



Healthy Generations

Maternal & Child Health Program
School of Public Health

Family
Planning

UNIVERSITY OF MINNESOTA

Volume 5: Issue 1
June 2004

Pregnancy Intention: Why Do We Measure It and Can We Measure It?

Wendy Hellerstedt, MPH, PhD

Inside this Issue:

- 4 Family Planning and Environmental Health
- 6 The Dynamics of Contraceptive Vigilance
- 8 Family Planning: The Policies and Politics
- 10 Family Planning Programs Reach Out
- 11 Collaboration Benefits Milwaukee's Underserved

Public health researchers need to understand gaps in family planning and reproductive health services. One indicator of such gaps is the proportion of pregnancies that are "unintended." The measure that is most familiar to policymakers, program developers, and researchers is really a measure of satisfaction with the timing of a pregnancy, although we have come to call it a measure of intention. This conventional measure has been used in national surveys, like the National Survey of Family Growth (NSFG)¹ and state surveys, like the Pregnancy Risk Assessment Monitoring System (PRAMS).²

The conventional measure is usually asked in a written or oral survey in the following manner: "Thinking back to just before you were pregnant, how did you feel about becoming pregnant?" Responses range from: (1) wanted to be pregnant sooner; (2) wanted to be pregnant then; (3) wanted to be pregnant later; and (4) did not want to be pregnant then or in the future. Those who choose response options 1 or 2 are categorized as having intended pregnancies, those who respond with option 3 are categorized as having mistimed pregnancies, and those who respond with option 4 are categorized as having unwanted pregnancies.



some of the women who experience pregnancies. Women who have had abortions are generally considered to have had unwanted pregnancies. There are no conclusive data about pregnancy intention for women who have experienced miscarriages.

The rates of mistimed and unwanted pregnancies in the U.S. are high. It is estimated that 49% of the pregnancies in the U.S. are unintended.^{3,4} At some point in their lives, it is estimated that 26% of the women in the U.S. have had a livebirth resulting from an unintended pregnancy and 39% have had an abortion resulting from an unintended pregnancy.⁴

It is thought that the rate of unintended pregnancy (i.e., mistimed and unwanted) was stable in the 1980s (about 54/1000 women aged 15-44 years) and has decreased to about 45/1000 women aged 15-44 years since then,⁴ although several states have not seen a decrease.² It is estimated that 50% of all unintended pregnancies are among women who did not use contraception,⁵ while the other half of the unintended pregnancies are necessarily the result of inconsistent or incorrect use of contraceptives.

Pregnancy Intention (Timing) Among Women who have had a Livebirth

Recently the Centers for Disease Control and Prevention (CDC) released a report about unintended pregnancy from its PRAMS surveillance data for 1999.² This report was based on data from 17 states with PRAMS surveillance. In these states, the percentages of

Continued on page 2

What Do We Know About Satisfaction with the Timing of Pregnancy?

Most of what we know about pregnancy intention comes from surveys of women who have had livebirths. It is important to consider that such women represent only

We are pleased to present this issue on family planning. Access to family planning services enables women and men to limit family size. It is a core element of a productive life, serving the physical, social, economic, and psychological health of individuals. And, as discussed in this issue, effective family planning is fundamental to controlling population size and is thus strongly associated with the health of the environment. While our issue focuses largely on domestic and local family planning efforts and issues, as we prepared this issue we remained mindful of how integral family planning is to women's health globally. It is estimated that each year, 80 million women have unwanted pregnancies. Worldwide, 600,000 women each year die from complications related to pregnancy or childbearing. And, globally, 20 million women each year experience unsafe abortions with 78,000 of these women dying as a result of such abortions.

Margaret Sanger, a founder of the American birth control movement, helped establish the principles that women have the right to control their bodies and that all women, regardless of social circumstances, should have access to family planning services. She also showed the world that a grassroots movement of women could result in powerful public health successes. Almost a century ago Sanger said that, "No woman can call herself free until she can choose consciously whether she will or will not be a mother." Today, many family planning advocates are still working tirelessly to convince individuals, in the U.S. and around the world, of this simple message.

- Wendy Hellerstedt, MPH, PhD and Erica L. Fishman, MSW, MPH

Back Page:

Healthy Generations
Videoconference
July 13, 2004



Pregnancy Intention: Why Do We Measure It and Can We Measure It?

Continued from front page

livebirths in 1999 that were the result of an unintended pregnancy varied by state, ranging from 34% to 52%. Percentages of mistimed births ranged from 27% to 36% and unwanted births ranged from 6% to 14%.² These data showed that unintended births were most common in young women, black women, women with less than 12 years of completed education, and women whose prenatal care was paid by Medicaid (Table 1). As shown in Table 1, among the 17 states, Louisiana often had the highest percentage of unintended births, within maternal characteristics groups, while Utah often had the lowest percentage of unintended births.

Table 1. Unintended livebirths, by maternal characteristics, 17 states, 1999 PRAMS

Maternal Characteristics	State percentage, range	States with lowest value	States with highest value
Age at delivery			
<20	66.3-84.4	AK	IL
20-24	32.4-64.7	UT	LA
25-34	23.7-37.2	NY*	AR
>35	18.4-35.7	UT	NM
Race			
White	32.1-44.4	NY*	AR
Black	46.2-76.7	CO	IL
Other**	33.4-44.4	OH	LA
Education			
<12 years	48.0-66.7	NM	LA
12 years	33.4-54.9	UT	AR
>12 years	25.3-39.5	NY	LA
Medicaid recipient			
Yes	50.1-70.0	UT	LA
No	23.5-37.7	ME	OK
* Does not include New York City			
** Other race varies by state, but includes Native American, Asian, and other nonwhite			
Source: PRAMS surveillance data, 1999 (2)			

The PRAMS findings are consistent with Henshaw's report of unintended births in the U.S. among women surveyed for the NSFG, in which he concluded that disadvantaged women—including women living in poverty, those with poor education, those who are nonwhite, and those who are 15-19 years old—are disproportionately at risk for unintended births.⁴

Is Pregnancy Timing a Good Measure of Intention?

The conventional measure of intention (i.e. satisfaction with pregnancy timing) is good, if one considers its correlation with risk factors. Women who report their pregnancies are mistimed or unwanted are also more likely to report poor pre-conception behaviors,^{5,7} poor prenatal care behaviors,^{6,8,9} and poor birth outcomes.⁸ The highest risk women are those who report their pregnancies were unwanted. Because the conventional measure is correlated with risk, it is an indicator for a Healthy People 2010 goal to reduce the nation's unintended pregnancy rate from 49% to 30% by 2010.³

Is Pregnancy Timing the Best Measure of Intention?

The measure of satisfaction with pregnancy timing, while good, also has problems. Its categorization of women whose pregnancies are unwanted and whose pregnancies are well-timed may be more useful than its categorization of mistimed pregnancies. Women categorized with mistimed pregnancies include women who wanted to be pregnant a month later to several years later. Obviously, this category of "mistimed" pregnancies includes a varied group of women—some of whom may not label their pregnancies as "unintended."

Adding to concerns about the imprecision of the timing measure for pregnancy intention, Trussell and colleagues found that not all contraceptive failures are considered "unintended" pregnancies and a considerable proportion of women with contraceptive failures consider themselves happy or very happy with their pregnancies.¹⁰ Such apparent contradictions have led researchers to consider other measures of pregnancy feelings, including ambivalence about motherhood¹¹ and ambivalence about pregnancy with a specific partner.¹² Recent qualitative work has also demonstrated that pregnancy "intention" is not a simple construct: it is not the same as pregnancy planning and it does not necessarily tap into the myriad of feelings women may have about pregnancy.¹³ The NSFG—starting with its 1995 survey—added questions about pregnancy feelings, in addition to the conventional question about timing, in order to more fully represent the range of feelings women have about their pregnancies.¹⁴ Table 2 describes some newer research and surveillance questions about pregnancy.

