Family Planning 9

Lead Agency:

Office of Population Affairs

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Goal: Improve pregnancy planning and spacing and prevent unintended pregnancy.

Introduction*

Family planning affects the well-being of women, men, children, families, and society at large. Significant need exists for publicly supported family planning, with 17.4 million women estimated to need such services in 2004.[1]

Family planning contributes significantly to achieving Healthy People 2010's two overarching goals of increasing quality and years of healthy life and eliminating health disparities.[2] This contribution is reflected in each of the 13 objectives in the focus area. Improved child health and development is associated with healthy planned pregnancies.[3] Conversely, a woman experiencing an unintended pregnancy is at greater risk for delayed prenatal care, depression, and other personal and relationship problems.[3] Closely spaced births carry additional health risks for the mother and child.[3] Preparation for a healthy pregnancy can help both parents minimize economic hardship, achieve educational and career goals, and stabilize their relationship.[3] Some methods of contraception, such as condoms, have the added benefit of lessening the likelihood of the spread of sexually transmitted diseases (STDs), including the human immunodeficiency virus (HIV).

The data available in this midcourse review show that substantial progress was made in several areas. Teen pregnancy rates declined substantially, indicating increases in abstinence and significantly greater condom use among teens aged 15 to 17 years. However, increased rates for childbearing during later reproductive years may have been responsible for a lack of progress on the objectives relating to closely spaced births and infertility.[4, 5]

Progress toward eliminating health disparities by income was made for birth spacing. Birth spacing refers to the time interval from one child's birth date until the next child's birth date. However, health disparities by race and ethnicity increased significantly for adolescent pregnancy.

Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

Three developmental objectives became measurable: emergency contraception (9-5), male involvement in pregnancy prevention (9-6), and insurance coverage for contraceptive supplies and services (9-13). The objective for reproductive health education (9-11) was revised; subobjectives were added to track both informal and formal education on a variety of reproductive health topics.

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* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at http://wonder.cdc.gov/data2010. See the section on DATA2010 in the Technical Appendix for more information.

The wording for emergency contraception (9-5) was changed from "the proportion of family planning agencies that offer emergency contraception at a clinic site" to "the proportion of health care providers who actually provided emergency contraception to clients" to reflect the data collected. The data were collected through a periodic survey of agencies and clinics providing subsidized family planning services in the United States and its jurisdictions.[6] The survey covered family planning agencies and clinics only and not all health care providers.

Male involvement (9-6) was revised to incorporate the latest information provided by Cycle 6 (2002) of the National Survey of Family Growth (NSFG). In 2002, for the first time, the survey covered males aged 15 to 44 years and fatherhood and reproductive health topics similar to those for females.[7]

Reproductive health education (9-11) was revised to reflect survey data that measured males and females aged 15 to 19 years who reported receiving both formal and informal instructions before turning age 18 years on four topics—abstinence, birth control methods, HIV/acquired immune deficiency syndrome (AIDS) risk reduction through safer sex practices, and STDs. Developmental subobjectives were also included to track formal and informal HIV/AIDS prevention education (9-11e, f, m, and n) and formal STD prevention education (9-11g and h). Data from NSFG are anticipated for assessing these subobjectives by the end of the decade.

Insurance coverage (9-13) was modified to measure results in terms of health insurance plans rather than policies. The modification better reflected the survey's wording.

Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 9-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

Data to measure progress toward the targets were available for birth spacing (9-2), contraceptive use (9-3), emergency contraception (9-5), adolescent pregnancy (9-7), abstinence before age 15 years (9-8a and b), abstinence among adolescents aged 15 to 17 years (9-9a and b), pregnancy prevention and STD protection (9-10a through h), and problems in becoming pregnant or maintaining pregnancy (9-12). Four objectives moved toward their targets: adolescent pregnancy in females (9-7), abstinence before age 15 years (9-8), abstinence among adolescents aged 15 to 17 years (9-9), and pregnancy prevention and STD risk reduction in adolescents aged 15 to 17 years (9-10). Within pregnancy prevention and STD protection (9-10), six subobjectives exceeded their targets.

The causes for progress toward the targets are not known. However, a study to assess declining pregnancy rates for teens aged 15 to 17 years from 1991 to 2001 indicated that an estimated 53 percent of the decline was due to decreased sexual experience and 47 percent was due to increased contraceptive use.[8]

Four objectives moved away from their targets: birth spacing (9-2), contraceptive use in females aged 15 to 44 years (9-3), access to emergency contraception (9-5), and infertility (9-12).

Tracking data were not yet available for five objectives: intended pregnancy (9-1), contraceptive failure (9-4), male involvement in pregnancy prevention (9-6), reproductive health education (9-11a through p), and insurance coverage (9-13). Baselines and targets were set for the formerly developmental objectives of male involvement in pregnancy prevention (9-6) and insurance coverage for contraceptive supplies and services (9-13). Data to measure progress toward all of these objectives, with the possible exception of the six developmental subobjectives in reproductive health education (9-11), are anticipated by the end of the decade.

