

REDUCING TEENAGE PREGNANCY

Although the rate of teenage pregnancy in the United States is at its lowest level in nearly 40 years, it remains one of the highest among the most developed countries in the world. Approximately 57.4 per 1,000 women aged 15–19 — nearly 615,000 American teenagers — become pregnant each year (Kost and Henshaw, 2014). The majority of these pregnancies — 82 percent — are unintended (Finer & Zolna, 2014).

Moreover, because the average age of menarche has reached an all-time low of about 12 or 13 years old (Potts, 1990), and because six out of 10 young women have sex as teenagers (Martinez et al., 2011), most teenage girls are at risk of becoming pregnant.

The consequences of adolescent pregnancy and childbearing are serious and numerous:

- Pregnant teenagers are more likely than women who delay childbearing to experience maternal illness, miscarriage, stillbirth, and neonatal death (Luker, 1996).
- Teen mothers are less likely to graduate from high school and more likely than their peers who delay childbearing to live in poverty and to rely on welfare (Hoffman, 2006).
- The children of teenage mothers are often born at low birth weight, experience health and developmental problems, and are frequently poor, abused, and/or neglected (Hoffman & Maynard, 2008; Martin et al., 2013; NCPTUP, 2010.).
- Teenage pregnancy poses a substantial financial burden to society, estimated at \$9.4 billion annually in lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system (NCPTUP, 2013).

As a result, the United States needs a number of initiatives to reduce its teenage pregnancy rate and the negative outcomes that accompany it. These initiatives should incorporate responsible, medically accurate sex education and information in the schools and in the media, improvements in funding for and access to family planning services, and youth development programs to improve the life options of impoverished teens.

In 2009, recognizing that evidence-based sex education programs were effective in promoting sexual health among teenagers, the Obama administration transferred funds from the Community-based Abstinence Education Program and budgeted \$114.5 million to support evidence-based sex education programs across the country. The bulk of the funds — \$75 million — was set aside for replicating evidence-based programs that have been shown to reduce teen pregnancy and its underlying or associated risk factors. The balance was set aside for developing promising strategies, technical assistance, evaluation, outreach, and program support (Boonstra, 2010). This was the first time federal monies were appropriated for more comprehensive sex education programs (SIECUS, n.d.).

Though off to a good start, none of these initiatives can succeed without a general reassessment of the attitudes and mores regarding adolescent sexuality in the U.S. Presently, an unrealistic emphasis is placed on preventing adolescent sexual behavior, which overlooks the fact that sexual expression is an essential component of healthy human development for individuals of all ages (Freud, Maslow et al., as cited in Zimbardo, 1992). The majority of the public recognizes this fact — 63 percent of Americans believe that sexual exploration among young people is a natural part of growing up (SIECUS, 1999).

An influential minority of individuals promote unrealistic, abstinence-only programs and parental consent requirements for obtaining contraception that deny American teens accurate information about and confidential access to family planning services to prevent pregnancy. However, even individuals who support abstinence-only programs and parental consent recognize the dangers of such measures.

Planned Parenthood believes that it is important to help teens delay having sexual intercourse, but it also believes that policymakers must accept the fact that teens engage in sexual behavior, and they must initiate and provide funding for various programs and interventions that will facilitate responsible sexual behavior.

Sex Education Can Help Prevent Teenage Pregnancy

Sex education that is responsible and medically accurate, begins in kindergarten, and continues in an age-appropriate manner through the 12th grade is necessary given the early ages at which young people are initiating intercourse — 6.2 percent of students nationwide report having sex before the age of 13, 43.8 percent by grade 10, and 63.1 percent by grade 12 (CDC, 2012). In fact, the most successful programs aimed at reducing teenage pregnancy are those targeting younger adolescents who are not yet sexually experienced (Frost & Forrest, 1995).

Sex education programs that are balanced and realistic, encourage students to postpone sex until they are older, and promote safer-sex practices among those who choose to be sexually active have been proven effective at delaying first intercourse and increasing use of contraception among sexually active youth. These programs have not been shown to initiate early sexual activity or to increase levels of sexual activity or numbers of sexual partners among sexually active youth (Kirby, 2007; Kohler et al., 2008).

