

# PREVENTING TEENAGE PREGNANCY

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## The Problem

**Frequency.** Approximately one million adolescent women become pregnant every year, and it is estimated that two out of every five (40%) 14-year-old American girls will become pregnant before they reach their 20th birthday (85% of which will be unintended). Approximately half of adolescent pregnancies end in birth, one-third in abortion, and the rest in miscarriages. Also, one-eighth of all adolescents 13 through 19 years of age and about one-fourth of sexually experienced adolescents become infected with a sexually transmitted disease (STD), including HIV (AIDS) each year.

**Costs.** The costs of a teenage birth include less education for the mother, larger families, greater likelihood of a single-parent family, and fewer economic resources. Approximately 53% of Aid to Families with Dependent Children, a \$22.2 billion government assistance program in 1992, goes to families that started with a teenage birth.

**Contraception.** An adolescent who is sexually active and does not use any contraception has a 90% chance of getting pregnant, and, if her partners are infected, she has a 90% of contracting a STD in one year. While contraceptive use has increased among teenagers and is almost as prevalent and as effective as that of unmarried 20-year-olds, it is not used frequently enough or in the most effective manner by either group. This is because 1) a substantial number of young women are pressured or forced to have sex, often by older males; 2) most forms of effective birth control require advanced planning which adolescents do not do well; 3) contraceptive materials are not conveniently available to teenagers; and 4) some teenagers, especially those from very-low-income and/or abusive

families living in depressed or violent neighborhoods may not be sufficiently motivated to prevent pregnancy.

### **Types of Prevention Programs**

Prevention programs typically attempt to delay the initiation of sexual activity, reduce the frequency of sexual intercourse and the number of different partners, promote the use of family planning and contraceptives, prevent sexually transmitted diseases, and/or prevent pregnancies. Numerous programs have been tried, and they fall into three broad categories: 1) Education---to educate young people about sexuality, how to control their own behavior and that of their partners in sexual situations, and family planning and contraception; 2) Contraception---to make means of contraception and medical services readily available and at appropriate cost and privacy to those who are sexually active; and 3) Life options---to provide teenagers at highest general risk with reasonable life options, principally a hope for a personal future of competence and self-sufficiency, to motivate these adolescents to delay sexual activity and prevent pregnancy and disease.

### **The Effectiveness of Prevention Programs**

Research evaluating such prevention programs converges on the following conclusions:

- **No credible or consistent evidence exists that providing sexual information or even contraception will encourage the initiation or frequency of sexual activity.**
- **Several types of programs have specific positive effects that may indirectly contribute to delaying or reducing sexual activity and preventing pregnancy:**

1. Sex education programs can effectively provide information concerning reproduction and

contraception, but they do not seem to influence attitudes toward or actual sexual behavior. However, many sex education programs are short, superficial, and avoid direct discussions of family planning and contraception.

2. Family communication programs can help increase the number and frequency of discussions about values and sexual behavior among parents and their children, but no evidence exists that they directly alter sexual behavior or pregnancy rates.

3. Decision-making training can increase problem solving and communication skills, and some evidence suggests that it can delay the initiation of sexual activities and increase contraceptive practice.

4. Programs to improve school performance can boost academic achievement and prevent dropping out of school.

5. Youth employment programs can teach job skills, place teenagers in jobs, and perhaps delay the initiation of sexual activity and prevent pregnancy.

**•Providing education about and access to contraception has been demonstrated to be the most effective method of reducing teenage pregnancy rates, although how such services are delivered to teenagers influences the effectiveness of this approach:**

1. Free-standing pregnancy and family planning clinics providing no-cost services are valuable for low-income teenagers and clearly reduce births, but they are less effective at reducing pregnancies because the majority of clients have been sexually active for an average of 11 months prior to their first visit and may already be pregnant.

