#93-13

TEENAGE CHILDBEARING: A PRAGMATIC PERSPECTIVE

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Washington, DC

July 1993

The public information support provided by the William and Flora Hewlett Foundation is gratefully acknowledged.

Teenage Childbearing: A Pragmatic Perspective

In agricultural times, teenage childbearing was common in the United States. As recently as after World War II, teen birth rates were very high, peaking in the late 1950s, when 9% of females 15-19 gave birth each year. Teen birth rates declined across the next two decades; however, between the mid-1970s and mid-1980s, no further declines occurred. Every year, about 5% of females aged 15-19 gave birth.

Then, astoundingly, in the late 1980s, teen birth rates in the United States began to rise again. In 1990, the latest year for which we have data, 6% of females 15-19 gave birth. (Chart One) Moreover, the increase in the birth rate has not been confined to just one sub-group of teens; the rate has risen among black, white and Hispanic teens. (Chart Two)

During the past several decades teen birth rates have generally been lower in Europe than in the United States and they have been falling even lower. In 1989, the teen birth rate was twice as high in the U.S. as in the United Kingdom and six times higher than the teen birth rate in France, Denmark, and (western) Germany. (Chart Three)

Obviously the trend in the U.S. teen birth rate is an anomaly. Not only is the rate high, but unlike comparable countries, the rate of births to U.S. teens is rising. Is this a problem?

Is Teenage Childbearing a Problem?

A debate has raged over the precise causal role of early childbearing in outcomes such as school dropout and poverty. To many service providers, this debate seems academic and irrelevant. And indeed, in one sense this debate is

irrelevant to service providers, who face young, unmarried, impoverished mothers in need of assistance. Whether the needs of these young women are due to their backgrounds or to the fact they had a birth as an adolescent, these young mothers still present pressing and broad service needs. The data clearly show that teen mothers are very much an at-risk group which consumes substantial public dollars. Analyses conducted at Child Trends indicate that more than half of all AFDC recipients were teens when their first child was born. Only about half of school age mothers complete high school or a GED by age 27 and three in four school-age mothers experience poverty at some time during their child's first five years.

Moreover, the rapid arrival of new generations taxes the capacity of families, neighborhoods, and government at all levels. If a new generation begins every 16 years, rather than, say, every 24 years, societal population growth is much more rapid and the ratio of dependents to adults is much higher.

A very simplified example in which both a 16-year-old and a 24-year-old mother each have just two births and future generations replicate their mother's childbearing pattern is shown in Chart 4. (All births are twins, to keep birth spacing differences from complicating the example.) After just 48 years in this example, the original 16-year-old mother would have eight **great** grandchildren, while the original 24-year-old mother would just have four grandchildren. Since studies show teen mothers actually have larger families and more closely spaced births than women who delay childbearing, this chart may not only over-simplify but even under-estimate the difference. Moreover, because teen mothers are more often single parents, the ratio of dependents to adults tends to be higher than in families formed older women. Of concern is

the strain on time and other resources that is posed by this rapid entry of new generations at both the family and community level.

Although the debate over whether adolescent childbearing actually causes negative consequences may seem unimportant to service providers, the issue is nevertheless important to formulating appropriate preventive interventions. It is well established that adolescent mothers and their babies are economically and socially disadvantaged and incur public costs. If taxpayers and policy makers would like to encourage teens to postpone childbearing, the appropriate intervention is different if the disadvantages experienced by adolescent parents are due (a) to the disadvantaged backgrounds of those women who become teenage mothers or (b) due to the birth itself. For example, if the birth is the sole cause of the negative consequences associated with early childbearing, then preventing teen sex, pregnancy, and childbirth and providing ameliorative services to help teen parents represent the appropriate intervention approach. If, on the other hand, the negative consequences associated with early childbearing are due not to the birth but to the circumstances of those women who have births as teens, then the appropriate interventions involve broad societal changes such as reducing economic inequality, racism, and poverty among families and enhancing educational and occupational opportunities for all youth.

