Services for and Needs of Pregnant Teenagers in Large Cities of the United States, 1976

PREGNANCY AMONG TEENAGERS is a major public health problem, with serious medical, health, educational, social, psychological, and vocational implications for the mother and baby. Toxemia and prolonged labor are more common among teenagers than among older women; infant, perinatal, and maternal mortality rates are higher; and the incidence of low birth weight is higher. Further, the risk of child abuse and suicide by teenage mothers is higher. These risks are greater for the very young teenagers and for those aged 18 and 19 years. Because a 1970 survey of 130 large American cities revealed major unmet needs in the care of pregnant teenagers (*1*), we repeated the survey in 1976 to see if progress had been made in the intervening 6 years.

Presently, there are more than 20 million females in the age group 10–19 years, the largest number ever of adolescent girls in the United States. According to one survey, more than a quarter of the young women aged 15–19 are sexually active. Overall rates of childbearing among U.S. teenagers have fallen in recent years, from a high of 97.3 births per 1,000 women 15–19 years old in 1957 to 58.7 in 1974. Because the decline in the fertility rate among older women has been greater than among teenagers, births to teenagers now account for a larger percentage of all U.S. births—in 1974, they comprised 19 percent of all births. The number of births to 10- to 19-year olds has remained approximately the same—in 1974, the number was 608,000; 12,529 were to girls under age 15, and 595,449 to girls aged 15–19 years. From 1970 to 1974, birth rates declined among all teenage nonwhites; among whites the birth rates increased for ages 14 and 15, remained the same for age 16, and declined for ages 17–19 (*2*).

The illegitimacy rate (number of births per 1,000 unmarried women) from 1960 to 1974 declined for all age groups over 20, but increased by 52 percent

Table 1. Status of response by the large cities to the questionnaire, by size of city

Size of city [1]	Number of cities	Responding cities [2]	Nonresponding cities [3]	Percent responses
1 million and more	6	6	..	100.0
750,000–999,999	4	2	2	50.0
500,000–749,999	16	15	1	93.8
350,000–499,999	14	13	1	92.9
250,000–349,999	16	15	1	93.8
175,000–249,999	19	18	1	94.7
150,000–174,999	15	11	4	73.3
125,000–149,999	25	17	8	68.0
100,000–124,999	38	28	10	73.7
Total	153	[4] 125	[5] 28	81.7

[1] 1970 population census.
[2] Covering both health and education departments.
[3] No responses or responses covering only 1 department.
[4] Includes 104 cities with responses from both the local department of health and the local department of education and 21 cities with responses from either of these departments but including consultation with the other department.
[5] Includes 15 cities from which neither department responded and 13 cities from which 1 department responded without consultation with the other department.

for those aged 15 to 19. In actual numbers, out-of-wedlock births to teenagers more than doubled, from 92,000 in 1960 to 221,400 in 1974. In 1974. there were 10,600 such births to girls under 15 and 210,800 to those aged 15 to 19 (*2*).

For wed as well as unwed teenagers who become pregnant at a very young age, the probability of poverty conditions is high; both wed and unwed girls have the common problems of incomplete education, low income status, psychological and developmental problems, excessive fertility, and probable social dependency (*3*).

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Questionnaire Survey

In 1976, a survey was made of the services for and needs of pregnant teenagers in large U.S. cities (excluding Arlington County, Va.). An 8-page questionnaire was mailed to the health officer and superintendent of schools of the 153 cities with populations of 100,000 or more, according to the 1970 census.

