Rhode Island KIDS COUNT

Issue Brief

TEEN PREGNANCY AND PARENTING IN RHODE ISLAND

Over the past decade, teen pregnancy rates and birth rates have been declining both nationally and in Rhode Island.[1,2] This significant decline has been recognized as an important public health success that has improved the life chances of both teenage girls and babies and reduced the number of families living in poverty.[3,4]

Further reducing the number of births to teens remains a critical goal due to the high economic and social costs of teen childbearing. Teen pregnancy and parenting threatens the development of teen parents as well as their children. Nationally less than half of teen mothers under age 18 receive a high school diploma.[5] Teen parents are less likely to have the financial resources, social supports and parenting skills needed for healthy child development.[6] Children born to teens are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, or become teen parents themselves.[7,8]

In 2004, the Rhode Island teen birth rate was 32.9 per 1,000 girls ages 15-19, lower than the national rate of 41.1 per thousand. Rhode Island ranked 15th in the nation, behind all 5 other New England states, plus Iowa, Maryland, Minnesota, New Jersey, New York, North Dakota, Pennsylvania, Washington, and Wisconsin.[9] Teen birth rates in the United States are among the highest in the industrialized world.[10]

TEEN BIRTH RATE BY AGE GROUP, 2004

(rate per 1,000 girls)

AGE	RHODE ISLAND	U.S.	RI RANK
15-17	17.1	22.1	17th
18-19	56.7	70.0	15th
15-19	32.9	41.1	15th

Source: Martin, J.A., Hamilton, B.E., Sutton, P.D., Ventura, S.J., Menacker, F., Kirmeyer, S. (2006). *Births: Final data for 2004. National vital statistics reports,* 55(1). Hyattsville, MD: Centers for Disease Control and Prevention. Note: 1st is best, 50th is worst.

In 2005 in Rhode Island there were 1,117 babies born to mothers younger than age 20. Almost one in ten (9%) of all babies born in Rhode Island in 2005 were born to teen mothers.[11]

DECEMBER 2006

A DETAILED LOOK AT TEEN PREGNANCY DATA

The teenage pregnancy rate in the United States is at the lowest level in 30 years. The birth rate for teens across the U.S. age 15-19 declined by 33% between 1991 and 2004.[12] During the same time period, the birth rate for teenage girls in Rhode Island ages 15-19 declined by 26%.[13]

Nationally, approximately 51% of teenage pregnancies end in live births, 35% end in abortions, and 14% result in miscarriage or stillbirth.[14] The national teenage abortion rate has been declining rapidly, falling by 50% since 1983.[15]

Research indicates that both increased sexual abstinence and changes in contraceptive practice, including increased use of long-lasting hormonal contraceptives, are responsible for the significant declines in teenage pregnancy in the past decade.[16,17,18]

RHODE ISLAND TEEN PREGNANCIES AND BIRTHS BY AGE, 2005

AGE	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES	NUMBER OF ABORTIONS	NUMBER OF BIRTHS
12	0	0	0	0
13	8	0	4	4
14	32	0	12	20
15	85	2	41	42
16	192	6	61	125
17	322	11	117	194
18	577	19	217	341
19	691	17	259	415
Total	*1,907*	*55*	*711*	*1,141*

Source: Rhode Island Department of Health, Maternal and Child Health Database, 2005 provisional data. All miscarriages (fetal deaths) and induced abortions are required to be reported to the state.

Note: Pregnancies are calculated by adding miscarriages plus abortions plus births. The rate of miscarriages calculated from these data is substantially below national estimates. It is likely that miscarriages are under-reported among teens.

ADOPTION

Very few teenage mothers (estimated at less than 1% nationally) voluntarily relinquish their children for adoption.[19] Data on the age of birth mothers voluntarily relinquishing children for adoption is not available in Rhode Island. The proportion of teens and unmarried women placing their children for adoption has declined sharply over the past 50 years across the United States.[20]

AVERAGE AGE AT FIRST BIRTH

The age at which women give birth for the first time has been steadily increasing for the past 35 years.[21] Since 1970, the national average age at first birth has increased by four years. In 2004 the mean age of first-time mothers was 25.2 years in the U.S. and 26.3 years in Rhode Island.[22,23]

TEENS AT HIGHEST RISK FOR PREGNANCY AND PARENTING

"Simply put, girls with prospects do not have babies."
Janet Rich-Edwards, Harvard Medical School [24]

Teen pregnancy and childbearing are closely tied to family poverty. Teens residing in low-income neighborhoods with high concentrations of single-mother households and low levels of social organization are at greater risk for early pregnancies.[25] While teen pregnancy occurs in families of all income levels, as many as 83% of young women who give birth are from poor or low-income families.[26]

◆ Girls whose mother gave birth as a teen or whose sister became pregnant as a teen are more likely to become pregnant and give birth as an adolescent.[27] Researchers estimate that at least one-third of parenting teens (both males and females) are themselves children born to teen mothers.[28]

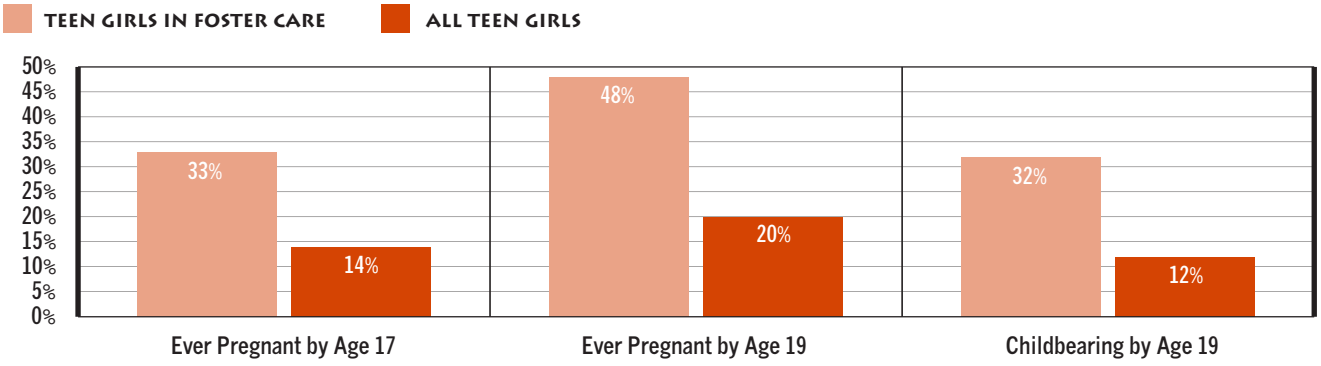
◆ Lower parent education levels are linked to increased incidence of teen pregnancy.[29] Disengagement from school and poor academic achievement are also predictors of teen pregnancy and child bearing.[30,31] Almost one-third of teen mothers drop out of school before becoming pregnant.[32]

