DELIVERING better EDUCATION
ARKANSAS HAS THE THIRD HIGHEST TEEN BIRTH RATE AND TEEN PREGNANCY RATE IN THE UNITED STATES.
ABSTRACT

A review of public health data for the 50 states shows that Arkansas has the third highest teen birth rate and teen pregnancy rate. These outcomes impact Arkansas teens in general, and Arkansas women in particular in terms of increasing negative health outcomes, as well as negatively impacting potential educational attainment, thus increasing the economic burden on women. This report synthesizes findings from recent health data collected by the Centers for Disease Control and Prevention (CDC), the U.S. Department of Health and Human Services (HHS), and peer-reviewed scientific research to demonstrate the health disparity facing Arkansas teens with regard to the short and long-term health, educational, and economic consequences of teen pregnancy. Based on the synthesized data, recommendations and action steps to improve outcomes for Arkansas teens and women are provided.
TEEN MOTHERS ARE MORE LIKELY TO LIVE IN POVERTY.
INTRODUCTION

Unintended pregnancy among teens is associated with long-term health and social consequences for those teens, and their families, and communities. The CDC released the most recent national data on teen pregnancy rates, showing record lows in 2009. Although teen pregnancy rates have been declining since 1990, demographic and geographic disparities persist, perpetuating negative health and economic outcomes, particularly for teen mothers. For example, teen mothers are less likely to graduate from high school and attend college, and are more likely to live in poverty than teens without children. Without adequate education, teen mothers face significantly reduced lifetime earnings potential, are more likely to live and stay in poverty, and are at an increased risk of having a daughter who experiences a teen pregnancy, thus perpetuating a cycle of poverty. Teens in Arkansas bear an increased burden when it comes to teen pregnancy as compared to their national peers. Teens in Arkansas are more likely to experience pregnancy and become parents compared to teens living in other states. Teen pregnancy and parenthood often result in both short and long-term negative social, economic, and health-related outcomes, which disproportionately impact teen girls. This report will focus on the impact of teen pregnancy and parenthood on young women in Arkansas, and provide action steps to reducing teen pregnancy.

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As a partner with the Clinton Foundation through the Clinton Health Matters Initiative (CHMI) for Central Arkansas, the Women’s Foundation of Arkansas is pleased to offer this report as a means of working across sectors to develop and implement coordinated, systemic approaches to creating healthier communities. Understanding and addressing the economic, education, and health needs—in this case teen pregnancy and its implications for completing an education—of Arkansas women can only lead to stronger, healthier communities.
TEEN PREGNANCY & RISK BEHAVIOR

Based on the most recent available state data, among teens ages 15-19, Arkansas had the third highest teen pregnancy rate and teen birth rate in the United States. The teen pregnancy rate in Arkansas is 28% higher than the national average (73 vs. 57 pregnancies per 1,000), and the teen birth rate is 70% higher than the national average (45.7 vs. 27 births per 1,000) among young women ages 15-19. In other words, compared to other states, Arkansas teens are experiencing higher rates of pregnancy and keeping the pregnancy to term compared with teens in other states.

Rates of teen pregnancy and birth have steadily declined across the U.S. since these rates peaked around 1990. However, teen pregnancy rates in Arkansas have been declining at a slower pace compared with the national average, as shown in the chart on page 8. Between 1988 and 2008, teen pregnancy rates declined 38.7% nationally and 28.7% in Arkansas. These findings suggest that whatever mechanisms are aiding in the reduction of teen pregnancy in the U.S. (e.g., increased access to and use of highly effective contraceptive methods) are not reaching teens in Arkansas in the same way.

To understand why teens in Arkansas experience higher rates of teen pregnancy and birth compared with their peers across the country, it is necessary to examine adolescent sexual risk behavior. Just as Arkansas teens experience higher rates of teen pregnancy and parenthood compared with teens nationally, they also report higher rates of sexual behavior. Compared with their peers across the country, teens in Arkansas report higher rates of ever engaging in sexual activity, engaging in sexual intercourse within the last three months, having had four or more sexual partners, and initiating sex before age 13. In 2011, approximately half (50.3%) of high school-aged teens in Arkansas reported having engaged in sexual intercourse, over a third (38.1%) reported sexual intercourse in the past three months, 19.5% reported having had four or more sexual partners in their lifetime, and 8.4% reported initiating sex before age 13. It is important to note that by engaging in these behaviors, Arkansas teens are not only increasing their risk for pregnancy, but they are also increasing their risk for contracting sexually transmitted infections (STIs) such as Chlamydia, gonorrhea, herpes, and human papillomavirus (HPV).

Teens’ engagement in sexual activity is not necessarily problematic in and of itself. However, sexually active teens in Arkansas are not taking the necessary preventative measures to reduce the risk of unintended pregnancy and STIs. For example, teens in Arkansas use protection at the third lowest rate nationally. Among those who had reported engaging in sexual intercourse in the past three months, nearly three-quarters (72.3%) reported not using a highly effective birth control method (i.e., the birth control pill, injectable birth control, birth control ring, birth control implant, or
Intrauterine device) before last intercourse, nearly half (44.9%) reported not using a condom the last time they had sex, and 19.1% reported consuming alcohol or using other drugs the last time they had sex.13 Alcohol or drug use prior to sexual activity is problematic because teens may be less likely to use contraceptive methods, including condoms, when they have consumed drugs or alcohol. Teens are also at an increased risk of experiencing forced, coerced, or nonconsensual sex (i.e., sexual assault or rape) when under the influence of drugs or alcohol.14,17,18,19

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<th>Sexual Behaviors</th>
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<tbody>
<tr>
<td>Ever engaged in sexual activity</td>
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<td>Engaged in sexual intercourse within the last 3 months</td>
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RATES OF PREGNANCY & BIRTH AMONG TEENS AGES 15-19 IN ARKANSAS & THE U.S.