The accumulated research suggests that <u>both</u> factors matter: the disadvantages associated with early childbearing are due to the disadvantaged backgrounds of the women who become adolescent mothers and also to the additional disadvantages posed by early childbearing in a modern, technological, and competitive society. Thus, both types of interventions are important.

In other words, teenage childbearing doesn't happen randomly. It is far more common among adolescents from low income, single parent families in disadvantaged communities, among adolescents having difficulty in school, and among minority youth. These youth are more likely to be sexually active, more likely to experience pregnancy, and more likely to carry to term than are more advantaged adolescents.

However, the occurrence of a birth often compounds the difficulties faced by adolescents. Despite the considerable family and community support provided to young mothers and their children, and heartwarming examples of young parents who turn their lives around and become successes for the sake of their children, by and large early childbearing attenuates the economic and social well-being of young women and their children.

There are, of course, some individuals who are so disadvantaged that the timing of the first birth makes little difference to their futures. They lack job skills, job opportunities, and marriage opportunities, and will require community support whether they become mothers at age 15 or age 30. In fact, Arline Geronimus has argued persuasively that for extremely disadvantaged women teenage childbearing is actually healthier than delayed childbearing, because of the rapid decline in physical health among very poor women, particularly poor minority women. However, such women comprise a small component of all U.S. women. In general, it appears that adolescent childbearing does diminish the social and economic well-being of women and their families, over and above the effect of the woman's own background.

What Interventions Are Appropriate?

As the National Research Council concluded in 1986, there are no simple solutions, no "silver bullets". Multiple interventions are necessary. We need to develop effective ways to encourage teens to delay having sex and to use contraception if they do have sex. We also have to provide options for those teens who experience pregnancy, as well as assistance for those who carry to term and decide to raise the child.

Sex. During the 1980s, despite vocal concern over AIDS, pregnancy, abortion, and family values, teens initiated sex at ever younger ages. Data from the 1988 National Survey of Family Growth indicate that by their eighteenth birthday, 56 percent of white females, 67 percent of black females, 70 percent of white males, and 85 percent of black males have had sexual intercourse.

There are strong practical arguments for delaying the initiation of sex. Accumulating partners over a period of years greatly increases the risk of acquiring a sexually transmitted disease, which can undermine health and future fertility and, in the case of AIDS, cause death. In addition, the Alan Guttmacher Institute calculates that more than a million pregnancies occur every year to American adolescents, including more than 400,000 that end in abortion and more than 100,000 miscarriages. The risk of pregnancy is considerably greater among younger adolescents than older couples because they are less adequate contraceptors.

European nations tend to be quite direct about the inappropriateness of adolescent childbearing and the appropriateness of delaying sexual debut until the adolescent can take responsibility for his or her sexual behavior. No

clear policy has emerged in the United States, perhaps because harsh rhetoric has obscured the common ground on the issue. Not just moral, but practical, logical, scientific and even feminist arguments can be made for abstinence until teens are ready to protect themselves against STDs and pregnancy. The argument for delaying sex can be made in the home, in religious groups, and in youth organizations such as Boy and Girl Scouts. However, many adolescents, especially those adolescents most likely to start having sex early in adolescence, are unlikely to belong to organizations or families that provide support for delaying sex. Because the school is the one location where adolescents are collected together, school-based programs also need to be considered.

Although education is a state and local function, the Federal government can play a role in developing model curricula, supporting rigorous long-term evaluations of the impact of sex education models, and funding research. Studies to date suggest that sex education programs have quite weak effects. Junior high students need to delay sex for years, not months; to achieve such delays will require stronger and earlier interventions.

While public opinion polls suggest widespread support for sex and AIDS education in schools, it is undoubtedly necessary to consider local conditions in developing and implementing sex education programs. But high school and even junior high are too late to begin sexuality education, and classses need to focus on boys as well as girls. These programs cannot just push abstinence, however. Just providing information about health and reproduction and contraception is not sufficient, either. Training in the skills to communicate and negotiate with peers and a partner are also essential. Initial data suggest that providing information about contraception does not

undermine the abstinence message. In fact, it appears that teaching both topics together may be the most effective strategy.

