
Risk-Focused Prevention of Early Teen Sexual Activity: Implications for Policymakers

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Worrying that their daughter will be pressured into sex is one of the two top concerns of Wisconsin parents according to recent studies of 2,129 parents (Bogenschneider & Tsay, in press). Yet parents' worries about too-early sexual activity differ from worries about other risky behaviors. Parents hope their children will never become drug users, but we do want our children to be responsible partners in sexually fulfilling relationships—someday. We want them to experience feelings of attraction to another person—someday. We just want them to wait (Kirby et al., 1994). There are many good reasons for teens to delay.

Most teens think the best age to become sexually active is later than they actually begin. Almost 9 in 10 (86%) of births to unmarried teens are unintended (Moore, 1995). These accidental pregnancies can cause feelings of guilt, exploitation, and regret (Kirby et al., 1994). Too-early pregnancies can also interfere with teens' educational goals, employment opportunities, and marriage prospects. Teenagers have the highest rates of sexually transmitted diseases. Many young adults who are HIV positive contracted the virus during the teenage years.

The costs of early sexual activity can be measured in lost potential and personal suffering of teens and their families. There are costs to society, too. Aid to Families With Dependent Children, food stamps, and Medicaid for families with children born to teenagers cost more than \$25 billion annually (Kirby et al., 1994).

This paper describes a promising risk-focused approach for preventing early sexual activity. In keeping with the objectives of Family Impact Seminars, this report gives special attention to the role of teenager's families, drawing on recent studies of Wisconsin parents in 12 primarily rural and small town communities. The paper identifies five of the country's most successful teen pregnancy prevention programs. The paper concludes with implications for policymakers who want to prevent early teen sexual activity and unintended pregnancies.

Do we know enough to prevent early teen sexual involvement?

One of the most effective prevention models of the last two decades is the risk-focused approach used to prevent heart and lung disease (Bogenschneider, in press). This model showed that heart disease rates can be reduced by informing people about the risks of smoking, inactivity, and high-fat diets and encouraging them to change their habits and lifestyles (Hawkins, Catalano, & Miller, 1992). Teenage sexual activity, like heart disease, is influenced by multiple risk factors such as problems at home and negative peer pressure at school. More risk factors mean greater danger.

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A risk factor is any hazard that increases a young person's vulnerability to early, unprotected intercourse. The presence of a risk factor does not guarantee that sexual experimentation will occur, but it does increase the odds. These risks may come from a variety of sources. Some risks stem from the teen himself or herself. Others are the result of the settings in which the teen lives—family, peers, school and work environments, and community (Bronfenbrenner, 1979, 1986).

Delaying the onset of teen sexual activity is one of the surest ways to prevent unintended teen pregnancy. Early sexual experimentation means that younger people are exposed to risk for a longer time; they will have more partners (Miller, 1995), and they are less likely to be mature enough to avoid negative consequences (Higgins, 1988). This paper identifies the risk factors for sexual initiation—the first step toward teenage pregnancy.

Risk factors for early teen sexual activity

Individual risk factors

Physical or sexual abuse. A history of physical and sexual abuse doubles the chances that an adolescent will be sexually active (Moore, Miller, Gleib, & Morrison, 1995a). It lowers the age of first sexual intercourse (Moore et al., 1995a). For sexually active girls with only one risk factor, the second most common risk is a history of abuse (Small & Luster, 1994).

Use of alcohol and other drugs. Using drugs elevates the risk that a teen will have sex before age 16 (Moore et al., 1995a; Small & Luster, 1994). Teenage boys who use alcohol or cigarettes are 39% more likely to engage in early sex. The risk is 173% higher for marijuana users and 235% higher for those who use other illicit drugs. For girls, the risk for early sex is 80% higher for those who use alcohol or cigarettes; 245% higher for those who use marijuana; and 400% higher for those who use other illicit drugs. The findings held most strongly for European American and Hispanic girls.

Involvement in other deviant behaviors. Compared with virgins, sexually active 15- to 17-year-olds are several times more likely to be involved in other problem behaviors— theft, violence, or drug use. They are more likely to be expelled or suspended from school. Teens who become involved in deviant activities at a young age are more apt to hang out with friends with more sexually permissive beliefs and behaviors (Dryfoos, 1990; Moore et al., 1995a).

Race. African American teenagers begin having sex earlier than European Americans or Hispanics (Dryfoos, 1990; McLean, 1993; Moore et al., 1995a). African American teenagers are 90% more likely than European American teenagers to have intercourse outside of marriage. After taking into account mothers' education and marital status, and teens' education and religious affiliation, African American teens are still 50% more likely to have nonmarital intercourse. When neighborhood characteristics such as median family income, racial make-up, and proportion of employed women are taken into account, the likelihood that African American teenagers would be sexually active drops to 36% higher than that

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of European American teens. Early sexuality among African American teenagers is influenced by neighborhood as well as personal and family factors (Moore et al., 1995a).

