

MCH EPI Conference

Plenary III – Beginning with the End in Mind:

Healthy Families Start with Family Planning

(A life course perspective)

December 9 – 11, 2009

CHRISTINE GALAVOTTI: Welcome and thank you for coming to this third of the Plenaries for the MCH Epi Conference.

Last night I had dinner with Michael Kogan and I asked him if he thought that family planning was considered important to the MCH world. And without hesitating for a moment, he said, “No.” So, in short, that’s why we organized this plenary session. I think by bringing together this really amazing panel of speakers who are leaders in the field of reproductive health, they’re going to really show you what a tremendous contribution preventing unintended pregnancy and family planning can make to improving the health of women, infants, and families.

And so first, Dr. Ward Kates will provide the global picture and talk about why family planning matters to maternal and child health globally.

Next, Dr. Larry Finer will provide the epi overview of unintended pregnancy in the US and trends and address some of the data needs and analytic challenges in looking at this issue domestically.

After that, Debbie Kaplan will give a big city example and describe the innovative ways New York City is using data to focus their efforts to prevent and evaluate the success of their programs in teen pregnancy prevention.

And finally, Sarah Brown will issue a challenge and talk about ways in which epidemiologists and state and local policymakers and program folks can really, what they can do in terms of surveillance research, practice, and policy, to further this agenda.

I'm going to begin with a brief intro of the speakers. We'll hold questions until the end and, so let me begin. Dr. Ward Kates has degrees in history, medicine, public health, and epidemiology and he's either worked for or graduated from every research institution in the new world. Perhaps the old world. He's also a member of the Institute of Medicine and a Fellow of the American College of Preventive Medicine. He's past president of the Society for Epidemiologic Research and the Association of Reproductive Health Professionals. In 1994, he joined the Family Health International North Carolina, an organization which has offices in 35 countries around the world and he currently serves as president of research. And one other important less well known fact about Dr. Kates, is that he was actually my first boss at CDC.

Dr. Larry Finer joined the Guttmacher Institute in 1998 as Director of Domestic Research. He's responsible for supervising Guttmacher's research portfolio of US

focused projects on family planning services, contraceptive use patterns, pregnancy and abortion, and adolescent reproductive health. He also serves as a senior lecturer in the Department of Population and Family Health at Columbia University's Mailman School of Public Health. And in 2004, he received the Outstanding Young Professional Award from the Population Family Planning and Reproductive Health Section of the American Public Health Association. He received his AB in psychology from Harvard and his PhD in population dynamics from the Johns Hopkins School of Public Health.

Deborah Kaplan is the Assistant Commissioner of the Bureau of Maternal Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene, where she's worked for the past eight years. The primary goals of the Bureau are to reduce teen pregnancy, make breastfeeding the norm, and promote health equity for mothers. The Bureau addresses these goals through a range of innovative initiatives and research, some of which you're going to be hearing about today. Ms. Kaplan received her Bachelor of Science degree in physician assistance training from Johns Hopkins and she holds a Masters degree in public health and community health education from Hunter College and is currently enrolled in the doctoral program in public health at City University of New York.

Finally, Sarah Brown is the CEO of the National Campaign to Prevent Teen and Unplanned Pregnancy, a private, non-profit initiative organized in 1996 that focuses on preventing both teen pregnancy and unplanned pregnancy among young adults. Before co-founding the national campaign, she was a senior director at the Institute of

Medicine, where she led studies on a wide variety of issues in maternal and child health and in reproductive health. She served on numerous advisory committees and boards nationwide and speaks frequently on issues of teen sex and unplanned pregnancy, appearing on television, radio, and print. And she has received numerous awards, including the Institute of Medicine's Cecil Award for Excellence in Research and the Martha May Eliot Award of the American Public Health Association.

So please join me in welcoming this really wonderful panel and I'm going to turn it over to Dr. Kates.

WARD KATES: Thanks so much, Chris, and boy, it really is an honor to be here with these colleagues and so many other colleagues and friends in the audience. It's been forever since I really have addressed a domestic MCH group and it's wonderful to get connected again.

We're going from the global to the national to the local to the advocacy over the course of these four talks and the global was really kicked off wonderfully by a session chaired by Roger RoCHAT, a colleague, like Sarah, young colleague at the time in the '70's when we were all beginning and I'm just going to springboard many of the issues that were raised at that international session.

What I'm going to talk about quickly is the historical perspective on international family planning, talk about why now, why the need for renewal now and what are the benefits

therein and what are some of the perspectives for the future. But before I do, I want to give a plug for a publication one week ago, just one week old, that everyone in this audience interested in global reproductive health needs to memorize. And that's adding it up by the Guttmacher Institute and you can click on it and download it and be sure to make all your slides with it, it has great information about the benefits of family planning and much of what I'm going to say also is referenced there.

Well, in terms of historical perspective, the field of sexual and reproductive health has really gone through a roller coaster type of experience. Beginning with Cairo, the International Conference on Population and Development where reproductive rights were truly advocated, moving to Beijing and the International Conference on Women, we were on a high. But then there was a little thing called congressional elections, the MDG's without any sexual and reproductive health, the presidential elections, and it was only through concerted movement to try and get sexual and reproductive health into the millennium development goals that they appeared at all.

There was polarized politics with the Mexico City or Global Gag Rule, there was revisionist terminology where some of us had to pull the term reproductive health out of different statements that were being made. And of course, funding limitations without any growth in global family planning investment, in fact, a net decrease over some of those years. But worse, and I bet most of this audience felt this way, was this chilling effect that bit by bit as things started getting rejected or people started getting

questioned or things were censored that it had on both science and services and advancing it forward, we just would go to different areas where things were not so hard.

But, we're in a new era and one day after inauguration, President Obama said for too long international family planning assistance has been used as a political wedge issue. The subject of a back and forth debate that has served only to divide us, when in fact it should be the common ground internationally upon which all of our millennium development goals are built. And why do I say that? What are the real benefits?

Well, clearly the main benefit at both a population level and an individual level, is reducing unintended pregnancies and therefore the need for abortion. A lot of things worked through that, in addition, improving maternal and infant health, preventing HIV, enhancing women's, especially education, but education overall, reducing hunger. Does this look familiar? Like our millennium development goals put forth by the UN?

Stabilizing societies by reducing the youth bulge, the main demographic impetus for an unstable society, and protecting the environment.

What are the data? And I'm just going to show you some snippets that are updated.

Again, I play with this talk a lot these days. This was an analysis done by Charlie Westoff of Princeton, where he was comparing the rise of modern contraception in Russia after the fall of the Iron Curtain, indexed there on the Y axis as 1, 100, and that went up 78 percent by 1998 and you can see that abortion, actually as a method of

family planning that had been popular in eastern European countries, went down. Clear temporal correlation.