Table 2. Questions used in the National Survey of Family Growth to examine pregnancy feelings among women who had livebirths

Concept	Question	Response options
Pregnancy avoidance	How much did you want to avoid/want to get pregnant?	5-point scale from wanted to avoid to wanted to get pregnant
Happiness	How happy did you feel when you found out you were pregnant?	5-point scale from very unhappy to very happy
Tried to get pregnant	How much were you trying to get pregnant?	5-point scale from not trying to get pregnant to really tried hard to get pregnant
Wanted a baby with partner	In the month before your pregnancy, did you want a baby with your partner at the time?	Yes or no
Partner wanted a baby	Right before you became pregnancy, did your partner want to become pregnant?	Yes or no
Pregnancy, childbearing, or parenting feelings	Examples. How much did you: - Think the baby would keep you from going out? - Look forward to new experiences with the baby? - Look forward to telling friends you were pregnant? - Dread telling friends you were pregnant? - Worry you did not have enough money to take care of the baby? - Think the baby would improve your relationship with your partner? - Look forward to buying things for the baby?	5-point scale from not at all to a tremendous amount

Future Work

While the conventional measure of pregnancy intention may not tap into the complexity of pregnancy feelings, it is an important measure of gaps in reproductive health services. In order to advocate for family planning monies, we will continue to link measures of intention with services, including the conventional measure about satisfaction with the

timing of a pregnancy. For example, recently Rachel Benson Gold examined six state Medicaid family planning waiver programs and found that all programs resulted in substantial savings, ranging from \$56 million over three years in South Carolina to \$20 million in a single year in Oregon. She reported that even as the programs saved money, geographic availability of family planning services increased and clinics served more clients. Not surprisingly, in two states this translated into a measurable reduction in unintended pregnancy among Medicaid-eligible women.¹⁵ What we may never be able to measure is how important family planning—and the avoidance of unintended pregnancies—is to the quality of life of women.

References

1. National Center for Health Statistics, Centers for Disease Control and Prevention. National survey of family growth. Available at: <http://www.cdc.gov/nchs/nsfg.htm>. Accessed May 24, 2004.
2. Beck L, Johnson C, Morrow B, Lipscomb LE, Gaffield ME, Colley Gilbert B, et al. PRAMS 1999 surveillance report. Atlanta, GA: Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention; 2003. Available at: <http://www.cdc.gov/reproductivehealth/prams/pdf/1999PRAMSurv.pdf>. Accessed May 24, 2004.
3. U.S. Department of Health and Human Services. Healthy people 2010 with understanding and improving health and objectives for improving health, 2 vols. 2nd ed. Washington, DC: U.S. Government Printing Office; 2000.
4. Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24-9.
5. Burnhill M. Contraceptive use: the U.S. perspective. *Int J Gynecol Obstet* 1998;62(Suppl 1):S17-23.
6. Hellerstedt WL, Pirie PL, Lando HA, Curry SJ, McBride CM, Grothaus LC, et al. Differences in preconceptional and prenatal behaviors in women with intended and unintended pregnancies. *Am J Public Health* 1998;88:663-6.
7. Locksmith GJ, Duff P. Preventing neural tube defects: the importance of periconceptional folic acid supplements. *Obstet Gynecol* 1998;91:1027-34.
8. Kost K, Landry DJ, Darroch JE. The effects of pregnancy planning status on birth outcomes and infant care. *Fam Plann Perspect* 1998;30:79-88.
9. Pulley L, Klerman L, Tang H, Baker B. The extent of pregnancy mistiming and its association with maternal characteristics and behaviors and pregnancy outcomes. *Perspect Sexual Repro Health* 2002;34:206-11.
10. Trussell J, Vaughan B, Stanford J. Are all contraceptive failures unintended pregnancies? *Fam Plann Perspect* 1999;31:246-7 & 260.
11. Luker KC. A reminder that human behavior frequently refuses to conform to models created by researchers. *Fam Plann Perspect* 1999;31:248-9.
12. Zabin LS. Ambivalent feelings about parenthood may lead to inconsistent contraceptive use and pregnancy. *Fam Plann Perspect* 1999;31:250-1.
13. Peterson R, Moos M. Defining and measuring unintended pregnancy: issues and concerns. *Women's Health Issues* 1997;7:234-40.
14. Peterson L, Mosher W. Options for measuring unintended pregnancy in cycle 6 of the National Survey of Family Growth. *Fam Plann Perspect* 1999;31:252-3.
15. Gold R. Doing more for less: study says state Medicaid family planning expansions are cost-effective. *Guttman Report on Public Policy* 2004;7:1-3. Available from: <http://www.guttmanreport.org/pubs/journals/gr070101.html>. Accessed May 24, 2004.

Wendy Hellerstedt, MPH, PhD, is an Associate Professor in the Maternal and Child Health Program, Division of Epidemiology, School of Public Health, University of Minnesota.

Interested in more information on family planning?

There are many excellent websites containing information on research, program history, advocacy efforts, contraceptive technology, sexuality education and more. Links to relevant sites can be found at: <http://www.epi.umn.edu/mch/resources/>

Innovations in Contraception Funding — Wisconsin's Family Planning Waiver Program

In January 2003, women in Wisconsin began receiving reproductive health services through an exciting new program funded by Medicaid, Wisconsin's Family Planning Waiver Program. It provides contraception counseling and access, breast and cervical cancer screening, and sexually transmitted infection (STI) screening and treatment to sexually active, low-income women aged 15-44 years old. To be eligible, women must not receive full-benefit Wisconsin Medicaid, BadgerCare, or Healthy Start. They also must have a family income that does not exceed 185% of the federal poverty level. Minors and dependents are eligible based on their own income. Income is disregarded for full-time college students younger than 19 years old. The program receives 90% of its funding from the federal government and 10% from the state. Both the state and program recipients benefit: women receive needed reproductive health services through Medicaid-certified providers and the state saves money by decreasing unintended births to women who are at economic risk for becoming Medicaid recipients. Over 50,000 women—many from rural communities—enrolled in the first year and momentum continues to build.

The waiver program is not entirely free from controversy. Some citizens and legislators feel that any kind of contraception is morally wrong and therefore should not be provided by the government. In addition, some lawmakers fear that providing contraception will promote teen sexual behavior, although research does not show that the provision of contraceptive education and access changes risk behaviors. The waiver program has some quantifiable benefits: it has brought federal funds to Wisconsin and it is estimated that its services may have prevented over 24,000 unintended pregnancies in 2003. Through its screening and education services, it is likely responsible for preventing countless STIs. Most important, its services are targeted to economically vulnerable women; by improving their reproductive health, the program indirectly promotes their social and economic health as well.





Family Planning and Environmental Health: Six Billion and Counting

Liz Radel and Wendy Hellerstedt, MPH, PhD

We often think about family planning programs and policies at the level of the individual. We know that, in the U.S. alone, there are an estimated 3.5 million unintended pregnancies every year.¹ Women and couples experience high rates of contraceptive failure or simply do not consistently use contraceptives.² Many agree that improving reproductive options will enhance the quality of life for women, couples, and families. The link between environmental health and family planning programs and policies is also a quality of life concern. The more people, the more consumption and the more waste. The world's population doubled in the last half of the twentieth century, reaching six billion people in 1999.³ At the current growth rate, the earth's population will increase by one billion people every 14 years, reaching 12 billion people in approximately 50 years.³ To contain growth, it is critical that we develop and support family planning programs and policies.

