issue of the *SIECUS Report*, we decided to broaden its focus to include more than pregnancy issues, and, therefore, call it “Current Issues Relating to Pregnancy and Parenting.”

As with so many issues relating to sexuality, discussions are not simple or easy. This *SIECUS Report* again proves that point. The issue of pregnancy brings up other important subjects such as adoption, abandonment, insurance, drug rehabilitation, and more.

We hope this *SIECUS Report* serves as a starting point for thoughtful discussions on these and other related subjects.

“TRAINING OF TRAINERS” SCHEDULED FOR JULY 30-AUGUST 2

Planned Parenthood Federation of America’s *Training of Trainers II (TOT II)* is scheduled for July 30 to August 2 in San Francisco, CA. It is designed for experienced trainers who want to improve their skills. It will include intensive work on understanding training design, refining platform skills, examining trainer style, and improving group facilitation and group processes.

For more information: Glenn Northern, Planned Parenthood Federation of America, 1782 Massachusetts Avenue, N.W., Washington, DC 20036. Phone: 202/973-4851. Fax: 202/296-3242. E-mail: glenn.northern@ppfa.org
Web site: <http://www.ppfa.org>

CRITICAL ISSUES
ABOUT PREGNANCY AND PARENTING

T a m a r a K r e i n i n , M . H . S . A .

I came into the field of sexual health through my work on adolescent pregnancy-prevention programs, and, like everyone else in this field, I have been pleased to see the teen pregnancy and birth rates drop in recent years. Many factors have likely influenced such declines, including fewer teens engaging in sexual intercourse and more teens using condoms and other contraceptive methods.

One factor that is often overlooked is the impact of the economy on teen childbearing. Carol Cassell, who directs the consulting firm Critical Pathways in Albuquerque, NM, points to studies showing the economic reasons teens become parents. These factors include a lack of confidence in the future, limited opportunities, and the perception that they are destined for a life without economic security.

ECONOMIC VARIABLES

I, like many of my colleagues, believe that the strong economy of the late 1990s was in many ways responsible for the reduction in teen pregnancies and births.

As our economy falters and the future seems less certain, we must thoroughly examine the relationship between adolescent childbearing and socio-economic variables such as poverty, race/ethnicity, class, opportunities for academic achievement, and the possibilities of a secure financial future.

In examining these issues, it is important to realize that adolescent pregnancy does not affect all communities in the same way. For example, while African American teens have experienced the greatest recent decline in pregnancy rates, rates among Latina teens have not declined as significantly.

SUPPORT FOR TEEN PARENTS

The need to look at race/ethnicity, poverty, and class together is particularly apparent in light of upcoming debates in Washington over TANF funding. Federal and state rules for TANF—officially known as Temporary Assistance for Needy Families—affect the ability of teen mothers to receive the support they need to finish their education, find employment, and delay repeat pregnancies.

Young people growing up in poverty need to possess not just average but above-average psychological resources and strengths to avoid becoming involved in a teen

pregnancy. It is our job as advocates, educators, and caring adults to ensure our youth find such resources. TANF-funded educational programs, as they are currently conceived, may not be the way to reach this goal.

PROVEN PREVENTION STRATEGIES

Research has proven that teen pregnancy-prevention initiatives that incorporate aspects of youth development programs and include information about sexuality can help break the cycle of adolescent pregnancy, childbearing, and poverty. Yet the federal government continues to spend its welfare dollars on unproven abstinence-only-until-marriage programs and a host of other initiatives designed to decrease the number of “out-of-wedlock” pregnancies.

Instead, we need to support our young people and their families and provide them with culturally appropriate prevention programs that implement proven strategies to reduce teen pregnancy.

NUMEROUS POLICIES

With the reauthorization of TANF funding scheduled for debate in Congress over the next few months, many important issues related to pregnancy and parenting are likely to receive attention. For example, in addition to the welfare funding dedicated to abstinence-only-until-marriage education, the federal government is putting aside \$300 million of this money for programs that promote marriage.

Supporters of this program point to research that suggests children in two-parent families are less likely to live in poverty as the reason that marriage is vital. It is short-sighted, however, to believe that marriage in and of itself is a cure for poverty. And in funding such programs the federal government seems to be making a broader statement about the ideal family structure.

TANF programs are not the only place where federal and state policies weigh in on issues such as what constitutes a family, who can be a parent, and how pregnant women are treated. In recent years, states have implemented policies that restrict the opportunities for gays and lesbians to become parents, limit minors’ access to prenatal care, and punish rather than treat pregnant women who use drugs.

A NEW VISION OF HOMOSEXUAL PARENTS

Recently, comedienne and television talk show host Rosie O'Donnell challenged one such policy and, in so doing, challenged our society to reconsider our vision of an ideal parent. O'Donnell publicly stated that she is gay and that she and her same-sex partner of four years are raising three children together. O'Donnell made the decision to come out to draw attention to a same-sex Florida couple who is taking the state to court after it denied their right to adopt one of five foster children they have raised.

In her first televised interview on the subject, O'Donnell articulated to ABC commentator Diane Sawyer what gay rights advocates have been saying for years—that children thrive in homes with parents who love them and love each other, regardless of the parents' gender or sexual orientation. Throughout the interview, O'Donnell compared the loving environment in which she is raising her children to her own difficult childhood in a heterosexual household. She pointed out that sexual orientation is not related to the ability to be a good parent.

O'Donnell acknowledges that in today's society the

children of gay parents face unique challenges but that these challenges are based on societal pressure and intolerance. The solution, therefore, is not to prevent gays and lesbians from becoming parents but to encourage acceptance for all kinds of families.

It took courage for Rosie O'Donnell to call attention to her personal life knowing that some of her fans will not approve and that it may affect her popularity. However, she chose to take this risk because she felt she could put a familiar face onto an unfamiliar concept and hopefully change how this country envisions gay parents.

CHALLENGES FOR THE FUTURE

I have spent most of my 20-year career as an advocate for young people, and I feel that addressing these issues of pregnancy and parenting is vital for the future of our youth.

While we may have made progress in some areas, such as broader acceptance of homosexual parents and declines in the adolescent pregnancy and birth rates, we cannot become complacent. We must create policies based on research rather than ideology and design programs that promote healthy families.

IN THEIR OWN RIGHT IS NEW REPORT ADDRESSING SEXUAL, REPRODUCTIVE HEALTH NEEDS OF AMERICAN MEN

In Their Own Right: Addressing the Sexual and Reproductive Health Needs of American Men is a just-released report from The Alan Guttmacher Institute (AGI) indicating that men lack essential information, access to important services, and, in many cases, even awareness that they have sexual and reproductive health needs of their own.

“In treating major public health problems such as unintended pregnancy and sexually transmitted diseases primarily as women's issues, we as a country have been fighting with one hand tied behind our back,” said Sara Seims, AGI president and CEO. “In order to take the next steps toward building a healthier society, we must pay more attention to men, who have sexual and reproductive health needs in their own right, as well as in their roles as partners and fathers.”

Many of the study findings on men mirror what previous studies have found for women. On nearly every indicator—including age at first intercourse, marriage and divorce rates, early fatherhood and living apart from their biological children, rates of sexually transmitted disease (STD) infection, and health insurance coverage—poor men fare worse than better-off men, and minority men fare worse than White men. The report concludes that helping men obtain the sexual and reproductive health information and services they need to protect their own health and well-being also should result in lower levels of STDs, fewer unwanted pregnancies and births, and better parenting.

“Our findings make it clear that in order to promote healthy relationships, we need to go beyond existing policies and programs and pay attention to the importance of information, counseling and services—for men and women. What increasingly is seen as good for men in their own right should also ultimately benefit men and women as individuals, couples, their families and society as a whole,” said Dr. Seims.

For more information: The Alan Guttmacher Institute, 120 Wall Street, New York, NY 10005. Phone: 212/248-1111. E-mail: info@guttmacher.org Web site: www.agi-usa.org

LET IT SHINE: PROMOTING SCHOOL SUCCESS, LIFE ASPIRATIONS TO PREVENT SCHOOL-AGE PARENTHOOD

Carol Cassell, Ph.D.
Director, Critical Pathways
Albuquerque, NM

Although it is difficult to untangle the pathway of adolescent parenthood from the intricate web of economic, cultural, and social forces that influence the life course of an adolescent, it is abundantly clear that the factors influencing a teenager at risk for pregnancy intersect at the crossroads of poverty and academic achievement. Of course, not all pregnancies or school academic problems lead to adolescent parenthood or to dropping out of school. Still, there is mounting evidence that these problems share common roots and consequences, and often a student with one of these problems will be a candidate for the other.

School dropout problems and school-age parenthood have each been the focus of a variety of prevention efforts; however, the connecting link between poverty, adolescent pregnancy, and lack of academic achievement is rarely addressed by coordinated school and community intervention programs. Given the antecedents of pregnancy and school failure, programs need to combine efforts and pay more attention to increasing a teenager's motivation to avoid pregnancy and stay in school. And, conversely, for young women and men to have the motivation to avoid involvement in a pregnancy and to succeed in school, they must have concrete options for their futures.

The Connection between Lack of School Success and Adolescent Pregnancy and Childbearing

***“If adults are meaning for teens to have babies,
they’re doing a great job.”***

(California Teenager, 1998)

This article discusses the connections between school success and school-age parenthood, revisits the context of adolescent pregnancy and parenthood, examines the causes and consequences of parenthood and school achievement on both the teenage mother and her children, and provides recommendations for preventing adolescent childbearing through programs that help young people overcome obstacles to school success and provide support for their life aspirations.

Recent studies have found that two critical problems many adolescents face—pregnancy and school failure—are

intertwined. This becomes apparent in the research uncovering the direct correlation between youth that experience school failure and drop out of school and youth at risk for being involved in a pregnancy and school-age parenthood.¹

Exploring the relationship of academic ability to the potential for teenage parenthood, the *High School and Beyond Study* found that sophomores (both females and males) with low academic ability were twice as likely to become parents by their senior year as those students with high academic ability. Looking at skill levels, the *National Longitudinal Survey of Youth* found that teen girls in the bottom 20 percent of basic reading and math skills were five times more likely to become mothers over a two-year high school period than those in the top 20 percent.²

Although it is common wisdom that the primary reason girls drop out of school is because they are pregnant, recent analyses show that many teen mothers dropped out of school before they got pregnant. A survey of never-married women in their twenties showed that among those who became both pregnant and school dropouts, 61 percent of the pregnancies occurred after dropping out of school; another survey of very young welfare recipient mothers showed that 20 percent were already out of school before they conceived.³

Compounding the problem is that pregnant teens and teen mothers have poor school attendance and experience low levels of academic success. In reviews of antecedents of high-risk behavior related to adolescent pregnancy, students at risk include those with low expectations for school achievement who do not engage in school activities and those with parents who are not supportive or not involved with their child's academic experiences.⁴ Moreover, studies show that a sense of limited future educational and job opportunities contribute to a lack of motivation to either practice or use contraceptives effectively.⁵

The link between students' capability to be successful in school and their capacity to avoid school-age pregnancy is further reinforced by the *National Study of Adolescent Health (ADD Health)* report. The researchers found that adolescents stand a better chance of avoiding risky behavior—including postponing sexual intercourse and pregnancy—when they experience and express strong connections to their school.⁶

WHO ARE THE MOTHERS?

Although recent statistics demonstrate a decline in both pregnancy and childbearing, the problem of teen pregnancy and parenthood is still of great magnitude. Approximately four in 10 girls become pregnant each year, and there is approximately one birth for every 20 women between 15 and 19 years of age. While most pregnant teens are 18 or 19 years old, approximately 40 percent are 17 or younger.⁷ Of the four million babies born each year, one out of eight are born to a teenager, one out of four are born to a mother with less than a high school education, almost one out three to a mother who lives in poverty, and one out of four to an unmarried mother.⁸

While the current decline in rates is encouraging, a continued decline of adolescent pregnancy and birth rates is not certain. Although the teen birth rate has decreased, the number of births to teens has increased, reflecting an overall increase in the U.S. teen population. Between 2000 and 2010, the number of girls 15 to 19 years of age is estimated to increase by nearly 10 percent. Unless birth rates continue to decrease, the population increase of teen girls may very well mean an increase in teen pregnancies and births.⁹

Revisiting the Context of Adolescent Pregnancy

“Adolescent health is influenced not only by the strengths and vulnerabilities of individual adolescents but also by the character of the setting in which they lead their lives.”

(ADD Health, 1998)

Understanding the context of teen pregnancy means understanding the impact of pregnancy upon the life of an individual girl and her family. Although the terms *adolescent pregnancy*, *teenage pregnancy*, and *school-aged parenthood* are usually interchangeably applied to pregnancies among young women in the teen years, the reality is not interchangeable. Pregnancy has vastly different implications for a girl in the developmental stage of early adolescence than for a young woman on the cusp of adulthood.

The experience of pregnancy and the outcomes of childbearing are not the same for the 18- or 19-year-old high school graduate who is married, planning marriage, working, or attending college and for the 13- or 14-year-old student or school dropout. In addition to the economic consequence, a vast majority of young girls under 17 years of age, as appropriate to their development, are biologically and psychologically too immature to raise a child.

Contributing to the cycle of pregnancy, childbearing, and poverty is the way in which adolescents resolve their pregnancies. Young women who come from advantaged

families generally have abortions. Childbearing, on the other hand, is concentrated among teenagers who are poor and low income: more than 80 percent of young women who give birth are either poor or low income.¹⁰

WHO ARE THE FATHERS?

There is little information about the young men who father children, an issue complicated by the fact that some of the fathers are out of school or past high school age.