Objectives that met or exceeded their targets. Several subobjectives under pregnancy prevention and STD risk reduction (9-10c through h) surpassed their targets. Between 1995 and 2002, use of condoms plus hormonal methods at first intercourse exceeded its target. Among unmarried females aged 15 to 17 years (9-10c), condom plus hormonal method increased from 7 percent to 16 percent, surpassing the target of 9 percent. Usage among unmarried males (9-10d) increased from 8 percent to 12 percent, exceeding its target of 11 percent. Targets for condom use at last intercourse by teens aged 15 to 17 years were also surpassed: Usage by females (9-10e) increased from 39 percent to 56 percent, exceeding the target of 49 percent, while usage by males (9-10f) increased from 70 percent to 84 percent, exceeding the target of 79 percent. Finally, the targets for condom plus hormonal use at last intercourse by teens aged 15 to 17 years were also exceeded. Usage by females (9-10g) increased from 7 percent to 24 percent, exceeding the target of 11 percent, while male usage (9-10h) rose from 16 percent to 24 percent, above the target of 20 percent.

Objectives that moved toward their targets. Progress toward targets was noted for adolescent pregnancy (9-7), abstinence before age 15 years (9-8), abstinence among adolescents aged 15 to 17 years (9-9), condom use at first intercourse for unmarried females aged 15 to 17 years (9-10a), and condom use at first intercourse for unmarried males aged 15 to 17 years (9-10b).

Between 1996 and 2000, 54 percent of the targeted change in adolescent pregnancy (9-7) was achieved; pregnancies declined from 67 births per 1,000 females aged 15 to 17 years to 54 births per 1,000 females. Female abstinence before 15 years of age (9-8a) achieved 86 percent of the targeted change between 1995 and 2002, while 67 percent of the targeted change was achieved for males (9-8b). During the same time period, abstinence among adolescents aged 15 to 17 years moved toward its target. In addition, 62 percent of the targeted change for females (9-9a) and 61 percent of the targeted change for males (9-9b) were achieved. Finally, condom use at first intercourse by unmarried adolescents 15 to 17 years of age made progress, reaching 33 percent of the targeted change for females (9-10a) and 46 percent of the targeted change for males (9-10b).

Objectives that moved away from their targets. Four family planning objectives moved away from their targets: birth spacing (9-2), contraceptive use by women at risk of unintended pregnancy (9-3), family planning clinics providing emergency contraception (9-5), and infertility among married women (9-12).

The reasons why birth spacing (9-2) moved away from its target are not clear. Research is needed to clarify whether closely spaced births were intended, whether the outcomes of these births were healthy, and how old the mothers were at first and second birth. The data for birth spacing (9-2) by family income level showed an increase in closely spaced births between 1995 and 2002 for all income groups. A sharp increase in closely spaced births occurred among the middle/high-income group (from 7 percent to 15 percent).[4] A smaller increase was noted among poor females (from 20 percent to 25 percent). This

result may suggest that at least some of the increase was deliberate, but further research using NSFG and other sources may clarify this unexpected finding. Better information about family planning supplies and services, as well as improved access to those services, can assist couples in achieving preferred birth-spacing intervals.[9]

For teens, investments in abstinence education focus on preventing a first pregnancy. In addition, "secondary prevention" through the provision of services to pregnant and parenting teenagers can help them avoid or delay a subsequent pregnancy.[10]

In 2002, 13.5 million women received family planning or medical services from clinics.[11] Although 98 percent of women have used at least one contraceptive method at some time in their lives, data showed that the proportion of adult (not teen) women at risk of pregnancy who are currently using contraception (9-3) dropped significantly between 1995 and 2002. The decreases appeared to be greater among black non-Hispanic females (from 90 percent to 85 percent) than among white non-Hispanic females (93 percent to 91 percent) and greater among poor females (92 percent to 86 percent) than among middle/high-income females (93 percent to 90 percent).

The developmental objective for emergency contraception (9-5) became measurable. Between the baseline year of 1999 and 2003, the percentage of family planning clinics providing emergency contraception (9-5) decreased from 80 percent to 79 percent, respectively, moving away from the target of 90 percent. The baseline in 1999 was 80 percent; the target is 90 percent. Access to emergency contraception varies by State.[12]

Between 1995 and 2002, difficulties in initiating and maintaining a pregnancy among married women 15 to 44 years of age (9-12) increased from 13 percent to 15 percent, moving away from the target of 10 percent. The National Infertility Prevention Program, a collaboration between the Centers for Disease Control and Prevention and the Office of Population Affairs, is an example of a program effort focused on infertility prevention. The program supports chlamydia screening and treatment services for low-income, sexually active women attending family planning clinics. Untreated chlamydia can cause severe and costly reproductive and other adverse health consequences, including pelvic inflammatory disease (PID) that may lead to infertility. At least 15 percent of infertile American women are infertile because of tubal damage caused by PID.[13] Although universal screening of sexually active females for chlamydia is required to detect asymptomatic disease and reduce the risk of infertility, overall only 60 percent of women aged 15 to 19 years in the United States are screened for chlamydia.[14] Other contributing factors may be an increase in the proportion of women who delay childbearing to later ages, improved diagnosis of infertility, or both.

