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# Preventing Teenage Pregnancy: New Dilemmas and New Solutions

*Marion Howard*

## What is the problem?

**W**hy do we have a continuing unacceptably high rate of births to young people? The basic answer is clear—it is a change in our culture combined with a biological change in beginning fertility. Adult attitudes, values, and behaviors surround young people with inconsistent, often conflicting and, many times, negative messages about responsible sexual behavior. The impact of change on youth from a more conservative and consistent culture to this new one is compounded by the fact that the beginning age of fertility has been lowering 3 months every 10 years for the last 100 years. Whereas a hundred years ago, on the average, girls did not become fertile until around age 17; half of all girls now have the capacity to become pregnant before age 12! Boys' fertility follows roughly a year later.

The result of these two changes is that we now have a generation of youth who are making decisions about sexual actions in an environment that is sexually provocative but contains few sexual rules. They are making these decisions without having completed some of the most important phases of their growth and development, including their cognitive, psychosocial, and moral growth. Indeed, without yet knowing fully who they are, and without yet being able to clearly see the consequences of their actions, young people are deciding to have sexual intercourse, deciding protection is an option rather than a necessity, and deciding to have a baby before they have a chance to complete their education and become financially self-supporting.

## What can we do?

We cannot change the biological clock. And it is unlikely we can quickly change our culture. Therefore, as our young people grow to sexual maturity within our current framework, it is important to help them manage their sexual actions as responsibly and as consequence-free as possible. Three approaches—*insulation*, *minimization*, and *delay of onset*—have been suggested as ways to help youth manage their participation in a variety of negative health behaviors such as smoking, drinking, or other drug use, as well as premature sexual involvement.

### Insulation

As applied to interventions in the field of teenage pregnancy prevention, it is clear that insulating young people from the harmful effects of sexual behavior has been the major intervention choice by health professionals over the last two decades. Since pregnancy at a young age is seen as being potentially harmful to both the teenage parents and their offspring, health service providers have sought to pro-

vide birth control services to young people, seeing use of contraceptives as potentially the most successful intervention in pregnancy prevention.

The difficulty in applying this insulating approach has been the ambivalence of society regarding sexual behavior, particularly sexual behavior among young people. Although there generally has been positive acceptance of other health measures designed to protect children from negative health outcomes, there has been no such mandate for contraceptive use. For example, it is acceptable when schools require immunizations before children can attend classes, but schools can become battlegrounds when clinics in schools want to provide methods of protection against pregnancy or sexually transmitted diseases, or even when teachers or counselors want to refer young people to health centers where such services are available. Sometimes, even the notion of providing factual information in school classrooms about the various kinds of birth control methods and how to use them effectively, has met with opposition.

Adults who wonder why adolescents do not use contraception often cannot conceptualize the world as it is experienced by adolescents—a world in which confusing and conflicting messages occur. For example, there is no advertising of contraceptives on television, even for adults. There is no role modeling in the movies or on television of adults using contraceptives as a part of daily lives. There are no sanctioned supportive measures in the teen world, such as using school buses to transport youth to health clinics. Because society is fundamentally ambivalent about sexual behavior among youth, there are no public attitudes that make teenagers feel proud when they use contraception. Most often, it is left to adolescents to overcome their own ignorance and concerns about birth control, to find their own motivation to use birth control, to arrange their own transportation to get to services, to develop their own courage to face adults, some of whom are likely to disapprove of adolescent sexual behavior and, by association, their need for and use of contraception. Hence we live in a society that has never really tried a genuine “contraceptive approach” to preventing teen pregnancy.

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### **Minimization**

Another suggested strategy is to help young people *minimize* their involvement in sexual behavior, thereby reducing the likelihood of harmful outcomes. This might include limiting involvement in sex to short term experimentation or limiting the number of partners an adolescent might have over an extended period. Although pregnancy can occur at any time, satisfying curiosity about sex, particularly if birth control is used, and then not engaging in sexual relations further, could reduce the possibility of pregnancy. Since adolescents who obtain birth control have difficulty in using it consistently, minimization of sexual involvement could reduce the likelihood of pregnancy, even among youth who have sought out contraceptive methods. This approach rarely has been tried with adolescents. Because of societal ambivalence about teenage sexual involvement, interventions aimed at minimizing (not total prevention of) sexual involvement have not been forthcoming. Primarily they have been used with girls who already have given birth to a

baby. This approach to *minimization* makes the young person pay a “one pregnancy penalty” before intensive support is given.

