Fertility and Family Planning among White Teenagers in Metropolitan Atlanta

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Family planning services available to teenagers in the Atlanta metropolitan area are described, and fertility patterns among white teenagers are examined.

Introduction

Medical, social, and economic hazards of teenage pregnancies persist as formidable problems in both the private and public health spheres.1-3 Teenagers are more likely than older women to conceive out-of-wedlock and are less apt to receive adequate prenatal care. Births to young teenagers are associated with relatively high rates of prematurity and thus increased infant mortality.4,5

Despite these problems, teenagers have traditionally faced barriers to receiving family planning services. Information concerning all aspects of human sexuality, including contraception, has not been readily available from the schools or the media. When a minor attempts to receive family planning services in most states, she must prove she is either married or emancipated (often by bearing a child), or that she has parental consent. In Atlanta, however, a metropolitan family planning program has provided services to teenagers since the late 1960s, and in July, 1972, a Georgia law went into effect essentially allowing complete family services to minors without parental consent.6 The purpose of this study was to examine fertility patterns among white teenagers in Metropolitan Atlanta and to characterize their utilization of family planning services.

Methods

Fertility data were derived from 1960 and 1970 U.S. Census reports, vital statistics from the Georgia Department of Human Resources, and special analyses of Fulton County births by the Family Planning Evaluation Branch, Center for Disease Control (CDC).* Fertility rates and out-of-wedlock birth ratios of teenagers† were calculated for each year between 1960 and 1971 by age and race for the State of Georgia and the counties of the Atlanta Standard Metropolitan Statistical Area (SMSA‡) (Figure 1).

Descriptions of services offered to teenagers were obtained from personnel of the Atlanta Area Family Planning Council (A AFP C) and directors of the Community Crisis Center Women’s Clinic (Crisis Center), the DeKalb County Health Department, and Planned Parenthood. Patient characteristics were obtained from the computerized record system sponsored by AAFP C and maintained at CDC.7 Tabulations of all white teenagers receiving family planning services were made by the agency providing service.

Records of 2,753 white teenagers who made their first visit to one of the three agencies listed above between September 1, 1970, and March 31, 1972, were analyzed for clinic attendance. Samples of teenagers admitted to Planned Parenthood’s Downtown Clinic and to the Crisis Center between September 1, 1970, and February 28, 1971, were analyzed for age, parity, method of contraception, and

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* Fry, R. Unpublished data.
† Unless otherwise specified, the teenage group includes individuals ages 13 to 19.
‡ Clayton, Cobb, DeKalb, Fulton, and Gwinnett Counties.
FIGURE 1 Atlanta Standard Metropolitan Statistical Area.

clinic of attendance. A sample of white teenagers admitted to DeKalb County clinics between September 1, 1970, and December 31, 1971, was also analyzed for these variables. In addition, the record system provided a listing of these women by census tracts, which were stratified into socioeconomic levels on the basis of education, crowding, and poverty.  

To assess the continuity of care provided, program continuation rates among the subsample of Planned Parenthood and Crisis Center enrollees were studied. (The DeKalb County group was too small to permit this kind of analysis.) Program continuation was measured by the interval between the first visit and the last scheduled appointment or the time of known discontinuation of clinic attendance. Records of the Crisis Center and Planned Parenthood participants were taken from the computer tape, and the dates of visits and scheduled appointments were transferred to punch cards for life table analysis of the continuation rates. If an individual returned to the clinic 2 or more months after a scheduled appointment, she was considered to have ended her attendance at the date of her last scheduled appointment, and subsequent visits were disregarded.

Results

Fertility Characteristics

In Georgia in 1970, 22,331 births occurred to women 19 years of age or younger, representing 23 per cent of all births for that year. In the Atlanta SMSA, infants were born to 6,005 of the 104,105 women ages 12 to 19 in 1970. The 76,121 whites in this age group accounted for 3,383 of these births.  

