

2006

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Repository Citation

Meana, M., Thaler, L. (2006). Teen Sexuality and Pregnancy in Nevada. In Dmitri N. Shalin, *The Social Health of Nevada: Leading Indicators and Quality of Life in the Silver State* 1-29.

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Teen Sexuality and Pregnancy in Nevada*

Introduction

The United States has the highest rate of teen pregnancy in the fully industrialized world. While the rates have been declining in the last 15 years, it remains a source of concern that

- 34% of teenage girls in the U.S. are becoming pregnant at least once before the age of 20.
- The teen pregnancy in the U.S. rate is ten times that of Japan, four times those of France and Germany, and nearly twice that of Great Britain.

Despite the fact that sexuality and family planning have been divisive political issues in this country, there is a near consensus that a reduction in teen pregnancy rates should be a health priority. When teens get pregnant, the potential harm to the mother, the child, and society at large can be wide-reaching.

Teen mothers tend to function less effectively compared to their non-childbearing peers. Early childbearing further compounds the poverty and low educational attainment that are the precursors of teen pregnancy. Childbearing interferes with important developmental tasks facing adolescents who then have to juggle competing demands of growing up and parenting. Compared to their peers who postpone childbearing, teenage mothers tend to have

- more psychological problems
- lower graduation rates
- less stable employment
- greater reliance on social assistance and welfare
- higher poverty rates
- more marital instability
- and more frequent health problems

Research findings show that the babies of teen mothers also suffer.

- Children of teen mothers are likely to have lower birth weight, which raises the probability of infant death, blindness, deafness, chronic respiratory problems, mental retardation and mental illness, as well as doubling the chances that the child will later be diagnosed with a disability such as dyslexia or hyperactivity.
- Children born to teen mothers receive less medical care, partly because many teen mothers have no health insurance.
- Children of teen mothers are 50% more likely to repeat a grade, under-perform in standardized tests, and less likely to complete a high school degree than children of older mothers.
- Reported incidents of abuse and neglect of children are twice as common in families headed by a teen mother than in families in which childbearing has been delayed until the mother is in her early twenties.

Finally, society pays dearly for teen pregnancy.

- Each year the federal government alone spends approximately \$15 billion to help families that began with a teenage birth. These are costs associated primarily with welfare, health care, foster care, and criminal justice.
- Teachers and schools can become over-burdened by the numerous special needs of children born to teen parents ill-equipped to help their children succeed.
- A study estimating the cost-effectiveness of one teen pregnancy and sexually transmitted infection (STI) prevention program found that for every dollar invested in the program, \$2.65 in total medical and social costs were saved.

For all of these reasons, the US government has targeted teen pregnancy with legislation intended to curb the problem. When welfare reform was enacted in 1996, Congress placed a high priority on reducing teen pregnancy and the law required the **Department of Health and Human Services**, <http://www.hhs.gov/>, to establish and implement a strategy for preventing out-of-wedlock teenage pregnancies across the country through the use of grants to help states establish prevention programs. Various extensions of this law have been passed over the course of years. The 108 th

Congress on March 12, 2003 adopted **Resolution 91** "Expressing the sense of Congress that the Nation should strive to prevent teen pregnancy by encouraging teens to view adolescence as a time for education and growing up and by educating teens about the negative consequences of early sexual activity." The emphasis on abstinence education was initiated in 1996 during the Clinton administration and, consequently, strongly promoted by the Bush administration over the alternative of comprehensive sex education encompassing instruction in contraceptive practices. Much controversy surrounds this issue, yet regardless of the approach, all parties agree that a reduction in teen pregnancies and births is an important national goal.

Nevada began its statewide teen pregnancy prevention initiative in January 1996, when the **Nevada State Health Division**, <http://health2k.state.nv.us/>, and Attorney General released a plan containing recommendations for actions to be taken during the next four years in an effort to reduce Nevada's high teen pregnancy rates. Then Governor Miller established the Youth Advisory Council in 1996 and appointed the first 10 youth to serve on the Council in May of that year. Governor Guinn appointed members in 2000, continuing the State commitment to youth involvement in decisions that affect them. The **Nevada Public Health Foundation**, <http://www.nphf.org/>, was also established at that time, and it has since raised nearly \$1 million related to teen pregnancy prevention. The Nevada State Health Division developed a resource center containing information on developing community-based teen pregnancy programs and research findings. Approximately 40 Community Action Teams were also formed throughout the state to develop and implement teen pregnancy prevention programs. Unfortunately, lack of funding led to the inactivation of these Community Action Teams. Currently, the State's teen pregnancy program works with a network of community-based coalitions focusing on teen pregnancy prevention, as well as other issues. These coalitions receive most of their funding from the Bureau of Alcohol and Drug Abuse.

Historical Perspective

Until the 1960's, teen parenthood was not generally considered a problem in the U.S. Two developments helped raise society's awareness in this area. One was the increasing rates of sexual activity among teenagers, another – the decreasing rates of marriage.

- The rise in sexual intercourse among teenagers leveled off by the 1980's when approximately half of Caucasian females and three-fourths of African-American females had had intercourse by the age of 18.

Because of the faulty and sporadic use of contraception, a significant number of those having intercourse became pregnant. In actuality, teen pregnancy rates had been declining gradually since the 1970's, but it was matched by a decline in the proportion of teens who married before childbirth. Thus, teen pregnancies were decreasing overall while unwed teen pregnancies were skyrocketing. Teen pregnancy had become an identified social problem and the focus of much concern.

- In the 1950's, less than a third of first births to teen mothers were conceived out of wedlock.
- By the 1980's, close to two-thirds of all Caucasian teen mothers were unmarried when they became pregnant.
- And almost all (97%) of African American teen mothers were single at the time of conception in the 1980's.

The HIV epidemic of the 1980's added urgency to the question of teen sexuality and sex education, with attention shifting toward abstinence and safe sex practices. The 1990's saw a flurry of governmental initiatives aimed at reducing the teen pregnancy rates in the U.S. and other industrialized countries. As a result, significant reductions in pregnancy rates have been achieved throughout the industrialized world. Still, the United States continues to trail other industrialized countries, and the state of Nevada lags behind most other States.