Objectives that could not be assessed. Tracking data for five objectives were unavailable at the time of the midcourse review. Data to track intended pregnancy (9-1) and contraceptive failure (9-4) are anticipated by the end of the decade. With the availability of additional data, progress toward the targets for the objectives regarding male involvement in pregnancy prevention (9-6) and insurance coverage for contraceptive supplies and services (9-13) will be assessed by the end of the decade. Similarly, data for the 16 reproductive health education subobjectives (9-11a through p) are anticipated by the end of the decade.

Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 9-2), which displays information about disparities among select populations for which data were available for assessment.

Data to measure racial and ethnic disparities were only available for the Hispanic, black non-Hispanic, and white non-Hispanic populations. The black non-Hispanic and the Hispanic populations each had data available for 28 family planning objectives and subobjectives.

The white non-Hispanic population had the best rates, with disparities of at least 10 percent, for the following objectives and subobjectives: intended pregnancy (9-1), contraceptive use (9-3), contraceptive failure (9-4), adolescent pregnancy (9-7), abstinence for females aged 15 to 17 years (9-9a), condom plus hormonal use at first intercourse for unmarried males aged 15 to 17 years (9-10d), formal birth control methods education for females aged 15 to 19 years (9-11c), formal birth control methods education for males aged 15 to 19 years (9-11d), informal abstinence education for females aged 15 to 19 years (9-11i), informal abstinence education for males aged 15 to 19 years (9-11j), informal birth control methods education for females aged 15 to 19 years (9-11k), informal birth control methods education for males aged 15 to 19 years (9-11l), and informal STD education for females aged 15 to 19 years (9-11o). The black non-Hispanic population had the best rates of unmarried males aged 15 to 24 years who received birth control advice from a physician (9-6c) and for condom use at last intercourse among unmarried males aged 15 to 17 years (9-10f).

The middle/high-income population had the best rate, with significant income disparities or disparities of at least 10 percent, for intended pregnancies (9-1), birth spacing (9-2), contraceptive use (9-3), contraceptive failure (9-4), unmarried males aged 15 to 24 years who had gone to a family planning clinic with a female partner (9-6a), unmarried males aged 15 to 24 years who have received birth control counseling from a family planning clinic (9-6b), condom plus hormonal use at first intercourse for unmarried females aged 15 to 17 years (9-10c), condom plus hormonal use at first intercourse for unmarried males aged 15 to 17 years (9-10d), formal birth control methods education for females aged 15 to 19 years (9-11c), formal birth control methods education for males aged 15 to 19 years (9-11d), informal abstinence education for males aged 15 to 19 years (9-11j), informal birth control methods education for females aged 15 to 19 years (9-11k), and informal birth control methods education for males aged 15 to 19 (9-11l). The near-poor group had the best rates for informal abstinence education for females aged 15 to 19 years (9-11i), informal STD education for females aged 15 to 19 years (9-11o), and informal STD education for males aged 15 to 19 years (9-11p).

In 2002, the disparity in birth spacing (9-2) between poor women and women of middle/high income was 50 percent to 99 percent. This disparity decreased by more than 100 percentage points after 1995. All income groups moved away from the target. The decrease in disparity occurred because closely spaced births increased at a greater rate for middle/high-income females than for poor females.

In 2000, the adolescent pregnancy rates (9-7) of the Hispanic and black non-Hispanic populations were more than twice the rate of the white non-Hispanic (best) population. The disparities between these populations and the best group increased between 1996 and 2000. Overall, the disparities from the best rate for these two populations exceeded 100 percent.

