Teenage Pregnancy in Developed Countries

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Although adolescent fertility rates have been declining in the United States, as they have in virtually all the countries of western and northern Europe, teenage fertility is still considerably higher in the United State than in the great majority of other developed countries. There is a large differential within the United States between the rates of white and black teenagers. However, even if only whites are considered, the rates in the United States are still much higher than those in most of the other countries. The gap between the United States and the other countries is greater among younger adolescents (for whom the great majority of births are out of wedlock and, presumably, unintended) than it is among older teenagers. Abortion rates are also higher among U.S. teenagers than among adolescents in the dozen or so countries for which there are data.

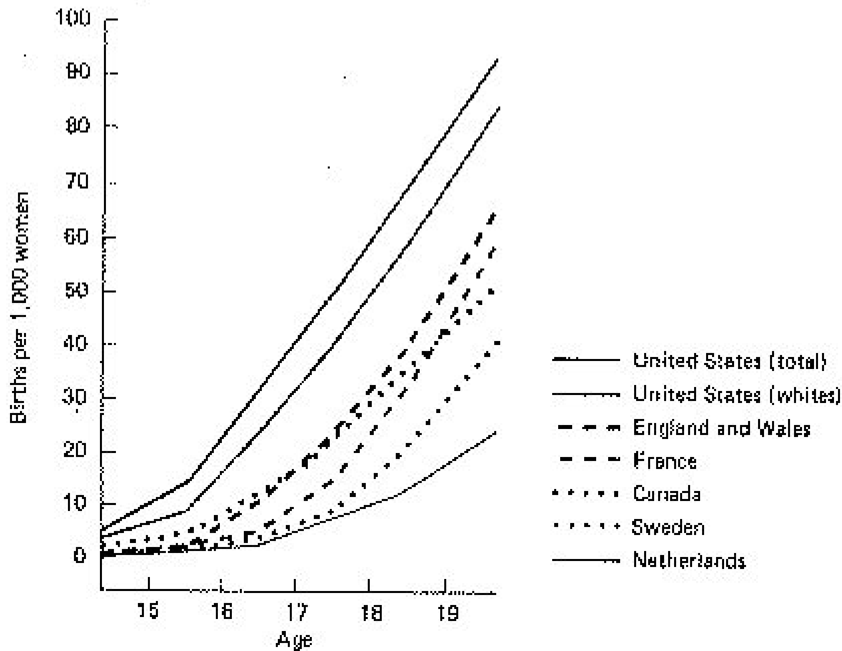
Two major questions were suggested by these comparisons: Why are teenage fertility and abortion rates so much higher in the United States than in other developed countries? And, since most teenage pregnancies in the United States are unintended, and their consequences often adverse, what can be learned from the experience of countries with lower adolescent pregnancy rates that might be useful for reducing the number of teenage conceptions in the United States?

Case Studies

The five countries selected for the case studies in addition to the United States - Canada, England and Wales, France, the Netherlands and Sweden - were chosen on the basis of three considerations: Their rates of adolescent pregnancy are considerably lower than that of the United States, and it was believed that sexual activity among young people is not very different; [and] the countries are similar to the United States in general cultural background and stage of economic development....

Figures 1, 2 and 3 present, for the United States and each of the five countries, 1981 birthrates, abortion rates and pregnancy rates by single year of age. The exceptional position of the United States is immediately apparent. The U.S. teenage birthrates, as Figure 1 shows, are much higher than those of each of the five countries at every age, by a considerable margin. The contrast is particularly striking for younger teenagers. In fact, the maximum relative difference in the birthrate between the United States and other countries occurs at ages under 15. With more than five births per 1,000 girls aged 14, the U.S. rate is around four times that of Canada, the only other country with as much as one birth per 1,000 girls of comparable age.

Figure 1 *Births per 1,000 women under age 20, by woman's age, case-study countries, 1981*



Teenagers from the Netherlands clearly have the lowest birthrate at every age. In 1981, Dutch women aged 19 were about as likely to bear a child as were American women aged 15-16. The birthrates are also very low in Sweden, especially among the youngest teenagers. Canada, England and Wales, and France compose an intermediate group. Birthrates are relatively high for Canadian girls aged 14-16, and rise gradually with age. The French rates are low among women up to age 18, but increase very sharply among older teenagers.

In 1981, as Figure 2 shows, the relative positions of the countries with respect to abortion are surprisingly close to the pattern observed for births. The United States has by far the highest rate, and the Netherlands, very much the lowest, at each age. French teenage abortion rates climb steeply with age,* while the Canadian curve is somewhat flatter. The rate for England and Wales rises relatively little after age 17. The chief difference between the patterns for births and abortions involves Sweden, which has age-specific abortion rates as high as, or higher than, those of any of the other countries except the United States.

The teenage pregnancy rates necessarily follow the same pattern, as Figure 3 reveals. The U.S. rates are distinctly higher than those of the other five countries; the Dutch rates are clearly lower. The French teenage pregnancy rates appear to be low among teenagers 16 and younger, and after that age, to be high. The reverse is true of Canada. [Teenage pregnancy rates are calculated as the sum of births and abortions experienced by women of a given age divided by the midyear estimate of the female population of that age.]