Like teenage mothers, the males who father their children tend to be poor, are often continuing an intergenerational practice (many are from families who experienced teenage childbearing), live in low-income communities, and have low educational achievement. In addition, like early motherhood, early fatherhood appears to have negative consequences of poor school attendance and dropping out of school. Because they obtain less education, these fathers are more likely unemployed, and have lower long-term employment and lower earnings than their counterparts who delay parenthood.¹¹

THE UNINTENDED PREGNANCY

A critical factor contributing to the complexity of teen pregnancy is that a vast majority of these pregnancies—approximately 85 percent—are not planned or intended. While many teenage pregnancies occur despite the use of contraception, an appreciable portion are the result of a confusing and conflicting set of beliefs and behaviors, from a teen’s ambivalence about pregnancy to her lack of capacity to prevent it, to her inability to make clear decisions and then act on those decisions: to abstain from sexual intercourse, to be sexually active, or to always use contraception.¹²

Although a majority of pregnant teenagers report that they did not seek pregnancy or “intend” to get pregnant, many of these young women didn’t take actions to prevent pregnancy, either. To underscore the behavioral implications of unintended pregnancy, it is not uncommon to hear teenage girls who are pregnant unintentionally blame it on “bad luck” or “being swept away” or “something that just happened.”¹³

SEXUAL ABUSE, RAPE, AND PREGNANCY

Although the scientific data is sparse, those experienced in working with sexual abuse and rape and those experienced in working with pregnant teens are well aware of the connection between sexual abuse in childhood and pregnancy in adolescence.¹⁴

It appears that a traumatic underlying cause of teen pregnancy, for many young teenage girls, is that sexual intercourse was involuntary and coerced. The younger a

sexually experienced teenage girl is, the more likely she is to have had involuntary sexual intercourse. For example, 74 percent of young women under 13 who have had sexual intercourse reported having had it involuntarily, as compared to 40 percent of girls 15 and under.¹⁵

A study conducted by the An Ounce of Prevention Fund found that, of the teens who experienced a first pregnancy by age 16, 60 percent reported that they had been forced into an unwanted sexual experience. And a study of teen mothers in Washington State indicated that two thirds were victims of molestation, rape, or attempted rape before their first pregnancy. Forty-four percent of the girls had been raped by age 13.¹⁶

WANTED OR EXPECTED ADOLESCENT CHILDBEARING

Despite realities to the contrary, adolescent parenthood is not always considered a negative among some disadvantaged young women. Having a baby enables the adolescent to enter and become part of a community of young mothers. Parenthood is often the most available marker of success and social power in the face of an otherwise limited life. For these teen mothers, pregnancy and childbirth may be seen as the ticket to achieving an adult status and a sense of independence.¹⁷

Girls growing up in poverty need to possess not just average but above-average psychological resources and strengths to avoid becoming a pregnant teen.

Not only is it a challenge for young women growing up in poor families to achieve educational competencies and use them effectively, but success in these avenues may uproot them from their families, peers, and neighborhoods. If teenage childbearing is generally acceptable in her family and in her community, it is difficult for a young woman to go against the cultural grain.

For an ambitious young woman, the comfort of belonging is often altered when her education or occupational skills go beyond what her family accepts; and more importantly, what her friends, and especially her male partner, approve of. In a community of high teen pregnancy rates, if a young woman fears being different or isolated from her friends, she may come to believe that having a baby is “no big deal.”¹⁸

CHALLENGES TO SCHOOL SUCCESS

Pregnancy and parenting pose major challenges to full-time school attendance. Responsibilities of child-rearing, lack of support from families and peers, and their own immaturity add up to significant barriers for teen parents to stay in school. As a result, adolescent mothers drop out at a staggering rate, and those who have already dropped out are less likely to

return to school. Adding to the problem of teen mothers' lack of education is the fact that about 25 percent of them dropped out of school before they became pregnant.¹⁹

Only about 30 percent of adolescent mothers earn a high school diploma, compared to 76 percent of those who postpone childbearing.²⁰ Controlling for a wide range of background variables, researchers found that adolescent childbearing alone accounts for more than 40 percent of this difference in graduation rates.²¹

REPEAT CHILDBEARING AND SCHOOL FAILURE

The need to prevent teen pregnancy—primary prevention—has garnered public attention and support. Although the numbers are significant, the issue of secondary prevention—repeat pregnancies among adolescent mothers—receives less attention.²²

Teen mothers often have short intervals between their first and second births, particularly compared with older mothers. Some 19 percent of adolescents who become mothers at ages 15 through 17, and 25 percent of those who were 18 to 19 when they first gave birth, have a second child within two years.²³ Having a second child within a year or so of the first is a significant barrier to completing high school. While a young woman may be able to overcome the life-course transition of becoming a mother if she has one child—and still finish school and obtain an entry-level job—these tasks become considerably more difficult if she has more than one child.²⁴

Overall, most teen mothers obtain less education and have lower future family incomes than young women who delay motherhood. Teen mothers are more likely than women who do not have a child before 20 years of age to be poor later in their lives: some 28 percent of women who became mothers as teenagers are poor in their twenties and early thirties.²⁵ Many of these poor women are not poor because they had a baby; they were already poor, but having a baby made their situation worse. If they had delayed their first birth to 20 years of age or older, the numbers of those poor would be reduced to an estimated 16 percent.²⁶

On a positive note, programs that enhance academic outcomes for adolescent mothers and make special efforts to allow adolescent mothers to stay in school and graduate can have a positive effect on breaking the cycle of school-age parenthood and school failure. The National Educational Longitudinal Study confirms that a high-school-age mother's involvement in school activities after the birth of her first child, or earning a high school diploma or a GED, were strongly associated with postponing a second pregnancy.²⁷

The most significant negative consequences of teen childbearing are those burdens shouldered by the children themselves, caught in the crossfire of school failure and too-

**The Cycle of School Failure
for Children of Adolescent Mothers**

“The odds are stacked against the offspring of adolescent mothers from the moment they enter the world.”

(Rebecca Maynard, Kids Having Kids)

early parenthood. The daughters of a teen mother are 22 percent more likely to become teen mothers themselves, and compared to those born to older mothers, young adult children of teenage mothers are 30 percent more likely to neither work nor go to school.²⁸

THE REPORT CARD

Throughout their school years, the children of adolescent mothers do much worse than the children of older mothers.

They are two to three times less likely to be rated “excellent” by their teachers and 50 percent more likely to repeat a grade. And they perform significantly worse on tests of their cognitive development, even after differences in measurable background factors have been screened out.²⁶

Rather than declining over time, the educational deficits of children born to adolescent mothers appear to accumulate, causing the child to fall further behind in school as he or she grows older. Only 77 percent of the children of adolescent mothers earn their high school diplomas compared with 89 percent of a comparison group. More than half of the difference is due to these children becoming adolescent parents.²⁹

SINGLE MOM HOUSEHOLDS

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 the childhood with only one parent. Being raised by one parent—one who is a young teen mother—may cast a long shadow over the lives of many of these children. Compared to their peers growing up with two parents, those who grow up in poor, single-parent homes 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 out of school and out of work.³⁰ Even after adjusting for various social and economic differences, children who grow up in single-parent homes have lower grade point averages, lower college aspirations, and poorer school attendance records.³¹

CONCLUSION

Adolescent childbearing and school failure not only have immense lifetime consequences for both individuals and their families, but they are also a major burden on school and

community resources. Over the last two decades, a substantial body of evidence has been compiled suggesting that motivating young people to delay childbearing into their twenties and reducing the drop-out rates of pregnant and parenting adolescents are worthy public policy goals.

While there is a wide array of governmental and private sector programs directed at preventing school dropouts and at preventing teen pregnancy, their effectiveness is often reduced because each operates within a narrowly defined orbit. As a result, they fail to address the complexity of the problems that adolescents and their families deal with every single day. In order to make a significant impact on social and economic disadvantage, agencies and organizations need to adapt an eye-on-the-prize strategy.

Even though turf issues are real and have to be realistically dealt with, efforts made to prevent pregnancy and those focused on helping adolescents stay in school can achieve both goals by coordinating programs and resources.

Providing an Element of Hope

“This little light of mine, this little light of mine, let it shine, let it shine, let it shine!”

(Fannie Lou Hamer, civil rights activist)

Although this coordinated approach may break new ground in many communities, there are effective models to build upon such as The Children’s Aid Society—Carrera Program and The Teen Outreach Program (TOP). There are also programs such as The Community Coalition Partnership Programs for the Prevention of Teen Pregnancy, which appear to be promising.³²

Changing old patterns of providing services and programs to youth and their families does present many challenges. Yet it is encouraging to keep in mind that academic difficulties need only be surmounted through high school to minimize the drop-out risk, and pregnancy need only to be delayed until adulthood to have an a positive impact on young people’s lives.

Clearly, a lack of confidence in the future, a sense of limited opportunities, and perception of a life without economic security differentiates school-age parents from those who delay sexual intercourse or use contraceptives consistently.

As many teens growing up in poverty or from working-class poor families do not believe that they have educational or career opportunities, becoming pregnant does not cause the fear of forfeited opportunities that a middle-class teenager perceives.

They often feel they have nothing to lose by becoming a parent; no door will be closed because they believe that no

doors are open to them anyway. The belief that there is a positive, attainable future worth planning and preparing for—that there is have a future worth having—is the most powerful element in a young person’s decision to avoid pregnancy and stay in school.

Based on what we know about the antecedents of school failure and school-age parenthood, communities and schools should engage young people in safe, structured fun and enriching activities focused on building self worth and self confidence. Communities can support a wide variety of activities that allow youth to succeed in school: academic, sports, and arts programs; after-school programs such as tutoring and field trips; and mentoring and community service responsibilities.

Simply put, it is adults who pave the way for youth to become successful. We can offer opportunities for young people to be an integral part of school and community life, encourage them to aspire to a rewarding, joyful future, and provide the resources to insure the achievement of their hopes and dreams.

It is imperative that we continue to fund and evaluate programs, such as the ones mentioned above, that combine work on teen pregnancy prevention, youth development, sexuality education, and reproductive health care.

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THE SAFE MOTHERHOOD INITIATIVE

Every minute of every day, somewhere in the world and most often in a developing nation, a woman dies from complications related to pregnancy or childbirth.

For each woman who dies, many more suffer damage to their health. In addition to maternal deaths, each year over 15 million women experience severe pregnancy-related complications which lead to long-term illness or disability.

These statistics are one of the most stark indicators of the widening gap between rich and poor—both within and between countries. For each woman who dies of maternal causes in the developed world, 99 will die in the developing world. A woman in Afghanistan or Sierra Leone has a one in seven risk of death during her reproductive years; in Peru it is one in 85, in China one in 400 and in Norway one in 7,300.

The greatest tragedy is that these approximately 600,000 maternal deaths and over 50 million cases of disability that occur each year are largely preventable. They are caused by social injustices such as early marriage and violence, by poverty which leads to malnourishment and anemia, by undesired fertility, and by lack of access to adequate maternity services and to safe, legal abortion.

A coalition of the world’s leaders in maternal and child health has launched the global Safe Motherhood Initiative. The Safe Motherhood Inter-Agency Group includes the United Nations Population Fund, the United Nations Children’s Fund, the International Confederation of Midwives, the International Federation of Gynecology and Obstetrics, the International Planned Parenthood Federation, the Population Council, the Regional Prevention of Maternal Mortality Network (Africa), the Safe Motherhood Network of Nepal, the World Bank, and the World Health Organization. Family Care International serves as the secretariat.

For more information: Family Care International, Secretariat, Inter-Agency Group for Safe Motherhood, 588 Broadway, Suite 503, New York, NY 10012. Phone: 212/941-5300. E-mail: smi10@familycareintl.org Web site: www.smi-usa.org

STATES IMPLEMENT 'SAFE SURRENDER' LAWS FOR PEOPLE WHO GIVE UP THEIR BABIES

Stacy Weibley, M.A.
SIECUS Senior Public Policy Associate

Although media reports of abandoned babies appear on the rise, experts caution that this is not necessarily evidence that the numbers have dramatically increased. In fact, there are no official statistics although the federal government estimates the number of babies left in hospitals by women who are HIV-positive or addicted to drugs is approximately 20,000 a year.¹ These numbers clearly fail, however, to provide an accurate and full picture. And state-specific statistics are rare.

NEW WAVE OF LAWS

The spate of high-profile abandoned babies has incited a wave of state “safe haven” or “safe surrender” laws that allow troubled parents to safely and anonymously surrender their child to a third party. Thirty-five states currently have such laws. (See chart on page 34 for more specific information.)

Sponsors of safe haven legislation argue that prosecuting and punishing parents for abandoning their babies does not deter them from taking such desperate measures. They also hope that the legislation will save infants who may otherwise be left to die.

Unfortunately, little research exists on the abandonment phenomenon, and there is no evidence that those at risk will avail themselves of the mechanisms provided for “safe surrenders.”

In the face of such ambiguity, fierce debate is currently being sparked by those who argue that such “safe haven” laws are ill-conceived and harmful, those who contend that the potential to save even one life is paramount, and those who view these laws as a superficial approach to broader societal problems.

SAFETY AND ANONYMITY

Texas was the first state to enact safe surrender legislation, in September 1999, after 13 babies were found abandoned in the Houston area during a 10-month period.² Other states soon scrambled to enact similar legislation, with 35 states now having passed such laws, each with unique stipulations attached.

Crafting such legislation proves difficult, given the lack of information about key issues. We know very little, for example, about who abandons their babies and under what circumstances.

“We don’t really know who these women are. There just isn’t any good data or research on this,” notes Judith Hay, a

spokeswoman for Harris County Child Protective Services in Houston.³

Individuals usually make decisions to abandon newborns in part out of fear that others will discover the pregnancy. In response to this fear, safe haven laws are designed to explicitly or implicitly provide an anonymous way for parents to relinquish their babies. Only two states require havens to actively seek the identity of the babies’ parents, and 12 states specifically provide anonymity.⁴

Experience has also shown that individuals usually make decisions spontaneously and in situations of crisis soon after the birth of an unexpected or unintended baby. As a result, state laws usually restrict the age of babies that individuals can legally relinquish. The most commonly designated lapse of time between birth and surrender is 72 hours.⁵

Protection for parents who surrender their babies is another obvious critical component of safe haven laws. As a result, each state provides a legal alternative for the surrender of an unharmed baby. Twenty-one states offer immunity from prosecution or specify that the act of safely surrendering a child does not constitute abuse or neglect. Fourteen states provide parents with an affirmative defense to prosecution for abandonment.⁶

Under Texas law, for example, “a mother who abandons her child is still subject to prosecution. However, if prosecuted, the judge will instruct the jury that they must acquit her if she has followed the guidelines in the law,” said Marie Dixon, a spokeswoman for U.S. Representative Sheila Jackson Lee (D-TX). “We’re hoping that if prosecutors know this defense is out there, they won’t prosecute,” she said.⁷

NEGOTIATING FINER POINTS

Safety and anonymity seem to mark the end of any façade of consistency among state laws regarding abandoned babies. Discrepancies and controversy increasingly emerge when legislators negotiate finer points.