The data indicates that, historically, Nevada's teen pregnancy issue mirrored that of the rest of the country, although the problem in this state was always more severe. From the records available, it

seems that concern about teen pregnancy in the state followed the recognition of it being a national problem. One might think that the prominence of the sex industry in this state might have made us more aware of sexuality-related problems, but it may have had the opposite effect. The centrality of the sex industry may have blinded Nevadans to the fact that there was an aspect of sexuality that was damaging the social life of the state rather than encouraging its growth – teen pregnancy. Both the financial and human cost of teen pregnancy would prove to be a blight on the State’s social health report card.

Teen Sexuality

Since sexual activity precedes pregnancy, we must understand the nature and pattern of teen sexuality to take effective measures in reducing teen pregnancies. Research strongly suggests that adolescent sexual activity reflects the environment within which the teenager comes of age. Family, school, and peer relationships are particularly important in this respect. Here is a summary of main findings in this area:

- Teens growing up in families disrupted by divorce and remarriage tend to have intercourse at an earlier age.
- Earlier onset of sexual activity correlates with low parental monitoring, as well as with permissive sexual attitudes and behavior in parents.
- Sexually active adolescents have been found to perform more poorly in school, start dating earlier than their peers, and have more friends encouraging sexual experimentation.
- Early sexual activity has been linked to a greater number of sexual partners over time and an increased risk of teen pregnancy and sexually transmitted infections.
- The younger a girl is when she becomes sexually active, the more likely she will end up pregnant as a teenager.
- Sexual activity during adolescence has been associated with a host of risk-taking activities, including substance use and delinquency.

The latest data from the **Youth Risk Behavior Survey** (YRBS), <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>,

of the **Centers for Disease Control and Prevention** (CDC), <http://www.cdc.gov/>, indicates that more teens are delaying having sex today than they were over ten years ago. Here are some key results from this 2003 survey that covered 29 states, including Nevada:

- 46.7% of all high school students reported having had sexual intercourse. This represents a 13.7% decrease from 1991 (see Figure 1).
- 14.4% of all high school students reported having had 4 or more sexual partners in their lives – a 23% decrease from 1991.
- 45.4% of Nevada high school girls reported having had intercourse, which ranked the Silver State 14th highest in the nation.
- 4.2% of high school girls polled in Nevada reported that their first intercourse experience was before the age of 13 – the 7th highest rate in the U.S.
- 16.6% of girls in the Silver State reported that they had already had 4 or more sexual partners – the 3rd highest rate in the country.

The 2003 YRBS statistics for Nevada high school girls were not broken down by ethnoracial characteristics, but the national statistics on teen sexual activity and ethnicity in high school girls were as follows:

- 43% of Caucasian, 61% of African-American, and 46% of Hispanic girls had had sexual intercourse.
- 3% of Caucasian, 7% of African-American, and 5% of Hispanic girls had had their first intercourse experience before the age of 13.
- 10% of Caucasian, 16% of African-American, and 11% of Hispanic girls had had 4 or more sexual partners.

Sexual activity other than vaginal intercourse is also commonly reported by teens. The 2002 **National Survey of Family Growth** (NSFG), <http://www.cdc.gov/nchs/nsfg.htm>, conducted by the Center for Disease Control provided relevant national statistics on other sexual activities. At ages 15-19:

- More teens reported having had oral sex than sexual intercourse, while 85% of all teens who had had sexual intercourse had also had oral sex.
- 12% of boys and 10% of girls had had heterosexual oral sex but not vaginal intercourse.
- 11% of females and 11% of males reported having had heterosexual anal sex.
- 5% of males and 11% of females had had sexual contact with a same-sex partner at some point in their lives.

Comparing this data to prior surveys, we can see a rise in the rate of oral sex. It is not entirely clear what drives this trend. The increase may indicate that teenagers view oral sex as a way to maintain their virginity, narrowly defined as vaginal intercourse. It is also possible that oral sex is regarded as an alternate method of birth control. Thus, even though teens are delaying sexual intercourse compared to a decade ago, there may be a rise in sexual activity other than vaginal intercourse.

Interestingly, teenage girls often describe early sexual experiences as less than pleasant. Some report being coerced into early sexual intercourse. And even when they were not, young girls say they wish they had put off their first sexual encounter.

- One in 10 young women who first have sex before the age of 15 reports that it was not voluntary.
- Teen girls who are under 15 years of age and who are sexually experienced are more likely than sexually experienced older teens to say they “wish they’d waited.”

The good news is that most recent surveys indicate that more and more teens are doing just that – waiting.

Teen Pregnancy and Birth Rates

Nevada followed the national trend in declining teenage birth rate, which went down considerably beginning in the early 1990’s.

- The teen birth rate in the U.S. has plummeted by 33% from 1991 when it peaked at 61.8 live births per 1,000 women aged

15-19 years to 41.6 live births in 2003 – a record low for the nation.

- The teenage birth rate has declined in all ethnic groups, with the biggest decline observed among African-Americans.
- On a state-by-state basis, the declines in birth rates from 1991 ranged from a high of 52% in Vermont to a low of 15% in Nebraska.
- In 2003 Nevada had the 10 th highest teen birth rate in the country.
- According to the CDC **National Vital Statistics Report**, http://thinktwice.com/cdc_2001.pdf, in 2003 Nevada's birth rate for teens 15-19 was 53.0 live births, down from 74.5 in 1991.

The rate of teen pregnancy (as opposed to the rate of teen births) is usually calculated by adding births, fetal deaths, and abortions, which is why it is always significantly higher. Ethnic differences persist in the teen pregnancy and birth rate in Nevada as well.