Beyond sex education, efforts to improve schools, housing, safety and economic opportunities for poor children and minority groups are also necessary to counter the perception, unfortunately often grounded in reality, among disadvantaged youth that the early initiation of sex won't affect their future.

Contraception. The weight of the evidence indicates that encouraging teens to delay sex until they are older and able to manage both the technical aspects of getting and using contraception and the interpersonal tasks involved with using contraception is both practical and sensible public policy. However, we cannot assume that most teens or even many teens will postpone sex until they marry. In a national survey of youth aged 18-22 in 1988 87 percent of teens said they thought sex was wrong at ages 14-15; but only 52 percent said they felt sex was wrong at ages 16-17. And only 23 percent felt that women who are unmarried should never have babies. Sex education programs need to realistically address the needs of contemporary youth; this implies encouraging teens to delay having sex but also preparing them to prevent pregnancy and avoid STDs when they do have sex.

Well into their twenties, Americans tend to be less effective contraceptors than couples in other Western democracies nations, according to demographer Charles Westoff. He notes that young Americans are both less likely to use a method at all and less likely to use an effective method.

Several reasons account for poor contraceptive use among American teens. Some reflect societal attitudes and some reflect the availability, cost and convenience of contraceptive methods.

One major factor leading to late and ineffective contraceptive use is the ambivalence which teens experience regarding being sexually active and becoming pregnant. Many teens feel ambivalent about being a virgin; but they also feel ambivalent about having sex. Reluctant to acknowledge to themselves or anyone else that they are going to engage in sex, especially at first, teens don't want to appear "prepared." Sex is supposed to "just happen" and teens are supposed to be "carried away by the moment." Bringing a condom or diaphragm on a date doesn't fit this unprepared image. Teens also don't want to lose the spontaneity of sex, which many say using contraception would do.

Yet adolescents don't want an image of promiscuity either. Being on the birth control pill suggests not only that you planned for sex, but that you may have other partners. Teens regularly comment that suggesting the use of a condom to protect themselves from AIDS is difficult, because the suggestion indicates they think their partner might have an STD and this would suggest promiscuity or even homosexuality, so they take the risk rather than insist on condoms. Adults often shake their heads at the irrationality of such behavior, forgetting how often adults also take risks in order to maintain an image. Negotiating the use of contraception is a very difficult and potentially embarrassing task, and many teens would prefer to ignore the issue. This is one of the topics that sex education needs to address: how to bring up the issue of contraception with a date and negotiate use of birth control while still looking "cool" and maintaining a positive relationship.

Consistent and correct contraceptive use is more often found among older teens; those in more established relationships; and among teens who have been having sex for a while who have become comfortable with the idea of sex and have learned how to communicate with a partner. Obviously, at some time in

high school or junior high school, sex education programs need to provide in-depth information about methods of contraception, how to use them, and where to obtain them.

Some have feared that mentioning contraception in sex education programs condones and thus encourages teens to have sex. Others have argued that you cannot both encourage abstinence and contraceptive use, that teens cannot absorb this "double message." However, the available evidence suggests that sex education either has no effect on sexual initiation or that it delays sexual debut, even if contraception is discussed. In fact, some recent studies have shown that programs combining messages about delaying sex with messages encouraging contraception when sex is eventually initiated have the desired effects, particularly among young teens, of both delaying first sex and reducing the frequency of unprotected sex.

Another compelling explanation for the higher rates of childbearing among low income and minority teens is the "opportunity costs" hypothesis. This perspective suggests that adolescents from poor families and communities feel they have "nothing to lose" by having children during their teen years. Contraception is a "hassle to obtain and a hassle to use;" it's embarrassing and expensive and it's not worth the trouble. The unfortunate fact is that, to some extent, these teens are correct. Getting and using contraceptive methods is a hassle. The educational and occupational opportunities of adolescents from low income families and communities are poor. Having a child during their teen years is not going to curtail the lives of youth in poor neighborhoods, families and schools to the extent that it would affect middle class adolescents.

