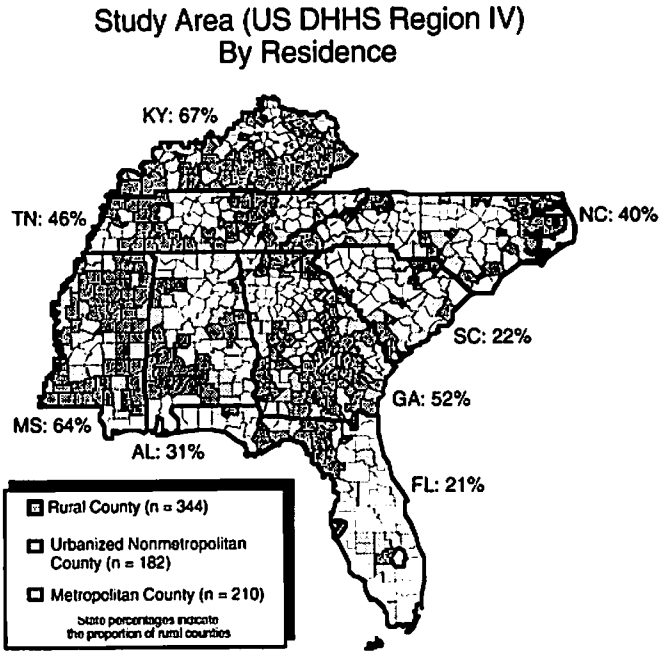
ADOLESCENT PREGNANCY STUDY FOCUSES ON RURAL YOUTH: Rural Teen Pregnancy as Prevalent as Urban

The face of adolescent pregnancy is changing as teens in both urban and rural areas are increasingly confronted with issues of violence, illicit drugs, and earlier sexual activity. Traditionally, the image of pregnant teenagers is cast in inner-city ghettos as something confined to unmarried, impoverished youth from troubled families. New research documents a clearer picture of the real and far-reaching problem of teen pregnancy in the United States that extends well into the pastoral settings of rural America. Despite increased interest in recent years in adolescent health research, very few studies have examined the relationship between rural residence and teen pregnancy antecedents and consequences. This is the first attempt to synthesize what is known about the rural pregnant adolescent, the services that are provided, how they are delivered, by whom they are delivered and where, and who pays for the services. This research was funded under a Delivery Order agreement from the US Agency for Health Care Policy and Research (AHCPR) to the North Carolina Rural Health Research Program in the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. The research focused on the eight states of US DHHS Region IV (see map), and covered three major areas related to adolescent pregnancy and childbearing among rural teens. A summary of findings and key points from each of the three project areas is included below. Readers are directed to Working Papers No. 40, 41, and 42 for further information.



I. Literature Review Findings

Neither the scope nor the impact of adolescent pregnancy in rural areas has been studied extensively, or widely reported in the literature.

Scarcity of Information: Fewer than 10 identified citations contained information specific to rural adolescent pregnancy out of a review of over 2,000 citations in 10 on-line bibliographic databases.

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Existing studies comparing urban and rural youth report similar rates of high-risk behaviors influencing adolescent pregnancy and early childbearing.

Rural youth, including females, use drugs as much if not more than their urban and suburban counterparts:

- Forty-three percent of rural and 40 percent of urban youth report alcohol use.
- Teens in rural areas begin drinking at earlier ages with one-half of rural versus one-third of urban youth reporting having had their first drink at age six to eight years.
- A much higher proportion of rural youth (80%) versus urban youth (63%) report parental approval of drinking.
- Eight percent of both urban and rural youth report cocaine use.

High proportions of both urban and rural youth are sexually active in their teen years.

- Over 50% of rural teens and close to 70% of urban teens have had intercourse.
- The mean age of first intercourse among rural youth in one study was 14 years. By the 12th grade, 55% of rural teens were sexually active.
- Among 7th- to 12th-grade youth in a rural sample in Minnesota, 29% had had sexual intercourse.

Youth risk behaviors are similar for rural and urban teens, but adolescents living in rural areas experience fewer economic and educational opportunities, a higher degree of social isolation, and other barriers that contribute to poor health outcomes.

Rural Residence, Poverty, and Insurance

Rural youth are more likely than urban youth to be living in poverty. Even though rural youth are 22% more likely than metro youth to be living in poverty, rural youth are 20% less likely to be covered by public assistance. Close to 1.8 million rural youth ages 10 to 19 years had no health insurance coverage in 1984, the latest year for which these data have been compiled by residence.