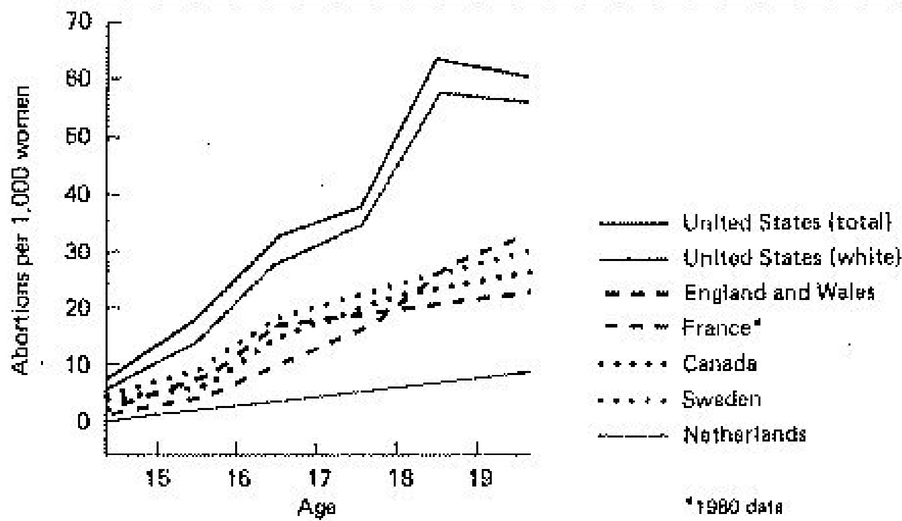


Figure 2 *Abortions per 1,000 women, by woman's age, 1981*

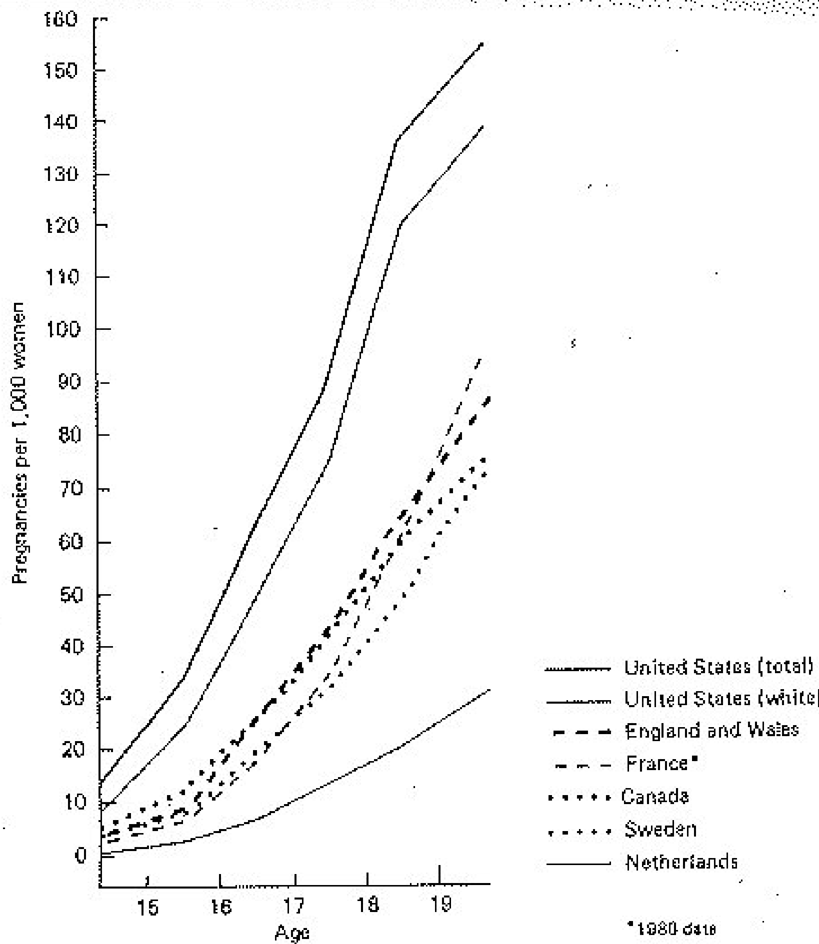
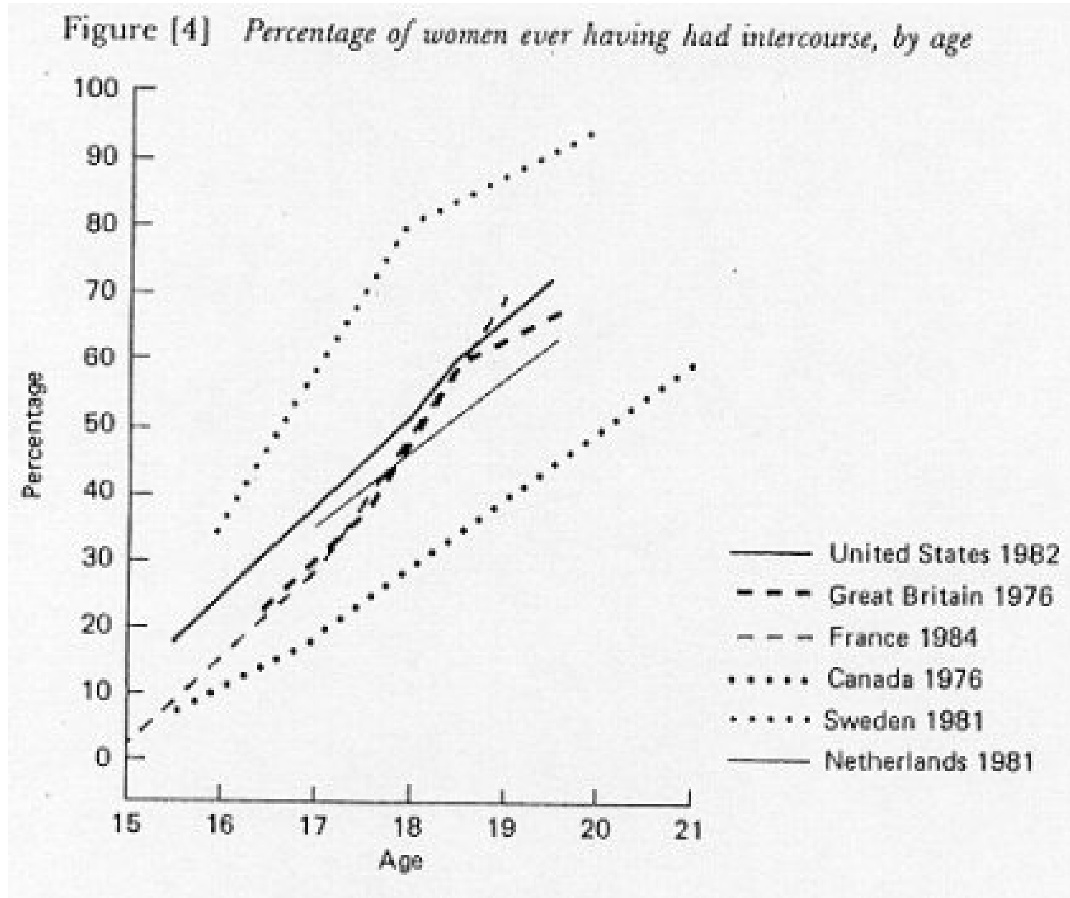


