"STATE EFFORTS TO REDUCE UNPLANNED PREGNANCY"
CONFERENCE CALL
MONDAY JUNE 23, 2008
AT 2 PM CENTRAL TIME

OPERATOR: This is a recording of the National Campaign to Prevent Teen Pregnancy Teleconference, Monday, June 23, 2008, 3:00 p.m. Eastern Time.

Excuse me everyone, and thank you for your patience while holding. We now have our speakers in conference. Please be aware that each of your lines is in a listen-only mode. At the conclusion of the presentation we will open the floor for questions. At that time instructions will be given if you would like to ask a question. I would now like to turn the conference over to Ms. Sarah Brown. Ms. Brown, you may now begin.

SARAH BROWN: Thank you so much, and welcome to everybody on the call. I hope I don't sound like a frog. I've had a sort of a hoarse throat for several days now, and I think it hasn't gotten better. So I'll just proceed here and hope you can understand me. We're so happy that you're all with us for our national conference call, State Efforts to Reduce Unplanned Pregnancy. We believe that we have over 160 people registered for this call from all over the country from 37 states, from the District of Columbia, Puerto Rico. We have friends from state and local health departments, state coalitions, foundations, advocacy groups, federal and state government, and more, and we're just delighted with this participation. And as you'll hear a little more in a minute we have a really distinguished group of panelists on this call to share with us the work that they've been doing in particular states and communities in the US, and among them is one of our wonderful board members, Dr. Kimberlydawn Wisdom from Michigan who also leads our state and local action advisory group. And I want to personally thank you Dr. Wisdom, and each panelist

who Kristen Tertzakian will introduce in just a minute for all that you're doing on this issue. We're all deeply grateful coast to coast.

Now as some of you know, with a generous grant from the Hewlett Foundation recently the campaign has recently expanded our mission to include preventing unplanned pregnancies, especially among single, young adults in their 20s. I want to assure you that our focus on preventing teen pregnancy also continues, and given the media storm that Jamie Lynn Spears' baby has set off and the Gloucester, Massachusetts story, which gets more confusing every minute, it's very clear that both of these issues have great traction.

In a minute our wonderful Senior Manager of Research, Katy Suellentrop, is going to give you some data about unplanned pregnancy in the US in general, and a little bit of information about why we chose to focus on this group in just a minute, the young adults that is. But I want to remind you just of the few key sort of benchmark numbers. Current data suggests that fully half of all pregnancies in the US, the 6.4 million, half of those are unplanned. That's by the woman's report. I think if we added the man's report it might be more. Of the more than three million unplanned pregnancies in this country, three quarters of the women under 20, excuse me, under 30, and that includes teens of course. More than seven in 10 pregnancies to unmarried women are unplanned, and more than one third of all unplanned pregnancies are single women in their 20s. In other words, it's not just teens. This problem of pregnancy planning is far larger than just teens.

Now pregnancy planning, which includes pregnancy prevention of course, has obvious benefits. And given that well over 90% of Americans, I think it's something like 98% of Americans, have practiced family planning at one time or another, it's clear that its value is widely appreciated. But I want you to know that even so, typical campaign; we're busy assembling data about the value of pregnancy planning and the consequences of unplanned pregnancy for any who might doubt this most basic fundamental concept. As

you know, a growing body of research shows that unplanned pregnancy is associated with a number of important consequences, including late entry into prenatal care, missed opportunities therefore, among other things, for preconception care, and unplanned pregnancy of course lies behind the vast majority of abortions. And for the children born as the result of an unplanned, especially an unwanted pregnancy, there are elevated risks of neglect, behavioral and cognitive (inaudible), and of course the economic hardship that often surrounds these births too, particularly because so many are just single women.

Now over the past year many of us at the Campaign, and many of our colleagues on the board and in our advisory group has been traveling around the country to find out what people are saying about unplanned pregnancy; about how big a problem this is for providers, for people on the ground, how people understand this problem, and what they're doing to address it at the state and community level. I mean if you think about it for our first 10 years we focused pretty intensely and exclusively on teens, and we've been spending a lot of time trying to learn about how these issues play out in the older decades of life. It's been fascinating, and many of you on this call, we've met or got to know better on the learning tour, and I just want to extend again our appreciation to you for all that you've shared with us about your experiences and your thoughts and your action plans.

All of the panelists, and many of you joining today are doing terrific work to address this larger problem of unintended and unplanned pregnancy every day. Now we highlighted a few examples of these efforts at our facts sheet, which I think we e-mailed to all the people who registered for this call, and I hope you had a chance to look at it. We are constantly impressed by the innovative ways in which groups all over the country are reaching millions of individuals, women and men, with direct services and information that encourage careful attention to pregnancy planning and family formation.

Now my final comment is just to remind you all, I think most of you know it, but the National Campaign has recently posted a grant announcement on our website that's to support a few state and local groups to develop initiatives on unplanned pregnancy, or to take nascent ones maybe to the next level. And we certainly hope that many of you are planning to apply. The deadline is only a week from today, June 30th at 4 p.m. But you know it's still a week, maybe if this is news to you, and we really welcome new ideas and diversity of approaches.

So with that let me turn it over to Katy Suellentrop who's going to do the numbers for us in more depth. And again, thanks to you all and welcome to this call.

KATY SUELLENTROP: Thank you Sarah. Good afternoon everyone. Thank you so much for taking time out of your busy day to join us on this conference call to talk more about reducing unplanned pregnancy within state and local communities. I have the fascinating job to provide you with a bit more data on unplanned pregnancy in the United States. And I realize in the absence of figures and something to look at it's sometimes challenging to keep all the numbers straight, so I promise to be brief. And I would encourage you to take a look at our website. We have a lot more information about unplanned pregnancy on there, and we have several fact sheets specifically focused on unplanned pregnancy among unmarried women in their 20s. We also have a state specific data section on our website. I don't know if you've checked out the new state specific data section. We've revamped it a little bit. It includes a ton of information about teen pregnancy, but it also includes statistics about unplanned pregnancy by state for those states that have those numbers available. And it's generally the PRAMS states, and some information about contraceptive use among women not trying to get pregnant, and a little bit of information about Medicaid Family Planning

Waiver. So we are really trying to get information at the state level, and I would encourage you to check that out, and as it becomes available we'll do our best to add to that.

As Sarah mentioned just a moment ago, half of all pregnancies in the United States are unplanned, which is more than three million pregnancies each year. Women age 20 to 29 account for 55% of unplanned pregnancies, and experience more than one and a half million unplanned pregnancies a year. To put it into context, an overwhelming majority of pregnancies to teens are unplanned, and preventing teen pregnancy, as we mentioned earlier, remains an important goal. However, women in their 20s actually account for a majority of all unplanned pregnancies, so the teen slice of the pie is a little bit smaller. And it's important to consider these unplanned pregnancies to women in their 20s as well. In addition, while the teen pregnancy rate has decreased in the last decade, at least through 2004, which is the latest data that we have available, the rate of unplanned pregnancy among women in their 20s was essentially unchanged between 1994 and 2001. And it even increased slightly among those women age 25 to 29.

