Family Planning

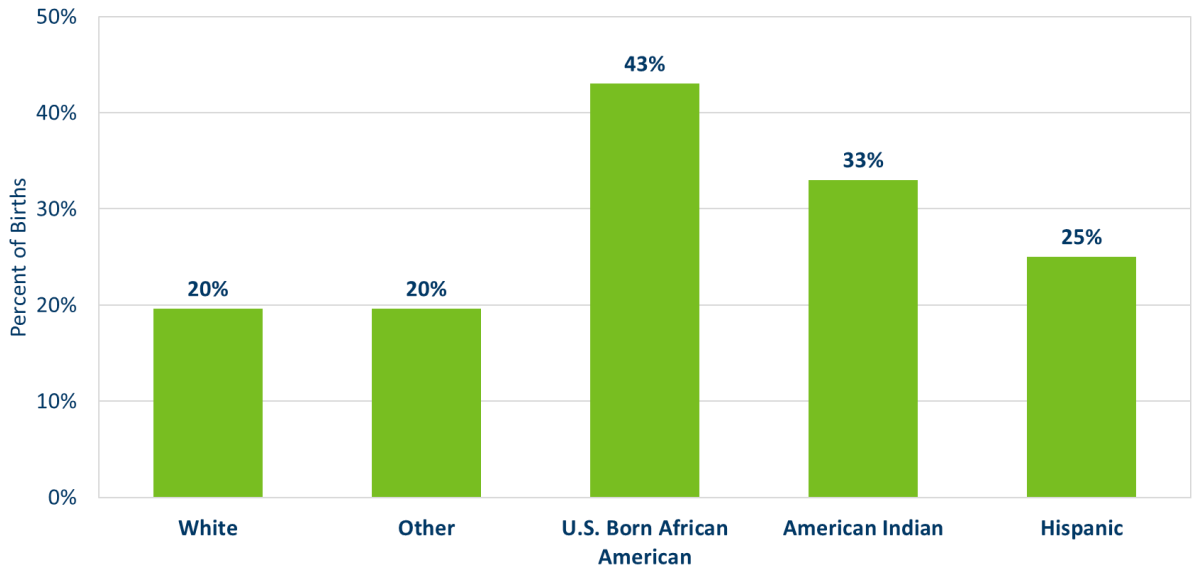
CHOOSING WHEN TO HAVE A BABY, HOW MANY CHILDREN TO HAVE, OR TO PREVENT AN UNINTENDED PREGNANCY

Why It's Important

Choosing when to have a baby and how many children to have can have many benefits to the mother, partner, and child over the lifespan including increasing the ability for women to pursue higher education and greater family financial security. Family planning reduces the rate of unintended pregnancies, improves the health of women and children, improve birth spacing, and reduces sexually transmitted infection (STI) rates. Family planning has been regarded as one of public health's greatest achievements of the 20th century by empowering families to be able to achieve desired birth spacing and family size which resulted in the reduction of infant and maternal mortality.[1] Family planning is comprehensive medical, social, and educational activities which enable individuals to determine the number and spacing of their children and to select the means by which this may be achieved. To promote healthy birth intervals and an increased number of intended pregnancies, family planning is required and often takes the form of a medical contraceptive method such as a hormonal pill or intrauterine device (IUD).

Almost half of all pregnancies in the United States are unplanned with young, low-income, and minority women at a higher risk of having an unintended pregnancy.[2] In Minnesota from 2013 to 2016, the unintended pregnancy rate for U.S. born African American women was double that of non-Hispanic white women and the rate for American Indian women was 1.5 times greater than non-Hispanic white women. When a pregnancy is unintended, unwanted, or poorly timed, a mother and her baby are at higher risk for problems during and after pregnancy including increased risk of pre-term delivery, infant being born low birth weight, and stillbirth.[3]

Figure 1. Percentage of Minnesota Births Unintended by Race/Ethnicity, 2013-2016



Source: Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS)

Improper birth spacing (i.e. birth interval), defined as a period of less than 18 months from birth to birth, is associated with several health outcomes for mothers and babies. Research has suggested that conception within 6 months of a live birth is associated with an increased risk of premature birth, low birth weight, and congenital disorders.[4] Healthy People 2020 considers a birth with an interval of less than 18 months from birth to birth an adverse health outcome and have dedicated a family planning objective to improving pregnancy planning and spacing.[5]