DECLINES IN TEEN PREGNANCY RATES IN ARKANSAS AND THE U.S., 1988-2008
REPORTED SEXUAL BEHAVIORS AMONG HIGH SCHOOL STUDENTS IN ARKANSAS & THE U.S., 2011

- **Engaged in sexual intercourse within the last 3 months**
  - Arkansas: 35%
  - U.S.: 15%

- **Have had 4 or more sexual partners**
  - Arkansas: 15%
  - U.S.: 10%

- **Initiated sex before age 13**
  - Arkansas: 6%
  - U.S.: 7%

REPORTED SEXUAL RISK BEHAVIOR DURING LAST SEX AMONG SEXUALLY ACTIVE TEENS IN ARKANSAS, 2011

- **Didn't use highly effective birth control method**
  - Arkansas: 80%

- **Didn't use condoms**
  - Arkansas: 60%

- **Consumed alcohol**
  - Arkansas: 20%
IMPACTS OF TEEN PREGNANCY ON WOMEN’S EDUCATIONAL ATTAINMENT

“Less than two percent of teen mothers will graduate from college by age 30.”

In 2012, 4,310 Arkansas girls ages 15-19 gave birth. Though this number has come down from 8,190 teens ages 15-19 giving birth in Arkansas in 2008, rates of teen pregnancy in Arkansas are still disproportionately high. Unfortunately, teen pregnancy and parenthood results in short and long-term negative outcomes for teens, their families and, over time, the community at large, and takes the largest toll on teen girls. Nationally, approximately half of teen mothers finish high school by age 22, which is four years later than typical graduation age (age 18 for most teens in the U.S.). By contrast, approximately 89% of women who do not experience a teen pregnancy finish high school. Furthermore, teenage girls who have a child prior to age 18 are even less likely to graduate from high school; approximately 38% of teen girls who get pregnant before age 18 will graduate high school, with an additional 19% completing a GED. Although some teen girls do complete high school, less than 2% of teen mothers will graduate from college by age 30, which is eight to nine years later than typical college graduation age. These findings demonstrate the significant impact teen pregnancy and motherhood can have on young women’s educational goals, which can impact their future employment and earnings, and even the educational attainment of future generations.
For example, approximately two-thirds of children of teen mothers complete high school (compared to 81% of children of older parents), and nearly one third of daughters of teen mothers will experience teen pregnancy. In Arkansas, teen pregnancy and parenthood bring substantial social and economic costs through immediate and long-term impacts on teen parents and their children, with women bearing the brunt of this burden. Additionally, approximately 20% of infants born to Arkansas teens were not the teens’ first child. The more children a woman has during her teen years, the less likely she is to complete high school or earn a college degree and maintain employment, and the more likely she is to live in poverty. Children of teen mothers are more likely to drop out of high school, have more health-related problems, and are at an increased risk of incarceration during adolescence compared to children without teen moms. Additionally, children of teen mothers are more likely to experience teen pregnancy and childbirth as a teen, and are more likely to experience unemployment as an adult. Children of teen mothers often score lower on early childhood development indicators and school readiness measures compared to children of older women. As a result, children of teen mothers generally have lower educational performance, score lower on standardized tests, and are twice as likely to repeat a grade compared to their peers born to older mothers. In fact, in 2011, 19% of young adults ages 18-24 in Arkansas did not work or go to school, and did not have a degree past their high school diploma. Taken together, these findings demonstrate how teen pregnancy and parenthood perpetuate a cycle of poverty through continued low educational achievement among teen mothers and their children, and economic hardship facilitated by lack of education, particularly among Arkansan women.

“The annual cost of teen childbearing in Arkansas was $143 million in 2008.”
THE HIGHEST TEEN PREGNANCY RATES OCCUR IN THE MOST RURAL REGIONS OF THE STATE.
ECONOMIC COSTS OF TEEN PREGNANCY

It is unquestionable that the negative impact of teen pregnancy on educational attainment has an economic impact on the individual teen, her family, and, over time, the larger community. As such, the high rate of teen pregnancy in Arkansas may be a contributing factor to the high rates of poverty in the state as a whole, which disproportionately impact specific regions of the state.\(^{10}\) For example, much like national trends, the highest teen pregnancy rates occur in the most rural regions of the state. Such areas often lack access to support services that are more readily available in urban and suburban areas, resulting in an increased burden to teen mothers. For a detailed breakdown of teen pregnancy rates by county in Arkansas, see the Appendix.

As previously demonstrated, teen pregnancy significantly impacts the educational potential for teen parents, and teen mothers in particular. Low levels of educational attainment, in turn, negatively impact teen mothers’ opportunities for quality employment and employment in general. This lack of opportunity impedes women from escaping poverty and achieving financial security. This is particularly unfortunate for women, given that they already earn an average of 77% of what men earn, placing them at an even greater financial disadvantage.\(^{11}\) Furthermore, teen mothers’ long-term earning potential takes a substantial hit because they lack educational credentials or take longer to obtain degrees, and, as a result, accrue more student loan debt. It is important to note that the economic disparity between teen parents and individuals who did not experience pregnancy and parenthood as teens should not be attributed entirely to teen childbearing. However, even after controlling for myriad other factors (e.g., growing up in poverty, having parents with low levels of educational attainment, growing up in a single-parent family, having poor performance in school), the CDC maintains that teen parenthood has a negative impact on a teen’s health and income.\(^{12}\)

On the surface, these findings demonstrate an economic burden to the individual, but the larger economy is also negatively impacted. For example, Arkansas taxpayers spent $3.3 billion in costs associated with teen childbirth between 1991 and 2010.\(^{33}\) The annual cost of teen childbearing in Arkansas was $143 million in 2008.\(^{34}\) In addition to the costs associated with teen pregnancy, teen childbearing has significant economic, social and health costs for the state of Arkansas, which can include social programming needed to support childrearing for teen parents, such as Medicaid, Temporary Assistance to Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Head Start.\(^{35,36,37,38}\) Specifically, according to the National Conference of State Legislatures,\(^{39}\) direct costs associated with teen childbearing include $34 million spent on public health care (such as
Medicaid), and $11 million for child welfare. An additional $21 million and $45 million in indirect costs associated with teen pregnancy were spent on higher rates of incarceration in Arkansas and lost tax revenue due to lower earnings and spending, respectively. In 2012, approximately 20% of Arkansans in general, and over 25% of Arkansans under the age of 18 lived below the federal poverty level (i.e., approximately $23,500 for a family of four). Similar to educational attainment, poverty is both a cause and consequence of teen pregnancy that continues to contribute to economic hardship for teen parents, and impacts teen mothers specifically, given that they end up doing an overwhelming majority of the child-rearing.

