

Best Intentions

*Unplanned Pregnancies
& the Well-Being of Indiana Families*

Endorsed
by the Indiana
Section of ACOG
and AAP, Indiana
Chapter.

CALL TO ACTION



INDIANA
PERINATAL
NETWORK
www.indianaperinatal.org

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Department of Health

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Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

Indiana State Department of Health

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April 2007

We are pleased to present to you *Best Intentions: Unplanned Pregnancies and the Well-being of Indiana Families*. The issues related to unplanned pregnancies are very complex and can have far reaching impact on the health of individual women, infants and entire communities. Community efforts to address this emotional issue can be further complicated by competing social, political, cultural, religious and medical factors. The goals and recommendations contained in this “call to action” are evidence-based and designed to improve the well-being of families throughout Indiana.

This report includes actionable and measurable 10-year goals for the state and specific recommendations for the general public, healthcare providers and public policy makers. Underlying position statements emphasizing the need for all parties to find common ground solutions to this important issue are also identified.

Best Intentions: Unplanned Pregnancies and the Well-Being of Indiana Families was developed through a collaborative effort of the Indiana State Department of Health and the Indiana Perinatal Network. This report culminates the year-long efforts of 25 public and private healthcare professionals, clergy and human service providers throughout the State of Indiana.

For the health of our state, we must now move forward to develop the key partnerships needed to implement the recommendations and continue the work of this dedicated group of professionals. This comprehensive, common ground approach to addressing unplanned pregnancies will go a long way to help ensure that all children come into the world supported by adults, ready to learn and with the opportunity to succeed.

Sincerely,

Judith A. Monroe, MD
State Health Commissioner

Larry Humbert, MSSW, Pg Dip
Interim Executive Director, Indiana Perinatal Network

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executive summary



Nothing is more important to our well being than bringing healthy children into our world, supported by adults, ready to learn and with the opportunity to succeed. Being born to Indiana parents who aren't adequately prepared for parenthood could have serious implications for the infant's short and long term health, as well as the economic prosperity of families and entire communities. It is crucial for all parties involved to find common-ground approaches and solutions to this complex, emotional and sometimes controversial issue.

10 YEAR GOALS

- I: Assure access to comprehensive and culturally appropriate preconception and interconception health care for all adolescents, women and men.
- II: Ensure that parents, the general public, media, schools, faith-based organizations and other community organizations are aware of the incidence and potential consequences associated with unplanned pregnancies and involved in preventive strategies.
- III: Ensure that federal, state and local policies encourage access to primary health services that support women and men in achieving reproductive health plans.

RECOMMENDATIONS

For Providers

- I: Develop statewide care recommendations and guides for professionals (including pediatricians, obstetricians and family practice physicians) that include preconception care, pregnancy planning and interconception care in their routine scope of practice:
 - a) Counseling parents of infants and young children about the benefits of pregnancy planning and spacing for themselves and their families.
 - b) Ongoing assessment of a reproductive life plan with all patients.
 - c) Interconception care aimed at planning the next pregnancy, especially to reduce the risk of poor birth outcomes reoccurring.
 - d) Suggested screening tools.
- II: Increase awareness of the most current information on all forms of contraception (including emergency methods), as well as skills to discuss the subject with patients.
- III: Develop tools for providers to educate parents with the most current sexual health information and help to equip parents to discuss the subject with their children.
- IV: Where appropriate, disseminate information regarding evidence-based model programs for replication.
- V: Develop a curriculum to educate providers about assuming a learner's stance to gain valuable information about patients' religious and cultural beliefs related to the role of the family, fertility and family planning.

Personal quotes throughout this report originate from pregnant and parenting women who participated in Marion and Lake county focus groups in 2004 and Marion county residents during a 2005 discussion.



For Community Organizations

- I: Launch a sustained, professionally produced statewide public awareness campaign that:**
 - a)** Highlights the prevalence and consequences of unplanned pregnancies.
 - b)** Emphasizes the importance of delaying sexual activity and the onset of a first pregnancy, as well as the benefits of pregnancy spacing.
 - c)** Encourages male responsibility.
 - d)** Helps facilitate adult/child communication.
 - e)** Informs how and where to find contraception, parent support and adoption services.
- II: Create a broad-based coalition to advocate for a “whole life/ personal responsibility” curriculum that is incorporated into a variety of classes, educational programs and community organizations.**
- III: When appropriate, increase the coordination and co-location of contraceptive services and other health and social programs that serve individuals at high risk of unplanned pregnancy.**



For Public Policy Makers

- I: Encourage the federal government to expeditiously act on the Medicaid Family Planning waiver submitted by the Office of Medicaid Policy and Planning (OMPP).**
- II: In the fall of 2007, convene a statewide summit that draws public and private organizations from a variety of sectors to increase awareness and explore feasible interventions at the state and local level.**
- III: Implement a broader “income based” Medicaid family planning waiver program.**
- IV: Use federal options, waivers and state general revenues to increase coverage for low income women of childbearing age and men, including the State Children's Health Insurance Program.**

rationale & position statements

...while unintended pregnancies are not exclusive to teenagers, the national and state decline in teen pregnancies and births is likely the result of teenagers delaying sexual intercourse and tending to use contraception.

—Sarah Brown, Director, The National Campaign to Prevent Teen Pregnancy

RATIONALE

Nothing is more important to our well-being than bringing healthy children into our world, supported by adults, ready to learn and with the opportunity to succeed. Being born to Indiana parents who may not be adequately prepared for parenthood may have serious implications for the infant's short and long term health as well as the economic prosperity of their families and entire communities. Currently Indiana ranks in the bottom one-third of the 50 states in measures of infant mortality, low birth weight, and other infant health indicators.¹

POSITION STATEMENTS

Below are positions to keep in mind as a frame of reference when reading this document and when considering the issues.

WE...

- ▶ BELIEVE that to overcome poor health outcomes and problems related to unplanned pregnancies (including abortion), people of all ages need the opportunity to be adequately prepared for pregnancy, thus increasing the likelihood that children are born healthy and into safe and nurturing homes.
- ▶ BELIEVE that people should freely and responsibly determine the number and spacing of their children, while emphasizing that studies show an interval of 18 to 24 months between pregnancies promotes the optimal health of women and infants.
- ▶ ACKNOWLEDGE this is a complex, emotional and sometimes controversial issue. It is in the best interest of all to find common ground to achieve the mutual goal that all children deserve to be born healthy and into a safe and nurturing home.
- ▶ BELIEVE that when Indiana's health education programs (including those emphasizing abstinence) include medical information, it should be scientifically accurate—defined as "information supported by research conducted in compliance with scientific methods, published in peer review journals and recognized as accurate and objective by professional organizations and agencies with expertise in the field."
- ▶ EMPHASIZE that only two behaviors reduce the risk of pregnancy or fatherhood: abstinence or consistent use of effective birth control the individual deems acceptable. All Indiana health education programs need have at least one, if not both, of these valid approaches as the ultimate goal.
- ▶ ACKNOWLEDGE this complex issue is complicated by medical, political, social, cultural and religious implications. It can be a highly personal issue with different meanings for different people at different times of life. For example, some women and men view pregnancy as a fact of life and accept it whenever it occurs, while others feel strongly that all pregnancies should be planned.
- ▶ BELIEVE that availability of all forms of birth control and reproductive health services are an important component of primary, preventative health care that can improve the health of women, children and families.



scope of the problem, consequences & associated costs

VISION

Women and men of all ages in Indiana will be well prepared for pregnancy to increase the likelihood that children are born healthy and into a safe and nurturing home.