Earlier puberty. Teenagers become physically mature at younger ages than their parents and grandparents. The age at which young people are capable of reproducing has dropped by 3 months every 10 years during the last century. In 1890, girls began menstruating at the age of 15 or 16. In 1980, the average age of first menstruation was under 13 years. Young people today become fertile several years before they become mentally, socially, and morally mature. Not all adolescents mature at the same time. Some girls begin menstruating at 9 years of age; others begin at 16. Boys may reach physical maturity anytime between 10 and 17 years of age. Adolescents who mature early report sexual activity levels two to three times higher than peers who mature later (Moore et al., 1995a).

Limited religious affiliation. Adolescents who attend religious services rarely or not at all become sexually active at an earlier age than those who attend regularly (Dryfoos, 1990; McLean, 1993; Moore et al., 1995a).

Family risk factors

Single parent or disrupted family. Unmarried daughters of single parents are three times more likely to bear a child than girls living in stable families (Benson & Roehlkepartain, 1993; Dryfoos, 1990; McLanahan & Booth, 1989; McLanahan & Sandefur, 1994). Adolescents aged 11 to 17 who experienced a marital disruption are one and a half times more likely to have started having sex. The absence of a father and the presence of a stepfather are related to earlier physical maturity (Hetherington, 1993). Girls in remarried families menstruated 8 months earlier than those in intact families. Girls in divorced families menstruated 4 months earlier than girls in intact families. These early maturing girls were more apt to be sexually active.

Permissive parental values regarding teen sexual behavior. For both boys and girls, teens whose mothers have more permissive attitudes toward teen sex, those whose parents are least strict, and those who believe their mother had sex before marriage had higher levels of sexual activity (Moore et al., 1995a; Small & Luster, 1994).

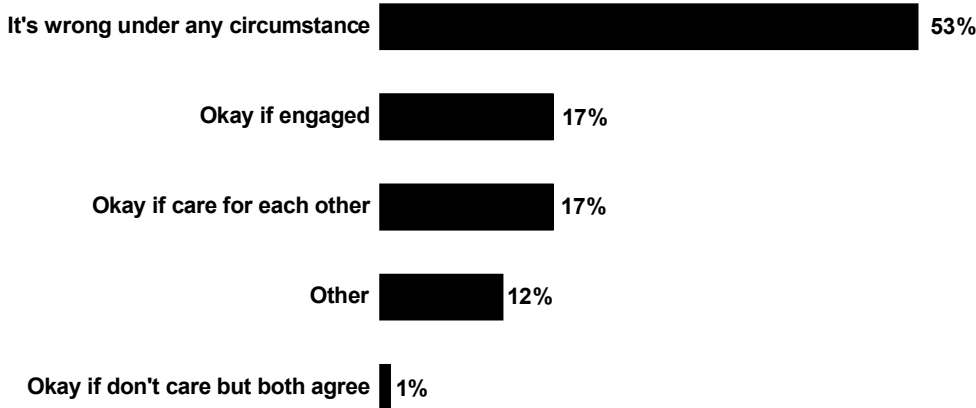
In recent studies of more than 1,600 Wisconsin parents, 7 out of 10 parents believed that premarital sex was wrong under any circumstances or okay only if the couple is engaged to be married (see Figure 1). The remaining 30% of parents were more tolerant of teen premarital sex (Bogenschneider & Tsay, in press).

Poor parental monitoring. Teens who are not closely monitored are at greater risk for early sexual activity. The effect of parental monitoring appears to be stronger for younger teens (Small & Bogenschneider, 1991; Small & Luster, 1994; Small & Silverberg, 1991). Our studies of Wisconsin parents raise questions about how well parents monitor the activities of their 8th to 12th graders. More than 8 out of 10 parents (83%) think it is *unlikely* their own child is sexually active (see Figure 2). Fewer than 1 in 10 think it *likely* their child is sexually active (Bogen-

schneider & Tsay, in press). However, in studies of almost 37,000 teens in Wisconsin, about 4 out of 10 report being sexually active (Small, 1995).

