Teen Childbearing and Public Policy

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Abstract

Rates of teen pregnancy and childbearing in the United States have declined by almost one third since 1991, but the U.S. still far exceeds other developed countries, and teen mothers have become less and less likely to be married. It is increasingly well documented that early parenthood is related to a variety of adverse consequences, such as learning deficits for children, decreased educational attainment and employment of parents, lessened probability that parents will marry, and increased welfare dependency. This paper reviews and assesses the evidence linking early childbearing to adverse consequences, and it concludes by describing public policy proposals to reduce teen pregnancy.

INTRODUCTION

About 80 percent of teen pregnancies and 60 percent of all pregnancies in the United States are unintended at conception (Alan Guttmacher Institute, 1999; Henshaw, 1998). When adolescent females give birth, approximately 80 percent are unmarried, compared to 34 percent of women of all ages (Ventura, Mosher, Curtin, Abma, & Henshaw, 1999). Martial status is strongly related to pregnancy intentions and pregnancy outcomes; about three quarters of pregnancies that occurred in 1995 among married women resulted in live births, compared to less than half among unmarried women (Ventura et al., 1999).

In the United States, childbirth is the most common outcome of teen pregnancy, accounting for a little over half, with abortions terminating about one-third, and the rest ending in miscarriages (Henshaw, 2003). Teen pregnancy can be conceptualized as the sum of the following components, which are also depicted in Figure 1:

TEEN PREGNANCY = MISCARRIAGES + ABORTIONS + LIVE BIRTHS

(Figure 1 About Here)

Pregnancies among adolescent females have been on the decline since they peaked in 1991, when they reached a high of 117 pregnancies for every 1000 females between the ages of 15-19 (Henshaw, 2003). Data for the year 2000 showed a 31 percent drop since 1991 in the U. S. teen pregnancy rate equaling 86 pregnancies per 1000 or 800,000 per year (Henshaw, 2003). Parallel declines have occurred in both teen abortion and birth rates (see Figure 2).

(Figure 2 About Here)

Among developed counties, United States teen pregnancy and birth rates are

among the highest in the world (Singh & Darroch, 2000). In the Netherlands the teen pregnancy rate is very low (about 12 per 1000 females) and many other European countries have teen pregnancy rates under 40 per 1000 (Singh & Darroch, 2000). For Australia, Canada, New Zealand and additional European counties, the rates are moderate, between 40 and 69 per 1000. Of developed countries, only the Russian Federation along with its neighbors Belarus, Bulgaria and Romania compare to the United States (see Figure 3), having extremely high teenage pregnancy rates (above 69 per 1000).[i]

(Figure 3 About Here)

Many researchers have focused on the individual, family, and community characteristics that are believed to be related to having unprotected sexual intercourse and becoming pregnant or causing a teen pregnancy (Kirby, 2001; Miller, Bayley, Christensen, Leavitt, & Coyl, 2003; Miller, Benson, & Galbraith, 2001). Teen females who are older, black or Latino, those who have poor grades or lacked education plans are more likely to be sexually active and to neglect contraceptive use. Further, teens who were physically or sexually abused, have low religiosity, use controlled substances, or who display psychosocial deviance are at higher risk than others. At the family level, low parental education and income, living in a single parent home, lacking parental support or supervision, and having parents with permissive sexual values all have been associated with sexual activity and non-use of contraceptives. Permissive peer sexual values and low neighborhood SES are other notable risk factors. Adolescent females who exhibit or experience a greater number of these risk factors are more likely to experience early childbearing than those with fewer of these characteristics (Small &

Luster, 1994).

CONSEQUENCES OF TEEN CHILDBEARING

Teen Mothers

Teen pregnancy and childbearing problems are compounded by the fact that more and more pregnant teens are facing the responsibilities of parenthood alone. As shown in Figure 4, the 15 percent of all teen births to mothers who were not married in 1960 (Ventura & Bachrach, 2000) increased dramatically until 1994, when it leveled off and has remained consistent at about 80 percent of teenage mothers giving birth outside of marriage (Martin & Park-Sutton, 2002). Teen mothers who have children outside of marriage are at a greater disadvantage both before and after giving birth. Teens who come from poverty or low-income situations are more likely to be sexually active and less likely to use contraceptives (Miller, Benson, & Galbraith, 2001). Poor or low-income adolescents make up 38 percent of women ages 15-19, but they account for 73 percent of all pregnancies among 15-19 year olds. Nearly 60 percent of all teen mothers live in poverty at the time they give birth (Alan Guttmacher Institute, 1994). Women who become pregnant as teenagers are also less likely to become married later on, compared to those who decide to postpone childbirth (Bennett, Bloom, & Miller, 1995).