DEFINITIONS

Because of the significant problems associated with many unplanned pregnancies, this issue has been widely studied in an attempt to understand its full scope and prevalence.

The Centers for Disease Control and Prevention (CDC) classifies *unintended pregnancy* as *mistimed* or *unwanted*. *Mistimed* describes pregnancies that are desired either later or sooner. *Unwanted* describes pregnancies that are not desired now, later or any time in the future. It's important to consider these terms and definitions because *unwanted* and *mistimed pregnancies* likely represent different life-choice considerations and infant health outcomes.

These statistical classifications do not describe the full spectrum of unintended pregnancies and assume that pregnancy is a conscious decision.² The concept of planning pregnancy may be inconsequential to some people and feelings about pregnancy and a subsequent birth can change several times throughout the course of pregnancy. On the other hand, ambivalence about avoiding pregnancy could manifest itself in imperfect contraception use.³

Another limitation of unplanned pregnancy survey questions is that most measure a woman's intentions *after birth*. The birth of an infant may influence the woman's response to the intent of pregnancy and responses can become more positive over time.⁴ When asked retrospectively, certain subgroups of women may be more likely to classify births as *wanted*. *Recall error*—that is, not wanting to admit a negative opinion or perceived mistake about a significant life event—may also influence responses.⁵

We have chosen the term *unplanned pregnancy* as inclusive of *mistimed* and *unwanted*, but acknowledge the ongoing difficulty between the meaning and application of these terms.

National Data

The United States does not differ significantly from many other industrialized countries in patterns of sexual activity, but has higher levels of unplanned pregnancies, teen pregnancies and births, and higher rates of abortion.⁶ The literature indicates that half of unintended pregnancies result in live births and the other half end with abortion.

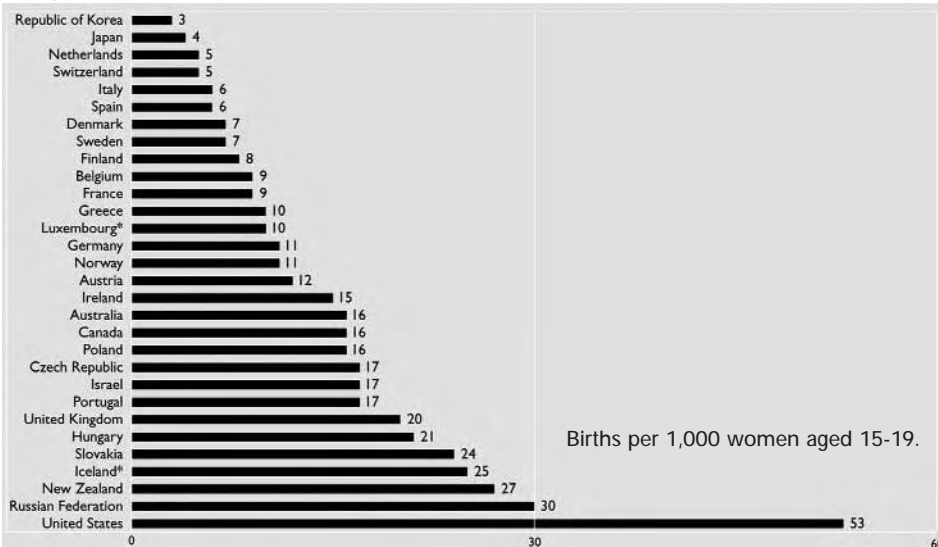




“A child whose birth is eagerly awaited has the best chance of getting off to a healthy start in life. A wanted child is far more likely than an unwanted one to enter a loving, nurturing home environment that encourages healthy growth and development.”

—Select Panel for the Promotion of Child Health

Early Motherhood in the Industrialized World



Source: UNFPA, *The State of World Population*, 2003. Data denoted by * are from UNICEF, “A League Table of Teenage Births in Rich Nations,” Innocenti Report Card No. 3, July 2001.

- ▶ The most recent national data (2001) indicates that approximately half of all pregnancies are unplanned.⁷ Since 1994, the overall rate of unplanned pregnancies has remained stable; however, for women with incomes at or below the poverty level, the rate increased by nearly 30 percent. Among women with incomes that are double the poverty level, the rate decreased by 20 percent.⁸
- ▶ Numerous studies found higher rates of unplanned pregnancies among younger, less educated, unmarried, low income and African American women.^{9, 10, 11, 12}

Indiana Data

- ▶ In 1994, the last year in which statewide data was collected via the CDC Pregnancy Risk Assessment Monitoring System (PRAMS), nearly 40 percent of pregnancies were unplanned.¹³
- ▶ According to an abbreviated 2002 version of the PRAMS survey, more than 50 percent of women reported an unplanned pregnancy.¹ This survey was conducted with 565 women in eight hospitals in Marion, Lake and St. Joseph counties.
- ▶ A 2004 *Indiana Access* survey found that 72 percent of women had an unplanned pregnancy, with 45 percent wanting to be pregnant later and 27 percent never wanting to be pregnant. This survey was conducted with 525 socially high risk, inner-city, primarily Medicaid-eligible women during their postpartum hospital stays at Wishard and Methodist Hospital in Indianapolis. In this study, the rate of unplanned pregnancies for African American women was 83 percent compared to 74 percent for white women and 45 percent for Hispanic women. Women 10 to 17 years of age had the highest rate of mistimed pregnancies while women 25 to 34 and 35 plus years of age had the highest rate of unwanted pregnancies.¹⁵

In February 2006, the Guttmacher Institute reported on the efforts, commitment and creativity of each state and the District of Columbia in addressing unplanned pregnancies, as well as the state's progress from 1994 to 2001. Overall, Indiana ranked 49th out of 51—only Nebraska and North Dakota were worse in addressing and making progress on the problem.¹⁸

- ▶ Between 2000 and 2004 an average of 12.6 percent of all pregnancies in Indiana ended in abortion.¹⁶ However, since this figure is based on procedure reports received by the Indiana State Department of Health which does not include abortions provided out of state to Indiana women, it may under represent the actual percentage, especially in light of a national rate of 24.3 percent.

In Indiana, there is no method to assess the ongoing incidence of unplanned pregnancies statewide. Beginning in 2007, information about intent of pregnancy will be included on the birth certificate. While this will provide a new source of statewide data, the limitations of survey questions previously noted may influence the accuracy and usefulness of this data.

