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Childbearing by Teens: Links to Welfare Reform

Richard Wertheimer and Kristin Moore, Child Trends, Inc.

Teenage pregnancy and childbearing have been a continuing source of concern to health practitioners, educators, the media, politicians, and the public. Teen childbearing is associated with numerous negative outcomes for both the mother and her children and with costs to society—including welfare costs—and has been a major focus of welfare reform efforts.

Teen Childbearing Rates

Although childbearing rates among teens are lower than during the baby boom, a strong decline was interrupted in the 1980s, and a recent resumption of the decline has not returned birth rates to the levels reached in the mid-1980s.

As shown in figure 1, between 1960 and 1986, the teen birth rate dropped dramatically—especially for women ages 18–19. However, between 1986 and 1991 the teen birth rate for both older and younger teens rose substantially. Since 1991, the birth rate for older teens has declined by approximately 8 percent to 87 per thousand in 1996, while the rate dropped by about 12 percent for younger teens to 34 per thousand.

Childbearing by Marital Status

Important differences in childbearing have occurred between married and unmarried teens. Between 1960 and 1995, the birth rate for *married* teens dropped by over 30 percent from 531 births per thousand to 362 births per thousand. Over the same period, the birth rate for *unmarried* teens nearly tripled from 15 births per thousand to 44 per thousand.

Between 1960 and 1996, the number of births to married teens dropped from about 465,000 to about 119,000, due to the drop in both the married teen birth rate and the percentage of teens who were married. Over the same period, the number of births to unmarried teens quadrupled from about 87,000 to about 376,000. In 1960, as shown in figure 2, only 16 percent of births to teens were nonmarital; by 1996, 76 percent of teen births were nonmarital.

Between 1960 and 1996, the number of births to unmarried teens quadrupled from about 87,000 to about 376,000.

Links to Welfare Prior to Welfare Reform in 1996

When an unmarried teenager bears a child, society often foots the bill because the teenager is likely to go on welfare. Over three-quarters of all unmarried teenage mothers began receiving cash benefits from the Aid to Families with Dependent Children (AFDC) program within five years of the birth of their first child (Adams and Williams 1990). Indeed, 55 percent of all AFDC mothers were teenagers at the time of their first birth, and 44 percent of

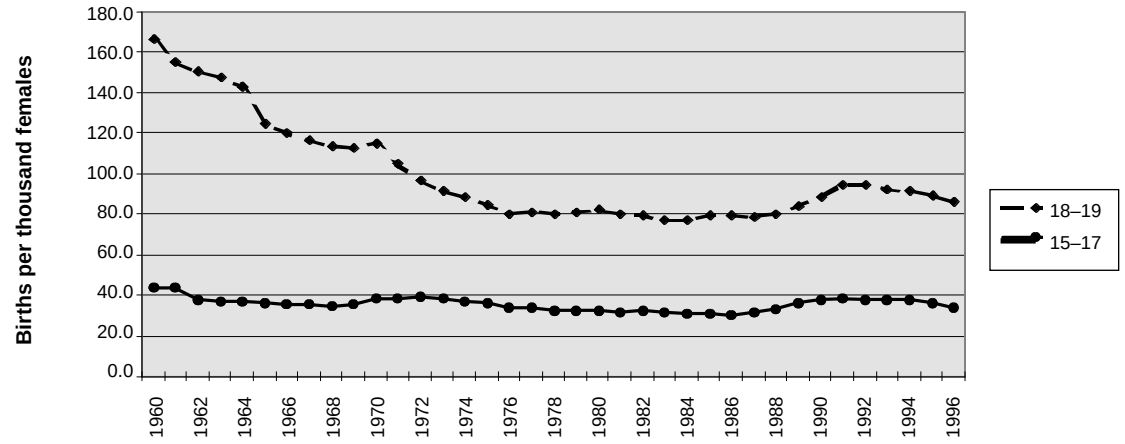
AFDC mothers were *unmarried* teenagers (Moore et al. 1993a; Zill 1996).

The connection between welfare programs and childbearing by teens evolved because AFDC was generally targeted on families with only one able-bodied parent. Since teen mothers have usually been unmarried in recent years, they usually qualified for AFDC. Participation in AFDC qualified these families for food stamps and Medicaid as well.

Because the U.S. welfare system has historically been designed to serve single-parent families rather than two-parent families and childless couples, it has been suggested that AFDC provided incentives for young women to have children. The belief that the welfare system has encouraged teen childbearing, and especially nonmarital teen childbearing, clearly affected the 1996 welfare reform legislation, which includes several provisions designed to reduce both teenage and nonmarital childbearing. This belief cannot be examined in an experimental study, but a variety of less rigorous methods have been used to examine the topic.