According to the **Center for Health Data and Research** (CHDR), <http://health2k.state.nv.us/nihds/center.htm>,

- Native-American teens had the lowest rate of teen pregnancies in 2002 at 53.1 pregnancies per 1,000 teen females, and African-Americans had the highest teen rate at 111.8 (see Figure 2).
- **The Nevada Interactive Health Database** (NIHD), <http://health2k.state.nv.us/nihds/>, reports that in 2003, Caucasian teens had the lowest birth rate at 29.1 births per 1,000 teen females, while Hispanic teens had the highest rate with 81 births per 1,000 teen females (see Figure 3).

The National Campaign to Prevent Teen

Pregnancy (NCPTP), <http://www.teenpregnancy.org/>, reports interesting county-by-county data on teen pregnancies and births, which signals where prevention efforts may have to be stepped up. In a national analysis of 458 counties of comparable size,

- Washoe county ranked 259 in the number of teen births while Clark County ranked 291.

- With the exception of Washoe, all counties in Nevada have seen an appreciable decline in teen pregnancy in the 10-14 year old age group (see Figure 4).
- A declining trend is also evident in the 15-17 year old age group in all Nevada counties, although Clark county appears to be taking the lead in this age group (see Figure 5).
- In 2002, Humboldt county had the highest pregnancy rate with 95 pregnancies per 1,000 females aged 15-19, and Elko had the lowest with a teen pregnancy rate of 39 (the teen pregnancy rate for most Nevada counties is presented in Figure 6).

The impressive strides that Nevada has made toward the reduction of teen pregnancy have contributed significantly to the quality of life in Nevada. It has been suggested that the current 29% decline in birth rates may have contributed to the following improvements in the year 2002:

- A 5% decline in the proportion of children under age six living with a single mother – 2,500 fewer children under age six living with a single mother
- A 1% improvement in the state's poverty rate for children under six – 1,800 fewer children under age six living in poverty

Despite the substantial improvement in Nevada's teen pregnancy and birth rates, a lot more work remains to be done. Nevada still lags behind much of the country, and teen pregnancy and birth rates remain comparatively very high. A new generation of teenagers appears on the scene every year, and neither the nation nor the state of Nevada can rest on its laudable progress. Exquisitely sensitive to various social factors, the tide of teen pregnancy can surge upward again if we do not remain vigilant and proactive.

Teen Contraceptive Use

Teens who have sex at an early age are less likely than older teens to use contraception the first time they have sex. This is clearly a

cause for concern, and this young age group needs to be targeted in sex education efforts, early though it may seem to some adults.

- In 2002, some 25% of teen females and 18% of teen males used no method of contraception at first intercourse.
- Of those who had first intercourse before the age of 14, 35% of girls and 24% of boys report that they did not use any contraception the first time they had sex.

The 2003 YRBS data on 29 states presents important national and Nevada-specific statistics on contraceptive use during the last episode of sexual intercourse among high school students.

- 53% of Nevada girls reported their partner having used a condom, which ranked Nevada 3rd lowest among the states in relation to condom use.
- 24% of Nevada girls reported having been on the birth control pill – the 14th lowest ranked state on birth control pill use.

The NSFG 2002 data for the U.S. showed the following trends in birth control:

- The most popular method was the condom, with 66% of girls and 71% of boys using this method at first intercourse.
- Nearly all teens who have ever had intercourse (98%) had used at least one method of birth control.
- The most common methods in 2002 were the condom (used by 94%), and the pill (used by 61%).
- The injectable methods, primarily Depo-Provera, had been used by 21% of sexually experienced teens.
- The trend from 1995 to 2002 indicates that pill use had increased from 52% to 61%; the very effective injectable methods had increased from 10 to 21%; and 8% had used emergency contraception – the high-dose oral contraceptive taken shortly after intercourse.

Ethnic differences were also evident in contraceptive use.

- Hispanic teens reported the lowest use of the pill and condom.

- Yet both Hispanic and African American teens had higher use of injectable contraceptives than Caucasian teens (see Figure 7).

Thus in 2002, teens were more likely to use contraception at first sex and at most recent intercourse than they were in 1995. The use of the condom has continued to increase, and so has the combined use of condom and a hormonal contraceptive. Ethnoracial differences persist, but all groups show marked increases in contraceptive use.

Teen Abortions

Abortion in general and teen abortion in particular are indicators which have a strong bearing on the quality of life in the nation and the state.

- Half of all pregnancies to American women are unintended and half of these end in abortion.
- Approximately 21% of all pregnancies end in an induced abortion.
- Approximately one third of all teen pregnancies end in an induced abortion.
- There has been a decrease in abortion rates over the past decade and the decline was greatest among 15-17 year olds, women in the highest income categories, those with college degrees and those with no religious affiliation.

When it comes to teen abortion in Nevada, the trends continue to be alarming.

- In 2000, Nevada ranked 4th in the nation on the number of abortions induced in females aged 15-19.
- In 2003, the percentage of all known induced abortions in Nevada by those in the 10-19 age group was 16.2% – unchanged from 2002.
- In 2002, 1,458 of the 5,122 teen pregnancies in the state ended with an induced abortion, yielding a teen abortion/pregnancy ratio of 28% – a decline of 3% from 2001.

- In 2002, the highest teen abortion/pregnancy ratio among Nevada counties was in Douglas County (35%), followed by Mineral County (33%) and Washoe County (31%).
- Clark County and Carson City County had ratios of 29% and 28%, respectively (see Figure 6).

Wherever one stands on the abortion issue, it is clearly undesirable for young women to undergo this distressing procedure that entails physical risks and incurs psychological costs for many girls.

Sexually Transmitted Infections and HIV in Teens and Young Adults

Among the main risks that the sexually active teenager faces is the transmission of infections and HIV. The annual incidence of STI's among young Americans is unknown. A major obstacle to the diagnosis, treatment, and surveillance of STI's is that many of these infections have few, if any, recognizable symptoms and only a handful of them are reportable to the CDC. All of this makes reliable estimates difficult to obtain. We do know, however, that compared to adults, adolescents are at higher risk for acquiring STI's. Young people acquire nearly half of all new STI's.