Emerging Issues

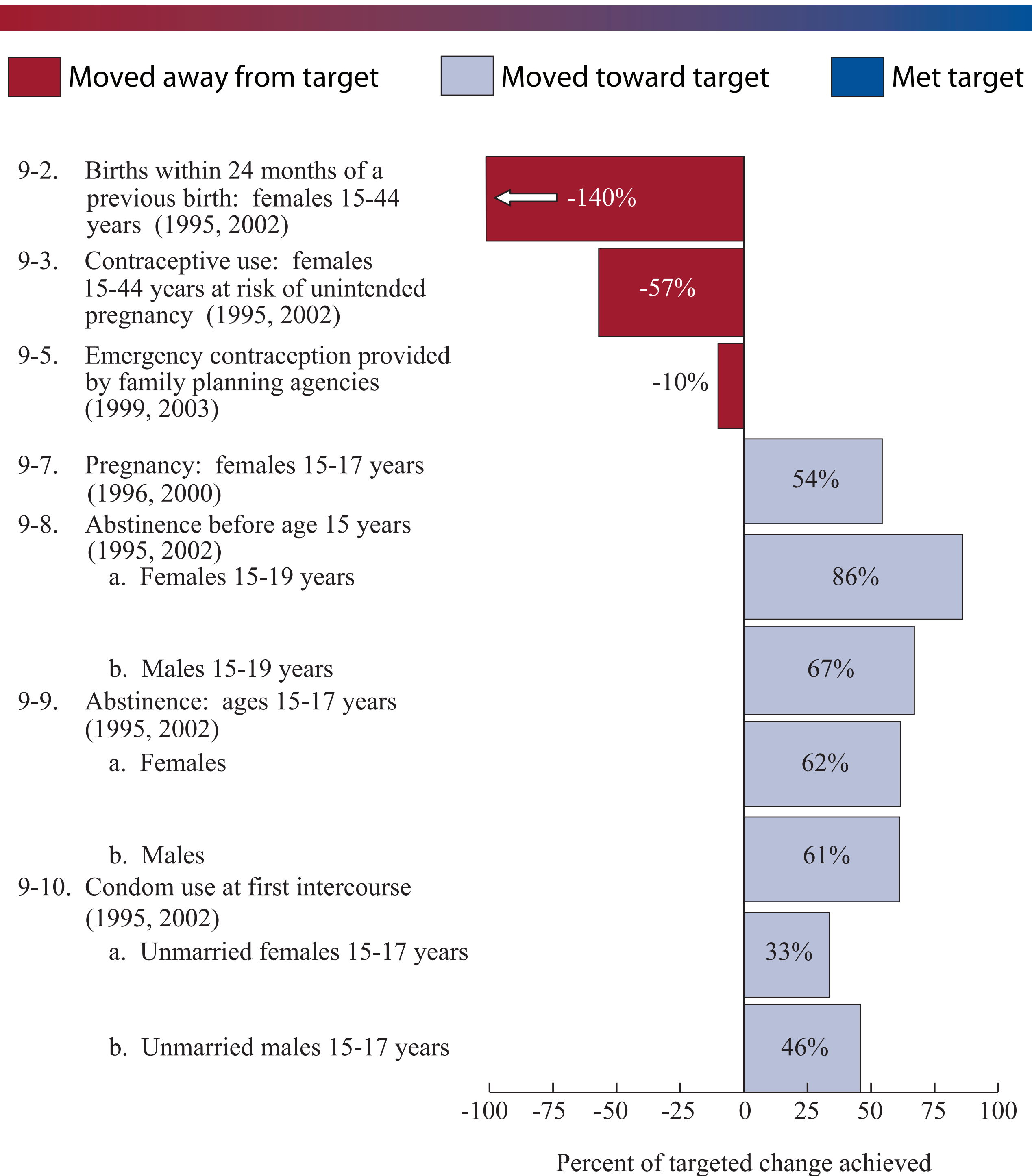
Over the past decade, many public and private efforts have emphasized adolescent pregnancy prevention through abstinence and responsible behavior. Nearly all States (44) reported statewide family planning initiatives to prevent teen pregnancy in 2001. The number of States reporting the provision of school-based abstinence education increased from 26 to 36 in 2001.[15]

Understanding and analyzing important antecedents and outcomes of pregnancies is a challenge. The simple dichotomous measures of intended versus unintended pregnancy may not accurately predict desired outcomes and may not reflect those individuals who are ambiguous regarding pregnancy planning and contraception. More complete measures of a woman's or couple's feelings about a pregnancy may be more useful in understanding contraceptive use, prenatal care, and birth outcomes.

A study of pregnancy intended among women attending public health clinics has found that measuring happiness, effort in achieving the pregnancy, intendedness, and whether the woman wanted a baby with her partner best captures the notion of pregnancy desirability.[16] Cycle 5 (1995) and Cycle 6 (2002) of NSFG had continuous measures of happiness or unhappiness to be pregnant, trying to get pregnant or avoiding pregnancy, wanting to get pregnant with a particular partner, as well as other measures that can be used to evaluate the degree to which women and their partners are able to control the timing and number of births.

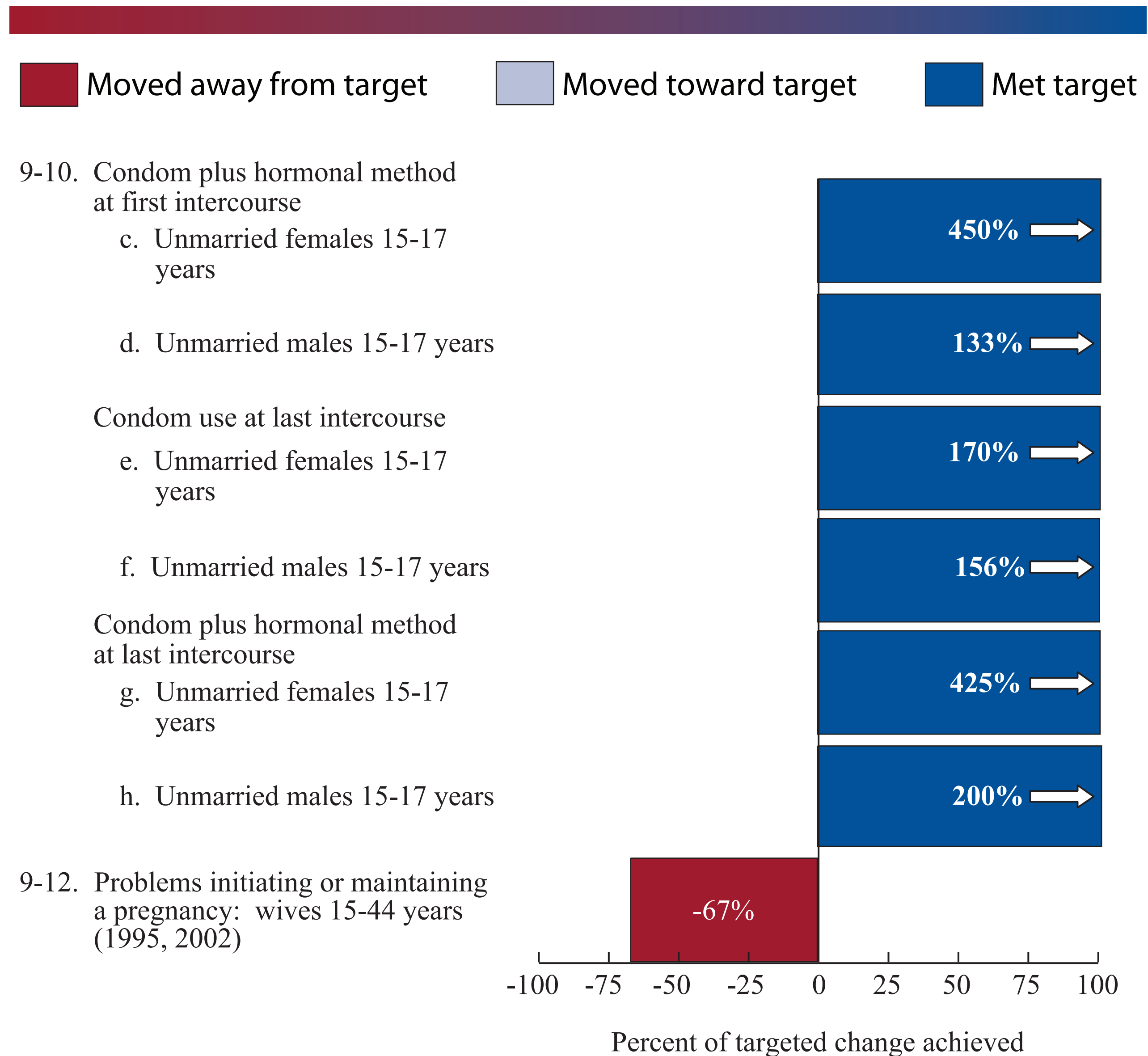
In addition, at the Family Planning Progress Review in December 2004, the concept of preparedness for pregnancies was raised.[17] The Office of Population Affairs is investigating how the concept of "preparation for pregnancy" could be defined and used.[10]