Figure 2 presents age-specific fertility rates for white teenagers in DeKalb and Gwinnett Counties and in the Atlanta SMSA for 1970. There were no births to 12-year-old whites in the five counties during the year. Gwinnett County had the highest fertility rate for each year of age above 14 with a peak of 191 births per 1,000 females age 19, and an overall rate of 71 per 1,000 for the entire 13
to 19 group. DeKalb County exhibited the lowest rate for each year of age above 15 with a maximum of 117 births per 1,000 females 19 years of age and an overall rate of 42 per 1,000. Clayton, Cobb, and Fulton Counties showed intermediate values at each age. The fertility rate for white teenagers in the Atlanta SMSA was 51 per 1,000 in 1970.

White teenage fertility rates declined between 1960 and 1970 in each of the five counties as well as in the Atlanta SMSA as a whole (Table 1). In 1960, Gwinnett County demonstrated the highest and DeKalb County the lowest fertility rates for this group, 75 and 58 per 1,000 women, respectively. In addition, DeKalb County experienced the greatest percentage decrease in fertility during the decade (27.6 per cent), while Gwinnett had the smallest percentage decline (5.3 per cent).

The fertility rates for white teenagers in the Atlanta area are generally lower than the rates for teenagers of other races. In 1970, the overall fertility rate of teenagers of races other than white in the Atlanta SMSA was 108 per 1,000 with a range of from 100 per 1,000 in Clayton County to Gwinnett County's total of 126 per 1,000. Between 1960 and 1970, the teenage fertility rate for all races fell from 130 to 108 births per 1,000, a decrease of 21.5 per cent, which is similar to the decrease for white teenagers for that period. Decreases in fertility rates for teenagers of races other than white were noted in four of the five metropolitan counties. The only exception was Gwinnett County, which showed an increase of nearly 25 per cent for that period.

The distribution of births to white teenagers by birth order is presented in Figure 3 for Georgia and for the Atlanta SMSA for the years 1960 and 1970. Between 1960 and 1970, the percentage of first order births to white teenagers in Metropolitan Atlanta increased from 72.9 per cent to 82.1 per cent, second order births declined from 21.7 per cent to 15.5 per cent, and third and higher order births fell from 5.4 per cent to 2.4 per cent. A similar trend was noted for the state as a whole. Each of the five counties demonstrated similar decreases in the relative number of high order births.

Table 2 shows the ratio of out-of-wedlock births to all live births for white teenagers in 1971. DeKalb County showed by far the highest out-of-wedlock ratio, but this is due in part to the presence of a Florence Crittendon Home. Many of the unwed mothers list DeKalb as their place of residence at time of delivery, although officials of the Home state that relatively few of the women are full-time residents of the county. Gwinnett County, with the highest overall fertility rate for white teenagers, showed the lowest out-of-wedlock ratio among the metropolitan area counties.
Clayton and Cobb Counties were substantially lower than the statewide figure, while the ratio for Fulton County white teenagers was slightly higher than the state figure. Tabulations of out-of-wedlock birth ratios for selected years between 1960 and 1971 show that in earlier years there was a rising trend in the five counties and the state; this trend was reversed between 1970 and 1971.

Family Planning Services

Publicly supported family planning services are currently provided by 50 clinics in more than 30 locations throughout Metropolitan Atlanta. The AAFPC coordinates the activities of the five sponsoring agencies: Emory University Family Planning Program at Grady Memorial Hospital, Fulton County Health Department, DeKalb County Health Department, Planned Parenthood, and the Atlanta Southside Comprehensive Health Center.

Table 3 presents the distribution of white teenagers among the five agencies in the AAFPC. Active patients are defined as those who are not more than 2 months overdue for a scheduled appointment. Most white teenagers have been served by Planned Parenthood and by the Grady clinics, including the Crisis Center. The Southside Comprehensive Health Center, an Office of Economic Opportunity project, draws its patients from a predominantly black neighborhood and thus has the smallest number of white participants. Further analysis of the data in Table 3 focuses on a few major providers of care to white teenagers. Nearly 50 per cent of the white teenagers active in Atlanta clinics are served by the Downtown Clinic of Planned Parenthood, while the Crisis Center (data included in the Emory-Grady total) serves 17.5 per cent, and the 14 DeKalb County clinics serve a total of 6.8 per cent.

