
Pregnancy Planning and Unintended Pregnancy

The rate of unintended pregnancies in the United States is higher than that of many other industrialized countries, with 57 percent of all pregnancies and 44 percent of all births unintended.¹ Over the past several decades, sexual activity among teens and births to unmarried women have increased, age of first sexual activity has steadily decreased, and marriage has been increasingly delayed,² all contributing to the high rates of mistimed and unwanted pregnancies. Although the rates of mistimed births remained constant through the 1980s, the rate of unwanted births increased.³

Three-quarters of women have had intercourse by age 19, and among adolescents intercourse is rarely planned.⁴ Only 40 percent of women used contraceptive services in the year during their first intercourse.⁵ Nevertheless, in the first half of the 1990s, teen birth rates fell in all 50 states, dropping by at least 5 to 10 percent in 37 states. The largest declines were reported among African-Americans.⁶ Still, over 10 percent of all births each year are to women aged 15-19,⁷ and teen birth rates remain far higher among African Americans (91.7 per 1,000), Hispanics of any race (101.6), and Native Americans (75.1) than among whites (48.4) and Asians or Pacific Islanders (25.4).⁸

Predictors and Consequences of Unintended Pregnancy

A disproportionate number of women who have unintended pregnancies are at the lower or upper ends of the reproductive age span.¹ Among ever-married women, the prevalence of unwanted births increases with age and parity, most likely because these women have already reached their desired family size.

The consequences of unplanned pregnancies may include inadequate prenatal care;⁹⁻¹² greater numbers of abortions; and poor birth outcomes, although the data on this point are mixed.¹³ There is some evidence that the apparent link between adverse outcomes, such as low birthweight, and unplanned pregnancy is actually due to confounding maternal and paternal factors (e.g. age, employment status, and parity).^{14,15}

Unplanned pregnancies also incur higher medical costs. The estimated annual medical costs of unintended pregnancies reach \$13 billion.¹⁶

Unintended pregnancy in adolescence has been linked to inadequate prenatal care, low birthweight, infant mortality, child abuse and neglect, and lower educational and economic status for both mother and child.¹⁷ Nearly half of mothers receiving Aid to Families with Dependent Children (AFDC) were less than 17 years of age when they had their first child.¹⁸

About one-quarter of teenage mothers have a second child within 24 months of their first birth,¹⁹ and the prevalence of closely spaced second births is greatest (31%) among women whose first birth occurred prior to age 17.²⁰ African American women are 1.6 times as likely as white women to have an interval of less than 18 months between deliveries.¹⁹ Several investigators have proposed a link between intervals of less than six months between pregnancies and poor pregnancy outcomes, including low birthweight, intrauterine growth retardation, preterm delivery, and perinatal mortality.²¹⁻²⁴

Contraception

Nearly half of unintended pregnancies occur to women who report having used reversible contraception at the time of conception.¹ The remaining unintended pregnancies occur among women not using contraception. Several factors may curb the use of available contraceptive methods, including parity, lactation, and protection against sexually transmitted diseases (STDs).²⁵ For younger women, embarrassment, concerns about privacy, and lack of access to medical services may present a serious barrier.⁵ Only 40 percent of women use contraception in the year of first intercourse.⁵

Despite a relatively high failure rate in typical use, most birth control methods approach 100 percent efficacy when used correctly and consistently. The combined first-year failure rate for all methods except sterilization was 14 percent in 1988.²⁶ Due to inconsistent or incorrect use, non-use, or failure of contraceptive methods, 3 million women unintentionally become pregnant each year.⁵

Contraceptive failure of condoms accounts for 32 percent of unintended pregnancies among women seeking abortion services.²⁷ Condom use more than doubled in the 1980s, probably due to concerns about HIV transmission.²⁶ While condoms are highly effective in preventing transmission of STDs, their high contraceptive failure rate is of concern. The oral contraceptive pill is the most popular of all reversible contraceptive methods, although it does not protect against STDs.

Emergency contraceptive treatment, or “morning after pills,” have remained relatively unknown and inaccessible in the United States,²⁸ and despite FDA approval in 1997, contraceptives are not marketed and packaged for emergency use.²⁹ Manufacturers have been reluctant to apply to the FDA for approval of their products as emergency contraception, and physicians are reluctant to prescribe them due to concerns about legal liability.²⁸ New in-roads, however, are being made: Washington State has initiated a pilot program with pharmacies and physicians, and the emergency contraceptive pill is increasingly available in university, and family planning clinics.

Pregnancy Planning Services

Provider roles in counseling: Health care providers are in a unique position to counsel women about pregnancy planning. Results of studies on counseling among physicians are mixed.

