Teenage Sexual and Reproductive Behavior in Developed Countries

Can More Progress Be Made?

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Occasional Report No. 3
November 2001

THE ALAN GUTTMACHER INSTITUTE
NEW YORK & WASHINGTON

Acknowledgements

This report is part of The Alan Guttmacher Institute's (AGI) cross-national study, *Teenage Sexual and Reproductive Behavior in Developed Countries*, conducted with the support of The Ford Foundation and The Henry J. Kaiser Family Foundation.

The summary report, *Can More Progress Be Made?* was written by Jacqueline E. Darroch, senior vice president and vice president for research, Jennifer J. Frost, senior research associate, and Susheela Singh, director of research, all of The Alan Guttmacher Institute, and the Study Team.

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The authors would like to thank Sara Seims, president, Cory Richards, senior vice president and director of public policy, Beth Fredrick, vice president and director of communications and development and Pat Donovan, director of publications, all of The Alan Guttmacher Institute, for on-going guidance over the course of this project and for comments and reviews of earlier drafts of this report. Thanks also go to Kathleen Kiernan, Deirdre Wulf and James Wagoner for their comments and review of the manuscript; and to Yvette Cuca, Erin Carbone, and Jennifer Swedish for help with research assistance, formatting, and other tasks related to the production of this report. Finally, special thanks go to Vanessa Woog for continued assistance throughout the study and for tremendous effort in finalizing and formatting all the reports in this series.

Other publications in the series *Teenage Sexual and Reproductive Behavior in Developed Countries* include country reports for *Canada, France, Great Britain, Sweden* and *The United States* and an Executive Summary of this report.

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Teenage Sexual and Reproductive Behavior in Developed Countries

Executive Summary

There is strong consensus in the United States that teenage pregnancy and birth levels are too high. Despite dramatic decreases in teenage pregnancy rates and birthrates in the United States over the past decade, this country still has substantially higher levels of adolescent pregnancy, childbearing and abortion than in other Western industrialized countries. Moreover, teenage birthrates have declined less steeply in the United States than in other developed countries over the last three decades (Chart 1, page 2).

While much can be learned from the experience and insights of people in the United States who are engaged in efforts to reduce teenage pregnancy rates and birthrates, important lessons can also be learned from other countries. Cross-national comparisons can help to identify factors that may be so pervasive, they are not readily recognized within the United States; such comparisons can also suggest new approaches that might be helpful.

This executive summary presents the highlights of a large-scale investigation, Teenage Sexual and Reproductive Behavior in Developed Countries, conducted in Sweden, France, Canada, Great Britain[1] and the United States between 1998 and 2001 (see box, page 2). Teenage pregnancy rates and birthrates in these five countries vary widely, with the lowest rates in Sweden and France, moderate rates in Canada and Great Britain, and the highest rates in the United States. Although the focus of this executive summary is on what the United States can learn from the other countries, many of the insights gained may also be useful to them, as well as to countries not involved in this study.

Beneath the generalizations necessary when making cross-national comparisons, there are often large differences across areas and groups within a country, and varying national contexts and histories. While all of the study countries have democratic governments and are highly developed, they differ in some basic respects, such as population size and density, and political, economic and social perspectives and structures. For example, the United States has long emphasized individual responsibility for one's own welfare. As much as possible, government is expected to stay out of people's lives, especially in the area of health and social policy, and only as a last resort, to play a remedial role as provider of assistance.

The resulting deregulated, individualistic society has tended to foster more fluid social structures, greater flexibility and innovation, and more economic vibrancy than can be found in much of Europe. On the other hand, the social and political commitment to providing a social and economic safety net, including health care for all, which has been so strong in Europe since World War II, is largely missing from the United States. The large U.S. population, geographic area and economy encompass far greater diversity than is found in the other study countries, but the United States is also characterized by greater inequality and more widespread poverty, which are compounded by the country's history of slavery and racism.

Major Conclusions

■ Continued high levels of teenage childbearing in the United States compared with levels in Sweden, France, Canada and Great Britain reflect higher pregnancy rates and smaller proportions of pregnant teenagers having abortions. Since timing and levels of sexual activity are quite similar across countries, the high U.S. rates arise primarily because of less, and possibly less-effective, contraceptive use by sexually active teenagers.

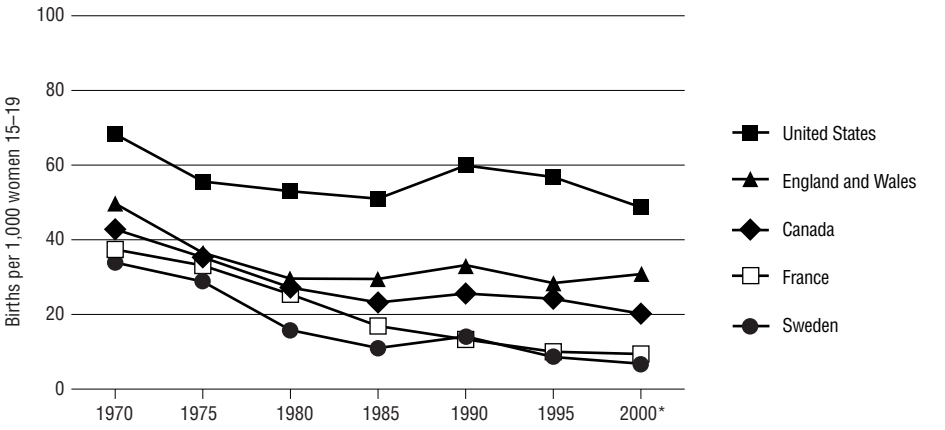
■ Growing up in conditions of social and economic disadvantage is a powerful predictor of early childbearing in all five countries. The greater proportion of teenagers from disadvantaged families in the United States contributes to the country's high teenage pregnancy rates and birthrates. At all socioeconomic levels, however, American teenagers are less likely to use contraceptives and more likely to have a child than their peers in the other countries.

■ Stronger public support and expectations for the transition to adult economic roles, and for parenthood, in Sweden, France, Canada and Great Britain than in the United States provide young people with greater incentives and means to delay childbearing.

■ Societal acceptance of sexual activity among young people, combined with comprehensive and balanced information about sexuality and clear expectations about commitment and prevention of childbearing and STDs within teenage relationships, are hallmarks of countries with low levels of adolescent pregnancy, childbearing and STDs.

■ Easy access to contraceptives and other reproductive health services in Sweden, France, Canada and Great Britain contributes to better contraceptive use and therefore lower teenage pregnancy rates than in the United States. Easy access means that adolescents know where to obtain information and services, can reach a provider easily, are assured of receiving confidential, nonjudgmental care and can obtain services and contraceptive supplies at little or no cost.

Chart 1. Teenage birthrates declined less steeply in the United States than in other developed countries between 1970 and 2000.



*Data are for 1997 in Canada, 1998 in France and 1999 in England, Wales and Sweden.

Pathways to High U.S. Rates

Teenage pregnancy levels are higher in the United States than in the other study countries.

U.S. teenagers have higher birthrates than adolescents in the other study countries because they are much more likely to become pregnant, and because those who become pregnant are less likely than pregnant adolescents in the other countries to have abortions (Chart 2). At the same time, however, U.S. teenagers also have a higher abortion rate than their peers in the other countries because they are more likely to become pregnant unintentionally.

In addition to having higher rates of unplanned pregnancy, teenage women in the United States are more likely than their peers in the other countries to want to become mothers. Surveys indicate that even if only those teenagers who wanted to become mothers did so, the resulting teenage birthrate in the United States (18 per 1,000 women aged 15–19) would still be higher than the total adolescent birthrates in France and Sweden and about two-thirds as high as the total teenage birthrates in Great Britain and Canada.

Differences between countries in levels of sexual activity are too small to account for the wide variation in teenage pregnancy rates.

Levels of sexual activity and the age when teenagers become sexually active do not vary appreciably across the five countries (Chart 3). Moreover, most measures indicate less, rather than more, exposure to sexual intercourse among teenage women and men in the United States than among those in the other four countries.

However, some potentially important differences exist between countries in patterns of teenage sexual activity. Teenagers in the United States are the most likely to have sexual intercourse before age 15. They also appear, on average, to have shorter and more sporadic sexual relationships. For example, American teenagers who had intercourse in the past year are more likely to have had more than one partner than young people in the other countries, especially those in France and Canada (Chart 4).

Less contraceptive use and less use of hormonal methods are the primary reasons U.S. teenagers have the highest rates of pregnancy, childbearing and abortion.

U.S. teenagers are less likely to use any contraceptive method than young women in the other study countries and are also less likely to use the pill or a long-acting reversible hormonal method (the injectable or the implant), which have the highest use-effectiveness rates (Chart 5, page 4).

Data on the effectiveness with which women and men use contraceptive methods are available only for the United States. However, estimates using these effectiveness rates and country method-use patterns suggest that less-successful use of contraceptive methods also contributes to higher pregnancy rates among U.S. teenagers.

More sexual partners, a higher prevalence of infection and, probably, less condom use contribute to higher teenage sexually transmitted disease (STD) rates in the United States.

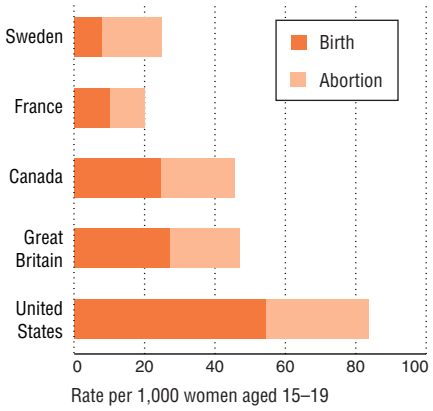
STD rates are higher among U.S. teenagers than among adolescents in the other study countries. U.S. teenagers have more sexual partners than teenagers in the other study countries, especially France and Canada. This increases their risk of contracting an STD, including HIV. Moreover, while sexually active teenagers in the United States are more likely than their counterparts in the other countries to rely on condoms as their main method, available data suggest they are less likely than teenagers in Great Britain and probably Canada to use condoms in addition to a hormonal method. Thus, American teenagers who are sexually active are more likely to be exposed to the risk of STDs and may be less likely to use condoms. Higher levels of STD infection in the U.S. population as a whole than in the other study countries suggest that another factor contributing to high STD levels among teenagers is the greater prevalence of both viral and untreated bacterial STDs among their partners.

Information Sources

Collaborating research teams carried out case studies for each of the five countries. The study teams used a common approach to gather information and prepare in-depth country reports. The project also included two workshops, analyses of teenage pregnancy and STD levels in all developed countries, and site visits by the U.S. study team, who were also the project leaders, that involved extensive consultation with reproductive health professionals in each of the focus countries.

Study-team participants were in Canada, Eleanor Maticka-Tyndale, Alex McKay and Michael Barrett; in France, Nathalie Bajos and Sandrine Durand; in Great Britain, Kaye Wellings; in Sweden, Maria Danielsson, Christina Rogala and Kajsa Sundström; and in the United States, Jacqueline E. Darroch, Jennifer Frost, Susheela Singh, Rachel Jones and Vanessa Woog. Project funding was provided by The Ford Foundation and The Henry J. Kaiser Family Foundation.

Chart 2: U.S. teenagers have higher pregnancy rates, birthrates and abortion rates than adolescents in other developed countries.



Note: Data are for mid-1990s.

Society's Influences on Teenagers' Behavior

The behavior of young people in the study countries and the types of policies and programs developed for teenagers reflect the social, historical and governmental contexts of the individual countries. For example, the unplanned pregnancy rate among women aged 15–44 in the early to mid-1980s was much higher in the United States than in Sweden, Canada and Great Britain; the U.S. rate was similar to the rate in France. The abortion rate in the mid-1990s was higher not only among teenagers but also among women in their 20s and among all women aged 15–44 in the United States than in any of the other study countries. The greatest differences in abortion rates were not among teenagers but among women in their early 20s, with the U.S. abortion rate at 50 per 1,000 women aged 20–24, compared with rates in the other study countries no higher than 31 per 1,000.

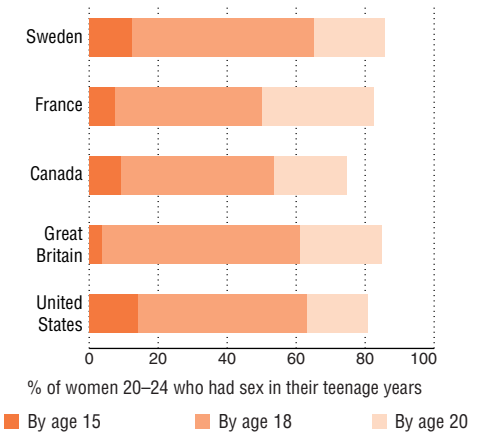
Social and economic well-being and equality are linked to lower teenage pregnancy rates and birthrates.

•*Government commitment to social welfare and equality for all members of society provides greater support for individual well-being in other countries than in the United States.* The philosophy that individuals are responsible for their own welfare and that the government should stay out of people's lives as much as possible, especially in the areas of health and social policy, contributes to widespread inequity in the United States. For example, one-fifth of U.S. women of reproductive age have no health insurance. The national and local governments play a remedial role, making services such as public health clinics, housing and income assistance available to poor, uninsured and other disadvantaged people. However, because public services are primarily for the disadvantaged, their use carries a stigma in many communities. Numerous nongovernmental organizations help make up for the lack of public services, but their coverage and scope vary widely.

In contrast, the other study countries, especially Sweden and France, have stronger social welfare systems, and are committed to reducing economic disparity within their populations. Government provides or pays for basic services such as health care for everyone. Public services are therefore considered a right, and no stigma is attached to their use.

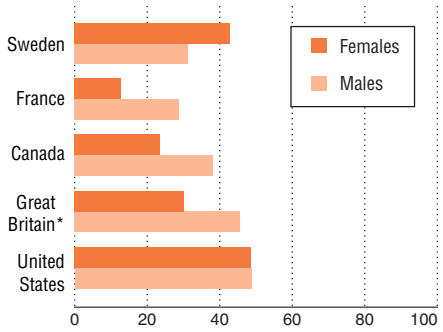
•*Compared with adolescents in the other countries, U.S. teenagers are more likely to grow up in disadvantaged circumstances and those who do are more likely to have a child during their teenage years.* In all of the study countries, young people growing up in disadvantaged economic, familial and social circumstances are more likely than their better-off peers to engage in risky sexual behavior and to become parents at an early age. Although the United States has the highest median per capita income of the five countries, it also has the largest proportion of its population who are poor. The higher proportion of teenagers from disadvantaged backgrounds contributes to the high teenage pregnancy rates and birthrates in the United States.

Chart 3: Differences in levels of teenage sexual activity across developed countries are small.



Note: Data are for mid-1990s.

Chart 4: Among teenagers who had sex in the last year, those in the United States are more likely than those in other developed countries to have had two or more partners.



*Data for 16–19-year-olds. *Note:* Data are for mid-1990s.

At all socioeconomic levels, however, U.S. youth have lower levels of contraceptive use and higher levels of childbearing than their peers in the other study countries. For example, the level of births among U.S. teenagers in the highest income subgroup is 14% higher than the level among similarly advantaged teenagers in Great Britain and higher than the overall levels in Sweden and France. Differences are greatest among disadvantaged youth: U.S. teenagers in the lowest income subgroup have birth levels 58% higher than similar teenagers in Great Britain. Not only do Hispanic and black teenagers in the United States, who are much more likely than whites to be from low socioeconomic circumstances, have very high pregnancy rates and birthrates, the birthrate among non-Hispanic white teenagers (36 per 1,000) is higher than overall rates in the other study countries.

Strong and widespread governmental support for young people's transition to adulthood, and for parents, may contribute to low teenage birthrates in the countries other than the United States.

Adolescence is viewed in all the study countries as a time of transition to adult roles, rights and responsibilities. However, while Sweden and France, and to some extent Great Britain and Canada, seek to help all youth through this transition, the United States primarily assists only those in greatest need.

•*Education and employment assistance help young people become established as adults.* In the United States,

the transition to adult roles and the process of settling on a vocation and finding employment are generally up to the individual adolescent and his or her family. Government employment training and assistance programs tend to be remedial and directed at small numbers of poor youth who are unable to find work on their own. The U.S. approach offers great freedom of choice and flexibility for many, but does little to help those who are less knowledgeable about opportunities for school and work or are less able to take advantage of them on their own.

Youth in the other countries tend to receive more societal assistance and support for this transition, in the form of vocational education and training, help in finding work, and unemployment benefits. Such assistance is available to all youth through both public programs and private employers. These efforts not only smooth the transition from school to work but also convey to teenagers that they are of value to society, that their development and input are important, and that there are rewards for making the effort to fit into expected social roles.

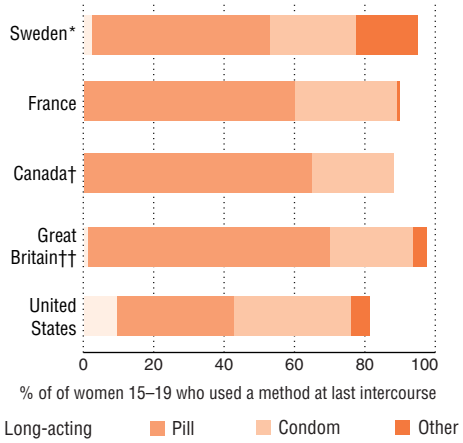
•*Support for working parents and families signifies the high value of children and parenting, and gives youth the incentive to delay childbearing.* In the United States, paid maternity leave is rare and child benefits are available only to some poor women and families. In the other study countries, working mothers (and sometimes fathers) are guaranteed paid parental leave and other benefits. Although the parental leave and family support policies in these countries, particularly Sweden and France, are quite generous in terms of time and money, they are not an incentive for younger women and teenagers to have children, because parental leave payments are tied to prior salary levels. These policies appear to reinforce societal norms that childbearing is best postponed until a young couple's careers have been established. Support for working parents thus offers young people both the incentive to delay childbearing until they have completed school and become employed and the assurance that they will be able to combine work and childrearing.

Positive attitudes about sexuality and clear expectations for behavior in sexual relationships contribute to responsible teenage behavior.

•*Openness and supportive attitudes about sexuality in other countries have not led to greater sexual activity or risk-taking.* The U.S. society is highly conflicted about sexuality in general and about expectations for adolescent behavior in particular. Adults in the other countries are less conflicted about both sexuality and teenage sexual activity, at least for older teenagers.

Although a majority of adults in all five countries frown on young people's having sex before age 16, such behavior is more likely to be accepted in Sweden and Canada (where 39% and 25%, respectively, think it is not wrong at all or only sometimes wrong) than it is in the United States and Great Britain (where 13% and 12%, respectively, hold these views).[2] Adults in the other countries are also much more accepting of sex before marriage than are Americans: 84–94% in Canada, Great Britain and Sweden, compared with only 59% in the United States. Although there are no comparable data for France, initiation of intercourse before marriage or cohabitation is the norm there. In spite of these differences in attitudes, similar proportions of young people in all the study countries become sexually active during their adolescence.

Chart 5: U.S. teenagers are less likely to use a contraceptive method and to use a hormonal method than teenagers in other developed countries.



*Data are for 18–19-year-olds. †The condom category includes all methods other than the pill, but the condom is the predominant "other method." ††Data are for 16–19-year-olds. *Note:* Users reporting more than one method were classified by the most effective method. Data are for early to mid-1990s.

•*There is a strong consensus in countries other than the United States that childbearing belongs in adulthood.* Young people in Europe are usually considered adults only when they have finished their education, become employed and live independently from their parents. And only when they have established themselves in a stable union is it considered appropriate to begin having children. This view is most clearly established in Sweden and France, but it is also more common in Canada and Great Britain than in the United States.

Few adolescents in any of the study countries meet these criteria for parenthood. For example, the proportion of adolescent women who are married or cohabiting ranges from 4% to roughly 10% in these countries. Nonetheless, of the few teenage births that occur in Sweden and France, 51% in each country are to young women who are married or cohabiting, compared with 38% in the United States (data are not available for Canada or Great Britain). Because the overall teenage birthrate in the United States is so high, the birthrate among women who are not in union—37 per 1,000—is much higher than in Sweden and France—no more than 5 per 1,000.

•*Countries other than the United States give clearer and more consistent messages about appropriate sexual behavior.* Positive acceptance of sexuality in countries other than the United States is by no means value-free. In France and Sweden in particular, sexuality is seen as normal and positive, but there is widespread expectation that sexual intercourse will take place within committed relationships (though not necessarily formal marriages) and that those who are having sex will protect themselves and their partners from unintended pregnancy and STDs. In these countries, and also increasingly in Canada and Great Britain, sexual relationships among adolescents are accepted by others. This acceptance carries with it expectations of commitment, mutual monogamy, respect and responsibility.

While adults in the other study countries focus chiefly on the quality of young people's relationships and the exercise of personal responsibility within those relationships, adults in the United States are often more concerned about whether young people are having sex. Close relationships are often viewed as worrisome because they may lead to intercourse, and contraception may not be discussed for

fear that such a discussion might lead to sexual activity. These generalities across countries are borne out in the behavior of young people. As was noted earlier, teenagers in the United States who have had sex appear more likely than their peers in the other countries to have short-term and sporadic relationships, and they are more likely to have many sexual partners during their teenage years.

•*Comprehensive sexuality education, not abstinence promotion, is emphasized in countries with lower teenage pregnancy levels.* In Sweden, France, Great Britain and, usually, Canada, the focus of sexuality education is not abstinence promotion but the provision of comprehensive information about prevention of HIV and other STDs; pregnancy prevention; contraceptives and, often, where to get them; and respect and responsibility within relationships. Sexuality education is mandatory in state or public schools in England and Wales, France and Sweden and is taught in most Canadian schools, although the amount of time given to sexuality education, its content and the extent of teacher training vary among these countries and within them as well. In Sweden, the country with the lowest teenage birthrate, sexuality education has been mandated in schools for almost half a century, which reflects, and promotes, the topic's acceptance as a legitimate and important subject for young people.

Extremely vocal minority groups in the United States pressure school districts not to allow information about contraception to be provided in sexuality education classes, and substantial federal and state funds are directed to promoting abstinence for unmarried people of all ages, particularly for adolescents. Some 35% of the school districts that mandate sexuality education require that abstinence be presented as the only appropriate option outside of marriage for teenagers and that contraception either be presented as ineffective in preventing pregnancy and HIV and other STDs or not be covered at all.

•*Media is used less in the United States than elsewhere to promote positive sexual behavior.* Young people in all five countries are exposed through television programs, movies, music and advertisements to sexually explicit images and to casual sexual encounters with no consideration for preventing pregnancy or STDs. However, entertainment media and advertising messages about sexuality are seemingly less influential in the other countries than in the United States, because they are balanced by more pragmatic parental and societal attitudes and by nearly universal comprehensive sexuality education.

Pregnancy and STD prevention campaigns undertaken in the United States generally have a punitive tone and focus on the negative aspects of teenage childbearing and STDs rather than on promotion of effective contraceptive use. The media have been used more frequently in the other countries for public campaigns to prevent STDs and HIV; the messages are generally positive about sexuality and are more likely to be humorous than judgmental. For example, the Swedish government works closely with youth to publish a frank and informative periodical magazine featuring subjects such as love, identity and sexuality that is widely read—and trusted—by young people. A government contraceptive campaign in France used television spots to air the message, "Contraception: The choice is yours."

Contraceptive use is higher, and pregnancy and STDs less common, where teenagers have easy access to sexual and reproductive health services.

•*Only in the United States do substantial proportions of adolescents lack health insurance and therefore have poor access to health care.* Study countries other than the United States have national systems for the financing and delivery of health care for everyone. Although the systems vary, they provide assurance that teenagers can access a clinician.

In contrast, substantial proportions of U.S. teenagers and their families have no health insurance, and some who do have insurance may not be covered for contraceptive supplies or may fear that using insurance for reproductive health services will compromise their confidentiality, since their coverage usually comes through their parents' policy. Many teens, regardless of their insurance status, turn to public health care providers for contraceptive services.

•*Contraceptive services and other reproductive health care are generally more integrated into regular medical care in countries other than the United States.* In Sweden, France, Great Britain and Canada, contraceptive services are usually integrated into other types of primary care. This not only contributes to ease of access, but also lends support for the notion that contraceptive use is normal and important. In the United States, in contrast, contraception is still not fully accepted as basic health care. It is often not covered by private health insurance policies and, at least for teenagers, not always provided confidentially and sensitively by private physicians, who provide most people's care. The fact that teenagers rely heavily on family planning clinics rather than the family doctor for contraceptive services simultaneously stigmatizes the clinics for providing care that is somewhat outside the mainstream and their teenage clients for doing something wrong by seeking those services in the first place.

•*U.S. teenagers have greater difficulty obtaining contraceptive services than do adolescents in the other study countries.* Youth in the study countries obtain contraceptive services and supplies from a variety of providers, including physicians, nurse clinicians and clinics that either provide care to women and men of all ages or serve adolescents exclusively. No one type of contraceptive service provider appears necessarily the best for teenagers. What appears crucial to success is that adolescents know where they can go to obtain information and services, can get there easily and are assured of

Table 1: The cost of reproductive health care for teenagers varies by country and by type of service.

Service	Sweden	France	Canada	Great Britain	United States
Clinic visit	Free	Free	Free	Free	Mostly free
Private physician visit	Free	Pay full cost; insurance will reimburse 80%	Free	Free	Pay full cost; insurance may reimburse at varying levels
Pill prescription	Initial cycles free; then $1–3 per cycle	Free at clinic; $1–7 at pharmacy	Initial cycles free; then $3–11 per cycle	Free	Free or discounted at clinics; $5–35 per cycle at pharmacy

receiving confidential, nonjudgmental care, and that these services and contraceptive supplies are free or cost very little.

In all five countries, teenagers seeking contraceptive services from clinic providers are guaranteed confidentiality, both legally and in practice. However, in the United States, numerous attempts to reverse this policy have been made at the national and state levels. While private physicians are usually legally protected from liability for serving minors on their own consent, there is little information about whether they always provide confidential care. Regulations in Great Britain state that physicians may prescribe contraceptives for an adolescent younger than 16 if it is in her best medical interest and she can give informed consent, but controversy about the standards and changes in policy guidelines have left many youth confused about whether they can obtain care confidentially from clinics or from private physicians.

Contraceptive services and supplies are free or low-cost in Sweden, France, Canada and Great Britain. In the United States, the cost of care and supplies can be very high and depends on the type of provider; a young person's income level; whether she is covered by health insurance that includes contraceptive coverage and, if so, whether she feels comfortable with the possibility her parents will know she used that coverage (Table 1, page 5).

Providers' attitudes may influence teenagers' choice of a method. In countries other than the United States, the pill is the method usually offered to young women and most providers view oral contraceptives as the best method for adolescents and assume that young people are able to use them effectively. In the United States, almost all providers offer the pill along with a range of other methods, and many young women have turned to long-acting hormonal methods because of their own or their provider's perception that these may be easier to use successfully.

Sweden offers examples of ways to provide youth-friendly services. All Swedish providers guarantee confidentiality for young people seeking contraceptive and STD information and services; youth who seek STD testing are considered to be acting responsibly. In addition to maternal and child health clinics, youth clinics throughout the country provide primary health care, including contraceptive and STD services, and psychological counseling to adolescents. These clinics are run by nurse-midwives who have direct authority to prescribe oral contraceptives. Young people often make informational visits to these clinics as part of school programs, and the clinics offer hotlines to call for information, advice and appointments.

Other approaches have been used in France, where many family planning clinics offer sessions just for teenagers on Wednesday afternoons, when public schools throughout the country are closed. A recent government media campaign offered a hotline and brochures to help publicize government health clinics that provide free contraceptives to youth.

•*In study countries other than the United States, there is easier access to abortion.* There is relatively little controversy in Sweden, France, Canada and Great Britain over the provision of abortion services, which are often provided through government health services or covered by national health insurance, and which are available confidentially to teenagers, although providers often encourage young women to involve their parents. In contrast, almost all abortion services in the United States are provided by private organizations, separate from women's regular sources of medical care. Abortion is barred from coverage in federal and most state insurance programs, except in cases of rape, incest and danger to the woman's life. Many American teenagers live in states that mandate parental consent or notice, or approval by a judge, before minors can obtain abortions.

Final Thoughts

The findings suggest that improving adolescents' prospects for successful adult lives and giving them tangible reasons to view the teenage years as a time to prepare for adult roles rather than to become parents are likely to have a greater impact on their behavior than exhortative messages that it is wrong to start childbearing early. Many in the United States give little support to young people as they establish sexual relationships. They consider adolescents to be developmentally incapable of making good judgments about their own behavior and of using contraceptives and condoms effectively. In contrast, the other countries—most notably Sweden and France—appear to have clear social expectations that young people can and will make responsible decisions about sexual relationships, use contraceptives effectively, prevent STDs and obtain health services they need in a timely fashion, and that adults should provide them with guidance, support and assistance along the way. Where young people receive social support, full information and positive messages about sexuality and sexual relationships, and have easy access to sexual and reproductive health services, they achieve healthier outcomes and lower rates of pregnancy, birth, abortion and STDs.

[1] Great Britain comprises England, Scotland and Wales. Some of the study information is available only for England and Wales.

[2] Widmer ED, Treas J and Newcomb R. Attitudes toward nonmarital sex in 24 countries, *Journal of Sex Research,* 1998, 35(4):349–357.

The full report, *Teenage Sexual and Reproductive Behavior in Developed Countries: Can More Progress Be Made?*, and separate reports for Sweden, France, Canada, Great Britain and the United States are available for purchase. To order, call 1-800-355-0244 or 1-212-248-1111, or visit www.guttmacher.org and click "buy."

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Part A: Introduction, Background and Study Design

Chapter 1. Introduction

Levels of adolescent pregnancy and childbearing differ widely across developed countries, with teenagers in the United States becoming pregnant and bearing children at much higher rates than teenagers in Canada or Europe.[1] The incidence of sexually transmitted infections (STDs) is also much higher among youth in the United States compared to youth in other developed countries.[2] There is a strong consensus in the United States that these rates are too high. Thus, over the past two decades, researchers, policy analysts and advocates in the United States have examined the experience of European nations in an attempt to learn from their greater success in achieving lower levels of teenage pregnancy and STDs.[3]

Building upon the findings of these prior studies, we undertook a new investigation of the variation in adolescent sexual and reproductive behavior that included in-depth case studies of the circumstances, experiences, policies and programs found in five countries: Canada, France, Great Britain, Sweden and the United States. The case studies were designed to obtain current information on three key factors previously identified as critical to variations in adolescent sexual and reproductive behavior across developed countries: levels of social and economic disadvantage, societal openness about sexuality, and the accessibility of sexual and reproductive health services to youth. Each case study was conducted in collaboration with a team of researchers from the study country. This approach allowed greater insight into the underlying causes of variation among countries, and the collaborative process facilitated the clarification of observations made by both the in-country study team and the U.S. researchers. Specifically, the in-depth case studies addressed the following questions:

What role does social and economic disadvantage play in explaining variation among countries in adolescent reproductive behavior? And what steps have societies taken to reduce disadvantage or to support youth and families during their formative years?

How do countries differ in terms of societal attitudes, policies and programs regarding sexuality and sexuality education and information provision?

How do countries differ in their provision of and support for adolescent access to contraceptive and other reproductive health services?

Finally, what potential new approaches are suggested by examples of programs and policies that have been adopted in each country?

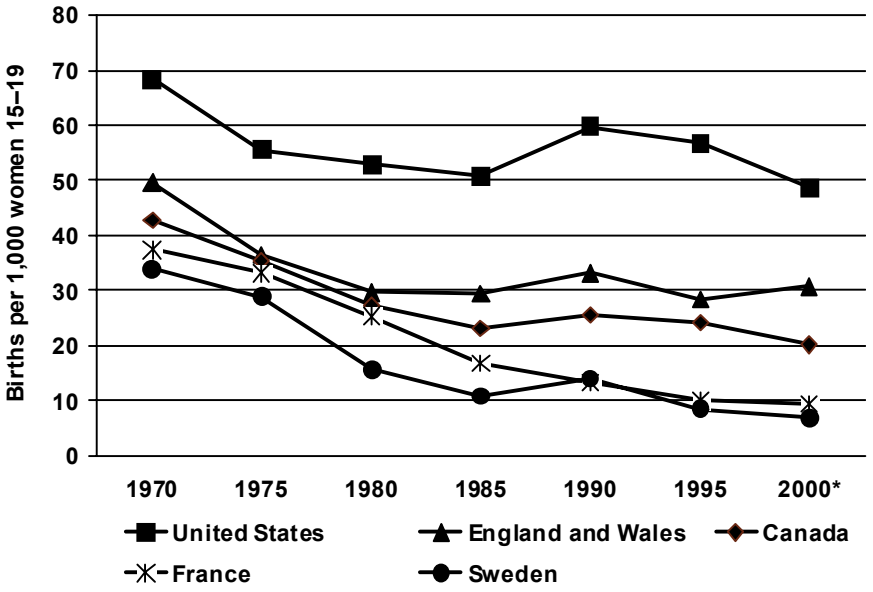
This report summarizes the findings from these case studies and draws upon the insights gained to suggest additional strategies for lowering adolescent pregnancy and STDs in the United States.

Background

A cross-national examination of adolescent reproductive behavior by The Alan Guttmacher Institute (AGI) and collaborating researchers in the early 1980s found that the United States had an exceptionally high teenage birthrate as compared to other industrialized countries.[4] And, although the adolescent birthrate in the United States declined nearly 30% between 1970 and 2000 (Figure 1-1, page 14),[5] it remains much higher than the rates found in the other study countries and the decline here was less steep than the declines experienced elsewhere. In fact, the current U.S. rate of 49 births per 1,000 women aged 15–19 is only slightly below the level found in 1985 (51 per 1,000 in 1985).[6]

Adolescent pregnancy and birthrates in many other developed countries were substantially lower than the United States in 1970 and have fallen much more steeply since then, widening gaps between the United States and other countries on these measures. The trends in the four other countries investigated in this current study illustrate these changes. For example, the teenage birthrate in England and Wales decreased

Figure 1-1. Teenage birthrates declined less steeply in the United States than in other developed countries between 1970 and 2000



*Note: Data are for 1997 in Canada, 1998 in France and 1999 in England and Wales and Sweden.

38% between 1970 and 1995, to 31 per 1,000 in 1999; and in Canada teenage births fell over 50% from 43 per 1,000 to 20 per 1,000 in 1997. Births to adolescents dropped even more steeply in France (75%, to an estimated 9 per 1,000 in 1999) and in Sweden (80%, to 7 per 1,000 women aged 15–19 in 1999).

Prior in-depth country analyses found only small differences in timing and levels of sexual activity across adolescents in the studied countries (United States, Canada, England and Wales, France, the Netherlands and Sweden) but wider differences in contraceptive-use patterns and in abortion levels. Sexually active teenagers in the United States were less likely than those in other countries to use highly effective methods of contraception and pregnant U.S. adolescents were more likely to give birth.[7]

AGI studies and other cross-national investigations of developed countries provided strong indication that key factors responsible for country differences in adolescent sexual and reproductive behavior are variations in attitudes about sexuality, in service delivery and in socioeconomic disadvantage.[8] Similarly, these studies have concluded that more comprehensive sexuality education, greater societal openness regarding sexuality and adolescents having easier access to reproductive health services are fundamental to lower rates of adolescent pregnancy and STDs in Western European countries and Canada compared to the United States.[9] The importance of looking at the societal context of behavior across countries has also been borne out by prior studies that included all women of reproductive age. In the early to mid-1980s, unplanned pregnancies in the United States among all women were higher than in most other comparison countries;[10] and, in the 1990s, the U.S. abortion rate among all women was considerably higher than the rates for women in the other study countries.[11]

Contributing to cross-national differences may be the fact that in Europe, policymakers pay a great deal of attention to the importance—and the challenges—of improving education and training so as to better prepare young people for adulthood and enhance the country's economic competitiveness. Europeans also give greater attention than do Americans to the interrelationships between these aspects of young peoples' lives and their sexual and reproductive behavior and health.[12] Finally, even though many European countries are concerned about low birth-

rates and some have put in place specific pro-natalist policies, these have not translated into support for childbearing among adolescents.[13]

In the United States, it is not only high levels of teenage pregnancy and childbearing that continue to be the focus of social policy, advocacy and controversy. Rather, the United States appears unique in its widespread concern about adolescent sexual behavior, in and of itself, and in the development of public policies aimed at dissuading young people from sexual activity.[14]

The Current Study

The results presented here summarize a large, collaborative investigation into the current role of key factors in determining ongoing differences in adolescent reproductive behavior among developed countries. As a first step in this investigation, AGI researchers compared levels and trends in adolescent pregnancy, birth and abortion, and incidence of sexually transmitted infections across a large number of developed countries. The results of this comparison have been published elsewhere[15] and are summarized briefly here.