One of the first points is the issue of fraud. When debating a New Hampshire law, state Representative Charles LaVerdiere (D) asked, “What if the person who is dropping off the child is not the mother? There are a million ‘what ifs’ here.”⁸

To prevent imposters from relinquishing babies, approximately half of all state laws authorize only parents to surrender a baby to a safe haven. An additional 12 state laws

allow a person designated by the parent to assume this role. Five states, however, do not specify who may legally relinquish a baby, fueling cries of concern and raising the question of how to verify, when identification is not required, that parents truly wish to surrender their child.⁹

Another key point is defining a “safe haven” and ensuring appropriate care. The most common state-designated haven, or “emergency service provider,” is a hospital. Yet many states have approved other people and entities, including child welfare agencies, churches, hospitals, and fire stations.

Twenty-eight states require safe havens to perform any act necessary to protect the health and safety of a relinquished baby.

Yet, only nine states provide for the reimbursement of costs associated with these services, raising issues of sustainability in the event that such safe havens are frequently utilized.¹⁰

One final point of contention lies in the creation of mechanisms for parents to reclaim custody of their children. The very intent of the state laws is to target parents who spontaneously decide to relinquish their children. Thus, it should not be surprising that some parents may want to reclaim their babies after they have given the situation greater thought.

Only 16 states have such procedures. In such cases, the option to reclaim parental rights often has a time limit and requires that parents prove maternity or paternity with a blood or tissue test. In all cases, the court or child welfare agency must make a placement decision based on the best interests of the child.¹¹

RESPONDING TO OPPOSITION

While “safe haven” legislation has found support with some anti-abortion and reproductive health groups, legislators have blocked passage in some states, including Georgia, where one legislator called the proposal “abortion without death.”¹²

Ultimately, many opponents are seeking greater accountability. Rep. Bill Graves (R) of the Oklahoma House of Representatives echoed these sentiments when he referred to “safe haven” laws as a means for “institutionalizing irresponsibility.” Senator Ed Pugh (R) of the Kansas Senate offered, “We’re suggesting that people leave babies at police and fire stations. We’ve got the ultimate disposable society then, haven’t we?”¹³

Other opponents base their claims on arguments that such legislation denies paternal rights, jeopardizes the adoption process by failing to require medical histories, and encourages abandonment.

Some state legislatures have attempted to address these issues through additional provisions. For example, in an effort to address concerns about the potential to undermine paternal rights, nine states require the publication of the relinquishments in local newspapers with information about how parents can assert a claim of paternal rights. Three states take this a step further and require a reasonable search for the non-relinquishing parent, be it the mother or father.¹⁴

In an effort to provide adoptive parents, and adoptees themselves, with a more complete history, some states attempt to collect confidential information from relinquishers,

FEDERAL RESOLUTION TO COLLECT INFORMATION ON BABIES ABANDONED IN PUBLIC PLACES

A federal resolution (HR 465) proposing that local, state, and federal governments should collect and disseminate statistics on the number of babies abandoned in public places was passed in April 2000. Resolutions, however, merely express principles and opinions and are non-binding.

Several additional safe haven bills that focus on research and funding were also introduced on the federal level, but none have passed. For example:

- U.S. Rep. Melissa Hart (R-PA) introduced HR 2018, which would have authorized states to use welfare funds to support the promotion of state safe haven programs.
- U.S. Rep. Phil English (R-PA) introduced an amendment in a still-pending bill titled the Promoting Safe and Stable Families Act, which would have allowed states to fund state safe haven programs.
- U.S. Rep. Sheila Jackson Lee (D-TX) has reintroduced the Baby Abandonment Prevention Act of 2000, which would create a task force in the Bureau of Justice Statistics to gather information about the incidence of baby abandonment and then report these findings to Congress. This bill is currently under consideration.

—Katie Pollock, Child Welfare League of America

although no states require this information. In fact, only 20 state laws provide procedures for “safe haven” personnel to request medical history information, and fewer states seek other identifying information, such as ethnic heritage or family identity.¹⁵

SEEKING BROADER CHANGE

There is a general lack of public awareness about safe surrender laws throughout the nation. Fifteen states have sought to address this issue by developing public information campaigns, including the creation of toll-free hotlines, written educational materials, and public service announcements.

Only two states, however, have made provisions for funding such campaigns and only one of these states actually allocates funds.¹⁶

Many advocates suggest that real change can only occur if we seek long-term solutions by collecting information. Eight state laws recognize this need and require the collection of data. Some states simply require the documentation of the number of babies relinquished.

Other states must track a variety of information, including the number of completed medical questionnaires, the number of parents reclaiming their children, the outcome of placement proceedings, and the number of relinquished babies who show signs of abuse or neglect.¹⁷

While any attempt to gain a better understanding of these issues will expedite long-term solutions, some wonder if efforts would be better spent on prevention programs. Indeed, better prevention programs could render all of the above issues moot.

Mike McGee of Planned Parenthood Federation of America believes this is precisely the point. According to him, “The real problem is a society that sends powerful but mixed messages: ‘Sex is glorious. Sex is shameful.’ The result is pregnant teens who can’t even acknowledge that they are pregnant. A [“safe haven”] program...may help some girls, but it’s a band-aid after the fact.”¹⁸

Dr. Donald Marzzo, associate medical director of a non-profit agency that provides counseling services to pregnant women, concurs, suggesting that funds might be better directed “to heighten awareness of contraception as well as emergency contraception to prevent these unwanted pregnancies in the first place.”¹⁹

What could have helped these parents avoid unintended pregnancy? How could these individuals been made aware of other options? What could have helped them feel more connected and ultimately, less compelled to keep their pregnancies a secret? For many, the answer is clear: prevention through education and outreach.

CONCLUSION

The states’ “safe surrender” laws are extremely varied, as illustrated in this article. We have perhaps been unable to reach a

clear consensus on this subject because our eyes are more clearly focused on the glaring failure to address the need for prevention.

We must recognize that a willingness to engage in a discussion about the reality of many people’s lives will save lives. We must also ensure that all people are provided with the information they need—about basic reproductive health, decision-making, contraception, and self-esteem—so that they fully realize every opportunity to make responsible decisions.

It is incumbent upon advocates of reproductive and sexual health to make this connection between prevention and education, to courageously bring this dialogue to the forefront, and to insist on change.

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ASIAN PACIFIC ISLANDER SUBPOPULATIONS: A TRUE LOOK AT TEEN PREGNANCY

Tracy A. Weitz, M.P.A.*

Project Director

National Center of Excellence in Women's Health
Center for Reproductive Health, Research, and Policy
University of California at San Francisco
San Francisco, CA

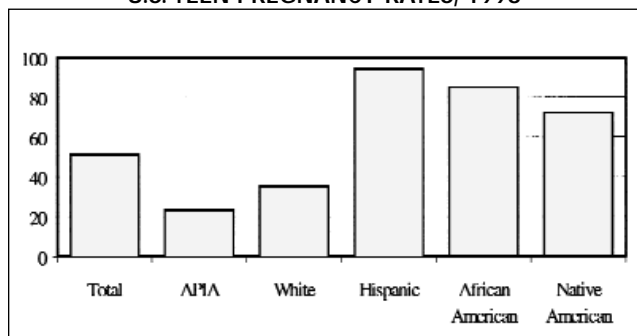
Over the past two decades, there has been a national focus on the issue of teen pregnancy. However, the agenda created to address this important issue has been based on an incomplete understanding of the available data.

The box titled "U.S. Teen Pregnancy Rates, 1998" presents the picture of how teen pregnancy has been constructed as a racial/ethnic issue.¹ The impression given is that teen pregnancy is not a concern for Asians and Pacific Islanders (APIs).

The diversity of the API subpopulations that comprise this aggregate, however, is obscured. As a result, API communities are often ignored by public health campaigns, policymakers, and community services programs working on the critical issue of teen pregnancy prevention.

In 2000, a collaborative project was developed to debunk the myth that adolescent pregnancy is not an issue for the API community and inform policymakers of the need to provide resources to support teen pregnancy-prevention efforts in the API subpopulation communities.

U.S. TEEN PREGNANCY RATES, 1998²



TEEN PREGNANCY AND APIs

Over the past two years, a team comprised of members of the National Center for Excellence in Women's Health at the University of California at San Francisco (USCF), the Center for Reproductive Health, Research, and Policy at USCF, and Asians and Pacific Islanders for Reproductive Health has sought to understand teen pregnancy as an issue that includes API communities.

The project, *Teen Pregnancy among API Communities: The Importance of Understanding Subpopulations*, was funded by The

California Wellness Foundation as part of its Teen Pregnancy Prevention Initiative.

The project has two concentric goals: to include APIs in discussions about teen pregnancy while simultaneously understanding the large context in which the problem of teen pregnancy is situated and constructed.

To meet these goals, the project team has undertaken:

- An analysis of teen births among APIs, using the California birth certificate data
- An analysis of the utilization of California state family planning services provided through the FamilyPACT program
- Interviews with community representatives regarding how they see the issue of teen pregnancy
- Direct work with API youth to understand how they negotiate the issues of teen pregnancy and teen pregnancy prevention
- An analysis of the role of teen pregnancy in welfare reform efforts
- The development of policy recommendations

This article presents highlights from each of these project activities. A full report is available from the UCSF Center for Reproductive Health Research and Policy at www.repro-health.ucsf.edu.

DISAGGREGATION

According to the 2000 Census, approximately 3.8 million APIs currently live in California.³ Although they comprise only four percent of the national population, APIs make up over 11 percent of the population in California, and 36 percent of all APIs living in the United States reside in the state.⁴

By the year 2020, it is estimated that between 7.4 and 8.5 million APIs will live in California.⁵ The Californian API adolescent population (ages 10 through 19) will also increase nearly 45 percent from 1995 to 2005, to roughly 750,000 youths.⁶

The box titled "APIs in California, 2000 Census" presents the distribution of APIs by subpopulation.⁸ Chinese and Filipinos make up the largest majority of APIs, with nearly 27 percent and 25 percent, respectively, followed by

APIs IN CALIFORNIA, 2000 CENSUS⁷

Race/Ethnicity	#	%
Asian	3,697,513	10.9%
Asian Indian	314,819	0.9%
Chinese	980,642	2.9%
Filipino	918,678	2.7%
Japanese	288,854	0.9%
Korean	345,882	1.0%
Vietnamese	447,032	1.3%
Other Asian	401,606	1.2%
Pacific Islander	116,961	0.3%
Native Hawaiian	20,571	0.1%
Guamanian/Chamorro	20,918	0.1%
Samoan	37,498	0.1%
Other Pacific Islander	37,974	0.1%

Vietnamese (12 percent), Korean (9 percent), Asian Indian (8.5 percent) and Japanese (8 percent).⁹

Nearly half of the Filipino population in the United States lives in California,¹⁰ and the state also has the largest Hmong population in the United States at approximately 70,000.¹¹

The API population, however, comprises more than 50 distinct ethnic populations, with large variations in national origin, language, culture, socioeconomic profile, immigration experiences, and levels of acculturation.

Aggregation of the data continues to keep API teen concerns hidden, with limited resources and services addressing their needs. Throughout this project, disaggregation of the data related to teen pregnancy was a major goal.

PROJECT RESULTS

Utilizing the California Birth Certificate Data for years 1989 through 1998, analysis was conducted for 15 subpopulations of APIs: Chinese, Japanese, Korean, Indian, Filipino, Vietnamese, Cambodian, Thai, Laotian, Samoan, Guamanian, Eskimo/Aleut, Hawaiian, and two residual categories for other Asians and other Pacific Islanders.

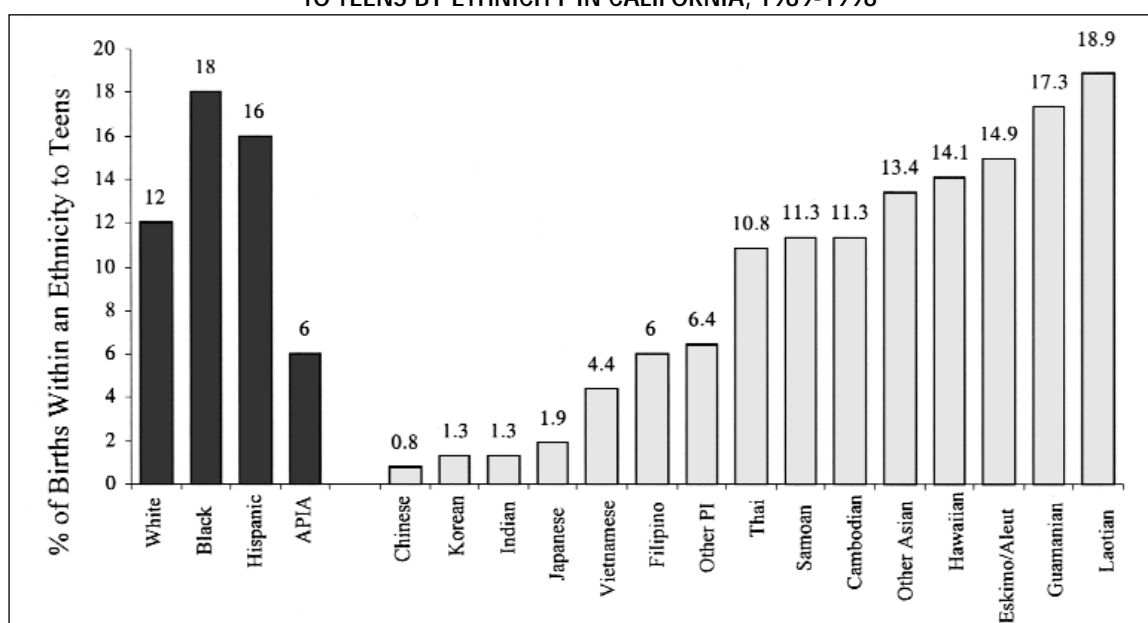
Eight variables were included in the analyses of teen births: ethnicity, marital status, age of baby's mother and father, mother's education level, foreign-born status, health insurance status, use of prenatal care, and zip code of residence.