Approximately two thirds of all unplanned pregnancies occur to unmarried women, and in 2001 more than one million unplanned pregnancies occurred to unmarried women age 20 to 29. Just to give you a little bit more of a portrait of the unplanned pregnancies among unmarried women in their 20s, I'll share a few more numbers with you, and I know this is a lot of numbers. These are all available in a fact sheet called *Unplanned Pregnancies Among 20-Somethings: The Full Story*. Forty percent of all unplanned pregnancies to unmarried 20-somethings occur to women with at least some college education, and 35% occur to women with an income level equal to or above 200% of the federal poverty threshold. Furthermore, 44% of unplanned pregnancies to unmarried women in their 20s occur to non-Hispanic white women; 32% occur to non-Hispanic black women; and 19% occur to Hispanic women. And again we have some figures that go with

those numbers that paint a nice portrait of what unplanned pregnancy, what that looks like among this population.

Unfortunately we don't have as much data about unplanned pregnancy reported by men in the United States, but we do have a little bit from the National Survey of Family Growth. And we recently released a fact sheet with information based on these reports for men. We're hoping to release more in the coming months. Among all men 35% of births were reported to be the result of an unplanned pregnancy, and in addition more than half of births fathered by men aged 20 to 24 are unplanned. So most, all of the data for men are going to be based on the births, not on the pregnancy, just to give you an idea.

And some of the key consequences, as Sarah mentioned before, of unplanned pregnancy include the reduced opportunity to pursue preconception care, late entry into prenatal care, infant mortality, and low birth rates. Children born from unplanned, and especially unwanted pregnancies are also at greater risk of child abuse and neglect for a mother to child attachment, cognitive and physical deficits and more. We also recently released a (inaudible) research brief focused on the family consequences of unplanned pregnancies that result in a live birth. The report focuses on the family environment and the relationship between parents, and find that parents having a birth which followed an unplanned pregnancy are significantly less likely to be in a stable relationship, and experience more relationship conflict and less relationship happiness than those that have had a birth following a planned pregnancy. More specifically among mothers having an unplanned pregnancy who are single when they become pregnant, more than half remain single by the time their child is two years old. So we've, I think this data is well described when we talk about teen pregnancies and sometimes teens say that a pregnancy or a birth will cement that relationship, and we know from the data that that doesn't seem to be the case. And it also doesn't seem to be the case among older women having unplanned

pregnancies. Among co-habiting couples who experience an unplanned pregnancy and birth, one quarter will break up within two years of the birth, 42% will remain cohabiting, and only about one third will end up getting married. Again, as Sarah mentioned, unplanned pregnancies are also at the root of virtually all abortions in the United States, which totaled 1.2 million in 2005.

The National Campaign has had a great opportunity to learn more about what the general public believes. We've done some polling research and we found that Americans strongly support the goal of reducing unplanned pregnancies in the United States. However, most Americans underestimate the extent of the unplanned pregnancy problem. In fact, only one in five Americans know that women in their 20s have the largest number of unplanned pregnancies. Most people believe that unplanned pregnancy is primarily a teen problem, not surprising considering all the press, especially the press that has been generated lately. However, when it comes to pregnancy planning, 20 years old does not appear to be a magical age, and it remains the case that unplanned pregnancy is far too common among women that are over, that are out of their teens as well.

And with that I'll turn it over to Kristen who's going to introduce our panel. And again, please feel free to e-mail or call if you have any questions about the data.

KRISTEN TERTZAKIAN: Well good afternoon everyone. This is Kristen Tertzakian from the National Campaign, and we are fortunate to have six expert speakers that will share their success stories and innovations to reduce unplanned pregnancy. In order to use our time efficiently we will ask each of our panelists a question or two, and then we'll open up the lines for our participants to make comments and ask questions. I wanted to just take a brief minute to thank Jennifer Drake, the National Campaign's outreach associate who organized this call today, and she also authored the fact sheet highlighting state and local

efforts to reduce unplanned pregnancy among adults that Sarah mentioned earlier. You all have a copy of the fact sheet in addition to the materials that each speaker provided, which goes into more depth on their program.

So let me briefly introduce our speakers. We have Claire Brindis, who is the Interim Director of the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco. Claire is a longtime friend of the National Campaign, and has served on several of our advisory groups. Currently she is a member of our Latino Initiative Advisory Group. We also have Deborah Harris, who is the Women's Health Coordinator at the Virginia Department of Health, and she oversees several public health initiatives, including teen and unplanned pregnancy prevention programs for the state of Virginia. We also have Larry Humbert, who's the Executive Director of the Indiana Perinatal Network, and he is a member of the National Campaign's State and Local Action Advisory Group. We're very lucky to have Christie Vilsack today. She's the Executive Director of the Iowa Initiative to Reduce Unintended Pregnancies. Christie is also the former First Lady of Iowa. Also hailing from California we have Laurie Weaver, who is the Chief of the Office of Family Planning at the California Department of Public Health. She oversees California's multifaceted pregnancy prevention program in addition to the state's family planning program. She's also a member of the Campaign's State and Local Action Advisory Group. And last, but not least, we have Dr. Kimberlydawn Wisdom, who wears several hats. She is the Surgeon General for the state of Michigan, and the Vice President of Community Health Education and Wellness at the Henry Ford Health System. Kimberlydawn chairs the National Campaign State and Local Action Advisory Group, as Sarah mentioned. She's also a member of our board of directors. So thank you to all of our speakers for joining the call today.

And without further ado we'll go into the questions for our panelists, and we'll start off with Iowa. Iowa's initiative aims to reduce unintended pregnancies by expanding knowledge about pregnancy prevention, increasing access to contraception, and encouraging state investment in this issue. Now the task of raising awareness and changing attitudes and social norms is a formidable one. Christie, what specific strategies are you employing across Iowa to achieve this goal?

CHRISTIE VILSACK: Well first of all thanks for inviting me, and I think our program is probably the youngest of all that are here today. We are new, and the advent of the Iowa Initiative happened in January, so I'm not sure that we have successes to report yet, but certainly progress. And it might be interesting to the people on the call to hear how we're getting started. I thought I would speak briefly about three areas that we are really concentrating on: networking, research, and public outreach, in terms of changing social norms. And really we realize that in order to change the attitudes and the views of the young adult women whom we're focusing on we have to do that among ourselves.

So we start off with networking among ourselves. We are a huge coalition of family planning entities in Iowa, and so one of the first things that we decided to do is that we actually needed to get on the phone every week with leaders who had been working in this area for years and years and actually get on the phone and talk with one another about several different areas. First of all it may seem like a simple thing, but we, the five partners at the state level basically talk about what's been happening at conferences they've attended, what's happening in the legislature during the legislative session, what's happening with Congress, what's happening in our own professional lives each week to see how we can support each other. And as I said, that may seem like a small thing, but we

have realized each week that our calls, which we thought, might be 10 or 15 minutes have been extended and expanded, and we really are talking for the first time for many of us.