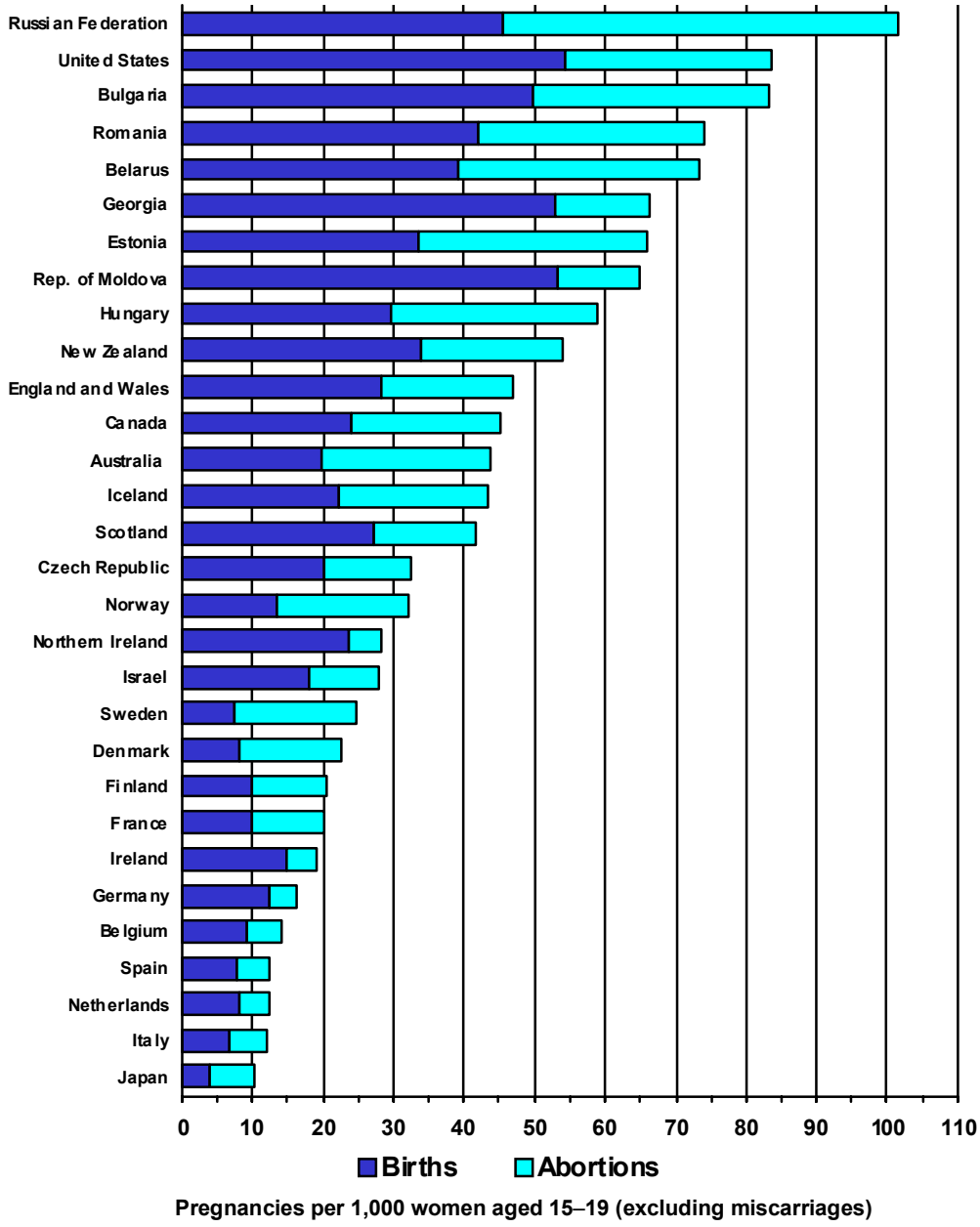
Trend data on adolescent birthrates were compiled for 46 countries over the period 1970–1995. Abortion rates for a recent year were available for 33 of the 46 countries, and data on trends in abortion rates could be gathered for 25 of the 46 countries. STD incidence data on syphilis, gonorrhea and chlamydia were obtained for as many as 16 countries. Data for the mid-1990s reveal that the level of adolescent pregnancy varies by a factor of almost 10 across the developed countries, from very low rates in Italy, Japan and the Netherlands (10–12 pregnancies, excluding miscarriages, per 1,000 adolescents per year) to an extremely high rate in the Russian Federation (more than 100 per 1,000). Most western European countries have low pregnancy rates (under 40 per 1,000); moderate rates (40–69 per 1,000) occur in Australia, Canada, New Zealand and a number of European countries. A group of five countries—Belarus, Bulgaria, Romania, the Russian Federation and the United States—have pregnancy rates of 70 or more per 1,000, excluding miscarriages (Figure 1-2, page 16).[16]

This investigation showed that adolescent birthrates have declined in the majority of developed countries since 1970, and in some cases have been more than halved. Similarly, pregnancy rates in a majority of countries with accurate abortion reporting showed declines. However, decreases in the adolescent abortion rate were much less consistent across developed countries.

The review of STD incidence among adolescents across developed countries revealed that the incidence of syphilis, gonorrhea and chlamydia has generally decreased during the 1990s among developed countries, with the exception of syphilis in the Russian Federation, where it rose dramatically in the 1990s. When compiling these data, the researchers found that STD data were lacking for many countries, and even for those countries with somewhat reliable reporting systems the data are thought to underestimate true STD incidence. In most countries with data, the incidence of syphilis among adolescents was quite low, while gonorrhea incidence was many times higher in several countries and disproportionately affects adolescents and young adults. Gonorrhea rates among adolescents were as high as 600 per 100,000 (in the United States and the Russian Federation). Similarly, in all countries with good reporting, chlamydia incidence was extremely high among adolescents (between 500 and 1,200 cases per 100,000), with the highest reported rates in Denmark and the United States.[17]

The remainder of the investigation, reported on here, was an in-depth comparison of the United States and four other developed countries: Canada, France, Great Britain and Sweden. Separate working papers present the case study reports for each of these five focus countries.[18]

Figure 1-2. Teenage pregnancy is more common in the United States than in most other industrialized countries



Chapter 2. Case Study Design, Country Contexts and Data Sources

Case Study Design

Country Selection

The five focus countries in this project were selected on a number of criteria: to build on the knowledge base of AGI's prior investigations; to include countries that share major similarities with the United States and therefore have particular policy relevance; and to compare countries that span a range in teenage pregnancy levels.

Using these criteria, four countries in addition to the United States were selected. Canada and Great Britain have teenage pregnancy rates that are much lower than that of the United States, yet they share many cultural similarities with the United States. Sweden and France now have very low pregnancy rates but have experienced great variation in teenage pregnancy rates since the mid-1980s, and have developed policies and programs specifically to address rates that were considered too high.[a]

Country Report Preparation

Teams of researchers in each of the five focus countries, in collaboration with the U.S. investigators, prepared case study reports for their country. (Members of the study team are listed in the Acknowledgments.) Study-team members included medical and social scientists, advocates and service providers who had experience and knowledge regarding adolescent sexual and reproductive behavior and health. Many of them were especially knowledgeable about one or more of the key topical areas of concentrated investigation.

The U.S. team designed the study, secured funding and oversaw the project. They identified the study focus and design, drafted the initial study outline, recruited study team members and made site visits to each country to work with the study teams and to visit programs, officials and researchers. The full study team met together twice during the project to finalize project goals, to design and plan work efforts, to review country findings and to discuss conclusions. Finally, drafts of each country report were reviewed by the U.S. study team, and comments were provided to the researchers from each country for use in finalizing the reports.

Each team worked from a common outline to describe their country, using quantitative data on sexual and reproductive health behavior as well as survey and other available information documenting social attitudes and service delivery. (See Appendix B for a copy of the outline used by each study team.) When data were lacking, country consultants drew upon other sources or on informed impressions about the topic for their country. They also described characteristics of their country from a qualitative perspective, drawing from available research, their own experience and knowledge, and interviews and consultation with other experts. The qualitative focus for describing each country was flexible enough to be adapted to each country's uniqueness and to new insights generated during the investigation.

It is extremely difficult, however, to distill the richness and variation of behaviors and attitudes of groups throughout a country into the types of summary descriptions needed for this work. Thus, while the case studies provide a good grasp of the general conditions of each country, they do not fully capture the variation that exists across all areas or groups within each society. This is especially the case for minority groups, whether they are immigrants, racial or ethnic minorities or from low-income or other disadvantaged groups.

[a] The Netherlands was included as a focus country in AGI's prior cross-national investigation of teenage pregnancy and childbearing. Funding limitations necessitated including a smaller number of countries in this project.

Summary Process

The U.S. study team was responsible for summarizing the results of all components of this investigation. In drafting this report, the authors have made comparisons across the five study countries drawing upon the data and insights provided in the country reports, the observations made during site visits to each country, and review of relevant literature. The report has been reviewed by the study teams from each country and outside experts and revised to reflect their comments. Although each study team member contributed in an integral way, the U.S. team bears ultimate responsibility for this volume.

Country Contexts

The five study countries have the advantage of spanning a wide range in teenage pregnancy rates and birthrates—from about seven births per 1,000 females aged 15–19 in Sweden to nearly 50 per 1,000 in the United States in 2000. There are three distinct groups: Sweden and France have the lowest teenage birthrates and pregnancy rates; Canada and Great Britain have moderate adolescent birthrates and pregnancy rates; and the United States has the highest teenage birthrate and pregnancy rate.

All five focus countries have democratic governments and are highly developed and industrialized. However, they differ in some basic respects—population size and density, as well as political, economic and social structures—factors that may affect health service provision and needs and ultimately influence adolescent sexual and reproductive behavior. Country size and population density are measures that may reflect the extent of similarity and diversity within a country in terms of backgrounds, attitudes, exposure to media and other information sources, as well as the availability of education, social and health services. Efficient provision of such services is often more difficult in less densely populated areas, where access may be limited by the distances people need to travel, greater difficulty in getting information about where to go for services and greater program costs to serve small numbers of young people. The locus of control over policies and education, social and other services also impacts similarity and diversity in the conditions under which people live.

The economic standing of countries, reflected here by per capita GNP, provides some comparison of economic resources available to each country's residents. There are even wider differences, however, in the extent of disparity in income distribution across countries than might be suggested by variation in per capita GNP. And, differences across countries in the types and amounts of services provided by government are reflected to some extent in the percentage of gross domestic product accounted for by taxes.

All of the case study countries but the United States have parliamentary forms of government, assuring a level of consensus between legislative and executive branches. In contrast, it has been common in most recent years in the United States for different parties to control the two branches of government, terms are fixed by law rather than reflecting majority power and disagreements can lead to ongoing stalemate. While there is ample room for disagreement and opposition in all the countries, the majority in the parliamentary systems has a greater chance for pursuing its policy objectives, so long as it retains public support.

United States

The United States is the largest of the five countries studied, with a population of 275 million and overall population density of 76 people per square mile, varying from dense cities to large expanses of sparsely settled rural areas (Table 2-1). While the national government is a strong focus of attention, states and localities are generally responsible for the administration of social services, for some of which they receive funding from the federal government, and for education and public health services. Historically, the United States has emphasized individual responsibility for one's own welfare. As much as possible, government is expected to stay out of people's lives and only, as a last resort, play a remedial role as provider of assistance. Consequently, the tax burden is lowest in the United States, reflecting less public provision of social and health services. In 1999, for example, 14% of children and youth under age 18 and 29% of those aged 18–24 had no health insurance coverage during the entire year.[19] Public health services have been set up to provide some types of health care to very poor people in the United States who cannot access private care. However, because public services are primarily for those who are disadvantaged, their use carries a stigma in many communities. Numerous nongovernmental organizations help to make up for the lack of public services, but their coverage and scope vary across the country. Although the United States has

Table 2-1. Selected demographic and economic indicators, mid- to late-1990s, Sweden, France, Canada, Great Britain and the United States

Indicator	Sweden	France	Canada	Great Britain†	United States
DEMOGRAPHIC INDICATORS					
Population, 2000 (millions)*	8.9	59.1	31.3	56.2	274.9
Sq miles (000s)*	159	211	3,560	93	3,539
Population per sq mile, 1999*	56	279	9	632	76
ECONOMIC INDICATORS					
GNP per capita, 1995*	$24,730	$26,290	$19,000	$19,020	$27,550
TVs and radios per capita, 1994*	1.4	1.5	1.7	2.0	2.9
Taxes as % of GDP, 1996*	56%	48%	37%	36%	32%
% of children in families below median income**	4%	10%	16%	21%	26%

Sources: *U.S. Bureau of the Census, *Statistical Abstract of the United States: 1998* (118th ed.), Washington, D.C.: U.S. Bureau of the Census, 1998; ***Teenage sexual and reproductive behavior in developed countries: Country reports,* 2001, (see text reference 18);
†Demographic and economic data for Great Britain includes Northern Ireland.

Note: The order of the five countries in this and all subsequent tables and figures is based on their relative rank on rates of teenage childbearing. Sweden is listed first since it has the lowest rate of teenage childbearing, followed by France, Canada, Great Britain and the United States.

the highest gross national product of the five countries ($27,550 per person), a higher proportion of the population is poor or low-income than in any other case-study country. Some 26% of children live in families under the median income, for example. Americans appear fairly accepting of such disparity, however, with 55% of adults saying they are proud of the fair and equal treatment of all groups in American society.[20] Mass media is a ubiquitous part of life in modern society that many see as important in transmitting negative and positive images and messages about sexuality. Media saturation, measured by the numbers of televisions and radios per capita, is greatest in the United States—roughly twice the levels of France and Sweden and substantially higher than in Canada and the United Kingdom.

France

France has a population less than one-fifth that of the United States, but it is much more densely populated at 279 people per square mile. The central government has broader responsibilities in France than in the United States, overseeing education and social services, which are administered at regional and local levels. The tax level is much higher than in the United States (48%), with more services provided in the public sector and essentially all people covered by some form of health insurance. GNP per capita in France ($26,290) is only slightly less than in the United States, but it is much more evenly distributed across the population. Only 10% of French children live in families under the median income, compared with the 26% found in the United States (Table 2-1).

Sweden

Sweden has a small population of 9 million people, settled in a few large cities and sparsely throughout the rest of the country for an average population density of 56 people per square mile. Although local communities and schools have recently become responsible for their own curricula and communities provide social and health services, there is strong central guidance and coordination. Public responsibility for a wide range of social and health services has been a long-standing priority in Sweden, reflected in the highest tax level of the case-study countries (58%), as well as in the fact that health service provision is virtually universal and people across all income levels use public health and social services. Swedish income ($24,730 GNP per capita) is relatively high, though somewhat lower than in France or the United States. Reducing economic disparity has been a clear, agreed-upon goal for many years in Sweden and only 4% of Swedish children live in families below the median income (Table 2-1). In fact, even though economic disparity is least in Sweden, there appears to be less tolerance of it than in the United States—only 40% of Swedes feel proud of the fair and equal treatment of all groups.[21]

Canada

Canada's population is roughly one-tenth that of the United States in a country of similar size. The country is sparsely settled, at nine people per square mile, but this figure is misleading because most Canadians live along the U.S. border, many in large cities. Provincial governments are quite strong in

Canada. These and local governments are responsible for education and social and health services. The per capita GNP in Canada is the lowest of the countries studied here and is virtually the same as that of the United Kingdom. There is more disparity of income in Canada than in France or Sweden, but less than in the United States, with 16% of Canadian children in families living under the median income. Taxes account for slightly more of the GNP in Canada than in the United States (37%), but substantially less than in France or Sweden. Almost all Canadians have health insurance coverage.

Great Britain[b]

Great Britain, like France, has a population less than one-fifth that of the United States, but it is by far the most densely populated of the case-study countries with 632 people per square mile. Great Britain has a more centralized government than the United States or Canada, but less so than France and Sweden. In Great Britain, local areas are responsible for education and social services, but most policies are set nationally. Income levels, as reflected in the GNP per capita, are similar to Canada and substantially lower than in France, Sweden or the United States. The tax level is also similar to Canada (36% of GNP). Of the case-study countries, Great Britain is closest to the United States in extent of economic disparity, with 21% of children in families under the median income level. There is, however, a long tradition of national health service provision, used by people from all socioeconomic levels. Health care is virtually universal. The overall level of social supports in Great Britain is less, however, than in France or Sweden and is probably most comparable to the United States.

Sources of Data

Study teams drew upon many different kinds of data sources for the case-study reports, which are the primary sources for this summary. These include vital statistics and survey data on levels and trends in adolescent sexual and reproductive behavior and on variations across demographic subgroups; survey data, research reports and informants' statements about society's attitudes, approaches and services regarding sexuality, sex education and reproductive care for adolescents; and descriptions of examples of specific interventions.

Birth and Abortion Statistics

Birth data were obtained from published vital statistics reports and from unpublished government data provided by special request to the study teams. Data on births are close to completely reported for these five developed countries, which all have long-established birth registration systems.

Data on the number of abortions occurring to adolescents were also obtained from government statistical agencies. Abortion is legal under broad grounds in all five countries, and reporting of all procedures is required in Canada, France, Great Britain, Sweden and in most U.S. states. Reporting of abortion procedures is believed to be near complete in Canada, Great Britain and Sweden.[22] In France, studies evaluating data quality in the late 1980s and mid-1990s have shown a substantial level of underreporting, possibly as high as 25%.[23] However, we did not inflate the reported abortions to teenagers in France because there is no consensus on the level of underreporting, nor if it applies equally across age-groups. Comparison of officially reported abortions in the United States with an independent survey of all known providers indicates that official statistics underreport abortions by approximately 13%.[24] For the United States, we therefore used estimates of abortions based on AGI's abortion provider survey (which is judged to be almost complete) and the age distribution of officially reported abortions.[25]

The measures of birth, abortion, and pregnancy presented here are standard ones: Rates are calculated as the number of events (for example, births) per 1,000 women aged 15–19 per year. The abortion ratio is calculated as abortions per 100 pregnancies (births plus abortions) in a given year. The pregnancy rate includes only births and abortions (that is, it excludes miscarriages).[c]

The birthrates and abortion and pregnancy rates presented here are calculated according to the woman's age at the time the pregnancy ended. To obtain comparable rates for the five study countries, it was necessary to adjust the data from France, where events are reported according to the age the

[b] Throughout this report we focus primarily on data and findings from Great Britain (including England, Wales and Scotland). In some cases, data are specific to England and Wales (and exclude Scotland) and we indicate this whenever relevant.

[c] Miscarriages may be estimated using an established formula (no. of miscarriages equals 0.2 x births + 0.1 x abortions). This calculation approximately accounts for miscarriages that occur after eight weeks from the last menstrual period.

woman would attain during the calendar year in which the event (birth or abortion) occurred, rather than according to her age in completed years. We present the adjusted rates in order to facilitate comparison with the other case-study countries.[d]

Sexual Activity, Timing of the First Birth and Contraceptive Use

Data on these topics come from the most recent surveys that interviewed adolescents on sexual and reproductive behaviors. Table 2-2 (page 22) lists the main surveys used for each country and the variables available from each survey. Countries vary in coverage of the adolescent age-group, with some including all 15–19-year-olds, and others only younger or only older teenagers. Not all surveys obtained information on all the main aspects of sexual and reproductive behavior. Surveys in the United States and Great Britain obtained the largest range of measures of sexual and reproductive behavior, with much more uneven coverage in the other three countries.

Data on age at first intercourse and age at first birth were available from at least one survey for all five countries. Data on contraceptive use at first intercourse were available only for younger teenagers (15–17-year-olds) in France and for 16–18-year-olds from a small sample survey in Sweden, but were not available for Canada. A measure of recent contraceptive use (either current use or use at last intercourse) was available for all five countries. In the case of France, data on younger teenagers (15–17) are from the 1994 Survey of Sexual Behavior of Young People and data for older teenagers (18–19) are from the 1992 Survey of Sexual Behavior. In the case of Sweden, national data were available only for teenagers aged 18–19, and data for 16–18-year-olds were available only from a small sample survey.

We used two methods when dealing with missing data. When no information was available on whether a behavior or an event had occurred, such cases were omitted from calculations (for example, from percentage distributions). When the available information indicated that the event had occurred (for example, the respondent had initiated intercourse), but the age at first intercourse was unknown, such cases were assumed to have had the same proportional distribution as events for which there was information.

Socioeconomic Characteristics

Great variation across the countries in the availability of data on socioeconomic variables and in how these variable are defined and categorized limited the aspects of disadvantage we could include and the comparisons we could make. As in the case of reproductive behavior, more measures of socioeconomic characteristics were available for the United States and Great Britain than for Canada, France and, especially, Sweden. For each variable, we matched categories as closely as possible. For example, for each of the four countries with measures of income or poverty, we created three categories of as equal size as feasible from the data available to reflect low, medium and high economic status. Similarly, we developed a three-tiered classification for low, medium and high educational attainment. Race, ethnicity and immigrant status do not translate easily or directly into comparative measures of disadvantage, because minority groups in the study countries originate from different countries and cultures; may differ in values, attitudes and behavior; and may not be socially or economically disadvantaged relative to the majority group. For race and ethnicity, we compared the white and non-white categories used in Canada and Great Britain with the three categories used in the United States: non-Hispanic white, non-Hispanic black and Hispanic.

Immigrant status is categorized into two groups, foreign-born and native-born, in all four countries with this measure (Canada, Great Britain, Sweden and the United States). However, there is great variation across countries in where immigrant groups come from: in Canada and Britain, a large proportion are from Asia, though the Caribbean and Sub-Saharan Africa are also represented; in the United States, a large proportion are from Latin America and the Caribbean, though substantial numbers are from other regions of the world as well; immigrants in Sweden are mainly from Finland, Turkey and Greece. Although data are not available on adolescent behaviors by immigrant status for France, the proportion foreign-born is substantial, and immigrants from French-speaking countries of North and Sub-Saharan Africa are the largest groups.

[d] In effect, age in France is calculated as the difference between the year in which the event (birth or abortion) occurred and the woman's year of birth. The use of this method for calculating age has a substantial impact on birthrates and abortion rates for adolescents, with rates based on age attained being substantially lower than those based on completed age at the event. For more on the procedure for adjustment and for unadjusted rates, see Singh S and Darroch JE, 2000 (reference 1).

Table 2–2. Characteristics of and measures available in surveys of sexual and reproductive behavior in Sweden, France, Canada, Great Britain and the United States, mid-1990s

Country and survey	Characteristic					Measure of behavior				
	Year of survey	Age-range	National sample	Sample size		Age		Method		
				Male	Female	At first sex	At first birth	At first sex	Current use	At last sex
Sweden										
Two surveys in towns in Northern Sweden	1986	16–18	No	533*	na			X		
	1991	16–18	No	253	223			X		X
National Swedish Survey	1996	18–74	Yes	1,335	1,475	X				X
Swedish Family Survey	1992–1993	23–43	Yes	1,666	3,318		X			
France										
Survey of Sexual Behavior of Young People	1994	15–17	Yes	3,340	2,838	X		X		X
Survey of Sexual Behavior	1992	18–49	Yes	8,951	11,104	X				X
Survey on Families and Employment	1994	20–49	Yes	1,941	2,944		X			
Canada										
General Social Survey	1995	≥15	Yes	3,743	4,166		X		X	
National Population Health Survey	1996	15–49	Yes	21,310	22,834	X				
Great Britain										
National Survey of Sexual Attitudes and Lifestyles	1990–1991	16–59	Yes	8,384	10,492	X	X	X		X
United States										
National Survey of Family Growth (Cycle 5)	1995	15–44	Yes	na	10,847	X	X	X	X	X
National Survey of Adolescent Males	1995	15–19	Yes	1,729	na	X	X	X	X	X

*Total sample size, not divided between males and females. *Notes:* na=not applicable. Order of countries in all tables is based on levels of birthrate (from lowest to highest). Analyses were carried out on data files, except for the following sources for Sweden, for which only published data could be used: **Two surveys in towns in northern Sweden**—Swedin G et al., Big changes in adolescent sexual behavior, *Lakartidningen*, 1994, 91(11):1083–1084 (in Swedish); and **National Swedish Survey**—Lewin B, ed., *Sex in Sweden: On the Swedish Sexual Life, 1996,* Stockholm: National Institute for Public Health, 1998, p. 11 (in Swedish).

Lacking exactly comparable measures of disadvantage for the five countries, we made approximate comparisons based on relative differences within societies and using data and definitions available in each country. Overlap between dimensions of disadvantage complicates interpretation of simple differentials within and between countries. For example, race and ethnicity often correlate highly with income and education and racial or ethnic differentials are often proxies for socioeconomic differences.[26] Furthermore, minorities may face discrimination even when they are not poor; large numbers of the majority white population also are poor; and values and attitudes vary among racial and ethnic groups and may influence adolescent behavior independently of income and social status.

Measurement of social and economic disadvantage in a society is itself a function of the extent to which disadvantage exists. Where disadvantage is minimal, as in Sweden, it is often not measured. Moreover, the

existence of data on socioeconomic status and disadvantage in a particular country often depends on these variables' political relevance. For example, in France and to some extent in Canada and Great Britain, race and ethnicity are perceived to be less important than other measures, such as income and occupation, and information on race is often not collected. However, the historical and political relevance of race is quite different in the United States than in the other countries and is reflected in the wide practice of incorporating race and ethnicity as variables in most U.S. data collection efforts.

Attitudes and Values

Study teams used information from a variety of types of sources to describe their country's attitudes and values regarding sexuality in general and adolescent sexual and reproductive behavior in particular. National survey data asking respondents about the acceptability of certain behaviors such as premarital, extramarital, homosexual or adolescent sexual activity were available for all five countries. Additional national or regional/local survey data were available from some countries that covered related topics. For example, several countries had recently conducted national surveys of youth or all people that included information on sexual behavior, sex education, sources of and attitudes about sexual or reproductive health information, and patterns of communication regarding sexual matters, among other topics.

In addition, study teams used publicly available information on laws and regulations regarding a number of related areas, including sexual activity, marriage and sexual practices, and media restrictions regarding sexual matters, nudity and advertising of contraceptives. Other sources included published and unpublished academic, government and policy reports, as well as newspaper articles or other media products. Finally, study teams were encouraged to provide their own expert opinions when describing the situation for their country. These "expert opinions" were based upon the experiences of the researchers living in each country, interviews or personal communication that they conducted with other local experts and reference to publicly available information regarding public opinion, norms and attitudes toward adolescents and the provision of sexuality education.

Health Care Services

For the most part, data on service provision within each country come from published descriptions of the health care delivery systems, health care insurance mechanisms, and reports of special services available for adolescents. Government documents or health department guidelines on service provision were often referred to and quoted. In some countries, government health departments or independent organizations have collected service data on the numbers of women or teenagers obtaining certain kinds of services from some providers. Other information came from surveys of health care providers or of clients obtaining care from certain kinds of providers or in certain local areas. One study team (Canada) conducted its own survey of adolescent reproductive and sexual health care specialists all over the country, requesting information on the types and accessibility of services in different communities and regions. In addition, government handbooks on service provision and official data on health care expenditures were often used by study teams.

Policies Regarding Family Supports and Youth Development

In addition to the above types of sources used by study teams to describe family and youth policies and programs of their countries, we have included data from Columbia University's Clearinghouse on International Developments in Child, Youth and Family Policies.[27]

Program and Policy Interventions

Included in the country reports and in this summary are numerous examples of interventions thought to affect teenage sexual and reproductive behavior. Study teams were requested, in the country report outline, to provide descriptions of programs, policies, initiatives or laws in each of three substantive areas: (a) Interventions that directly or indirectly impact or illustrate societal views about sexual behavior and the socialization of adolescents about sex; (b) Interventions that have impacted the availability and accessibility of reproductive health care services to adolescents and/or have encouraged responsible contraceptive and disease preventive practices among youth; and (c) Interventions that have been implemented to assist youth from economically or socially disadvantaged populations. The study teams were asked to provide descriptions of two to four interventions in each area and to choose interventions, whenever possible, that were generalized or large

efforts, innovative efforts, demonstrated effective efforts, or efforts that were thought to have potential for effective results. Since few of these programs have been evaluated, they are not necessarily all illustrations of successful interventions. In fact, examinations of intervention evaluation in the United States have shown that many have little or no effect for a variety of reasons, ranging from their design and focus, their length and intensity and other contextual influences.[28] Therefore, the programs described here illustrate types of interventions that are being undertaken in the various countries to address issues of adolescent sexual and reproductive behavior and health and, hopefully, will provide suggestions for further innovation, evaluation and replication in other settings.

Part B: Adolescent Sexual and Reproductive Health: Differences Across Countries and Among Groups Within Countries

Chapter 3. Adolescent Pregnancy and STDs: The Role of Sexual Activity and Contraceptive Use

Introduction[e]

Rates of teenage pregnancy and STDs vary widely across the five developed countries studied. As a first step in understanding the reasons that lie behind cross-national differences in pregnancy and STD rates, we examined differences in two factors closely related to these outcomes—sexual activity and contraceptive use. These two proximate determinants are themselves strongly influenced by more fundamental factors and conditions—the level of social and economic disadvantage, which may affect adolescents' ability and motivation to plan for the future, societal attitudes and values regarding teenage sexual behavior, and ease of availability and accessibility of contraceptive services—all of which are the focus of later chapters in this report.

Differences across countries in level of sexual activity may mean that adolescents' exposure to the risk of pregnancy and STDs differs substantially. However, cross-national differences in the second factor—use of condoms and other contraceptives—may counterbalance this by providing protection against these risks. To best evaluate the role of these two factors, more detailed and specific information is needed than what is actually available. For example, the proportion of teenagers who have ever had intercourse is a useful measure, but more specific data, such as the proportion who are currently sexually active and the frequency of intercourse among those who are sexually active, are also important factors that may influence pregnancy rates; in addition, the number of sexual partners and the type of relationships (for example, short term or longer term, monogamous or not, heterosexual or homosexual) are key factors that should be considered in assessing the role of sexual behavior in STD risk and incidence. In the case of contraceptive use, the pattern of use (use at first intercourse, current use or use in a recent time period), the proportions of teenagers using specific methods, and the effectiveness of use of each method are all relevant factors in explaining variation in teenage pregnancy. In addition, proportions using the condom and patterns of condom use (for example, whether it is used every time, used in certain types of relationships only) are factors that relate to STD incidence. While we do not have information on all of these measures, some information is available to help us assess variation in these two key factors of sexual activity and method use across countries.

We first describe current national rates of teenage pregnancy and sexually transmitted diseases before discussing the role of sexual activity and contraceptive use. We then present measures of sexual activity and contraceptive use for which we have comparable data for two or more of the five focus countries. Information on the data sources and methodology was presented earlier in Chapter 2.

Pregnancy and Childbearing

In the mid-1990s, the pregnancy rates for France and Sweden were 20 and 25 per 1,000 women aged 15–19, respectively (Table 3-1, page 28).[f] The

[e] Much of the text in this chapter is published separately, see Darroch JE, Singh S, Frost JJ and the Study Team, Differences in teenage pregnancy rates among five developed countries: The roles of sexual activity and contraceptive use, *Family Planning Perspectives*, 2001, 33(6): 244-250 & 281.

[f] The pregnancy rates presented here are the number of pregnancies per 1,000 women aged 15-19 at the time the pregnancy ended. These pregnancy rates are obtained by summing the birth and abortion rates, and they exclude spontaneous pregnancy loss or miscarriages. For example, in the United States the adolescent pregnancy rate in 1996, including miscarriages, would be 97, compared to a rate of 84 when miscarriage is not included. For France, where events are reported according to age attained during the year of the birth or

adolescent pregnancy rates were approximately twice that level in Canada and Great Britain (46 and 47 per 1,000, respectively) and four times that level in the United States (84 per 1,000). Differences between the United States and the other four countries are even larger for younger teenagers than for older ones. The pregnancy rate among 15–17-year-olds in the United States is five times that in France (rates of 53 and 10 per 1,000, respectively), compared with somewhat less than a fourfold difference among 18–19-year-olds (rates of 131 and 35 for the United States and France, respectively).

The proportion of young women aged 20–24 who had a child before age 20 is a useful summary indicator that reflects the differences in teenage birthrates by country. This proportion is lowest in Sweden (4%), slightly higher in France (6%), much greater in Canada and Great Britain (11% and 15%, respectively), and highest in the United States (22%). Differences in the proportion giving birth by age 15 and by age 18 are also much higher in the United States than in the other four countries (Figure 3-1).

Whether adolescents plan their pregnancies and have intended births are key factors in understanding the implications of adolescent pregnancies and births. Although there are no comparable data on these issues for all five of the focus countries, some related information does cast light on the subject. In the early to mid-1980s, the unplanned pregnancy rate among all women aged 15–44 was much higher in the United States than in Sweden, Canada and Great Britain; the U.S. rate was similar to the rate in France.[29] Recent, national survey-based information for the United States shows that 78% of all pregnancies and 66% of births to adolescents in the early 1990s were unintended.[30g] Counting only intended births, the *intended* adolescent birthrate in the United States was about 18 births per 1,000 teenagers per year in the mid-1990s—a rate that is approximately twice the overall adolescent birthrate in France and Sweden, and is about two-thirds as high as the overall adolescent birthrate in Canada and Great Britain. The *unintended* pregnancy rate in the United States (roughly 66 per 1,000 in the mid-1990s) is still,

Table 3–1. Birth, abortion and pregnancy rates and abortion ratio, by country, according to age-group, mid-1990s

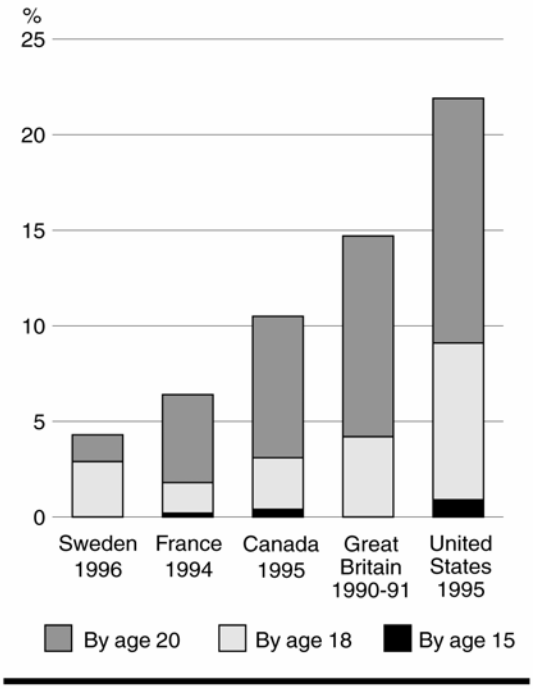
Country	Ages 15–19				Ages 15–17				Ages 18–19			
	Births per 1,000	Abortions per 1,000	Pregnancies per 1,000	Abortion ratio	Births per 1,000	Abortions per 1,000	Pregnancies per 1,000	Abortion ratio	Births per 1,000	Abortions per 1,000	Pregnancies per 1,000	Abortion ratio
Sweden (1996)	7.8	17.2	25.0	68.8	2.7	13.7	16.4	83.5	15.5	22.6	38.1	59.3
France* (1995)	10.0	10.2	20.2	50.5	3.5	6.8	10.3	66.0	20.0	15.2	35.2	43.2
Canada (1995)	24.5	21.2	45.7	46.4	13.6	13.8	27.4	50.4	40.0	32.2	72.2	44.6
Great Britain† (1995)	28.3	18.4	46.7	39.4	14.8	13.8	28.6	48.3	49.8	25.6	75.4	34.0
United States (1996)	54.4	29.2	83.6	34.9	33.8	19.0	52.8	36.0	86.0	44.9	130.9	34.3

*Rates are adjusted to the young woman's age in completed years when the event occurred, to be comparable with other countries. Rates are not inflated for the underreporting of abortions. †Rates for Great Britain (which comprises England, Wales and Scotland) are calculated by combining data for these administrative areas. *Notes:* Pregnancy rates include births and induced abortions but do not include spontaneous abortions or miscarriages. The abortion ratio is the number of abortions per 100 pregnancies, excluding miscarriages.

abortion, all rates discussed are adjusted for the difference in age reporting to make them comparable with other countries. However, the rates shown in Table 3-1 are not adjusted for abortion underreporting in France, where the level of underreporting is estimated to vary between 10%-25% (see reference 23). If we assume that teenagers have the same level of abortion underreporting as all women are estimated to have, the adolescent abortion rate for France would be in the range of 11.3-12.8, and the pregnancy rate would be between 21.3-23.5, somewhat higher than the rate of 20 shown in Table 3-1.

[g] Births were classified as "unintended" if the mother reported when surveyed that she wanted to have a child but at a later time, or if she did not want a child (or another child) at all. All other births were termed "intended." Unintended pregnancies are the sum of unintended births and abortions, which are all considered to have been unintended conceptions.

Figure 3–1. Percentage of 20–24-year-old women who had a birth by ages 15, 18 and 20



however, substantially higher than the *total* pregnancy levels of the other four study countries.

Teenagers who experience pregnancy differ across countries in their likelihood of resolving the pregnancy by abortion (measured by the abortion ratio, which is the proportion of pregnancies that end in abortions, excluding miscarriages). In the mid-1990s, the abortion ratio for 15–19-year-olds ranged from 35 abortions per 100 pregnancies in the United States (that is, 35% of pregnancies to 15–19-year-olds were resolved by abortion) to 69% in Sweden (Table 3-1). The proportion of teenage pregnancies ending in abortion in Great Britain is similar to the United States (a ratio of 39%) while levels in Canada (46%) and France (51%) are somewhat higher, but still much lower than the level in Sweden. In France, Great Britain and Sweden, the abortion ratio is substantially higher among younger teenagers aged 15–17 than those aged 18–19. This indicates that younger adolescents who become pregnant are less likely than those who are older to want to have a child at that time and to feel ready to become parents. The difference in the abortion ratio between older and younger teenagers is small in Canada and minimal in the United States (Table 3-1).

Although U.S. teenagers are less likely to resolve their pregnancies with an abortion than teenagers in the other countries because the U.S. teenage pregnancy rate is so much higher than in other countries, the teenage abortion rate is higher in the United States than in any other country. Moreover, in the mid-1990s, the abortion rate was higher not only among teenagers but also among women in their 20s and among all women aged 15–44 in the United States than in any of the other study countries. The greatest differences in abortion rates were not among teenagers but among women in their early 20s, with the U.S. abortion rate at 50 per 1,000 women aged 20–24, compared with rates in the other study countries no higher than 31 per 1,000.[31]

Childbearing among unmarried adolescents has attracted policy attention because of potential consequences to the young women and their children, as well as to society; however, the measure is defined differently across countries, with some classifying cohabiting teenagers as unmarried, and others grouping married and cohabiting together, considering only those who are single as unmarried. In the latter case, cohabiting couples are often socially and legally considered the equivalent to married couples and their relationships are often long-term ones. In France and Sweden 51% of adolescent births are to teenagers who are either married (17% and 18%, respectively) or cohabiting (35% and 33%, respectively). A much lower proportion of adolescent births are to married teenagers in the United States (25%) and Great Britain (13%); however, estimates for these two countries group together births to women who are cohabiting or unmarried. Because the overall teenage birthrate in the United States is so high, the birthrate among women who are not in union—37 per 1,000—is much higher than in Sweden and France—no more than 5 per 1,000.

Incidence of STDs

Available information on STD incidence suffers from many limitations. Data vary in completeness even for the three bacterial STDs that have been recognized and documented for the last few decades by many developed countries. Data on viral STDs are not required to be reported in many countries, and as a result are rarely available at the national level. Estimates of the incidence of viral STDs are available for some countries, mostly through surveys that carry out bio-marker testing; however, data are also often not comparable across countries because of many differences in study design, including differences in the type of tests used and in their specificity or

accuracy of detecting STDs.

