Family Planning and Perinatal Health

GOAL

Improve pregnancy planning and spacing, prevent unintended pregnancy, and improve the health of women and infants.

Overview

Although couples today can have considerable control over their fertility, half of all pregnancies nationally are unintended. When pregnancies are planned and desired, the health of mothers, infants, and the entire family improves.

Measurements that gauge the health status of pregnant women and infants are a key barometer not only of the health of a family but also of the entire society since so many community factors and support systems contribute toward the health of these two vulnerable populations.

Overall, Maine is doing well in the areas of reproductive and perinatal health compared to other states. However, there is much room for improvement. Worldwide, for instance, the United States ranks 25th for infant mortality and ranks poorly for teenage birth rates among developed countries.

Successful strategies and systems implemented in Maine and other geographic areas are important to recognize and understand if we are to maintain and improve upon our successes in family planning and perinatal health. Particularly as our population in Maine becomes more diverse, assuring that our strategies are culturally competent and linguistically appropriate is also important if we are to improve the health of all Maine families.

The Centers for Disease Control and Prevention characterizes family planning as one of the "Ten Great Public Health Achievements" of the twentieth century.

Strategies

PRIMARY
SECONDARY
TERTIARY

- **Community-Based Initiatives:** Examples of community-based efforts include Healthy Communities, Child Abuse and Neglect Councils, community-based domestic violence prevention initiatives, Communities for Children, and Healthy Maine Partnerships that all work to create community environments that are healthier for families.
- **Comprehensive Family Life Education:** Over the past two decades, Maine schools have increasingly provided comprehensive school health education, with one component being sexual health, including abstinence.
- **Universal Vaccinations:** For the past five years, all necessary childhood vaccines have been provided free by the Bureau of Health to licensed health care providers for all children.
- **Folic Acid:** Ensuring that all women of reproductive age take adequate folic acid is critical to preventing spina bifida and other neural tube defects.
- **Public Health Nursing:** Specific attention to reproductive and perinatal health issues began in Maine in 1920 with the development of Public Health Nursing, which was established to address Maine's high infant mortality rate (which was then 102 per 1,000 live births) through working with high risk families. They also employ primary prevention strategies such as providing community education on hygiene, nutrition, and perinatal care.
- **Universal Home Visits:** Although traditionally home visits to families in the perinatal period have been offered to high-risk families (secondary prevention), Maine's system of home visits is being expanded to include almost all newborns to first-time parents (primary prevention).
- **Nutrition:** Supplemental nutrition and education through such programs as Food Stamps, WIC (Women, Infants and Children), Healthy Maine Partnerships Campaign, and University of Maine Cooperative Extension assure proper nutrition to pregnant women and young children, with a focus on those at high risk for poor nutrition.
- **Screening Programs:** Preconception and prenatal genetic testing and counseling services, universal newborn screening for metabolic disorders, and newborn hearing tests are common screening programs that help identify risks and problems early so timely interventions can improve chances for healthy outcomes.
- **Preventive Care:** Availability of preventive reproductive health care through private and public providers, such as Maine's 30 family planning clinics as well as rural, migrant and Indian health centers, assure women and infants have access to effective preventive care – including preconception, prenatal, and postnatal care, tobacco cessation and substance abuse treatment programs. Additionally, EPSDT (Early Periodic Screening Development Treatment Program) assure those children with MaineCare insurance (previously Medicaid or Cub Care) have access to preventive care.
- **Access:** MaineCare (Medicaid and Cub Care) covers all pregnant women and infants under 200% of the Federal Poverty Level ($3,017 monthly income for a family of four in 2002), which is about 40% of pregnant women and infants in Maine.
- **Specialty Care:** Transportation services to and availability of specialty care for high-risk pregnancies and sick infants are important for the health of all Maine pregnant women and infants. Maine's tertiary care hospitals provide these critical services throughout Maine, and programs such as Katie Beckett and Children with Special Health Needs Program assure coverage for specialty care for some disabled or sick children.