When disaggregation is taken into account, the teen birth picture for APIs is very different from the picture presented earlier. As an aggregate, fewer than six percent of births to APIs in California are teen births, whereas the proportion for whites is double that figure at 12 percent, for Hispanics 16 percent, and for African Americans 18 percent.

This aggregate figure, however, masks the very high proportion of teen births among certain API subpopulations. In the Laotian community, for example, 19 percent of births are to teen mothers and in the Guamanian community, 17 percent of births are to teen mothers. Among Cambodians and Thais, 11 percent of births are to teen mothers. At the other extreme, less than one percent of Chinese births are to teen mothers, and fewer than two percent of Japanese, Korean, and Indian births are to teens. The Vietnamese and Filipinos are close to the overall average for APIs. Data for the 15 subpopulations for which data is available is in "Percentage of All Births within an Ethnicity to Teens by Ethnicity in California, 1989-1998."

In addition to overall birth data, sub-analyses were

PERCENTAGE OF ALL BIRTHS WITHIN AN ETHNICITY TO TEENS BY ETHNICITY IN CALIFORNIA, 1989-1998



conducted for each subpopulation which include:

- Percentage of births to teens
- Average age of teen mothers
- U.S. and foreign-born status
- Average age difference with father of baby
- Percentage of births to married teens
- Percentage entrance into prenatal care (PNC) in first trimester
- Health insurance coverage for PNC
- State map locating hot spots for teen births

**CALIFORNIA LAOTIAN TEEN BIRTHS,
1989–1998**

Births to teens: 18 percent
Average age: 17.3
Foreign born: 95 percent
Average age difference with partner: 5.2 years
Married: 59 percent
PNC in first trimester: 57 percent
Medi-Cal: 90 percent
Potential target communities: Stockton, Fresno,
Central Sacramento, Moreno Valley

A summary table of results for each population was produced for the project. An example for the Laotian community is in “California Laotian Teen Births, 1989–1998.” Across subpopulations, comparisons allow for the identification of features unique to the subpopulation of interest.

In the case of the Laotian community, it is important to highlight that 59 percent of Laotian girls are married at the time they give birth. This figure is distinctly different from the one included in the national dialogue on teen pregnancy, where 79 percent of births to teen mothers are considered “out-of-wedlock.”¹²

As a result, efforts directed at promoting abstinence-only-until-marriage may not address the needs of teens giving birth within the Laotian community.

Limitations of the analysis. Data is usually reported as pregnancy rates for the population of interest. Pregnancy rates are calculated as the number of pregnancies divided by the population, usually presented as pregnancies per 1,000 women.

To conduct these calculations, three variables are required: number of births to the population, number of abortions to the population, and number of girls in the population. The analysis conducted for this project was only able to calculate the first of these figures—number of births.

There is currently no accurate data for abortions to API subpopulations. California does not collect data on abortions

for any population, thus limiting even the ability to estimate the number for APIs.

The estimate for abortions among the API population at the national level was developed using data from independent periodic surveys of abortion clients and reports to the U.S. Centers for Disease Control and Prevention (CDC) from states that do have abortion reporting requirements (most of which do not collect data specifically for APIs but rather for the category of “other”).

As such, the estimated number of abortions for APIs is not well established. In addition, given that births vary so dramatically across API subpopulations, it is assumed that abortion numbers also vary. As such, utilizing the aggregate estimate for abortions for APIs, even if available, would result in highly problematic calculations for API subpopulations.

Given these limitations, pregnancy rates cannot be calculated for API subpopulation youth. In utilizing the birth certificate data, the project calculates the proportion of all births that are to teens, by subpopulation. A limitation of this methodology is that the results reflect the age structure of the subpopulations. That is, if a group has many young members, as with recent immigrants, then, as a whole, the group will have relatively more births to young women 15 through 19 years of age than to older women, compared to that of a subpopulation with an older age structure.

To construct a teen birth rate that is clean of the age structure of the population, Census data of how many women in each sub-population live in California at the time is required. However, since the API population is rapidly growing, and the increases are uneven among the different ethnicities, the 1990 Census data is obsolete for that purpose.

Utilization of California family planning services provided through the FamilyPACT program. California’s innovative FamilyPACT (Planning, Access, Care, and Treatment) program provides comprehensive family planning services, including STD screening and treatment, pregnancy tests, contraception, and HIV screening and counseling to low-income men and women who are at or below 200 percent of the federal poverty level and who do not have insurance or Medi-Cal (Medicaid) for services.

Most adolescents in California are eligible to receive FamilyPACT services since eligibility is calculated on the basis of personal income rather than family income. Analysis, based on the billing and claims data from the FamilyPACT program, 1997 through 1998, shows that API teen enrollment in the program comprises six percent of total teen enrollment, a relatively smaller proportion than the percentage of API teens in the state population (11 percent).

Unfortunately for the purposes of linking family planning and birth data, the FamilyPACT program does not utilize the same racial/ethnic categories as the birth certificate data. Instead, clients are categorized into three ethnicities: Asian,

Pacific Islander, and Filipino. Clients can further identify by primary language: English, Cantonese, Hmong, Cambodian, Korean, and Vietnamese.

To develop the most complete subpopulation analysis possible within the existing data, these two fields are combined to create nine subpopulations for analysis: Filipino, Pacific Islander, Asian-English-speaking, Cantonese-speaking, Hmong-speaking, Vietnamese-speaking, Cambodian-speaking, Korean-speaking, and other Asian language-speaking.

There are, however, limitations to these classifications. For example, if an English-speaking Chinese teen seeks FamilyPACT services, she will be categorized as “Asian-English-speaking” as would an English-speaking Vietnamese teen, and an English-speaking Cambodian teen.

Thus this data provides challenges to trying to understand family planning utilization by API subpopulations. Despite these limitations, analysis of the FamilyPACT data provides additional insight into the needs of subpopulations of API youth in California at risk for teen pregnancy.

A breakdown of the percentage of API clients served by ethnicity/language grouping is provided in the box titled

API FAMILYPACT CLIENTS	
Ethnicity-Language	API clients
Filipino	42 percent
Asian, English-speaking	29 percent
Pacific Islander	9 percent
Cantonese-speaking	4 percent
Hmong-speaking	4 percent
Other Asian language	4 percent
Vietnamese-speaking	4 percent
Cambodian-speaking	2 percent
Korean-speaking	2%

“API FamilyPACT Clients.” A little over 40 percent of the clients identify as Filipina. Another 30 percent are Asian, English-speaking clients.

Analyses were conducted for both services sought and the types of contraception received by API teens.

Of particular note is the number of teens who sought only a pregnancy test. This information has important implications for understanding risk of pregnancy among API youth since they indicate that youth are engaging in sexual activity and may not be using contraception.

Overall, nearly 40,000 teens or 20 percent of the total number of enrolled teenagers in FamilyPACT, visited the clinic for a pregnancy test and no other services. By comparison, approximately 28 percent of the total number of API clients receiving family planning services received only a pregnancy test. Pacific Islanders, Filipinos, and Vietnamese-

speaking teens were more likely among the APIs to have a pregnancy test, with Cantonese-speaking and Asian English-speaking the least likely to request only a pregnancy test. Results for all available subpopulations are in “Teens Seeking Pregnancy Tests from FamilyPACT Provider.”

Analysis of welfare reform. Both the community representatives and the youth identified the issue of welfare reform as central to understanding teen pregnancy in API subpopulations. In regard to its impact, both youth and service providers spoke mostly about its negative effects.

Participants shared their dismay over the ways in which the recipients of Temporary Assistance to Needy Families (TANF) are treated. They cited the lack of available interpreters, the invasion of privacy by social workers, the dead-end job placements, and the overall disrespect shown by government staff.

When presented with the major components of welfare reform and asked about their effect on teen pregnancy prevention, many youth talked about their regressive values. For example, some of the youth challenged the use of paternity identification. One youth said, “What does that have anything to do with whether the girls should get assistance? That’s discrimination.”

Others felt that the “pro-marriage” and “family cap” tenets mirrored the agenda of controlling the reproductive rights of women in the United States. “This is an outright attack on the rights of poor women! The government doesn’t dictate the number of children middle-class families have, and they should not be trying to promote the notion that a nuclear family is the best for everyone,” said one participant.

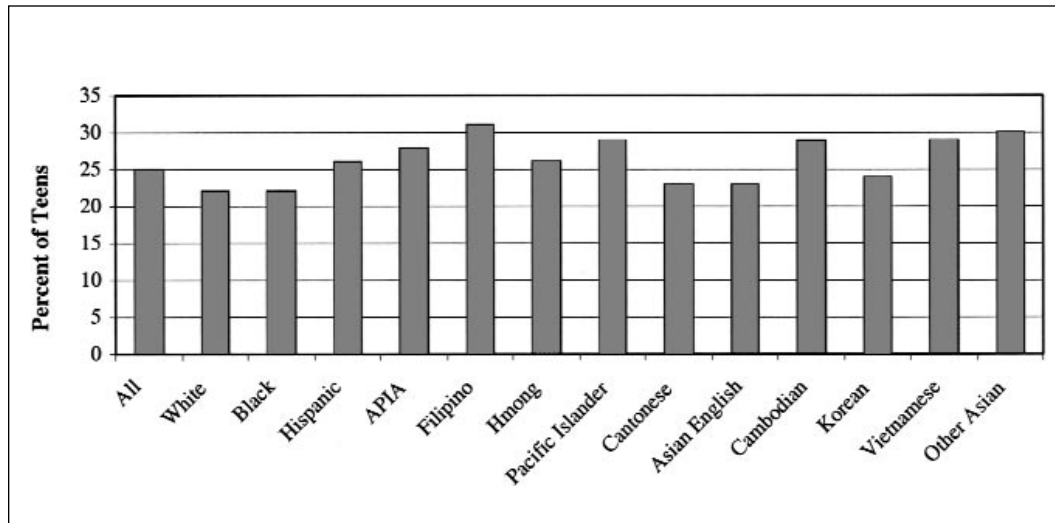
When asked to identify the major consequences of welfare reform on API youth and their families, service providers expressed feelings of frustration. Many were unhappy with the stipulations which they felt prevented poor families from moving out of poverty: “With the five-year limit coming up, we are seeing a lot of our families being bumped off of the roles. These are families with hard working parents who are holding down two to three jobs, and they are still not able to earn enough to support themselves and their kids. This hurts our communities and our youth. How are they supposed to have a future?”

In summary, they found that low-income and poor women of color often bear the brunt of welfare reform policies. By promoting abstinence-only programs, mandating that teenagers receiving assistance live at home, providing a paternity requirement, and a dictating a cap on children who are eligible, lawmakers are severely restricting the reproductive freedom of poor women and their families.

POLICY RECOMMENDATIONS

The report makes the following policy recommendations:

TEENS SEEKING PREGNANCY TESTS FROM FAMILYPACT PROVIDER



- Teen pregnancy should be recognized as an important issue for API communities
- Data should be collected by subpopulations at all levels of policymaking and program development
- API communities experiencing high teen births should have access to resources, services, and programs related to teen pregnancy prevention
- Programs and services should be designed specifically to address the unique cultural and linguistic features of API subpopulations of high need
- Programs and services should address the root causes of teen pregnancy
- The dialogue of teen pregnancy should be reframed within the context of reproductive freedom
- Welfare reform should be seen as central to understanding teen pregnancy among API communities

The project team included Tracy A. Weitz, M.P.A., Cynthia Harper, Ph.D., Eveline Shen, M.P.H., Regina Acebo, B.A., Anshu P. Mohllajee, B.A., and Nancy Milliken, M.D. **—Editor**

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WOMEN OFTEN UNAWARE OF EMERGENCY CONTRACEPTION

Emergency contraception (EC), often referred to as the “nation’s best-kept secret,” is a high dose of regular birth control pills that can reduce a woman’s chance of becoming pregnant by 75 to 88 percent if taken within 72 hours of unprotected intercourse. Advocates note that the U.S. Food and Drug Administration (FDA) approved two products, Preven and Plan B, for use as ECs in 1998 and 1999, respectively.

According to a Kaiser Family Foundation survey, a quarter of women 18 to 44 years of age have never heard of EC, and nearly two-thirds of women in that age group do not know that EC is available in the United States.

It is also estimated that only two percent of American women have ever used emergency contraceptive pills (ECPs). This has been attributed to a lack of awareness about the product, access issues, and misconceptions about how it works. Efforts are now being undertaken to increase availability of and awareness about EC.

PUBLIC INFORMATION

This spring, the Reproductive Health Technologies Project and a coalition of medical and women’s policy groups, including SIECUS, will launch a public information campaign about EC.

The campaign, *Back Up Your Birth Control*, seeks to educate women and health care providers about EC. A phone number and Web site provide free information on how to prevent pregnancy after sexual intercourse as well as contact information on health care professionals across the country who can provide EC.

LEGISLATION

Legislative efforts are also being utilized to increase the availability and use of EC. In Congress, U.S. Rep. Louise McIntosh Slaughter (D-NY) is expected to introduce a bill this year that will create a public information campaign to educate women and health care providers about EC.

Over-the-counter status. Other legislative efforts include attempts to give EC over-the-counter status and to mandate that hospitals make it available to sexual assault victims. These efforts will eliminate the most ominous barriers to widespread use.

Advocates such as the American College of Obstetricians and Gynecologists have already argued that EC fulfills the FDA’s requirements for over-the-counter status. In addition, Hawaii and Virginia have introduced bills that will allow pharmacists to dispense EC without a prescription. Minnesota, New Hampshire, and Oregon also introduced similar bills last year.

Currently, however, EC is available from a pharmacist without a prescription only in the states of Washington and California. France, the United Kingdom, Belgium, South Africa, Albania, Denmark, Portugal, and parts of Canada currently allow pharmacists to dispense EC without a prescription.

Availability during emergencies. Surveys have shown that most hospitals, including 82 percent of Catholic hospitals, do not provide EC to rape survivors. In 2001, five states (Hawaii, Illinois, Kansas, Minnesota, and New York) introduced “EC in the ER” bills. This year, seven states (Arizona, California, Florida, New Jersey, South Dakota, Washington, and Wisconsin) introduced similar legislation that would require hospitals to provide EC to rape survivors upon request or refer them to a facility that would provide it. A similar Maryland bill would require hospitals to provide information about EC but would not require that they dispense it.