2. School-based and school-related health clinics that provide a variety of health services are effective at dispensing those services to high-risk populations of adolescents. While these programs

can delay sexual activity, increase contraceptive use, and lower pregnancy rates, these benefits are not always strong, consistent, or pervasive, perhaps because not all young people take advantage of the reproductive health services component of the program. School-related clinics that focus education, counseling, and family planning and contraceptive services around reproductive health and behavior education and are operated by health professionals can produce substantial delays in initiating sexual behavior, increased contraception use, and reductions in pregnancy rates, but only one such intensive program has been tried and tested.

- **Cost-benefit studies generally have not been conducted**, but the estimated costs of early pregnancy in terms of welfare, medical, food stamps, social services, and housing are so high (e.g., 20-year discounted public expenditures in 1985 were approximately \$18,000 for a birth before age 18 and \$11,500 for a birth at 18 or 19 years of age) that even the most expensive version of the most expensive approach (school-related clinics) would be cost-effective if it prevented one pregnancy prior to age 18 in every 145 adolescents it serves.

## **Recommendations**

This literature points to several recommendations.

- **Effective prevention must start early, before junior high school.**
- **The effectiveness of prevention programs varies directly with their objectives and the directness and intensity of their efforts.** Limited objectives produce results limited to those objectives; low intensity programs that do not confront the issues of abstinence, control, responsibility, family planning and contraception, and life options directly, authoritatively, and forcefully are not very effective.

- **Comprehensive integrated prevention efforts are required that take a three-pronged approach:**
  1. Education pertaining to responsible heterosexual relations, resisting the pressure to have sex, and reproductive health and behavior;
  2. Convenient, affordable, and confidential access to reproductive health services, including family planning and contraceptive materials and how to use them; and
  3. Motivation to delay sexual activity and use family planning and contraception by providing a realistic hope for current educational success and future psychological and financial self-sufficiency.
- **If they are to be effective, sex education programs conducted by the schools must be intensified.** They should cover dating, heterosexual relations and responsibilities, decision making and personal control in sexual situations as well as clear, direct, and comprehensive information regarding all types of sexually transmitted diseases, family planning and contraception, and the consequences of early childbearing. Peer leaders who are well-trained and supervised by health professionals may be particularly effective at imparting information, leading discussions, and guiding role playing on how to control sexual situations and behavior. However, programs that emphasize abstinence and delaying sexual initiation have reported average delays of only 3-7 months in high-risk groups. While this is valuable, such an approach alone has not been shown to be able to reduce substantially teenage pregnancy rates without additional programming aimed at family planning and contraception.
- **School-related health clinics operated by health professionals** (e.g., hospitals, medical schools, medical clinics) that deliver a wide-range of medical and behavioral services should be established on or near schools in high-risk areas. While delivering a variety of health

services, the reproductive health program should be a major function of the clinic. Clinic professionals should assist or conduct health and sexual health education classes in the schools, and required sexual health education programs in the schools should be linked directly with the clinics. The clinics should be open all year, at convenient hours, and should balance student confidentiality and parent's permission.

- **Youth need to be educationally, occupationally, and psychologically prepared for productive and self-sufficient lives and given a realistic hope that such goals can be obtained.** Whether conducted by the schools, public services, or private agencies (perhaps in partnership), greater efforts must be made to insist on basic educational achievement, provide personal and vocational counseling and preparation, and offer additional educational and employment opportunities for all young people who make the effort. Special efforts might include providing tutoring and remedial work, perhaps on a mandatory basis (e.g., required after school or Saturday morning tutoring, especially performed by peers who are paid and supervised by teachers); offering incentives (e.g., paying jobs for those who attain minimum levels of academic performance); and providing individualized counseling, job training, internships, and permanent employment opportunities to all students, but especially those in high-risk areas.
- **Reproductive health clinics for adolescents as well as young adults** should be increased, perhaps operating with government funds but offering services to all persons of all income levels on a sliding scale.
- **These programs and services above should be integrated** in practice at the school and local level as well as at the funding and government level.

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## **References**

This summary and its comparison report is based primarily, but not exclusively, on the following references:

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