We've also organized meetings to bring partners and providers to Des Moines so that we can all share information together. We recently had Larry Finer from the Guttmacher Institute come to talk to us about how numbers are generated. We're expecting Sarah Brown in the fall, and we're excited about that. We also for the first time last week got the department heads from our Department of Health, our Department of Human Services, and Department of Education together to talk about sexuality education for the very first time, and they agreed to start meeting several times a year, and to create some coalitions at lower levels in state government as well because we realized as we started looking at what's actually being taught in schools in Iowa that nobody knows for sure, and that the people in the Department of Health and the Department of Human Services are sometimes working at cross purposes. And we have a new bill in Iowa that directs, that mandates us to teach medically correct information, so we want to make sure that we start that conversation, and that we do it at the proper level and then work it down through state government.

We also are meeting with leaders of other organizations that support family planning; organizations that support at-risk adolescents, school nurses, the Commission on the Status of Women. We're looking for all the non-traditional partners we can find, and we're trying to bring these people together to network with one another so that we change our own idea of ourselves as professionals dealing with this issue. And then we're going out to Main Street, and we have what we call a Let's Talk About It campaign. And our goal is really to make it acceptable to talk about sexuality issues on Main Street, and in forums, and in places where people might've been uncomfortable to do that in the past. As First Lady I had a remarkable opportunity to travel around the state and create relationships with people at the civic level,

and so I'm taking advantage of that and I'm going back. And I used to talk about literacy and libraries and education, and now I'm talking about sex to Rotarians and Kiwaniannes and anybody who will listen. And it's been really interesting as we try to get people to realize that it doesn't matter whether you're at a football game or a church or a donut or in a coffee shop that these are issues that affect us all, and they're really affecting the fabric of our communities and our families. And so we're out there talking to the mainstream organizations, those that I just mentioned, but I'm also looking at some other organizations, especially women's organizations, PEOs, Trites (sp?), business and professional women, all of those traditional women's organizations and I'm trying to engage them at the state level, we're trying to engage them at the state level in conversations about what we're teaching in schools. What is access, what access is available in our individual communities so that we can attack this issue at the local level?

We're also trying to make mainstream events like clinic openings, mainstream Chamber of Commerce events. We're inviting the mayor, the county board of supervisors, the Chamber of Commerce in their ambassador jackets. We're trying to make opening a family planning clinic on Main Street in Small Town, Iowa as normal and as mainstream as opening the dance studio. Literally we opened one recently right next to a dance studio where nine-year-old young women are learning to be physically and mentally and emotionally strong and healthy, and later in their lives that family planning clinic next door will help them do the same. We opened a family planning clinic and invited all of those people to a hospital in Small Town, Iowa where the new family planning clinic is located between the wellness center and the nursing home. So it's those things that seem very small, but it's trying to change behaviors and change norms to help people understand that it's okay. This is economic development. It's Main Street Iowa and these are issues that we should all be talking about.

And then we've gotten some help from one of our larger newspapers, Lee Enterprises in the Quad-City has embraced this issue, and they have offered to partner with us to sponsor roundtables to talk about these issues at the community level in all of the communities where they have newspapers. So we're going to be doing that in the fall. We're also sitting down as we travel around the state talking to mayors and city council members and county commissioners and county boards of supervisors to tell them and suggest that there are ways that they can engage citizens in conversation, just in regular, everyday conversation to make this a mainstream issue.

And we're also encouraging in all of these venues, encouraging parents and grandparents to talk to their children. As awkward as it seems, as hard as it may be, that it's really making the effort, and really engaging the community to find out what their children know before they leave home to go to college.

So then along with that, and more specifically aimed at our 18 to 30-year-olds, part of our mission is to change behaviors and change social norms among 18 to 30-year-olds, and really engage them in a conversation about long-acting, reversible contraceptives. So we have a pretty extensive social marketing program research component to the initiative, and this is led by Mary Losch at the University of Northern Iowa and her team of researchers at the University of Northern Iowa and the University of Alabama, and they basically are going to be really collecting data and focusing on these five programs. One of them will be engaging hairstylists in 10 of our counties and keeping track of the data. We're going to be training the hairstylists, we're going to be helping them help their customers and clients, especially in the population of 18 to 30-year-olds, but also their mothers and grandmothers to understand the importance of long-acting, reversible contraceptives; helping them understand how to find it, where to get it, find out more information about it. We're also going to be engaging pharmacists across the state of Iowa and helping them, train them,

and helping them understand that it's really important to get over-the-counter pharmaceuticals out there in a place like next to the Motrin where people can access it and where they're not embarrassed to have to ask for it. And also help them in their counseling role as well. We also are creating Latino radio dramas, which we understand have been effective with cardiovascular disease and diabetes, and introducing some of the issues of long-acting, reversible contraceptives and unintended pregnancies on our Latino radio stations here in Iowa. We're also going to be doing an extensive social marketing campaign with college students, offering free condoms, engaging students in local events and bars and any place that we can find them and get a hold of them on college campuses. As well as a statewide social marketing campaign using MySpace, Facebook, the print media as well.

So our goal in the end is to assure that tens of thousands of women, excuse me, who don't have access in Iowa to long-acting, reversible contraceptives and other means of birth control can find out about it and have it. But in order to sustain network, we have to change the way parents and grandparents see the issue. We have to change the way community leaders see the issue, as well as engaging our 18 to 30-year-olds in this, in these prevention efforts so that we can encourage people and encourage voters to encourage their legislators that it's important to invest public money now so that we don't have to do it later.

Thanks a lot.

KRISTEN TERTZAKIAN: Thank you so much Christie. I mean that's just amazing how much you've been able to accomplish in less than six months.

CHRISTIE VILSACK: Well I just touched on a few things, but I didn't want to take more than my time. So I'd be glad to answer questions later, and I apologize if I talked too fast, but I had a lot that I wanted to get out in a short amount of time.

KRISTEN TERTZAKIAN: Yeah –

CHRISTIE VILSACK: But I'm excited to listen to what everybody else has to say because it's amazing what's going on out there.

KRISTEN TERTZAKIAN: It is, and I mean I think it's amazing how you've managed to reach so many different partners from families, policymakers, state government, media, communities, even hairstylists. And your messages will have a far reach into Iowa, and we really look forward to learning more from your initiatives as the months and years go on. So thank you so much for being with us today.

CHRISTIE VILSACK: Thanks.

KRISTEN TERTZAKIAN: Well let's turn now to California, to Claire and Laurie. California is one of 26 states that have been granted Medicaid Family Planning Waivers from the federal government to expand family planning services to individuals who lack coverage or would otherwise be ineligible to receive them through Medicaid. California's waiver program called Family PACT is one of the most comprehensive and successful waiver programs in our country. Like other states, California has demonstrated that expanding access to family planning services is cost effective, and can save the federal and state governments millions of dollars by preventing unplanned pregnancies for which Medicaid, or what California calls

Medi-Cal, would otherwise pay for by providing prenatal and maternity care. So this is a two-part question for Laurie and Claire. Can you briefly describe Family PACT, and also share some stories, some of the recent research you worked on to evaluate the cost effectiveness of the program?

LAURIE WEAVER: Hi. Good afternoon. This is Laurie Weaver. I'm going to start first with a brief overview about the Family PACT program for those of you that are not familiar with it, and then Claire as our evaluator is going to discuss with you some of our recent research and some of the studies that we're currently participating in to evaluate our cost effectiveness.

