COALITION FOR FAMILY HEALTH

Report on the Costs of Teen Pregnancy in Ohio

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By Emily Spencer, MSSA, LSW
With Foreword by Dianne Kerr, PhD, CHES

Foreword

As they say in politics, “As Ohio goes, so goes the nation.” Sadly, in this case, we have seen in Ohio, since 2005, an increase in teen pregnancy that has now occurred nationwide. According to the National Center for Health Statistics, the US experienced a 3% increase in the teen birth rate between 2005 and 2006, the first increase since 1991. Most of these pregnancies were unintentional. This, combined with a newly released study by CDC researchers disclosing 1 in 4 adolescent girls (aged 14-19) has a sexually transmitted disease (HPV, chlamydia, trichomoniasis, or herpes) is truly heartbreaking, particularly when one recognizes that HPV may cause cervical cancer and chlamydia infertility.

Many believe these increases in teen births and STDs are due to federal policies that have placed ideology over science in the form of abstinence-only education. Our government has spent a billion dollars on these failed curricula that have teachers telling students “condoms don’t work” or at the least exaggerating their failure rates while at the same time giving the edict “don’t have sex until you are married.” The average age of marriage (now over 25 years of age for young women and 27 years of age for young men) makes the “don’t have sex before marriage” rule particularly difficult to follow and makes no allowance for gays and lesbians who cannot legally marry. It is no wonder that many students who undergo abstinence only education, fail to use condoms when their vows of abstinence do break, or when they inevitably do have sexual contact. They must feel the situation is quite hopeless when they are led to believe if they don’t “say no” they may as well not use an “ineffective” condom and their odds are great of contracting an STD/STI which is likely incurable and perhaps fatal.

In this white paper, Spencer examines the teen pregnancy statistics, their impact, and costs to our state and makes recommendations on how to reduce them with a variety of strategies

based on primary prevention efforts. These recommendations include family communication and improved community resources for parents and comprehensive sexuality education in the schools. Comprehensive sexuality education (also known as abstinence-plus education) has been proven to delay the initiation of sex and to increase condom use among students when they do become sexually active. In addition, Spencer asks us to take a different look at how we view adolescence and adulthood in our culture. For example, having a baby is not so much a sign of being an adult as having a job and supporting oneself. Perhaps a change in social norms is needed to instill that value among our teens.

Like other health care costs, the costs for teen pregnancy could best be reduced with primary prevention strategies. It is time we reduce teen pregnancy with real sexuality education (comprehensive sexuality education) and contraception access in Ohio. Spencer's recommendations are sound and will not only save Ohio money, but will also reduce the high emotional and social costs of premature parenthood among our teens.

Dianne L. Kerr, PhD, CHES
Associate Professor, Health Education and Promotion
Kent State University

Executive Summary

This report investigates the nature of teenage pregnancy and its impact on the state of Ohio. Ohio's teenage pregnancy rate of 65.1 per 1,000 teens is the 28th highest in the country.[1] Like the rest of the nation, Ohio experienced a major decline in teen pregnancy since 1991; however, it now appears that the rate has not only leveled off, but is beginning to increase. This is cause for concern. An overwhelming amount of federal, state, and local funds are spent dealing with the consequences of teen pregnancy. With rates on the rise, more money will be spent on the costs of early childrearing rather than addressing the root causes of teenage pregnancy, unless major changes are made.

Despite the recent focus on abstinence-only education in the US, the majority of Ohio teens are having sex before they leave high school. The 2005 Ohio Youth Risk Behavior Survey found that almost two-thirds of students in Ohio have had sex by the twelfth grade, with higher rates in more urban areas such as Cleveland. Many teens are not protecting themselves; for example, 40% reported not using condoms during their last sexual intercourse.[2] These teens have a higher risk of contracting a sexually transmitted infection (STI), and females have a 90% chance of becoming pregnant within a year if they do not use contraception.[3]

There are many individual consequences for teenage mothers, fathers, and their children, including low education attainment, higher rates of poverty, and poorer health. Yet, teenage pregnancy also has far-reaching consequences for the larger community, and is detrimental to Ohio as a whole economically, socially, and politically. It is a contributing factor to an increase in many concerning state trends, such as:

- Poverty
- Health and Medicaid costs
- Premature birth
- Infant mortality
- Increased school drop-out rates and lower levels of education
- Homelessness
- Domestic violence
- Increased foster care enrollment and expenditure
- Insufficient child support
- Abortion rates

Cumulatively, Ohio spends a considerable amount of money annually addressing these areas, yet not nearly as much is spent on prevention.

Because reducing Ohio's teenage pregnancy rate would have major positive impacts on many areas of expenditure and be beneficial to many Ohioans' quality of life, it makes sense for Ohio to put more effort and funding towards preventing unwanted and teenage pregnancy rather than pay for its consequences later.

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[1] Guttmacher Institute. Fact Sheet: *Contraception Counts: Ohio*, March 2006
[2] ODH (2005). Ohio YRBS
[3] Harlap S, Kost K and Forrest JD, *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States*, New York: AGI, 1991.

This report examines the ways in which our communities are impacted by pregnancies and births to women under the age of twenty. A review of current data and literature determines the cost to Ohio-- economically, socially, and politically--from teen births. It examines the benefits of increasing money spent on prevention of unintended pregnancy in Ohio. It also examines the cost of supporting teen-parent families.