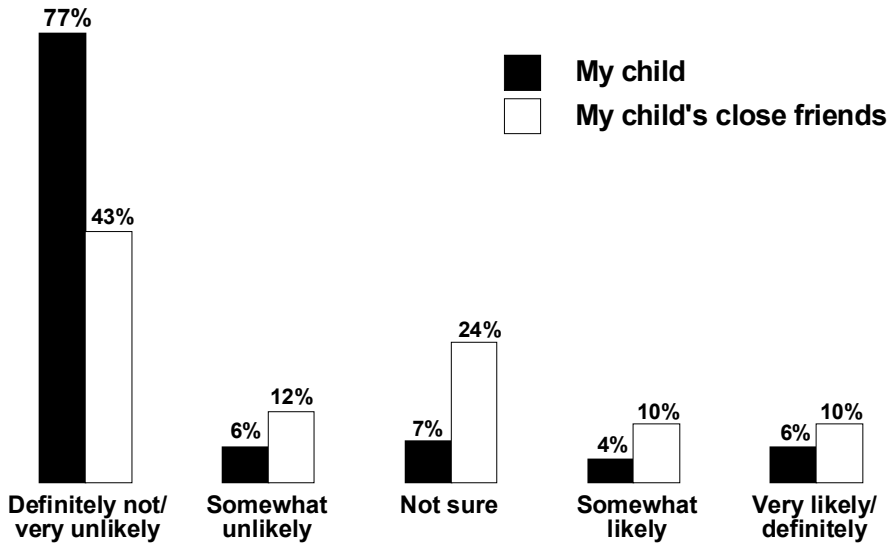
About 2 out of 10 of these parents believe their child's close friends are sexually active. Thus, parents are twice as likely to think their child's close friends are sexually active than they are to think the same about their own child. Parents seem to be saying, "Other kids are involved, but not my kid."

Figure 1. Wisconsin parents' values about premarital teen sex



Note. Graph displays data from 1995 study of 1,679 parents of 7th to 12th graders in one urban, one suburban, and two rural Wisconsin communities (Bogenschneider & Tsay, in press).

Figure 2. Reports of Wisconsin parents about the likelihood their child or their child's close friends are sexually active



Note. Graph displays data from a 1995 study of 1,292 parents of 8th to 12th graders in a rural, suburban, and urban community in one Wisconsin county (Bogenschneider & Tsay, in press).

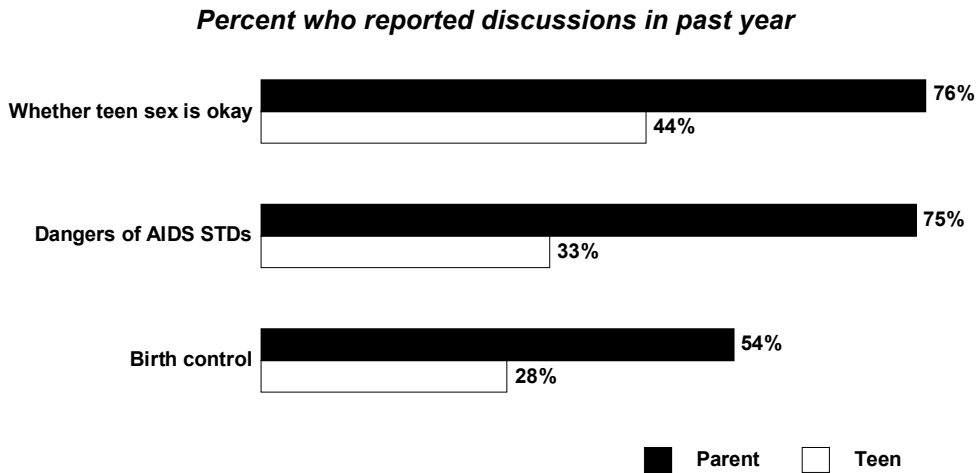
Lack of family support and closeness. Teens' attitudes and values about sex are affected by early experiences in the family and by family influences such as religious training, parental values, marital history, and parenting practices. For example, early communication patterns and the daughter's feelings about her relationship with her mother determine whether or not mothers and teenage daughters talk about sex. Without a history of open communication, it is hard for mothers to establish a pattern of frequent communication when daughters are 14 to 16 years old (Fox & Inazu, 1980). Low levels of parental support increased teen depression and alcohol use, two factors related to teen sexual intercourse. Depression has a stronger influence on sexual behavior for females; alcohol use is more important for males (Moore et al., 1995a).

Poor parent/teen communication about sex. Open family communication in general—not just communication about sexuality—may be a powerful predictor of teen sexual behavior (Fisher, 1986). Some studies reported that good communication delays first-time sex and promotes use of contraceptives, especially among daughters (Fox & Inazu, 1980; Holtzman & Rubinson, 1995; Leland & Barth, 1993; Moore, Peterson, & Furstenberg, 1986; Newcomer & Udry, 1985). Other research found the opposite (Fisher, 1986; Furstenberg, Herceg-Baron, Shea, & Webb, 1984). The reason for these mixed results may be inadequate attention to parental values, the quality of the communication, and the parent's "intent" to be either guide or protector (Fox & Inazu, 1980; Moore et al., 1995a). In one study, daughters were less likely to begin having sex when parents communicated with them, but this was true only in families where parents held traditional views about marriage, divorce, division of labor, and maternal employment. Sometimes parent/child communication is a response to the teen's sexual activity—not something that precedes it—with the parent serving more of a "protector" role (Fox & Inazu, 1980). Daughters who reported talking with their mothers about contraception were about three times more likely to have used an effective method at last intercourse than girls who said they hadn't talked about it with their mothers (Newcomer & Udry, 1985). Overall, mothers are more likely to talk with their teens about sexual issues than fathers. In general, parents report talking to teens about sexuality more often than teens say they've had this discussion with their parents (Bogenschneider & Tsay, in press; Furstenberg et al., 1984; Newcomer & Udry, 1985). About three fourths of Wisconsin parents and one half of their children reported that they had talked about teen sex and the dangers of AIDS and other sexually transmitted diseases (see Figure 3). Discussions of birth control were reported less often by only about half of parents and one fourth of teens.

