Report on Access to Family Planning Resources in Ohio

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By Emily Brzezicki, MSSA, LSW

Foreword by Crystal Ward Allen, MSW, LSW
Executive Director, Public Children Services Association of Ohio

Foreword

I am honored to be asked to author the foreword for this paper, written on behalf of the Coalition for Family Health. Representing public child welfare agencies across Ohio, I know the value of strong, stable families and supportive communities in creating positive child outcomes.

Few would argue that one of the most important life decisions to be made – when and with whom to have a child – is best done with intention, thoughtfulness and joy. As outlined in this paper, about half of all births in Ohio are the result of unintended pregnancies. The resulting financial costs to government and the private health insurance industry are great. More importantly, the costs related to child well-being are also great.

Child outcomes are greatly improved when children are born to parents who are prepared physically, emotionally, and financially. In the field of child welfare, I see direct correlations between unintended pregnancies, unprepared parents, and poor child outcomes:

- Families that have children born to teen parents are more likely to have open child welfare cases. One survey found one-third of all open cases had children born to teen parents.
- Children born to teens are more likely to end up in foster care.
- Studies show foster youth are two and a half times as likely as other youth to get pregnant as a teen.
- Teen and unintended pregnancies are likely to disrupt educational aspirations, subsequently leading to lower family income or poverty.

So, how do we prevent teen and unintended pregnancies? Unfortunately, there is no silver bullet, but like most complex issues, multiple strategies must be applied. The National Campaign to Prevent Teen and Unintended Pregnancies is an amazing organization that surveys youth, parents, young adults, professionals, and the general public. They also host think tank exercises, and convene the medical, service provider, and research communities. Then they package it all in readable materials to communicate with the media, policy makers, and others. Using their information, in combination with other research, data and opinion, I have formed a few opinions myself. It is neither conservative nor liberal, but grounded in research and data, experience and critical thought.

Youth and young adults need strong, clear messages as well as medically-accurate and age-appropriate information from the adults in their life. They need to know how to wait, know how to communicate, know about biology and contraception, and embrace personal responsibility. Sex has consequences. These messages and information should be given equally to males and females. More specifically:

- Teens should hear clear value messages – abstain / delay sex during the teen years.
- Focus on issues of partner communication, negotiation, and advance planning regarding sex and relationships.
- Teach children and youth accurate biology so they understand the implications of sex.
- Teach youth about contraception and STD protection and consider not just effectiveness but accessibility, cost, and capacity for accurate use of various methods.

- Promote critical planning and thinking skills with youth.

The Public Children Services Association of Ohio (PCSAO) has been intentional about better educating child welfare professionals, foster and kinship caregivers, and foster youth (and all child welfare involved youth) about pregnancy prevention strategies and messages. We know it is a child abuse prevention strategy to prevent unintended pregnancies and we have a target audience. Strategies include trainings for all, distribution of materials to assist parents, caregivers, and caseworkers to talk with youth about sex and relationships, and promotion of critical thinking activities for youth, such as the National Day to Prevent Teen Pregnancy activities in May.

When Governor Ted Strickland created the Anti-Poverty Task Force in 2008, PCSAO actively discussed the relationship between unintended pregnancy, child welfare, and poverty. The first set of recommendations wisely directed the Ohio Department of Job and Family Services to initiate work to join 27 other states that have a Medicaid Family Planning Waiver. This waiver would expand reproductive health services to low income men and women and include preconception healthcare, contraceptive counseling and services, STD prevention services and treatment, HIV testing, and counseling. Ohio is well on our way to submitting the Medicaid waiver request and we are looking forward to direct cost savings as experienced by other states. Clearly, the Anti-Poverty Task Force also considered the significant poverty related costs associated with unintended pregnancies, thus making accessible family planning services an excellent anti-poverty strategy.

PCSAO has also joined with other groups, such as the Coalition for Family Health, to support a broad continuum of policy and practice aimed at prevention of unintended pregnancies. We support Family Planning Waiver activities, contraceptive equity policies, and available emergency contraceptive care in hospital settings. We support comprehensive sex education curriculum development for the schools. Even with local decisions, many school systems would love to have an evidence-informed, comprehensive sex education curriculum.

It is time to join with others to promote and build on effective communication strategies for today's young people. Resources are scarce so innovation is necessary. We know the internet is a great informative and interactive tool for reaching youth. Use of social media is just emerging as an effective tool to reach young people. I hope we develop partnerships with healthcare experts such as Planned Parenthood and/or others to create teen peer counselors for pregnancy prevention. We need to work with our faith-based and other community entities to promote conversations with youth groups and between parents and youth.

Healthy families are a value embraced by all – conservatives and progressives, faith-based groups and educators, the media, and the general public. Reducing unintended pregnancies will promote that happiest of all events – the birth of a child to those who are ready and willing to parent.