And here's a presentation given by John Ross of Features at the Kampala Conference in Uganda, a major conference three weeks ago, that at least several of us in the audience attended. And what John did was to look at the number of maternal deaths in developing countries in the 15 years from 1990 to 2005 and there are actually three factors in this calculus. The total women of reproductive age, the general fertility rate, which is a proxy for contraception and fertility, and then the maternal mortality rate, MMR, which is a proxy for obstetric care. Now, you take those three things and together the calculus adds up to the number of maternal deaths. And the good news is, despite an almost 1.2 billion increase in women of reproductive age, this was offset in the developing world by a decline, an overall decline in the fertility rate and an improvement in the maternal mortality ratio in obstetric care, leading to a decline of 600,000 maternal deaths over those 15 years. But now all areas are equal and when you look at Sub-Saharan in Africa, it's very different. Here you have this population momentum going higher, almost over 700 million additional women of reproductive age in this interval, the fertility decline was much less because of decreased access to family planning and obstetric improvements were even less, leading in Africa to a net increase, an increase in maternal deaths over this time, unlike the rest of the developing world. Look at that and you'll see what challenge we have in that part of the world.

One of my favorite topics is how family planning is absolutely the best kept secret in HIV prevention. WHO has a four-phase approach to it, beginning with preventing women from getting infected at all, then a second approach would be for the infected woman reducing unintended pregnancy. So the third approach is what we commonly think of as preventing maternal to child transmission, which is giving anti retro-virals during pregnancy and now in the breastfeeding interval in order to reduce viral load and the infectiousness of the woman in the what I call discordant couple of an infected woman and her child. And then finally, providing anti retro-virals and her family for survival and thriving. But what we talk about, the best kept secret, is this element to family planning.

And here is a presentation made by Wolf Pladuck of CDC, of the CDC staff in Uganda, given again, three weeks ago, in Kampala and published just about that time in PLOS1. A wonderful model where he looked at the sort of comparing affects of anti retro-virals, ARV, current use of family planning, potential use of family planning to prevent unwanted fertility by addressing need, in Uganda in 2007 and the affect that each of those has on sparing infants from HIV infection. Well, this traditional approach of giving anti retro-virals prevented about 2,200 infants from being infected. Whereas current use of contraception by preventing the unintended pregnancies prevented 6,000 infants from getting infected.

If you could meet all the un-met need in Uganda, that would add another 5,000. So together, together we see that the combined effects of current family planning and unwanted fertility could be five times higher the number of infant deaths prevented than

the traditional anti retro-viral approach. And as I say, do the math. And if you do the cost math, it's even more impressive.

And the same general relationship holds for the cost of pediatric anti retro-viral medicines for those infants that are born with HIV infection. Very nice analysis in PLOS1.

And how well are we doing with our HIV prevention best kept secret? Well, here along the Y axis are some proven HIV prevention approaches. In 2004, we weren't really doing too well in terms of coverage for these, and of course, male circumcision wasn't even recognized at that point. When we went to 2007, we started seeing some improvement, especially as you saw the four lines down anti-retro-virals and by 2008, we were doing even better for anti-retro-virals. But what are we doing with regard to contraception? It's still is not very widely used and available as an HIV prevention approach and we have to go a lot further as the **** five-year strategic plan just released, just showed in terms of overall prevention.

For enough for HIV, how about other factors affecting women? Family planning prolongs education. Why? Pregnancy is the main reason women drop out and lots of, more than half of African girls, or less than half of African girls actually even complete primary school and population growth puts pressure on an already crowded infrastructure.

And if you look last column under the age 18, anywhere from 30 to 50 percent of these countries have 18 year old women who have either been pregnant or already have children. Major affect on, a factor in population growth, women's education.

Family planning also empowers women. In a series of qualitative studies and quantitative studies done by a project that we host, it's called the Women's Studies Project, again, a lot of this is well known to you, but we have good data to show these correlations now, that women who use family planning are more likely to be employed in Indonesia, Zimbabwe, and Bolivia, that unplanned pregnancies interrupt work and career plans in Egypt and in Brazil and Indonesia, there's an association between the more effective, long-acting contraceptive methods, which is associated of gradiance of pay and likelihood of women working for pay. Effective contraception empowers women.

And for those of you who haven't read this wonderful book, *Half the Sky* by Nicholas Kristof and Sheryl WuDunn, it's very inspiring in terms of the role that empowering women can have on development.

Family planning reduces hunger. In 1997, when we look across the undernourished total population of world grain stocks, we see 775 million were undernourished. The total population in the 50 least developed countries was 2.6 billion and we had 108 days of grain stocks, that was 1997. What happens in 2007? Well, the undernourished population rises, the total population rises, and the world grain stocks decline. What will

happen in 2017? The undernourished will continue to rise, the total population will continue to rise and we don't even have an estimate, given a variety of environmental plus demand factors on what the world grain population will even look like. Family planning reduces hunger.

Family planning also stabilizes society. I mentioned a little bit about the youth bulge. Interesting correlations with that and sort of Freedom House's depiction of countries with the greatest evolution toward democracy. But even the 911 Commission talked about how high birth rates and the youth bulge, especially young men, is a sure prescription for social turbulence.

Family planning protects the environment. Preventing unintended pregnancies is a factor most amenable to intervention in the environmental calculus. Many women want fewer children, have un-met needs as we talked about earlier, increasing rights-based family planning is the fastest way to address that wing of the calculus and rapidly growing population exacerbates whatever gains we have in our green technology.

I just want to point out, as look at what are the three components of population growth, the key components. If you look at the bottom up, the population momentum is already here. Those are the people who are already born. Those are the people who are going to be having children. We can't do anything about that, that's momentum.

The second is the high desired family size in many countries. Why is that? What affects that? The education of women and the survival of children. But the thing we can do something about immediately is unwanted fertility. That's access to family planning.

And family planning is five times cheaper than conventional green technologies, as we've shown by a recent analysis out of the London School of Economics. So in terms of reducing carbon dioxide emissions by a ton. That probably didn't come out right, did it?

Anyway, a fascinating analysis that is an interesting model on how we need all of these together, it's a necessary but not sufficient approach. It also, for \$27 invested in Zambia saves a whole host of dollars that are oriented toward further gains than trying to achieve the MGD's.

Where are we going in the future? Rather than bemoaning PEPFAR, which tends to be something that happens a lot, boy, HIV gets all this money, my view is we ought to learn from it and emulate it and let's get our field stronger.

Leadership, here is President Obama in Norway today, accepting the Nobel Prize, talking about maternal health. My goal is that the Obamas should never sit down to dinner with their kids without at least having family planning a topic of discussion. Okay.

