Sex Education, Access to Contraception, and Rates of Teen Pregnancy: A Comparison of the Federal Republic of Germany and the United States

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Introduction

Today, teens are becoming sexually active at an earlier age and have more sex partners than teens of previous generations (Centers for Disease Control and Prevention [CDC], 2000). In the United States during the 1960s it is estimated that 20% of males and 45% of females were virgins at age 19. However, by the 1980s, fewer than 20% of all 19 year-olds were virgins (Singh, 2000). Nationally, 50% of all U.S. high school students have experienced sexual intercourse (CDC, 2000). Researchers estimate that by age 19, approximately 80% of all American teens have engaged in sexual intercourse. However, some research shows evidence of a slight decrease in this trend (CDC, 2000; Kaiser Family Foundation [KFF], 2000). According to recent CDC data, the percentage of high school students who experienced sexual intercourse declined from an estimated 54% in 1991 to 48% in 1997 (CDC, 2000). The 1999 Youth Risk Behavior Survey (YRBS) estimates that 50% of the high school students surveyed had engaged in sexual intercourse at least once during their lifetime, and among these students, males report slightly higher rates of sexual activity than females (52.2% versus 47.7%). However, among students reporting abstinence, the proportion of males (30.5%) is greater than the proportion of females (23.9%). Similar rates of sexual activity were reported among males (36.3%) and females (36.2%) who described themselves as currently sexually active (CDC, 2000).

In addition to the decrease in rates of sexual intercourse, teenage pregnancy rates also appear to be declining. Experts attribute the decline in U.S. teen pregnancy and birth rates to a substantial increase in contraceptive use by sexually active teens. Despite this presumed trend, it is estimated that more than 900,000 adolescents become pregnant each year (MacKay, Fingerhut & Duran, 2000). Presently, the United States continues to have the highest teen birth rate among all industrialized nations and a higher teen birth rate than over 50 developing nations (Abma, Chandra, Mosher & Piccinino, 1997; Advocates for Youth, 1999). An Alan Guttmacher Institute (AGI) study suggests that despite the decline in U.S. teen pregnancy and teen birth rates, the U.S. rates continue to be much higher than those of Canada, France, Sweden, and Great Britain (AGI, 2001a). Furthermore, the U.S. has the highest rate of teen abortions in the industrialized world, and a rate of gonorrhea infections 25 times that of Germany (Advocates for Youth, 1999).

The consequences of adolescent pregnancy and childbirth are numerous and include a higher risk of maternal illness, miscarriage, serious complications during pregnancy for both the mother and infant, as well as higher numbers of stillborn, premature and low-birth-weight babies (Alters & Schiff, 2001; Luker, 1996). Teen mothers are less likely to be married or to graduate from high school, and are more likely than peers who delay childbearing to live in poverty and to rely on welfare (Alters & Schiff, 2001; Annie E. Casey Foundation [AECF], 1998). As a result, pregnancy and childbearing among adolescents is viewed by most authorities as disadvantageous, both to the adolescents involved and to society (AECF, 1998; Alters & Schiff, 2001; Bozon & Kontula, 1997; National Campaign to Prevent Teen Pregnancy [NCPTP], 2001).

In response to the numbers of adolescents engaging in sexual activity and the problem of adolescent pregnancy, many middle and high schools across the nation have implemented sexuality education programs (Allgeier & Allgeier, 2000). In general, the approaches to sex education can be described as teaching sexual abstinence until marriage or postponement of early sexual involvement (Allgeier & Allgeier, 2000; NCPTP, 2001). Although many adolescents state a desire for factual information concerning sexuality and contraception (KFF, 2000), most enter puberty with little accurate information, and the possibility exists that they will not receive sexual and contraceptive information while in high school (Connolly, 2001). The lack of sexual and contraceptive information available to American adolescents has been influenced by individuals and groups who believe that high levels of adolescent sexual activity and the resulting unintended pregnancies are caused by school-based sex education programs (Allgeier & Allgeier, 2000; Kirby, Barth, Leland & Petro, 1991; Kirby, Waszak & Ziegler, 1991).