Crystal Ward Allen, MSW, LSW
Executive Director
Public Children Services Association of Ohio

Executive Summary

The state of Ohio is one of the worst states in the nation in terms of access to family planning resources. Within the state, the availability of publicly supported family planning clinics does not meet the growing need of the women of this state and family planning laws and policies are among the most restrictive in the nation. This lack of support for family planning in Ohio has translated into billions of dollars being spent annually on costs associated with unintended pregnancy and treatment for sexually transmitted infections.

Restrictions in family planning policies are most detrimental to low-income and teenage women. The limited number of family planning clinics receiving public funds, the inability of clinics to purchase low cost birth control, and the lack of medical insurance among this population are factors that explain why low-income women are five times more likely to have an unintended birth compared to their more affluent counterparts. Policies that do not guarantee minors' access to family planning resources, or require parental consent, make teens more resistant to utilizing these resources -- making them susceptible to pregnancy and disease. A lack of medically accurate and age-appropriate sex education leaves teens without the proper tools to protect themselves from these dangers, which will follow them into adulthood.

The lack of access to family planning has many implications for the state of Ohio. Research has found that nearly half of the children born in 2004 through 2007 were from unintended pregnancies. These numbers show that there is extensive public and private medical spending on the pregnancies, births, and first year of life medical costs that can be reduced by implementing better family planning services. In 2004, Ohioans collectively spent an estimated $460 million on prenatal and birth related medical costs of unplanned pregnancies, over $170 million of this paid by Ohio Medicaid. This figure increases to $900 million when accounting for the first year of life medical costs associated with unplanned pregnancies. There is also a significant amount of money spent annually on the identification and treatment of sexually transmitted infections.

Infants and children born as a result of unintended pregnancies tend to fare worse than those whose pregnancies were planned. They are more likely to be born preterm, have low birth weights, higher infant mortality rates, be abused, do worse in school, and have more behavioral difficulties.

The research shows that preventing unintended pregnancy through increased access to family planning resources is good policy. It produces healthier families and communities and is also economically beneficial.

Introduction

State of Family Planning in Ohio

Ohio is one of the worst states in the nation when it comes to access to contraceptives. Ranking 48th among the 50 states and the District of Columbia, Ohio only surpassed Indiana, North Dakota and Nebraska.[1] There is less availability of publicly supported family planning clinics, a greater number of women who need them and Ohio's family planning laws and policies are among the most restrictive in the nation.

According to the Guttmacher Institute[2], there were 645,540 Ohio women ages 13-44 in need of publicly funded services and contraceptive supplies in 2006. Only 30% of this need was met by the existing 190 family planning health centers. Public financing mechanisms include Medicaid, state, and federal Title X funding. Nationally, the average public expenditure from all sources was $106 per woman in need. Yet Ohio invested a total of only $50 per woman in need, a 2% decrease in support between 1994 and 2006. The Title X national family planning program is the only funding stream exclusively dedicated to providing services that prevent unintended pregnancy. It has been underfunded for over 25 years. The 79 (of the total 190) family planning health centers that receive Title X support met only 18.6% of the need in 2006. The synergy between Medicaid and Title X provides an efficient model; but Ohio's current stringent Medicaid eligibility requirements and level of Title X funding leaves thousands of uninsured, underinsured, and low income women without the affordable health care they need. There is simply not enough public financing in the system to meet current needs without expanding Medicaid to more Ohio women and increasing Title X federal support.

Contraceptive Access to Low-Income Women

Low-income women are at greater risk for unintended pregnancy than women who are more affluent. Women who are at or below the poverty level are four times more likely to have an unintended pregnancy and five times more likely to have an unplanned birth than women who are above 200% of the poverty line.[3] Nearly one out of every six women in Ohio was at or below the poverty line in 2006.

Nationwide, between 1995 and 2002, there was a dramatic fall in contraceptive use (from 92% to 86%) among low-income women at risk for unintended pregnancy. Also, between 1994 and 2001, unplanned pregnancy rates increased 29% among low-income women, even though they fell by 20% among women who were more affluent.[4]

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[1] Guttmacher Institute. Contraception Counts, March 2006 (www.guttmacher.org/pubs/state_data/states/ohio.pdf)
[2] Gold RB et al., Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System, New York: GI, 2009 (http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf)
[3] Gold, R. (2006). Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of 'Equity and Common Sense'. *Guttmacher Policy Review,* 9 (3). (http://www.guttmacher.org/pubs/gpr/09/3/gpr090302.html)
[4] Gold, R. (2006). Rekindling Efforts to Prevent Unplanned Pregnancy: A Matter of 'Equity and Common Sense'. *Guttmacher Policy Review,* 9 (3). (http://www.guttmacher.org/pubs/gpr/09/3/gpr090302.html)

Rising contraceptive prices and lower numbers of insured low-income women may mean less access to contraception. Nationally, 41% of women who are poor and at risk for pregnancy are uninsured and 37% of them are covered by Medicaid and the State Children's Health Insurance Program (SCHIP). Only 20% of these women have private health insurance.[5] Those without insurance coverage for contraceptives may rely on family planning clinics; less reliable, over-the-counter forms of birth control; or use none at all. Lower-cost over-the-counter contraceptives, periodic abstinence, and no method of contraception have much higher failure rates than the methods available by prescription or in family planning clinics.[6]

Access to family planning clinics can be challenging for low-income individuals due to many factors, such as transportation and scheduling. Whereas all but 16 of Ohio's 88 counties have some type of women's health care provider, family planning is not always their core mission. Title X is the nation's only federally funded family planning program and is not available in the majority of Ohio counties. Consequently, low income individuals may have to travel long distances to receive affordable birth control. These are the same individuals who likely have less flexibility with their employers to take time off for traveling purposes. Lack of public transportation, especially in rural areas, presents additional barriers.

