Family Planning

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PROGRESS REVIEW

In the 27th session of the second series of assessments of *Healthy People 2010*, Assistant Secretary for Health ADM Joxel Garcia convened a Progress Review on Family Planning. He was assisted by staff of the lead Agency for this *Healthy People 2010* focus area, the Office of Population Affairs (OPA) of the U.S. Department of Health and Human Services (HHS). ADM Garcia commended the Family Planning focus area as a good example of the kind of Healthy People feature that so many other parts of the world are drawn to emulating. He noted that, in his long experience with the Pan American Health Organization and in other public health work in the United States and abroad, he found that many sections of our national health protection and promotion initiative were replicated virtually intact in other countries aspiring to increase the health status of their own citizens. Because ADM Garcia had to depart early, Acting U.S. Surgeon General Steven Galson assumed the role of Chair of the Progress Review.

The complete November 2000 text for the Family Planning focus area of *Healthy People 2010* is available online at **www.healthypeople.gov/document/html/volume1/09family.htm**. Revisions to the focus area chapter that were made at the January 2005 Midcourse Review are available at **www.healthypeople.gov/data/midcourse/html/focusareas/fa09toc.htm**. For comparison with the current state of the focus area, the report on the first-round Progress Review (held on October 20, 2004) is archived at **www.healthypeople.gov/data/2010prog/focus09/2004fa09.htm**. The meeting agenda, tabulated data for all focus area objectives, charts, and other materials used in the Progress Review can be found at a companion site maintained by the National Center for Health Statistics (NCHS)/Centers for Disease Control and Prevention (CDC): **www.cdc.gov/nchs/about/otheract/hpdata2010/focusareas/fa09-fp2.htm**. That site has a link to **wonder.cdc.gov/data2010**, which provides access to detailed definitions for the objectives in all 28 focus areas of *Healthy People 2010* and periodic updates to their data.

Data Trends

Richard Klein, Chief of the NCHS Health Promotion Statistics Branch, presented an overview of data related to the Family Planning objectives. He noted that 3.1 million unintended pregnancies occurred in the United States in 2001, the most recent year for which data are available. Consequences of unintended pregnancy include: increased health care costs and a greater likelihood that the affected mothers will smoke or use alcohol during pregnancy, will suffer depression, will fail to finish school, will bear babies of low birth weight, will not breastfeed the child, will devote less time and attention to the child, and will have low income if unmarried. In the United States, 11 percent of females aged 15 to 44 years are at risk of unintended pregnancy, compared with only 3 percent of those in France and in Scotland who are in that age group. Pregnancies that are unintended amount to

half the total in the United States compared with 33 percent of the total in France and 28 percent of the total in the United Kingdom. In 2004, childbearing by teenagers in the United States cost taxpayers at least $9.1 billion. However, unintended pregnancies to teenagers account for only 21 percent of all unintended pregnancies. Of the focus area objectives and subobjectives that were retained after the 2005 *Healthy People 2010* Midcourse Review, 6 have met or surpassed their targets, 5 are moving toward their targets, 3 are getting worse, 5 show little or no change, and 20 have baseline data only. Mr. Klein then provided a more detailed examination of objectives that the focus area workgroup selected to highlight at the Progress Review.

(Obj. 9-1): In 2002 (the most recent year for which data are available), 51 percent of pregnancies among females aged 15 to 44 years were intended. By racial and ethnic group for whom data were available and by income level, the proportions of pregnancies that were intended were as follows: non-Hispanic black, 31 percent; Hispanic, 46 percent (a decrease from 52 percent in 1995); non-Hispanic white, 60 percent; poor, 38 percent; near poor, 43 percent; and middle or high income, 62 percent. The target for intended pregnancies in all population groups is 70 percent. In 2002, the target was surpassed by females in the age group who were currently married (73 percent) and by those who were college graduates (74 percent). By age group, 18 percent of pregnancies among females aged 15 to 19 years were intended in 2002, compared with 67 percent of those among those aged 30 to 34 years and 71 percent of those aged 35 to 39 years.