Table 2. Provision of special programs to pregnant teenagers and number of teenagers served, by size of city

Size of city	Number of cities responding	Special programs: Provided	Special programs: Not provided	Percent provided	Number of teenagers served, 1974–75: Under 100	100–499	500–999	1,000 or more	Not available
1 million and more ...	6	6	..	100.0	..	..	1	5	..
750,000–999,999	2	2	..	100.0	..	..	2	..	..
500,000–749,999	15	14	1	93.3	2	8	3	..	1
350,000–499,999	13	13	..	100.0	2	8	1	..	2
250,000–349,999	15	14	1	93.3	2	9	..	1	2
175,000–249,999	18	17	1	94.4	5	10	..	..	2
150,000–174,999	11	7	4	63.6	2	3	..	..	2
125,000–149,999	17	9	8	52.9	4	4	..	..	1
100,000–124,999	28	25	3	89.3	14	6	..	..	5
Total	125	107	18	85.6	31	48	7	6	15

During the spring and fall of 1976, three followup questionnaires were mailed to the same officials. Responses covering both the departments of health and of education were received from 125 or 81.7 percent of the 153 cities (table 1).

Questionnaire Responses

Special programs for pregnant teenagers. Of the 125 respondent cities, 107 or 85.6 percent reported having a special program of some type for pregnant teenagers in 1976 (table 2). In general, the larger cities had higher percentages of special programs. In 1970, 111 (85.4 percent) of the 130 respondent cities reported having special programs. Despite the seriousness of the problem, the number of large cities with special programs did not increase from 1970 to 1976. Caseload data were provided by 92 cities in 1976. In general, the caseloads were relatively small; for instance, 31 cities (about one-third of the cities that provided caseload data) reported that they provided care for fewer than 100 girls a year. Only 13 cities (about one-seventh of cities reporting caseloads) indicated that they provided care for 500 girls or more a year. These data point to a need to explore the issue of expanding existing programs for pregnant teenagers.

Special programs are sponsored by many agencies, but local departments of education are by far the most frequent sponsors (table 3). The establishment of new special programs increased progressively and reached a peak from 1966 to 1970. During these years, 57 cities had established such programs.

Data were requested on the total cost of special programs and the sources of funds for the school year 1974–75. Many programs are funded by a number of sources, perhaps because the amount of financing needed would be difficult for any single agency to allot. Thus, the need for combined funding is obvious. As shown in table 3, the most frequent sources of funds are the education departments, and they may represent local, State, or Federal funds (Elementary and Secondary Education Act).

Of the 107 cities with special programs, 76 reported information on costs and on numbers of girls served during the 1974–75 school year. The reported average cost per girl that year was $546.17 for programs that were specially funded.

A special program of medical care for pregnant teenagers was reported by 68 cities; 3 cities did not respond to this question. The smaller cities were less likely to have such a program. Of the many sources of medical care for pregnant teenagers, hospitals and health departments were the most frequently re-

Table 3. Special programs for pregnant teenagers, by sponsorship, sources of funds, and sources of medical care

Sponsorship and sources	*Number of cities*
Sponsorship	
Official agencies:	
Education department	90
Health department	19
Maternity and Infant Care Projects	7
Welfare department	7
Model cities	1
Other official agencies	11
Voluntary agencies:	
Florence Crittenton	9
Salvation Army	7
Y.W.C.A.	4
Red Cross	2
Planned Parenthood	1
Other voluntary agencies	7
Hospitals	7
Medical schools	4
Other	1
Sources of funds	
Official agencies:	
Education department	60
Welfare department	13
Health department	11
Maternity and Infant Care Projects	3
Model cities	1
Other official agencies	[1] 78
Voluntary agencies:	
Florence Crittenton	3
Salvation Army	2
Y.W.C.A.	1
Other voluntary agencies	12
United Fund	7
Other	3
Sources of medical care	
Official agencies:	
Health department	29
Maternity and Infant Care Projects	14
Welfare department	7
Education department	5
Hospitals and clinics:	
Hospitals	35
Clinics (type unspecified)	12
Prenatal clinics	9
Private physicians	25
Medical schools	11
Miscellaneous:	
Family planning	2
Planned Parenthood	1
Maternity homes	1
Well-child conference	1
U.S. Navy	1
Other	11

[1] 38 State, 25 local, 13 Federal (type not stated), 1 title 19, and 1 was the Appalachian Regional Committee.

ported, followed by private physicians and Maternity and Infant Care Projects (table 3).