Rural Residence and Confidentiality

Rural adolescents have less anonymity than urban teens. Confidentiality issues may contribute to adolescents' reluctance to seek reproductive health services, counseling, or public assistance even when available.

II. Data Findings and Availability

Despite differences in population distribution across metro and rural* areas in the Southeast, the rates of teen pregnancy and childbearing in rural areas are comparable to those in more urban areas.

Pregnancy Rates

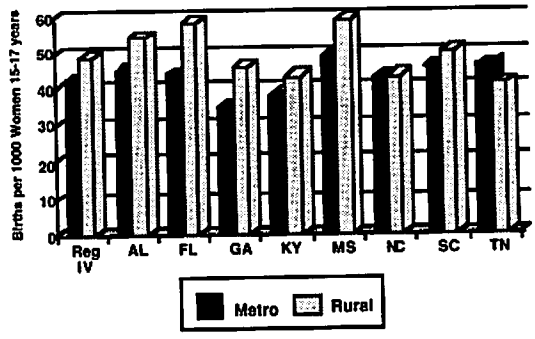
Teens in rural areas are experiencing pregnancy at about equally high rates as their metro counterparts. The pregnancy rate for rural 15 to 19 year olds in 1990 was 93.2 per 1000, compared with 97.7 for metro teens. While rural teens become pregnant at about the same rate as metro teens, they are much more likely to give birth. The birth rate for rural teens is 77.4 per 1000 vs. 66.3 for metro teens, and in some states the birth rates for teens 18 to 19 years are 30 to 40 percent higher than the metro rates.

* Rural defined as thinly populated or less urbanized counties not adjacent to a SMSA. [Codes 7-9 of USDA Rural–Urban Continuum Codes; see Butler & Beale. (1994) Rural-Urban Continuum Codes for Metro and Nonmetro Counties, 1993. Agriculture and Rural Economy Division, Economic Research Service, US Department of Agriculture. Staff Report No. AGES 9425.]

Birth Rates

In almost all states studied, birth rates for teens in rural areas exceed those for 15 to 19 year olds in metro counties. Overall, the birth rate for rural teens is 77.4 births per 1000 compared with 66.3 per 1000 for metro 15 to 19 year olds. White rural teens have much higher birth rates than white teens in metro areas (66.5 versus 50.9 per 1000); for black teens, the rural childbearing rate (109.1) is lower than the metro rate (114.3). For older teens aged 18 to 19, birth rates for both blacks and whites are higher in rural than urban areas—in some states as much as 30 to 40 percent higher.

Birth Rates for Adolescents Aged 15-17, 1990
US DHHS Region IV



Abortion Rates

Abortion rates vary considerably across states in the Region. Adolescents and older women in North Carolina have abortion rates that are twice those of women in Mississippi (36.4 vs. 16.9 per 1000 for 15 to 19 year olds, and 26.8 vs. 13.8 per 1000 for women 20 to 34 years, respectively). Rural women of all ages have lower abortion rates than their metro counterparts, with a rural teen rate (16.2) about half that of metro teens (32.7). Rural black teens have a much lower rate than metro black teens (17.1 versus 43.6). Although not as pronounced, a large difference also exists in abortion rates among white teens (15.7 for rural 15 to 19 year olds, compared with 27.7 for their metro counterparts).

Repeat Pregnancy

Repeat pregnancy is common among teens in the region; in both rural and metro areas close to 30% of all births to 15 to 19 year olds are the result of repeat pregnancies. Almost half of all rural black teens aged 18 to 19 years giving birth in 1990 were experiencing repeat pregnancies. One-third of rural white 18 to 19 year olds also experienced repeat pregnancies. The proportions are only slightly higher in metro areas: 52 percent for black teens and 35 percent for white 18 to 19 year olds. Of great concern is repeat pregnancy for very young adolescents, with more than five percent of 10 to 14 year olds giving birth in 1990 having repeat pregnancies.

Findings for Early Adolescents

In the five Southeastern states that report pregnancy data, a total of 2636 10 to 14 year olds became pregnant in 1990. Over 1500 very young adolescents gave birth in 1990. The youngest adolescents have the highest abortion ratios of any age group, with over 40% of pregnancies to 10 to 14 year olds ending in abortion. This is especially true for white metro teens with over 60% of pregnancies ending in abortion. In rural areas, 49 percent of pregnancies to young white teens and 28 percent of pregnancies to young black teens end in abortion.