Health Disparities

(Populations at risk for experiencing barriers to family planning and perinatal health, based on national data in *Healthy People 2010*)

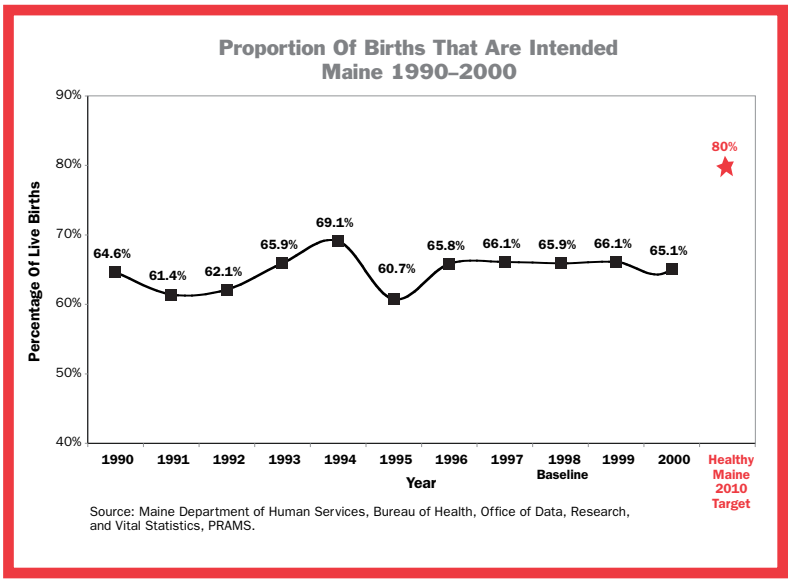
- **Young mothers under age 16** (higher rates of unintended pregnancy, lower rates of early and adequate prenatal care, higher rates of infant mortality)
- **Older mothers over age 44** (higher rates of infant mortality)
- **African Americans** (higher rates of unintended pregnancy, lower rates of early and adequate prenatal care, higher rates of young maternal age and high birth order, higher infant and maternal mortality rates, higher rates of low birth weight, lower rates of breastfeeding, higher rates of death from sudden infant death syndrome)
- **Hispanics** (less likely to receive early prenatal care)
- **Native Americans** (less likely to receive adequate prenatal care, higher rates of fetal alcohol syndrome)
- **Low Socioeconomic Status** (higher rates of unintended pregnancy)

Objectives

Objective numbers are *Healthy People 2010* objective numbers.

- **9–1 Increase the proportion of births that are intended.**

Healthy Maine 2010 Baseline: 65.9%
Healthy Maine 2010 Target: 80%

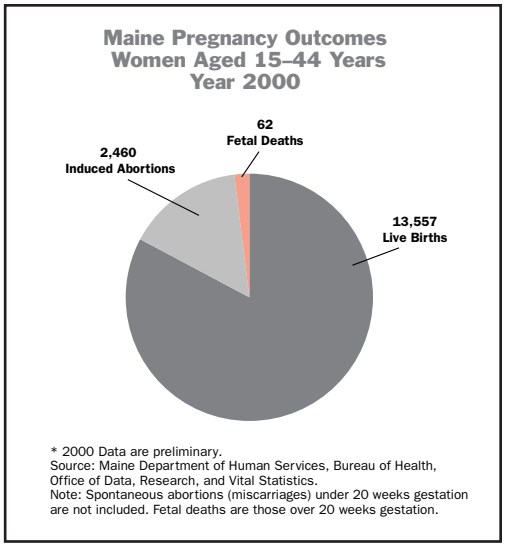


It is difficult to ascertain the proportion of all *pregnancies* that are intended since pregnancies include those that result in live births, induced abortions, fetal deaths, and miscarriages (spontaneous abortions), and there is no ongoing survey that asks all pregnant women whether their pregnancy was intended or not. A national attempt to measure this using a number of different data sources resulted in an estimate that 51% of all pregnancies were intended in 1995. The Healthy People 2010 9–1 objective is to increase the proportion of *pregnancies* that are intended.