Figure 3 *Pregnancy rates per 1,000 women by woman's age, 1981*



Thus, the six countries represent a rather varied experience. At one extreme is the United States, which has the highest rates of teenage birth, abortion and pregnancy. At the other stands the Netherlands, with very low levels on all three measures. Canada, France, and England and Wales are quite similar to one another. Sweden is notable for its low adolescent birthrates, although its teenage abortion rates are generally higher than those reported for any country except the United States. It is noteworthy that the United States is the only country where the incidence of teenage pregnancy has been increasing in recent years. The increase reflects a rise in the abortion rate that has not been completely offset by a decline in the birthrate. For both younger and older teenagers, the disparity between the U.S. pregnancy rates and those for other countries increased somewhat between 1976 and 1981.

In the United States, the pregnancy rates among black teenagers are sufficiently higher than those among whites to influence the rates for the total adolescent population, even though in 1980, black teenagers represented only 14 percent of all 15-19-year-olds. Restriction of the international comparisons to pregnancy rates among white U.S. teenagers reduces the difference between the United States and other countries by about one-fifth. However, the pregnancy rate for white U.S. adolescents remains much higher than the rates for the teenage populations in the

other countries, as shown in the table [below]. What is more, some of the other countries studied also have minority populations that appear to have higher-than-average teenage reproductive rates (e.g., Caribbean and Asian women in England), so that it would not be appropriate to compare white U.S. rates with rates for the total adolescent population in those countries.

A common approach was established for the study of the six countries selected for close examination. Detailed information on teenage births and abortions was collected, and a systematic effort was made to assemble quantitative data on the proximate determinants of pregnancy - specifically, the proportion of teenagers cohabiting, rates of sexual activity among those not living together and levels of contraceptive practice. In addition, the investigators sought descriptive material on a number of related topics: policies and practices regarding teenage access to contraceptive and abortion services, the delivery of those services, and the formal and informal provision of sex education. Several aspects of teenage life were explored to try to enhance understanding of certain social and economic considerations that might influence the desire to bear children and contraceptive practice. These include the proportions of young people in school, employment and unemployment patterns, the move away from the family home, and government assistance programs for young people and, particularly, for young unmarried mothers.

Teams of two investigators each visited Canada, England, France, the Netherlands and Sweden for one week and conducted interviews with government officials, statisticians, demographers and other researchers, and family planning, abortion and adolescent health service providers. These interviews provided the opportunity to discuss attitudes and other less tangible factors that might not otherwise have been possible to document, and helped the investigators to identify other sources of data.

The five countries that were visited and the United States have much in common. All are highly developed nations, sharing the benefits and problems of industrialized modern societies. All belong essentially to the cultural tradition of northwestern Europe. All have reached an advanced stage in the process of demographic transition. Life expectancy is over 70 years for men and women of all the countries. Finally, all have fertility levels below that required for replacement. Yet, as Figure 3 demonstrates, teenage pregnancy rates in the six countries are quite diverse. However, the consistency of the six countries' positions in Figures 1 and 2 points to an immediate and important conclusion: The reason that adolescent birthrates are lower iii the five other countries than they are in the United States is not more frequent resort to abortion in those countries. Where the birthrate is lower, the abortion rate also tends to be lower. Thus, the explanation of intercountry differences can focus on the determinants of pregnancy as the antecedent of both births and abortions.