Six Billion and Consuming

The substantial population growth in the past 50 years has put a burden on the earth's limited resources and, therefore, a burden on individual well-being. These resources will continue to be taxed as the world's population grows at unprecedented rates. The environmental effects of overpopulation include:

Global warming. As the population has increased, so has the use of fossil fuel, deforestation, and the production of chemicals—all of which produce carbon dioxide and other greenhouse gasses.⁴ As a result of increases in greenhouse gasses, surface temperatures rose 0.6° C in the past century⁵ and this is likely to be the largest temperature increase in the past millennium. Even a seemingly small climatic change may have multiple effects on the ecosystem, including changes in snow cover, sea level, and extreme weather.⁵ Potential adverse health effects from these changes include increases in weather-related illnesses, infectious diseases, and malnutrition.⁶

Air quality. More people means more cars, more factories, and more air pollution. Over one billion people suffer the health effects of dangerously high air pollution. In some cities, like Bangkok, Manila, and Beijing, air pollution is one of the leading causes of respiratory infection and premature death. It is estimated that breathing the air in Mexico City is the health equivalent of smoking three packs of cigarettes a day.⁷ A related concern is the destruction of ozone in the high atmosphere, which allows more ultra-violet light to reach the earth, thus affecting the health of plants and animals.⁸

Food production declines. In the last decade, the population rate has grown faster than the rate at which food can be produced.⁹ If the population continues to grow as projected and food production rates do not change, the world may be faced with food shortages within decades. Food availability is not only related to the increased consumption demands of a growing population, but to higher population densities in traditionally agricultural areas, resulting in the loss of acreage for farming.

Fisheries. Many fish stocks around the world have become severely depleted because of pollution from oil spills and toxic chemicals, overfishing, and habitat destruction.¹⁰

Plant and animal diversity. As the population increases, the diversity and number of plants and animals decreases. At least one entire species of animal or plant is lost every 20 minutes—about 27,000 species per year. This is a rate of extinction that has not occurred in 65 million years.¹¹

Water consumption. Today, 31 countries with a collective population of half a billion people are experiencing water shortages for all

or part of the year.⁷ It is estimated that in 20 years, two-thirds of the world's population will be affected by water scarcity.¹² Less than one percent of the earth's water is now suitable for human consumption¹³ and the water supplies may be depleted as demand for water increases and contamination by chemicals increases.



Close to Home: What Role Does the U.S. Play in Global Environmental Health?

A nation's impact on the environment can be estimated by examining two pieces of information: its total population and the resources used by each citizen. While the United States makes up less than 5% of the world's population, we consume 30% of all the world's resources each year.⁷ The average American uses over 35 times as many resources as does the average person living in India.⁷ If all of the world's population lived like Americans live, we would need four earths to sustain us.¹⁴ As a nation that consumes so many of the world's resources, it is our responsibility to address the environmental issues related to population growth. We can address these issues by advocating for policies that support global access to contraception education and availability. We can also speak out against global and local gag rules, which prohibit agencies from receiving public dollars if, with any organizational dollars, they provide legal abortion services, advocate for abortions, or counsel or refer for abortions. Finally, we must work to accept and support women and couples who choose to be childless. A first step toward this rarely discussed goal is to acknowledge that while historically women and couples without children have been stigmatized, the choice to be childless is a legitimate family planning goal and it is as "natural" as childbearing.

Abraham Lincoln said that "...[one] cannot escape the responsibility of tomorrow by evading it today." As Americans, it is our obligation to the earth's future generations to lessen our "ecological footprint" on the expanding world. Family planning is ultimately about creating the healthiest physical, emotional, and social environment possible for all living creatures.

For further information: The Population Connection (formerly known as Zero Population Growth), <http://www.populationconnection.org> or 1-800-POP-1956; the Population Resource Center, <http://www.prcdc.org>; and the United Nations Population Fund, <http://www.unfpa.org/index.htm>

References

1. Henshaw SK. Unintended pregnancy in the United States. *Fam Plann Perspect* 1998;30:24-9 & 46.
2. Trussell J, Vaughan B. Contraceptive failure, method-related discontinuation and resumption of use: results from the 1995 National Survey of Family Growth. *Fam Plann Perspect* 1999;31:64-72 & 93.

3. Clarke R, editor. Global environmental outlook. United Nations Environment Programme; 1999.
4. Meyerson FAB. Population dynamics and global climate change. Population Resource Center; 2002. Available at: <http://www.prcdc.org/summaries/climateupdate02/climateupdate02.html>. Accessed May 24, 2004.
5. Houghton JT, Ding Y, Griggs DJ, Noguier M, van der Linden PJ, Dai X, et al, editors. Climate change 2001: the scientific basis. Cambridge, England: Cambridge University Press; 2001.
6. Haines A, Patz JA. Health effects of climate change. JAMA 2004 Jan 7;291(1):99-103.
7. Hinrichsen D. 6,000,000,000 consumption machines. International Wildlife [serial online]. 1999 Sep/Oct. Available from: <http://www.nwf.org/internationalwildlife/1998/6billionso.html>. Accessed May 24, 2004.
8. U.S. Environmental Protection Agency. Environmental indicators: ozone depletion; 2003 Jul 7. Available at: <http://www.epa.gov/docs/ozone/scienceindicat/index.html>. Accessed May 24, 2004.
9. Khush GS. Green revolution: preparing for the 21st century. Genome 1999;42(4):646-55.
10. Tibbetts J. Ocean commotion. Environment Health Perspect 1996 Apr;104(4):380-5.
11. Levin PS, Levin DA. The real biodiversity crisis. Am Sci 2002 Jan/Feb;90(1):6-9.
12. MacDonald R. Providing the world with clean water [Editorial]. BMJ 2003 Dec 20;327(7429):1416-8.
13. World Health Organization. Health in water resources development. Available at: http://www.who.int/docstore/water_sanitation_health/vector/water_resources.htm. Accessed May 24, 2004.
14. United Nations Development Programme, Human Development Report 1998. New York: Oxford Press; 1998.

Liz Radel is a first year Masters of Public Health student and Wendy Hellerstedt, MPH, PhD is an Associate Professor in the Maternal and Child Health Program, Division of Epidemiology, School of Public Health, University of Minnesota.

MAKE YOUR OWN TABLES ABOUT NATIONAL FAMILY PLANNING USE AND SERVICES!

The Alan Guttmacher Institute (AGI) has a tablemaker on its website (www.agi-usa.org) that includes data from several national surveys. The following table was constructed in less than a minute using this tablemaker:

Contraceptive use in the United States among 15-49 year-old sexually active women

	% using any birth control method	% relying on female or male sterilization	% using a modern reversible birth control method	% using a traditional birth control method
Total women surveyed	79	34	42	3

Source: National Survey of Family Growth, 1995. Table developed through tablemaker program, Alan Guttmacher Institute (www.agi-usa.org).

Note: Modern methods include the pill, IUD, injectables, condoms, diaphragm, foam and jelly. Traditional methods include periodic abstinence and withdrawal.

Interested in making a difference?