Single mothers of all ages have lower educational attainment. Teen mothers are more likely to drop out of high school, and less likely to obtain a high school diploma. Among teens that have given birth, only 30 percent earned a diploma by the age of 30, compared to 85 percent of those who postponed childbirth (Hotz, McElroy, & Sanders, 1997). Corresponding to their lower education, teen mothers also have lower

employment and a significantly lower earning potential. Typically, earned wages of adolescent mothers account for only one-third of their total income, the remaining two-thirds consisting of child support, extended family support, and public assistance (REF).

Adolescents who get pregnant also put themselves at greater risk for medical complications. Adolescent pregnancy has been linked to poor maternal weight gain, pregnancy-induced hypertension, anemia, sexually transmitted diseases, and the teen mother is more than twice as likely as an adult mother to die of complications due to pregnancy (Committee on Adolescence, 1999).

Children Born to Teenage Mothers

Women who have unintended pregnancies are both less likely to receive prenatal care, and more likely to expose developing fetuses to harmful substances such as alcohol and tobacco (Brown & Eisenberg, 1995). Because only about 20 percent of all teenage mothers intended to get pregnant (Henshaw, 1998), their unplanned children suffer higher rates of infant death and low birth weight than those who were planned; they are also more likely to experience abuse and/or neglect, further comprising their normal development (Brown & Eisenberg, 1995).

Adolescent childbearing also has an effect on the type and quality of care and nutrition received by young children. About 60 percent of older mothers report their children's health as "excellent," compared to only 38 percent of adolescent mothers (Wolfe & Perozek, 1997). Based on these figures, the children of adolescent mothers might be expected to spend more time in the care of a physician, but the opposite is true; children of adolescent mothers see a physician about half as often (2.3 versus 4.8 times a year) as children born to older parents (Wolfe & Perozek, 1997). Factors such

as motivation, peer support or influence, and community context are responsible for at least one third of this difference. In spite of their less frequent doctor visits, adolescent mothers spend 20 percent more for children's medical care than their later bearing counterparts. Of the $3,700 in medical services spent annually per child by adolescent mothers, about one half is paid for through public assistance (Wolfe & Perozek, 1997).

Children of adolescent mothers also are more likely to grow up in homes in which parents provide less emotional support and cognitive stimulation. Parental affection, books, games, and educational toys are less available, on average, especially in homes were the mother is working increased hours or the child's father is absent. Children born to younger teenage mothers (those younger than 18) score lower in cognitive tests of mathematics, reading recognition, and reading comprehension than children born to parents in their early twenties (Hotz, McElroy, & Sanders, 1997), even after controlling for differences in the mother's socioeconomic backgrounds. When children of teenage mothers enter school, they are 70 percent less likely to be rated at the top of their class (Hotz et al., 1997). As school performance lags, perhaps in part due to lower levels of cognitive stimulation at young ages and inferior nutritional and emotional support, children of adolescent mothers are also more likely to drop out of high school than peers with older mothers (Haveman, Wolfe, & Peterson, 1997). Approximately 57 percent of this difference can be attributed to the effects of adolescent childbearing and closely related factors (Maynard, 1996).

There are serious economic consequences of being raised by a teenage mother. Most teenage mothers are single when they give birth, and are more likely to remain single well into their 30's. Single mother households have a median income of $18,000

per year compared to over $50,000 per year for two-parent families (McLanahan & Scwartz, 2002). Family income is related to the types and quality of neighborhoods children live in, the schools they attend, and frequency of moving. As they grow older, children of teenage mothers are at greater risk for running away from home (Moore, et al., 1997) and sons born to teen mothers are more likely to spend part of their lives in prison (Grogger, 1997). Children of teenage mothers are also more likely to become parents themselves before the age of 19, and are more likely to bear children out of wedlock when compared to children born to women who delayed birth.