- 19 million STD infections occur annually, almost half of them among youth ages 15-24.

Chlamydia remains the most commonly reported infectious disease in the United States and its incidence continues to rise, although this may be in part due to increasingly sensitive diagnostic tests and improved case reporting. The CDC estimates, based in part on the **STD Surveillance Report for 2004**, <http://www.cdc.gov/std/stats/toc2004.htm>, that

- The national rate of reported chlamydia for 2004 was 317 cases per 100,000 population, an increase of 4% from 2003.
- In descending order of reported cases, Nevada ranked 26th of 50 states in the number of chlamydia cases reported in 2004.
- The positivity rate (percentage of swabs that prove positive for the infection) for chlamydia in women aged 15-24 tested in

family planning clinics ranged from a low of 3.2% in West Virginia to a high of 16.3% in Mississippi.

- Nevada's positivity rate in this population was 3.9% – one of only 3 states with a positivity rate for chlamydia lower than 4%.

This low positivity rate may reflect a sampling bias, however, for it covers only women who actually went to family planning clinics and got tested. In any case, chlamydia is of serious concern as it can have severe health consequences for women, including pelvic inflammatory disease, ectopic pregnancy, and infertility. An added risk of all STI's is that they facilitate the transmission of HIV. On the other hand, chlamydia can be easily cured with antibiotics, making surveillance a high priority.

Gonorrhea is the second most commonly reported infectious disease in the country, although rates in 2004 were at an all time national low of 113.5 cases per 100,000 population.

- The highest rates of gonorrhea among women are in the 15-19 year old age group, which in 2004 had 611 cases per 100,000.
- In descending order of reported cases, Nevada ranked 14th of 50 states in the number of gonorrhea cases reported in 2004 with a rate of 137 cases per 100,000.
- Nevada's positivity rate in that year was at 0.9% of women aged 15-24 tested in family planning clinics, making the state one of 35 with positivity rates of less than 1% for that age group.
- Despite national success in lowering the prevalence of gonorrhea, major racial disparities persist, with African Americans 20 times more likely to contract the disease. African American women aged 15-19 have the highest rate of any group with 2,790 cases per 100,000 population.

Even though concern about drug resistance is growing, gonorrhea is usually easily cured. Untreated, it can cause serious health problems for men and women.

Syphilis, once considered to be under control, has made a comeback in recent years.

- After an all-time incidence low in 2000, the national syphilis rate rose for the fourth consecutive year.
- In descending order of reported cases, Nevada ranked 14 of 50 states in the number of syphilis cases reported in 2004, with 253 cases reported in the state – a 71% increase from 2003.

Genital herpes increased dramatically for a couple of decades and then stabilized.

- In the 1980's, the number of diagnosed cases of genital herpes was 11 times that in the 1970's. Rates have remained relatively constant ever since, but 15-24 year olds are estimated to account for at least 40% of new cases.

Human papilloma virus (HPV) is the most common of the non-reportable STI's.

- 74% of HPV infections in 2000 were estimated to have occurred to young Americans.
- The prevalence rate for youth aged 14-19 is estimated to be 35%.

Trichomoniasis infections are common among those aged 15-24, as they are estimated to account for 25% of them.

HIV and AIDS are a source of concern, both nationally and locally.

- The CDC estimates that 800,000-900,000 persons in the United States are infected with HIV and approximately 40,000 new infections occur each year.
- The incidence of HIV and other STI's among men who have sex with men has remained high. According to the distribution of AIDS cases in the United States by the recorded route of infection, an estimated 75% of HIV infections in 2002 were acquired through sexual intercourse. Half of these were contracted by individuals aged 15-24.
- Nevada's AIDS rates are disproportionately high – the Silver State ranked 14th in the nation for the rate of adolescents and adults living with AIDS, 18th in the nation for the annual AIDS case rate, and 20th for the number of new HIV cases.

- In 2004, there were 10 newly diagnosed HIV or AIDS cases in the 13-19 age group. Although this represents only 1.8% of the state's new cases for that year, it remains a disturbing statistic that can be lowered further through efforts to curb teen sexual activity and/or ensure that it is practiced safely.

Considering the potential impact of STI's on fertility, childbearing, health of the neonate, life expectancy of the teen, as well as the physical, psychological, and relational problems often reported by teens with these diseases, STI's remain one of the most worrisome negative outcomes of early teen sexual activity.

Sex Education

There are few areas more controversial in our society and culture than teen sexuality. The debate is raging about whether education and social policy should center on abstinence, contraceptive education, or a combination of both (comprehensive sex education). The sides in this debate have been drawn along political and religious lines, and emotions run high on both sides.

The abstinence proponents believe that abstinence is the only foolproof way to prevent pregnancy and that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects. They also fear that sex education that includes safe sex practices may be sending a mixed message about the appropriateness of teen sex. The comprehensive sex education proponents also believe that abstinence is preferable in teens and that sex that happens in the context of a loving relationship is ideal. However, they fear that a substantial proportion of teens will not adhere to abstinence and, in the absence of contraceptive education, many sexually active teens will be at higher risk for pregnancy, STI's and HIV. Each side of the sex education debate provides empirical data to support its position, yet an evaluation of the data is complicated by cross-study differences in methodologies and population samples. Considering the difficulty in sorting out what the most effective programs are, the current legislative promotion of abstinence education cannot be said to be driven primarily by empirical support.

In Fiscal Year 2004, Nevada received federal funding of \$280,174 for abstinence education. This was matched with in-kind services worth \$210,131. Nevada Revised Statute 389.065 which governs sex education in Nevada's schools stipulates that,

- the board of trustees of each school district shall establish a course covering factual instruction concerning HIV and instruction on the human reproductive system, related communicable diseases and sexual responsibility.
- each board of trustees shall appoint an advisory committee consisting of 5 parents of children who attend schools in the district and four representatives, one each from the professions/occupations of medicine/nursing, counseling, religion, pupils who attend schools in the district, or teaching.
- this committee shall advise on the content of covered in the course as well as the recommended ages of the pupils to whom the course is taught.