As shown in table 4, the following five services were provided most frequently in the special programs for pregnant teenagers: counseling, special education, family life education, instruction in nutrition, and special health classes. Least frequently provided were treatment for alcoholism, treatment for drug abuse, abortions, services for juvenile delinquents, and maternity homes. Although contraception and sex education should be given high priority for sexually active teenagers, 10 other services (counseling, special education, family life education, nutrition, special health classes, sex education, social service, home visiting, interdisciplinary staff, and vocational assistance) were provided more frequently than contraception, and the 5 most frequently provided of these 10 services were provided more frequently than sex education.

The types of providers of medical care for pregnant teenagers are listed in the following table by medical and nonmedical categories; interestingly, the nurse midwife and the nurse practitioner are playing an increasingly important part in providing such care.

Types of providers	*Number of cities*
Medical:	
Obstetrician	79
General practitioner	51
Pediatrician	33
House staff	12
Other	6
Nonmedical:	
Nurse practitioner	20
Nurse-midwife	8
Other	5

Table 4. Content of special programs for pregnant teenagers, by size of city

Special program	*Size of city*									*Total number of programs*
	1 million and more	*750,000–999,999*	*500,000–749,999*	*350,000–499,999*	*250,000–349,999*	*175,000–249,999*	*150,000–174,999*	*125,000–149,999*	*100,000–124,999*	
Counseling	6	2	13	12	14	17	6	12	22	104
Special education	6	2	12	12	14	14	7	11	22	100
Family life education	6	2	12	13	14	15	8	10	20	100
Nutrition program	6	2	12	10	14	15	8	10	22	99
Special health classes	6	2	12	12	15	12	7	10	21	97
Sex education	6	2	10	12	15	13	6	10	19	93
Social service	6	2	13	11	14	16	4	9	16	91
Home visiting	6	2	12	10	12	13	6	7	18	86
Interdisciplinary staff	6	2	10	10	12	13	5	4	19	81
Vocational assistance	6	2	8	8	13	11	5	5	18	76
Contraception	5	2	7	9	11	8	3	7	11	63
Special medical care	5	2	8	9	7	10	1	6	11	59
Adoption	5	2	7	6	9	9	1	6	9	54
Day care of infants	2	1	7	8	8	8	3	3	10	50
Special work with fathers	4	1	9	4	7	9	2	5	8	49
Pregnancy testing	3	2	7	8	7	6	1	8	6	48
Psychiatric service	3	2	7	7	7	7	..	3	6	42
Legal advice	2	1	8	6	5	5	2	4	6	39
Truancy	2	1	7	4	3	7	2	5	6	37
Maternity homes	4	1	4	6	5	5	1	4	4	34
Juvenile delinquency	..	1	6	3	3	5	1	6	5	30
Abortion	2	..	4	4	5	4	1	4	5	29
Treatment for drug abuse	..	2	4	3	2	1	..	4	5	21
Treatment for alcoholism	..	2	4	2	3	1	..	3	5	20
Number of cities responding	6	2	15	13	15	18	11	17	28	125

Hospitals and private physicians' offices were reported as the places where pregnant teenagers most frequently receive medical care (table 5). Most of the cities reported that teenagers are now being delivered in hospitals. None of the cities reported that maternity homes are still being used for deliveries. The hospitals used are frequently those administered by city or county government and are tax supported. Provision of pregnancy testing was reported by 87 percent of the cities, most frequently by health departments and Planned Parenthood (table 5). Concerning the places providing care for infants (table 5), as found in the 1970 survey (*1*), Maternal and Infant Care and Children and Youth Projects are playing a small role in providing medical care for infants.