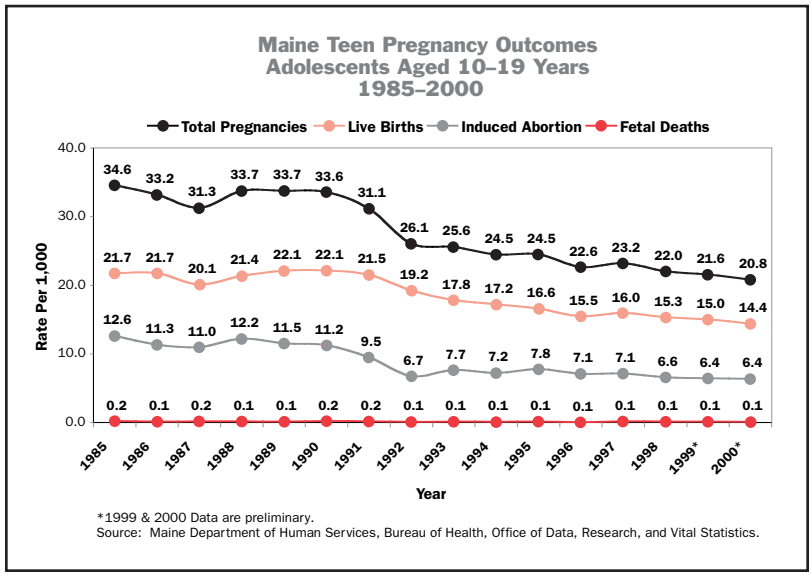
Maine's PRAMS survey asks a number of questions to a sample of women several months after giving birth, including whether or not they had intended to become pregnant. Therefore, the results of this question are used as the way to measure this Healthy Maine 2010 objective. However, it is limited by the fact that pregnancies, both unintended and intended, result in outcomes other than a live birth. Yet the only women interviewed by PRAMS are those who experienced a live birth. Therefore, the Healthy Maine

2010 9–1 objective is to increase the proportion of *births* that are intended.

There is room for much improvement in this objective since other developed countries often enjoy higher rates of intended pregnancies. For instance, the Netherlands has an estimated rate of intended pregnancies of 94%. In the US, adolescents are at highest risk for unintended pregnancy. An estimated half of all women ages 15–44 have had an unintended pregnancy at one time.



Increasing the proportion of intended pregnancies gives us great opportunity to improve the health not only of mothers and babies, but also of entire families. For instance, improvements in this objective can result in improvements in infant health, in educational attainment and employment opportunities for both parents, as well as reductions in welfare dependency, child abuse, and neglect.



Two strategies are critical to achieving this Healthy Maine 2010 objective:

1) *increasing access to comprehensive family life education in our schools and communities; and*
2) *increasing access to preventive reproductive health care.*

The Family Planning Association of Maine receives Federal Title X funds as well as other State, Federal and private funds to work with communities and partners across the State to help implement these strategies. A recent success in implementing these strategies was achieved in 2002 when the Maine Legislature passed An Act to Expand Family Life Education Services in Maine Schools, that for the first time defines and supports comprehensive family life education in Maine statute (see insert).

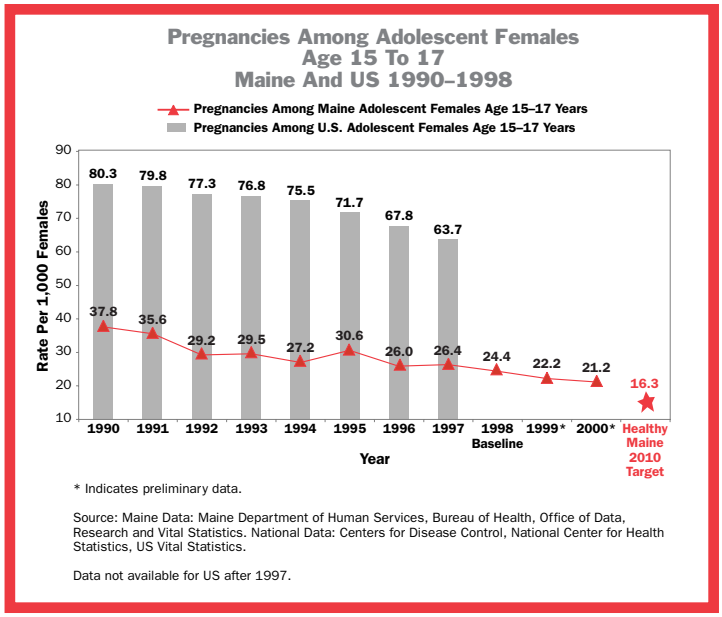
Induced abortions and teenage pregnancies correlate with unintended pregnancies, though a small percentage of teenage pregnancies and those pregnancies that end in induced abortions are intended. In order to add pertinent information to this objective about unintended pregnancies other than those that result in live births, charts are included on these subjects.