Fathers of Teenage Pregnancies

Almost two-thirds of fathers of children born to teenage mothers are older than 20 years of age (Landry & Forrest, 1995). Elo, King, and Furstenberg (1999) reported that the number of adolescent mothers failing to report fathers' ages on birth certificates has increased from 13 percent in 1960 to 40 percent in 1990. Taking into account the missing data, Elo, King, and Furstenberg (1999) confirmed earlier estimates of adult males who father adolescent pregnancies. Probably due to their potential criminality, there is little information available about the adult males who father adolescent pregnancies.

The teenage males who father approximately one-third of adolescent pregnancies are somewhat better described in the literature. Adolescent fathers are significantly over-represented in the blue-collar labor force and are under represented in white-collar occupations (Buchanan & Robbins, 1990). These fathers are similar to teenage mothers in that they also tend to complete less schooling by age 27 as compared to those who waited to father children until age 21. Studies have

documented the early involvement in delinquent activities and/or illegal drug use by teenage fathers (Stouthamer-Loeber & Wei, 1998; Thornberry, Smith, & Howard, 1997). Over a span of 18 years following the birth of a first child during adolescence, young fathers earn about one-quarter less than men who delay fatherhood. More than half of this deficit can be directly attributed to early childbearing and other closely related factors (Brien & Willis, 1997).

Non-residential father involvement in terms of physical interaction and regular financial support is important for positive child outcomes (Lamb, 2002; McLanahan & Carlson, 2002; Pleck, 1997). On average, non-residential fathers earn wages sufficient to offset as much as 40-50 percent of welfare support to adolescent mothers and their children (REF). Policy makers have argued that increasing established paternity, increasing support orders for qualifying families, setting fair awards, and enforcing collection of those awards would significantly reduce state obligations to poor families (Garfinkel, Miller, & McLanahan, 1998). However, only about 15 percent of never-married teen mothers are awarded court-ordered child support, and most of those receive less than half of the amount awarded (REF). Often it is inability, rather than unwillingness, to pay support that prohibits the collection of financial resources from fathers (Sorensen & Zibman, 2001). Related issues include second family formations, and income status of fathers. Current calculations of support obligations fail to consider the demands of second family formations, and poor fathers are more likely to be targets of support orders because their children are more likely to be involved in welfare dependency than children whose fathers are more financially secure (Garfinkel, Miller, McLanahan, & Hanson, 1998).

Consequences For Society

Direct economic costs of adolescent childbearing are estimated at about $7 billion annually (NCPTP, 2003). Direct costs include welfare and food stamp benefits ($2.2 billion), medical expenses ($1.5 billion), loss of tax revenue ($1.3 billion), foster care ($0.9 billion), and incarceration expense ($1 billion). If these costs were combined with other disadvantages faced by adolescent mothers, a total savings to taxpayers of between 13 and 19 billion dollars per year could be achieved if teenage childbearing could be effectively delayed.

Beyond the economic loss to society, adolescent childbearing also strains the time, resources, and effectiveness of public programs and systems. Controlling for a moderate range of background factors, researchers estimate the combined direct and indirect cost of adolescent childbearing at approximately $21 billion per year (Maynard, 1997). These large public costs are partially responsible for generating a concerted public policy focus on reducing teen pregnancy. A summary of these major consequences to teen mothers, fathers, their children, and society is shown in Table 1.[ii]

(Table 1 About Here)

PUBLIC POLICY EFFORTS

What can be done through public policy to decrease the incidence of teen pregnancy and to create healthier environments for children growing up in homes headed by adolescent mothers? Finding solutions for adolescent pregnancy is difficult, beginning with defining the problem itself. Consider this list of volatile issues: adolescent sexual intercourse, contraceptive use, pregnancy, abortion, adoption, and the rights of children versus those of parents. Paraphrasing a National Research

Council report (Hayes, 1987), some view the problem as early nonmarital sexual activity--if teens were not having intercourse they would not become pregnant; others argue that public programs should help sexually active teens avoid pregnancy by using contraceptives; other view the problem as early childbearing--suggesting that pregnant teens should be supported in choosing abortion; others view the problem as premature parenthood, suggesting the option of adoption. In short, even the analysis and description of these issues, much less prescriptions for altering social policies, are based on social constructions that are highly value laden and controversial (Miller, 1992). The main focus here is to highlight current policy efforts and consider their efficacy in a wide range of settings to better inform policymakers charged with distributing limited resources. Prevention and intervention efforts could be made at each decision crossroad (i.e., engaging in sex, using contraception, abortion, adoption, teen-parenting). Figure 5 portrays those key decision points.

(Figure 5 About Here)

What Should be the Role of Government?