We need broad political support. Resources, resources, resources, whether financial, human, or infrastructure, drugs and commodities, we can't have stock outs, as often happens in many of these low resource settings, and what you guys stand for, evaluation. Not just domestically, but especially globally.

What about a whole alliance for contraception? We have a vaccine alliance, a global vaccine alliance, a global microbicide alliance, a global TB alliance, how about a global contraceptive alliance? Where's our Bono, where's the celebrity that's going to be talking about global family planning?

And finally, the President's Global Health Initiative, which as many of you may not have heard about if you're oriented domestically, for those of us in the global arena, it's our blueprint for the future. And what are the four pillars? Well, the main infectious diseases number one, but followed by maternal and child health, and a separate bullet—not a combined bullet, a separate bullet for intended pregnancies, and finally, neglected tropical diseases. So with these as the foundation of what we're going forward in the Global Health Initiative, family planning remains fundamental to that and as the Secretary of State has said, foundational to achieving the Millennium Development Goals.

Thanks so much.

[Applause]

DEBORAH KAPLAN: I really believe so strongly in the power of data to inspire to do things. And just one quick example before I delve into our specific work in New York City, is that we were able to link our vital statistic data, I'm not going to be showing you that here today, with our school administrative data. So we were able to show teen birth rates by school. And then we met with principals and we showed them their birth rates at their schools and many of them were really shocked. And we were able to show them teens over the last three years, some who had dropped out since then, and the ability to show them that data, was a way of convincing them why they had to let kids go to their school based health center, not just during lunch time, but any time during the day so that they could get contraception, which we're not offering at all our high school school-based health centers in New York City.

[Applause]

I want to also say, well, you're in New York City, so of course you can do all these things, you know? And I think it is true that, you know, in that eight year period that Ward talked about, we had a mayor who spoke at (inaudible) lunches and who is committed to reproductive rights and then we had a health commissioner who moved recently to another part of the country and who was supportive of reproductive rights. But we also have a very complex city with 125,000 births a year and with many, many hospitals in competing systems and a very diverse community with a lot of poverty and dramatic health disparities. So while we had a political environment that allowed us,

allowed us to do our work, what I think is in some ways, if we can do it in New York, you can do it in other places, you have to work on the political will and I know that's often a barrier, but I think it's incumbent on us all to look creatively at what we can do with and without money to change some of the norms in our institutions. To make sure that reproductive health and contraception are part of the continuum of reproductive health care and maternal child healthcare.

So I'm going to start, I'm with Bureau of Maternal Infant Reproductive Health Services, I've now been there almost nine years and I come from the reproductive health world and have really now expanded it to incorporate all of maternal child health as well. And so I felt it started in my Bureau with a vision that very clearly and unquestionably connects maternal and infant health with reproductive health and pregnancy and preventing unattended pregnancy. And so our vision statement is, and we actually have it on umbrellas now that my staff carry around, we envision a world where all people live healthy, fulfilling, sexual and reproductive lives and where all children are wanted, born healthy, nurtured, and loved. And we have this all over our Bureau, it's something that we felt people needed to have that sense of purpose and commitment and interconnectedness of our work every day. Despite the fact that there's so much important work to do, we made a decision to stick to three key goals, where we felt we could move the work and try to make some changes that eventually will happen on a population level in New York City. I mean, that's a big, big goal to get there, but we're striving to do things that we think can eventually be scaled up like that and prevent teen pregnancy is one of our three top goals.

I think, you know, in terms of thinking of what are the key things that have led us to where we are now in terms of really having a very robust on-the-ground work around teen pregnancy prevention and I'm really just going to talk about teen pregnancy prevention, there's other work we're doing in reproductive health, but I want to focus for today. One is to, and we've heard about the connections in the first talk, about connecting teen pregnancy and birth to other public health and social outcomes.

Second is to develop a unified agency message which I'll share with you in a moment. To have a multi-level approach that looks at the data, that looks at programs on the ground, but that also looks at a policy agenda. And in times of recession and economic challenges like we all have now, policy is a place, data and policy are two areas that often don't cost money, but can have huge affects. We need to advocate for policy change, get buy in from senior leadership, and at the end I'll show you how now teen pregnancy is one of the top goals of the Department of Health in New York City. And then what I'm focusing on today, dated action.

So we decided in our agency and I know many agencies have that, we have the message coming out from school health, the message coming out from reproductive health, the message coming out from HIV and STD, and we were all, some people were talking about condoms, some were talking about contraception, we weren't saying the same thing and that we had to embrace it under the theme of teen sexual health. So we got together and hammered out a message that talked about how not to get pregnant or

get sexually transmitted infections, giving a dual description that we felt was not contradictory, that says choosing not to have sex is the surest way not to get pregnant or to have an STI, and if you are sexually active, use condoms and another effective contraceptive method. And in our state, minors do have a right to get these services without parental consent, which certainly has a huge impact on what we can do. But that said, in our school it is only recent that we've been able to say in high schools that teens can get birth control at school-based health centers. So that's even with the minor's rights.

And outside, I brought some samples of our materials, so for anyone who wants to get some of these, this is a brochure we developed. So I'm going to show a little local data, but though I'm going to really be focusing on the action, but just using it to really show the integration. We developed a trend chart, trend book or teen pregnancy data from 1997 to 2007 and we've looked at both vital statistic data, as well as data from the youth risk behavior survey and we show both in this book and we'll be updating the book every year it's online and people from the public can access this data and look at it. So we see that just like Larry talked about the US, the pregnancy rates, while they have gone down and in fact, they went down 28 percent over the last 11 years in New York City up to 2007, there has been a real slow and stagnation in New York City, as in the nation in the last few years. And we remain substantially higher than the US, so in the most recent data in the US for 2004, New York City was 22 percent higher than New York State. And just to think of it in numbers, that meant that in 2007, we had over 22,000 teen pregnancies between the ages of 15 and 19 in one year.

We also, through our YRBS data, looked at, in addition to looking at the number of teens who say, percent of teens who say they have ever had sex. We look at teens who say that they used birth control or condoms had less sex. And what we found is in New York we are actually ahead of many other states and I should make clear, we have our own data for YRBS as a city. So we have our state data, but we also collect local city data.

Over 64 percent were using only condoms, very few, 7 percent, said this is the last time they had sex, among teens who said they'd had sex in the last 3 months, only 7 percent were using pill or Depo. And in the most recent YRBS, which was 2007, those were the only methods that we were able to ask about. And we've now made a change in our New York City data, which I'll share with you in a moment, where we are going to be asking, we are asking right now, it's on the street right now, we're fielding the 2009 and we're asking about every single method of contraception.

We see that with the dual method, which is the top golden standard of recommendation, only 3.4 percent of teens said that's what they did at the last sex, and so we know over a quarter of teens who are sexually active were unprotected the last time they sex, according to 2007 data.