The Desire for Pregnancy

Are the differences in adolescent birthrates due to the fact that in some countries, higher proportions of young women choose to become pregnant? The number of marital births per 1,000 teenagers is higher in the United States than in any other of the countries studied, and the

proportion of teenagers who are married is at least twice as high in the United States as in the other countries (not shown). Data on teenagers' pregnancy intentions are available only for the United States. In 1980, 76 percent of marital teenage pregnancies and only nine percent of nonmarital teenage pregnancies were intended. On the assumption that all pregnancies ending in abortions are unintended, and that a large majority of nonmarital births are the result of unintended pregnancies (except in Sweden, where nonmarital childbearing has traditionally been free of social stigma), the distribution of pregnancy outcomes ... sheds some light on the contribution of unintended pregnancy to the differences among the six countries. The combined fraction of all pregnancies accounted for by abortions and nonmarital births is approximately three-quarters in the United States and Canada, close to two-thirds in England and Wales and France, and only about one-half in the Netherlands. Thus, in England and Wales, France and the Netherlands, unintended pregnancy appears to constitute a smaller part of adolescent pregnancy than it does in the United States. Even more striking is the fact that the abortion rate alone in the United States is about as high as, or higher than, the overall teenage pregnancy rate in any of the other countries.

Exposure to the Risk of Pregnancy

Figure [4] illustrates some recent findings on levels of sexual activity (defined here as the proportion who have ever had intercourse) among teenagers in the six countries. The data should be interpreted cautiously, however, as there are numerous problems of comparability and quality. (Two potentially important aspects of sexual activity among adolescents-the number of sexual partners and frequency of intercourse could not be examined because data on them were not available for most countries.)

The most striking observation from the figure is that the differences in sexual activity among teenagers in the six countries do not appear to be nearly as great as the differences in pregnancy rates. Sexual activity is initiated considerably earlier in Sweden than elsewhere. By age 16, around one-third of all Swedish girls have had intercourse, and by age 18, four-fifths have done so. In Canada, by comparison, women may have had their first sexual experience later than the average for all six countries. At ages 16-17, only one out of five girls is sexually active. Smaller proportions of women are reported as having initiated sexual intercourse before the age of 18 in both Great Britain (England, Wales and Scotland) and France than in the United States. However, a rapid catch-up seems to take place, and in France the proportion of young women who have had intercourse by the time they are 19 appears to be higher than that found in the United States. The median age at first intercourse is very similar for the United States, France, Great Britain and the Netherlands, is about a year younger in Sweden, and may be about a year higher in Canada.

These data indicate that the variation in adolescent pregnancy rates shown in Figure 3 cannot, by and large, be explained by differences in levels of sexual experience. The examples of the Netherlands and Sweden make it clear that the postponement of first intercourse is not a prerequisite for the avoidance of early pregnancy. It does seem possible that reduced sexual exposure among younger Canadian teenagers is partly responsible for keeping their pregnancy

rates relatively low. The difference in pregnancy rates between the Netherlands and Sweden may also be partly attributable to the older age at sexual initiation in the Netherlands.

Contraceptive Use

The data on contraceptive practice were, likewise, derived from surveys that differed widely in their design and approach to the issue. Nevertheless, it is possible to make some estimates of proportions using any contraceptive method, and proportions using the pill, at various ages. Contraceptive use among French teenagers is probably underestimated because condom use was not included in the published results of the survey. It is likely, therefore, that the United States has the lowest level of contraceptive practice among teenagers of all six countries. In particular, pill use appears to be less widespread among U.S. teenagers than among those in the other countries. This difference suggests that American adolescents use less effective contraceptives to avoid accidental pregnancy, even if they are using a birth control method.

Access to Contraceptive and Abortion Services

Contraceptive services appear to be most accessible to teenagers in England and Wales, the Netherlands and Sweden. In England and Wales and the Netherlands, those seeking care may choose to go either to a general practitioner (limited to their own family doctor in the Netherlands) or to one of a reasonably dense network of clinics. The Dutch clinic system is less extensive than the British one, but it is directed largely toward meeting the special needs of youth, whereas in England and Wales, there are relatively few clinics specially designed for young people. In Sweden, there are two parallel clinic systems, one consisting of the primary health care centers that serve every community, and the other consisting of a less complete network providing contraceptive care and related services to the school-age population.

Canada, France and the United States also have clinic systems, but these appear to be less accessible than those found in the other countries. (In France, however, the clinic system has expanded considerably since 1981.) The Canadian clinic system is uneven, with fairly complete coverage for adolescents in Ontario and (Quebec, and scattered services elsewhere. The U.S. clinic network is reasonably accessible in a strictly geographic sense. Moreover, all family planning clinics receiving federal funds are required to serve adolescents. A basic drawback of the U.S. clinic system, however, is that it was developed as a service for the poor, and is often avoided by teenagers who consider clinics places where only welfare clients go.

