Office of Adolescent Health Webcast

A Global Look at Adolescent Pregnancy Prevention: Strategies for Success

National Teen Pregnancy Prevention Month

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US Trends
• 750,000 pregnancies among women 15-19 years
• 7% of the population
• Pregnancy rate=68 per 1000
• Birth rate: 40.2 per 1000 (35% lower than 1991)
• Abortion rate: 17.8 per 1000 (59% lower that in 1988)

- Kost and Henshaw, 2012
Pregnancy, birth, and abortion rates for teens aged 15-17: United States

Pregnancy, birth, and abortion rates for teens aged 18-19: United States
Pregnancy rates for teens aged 15-17, by race and Hispanic origin: United States, 1990-2008

Figure 1. Never-married females and males aged 15–19 who have ever had sexual intercourse: United States, 1988–2010

NOTE: See Table 1.
Figure 2. Use of contraception at first sex among females aged 15–19, by method used: United States, 2006–2010.
International Comparisons
Sexual debut during adolescence is the norm for females.
International comparison of teen birth rates, 2009

Teen birth rate (births per 1,000 women ages 15-19)

Sources: CDC’s National Center for Health Statistics, UNECE Statistical Database, and United Nations Demographic Yearbook, 2009-2010
Teen birth rates in low and middle income countries compared with Switzerland at 4 per 1000 and U.S. at 40 per 1000
- Teens in the U.S. are more likely to give birth than teens in any other industrialized country
- The teen birth rate in the U.S. is comparable to a number of countries in the developing world
A social determinants model for understanding adolescent pregnancy risk
Macro

National Wealth
National Norms and Priorities
Political Events

Income Inequality
Economic Forces

Racism/Discrimination

Historical Events

War/Conflict
- Neighborhood institutional resources
- Collective socialization
- Neighborhood deprivation
- Contagion or epidemic effects
<table>
<thead>
<tr>
<th></th>
<th>Pregnant</th>
<th>Non-Pregnant</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother’s education (primary school only)</strong></td>
<td>63.8</td>
<td>39.8</td>
<td>p &lt; .01</td>
</tr>
<tr>
<td><strong>Father’s education (primary school only)</strong></td>
<td>67.5</td>
<td>38.2</td>
<td>p = .002</td>
</tr>
<tr>
<td><strong>Low family cohesion</strong></td>
<td>12.8</td>
<td>2.3</td>
<td>p &lt; .01</td>
</tr>
<tr>
<td><strong>Youth participates in family decision-making</strong></td>
<td>36.9</td>
<td>56.8</td>
<td>p = .004</td>
</tr>
</tbody>
</table>

(Guijarro, Blum et al 1999)
<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>p</td>
<td>N</td>
</tr>
<tr>
<td>Smoking</td>
<td>79</td>
<td>9.8</td>
<td>.001</td>
<td>127</td>
</tr>
<tr>
<td>Drug use</td>
<td>64</td>
<td>7.9</td>
<td>.001</td>
<td>44</td>
</tr>
<tr>
<td>Age at 1st sex &lt;15 yr</td>
<td>300</td>
<td>38.4</td>
<td>.01</td>
<td>110</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>13</td>
<td>1.9</td>
<td>.05</td>
<td>27</td>
</tr>
<tr>
<td>Suicidal</td>
<td>164</td>
<td>20.3</td>
<td>.001</td>
<td>270</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>54</td>
<td>6.6</td>
<td>.01</td>
<td>75</td>
</tr>
</tbody>
</table>

(Anteghini, Blum et al 2001)
School/Peers
Teachers supports and expectations
Safe Schools
Academic Performance
Pro-social peer network

Macro
National Wealth
Income Inequality
Racism/Discrimination
War/Conflict

Community
Racism/Discrimination
Minority Status
Education Opportunities
Employment Opportunities
Poverty
Social Disruption
Violence/Incarceration
Residential Instability
Urban/Rural
Built/ Environment
Social Cohesion

