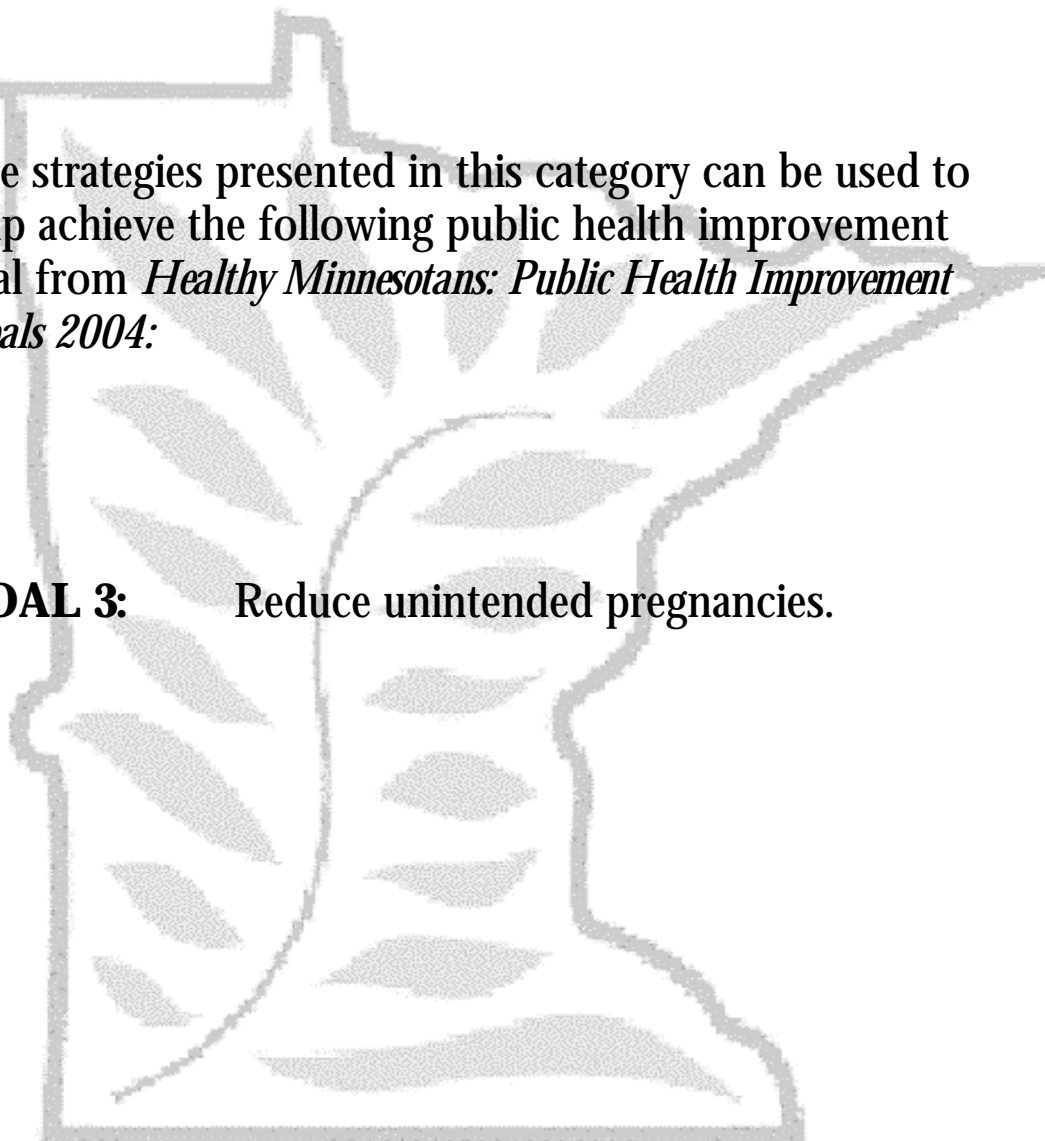


Category:

UNINTENDED PREGNANCY

The strategies presented in this category can be used to help achieve the following public health improvement goal from *Healthy Minnesotans: Public Health Improvement Goals 2004*:

GOAL 3: Reduce unintended pregnancies.



CATEGORY: UNINTENDED PREGNANCY

Introduction	1
Unintended Pregnancy	5

About half of all pregnancies in the U.S. are unintended. An unintended pregnancy is one that is identified by the mother as either unwanted or mistimed at the time of conception. Unintended pregnancy is both frequent and widespread. It occurs in all segments of society, not just among teens, unmarried women, poor women and minorities.

The 1995 National Survey of Family Growth indicates the following percentages of unintended pregnancies by age:

- ▶ 75% for women 15-19
- ▶ 59% for women 20-24
- ▶ 40% for women 25-29
- ▶ 33% for women 30-34
- ▶ 41% for women 35-39
- ▶ 51% for women over 40

While the percentages are higher for younger women, in absolute numbers, women ages 20-34 account for most unintended pregnancies because more women in those age groups become pregnant.

Although 77% of pregnancies to never married women are unintended, 31% of pregnancies to married women are unintended. Poverty is a risk factor for unintended pregnancy: the following are the percentages of unintended pregnancies by Federal Poverty Level (FPL):

- ▶ 61% for women <100% FPL
- ▶ 53% for women 100-199% FPL

However, even among women at greater than 200% FPL the percentage of pregnancies that are unintended is 41%

The consequences of unintended pregnancies are serious. When a pregnancy is begun without planning and intent, there is less opportunity to prepare for an optimal outcome. Unintended pregnancies are associated with adverse maternal behaviors such as delayed entry to prenatal care, poor maternal nutrition, cigarette smoking, and use of alcohol and other drugs. Women whose pregnancies are unintended are more likely to have infants who are low birth weight and are less likely to breastfeed. Their infants are more likely to be abused and more likely to die in their first year. Other negative social outcomes such as reduced education and career attainments of parents, increased welfare dependency, divorce, and domestic violence are associated with unintended pregnancy. Children born from unintended pregnancies are more likely to be raised by one parent, and these children are more likely to become teen parents themselves. Further, about half of all unintended pregnancies end in abortion.