One benefit of school-based sex education about HIV is that it sparks discussions between students and their parents (Holtzman & Rubinson, 1995). As shown in Figure 4, almost all of 3,146 Wisconsin parents believe sexual abstinence and the dangers and risks of getting AIDS should be taught in school. Most parents (84%) think birth control should be taught in the schools. Among those who disagree, only 5% strongly disagree (Bogenschneider & Tsay, in press).

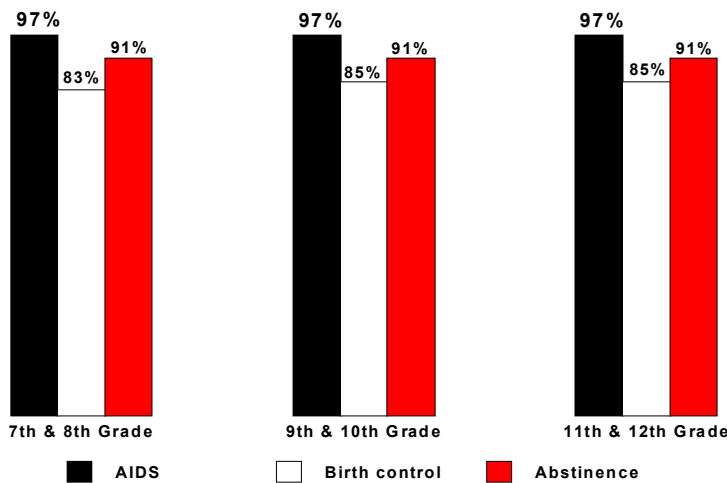
Low parental education. Teenagers with more educated parents tend to delay their first intercourse. If they are sexually active, they are more likely to take steps to reduce the risk of pregnancy (Dryfoos, 1990; McLean, 1993; Moore et al., 1995a). Having a mother who has completed high school cuts by half the chances that her daughter will have a baby before she is married. (An, Haveman, & Wolfe, 1991).

Figure 3. Wisconsin parent/teen discussions about sexual issues



Note. Graph displays data from a 1995 study of 1,299 parents and 1,225 teens in a rural, suburban, and urban community in one Wisconsin county.

Figure 4. Wisconsin parents' views on sex education being taught in the school



Note. Graph displays data from 3,132 parents in two Wisconsin counties.

For sexually active teens who report only one risk factor, having a steady boyfriend or girlfriend is the most common risk factor for both males and females.

Poverty. Teenagers from low-income families are at greater risk for early sexual activity and childbearing (Dryfoos, 1990; Moore et al., 1995a; Small & Bogenschneider, 1991).

Having older siblings. Younger siblings are more likely to be sexually active at any given age than their older siblings at the same age. Having a sister who is perceived to be sexually active or who has had a baby is related to more permissive attitudes and to having a first sexual experience at a younger age. These findings hold for European American but not for African American siblings (Moore et al., 1995a).

Peer risk factors

Perceiving one's friends to be sexually active. Among both boys and girls, perceiving that one's best friends are sexually active is the most potent predictor of the frequency of sexual intercourse. This factor also is related to a permissive attitude and a younger age of first intercourse among girls (Dryfoos, 1990; Moore et al., 1995a). What teens *believe* their peers do is a stronger influence than what peers *actually* do (McLean, 1993; Moore et al., 1995a). Teenagers tend to overestimate the number of their peers who are sexually active (Howard, 1988). Teens appear to turn to peers to compensate for the lack of a close parent/child relationship (Moore et al., 1995a).

Early and frequent dating. Females who start to date early are more apt to have their first sexual experience at a younger age. The more often adolescents date, the more likely they are to have sexual intercourse. Sexual intercourse usually begins in a dating relationship, and most ongoing sexual involvement occurs in a committed relationship (McLean, 1993; Moore et al., 1995a; Small & Bogenschneider, 1991; Small & Luster, 1994). Having a steady boyfriend or girlfriend is a powerful influence on sexual activity even when no other risk factors are present. Even teens who come from strong families, earn good grades in school, and live in a supportive neighborhood are more apt to be sexually active if they have a steady boyfriend or girlfriend. For sexually active teens who report only one risk factor, having a steady boyfriend or girlfriend is the most common risk factor for both males and females (Small & Luster, 1994).

