

OAHP Key Adolescent Health Issue



Reproductive Health

Introduction

Adolescence marks the period between childhood and adulthood when youth experience a wide range of physical and psychosocial changes. The physical changes of puberty result in maturation of the reproductive system, while the cognitive and psychosocial developmental processes allow for abstract reasoning and problem solving. These changes can be overwhelming and confusing and as adolescents strive to define who they are, participation in risky behaviors is frequently part of the normal developmental process. Because adolescents do not always anticipate the consequences of their behavior, particularly as they relate to their reproductive health, there can be adverse outcomes such as unplanned pregnancies, sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV) and other related long term health sequelae. Communication is critical during this transitional period. Sustained and ongoing communication between families and their teen can provide the reassurance and support needed to impact an adolescent's behaviors and guide youth to make healthy and informed choices. Providing resources to support this role is important in helping to strengthen these relationships. This section of the strategic plan aims to address key reproductive health issues in an effort to facilitate a healthy and successful transition into adulthood for all adolescents.

For a variety of psychosocial and biologic reasons, compared to other age groups, teens who are sexually active, have among the highest rates of STIs. Many cases of AIDS in adults are related to HIV infection first acquired during adolescence. Primary prevention of STI and HIV infections, as well as early identification and treatment, are critical for preventing the complications and long term sequelae of these infections including: pelvic inflammatory disease, tubo-ovarian abscess, infertility, chronic pelvic pain, ectopic pregnancy, and cervical cancer.¹ To provide for a measurable improvement, health care providers should routinely ask about sexual behaviors; universally screen for



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asymptomatic infections among sexually active teens; and provide developmentally appropriate nonjudgmental risk prevention counseling. Although recommendations for confidential STI and HIV screening and preventive counseling in adolescents have been published by national organizations, barriers such as explanation of benefits statements from health insurers and bills for laboratory services create obstacles to ensuring confidential services for many teens.¹ The OAHP's strategic plan aims at improving the implementation of recommended preventive STI/ HIV counseling and screening in adolescents by increasing partnerships to address these services in this age group.

The most common STI in the United States is the Human Papilloma Virus (HPV). Though HPV can be prevented via vaccination, the national and state rates of HPV vaccination and completion still remain low. In Ohio, in 2011, only approximately one-third of female adolescents age 13 through 17 completed the three dose series.² Although an analysis of national data showed that the prevalence of vaccine related HPV types among adolescent females declined 56%, when comparing the pre-vaccine time frame (2003-2006) to post-vaccine time frame (2007-2010),³ the most recent national data shows that immunization rates are leveling off rather than increasing suggesting missed opportunities.⁴ Due to the low rates of vaccination initiation and completion in Ohio and the potential to prevent significant HPV related disease, the OAHP has made the initiation and completion of HPV vaccination series in both males and females a priority. We hope that through education of health care providers and families as well as improving reminder systems both at the level of the clinician and statewide, we can increase the number of adolescents protected from this virus.

Another unfortunate consequence of sexual activity is teenage pregnancy and birth at a time when youth are not prepared to parent. The good news is that the rate of teenage pregnancy and birth rates have been steadily decreasing both nationally and in Ohio since 2008.^{5,6} According to the Centers for Disease Control and Prevention, teen pregnancy reduction is a "winnable battle."⁷ Nationally, the decrease in pregnancy rates is attributed both to decisions by youth to delay sexual activity as well as the use of more effective contraception by those who choose to be sexually active. Many counties throughout Ohio have adopted an abstinence education message as one strategy designed to protect youth from the physical, psychological and economic

consequences associated with teenage sexual activity and non-marital childbearing. In addition to encouraging teens to delay the initiation of sexual activity, CDC recommends a comprehensive evidence-based approach which includes increasing the use of effective contraception with an emphasis on long acting reversible methods, including the (Intrauterine Device) IUD and implantable rod, as well as providing education on the prevention of STIs and HIV infection.⁷ The approach by the OAHP aligns with that of the CDC with the goal of continuing the decreasing trend in pregnancy and birth rates in adolescents by providing continuing education and training of health care providers, adolescents, and families about abstinence and contraception with an emphasis on Long Acting Reversible Contraceptives (LARC). As STIs and pregnancy can occur concurrently, we also plan to promote the use of dual contraceptive methods to protect against both from occurring simultaneously.