In 2005, an Indiana Youth Risk Behavior Survey of 1,500 students in grades 9 to 12 at 53 public high schools found:

- ▶ The percentage of youth who had *ever engaged in sexual intercourse* declined from 48.8 percent in 2003 to 44.5 percent in 2005.
- ▶ The percentage of youth who are *currently sexually active* declined from 38 percent in 2003 to 34.6 percent in 2005.
- ▶ Condom use during the most recent instance of sexual intercourse *increased* from 55.4 percent in 2003 to 62.6 percent in 2005. The increase reported by females of their partner was *nearly 13 percent compared to 1.6 percent for males.*¹⁷

CONSEQUENCES OF UNINTENDED PREGNANCY

Medical

A literature review reveals several consequences associated with unplanned pregnancies. Compared to women with intended pregnancies, *women with unplanned pregnancies:*

- ▶ *Are less likely to seek first trimester prenatal care.*^{4, 6, 19, 20}
- ▶ *Are more likely to use alcohol and tobacco during pregnancy.*^{4, 6, 19, 20, 21}
- ▶ *May be at greater risk of physical abuse, while the relationship with her partner is at greater risk of dissolution.*⁶
- ▶ *Are more likely to have an abortion.*^{4, 6}
- ▶ *Have infants/children who are at increased risk for abuse and neglect, and reduced cognitive, behavioral and emotional development.*^{6, 20, 22}
- ▶ *Are less likely to breastfeed.*^{6, 20, 22, 23}

Short Intervals Between Pregnancies

A recent review of 67 rigorous studies involving a total of 11 million pregnant women (20 U.S. studies and 47 studies conducted in 61 different countries) compared babies born at intervals of 18 to 23 months after a previous pregnancy to babies

born at less than 18 months. Babies born at shorter pregnancy intervals had:

- ▶ A 61 percent increased risk of low birth weight;
- ▶ A 40 percent increased risk of prematurity; and
- ▶ A 26 percent increased risk of being small for their gestational age.²⁴

A study of live births in Indiana from 1994 to 1998 shows that nearly 19 percent of children were conceived in less than 12 months; more than 6 percent were conceived in less than six months and nearly 2 percent were conceived in less than three months following the previous birth. Poor birth outcomes were associated with these shorter birth intervals *even when controlling for other social, demographic and behavioral factors.*²⁵

Financial Impact on Indiana

Women experiencing an unplanned pregnancy are at increased risk for economic hardship, failure to achieve educational and career goals and for becoming dependent on public assistance.⁶

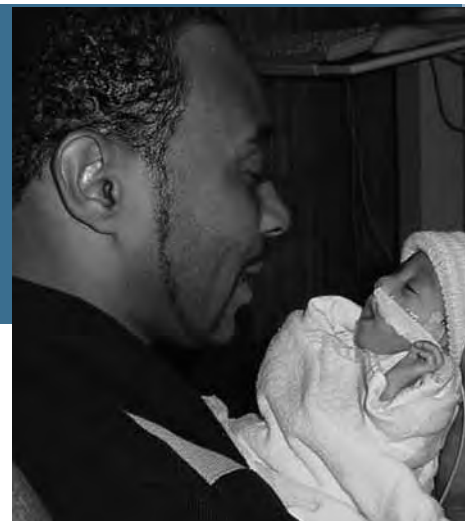
Teen Pregnancy

- ▶ Expectant mothers are *less likely to seek first trimester prenatal care.*^{4, 6, 19, 20}
- ▶ More than *half of mothers on public assistance had their first child as a teen. Among these mothers, one-fourth have a second child within 24 months, further impeding their ability to finish school, retain a job and escape poverty.*²⁶
- ▶ Sons of teen mothers are *13 percent more likely to be incarcerated.*²⁶
- ▶ Daughters of teen mothers are *22 percent more likely to become teen mothers.*²⁶

In November 2006, The National Campaign to Prevent Teen Pregnancy published an extensive assessment of the economic impact of teen pregnancy for the United States as a whole and for each state. On the national level, *teen pregnancy costs taxpayers more than \$9 billion each year.*²⁷

For Indiana, this analysis found:

- ▶ In 2004, teen childbearing cost the state's taxpayers at least \$195 million.
- ▶ During the period of 1991 to 2004, more than 157,000 births occurred to teens, costing taxpayers a total of \$3.6 billion.
- ▶ From 1991 to 2004, a 28 percent decline in the teen birth rate saved taxpayers an estimated \$123 million in 2004.



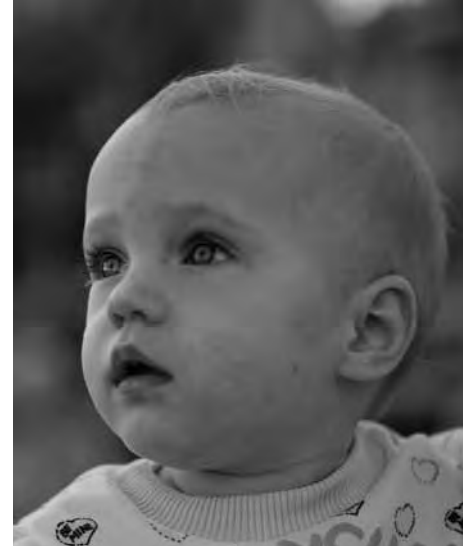
For each month less than 18 months between pregnancies, the risk for low birth weight increased by 3.25 percent; prematurity by nearly 2 percent and small for gestational age increased by 1.52 percent.²⁴





A previous study conducted by this organization found that a 26 percent decline in Indiana's teen birth rate between 1991 and 2002 translated to 6 percent fewer children living in poverty in 2002 and 7 percent fewer children living in single mother households during 2002.²⁶

One analysis concluded that without the provision of free and low cost access to family planning services (federally funded through Title X of the Public Health Services Act), teen pregnancies in the U.S. would have jumped by 20 percent in the 1980s and 90s.²⁸



Contraception

Every public dollar spent on family planning services saves \$3 in Medicaid costs for prenatal and newborn care.²⁹

A 2003 federally commissioned evaluation of Medicaid family planning expansion programs found improved access to care and geographic availability of services, while producing a cost savings for the government.³⁰

To help avoid an unplanned pregnancy, Indiana women can receive comprehensive reproductive health services and contraceptive supplies at Title X clinics for approximately \$250 per year. Since these clinics offer federal public health rates, the cost of contraceptives is usually lower than if obtained at physicians' offices. However, due to pharmaceutical price increases, Title X costs are expected to rise.

contributing factors

Contraception Use

- ▶ *Half of unplanned pregnancies occur among couples who used some form of contraception the month prior to becoming pregnant. These instances are due either to improper or inconsistent use of the contraceptive or failure of the method itself.*³³
- ▶ *The other half of unplanned pregnancies occur among the 11 percent of women who use no contraception even though they are not trying to become pregnant.*³²
- ▶ *Sexually active women not using contraception are two to three times more likely to have an unplanned pregnancy compared to women using an effective method.*³³

According to the *Indiana Access* study with high risk, predominantly Medicaid eligible women:

