New York State
Touchstones

New York State
Council on Children and Families

Tracking Recent Teenage Pregnancy and Birth Rates:

New York State and the United States

This Report is Part of a Series of NYS Touchstones/KIDS COUNT Special Reports

State of New York
George E. Pataki, Governor

New York State
Council on Children and Families
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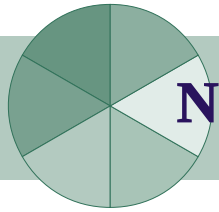
Mission Statement

The Council, a State agency within the Executive Department, is charged with acting as a neutral body to coordinate the State health, education and human services systems to ensure that all children and families in New York State have the opportunity to reach their potential.



New York State Touchstones Vision

Children, youth and families will be healthy and have the knowledge, skills and resources to succeed in a dynamic way.

May 2001

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Message from Alana M. Sweeny

Executive Director, NYS Council on Children and Families

May 2001

Dear Friends:

It is a pleasure to share some good news about New York State's declining teenage pregnancy and birth rates during the past decade. This special report, one of a series of ***New York State Touchstones/KIDS COUNT Special Reports*** that are being prepared with support from the Annie E. Casey Foundation, focuses on teenagers 15-19 years of age and examines New York State and national trends as well as teenage childbearing behaviors and interrelated societal factors influencing these recent trends.

Recognizing the far-reaching consequences associated with teenage pregnancies and births, we must ensure that these rates continue to decline. In New York State, Governor George Pataki created the Task Force on Out-of-Wedlock Pregnancies and Poverty and charged the Task Force with developing recommendations regarding goals and strategies for the reduction of out-of-wedlock pregnancies, with a special emphasis on teenage pregnancies.

These strategies need to reach beyond behaviors and risk factors and focus on sustained efforts to foster positive youth development. Teenagers will continue to face challenges. However, support from families, schools, friends and the community can help them develop the knowledge and skills to make positive life choices, including abstinence and postponing pregnancies.

The Council on Children and Families and its member agencies strive to design, implement and evaluate coordinated, efficient services that promote children and families' physical, emotional, spiritual, social and economical well-being. I am confident that the insight we gain from the recent trends will spur the development of private and public policies and programs to continue to help children and teenagers gain self-control, self-respect and self-efficacy, understand the consequences of their life choices and take responsibility for those choices.

In the spirit of shared commitment, we can join together to foster positive youth and family development that in turn encourage healthy lifestyles for children and families throughout New York Sate.

Sincerely,

Alana M. Sweeny

New York State Touchstones / KIDS COUNT

New York State TOUCHSTONES establishes a set of goals and objectives to improve outcomes for children and families and identifies a set of health, education and well-being indicators to help measure progress towards meeting those goals.

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This special report is a product of the NYS Council on Children and Families and was written by Toni Lang, a policy analyst and the KIDS COUNT Project Manager at the Council. The Council thanks the New York State Department of Health for their assistance with data collection and editing. Also, thanks are extended to the Council's staff for their reviewing and editing contributions. This production could not have been completed without their help.

In addition, the New York State Touchstones/KIDS COUNT Project wishes to thank the Annie E. Casey Foundation for its financial support and its commitment to help build better futures for all children. For information about the Annie E. Casey Foundation and the KIDS COUNT Initiative, visit their web-site at www.aecf.org.

Table of Contents

Some Good News:

During the first half of the 1990s, states with high teenage pregnancy rates as well as states with low rates indicated a downward trend in rates (1).

- The national pregnancy rate, in 1995, was 101 pregnancies per 1,000 young women 15-19 years of age, the lowest rate since 1975 (2).
- The 1996 rate of 97 pregnancies per 1,000 women 15-19 years of age represents a 17 percent decrease* since 1990's peak rate of 117 pregnancies per 1,000 women 15-19 years of age (3).

Birth rates for teenagers followed a similar downward pattern during the 1990s as nearly all states reported a statistically significant decline (4).

- The 1998 national rate of 51.1 births per 1,000 women 15-19 years of age was 18 percent lower than the 1991 rate of 62.1 births per 1,000 women 15-19 years of age. While the 1991 rate was the highest rate recorded in 20 years, it was not the highest rate ever recorded. Peaking in 1957, at 96.3 births per 1,000 women 15-19 years of age, the latter half of the 1950s reported the highest birth rates for women 15-19 years of age (4,5).
- According to the Department of Health and Human Services report, National Vital Statistics System, *Teenage Births in the United States: National and State Trends, 1990-96,* teenage birth rates declined for White, Black, American Indian, Asian or Pacific Islander and Hispanic women 15-19 years of age (4).
- The birth rate for non-Hispanic Black teenagers has had the largest decline, down 26 percent from 1991 to 1998 for women 15-19 years of age (118.9 vs. 88.2 births per 1,000 women, respectively)–yielding the lowest rate ever reported for non-Hispanic Black teenagers (5,6). This reflects a 32 percent decrease for non-Hispanic Black teenagers 15-17 years of age (86.7 vs. 58.8, respectively) (5).
- The national birth rate for women 15-17 years of age fell 5 percent from 1997 to 1998 to 30.4 births per 1,000 women 15-17 years of age–a record low (5).

While all age groups reported a decline in childbearing patterns during 1991-1996, the younger teenagers, 14 years of age and younger, reported a greater decline than the older teenagers, 15-17 and 18-19 years of age (14%, 12%, and 8% decrease, respectively) and the patterns continued in 1997 and 1998 (5,7).

*A decrease is calculated by first determining the difference between two points in time [subtract the base rate from the current rate] followed by dividing the base rate into the difference. In this case 97-117= -20; -20/117= -.17 or 17% decrease. Whenever this report refers to a decrease, this formula has been applied.

New York State and the United States witnessed a significant decrease in teenage pregnancy and birth rates during the 1990s. Still, approximately 900,000 US teenage women 15-19 years of age (including 52,592 New Yorkers) were pregnant in 1996.

Teenage births are considered a major contributing factor to poverty and welfare dependence as a growing proportion of teenage mothers are unwed and more than half of welfare spending goes to families formed by a teenage birth (8). Consequently, reducing out-of-wedlock births, especially by teenagers, has been targeted at both the national and state levels. To address teenage pregnancy rates, states must develop services to help youth and families gain the needed skills and competencies to become self-reliant and to help strengthen their communities.

In New York State, Governor George Pataki issued an Executive Order in 1997, creating the Task Force on Out-of-Wedlock Pregnancies and Poverty. The Governor charged the Task Force with developing recommendations regarding goals and strategies for the reduction of out-of-wedlock pregnancies, with a special emphasis on teenage pregnancies.

The New York State Council on Children and Families (Council) and its 13 member agencies have built a foundation upon which it can measure outcomes across all service delivery systems using common indicator data, called Touchstones. Six life areas have been identified (economic security, physical and emotional health, education, citizenship, family, and community) as well as goals and objectives that set the framework for each area. With support from the Annie E. Casey Foundation through its KIDS COUNT program, the Council published the New York State Touchstones/KIDS COUNT 1998 Data Book and 2000 Data Book, which incorporated the identified set of common goals, objectives and outcome measures that cut across all systems. The Data Books provide a statistical snapshot of children and families in New York State. This report has incorporated the Touchstones framework and will examine the protective and contributing factors influencing teenage sexual behavior within each of the six life areas.

Purpose of Report

This special report, one of a series of New York State Touchstones/KIDS COUNT Special Reports that are being prepared with support from the Annie E. Casey Foundation, examines national and New York State data to identify recent teenage pregnancy and birth rate trends. For decades, researchers have studied possible factors that influence teenage sexual behavior. As a result, many individual, family, community and societal factors have been identified that put a teenager at increased risk for pregnancy. Contributing factors, highly correlated to teenage pregnancies and often difficult to separate, are examined (e.g., lower economic status and lower educational attainment), as are the consequences stemming from teenage pregnancy (e.g., lack of prenatal care, low birth weight infants, and lower educational attainment). What factors or combination of factors have influenced recent changes in teenagers' sexual behavior and led to these decreasing teenage pregnancy and birth rates? This report is a descriptive collection of data and intends to provide insight into the recent trends and contributing factors. Hopefully, it will stimulate further discussion and provide information to help generate hypotheses for further investigation.