Many family planning clinics do not have sufficient revenues to sustain adequate levels of staffing and, therefore, cannot meet the needs of patients. Access would be enhanced by having convenient clinic hours in the evening and on Saturdays. Also needed is the money to support the infrastructure of the clinic so that more women and men in need can be served at Title X sites since Title X has been level funded for so long. Simply having a Title X provider in the county does not assure those in need are seeking and receiving care.

Medicaid Funding for Family Planning

The consequences of unplanned pregnancy are costly to all Ohioans. Ohio Medicaid currently covers parents up to 90 percent of the Federal Poverty Level (FPL), and family planning services are among the Medicaid benefits for parents.

Many states have achieved improved maternal and child health outcomes while reducing costs to their state Medicaid programs by increasing eligibility and thereby financial access to family planning and preconception care services. Some have increased family planning coverage for women who would have lost their Medicaid postpartum (such as Arizona, Maryland, Missouri, and Rhode Island), for those losing coverage for any reason (Delaware and Florida), and many states have expanded coverage based on income (California, New York, Washington and others).[7] Expanding this coverage saved states millions of dollars annually. Independent

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[5] Gold RB et al., Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System, New York: GI, 2009 (http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf)

[6] Wheaton, Joy Mara, MD "A Woman's Guide to Understanding Today's Birth Control Choices, Association of Reproductive Health Professionals, 2009 (www.arhp.org/uploadDocs/UnderstandingBirthControl.pdf)

[7] Gold, R. (October 2007) Medicaid's role in family planning (Women's Issue Brief) Guttmacher Institute and the Kaiser Family Foundation. (http://www.guttmacher.org/pubs/IB_medicaidFP.pdf)

evaluations estimate huge cost savings – $75 million in Arkansas over 5 years and $76 million in Alabama over 3 years.[8]

Pregnant women are covered by the Ohio Medicaid Program up to 90 percent of the FPL, but lose Medicaid eligibility 60 days postpartum or after a miscarriage.

Efforts are underway for the state to file an application with the Centers for Medicare and Medicaid Services (CMS) by the end of this calendar year to expand Medicaid eligibility. The application would seek to increase eligibility to 200 percent of the FPL for women without other public or private sources of funding for family planning and preconception care services. If such an application were to be approved, it would extend eligibility for family planning and preconception services to over half a million Ohioans.[9]

In 2008, the Ohio Medicaid Family Planning Workgroup, comprised of less than 10 members, grew to a coalition representing over 30 organizations. The Ohio Medicaid Family Planning Waiver Coalition includes the trade associations for family practice providers, OB/GYNs, pediatricians and osteopaths in Ohio, as well as the Ohio Association of Health Commissioners, Public Children's Services Association of Ohio, Voices for Ohio's Children, Children's Defense Fund, March of Dimes, and family planners and supporters from around the state. These are just a few of the organizations that are currently working together to support a family planning expansion in Ohio.

One of the most attractive features of a family planning waiver is the cost-savings that are gained. Given the cost-savings realized by other states, the approval of a Medicaid waiver will likely result in significant cost savings to the state of Ohio and provide access to important prevention services for an at-risk population, particularly in minority communities.

When considering the net savings per birth averted under family planning waiver programs in six states (AL, AR, CA, NM, OR, and SC) is nearly $5,000, one can conclude that 200 unplanned Medicaid births will produce a net savings of approximately $1 million. This net savings estimate is supported by the Medicaid fee-for-service expenditures for CY 2002 of $2,727.15 for birth expenditures and $2,517 for the child's first year of life – a total of $5,244.15.[10]

As further evidence of support, in 2008, the Governor's Anti-Poverty Task Force identified securing a Medicaid Family Planning Waiver as a major strategy to address poverty. With the support of Governor Strickland and other stakeholders across the state, staff from the Ohio Department of Job and Family Services was assigned to the project that fall, and began collaborating with the Waiver Coalition, working together on a family planning waiver for Ohio.