Planned Parenthood's clinics meet at their modern downtown facility 2 mornings per week, in late afternoon sessions on weekdays, and all day Saturday. Local physicians contract to work in these clinics, and there is a salaried staff of nurses, counselors, and administrators. Fees are based on ability to pay. None of the clinic sessions are especially designed for teenagers nor is recruitment specifically directed at this group. As of June, 1972, white teenagers accounted for approximately 22 per cent of Planned Parenthood's population.

The Crisis Center is located in a remodeled house in what used to be Atlanta's midtown "hippie" district. Family planning is one of several free medical and social services offered at the center. It is staffed entirely by volunteer health workers and receives supplies from Grady Hospital and the Division of Maternal and Child Health, Georgia Department of Human Resources. The decor and atmosphere are typically "free clinic"—old chairs, sofas,
floor space for sitting, and splashes of paint and posters on the walls. Members of the staff dress as casually as the patients. The clinic operates 1 night a week for about 4 hr. Recruitment is by word of mouth and through notices in the local underground newspaper. Over 99 per cent of the women seen at the clinic are white, and one-half are teenagers.

The DeKalb County clinics are operated at several locations throughout the county at different times of the month. They are staffed by contract physicians who see the patients 1 week after preliminary evaluation by the nursing staff. The Health Department sponsors discussions on family planning in neighborhood centers and is now developing a program of instruction to be offered in the county schools, both of which tend to channel young women toward participation in the clinics. As of June, 1972, less than 10 per cent of the DeKalb County clinic population were white teenagers.

**Patient Characteristics**

Table 4 lists selected characteristics of the 319 white teenagers admitted to the Planned Parenthood clinics and the 216 admitted to the Crisis Center between September 1, 1970, and February 28, 1971, and the 179 white teenagers admitted to DeKalb County clinics between September 1, 1970, and December 31, 1971. The mean age at first visit for the three clinics is similar, ranging from 17.5 at the Crisis Center to 17.9 years at Planned Parenthood. However, over 86 per cent of the Crisis Center and Planned Parenthood patients have never been married compared with 32.4 per cent of the white teenagers in DeKalb clinics.

Data on the number of living children were absent from one-third of the records. Given this limitation, however, there is a substantial difference between the 41.9 per cent reporting one or more living children in DeKalb clinics and the 5 per cent and 6 per cent so reporting at the other clinics. This difference is consistent with the information on marital status noted above.

Because many of the teenage population had not yet attained their ultimate educational status, traditional assessment of years of education completed was unsuitable for analysis of this group. Instead, age-education grids were constructed for the three clinic samples to determine the number who had not attained an education level appropriate for their age. (A more detailed explanation of age-education grid analysis is presented in Appendix A). Table 4 shows that 30.2 per cent of the white teenagers attending DeKalb clinics showed this type of educational deficiency, a percentage that is between 4 and 6 times greater than those computed for the other two clinics.

The first method of contraception chosen by white teenagers in the three clinic groups was predominantly the oral contraceptive. Of the Planned Parenthood patients 96.6 per cent began using birth control pills, while only 2.2 per cent had an IUD inserted. Of the Crisis Center group, 82.4 per cent chose pills while 11.6 per cent received an IUD. In contrast, only 55.3 per cent of DeKalb teenage patients obtained pills, while 34.6 per cent accepted an IUD.