Although American youth lack access to sexuality and contraceptive information, the Federal Republic of Germany seeks to provide its youth with information from elementary school forward. In addition, Germany has been able to maintain a teen pregnancy rate that is just one-fifth that of the United States (International Planned Parenthood Foundation [IPPF], 2000a; 2000b). With a per capita GNP similar to that of the U.S., Germany has been able to achieve this preferable level through federal legislation that provides for sex education and family planning counseling, and for contraceptive prescriptions free of charge to women under the age of 18. Contraceptives are widely available in Germany and oral contraceptive use is one of the highest in the world (IPPF, 2000a). The remainder of this paper further compares and contrasts sexuality education, access to contraception, and teen pregnancy rates in Germany and the United States.

Sexuality Education in the United States

The Sexuality Information and Education Council of the United States (SIECUS) defines sexuality education as
“a lifelong process of acquiring information and forming attitudes, beliefs, and values about identity, relationships, and intimacy” (SIECUS, 1999, p.1). In the U.S., the federal government does not dictate sexuality education or its content in schools, thereby allowing control of sexuality education to rest in the hands of the individual states. Control at this level has resulted in some states setting the guidelines for sexuality education curricula or subject matter, and other states allowing decisions to be made at the local level (Gold & Sonfield, 2001). In addition, subject matter inclusion standards range from abstinence-only programs to comprehensive sexuality education courses that include information ranging from abstinence to abortion, and include information on sexually transmitted diseases and HIV/AIDS (KFF, 2000; Satcher, 2001; SIECUS, 1999).

Parents of middle and high school students report a desire for schools to offer their children a wide range of sexuality related topics. Parents acknowledge the need for the core elements of sexuality education, namely, HIV/AIDS, other STDs, reproduction, and abstinence information. However, parents also state the need for information relating to safer sex and negotiation skills (KFF, 2000). According to the KFF report on sex education in American schools, 18 states require schools to provide sexuality education. Among the states requiring schools to provide sexuality education, some require the schools to teach abstinence, and do not require the curriculum to include information about contraception, while other states require schools to teach abstinence and include information about contraception (SIECUS, 1999). Only a few states require that sexuality education consist of information on both abstinence and contraception (SIECUS, 1999). The KFF report states that 34 states and the District of Columbia require HIV/STD information to be included in sexuality education courses. Currently, the provision and content of sexuality education curricula in American schools is inconsistent (KFF, 2000; SIECUS, 1999).

The existing inconsistencies relating to the content of school-based sexuality education curricula are influenced by a variety of sources. While state legislatures and departments of education influence decisions relating to sexuality education, final decisions about curricula usually are determined locally, and typically with the input of state or community advisory committees that develop, review, or recommend appropriate sexuality education materials and concepts (KFF, 2000; SIECUS, 1999). Ordinarily, when specific topics are not included in sexuality education programs, principals attribute the exclusion to a school or district policy (KFF, 2000).

Studies have shown that that the earlier sexuality education begins, the greater the likelihood that young people will remain abstinent and use protection when they do become sexually active (SIECUS, 1999). Among Americans who support sexuality education, 93% believe that it should be taught in high school and 84% support it at the middle/junior high school level (SIECUS, 1999). Thus, most schools concentrate on sexuality education in grades seven through nine and confine the unit to the health or science curriculum (KFF, 2000).

Although a majority of parents acknowledge the need for some form of school-based sexuality education, actual funding for these programs is often limited or non-existent. In recognition of the need for some type of school-based sexuality education, Title V of the Social Security Act was amended in 1996 to encourage states to provide school-based abstinence education (SIECUS, 1999). The amended legislation provided for five years of guaranteed funding for abstinence-based sexuality education programs aimed at groups considered at high-risk for out-of-wedlock pregnancy. As a result, 698 abstinence-until-marriage programs were funded in 48 states (SIECUS, 1999). According to recent research findings, one in three public schools teaches abstinence as the only option (KFF, 2000).

Abstinence-until-marriage programs do not acknowledge teen sexual behavior because many proponents believe that sex outside of marriage is immoral and self-destructive (Strong, DeVault & Sayad, 1999). Such programs are irrelevant for youth who already have made the decision to postpone marriage, or for youth who will never marry. Consequently, these programs do not teach young people how to protect themselves when they do become sexually active, or how to communicate with their partner concerning the need for protection from pregnancy or STDs. In addition, an abstinence-only curriculum that begins in high school may be irrelevant for students who have already begun having sexual intercourse. Currently, none of the published studies relating to abstinence-only programs have demonstrated consistent and significant program effects in relation to delaying the onset of intercourse (Allgeier & Allgeier, 2000; Price, 2001; Satcher, 2001; SIECUS, 2001). Moreover, any presumed delay in the initiation of conventional sexual intercourse may not necessarily mean a concomitant delay in the advent of other high risk sexual activity (e.g., oral sex, anal sex, and so on). This lack of supportive data notwithstanding, abstinence-only curricula have been widely adopted in many American schools (Strong, et al., 1999), and supported by conservative politicians (Connolly, 2001; Price, 2001).