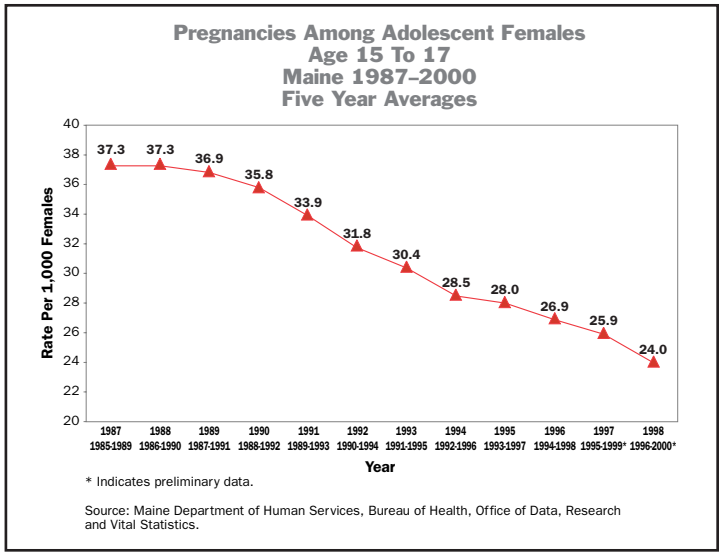
Miscarriage data is not included in these charts since nationally and Statewide there are no reliable ongoing data sources on the proportions of pregnancies that end in miscarriage (spontaneous abortion). With the advent of early home-pregnancy testing, it is increasingly recognized that a significant proportion of pregnancies end this way.

- **9–7 Reduce pregnancies among adolescent females (15–17 years).**

  Healthy Maine 2010 Baseline: 24.4
  Healthy Maine 2010 Target: 16.3

Although Maine is proud to have one of the lowest adolescent pregnancy rates in the country over the past eight years, there are many developed countries that have lower rates. For instance, Maine's rate is almost four times that found in the Netherlands and Japan. Additionally, Maine's rates are not as impressive when compared to the US rates for non-Hispanic whites. However, Maine has seen the sharpest decline in the country among its teenage pregnancy rates ages 15–19 during the 1990s.





The consequences of adolescent pregnancy are staggering to the entire family – teenaged mothers are less likely to get or stay married, less likely to complete high school or college, more likely to require public assistance, and to live in poverty. Infants born to teenaged mothers are more likely to suffer from low birth weight, neonatal death, sudden infant death syndrome, child abuse or neglect, and behavioral and educational problems at later stages.

The two strategies mentioned previously of improving access to comprehensive family life education in our schools and communities as well as improving access to preventive reproductive health care are critical to improving this objective.

MAINE STATUTE DEFINITION OF COMPREHENSIVE FAMILY LIFE EDUCATION

Enacted 2002

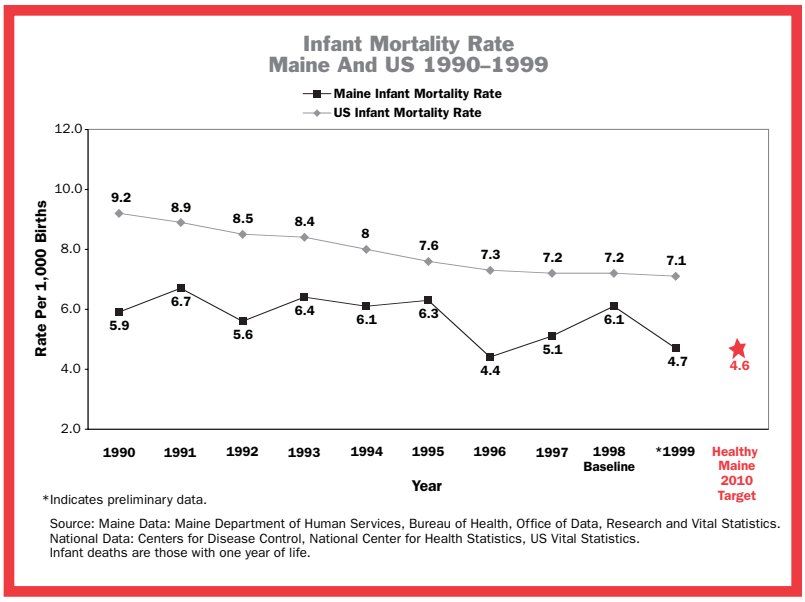
"Comprehensive family life education" means education in kindergarten to grade 12 regarding human development and sexuality, including education on family planning and sexually transmitted diseases, that is medically accurate and age appropriate; that respects community values and encourages parental communication; that develops skills in communication, decision making and conflict resolution; that contributes to healthy relationships; that promotes responsible sexual behavior with an emphasis on abstinence; that addresses the use of contraception; that promotes individual responsibility and involvement regarding sexuality; and that teaches skills for responsible decision making regarding sexuality. (Sec. 1. 22 MRSA §1902, sub - §1-A)