◆ Girls with a history of sexual abuse are more likely to become pregnant. As many as 50% to 60% of girls who become pregnant in early to mid-adolescence are reported to have a history of childhood sexual abuse or physical abuse.[33]

TEEN PREGNANCY AMONG YOUTH IN FOSTER CARE

A recent national study highlighted that youth in foster care have much higher rates of pregnancy and childbearing than other youth.

PREGNANCY AND CHILDBEARING AMONG GIRLS IN FOSTER CARE, UNITED STATES

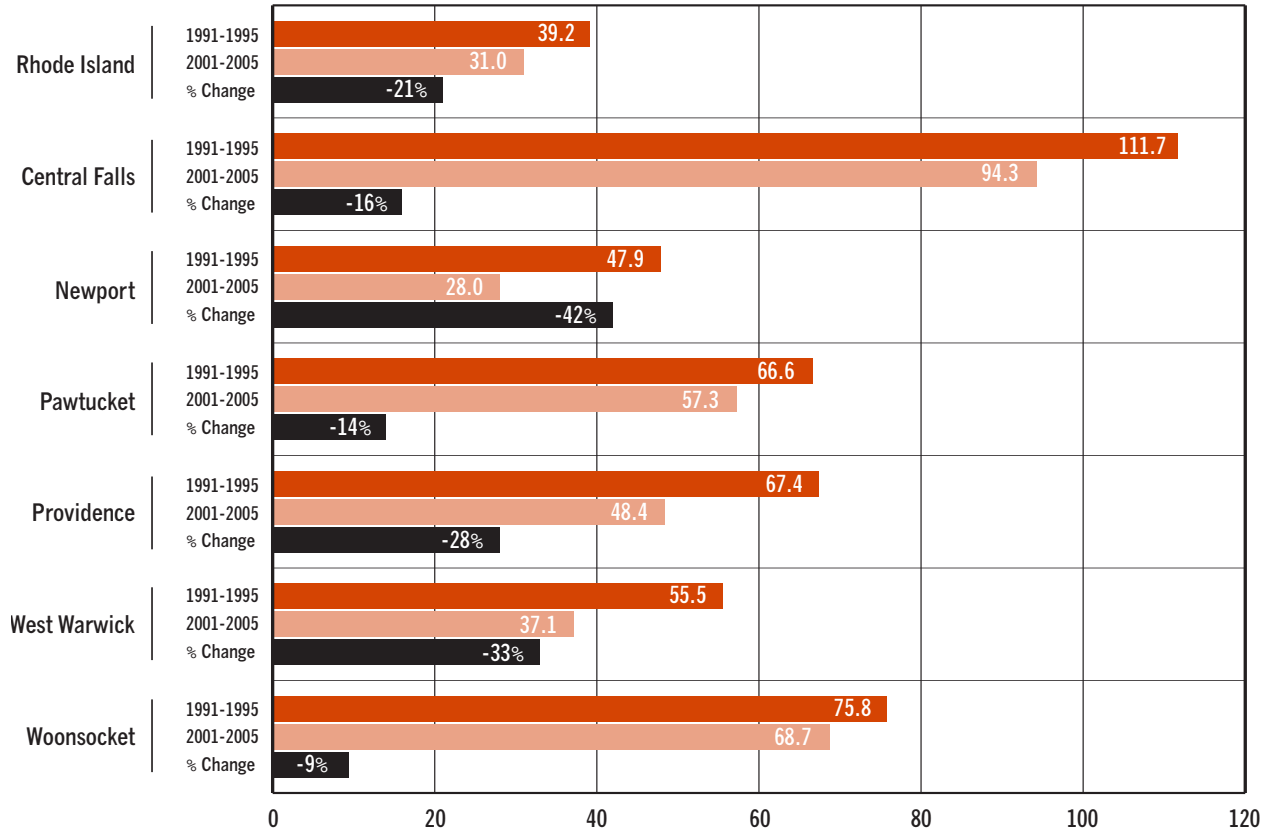


Source: *Science says: Foster care youth.* (2006). Washington, DC: National Campaign to Prevent Teen Pregnancy.

TEENAGE CHILDBEARING TRENDS

Although the Rhode Island teen birth rate is lower than the national teen birth rate, the Rhode Island rate has not declined as steeply as in many other states. Nationally, the birth rate for younger teens age 15-17 fell 43% while the rate for teens age 18-19 declined 26% between 1991 and 2004.[34] In Rhode Island, the birth rate declined by 37% for younger teens (15-17) and by 11% for older teens (18-19) during the same time period.[35]

TEEN BIRTH RATE, AGES 15-19 (PER 1,000 TEEN GIRLS) RHODE ISLAND AND CORE CITIES, 1991-1995 AND 2001-2005



Source: Rates calculated by Rhode Island KIDS COUNT using Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database for births to teens in 1991-1995 and 2001-2005 and Census Bureau data from Census 1990 and Census 2000.

