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Adolescent Pregnancy

To the Editor.—Ms Spitz and colleagues¹ document persistently high rates of adolescent pregnancy in the United States, and Dr Litt² 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 7 births to teenagers.³ 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.³

Access to contraceptives remains limited. While more than 50% of high school-aged adolescents are sexually active, only 8.4% of high schools make condoms available to students, even though the promotion and distribution of condoms does not increase adolescent sexual activity.⁴ Only 15% of health insurance plans routinely cover the most effective contraceptive methods (two thirds do not pay for birth control pills), despite the fact that all methods of contraception are more effective and less costly than no method.⁵ Even so, two thirds of private plans (albeit few 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 46 511 marital and unwed births to school-aged girls in California in 1993 (for which fathers' ages were provided for 85%), 71% were fathered by men whose mean age was 22.6 years, an average of 5 years older than the mothers.⁶ 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 2 to 4 times higher than can be predicted from corresponding rates among peer teenaged males. In fact, they are closer to the rates among adult males.⁷ 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.⁸

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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1. Spitz AM, Velebil P, Koonin LM, et al. Pregnancy, abortion, and birth rates among US adolescents—1980, 1985, and 1990. *JAMA*. 1996;275:989-994.
2. Litt IF. Pregnancy in adolescence. *JAMA*. 1996;275:1030.
3. Males MA. Adult involvement in teenage childbearing and STD. *Lancet*. 1995;346:64-65.

To the Editor.—Adolescent pregnancy is associated with a variety of individual and societal costs, as the study by Ms Spitz and colleagues¹ notes, and the phenomenon has become an increasingly important element in policy debate. Conservatives and liberals alike are eager to uncover the root causes of adolescent childbirth. We were surprised, therefore, at the study's concluding statement that "95% of adolescent pregnancies are unintended," implying that adolescent pregnancy is accidental. First, we wonder how this 95% figure was obtained. Surveying teens with children about their intent is problematic. Whatever the teen's prepregnancy state of mind, if she has now been hit by the reality of child rearing, her current feeling will likely be that she did not intend these particular consequences. Citing this 95% figure, without questioning further, obscures deeper issues facing American adolescents.

Perhaps adolescent childbirth has less to do with sex and contraception and more to do with the physical and emotional world of American teenagers. The study by Spitz et al notes that adolescent pregnancy can lead to reduced income and educational opportunities; however, other studies imply that reduced opportunities contribute to adolescent pregnancy.² Interviews with unwed mothers in impoverished circumstances often reveal the hope that a child will bring meaning into their lives.³ Unfortunately, adding a baby to the equation causes the cycle of poverty to spiral further.

Questioning the 95% figure also means rethinking the sex education strategies Spitz and colleagues suggest for curtailing adolescent pregnancy. For example, there is evidence that family planning classes do not decrease the rate of subsequent births for mothers on welfare.⁴ If America is truly interested in reducing adolescent pregnancy, we must focus not only on contraception but also on providing young women and men with a reason to make responsible childbearing decisions. When teens in poverty have educational and employment opportunities, emotional support, role models, and moral encouragement, perhaps they will look less to early childbearing as a source of fulfillment. Professionals and lay people from all fields must join forces to thoughtfully address these deeper needs of our adolescents.

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3. Williams CW. *Black Teenage Mothers. Pregnancy and Child Rearing From Their Perspective*. Lexington, Mass: Lexington Books; 1991.
4. Besharov DJ. Welfare: an albatross for young mothers. *Wall Street J*. February 28, 1996:A14.

To the Editor.—We are confident that Dr Litt's Editorial¹ 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 protective behaviors." We are unsure what "psychosocial maturity" means. However, most parents we talk with believe their adolescent children, regardless of age, have not quite "arrived." Two recent studies show that even in stable heterosexual relationships with 1 human immunodeficiency virus (HIV)-infected partner, only 50% of the couples used condoms consistently and correctly, despite being informed of risks.^{2,3} Will adolescents, who do not know the HIV status of their partners and who have a propensity

risks, achieve better results? And, Litt proposes that adolescents receive counseling on methods of pregnancy and STD protection prior to first intercourse experience. We urge that this counseling include mention of the following facts: (1) contraceptive failure rates (eg, the average first-year failure rate of contraception for women, regardless of age and/or marital status, is 7.3% for oral contraception and 15.8% for condoms⁴); (2) oral contraception offers no protection against STDs; (3) condoms offer little or no protection against STDs such as HIV; and (4) women are generally at greater risk than men.