Condoms are widely available in England and Wales, the Netherlands and Sweden. They not only are available from family planning clinics and pharmacies, but also are sold in supermarkets and other shops and in vending machines. In France and in many parts of Canada and the United States, condoms are less freely available.

Confidentiality was found to be an important issue in every country. Even where attitudes about sex are very open, as in the Netherlands and Sweden, the research teams were told that young people wish to keep their personal sex lives private. The need for confidential services is probably best met in Sweden, where doctors are specifically forbidden to inform parents about an adolescent's request for contraceptive services. Dutch doctors also are required to keep the visit confidential if the teenager requests it; and the services in Dutch clinics are entirely confidential. French official policy stipulates that clinic services for women under age 18 be absolutely confidential. Although the prescription of contraceptives to girls younger than 16 without a requirement that the parents be informed is now being legally contested in Britain, the practice was followed through the period covered by this study, and the British government is seeking to preserve confidentiality for young teenagers. In Canada and the United States, many individual doctors insist on parental consent before they will provide contraceptives to minors. However, most family planning clinics in Canada and the United States provide services to young women without any such restriction.

Like all medical care, contraceptive services, including supplies, are provided free of charge to young people in England and Wales and Sweden. Free services and supplies are available from clinics to French women under age 18; and for older teenagers, most of these expenses are reimbursable under social security. Contraceptive services provided by Dutch family doctors are covered under the national health insurance scheme, but the clinics charge a small fee. Until very recently, no charge was made to have a prescription filled at a pharmacy. In Canada, doctors' services are likewise covered by national medical insurance, and clinic services are free; but all patients except those on welfare have to pay for supplies obtained from pharmacies. The potential expense of obtaining contraceptive services in the United States varies considerably. Indigent teenagers from eligible families are able to get free care through Medicaid, and others do not have to pay anything because of individual clinic policy; otherwise, clinic fees are likely to be modest. On the other hand, consulting a private doctor usually entails appreciable expense, as does purchase of supplies at pharmacies.

An additional observation concerns the central role of the pill everywhere outside the United States. In each country, the research teams were told that the medical profession accepts the pill as a highly appropriate, usually *the most* appropriate method for adolescents. Moreover, a pelvic examination is not necessarily required before the pill can be prescribed in some of these countries. The emphasis on pill use emerged more clearly from the interviews than from the incomplete statistics on contraceptive use summarized in Figure, 6. By contrast, in the United States, there seems to be a good deal of ambivalence about pill use, both on the part of the medical profession and among potential young users. In the United States, medical protocol requires that a pelvic examination be performed before the pill can be prescribed, a procedure some young people find daunting. Whether justified or not, this requirement undoubtedly influences method selection among young women.

Postcoital contraceptive pills have been available at many family planning clinics in the United Kingdom for a number of years. Postcoital IUD insertion and oral contraceptives are available in the clinics run by both the Dutch and the French family planning associations. However, it is unlikely that these methods are sufficiently widely utilized to influence the birthrate appreciably. In Sweden, the morning-after pill is not yet permitted for general use. The

federal Food and Drug Administration has not approved postcoital use of pills in the United States, and no plan exists to market them, but they are available in some college health clinics and rape treatment centers.

Geographically, abortion services are most easily accessible in the Netherlands and Sweden. Although services are theoretically in place throughout England and Wales and France, wide differences in the abortion rates by area are believed to be attributable to variation in the availability of abortion facilities. In all three countries, as in Canada and the United States, services are likely to be found in cities. In Canada, England and Wales, and France, abortions typically involve at least an overnight hospital stay.

In Sweden, there is no charge for abortion; Canadian women usually pay only a small portion of the cost; and abortions obtained under the national health service in Britain are also free. However, because of bureaucratic delays in the national health service, almost half of British women choose to pay for an abortion in the private sector. In the Netherlands, the cost of an abortion is borne by the patient but is not high. The same was true in France up until 1982, when the service became free. Most U.S. women must pay for the abortion procedure themselves. For a second-trimester abortion, in particular, the cost may be substantial.

Sex Education

Sweden has the distinction of being the first country in the world to have established an official sex education curriculum in its schools. The curriculum, which is compulsory and extends to all grade levels, gives special attention to contraception and the discussion of human and sexual relationships. Perhaps most important, there is a close, carefully established link in Sweden between the schools and contraceptive clinic services for adolescents. None of the other countries comes close to the Swedish model. Sweden established this link in 1975, following liberalization of the abortion law, because of concern that liberalized abortion access might otherwise result in a sharp rise in teenage abortion rates. In fact, adolescent abortion rates have declined dramatically since 1975, whereas the rates for adults have not changed much. (In the other countries studied, teenage abortion rates have *not* fallen during this period.) The Swedish authorities credit the combination of sex education with the adolescent clinic program for the decline.

In Canada, England and Wales, and the United States, school sex education is a community option, and it is essentially up to the local authorities, school principals or individual teachers to determine how much is taught and at what age. In England and Wales, however, there is a national policy favoring the inclusion of topics related to sex and family life in the curriculum, whereas there is no such national policy in Canada and the United States. French policy now mandates broad coverage of sexuality for all adolescents, although in practice, interpretation of this provision similarly devolves on local decision-makers.