There are financial burdens for unintended pregnancy as well. The Department of Human Services estimates that in Minnesota in 2001, there were 18,553 subsidized deliveries at an average cost of \$3,386 for a total of \$62,819,540. There were 22,144 recipients of first year services at a cost of \$6,894 for a total of \$152,669,942. If half of those pregnancies were unintended, the estimated cost for births and first year services from pregnancies begun without planning or intent is \$107,744,741.

At the national level, the *Healthy People 2010* goal is to increase to at least 70% the proportion of pregnancies that are intended.

According to the Institute of Medicine (IOM) report on *The Best Intentions*, the US goal has already been achieved by other industrialized nations. The Institute of Medicine report calls for a new social norm where all pregnancies are consciously and clearly desired at conception. This will require a long-term effort to educate the public on the social, economic, and public health burdens of unintended pregnancy and stimulate interventions to reduce such pregnancies. The IOM recommends that efforts be structured around the following five goals:

- ▶ Improve knowledge about contraception and reproductive health.
- ▶ Increase access to contraception.
- ▶ Address the roles attitudes and motivation play in avoiding unintended pregnancy.
- ▶ Develop and evaluate local initiatives.
- ▶ Stimulate research on contraceptive methods, organizing services, and the determinants and antecedents of unintended pregnancy.

The National Association of City and County Health Officials published a set of action steps for local health departments in 1996. The report calls for more reproductive health education and more access to clinical reproductive services.

Access to quality family planning information and services is an important factor in planning for healthy pregnancies and preventing unintended pregnancies. The use of contraception increases the interval between births and contributes to a reduction in low birth weight, since a short interval between births is a well-established risk factor for low birth weight. Contraception also plays a role in the reduction of some sexually transmitted diseases that lead to

future infertility. For related strategies, see the section “STD/HIV/AIDS” in the *Infectious Disease* category.

Of special concern is the high rate of unintended pregnancy among teens. Children of teen mothers are at a greater risk of growing up in a single-parent family, of having less-educated and less securely employed parents, and, therefore, of spending more time living in poverty. In addition, children of adolescent parents have higher risks of lower intellectual and academic achievement, lower educational expectations, and more behavioral disorders than do children born to older parents. Teen mothers are also more likely than older mothers to need the support of public assistance. In Minnesota in 1999, 48% of families who received Minnesota Family Investment Program (MFIP) funds began with a birth to a teen. It is estimated the 80% of all adolescent mothers will sometime receive government assistance during the 10 years following the birth of their first child.

There is no easy answer or single reason teens get pregnant. Many social systems influence their lives and behaviors. Risk factors include poverty, homelessness, school problems, dating at an early age, alcohol and substance abuse and other risk behaviors. Research indicates that teens are less likely to become pregnant if they have close, positive connections with caring adults, have life opportunities and goals, use contraceptives if sexually active, and are doing well in school. For related strategies see: the *Alcohol, Tobacco and Other Drugs* category; the section on “Adolescent Health - Parenting and Youth Development” in the *Child and Adolescent Growth and*

Development category; the section on “Mental Health” in the *Mental Health* category, and the section on “Youth Violence” in the *Violence* category.

Also of concern is that unintended pregnancies occur more frequently among some minorities and racial groups. Nationally, 72% of pregnancies among African American women and 49% of pregnancies among Hispanic women were unintended. Strategies to reduce unintended pregnancy must be culturally and ethnically specific to the population to be served and grounded in what research shows works. For more information, see the section, “Eliminate the Disparities” in the *Service Delivery Systems* category, and report, *Health Profile of Populations of Color* (MDH, 1997).

If more pregnancies were intended, there would be more healthy mothers and babies, health care costs would be reduced, both teenage and non-marital childbearing would be reduced, poverty and welfare dependence would be reduced and abortion would be reduced dramatically. The strategies presented here describe a multifaceted, comprehensive approach, involving public health professionals, medical clinicians, nonprofit corporations, the educational system, communities, and others with an interest in reducing unintended pregnancy. Population-based strategies must be implemented on the individual, community, and system levels in order to lower the rates of unintended pregnancy in Minnesota.

CATEGORY: Unintended Pregnancy

TOPIC: UNINTENDED PREGNANCY

The strategies below can be used to work on this topic.
Organizations that may play a role in implementing each strategy are indicated.

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Provide assessment, policy development and planning, and assurance activities to reduce the incidence and prevalence of unintended pregnancy.	✓	✓	✓	✓	✓		Government Social Services
Provide or accessible, comprehensive family planning services specifically designed to meet the cultural, age, and gender needs of clients in a variety of settings.	✓	✓	✓	✓	✓		Media
Develop multi-faceted programs that support the prevention of adolescent pregnancy.	✓	✓	✓	✓	✓		Media
Improve public knowledge about family planning and reproductive health.	✓	✓	✓	✓	✓		Media
Promote healthy sexual behaviors.	✓	✓	✓	✓	✓		Media

Strategy: Provide assessment, policy development and planning, and assurance activities to reduce the incidence and prevalence of unintended pregnancy.

	Systems	Community	Individual
Primary	U	U	U
Secondary	U		
Tertiary	U		

Background:

The Institute of Medicine Report on Unintended Pregnancy, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, suggests that despite the national attention on teen pregnancy and non-marital childbearing and the continuing controversy over abortion, the common antecedent of all three - pregnancy that is unintended at the time of conception - remains essentially invisible. It recommends a new national understanding about this problem and a consensus that pregnancy should be undertaken only with planning and intent. Moving towards a goal where all pregnancies are consciously and clearly desired at conception would require a long term effort to educate the public on the social, economic, and public health burdens of unintended pregnancy and stimulate interventions to reduce such pregnancies.