Opposition to the legislation. Legislative efforts are also expected from opponents of EC. Rep. Melissa Hart (R-PA) has said that she will introduce a bill to block access to EC to minors at school-based health centers. She attempted to include this in the Labor, Health and Human Services appropriations bill last fall but was forced to withdraw it.

Some legislators have attempted to conflate EC and mifepristone (or the “abortion pill”) but the products are vastly different. While mifepristone induces expulsion of an already-implanted egg, EC inhibits ovulation, fertilization, or implantation. In addition, EC cannot cause abortion. If an egg is already implanted in a woman’s uterus, EC will not terminate that pregnancy nor will it cause any harm to the developing fetus.

For more information, call the EC hotline at 1-888-NOT-2-LATE.

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TEMPORARY ASSISTANCE TO NEEDY FAMILIES: VITAL STRATEGY TO PREVENT NON-MARITAL BIRTHS

Jodie Levin-Epstein

Senior Policy Analyst
Center for Law and Social Policy
Washington, DC

The impending reauthorization of the welfare reform block grant for the Temporary Assistance to Needy Families (TANF) program provides an opportunity for the federal government to recognize that teen pregnancy prevention is a vital strategy to address non-marital births in the United States. The numbers underscore the value of the strategy.

Approximately 80 percent—or 400,000—of the nearly 500,000 teen births¹ that occurred in the United States in 2000 were non-marital.² And historically, 40 to 50 percent of older mothers who receive welfare became parents first as teenagers. Such mothers also tend to have longer stays on welfare.

Fully 50 percent of all first non-marital births are to teens. Researchers recently noted that increases in non-marital first births have driven the increase in non-marital fertility over the last 25 years.³ In addition, approximately 20 percent of the 500,000 teen births that took place in the United States in 2000 were not the teen mother's first child: nearly 100,000 of those teens were giving birth to a second child.⁴

RECOMMENDATIONS

The Center for Law and Social Policy (CLASP) makes these recommendations:

- **Replicate and adapt proven teenage pregnancy-prevention programs. Continue to evaluate new pregnancy-prevention innovations**

The federal government should create a Family Formation Fund to redirect the \$100 million in “illegitimacy” bonus funds currently rewarded annually to up to 5 states that reduce their non-marital births (and decrease their abortion rate).

This Family Formation Fund should, among other goals, provide states and localities with the money to replicate proven teen pregnancy-prevention initiatives. Strong evaluation evidence, now available, provides models of effective programs that span a wide spectrum of ideology and would allow communities to choose curricula and activities that meet their own needs and norms. Some of the re-directed monies also should be spent on testing emerging, promising program modes.

- **Revisit the restrictive abstinence-only-until-marriage-education currently funded by the federal government**

There is currently no research that indicates the federal government's abstinence-only-until-marriage education programs help prevent pregnancy. There is, however, new evidence that this approach may put uninformed individuals at risk for unintended pregnancy and/or sexually transmitted diseases.

In the face of such potential health risks, the federal government needs to closely scrutinize its continued funding (\$533 million in combined federal and state matching dollars since 1996) of such programs. To the extent that federal funds are made available, states should have the flexibility to shape their own abstinence and pregnancy-prevention education programs.⁵

- **Implement a “transitional compliance” period during which teen parents can begin to participate in TANF**

TANF reauthorization should encourage states to reach out to needy teen parents through a “transitional compliance” provision—a period of 180 days for those who do not meet certain program rules when they apply. This would give states time to provide customized case management to help teens meet these requirements.

TANF requires teen parents to meet two eligibility criteria that reflect goals specific to teens—attending school and living in an approved setting. Participants are also subject to other eligibility rules not limited to teens, such as cooperation regarding child support.

Teen mothers seeking TANF services sometimes do not meet these requirements when they apply. Most state policies allow caseworkers the flexibility to work with such teens. Yet, emerging research suggests that this flexibility is not used by some local officials and this results in a “perverse effect” since the very teen parents who need the help the most—those who are not in school/training and those without a proper place to live are sometimes not even given applications.

A federal transitional compliance period would send the

signal to states that Congress wants needy teen parents to enter TANF in order to get assistance in meeting the requirements related to schooling/training and living arrangements.

- **Increase funding for “second chance” homes for TANF parents**

To assist teen parents who do not have appropriate living arrangements, funds beyond the TANF block grant amounts are needed for “second chance” homes.

The goal of residing with parents and relatives may make sense for many teen parents, but it may prove problematic for others. The likelihood of family violence should exempt some from such living arrangements.⁶

In addition, others should not have to live with relatives who might undercut efforts to raise a child or with those who might cause emotional distress.⁷

Second chance homes provide teen mothers a stable and safe place to live while receiving TANF support services. A CLASP survey has found that 13 out of 20 state administrators that addressed the question of implementing the living arrangement rule had specific concerns about a lack of alternative housing options or difficulties in assessing the safety of current living arrangements.⁸

This underscores the need for alternative living arrangements⁹ as well as the need for improved assessment of living arrangements.¹⁰

While \$19 million was recently added to the Transitional Living Program (part of the Runaway and Homeless Youth Program) there remains a pressing need for additional funds for both parenting and non-parenting teens in need of supportive shelter.

- **Improve current sanction policies for TANF parents**

Improvements to existing TANF sanction policies should benefit parents of all ages. CLASP recommends that they better address such issues as the sanction notice process as well as how sanctions are resolved.

For all families, sanctions are significant because they result in the loss of immediate income. Very young families may prove particularly vulnerable to the ill effects of such financial instability. There is evidence of poor outcomes for children in welfare families resulting from family turbulence related to such sanctions.¹¹

A 2000 CLASP survey found that nearly 2,500 teen parents in five responding states were sanctioned in just one month for failure to comply with TANF’s school/training requirement.¹²

The sanction rate for teen parents in these five states

ranged from six to 23 percent, and all five of the states imposed a higher sanction rate for teen parents in comparison to the sanction rate for families.¹³

Reauthorization of TANF should be viewed as an opportunity to foster provisions that would further an understanding of the extent of this problem, why it is happening, and its impact.

Some initial ideas include:

- 1. Arranging for the U.S. Department of Health and Human Services to conduct a study of sanctions**

An examination of TANF programs in a handful of states would help to fully understand the nature, extent, and impact of sanctions. Such a study would explore questions like: “What rules are generating the most sanctions?” “Are teens sanctioned at rates higher than families headed by adults?” and “Are sanction policies understood by teen parents in advance of the sanction?”

- 2. Arranging for in-state reports on teen parent sanctions**

State-collected data, reported by county (or other appropriate jurisdiction), should help administrators self-assess operations related to sanctions. The federal government already requires states to report sanctions relating to a teen parent’s failure to attend school or to comply with an individual responsibility plan. Such data could serve as a management tool to help improve the system of sanctions. The in-state report should collect information on sanction procedures that local jurisdictions use in an effort to avoid inappropriate ones.

- **Eliminate the time-limit clock for teen parents complying with TANF’s education and training requirements. Start the time clock at age 20**

For those TANF teen parents who are complying with education and training, the time-limit clock should not start.

TANF’s time-limited assistance and the “work first” approach are intended as incentives for young parents to find employment. While minor teen parents are usually directed toward education, older teen parents often are not. These include parents as young as 18 who are not participating as full-time students in a secondary school or equivalent training.

New research indicates that education may be particularly important if teen mothers are to achieve economic self-sufficiency. By their late twenties, women who have ever received welfare, who have not completed high school, who have given birth as a teen, or who have had three or more children are unlikely to find a “good” job,¹⁴ relative to other recipients without such characteristics.

In addition, less than one in five women who gave birth

to their first child before turning 18 years of age are predicted to work primarily in a “good” job, even though more than half will be working steadily by their late twenties.¹⁵

Such outcomes suggest that time limits may force disadvantaged TANF recipients, such as teen mothers or those without a high school education, into the workforce before they are ready. Those who are teen mothers and have no high school education are particularly challenged in securing employment with livable wages.

- **Improve collection of teen parent data that include more specific information**

States collecting data on TANF services should include such basic information on teen parents as the estimated number of TANF-eligible teen parents in the state, assessment procedures, and inter-agency coordination.

A CLASP survey analysis of teen parent participation in TANF found that the number of young parents eligible for TANF services is likely undercounted and that the status of such parents is often unknown.

For instance, among the 10 states that reported to CLASP, the number of teen parents participating in their TANF programs was half that reported by the federal government. The 10 states were also often unable to report the number of teens subject to the state’s school/training requirement or where teen parents were living.¹⁶

While federal reporting may improve some of the limited information available about teen parents participating in TANF, more state data is needed to obtain an accurate picture of the treatment of teen parents.

CONCLUSION

With TANF up for reauthorization this year as part of welfare reform, the federal government has a unique opportunity to make this program a vital part of its teen pregnancy-prevention efforts.

SIECUS believes that the CLASP recommendations discussed in this article would go a long way toward making TANF a valuable and realistic program.

(This article was adapted with permission from CLASP’s reauthorization comments to the U.S. Department of Health and Human Services.)

—**Editor**

For more information, contact Jodie Levin-Epstein or Christine Grisham, (Jodie@clasp.org or cgrisham@clasp.org, CLASP, 1015 15th Street N.W., Suite 400, Washington, DC 20005. Phone: 202/906-8000.

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AMERICAN ACADEMY OF PEDIATRICS SUPPORTS ADOPTION BY SAME-SEX PARTNERS

The American Academy of Pediatrics (AAP) announced this month its support for both “coparent” and “second-parent” adoption by same-sex couples.

Coparent adoption grants a couple joint custody of a child, while second-parent adoption refers to the process whereby one parent maintains legal parental status and the partner seeks equal parental rights.

The report was issued in response to the organization’s view that children living with same-sex parents deserve to have two legally recognized parents.

The AAP report indicates that “there is a considerable body of professional literature that suggests children with parents who are homosexual have the same advantages and the same expectations for health, adjustment, and development as children whose parents are heterosexual.”

Dr. Ellen Perrin, a behavioral pediatrician at Tufts New England Medical Center, concurred, stating, “There are more similarities than differences in parenting styles and attitudes among gay and non-gay parents.”

In addition, the report indicates that the key factor in healthy child development has more to do with the quality of relationships within a family than with the particular family structure. Children are better adjusted when their parents report greater relationship satisfaction, higher levels of love, and lower interparental conflict regardless of their parents’ sexual orientation.

According to the AAP report, coparent or second-parent adoption in a same-sex relationship is beneficial in that it provides custody rights for both parents in the event that one parent becomes ill or dies.

In addition, it protects the rights of both parents to have custody and visitation privileges if the couple separates. Finally, same-sex adoption ensures the child’s eligibility for health benefits from both parents, provides legal grounds for both parents to provide consent for medical care, and creates the basis for financial security for children by ensuring eligibility to Social Security survivor’s benefits and requiring both parents to pay child support.

Between one and nine million children in the United States are estimated to have at least one parent who is lesbian or gay. In addition, lesbians and gay men are increasingly becoming parents on their own or in the context of established same-sex relationships. According to the November 2001 Kaiser Family Foundation survey, almost half of lesbians, gays, and bisexuals (49 percent) who do not have children would like to adopt children of their own at some point.

For this reason, the AAP recommends that pediatricians become familiar with the professional literature regarding gay and lesbian parents and their children and support the right of every child and family to the financial, psychological, and legal security that results from having both parents legally recognized.

In addition, the AAP advises that pediatricians advocate for initiatives that establish permanency, through coparent or second-parent adoption, of children of same-sex partners. According to Dr. Perrin, a change in state laws is necessary to give gay parents the legal right to adopt their partner’s children. She adds, “In most states, there’s no assurance that the court will agree to adoption.”

Nationwide, approximately half the states have allowed second-parent gay adoptions, where one partner already is a legal parent, says Patricia Logue, an attorney with the gay rights advocacy group Lambda Legal Defense and Education Fund. Many experts indicate that AAP’s endorsement is likely to carry weight in courts and legislatures because the group, which represents 55,000 pediatricians, enjoys wide respect.

A November 2001 survey conducted by the Kaiser Family Foundation finds that 46 percent of the general public supports adoption rights for gay and lesbian couples, and more than half of the general public (56 percent) say they believe gay and lesbian couples can be just as good parents as can heterosexual couples.

Along with the AAP, the American Academy of Child and Adolescent Psychiatry and the American Psychological Association also support same-sex adoption.

To view the full report, contact AAP at: www.aap.org/policy/020008t.html

AFRICAN AMERICAN MOTHERS' SUBSTANCE ABUSE: PUNISHMENT OVER TREATMENT?

Assata Zerai, Ph.D.

Assistant Professor, Sociology Department
Senior Research Associate, Center for Policy Research
and

Rae Banks, Ph.D.

Assistant Professor, Department of African American Studies
Syracuse University
Syracuse, NY

In the never-ending “war” on drugs, the battle over maternal substance abuse, always on shifting and contested ground, is escalating.

Medical researchers have become increasingly vocal in their protests against criminal sanctions for pregnant women’s illicit drug use.¹ Armed with compelling research summarizing more than a decade of study, they offer evidence that while drug abuse can and sometimes does compromise the health of exposed infants and children,* the problem is neither as prevalent nor as damaging to a child’s development as earlier reports indicated.²

That research strongly suggests that the social environment can be as damaging as drug use. Most critically, medical researchers argue that prenatal care reduces the risks of exposure to drugs in utero.³

Based on this evidence, they call for an end to criminal sanctions on the grounds that the threat of punishment is more of a barrier to prenatal care than a deterrent to drug abuse.⁴ Yet helping expectant drug abusers to get prenatal care is not a focal point of policy—punishment is.

PUNISHMENT OVER TREATMENT

A survey of drug treatment and rehabilitation programs in the United States reveals that after a relatively short-lived increase in such programs for pregnant women, intervention strategies to control prenatal drug abuse are increasingly punitive as opposed to therapeutic.⁵

Untold numbers of women continue to lose custody of their children in jurisdictions where drug use is considered prima facie evidence that they are unfit mothers.⁶ Today women who abused cocaine while pregnant languish in American prisons such as those in South Carolina, setting an ominous precedent.

After a protracted legal battle, in March of 2001, in a 6–3 decision, the United States Supreme Court ruled in *Ferguson v. City of Charleston* (532 U.S. 67) that South Carolina’s policy of testing women for drugs without warrants or their consent was an unconstitutional search.

