erringes is limited, either by legal restrictions or by the attitudes of legal vendors of syringes toward illegal drugs. Elaborate compensatory responses have developed: Injection drug users share syringes, without regard to safety; they disinfect syringes (often imperfectly) using bleach; they buy syringes on the black market at prices several times higher than in stores; they rely on friends or relatives with regular legal access to syringes (such as diabetics); and they establish underground syringe exchanges.\textsuperscript{32} We suspect that if teenagers were faced with limited contraceptive access, similar compensatory responses would develop, and many teenagers would continue to have sex (both safe and unsafe).

Even without new obstacles to seeking contraceptives, current contraceptive practice is not perfect: During 20\% of the time when adolescents are at risk for pregnancy, they do not use contraceptives. A number of factors continue to interfere with adolescents’ consistent contraceptive use, including social issues such as power dynamics between men and women and poverty status.\textsuperscript{33} In addition, each method has a characteristic failure rate, reflecting limitations inherent to the method, as well as less-than-perfect use patterns.

Our methods may have led us to underestimate the number of pregnancies averted by contraceptive use. First, we calculated benefit from contraception only for those months when adolescent respondents were not pregnant. By so doing, we counted contraceptive failures twice: explicitly by incorporating failure rates into our equation for pregnancies averted, and implicitly by excluding respondents and respondent-months when pregnancy occurred due to contraceptive failure. We could have countered this bias by assuming perfect contraceptive use during months in which adolescents were not pregnant or including months during pregnancy due to contraception failure. However, we preferred to use the method that we selected because it is slightly conservative and, we think, easier to document and understand.

Second, we did not adjust contraceptive failure rates for the difference between the first 12 months and subsequent failure rates, which for all age-groups may require a 27\% reduction in estimated failure rates.\textsuperscript{34} However, the adjustment for teenage users is likely to be smaller, since a great proportion of teenage contraceptive use is in the first, more failure-prone year.

The cost savings from these averted pregnancies are considerable. Researchers have estimated that the medical cost of pregnancy is about $3,200 for a woman who does not intend to be pregnant, yet is sexually active and not practicing contraception. These costs include the average medical care required for a full-term pregnancy and delivery, spontaneous or induced abortion, and ectopic pregnancy, weighted to reflect the proportion of pregnancies that result in each of these respective outcomes.\textsuperscript{35} This estimate does not include other costs to states, however, such as children’s Medicaid or public assistance payments.

Cost savings to the public sector for funding contraceptives are well documented. One analysis found that in 1988, 24\% of U.S. women using a reversible method of contraception received family planning services in publicly funded family planning clinics or with Medicaid reimbursement. Assuming a shift to less-effective contraceptive practices, about 1.3 million additional unplanned pregnancies would occur per year in the absence of these services. These pregnancies would cost approximately $1.2 billion in public funds for pregnancy care and abortions, compared with only $412 million spent for the family planning services.\textsuperscript{36} Thus, publicly funded contraceptive services resulted in substantial savings to society.

A study of the use of specific contraceptive methods among adolescents found that these methods are extremely cost-effective.\textsuperscript{37} The average annual cost per adolescent at risk of unintended pregnancy who uses no method was estimated to be $1,267 in the private sector ($677 in the public sector), and climbed to $5,758 over five years ($3,079 in the public sector). Contraceptive use, regardless of the method or payment mechanism, is cost-effective. For example, use of the implant, an extremely effective method, costs approximately $1,533 over five years in the private sector. This translates into an estimated savings of $4,225. The male condom, which is less expensive but also less effective, is estimated to save $4,301.

Given the high personal and social costs associated with adolescent pregnancy in this country, access to reproductive health services remains important for adolescents across all socioeconomic groups, and is even more so for groups who may not be able to pay for health services and contraceptive supplies. More than half (56\%) of 15–19-year-olds who gave birth in the United States in 1988 had an annual family income below $12,000, while only 17\% had a family income of more than $25,000.\textsuperscript{38} The high contraceptive failure rate among adolescents, particularly among those at or just above poverty level, also implies the necessity of continuing educational, counseling and support services to assist them in their contraceptive choices and in using their selected methods consistently.

References

7. AGI, 1994, op. cit. (see reference 4).