When motivation for getting and using contraception is so low, one approach is to make services highly accessible, for example, in the school itself. However, as Douglas Kirby and his colleagues have noted, school-based clinics have had only minimal success in lowering the birth rate among students. This lack of impact may reflect the fact that most school clinics do not advertise very visibly nor do they actually dispense contraceptive supplies in the schools. Reflecting their low motivation, teens don't regularly make the trip to a clinic outside of the school to get the supplies they need.

Consistent use of contraception is also a problem. The lives of poor youth are undermined by multiple problems such as violence, unemployment, and family disorganization, and many see little hope of escape for themselves. The consistent practice of contraception is often not the highest priority for such youth. One particularly strong education and training intervention, which also provided sex education including information about birth control, the Summer Training and Employment Program or STEP, did not find long-term effects on the fertility of the at-risk teens who participated. It is suggested that the duration and intensity of this program may not have been sufficient to produce lasting impacts, given the multitude of risks faced by the teens served by STEP.

Access to contraceptive services is another important part of the picture. Given the ambivalence and low motivation for contraception among U.S. teens, the presence of even modest barriers to obtaining contraception is likely to lead teens to forego contraception.

Federal funding for family planning services declined by about a third over the decade of the 1980s, according to the Alan Guttmacher Institute.

Medicaid, and state and local funds made up some of the difference; however, it appears that patient fees also rose during the 1980s and less was spent per patient. Since the needs of patients became more complex during the 1980s, with the spread of sexually transmitted diseases including AIDS, the strain on clinic services and staff has been intense.

In a survey of state family planning administrators conducted by Child Trends and funded by the Kaiser Foundation, every state administrator noted that the demand for services exceeds their capacity to provide services. The effect of this decline in funding and service capacity on adolescent behavior has not been examined; but anyone who has tried to get an adolescent to consistently wear a helmet or complete a demanding homework assignment can imagine the effect that lesser convenience, poorer accessibility, longer waiting periods, and less personal attention will have on the number of adolescents who actually receive medical assistance. In fact, the only method for which a significant increase in use was documented among U.S. teens during the 1980s is a method that is available from drug stores -- condoms. Increased use of condoms is presumed to reflect concern about STDs including AIDS. Whether this increase also reflects adolescent frustration with obtaining medical methods is not known.

Greater use of condoms is, of course, a positive trend in the sense that condom use greatly reduces the risk of STD infection while also being a very effective contraceptive if used correctly and regularly. Even if other methods such as the pill or Norplant are used, condom use is necessary to prevent STDs. This is a major challenge - getting teens to protect themselves against <u>both</u> pregnancy and AIDs.

Regular and consistent use of a reliable method of contraception with all partners at every sex act is a goal for U.S. teens that is far from being achieved. Sex education that encourages contraceptive use on this level is not likely to be offered in all U.S. communities during the coming decade. Providing resources to the family planning clinic system to facilitate better counselling represents one avenue. The Association of Reproductive Health Professionals is working with medical professionals to improve their capacity to educate and counsel patients to avoid unintended pregnancy. Increased numbers of religious and other youth-serving groups including job training programs may also choose to provide detailed information about contraceptive use.

As policy makers debate health reform, ways to provide full and adequate coverage for contraception need to be a part of the debate. However, the value of maintaining a free-standing clinic system needs to be considered as well. The convenience, anonymity, and low cost associated with going to a family planning clinic for counselling, for an STD test, for birth control supplies, or for a pregnancy test are very important to teens.