BIRTHS TO OLDER TEENS

◆ Historically, states have tracked teen birth rates and focused policy attention on reducing births to teens ages 15 to 17 (and younger age groups as well). In more recent years, the definition of teen childbearing has been expanded to include teens ages 18 and 19 because researchers are increasingly finding that babies born to slightly older teens do not have much better outcomes than those born to teens in younger age groups.[36]

◆ Families who delay childbearing until their mid to late 20s are more likely to be educationally and economically strong and have children who are healthier and more successful in school.[37]

BIRTH TO TEENS, AGES 15-19, RHODE ISLAND, 2001-2005

CITY/TOWN	NUMBER OF BIRTHS TO GIRLS AGES 15-17	BIRTH RATE PER 1,000 GIRLS AGES 15-17	NUMBER OF BIRTHS TO GIRLS AGES 18-19	BIRTH RATE PER 1,000 GIRLS AGES 18-19	NUMBER OF BIRTHS TO GIRLS AGES 15-19	BIRTH RATE PER 1,000 GIRLS AGES 15-19
Barrington	1	0.5	5	6.8	6	2.1
Bristol	11	5.9	40	10.8	51	9.1
Burrillville	10	5.6	38	36.2	48	16.9
Central Falls	109	58.1	216	137.6	325	94.3
Charlestown	7	10.4	11	N/A	18	18.1
Coventry	33	10.3	67	39.6	100	20.4
Cranston	92	13.4	182	45.2	274	25.1
Cumberland	22	7.0	39	26.7	61	13.3
East Greenwich	7	4.9	7	14.0	14	7.3
East Providence	41	9.0	142	61.6	183	26.6
Exeter	4	5.5	10	N/A	14	13.7
Foster	2	N/A	11	N/A	13	19.4
Glocester	5	4.4	16	26.9	21	12.1
Hopkinton	10	11.5	15	N/A	25	19.5
Jamestown	3	5.3	3	N/A	6	8.2
Johnston	25	10.9	46	35.1	71	19.7
Lincoln	13	5.9	36	38.3	49	15.7
Little Compton	0	N/A	5	N/A	5	N/A
Middletown	6	4.4	39	57.4	45	22.0
Narragansett	3	2.4	17	15.6	20	8.5
New Shoreham	0	N/A	0	N/A	0	0.0
Newport	60	30.2	92	26.8	152	28.0
North Kingstown	13	4.9	42	34.7	55	14.2
North Providence	28	11.3	64	43.4	92	23.3
North Smithfield	2	2.0	14	N/A	16	10.8
Pawtucket	214	31.4	437	96.3	651	57.3
Portsmouth	8	4.8	15	24.8	23	10.1
Providence	820	48.1	1,434	48.7	2,254	48.4
Richmond	6	7.4	12	N/A	18	16.2
Scituate	4	3.3	13	25.2	17	9.8
Smithfield	6	3.4	19	7.0	25	5.6
South Kingstown	15	5.5	35	4.2	50	4.5
Tiverton	7	5.2	24	32.9	31	14.9
Warren	8	8.0	25	43.1	33	20.9
Warwick	74	9.4	182	45.9	256	21.6
West Greenwich	2	3.7	7	N/A	9	10.8
West Warwick	45	18.3	108	64.9	153	37.1
Westerly	31	14.3	79	71.5	110	33.6
Woonsocket	175	41.3	310	109.9	485	68.7
Core Cities	1,423	41.3	2,597	59.7	4,020	51.6
Remainder of State	499	7.8	1,260	28.6	1,759	16.2
Rhode Island	1,922	19.5	3,857	44.0	5,779	31.0

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 2001-2005. Data for 2004-2005 are provisional. The denominator is the number of girls in that age group according to Census 2000, multiplied by five to compute a rate over five years.

Notes to Table: Rates are not calculated for cities and towns with less than 100 girls in the age category, as rates for small denominators are statistically unreliable. Core cities are Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket.

RHODE ISLAND COMMUNITIES WITH HIGH CONCENTRATIONS OF TEEN BIRTHS

Across the state, 9% of all births are to a mother under the age of 20.[38] Some communities in Rhode Island have a much higher concentration of teen births. Communities with high concentrations of teen parents face increased challenges for their school systems, both to educate the teen mother and to educate the child of the teen mother upon entry to school.

BIRTHS TO TEENS AGES 15-19 AS A PERCENTAGE OF ALL BIRTHS, CORE CITIES AND RHODE ISLAND, 2001-2005

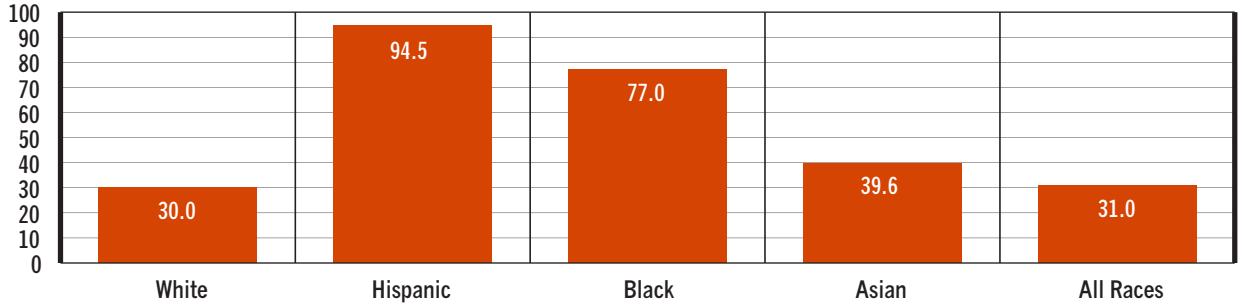
CITY/TOWN	NUMBER OF BIRTHS TO TEENS	TOTAL NUMBER OF BIRTHS	OF ALL BIRTHS IN CITY, % TO MOTHERS UNDER AGE 20
Central Falls	325	1,989	16.3%
Woonsocket	485	3,184	15.2%
Providence	2,254	14,862	15.2%
Pawtucket	651	5,569	11.7%
Newport	152	1,558	9.8%
West Warwick	153	2,003	7.6%
Rhode Island	5,779	64,270	9.0%

Source: Rhode Island Department of Health, Maternal and Child Health Database, 2001-2005 average.