Prevention necessitates a multi-faceted plan. This report concludes that both cultural and policy changes are crucial, including:

- Open and honest communication about sexuality within the family
- Comprehensive sexuality education in schools
- Increased access to birth control
- Evaluation of teen pregnancy prevention programs
- Changed cultural expectations of adolescence and adulthood

Introduction

U.S. Teenage Pregnancy Trends

Teenage pregnancy has been a major issue in the U.S. for decades. Births to teenage mothers steadily declined from the mid-1950s until 1987, when the rate dramatically increased. In 1991, teen birth rates hit their twenty-year peak, and declined for fourteen years.[4] According to recent research, the vast majority (86%) of the decline is due to increased contraceptive use among teenagers while roughly 14% of the decline is due to increased abstinence.[5] Not only did this decline begin to plateau, much like declines in teen sex rates; the national teen birth rate rose 3% in 2006. [6,7]

Compared to other developed nations, the United States falls far behind in preventing teen pregnancies. The United States has markedly higher teen birth and abortion rates than Canada, France, Great Britain, and Sweden even though teen sex rates are comparable.[8] Youths in the U.S. have less access to contraceptive and abortion services as well as less cultural motivation to delay parenthood than those in other countries.[9] In short, the U.S. has fallen sorely behind other countries in its ability to protect teens and meet their sexual health needs.

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[4] The National Campaign to Prevent Teen Pregnancy (2006). Teen birth rates in the United States, 1940-2005. Retrieved October 11, 2007 from www.teenpregnancy.org.
[5] Santelli, John S., et al. (2007). "Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use." *American Journal of Public Health*, 97(1), 150–6.
[6] Stein, R. (July 22, 2007). Teen Sex Rates Stop Falling, Data Show. *Washington Post.*
[7] CDC (2007) Births: Preliminary Data for 2006. *National Vital* Statistics *Reports*, 56 (7).
[8] Darroch, J., Susheela, S., & Frost, J. (2001). Differences in teenage pregnancy rates among five developed countries: the roles of sexual activity and contraceptive use. *Family Planning Perspectives*, 33(6).
[9] Ibid.

Ohio Teenage Pregnancy Trends

Teenage pregnancy has been a major issue for Ohio over the last two decades. Between 1990 and 2000, the teen pregnancy rate in Ohio declined 20%[10], yet that decline began to plateau and rates began rising again in 2005.[11] Ohio is currently ranked 28th in the nation in teen pregnancy[12], with a pregnancy rate of 65.1 per 1,000 teen girls ages 15-19 in 2005. Teenage pregnancies in Ohio resulted in 15,713 live births and 6,057 abortions to parents under twenty years of age in 2005.[13] In 2000, the national pregnancy rate for young women aged 15-19 was 84 pregnancies per 1,000 females, while Ohio's rate was slightly better, at 74.[14] Although Ohio has a better rate than the United States as a whole, the United States has the highest rate of teen pregnancy among developed nations.[15] Thus, much work remains to be done to reduce teen pregnancy rates in Ohio and the US.

In Ohio, many teen births are disproportionately clustered together in different communities in the state. A study performed by the Child Defense League in 1994 found that over half of the births to teens in Ohio took place in only 48 of more than a thousand communities in the state.[16] Accounting for the decline in teen pregnancy that has taken place since this study was completed, many of these communities continue to have elevated birth rates in comparison with the rest of the state. In 2005, Ohio made national news with the number of pregnant teens at Timken High School in Canton. During the 2004-05 school year, more than 13% of the female students at this school were pregnant (65 pregnant students out of 490 female students).[17] Yet, the students of Timken High were not an anomaly for Canton; since 2005 teen births accounted for more than a fifth of the births in the city.[18] On average, Canton has teen birth rates that are comparable to many of the urban cities in Ohio. The greatest number of teen births occurs in urban areas, such as Cleveland, Columbus, and Cincinnati.[19] The highest teen birth rates are primarily in southern Ohio counties, such as Fayette, Highland, Vinton, and Pike, all of which had teenage birth rates over 60 births per 1,000 15-19 year old women in 2006.[20]

Teen Sexual Behaviors

The vast majority of teens in Ohio are having sex before they reach adulthood. According to the 2005 Ohio Youth Risk Behavior Survey, just under half of all Ohio high school students have had sex, and by the twelfth grade, this increases to nearly two-thirds of students.[21] In more urban areas, such as Cuyahoga County, more than 70% of all students, and 77.9% of twelfth graders,

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[10] Guttmacher Institute. Fact Sheet: *Contraception Counts: Ohio,* March 2006.
[11] Ohio Department of Health, Center for Vital and Health Statistics
[12] Guttmacher Institute. Fact Sheet: *Contraception Counts: Ohio,* March 2006.
[13] Ohio Department of Health, Center for Vital and Health Statistics
[14] Guttmacher Institute (2006). In Brief: *Contraception Counts: Ranking State Efforts*
[15] Darroch, J. (2001) Teenage Sexual and Reproductive Behavior in Developed Countries Can More Progress Be Made? *Occassional Report no. 3*
[16] Children's Defense Fund (1994). *A higher price to pay: teenage pregnancy in Ohio, 1994.*
[17] O'Brien, S. (August 26, 2005). American Morning Transcript. Cable News Network
[18] City of Canton (2006) City of Canton Annual Report 2005 accessed September 2007 from www.cantonhealth .org
[19] Child Trends (2006). Facts at a glance. *The William and Flora Hewlett Foundation.*
[20] Ohio Department of Health, Center for Vital and Health Statistics
[21] ODH (2005). Ohio YRBS

have had intercourse at least once.[22] Among Ohio high school students, only 61.7% used condoms the last time they had sex, and only a fifth had used oral contraceptives.[23] Contraception use was much lower in the Cleveland area, with only 59.7% reporting condom use and less than 5% utilizing birth control pills.[24] This is particularly troubling since a teen that is sexually active and not using contraceptives has a 90% chance of becoming pregnant within a year.[25] Nearly a quarter (22.7%) of Ohio high school students used drugs or alcohol before the last time they had sex. [26] Therefore, many of these students are making decisions under the influence of drugs or alcohol, putting themselves at risk for pregnancy and sexually transmitted infections. By the twelfth grade, 21.9% of Cleveland students had either been pregnant or impregnated someone.[27] This indicates that current policies are not effective in reducing either sexual activity or teen pregnancy.