New methods such as Norplant provide long-term protection and do not require users to make a decision to use the method each time they have sex. Nevertheless, they are unlikely to be a "silver bullet" resolving the burden of contraception among teens because they don't get around the problems of teenage ambivalence about sex, adolescent procrastination, lack of access to health care, and cost. However, with adequate funding and greater availability, Norplant could make a particular contribution to preventing second pregnancies. And gradually when teens become more logical and planful about sex, it is reasonable to expect more and more never-pregnant teens to

seek the long-term, low hassle protection provided by a method such as Norplant. But Norplant doesn't prevent STDs. The need for condom use cannot be escaped. Only persons free of STDs in monogamous relationships can ignore condom use. Achieving early and consistent contraceptive use among teens represents a major challenge for this country.

Pregnancy

The debate about pregnancy outcomes has changed radically in the past several months. The debate about abortion in the next several years seems unlikely to focus on legality but on access.

Much of the abortion debate could have been avoided and can be defused in the future by preventing the need for abortion. The majority of the 1.6 million abortions occurring annually in the United States could be prevented by better use of contraception and/or more judicious sex. Charles Westoff estimates that if all U.S. teenagers at risk used the pill, the rate of unintended pregnancy among teens would decline by 70 percent. Such a reduction would obviously reduce the number of abortions performed by several hundred thousand.

Preventing unwanted pregnancy is a topic on which there is considerable common ground. Only a minority of the public think abortion is a desirable policy or personal option; and only a minority are unalterably opposed on all grounds under all circumstances. Most Americans hold deep reservations about abortion yet accept or uphold the legality of abortion. Reducing the need for abortion is an achievable policy goal, and one on which there is considerable consensus. As discussed above, encouraging a delay in sexual debut and

continuous use of effective contraceptives once sex is initiated would prevent hundreds of thousands of unwanted pregnancies.

Even with delayed sexual intercourse, improved contraception, and access to abortion, some teens will continue to become pregnant and have babies. The value of prenatal care, nutrition, and continued schooling are not in debate. Programs to serve pregnant teens are under-funded but their value is not controversial. Rather, debate focuses on how stringent to be in the demands made of adolescent parents to be responsible and self-supporting. For example, interventions are being implemented or discussed that enforce school attendance among teen parents on AFDC, require residence with the grandparents, and seek enforcement of child support obligations.

Results from the Teen Parent Demonstration conducted by Mathematica Policy Research and the LEAP evaluation conducted by the Manpower Development Research Corporation both indicate that these very demanding approaches can succeed in getting young parents who receive AFDC back into high school. Whether these approaches can bring young parents out of poverty is another question. The issues being considered in current welfare reform discussions are highly relevant to the population of teens who become parents, whether or not they receive AFDC. Tabulations conducted at Child Trends show that in their late twenties, a third to a quarter of school age parents still receive welfare, and in addition a majority are poor or near-poor. Providing health care and child care, facilitating adoption, enhancing earnings, increasing the reliability and amount of child support payments, making marriage more feasible, and improving employment prospects through education and training should assist both teen parents and the children they are raising.

Programs and policies do make a difference. Legal and social changes have made it more feasible for school-age mothers to return to high school or complete a GED, and recent studies indicate that early childbearers are about as likely to complete high school as comparable women who do not become adolescent mothers. However, today a high school diploma is not a sure ticket out of poverty for an unmarried mother. College or technical training after school, combined with access to a second income through marriage or child support, are necessary to move parents not just above the poverty line but truly out of poverty.

It is ironic that such a private behavior as adolescent sexual activity is so deeply enmeshed in most of the major public debates that have challenged public policy makers at the Federal and the local level. Abortion. Sex education. Contraception. Racial equality. Welfare. Child support. School reform. Immigration. Opportunities for women. Child care. Single parent families. Children in poverty.

A problem that is so deeply a part of so many other problems requires attention. But it should also be clear that no single, quick fix approach is going to reduce the incidence of adolescent pregnancy and childbearing. Rather a pragmatic, multiple-step approach is needed that helps teens delay sex, use contraception effectively if they have sex, have real choices if they become pregnant, and become self-sufficient if they become parents.