- ▶ *At the time of conception, 72 percent of women were not using any form of birth control;*
- ▶ *68 percent of the women with an unplanned pregnancy were not using birth control; and*
- ▶ *Nearly one-third of the women who did not get prenatal care as early as they wanted did not know they were pregnant.*

Factors that influence effective contraceptive use include:

- ▶ Age
- ▶ Marital status
- ▶ Ambivalence about becoming pregnant
- ▶ Partner attitudes
- ▶ Side effects (both real and perceived)
- ▶ Satisfaction with health care provider
- ▶ Cultural, religious and political beliefs
- ▶ Costs³¹

Higher contraceptive failure rates occur among women who are cohabitating, unmarried, earning incomes below 250 percent of the federal poverty level, black, Hispanic, adolescents and in their 20s.³³

With the increasing population diversity, numerous social and cultural factors shape contraceptive use and pregnancy prevention. Effective programs to prevent unplanned pregnancy must *use terms that are familiar to women and build upon and support their cultural beliefs and practices.*^{4, 34}

A recent study of low-income inner-city women found that *less than 12 years of education is a strong predictor of repeat unplanned pregnancies.* The study also revealed that use of less effective contraceptive methods and inconsistent use of methods, as expressed during the first postpartum interview, strongly correlates with unplanned pregnancy at the second postpartum interview. The authors conclude that additional support



“In treating major public health problems such as unplanned pregnancy and sexually transmitted diseases primarily as women’s issues, we as a country have been fighting with one hand tied behind

our back.”

—Sara Seims, President & CEO, Alan Guttmacher Institute

services for this vulnerable group of women with low educational status could help to reduce the risk of rapid repeat pregnancies.³⁵

Evidence shows that comprehensive sexual education programs that provide medically accurate information about both abstinence and contraception can help to delay the onset of sexual activity in young people, reduce their number of sexual partners and increase contraceptive use when they become sexually active. These findings were underscored in the *2001 Call to Action to Promote Sexual Health and Responsible Sexual Behavior* issued by former Surgeon General, David Satcher.³⁶

Role of Men

Planning pregnancy is an issue for men and women. Attitudes and behaviors of male partners may influence women’s intentions, sexual behavior, contraceptive use and parenting.

The first comprehensive analysis of the sexual and reproductive health needs of American men identified gaps in information and services that can impact men, women and families.³⁷

Some key findings specific to men include:

- ▶ Most American men *start engaging in sexual intercourse in their teens, and by their late 20s, half are married and have become fathers.* According to the 2005 Indiana Youth Risk Behavior Survey, *46 percent of male students in grades 9 to 12 report having sexual intercourse.*³⁸ *Therefore, American men are sexually active and unmarried for an average of nearly 10 years.*
- ▶ *First-time condom use among young men increased sharply from the early 1980s to the mid 1990s, but nearly 40 percent of 20- to 27-year-old men think that condom use poses health risks.*
- ▶ *While more men use a condom the first time they engage in intercourse, over time, condom use declines in favor of reliance on female methods.*
- ▶ *Each year, about half of births and abortions involve men in their 20s.*

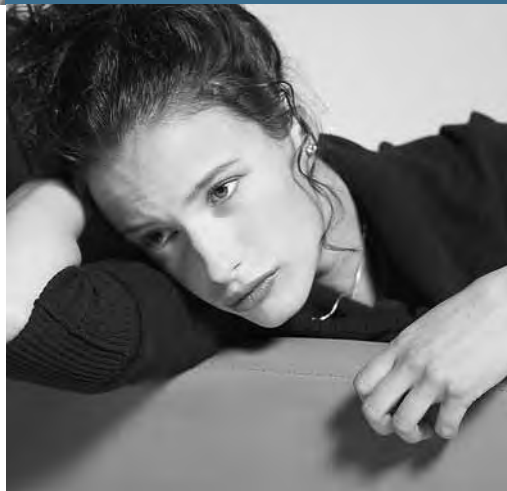
As is the case with women, affluent men fare better than poor men, and white men fare better than men of color on these indicators:³⁷

- ▶ Age of first intercourse
- ▶ Marriage and divorce rates
- ▶ Early fatherhood
- ▶ Living apart from biological children
- ▶ Rates of sexually transmitted infections
- ▶ Health insurance coverage

Young men in particular need information, counseling and skill building to help them resist peer pressure, make informed and positive decisions, take responsibility for their actions and communicate effectively



with their partners about sexual health and personal matters. Community based organizations such as churches and youth groups are emerging as important sources not only of information, but also as valuable sources of the critical counseling and skill building services men need on issues of sexuality, relationships, marriage and parenting.³⁷



"I kept telling you that you were pregnant. Everybody knew it before you did. Girl you were in denial."

—Conversations with community residents

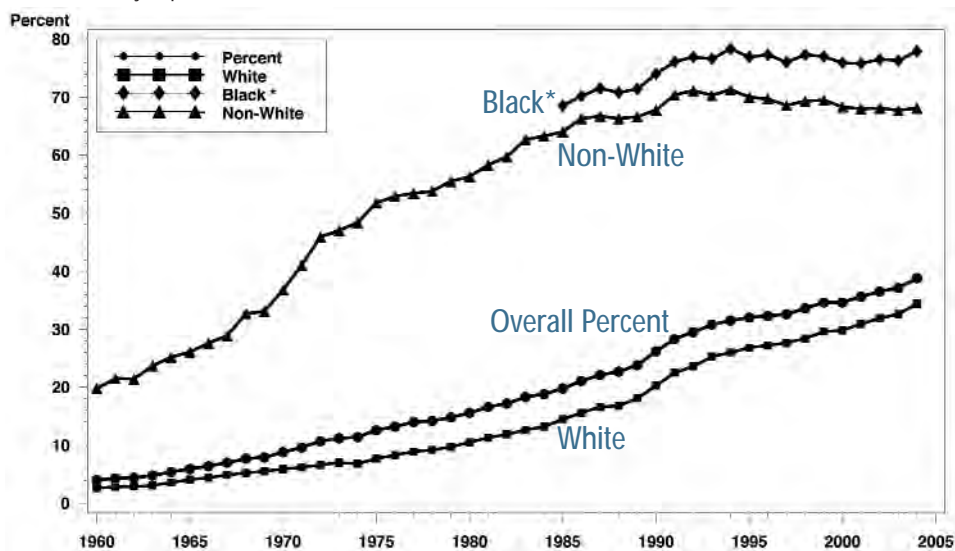
Births to Unmarried Women

Compared to married women, research finds that unmarried women in the United States are more likely to indicate an unplanned pregnancy. Preliminary data for 2004 shows that:

- ▶ *Childbearing among unmarried women increased 4 percent in 2003 to an all-time high of 1.5 million births.³⁹*
- ▶ *More than 80 percent of teen births are to unmarried women.³⁹*
- ▶ *More than half of births to women in their early 20s and nearly 30 percent of births to women 25 to 29 years of age involve unmarried women.³⁹*
- ▶ *In Indiana during the past 40 years, births among unmarried women increased significantly. In 2004, nearly 36 percent of births involved unmarried women.⁴⁰*

Percent of Births to Unmarried Parents by Race of Mother: Indiana Residents 1960-2003

Indiana Natality Report, 2004



This figure was run on June 30, 2006.
 * Information not available prior to 1985. These births were reported as non-white.
 Source: ISDH, ERC, DAT; Table 1.

call to action

To tackle this complex issue and realize the goals of bringing healthier children into the world and promoting their long term development, a variety of approaches are required among multiple public and private organizations operating at local, state and national levels. In addressing this issue, we establish the following goals and make recommendations based on the research and findings presented in this document. The support of these short and long term recommendations hinges on the efforts of all involved parties to continuously seek common ground.