The Netherlands is a case apart. Coverage of sex in the school curriculum is limited on the whole to the facts of reproduction in natural science classes. The Dutch government,

nevertheless, encourages the teaching of contraception indirectly by subsidizing mobile educational teams that operate under the auspices of the private family planning association. At the same time, in recent years there has been an explosion of materials on contraception and other sex-related topics in the media, much of which is of a responsible and informative nature. Youth surveys show that knowledge of how to avoid pregnancy appears to be virtually universal.

In Sweden, sex education is completely accepted by the vast majority of parents, most of whom themselves had sex education while they were in school. Objections are confined to the immigrant community, for some of whom sex education represents a direct challenge to their own traditions. British law requires schools offering sex education to notify the parents. In the United States, many of the school districts that provide sex education give parents the option of excusing their children from such courses.

The Wider Context: Differences between the U.S. and the other countries

Consideration was given to a number of other social, economic and political factors that appear to be related to the phenomenon of adolescent pregnancy. The investigators who visited the four European countries were struck by the fact that in those countries, the government, as the main provider of preventive and basic health services, perceives its responsibility in the area of adolescent pregnancy to be the provision of contraceptive services to sexually active teenagers. This commitment to action and the enunciation of an unambiguous social policy appear to be associated with a positive public climate surrounding the issue. Teenage childbearing is viewed, in general, to be undesirable, and broad agreement exists that teenagers require help in avoiding pregnancies and births.

Another aspect of government involvement in and commitment to contraceptive services for teenagers has to do with the rationale for such programs. In France, the Netherlands and Sweden, the decision to develop such services was strongly linked to the desire to minimize abortions among young people. In France and the Netherlands, for example, conservative medical groups had shown some reluctance to endorse the provision of contraceptives to young, unmarried women. Apparently, the alternative of rising abortion rates among teenagers helped to persuade them that such services were justified. In Sweden, the connection was made explicit by the government, and the 1975 law that liberalized abortion also laid the groundwork for the development of contraceptive services for young people, with the specific understanding that prevention of the need for abortion could best be achieved by putting safe, effective, confidential services within the reach of all teenagers. In the United States, in contrast, some powerful public figures reflect the view that the availability of contraceptive services acts as an incitement to premarital sexual activity and claim, therefore, that such services actually cause an increase in abortions.

The use of contraceptive services is obviously made simpler in the European countries, as in Canada, by the fact that medical services of all kinds are easily accessible through national health programs, and teenagers, in particular, grow up accustomed to using public health facilities or to visiting their local general practitioner as a matter of course. This combination of

ease of accessibility and familiarity with the health care system probably serves to remove many of the social, psychological and financial barriers to contraceptive services experienced by young people in the United States.

There seems to be more tolerance of teenage sexual activity in the European countries visited than there is in most of the United States and in parts of Canada. Such acceptance of adolescent sexuality is unremarkable in a country like Sweden, with its long history of support for sexual freedom, and the absence there of taboos against premarital sex. However, such acceptance represents a considerable break with traditional standards in the Netherlands, France and, in Canada, Quebec. One reason for the more successful experience of the European countries may be that public attention was generally not directly focused the morality of early sexual activity but, rather, was directed at a search for solutions to prevent increased teenage pregnancy and childbearing.

In the United States, sex tends to be treated as a special topic, and there is much ambivalence: Sex is romantic but also sinful and ditty; it is flaunted but also something to be hidden. This is less true in several European countries, where matter-of-fact attitudes seem to be more prevalent. Again, Sweden is the outstanding example, but the contrast with the United States was evident in most of the countries visited. Survey results tend to bear out this impression, although the questions asked are not directly comparable from country to country. For instance, in 1981, 76 percent of Dutch adults agreed with the statement that "sex is natural - even outside marriage," whereas in 1978, only 39 percent of Americans thought premarital sex was "not wrong at all." ...

While the association between sexual conservatism and religiosity is not automatic, in the case of the United States the relationship appears to be relatively close. The proportion of the population who attend religious services and feel that God is important in their lives is higher in the United States than in the other case-study countries. Although England and Wales and Sweden have an established church, both countries are more secular in outlook than the United States. Moreover, in the Netherlands, France and Quebec Province, increasing secularization is believed to be an important aspect of recent broad social changes. Fundamentalist groups in America are prominent and highly vocal. Such groups often hold extremely conservative views on sexual behavior, of a sort rarely encountered in most of Western Europe. Both the nature and the intensity of religious feeling in the United States serve to inject an emotional quality into public debate dealing with adolescent sexual behavior that seems to be generally lacking in the other countries. It is notable that religiosity was found to correlate highly with adolescent fertility in the 37-country study, although the number of country observations was small.

Although all six countries included in the survey are parliamentary democracies, the nature of each country's political institutions differs, and there is considerable variation in the way in which public issues are developed and public policies formulated. The U.S. political system appears to foster divisiveness and confrontation at many levels of society, while these elements seem less salient a part of political life in the other countries. In addition, the United States is distinguished by the widespread use of private funds to mount political campaigns and create myriad pressure groups. While the American confrontational style may have its political uses, it makes the resolution of certain emotionally charged issues hard to achieve. Positions

tend to become polarized, and the possibilities for creative compromise are narrowed. The most interesting country to contrast with the United States, in terms of political style, is probably the Netherlands. It has strong and diverse religious and political groups, but a complex range of formal and informal conventions exists to defuse and resolve ideological conflicts before these emerge into the open. As a result, through accommodation and negotiation, the Dutch administrations of all political tendencies have, in the past 15 years or so, been able to make birth control services available to teenagers without exacerbating divisions in the society.

