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Family Planning

Lead Agency: Office of Population Affairs

Contents

Goal

Improve pregnancy planning and spacing and prevent unintended pregnancy.

Overview

In an era when technology should enable couples to have considerable control over their fertility, half of all pregnancies in the United States are unintended.[1] Although between 1987 and 1994 the proportion of pregnancies that were unintended declined in the United States from 57 to 49 percent,[2] other industrialized nations report fewer unintended pregnancies,[3] suggesting that the number of unintended pregnancies can be reduced further. Family planning remains a keystone in attaining a national goal aimed at achieving planned, wanted pregnancies and preventing unintended pregnancies. Family planning services provide opportunities for individuals to receive medical advice and assistance in controlling if and when they get pregnant and for health providers to offer health education and related medical care.

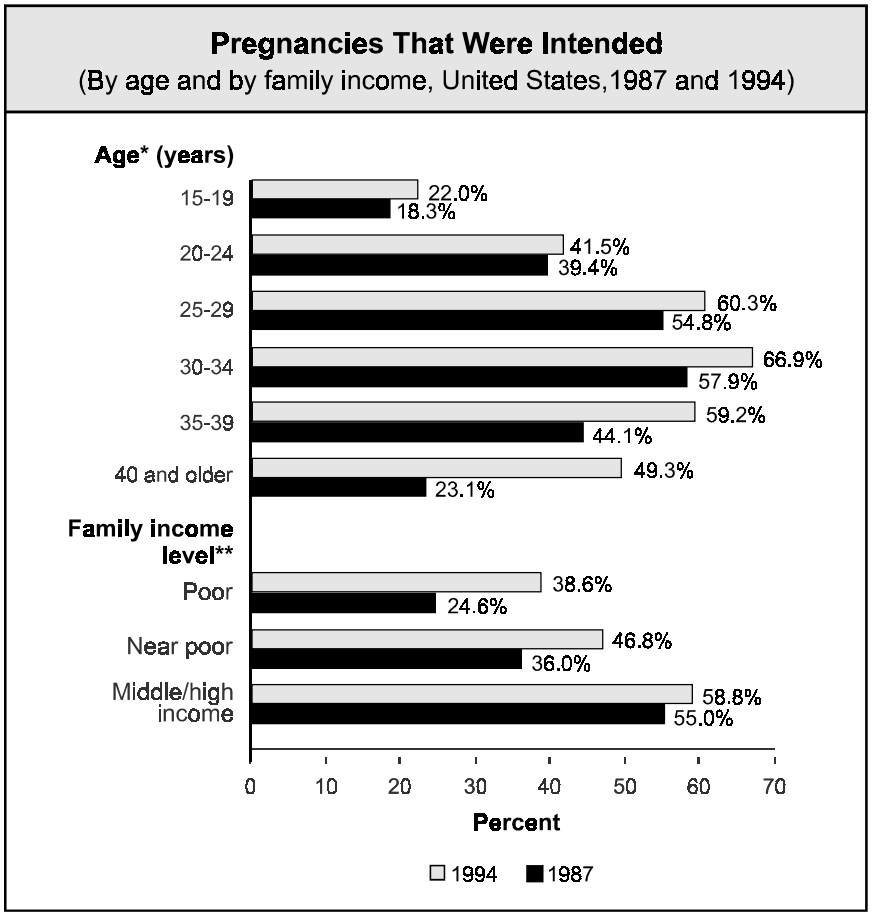
The family planning objectives for Healthy People 2010 echo the recommendations contained in the 1995 Institute of Medicine report *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*.[4] The foremost recommendation of the report calls for the Nation to adopt a social norm in which all pregnancies are intended—that is, clearly and consciously desired at the time of conception. Emphasizing personal choice and intent, this norm speaks to planning for pregnancy, as well as to avoiding unintended pregnancy.

Unintended pregnancy rates in the United States show a decline, probably as a result of higher contraceptive use and use of more effective contraceptive methods.[2] Despite this improvement, unintended pregnancy remains a common problem, and further progress is needed.

Issues and Trends

One important determinant of pregnancy and birth rates is contraceptive use. The proportion of all females aged 15 to 44 years who currently are practicing contraception (including females who have been sterilized for contraceptive reasons and husbands or partners who have had vasectomies) rose from about 56 percent in 1982 to 60 percent in 1988 and 64 percent in 1995.[5] However, 5.2 percent of all females aged 15 to 44 years had intercourse in the past 3 months and did not use contraceptives.[5]

No one method of contraception is likely to be consistently and continuously suitable for each woman, man, or couple. Total abstinence is the only fool-proof



Sources: *Henshaw, S.K. Unintended pregnancy in the United States. *Family Planning Perspectives* 30(1):24-29, 46, 1998. **Brown, S.S., and Eisenberg, L. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families.* Washington, DC: National Academy Press, 1995.

method of contraception. Sterilization, the most common method of contraception in the United States, has near-perfect effectiveness and differs from other methods because it is usually permanent.[5]

Used by an estimated 10 million females, combination oral contraceptives are the most popular method of reversible contraception in the United States. Other hormonal contraceptives, such as injectables and implants, and intrauterine devices (IUDs) have the appeal of providing effective contraception without the need for daily compliance. For barrier methods, such as the condom and diaphragm, the average effectiveness is more variable. Used correctly and consistently, condoms can prevent both pregnancy and disease. Other barrier methods include the diaphragm, cervical cap, and female condom, which may reduce the risk but do not prevent sexually transmitted diseases (STDs) that primarily affect the cervix. Spermicides used alone (foams, creams, and jellies), coitus interruptus (withdrawal), and periodic abstinence (calendar rhythm) are other options; however, their effectiveness in actual use is lower than that for other methods.

