

Teen Pregnancy in North Carolina

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Every 28 minutes, a North Carolina teen becomes pregnant. Why should we care? Teen pregnancy can be associated with many other critical social issues such as poverty and income, health, education, child welfare, and irresponsible fatherhood. Risky behaviors such as drugs and alcohol, juvenile crime, and dropping out of school are linked with adolescent childbearing. If the trend of teen pregnancy could be turned, we would see a major reduction of social problems afflicting children in North Carolina as well as the United States. A decrease in school drop out rates, crime, and child abuse and neglect would be likely.

Teen pregnancies also result in the possibility that the child will have a higher rate of developmental risks. These children report poorer physical and mental health compared to children of planned pregnancies. A report from Child Trends indicates that after controlling for numerous background factors, two-year-old children who were born as a result of an unplanned pregnancy have significantly lower cognitive test scores when compared to children born as the result of an intended pregnancy.¹

Another challenge comes simply from the fact that the child is usually born to a single mother. When compared to children raised with two parents, the child of the one-parent family is more likely to be poor, drop out of school, and have lower grade-point averages, lower college aspirations, and poorer school attendance. The data suggests that reducing teen pregnancy will increase the proportion of children born into circumstances that better support their growth and development.¹

What Do the Numbers Say?

The United States has the highest teen pregnancy rate of all industrialized countries, and North Carolina ranks 37th out of the 50 states with 50 being the highest.² North Carolina's teen pregnancy rate continues to hold steady, with 2007 rates nearly the same as those over the previous four years. The five-year plateau follows a 14 year decline that resulted in the state's lowest ever rates in 2003. The state's adolescent pregnancy rate has

declined by 36% since 1992.³ The 2007 pregnancy rate for teens ages 15 through 19 was 63.0 pregnancies per 1,000 girls, compared to 63.1 per 1,000 in 2006, according to the State Center for Health Statistics.

The total number of North Carolina teens aged 15-19 who were pregnant in 2007 was 19,615. Nearly 29.4% of those pregnancies were to girls who had been pregnant at least once before. There were 404 pregnancies among 10 to 14-year-olds in 2007. Among minority populations, Hispanic teens had the highest pregnancy rate, although their rate has dropped nearly

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7% since 2003. The 2007 pregnancy rate among Hispanic adolescents in the state was 167.4 per 1,000 girls aged 15-19, a 3.3% decrease from the 2006 rate of 173.1. African American teens had a 2007 pregnancy rate of 87.1 per 1,000 girls, compared to 86.2 in 2006.³ The number of pregnancies among American Indian teens and other minority groups was too low to calculate reliable rates. In 1992, the minority teen pregnancy rate was two times higher than the Caucasian rate. The pregnancy rates have since narrowed.

A Look at the Nation

In the United States, the teen pregnancy rate is more than nine times higher than that in the Netherlands, nearly four times higher than the rate in France, and nearly four times higher than that in Germany.⁴ National data from the Youth

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Risk Behavior Surveillance System released by the Centers for Disease Control and Prevention (CDC) show that nearly half of all high school students have ever had sex and 7% had sex before age 13.⁵ Moreover, less than two-thirds of sexually active high school students report using a condom the last time they had sex.

During the 1990's progress was made regarding teen sexual behavior. Between 1991 and 2001 the proportion of sexually experienced high school students decreased by 16%, and the proportion of sexually active high school students who used condoms increased by 25%. Teen pregnancy and birth rates declined steadily each year. Teen sexual behavior in this decade is holding steady.¹ There has been virtually no change since 2001 in the proportion of high school students who have had sex or since 2003 in the proportion of sexually active high school students who used condoms the last time they had sex. The teen birth rate increased 3% between 2005 and 2006.²

The Economic Bottom Line

Teen pregnancy and child-bearing have significant economic and social costs. Progress towards reducing teen pregnancy will benefit the national and state economies and improve the educational, health, and social prospects of the teens and their children.

In North Carolina, the cost to taxpayers (federal, state, and local) associated with teen childbearing is estimated to be at least \$312 million in 2004, of which \$128 million (41%) are federal costs and \$184 million (59%) are state and local costs.² To break these figures down, the average annual cost in North Carolina of teen childbearing is \$1,503 per teen birth. It is important to note that costs of births to young teens are much greater than costs of births to older teens, and the average annual cost associated with a child born to a mother age 17 and younger is \$3,868. In North Carolina, only \$2.5 million is spent each year to prevent teen pregnancies. When weighed against the \$312 million spent to deal with the consequences of teen pregnancy it is clear that an increase in prevention dollars will benefit everyone in the long run.