According to the IOM report, unintended pregnancy is not just a problem of individual behavior; it is also a problem of public policy and institutional practices. No single factor accounts for the high rates of unintended pregnancy; there are socio-economic, cultural, educational, organizational and individual components. Studies conducted nationally and in Minnesota indicate that many insurance

companies, health plan companies, and managed care plans either do not cover the cost of family planning exams and contraceptives or require co-payments or other cost sharing. These financial barriers can limit access to needed family planning services that require contact with a health care professionals and the use of more effective contraceptive methods. Some women, men, and adolescents in need of family planning services may be unwilling to seek services unless they can receive these services in a confidential manner. Some billing processes by commercial insurance companies, health plans, or health maintenance organizations could threaten patient confidentiality.

Assessment, planning, policy development and assurance activities include collaborating across disciplines to understand the complex factors associated with unintended pregnancies, reducing barriers to information and services, and developing better ways to organize, finance, and evaluate appropriate services. Activities that support this strategy include:

- < Conduct local surveys on the community’s general knowledge about contraception and reproductive health.
- < Conduct community needs assessments to determine need and support for family planning services. If needs assessment information is current, provide information to the community.
- < Work with local pregnancy prevention programs to design evaluations that determine the program’s impact on unintended pregnancy.
- < Convene a group of community leaders from the health education, social service, business and other sectors to look at unintended pregnancy in the community.
- < Apply for funding for an unintended

- pregnancy prevention program that has a carefully planned evaluation component.
- < Educate providers and educators on the effect of cultural mores on individual behavior.
- < Survey clients to assess perceived or actual barriers to obtaining or using family planning.
- < Conduct local research on men's attitudes and perceptions about family planning and use the findings to develop appropriate programs for men.
- < Conduct local research with racial and ethnic groups in your community to determine attitudes and perceptions about family planning, and use the findings to develop appropriate programs for these populations.
- < Share information on successful pregnancy prevention demonstration programs with other agencies, providers, and organizations.
- < Work with private providers to develop and evaluate interventions they can use with their clients.
- < Work with insurers to cover comprehensive family planning services, including prescription methods as part of their standard benefits.
- < Advocate for billing policies that maintain patient confidentiality.
- < Work with insurers to adapt reimbursement policies and procedures that protect patient confidentiality.
- < Work with companies that buy the insurance to include comprehensive family planning services and to request confidential reimbursement policies for family planning services when they purchase policies.
- < Inform individuals in managed care plans of the ability to access family planning services from the provider of their choice within the health plan.
- < Provide a list of agencies that provide family planning services in a confidential manner.
- < Educate community members, physicians, and other providers about the public health implications of Minor's Consent to Health Services issues.
- < Assess the impact of private providers on access to contraceptive services and share this information with policy makers.
- < Link local research on pregnancy prevention with research in psychology, demography, and sociology.
- < Assess the rate of unintended pregnancy among prenatal care, or WIC clients.
- < Monitor the length of time between when individuals call for family planning appointments and when they can get appointments.
- < Obtain funding for the provision of subsidized family planning services.

Additional resources:

Bibliographic resources:

- < Alan Guttmacher Institute (AGI). 1999. *Facts in Brief, Contraception Counts*, Washington D.C.
- < Hatcher et. al. *Contraceptive Technology*. (17th Edition). New York: Irvington Publishers, Inc. Contact: Bridging the Gap Communications, P.O. Box 33218, Decatur, GA 30033 [\$39.95 plus tax and shipping], or the Planned Parenthood Resource Center, at (612) 823-6568.
- < Institute of Medicine. 1995. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. National Academy of Medicine Press.
- < Kaiser Permanente Medical Group. December 1999. *Things a Department Can Do to Reduce Unintended*

- Pregnancy*, San Diego, CA.
- < N.A.C.C.H.O. Spring 1996. *Unintended Pregnancy: Prevention Strategies for Local Health Departments*.
 - < Program for Appropriate Technology in Health. 1999. *Quarterly Update for Collaborating Prescribers*, Seattle.
- Organizational resources:
- < Alan Guttmacher Institute, at (212) 248-1951, <http://www.agi-usa.org>, 120 Wall Street, New York, NY 10005.
 - < MN Family Planning/STD Hotline, at (800) 783-2287.
 - < SIECUS (Sex Information and Education Council of the United States), at (212) 819-9770, <http://www.siecus.org/>, 130 West 42nd St., Suite 350, New York, NY, 10036-7802.

Evidence for this strategy:

At the national level, the *Healthy People 2010* goal is to reduce to 30 percent the proportion of pregnancies that are unintended. If this goal were achieved it would mean 200,000 fewer births each year that were unwanted and 800,000 fewer abortions annually as well. Research indicates that every tax dollar spent for contraceptive services saves an average of \$3 in Medicaid costs for pregnancy-related health care and for medical care of newborns. According to *Business and Health*, adding coverage of contraceptives would add about 1 percent to employer's total health costs. But the additional cost would see an immediate return on investment through savings in sick time, maternity leave, replacement costs and reduced medical costs for unintended pregnancies. During a novel pilot project in Western Washington that enabled pharmacists to prescribe emergency contraceptive pills (ECPs) directly to

women through collaborative drug agreements with doctors, 1,000 pharmacists and 140 pharmacies provided about 12,000 prescriptions in 16 months of service, potentially preventing 700 or more unintended pregnancies (assuming a 10% pregnancy risk and 75% method effectiveness). A clinic in the Kaiser Permanente system in San Diego made reducing unintended pregnancy a strategic goal. Strategies included educating providers and staff about unintended pregnancy, finding opportunities to educate patients, prescribing birth control and following up on use, increasing access to emergency contraception, and reducing administrative barriers to family planning appointments. In three years they reduced the number of abortions in their practice by 25 percent. The Alan Guttmacher Institute has conducted studies on the need for family planning services, has estimated the numbers of pregnancies averted by publicly supported clinics, and has produced state-level reports.

Has this strategy been implemented in Minnesota?