It is unlikely that Americans will soon resolve the debate relating to the provision and content of school-based sexuality education programs. Supporters of abstinence-only curricula feel that discussions concerning sexuality should be minimal, or left out of schools completely with responsibility for sexuality education placed entirely on the parents (Kirby, 1999). Proponents of sexuality education range from those who favor comprehensive school-based programs, to those who favor programs focusing mainly on HIV/AIDS and STD transmission (Strong, et al., 1999). It should be noted that although many authorities believe that sexuality education should be left up to parents, youth report receiving minimal sexuality information from their parents. According to one report, only 32% of 13-to-18-year-olds said they received information about sex from their parents (KFF, 2000). The majority of sexuality-related information was obtained from their friends. In fact, various studies report that just 10% of males and 16% of females cite their parents as the primary source of sexuality information.
their sexuality education (Ansuini, Fiddler-Woite & Woite, 1996). In many cases, when parents do communicate with their children about sex it appears that attitudes and values are conveyed much more often than facts about intercourse and contraception (Allgeier & Allgeier, 2000). Ironically, although Americans worry about providing adolescents with too much sexuality and contraceptive information, the U.S. maintains the highest rates of teen pregnancy, abortion, and childbirth among Western nations (Carroll & Wolpe, 1996).

Sexuality Education in Germany

Since the late 1960s, Germany has subscribed to the "Emancipatory Sex Education" (ESE) model of delivering sexuality education in the schools (Koch, 1994). According to the German Federal Centre for Health Education (or Bundeszentrale für gesundheitliche Aufklärung [BzgA]), this practice asserts that sexuality is a natural part of human development and should be discussed openly, rather than limited to exposing youth to moralistic or judgmental views (BzgA, 1996). Within the ESE model students are exposed to the concepts of sexuality gradually over time, beginning in childhood and extending throughout their school career, with issues relating to sexuality integrated into the classroom by all teachers, not just specially prepared science educators (Koch, 1994).

The BzgA (1996) defines sexuality as "an existential, basic need of human beings and a central part of their identity and the development of their personality" (p.3). Sexuality is viewed as an important element of an individual's lifestyle, and includes physical, psychological, and social components (BzgA, 1999). The BzgA (1996) defines the goal of sex education as that of "dealing with sexuality and contraception in a self-determined and responsible manner" and declares that sex education "can only be successful if sexuality can be viewed and discussed openly as an integral part of health" (p.3).

The goal of sexuality education in Germany is not only to provide information about contraceptives and contraceptive methods, but also to promote the idea that sexuality is an essential element of personality development and lifestyle. BzgA (1999) documents state that German youth should learn how to take self-responsible, partner-responsible attitudes toward sexuality in general (BzgA, 1999). Attitudes such as these are considered as healthy and necessary life components. The implementation of sexuality education in Germany is two-fold: (1) It is implemented to prevent unwanted pregnancy and STDs; and, (2) Its purpose is to enable people to lead a happy and safe life in relation to their sexuality.

The ability of Germans to discuss sexuality openly is affected by an acknowledged difficulty related to talking about sexuality and resulting communication barriers (BzgA, 1996). Although an unintended pregnancy can result from the non-use or incorrect use of contraceptives, it can also result from the inability of sex partners to communicate with one another concerning sexuality and contraceptive use. In July 1992, recognizing sexuality education as a public task, the German government issued the German Act on Assistance for Pregnant Women and Families (BzgA, 1999), an act to provide comprehensive sexuality education for German youth. The task of sexuality education in the schools is to avoid indoctrinating students to defined standards and values, but to contribute to youth’s ability to make sound judgments, and to develop their own sense of values and conscience, thereby, empowering them to take control of the way they lead their own lives (BzgA, 1999; Marburger, 1999). Also, the provision of comprehensive sexuality education is expected to lower communication barriers and improve preventive attitudes toward human sexuality (BzgA, 1996).