A slight majority of the studies analyzing the effects of these incentives have found a statistically significant positive association between the generosity of the welfare system and nonmarital birth rates.[1] However, the estimated effects vary widely, tend to be smaller for younger women and black women, and fail to explain the rise in nonmarital fertility over the past 25 years. In short, "the uncertainty introduced by the disparities in the research findings weakens the strength" of the conclusion that the generosity of the welfare system increases nonmarital fertility (Moffitt 1997).

Figure 1
Teen Birth Rate (Births per Thousand Females), Ages 15–17 and 18–19, 1960–1996



Source: Ventura et al. (1997).

Links to Other Social Problems

Even before becoming pregnant, young mothers-to-be have substantial disadvantages. Numerous studies have found that early childbearing is predicted by early school failure, early behavioral problems, family dysfunction, and poverty (Moore et al. 1995).

Both because of these underlying problems and probably also because of teenage motherhood itself, teenage mothers and their families experience greater social and economic problems than older, two-parent families. Researchers agree that much or most of the negative consequences linked with early childbearing are due to the disadvantaged backgrounds of the mothers (Maynard and Rangarajan 1994; Bachrach and Carver 1992). Some researchers argue that all of the consequences reflect background differences (Hotz et al. 1997; Geronimus and Korenman 1993), but most researchers find small to moderate negative effects due to the burden of having and raising a child while still an adolescent (Moore et al. 1993b; Hoffman et al. 1993; Maynard 1997; Moore and Wertheimer 1982).

The disadvantages experienced by teen mothers tend to translate into poorer outcomes for their children. For example, the children of teen mothers score lower on achievement tests and live in less supportive home environments than the children of older mothers (Moore et al. 1995).

Welfare Reform: Autonomy for the States

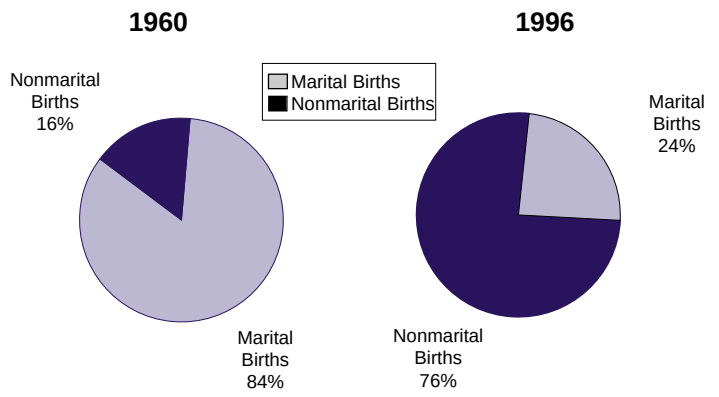
One policy response to this complex situation was the provisions of the 1996 welfare reform legislation specifically designed to reduce teen fertility. However, perhaps the most important provision of the legislation was granting states a high degree of autonomy in the kind of welfare program each would offer.

Prior to the 1990s, states had little control over the provisions of welfare programs other than setting benefit levels for AFDC. The granting of state waivers in the early 1990s and the welfare reform legislation of 1996 have dramatically shifted authority from the federal government to state governments, at least in part because

of a belief that local problems need local solutions.

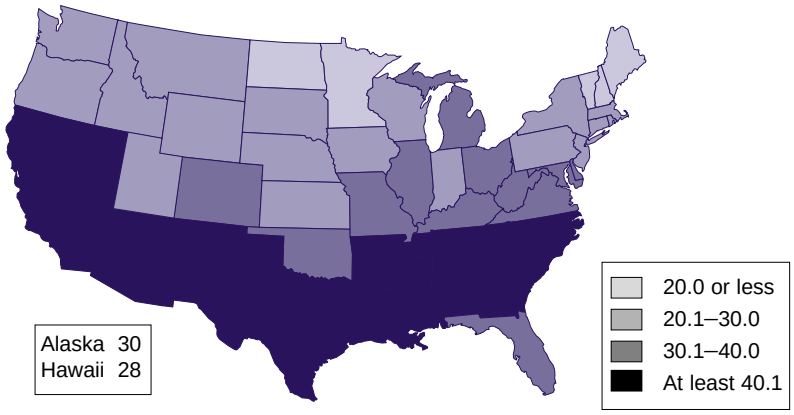
The welfare reform legislation provides states with both financial incentives and unprecedented flexibility for dealing with teen and nonmarital childbearing. As we shall see in the next section, there is substantial variation in the incidence of teen childbearing across the states.