Yes, several assessment, policy, planning and assurance activities have been implemented. For example, the MDH Family Planning Special Projects grant program uses an assessment tool. A Statewide Plan For Teen Pregnancy Prevention and Parenting was recently developed which includes policy and planning implications. The Adolescent Health Care Coalition is focusing on strategies to support confidential reimbursement policies and practices for family planning services. MN SAFPLAN (State Association for Family Planning) is engaged in implementation of activities related to this strategy.

Indicators for this strategy:

- < Unintended pregnancy rates.
- < Number of subsequent births in Medicaid population that are farther apart than 24 months.
- < Availability of providers with billing practices that maintain confidentiality.
- < Availability of culturally competent information and services.
- < Availability of services for men.
- < Community intervention with an evaluation component.
- < Public awareness of the factors that promote and decrease unintended pregnancy
- < Public awareness of the ability to access the provider of their choice for family planning services outside of their insurance physician-mandated networks.
- < Number of providers of confidential family planning services in a community.
- < Number of health plans with billing procedures that maintain patient confidentiality.

For more information contact:

- < Judy Bergh, at (651) 281-9994, judith.bergh@health.state.mn.us, MDH Family Planning Special Projects Consultant.
 - < Pam Hayes at (651) 281-9954, pamela.hayes@health.state.mn.us, MDH Reproductive Health Planner
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Strategy: Provide or assure accessible, comprehensive family planning services specifically designed to meet the cultural, age, and gender needs of clients in a variety of settings.

	Systems	Community	Individual
Primary	U		U
Secondary	U		U
Tertiary			

Background:

Family planning services promote and protect public health by decreasing unintended pregnancy. Family planning is the voluntary planning and action by individuals to prevent, delay, or achieve a pregnancy. Family planning services include counseling and education, pre-conception care, screening and laboratory tests, and family planning methods. Family planning methods include abstinence, natural family planning, and all FDA approved methods of fertility control including emergency contraception and sterilization.

According to the Institute of Medicine (IOM), one of the causes of unintended pregnancy is the combination of financial and structural factors that make access to prescription methods of contraceptives a complicated and expensive process. Accordingly, they recommend improving access to comprehensive low-cost family planning services. The IOM report recommends that barriers to information and services can also be reduced by: increasing the proportion of policies that cover contraceptive services and supplies, and broadening the range of health professionals and institutions that promote and provide methods of family planning.

Of couples who regularly engage in sexual intercourse without contraception, 89 percent will conceive in one year. According to the *American Journal of Public Health*, in five years one sexually active woman would become pregnant 4.25 times without contraception. To use a contraceptive effectively, individuals must have access to it, be able to afford it, understand the effectiveness of the method, and know how to use it correctly. Activities that support this strategy include:

- < Collect data on the need for family planning services and whether that need is being met.
- < Survey clients to assess perceived or actual barriers to obtaining or using family planning
- < Assure availability of different contraceptive methods, including abstinence, natural family planning, and all FDA approved methods.
- < Provide family planning services that are culturally and ethnically specific.
- < Recruit bi-lingual/bi-cultural service providers.
- < Use clinicians who can respond to gender or cultural concerns of clients.
- < Provide family planning services that are specific to men's needs.
- < Hold clinics at times that are convenient to clients, e.g., expand hours of clinic operation to include some evenings and weekends.
- < Have family planning material available in languages appropriate to clients.
- < Reduce administrative barriers to timely family planning appointments.
- < Monitor the length of time between when individuals call for family planning appointments and when they can get appointments.
- < Increase the proportion of health care providers and pharmacies that provide information about or access to emergency contraception.
- < Provide non-directive counseling at times and places convenient for clients.
- < Develop patient follow-up programs to increase continuation rates of contraceptive use.
- < Increase coordination and collaboration between family planning services and other health and social programs that serve at risk clients.
- < Develop an informational brochure to increase awareness of family planning providers in the community.
- < Include consumers in the development of programs.
- < Work with Medical Assistance and other health and social programs on family planning access issues.
- < Work with local hospitals, medical schools and family planning agencies to develop continuing education for care givers on family planning and contraceptive management.
- < Develop an informational brochure to increase awareness of the ability of health plan company members to access the provider of their choice for family planning services outside of their insurance physician-mandated networks.
- < Develop a simple referral form to assure continuity of care and adequate follow-up.
- < Provide information to youth-serving professionals on how to access family planning services, so that they can provide consistent information to their clients.
- < Include information and non-directive counseling on family planning during school sport physicals and general medical visits.
- < Support schools that are interested in providing abstinence and contraceptives

as part of their health services.

- < Develop health clinics that are school-linked, school-based, or both.

Additional resources:

Bibliographic resources:

- < Bongaarts, J. and Westoff, CF. September 2000. The potential role of contraception in reducing abortion. *Studies in Family Planning*, 31:193-202.
- < Cawthon, L. June 2001. *First Steps Database: Post-Partum Family Planning Services*, Department of Social and Health Services, Research and Data Analysis.
- < Centers for Disease Control and Prevention's Task Force on Community Preventive Services. *The Community Guide*, available at: <http://www.thecommunityguide.org>.
- < Forrest JD., and Samara, R. 1996. Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures. *Family Planning Perspective*, 28(5):188-195.
- < Hatcher, et.al. *Contraceptive Technology*. (17th Edition). New York: Irvington Publishers, Inc. Contact: Bridging the Gap Communications, P.O. Box 33218, Decatur, GA 30033 [\$39.95 plus tax and shipping], or the Planned Parenthood Resource Center, at (612) 823-6568.
- < Henshaw, Stanley K. 1998. *Family Planning Perspectives: Unintended Pregnancy in the United States*. Contact: Alan Guttmacher Institute, at (212) 248-1951, <http://www.agi-usa.org>, 120 Wall Street, New York, NY 10005.
- < Institute of Medicine. 1995. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. National Academy of

Medicine Press.