Directly related to this issue is the fact that with the exception of Canada, the United States is a much larger country than any of the others, in terms of both its geographic and its population size. In smaller, more compact countries, where lines of communication are more direct, it is easier than in the United States to engage in a national debate that includes all the appropriate parties to the discussion. For example, in the early 1960s, debate within the Dutch medical community over the advisability of prescribing the pill to teenagers quickly resulted in a broad consensus. A similar process would be much harder to implement in the United States. As a result, informing concerned professionals about the terms of a debate may be as hard as keeping the general population up to date on any issue.

Another closely related facet of national life is the extent to which political and administrative power is concentrated in the national government. France is often cited as the epitome of a centralized state, and even the existence of two "nations" within England and Wales is a simple arrangement compared with the federal systems of Canada and the United States. Both countries have two-tiered government structures, with some powers delegated to the central government and some reserved to the provinces or states. This structure has two main consequences: First, major differences can develop within the country in policy-making. Second, the task of giving shape to social change, in terms of public policies and programs, becomes enormously complicated because of the many bureaucracies that must be dealt with and the sometimes indeterminate boundaries of their separate jurisdictions.

Many observers from different backgrounds have suggested that early teenage childbearing in the United States is a response to social anomie and to a sense of hopelessness about the future on the part of large numbers of young people growing up in poverty. In the course of the country visits, the investigators collected information on teenage education and employment patterns, in order to explore further the possible association between career and life opportunities for young people and their attitudes toward reproductive planning. The finding was that educational opportunities in the United States appear to be as great as, or greater than, those in other countries, except, possibly, Sweden. In Sweden, about 85 percent of young people aged 18-19 are pursuing academic or vocational schooling. In Canada and France, most young people leave school at around 18, as they do in the United States, although a higher proportion of U.S. students go on to college. However, in the Netherlands, only about half of girls are still in school at age 18, while in England and Wales, the majority of young people end their full-time schooling at age 16.

The employment situation is difficult to compare or assess, since definitions of labor-force participation and unemployment differ from country to country. The most that call be concluded is that unemployment among the young is considered a very serious problem

everywhere, and young people themselves are universally uneasy oil this score. The chances of getting and keeping a satisfying or well-paying job do not appear to be worse in the United States than in other countries. To a greater extent than in the United States, however, all the other countries offer assistance to ease the problem, in the form of youth training, unemployment benefits and other kinds of support.

It is often suggested that in the United States, the availability of public assistance for unmarried mothers creates a financial incentive for poor women, especially the young, to bear children outside of marriage. Yet, all the countries studied provide extensive benefits to poor mothers that usually include medical care, food supplements, housing and family allowances. In most cases, the overall level of support appears to be more generous than that provided under the Aid to Families with Dependent Children program in the United States. Benefits in the other countries tend to be available regardless of women's marital or reproductive status, although in England and Wales and in France, at least, special supplementary benefit programs for poor single mothers also exist. In those countries, however, the existence of considerable financial support for out-of-wedlock childbearing does not appear to stimulate adolescent birthrates or explain the differences between their rates and the U.S. rates.

The final difference between the United States and the other countries that may be relevant to teenage pregnancy concerns the overall extent and nature of poverty. Poverty to the degree that exists in the United States is essentially unknown in Europe. Regardless of which way the political wind's are blowing, Western European governments are committed to the philosophy of the welfare state. The Dutch and the Swedes have been especially successful in achieving reasonably egalitarian societies, but even in England and Wales and France, the contrast between those who are better off and those who are less well off is not so great as it is in the United States. In every country, when respondents were pressed to describe the kind of young woman who would be most likely to bear a child, the answer was the same: adolescents who have been deprived, emotionally as well as economically, and who unrealistically seek gratification and fulfillment in a child of their own. Such explanations are also given in the United States, but they tend to apply to a much larger proportion of people growing up in a culture of poverty....

Policy Implications

Many widely held beliefs about teenage pregnancy cannot explain the large differences in adolescent pregnancy rates found between the United States and other developed countries: Teenagers in these other countries apparently are *not* too immature to use contraceptives consistently and effectively; the level and availability of welfare services does *not* seem correlated with higher adolescent fertility; teenage pregnancy rates are *lower* in countries where there is greater availability of contraceptive services and of sex education; levels of adolescent sexual activity in the United States are not very different from those in countries with much *lower* teenage pregnancy rates; although the teenage pregnancy rate of American blacks is much higher than that of whites, this difference does not explain the gap between the pregnancy rates in the United States and the other countries; teenage unemployment appears to be at least as

serious a problem in all the countries studied as it is in the United States; and American teenagers have more, or at least as much, schooling as those in most of the countries studied. The other case-study countries have more extensive public health and welfare benefit systems, and they do not have so extensive and economically deprived an underclass as does the United States.