The majority of this report focuses on teenagers 15-19 years of age, as this age group constitutes the majority of childbearing teenagers. While pregnancy and birth rates for adolescent women younger than 15 years of age have been low and have declined during the 1990s, the circumstances surrounding these pregnancies and births are often different from older teenage pregnancies and require further consideration. This report will examine the national trends, New York State trends, teenage sexual and reproductive behavior, contributing and protective factors and consequences associated with teenage pregnancies and births, and draw conclusions based on this research.

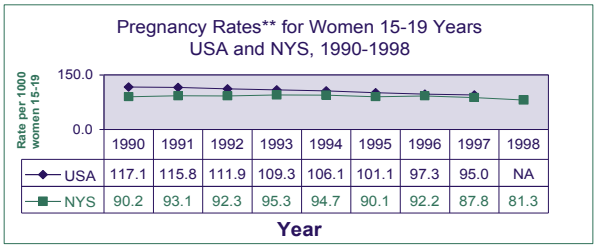
National Trends

After a 20 year upward spiraling trend, the 1990s marked a decrease in both the pregnancy and birth rates for teenagers in the United States. Still, there were approximately 900,000 pregnancies each year among teenage women 15-19 years of age–meaning 40 percent of teenage women 15-19 years of age became pregnant before their 20th birthday (9). Our nation continues to have one of the highest teenage pregnancy rates of any industrialized nation. The United States rate is twice as high as England, Wales, and Canada, and nine times higher than the Netherlands or Japan rate (10).

New York State Trends

New York State experienced a similar decrease in teenage pregnancy and birth rates, and has consistently reported lower teenage pregnancy and birth rates than the national average (Table 1 and Table 2). The Annie E. Casey Foundation reported that, in 1996, with a birth rate of 42 per 1,000 women 15-19 years of age, NYS ranked the 15th lowest in the country and 22 percent lower than the national rate of 54 births per 1,000 women 15-19 years of age (2). However, nine percent (52,592) of women 15-19 years of age became pregnant and an additional 1,576 pregnancies occurred to girls less than 15 years of age (11).

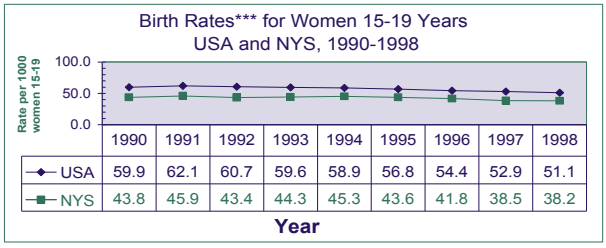
Table 1.
Teenage Pregnancy Rates for NYS and US Women 15-19 Years of Age, 1990-1998.**



	1990	1991	1992	1993	1994	1995	1996	1997	1998
USA	117.1	115.8	111.9	109.3	106.1	101.1	97.3	95.0	NA
NYS	90.2	93.1	92.3	95.3	94.7	90.1	92.2	87.8	81.3

Source: NYS data – NYS Department of Health, 2001 (11);
USA data – Alan Guttmacher Institute, 1999 (13).

Table 2.
Teenage Birth Rates* for NYS and US Women 15-19 Years of Age, 1990-1998.**

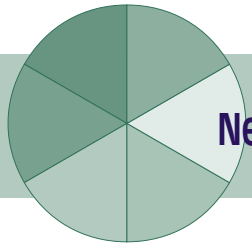


	1990	1991	1992	1993	1994	1995	1996	1997	1998
USA	59.9	62.1	60.7	59.6	58.9	56.8	54.4	52.9	51.1
NYS	43.8	45.9	43.4	44.3	45.3	43.6	41.8	38.5	38.2

Source: NYS data – NYS Department of Health, 2001 (11).
USA data – National Center for Health Statistics, 2000 (5).

** Pregnancy rates are calculated by combining the number of live births, induced abortions and spontaneous fetal deaths per 1,000 women in the specified age category in the calendar year in which the birth, or fetal loss occurred. NYS pregnancy rates are based on vital records of events to NYS residents. USA pregnancy rates are based on estimates, as not all states report fetal deaths. Due to suspected underreporting of spontaneous fetal deaths, particularly for those <20 weeks gestation, caution should be used when analyzing total pregnancy data.

*** Birth rates are the reported number of live births per 1,000 women in the specified age category in NYS and USA. NYS rates are based on vital records of events to NYS residents.



New York State is approaching its own goals.

In 1996, *Communities Working Together for a Healthier New York*, a project of the State Health Department's Public Health Council, set health objectives to prevent the leading causes of disability, morbidity and premature mortality in New York State. Included in those objectives is the charge to reduce the adolescent pregnancy rate, by the year 2006. As depicted in Table 3, New York State is already approaching its goals.

Table 3. *Communities Working Together for a Healthier New York* Adolescent Pregnancy Rates, Goals and Baselines as well as Rates and Percent Decreases from 1993 to 1998.

Goals	1993 Baseline Rates	Rates as of 1998	Percent Decrease from 1993 to 1998
To reduce the adolescent pregnancy rate to no more than 2 per 1,000 girls 10-14 years of age	3.2 pregnancies/1,000 girls aged 10-14 years	2.0 per 1,000 girls 10-14 years of age	38%
To reduce the adolescent pregnancy rate to no more than 50 per 1,000 girls 15-17	65.6 pregnancies/1,000 girls aged 15-17 years	50.7 per 1,000 girls 15-17 years of age	23%

Source: NYS Department of Health, 2001 (11, 12).

Teenage women, 18-19 years of age, compose the majority of childbearing teenagers.

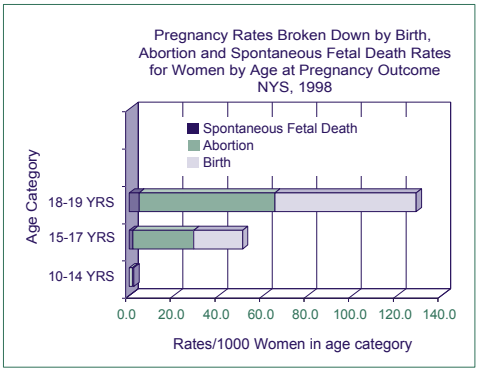
According to research conducted by the Alan Guttmacher Institute, most very young teenagers have not had intercourse, as 8 in 10 girls and 7 in 10 boys are sexually inexperienced at age 15 (10).

The likelihood of teenagers becoming sexually active increases steadily with age (10).

In fact, the majority of teenage pregnancies (including births, spontaneous fetal deaths and abortions†) in NYS and the USA are reported for women 18-19 years of age. As depicted in Figure 2, the 1998 NYS pregnancy rates for women less than 20 years age of are:

- 2.0 per 1,000 women 10-14 years of age;
- 50.7 per 1,000 women 15-17 years of age;
- 128.6 per 1,000 women 18-19 years of age.

Figure 2. 1998 Birth, Spontaneous Fetal Death and Abortion Rates for NYS Women by Age at Pregnancy Outcome, 1998.



Source: NYS Department of Health, 2001 (11).

† Abortion rates are based on vital records of events to NYS residents. Abortion numbers and rates are imperfect and/or nonexistent in many states. Care should be used in interpreting and comparing teenage abortion and pregnancy data at the national level.