- < N.A.C.C.H.O. Spring 1996. *Unintended Pregnancy: Prevention Strategies fro Local Health Departments*.
 - < United States Department of Health and Human Services. November 2000. *Healthy People 2010*, Vol. 1, Chapter 9, <http://www.healthypeople.gov/>.
- Organizational resources:
- < MN Family Planning/STD Hotline, at (800) 783-2287 or (651) 645-9360 (Twin Cities metropolitan area).
 - < Office of Population Affairs, United States Department of Health and Human Services, <http://opa.osophs.dhhs.gov>

Evidence for strategy:

The research indicates that every tax dollar spent for contraceptive services saves an average of \$3 in Medicaid costs for pregnancy-related health care and for medical care of newborns. The average cost for pregnancy related care in a managed care system is about \$4000. Over five years, the prescription methods save between \$13,373 and \$14,122 by preventing unintended pregnancies. Research also suggests that services that are culturally sensitive to the needs of the clients may enhance contraceptive acceptance and use. These services are more likely to be available if services are provided in a variety of settings. A Washington state Medicaid report on birth spacing in a population qualified for family planning services for one year after delivery showed that the two-year subsequent birth rate was two to three times higher for women who did not receive family planning services compared to those who did. According to a study featured in the June 2002 issue of *Pediatrics*, focusing more on providing family planning and prenatal care services could help improve infant mortality rates. That study indicated that if the United

States could be certain that every pregnancy is wanted and that mothers receive effective health care for themselves and their fetuses, there would likely be lower rates of low birthweight and other health problems. In addition, according to a study by the Population Council, even small increases in contraceptive use will decrease abortion rates. Other research is available to estimate the number of pregnancies averted by women who use family planning services.

This strategy is strongly recommended by the Institute of Medicine, the Centers for Disease Control and Prevention's Task Force on Community Preventive Services (see Community Guide at: <http://www.thecommunityguide.org>).

Has this strategy been implemented in Minnesota?

Yes, the MDH Family Planning Special Projects (FPSP) grant program funds many projects throughout most of Minnesota, serving 62 of 87 counties. FPSP funds are distributed on a population-based formula to eight regions in the state, thus maximizing geographic accessibility. Services are provided in a variety of settings, including freestanding clinics, community clinics, private physician offices, and public health offices. Grantee agencies provide comprehensive services, including: public information to inform the general population about the importance of family planning and how to obtain services; outreach to specific populations in need of subsidized services; age and culturally appropriate education and counseling about reproductive health and contraceptive options; provision of all FDA approved contraceptives, including Natural Family Planning and sterilization; provision of appropriate medically related reproductive health services; follow-up care

of contraceptive clients as needed; and referral to other services as needed. FPSP funds also support a statewide Family Planning and STD Hotline for referral to services and to answer family planning and STD related questions.

Title Ten of the Public Health Service also funds subsidized family planning services in Minnesota. The major recipient of Title X funding in Minnesota is Planned Parenthood of Minnesota/South Dakota, which uses its Title X funds to provide services in clinics that are located throughout the state. Two other recipients of Title X funding are the St. Paul-Ramsey County Department of Health which provides subsidized family planning services at the Public Health Center in St. Paul to residents of Ramsey County, and the MDH, which contracts with Teenage Medical Services to provide family planning services to adolescents in a low-income, racially diverse neighborhood of South Minneapolis. Both Title X and FPSP grantees provide services on a sliding fee scale; no one is denied service based on inability to pay. All grantee agencies commit to minimizing barriers to access wherever possible.

Indicators for this strategy:

- < Unintended pregnancy rates.
- < Number of subsequent births that are farther apart than 24 months.
- < Medicaid costs for deliveries and first year expenses of pregnancies that are unintended at the time of conception.
- < Number of health care providers and pharmacies that offer emergency contraception.
- < Number of health insurance providers that cover family planning services and methods.
- < Number of agencies that provide

subsidized family planning services in a community.

- < Geographic areas without subsidized family planning services.
- < Adolescent pregnancy rates.
- < Proportion of sexually active ninth and twelfth graders who participate in the Minnesota Student Survey and report always using birth control.
- < Numbers of bi-lingual/bi-cultural family planning providers.
- < Number of professionals trained in adolescent health.

For more information contact:

- < Pam Hayes at (651) 281-9954, pamela.hayes@health.state.mn.us, MDH Reproductive Health Planner.
- < Judy Bergh, at (651) 281-9994, judith.bergh@health.state.mn.us, MDH Family Planning Special Projects Consultant.
- < Erica Fishman, at (612) 625-4891, Maternal and Child Health Program, School of Public Health, U of M.

Strategy: Develop multi-faceted programs that support the prevention of adolescent pregnancy.

	Systems	Community	Individual
Primary	U	U	U
Secondary	U	U	U
Tertiary			U

Background:

Teen pregnancy is not just another single issue. Success at reducing teen pregnancy depends on unifying the efforts of parents, community based organizations, state agencies, legislators, research communities,

business leaders, faith organizations and schools. The importance of a multi-faceted approach are detailed in the Minnesota State Plan for Teen Pregnancy Prevention and Parenting (www.moappp.org). Development and support for a continuum of programs from abstinence to comprehensive programs based on current research and best practices is essential to reducing teen pregnancy.

The recommendations of the State Plan are derived from current research and best practices. Specifically the plan calls for:

- < Use of data and evaluation to inform program planning and continuous improvement
- < Programs grounded in a youth development approach.
- < Elimination of health disparities.
- < Support and coordination of resources and services for teen-parented families.
- < Assurance of community partnerships.
- < Involvement of parents and other caring adults.
- < Inclusion of men and boys.
- < Support of comprehensive sexuality education.

Activities that support these recommendations include:

Systems

- < Disseminate the Minnesota State Plan for Teen Pregnancy Prevention and Parenting and hold discussions about the implications of policy development at the systems level.
- < Improve outcomes by focusing programs and adequate resources to youth and families with the greatest needs.
- < Mandate and support on-going data collections and evaluation to assure the most effective programming and resources for youth and communities.