Nevertheless, a compilation of available information on incidence of the three bacterial STDs among adolescent men and women in developed countries was carried out as part of this project.[32] Some basic measures are presented for the five study countries (Table 3-2). Summary highlights from these data include:

The United States has a much higher incidence of all three bacterial STDs than the other four countries. In the case of gonorrhea, the difference is even greater than is apparent from these data, because the United States has been judged to have a higher level of underreporting than the other countries.

Female adolescents have much higher reported infection rates than male adolescents for almost all STDs in all countries. While part of this difference is due to the greater likelihood of women being screened through regular gynecological care (an extreme instance is seen in the case of chlamydia in France), the greater physiological susceptibility of young women is also a contributory factor.

Young people aged 15–24 account for a high proportion of all cases of gonorrhea and chlamydia—half to two-thirds in some countries.

It is important to note that even in those countries that have relatively good reporting systems the actual incidence of sexually transmitted infection is probably substantially higher than the rates shown here. These measures are dependent not only on the quality and completeness of reporting to national health systems, but also on the characteristics of an STD and whether symptoms are serious enough that individuals seek medical care. Many infected individuals will not experience obvious symptoms even when the disease is communicable. Females are less likely to have obvious symptoms, but are more likely to be screened on a regular basis because many make regular gynecological visits. Nevertheless, even though estimates of the overall level may be too low, these data provide some indication of the relative differences across countries.

Table 3-2. Annual syphilis, gonorrhea and chlamydia rates for adolescents by gender and for the general population, and the percentage of total STD cases that are among young people, mid-1990s, Sweden, France, Canada, England and Wales and the United States

		Rate per 100,000				% of total cases that are among young people aged:		
		Adolescents 15–19			General			
Country	Year	Female	Male	Total	population	15–19	20–24	15–24
SYPHILIS								
Sweden	1995	1.2	0.0	0.6	0.8	4	10	14
Canada	1996	0.9	0.3	0.6	0.3	15	20	35
England and Wales	1996	0.2	0.2	0.2	0.3	5	11	16
United States	1996	8.6	4.3	6.4	4.3	10	17	27
GONORRHEA								
Sweden	1995	2.0	1.5	1.8	2.8	4	18	22
France*	1996	8.4	7.0	7.7	8.4	10	24	34
Canada	1996	86.4	33.3	59.4	16.8	24	27	50
England and Wales	1996	83.4	51.5	67.0	22.4	20	30	51
United States	*1996*	*758.2*	*394.8*	*571.8*	*125.1*	*31*	*29*	*60*
CHLAMYDIA								
Sweden	1995	921.0	235.2	569.6	156.0	21	45	66
*France**	*1996*	*110.9*	*1.6*	*55.1*	*60.2*	*10*	*28*	*38*
Canada	1996	998.6	148.5	563.3	114.8	33	37	69
England and Wales	*1996*	*339.0*	*74.2*	*202.9*	*75.9*	*23*	*34*	*57*
United States	*1996*	*2,067.0*	*245.8*	*1,131.6*	*192.6*	*31*	*24*	*55*

*General population rates for France are calculated using the number of infection cases per 100,000 population at ages 15–59.

Note: Italics indicate that the country has medium or low reporting rates; that is, fewer than 70% of diagnosed cases are estimated to be reported.

Sexual Activity

In all five countries, the large majority of young women have first intercourse while they are teenagers. The proportion of women aged 20–24 who had first intercourse before age 20 varies from 75% in Canada to 85–86% in Great Britain and Sweden; France and the United States are in between with 83% and 81%, respectively (Table 3-3). The median age at first intercourse[h] for women aged 20–24 ranges from 17.1 to 17.5 in Canada, Great Britain, Sweden and the United States, but is slightly higher (18.0) in France. Comparative data for a larger number of developed countries also suggest that the timing of sexual initiation has become increasingly similar across developed countries and is similar among young men and young women as well.[33]

Although available measures of sexual experience among 15–19-year-olds are not completely comparable for the five focus countries, data for this age-group suggest that sexual activity among adolescents also varies relatively little across the five countries. Moreover, the data are fairly consistent with findings on proportions of 20–24-year-olds who had had sex by age 20. Among all 15–19-year-old females, the proportion who ever had intercourse ranged from 49% in France to 51% in Canada and the United States but was substantially higher in Great Britain (61%). This latter finding is partly due to the slightly older age-group for which data are available (those aged 16–19).[i] The proportion of females aged 15–17 who have ever had sexual intercourse is similar in three countries for which this information is available (37–38%), and is somewhat higher in Great Britain (41%), where the data are for 16–17-year-olds (Table 3-3). There is greater variation across the five focus countries for teenagers aged 18–19: sixty-seven percent of French and 71% of U.S. and Canadian 18–19-year-olds have ever been sexually active compared with 79–80% in Great Britain and Sweden. Overall, while differences across countries in the proportion who have had sex by age 18 and by age 20 are fairly small, a substantially higher proportion of teenagers in the United States begin having sex before age 15 (14%) than do teens in Canada, France and Great Britain (4–9%). The U.S. proportion is only slightly higher than the level in Sweden (12%).

Table 3–3. Percentage of adolescent females who ever had sexual intercourse, by age; percentage who had intercourse in the past three months; percentage of 20–24-year-olds who had sex before age 20, by age; and median age at first intercourse among 20–24 year-olds—all according to country

Country	% ever had sex			% who had intercourse in past 3 months*	% who had sex before given age†			Median age at first sex†
	15–19	15–17	18–19		15	18	20	
Sweden‡ (1996)	na	na	80.3	78.7	12.2	65.2	85.6	17.1
France (1992,1994)	49.3§	37.9	67.1	63.9	7.4	50.1	82.5	18.0
Canada (1996)	50.9**	37.4	70.9	u	9.1	53.4	75.2	17.3
Great Britain (1990–1991)	61.1††	40.9‡‡	78.5	62.2	4.1	63.8	84.8	17.5
United States (1995)	51.3	38.3	70.7	58.7	14.1	63.1	80.6	17.2

*Among 18–19-year-olds. †Among 20–24-year-olds. ‡Data are available only for 18–19-year-olds; there are no recent data on sexual activity among 15–17-year-olds. (Source: 1996 National Swedish Population Survey.) §The estimate for 15–19-year-olds is synthetic, obtained by combining results on 15–17-year-olds from the 1994 Survey of Sexual Behavior of Young People and results on 18–19-year-olds from the 1992 Survey of Sexual Behavior, and applying these proportions to the 1995 populations for both age-groups. **The 1990 Health Promotion Survey, which had a much smaller sample, shows higher levels of teenage sexual activity (57.4% of 15–19-year-olds were ever sexually active). ††16–19-year-olds. ‡‡16–17-year-olds. *Note:* u=unavailable.

[h] The median age at first intercourse is the age by which 50% of all women aged 20-24 had had intercourse. For the United States the estimate (17.2) differs from a previously published estimate for 15-19-year-olds (a median of 17.4), The Alan Guttmacher Institute, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics*, New York: AGI, 2000, Chart 2, p. 10.

[i] The comparable proportion sexually active among 16-19-year-olds in the United States is 58%, still somewhat lower than the proportion in Great Britain.

Data on the proportion of all 18–19-year-old women who are currently sexually active (i.e., who had sex in the last three months) are available for four countries. The United States has the lowest proportion (59%), with France and Great Britain (62–64%) having somewhat higher levels, and Sweden (79%) having the highest level (Table 3-3). When expressed as a proportion of those who have ever been sexually active, these data also provide an indicator of continuity of adolescent sexual relationships, once intercourse is initiated. Continuity is higher in France and Sweden (where about 95% of 18–19-year-olds who have initiated intercourse are currently sexually active) than in Great Britain (79%) or the United States (84%).

The proportion of sexually active people who have had two or more sexual partners in the past year is often used as an indicator of potential risk for STDs. Some information on multiple partnership among adolescents is available, although measures are not exactly comparable across countries (Table 3-4). The proportion of those who were sexually active within the past year who had two or more sexual partners in that time period is substantially higher among teenage women in the United States than in Canada, Great Britain and France when we compare similar age-groups, but it is only slightly higher than the proportion among 18–19-year-olds in Sweden. The proportion of sexually active adolescent men who had two or more sexual partners in the past year is also highest in the United States, with Great Britain a close second among 16–19-year-olds. Adolescent men are generally much more likely than young women to have had two or more sexual partners in the past year in Canada, France and Great Britain and slightly more likely to have done so in the United States. In Sweden, however, the situation is reversed.

A more refined measure, only available for France, is the proportion of 15–17-year-olds who, having had their first intercourse at least one year before the interview and having been sexually active during the past year, have had two or more sexual partners in the past year. This proportion is almost one-third (31%) for women and one-half (45%) for men. In contrast, the proportion of 15–17-year-olds sexually active in the past year who had two or more sexual partners is higher in the United States (44% for women and 53% for men).[j]

Contraceptive Use

Information on contraceptive use is available for all five countries; although the data are somewhat limited. Some surveys obtained multiple measures of method use, including both use at first intercourse and use at last intercourse (or during a recent time period), while others did not. For surveys that allowed reporting of simultaneous use of two or more methods, we created a measure that prioritized contraceptive methods according to effectiveness, so that the most effective methods (sterilization, long-

Table 3–4. Percentage of sexually active adolescents with two or more sexual partners in the past year, by sex and by age, according to country

Country	Women				Men			
	15–19	18–19	16–19	15–17	15–19	18–19	16–19	15–17
Sweden (1996)	u	42.8	u	u	u	31.3	u	u
France (1992, 1994)	u	12.8	u	31.0*	u	28.8	u	45.3*
Cauda (1996)	23.9	23.5	u	24.3	32.1	38.1	u	24.8
Great Britain (1990–1991)	u	u	30.1	u	u	u	45.5	u
United States (1995)	46.5	48.6	47.2	43.8	50.8	48.8	50.5	53.3

*This value is not exactly comparable with the others because it is based on those who had first intercourse at least one year ago and who were sexually active in the past year. *Note:* u=unavailable.

[j] This proportion is understated for U.S. adolescents compared with French teenagers because in the French data the measure is based on sexually experienced teenagers who were sexually active throughout the past year, while for the United States, all sexually active teenagers were included, even those who first had intercourse within the past year.

acting hormonal methods, the IUD and the pill) were given higher priority than such less-effective methods as the condom, spermicides, withdrawal and periodic abstinence. Thus, a person using both the pill and condoms was classified as a pill user, while someone using condoms and spermicides was classified as a condom user. The data on condom use are based on questions concerning prevention of pregnancy and do not always include use of the condom for STD prevention only. Thus, we do not have measures of total condom use, nor do we have comparable data on dual contraceptive use for all the study countries.

Use at First Intercourse

Information on contraceptive use at first intercourse is available for four of the five focus countries (Table 3-5, no national data are available for Canada). Adolescents in France are substantially more likely to have used a method at first intercourse than those in the other 3 countries—89% of 15–17-year-olds having done so. The proportion of adolescent women who did not use any method at first intercourse was highest in the United States (25%), while proportions are only slightly lower in Great Britain and Sweden (21–22%). The condom is the method most likely to be used at first intercourse, with 61–67% of young women reporting using condoms at first sex in France, Great Britain and the United States and 41% of young women in Sweden. In Sweden, teenagers were much more likely than in other countries to use "other" methods—mostly withdrawal—at first intercourse: Twenty-four percent did so in Sweden compared with 4–7% in the other three countries. Few adolescent women in any of the countries reported using the pill at first intercourse, although U.S. adolescents were somewhat less likely to do so (8%) than were those in the other three countries (13–15%).

Table 3–5. Percentage distribution of ever sexually active women, by method used at first intercourse; and percentage distribution of currently sexually active women, by method used at last intercourse—all according to country

Measure and country	Age-group	Injectable/ implant/IUD	Pill	Condom	Other methods*	No method	Total
Method used at first intercourse†							
Sweden (1991)	16–18	0.0	13.0	41.0	24.0	22.0	100.0
France (1994)	15–17	0.0	15.1	66.5	7.1	11.3	100.0
Great Britain (1990–1991)	16–19	0.0	12.5	61.4	5.1	21.0	100.0
United States (1995)	15–19	0.5	8.0	62.8	4.0	24.7	100.0
Method used at last intercourse							
Sweden (1996‡)	18–19	2.1	49.9	24.1	17.3	6.5	100.0
France (1992, 1994§)	15–19	0.0	59.2	28.4	0.6	11.9	100.0
Canada (1995**)	15–19	††	63.7	††	23.1‡‡	††	100.0
Great Britain (1990–1991§§)	16–19	1.3	67.5	23.3	3.8	4.1	100.0
United States (1995*†)	15–19	9.3	32.5	33.0	5.2	20.0	100.0

*Includes withdrawal, rhythm, diaphragm, cap, female condom and spermicides. †Among women who have ever had intercourse. ‡Excludes those who never had sex, those who did not have intercourse in the past three months and those not at risk for unintended pregnancy (pregnant, postpartum, seeking pregnancy, and infecund or sterile). §Estimated by applying distributions for 15–17-year-olds (1994) and 18–19-year-olds (1992) to estimated number sexually active in each age-group in 1995. Women who never had intercourse and those classified as "method not reported" or "no intercourse" were excluded from the base population. Women in other categories usually considered to be "not at risk of unintended pregnancy," such as those who were pregnant, trying to become pregnant and postpartum, were not identified and therefore could not be excluded. **Based on current contraceptive use data from the 1995 General Social Survey. Women who were not sexually active and those who were infecund or pregnant were excluded. ††Estimate does not meet Statistics Canada standards for size of denominator or numerator.‡‡This category is "any method other than the pill," and consists primarily of condom users. The proportions using methods other than the pill are based on too few cases to be shown separately. §§Based on women who were sexually active in the three months before interview. Women who were not at risk of being pregnant, being postpartum or trying to become pregnant were not identified and therefore could not be excluded. *†Method used at last intercourse during the three months before interview. Those who have never had sex, who did not have intercourse in the past three months and who were not at risk of unintended pregnancy (pregnant; two months or less postpartum; seeking pregnancy; and infecund or sterile) were excluded. *Note:* Women who reported more than one method were classified according to the most effective method they reported using.

Use at Last Intercourse or Current Use

Some information on adolescents' recent contraceptive use (either use at last intercourse or current use) was available for all five countries; however, these data were not fully comparable across countries, which should be borne in mind when making comparisons.[k] Differences across countries in recent use are greater than those in use at first intercourse. The proportion of sexually active adolescents at risk of an unintended pregnancy who were not currently using any method is especially high in the United States (20%) and is lowest in Sweden and Great Britain (4–7%).

Data for 15–17-year-olds in France unexpectedly show a low level of non-use among younger adolescents (7%), lower even than the level found among older teenagers (15%), based on the 1992 Survey of Sexual Behavior (not shown). In the case of Canada, data available from a large sample survey of students in grades 7–12 (high school) in British Columbia show that 13% of those who have ever had intercourse did not use a method at last intercourse. These data, combined with national information showing that 87% of Canadian teenagers were using the pill or another method at last intercourse, suggest that nonuse among sexually active adolescents in Canada falls between the higher levels seen in the United States and the lower levels found in the European countries.

Some notable differences in method choice were also found across countries, with the United States standing out in a number of respects. It is the only country where a substantial proportion of adolescents used long-acting methods of contraception, such as the injectable and the implant. Overall, however, the United States had much lower use of medical methods such as the pill, injectable, implant and IUD: Fifty-two percent of 15–19-year-old U.S. women using contraceptives at last intercourse relied on these methods, compared with 56% of Swedish 18–19-year-olds, 67% of French 15–19-year-olds, 72% of British 16–19-year-olds and 73% of Canadian 15–19-year-olds. (These proportions are based on method users only, and have been recalculated based on data shown in Table 3-5.)

In the four focus countries with comparable data, condoms were the method of choice for a large proportion of currently sexually active adolescent women who were practicing contraception: Between 23% and 33% had used condoms during their last intercourse or in the recent past. Total condom use was somewhat higher, however, because we categorized those using a hormonal method in addition to condoms as users of hormonal methods.

Although we could not precisely estimate the proportion of Canadian teenagers using condoms because of the small number of adolescents surveyed in the 1995 General Social Survey of Canada, almost all of the 23% of teenagers who reported using methods "other than the pill" were in fact using the condom as their most effective method at last intercourse. In addition, supportive (although not exactly comparable) data from various Canadian surveys show that condom use by teenagers seems to be equal to or more prevalent than levels observed in the other four focus countries. The 1996 National Population and Health Survey found that 70% of single, sexually experienced 15–19-year-old Canadian women (and 81% of 15–19-year-old Canadian men) reported using a condom at last intercourse. Condom use at last intercourse was also high (49%) in a large sample of high school students (grades 7–12) in British Columbia.

These high levels of condom use along with high levels of pill use (Table 3-5) suggest that a large proportion of sexually active Canadian teenagers are using condoms, and that the proportion using both the pill and the condom (dual use) is also probably quite large. In the United States, overall current use of condoms by adolescents (whether used alone or with other methods) is estimated to be 38% of all sexually active teenage women who are at risk of unintended pregnancy.[34] Dual use of the condom and a hormonal method is practiced by approximately 7% of currently sexually active adolescents, with little difference among younger and older teenagers; and the proportion of sexually active teenage women

[k] The age-groups for which data are available for Sweden (18-19) and Great Britain (16-19) differ from what is available for the other three countries (15-19). Data for a small-scale survey of 16-18-year-olds in Sweden show method patterns and level of use very similar to the results for 18–19-year-olds, providing a basis for generalizing to all 15–19-year-old females from the data for 18–19-year-olds. (The latter data are from a larger sample and provide a more reliable estimate.) Further, the measure available for Canada is current contraceptive use, while for the other countries, the measure presented is use at last intercourse, among those who had intercourse in the past three months. Measures of recent contraceptive use (whether current or at last intercourse) should be based on those who are at risk of unintended pregnancy. As noted in Table 3-5, available data do not always approach this goal. In the case of Canada and France, certain small groups that should have been excluded are not, because they could not be separately identified. Since these groups are likely to be nonusers, the impact is to make the proportion of nonusers higher than it would otherwise be.

practicing dual use at first intercourse is slightly lower, about 5%.[35] By comparison, data for France show that both at first intercourse (teenagers aged 15–18) and among currently sexually active teenagers (18–19-year-olds), 10–12% report dual use. In Great Britain, dual use is very low at first intercourse (2–3%), but it is much higher among currently sexually active teenagers (aged 16–19): Twenty-seven percent for the whole group, with little difference among younger and older teenagers. Considering both primary condom use and dual use of condoms with hormonal methods, it therefore appears that at least in Great Britain and probably Canada, overall condom use is likely to be higher than in the United States. French data indicate similar overall proportions of teenagers using condoms as in the United States, but include only older teenagers (18–19). In Sweden, national data on dual use are not available. In addition to overall lower condom use than in some of the study countries, it is possible that U.S. teenagers are less effective or consistent in their use of condoms than are teenagers in other countries.

Younger adolescents aged 15–17 are more likely to use the condom than are older teenagers. This pattern is found in the three countries (France, Great Britain and the United States) for which data are available for both younger and older teenagers.

Discussion

Despite the recent decline in adolescent pregnancy in the United States, the current rate is 2–4 times higher than that in the four other developed countries included in this analysis. The rates of intended births and intended pregnancies in the United States are much higher than the *total* rates in France and Sweden and are probably as high or higher than the intended teenage birthrates in Canada and Great Britain. Most of the difference in pregnancy rates between the United States and the other study countries is due to the high unintended pregnancy rate in the United States, however, which is much higher than the total teenage pregnancy rates of all other study countries.

In most developed countries adolescent pregnancy rates and birthrates declined more between 1970 and the mid- to late-1990s than they did in the United States.[36] Even as researchers seek to explain the reasons for the recent decline in pregnancies and births in the United States,[37] we also need to understand why the United States continues to have rates that are so much higher than those in other developed countries. This chapter has examined information available on the two main proximate determinants of the pregnancy rate—sexual activity and contraceptive use—with the aim of assessing their roles in explaining differences between countries in adolescent pregnancy and STD rates. While these two proximate determinants are among the immediate or direct causes of variations in teenage pregnancy, they are only a first step, and are themselves influenced by a large number of social, economic, political and cultural factors as well as by the characteristics of individual adolescents, which are explored further in the following chapters.

The available data indicate that variation in sexual behavior is not an important contributor to explaining differences in teenage pregnancy between the United States and the other study countries, or even differences between France and Sweden on the one hand and Canada and Great Britain on the other hand. In the five countries, the age at first intercourse, the proportion who have ever had intercourse and the proportion who have had sex before age 20 differ little, although the percentage of teenagers who first had intercourse before age 15 is greater in the United States and Sweden than in the other study countries. Although the available data on continuity of being in a sexual relationship (that is, the proportion currently sexually active among those who have ever been sexually active) are limited to the 18–19 age-group, they indicate that potential exposure to pregnancy is greater in Sweden and slightly greater in France and Great Britain compared to the United States. This finding suggests that, all else being equal, the pregnancy rate in the United States should be no higher than—or even lower than—rates in the other countries.

Data on certain other aspects of sexual behavior, however, such as frequency of intercourse and type and duration of sexual relationships, may influence exposure to pregnancy and STD risk. Such information is mostly not available and is not measured in a comparable way across countries; however, it is possible that some of these aspects of sexual behavior may partly explain cross-national differences in reproductive health outcomes.

While teenagers in the United States are not much different from those in other countries in terms of their level and timing of sexual activity, U.S. teenagers who are sexually active are typically more likely than those of the same age in other countries to

have had more than one sexual partner in the past year. This may contribute to the relatively high levels of STDs evident in the United States.[38]

The level of condom use at first sex is lower in the United States than in France, though it is higher than the level in Sweden and similar to that in Great Britain. Use of the condom at last intercourse as the primary method is higher in the United States than in the other study countries. However, overall condom use (used along with a hormonal method or as the most effective method), is lower in the United States than it is in Great Britain and, most likely, in Canada, and it is similar to levels in France. Though not conclusive, this suggests that the higher STD rates among U.S. teenagers may reflect lower overall levels of condom use as well as greater exposure to infected partners (both by having sex with more partners over a given time period and by greater prevalence of STDs in the country as a whole), leading to a higher chance that any one partner will carry an STD.

National differences in current contraceptive use are substantial, with the proportion of adolescent women who are at risk of an unintended pregnancy and who are not using a method being greater in the United States than in the other study countries. Use of modern methods with the lowest failure rates (the pill, the injectable, implants and the IUD) is lower in the United States than in the other countries. These differences are consistent with national differences in pregnancy rates and appear to be the more likely cause of the higher teenage pregnancy rates in the United States than any differences in sexual behavior.

While these differences in contraceptive use are likely to contribute substantially to variations in pregnancy rates, they do not appear large enough to totally account for the much higher teenage pregnancy rate in the United States. In addition to variations in the levels and patterns of method use among those trying to avoid becoming pregnant, there may also be cross-national differences in levels of effectiveness of method use. Use-failure rates for reversible methods are high for adolescents and young adults in the United States, but comparable data are not available for the other study countries.[39]

There are many possible reasons that may explain cross-national variations in contraceptive use. Differences in societal attitudes toward adolescent sexual activity can influence provision of reproductive services for adolescents. Thus, contraceptive services and supplies are available free or at low cost for all teenagers in the four developed countries other than the United States and concrete efforts are made to facilitate their easy access to such services. There also may be differences in adolescents' attitudes toward contraceptive methods, in the accuracy of their knowledge of how to use methods, in fear of side effects, in the level of confidentiality and in the extent of parental support or opposition. Use patterns and effectiveness of use are also likely to be influenced by adolescents' motivation to delay parenthood and to avoid unintended pregnancy, which may in turn be influenced by job and educational opportunities and social support (or the lack of it) for young mothers. Country comparisons in these areas are explored in the following chapters.

In combination with its higher teenage pregnancy rate, the United States also has a lower abortion ratio than the other four study countries, particularly among adolescents aged 15–17. Although the lower abortion ratio may reflect the possibly greater difficulty American adolescents have in accessing abortion services than teenagers have in the other countries, it also provides some support for the interpretation that motivation to delay early motherhood is lower, acceptability of adolescent childbearing is greater and antiabortion sentiment is greater among U.S. adolescents. In fact, the proportion of pregnancies that is intended is somewhat higher among older teenagers than among younger ones—25% compared with 17%.[40] This interpretation may also apply to older adolescents aged 18–19 in Great Britain for whom the abortion ratio is about the same as that in the United States.

Research within the United States and Britain shows that there is great variation among adolescents in the motivation to prevent pregnancy and in ambivalence about having a birth during their adolescent years. There is lower motivation and greater ambivalence (as well as more positive attitudes toward having a baby) among teenagers who have lower educational and job aspirations and expectations, among those who are not doing as well in school, among those in poor and single-parent families, as well as among black and Hispanic teenagers in the United States.[41] Some of these factors are explored in the next chapter.

Chapter 4. Socioeconomic Disadvantage and Teenage Sexual and Reproductive Behavior

Introduction[1]

Over the past two decades, as mentioned in Chapter 1, researchers and advocates in the United States have examined the experiences of Canada and of countries in western Europe in an attempt to learn why adolescents in these countries have fewer pregnancies and are less likely to acquire a sexually transmitted disease.[42] Some researchers suggest that the answers lie in other developed countries' more comprehensive sexuality education, greater societal openness regarding sexuality and adolescents' greater ease of access to reproductive health services.[43] In addition, researchers have suggested that cross-country variation in the extent of social and economic disadvantage may contribute to differences in rates of teenage pregnancy, childbearing and STDs.[44] However, to date, this potential contribution has received little attention.

Disadvantage has been characterized by such factors as living in poverty; being poorly educated; having poorly educated parents; being raised in a single-parent family or in an economically struggling neighborhood; and lacking educational and job opportunities. In some contexts, such as in Great Britain and the United States, belonging to a racial or and ethnic minority group and being foreign-born have strong links to socioeconomic disadvantage. These characteristics frequently are used as proxies for disadvantage or as indicators of disadvantage because of social discrimination.[45] The extent to which race, ethnicity or immigrant status indicates social and economic disadvantage varies by subgroup and by country, depending not only on economic status, but on factors such main language spoken, level of education (which is closely linked to occupation and income) and the extent of discrimination.

Disadvantage is associated with several factors that can influence teenage sexual and reproductive behavior and outcomes, including lowered personal competence, skills and motivation; limited access to health care and social services; lack of successful role models; and living in dangerous and risky environments.[46] Some researchers have argued that among disadvantaged adolescents in the United States, particularly black adolescents, accepting or even wanting a pregnancy is normative—it is a rational response to their lack of alternative opportunities—and that their families and communities are realistic in accepting adolescent childbearing and in providing social support for young and single mothers.[47] However, in other research, the majority of all women who gave birth before age 20 reported that the birth was not wanted at that time (66% of all women, 46% of Hispanics, 67% of whites and 77% of blacks).[48] Although teenage childbearing would appear to be normative among some black teenagers and poor teenagers in the United States, the situation is more complex, and the scarcity of alternative opportunities for youth in disadvantaged subgroups may well be an important contributing factor to teenage childbearing.

Researchers in the United States have identified several associations between disadvantage and adolescent sexual and reproductive behavior. Whether measured at the individual, family or community level, being disadvantaged is associated with an earlier age at first intercourse;[49] less reliance on or poor use of contraceptives;[50] and lower motivation to

[1] Much of the text in this chapter is published separately, see Singh S, Darroch JE, Frost JJ and the Study Team, Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: the case of five developed countries, *Family Planning Perspectives*, 2001, 33(6): 251-258 & 289.

avoid, or ambivalence about, having a child.[51] Once pregnant, disadvantaged adolescents are less likely than other adolescents to have an abortion, and are more likely to have a child and have a premarital birth.[52] Exactly how disadvantage affects these behaviors, however, is still not fully understood.

Although there is much less research on the association between disadvantage and adolescents' sexual and reproductive behavior in other developed countries, some patterns and relationships similar to those in the United States have been identified. In Canada, an analysis that used geographic mapping at the census tract level showed a strong association between low income and high adolescent birthrates and high STD rates among 15–24-year-olds in Toronto, while a study of high school students in Toronto found that those who had higher educational aspirations had their first birth at a later age.[53]

In Great Britain and France, researchers have identified an association between living in a disrupted family, whether due to parental divorce or other circumstances, and beginning sexual activity and parenthood at a young age.[54] Researchers in France also have found that the teenage birthrate is highest in *départements* (administrative areas) in the north, where poverty and unemployment are highest; and in-depth qualitative research has shown that many adolescents who have a baby are reacting to problems in their family, including poverty and abuse.[55]

The association between socioeconomic deprivation and teenage pregnancy and childbearing is well established in Great Britain.[56] A longitudinal study there shows that the risk of becoming a teenage mother is almost 10 times higher among women whose family is in the lowest social class than among those whose family is in the highest class. In addition, teenagers who live in public housing (an indicator of low income) are three times more likely than their peers in owner-occupied housing to become mothers.[57] Throughout Scotland, from the early 1980s to the early 1990s, pregnancy rates increased in the most deprived areas and, on average, either remained the same or decreased in the most affluent areas. But, the relationship between disadvantage and teenage pregnancy can also vary over time. In Scotland, socioeconomic deprivation explained a larger proportion of local variation in teenage pregnancy rates in the 1990s than it did in the 1980s.[58]

One study in Sweden concluded that pregnant teenagers are much more likely than teenagers who are not pregnant to be from broken homes and to be of low socioeconomic status.[59] Another large-scale Swedish study, of women who had their first child between 1954 and 1989, found that women whose parents were either not gainfully employed or were blue-collar workers were more likely than other women to have given birth in adolescence.[m60]

Many factors can mitigate the effects of socioeconomic disadvantage on adolescents' behaviors, including adolescents' biological and developmental characteristics; the quality of their communication and relationship with parents, peers and partners; family stability, availability of parental time and supervision, and level of parental authority and control; adolescents' values, beliefs, attitudes, sense of control over their life, motivation and expectations; and their receipt of sexuality education and access to reproductive health services.[61] The extent to which these factors vary across countries may contribute to differences in adolescent sexual and reproductive behavior.

In this chapter, we explore the relationship between disadvantage and adolescents' sexual and reproductive behavior, measured by income, poverty status or social class; educational status; and employment status. We also include race, ethnicity and immigrant status because these are often proxies for socioeconomic status or social discrimination and may be associated with poor access to resources within countries. It should be recognized, however, that these latter measures do not translate easily or directly into a comparative measure of disadvantage because minority groups in the study countries originate from different countries and cultures—they may differ in values, attitudes and behaviors and they may or may not be socioeconomically disadvantaged relative to the majority group. Another limitation is our inability to measure other dimensions of disad-

[m] In Sweden in the early 1990s, rising unemployment resulted in higher levels of postponement of childbearing among low-income women (those who had no stable connection to the labor force either because they were unemployed, attending school or lacked insurance income from earlier employment) than among employed or highly educated women in large part because Swedish policy bases parental leave benefits on income in the year before a child's birth. The birthrate and early childbearing rates declined overall, and the declines were largest and most rapid among poor and less-educated women. (Sources: Landgren Möller E and Hoem B, Lowly educated women postpone childbearing, *Välfärdsbullentinen Nr 2, SCB, Statistics Sweden,* 1997 (in Swedish); Statistics Sweden, *Childbearing and female employment: The rise and fall of fertility 1985–1997. SCB, Statistics Sweden,* 1998:1 (in Swedish).)

vantage that are difficult to quantify and for which there are few comparable data across countries: these include quality of education and training, job skills, access to job and training opportunities, the impact of geographic location and discrimination.

In general, in western European countries, and to some extent in Canada, the proportion of the population that is poor or otherwise disadvantaged is smaller than the proportion in the United States. In addition, Canada and countries in western Europe are committed, though to varying degrees, to the philosophy of the welfare state. Although government policies have varied over recent decades, these countries offer considerable assistance to youth—including vocational training, assistance with finding a job and unemployment benefits—to ease the transition from adolescence to adulthood. By comparison, the government plays a more limited role in the United States, and that role varies greatly across the country.

Building on current data, we go beyond previous research to address three questions. First, within these five countries, are there differences in adolescent childbearing among socioeconomic subgroups, and to what extent are differences explained by variation across subgroups in sexual behavior and contraceptive use across subgroups? Second, how similar is the sexual and reproductive behavior of adolescents in comparable socioeconomic subgroups across countries? Finally, do differences in socioeconomic composition across countries explain national differences in teenage reproductive behaviors and outcomes?

We examine teenage childbearing and two of its proximate determinants, sexual activity and contraceptive use. The data presented are descriptive and document bivariate relationships using the most recent data available. Information on data sources and methodology is presented in Chapter 2. Because comparative information on pregnancy rates and abortion ratios by socioeconomic subgroups is not available, we do not directly address the relationship between socioeconomic status and adolescent pregnancy and abortion. However, studies from the United States show that there are smaller differences among poverty status groups in teenage pregnancy rates than in birthrates, primarily because higher-income teenagers who become pregnant are more likely than lower-income adolescents to have abortions.[62] In addition, although the incidence of sexually transmitted diseases is also much higher in the United States than in the other four case-study countries, because of a lack of comparative information on the relationship between socioeconomic status and STD incidence, we are unable to analyze these this interrelationship.[63]

Variation in Extent of Socioeconomic Disadvantage

We examined relative differences among countries in the extent of disadvantage by using both specific indicators for the general population and percentage distributions of women aged 20–24 on key measures of socioeconomic status. These latter measures provide relative differences among countries and are useful for understanding information presented subsequently on adolescent sexual and reproductive behaviors for these subgroups; however, because the groupings are not standardized across countries, these distributions cannot be used as an indication of absolute cross-national differences in extent of disadvantage.

The level of economic disadvantage in the five countries, as measured by the proportion of the population with an income below 50% of the median, varies substantially. Seventeen percent of the U.S. population has an income at this level, compared with 8–9% in France and Sweden, and 11% in Canada and Great Britain (Table 4-1, page 40). Another indicator of income distribution is the ratio of the proportion of income received by the richest 20% of the population to the proportion received by the poorest 20%. The higher this ratio, the greater the inequality in income distribution. This ratio is 3.6 in Sweden; 5.2–6.5 in Canada, France and Great Britain; but is 8.9 in the United States (Table 4-1). In the four countries with data on economic status of women aged 20–24, there are substantial proportions of young women in all three categories of economic status.

The available data on youth unemployment show a mixed picture across countries. The proportions of men and women aged 15–24 who are in the labor force but are not working are extremely high in France (22–30%), moderate in Canada (14–17%) and Sweden (16–18%), and lower in Great Britain (11–14%) and the United States (10–11%). This variation is partly a reflection of overall national differences in level of unemployment (which range from 5% in the United States to 12% in France). In addition, the proportion of youth who are in the labor force and employed varies across countries, depend

Table 4–1. Population indicators of socioeconomic disadvantage and percentage distributions of women aged 20–24, by selected socioeconomic characteristics, five developed countries, mid- to late 1990s

Measure	Sweden	France	Canada	Great Britain	United States
POPULATION INDICATORS					
% of population at <50% of median income	8.7	8.4	10.6	10.6	17.3
Income distribution					
% going to richest 20%	34.5	40.2	39.3	43.0	46.4
% going to poorest 20%	9.6	7.2	7.5	6.6	5.2
Ratio of richest to poorest	3.6	5.6	5.2	6.5	8.9
Unemployment rate					
Males 15–24	17.5	21.9	16.6	13.8	11.1
Females15–24	16.1	30.0	13.7	10.5	9.8
Total population	8.2	11.7	8.3	6.3	4.5
% of population 16–65 functionally illiterate	7.5	u	16.6	21.8	20.7
% of population 15–19 foreign-born*	4.5	6.6	13.2	6.5	9.5
% DISTRIBUTIONS OF WOMEN 20–24					
Economic status†					
Low	u	47.0	24.6	17.3	31.2
Medium	u	37.5	33.4	62.9	35.8
High	u	15.6	42.0	19.8	33.0
School/work status‡					
In school only	39.7	34.2	9.6	7.8	11.2
In school and working	u	u	30.1	u	20.9
Working only	40.4	57.6	49.3	62.3	48.1
Neither	19.8	8.2	11.0	29.8	19.9
Educational attainment§					
Low	10.2	25.9	21.4	11.3	13.9
Medium	66.4	51.1	37.0	43.1	32.4
High	23.4	23.0	41.6	45.6	53.7
Race/ethnicity**					
White	98.1	u	87.6	93.9	67.3
Hispanic	u	u	u	u	12.8
Black	u	u	u	u	14.6
Other	1.8	u	12.4	6.1	5.3
Total	100.0	100.0	100.0	100.0	100.0

*For Sweden and Great Britain, the value presented is the percentage of the total population who hold foreign citizenship. †For France, economic status is based on monthly family income: Low=less than Fr 8,000, middle=Fr 8,000–15,000, high=Fr 15,000 or more per month. For Canada, economic status is based on family income: Low=first and second quintiles, middle=third quintile, high=fourth and fifth quintiles. For Great Britain, economic status is based on parents' occupation: Low=semiskilled or unskilled, medium=skilled, high=intermediate or professional. For the United States, economic status is based on family income, as a percentage of the federal poverty level: Low=less than 149%, medium=149–299%, high=300% or more. ‡For Great Britain, "working only" denotes working for pay at least 10 hours a week. For Great Britain and Sweden, "neither" includes respondents who were in school and working. For France, "working only" includes those who were both working and in school. §For Sweden, low=nine years of public school or upper secondary technical line, medium=upper secondary or theoretical line, high=university; data are based on both men and women. For France, low=nine years of schooling or first technical qualification, medium=high school diploma, high=university or other postsecondary training. For Canada, low=less than complete secondary education, medium=complete secondary, high=any postsecondary education. For Great Britain, low=no certificate or formal qualifications, medium=O levels, high=A levels or university. For the United States, low=less than high school diploma, middle=grade 12 or high school diploma, high=any postsecondary education or training. **For Great Britain and Canada, other=nonwhite. For Sweden, other=any non-European origin. For countries other than the United States, data include both men and women. *Notes:* Countries are ordered according to their adolescent birthrate, from lowest to highest, in this and all tables and figures. u=unavailable. *Sources:* **Income distribution, unemployment and illiteracy:** United Nations Development Programme, *Human Development Report, 2000*, New York: Oxford University Press, 2000. **Race, ethnicity and immigrant status:** Sample surveys and Council of Europe, *Recent Demographic Developments in Europe, 1999*, Strasbourg, France: Council of Europe Publishing, 1999. **Educational attainment:** Data for Canada and Sweden are based on special tabulations of Family and Fertility Surveys; all others are from country case study reports (see reference 18).

ing on the proportion who are enrolled in school, apprenticeships, university or other sources of further education.