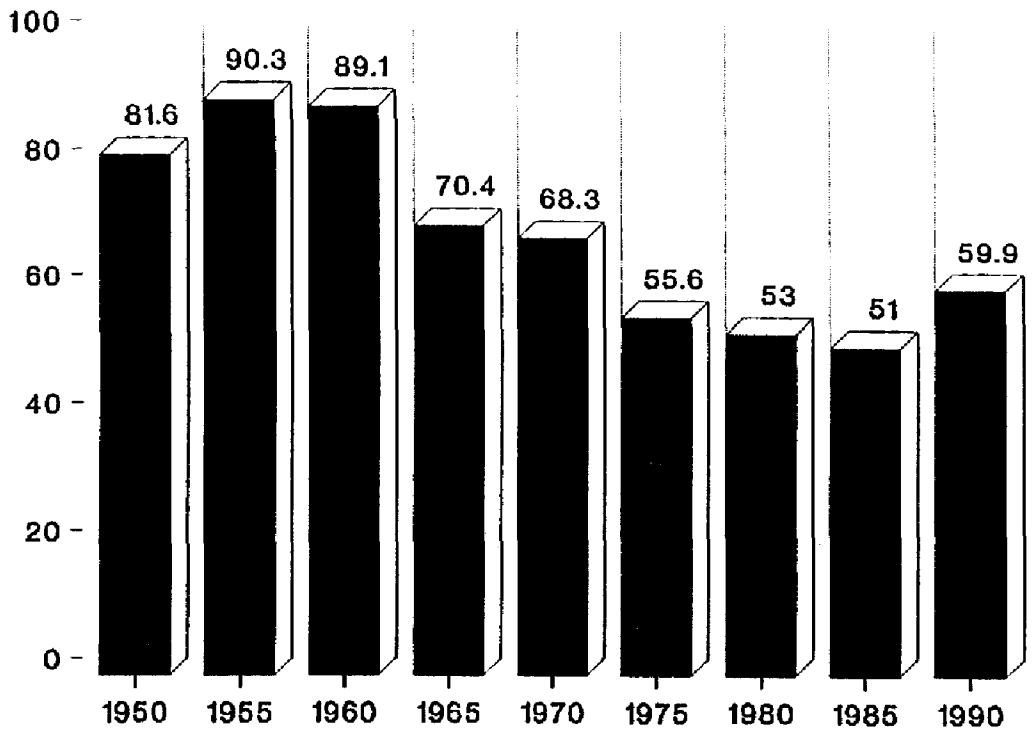

Chart 1. Birth Per 1,000 US Females Aged 15–19:
The teen birth rate rose again in the late 1980s.
Source: National Center for Health Statistics