Consider a Master's in Public Health (MPH) Degree in Maternal and Child Health (MCH)

Kristi Van Riper finished her MPH program in MCH this spring. She chose the University of Minnesota School of Public Health (SPH) because of its strong reputation and the MCH program because of her interest in reproductive health.

Her first meeting with her advisor, Associate Professor Wendy Hellerstedt, MPH, PhD, was memorable. She remembers the energy and enthusiasm Wendy displayed. She also remembers the strong research focus Wendy discussed with her. While Kristi was not sure she wanted to pursue a research project, she did so with great success. Prior to her graduation she submitted a manuscript to a major journal that describes the results of a project she designed and conducted.

Her research involved a survey of pharmacists in South Dakota about emergency contraceptive pills (ECP). As Kristi prepared the survey, she took classes on research methods and data analysis. She wanted to determine if attitudes, beliefs, and knowledge affect ECP dispensing in a state that has limited access to abortion and a pharmacist conscience clause (i.e., pharmacists are not required by law to provide a medication they feel is morally wrong). ECPs must be taken soon after unprotected intercourse to be effective. Pharmacies, which are usually open on weekends and often open 24 hours/day, could be an efficient venue for access. Her survey results showed a clear need for ECP education among pharmacists: the majority of respondents did not know how ECPs worked and expressed little comfort about counseling women about their use.

Kristi believes being at the University of Minnesota made her project successful.

Kristi believes being at the University of Minnesota made her project successful. "Each time I met with Wendy, she told me how cool this project was and how great the outcome would be. I became re-energized after each meeting," Kristi said. Right before her graduation, she accepted a position as a health educator and thus began her career as an MCH professional.

What is the MCH Program? It is a training program for MPH students who are interested in promoting and preserving the health of families, including women, children, and adolescents. The Program is in the Division of Epidemiology in the School of Public Health at the University of Minnesota.

Who should apply? People who care about vulnerable populations and want careers in program planning and development, evaluation, surveillance, assessment, teaching, or research. The program offers a special emphasis on MCH epidemiology for interested students. Clinical professionals and others with advanced degrees who are interested in administering MCH-related health programs or conducting research projects are also encouraged to apply. Individuals with advanced degrees may have the option of completing the two-year MPH Program in one year.

For further information about the MCH Program, call 612-626-8802 or 1-800-774-8636; e-mail gradstudies@epi.umn.edu; or visit <http://www.epi.umn.edu/mch> and www.umn.edu/sph.



The Dynamics of Contraceptive Vigilance

Carolyne Swain, MS and Cathleen Conway-Johnson, PhD

Contraception and contraceptive behavior are critical issues for women's health care. Of the more than 60 million U.S. women of child-bearing age (15-44), only 5% of the sexually active women who are not pregnant, infertile, or trying to get pregnant report that they are not contracepting.¹ However, despite the high percentage of reproductive age women practicing some method of birth control (64%) and the availability of highly effective contraceptive methods, data also indicate that each year more than 1.7 million actively contracepting women experience a pregnancy.^{1,2} The gap between "perfect use" and "actual use" of contraceptives reflects the overall level of contraceptive non-compliance or lack of vigilance associated with a given method. The challenge for family planning providers is to recognize the myriad of personal, societal, and contextual factors that affect contraceptive choices, compliance, and vigilance. The goal for family planning providers must be to incorporate that knowledge into practice so that they can individualize counseling and assist each woman in selecting a method that she can use consistently and correctly to avoid an unplanned pregnancy.

The Personal Nature of Contraceptive Compliance

Effective contraceptive counseling requires more than simple presentation of information in order to motivate an individual to consistently and correctly use her method or methods of choice. Several theoretical models of individual behavior have been employed to explain contraceptive behavior.³ For example, Social Learning Theory directs attention to personal, environmental, and behavioral factors such as knowledge, attitude, expectations, self-efficacy, social norms, and community. The Theory of Reasoned Action assumes human beings are rational decision makers who use the information provided to them before acting. Similarly, the Health Belief Model examines individual perceptions, modifying behaviors, and likelihood to act. Each of these models focuses on dimensions of decision-making and behavior in the individual. Effective family planning providers tailor interventions to clients based on an understanding of these behavior change models and the client's particular situation.

Both Luker and Miller address the dyadic and dynamic nature of contraceptive behavior. Luker points out that both contraception and pregnancy have risks and benefits that each woman evaluates. She proposes that, although women develop habits of contraceptive behavior over time, they may not evaluate the consequences of their behavior with each encounter and therefore may not consistently contracept with every sexual event. Thus, the degree of contraceptive vigilance practiced waxes and wanes over time and with changes in circumstances.⁴ Family planning counselors and clinicians should routinely reevaluate both a woman's personal circumstances and her chosen method to ensure the best fit. Miller posits a number of personal and situational conditions that affect contraceptive compliance. He suggests that a woman's contraceptive behavior is conditioned by her own perception of susceptibility to pregnancy, expectations about future pregnancy, contraceptive preferences, the interaction of user and method characteristics, partner and community context, and, perhaps most important, her

own stability as evidenced in educational attainment, daily routine, and mood. He concludes that "contraceptive vigilance is a delicate internal balance" of competing dimensions.⁵

Overall, contraceptive behavior is an extremely complex and individualized behavior that requires the woman to develop a habit of protected intercourse and extinguish impulsive, unprotected intercourse. Contraceptive behavior encompasses method choice and initiation, method use, and method changes across the life span. The decision to contracept must be continuously reviewed and remade within the context of dynamic relationships. In addition, the woman must overcome inhibitions or embarrassment about exposing her private sexual life to the public gaze, whether it is the clinic visit and exam, the prescription fill and purchase, or condom supply purchase.

For each woman, contraceptive behavior creates a feedback loop, which constructs a learned experience so that a series of repetitive decision outcomes aggregate and anchor future decisions. Continual contraceptive vigilance requires that decisions yield the anticipated results. In long-term relationships, a woman may experience contraceptive fatigue, or growing difficulty in sustaining consistent contraceptive use, perhaps because the desired outcome is a negative, such as the absence of pregnancy, and thus more difficult to correlate with individual habitual actions than a positive outcome would be.



Correlates of Contraceptive Compliance

Multiple research studies have evaluated the role of intention in contraceptive use and fertility⁶ as well as factors contributing to impaired contraceptive vigilance.⁵ The list of factors includes a negative attitude about contraception; a negative attitude about a particular method; initiating a new method or changing methods; low support from peers,

partner(s), or parents; poor communication skills; other risk behaviors like using alcohol and illicit drugs; an ideology of 'true love'; the negative appearance of 'planning' intercourse; religiosity; method adverse side effects like breakthrough bleeding, weight gain, and mood swings; clinical access problems; concerns about fertility; the social value of a child; virginity pledges; abstinence-only messages that exclude contraceptive information; lack of knowledge about methods; type of relationship (e.g., steady, casual, main, transient); age disparity between partners; ethnicity; education; and marital status.⁵

Confounding these are profound changes in sexual development and marriage patterns in the U.S. over the last 25 years that also affect contraceptive behavior. Sexual debut, now occurring at an average age of 17.4 for girls and 16.9 for boys in the United States,⁷ often occurs outside marriage or a committed relationship, and sexual relationships can be multiple and transitory. Most women are in the workforce and many delay childbearing, with the average age of first birth for women now at 25 years.⁸ Given that the average age of menopause is 51 years,⁹ women have more than 30 potentially fertile years. Most adults in a heterosexual relationship will spend considerably more time and money during their reproductive years attempting to avoid pregnancy than attempting to conceive.