The proportion of women 20–24 who have a high level of education (some years of university or other postsecondary school) is larger in Canada, Great Britain and the United States (42%–52%) than in France (23%). In Sweden, 23% of young women have attended university, but the proportion who have obtained other postsecondary education is unavailable. However, the proportions with low educational attainment are more similar across the five countries spanning a narrower range, from 10% in Sweden to 26% in France. For a more standard measure of educational competency in a country, we also examined the proportion of persons aged 16–65 who are functionally illiterate. Compared with data for high educational attainment across countries, the measure (available for all countries except France) shows a different pattern: The proportion of the population that is illiterate is smallest in Sweden (8%), much larger in Canada (17%) and even larger in the United States and Great Britain (21–22%).

The proportion of adolescents (15–19) who are foreign-born is larger in Canada and the United States (13% and 10%, respectively) than in the other three countries (5–7%). However, there is even greater variation across countries in the proportions of their populations who are racial and ethnic minorities. Moreover, classification according to race and ethnicity, and availability of such statistics, varies from country to country. The proportion of young women who are classified as nonwhite, and, in the United States, as black or Hispanic, ranges from 2% in Sweden and 6% in Great Britain to 12% in Canada and 33% in the United States. A substantial proportion of the minority populations in Canada and Great Britain come from the South Asian subcontinent, while the minority population in the United States is primarily black or Hispanic.

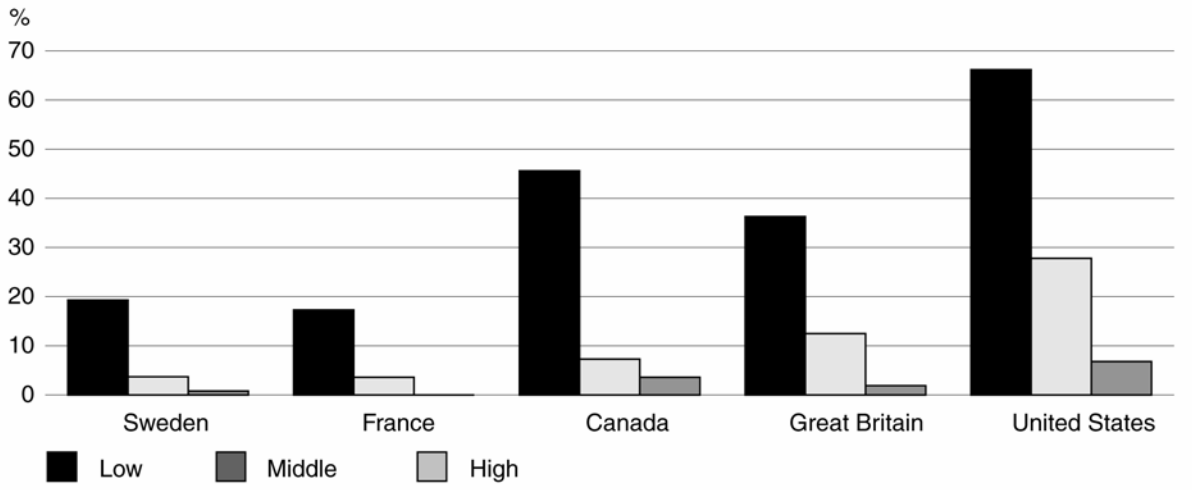
The presence of just one of these aspects of disadvantage in an adolescent's life can be associated with poor reproductive health outcomes. However, it is important to take into account that often in adolescents' lives, several aspects of disadvantage coincide, compounding the impact of disadvantage and increasing the probability of such outcomes. For example, poverty is significantly greater among First Nations or aboriginal people in Canada and Native Americans in the United States, compared to the rest of the populations, and these groups experience much higher levels of disadvantage in many other respects as well, including low education, unemployment, poor health and discrimination. In both France and Sweden, the young people who are most affected by problems of disadvantage and social exclusion are those who are from some immigrant groups; in addition, less educated and less trained youth also experience problems in finding stable jobs and suffer from inadequate social integration. In Great Britain, in addition to particular problems of social exclusion experienced by minority racial and ethnic groups (for example, the unemployment rate among all minorities is more than twice the level among the white population [64]), there are other groups that are also highly disadvantaged, such as the inner-city populations in the old manufacturing urban areas in the North. In the United States, poverty, unemployment and low education are at much higher levels among black, Hispanic, Native Americans and other racial and ethnic minorities compared with non-Hispanic whites. For example, the unemployment rate among black males aged 20–24 is 18%, compared to 7% among Hispanics and whites. Racism and discrimination are additional disadvantages that minority groups face in all countries, although the degree is likely to be variable across countries.

Adolescent Childbearing

In all five countries there is a strong negative association between level of educational attainment and having a child before age 20 (Figure 4-1, page 42). In Sweden and France, fewer than 1% of the best educated 20–24-year-old women had a child before age 20, compared with almost 20% of those with the least schooling. In France, other data show that 2% of adolescent women in academic programs had ever been pregnant, compared with 15% of adolescent women in vocational programs.[65] In Great Britain and Canada, the proportions are somewhat higher: 2–4% among women with the most education and 36–46% among the least educated. At all levels of educational attainment, U.S. women had the highest levels of adolescent childbearing: Seven percent of young women with some college education, 28% of those with a middle level of educational attainment and 66% of those with less than a high school education had had a child before age 20.

Women in the United States also had the highest levels of childbearing before age 18 at all three levels of educational attainment. Among women 20–24 with less than a high school education, 34% gave

Figure 4–1. Percentage of 20–24-year-old women who gave birth before age 20, by educational attainment



Note: For definition of categories, see Table 4–1.

birth before they were 18, compared with 6–19% in the other countries (not shown). Nine percent of American women aged 20–24 with a middle level of educational attainment gave birth before they were 18, compared with 3% or fewer of these women in the other countries. Finally, 3% of 20–24-year-old women in the United States with the highest level of education gave birth before age 18, compared with 1% or fewer in the other countries.

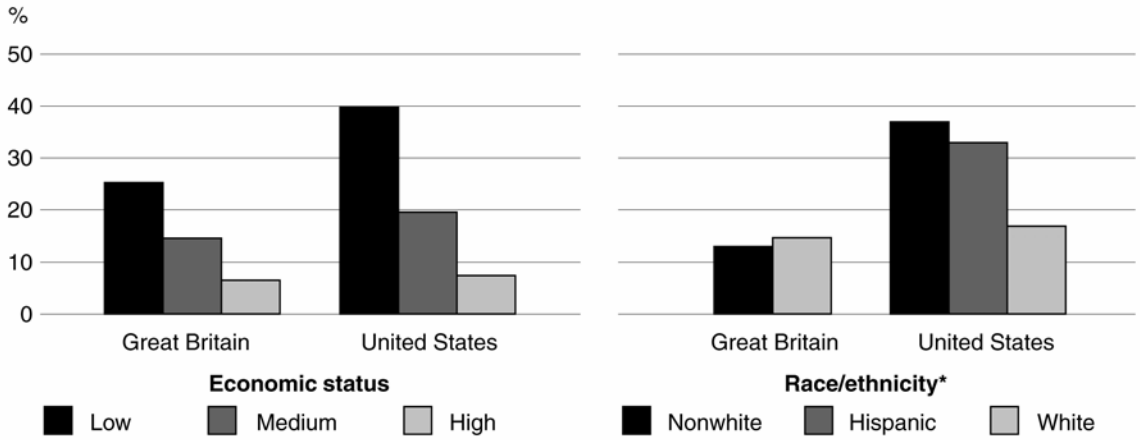
In the United States and Great Britain, which have data on adolescent childbearing according to economic status and race and ethnicity, there is a strong negative association between economic status and having a child before age 20 (Figure 4-2). The difference in childbearing levels among women in the lowest and highest income groups is much wider in the United States than in Great Britain. However, at all three economic levels, U.S. teenagers have higher levels of childbearing than their peers in Great Britain. At the low economic level, U.S. teenagers in the United States are 79% more likely to have a child by age 18 (18%, vs. 10% in Great Britain) and 58% more likely to have given birth by age 20 (40% vs. 25%). The differential is smaller, but continues among those in the high economic status group: U.S. teenagers in this group are 36% more likely to have had a child by age 18 (3.4% vs. 2.5%) and 14% more likely by age 20 (7.4% vs. 6.5%).

The proportion of black and Hispanic 20–24-year-old women in the United States who had a birth before age 20 is much larger than the proportion of nonwhites in Great Britain (33–37% vs. 13%, Figure 4-2). Among whites, differences are smaller, but in the same direction (17% in the United States and 15% in Great Britain).[n] In Great Britain, there is little difference between whites and nonwhites in the proportion of 20–24-year-olds who had a child by age 20. In Canada, although data are not available on adolescent childbearing by race and ethnicity, the much lower proportions who are sexually active by age 20 among nonwhite young women (see below) suggest that they are much less likely to become adolescent mothers than are white Canadians.

Available data also show substantial differences in adolescent childbearing according to immigrant status. In the United States and Sweden, adolescents who are recent immigrants have higher levels of childbearing than native-born adolescents. However, in Canada and Britain, recent immigrants have lower levels of adolescent childbearing than women who were born there. These different patterns reflect, in part, differences in the cultural background of immigrants in each country. In Sweden, the birthrate among adolescents was 7 per 1,000 for citizens, while it was 30 per 1,000 for adolescents who were

[n] Adolescent birthrates for the United States show similarly large racial and ethnic differences. The rate is highest among Hispanic teenagers (102 per 1,000 in 1996), slightly lower among black teenagers (91 per 1,000) and much lower among white teenagers (38 per 1,000) (Source: reference 30).

Figure 4–2. Percentage of 20–24-year-old women who gave birth before age 20, by economic status and by race and ethnicity



*For the United States, "nonwhite" signifies non-Hispanic black. Other nonwhite non-Hispanics are not shown. *Note:* For definition of categories, see Table 4–1.

not citizens; the birthrate ranged from 18 per 1,000 among noncitizen adolescents from Finland to 34 per 1,000 among those of Turkish origin.[66]

In the United States, 29% of foreign-born women aged 20–24—a majority of whom are from Latin America and the Caribbean, where premarital and early childbearing occur at moderate to high levels—had a child before age 20, compared with 21% of those who were born in the United States. In Great Britain, 15% of native-born young women have a child during adolescence—twice the proportion among foreign-born women, a large fraction of whom are from South Asia. In these communities, premarital sex and childbearing is strongly censored. In Great Britain, the proportion of households with children in which the parents are cohabiting or in which only one parent is present is much smaller among households headed by persons of Asian origin than in households headed by whites or blacks.[67]

Within countries, certain geographical areas are likely to have greater than average concentrations of people who are disadvantaged, whether because of poor resources, lack of educational and employment opportunities, migration and settlement patterns or discrimination. Comparisons of regions within and across countries provide further illustration of differences by disadvantage and by country. We also found large regional differences in adolescent childbearing within countries. In Great Britain, the poorest districts—principally the inner-city areas of London and several large, old industrial cities of northern England—have teenage pregnancy rates and birthrates up to six times higher than the most affluent areas.[68] In Sweden, there is relatively little difference by area in socioeconomic levels or in adolescent birthrates, except for somewhat higher teenage birthrates in remote northern areas with few inhabitants.[69] In Canada, the teenage birthrate in the Northwest Territories (87 per 1,000 teenage women per year), is much higher than the national average (23 per 1,000). This region has the highest concentration of aboriginal people, who are one of the most disadvantaged groups in Canada. The teenage birthrate also is quite high (34 per 1,000 in 1996) in the prairie provinces (Alberta, Manitoba and Saskatchewan), which are predominantly rural and are the most conservative provinces.

In the United States, differences in adolescent pregnancy rates and birthrates across regions and across states are large, but rates in states with the lowest levels exceed rates in all the study countries. For example, in 1996, the teenage birthrate ranged from roughly 30 per 1,000 in some states in the Northeast and Midwest to more than 70 per 1,000 in several states in the South, which generally have larger proportions of residents who are black or Hispanic and low-income. Teenage pregnancy rates ranged from about 50–60 per 1,000 in a handful of states, to more than 90 per 1,000 in 24 states.[70] In addition, adolescent birthrates vary widely across

smaller geographic areas, such as communities or neighborhoods. An analysis of adolescent birthrates across zip codes in California found that they were highly related to the proportions of families living below poverty within each area.[71]

Sexual Activity

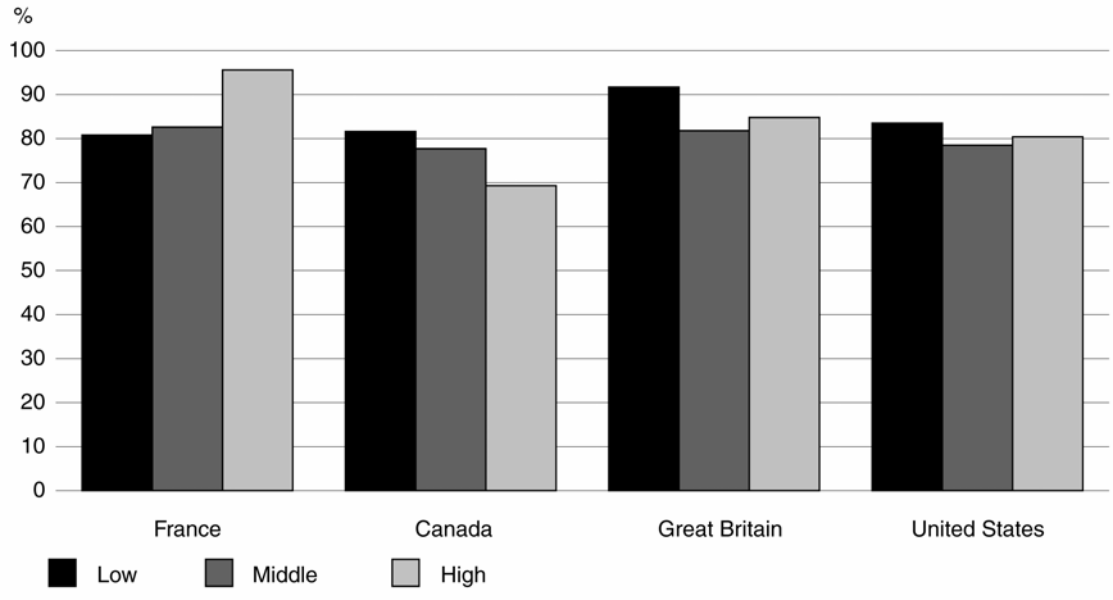
Four countries have data on timing of first intercourse according to economic status. In Canada, Great Britain and, especially the United States, differences in the initiation of sexual activity according to economic status are relatively small and women in the lowest economic group in these countries are somewhat more likely than those of higher economic status to have initiated intercourse before age 20 (Figure 4-3). By contrast, in France, a larger proportion of women in the highest income group than in the lowest income group became sexually active before age 20. The small sample size of the highest income group may explain this unexpected finding, especially considering the opposite pattern found according to educational attainment (discussed below).[o]

Differences in initiation of sexual activity across levels of educational attainment are large and are consistent in the two countries with relevant data (Table 4-2). In the United States, 95% of 20–24-year-old women with less than a high school education became sexually active before age 20, compared with 72% of those with some postsecondary education. In France, the proportion was 91% among those with the least education and 79–80% among those who had completed high school or who had some postsecondary education.

Data on young women's sexual activity before age 20 according to their current school and employment status are available for Canada, Great Britain and the United States. The findings are similar to those for educational attainment: In all three countries, young women aged 20–24 who are continuing their education were less likely to have begun sexual activity before age 20 than those who were working only or who were neither working nor in school.

Variations in young women's initiation of sexual activity according to race and ethnicity and immigrant status also are substantial. In Canada, nonwhite women aged 20–24 are much less likely than white women to have become sexually active before age 20

Figure 4–3. Percentage of 20–24-year-old women who had first intercourse before age 20, by economic status



Note: For definition of categories, see Table 4–1.

[o] The number of unweighted cases at the highest income category was 66 women. The sample size for the two lowest education groups combined was 99 women.

Table 4–2. Percentage of 20–24-year-olds who began sexual activity before age 20, by various measures of disadvantage

Measure	France	Canada	Great Britain	United States
Educational attainment				
Low	91.4	u	u	95.3
Medium	78.8	u	u	89.0
High	80.3	u	u	71.8
School/employment*				
In school only	u	55.2	76.3	70.3
In school and employed	u	66.3	u	70.8
Employed only	u	80.2	83.3	82.6
Neither	u	89.6	90.3	92.2
Race/ethnicity†				
White	u	80.1	86.2	81.1
Hispanic	u	na	na	74.2
Nonwhite	u	38.4	62.3	89.2
Immigrant status				
Foreign-born	u	42.2	67.0	70.1
Native-born	u	79.0	85.4	81.7

*Educational and school/employment categories are defined in Table 4–1. †For the United States, "nonwhite" signifies black non-Hispanic. *Notes:* u=unavailable. na=not applicable.

(38% vs. 80%); the differential between foreign-born women and native Canadians is about the same (42% vs. 79%). In Great Britain, the differences are in the same direction: Nonwhite and foreign-born women are less likely to have become sexually active by age 20 (62% and 67%, respectively) than are white and native-born women (86% and 85%, respectively). Differences in the United States are smaller: the proportion of young women who had sexual intercourse before age 20 ranges from 74% among Hispanics to 81% among whites, and 89% among blacks; similarly 70% of foreign-born and 82% of native-born women were sexually active as adolescents.

Contraceptive Use

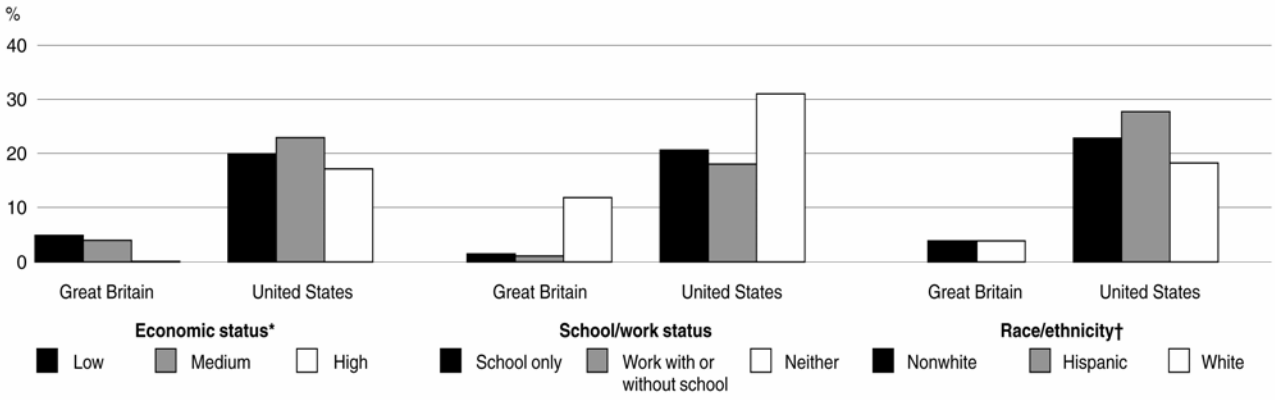
In both Great Britain and the United States, economic disadvantage is linked to a low level of contraceptive use at first intercourse. Seventy percent of the most disadvantaged sexually experienced 16–19-year-olds in Great Britain and 15–19-year-olds in the United States used a method on this occasion, compared with 81–86% of better-off groups in Great Britain and 78% in the United States (data not shown).

Data on French 15–18-year-olds' contraceptive use at first intercourse indicate no difference according to educational level; at all three levels of education, 88–90% used a method. However, in the United States, 72% of 15–19-year-olds who have less than a high school education used contraceptives at first intercourse, compared with 80–83% of adolescents who have at least completed high school. In Great Britain, differences by level of educational attainment are even larger: Forty-nine percent of 20–24-year-olds with low educational attainment used a method at first intercourse, compared with 80% of those with high levels of attainment (data not shown).

Differences in current or recent contraceptive use within each country according to socioeconomic status are smaller than for use at first intercourse. However, British adolescents at all income levels are much less likely to not use contraceptives than are their American counterparts. In Great Britain, 5% of currently sexually active 16–19-year-old women of the lowest socioeconomic status, 4% of middle status and virtually none of the highest status did not use a method at last intercourse (Figure 4-4, page 46). In the United States, 20% of the poorest 15–19-year-old women and 17–23% of those in the two higher-income groups used no method at last intercourse. In Canada, data are available only on condom use at last intercourse. They indicate that lower-income adolescent women are somewhat more likely than their better-off peers to use condoms. Among lowest-income, single, sexually experienced 15–19- year-old women, 81% used a condom at last intercourse, compared with 76% of those in the highest-income households.[72]

Great Britain and the United States are the only countries with national data on contraceptive use at last intercourse according to adolescents' school and employment status. In Great Britain, only 2% of all sexually active women who are in school full-time and 1% of those who are working did not use a contraceptive method at last intercourse, while 12% of those engaged in neither of these activities did not use a method (Figure 4-4). In the United States, those who are neither working nor in school also are

Figure 4–4. Percentage of 15–19-year-old sexually active women who did not use a contraceptive method at last intercourse, by various measures of disadvantage



*For definition of categories, see Table 4–1. †For the United States, "nonwhite" signifies black non-Hispanic. Other nonwhite non-Hispanics are not shown. *Notes:* Percentages are based on those who had intercourse in the past three months. For the United States, data are for 15–19-year-olds at risk of pregnancy—that is, those who were sexually active in the past three months who were not pregnant, postpartum (gave birth less than two months ago), seeking pregnancy, infecund or sterile. For Great Britain, data are for 16–19-year-olds who were sexually active in the recent three-month period. Those groups that should have been excluded because they are not at risk of pregnancy (that is, women who were pregnant, postpartum, seeking pregnancy, infecund or sterile) are included, because they could not be separately identified. Because these groups are likely to be nonusers, the impact is to make the proportion of nonusers higher than it would otherwise be.

the most likely to have used no method at last intercourse.

Comparable data are not available for Canadian adolescents. However, among single, sexually experienced 15–19-year-old women participating in a national survey, those who were in school only or were in school and working were more likely to report having used a condom at last intercourse (70–80%) than those who were not in school (a group that included adolescents who were working as well as neither in school nor working—61%).[73]

Finally, white and nonwhite adolescents in Great Britain are equally likely to report using no method at last intercourse (4%). In the United States, black or Hispanic teenagers are more likely than white adolescents to have used no method at last intercourse: Twenty-eight percent of Hispanic teenagers did not use a method at last intercourse, compared with 23% of black teenagers, and 18% of white teenagers (Figure 4-4).

Discussion

Despite being significantly limited by a lack of comparable information on all measures for all five countries, we have found consistent patterns of relationships between socioeconomic disadvantage and adolescent sexual and reproductive behavior. There are large differences in early childbearing across income and educational attainment levels, with poorer and less-educated young women being more likely to have a child during adolescence. We also found large differences across racial and ethnic groups and immigrant status groups within countries, but the nature of these differences varies by country because of differences in culture and values of the particular minority or immigrant groups within each country. In the United States, Hispanic and black teenagers and immigrant teenagers, a high proportion of whom are from Latin America and the Caribbean, are more likely than the majority white population to have a teenage birth. By comparison, in Canada and Great Britain, minority groups and foreign-born young women, a high proportion of whom are from South Asia, are less likely than the majority white population to have a teenage birth. The prohibitions against premarital sex and premarital childbearing are very strong among immigrant groups from the Indian subcontinent. By comparison, public opinion surveys show that the large majority of adults in a range of developed countries now consider premarital intercourse to be acceptable.[74]

Differences in initiation of sexual activity across socioeconomic subgroups are relatively small and in most cases are unlikely to contribute significantly to subgroup differences in adolescent pregnancy rates and birthrates. In the United States and Great Britain, poor teenagers are more likely than better-off teenagers to initiate sexual activity before age 20. In the United States, black adolescents, many of whom are poor, are more likely to initiate sexual activity before age 20 than are white and Hispanic teenagers. These differences are consistent with differences in levels of pregnancy and childbearing across socioeconomic and ethnic and racial groups, but the

differences in initiation of sexual activity are much smaller.

In Canada and Great Britain, differences in initiation of sexual activity among adolescent women by immigrant status and by race and ethnicity are large and are consistent with differences in adolescent childbearing: Both sexual activity and childbearing before age 20 are less common among the foreign-born adolescents and among nonwhite adolescents, than among native-born and white adolescents.

We also found substantial differences in adolescents' sexual activity according to educational attainment. This finding is consistent with the findings of multivariate studies showing that adolescents who have greater motivation to obtain an education and better access to educational opportunities are also motivated to delay sexual activity and childbearing.

Adolescents' use of contraception at first intercourse varies substantially according to income or social class in the United States and Great Britain, very little in France. In the United States and Great Britain, differences in recent contraceptive use are much smaller than those at first intercourse. However, at all socioeconomic levels, adolescents in the United States are much more likely than adolescents in Great Britain to report that they do not use contraceptives, which could be an important factor in explaining national differences in teenage pregnancy levels across the two countries. In addition, data available only for the United States show that poor and minority adolescent women (and older poor and minority women) are less-successful contraceptive users.[75] This could also contribute to higher teenage pregnancy rates in disadvantaged groups in the United States.

The large size of disadvantaged groups in the U.S. population, combined with the disadvantaged teenagers' greater likelihood of having a child, is an important factor in explaining national differences in teenage childbearing. The proportion of the U.S. population that is poor (those whose income is less than half the median income) is at least two-thirds larger than that of the other four study countries. One-third of U.S. adolescents are black or Hispanic, and a large proportion of these minority groups are disadvantaged in many respects. This proportion is at least twice the proportion of racial and ethnic minorities in the populations of the other four study countries.

However, a large concentration of socioeconomic disadvantage in the U.S. population is not the only factor in the country's higher adolescent pregnancy rate. When we compared adolescents of similar status across countries, we found large differences in almost all measures of sexual and reproductive behavior and disadvantage. A larger proportion of low-income 20–24-year-old women in the United States than of British women in the lowest social status group had their first child during adolescence (40% compared with 25%). Moreover, the birthrate for white teenagers alone in the United States is much higher than the rate for all teenagers in Great Britain (38 per 1,000 vs. 28 per 1,000).

Other factors that could influence cross-country differences in adolescent childbearing rates include differences in public perceptions of the social and economic costs of early childbearing, societal attitudes and openness regarding sexuality, and the ease of access to information and services. In France and Sweden, there appears to be a strong and universal perception that having a child during adolescence is undesirable, while in the United States, this attitude is much less strong and much more variable across groups and areas of the country. Canada and Great Britain fall somewhere between these two situations.

Unlike the United States, the other countries have national health care systems, facilitating adolescents' access to contraception. In addition, whereas the U.S. populations is heterogeneous and spread over a large geographic area, the populations of the four countries are concentrated in relatively small areas,[p] which increases accessibility to services and the likelihood that policies and programs will be implemented uniformly.

Nevertheless, socioeconomic disadvantage correlates strongly with adolescent reproductive behaviors and outcomes, and is worthy of the policymakers' attention. Improving adolescents' socioeconomic status is a way to prevent their having poor reproductive health outcomes—not only unplanned or early pregnancies or births, but also STDs. While becoming a teenage mother may not have devastating consequences and may even be positive in some respects for some teenagers, it is likely to "compound the handicaps imposed by social disadvantage."[76] Approaches to lowering teenage birthrates in the United States should include both reducing the

[p] Although Canada is immense in area, most of the population resides in urban areas just north of the border with the United States.

numbers of young people growing up in disadvantaged conditions and helping those who are disadvantaged overcome the obstacles they face.

Over the past two decades, policymakers in Europe have recognized the need to prepare young people for a labor market that is increasingly technology-driven and that requires education and training beyond the high school level. Differences in government policies and programs to assist teenagers in making a smooth transition from school and college into the labor force probably affect teenagers' motivation to delay pregnancy and childbearing and in their ability to plan for the future (discussed further in Chapter 5).

Countries in Europe prioritize the need to reduce "social exclusion" as a means of reducing socioeconomic disadvantage. By contrast, in the United States, with its high levels of disadvantage, government programs to assist young people are less comprehensive and probably play a smaller role in redressing imbalances in the life prospects of disadvantaged adolescents—the very imbalances that condition these adolescents' reproductive choices, decisions and behavior.

Part C: Social Support, Societal Attitudes and Service Provision: Factors That Contribute to the Variation Among Countries in Teenage Sexual and Reproductive Behavior

Chapter 5. Support for Families and for Youth Development

Introduction

There are long-standing as well as recent differences across the study countries in the levels and types of support provided for families, children and youth. In some countries, such support is linked directly to disadvantage, and benefits are primarily available to poor or low-income women, families or children—often with numerous restrictions attached. Elsewhere benefits or support are provided universally to residents at critical times in family formation or transition, such as when new children are added to a family or when young people transition from school to work and adult roles. In many ways, the types of support provided by society, either to disadvantaged groups or to all residents at critical times, may directly or indirectly impact on adolescent sexual and reproductive behavior. In this chapter we look specifically at the kinds of support that countries provide to new mothers and fathers, to families with children, and at examples of programs and policies that impact youth in their transition to adulthood. And, we draw links between the types of policies implemented, the philosophies behind these policies, and adolescent sexual and reproductive behavior.

Support for Childbearing and Parenting

Over the past 30 years, with the rise in female labor force participation, child care and maternity leave have emerged as critical policy issues, especially in Europe.[77] Among all five study countries, female labor force participation has risen in the last three decades; currently two-thirds to three-quarters of all adult women are employed in Sweden (75%), the United States (71%), Canada (68%) and Great Britain (66%); and six in 10 women are employed in France (60%).[78] Public policies in all five case-study countries provide at least some financial and social service supports for women with young children, either to special groups or to all women. All countries but the United States mandate some amount of paid maternity leave for working mothers and all but the United States and Canada provide universal child cash allowances (Table 5-1, page 52). Unless otherwise stated, the benefits described here apply to all mothers or all parents regardless of age, and therefore include adolescent mothers and families.

Sweden

Benefits are most extensive and generous in Sweden. Paid parental leave is available for 16 months after childbirth. The parents can share this period of leave. For working parents, 13 months, of which at least one month must be used by the father or lost, are compensated at 80% of income in the prior year. After that period, parents are entitled to three months' leave with a minimum payment. Mothers may also take an additional three months of unpaid maternity leave, and job protection is guaranteed during the entire period. Parents who have not been working in the past year also receive benefits, though they are low—equal to the minimum payment for the entire period. Thus, it is difficult for women to have children until they have established themselves in the workforce, and most young women think it is worthwhile to postpone starting a family until they and their partners have higher incomes. The importance of the woman's financial contribution to household income also means that men have an interest in postponing having children until they and their partners are established in good jobs. All Swedish families receive an additional monthly allowance for each child regardless of their income. There is no stigma to cohabitation, and children have the same legal rights whether or not their parents are married. If the mother is not in a continuing relationship with the baby's father, the government will

collect child support payments from him. If a non-custodial parent is unable to pay the child support required, the government will provide an additional allowance, guaranteeing that all children receive sufficient support.

Young Swedish women who have children can use publicly available child-care services, like all parents in Sweden. However, child care generally does not accept infants, since it is expected that mothers, and increasingly fathers, will be home to care for infants and young children, supported by parental leave payments. As a result, those who become mothers while in school are often set back a year in their education.

France

France has a variety of public supports for parents and families. Maternity leave is guaranteed for working women at 100% of women's salaries for 16 weeks and includes six weeks of compulsory leave prior to childbirth. Mothers of twins, multiple births or third and higher-order births have guaranteed maternity leaves of 26–46 weeks. Although single parents have priority access to public day-care centers, there is a shortage of available places. An additional benefit allows working parents to receive a reduction in payroll taxes to help pay for in-home day care. All French families receive an allowance for each child, paid regardless of family income. However, families must have at least two dependent children to begin collecting this benefit. Families with only one child are not eligible, although they may receive a smaller benefit. Families with three or more children receive even higher benefits. Other financial supports for parenting are particularly intended for low-income parents and families, including an income-tested supplementary family allowance for large families (three or more children with youngest under age three), a means-tested single-parent allowance and an income-tested housing allowance.

Table 5-1. National policies that support families, mid- to late-1990s, Sweden, France, Canada, Great Britain and the United States

Country	Maternity and Paternity benefits		Family and Child Allowances
	Duration	% of wages paid	
Sweden	Parental leave: Total 19 months 13 months (at least 1 month for father) 3 months 3 months	 80% low flat rate Unpaid	Universal, non-income-tested allowance of about $70/month per child; additional allowances for large families (3+children) or children of single parents
France	Maternity: 16 weeks for first 2 children, inc. compulsory 6 weeks before birth; 26 weeks for third child; 34 weeks for twins; 46 weeks for multiple births Paternity: 3 days	 100% 100%	Universal, non-income-tested allowance for families with 2+ children of about $90/month for each of first 2 children and $113/month for each subsequent child; also income-tested allowance for large families; young child allowance; orphan allowance; income-tested housing allowance; and allowance to subsidize in-home child care up to age 3
Canada	Maternity: Total 17 weeks 15 weeks 2 weeks Parental leave: 10 weeks	 55% unpaid 55%	No universal family allowance; income-tested tax benefit with maximum of about $660/year for each qualified child; also earned income supplement and child-care subsidy for low-income working families
Great Britain	Maternity: Total 18 weeks 6 weeks 12 weeks Parental leave: 13 weeks	 90% low flat rate Unpaid	Universal, non-income-tested allowance of about $80/month for first child and $54/month for each additional child; additional supplement for single-parent families; working family tax credit for low-income working families includes a maximum tax credit of about $1,000/month for child-care costs in families with 2+ children
United States	Family leave: 12 weeks	Unpaid	No universal family allowance; income-tested child-care tax benefit and earned income tax benefit for low-income working families

Source: The Clearinghouse on International Developments in Child, Youth and Family Policies at Columbia University (see text reference 27)

Canada

In Canada women who have been working receive greater financial benefits when their babies are small than women who have not been employed or who earn low wages, and the amount of maternity benefits depends on the level of pay the woman had been earning. Working mothers are entitled to 15 weeks maternity leave, paid at 55% of their pay if they choose to stay home with their infant for that time. An additional 10 weeks of parental leave is available, also at 55% of prior pay, for either mothers or fathers. Finally, mothers may also take two additional weeks of unpaid leave. Canada does not provide a universal family allowance for all children, but does have an income-tested tax benefit that includes 90% of families, providing greater benefit for the first than for second or subsequent children. There is also a child-care subsidy applied toward day-care or baby-sitting costs for low-income parents who are in the labor force or in school.

Great Britain

Working women in Great Britain receive statutory maternity pay directly from their employer, financed through payroll taxes. Maternity benefits equal 90% of women's prior pay for six weeks and an additional 12 weeks of benefits are provided at a low flat rate. Women who are not eligible because they have left their jobs or are self-employed receive a parallel benefit, the Maternity Allowance, which the government pays at the low flat rate for up to 18 weeks. All families in Great Britain are eligible to receive an allowance for each child; additional supplements are available for single-parent families. Low-income families may claim a tax credit to cover child-care expenses that is much more generous than a similar policy in the United States, up to $1,000 per month for families with two or more children.

United States

Even though women's labor force participation in the United States is almost as high as in Sweden,[79] there are far fewer supports for combining parenting and employment. Some government benefits are available for very poor women with children. Teenage mothers must be allowed to continue attending school and are often provided with child care in school. There are, however, no child-care provisions or financial supports for young mothers who attend college or for mothers who are not very poor, whether or not they are working. Federal law allows employees to request up to 12 weeks of unpaid family leave at the birth of children (or for other family or medical emergencies) and requires that after taking such leave, employees be restored to their original jobs or an equivalent job with equivalent pay, benefits and other conditions. The United States is alone among industrialized countries in the fact that no paid maternity leave is mandated. Whether working women receive any paid maternity leave depends on their employer. In addition, most child care that is available is expensive and must be paid for by the parents. Teenage mothers are disproportionately from disadvantaged back-grounds[80] and most of them, like older mothers who are poor, depend on government benefits that come from a variety of federal and state programs. Because higher education is expensive and undergraduate students seldom receive assistance with child care or subsidized housing, most teenage mothers' education ends at the high school level. Tax credits for child-care expenses are offered, at the federal level and by some states, but the amount of this credit is much less than the actual cost of child care.

Although research is inconclusive,[81] many in the United States believe that welfare benefits provide teenagers as well as older women with an incentive to bear children. Beliefs such as this contributed to the thinking behind revisions in federal welfare policies that were enacted with the explicit goal of preventing and reducing the incidence of out-of-wedlock pregnancies. The prior entitlements of cash assistance to qualifying poor families (usually single mothers with children) were replaced with time-limited benefits, assistance in making the transition from welfare to work, and policies aimed at "reforming" sexual behavior and "restoring" traditional family norms through the promotion of abstinence-outside-of-marriage and rewards to states that reduce out-of-wedlock pregnancies and births among all women in the state, regardless of their income. Additional provisions require that unmarried minor mothers live at home or in some other supervised setting and stay in school in order to receive benefits. Although several evaluations are ongoing, to date there is little evidence that these policies have been successful in reducing nonmarital births, among American women in general and among welfare recipients in particular.[82]

In sum, the parental leave and family support policies in Europe, particularly in Sweden and France, are quite generous and provide working

women with the opportunity to choose to stay at home with their infants and young children, if they wish to do so. At the same time, they do not appear to provide younger women or teenagers with incentives to have children as a way of collecting benefits. In fact, because the benefits are tied to prior salary levels (a situation true in Great Britain and Canada as well), these policies may help to reinforce the societal norm that childbearing is best left until a young couple's careers have been established. In the United States, paid maternity leave is rare and child benefits are available only to poor women and families.

Approaches to Adolescence and Integration of Youth into Society

Comparison of some of the policies and programs that address youth in the five study countries shows they vary substantially in approach and in whether they are provided to all young people or are aimed primarily at improving the opportunities for the least advantaged youth. (See Table 5-2, for examples of some of the programs and initiatives that assist youth in the transition to adulthood.) The country-study teams identified a variety of programs as especially helpful to adolescents, including those that assist youth in their transition from school to work (for example, job counseling and training), provide unemployment benefits, assist adolescent mothers to complete their education, and provide social and financial supports for homeless youth or other disadvantaged groups.