Of interest in the sex education debate is the fact that Nevadans appear to support comprehensive sex education. According to the CDC's Behavioral Risk Factor Surveillance System in 2000,

- 98.9% of Nevadans think that students should receive education about HIV and AIDS in school.
- 76.5% believe that this education should begin in elementary school.
- 88.9% of Nevadans would encourage a sexually active teenager to use a condom.

It is important that we bridge the gap between science and current policy and stop ideology from preventing the provision of services to teens – services and education that can be instrumental in reducing teen pregnancies and all of their attendant problems. We actually do know what works in terms of sex education.

Extensive research conducted over 20 years has identified the more effective sex education programs. Programs that include these features are more likely to be effective than programs missing even just one of these elements. An effective sex education program offers the following recommendations:

- Focus on the reduction of behaviors that lead to unintended pregnancy or STI/HIV transmission.
- Use research findings and theoretical advances to influence health-related behavior.
- Include clear message about the importance of abstaining from sexual activity and using contraception.
- Provide accurate information about risks of teen pregnancy and about ways to avoid intercourse or protect against pregnancy and STI's/HIV.
- Spell out social pressures that influence sexual behavior.
- Teach communication, negotiation and refusal skills.
- Incorporate interactive procedures and personalization methods in teaching practice.
- Match didactic methods to age, sexual experience, and culture of teens.
- Make sure that the sex education program is of sufficient length (more than a few hours).
- Train and retain committed educators.

The Work Ahead and Policy Implications

The 1979 Surgeon General Report, *Healthy People 2000*, <http://www.cdc.gov/tobacco/sqr/index.htm#1970s>, established the national health objectives which served as the basis for state and community plans. Like its predecessors, *Health People 2010*, <http://www.healthypeople.gov/default.htm>, is a national strategy for significantly improving the health of Americans over the first decade of the 21st century. The two-volume report was published by the United States Department of Health and Human Services and identified 28 national focus areas to increase quality and years of healthy life and to eliminate health disparities. Four of these areas relate directly to teen sexuality and teen pregnancy: (1) family planning, (2) STI's and HIV, (3) maternal health, and (4) infant and child health.

Nevada's report card on its 2010 Healthy People objectives is relatively positive, yet much work lies ahead. Teen pregnancy rates have decreased substantially, and we are nearing the 2010 target. However, considering the accelerated rate of decrease in other parts

of the country, Nevada should – and could – be more ambitious, aiming for lower rates than the ones spelled out at the time when the Healthy People 2010 objectives had originally been established. Decreases in teen sexual activity are clearly evident in our state, but they still fall short of 2010 goals. We have a long way to go, particularly when it comes to STI's. All in all, progress is evident but it needs to be accelerated through social initiatives and effective education grounded in empirical evidence.

We have seen earlier that the United States lags behind most European nations in the areas of preventing teen pregnancy, abortion, and STD. What is Western Europe doing differently? A number of explanations are possible here. One is that the rate of poverty and inequality in these countries is substantially lower than in the U.S. Another explanation is that European countries espouse comprehensive sex education approaches and make contraceptive services and supplies available at low cost for all teenagers. There may also be differences in adolescents' attitudes toward contraception, accuracy in their knowledge of how to use methods, and in the extent of parental support. Some of the differences may also be attributable to differences in data collection. The answer to this intriguing question remains unclear but it is definitely worthy of exploration.

The prevention of teen pregnancy involves more than combating high risk behavior. To make further strides in this area we have to address the social forces behind the problem, and most urgently the plight of the teens growing up in the economically and socially strained circumstances. Teen pregnancy rates are the highest among groups with lower socio-economic status and opportunities. The most effective, albeit most complex, way to reduce teen pregnancy and birth rates is to improve the social context within which teens prone to early pregnancy live: poverty, lack of community, detachment from school, work or other important social institutions, and distant relationships with parents, and assorted other caregivers. Teen pregnancy rates are a mirror of the social health of the community, the state, and the nation. Teens need reasons to make responsible decisions about sex, and no reason is

more motivating here than the realistic belief that they have a prosperous, successful future ahead.

Conclusion

Both the country as a whole and state of Nevada have made significant progress in reducing teen pregnancies. It is important that we celebrate these reductions and give appropriate credit to the national and state-wide efforts to raise consciousness about the impact of teen pregnancy. It is also important that we support young teens when they find themselves in the unenviable position of impending parenthood by expanding their choices and providing resources. But most crucial of all in our struggle to reduce teen pregnancy is to continue our efforts and not let recent gains make us complacent.

We need to keep in mind that each year a new cohort of teens enters the scene, making it necessary to renew our efforts. The number of girls aged 15-19 are expected to increase substantially by the year 2010. This means that even declining rates will not necessarily result in fewer teen births. We cannot rest on the progress achieved so far, undeniable though it is. Nor should we allow the honest differences of opinion among parents and sex educators to impede efforts to reduce teen pregnancy and achieve our shared goal – healthy, happy adolescents aspiring to succeed and unhampered by premature obligations they are ill equipped to handle.

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Community Resources

The following list is by no means exhaustive. Rather, it is a selection of community resources providing services of relevance to teens with needs related to sexual activity, contraception, pregnancy, birth, sexually transmitted infections, and HIV/AIDS.

Planned Parenthood, Health centers that provide culturally competent, high quality, affordable health care and health care education.

3220 W Charleston Blvd., Las Vegas, NV 89102, Tel. 702-878-7776.

3320 E. Flamingo Rd, Ste 54, Las Vegas, NV 89121, Tel. 702-547-9888.

3940 Martin Luther King Blvd #105, North Las Vegas, NV 89032 , Tel. 702-642-3313.

455 W. 5 th Street, Reno, NV 89503, Tel. 775-688-5555.

4385 Neil Road #5, Reno, NV 89502, Tel. 775-829-2211.

948 Incline Way, Incline Village, NV 89451, Tel. 775-298-0026.

Clark County Health District, STI Clinic testing for Chlamydia, HIV, gonorrhea, syphilis. 625 Shadow Lane, Las Vegas, NV 89106. Tel. 702-383-1201.