A range of sexual expression (oral, anal, and vaginal) and partners (homosexual, bisexual, and heterosexual) has become increasingly

acceptable, especially among adolescents and young adults, with concomitant heightened risk of disease transmission. All of this accentuates the urgency for a heightened contraceptive vigilance that incorporates infection prevention and minimizes contraceptive fatigue.

The Counselor's Role

The counselor has responsibility for devising a mutually acceptable contraceptive/infection prevention strategy with each client and for counseling that client within the context of their personal life. Oakley identifies a constellation of attributes that may require a modified counseling approach. They include: no successful previous behavior from which to generalize, no future plans, no support to avoid unintended pregnancy, short term sexual relationships, cognitive impairment, previous unintended pregnancy, visit not initiated by the client, and acceptability of unintended pregnancy in the next 6-12 months.¹⁰ Counselors should build on the information garnered during the family planning encounter to individualize the contraceptive counseling approaches. A complete and thorough social and medical history should be obtained at the first family planning encounter and should be routinely updated. The social history should include age, educational attainment, partner status, housing arrangements, employment, ethnicity, and primary language. The medical history should include sufficient information to evaluate method eligibility and guide the array of options that can be presented.

Particular attention should be given to previous experience with contraceptive methods and the partner's preferences. Childbearing intention, frequency of intercourse, and attitudes about abortion, adoption, and sexually transmitted infections (STIs) should be evaluated. Has she had previous success with a method? What problems, if any, has she encountered in the past? What did she do about them? How important is it not to get pregnant? What would she do if she got pregnant or contracted an STI? The client's values can then be incorporated into the recommendations. In some cases, women or their partners may need to be referred for additional education or counseling to maximize compliance potential.

The method-specific counseling should be client-centered. The clinician should give explicit instructions on correct use and discuss the relative effectiveness of the chosen method. Any concerns and questions the client may have should be fully addressed and anticipatory guidance about common or nuisance side effects should be provided while method benefits and goodness of fit should be emphasized. It is important that the client be given a contact name and phone number to call if she encounters any problems and written follow-up instructions should also be provided.

Institutional Resources for Contraceptive Compliance

Appropriateness and adequacy of institutional systems will increase the likelihood of contraceptive compliance and vigilance. A woman's ability to translate intention to behavior can be constrained by limited resources. Minimally, the clinic location, fees, services, and hours should be compatible with community needs. An easily accessible triage system and after-hours availability are critical to support a woman's contraceptive vigilance. Recently developed models of comprehensive care include the FIND, CARE, and SERVE Model that offers a checklist of activities and services demonstrated to maximize contraceptive counseling for teenagers.¹¹

Finally, resources typically used in business have been translated to the social service sphere. Social marketing has become a new outreach tool in the hands of institutions and communities to modify social norms. The CDC Youth Media Campaign¹² and The Campaign for Healthy Behaviors: A Social Marketing Campaign for the Massachusetts

Family Planning Program¹³ are two recent examples of efforts to raise awareness of family planning and increase utilization of family planning clinics.

Conclusion

Contraceptive behavior is a complex behavior situated in the intimately private life context of sexual activity, but subject to the social gaze of public morality. Method-specific counseling should be client-centered with a focus on counteracting contraceptive fatigue; yet improving contraceptive vigilance also requires clinical and community efforts. And, because contraceptive behavior is embedded in a relationship, the partner is neither silent nor invisible and must be included in contraceptive decision-making. While this article focused on contraceptive counseling from the woman's perspective, the savvy counselor will consider what her client has to say about the partner's preference, as this will have an impact on her client's choices and commitment to contraception.

Counteracting contraceptive fatigue is time-consuming, requiring a multi-faceted approach and ongoing dialogue, but it is critical to ensuring a woman's contraceptive success. The overarching goal must be to ensure that a woman has the resources she needs when she needs them and the support to obtain and use those resources.

References

1. Piccinino LJ, Mosher WD. Trends in contraceptive use in the United States: 1982-1995. *Perspect Sex Reprod Health* 1998;30(1):4-10,46.
2. Vaughan B, Trussel J, Menken J, Jones EE. Contraceptive efficacy among married women aged 15-44 years. U.S. Department of Health and Human Services Publication (PHS) 80-1981. Available at: http://www.cdc.gov/nchs/data/series/sr_23/sr23_005.pdf. Accessed June 4, 2004.
3. Elder JP, Ayala GX. Theory and intervention approaches to health behavior change in primary care. *Am J Prev Med* 1999;17(4):275-84.
4. Luker K. *Taking chances: abortion and the decision not to contracept*. University of California Press; 1975.
5. Miller W. Why some women fail to use their contraceptive method. *Fam Plann Perspect* 1986;18(1):27-32.
6. Santelli J, Rochat R, Hatfield-Timachy K, Gilbert BC, Curtis K, Cabral R, et al. The measurement and meaning of unintended pregnancy. *Perspect Sex Reprod Health* 2003;35(2):94.
7. The Alan Guttmacher Institute. *In their own right: addressing the sexual and reproductive health needs of American men*, New York; 2002. Available at: <http://www.agi-usa.org/pubs/itor.html>. Accessed on June 4, 2004.
8. Martin J, Hamilton B, Sutton P, Ventura S, Menacker F, Munson M. Births: final data for 2002. *Natl Vital Stat Rep* 2003;52(10):1-114. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_10.pdf. Accessed on June 4, 2004.
9. Forrest J. Timing of reproductive life stages. *Obstet Gynecol* 1993;82(1):105-11.
10. Oakley D. Rethinking patient counseling techniques for changing contraceptive behavior. *Obstet Gynecol* 1994;170(5):1585-90.
11. Hatcher R, Trussel J, Stewart F, Cates Jr. W, Stewart GK, Guest K, et al. *Contraceptive Technology*, 17th ed. New York, New York: Ardent Media Inc.; 1998.
12. Frazee JL, Shacham E. Concepts and messages for VERB it's what you do. *Social Marketing Quarterly Conference Abstracts* 2003 Winter;9(4):51.
13. Edland K. The campaign for healthy behaviors: a social marketing campaign for the Massachusetts family planning program. *Social Marketing Quarterly Conference Abstracts* 2003 Winter;9(4):42.

Carolyn Swain, MS is the President and Cathleen Conway Johnson, PhD is the Clinical Educator at Midwestern Professional Research & Educational Services, Inc.



Amy K. Brugh, MPH

Family planning plays a vital role in improving the health and economic status of women and their families. Access to high quality, affordable family planning services is a cost-effective way to reduce unintended pregnancy and abortion. The availability of family planning services is considered one of the ten greatest public health achievements of the past century.¹ It has provided health benefits such as smaller family size and longer intervals between the birth of children; increased opportunities for preconceptional counseling and screening; fewer infant, child, and maternal deaths; and the use of barrier contraceptives to prevent pregnancy and transmission of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs).^{1,2} Public health has played a critical role in promoting policies and programs that support these essential public health services, especially to economically and socially vulnerable women.

Family planning policy

Family planning policies and programs in the U.S. were initially designed to address the need to reduce family size and rates of poverty rather than to address the health and social needs of women.³ With the approval of the birth control pill by the Food and Drug Administration in 1960, means to control fertility became more convenient, yet restrictive laws and policies prohibited easy access to family planning services. This began to change in the mid-1960s. Two U.S. Supreme Court decisions in 1965 and 1972 had a major impact on the cultural norms about access to family planning services. In 1965, the *Griswold v. Connecticut* case struck down a Connecticut state law that prohibited the use of contraceptives by married couples. The justices found that the U.S. Constitution contains a right to privacy provision that applies to a married couple's decision to use contraception. Then in 1972, with *Eisenstadt v. Baird*, the Court struck down a Massachusetts law that allowed the sale and distribution of contraceptives only to married couples. The Court found that the right to privacy applies to individuals as well as married couples.⁴ These two U.S. Supreme Court cases were revolutionary in allowing women to have access to family planning services, therefore allowing them to make decisions about their education and employment and better plan the size of their families.