Figure 2
Percentage of Teen Births by Marital Status, 1960 and 1996



Sources: U.S. Department of Health and Human Services (1995) and Ventura et al. (1998).

Figure 3
Teen Birth Rate (per Thousand), 15- to 17-Year-Olds, 1995



Source: National Center for Health Statistics.

State Variation in Teen Childbearing

The fertility rate of young women ages 15–17 varies from 11 births per thousand in Vermont to 58 births per thousand in Mississippi. As shown in figure 3, this substantial variation in teen fertility by state has a striking geographic pattern. In the Sunbelt states, birth rates generally exceed 40 births per thousand females ages 15–17, while in upper New England and parts of the upper Midwest, teen birth rates are less than 20 births per thousand.

This geographic pattern is partly due to the fact that teen fertility rates are substantially higher for Hispanic and black teens than for white, non-Hispanic teens, and Sunbelt states generally have higher percentages of blacks and Hispanics than states in New England and the upper Midwest. However, even after taking account of the racial/ethnic differences in states' teenage population, substantial differences in birth rates remain. For example, in 1992, Tennessee's teen birth rate of 71 births per thousand was nearly double Minnesota's rate of 36 per thousand. If the racial/ethnic composition of Tennessee's teen population had been the same as Minnesota's, Tennessee's birth rate would *still* have been 61 births per thousand. Thus, less than 30 percent of the difference in the two states' birth rates is attributable to the difference in the racial/ethnic composition of their teen population (Henshaw 1997). In fact, the primary reason for the difference in the two states' birth rates is that the white, non-Hispanic birth rate in Tennessee (59 births per thousand) was more than double the Minnesota rate (29 births per thousand).[2]

Given this wide variation in childbearing behavior across the country, states may wish to pursue different strategies to reduce teen fertility. The next section describes some of the options.

State Policy Options for Discouraging Teen Childbearing

The state policy initiatives currently receiving the greatest attention are those mandated by the 1996 welfare reform legislation. They include:

- Restrictions on benefits to unwed teenage parents under age 18 who do not live at home and attend school.
- Bonuses to the five states that rank highest in decreasing out-of-wedlock births while decreasing abortion.
- An abstinence education program that will invest $50 million in federal funds annually for five years.
- A requirement that states outline how they intend to establish goals and act to prevent and reduce the incidence of nonmarital pregnancies, with special emphasis on teen pregnancies.
- A requirement that the Secretary of the Department of Health and

Human Services establish national goals to prevent teen pregnancy and ensure that at least 25 percent of the communities in the United States have teenage pregnancy prevention programs in place.

- A requirement that the Attorney General study the linkage between statutory rape and teenage pregnancy and educate state and local criminal law enforcement officials on the prevention and prosecution of statutory rape.

Unfortunately, the research literature provides limited guidance on how effective these policies are likely to be. Findings include:

- Staying in school has been shown to be associated with lower first-birth rates to teens, and both staying in school and living with parents have been shown to be associated with lower second-birth rates to teens (Manlove 1998; Manlove et al. 1998). However, research has not yet established whether either staying in school or living at home *causes* the rate of first or repeat teen births to be lower (Long et al. 1996). Thus, the provision of the welfare reform legislation to restrict benefits to women under age 18 unless they stay home and stay in school is a reasonable initiative but not one that has been demonstrated to work in a controlled environment.

- While abstinence is completely effective in preventing pregnancy, there has been little rigorous research on the effectiveness of abstinence-only programs. Consequently, the jury is still out on whether abstinence programs can significantly reduce teen childbearing (Kirby 1997), and it is important to conduct rigorous evaluations of initiatives implemented with funds provided by the 1996 welfare reform legislation.

- Initiatives to increase enforcement of statutory rape laws are likely to have only a modest impact on teen fertility. Although there is substantial variation in statutory rape laws across the states, an age difference of about five years is usually required for sex between a girl age 15 to 17 and an older man to be considered a felony. Research has shown that births to unmarried girls ages 15–17 whose partners are at least five years older account for only 8 percent of births to females ages 15–19 (Lindbergh et al. 1997). Nevertheless, unwanted and nonvoluntary sex is an important problem when it occurs, and it is particularly common among younger adolescents (Moore et al. 1998).