Contraceptive method choices are far from ideal. Even with all financial and knowledge barriers removed, effective and consistent contraceptive use is diffi-

cult. Contraceptive research and development efforts must be expanded to bring new methods to the market, methods that combine high contraceptive efficacy and ease of use with protection against STDs and human immunodeficiency virus (HIV). Increased attention also must be given to bringing new methods to the United States, including male methods of contraception, spermicide, and microbicide alternatives. Improving the range of contraceptive choices increases the likelihood that individuals and couples will be able to find a contraceptive method that suits them. Greater choice enhances individuals' control over their fertility and reduces the risk of unintended pregnancy.

Reducing unintended pregnancies is possible and necessary. Unintended pregnancy in the United States is serious and costly and occurs frequently. Socially, the costs can be measured in unintended births, reduced educational attainment and employment opportunity, greater welfare dependency, and increased potential for child abuse and neglect. Economically, health care costs are increased. An unintended pregnancy, once it occurs, is expensive no matter what the outcome. Medically, unintended pregnancies are serious in terms of the lost opportunity to prepare for an optimal pregnancy, the increased likelihood of infant and maternal illness, and the likelihood of abortion.[4] The consequences of unintended pregnancy are not confined to those occurring in teenagers or unmarried couples. In fact, unintended pregnancy can carry serious consequences at all ages and life stages.[4]

With an unintended pregnancy, the mother is less likely to seek prenatal care in the first trimester and more likely not to obtain prenatal care at all.[6, 7] She is less likely to breastfeed[8] and more likely to expose the fetus to harmful substances, such as tobacco or alcohol.[4] The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused, and not receiving sufficient resources for healthy development.[9] A disproportionate share of the women bearing children whose conception was unintended are unmarried or at either end of the reproductive age span—factors that, in themselves, carry increased medical and social burdens for children and their parents. Pregnancy begun without some degree of planning often prevents individual women and men from participating in preconception risk identification and management.

For teenagers, the problems associated with unintended pregnancy are compounded, and the consequences are well documented. Teenaged mothers are less likely to get or stay married, less likely to complete high school or college, and more likely to require public assistance and to live in poverty than their peers who are not mothers. Infants born to teenaged mothers, especially mothers under age 15 years, are more likely to suffer from low birth weight, neonatal death, and sudden infant death syndrome. The infants may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages.[10] Nearly 1 million teenage pregnancies occur each year in the United States.[11] Clearly, the solution to the problem needs to be found.

Unintended pregnancy is expensive, and contraceptives save health care resources by preventing unintended pregnancy.[12] The pregnancy care cost for one woman who does not intend to be pregnant, yet is sexually active and uses no contraception, is estimated at about $3,200 annually in a managed care setting.[12, 13] Estimates of the overall cost to U.S. taxpayers for teenage childbearing range between $7 billion and $15 billion a year, mainly attributed to higher public assistance costs, foregone tax revenues resulting from changes in productivity of the teen parents, increased child welfare, and higher criminal justice costs.[14] Unintended births to teenagers, which account for about 40 percent of teenaged pregnancies, cost more than $1.3 billion in direct health expenditures each year.[15]

Induced abortion is another consequence of unintended pregnancy. Although the numbers of abortions in this country have been declining over the past 15 years,[16] approximately one abortion occurs for every three live births annually in the United States, a ratio two to four times higher than in many other Western democracies. Just as unintended pregnancy occurs across the spectrum of age and socioeconomic status, women of all reproductive ages, married or unmarried, and in all income categories obtain abortions.

Abortion results when women have unintended pregnancies, and adequate access to family planning services reduces the number of unintended pregnancies. Each year, publicly subsidized family planning services prevent an estimated 1.3 million unintended pregnancies.[17] For every $1 spent on publicly funded contraceptive services, $3 is saved in Medicaid bills for pregnancy-related health care and medical care for newborns.[17]

Disparities

Unintended pregnancies occur among females of all socioeconomic levels and all marital status and age groups, but females under age 20 years and poor and African American women are especially likely to become pregnant unintentionally.[4] More than 4 in 10 pregnancies to white and Hispanic females are unintended; 7 in 10 pregnancies to African American females are unintended. Unintended pregnancies during contraceptive use are most common among African American and Hispanic females. Poverty is strongly related to greater difficulty in using reversible contraceptive methods successfully, with these females also the least likely to have the resources necessary to access family planning services and the most likely to be affected negatively by an unintended pregnancy. For this reason, publicly subsidized family planning services are important. Yet, half of all females who are at risk for an unintended pregnancy and need publicly subsidized family planning services are not getting them.[18] Clearly, while these programs have contributed substantially to preventing unintended pregnancy, the need for services continues to outstrip resources available.

Difficulty in obtaining and paying for care is, of course, exacerbated for poor and low-income people. Several Federal programs support family planning services, with most targeting poor or low-income females. The Medicaid program is the

largest, but reimbursement for family planning services is typically not available to adolescents, women without children, women who are married, and working poor women whose income may just exceed the eligibility level.