GOAL I

- ▶ Assure access to comprehensive and culturally appropriate preconception and interconception health care for all adolescents, women and men.

Preconception and interconception care is defined as *care that promotes the health of women of reproductive age before conception to help improve pregnancy outcomes.*⁴¹

Role of Health Care Providers

A nationwide panel of experts convened by the Centers for Disease Control (CDC) recently recommended that improving preconception health calls for “*individual responsibility across the life span, where each man, woman and couple are encouraged to have a reproductive life plan.*”⁴¹ This recommendation follows an American College of Obstetricians and Gynecologists (ACOG), Committee on Gynecologic Practice Opinion released in 2005.⁴²

A reproductive life plan requires an ongoing conscientious assessment of the desirability of a future pregnancy, action steps to either prevent or plan for an optimal pregnancy and an evaluation of current health status and other issues relevant to a healthy birth. This life span perspective underscores how *certain recommendations are more relevant to women at different life stages and varying levels of risk.* For example, health promotion, risk screening and interventions are different for a young woman who has never experienced pregnancy than for a woman over 35 years of age who has three children. Women with chronic diseases, previous pregnancy complications or behavioral risk factors might need more intensive interventions. As described earlier, adopting and supporting a reproductive life plan can help more women achieve a healthy pregnancy interval.

Some health care professionals might be reluctant to discuss sexual history with patients due to embarrassment, feeling ill-prepared, a belief that such history is not relevant to the chief complaint and time





constraints. Patients report that physician discomfort and anticipation of a non-empathetic response are barriers to discussing sexual health.⁴³ Health care professionals can help determine a woman's level of risk for an unplanned pregnancy by asking a few questions about contraceptive history and eliciting information about her desire to ever become pregnant.⁴⁴

"I didn't think I was pregnant because I still had my periods."

—Conversations with community residents

Contraception

Clinicians should take the time to help patients select a contraception method that is right for them—*medically and personally*. Counseling must include a discussion of options, advantages and disadvantages; as well as evidence-based side effects, failure rates and risks as perceived by the patient. If numerous options confuse patients, it can be helpful to group them into two major categories: hormonal and barrier, as well as “other” options that do not fit into either category.⁴⁵ A *comprehensive list of current forms of contraception, effectiveness rates, side effects and common myths will be posted shortly at www.indianaperinatal.org/programs-indiana-survey-data.aspx.*

Since nearly half of unplanned pregnancies occur among women who use birth control during the month they conceive, clinicians should routinely follow-up with patients to reduce the possibility of misuse or contraceptive failure.⁴⁵

An accurate knowledge of contraceptive methods may be positively associated with appropriate use. However, reservations about the method itself, partner support of the method and women's beliefs about their own fertility can be important factors that determine long term use.³¹

Concerns about sexually transmitted infections, including HIV, are essential to understanding contraceptive choices. *Motivation to prevent both disease and pregnancy is significantly associated with consistent barrier method use.* Women who report condom use to protect against both disease and pregnancy use the method more consistently than others. Efforts to integrate the two types of prevention messages can increase the consistency of contraceptive use by capitalizing on both intentions.⁴

Availability of Emergency Contraception

As a safe and effective mechanism to reduce the number of unplanned pregnancies and abortions, the Food and Drug

*A 2004 position paper of the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), ACOG and the Society for Adolescent Medicine calls for **providers to ensure access to needed health services for all adolescents, including sexual and reproductive health services, and to encourage adolescents to involve their parents in the discussion.***

Emergency contraception, also called the morning-after pill, is a higher dose of the same hormones found in ordinary birth control pills. It is highly effective in reducing a woman's chance of pregnancy after a contraceptive failure or unprotected sex, including rape. If taken within 72 hours, EC prevents up to 89 percent of pregnancies; it is most effective if taken within 24 hours of unprotected sex.⁵⁰

—ACOG Communications, Sept. 11, 2006

Administration (FDA) approved the over-the-counter availability of emergency contraction (EC) for women 18 years of age and older. EC is available with a prescription for women under the age of 18.

Despite the long term availability of EC with a prescription, statewide access to this “second chance” form of contraception is limited and inconsistent. Lack of knowledge about the availability, timing of use, and misconceptions about the mode of action by providers, pharmacists and women all contribute to the lack of access.^{46, 47, 48}

In particular, the mistaken assumption persists that Plan B (also known as *EC* or the *morning-after pill*) is the same class of drug as mifepristone (also known as *Mifeprex* or *RU-486*; sometimes known as the *abortion pill*). This is not true. The two medications have widely different modes of action and uses in therapy. EC contains hormones found in birth control pills and prevents pregnancy by stopping ovulation or fertilization. Mifepristone blocks the use of a key hormone needed to establish and maintain a pregnancy, so it is indicated for the medical termination of an intrauterine pregnancy. A recent study found that while health care providers and pharmacists who attend in-service training increased their overall knowledge of EC, some misconceptions about side effects and mode of action persisted. The authors of this study recommend ongoing training and developing specific protocols as two strategies to increase access.⁴⁹

Provider Recommendations

- I: **Develop statewide care recommendations and guides for health care professionals, including pediatricians, obstetricians and family practice physicians to include preconception care, pregnancy planning and interconception care in their routine scope of practice to include:**
 - a) Counseling parents of infants and young children about the benefits of pregnancy planning and spacing for both themselves and their young families.
 - b) Ongoing assessment of a reproductive life plan with all patients.
 - c) Interconception care aimed at planning the next pregnancy, especially to help reduce the risk of poor birth outcomes reoccurring.
 - d) Suggested screening tools.
- II: **Update Indiana providers with the most current information about all forms of contraception (including emergency contraception), as well as equip them with the skills to broach and discuss the subject with patients.**

- III: Develop the necessary tools for providers to educate and equip parents with the most current sexual health information.
- IV: Disseminate information on evidence-based model programs for replication where appropriate.
- V: Develop a curriculum to inform providers on how to adopt a “learner’s stance” to gain valuable information about patients’ religious and cultural beliefs related to the role of the family, fertility and family planning.

GOAL II

- ▶ Ensure that parents, the general public, media, schools, faith-based organizations and other community organizations are aware of the incidence and potential consequences associated with unplanned pregnancies and involved in preventive strategies.

