

U.S. Teen Birth Rates Tumble to Record Low

BY HEIDI SPLETE

FROM MORBIDITY AND MORTALITY WEEKLY REPORT

Teen birth rates in the United States fell by 37% over the past 2 decades, reaching the lowest rate ever recorded, according to data from the Centers for Disease Control and Prevention.

Despite those promising data, “we still have a ways to go to improve our teen birth rate to reflect what is seen in other parts of the world,” Ursula Bauer, Ph.D., director

of the National Center for Chronic Disease Prevention and Health Promotion, said in a teleconference.

The birth rate for girls aged 15-19 years in 2008 and 2009 was 39 per 1,000 girls in the United States, Dr. Bauer and Dr. Wanda Barfield, director of the division of reproductive health, National Center for Chronic Disease Prevention and Health Promotion, wrote in the report, which was published in *Morbidity and Mortality Weekly Report* (2011;60:1-8).

However, teen birth rates in the United States are as much as nine times higher than in many other developed countries. Teen birth rates for 2008-2009 were 27 per 1,000 in Great Britain, 10 per 1,000 in Germany and France, and 6 per 1,000 in Sweden and Denmark.

The researchers, from the Centers for Disease Control and Prevention (CDC), reviewed National Vital Statistics System data from 1991 to 2009 on teen birth rates, as well as National Youth Risk Behavior Survey data on sexual activity and contraceptive use. They also reviewed data on sex education and the use of reproductive health services for teens aged 15-19 years from

the 2006-2008 National Survey of Family Growth.

In 2009, teen birth rates were lowest in the Northeast and upper Midwestern states and highest in the Southern states. The states with the lowest birth rates – Connecticut, Massachusetts, New Hampshire, New Jersey, and Vermont – posted rates ranging from 16 to 23 births per 1,000 girls aged 15-19 years. The states with the highest rates – Arkansas, Mississippi, New Mexico, Oklahoma, and Texas – had rates ranging from 59 to 64 births per 1,000 girls aged 15-19 years.

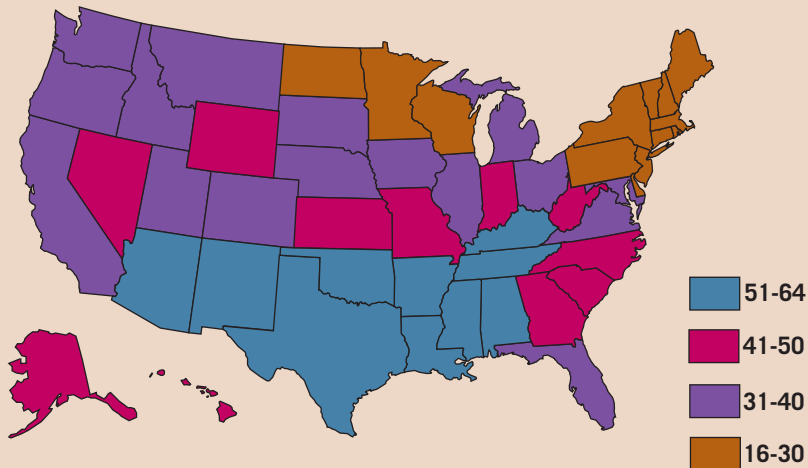
The number of teens having sex declined across white, black, and Hispanic ethnicities for both boys and girls, but black and Hispanic girls remained at least twice as likely as white girls to become teen mothers. Approximately 46% of teens in the United States have had sexual intercourse – down from 54% in 1991 – and 12% of those teens used no contraception, down from 16% in 1991.

“Health care providers have a key role to play in bringing down teen birth rates and teen pregnancy rates,” said Dr. Bauer. “Talking to teens, both boys and girls, about sexual health and reproductive health, and talking about available contraception, is very important for health care providers in their encounters with teens,” she said.

According to a CDC fact sheet, health care providers can help reduce the teen birth rate in the United States by making more birth control options available to sexually active teens, including long-acting methods such as IUDs, and by educating teens about the proper use of birth control options, including condoms and oral contraceptives.

For the complete MMWR Vital Signs report on teen birth rates, visit www.cdc.gov/vitalsigns.