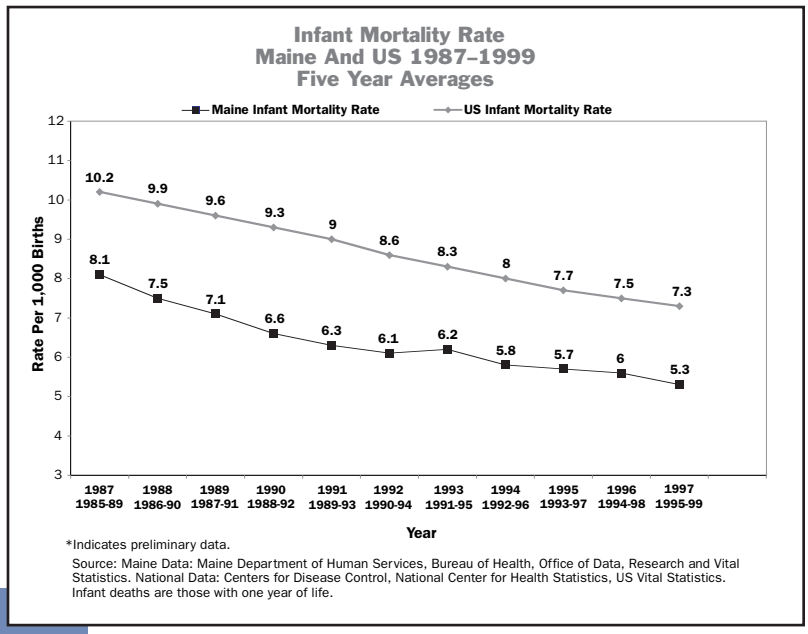
- **16–1 Reduce infant deaths.**

Healthy Maine 2010 Baseline: 6.1
Healthy Maine 2010 Target: 4.6

Infant death is a critical indicator of the health of a society since it reflects the overall state of maternal and infant health and the many social, environmental, and health care system factors that contribute toward the health of both these vulnerable populations. One hundred years ago in Maine, about one in eight babies born did not live to see their first birthday. Today, for babies born full term, that number has dropped to one in 1,000. During the last decade, Maine has consistently had the lowest or one of the lowest infant mortality rates in the nation.

Infant mortality is made up of two major components: neonatal mortality (death in the first 28 days of life) and postneonatal mortality (death from one month of age until the first birthday). The leading causes of neonatal death are birth defects, disorders due to prematurity and low birth weight, and pregnancy complications. The leading causes of postneonatal mortality include sudden infant death syndrome (SIDS), birth defects, and injuries.





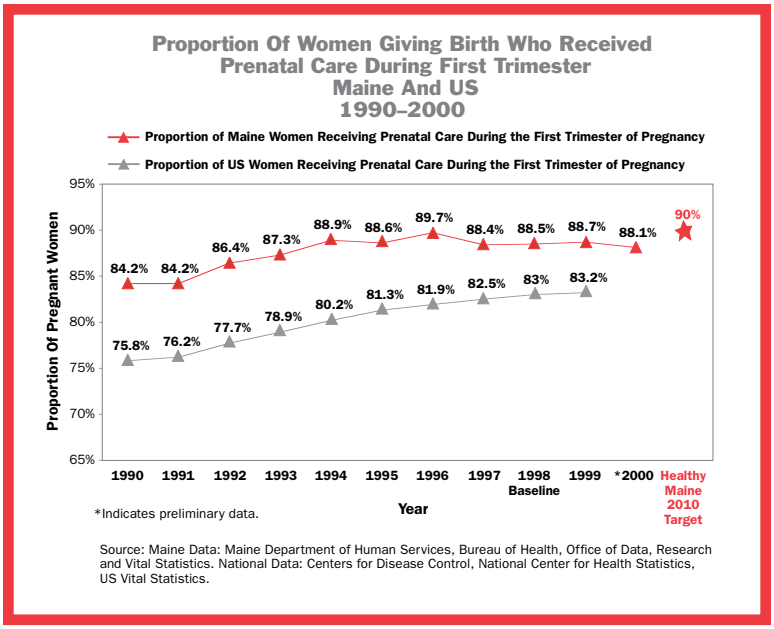
What is Title X?