Table 5 shows the socioeconomic status of white teenagers in the three clinic groups. An average of 20 per cent of each group (over 30 per cent at the Crisis Center) were excluded from this analysis because they resided in areas outside Metropolitan Atlanta or because their addresses were unknown or unclassifiable. The Crisis Center population is evenly distributed among the three higher classes with only 4 per cent in the lower socioeconomic group. Seventy per cent of the DeKalb group is in the middle class, and while substantially fewer DeKalb women are in the upper class, there is a larger percentage of upper middle class teenagers in the DeKalb group. Planned Parenthood has slightly less representation in the middle classes and a higher representation in the upper class. Overall, nearly two-thirds of the white teenagers come from upper middle or upper class areas, while 10 per cent reside in census tracts in the low socioeconomic areas. Eighty per cent of the clinic populations come from the Atlanta Metropolitan area including 40 per cent from Fulton County, 35 per cent from DeKalb, and 4 per cent from Clayton, Cobb, and Gwinnett Counties. Nine per cent were listed as coming from other areas outside Atlanta, while slightly over 10 per cent were unknown.

**Clinic Attendance and Continuation**

Of the 2,753 white teenagers who were admitted to the three AAFPJ clinics after September 1, 1970, over 50 per

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**TABLE 3—White Teenagers in the Atlanta Area Family Planning Services Program, June, 1972**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Enrolled No.</th>
<th>Enrolled %</th>
<th>Active No.</th>
<th>Active %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Parenthood</td>
<td>2,267</td>
<td>50.8</td>
<td>1,397</td>
<td>59.3</td>
</tr>
<tr>
<td>Emory-Grady†</td>
<td>1,763</td>
<td>39.6</td>
<td>749</td>
<td>31.7</td>
</tr>
<tr>
<td>DeKalb County Health Dept.</td>
<td>327</td>
<td>7.3</td>
<td>160</td>
<td>6.8</td>
</tr>
<tr>
<td>Fulton County Health Dept.</td>
<td>96</td>
<td>2.2</td>
<td>53</td>
<td>2.0</td>
</tr>
<tr>
<td>Southside</td>
<td>4</td>
<td>0.1</td>
<td>1</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>4,457</td>
<td>100.0</td>
<td>2,360</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Source: AAFPC Record System.
† Includes Crisis Center.
Discussion

White teenage fertility rates in Metropolitan Atlanta demonstrate the typical pattern of a low rate in the young ages followed by a rise which leads to a peak in the early part of the third decade. Although only a few similar studies have been reported, the Atlanta rates for 1960 are comparable to those reported for the city of Baltimore in 1961 by Stine and associates but are considerably higher than the rates reported by Keeve et al. for the central city of an unspecified mid-Atlantic metropolitan county for the decade 1958–1967. The differences among the counties within the SMSA, especially the relatively high rates at each age for Gwinnett County, deserve further study. Although teenagers of races other than white had substantially higher fertility rates between 1960 and 1970, white teenagers delivered 3,383 newborns in 1970 or 55 per cent of the Atlanta area births to teenagers in that year. Thus, while the rates of white teenage fertility are lower, in absolute numbers white teenagers account for the majority of teenage births in this area.

The time trends in overall fertility and birth order between 1960 and 1970 and the more recent changes in out-of-wedlock births suggest decreases in teenage fertility rates. Among the possible explanations for these phenomena are increased access to abortion and widespread use of contraceptive services. There is evidence that both types of services are being utilized by white Atlanta area teenagers.

Information on induced legal abortions is available from the 1970 and 1971 National Abortion Surveillance Report. In 1970, 205 teenagers received legal abortions in Georgia, and an estimated 300 teenagers may have had them in other states. Assuming that two-thirds of abortions were obtained by whites (the overall white to black ratio is 2:1) and that one-half are performed on residents of the Atlanta area, then about 160 abortions were performed on white Atlanta teenagers. Similar analysis for the 1971 data leads to an estimate of 500 abortions or an abortion to live birth ratio of about 1 to 6.

Family planning services in Atlanta have been responsive to the contraceptive need of the teenagers, despite the past legal ambiguity of providing these services to unmanipulated minors. As of June, 1972, before the revised medical consent law went into effect, over 4,400 white teenagers had been served by, and 2,360 were still active in, Atlanta area clinics. Our study of women attending these clinics indicates that different populations are served in different clinic settings and that more than one approach to delivery of service to teenagers may be needed.