Sexuality Education in Ohio

In 2007, Ohio made a strong show of support for comprehensive sexuality education by becoming the 8th state to reject federal funding for abstinence-only education. However, there is still much room for further advances. State money that was earmarked to match those funds will now be used to support abstinence and adoption education programs. Although these programs will be more comprehensive than stringently-defined abstinence-only-until-marriage programs, it remains to be seen whether effective and evaluated comprehensive programming will be implemented. Recent studies have found no evidence that abstinence-only programs delay sexual intercourse, reduce the number of sexual partners, or initiate a return to abstinence. On the other hand, comprehensive sexuality education programs that support both abstinence and the use of condoms tend to be effective in eliciting positive behavioral changes in teens.[28]

In 2006, Ohio received $7,882,616 in federal funds for abstinence-only-until-marriage programs.[29] Basic rules and regulations of programs receiving these funds are outlined in Section 510(b) of Title V of the Social Security Reform Act (P.L. 104-193). In order to receive Title V funds, a program must meet what is commonly referred to as the A-H criteria which state that the program must:

A. Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
B. Teach abstinence from sexual activity outside marriage as the expected standard for all school age children;

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[22] Center for Adolescent Health, Case Western Reserve University (2004). *Cleveland Municipal School District Risk Behavior Survey.*
[23] ODH (2005). Ohio YRBS
[24] Center for Adolescent Health, Case Western Reserve University (2004). *Cleveland Municipal School District Risk Behavior Survey.*
[25] Harlap S, Kost K and Forrest JD, *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States*, New York: AGI, 1991.
[26] ODH (2005). Ohio YRBS
[27] Center for Adolescent Health, Case Western Reserve University (2004). *Cleveland Municipal School District Risk Behavior Survey.*
[28] Kirby, D. (November 2007) Emerging answers 2007. *The National Campaign to Prevent Teen and Unplanned Pregnancy.*
[29] SIECUS (2007) State Profile: Ohio. Received October 2007 from www.siecus.org.

C. Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
D. Teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;
E. Teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
F. Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;
G. Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and
H. Teach the importance of attaining self-sufficiency before engaging in sexual activity.[30]

Recent research has found such programming to be ineffective in preventing teenage pregnancy. These programs based on abstinence have left many Ohio teenagers without thorough knowledge of pregnancy prevention. In addition, there is not empirical evidence to support Letter E (harmful psychological and physical effects of sexuality outside of marriage.)

Individual Effects of Teen Pregnancy

In 2005, the teen birth rate in the United States was 40.4 births per 1,000 15-to 19-year old women, which accounted for 414,406 births to teens in 2005 alone.[31] The challenges of teen births are numerous:

- 50% of adolescents who have a baby become pregnant again within two years of the baby's birth.
- Fewer than half of teenage mothers complete high school, making it less likely for teen mothers to have the skills necessary to qualify for a well-paying job.
- Almost 50% of all teen mothers and more than 75% of unmarried teen mothers begin receiving welfare within five years of the birth of their first child.
- Nearly 80% of fathers of children born to teen mothers do not marry the mothers.
- On average, teen fathers pay less than $800 a year in child support.
- Children born to teen mothers are more likely to have low birth weight and related problems such as infant death, blindness, and mental retardation.
- Children of teen parents often receive inadequate parenting, are subject to abuse and neglect, and often have insufficient health care.
- Children of teen parents are 50% more likely to repeat a grade, perform poorly on standardized tests, and ultimately less likely to complete high school.[32]

There is no question that giving birth as a teen leaves both the parent and child vulnerable to many risks that can have major effects on their lives. Yet parents and children are not the only

[30] Title V, Section 510 (b)(2)(A-H) of the Social Security Act (P.L. 104-193).
[31] Hamilton, B.E., Martin, J.A., & Ventura, S.J. (2006). *Preliminary Data for 2005.* Health E-Stats. Released November 21, 2006.
[32] CFOC (2000). Educator Resource Center: The effects of teen pregnancy. Received October 11, 2007 from www.cfoc.org.

people that are affected by teen pregnancy – young pregnancy unnecessarily burdens our community's larger systems, such as healthcare, public assistance, workforce and education.

Problems

Poverty

Poverty in Ohio is on the rise. In 2006, 13% of the population was living below the poverty line, including 22% of children under the age of six, which is slightly higher than the national average. More than a third of Ohio's children live in families where no parent has full-time, year round work.[33] In 2007, both Cincinnati and Cleveland ranked in the top five poorest cities in the nation (third and fourth respectively), and six of Ohio's ten largest cities had a poverty rate over 25%.[34]

Teen parents, especially teen mothers, are more likely than the rest of the population to live in poverty. Nationally, two-thirds of families with a young, unmarried mother are poor.[35] There are also a disproportionate number of low-income teens that become pregnant before age 20. Low-income adolescents make up 38% of women between the ages of 15 and 19, yet they account for nearly three-fourths of the pregnancies to the group.[36] Research comparing teenage parents to teenagers of similar socioeconomic conditions found that those who have given birth have much more financial difficulty than those who have not.[37] Therefore, the poverty experienced by young parents is not simply a continuation of economic problems, but exacerbated by the struggles of parenthood. These parents tend to have lower educational attainment, which gives them less earning potential and lower employment rates. The majority of teen mothers' income comes from public assistance and extended family and child support.[38]

In 2004, Ohio spent $833,955,342 in Temporary Assistance to Needy Families (TANF), a block grant from the federal government.[39] This money is used for programs to aid those in need, including Ohio Works First (OWF) and Protection, Retention, and Contingency (PRC). However, these programs have work requirements and time limits, which can be difficult for teen parents to comply with, thus leaving some families without help. OWF's Learning, Earning, and Parenting Program (LEAP) was developed to encourage parents under the age of twenty to finish high school through a system of rewards and sanctions.[40] Even though this program has improved the school enrollment of young mothers, it costs more than $2,000 per mother in administrative costs and support services.[41] Special Supplemental Nutrition Program for