Passed by Congress in 1970, Title X of the Public Health Service Act provides funding and regulations pertaining to family planning. As a result, a broad range of effective and medically approved family planning services are provided for across the country.

Preventable pregnancy complications resulting in fetal or neonatal death include those associated with alcohol use (nationally, fetal mortality is 77% greater in women who regularly use alcohol), tobacco (nationally, fetal mortality is 35% greater in women who regularly use tobacco), and illegal substances. Tobacco addiction is also associated with unhealthy low birth weight, prematurity, sudden infant death syndrome, and respiratory problems in newborns as well as an estimated 15% of costs for all complicated births.

- **16–6 Increase the proportion of pregnant women who receive early and adequate prenatal care.**

Healthy Maine 2010 Baseline: 88.5%
Healthy Maine 2010 Target: 90%

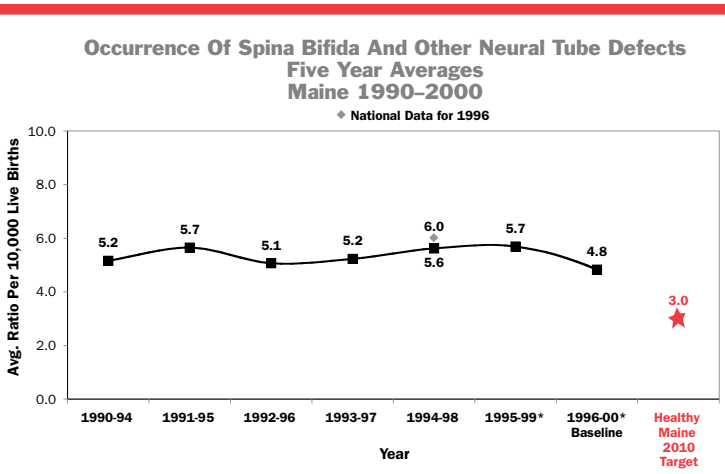


Much of prenatal care consists of screening for risks, treating any medical condition or risk that arises, and providing education. Therefore, early and ongoing adequate prenatal care is essential to a healthy pregnancy and baby.

This objective is measured from data obtained from birth certificates and therefore only detects prenatal care among those women who give birth. Although Maine has seen steady increases in this objective over the past decade to almost achieving the Healthy Maine 2000 and 2010 objectives of 90%, the challenge is now to determine who are those most likely to not receive early and adequate prenatal care, and focus our efforts on them. Nationally, mothers who are adolescents, African Americans, Native Americans, and Hispanics are most likely to not receive early and adequate prenatal care. Recent Medicaid expansions in Maine to include pregnant women to 200% of Federal poverty level should also help achieve this objective.

- **16–15 Reduce the occurrence of spina bifida and other neural tube defects.**

Healthy Maine 2010 Baseline: 4.8
Healthy Maine 2010 Target: 3.0



Neural tube defects, including spina bifida, occur when the fetal neural tube fails to close fully, interrupting development of the central nervous system.

About half of all neural tube defects can be prevented when women take adequate folic acid from one month before conception through the first three months of pregnancy. Rates of neural tube defects and death from this relatively common birth defect can be substantially reduced if all women capable of becoming pregnant consume 400 micrograms of folic acid daily. Since about one-third of Maine births are unplanned, it would be beneficial if all women of reproductive age (15–44 years) took daily folic acid.

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Over the past two decades, Maine has employed the two major Statewide strategies of increasing access to comprehensive family life education in our schools and communities as well as increasing access to preventive reproductive health care. As a result, teaching comprehensive family life education has increasingly become a community and school standard in Maine, and there are now 30 family planning clinics throughout the State. Maine has seen marked success using these strategies:

Decline in Teen Pregnancy Rates: In 1979, Maine's teen pregnancy rate was 67.9 per 1,000 females aged 15–19. The rate has decreased more than 35% to 41.3 per 1,000 in 2000, the sharpest decline in the country.

Decline in Teen Abortion Rates: Abortions among teens (ages 15–19) have dropped by 39% from 1988 to 2000.

Increase in Teen Abstinence: In 1991, 42% of high school students reported never having sexual intercourse, and in 2001 this increased to 53.7% (Maine Youth Risk Behavior Survey).