An estimated 6.6 million females receive services from subsidized family planning providers annually, slightly less than one-half of those considered to be in need of subsidized family planning services (those at risk of unintended pregnancy and with a family income less than 250 percent of the poverty level).[19] Family planning programs consisting of some 3,000 agencies with over 7,000 clinic locations provide nearly 40 percent of family planning services in the United States. Health departments represent nearly half of these locations, along with hospitals, community health centers, and other public and nonprofit organizations. Nearly two-thirds of all females served (4.2 million) obtained care at 1 of 4,200 clinics receiving funds from the Federal Title X Family Planning Program.[19]

Opportunities

A 1995 survey of the Nation's family planning agencies estimated that almost 70 percent of agencies have at least one special program of outreach education or service to meet the needs of teenagers. Fewer have special programs for hard-to-serve populations, such as homeless persons, persons with disabilities, or substance abusers.[20] Furthermore, whether those agencies target their services or simply provide care to those who happened to seek it is not known.[21] The need for family planning services among all these groups is undeniably great. In the case of substance abuse, the link between illegal drug use and infection with HIV has meant more Federal and State funding for programs designed to reach these groups. Thus, substance abusers may be more likely to be targeted by family planning agencies than other hard-to-reach populations. Some programs focus specifically on HIV prevention, whereas others offer comprehensive family planning services and related education and counseling.[21]

Language and cultural differences are significant barriers to serving non-English-speaking population groups. Providers report that they often have difficulty finding staff with appropriate language skills who also have adequate family planning skills and experience. Furthermore, simply speaking the language of the client is not sufficient; the provider also must be able to relate on a cultural level.[21] Persons of various ethnic backgrounds often are uncomfortable talking to strangers about intimate topics, such as sex and birth control, let alone undergoing a pelvic or breast exam. Some racial and ethnic groups tend to visit a doctor only when they are sick and not to seek preventive services, including family planning. Reaching such populations can be difficult.

Providing outreach, education, and clinical services to hard-to-reach populations is expensive. Frequently, these groups have more health problems than less disadvantaged family planning clients, and these health problems are not necessarily confined to family planning. One study estimated that the cost of providing services to homeless women is twice that of other women, with homeless women at

such high risk of gynecological problems that they must undergo a complete exam and diagnostic workup at every visit.[21] Disabled individuals often require extra staff, equipment, and time (especially if they are clients with developmental disabilities) to ensure contraceptive compliance and to deal with side-effect issues.[21] The extra time, effort, and expense required to reach hard-to-serve groups undoubtedly discourage some family planning agencies from implementing programs for these populations.[20] Clearly, there is a need to expand services to hard-to-reach populations and to find effective strategies to overcome barriers to services experienced by individuals in these populations.

Finally, public education and information about family planning need to be expanded. Public education efforts and the media could help persons to understand better the benefits of sexual abstinence. Numerous studies and polls indicate a disturbing degree of misinformation about contraceptive methods. The modest health risks of oral contraceptives frequently are exaggerated, whereas the more considerable benefits are underestimated. Knowledge about emergency contraception is not widespread, and the relative effectiveness of various contraceptive methods often is not well understood. Moreover, the risk of unintended pregnancy in the absence of contraceptive use is underestimated, and many population groups lack accurate information on STDs and reproductive health in general.[22] The media—print, broadcast, and video—must be encouraged to help in the task of conveying accurate and balanced information on contraception, highlighting the benefits as well as the risks of contraceptives.

Access to quality contraceptive services continues to be an important factor in promoting healthy pregnancies and preventing unintended pregnancies. Although people in the United States view contraception as basic to their lives and their health care, health insurance plans traditionally have not covered family planning services. Three-fourths of U.S. women of childbearing age rely on private insurance; the extent to which they are covered for contraception can differ dramatically depending on the type of insurance.[23] Traditional plans provide the least comprehensive coverage for family planning services, while health maintenance organizations (HMOs) and newer managed care plans provide more comprehensive contraceptive coverage. 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.

Interim Progress Toward Year 2000 Objectives

Of the 12 family planning Healthy People 2000 objectives, progress has been made for 9 objectives. Substantial decreases have occurred in unintended pregnancy. The use of contraceptives among females aged 15 to 44 years at risk for unintended pregnancy has increased. The pregnancy rate for females using a con-

traceptive method has declined. Increases in adolescents' abstinence from sexual intercourse have occurred, as well as in their use of contraceptives. Although short of the year 2000 targets, decreases in adolescent pregnancy have been reported. Data are not available to update objectives on family planning counseling and age-appropriate preconception care counseling.

Note: Unless otherwise noted, data are from the Centers for Disease Control and Prevention, National Center for Health Statistics, *Healthy People 2000 Review, 1998–99*.

Family Planning

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

Number	Objective Short Title
9-1	Intended pregnancy
9-2	Birth spacing
9-3	Contraceptive use
9-4	Contraceptive failure
9-5	Emergency contraception
9-6	Male involvement in pregnancy prevention
9-7	Adolescent pregnancy
9-8	Abstinence before age 15 years
9-9	Abstinence among adolescents aged 15 to 17 years
9-10	Pregnancy prevention and sexually transmitted disease (STD) protection
9-11	Pregnancy prevention education
9-12	Problems in becoming pregnant and maintaining a pregnancy
9-13	Insurance coverage for contraceptive supplies and services

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

Target: 70 percent.

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

Target setting method: Better than the best.