The German Act on Assistance for Pregnant Women and Families assigned a number of responsibilities to the German Federal Centre for Health Education (BzgA, 1996; 1999). These responsibilities include developing sexuality education materials geared to various age and social groups for the purpose of preventive health care and avoidance of unintended pregnancy (BzgA, 1996; 1998a; 1999). The legislation also mandates the design of comprehensive sexuality education in a manner that addresses the widest possible range of age and target groups. Sexuality education programs include not only information on biological processes, but also information on motivation. In addition, programs are designed to promote competence in areas relating to options for unwanted pregnancy. Other components of the program include exposure to information about the contraceptive responsibility of both partners, tolerating alternative lifestyle choices, improving or developing communication skills, issues relating to intimacy and tenderness, and issues relating to sexual exploitation, violence and abuse (BzgA, 1999).

The consensus of opinion among the German Federal States (die Länder) is that the development of sexuality begins at birth, with the major developmental points in individual personality occurring during the periods of childhood and youth (BzgA, 1999; Marburger, 1999). As a result, it is believed that effective sexuality education is necessary long before puberty, or at the latest, during the fifth or sixth grade (Marburger, 1999). Sexuality education is viewed as a means of enabling children and youth, as well as their parents, to express their own sexuality beliefs and values, thus providing an impetus to question and discuss sexual roles critically, and empower relationships among men and women (BzgA, 1996).

Germans recognize that sexuality education occurs both in the schools and at home, and also acknowledge the presence of other contributing factors to sexuality education such as one’s peers and the influence of the mass media. The growing presence of immigrants in German society and the school system has added cultural complexities to the development and implementation of comprehensive sexuality education programs (BzgA,
Although sexuality education occurs in German schools, a large number of German youth report receiving information relating to sexuality at home. In a BzgA-sponsored study addressing adolescent sexual behavior, 69% of females and 43% of males identified their mother as the primary source of their sexuality education. Furthermore, 72% of parents report contributing to the overall sex education of their daughters, and 55% state they educate their sons (Koch, 1994). In Germany, the family is recognized as having the dominant role in a young child's socialization process (Marburger, 1999). The importance of family influence is demonstrated by studies positively correlating contraception as a topic of conversation in the home, and the use of a contraceptive at first intercourse (BzgA, 1998a). Researchers for the BzgA (1998b) state that in one sample of German youth, 89% of girls and 88% of boys (ages 14-17 years) said they used contraceptives during their first intercourse. Marburger (1999) asserts the need for sex education programs to recognize the importance of family background and its role in the learning experiences of each child, while concurrently charging schools with the task of creating a climate of instruction that does not exclude students with thoughts, feelings, and actions that may differ from the modal or normative constellation. German teens indicate that sexuality education in the schools is the second most common source of knowledge about sex (BzgA, 1998a). Currently, the most commonly discussed topics in schools are biological facts, contraception, and STDS. Within the last few years, however, socially sensitive or controversial subjects such as prostitution, pornography, homosexuality and sexual violence and abuse have been included in classroom discussions.

In Germany, schools are mandated to integrate sex education into their curriculum. This mandate can overrule objections by parents who believe that sexuality education may lead to promiscuity. In Bavaria, Germany’s largest and most politically conservative state, and one that is predominantly populated by Catholics, a 1999 German court upheld a 1977 ruling that mandatory sexuality education did not infringe upon parental rights (Catholic World News, 1999).

Schools also must provide access to community counseling centers that offer information and guidance to German youth (BzgA, 1998b). According to the German Pregnancy Law (Das Schwangerschaftskonfliktgesetz) all people are entitled to free counseling at a recognized counseling center. The law specifically states that every person is entitled to obtain information and counseling about sexuality education, including contraception and family planning, as well as pregnancy-related issues from a recognized counseling center (BzgA, 1999). As a result of this mandate, counseling centers are easily accessed, require little personal information and guarantee confidentiality. Therefore, counseling centers experience popularity and minimal stigma. Furthermore, sexuality education through the mass media has been implemented for years in Germany. In fact, one of the stated objectives of the BzgA directly addresses the provision of sex education through media channels. In Germany, sexuality education through multiple means of mass communication is a central component of the BzgA’s efforts. Mass communication efforts that are widely received by the German people include the use of print and audio-visual media, as well as educational segments shown on television and in cinemas (BzgA, 2000a).