RACIAL AND ETHNIC DISPARITIES

Nationally, birth rates are higher for Hispanic, Black and Native American teens than for white teens. Teen birth rates are highest for Hispanic teens with almost one-quarter of Hispanic women giving birth before age 20 compared with 13% for U.S. women overall.[39] Hispanic teen birth rates are also declining more slowly than for teens of other ethnicities.[40] Although birth rates for Black teens are also very high nationally, rates have been declining the most rapidly for this group. There was a 47% decline for Blacks versus 33% decline for all races between 1991 and 2004.[41]

TEEN BIRTH RATES, AGES 15-19 (PER 1,000 TEEN GIRLS) BY RACE/ETHNICITY, RHODE ISLAND, 2001-2005



Source: Rhode Island Department of Health. Maternal and Child Health Database, 2001-2005 average. Note: Race and Hispanic origin are reported separately on birth certificates. Persons of Hispanic origin may be of any race. Data for Native Americans is not available due to small numbers.

MULTIPLE RISK FACTORS

SINGLE MOTHERHOOD

◆ Reflecting a national social trend toward single parenthood, the majority of teen mothers are not married at the time of birth.[42] Eighty-two percent of births to mothers under age 20 in the U.S. are nonmarital.[43] In Rhode Island, 91% of births to teen mothers, ages 15-19, are nonmarital.[44] Teen mothers are less likely to ever marry than their non-parenting peers.[45] They are also at increased risk of divorce when they do marry compared to women who are older.[46] Children living in single parent families are more likely to live in poverty, do poorly in school, and earn less as adults.[47]

EDUCATIONAL STATUS OF TEEN MOTHERS

◆ Most teen mothers do not complete high school before giving birth. Teen pregnancy is a major factor influencing the high school drop out rate. In 2004, one-third of teen girls who dropped out of school in the U.S. cited pregnancy as the reason for doing so.[48] One national research project found that 58% of teen mothers drop out before or during pregnancy. Ultimately less than half of teen mothers under age 18 receive a high school diploma.[49] Recent research in Providence estimated that 40% of female dropouts are mothers.[50]

REPEAT BIRTHS TO TEENAGERS

◆ A teenager who has already had a baby is at increased risk of having another. National data indicate that approximately 25% of teen mothers have a second birth within 24 months.[51] Between 2001 and 2005 almost one in five (19%) births to a Rhode Island teenager ages 15-19 was a repeat birth. Nationally, 21% of all teen births were repeat births in 2004.[52] Having more than one child as a young, unmarried mother vastly increases the challenges faced in completing education and becoming economically self-sufficient.[53]

REPEAT BIRTHS TO TEENS, RHODE ISLAND, 2001-2005

AGE	TOTAL NUMBER OF BIRTHS	NUMBER OF REPEAT BIRTHS	PERCENT
12-14	102	1	1%
15-17	1,922	174	9%
18-19	3,857	919	24%
Total	*5,881*	*1,094*	*19%*

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 2001-2005. Data for 2004-2005 are provisional.

TEENAGE PARENTING: IMPACT ON THE CHILD

Children born to teen parents face many challenges. They are at greater risk of an array of adverse health, developmental, educational, and social outcomes than are children born to older parents.

HEALTH

◆ Children born to teenage mothers are more likely to be born prematurely and at low birthweight and face a greater risk of infant mortality.[54] In Rhode Island in 2001-2005, 13.0% of births to teens ages 15-19 were premature and 9.8% were low birth weight. In comparison, 11.8% of all births in Rhode Island were premature and 8.0% were low birth weight.[55] Epidemiologists report that these adverse health outcomes for newborns of teen mothers are likely caused by the social and economic factors that lead to teen pregnancy rather than maternal age by itself.[56]

EDUCATION

◆ Children of teen parents have lower school readiness skills, including math, language and social skills.[57] They are also more likely to do poorly in school. They are fifty percent more likely to repeat a grade, have lower performance on standardized tests, and are more likely to drop out of high school.[58] Poor education outcomes translate into sizable costs to society and reduced earnings over a lifetime.[59]

SAFETY

◆ Children born to teen mothers are at increased risk of child abuse and neglect. A study in Illinois revealed that reported cases of child abuse or neglect are twice as common for teen mothers than for women who had a first birth between ages 20-21. The study also showed that teen mothers are 2.2 times more likely to have a child placed in foster care before the baby reached age 5 than for women who waited until at least age 20 to have a baby.[60]

INCARCERATION

◆ The sons of teen mothers are 2.2 times more likely to be incarcerated than the sons of mothers who delayed childbearing until their early twenties.[61] Researchers have estimated that if all young teen mothers delayed births until age 20-21, the total state prison population would decline by 11.2%.[62]

INTERGENERATIONAL POVERTY

◆ The daughters of teen mothers are 22% more likely to become teen mothers themselves.[63] Researchers recognize the repetition of teen births from generation to generation as a major driver of poverty.

◆ Of the 5,779 Rhode Island teens ages 15-19 who had a baby from 2001-2005, 37% (2,133) were white non-Hispanic, 34% (1,973) were Hispanic, 13% (735) were Black non-Hispanic, 5% (263) were Asian, 2% (125) were Native American, <1% (7) were another race and 9% (543) were of unknown ethnicity.

Source: Rhode Island Department of Health, Maternal and Child Health Database, 2001-2005. Percentages may not add to 100 due to rounding.

TEENAGE PARENTING: IMPACT ON THE MOTHER

Having a child and juggling the responsibility of parenting while still an adolescent is a daunting task.

◆ Compared to women of similar socio-economic status who postpone childbearing, teen mothers are more likely to receive public assistance.[64] Almost half of all teen mothers and over three-quarters of all unmarried teen mothers begin receiving cash assistance within 5 years of delivering their first baby.[65] Nationally, 52% of all mothers receiving cash assistance had their first child when they were teens.[66]

◆ Teen mothers are less likely to complete high school. Only 40% of teen mothers younger than age 18 and 63% of teen mothers ages 18 and 19 complete high school, while about three-quarters of women who delay birth until age 20 or 21 attain a regular high school diploma.[67] Another 23% of teen mothers younger than age 18 and 11% of teen mothers ages 18 and 19 eventually attain a GED.[68] Lower education levels translates into reduced lifetime earnings.[69] Less than 2% of teen mothers younger than 18 and only 3% of teen mothers ages 18 and 19 complete a four-year college by age 30.[70]

◆ One in five teen mothers in Rhode Island has another baby while still a teenager. Repeat births further impede a teen mother's ability to finish school, be employed and develop their own potential as a young adult while parenting one or more children.[71]

WHAT ABOUT THE FATHERS?