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Pregnancies Among Females Aged 15 to 44 Years, 1995	Intended Pregnancy
	Percent
TOTAL	51
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	28
White	57
Hispanic or Latino	51
Not Hispanic or Latino	51
Black or African American	DNA
White	DNA
Family income level	
Poor	39
Near poor	47
Middle/high income	59

Pregnancies Among Females Aged 15 to 44 Years, 1995	Intended Pregnancy
	Percent
Select populations	
Age groups	
15 to 19 years	22
20 to 24 years	42
25 to 29 years	60
30 to 34 years	67
35 to 39 years	59
40 to 44 years	49
Marital status	
Currently married	69
Formerly married	38
Never married	22

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

A significant decline in the rates of unintended pregnancy has occurred, indicating that progress toward a goal of increased intended pregnancy is possible. Between 1987 and 1994, the proportion of pregnancies that were unintended declined from 57 to 49 percent.[2] By comparison, the percentage of unintended pregnancy is much lower in some other countries—in 1994–95, it was 39 percent in Canada and 6 percent in the Netherlands.[3] Overall, females in the United States spend three-fourths of their reproductive years trying to avoid pregnancy.[17] Unintended pregnancy often is mistakenly perceived as predominantly an adolescent problem; however, unintended pregnancy is a problem among all reproductive age groups. In 1994, nearly one-half (48 percent) of females aged 15 to 44 years had at least one unintended pregnancy in their lifetime, more than one-fourth (28 percent) had one or more unplanned births, nearly one-third (30 percent) had one or more abortions, and 1 in 10 (11 percent) had both an unintended birth and an induced abortion.[2] A goal of 70 percent is ambitious and will require strategies to reduce the gaps among population groups.

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

Target: 6 percent.

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

Target setting method: Better than the best.

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Females Aged 15 to 44 Years, 1995	New Birth Occurred Within 24 Months of Previous Birth
	Percent
TOTAL	11
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	14
White	10
Hispanic or Latino	14
Not Hispanic or Latino	10
Black or African American	14
White	10
Family income level (aged 20 to 44 years)	
Poor	20
Near poor	11
Middle/high income	7
Disability status	
Persons with disabilities	DNC
Persons without disabilities	DNC
Select populations	
Age groups	
15 to 19 years	9
20 to 24 years	14
25 to 29 years	10
30 to 34 years	11
35 to 39 years	10
40 to 44 years	DSU

Females Aged 15 to 44 Years, 1995	New Birth Occurred Within 24 Months of Previous Birth
	Percent
Marital status	
Currently married	11
Formerly married	13
Never married	11

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

Encouraging females of all ages to space their pregnancies adequately can help lower their risk of adverse perinatal outcomes. To the extent that very closely spaced pregnancies are unplanned, unintended pregnancy may increase the risk of low birth weight.[4] A recent study indicates that females who wait 18 to 23 months after delivery before conceiving their next child lower their risk of adverse perinatal outcomes, including low birth weight, preterm birth, and small-for-size gestational age.[24] Health care providers can help all new mothers understand that they can become pregnant again soon after delivery and should assist them with contraceptive education and supplies.

For adolescents, bearing a child is associated with poor outcomes for young females and their children. Giving birth to a second child while still a teen further increases these risks. The prevention of second and subsequent births to very young females is of great interest to public health. Research has shown that such births are associated with physical and mental health problems for the mother and the child.[25] Yet, analysis indicates that in the 2 years following the first birth, teenaged mothers have a second birth at about the same rate as other mothers. In 1997, nearly one in every five births to teenaged mothers was a birth of second order or higher.[26]

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

Target: 100 percent.

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

Target setting method: Total coverage.

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

Females Aged 15 to 44 Years at Risk of Unintended Pregnancy, 1995	Used Contraception
	Percent
TOTAL	93
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	90
White	93
Hispanic or Latino	91
Not Hispanic or Latino	93
Black or African American	90
White	93
Family income level	
Poor	92
Near poor	91
Middle/high income	93
Select populations	
Age groups	
15 to 19 years	81
20 to 24 years	91
25 to 29 years	94
30 to 34 years	94
35 to 39 years	95
40 to 44 years	93
Marital status	
Currently married	95
Formerly married	92
Never married	88

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

The percentage of at-risk females using any form of contraception rose from 88 in 1982 to 93 in 1995.[27] Increasing the target to 100 percent by 2010 will be challenging and could reduce dramatically occurrences of unintended pregnancy. Poor or nonexistent contraceptive use is one of the main causes of unintended pregnancy, with unintended pregnancy occurring among two groups: females using no contraception and females whose contraceptives fail or are used improperly. In the

United States, the small proportion of females who are at risk of unintended pregnancy and use no method of contraception account for over half of all unintended pregnancies. Reducing the proportion of sexually active persons using no birth control method and increasing the effectiveness (correct and consistent use) with which persons use contraceptive methods would do much to lower the unintended pregnancy rate.[28] Just reducing the proportion of females not using contraception by half could prevent as many as one-third of all unintended pregnancies and 500,000 abortions per year.[29]

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

Target: 7 percent.

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

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

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Females Aged 15 to 44 Years Using Reversible Contraception, 1995	Experienced Pregnancy
	Percent
TOTAL	13
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	DNC
White	DNC
Hispanic or Latino	15
Not Hispanic or Latino	DNA
Black or African American	20
White	11
Family income level	
Poor	DSU
Near poor	18
Middle/high income	10

Females Aged 15 to 44 Years Using Reversible Contraception, 1995	Experienced Pregnancy
	Percent
Disability status	
Persons with disabilities	DNC
Persons without disabilities	DNC
Select populations	
Marital/cohabiting status	
Married	9
Cohabiting	22
Unmarried, not cohabiting	14

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

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The public health benefits of improved contraceptive practices are potentially enormous. Whether fertile females who are sexually active and do not want to get pregnant experience an unintended pregnancy is a function of their choice—and their partners' choice—of contraceptive methods and how effectively they use them. The efficacy of reversible contraceptive methods depends on consistent and appropriate usage. Unintended pregnancies experienced by females using reversible methods are primarily a result of inconsistent and/or inappropriate use.[30] Ideally, an objective would focus on consistent and correct use of a particular method. The data, however, cannot address the role that method switching may play in unintended pregnancy.