Figure 9-1. Progress Quotient Chart for Focus Area 9: Family Planning



See notes at end of chart. *(continued)*

Figure 9-1. *(continued)*



Notes: Tracking data for objectives 9-1, 9-4, 9-6a, b, and c, 9-11a through p, and 9-13 are unavailable.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left(\frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}}\right) \times 100$$

Figure 9-2. Disparities Table for Focus Area 9: Family Planning

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

Population-based objectives	Characteristics													
	Race and ethnicity								Income				Disability	
	American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	**Summary index**	Poor	Near poor	Middle/high income	**Summary index**	Persons with disabilities	Persons without disabilities
9-1. Intended pregnancies: females 15-44 years (1995) †						I	B[1]				B			
9-2. Births within 24 months of a previous birth: females 15-44 years (1995, 2002) *					B				⇊↓		B	⇊		
9-3. Contraceptive use: females 15-44 years at risk of unintended pregnancy (1995, 2002) *							B			b	B			
9-4. Contraceptive failure: females 15-44 years (1995) †							B				B			
9-6a. Gone to family planning clinic with female partner: unmarried males 15-24 years (2002) *					B						B			
9-6b. Received from family planning clinic birth control counseling: unmarried males 15-24 years (2002) *						B					B			
9-6c. Received advice and counseling from doctor on birth control: unmarried males 15-24 years (2002) *						B				B				
9-7. Pregnancy: females 15-17 years (1996, 2000) †					↑	↑	B	↑						
9-8a. Abstinence before age 15 years: females 15-19 years (1995, 2002) *														
9-8b. Abstinence before age 15 years: males 15-19 years (1995, 2002) *														
9-9a. Abstinence, ages 15-17 years: females (1995, 2002) *					b		B			B				
9-9b. Abstinence, ages 15-17 years: males (1995, 2002) *														
9-10a. Condom use at first intercourse: unmarried females 15-17 years (1995, 2002) *														
9-10b. Condom use at first intercourse: unmarried males 15-17 years (1995, 2002) *														
9-10c. Condom plus hormonal use at first intercourse: unmarried females 15-17 years (1995, 2002) *						B				↑	B			
9-10d. Condom plus hormonal use at first intercourse: unmarried males 15-17 years (1995, 2002) *							B				B			
9-10e. Condom use at last intercourse: unmarried females 15-17 years (1995, 2002) *														
9-10f. Condom use at last intercourse: unmarried males 15-17 years (1995) †						B								
9-10g. Condom plus hormonal use at last intercourse: unmarried females 15-17 years (1995, 2002) *														
9-10h. Condom plus hormonal use at last intercourse: unmarried males 15-17 years (1995, 2002) *														
9-11a. Formal abstinence education: females 15-19 years (2002) *														

(continued)

Figure 9-2. *(continued)*

Population-based objectives	Characteristics: Race and ethnicity: American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Income: Poor	Near poor	Middle/high income	Summary index	Disability: Persons with disabilities	Persons without disabilities
9-11b. Formal abstinence education: males 15-19 years (2002) *														
9-11c. Formal birth control methods education: females 15-19 years (2002) *							B				B			
9-11d. Formal birth control methods education: males 15-19 years (2002) *							B				B			
9-11i. Informal abstinence education: females 15-19 years (2002) *						b	B			B				
9-11j. Informal abstinence education: males 15-19 years (2002) *							B				B			
9-11k. Informal birth control methods education: females 15-19 years (2002) *							B				B			
9-11l. Informal birth control methods education: males 15-19 years (2002) *							B				B			
9-11o. Informal sexually transmitted disease education: females 15-19 years (2002) *						b	B			B				
9-11p. Informal sexually transmitted disease education: males 15-19 years (2002) *						B				B				
9-12. Problems in conceiving or maintaining a pregnancy: wives 15-44 years (1995, 2002) *					B	b								

Notes: Data for objectives 9-5, 9-11e through h, 9-11m and n, and 9-13 are unavailable or not applicable.

