Preventing Unintended Pregnancies: The Impact of Publicly Funded Contraceptive Services

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Background

The changing political priorities about reproductive health in the United States and overseas raise questions about the impact of publicly funded contraceptive services and the need for continued funding of these efforts. A frequent question asked, is does access to public services prevent unintended pregnancies and abortions? How will women's behavior change if access to publicly funded contraceptive services is impeded?

In response to the on-going need for impact data, The Guttmacher Institute has periodically conducted studies measuring the impact of publicly funded family planning services on preventing unintended pregnancy. In 1990 (Forrest and Singh) and in 1996 (Forrest and Samara) separately showed that almost one in four women obtained family planning services from a publicly funded clinic or a private physician reimbursed by Medicaid. If these services were not available, the authors found that over one million additional pregnancies would occur each year. Forrest and Samara (1996) found that almost one third would involve women between the ages of 15 and 19 and 61 percent of the additional pregnancies would be in families below 200 percent of the poverty line. Furthermore, over half a million of the unintended pregnancies would result in additional abortions.

Since the last study, several new contraceptive methods have been developed and introduced such as the birth control Patch and the monthly injectable, Lunelle. Moreover, contraceptive behavior has changed. For instance, between 1982 and 2002, the percentage of women with a partner who had ever used a condom rose from 52 percent to 90 percent (Mosher et al. 2004). There were also changes in contraceptive behavior such as a decline in the use of the IUD, sponge, diaphragm, calendar rhythm method, and spermicidal sponge. Changes in service use also occurred. For example, 29 percent of women between the ages of 15 to19 received family planning services in 1995 compared to 40 percent in 2002. The Title X family planning program served 4.2 million women in the year prior to the 1995 survey and 5.4 million prior to the 2002 survey. These important changes in access to services and contraceptive behavior called for a revisit of the study using recent data from the 2002 National Survey of Family Growth (NSFG).

Methods and assumptions

We used Cycle 6 of the NSFG to identify women who were users of contraceptive services and who visited a publicly funded provider to identify our study population. The NSFG is a nationally representative sample of women ages 15 to 44 that were surveyed in 2002. (Men were also included for the first time in the study but we did not utilize their data for this analysis.) For each woman, we identified the contraceptive method

she used in the month prior to the survey. Women were also characterized by their age, marital status, race, and income level (four age categories, three union status groups, two race groups and three poverty levels).

Without being able to conduct a truly experimental study of contraceptive behavior that purposely denied women publicly funded contraceptive services, we constructed four hypothetical scenarios to estimate how women's behavior would change if public services were no longer available. In general, we hypothesized that in the absence of public services women would switch to more non-prescription methods that would be less effective in preventing unplanned pregnancies. Each scenario produces a different contraceptive method mix that would result in different numbers of unintended pregnancies, births and abortions.

In Scenario 1, we assumed that in the absence of publicly funded contraceptive services, the population of public users would shift to the contraceptive method mix found among those women (with the same socio-economic characteristics of public users) who did not use public services in the prior year. For Scenario 2, we assumed that in the absence of public services, public users would assume the contraceptive method mix found among women who discontinued the pill during the month after discontinuing use (adjusting for women who quit the pill to become pregnant and including only those who moved to nonprescription methods). In Scenario 3, we assumed that public users would return to the contraceptive method mix used by women prior to their visit to a publicly funded clinic. Finally, in Scenario 4, we assumed that women would no longer use any method of contraception if they could not access public services. For most of the analysis, we used the NSFG, Cycle 6, except in Scenario 3. Since the NSFG did not ask women what contraceptive method they used prior to their first public clinic visit, we will obtain external data from the client records of a publicly funded clinic sample.

Given the assumptions inherent in each scenario, we calculated the contraceptive method mix for each scenario. To arrive at the new method mix for each scenario, we applied the method distribution of each SES subgroup (categorized by a particular combination of age, marital status, race, and poverty level) in the scenario population to the corresponding subgroup in the study population. We summed the methods across the subgroups and obtained a new method distribution.

We then used these hypothetical distributions to calculate the number of unintended pregnancies, births and abortions that would arise if women did not have access to publicly funded contraceptive services and would have to alter their contraceptive behavior given the particular scenario. Failure rates for 0 to 12 months were calculated for each contraceptive method by SES subgroup. We applied these rates to each of the SES subgroup of women in the study population as well as in each of the scenarios. The calculations produced the number of pregnancies resulting from method failures for the study population and for each scenario. We also made assumptions about the abortion and the birth percentages. We then summarize the number of pregnancies, abortions, and births for the study population and for each scenario. To calculate

pregnancies averted, we subtract the actual number of pregnancies occurring among women in the study population from the hypothetical number expected given each scenario. We use the average of the figures from scenarios 1, 2 and 3 as the estimate of total pregnancies, births and abortions averted by publicly funded services annually. (Scenario 4 is used to estimate and illustrate the gross number of pregnancies that might occur if no contraception at all were used, but it is not included in our estimate of average "expected" pregnancies.)

Expected findings

What we expect this study to illustrate – as the prior studies did – is that funding public family planning clinics and reimbursement of physicians for reproductive services through Medicaid are critical in providing women with access to important reproductive health care services and helping these women to avoid millions of unintended pregnancies each year. Since this analysis replicates similar prior analyses, we can also assess whether or not there has been any change in the proportion of pregnancies averted per client among publicly funded family planning providers. Finally, data on the impact of public services are desperately needed by state and local agencies to document the impact of their programs and thereby to secure continued funding for reproductive health services. We will be able to show that discontinuing publicly funded family planning services would be detrimental to many women, especially those who are poor or young, and would sharply increase the number of unintended pregnancies, births and abortions in the country.

References

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