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[33] Kids Count (2006). *Profiles by State: Ohio*. Annie E. Casey Foundation (www.kidscount.org)
[34] The Plain Dealer (August 29, 2007). *Ohio cities facing poverty.*
[35] Sawhill, I.V., Analysis of the 1999 Current Population Survey.
[36] Kowaleski-Jones, L., ed. (2006). *Fragile Families and the Married Agenda.* Boston: Springer US.
[37] National Campaign to Prevent Teen Pregnancy. (1997). Whatever happened to childhood? The problem of teen pregnancy in the United States. Washington, DC: Author.
[38] Kowaleski-Jones, L., ed. (2006). *Fragile Families and the Married Agenda.* Boston: Springer US.
[39] CWLA (2007). Fact Sheet: Ohio's Children 2007.
[40] Ohio Department of Jobs and Family Services, Meigs County. Received Sept. 20, 2007 from http://www.meigsdjfs.net/Ohioworks.htm
[41] US Department of Education (2006). Intervention: Financial incentives for teen parents to stay in school. *What Works Clearinghouse.*

Women, Infants, and Children (WIC) and Help Me Grow are programs that help young parents feed and learn about their infants. Help Me Grow is funded through both state and federal funds and costs $68 million annually[42], while the federally funded WIC in Ohio had more than $220 million in expenditures.[43] Decreasing the number of pregnancies and births that occur in the teen years would lessen poverty rates and, consequently, expenditures on these programs would decrease.

Health and Medicaid

One of the detriments of young parenthood is that children of young mothers tend to have poorer health than those born to adults. Only 38% of adolescent mothers describe their children as being in "excellent" health, compared to 60% of older mothers. Although the children are in poorer health, the children of adolescent mothers see physicians less than half as often as do those of older mothers. About half of the medical costs to children of teen mothers are paid by public assistance.[44]

Due to the level of poverty in teen parents, many of these families utilize welfare programs, especially Medicaid. Nationally, pregnant women and children under six years of age are eligible for Medicaid up to 133% of the poverty line.[45] Therefore, a teen that is pregnant with her first child can have an income up to $13,579.30 and have Medicaid coverage.[46] In January 2008, Ohio raised its Medicaid threshold for pregnant women and children to 200% of poverty, thus even more young families will be eligible for coverage. Studies have found that 81% of women who have given birth out-of wedlock before their twentieth birthday have been on welfare before the age of thirty.[47] Since 88% of young births in Ohio (compared to 81% nationally) were to unmarried teens in 2003, there is a host of teen mothers that need assistance from the state.[48] Nationally, Medicaid covers nearly three-quarters of the total charges for births to teens, which, in general, are associated with many risks, such as premature births and infant mortality.[49]

Premature Birth to Teen Mothers

Premature birth is a major concern for pregnant teenagers. Teen mothers are much more likely to experience a preterm birth, defined as less than 37 weeks gestation, than are adults in their twenties and thirties. More than 14% of Ohio teen births between 2002 and 2004 were preterm, accounting for nearly 1,500 births. Of these, 309 were born before 32 weeks gestation, which leaves the infant extremely vulnerable.[50] The youngest teens, those conceiving before their

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[42] Voices for Children, Greater Cleveland (2005). "Ohio's Help Me Grow Program – An Investment that Works".
[43] US Department of Agriculture (2007). *Ohio WIC*: 2006 Annual Report
[44] Kowaleski-Jones, L., ed. (2006). *Fragile Families and the Married Agenda.* Boston: Springer US.
[45] Center for Medicare and Medicaid Services (2005) Medicaid at a Glance. *Department of Health and Human Services.*
[46] U.S. Department of Health & Human Services (2007). The HHS 2007 Poverty Guidelines. Received September 28, 2007 from http://aspe.hhs.gov/
[47] Paul Offner (2005). Welfare Reform and Teenage Girls. *Social Sciences Quarterly*, 26 (2), 306-322.
[48] The National Campaign to Prevent Teen Pregnancy (2007). Demographic Data: Ohio received August 2007 from www.teenpregnancy.org.
[49] HCUP (2007). Statistical Brief # 14: *Childbirth-Related Hospitalizations among Adolescent Girls, 2004.*
[50] CDC (2007). Preterm birth: US/State, 1996-2004 received September 2007 from www.cdc.gov.

sixteenth birthday, are twice as likely as adults to have preterm births.[51] Teens are also increasingly vulnerable to preterm labor during a second birth.[52] Teen susceptibility to preterm labor is associated with factors such as having a growing body with immature reproductive organs, vulnerability to sexually transmitted infections and infections of the reproductive tract, pregnancy related hypertension, low gestational weight, poor prenatal care, and stress.[53]

Premature birth has many economic, social, and medical consequences. Children that are born premature have increased rates of health problems such as cerebral palsy, recurrent infections, blindness, poor growth, and behavioral and cognitive deficits.[54] Since they have not had the time to develop in the womb, most premature infants spend time in Neonatal Intensive Care Units (NICUs), those with the shortest gestation needing the most aid. Research by William Gilbert and colleagues found that a child born at 36 weeks averaged $2,600 in neonatal care and is less likely to suffer from health problems and cognitive and behavioral deficits than a child born at 32 weeks, which averaged $18,900 in neonatal costs.[55] Ohio's two-year rate of 309 births at less than 32 weeks to teen mothers alone incurs substantial costs to be paid for NICU services.

