

AMERICAN ACADEMY OF PEDIATRICS

Committee on Adolescence

Adolescent Pregnancy—Current Trends and Issues: 1998

ABSTRACT. Although the prevention of unintended adolescent pregnancy is a primary goal of the American Academy of Pediatrics and society, many adolescents continue to become pregnant. Since the last statement on adolescent pregnancy was issued by the Academy in 1989, new observations have been recorded in the literature. The purpose of this new statement is to review current trends and issues on adolescent pregnancy to update practitioners on this topic.

Adolescent pregnancy in the United States continues to be a complex and perplexing issue for families, health care professionals, educators, government officials, and youth themselves.^{1,2} Since 1989, when the last statement on this topic was issued by the American Academy of Pediatrics,³ many important observations and trends have been noted. In this statement, pediatricians are provided more recent data on adolescent sexuality, contraceptive use, and childbearing as well as recommendations for addressing adolescent pregnancy in their communities and practices.

SEXUAL ACTIVITY

The percentage of American adolescents who are sexually active has increased significantly in recent years.⁴⁻⁷ Currently, 56% of girls and 73% of boys have had sexual intercourse before 18 years of age.^{7,8} The average age of first intercourse has decreased to age 17 years for girls and 16 years for boys.⁹ Approximately 1/4 of youth report first intercourse by 15 years of age.^{6,7} Younger teenagers are especially vulnerable to coercive and nonconsensual sex. Involuntary sexual activity has been reported in 74% of sexually active girls younger than 14 years and 60% of those younger than 15 years.⁶ Sexually active youth, like older unmarried adults, usually develop a pattern called serial monogamy over time, which is characterized by monogamous, short-lived relationships with successive partners. Current surveys indicate that 19% of sexually active high school students report having had four or more successive sexual partners.^{6,7}

There are several predictors of sexual intercourse during the early adolescent years, including early pubertal development, a history of sexual abuse, poverty, the lack of attentive and nurturing parents,

cultural and family patterns of early sexual experience, a lack of school or career goals, and poor school performance or dropping out of school.^{1,2,4,6,7} Factors associated with a delay in the initiation of sexual intercourse include living with both parents in a stable family environment, regular attendance at places of worship, and increased family income.^{4,6,7}

CONTRACEPTIVE USE

Despite increasing use of contraception by adolescents at the time of first intercourse,⁶⁻⁸ 50% of adolescent pregnancies occur within the first 6 months of initial sexual intercourse.⁶ Many adolescents who use contraceptives that require a prescription or clinician insertion delay seeing a clinician for a contraceptive prescription until they have been sexually active for 1 year or more.⁶ Adolescent women, like adult women, have changed in their preferences for contraceptive methods in recent years, with decreases in pill use and increases in injectable contraceptive use.¹⁰ Factors associated with increased consistent contraceptive use among sexually active youth include academic success in school, anticipation of a satisfying future, and being involved in a stable relationship with a sexual partner.¹¹

TRENDS IN ADOLESCENT CHILDBEARING

Overview

Approximately 1 million teenagers become pregnant in the United States each year; most of these pregnancies are among older teenagers, ie, those 18 or 19 years old.¹² Approximately 51% of teenage pregnancies end in live births, 35% end in induced abortion, and 14% result in a miscarriage or stillbirth.^{1,2,4,6,12} Historically, the highest teenage birth rates in the United States were during the 1950s and 1960s before the legalization of abortion and the development of many forms of contraception.¹² After the legalization of abortion in 1973, birth rates for US females 15 to 19 years old decreased sharply until 1986, when rates again rose steadily until 1991. Decreases have occurred every year since 1992 (Fig 1).¹²⁻¹⁴ Although these decreases are viewed with much optimism, the teenage birth rate in 1996 (54.7 live births/1000)¹³ was still higher than the rate for 1980.¹²

Other trends in teenage pregnancy statistics are equally worrisome. Although birth rates have been decreasing steadily for white and black teenagers in recent years, 1996 is only the first year that birth rates have dropped for Hispanic teenagers.¹⁴ Although birth rates have dropped for older teenagers, 15- to 19-year-olds, they have remained stable for adoles-

This statement has been approved by the Council on Child and Adolescent Health.