Following the *Griswold* case, the U.S. Congress began to act on the need to address family planning policy as a public health issue. The federal government's first family planning grant program began in 1965 as part of the Johnson administration's War on Poverty. This led to a patchwork of widely varying publicly subsidized programs across the country. In 1969, President Nixon stated that, "No American woman should be denied access to family planning assistance because of her economic condition." In 1970, Congress established Title X of the Public Health Service Act and launched the nation's family planning program.³ This federal program was designed to address the lack of access to family planning services, primarily for the nation's poor and uninsured women. The argument behind this historic and ground-setting program was that if individuals had more access to family planning services, they would be more likely to reduce the size of their families and would be more able to adequately care for their family's needs.

For over 30 years, the federal Title X program has provided affordable, confidential family planning services to women, men, and teens through public health agencies and non-profit family planning clinics. The vast majority of women receiving services through this program are poor or low-income and uninsured or underinsured. In

addition to providing low cost or free birth control services and pregnancy diagnosis and counseling, the program provides other vital health care services such as breast and cervical cancer screenings; STI and HIV prevention education, counseling, and treatment; basic infertility services; and screenings for hypertension. Many clinics also offer screening for anemia and diabetes. One of the most significant contributions of the Title X program was the development of a set of clinical and counseling standards for the provision of services and supplies.³ This program is also unique because, unlike most public health programs that are reimbursed for each service they provide, every person who seeks care is entitled to receive services at no cost if her/his income falls below 100% of the federal poverty level.³ Title X supports a nationwide network of approximately 4,600 clinics and provides reproductive health services to approximately 5 million persons each year. Every year, Title X-supported clinics enable one million women to avoid unintended pregnancies.⁵ Without Title X, the number of teenage pregnancies would have been 20% higher for this period.³ By law, no Title X funds have ever been spent on abortion.³

Following the precedent set by the federal government, most state legislatures also appropriated funds to subsidize family planning services. In 1978, the Minnesota legislature designed a program to meet the high need for family planning services, education, and outreach unmet by Title X funding. The Family Planning Special Projects (FPSP) program was established to fund local governmental public health agencies, tribal governments, and non-profit family planning clinics to provide outreach, education, and clinical family planning services. Title X-funded programs are also eligible to compete for FPSP funds. Program standards were modeled on those of the Title X program.

In 2002, the Minnesota Department of Health reported that its FPSP program served over 28,000 women in Minnesota who needed birth control services and reached over 76,000 women, men, and teens through education and outreach programs.⁶

Family planning politics

Contrary to its solid history and successful public health outcomes, the Title X program is still often under Congressional scrutiny and attack by anti-family planning elected officials, appointed officials, and special interest groups. Title X lost a significant amount of funding during the 1980s but received increased appropriations during the Clinton administration. However, inflation has outstripped this increase in funding. If funding for Title X had kept pace with inflation since 1980, it would now be funded at \$643 million instead of \$278 million. This year, the President's budget proposed no funding increase for the program.⁷ In contrast, the President's budget proposed to double the funding for abstinence-unless-married education programs despite the fact that they have not been shown to be effective in preventing unintended pregnancy and STIs. In addition to efforts to limit Title X funding, the recent decision of the Food and Drug Administration to not approve over-the-counter access to Plan B, an emergency contraceptive pill, after its own advisory board recommended approval, highlights the impact of politics on family planning.

In recent years, the Minnesota state legislature has unfortunately not been a strong advocate for the FPSP program, even though the program has been shown to reduce public health costs for the state by reducing the number of Medicaid-funded births. The Minnesota House has especially been neglectful in adequately funding Minnesota's family planning services, education, and outreach needs, and has even proposed cuts and onerous restrictions to the state's program. Proposed restrictions have included attempts to repeal the state statute allowing

physicians to provide birth control to minors without their parent's consent and restrictions about which agencies could receive state appropriated funds.

The future of family planning

Family planning programs currently face enormous challenges to meeting the unmet need for services. While publicly-funded family planning clinics have always served economically vulnerable people, clinics are increasingly seeing individuals with multiple health and social needs, including substance use, homelessness, mental illness, and exposure to violence.⁸ Over the last two decades, the need for access to family planning services that are accessible and affordable have outweighed the demand. In 1997, there were 255,870 Minnesotan women who needed publicly supported contraceptive services. Of these women, 77,820 were younger than 20 and 178,050 were women aged 20-44 who lived below 250% of the federal poverty level. Family planning clinics in Minnesota served 89,620 women that year, leaving an unmet need of 166,250.⁹ Many clinics are also seeing an increase in immigrants who are not fluent in English and thus they need to provide translation services.¹⁰ Expansion of services to men also requires that some staff learn new skills. Developing the expertise to serve these populations is a time-consuming and expensive proposition. The rising costs of contraceptives and medical technologies, as well as the increased cost of clinic personnel, have made it difficult to maintain current client caseloads.^{8,10}

Access to high quality, affordable family planning services that are designed to help women make healthy choices about planning their pregnancies has prevented unintended pregnancy and STIs. Many health experts and public health officials believe that the integrity of the national Title X system and the state FPSP system will be in jeopardy if they are not adequately funded or if restrictive changes to the existing laws and policies are enacted.

As we move forward at the federal and state levels, policies must reflect the need for family planning services and should be based on sound science and public health data. It is incumbent upon our elected officials and other policy makers to support these programs and the statutory and regulatory requirements that allow these programs to flourish. According to polls, the majority of Americans support publicly-funded family planning programs.¹¹ Their voices need to be heard.

Ways to stay informed

Changes to legislation and public policy can affect the ability of Title X-and FPSP-funded clinics to provide services. Several websites have excellent advocacy information, including updates on relevant legislation. They also provide great educational materials and action steps. To find a list of these websites visit www.epi.umn.edu/mch. Information can also be found at Planned Parenthood Federation of America, Inc. www.plannedparenthood.org/action; Alan Guttmacher Institute www.agi-usa.org; and the Association of Reproductive Health Professionals www.arhp.org/advocacy. State legislative websites are also useful. For example, Minnesota's website, www.leg.state.mn.us, makes it possible for people to track the progress of specific legislation.

References

1. Centers for Disease Control and Prevention. Ten great public health achievements – United States, 1900-1999. *MMWR Morb Mortal Wkly Rep* 1999 April 2;48(12):241-3.
2. Centers for Disease Control and Prevention. *MMWR Morb Mortal Wkly Rep* Achievements in public health, 1990-1999: family planning 1999 December 2;48(47):1073-80.
3. Gold R. Title X: three decades of accomplishment. *Guttmacher Rep Public Policy* 2001 Feb;4(1). Available at: <http://www.guttmacher.org/pubs/journals/gr040105.html>. Accessed June 9, 2004.