◆ Information about teenage fathers is difficult to find. Fourteen percent of all birth certificates in the U.S. and 13% in Rhode Island do not contain information about the age of the father.[72] For babies born to teenage mothers in Rhode Island, 33% did not contain information about the age of the father in 2005.[73] Using a statistical technique developed to estimate the age of fathers, the birth rate for teenage boys ages 15 to 19 was estimated at 17.0 per 1,000 teen boys (versus 32.9 per 1,000 teen girls ages 15-19) nationally for 2004.[74]

◆ Research indicates that teen fathers are similar to teen mothers in many ways. They are more likely to have poor academic performance and be disengaged from school, drop out of school, come from low-income families and live in high-poverty neighborhoods.[75,76] They are also more likely to have exhibited delinquent and anti-social behavior and to have higher arrest rates than their peers who do not father children as teens.[77] National data indicate that approximately 20-26% of incarcerated teenage boys are fathers.[78]

◆ Many young, unmarried fathers are involved around the time of their child's birth and give money or buy things for the baby, are present at the time of the baby's birth, and visit the baby's mother in the hospital.[79] Some are also living with the mother at the time of the birth. However, father involvement typically decreases over time, particularly if the father and child live apart.[80] The quality of the mother-father relationship and whether or not they live together predicts the likelihood of father involvement with the child over time.[81]

WHAT WORKS TO PREVENT TEEN PREGNANCY

Teen pregnancy prevention is best addressed by using a multi-strategy approach that meets the developmental needs of teens, provides opportunities to build career and leadership skills, offers accurate information about sex and sexuality, and increases access to reproductive health care services.

◆ *Intensive, long-term youth development programs for adolescents* that also provide accurate information about sex and sexuality can delay initiation of sexual activity, reduce the frequency of sexual activity and reduce pregnancies and births.

◆ *Comprehensive sex education programs* delivered by well-trained teachers or peer leaders that deliver clear, accurate messages and provide opportunities for participants to practice communication and refusal skills can have a positive influence on teens' sexual behavior.

◆ *Clinic-based programs that feature one-on-one counseling* with clear messages about abstinence and contraceptive use can delay the initiation of sexual activity and increase appropriate and effective use of contraceptives among youth who are sexually active.

◆ *Intensive, long-term nurse home visiting programs* for young teenage mothers can reduce the likelihood of repeat births during the teen years and improve outcomes for their children.

◆ *High-quality, intensive early childhood programs* that improve school readiness and education outcomes among disadvantaged young children can have long-term positive impacts on pregnancies and births in adolescence.

From Manlove, J., Terry-Humen, E., Papillo, A.R., Franzetta, K., Williams, S., & Ryan, S. (2002). *Preventing teenage pregnancy, childbearing, and sexually transmitted diseases: What the research shows.* Washington, DC: Child Trends.

Poor academic achievement is a key predictor of teen pregnancy. About one-third of teen mothers drop out of school before becoming pregnant.[82] A key strategy to prevent teen pregnancy is to ensure that all children have the support they need to succeed in school, beginning in elementary school. Research shows that children who are not performing at grade level by fourth grade are more likely to drop out of high school.[83]

EMERGENCY CONTRACEPTION

◆ Emergency contraception, a concentrated dose of the hormone found in many birth control pills, can reduce the risk of a woman becoming pregnant by about 75% when taken within 3 days of unprotected sex.[84] As of November 2006, emergency contraception is now available in the United States for women 18 and older. Emergency contraception can be obtained from a pharmacy counter without a prescription. However, research indicates that most women and teens are unaware that a back-up birth control method is available, and most health care providers do not routinely discuss emergency contraception with their patients.[85] Efforts in other countries and in some states in the U.S. to educate women and physicians about the availability of emergency contraception have led to reductions of unintended pregnancies.[86] The American Academy of Pediatrics supports over-the-counter availability of emergency contraception for all teens, citing evidence that it has potential to significantly reduce teen pregnancy rates.[87]

TEENAGERS, HEALTH INSURANCE, AND REPRODUCTIVE HEALTH CARE

◆ Having health insurance is essential to accessing health care, including basic primary care during adolescence, reproductive health services and access to many effective forms of contraception. Nationally teens ages 12 to 17 are more likely to be uninsured than children younger than age 12. Young people ages 18-24 are the age group most likely to lack health insurance. National statistics indicate that 31% of people in the young adult age category are uninsured.[88] In Rhode Island, RIte Care provides health insurance coverage for income-eligible children and youth up to age 19.

◆ Even when they have insurance, teens and young adults visit doctors less frequently than other age groups.[89] Fewer visits by teens to primary care providers means there are fewer opportunities to provide individual education and counseling about core components of adolescent preventive health care. Access to basic health care services is important to delaying pregnancy and to ensuring that young men and women receive the health care they need to have a healthy pregnancy in the future. Despite national recommendations from the American Medical Association to incorporate routine preventive counseling into adolescent health care visits, data from general medical exam visits across the United States show that family planning and contraception was discussed at only 8% of visits.[90]

◆ The legal ability of minors ages 12 to 18 to consent to a range of health care services – including reproductive health care – has expanded significantly over the past 30 years. As of October 2006, 25 states and the District of Columbia allow all minors over age 12 to consent to contraceptive services. Another 21 states allow a specific category of minors to consent to contraceptive services. Rhode Island law is silent on this matter which can be problematic for physicians.[91]