Many sex education programs in the United States caution young people to not have sex until they are married (Landry et al., 1999). However, most abstinence-only programs are not effective because they fail to delay the onset of intercourse and often provide information that is medically inaccurate and potentially misleading (Kirby, 2007; Kohler et al., 2008; Lin & Santelli, 2008; Trenholm et al., 2007). Only 11 states plus the District of Columbia require sex education that includes information about contraception. Six other states require that if sex education is provided, it must include information about contraception (Guttmacher Institute, 2014c). Recent studies show that more teens receive formal sex education on “how to say no to sex” (87 percent of teen women and 81 percent of teen men) than on contraception methods (70 percent of teen women and 62 percent of teen men) (Martinez et al., 2010).

The Majority of Americans Support Sex Education that Is Responsible and Medically Accurate

Three decades of national polling has shown that the vast majority of Americans, especially American parents, have long supported comprehensive, medically accurate sex education (Harper, 1981). During this time, the overwhelming majority of Americans have wanted their children to receive sex education that includes a variety of subjects, including communications and coping skills, the emotional aspects of sexual relationships, sexually transmitted infections including HIV/AIDS, how to use contraception (85 percent) and condoms (84 percent), sexual orientation (76 percent), abortion (79 percent), and the consequences of becoming sexually active (94 percent) (KFF, 2000). Only 36 percent of Americans have supported abstinence-only educational programs (Bleakley et al., 2006), and 56 percent of Americans have not believed that abstinence-only programs prevent sexually transmitted infections or unintended pregnancies (Research!America and APHA, 2004).

Additional studies have shown that parental opinions regarding sex education are similar between states that teach comprehensive sex education and states that mandate abstinence-only programs.

- A 2006 survey of parents in North Carolina — a state that mandates abstinence-only education — found that 91 percent of parents support sex education in the schools, with 89 percent supporting comprehensive sex education — including discussions of sexual orientation, oral sex, and anal sex (Ito et al., 2006).
- A 2007 survey of California parents found that regardless of educational attainment, political or religious affiliation, or place of residence, nearly 90 percent believe their children should have comprehensive sex education in the classroom (Mangaliman, 2007).
- A 2011 study of parents in Harris County, Texas — the third most populous county in the U.S. — found that a majority supports sex

education in middle school that would include abstinence messages as well as medically accurate information and instruction on the use of condoms and other kinds of contraception. Despite the desires of parents, however, nearly three out of four Texas school districts implement abstinence-only programs that have no evidence of effectiveness (Texas Freedom Network, 2011; Tortolero, 2011).

- A recent study in Mississippi showed that 92 percent of Mississippi parents support abstinence-plus sex education in schools. In this state — with the highest teen pregnancy and gonorrhea rates in the country — the overwhelming majority of parents want to move from abstinence-only programs to abstinence-plus curricula that include information about birth control, relationships, and sexually transmitted infections (McKee, 2011).

Every reputable sex education organization in the U.S., as well as prominent health organizations including the American Medical Association, has denounced abstinence-only programs. For example, a 1997 consensus statement from the National Institutes of Health concluded that legislation discouraging condom use on the grounds that condoms are ineffective “places policy in direct conflict with science because it ignores overwhelming evidence... Abstinence-only programs cannot be justified in the face of effective programs and given the fact that we face an international emergency in the AIDS epidemic” (NIH, 1997).

The National Coalition to Support Sexuality Education now has over 140 member organizations that include the American Medical Association, the American Public Health Association, the American Psychiatric Association, the American Psychological Association, the National Urban League, and the YWCA of the U.S.A (NCSSE, 2008).

Teenagers also express the need for responsible, medically accurate sex education:

- Nationwide, more than three-quarters of teens aged 15–17 report that they need more information about birth control, HIV/AIDS, and other sexually transmitted infections (STIs), and a third are

unaware that having an STI increases the risk of getting HIV (KFF, 2003). Another survey found that the majority (86 percent) of young people aged 12–19 say they have all the information they need to avoid an unintended pregnancy. Yet only 36 percent say they know “a lot” or “everything” about birth control pills and how to use them, and 36 percent say they know only “a little” or “nothing” about condoms (Albert, 2012).

- Sixty-three percent of teens aged 15–17 would like more information on the different methods of contraception available; 29 percent would like more information on how to use condoms; and 59 percent would like more information on where to go to get tested for HIV and other STIs (KFF, 2003). Forty-nine percent of young people aged 12–19 wish that young people received more information about both abstinence and contraception rather than just one or the other (Albert, 2012).
- Half of teens have not heard of emergency contraception and do not know that there is something a woman can do to prevent pregnancy after unprotected sex. More than a quarter of teens incorrectly believe that birth control pills provide protection from STIs, including HIV/AIDS (KFF, 2003).