In Arkansas, teen pregnancy and parenthood also indirectly impact the economy of the state through education. As demonstrated in the chart on page 15, approximately 71% of working Arkansans completed a high school degree or less, with only 22% completing a four-year degree or going on to graduate school. This is particularly problematic because, on average, college graduates earn over $1 million more during their lifetime compared to individuals who drop out of high school. Unfortunately, such consequences tend to cycle and perpetrate economic hardships that can continue to financially impact the state of Arkansas.

Because fewer Arkansas teens are completing high school and going on to college, the population of the state will be less educated, less prepared, and less competitive in the workforce, which impedes earnings potential and increases the need for federal and state support. Arkansas collects less revenue in taxes, loses out on purchasing power, and experiences reduced worker productivity as a result of teen pregnancy and parenthood. In fact, according to the Alliance for Excellent Education, increasing high school graduation rates in Arkansas would significantly boost the state’s economy. If 90% of teens in Arkansas had graduated from high school in 2012, the state would have experienced a $64 million increase in annual earnings, and an approximately $5 million increase in annual state and local tax revenue.
“If 90% of teens in Arkansas had graduated from high school in 2012, the state would have experienced a $64 million increase in annual earnings.”
CURRENT SEXUAL HEALTH PROGRAMMING & BEST PRACTICES

Teen pregnancy remains a salient public health issue both nationally and in Arkansas. To understand why rates of teen pregnancy in Arkansas are so much higher than most other states, it is critical to examine the current sexual health policies and services for teens in the state, and compare them to what has been done to effectively reduce teen pregnancy among teens nationwide. This will allow us to understand what we could be doing in Arkansas to help address this persistent problem.

ARKANSAS

Half of teens in Arkansas are sexually active, and the majority of sexually active teens in Arkansas are not using condoms or highly effective forms of birth control, nor are they learning about such methods of contraception in sex education.45,46

BEST PRACTICE

Fortunately, approaches to lower unintended and teen pregnancy rates have been well documented in the scientific literature. For example, research has shown that recent declines in teen pregnancy rates can be explained by fewer teens being sexually active, and by sexually active teens using birth control, including highly effective forms of birth control, more frequently.47

The CDC48 recommends that communities adopt the following strategies to prevent teen pregnancy:

- Include evidence-based sex education that provides accurate information and supports the needs of teens throughout their development;
- Include efforts to help parents and teens communicate effectively with each other;
- Ensure sexually active teens have access to effective and affordable contraceptives.

Consequently, federal health agencies, state and local health departments, schools, youth providers, and parents have worked together to respond to the need to improve health outcomes among teens, particularly through providing sex education to youth and increasing access to contraceptives through school-based health centers (SBHCs). This report primarily focuses on sex education due to it being a cost-effective primary prevention strategy (i.e., providing youth with the age-appropriate information they need to make healthy decisions before they engage in sexual activity), but also looks at SBHCs as a promising approach to increasing teens’ access to affordable and effective contraception.
“Half of teens in Arkansas are sexually active.”
Sex education is an important strategy to reduce unintended pregnancy among teens because effective sex education focuses on delaying sex among abstinent teens and promoting the use of condoms and other forms of contraception among sexually active teens. School-based sex education provides communities with the opportunity to work with youth and their families to promote healthy behaviors. Although parents can be the primary sex educators for their children, we know that, nationwide, parents overwhelmingly support sex education being offered in schools. For example, based on a national poll conducted by the Kaiser Family Foundation, 93% of parents of 7th and 8th graders and 91% of parents of 9th through 12th graders believed that it is important to have sex education included as part of the school curriculum. Conversely, very small percentages (4% of parents of junior high school students and 6% of parents of high school students) of teen parents believe sex education should not be taught in school.

Currently, there are two overarching frameworks for sex education: (1) comprehensive sex education, and (2) abstinence-only sex education. Comprehensive sex education promotes abstinence as the most effective method of prevention, and also includes information about condoms and other forms of birth control. Abstinence-only education programs stress abstinence, discuss sex only in the context of marriage, and do not discuss condoms and contraception, except to describe failure rates.

“Arkansas is one of only 14 states that do not require schools to provide either sex or STI/HIV education.”
SEX EDUCATION IN ARKANSAS

STATE LAW ON SEX EDUCATION
Arkansas is one of only 14 states that do not require schools to provide either sex or STI/HIV education. However, if schools choose to include sex education or STI/HIV education in their health education course, state law requires that abstinence be stressed. According to Arkansas Code § 6-18-703, public school sex education and HIV/AIDS prevention education programs must “emphasize premarital abstinence as the only sure means of avoiding pregnancy and the sexual contraction of acquired immune deficiency syndrome and other sexually transmitted diseases.” Arkansas law states that abstinence must be stressed despite the fact that research has consistently demonstrated that abstinence-only programs are ineffective in reducing negative sexual health outcomes among teens.

FUNDING FOR SEX EDUCATION
Abstinence-only sex education programming is often the option presented to Arkansas teens as part of their health curriculum. In 2010, Arkansas received over $600,000 in Title V state abstinence-only education funds. However, Arkansas did receive $480,000 as part of the Personal Responsibility Education Programming (PREP), which emphasizes abstinence, but also utilizes evidence-based, medically accurate sex education that includes information on contraception, STI prevention, and responsible decision making.

BOARD OF EDUCATION REQUIREMENTS FOR SEX EDUCATION
Sex education content requirements in Arkansas are less clear than those for other health topics. Although there is no sex education mandate in Arkansas, in order for public schools to be accredited by the Arkansas Board of Education, they must offer health and safety education. Students are required to complete one-half unit in order to graduate, though there are no specific mandates related to the content. The Health and Wellness Framework divides curriculum standards by grades K-8 and 9-12, with specific guidelines for each year. A review of Arkansas’ Health and Wellness Framework from 2011 reveals that the curriculum included limited guidelines and no specific content standards related to sexual health topics. By comparison, content topics such as alcohol, tobacco, and other drugs and nutrition have specific content standards. Table 1 (see Appendix) includes a detailed assessment of each content standard related to sexual health according to the Health and Wellness Frameworks from 2008 used to guide health curriculum.