Birth Outcomes

- The rates of poor birth outcomes for teens in rural areas are often as high, and sometimes higher, than those for teens living in metro areas. This is true for both black and white teens alike.
- The infant mortality rate among black 15 to 19 year olds is 15.4 in rural areas versus 15.6 in metro areas. Among white teens, the infant mortality rate is 11.2 in rural areas versus 11.4 in metro areas.

- The low birth weight rate among blacks is 13.8 in rural areas versus 13.7 in metro areas. For whites, the low birth weight rate is 8.0 in rural areas versus 7.8 in metro areas.
- The youngest teens, 10 to 14 years old, seem to be at a special disadvantage in rural areas. Infant mortality rates for births to the youngest black teens are 28.5 per 1000 in rural areas versus 17.2 in metro areas. Rates of low birth weight are as high as 16.8 percent for black rural 10 to 14 year olds and 15.2 for black metro teens.

Infant Mortality Rate* by Race and Residence Adolescents (15-19 yrs), Region IV, 1990

	White		Black	
State	Metro	Rural	Metro	Rural
AL	12.2	11.0	18.0	15.8
GA	6.5	6.9	8.2	11.2
KY	11.3	10.3	18.0	--
MS	12.6	17.5	17.2	19.9
NC	12.9	14.4	14.0	12.2
SC	12.1	--	20.8	13.5
TN	12.5	11.7	20.1	--
Region IV	11.4	11.2	15.6	15.4

* No. Infant Deaths < 1 year per 1,000 Live Births
-- Insufficient data to calculate rate

Although the problem of adolescent pregnancy is as important in rural as in urban areas, national and state data currently are not organized for analysis of teen fertility outcomes and risk factors by residence. The paucity of information specific to rural residence in survey databases is attributable primarily to the lack of coding by county. Other major limitations include inconsistent age breakdowns, collection methods, and confidentiality restrictions across all states.

III. Findings: Programs and Services

Adolescents in urban areas generally have broader networks of both public and private health and social service agencies; teens in rural areas are limited to services available through public sector agencies, usually the local health department.

- Every county in each Region IV state has at least one health department serving the local population.
- None of the rural counties in Region IV has a Planned Parenthood facility located in the county. Rural teens must either travel out of their counties, or gain access to family planning services through their local health departments or rural health centers.
- In a national survey of comprehensive programs for adolescents, only 25 percent of rural programs in Region IV provided prenatal care on site and less than half provided family planning services on site. Eighty-four percent of programs and services that serve rural youth are physically located in an urban or suburban area.
- As of 1990, of the 1425 community and migrant health centers (C/MHCs) and rural health clinics (RHCs) nationally, 60 percent were located in rural areas. All C/MHCs provide prenatal care and reproductive health services to adolescents. As part of a special initiative within C/MHCs, the Comprehensive Prenatal Care (CPC) Program, directed toward improved birth outcomes for teens, has tripled its services to pregnant teens since 1992. One-third of the CPC programs in Region IV are located in rural areas.

The availability of abortion varies greatly in both urban and rural areas across Region IV states, resulting in marked state differences in abortion rates for all women, including teens.

State Access Differences

In seven of the eight states studied, over 90% of the non-metro† counties lack an abortion provider; in Alabama, Kentucky, and Mississippi the only abortion providers are in metro counties. In only one state, North Carolina, more than half (53%) of women in non-metro counties have abortion providers.

† Metro defined by OMB classifications, based on 1980 census.

Barriers to Access

The largest and most consistent difference between metropolitan and rural areas is in the likelihood of obtaining an abortion. Rural women may be more likely than metropolitan residents to delay obtaining their abortions because they lack money for both the procedure and travel-related costs.

Percent of Women* Living in Counties without Abortion Providers: Metro vs. Non-Metro**

State	Percent of METRO women living in counties WITHOUT an abortion provider	Percent of Non-Metro women living in counties WITHOUT an abortion provider
NATIONAL	16	83
Alabama	35	100
Florida	13	94
Georgia	25	80
Kentucky	47	100
Mississippi	36	100
N. Carolina	12	47
S. Carolina	48	89
Tennessee	22	98

Source: Henshaw and Van Vort (1992).
*Women aged 15-44, based on 1987 population estimates provided by market statistics.
**Metro defined by OMB classifications, based on 1980 census.