Children born prematurely constitute one of Medicaid's highest cost populations.[56] Medicaid is responsible for covering most of the expenses related to preterm births to teenage mothers. Nationally, Medicaid was billed for nearly three-fourths of the total costs of teen births in 2004.[57] Private insurance is generally not sufficient to handle the chronic and diverse needs of these children, due to gaps in policy coverage.[58] In order to provide comprehensive health services that are unavailable in the family's community, some families have needed to relinquish custody of their child. This assures the child is eligible for Medicaid and receives necessary treatments, which some child welfare agencies will not help provide unless the state or county has custody of the child.[59]

Infant Mortality

The United States has a high infant mortality rate in comparison to the rest of the developed world. In 2007, the U.S. was ranked 42nd in the world, with a rate of 6.37 infant deaths per 1,000

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[51] Stevens-Simon, C. (2002). Does incomplete growth and development predispose teenagers to preterm deliver? A template for research. *Journal of Perinatology, 22,* 515-323.
[52] Smith GCS and Pell JP (2001), Teenage pregnancy and risk of adverse perinatal outcomes associated with first and second births: population based retrospective cohort study, *BMJ,* 323(7311):476–479.
[53] Stevens-Simon, C. (2002). Does incomplete growth and development predispose teenagers to preterm deliver? A template for research. *Journal of Perinatology, 22,* 515-323.
[54] Crowley, J. (2006). Profiles of Medicaid's Highest Cost Populations. *The Kaiser Commission on Medicaid and the Uninsured,* 12-14.
[55] Gilbert, W. (2003). The cost of prematurity: quantification by gestational age and birth weight. *Obstetrics & Gynecology* 102 (3), 488-492.
[56] Crowley, J. (2006). Profiles of Medicaid's Highest Cost Populations. *The Kaiser Commission on Medicaid and the Uninsured,* 12-14
[57] HCUP (2007). Statistical Brief # 14: *Childbirth-Related Hospitalizations among Adolescent Girls, 2004.*
[58] Crowley, J. (2006). Profiles of Medicaid's Highest Cost Populations. *The Kaiser Commission on Medicaid and the Uninsured,* 12-14
59 National Council on Disability (September 2002). Castaway Children: Must Parents Relinquish Custody in Order to Secure Mental Health Services for Their Children.

live births.[60] Ohio's infant mortality rate in 2005 was 8.3 deaths per 1,000 live births; that year there were 1,225 infant deaths in Ohio[61], ranking it 38th in infant mortality in the nation.[62]

Nationally, the highest infant mortality rates are to teen mothers. Of the youngest mothers, those under fifteen years of age, 17.6 out of 1,000 infants died in the first year (2002 statistics). Of all mothers under twenty years old, the rate was 10.4, still significantly higher than the national average.[63] Increased infant mortality is associated not only with youth, but also with not finishing high school, being unmarried, and preterm birth, all of which are issues that teen parents are more inclined to face than older parents.[64]

The risks and causes of high infant mortality are not just individually based; they are reflections of the community as a whole. Infant mortality is a social indicator that measures more than the number of infants that die before their first birthday, but also illustrates many of the serious social, economic, and environmental problems of a neighborhood, state, or nation. High infant mortality rates are associated with discrimination, high fertility, overcrowding, ignorance, low educational level (especially in females), lack of sanitation, exposure to toxic substances, low family income, and a lack of resources in communities.[65]

Education

Lack of educational attainment is a major issue for teen parents. The leading reason that adolescent girls drop out of school is parenthood. Fewer than half of all teen mothers ever graduate from high school, and less than two percent of teen mothers graduate from college by the age of 30.[66] Of those who stay in school, many will have to repeat a grade. In 2004, it cost $184 million nationally to hold students back a grade, which translated into roughly $9,000 a student.[67] Therefore, teen parents that must repeat a grade cause both social and monetary harm to Ohio's resources. Teen fathers also complete less schooling than those who wait until adulthood to become a parent. Advanced education is becoming more and more necessary to obtain a job that pays a living wage, which means that many teen parents face a lifetime of un- or underemployment. Adolescent fathers are over-represented in blue-collar work and tend to make about a quarter less than those who postpone fatherhood. [68]

Lack of education is a contributing factor to poverty and poor health outcomes. Parents with low educational attainment have higher rates of premature birth, infant mortality, homelessness, poverty, and are less likely to receive child support than those who have completed high school.

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60 CIA (2007). The World Factbook. Received September 2007 from www.cia.gov.
[61] Ohio Department of Health (2005). Information Warehouse. Received November 2007 from http://dwhouse.odh.ohio.gov/
[62] United Health Foundation (n.d.). America's Health Rankings. Received November 2007 from www.unitedhealthfoundation.org.
[63] CDC (2004). New CDC report confirms increase in 2002 infant mortality rate. *National Vital Statistics Reports*, 53 (10).
[64] Ibid.
[65] Foege Holmes, G., MD (nd). "Child & Family Health Infant Mortality" received September 28, 2007 from www.pitt.edu.
[66] The National Campaign to Prevent Teen Pregnancy. "Why it matters: Teen Pregnancy and Education".
[67] KnowledgeWorks Foundation (2007) Fast Facts. Received on October 8, 2007 from www.kwfdn.org
[68] Kowaleski-Jones, L., ed. (2006). *Fragile Families and the Married Agenda*. Boston: Springer US.

As stated previously, dropping out of high school has become commonplace for teen parents causing Ohio to implement the LEAP Program to provide incentives to teen parents to stay in school. According to Johannes Bos and Veronica Fellerath, LEAP increased school attendance by 14% but failed to increase graduation rates.[69] Since the leading cause of not finishing high school for teenage girls is motherhood, a reduction in teen pregnancy would allow more of these young women to finish high school and possibly go on to college.

Homelessness

Homelessness is another major issue in Ohio to which young pregnancy contributes. Teen parenthood puts one at considerable risk for becoming homeless. Studies about teens and homelessness have found that between 40% and 60% of young females living on the street have had at least one teenage pregnancy.[70] Parents that have been homeless are much more likely to have their children placed in the foster care system. Nationally, it costs on average $47,608 to care for the children of a homeless family in foster care, which is considerably more than the costs to shelter these families.[71]

Regardless of the cost, just finding a place to live as a young parent can be a challenge, since shelters and transitional housing often do not accept those under 18, and remaining in familial homes may no longer be an option, due to overcrowding, financial issues, or even abuse.[72] This is particularly troubling since minor parents must live with a parent or other responsible adult in order to receive cash assistance.[73]

Many of the factors that contribute to the risk of homelessness are characteristic issues of teen parents, such as poverty, especially due to low wages, unemployment, medical bills, cuts in welfare programs, and domestic violence.[74] For these reasons, families headed by young mothers, especially those who have dropped out of school and were teens when they became pregnant, are considered the fastest growing subset of the homeless.[75] Lowering rates of unplanned and teenage pregnancy, therefore, would reduce the number of homeless families in Ohio.

