THE BROOKINGS INSTITUTION

THE PROMISE OF BIRTH CONTROL
A FUTURE OF CHILDREN EVENT

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**Introduction and Overview of Policy Brief:**

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**Overview of Volume:**

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P R O C E E D I N G S

MR. HASKINS: Welcome to Brookings. My name is Ron Haskins, and along with Richard Reeves, it's an announcement of sorts. I run the Center on Children and Families, and my former co-director, Belle Sawhill is fortunately here to watch me carefully and correct all my errors, which often take about a third of the event. I'm glad that you were able to come this morning. Our audience it's always, if we start at 9:30 everyone comes at 9:40, it's amazing how that works out. But that's the way it is.

Here's the plan for the event today. I'm gonna make some introductions. Then we're gonna have Belle review the volume, of *Future Children*. We're here primarily to talk about the policy brief, but the volume, of course, I think is the best, if you want to go to one place to know about the status of research and thinking about marriage, this volume is it. It's an extremely good volume. I think eight chapters, or seven chapters on various aspects of marriage. Including several chapters focused on birth control, and given our interest in birth control here, we decided we'd focus this event on birth control, so that's what we're here to talk about.

When Belle finishes reviewing the volume, I'm gonna review the policy brief. And then we're very fortunate to have Lieutenant Government Northam here, and I'll talk more about him in just a minute. And then that's good. We'll give you a chance to ask him questions after we ask him some questions. And then we'll have a panel, a magnificent panel of people who are great experts on this issue. And I'll ask them some questions, and hopefully we'll have some disagreements, and then we'll give the audience a chance to stump the panel.

In introducing Belle, this wonderful book I put a tag on here to remind myself which chapter, but *Generation Unbound: Drifting into Sex and Parenthood without Marriage*. So Chapter 6 in this volume is something on this topic that I think is about as good as you're gonna get. For a short treatment, there's nothing better. And Belle is one

of the great experts on this issue in the country. So Belle Sawhill, she doesn't get to talk about birth control, she has to talk about marriage and the volume. But thank you.

MS. SAWHILL: Thanks, Ron. Now I want a little help here on the slides. Oh good, there they are. Do we need for the --

MR. HASKINS: No, that's the wrong one.

MS. SAWHILL: Oh, that is the wrong one, yeah. Anyway, let me say a few words while we're sorting that out. Thank you very much for being here, by the way. I really appreciate it. And this is a wonderful volume. We do this in conjunction with our partners at Princeton University. The editor-in-chief of this volume is Sara McLanahan. And a number of our Princeton colleagues are here today. I can't mention all of them, but there are three or four of them here, and particularly want to mention John Wallace is the managing editor of the volume. John, where are you? Thank you. And it's been a wonderful partnership over about a decades' time now. And as Ron suggested, this volume, I think, is one of the best volumes we've ever done.

We did a volume about ten years ago on marriage, and were asked to sort of revise and update it this year. And we got a new set of authors and they were terrific people, and they all wrote great chapters. I can't possibly do justice to the whole volume. I think there're copies outside and you can feel free to take one and read it at your leisure. I will show you the Table of Contents here, so you get a sense of what's in the volume and who contributed to it.

So, I can't, as I say, do more than just give you the highlights and a few comments from me. Let's start with just what's been happening. I think as you all know, marriage is in retreat. It's been declining from about 85% back in 1950 to around 60% now, this is for the age group 30 to 44. You can look at this in different ways. But however you look at it you see these kinds of declines.

Now, just because marriage has been declining, doesn't mean people aren't still having children. They're just having them outside of marriage instead of inside

of marriage. And here's the data from the volume on that issue. And as you can see here, we have very high rates of unwed childbearing in the U.S. now. Overall about 40% of all kids are born outside of marriage. This varies both by class and by race. If you look at education as a proxy for socioeconomic status, or class, you can see that the rate declines sharply with more education.

But keep in mind that this last category here, where the rates are quite low, the college educated, those with college degrees, is a small group still. It's only about 30% of the population. So the other lines here refer to the other 70%. And then within each education category there are racial gaps. And we had an entire chapter in the volume on these gaps by race and by class.

We also had an entire chapter on same-sex marriage. As we were preparing the volume, the Supreme Court was considering what to do. And as you all know, in June they finally legalized same-sex marriage. And that made this whole discussion very interesting and very timely. And part of the debate leading up to all the court decisions was about whether same-sex couples are good for kids or not, whether this is a good environment in which to raise kids. And there are a lot of research studies on that. Not all of them of equal merit, but our author did a nice review of that evidence and a lot of other evidence and background, including the legal background on this movement to legalize same-sex marriage. And he finally concludes, after looking at all the evidence, that you really can't come to the conclusion that relationships are not good for kids.