> *"[Women, children, and families in Minnesota need] access to affordable and reliable birth control, and family planning options from actual health professionals. The ability for women to control their family planning is vital for their own lives, as well as their current and future children's lives."– Needs Assessment Discovery Survey Respondent*

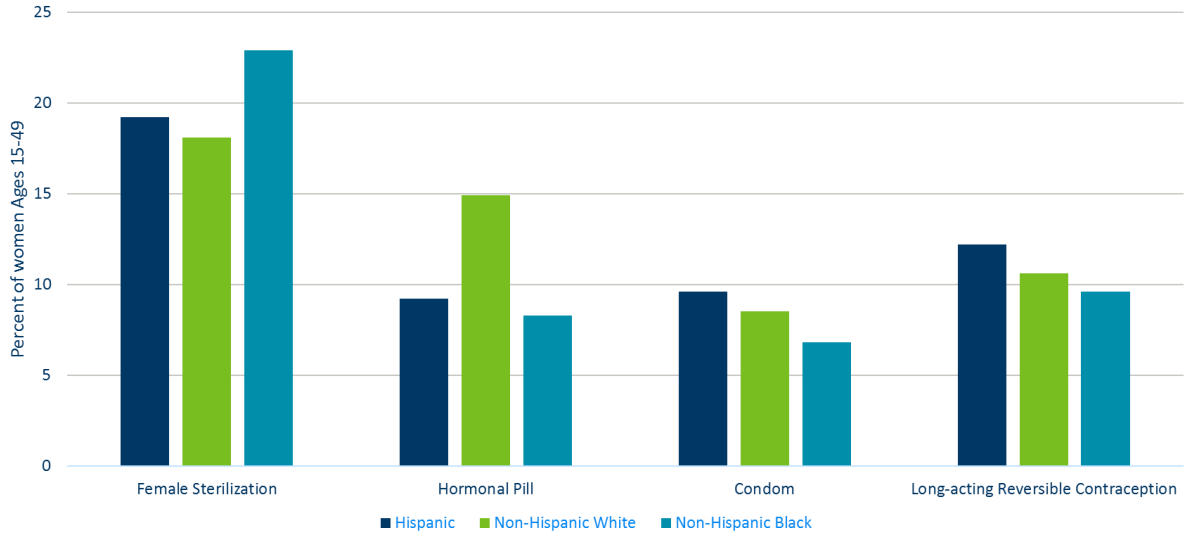
Focus on Health Equity

Equal access to family planning services is necessary to promote similar rates of healthy birth spacing and pregnancy intention across racial and ethnic groups, socioeconomic classes, and between urban and rural areas in Minnesota.

Racial and Ethnic Differences

Throughout American history, African American/Black and American Indian women have been subject to experimental and dangerous gynecological procedures, including sterilization without consent or knowledge of the procedure they were undergoing. This experience impacts the forms of birth control that many women of color and American Indians are comfortable using. The birth control pill, patch, ring, and Depo shot are methods where you know what is happening to your body and can decide to stop using them without having to return to a clinic. In contrast, women of color and American Indians are less likely to choose long-acting methods like the intrauterine device (IUD) and Nexplanon.[6]

Figure 2. Type of Contraceptives Used by American Women Ages 15-49



Source: Centers for Disease Control and Prevention

"Women need access to sexual health resources. Birth control, menstrual supplies, and just overall sexual education -- it's appalling to see just how uneducated females are about their reproductive system still in 2018." – Needs Assessment Discovery Survey Respondent

Rural and Urban Differences

According to the Prevention Research Center, 47.5 percent of rural counties in Minnesota do not have a sexual health clinic.[7] Out of Minnesota's 87 counties, 60 are classified as rural and 28 of these counties do not have a clinic providing specialized reproductive health services. The most rural counties tend to have the highest proportion of the population living in poverty, have lower high school graduation rates, and little access to reproductive healthcare- all of which put women at a higher risk of having an unplanned pregnancy.