So how are we looking at our, what we decided to do is really get a sense, are we reaching the teens we need to reach to reduce teen pregnancy in New York City? And

so we did a landscape and this does not cover all teens in New York City. We're looking at 15 to 19 year olds where we have much more reliable denominators in terms of the population. And so when we look at teens 15 to 19 and then we break it out further by 15 to 17 and 18 to 19, we decided then, let's look at, how many are in school and how many are not? How much of our strategy, if we do it in school, how many teens will we actually reach through that strategy? And then we took it a level further and we stratified, now just looking at 15 to 17 year olds, because we wanted to then zero in, let's look at those teens who are in school. First of all, we see that 22 percent are out of school in that age group. So that's a lot of teens who are not even in school for any intervention we do. And then in high schools in New York City, while about 76 percent are in public high schools, we have other teens in private and special ed. We did another breakout based on YRBS data, looking at of the teens in each of these groupings, how many are sexually active and not? And in New York City, 31 percent of teens said they had had sex in the last three months. The definition in the YRBS. And so we put 31 percent in the sexually active group and 69, and obviously this is a rough estimate, there are differences by race, ethnicity, and in fact, in the private schools, where there is a much higher white population, we did 25 percent sexually active.

And then one more further stratification, under sexually active in public schools, we wanted to look at how many of our kids who are sexually active in public high schools are in schools with school-based health centers and it's about a quarter of sexually active teens in public high schools. So this was kind of a reality check on how many of the teens at risk of pregnancy are we reaching? And I'm now going to share with you

four different strategies to reach different segments. And the first group I'm going to focus on are those teens in public high schools who are sexually active among all the teens in the school and in our school-based health centers. And this is a map of New York City that shows teen pregnancy rates by region and so you see the huge disparity and I'm not going to talk too much about the geography of New York, the smaller island is Staten Island and the bigger islands are the other boroughs of New York City. And the places where you see the darkest colorings are the highest teen pregnancy rate. So remember that the citywide rate was 83.2. The rate for white teens was 20.2 and for black, non-Hispanic teens, it was about 122. So we had about a five-fold difference between white non-Hispanic and black non-Hispanic. And the darker colors are in the South Bronx, Harlem, East Harlem, parts of Brooklyn, and the tip of Staten Island.

So we are now looking again at that group of teens in school-based health centers and what we did is we thought, a real role that school-based health centers can play in high schools is to provide contraception. But what we initially got was a grant to do emergency contraception. This came from our mayor, to do emergency contraception and we did a program in school-based health centers, thinking we're going to enhance what they're already doing. And we went into these high schools and the school-based health centers and found out that we were trying to give them plan B and there was no plan A. In fact, many of these school-based health centers in high schools were not providing any reproductive healthcare. They were not taking a sexual history and they were, you know, doing many, many other services, but this was not incorporated into their care. There were a few select ones who were doing an amazing job. And many

below the radar screen, because they didn't know if they could give out birth control in schools.

So we leveraged that experience to ultimately get a very large anonymous grant based on our findings to fund three years of funding to fund this in all 40 school-based health centers where we are purchasing contraception, including the vaginal ring, including all the methods, and we've created now four regional centers to refer teens for IUD's and Implanon. And we are finding that teens are going for IUD's. It's very early, it's just been the last four months, so I can't show you any data on this. We did focus groups with teens and we are looking very carefully at this and one thing we're very pleased is that in partnership with the CDC and our own local epi folks, we were able to add four questions to the YRBS, and if anyone who's tried to add questions to the YRBS, it is unbelievably hard to get anything in there, and we got four questions and we were able to over-sample the schools with school-based health centers so we will be able to compare teens in schools with school-based health centers to teens in schools without school-based health centers and we will be able to find out about every method of contraception.

Okay, back to our data. And now we're looking at teens in public high schools without school-based health centers. And what we've done there, just very quickly, is we've been experimenting with different ways to do this, we're doing school-linked work, where we're taking Department of Health staff at the schools, providing information, then once a week they show up at a clinic and we try to link the teen to the clinic. They

know the person, it's someone they've built a trusting relationship with. I'm not going to say that because of time.

And then there's all of these other teens, either because they're out of school or because they're not in public high schools, or because they don't want to use the school-based health center. Not every teen wants to get their care in a school who are sexually active and at risk of pregnancy. And again, back to where do we target this? So we looked at our vital statistic data and where we have the highest teen pregnancy rates and we've implemented something called Healthy Teens Initiative. We provide training and technical assistance as we do in the school-based health center model, to community providers to change their systems and help them deliver high quality, state-of-the-art contraceptive services and the focus is on increasing contraceptive availability and use in teens. And we use, we developed a provider guide around state-of-the-art training and provision of service using Quick Start, which is one of our major things that we're proposing, we're supporting, which is starting teens on birth control at any time during their menstrual cycle if they're not pregnant and we're really working hard to get providers to embrace this. I think some of the big barriers are really changing the provider culture around not withholding contraception because of concerns and often it ends up being withholding. And this is just our guide, there's samples of it outside.

And one other piece we've done, which is part of something actually that our previous commission, Tom Frieden, started as a public health detailing campaign, where we've learned from the drug detailers, and we've decided that instead of detailing drugs, we're

detailing public health and we have these highly trained public health educators who go into our poorest communities and bring information and resources providers. And we did one on contraception and in that case, we actually did bring drugs, we brought some plan B with us, which was a big hit. And so we still have all those materials for providers.

And last, in terms of an example, is looking at preventing subsequent pregnancies. In New York City, we know, and I think this is probably true around the country, that there is a high percentage of teens who get pregnant who had a previous pregnancy. In fact, among 15-17 year olds, 26.8 percent were pregnant previously, among the older teens, it is even more common. And about 8 percent of the 15-17 year olds who are pregnant already had one live birth. And I'm going to give you that information, one second, for the older teens. Well, in any event, so we are very concerned about this and something we brought to New York City, it's a national program and many of you may have heard of it, we brought it in 2003, is the Nurse Family Partnership, which is a home visiting program for low income females who are now the largest urban site in New York City. In New York City, we are New York City. We are the largest urban site in the country. And that's because, I think, we went in with a population level strategy where we said, "We are bringing this in and we want to serve every low income woman in New York City over time." And this has been shown and proven through **** control trials to delay subsequent pregnancies and we believe it is a really effective component of teen pregnancy prevention, as well as overall maternal and infant health.

The other last piece I have to talk about is changing policies and social norms and part of that is removing barriers to teens accessing reproductive health services. There are some that have to do with state laws and then there are some that have to do with education and information. And one of the key areas we've been working with our State Department of Health, as well as our local Medicaid office, is increasing access to Medicaid and expanded family planning, as well as Medicaid reimbursement, because we know all our clinics, community and family planning, are struggling with their finances and being able to stay afloat. And so if we can increase their revenue, and it really is a revenue issue for many of them, and we know Title 10 has been flatlined for a long time, we can hope that they can provide these services, that they can give IUD's and other birth control methods and no prescriptions, the real contraception.