New York State Reports Geographic Variation

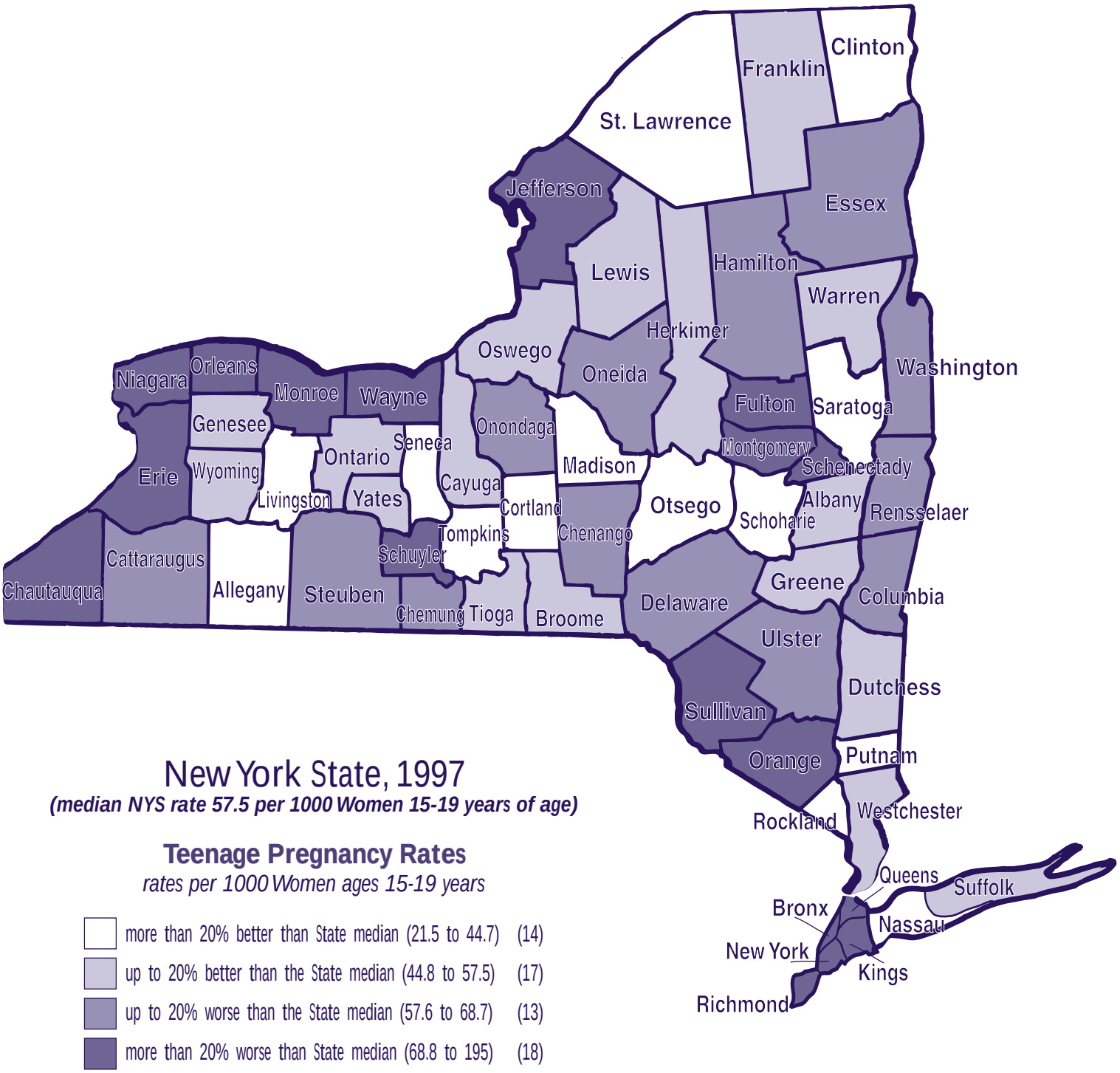
While overall New York State is approaching its goal to reduce teenage pregnancy rates, there is substantial variation in the magnitude of teenage pregnancy and birth rates by geographic location. For example, in 1997 New York State's 62 counties reported teenage pregnancy rates ranging from 21.5 to 194.5 per 1,000 women 15-19 years of age. Four of the five counties comprising New York City and one upstate county reported the five highest rates (Bronx–194.5; New York–135.6; Kings–131.8; Sullivan–115.6; and Queens–107.0 per 1,000 women 15-19 years of age). Rural counties, dispersed throughout the state, reported the five lowest rates (Putnam–21.5; Otsego–27.3; Livingston–29.9; Schoharie–30.4; and Tompkins–30.5). Thirty counties were within 20 percent of the State's median rate of 57.5 per 1,000 women 15-19 years of age (46.0 to 69.0/1,000 women 15-19 years of age), as depicted in Figure 3. Yet, zip code data reveals significant variation within counties as some teenage pregnancy and birth rates in rural counties by zip codes are among the highest 10 percent statewide.

Teenage Pregnancy Statistics per 1,000 women 15-19 years of age NYS Counties, 1997

Mean	**62.9**
Median	**57.5**
Mode (whole number)	**57**
Minimum	**21.5**
Maximum	**194.5**

Teenage pregnancy statistics, by county –

Figure 3. New York State Counties' Teenage Pregnancy Rates for Women 15-19 Years of Age, in 1997, Designated as Better Than or Worse Than the NYS Median Rate of 57.5 per 1,000 Women 15-19 Years of Age.

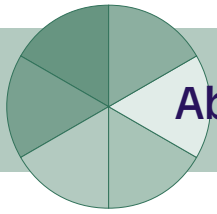


Source: NYS Department of Health, 2000 (11).

Tracking Trends

Numerous sexual behaviors can affect teenage pregnancy rates, including abstinence and use of contraception (this includes more consistent use and/or use of more effective contraception methods). The following looks at teenage sexual and reproductive behaviors.

"I feel that many teens believe that they should wait. I'm going to wait until I'm ready."
–NYS YRBS female respondent, Grade 10 (14)



Abstinence

The most effective way for any individual or couple to prevent pregnancies is by abstaining from sexual intercourse. Abstinence promotion consists of holistic and sustained efforts to foster a healthy lifestyle and development of self-control, self-respect and self-efficacy. Strategies taking this approach acknowledge the social, intellectual, physical and moral dimensions of sexuality (15). Within each of these intertwined domains, teenagers confront sexual pressures and must make choices. With skills, knowledge and support, teenagers can understand the consequences of their choices, take responsibility for their choices and make positive life choices. The following examines the recent increase in the number of teenagers choosing to abstain from sexual intercourse.

- The 1995 National Survey of Family Growth reported the first decline in women 15-19 years of age who had ever had intercourse–from 55% in 1990 to 50% in 1995 (16).
- The National Institute of Child Health and Human Development reported a decline in never-married males 15-19 years of age who had ever had intercourse–from 60% in 1988 to 55% in 1995 (16).

New York State participates in the Center for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS), a component of the Youth Risk Behavior Surveillance System (YRBSS).

The YRBS is a national survey asking high school students (9-12 grades) about their behaviors related to priority health risks (14). The national survey has collected sexual behavior data biennially since 1991 and has identified significant changes in behavior between 1991 and 1999. New York State introduced sexual behavior questions in its 1996 survey and continued to use those questions in its 1999 survey.

The 1999 NYS data will be compared to the 1999 national data and any significant changes†† in the national data between 1991 and 1999 will be noted (17,18).

††Significant linear change where $p \leq 0.05$

- 42.4% of NYS students compared to 49.9% of the students nationwide reported that they had sexual intercourse during their life. The 1999 national responses reflect a significant decrease (7.8%) from 1991 in students reporting that they had ever had sexual intercourse (1999–49.9%, 1991–54.1%).
- 6.1% of NYS students reportedly had sexual intercourse for the first time before age 13 compared to 8.3% of students nationwide. Significantly, the national data reveal male students (12.2%) were more likely than female students (4.4%) to have initiated sexual intercourse before the age of 13 years. The national data reflect no significant change from 1991 to 1999.
- 29.7% of NYS students, compared to 36.3% of students nationwide, reported that they had sexual intercourse during the past three months. Nationwide, Black students (53.0%) were significantly more likely than Hispanic and White students (36.3% and 33.0%, respectively) to be currently sexually active. There was no significant national change from 1991 to 1999.
- 12% of NYS students, compared to 16.2% nationwide, reported that they had sexual intercourse with four or more people during their life. 1999 national responses reflect a significant (13.4%) decrease from 1991 responses in students reporting sexual intercourse with four or more people in their life (1999–16.2%, 1991–18.7%).

The national Alternative High School Youth Risk Behavior Survey (ALT-YRBS) is another component of the Youth Risk Behavior Surveillance System (YRBSS); it was conducted in 1998 to measure priority health-risk behaviors among students at alternative high schools. Alternative high schools serve approximately 280,000 students nationwide who are at high risk of failing or dropping out of regular high school or who have been expelled from regular high school because of illegal activity or behavioral problems (19). Comparing ALT-YRBS results with 1999 national and NYS YRBS results demonstrates that the prevalence of risky sexual behaviors is significantly higher among students attending alternative high schools than with students at regular high schools (17,19). The 1998 ALT-YRBS reports that:

- 87.8% of students had sexual intercourse during their lifetime (compared to 42.4% of 1999 NYS students and 49.9% of 1999 students nationwide);
- 22.0% of students had initiated sexual intercourse before age 13 year (compared to 6.1% of 1999 NYS students and 8.3% of 1999 students nationwide);
- 68.5% of students reported that they had sexual intercourse during the past three months (compared to 29.7% of 1999 NYS students and 36.3% of 1999 students nationwide);
- 50.4% of students had sexual intercourse with four or more sexual partners during their lifetime (compared to 12% of 1999 NYS students and 16.2% of 1999 students nationwide).