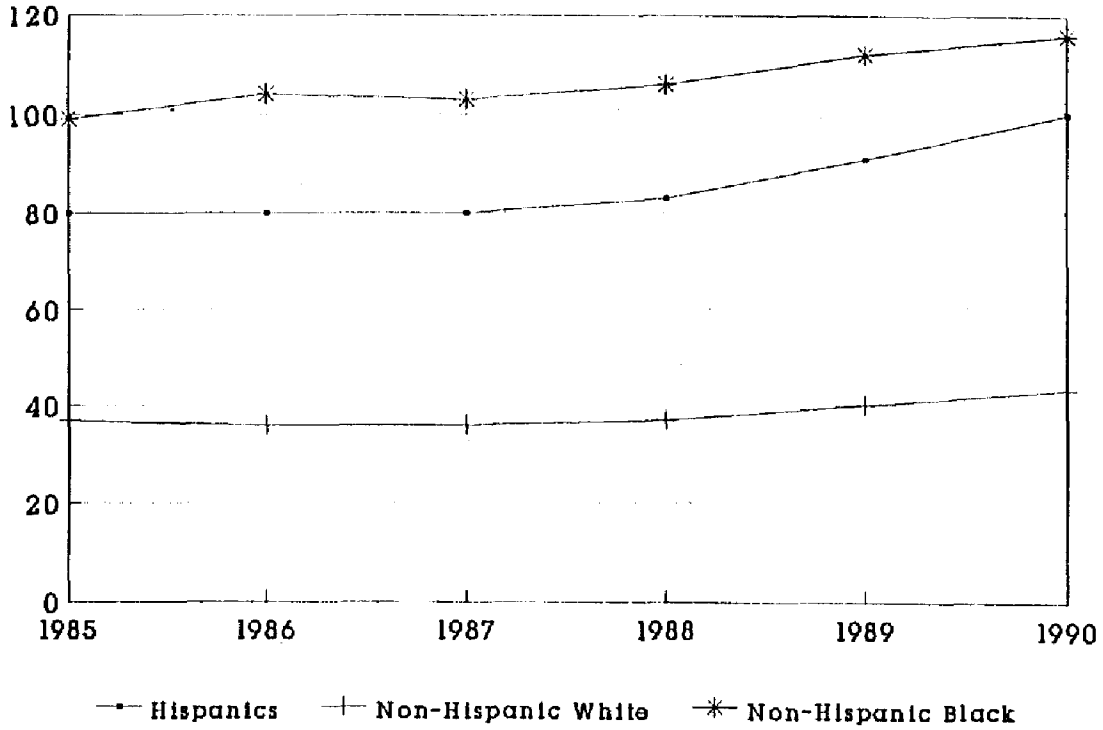

Chart 2. US Births Per 1,000 Teens 15–19 by Race and Ethnicity: The teen birth rate rose in the late 1980s among black, white and Hispanic teens.
Source: National Center for Health Statistics