In a nation that emphasizes the importance of individual privacy rights and self-determination, the legislation of sexual behavior is approached reluctantly (REF), even with youth (REF). To complicate the issue further, the individual right to parent as one chooses has been long protected by legislation and there is a social expectation that government will not interfere with parenting unless children are at serious risk (Bogenschneider, 2002). The 1996 welfare reform act placed the responsibility of parenting squarely in the hands of biological or adoptive parents (Bogenschneider, 2002), allowing only very limited involvement of the government (especially to provide

tangible support).

Public policy has limited influence on the overt behaviors of citizens and especially youth (REF). It would seem then, that resources should be placed where research has shown that public policy could make the most positive difference. Rigorous, objective policy analysis in this area is unfortunately very limited.

Prevention Policy

Sexual education. There have been three main approaches to presenting sexual and contraceptive information to adolescents: 1) abstinence-only, 2) abstinence-first, and 3) abstinence-plus.

Abstinence-only. Abstinence-only curricula teach teens that delaying sexual intercourse until marriage is the only sure way to avoid unwanted pregnancy and sexually transmitted infections. Alternative methods of avoiding these outcomes are not discussed and the costs of premature sex to self, family, friends, and society are highlighted. In 1981, the Adolescent Family Life Act (AFLA) was passed with a primary goal of decreasing the incidence of adolescent pregnancy. As part of that effort, $11 million dollars was allocated in 1981 for abstinence-only education (Kaiser Family Foundation, 2002a). The 1996 welfare reform legislation continued emphasizing abstinence-only curricula (Brindis, 2002) allotting $250 million over five years for block grants to states presenting an abstinence message. Despite the current political endorsement of abstinence-only curricula, research on its effectiveness has been sparse. Kirby (2001) reported that only three rigorous evaluations have been conducted, and none found any impact on adolescent sexual behavior. Kirby stated however, that not enough definitive research has been conducted to make a scientific

judgment about the effectiveness of abstinence-only curricula.

Abstinence-first. Abstinence-first curricula emphasizes the importance of teaching that sexual abstinence should be the first — but not necessarily the only — message about sex conveyed to teenagers. Although there has been little research on the efficacy of this approach, it amplifies the dialectic exchanged between parents, youth, and teen pregnancy prevention advocacy groups across the nation (National Campaign to Prevent Teen Pregnancy, 2001). In a review of parental response to this issue, most parents contended they favored an "abstinence as the best option" message that included the positive impacts of waiting. However, many teens and parents agreed that since half of high school-aged teens have had intercourse, a tailored message for sexually active teens should emphasize the importance of contraceptive use for STD and pregnancy avoidance.

Abstinence-plus. In 2000, thirteen states required both abstinence and contraception education in their schools (Brindis, 2002). This approach emphasizes both the importance of delaying sexual intercourse and the use of contraception to avoid pregnancy and sexually transmitted infections. Rigorous evaluations (i.e. random assignment, large sample sizes, long-term follow-up) of school-based and community sex/HIV education programs based on these dual messages have shown statistically significant and programmatically important reductions in the frequency of sex, as well as increases in condom and contraceptive use, delays in sexual initiation, and decreases in unprotected sex (Coyle et al., 1999; Jemmott, Jemmott, & Fong, 1998). The findings are mixed, however, because some programs did increase condom or contraceptive use, but others did not, and less effect has been demonstrated on reducing adolescent

pregnancy (Kirby, 2001). Data show that sex and HIV education programs do not significantly increase adolescent sexual activity, a concern that has made adolescent sex education programs controversial.

Family education programs. Kirby and Miller (2002) reviewed several approaches to increasing parent-child sexual communication (e.g., multi-session family programs, parent only, school orientation programs, school homework assignments, and college sexuality education). They concluded that the relation between parent-child sexual communication and adolescent sexual behavior is more complex than a direct link, and that programming must addresses the complex issues around communication barriers, parent-child relationship quality, and parental values about adolescent sexuality. Additionally, they recommend that parent-child sexual communication might best be delivered as part of a comprehensive parent-child program.