A 1998 study of the sexuality and abstinence education policies in United States public school districts found that 67% of the districts had initiated a sexuality and abstinence education policy.

Of those districts, 65% had a policy allowing discussions of contraception as effective in preventing pregnancy and disease, while 35% either prohibited or severely limited such discussion (20).

The following is a breakdown of the percent of districts initiating a sexuality and abstinence education policy, the types of policies that have been initiated, and the percent of students attending school in districts per policy:

- 67% of the districts had initiated a sexuality education policy and of those districts:
  - 14% had a comprehensive sexuality and abstinence education policy that addresses abstinence in a broader educational program to prepare adolescents to become sexually healthy adults (9% of students were in districts that have a comprehensive sexuality education policy.);
  - 51% had an abstinence-plus policy that treats abstinence as the preferred option, but permits discussion about the benefits of contraception (45% of students were in districts with an abstinence-plus policy.); and
  - 35% had an abstinence-only policy that treats abstinence as the only option outside of marriage, with discussion of contraception either prohibited entirely or limited to its ineffectiveness in preventing pregnancy and disease (32% of students were in abstinence-only policy districts.).
- 33% of the districts had no policy (14% of students were in districts that have no policy) (20).

Contraception

With a greater awareness of sexually transmitted diseases, causes and consequences of teenage pregnancies and new, effective contraceptive methods, research suggests that there has been a shift in the method of contraception use among unmarried women of all ages. Along with the adoption of new methods (i.e., injectable and implant) and slight increase in the use of contraception, there has been a substantial decrease in pill use and an increase in condom use. In addition, the Center for Disease Control and Prevention reports that while the rate of sexually experienced teenagers has stabilized; teenagers at first intercourse are more apt to use contraceptives (7). Among the findings related to teenage contraception use:

- Teenagers are more likely than older women are to practice contraception sporadically or not at all over the course of a year (10).
- A sexually active teenager who does not use contraceptives has a 90% chance of pregnancy within one year (10).
- Of the 2.7 million teenage women who use contraceptives, 44% (more than 1 million women) rely on the pill, 38% rely on condom use, approximately 10% rely on the injectable, 4% on withdrawal and 3% on the implant (10, 21).
- The first national data on the injectable and implant methods were collected in 1995, showing that women younger than 24 years of age were most likely to rely on those methods (e.g., 15% women 15-17 years of age were using the injectable and 4% were relying on the implant) (21).
- Condom use, from 1988 to 1995, has increased in every age group (22).
- The use of the pill, from 1988 to 1995, dramatically declined for teenagers (from 59% to 44%) (22).

The national YRBS data, while examining a more restricted age group of teenagers (Grades 9-12), support these findings related to the use of condoms and pills.

Students show a significant increase in condom use and a significant decrease in pill usage:

- The 1999 national YRBS responses denote a significant decline (22%) in reported pill usage at last sexual intercourse from 1991 to 1999 (1991–20.8%, 1999–16.2%). In the 1999 NYS YRBS, of the students who reportedly had sexual intercourse during the past three months, 11% of male students had partners who used birth control pills and 19.1% of female students used birth control pills before their last sexual intercourse compared to 11.8% of male students and 20.4% of female students nationwide. Nationwide, White students (21.0%) were significantly more likely than Black and Hispanic students (7.7% and 7.8%, respectively) to report birth control pill use (17,18).
- Of the 1999 NYS YRBS students reportedly having sexual intercourse during the past three months, 67.6% of male students and 58.9% of female students used a condom during their last sexual intercourse compared to 65.5% of male students and 50.7% of female students nationwide. 1999 national responses reflect a 25.5% increase from 1991 responses in students using a condom during their last sexual intercourse (1999–58.0%, 1991–46.2%) (17,18).
- In 1999, students nationwide reported condom use highest among 9th graders (66.6%) and lowest among 12th graders (47.9%), while use of birth control pills increased from 12.0% in 9th grade to 24.9% in 12th grade (17).

The National Survey of Family Growth (NSFG) found increases in the use of contraceptives at the time of first intercourse among women of all ages, up from 64% in the late 1980s to 76% in the 1990s.

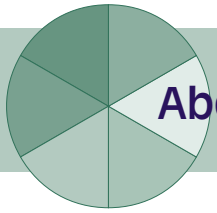
- A major contributing factor is that condom use increased from 18% in the 1970s to 36% in the late 1980s and 54% in the 1990s (16).

The increase in condom use found in the National Survey of Family Growth analyses could be related to another finding from the survey–90% of teenage women 18-19 years of age reported that they have received formal instruction on sexually transmitted diseases, safe sex to prevent HIV and how to say no to sex (16).

- The 1999 NYS YRBS results support this related finding as 91.0% of students indicated they were taught about AIDS or HIV infection in school, with an increase noted between 9th grade and 12th grade. The 1999 National YRBS results show a significant increase (8.8%) in the number of students being taught about AIDS or HIV infection as compared to the number of students in 1991 (90.6% vs. 83.3%). However, nationally White students (92.2%) were significantly more likely than Hispanic (84.1%) to have received HIV education in school (17,18).

Between 1990 and 1996, the pregnancy rate among sexually experienced teenagers fell 16%–from 224 to 190 pregnancies per 1,000 women 15-19 years of age (23).

- The National Center for Health Statistics (NCHS) data show a dramatic 21% decline between 1991 and 1996 in the proportion of teenagers giving birth a second time. 25% of teenage mothers were currently using long-acting methods of contraception (e.g., implants and injectable options) (23).



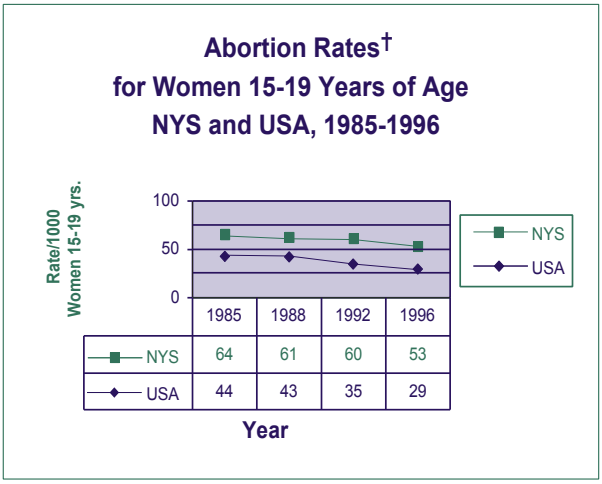
Abortion

Since 1980, the abortion rate† among sexually experienced teenagers has steadily declined, as fewer teenagers are becoming pregnant and fewer pregnant teenagers are having abortions (10). Therefore, abortion is not the driving force behind the declining teenage birth rates.

Approximately 35% of US teenage pregnancies end in abortion (e.g., in 1996, approximately 274,000 US teenage pregnancies ended in abortion) (10,24).

- USA teenagers' abortion rate declined 3% between 1995 and 1996. Since 1985, the rate has dropped 34%, from 44 to 29.2 abortions per 1,000 women 15-19 years of age (Table 3). At the same time, the proportion of teenage pregnancies ending in abortion has fallen from 46% to 35%–the 11% difference reflects a 24% decline (24).
- The NYS abortion rate for women 15-19 years of age declined 12% between 1995 and 1996. Since 1985, the NYS rate has fallen from 64 to 53 abortions per 1,000 women 15-19 years of age–the 11% difference reflects a 17% decline. (Table 3).

Table 3. Abortion Rates for Women 15-19 Years of Age in NYS and USA, 1985–1996.



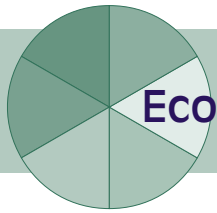
Source: Alan Guttmacher Institute, 1999 (24).

†NYS abortion rates are based on vital records of events to NYS residents. Abortion numbers and rates are imperfect and/or nonexistent in many states. Care should be used in interpreting and comparing teenage abortion and pregnancy data.