Content related to sexual health does appear under other content standards. As shown in Table 1, limited aspects of sexual health content (e.g., puberty, HIV/STI transmission, abstinence, and pregnancy prevention) are included in many of the broad content standards (i.e., Human Growth
and Development, Disease Prevention, Community Health Promotion, Healthy Life Skills and Relationships), excluding the five physical education and leisure content areas and Alcohol, Tobacco, and Other Drugs in the K-8 curriculum and Nutrition in both the K-8 and 9-12 curriculum. It is important to note that the description of such content in the K-12 standards is vague and provides limited direction to teachers. For example, one health standard under the Human Development Framework for 9-12 states, “Describe behaviors and methods for pregnancy prevention, including abstinence.”60 This content standard only makes a specific stipulation about abstinence, omitting mention of hormonal methods of birth control, which are highly effective at preventing pregnancy, and latex condoms, which provide protection against STI and HIV as well as pregnancy.

Due to the lack of state mandates or clear guidelines, sex education content in Arkansas is primarily left to the discretion of individual school districts. Arkansas curriculum standards for physical and health education include components of HIV and STI education beginning in grade five. However, aside from requirements related to stressing the importance of abstinence and the possible physical, emotional, and social consequences of sexual activity, no other content standards are specified. Most importantly, there is no specific language about pregnancy prevention. It is particularly discouraging that there is no discussion of sex under the influence of alcohol and other drugs in the K-8 curriculum given that 19.1% of Arkansan teens reported consuming alcohol or utilizing other drugs prior to engaging in sexual intercourse.61

**SEX EDUCATION CONTENT AND IMPLEMENTATION**

Sex education content and implementation is inconsistent and varies widely by school district. According to the 2012 Arkansas School Health Profiles, 42% of high schools require students to take at least two health education courses, and 84% utilize health education curriculum that addresses all eight national standards for health education.62 Table 2 (see Appendix) outlines the percentage of secondary schools in the state of Arkansas in which teachers reported covering specific sexual health topics in the school’s required health course during the 2011-2012 academic year. National medians are included in the table for comparison purposes.

The percentage of school teachers who reported covering topics related to HIV, STI, and condom use are fairly similar when comparing Arkansas to the national medians, though Arkansas still falls below national median rates.63 However, the percentage of teachers who reported covering topics related to hormonal birth control methods is much lower among Arkansas teachers compared with the national data.64 Although a causal relationship cannot be drawn from such findings, these data suggest that one possible reason Arkansas has such high rates of teen pregnancy and birth compared
with national rates is due to the lack of education regarding hormonal birth control methods, which have been deemed by the CDC to be highly effective methods of pregnancy prevention.

**BEST PRACTICE FOR SEXUALITY EDUCATION**

In 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy published Emerging Answers, a meta-analysis of findings from 115 studies, which examined sex education programming over the previous six years. The report identified a number of sex education programs that were effective in reducing sexual behaviors that could lead to unintended pregnancy, including delaying first sexual intercourse; reducing frequency of sexual intercourse; reducing number of sexual partners; increasing condom use; and/or increasing use of contraceptive methods. Programs that have been shown to impact these behaviors are known as evidence-based interventions (EBIs).

The report concluded that effective sex education programs focus on specific behaviors, such as abstaining from sex and using condoms or other contraceptives when engaging in sex. This report and subsequent research has overwhelmingly found several comprehensive sex education programs that have been shown to positively impact behaviors that may lead to preventing unintended pregnancy and STD (e.g., delaying first sexual intercourse, increasing condom use, increasing contraception use), while abstinence-only sex education programs have not been shown to be effective in delaying first sexual intercourse or in changing other behaviors. Thirty-one comprehensive sex education programs are listed on the federal Office of Adolescent Health’s list of EBIs because they were effective in changing behaviors that increase the likelihood of teen pregnancy and STI/HIV transmission. The CDC’s Guide to Community Preventive Services has also reviewed abstinence programs and comprehensive risk reduction programs and found similar results.

Numerous comprehensive sex education programs have been rigorously evaluated, and have been shown to impact young people’s behavior. Based on the research about what works in sex education, public health agencies and organizations have called for investment in comprehensive, medically accurate sex education. Public health organizations such as the American Academy of Pediatrics (AAP), the American Medical Association (AMA), the American Psychiatric Association, the American Psychological Association, and the American Public Health Association have endorsed comprehensive sex education. For example, the AAP recommends that pediatricians “encourage and participate in community efforts to delay onset of sexual activity and to prevent first and subsequent adolescent pregnancies and advocate for implementation and investments in evidence-based programs that provide comprehensive information and services to youth.” The AMA
“[u]rges schools to implement comprehensive, developmentally appropriate sexuality education programs,” which include specific guidelines such as being “based on rigorous, peer reviewed science.”

Furthermore, the federal Teen Pregnancy Prevention Initiative (TPPI) and Personal Responsibility Education Program (PREP), administered by the federal Office of Adolescent Health (OAH) and the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) respectively, have recently invested $180 million per year for five years in replicating EBIs and testing promising programs to add to the list of EBIs. While there is copious evidence supporting the effectiveness of comprehensive sexuality education and EBIs, the peer-reviewed scientific literature has shown that abstinence-only education is largely ineffective. For example, researchers found that abstinence-only sex education programs did not delay sexual initiation, nor were the programs effective in reducing the number of teens’ sexual partners. Additionally, abstinence-only programs were also not effective in increasing teens’ use of condoms and contraception when they did engage in sexual intercourse.

Instead, researchers and public health professionals suggest that abstinence should be included as part of a comprehensive approach to teaching sexuality. For example, the APHA recommends that, “[s]tates should support school districts and local schools to implement abstinence education as a part of comprehensive sexuality education and as an integral part of comprehensive K-12 school health education.”

**SCHOOL-BASED HEALTH CENTERS**

In addition to providing sex education, the CDC recommends increasing teens’ access to effective contraceptives. School-based health centers (SBHC) are an important strategy for improving access to health care, particularly among the most economically disadvantaged communities, similar to many communities in Arkansas. SBHCs and school-linked health centers provide access to a number of primary health care services for students such as access to contraceptive methods, and have been shown to have a positive impact on numerous health and educational outcomes. Researchers also found that a few SBHCs may have reduced teen pregnancy or birth rates, and sexually active females were more likely to have used hormonal contraceptives if their school had an SBHC.

Arkansas state law indicates that SBHCs are permitted to prescribe and distribute contraceptives with written parental consent; however, state funds cannot be used to purchase contraceptives, which restricts access to highly effective methods of pregnancy prevention. The latest Census Report of School-Based Health Centers shows that there were seven SBHCs in Arkansas in 2010-2011, and the Arkansas Department of Education (ADE)
Office of Coordinated School Health (CSH) shows 11 SBHCs in 2011-2012. The extent to which contraceptive methods are actually provided at SBHCs in Arkansas varies based on school district policy. As such, if SBHCs are restricted from providing access to highly effective contraceptive methods, the extent to which they will be effective in reducing teen pregnancy is questionable.