In addition to the policy initiatives states are undertaking as part of welfare reform, states have many other options for reducing teenage childbearing, including the following:

- Using their education system, states can design a model sex education curriculum intended for implementation by local school districts. The curriculum could incorporate any of the following features found to be effective in reducing teen pregnancy (Kirby 1997):

  (1) Focus on both delaying first intercourse and using contraception;
  (2) Vary content and approach depending upon the age and/or experience of student;
  (3) Include at least 14 hours of instruction or other learning-related activities;
  (4) Implement the program in a small-group setting;
  (5) Use active learning methods (e.g., discussion, games, etc.);
  (6) Provide information on risks of unprotected sex (e.g., HIV/AIDS, STDs, pregnancy);
  (7) Address social pressures to engage in sexual activity;
  (8) Provide practice in negotiation and refusal skills;
  (9) Include only teachers who are committed to the program's goals and methods; and
  (10) Provide at least six hours of training to these teachers.

- Assuming a state designs a model curriculum, it could mandate use of the curriculum in all local school systems, or it could simply encourage its use while allowing local school systems to modify the program to suit local preferences.

- In addition to education programs, states can take advantage of a number of federal programs whose funds can be used to provide family planning counseling, HIV and STD education, and contraceptive services to teens and unmarried women. These include Title X of the Public Health Services Act, Title V of the Maternal and Child Health Act, Title XIX of Medicaid, Title XX (Social Services Block Grants) of the Social Security Act, and various services provided by the Centers for Disease Control and Prevention.

- States can also set up or participate in coordinated statewide initiatives to prevent teen and nonmarital childbearing. These initiatives may be organized by the office of the governor, a lead state agency, or a state nonprofit organization. The purpose of these initiatives is to coordinate the activities of the state government and private initiatives so that a similar philosophy is used by all institutions providing services, duplicative services are eliminated, and the services reach the maximum number of persons needing them. Some evidence suggests that the presence of such a coordinated approach is associated with a lower state pregnancy rate (Moore et al. 1994).

- Also, states can develop or expand programs designed to enhance the educational and social development of children and youth. Efforts to affect the underlying predictors of early childbearing (poverty, family dysfunction, early behavior problems, and early school failure) represent a costly and time-consuming investment but may evoke less controversy and may prevent other problems (such as school dropout) as well as teen childbearing (Moore and Sugland 1996). Again, rigorous research to identify the most successful and cost-effective approaches is needed.

- Prenatal and infancy home visitation programs by nurses have been found to be effective in reducing second pregnancies in disadvantaged mothers in two trials—one consisting primarily of white mothers and one consisting primarily of black mothers (Olds et al. 1997). The cost of the program was more than offset by reduced welfare expenditures.

Other plausible initiatives that might reduce the incidence of teen childbearing include:

- Educating health care providers, especially family practice physicians and pediatricians, about the need to be proactive in discussing sexual issues with their teenage patients, both male and female. These issues include the desirability of sexual abstinence and how to say no to sex; the consequences of sexual activity (e.g., unintended pregnancy and STDs); and how to use both barrier and medical methods of contraception effectively.

- Increasing health insurance coverage for teenagers so that more teens will have access to reproductive health care services.

- Informing males about their child support obligations should they father a child.

What States Are Doing Now

While it is too soon to describe the specific programs states are enacting in response to the initiatives mandated by welfare reform, we can explore the teen pregnancy initiatives already under way prior to welfare reform.

States vary widely in their policies and programs to discourage teen childbearing. Child Trends, Inc., as part of a research project designed to assess the effect of state policies and programs on teen fertility, conducted a survey of all 50 states to obtain information on each state's policies and programs directed at teen pregnancy during the early and middle 1990s.[3] As shown in table 1, 19 states have an official policy requiring or encouraging pregnancy prevention programs in the public schools, and 12 states have created model curricula. However, in all but two states, local school districts have the final say over the content of these programs.

In the 12 states with model curricula, the programs typically include (1) a focus on both delaying first intercourse and using contraception, (2) content and approach that vary with the age of the student, (3) information on the risks of unprotected sex, and (4) a focus on how to respond to social pressures to engage in sexual activity.

In contrast with these relatively modest efforts in the area of pregnancy prevention education, states have been more aggressive in educating students about HIV/AIDS. All but eight states have an official policy regarding HIV/AIDS education in the public schools, and in all but one of those states that policy requires or encourages HIV/AIDS education. Similarly, 35 states have an official policy requiring or encouraging education on STDs.

About two-thirds of the states offer family planning services to teens statewide—generally outside of schools. Twelve states offer contraception education in schools, but only three states offer contraceptive clinics in schools—and then only in *some* high schools. Nearly all states use federal money from at least two sources to fund family planning services to teens, and 44 states reported using state or local money as well. Among the 30 states that reported how much the state budgeted of its own money for teen pregnancy prevention, responses varied from zero to $78 per female age 15 to 19, with a median value of $8 per teen female.