Family
Behaviors
Conflict/Violence
Monitoring
Communications
Financial & Social Capital
Birth Spacing
Family Mobility
Expectations
- Increased contraceptive use
- Later age of first pregnancy
- Later age of marriage
- Greater access to health information
- Less substance use
- Less depression/suicidality
Safety: physical, emotional and academic
High academic expectations coupled with support
Connectedness to adults in the school
Opportunities for social engagement
among **Caribbean youth**

<table>
<thead>
<tr>
<th>Risk Behavior</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low*</td>
<td>High*</td>
</tr>
<tr>
<td>Sexual debut</td>
<td>79.0</td>
<td>49.2</td>
</tr>
<tr>
<td>Violence</td>
<td>68.1</td>
<td>39.9</td>
</tr>
<tr>
<td>Regular alcohol use</td>
<td>62.1</td>
<td>8.6</td>
</tr>
<tr>
<td>Smoke cigarettes</td>
<td>51.3</td>
<td>9.1</td>
</tr>
</tbody>
</table>

* Net of any other protective factors and holding risk factors constant

Blum, Ireland, 2004
Youth in school are *less likely* to have sex early.
Students who feel connected to school are less likely to become pregnant.

Levels of connectedness

Percent ever Pregnant
### Risk and Protective Factors for Adolescents

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Early Sex</th>
<th>Substance Use</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive relationship with parents</td>
<td>![Circle]</td>
<td></td>
<td>![Circle]</td>
</tr>
<tr>
<td>Conflict in the family</td>
<td></td>
<td>![Triangle]</td>
<td>![Triangle]</td>
</tr>
<tr>
<td>Positive school environment</td>
<td></td>
<td></td>
<td>![Circle]</td>
</tr>
<tr>
<td>Friends who are negative role models</td>
<td>![Triangle]</td>
<td>![Triangle]</td>
<td></td>
</tr>
<tr>
<td>Positive relationship with adults in the community</td>
<td></td>
<td></td>
<td>![Circle]</td>
</tr>
<tr>
<td>Having spiritual beliefs</td>
<td>![Circle]</td>
<td></td>
<td>![Circle]</td>
</tr>
<tr>
<td>Engaging in other risky behaviors</td>
<td></td>
<td>![Triangle]</td>
<td></td>
</tr>
</tbody>
</table>

“Broadening the Horizon” Evidence from 52 countries: http://www.who.int/child_adolescent_health/documents/en
Effective programs: What do we know? What can we learn?
Group-Based Comprehensive Sexual Risk Reduction Interventions reduces HIV, STI and pregnancy risk
Access to family planning services increase contraceptive use
Parental or spousal requirements for consent to services impede contraceptive use
Over-the-counter access to hormonal and barrier contraception increases contraceptive use
STD/HIV testing and treatment combined with family planning services improves contraceptive use
- **Multifaceted programs** are most effective: education, skill-building, positive youth development and contraception promotion (any one of these alone does not appear to work).
- **Abstinence or sexual delay interventions** show limited evidence of effectiveness.
- **Post-partum counseling** increases contraception use and reduces second births (Nepal, Pakistan).
- **Home visitation programs** reduce repeat pregnancies within 2 years (USA). OR 0.35. So does **enhanced well-child visits** (OR 0.35).

(Oringanje, et al., Cochrane Systemic Review Database, 2009)
- Nations with the most sex-positive sexual instruction have best outcomes
- Societal acceptance of adolescent sexual relationships
- Comprehensive information about sexuality
- Clear expectations about preventing pregnancy and STIs
Focus on the doable and where the evidence is strongest!
- Universal access to contraceptive services
- Provision of HPV vaccine for adolescent males and females
- Condom education and provision
- School retention
- Life skills training
The Office of Adolescent Health’s Teen Pregnancy Prevention Resource Center:

Also:

- National Center for Health Statistics
  www.cdc.gov/nchs
- Youth Risk Behavior Surveillance System
  www.cdc.gov/yrbs
- Office of Adolescent Health
  www.hhs.gov/ash/oah/
Connect With Us!

Use OAH’s Award Winning Website
www.hhs.gov/ash/oah/

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Sign up for E-Updates

Watch us on YouTube
www.youtube.com/teenhealthgov
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