- < Fund, reward and endorse programs that are based on current research and data.
- < Ensure a quality education for all children, regardless of socioeconomic level, racial, ethnic or cultural background, to develop productive life skills and a promising future.
- < Build systems and processes that assist families in creating an environment that contributes to the well-being and success of youth.
- < Endorse comprehensive sexuality education that includes information about abstinence and contraception as important components of a complete education.
- < Ensure that sex education reflects research-based approaches, is culturally relevant, and assures inclusion of all students.

Community

- < Formally embrace youth development strategies that use dual approaches of reducing risks and promoting the strengths of individual, their families and the community.
- < Recognize and engage youth as resources within their families, schools, and communities.
- < Assure that program planning and implementation involve the targeted populations and acknowledge the diversity of cultures and communities.
- < Convene all segments of the community to assure the ongoing development and progress of a plan to address teen pregnancy prevention.
- < Use a health promotion approach that emphasizes changing community norms to support positive healthy behaviors through community partnerships.
- < Foster collaboration among the whole community both public and private sector, to help solve the problems of teen

pregnancy and teen parenting.

Individual

- < Implement evidence-based curricula.
- < As an adjunct to teacher-led instruction, train and support peer educators/leaders who can role model social skills and lead role-plays.
- < Implement educational programs to improve parent/child communication about healthy sexuality.
- < Implement programs designed to improve access or to provide comprehensive sexuality education.
- < Implement programs to address emotional, legal, financial etc. responsibilities of paternity.
- < Provide training to health care workers and others who work with adolescents on how to talk to youth about reproductive health issues.
- < Implement programs that include multi-faceted components including curriculum implementation, community-organizing activities and public awareness.
- < Implement effective Service Learning Programs.
- < Implement youth development programs that combine life skills and sexuality education with involvement in community service.
- < Provide assistance with academic subjects/homework beyond regular classes that will lead to school success.
- < Provide mentoring opportunities – one-on-one regular contact for an extended period of time with trained adult for recreation, skill/relationship building.
- < Implement programs that provide meaningful activities that enhance parent/youth communication and promote connectedness.
- < Implement programs that focus on parent/caregiver education skill building

- and involvement with their children.
 - < Implement after school activities that are linked with community resources (schools, faith communities, mosques, synagogues, etc.) to engage youth in physical activity, technology, leadership, etc.
 - < Provide employment opportunities and skill development through apprenticeships with business/other employers to assist youth in learning marketable skills while experiencing work.
 - < Implement programs for sisters of teen girls who became pregnant and offer individual case management and group activities and services.
 - < Implement life skills education/training for adolescents that include skills such as communications, decision-making, and goal setting.
 - < Develop intensive programs that last through high school and include: 1) family life and sex education; 2) regular attendance throughout school culminating in graduation; 3) a work-related intervention; 4) self-expression through the arts; and 5) individual sports.
 - < Implement a program that provides opportunities to meet with other pregnant or parenting teens to develop problem-solving skills, sense of uniqueness, personal power etc.
- < Institute of Medicine. 1995. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. National Academy of Medicine Press.
 - < Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP). *Community Empowerment Manual*. (800) 657-3697, or (651) 644-1447 Twin Cities Metro Area, P. O. Box 40392, St. Paul, MN 55104.
 - < National Campaign to Prevent Teen Pregnancy. 2001. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, by Douglas Kirby, Ph.D.; and *Get Organized: A Guide to Preventing Teen Pregnancy*. www.teenpregnancy.org.
 - < Philliber Research Associates. *Creating and Evaluating Successful Teen Pregnancy Programs*, <http://www.philliberresearch.com/>.
 - < University of Minnesota, Maternal and Child Health Program. May 2002. *Healthy Generations* Vol. 3, Issue 1. The focus of this issue is teen pregnancy, www.epi.umn.edu/mch.
 - < *A Work in Progress: Building a State Plan for Teen Pregnancy Prevention and Parenting, First Release*. April 2002. For more information email: www.moapppp.org or prc@umn.edu or call (612) 626-2820.

Additional resources:

- < Advocates for Youth. *Communities Responding to the Challenge of Adolescent Pregnancy Prevention*, at <http://www.advocatesforyouth.org>.
 - < Child Trends, *Next Steps and Best Bets: Approaches to Preventing Adolescent Childbearing*, <http://www.childtrends.org>.
- Organizational resources:
- < Alan Guttmacher Institute, at (212) 248-1951, <http://www.agi-usa.org>, 120 Wall Street, New York, NY 10005.
 - < Minnesota Coordinated School Health Program: www.mnschoolhealth.com.
 - < Minnesota Department of Health, Youth Risk Behavior Endowment web sites. For more information see the website for strategies resources at:

www.health.state.mn.us/strategies/.

Click on “Youth Risk Behavior Endowment” and “Youth Risk Behavior Directory”.

- < Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP), at (www.moappp.org), and at (800) 657-3697, or (651) 644-1447 Twin Cities Metro Area. P.O. Box 40392, St. Paul, MN 55104.
- < National Teen Pregnancy Prevention Research Center, prc@umn.edu or (612) 626-2820.
- < SIECUS (Sex Information and Education Council of the United States), at (212) 819-9770, <http://www.siecus.org/>, 130 West 42nd Street, Suite 350, New York, NY 10036-7802.

Evidence for strategy:

Unlike just a few years ago, evidence based research now exists about what works in the prevention of teen pregnancy. There is good evidence that programs that combine both sexuality education and youth development can reduce pregnancy for as long as three years. Both service learning programs and sex and HIV education programs have now been found to reduce sexual risk taking or pregnancy in different settings. In early 2003 the short term impact findings regarding abstinence education funded by Title V, Section 510 will be released. These findings will provide empirical evidence on the effectiveness of abstinence education programs.

Has this strategy been implemented in Minnesota?

Yes. Many programs recently received TANF funding to enhance and expand their multi faceted efforts to prevent teen pregnancy. All Counties, Tribes and 20

community-based grantees are eligible to receive funds to implement a rich array of multi faceted programs. MN Education Now and Babies Later is an example of a specific program that uses curriculum, community organizing and a public awareness campaign focused on changing community norms to support abstinence or postponing sexual involvement for youth 12-14.