“In addition to providing sex education, the Center for Disease Control recommends increasing teens’ access to effective contraceptives.”

“Abstinence-only sex education programs did not delay sexual initiation, nor were the programs effective in reducing the number of teens’ sexual partners.”
'CHILDREN OF TEEN MOTHERS ARE MORE LIKELY TO EXPERIENCE TEEN PREGNANCY & CHILD BIRTH AS A TEEN.'
SUMMARY & RECOMMENDATIONS

Teens in Arkansas experience some of the highest rates of teen pregnancy in the country. Recent declines in teen pregnancy have been slower in Arkansas compared with the national average. In order to change the status quo and improve rates of teen pregnancy, as well as the educational and economic side effects resulting from teen pregnancy, policymakers, school districts, health care providers, and parents should utilize a coordinated approach. Based on surveillance data and a review of best practices, six action steps are listed below.

ACTION 1: CONTINUE AND IMPROVE INVESTMENT IN SEX EDUCATION IN ARKANSAS
Given the high rates of teen pregnancy and the economic burden associated with teen pregnancy, improved prevention mechanisms are essential, and could save the state significant funds. Arkansas teens are in need of comprehensive sex education programs that have been rigorously evaluated, and have been shown to delay sexual initiation and increase correct and consistent contraceptive use. Arkansas should continue and sustain participation in the federal PREP program to fund evidence-based sex education, which focuses on promoting both abstinence and hormonal contraceptive and condom use.

ACTION 2: IMPROVE SEX EDUCATION STANDARDS AND GUIDELINES IN ARKANSAS SCHOOLS AND SCHOOL-BASED HEALTH CENTERS

It is critical to young people’s sexual health that they receive high-quality sex education in school. School districts should discontinue ineffective and inaccurate abstinence-only programs. School-based health standards and guidelines should provide clear messaging around comprehensive sexuality education, focusing on condoms and contraception as effective strategies to prevent unintended pregnancy among sexually active teens, while also continuing to promote abstinence as an effective strategy for pregnancy prevention. Additionally, school-based clinics should provide medically accurate and age-appropriate sexual health information, including information about condoms and birth control.

ACTION 3: IMPROVE ACCESS TO SEXUAL HEALTH SERVICES IN SCHOOL-BASED AND COMMUNITY-BASED CLINICS
In addition to increased education, the CDC recommends increased access to health services as a means to reduce rates of teen pregnancy. There should be increased investment in school-based clinics, particularly in communities that are disproportionately impacted by high levels of pregnancy among teens such as the most rural regions of Arkansas. State funding should be allowed to purchase condoms and birth control in school-based clinics. This recommendation is consistent with the Academy of Pediatrics’ recent
THE LINK BETWEEN TEENAGE PARENTHOOD AND REDUCED EDUCATIONAL ATTAINMENT IS UNQUESTIONABLE, PARTICULARLY FOR TEEN MOTHERS.
recommendation, which states, “[s]chools should be considered appropriate sites for the availability of condoms because they contain large adolescent populations and may potentially provide a comprehensive array of related educational and health care resources.” Providing teens with better access to highly effective contraceptive methods will substantially reduce the rates of teen pregnancy.

**ACTION 4: PROVIDE EDUCATIONAL SUPPORT FOR TEEN MOTHERS**

The link between teenage parenthood and reduced educational attainment is unquestionable, particularly for teen mothers. Making sure teenage mothers complete high school and even college would substantially increase their earnings potential, which would not only be individually advantageous, but would also benefit the state of Arkansas economically. Improved services and better mechanisms to support teenage mothers with regard to acquiring an education and completing their degrees would, therefore, greatly reduce the economic burden of teen parenthood on young women and the state of Arkansas.

**ACTION 5: IMPROVE FAMILY AND COMMUNITY INVOLVEMENT IN SEX EDUCATION**

Families and communities play a strong role in promoting adolescent sexual health. Parents and other trusted adults should provide honest, factual information about sex and sexuality to give youth the information they need to make healthy decisions. However, parents and adults may not have this information or may not feel comfortable talking to their teens about healthy sexual practices. Many of the evidence-based sex education programs include components that push parent/family involvement. As such, community-based organizations and faith-based organizations should work with parents and teachers to improve communication with children and teens regarding sex, sexuality, and healthy sexual decision making.

**ACTION 6: CONTINUE RESEARCH EFFORTS TO BETTER UNDERSTAND THE IMPACTS OF TEEN PREGNANCY AND CHILDBIRTH ON THE ECONOMIC OUTCOMES FOR WOMEN AND ARKANSAS**

A wealth of research suggests that teenage pregnancy and parenthood negatively impacts women’s economic potential both in terms of earning potential and reliance on public assistance. Continued research investigating the impacts of teen pregnancy and parenthood, as well as mechanisms to help support teen mothers would be helpful to address this issue. As the state would benefit economically and socially from investments in reducing teen pregnancy and birth, research to further document the relationships between teen pregnancy and birth and educational attainment and economic outcomes should be both encouraged and supported. Such research could be utilized to better understand this persistent problem in order to develop and implement evidence-based interventions.
CONCLUSIONS