Access Restrictions Steadily Increase

Lack of access to abortion in non-metro areas was intensified between 1985 and 1990 when a 13% reduction occurred in the number of hospitals offering these services and restrictive legislation increased. Minors are required to obtain parental consent prior to abortion in 36 states, and mandatory waiting periods are becoming increasingly common.

Public resources, regardless of residence, are most often directed to supporting the consequences of teen pregnancy rather than its prevention.

Per Capita Spending and Differences in Investments

Per capita expenditures on Medicaid, Aid to Families with Dependent Children (AFDC), and Food Stamps for families headed by adolescents in Region IV states in 1991 ranged from $362.40 in Alabama to as high as $1189.00 in Tennessee. Investments per capita in primary prevention of pregnancy among teens (including state sources, Title X, and other federal sources like Medicaid and block grants) range from only $5.30 in Alabama to $15.40 in Florida. The ratio of expenditures to investments ranges from 65:1 in Florida to as high as 186:1 in Mississippi.

Distribution of Public Assistance

Public assistance health coverage for adolescents as a group, especially in the South, lags far behind any other age group. In contrast, public assistance levels for teens once pregnant, or having given birth, are very high: 25 percent of teen mothers receive AFDC and 70 percent of AFDC women under age 30 had their first child as a teenager. Figures on public assistance for rural teens are not available, but income-eligible women in rural areas are generally less likely to receive public assistance.

Conclusions

Success in effectively addressing the problem of teen pregnancy, be it inner-city, suburban, or rural youth, involves a range of social, educational, and health factors. The political will of a community to acknowledge the problem and then approach it using the unique combination of resources available locally will determine the extent of success. The risk factors confronting today's youth—violence, drugs, sex, joblessness—exist throughout urban and rural sectors of society. However, adolescents living in isolated, rural communities have their own set of cultural, socioeconomic, and political barriers to

overcome, and programs that work in urban areas will not necessarily work well in a rural community in addressing parallel issues. The problem of teen pregnancy is worsening for both urban and rural adolescents, and the solutions must be developed using creative funding strategies in the wake of reduced federal resources.

This research represents the first comprehensive study of rural adolescent pregnancy and efforts to develop rural adolescent pregnancy prevention programs. Results indicate that rural teens are:

- As likely as their urban counterparts to be at risk for early and unplanned pregnancies;
- At higher risk of giving birth;
- As likely to have poor birth outcomes; and
- As likely to experience repeat pregnancies as teens in urban and metropolitan areas.

Despite these data, little research exists that focuses explicitly on teens in rural communities, or the determinants that may explain differences in social norms, use of reproductive health services, and other factors unique to this high-risk population. While this study established a number of key facts, and provided a comprehensive review of the problem of early and unplanned pregnancy and childbearing for teens in rural areas, it confirms the need for further systematic research. Given current welfare and health care reform, there are important questions which demand immediate attention:

- How will services, the costs of which were formerly covered by the public sector, be provided to rural adolescents?
- Will welfare reform pressures that discourage out-of-wedlock childbearing have different effects for rural versus urban adolescents, and are the effects of non-marital childbearing different for rural versus urban teens?
- Will reduced access to services such as family planning and safe, legal abortion affect rural teens more severely than teens in other areas?
- Will rates of pregnancy decrease, or complications from unsafe abortion rise?

The apparent lack of correlation between rural adolescents' use of health services and health outcomes is perplexing:

- To what extent are rural teens using health services in their local community or traveling outside their rural areas to seek counseling, contraceptives, prenatal care, or abortion?
- Do teens in rural areas prefer using services outside their community in terms of confidentiality and anonymity?
- How should services for risk factors, such as alcohol, tobacco, and other drug abuse be different for rural, pregnant teens?

Until recently, little emphasis had been given to rural teens as a high-risk population with special needs. Nearly one-quarter of our nation's youth live in rural areas of the country, and it is therefore necessary to focus on this group with its unique needs, if indeed we are to succeed in reducing rates of high-risk behaviors and poor health outcomes among our nation's youth. ✹

Funding for this project was provided through a Delivery Order [Contract No. 282-93-0038] from the U.S. Agency for Health Care Policy and Research to the North Carolina Rural Health Research Program in the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.