And lastly, that our agency now has a city policy called Take Care New York and for the 2012 goal, one of our top goals is teen pregnancy prevention and we've come up with a goal of reducing it by a certain percent within four years. It's very ambitious and it's aspirational, honestly, but we think it's important to have an aspirational goal for this.

So in conclusion, I think it's critical that every city and state in this country make teen, reduction of teen and unintended pregnancy a priority and a key component without question or maternal and child health. And the key strategies are consistent messaging, always including issues about pregnancy prevention and preventing unintended pregnancy whenever you talk about infant and child health, just like Obama is going to

do at his dinner table, well, you should be doing it at all your dinner tables and meeting tables.

It's increasing contraceptive access, we've kind of had this very focused approach around contraception and really talking a lot about it because it's been an issue for providers and the community and we just keep talking about it. Bringing out the, strengthening the evidenced-based programs and advocating for policy change and really using your data as a powerful tool to bring about change in your communities, your cities, and your states. Thanks.

[Applause]

SARAH BROWN: Hello, everybody. I think I'm your last speaker and I think I better be short because I think I'm the only thing that stands between you and what, dinner? A drink, maybe? Looking at your emails, calling home? But I think as you saw from all of us up here, we all feel passionately about this. So if I do go on, Chris, you'll get the hook, or do get the hook.

Chris Calavotti gets an enormous amount of credit for organizing this plenary session with Lori Gavan and others and I really thank her and Lori as well for doing this and I thank all of you for coming. It shows your interest and we're all very grateful.

So my basic premise in standing here is what has been already presented very powerfully by everybody else. Family planning, which the CDC has listed as one of the 20th century's greatest public health achievements on a level with vaccinations and modern sanitation, is in this country of relatively low profile, poorly understood, and inadequately financed. I also believe and would posit that the US compares poorly to numerous other developed nations in particular in our family planning systems and services, but also even to some developing countries as well. And as a consequence, we have, of course, as we've learned about very well, very high levels about teen pregnancy and unintended, unplanned pregnancy.

Now, all of us here in front and I hope a lot of you sitting there, wish it weren't this way. But I think in order to make things better, we have to have a real understanding of why is family planning out in the cold? Because if we don't know why it's out, how can we bring it in?

Now, this is Aunt Sarah's list and every time I put it up, I think of four or five more things. The question again is why is family planning out in the cold? Well, first of all, I think through a variety of actions, both intentional and unintentional, in this country pregnancy prevention has been conflated with abortion. And I notice this most in my work in Washington on Capitol Hill. I walk in all freshly dressed and bright eyed and I say, "Senator or Congressman or whatever, I'd like to talk to you about family planning," and the answer is, "Well, we have already issued statements on abortion." And I said, "No, I didn't say that," and so it goes.

Unplanned, unintended pregnancy is in fact, as a concept even, poorly understood. I mean, if I go into a party—or do I go to parties? Occasionally—and someone says what do you work on? If I say teen pregnancy, everybody goes, “Oh, that’s great! Huge problem, good for you, that’s wonderful.” If I say I’m working on helping to reduce unintended or unplanned pregnancy, there’s just going to be a quizzical look. What does that mean? Not hostility necessarily, but misunderstanding or no understanding.

There are a lot of fears and myths in this area among individuals about family planning, a lot of fear. I’m going to get to that in a minute, and confusion. There has certainly been insufficient leadership, particularly in the public sector in recent years, about what I call old fashioned family planning. There are separate funding streams for family planning. Not always, but, you know, the Title 10 program is clearly labeled as family planning. We have a maternal and child health services block grant, as you all know, and family planning is an allowable use, of course, some of the states represented here do a great job with that, but a lot of people see these as separate funding streams.

And partly as a consequence of that, I think family planning is quite isolated. I have been in a variety of states and communities where literally the sort of pediatric, OB/GYN well child services will be in one building and down the street, behind the parking lot, over next to Burger King, maybe, is the family planning clinic, not even co-located, it’s isolated.

There is also a sort of complex history of family planning in the US, not only the recent chill in public policy, but there is a racial and an ethnic history here that a number of us are aware of that lingers in many communities and I'm going to speak about that a little more as well.

So the net result is that we have, as I said, a community of interest, family planning, that is out in the cold. And when we have time, maybe in question and answer, I'd be interested in what you all think in addition to those few things I listed. Again, you can't fix it if you don't know what's causing it. Why has family planning sort of fallen off the radar screen? But really more important for this session, what can we do and what can you do? I mean, my core idea here today is that the people in this room, MCH epidemiologists can make a difference. I think you can help bring this back into national prominence.

So here's a few ideas for you about how to do that, as leading scientists. First of all, I think you need, as an intellectual matter, to embrace family planning, pregnancy planning, as a core part of this MCH epi discipline. Now, here I'm going to give you two scenarios. A couple of you I know have seen this, so I apologize. But here's sort of how the way I see it. How I see this issue. All of us in this room, I believe, share a common goal: Strong and healthy families and children. And we understand that we live in a very complex social environment, more complex all the time. And the MCH community has for many years, and with great distinction, worked on pregnancy, prenatal care, and all

that you all know, birth, childbirth, infancy, and of course, the larger and huge world of child and family health.

Now, it is true that with the leadership of CDC and others, that there was a little, or has been, or is, some interest in sort of saying, well, let's start just a little earlier or maybe just before pregnancy starts and so we have the world of pre-conception care. And I saw there were some sessions on that and I was delighted about that.

But I really think that pre-conception care isn't the true beginning of this whole odyssey of building stronger children and families. I really think this is the full scenario and the MCH people have generally stayed on the right side of that dotted line with great distinction, with great distinction. But as every single speaker has argued before me, and so I'm not going to repeat it, if you really want to start at the beginning, you start at conception. And if you really want to start at that, it's, well, who's having sex, are they or are they not using contraception? What is their intention? Both the man and the woman. This, on the left, in my view, is really the beginning. It is not assume a six-week pregnant woman and now let's get really busy with prenatal care. That's obviously important, but that's actually a little bit late in the game.

Second idea, and this has been mentioned a number of times as well, get to know the data systems that bear on pregnancy planning, family planning, in your communities and states. Now, they've all been mentioned, I think, today except for one. The National PRAMS, of course that's at the state level, I mean, at the state level, but I think of it as

national because I think of it as coming from NCHS in part. The NSFG, for sure. At the state level, we've already talked about PRAMS and YRBS, but who here knows about or works with the BRFSS dataset? Oh. Well, that's okay, I mean, that's some. That of course is the behavioral risk factor surveillance system, which is critical and I think really is something you all need to understand. And I have here in my hot little hand a copy of all the state BRFSS coordinators and Chris Calavotti has 50 copies of these individuals and they should be your friends and you should learn what they've collected, how you can help, how again you can get optional questions on and so forth. So there are data systems that can help.