Table 5. Places providing medical care for pregnant teenagers, pregnancy testing, and medical care for infants

Place	*Number of cities*
Care for pregnant teenagers	
Hospitals	54
Private physicians	44
Clinics	32
Health department	23
Maternity and Infant Care Projects	10
Medical schools	10
Education department	6
Other	11
Pregnancy testing	
Health department	57
Planned Parenthood	49
Clinics	26
Hospitals	12
Family planning	10
Private physicians	10
Maternity and Infant Care Projects	7
Medical schools	5
Welfare department	3
Model cities	2
Other	21
Care for infants	
Official agencies:	
Health department	27
Well-child conferences	19
Maternity and Infant Care Projects	7
Children and Youth Projects	4
Model cities	1
Other official agencies	4
Hospitals	48
Private physicians	45
Clinics	25
Private pediatricians	7
Medical schools	6
Other	3

Contraception. A total of 109 cities reported that they provided contraceptive services for teenagers. Generally, the smaller the cities, the less likely that such services are available.

Planned Parenthood and health departments were the most frequently mentioned providers of contraceptive services to teenagers, as shown in the following table:

Agency providing contraceptive services to teenagers	*Number of cities*
Planned Parenthood	64
Health department	61
Private physicians	19
Family planning	16
Clinics	16
Hospitals	11
Medical schools	5
Maternity and Infant Care Projects	4
Other	11

The cities reported certain restrictions on contraceptive services to teenagers; 21 cities have an age restriction, 21 require parental consent, 12 have legal restrictions, 8 require payment of a fee, 5 require a financial eligibility test, 4 provide the services only to married teenagers, and 2 provide the services only to teenagers who have had a previous pregnancy.

Abortion. Some 70 percent of the cities reported that abortion services are available to teenagers. In general, the smaller the city, the greater the likelihood that abortion services are not available to teenagers. The most frequent restrictions on abortion services reported are the length of gestation, 48 cities; legal, 27 cities; and parental consent, 16 cities.

Special education. Most of the cities (88.0 percent) provided special education, most frequently in a special school (94 cities). Eleven cities reported having a waiting list, ranging from 30 to 162 girls. This is more obvious in the largest cities. The waiting period reported ranges from 2 weeks to two semesters of school. Most cities reported the inclusion of family life education, 102 cities; provision of special health classes, 101 cities; 96 cities reported provision of sex education; and 70 cities reported provision of premarital or marital counseling. The larger the city, the more likely it is to provide such counseling.

Social service. Most cities reported the availability of social service. It is less likely to be available in the smaller cities. As shown in the following table, the most frequent sources of social service are the welfare departments, voluntary agencies, and health departments.

Sources of social service	*Number of cities*
Welfare department	65
Voluntary agency	33
Education department	32
Health department	15
Hospitals	8
Maternity and Infant Care Projects	8
Adolescent clinics	3
Protective services	2
Other	22

Services available more frequently include counseling, adoption, foster home service, and financial support. Those services least available are housing, day care, transportation, help for the father, and clothing.

Nutrition. About 85 percent (106) of the cities reported the provision of nutrition service for pregnant teenagers. In general, the larger the city, the more likely the service is available. The content of these services most frequently consists of nutrition education. Services least frequently available are special feeding in special classes or maternity homes, commodity distribution program, and special school breakfast.

Followup services. Of the 107 cities that had a special program, 69 or 64.5 percent had followup services—58 cities reported that their program covered followup for both mother and infant; 10 cities, the mother only; and 1 city, the infant only. The followup duration was a year or less for both mother and infant, and the services were mainly medical and social.

Dropouts. For the 91 cities reporting dropouts from the special program, 65 cities reported that more dropouts occurred during pregnancy, and 50 cities reported that more occurred after delivery. The reasons given by the teenagers for such dropouts most frequently were "lack of interest," "lack of day care," and "medical or home problems."

Child abuse and neglect. Of the 125 responding cities, only 17 viewed child abuse and neglect as a problem.

Unmet needs of pregnant teenagers. The numbers of unmet needs reported by the large cities for pregnant teenagers are shown in table 6. All but 10 of the 125 responding cities reported at least 1 unmet need; the most frequently reported need was for social service. Social service includes outreach, support services, psychological and emotional support, foster care, special group homes, education for putative fathers, rape counseling, legal services for minors, child abuse program, emergency housing, making the mother aware of community resources, crisis intervention, marriage couseling, and adoption services.