Many women living in rural areas in greater Minnesota have to drive upwards of 2 hours to receive prenatal obstetric care and sometimes farther to deliver their babies. In 2015, 28 counties in Minnesota lacked a hospital with obstetric services with more obstetric units slated to close in the coming years.[8] Substantial resources are required to access prenatal and birthing care when mothers have to take time off work, find childcare for any children they have at home, drive to a clinic with obstetric services, and pay for lodging if she needs to stay overnight. Higher rates of stress, anxiety, and preterm birth are present in rural communities without obstetrics care, all of which can cause negative health outcomes for mom and baby.

Additional Considerations

Research by the Guttmacher Institute determined that between 26 and 30 percent of Minnesota women between the ages of 18 and 49 at risk for unintended pregnancy were not currently using contraception at all.[9] Using contraception during the postpartum period is crucial to improving birth spacing. Seeing a medical provider for a postpartum visit is important to receive education on birth controls options and family planning care after giving birth. In 2015 in Minnesota, 89.7 percent of new mothers completed a maternal postpartum visit. According to PRAMS 2012-2015 data, the percentage of women using contraception after birth decreased from 83.5 percent to 78.4 percent over this period of 3 years. Nationally, mothers that have lower levels of household income and educational attainment are more likely to have shorter birth intervals. Additionally, women that are uninsured, Hispanic, black or live in rural areas are less likely to have access to family planning services necessary for successful birth interval planning.

Important Note on Equity and Intersectionality

The Minnesota Department of Health's Title V Needs Assessment Team acknowledges that structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person's ability to access health care, and not all communities are impacted in the same way.

All people living in Minnesota benefit when we reduce health disparities.

We also acknowledge that the topic addressed in this data story does not exist in isolation– which is important to remember as we do needs assessments and as we start thinking about how we approach solutions. In addition to the needs themselves being intersectional, there are also intersecting processes and systems through which power and inequity are produced, reproduced, and actively resisted.

Citations

1. Centers for Disease Control and Prevention. (1999). Achievements in Public Health, 1900-1990: Family Planning. *Morbidity and Mortality Weekly Report 48*(47): 1073-1080.
2. Frost, J.J., Frohwirth, L. and Zolna, M.R. (2016). Contraceptive Needs and Services, 2014 Update. Guttmacher Institute. Retrieved from https://www.guttmacher.org/sites/default/files/report_pdf/contraceptive-needs-and-services-2014_1.pdf.
3. Centers for Disease Control and Prevention. (2016). Reproductive Health: Unintended Pregnancy. Retrieved from https://www.cdc.gov/reproductivehealth/contraception/unintendedpregnancy/.
4. Mayo Clinic. (2017). Family planning: Get the facts about pregnancy spacing. Retrieved from https://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072.
5. Healthy People 2020. (2019). Family Planning. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/family-planning.
6. Daniels, K. and Abma J.C. (2018). Current Contraceptive Status Among Women Aged 15–49: United States, 2015–2017. NCHS Data Brief No. 327. National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db327-h.pdf.
7. Farris, J., Austin, J., & Brown, C. (2018). 2018 Adolescent Sexual Health Report. University of Minnesota Healthy Youth Development-Prevention Research Center. Retrieved from https://www.pediatrics.umn.edu/sites/pediatrics.umn.edu/files/2018_ashr_report_final_0.pdf.
8. Richert, Catharine. (2019, January 22). “Rural hospitals retreat from delivering babies; small towns pay the price.” MPR News. Retrieved from https://www.mprnews.org/story/2019/01/22/rural-clinics-end-baby-delivery-small-town-minn-pays.
9. Douglas-Hall, A., Kost, K., and Kavanaugh, M.L. (2018). State-Level Estimates of Contraceptive Use in the United States, 2017. Guttmacher Institute. Retrieved from https://www.guttmacher.org/sites/default/files/report_pdf/state-level-estimates-contraceptive-use-in-us-2017.pdf.

Child and Family Health Division
Title V Maternal and Child Health Needs Assessment
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-3589
health.cfhcommunications@state.mn.us
www.health.state.mn.us

8/1/2019

To obtain this information in a different format, call: 651-201-3589. Printed on recycled paper.