Nationally, the overall cost to taxpayers is estimated to be at least \$9.1 billion a year. The total costs include those attached to teen mothers, their partners, and children born to teen mothers. The most significant costs are associated with poorer outcomes for the children of teen parents as compared to the outcomes for children born to mothers who are 20-21 years old.²

What Does Prevention Look Like in North Carolina?

In 1995 the North Carolina General Assembly revised the Basic Education Plan to include a comprehensive school health program. The health program includes instruction focused on disease control and abstinence education. In addition, the federal government has included requirements of abstinence education in No Child Left Behind (NCLB). The guidelines for NCLB contain little information on health and sex education, leaving

the states the power to develop their own laws, policies, and curriculum. What NCLB does provide, however, is clear and concise. NCLB prohibits the funds to be used to develop programs or distribute materials that are designed to encourage sexual activity, to distribute any obscene materials to minors, or to provide sex education or HIV prevention education unless that instruction is age appropriate and includes the health benefits of abstinence.⁶ NCLB further prohibits recipients of federal money from distributing contraceptives in schools.

The 1995 revisions made by the General Assembly of North Carolina include a complete K-9 health plan requiring all school systems to offer, among other topics, prevention of sexually transmitted disease (STD) and sexual abstinence until marriage instruction to all 7th, 8th, and 9th graders. The General Assembly further adopted policy guidelines to instruct the State Board of Education (SBE) or local boards when adopting curriculum or policy. Any program adopted by the SBE must provide biological or pathological information related to the human reproductive system. It must focus on the benefits of abstinence until marriage and the risks of premarital sexual intercourse and establish abstinence as the expected standard for all school-age children. Positive reinforcement for abstinence should be offered and opportunities for interaction between the parent and student should be given. Students are to be made aware of the difference between risk reduction through use of contraceptives and/or condoms and risk elimination through abstinence. For any instruction concerning contraceptive or prophylactics, accurate statistical information on their effectiveness and failure rates for preventing pregnancy and sexually-transmitted diseases, including HIV/AIDS, in actual use among adolescent populations must be given. Students must be informed of the current legal status of certain homosexual acts that are a significant means of transmitting diseases including HIV/AIDS. Students must understand that a mutually faithful, monogamous, heterosexual relationship in the context of marriage is the best lifelong means of avoiding diseases transmitted by sexual contact, including HIV/AIDS. They must be aware that the instruction in the use of and/or demonstration of condoms is a part of the sexuality education program.⁶ Following these guidelines, the SBE adopted curriculum objectives for STD prevention and abstinence until marriage for students in the 7th, 8th, and 9th grades.

Local boards of each school system must provide a comprehensive health education program that meets all the requirements of the Basic Education Plan and all objectives established by the SBE. A local board must conduct a public hearing before it "adopts" any health curriculum. The public hearing should adequately notify the community, and the board must allow for public inspection of all instructional materials and objective of the expanded sex-education curriculum 30 days before the hearing. The board must keep the instructional material and objections open for public review 30 days following the hearing. Each year before the students receive the sexuality instruction, the board must give parents or legal guardians an opportunity to review the objectives and materials. The local board must also develop a policy that

allows parents to either provide or withhold consent for their student's participation in any or all of these programs.

Neither the federal government nor the state prohibits a local school board from teaching about contraception, but the state does require curriculum about contraception to include accurate statistical information about its effectiveness and failure rate. The General Assembly also allows local boards to provide students information on where to obtain contraceptive if this information is included in the parental consent form. Under no circumstances, however, can a local board develop a program that makes available or distributes contraceptive to students. The SBE adopted objectives for teaching about contraception for 7th and 8th grade only. These students must receive information "on the effectiveness and failure rates of condoms as a means of preventing STDs

including HIV/AIDS."⁶ In the 8th grade this is reinforced with an expansion to include other forms of contraception.

Abstinence curriculum is the policy of North Carolina. Local boards must meet the minimum objective of contraceptive instruction. Since 1995, local school systems have been in a state of confusion and fear; therefore, many systems do not have any sexuality curricula in place even though it is mandated. Many professionals in the field believe we are seeing the repercussions since teen pregnancy is no longer in a decline. Efforts continue to be made toward educating school personnel and practitioners about the requirements of the state law. Until teen pregnancy is recognized as a reproductive health issue and that prevention is the key, North Carolina will continue to experience the reality of children having children. **NCMJ**

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