Years in parentheses represent the baseline data year and the most recent data year (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (for example, race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

The **best group rate** at the most recent data point.
- B — The group with the best rate for specified characteristic.
- b — Most favorable group rate for specified characteristic, but reliability criterion not met.
- (blank box) — Best group rate reliability criterion not met.

Disparity from the best group rate at the most recent data point.

Percent difference from the best group rate
- Less than 10 percent or not statistically significant
- 10-49 percent
- 50-99 percent
- 100 percent or more

Changes in disparity over time are shown when the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available.

Increase in disparity (percentage points)
- ↑ 10-49
- ↑↑ 50-99
- ↑↑↑ 100 or more

Decrease in disparity (percentage points)
- ↓ 10-49
- ↓↓ 50-99
- ↓↓↓ 100 or more

Availability of data.
- Data not available.
- Characteristic not selected for this objective.

* The variability of best group rates was assessed, and disparities of ≥ 10% are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

† Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

[1] Data include persons of Hispanic origin.

Objectives and Subobjectives for Focus Area 9: Family Planning

Goal: Improve pregnancy planning and spacing and prevent unintended pregnancy.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010.*

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.[1]

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

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[1] See Technical Appendix for more information on baseline and target revisions.

NO CHANGE IN OBJECTIVE

9-1. Increase the proportion of pregnancies that are intended.

Target: 70 percent.

Baseline: 51 percent of all pregnancies among females aged 15 to 44 years were intended in 1995.

Target setting method: Better than the best.

Data sources: National Survey of Family Growth (NSFG), CDC, NCHS; National Vital Statistics System (NVSS), CDC, NCHS; Abortion Provider Survey, The Alan Guttmacher Institute; Abortion Surveillance Data, CDC, NCCDPHP.

NO CHANGE IN OBJECTIVE

9-2. Reduce the proportion of births occurring within 24 months of a previous birth.

Target: 6 percent.

Baseline: 11 percent of females aged 15 to 44 years gave birth within 24 months of a previous birth in 1995.

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

NO CHANGE IN OBJECTIVE

9-3. Increase the proportion of females at risk of unintended pregnancy (and their partners) who use contraception.

Target: 100 percent.

Baseline: 93 percent of females aged 15 to 44 years at risk of unintended pregnancy used contraception in 1995.

Target setting method: Total coverage.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

NO CHANGE IN OBJECTIVE

9-4. Reduce the proportion of females experiencing pregnancy despite use of a reversible contraceptive method.

Target: 7 percent.

Baseline: 13 percent of females aged 15 to 44 years experienced pregnancy despite use of a reversible contraceptive method in 1995.

Target setting method: Better than the best (retain year 2000 target).

Data sources: National Survey of Family Growth (NSFG), CDC, NCHS; Abortion Patient Survey, The Alan Guttmacher Institute.

ORIGINAL OBJECTIVE

9-5. (Developmental) Increase the proportion of health care providers who provide emergency contraception.

Potential data source: The Alan Guttmacher Institute.

OBJECTIVE WITH REVISIONS

9-5. ~~(Developmental)~~ Increase the proportion of ~~health care providers who provide~~family planning agencies that offer emergency contraception.

Target: 90 percent.

Baseline: 80 percent of family planning agencies offered emergency contraception in 1999.

Target setting method: 13 percent improvement.

~~Potential d~~Data source: The Alan Guttmacher Institute.

REVISED OBJECTIVE

9-5. Increase the proportion of family planning agencies that offer emergency contraception.

Target: 90 percent.

Baseline: 80 percent of family planning agencies offered emergency contraception in 1999.

Target setting method: 13 percent improvement.

Data source: The Alan Guttmacher Institute.

ORIGINAL OBJECTIVE

9-6. (Developmental) Increase male involvement in pregnancy prevention and family planning efforts.

Potential data source: National Survey of Family Growth (NSFG), CDC, NCHS.

OBJECTIVE WITH REVISIONS

9-6. ~~(Developmental)~~ Increase male involvement in pregnancy prevention and family planning efforts.

Target and baseline:

Objective	Increase proportion of	2002 Baseline	2010 Target
		Percent	
9-6a.	Unmarried males who have gone to a family planning clinic with their female partner or girlfriend within the past 12 months	21	22
9-6b.	Unmarried males aged 15 to 24 years who received birth control counseling or methods from a family planning clinic in the past 12 months	31	37
9-6c.	Unmarried males aged 15 to 24 years receiving advice or counseling from a doctor or other medical care provider about using methods of birth control, including condoms	21	37

Target setting method: Better than the best.