California's waiver was originally started, or California Family PACT program originally began in 1996 with support of our then governor Pete Wilson, and it was a state only program at that time. Subsequently we filed for a Medicaid Family Planning Waiver as you mentioned, and that was approved by, our application was approved by the federal government in 1999. We have virtually doubled the size of the program since the inception of the waiver services, and in last year served approximately 1.7 million low-income men, women, and adolescents in the state of California. We are fortunate to have a public and a private provider network that serves our client population throughout the state. And for the most part these public and private providers are located in areas with relatively high population. We have both county government and community clinics participate in the program, as well as individual private providers. In order to be Family PACT providers we ask that our provider community be a Medi-Cal provider in good standing so that they are familiar with the billing requirement for our state Medi-Cal program, and some of the other educational opportunities available to them through the state program. So it's been a very, very effective partnership that has allowed the state to expand very, very quickly.

As the current caretaker for this program, it's exciting to see the number of people that we're serving that are benefiting from access to family planning services throughout their communities. We had an extensive media campaign that was unfortunately canceled when we were in tough budgetary times in 2003, 2004. We still have a good effect from that media campaign and are still receiving a number of calls to our 1-800 line that provides information about the Family PACT program in seven different languages, and provides the caller to access the location of a Family PACT provider using a zip code locator system on the telephone. There is also information about birth control methods and sexually transmitted infections. And that line still receives hundreds of thousands of calls every month, and has been instrumental in helping keep our Family PACT providers and clients with easy access to each other.

At this point I'm going to let Claire talk a little bit about some of the recent research. We have a large evaluation contract with UCSF, and it has given us the opportunity to look at many, many interesting aspects of family planning services within the state of California. And I'm sure you'll be interested in some of those.

CLAIRE BRINDIS: Thanks Laurie, and good morning and good afternoon to everyone. And thanks again to the National Campaign for including us today in this very important meeting. And I want to applaud our neighbors in Iowa who've gone through so much pain in the last few months around weather that they have made such a strong commitment to family planning.

It's my pleasure to represent a wonderful team of multidisciplinary professionals from health economists and demographers to anthropologists and sociologists who in partnership with the state have actually been doing a lot of work around monitoring the programs as well as the evaluation of the program. And as Laurie, who is extremely committed to evaluation,

has just shared with you, the program has been very successful in reaching many, many women and men, as well as adolescents throughout the state. I think it's really important to point out that in our studies we've used different methods. We've used both claims data analysis as well as client exit interviews to learn about people's satisfactions with the program, as well as medical record reviews, provider surveys. We've done telephone access surveys where we actually pretend that we're patients, having different scripts to see how difficult or easy it is to be able to access care. And we've also been analyzing fertility trends, and have recently conducted a qualitative study comparing Latinas who have, who are child bearing during adolescence as compared to Latinas who delay child bearing into their 20s.

In the few minutes I have today I just want to highlight a couple of things. One is that the program, because it is so culturally sensitive and responsive to the demographic profile of our large state, has really shown that if you do implement services that are ethnically and culturally and linguistically appropriate both in private doctors offices as well as in public clinics, that a very diverse population will access care. So about 64% of our patients are Latina or Latino. And the rest of the group are represented by African American at 6%, Asian and Filipino at 7%, smaller numbers for Native Americans, and about 20% for white. As a Latina woman I think it's really important to point out that sometimes we have stereotype images of clients who will or will not accept services, and I think the point of this evaluation data is that clearly when services are appropriate and of high quality people will seek care.

A second area of our studies have been really to look at what are the number of pregnancies that are averted by the availability of family planning services through this network of providers in most counties of our state. And the studies that we've conducted have demonstrated that over 200,000 pregnancies have been averted to female clients.

And the key here is in fact wherever you may be on the continuum of support for family planning, a key outcome here is that a number of these pregnancies would've ended up as an abortion. Approximately 78,000 of these pregnancies would've ended up in abortion as compared to about 94,000 that ended up in an unintended birth, about 30,000 miscarriages, and about 2,000 ectopic pregnancies. So as Sarah Brown and her colleagues at National Campaign point out to you the limitations and the implications of the human decisions that are related to these very important topics, it is important to have data to be able to substantiate these from the state perspective as well as from the national perspective.

A third area that we have really focused on is how do these pregnancies and the fact that the program has been able to avert the pregnancies from happening really impact the cost to the state as well as the cost to the federal government, let alone social and personal costs. And so there's been an extensive review of what were the averted costs, and what is the cost benefit ratio of investing in these kinds of programs. And we've been able to show that with the types of contraceptives that women and men receive following their visit as compared to the contraceptives that they were or were not using, or the effectiveness of those contraceptives that they were using or not using before they came into the clinic, that the program has actually been able to be very cost effective. For every pregnancy that the program has helped to avert it has saved approximately $5400 up to two years after pregnancy. And this, given the number of pregnancies, would have, has saved the public sector over a billion dollars up to two years following this averted pregnancy. And if you, a billion dollars sometimes may be hard to translate into our day-to-day language, so we've translated so that for every dollar spent Family PACT saves $2.76 up to two years after pregnancy. And let me comment this is a very conservative argument given that we know that the long-term costs of an unintended pregnancy go far beyond the first two years of that child's life.

We've also looked at the cost savings as it pertains to different contraceptive methods, as well as one final study. We've shown that giving women access to (inaudible) cycles and more extensive numbers of cycles, 13 months of cycle, of family planning control pills is cost effective as compared to many programs who have a policy of only giving one-month or three-month cycles to women. In fact, women are conscientiously using these contraceptive methods, and it costs money both to the site itself as well as to the woman and to society in general in terms of the fact that these additional cycles of birth control pills do help avert cost.

I'll stop there and look forward to hearing other comments.

KRISTEN TERTZAKIAN: Well Laurie and Claire, thank you so much. And you know you can't see us, but a bunch of us from the National Campaign are sitting around the phone, and as you're mentioning these numbers, the number of people you're serving combined with the cost savings, all of our eyes are lighting up. And it's just so amazing what you're both doing out there in California. So thank you so much.

Let's turn now to Michigan. In Michigan Governor Granholm elevated unintended pregnancy as the priority issue by releasing the Governor's Blueprint for Reducing Unintended Pregnancies in 2005. This effort is led by the surgeon general, Dr. Kimberlydawn Wisdom, and her team at the Michigan Department of Community Health. One of the provisions in the Blueprint was creating a clinical guideline for all healthcare providers to use when seeing a patient, woman or man, 18 years or older in order to engage the broader healthcare community in pregnancy planning and prevention. Kimberlydawn, can you describe the guideline and talk a little about the process to create it, and any results you've seen to date?

DR. KIMBERLYDAWN WISDOM: I would be delighted to do that. But first I'm just pleased to be a part of this esteemed panel, and so delighted that the National Campaign asked me to participate in this panel discussion. First I'd like to just say how fortunate Michigan has been to have a governor that's been so committed to the maternal and child health issues across the board. And she has demonstrated her commitment by establishing the Governor's Blueprint to Prevent Unintended Pregnancy. So let me just give just a quick overview of the three aspects of the Blueprint, and then I'm going to delve into the third item in a little more detail, which entails the actual clinical guideline that has been previously mentioned.