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

Potential data source: The Alan Guttmacher Institute.

The *U.S. Guide to Clinical Preventive Services*[16] identifies postcoital administration of emergency contraceptive pills (ECP) after unprotected intercourse as an effective means of reducing subsequent pregnancy. ECP is estimated to reduce the risk of subsequent pregnancy by 75 percent. Yet this method, which has the public health potential of significantly reducing unintended pregnancy, is not well known and not yet widely available to the public. Surveys indicate that knowledge and use of postcoital contraception remains low among patients and clinicians alike.[29] In 1995, less than 1 percent of females in the United States reported ever having used ECP.[31]

Several developments, however, have formalized recognition within the medical community of ECP as an effective means of preventing pregnancy, including the American College of Obstetricians and Gynecologists issuance of practice guidelines for emergency oral contraception. Barriers to the more frequent use of ECP

include a lack of physician awareness of the method, a lack of public awareness of the method's availability, and a lack of access by patients to a physician who will prescribe the method.[32] Increased public awareness, including culturally and linguistically competent education about ECP as well as direct access to and insurance reimbursement for ECP, would contribute significantly toward attainment of this objective.

In February 1997, the Food and Drug Administration (FDA) announced that certain regimens of combined oral contraceptives are safe and effective for ECP when initiated within 72 hours after unprotected intercourse.[33] The FDA notice was intended to encourage manufacturers to make this additional contraceptive option available.[33] One product, an emergency contraceptive kit, has been approved by FDA and is being marketed. On July 28, 1999, FDA approved the first progestin-only emergency contraceptive.

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

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

There is increasing recognition of the value of male involvement in pregnancy prevention and family planning. Several related developments in public health and welfare demonstrate that male involvement is key, including culturally and linguistically appropriate programs promoting condom use and addressing HIV and STD prevention, culturally and linguistically competent services targeting men as part of managed care marketing strategies, emphasis on male responsibility in welfare, child support enforcement, and pregnancy prevention efforts. Concern about the spread of HIV and other STDs and the recognition of condoms as the most effective way of preventing transmission during intercourse have accentuated the need to change the sexual behavior of males. The need for rapid treatment of male partners of females testing positive for bacterial STDs is a critical element in slowing not only STD spread but also that of HIV.

Yet, information about how males could and should participate in pregnancy prevention programs is lacking. For many years, reproductive policy in the United States concentrated almost entirely on females. The National Survey of Adolescent Males (NSAM), begun in 1988 by the Urban Institute and repeated again in 1995, collected the first national trend data on the reproductive behavior of male teens. An Urban Institute survey of publicly funded family planning clinics found that males make up more than 10 percent of the total clientele in only 13 percent of clinics. An average of 6 percent of clients are males. Males represent an even smaller share of clients who receive family planning services subsidized by the Title X program (2 percent in 1991) or by Medicaid (2 percent in 1990).[34] Even though males do not actually get pregnant, integrating them in prevention programs makes sense. Males must be included in any efforts to address unintended pregnancy.[35]

The next National Survey of Family Growth (NSFG) is being expanded to include males, providing an avenue for institutionalizing data collection about male fertility that will be reflected in the Healthy People 2010 objectives. Over the course of Healthy People 2010, male measures for family planning objectives will shift from NSAM to NSFG. NSFG will be able to collect information from males about sexual activity, contraceptive use, pregnancies to which they contribute, and the outcomes of these pregnancies, as well as male perceptions of their and their partners' views on the intendedness of pregnancies and births. NSFG will cover a broader range of male age groups than had been covered under the NSAM, which included only males aged 15 to 19 years.

9-7. Reduce pregnancies among adolescent females.

Target: 43 pregnancies per 1,000.

Baseline: 68 pregnancies per 1,000 females aged 15 to 17 years occurred in 1996.

Target setting method: Better than the best.

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Females Aged 15 to 17 Years, 1996	Pregnancy
	Rate per 1,000
TOTAL	68
Race and ethnicity	
American Indian or Alaska Native	DNC
Asian or Pacific Islander	DNC
Asian	DNC
Native Hawaiian and other Pacific Islander	DNC
Black or African American	124
White	58
Hispanic or Latino	105
Not Hispanic or Latino	62
Black or African American	128
White	44
Family income level	
Poor	DSU
Near poor	DSU
Middle/high income	DSU

Females Aged 15 to 17 Years, 1996	Pregnancy
	Rate per 1,000
Disability status	
Persons with disabilities	DNC
Persons without disabilities	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

The teenage pregnancy rate in the United States is much higher than in many other developed countries—twice as high as in England and Wales, France, and Canada and nine times as high as in the Netherlands or Japan.[10] Teenage pregnancy remains an intense national issue, within the context of public health and welfare reform, concerning the optimum potential of the Nation's youth and the growth and development of newborns. Most adolescent childbearing occurs outside marriage, a trend that has increased markedly during the past two decades. In 1997, 78 percent of births to adolescent females (under age 20 years) were out of wedlock, compared to 44 percent two decades earlier (1977).[26]

Females under age 15 years experience about 30,000 pregnancies each year.[36] Consensus is widespread that all pregnancies in this age group are inappropriate and that ideally the target number should be zero. Nearly two-thirds of pregnancies in this age group end in induced abortion or fetal loss. Because of the relatively small numbers of events (and small sample sizes for fetal losses) involved, the resulting rates are not as stable as for older females. Almost no discernible decline in pregnancy rates for this age group occurs on an annual basis. Therefore, baseline and target data for pregnancies among adolescents under age 15 years are not included in this objective.[36]

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

Target and baseline:

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

Target setting method: Better than the best.

Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.