Parents

When parents talk early with their children (that is, well before they become sexually active) about sexual and contraceptive beliefs and values, *these conversations may lead to less sexual risk-taking, delay the initiation of sex or increase the use of condoms or other contraceptives.* This effect is more likely when adolescents and parents feel a sense of connection, when parents disapprove of having sex or support contraceptive use, and when parents discuss sexuality in an open and comfortable manner. *See page 26 for a list of helpful tips for parents.*

A 2003 survey of over 500 adult Indiana residents conducted by the Social Science Research Center at Ball State University found:

- ▶ A large percentage of adults provided inaccurate responses on such issues as HIV transmission, pregnancy prevention and human papilloma virus (HPV).
- ▶ More than 25 percent of the adults said they rarely or never talked about such topics as condoms, sexual health check-ups, media images of sexuality or peer pressure to have sex.

The most common reasons cited by parents for not discussing sexuality was *not knowing how to bring it up; being worried about saying the wrong thing; and embarrassment.*⁵¹

These findings are consistent with a 2002 nationwide study of 15 to 17 year olds that found *being embarrassed and not knowing how to bring up the subject* were two common reasons why *teenagers did not discuss sexuality with parents.*⁵¹

Schools & Other Community Organizations

Historically, schools serve as the vehicle for delivering educational and support programs on a broad range of health



Parents are children’s first and most significant teachers about values and moral expectations. They should be the first to discuss sex, love and relationships with their children. In fact, teens consistently say that they want to hear from their parents about these issues.⁴⁴



Throughout instruction on human sexuality or sexually transmitted diseases, an accredited school shall: (1) require an educator to teach abstinence from sexual activity outside of marriage as the expected standard for all school age children; (2) include in the instruction that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; and (3) include in the instruction that the best way to avoid sexually transmitted diseases and other associated health problems is to establish a mutually faithful monogamous relationship in the context of marriage.

—IC 20-30-5-13, *Instruction on human sexuality or sexually transmitted diseases*

issues and life skills. Examples of effective school-based curricula and programs exist. However, a 2005 Indiana University survey of 400 Indiana teachers, school counselors and school nurses in public middle schools and high schools found that *less than 50 percent of teachers cover vital topics such as sexually transmitted diseases, sexual decision making, pregnancy, sexual abuse and contraception*. The majority of teachers surveyed were also confused about the current requirements and limitations of Indiana law regarding sexuality education and felt unprepared to answer questions from many of their students. The study recommends that teachers, school administrators and interested community individuals adopt a *comprehensive curriculum* to help promote healthy decision making among students.⁵¹ While Indiana Code requires coverage of the topic of abstinence, it does not specifically state that this is the only topic that can be addressed.

Given the variability of school board policies/practices regarding sexual health topics coupled with a myriad of competing curriculum topics, it's advantageous to utilize other community-based organizations to deliver important educational messages on sexual health issues. Enlisting the support of a broader range of community organizations helps to reach teenagers who have dropped out of school as well as older individuals. Visit www.indianaperinatal.org/programs-indiana-survey-data.aspx for a list of programs shown to effectively delay sexual activity, improve contraceptive use among sexually active teens and/or prevent teen pregnancy.

Faith-Based Community

Research shows that religious faith and strong moral values can help protect young men and women from sexual activity, teen pregnancy and other risky behaviors. Many faith-based groups design abstinence and family planning programs to address unintended pregnancy. A review of research produced the following suggestions to the faith-based community:

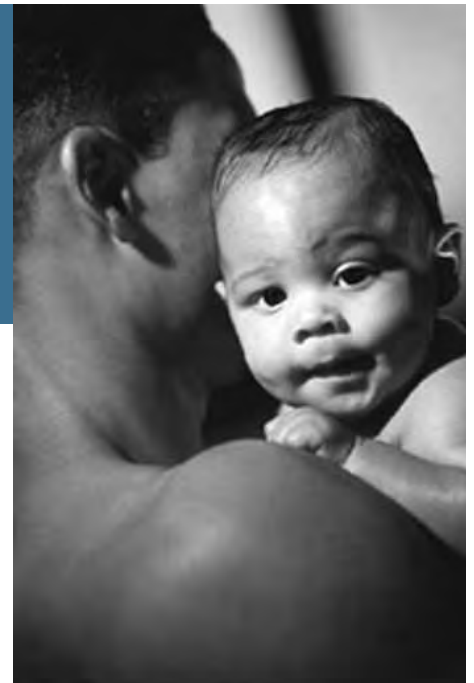
- I: Early and ongoing discussions about sex and relationships within the context of religious faith can provide children with an adult perspective that guides them. Discussions can transpire in places of worship or in less formal settings such as youth groups, camps, parent groups, family retreats and social activities.
- II: Faith leaders can help parents and their sons and daughters converse productively about the dichotomies between religious values and shifting cultural messages. These leaders can encourage early and frequent

conversations between parent and child that express the hopes a parent has for their child and reinforce the importance of education and skills in securing their future.

- III: Encourage open and honest discussions about the challenges and choices confronting young people. More specifically, the faith-based community can provide parents with questions to pose to their children about their friends and relationships, as well as their education, career goals and personal dreams. Parental inquiries about what a child is reading, watching and listening to can often start a conversation about relationships, values and expectations.
- IV: Among young girls and boys, religious leaders should reinforce the message that while childbearing and parenthood are gifts, early pregnancy and parenthood can seriously compromise opportunities for stable relationships, healthy marriages and supportive homes for children.⁵²

Community Recommendations

- I: Launch a sustained, professionally produced statewide public awareness campaign that:
 - a) Highlights the incidence and consequences of unplanned pregnancies.
 - b) Emphasizes the importance of delaying sexual activity and the onset of a first pregnancy while addressing healthy pregnancy spacing.
 - c) Encourages male responsibility.
 - d) Encourages communication between adults and children.
 - e) Highlights how and where to find contraception, parenting support and adoption services.These social marketing campaigns should be tailored to different ages and cultures, be driven by consumer-focused research and strive to engage the faith-based community at all levels of planning and implementation.
- II: Create a broad-based coalition to advocate for a *whole life/personal responsibility* curriculum that is incorporated into a variety of classes, educational programs and community organizations.
- III: When appropriate, increase the coordination of co-locating contraceptive services with other health and social programs that serve individuals at high risk of unplanned pregnancy (i.e. community health centers, STD clinics, homeless centers, drug treatment programs, Woman Infant and Child Nutrition Services, well-child and immunization clinics).



"I think birth control is great. It helps you not have a bunch of kids. I wish I would have used it from the start, but I didn't take it seriously until I had a baby."

—Conversation with a male community resident



"I would try to get girls to hear me personally talk about my experience with two children at a young age and let them know it is not easy, nor is it cute. It is a blessing, but a blessing can wait until the right time."

—Conversations with community residents

GOAL III

Ensure that federal, state and local policies encourage access to primary health services needed to support all women and men to achieve their reproductive health plan.

Medicaid

In 2005, the Indiana General Assembly passed legislation requiring the Office of Medicaid Policy and Planning (OMPP) to apply for a demonstration waiver by January 1, 2006 to extend Medicaid coverage of family planning services for certain women. Upon implementation, Medicaid coverage for family planning services will continue for an additional 24 months among enrolled postpartum women. The intent of this legislation is to decrease the number of repeat and closely spaced pregnancies in currently enrolled women, improve birth outcomes and reduce Medicaid expenditures.