Community education programs. Most community-wide approaches to teen pregnancy prevention are multifaceted (Kirby & Miller, 2003). Evaluating such programs is difficult because the unit of analysis is often the community and not the individual. At the community level, media public service announcements (Doninger, Riley, Utter, & Adams, 2001) increased condom availability (Kirby & Brown, 1996; Polen & Freeborn, 1995), and small-group workshops (Polen & Freeborn, 1995) have shown success in decreasing overall teen pregnancy rates. Multi-agency, community-wide collaboration showed promise in one community (Koo, Dunteman, George, Green, & Vincent, 1994), although replication in another community did not produce significant results (Paine-Andrews, Harris, Fisher, Williams, Fawcett, & Vincent, 1999). Community-wide education about abstinence or contraceptive use has not been

reported to increase adolescent sexual activity (Kirby, 2001). More intensive programs are more effective; however when programs end, the use of condoms and pregnancy rates return to pre-program levels (REF).

Contraception Availability

In 1970 the federal government enacted Title X of the Public Health Service Act which required that a nationwide family planning services program be created and that clients of the program would be provided services regardless of age or marital status (Brindis, Pagiaro, & Davis, 2000). Federally-funded family planning services are estimated to prevent 1.3 million unplanned pregnancies per year (Alan Guttmacher Institute, 2002) or 20 million unwanted pregnancies over the last 20 years, nine million of which would have ended in abortion (Alan Guttmacher Institute, 2000). For every dollar spent on family planning services, three dollars are saved in Medicare costs for pregnancy and newborn care (Alan Guttmacher Institute, 2000). This figure does not take into account money spent on welfare and food stamp benefits, foster care, prison, and lost tax revenue.

Title X family planning programs are required to deliver needed services such as contraceptives, gynecological treatment, and HIV/STD tests and treatment with a focus on poor women (Alan Guttmacher Institute, 2000). This is important in preventing adolescent pregnancy because teenage females are more likely than older women to depend on publicly supplied contraceptives (Frost & Bolzan, 1997). A nationwide study of government policies and teen sexual behaviors found that states with more family planning clinics per capita of teenage women also reported higher contraceptive use (Averett, Rees, & Argys, 2002). Reductions in adolescent sexual activity or overall

pregnancy rates have not been related to the provision of one-on-one health center consultations about sexual behavior, abstinence, and types of contraception, but increased condom and contraception use has been reported (Kirby, 2001).

In 1981 Title X was amended to encourage family-of-origin participation in the contraception and abortion decisions of minors (Brindis, 2002). Because of concerns regarding confidentiality in adolescent utilization of family planning services, states have struggled with requiring parental involvement. In a survey of Planned Parenthood clients, a little over half of adolescent females indicated that they would not seek reproductive services if parental notification was required (Reddy, Fleming, & Swain, 2002). Additionally, of those who indicated they would stop using family planning services, only one percent reported they would stop having sexual intercourse; almost 30 percent stated they would have unprotected sex. According to a telephone survey of youth regarding use of health care services, the most commonly sought confidential care is related to reproductive health (Klein, McNulty, & Flatau, 1998).

Indirect Prevention Efforts

Family support and early intervention. Several family characteristics such as family structure (Lammers, Ireland, Resnick, & Blum, 2000; Miller, Norton, Curtis, Hill, & Young, 1997), parental education (Resnick, et al., 1997; Steinmetz, 1999), parental employment status (Miller & Moore, 1990), poverty status (Harris & Marmer, 1996), and quality of the parent-child relationship (Boyer, Tschann, & Shafer, 1999; Dittus & Jaccard, 2000; Miller, 2002) have been correlated with adolescent sexual behavior and pregnancy. Some general early intervention programs that did not specifically target reducing teen pregnancy have, none-the-less, demonstrated promising long-tem

results: after an intense, full-time preschool intervention, participants had significantly lower levels of early childbearing than those who did not participate (Campbell, Ramey, Pungello, Sparling, & Miller-Johnson, 2002). Although expensive and labor intensive, more longitudinal studies designed to investigate the impact of such early intervention programs on adolescent childbearing are needed.

Youth development programs. A relatively recent approach to reducing teen pregnancy is through youth development programs that focus on a variety of activities such as service learning, academic achievement, and vocational training (Kirby, 2001). These programs have shown promise, although more research is needed to determine the actual reasons for success. Service learning and academic programs have shown success for the duration of participation (Allen, Philliber, Herrling, & Kuperminc, 1997; see Kirby 2001 for extensive review). Kirby (2001) reported that vocational training efforts have not been as well documented and additional study is needed to understand their impact on teen pregnancy. He hypothesized that providing opportunities for community service, increasing adolescents' attachment to school, increasing academic success, providing employment opportunities, increasing contact with caring adults, and providing supervised activities reduce the likelihood of teen pregnancy.