Clearly, then, it *is* possible to achieve lower teenage pregnancy rates even in the presence of high rates of sexual activity, and a number of countries have done so. Although no single factor has been found to be responsible for the differences in adolescent pregnancy rates between the United States and the other five countries, is there anything to be learned from these countries' experience that can be applied to improve the situation in the United States?

A number of factors that have been discussed here, of course, are not easily transferable, or are not exportable at all, to the United States: Each of the other five case-study countries is considerably smaller, and all but Canada are more compact than the United States - making rapid dissemination of innovations easier; their populations are less heterogeneous ethnically (though not so homogenous as is commonly assumed - most have substantial minority nonwhite populations, usually with higher-than-average fertility); religion, and the influence of conservative religious bodies, is less pervasive in the other countries than it is in the United States; their governments tend to be more centralized; the provision of wide-ranging social and welfare benefits is firmly established, whether the country is led by parties labeled conservative or liberal; income distribution is less unequal than it is in the United States; and constituencies that oppose contraception, sex education and legal abortion are not so powerful or well funded as they are in the United States.

Some factors associated with low pregnancy rates that *are*, at least theoretically, transferable receive varying levels of emphasis in each country. For example, school sex education appears to be a much more important factor in Sweden than it is in the other countries: a high level of exposure to contraceptive information and sex-related topics through the media is prominent in the Netherlands; condoms are more widely available in England, the Netherlands and Sweden. Access to the pill by teenagers is probably easiest in the Netherlands.

On the other hand, although initiation of sexual activity may begin slightly earlier in the United States than in the other countries (except for Sweden), none of the others have developed official programs designed to discourage teenagers from having sexual relations - a program intervention that is now advocated and subsidized by the U.S. government. The other countries have tended to leave such matters to parents and churches or to teenagers' informed judgments.

By and large, of all the countries studied, Sweden has been the most active in developing programs and policies to reduce teenage pregnancy. These efforts include universal education in sexuality and contraception; development of special clinics - closely associated with the schools where young people receive contraceptive services and counseling; free, widely available and confidential contraceptive and abortion services; widespread advertising of contraceptives in all media; frank treatment of sex; and availability of condoms from a variety of sources. It is notable that Sweden has *lower* teenage pregnancy rates than have all of the countries examined, except for the Netherlands, although teenagers begin intercourse at earlier ages in Sweden. It is

also noteworthy that Sweden is the only one of the countries observed to have shown a rapid decline in teenage abortion rates in recent years, even after its abortion law was liberalized.

The study findings point to several approaches observed in countries other than Sweden that also might help reduce teenage pregnancy rates in the United States. These include upgrading the family planning clinic system to provide free or low-cost contraceptive services to *all* teenagers who want them, and publicizing the fact that these services are not limited to the poor; establishment of special adolescent clinics, including clinics associated with schools, to provide confidential contraceptive services as part of general health care; encouraging local school districts to provide comprehensive sex education programs, where possible, closely integrated with family planning clinic services; relaxation of restrictions on distribution and advertising of nonprescription contraceptives, especially the condom; dissemination of more realistic information about the health benefits, as well as the health risks, of the pill; and approval of the use of postcoital methods.

In sum, increasing the legitimacy and availability of contraception and sex education (in its broadest sense) is likely to result in declining teenage pregnancy rates. That has been the experience of many countries of Western Europe, and there is no reason to think that such an approach would not also be successful in the United States.

Admittedly, application of any of the program and policy measures that appear to have been effective in other countries is more difficult in the United States nationally, where government authority is far more diffused. But their application may, in fact, be as easy or easier in some states and communities. Efforts need to be directed not just to the federal executive branch of government, but to Congress, the courts, state legislatures, local authorities and school superintendents and principals - as well as to families and such private-sector and charitable enterprises as insurance companies, broadcast and publishing executives, church groups and youth-serving agencies.

Among the most striking of the observations common to the four European countries included in the six-country study is the degree to which the governments of those countries, whatever their political persuasion, have demonstrated the clear-cut will to reduce levels of teenage pregnancy. Pregnancy, rather than adolescent sexual activity itself, is identified as the major problem. Through a number of routes, with varying emphasis on types of effort, the governments of those countries have trade a concerted, public effort to help sexually active young people to avoid unintended pregnancy and childbearing. In the United States, in contrast, there has been no well-defined expression of political will. Political and religious leaders, particularly, appear divided over what their primary mission should be: the eradication or discouragement of sexual activity among young unmarried people, or the reduction of teenage pregnancy through promotion of contraceptive use.

American teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: Movies, music, radio and TV tell them that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are likely to be divorced or separated but involved in sexual relationships. Yet, at the same time, young people get the

message good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy. For example, they are more likely to hear about abortions than about contraception on the daily TV soap opera. Such messages lead to an ambivalence about sex that stifles communication and exposes young people to increased risk of pregnancy, out-of-wedlock births and abortions.

QUESTION: What factors OTHER than education bring down the pregnancy, birth and abortion rates?

From Elise F. Jones et al., "Teenage Pregnancy in Developed Countries." Excerpted from "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," in *Family Planning Perspectives*, Vol. 17, No. 2, March/April 1985, pp. 53-63.