The Blueprint, one aspect of it is to increase public knowledge and provide skills to avoid unintended pregnancy. And an effort called Talk Early, Talk Often sounds somewhat like the effort that Iowa was referring to to engage parents around discussions with their middle-aged school children around abstinence and behaviors. Secondly, we also have an initiative to improve family planning services, to increase family planning services to low-income women, and we call that Plan First. It sounds similar to the Family PACT in California, through the Medicaid 1115a Waiver. And thirdly, the area that I'm going to focus on mostly as part of the Governor's Blueprint is engaging Michigan's healthcare community in a statewide effort to reduce Michigan's unintended pregnancy rate. And the approach is then very much in the healthcare settings to not miss any opportunity to talk with the woman about her intentions to become pregnant or to avoid a pregnancy.

In September of 2006, well the Governor's Blueprint was launched 2004/2005, and in 2006 a 40-member Michigan provider task force, a blue ribbon task force of experts in women's health volunteered their time, over a year's period, to draft a new clinical guideline, which was subsequently approved by our Michigan Quality Improvement Consortium, what we call MQIC. And I'll give you a little bit more detail about that, but that's the sanctioning

body of clinical guidelines in the state. The panel was chaired by Dr. Petroff, who is a medical officer at one of our health plans, and also chair of the Medical Director's Committee for the Michigan Association of Health Plans. So we had his involvement. The 40-member group was very multidisciplinary; it included physicians, social workers, nurses, and nurse practitioners, health plans as I mentioned, state and local public health, universities and medical schools, school based health centers, and Title X clinics. And they all met under the auspices of having a year to develop this guideline that would be part of the Governor's Blueprint for Preventing Unintended Pregnancies.

The task force met about every other month for that year, and there was a dissemination in communication portion of the task force, and there was also the clinical guideline development group. So we were split into two groups to move forward in developing the guideline, and as well as communicating it. MQIC, the Michigan Quality Improvement Consortium that I alluded to earlier, their membership represents health plans that cover about six million Michigan residents. And Michigan currently has about 10 million residents. MQIC also has representatives from physicians' organizations, and they've issued guidelines for clinicians on preventing unintended pregnancies. They were the one that sanctioned the guideline, but they've also issued many other types of guidelines since their inception in 1999; guidelines on asthma, diabetes, depression, heart failure, so forth and so on. And typically they're just one page, one sided, one page guidelines to make it very easy for clinicians to practice in an evidence based manner.

The actual guideline, which is actually on the website that I'll give you that URL in a moment, was developed primarily for adults 18 years of age and older. And it gives talking points for doctors and other healthcare providers when counseling patients on their plans to prevent unplanned or unwanted pregnancies. And it is recommended that clinicians conduct an assessment and discuss pregnancies during and certainly a patient's annual

health exam, but also as frequently as possible in terms of at the physician's discretion, but with the notion of not missing any opportunities to talk about unwanted or unplanned pregnancies, even in emergency room setting, and my specialty's emergency medicine. So we wanted to make it simple, and the ability to utilize the guideline, so simple that it would be utilized on a regular basis.

The guideline was built from several evidence based sources, and primarily we used the report that came out from the Centers for Disease Control, their recommendation that came out in the Morbidity and Mortality Weekly Review in 2006. And also part of the guideline, this is the area that the communications dissemination group developed, there was a fact sheet to provide to patients as well. And the fact sheet, we have the female fact sheet online. The male fact sheet is still undergoing a little bit more in terms of development. But the fact sheets are designed in a way so that they were tested for health literacy and as well as overall focus group tested to ensure that they were appropriate for the audience, for the target audience. All the materials that I've mentioned are free, downloadable, and printable from the website at michigan.gov/mdch for Michigan Department of Community Health. Scroll down, look for the surgeon general link, and you'll see all of the materials that we've developed to date on that link. And we will be adding some more materials to that link as soon as they complete the, go through the final review process.

KRISTEN TERTZAKIAN: Thank you so much Kimberlydawn. You know as far as we're aware Michigan is the first state to create such a clinical guideline for all healthcare providers to reduce unintended pregnancy, and we really hope other states follow your lead. So thank you very much.

DR. KIMBERLYDAWN WISDOM: You're very welcome.

KRISTEN TERTZAKIAN: Well next door from Michigan is Indiana. And Larry Humbert and his team at the Indiana Perinatal Network are leading efforts to reduce unplanned pregnancy and issued a comprehensive, common ground call to action report titled Best Intentions. This was released in 2007. The Indiana Perinatal Network encouraged a wide range of sectors to work together to increase planned and properly spaced pregnancies in Indiana over the next 10 years, with specific recommendations to achieve this goal. So this question is for Larry. Can you describe how you brought together such a diverse group of people, some of whom had not been focusing on this issue, and build common ground in the state?

LARRY HUMBERT: Sure, I'd be happy to do that. I think in the way of a little bit of background, I think the reason it was kind of easy for us to do this is this really matches up very closely to what our mission is. We are a statewide not for profit organization that has a long history of sort of being a neutral forum here in the state of Indiana to develop consensus around some of the more complicated perinatal issues. And usually when we started to look at consensus the first thing we do is to develop a consensus statement or a call to action document. So we had about a 10-year history of doing things like this for issues like substance use during pregnancy, postpartum depression, breastfeeding, safety practices, so this is kind of a natural thing for us to do. And I think many people in the state look for us to sort of serve as this convening, neutral, collaborative body for this.

I think we also were able to take advantage of some good timing on this. We also, right about the time that this document was being done, were working on a Family Planning Waiver that we still are working on. But again, it provided some strong impetus and

momentum for this. We had also as part of another national project we were involved in had just done some pretty extensive quantitative research that particularly with the Medicaid population here in the Indianapolis area, and found an unintended pregnancy rate with these women to be about 75%. So we had a couple of things that sort of got us going along with the, with sort of our history and mission of being a consensus and convener around issues like this.

I think the other thing that we did is we were very clear with the advisory group, people who worked with us on this, really what their expectations were, and wanted to be very clear that we really were interested in doing a consensus statement that really focused on common ground solutions. I think we wanted to hear and respect people's opinion and input, and I think we were very clear as to what we wanted to have them produce. I think from our perspective at the outset, by and large, even the folks that might not have been as enmeshed in the issue as you would've thought, I think by and large these people really kind of got it, and I think that they kind of understood what the potential implications were of this issue. And I think they also understood that this is very much of an issue not just for teenagers. And I think they also were kind of tired of some of the divisiveness that had gone on in our state, and that sometimes continues to go on in our state around this pretty delicate issue. So somebody wanting to bring together a balanced group of people to come up with a more balanced, middle of the road statement about it, I think that people were hungry for that kind of approach.

KRISTEN TERTZAKIAN: Thank you so much Larry. And you have a wonderful way of communicating how (sp?) everyone had the chance to read the report, which Jennifer sent out in the e-mail to all the call participants.

Well last but not least we'll head over to Virginia where providers everywhere are constantly struggling with the challenge of engaging men in pregnancy prevention and family planning, both in clinical settings, and more broadly. Deborah through your leadership the 11 grantees funded by Virginia's Partners in Prevention program are reaching large numbers of men, and you have plans to increase the number of men served in the coming year. Can you explain how you have achieved this goal?

