Termination of Pregnancy: Public Policy Perspectives

Sue Dyson and Anne Mitchell

The recent debate

about the pregnancy rate among adolescents in Australia has led to increased interest in the most successful way to prevent unintended pregnancies, and in the potential contribution of sex education with young people in schools. We address these questions in the light of the available evidence on effective sexual health education, and current Australian policy and practice.

Teenage pregnancy and its outcomes

In Australia in 1995 there were 43.6 pregnancies per 1000 young women aged 15–19 years, and this rate had been stable for the previous 10 years. This is relatively low in comparison to the same age group in the USA (83.6 per 1000), and is comparable to other Western developed nations like New Zealand (54 per 1000), England (47 per 1000) and Canada (45.4 per 1000). Overall in Australia in 1995, there were 19.8 births and 23.8 terminations per thousand young women aged 15–19 years. The vast majority of the births (88%) were to single women, and at least some of them were probably the result of planned and wanted pregnancies.

Many studies have demonstrated that there are negative associations between early childbearing and social, economic and health outcomes, both for the mother and for society. For young women, the social, emotional and physical consequences of early motherhood can present a considerable burden, including an increased risk of antenatal complications and mortality, failure to complete schooling, socioeconomic disadvantage and maternal depression. The children of teenage mothers have been found to have increased rates of health problems, physical injury, behavioural and cognitive difficulties and educational underachievement.

These problems are not only a consequence of teenage parenting, as teenage pregnancy is associated with economic and social disadvantage. In Australia and other similar countries, births to teenagers are higher in disadvantaged and remote areas than in urban or affluent areas.

Accurate data is collected on the number of terminations in South Australia, Western Australia and the Northern Territory, but SA is the only state that publishes these data. In the period 1995–1999, a little over half of all teenage pregnancies in South Australia ended in a termination. These factors have led to calls for improved interventions, including sexual health education, to reduce the number of pregnancies.

Success of interventions to prevent teen pregnancy

Few programs have proven successful in preventing unintended pregnancy in teenagers. Those that have been evaluated and have shown long-term positive effects have been social interventions that start early to address social disadvantages. The Children’s Aid Society–Carrera Program in New York worked with 600 disadvantaged adolescents aged 13–15 over a 3-year period. Half were assigned to a control group and half received an intervention that involved a comprehensive youth development program including a “job club”, tutoring and homework.
help, family life and sex education, self expression through the arts, and individual sport activities. The control group received a less intensive after-school program typically run for disadvantaged youth by the Children's Aid Society. After 3 years the control group were twice as likely as the intervention group to report a birth. Furthermore, the girls in the intervention group were less likely to be sexually active or to have been pregnant. This program was offered to both boys and girls, and the changes were all noted in the girls; no effect was noted on the behaviour of the boys.

A few other longer-term interventions have also been shown to have some impact on preventing teenage pregnancy. An evaluation of day care programs for pre-schoolers aimed at families from lower socioeconomic areas in the USA showed lower rates of teenage pregnancy to be among its long-term beneficial effects, particularly when programs with parents were included.

While these kinds of interventions have proven successful, school-based education remains the most efficient way of reaching the greatest number of young people before they become sexually active. These programs have in recent years had a twofold objective: to minimise the incidence of teenage pregnancy through reducing levels of sexual activity and use of contraception, and to prevent the transmission of sexually transmitted infections (STI) and blood-borne viruses (BBV).

In the USA in recent years there has been a focus on abstinence-only programs with young people in schools. A number of evaluations of these programs have determined that not only do they fail to delay first intercourse or reduce levels of sexual activity in teenagers, but they may increase the risk of not using condoms or other contraceptives for those who do become sexually active.

Internationally, there have been a number of sexual health programs introduced in schools with the expressed purpose of reducing teenage pregnancies. A randomised controlled trial to assess the value of sex education carried out in Scotland found changes in knowledge and attitudes in the education group but no changes in sexual behaviour. A Canadian study by DiCenzo and colleagues reviewed the effectiveness of primary intervention strategies aimed at delaying sexual intercourse, improving use of birth control and reducing the incidence of unintended pregnancies in adolescents. These interventions took place in school sex education programs, school-based clinics, family planning clinics and community-based programs in North America, Australia, New Zealand and Europe. The meta-evaluation selected trials in 22 published and unpublished reports that randomised young people to intervention and control groups, and concluded that none of these primary intervention strategies were successful in achieving any of these aims.

The authors note that to date there is no clear solution to the problem of high pregnancy rates among adolescents in developed countries like the USA, Canada and Australia. They suggest that programs should begin earlier, and that the social determinants of unintended pregnancy need to be better understood. They suggest that approaches in countries such as the Netherlands, where there are low pregnancy rates among teenagers, and other types of social intervention programs that work, such as drug education programs, should be carefully examined. They further note that few sexual health interventions are designed with input from those for whom such programs are intended, and argue that consulting with young people about both content and process would be an important step in designing effective programs.