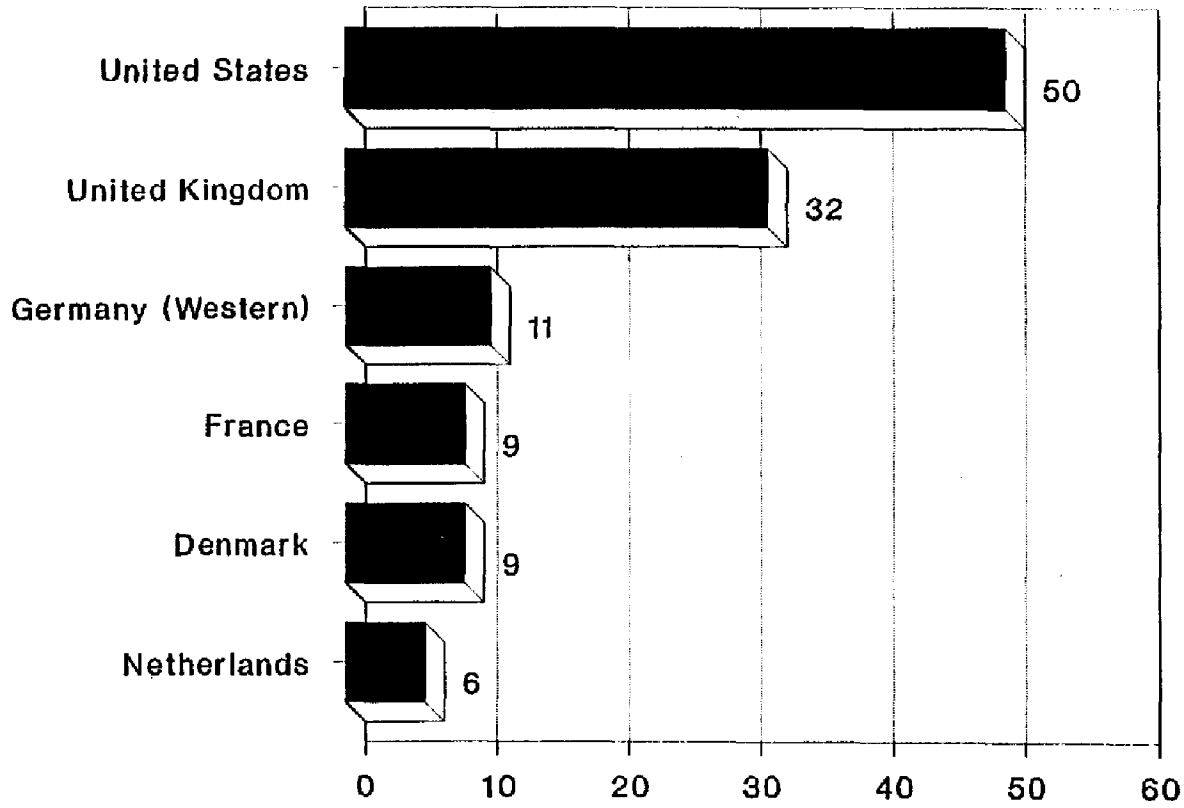

Chart 3. Births Per 1,000 Females Aged 15–19 in 1989: Birth rates are two to ten times higher in the US than in comparable European nations.
Source: Henry Davis TransNational Family Institute

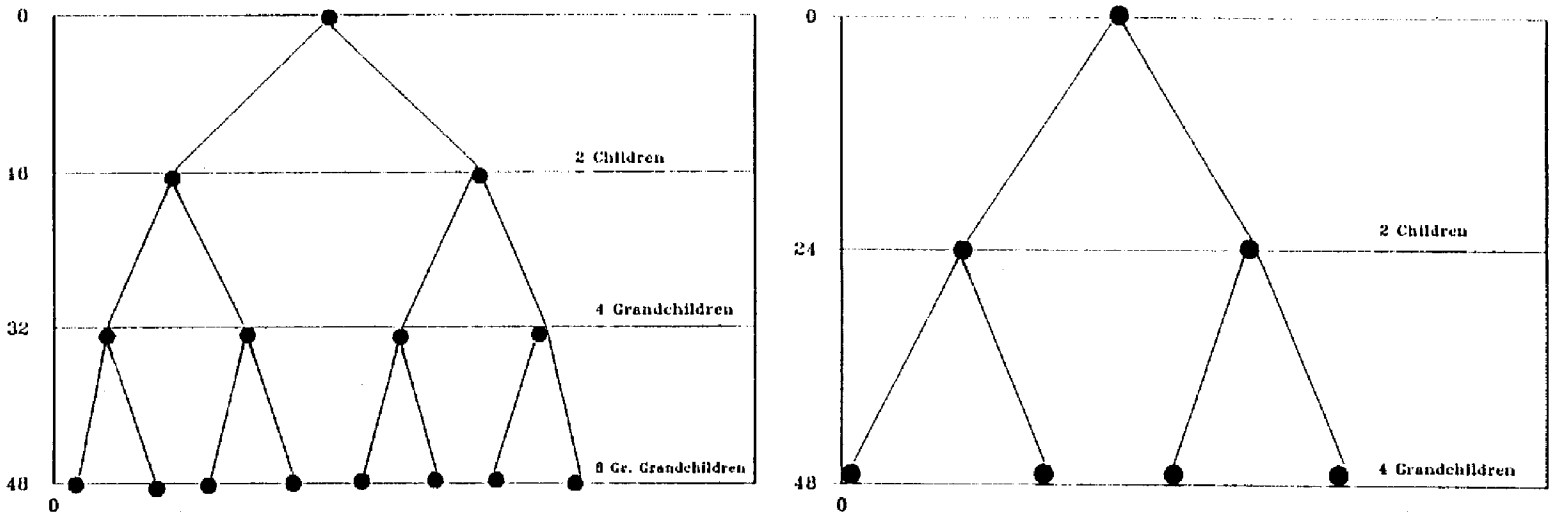

Chart 4. Hypothetical Example of Early Childbearing:
After just 48 years, a 16-year-old mother could have
8 great-grandchildren, while a 24-year old mother would have
just 4 grandchildren, if each generation followed the
pattern of the mother.