Compared to other states in the U.S., Arkansas has the third highest teen birth rate and teen pregnancy rate. Because teen girls end up doing a majority of the childrearing, teen pregnancy and parenthood disproportionately impact young women in Arkansas. This is an unfortunate burden placed on young women, which impacts their health as well as their social and economic wellbeing. This report provides substantial evidence of the negative health and economic outcomes experienced by teenage mothers, and gives clear recommendations for improving the status quo. Given that the problem is multidimensional, the response must be multidimensional as well. Improved sexuality education and access to primary prevention (i.e., highly effective birth control methods) can help reduce the rate of teen pregnancy. Additionally, educational support for teen mothers aimed at helping them graduate from both high school and college is drastically needed. Current approaches to address these issues have not been effective. We must work together to provide women in Arkansas with their best chance for education and an economically sound future.
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<td><strong>HUMAN GROWTH &amp; DEVELOPMENT</strong></td>
<td>Sexual health not addressed</td>
<td>Puberty</td>
<td>Changes that occur during adolescence (physical, social, emotional)</td>
</tr>
<tr>
<td><strong>DISEASE PREVENTION</strong></td>
<td>Sexual health not addressed</td>
<td>Communicable and non-communicable diseases</td>
<td>Communicable and non-communicable diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussion of STD, transmission, consequences of transmission, symptoms, prevention mechanisms, social implications of STD, and develop avoidance strategies.</td>
<td>Discussion of STD, transmission, consequences of transmission, symptoms, prevention mechanisms, social implications of STD, and develop avoidance strategies.</td>
</tr>
<tr>
<td><strong>COMMUNITY HEALTH &amp; PROMOTION</strong></td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
</tr>
<tr>
<td><strong>HEALTH LIFE SKILLS &amp; RELATIONSHIPS</strong></td>
<td>Interpersonal Relationships &amp; Human Sexuality Not Addressed</td>
<td>Interpersonal Relationships &amp; Human Sexuality</td>
<td>Interpersonal Relationships &amp; Human Sexuality</td>
</tr>
<tr>
<td></td>
<td>Decision making</td>
<td>• Verbal and nonverbal communication skills</td>
<td>• Appropriate ways of showing affection</td>
</tr>
<tr>
<td></td>
<td>K: recognize personal space.</td>
<td>• Identifying inappropriate behavior</td>
<td>• Refusal skills</td>
</tr>
<tr>
<td></td>
<td>Grade 1: Identifying benefits of healthy relationships; understand consequences of choices in relationships</td>
<td>• Define abstinence as it relates to risky behavior</td>
<td>• Understand abstinence as it relates to risky behavior</td>
</tr>
<tr>
<td></td>
<td>Grade 3: Develop skills that promote positive relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALCOHOL, TOBACCO &amp; OTHER DRUGS</strong></td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
</tr>
<tr>
<td><strong>PERSONAL HEALTH &amp; SAFETY</strong></td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
<td>Violence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Identifying situations that threaten personal safety and may result in abuse including sexual abuse</td>
</tr>
<tr>
<td><strong>NUTRITION</strong></td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
<td>Sexual health not addressed</td>
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</tbody>
</table>
### Curriculum for Both K-8 and 9-12, 2011 (Arkansas Code § 6-18-703)

<table>
<thead>
<tr>
<th>Grade 7</th>
<th>Grade 8</th>
<th>Grades 9–12</th>
</tr>
</thead>
</table>
| Changes that occur during adolescence (physical, social, emotional) | Changes that occur during adolescence (physical, social, emotional) | ▪ HW.2: Describe behaviors and methods for pregnancy prevention, including abstinence  
▪ HW.3: Compare and contrast abstinence to other forms of contraception |
| Communicable and non-communicable diseases  
Discussion of STD, transmission, consequences of transmission, symptoms, prevention mechanisms, social implications of STD, and develop avoidance strategies. | Communicable and non-communicable diseases  
Discussion of STD, transmission, consequences of transmission, symptoms, prevention mechanisms, social implications of STD, and develop avoidance strategies. | ▪ HW.1: Compare and contrast communicable and non-communicable diseases. (e.g., STD, HIV/AIDS, bacterial/viral infections, heredity, lifestyle, environment)  
▪ HW.3: Discuss methods to prevent, reduce, and treat communicable and non-communicable diseases. (e.g., abstinence, diet, exercise, medications, refrain from risky behaviors, vaccines)  
▪ HW.5: Review methods of HIV/STD transmission and contraction  
▪ HW.6: Investigate treatments involved with STD (e.g., counseling, medications, vaccines) |
| Sexual health not addressed | Sexual health not addressed | ▪ HW.1: Access resources that aid an individual in maintaining a healthy lifestyle. (e.g., American Heart Association, American Red Cross, Department of Human Services, Health Department, hospitals, HIV/AIDS clinics, emergency management teams, mental health agencies, State Dental Associations, school) |
| Interpersonal Relationships & Human Sexuality  
- Consequences of sexual interaction  
- Refusal skills  
- Identify the benefits of abstinence as it relates to sexual behavior | Interpersonal Relationships & Human Sexuality  
- Evaluating how sexual decisions influence future, family, peers, community, and future life-mate. | ▪ HW.1: Identify healthy and unhealthy behaviors in relationships (e.g., communication skills, controlling, co-dependency, jealousy)  
▪ HW.4: Apply a variety of strategies and/or skills to demonstrate respect for and responsibility to self and others  
▪ HW.5: Apply a decision making process to various life situations (e.g., addictions, drug use, immunizations, medical check-ups, oral health, sexual activity, teen pregnancy)  
▪ HW.6: Analyze the importance of sexual abstinence and other forms of contraception in teen relationships (e.g., confidentiality, emotional issues, social stigmas)  
▪ HW.7: Examine short-term and long-term responsibilities and consequences of sexual behaviors (e.g., contraception, pregnancy, medical tests)  
▪ HW.8: Utilize effective coping strategies and other refusal skills (e.g., guided practice, role playing) |
| Sexual health not addressed | Sexual health not addressed | Sexual health not addressed |
| Violence  
Develop responses to avoid situations that threaten personal safety including sexual harassment | Sexual health not addressed | ▪ HW: Identify physical, emotional, and legal consequences of abusive and risky situations (e.g., bullying, cyber-bullying, date rape, DUI, Internet dangers, sexual abuse, teen pregnancy, seat belts, sexting) |
| Sexual health not addressed | Sexual health not addressed | Sexual health not addressed |
IMPROVED SEXUALITY EDUCATION AND ACCESS TO PRIMARY PREVENTION CAN HELP REDUCE THE RATE OF TEEN PREGNANCY.
### APPENDIX TABLE TWO