Indicators for this strategy:

- < The rate of pregnancy for teens 15-19.
- < The rate of births for teens 15-19.
- < The rate of births for teenagers of racial/ethnic groups 15-19.

For more information contact:

- < Jill Briggs, at (651) 281-9781, jill.briggs@health.state.mn.us, MDH Teen Pregnancy Prevention Coordinator.
- < Gabriel McNeal, at (651) 281-9962, gabriel.mcneal@health.state.mn.us, MDH MN ENABL Coordinator, MN ENABL Program.
- < Nancy Nelson, at (800) 657-3697 or (651) 644-1447 (Twin Cities Metro Area), Director of MOAPPP for comprehensive adolescent pregnancy prevention programs.
- < Sarah Smith, at (651) 281-9960 or sarah.smith@health.state.mn.us, MDH MN Abstinence Education Coordinator, MN Abstinence Education Program.
- < Kristen Teipel, at (612) 624-0182, MCH Project Coordinator for the National Adolescent Health Center for MCH Personnel, Konopka Institute.

Strategy: Improve public knowledge about family planning and reproductive health.

	Systems	Community	Individual
Primary	U	U	U
Secondary		U	U
Tertiary			U

Background:

According to the Institute of Medicine one of the reasons for the high rates of unintended pregnancy in the U.S. is that Americans lack adequate knowledge about contraception and reproductive health. Accordingly, they recommend improving access to balanced accurate information about the benefits and risks of contraceptive methods for both women and men of all ages. Increased awareness of family planning in the community will increase access to needed services.

Activities that support this strategy include:

- < Initiate a marketing campaign on the consequences of unintended pregnancy and the need for family planning and reproductive health information and services.
- < Develop public health information efforts targeting individuals of all ages.
- < Broaden family planning outreach efforts to include men.
- < Broaden the range of service providers (visiting nurses, social workers, and health promotion staff) that provide family planning information.
- < Establish linkages with professionals and programs that deal with the target population to keep them informed of the family planning services in the community.
- < Use existing materials from family

- planning organizations and websites; adapt for local use.
- < Provide programs that target men and women.
- < Provide information on contraceptive methods available and how to support a partner's use of contraception.
- < Provide accurate information on the risks and benefits of each contraceptive method.
- < Provide written materials in several languages.
- < Provide written materials on where low-cost family planning services are available.
- < Provide promotional items advertising the family planning hotline.
- < Hold meetings at a time convenient to the individuals.
- < Distribute non-prescription methods.
- < Provide "Parents As Sex Educators" classes for parents and caregivers, so that they can feel more comfortable providing guidance and education to their children.
- < Develop table tents and laminated bathroom posters advertising the family planning hotline.
- < Develop an informational brochure to increase awareness of family planning methods and providers.
- < Develop posters and brochures that include types of services provided and how to access them.
- < Place information in locations, which the target population frequents (e.g., bars, factories, laundromats, grocery stores, beauty salons, and physician offices).
- < Develop promotional items (e.g., pens, cups, key chains, and paycheck-stub messages).
- < Develop and air radio spots.
- < Work with school drama classes.
- < Develop a cable TV show.

- < Utilize the family planning hotline phone number, as well as local numbers.

Additional resources:

Bibliographic resource:

- < Stern, G. 1992. *Marketing Workbook for Nonprofit Organizations*. St. Paul, Minnesota: Amherst H. Wilder Foundation.

Organizational resources:

- < Family Planning Hotline Materials, at (800) 783-2287 or (651) 645-9360 (Twin Cities metropolitan area).
- < Management Sciences for Health, www.msh.org.
- < SIECUS (Sex Information and Education Council of the United States), at (212) 819-9770, <http://www.siecus.org/>, 130 West 42nd St., Suite 350, New York, NY, 10036-7802.

Evidence for strategy:

Healthy People 2010 cites numerous studies indicating a disturbing degree of misinformation about contraceptive methods and recommends increased public education efforts and improved accuracy in the media. The MDH family planning program staff have conducted marketing training sessions with several Family Planning Special Project Grantees. Agencies that have completed and implemented their marketing plans have reported an increase in the number of clients using their programs.

Has this strategy been implemented in Minnesota?

Yes, approximately 10 MDH Family Planning Special Project Grantees have implemented a marketing plan. Contact the MDH Family Planning staff (see “For More Information Contact:” below) for names of these agencies. This strategy has also been

used in programs internationally.

Indicators for this strategy:

- < Number of clients utilizing family planning programs.
- < Number of clients who heard about services through marketing efforts.
- < Calls to hotlines for family planning information.

For more information contact:

- < Judy Bergh, at (651) 281-9994, judith.bergh@health.state.mn.us, MDH Family Planning Special Projects Consultant.
- < Pam Hayes at (651) 281-9954, pamela.hayes@health.state.mn.us, MDH Reproductive Health Planner.

Strategy: Promote healthy sexual behaviors.

	Systems	Community	Individual
Primary	U	U	U
Secondary			
Tertiary			

Background:

Sexual behavior is a part of normal human experience. Healthy sexual behaviors are consensual, non-exploitive, based on shared values, respect for relationships and people with different values, and honest.

Individuals and couples who engage in healthy sexual behaviors have lower risks of unintended pregnancy and of contracting a sexually transmitted disease than those who do not. Unhealthy sexual behavior can have a number of physical, and mental health effects including unintended pregnancy, HIV and other sexually transmissible diseases. These in turn can lead to a variety

of other problems, including depression, substance abuse, infertility and increased health care costs. Having sexual contact at a time or in a way that is not wanted can lead to lower self-esteem and feelings of isolation and vulnerability.

Activities that promote healthy sexual behavior like healthy sexuality education, abstinence, delaying sexual intercourse, and consistent and correct use of contraceptives can have a positive impact on individual and community health. The Institute of Medicine report, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, states that any effort to reduce unintended pregnancy must address the fact that the personal feelings, attitudes and motivations of individuals and couples can affect the risk of unintended pregnancy.