Table 6. Number of unmet needs reported by large cities for teenage pregnant girls and for their infants, by type of unmet need

Type of unmet need	*Number of unmet needs reported*	
	For teenage pregnant girls	*For infants*
Social services	66	27
Health education	64	45
Health services	41	20
General and administrative services	28	8
Vocational services	26	..
Educational services	25	9
Financial assistance	15	5
Transportation	15	8
Funds in general	13	3
Nutrition services	12	10
Day care	..	89

The second most frequent need reported is for health education. This includes family life education, sex education, parenting classes, contraception counseling, and making the teenager aware of community resources.

The third most frequent need reported is for health services. This includes the need for early medical care, second-trimester abortions, the availability of abortions without parental consent, additional preventive care, availability of pregnancy testing, additional multidisciplinary centers for early prenatal care, dental care, and family planning.

The fourth most frequent need is for general and administrative services, which include expansion of the program for pregnant teenagers and for followup as well as an expanded program for fathers, better coordination between the education and health departments, more staff, and easing of "red tape" in services and care.

The need for vocational services consists of assistance in providing jobs, job training and counseling, and work-oriented education. The need for educational services includes continuing education during and after pregnancy, programs for those teenagers not interested in academic programs, home tutoring, special education for the retarded, teen-parent centers, and life sciences courses.

The need for financial assistance consists of supplemental income for the mother, funding for health care, more adequate aid to dependent children (ADC) grants, and more facilities to furnish free delivery services.

The need for transportation consists of finding ways to take the mother to and from the school and the program.

The need for more funds in general consists of more adequate funding for this program and for a comprehensive care program for all pregnant teenagers.

The need for nutrition services consists of nutrition education, of a more adequate diet for the teenager, and of food supplements.

Unmet needs of infants. All but 22 of the 125 responding cities reported at least 1 unmet need for infants (table 6). The most frequent unmet need reported was day care, including more facilities, funds, staff, and additional day care centers with medical facilities. Day care includes infant and child care services in both community and school, availability of baby sitters, and coordination of special programs for the mothers with day care resources.

The second most frequent need is for health education for the mother in the care of her baby concerning infant participation in infant stimulation, early childhood education, and long-term followup of the child.

The third most frequent need is for social service, which includes training the mother for the role of parent, child abuse and neglect counseling, more growth and development programs, and identification of preschoolers who may develop learning problems.

The fourth most frequent need is for health services. This includes the need for better and less expensive prenatal care, more resources for "sick" as opposed to "well-child" care, more preventive care, greater accessibility to well-baby clinics, and additional public health nursing resources.

The need for nutrition services includes more nutrition programs, food for infants, and training of mothers in the proper feeding of their infants. Education services include training mothers in child care. Transportation services are needed for the mother and her infant to ease their travel to and from the various services. Clothing and furniture, such as cribs, are needed for infants. General and administrative services are needed to permit followup of infants, with free exchange of information about them and their records among cooperating programs.

Comparison of 1970 and 1976 Data

A comparison of the findings of the 1970 and 1976 surveys revealed that significant changes occurred with respect to the services for and needs of pregnant teenagers in the large cities (table 7).

None of the respondent cities in 1976 reported that maternity homes sponsor special programs, nor do they provide medical care for pregnant teenagers. In 1976, more cities were including family life education, nutrition programs, and day care for infants in their special programs than in 1970.

The pediatrician's role as a provider of medical care for the pregnant teenager decreased and the general practitioner's role increased. The well-child conference declined markedly as a source of medical care for infants and children. On the other hand, the number of cities reporting health departments and hospitals as sources of such care increased significantly in 1976.

Pregnancy testing increased markedly, particularly by Planned Parenthood and health departments. The number of cities that provide contraceptive services to teenagers increased by almost 50 percent; again, Planned Parenthood and health departments are the major providers of these services. During the years between the surveys, the number of restrictions on provision of contraceptive services to teenagers decreased—particularly the restrictions concerned with parental consent, marital status of the teenager, and history of previous pregnancy.