Sex Education Is a Success in Other Developed Nations

European countries have already demonstrated great success with sex education. For example:

- The Netherlands, where sex education begins in preschool and is integrated into all levels and subjects of schooling, boasts one of the lowest teen birth rates in the world — 4.8 per 1,000 women aged 15–19 — a rate six times lower than that of the U.S. (Berne & Huberman, 1999; United Nations, 2013). Likewise, the Dutch teenage abortion rate is approximately two times lower than that of the U.S., and its HIV prevalence rate is three and a half times lower (Kost & Henshaw, 2014; Statistics Netherlands, 2011; UNAIDS, n.d.).

- In Germany, where sex education is comprehensive and targeted to meet the reading and developmental needs of the students, the teenage birth rate is three and a half times lower than that of the U.S.; its teenage abortion rate is about four and a half times lower; and its HIV prevalence rate is three and a half times lower (Destatis, 2014; Kost & Henshaw, 2014; UNAIDS, n.d.; United Nations, 2013).
- France has a nationally mandated sex education program that begins when students are 13. Parents are prohibited from withdrawing their teenagers from the program. France's teenage birth rate is three times lower than that of the U.S., and its HIV prevalence rate is nearly two times lower (Berne & Huberman, 1999; UNAIDS, n.d.; United Nations, 2013).

The most effective programs in the U.S. combine medically accurate information on a variety of sexuality-related issues, including abstinence, contraception, safer sex, and the risks of unprotected intercourse and how to avoid them, as well as the development of communication, negotiation, and refusal skills. Teens who have sex education are half as likely to experience a pregnancy as those who attend abstinence-only programs (Kohler, et al, 2008). A 2007 review of sex education curricula found that the most effective comprehensive programs lowered risky sexual behavior by about one-third (Kirby, 2007).

Increased Use of Contraception Accounts for 86 Percent of the Recent Decline in Teenage Pregnancy

The rate of teenage pregnancy in the United States has declined to its lowest level in decades. Between 1990 and 2010 it decreased from 116.9 pregnancies per 1,000 women aged 15–19 to 57.4 per 1,000, a drop of 51 percent (Kost and Henshaw, 2014).

An analysis of data from the National Survey of Family Growth (NSFG), the major source of government data on population and reproductive health, found that 86 percent of the decline in teen pregnancy rates through 2002 occurred because

teens were using contraceptives better (Santelli et al., 2007). This figure is even higher than analyses from earlier years that found that from 47 to 80 percent of the decline could be attributed to improved contraceptive use (Santelli et al., 2004; Saul, 1999). A different study suggested that another cause for the reduction of teen pregnancy is that adolescents are increasingly substituting other kinds of sexual activity for vaginal intercourse (Weiss & Bullough, 2004).

The Media Has an Important Role in Pregnancy Prevention

Another source of teen information about sex is the media:

- In the U.S., one in three television programs contains a scene devoting primary emphasis to sexual behavior, and one in 10 contains a scene in which intercourse is depicted or strongly implied, yet sexual precautions and the consequences of sexual behavior are rarely depicted (Kunkel et al., 2005).
- Research shows that mass media portrayals contribute to sexual socialization — watching programs high in sexual content has been correlated with the early initiation of adolescent sexual intercourse, particularly among white teens (Brown et al., 2006; Collins et al., 2004).

The U.S. needs a long-term teenage pregnancy prevention media campaign that addresses the consequences of sexual behavior. At present, most major networks do not air commercials or public information campaigns about sexual health. An analysis of the sexual content in television, magazines, music, and movies popular among young teens found very rare depictions of sexually healthy behavior: 12 percent of all popular media content was sexual in nature, but less than one-half of one percent discussed or portrayed sexual health (Hust et al., 2008). Developed countries such as the Netherlands, Germany, and France, in which teenage birth rates are many times lower than that of the U.S., promote healthy, lower-risk sexual behavior through national media campaigns that have a high degree of influence with young women and men (Berne & Huberman, 1999).

Easy Access to Contraception Helps Reduce the Incidence and Cost of Teen Pregnancy

Easy and confidential access to family planning services through health centers, school-linked health centers, and condom availability programs have been found to help prevent unintended pregnancy.

Contraceptive use is also cost-effective. The average annual cost associated with teen pregnancy, per taxpayer, is \$1,682 (NCPTUP, 2013). That is up to nine times the cost of a year's supply of the pill at many women's health centers. It is up to 40 times the annual cost of an IUD (PPFA, 2014).