Comprehensive Approaches

Based on his thorough review, Kirby (2001) concluded that middle and high school prevention programs should include: (a) Instructional techniques that encourage youth involvement in and attachment to school; (b) Sex education programs that address both pregnancy and STD/HIV; (c) Service-learning programs that incorporate community service and ongoing small group discussions; (d) School-based or school-

linked clinics that focus upon reproductive health and give clear messages about abstinence and use of contraception; (e) School condom availability programs. Theoretically-based programs that address the numerous antecedents and risk-factors that affect teen pregnancy and provide information about sexual behavior, consequences, and information about abstinence and access to contraception are likely to be most effective in reducing teen pregnancy.

Kalmuss, Davidson, Cohall, Laraque and Cassell (2003) more recently assessed the findings of many different types of programs dealing with adolescent pregnancy and made the following recommendations: (1) intervention should begin earlier, and target younger adolescents. (2) Programs need to be modeled towards minority teenagers. Because of early vaginal sex among black youth, and low contraceptive use among Hispanic teenagers, new models need to be developed that are geared specifically towards these groups and their needs. (3) Pregnancy interventions need to be systematically linked to other programs that deal with socioeconomic disadvantages, because research is clear in linking economic and disadvantage to an increased risk for teenage pregnancy. Vocational, educational and counseling programs partnerships could be formed focusing on the goal to decrease teen pregnancy. (4) Because many youth lack the skills needed to practice safer sex, programs need to deal with the communication, negotiation, and refusal skills required for effective contraceptive use. Programs that deal only with the techniques of proper condom use might be ineffective because teens cannot emotionally or mentally put themselves into these situations. (5) Programs need to more effectively address the influence of peers, social norms, and pressures to have sex. Small intervention groups can become part of adolescents'

social and friendship networks, reinforcing normative and behavioral changes long after the program has concluded. (6) Program planners should not assume that all sex is volitional. Current models fail to take into account that some proportion of early sexual activity is involuntary or coercive. (7) Program planners should not assume that sexual activity is limited to vaginal sex. Adolescents engaging in alternate forms of sexual activity need to be warned of the risks for STI's associated with these practices, as well as how to protect themselves. (8) It should not be assumed that teenagers are motivated to prevent pregnancy. Many teenagers, especially those most at risk for pregnancy, are ambivalent when it comes to teen pregnancy, so they take few, if any steps to avoid it. Programs need to focus more on these ambivalent feelings which affect teens' motivations to delay sex or use contraception.

Intervention Policy

Family planning clinics are required to provide "options counseling" for any woman who has a positive pregnancy test at the clinic (REF). Options that could be discussed include abortion, adoption, and parenting.

Abortion Policy and Teen Pregnancy

Since the passage of *Roe v. Wade* in 1973, the Supreme Court has made two major decisions regarding adolescent females' right to seek abortions (The Kaiser Family Foundation, 2002b). In July of 1976 the Court ruled that parents could not block their adolescent daughters' rights to an abortion. However, in 1983, the Court ruled that states could require parental notification for females under the age of 18, as long as a judicial alternative existed for extreme cases.

The availability and cost of abortions varies greatly across the nation. In 2000,

abortion providers were established in 13 percent of all U.S. counties, where 66 percent of women ages 15-44 resided (Alan Guttmacher Institute, 2002). In 2001, an abortion at 10 weeks gestation cost an average of $372 (Henshaw & Finer, 2003). The Kaiser Family Foundation (2002b) reported thirty-two states currently provide Medicaid funding for abortions that are life threatening, where conception occurred through rape, or in extreme cases. A nationwide study comparing state level policies found that availability or cost of abortion was unrelated to adolescent sexual activity and contraceptive use (Averett, Rees, & Argys, 2002).

In 2000, 19 percent of all abortions were to adolescent females (Alan Guttmacher Institute, 2002), and approximately, 35 percent of teen pregnancies ended in abortion (Henshaw, 2003). Adolescent childbearing would be increased by abortion policy that included 1) mandatory waiting periods, 2) increased cost or less availability, and 3) required parental notification. While all of these would logically make obtaining abortion services more difficult, little evaluation of such policies has been conducted. Joyce and Kaestner (2001) found that teens living in a state with a 24-hour waiting period were more likely to seek out-of-state abortions than teens residing in the neighboring state with a 1-hour waiting period.