~~Potential d~~Data source: National Survey of Family Growth (NSFG), Cycle 6, CDC, NCHS.

REVISED OBJECTIVE

9-6. Increase male involvement in pregnancy prevention and family planning efforts.

Target and baseline:

Objective	Increase proportion of	2002 Baseline	2010 Target
		Percent	
9-6a.	Unmarried males who have gone to a family planning clinic with their female partner or girlfriend within the past 12 months	21	22

REVISED OBJECTIVE *(continued)*

9-6b.	Unmarried males aged 15 to 24 years who received birth control counseling or methods from a family planning clinic in the past 12 months	31	37
9-6c.	Unmarried males aged 15 to 24 years receiving advice or counseling from a doctor or other medical care provider about using methods of birth control, including condoms	21	37

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), Cycle 6, CDC, NCHS.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

9-7. Reduce pregnancies among adolescent females.

Target: 43 pregnancies per 1,000.

Baseline: 67[1] pregnancies per 1,000 females aged 15 to 17 years occurred in 1996.

Target setting method: Better than the best.

Data sources: Abortion Provider Survey, The Alan Guttmacher Institute; National Vital Statistics System (NVSS), CDC, NCHS; National Survey of Family Growth (NSFG), CDC, NCHS; Abortion Surveillance Data, CDC, NCCDPHP.

[1] Baseline revised from 68 after November 2000 publication.

NO CHANGE IN OBJECTIVE

9-8. Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years.

Target and baseline:

Objective	Increase in Adolescents Aged 15 to 19 Years Never Engaging in Sexual Intercourse Before Age 15 Years	1995 Baseline	2010 Target
		Percent	
9-8a.	Females	81	88
9-8b.	Males	79	88

NO CHANGE IN OBJECTIVE *(continued)*

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

NO CHANGE IN OBJECTIVE

9-9. Increase the proportion of adolescents who have never engaged in sexual intercourse.

Target and baseline:

Objective	Increase in Adolescents Aged 15 to 17 Years Never Engaging in Sexual Intercourse	1995 Baseline	2010 Target
		Percent	
9-9a.	Females	62	75
9-9b.	Males	57	75

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

NO CHANGE IN OBJECTIVE
(Data updated and footnoted)

9-10. Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease.

Target and baseline:

Objective	Increase in Contraceptive Use at First Intercourse by Sexually Active, Unmarried Adolescents Aged 15 to 17 Years	1995 Baseline	2010 Target
		Percent	
	Condom		
9-10a.	Females	69[1]	75
9-10b.	Males	72	83
	Condom plus hormonal method		
9-10c.	Females	7	9
9-10d.	Males	8	11

NO CHANGE IN OBJECTIVE *(continued)*
(Data updated and footnoted)

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

Target and baseline:

Objective	Increase in Contraceptive Use at Last Intercourse by Sexually Active, Unmarried Adolescents Aged 15 to 17 Years	1995 Baseline	2010 Target
		Percent	
	Condom		
9-10e.	Females	39	49
9-10f.	Males	70	79
	Condom plus hormonal method		
9-10g.	Females	7	11
9-10h.	Males	16	20

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

[1] Baseline corrected after November 2000 publication.

ORIGINAL OBJECTIVE

9-11. Increase the proportion of young adults who have received formal instruction before turning age 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases, and abstinence.

Target: 90 percent.

Baseline: 64 percent of females aged 18 to 24 years reported having received formal instruction on all of these reproductive health issues before turning age 18 years in 1995. (Data on males will be available in the future.)

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

OBJECTIVE WITH REVISIONS

9-11. Increase the proportion of young adults who have received formal or informal instruction before turning age 18 years on the following reproductive health issues: abstinence, ~~including all of the following topics:~~ birth control methods, HIV/AIDS prevention through safer sex practices, and sexually transmitted diseases.

Target and baseline:

Objective	Increase in Young Adults Aged 15 to 19 Years Who Have Received Instruction on Reproductive Health Issues Before Turning Age 18 Years	2002 Baseline	2010 Target
		Percent	
	Formal instruction		
	Abstinence		
9-11a.	Females	86	88
9-11b.	Males	83	85
	Birth control methods		
9-11c.	Females	70	73
9-11d.	Males	66	70
	HIV/AIDS prevention through safer sex practices		
9-11e.	Females	Developmental	
9-11f.	Males	Developmental	
	Sexually transmitted diseases		
9-11g.	Females	Developmental	
9-11h.	Males	Developmental	
	Informal instruction		
	Abstinence		
9-11i.	Females	57	62
9-11j.	Males	45	49
	Birth control methods		
9-11k.	Females	51	57
9-11l.	Males	33	38
	HIV/AIDS prevention through safer sex practices		
9-11m.	Females	Developmental	
9-11n.	Males	Developmental	

OBJECTIVE WITH REVISIONS *(continued)*

	Sexually transmitted diseases		
9-11o.	Females	51	60
9-11p.	Males	52	57

~~**Target:** 90 percent.~~
~~**Baseline:** 64 percent of females aged 18 to 24 years reported having received formal instruction on all of these reproductive health issues before turning age 18 years in 1995. (Data on males will be available in the future.)~~

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

REVISED OBJECTIVE

9-11. Increase the proportion of young adults who have received formal or informal instruction before turning age 18 years on the following reproductive health issues: abstinence, birth control methods, HIV/AIDS prevention through safer sex practices, and sexually transmitted diseases.