School risk factors

Low academic achievement. Regardless of race and gender, teens who get low grades or who have been retained in a grade are more likely to be sexually active (Dryfoos, 1990; McLean, 1993; Small & Bogenschneider, 1991; Small & Luster, 1994).

Limited aspirations. Students with high educational aspirations are more likely to postpone sexual intercourse (Dryfoos, 1990; McLean, 1993; Small & Bogenschneider, 1991). Of sexually experienced male and female teenagers with only one risk factor, worry about future vocational prospects was among the most common risk factor (Small & Luster, 1994). High rates of teenage childbearing

among disadvantaged teens may be due to their perception of a bleak future. They have little motivation to delay sex or avoid pregnancy (Moore et al., 1995a).

Negative attitudes toward school. Girls with positive attitudes about school are at less risk (Small & Luster, 1995). These positive attitudes are thought to stem from a range of good experiences—a special relationship with a teacher, opportunities for leadership, or involvement in activities such as sports, music, or art (Small & Bogenschneider, 1991).

Community/neighborhood risk factors

Few employment opportunities. In communities with more job opportunities, boys are less apt to report fathering children (Dryfoos, 1990; Duncan, 1995; Moore et al., 1995a; Small & Luster, 1994). Young mothers who live in areas where there are more jobs are more apt to be married when they have children (Duncan, 1995).

Low-income, disorganized communities. Teens who grow up in communities or neighborhoods with lots of resources are less apt to be sexually active or to bear children out of wedlock. The resources that matter most are not yet clear. However, teens are less likely to have babies if they live in neighborhoods or communities where families have higher socioeconomic status, where there is less residential turnover, and where adults or neighbors monitor the behavior of teens. In general, personal and family risk factors are stronger influences on teen sexual behavior than neighborhood influences (Duncan, 1995; Moore et al., 1995a).

Permissive societal attitudes about sex. Teens are more likely to get involved in behaviors that are acceptable to the community than in behaviors that are strongly sanctioned (Baumrind, 1987). Nonmarital births have nearly doubled at every age in the last two decades (Bumpass, 1995). More than half of all marriages now end in divorce. And half of all Americans under age 40 have lived with a partner without being married. The fact that 85% of unmarried teens have had intercourse before age 20 (Bumpass, 1995) should come as no surprise. Today's youth appear to be maturing successfully into the adult roles they have observed (Bogenschneider, Small, & Riley, 1990).

Since young adults are much more accepting of sex outside marriage than older adults, it is likely that societal disapproval of teenage nonmarital sex will continue to decline. Only one fifth of all people between the ages of 20 and 29 disapprove of sex among unmarried 18 year olds. Four fifths of people over 70 disapprove (Bumpass, 1995).

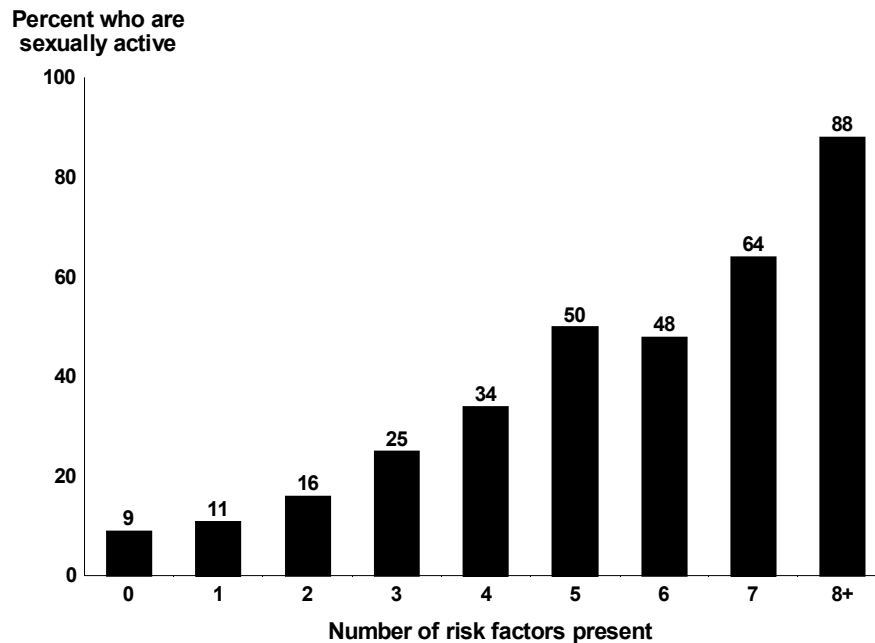
Comprehensive approaches that target multiple risks