Adolescence in all the countries studied is a time of preparation for, and sometimes entry into, the world of work; but youth and adulthood are treated somewhat differently across the study countries. In both Sweden and France, young people generally are not considered to be adults until they have finished their education, are employed and live on their own. To support youth in this transition, programs and policies have been implemented that link schooling with vocational training, career development and employment strategies. Adults in Sweden appear quite conscious of their responsibility to integrate youth into adult society, and to support youth as they learn to take on adult statuses. In 1994, a separate governmental agency for youth, the National Board of Youth Affairs, was established to help integrate youth into society through work and increase their influence on both their own living conditions and the entire social system. Youthful individuality is respected and encouraged, with clear expectations for responsible behavior. In France, a number of training mechanisms and incentives are available to employers who hire young people.

In Canada and in Great Britain, there is, in general, a somewhat less structured approach than in Sweden or France regarding the role of government in integrating adolescents into adult employment, though Great Britain has recently initiated several national programs for apprenticeship and employment training (Table 5-2). In general, having a strong link between schools and the workplace is a strategy that is much more common in Europe than in the United States.[83] For example, in France there is growing enrollment in vocationally oriented tracks and a shift toward mixing work with schooling. In Britain, a youth training track was designed to strengthen the school-to-work transition. In Sweden, where the vocational track in high school was already well developed, recent changes have added a year of rotation between schools and the workplace. However, these approaches usually are based on young people making a decision during high school about the career or vocational track they will follow.

In the United States, there are fewer organized means to help and to guide adolescents in obtaining further education, training and employment after high school or in helping those who do not complete high school. What they do after high school and where they go to college, if they do attend, is determined primarily by the resources available to them, the adolescents' own motivation, his/her access to information on how the system works and family support, unless they show exceptional aptitude and achievement. Some U.S. programs do target the most disadvantaged youth and provide job training or assistance, but these are not comprehensive or systematically organized and are scattered throughout the country and are available only to some youth. While the U.S. approach may offer greater freedom of choice and flexibility for many, it does little to help those who are less knowledgeable about opportunities for school and work or less able to take advantage of them on their own.

A review of youth labor market policies in developed countries highlighted the fact that the United States differs from other countries in that a much lower proportion of youth had settled into a stable job or a career path even after being in the labor market for 10 years or so (those aged 29 to 31 years old). Between one-quarter to one-half of U.S. white men,

Table 5-2. Examples of interventions that assist youth in the transition to adulthood, five developed countries

Intervention and Country	Description
Sweden	
National Board of Youth Affairs	Allocates aid to NGOs and initiates youth activities aimed at improving the living conditions of young people and enhancing their influence over social developments
Xist, a multi-activity house for school dropouts	House for dropouts run by NGO with municipal support to strengthen girls' possibilities in their private lives, their working lives and in society as a whole; includes high school studies, life skills training and social support for young parents
France	
Information and guidance facilities for training and integrating young people	Information and guidance facilities for those <25 with social and/or vocational integration problems. Provides legal advice, education and training information, job-seeking guidance and training.
Work contracts specifically for young people	Provide partial exemptions from payroll taxes for employers of <25. Include apprenticeship contracts for 15–25-year-olds that combine training and compensated vocational experience. Jobs for youth involve leadership, sports, education, safety and new technologies, with government paying 80% of young person's salary. Solidarity Employment Contracts for first work experience: Limited to 20 hours work per week, with government paying part of salary.
Training mechanisms or programs for least-qualified young people	Army and National Education Ministry screen young people for reading problems and guide them to remedial programs. Training programs for people with literacy problems. Journey to Employment Access/TRACE program to identify youth "at risk of vocational exclusion" and offer them an individualized track (and related assistance) toward lasting vocational integration. Media campaigns about army job prospects, particularly but not solely for young people with few or no job qualifications.
Canada	
"Backpack clinics" and programs for sub-populations of youth: low-income, Aboriginal and Inuit, street-involved	Social support, recreational facilities, information, workshops, skills-building activities, counseling, sexual health resources (condoms), HIV and STD testing, "backpack clinics," referral to other services. A variety of types of programs, implemented at the local level are described.
Youth internship programs	National government program that provides wage subsidies to employers who hire youth aged 15–30 who are out-of-school, unemployed, or underemployed. The program emphasizes youth employment in areas such as science, technology and international trade.
Youth Service Program	National government program that provides funding to organizations that create community service projects for youth facing barriers to labor market participation. The program stresses job and life skills.
Web Youth Resource Network	National government website provides youth with career planning information, links to available work experience programs and job opportunities.
Great Britain	
Work-based training for young people	The national government sponsors two work-based programs: National Traineeships and Modern Apprenticeships, which provide youth with training leading to vocational qualifications and with broad-based skills
Investing in Young People	National government strategy to improve participation and attainment of youth aged 16–19. Includes measures that affect schools, colleges and work-based training, as well as career planning.
Welfare-to-work	Series of measures designed to tackle youth and long-term unemployment, to promote employability and develop skills, and move more people from welfare to work. All young unemployed people are guaranteed education and training opportunities.
Social exclusion unit strategy for teenage pregnancy	To lessen the risks of young parents suffering the consequences of social exclusion, measures focus on getting more teenage parents back into education, training or employment. Included is a special action targeted on prevention for the most vulnerable groups, including children looked after by a local authority, those excluded from school and young offenders.
United States	
Job Corps	Educational and vocational training and job placement services for disadvantaged youth. Most participants live in Job Corps dormitories and can stay enrolled up to two years. Also provides social skills training, health services, health education, modest living allowance and clothing allowance.
Boys and Girls Clubs of America	Education, career/employment and health programs. Examples are homework help, tutoring, exposure to work and career opportunities, job-hunting and interview training, health education, sports and after-school and summer activities.
Teenage Parent Demonstrations Programs	Welfare "experiments" that tried to increase proportion of young mothers going to school, in job training and/or employment-related activities by monetary rewards and penalties.

Sources: *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports*, 2001, see text reference 18.

including those who were high school dropouts, high school graduates, and those with some college and or with a college degree, had failed to find a stable job by the time they were age 30, (that is, they had held jobs for less than one year), as compared with approximately 8–10% of similar men in West Germany (data for mid- to late-1980s).[84] (Similar data for the other study countries are not available.) This review also concludes that the main focus of U.S. youth labor market policies has been on non-college-bound minority youth and that other groups of youth have been essentially left alone. Moreover, even the existing targeted programs have served only an estimated 5–10% of the Americans eligible for participation, and have had mixed success. The Job Corps program has had some positive results on employment and earnings and decreased welfare receipt. But other demonstration projects, such as JobStart, did not result in any earnings increase by 24 months after the program started.[85]

Differences in government policies and programs that assist teenagers in making a smooth transition from school and college into the labor force, as well as different attitudes and norms about when it is appropriate to have a child, are likely to make a difference in teenagers' motivation to delay pregnancy and childbearing and in their ability to plan for the future. Social norms are clearest in Sweden and France—adolescence and even early adulthood are not wise or appropriate times to begin childbearing. However, teenage childbearing is so low in these countries and represents such a small public cost that there is little concern about its economic impact. In Canada, Great Britain and the United States, the timing of childbearing is viewed more as a matter of individual choice. And, in the United States, the high levels of adolescent childbearing require significant public financial and social support so that people are more likely to be concerned about teenage childbearing as an economic issue.

Policymakers in many European countries now pay a good deal of attention to the challenge of improving education and training to better prepare young people for adulthood and for an increasingly technological labor force that requires education and training beyond the high school level.[86] It is likely that this emphasis on training helps to make the transition to adulthood more transparent, and that young people are more likely to see the value of delaying parenthood. Although a growing emphasis on youth development among those who work with adolescents in the United States has demonstrated the importance of educational and personal development in equipping young people for adulthood, youth development approaches have not attained the level of national recognition, policy or programming that it has in Europe. Recent government efforts to reduce teenage pregnancy and childbearing in the United States include increased funding of teaching abstinence and measures such as reduced benefits and support payments to mothers on welfare, rather than providing comprehensive, supportive choices that would motivate young people to delay childbearing.[87]

Chapter 6. Attitudes, Values and Norms Toward Sexuality and Teenage Sexual and Reproductive Behavior

Introduction

Societal attitudes and norms about sexuality, in general, and about adolescent sexual and reproductive behavior, in particular, can be highly influential in affecting young people's behavior. The attitudes, expectations and messages expressed by people around them guide and inform what young people will view as appropriate, and inappropriate, ways for them to act. They set the contexts in which young people feel comfortable, or unable, to turn to adults with questions or for support on the sensitive issues of sexual behavior and sexual health.

Societal attitudes and norms are also important in influencing public policy on issues related to the provision of education, information and services related to sexual and reproductive behavior and health. Whether codified in laws and policies or simply represented in actual practice, they can exert substantial influence over what behaviors are acceptable or undesirable. How the issue of sexuality is framed in public debate, how much controversy it generates and whether debate centers around moralistic or public health concerns may all ultimately impact the quality and comprehensiveness of sexual and reproductive health services provided for youth, as well as a variety of types of related policies affecting social welfare, health and education. For example, funding levels for special adolescent services, priorities for sex education and laws and policies affecting adolescents' access to a full range of sexual and reproductive health information and services are often influenced by societal attitudes toward sexuality.

Attitudes Toward Sexuality

Sexuality in General

Public discourse and attitudes about sexuality vary widely across the five study countries. Based on the qualitative descriptions provided by each study team and personal observation through site visits, it is clear that, among the five countries, Sweden is the most generally accepting of sexuality as a normal and positive part of life. Sexuality is also openly acknowledged and accepted in France. Anglophone countries have traditionally had a more ambivalent attitude about sexual behavior. Great Britain and the United States share a more judgmental, puritan attitude about sexual behavior. This is somewhat less so in Canada, but varies widely among provinces.

Variation among countries in public attitudes toward sexuality can be illustrated both by comparing how sexuality is portrayed in the media and by looking at responses to questions on the acceptability of different types of sexual behavior. In both France and Sweden, partial nudity is common in advertisements and the media. In France, on-screen nudity and erotic scenes are fairly prevalent and accepted, and the issue of sex in the media does not arouse much public concern. In Sweden, there is current public concern about increased sexual content in the media and the greater availability of pornography through cable and the Internet. In the United States, Great Britain and Canada (largely because it receives much of its entertainment media from the United States), sexual imagery in the media is often used to sell products. And, although explicit sexual content or eroticism is not broadcast on network television, cable channels and Internet sites with such content are widely available. Moreover, although some segments of these societies are concerned about the level of sexual imagery common in the media, little has been done to reduce such images or to counter them with more responsible messages about sex and sexual

behavior.

Most adults among all of the five study countries think that sex before marriage is "not wrong at all" or wrong "only sometimes" (see Table 6-1).[88] This is overwhelmingly the case for Sweden (94%) and in Canada and Great Britain (84% in both countries). Data are not available for France, but the level there is also probably high. In contrast, only 59% of adults in the United States think that sex before marriage is acceptable, even though 87% of sexually experienced U.S. women aged 20–44 in 1995 had had intercourse before marriage.[89] Acceptance of sex before marriage does not translate to approval of extramarital relationships in any of the five countries. Approval of extramarital sex is highest in France (roughly 35%), 10–12% in Canada and Great Britain and very low (6%) in Sweden and the United States. The French and Canadians are most accepting of homosexual sex (75% and 56%, respectively). Levels of acceptance are much lower in Sweden and Great Britain (36–38%) and lowest in the United States (26%). However, there has been a move in Sweden toward greater acceptance of homosexuality during the 1990s. A national survey in 1999 showed that only 35% of male and 16% of female respondents disapproved of homosexual relationships.[90]

Adolescent Sexual Behavior

In contrast to general approval of premarital sex, most adults in the study countries think that sex before a relatively early age, 16, is always or almost always wrong. Some 39% of adults in Sweden and 25% of Canadians approve of sex before age 16, as do only 12–13% of adults in Great Britain and the United States.[91] Although there are no comparable data for France, initiation of intercourse before marriage and cohabitation are the norm there, thus it is more likely that public opinion is more similar to Sweden and Canada than to Great Britain or the United States. The wide gaps between views about sex before age 16 and sex before marriage suggest that sexual activity among unmarried adolescents is increasingly seen as acceptable as they become older.

• *Sweden.* Public discourse in Sweden is the clearest of the case-study countries in viewing sexuality among young people as natural and good. At the same time, clear expectations are set regarding responsible sexual behavior and supportive services and incentives are provided. There are no organized attempts to convince young people not to have sexual intercourse. Attitudes about sexual matters are open, and in many families it is common for a young person to have their boyfriend or girlfriend spend the night. Monogamy is the norm for sexual relationships, but it is common, and accepted, that people will have several partners over their lifetime. At the same time, strong social norms exist about responsibilities of sexual partners, which include protection against infection and unwanted pregnancy and fidelity to one's current partner. Young people are

Table 6-1. Attitudes toward sexuality, mid- to late-1990s, and levels of adolescent childbearing, 1975 and mid-1990s, Sweden, France, Canada, Great Britain and the United States

Measure	Sweden	France	Canada	Great Britain	United States
Attitudes toward sexuality					
% of adults approving of specific activity:*					
Sex before marriage	94%	na	84%	84%	59%
Extramarital sex	6%	35%	12%	10%	6%
Homosexual sex	38%	75%	56%	36%	26%
Sex before age 16	39%	na	25%	12%	13%
Adolescent childbearing					
1975: % of births to women <20	8%	9%	9%	10%	16%
mid-1990s: % of births to women <20	2%	2%	7%	9%	14%
mid-1990s: % of births to women <18	0.3%	0.6%	4%	5%	9%

* Not wrong at all or only sometimes wrong.

Sources for "attitudes": Widmer ED, Treas J, Newcomb R, Attitudes toward nonmarital sex in 24 countries, *Journal of Sex Research* , 1998, 35(4):349-357; attitudes in France from Spira A, Bajos N, ACSF Group, *Les Comportements en France,* 1993, plus personal communication with N Bajos.

Sources for "adolescent childbearing" 1975: Jones EF at al., *Teenage Pregnancy in Industrialized Countries* , New Haven, CT: Yale University Press, 1986; mid-1990s: *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports,* 2001 (see text reference 18).

taught that they are expected to practice contraception, and getting tested for STDs is considered responsible behavior. Unintended pregnancies, abortions and STDs are viewed in a fairly nonjudgmental manner, as indicators of the need for greater attention to preventive services and behavior rather than as a reason young people should not have sex.[92]

In Sweden, there is also strong emphasis on individual decision-making regarding sexual behavior and on equality between the sexes. Partners are usually fairly close in age and, on average, girls begin sexual activity at slightly younger ages than do boys.[93] Societal concern about sexuality is focused on behaviors that are unhealthy or that go against the strong norms of sexual equality. For instance, school and health service personnel quickly intervene with special counseling and education in cases where young people verbally or physically harass other students in a sexual way. Other aspects of sexuality that are considered problematic are sexual assault, abuse, rape and incest. Prostitution is viewed as inappropriate because it exploits women, and, in 1999, a new Act on Violence Against Women made the purchase of sexual services a criminal offence.

• *France.* In France, intercourse is socially accepted as part of couple formation, well before cohabitation or marriage, and parents increasingly accept that their adolescents will bring their partners home for the night or weekend. However, sexual relationships among very young adolescents is considered problematic. Other aspects of teenage behavior that are considered problematic are early pregnancy and childbearing, STDs, a large age gap between sexual partners, and sexual violence, rape and incest. Some 15% of girls aged 15–18 report having been forced to have sexual intercourse.[94] Young girls typically are in sexual relationships with boys who are substantially older, though the trend toward earlier sexual intercourse may have contributed to a narrowing of the age gaps. In 1994, for example, 35% of sexually active girls aged 15 had partners who were over age 18.[95] Currently, although there is some concern within the medical and sociological communities about adolescent pregnancy and childbearing and society's routine acceptance of sexuality among adolescents, there are no organized attempts to promote abstinence among French teenagers, either in messages targeted to the public at large or in prevention messages disseminated at schools.

• *Canada.* With respect to openness about sexuality, Canada can be considered slightly more conservative than Sweden and France, fairly similar to Great Britain and more liberal than the United States. Over the last two decades, Canadians have become increasingly comfortable with open discussion of sexuality and sexual behavior and more tolerant, if not accepting, of a wider diversity of sexual norms and behaviors.[96] From both public and governmental perspectives, adolescent sexual behavior is not considered problematic so long as laws are not being broken and the behaviors do not have negative health consequences for the individual or place an economic burden on society. Thus, in Canada, discussion of adolescent sexual behavior tends to be focused not on moral or religions implications, but rather on potential health consequences such as STDs and unintended pregnancy and, increasingly, on the costs of social assistance and medical services to teenage mothers and their children. There is variation across the country, however. While most messages at the federal and provincial level balance encouragement for postponing first sexual intercourse, abstinence and consistent contraceptive and safer sex behaviors, abstinence-only programs have made inroads in some places, particularly in the more conservative prairie provinces.[97]

• *Great Britain.* There is a good deal of controversy about sexual matters in Great Britain, and youth receive conflicting messages about what values are acceptable. The use of sexual imagery in the media to sell products conveys a message that being sexually active is the norm and that premarital sex is generally accepted. Although the AIDS epidemic increased openness about adolescent sexual behavior and the ability of young people to talk about and negotiate safer sex, it was also seen by some as evidence of decadence and declining moral standards.

There are differences within British society regarding the extent to which teenage sexuality is deemed problematic, and adults are often uncomfortable discussing sexuality with teenagers in a frank manner.[98] The media often present early sexual activity and teenage pregnancy as serious social problems, and media-driven public concern over such issues as precocious sexual activity contributes to confusion about what values are acceptable and leads to conflict rather than consensus. The right-wing press reflects some public attitudes, accusing teenage mothers of becoming pregnant in order to secure public housing and social supports; some see these supports as "subsidizing teenage sex."[99] Yet

government agencies have thus far resisted pressure to encourage young people to delay sexual intercourse and have focused on prevention of STDs, HIV and unintended pregnancy. The legal age of consent for intercourse for young women (16 in England, Wales and Scotland and 17 in Northern Ireland) is virtually universally known (96% of men and women know this). But over two-thirds of men and women think, incorrectly, that it is against the law for a man under age 16 to have sex.[100] Misperceptions like these, and heavy media coverage of a failed attempt to require parental consent before women under age 16 could obtain contraceptives, have contributed to many teenagers thinking it is illegal for those under 16 to ask for contraception or to obtain it confidentially.

The current government in Great Britain has undertaken a high-level initiative to reduce teenage pregnancy rates—ideally to halve the number of conceptions to women under age 18 over the next few years—and to reduce the "social exclusion" of young parents. The focus of this initiative and its action plan is on decreasing teenage pregnancy and childbearing through improved education, services and employment opportunities for youth; not on policies aimed at changing the sexual behavior of youth.[101] The fact that this is a cabinet-level initiative gives the initiative high prominence within the country and illustrates government resolve for this approach.

• *United States.* Youth in the United States also receive many contradictory and conflicting messages regarding appropriate sexual behavior. Many adults accept that teenagers will be sexually active, and the overwhelming majority favors providing them with sexuality education that covers contraception and supports their access to contraceptive services.[102] People with these opinions are often fairly quiet, however, overshadowed by a vocal minority promoting abstinence outside marriage and opposing access to and use of contraception and abortion. At the governmental level, the federal and state governments provide funding for contraceptive services that are available to all women and men regardless of age and income. A fairly recent federal-state program also provides funding for abstinence-only educational programs in which abstinence is emphasized as the only certain way to avoid out-of-wedlock pregnancy, STDs and other associated health problems, and abstaining from sex outside of marriage is the expected standard for all. Sexual activity outside of marriage is portrayed as having harmful psychological and physical effects, and bearing children out-of-wedlock is characterized as having harmful consequences for the child, the child's parents and society.[103]

These abstinence-based policies not only reflect conservative religious attitudes in the United States, but also the fact that many adults in the United States view adolescents as developmentally incapable of preventing unintended pregnancies and STDs. High contraceptive failure rates and unintended pregnancy and STD rates among teenagers are seen as indications that adolescents cannot manage responsibilities of sexual relationships, rather than that they do not have adequate access to information, services and support to enable them to be successful.

Public concerns in the United States are greatest about very young adolescent girls having sex, about age differences between partners and pressure on young women to have sex, and about the types of sexual relationships teenage women have. In general, male partners are about two years older than women with whom they have sex and 36% of sexually active young women aged 15–17 have partners who are three or more years older than they are.[104] One in eight women aged 15–19, a quarter of those who have ever had sexual intercourse, have been forced to have sex.[105] The fact that many adolescents have short-term relationships and that some, like unmarried adults, have sex with more than one person within a given time period, has led not only to concerns about teenagers' exposure to STDs, including HIV, but also to perceptions that they are promiscuous. Thus, although the typical sexually active adolescent woman began intercourse voluntarily when she was 17 and has had only one partner in the past year, teenagers are often portrayed in public discourse as sexually active since they were very young, promiscuous, and incapable of preventing negative health and emotional consequences because of their young age, because of pressure from uncooperative partners or because they are unaware or unconcerned about the risks of STDs and pregnancy.

Recently, a White House teenage pregnancy prevention initiative (under the Clinton administration) gave rise to an independent organization, the National Campaign to Prevent Teenage Pregnancy. Although its board of directors includes legislative and political figures, as well as academics and activists representing all perspectives, the Campaign

has made a great effort to remain independent from the government and relies on private foundation funding. The Campaign provides information and technical assistance to state and local groups working to prevent teenage pregnancy. It aims to represent the full spectrum of U.S. opinion on adolescent sexual and reproductive behavior, integrating abstinence-only and comprehensive sexuality education and services into its working groups and messages.

Attitudes Toward Teenage Pregnancy

Attitudes Toward Teenage Childbearing

Public opinion in all five countries tends to see adolescent childbearing as unwise, but this is strongest in Sweden and France and least so in the United States. In both Sweden and France, there is a strong consensus that having children is something for adults to do, and that those who plan to become parents should do so only when they have completed their education, obtained work and have established themselves in a committed relationship, whether or not they are formally married. Few adolescents in any of the study countries meet these criteria for parenthood. For example, the proportion of adolescent women who are married or cohabiting ranges from less than 4% in Canada, 6% in France and 8% in the United States to roughly 10% in Sweden.

Only 2% of births in Sweden and France are to adolescents, a decrease from 8% in the mid-1970s (Table 6-1).[106] The "image" of who has children is typically that of a woman in her late 20s or 30s who is living with her partner and who is employed. In fact, in Sweden, the National Office for Youth supports a Young Parents Association, which provides communication opportunities between young parents who feel they are disregarded by others as being too young to have children. "Young" parents are defined in this organization as those under age 25.

Teenage births accounted for 10% of all births in Canada and Great Britain in 1975 and 7% and 9%, respectively, in the mid-1990s (Table 6-1). In these countries, there have been few strong, consistent messages regarding appropriate timing for beginning childbearing; and, as in the United States, these messages differ among segments of society. Public disapproval of adolescent childbearing stems mainly from a concern over the public costs of supporting young mothers and their children.

The United States has historically been a country with young childbearing relative to western Europe. In 1975, 16% of births in the United States were to teenagers, compared with 14% in 1995. There are wide differences across the country in views about teenage motherhood. In middle and upper income communities, having a baby as a teenager is generally considered problematic because it interferes with a girl's chances of attending college and getting a good job. In communities that are less affluent and where parents have had less education themselves, girls have fewer chances of going on to higher education after high school, hence having a child is seen as less disruptive. In fact, it may be accepted as an alternative way of achieving adult status. For some groups in the United States, however, the distinction is not the age, educational or economic status of a young woman when she has a child, but whether or not she is married. From this perspective, marriage makes teenage childbearing morally and socially acceptable. One proposed "solution" to teenage childbearing is the promotion of marriage for pregnant young people.

Attitudes Toward Abortion

In all the study countries, avoiding unintended pregnancies is seen as preferable to induced abortion. There is, however, much less public controversy about abortion in Sweden, France, Canada and Great Britain than in the United States. Much of the activity against abortion that does exist in those countries is marginalized and is often seen as arising from ties to U.S. anti-abortion organizations. Opposition does appear, however, to be increasing in some areas. In France, anti-abortion activists are thought to be responsible for the ransacking of family planning facilities that counsel women who do not qualify for abortions because they are beyond the gestational limit for legal abortion. This limit has been, until recently, 12 weeks (since last menstrual period, or LMP) and French women often seek abortions in other European countries with longer gestational limits. In Canada, abortion service providers have been attacked, mostly along the U.S. border, as they have been in the United States.

However, in general, there is support for access to abortion in the European countries and Canada, both among public and government officials, and recent debates have centered on proposals to expand abortion access, not on proposals to restrict its access. For example, in May 2001, the French Parliament passed a bill to extend the period in which abortions

may be performed from 12 weeks LMP to 14 weeks LMP and eliminated the requirement for parental consent by minors seeking abortion, so long as another adult, of the minor's choice, is involved. In Canada, after a recent stabbing of an abortion provider in British Columbia, the provincial government provided funds to increase security protection of abortion provider staff and facilities. In these countries, abortion is generally seen as a reasonable, though regrettable, option for adolescents who become pregnant.

While there is public support in the United States for maintaining the legality of abortion,[107] there is also very strong and vocal opposition to the provision of abortion and to women having abortions. Abortion services are highly concentrated in medium and large urban areas; many states require that providers notify or obtain consent from parents of young women under age 18 seeking abortions or that the teenager obtains permission from a court before obtaining an abortion; public funding for abortions for poor women is not available in most states; and picketing of abortion facilities is commonplace.[108]

Socialization of Youth Toward Societal Norms

School-Based Sexuality Education

One of the most obvious ways societies socialize youth about attitudes and expectations related to sexual and reproductive behavior is through school-based sexuality education. All of the countries studied incorporate such instruction into schools. There are differences, however, in the length and content of instruction, in whether or not it is required and in the extent of consensus or conflict it engenders within the country (Table 6-2).

• *Sweden.* Sexuality education has been required in Swedish schools since 1955, but the guidelines and curricula have been revised a number of times. In the mid-1970s, efforts to improve prevention of adolescent pregnancies in the context of broadened access to abortion led to revised national guidelines and a new curriculum, called "Sexuality and Interpersonal Relationships," which shifted the focus from reproductive biology, contraceptive methods and STDs to a stronger emphasis on interpersonal relationships. In the 1990s, there has been increased priority on prevention of STDs, prevention of sexual abuse and violence and promotion of gender equality.

Recent decentralization of school management and administration in Sweden has given school principals greater freedom, within government guidelines and curricula. National curricula contain overriding goals, but the more detailed manuals for teachers have been replaced by reference materials. Biology classes continue to cover reproductive biology, contraceptive methods and STDs; abstinence is not a goal of sexuality education in Sweden. "Sexuality and Interpersonal Relationships" is now an overarching theme rather than a core subject, and the school principal may choose whether and how to integrate it into teaching. Some local area health councils, such as the one covering the greater Stockholm area, provide sexuality education materials and training for teachers and other professionals who work with young people (Table 6-2).

There is great variation in actual implementation of sexuality education in Swedish schools, from an intense study block over several days spanning many subject areas and including values clarification, role playing, art, and discussions of relationships to teaching of reproduction only from a biological perspective. Most students (boys as well as girls) visit a local health center or youth clinic as part of sexuality education, usually in grade 8 or 9. In the sixth grade, girls may also visit the health center, or health center staff may visit their school, for discussions about menstruation. An assessment of upper secondary schools showed that 38% of the schools had only a single-day workshop on sexuality education or a visit to the local health center or youth clinic so that young people will know where to get sexual and reproductive health services.[109] In fact, in the last years of compulsory school, sexuality education is usually taught in biology (90% of schools) and brought up in civics and religion classes in only 40% of schools.[110]

• *France.* Sexuality education in France is much more limited than in Sweden, but it is also mandatory. In middle schools, students must receive a minimum of two hours each year of discussion specifically related to sex and responsibility, relationships, dimensions of human sexuality and types and location of resources to prevent STDs and unwanted pregnancy. In addition, teaching of reproduction is provided in biology classes, and sex education is covered in health education workshops that all students in secondary education must attend. Sexuality education is not used to promote abstinence. However, few teachers have been trained to teach this subject and schools vary widely in what is taught. To help improve the situation, the national Ministry of Education has recently organized national

Table 6-2. Examples of interventions aimed at affecting adolescents' sexual attitudes and behaviors through school-based sexuality education, five developed countries

Intervention and Country	Description
Sweden	
Sexuality and Interpersonal Relationships	The National Agency for Education provides sexuality education reference materials to schools. These guidelines focus on feelings and sexuality and emphasize dialogue rather then lecturing students. Teaching goals cover basic facts, norms and values, social and psychological contexts and personal decision-making.
The Main Thread	The Stockholm County Council unit for promoting sexual health and preventing HIV/STDs, LAFA, funded with federal money, develops sexuality education teaching methods and produced a methodological handbook of 40 different teaching methods for use in *Sexuality and Interpersonal Relationships.*
France	
Training in sexuality education	The Ministry of Education organizes a national training program to train physicians, school nurses, social workers, management or supervisory personnel, teachers and guidance counselors to facilitate their involvement in sexuality education. Training is conducted by local school districts using funds specfically earmarked by the Community Health Office.
Mandated sexuality education	The Ministry of Education mandates that students in middle schools (ages 11–15) receive two hours per year of sexuality education covering issues self-image, legal, social and ethical dimensions of human sexuality, relationships, preventive behaviors and sources of care; in addition to covering physiology, STDs, contraception, abortion and assisted reproduction in the life and earth sciences curriculum. Sexuality education is also included in the 40 mandated hours of citizenship and health education provided during the first four years of secondary education.
Canada	
Canadian Guidelines for Sexual Health Education	Health Canada, the national ministry of health, developed, with nongovernmental participation, and distributed 30,000 copies of a 33-page booklet of (voluntary) guidelines targeted to anyone developing and delivering sexuality education programs. The guidelines are based on principles of democratic society, achievement of positive outcomes and avoidance of negative outcomes.
Skills for Health Relationships	A joint venture of national and provincial ministries of health and education developed and distributes a curriculum on sexuality, AIDS and other STDs for grade 9 (aged 13–14) to any school, school board or ministry of education that assumes costs of duplicating the materials for their own use. In-service teacher training is also available. The curriculum is thoretically based, and supports abstinence, use of protective measures by sexually active youth and compassion and tolerance.
Great Britain	
Action Plan to Reduce Teenage Pregnancy	The Government's Social Exclusion Unit's action plan to reduce teenage pregnancies will include a new guidance for schools on sexuality and relationships education which helps young people deal with pressures to have sex too young and encourages contraceptive use if they do have sex, along with new school inspection and better teacher training.
United States	
The Guidelines for Comprehensive Sexuality Education, Kindergarten–12th Grade	A private, not-for-profit organization, SIECUS, with foundation funding convened a volunteer task force to develop a framework to promote and facilitate the development of comprehensive sexuality education programs from kindergarten through 12th grade. SIECUS sells the publication and makes it available free on its website.
Abstinence-only education	The federal and state governments fund programs of abstinence-only education programs focused on youth aged 12–18. Local programs range from media campaigns to after-school activities with educational classes related to abstinence. Some programs substitute for contraceptive education; some complement contraceptive education; some replace contraceptive education with emphasis on contraceptive failure and risks.

Sources: *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports* , 2001, see text reference 18.

training for staff involved in sex education and health education workshops include discussion of sexual and reproductive health issues.

• *Canada.* Education is a provincial and local responsibility in Canada and thus varies across the country. In general, the society recognizes that teenagers require access to sexual and reproductive health education. Sexuality education is taught in most schools and usually includes comprehensive, accurate information about how to use and where to get birth control methods. Abstinence is presented in most sexuality education programs as a good choice, but not as a moral necessity. The few Roman Catholic schools in Canada typically teach abstinence as the only appropriate behavior for teenagers, however. Some communities, especially in the prairie provinces, have had controversies over the content of school-based sexuality education. These have been relatively infrequent and usually resolved with a decision to teach comprehensive information.

• *Great Britain.* In Great Britain, sexuality education has generated considerable controversy and has never been fully accepted or integrated into society. However, although there has been some pressure from minority groups to adopt an abstinence approach in sexuality education, government agencies have resisted pressure to encourage young people to delay sex. Sexuality education, including information about HIV/AIDS and STDs, is compulsory in all state-maintained schools in England and Wales. Sexuality education requirements focus on biological aspects of reproduction and prevention, including contraceptive methods. Young people express dissatisfaction with this focus, however, saying they want more information about sexual relationships, feelings, emotions and AIDS.[111] Improving sexuality education is one focus of the new national campaign to reduce adolescent pregnancy and childbearing. The national campaign includes new guidances on teaching sexuality education, including directing youth to places they can obtain services.

• *United States.* Since education is a state and local responsibility in the United States, there is great variation in whether sexuality education is taught and what topics are covered when it is. Sexuality education engenders controversy in many communities. In the 1996–1997 school year, there were more than 500 local controversies spread across all 50 states. Most of these involved groups promoting abstinence-only programs over an existing or proposed more comprehensive sexuality education program.[112]

Only 69% of public school districts require that sexuality education be taught, and 35% of these require that students be taught that abstinence is the only appropriate option outside of marriage for teenagers and that contraception, if it is covered at all, must be presented as ineffective in preventing pregnancy and STDs/HIV.[113] Almost all public secondary schools (grades 7–12) offer sexuality education, though almost two-thirds inform parents that they may remove their child from class and about a third require written parental consent for students to attend sexuality education classes. Teachers say that abstinence is the most important message they are trying to convey to students. Almost a quarter teach that abstinence is the only way of preventing pregnancy and STDs and two-thirds present it as the best alternative. While most (60%) sexuality education teachers present birth control as effective in preventing pregnancy and condoms as effective for preventing STDs, including HIV, only one-third discuss where students can go for birth control, 28% present contraceptives and condoms as ineffective and 12% do not cover them at all.[114]

Media Messages About Adolescent Sexuality

Youth in all of the case-study countries are exposed to commercial radio, TV, videos and films that often portray sexuality in an exploitative way and that seldom portray or discuss contraception or condom use as part of sexual behavior. Much of this entertainment media comes from the United States. However, the degree of exposure to such media may differ among countries: Youth in the United States are most likely to have television and radios readily accessible, followed by Canada and the United Kingdom, France and Sweden (see Chapter 2, Table 2-1). Countries also show substantial variation in the types of programming and media produced in each country; and in the extent and use of official media campaigns and efforts to influence sexual or reproductive behavior (Table 6-3, page 66). In this section, we discuss the general media environments found in each country and summarize some of the official campaigns that have used the media to socialize youth regarding appropriate sexual or reproductive behavior.

• *Sweden.* An open attitude toward sexual matters is a feature of Swedish society and sexuality and personal relationships are regularly discussed in radio and television broadcasts, as well as in newspapers,

magazines and books. There has recently been more media coverage of negative aspects of sexuality, such as sexual assault, rape and prostitution, as well as wider concern about the impact of access to media, such as cable talk shows from the United States and pornography channels, videos and the Internet. Concerns about such commercial exploitation of sexuality have risen, as has debate about the wisdom of allowing continued openness.

There are a number of ways in which more "official" government and nongovernment organizations in Sweden provide information and guidance for young people regarding sexuality and relationships. Examples include the National Institute of Public Health working closely with youth to publish a quarterly periodical featuring such subjects as love, identity and sexuality, issuing educational materials and carrying out outreach campaigns together with nongovernmental organizations (Table 6-3). The Swedish government is generally seen as a welcomed and trusted adult voice of guidance for young people.

Many of the media and outreach efforts in Sweden are funded for HIV prevention. Among government and nongovernmental organizations and experts, it was felt that HIV should not be addressed on its own, but integrated into ongoing efforts. Thus, the additional funding and energies around HIV invigorated and expanded teaching on sexuality and relationships so that HIV was incorporated into them not as a disease issue, but as part of a broader picture of sexuality. The resulting efforts reflect judgments that issues of sexuality should not be addressed through mass campaigns but that there should be increased communication and dialogue with young people about sexuality, and that youth should be included in the efforts.

• *France.* In France, the government periodically runs countrywide media campaigns regarding public health, using television and radio that are limited in duration. Condom ads and campaigns often use humor and recognition of difficulties of adopting preventive behaviors, but they have run into opposition at times. A contraceptive campaign in 1992 used television spots to air the message of "Contraception, it's simple when you talk about it." This replaced a more pointed message—"Contraception, so that you can concentrate on love"—several days prior to its launch because of protests to the prime minister. Since then, government media campaigns about AIDS have been aimed especially at young people and certain social groups. An awareness campaign in 1992–1993 regarding low-priced condoms was conducted by the Ministry of Health and the French AIDS Prevention Agency (AFLS). Some 83% of the French public reacted positively to the campaign posters and TV ads. The most recent campaign about contraception, in 2000, focused on freedom, choice, responsibility and personal development, and promoted sources of information on where teenagers can obtain services (Table 6-3). A slogan used in this campaign is "Contraception—The Choice is Yours."

Women's magazines and other mass media in France carry messages promoting condom use and advocating HIV prevention, but they seldom carry messages promoting contraceptives, such as oral contraceptives or emergency contraceptive pills. In fact, many of the articles on contraception in women's magazines are of relatively low quality. On the other hand, partial nudity is well-accepted in media. While there are some who protest commercials that present degrading and stereotypical images of women or that might incite violence toward women, the issue of sex in the media generally does not arouse much public attention or governmental action, although recently there has been more public discourse around these issues.

• *Canada.* Much of the television, magazine and film media in Canada is imported directly from the United States. However, in contrast to the situation in the United States, the advertising of condoms on Canadian television and in magazines has become increasingly common, though only in terms of STD prevention and not as a means of contraception. There have been few large-scale or concentrated efforts to reach large numbers of Canadian adolescents on a consistent basis with messages about sexuality. However, the federal Ministry of Health (Health Canada) has actively supported initiatives promoting adolescent sexual health, such as the development of national guidelines and curriculum for sexual health education and the national distribution of an STD prevention booklet (Table 6-3). Public campaigns are usually conceived and delivered at the local level, sometimes funded by Health Canada.