Because the effects of unhealthy sexual behavior are so broad, promotion of healthy sexual behaviors can have a major impact on the health and well being of a community. The challenge of achieving sexual health is, on one hand, a personal matter and individuals should take responsibility for their sexual health. On the other hand, public health practitioners should also recognize the role that community responsibility plays in protecting sexual health. Community responsibility includes access to information and services that give individuals the ability to make appropriate reproductive health choices. A related issue is how we communicate about sex and sexuality in the United States. Parents and teachers need to be able to talk frankly with young people about responsible sexual behaviors; sex partners need to talk honestly about safe behaviors; and health care providers need to talk comfortably and knowledgeably with patients about sexuality

and sexual risk. Responsible sexual behavior is listed as one of 10 leading health indicators in *Healthy People 2010*.

Activities that support this strategy include:

- < Provide comprehensive sexuality education from a variety of sources, including parents, schools, faith institutions, peers, and the mass media.
- < Support schools in using a comprehensive sexuality education curriculum that emphasizes healthy sexuality, skill building, and factual information.
- < Provide “Parents As Sex Educators” classes for parents and caregivers so that they can feel more comfortable in providing guidance and education to their children.
- < Promote the Minnesota Family Planning Hotline as a place people can call to find information on healthy sexuality.
- < Provide training on non-directive counseling, provision of factual information, and culturally appropriate interventions.
- < Develop education programs that target ethnic and cultural groups.
- < Increase coordination and collaboration between family planning services and other health and social programs that serve at risk clients.
- < Support the effort of parents, families, religious and community institutions that provide sexuality education.
- < Work with organizations that provide continuing education to health professionals to improve their curriculum and to offer more training on sexuality.
- < Meet with medical providers regarding the importance of discussing sexual health concerns at all medical visits,

including the use of birth control for clients who are sexually active.

at (212) 819-9770,
<http://www.siecus.org/>, 130 West 42nd
St., Suite 350, New York, NY, 10036

Additional Resources:

Bibliographic resources:

- < Institute of Medicine. 1995. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Institute of Medicine, National Academy of Medicine Press.
- < Maternal and Child Health Program, University of Minnesota. May 2002. *Healthy Generations: Vol. 3, Issue 1*. This issue focuses on teen pregnancy and can be found on the web at www.epi.umn.edu/mch.
- < Office of the U.S. Surgeon General. 2001. *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior*. Rockville, MD: US Government Printing Office. Available from: www.surgeongeneral.gov/library/sexualhealth/.

Organizational resources:

- < Coordinated School Health Program. The MN Department of Children, Families and Learning, contact Kathy Brothen, at (651) 582-8842 or kathy.brothen@state.mn.us; and MDH, contact: Cara McNulty at (651) 281-9885, or cara.mcnulty@health.state.mn.us.
- < Minnesota Family Planning Hotline, (800) 783-2287 or (651) 645-9360 (Twin Cities metropolitan area).
- < Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP), at (www.moapp.org), and at (800) 657-3697 or (651) 644-1447 (Twin Cities metropolitan area), P.O. Box 40392, St. Paul, MN 55104.
- < SIECUS (Sex Information and Education Council of the United States),

Evidence for this strategy:

The Centers for Disease Control and Prevention has summarized the common elements of successful interventions. These included having a clearly defined audience, goals, and objectives; having a basis in sound behavioral and social science theory; having a focus on reducing specific risk behaviors; having opportunities to practice relevant skills; and including a broader context relevant to the risk population. Adolescents and adults often perceive that providers are uncomfortable discussing sexuality and lack adequate communications skills on this topic. An international study of sexuality education programs found that the best outcomes were obtained when education was provided prior to the onset of sexual activity and when information about both abstinence and contraception and STD prevention were included. The same study also found that sexuality education does not encourage sexual experimentation or increased sexual activity.

Has this strategy been implemented in Minnesota?

This strategy has been used in the Federal Title X Family Planning Program where they have held sessions on communicating effectively with clients about sexual health issues. Many school districts in Minnesota offer age appropriate comprehensive sexuality education to their students. Staff at the Department of Children, Families and Learning can provide assistance regarding curricula. Also, many public health agencies provide or participate in "Parents As Sex Educators" programs. They also work with teachers, school nurses and administrators in

assuring accurate, comprehensive sexuality education is provided to students. Contact MDH staff for names of agencies implementing this strategy.

Indicators for this strategy:

- < Number of public health practitioners with specific training in sexuality, and sexual health issues.
- < Proportion of providers who provide appropriate counseling on sexual health issues.
- < Proportion of sexually active people who effectively use contraceptives to prevent unintended pregnancy.
- < Number of school districts in Minnesota with comprehensive sexuality education programs.
- < Percentage of twelfth graders who report on the Minnesota Student Survey that they get information about sex from parents and school.
- < Numbers of adolescents who are abstinent or delay initiation of sexual intercourse.
- < Percentage of adolescents who reported on the Minnesota Student Survey that they are sexually active and use contraceptives.
- < Number of calls to the Family Planning Hotline with questions about healthy sexuality.
- < Number of school staff and social service professionals with specific training in sexuality, and sexual health issues.

For more information contact:

- < Pam Hayes at (651) 281-9954, pamela.hayes@health.state.mn.us, MDH Reproductive Health Planner.
- < Judy Bergh, at (651) 281-9994, judith.bergh@health.state.mn.us, MDH

Family Planning Special Projects Consultant.

- < Jill Briggs, at (651) 281-9781, jill.briggs@health.state.mn.us, MDH Teen Pregnancy Prevention Coordinator.
- < Kathy Brothen, at (651) 582-8842 or kathy.brothen@state.mn.us, Coordinated School Health.
- < Sarah Stoddard Nafstad, at (651) 281-9956 sarah.nafstad@health.state.mn.us, MDH Adolescent Health Coordinator.