Target and baseline:

Objective	Increase in Young Adults Aged 15 to 19 Years Who Have Received Instruction on Reproductive Health Issues Before Turning Age 18 Years	2002 Baseline	2010 Target
		Percent	
	Formal instruction		
	Abstinence		
9-11a.	Females	86	88
9-11b.	Males	83	85
	Birth control methods		
9-11c.	Females	70	73
9-11d.	Males	66	70
	HIV/AIDS prevention through safer sex practices		
9-11e.	Females	Developmental	
9-11f.	Males	Developmental	
	Sexually transmitted diseases		
9-11g.	Females	Developmental	
9-11h.	Males	Developmental	

REVISED OBJECTIVE *(continued)*

	Sexually transmitted diseases		
	Informal instruction		
	Abstinence		
9-11i.	Females	57	62
9-11j.	Males	45	49
	Birth control methods		
9-11k.	Females	51	57
9-11l.	Males	33	38
	HIV/AIDS prevention through safer sex practices		
9-11m.	Females	Developmental	
9-11n.	Males	Developmental	
	Sexually transmitted diseases		
9-11o.	Females	51	60
9-11p.	Males	52	57

Target setting method: Better than the best.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

NO CHANGE IN OBJECTIVE

9-12. Reduce the proportion of married couples whose ability to conceive or maintain a pregnancy is impaired.

Target: 10 percent.

Baseline: 13 percent of married couples with wives aged 15 to 44 years had impaired ability to conceive or maintain a pregnancy in 1995.

Target setting method: 23 percent improvement.

Data source: National Survey of Family Growth (NSFG), CDC, NCHS.

ORIGINAL OBJECTIVE

9-13. (Developmental) Increase the proportion of health insurance policies that cover contraceptive supplies and services.

Potential data source: The Alan Guttmacher Institute.

OBJECTIVE WITH REVISIONS

9-13. ~~(Developmental)~~ Increase the proportion of health insurance ~~policies~~ plans that cover contraceptive supplies and services.

Target: 90 percent.

Baseline: 86 percent of employment-based insured health plans routinely covered all five leading methods of contraception: diaphragm, implant, injectable, intrauterine device (IUD), and oral contraceptive pills in 2002.

Target setting method: 5 percent improvement.

~~Potential d~~Data source: The Alan Guttmacher Institute.

REVISED OBJECTIVE

9-13. Increase the proportion of health insurance plans that cover contraceptive supplies and services.

Target: 90 percent.

Baseline: 86 percent of employment-based insured health plans routinely covered all five leading methods of contraception: diaphragm, implant, injectable, intrauterine device (IUD), and oral contraceptive pills in 2002.

Target setting method: 5 percent improvement.

Data source: The Alan Guttmacher Institute.

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Related Objectives From Other Focus Areas

1. Access to Quality Health Services

1-3. Counseling about health behaviors
1-7. Core competencies in health profession training

3. Cancer

3-3. Breast cancer deaths
3-4. Cervical cancer deaths
3-10. Provider counseling about cancer prevention
3-11. Pap tests
3-13. Mammograms

7. Educational and Community-Based Programs

7-2. School health education
7-3. Health-risk behavior information for college and university students
7-11. Culturally appropriate and linguistically competent community health promotion programs

11. Health Communication

11-3. Research and evaluation of communication programs
11-6. Satisfaction with health care providers' communication skills

13. HIV

13-1. New AIDS cases
13-5. New HIV/AIDS cases
13-6. Condom use
13-14. HIV-infection deaths
13-15. HIV diagnosis prior to AIDS
13-17. Perinatally acquired HIV infection
13-18. Heterosexually transmitted HIV/AIDS in women

14. Immunization and Infectious Diseases

14-3. Hepatitis B in adults and high-risk groups
14-9. Hepatitis C
14-28. Hepatitis B vaccination among high-risk groups

15. Injury and Violence Prevention

15-34. Physical assault by intimate partners
15-35. Rape or attempted rape
15-36. Sexual assault other than rape

16. Maternal, Infant, and Child Health

16-3. Adolescent and young adult deaths
16-4. Maternal deaths
16-5. Maternal illness and complications due to pregnancy
16-6. Prenatal care
16-16. Optimum folic acid levels
16-17. Prenatal substance exposure

19. Nutrition and Overweight

19-12. Iron deficiency in young children and in females of childbearing age
19-13. Anemia in low-income pregnant females
19-14. Iron deficiency in pregnant females

25. Sexually Transmitted Diseases

25-1. Chlamydia
25-2. Gonorrhea
25-3. Primary and secondary syphilis
25-4. Genital herpes
25-5. Human papillomavirus infection
25-6. Pelvic inflammatory disease (PID)
25-7. Fertility problems
25-9. Congenital syphilis
25-11. Responsible adolescent sexual behavior
25-13. Hepatitis B vaccine services in STD clinics
25-16. Annual screening for genital chlamydia

26. Substance Abuse

26-19. Treatment in correctional institution