Other studies have disputed DiCenzo and colleagues' findings. In the USA, Kirby reported that rigorous studies of some sex education and HIV education programs in the USA have shown sustained positive effects on behaviour for as long as 3 years. Furthermore, McKay pointed out that DiCenzo's evaluation focused only on programs aimed at reducing teenage pregnancy, and argued that most programs have much wider aims than simply reducing the pregnancy rate. During the 1970s and early 80s, preventing pregnancy was the primary aim of sex education programs, but, with
the advent of HIV, from the late 1980s resources and expertise have been directed at reducing the risks associated with the transmission of HIV and STIs. As-Sanie argues that the most effective sex education programs are those that both present abstinence as the only effective way of preventing unintended pregnancy and the spread of STIs and BBVs and also discuss contraception and consistent condom use for those who are sexually active. She points out that successful programs can vary in their approach, but that the characteristics of effective programs include a focus on high-risk sexual behaviours; the provision of accurate, age-appropriate and culturally sensitive information; active inclusion of all participants; and allowing time for interactive exchange and teaching communication skills.4

There is clearly a degree of uncertainty about how effective sex education can be in preventing unwanted pregnancies. It is notoriously difficult to evaluate, as young people’s sexual decision making and behaviour is subject to so many complex influences. Australian young people nominate school programs as their favoured source of sexual health information, so they are themselves attesting to the worth of continuing to go down this path.14

**Sex education in Australia**

The reality of this range of behaviours and constellation of risks clearly provides a mandate for sexual health education from an early age. This education must be more comprehensive than the simple provision of information. In formulating the life skills which young people need in relation to their sexual health, the World Health Organization has legitimized this broader agenda. Young people need to learn to:

- make sound decisions about relationships and sexual intercourse and stand up for those decisions
- use negotiation and refusal skills regarding sex
- recognize a situation that might turn risky or violent
- know how and where to ask for help and support
- know how to negotiate protected sex and other forms of safe sex when ready for sexual relationships.17

This more social and relational agenda provides an excellent blueprint for designing sound programs and it is one Australia is beginning to heed.
Sex education in schools in Australia is a state and territory responsibility and has been a somewhat ad hoc and uncoordinated affair with many players involved. Despite this fact, a great deal of good and innovative work has been done in the area over the past few years. There will always be political and social anxieties about the role of schools in sex education, and this has meant that the structure and content of many existing school-based programs have been narrowly focused on the safer option of disease prevention instead of looking at the more socially oriented health enhancing behaviours. Efforts to change this focus are often contested and progress can be slow at both local and national levels.

Frustrations experienced at the level of individual schools, or in individual states and territories, led in 1998 to the development of a national policy framework and an evidence-based blueprint for how education systems and schools can best approach the area and, to some degree, have their programs protected from the vicissitudes of local politics. This policy framework, and the professional development and classroom materials which support it, argued for a whole school approach as the basis of a comprehensive sexual health program. This framework fits within the national curriculum, which endorses a focus on the significance of personal decision making and behaviours, and on community structures and practices, in promoting health. “Talking sexual health: a national framework for education about HIV/AIDS, STDs and blood-borne viruses in secondary schools” recognises that individual schools, education authorities and agencies have their own particular values, needs and requirements.

The national acceptance of this framework and its implementation in many schools in all states and territories has been a great step towards the universal provision of sound sexuality education in schools across Australia. However, this approach still relies on the climate and good will of the individual school. Until we have universal sexuality education provided to all young people as an unquestioned right, we will continue to see unacceptable levels of adverse outcomes.

References

Late terminations of pregnancy – an obstetrician’s perspective

David Ellwood

The recently reignited debate on abortion has raised many questions, including the number performed, the age of the women and indications for the procedure. Those on the “pro-life” side of the highly polarised participants have also focused attention on “late abortions”. There have been suggestions that there may be large numbers of late terminations of pregnancy being performed, in some cases close to full term, with no medical indication other than a woman’s choice not to continue the pregnancy. Indeed, the phrase “partial-birth abortion” which is sometimes used by political activists on the pro-life side may lead the uninformed listener to conclude that this is something close to infanticide, being performed at a time when survival for the infant is a realistic possibility. What then is the real situation with late terminations in Australia?

The term “late termination” is understood by most obstetricians to mean one that is carried out at or above 20 weeks’ gestation. This legal watershed, beyond which the fetus attains a legal identity, often triggers a change in the decision-making process when a request for termination is made. This depends on the practice and laws that apply in various jurisdictions.