Ohio data from a survey of parents and adolescents in the Title V Ohio Abstinence program in 2007 was consistent with numerous national samples demonstrating that the majority of both parents and adolescents prefer that reproductive health education occur primarily in the home with additional education provided in the schools.⁸ Parent-adolescent communication about these topics are important but can be challenging. The 2007 Ohio survey also showed that approximately two-thirds of parents and adolescents would have been interested in attending courses designed to improve their communication on these topics, if they had been available. Further, as an adolescent progressed from 6th to 12th grade, both parents and adolescents endorsed that more comprehensive messages about pregnancy and STI/ HIV prevention should be taught in schools in addition to abstinence. Despite these findings, as of 2012, less than one-fifth of schools in Ohio schools reported that their lead health education teachers, for grades 6-12, were getting continuing education on pregnancy, STIs, or HIV prevention.⁹ Health education standards are necessary to assist health teachers in addressing the skills and competencies that youth will need to make informed and healthy decisions. As of the summer of 2013, Ohio has no health education standards to help guide School Districts and/or their health teachers. A 2012 survey of parents in Ohio indicated that they overwhelmingly (89.2%) favored statewide health education standards.¹⁰ Such standards would provide a framework for local districts to choose the curriculum used in the classroom.

The following examples highlight some of the state and local level efforts addressing Reproductive Health issues for adolescents and young adults:

The **Reproductive Health and Wellness Program (RHWP)** is administered by ODH and provides funds to 50 counties through local health departments, community action groups, and nonprofit agencies for reproductive health care for men and women. Included services address contraception, STIs, and health education including teen pregnancy prevention and prevention of sexual coercion/ relationship violence. In 2012, approximately one quarter of those served were adolescents.

The **Ohio Department of Health STD Prevention Program** is focused on the prevention and control of STIs with efforts that complement activities conducted by local public health departments, Infertility Prevention Project (IPP) sites, and other healthcare providers. In addition to providing access to STI and HIV testing, the STD Prevention Program also regularly provides educational materials, statistical summaries, program resources and treatment guidelines, and other requested technical assistance.

The **Ohio Department of Health Immunization Program** seeks to reduce and eliminate vaccine-preventable diseases among Ohio's children and adolescents through the federally-funded Vaccines for Children (VFC) program which supplies vaccine at no cost to public and private health care providers who enroll and agree to immunize eligible children and teens in their medical practice or clinic.

The **Ohio Chapter of the American Academy of Pediatrics** conducted an Adolescent Immunization Expert Round Table in the Spring of 2013 which included a review of the vaccines in the current vaccination platform; resources for immunization of adolescents; and focus groups to identify issues relevant for initiation and completion of these vaccinations. Next steps are to develop and implement a quality improvement program to address adolescent vaccination among clinicians in Ohio.

The Ohio **Abstinence Education Program** has the goal of increasing the number of youth who abstain from sexual activity and other related risky behaviors to reduce out-of-wedlock births and STIs. The inclusion of an abstinence education message is a critical component of Ohio's comprehensive prevention efforts that is respectful and responsive to the diverse populations, regions, and values across the state. Ohio's program is primarily school based and focuses on prevention education for youth 11-18 years to promote good decision making and positive healthy behaviors. This program builds upon the strategy of local control, community collaboration and evidence supported program design within the guidelines established by the Title V Abstinence Education Grant Program.

The **Personal Responsibility Education Program (PREP)**, designed by ODH, is a collaborative effort with the Ohio Department of Job and Family Services and the Ohio Department of Youth Services and focuses on prevention education for youth in foster care and the juvenile justice systems who are the most vulnerable youth at risk for unplanned pregnancy, STIs and HIV. PREP provides education, outside of the school day, for youth age 14-19, by training staff in those systems to deliver evidence-based pregnancy prevention programming on both abstinence and contraception for the prevention of pregnancy, STIs, and HIV/AIDS as well as three adulthood preparation subjects to assist youth as they transition out of placement into independent living.