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[8] Sills, S. "Cost-Effectiveness of Medicaid Family Planning Demonstrations." *State Health Policy Briefing*, National Academy for State Health Policy 2007. (http://www.nashp.org/Files/shpbriefing_familyplanning.pdf)
[9] Ohio Family Planning Waiver Coalition (January 2009). Concept Paper: Section 1115 Medicaid Family Planning Waiver for the State of Ohio.
[10] Ohio Department of Job and Family Services. Pregnant Women, Infants, and Children. June 2006 (as cited in Ohio Family Planning Waiver Coalition (January 2009). Concept Paper: Section 1115 Medicaid Family Planning Waiver for the State of Ohio)

Additionally, Governor Strickland has championed an effort to support the inclusion of the Medicaid Family Planning State Option in national health care reform legislation. This small but important change in federal law would provide the needed flexibility to quickly and efficiently expand coverage for basic preventive health care under Medicaid.

In his letter to Congressional leaders, signed by 15 additional governors, Gov. Strickland noted that "(t)he Medicaid Family Planning State Option is a proven approach to expanding coverage for basic women's health care, while at the same time generating significant cost savings for states and the federal government. In states like Ohio, this new option will improve women's access to quality, affordable preventive health care, such as breast and cervical cancer screenings."

Provider Refusal

There is an ongoing debate among health care professionals and within the field of bioethics to determine the balance between honoring the healthcare provider's own beliefs and the provider's responsibility to respect and meet the patient's needs. The professional medical associations have primarily taken the stance that health care providers may withdraw from providing services that are in violation of their moral or religious beliefs, but must ensure that patients are able to receive information and the services while maintaining the dignity and respect they deserve.[11] The majority of this dilemma plays out in the areas of abortion, contraception, and other forms of reproductive healthcare.

Currently, the state of Ohio has a policy that permits both individual providers and institutions to refuse to provide abortion services. The state does not have an explicit policy about the rights of medical providers and the institutions they work for to refuse contraception or sterilization to their patients.[12] This lack of policy has left many people on both sides of the debate in vulnerable positions.

Emergency Contraception

In 2006, emergency contraception (EC) was made available for purchase over-the-counter in pharmacies for women 18 and older. Access has since been expanded to those 17 and older. Yet, the debate between the right to refuse and responsibility to the patient has played out in this area as well. In Ohio, there are no policies guaranteeing that a pharmacist will dispense the medication with or without a prescription, or that pharmacies will stock it. Yet, there are no policies in play that explicitly allow pharmacists or pharmacies to refuse to dispense EC.[13]

Currently, the position the state of Ohio holds on EC is that emergency rooms are required to provide information about and dispense EC upon request, yet there is no mechanism in place to

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[11] Sonfield, A (2005). Rights vs. responsibilities: professional standards and provider refusals. *The Guttmacher Report on Public Policy.* 8(3):7–9. (http://www.guttmacher.org/pubs/tgr/08/3/gr080307.html)
[12] The Guttmacher Institute (September 2009). State Policies in Brief: Refusing to provide health services. (http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf)
[13] The Guttmacher Institute (September 2009). State Policies in Brief: Emergency contraception (http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf)

enforce this.[14] A survey by the NARAL Pro-Choice Ohio Foundation found that only 17% of hospitals surveyed gave EC to all patients, as long as there were no medical conditions that would prohibit use. They also found that only 56% of hospitals surveyed guaranteed access to EC for rape survivors. Seven percent of the hospitals surveyed did not dispense EC to anyone (including rape survivors).[15] Additionally, only two of the hospitals told patients that EC could be purchased directly from a pharmacist without a prescription.[16]

Moreover, the lack of access to EC is not all due to policy, but due to misinformation and disapproval. Two of the hospitals surveyed gave medically inaccurate information, referring to EC as the "abortion pill" or saying that the medication would be harmful to a fetus if the woman took it when she was already pregnant.[17] Such medically inaccurate information cuts patients off from a valuable resource. EC will not affect an existing pregnancy but, if used properly, may prevent an unintended one from occurring.

Minor's Consent Policy

Even though Ohio remains neutral on many aspects of minors' access to reproductive health care, this lack of policy may leave minors vulnerable to the personal beliefs of individual providers. In the state of Ohio, there is no explicit policy on minors' ability to consent to contraceptive, prenatal services, or medical care for their child.

Title X family planning programs are required to encourage parental involvement but are mandated to provide confidential services to teens. All providers must comply with state sexual abuse reporting laws. However, some healthcare providers may allow minors access to contraceptives or prenatal care without their parent's consent or knowledge, while some may mandate parental involvement for insurance coverage purposes and other reasons.