(Obj. 9-4): In 2002, the probability of having an unintended pregnancy in a year of contraceptive use ("failure rate") was 12.4 percent for all females aged 15 to 44 years. By racial and ethnic group for whom data were available and by income level, the proportions becoming pregnant while using contraception were as follows: non-Hispanic white, 10 percent; Hispanic, 15 percent; non-Hispanic black, 21 percent; middle or high income, 8 percent; near poor, 18 percent; and poor, 20 percent. Among married females, the proportion in 2002 was 10 percent, compared with 22 percent among those who were cohabiting. The target for all population groups is 8 percent. The proportions of females in the age group for whom contraception failed in 2002 by the method of contraception that was being used were as follows: injectables, 6.7 percent; pill, 8.7 percent; male condom, 17.4 percent; withdrawal, 18.4 percent; and calendar/rhythm, 25.3 percent. Contraceptive failure rates did not improve overall or for any age or racial or ethnic group between 1995 and 2002.

(Obj. 9-7): The rate of pregnancy among females (including live births, induced abortions, and fetal losses) aged 15 to 17 years decreased from 63 per 1,000 population in 1996 to 42 per 1,000 in 2004. By racial and ethnic group for whom data were available, the pregnancy rates per 1,000 in 2004 among that age group were as follows: non-Hispanic white, 22 (40 in 1996); non-Hispanic black, 80 (130 in 1996); and Hispanic 83 (109 in 1996). The target for all groups is 39 pregnancies per 1,000. Preliminary data indicate that, both for this age group and for females aged 18 to 19 years, the birth rates increased in 2006.

(Obj. 9-6a): In 2002 (the most recent year for which data are available), 21 percent of unmarried males aged 15 to 24 years had accompanied their female sexual partner to a family planning clinic during the preceding 12 months. The target is 22 percent. The percentages of young men who had accompanied their partner to a family planning clinic, by their age group, in 2002 were as follows: aged 15 to 17 years, 13 percent; aged 18 to 19 years, 17 percent; aged 20 to 21 years, 25 percent; and aged 22 to 24 years, 24 percent.

Miscellaneous Related Data Not Pertaining Directly to the Family Planning Objectives

Of females aged 15 to 19 years who had never been married, 46 percent had ever had sexual intercourse in 2002, compared with 49 percent in 1995. Among those aged 15 to 17 years, 30 percent had ever had sexual intercourse in 2002, compared with 38 percent in 1995. Among those aged 18 to 19 years, 69 percent had ever had sexual intercourse in 2002, compared with 68 percent in 1995. Of males aged 15 to 19 years who had never been married, 46 percent had ever had sexual intercourse in 2002, compared with 55 percent in 1995. Among those aged 15 to 17 years, 31 percent had ever had sexual intercourse in 2002, compared with 43 percent in 1995. Among those aged 18 to 19 years, 64 percent had ever had sexual intercourse in 2002, compared with 75 percent in 1995. Between 1995 and 2002, the only statistically significant differences were reported for females and males aged 15 to 17 years and for males aged 18 to 19 years.

Of females aged 15 to 19 years who had never been married, 83 percent had used contraception at last intercourse in 2002, compared with 71 percent in 1995. Among those aged 15 to 17 years, 86 percent had used contraception at last intercourse in 2002, compared with 67 percent in 1995. Among those aged 18 to 19 years, 81 percent had used contraception at last intercourse in 2002, compared with 74 percent in 1995. Of males aged 15 to 19 years who had never been married, 91 percent had used contraception at last intercourse in 2002, compared with 82 percent in 1995. Among those aged 15 to 17 years, 92 percent had used contraception at last intercourse in 2002, compared with 83 percent in 1995. Among those aged 18 to 19 years, 90 percent had used contraception at last intercourse in 2002, compared with 81 percent in 1995. Differences between 1995 and 2002 are statistically significant for the following groups: females in total and females aged 15 to 17 years.

During the decade before 1980, 43 percent of females aged 15 to 44 years used some method of contraception at first premarital intercourse; 22 percent used a condom. During the 1980s, 61 percent of females in that age group used some method of contraception at first premarital intercourse; 38 percent used a condom. In the period 1990–1994, 70 percent of females in the age group used some method of contraception at first premarital intercourse; 58 percent used a condom. In the period 1995–1998, 73 percent of females in the age group used some method of contraception at first premarital intercourse; 61 percent used a condom. In the period 1999–2002, 79 percent of females in the age group used some method of contraception at first premarital intercourse; 67 percent used a condom.