- Providers of obstetric and gynecologic services initiate discussions about birth control and sexual activity with only about a third of new patients, and about STDs with only 12 percent.³⁰
- Family practice and pediatric physicians more regularly counsel patients about preventing pregnancy and STDs, but often feel they are not effective in their counseling.^{31,32}

- Physicians report a high level of counseling for adolescent patients, with 97 percent of pediatricians in one study counseling teenage patients about STDs and 62 percent nearly always taking a sexual history.³¹

Much of women's primary care is delivered by non-physician providers.³³ Primary care delivered by non-physicians seems to be equal in quality to that provided by physicians, and non-physician providers may actually do a better job of preventive care and communicating with patients.³⁴ The gender of the provider may also be important, with female physicians spending more time both listening to and educating patients than do their male counterparts.³⁵ Female physicians are also more likely to perform screening tests such as pap smears.³⁶

Deficiencies in physician training may account in part for inadequacies in women's reproductive health care.³⁴

- Women's health curricula for medical students and for residents in family practice, internal medicine, obstetrics and gynecology, and psychiatry are offered in a minority of medical schools.³³

Integration of reproductive health services: Improved integration of different types of reproductive health services would likely aid prevention efforts.^{37,38} Although many providers already do offer integrated services (both family planning and STD services, for example), federal categorical funding streams create administrative burdens.³⁹

Public pregnancy planning programming: Title X of the Public Health Service Act has funded the provision of family planning services, as well as related research and training, since its creation in 1970. However, due to only modest federal funding of Title X and expansions in Medicaid eligibility throughout the 1980s and 1990s, Medicaid is currently the primary federal financing mechanism for family planning services.⁴⁰ State Title V MCH Programs, and state appropriated dollars also support public family planning services in a number of states.

By the end of 1997, a total of nine states had waivers approved by the Health Care Financing Administration to expand access to Medicaid family planning services. These 1115 waivers allow states to make family planning services more widely accessible with the objective of addressing the issue of short interpregnancy periods, which tend to occur more frequently in low-income minority women. Without this waiver approach, low-income, non-poor women's Medicaid eligibility is tied to pregnancy status. The federal reimbursement to states for family planning expenditures is set at 90 percent, as opposed to about 50 percent for other services.

The welfare reform law enacted in 1996 replaced AFDC with the Temporary Assistance for Needy Families (TANF) block grant. Prior to this legislation, states were required to fund family planning services for welfare recipients. Although that mandate no longer exists, and in general states are barred from using TANF funds for medical services, states are permitted to use TANF funds for pre-pregnancy family planning services.⁴¹

Abortion

Of the six million pregnancies that occur in the United States annually, 1.6 million end in abortion.⁴² Women seeking abortion are more likely than women in the general population to be white, Hispanic, between the ages of 19 and 24, separated or never-married, enrolled in Medicaid, and earning less than \$15,000 annually.²⁷

Public funding of abortion is supported almost entirely by the states; federal Medicaid dollars cover abortions only in the event that the woman's life is threatened or the pregnancy is the result of rape or incest. Only 13 states and the District of Columbia provide funds for abortion for Medicaid recipients, and only four and the District of Columbia fund abortions without restrictions on the reason for the procedure.⁴⁰

Women seeking abortions face numerous barriers.

- Prohibitions on public funding of abortions restrict the ability of poor women to end unwanted pregnancies.²⁷
- In 1993, almost one in ten women seeking an abortion outside a hospital had to travel over 100 miles.⁴³

- Harassment of abortion providers and patients has reduced access to abortion services.⁴³
- Most abortions are paid for out-of-pocket because women seek confidentiality or do not have insurance that covers the procedure.⁴³ However, the average cost of an abortion at a non-hospital facility ranges from \$600 to over \$1,000 depending on gestational age. Cost is thus a major barrier for many women seeking abortion.

Issues for Policy, Practice, and Research*

Health education efforts should be aimed at increasing the correct use of contraceptives and should not focus narrowly on adolescents, who account for a relatively small proportion of births.

The cost of contraceptive drugs and devices and related physician fees may deter significant numbers of women,⁴⁴ particularly if insurance coverage of contraceptive services is minimal; only 33 percent of traditional indemnity plans cover oral contraceptives.⁴¹ However, federal legislation recently introduced would require any insurance plan that covers prescription drugs to cover contraceptive drugs, and any covering outpatient services to cover contraceptive services.⁴⁵

Careful consideration should be given to the possibility of making oral contraceptive pills available over-the-counter, weighing the benefits of reducing rates of unintended pregnancy against the possible detrimental effects of eliminating an important incentive for regular gynecological check-ups. The effect of over-the-counter status on cost and accessibility also remains undetermined.

A key goal of the 1996 welfare reform legislation is to reduce the numbers of out-of-wedlock pregnancies. Toward that end, the federal government is providing \$850 million over five years to promote abstinence education for unmarried individuals and to reduce out-of-wedlock births and abortions. Although the law does not mandate "family caps" which deny increased assistance to women who have more children while on welfare, states have the option to enact them. Prior to the legislation, 21 states and the District of Columbia had family caps. Recent studies in New Jersey and Arkansas, however, show no effect of the caps in reducing births among welfare recipients.⁴⁶ Perhaps due to these findings, interest in family caps is declining; in 1997, only four states adopted family caps.⁴⁶

With low recognition and availability of emergency contraception, further research is warranted to address how best to educate women and providers about its use.

The high rate of contraceptive failure for condoms, widely used to prevent the transmission of STDs, points to the need for development of improved methods of contraception -- methods which are highly effective in preventing both pregnancy and STDs.

Finally, evaluations of the effects of family caps, abstinence-based education, and other aspects of welfare reform related to pregnancy planning are needed to inform future policy decisions.

* Given the formative nature of our research on this topic, this material does not reflect an exhaustive list of potential issues of concern. Rather, the material below reflects selected preliminary ideas generated to stimulate dialogue and further study. In addition, certain issues may have been intentionally omitted from this section in favor of their incorporation in other materials prepared as part of a broader initiative to review the state of the field of perinatal and women's health.

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