Contributing and Protective Factors and Consequences

The six life areas (economic security, physical and emotional health, education, citizenship, family, and community) identified in the Touchstones framework address the physical, emotional, social, spiritual, academic and economic environments that can offer supports to children, teenagers and families. While families are a critical and primary influence on the healthy development of children and teenagers, peers, schools, faith-based organizations, neighborhoods, youth organizations, and other organizations in the communities help shape the lives of children and families. Families need access to a dynamic support system in order to provide the environments that promote positive youth development. Yet, positive youth development does not rest solely with the family. As teenagers fine-tune their identity and develop autonomy and independence from their parents, relationships with peers and adults and activities need to provide support, guidance and challenges to develop the skills and competencies needed to grow up healthy, caring, and responsible. The following examines some of the consequences and factors contributing to and protecting teenagers from teenage pregnancies and births within each life area. The factors and life areas are interrelated, not mutually exclusive.

"Give a man a fish, and he will eat for a day. Teach a man to fish and he will eat for a lifetime."
–Author Unknown



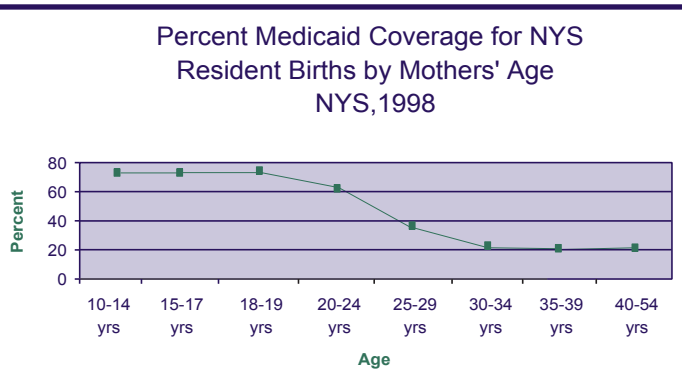
Economic Security

Teenage childbearing is not only associated with major health and developmental risks for the mother and child, but also it raises serious questions regarding the mother's ability to provide and receive adequate care. Social, physical, emotional and financial supports encourage and afford this essential care. If these supports have not been established, as is the case for many teenage mothers, adequate care may not be a reality. Teenage births increase the demands and stresses on the young parents as well as hinder the teenagers' social, economic, and educational growth. Without adequate education and training, teenagers lack the skills to compete in the job market and to attain economic security as the US economy requires a more technologically skilled labor force (8).

- As reported in the national KIDS COUNT Special Report, *When Teens Have Sex: Issues and Trends*, some experts estimate the national annual cost for births to teenagers is nearly $7 billion. This includes lost tax revenues and increased public spending on public assistance, child health care, foster care, and the criminal justice system (2).
- 5% of mothers on welfare are teenagers, and 1% (about 32,000) are less than 18 years of age (25). Conversely, 73% of never married teenage mothers receive welfare within 5 years of giving birth. Yet, 66% of never married mothers in their early 20s also receive welfare within 5 years of giving birth (8).
- Teenage mothers who eventually receive assistance are likely to require assistance for a long period of time (8,25).
- Initially, teenage fathers who support their offspring make more money and work more hours than their non-parenting peers do. However, adults who were teenage fathers are less educated and earn less than their non-parenting teenage peers in the long-run (8).

In 1998, in New York State, childbearing expenses for mothers under 20 years of age were more than 2 times as likely to be covered by Medicaid than mothers 25-29 years of age (73.2% vs. 36.0%), Figure 4.

Figure 4. Percent of Medicaid Coverage for NYS Resident Births by Mothers' Age, 1998.
Source: NYS Department of Health, 2001 (11).



"If you have no confidence in self, you are twice defeated in the race of life. With confidence, you have won even before you have started."

–Marcus Garvey

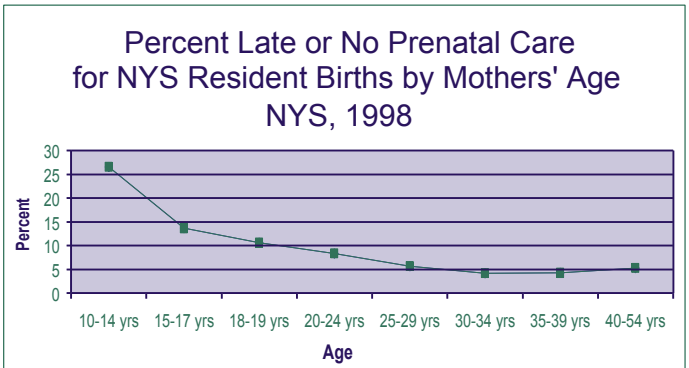
Physical and Emotional Health

Teenage pregnancies and births can be dangerous for both mother and child. The mother may suffer prolonged or obstructed labor if her pelvis is undersized because of incomplete skeletal growth (26). While medical advances in the United States and developed countries have reduced the risk of maternal and child morbidity and mortality related to childbearing, the worldwide risk of maternal death during childbirth is 2 to 4 times higher among mothers 17 years of age or younger than among mothers 20 years of age or older. Mortality and morbidity rates worldwide are also higher among infants born to young mothers. Compared to babies born to mothers 20 years of age or older, babies born to mothers 15-19 years of age have a 30% greater risk of dying in the first year of life (26). As reported in the New York State Touchstones/KIDS COUNT 1998 Data Book, the likelihood that a woman will give birth to a healthy, full-term baby increases with quality prenatal care (27). Early and regular prenatal care is the most effective method to identify and avoid the preventable causes of low birth weight, pre-term delivery, and maternal and infant mortality.

Late or no prenatal care –

Adequate prenatal care is considered to be care beginning within the first three months of pregnancy [first trimester] and including 12 to 13 visits over the course of the pregnancy. In New York State during 1998, a mother under 20 years of age was significantly more likely to receive late or no prenatal care than a mother over 20 years of age (11). While women over 25 years of age have the lower percent of late or no prenatal care, the percent substantially increases as the mother's age decreases (Figure 5).

Figure 5. Percent of Late/No Pre-natal Care for New York State Resident Births by Mother's Age, 1998.



Source: New York State Department of Health, 2001 (11).

Compared to mothers 25 to 29 years of age:

- mothers 10-14 years of age were more than 4 times as likely to receive late or no prenatal care (26.5% vs. 5.6%);
- mothers 15-17 years of age were almost 2.5 times as likely to receive late or no prenatal care (13.7% vs. 5.6%); and
- mothers 18-19 years of age were almost 2 times as likely to receive late or no prenatal care (10.6% vs. 5.6%)

Late prenatal care is defined as prenatal care during the third trimester of the pregnancy. The month in which prenatal care began is determined by calculating the interval between the date of last normal menses and the date of the first prenatal visit. NYS rates are based on vital records of events to NYS residents.

In 1998, New York State reported that 11.7 percent of births to teenage mothers 15 to 19 years of age received late or no prenatal care. This is a substantial decrease from the 14 percent reported in 1996 when New York State ranked 45th nationally (14% vs. 10%, respectively) (2).

Low birth weight babies –

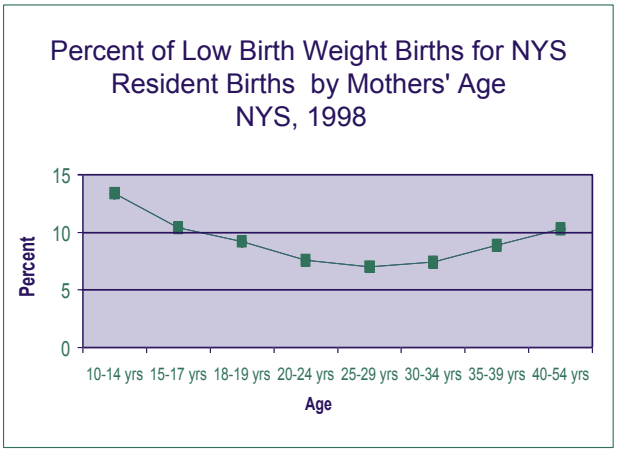
Low birth weight babies (less than 2,500 grams or 5.5 pounds) are at increased risk of infant mortality and long-term developmental problems such as mental retardation, birth defects, cerebral palsy, epilepsy, hearing and speech problems, visual impairment, and chronic respiratory ailments (27). In New York State during 1998, Department of Health information shows (Figure 6) teenage mothers were more likely to have a low birth weight birth than were mothers 20 to 34 years of age (11).

Compared to mothers 25-29 years of age (who have the lowest percent of low birth weight births):

- mothers 10-14 years of age are almost twice as likely to have a low birth weight birth (13.4% vs. 7.0%);
- mothers 15-17 years of age experienced 49% more low birth weight births (10.4% vs.7.0%); and
- mothers 18-19 years of age experienced 31% more low birth weight births (9.2% vs. 7.0 %).