Of these policy issues, the most controversial is probably a minor's ability to obtain an abortion without parental consent or notification. According to the Alan Guttmacher Institute (2002), 43 states required parental consent of one or both parents before minors can receive abortions, although only 32 states are known to actively enforce the law. Brindis (2002) reported that in the early 1990's, three-quarters of teens under the age of 16 seeking abortion told at least one parent, regardless of state law.

However, a little less than half of older minors (17-year-olds) discussed their abortions with a parent.

Adoption Policy and Teen Pregnancy

It is estimated that less than 5 percent of adolescent pregnancies are resolved through adoption yearly (Miller & Coyl, 2000). Choosing to place a child for adoption is more common among white adolescent females and those with higher educational expectations (Miller & Coyl, 2000). Additionally, pregnant teens who have seen adoption modeled by friends or family are more likely to place their children for adoption (Namerow, Kalmuss, & Cushman, 1993). Little research has been conducted on adoption policies and adolescents' decisions to place their children for adoption. Adolescents who wish to make an adoption plan are afforded the same treatment as adults making this decision (Hollinger, 2000), even though their minor status does not allow them to enter into commercial contracts or, in most cases, obtain an abortion without parental consent (Durcan & Appell, 2001). Although this policy eases the placement of children born to adolescent parents, it does raise concerns about adolescent females readiness to choose adoption. There is no added protection in current restoration policies for adolescent mothers who change their mind about the adoptive placement of their children (Durcan & Appell, 2001).

Teen Pregnancy and Parenting: Improving Their Futures

Welfare reform. The 1996 welfare reform act contained several components specific to adolescent parents and more recent amendments continue to address circumstances under which adolescent parents are able to collect monetary benefits (Grisham & Levin-Epstein, 2003). Current provisions require adolescent parents to (1)

attend secondary education or employment training at least 20 hours per week (with a limit of two years), (2) live in an approved setting (usually with family-of-origin or in an approved group home), and (3) to comply with education and residential regulations within 60 days of receiving benefits. Additionally, the time-limit clock that restricts cash benefits to five years does not start for adolescent parents until the age of 19.

The 1996 welfare reform act also advised states to make specific efforts to encourage marriage among unwed teen mothers, and to increase child support collection from absent fathers (Single-Rushton & Garfinkel, 2002). Data about the results of these new welfare changes are mixed. If teens planned to marry or were in a committed relationship before the pregnancy occurred, the policy has been effective in offering incentives to help such couples take steps toward marriage (REF). On the other hand, if the pregnancy was the result of a friendship or casual relationship, then the policy does little to encourage teens to marry (REF). Unwed mothers must establish paternity before child support can be ordered by the court (Single-Rushton & Garfinkel, 2002). However, after a baby is born most unwed teen mothers do very little to establish paternity, so the program has done little good for those who it was designed to help the most (McLanahan, 1999). Recent research utilizing the 1997 and 2000 National Survey of Youth suggests that the 1996 policies directed toward teenage mothers did reduce the overall likelihood of welfare dependency (Acs & Koball, 2003). After 1996 teenage mothers have been slightly more likely to live with their parents than those in the past.

Reducing subsequent pregnancies. Although most would agree that the issue of second births among adolescent mothers (especially rapid ones) is a problem, this

matter has received less attention than first adolescent pregnancies. It has been estimated that about one-fifth of annual births to adolescent mothers are second and higher order births (Martin, et al., 2002). Klerman (2003) summarized the recent research that teen mothers with lower educational expectations, live-in boyfriends or husbands, and those who had an intended first pregnancy are at higher risk for subsequent pregnancies. Klerman (2003) also outlined the negative consequences of second births (above and beyond initial adolescent childbearing) as including significantly larger decreases in economic self-sufficiency and educational attainment. Consequently, adolescent mothers who have subsequent children while still in their teens have increased demands for resources, with a decreased likelihood of increasing their earning power. There have been several approaches to reducing the likelihood of subsequent pregnancies including home visits, family interventions, school interventions, and community-wide efforts (Klerman, 2003). However, Klerman concluded that program evaluations to-date need more methodological rigor before conclusions can be made about their effectiveness.

Conclusions (Yet to be Written)

1. Likely that family planning services (Title X) and abstinence education (Title XX) will persist.
2. Growing acceptance if “abstinence first” message (NCPTP polling data).
3. National Campaign to Prevent Teen Pregnancy model of prevention.