SCHOOL-BASED AND SCHOOL-LINKED SERVICES

◆ Community or school-based health clinics that have a strong focus on reproductive health, provide the opportunity for one-on-one counseling, promote clear messages about abstinence and contraception, and supply or prescribe contraceptives can reduce teen pregnancy rates.[92] A sexually active teenager who does not use contraception has a 90% chance of becoming pregnant within one year.[93]

◆ National studies have shown that the provision of condoms or other contraceptives through school-based health clinics does not increase sexual activity.[94] However, national surveys reveal that 76% of school-based health centers are prohibited from providing contraceptive services on-site – mostly by school or district policy.[95] A recent study in Denver, found that school-based health centers that identify, intervene and follow-up with students engaged in risky sexual behaviors led to a rapid and significant decline in teen pregnancy compared to communities without school-based health centers.[96]

◆ There are 7 school-based health centers serving middle and high school students in Rhode Island by providing a broad range of health care services, including screening for sexually transmitted diseases. Only one provides contraceptive services with parental permission.[97]

WHAT WORKS TO IMPROVE OUTCOMES FOR CHILDREN OF TEEN PARENTS

NURSE-FAMILY PARTNERSHIP

◆ Intensive, long-term nurse home visiting programs for pregnant and parenting teen mothers can improve pregnancy outcomes, child health and development, and family economic self-sufficiency. The Nurse-Family Partnership, a national model implemented in 21 states, provides regular home visits to mothers beginning in the 16th week of pregnancy and continuing through the first two years of the child's life. It has been shown to improve prenatal health, reduce the incidence of child abuse and neglect, reduce subsequent pregnancies, increase intervals between births, increase maternal employment, and improve school readiness. The program also produces long-term benefits to children including fewer behavior problems and less delinquency in adolescence.[98] Two independent studies have found that when the program is implemented with higher-risk families it provides a significant return on investment – saving government money in the long run.[99,100]

EARLY HEAD START

◆ Participating in an Early Head Start program can promote healthy prenatal and birth outcomes, support early care and education of infants and toddlers, and foster healthy family relationships. Early Head Start is designed to provide high-quality child and family development services to very low-income pregnant women and families with infants and toddlers either through home visiting or a center-based program. Administered by the U.S. Department of Health and Human Services, Administration on Children, Youth, and Families (ACYF), Early Head Start produces significant cognitive and language development gains in participating children and more positive interaction with their parents. Early Head Start mothers have fewer subsequent births within two years of enrollment and are more likely to participate in education and job-training activities.[101] In Rhode Island there are 5 Early Head Start programs serving 5 percent of all eligible infants and toddlers.[102]

VERY HIGH-QUALITY EARLY CARE AND EDUCATION

◆ Very high-quality early care and education programs can produce remarkable long-term effects on children. Research on the Perry Preschool Project, the Abecedarian Project and the Chicago Child-Parent Centers – all model programs developed to help young children at risk for school failure – has shown a strong return on investment with children experiencing fewer special education placements, better academic performance, higher high school graduation rates, fewer arrests, and more employment.[103] Each of these programs had similar characteristics. They began several years prior to school entry, provided intensive services for more than one year, had small class sizes and low numbers of children per teacher, and were staffed by highly educated teachers that were compensated fairly.[104]

Effective family-focused interventions share several common design features:

◆ Programs start early in life and are intensive and long-lasting (e.g. weekly home visits for two to three years).

◆ Services are community-based and are individualized to meet specific family needs and goals.

◆ Staff are highly trained, very knowledgeable about specific content areas and have strong relationship skills.

Source: Shonkoff, J.P. & Phillips, D.A. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, DC: National Academy Press.

YOUTH DEVELOPMENT PROGRAMS AND TEEN PREGNANCY PREVENTION

Youth development programs aim to improve educational and economic opportunities, while at the same time reducing risk behaviors, and are based on a firm belief in the value and potential of each and every young person. Youth development programs that are most effective at preventing teen pregnancy incorporate the following elements:

- Provide individualized care to underserved teens to ensure delivery of 3 vital components – youth development, comprehensive sexuality education, and access to contraceptive services.
- Tailor the dosage, intensity and length of service to match youth's reality, experience, needs and assets. Teens at high risk of pregnancy need individualized, intensive services. Because comprehensive, intensive programs are expensive, they should be targeted to those most in need.
- Provide specific, accurate information to help teens prevent pregnancy, especially those teens that are already parents.
- Begin interventions before puberty. At a minimum, prevention programs should begin before sexual initiation. Programs need to begin early in communities with high rates of teen pregnancy.
- Target the children and siblings of teen parents for special services.
- Address barriers to participation and use incentives to encourage consistent participation in the program.
- Tailor programs to meet the cultural, racial/ethnic and language backgrounds of participants.
- Are prepared for difficult issues, such as child sexual abuse, to surface.

Adapted From: Brindis, C. & Davis, L. (1998). *Linking pregnancy prevention to youth development.* Washington, DC: Advocates for Youth.

AFTER SCHOOL PROGRAMS

Research suggests that after school programs for teens can be an effective tool to prevent teen pregnancy. In particular, studies have shown that:

- Teens with extensive unsupervised time are more likely to engage in risky sexual behavior.
- Adult supervision is strongly linked to reduced sexual risk behaviors among teens.
- After school program may reduce teen sexual risk behaviors by involving teens in structured, constructive, engaging activities.
- Programs that enable teens to envision realistic future opportunities for themselves and establish education and career aspirations provide incentives for teens to delay sexual activity, pregnancies and births.

Source: Manlove, J., Franzetta, K. McKinney, K., Papillo, A.R., & Terry-Humen, E. (2004). *A good time: After school programs to reduce teen pregnancy.* Washington,DC: National Campaign to Prevent Teen Pregnancy.