According to Justice Stevens, who delivered the opinion

of the Court, this policy, allegedly adopted for reasons of health, was especially egregious because its “immediate objective...was to generate evidence for law enforcement.”⁷

Signaling that the legal battle is far from over, two months later South Carolina demonstrated its intention to continue to choose punishment over treatment when a jury convicted a woman of homicide in the death of her stillborn child in 1999.⁸ An autopsy revealed evidence of cocaine in the infant’s system. The mother was sentenced to 12 years imprisonment in spite of the fact that experts could not provide unequivocal evidence that cocaine caused the baby’s death.

To add to the irony, even South Carolina’s prosecutor in this case agrees that “there is not enough money—there aren’t enough resources—committed to drug and alcohol treatment.”⁹ In fact, critics charge that South Carolina ranks last among the states in availability of drug treatment and report that when the drug testing policy was initiated in Charleston, the hospital that conducted the tests refused to treat pregnant drug abusers.¹⁰

Obviously, the battle over the criminalization of drug abuse during pregnancy is not over. Lawyers advocating for so-called “crack moms” will have to return to the South Carolina Supreme Court to appeal that court’s ruling that using cocaine when a fetus is viable is a criminal offense.

(The authors write that criminal prosecutions have been tried in at least 30 states and that all the cases with the exception of South Carolina have now been overturned. That is why they used South Carolina as an example: the state has the potential to set a legal precedent that could start prosecutions across the country all over again. —*Editor*)

LIMITED POLICY OPTIONS

The usual conservative–liberal dichotomy that defines the relationship between the social environment and maternal drug abuse offers illusory and simplistic notions of the environment and then serves up a limited range of policy options.

Conservatives, for example, claim that prenatal substance abuse is the product of a self-generating community of

dependent, undisciplined, and undeserving deviants. It is a relatively short step from insisting that welfare and other social supports be withheld to endorsing the notion that these women should be punished.

Liberals claim that this problem is the result of a racially stratified social system that distributes its resources inequitably. They argue that we can resolve the problem with a more equitable distribution of resources such as jobs, housing, and health care.

But advocating for urban communities, the poor, and those addicted to drugs in a conservative climate is simply not politic. Consequently, federal and state anti-drug budgets continue to support law enforcement over treatment and prevention. Most significantly, treatment for pregnant women remains exceedingly scarce.

What both liberals and conservatives ignore is that the social environment is not fixed but is constructed out of ordinary practices and everyday decisions made in arenas far from the inner cities in which a disproportionate share of poor women are trapped.

COMPROMISING PRENATAL HEALTH

The warnings of medical experts and critics of punitive prenatal drug testing policies remain compelling: the threat of prosecution or of losing their children is likely to act as a deterrent for women who might otherwise seek the prenatal care vital to their health as well as that of their infants.¹¹

New criminal charges emerge and punitive policies that do nothing to help expectant mothers or their children endure because prenatal substance abuse is one of the growing numbers of public health and other social problems in which “the realm of the private is permeated with real or public politics.”¹²

The politics of race, in particular, legitimate punishment as a policy option, usually under the guise of upholding family values. Sometimes it is explicitly based on an essential belief in the inferiority of Black people.¹³ Of the more than 200 women in 30 states who have been prosecuted to date for prenatal drug abuse, estimates are that from 70 to 80 percent are Black.¹⁴

In the recent Supreme Court case, nine of the 10 plaintiffs were Black and all of them were poor. A greater share of African American as opposed to European-American mothers who seek prenatal care are tested for drug use¹⁵ and lose custody of their children, often without hearings, investigations, or any of the trappings of due process.¹⁶

It is at the intersection of the triple axes of oppression—race, class, and gender subordination—that the health and well-being of Black women and their children have been compromised well beyond the bounds of individual women’s culpability or the collective burden of racism.

PUNITIVE SANCTIONS

As social scientists, we argue that while a second generation of research focusing on the social environment is necessary, it is not sufficient to generate policies designed to help mothers and their children. It is imperative that this new research agenda recognize and contest the ways that gender, race, and class oppression organize the social meaning of women’s addiction, construct prenatal drug abuse as a distinctive problem, and position poor African American women as targets of punitive sanctions in ways that set them apart from African American men, European-American women, and other Black women with greater resources at their disposal.**

We contend that since the South Carolina precedent is so broadly constructed, it is bound to have a pernicious effect, rendering all women and especially poor African American women “potentially criminally liable for myriad acts.”¹⁷

Even before this decision, women were prosecuted for having sex while pregnant and failing to keep doctor’s appointments, and jailed because there were no drug treatment programs available.^{18***} Charles Condon, the politically ambitious attorney general of South Carolina, is already threatening to impose criminal sanctions for the use by pregnant women of legal substances such as cigarettes and alcohol.

In spite of the fact that America has historically considered maternal illicit substance use a public health problem, in this highly politicized social climate the simplistic policy of punishing prenatal drug abuse was born. The “crack mother” made it expedient to construct people in trouble as people who make trouble.¹⁹

Through the analytic lens of inter-sectionality, we content that interlocking gender, race, and class inequalities and the institutional powers that fuel them constructed the “crack mother” as a social phenomenon that overshadows and obscures the problems of maternal substance abuse.

We argue further that non-punitive policies cannot be developed without uncovering the social relations of domination which structure social inequality, shape institutional power, and (dis)organize our thinking²⁰ so that, for more than a decade, America has allowed punishment to override healthful, alternative strategies that do protect children.

In short, we are at a crossroads, a critical moment in our efforts to define the problem of maternal substance abuse and what we, as a society, will do about it. As social scientists, women, and mothers, we find it unacceptable to choose to continue down the punitive path, running the risk of punishing more and more women for more and more offenses while ignoring the opportunities for prevention and intervention generated by almost two decades of research.

Alternatively, we believe that there is, at hand, sufficient empirical evidence to develop a policy agenda that will

protect the health as well as the rights of pregnant and parenting substance abusers and their children.

HEALTH-RELATED POLICIES

Our goal is to take the first step toward a new policy agenda that liberates mothers, children, and this society from non-productive, punitive interventions and that charts a course toward health-based policies that help mothers to help their children.

The approach to the problem of maternal substance abuse should be based on a better empirical foundation by recognizing its complexities, including the role of race, class, and gender oppression. We consequently suggest that a full range of public health-oriented prevention and intervention strategies should be devised.

We propose alternative research and policy agendas based on quantitative and qualitative data designed to resist and ultimately dismantle gender, race, and class subordination, a necessary milestone on the road to healthful, affirming policies on maternal substance abuse.

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NOTES

* We cast a wide net when we refer to that group of children who are "drug-exposed" because the effects of maternal substance abuse are as much social as they are biological, if not more so. We define

"drug-exposed" children as those whose mothers or fathers ever used cocaine during the mother's pregnancy or any time during the life of the child.

** Black feminist theory is inclusive in that it accounts for Latinos, Native Americans, Asians and other similarly situated groups. These comparisons reflect our particular focus on poor African American women.

*** In 1985, Pamela Rae Stewart, a European-American woman, was charged with taking barbiturates and failing to follow doctor's orders to refrain from sexual intercourse. The case was dismissed in 1987 on the grounds that existing statutes did not cover these offenses. In 1988, an African American woman was convicted of forgery in Washington, DC, but was imprisoned chiefly because she was addicted and pregnant and because the judge, determined to intervene in her drug-taking, could find no treatment program that would accept her.

(This article was adapted with permission by the publisher and authors from the upcoming book Dehumanizing Discourse, Anti-Drug Law, and Policy in America: A "Crack Mother's" Nightmare.) —**Editor**

WEB SITES WITH INFORMATION ON PREGNANCY ISSUES

- Advocates for Youth
www.advocatesforyouth.org
- Alan Guttmacher Institute (AGI)
www.agi-usa.org
- American College of Obstetricians and Gynecologists
www.acog.org
- Centers for Disease Control and Prevention's National Center for Health Statistics
www.cdc.gov/nchs
- National Campaign to Prevent Teen Pregnancy
www.teenpregnancy.org
- National Organization on Adolescent Pregnancy, Parenting, and Prevention (NOAPPP)
www.noappp.org
- Planned Parenthood Federation of America (PPFA)
www.plannedparenthood.org
- Sexuality Information and Education Council of the United States
www.siecus.org

PREGNANCY AND STATE POLICIES

States have a variety of policies on pregnancy-related issues. Seven subjects are examined in these charts: (1) substance abuse by pregnant women, (2) infertility insurance coverage, (3) Medicaid family planning waivers, (4) minors’ access to prenatal care, (5) “safe surrender” of infants, (6) human cloning, and (7) gay and lesbian adoption.

All charts were compiled by Kate Bowen, SIECUS public policy associate.

**CHART 1
SUBSTANCE ABUSE DURING PREGNANCY**

Substance abuse during pregnancy can cause harm to both the mother and the fetus. Legislators have attempted to curb this problem with a variety of approaches. There are currently 34 states with policies relating to substance abuse by pregnant women. The consequences for women range from reporting and testing by health care professionals (the results of which are often used in child welfare proceedings) to termination of parental rights or forced rehabilitation. If a state is not listed, there is no relevant law.

	Terminates Parental Rights	Civil Commitment Authorized	Reporting Required	Health Care Professionals Must Test	Priority Access to Treatment	Create or Fund Treatment
AZ			X		X	
AR						X
CA						X
CO						X
CT						X
FL	X					X
GA					X	
IL	X		X			X
IN	X					
IA			X	X		
KS					X	
KY						X
LA						X
MD	X					X
MA			X			
MI			X			
MN	X	X	X	X		X
MO					X	X
NV	X					
NE						X
NY						X
NC						X
OH	X					X
OK					X	

	Terminates Parental Rights	Civil Commitment Authorized	Reporting Required	Health Care Professionals Must Test	Priority Access to Treatment	Create or Fund Treatment
OR						X
PA						X
RI	X					
SC*	X					
SD	X	X				
TX	X				X	
UT			X			
VA	X			X		X
WI	X	X			X	
WA						X

* South Carolina's Supreme Court held that the state's criminal child endangerment statute includes "maternal acts endangering or likely to endanger the life, comfort, or health of a viable fetus." Thus, substance abuse by pregnant women is a criminal act in South Carolina.

CHART 2 INFERTILITY INSURANCE LAWS

Whether or not infertility treatments are covered by insurance depends on where individuals live and where they have their insurance plans. Some states have enacted laws that require insurers to either offer or cover some infertility treatment or testing. A mandate to offer requires insurance companies to make available for purchase a plan that offers coverage of infertility treatment. An employer is not required, however, to pay for the coverage. A mandate to cover requires insurance companies to provide coverage for infertility treatments in every policy they offer. Of the 14 states with mandates relating to insurance coverage for infertility, four require that potential parents be married. There are many additional variations among the state laws. If a state is not listed, there is no relevant law. There are exemptions and requirements not listed here.

	Mandate to Cover	Mandate to Offer	Must Be Married and Spouse's Spem Used
AZ	X		X
CA		X	
CT		X	
HI	X		X
IL	X		
MD	X		X
MA	X		
MT	X		
NJ	X		
NY	*		
OH	X		
RI	X		
TX		X	X
WV	X		

* New York mandates that insurance companies cover the "diagnosis and treatment of correctable medical conditions." Thus, insurers must cover treatment of any correctable condition even if the only result of the condition is infertility. The law does not, however, require coverage for reversal of sterilization or for procedures intended to produce pregnancy.

**CHART 3
MEDICAID FAMILY PLANNING WAIVERS**

The federal government requires every state to cover pregnancy-related care and family planning services through Medicaid for 60 days postpartum to women with incomes at or below 133 percent of the federal policy level. Most states usually cut off Medicaid eligibility to people with incomes under that level. Since 1993, some states have expanded Medicaid eligibility for family planning services to women who would otherwise lose coverage because of their income levels by applying for “waivers” of federal policy from the federal government. These waivers allow states to either continue coverage for postpartum women for longer than the requisite 60 days or to grant coverage to women, regardless of whether they are postpartum, based on a percentage of the federal policy level. The result of these waivers is to extend family planning services through Medicaid to women who would otherwise not be eligible because their income levels are above their state’s Medicaid eligibility ceiling. If a state is not listed, there is no relevant policy.

	Extend for Women Losing Medicaid Post-partum (amount of time)	Grant Coverage Based on Income (income ceiling as percentage of federal poverty level)	Extend for Women Losing Medicaid for Any Reason (amount of time)
AL*	approved (2 years)	approved (133%)	
AZ	approved (2 years)		
AR		approved (133%)	
CA		approved (200%)	
CO		pending approval (150%)	
DE			approved (2 years)
FL	approved (2 years)		
GA	pending approval		
MD	approved (5 years)		
MS			
MO	approved (2 years)		
NM		approved (185%)	
NY	approved (22 months)	pending approval (200%)	
NC		pending approval (185%)	
OK		pending approval (185%)	
OR		approved (185%)	
RI	approved (2 years)		
SC		approved (185%)	
VA	pending approval		
WA		approved (200%)	
WI		pending approval (185%)	

* Mobile County Only.

**CHART 4
MINORS’ ACCESS TO PRENATAL CARE**

Whether a minor can consent to confidential prenatal care varies from state to state, but the trend over the last 30 years has been to allow minors greater authority to consent to their own health care. Among the states that have policies or laws regarding minors’ access to prenatal care, there are variations in the age at which a minor can consent (with some states requiring only that a minor is “mature” enough to understand the treatment), whether physicians can inform the minor’s parents about the care, and whether the policy is for prenatal care or for medical care in general. If a listed state has no information in the chart, that state allows minors to consent to prenatal care at any age. If a state is not listed, there is no relevant policy.

	Age, If Any, Minor Must Be	Physician May Inform Parents	Medical Care in General
AL			
AK			
AR			
CA			
DE	12	X	
DC			
FL			
GA			
HI	14	X	
ID			
IL*			X
KS	"mature"		
KY		X	
MD		X	
MA			
MI		X	
MN		X	
MS			
MO		X	
MT		X	
NV	"mature"		X
NH	"mature"		X
NJ		X	
NM			
NY			
NC			
OK		X	
OR	15	X	X
PA			
SC	16		X
TN			
TX		X	
UT			
VA			
WA	12	X	

* Illinois allows a minor to consent if her health requires it, if she is a parent, or if she is referred by a specified professional. Idaho bases its policy on the interpretation of state law by the attorney general's office. Washington State bases its policy on a state supreme court decision holding that minors have the same constitutional rights as adults.