**Sexuality Education Contrasted**

A common element between German and American parents is the concern that sexually explicit instructional material and information may be too open, or too explicit for their children. In both countries, a common fear among parents is that comprehensive sexuality instruction may invite adolescents to initiate sexual activity.

Currently, much of the research indicates that neither the level of sexuality information nor use of contraception influences the frequency of adolescent sexual activity. It also appears to be unrelated to the age of first intercourse, the frequency of intercourse, or the number of sex partners (Marburger, 1999; Satcher, 2001). In the U.S., despite evidence pointing to the effectiveness of school-based sexuality education programs and to the efficiency of using schools as a mechanism for these programs, comprehensive school-based sexuality education remains controversial, and for the most part, more of a perceived reality than an actual one. However, while many of these same concerns exist among German parents, the German government has decided to rely upon the available scientific evidence pointing toward the effectiveness of school-based sexuality education. While American sexuality education programs are limited by political and educational concerns, German educators are urged by the government to listen to parental concerns with empathy and respect, but to advise parents that "ignorance doesn’t protect children and that knowledge of sexual phenomena promotes considered actions" (Marburger, 1999, p.29).

Although it appears that the provision of sexuality information in American schools will remain limited in the foreseeable future, German educators are committed to increasing the sexual knowledge base of all students. The goal of comprehensive sexuality education in Germany is not to indoctrinate young people to a certain sexual ideology, but to enable them to develop their own sense of values and conscience, so that each individual will be in control of the way he or she chooses to lead a life as a sexual being (Marburger, 1999).

**Access to Contraceptives Among Adolescents in the United States**

Previous research indicates that maternal birth rate consistently increases with age (MacKay, et al., 2000).
Thus, 19-year old females are nearly seven times as likely to give birth as 15-year old females. In addition, recent CDC estimates indicate that females age 13-19 years account for nearly 13% of all births each year. When broken down by age groups, this rate translates into a rate of 51.5 births per 1000 females ages 15-19 years, and 2.6 births per 1000 females ages 13-14 years of age (MacKay, et al., 2000).

Consistent contraceptive use is one of the most important determinants of pregnancy and birth rates (U.S. Department of Health and Human Services [USDHHS], 2000). According to an Alan Guttmacher Institute report, approximately 5 million adolescent females in the U.S. need reproductive and contraceptive services (AGI, 2001b). Additional data estimate that nearly one million pregnancies occur annually among adolescents, most of which are unintended (USDHHS, 2000).

This level of unintended pregnancies has serious economic and social consequences. The overall annual costs of adolescent pregnancy to the U.S. taxpayer are estimated to range from $6.9 billion to $18.6 billion, with unintended births alone accounting for 40% of adolescent pregnancies and costing more than $1.3 billion in direct health expenditures, not including the costs of induced and spontaneous abortions (USDHHS, 1998).

Consistent social costs are numerous and are measured in events such as reduced educational attainment and employment opportunities, increased welfare dependency and increased potential for family violence and child neglect (USDHHS, 2000). The economic and social costs of unintended pregnancy can be mitigated through contraceptive services that are both available and accessible to adolescents (USDHHS, 1998; 2000).

It is estimated that in 1994, federal monies spent on contraceptive services and supplies totaled $715 million (Sollom, Gold & Saul, 1996). These funds went primarily to family clinics with low-income clientele, as well as to private practitioners who accepted Medicaid patients (Sollom, et al., 1996). While these expenditures may seem excessive to some, research estimates that for every dollar spent on publicly funded contraceptive services, 3 dollars are saved in Medicaid bills for pregnancy-related health and medical care (Forrest & Samara, 1996).

The most common forms of birth control among sexually active adolescents are condoms and oral contraceptives (Hatcher, Trussell, Stewart, et al., 1998; USDHHS, 1998; 2000). Of late, the use of oral contraceptives at most recent intercourse has decreased from 42% to 23%. However, it is believed that some of the decrease may be attributed to the adoption of newer forms of hormonal contraceptives such as Depo-Provera and Norplant (USDHHS, 2000). Overall, American adolescents rely on oral contraceptives to prevent pregnancy less often than do adolescents in other countries. In the U.S. only 11% of adolescents report using the oral contraceptive pill at first premarital intercourse (Hatcher, et al., 1998).