There is very little discussion of contraceptive use on popular television programs in Canada, but call-in radio programs which provide advice on sexuality issues to youth and young adults are increasingly common in Canada. These tend to be nonjudgmental and frequently emphasize consistent contraceptive and condom use in a sex-positive manner.

Table 6-3. Examples of interventions aimed at affecting adolescents' sexual attitudes and behaviors through media campaigns, five developed countries

Intervention and Country	Description
Sweden	
Glow	The National Institute for Public Health produces a free, non-commercial, quarterly publication, *Glow*, with extensive input from youth. It is Sweden's largest periodical for youth (180,000 copies), and features such subjects as love, identity, sexuality, sports and alcohol. It is distributed in schools and other places youth visit.
The Peer Journal	A privately published monthly magazine for ages 8–13 has been distributed at low cost to school children for 20–30 years at low cost. It includes material about love and being together, letters from readers, cartoons on most subjects from birth to death, such as relations with parents, divorce, single mothers, love, friendship, growing up and puberty.
The Bun	For the past 13 years, youth have produced a popular weekly program for young teenagers on public television that covers sexuality, love and relationships through music, interviews, life histories, short documentaries, questions and answers and vivid dialogue between youth and young adults.
Summer campaigns for HIV prevention	The National Institute of Public Health, together with the Swedish Association for Sex Education (RFSU) and the Swedish Federation for Gay & Lesbian Rights (RFSL) work jointly to improve knowledge and increase condom use. The National Institute of Public Health provides financial support and information materials and trained information workers from RFSU and RFSL conduct outreach activities through dialogue and condom distribution during the summer at places where youth congregate such as beaches, discos, rock concerts, shopping centers and campgrounds.
Internet site	RFSU runs an interactive internet site for questions on sexuality, contraception and STDs.
France	
Operation "Low-priced condoms"	The government's AIDS Prevention Agency used TV spots, posters and radio in an HIV awareness campaign targeting young people which included 1-franc condoms for youth. Campaign slogans were "Go out covered–1-franc condoms" and "Youth rate for all–1-franc condoms."
Communication campaign about contraception	A year-long media campaign using TV spots, radio, press and schools to increase support for contraception and young people's awareness of service sites. A low-cost telephone line for one year to answer technical questions about contraception and direct young people to sites where they can get contraceptive information and prescriptions. A small information brochure about contraceptives and publicizing the telephone line was published. Local groups are encouraged to distribute the brochure and integrate the campaign into mandatory school sex education sessions.
Canada	
Style: Doing the Right Thing	A social marketing campaign in Yukon Territory aimed at 15–29-year-olds to reduce rates of chlamydia used radio spots, bus signs and distributed prevention brochures and condoms in a case designed to look like a rock CD.
Poster campaign	The city of Toronto, Canada's largest city, put posters promoting condom use and emergency contraception in city bus shelters.
Television and Radio advertising	Music video television stations and youth-targeted radio stations carry advertising for condoms. These advertisements refer to condoms as a method of STD prevention but not as contraception.
Internet sites	A number of public health agencies provide web-based sexuality and reproductive health and education resources designed for youth.
Youth help phone lines	The Kids Help Phone provides youth with a toll-free, sexuality-related information and referral hotline. In addition, a number of provincial/municipal Planned Parenthoods and local public health departments provide similar phone lines.

continued next page

Table 6-3. Examples of interventions aimed at affecting adolescents' sexual attitudes and behaviors through media campaigns, five developed countries

Intervention and Country	Description
Great Britain	
Condom adverstising	Commercial condom manufacturers run ads on TV and at movie theaters. To counter accusations of encouraging promiscuity, a leading company developed sexuality education leaflets and information on how to prevent STDs. Ads for the female condom have appeared in women's magazines, but complaints caused them to be removed from posters and a national newspaper.
Young women's magazines	Numerous magazines for young women convey a tremendous amount of sex-positive information for young women. They have no counterpart in young men's culture.
Helpline	The private Welsh Family Planning Association runs a sexual health advice service for teenagers Monday to Friday, 9–5.
United States	
The National Campaign to Prevent Teenage Pregnancy	Private organization that grew out of a White House initiative encourages entertainment media to educate people about teenage pregnancy and encourage sexually responsible behavior. The Campaign is sponsoring a nationwide series of public service advertisements in teenage media about the possible consequences of sex. The images are of single young people and are quite unflattering, with large and negative words (cheap, dirty, nobody, reject, useless and prick) appearing to label each person, but which are actually (in small letters) linked to negative consequences of having sex, using no contraceptive or becoming pregnant.
Internet sites	Numerous private and commercial sites, such as Planned Parenthood Federation of America's *Teenwire*, gURL.com, sexetc.org, smartgirl.com and DrDrew.com provide teenagers (and adults) with frank and sometimes explicit information about sexuality and relationships, covering topics such as physical development, relationships, contraception, STDs and abstinence, as well as general news and answers from experts to questions they submit. Many of these are aimed at females. In addition, numerous pornographic sites are on the internet. Filtering software is used by many parents, schools and libraries to deter access to such sites.
Television advertising	TV networks accept public service announcements for condoms if the message is disease prevention and they are not aired when children would be likely to watch. Recently some magazines and cable and local television stations have accepted advertisments placing condom use in the context of sex for pleasure.
Magazines for young girls	Some magazines aimed at girls aged 10–13 carry explicit articles about sexuality issues, including contraception, STDs, teenage pregnancy, oral sex and how to tell when you are mature enough to have sex for the first time.

Sources: *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports*, 2001, see text reference 18.

• *Great Britain.* Many young women's magazines in Great Britain provide accurate and positive information about sexuality and relationships, including information about contraceptives, STDs, HIV and abortion. This contrasts with heavy coverage of sex scandals in much of the press that presents an exploitative and negative view of sexuality. The government's national campaign to prevent teenage pregnancy includes plans for using the media to advise youth and direct them to services.

• *United States.* Many local, state and national organizations in the United States aim media messages at young people. They often focus on negative aspects of sexuality as a way of "scaring" youth into abstinence or more responsible behavior. Many seem to assume that young people are either unaware that having a child when young will hold them back from other goals; that they don't care or even want to have children while in their adolescence; or that young men take no responsibility for pregnancy prevention or for a child if their partner has a baby. A recent series of ads, developed in consultation with youth, offers extremely negative views of teenagers who do have intercourse, become pregnant or get an STD: depressing images of a teenager are overwritten in large type with words such as "loser", "cheap" and "dirty" (Table 6-3). [115]

In the United States, media efforts aimed at preventing teenage sexual activity and pregnancy seldom refer to contraception or to where young people can get services, although condoms are increasingly mentioned, primarily for disease prevention. Dialogues with television writers and producers by nongovernmental organizations, such as Advocates for Youth and the National Campaign to Prevent Teen Pregnancy, have caused some popular programs to include vignettes around such issues. When a popular television show featured the issue of emergency contraceptives, calls to a national emergency contraception referral hotline run by a nongovernmental group increased dramatically, but soon returned to baseline levels.[116]

Discussion

Adolescence is a time of transition to sexual relationships in all of the study countries and comparisons across countries show fairly narrow differences in the proportions of teenagers who have had sexual intercourse. However, the countries are quite different in their perspectives on adolescent sexual behavior. It is viewed most positively in Sweden and generally accepted in France and Canada. In contrast, a good deal of contention exists in both Great Britain and the United States over whether teenage sexual activity is a personal issue that should be left to individual choice or whether it is a moral issue that calls for policy and programmatic intervention. However, the United States stands alone among these five developed countries in its widespread and publicly supported efforts to promote abstinence among unmarried teenagers.

All the countries studied here are concerned about minimizing negative outcomes of sexuality, such as unwanted pregnancy, abortion and STDs. In Sweden, France, Canada and Great Britain, adults and government expect that young people are capable of acting responsibly and focus on providing information and accessible services. There is strong consensus in Sweden and France that teenage childbearing is unwise, that sexual behavior among adolescents is acceptable, especially among older teenagers, and that sexually active adolescents should and can act to prevent pregnancy and STDs. This is also generally the case in Canada and Great Britain, although consensus around these issues is less firm, especially in Great Britain, and the positions are all less strongly held. While this is also the majority position in the United States, there is considerable dissension around each of these issues, especially around whether or not young people should have sexual relationships. Thus, while in other countries the focus is on addressing adolescent sexuality with information and services to make it as positive and healthy as possible, in the United States much of the focus is on lecturing or frightening young people away from sexual behavior, either for moral reasons, unless they marry young, or with the assumption that it will be harmful to them.

School-based sexuality education occurs in all the countries and there is variation across schools in all countries. Sexuality education is used mostly to impart basic knowledge about reproduction, contraceptive use, STD prevention and where to go for services, although historically the focus in Sweden places more emphasis on interpersonal relationships. The United States is the only country where abstinence is promoted as the best choice until marriage and it appears to be the only country where students are taught that contraceptives and condoms are not effective or are not taught about them at all.

Messages, expectations and norms about what is expected or accepted in terms of adolescent behavior

are communicated in numerous ways. Some of these expectations are conveyed through the types of support that societies provide to youth and young families as they take on adult roles. In addition, sexuality education and media campaigns have been used in all countries to convey messages about expected behaviors and service availability, although the scope and focus of school-based education, the messages broadcast and the extent of the campaigns vary widely among countries.

The breadth of central government involvement in conveying messages and expectations for youth varies, depending, in part, on the political structure of the country and on how comfortable the government is being associated with issues regarding sexuality and teenagers. In all countries, government plays some role in assuring confidential access to services for teenagers. The government in Sweden has historically taken an active role promoting sexual rights and health and there is close cooperation between government and nongovernmental organizations. The French government has traditionally been less active, but sexual rights have always been part of the women's rights movement in France and the current Minister for Women's Rights has taken an active role in promoting positive messages about sexuality. In Great Britain, a program for teenage pregnancy prevention was initiated and is being carried out at the cabinet level, that is, the highest level of government. In the United States, the teenage pregnancy prevention initiative begun under White House auspices was moved into the private sector, both to shield it from political pressures and remove the administration from such a controversial issue.

The fact that study countries other than the United States have attitudes more accepting of adolescent sexual behavior but similar levels of intercourse among their teenagers, suggests that promotion of abstinence in the United States has not had great impact. Lower teenage pregnancy and birthrates in these other countries probably reflect both stronger norms against teenage parenthood and greater expectations that sexually active adolescents should, and can, be able to prevent unintended pregnancies and STD, combined with information and services to help them achieve these goals. A question remains, however, whether the United States can drastically lower its teenage birthrates without becoming more open to the reality of adolescent sexuality, more active in providing helpful information and services, and more focused on aiding teenagers as they become integrated into adult roles of employment, families and parenting.

Chapter 7. Provision of Sexual and Reproductive Health Services for Youth

From a policy perspective, comparing countries' approaches to service provision and looking at potential relationships between services and adolescent behavior is critical. In our search for programs or policies that could be adapted to other settings or countries, it is possible that those related to how or what services are provided to adolescents may be more easily transferred than policies or programs that address disadvantage or more closely reflect societal attitudes toward sexuality. Providing affordable, accessible sexual and reproductive care to adolescents may, in fact, be one way that countries can help to mitigate some of the negative effects of disadvantage on adolescent reproductive behavior. On the other hand, the efforts made to provide sexual and reproductive health care to adolescents are often dependent on societal attitudes toward the acceptability of youth sexuality.

Health Care Delivery Systems

Accessibility of sexual and reproductive care begins with, but is not totally determined by, the overarching systems of delivering health care in each country. These systems differ among the five study countries: Most residents of France, Sweden, Canada and Great Britain obtain medical care delivered by a national service system or paid for by universal government or employer financed national health insurance. In the United States, there is a non-universal mixed system of public and private health insurance that leaves a considerable proportion of residents without any medical coverage at all.

Although universal health care is a feature in four of the countries studied here, the actual systems used to finance and deliver health care vary substantially from country to country. Countries differ in the relative importance of national versus regional or local responsibility for financing of services, in who is covered, in the systems of reimbursement, in the amounts of copayments required and in the way services are delivered.

Sweden

In Sweden, the goal of the public health system is to provide health services for the entire population on an equal basis. County councils are responsible for financing and operating health and medical services and for establishing fees for services, which vary between $8 and $40 for consultation and treatment. Certain services, including maternal and child health care and family planning, are provided free of charge. Prescription drugs are also subsidized under the Swedish health system, and clients are charged a copayment for each prescription obtained.

France

In France, medical care for nearly everyone is covered, in part, by national health insurance (NHI), which is generally financed through employer and employee payroll premiums. Under this system, clients usually pay providers for services received and then seek reimbursement from NHI, although clients obtaining services from public hospitals do not have this requirement. NHI provides only partial reimbursement, charging a copayment that varies according to the type of service—ambulatory care copayments are typically higher than hospital care copayments.[117] Copayments are waived entirely for some services. Many French residents have supplemental health insurance, either purchased individually or provided by their employer, that covers these copayments, and indigent people may have these costs covered by government-financed medical aid. NIH covers many, though not all, prescription drugs under the same pattern whereby clients pay the full initial fee and claim reimbursement from NHI minus

a required copayment.

Canada

In Canada, medically necessary health care for all Canadians is financed through 10 provincial and two territorial health insurance plans. These plans are funded through a combination of federal and provincial government contributions, primarily using general revenues, sales taxes or other general taxes, and employer-employee contributions in Ontario. Canadians seeking medical care can go to private providers or clinics and present their provincial medical insurance card to receive care with no direct cost. Prescription drugs, however, must be purchased from pharmacies and are not generally covered under national health insurance.

Great Britain

In Great Britain, the National Health Service (NHS) provides medical care to everyone, free of charge, funded by means of flat-rate salary contributions. Patients do not pay any out-of-pocket fees for doctor's visits, hospital care or prescription drugs. In addition, a parallel private system of health care is utilized by increasing numbers of wealthy and middle-class residents.

United States

In the United States, health insurance is generally an individual or family responsibility, purchased or obtained as a benefit through employer-based coverage. Those who are not employed, whose employers do not offer health insurance or who cannot afford to purchase health coverage either rely on public insurance or have no coverage. Nationwide, one in five women of reproductive age is not covered by either public or private health insurance.[118] Public insurance is available to poor women and their dependent children and to some men; eligibility for coverage is set by states within federal guidelines based on income and family size. Historically, private physicians have not readily accepted public insurance; those with public coverage must typically rely on public providers or those few private physicians willing to accept public insurance payments. This insurance is seen as a form of welfare and carries a social stigma. Coverage for contraceptive and reproductive health services, as well as the amount Americans pay for prescription drugs, varies widely depending on the type of insurance plan they have. Public insurance usually covers a full range of prescription contraceptive methods and preventive services and pays the full cost for certain covered drugs. On the other hand, few private insurance plans cover a full range of contraceptive methods and some do not include any prescription drugs, while others charge a copayment for covered drugs.[119]

Sexual and Reproductive Health Services for Adolescents

Within each country, some variation from the general system of financing or delivering health care services occurs in the provision of services to adolescents and for health care services related to sexual behavior, such as contraceptive, STD- or abortion-related care. Moreover, the degree of accessibility of sexuality-related health care services for adolescents in each country reflects both society's level of commitment toward ensuring general access to health care and attitudes toward the rights and responsibilities of sexually active youth.

In discussing and comparing the countries' efforts and successes in providing sexual and contraceptive services to youth and some of the barriers they face we highlight four areas: The availability and accessibility of sexual or reproductive health care services for youth, including the types of providers used by adolescents; the relative costs of sexual and reproductive health care and contraceptive supplies to youth; the availability of confidential medical services and the legalities of providing care with or without parental consent or notification; and the extent of societal support for youth in accessing available services and in adopting and successfully practicing effective methods of protection against unintended consequences of sexual behavior.

Youth Access to Sexual and Reproductive Health Services

Adolescents in all five study countries can obtain sexual and reproductive health care services from both youth-focused settings specializing in such services and from settings that serve people of all ages, often for a variety of medical conditions. However, the relative importance of different settings varies from country to country. Because youth-focused clinics often provide care during times that are convenient for teenagers, have a more teenage-friendly environment, employ staff that have more expertise and experience working with adolescents and can ensure greater confidentiality of care, it is

generally believed—and some evidence has shown—that adolescents who have access to such clinics are more likely to seek care on a timely basis and feel more comfortable seeking sexual health services.[120] We therefore look specifically at the availability of youth-focused services to teenagers in each country, as well as at youth access to care in other settings.

• *Sweden.* In Sweden, sexual and reproductive health care services for adolescents historically have been available, and continue to be available, through maternal and child health clinics located in public health centers. At these units, which are widely available throughout the country, prenatal care and contraceptive services are offered free of charge to all residents. The first youth clinic was opened in 1970 because it was recognized that teenagers were often uncomfortable seeking care along with pregnant women or older women and that the specific needs of adolescents would be better met by separate service sites. By the mid-1980s, the number of youth clinics in Sweden had risen to 70 sites nationwide. With the rise of HIV/AIDS and continued commitment toward improving adolescent access to and use of sexual and reproductive health services, the number of youth clinics continued to increase and now stands at 200.

In Sweden, teenagers can choose to consult either a midwife or physician at the local maternal and child health center or turn to a youth clinic for contraceptive or STD services. Although the number of teenagers relying on each type of care is unknown, in areas where youth clinics are available they are the most popular source of sexual and reproductive health care among teenagers. A study of youth in one town found that 95% of all girls and 18% of all boys in the town visited the youth clinic for individual counseling and services at least once between the ages of 17 and 20.[121]

Youth clinics in Sweden not only provide sexual and reproductive health care, including contraceptive and STD services, but offer psychological counseling and counsel youth having problems with parents, peers or school issues. Midwives provide most of the care related to sexual health, including provision of physical exams and dispensing of hormonal contraceptive methods; general practitioners and specialty doctors are available for supervision and consultation when necessary. Social workers and psychologists provide most of the counseling services. Together, all of the staff of the youth clinic form a team whose stated objective is "to prevent physical and mental ill-health; strengthen young people in coping with their sexuality and respecting themselves; and preventing unwanted pregnancies and sexually transmitted disease"[122] (see Table 7-1, page 74). Youth seeking to terminate an unintended pregnancy will receive information and counseling at the youth clinic, while the actual procedure will be performed on an outpatient basis at the hospital.

• *France.* In France, most youth obtain sexual and reproductive health care from private physicians or family planning clinics that serve women of all ages. Although the proportion of teenagers obtaining care from each type of source is unknown, data from 1993 show that 95,000 minors (under age 18) were served at family planning clinics. This number can be compared to an estimated 380,000 sexually active minor women in France,[q] suggesting that approximately one-quarter of minors who might have needed services went to clinics. Thus, approximately three-quarters of minors in need of contraceptive services either visited private physicians or hospitals or depended on non-prescription methods and made no visit. Of the approximately 1,000 family planning clinics in France, about 60 offer special dedicated sessions for teenagers on Wednesday afternoons—a time when public schools in France are closed. Most clinics provide STD testing and treatment as well as contraceptive care. In addition, youth and adults may attend a network of "Anonymous Free HIV Information and Screening Centers." Anyone seeking abortion services must contact a "Center for Voluntary Termination of Pregnancy." Most of these are located in public or private hospitals and some are associated with the hospital's family planning clinic. Recently, several reports have emphasized the value of separate facilities for teen-focused health care as a means of improving adolescent access to and use of sexual and reproductive health care services.[123] As a first step toward meeting these identified needs, at least two dedicated youth clinics (Teen Info Units) have recently been established that provide both contraceptive and STD services. Care at these sites is free and youth may attend anonymously (see Table 7-1).

• *Canada.* Canadian youth have access to private physicians, public health family planning or sexual health clinics that serve both youth and adults, and some clinics for teenagers run by the public health department, although no data are available on the

[q] Estimated by multiplying the total number of women aged 15-17 (1 million) by the percentage who ever had sex (38%).

percentages of youth obtaining care from different sources. Private organizations such as Planned Parenthood also provide information, counseling and some contraceptive services to Canadian youth. Youth can usually obtain both contraceptive and STD services from the above sources. In addition, public health departments may also run STD clinics that are available to teenagers. Abortion services are available at hospitals and private clinics. Abortions performed at hospitals are fully covered by National Health Insurance; those that are performed privately may be fully, partially or not at all covered by NHI, depending on the specific regulations of each province.

In both Canada and Great Britain, the benefits of youth-focused sexual and reproductive care are recognized by some; however, the resources and commitment necessary to make such services widely available in each country are not readily forthcoming. In these countries, establishment of youth clinics through the public health department is at the discretion of the local health authorities. However, in both countries, public health departments have faced recent reductions in overall funding for reproductive health care services.

• *Great Britain.* In Great Britain, youth can obtain sexual and reproductive health services from general practitioners, public and private family planning clinics and some public health clinics that offer integrated services. A number of Young People's Advice Centers (YPAC) provide advice and counseling and refer teenagers for specialty services, and some of the community family planning clinics offer special times or sites for youth. Private organizations such as the Brook Advisory Clinics also provide youth-centered care. A pilot project in Scotland to set up biweekly youth clinics within a local pharmacy was not continued due to the controversy generated (see Table 7-1). Although the number of teenagers who are served at youth-focused sites is unknown, the number of British youth served at family planning clinics overall has risen over the past decade: in 1998–1999, 22% of all women aged 16–19 visited a family planning clinic, representing approximately 36% of sexually active teenage women. This is fairly consistent with a finding from a sample survey of 16–24-year-old women, in which 68% reported that their first visit for contraceptive services was to a general practitioner. In Great Britain, youth can obtain STD services from general practitioners, some family planning clinics, genito-urinary clinics and some public health clinics that offer integrated services. Abortion services are offered through the NHS, but women must first obtain a referral from a general practitioner. In addition, youth may obtain abortions from clinics run by private organizations such as the British Pregnancy Advisory Service or Marie Stopes International.

• *United States.* In the United States, both ambivalence and controversy around youth access to contraception and a lack of public funding for youth clinics hamper expansion of such services to more adolescents. Youth obtain sexual and reproductive health care services primarily from private physicians or from one of the more than 7,000 publicly subsidized family planning clinics nationwide. Among youth reporting family planning services in the prior year, about half went to clinics and half went to private doctors or health maintenance organizations. Some of these clinics serve teenagers and others have special times when only youth are served—teenagers are the majority of clients at 7% of all publicly funded clinics, about 500 sites altogether that primarily serve youth. A movement to establish and expand school-based clinics in America's public schools only partially addresses the sexual and reproductive health needs of youth; most of these sites, for example, do not offer contraceptive care or methods. In some large urban areas, comprehensive youth clinics have been established and have been quite successful in serving youth in specific neighborhoods. For the most part, these clinics have been located in and targeted toward high-risk youth in inner cities, and staff at these sites often coordinate a number of other social services for these youth, in addition to providing sexual and reproductive health care. However, such clinics are available only to a small percentage of U.S. adolescents (see Table 7-1). STD services are often provided at family planning clinics and may also be obtained from separate STD clinics operated by public health departments throughout the United States. Teenagers may obtain abortion services from some hospitals and, more often, from private clinics run by Planned Parenthood or other abortion clinics.

Cost of Care to Adolescents

Another important factor determining the accessibility of sexual and reproductive health care services and supplies to youth is how much a young person will have to pay out of pocket to obtain both medical care and contraceptive supplies. In this regard, youth

Table 7-1. Examples of interventions aimed at providing or affecting adolescent use of contraception and sexual and reproductive health services, five developed countries

Intervention and country	Description
Sweden	
Youth clinics	Youth clinics are run by municipalities or county councils. Staff provide counseling and individual talks with youth, outreach in schools and youth centers, health education regarding puberty and contraceptive and STD services.
Midwives	Midwives have prescribing authority for oral contraceptives and provide other medications under standing orders. They provide contraceptive services themselves and refer for some methods and (STD) treatments. They have been trained as counselors and provide education and counseling on sexuality, gender and interpersonal relations in public health and youth-friendly clinics.
RFSU (Swedish Association for Sex Education) and RFSL (Swedish Federation for Gay & Lesbian Rights)	RFSU trains information workers in sexuality education and prevention; runs sexuality information programs with organizations for young immigrants and youth with functional disorders; runs a drop-in clinic for youth in Stockholm and a separate clinic for young men where they provide services and develop and test methods for counseling and services that are spread throughout the country through training programs and publications. RFSL informs young people about homosexuality and supports homosexual and bisexual youth through special activities and groups. Both groups contribute to summer campaigns for HIV prevention, with information and condom outreach activities.
Abortion-prevention program launched in connection with liberalization of abortion	To prevent need for abortion, contraceptive services were provided free of charge and the price of contraceptives subsidized. Health education program on sexuality and interpersonal relations, with special funds to assist women's, youth and immigrant organizations. Community-based project to develop and test methods for communication and information regarding sexuality and interpersonal relationships; training of social, school and health professionals.
Enhancing access to contraceptives by reduced price	A rise in teen abortions was linked to changes in the public health insurance system that increased the price of pills fourfold. Trials with free or subsidized pills for young women were carried out in various areas of the country. There was some evidence of small decreases in abortion in the study areas, especially when combined with other preventive measures.
France	
Teen Info Units	Two teenage clinics (in Poissy, a Paris suburb, open in 1993 and in Strasbourg, a big city in northeastern France, opened in 1999) provide dedicated youth reproductive and sexual health services: listening and counseling services, contraception (condoms and pills are available and free) and STD services. All care is free, confidential and anonymous. Identification is not required and no medical records are established.
Communication campaign about contraception	Launched in January 2000, the goals of this government-sponsored campaign are to reaffirm the rights to contraception and to improve knowledge about contraceptive methods, including emergency contraception. Components include TV spots, radio and print messages, a telephone hotline and nine million copies of an information brochure on contraceptive methods distributed throughout the country. An evaluation is ongoing.
Study-action on reducing unwanted pregnancy	Government-sponsored funding to define and carry out programs to reduce unwanted pregnancy in local areas, with coordinated initial assessment and impact evaluation. Communities submitted proposals and several have been chosen to identify needs and develop local interventions. Projects include interviews of professionals and of adolescents used in a video for training professionals; increased or innovative school sex education sessions; follow-up on contraceptive use; support for pregnant adolescents who do and do not want to carry to term. Projects are still in early stages.
Measures planned for improving conditions of access to abortion	A variety of measures intended to better enforce a 1975 abortion act, including requirements that public hospitals must incorporate contraception into ob/gyn departments. Future chiefs of ob/gyn must agree to provide abortions. Professionals are encouraged to work locally in networks with abortion centers to provide services. Abortion centers must offer all methods of abortion (including drug-induced) and anesthesia to women. Regional Birth Commissions must verify availability and accessibility of contraceptive and abortion information, assess difficulties in getting an abortion, assess area needs for abortion services. In addition, action has been taken to amend the abortion act to affirm a minor's right to an abortion with confidentiality from her parents and to allow abortions up to 14 weeks gestation.

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Table 7-1. Examples of interventions aimed at providing or affecting adolescent use of contraception and sexual and reproductive health services, five developed countries

Intervention and country	Description
Canada	
Make Noise: Empowering Youth to Confront HIV/AIDS	Youth carried out interviews to document issues concerning youth and HIV/AIDS, availability of information, quality and accessibility of existing services and made recommendations for improving youth services and described model programs, especially for out-of-mainstream youth.
Just Loosen Up and Start Talking!	Youth interviewed other youth to document barriers to education and services and explore possible solutions to problems of delivery and access. Report is narrative summary of their comments and advice.
Sexuality/reproductive health clinics	In many but not all communities in Canada, local public health departments and/or Planned Parenthoods provide sexuality and reproductive health counseling. Some clinics include access to contraception. In addition, a small number of schools have clinics that provide contraceptive services.
Young women's experiences obtaining sexual health services and education	In-depth interviews with young women about barriers to school health education, to obtaining physician services and to use of pharmacies for sexual health needs.
Great Britain	
The Gillick Case	In 1982, a private citizen sought a high court ruling against the Department of Health and Social Service's guidance that would allow her teenage daughter to be provided with contraceptive advice or treatment without her permission. The High Court ruled in favor of the DHSS, but an Appeal Court overturned the ruling saying that parental consent was judged to be important. Finally, in 1985, the House of Lords ruled further to accept the original guidance allowing for confidential services to minors. The confusion generated by the case continues to create uncertainty about confidentiality among youth.
North of England initiatives	In areas of high teenage pregnancy in northeastern England, a number of initiatives have been piloted: afterschool health clubs that provide information and advice on sex and contraception; weekly school-based clinics where youth can obtain information, counseling and services, including contraception; efforts to boost the self-esteem of young girls; and special cards that allow teens to obtain contraception at clinics without seeing a doctor.
Sexual health service in Boots, the Chemist	In 1998, a pilot project was initiated by the Greater Glasgow Health Trust and Boots the Chemist, a well-known pharmacy in Britain. At twice-weekly youth clinics, held at the pharmacy, young people could obtain information and contraception, including emergency contraception. Family planning agencies endorsed the project, but heated debate and controversy was generated within the press and among private practitioners. Hate mail, security problems, threatened boycotts all contributed to the fact that the pilot project was not extended.
Welsh helpline	A telephone helpline, offering contraceptive advice to teenagers, was initiated in Wales. It is run by the Family Planning Association and is available Monday through Friday, 9 to 5, and is to be expanded into the early evening.
United States	
Publicly subsidized family planning clinics	Over 7,000 publicly subsidized clinics offer family planning services to U.S. women. Over 4,000 of these receive some of their funding through the federal Title X program, which requires confidential contraceptive services to teens. A variety of organizations run these clinics (hospitals, health departments, Planned Parenthoods, community health centers), and some provide dedicated teenage care at separate sites or times, but most serve women of all ages.
School-based clinics	An increasing number of school-based or school-linked clinics are available to youth. However, most of these do not offer contraceptive services
Comprehensive youth centers	Several intensive programs that offer both information and access to sexual and reproductive health services, as well as youth development including homework help, career guidance, job training, art and drama and sports have been implemented, mostly in high-risk inner-city neighborhoods. An example is the program initiated by Michael Carrera through the Children's Aid Society. Evaluations are ongoing and are promising.
Plain Talk about Sex	Neighborhood-based program to assess community needs regarding youth and sexuality, develop consensus about interventions, increase adult-youth communication about sexuality. Interventions range from home health parties to teenage leadership program, a Teen Center providing access to reproductive health services, opportunities for young men to discuss sex and relationships with their peers in a nonthreatening environment and establishment of a organization for young black men.

Sources: *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports*, 2001, see text reference 18.

in Great Britain are provided the greatest access among the five countries studied. Here, all services, whether obtained from private physicians or clinics are provided without charge under the National Health Service, as are all prescriptions, including oral contraceptives.

Youth in Canada and Sweden have similar free access to sexual and reproductive health care services, no matter where they go to seek that care. However, typically they will receive an initial free supply of oral contraceptives but will have to purchase additional supplies themselves, usually at a significantly reduced rate, ranging from $1–3/cycle for oral contraceptives in Sweden to $3–11/cycle in Canada.

In France, youth who obtain sexual or reproductive health care from family planning clinics receive it free and are provided with free contraceptive methods such as condoms and oral contraceptives. However, youth who obtain sexual and reproductive health services at physicians' offices must initially pay the office fee and later seek reimbursement through the National Health Insurance (NHI). Similarly, if they obtain a prescription for oral contraceptives from a private physician, they (or their parents) will need to pay the pharmacy charge for the method and later seek reimbursement through NHI. Depending on the specific formulation for oral contraceptives prescribed, youth may or may not be fully reimbursed for the cost of these supplies.

Finally, in the United States, adolescents may or may not have to pay for sexual health and contraceptive services and supplies, depending upon where they go to seek care. About half of all teenagers obtaining reproductive care report visiting publicly subsidized clinics. Most of these teenagers will be served without charge or for reduced fees and are likely to receive free or reduced-cost contraceptive supplies. The other half of adolescents obtain care from private physicians; some of these teenagers have private insurance that may cover visit costs and others have to pay for the cost of services themselves. For youth obtaining care from private physicians, prescription methods must usually be purchased at a pharmacy; some insurance plans cover these drugs for a copayment (often $5 to $25 per prescription), but typically only one cycle of pill supplies are dispensed at a time; other women pay the full cost of prescription methods themselves.

In all five countries, condoms are available to youth in a variety of settings. Free condoms are often available at clinics and are sometimes dispensed at schools. Condoms can also be purchased from pharmacies, grocery stores, convenience stores, vending machines and other locations. In France, promotion of condom use has been the most vigorous, including media campaigns and allocation of public subsidies to make condoms more affordable. During earlier campaigns, condoms could be purchased for as little as 10 francs for 10 condoms (about $1.30 or 13 cents/condom). Now condoms in France are typically sold for about 50 francs for 10 condoms (about $6.50 or 65 cents/condom) in pharmacies. Among the other countries, condoms that are not dispensed free typically can be purchased for between 50 cents and $1 per condom.

Right to Confidential Services

In all five countries, most sexually active adolescents are able to obtain access to sexual or reproductive health care services confidentially, without the knowledge or consent of their parents, if they so desire. However, in some countries this varies according to the age of the teenager, the type of provider from whom care is sought, regional or state regulations pertaining to minors' rights, the specific services requested by the teenager and the attitudes and beliefs of the doctors themselves. Moreover, in some countries, confusion over whether or not a provider will notify a young person's parent generates fear among teenagers and ultimately limits their access to needed services.

Sweden and Canada have the clearest and most consistent policies on adolescents' rights to confidential sexual and reproductive health care services. In Sweden, anyone, of any age or marital status, has the right to consent to confidential contraceptive, STD or abortion services and providers must respect a teenager's decision not to involve or notify their parents of this care. Thus, in Sweden, fear that a parent will find out about a teenager's sexual activity because of a visit to a clinic is rarely a reason for avoiding care. On the other hand, youth clinic staff often actively encourage teenagers, particularly younger ones, to talk to their parents about their relationships and any problems they may be having related to their decision to become sexually active. Especially in the case of pregnancy and abortion, youth receive counseling and help in telling parents and most ultimately do involve their parents; however, no one is denied care if they choose not to tell a parent.

Similarly, in Canada, minors can consent to medical treatment, including contraceptive, STD and abortion services, if they are "capable of understanding the information about a treatment and of appreciating the risks and likely consequences of treatment."[124]

In Great Britain, teenagers of all ages may obtain contraceptive and abortion services without informing their parents under certain circumstances. When providing services to women under age 16, a Department of Health and Social Services (DHSS) guidance requires providers to attest to a young person's competence in the following manner: the teenager must understand the advice and have sufficient maturity to understand what is involved; she will not be persuaded to inform her parents, nor to allow the doctor to inform them; and she will very likely begin or continue having sexual intercourse with or without contraceptive treatment. However, although the current regulations mandate confidential treatment, there is a good deal of confusion among young people about these regulations. In the mid-1980s, an appeals court concluded that parental consent was important and ruled that the DHSS guidance on this matter was unlawful. The House of Lords reversed this ruling, but the controversy and confusion generated then, as well as continued discussion in the press about the need to toughen guidelines, created an atmosphere in which many young people believe they cannot seek contraception if they are younger than 16 (see Table 7-1). Moreover, they often fear that their general practitioner will tell their parents if they seek sexual or reproductive health care services.[125]

In France, confidential access to sexual and reproductive health care is guaranteed at family planning clinics (CFEF) to all adolescents; however, physicians may and often do require parental consent for minors (those under age 18) seeking sexual or reproductive health services. Minors seeking abortion have been required, until 2001, to obtain parental consent and rarely did doctors make any exceptions to this rule. In May 2001, the French Parliament adopted a bill that changed this requirement, allowing girls under age 18 to decide for themselves, without their parents' consent, whether to have an abortion after two consultations with a doctor, so long as an adult of their choice was involved in the decision (see Table 7-1).

Finally, in the United States, whether or not a minor (those under age 18) will be required to obtain parental consent is dependent upon the state in which she lives, the type of provider she visits and the service she requests. Most teenagers are able to receive confidential contraceptive- or STD-related care from some providers in their state. All clinics that receive federal family planning funds must ensure confidential contraceptive and STD care to all clients regardless of age or marital status. In addition, in 26 states and the District of Columbia laws are in place authorizing doctors to provide appropriate care to minors without parental consent. In the remaining states, minors may consent under certain circumstances or there is no explicit policy on the subject. In two states, Texas and Utah, statutes prohibit the use of state funds to provide contraceptive services to minors without parental consent (though this prohibition does not affect services in federally funded clinics). Minors seeking abortion services are more likely to be faced with difficulties in obtaining confidential care. Only two states and the District of Columbia explicitly affirm the right of minors to consent to an abortion without parental consent. Forty-one states require women under age 18 seeking an abortion either to involve a parent in their decision or to petition to have this requirement waived, usually by obtaining judicial authorization. The confusion of all these different state regulations concerning abortion and parental consent have resulted in many teenagers believing that abortion for minors is illegal altogether in their state.[126]

Supporting Youth in the Effective Use of Contraception

In order for adolescents to access services successfully, they must be informed of these services and counseled in ways that contribute to effective use of methods obtained. Styles of counseling about appropriate and effective use of methods, ways of dispensing contraceptive supplies, procedures for dealing with method-use problems and the attitudes of providers concerning youth sexual behavior are other factors that may influence service provision to teenagers and ultimately affect how effectively they use the contraceptive methods obtained.

Based on the reports from our consultants and site visits to each country, it is clear that the ways that providers and the community as a whole support youth in effective contraceptive use varies from country to country, and within countries one consistent path is not always followed. Overall, the steps taken in Sweden to help youth successfully adopt and

continue effective contraceptive practices are the most consistent and well articulated. In other countries similarly effective practices are found in certain areas, within specific clinics or among certain dedicated providers, but among the other four other countries studied here, the overall national commitment and allocation of resources toward this goal does not match the Swedish effort.

A key factor indicating community support for youth services is how youth are informed about where they can go to obtain sexual and reproductive health services. In Sweden, schools take the lead in telling youth about available clinic services. Students often visit the clinic as part of sexuality education and notices with the locations and times that the youth clinics are open are posted on school bulletin boards. In all other countries, the ways that youth are informed about available services vary dramatically from community to community, and are usually dependent on staff at local clinics taking the initiative to reach out to schools (if allowed to) or other community organizations providing messages and information about the services available to youth. France has recently conducted a national campaign that included publicizing a hotline that youth could call to find out about service locations (see Table 7-1); and, in other countries, private service organizations like Planned Parenthood or the Brook Advisory Clinics provide similar hotlines that youth may call to obtain information about the types and location of available services, as well as get information about particular sexual or reproductive health issues. We did not, however, find organized efforts by any country to promote or inform youth about the availability of care through private physicians, even though a high proportion of youth depend on these providers for their sexual and reproductive health care.