NYS percents of low birth weight births are based on vital records of events to NYS residents.

Figure 6: Percent of Low Birth Weight Births by Mother's Age among New York State Resident Births, 1998.

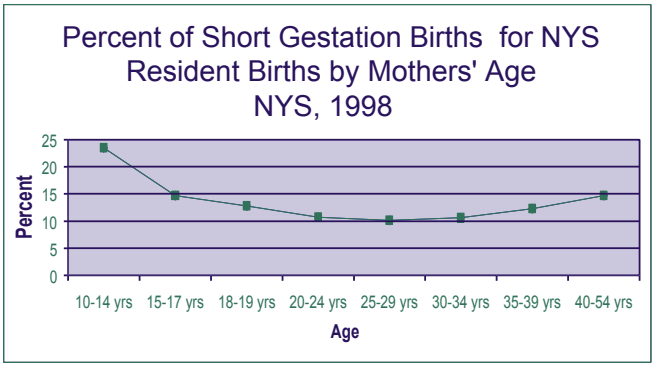


Source: New York State Department of Health, 2001 (11).

Premature babies or pre-term births –

For 1998, the NYS Department of Health reports the percent of pre-term or short gestational births (gestation period of less than 37 weeks) for mothers under 20 years of age followed the same pattern as low birth weight births–the young mother has a greater percent of pre-term births compared to women 20-34 years of age (Figure 7).

Figure 7: Percent of Short Gestational Births for New York State Resident Births by Mother's Age, 1998.



Source: NYS Department of Health, 2001 (11).

Compared to mothers 25 to 29 years of age:

- mothers 10-14 years of age experienced more than twice as many pre-term births (23.5% vs. 10.1%);
- mothers 15-17 years of age experienced 46% more pre-term births (14.7% vs. 10.1%); and
- mothers 18-19 years of age experienced 27% more pre-term births (12.8% vs. 10.1%).

NYS percents of short gestation births are based on vital records of events to NYS residents.

Mental health –

Numerous studies have examined the physical and mental health of teenagers who participate in sexual activities. Findings from these studies include the following:

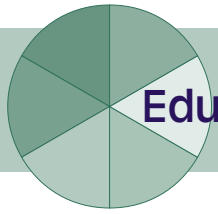
- Teenage men and women who participate in risky behaviors, such as drinking and drug use, are more apt to be sexually active than teenagers who do not participate in other risky behaviors (28).
- A recent study suggests that for teenage women, sexual activity, unprotected sex and childbearing are associated with depression, low self-esteem and little sense of control over their lives. The findings for teenage men lacked such an association and often suggested that sexually active teenage men had the opposite attitudes and self-perceptions (28).

A study conducted by the American Association of University Women (AAUW) shows girls 11-17 years of age acknowledged that sexual pressure comes from boys, other girls, friends and the media.

According to this research, "Girls want to learn how to say 'yes' to relationships without automatically saying 'yes' to sex. They don't want sex to be an all or nothing issue. They're missing the middle ground of affection, intimacy, and relationships (29)." In addition, the study showed that:

- pressure to have sex was an issue for all girls in the study except 11 year olds;
- 43% of the girls cited pregnancy as the "major issue or struggle" in their lives (57% of Blacks, 62% of Hispanics, 21% of Whites, 19% of Asian-Americans and 31% Native Americans); and
- White and Asian-American girls were more likely to describe pregnancy as an "accident" while Black and Hispanic girls described pregnancy as a "choice" (29).

"Genius without education is like silver in the mine."
–Ben Franklin



Education

The new, higher standards for learning being established in New York and most other states aim to increase students' problem-solving abilities, helping them become more independent thinkers. For each grade level, all children will be expected to acquire a working knowledge of each subject, and develop competence in applying that knowledge to meaningful tasks (30). Children will be better equipped to use their knowledge of all subject areas to solve real-life problems and to handle real work situations. While the new learning standards will put additional demands on students, teachers and parents, the skills and competencies developed in the process are necessary because the world is becoming increasingly complex, and New Yorkers must be prepared to compete successfully in the global economy (30).

While the initial challenges may make high school graduation more difficult, the progressive development of skills and competencies will better equip students to succeed in school and life. According to research conducted by Search Institute, an independent, nonprofit, nonsectarian organization whose mission is to advance the well-being of adolescents and children, "Academic success is related, in part, to students' social competence and their ability to adapt to different environments. Thus, the more equipped young people are to navigate life, the more they are likely to achieve in school (31)."

The following research examines the relationship between teenage women succeeding in school and the reduced risk of teenage pregnancy and birth. In fact, research suggests that the higher a woman's level of education, the more likely she is to delay marriage and childbearing.

- Child Trends research suggests that girls' success in pre-high school grades is inversely related to teenage pregnancy and birth. Girls who had been held back a grade before the eighth grade were twice as likely to become mothers by the twelfth grade as girls who had not been held back (32).
- Researchers, using US Department of Education data, found that school engagement is associated with a lower risk of a school-age birth (33).

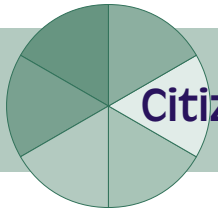
Studies conducted by Child Trends suggest that the presence of safety issues (e.g., violence, drug use and crime) in the school environment increases the risk of teenage pregnancy (32,34). In particular one study found that:

- White students who reported that school violence and substance abuse were high were at a greater risk for having a child while they were teenagers, and
- Black students in schools where teachers reported a safer environment had a lower chance of having a child before the twelfth grade (32).

With more open policies towards pregnant teenagers attending school, access to GED classes, and welfare reform incentives to complete high school, 70% of teenage mothers now complete high school. Still, teenage mothers are less likely than their peers who delay childbearing to go on to college (10). Child Trends research, conducted by Jennifer Manlove, illustrates the following complex cause and effect relationships between low school performance and teenage pregnancies:

- a strong attachment to school is associated with avoiding a school-age birth for White, Black, and Hispanic girls;
- dropping out of school increases the likelihood of a school-age pregnancy; (In New York State, the annual drop out rate decreased 13% from the 1992-93 school year to the 1996-97 school year [from 3.9% to 3.4% in grades 9 through 12, respectively]);
- White and Hispanic teenagers, who drop out of school, especially at a young age, are more likely to become teenage mothers than are teenagers who stay in school. For Black teenagers, dropping out of school was not significantly related to the risk of a teenage birth;
- almost 60% of teenagers with a school-age pregnancy dropped out at some point between the 8th and 12th grades. More than a quarter of these teenage mothers (28%) dropped out before they were pregnant and another 30% dropped out after becoming pregnant. The remaining 42% were still in school;
- a strong performance in school and high levels of school involvement are associated with a reduced risk of pregnancy for Black, White, and Hispanic girls; and
- after controlling for family background characteristics, high grades (among Black and White teenagers), high test scores (for Blacks, Whites, and Hispanics), and high expectations for post-secondary education (for Blacks and Hispanics) were associated with a reduced risk of school-age pregnancy (33).

"Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect."
–Chief Seattle



Citizenship

As stated in testimony before the House Select Committee on Children, Youth and Families, the Center for Youth Development & Policy Research proposes, "All young people have basic needs that are critical to survival and healthy development. They include a sense of safety and structure; belonging and membership; self-worth and an ability to contribute; independence and control over one's life; closeness and several good relationships; and competency and mastery. At the same time, to succeed as adults, all youth must acquire positive attitudes and appropriate behaviors and skills in five areas: health; personal/social; knowledge, reasoning and creativity; vocation; and citizenship (35)."

Youth development, as defined by the National Collaboration for Youth Members, is "a process which prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent. Positive youth development addresses the broader developmental needs of youth, in contrast to deficit-based models which focus solely on youth problems (35)."

Mentoring, a one-to-one relationship, provides an opportunity for a caring adult to support and encourage a teenager's growth and development. The roles of mentors are diverse–offering a shoulder to cry on, giving a pat on the shoulder, being an educator, or acting as a coach.

The positive relationship helps the teenager develop self-confidence, self-efficacy and self-control. Evaluations of mentoring programs have shown positive outcomes and those outcomes have been shown to reduce the risk of teenage pregnancies and births.