Adolescents Aged 15 to 19 Years, 1995	No Intercourse Before Age 15 Years	
	9-8a. Females	9-8b. Males
	Percent	
TOTAL	81	79
Race and ethnicity		
American Indian or Alaska Native	DSU	DSU
Asian or Pacific Islander	DSU	DSU
Asian	DSU	DNC
Native Hawaiian and other Pacific Islander	DSU	DNC
Black or African American	70	50
White	83	84
Hispanic or Latino	76	73
Not Hispanic or Latino	81	79
Black or African American	69	51
White	83	86
Family income level		
Poor	DSU	DNC
Near poor	DSU	DNC
Middle/high income	DSU	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

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

Target and baseline:

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

Target setting method: Better than the best.

Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.

Adolescents Aged 15 to 17 Years, 1995	Never Engaged in Sexual Intercourse	
	9-9a. Females	9-9b. Males
	Percent	
TOTAL	62	57
Race and ethnicity		
American Indian or Alaska Native	DSU	DSU
Asian or Pacific Islander	DSU	DSU
Asian	DSU	DNC
Native Hawaiian and other Pacific Islander	DSU	DNC
Black or African American	51	24
White	63	64
Hispanic or Latino	49	50
Not Hispanic or Latino	64	57
Black or African American	52	24
White	65	65
Family income level		
Poor	DSU	DNC
Near poor	DSU	DNC
Middle/high income	DSU	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Sexual experience, and particularly age at first intercourse, represents a critical indicator of the risk of pregnancy and STDs. Although all forms of intercourse (vaginal, oral, and anal) involve risk of disease transmission, this chapter focuses on avoiding unintended pregnancy and not on sexual behavior per se. Therefore, the relevant objectives reference heterosexual, vaginal intercourse only. Youth who begin having sex at younger ages are exposed to these risks over a longer period of time. Research has shown that youth who have early sexual experiences are more likely at later ages to have more sexual partners and more frequent intercourse.[37] Adolescents should be encouraged to delay sexual intercourse until they are physically, cognitively, and emotionally ready for mature sexual relationships and their consequences. They should receive education about intimacy; setting limits; resistance to social, media, peer, and partner pressure; the benefits of abstinence from intercourse; and prevention of pregnancy and STDs. Because many adolescents are or will be sexually active, they should receive support and assistance in developing the skills to evaluate their readiness for mature sexual relationships. Culturally and linguistically appropriate materials are needed that can capture the attention and affect the behaviors of these youth.

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

Target and baseline:

Objective	Increase in Contraceptive Use at First Intercourse by Sexually Active, Unmarried Adolescents Aged 15 to 17 Years	1995 Baseline	2010 Target
		Percent	
	Condom		
9-10a.	Females	67	75
9-10b.	Males	72	83
	Condom plus hormonal method		
9-10c.	Females	7	9
9-10d.	Males	8	11

Target setting method: Better than the best.

Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Sexually Active, Unmarried Adolescents Aged 15 to 17 Years, 1995	Used Condom at First Intercourse		Used Condom Plus Hormonal Method at First Intercourse	
	9-10a. Females	9-10b. Males	9-10c. Females	9-10d. Males
	Percent			
TOTAL	67	72	7	8
Race and ethnicity				
American Indian or Alaska Native	DSU	DSU	DSU	DSU
Asian or Pacific Islander	DSU	DSU	DSU	DSU
Asian	DSU	DNC	DSU	DNC
Native Hawaiian and other Pacific Islander	DSU	DNC	DSU	DNC
Black or African American	60	60	9	12
White	72	77	6	8
Hispanic or Latino	52	64	DSU	7
Not Hispanic or Latino	71	70	7	7
Black or African American	60	61	9	11
White	75	79	6	8

Sexually Active, Unmarried Adolescents Aged 15 to 17 Years, 1995	Used Condom at First Intercourse		Used Condom Plus Hormonal Method at First Intercourse	
	9-10a. Females	9-10b. Males	9-10c. Females	9-10d. Males
	Percent			
Family income level				
Poor	DSU	DNC	DSU	DNC
Near poor	DSU	DNC	DSU	DNC
Middle/high income	DSU	DNC	DSU	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

Target and baseline:

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

Target setting method: Better than the best.

Data sources: Females—National Survey of Family Growth (NSFG), CDC, NCHS; Males—National Survey of Adolescent Males (NSAM), Urban Institute.

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Sexually Active, Unmarried Adolescents Aged 15 to 17 Years, 1995	Used Condom at Last Intercourse		Used Condom Plus Hormonal Method at Last Intercourse	
	9-10e. Females	9-10f. Males	9-10g. Females	9-10h. Males
	Percent			
TOTAL	39	70	7	16
Race and ethnicity				
American Indian or Alaska Native	DSU	DSU	DSU	DSU
Asian or Pacific Islander	DSU	DSU	DSU	DSU

Sexually Active, Unmarried Adolescents Aged 15 to 17 Years, 1995	Used Condom at Last Intercourse		Used Condom Plus Hormonal Method at Last Intercourse	
	9-10e. Females	9-10f. Males	9-10g. Females	9-10h. Males
	Percent			
Asian	DSU	DSU	DSU	DSU
Native Hawaiian and other Pacific Islander	DSU	DSU	DSU	DSU
Black or African American	48	78	10	19
White	38	67	6	15
Hispanic or Latino	26	59	DSU	10
Not Hispanic or Latino	42	65	9	17
Black or African American	47	78	10	18
White	40	69	8	16
Family income level				
Poor	DSU	DNC	DSU	DNC
Near poor	DSU	DNC	DSU	DNC
Middle/high income	DSU	DNC	DSU	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