Some of the studies that have suggested that the kids didn't do so well with couples, where done during an era, or a period of time, when because of the stigma and the lack of legalization of marriage, the kids were being born in somewhat unstable circumstances. They might have been the product, for example, of an opposite sex marriage and then later that couple broke up and the gay or lesbian parent moved into a same-sex relationship, and the children came with that parent. And that led to some

instability in the lives of the children, and that most researchers believe is actually not a good thing for kids.

In the future it'll be very different. And my book, which Ron was nice enough to mention, talks a lot about people drifting into parenthood. And I use the word drifting very consciously, because I think that's a lot of what's happening. This is unplanned pregnancies and births. But in the same-sex world by definition when people have kids they do it by choice.

Now we had another very interesting chapter on the extent to which marriage matters for child wellbeing. Is a child who grows up in a two-parent family better off than a child that grow up in a one-parent family. Are children in married families better off than children in cohabiting families. And this chapter adds to all the literature on those issues, and basically all of that literature, of which there's a ton now, has led I think pretty much to a consensus that on average growing up in a two-parent married family is better for kids than not.

That said, you have to then ask, well, why should marriage matter? And one reason it matters is simply because the people who marry, are a self-selected group. They have other characteristics like education and more income that's helpful to their kids. But there are other reasons as well, and this author, David Ribar, goes through all those other reasons, and in the end concludes that all of them have some evidence of making a different for children's lives. And that if we wanted to replace marriage, for example, with government programs that made up for the lost income of the second parent, or other things of that sort, we could do that but it wouldn't fully replace the benefits that children now derive from marriage itself.

We had a lot of debate around the production of the volume, and amongst the authors about whether or not, or why there's been this decline. Everybody agreed there was a decline. The issue is why. And these are the usual factors that get debated and talked about. Women's new opportunities have made them clearly less

dependent on marriage. It's no longer something they need for their economic wellbeing. And then there's the argument that men, especially less education men, have not been doing well in the labor market, declining employment and earnings, and that has made them less marriageable. And this lack of marriageable men, it is argued, has been a contributing factor to the decline in marriage.

Finally, there are arguments about whether government programs are inhibiting marriage because if you marry somebody that has additional income, you may become ineligible for various programs and that may discourage marriage. And Ron Haskins, in his chapter, does a very nice job of reviewing that and other government programs including marriage education programs, and some others that we'll get to.

And then of course there's been a huge change in the culture and attitudes about marriage. I like to talk about just how our language has changed around these issues. Used to be that we called someone who had a baby outside of marriage, we called the child an illegitimate child. I mean as recently as three or four decades ago we used that term quite commonly. We wouldn't think of doing that today. We called people who were cohabiting, living in sin. Imagine using that term today? So that's just an illustration of how much attitudes and culture has changed here.

Brad Wilcox, who is a big advocate of how we need to change the culture, bring back civil institutions and religious institutions to support marriage, wrote a very nice chapter with his coauthors on that set of issues.

And I would say there was some differences of opinion between the group of authors about the relative importance of all of these factors, but everybody agreed that you can't just say it's one or the other. You can't just say it's economics or culture, for example. It's both.

So this is probably my last and probably most important slide here. And the one you're probably most interested in, which is, well, is there anything we can do about these trends if we think they haven't been ideal for children. And the Bush

Administration pioneered a set of marriage education programs. And thanks to Ron Haskins and others, those programs were very carefully evaluated and by the time we produced this volume, we finally had the results. And the results are not very encouraging.

They didn't show that we were able to move the needle very much using marriage education programs. Some people would say, "Well, we need to try harder. We need a new generation of such programs." And that's a legitimate argument.

Other people argue that we need to reduce the so-called marriage penalties in both tax and benefit programs. We've done a fair amount of that already. It's very expensive to do it, because it requires moving eligibility for these programs quite far up the income scale. And when you do that, you're getting into the thicker part of the income distribution and it's costing you a lot of money. And there isn't a huge amount of evidence that it moves the needle behaviorally.

So that's an issue, but I don't think it's one that is got a lot of promise to it.

Finally, we have here, or not finally but second to last, we have improving either men's or women's economic prospects and hoping that that will help them to marry or form more stable unions at least. That's been a big issue of debate of late. And one of the most interesting chapters, to me probably the most interesting chapter in this whole volume, is the one by Danny Schneider, a professor at Berkeley, who looked at 15 social experiments, all designed to improve the economic status of either men or women, usually more disadvantaged men or women. All of the programs have been evaluated using randomized controlled trials, and most of them were focused on looking at what happened to the economic status of the recipients compared to a control group.