DEBORAH HARRIS: Yes. First of all, thank you so much for inviting me to present. It's such an important topic. Just a little bit of history about my program is that we actually began in 1998. And my goal for Partners, or the goal of the Partners in Prevention program is to decrease non-marital birth. We are funded through the Temporary Assistance to Needy Families block grant, and as many may be aware that a few years back there was incentives to decrease out of wedlock birth or non-marital birth, and that's where our funding originally came from. In working with this population talking about getting married before you had children wasn't something that was well received. However, if we back the bus up a little bit and talked about, you know, preventing an unplanned pregnancy as the National Campaign has stated, you know, 70% of the issue may be addressed by focusing on unplanned pregnancy.

So in 2004 we actually started requiring the sites rather than doing health promotion campaigns and handing out information about the impact of non-marital birth, we actually had them start doing direct services to the population to promote sustained behavior change. And so the first year in 2004/2005 there were only 13% of the participants were male. And many of them were women, and you know, it was easy. They were focusing on going to the clinic and giving information out about, you know, how to reduce your risk of a non-marital birth. And again many of the men didn't want to participate because we talked

about non-marital birth. So in 2005 the sites were challenged with increasing male involvement, and they increased a little bit, but not a lot. So in 2006 they were given a directive to increase male involvement and they got to 37%. And we just looked at the 2007 numbers and we're actually at 51% male and 49% women.

How we got to get to focusing on more men is we went to areas where men actually hang out and you know they're not going to the doctor. We actually started sponsoring sports leagues, and in order to participate in the sports leagues such as flag football or basketball, or you know, sports programs, men had to actually participate in the Partners in Prevention message. We actually didn't focus on getting married before having children; we actually focused on what their role was in preventing an unplanned pregnancy. And in order to continue participating in these programs the men actually had to recruit or become a health advisor. We're very excited. I was actually very shocked to see that we're now at 51% male. Another way that we did this is the site saw that when they just had group dynamics or group programs and they just, you know, offered an intervention that it was by chance that it was male and female. But if they made specific male interventions like the flag football that men were more, you know, willing to come to these. Another place that we actually target is at the probation, parole, or with prisons, you know three months before release. We're actually focusing on male responsibility, decrease of high-risk sexual behaviors, talking about preventing an unplanned pregnancy. And we're closing the loop because if these men, you know, when they are released from prison and they meet certain criteria like they develop a resume and they get a job interview they can come back to some of these programs and we'll buy them their first suit.

So I mean we, the way that we're targeting men is we're looking at services that enable them, and we're also looking at venues other than the providers' offices. And I am very excited about the new campaign that we've started. If any of you are interested, you

can visit our website at www.vahealth.org/pip, and click on public service announcement. It's actually called Have a Plan, and we actually are targeting men. We have gender specific radio PSAs for men and women and the roles that each of them can take in reducing their own respective risk of an unplanned pregnancy.

KRISTEN TERTZAKIAN: Thank you so much Deborah. Again we're sitting around the phone here, and when you said that for 2007 51% of the clients were male, I mean that's just amazing.

DEBORAH HARRIS: We were shocked with those numbers. But these sites, I'm telling you, they really, once they realized that they could very easily develop an intervention for men separate from what they're doing, and it was actually less work than having them combined, they actually say it's easier to get the men. And in March we have two sites competing against each other, March Madness in basketball, and the only way that these men could participate is if they're the highest recruiters for the program.

KRISTEN TERTZAKIAN: Well that's really innovative, and it's different than what traditional family planning and reproductive health programs typically do. And so we really thank you for being on the call today and talking about Partners in Prevention.

Well now we will open up the lines for questions and comments, so I'll turn it over to our operator Ashley. But please feel free to address a question to the panel as a whole, or to individual speakers. And we also welcome your comments on reducing unplanned pregnancy among young adults from your own state or community as well.

OPERATOR: At this time we will open the floor for questions. If you would like to ask a question, please press the star key followed by the one key on your touchtone phone now. Questions will be taken in the order in which they are received. If at any time you would like to remove yourself from the questioning cue, press star, two. Again, that's star, one to ask a question. And our first question comes from Chris Mesler.

CHRIS MESLER: Hi, it's Chris Mesler in New York State. I just wanted to congratulate Virginia. It seems like you're hitting the underlying issue that always seems to float up to the surface, and that's the economic issues here. And I really wanted to commend you for what you're doing working with young males and really working with interview skills, and the fact that if they've attended that you'll buy them their interview suit. I think that's incredible. And I just wanted to congratulate you.

DEBORAH HARRIS: Thank you.

OPERATOR: Thank you. And our next question comes from Don Niles.

DON NILES: Yes. I'd just like for Virginia to repeat their website address please.

DEBORAH HARRIS: Sure. It's www.vahealth.org/pip. It's actually on some of the program material that was sent out. The address is at the bottom of the program material. Please check out the PSAs. There's gender specific PSAs as well, radio PSAs, as well as a television PSA.

DON NILES: Thank you.

DEBORAH HARRIS: They're pretty good.

DON NILES: All right.

OPERATOR: Thank you. Our next question comes from Nancy Anderson.

NANCY ANDERSON: Hi. This is Nancy Anderson. I'm calling from Washington State. I have a question for the group overall. I'm the office chief for the Office of Family Services in Washington State Medicaid. Family planning comes out of my office. When I began working here I think I didn't realize how delicate still the question of family planning is. And I notice people talking about a delicate issue and common ground, and I'm wondering if I could hear a little bit more from the group about how they approached what, I mean to me it's surprising in 2008 what is still publicly a delicate issue, planning one's family size. Thank you.

LARRY HUMBERT: This is Larry from Indiana. That really hits exactly to the experience that we had in our state when we were going about doing the family planning waiver. When it was first talked about, about family planning and contraception, over the course of two or three sessions of our general assembly it didn't really get all that far. When it finally did get passed, it was really presented as a proper birth spacing, child spacing kind of frame. And either the politics had changed or something, I'm not sure, but I think that that different frame of reference, moving from family planning to proper birth spacing and health implications that exists if births aren't properly spaced. And also in our state having such a high percentage of birth to Medicaid women it seemed like that different frame of mind got

people's attention a little bit, and may have taken it away from what was previously a pretty sensitive or sometimes divisive issue.

DEBORAH HARRIS: This is Deborah in Virginia. I just wanted to look at it, or frame it as family planning means different things to the genders. For men in the men that I work with family planning means, hey they're married and they're thinking about having children. You really when working with some of these men to get them involved in taking a role in birth control, you really actually have to call it pregnancy prevention. For the women they understand what family planning is, but to actually get the men in the door or to even consider using contraception you need to talk about pregnancy prevention.

OPERATOR: Thank you. Our next question comes from Barbara Huberman.

BARBARA HUBERMAN: Hi. I just wanted to put this out to all the panelists. If the Family Planning Waiver Program has made such incredible benefits happen, why are states reluctant to apply for it?

CLAIRE BRINDIS: Hi Barbara. This is Claire.

BARBARA HUBERMAN: Hey Claire.