Both Planned Parenthood and the Crisis Center serve young white women who typically are unmarried, have no living children, have achieved educational levels appropriate for their ages, live in upper middle or upper class areas, and use oral contraceptives. Both clinics are located downtown and have little association with the communities in which most of their patients reside. Planned Parenthood has been receptive to the contraceptive needs of teenagers but requires that they be integrated within the general clinic population. The atmosphere at the Crisis Center, created in part by clinic workers who are only a few years older than the patients, is obviously directed toward a younger population. In both clinics young women come specifically for contraceptive or pregnancy-related services, although other counseling and referral are available.

In contrast to the other clinics, the DeKalb County clinic population tends to be married, parous, and less likely to have completed appropriate schooling. This is compatible with the sequence of early pregnancy leading to marriage, termination of schooling, and establishment of a household. The DeKalb clinics are conducted in the context of a full range of health services available to residents of the county; family planning appears to be one of the services utilized by young DeKalb families. The several clinic locations and times, the formal clinic setting, and other

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**TABLE 5—Socioeconomic Status of White Teenagers Admitted to Selected Atlanta Family Planning Clinics, 1970–1971**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>No.</th>
<th>Lower</th>
<th>Middle</th>
<th>Upper</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Center</td>
<td>145</td>
<td>4.1</td>
<td>31.7</td>
<td>30.4</td>
<td>33.8</td>
</tr>
<tr>
<td>DeKalb County</td>
<td>118</td>
<td>13.6</td>
<td>28.8</td>
<td>41.5</td>
<td>16.1</td>
</tr>
<tr>
<td>Planned Parenthood</td>
<td>240</td>
<td>11.7</td>
<td>23.8</td>
<td>25.8</td>
<td>38.7</td>
</tr>
</tbody>
</table>

* Source: AAFPC Record System.

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The percent had made only one visit as of March 31, 1972. White teenagers admitted to one clinic tend to return to that clinic if they continue to receive services in the Atlanta area. Of the 91 women (3 per cent of the total group) who received service at another facility in the Atlanta area, over one-half went to Planned Parenthood. Most of the remainder went to Grady clinics, including some from Planned Parenthood and DeKalb County who were seen later at the Crisis Center.

Cumulative clinic continuation rates for the Crisis Center and Planned Parenthood are plotted in Figure 4. In the first 6 months, the probability of continuation fell gradually to 0.89 in the Crisis Center and 0.97 in Planned Parenthood clinics. Between 6 and 7 months, the rates dropped precipitously to 0.35 and 0.51, respectively, followed by another gradual decline to 0.26 and 0.38 at 12 months. In the 13th month, probabilities declined even further to 0.15 at the Crisis Center and 0.23 at Planned Parenthood. Beyond 13 months, the number remaining in the cohort from each clinic was too small for statistical analysis.

Because data for continuation rates were obtained from computerized records and no effort was made to follow up, no reasons for discontinuation were ascertained. Neither age nor parity varied significantly with length of clinic continuation. In both groups, over 90 per cent chose oral contraceptives.
services, such as immunization, create a neighborhood clinic approach that is convenient to young married women in the county.

Given these differences in population and approach, it would have been valuable to compare continuation patterns among the three clinics. However, because of the smaller size of the DeKalb population, continuation rates were obtained only for Planned Parenthood and the Crisis Center. The continuation data for the latter clinic show a sharp decline between the 6th and 7th month of program participation. This decline represents discontinuation after the first scheduled revisit since most women had received a 6-month supply of pills after the first visit. A secondary decline occurs between 12 and 13 months and represents both missed second revisits among pill users and missed yearly checkups among the smaller number of IUD wearers.

The continuation data further indicate that only 1 of 4 white teenagers who accept contraception at the Crisis Center and 2 of 5 at Planned Parenthood continue in the clinic after 1 year.