In 2002, receipt of specified reproductive health services by males aged 15 to 24 years from racial and ethnic groups for whom data were available was as follows: birth control advice—non-Hispanic whites, 8 percent; non-Hispanic blacks, 20 percent; and Hispanics, 15 percent; advice about sexually transmitted diseases (STDs)—non-Hispanic whites, 8 percent; non-Hispanic blacks, 19 percent; and Hispanics, 16 percent; and HIV advice—non-Hispanic whites, 9 percent; non-Hispanic blacks, 24 percent; and Hispanics, 17 percent.

Key Challenges and Current Strategies

OPA Acting Director Evelyn Kappeler and Susan Newcomer of the National Institute of Child Health and Human Development (NICHD)/National Institutes of Health made presentations on the principal themes of the Progress Review. Their statements, the discussion that ensued, and Progress Review briefing materials

prepared by an interagency workgroup identified a number of barriers to achieving the objectives, as well as activities under way to meet these challenges, including the following:

Barriers

- Family planning programs are often hampered by shortages of funding, difficulties in recruiting and retaining staff, and problems of access arising from geography and some clients' limited proficiency in English.
- An estimated one-half of all unintended pregnancies occur to women who were using a method of contraception.
- Recent studies show a strong association between a woman's ambivalence toward pregnancy and inconsistent use or non-use of contraception.
- Condom use is a particularly sensitive issue in relationship dynamics because the use of condoms in an ongoing relationship often triggers doubts or questions about fidelity, especially among adolescents.
- Barriers to effective contraceptive use include a woman's relationship with her partner, difficulty in obtaining a method, and difficulty in method use. The effectiveness of the method depends on the effective use by both the woman and her partner.
- Although health insurance coverage for contraceptive supplies and services has improved considerably, some individuals still are not covered. For many who are covered, co-pays and deductibles may be economic barriers. Delays in monthly prescription refills may also affect contraceptive usage.
- An analysis of studies published over the last 40 years, from 1966 to 2006, indicated that interpregnancy intervals shorter than 18 months and longer than 59 months were significantly associated with increased risk of adverse perinatal outcomes.
- Although the number of males served in Title X clinics has increased in recent years, males continue to make up only about 5 percent of the total number of clients served. Men typically do not receive reproductive health services because health care providers do not recognize what their needs are, and the typical method of birth control for men—the condom—does not require a health care visit. Men's perceptions of their own needs for health care also are limited because many STDs are asymptomatic.
- One study found that teenagers rated high in cognitive susceptibility to having sex were eight times more likely than those rated as nonsusceptible to actually have sex for the first time during the succeeding 12 months.
- Adolescents who have recently moved are about one-third more likely than non-movers to begin having sex. Much of this difference is attributable to higher levels of delinquency and lower levels of academic performance among members of the movers' new school-based friendship networks.
- In several studies in which researchers monitored media programming and sexual behavior over time, the researchers found that adolescents who watched television programs with more sexual content were subsequently less fearful about the negative consequences of sex and were more likely to initiate sexual intercourse than those exposed to media with less sexual content.
- Although the teenage birth rate has been decreasing and reached a record low in 2004, nearly one-fifth of U.S. teen births were repeat births—that is, births to teens who were already mothers.
- Parental involvement is associated with positive adolescent reproductive health behavior, but rates of parent participation in intervention programs historically have been low, especially among parents of at-risk children.