Domestic Violence

Domestic violence is extremely prevalent among young parents; more than 70% of pregnant or parenting teen mothers are abused by their partners.[76] Pregnancy is a high-risk time for victims

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[69] Bos, Johannes M., and Veronica Fellerath (1997). LEAP: Final Report on Ohio's Welfare Initiative to Improve School Attendance among Teenage Parents: Ohio's Learning, Earning, and Parenting Program. *Manpower Demonstration Research Corporation*, New York.

[70] Haley, N. et al. (2004). Characteristics of adolescent street youth with a history of pregnancy. *North American Society for Pediatric and Adolescent Gynecology*, 17,313-320.

[71] Office of Policy Development and Research, U.S. Department. of Housing and Urban Development (September 1994). Evaluation of the Emergency Shelter Grants Program, Volume 1.

[72] ASPE (2000). *Second Chance Homes:* Providing Services for Teenage Parents and Their Children.

[73] Paul Offner (2005). Welfare Reform and Teenage Girls. *Social Sciences Quarterly*, 26 (2), 306-322.

[74] National Coalition for the Homeless (2007). *Fact Sheet #12*.

[75] Homes for the Homeless (1996). *The Age of Confusion: Why so many teens are getting pregnant, turning to welfare and ending up homeless."*

[76] OCJS (2007). Teens and dating violence. *Family Violence Prevention Center*.

of domestic violence and this places pregnant teens at even greater risk for abuse than pregnant adults. A study of young mothers on welfare found that two-thirds of the teens that reported abuse by partners had also experienced contraception sabotage by those partners.[77] Therefore, having a young birth does not only increase risk of violence, it also causes victims to feel trapped in abusive relationships. When children are brought up in abusive homes, they learn abuse and may perpetuate the cycle.[78] It is also extremely dangerous for children to live in homes with abusive relationships, and may be grounds for the children to be placed in protective custody.

Domestic violence is not simply an issue that effects individuals, but is detrimental to society as a whole. Studies have found that Medicaid expenditures and claims in both 1997 and 1998 were double for those involved in highly violent relationships than for those in nonviolent relationships. Conservatively, they found that people in violent relationships were three times as likely as those who were not in violent relationships to have annual Medicaid expenditures over $5,000, which resulted in an average difference of $3,000 on Medicaid expenditures between the two groups.[79]

Foster Care

Teenage pregnancy and foster care have a cyclical relationship. First, adolescent girls in foster care are two-and-a-half times more likely as those not in the foster care system to have been pregnant by the age of nineteen.[80] Teen parents are also more prone to abuse or neglect their children than adult parents, and mothers under eighteen are 2.2 times as likely as adult mothers to have a child placed in the foster care system.[81] Therefore, teens in the foster care system (who may have experienced abuse or neglect as children) are more likely not only to have children, but to have children placed into the foster care system. This increased likelihood for abusing or neglecting their children results from a tendency of teens to be impulsive and lack decision-making capabilities; they may have also learned that violence is normal, may have difficulties handling stress, and are prone to poverty.[82]

According to the Child Welfare League of America, 18,004 children in Ohio lived apart from their families in out-of-home care at one point in 2004, and of those, 4,907 were waiting to be adopted.[83] Also in 2004, Ohio spent more than $930 million for child welfare services, 57% of which came from state and local funds.[84] Moreover, children in foster care are considered one

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[77] Center for Impact Research (2000). Domestic Violence and Birth Control Sabotage: A Report from the Teen Parent Project. *Center for Impact Research*: Chicago, Il.

[78] Strauss, Murray A., Gelles Richard J., and Smith, Christine. 1990. Physical Violence in American Families; Risk Factors and Adaptations to Violence in 8,145 Families. New Brunswick: Transaction Publishers.

[79] Coker, Ann (2004). Physical partner violence and Medicaid utilization and expenditures. *Public Health Reports (119)*, 557-567.

[80] Bilaver, L.A & Courtney, M.E. (2006). *Science Says #27: Foster Care Youth.* National Campaign to Prevent Teen Pregnancy: Washington, DC.

[81] Ibid.

[82] Lowenthal, B. (1997) "Teenage Parenting: Challenges, Interventions, and Programs". Childhood Education. FindArticles.com. 1 Oct. 2007.

[83] CWLA (2007). Fact Sheet: Ohio's Children 2007.

[84] Scarcella, C.A.; Bess, R.; Zielewski, E.H.; & Geen, R. (2006). *The Cost of Protecting Vulnerable Children V: Understanding State Variation in Child Welfare Financing*. Washington, DC: Urban Institute.

of Medicaid's most costly populations. In 2001, Medicaid spent more than $90 million for health care services for children in foster care.[85] Since teen parents are more likely than adult parents to have a child placed in foster care, reducing the number of teen pregnancies would reduce Ohio's foster care enrollment and expenditure, saving taxpayer dollars.

Child Support

Child support is a major issue in the finances of young parents. Unmarried teen mothers generally receive less child support from their child's father than older mothers. Studies show that approximately a quarter (between 20% and 30%) of non-custodial teen fathers come in contact with Child Support Enforcement Programs.[86] Additionally, only about 15% of teen mothers receive court-ordered child support from their child's father and the vast majority of those receive less than half the awarded amount.[87] Since so few custodial teen parents are receiving child support and so many depend on welfare for survival, the state of Ohio pays much of this difference through various welfare programs.