There are two major health consequences of unprotected intercourse among youth—STDs, including HIV infection, and unintended pregnancy. Although abstinence is the most effective way for adolescents to avoid STDs and pregnancy and should be stressed as the certain way to prevent STDs and pregnancy, sexually active teens must be taught to use condoms properly, effectively, and consistently. Teenaged females and males who depend upon hormonal methods of contraception must be educated about the inability of these methods to prevent STDs. (See Focus Area 13. HIV and Focus Area 25. Sexually Transmitted Diseases.) Condom use must be promoted in conjunction with other contraceptive methods.[38]

Public health messages encourage individuals whose behavior places them at risk of exposure to STDs, HIV, and unintended pregnancy to use condoms, as well as effective pregnancy prevention methods, consistently and correctly.[39] Sexual intercourse in the teen years, especially first intercourse, often is unplanned and unprotected by contraception. Condom use at last intercourse has risen substantially and significantly among both male and female teenagers, suggesting more protection from STD transmission. Condom use at first intercourse also has risen—an

important indicator of how well teenagers anticipate and plan for protection at the initiation of sexual activity. Culturally and linguistically appropriate materials are needed that can capture the attention and affect the behaviors of these youth.

While condom use has risen among most teenagers, the use of oral contraceptives has dropped dramatically, suggesting greater vulnerability to unintended pregnancy if other hormonal methods or consistent use of condoms is not practiced. Among currently sexually active females, the use of oral contraceptives at last intercourse fell from 43 percent to 25 percent between 1988 and 1995. The reductions in the use of oral contraception are evident across African American, Hispanic, and white teenagers. Some of the reduction in oral contraceptive use is counteracted by the adoption of new hormonal methods of contraception, such as hormonal implants and injectables. In 1995, 7 percent of sexually active teenaged females overall used these methods at last intercourse. They were used most widely among sexually active African American teenaged females: 16 percent reported using either a hormonal implant or an injectable at last intercourse.[40]

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

Target: 90 percent.

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

Target setting method: Better than the best.

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Females Aged 18 to 24 Years, 1995	Received Reproductive Health Instruction Prior to Age 18 Years		
	9-11. Aged 18 to 24 Years	Aged 18 to 19 Years*	Aged 20 to 24 Years*
	Percent		
TOTAL	64	80	57
Race and ethnicity			
American Indian or Alaska Native	DSU	DSU	DSU
Asian or Pacific Islander	DSU	DSU	DSU
Asian	DSU	DSU	DSU

Females Aged 18 to 24 Years, 1995	Received Reproductive Health Instruction Prior to Age 18 Years		
	9-11. Aged 18 to 24 Years	Aged 18 to 19 Years*	Aged 20 to 24 Years*
	Percent		
Native Hawaiian and other Pacific Islander	DSU	DSU	DSU
Black or African American	65	81	59
White	64	81	57
Hispanic or Latino	56	69	51
Not Hispanic or Latino	65	82	58
Black or African American	66	80	60
White	65	83	58
Family income level			
Poor	63	82	56
Near poor	58	76	52
Middle/high income	66	81	60
Sexual orientation	DNC	DNC	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.
*Data for females aged 18 to 19 years and 20 to 24 years are displayed to further characterize the issue.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

All adolescents need education that teaches the interpersonal skills they will need to withstand pressure to have sex until they are ready and that includes up-to-date information about methods to prevent pregnancy and STDs. More important, they need to receive this education before they start having sex. Ideally, such education would be developmentally appropriate, include special education students, be culturally and linguistically appropriate, be medically accurate, involve parents, and be linked into a broader context of avoiding risky health behaviors and promoting improved health. Education and knowledge, however, are not enough. Adolescents need strong reinforcement from parents, schools, the media, and other sources about the importance of making conscious, informed, responsible decisions regarding whether to have intercourse; the necessity of consistent, correct condom use to protect themselves and their partners against STDs and HIV; and the use of effective contraception to prevent unintended pregnancy. (See Focus Area 13. HIV and Focus Area 25. Sexually Transmitted Diseases.)

Becoming a sexually healthy adult is a key developmental task of adolescence. Adults can encourage adolescent sexual health by providing accurate information and education about sexuality, fostering responsible decisionmaking skills, offering support and guidance in exploring and affirming personal values, and model-

ing healthy sexual attitudes and behaviors. Discussions between parents and their children about sexuality and their family value system related to sexual behavior are crucial. Yet, many parents of adolescents aged 10 to 15 years in families today do not talk enough about such important topics as relationships and becoming sexually active.[41]

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

Target: 10 percent.

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

Target setting method: 23 percent improvement.

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

NOTE: THE TABLE BELOW MAY CONTINUE TO THE FOLLOWING PAGE.

Married Couples With Wives Aged 15 to 44 Years, 1995	Impaired Fecundity
	Percent
TOTAL	13
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	14
White	13
Hispanic or Latino	13
Not Hispanic or Latino	13
Black or African American	14
White	13
Family income level (aged 20 to 44 years)	
Poor	15
Near poor	13
Middle/high income	13

Married Couples With Wives Aged 15 to 44 Years, 1995	Impaired Fecundity
	Percent
Select populations	
Parity status	
Parity 0	25
Parity 1 or more	10

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

NOTE: THE TABLE ABOVE MAY HAVE CONTINUED FROM THE PREVIOUS PAGE.

A woman is classified as having impaired fecundity if it is impossible for her (or her husband or cohabiting partner) to have a baby for any reason other than a sterilizing operation, it is difficult or dangerous to carry a baby to term, or she and her partner have not used contraception and have not had a pregnancy for 3 years or longer. Impaired fecundity includes problems carrying pregnancies to term in addition to problems conceiving, whereas infertility includes only problems conceiving. By 1995, there had been a small overall decline in infertility, which was more marked in Hispanic couples.