American adolescents strongly express the need for privacy in matters relating to their own sexuality, as well as feelings of embarrassment when interacting with health care providers (Hatcher, et al., 1998). The need for privacy, coupled with feelings of embarrassment, translates into the presence of numerous barriers between adolescent females and their ability to use contraception consistently and effectively. In addition, the inability to communicate their desire for effective contraceptive methods also may be a barrier. Mosher and Horn (1988) state that among females aged 15 to 24 years, these barriers translate into an average delay of 23 months between initiation of sexual activity and an initial family planning visit. An additional barrier occurs when adolescent females are faced with health care providers who refuse to provide contraceptive services without parental consent.

Family planning experts recognize that it is not realistic to expect individuals to avoid unintended pregnancies if they do not have access to comprehensive family planning services (USDHHS, 1998). The United States Census Bureau estimates that 44 million Americans do not have health insurance; of these, 11 million are children (Eng, 2001), and among those who have insurance coverage, family planning and contraceptive service coverage is limited (USDHHS, 1998). In addition, among Americans with HMO coverage, 40% cover the five most effective methods of contraception: Norplant, Depo-Provera, IUDs, oral contraceptives, and the diaphragm, and 7% provide no coverage (AGI, 2001b). Among private insurance companies, it is estimated that 15% cover the five most effective forms of contraceptives (USDHHS, 2000). It should be noted that among the five most effective forms of contraception, only Depo-Provera and oral contraceptives are consistently recommended for adolescent females (Greenberg, Bruess & Haffner, 1999).

Family planning funding mechanisms available to states include the Maternal Child Health (MCH) Block Grant, Social Services Block Grant, Temporary Assistance for Needy Families (TANF), and the Children’s Health Insurance Program (Gold & Sonfield, 1999). Each of these programs provides for family planning services; however, the offerings are neither coordinated nor standardized. For example, the program most appropriate for adolescent family planning services is the Children’s Health Insurance Program (CHIP), which provides health coverage to uninsured children and adolescents younger than age 19 who are generally in families with incomes below 200% of the poverty level. Under this plan, each child is eligible to receive necessary preventive health services and education. However, states have individual control over which services are provided, including pre-pregnancy family planning services (Gold & Sonfield, 1999).

A 1997 fiscal year assessment of states providing family planning services reveals that block grant funds for government-supported family planning services are not used by states in the same manner (Gold & Sonfield, 1999).
Although almost every state uses the MCH block grant for family planning, only 15 states used the social services block grant for this purpose (Gold & Sonfield, 1999). Also, services provided by state program expenditures differ. The authors conclude that family planning does not appear to be a priority for either program, and political forces ultimately determine how services are provided by each state.

Although consistent contraceptive use is cited as the most effective means of preventing pregnancy, the lack of family planning programs, as well as inconsistencies in accessibility among existing programs that provide services and contraceptives to American adolescents, compromises their ability to prevent an unintended pregnancy. As a result, the associated social and economic costs continue to burden American society.

Access to Contraceptives Among Adolescents in Germany

Access to safe, effective, affordable and acceptable methods of contraception is described as a central aspect of "human reproductive rights" (BzgA, 2000a). Teenage pregnancy rates are considered to be reliable indicators of adolescent sexual health and behavior, and are also viewed as reflective of contraceptive access and use. The number of births to adolescent females aged 15 to 19 years has been falling in Germany since 1980, with a 1992 rate of 12.7 births per 1000 women in the referent age group (Remberg, 1999). According to 1996 statistics published by the German Federal Statistics Office (German Federal Statistics Office, 1998) there were 55,585 births to women 21 years of age and younger, of which 1,803 children were born to women ages 16 and younger. A 1998 study of 1,468 women (BzgA, 2000b) revealed that among the pre-unification generation of 17-year-olds, a smaller proportion of females from East Germany (8.1%) showed a preference toward having no children at some time in their lives than their West German counterparts (22.6%). Among post-unification 17-year-olds, these figures were more closely aligned – 15.4% and 16.7% respectively. Overall, the pregnancy rate among German adolescents is significantly lower than that of Americans.

Although the lower birth rate is affected by the availability of contraceptives, German abortion-related law also influences the low rate of teenagers giving birth. The abortion-related law states that all pregnant women have the right to choose whether to continue or terminate a pregnancy, and since 1993, abortions generally have been allowed during the first 12 weeks of pregnancy. Although German women are afforded the freedom of choice concerning an abortion, paragraph 218 of the Das Strafgesetzbuch describes abortion as "not punishable but unlawful," and medical insurance pays for an abortion only under certain circumstances (e.g., when imminent dangers occur for the mother).