However, given the policy's narrow scope of eligibility for postpartum women only, its impact on the number and spacing of pregnancies statewide is uncertain. Historically, states that implement Medicaid demonstration projects that cover *all low-income women and men* reach more individuals. This expanded eligibility structure is shown to increase access to effective contraceptive services and more significantly impact the rate of unplanned pregnancies throughout an entire state.⁵³

Private Insurance

As noted in *Healthy People 2010*, "increased access through insurance coverage for family planning is important because in the absence of comprehensive coverage, many women may opt for whatever method may be covered by their health plan rather than the method most appropriate for their individual needs and circumstances. Other women may opt not to use contraception if it is not covered under their insurance plan."

Research and experience suggest that contraceptive coverage does not increase insurance premiums and those employers providing such coverage can, in fact, *save money by avoiding costs associated with unplanned pregnancies*. A 1995 analysis of cost data from managed care plans of large employers in 45 major metropolitan areas found that 15 methods of contraception were cost effective when compared to the direct medical cost of unplanned pregnancies, with savings ranging from \$9,000 to \$14,000 over a five-year period.⁵⁴

While almost all insurance plans cover prescription drugs, many do not provide coverage for the range of FDA-approved contraceptive drugs and devices. Currently 24 states require insurers that cover prescription drugs to also cover the full range of FDA-approved contraceptive drugs and devices. Some states have adopted policies that allow employers or insurers the right to refuse to cover contraceptives based on religious or moral objections. In addition, several states have limited mandates that apply to either specific types of insurers or to coverage written for a segment of the insurance market. For example, federal law requires insurance coverage of contraceptives for federal employees and their dependents.⁵⁴

Recently the U.S. Equal Employment Opportunity Commission determined that an employer's failure to include contraceptives in its prescription drug plan constitutes gender discrimination.⁵⁵

Public Policy Recommendations

- I: Encourage the federal government to *expeditiously act on the Medicaid Family Planning waiver* submitted by the Office of Medicaid Policy and Planning (OMPP).
- II: In the fall of 2007, convene a statewide summit that draws public and private organizations from a variety of sectors to increase awareness and explore feasible interventions at the state and local level.
- III: *Implement a broader income-based Medicaid family planning waiver program.*
- IV: *Use federal options, waivers and state general revenues to increase coverage for low income women of childbearing age and men, including enrollees of the State Children's Health Insurance Program.*

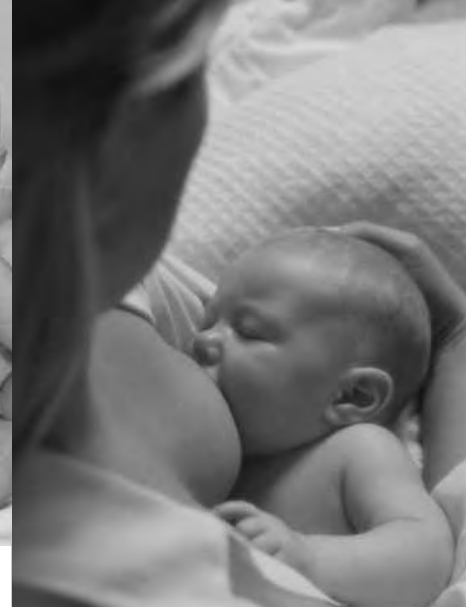


"You need someone to support you because you feel afraid sometimes and you feel shame."

—Conversations with community residents

measuring success

Mechanisms are currently in place to track progress and many of these measures mirror the multiplicity of contributing factors as well as the common-ground solutions. However, these measures are imperfect and might not accurately reflect the complexity of this issue, the depth of emotions experienced by a pregnant woman and her partner and the resulting impact on birth outcomes. We recommend continuous exploration and study of this issue with the hope of developing more meaningful definitions and measures.



BY 2017

- I: Increase by 20 percent the percentage of births spaced at least 18 months apart (source: ISDH Vital Statistics).
- II: Decrease to 9 percent the pregnancies that result in abortions (source: ISDH Vital Statistics).
- III: Increase to 65 percent the ninth to twelfth graders who delay the onset of sex (source: Indiana Youth Risk Behavior Survey).
- IV: Increase to 80 percent the teens who used condoms during their last act of sexual intercourse (source: Indiana Youth Risk Behavior Survey).
- V: Increase planned pregnancies to 60 percent (source: ISDH Vital Statistics, beginning 2007).

To meet these 10 year goals, we strongly recommend the creation of a statewide strategic plan that identifies a lead agency, specific action steps and responsible organizations. IPN and individuals who collaborated in the completion of this document stand ready to assist with this strategic planning process.



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ten tips for parents to help their children avoid teen pregnancy

What can parents do to help their children avoid teen pregnancy and parenthood? These practical tips, based on research with children and parents, reinforce what many parents already know, such as the importance of maintaining a close relationship with their children, setting clear and realistic expectations and being available to talk about other important matters.

Remember, the nearly 10,000 teenage girls who become pregnant every year in Indiana do not do this alone! Boys also need to know that teen pregnancy and parenthood have serious consequences—don't leave them out of conversations about responsibility, sex, values and relationships.

1. Be clear about your own sexual attitudes and values.

Communicating with your sons and daughters about sex, love and relationships is easier when you are certain in your own mind about these issues. Prior to talking with your child, consider the following questions:

- ▶ *What do you really think about school-aged children being sexually active or becoming parents?*
- ▶ *What do you think about encouraging teenagers to abstain from sex or to use contraception?*
- ▶ *Were you sexually active as a teenager or before you were married and how do you feel about that now? How does your experience impact what you say to your son or daughter?*

2. Talk with your children early, often and specifically about sex and relationships.

All kids need communication, guidance and information. Resist “the talk”—*instead make it an 18-year conversation*. If you have regular conversations, you won't worry so much about making a mistake or saying something wrong because you have the opportunity to discuss things again. When you initiate the conversation, make it honest, open and respectful. If you can't think of how to start a conversation, consider using situations shown on TV or movies. Discuss the differences between love and sex and remember to talk about reasons why kids find sex enticing. Discussing only dangers and diseases could miss many of the issues on a teenager's mind.

3. Be a parent with opinions.

In addition to being “askable,” be a parent with a point of view. Tell your children what you honestly think. Don't be afraid to say such things as:

- ▶ *Because sex should be associated with commitment, I think kids your age are simply too young to have sex.*
- ▶ *Our family values or religion say that sex should be an expression of love within marriage. I expect you to wait.*
- ▶ *When you eventually do have sex, always use protection until you are ready to have a child.*
- ▶ *It's not unusual to find yourself in an unexpected sexually charged situation. Think about how you might handle this in advance. Will you say no? Will you use protection?*

4. Supervise and monitor your children at all ages.

Establish rules, curfews and expectations about your child's behavior, preferably through an open family discussion. Despite what your children say, supervising and monitoring their whereabouts doesn't make you a nag; it makes you a concerned parent.