Thus, those teens most likely to initiate sexual intercourse are those who face many risks. Sadly, these circumstances make it difficult for those youth most at risk of becoming teen parents to raise a competent, caring child (Moore et al., 1995a). According to Small and Luster (1994), those teens most likely to become sexually active have

- ❖ the least support for delay, specifically, little support from family, church, and community, and heavy reliance on peers
- ❖ the fewest restraints on sexual behavior due to poor parental monitoring, early and frequent dating, and unstable families and communities
- ❖ the fewest reasons to postpone sexual involvement (that is, limited success and involvement in school; limited aspirations; few employment opportunities; perceptions that one's friends are sexually active; permissive parent, peer, and societal values regarding teen sex)
- ❖ other behaviors and experiences that place them at risk, such as a history of physical and sexual abuse, poverty, alcohol or substance use, and involvement in other deviant behaviors

Furthermore, the more risk factors, the greater the danger. Figure 5 shows the cumulative risk that a teen will be sexually active depending upon the number of risk factors (e.g., poor academic achievement, poor parental monitoring, use of alcohol). As the number of risk factors increases, so does the likelihood that a teen will be sexually active. With no risk factors or only one or two, the chances for sexual activity are slim; With nine or more risk factors, the chances are quite high (Small & Bogenschneider, 1991).

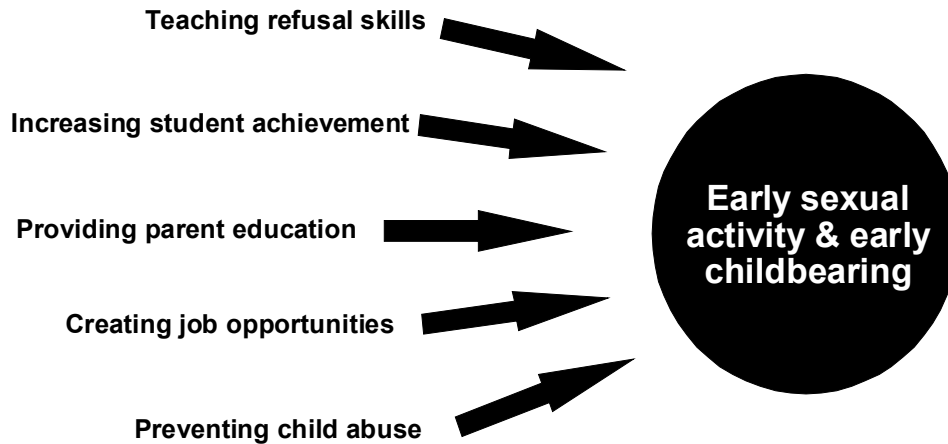
Figure 5. The cumulative risk a teen will be sexually active



Preventing early sexual experimentation requires a comprehensive, multidimensional approach (see Figure 6). Investing all efforts in a single solution is not likely to be effective, but that is what most programs have done. When we offer only sex education or family planning in the school (Brooks-Gunn & Furstenberg, 1989) we give scant attention to providing teens with goals and a

reason to postpone parenthood. Strong families and communities are important to preventing early sexual activity. They could be more involved. Churches and youth organizations could provide sex education. Older youth could teach younger peers refusal skills. Schools could increase student engagement and boost grades. Parent educators could begin when children are young to improve parent/child relationships and communication. Communities could launch campaigns to provide jobs and prevent child abuse.

Figure 6. Multidimensional program focus



There are no simple solutions. Promoting healthy development and encouraging wise and responsible decisions by our young people requires creating the many conditions that can nurture and support them. Some prevention programs which have done just that are described in the next section.

Successful teenage pregnancy prevention programs

Policymakers want an answer to the question, “Do teenage pregnancy prevention programs work?” (See also Howard and Vincent in this report.) In a recent article in a reputable scientific journal, the authors identify five prevention programs with rigorous evaluations (Frost & Forrest, 1995). Their conclusion: All five programs were successful in delaying sexual involvement, increasing contraceptive use, or preventing teen pregnancy for some teens. The programs and their results are described in Table 1 (for full details on these programs, see Miller, Card, Paikoff, & Peterson, 1992; Frost & Forrest, 1995; Webster & Weeks, 1995).

Overall, four of these programs delayed the onset of sexual activity among teenagers, three increased contraceptive use, and three reduced pregnancies. These five carefully evaluated programs answer some questions frequently raised by policymakers and programmers (Frost & Forest, 1995).