Many of the characteristics that are correlated with not receiving support are also descriptive of teen parents. According to the U.S. Census Bureau, only 40% of people who were never married, live below poverty, or are under thirty years of age receive full child support.[88] Also, many young mothers are unaware of their right to receive child support or have unofficial agreements with the fathers. Even though the majority of teen births are to young mothers and adult men, when teens are the fathers of children, less child support is paid and less income is earned.

When teen parents do not receive child support, the children suffer economically and cognitively. Children who receive child support are more likely to finish high school and attend college than those who do not. Also, children, especially young girls, do better academically when they receive child support, not only because there is more money for education, but because they receive more emotional support from their fathers. Receiving child support is known to help reduce much of the negative academic effects that young girls tend to experience when their parents separate.[89] Since 88% of teen births in Ohio occur to unmarried parents, the issues that arise around delinquent child support payments are extremely relevant to this population and could be mitigated by a reduction in teen pregnancy.

Abortion

Not all teen pregnancies are carried to term. In 2005, there were 6,057 abortions to Ohio women under the age of twenty. There were more abortions to women under fifteen years old than there were live births (240 abortions to 238 live births) and more than one abortion for every three live

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[85] CWLA (2007). Fact Sheet: Ohio's Children 2007.
[86] Pirog-Good, M. (1995). Child Support Enforcement for Teenage Fathers: Problems and Prospects. *Journal of Policy Analysis and Management,14(1),*25-42.
[87] Kowaleski-Jones, L., ed. (2006). *Fragile Families and the Married Agenda.* Boston: Springer US.
[88] US Census Bureau (2007). Custodial Mothers and Fathers and their Child Support: 2005. *Current Population Reports.*
[89] CLASP. (2004). Research Fact Sheet: *Child Support Payments Benefit Children in Non-Economic as well as Economic Ways.*

births to women aged 15 to 19.[90] Medicaid in Ohio only covers abortion in cases of rape, incest, and life endangerment, following the minimal coverage requirement stated in the Hyde Amendment, which limits federal funding of abortions to these circumstances.[91] Between 20% and 35% of Medicaid-eligible women who would have chosen abortion if public funds were available end up carrying pregnancies to term.[92] Also, lack of public funds may cause women to delay having an abortion until they have raised enough to pay for it, increasing both the cost of abortion and its risks.[93]

Under amended House Bill 421, passed in 1998, women under the age of eighteen must obtain parental consent and wait a 24-hour period in order to have an abortion. A study done in states that do not have parental consent laws found that 61% of teens having abortions tell a parent, and that 30% of those who did not inform their parents had histories of family violence.[94] In order to avoid parental notification of an abortion, minors may go through the process of judicial bypass. In this process, a hearing is held within five days of the minor filing a petition to the courts. The minor is assigned counsel and together they present the case. The court issues a decision within 24 hours of the hearing.[95] Judicial bypasses are not time- or cost-effective. In the seven largest counties in Ohio, 515 teens requested judicial bypass in the years 2000-2003, and the bypass was granted 86% of the time.[96] The woman seeking the abortion pays nothing for the judicial review; therefore, the jurisdiction of the court must absorb court costs and legal fees for a judicial bypass that will be granted in the vast majority of cases. Reducing teen pregnancies would therefore also reduce abortion rates and the costs associated with judicial reviews.

Recommendations

Open and honest communication about sexuality within the family

The majority of Americans believe that the family should be the primary provider of sexuality education.[97] Parents need to begin honest and nonjudgmental conversations about sex and its consequences at an early age to help ensure that children feel comfortable talking about these topics and view their parents as resources. Parents must have current and accurate information about sexuality in order to give their children the best knowledge base possible. Children who can be honest with their parents about sexuality feel more confident purchasing and utilizing birth control and communicating with partners about protection.[98]

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[90] ODH (2006) "Induced Abortions in Ohio, 2005 Report" received September 2, 2007 from www.odh.ohio.gov.
[91] NAF (2006). Public Funding for Abortion: Medicaid and the Hyde Amendment. *National Abortion Federation.*
[92] Heather Boonstra and Adam Sonfield, (April 2000) Rights Without Access: Revisiting Public Funding of Abortion for Poor Women. *The Guttmacher Report on Public Policy*, 3 (2).
[93] NAF (2006). Public Funding for Abortion: Medicaid and the Hyde Amendment. *National Abortion Federation.*
[94] Henshaw, Stanley K., & Kathryn Kost. (1992). "Parental Involvement in Minors' Abortion Decisions." *Family Planning Perspectives*, 24(5), 196-207 & 213.
[95] General Assembly of the State of Ohio. (1998) Amended House Bill Number 421 § Sec. 2919.121, Received online from http://www.legislature.state.oh.us
[96] Trexler (2003) State Politics & Policy /*Akron Beacon Journal* Examines Judicial Bypass for Minors Seeking Abortion in Ohio. *Kaiser Family Foundation.* Received online at www.kaisernetwork.org.
[97] SIECUS (2005) Adolescents would prefer parents as primary sexuality educators. *Families are Talking.*
[98] Lagina, N. (2002) Parent-Child Communication: Promoting Sexually Healthy Youth. *Advocates for Youth.*

Resources in the community are necessary to educate parents about not only their children's sexual health but also their own. Information about sexual health is constantly changing and it is necessary to understand the impact that this information has on everyday life of Ohio families. The educational needs of people with respect to sexuality change throughout the life span, necessitating a life-long learning approach.[99] Parents who are comfortable with their own sexuality will be better equipped to answer the questions that their children have in open and honest ways. Ongoing communication about sexuality and the impact of teen pregnancy ideally should be a means by which parents pass on their values and expectations to their children.

