Teen Pregnancy In Rhode Island: Policies To Improve Outcomes

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The United States has one of the highest rates of teen pregnancy among industrialized countries, with more than 750,000 pregnancies each year among women less than 20 years of age.[1] Though teen pregnancy rates in the US had declined each year since 1991, the most recent national data show that rates of teen pregnancy, abortion, and birth are on the rise.[1] Rhode Island has 2,430 teen pregnancies per year, the highest prevalence among the New England states. In Rhode Island, 51% of these pregnancies result in live births and 35% in abortion.[2] Rates of teen pregnancy in Rhode Island vary by region: the highest rates from 2003-2007 were seen in Central Falls (95.5 births per 1,000 teens), followed by Woonsocket (65.2 births per 1,000 teens), Pawtucket (58.7 births per 1,000 teens), and Providence (48.0 births per 1,000 teens). [3]

Births to teens have long been associated with adverse outcomes, including individual and familial poverty and reduced educational attainment.[4,5,6] Children born to adolescent parents experience higher rates of behavioral and developmental disorders, substance abuse, depression, early sexual activity, and teen pregnancy.[7] Nationally, about 20% of births to teens are repeat births, which place additional socioeconomic and health pressures on teen parents.[8] In Rhode Island, the repeat birth rate in 2004 was 19% for women ages 15-19.[8]

Prevention of Teenage Pregnancy and Birth

Sexual education in schools

Comprehensive sexual education is an important tool to prevent teen pregnancy. From 1996 to 2009, federal funding of sexual education programs was available only for abstinence-only programs, which exclusively teach the benefits of abstaining from sexual activity.[9] Comprehensive sexual education programs promote abstinence but also provide information on contraception for pregnancy prevention and condoms for prevention of sexually transmitted infections. Well-designed studies of abstinence-only sexual education programs have found no significant impact on teen sexual activity or rates of unprotected sex.[9, 10] However, a population-based study of US sexual education programs found that teens who received comprehensive sex education were significantly less likely to become pregnant than those who received abstinence-only or no sex education.[11]

State law mandates that Rhode Island schools offer sexual education, including instruction on sexually transmitted infections and HIV, but requires abstinence to be emphasized and permits parental opt-out from participation.[12] From 2003-2007, Rhode Island received federal money to support abstinence-only education; the majority of this funding was distributed to community-based organizations. In 2008, Rhode Island declined Title V federal funding for abstinence-only-until-marriage programs. [13] Currently there is no standardized sexual education curriculum for Rhode Island schools and little teacher training or supervision.

Access to Contraception

Rhode Island is one of 27 states that require insurers to provide coverage of the full range of FDA approved contraceptive options.[14] However, approximately 62,670 reproductive-age, sexually-active Rhode Island women are in need of publicly-funded contraceptive services.[15] Among these, 19,660 (31.4%) are teens. A sexually active teen not using contraception has a 90% chance of pregnancy within one year.[16] In 2005, only 23% of Rhode Island teenagers in need received care from publically funded clinics.[17] In 2006, Rhode Island's family planning clinics received $3,778,000 from federal and state governments, or approximately $60 per woman in need of services.[18] These clinics are expected to deliver sexually transmitted infection screening and treatment, cervical cancer screening, education, contraceptive methods, and counseling to ensure consistent and correct use of contraception.

In addition to funding barriers, issues of consent may limit teens' access to contraceptive services in Rhode Island. While Connecticut allows confidential contraceptive access to married minors, and Massachusetts funds a statewide program to give all minors access to confidential contraceptive care, Rhode Island is one of only four states with no explicit policy on minors' authority to consent to contraceptive services.[19] As a result minors in Rhode Island are not assured confidentiality regarding contraceptive care and may have difficulty obtaining contraception if they are afraid to inform their parents of their sexual activity. Furthermore, Rhode Island lacks an emancipated minor law for parenting teens, so even those who already have children may need parental consent to obtain contraception to prevent repeat pregnancies.

Federal law requires access to confidential contraceptive services for all teens covered by Medicaid. While Rhode Island law does not prohibit physicians from providing contraceptives to minors without parental consent, there is no law protecting those who prescribe contraception to teens. Rhode Island's silence on this issue may discourage physicians from providing teens with confidential access to contraception. Programs such as California's comprehensive teen pregnancy prevention program which expand free confidential contraception and comprehensive sexual education for all teens are associated with reduced rates of teen sexual activity as well as substantially fewer births to teens.[20]

Another potential barrier to effective contraception for teens is lack of awareness among primary care providers about the safety of long-acting reversible contraceptive methods such as in-

trauterine contraception among teenagers. Historically, intrauterine devices were recommended only for monogamous women who had already given birth, but current evidence supports their safety and efficacy in nulliparous women.[21,22] Intrauterine devices and contraceptive implants are the most effective methods of reversible contraception available and should be discussed with all sexually active adolescents.

In addition, emergency contraception offers a chance to prevent pregnancy to women who have had unprotected intercourse or contraception failure or who have experienced sexual assault. Teens can use it correctly, and access to emergency contraception does not increase risky sexual behavior.[23]

Federal law recently made levonorgestrel-containing emergency contraception available to all women ages 17 and older without a prescription, as it has no contraindications or drug interactions, does not cause birth defects, and is nontoxic.[23]

Ten states including Massachusetts have laws allowing pharmacists to dispense emergency contraception without a prescription through collaborative-practice agreements.[24] These laws now apply specifically to minors under age 17, given the recent federal legislation. As mentioned above, Rhode Island lacks any such policy regarding contraceptive access for minors.