- ❖ **Do we know how to delay initiation, increase contraceptive use, and prevent pregnancy?** The simple answer is yes. Using slightly different methods, each of these flagship programs changed the behavior of teens. Unfortu-

Table 1. Five rigorously evaluated teenage pregnancy prevention programs

Program	Program description	Program intensity	Population	Results
Postponing Sexual Involvement, Atlanta, Georgia	Older teenagers (11th and 12th graders) teach younger peers how to recognize and resist pressures to become sexually active. Strong abstinence message. Contraceptive use taught by staff from nearby clinic.	10 classes over 3 months	8th graders, low income, urban, Black	Delayed sexual initiation for males and females with the strongest effects for males; increased contraceptive use; reduced pregnancies
Reducing the Risk, California	Trained high school teachers teach adolescents skills to resist risky behaviors including sex education, refusal skills, and contraceptive education; promotes discussions between parent and child.	15 classes over 3 weeks	9th and 10th graders, mixed income, rural and urban, mixed race and ethnicity	Delayed sexual initiation; increased use of contraceptives; increased discussion with parents.
School/Community Sexual Risk Reduction Program, South Carolina	A multifaceted approach including a sex education curriculum; graduate level training for school personnel; training of peer leaders; a mini-course for clergy, church leaders, and parents; media campaign; job placement; referrals to physicians and other health professionals.	Varied	14-17 year olds, low income, rural, mixed race	50% reduction in teen pregnancies.
Self Center, Baltimore	School-based sex and reproductive health education and counseling with medical services at a nearby clinic. Social worker/nurse practitioner staffed school's Self Center in morning and made appointments for nearby clinic where they worked in afternoon.	Continuous	Middle and high school students, low income, inner city, mostly Black	Delayed sexual initiation; increased contraceptive use; reduced pregnancies (only girls were studied).
Teen Talk, Texas and California	A 12-15 hour curriculum on sex education taught at community agencies and one school; included abstinence, life skills, and contraceptive education; designed to be implemented by trained staff.	6 sessions (12-15 hours) over 2-3 weeks	13-19 year olds, low income, rural and urban, mixed race and ethnicity	Delayed sexual initiation, only among boys.

nately, not all prevention programs are likely to be as effective as these five. Most programs targeted teens in the school setting, but some addressed risks in families and communities as well. The success of the School/Community Sexual Risk Reduction Program in South Carolina is credited to its targeting of multiple risk factors.

- ❖ **Can programs succeed by promoting both abstinence and contraceptive use?** Again, the answer is yes. Three of these programs delayed the initiation of sexual activity, while also increasing contraceptive use among those who are sexually active.
- ❖ **Do these programs work equally well for all adolescents?** No. Programs were more successful in delaying sexual activity with younger teens than older teens. Most of the participants in these successful programs were African Americans living in low-income areas. We don't know if the programs will work as well with teens of other races or incomes.
- ❖ **What are the features of the programs most effective in preventing teen pregnancy?** The two programs most successful in preventing pregnancy were most active in providing access to contraceptive services.
- ❖ **Can these programs be improved?** Yes. These programs reduced teen sexual initiation by an average of 15% and contraceptive use by an average of 22%. None of these programs persuaded all teens to delay sex, use contraceptives, or avoid pregnancy.

Implications for policymakers

The intent of this briefing report is not to lobby for specific policies, but to encourage debate about the potential consequences of a range of policy strategies. I do not present an exhaustive review of implications for policymakers. Instead, I briefly summarize policy options from sources spanning the political spectrum. These implications may be used as a checklist when considering proposed policies and programs to address the problems of teen sexuality. Some of these options may be more important in some settings or communities than others.

- ❖ **Avoid the easy answers.** Solutions must target multiple risk factors in several parts of the teen's world (Bogenschneider et al., 1990). There are many causes, and no single strategy will work for every teenager. Policy and programs should consider questions such as these: "What risk factors are addressed?" "Do I address several risk factors in different parts of the teen's world?" Limiting programs to only the school setting will miss the adult males who impregnate many young teenagers. According to Ooms (1995), all teenagers are at risk but disadvantaged teenagers may be at greatest risk. These high-risk teens need the most complex, multifaceted, and expensive solutions.
- ❖ **Adapt programs to the values of the family, culture, and community.** We cannot be sure that the risk factors identified in this paper apply equally to

Solutions must target multiple risk factors in several parts of the teen's world.

all youth and families and to communities with different cultures, religions, economic conditions, and histories (Bogenschneider et al., 1990). Can policies recognize and take into account diverse views on teenage pregnancy and allow parents to select a teen sexuality curriculum that is appropriate for their child? Can policies encourage communities to choose a prevention strategy consistent with local values and priorities?