But many of them, 15 of them, actually had evidence on what happened to marriage. And what he finds is that with two exceptions out of the 15, improving male

economic prospects did not move the needle on marriage. For women it did. For women there was a lot more increase in marriage rates after a program improved their economic prospects. So he'll let you mull over why that might be.

A final issue here is one that we're gonna spend, hopefully the rest of the morning talking about, or most of the morning, and that is reducing unplanned pregnancies. When you think about what I started with, which is marriage is declined, but people are still having kids. And then you think about who's having the kids, it's mostly younger women and women in their twenties. And 60% of those births to young single women are unplanned, according to the women themselves. And that's from the government data with a sample of 20,000 people and so forth. So I think that's pretty solid. Although we can debate about whether there's some nuances here, what does unplanned really mean.

And if that's the case, then one way to improve the prospects of the children and help the women as well, is to enable them to only have children when they really want to have children and feel ready, and that would mean they would be older, more mature, more experienced, completed their education, and more likely to be in a stable relationship with a stable partner. So this is a very promising direction and one we're gonna talk more about. Because what came out of this entire effort to produce this volume, was that this was one of the few areas that we saw where you could probably make some difference. And you're gonna be hearing now from some people who know a lot more about that.

So I'll stop and turn this back to Ron.

MR. HASKINS: Thank you, Belle. So Belle already gave my introduction for me, which is if you're really interested in marriage and think marriage has a big impact on children's wellbeing, and then we look around for interventions that have an impact according to good studies, random assignment studies, pretty much the only thing that really has consistently shown an impact are -- thank you. The only thing that

has consistently shown an impact is reducing non-marital births.

And there's some evidence, I would not say it's scientifically persuasive, but women who do not have out of wed locked births, have a greater chance of subsequently marrying. There's also studies on women who have not an out of wedlock birth have more stable marriages, and so forth.

So someone interesting in marriage, this would be something that they would focus on. Not that they do in the real world, I'll get to that in a few minutes and so will the lieutenant governor. But this is the strategy that really makes a difference. And then in and of itself, it makes a big difference for several other things which I'm gonna talk about right now. So that's why we selected, in a volume on marriage, we selected a topic of non-marital births and birth control.

So first of all, we've had this enormous increased, Belle talked about this a little bit, but if you're like me you forget stuff in about five minutes. So five minutes is up, now I'm gonna repeat it. And the message here is extremely important, which is that we've had an onslaught of non-marital births. So if there's something that results from non-martial births, that it's not good for the country, or not good for children, or not good for couples, then it's a problem and it's getting worse and worse and worse.

I would direct your attention, I'm not gonna talk about this too much, but there has been a certain amount of stability over the last, it depends on what measure you use, but over the last decade, and in fact even more than that, if you look at the rate of non-martial births per thousand women between, I think the date is 18 and 54 or something like that, has been pretty stable for over two decades. So we still have these enormous rates. And as Belle said, over 40% of America's kids are now born outside marriage. So it's a big problem, but for some reason it seems to have slowed down a little bit, so that's a good thing.

Now here comes an aspect of this that I think often is missed by people, and that is who is having all these non-marital births? We always like to be politically

correct and don't always like to point out exactly who is doing that could put their kids at risk, or who could take actions, or result in more government spending, and so forth.

So here you can see very clearly that there're big ethnic differences across blacks, Hispanics, and white in rates of non-marital births. Many of you probably know the famous article that Moynihan wrote about family composition and his thesis was basically that blacks are not going to be able to take advantage of all the rights that they're winning back in the 1960s, as a result of civil right revolution, because the black family has disintegrated. And that, of course, was extremely controversial. I don't recall any academic fight, maybe over bell curve, it was the only other academic fight that I can think of that was so intense and nasty. It was really ugly.

And now I think we all have come -- Harvard just did a volume a couple years ago, and basically the volume says Moynihan was right, now what do we do. Because it spread throughout the whole society. And in fact, the rate for white births now is higher than it was when Moynihan wrote his alarmist report about the impacts on blacks. But anyway, so if it does bad things they're gonna be differences among ethnic groups.

And, equally bad, the same thing is true of education levels. So moms with less education are more likely to have a non-marital birth. Moms with less [sic] education are less likely to have a non-martial birth. So we have the most disadvantages groups in our society, who are having more non-martial births.