Although infertility itself does not represent a serious public health threat, it carries significant personal, societal, and economic consequences that call for data surveillance and action. Infertility due to STDs is a preventable condition. Diagnosis and treatment of infertility are very costly, time-consuming, and invasive, and they can place immense stress on marital and family relations. Furthermore, those costs are likely to rise. The trend to delay childbearing (fecundity becomes increasingly impaired with age), the availability of fewer infants for adoption, and the development of new drugs and treatment procedures will mean that more and more couples seek expensive infertility services.

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

Potential data source: The Alan Guttmacher Institute.

In a 1995 report, the Institute of Medicine concluded that among the reasons for high rates of unintended pregnancy in the United States was lack of contraceptive coverage by private health insurance.[4] The report noted that many privately insured females who need contraceptive care must go out of plan and pay for it themselves, use over-the-counter methods that may be less effective, or not use any method at all. It recommended increasing the proportion of health insurance policies that cover contraceptive services and supplies.

The issue of private insurance coverage for reversible contraceptive methods affects most women and their families. Both newer managed care insurance plans

and traditional fee-for-service insurance plans are more likely to pay for general gynecological services than they are to cover contraceptive services or supplies.[42] Many insurance plans do not cover reversible contraceptive methods. A 1993 survey conducted by the Alan Guttmacher Institute found that half of indemnity plans and 7 percent of health maintenance organizations (HMOs) do not cover nonpermanent contraception. The survey also found that plans that do cover contraceptive services and/or supplies are often inconsistent in which methods they cover and have a pronounced bias toward covering permanent surgical methods.[43]

Related Objectives From Other Focus Areas

1. Access to Quality Health Services
- 1-2. Health insurance coverage for clinical preventive services
- 1-3. Counseling about health behaviors
- 1-7. Core competencies in health provider training

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

7. Educational and Community-Based Programs
- 7-2. School health education
- 7-3. Health-risk behavior information for college and university students
- 7-9. Health care organization sponsorship of community health promotion activities
- 7-11. Culturally appropriate and linguistically competent community health promotion programs

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

13. HIV
- 13-1. New AIDS cases
- 13-5. New HIV cases
- 13-6. Condom use
- 13-7. Knowledge of serostatus
- 13-9. HIV/AIDS, STD, and TB education in State prisons
- 13-10. HIV counseling and testing in State prisons
- 13-12. Screening for STDs and immunization for hepatitis B
- 13-14. HIV-infection deaths
- 13-15. Interval between HIV infection and AIDS diagnosis
- 13-17. Perinatally acquired HIV infection

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

15. Injury and Violence Prevention

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

16. Maternal, Infant, and Child Health

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

19. Nutrition and Overweight

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

25. Sexually Transmitted Diseases

25-1. Chlamydia
25-2. Gonorrhea
25-3. Primary and secondary syphilis
25-4. Genital herpes
25-5. Human papillomavirus infection
25-6. Pelvic inflammatory disease (PID)
25-7. Fertility problems
25-8. Heterosexually transmitted HIV infection in women
25-9. Congenital syphilis
25-10. Neonatal STDs
25-11. Responsible adolescent sexual behavior
25-12. Responsible sexual behavior messages on television
25-13. Hepatitis B vaccine services in STD clinics
25-14. Screening in youth detention facilities and jails
25-15. Contracts to treat nonplan partners of STD patients
25-16. Annual screening for genital chlamydia
25-17. Screening of pregnant women
25-18. Compliance with recognized STD treatment standards
25-19. Provider referral services for sex partners

26. Substance Abuse

26-19. Treatment in correctional institutions

Terminology

(A listing of abbreviations and acronyms used in this publication appears in Appendix H.)

Contraception (birth control): The means of pregnancy prevention. Methods include permanent methods (vasectomy for men and tubal ligation for women) and temporary methods (for example, hormonal implant, injectable, birth control pill, emergency contraceptive pills, intrauterine device, diaphragm, female condom, male condom, spermicidal foam/cream/jelly, sponge, cervical cap, abstinence, natural family planning, calendar rhythm, and withdrawal).

Emergency contraceptive pills (ECPs): The use of prescribed doses of birth control pills to prevent pregnancy following unprotected vaginal intercourse. The pills must be taken within 72 hours of having unprotected sex.

Family planning: The process of establishing the preferred number and spacing of one's children, selecting the means to achieve the goals, and effectively using that means.

Federal Title X Family Planning Program: A program created in 1970 as Title X at the Public Health Service Act. The program provides grants for the provision of family planning information and services.

Impaired fecundity: A broad term used to describe problems with pregnancy loss as well as problems conceiving a pregnancy.

Infertility: Failure to conceive a pregnancy after 12 months of unprotected intercourse.

Intended pregnancy: A pregnancy that a woman states was wanted at the time of conception.

Mistimed conception: Those that were wanted by the woman at some time in the future but occurred sooner than they were wanted. For example, a woman became pregnant at age 18 years but actually wanted to have her first child at age 21 years.

Parity: The number of live births a woman has had.

Unintended pregnancy: A general term that includes pregnancies a woman reports as either mistimed or unwanted at the time of conception. If an unintended pregnancy occurs and is carried to term, the birth may be a wanted one, but the pregnancy would be classified as unintended.

Unwanted conception: Those that occurred when the woman did not want any pregnancy then or in the future. For example, a woman wanted only two children but became pregnant with her third.

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