Teens who are uncomfortable sharing this information with parents may bypass the services altogether, leaving the youth at risk for pregnancy or related complications. There is policy specifically allowing minors to consent to STI and adoptive services. This allows minors to deal with the consequences of not using preventive services, but does not protect their ability to prevent such issues in the first place. Ohio law necessitates one-parent consent with judicial bypass provisions for minors seeking abortion services.[18]

Sexuality Education in Ohio

Recent studies have found no evidence that abstinence-only programs delay sexual intercourse, reduce the number of sexual partners, or initiate a return to abstinence. On the other hand,

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[14] Id.
[15] Miracle, J. (2007). Access 2007. *NARAL Pro-Choice Ohio Foundation* (www.prochoiceohio.org/assets/files/2007execsumm.pdf)
[16] Id.
[17] Id.
[18] The Guttmacher Institute (September 2009). State Policies in Brief: An Overview of Minors' Consent Laws. (http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf)

comprehensive sexuality education programs that support both abstinence and the use of condoms tend to be effective in eliciting positive behavioral changes in teens.[19]

In 2007, Ohio made a strong show of support for comprehensive sexuality education by becoming the eighth state to reject federal funding for abstinence-only education. Additionally, state money that had been earmarked to match those funds and was intended to support abstinence-only programs has since been "zeroed out" of the state budget. However, there is, as yet, no state policy that mandates the teaching of comprehensive sexuality education. School districts must take the initiative to integrate a comprehensive sex education program into their schools.

The Cleveland Metropolitan School District (CMSD) recently completed its second year of a comprehensive, abstinence-inclusive K-12 sex education program called the Responsible Sexual Behavior Initiative. Unprecedented collaboration among the school district, the city of Cleveland, local health departments and many youth serving organizations made the program possible. Community leaders recognized that teen pregnancy and disease prevention are economic and human resource issues that have long-term individual and societal costs. Ohio's young people are our future. Investing in age-appropriate and medically accurate sex education that encourages educational attainment, responsible decision-making and healthy behavior creates a stronger future for our state.

Program evaluations document the following results:

- Students in 1st through 3rd grades reported they learned about good touch/bad touch, and what to do if someone tries to touch them inappropriately, and about respecting others;
- Students indicated they are more likely to behave responsibly, such as stating they would not allow themselves to be coerced into sex;
- High school students had significantly better attitudes regarding protecting themselves and their partners if and when they choose to engage in sexual activity;
- Parents and teachers overwhelmingly believe these lessons are important for their children and students.[20]

In fiscal year 2008, Ohio received $6,376,091 in federal funds for abstinence-only-until-marriage programs.[21] However, recent research has found abstinence-only programming to be ineffective in preventing teenage pregnancy. These programs have left many Ohio teenagers without a thorough knowledge of pregnancy prevention, leaving a legacy of ignorance about their bodies and how to protect themselves from pregnancy, disease and abuse. A recent study found that

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[19] Kirby, D. (November 2007) Emerging Answers 2007. *The National Campaign to Prevent Teen and Unplanned Pregnancy.* (http://www.thenationalcampaign.org/EA2007/EA2007_full.pdf)
[20] Philliber Research Associates (December 2008). Evaluation of Responsible Sexual Behavior in the Cleveland Metropolitan School District.
[21] Sexuality Information and Education Council of the United States, Ohio State Profile Fiscal Year 2008 (http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1136)

students who receive comprehensive sex education are 50% less likely to become pregnant than those who receive the abstinence only instruction.[22]

Ohio teenagers are not the only ones left vulnerable by abstinence-only programs; many adults are vulnerable as well. With 36% of women aged 20-44 being single and nine in ten of these women being sexually active, there is a significant population of women that do not only need access to contraceptives, but also information about their overall well-being.[23] Women, regardless of age or marital status, who receive abstinence-only instruction are left without the knowledge of how protect themselves from unintended pregnancy or sexually transmitted infection if they choose to be sexually active. Additionally, because abstinence-only unless married programs lack a comprehensive approach to birth control, even women who wait until after marriage to become sexually active are left at risk for unplanned pregnancies.

The facts show that abstinence-only programs, alone, do not work.

- Multiple peer-reviewed studies have found that comprehensive sexuality education programs that teach teens about abstinence, contraception and disease control are effective at delaying onset of intercourse, reducing the frequency of intercourse, reducing the number of sexual partners, and increasing condom and contraceptive use. [24]
- A 2005 report by Dr. Scott Frank, Director of Public Health at Case Western Reserve University School of Medicine, concluded that abstinence-only-until-marriage programs in Ohio have implemented curricula in schools throughout the state that "contain misleading and false information, scientific errors, and substantial inaccuracies regarding gender stereotypes, STDs, and contraception."[25]

Additional research concludes that parents see the value of comprehensive sex education being provided in their children's schools.

- A 2007 Quinnipiac University poll found that 71% of Ohio voters *(81% for voters who have kids in school)* felt that the best approach to sex education in Ohio's schools is to focus equally on abstinence as well as the value of condoms and contraception use.[26]
- A Kaiser Family Foundation survey found that 98% of parents want their children to learn about HIV/AIDS and other sexually transmitted diseases, and more than 85% believe teens need to have accurate information on birth control and how to protect themselves.[27]

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[22] Kohler, P., Manhart, L., and Lafferty, W. (April 2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42 (4), 344-351. (http://www.cfw.org/Document.Doc?id=242)

[23] Duberstein, L. & Singh, S. (2008). Sexual Behavior of Single Adult American Women. *Perspectives on Sexual and Reproductive Health*, 40(1):27–33 (http://www.guttmacher.org/pubs/psrh/full/4002708.pdf)