### **Delay of onset**

Yet another approach is to help adolescents delay the onset of behaviors that have potentially harmful consequences. This approach may be a particularly appropriate one for application to sexual behavior because sexual intercourse is the one behavior (as opposed to smoking, drinking, or drug use) that adults expect and want young people to engage in later on in life.

Delaying the onset of sexual behaviors has long been an implicit approach to preventing teenage pregnancy. Most of the older adults in our society grew up in a time when it was generally understood by adults and youth alike that young people were not to have sexual intercourse. However, recently it has been necessary to make messages about remaining abstinent more explicit. This has been needed because of a change in adult sexual values and behaviors that has led to a change in adolescent sexual behavior. As marriage has been pushed to older and older ages, as more than half of all marriages end in divorce while people are still very young, as sexual behavior outside of marriage has become more common and accepted, as sexual actions among unmarried people have been regularly displayed to young people by the media, young people have lost the role models needed to help them believe that abstinence is their best choice. In the 1970s, abstinence among adolescents was the norm. For example, only 4.7% of 15-year-old girls had had sexual intercourse. By the late 1980s, however, over five times as many girls were sexually involved at that age.

The philosophy of *delaying the onset* is to allow young people to postpone behaviors with potentially harmful consequences until they are older and can more clearly see the implications of their behavior on their future. The delay also is intended to help young people postpone such behaviors until they are old enough to take full responsibility for the consequences of their actions.

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### **How can we use these approaches?**

Educational interventions that appear to offer promise of reducing teen pregnancy are those that incorporate more than one approach, for example, *insulation* and *delay of onset*. These interventions are aimed at helping young people manage their sexual behavior, by both refraining from sexual activity and protecting themselves if they do have sexual intercourse. These multiple approach interventions have received intensive evaluation and have demonstrated reduction in sexual involvement, increase in birth control use, reduction in teenage pregnancy.

The successful programs tend not to be didactic but more experiential for young people, helping them to personalize risks. Such programs are developmentally appropriate, presenting information and services one way to younger adolescents, another way to older adolescents. They also are skill based, helping young people actually develop abilities to deal with social and peer pressures toward sexual in-

volvement or negotiate systems and interpersonal relationships to obtain and use birth control.

These programs try to change perceptions of peer norms—making it more acceptable to refrain from sexual activity or more acceptable to use contraception. Such programs are value based—often they are designed to support a given value—such as avoidance of sexual intercourse or pregnancy at young ages. Some of the programs also are linked to health care settings that offer birth control services.

One intervention, Postponing Sexual Involvement, was able to significantly delay sexual involvement throughout both the 8th and 9th grades among low-income male and female youth who were given the program as opposed to such youth who did not have the program. In the 8th grade, low-income youth who did not have the program were four to five times more likely to become sexually involved. At the end of the 9th grade, there was still a one-third reduction in sexual involvement among low-income boys and girls who had had the program as opposed to those low-income youth who had not participated. Among those low-income youth who became sexually involved, if they had had the Postponing program, they were more likely to limit involvement in the behavior. Moreover, at the end of the 9th grade, low-income youth who had the combined program were more likely to use birth control and twice as likely to say they used it because of what they learned in school. Pregnancies also were reduced.

As implemented in its home community, Atlanta, Georgia, Postponing Sexual Involvement for Young Teens was added to a Human Sexuality module that provided factual information on anatomy and physiology of the reproductive system, becoming a parent, sexually transmitted infections, birth control, and decision-making. One unique feature of the combined program was that the Grady Memorial Hospital Adolescent Reproductive Health Center trained 11th and 12th grade Teen Leaders to present the five classroom period Postponing Sexual Involvement part of the program in the 8th grade. Under the supervision of the Center's adolescent counselors, the teen leaders provided information designed to help adolescents explore attitudes and feelings about managing physical feelings within relationships. They also taught adolescents skills to resist social and peer pressures to become sexually involved and served as role models of youth who were successful in the teen world without being sexually involved.