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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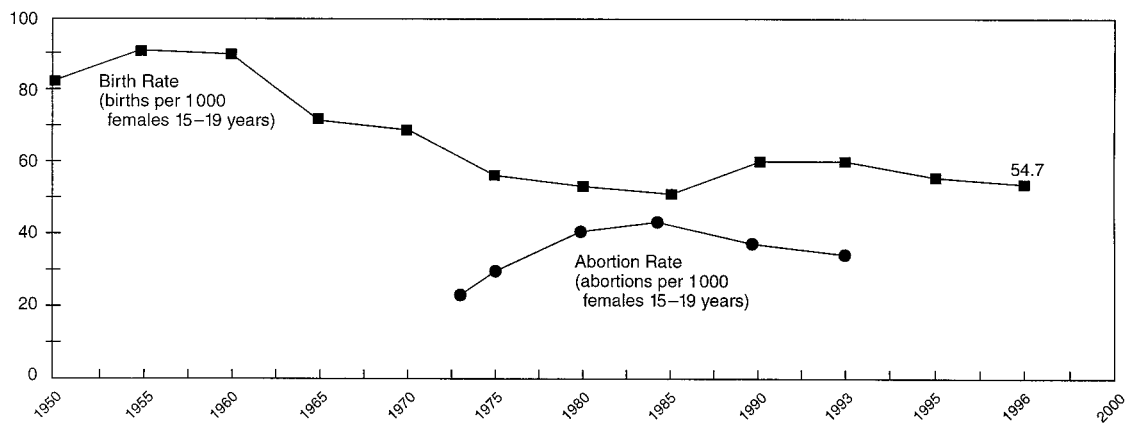


Fig 1. Trends in birth rates and abortion rates among adolescent females age 15 to 19 years. (Adapted from Moore.)¹¹

cents younger than 15 years.¹⁴ Also, once a teenager has had one baby, she is at increased risk for having another. Approximately 25% of teenage births are not first births.¹³

Adolescents at Risk of Becoming Parents

Poverty is correlated significantly with adolescent pregnancy in the United States. Although 38% of adolescents live in poor or low-income families, ~83% of adolescents who give birth and 61% who have abortions are from poor or low-income families. At least one third of adolescents who become parents (males and females) are themselves the product of a teenage pregnancy. Approximately 50% to 60% of adolescents who become pregnant have a history of childhood sexual or physical abuse.⁶

Increased Rates of Unmarried Childbearing

The birth rate to unmarried female adolescents has been rising steadily for the last 30 years. In 1993, 72% of all births to adolescents were outside of marriage.¹² The increasing birth rate to unmarried adolescents is primarily attributable to the tripled rate of births to unmarried white adolescents. Birth rates for unmarried adults also have risen dramatically so that, at present, adolescents account for a smaller percentage of total out-of-wedlock births than in 1970: 30% in 1993 versus 50% in 1970. Births to unmarried teenagers reflect a larger societal trend toward single parenthood.^{5,14,15}

Unintended Versus Intended Pregnancy

Greater than 90% of 15- to 19-year-olds describe their pregnancies as being unintended, and >50% of those unintended pregnancies end in abortion,¹⁶ compared with 35% of adolescent pregnancies overall.¹² Some adolescent pregnancies are intended because the young woman is motivated to become pregnant and have children. Like adults, adolescents give many reasons for wanting to have children; the reason some adolescents are motivated to be mothers at an early age is unclear.¹

Comparison With International Statistics

The United States has the highest adolescent birth rate of all developed countries, despite sexual activ-

ity rates that are similar or higher among Western European teenagers than rates observed for teenagers in the United States.^{8,13,15,16} For every 1000 females 15 to 19 years of age in 1992, 4 gave birth in Japan, 8 in The Netherlands, 33 in the United Kingdom, 41 in Canada, and 61 in the United States (Fig 2).¹³ Some individuals erroneously believe that the higher birth rate for American adolescents compared with their peers in other countries is attributable solely to high birth rates among American minorities. However, non-Hispanic white adolescents in the United States have higher birth rates than the birth rates for teenagers observed in any other developed country.^{6,17} The reasons for this contrast are unclear, but European teenagers may have greater access to and acceptance of contraception. The contrast also may be related to the universal sexuality education that exists in some European countries. Welfare benefits tend to be more generous in Europe than in the United States; thus, it is unlikely that the present welfare system motivates American teenagers to have children.