<table>
<thead>
<tr>
<th>Topic</th>
<th>6TH - 8TH GRADE AR</th>
<th>NATIONAL MEDIAN</th>
<th>9TH - 12TH GRADE AR</th>
<th>NATIONAL MEDIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>The difference between HIV &amp; AIDS</td>
<td>71.3</td>
<td>73.5</td>
<td>95.1</td>
<td>94.2</td>
</tr>
<tr>
<td>How HIV &amp; other STDs are transmitted</td>
<td>75.6</td>
<td>76.3</td>
<td>96.5</td>
<td>95.3</td>
</tr>
<tr>
<td>How HIV &amp; other STDs are diagnosed &amp; treated</td>
<td>66.3</td>
<td>67.9</td>
<td>90.8</td>
<td>92.0</td>
</tr>
<tr>
<td>Health consequences of HIV, other STDs &amp; pregnancy</td>
<td>69.4</td>
<td>72.5</td>
<td>95.2</td>
<td>94.3</td>
</tr>
<tr>
<td>The relationship among HIV, other STDs &amp; pregnancy</td>
<td>70.0</td>
<td>67.7</td>
<td>93.6</td>
<td>92.6</td>
</tr>
<tr>
<td>The relationship between alcohol/other drug use &amp; risk for HIV, STDs &amp; pregnancy</td>
<td>73.9</td>
<td>71.6</td>
<td>95.1</td>
<td>93.3</td>
</tr>
<tr>
<td>The benefits of being sexual abstinent</td>
<td>78.0</td>
<td>75.8</td>
<td>96.4</td>
<td>94.8</td>
</tr>
<tr>
<td>How to prevent HIV, other STDs &amp; pregnancy</td>
<td>76.6</td>
<td>74.2</td>
<td>96.6</td>
<td>94.9</td>
</tr>
<tr>
<td>How to access valid and reliable information, products, &amp; services related to HIV, other STDs &amp; pregnancy</td>
<td>67.3</td>
<td>62.1</td>
<td>91.7</td>
<td>90.7</td>
</tr>
<tr>
<td>The influence of media, family, &amp; social &amp; cultural norms on sexual behavior</td>
<td>69.4</td>
<td>69.4</td>
<td>91.8</td>
<td>91.8</td>
</tr>
<tr>
<td>Communication &amp; negotiation skills</td>
<td>68.8</td>
<td>68.4</td>
<td>88.9</td>
<td>89.9</td>
</tr>
<tr>
<td>Goal setting &amp; decision making skills</td>
<td>67.4</td>
<td>67.3</td>
<td>88.2</td>
<td>88.6</td>
</tr>
<tr>
<td>Compassion for persons living with HIV or AIDS</td>
<td>58.8</td>
<td>56.4</td>
<td>81.4</td>
<td>76.5</td>
</tr>
<tr>
<td>How to create &amp; sustain healthy &amp; respectful relationships</td>
<td>73.4</td>
<td>72.1</td>
<td>90.3</td>
<td>91.3</td>
</tr>
<tr>
<td>Efficacy of condoms</td>
<td>46.4</td>
<td>47.0</td>
<td>77.9</td>
<td>80.2</td>
</tr>
<tr>
<td>Importance of using condoms correctly &amp; consistently</td>
<td>40.4</td>
<td>40.4</td>
<td>70.0</td>
<td>70.9</td>
</tr>
<tr>
<td>How to obtain condoms</td>
<td>24.0</td>
<td>22.2</td>
<td>47.3</td>
<td>52.9</td>
</tr>
<tr>
<td>How to correctly use a condom</td>
<td>12.6</td>
<td>16.5</td>
<td>33.2</td>
<td>45.1</td>
</tr>
<tr>
<td>All 4 condom use topics</td>
<td>11.8</td>
<td>14.3</td>
<td>32.4</td>
<td>38.6</td>
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<tr>
<td>How to obtain contraceptives other than condoms</td>
<td>20.5</td>
<td>20.7</td>
<td>49.8</td>
<td>52.6</td>
</tr>
<tr>
<td>How to correctly use contraceptives other than condoms</td>
<td>18.2</td>
<td>18.2</td>
<td>44.3</td>
<td>52.3</td>
</tr>
<tr>
<td>Importance of using contraceptive methods, other than condoms, consistently &amp; correctly</td>
<td>27.7</td>
<td>27.7</td>
<td>57.5</td>
<td>63.2</td>
</tr>
<tr>
<td>Importance of using a condom at the same time as another form of contraception to prevent both STDs &amp; pregnancy</td>
<td>30.8</td>
<td>30.8</td>
<td>59.0</td>
<td>63.2</td>
</tr>
<tr>
<td>All 4 contraceptive topics</td>
<td>16.4</td>
<td>16.4</td>
<td>41.2</td>
<td>46.4</td>
</tr>
<tr>
<td>All 22 HIV, STD, &amp; pregnancy prevention topics</td>
<td>11.2</td>
<td>9.1</td>
<td>27.0</td>
<td>32.3</td>
</tr>
<tr>
<td>Birth control pill</td>
<td>–</td>
<td>–</td>
<td>45.2</td>
<td>56.7</td>
</tr>
<tr>
<td>Birth control patch</td>
<td>–</td>
<td>–</td>
<td>32.4</td>
<td>48.3</td>
</tr>
<tr>
<td>Birth control ring</td>
<td>–</td>
<td>–</td>
<td>25.5</td>
<td>47.3</td>
</tr>
<tr>
<td>Birth control shot</td>
<td>–</td>
<td>–</td>
<td>33.9</td>
<td>51.9</td>
</tr>
<tr>
<td>Implants</td>
<td>–</td>
<td>–</td>
<td>28.2</td>
<td>43.6</td>
</tr>
<tr>
<td>Intrauterine device</td>
<td>–</td>
<td>–</td>
<td>27.7</td>
<td>51.6</td>
</tr>
<tr>
<td>Emergency contraception</td>
<td>–</td>
<td>–</td>
<td>30.0</td>
<td>42.9</td>
</tr>
<tr>
<td>All 7 contraceptives</td>
<td>–</td>
<td>–</td>
<td>19.2</td>
<td>37.7</td>
</tr>
</tbody>
</table>
BIRTHS TO TEENS;
RATE PER 1000 FEMALES AGES 11-17; ARKANSAS BY COUNTY, 2011

STATE 10.2%

Source: Arkansas Department of Health, Center for Health Statistics

<table>
<thead>
<tr>
<th>Infant Health Indicators</th>
<th>Pulaski County</th>
<th>Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births to Teens, Ages 11-17, 2011 (Rate/1000)</td>
<td>10.5</td>
<td>10.2</td>
</tr>
<tr>
<td>Low Birth Weight Babies, 2011 (Percent of all births)</td>
<td>10.4</td>
<td>9.1</td>
</tr>
<tr>
<td>No Prenatal Care during First Trimester, 2011 (Percent of all births)</td>
<td>9.8</td>
<td>18.3</td>
</tr>
<tr>
<td>Infant Mortality Rate, 2011 (Rate/1000 live births)</td>
<td>8.2</td>
<td>7.0</td>
</tr>
</tbody>
</table>
CHILDREN LIVING IN POVERTY; PERCENT OF POPULATION UNDER AGE 18; ARKANSAS BY COUNTY, 2011