Teen Births Highest in South-Central Region in 2009 (per 1,000 girls aged 15-19)



Source: National Center for Health Statistics

ELSEVIER GLOBAL MEDICAL NEWS

Study Finds 1 in 15 Late Preterm Births Could Be Avoidable

BY SHARON WORCESTER

FROM OBSTETRICS & GYNECOLOGY

One in 15 neonates in a large, retrospective, observational study was delivered at 34-36 weeks' gestation for potentially avoidable or elective precursors for late preterm delivery, and those deliveries were associated with greater risk of neonatal morbidity and mortality than were deliveries at or after 37 weeks for the same indications.

The findings suggest that nearly 7% of late preterm births – and possibly their associated morbidity and mortality – could be avoided, according to Dr. S. Katherine Laughon of the Eunice Kennedy Shriver National Institute of Child Health and Human Development and her colleagues.

The investigators also found that different precursors for late preterm deliveries were associated with differing rates of neonatal morbidity in the study, a factor that has implications for counseling patients about the risks and benefits of late preterm delivery, they reported.

Nearly 66% of preterm deliveries were late preterm deliveries in this study, which compared 15,136 singleton gestations delivered late preterm (between 34 weeks and 36 weeks 6 days) vs. 170,593 gestations delivered between 37 weeks and 41 weeks 6 days. The investigators used data from the Consortium on Safe Labor, a study that included 228,668 deliveries from 12 clinical centers and 19 hospitals representing nine American College of Obstetricians and Gynecologists districts in 2002-2008.

Precursors for late preterm birth included spontaneous labor in 30% of cases, preterm premature rupture of membranes (PPROM) in 32% of cases, and medical indications for an

obstetric, maternal, or fetal condition in 32% of cases. The cause of late preterm birth was unknown in 6% of cases, the investigators said (*Obstet. Gynecol.* 2001;116:1047-55).

The investigators found that among the “indicated” categories, 18% were for soft – or potentially avoidable – precursors. Additionally, in the “unknown” category there were 175 elective deliveries with no other maternal-fetal or obstetric complications, “and together these 1,044 soft or elective precursors made up 6.9%, or approximately 1 in 15, of all late preterm deliveries,” they noted, adding that the “adjusted risk of oxygen use, transient tachypnea of the newborn, mechanical ventilation, respiratory distress syndrome, pneumonia or newborn sepsis, and admission to the NICU all were significantly decreased for neonates with soft or elective precursors delivered at 37, 38, 39, and 40 weeks of gestation compared with late preterm.”

No increase in the risk of stillbirth or neonatal mortality was seen with expectant management of these soft precursors, suggesting that at least 1 in 15 of the deliveries with soft precursors could have been expectantly managed until 39 weeks' gestation, they said.

Furthermore, the differences in neonatal outcomes based on precursor type suggest that “the underlying pathology for precursors is an important determining factor in neonatal morbidity.” Based on these findings, the investigators recommended that elective deliveries be postponed until 39 weeks' gestation. “More prospective data are needed and guidelines should be developed to help providers and women decide which soft precursors can be managed expectantly,” they said.

Dr. Laughon and her associates said they had no relevant financial disclosures.

Delay Delivery When Possible

These findings provide important information about the risks of delivery prior to term – including in the late preterm – and particularly in women with “soft” precursors for late preterm delivery, Dr. Erol Amon said in an interview.

Most research on complications associated with preterm delivery involves babies born before 32 weeks' gestation, he said, noting that because babies born in what is now known as the late preterm period (previously known as near term) typically do quite well, there is some complacency when it comes to delivering in this time period.

However, as this well-conducted study demonstrates, they don't always do well, and for that reason it is important to delay delivery when possible, he said.

The take-home message, he said, is that there is a great deal of physician intervention in this category of patients who have soft precursors for late preterm delivery, but that's not to say physicians are

doing anything wrong.

“In the vast majority of cases they are doing the right thing,” Dr. Amon said.

The decision not to manage these patients expectantly may be an understandable result of concern regarding stillbirth, and although this study suggested that there was no increased risk of stillbirth with expectant management, it wasn't designed for that purpose, so that finding is not conclusive, he said.

Guideline development, as recommended by the authors, could indeed help with decision making in that small percentage of patients with soft or unknown indications for late preterm birth, in whom expectant management might be the best policy, he said.

DR. AMON is professor of obstetrics and gynecology, and director of maternal-fetal medicine at St. Louis University, Mo. Dr. Amon disclosed that he has received honoraria from Alere for speaking on late preterm birth.

VIEW ON THE NEWS