At present more than one-third of the states have developed a written multi-agency plan to coordinate programs and policies affecting teenage pregnancy. Of these, 13 states have a multi-agency task force or committee that meets at least annually to discuss goals, activities, or progress toward meeting the plan's goals.

Conclusion

Even though there is a strong consensus among policymakers that it is important to reduce teen childbearing, the United States has not yet reached consensus on how to achieve this goal. There is wide variation in teen fertility across the states and also wide variation in state policies and programs to discourage teen childbearing.

If this variation in both behavior and policy is subjected to rigorous analysis and evaluation, we may be able to learn more over the next few years about which state policies and programs are associated with lower state rates of teen childbearing after taking account of state differences in other factors linked to teen childbearing.[4] Given the diversity of teen childbearing behavior across the states, it may turn out that different approaches will be successful in different parts of the country. If successful strategies are identified, states could adopt the best practices of states facing challenges similar to their own.

Delaying births past the teen years will not prevent all of the negative outcomes associated with adolescent childbearing unless the many disadvantages faced by teen mothers even before they become pregnant are also addressed. Nevertheless, reducing teen childbearing can contribute to better outcomes for both teenagers and children.

Notes

1. A positive association does not necessarily imply that welfare generosity encourages nonmarital pregnancy. An equally plausible hypothesis is that relatively generous benefits provide an alternative to marriage for pregnant teens.

2. White, non-Hispanic birth rates calculated by Child Trends, based on tabulations in Henshaw (1997).

3. Financial support for the survey was provided by the Charles Stewart Mott Foundation.

4. Making a definitive case that the programs and policies are actually *causing* the reductions in teen childbearing would require an experimental program design in which teens are selected randomly for either the pregnancy prevention program or for a control group not receiving the services offered by the program. Then the childbearing behavior of the two groups

would be compared over time. Implementing this approach is not possible if a program or policy is mandated for all teens.

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Table 1
State Policies and Programs Concerning Teen Pregnancy Prevention, 1997

State	Pregnancy Prevention Policy in Public Schools	Model Curriculum	HIV Education in Public Schools	STD Education in Public Schools	Family Planning for Teens Statewide	Contraceptive Education in Public Schools	Contraceptive Clinics in Public Schools	Teen Pregnancy Prevention Budget per Teen Female	Multi-Agency Plan for Teen Pregnancy Prevention	Multi-Agency Task Force for Teen Pregnancy Prevention
AL			x	x	x			na		
AK			x	x				na	x	x
AZ								$22		
AR	x	x	x	x	x			na	x	x
CA			x	x	x			$78		
CO								$8	x	x
CT			x			x	x	$20		
DE	x	x	x	x		x		$43		
FL			x	x	x	x	x	$13		
GA			x	x	x		x	$14	x	
HI	x	x	x		x	x		$3		
ID			x		x			$5		
IL	x		x	x	x			na		
IN			x	x	x			$8		
IA	x		x	x	x			$10		
KS	x		x	x	x			$5		
KY					x			$7	x	x
LA	x		x	x	x			$13		
ME	x	x	x	x				na		
MD	x	x	x	x	x	x		$22	x	x
MA					x			$24		
MI			x	x				na		
MN	x	x	x	x	x			$7		
MS						x		$0		
MO			x	x	x			$2	x	x
MT	x		x	x	x			na	x	x
NE			x	x	x			$0		
NV	x	x	x	x	x	x		$0	x	x
NH			x	x				na		
NJ	x	x	x	x	x	x		$5	x	
NM			x					na	x	x
NY			x		x			na		
NC	x		x	x	x	x		na		
ND			x	x				na		
OH			x	x	x			$33		
OK			x	x				na	x	x
OR	x	x	x	x				na		
PA			x					na		
RI			x	x	x			na	x	
SC	x	x	x	x	x	x		na	x	x
SD					x			na		
TN	x		x	x				$4		
TX					x			$7		
UT			x	x				$8		
VT	x		x	x	x	x		$12	x	
VA	x				x			$26		
WA			x	x				$6		
WV		x	x	x	x	x		na	x	x
WI		x	x	x	x			$11	x	x
WY					x			na		

Note: Financial support for the survey used to collect the information in this table was provided by the Charles Stewart Mott Foundation.

About the Authors

Richard Wertheimer is an economist and senior research associate at Child Trends. He co-authored one of the first estimates of the costs of adolescent childbearing and is currently conducting research on the relationship between adolescent childbearing and state policies.

Kristin Moore is a social psychologist and president of Child Trends. She has done research on the trends, antecedents, and consequences of adolescent childbearing for more than two decades.

This series is a product of Assessing the New Federalism, *a multi-year project to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director and Anna Kondratas is deputy director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.*

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