SELECTED STATE STRATEGIES TO PREVENT TEEN PREGNANCY

RITE CARE/RITE SHARE

◆ RIte Care/RIte Share is Rhode Island's Medicaid managed health insurance program for low-income children and families. Children are eligible until they turn 19. As of December 2005, 79,964 children under age 19 were enrolled in RIte Care.[105] Recent three year averages from the U.S. Census Bureau show that only 6.6% of Rhode Island's children under age 18 are uninsured, compared to 11.1% of children nationally.[106]

◆ RIte Care/RIte Share is an important tool to reach teenagers in lower income families. In 2006, all three RIte Care plans in Rhode Island scored above the 90th percentile compared to other Medicaid plans in the United States for the number of annual adolescent preventive health care visits per enrolled teen.[107]

FAMILY PLANNING CLINICS

◆ Title X of the federal Public Health Service Act provides funding for a national network of family planning clinics for low-income patients. They are a particularly important means of providing confidential care to adolescents. Funded services include contraceptive counseling, birth control, reproductive health services, and diagnosis and treatment of sexually transmitted diseases. Nationally and locally, Title X clinics are facing increasing financial pressures as the cost of contraceptives and diagnostic tests increases and Medicaid reimbursements do not keep pace with costs.[108]There are nine Title X funded health care organizations in Rhode Island, which operate a total of 20 clinical sites. In 2005, these sites served 21,892 individuals, including 5,105 teens under age 20.[109]

◆ A recent national report ranked Rhode Island 45th among the 50 states for the availability of subsidized contraceptive services and supplies for low-income women and 47th for state funding to deliver contraceptive services and supplies.[110] In 2001 in Rhode Island, state and federal spending totaled $39.41 for contraceptive services per woman in need compared to $74.98 per woman in need for the United States as a whole.[111]

COMPREHENSIVE HEALTH EDUCATION IN PUBLIC SCHOOLS

◆ HIV/AIDS, human sexuality, and family life education are required by state law to be taught in public schools as part of comprehensive school health education. The Rhode Island Department of Education has developed standards for sexuality/family life education which include teaching abstinence as the preferred method of pregnancy prevention but also include providing specific information about contraception methods. Parents may exempt their children from participation in the program by providing written notice to the school principal.[112]

◆ The Rhode Island Department of Education, with its partner, the Rhode Island Department of Health, has launched a public web site (www.thriveri.org) and a 30-hour on-line professional development program (the Thrive e-Academy) for teachers to learn about comprehensive health education.[113]

TEEN PARENTS ENROLLED IN THE FAMILY INDEPENDENCE PROGRAM

◆ **Adolescent Self-Sufficiency Collaboratives** (ASSC) are administered by the Rhode Island Department of Human Services as part of the state's efforts to support the Family Independence Program (FIP). Federal rules related to the Temporary Assistance for Needy Families (TANF) welfare program require that states ensure minor parents under age 18 live in an approved supervised arrangement (either at home with their parents or other adult guardian or in another approved alternative setting) and participate in education leading to a high school diploma or GED in order to receive cash assistance. The Adolescent Self-Sufficiency Collaboratives work with teens enrolled in the Family Independence Program so that they meet these requirements for cash assistance but services are also available to all young parents. In 2005, more than two-thirds (69%) of ASSC clients were also enrolled in FIP.[114]

Adolescent Self-Sufficiency Collaboratives provide case management to ensure teen parents enroll and maintain attendance in school, GED classes and/or employment. They also provide opportunities for pregnant and parenting teens to explore careers and provide information about establishing paternity and child support. The Department of Human Services contracts with 5 community agencies who act as ASSC collaborative lead agencies. In 2005, a total of 1,145 teen mothers were enrolled in an ASSC. Annual funding for ASSC averaged $711 per teen enrolled.[115]

◆ **New Opportunity Homes** are adult-supervised residences for pregnant and parenting minor teens and their children. They were created specifically for youth who could not live with their parents due to issues of abuse, neglect or over-crowding. Homes are voluntary and require that girls follow the rules. In Rhode Island, there are 5 residences with a total capacity of 16 mother-infant pairs. The level of supervision varies from level one (24 hour supervision) to level two (16 hour supervision) to level three (8 hour supervision). Homes are in Cranston, Providence, Pawtucket, Newport, and Johnston. New Opportunity Homes coordinate care and case management with Adolescent Self-Sufficiency Collaboratives. Length of stay has varied from one day to 2 1/2 years. In 2005, twenty-five young mothers were served in New Opportunity Homes. Annual funding for New Opportunity Homes averaged $24,798 per teen.[116]

TEEN PARENTS AND TANF

◆ About 5% of the caseload of the Family Independence Program are teen parents, in line with national data.[117] Federal TANF rules have requirements that teens be pursuing a high school diploma or GED and have adult supervision, but states play a significant role in designing specific incentives and supportive services. National research has found that few states allocate the resources necessary to offer a full range of specialized services for teen parents, and most states have not devised administrative and organizational policies needed to foster effective programs. Few programs address the needs of teens as well as their children.[118]

◆ Effective programs for teen parents are two-generational. Programs that work with high-risk families are rarely simple, inexpensive or easy to implement. The most effective programs allocate sufficient resources per client to provide intensive, comprehensive services over time and monitor outcomes for the teen parent as well as their child.[119]

RECOMMENDATIONS TO PREVENT TEEN PREGNANCY

The implementation of these recommendations will require state government leadership and collaboration across state agencies. Rhode Island teens would benefit from a comprehensive state strategy to reduce the teen pregnancy rate and provide intensive supportive services to teen parents and their children. Teen pregnancy is an issue that cuts across the areas of education, health, mental health, human services, child welfare and economic development.

IMPROVE ACCESS TO HEALTH CARE SERVICES FOR TEENS

◆ Ensure that all eligible teens are enrolled in RIte Care/RIte Share and receive the recommended annual primary care visit to address preventive health needs and anticipatory guidance.

◆ Provide more opportunities for primary care providers in Rhode Island to learn about current best practices in reproductive health care for teens and to encourage providers to incorporate reproductive health care counseling into every routine health care visit.

◆ Build on the success of RIte Care's Performance Goal Program by awarding financial incentives to RIte Care participating health plans that meet annual targets set for adolescent preventive health care visits and reductions in repeat births to teens.

◆ Advocate at the state and federal level to increase funding for the Title X Family Planning Program, an important source of confidential reproductive health care for adolescents.