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Table 1

Selected Consequences of Teen Parenthood in the United States

Adolescent Mother (Compared to later-bearing mothers)
1. Less likely to marry the father of their first child 2. More likely to become divorced 3. Twice as much time spent as a single parent prior to age 30 4. More likely to drop out of school 5. Less likely to earn a high school diploma 6. Work more hours at a lower rate of pay
Adolescent Father (Compared to later-bearing fathers)
1. Less likely to earn a high school diploma 2. More likely to work in a blue-collar occupation 3. More likely to experience lower income levels 4. More likely to engage in delinquent and criminal behaviors
Children of Adolescent Parents (Compared to children of older parents)
1. More likely to be born premature and of low birth weight 2. More likely to experience serious or life-threatening medical conditions at birth 3. Less likely to receive quality medical care and nutrition 4. Less likely to receive necessary emotional support and cognitive stimulation 5. More likely to drop out of school 6. More likely to become involved in delinquent and criminal behavior 7. More likely to bear children out of wedlock
Society
1. Increased financial burden to taxpayers and extended families 2. Additional strain on the resources of governmental programs and systems

Figure 1. Components of teen pregnancy.

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i. There may be many social reasons why the teen birth rates in the United States are so much higher than in other developed countries. While having a higher median income than most countries, the U.S. also has a greater percentage of those who are poor. This economic disadvantage is associated with more risky sexual behavior, increasing the likelihood of teenage pregnancy and parenthood. An economic and racial explanation can't account for the entire problem, however, because even among non-Hispanic white teenagers, the birthrate (36 per 1000) is still higher than most other developed countries (Alan Guttmacher Institute, 2001).

Basic values in American culture include individual responsibility, self-reliance, and that the government generally will stay out of people's lives. The stigma of public health care being only for the poor might keep some U.S. teens from going to clinics for contraception or medical assistance. One-fifth of women in the United States have no health care coverage during their reproductive years. In comparison, most other developed countries studied provide health care for all. Public health care is considered a right, and thus carries no stigma (Alan Guttmacher Institute, 2001).

In an AGI comparison of the U.S. with other countries, contraceptive services elsewhere are woven into all aspects of health care, giving teens a stronger message about its importance. Teens in these countries are assured of confidentiality when they go for contraceptive and pregnancy information and services, and contraceptives are provided for little or no cost. In the U.S., contraception is not a part of the health care system, not even among those privately insured. Confidentiality for teens, is a topic still hotly debated. As a result, teenagers in the United States are the least likely to use contraceptives, especially the most effective hormonal contraceptives. This lack of contraceptive use not only results in increased pregnancy, but also in an increase in STD's. The U.S. has the highest levels of STD infections of all countries studied (Alan Guttmacher Institute, 2001).

While teens in all countries have about the same frequency of sexual activity, teens in the U.S. have relationships of a shorter duration, with more sexual partners. This shorter duration, high turnover, relationships lead to an increase in the spread of STD's as well as decreasing the likelihood of the teen's feeling comfortable discussing the contraceptive use with their partners.

The media in other countries use messages about love and trust combined with humor to promote positive sexual messages. This creates a balance for the sexually explicit images that bombard teens in advertising and entertainment. In the U.S. the prevention ads tend to be punitive in nature, only portraying the negative aspects of pregnancy and STD's, without promoting contraceptive use (Alan Guttmacher Institute, 2001).

ii. Although teenage childbearing generally has been viewed as a serious social and economic problem, some researchers believe the average effect of a teenage birth is negligible, and that natural variance among individuals negates "one size fits all" conclusions (Hoffman, 1998). For example, Geronimus and Korenman (1992) compared sisters who had first births at different ages, and concluded that teenage

births were not the cause of the mothers' educational and economic problems, but that preexisting family economic deficits were most likely a contributing factor for the births. Additionally, Hotz, McElroy, and Sanders (1997), who compared teenage mothers to adolescent females of similar ages who miscarried, found the mothers were actually better off financially by their mid- to late twenties than those in the comparison (miscarried) group. Difference in education and welfare dependency were negligible. Negative effects on the children of teen mothers have also been questioned. Moore, Morrison, and Greene (1997) found children of teenage mothers to be no more at risk for depression, behavior problems, health problems, psychological well-being, or cognitive development than their later-born counterparts.