MEDICAL RISKS OF ADOLESCENT PREGNANCY

Pregnant adolescents younger than 17 years have a higher incidence of medical complications involving mother and child than do adult women, although there are emerging data that these risks may be

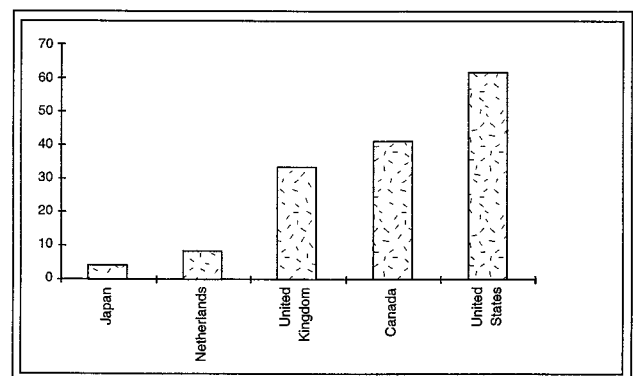


Fig 2. Birth rates for selected developed countries for adolescent females (births per 1000 females 15 to 19 years old) in 1992. (Adapted from Moore¹² and Ventura et al.)¹³

greatest for the youngest teenagers.^{10,18} The incidence of low birth weight (<2500 g) is more than double the rate for adults, and the neonatal death rate (within 28 days of birth) is almost three times higher.^{9,19} The mortality rate for the mother, although low, is twice that for adult pregnant women.^{2,7,10} Adolescent pregnancy has been associated with other medical problems, including poor maternal weight gain, prematurity (birth at <37 weeks' gestation), pregnancy-induced hypertension, anemia, and sexually transmitted diseases. Approximately 14% of births to adolescents 17 years old or younger are premature versus 6% for women 25 to 29 years old.¹⁹ Young adolescent mothers (14 years and younger) are more likely than other age groups to give birth to underweight infants, and this is more pronounced in the African American population.^{1,2,6,10,18,20-23}

Whether biological or social factors account for most medical complications is unclear. Recent reports address this controversy.^{21,22} The only biological factors that have been associated consistently with negative pregnancy results are low prepregnancy weight and height, parity, and poor pregnancy weight gain.²¹ Many social factors have been associated with poor birth outcomes, including poverty, unmarried status, low educational levels, drug use, and inadequate prenatal care.²⁴ A combination of biological and social factors may contribute to poor outcomes in adolescents. Furthermore, adolescents younger than 15 years still may be at risk for poor outcomes compared with adolescents 15 years or older.

PSYCHOSOCIAL COMPLICATIONS OF ADOLESCENT PREGNANCY

Psychosocial problems implicated in adolescent pregnancy include school interruption, persistent poverty, limited vocational opportunities, separation from the child's father, divorce, and repeat pregnancy. Research during the past decade, however, suggests that long-term negative social outcomes are not inevitable. Several long-term follow-up studies indicate that 2 decades after giving birth, most teenage mothers are not welfare-dependent; many have completed high school and many have secured regular employment, and they do not necessarily have large families.^{20,25} Comprehensive adolescent pregnancy programs seem to contribute to the good outcomes.²⁰

When pregnancy does interrupt an adolescent's education, a history of poor academic performance usually exists.²⁶ Having repeat births before 18 years of age has a negative effect on high school completion. Factors associated with increased high school completion for pregnant teenagers include race (African-Americans fare better than do white teenagers), being raised in a smaller family, presence of reading materials in the home, employment of the teenager's mother, and having parents with an increased educational level.^{23,25,26}

CHILDREN OF TEENAGE PARENTS

Research during the past decade supports the common belief that children of adolescent mothers

do not fare as well as do children of adult mothers from a psychosocial perspective.^{25,27} These children have an increased risk of developmental delay, academic difficulties, behavioral disorders, substance abuse, and becoming adolescent parents themselves.