There is one impact on both the mother and the children, and perhaps the father as well, that's undeniable. And that is they are much more likely to live in poverty. And I have not yet met anybody who makes the claim that poverty is good for kids or for adults. So five times the rate. Can you think of any intervention that products and impact of five times in an experimental group better than the control group? We don't have many like that. And yet here is kids are five times as likely to be poor if they're in a single parent family, which by definition every non-martial birth is in a single parent

family. So clearly there's a big impact on poverty.

And then if you want to just summarize, which is what I'm trying to do here, there are many, many other outcomes that's there's at least one, what I would call decent study. And for many of these, there's a whole literature featuring random assignment studies. So you have reduced poverty rates which is just there's no question about that. A lot of evidence that lower abortions rates, because women who are pregnant outside marriage are more likely to get an abortion. There's a lot of evidence on better spacing of babies, which is good for the kids, and for their mother. There's an increased likelihood of prenatal care. I didn't know this until recently, kids who are, I think it's twice as likely to get prenatal care, if they have a planned pregnancy rather than an unplanned pregnancy, or a birth outside marriage. There also is less postpartum depression among moms who have planned pregnancies. There are reduced partner separation rates. There's more education for the mothers. Belle's written about almost all of these things. And there are a lot of studies now on cost savings for government. I think that maybe the numbers are somewhat exaggerated sometimes, but the very good review of the evidence shows that LARCs, which I'm going to turn to right now, the benefit cost ratio is about $7.00 of benefits for every $1.00 of cost. And that does not include any of the long term benefits.

And there's a wonderful review, very literature, by Martha Bailey at the University of Michigan that shows big long term impacts. In fact, in the second generation moms who avoid early births have kids who do better than moms who do have early births. Their kids do better. They grow up to get more education, more income, less welfare and so forth. So no one has taken those measures into account, as far as I know. And it's definitely not included in the 7 to 1 figure. So this is a spectacular list of advantages. And if we could do something about non-martial births the mother would be better off, the child would be better off, the community they live in would be better off, and the nation would be better off. And the government would save money,

that's a pretty good list of benefits.

Now, we have in the last decade, or maybe a little more, come increasingly to realize that LARCs, long acting reversible contraception, which includes IUDs, and subdermal implants, and last up to ten years, that they can have a huge impact on pregnancy rates for women who want to avoid pregnancy. So this data is from one study, the St. Louis study. As far as I know, every study has shown roughly this same kind of thing. And it's the probability that a woman would get pregnant, if she's on various types of birth control.

So if a woman is on pill, patch, or ring, she's nine times as likely to get pregnant as if she's taking a LARC. And as I say, now I wouldn't focus on exact ratio here, but it's huge. And many studies have shown this, so there's no question LARCs area very, very effective. So if birth control produces good outcomes, and LARCs are the best form of birth control for ensuring that women don't get pregnant, then we want to focus a lot of attention on LARCs. And that's what we're gonna do here this morning.

We do have some barriers. I'm only gonna mention these now, because we've invited people to come and participate on the panel who are experts in these issues. So we're gonna reflect on these in more detail. But I've already talked about cost. In this case the initial cost of LARC is more than the initial cost of a pill. But in the long run, especially if it could last for a decade, it actually saves money, and then not to mention the impacts which also saves money. So in the long run this is a typical thing that government faces if you spend the money now, then you don't have to spend it later.

Provider training is an issue, it's becoming addressed thanks in part to Mark Edwards here. There are a lot of administrative issues. You have to, for most effective, you have to have available onsite, and you've got to have people available onsite. You don't want women to come in and say they would like to have birth control, and they might choose a LARC, and say, "Okay. Come back in a week." That's a bad approach.

We need better patient education about what the various forms of birth control are. We do not have to have a situation where women feel like they're pressured into taking LARCs, or any other form or birth control. And there are big socioeconomic and race issues that I mentioned in the first place.

So we have a great opportunity and that's one of the main reasons we want to have this event this morning. I think it was the main factor behind Belle's book. And definitely Belle was involved in establishing National Campaign to Prevent Teen Unplanned Pregnancy. And they are a great organization, I think if we could measure these things accurately. They've had a major impact on the decline, especially among teens in non-martial birth rates.

So we're on the right track. The question is how can we do it more effectively. And if we could, a lot of benefits would flow. So the rest of our event we hope to elucidate that issue a little more clearly.