STATE 27.8%

Source: U.S. Census Bureau, Small Area Income & Poverty Estimates

<table>
<thead>
<tr>
<th>Family Indicators</th>
<th>Pulaski County</th>
<th>Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Children in Single Parent Families, 2007-2011</td>
<td>40,222</td>
<td>44.3</td>
</tr>
<tr>
<td>Single Female Head of Household, 2010</td>
<td></td>
<td>26.8</td>
</tr>
<tr>
<td>Total Population Living in Poverty, 2011</td>
<td>63,000</td>
<td>16.6</td>
</tr>
<tr>
<td>Children Living in Poverty, 2011</td>
<td>21,239</td>
<td>23.3</td>
</tr>
<tr>
<td>Median Household Income (dollars), 2011</td>
<td>43,898</td>
<td>7.2</td>
</tr>
</tbody>
</table>
THE IMPACT OF TEEN PREGNANCY & BIRTH ON EDUCATION IN ARKANSAS

GRADUATION RATES;
ARKANSAS BY SCHOOL DISTRICT, 2011

STATE 80.7%

Source: Arkansas Department of Education, ADE Statewide Longitudinal Data System
BACHELOR’S DEGREE OR HIGHER; PERCENT OF POPULATION 25 YEARS AND OLDER; ARKANSAS BY COUNTY, 2007-2011

STATE 19.6%

6.5 - 11.8% 11.9 - 18.4% 18.5 - 31.3%

Source: U.S. Census Bureau, 2007-2011 American Community Survey

<table>
<thead>
<tr>
<th>Educational Attainment Rates</th>
<th>Pulaski County</th>
<th>Arkansas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population with a High School Diploma, GED or higher, 2007-2011</td>
<td>224,517</td>
<td>1,574,295</td>
</tr>
<tr>
<td>Population with an Associate Degree, 2007-2011</td>
<td>16,055</td>
<td>113,272</td>
</tr>
<tr>
<td>Population with a Bachelor’s Degree or Higher, 2007-2011</td>
<td>79,162</td>
<td>373,005</td>
</tr>
<tr>
<td>Population with a Graduate or Professional Degree, 2007-2011</td>
<td>29,056</td>
<td>124,878</td>
</tr>
</tbody>
</table>
## TEEN PREGNANCY, CHILDBIRTH AND PREGNANCY PREVENTION

**BASED ON THE DEPARTMENT OF HEALTH & HUMAN SERVICES**

**OFFICE OF ADOLESCENT HEALTH FACT SHEET (2013)**

<table>
<thead>
<tr>
<th></th>
<th>Arkansas</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teen pregnancy rate (per 1,000 females), 2008</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females 15-19</td>
<td>82</td>
<td>68</td>
</tr>
<tr>
<td>Females 15-17</td>
<td>43</td>
<td>37</td>
</tr>
<tr>
<td>Females 18-19</td>
<td>139</td>
<td>113</td>
</tr>
<tr>
<td>Percent decrease in teen pregnancy rates, 1988-2008</td>
<td>29%</td>
<td>39%</td>
</tr>
<tr>
<td><strong>Teen birth rate (per 1000 females)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females 15-19</td>
<td>50.7</td>
<td>31.1</td>
</tr>
<tr>
<td>Females 15-17</td>
<td>23.2</td>
<td>15.4</td>
</tr>
<tr>
<td>Females 18-19</td>
<td>91.0</td>
<td>54.1</td>
</tr>
<tr>
<td>Percent decrease in teen birth rate 1991 to 2011</td>
<td>36%</td>
<td>-9%</td>
</tr>
<tr>
<td>Percent low birth-weight births among females under 20, 2011</td>
<td>10.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td><strong>Percent of high school students using pregnancy prevention at or before last sexual intercourse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school students using a condom</td>
<td>55%</td>
<td>60%</td>
</tr>
<tr>
<td>High school females who used birth control pills</td>
<td>20%</td>
<td>23%</td>
</tr>
<tr>
<td>High school females who used Depo-provera, Nuva Ring, Implanon, or any UID</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>High school students who did not use any method to prevent pregnancy</td>
<td>15%</td>
<td>13%</td>
</tr>
</tbody>
</table>
### Number of Women Ages 13–44 in Need of Publicly Funded Contraceptive Services & Supplies, 2010

<table>
<thead>
<tr>
<th>State &amp; County</th>
<th>Total</th>
<th>Younger than 20</th>
<th>Ages 20–44 &amp; &lt;250% of federal poverty level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>198,090</td>
<td>47,430</td>
<td>150,660</td>
</tr>
<tr>
<td>Pulaski</td>
<td>26,390</td>
<td>5,190</td>
<td>21,200</td>
</tr>
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</table>
REFERENCES

10. Ibid.
11. Ibid.
12. Ibid.
21. Ibid.
22. Ibid.
24. Ibid.
25. Ibid.
28. Ibid.
45 Ibid.
46 Ibid.
48 Ibid.
55 Ibid.
THE IMPACT OF TEEN PREGNANCY & BIRTH ON EDUCATION IN ARKANSAS


53 Ibid.


55 Ibid.


58 Ibid.


60 Ibid.


63 Ibid.

64 Ibid.


66 Ibid.

67 Ibid.

68 Ibid.


www.hhs.gov/ash/oah/oah-initiatives/tp


78 Ibid.


81 Hayley Lofink et al., “2010-2011 School-Based Health Alliance Census Report,” School-Based Health Alliance (2013).


83 Hayley Lofink et al., “2010-2011 School-Based Health Alliance Census Report,” School-Based Health Alliance (2013).
BIBLIOGRAPHY


Lofink, Hayley et al., “2010-2011 School-Based Health Alliance Census Report,” School-Based Health Alliance (2013).


Due to the lack of state mandates or clear guidelines, sex education content in Arkansas is primarily left to the discretion of individual school districts.
WE MUST WORK TOGETHER TO PROVIDE WOMEN IN ARKANSAS WITH THEIR BEST CHANCES FOR EDUCATION AND AN ECONOMICALLY SOUND FUTURE.