CLAIRE BRINDIS: I think, you know, part of the conversations that we've heard today is that in every state it really requires a committed group of individuals very committed to bringing the program to their state. And I think the thought that 26 states have made those inroads really does speak to the spirit of social will that is occurring at the state level. We

certainly have in California learned a number of lessons about how to complete the application, how to work with the federal partners to make the program a reality. And each state has its own unique character, but I think you'll see that across this conversation today that there are a lot of universals and common interest in assuring access to healthcare. So I think my sense is that a group working at the local level, identifying partners like the ones we've talked about today, whether it's public or the private sector or a variety of other organizations, professional organizations, physicians, nurses, practitioners, et cetera, as well as the general public is really key to making this a reality. And we're hoping that with the joint experiences of this portfolio of states that have been on the call today that others will be inspired to think about what they can do in their own states about advancing this kind of agenda.

DR. KIMBERLYDAWN WISDOM: Hello. Kimberlydawn Wisdom here from Michigan in response to that question, and just some of the experience that I recall as Michigan was submitting their 1115a Waiver as people in the maternal and child health area, while they were pretty enthusiastic about submitting it there was a reluctance. There was a concern that they might invest a lot of time and energy into an effort that might not result in the funding needed. So I believe the application was submitted several different times before we actually received funding. I remember sort of a year and a half space at least where we were waiting for, to hear a word about funding. There was concern that there might be a lot of political ties to it such that there would be certain states that would not receive the funding because of some other effort at a political level that was not related to, you know, need and the importance of receiving funding. And let's see, there was one other aspect as well that I kept hearing concerns about, which I'm just blanking on. But anyway, we were delighted when we finally received word that we did receive the funding. But there was, you know,

concern all along that it may be met with a lot of challenges. And based on, even after a lot of labor-intensive work.

CHRISTIE VILSACK: And this is Christie Vilsack from Iowa. We got the waiver, I think in 2005, and it's been very successful in plugging some of the gaps for services for women. But we're now going, in Iowa going back to the legislature to ask for additional money to make sure that we catch the people who've fallen through the cracks on the Medicaid waiver. So we got our first appropriation this year, we're going to keep going back and make sure that we try and get everyone covered.

ANDREA KANE: This is Andrea Kane with the National Campaign. I think the other thing just to mention about the waivers is, you know, I think Kimberlydawn alluded to this, is a lot of work to get a waiver. And once you have it it's a lot of work to continue to evaluate it and meet all the federal requirements. You know I think it's fair to say it's quite burdensome even though it's well worth it once you do it. And I think in recognition of that, and many of you may know this, there is legislation pending in Congress that would allow states to make, to expand their eligibility for Medicaid Family Planning and make it an optional part of their Medicaid plan, thereby not having to go through this quite burdensome Medicaid process. And that's certainly an important part of the National Campaign's policy agenda. And I just wanted to make sure that folks were aware of that if you weren't already. I think, you know, there's sort of support building for that. There's no guarantee it will pass, but it's something that I think there's a lot of interest in just because these waivers are quite time consuming and rigorous and burdensome to apply for and to maintain.

DR. KIMBERLYDAWN WISDOM: One other aspect, Kimberlydawn here, to add to that, the other point that I was failing to remember, was that there was a sense that this is a demonstration project; it's under some demonstration umbrella. And it's been demonstrated to be effective so why is there a need to apply for something like this when it should be out of the demonstration phase and in more of the standard of, standard phase or implementation phase, as opposed to having to demonstrate that it's effective when other states have already proven that.

OPERATOR: Thank you. Our next question comes from Cheryl Kovar.

CHERYL KOVAR: Hello. This has been a very good call. I'm from North Carolina. I work for the Division of Public Health, the Family Planning Nurse Consultant. And we in North Carolina also have the Family Planning Waiver Program. And my question is for California. I was intrigued and I'd like to hear more when you said something about the cost effectiveness for giving the women 13-cycle versus giving them one month at a time or three months. Could you explain that a little more please?

CLAIRE BRINDIS: Sure, I'll do that. Thanks for your question. Our analysis looked at what were the impact on the women who when they received, you know a common, I think a common concern is if you give women too many months or too many cycles of pills that they may not continue to use them, or there may be some throw away pills or we may lose patients. But we looked at actually how many clients in our database had been receiving different amount of cycles for the one, three months, or 13 cycles. Then we looked at their profile; we looked at their patterns of utilization. And consequently the analysis that our team did showed that for women who got 13 cycles, they actually had a total of 14 months

of oral contraceptive protection as compared to women who received three cycles, where they only received about nine months of protection. And for those individuals who had one cycle, about seven months of protection. So let me explain what that means. That means basically that the kind of barriers that we put on women, meaning that if I give you only one month of cycle then you need to be very highly motivated to keep coming back to the clinic or the pharmacy for a refill. If I eliminate some of the barriers then we're more than likely to have longer coverage for the method that you choose if you choose an oral contraceptive. And I'm happy if you'd like additional information on our website, I'm happy to share that information with you or for you to send me an e-mail.

CHERYL KOVAR: Oh, I'd be happy to because here in North Carolina that has been one of our issues. As a nurse myself I've tried to advocate giving more and not putting up the barrier for women having to take time off of work or transportation, you know, and keep returning back to the clinic.

CLAIRE BRINDIS: Right. The argument is always well they'll lose them, we can't bill back to, you know the waiver for any other cycles. But I think that if they're there and they have them this is good data to support that it'd be a more effective contraceptor when they have them there than having to keep coming back.

LAURIE WEAVER: Right. If you'd like additional information, Dr. Diana Foster actually conducted the analysis as part of our team.

CHERYL KOVAR: Okay.

LAURIE WEAVER: She can be reached at greened—

CHERYL KOVAR: Okay.

LAURIE WEAVER: --@obgyn.ucsf.edu. So it's greened, all one word, @obgyn.ucsf.edu. And I'm saying that hopefully there will be other callers interested in getting the full analysis.

CHERYL KOVAR: Thank you very much.

LAURIE WEAVER: You're welcome.

OPERATOR: Thank you. Our next question comes from Lynn Procell.

LYNN PROCELL: Hi. I'm calling from Colorado from a local health department. And all of this state movement is excellent and it's really exciting, but from a local level would you suggest that we put more of our effort into getting the state to move as a group? Or do you think some of this can be successful on a local level?

LAURIE WEAVER: Hi, this is Laurie Weaver. I wanted to talk a little bit about what we've done with some of our local partners, county governments in particular. We recently held a conference for many of the counties throughout the state of California. We invited all 58, and I think we were very successful in getting representatives from 48 counties. And we presented information about the program, including cost benefits to the county for services provided and for births diverted. And we've recently followed up with a flyer that talks about the financial success that counties have had in providing Family PACT services to local

residents. I think in our case this outreach to the local partners was very, very effective in helping them understand their contribution to the state as a whole, and then again on the local level what a difference having an effective family planning program in their community served. And so I think that it's been in our case a very successful partnership to engage our local county health department, and to provide as much assistance as we can to them on a macro level and on a micro level as it were. So their success is ultimately our success, and what we can do to help the local counties has really been a great benefit to our program.

OPERATOR: Thank you. Our next question comes from Christopher Krause.