[24] Douglas Kirby, Ph.D. The National Campaign to Prevent Teen and Unplanned Pregnancy. "Emerging Answers: 2007" November 2007. (http://www.thenationalcampaign.org/EA2007/EA2007_full.pdf)

[25] Frank, Scott H., Report on Abstinence-Only-Until-Marriage Programs in Ohio, June 2005 (available for download at http://www.ppao.org/pdf/attachment_b.pdf)

[26] Quinnipiac University Polling Institute. "Ohio Voters Approve Of New Governor," May 15, 2007. (www.quinnipiac.edu/x1322.xml?ReleaseID=1063)

[27] Sex Education in America: A View from Inside the Nation's Classrooms, Kaiser Family Foundation, September 2000 (http://www.kff.org/youthhivstds/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13531)

Finally, it has been shown that comprehensive sexuality education saves money for Ohio's taxpayers.

- Teens that have children are much less likely to finish high school and are more likely to be victims of abuse.[28] They are also more likely to receive public assistance. 81% of unmarried women who have children before the age of 20 are on welfare within 10 years.[29]

These are compelling arguments for comprehensive, medically-accurate, abstinence-inclusive sex education.

Implications

Unintended Pregnancy

According to Ohio Pregnancy Risk Assessment Monitoring System (PRAMS) data, in 2004 nearly 45% of pregnancies in the state that resulted in a live birth were unintended.[30] That level remains fairly consistent over time, increasing slightly to 48% and 47%, respectively, and leveling off to 45% in 2007.[31] Therefore, there were over 66,000 unintended births that could have been prevented with sufficient family planning knowledge and support. Medical costs including pregnancy, birth, and infants' first year of life associated with unintended pregnancy in that year totaled over $900 million in the state Ohio.[32]

Teens are more likely to have preterm babies. Preterm children are one of Medicaid's costliest populations. These costs can be prevented with funding for birth control. Nationally, for every $1 spent on the family planning program, $4.02 is saved in averted Medicaid birth costs.[33] In Ohio, the savings is $4.70 for every $1 spent on the family planning program.[34]

A significant amount of unintended pregnancies can be attributed to misinformation and lack of access to contraceptives. Of the women who reported unintended pregnancy in 2004, 61.2% were not using contraceptives at the time of conception.[35] These pregnancies accounted for over 40,000 unintended births in the state. A few of the reasons that these women did not use birth control were that they did not think they could get pregnant at the time, had problems accessing

[28] Offner, Paul. "Welfare reform and teenage girls," *Social Sciences Quarterly*, 2005, 26(2): 306-322.
[29] Id.
[30] Ohio Department of Health, PRAMS Annual Data Summary 2004-2007 (http://www.odh.ohio.gov/ASSETS/1788CE8FAF5B4C10BEA188AC40116E2C/PRAMSDataSummary2004-2007.pdf)
[31] Id.
[32] Ohio Department of Health PRAMS Summary
[33] Frost, Jennifer J., et al. "The Impact of Publicly Funded Family Planning Clinic Services on Unintended Pregnancies and Government Cost Savings," Journal of Health Care for the Poor and Underserved 19 (2008): 778–796. (http://www.guttmacher.org/pubs/09_HPU19.3Frost.pdf)
[34] Id.
[35] Ohio PRAMS Data Summary 2004-2007, (www.odh.ohio.gov/odhPrograms/his/prams/pramsdata.aspx)

it, and they used it inconsistently.[36] Contraceptive use rose slightly between 2004 and 2007 with 43% of women reporting use in 2007.[37]

Children

Infants born from unintended pregnancies are more likely to have low birth weights, death in the first year, be abused, and receive insufficient resources than those born from pregnancies that were intended. These consequences continue into childhood. Studies have shown that children two years of age that were born as a result of an unintended pregnancy score significantly lower on cognitive tests measuring vocabulary, listening skills, problem solving, memory and communication than children born as a result of an intended pregnancy. Children of teenage parents, which are 80% unintended[38], tend to have poorer health, do worse in school, drop out of school more often, have higher incarceration rates, and have higher teen pregnancy rates than those children born to parents in adulthood.[39] Therefore, there are not only economic, but also social ramifications of unintended pregnancy that Ohio must face.

Sexually Transmitted Infections

Ohio's limited access to family planning services also affects the sexually transmitted infection (STI) rates in the state. Insufficient knowledge about the nature and prevention of STIs leaves many Ohioans vulnerable to these infections.

