

Can More Progress Be Made?

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 Britain¹ 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.

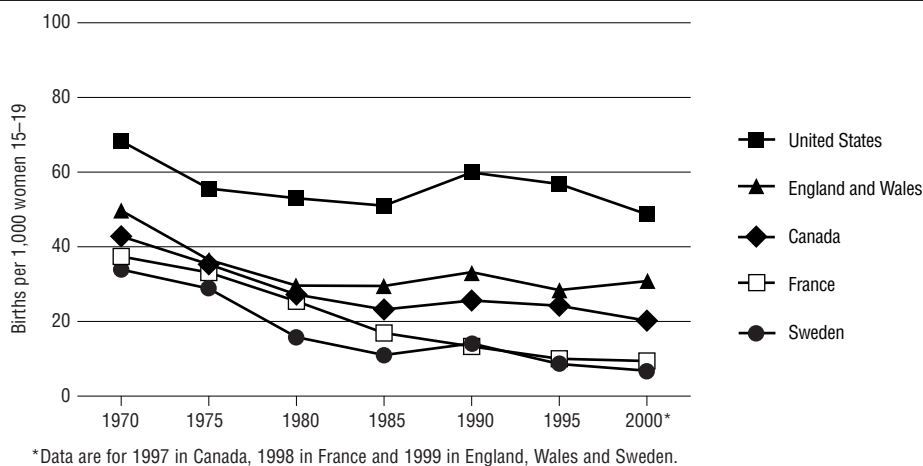
Beneath the generalizations necessary when making cross-national comparisons, there are often large differences across areas and groups within a country, and varying national contexts and histories. While all of the study countries have democratic governments and are highly developed, they differ in 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.



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.

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).

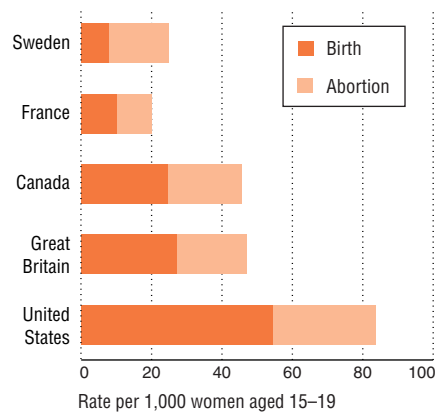
Data on the effectiveness with which women and men use contraceptive methods are available only for the United States. However, estimates using these effectiveness rates and country method-use patterns suggest that less-successful use of contraceptive methods also contributes to higher pregnancy rates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

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.

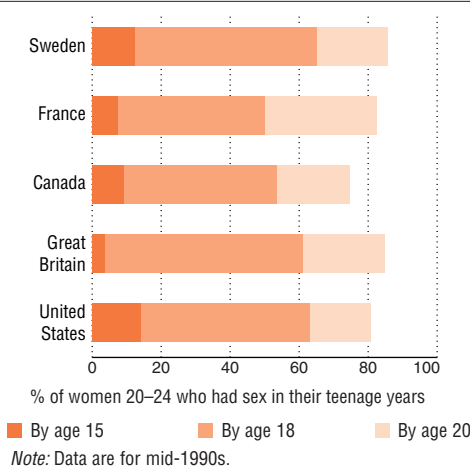
• *Government commitment to social welfare and equality for all members of society provides greater support for individual well-being in other countries than in the United States.* The philosophy that individuals are responsible for their own welfare and that the government should stay out of people's 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 non-governmental 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

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

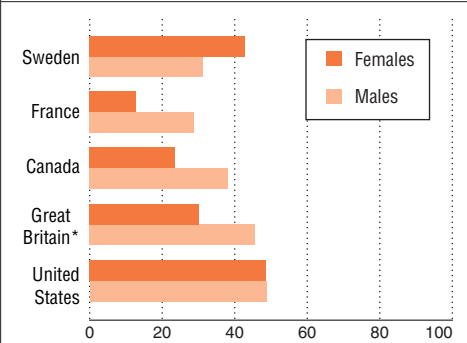


% of women 20–24 who had sex in their teenage years

■ By age 15 ■ By age 18 ■ By age 20

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.



% of 18–19-year-olds who had two or more partners

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

pregnancy rates and birthrates in the United States.

At all socioeconomic levels, however, U.S. youth have lower levels of contraceptive use and higher levels of child-bearing 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.

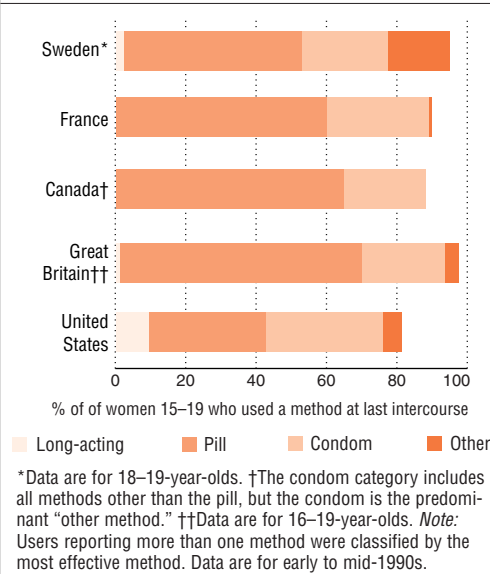
• *Support for working parents and families signifies the high value of children and parenting, and gives youth the incentive to delay childbearing.* In the United States, paid maternity leave is rare and child benefits are available only to some poor women and families. In the other study countries, 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 coun-

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.



tries 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.

• *There is a strong consensus in countries other than the United States that childbearing belongs in adulthood.* Young people in Europe are usually con-

sidered 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 child-bearing 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.

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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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