For example, in 1995 a study was conducted to assess the mentoring effects of the Big Brothers/Big Sisters Program. The study revealed that participants 10-16 years of age who met with their mentor an average of three to four hours each time, three times per month for one year were, when compared with non-mentored students:

- 52% less likely to skip a day of school;
- 37% less likely to skip a class;
- 46% less likely to start using illegal drugs;
- 27% less likely to start drinking;
- about 33% less likely to hit someone; and
- more likely to have more trusting and higher-quality relationships with their parents (36).

Involvement takes many shapes. Students, teachers, parents, coaches, and other community members can make a difference as seen in the following examples:

- A study of Western New York teenagers showed that female teenagers who participated in sports were less likely than their non-athletic peers were to engage in sexual activity and/or become pregnant. Athletic participation was unrelated to sexual behavior among male adolescents (37).
- Students involved in school clubs were less likely to have a child during their high school years. Specifically, leadership in school clubs by Black students and involvement in religious organizations by White students were found linked to a lower risk of teenage motherhood (34).
- According to a Child Trends study, high levels of parental involvement with their daughters' school were associated with a reduced risk of school-age pregnancy among Whites and Blacks (33).

"Alone we can do so little.
Together we can do so much."
–Helen Keller

Family

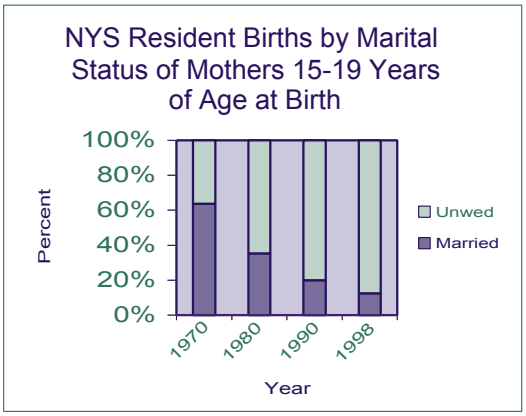
The family support structure for the teenage mother has changed during the latter half of this century as the majority of USA teenage mothers in the 1990s are unwed whereas the majority of teenage mothers prior to the 1980s were married (7). Now, with the majority of teenage births occurring to unwed mothers from impoverished backgrounds, the support structure and possibility for economic security for the young family are threatened. However, as stated by members of the Task Force on Out-of-Wedlock Pregnancies and Poverty, "no public policy should be instituted that encourages teenagers–pregnant or not–to become married before they are economically, emotionally and socially ready," and it is not the intention of this report to encourage, condone or condemn teenage marriages (15).

New York State has seen a similar trend but at a more accelerated pace as the percent of NYS out-of-wedlock mothers who were teenagers at the time of birth has reached 87.5% in 1998.

- In 1970, 36.2% of teenage mothers were unwed at time of birth.
- By 1980, the percentages reversed as 64.7% of teenage mothers were unwed at time of birth.
- By 1990, 80% of teenage mothers were unwed at time of birth.
- By 1998, 87.5% of teenage mothers were unwed at time of birth (Figure 8).

The number of NYS out-of-wedlock live births is imputed. NYS Public Health Law prohibits the specific statement on the birth certificate as to whether or not the mother of the child was married.

Figure 8. NYS Resident Births by Marital Status of Mothers 15-19 Years of Age at Birth.



Source: NYS Department of Health, 2001 (11).

The family as a protective factor –

In order to reduce the risk of teenage pregnancy, the family can offer emotional, physical, material, and economic supports that enable children to gain the skills, competencies, confidence and self-efficacy to become healthy, interdependent members of their families and communities. Each member plays a crucial, interdependent role. In addition, certain fathering roles (i.e., economic providers, protectors, caregivers, and teachers) are valued across major racial, ethnic, and cultural groups (38). Research conducted by Child Trends found that the family can provide protective attributes, which in turn reduce the risk of teenage pregnancy. For example:

- teenagers with supportive family relationships, who attend faith-based organizations frequently, who live with both of their parents, and who have better educated parents are less likely to initiate sex at a young age;

- teenagers who lack parental monitoring, communication channels, help in dealing with media and peer influences and models to provide values and goals for the future are more likely to become teenage parents;
- paternal praise (as opposed to harsh criticism or indifference) is associated with higher school achievement, higher educational goals, and better classroom behavior;
- children who do not live with their biological fathers are at a higher risk for poverty, school drop out, incarceration, and teenage pregnancy; and
- greater involvement by fathers in routine activities with their children (eating meals together, helping with homework, etc.) is associated with fewer behavior problems, greater sociability, and better school performance by children and adolescents (39).

"States are as the men, they grow out of human characters."

–Plato

Community

According to the National Governors' Association, "The continued ability of states to compete in the global economy hinges on how well they enable their younger citizens to attain the competencies and social attributes necessary to ultimately fuel economic growth and contribute to the well-being of their families and communities (40)."

The Institute for Student Achievement is an example of a New York State program having community service and family involvement as key components.

The school-based program provides counseling and academic assistance to middle and high school students who are having trouble in school. The program, which has both after-school and summer components, operates in six school districts in New York State, including schools in Long Island, New York City, Mt. Vernon, and Troy. The STAR (Success Through Academic Readiness) component, initiated in 1990 in Long Island, supports high school students through academic enrichment and counseling for at least two hours a day after school. The COMET (Children of Many Educational Talents) component, initiated in 1993, addresses the special needs of middle school students, helping them to improve communication, comprehension, and social interaction skills and to make the transition to high school smoothly. Evaluations of the program show the following achievements in school performance, a key factor related to reducing the risk of teenage pregnancies and births:

- every STAR student has graduated from high school;
- 96% have gone on to college; and
- test scores at participating Hempstead High School on Long Island improved so much that the State removed the school from its list of low-performing schools a year ahead of schedule (41).

Search Institute developed a research framework of youth developmental assets to help assess young people's positive growth and development. The 40 assets include external assets (focusing on positive experiences with the people and institutions in their lives) and internal assets (focusing on internalized qualities that guide choices and create a sense of centeredness, purpose, and focus). The external assets measure support, empowerment, boundaries and expectations, and constructive use of time while the internal assets measure commitment to learning, positive values, social competencies, and positive identity (42).

Based on Search Institute's surveys of almost 100,000 youth in grades 6-12 in 213 towns and cities in the United States, during the 1996-97 school year, the inverse relationship seen in Table 4 signifies the protective qualities associated with having a greater number of assets. On an ever-increasing scale, students with more assets were less likely to participate in the risky behavior. Research suggests this power is evident across all cultural and socioeconomic groups of youth (42).

Table 4. Percent of Students Within Each Category (number of possessed assets) Participating in Risky Behaviors.

Behavior	0-10 Assets	11-20 Assets	21-30 Assets	31-40 Assets
Problem Alcohol Use	53%	30%	11%	3%
Illicit Drug Use	42%	19%	6%	1%
Sexual Activity	33%	21%	10%	3%
Violence	61%	35%	16%	6%

Source: Search Institute, 1999 (42).

In addition, Search Institute research suggests that strong communities (defined as, "communities in which all young people are surrounded with multiple influences that give consistent messages of love, support, control, and positive values") are essential to positive youth development (42).

Based on a community data analysis of the 13 potential strengths in the youths' families, schools, peers and community and 16 at-risk behaviors (including, alcohol, tobacco, illicit drug use, sexual activity, depression/suicide, anti-social behavior, and school problems) in the community, Search Institute identified the following six strengths as key factors that when present for most youth in a community help reduce at-risk behaviors in a community:

- youth who avoid peers with negative behavior;
- youth who are motivated and committed in school;
- youth who are involved in structured activities;
- youth who attend religious services;
- youth who experience a caring and supportive school environment; and
- youth who have caring and supportive families (43).

The 112 small, mostly mid-western communities examined in this research averaged 2.9 of the six identified strengths. Eight of the communities had all six strengths while 19 of the communities had none of the strengths. As seen at the individual level, as the average number of strengths the community possesses increases, the average number of at-risk behaviors decreases. For example, in communities where youth experience none or one of the strengths compared to communities where youth experience all six strengths, the average youth is involved in 2.6 at-risk behaviors versus 1.6 at-risk behaviors, respectively. According to Search Institute, the "analyses also suggest that these strengths are more important to community health than demographic factors that are often blamed for youth problems (43)."