Ohio SNAPSHOT

- In 2011, 41.8% had been sexually active within the past three months; 17.5% (15.8% females, 19.0% males) had sexual intercourse with four or more persons during their lifetime; 6.1% of had their first sexual encounter before the age of 13 (4.3% females, 8.0% males).¹¹
- In 2011, 43.5% of 9th-12th graders who had sexual intercourse during the past three months reported using a condom during their last sexual encounter.¹¹
- In 2011, less than 10% of 9th-12th graders reported using a form of Long Acting Reversible Contraceptives (LARC).¹¹
- According to the 2011 YRBS, when compared to students across the country, those in Ohio were: significantly more likely to be sexually active (41.8 vs. 33.7)¹¹ and more likely to report not using hormonal contraceptives to prevent pregnancy before their last sexual intercourse (68.2 vs. 76.7).^{11, 12}
- In 2012, 40,222 cases of Chlamydia were reported in the 10-24 year old group representing 75% of all reported cases for that year. Of these, 35% (18,664 cases) were reported in 15-19 year olds and 39% (20,804 cases) were reported among 20-24 year olds.¹³
- In 2012, 10,460 cases of gonorrhea were reported in the 10-24 year old group representing 63% of all reported cases for that year. Of these, 27% (4,482 cases) were reported in 15-19 year olds and 35% (5,815 cases) were reported among 20-24 year olds.¹³
- In 2012, 279 cases of HIV were reported in the 15-24 year old group representing 25% of all reported cases for that year. Of these, 5% (59 cases) were reported in 15-19 year olds and 20% (220 cases) were reported among 20-24 year olds.¹⁴
- The adolescent birth rates have consistently fallen among 15-19 year olds in Ohio from 41.0 in 2008 to a historic low 33.5 per 1000 females in 2010; the rate among 20-24 year olds have also fallen and from 104.8 in 2008 to 93.8 per 1,000 in 2010.⁶
- According to the *Pregnancy Risk Assessment Monitoring System, Ohio Department of Health*, between 2006-2010, 82.5% of teen births were reported as unintended and 44.8% of those not intending to become pregnant were not using contraceptives at the time of conception.¹⁵
- According to the 2008 Title V Parent and Child Communication report, both parents and youth agreed that the majority of sexual education should be provided by family and supplemented by the school (83.5% parents, 68.7% youth).⁸
- In Ohio in 2011, 45.5% of female adolescents 13 through 17 received at least one dose of HPV and 34.8% received at least 3 doses. For those starting the series, 77.0% completed it within 24 weeks.²

Goals and Objectives

Goal 6: Adolescents and their families will be able to make informed decisions about their reproductive health.

Objective 6.1: Delay the onset of sexual activity.

Objective 6.2: Increase the number of schools with quality health education including evidence-based reproductive health.

Objective 6.3: Increase the communication between parent/guardian and teens about reproductive health.

Objective 6.4: Increase access and provision of reproductive health services to adolescents through medical homes and family planning clinics.

Goal 7: Reduce the rates of sexually transmitted infections in adolescents.

Objective 7.1: Increase screening rates for sexually transmitted infections, including Chlamydia, syphilis, gonorrhea, and Human Immunodeficiency Virus (HIV).

Objective 7.2: Increase Human Papillomavirus (HPV) vaccination initiation and completion in males and females.

Objective 7.3: Increase the use of dual contraceptive methods to reduce exposure to sexually transmitted infections and HIV in addition to pregnancy prevention.

Goal 8: Promote the continued downward trend in pregnancy and birth rates among adolescents.

Objective 8.1: Increase use of effective and appropriate contraception among adolescents including abstinence.

Objective 8.2: Increase the number of clinicians recommending the use of Long Acting Reversible Contraception (LARC) in adolescents.

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