Although access to abortion has restrictions, contraception is accessible to all youth in Germany. National health insurance ensures that reproductive and contraceptive health services are routine components of adolescent health care. Contraception is available to youth, and more specifically, oral contraceptives are available free of cost until the age of 18 years (IPP, 2000a). German youth are not required to obtain parental consent to acquire contraceptives. Ironically, although German law provides for free oral contraceptives to youth until age 18, a 1998 BzgA survey revealed that only 32% of boys and 69% of girls in Germany (ages 14-17 years) were aware that they can obtain oral contraceptives free-of-charge while under the age of 18 (BzgA, 1998a). However, among adolescents who have already experienced intercourse, the proportion of youth who were aware of contraceptive availability was higher (85% of the girls and 50% of the boys).

To address the lack of knowledge related to the availability of contraceptive services, the German government charged the BzgA with the task of expanding the knowledge base of the German people through research seeking to understand the public’s attitudes, values, and knowledge of sexuality and family planning (BzgA, 1998b; 2000a). To accomplish this goal the BzgA continues to conduct government funded research related to family planning and sexuality. The study results are used to create responsive programs and services that accommodate the reproductive and family planning needs of the German people (BzgA, 2000a). The results of this coordinated effort between the individual state and federal governments have the potential to continue to lower the rates of adolescent pregnancy and childbirth.

Discussions

These comparative data and programs suggest that sexuality education and family planning services exist in both countries, but that more comprehensive sexuality education programs and services are available in Germany. Comprehensive sexuality education does not appear to promote sexual initiation in Germany, as seen by the fact that German youth engage in first intercourse later than American youth. This delayed age at first intercourse occurs in spite of their exposure to comprehensive education beginning in elementary school, coupled with easy accessibility to contraceptives during adolescence.

Germany’s concept of emancipatory sex education (ESE) appears to be a promising practice and one that deserves exploration by American educators and public officials. Comprehensive sexuality education programs may have greater acceptance by those educators who have already implemented more comprehensive, and age-appropriate methods of sex education in certain American schools (Kirby, 1999; Kirby, Waszak, & Ziegler, 1991). Despite opposition, family planning programs utilizing full interventions including education, counseling, skills training, and youth development exercises have been successful at delaying first sexual intercourse, as well as increasing contraceptive use and safer-sex practices (Kirby, 1999; Kirby, Waszak, & Ziegler, 1991);
Main, Iverson, McGloin, et al., (1994). Combining these programs with the German concept of ESE, which places sexual development in the context of naturalness and acceptance, may influence youth to view sexuality as something other than the proverbial “forbidden fruit.” Thus, life experience and wisdom, coupled with guidance provided by their parents and other adults, become the key elements leading to choices and decisions. Implementing programs such as those described will require a change in American education policy, as well as close examination of personal and political viewpoints. The planning and implementation of comprehensive programs designed to provide sexuality education and family planning services to adolescents also will require the fortitude of individuals prepared to ride the waves of opposition. In addition, coordinated access to family planning services for all adolescents in the U.S. deserves some attention. This concept is especially pertinent since the pressure and need to expand services offered stretches an already challenged budget (AGI, 2001b).

Obviously, increasing knowledge of pregnancy prevention through comprehensive sexuality education in the schools, or increasing access to contraceptives alone does not solve the problem of teen pregnancy. Teen pregnancy is a multi-faceted phenomenon with numerous influential antecedents (American Academy of Pediatrics Committee on Adolescence, 1999; Kirby, 1999; Monahan, 2001). However, it is one that requires an open and honest dialogue between parents and their children, a dialogue that begins early in life and continues through young adulthood. The dialogue between parents and children can be enhanced through the development and implementation of innovative and comprehensive interventions that enable youth to gain confidence in their sexual identity and related health issues. American adolescents need comprehensive sexuality education programs that teach them skills that enable them to cope not only with birth control and pregnancy concerns, but also with other sexuality-related issues, including communication, sexual harassment, discrimination against lesbian, gay, and bi-sexual youth, and other matters (Kaiser, 2000; Price, 2001; Satcher, 2001). Programs that provide youth with a knowledge base obtained from reliable sources, and upon which they are able to make sound decisions are vital (Satcher, 2001). German youth presently have this opportunity and the results may be reflected in the lower rates of adolescent pregnancy and the related social and economic costs.

References


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