5. **Know your children’s friends and their families.**
Friends have a strong influence. Welcome your children’s friends into your home and get to know them. Try to meet and get to know the parents of your children’s friends and consider establishing common rules and expectations.
6. **Discourage early, frequent and steady dating.**
Allowing teens to begin steady one-on-one dating much before age 16 might lead to trouble—*support group activities instead*. Make your strong feelings about this known early on. If you wait until the situation arises, your son or daughter may think you just don’t like the particular person or situation.
7. **Take a strong stand against your child dating someone older.**
Try setting a limit of no more than two, or at most, a three year age difference. While older guys can be appealing to young girls, differences in power and life experiences can lead girls into risky situations such as unwanted sex or sex with no protection. The situation of young boys dating older girls/women poses similar risks.
8. **Help your teenagers identify options for the future that are more attractive than early pregnancy and parenthood.**
The chances that your son or daughter will delay sex, pregnancy and parenthood are significantly greater if their future appears bright. Explain how becoming pregnant or causing a pregnancy can slow down the best of plans.
9. **Let your children know that you place a high value on education.**
Encourage your child to take school seriously and set high, but realistic standards about their grades and behavior. School failure is often the first sign of trouble that could culminate in teenage parenthood. Monitor your child’s grades and discuss them together. Limit the number of hours your teenager spends on part-time jobs so he or she has enough time and energy to focus on school.
10. **Know about what your children are watching, listening to and reading.**
The media, including the Internet, send many messages about sex and relationships. Sex often has no meaning, unplanned pregnancy seldom happens, and few people seem to be married or even committed to each other. Talk with your children about how the media portray sex and relationships. Discuss what specifically worries or offends you about this portrayal and encourage your children to think critically about these situations.

—Adapted from *Tips for Parents, the National Campaign to Prevent Teen Pregnancy*, www.teenpregnancy.org

ADDITIONAL RESOURCES

TEEN PREGNANCY RESOURCES FOR PARENTS & TEENS

- ▶ www.teenwire.com
- ▶ www.iwannaknow.org
- ▶ www.sxetc.org
- ▶ www.notmenotnow.org

EFFECTIVE PROGRAMS:

- ▶ www.indianaperinatal.org/programs-indiana-survey-data.aspx

COMPREHENSIVE LIST OF CURRENT CONTRACEPTIVE METHODS

- ▶ www.indianaperinatal.org/programs-indiana-survey-data.aspx

current indiana laws regarding consent & confidentiality for minors

MINOR CONSENT & CONFIDENTIALITY—INDIANA LAW

I. Minor Consent

What is the age of majority/minority?

The age of majority in Indiana is eighteen years. IC § 1-1-4-5.

What is the age of consent for sexual activity?

While no statute specifically establishes an age at which a minor legally may consent to sexual activity, there can be criminal penalties for consensual sexual activity with a minor 16 years of age or younger. See IC § 35-42-4-9. There also can be criminal penalties for consensual sexual activity with a minor under 18 years of age when certain circumstances exist. For example, it is criminal “child seduction” for an adult who is the guardian, parent or child care provider for a minor less than 18 years old to engage in any sexual activity with that minor, irrespective of consent. IC § 35-42-4-7

Who generally consents for health care for minors?

Generally, a parent, guardian, or other person *in loco parentis* must consent for health care on behalf of a minor. IC § 16-36-1-5.

What exceptions allow minors or others to consent for health care?

Emancipated Minors:

“[A]n individual may consent to the individual’s own health care if the individual is: a minor and ...is emancipated.” IC § 16-36-1-3. While no statute specifically defines emancipation for this purpose, for the purposes of determining child support, a court will find a minor emancipated if the court finds that the child: (1) has joined the United States armed services; (2) has married; or (3) is not under the care or control of: (A) either parent; or (B) an individual or agency approved by the court.” IC § 31-16-6-6

Independent Minor Living Separate and Apart, Financially Independent:

“[A]n individual may consent to the individual’s own health care if the individual is: (1) a minor and (2) is: (i) at least fourteen (14) years of age; (ii) not dependent on a parent for support; (iii) living apart from the minor’s parents or from an individual *in loco parentis*; and (iv) managing the minor’s own affairs.” IC § 16-36-1-3

Married or the Military:

“[A]n individual may consent to the individual’s own health care if the individual is: a minor and (1) is or has been married; [or] (2) is in the military service of the United States.” IC § 16-36-1-3

For all three of these exceptions, minors may not consent if “in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care.” IC § 16-36-1-4.

Title X Family Planning, including Pregnancy Testing, Contraception: Federal regulations establish special access rules for family planning services funded through Title X. Federal law requires that Title X funded services be available to all adolescents, regardless of their age, without the need for parental consent. 42 C.F.R.59.5(a)(4); see *Does 1-4 v Utah Dept. of Health*, 776F.2d253 (10th Circ. 1985).

Providers delivering services funded in full or in part with Title X monies must comply with the federal regulations. Thus, minors of any age may consent to family planning services when those services are funded in full or in part by Title X monies.

Sexually Transmitted Diseases:

“An individual who has, suspects that the individual has, or has been exposed to a venereal disease is competent to give consent for medical or hospital care or treatment of the individual.” IC §16-36-1-3.

HIV/AIDS Testing & Care:

For services funded in full or in part by Title X, federal law requires the services be available to all adolescents, regardless of age.

For services not funded in full or in part by Title X, state consent law applies: “[A] person may not perform a screening or confirmatory test for the antibody or antigen to HIV without the consent of the individual to be tested...” IC § 16-41-6-1

Emergency:

“This section does not require consent to health care in an emergency.” IC § 34-18-12-9.

Emergency Sexual Assault Services:

“A hospital licensed under IC §16-21-2 that provides general medical and surgical hospital services shall provide emergency hospital services, in accordance with rules adopted by the victim services division of the Indiana criminal justice institute, to all alleged sex crime victims who apply for hospital emergency services in relation to injuries or trauma resulting from the alleged sex crime.”

“For the purposes of this chapter, the following crimes are considered sex crimes:

- (1) Rape (IC § 35-42-4-1)
- (2) Criminal deviate conduct (IC § 35-42-4-2)
- (3) Child molesting (IC § 35-42-4-3)
- (4) Vicarious sexual gratification (IC § 35-42-4-5).
- (5) Sexual battery (IC § 35-42-4-8); and
- (6) Sexual misconduct with a minor (IC § 35-42-4-9).” IC § 16-21-8-1.

The Indiana Attorney General has concluded that a parent’s or guardian’s consent is not required prior to rendering emergency medical treatment to a minor who is an alleged rape victim. 1978 Op.Atty.Gen. No. 19.



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The Indiana Perinatal Network (IPN) is an alliance of hundreds of individuals and organizations across Indiana committed to the beliefs that:

- Every mother deserves a healthy and safe pregnancy; and
- Every baby deserves to be born healthy and into a safe and nurturing home