And as has also been made clear, we can use these data to learn a lot more about the causes and prevention of unintended pregnancy and of course including teen pregnancy and the particular contributions of family planning. The list is very long of things for which, as Larry said, more research is needed. Let me add a few more. Some of these are duplicative. I mean, again, the extent of unintended pregnancy in your state, patterns, trends, sub-group differences to help target remedial efforts, I just will say that I've seen very little data on Native Americans in this context and I think it's a huge hole. Local barriers and risk factors, state and local systems that are in place to address unintended pregnancy, and family planning's one of them, how affective are they in your state or city? How can they be improved?

What is the role of unintended pregnancy and family planning in your state or community's level of education, poverty, and employment? I often say (inaudible) one of

the most important reasons to advocate for family planning is because of the state of the US economy and workforce. We used to say, well, we wanted you to get through high school because it's so tough to get a job without a high school education. Barack Obama was correct when he said, "The jobs we have lost have been at the lower end of the skill spectrum and they are not coming back." The new economy demands not only a high school education, but at least two years of additional training and to help young people get through those years of training, we have to have more focus on pregnancy planning and postponement.

Study innovation. Study what Debbie Kaplan's doing, using Larks in school settings. Study post-abortion and post-partum IUD insertion in this country. Document the value of pre-conception healthcare, which of course has to be anchored in family planning. I often will read things on pre-conception healthcare and I will get to about page 23 before family planning is even mentioned. Remember, in order to do it, the woman has to be not pregnant.

Number four, because so many pregnancies are to relatively young women, not to the elderly and aged among us, as you do your work, you have to be really well aware of current youth culture, because it affects how people think, what they do, how they get information and so forth. And I think often that some of us in this room still are frozen in this environment and we know it's not quite this way, I mean, we do live in the real world, but there are two people fall in love, and then he proposes to her on his knee, and then we have a wedding with a tiered wedding cake with pillars, remember that?

That separate the layers? And then we have a baby. Unfortunately those days are gone. And I'm not sure which way all these arrows go, but this is the way it is. And so when you do research on family formation and pregnancy and relationships and sex and contraception, this has to be the platform or the template. It's not some sort of an abstract thing, this is the way it is.

And as you learn, and as you develop increasing expertise in this area, it's really important to please get out the information. Be a megaphone. We do, at the national campaign, periodic surveys of sort of what's going on in cyberspace with regard to family planning and some of the better methods. We Twitter, we blog, we look at everybody else's, we go to social networking sites. And I think without, I'm going to overstate it just to make the point, bad news loves a vacuum. In the absence of good news about contraception and the benefits of family planning, we have a very complex cyber environment now in which every bad news story, every myth, every scare story about modern family planning, is firmly anchored, blogged about, and viraled—that's a verb now—viraled around the nation. And I think it's our responsibility, those of us who understand the facts and understand the promise here, to do some counter messaging. And we know that there's an enormous amount of fear.

We are, next Tuesday, releasing a report that we did with the Guttmacher Institute, we're calling it the *Fog Zone*, it's about young adults and their fears and myths and concerns in this area. Here are just a couple, here are just two numbers from that that will be coming out next week. 27 percent of unmarried young women, these were 18 to

29, believe that it is extremely likely or quite likely that by using birth control pills you will get a serious health problem like cancer. Extremely likely or likely. 30 percent say it's extremely or quite likely that if they use an IUD they're going to get an infection. And we have a lot of other items like that, but you sort of get to the end of it and you go, "Oh, my goodness. Oh, my goodness."

I think the image I have is that there will be one building in which on the top floor there we have maybe, I don't know, internal medicine or, you know, just general medicine. And then maybe over there we'll have the pediatric clinic and over there we'll have OB/GYN and then we'll have the family planning clinic, too. Because individuals move amongst those stages, they're not separate, they are just different times of your life and different intervals and why should they be so separate and so in the case of family planning, actually physically separate, down the block, and behind the parking lot, as I mentioned.

So assuming that we have all now convinced you of the link between family planning and maternal and child health, wear it proudly. Be assertive, be proud, be clear. I often find people in family planning sort of say, "Well, you know, that's what I do." Rather, "That's what I do! That has changed the lives of women and therefore men and families in the US."

I close again by reminding you, it has been labeled one of the ten greatest public health advances of the entire 20th century.

[Applause]

CHRISTINE GALAVOTTI: Okay. Well, we did leave just a couple of minutes, we have about five minutes for questions. So if there are any questions, it's really difficult to actually see out there, but there are, they're mics on either side of the room. So do we have any questions? Go ahead.

UNIDENTIFIED SPEAKER: From Chicago. In terms of estimating teen pregnancies, I know that the National Survey for Family Growth does that, but at the state level, in terms of the data, how, you said that the 49 percent estimated from the 15 to 19 group, 49 percent end in birth, right? Could you use teen birth and how does that estimate, you know, how can you use that estimate for pregnancies at the local level and state level?

UNIDENTIFIED SPEAKER: I'll try to answer that question. We are able to actually calculate teen pregnancy rates at the state level. We are able to combine data from vital statistics on births with some data from both the CDC and Guttmacher Institute on the incidence of abortion, which we are able to break down by age as well to calculate teen pregnancy rates.

So in terms of the work that we do, we're able to do that at the national and the state level. I suppose it would be possible to do it at even smaller levels than that, it would require birth data, perhaps at the county level, which is available, certainly. Although

you start getting into issues of residence, because, you know, if somebody's born in one county and lives in another county, that starts getting a little bit too detailed. But certainly we have and actually will within the next few months, be releasing new updated teen pregnancy rates by state and we're even able to break it out, I believe, within teens, 15 to 17 and 18 and 19, for example.

UNIDENTIFIED SPEAKER: I just want to make one quick comment on it. The problem for people who work in programs in government and so forth, is the lag in time. And I don't know what the year will be necessary for the new teen pregnancy data, but years ago we had a man on our board who was the CEO of General Mills. And he said in a board meeting, "Sarah, what's the teen pregnancy rate?" And I said, "Blah, blah, blah." And he said, "Well, what was it last month?" And I said, "Excuse me, that was actually for three-and-a-half years ago." He said, "Well, what is it right now?" I said, "I have no idea." He said, "Then you don't know what you're doing." You know, how can, we're doing these things in current time, you know, working the kind of work Debbie's doing, other things, and yet we can't measure the affects with population-based data until we have it three years later.

And so one of the things we all need to work on collectively is not just more data, but more timely data.