Washoe County District Health Department, Family Planning Program, provides routine gynecological exams, birth control, pregnancy testing, testing and treatment of sexually transmitted infections, HIV testing. Tel. 775-328-2470.

Huntridge Teen Clinic provides medical care for minor illnesses, sports or camp physicals and immunizations, as well as for birth control and testing for pregnancy and sexually transmitted diseases. Most services are free, but a sports physical costs \$15 and a PAP smear -- 5\$. 21 S. Maryland Pkwy, Las Vegas, NV 89104-3225. . Tel. 702-732-8776.

Family Health Services, Federally Funded Abstinence Education Programs throughout the state. Carson City, Tel. 775-684-4285.

City of Refuge, home for pregnant women, safe place, open to adolescents. P.O. Box 2663, 952 Qadosh Rd., Gardnerville, Nevada 89410. Tel. 775-782-2034.

Women's Resource Center provides free pregnancy tests, peer counseling, maternity clothes, baby clothes, diapers, limited ultrasounds. 67 E Lake Mead Dr., Henderson, Nevada 89015. Tel. 702-558-4445.

[First Choice Pregnancy Services](#) provides complete, accurate information and compassionate peer-counseling to women and couples who are making decisions about unintended pregnancies. Free services include pregnancy testing and pregnancy counseling. 860 E. Sahara Ave., Suite 1, Las Vegas, NV 89104. Tel. 702-294-

CARE (2273). 41 N Hwy 160, Ste 12, Pahrump, Nevada 89060. Tel. 775-751-2229, <http://www.firstchoicelv.org/>.

[Casa de Vida](#), maternity home for pregnant girls. 1290 Mill St., Reno, Nevada. Tel. 775-329-1070, <http://www.firstchoicelv.org/>.

Clark County Coalition of HIV/AIDS Services . These agencies, organizations, and informal groups in Clark County that provide services for the benefit of persons living with AIDS or affected by AIDS. Provide information, counseling, testing and other related needs for people living with HIV/AIDS. P.O. Box 26431, Las Vegas, Nevada 89126. Tel. 702-382-5533. Email: Info@cccoalition.org.

Crisis Pregnancy Center provides free services include maternity/infant care referral, post-abortion support, free pregnancy tests, pregnancy counseling, maternity and baby clothes, diapers, baby food/formula, baby furniture, pre-natal care support. 2915 W. Charleston, ste. 1, Las Vegas, NV 89102. Tel. 702-366-1247. 200 Brinkby Ave., Reno, Nevada. Tel: 775-826-5144. Helpline: 775-826-1999. Toll Free: 1-800-395-HELP.

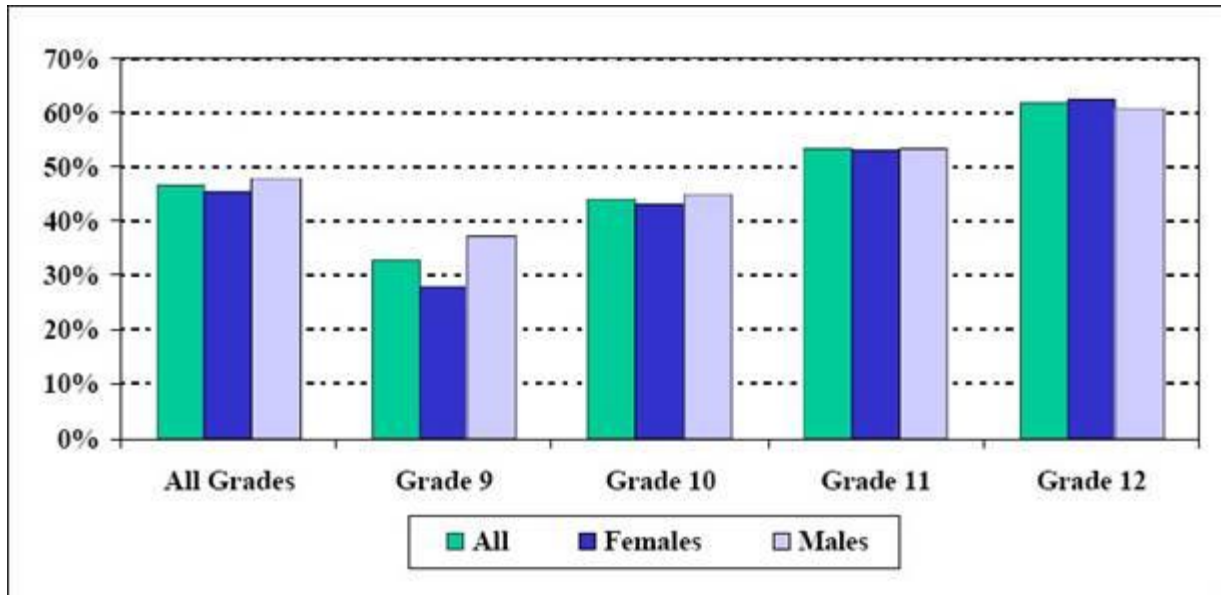
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Supplementary Materials

Figure 1

**Proportion of High School Students Who Have Had Sex At Least Once,
2003 (Grades 9-12, YRBS)**



	All Grades	Grade 9	Grade 10	Grade 11	Grade 12
All Teens	46.7%	32.8%	44.1%	53.2%	61.6%
Female Teens	45.3%	27.9%	43.1%	53.1%	62.3%
Male Teens	48%	37.3%	45.1%	53.4%	60.7%