◆ Use school-based health centers and school-linked services in communities with high teen pregnancy rates (Central Falls, Pawtucket, Providence, and Woonsocket) to provide more comprehensive reproductive health care services to students including contraceptive supplies and prescriptions.

PROVIDE MORE COMPREHENSIVE SEX EDUCATION FOR TEENS

◆ Gather data systematically to ensure public school teachers responsible for teaching sex education are well-trained and are delivering clear, accurate messages about contraception as well as sexual abstinence. Incorporate opportunities for students to practice communication and refusal skills into health education classes.

◆ Develop a public education strategy to inform women and men in Rhode Island (especially teens and young adults) about the availability of emergency contraception.

◆ Ensure all teens in foster care have access to youth development programs that includes access to comprehensive sex education and reproductive health care. Provide specific training and support to foster parents and DCYF staff so that they recognize that teens in their care are at increased risk for teen pregnancy and that they have the information and skills they need to provide information and support throughout adolescence.

EXPAND EDUCATION AND ECONOMIC OPPORTUNITY FOR VULNERABLE TEENS

◆ Improve public education systems to ensure more youth remain engaged in learning, stay in school, are connected to a caring adult, and do not fall behind academically.

◆ Provide real economic opportunity for adolescents, including school-to career options and realistic affordable post-secondary educational opportunities that give young people a vision for their future.

◆ Teen pregnancy needs to be understood within the context of youth development. Adopt a common conceptual framework for youth development and risk prevention that outlines essential cross system activities leading to positive youth outcomes.

RECOMMENDATIONS TO IMPROVE OUTCOMES FOR TEEN PARENTS AND THEIR BABIES

INVEST IN COMPREHENSIVE, INTENSIVE PARENT-CHILD PROGRAMS

◆ Identify resources to implement the Nurse-Family Partnership — a national model proven to improve birth outcomes, child well-being, and family economic self-sufficiency — in Rhode Island targeting pregnant mothers under age 20.

◆ Expand Early Head Start services in Rhode Island to serve more eligible pregnant mothers, infants and toddlers.

◆ Ensure children of teen parents have access to the highest quality early care and education available to help children develop to their potential. Support the development and delivery of high-quality early childhood education programs that improve long-term outcomes for children. Services delivered during early childhood can reduce pregnancy and childbearing rates in adolescence.

◆ Ensure that consistent evidence-based practices and accountability mechanisms are built into the Adolescent Self-Sufficiency Collaboratives in order to ensure attainment of the Family Independence Program's goals while closely monitoring the health, housing and parenting skills of teen parents.

PROVIDE COMPREHENSIVE HEALTH CARE AND TRANSITION SERVICES TO TEENS LEAVING STATE CARE

◆ Extend RIte Care health insurance coverage to youth between the ages of 19 and 21 who are exiting foster care. This is a Medicaid option under the federal Foster Care Independence Act.

◆ Ensure every teen in foster care transitions from state care with a permanent connection to a family, safe and affordable housing, a plan for employment and education, and access to health care.

ENSURE THAT PREGNANT AND PARENTING TEENS HAVE THE SUPPORT THEY NEED TO GRADUATE FROM HIGH SCHOOL

◆ Conduct an in-depth examination of school districts' efforts to educate pregnant and parenting teens and prevent drop outs – particularly in communities with high concentrations of parenting teens. Ensure districts have adequate plans and resources to provide high quality flexible education services, including home instruction, as needed during the pre- and post-natal periods. Schools that help connect teenage parents with high-quality child care can improve outcomes across two generations.

The Rhode Island Task Force on Premature Births has developed ten recommendations to improve the health of babies in Rhode Island by decreasing the morbidity and mortality associated with preterm births. Several of the Task Force Recommendations are especially relevant to the issue of teen pregnancy and parenting, including:

◆ Support a Medicaid family planning waiver for Rhode Island to offer family planning coverage based on income status for women who would otherwise be covered by Medicaid if they became pregnant. Seven of 22 states with family planning waivers also include income-eligible males.

◆ Expand and assure access to emergency contraception for low-income women. Ensure information on emergency contraception is provided and that there is immediate and advanced access for teens and adult women as a standard of care through RIte Care/RIte Share.

TEEN PREGNANCY AND PARENTING RESOURCES

NATIONAL RESOURCES

The National Campaign to Prevent Teen Pregnancy
www.teenpregnancy.org

The Healthy Teen Network
www.healthyteennetwork.org

Advocates for Youth
www.advocatesforyouth.org

Guttmacher Institute
www.guttmacher.org

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School-Based Health Centers
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401-222-5922

Title X Family Planning Clinics
RI Department of Health
Cheryl LeClair
401-222-4636

Adolescent Self-Sufficiency Collaboratives
RI Department of Human Services
Donalda Carlson
401-462-6833

Adolescent Obstetrics Clinic
Women & Infants' Hospital
401-274-1100

Adolescent Health Care Center/Teen Tot Program
Hasbro Children's Hospital
401-444-4691

Teen Clinic
Planned Parenthood of Rhode Island
401-421-9620

Early Head Start
RI Department of Human Services
Head Start-Child Care Collaboration Project
Larry Pucciarelli
401-462-3071

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ECONOMIC AND SOCIAL COSTS OF TEEN CHILDBEARING

◆ Teen parenthood is associated with increased infant mortality, low birthweight, prematurity, childhood illness, welfare dependence, educational problems, juvenile crime, and teen parenthood in future generations.[120,121] Each of these outcomes has a very real human cost. And each human cost is linked to increased costs to society including additional medical care, child protection and foster care, public assistance, and incarceration expenditures.[122]

◆ It is estimated that teen childbearing accounts for $9.1 billion in increased public sector costs annually across the United States.[123] Recent estimates indicate that current public costs of teenage childbearing in Rhode Island is $35 million per year due primarily to increased costs related to the poor outcomes for children of teen mothers.[124] The largest public sector cost associated with teen childbearing is lost revenue due to reduced earnings and lower taxes paid by the children of teen mothers over their own lifetimes.

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