When pregnancy has not been prevented and is unwanted, the backup of abortion services is necessary. The percentage of cities that provided abortion services for pregnant teenagers rose significantly in 1976 compared to 1970. The greater availability of pregnancy testing obviously makes it possible to use abortion services in the first trimester with much less risk to the teenager. A marked change occurred in the kinds of legal restrictions on abortion services by 1976. In 1970, 73 cities had legal restrictions, and in 28 cities length of gestation was a restriction; however, in 1976 only 27 cities had legal restrictions, but 48 cities had the restriction of length of gestation. Thus, the restriction of length of gestation increased while legal restrictions markedly decreased. It seems that a greater concern for the health of the mother is reflected in these changes.

The existence of waiting lists for admission of pregnant teenagers to programs of special education is decreasing. Special education programs in a greater number of cities include family life education, sex education, and special health classes. Also, a greater

Table 7. Statistically significant differences between results of 1970 and 1976 studies of services and needs of teenage pregnant girls in large cities of the United States

Item compared	Percent of cities			Chi-square	P
	1970	1976	Difference		
Special program sponsored by maternity homes	15.4	0	−15.4	18.80	< .001
Ability to provide cost of care information	42.5	71.0	28.5	17.07	< .001
Provision of family life education in special program	68.5	80.0	11.5	3.84	< .05
Provision of nutrition program in special program	65.3	79.2	13.8	5.39	< .05
Provision of day care for infants in special program	25.4	40.0	14.6	5.55	< .05
Pediatrician as provider of medical care	42.3	26.4	−15.9	6.45	< .05
General practitioner as provider of medical care in special program	23.8	40.8	17.0	7.64	< .01
Maternity homes as place where medical care is provided	5.4	0	− 5.4	5.05	< .05
Well-child conference as source of medical care for infants	46.9	15.2	−31.7	28.33	< .001
Health department as source of medical care for infants	10.0	21.6	11.6	5.64	< .05
Hospitals as source of medical care for infants	9.2	20.0	10.8	5.12	< .05
Provision of pregnancy testing	60.0	87.2	27.2	22.74	< .001
Pregnancy testing by health department	26.9	45.6	18.7	8.85	< .01
Pregnancy testing by Planned Parenthood	14.6	39.2	24.6	18.46	< .001
Provision of contraception	59.2	87.2	28.0	23.86	< .001
Provision of contraception by Planned Parenthood	32.3	51.2	18.9	8.60	< .01
Provision of contraception by health department	23.0	48.8	25.7	17.27	< .001
Parental consent as a restriction on provision of contraception	43.8	16.8	−27.0	20.70	< .001
Marital status as a restriction on provision of contraception	10.8	3.2	− 7.6	4.47	< .05
Prior pregnancy as a restriction on provision of contraception	13.8	1.6	−12.2	11.58	< .001
Provision of abortion services	16.9	70.4	53.5	72.13	< .001
Legal restriction on provision of abortion services	56.2	21.6	−34.6	30.49	< .001
Length of gestation as a restriction on provision of abortion services	21.5	38.4	16.9	7.87	< .01
Existence of waiting list for special education	26.2	8.8	−17.4	12.04	< .001
Provision of family life education in special education	70.0	81.6	11.6	4.05	< .05
Provision of sex education in special education	61.5	76.8	15.3	6.25	< .05
Provision of special health classes in special education	69.2	80.8	11.6	3.94	< .05
Provision of social services by welfare department	28.5	52.0	23.5	13.75	< .001
Provision of special nutrition program	68.5	84.8	16.3	8.57	< .01
Provision of nutrition education in special nutrition program	63.8	81.6	17.8	9.21	< .01
Provision of extra foods in special nutrition program	36.2	51.2	15.0	5.27	< .05
Provision of special school breakfast in special nutrition program	11.5	25.6	14.1	7.47	< .01
Provision of special school lunch in special nutrition program	37.7	51.2	13.5	4.18	< .05
Educational services as unmet need for pregnant teenagers	79.2	20.0	−59.2	87.08	< .001
General and administrative services as unmet need for pregnant teenagers	73.1	22.4	−50.7	63.53	< .001
Health services as unmet need for pregnant teenagers	58.5	32.8	−25.7	15.88	< .001
Financial assistance as unmet need for pregnant teenagers	36.2	12.0	−24.2	18.91	< .001
Health education as unmet need for pregnant teenagers	0	51.2	51.2	86.16	< .001
General and administrative services as unmet need for infants	15.4	6.4	− 9.0	4.38	< .05
Health services as unmet need for infants	36.2	16.0	−20.2	12.34	< .001
Health education as unmet need for infants	1.5	36.0	34.5	48.07	< .001