UNIDENTIFIED SPEAKER: And just to say one thing that's happening in that direction, to ring in for the NSFG team, the National Survey of Family Growth, which has just gone

to a continuous format instead of collecting data every seven years, they're collecting data all the time, and will get much more frequent analysis and we'll be able to do regular trend measures for all the variables in the dataset.

UNIDENTIFIED SPEAKER: Thank you all for a great presentation. I had a question about the issue of contraception, effective contraception, and cultural competence. I remember pretty vividly in the '90's when Norplant was disseminated as this great opportunity for a contraception for teens and the reaction from the Baltimore City School System about issues of genocide and, you know, just wondering if you could speak to those issues. And then the other issue related to that, or control, that often our contraception from public service is often measured right, like a teen maybe getting one month's worth of pills, have to come back, get themselves tested and prove they're not pregnant. Could you just talk a bit about those barriers?

UNIDENTIFIED SPEAKER: I'll start, I'm really glad you brought that up. That's been an issue we've been talking a lot in New York City, especially now as we've gotten more involved in providing contraception through school-based health centers. And in our public high schools, we're primarily, the majority of teens served in public high schools in New York City are African-American and Latino youth, that's the majority of the population. And we've been thinking particularly about how we message and talk about what we're doing and why we're promoting contraception. Because we know that there's a long—and Sarah eluded to it and I'm sure you have more to say about—a long history of experimentation and bad, and knowing that there's a lot of suspicion and

mistrust of why this is being promoted and this association with population control. And actually with IUD's we've even learned that some people, we've done focus groups and learned that some people think that IUD's are sterilization.

So I think what we're beginning to do, and actually I'm hoping to talk about it with Sarah more at dinner tonight, is look to talk to community members, to talk to leaders in the community, including leaders in the faith-based communities, around these issues and looking to community spokespeople who can help us talk to these issues in terms of contraception being away to, that's it's not about not having as—it's about having as many children as you want when you are, after you are a teenager. So that you're not increasing the likelihood that you'll live in poverty, not get out of school, and have a life with lots of choices in terms of your career and so on, and making sure that it's not an isolation from life goals for young people, or reducing children born to one culture or race or another, which I think it's so important, that those are still key issues on people's minds.

And your second question was?

UNIDENTIFIED SPEAKER: The controls that we often—

UNIDENTIFIED SPEAKER: Oh, yes, so that has been a huge part of our Quick Guide and our recommendations for providers has been, that's part of what I referred before about with providing withholding of not, that teens need to be, first of all, they don't need

a pelvic exam to get birth control. They don't need them, now we know, there's been new, the latest regulations on pap smears, but even before that, that you don't need a pap smear until you've had sex. It used to be until you've had sex for three years, now it's just until you're 21 period. And so we don't need these barriers for teens, and yes, we can give them many months of contraception so that they don't have, particularly that's with the pill or the ring, so that these don't have these delays. I totally support that. I think we have to really work hard to make that happen.

UNIDENTIFIED SPEAKER: I'm very glad you brought up that issue. I want to give you just one number from the survey we're releasing next week. 44 percent of African-Americans, single young adults, men and women, agree with this statement: "The government is trying to limit blacks and other minority populations by encouraging the use of birth control." For Hispanic young adults, the number is 46.

So that is very important to deal with. I think we all need to think hard about how to deal with it, but I think unless we face up to this and engage in it, we're not going to get where we want to go.

The second thing I would offer is that what Debbie just said about how these words are used is very important. I increasingly don't say anything about pregnancy prevention, I talk about pregnancy planning and timing. Because I think that by saying pregnancy prevention, we have inadvertently suggested that we don't want anybody to be pregnant ever. And as this discussion about the link between family planning and maternal and

child health, this is really about children and families. And so for young people, what we're saying is, or should be saying more is, "We understand the deep human desire and probably your personal desire to have children and families. Not everybody, but the vast majority by public opinion data." So all we're talking about is when. This a very nuanced discussion about timing, it's not about preventing.

UNIDENTIFIED SPEAKER: Okay. There's a lot of questions, so go ahead.

UNIDENTIFIED SPEAKER: Bill (inaudible) we've been very interested in the (inaudible) these questions on the BRFSS that rolled off and now they're optional and we've been paying for it for a while and we're fairly convinced that BRFSS could be really used in powerful ways in this direction and I understand we're supposed to persuade the voting process within BRFSS to make more of this stuff on to BRFSS, but I'm not sure where and how we're going to develop the political leadership with a process and effort to really actually make that happen. So what do we need to do to quit talking about it and then actually make it happen? And I don't think it's so simple as just to tell us go talk to our BRFSS support leaders.

UNIDENTIFIED SPEAKER: Well, it may not be that simple, but we have been, at the CDC level, been trying for a long time, for multiple cycles now, the BRF, to get those family planning questions on the core because when they've been allowed to be optional, only a couple of states have picked them up. We may still have a struggle to get them on the core, but perhaps if you talk up in your state, not just with your BRFSS

coordinator, but if other MCH folks in the state see the value of having that data at the state level, perhaps more states will at least take that as an optional part of their survey.

So we've been doing a lot, we've been trying hard at CDC to move that forward, but we really need the help from the states, people at the state level to say that they want this data and they need this data.

UNIDENTIFIED SPEAKER: I just wanted to encourage people to use, to be creative with the use of your YRBS and your PRAMS data. One of the posters yesterday by someone from my Bureau, Candice (inaudible) I think she already left, is around contraceptive use post-partum and we were able to just look at teens from our PRAMS data. So you can get some really valuable data from your PRAMS data. And from YRBS, we would be happy to share with any state the four questions we added and we got a lot of support from CDC. We came up with questions, there was a lot of back and forth and we were able to add four questions. So not to say that BRFSS isn't important, too, but PRAMS and YRBS are invaluable tools as well to assess what's going on in your states.

UNIDENTIFIED SPEAKER: Thank you for a really great afternoon session. I was just wondering, given the populations you were talking about, I know Ward mentioned at the global level, prevention of HIV, but is there room for preventing sexually transmitted infections somewhere close to the prevention of unintended pregnancies and teen pregnancies? I would love to hear your thoughts on that.

UNIDENTIFIED SPEAKER: Well, I think, you know, Debbie's data shows that they are framing the issue in a more comprehensive way. That, you know, you were talking about the idea of using both condoms and an effective contraceptive method, which is not to apply that condoms are not an effective method, but simply that they may not reach the highest level of contraceptive protection that some of the long-acting, nonreversible methods do. So, you know, maybe the messaging, and you know, we're seeing, I think, an opening up of receptiveness to those long-acting methods among adolescent communities, for example. You know, it used to be that nobody would prescribe an IUD for an adolescent, and now it's a new world.