Conclusion

Children bearing children–teenage pregnancies and births–create substantial negative consequences for the nation, states, communities, families, teenage mothers, fathers and children. Although the teenage pregnancy and birth rates in New York State and the United States declined during the 1990s and New York State has repeatedly reported lower teenage pregnancy and birth rates than the national average, the rates are still too high. In order to interpret the recent decline, the following teenage sexual behaviors have been observed. The fact that fewer teenagers are becoming pregnant and fewer pregnant teenagers are choosing to have an abortion indicates that abortion is not the factor driving the declining birth rates.

Research does suggest the following teenage sexual behaviors are related to the recent declining trend:	● fewer teenagers are sexually active; ● more teenagers are using long-acting, effective contraceptive methods; and ● more teenagers are using contraceptive methods consistently or correctly.

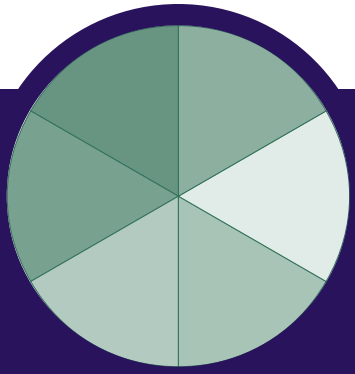
Consequently, the declining teenage pregnancy and birth rates reflect a combination of factors. According to an Alan Guttmacher Institute report, "about 20% of the decrease since the late 1980s is because of decreased sexual activity, and 80% of the decrease is because of more effective contraceptive practice–the methods teenagers are choosing to use and how well they are using them (23)." The use of the implant and injectable may represent a shift in contraceptive use rather than a significant increase. However, this shift appears to be having an impact on overall teenage pregnancy rates since the failure rates for the long-acting methods are so low (23).

Researchers attribute the recent trends in teenage sexual activity and contraceptive use to a variety of factors, including:	● greater emphasis on delaying sexual activity; ● more responsible attitudes among teenagers about casual sex and out-of-wedlock childbearing; ● increased fear of sexually transmitted diseases, especially Acquired Immune Deficiency Syndrome (AIDS); ● the availability of and use of long-acting, effective contraceptive methods, such as implant (Norplant) and the injectable (Depro-Provera) options; ● more consistent or correct use of contraceptive methods; and ● a stronger economy, with better job prospects for young people leading to stronger motivation to avoid pregnancy (2,4,5).

Teenage childbearing behaviors and risk factors contributing to those behaviors are interdependent with societal factors that influence the teenagers' economic security, physical and emotional health, education, citizenship, family, and community environments. In order to ensure that the rates continue to decline, the strategies need to reach beyond the behaviors and risk factors and focus on sustained efforts to foster a healthy lifestyle and development of self-control, self-respect and self-efficacy. Research suggests that "enhancing the connections of teenagers to their family and home, their school, and their community is essential for protecting teenagers from a vast array of risky behaviors, including sexual activity (4)." Teenagers will continue to confront sexual pressures and must make social, intellectual, physical and moral choices. With skills, knowledge and support, teenagers can understand the consequences of their choices, make positive life choices and take responsibility for their choices. According to the Carnegie Council on Adolescent Development, "Prevention of undesirable behaviors is one outcome of healthy youth development, but there are others: the production of self-reliant, self-confident adults who can take their place as responsible members of society (35)."

New York State's policies, programs and services are shifting from a crisis-driven focus to a strengths-based approach. For example, welfare reform, with an emphasis on moving welfare recipients off public assistance and into the work force, acknowledges the need to provide services that help families gain the necessary skills and competencies to become self-reliant and to help strengthen their communities. The new learning standards being established by New York and most other states aim to increase students' problem-solving abilities, to better equip students to use their knowledge of all subject areas to solve real-life problems and to handle real work situations. The New York State Family Development Training and Credentialing Program (FDC) provides front-line workers with the skills and competencies they need to empower families to attain a healthy self reliance and strengthen their communities.

The burden of teenage pregnancies and births in New York State and the United States rests on the teenagers, families, communities, states and the nation. The strategies to reduce this burden need to be responsive to societal needs as well as strengths-based, comprehensive and long-term. Ultimately, the health and well-being of the nation is interdependent on the health and well-being of the states, communities and families and, conversely, the health and well-being of New York State's children and families is interdependent on the health and well-being of the nation as a whole, individual states and communities. Reducing teenage pregnancies and births will enhance New York's economic security, physical and emotional health, education, citizenship, family and community well being.



New York State Touchstones
Life Areas, Goals and Objectives

Education

Goal 1: Children and youth will be raised in families with sufficient economic resources to meet their basic needs.

Objective 1: Children will be raised in households with sufficient economic resources to provide food, clothing shelter and other necessities.

Objective 2: Children and youth will receive adequate financial support from absent parents.

Goal 2: Youth will be prepared for their eventual economic self-sufficiency.

Objective 1: Youth will have skills, attitudes and competencies to enter college, the work force, or other meaningful activities.

Objective 2: Young adults who can work will have opportunities for employment.

Objective 3: Youth seeking summer jobs will have employment opportunities.

Physical and Emotional Health

Goal 3: Children and youth will have optimal physical and emotional health.

Objective 1: Children and youth will be born healthy.

Objective 2: Children and youth will be free from preventable disease and injury.

Objective 3: Children and youth will have nutritious diets.

Objective 4: Children and youth will be physically fit.

Objective 5: Children and youth will be emotionally healthy.

Objective 6: Children and youth will be free from health risk behaviors (e.g., smoking, drinking, substance abuse, unsafe sexual activity).

Objective 7: Children and youth will have access to timely and appropriate preventive and primary health care.

Objective 8: Children with special health care needs will experience an optimal quality of life.

Objective 9: Children and youth with service needs due to mental illness, developmental disabilities and/or substance abuse problems will have access to timely and appropriate services.

Education

Goal 4: Children will leave school prepared to live, learn and work in a community as contributing members of society.

Objective 1: Children will come to school ready to learn.

Objective 2: Students will meet or exceed high standards for academic performance and demonstrate knowledge and skills required for lifelong learning and self-sufficiency in a dynamic world.

Objective 3: Students will be educated in a safe, supportive, drug free and nurturing environment.

Objective 4: Students will stay in school until successful completion.

Citizenship

Goal 5: Children and youth will demonstrate good citizenship as law-abiding, contributing members of their families, schools and communities.

Objective 1: Children and youth will assume personal responsibility for their behavior.
Objective 2: Youth will demonstrate ethical behavior and civic values.
Objective 3: Children and youth will understand and respect people who are different from themselves.
Objective 4: Children and youth will participate in family and community activities.
Objective 5: Children and youth will have positive peer interactions.
Objective 6: Children and youth will make constructive use of leisure time.
Objective 7: Youth will delay becoming parents until adulthood.
Objective 8: Children and youth will refrain from violence and other illegal behaviors.

Family

Goal 6: Families will provide children with safe, stable and nurturing environments.

Objective 1: Parents/caregivers will provide children with a stable family relationship.
Objective 2: Parents/caregivers will possess and practice adequate child rearing skills.
Objective 3: Parents/caregivers will be literate.
Objective 4: Parents/caregivers will be positively involved in their children's learning.
Objective 5: Parents/caregivers will have the knowledge and ability to access support services for their children.
Objective 6: Parents/caregivers will provide their children with households free from physical and emotional abuse, neglect and domestic violence.
Objective 7: Parents/caregivers will provide their children with households free from alcohol and other substance abuse.

Community

Goal 7: New York State communities will provide children, youth and families with healthy, safe and thriving environments.

Objective 1: Communities will be economically sound.
Objective 2: The environment will be free of pollutants (e.g., air and water quality will meet healthful standards).
Objective 3: Neighborhoods will be crime free.
Objective 4: Adequate housing will be available.
Objective 5: Adequate transportation will be available.

Goal 8: New York State communities will provide children, youth and their families with opportunities to help them meet their needs for physical, social, moral and emotional growth.

Objective 1: Communities will make available and accessible formal and informal services (e.g., child care, parent training, recreation, youth services, libraries, museums, parks).
Objective 2: Adults in the community will provide youth with good role models and opportunities for positive adult interactions.
Objective 3: Communities will provide opportunities for youth to make positive contributions to community life and to practice skill development.

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http://www.state.ny.us/

Office of the Governor, Governor George E. Pataki
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Council on Children and Families
http://www.capital.net/com/council

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http://www.advoc4disabled.state.ny.us/

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Division of Probation and Correctional Alternatives
http://dpca.state.ny.us/

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