CHRISTOPHER KRAUSE: Hi. I'm from Cincinnati Children's Hospital, and I have a question about condoms. How do the various constituents that the panelists have referred to feel about condoms and messages about condoms? Is there a lot of consensus, or is it a controversial topic? And by constituents I'm talking about the 20 to 29-year-olds, their grandparents, the hairstylists, and the pharmacists, male and female.

CHRISTIE VILSACK: Well this is Christie Vilsack from Iowa. I just have a quick story. I spoke to a very large group of primarily business people at the downtown rotary club last weekend. Afterwards I was told that a man was relating a story about how he walked into his alma mater at the college library and had seen there a basket of condoms, and he was repulsed by it and thought it was a really horrible idea. But after having listened to me speak about really the crisis of STDs on campuses and around the country, and that one in four teenage girls has a sexually transmitted disease, he made the connection. And realized that what he had thought was really inappropriate probably in the context in which he had heard it is very appropriate. So I think a lot of it has to do with educating the public

and making sure people understand the need for that. And I was at the Urban Initiative in New York, and the mayor of New York City as an elected official makes a huge pitch for condoms and talks about how they pass them out in New York. So I think a lot of it is just educating people about the importance of using them, and getting rid of some of the myths that are out there about them.

DEBORAH HARRIS: Hi. This is Deborah from Virginia. I just wanted to say with regards to the men, you know many of them at the beginning we actually monitor at the beginning of intervention what form of birth control's being used, and if they're using an effective form of birth control at the end. And I must say that there was greater improvement in men reporting effective use of birth control, of course, which would be a condom. But it actually increased from pre to post in my population 14%. So we had men actually, you know, who weren't using condoms deciding to use them at post intervention. One of the things that we did see, especially when working with all male group is that many of them, you know, talked the macho stuff like I don't want to use it, you know, something with the feel and all of that. But many of these men are also products of a single parent home, and there wasn't somebody to model or anybody to show them, a male figure, to show them how to effectively and properly use a condom. So a lot of it is just enabling them, and you know, getting in there and just showing them this is how you use a condom. And it's, you know, having a greater increase in the number of men reporting effective birth control than women. And we had a 12% increase in women and a 14% increase in men. Something's going right.

CLAIRE BRINDIS: I just want to, this is Claire again from California. I want to acknowledge that condoms play a very important role in types of contraceptive methods that are given out

through the program. And it does been able to demonstrate that condoms are very effective in pregnancy reduction or avoidance, and it is definitely a very important message to the world about the fact that STDs, HIV, and pregnancy prevention are all really part of one conversation. I think that the world, perhaps reflecting the different silos of funding for other, perhaps other kinds of issues, maybe around particular concerns on STDs versus family planning. The reality is we all should be working together to assure that both men and women are able to plan for their children, plan when they're going to have them in their lives, and also have protection for their fertility so that when they actually want to be pregnant they will not have the crisis of having become unfertile because of a sub-clinical case of chlamydia. And I don't feel that we spend enough energy and time talking about protecting the fertility of individuals as well as helping them not have mistimed baby.

OPERATOR: Thank you. Once again if you would like to ask a question that's star, one on your touchtone phone now.

KRISTEN TERTZAKIAN: We're running out of time on the call so we'll take one more question. And just if I could I wanted to go back to the question from Colorado about investing time into getting a locality or community to focus on reducing unplanned pregnancy rather than a state. And I would highly encourage you to do so. In our fact sheet we highlight two communities, New York City and San Antonio, but I know that there are many more. And we even see that in teen pregnancy sometimes that a community will really invest a lot of time and effort and money into reducing teen pregnancy, but the state might not be. And sometimes that's what you need to happen is that a city or a county or community has a success story and then it'll bubble up to the state rather than the reverse.

OPERATOR: Thank you. And our last question comes from Joy Bran.

JOY BRAN: Hi there. I'm a public health educator, family planning educator in Hawaii on the island of Maui. And we're still having trouble getting our schools to want to be involved with this whole effort for, you know, various political reasons. But I'm wondering from Kimberlydawn in Michigan, how you, what was the role of your school based health centers in this whole planning prevention effort that you did? And how could we start from a, you know, a place where it's not accepted for school health centers to even talk about this issue? Maybe what are some steps we can take toward including pregnancy prevention in school-based health, you know, what their responsibilities are, their role is? Thank you.

DR. KIMBERLYDAWN WISDOM: Yes. Thank you for that question. And I think that question actually gets at some of the challenges that we've had in our state and what we're doing to address those challenges. We had for that blue ribbon panel that I referred to we had representatives from school health around the table, and the original plan was to develop sort of this one guideline for preventing unintended pregnancies across the spectrum of women's health from teen through later in a woman's life. However it became very clear very quickly that we would have to have two guidelines, one for those 18 years of age and older, and one for those below the age of 18 because we were met with so many challenges around addressing pregnancy or preventing pregnancy related issues in the school settings. And so we are in the process now of developing not so much to the Governor's Blueprint, but through another group of very committed individuals where many of them were part of this blue ribbon panel to develop a respected adolescent guideline to address some issues related to how to handle this in not only clinical settings, but also in school based health centers. Does that get at your question, or?

JOY BRAN: Well somewhat. Can you hear me?

DR. KIMBERLY DAWN WISDOM: Yes I can.

JOY BRAN: I mean condoms in the school are prohibited here. And we do have health centers on campus, and occasionally one of those people will just have a personal conviction that it's important to help kids, you know, where they could go, and how to access services. But the general policy, and I guess it would be maybe coming down from a health mandate or a health, you know, guideline, or part of that whole consensus about the health of our youth. And what specifically the role of a school health center is regarding sexual behavior or protection. And so I'm not quite sure how to work at it from my perspective, but I think it might be coming through the health department channel working with the Department of Education or something. Yeah.

CHRISTIE VILSACK: In Iowa that's what we're trying to do is work between the departments and involve certainly the Department of Education is mandated to provide medically correct information in schools. So we have local control, but they're trying to create a model core curriculum that will be not mandatory, but will be out there on the website, and go to all the schools to talk about what an ideal curriculum would look like, and put it out there for everybody. We don't mandate. Everything is done at the local level in Iowa so we can't force people to use it, but we are developing it and we are going to put it out there. And I've just asked those three departments to work together so that they can support one another in the school today, but also in after school programming that's

happening. And at Boys and Girls Clubs, Girl Scouts, the 4H, and all those other places so that there's some coordinated message.

KRISTEN TERTZAKIAN: Well I think we're at the end of our call as it's a little bit past 4:30. Thank you so much to our six speakers. We really enjoyed hearing your stories from your respective states. Thank you to Sarah and Katy from the National Campaign, and also to Jennifer Drake for organizing this call. And a huge thank you to all of you on the line who have spent the last hour and a half with us. Please check out our website, www.thenationalcampaign.org. We have much more information on state and community efforts, and data as well. And feel free to give us a call or shoot us an e-mail if you have any questions. So thank you to everyone.

FEMALE SPEAKER: Thank you.

LARRY HUMBERT: Thank you.

FEMALE SPEAKER: Thanks.

KRISTEN TERTZAKIAN: Bye-bye everyone.