4. Dailard C. What Lawrence v. Texas says about the history and future of reproductive rights. *Guttmacher Rep Public Policy* 2003 Oct;6(4). Available at: <http://www.guttmacher.org/pubs/journals/gr060404.html>. Accessed June 9, 2004.
5. Department of Health and Human Services, Office of Population Affairs. Office of Family Planning. Available at: <http://opa.osophs.dhhs.gov/titlex/ofp.html>. Accessed June 9, 2004.
6. Minnesota Department of Health. Family planning special projects grants. Available at: <http://www.health.state.mn.us/divs/fh/mch/familyplanning/spec-projects.html>. Accessed June 9, 2004.
7. National Family Planning and Reproductive Health Association. Letter to Congress; April 2004. Available at: <http://www.nfprha.org/uploads/SenatorLettertoAppropsMay2004.pdf>. Accessed June 9, 2004.
8. Dailard C. Challenges facing family planning clinics and Title X. *Guttmacher Rep Public Policy* 2001 Apr;4(2). Available at: <http://www.guttmacher.org/pubs/journals/gr040208.html>. Accessed June 9, 2004.
9. Alan Guttmacher Institute. Contraception counts: Minnesota. Available at: http://www.guttmacher.org/pubs/state_data/states/minnesota.html. Accessed June 9, 2004.
10. Gold R. Nowhere but up: rising costs for Title X clinics. *Guttmacher Rep Public Policy* 2002 Mar;5(5). Available at: <http://www.guttmacher.org/pubs/journals/gr050506.html>. Accessed June 9, 2004.
11. Feldt G. Congress is foiling America's desire for reproductive choice. *USA Today Magazine*, May 1999. Available at: http://articles.findarticles.com/p/articles/mi_m1272/is_2648_127/ai_54680898. Accessed June 9, 2004.

Amy K. Brugh, MPH is the Public Affairs Director for Planned Parenthood of Minnesota/South Dakota and a graduate of the University of Minnesota School of Public Health.

Data Moment

Evidence-based Public Health Decisions

There may be no other health area as sensitive as reproductive health, with concerns ranging from sexually transmitted infections, adolescent sexual behavior, contraception, and abortion. So many reproductive health issues are both intensely private and relentlessly public. Political will can be as forceful as social justice and public health evidence in informing public health programs and policies. Public health professionals, however, can never lose sight of our commitment to evidence-based decision-making in the interest of optimizing the health of all people. We must put aside our personal convictions and review the scientific evidence as thoroughly as we can to inform and serve the public. While it is true that scientific methods are not always perfect, they are the best we have—and they are superior to anecdotes, no matter how passionately presented. We need to trust the experts, and weigh heavily their conclusions. For example, last year the NIH convened a panel of over 100 experts on abortion and breast cancer and concluded, strongly, that there was no association between them. The summary report can be accessed at <http://cancer.gov/cancerinfo/ere-workshop-report>. Furthermore, in March 2004, the *Lancet*, one of the premier medical journals in the world, published a meta-analysis including thousands of women and came to the very same conclusion: abortion is not related to breast cancer. Individuals have the right to be opposed to legal abortion, but it is poor public health practice to misinform the public and suggest that it may be linked to breast cancer. It takes years of study and practice to understand how to read a research report. People who are unfamiliar with reading scientific reports may want to examine a short article called "Savvy use of research: tips for policy makers" on the University of Minnesota Children, Youth & Family Consortium website (<http://www.cyfc.umn.edu/policy/issues/briefings/savvyresearch.pdf>).



WISE GUYZ – Male Involvement Program

There is consensus about the importance of male involvement in teen pregnancy prevention. However, until recently very few programs were designed specifically to reach young men and to support them in making healthier decisions about their reproductive behavior. Among existing male involvement programs, employment programs in particular have been successful in reaching males with information about sexual



health and family planning. Eight years ago, Planned Parenthood of Minnesota/South Dakota (PPMSD) developed a health education and job preparation program known as Wise Guyz for males 13-17 in rural Brainerd, Minnesota, funded by Title X federal family planning funds. While the program is not exclusively for high-risk teens, about 75% of the participants are at increased risk for negative outcomes, including teen fatherhood and sexually transmitted infections (STIs). Over 200 young men have graduated from the program since its inception.

Casey Trandem, who has facilitated Wise Guyz for the past four years, recruits participants from local schools. Trandem says most of the guys who are interested participate because “a buddy told them to.” The program prepares the young men to educate their peers about options for their future, reproductive health, and making wise decisions. Participants also learn about diversity in their community from guest speakers who address issues such as race, class, and sexual orientation. Trandem believes that the success of the program is closely tied to the time he gets to spend mentoring the participants. “The best part of my job is really getting a chance to know these guys on a personal level.”

Wise Guyz has two phases, the first consisting of 32 hours of training in classroom sessions. The program covers a variety of male reproductive health topics and other issues teen males confront on a regular basis: anger management, drugs and alcohol, decision making, eating disorders, and depression. Phase Two places interested participants into volunteer positions in the Brainerd community, including in nursing homes, hospitals, and other service organizations. Throughout both phases, participants provide education to their peers, either one-on-one or in small groups, on the topics covered in the classroom.

The program's success is indicated by several factors. Evaluation data indicate that the program curriculum increases participants' knowledge of contraception; perceived susceptibility to pregnancy, STIs and human immunodeficiency virus (HIV); belief in the importance of avoiding STIs and early childbearing; and communication with parents about sex and birth control. Teen pregnancy prevention expert Douglas Kirby has identified all of these as factors that protect against unplanned pregnancy and STIs/HIV. Another mark of the success of the program is that for the last four years participants have applied and been accepted to attend a Life and Leadership Skills Institute for teen males in Atlanta, Georgia, which takes only 40 participants from all over the country. The young men who attend the Institute are selected in part because of projects they have designed to carry out in their communities.

The Wise Guyz program graduates are truly wise guys, who know how to spread their wisdom around!

For more information on the Wise Guyz program, contact Katherine Meerse at 612-821-6146. You may also visit PPMSD on the web at www.ppmsd.org. Weblinks to additional information on male involvement in family planning can be found at <http://www.epi.umn.edu/mch/resources/>.

Somali Family Planning (Child Spacing) Project

Minnesota International Health Volunteers (MIHV), an international and domestic health organization, recently developed the Somali Family Planning (Child Spacing) Project with funding from the Minnesota Department of Health. Through this project, MIHV will focus on providing culturally sensitive family planning health education to both health care providers who work with Somali patients as well as to the Somali community itself. This project was developed to serve Minnesota's Somali population, an estimated 11,000 to 60,000 people. Many Somalis came to the United States to escape their country's 1991 civil war and eventually settled in Minnesota, primarily in the Twin Cities.

In Somalia, women have on average 7 or 8 livebirths, but typically not all of their children survive beyond the first year. The infant mortality rate in Somalia is 125 out of every 1,000 babies,¹ compared with 7 out of every 1,000 babies in the United States.² It is expected that Somali women will experience lower infant mortality rates in Minnesota because of improved quality of life and access to comprehensive prenatal and postpartum care. As infant mortality rates decline in this population, family planning has become a relevant reproductive health issue for Somali-born women and the healthcare workers who serve them. For Somalis, like many other Africans, a culturally sensitive approach to family planning involves a focus on child spacing.

In the next year, the project will conduct focus groups with Somali-born immigrants and refugees to ascertain barriers to care and their level of knowledge on family planning/child spacing. Other activities to be implemented by MIHV include: promote and distribute a Somali child spacing booklet and video that were recently developed, create a Somali calendar with health messages, and develop and air a Somali TV program on reproductive health. They also plan to hold health provider forums on reproductive health for nurses and physicians. It is hoped that this program will serve as the crucial link between the Somali community and the clinics that work with Somali clients.