In 2006, Ohio spent $900,000 in state general revenue funding for STD Prevention – $200,000 for treatment medications and $700,000 for Hepatitis B vaccine for children eligible under the Vaccines for Children Program. Ohio ranked 33rd out of 50 states and the District of Columbia in per capita state funding for STD prevention, spending an average of $0.08 per capita.[40] With the exception of a policy on electronic laboratory reporting for STIs and related conditions, Ohio lacks policies in effect in some other states, such as prenatal screening for STIs, insurance coverage for HIV and STI screening, and mandatory age-appropriate comprehensive sex education for K-12. The American Social Health Association recommends that states strengthen their prevention funding and enact STI policies such as those mentioned above to strengthen prevention efforts.[41]

The Ohio Department of Health reported over 62,000 cases of Chlamydia, Gonorrhea, Syphilis in 2005.[42] Chlamydia rates increased from 370.4 to 398.8 per 100,000 persons between 2003

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[36] Ohio Department of Health, PRAMS News 2004
[37] Ohio PRAMS Data Summary 2004-2007, (www.odh.ohio.gov/odhPrograms/his/prams/pramsdata.aspx)
[38] Ohio Department of Health (2007). Teen births in Ohio: Ohio PRAMS 2000-2003. (http://www.odh.ohio.gov/ASSETS/6B3F2F4E948E49598E8670911EAA786C/TeenBirthsRpt.pdf)
[39] Florida State University Center for Prevention & Early Intervention Policy (2005). The Children of Teen Parents. (http://www.cpeip.fsu.edu/resourceFiles/resourceFile_78.pdf)
[40] American Social Health Association State Profile (http://www.ashastd.org/stdpreventionfunding/rpt_fundingdetail.cfm?_state=OH)
[41] American Social Health Association, "Show Me the Money:State Investment in STD Prevention, FY 2007 (http://www.policyresourcegroup.com/documents/stateinvestmentfullreport_2008forASHA.pdf)
[42] Ohio Department of Health, 2004-2008 Ohio Infectious Disease Status Reports (http://www.odh.ohio.gov/healthStats/disease/std/std1.aspx)

and 2007. Gonorrhea rates decreased during that same period.[43] In 2008, the number of reported cases in 2008 totaled 63,905.[44]

Increased syphilis cases in Ohio's urban areas contributed to the statewide increase between 2005 and 2008. The Cleveland Department of Health and Cuyahoga County Board of Health reported a "Syphilis outbreak" in their March 2009 Update. They drafted a Public Health Alert Letter for hospitals and medical providers. From July 2007 to November 2008, there were 123 new cases of early syphilis in Cuyahoga County, predominantly in the city of Cleveland, as reported to the Ohio Department of Health. Of particular concern is the increase in infection among youth age 14 to 24, representing 38% of the cases.[45] While actual numbers are low, the need for increased testing and more prevention education for young people is a public health imperative.

The annual cost to treat STIs in the United States is estimated to be $14.7 billion in 2006 dollars based on 2007 infection rates.[46] The total lifetime costs of STIs based on Ohio's 2005 STI cases is over $200,000,000.[47]

According to the American Social Health Association, three out of four Americans will be infected with HPV (Human papillomavirus) during their lifetime.[48] Even though the majority of HPV cases clear up on their own, it has also been known to cause the majority of cervical cancer cases. About 5,000 American women die annually from cervical cancer. That is why the American College of Obstetricians and Gynecologists recommends regular Pap tests to detect precancerous and cancerous irregular cell growth. HPV DNA testing is also available.

Vaccines are available to protect young women ages 13-26 from HPV, although the vaccine may be given to a child as young as nine years old. A series of three injections of the Gardasil vaccine can cost consumers as much as $600 from a private physician. Publicly funded health centers provide vaccines at a lower cost or sliding fee basis. In Ohio, some local public health departments serve children 18 and younger through Ohio's Vaccine for Children program, a federally financed program administered through the Ohio Department of Health for families who are un/underinsured or Medicaid eligible.[49]

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[43] Ohio Department of Health, STD Surveillance, HIV/STD Prevention Program. Data reported through 03/26/08.
[44] Ohio Department of Health, 2004-2008 Ohio Infectious Disease Status Reports (http://www.odh.ohio.gov/healthStats/disease/std/std1.aspx)
[45] Cleveland Department of Public Health/Office of Biostatistics, Syphilis Outbreak Update V 2.7rel.doc, March 2009. (http://www.clevelandhealth.info/Members/db/export09/syphreport09)
[46] American Social Health Association, "Show Me the Money:State Investment in STD Prevention, FY 2007 (http://www.policyresourcegroup.com/documents/stateinvestmentfullreport_2008forASHA.pdf)
[47] Chesson, H., et.al. (2004) Perspectives on Sexual and Reproductive Health "The estimated direct medical cost of sexually transmitted diseases among American youth, 2000" (http://www.guttmacher.org/pubs/psrh/full/3601104.pdf) based on incidence data from Ohio Department of Health
[48] American Social Health Association, www.ashastd.org, "Learn about STIs/STDs"
[49] VFC: Vaccines for Children, US Department of Health and Human Services , Public Health Service Act, Program Packet, 8-97 (http://www.odh.ohio.gov/odhPrograms/idc/immunize/vfc1.aspx)

Methodology

Unintended Pregnancy

The statewide estimates of pregnancies that were unintended were determined by applying findings from the 2004 PRAMS Report to the 2004 Ohio Department of Health birth data. Updates for 2005 through 2007 were added as available from the Ohio PRAMS 2004-2007 Data Summary, but were not used to calculate the costs of unintended pregnancies. The PRAMS data only includes pregnancies that ended with a live birth; therefore, figures did not need to be adjusted for miscarriage or abortion rates. These figures most likely underestimate the number of unintended birth in the state due to the retrospective nature of PRAMS.