Third, Litt proposes expanding adolescent access to school-based clinics and other family planning clinics. Yet research on the effectiveness of school-based clinics in reducing pregnancy rates is bleak. A study of such clinics in St Paul, Minn, found no significant decrease in birth rates.⁵ A recent study of a Philadelphia, Pa, program to lower adolescent pregnancy rates found that devoting increased resources to adolescent family planning clinics neither increased clinic use nor reduced adolescent pregnancy rates.⁶

We believe old approaches, as advocated by Litt and others, have proven themselves failures. To expand on failed approaches seems foolish. Therefore, we favor a different approach to sexuality education, one that includes the following: emphasizing character development with abstinence-oriented sexuality curricula; encouraging and equipping parents to participate; and identifying media shortcomings in their portrayal of sex, particularly in limited portrayals of consequences of irresponsible sexual activity.

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2. de Vincenzi I. A longitudinal study of human immunodeficiency virus transmission by heterosexual partners. *N Engl J Med*. 1994;331:341-346.
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In Reply.—We wholeheartedly agree with Dr Donohoe 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.¹

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.² 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.³ A recent analysis of NSFG survey data for 1988 and 1990 showed that 26% of teens changed their responses to questions about intendedness between the 2 survey years.⁴ Pregnancies that were initially reported as intended 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. Thorough 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 last 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.

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In Reply.—I thank Dr Donohoe for expanding on many of the points in my Editorial, especially the role of poverty and limited access to effective birth control. To these, he appropriately adds the role of older men in the experience of adolescent pregnancy. Whether the partner or perpetrator is a peer or an adult, however, the factors responsible for increased vulnerability of adolescent girls to unwanted sexual involvement are the same.

Drs Fitch and McIlhenny are critical of the 3 potential levels of intervention I describe, which they mistakenly characterize as interventions that have been tried and have failed. A careful re-reading of the Editorial will underscore my belief that the research findings with regard to pregnancy prevention among adolescents are inconclusive and inconsistent. The problem with most of the extant research is that it has tended to focus on 1 factor or a few factors, rather than on the multiplicity of etiologic factors. Although they take issue with my approach, 2 of the 3 alternative strategies they propose are essentially restatements of points I make, specifically involving family and community through early anticipatory guidance and attending to the presentation of sex irresponsibly in the media. Their other point, emphasizing abstinence-oriented sexuality curricula, is hardly new.

We all wish teenagers would postpone sexual activity until adulthood. The reality is that approximately half will not. Our failure to educate them about prevention of pregnancy and STDs cannot be excused because of our wish that they remain abstinent.

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HIV Counseling and Testing of Pregnant Women

To the Editor.—The Centers for Disease Control and Prevention (CDC) recommends that all pregnant women and women of childbearing age be counseled and encouraged to be voluntarily tested for the human immunodeficiency virus (HIV),¹ and California legally requires physicians to offer voluntary testing to all pregnant women.² Furthermore, the US Senate and House recently agreed on a bill that could require states to demonstrate that 95% of pregnant women get tested in order to receive Ryan White funds.³

The debate over whether testing should be mandatory, routine without explicit consent, or voluntary makes it important to assess physicians' beliefs about these policies and whether guidelines are being followed. We conducted a survey to examine physicians' self-reported beliefs and practices about HIV testing (n=121). Herein we report results concerning HIV testing of pregnant women, using a subsample of physicians who provide care for pregnant women (n=61). We randomly sampled primary care physicians (obstetricians-gynecologists, internists, family practitioners, and general practitioners) in 1995 from the 9-county San Francisco Bay Area using a mailed sur-