**CHART 5
SAFE SURRENDER LAWS**

“Safe surrender” laws provide safe and legal places for parents to give up unwanted newborns. These laws are intended to dissuade parents from abandoning their newborns in unsafe places where they are likely to die. Variations in the laws include: limits on the infant’s age; authorized people or places to which parents can relinquish the children; anonymous surrenders; required medical information; checks to see if a child is reported missing; identification bracelets to facilitate later attempts at reclamation; and surrender of the child by people other than the parent. If a state is not listed, there is no relevant law.

	Limit on Infant's Age	Authorized Personnel or Places	Anonymous	Medical Information Requested	Check if Child Is Missing	ID Bracelet	Others May Surrender
AL	72 hrs.	EMS					
AZ	72 hrs.	adoption, church, EMS, hospital		X	X		
AR	30 days	hospital, police	X				
CA	72 hrs.	hospital, “other designated place”			X	X	X
CO	72 hrs.	EMS, hospital					
CT	30 days	hospital		X	X		X
DE	14 days	hospital	X	X	X	X	X
FL	3 days	EMS, hospital	X		X		
ID	30 days	EMS, hospital, 911	X		X		
IL	72 hrs.	EMS, hospital					
IN	45 days	EMS					
IA	14 days	clinic, hospital		X	X		
KS	45 days	clinic, EMS					
LA	30 days	clinic, CPC, EMS, hospital, police	X				
MI	72 hrs.	EMS, hospital, police	X			X	
MN	72 hrs.	hospital	X		X	X	
MS	72 hrs.	adoption, hospital					
MT	30 days	EMS, hospital, police	X			X	
NV	30 days	clinic, EMS, hospital, police			X		
NJ	30 days	hospital, police	X	X	X		
NM	90 days	clinic, hospital		X	X	X	
NY	5 days	“appropriate” person or location					
NC	7 days	clinic, EMS, hospital, police	X		X		
ND	1 year	hospital		X	X		X
OH	72 hrs.	EMS, hospital, police			X	X	
OK	7 days	clinic, EMS, hospital, police	X		X		
OR	30 days	clinic, EMS, hospital, police			X		
RI	30 days	clinic, EMS, hospital, police		X	X		
SC	30 days	hospital	X	X	X	X	
SD	60 days	adoption, clinic, EMS, police					
TN	72 hrs.	clinic, hospital			X	X	

TX	30 days	EMS	X		X		
UT	72 hrs.	hospital	X	X	X		
WV	30 days	clinic, hospital			X		
WI	72 hrs.	EMS, hospital, police, 911			X		

AUTHORIZED PERSONNEL OR PLACES

911 = Allows a parent to use 911 and give infant to responding personnel; Adoption = Licensed adoption agency; Clinic = Health care clinic; CPC = Crisis pregnancy center; EMS = Emergency Medical Services or fire station; Police = Police station

CHART 6 HUMAN CLONING

While human cloning holds enormous promise for medical breakthroughs, it also creates moral and ethical questions. Recently, due to the tremendous increase in scientific knowledge and capability, the clash between science and those who have ethical concerns about cloning has come to a head. Some states have begun to pass laws that regulate cloning. Human cloning comes in two forms: reproductive cloning and therapeutic cloning. Stem cell research is a form of therapeutic cloning. The U. S. House of Representatives voted last year to outlaw both reproductive and therapeutic cloning, and the U. S. Senate is set to debate the issue this spring. Only five states prohibit cloning humans, and four of those make exceptions for research. If a state is not listed, there is no relevant law.

	Cloning of Humans Prohibited	Penalty Provided by Law	Exceptions
CA	X	license revocation; civil penalties	
LA	X	civil penalties	scientific research and cell-based therapies
MI	X	civil penalties	scientific research and cell-based therapies
RI	X	civil penalties	biomedical, microbiological, and agricultural research
VA	X	civil penalties	research purposes

Missouri limits use of state funds for human cloning research.

CHART 7 GAY AND LESBIAN ADOPTION LAWS

Coparent adoption grants a couple joint custody of a child while second-parent adoption refers to the process whereby one parent maintains legal parental status (either because that parent was the biological mother or father or because that parent adopted the child) and the partner seeks equal parental rights. The most common method for same-sex couples to jointly adopt children is through “second parent” adoption. Joint adoption of an unrelated child is much less likely to be permitted. Adoption laws for same-sex couples are unsettled and subject to change in many states. Because of the difference among the states, it is difficult to provide a complete and accurate legal summary. If a state is not listed, its adoption law in this area is unclear.

	Second Parent Adoption Permitted by Lower Court Precedent	Second Parent Adoption Permitted by High Court Precedent	Statute Permitting or Case Law Prohibiting Second Parent Adoption	Joint Non-Relative Adoption by Same Sex Couples	Individual Adoption by Homosexuals
AK	X				permitted
CA	X			permitted	permitted
CO*	X		prohibited by case law		

	Second Parent Adoption Permitted by Lower Court Precedent	Second Parent Adoption Permitted by High Court Precedent	Statute Permitting or Case Law Prohibiting Second Parent Adoption	Joint Non-Relative Adoption by Same Sex Couples	Individual Adoption by Homosexuals
CT	X		permitted by statute		
DE	X				
DC	X			permitted	
FL**			prohibited by statute	prohibited by statute	prohibited by statute
HI	X				
IL	X			permitted	permitted
IN	X				
IA	X				
KY				prohibited	
MD	X				permitted
MA				permitted	permitted
MI	X				
MN	X				
MS			prohibited by statute	prohibited	prohibited
NV	X				
NJ		X		permitted	permitted
NM	X				
NY		X		permitted	permitted
OH					permitted
OR	X				
PA*	X		prohibited by case law	permitted	permitted
RI	X			permitted	permitted
TX	X				
UT				state-sponsored adoptions prohibited	
VT		X		permitted	permitted
WA	X			permitted	permitted
WI			prohibited by case law	prohibited	

* In Colorado and Pennsylvania, there is conflicting case law regarding second-parent adoptions.

** In Florida, a federal appeals court is currently considering whether to reverse a lower court ruling throwing out a challenge to the state's ban on all homosexual adoptions.

**B U S H A D M I N I S T R A T I O N R E L E A S E S
2 0 0 3 B U D G E T P R O P O S A L**

W i l l i a m S m i t h

S I E C U S P u b l i c P o l i c y D i r e c t o r

Much has been made of Secretary of State Colin Powell's remarks on MTV encouraging condom use by sexually active young people. Powell offered his opinion when he was questioned about curbing the spread of HIV infection among teens.

Immediately following the broadcast, he was rebuffed by groups like Focus on the Family and Concerned Women for America, both of whom had previously been his staunch allies. In contrast, he was warmly embraced by public health advocates, many of whom have previously felt alienated from the Bush Administration and its policies.

Powell's remarks are encouraging. Yet, in spite of the Administration's attempts to convince the public otherwise, they represent a departure from current policy. President Bush's educational and fiscal priorities remain on the side of abstinence-only-until-marriage programs.

**N O , J U S T M O R E A B S T I N E N C E -
O N L Y - U N T I L - M A R R I A G E**

President Bush released his fiscal 2003 budget proposal on February 4 outlining his spending priorities for next year. Though Congress ultimately determines how much money the government will spend and on what programs, the President's budget is the starting point for discussion between his position and Congressional spending priorities.

And the President's proposal carries great weight in the budget process, especially in an election year, when the Republican-controlled House of Representatives is unlikely to buck his priorities.

For advocates of comprehensive sexuality education, his proposal represents an unusual scenario. First, and perhaps most interestingly, he seeks abstinence-only-until-marriage education 510(b) funding to remain level at \$50 million per year. This means he has no desire to see this particular program grow.

His proposal also earmarks two million new federal dollars to similar education efforts funded through the Adolescent Family Life Program (bringing fiscal 2003 funding of this program to \$31 million).

He does, however, make good on his campaign pledge "to spend as much money on abstinence-only-until-marriage

education programs as on contraception programs." And he continues to use "fuzzy math" in an attempt to secure \$135 million for abstinence-only-until-marriage programs in fiscal year 2003—a 33 percent increase over 2002—entirely through the Special Projects of Regional and National Significance-Community Based Abstinence Education (SPRANS-CBAE) program. That would bring the program's current budget from \$40 to \$73 million.

Advocates of abstinence-only-until-marriage programs have heralded the President's new proposals. Michael Schwartz, vice president of governmental relations at Concerned Women for America, called it "very good news" and said that "one of the problems of last year's budget was that it failed to include an increase in abstinence funding." He appears to have overlooked the \$20 million increase in SPRANS-CBAE funding in last year's federal budget—increasing it from \$20 to \$40 million.

In response to President Bush's proposed increase in federal funding of abstinence-only-until-marriage education, nearly 30 organizations, including SIECUS, sent a letter to the White House urging him to reconsider his proposal.

In addition, three members of Congress—Reps. Barbara Lee (D-CA), Lynn Woolsey (D-CA) and James Greenwood (R-PA)—sent a letter to the President expressing "strong concern" about his proposed increase. They cited the Family Life Education Act (HR 3469), of which the three are the current lead sponsors, as an example of how new federal dollars should be spent on sexuality education. If passed, HR 3469 will allocate \$100 million per year to scientifically sound sexuality education programs that include information on both abstinence and contraception.

A N D M O R E M A R R I A G E

President Bush's budget also proposes \$300 million in federal funds to promote marriage for those who receive benefits from the Temporary Assistance to Needy Families (TANF) program. While his budget does not contain details, the Bush Administration is promoting it as an anti-poverty measure based on data that children raised in two-parent families are less likely to grow up in poverty.

The Administration plans to fund the proposal by eliminating the “illegitimacy bonus” in the 1996 welfare reform law. This was designed to create a competition among states to reduce their out-of-wedlock births without increasing abortions. Since 1998, \$100 million—\$25 million per year to four states with the highest success rates—have been awarded to states with statistically insignificant reductions. The competition was a considerable failure.

While no one is sorry to see the “illegitimacy bonus” disappear, many advocates would like to see the money redirected to teen pregnancy prevention efforts, not marriage promotion.

HIV/AIDS PRIORITIES

The Bush Administration’s proposed spending on HIV/AIDS prevention, care, and treatment has done little to reassure advocates who are still concerned about his appointments to the Presidential Advisory Council on HIV/AIDS (PACHA) this January.

For example, he proposes to level fund the Ryan White CARE Act at \$1.911 billion in fiscal year 2003. He also intends to level fund HIV-, STD- and TB-prevention efforts at the U. S. Centers for Disease Control and Prevention at \$1.143 billion.

Considering that the CDC recently increased its estimate of HIV-infected Americans from approximately 600,000 to nearly one million and that an estimated 25 percent of those infected are unaware of their sero-positive status, the proposed budget fails to meet uphill efforts to halt the epidemic.

On the global front, HIV/AIDS funding fared no better. The Global Fund to Fight AIDS, Tuberculosis, and Malaria is

scheduled to receive a small increase of \$200 million and the HIV/AIDS programs of the United States Agency for International Development (USAID) are scheduled to receive a \$115 million increase.

Ironically, President Bush’s budget figures were made public the same day that *The Washington Post* reported on a study released by the World Health Organization and several United Nations agencies indicating that the “major obstacles” of “insufficient will and money” were the reasons why the global AIDS-related death toll could not be cut by 25 percent by 2010 and why deaths from malaria and tuberculosis could not be halved over the same period. The price tag for the global effort was estimated at \$12 billion over the next eight years. President Bush’s HIV/AIDS funding mentioned above would represent less than 20 percent of this amount.

CONCLUSION

The President’s budget proposals clearly indicate where his Administration’s priorities lie on issues of reproductive and sexual health. The main goals are the promotion of marriage regardless of circumstances and an insistence upon abstinence for all single people, regardless of age.

While the reauthorization of welfare reform is sure to continue to garner a great deal of attention for fiscal year 2003, advocates of reproductive and sexual health face a significant challenge.

Even though the annual federal appropriations cycle is always a struggle, it may prove more so this year. If President Bush’s approval rating remains high, and the battle for the control of Congress is as close as most political pundits predict, every elected official will tread lightly.

MAY IS “NATIONAL TEEN PREGNANCY PREVENTION MONTH”

May is “National Teen Pregnancy Prevention Month” designed to help young people make responsible choices about their sexual health and help them to advocate for themselves and their peers in preventing teen pregnancy in their schools and communities.

Those individuals interested in learning how they can participate in this activity, should check the Web sites www.ppfa.org or www.teenpregnancy.org

FACT SHEET

TEENAGE PREGNANCY, BIRTH, AND ABORTION

Pregnancy, birth, and abortion rates among teenagers in the United States have declined over the past decade but still remain an endemic public health issue.

Reasons for the decline include the increased motivation of youth to achieve higher levels of education; the availability of comprehensive sexuality education in schools, leading to young people's knowledge about contraception; more effective contraceptive use, and improved ability to negotiate contraceptive practice; and greater social support for services related to both pregnancy and disease prevention among adolescents.¹

Despite the decline, young women of color are disproportionately affected by teenage childbearing. In 2000, the birth rates for African American teenagers were reported as the lowest ever in the 40 years for which data for African American women are available. However, the rates for Hispanic teenagers remained the highest for any population group.²

PREGNANCY

Although pregnancy rates among adolescents have steadily declined in the past decade, the United States continues to have the highest adolescent pregnancy rates among industrialized nations.