Cost of Births on Medicaid

Medicaid costs were based on 2003 data from the Ohio Department of Health's average Medicaid spending on pregnancy related maternal costs, infant birth and the infant's first year of life medical costs. It applies these average dollar amounts to all the births averted that would have been covered by Medicaid, through expansions that cover pregnant women and children, up to 150% of poverty (2006 level). These figures assume single births. They do not include Medicaid costs for pregnancies that may have ended in miscarriage or stillbirth.

Cost of Non-Medicaid Births

Costs of births to mothers who would not be covered by Medicaid were figured separately because they would not be paid for by public spending. They were included because they would have significant impact on the economy of Ohio. These costs were figured by utilizing the average cost of pregnancy, infant's birth and first year of life medical costs as reported by a national study. This average accounts for the number of births at every gestational age in proportion to the state of Ohio. They did not account for pregnancy related costs for pregnancies that ended in miscarriage or stillbirth.

Sexually Transmitted Infections

The cost to the state of Ohio for STIs was calculated utilizing 2005 case data from the Ohio Department of Health. This data provided the incidence of four common STIs: Chlamydia, Gonorrhea, Syphilis, and HIV/AIDS. An estimate on the incidence of HPV was calculated by applying the national incidence rate to the population of Ohio. This study did not include the economic impact of STIs other than these five, due to a lack of reliable Ohio statistics.

The costs associated with these infections were calculated using data from research published in the January 2004 issue of *Perspectives on Sexual and Reproductive Health.* The cost per infection findings of this study were applied to the Ohio incidence of each of these infections. These results are a conservative estimate for the state, since they mainly examine the infections reported to the Ohio Department of Health, and do not account for infections that go unreported or for individuals who do not seek medical attention.

Discussion

The findings of this research show that family planning services are beneficial to Ohio in many ways. First, the providers of these services supply basic healthcare to people who may not have the means to access them. Many low-income women do not have health insurance, or do not have the time or transportation to access basic reproductive healthcare and family planning services. Ohio's economic downturn has swelled the ranks of the uninsured as many have lost their health care coverage with their jobs.

The impact of family planning goes far beyond the economic savings associated with medical costs. There are the costs averted and taxpayer savings associated with public assistance services that are less likely to be utilized when people are able to delay childbearing until they are prepared to parent. When teenagers are taught accurate information about their bodies and how to protect themselves and others from pregnancy and disease, they are given a tool to aid in delaying childbearing and allow themselves to finish their education and begin a career. When people are able to utilize family planning, they are empowered to make further decisions about their future and able to decide when they are personally ready to fully care for a child. This will lead to lower rates of cash assistance, food stamp, WIC, and foster care utilization, which will have a great economic impact on the state. This has the potential to lead to higher graduation and lower welfare rates in Ohio and break the cycle of generational poverty that many families in this area face.

Empowering people to wait until they are prepared to parent also has important social implications. Children of intended pregnancies tend to fare much better than those that were unintended. When parents intend to become pregnant, they have children that tend to be healthier, better adjusted and do better in school. Helping people to be responsible and delay pregnancy until they are prepared for parenthood empowers them to become better parents, which benefits the entire community.

Limitations

The Medicaid costs associated with births were taken from 2003 data and averaged. Therefore, the estimates may be undervalued due to medical inflation. The non-Medicaid costs were from 2007 national data applied to Ohio, due to a lack of statewide information on pregnancy, birth, and first year medical costs; therefore, there is a chance that pure Ohio figures would vary from these findings.

Conclusion

Prevention of unintended pregnancies is economically and socially smart.

Improving access to family planning services to low-income women benefits all Ohio citizens. When women are given the means to be responsible and prevent unintended pregnancy, the region and state save money on Medicaid. Increasing access to family planning to low income women ultimately reduces the number of women and children on Medicaid. Cost-savings are realized as the number of unintended pregnancies decreases; saving the state money that would

have been spent on medical expenses related to those pregnancies. It also allows couples to wait until they are ready to have children and space them accordingly, making the children more likely to receive proper care and resources without the need for public intervention.

The economic benefit of family planning services produces large savings that can be used in other aspects of the economy. The less money spent addresssing unintended pregnancy and its implications, the more money that is available to meet Ohio's critical needs in today's economic environment. Investing in family planning advances opportunity for those in need, rather than remediate issues that could have been easily prevented in the first place.

Organizations across Ohio are working towards this goal, but many lack the proper funding to fully meet the needs of their patients or the people of their communities. Preventing unintended pregnancy and sexually transmitted infections is good policy.

Coalition for Family Health · P.O. Box 984 · Columbus, Ohio 43216
http://www.coalitionforfamilyhealth.org