Adolescent Pregnancy

To the Editor.—Ma Spitz and colleagues' document persistently high rates of adolescent pregnancy in the United States, and Dr Litt mentions many of the factors responsible, including poverty and limited access to contraceptives. However, neither article adequately describes the scope and magnitude of these and other factors involved.

Forty percent of US girls live near or below poverty income levels, and these individuals account for 6 of 10 births to teenagers. Adolescent pregnancy rates in the United States are 3 to 10 times higher than those found among industrialized nations of Western Europe, and poverty rates among US youths are higher by a similar magnitude. In areas of the United States with adolescent poverty rates as low as those in Western Europe, adolescent pregnancy rates are similarly low. Access to contraceptives remains limited, and while more than 50% of high school-aged adolescents are sexually active, 84% of high schools make condoms available to students, although the promotion and distribution of contraceptives does not increase adolescent sexual activity. Only 10% of health insurance plans routinely cover the most effective contraceptive methods (two thirds of birth control pills), despite the fact that all methods of contraception are more effective and less costly than no method. Even so, two thirds of private plans (half of public programs) routinely cover induced abortions, and nine tenths pay for sterilization. This puts some women in the unenviable position of having to undergo a surgical procedure either to terminate a preventable pregnancy or to prevent current pregnancies at the cost of a lifetime of infertility.

Finally, neither Spitz et al1 nor Litt2 mentions the role played by adult males in childbearing by adolescents. Of 46,611 marital and unmarried births to school-aged girls in California in 1984 (for which fathers' ages were provided for 80%), 71% were fathered by men whose mean age was 22.6 years, an average of 5 years older than the mothers. Men aged 25 years and older father more children among California school-aged girls than boys younger than 18 years. And sexually transmitted disease (STD) and acquired immunodeficiency virus syndrome (AIDS) levels among females younger than 20 years are 3 to 4 times higher than can be predicted from corresponding rates among other adolescents. In fact, they are closer to the rates among adult males. Many sexual experiences leading to adolescent pregnancy are involuntary. More than half of sexually active girls younger than 15 years have experienced rape by an adult who is substantially older.

There remains much to be done to reverse the high rates of adolescent sexual activity, pregnancy, STD, and abortion. A thorough understanding of the factors involved may motivate physicians, politicians, and the public to concentrate less on strategies that blame and more on strategies that address the root causes of these important health problems.

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To the Editor.—We are confident that Dr Litt's editorial was written with good intentions and that she believes her 3 proposed interventions will decrease adolescent pregnancy and STD. However, they have been tried, and they have failed.

Litt's first proposal concerns postponing "initiation of sexual experimentation until psychosocial maturity guides prospective behavior." We are unsure what "psychosocial maturity" means. However, most parents tell their adolescent children, regardless of age, have not quite "arrived." Two recent studies show that even stable heterosexual relationships with human immunodeficiency virus (HIV)-infected partner, only 60% of the couples used condoms consistently and correctly, despite being informed of risks. Will adolescents, who do not know the HIV status of their partners and who have a propensity
In Reply.—We wholeheartedly agree with Dr Denofoe that programs need to address the role of adult males in childbearing by adolescents and to recognize that sexual activity among teens may not always be voluntary.

Ms Cheng and Dr Cheng questioned our statement that 95% of adolescent pregnancies are unintended. This percentage is based on nationally representative data collected in the 1990 National Survey of Family Growth (NSFG) Telephone Reinterview.3 The NSFG, a national household probability survey, collected data on females aged 15 to 44 years in 1990. In the NSFG, all teens who were ever pregnant, including those who had abortions, were asked if at the time of their last pregnancy they had intended to become pregnant.5 A recent analysis of NSFG survey data for 1988 and 1990 showed that 26% of teens changed their responses to questions about unintendedness between the 2 survey years.3 Pregnancies that were initially reported as unintended were later reported as unintended or vice versa. Despite these differences in responses between the 2 survey years, the overall reported percentage of unintended pregnancies for teens was 95% in 1990. Thus, questioning by clinicians in the clinic setting may often identify teens who did intend to become pregnant or who were ambivalent.

Even if the NSFG finding that 95% of adolescent pregnancies are unintended is an overestimate of unintendedness at conception, it is still clear that the overwhelming majority of teen-aged girls did not intend to become pregnant at the time of their pregnancy. Finally, we agree with Cheng and Cheng that efforts to reduce US adolescent pregnancy rates must focus not only on contraception, but also on providing young women and men with a reason to make responsible childbearing decisions.