Various studies have demonstrated that efforts to improve teenagers' access to contraception do not increase rates of sexual activity (Blake et al., 2003; Kirby, 2007; Kohler et al., 2008), but do yield a number of positive outcomes. For example:

- Students in Massachusetts high schools with condom programs were slightly less likely to report having had sexual intercourse (42 percent) than those in schools without such programs (49 percent).
- Sexually active teens in schools with condom programs were twice as likely to report using condoms during their most recent sexual encounter and using condoms to prevent pregnancy (Blake et al., 2003).

The American Academy of Pediatrics recommends that schools are appropriate sites for condom distribution (AAP, 2001). A majority of parents surveyed in Minnesota and New York City agreed that condoms should be made available in high schools (Eisenberg et al., 2009).

Confidentiality Attracts Teens to Contraceptive Services

Nearly 1.5 million teen girls in need of contraceptive services turn to publicly funded clinics (Guttmacher Institute, 2009). Confidential access to contraceptive services is crucial to preventing teenage pregnancy. Publicly funded family planning clinics prevent 460,000 teen pregnancies a year. Without publicly

funded family planning services, the number of unintended pregnancies and abortions would be nearly three-quarters higher among teens (Guttmacher Institute, 2013).

In *Carey v. Population Services International*, the U.S. Supreme Court ruled that minors have a constitutional right to privacy that includes the right to obtain contraceptives (Carey). Title X and Medicaid require that family planning services be provided to adolescents and that minors' confidentiality be protected (Jones, et al., 2005).

A survey of teen girls younger than 18 who sought health care services at family planning health centers found that 60 percent said their parents knew they were there. Of those whose parents did not know they were there, 70 percent would not use the clinic for prescription birth control if parental notification was required. One in five teens would instead stop using birth control or use the withdrawal method. Only one percent of teens reported that they would stop having sex in response to parental notification mandates (Jones et al., 2005).

Twenty-one states and the District of Columbia explicitly allow all minors to consent to contraceptive services without parental consultation or permission. Most other states have adopted "mature minor" rules that authorize minors to consent to contraceptive services under certain circumstances. Only four states lack an explicit policy on minors' authority to consent to contraceptive services (Guttmacher Institute, 2014b).

Increased Insurance Coverage for Contraception Will Help Reduce Teen Pregnancy

Expanding insurance coverage for contraception is one way to improve teenagers' access to contraception. Many teenagers cannot afford to pay for contraceptive methods. Pills cost \$180–\$600 per year; injections cost \$140–\$400 per year; implants cost up to \$800; IUDs cost \$500–\$1,000 (PPFA, 2014).

Starting in August 2012, the Affordable Care Act started making contraceptives available without copay to most U.S. women. Currently, however, many

private insurance plans do not provide adequate coverage for contraception — no U.S. health care policy pays for condoms (Berne & Huberman, 1999). However, by 2002, most prescription, reversible contraceptive services and supplies were covered by at least nine out of 10 typical employer-based health insurance plans (Sonfield et al., 2004). That increase was partly due to mandates in 28 states that require insurance policies that cover other prescription drugs to also cover all FDA-approved contraceptive drugs and devices (Guttmacher Institute, 2014a). Insurance plans in states with contraceptive benefit mandates are significantly more likely to cover the leading prescription methods (87–92 percent) than plans in states without mandates (47–61 percent) (Sonfield et al., 2004).

Countries with lower rates of teenage pregnancy — the Netherlands, Germany, and France — have liberal contraceptive coverage for contraceptive pills and devices, including free contraceptive services for teenagers (Berne & Huberman, 1999). In the U.S., however, many sexually active women remain unprotected — in 2011, one in five women of childbearing age was uninsured (HHS, 2013).

Poor and Low-Income Teens Most in Need of Contraceptive Coverage

Public funding for family planning could significantly help poor (family income is at or below the federal poverty level) and low-income (family income is between 100 and 199 percent of the poverty level) teenagers prevent unintended pregnancies.

- The lack of public funding for family planning is associated with unintended pregnancy among the poor. Between 2001 and 2008, the rate of unintended pregnancy among poor and low-income women increased, and poor women are more than five times more likely than higher-income women to have an unintended pregnancy (Finer & Zolna, 2014).
- When faced with an unintended pregnancy, many poor and low-income teens are likely to view early childbearing as a positive, desirable choice, and many choose to give birth with the hope of improving their lives (Herrman, 2008; MEE Productions, 2004).