Activities and Outcomes

- Created in 1970, the Title X (of the Public Health Service Act) family planning program is the only Federal program dedicated solely to family planning service delivery. In providing access to contraceptive services, supplies, and information, the program gives priority to those from low-income families, including the working poor and those who may not meet the narrow eligibility requirements of Medicaid. Currently, 88 service grantees are funded in a network of more than 4,500 clinic sites across the country. Nearly 75 percent of U.S. counties have at least one provider of contraceptive services that was funded by the Title X program. About 5 million clients are served each year.
- Title X family planning services are provided to clients within a package of closely related preventive care, including education and counseling related to birth control, gynecological services, physical exams, and clinical services when indicated. In addition, clients can receive breast exams and Pap tests to screen for cancer, STD testing, and HIV prevention education, counseling, testing, and referral for care. OPA, which administers the Title X program, has a Web site at **www.hhs.gov/opa**.
- The data from the Add Health study, funded by a range of Federal partners including NICHD, CDC, and OPA, have been a prolific source of information about adolescents as they move into adulthood. The study, initiated in 1994, is the largest, most comprehensive longitudinal survey of adolescents ever undertaken. The study began with an in-school questionnaire administered to a nationally representative sample of students in grades 7 through 12 and has followed up with a series of in-home interviews conducted in 1994–1995, 1996, 2001–2002, and 2008. The respondents are now in their late twenties or early thirties. Users of the multiple Add Health datasets have obtained more than 300 independently funded research grants and have produced more than 1,000 research articles.
- Medicaid covers contraceptive supplies and services to certain poor women. To date, 26 States have obtained approval from the Centers for Medicare & Medicaid Services to expand family planning services to women who would not otherwise qualify for Medicaid. These States offer Medicaid coverage, known as "family planning waivers," for family planning services, assisting large numbers of low-income people who might not have another source of coverage for family planning.
- The Adolescent Family Life program, which is overseen by OPA, funds programs for pregnant and parenting teens. Many of these programs aim to prevent repeat childbearing by teens through the use of mentoring programs, enhanced case management, home visits, parenting classes, and other efforts. Research has shown that nurse home-visiting programs, in which trained nurses visit expectant adolescents before and after the baby's birth, help reduce subsequent childbearing.
- One research project demonstrated that adding well-supervised community service to sexuality education and access to health services helped middle school students avoid subsequent risky behaviors, including violence and unprotected sex.
- In 2007, OPA in collaboration with the HHS Administration for Children and Families launched the *Parents Speak Up National Campaign* to encourage parents to talk with their children about waiting to have sex. The Campaign uses television, radio, print, and outdoor advertisements to reach a general audience, as well as public service announcements targeted toward blacks, Hispanics, and Native Americans. In addition, the Campaign includes a Web site, **www.4parents.gov**, that provides information about social norms among teenagers, setting goals for the future, establishing

rules and expectations about dating and sex, teaching refusal skills, and the consequences of teen sexual activity.

- OPA's Family Planning Male Training Center is a national institution that provides training designed to make family planning clinic staff better prepared to provide services to men and to communicate with men about family planning services. The Center also provides technical assistance to clinic staff on issues related to male reproductive health.
- The number of male clients served by the Title X family planning program more than doubled between 1999 and 2006, increasing from 127,098 to 272,409.
- The National Survey of Family Growth is the principal source of data for the Family Planning objectives. Beginning in 2002, the Survey for the first time began collecting information from males aged 15 to 44 years about fertility, sexual behavior, and fatherhood. Also, since 2006, the Survey is being conducted continuously, with data to be released at more frequent intervals (every 2–3 years).

What Needs To Be Done

Participants in the Progress Review made the following suggestions for public health professionals and policymakers to consider as steps to enable further progress toward achieving the objectives for Family Planning:

- Strengthen partnerships to enhance family planning service delivery and the provision of related preventive health services.
- Encourage health care providers, as part of their general inquiry into the well-being of patients, to ask teenagers about sexual activity, abstinence, use of condoms and contraception, history of STDs and pregnancy, and the need for information about other sexual health concerns.
- Take account of differences in age, race, and ethnicity to target more effectively interventions with young people.
- Give greater attention to relationships among teenagers in designing interventions to encourage youth to abstain from sex or to protect themselves from disease.
- Take additional steps to promote parents' communication with their teenage children about sexual matters.
- Increase research efforts to identify effective interventions for providing males with family planning/reproductive health services that are broader than STD and HIV prevention, testing, or treatment programs.
- Enhance collaboration with components of the Department of Education and other Federal agencies in areas that have a bearing on the Family Planning objectives.
- Draw and apply lessons from other countries and cultures that have rates of unintended pregnancy and teenage pregnancy lower than those in the United States.
- Given the current economic climate and the likelihood of constrained budgets within the Federal Government, make every effort to ensure that funds for family planning programs are used to optimal effect and that every opportunity for collaboration between agencies is exploited.

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[Signed March 16, 2009]

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