- Each year in United States, 800,000 to 900,000 adolescents 19 years of age or younger become pregnant³
- The pregnancy rate for teenagers 15 to 19 years of age fell 19 percent from 116 per 1,000 in 1991 to 94.3 in 1997, reversing an 11 percent rise from 1986 to 1991⁴
- From 1995 to 1997, the pregnancy rate for 15- to 19-year-olds decreased in 41 of the 43 reported geographic areas for which age-specific data were available⁵
- During 1995 to 1997, the pregnancy rate declined by 11.3 percent among females less than 15 years of age, by 10.7 percent among females 15 to 17 years of age, and by 5.8 percent among females 18 to 19 years of age⁶
- For each year from 1995 to 1997, the pregnancy rate for females 18 to 19 years of age was approximately 2.5 times that of females 15 to 17 years of age, and the rate for females less than 15 years of age was approximately one ninth that of females 15 to 17 years of age⁷
- From 1995 to 1997, the national number of pregnancies among females 15 to 19 years of age declined by 3.1 percent⁸
- In 1996, the pregnancy rate for females 15 to 19 years of age in the United States was 83.6 per 1,000 compared to:
 - 1995—France 20.2 per 1,000
 - 1996—Sweden 25.0 per 1,000

- 1995—Canada 45.7 per 1,000
- 1995—Great Britain 46.7 per 1,000

- In 1995, 14 percent of all sexually experienced males 15 to 19 years old were involved in a pregnancy. This included 10 percent of sexually experienced White males; 19 percent of sexually experienced Latino males; 22 percent of sexually experienced African American males.¹⁰

PREGNANCY RATES BY RACE/ETHNICITY

Despite the recent decline of pregnancy rates in the United States, young women of color continue to be disproportionately affected. In addition, adolescent pregnancy does not affect all communities in the same way. For example, while African American teens have experienced the greatest recent decline in pregnancy rates, those among Latina teens have not declined as significantly.

All Women

- In 1997, 2.6 per 1,000 women under the age of 15 became pregnant compared with 3.5 per 1,000 in 1990¹¹
- In 1997, 63.7 per 1,000 women 15 to 17 years of age became pregnant compared with 80.3 per 1,000 in 1990¹²
- In 1997, 141.7 per 1,000 women 18 to 19 years of age became pregnant compared with 162.4 per 1,000 in 1990¹³

White Non-Hispanic Women

- In 1997, 1.1 per 1,000 White women under the age of 15 became pregnant compared with 1.5 per 1,000 in 1990¹⁴
- In 1997, 41.1 per 1,000 White women 15 to 17 years of age became pregnant compared with 56.3 per 1,000 in 1990¹⁵
- In 1997, 102.4 per 1,000 White women 18 to 19 years of age became pregnant compared with 126.4 per 1,000 in 1990¹⁶

African American Women

- In 1997, 7.7 per 1,000 African American women under the age of 15 became pregnant compared with 11.8 per 1,000 in 1990¹⁷
- In 1997, 119.8 per 1,000 African American women 15 to 17 years of age became pregnant compared with 165 per 1,000 in 1990¹⁸
- In 1997, 248 per 1,000 African American women 18 to 19 years of age became pregnant compared with 295.3 per 1,000 in 1990¹⁹

Hispanic Women

- In 1997, 3.9 per 1,000 Hispanic women under the age of

- 15 became pregnant compared with 4 per 1,000 in 1990²⁰
- In 1997, 99.1 per 1,000 Hispanic women 15 to 17 years of age became pregnant compared with 101 per 1,000 in 1990²¹
- In 1997, 223.7 per 1,000 Hispanic women 18 to 19 years of age became pregnant compared with 231.4 per 1,000 in 1990²²

BIRTH

Like pregnancy rates, birth rates among adolescents in the United States have dropped in recent years. However, the rate continues to be more than four times that of many industrialized nations.

- In 2000, the United States had 48.7 births per 1,000 women 15 to 19 years of age. According to the latest available data, Denmark, Finland, France, Germany, Italy, Japan, the Netherlands, Spain, Sweden, and Switzerland each had less than 10 births per 1,000 women 15 to 19 years of age.²³
- The birth rate for females 10 to 14 years of age remained unchanged in 2000 with 0.9 births per 1,000. However, the number of births to females 10 to 14 years of age dropped 6 percent from 1999 to 2000, to 8,519; the lowest total reported in any year since 1966 (8,128).²⁴
- Between 1999 and 2000, the birth rate for females 15 to 17 years of age declined 5 percent to 27.4 per 1,000, an all-time low, and 29 percent per 1,000 from 1991 (38.7) to 2000²⁵
- In 2000, the birth rate for females 18 to 19 years of age declined 1 percent to 79.2 per 1,000. Since 1992, when the rate reached its recent high (94.5), it has declined 16 percent and is at its lowest point in more than a decade (78.5 in 1987).²⁶
- The birth rate for females 15 to 19 years of age declined 2 percent to 48.5 per 1,000 in 2000, another record low for the nation. This rate has declined 22 percent from 1991 when the rate reached a peak (62.1).²⁷
- From 1991 to 2000, birth rates for Mexican, Puerto Rican, Cuban, and “other” Hispanic teenagers fell by 6 to 13 percent each, while rates for American Indian and Asian Pacific Islander teenagers fell 20 to 21 percent, rates for non-Hispanic White teens fell 24 percent, and rates for African American teenagers fell 31 percent. The rate for African American teenagers in 2000 is an historic low (data available since 1960).²⁸
- In 1995, 22 percent of women 20 through 24 years of age in the United States had a child before age 20 in comparison to:²⁹
 - o 1996—Sweden 4 percent
 - o 1994—France 6 percent

- o 1995—Canada 11 percent
- o 1990-1991—Great Britain 15 percent

BIRTH RATES BY RACE/ETHNICITY

In recent years, birth rates among all races/ethnicities have declined, with young African American women experiencing the largest drop among all races/ethnicities.

All Women

- In 2000, the birth rate for women 10 to 14 years of age was 0.9 per 1,000 compared with 1.4 per 1,000 in 1990³⁰
- In 2000, the birth rate for women 15 to 17 years of age was 27.4 per 1,000 compared with 37.5 per 1,000 in 1990³¹
- In 2000, the birth rate for women 18 to 19 years of age was 79.2 per 1,000 compared with 88.6 per 1,000 in 1990³²

White Women

- In 2000, the birth rate for White women 10 to 14 years of age was 0.6 per 1,000 compared with 0.7 per 1,000 in 1990³³
- In 2000, the birth rate for White women 15 to 17 years of age was 23.6 per 1,000 compared with 29.5 per 1,000 in 1990³⁴
- In 2000, the birth rate for White women 18 to 19 years of age was 72.7 per 1,000 compared with 78.0 per 1,000 in 1990³⁵

African American Women

- In 2000, the birth rate for African American women 10 to 14 years of age was 2.4 per 1,000 compared with 4.9 per 1,000 in 1990³⁶
- In 2000, the birth rate for African American women 15 to 17 years of age was 50.4 per 1,000 compared with 82.3 per 1,000 in 1990³⁷
- In 2000, the birth rate for African American women 18 to 19 years of age was 121.3 per 1,000 compared with 152.9 per 1,000 in 1990³⁸

American Indian Women

- In 2000, the birth rate for American Indian women 10 to 14 years of age was 1.3 per 1,000 compared with 1.6 per 1,000 in 1990³⁹
- In 2000, the birth rate for American Indian women 15 to 17 years of age was 39.6 per 1,000 compared with 48.5 per 1,000 in 1990⁴⁰
- In 2000, the birth rate for American Indian women 18 to 19 years of age was 113.1 per 1,000 compared with 129.3 per 1,000 in 1990⁴¹

Asian or Pacific Islander Women

- In 2000, the birth rate for Asian or Pacific Islander women 10 to 14 years of age was 0.3 per 1,000 compared with 0.7 per 1,000 in 1990⁴²
- In 2000, the birth rate for Asian or Pacific Islander women

15 to 17 years of age was 11.5 per 1,000 compared with 16 per 1,000 in 1990⁴³

- In 2000, the birth rate for Asian or Pacific Islander women 18 to 19 years of age was 37 per 1,000 compared with 40.2 per 1,000 in 1990⁴⁴

Unmarried Women

- During 1999–2000, birth rates for unmarried women 15 to 17 years of age declined 4 percent to 24.4 per 1,000⁴⁵
- During 1999–2000 the birth rate for unmarried women 18 to 19 years of age dropped by approximately 1 percent to 62.9 per 1,000⁴⁶
- Between 1999 and 2000, birth rates for unmarried non-Hispanic women 15 to 19 years of age fell 4 percent and the rates for unmarried African American women 15 to 19 years of age fell 2 percent while the rate for Hispanic women 15 to 19 years of age increased approximately 1 percent⁴⁷

BIRTH RATES BY AGE AND RACE OF FATHER

There is very little information available regarding males involved with teen pregnancies and births.

- In 2000, the birth rate for all males 15 to 19 years of age was 20.2 per 1,000 compared with 23.5 per 1,000 in 1990⁴⁸
- In 2000, the birth rate for all White males 15 to 19 years of age was 16.8 per 1,000 compared with 18.1 per 1,000 in 1990⁴⁹
- In 2000, the birth rate for all African American males 15 to 19 years of age was 40.1 per 1,000 compared with 55.2 per 1,000 in 1990⁵⁰

ABORTION

Not all states collect data on abortion. Therefore, it is not possible to track trends for the entire country. Based on the data that is available, abortions rates are declining. Still, as with adolescent pregnancy and birth rates, abortion rates for teens in the United States remain higher than in other industrialized nations.

- From 1995 to 1997, the abortion rate for females 15 to 19 years of age decreased in 32 of the 43 geographic areas within the United States for which age-specific data were available⁵¹
- From 1995 to 1997, the abortion rate decreased 3.9 percent among females younger than 15 years of age (from 2.8 to 2.7 per 1,000), 10.1 percent among females 15 to 17 years of age (from 18.2 to 16.3 per 1,000), and 5.4 percent among females 18 to 19 years of age (from 39.6 to 37.5 per 1,000)⁵²

- From 1995 to 1997, in 25 of the 31 geographic areas where both birth and abortion rates decreased, the decrease in abortion rates exceeded the decline in birth rates⁵³
- In 1996, the abortion rate for females 15 to 19 years of age in the United States was 29.2 per 1,000 compared to:⁵⁴
 - o 1995—France 10.2 per 1,000
 - o 1996—Sweden 17.2 per 1,000
 - o 1995—Great Britain 18.4 per 1,000
 - o 1995—Canada 21.2 per 1,000

From 1995 to 1997, in 25 of the 31 geographic areas where both birth and abortion rates decreased, the decrease in abortion rates exceeded the decline in birth rates⁵⁴

ABORTION RATES BY RACE/ETHNICITY

All Women

- In 1997, 1 per 1,000 women under the age of 15 had induced abortions compared with 1.5 per 1,000 in 1990⁵⁵
- In 1997, 17.4 per 1,000 women 15 to 17 years of age had induced abortions compared with 26.5 per 1,000 in 1990⁵⁶
- In 1997, 43.1 per 1,000 women 18 to 19 years of age had induced abortions compared with 57.9 per 1,000 in 1990⁵⁷

White Non-Hispanic Women

- In 1997, 0.5 per 1,000 White women under the age of 15 had induced abortions compared with 0.8 per 1,000 in 1990⁵⁸
- In 1997, 11.6 per 1,000 White women 15 to 17 years of age had induced abortions compared with 21 per 1,000 in 1990⁵⁹
- In 1997, 28.4 per 1,000 White women 18 to 19 years of age had induced abortions compared with 46.5 per 1,000 in 1990⁶⁰

African American Women

- In 1997, 3.4 per 1,000 African American women under the age of 15 had induced abortions compared with 5.4 per 1,000 in 1990⁶¹
- In 1997, 40.6 per 1,000 African American women 15 to 17 years of age had induced abortions compared with 57.7 per 1,000 in 1990⁶²
- In 1997, 96.7 per 1,000 African American women 18 to 19 years of age had induced abortions compared with 117.4 per 1,000 in 1990⁶³

Hispanic Women

- In 1997, 1.2 per 1,000 Hispanic women under the age of 15 had induced abortions compared with 1.1 per 1,000 in 1990⁶⁴
- In 1997, 21.9 per 1,000 Hispanic women 15 to 17 years

of age had induced abortions compared with 24.3 per 1,000 in 1990⁶⁵

- In 1997, 55.7 per 1,000 Hispanic women 18 to 19 years of age had induced abortions compared with 59.5 per 1,000 in 1990⁶⁶

WHAT TEENS HAVE TO SAY ABOUT TEEN PREGNANCY

- 88 percent of teens 12 to 19 years of age think the number of teenage pregnancies in the United States is a serious problem⁶⁷
- Approximately 87 percent of teens 12 to 19 years of age say the teens they know think avoiding pregnancy is important⁶⁸
- Approximately 41 percent of teens 12 to 19 years of age say they have learned the most about preventing teen pregnancy from teachers and sexuality educators, and 34 percent say they have learned about preventing teen pregnancy from parents and other adults⁶⁹
- Approximately 63 percent of teens 12 to 19 years of age believe that other than teens themselves, parents, and adults are most responsible for fixing the problem of teen pregnancy⁷⁰
- Approximately 67 percent of teens 12 to 19 years of age feel that if they were to offer advice to leaders in Washington regarding teen pregnancy, they would suggest greater emphasis on both encouraging teens not to have sexual relations and on birth control or protection⁷¹
- Approximately 85 percent of teens 12 to 19 years of age feel that there has been more focus on preventing teen pregnancy in the past five years⁷²

PREGNANCY RISKS AND OUTCOMES

- 94 percent of teens believe that if they were involved in a pregnancy they would stay in school; in reality, 70 percent eventually complete high school⁷³
- 51 percent of teens believe that if they were involved in a pregnancy they would marry the mother/father; in reality, 81 percent of teenage births are to unmarried teens⁷⁴
- 26 percent of teens believe that they would need welfare to support a child; in reality 56 percent receive public assistance to cover the cost of delivery and 25 percent of teen mothers receive public assistance by their early twenties⁷⁵
- 32 percent of teens say they would consider an abortion; in reality, 50 percent of pregnancies to unmarried teens end in abortion⁷⁶

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Manuscripts are read with the understanding that they are not under consideration elsewhere and have not been published previously. Manuscripts not accepted for publication will not be returned. Upon acceptance, all manuscripts will be edited for grammar, conciseness, organization, and clarity.

To expedite production, submissions should adhere to the following guidelines:

PREPARATION OF MANUSCRIPTS

Feature articles are usually 2,000–4,000 words. Book and audiovisual reviews are typically 200–600 words.

Manuscripts should be submitted on 8½ x 11 inch paper, double-spaced, with paragraphs indented. Authors should also send a computer disk containing their submission.

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The beginning of an article should include the title, subtitle, author's name and professional degrees, and author's title and professional affiliation.

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