The success of the middle school intervention has led the Atlanta Public Schools to adopt a three-tier approach to pregnancy prevention. An age-appropriate adaptation of the middle school program is now being put in place in all elementary schools (Postponing Sexual Involvement for Preteens), and an age-appropriate adaptation is also being implemented in the upper grades (Postponing Sexual Involvement in High School). Thus students in the Atlanta Public Schools will receive consistent messages regarding abstinence in elementary, middle, and high

school. Information about protecting themselves from pregnancy and disease and links with community health care services will continue to be an integral part of the comprehensive approach so that the harmful effects for young people who experiment with sex are minimized.

### Implications for policymakers

Currently young people's sexual behaviors range all along a continuum. They need appropriate assistance wherever they are. Neglecting any one segment of youth limits our effectiveness in changing societal and peer norms regarding appropriate management of sexual feelings and behaviors, and reducing the incidence of teen pregnancy.

Combining *delay of onset*, *minimization*, and *insulation* can provide a positive set of strategies. For example, greater funding for school/health agency cooperation on teen pregnancy prevention could increase the likelihood of helping students receive linked information and services—encouraging health agencies to facilitate innovative programs in schools, including those aimed at delay of onset. It could also help schools facilitate better use of established community health services making them more youth accessible and friendly. Not all funding for interventions that could make a contribution to helping youth better manage their sexual behavior in today's society, needs to be new funds. Allowing existing funds to be used more creatively would help. Family planning programs, for example, are traditionally judged on how many patients they see in their family planning clinics, not on how many teens don't need to come because the programs reached out and helped them delay sexual involvement.

However, as we struggle with how to prevent teenage pregnancy, defining *teenage pregnancy prevention* as the problem may structure thinking about solutions in ways that prevent the very outcomes we are trying to achieve. Indeed, teenage pregnancy itself may be a consequence of other problems that we as a society are facing. In order to be successful at lowering teenage pregnancy to acceptable levels, do we need to address broader issues to overcome fundamental societal deficits along with supporting individual program strategies? For example:

- ❖ **Is the real problem that biological maturity has outstripped psychosocial maturity for our young and our society has not yet made appropriate adjustments?** Puberty is now occurring earlier (average age 12 for girls) while cognitive, psychosocial maturation is not completed until much later in adolescence. Is it realistic to expect immature youth to manage sexual feelings and behaviors in ways that avoid risk until society is ready to have them marry and bear children—minimally after they have finished high school, probably gone on for further education and training, and worked for a while? Cross-culturally, young people usually have become sexually involved around the time of puberty unless there have been strong societal restraints. Currently there are few societal constraints; indeed, there are many societal pressures *toward* unhealthy sexual involvement. The media keep sexual images constantly on the minds of young people and

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show sex in a superficial stereotyped way while adults feel free to avoid sexual restraint.

- ❖ **Is the problem that, in our society where unskilled untrained labor is not needed, we have no role for youth until they are out of their teens and educated?** Adolescents who have little or no hope of finding jobs that will help them escape from poverty are less likely than others to see the merit of future planning, including family planning. Racial discrimination compounds that problem. Even if one graduates from high school, if the best job one is ever going to have is behind a fast food counter, why postpone parenthood? If the violence in one's neighborhood makes one unsure there will even be a future, why postpone anything? Do young people also think they have to have sex or have a baby to *be somebody* because they are coming through systems that do not show them we love them, care about them, and have an immediate genuine need for them?
- ❖ **Is the problem how we view parenthood or are acting as parents?** Today, the majority of children in the United States have lived in a single parent home at one time or another. Children may see one or both parents date and become sexually involved with someone to whom they are not married. Are parents so involved with themselves and meeting their own needs that they do not take time to meet the needs of their children? Do parents need to be given a clearer indication of how their changed attitudes and behaviors affect our country's youth?
- ❖ **Is the problem that adults have not resolved problems between the sexes and this legacy is being passed to the young?** Battering, rape, and incest affect more women in our country than any other industrialized nation. Who teaches young men and young women to be caring and respectful of each other? Without that as a basis for a relationship, how can issues of abstinence and pregnancy prevention be resolved by youth?

Teenage pregnancy has become an enduring problem in our society. There are no simple solutions. We need to hold up a mirror to ourselves and other adults around us and ask: How do we, how does our society, role model what it means to be a man, what it means to be a woman, what responsible sexual behavior is? What do we need to change? How can we do it? When we can answer that, we will be closer to a solution of preventing teenage pregnancy.

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