Access to abortion

In addition to accessible and effective contraception, access to abortion is essential in reducing unwanted births to teens. In 2005 in Rhode Island, 5,290 women obtained abortions including 1,620 teens; in the same year, 22 of every 1,000 teen pregnancies in Rhode Island ended in abortion, compared with 19 per 1,000 teen pregnancies nationally. [25,26]

Rhode Island law creates multiple barriers for teens seeking to end unwanted pregnancies. First, Rhode Island is one of 32 states that prohibit the use of public funds (including Medicaid) to pay for abortion, except in cases of rape, incest or life endangerment.[25] This restriction also applies to insurance policies for public employees in Rhode Island. The federal Hyde Amendment prohibits use of federal Medicaid funds for abortion, and allows states to determine whether state Medicaid funds will be used to pay for abortions for low income women.

Second, Rhode Island is one of 35 states that require parental consent or notification for abortion.[25] Parental consent laws have little effect on rates of abortion among minors; they do, however, result in delays (with increases in cost and associated risk) and increase the number of minors who travel to another state for abortions.[27-28] Massachusetts also requires parental consent for abortion, but allows an exception for medical emergencies, and Connecticut does not require parental consent for abortion.[29] The number of Rhode Island teens who travel out of state to avoid parental consent laws is not known.

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Recommendations

We recommend the following actions:

1.) *Provide comprehensive sexual health education in schools.*

Rhode Island schools should provide a comprehensive, age-appropriate sexual health curriculum, including information on contraception and sexually transmitted infection prevention for middle and high school students. Our Commissioner on Education, district superintendents, and leadership at the Department of Health must implement a system of teacher training and oversight in order for this to be effective.

2.) *Improve access to contraception for adolescents.*

Legislative barriers prevent many Rhode Island teens from accessing effective contraceptive services. Minors in Rhode Island should be guaranteed confidential access to contraceptive services through primary care providers and family planning clinics. Education for primary care providers should emphasize the safety and efficacy of long-acting reversible contraceptive methods, including intrauterine contraception, in teenage women. Given its safety and potential to reduce unplanned pregnancy when used in a timely manner, emergency contraception should be made available to women under 17 without a prescription, as it is currently in 10 other states including Massachusetts.

3.) *Improve minors' access to abortion.*

As parental consent requirements have little impact on abortion rates, but result in delays in care and increase the number of teens who travel to other states to get abortions, parental consent for abortion should not be required for minors. Use of state funds such as Medicaid to pay for abortions for low-income women should also be permitted.

4.) *Provide educational opportunities to pregnant and parenting teens.*

Teens who become pregnant are less likely to graduate high school and more likely to live in poverty. Likewise, the children of these teen moms are more likely to grow up in homes where the income is significantly below the national poverty level. Pregnant teens should be encouraged to remain in school as long as possible and return to school after delivery as soon as possible. Day care programs based on site at schools have had success, yet in recent years these programs have been cut rather than expanded. [30] State funding should support programs that help teens complete their education.

Rhode Island's small size allows state-level initiatives to make great differences in the lives of its citizens. We must promote healthy teens; young people are the future of our state and their success or failure is in our hands.

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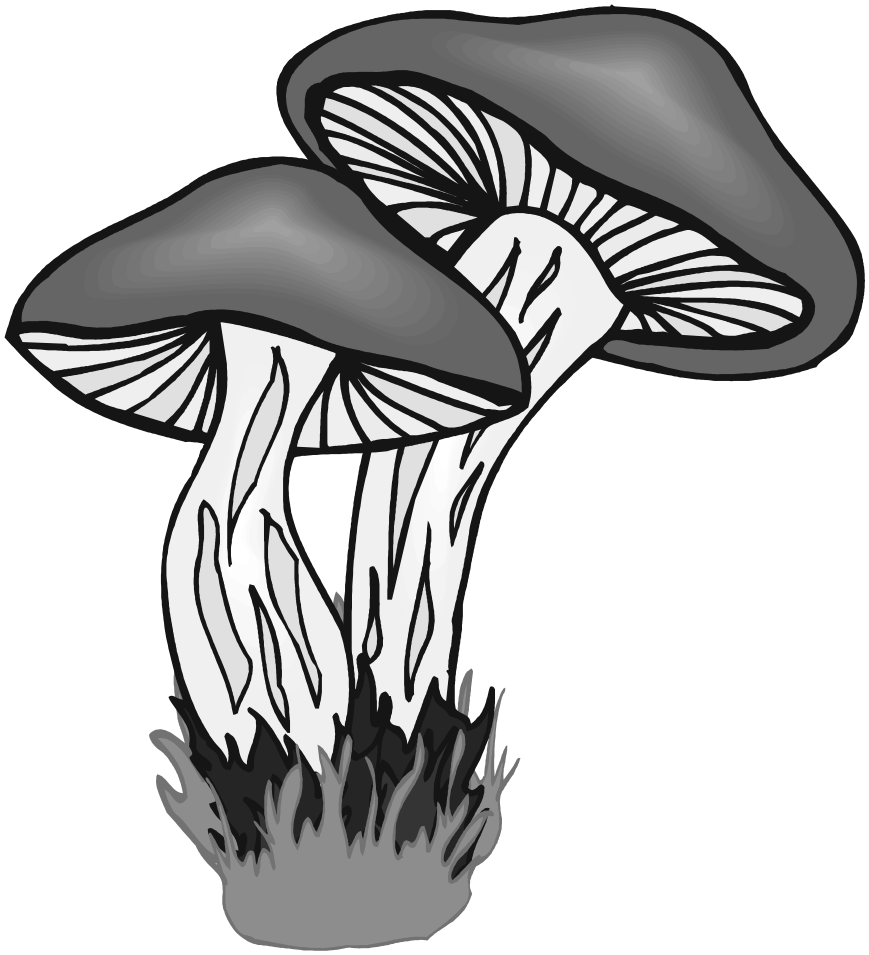

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