Factors that enhance the adoption and effective continuation of contraceptive methods in Sweden include nonjudgmental counseling by youth clinic midwives who are available to answer questions and respond to problems at the initial visit, at follow-up visits and during special times when clients can call the clinic for advice. Youth in Sweden, as well as the community at large, know about the location and availability of services at youth clinics, and these sites are considered not only inviting to young people but are appropriate to visit even for those who are not sexually active, since other medical and counseling services are offered.

Neither Sweden, France, Canada or Great Britain requires or recommends that young women have a pelvic exam on their first family planning visit, prior to obtaining a prescription for hormonal contraceptives. Since many young women fear that part of initiating contraceptive care, delaying the pelvic exam is thought to encourage youth to seek care on a more timely basis. In the United States, recent guidelines issued for Planned Parenthood clinics and for federally funded clinics give providers the option to allow clients obtaining hormonal methods to delay the pelvic exam for a maximum of three to six months. Thus, some youth providers in the United States are beginning to allow teenagers to delay the initial pelvic exam, but this has not been a common practice and still does not occur everywhere.

Looking at the ways in which youth are counseled when initiating contraceptive use, we find that providers in France, and those in Sweden to a somewhat lesser extent, take a fairly directive approach toward oral contraceptive use. Youth who attend the Wednesday afternoon teenage group sessions in French family planning clinics are primarily counseled about use of oral contraceptives (and the different pill formulations), and physicians there usually offer the pill to adolescent clients. In Sweden, midwives counsel youth toward a free and informed choice of contraceptive method, but also share their experiences about what methods are most appropriate given a person's age and life situation—for adolescents, oral contraceptives are thought to be the most appropriate for pregnancy prevention.

In Canada and Great Britain, it is less clear whether a consistent tendency toward directive or nondirective counseling is found among providers serving youth. Evidence suggests that private physicians in these countries take a more directive approach, primarily prescribing pills and doing little in the way of counseling about method choice.[127] In the United States, however, one of the key tenets of publicly subsidized family planning clinics is a commitment toward presenting every client with a wide range of available methods and allowing the client to choose the method most suitable for her. Thus, most family planning clinic clients receive a fair amount of counseling about different contraceptive methods, and nearly half of all teenagers make their first contraceptive visit to a family planning clinic. Others who make their first contraceptive visit or obtain further services from private physicians typically are provided with little contraceptive

counseling about a wide range of methods unless they specifically request it. And, although a majority of young women in the United States use oral contraceptives, growing numbers are now adopting use of the three-month injectable hormonal contraceptive.

Discussion

In comparing the provision of sexual and reproductive health care to adolescents across these countries, three overarching conditions appear to influence countries' success in this area: (1) society's general commitment to ensuring equal access to health care among all of its residents; (2) society's commitment to youth and to providing them with the resources and guidance necessary to become healthy and productive adults; and (3) society's recognition of the rights of adolescents to obtain sexual and reproductive health care.

Sweden provides a clear example of what can be achieved when a society has strong positive values on each of these conditions, illustrating the importance of societal commitment toward universal health coverage, youth development and recognition of the rights and responsibilities of sexually active youth. Here youth have ready access to both the services and supplies they need as well as to the support necessary to adopt and continue responsible behavior.

France also exemplifies a society with positive values on these three conditions, at least in principle. Universal health coverage is provided and valued, youth are given support and guidance as they make the transition to adulthood, and society does recognize the rights and responsibilities of sexually active youth. However, the services and support provided to French youth are not as clearly accessible as are those in Sweden. Although societal values and attitudes support and encourage young people to protect themselves against pregnancy and STDs, French youth must take more initiative to seek out appropriate services. There are few dedicated youth clinics and French teenagers may face obstacles related to confidentiality and cost of care that are not an issue in Sweden.

Canada and Great Britain have positive values on the first condition—equal access to health care by all residents is valued and provided. However, there is ambiguity and variation within both countries in their response to the second two conditions—the approach taken in assisting youth to make the transition to adulthood and, especially, recognition of the rights and responsibilities of sexually active youth. Controversy around the topic of sexual behavior and lack of commitment to prioritizing and allocating resources toward youth issues or sexual health care results in a patchy set of services and support that may be adequate for some youth but inadequate for others. Great Britain has recently embarked on a large national effort to reverse some of these trends, committing increased resources toward services related to both youth development and sexual health.

As a whole, the United States illustrates the case of a society that does not place high values on any of these three conditions—equal and universal access to health care is not provided, youth are often left on their own in making the transition to adulthood, and there is little public recognition of the rights and responsibilities of sexually active youth. Substantial proportions of U.S. teenagers and their families have no health insurance, and some who do have insurance may not be covered for contraceptive supplies or may fear that using insurance for reproductive health services will compromise their confidentiality, since their coverage usually comes through their parents' policy. Many teenagers, regardless of their insurance status, turn to public health care providers for contraceptive services. These public providers often struggle to maintain and expand contraceptive services for teenagers because, with their limited funds, they must also respond to clients with other health care needs. Moreover, the fact that teenagers rely heavily on publicly funded family planning clinics, rather than the family doctor, for contraceptive services simultaneously stigmatizes the clinics for providing care that is somewhat outside the mainstream and their teenage clients for seeking those services in the first place. In contrast, in other countries publicly funded health care services or insurance coverage extends across economic groups of society and is seen as a benefit for everyone.

However, interventions have been implemented in the United States that are promising and, in fact, are similar to some of the approaches used in other countries. The expansion of school-based and school-linked health clinics and the opening of new community-based teenage clinics suggest a rise in youth-focused care similar to youth clinics in Sweden or Teen Info Units in France. But, in order to have a real impact on adolescent behavior, these clinics would need to provide comprehensive sexual health care that includes open discussions with youth about sex and relationships, create environments that youth

feel safe coming to and ensure that all youth in the community are aware of these services. And, the numbers of such service sites would need to be greatly increased. Meeting these requirements present formidable challenges in the United States, as well as in Great Britain, where the location of clinics providing sexual health services to teenagers often generates considerable controversy.

Other approaches, such as community assessment of service availability and use and the development of multi-component interventions designed to meet the specific requirements of local communities are being tried in the United States and other countries. Often these multi-component interventions include programs for youth development and support, as well as improved access to sexual and reproductive health services. Such programs are most often implemented in the United States (and in other countries) in areas with relatively high adolescent birth and pregnancy rates—areas that are often disadvantaged in a number of ways. The programs therefore face significant challenges, both in terms of motivating and supporting youth to become productive adults and ensuring that they have access to the services, skills and supplies necessary to protect themselves from unintended consequences of sexual activity.

Finally, although the provision of accessible sexual and reproductive health services to teenagers varies widely among the five countries studied, little difference exists among countries in the sexual behavior of youth. Thus, it is apparent that providing easy access to contraceptive care and talking openly with youth about sexuality and relationships does not lead to greater or earlier sexual activity. But it does improve the ability of sexually active youth to avoid unintended pregnancies and disease. Acceptance of this one idea is critical if societies are to move beyond the current ideological and moral controversies that plague development of youth services and begin to make accessible and confidential sexual and reproductive health care a reality for all youth.

Part D: Summary Explanations and Policy Implications

Chapter 8. Summary and Conclusions

This project had three principal objectives: (1) To document current levels and trends over recent decades in teenage pregnancy, birth, abortion and STDs across developed countries; (2) To identify the key pathways of risk and protective behaviors that lead to variation in these levels; and, (3) To elucidate social factors and interventions likely to affect key teenage risk and protective behaviors.

The data and analyses presented in this report can be useful for all of the countries studied, and for other countries as well—both to understand how they compare to other developed countries and to draw insights and new ideas from the experiences of the five focus countries. However, much of this summary is from a U.S. perspective, since continued high levels of teenage pregnancy in the United States were the impetus for this effort.

Although this study has focused on adolescents, their behavior and the types of policies and programs affecting their lives reflect wider social, historical and governmental contexts in the individual countries. And, teenagers' sexual and reproductive behavior mirrors that of adults rather than being distinct from them. For example, the unplanned pregnancy rate among women aged 15–44 in the early to mid-1980s was much higher in the United States than in Sweden, Canada and Great Britain, but similar to France. Similarly, in the mid-1990s, the abortion rate was higher not only among teenagers but among women in their 20s and among all women aged 15–44 in the United States than in any of the other study countries. The greatest differences in abortion rates were not among teenagers but among women in their early 20s, with the U.S. abortion rate at 50 per 1,000 women aged 20–24, compared with rates in the other study countries no higher than 31 per 1,000.

For the most part, what has been learned in this study substantiates and extends findings from prior cross-national studies regarding the factors that contribute to variation among developed countries in teenage pregnancy and childbearing.[128] Less, and less effective, contraceptive use is still key to the exceptionally high teenage pregnancy and birthrates in the United States; and society's ambivalence and conflict about sexual issues leads to difficulties for teenagers in accessing contraceptive services.

In addition, the relatively high level of intended adolescent childbearing in the United States stands out as a notable, though not the primary, cause of differences between countries. Because of suggestions from prior work linking high levels of teenage birth to social and economic disadvantage, we devoted more effort in this project than in the prior studies to documenting the contribution of disadvantage to risk behaviors and outcomes. We found that though the impact of disadvantage is substantial, it alone does not account for the differences. Finally, in this current study, country efforts in helping youth make successful transitions to adulthood appear more important than in past studies. This is probably due both to new attention to youth education, training and employment in today's economies and to greater awareness of the fundamental importance of youth development efforts.

Cross-National Variation in Teenage Pregnancy, Birth, Abortion and STD Levels

Adolescent pregnancy, birth and abortion rates and STD levels vary widely across developed countries. Compared with all other developed countries, the United States ranks high in adolescent pregnancy and birthrates, moderate in abortion rates and high in levels of most STDs. And, the U.S. pregnancy rate is more than four times the French rate, three times the Swedish rate and almost twice as high as in Canada and Great Britain.

In the United States, a good deal of activity in recent years has focused on attempts to reduce the country's high teenage pregnancy and birthrates, and much attention has been given to declines in the U.S.

teenage pregnancy and birthrates during the 1990s. However, the United States started with much higher pregnancy and birth levels three decades ago, and since then Sweden, France, Canada and Great Britain have experienced even steeper decreases than has the United States.

Pathways to Country Variation in Pregnancy, Birth, Abortion and STD Levels

In our investigation of the possible pathways of risk and protective behaviors through which adolescents in the study countries experience or avoid unintended reproductive health outcomes, we have drawn upon substantial amounts of available quantitative and qualitative data. In Table 8-1, we provide a summary of some of this information by ranking countries on a variety of adolescent sexual and reproductive risk behaviors. These rankings reflect our best assessment of the situation in each country and are based on the findings presented in the country reports, reviews of the literature and discussions with the country consultants, as well as others involved with youth programs and policies whom we met during the country site visits. They also reflect the general standing of each country on a measure relative to other countries, not absolute magnitude of differences between countries. To summarize findings for different areas of focus, ranks are assigned according to whether adolescents in each country have a higher (H), moderate (M) or lower (L) likelihood of engaging in particular behaviors that heighten their risk for pregnancy or STDs. Ranks do not necessarily indicate the relative importance of different factors in contributing to variation in adolescent pregnancy or STD levels. The overall mean score and subset mean scores are rough summary indicators of a country's standing overall and its standing in each focus area.

Overall, the United States has a higher mean risk score on these measures than do the other countries—2.6 compared to 1.5–1.9; and, within each focus area except sexual activity levels, the United States also has higher mean subset scores than all other countries. The following discussion highlights some of the key findings in each area.

Teenage pregnancy levels are higher in the United States than in the other study countries.

A high pregnancy rate in the United States results in U.S. teenagers having exceptionally high levels of birth and abortion, compared with adolescents in other similar developed countries. In surveys, 66% of young women who had babies as teenagers report they had not planned to become pregnant at that time.[129] Assuming that pregnancies that ended in abortion were also unintended conceptions yields an estimate that 78% of teenage pregnancies in the United States (excluding miscarriages) were unintended conceptions.[130] While similar data are not available for the other study countries, insights can be gained by comparing intended and unintended pregnancies in the United States with total pregnancies in the other countries.

• *Intended births are high in the United States.* Some of the difference between the United States and other study countries in teenage pregnancy rates reflects higher levels of intended childbearing among U.S. adolescents, though measures of intention status are not available for births in the other study countries. The U.S. intended birthrate (about 18 per 1,000 in 1995) is much higher than the total teenage birthrates for Sweden and France (8–10 per 1,000) and is probably as high or higher than intended births in Canada and Great Britain, which have moderate total teenage birthrates of 25–28 per 1,000, comprising both intended and unintended conceptions.

• *Unintended pregnancies and births make up most of the difference between the United States and other study countries.* While a high level of intended childbearing in the United States accounts for some of the difference between the United States and the other study countries, most of the wide gaps in pregnancy and birthrates represent unintended conceptions. The unintended teenage birthrate in the United States (roughly 40 per 1,000 in 1995) is four times or more the low total birthrates in France and Sweden and about 1.4 to 1.6 times the total teenage birthrates in Canada and Great Britain, respectively.

• *High pregnancy rates, not less use of induced abortion, are key to high U.S. teenage birthrates.* Pregnant teenagers in the United States are in fact much more likely than similar teenagers in Sweden to have births and somewhat more so than teenagers in France, Canada and Great Britain. Some 65% of teenage pregnancies (excluding miscarriages) end as births in the United States, compared with 31% in Sweden, 49% in France, 54% in Canada and 61% in Great Britain (see Table 3-1, page 28). However, these differences cannot fully account for variation in birthrates among the study countries.

In fact, even though the proportion of pregnant

U.S. teenagers who have an abortion is lower than in other study countries, the proportion of *all* U.S. teenagers having abortions each year is highest there—29 per 1,000 women 15–19, compared with 21 or fewer per 1,000 in the other countries—due to there being so many more U.S. teenagers becoming pregnant each year (see Table 3-1). Thus, the high teenage pregnancy rate in the United States results in high rates of both teenage births and teenage abortions.

Differences between countries in levels of sexual activity are too small to account for the wide variation in teenage pregnancy rates.

On available measures, teenagers across study countries are quite similar in the timing of first sexual intercourse. The overwhelming majority of young women begin to have intercourse in their adolescence: Before they turn 18 at least half of young women in all the study countries have had sex, and at

Table 8-1. Country ranking on relative measures of teenage risk behaviors, distribution of country ranks and overall and subset mean risk scores, mid to late-1990s, five developed countries

Risk behaviors and Scores	Sweden	France	Canada	Great Britain	United States
RISK BEHAVIORS*					
Pregnancy levels and resolution					
Intended childbearing	L	L	M	M	H
Unintended pregnancies	L	L	M	M	H
Birth to abortion ratio	L	M	M	H	H
Sexual activity					
Early sexual debut	H	H	H	H	H
Current sexual activity	H	M	M	M	M
Sporadic sexual activity	L	L	M	M	M
Contraceptive use					
No contraceptive use at first sex	M	L	M	M	M
No current contraceptive use	L	M	M	L	H
Use of nonhormonal methods	M	L	L	L	H
STD risk					
Multiple partners	M	L	M	M	H
No current condom use	M	M	L	L	M
RISK SCORES**					
Distribution of ranks					
High	2	1	1	2	7
Moderate	4	4	8	6	4
Low	5	6	2	3	0
Summary scores					
Overall mean risk score	1.8	1.5	1.9	1.9	2.6
Subset mean risk scores					
Pregnancy levels and resolution	1.0	1.3	2.0	2.3	3.0
Sexual activity	2.3	2.0	2.3	2.3	2.3
Contraceptive use	1.7	1.3	1.7	1.3	2.7
STD risk	2.0	1.5	1.5	1.5	2.5

*Behaviors are coded according to their risk level for pregnancy, birth and STDs: L=lower risk, M=moderate risk, and H=higher risk.

**Subset mean scores are calculated by summing the scores of all items in a subset and dividing by the number of items in the subset, with L=1, M=2 and H=3. The overall mean risk score is the average of the four subset scores.

least three-quarters have sex before turning 20. And, U.S. teenagers are less rather than more likely than others to be currently having sex. Women aged 18–19 in the United States are somewhat less likely to be currently having sex than those in France and Great Britain and much less likely than women in Sweden (see Table 3-3, page 31). However, teenagers in the United States are the most likely to have sexual intercourse before age 15.

Young women in France and Sweden who have had sex appear to be in relationships or settings more conducive to less sporadic sexual exposure: 95% of 18–19-year-olds who have had sex are currently sexually active, compared with 79–84% in Great Britain and the United States (calculated from Table 3-3). While more frequent intercourse increases the risk for pregnancy among adolescents, more continuous and established relationships may also contribute to more ongoing and effective contraceptive use.

Less contraceptive use and less use of hormonal methods are the primary reasons U.S. teenagers have the highest rates of pregnancy, childbearing and abortion.

Adolescents who have sex without using a contraceptive have a high chance of becoming pregnant. Accidental pregnancy rates among method users are typically lowest for hormonal methods, such as oral contraceptives, injectables and implants, and IUDs. Thus the level of contraceptive use and the methods used are important potential determinants of unintended pregnancy levels among teenagers who are having sex.

Most adolescents in the case-study countries use some method, usually condoms, when they first have intercourse, but levels of non-use are higher in the United States, Sweden and Great Britain than in France. Roughly two in 10 teenagers in the United States, Sweden and Great Britain use no method at first sex, compared with only one in ten young French women (see Table 3-5, page 33).

Differences widen for subsequent use, however. American adolescents are least likely to use contraceptives currently, compared with moderate levels of non-use in France and Canada and low levels in Sweden and Great Britain. And, U.S. teenagers using methods are more likely than sexually active teenagers in the other countries to rely on non-hormonal methods which typically have higher use-failure rates.

While the differences in contraceptive use patterns coincide with the differences between the United States and other countries in pregnancy rates, they are probably not large enough to account for all of the variation. Data from the United States show much higher levels of accidental pregnancy among reversible contraceptive users of all ages than have been found in clinical trials and than are expected under conditions of correct and consistent use.[131] There are no similar contraceptive effectiveness studies from any of the other study countries. Weighting the study countries' method use patterns by U.S. effectiveness rates, however, suggests that their pregnancy rates would be more similar to levels in the United States if they had the same use-failure rates as U.S. teenagers than is now the case.[r] This implies that teenagers in the other study countries are not only more likely to use methods and to be using methods that offer higher potential success but are using their contraceptives more effectively than are teenagers in the United States.

More sexual partners, a higher prevalence of infection and, probably, less condom use contribute to higher teenage sexually transmitted disease (STD) rates in the United States.

Sexually active teenage women and men in the United States report more sexual partners in the past year than do those in the other study countries (see Table 3-4, page 32). However, more sexually active American women are using condoms with their partners as their primary method than in Sweden, Canada and Great Britain. On the other hand, the limited data available indicate that "dual use"—that is, use of other methods for contraception, usually

[r] If contraceptive users in each country used methods with the same levels of effectiveness as in the United States, the relationship between the country's teenage pregnancy rate relative to that of the United States would be unchanged if we statistically substituted the available U.S. rates. To test this, the proportions using each contraceptive method currently or at last intercourse (Table 3-5) were multiplied by the first-year contraceptive use-failure rates for women aged 18-19 in the United States. From Ranjit N, Bankole A, Darroch JE, Singh S, Contraceptive failure in the first two years of use: Differences across socioeconomic subgroups, *Family Planning Perspectives*, 2001, 33(1):19-27. The rate for withdrawal users was applied to the "other" category of use and we assumed an annual pregnancy rate for non-users of 75%. The resulting country pregnancy rates were .6-.8% of the U.S. level, much closer than is actually the case. From this, we infer that for the actual country pregnancy rates to be much lower relative to the United States, it is very likely that method users in the other countries are more successful contraceptive users.

hormonal methods, as well as the condom—is probably lower in the United States than in Great Britain and Canada. Thus, overall use of condoms for contraception and disease protection may actually be lower in the United States than in some of the other study countries.

The differences between U.S. teenagers and those in other countries in exposure to multiple partners and in levels of condom use are not so great as differences in reported rates of bacterial STDs. More research into the accuracy of reported levels of bacterial and other STDs, patterns of sexual behavior and overall condom use is needed. But, it appears that other factors are also contributing to the high U.S. teenage STD rates, such as a higher prevalence of STDs in the pool of partners with whom adolescents are having sex. In addition, it is possible that U.S. teenagers are less effective or consistent in their use of condoms than are teenagers in other countries.

Society's Influences on Teenage Sexual and Reproductive Behavior

It is, of course, difficult if not impossible to characterize an entire country. In any area of attitudes and behaviors, there inevitably is a range across geographic areas, social groups and individuals. The experiences of Sweden, France, Canada and Great Britain suggested many examples of interesting, and potentially effective, organized programs and interventions, including many that can also be found somewhere within the United States. However, none offered a "magic bullet" that alone could reduce U.S. teenage pregnancy and STD rates to levels of the comparison countries. Rather, the social, historical and governmental context of each country affects both youth behavior and the types of policies and programs directed toward them.

Identifying the key behaviors through which adolescents in some countries achieve very low levels of teenage pregnancy, birth and STD rates as compared with the adolescents in other countries is an important step in assessing potential points of effective intervention. Understanding social factors and interventions which are likely to be affecting the key teenage risk and protective behaviors moves even closer to insights into why the rates in the United States are so high and to more effective changes in the conditions underlying teenage behavior.

Table 8-2 (page 88) summarizes relative country rankings on key areas of potential influence explored in this study. Again, the rankings denote relative standing across countries on each measure on the basis of judgments formed through quantitative and qualitative work in this project. In this table, a higher score indicates that the country is relatively more likely to have conditions or approaches on that measure that contribute to lower teenage pregnancy, birth and STD rates. We have used five different ranks that span from very low (VL) to very high (VH) and have calculated an overall mean score and mean subset scores that serve as rough summary indicators of a country's standing relative to the other countries in this study. Here, higher overall and subset mean scores indicate conditions in the country leading toward lower adolescent pregnancy, birth and STD levels. Overall, Sweden and France have the highest mean scores; Canada and Great Britain are somewhat lower; and the United States has both the lowest overall score and the lowest mean subset scores.

Social and economic well-being and equality are linked to lower teenage pregnancy rates and birthrates.

• *Government commitment to social welfare and equality for all members of society provides greater support for individual well-being in other countries than in the United States.* The philosophy that individuals are responsible for their own welfare and that the government should stay out of people's lives as much as possible, especially in the areas of health and social policy, contributes to widespread inequity in the United States. For example, health insurance is generally purchased by individuals through employer-offered plans. Public insurance, Medicaid, is available for very low-income families, and one-fifth of women of reproductive age have no health insurance at all.[132] Government services, such as public health clinics, housing and income assistance, are available to poor or other disadvantaged people, but using public services carries a stigma in many communities. Many nongovernmental organizations help make up for the lack of public services, but their coverage and scope varies across the country.

In contrast, the other study countries, especially Sweden and France, have stronger social welfare systems and are committed to reducing economic disparity within their countries. Government provides basic services, such as health care, for everyone. Public services, such as public health insurance or clinics, are then considered a right of everyone in the society and no stigma is attached to their use.

Table 8-2. Country ranking on conditions contributing to lower teenage pregnancy, birth, abortion and STD rates, mid to late-1990s, five developed countries

Condition and Scores	Sweden	France	Canada	Great Britain	United States
CONDITION*					
Commitment to individual wellbeing					
Economic equality	VH	H	M	L	VL
Support for transition to adulthood and parenting					
Support for working mothers	VH	H	M	M	VL
Job training and employment assistance for youth	H	H	M	M	L
Nonjudgmental, positive approach to sexuality					
Openness regarding sexuality	VH	H	M	L	VL
Comprehensive sexuality education	VH	H	M	M	L
Abstinence/delay encouraged but not stressed	VH	VH	M	L	VL
Media used to promote responsible sexual behav	VH	H	M	M	L
Accessibility of reproductive health services					
Universal health coverage	H	H	H	H	L
Health services serve all economic groups	VH	H	H	H	L
Confidentiality assured for teens	H	M	H	M	M
Teenage-focused health services	H	M	M	L	M
Teenage access to contraceptive services	VH	H	H	H	M
Free or low-cost contraceptive supplies	H	H	H	VH	M
Teenage access to abortion services	H	H	M	H	L
Teenage access to STD services	VH	M	H	H	M
SUMMARY SCORES**					
Distribution					
Very high	9	1	0	1	0
High	6	13	6	5	0
Moderate/Mixed	0	3	9	5	6
Low	0	0	0	4	5
Very low	0	0	0	0	4
Mean scores					
Overall mean score	4.7	4.0	3.2	2.8	1.7
Subset mean scores					
Commitment to individual wellbeing	5.0	4.0	3.0	2.0	1.0
Support for transition to adulthood and parenting	4.5	4.0	3.0	3.0	1.5
Nonjudgmental, positive approach to sexuality	5.0	4.3	3.0	2.5	1.5
Accessibility of reproductive health services	4.4	3.6	3.8	3.8	2.6

* Conditions are coded according to their potential contribution to lower teenage pregnancy, birth, abortion and STD levels: VL=very low contribution, L=low contribution, M=moderate contribution, H=high contribution, VH=very high contribution.

**Subset mean scores are calculated by summing the scores of all items in a subset and dividing by the number of items in the subset, with VL=1, L=2, M=3, H=4 and VH=5. The overall mean risk score is the average of the four subset scores.

● *Compared with adolescents in the other countries, U.S. teenagers are more likely to grow up in disadvantaged circumstances and those who do are more likely to have a child during their teenage years.* Research in the United States has linked disadvantage, measured in a variety of ways, to many factors that contribute to higher pregnancy, birth and STD rates, including lower hopes and expectations for the future and lower motivation to delay childbearing, to difficulty obtaining reproductive and other health services and to less effective use of methods. And, in all of the study countries, young people growing up in disadvantaged economic, familial and social circumstances are more likely than their better-off peers to engage in risky sexual behavior and to become parents at an early age (see Figures 4-1 and 4-2, pages 42-43). Although the United States has the highest median per capita income of the five countries, it also has the largest proportion of its population who are poor. The higher proportion of teenagers from disadvantaged backgrounds contributes to the high teenage pregnancy rates and birthrates in the United States.

Although the differences in sexual behavior across

countries and socioeconomic groups are not large (see Figure 4-3, page 44), American teenagers in all socioeconomic groups are much less likely to use contraceptives than similar adolescents in other countries (Figure 4-4, page 46). And, though higher levels of unintended pregnancies, births and abortions are generally found among more disadvantaged adolescents in all countries, this is magnified by the fact that higher proportions of U.S. teenagers are socially and economically disadvantaged than in the other study countries, especially France and Sweden.

The higher proportion of disadvantaged teenagers in the United States is not the only reason the U.S. pregnancy and birthrates are so much higher than other countries, however. Comparing teenagers in roughly similar socioeconomic groups, levels of teenage childbearing among U.S. teenagers are higher than the levels for young women of similar socioeconomic status in the other study countries. For example, U.S. teenagers in the highest-income subgroup are 36% more likely to have a child by age 18 and 14% more likely by age 20 than are teenagers in the highest economic subgroup in Great Britain, and high-income U.S. teenagers are more likely to have children by ages 18 and 20 than are all teenagers in Sweden and France. Differences are greatest among disadvantaged youth: U.S. teenagers in the lowest-income subgroup are 79% more likely to have a child by age 18 and 58% more likely to have given birth by age 20 than similar teenagers in Great Britain. And although Hispanic and black teenagers in the United States, who are much more likely than whites to be from low socioeconomic circumstances, have very high pregnancy and birthrates, the birthrate among non-Hispanic white teenagers (36 per 1,000) is higher than overall rates in the other study countries.

Strong and widespread governmental support for young people's transition to adulthood, and for parents, may contribute to low teenage birthrates in the countries other than the United States.

Adolescence is viewed in all the study countries as a time of transition to adult roles, rights and responsibilities. However, countries other than the United States provide young people with more assistance and support in the transition to work, such as job training, unemployment insurance and more general support for youth development. Among the five study countries, these are most extensive in France and Sweden, but also more prevalent in Canada and Great Britain than in the United States.

• *Education and employment assistance help young people become established as adults.* There appears to be a greater societal awareness and consensus in study countries other than the United States that the country will benefit by investing in their young people and that adults are responsible to guide youth into adulthood. Such support, most evident in Sweden and France, is accompanied by clear expectations that young people are able to and will accept responsibility for themselves and become productive members of society.

Some of these differences are long-standing, such as in the areas of job training, unemployment insurance and social service protections for youth and young adults. Others are more recent, such as the new teenage pregnancy prevention initiative in Great Britain, which stems from concern that early childbearing makes individual and societal economic advancement more difficult. Most assistance and supports in countries other than the United States, and especially in Sweden and France, are available to all youth.

In contrast, efforts toward youth development in the United States tend to be available only to very poor youth and often are fairly small programs run by nongovernmental organizations. Government employment and assistance programs tend to be remedial and directed at small numbers of poor youth who are unable to find work on their own. Interventions focusing broadly on youth development are fairly recent. Those that address teenage pregnancy prevention at all, primarily do so in the broader context of personal development. Some programs also try to involve youth in developing and running programs, viewing youth as having competence and the ability to make positive contributions, rather than only presenting problems. (See Table 5-2, page 55, for program examples.)

Overall, the U.S. approach offers great freedom of choice and flexibility for many, but does little to help those who are less knowledgeable about opportunities for school and work or are less able to take advantage of them on their own.

Youth in the other countries tend to receive more societal assistance and support for this transition, in the form of vocational education and training, help in finding work, and unemployment benefits. Such assistance is available to all or most youth through both public programs and private employers. These

efforts not only smooth the transition from school to work but also convey to teenagers that they are of value to society, that their development and input are important, and that there are rewards for making the effort to fit into expected social roles.

• *Support for working parents and families signifies the high value of children and parenting and gives youth the incentive to delay childbearing*. In the United States, paid maternity leave is rare and child benefits are available only to poor women and families. In other study countries, working mothers (and sometimes fathers) are guaranteed paid parental leave. The parental leave and family support policies in these countries, particularly in Sweden and France, are quite generous and provide working women with the opportunity to choose to stay at home with their infants and young children, if they wish to do so. At the same time, these policies do not provide younger women or teenagers with any real incentive to have children, since family and child allowances for those who have not been employed are quite low. Because parental leave benefits are tied to prior salary levels (a situation also true for Canada and Great Britain), they may help reinforce societal norms that childbearing is best left until a young couple's careers have been established. The policies both offer young people incentive to delay childbearing until completing school and becoming employed and provide them with the assurance that they will be able to combine work and childrearing (see Table 5-1, page 52).

The lack of such incentives to delay childbearing may contribute to the higher level of desired pregnancy and the higher proportion of unintended pregnancies in the United States that go on to birth. These are most common among teenagers who are already in disadvantaged circumstances and who have little ground for believing that postponing childbearing will substantially improve their life condition.

Positive attitudes about sexuality and clear expectations for behavior in sexual relationships contribute to responsible teenage behavior.

• *Openness and supportive attitudes about sexuality in other countries have not led to greater sexual activity or risk-taking.* There is little variation in timing and levels of sexual activity among adolescents in the study countries, in spite of wide differences in public norms about sexuality in general and adolescent sexuality in particular. Attitudes and messages about sexuality are more positive and less ambivalent in the study countries other than the United States, especially Sweden and France. In the United States, society is highly conflicted about sexuality in general and about expectations for adolescent behavior in particular. There is heavy use of sexuality in advertising and entertainment, giving young people the impression that being sexually active is expected behavior and a way to be popular with others. Many adults accept that young people will be sexually active in their teenage years, and the overwhelming majority favors providing them with sexuality education that covers contraception and supports their access to contraceptive services.[133] At the same time, there is strong and vocal resistance by some to both sexuality education and the provision of contraceptive and other reproductive health services to adolescents.

There is a general consensus among adults in the United States that it is best for young people to delay having sexual intercourse. Except for those arguing for abstinence until marriage, however, there is no consensus on the age at which young people might responsibly and safely have sexual intercourse. Adults in other countries are less conflicted about teenage sexual activity, at least for older teenagers. Although a majority of adults in all five countries frown upon young people having sex before 16, such behavior is more likely to be accepted in Sweden and Canada (where 39% and 25%, respectively, think it is not wrong at all or only sometimes wrong) than it is in the United States and Great Britain (where 13% and 12%, respectively, hold these views).[134] Adults in these other countries are also much more accepting of sex before marriage than are Americans: 84–94% in Canada, Great Britain and Sweden view it as acceptable, compared with only 59% of Americans.[135] Although there are no comparable data for France, initiation of intercourse before marriage or cohabitation is the norm there.

• *There is a strong consensus in countries other than the United States that childbearing belongs in adulthood.* Young people in Europe are usually considered adults only when they have finished their education, become employed and live independently from their parents. And only when they have established themselves in a stable union is it considered appropriate to begin having children. This view is most clearly established in Sweden and France, but it is also more common in Canada and Great Britain

than in the United States. In France and Sweden, only 2% of annual births are to women under age 20, compared with 7–9% in Canada and Great Britain and 14% in the United States (see Table 6-1, page 58).

Few adolescents in any of the study countries meet these criteria for parenthood. For example, the proportion of adolescent women who are married or cohabiting ranges from 4% to roughly 10% in these countries. In fact, little teenage childbearing in the study countries is to married women, ranging from 13% in Great Britain to 25% in the United States. However, teenage births that do occur in Sweden and France are more likely to be in the context of a stable union: About half are to young women who are married (18% in Sweden and 17% in France) or cohabiting (33% in Sweden and 35% in France). In contrast, survey data indicate that only 38% of U.S. teenage births are to women who were either married or cohabiting and that 62% were not living with a partner. (Data are not available for Canada or Great Britain.) Because the overall teenage birthrate in the United States is so high, the birthrate among women who are not in union—37 per 1,000—is much higher than in Sweden and France—no more than 5 per 1,000.

• *Countries other than the United States give clearer and more consistent messages about appropriate sexual behavior.* Positive acceptance of sexuality in countries other than the United States is by no means value-free. In France and Sweden in particular, sexuality is seen as normal and positive, but there is widespread expectation that sexual intercourse will take place within committed relationships (though not necessarily formal marriages) and that those who are having sex will protect themselves and their partners from unintended pregnancy and STDs. In these countries, and also increasingly in Canada and Great Britain, sexual relationships among adolescents are accepted by others. For example, parents in Sweden and France are reported to accept their adolescent bringing home a boyfriend or girlfriend (with whom the teenager has a sexual relationship) to stay overnight or to spend the weekend. This acceptance carries with it the expectation of commitment, mutual monogamy, and respect and responsibility toward each other.

While adults in the other study countries focus chiefly on the quality of young people's relationships and the exercise of personal responsibility within those relationships, adults in the United States are often more concerned about whether young people are having sex. Close relationships are often viewed as worrisome because they may lead to intercourse, and contraception may not be discussed for fear that such a discussion might lead to sexual activity. These generalities across countries are borne out in the behavior of young people. As was noted earlier, teenagers in the United States who have had sex appear more likely than their peers in Canada, France or Sweden to have short-term and sporadic relationships, and they are more likely to have many sexual partners during their teenage years.

• *Comprehensive sexuality education, not abstinence promotion, is emphasized in countries with lower teenage pregnancy levels.* In Sweden, France, Great Britain and, usually, Canada, the focus of sexuality education is not abstinence promotion but the provision of comprehensive information about prevention of HIV and other STDs; pregnancy prevention; contraceptives and, often, where to get them; and respect and responsibility within relationships. Sexuality education is mandatory in state or public schools in England and Wales, France and Sweden and is taught in most Canadian schools, although the amount of time given to sexuality education, its content and the extent of teacher training vary among these countries and within them as well. In Sweden, the country with the lowest teenage birthrate, sexuality education has been mandated in schools for almost half a century, which reflects, as well as promotes, the topic's acceptance as a legitimate and important subject for young people. Here, visits to teenage health centers or to the school by health center staff are common, and instruction in Sweden often goes beyond specifics of sexual physiology and contraceptive use to focus more heavily on interpersonal relationships and respect for oneself and for others.

In contrast, although sexuality education is taught in almost all secondary public schools in the United States, teachers increasingly stress abstinence and provide limited accurate information about contraception. In 1999, 41% of sexuality education teachers reported that abstinence was their most important message, an increase from 25% in 1988; 40% reported either that they do not cover contraceptives or condoms or they teach that these methods are ineffective; and only about one-third reported telling students where they can go to obtain contraceptives.[136] There is frequent and heated controversy in many school districts about what young people

should be taught and about assumptions regarding effects of instruction on their behavior. These have resulted in, and are further spurred by, a large federal-state initiative to teach young people that no one should have sex outside marriage, to the exclusion of positive information about contraceptives and condoms for prevention. In fact, some 35% of the school districts that mandate sexuality education require that abstinence be presented as the only appropriate option outside of marriage for teenagers and that contraception either be presented as ineffective in preventing pregnancy and STDs/HIV or not be covered at all.[137]

• *Media is used less in the United States than elsewhere to promote positive sexual behavior.* Young people in all five countries are exposed through television programs, movies, music and advertisements to sexually explicit images and to casual sexual encounters with no consideration for preventing pregnancy or STDs. However, entertainment media and advertising messages about sexuality are seemingly less influential in the other countries than in the United States, because they are balanced by more pragmatic parental and societal attitudes and by nearly universal comprehensive sexuality education. Moreover, governments in Sweden and France have taken more proactive steps to use media to provide accurate information and promote positive and responsible sexual behavior. For example, governmental and private media campaigns in these countries generally have a positive and accepting tone about people having sex, are often quite frank and many times use a humorous touch. Some involve adolescents and young adults directly in production and distribution or as writers, editors and TV hosts. In Sweden, the government works closely with youth to publish a frank and informative magazine featuring subjects such as love, identity and sexuality that is widely read—and trusted—by young people. And, a government contraceptive campaign in France used television spots to air the message: "Contraception: The choice is yours."