Currently, Medicaid, Title X, and the State Children's Health Insurance Program (CHIP) are three government programs that subsidize contraceptive services for poor and low-income adolescents.

- Publicly funded family planning is cost-effective — every dollar spent on publicly subsidized family planning services saves \$5.68 on costs that would otherwise be spent on medical care, welfare benefits, and other social services to women who became pregnant and gave birth (Guttmacher Institute, 2013).
- One out of every five contraceptive clients served by publicly funded family planning centers is a teenager (Guttmacher Institute, 2013).
- Nearly 1.5 million teen girls in need of contraceptive services turn to publicly funded clinics (Guttmacher Institute, 2013).
- Despite these needs, public funding for family planning has been inconsistent over the years and has decreased in many states. Federal funding for family planning rose 18 percent between 1980 and 2006, but when inflation is taken into account, funding decreased or stagnated in 18 states and the District of Columbia between 1994 and 2006 (Sonfield, et al., 2008). This puts young people at risk because poor teens who cannot afford the full cost of contraception are more likely to turn to cheaper but less effective birth control methods (Frost et al., 2008).

Poor and High-Risk Teens Need Programs Aimed at Preventing Pregnancy

Although youth development programs for poor teens, such as academic tutoring, job training and placement, mentoring, and youth-led enterprise programs, have been found to significantly reduce teenage pregnancy rates, few adolescent pregnancy prevention programs directly address the problem of poverty (Kirby, 2007).

The National Campaign to Prevent Teen and Unintended Pregnancy recently released a report highlighting innovative collaborations where school systems, health sectors, public agencies, and

community-based organizations are working together to improve graduation rates by addressing teen pregnancy prevention. These examples may prove useful and able to be replicated in other school districts and communities with both high teen birth rates and high school dropout rates (Shuger, 2012).

Lesbian, bisexual, and abused teens, as well as teens who are sexually involved with older partners, are more likely than other teens to experience pregnancy, and they may need specialized programs to address their specific risk behaviors and to help them obtain services.

- Gay and lesbian teens are two to three times as likely as heterosexual teens to report having been or gotten someone pregnant (Saewyc et al., 1999; Blake et al., 2001). Lesbian and bisexual teens are also more likely to engage in frequent intercourse — 22 percent versus 15–17 percent of heterosexual or unsure teens (Saewyc et al., 1999).
- Teenagers who have been raped or abused also experience higher rates of pregnancy — 4.5 out of 10 pregnant adolescents likely have a history of abuse. Teen girls with a history of abuse are more than twice as likely to become pregnant as peers who do not experience abuse (Noll et al., 2009).
- For women younger than 18, the pregnancy rate among those with a partner who is six or more years older is 3.7 times as high as the rate among those whose partner is no more than two years older. Adolescent women with older partners also use contraception less frequently — one study found that 66 percent of those with a partner six or more years older had practiced contraception at last intercourse, compared with 78 percent of those with a partner within two years of their own age (Darroch et al., 1999).

Some states are enacting or more rigorously enforcing statutory rape laws to curb teenage

pregnancy among women with older partners by deterring adult men from becoming sexually involved with minors. However, experts assert that statutory rape laws do not reduce rates of teenage pregnancy, but do discourage teens from obtaining reproductive health care out of fear that disclosing information about their partner will lead to a criminal charge (Teare and English, 2002).

Pregnancy Prevention Programs Must Address the Role of Young Men

Young men are often overlooked as a group that plays an important role in reducing teenage pregnancy. A national survey found that 13 percent of sexually experienced teenage men had been involved in a pregnancy in 2002 (NCPTUP, 2006). Sex educators and reproductive health care providers must therefore present pregnancy prevention as the job of both partners to foster responsible sexual choices among young men and women.

Because young men who have unprotected intercourse also tend to engage in other risk behaviors such as fighting, carrying a gun or other weapon, attempting suicide, smoking cigarettes, drinking alcohol, and using drugs (Lindberg et al., 2000), programs designed to address these behaviors should optimally include a pregnancy-prevention component.

Recognition that sexual expression is a part and parcel of adolescent development will help guarantee teenagers the right to honest, accurate information about sex and access to high-quality reproductive health services that will empower them to express their sexuality in safe and healthy ways. Lower teenage pregnancy rates will follow as a natural outcome.

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