Figure 2

Bureau of Health Planning and Statistics Center for Health Data and Research

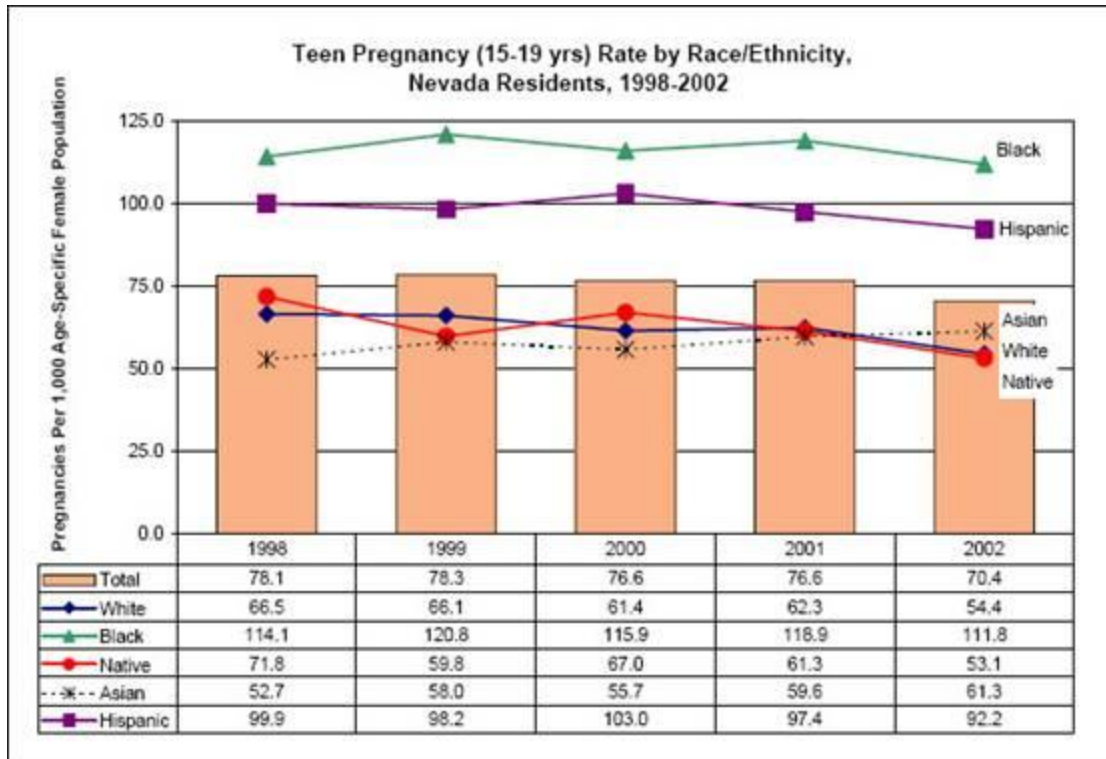


Figure 3

2003 Nevada Teen Births

Teen Birth Rate per 1,000 Teen Females (Ages 15 to 19)

Mother's Race/Ethnicity	Detail Information			
	Number of Live Births to Females of Ages 15-19 Years	Number of Females of Ages 15-19 Years	Teen Birth Rate per 1,000 Teen Females (Ages 15-19)	95% Confidence Interval
All	3,720	76,802	48.44	46.92 - 49.95
White	1,230	42,245	29.12	27.51 - 30.72
Black	456	6,749	67.57	61.58 - 73.56
Native American	64	1,284	49.84	37.94 - 61.74
Asian	136	4,452	30.55	25.49 - 35.60
Hispanic	1,787	22,072	80.96	77.36 - 84.56