Comprehensive sexuality education in schools

Comprehensive sexuality education conveys medically accurate information about sex, pregnancy, and sexually transmitted infections. Since the majority of teens choose to have sex before adulthood, comprehensive sex education also educates about methods of birth control and STI prevention. The objectives of effective comprehensive sexuality education programs are:

- Focused on clear health goals—the prevention of STD/HIV, pregnancy, or both;
- Focused narrowly on specific types of behavior leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), give clear messages about these types of behavior, and address situations that might lead to them and how to avoid them;
- Address sexual psychosocial risk and protective factors that affect sexual behavior (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) and change them.[100]

Current research has found that 40% of programs that utilized comprehensive sexuality education delayed initiation of sex, increased condom or contraception use, and reduced the number of sexual partners. It also found that more than 60% of these programs reduced unprotected sex, 30% reduced frequency of sex (including a return to abstinence), and nearly 40% had positive effects on two or more of these behaviors in teenagers.[101] Moreover, teens that received comprehensive sex education are 50% less likely to have a teen pregnancy than those who received abstinence-only sex education.[102] Sex education must take place in a safe environment that promotes participation, include various activities that are targeted to the population, utilize sound teaching methods, be culturally and developmentally sensitive, and cover topics in a logical order to promote effectiveness.[103] Teen pregnancy and its consequences need to be integrated into the regular curriculum of schools, so children can truly understand how becoming a parent before they are prepared will affect their future.

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[99] Haffner, D., October 18, 2007.
[100] Kirby, D. (November 2007) Emerging answers 2007. *The National Campaign to Prevent Teen and Unplanned Pregnancy*
[101] Ibid.
[102] Kohler, P., Manhart, L., and Lafferty, W. (April 2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42 (4), 344-351.
[103] Kirby, D. (November 2007) Emerging answers 2007. *The National Campaign to Prevent Teen and Unplanned Pregnancy*

Increased access to birth control

Ohio is currently ranked 48th in the nation in access to birth control.[104] Family planning clinics in the state are serving only a third of teenagers in need of contraceptive services.[105] Teens who feel uncomfortable communicating with their parents about contraceptives must have access to options to protect themselves. Research suggests that if parental notification was mandatory for teens to get birth control, one in five teens would continue having sex, but stop using protection. Only one percent would stop having sex.[106]

Birth control needs to be not only available, but also affordable. Teens who do not want their parents to know that they are using birth control are unable to use their parent's health insurance for hormonal contraceptives, and are therefore shouldering the rising cost of contraception themselves. This can add up to hundreds of dollars a year, which teens may not have. An inability to consistently afford birth control may lead to irregular use and raise the likelihood of pregnancy.

Evaluate teen pregnancy prevention programs

Teen pregnancy prevention programs must be evaluated for effectiveness in averting both first and repeat births to adolescents until adulthood. Research has found that the most successful teen pregnancy prevention programs include youth development, involvement of family and other caring adults, male involvement, cultural relevance, community-wide campaigns, service learning, employment opportunities, sexuality and AIDS education, outreach in teen pregnancy prevention, and access to reproductive health services.[107] There are many resources available to both teens and young parents, each with varying levels of success, utility, and access. Recent research on teenage pregnancy reduction programs found successful programming becomes ineffective when key areas of the curriculum are altered or used with inappropriate audiences.[108] Ongoing evaluation is imperative to understanding optimal ways to utilize resources. Therefore, in-depth data on ways teen parents are currently utilizing resources would identify areas in which additional funds are needed and where they can be cut.

Change cultural expectations of adolescence and adulthood

Cultural expectations of adolescence and adulthood vary significantly between the United States and other developed countries. Adolescence is defined in many developed countries as a time to complete schooling and prepare for the working world. One has not reached adulthood until he or she is employed, and has the rights and responsibilities that come with employment. The government bolsters these ideas by assisting people in finding work and giving incentives for

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[104] Guttmacher Institute. Fact Sheet: *Contraception Counts: Ohio*, March 2006
[105] Ibid.
[106] Rachel K. Jones**,** PhD; Alison Purcell, BA; Susheela Singh, PhD; Lawrence B. Finer, PhD (2005). Adolescents' Reports of Parental Knowledge of Adolescents' Use of Sexual Health Services and Their Reactions to Mandated Parental Notification for Prescription Contraception**.** *Journal of the American Medical Association***,** 293 (3).
[107] Moncloa, F., Johns, M., Gong, E., Russell, S., Lee, F., & West, E. (2003). Best practice in teen pregnancy prevention practitioner handbook. *Journal of Extension*, 41 (2).
[108] Kirby, D. (November 2007) Emerging answers 2007. *The National Campaign to Prevent Teen and Unplanned Pregnancy*.

being established in the working world before childbearing.[109] Yet in the United States, education and employment do not have the same importance in defining adulthood. Many people continue their education while working and taking care of families. Additionally, the importance of education is not a value in all subcultures in the U.S. Since childbearing is generally seen as an adult activity, youth in America may have children as an alternative way to prove their maturity.[110]

Changing cultural expectations of adulthood in our own communities could help prevent teen pregnancies because it would be less likely used as a proof of maturity. If the importance of education were reinforced throughout childhood in all schools, children would not only better understand adult expectations, but would have more faith in a promising future, leading to a drive for success. These teens would feel more invested in a future and therefore less likely jeopardize it through young parenthood.

Conclusion

This report concludes that teen pregnancy and parenthood have a dramatic impact on the social and economic functioning of the state of Ohio. Teen pregnancy is a contributing factor to many costly issues to the state, such as poverty, Medicaid, premature birth, child support, foster care, domestic violence, homelessness, education, and abortion. Reducing the number of teen pregnancies will reduce expenditures in many of these areas, potentially saving the state of Ohio millions of dollars. Therefore, it would be beneficial for Ohio to put more effort and funding toward preventing unintended and teenage pregnancy than to pay for its consequences later. Prevention requires a multi-faceted approach. Crucial changes, including increased access to birth control and comprehensive sexuality education, along with changing cultural views about sex and expectations of adolescents, are necessary steps toward prevention.

[109] Darroch, J. (2001) Teenage Sexual and Reproductive Behavior in Developed Countries Can More Progress Be Made? *Occassional Report no. 3*
[110] Ibid.