Current theory suggests that teenagers do not possess the same level of maternal skills as do adults. Although there is no evidence that teenage mothers are more likely to abuse their children, adolescents actually may be more neglectful of their children.²⁷ Although current political climate tends to require that adolescent mothers live at home with their own families to qualify for government assistance, there is mounting evidence that except for the youngest adolescents, intensive involvement of the adolescent's mother in rearing of the child may be deleterious for the adolescent and her child.^{24,28} Many adolescent parenting programs are exploring ways to involve the families of the parenting adolescent in child care activities that are helpful.

THE FATHERS OF INFANTS BORN TO ADOLESCENT MOTHERS

The fathers of infants born to adolescent mothers have been the focus of recent reports. Almost two thirds of adolescent mothers have partners older than 20 years of age.^{29,30} In some cases, teenage mothers with older partners may be the victims of sexual abuse through guile or coercion. Adolescent fathers are similar to adolescent mothers; they are more likely than their peers who are not fathers to have poor academic performance, higher school drop-out rates, limited financial resources, and reduced income potential.³¹⁻³³ Some fathers disappear from the lives of their teenage partners and children,³⁴ but many others attempt to stay involved. Many young fathers do not know how to be involved in their children's lives, and many current programs in adolescent pregnancy and parenting are exploring ways to reach and engage young fathers in the lives of their children.

ADOLESCENT PREGNANCY PREVENTION

Many studies and programs have addressed the challenging issue of prevention of adolescent pregnancy.^{1,2,6,7,11,16,17,19,20,35-41} Because adolescent pregnancy is a multifaceted problem, it demands multidimensional solutions that should be tailored to the needs of individual communities. As one researcher has noted, there are no easy answers.⁴² Many models of adolescent pregnancy prevention programs exist.⁴³⁻⁴⁵ Most successful programs include multiple and varied approaches to the problem, such as abstinence promotion, contraception availability, sexuality education, school completion strategies, and job training. Primary prevention (first pregnancy) and secondary prevention (repeat pregnancy) programs are both needed, with particular attention to the adolescents who are at highest risk for becoming pregnant and innovative programs that include males.^{38,46-48} Parents, schools, religious institutions, physicians, social agencies, government, and adolescents all have roles in successful prevention programs.

RECOMMENDATIONS

1. Pediatricians should encourage adolescents to postpone early coital activity. Abstinence counseling is an important role for all pediatricians.
2. Pediatricians should be sensitive to issues relating to adolescent sexuality and be prepared to obtain a developmentally appropriate sexual history on all adolescent patients.
3. Pediatricians should help ensure that all adolescents who are sexually active have knowledge of and access to contraception.
4. Pediatricians should encourage and participate in community efforts to prevent first and subsequent adolescent pregnancies. These efforts may vary widely from one community to another but should be directed to the specific needs of youth in that community.
5. Pediatricians should advocate for comprehensive medical and psychosocial support for all pregnant adolescents. Prenatal care should be tailored to the medical, social, nutritional, and educational needs of the adolescents and should include child care training.
6. Pediatricians should recommend that adolescent mothers not receive early postpartum discharge so that clinicians can ensure that the mother is capable of caring for her child and has resources available for assistance.
7. Pediatricians should advocate for the inclusion of the adolescent mother's partner and father of her child in teenage pregnancy and parenting programs with access to education and vocational training, parenting skills classes, and contraceptive education.
8. Pediatricians should serve as resources for pregnant teenagers and their infants, the teenager's family, and the father of the baby to ensure that optimal health care is obtained and appropriate support is provided.

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