Figure 4

Bureau of Health Planning and Statistics Center for Health Data and Research

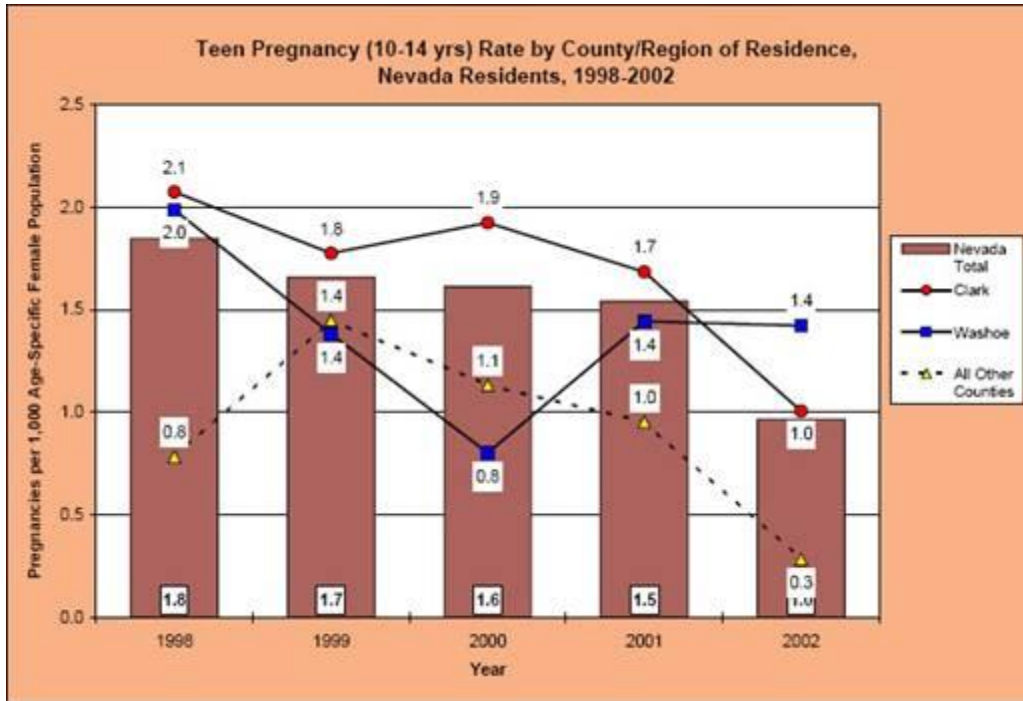


Figure 5

Bureau of Health Planning and Statistics Center for Health Data and Research

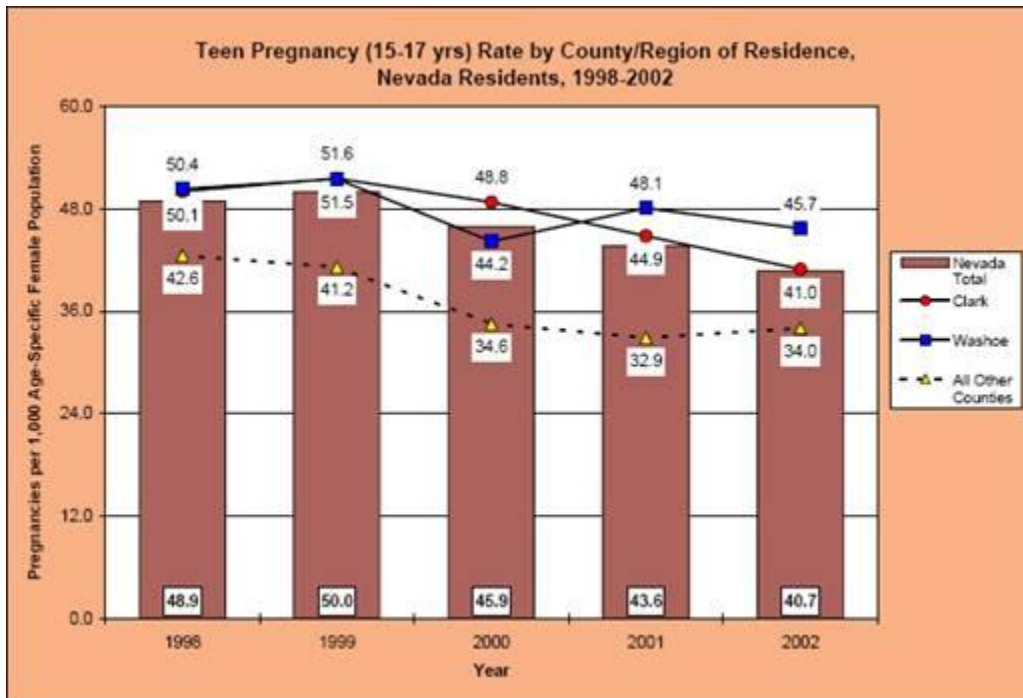


Figure 6

**Teen Pregnancy (15-19 yrs) by County of Residence
Nevada, 2002**

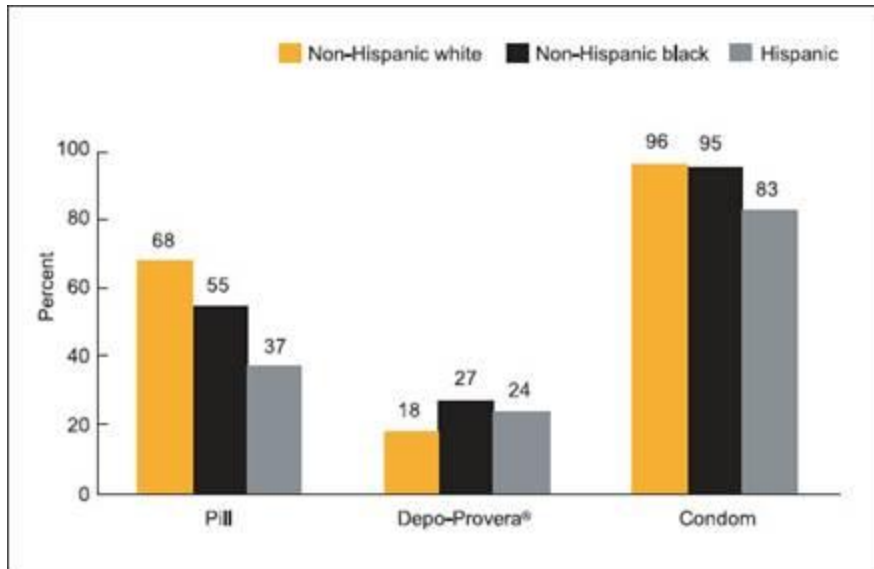
County of Residence	2002				
	Live Births	Fetal Deaths	Abortions	Total	Rate*
Carson City	101	2	40	143	81.62
Churchill	50	0	15	65	67.77
Clark	2,612	18	1,066	3,696	71.46
Douglas	35	0	19	54	39.70
Elko	63	1	11	75	39.18
Esmeralda	1	0	1		0.00
Eureka	1	0	0	1	---
Humboldt	46	0	10	56	95.11
Lander	10	0	2	12	---
Lincoln	3	0	0	3	---
Lyon	57	0	6	63	49.78
Mineral	7	1	4	12	---
Nye	44	0	8	52	50.15
Pershing	12	0	4	16	---
Storey	0	0	0	0	0.00
Washoe	583	4	267	854	78.01
White Pine	13	0	5	18	---
Nevada Total	3,638	26	1,458	5,122	70.38
Out of State	29	0	128	155	---
Unknown	0	0	0	0	---
Total	3,667	26	1,584	5,277	---

* Rate is per 1,000 age-specific female population.

Note: The rates for the counties where the total number of pregnancies was 20 or less are not shown, because of statistical reliability in the calculation of the pregnancy rate.

Figure 7

Percent of females 15-19 years of age who have ever had sexual intercourse, who have used the pill, the 3-month injectable (Depo-Provera), and the male condom, by race and Hispanic origin: United States, 2002



*This report stems from the Justice & Democracy forum on the Leading Social Indicators in Nevada that took place on November 5, 2004, at the William S. Boyd School of Law. The report, the first of its kind for the Silver State, has been a collaborative effort of the University of Nevada faculty, Clark County professionals, and state of Nevada officials. The Social Health of Nevada report was made possible in part by a Planning Initiative Award that the Center for Democratic Culture received from the UNLV President's office for its project "Civic Culture Initiative for the City of Las Vegas." Individual chapters are brought on line as they become available. For further inquiries, please contact authors responsible for individual reports or email CDC Director, Dr. Dmitri Shalin: shalin@unlv.nevada.edu.