For more information about providing family planning services to Somali women or materials developed as part of this project contact Sirad Abdurahman at 612-230-3253 (Sabdirahman@mihv.org) or Mahmooda Khaliq at 612-230-3251 (mkhaliq@mihv.org).

References

1. Halvorsen D. Delivering comfort. The Minneapolis Star Tribune 2004 May 4.
2. Matthews TJ, Menacker F, MacDorman MF. Infant mortality statistics from the 2001 period linked birth/infant death data set. Natl Vital Stat Rep 2003 Sep 15;52(2):1-26.

Planned Parenthood of Wisconsin and City of Milwaukee Health Department Collaboration Benefits City's Underserved



RoseMary Oliveira

Despite many years of efforts to address teen pregnancy and high rates of sexually transmitted infections (STIs), Wisconsin has the highest birth rate for black teens in the nation¹ and Milwaukee in particular continues to rank poorly in seven other key factors that determine an infant's chance of getting a healthy start in life.² Milwaukee also has the sixth highest chlamydia rate³ and the 11th highest rate of gonorrhea among cities of greater than 200,000 people in the country.⁴ To address these serious problems, on March 4, 2003, Milwaukee's legislative and policy-making body, the City Common Council, approved an innovative collaboration between Planned Parenthood of Wisconsin (PPWI) and the City of Milwaukee Health Department (CMHD).

PPWI and CMHD joined forces to increase the range of health care services available to underserved individuals in northwest Milwaukee by putting a PPWI health center inside an existing CMHD building. This was the first time family planning services were located with other health and human services in a CMHD building. Title X of the Public Health Service Act, the federally funded national family planning program, provides financial support for this partnership.

There was significant community debate about PPWI services being housed in a CMHD building, even though abortion services would not be performed at that center. The approval of the PPWI/CMHD collaboration came after months of discussion between the two agencies and was accepted when members of the City Common Council recognized the health, social, and financial benefits for the citizens of Milwaukee. For example, they learned that for every dollar spent on family planning services, three dollars are saved on services that would otherwise be spent on health and social services related to pregnancy.⁵ With this formula in mind, the \$200,000 investment in this new clinic could save the taxpayers of Milwaukee \$600,000 annually while providing enhanced health care services for more area residents.

"It is clear that residents of Milwaukee need access to basic reproductive health services," stated Jim Stewart, President and CEO of PPWI. "We continue to witness unacceptable health outcomes for our citizens. It is clearly the responsibility of concerned health care organizations to work with local governments in an effort to provide some remedy."

The PPWI center in the CMHD building offers services that include annual exams, breast and cervical cancer screenings, birth control, testing and treatment for STIs, and testing and counseling for human immunodeficiency virus. Services for men are also offered and include STI testing and treatment and screening for testicular cancer. Chao Thao, the center's administrator, stated that they have a "significant" number of male patients who come to the clinic for health care services. "Most often," she observed, "they arrive in groups." To encourage males to come to the center for health care, the center now reserves every Thursday from 1:00 – 4:00 p.m. exclusively for men's health services.

Since opening on May 1, 2003, the health center has provided daytime services for a total of 16 hours each week. Although limited

funding prohibits further clinic expansion, the hours it is open correspond with heavy volume days for other CMHD services in the building. In its first 10 months of operation, the center has seen 609 clients. Of these, 80 clients (13%) were male, 426 (70%) were minorities, and 227 (37%) were 19 years or younger.

Thao said that the relationship between PPWI and CMHD has been beneficial for both organizations. "We refer patients to CMHD for the

Women, Infants and Children Program and immunizations, and they refer patients to us for birth control." Thao and CMHD's Supervisor of Visiting Nurses met daily when the center first opened. Now that systems are in place, the meetings occur once per week to discuss refinements and other operational issues.

"A partnership with the City of Milwaukee Health Department is a commonsense solution to addressing the health care needs of underserved residents in a cost effective manner," said Stewart. "Through this partnership, we will strive to reduce the incidence of unintended pregnancy and sexually transmitted infections and improve the health of our citizens."

For more information on the collaboration and clinic services, contact Elizabeth Larson of PPWI at Elizabeth.Larson@ppwi.org.



References

1. The Alan Guttmacher Institute. U.S. teenage pregnancy statistics: overall trends, trends by race and ethnicity, and state-by-state information. Feb 19, 2004. Available at: http://www.guttmacher.org/pubs/state_pregnancy_trends.pdf. Accessed June 4, 2004.
2. Right Start Online 2003, Annie E. Casey Foundation. 2000 city rankings. Available at: http://www.aecf.org/kidscount/rightstart2003/2000_city_rankings.pdf. Accessed June 4, 2004.
3. Division of Sexually Transmitted Diseases, Centers for Disease Control and Prevention. STD surveillance report 2002: Table 7, Chlamydia. Available at: <http://www.cdc.gov/std/stats/tables/table7.htm>. Accessed June 4, 2004.
4. Division of Sexually Transmitted Diseases, Centers for Disease Control and Prevention. STD surveillance report 2002: Table 17, Gonorrhea. Available at: <http://www.cdc.gov/std/stats/tables/table17.htm>. Accessed June 4, 2004.
5. Forrest JD, Samara R. Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures. *Fam Plann Perspect* 1996;28(5):188-95.

RoseMary Oliveira is the Director of Government Programs for Planned Parenthood of Wisconsin.

Healthy Generations Videoconference

Family Planning
Tuesday, July 13, 2004
1-3 pm

Blue Earth County

Voyager Room
 410 S. 5th St.
 Mankato

Clay County

1st Floor Family Services Center
 715 11th St. N
 Moorhead

Crow Wing County

Courthouse
 Multimedia Room
 326 Laurel Street
 Brainerd

Hennepin County

MN Dept. of Health
 Chesley Room
 717 Delaware St. SE
 Minneapolis

Itasca County

Room J135
 123 NE 4th St.
 Grand Rapids

Nobles County

Commissioners Room
 315 10th Street
 Worthington

Olmsted County

4th Floor Government Center
 Admin & Vets Services Area
 151 4th St.
 Rochester

Ramsey County

MDH Distance Learning Center
 3rd Floor, Metro Annex
 130 E. 7th Street
 St. Paul

Stearns County

Human Services, ITV Room
 705 Courthouse Square
 St. Cloud

St. Louis County

Room 709 Government Services
 Center
 320 W. 2nd St.
 Duluth

Registration is free and limited by site. To register, contact Jan Pearson by email (pearson@epi.umn.edu) and provide your name, mailing address and the site you plan to attend. Certificates of Attendance will be provided. Please visit: <http://www.epi.umn.edu/mch/events/index.shtm> for any changes to these sites.

UPCOMING
 EVENTS

SAVE THE DATE!

**National Maternal Nutrition
 Intensive Course**

July 21-23, 2004

University of Minnesota

Distance Education Available

For information contact Jamie Stang at
 stang@epi.umn.edu

Proceedings from the 2004 MCH
 Summer Institute can be found at
<http://www.epi.umn.edu/mch/summer/>.
 At this site: Presenter information,
 PowerPoint slides, audio and video
 recordings of presentations.

Maternal and Child Health
 School of Public Health
 Division of Epidemiology
 University of Minnesota
 1300 So 2nd St Suite 300
 Minneapolis, MN 55454

Nonprofit Org.
 U.S. Postage
PAID
 Mpls., MN
 Permit No. 155



Supported in part by the
 Maternal and Child Health Bureau
 Health Resources and Services Administration
 US Department of Health and Human Services