In contrast, public service announcements and media campaigns in the United States often have a negative tone, focusing on risks of pregnancy or infection, using negative images of young people who have sex and usually restrict talking about contraception. Here, it is much more acceptable in the media to talk about condoms for prevention of disease than for prevention of pregnancy.

Contraceptive use is higher, and pregnancy and STDs less common, where teenagers have easy access to sexual and reproductive health services.

In the United States, some conservatives have argued that easy access to contraceptive services and legal abortion care provides youth with incentives to have sex, thereby increasing the numbers of teenagers at risk for pregnancy and STDs. The cross-national comparisons in this study strongly counter this view: Countries with accessible sexual and reproductive health services for teenagers have levels of sexual activity among adolescents similar to countries with less accessible services, but they have higher levels of contraceptive use and lower levels of teenage pregnancy, birth, abortion and STDs.

• *Only in the United States do substantial proportions of adolescents lack health insurance and therefore have poor access to health care.* Universal coverage for health care is the norm in the study countries other than the United States, as it is in almost all other Western developed countries. In some cases, the government actually provides the health services used by most of the population, such as the National Health System in Great Britain and public health clinics in Sweden. In other countries, almost everyone has insurance that gives them access to private physicians with no payment or with their fees reimbursed. Within such systems, there may be additional public health services set up to provide another alternative or to serve specific areas or populations.

Only in the United States is a large part of the population without health insurance, though many of the very poor are covered by public Medicaid insurance. Public health and other clinic services have been set up to serve low-income people, especially those without health insurance and those covered by Medicaid, which historically many private physicians will not accept. While care at many of the clinics is of high quality, the clinics are often considered to be second-rate and stigmatized. Most women who use these clinic services would prefer to see a private physician if they could afford access.

All countries have some providers that focus on serving groups with special needs. But in countries where almost everyone has access to health care and people of all incomes use the same providers, such specialized providers have less of a burden to fill gaps in the network of mainstream care. In contrast,

in the United States, the gaps are enormous. Rather than adding value to a generally adequate health care system, public providers often struggle to maintain and expand contraceptive services for teenagers because, with their limited funds, they must also respond to clients with other health care needs.

• *Contraceptive services and other reproductive health care are generally more integrated into regular medical care in countries other than the United States*. In Sweden, France, Great Britain and Canada, contraceptive services are usually integrated into other types of primary care. This not only contributes to ease of access, but also lends support to the notion that contraceptive use is normal and important. In the United States, in contrast, contraception is still not fully accepted as basic health care. It is often not covered by private health insurance policies and, at least for teenagers, not always provided confidentially and sensitively by private physicians, who provide most people's care. The fact that teenagers rely heavily on family planning clinics rather than the family doctor for contraceptive services simultaneously stigmatizes the clinics for providing care somewhat outside the mainstream and their teenage clients for seeking those services in the first place.

• *U.S. teenagers have greater difficulty obtaining contraceptive services and supplies than do adolescents in the other study countries.* Youth in the study countries obtain contraceptive services and supplies from a variety of providers, including physicians, nurse clinicians and clinics that either provide care to women and men of all ages or serve adolescents exclusively. No one type of contraceptive service provider appears necessarily the best for teenagers. Providing sexual and reproductive health services together with other types of primary care may improve continuity of services and method use; specialized sexual and reproductive health services have the benefit of employing staff that have more in-depth training and often a greater range of methods are offered. And, though some adolescents may be most comfortable in a teenagers-only setting, others feel less conspicuous and more comfortable in a setting where adults are also getting care. What appears crucial to success is that adolescents know where they can go to obtain information and services, can get there easily and are assured of receiving confidential, nonjudgmental care, and that these services and contraceptive supplies are free or cost very little.

In Sweden adolescents are clearly informed about available services (often through school) and have access to both maternal and child health centers and specialized youth clinics for a range of sexual, reproductive and primary care needs. Both sources strive to provide confidential, nonjudgmental care to adolescents. In other countries, sources for sexual and reproductive care for adolescents are not as widespread, or sometimes, even when care is available, teenagers may not know where to go or may not feel they will receive confidential or respectful care. This is particularly true for youth under age 18 in France and under age 16 in Great Britain, since there has been conflicting information in the press about the legality of care to minors and confidentiality is guaranteed only at clinics, not from private physicians. On the other hand, Great Britain is the most successful in providing contraceptive services and supplies at no cost to adolescents (and to adult women as well).

Specialized family planning clinics serve more teenage women in the United States than in other countries, usually together with older women. These offer the benefit of staff with special training regarding contraception and protection of adolescents' confidentiality. In addition, these clinics offer a range of contraceptive choices to women which may improve on contraceptive compliance by allowing women to choose the method best suited to their particular needs. However, youth in the United States are not uniformly informed about where they can go for these services, many communities lack family planning clinics, and youth may or may not be assured of receiving confidential care from private providers.

Finally, the availability of free or low-cost services and supplies varies among the countries. All services and prescriptions obtained under the British National Health Service are free. French youth can obtain services and supplies free from clinics, but those using physicians' offices must first pay a fee for the service and supplies and then obtain insurance reimbursement. Youth in Canada and Sweden have free access to sexual and reproductive health services no matter what provider they use. Oral contraceptives, the most common medical contraceptive among teenagers, cost $1–3 per cycle in Sweden and $3–11 per cycle in Canada. U.S. youth going to clinics obtain services and contraceptives free or at low cost, and nearly half of all adolescent women using the pill, for example, do obtain services from

clinics. Teenagers using private physicians may be charged a copayment of about $10 per visit if they have, and use, insurance coverage, or much more if they pay on their own. If contraceptive supplies are covered by their insurance they pay a copayment of about $5–20 per prescription; if not, the full charge is $25–30 per cycle.

• *In study countries other than the United States, there is easier access to abortion.* In all five study countries, efforts are made to reduce the need for abortion among both adolescents and adult women. However, in all countries but the United States, the key to reducing abortion is through better contraceptive provision and use; not, as is promoted by strong, vocal groups within the United States, through restrictions on or prohibition of abortion or through promotion of abstinence. In cases of unintended pregnancy, abortion is therefore supported as an acceptable way of resolving the pregnancy, with an emphasis on what individuals and society can do to reduce the likelihood of further unintended pregnancies occurring. Among these countries, there is relatively little controversy over the provision of abortion services, which are often provided through the government health services or covered by national health insurance. Services are available confidentially to teenagers, although providers often encourage young women to involve their parents. In contrast, almost all abortion services in the United States are provided by private organizations, separate from women's regular sources of medical care. Abortion is barred from coverage in federal and most state insurance programs, except in cases of rape, incest or danger to the woman's life. Many U.S. teenagers live in states that mandate parental consent or notice, or approval by a judge, before minors can obtain abortions.

Conclusions and Policy Implications

In this study, we have tried to "pull apart" different strands of the social context across the five study countries, looking to identify those factors that are key to the much lower teenage pregnancy and birthrates in Sweden and France, the relatively moderate rates in Canada and Great Britain and the very high rates in the United States. This has yielded some powerful insights, although at the same time it has further illuminated how intertwined different facets are within any one country. It had also revealed some striking differences between the United States and other countries that are not easily addressed and that warrant recognition both by policy analysts within the United States and by others in the international community who are quick to point to high U.S. teenage pregnancy rates as a symptom of serious social problems.

Among the many insights gained from this comparative study, four main conclusions stand out: (1) Assuring everyone in the country of basic levels of economic and social well-being is important. Growing up in conditions of social and economic disadvantage is a powerful predictor of early childbearing and providing universal access to health care, including sexual and reproductive health services, helps to mitigate some of the risk factors associated with disadvantage. (2) Educational and employment assistance, and support for parents and families, gives young people a stake in the society and a reason to delay becoming parents until they are established as adults. (3) Open, accepting attitudes about sexuality among adolescents, combined with clear expectations about committed relationships and prevention of teenage childbearing and STDs do not result in higher levels of teenage sexual activity, but do contribute to low levels of teenage pregnancy and childbearing, as well as STDs. The U.S focus on promoting abstinence has not led to less sexual activity, but the lack of consensus on providing contraceptive information and services has led to less contraceptive use; and (4) Ease of access to contraceptive and other reproductive services makes a difference. Crucial to success in serving adolescents is that they know where to obtain information and services, that they can get there easily, that they are assured of receiving confidential, nonjudgmental care, and that services and contraceptive supplies are free or cost very little.

These and other study findings provide insights as to the types of policies and programs that might be effective in lowering the high levels of teenage pregnancy, birth, abortion and STDs in the United States. Some are large-scale societal issues, such as the extreme disparity in socioeconomic status, which admittedly are difficult to address. There are also national, local and familial implications in findings about the importance of helping young people in their transitions to employment and other adult roles and the very positive impact of providing for paid parental leave for mothers—and fathers—with infants and young children. After many years of narrowly focused intervention efforts, there is increased interest in tying them together into more

comprehensive youth development initiatives. The findings suggest that actually improving adolescents' future prospects, giving them tangible reasons to view the teenage years as a time to prepare for adult roles rather than to become parents, is likely to have greater impact than exhortation and messages that it is wrong for them to start childbearing early.

The provision of contraceptive education and services within the general system of health care appears to be linked to higher levels of method use in countries other than the United States. But this is intertwined with, and possible largely due to, the fact that in these other countries there is near universal coverage for health care, independent of people's income. Thus, in other countries special efforts and funding can be focused on filling gaps and serving groups with special needs, rather than, as in the United States, providing a parallel medical care system for those who are poor and have no health insurance coverage. Even though the context in the United States is unique, the comparisons suggest lessons: In the longer term, universal access to health care coverage and services would likely contribute to better contraceptive use, improved detection and treatment for STDs, and lower rates of unintended pregnancy and infection. In the shorter term, other steps are suggested by the country comparisons. For example, better care for adolescents might be achieved by integrating contraceptive and STD discussions and services into private health care and by increasing the visibility of and respect for public family planning and STD clinics as sources of quality care for everyone, not only those who are poor.

However, there is no single path through which other countries have achieved lower teenage pregnancy and STDs levels. There are strong differences between the United States and other study countries in both social and economic contexts and in attitudes and programs focused specifically on sexual and reproductive health and behavior. In other countries, very low teenage childbearing rates have developed in the context of providing young women with attractive alternatives to early motherhood, through assistance in obtaining education and employment and supports that make it both easier to combine motherhood and work and more feasible to delay having children until one is established as an adult.

Finally, the images of youth, and expectations about their behavior, seem somewhat different across the countries. In all countries, young people were viewed as needing, and deserving, special attention and assistance in making successful and healthy transitions from childhood to adulthood. Yet, public opinion of teenagers in the United States often portrays them as antisocial, incapable and irresponsible people. For instance, even though the majority of unintended pregnancies and births, abortions and STDs occur among adults, they are often equated only with teenagers. And, many consider adolescents to be developmentally incapable of effective contraceptive and condom use and of making good judgments about their own health care. This view of adolescents helps support the focus on abstinence in the United States, which appears not only to be counterproductive in terms of achieving less sexual activity among youth here but also diverts attention from prevention of pregnancy and STDs.

In contrast, the impressions gained from other countries, Sweden and France especially, are of clear social expectations that young people can and will be able to make decisions about their sexual behavior, use contraceptives effectively, prevent STDs and obtain health services that they need in a timely fashion. Where young people do receive social support, full information and positive messages about sexuality and good access to sexual and reproductive health services, they indeed achieve healthier outcomes from sexual relationships.

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Appendix A

Sources and Data Points for Figures

Figure 1-1. Teenage birthrates declined less steeply in the United States than in other developed countries between 1970 and 2000

	Births per 1,000 women 15-19				
Year	Sweden	France	Canada	England and Wales	United States
1970	33.9	37.4	42.8	49.7	68.3
1975	28.8	33.1	35.3	36.5	55.6
1980	15.8	25.4	27.2	29.6	53.0
1985	11.0	16.9	23.2	29.5	51.0
1990	14.1	13.3	25.6	33.2	59.9
1995	8.6	10.0	24.2	28.4	56.8
2000	6.8	9.4	20.2	30.8	48.7

Sources: Jones EF at al., *Teenage Pregnancy in Industrialized Countries*, New Haven, CT: Yale University Press, 1986; Singh S and Darroch JE, Adolescent pregnancy and childbearing: Levels and trends in developed countries, *Family Planning Perspectives*, 2000, 32(1):14-23; and official statistics agencies in each country for most recent data (1997 in Canada, 1998 in France, 1999 in England and Wales and Sweden, 2000 in the United States).

Figure 1-2: Teenage Pregnancy is more common in the United States than in most other industrialized countries

	Rates per 1,000 women aged 15–19		
Country	Births	Abortions	Pregnancies*
Russian Federation	45.6	56.1	101.7
United States	54.4	29.2	83.6
Bulgaria	49.6	33.7	83.3
Romania	42.0	32.0	74.0
Belarus	39.0	34.3	73.3
Georgia	53.0	13.4	66.4
Estonia	33.4	32.8	66.2
Rep. of Moldova	53.2	11.6	64.8
Hungary	29.5	29.6	59.1
Latvia	25.5	29.0	54.5
New Zealand	34.0	20.0	54.0
England and Wales	28.4	18.6	47.0
Canada	24.2	21.2	45.4
Australia	19.8	23.8	43.6
Slovak Republic	32.3	11.1	43.4
Iceland	22.1	21.2	43.3
Scotland	27.1	14.5	41.6
Czech Republic	20.1	12.3	32.4
Norway	13.5	18.7	32.2
Northern Ireland	23.7	4.8	28.5
Israel	18.0	9.8	27.8
Sweden	7.7	17.2	24.9
Denmark	8.3	14.4	22.7
Finland	9.8	10.7	20.5
France	10.0	10.2	20.2
Slovenia	9.3	10.6	19.9
Ireland	15.0	4.2	19.2
Germany	12.5	3.6	16.1
Belgium	9.1	5.0	14.1
Spain	7.8	4.5	12.3
Netherlands	8.2	4.0	12.2
Italy	6.9	5.1	12.0
Japan	3.9	6.3	10.2

*Note: pregnancies exclude miscarriages

Source: Singh S and Darroch JE, Adolescent pregnancy and childbearing: Levels and trends in developed countries, *Family Planning Perspectives*, 2000, 32(1):14-23.

Figure 3-1. Percentage of 20–24-year-old women who had a birth by age 15, 18 and 20

	% had a birth by age:		
Country	15	18	20
Sweden, 1996	0.0	2.9	1.4
France, 1994	0.2	1.6	4.6
Canada	0.4	2.7	7.4
Great Britain, 1990/91	0.0	4.2	10.5
United States, 1995	0.9	8.2	12.8

Sources: figure reproduced from Darroch, et al., Differences in teenage pregnancy rates among five developed countries: The roles of sexual activity and contraceptive use, *Family Planning* Perspectives, 2001, 33(6):244-250 & 281; original data found in *Teenage Sexual and Reproductive Behavior in Developed Countries: Country Reports for Sweden, France, Canada, Great Britain and the United States*, Occasional Reports, Nos. 4–8, The Alan Guttmacher Institute, 2001 (see text reference 18).

Figure 4-1. Percentage of 20–24-year-old women who gave birth before age 20, by educational attainment

	% had a birth by age 20		
	Educational attainment level		
Country	Low	Middle	High
Sweden	19.3	3.7	0.8
France	17.3	3.6	0.0
Canada	45.6	7.3	3.6
Great Britain	36.3	12.5	1.9
United States	66.2	27.8	6.9

Sources: figure reproduced from Singh, et.al., Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries, *Family Planning Perspectives*, 2001, 33(6): 251-258 & 289.

Figure 4-2. Percentage of 20–24-year-old women who gave birth before age 20, by economic status and by race and ethnicity

	% had a birth by age 20		
	Economic status		
Country	Low	Medium	High
Great Britain	25.2	14.6	6.5
United States	39.7	19.5	7.4
	Race/ethnicity		
	Nonwhite	Hispanic	White
Great Britain	13.0	na	14.7
United States	36.9	32.9	16.8

Sources: figure reproduced from Singh, et.al., Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries, *Family Planning Perspectives*, 2001, 33(6): 251-258 & 289.

Figure 4-3. Percentage of 20–24-year-old women who were sexually active before age 20, by economic status, mid-1990s

	% sexually active by age 20		
	Economic status		
Country	Low	Middle	High
France	80.8	82.6	95.5
Canada	81.6	77.6	69.3
Great Britain	91.7	81.8	84.8
United States	83.5	78.5	80.4

Sources: figure reproduced from Singh, et.al., Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries, *Family Planning Perspectives*, 2001, 33(6): 251-258 & 289.

Figure 4-4. Percentage of 15–19-year-old sexually active women who did not use a contraceptive method at last intercourse, by various measures of disadvantage

	% using no contraceptive	
	Country	
Measures of disadvantage	Great Britain	United States
Economic status		
Low	4.8	19.9
Medium	4.0	22.9
High	0.1	17.1
School/employment status		
School only	1.5	20.6
Work (w/ or w/o School)	1.1	18.0
Neither	11.8	31.0
Race/ethnicity		
Nonwhite	3.9	22.8
Hispanic	na	27.7
White	3.9	17.8

Sources: figure reproduced from Singh, et.al., Socioeconomic disadvantage and adolescent women's sexual and reproductive behavior: The case of five developed countries, *Family Planning Perspectives*, 2001, 33(6): 251-258 & 289.

Appendix B

Country Report Outline

Sexuality, Contraceptive Use and Disadvantage: A Developed Country Investigation of the Sexual and Reproductive Health of Youth

Country Report Outline

REVISED – April 30, 1999

Part I. What are the current levels and recent trends in adolescent sexual and reproductive behavior in this country and how do these levels and trends vary among population subgroups?

Context: Documented differences exist between the United States and other industrialized western nations in rates of teenage pregnancy and childbearing – with the U.S. having much higher rates. Less is known about differences in teenage sexual activity and behavior among these countries and in variation in the incidence or prevalence of sexually transmitted diseases (STDs).

Goal: To understand which factors are most significant in contributing to differences in adolescent sexual and reproductive behavior, The Alan Guttmacher Institute (AGI) seeks detailed information on current levels and recent trends among young women and men and their consequences.

Consultant's role: To provide information and tabulations as outlined below. AGI will provide each country consultant with tabulations of some of these measures. Consultants will fill in the remaining measures, if available.

Possible Sources of information: Vital statistics, census data, survey data, health statistics.

Length of section: Maximum of 10 double-spaced pages of text + tables.

A. Describe, at the national level, current levels and recent trends in adolescent sexual behavior, birth rates, abortion rates and contraceptive method use.

Provide the following (See attached table specifications for details regarding age groups and years for which data are requested):

1. **Birth and abortion rates (per 1,000 women) (from vital statistics):**
   a) Birth and abortion rates (per 1,000 women) by age for selected years
   b) Birth rates (per 1,000 women) and abortion rates (when possible) by age and marital status for 1995

2. **STDs and HIV/AIDS (survey data):** AGI is collecting data on STD incidence among youth (15-19, 20-24) and will provide you with our tabulations for inclusion here. However, if you have any national survey data with questions about STDs (e.g. use of services, prevalence of disease, etc.), please let us know what these questions are and we will discuss with you whether and how best to use the data.

3. **Sexual activity and contraceptive use (survey data analyses):**
   a) Age at first intercourse by respondent's age at the survey and gender
   b) Age at first birth by respondent's age at the survey – females only
   c) Number of sexual partners in the past year by respondent's age and gender
   d) Frequency of intercourse in the past month by respondent's age and gender
   e) Contraceptive method used at first intercourse by respondent's age and gender
   f) Contraceptive method used at last intercourse by respondent's age and gender

g) Use of both condoms and selected medical methods at first and last intercourse by respondent's age and gender

B. Describe variation in adolescent sexual and reproductive behavior according to as many of the following socio-economic subgroups of the population as are possible for your country:
(The priority is to provide breakdowns for (a) income/poverty and (b) rural/urban; breakdowns for the other variables listed in (c) through (f) are also desired if data permits.)

a) Family income/poverty level/social class (choose one variable that breaks youth into a few groups according to their family's economic resources)
b) Type of place of residence - urban/rural status
c) Region/province of the country (group regions or provinces as appropriate and meaningful for the country)
d) race/ethnicity (when possible)
e) immigrant status (when possible)
f) School enrollment status and/or type of school enrolled in (when possible)

Tabulate each of the following four variables for those subgroups listed above that are possible for your country: (The attached table specifications are labeled Table B1 through B4, according to the dependent variables below. Included is a table shell that can be copied and used for each of the socio-economic variable breakdowns possible from available survey data. Adjust the tables according to the number of categories necessary for each variable and include variable names and category labels in the spaces provided.)

1. Age at first intercourse by respondent's age at the survey and gender
2. Age at first birth by respondent's age at the survey – females only
3. Contraceptive method used at first intercourse by respondent's age and gender
4. Contraceptive method used at last intercourse by respondent's age and gender

C. Describe the size and distribution of youth according to demographic or socio-economic groups. Include the following for the most recent year available: (If possible and appropriate, use the same survey data used for B., above. If not possible or available, use census or other national survey data.)

1. Youth according to marital/cohabitation status, age and gender
2. Youth according to family income/poverty level and age
3. Youth according to social class/parent's occupation and age
4. Youth according to urban versus rural and age
5. Youth according to region/province of the country and age
6. Youth according to race/ethnicity and age
7. Youth according to immigrant status and age
8. Youth according to school enrollment/employment status, age and gender

Part II. How "open" is this society in dealing with sexuality and sexual behavior, in general, and among adolescents, in particular?

Context: In AGI's 1986 study of adolescent pregnancy and childbearing among industrialized countries, an important determinant of variation was the degree to which sexuality and sexual behavior were openly addressed in public discussion, media and advertising and both formal and informal educational messages.

Goal: To assess the extent to which variation among societies in public attitudes and views of sexuality and sexual behavior continues to influence differences in adolescent behavior.

Consultant's role: To provide information about current public attitudes and norms related to "openness" about sexuality, detail about both formal and informal sexuality education and socialization processes and specific descriptions of interventions directed at these issues.

Possible Sources of information: Opinion polls, surveys that include attitudinal questions, existing literature/research in this area, general knowledge/observation of media and advertising methods, interviews with national or local persons responsible for educational policies and programs, published or unpublished evaluations or descriptions of programs, etc.

Length of section: Maximum of 12 double-spaced pages text + possible figures or appendices related to programs or interventions described.

A. What are society's attitudes and norms about sexuality and sexual behavior, both in general and towards adolescents? (Approximately 4-5 pages)

1. Introduction
   a. Comment on the general level of "openness" toward sexuality within this country. Provide examples that illustrate society's acceptance, tolerance or discomfort with sexuality and sexual behavior, generally and particularly with regard to teens.
   b. Comment on those aspects, if any, of current adolescent sexual or reproductive behavior that are considered to be problematic. (e.g., early/nonmarital sexual activity, early/nonmarital pregnancy, early/nonmarital childbearing, public financial support for young mothers and their children, the spread of HIV and STDs, higher birthrates among minority populations, older partners, incest, sexual abuse, violence, rape, etc.) How widespread is the belief that these behaviors are problematic? Is this an issue of contention among segments of society?
   c. Are there any national (governmental or nongovernmental) efforts to change current adolescent sexual and reproductive behavior?
   d. Has the level of "openness" toward sexuality or concern for adolescent sexual and reproductive behavior changed significantly over the past two decades?

2. Indicators of society's attitudes and norms that may be available from survey data: If possible, describe survey data results for the following types of questions:
   a. Attitudes toward sexuality:
      - premarital sex
      - sex before age 16
      - extramarital sex
      - homosexual sex
      - Note: Some information on each of the above items for all countries except France is available in an article by Widmer et al (a copy of article attached to mailed version). These authors use a classification according to the percent who think each behavior is always wrong, almost always wrong, only sometimes wrong, not wrong at all. Comment on their results for your country and provide additional data if available.
   b. Communication about sex
      - % of teens (if possible, or of all people) who report talking with their partner about sex or contraception and the frequency of such communication,
      - % of teens who report talking to their parent about sex or contraception (and frequency of communication), and
      - % of parents who report talking to their children about sex or contraception.
   c. Sexual pleasure
      - Are questions on sexual pleasure included on surveys? What questions?

3. Indicators of society's concern about adolescent sexual and reproductive behavior that may be inferred from legal regulations:
   a. Sex and marriage:
      - What is the legal age of sexual consent?
      - Are there statutory rape laws?
      - What is the legal age of marriage without parental consent?
      - Are people generally aware of these laws; do they influence teenage behavior or adult response to teen behavior; and how strictly are they enforced?
   b. Services to adolescents:
      - Is there a legal age for obtaining abortion, contraceptive, STD or prenatal care services without parental consent/notification? What is the legal age for each?
      - Are the legal ages adhered to in practice by clinicians and how easy is it for younger teens to get an exception to parental notification or consent requirements?

4. Indicators of society's attitudes and norms related to sexual and reproductive behavior that can be illustrated by looking at the treatment of sexuality and contraception in the media:
   a. Are there formal or informal broadcast standards that prohibit advertising of:
      - condoms
      - oral contraceptives

      On or in:
      - television (at certain times of the day)?
      - general interest magazines?
      - teen directed magazines?
      - daily newspapers?
   b. Are these standards unique to contraception or are there other products that are similarly prohibited?
   c. In practice, are condoms and the pill advertised, and in which kinds of media?

d. Are there any studies that have looked at or tried to quantify the way sex is depicted in television broadcast programming – for example, what % of episodes dealing with sex show irresponsible sexual behavior versus responsible sexual behavior?
e. Is full frontal nudity (of males or females):
   - often,
   - occasionally or
   - never

   Shown on or in:
   - prime-time television
   - general interest magazines
   - teen directed magazines
   - daily newspapers?

f. Is the issue of coverage of sexuality by the media discussed publicly by national and/or local leaders or policymakers? Do people think that there is too much sex in the media, or that the values being portrayed are negative and damaging? Have there been efforts to control what children or adolescents see on television or on the internet regarding sex?

B. How are young people socialized about sexuality, sexual behavior and sexual responsibility? (Approximately 4-5 pages)

1. What do young people themselves say about the information they receive about sex? If available, summarize findings from existing studies reporting on surveys that have asked youth:
   - Where they get information about sex;
   - Whether they think they get enough information from these sources; and
   - What additional information they would like to have received.

2. Sex Education in Schools
   a. Have national guidelines been implemented that mandate whether or not sexuality education should be included in public schools? If so, do they provide recommended or required curriculum?
   b. Describe the focus, scope and intensity of sexuality and reproductive health information and education that is formally provided in schools. Include, if possible, information on:
      - The quantity or intensity of instruction; e.g. how many hours per week instruction is offered?
      - The timing of instruction; e.g. at what ages/levels/grades?
      - Is instruction elective or mandatory?
      - Is instruction provided in all schools or only in certain types of schools?
   c. Does the type, scope or focus of sex education in the schools vary across provinces/states/communities? Are there any studies looking at this variation?
   d. Is the topic of "abstinence" included in school-based sexuality education for teens? If so, is it presented as the "best" choice for teens, as a possible option, or excluded from consideration? If excluded, is it because abstinence is not even considered a realistic possibility for teens?
   e. Is the topic of contraceptive use (including instructions on how to use and where to obtain supplies) included in school-based sexuality education for teens?

f. Has there been controversy (at the national level/among certain communities) about what is/should be taught in the schools regarding sex and reproductive behavior?
g. Has the provision of sexuality education in schools changed in recent years?

3. Describe and comment on some of the other sources of information about sex and sexual behavior that adolescents rely on, such as parents, peers, the media, or the internet.
   - Have there been any studies or can you comment on the relative importance of different types of sources, including their importance relative to school-based sexuality education?
   - Are some types of sources considered to be more or less accurate than others?
   - Have there been any efforts to improve or enhance the quality of any of these other sources of information, such as programs to help parents communicate more and more effectively with teens about sex or programs to train peers or peer leaders to talk to other teens about sex? What is the scale of such efforts?

C. Describe 2 – 4 interventions (programs, policies, initiatives, laws) that have been implemented in recent years that directly or indirectly impact or illustrate societal views about sexual behavior and the socialization of adolescents about sex.
(Approximately 1 page per intervention, with supporting documents/appendices if necessary)

(Note: The focus of the interventions reported here should differ from the focus of the interventions described in Parts III and IV. However, it might be possible that one component of a large effort might be included here, while another component might be discussed in the later section.)

For this section, possible interventions could include, for example, media campaigns, innovative educational methods (peer education programs, mentor programs), laws or regulations to change teenage sexual behaviors, community outreach activities, government task forces or initiatives, AIDS/condom use campaigns, or policies related to the provision of sexuality education.

Use the following criteria to choose interventions for inclusion:
- Generalized, large efforts (national or state/provincial efforts preferred)
- Innovative efforts
- Effective efforts, those with demonstrated impact, if possible
- Or efforts that have not been successful, but illustrate types of programs that were originally thought to have promise.

For each intervention, describe:
- The goal (to decrease teen pregnancy or STDs, to change sexual behavior, etc.),
- The history of the effort (recent or long-term, change of focus, etc.),
- Initiator of the effort and funding sources (government versus private),
- Target population (all adolescents, disadvantaged adolescents),
- Focus on girls or boys or both,
- Scope of adolescent population in country affected,
- Method and mode of action of the effort, and the
- Effectiveness/impact of the effort (if known).

Part III. How accessible is reproductive health care to adolescents and what is the level of social support for adolescents to use contraception and other reproductive health services?

Context: In order for sexually active adolescents to avoid unintended pregnancy and STDs and avoid becoming an adolescent parent, they must be able to access information and services related to preventing pregnancy and disease and terminating unwanted pregnancies, and have the support and encouragement needed to consistently and correctly use contraceptive and/or disease prevention methods.

Goal: To assess the strengths and weaknesses of current contraceptive and reproductive health care service provision to adolescents and to document the level of public support for adolescent use of these services.

Consultant's role: To provide information about how contraceptive and reproductive services are provided to youth and the level of public support for these services and to assess the adequacy of existing services.

Possible Sources of information: Existing literature/research in the area, reports/data from government sources; interviews with Ministries of Health or their representatives (if publicly supported health care is main source) or with Family Planning Association leaders, if present, and heads of sex education organizations, other health care providers, or medical professional association leaders; evaluations or reviews of programs.

Length of section: Maximum of 12 pages double-spaced text + possible tables, figures or appendices.

A. How accessible are reproductive health care services to adolescents and where do adolescents go to obtain contraceptive and other reproductive health care services?

(Approximately 4-5 pages)

1. Introduction: In general, are reproductive health care services (broadly defined to include contraceptive information and services, STD and HIV testing and treatment, prenatal and maternity services and abortions) thought to be easily accessible to adolescents? Overall, is there broad societal or government agreement that such services should be made accessible to adolescents? Are there any important barriers to youth's access to some or all of these services? If so, what kinds of barriers? Do these barriers mainly affect particular groups of individuals? (which groups?, how large are these groups?)

2. Describe the system of health care provision that is available to and used by adolescents for both general primary care, as well as for reproductive health services. Include discussion of:
   a. The structure and financing of health care services (in general, and specifically for youth if different than the system for others)

b. The types of sources where health care services are provided to adolescents:
   - What is the mix of office-based physician care versus clinic care available to and used by adolescents? What kinds of clinics do adolescents use?
   - Which of these sources of care are most important for adolescents?
   - How available are these sources of care to youth?
   - Is the mix of sources used by adolescents similar or different from the mix of sources used by adults?

c. The availability of special youth focused clinics that provide reproductive care:
   - Are there clinics that specialize in providing reproductive health services for adolescents?
   - Are these clinics integrated with the general system of health care or are they independently operated?
   - If they are independent, do the youth clinics have links to other providers?
   - What percent of youth obtain care from special youth clinics compared with those that get care from providers used by people of all ages?
   - Is it the general perception that youth are better served by such special youth focused clinics or is it felt that general providers are just as good?

4. Provide additional detail about the use of contraceptive methods and availability of contraceptive supplies to youth:
   - What methods of contraception are available and used by adolescents?
   - What are the sources/locations where most youth obtain contraceptive supplies (oral contraceptives or condoms)?
   - Are adolescents, themselves, required to pay for the purchase of contraceptive supplies (oral contraceptives or condoms)? (If so, how much, on average for a 1-month cycle of pills or a box of 10 condoms?)
   - What is the typical and maximum cost that an adolescent might have to pay, themselves, for an initial contraceptive visit? Does that include supplies, e.g. a 3-month supply of pills?
   - What is the availability of services and/or programs to provide young men with contraceptive information and supplies?

B. Discuss the ways that this society delivers messages that encourage responsible contraceptive and disease preventive behavior on the part of sexually active adolescents.
(Approximately 4-5 pages)

1. Are the following approaches used and how extensively and intensively are they used?
   - Outreach through advertising or publicity of available contraceptive and reproductive health care services,
   - Public education campaigns, such as condom use campaigns,
   - Services in schools/linked with schools or referrals from school-based sources or teachers,
   - Outreach/education encouraging male use and involvement in use,
   - Discussion of contraceptive use by media personalities, on popular TV programs, etc.

2. What is the nature of those public messages that are directed toward adolescents concerning sexuality, contraception and disease preventive strategies:
   - Are messages usually nonjudgmental?
   - Are adolescents often faced with competing, inconsistent messages? E.g. popular media presents sex as prevalent and positive while other sources may promote messages that describe sex (for teens or nonmarital) as aberrant, unhealthy and socially unacceptable.
   - Are messages clear about the importance of consistent contraceptive method use?
   - Or, if teens are expected to delay becoming sexually active, do messages fail to give clear or accurate information on contraceptive use or STD prevention?
   - Are messages focused on young women, young men or both?

C. Describe 2-4 specific interventions (programs, policies, laws) that have impacted the availability and accessibility of reproductive health care services to adolescents and/or have encouraged responsible contraceptive and disease preventive practices among youth?
(Approximately 1 page per intervention, with supporting documents/appendices if necessary)

For this section, possible interventions could include those that focus on improving or maintaining the level of contraceptive responsibility practiced by sexually active youth, programs/policies that impact the accessibility of services to youth; laws/court decisions guaranteeing youth access to certain reproductive health care services (e.g. contraception, abortion – with or without parental involvement.

For these descriptions, use the same criteria and include the same descriptions as in Part IIC:

Use the following criteria to choose interventions for inclusion:
- Generalized, large efforts (national or state/provincial efforts preferred)
- Innovative efforts
- Effective efforts, those with demonstrated impact, if possible
- Or efforts that have not been successful, but illustrate types of programs that were originally thought to have promise.

For each intervention, describe:
- The goal (to decrease teen pregnancy or STDs, to change sexual behavior, etc.),
- The history of the effort (recent or long-term, change of focus, etc.),
- Initiator of the effort and funding sources (government versus private),
- Target population (all adolescents, disadvantaged adolescents),
- Focus on girls or boys or both,
- Scope of adolescent population in country affected,
- Method and mode of action of the effort, and the
- Effectiveness/impact of the effort (if known).

Part IV. How does economic and social disadvantage impact levels and trends in adolescent sexual and reproductive behavior and their consequences? What are the existing policies and programs to reduce the negative consequences of disadvantage?

Context: In the United States, one factor influencing high adolescent pregnancy and childbearing rates is the presence of large economically and socially disadvantaged subgroups (particularly, but not solely from racial or ethnic minority groups). These subgroups often have much higher adolescent pregnancy and childbearing rates than those found among more economically advantaged groups.

Goal: To identify disadvantaged subgroups in other countries and explore differences in their behavior and in the benefits and services available to and used by such groups.

Consultants role: To provide information on the mechanisms for providing social assistance to disadvantaged populations in each country and to describe any special interventions directed toward youth from disadvantaged populations.

Possible Sources of information: Census and survey data, existing literature/research in this area, interviews with government officials in charge of social welfare programs and with researchers who study this area, minority organizations and youth-based advocacy groups.

Length of section: Maximum of 12 double-spaced pages of text + possible figures or appendices.

A. Describe the prevalence and distribution of economically, socially or culturally disadvantaged subgroups resident in this country.
(Approximately 3-4 pages)

- Who are these groups and how large are they (relative to the general population)?
- Is there a broad societal/governmental consensus that all or some of these groups need government assistance or public support, e.g. for housing, childcare, living expenses, food, or health care services?
- Is there conflict or disagreement about the level, scope or type of public assistance that disadvantaged groups should receive?
- Is the current level of public support provided to disadvantaged groups considered adequate?
- Have their been any major changes in the provision of public support in recent years?

B. Describe the country's system of social welfare or public support designed to assist poor or disadvantaged populations, including any laws, regulations or practices related to the provision or withholding of social benefits to young women with children.
(Approximately 3-4 pages)
Include discussion of:

- Who qualifies for public support;
- What benefits are provided; and

- What regulations and/or limitations are placed on the provision of public support, including time limits and regulations based on family size or composition?
- Are there any regulations regarding provision of support or services specifically for disadvantaged youth? If so, what are they?

C. What interventions or programs have been implemented to assist youth from economically or socially disadvantaged populations? Have some of these interventions focused on sexual or reproductive behavior, either to influence behavior or to meet existing service needs? (Approximately 4-6 pages)

1. Describe existing policies and programs that are specifically directed towards assisting disadvantaged youth in making the transition from youth to adulthood. If programs are generally directed toward all youth, including those who are disadvantaged, describe, then comment on the degree to which disadvantaged subgroups of young people actually benefit from the existing policies and programs, and on existing gaps and needs. Include information on:

   - What educational, vocational or military options are available for young people who do not advance to university studies? Are these options clearly communicated to youth?
   - Are there programs that are designed to teach youth job-search and decision-making skills?
   - Are there programs that are designed to expand youth education, employment or training opportunities?
   - How widespread and comprehensive have these efforts been?
   - How successful have these efforts been? (if known)
   - Who funds such programs? Are they all funded by national, provincial or local government or are they also funded through other sources?
   - Have there been changes in recent years in the level of support for programs that affect youth? Either improvements or reductions in the level of support?

2. Describe 2 – 4 specific programs focused on impacting the sexual or reproductive behavior of disadvantaged youth (if such programs exist).

   For these descriptions, use the same criteria and include the same descriptions as in Part IIC and Part IIIC.

Part V. Describe any other factors that are considered important to understanding current levels or recent changes in adolescent sexual and reproductive behavior in your country.

Length of section: Maximum of 3-6 double-spaced pages of text, if necessary.