Several reasons for clinic discontinuation can be postulated. This young unmarried population may not require continuous contraception because they have intercourse relatively sporadically. A second factor is the high mobility of a population which includes many college students who leave the area and others who come to the city from surrounding areas only to obtain birth control supplies (a pattern thought to be more common with Crisis Center patients). Other possibilities include transfer to the care of a private physician or school clinic, planned or unplanned pregnancies, and dissatisfaction with the clinic. In this study, there was no correlation between length of continuation and age or parity. Assessment of the possible reasons for discontinuation and for the different rates between the Crisis Center and Planned Parenthood groups would require individual patient follow-up which was beyond the scope of this study.

An additional factor in the delivery of family planning services to teenagers is the utilization of private physicians. There is no good estimate of the extent to which private doctors serve teenagers, and we did not attempt to answer this question in our study. However, it is interesting to note that a majority of white teenagers receiving clinic services reside in areas of relative affluence likely to have adequate numbers of physicians to provide contraceptive care. This suggests that other than financial barriers exist to obtaining care from the private sector and that public clinics do fill a significant need in the Atlanta area.

Conclusions

This study was designed primarily to describe fertility rates of and contraceptive services to white teenagers, and it raises more questions that it answers. There are, however, some general points and specific recommendations to be made about both the provision of service and approach to future research. The premise of these recommendations is that fertility of white teenagers is significant and that this group has demonstrated a demand for contraceptive services to control their fertility.

There are different populations within the group of white teenagers. Some seek contraception soon after they begin sexual activity, while others have gone through the cycle of early and possibly unwanted pregnancy, dropping out of school, and marriage before coming to clinic. These
groups should be reached by several complementary approaches including:

- Education in the area of human reproduction, including contraception, beginning in early school grades;
- Presentation by the mass media of similar educational material plus information on where to obtain services;
- Postpartum education and service programs in hospitals.

While the number of new white teenage patients is increasing, continuation rates are low. Further study of the reasons for discontinuation of clinic attendance is needed. Until such data allow the clinics to focus on the causes of discontinuation, some approaches might be to:

- Form advisory groups among teenage patients to obtain feedback on clinic activities;
- Send appointment reminders before scheduled visits and/or provide follow-up after missed appointments. (However, these procedures should be carefully considered; many young women, especially those living with their parents, may not want to be contacted by the clinic.)
- Ask women at each visit whether they are likely to be in the Atlanta area when they are scheduled to return. If not, and if their new residence is known, referral might be made to an appropriate agency for continued care.

The utilization of public clinics by teenagers residing in upper and upper middle class areas suggests that there may be attitudinal barriers to contraceptive care between teenage women and physicians. It is also likely that many young women are receiving birth control information and supplies from private physicians. Both issues deserve further study. A more immediate activity would be to educate physicians through local medical society and obstetrician-gynecologist groups about fertility levels, out-of-wedlock births, abortion ratios, and use of public family planning services among teenagers, with emphasis on data for the communities in which the physicians practice.

References


APPENDIX A

AGE-EDUCATION ANALYSIS

In dealing with the teenage population the standard measure of educational accomplishment, the mean years of school completed, may be misleading, since many young women have not been exposed to even a complete high school experience. Our approach to this problem was to relate accomplishments to a standard at each age by constructing an age-education grid with age on the vertical and education on the horizontal axis as shown below.

**Age-Education Grid**

<table>
<thead>
<tr>
<th>Age (Years Completed)</th>
<th>Education (Years Completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;8</td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>X</td>
</tr>
<tr>
<td>11</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>X</td>
</tr>
<tr>
<td>&gt;12</td>
<td>X</td>
</tr>
</tbody>
</table>

X = Below Standard; Y = At or Above Standard.

For this report we looked at the percentage of women who had inappropriately low levels of education for their age. This was determined by assuming that an 18-year-old should have completed at least 11 years of schooling, a 17-year-old, 10 years, and so on (other standards might be employed for other communities). The number of individuals to the left of the diagonal is divided into the total group to attain the proportion behind their school cohort, and the results are compared for different groups.