And so if you're able to combine the effectiveness of the long-acting methods with the STD prevention capabilities of methods like condoms, you have both pieces of the puzzle.

UNIDENTIFIED SPEAKER: Who's next? Oh, go ahead.

UNIDENTIFIED SPEAKER: You know, one of the initiatives I didn't mention is our Bureau of STD is doing a urine screening for Chlamydia and Gonorrhea in the schools and they've created this program where they go in and they go to classroom, they have an assembly of students and they give out brown bags with urine containers in them and everyone gets a brown bag with a urine container and then whoever wants to bring one back with, you know, they all have to bring them back, and about half the students

are doing that and we're testing for Chlamydia and Gonorrhea that way and then they can go on a protected website to get their results. This is actually funded through CDC to some degree.

And what we've done is now look at, okay, let's make sure that when they come for that, they're also getting linked to pregnancy prevention and likewise, when we're talking about pregnancy prevention. And I think it's really making sure that those are integrated, because obviously the risks, the behaviors that lead to both are the same.

UNIDENTIFIED SPEAKER: Great, thank you. Okay. Go ahead. We're a couple minutes over, but if we just take a few more minutes, I think we'll—

UNIDENTIFIED SPEAKER: I work for a state health department, I work a lot with state and local health departments in general and a lot of our activities, the specific activities of things we do is to identify and work with high risk women. One of the legacies we have from the 1980's is the Institute of Medicine report defining pregnancy intendedness. There is no distinction made in that report and in much of our current work about the distinction between mistimed and unwanted pregnancies and the work we've been doing, including a poster that's up today, is that women who have unwanted pregnancies are at much greater risk for a variety of health outcomes than women who have mistimed. And yet, less than 10 percent of women have mistimed and close to half of pregnancies are, I'm sorry, a much smaller number of unwanted and a larger number of mistimed.

It would be useful for family planning people to work with maternal and child health people to keep that distinction clear because it really is valuable to work with the people who have the greatest risk.

UNIDENTIFIED SPEAKER: Well, I couldn't agree with you more. I think all of us who have been interested in the measures, through the NSOG and other systems, have long understood that we wish we could have all sorts of scales and continuums and much more nuanced measures of pregnancy intent. And just to further complicate it, I've often thought that the definition of a fully intended pregnancy should include the man's intent as well as the woman's. And we know that there's quite a bit of dissonance. I mean, if the test was to constitute a fully planned and intended pregnancy, both the man and the woman would have to answer in the affirmative to the classic set of questions. I wonder how many pregnancies would be fully planned, I don't know, but I think it's less than half, for sure.

So I'm sure Larry can comment at great length about the different scales within the NSOG and I think this next round increasingly is going to have more on the extent of mistiming. I think the distinction is going to be drawn between two years and more mistimed. And there's a difference, something is mistimed by 10 years, that's very different than mistimed by 18 months. So even if we separate mistimed from unwanted, within the timing area, we also need to draw some distinctions between a little bit and a lot.

UNIDENTIFIED SPEAKER: I would agree with that, and I think you framed it a good way by saying that it's sort of the legacy of the demographic, the fact that this measure was originally a demographic measure, rather than a public health measure. But it is in fact the case that all these datasets collect information, they ask women mistimed versus unwanted and I think that most people in the field—the point I thought you were going to make is that we need more nuanced measures, which I think we do, and I think there's a pretty broad recognition in the field about that. I think there are also some issues with the fact that people of different ages are more likely to—younger women in particular are likely to report a pregnancy as being unwanted, when in reality it is just mistimed for a long period. So a woman who is 18 or 19 might be saying that her pregnancy was unwanted, but really it should be considered mistimed by, you know, several years and this idea of segregating out the pregnancies that are just mistimed by a short period and lumping those that are mistimed with a longer period with those that are unwanted, I think will take a step toward resolving that problem.

UNIDENTIFIED SPEAKER: Okay. One more question, thanks.

UNIDENTIFIED SPEAKER: Thank you. I was really excited to hear about the data to action in New York City and you talked a lot about increasing access to contraception, but they may be only part of the equation with the other part being motivation to delay childbearing. And I've heard it said that hope is the most effective contraception and so having that hope for the future and having access to economic, educational,

employment opportunities. So what are you doing around, like youth development and especially in light of the economic recession when employment opportunities are decreasing?

UNIDENTIFIED SPEAKER: I wholeheartedly agree with you and I sort of had slides in there about that initially and then I just decided I had to stay really focused, but I agree that we can't act that, just because contraception is available that there's a big deal for a person to actually feel that they want to prevent a pregnancy. And when you look at how young people look at the benefit risk equation, they're looking at much more immediate issues in terms of their decision making. And actually, I think there's a lot of qualitative research that's very helpful in getting a better handle on this.

So what are we doing? I think one, and this is not going to be a full answer because I think there's a lot that we're not doing, that we need to keep looking at. I mean, one idea behind, and this is not primary pregnancy prevention, but one idea in terms of secondary is nurse family partnership, which we know actually, on an individual level, has an impact in helping women and teens get out of poverty. In terms of primary prevention, there's a very recent cross government getting together, where we have people sitting at the table together who are from our local Medicaid office, from criminal justice system, juvenile detention and homeless services, etc., where we're all sitting around and looking at what are the cross-agency ways we can look at this issue that get at some of what you're talking about.

I think there are issues around, and this is not answer as much as, you know, a question to your question is, how can our educational system make these issues part of what their mission is? So that, you know, it can't just be about reading and writing and high stakes tests if young people are coming in and not feeling a sense of hope. And we know there are some models that really, comprehensive teen pregnancy prevention models, and we actually partner with a Carrera model, you know, which it sounded like you might have been thinking of, I don't know, which is a comprehensive program that gets at this issue and it's sort of prohibitive for the city to scale that up.

So I think it's an ongoing question, we have to remember that just offering contraception isn't enough and that there's a whole piece around young people seeing a reason to prevent a pregnancy.

I guess one last thing to say is that as part of an overall poverty initiative that our mayor started, one of the recommendation that came from our agency was service learning. And service learning has been proven by evidence to reduce teen pregnancy, even if you don't mention sex once. And certainly it's better if you do, but that's not where the evidence comes from. And you know, I think a lot of the thinking of why it works is because it gives young people both skills and a sense that with a, working with an adult, that they actually have a contribution to make and that they have a place to play in the community with adult role models who help them see hope for their futures. So we've now, that's been implemented in part of New York City and we're hoping to expand that further.

UNIDENTIFIED SPEAKER: Okay.

UNIDENTIFIED SPEAKER: But there's a lot more to do.

UNIDENTIFIED SPEAKER: Thank you. I'm going to let everyone go and the speakers would probably stay for a few more minutes to answer additional questions. Thank you so much.

[Applause]