number of cities reported that welfare departments are offering social services to pregnant teenagers.

More cities were offering special nutrition programs to pregnant teenagers in 1976 than in 1970, and more cities with such programs were including extra foods, special school breakfasts, and special school lunches.

The 1976 survey showed marked reductions in certain unmet needs compared to the 1970 survey. In 1976, educational services, general and administrative services, health services, and financial assistance decreased significantly as unmet needs for pregnant teenagers. However, the number of cities that reported health education for the mother as an unmet need increased significantly. Although significant decreases occurred in the reported unmet needs of infants for general and administrative services and health services, the unmet needs for health education services for mothers to help them care for their infants increased markedly.

Discussion

From 1970 to 1974, in the United States there was a drop of 7.4 percent in live births to mothers under age 20 (from 656,460 to 607,978). However, the decrease in live births to mothers in this age group in the 153 large cities during the same period was almost twice as great, 13.5 percent (from 217,228 in 1970 to 187,900 in 1974). These figures indicate that —despite an increased number of females in that age group from 1970 to 1974 and an increase in sexual activity (*2*) —the number of births and the rates for these teenagers have dropped significantly. In the large cities, the live births to teenagers constituted 33.1 percent of all live births to this age group in 1970 and 30.9 percent in 1974.

The 92 cities that reported the number of pregnant teenagers in special programs in 1974 served a total of 29,023 girls. But the same cities reported 141,255 live births to teenagers in 1974, according to R. L. Heuser, Chief of the Natality Statistics Branch, National Center for Health Statistics. This means that only 20.5 percent or 1 in 5 of all pregnant teenagers needing special programs were accommodated. Thus, more efforts are needed in outreach, health education, special programs, and provision of facilities to care for pregnant teenagers.

Major changes occurred in services for pregnant teenagers in the large cities between 1970 and 1976. Among these changes, there were both significant increases and decreases.

Increases. In 1976 more of the large cities reported that pregnancy testing and contraceptive and abortion services were available to teenagers. This is evidence of society's movement, in general, toward liberalization of the abortion laws and of making pregnancy testing and contraception available to all women in the United States. Teenagers have benefited from this general pattern. At the same time, the welfare departments of almost twice as many cities were providing social service assistance in 1976 as in 1970. The need for health education, or at least recognition of the need, for teenagers increased greatly from 1970 to 1976; this applies both to the mother herself and to the care of her baby.

Decreases. Fewer of the large cities reported constraints in making contraceptive services available to teenagers, particularly the requirement of parental consent or a prior pregnancy. Also, fewer cities reported having legal restrictions regarding abortion. The role of the maternity home has declined (*4*). Fewer cities reported having a waiting list for special education; this is surprising since relatively small numbers of girls were reported as receiving this service. Fewer cities reported as unmet needs such services as education, health, financial assistance, and general and administrative services. Since the roles of the well-child conference and of the pediatrician have declined, the question arises as to what kinds of services, if any, have replaced them.

Conclusions

Although the 1976 survey revealed that progress has been made since 1970 in the provision of services to pregnant teenagers and their babies, serious unmet needs still remain. These needs include social and health services and health education for the mother herself and day care and health and social services for the infant. Because teenage pregnancy is a major public health problem in the United States, much more attention and public support are strongly indicated.

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