- ❖ **Act to strengthen families.** (Moore, Sugland, Blumenthal, Gleib, & Snyder, 1995b). Most parents, like most adolescents, want to delay pregnancy (Moore et al., 1995b; Wells, 1992). Many parents could benefit from advice on how to accomplish this goal. Programs that begin early hold the greatest promise, since communication patterns are established long before the teenage years. For example, the Perry Pre-School Program, intended to prevent school failure, ended up preventing more than poor report cards. This daily high-quality preschool program for low-income 3- and 4-year-olds included frequent home visits and monthly parent meetings. As teenagers, program participants were less likely to become pregnant than those who did not participate (Moore et al., 1995b).
- ❖ **Involve peers.** Peers can be powerful role models and sources of support (Moore et al., 1995a). Older students can teach younger kids to recognize pressures to become sexually active and to practice refusal skills. Peer educators who encourage others to delay sex are, themselves, more likely to wait (Moore et al., 1995b). Peer approaches could be even more effective if they were accompanied by programs for parents on their role in prevention and by school and community campaigns to reduce negative peer pressure (Bogenschneider, 1994).
- ❖ **Pay more attention to the role of men and boys.** (Ooms, 1995). Traditionally, efforts to reduce out-of-wedlock childbearing have focused on changing the behavior of young women. There has been little attention to the role of men (Moore et al., 1995b; Ooms, 1995). Few prevention efforts target the older males who are responsible for two out of three pregnancies in young women under the age of 19. And few acknowledge the role sexual coercion plays in early sexual activity among females (Moore et al., 1995a).
- ❖ **Consider marriage as one viable resolution to teenage pregnancy.** The main reason for the increase in nonmarital births is not higher rates of teen sexual activity; it is lower rates of marriage. Yet, the discussion of marriage for teenage parents is almost taboo (Ooms, 1995). While marriage is probably not right for all teens, it might be right for some. More research and discussion is needed on teen marriages. These marriages may be more resilient than previously believed (Ooms, 1995). Marriage may also benefit fathers who sometimes cut back on deviant behaviors when they assume responsible work and family roles (Steinberg, 1991).

- ❖ **Improve education.** Improving school achievement of low-income males and females may have the unexpected effect of reducing teen births. Improving academic achievement among teens could reduce nonmarital births, especially in the next generation (An et al., 1991; Ooms, 1995).
- ❖ **Work to prevent all kinds of risk.** Prevention efforts aimed at alcohol and other drugs, violence, and truancy may work indirectly to prevent teen pregnancy. Risky teen behaviors often occur together; efforts to prevent one may prevent others.
- ❖ **Set realistic and well-defined goals.** (Wells, 1992). Is the intent of the policy or program to prevent early onset of sexual activity? Among sexually active teens, is the goal to promote contraceptive use? Is the goal to prevent HIV infection since some of our most effective contraceptives leave teens at risk of HIV? Will programs be most effective if focused on all teenagers? Would targeting high-risk neighborhoods or communities be more efficient?
- ❖ **Intervene early and continuously.** (Dryfoos, 1990). Nationwide, 9% of 12 year olds and 16% of 13 year olds have had sexual intercourse (Frost & Forrest, 1995). Even our most successful prevention programs do not work after teens become sexually active (Howard & McCabe, 1990). Furthermore, ongoing efforts help ensure that healthy behaviors are sustained (Dryfoos, 1990).
- ❖ **Develop age-appropriate programs and policies.** A program that is effective for early adolescents may be ineffective for older teens. For example, teens teaching refusal skills to younger peers is one of the most effective prevention strategies (Howard & McCabe, 1990), especially if implemented between 6th and 9th grade when peer pressure peaks (Steinberg, 1991). Prevention programs are more effective if they are calibrated to advances in adolescents' thinking as they mature. Prevention programs for children younger than 11 or 12 should focus on the immediate, concrete results of being involved in risky behaviors. The argument that your clothes won't fit and that your friends and teachers will look at you differently works with younger teens. They are less impressed by the argument that getting pregnant may interfere with their educational plans. Adolescents older than 13 are more able to see the long-term consequences of their actions and imagine how they would handle them (Steinberg, 1991). Policymakers should consider whether policies on parental consent and notification should be the same for parents of 14 year olds as those for parents of 19 year olds.
- ❖ **Make a long-term public commitment led by state and local leaders.** (Wells, 1992). Success may depend on whether we attack teen pregnancy with the same enthusiasm and commitment we have invested in welfare reform, property tax relief, or keeping jobs in the state. In the upcoming elections, will teen pregnancy surface in the campaigns of candidates for school boards, the legislature, Congress, and the presidency? Are citizens content to do nothing or to respond half-heartedly? Or will citizens demand that youth and family issues be a high priority?

Summary

Most teens become sexually active at a younger age than they think is best. This paper identified multiple factors that increase the odds of early sexual involvement. This risk-focused approach to prevention holds promise if policies and programs make a real attempt to reduce the number of risks teens face and enhance their ability to resist those risks.

The paper highlights five teen pregnancy programs that have delayed sexual initiation, increased contraceptive use, and reduced pregnancies. Programs like these can be successful in changing teen behaviors. This success will be short-lived, however, without strong family, peer, and community support to ensure that healthy behaviors, once begun, are sustained.



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