Next we're gonna have Lieutenant Governor -- wait don't get up yet. I have a 15-minute introduction here. (Laughter) It begins with your mother and her background and you know. So Lieutenant Governor Northam was kind enough to agree to drive all the way up here, I guess we would say to Washington to talk at this event. We had the idea because he's a governor. Politicians talk, we all know that, but very few of them can write more than a sentence. I don't know if you've ever noticed that. But I spend a lot of time with policymakers, I know this to be true. (Laughter) And yet, he wrote an editorial about what he hoped Virginia would do with regard to reducing non-martial births, and mentioned LARCs and so forth. So it was really a very nice column. And I thought, "Wow, who is this guy?"

And then, by coincidence, the next week I met him because we were in a meeting bout preschool. This was one of his real focuses, since he's been an elected official, has been preschool. So it turned out well and they were able to clear his schedule and so he came. So he is a doctor. He's a pediatric neurologist. He has an

undergraduate degree from Virginia Military Institute and then a medical degree from Eastern Virginia Medical School. And he's not only Lieutenant Governor, but he's active in practice, plus he teaches. So he doesn't get a good night's sleep very often. (Laughter)

And, as I said, his political career began in 2008 when he was elected to the Virginia State Senate, and then he's been Lieutenant Governor since 2013. I want to tell you that I know for sure that he's a very open-minded individual. And the reason I know that, is that his son is doing his --

DR. NORTHAM: Residency.

MR. HASKINS: -- residency. Thank you for that complicated term, residency, at the University of North Carolina at Chapel Hill, which is not overly popular in Virginia. So you can tell he's a very open-minded gentleman. So, Lieutenant Governor, thank you very much for coming. (Applause)

DR. NORTHAM: Well good morning. And Ron, thank you so much for the kind introduction. And my son, Wes, we have two children, he's doing his neurosurgery training in Chapel Hill. And that was not exactly his first choice, but being a Virginia you any port in a storm. But he's enjoying it down there and working hard, and having a good experience.

Belle, thank you so much for your comments. And I really appreciate the opportunity to be here this morning. It takes me away from Norfolk, which is where I practice medicine, and the City of Richmond, which is our capital in Virginia. So it's nice to get a day up in the nation's capital. And I would like to also to take this opportunity to thank the Brookings Institution as well as Princeton for all of the great work that y'all are doing.

Now, one might ask why is a pediatric neurologist before you this morning talking about contraception. And I will try to go through in the next maybe 10 to 15 minutes and explain that. But as a practitioner, as a pediatric neurologist and also as

a policymaker in the Commonwealth of Virginia, the concept of contraception, and as way to decrease unintended or unplanned pregnancies, also to decrease the number of abortions, not in in Virginia but in this country and our society, and also to increase the health and wellbeing of our children and their family. So it's an important concept from both a practitioner and a policymaker. And I want to just go through those steps with you a little bit this morning.

I, as Ron said, a lot of people don't realize the Lieutenant Governor, at least on paper in Virginia, is a part-time job. So unless one is independently wealthy, which Ron, I'm not, then --

MR. HASKINS: (off mic)

DR. NORTHAM: I know you are. That's why I just wanted to clarify things. (Laughter) So we continue to have another job. And my job is being a pediatric neurologist. So about three to four days, depending on what's going on in the schedule, I see about 15 to 18 patients a day. A lot of my patients are teenagers. And when we say teenagers from the 15 to 19 age range. We actually see patients after age 18, but most of my population is starting prenatally up until 18 to 19.

And interestingly a lot of my patients are epileptics, as you may imagine, or perhaps have migraines, but are on medications that can affect the health and wellbeing of a fetus. So we deal with individuals in that age group who become pregnant and those become interesting discussions and dilemmas for a lot of these folks. So to be able to prevent those pregnancies, especially in that time of one's life is very important.

A second comment I would make is that we see a lot of individuals as pediatric neurologists, in the neonatal intensive care unit. And we are able to maintain life in now 22 to 23 week fetuses, newborns. And for better or worse that becomes somewhat of a challenge in a couple of ways. The morbidity, as you may imagine, in a 22 or 23 week fetus is fairly high. There are obviously some great outcomes, but not all of them are good outcomes.

And so if you look at financially what happens to take care of these babies, probably a conservative estimate would be a million dollars up to four to five million dollars, up to a year-plus in our neonatal intensive care units. And what I have found, in taking care of these individuals, because when you take care of babies, you also take care of parents. In this case most of the time mothers. But while that baby is in our hospital, or in our NICU, as we say, oftentimes the mother will become pregnant with her second or third baby. And so how can we stop that process?

And I see these individuals in my office as well, usually the mothers bring the families in, and the mother may be less than 20 and have one, two, or three children. And so I describe it as this kind of vicious cycle of poverty. And so as a physician I have watched that during my 25 years' of practice, and then that carries over into policymaking.

Now, so when we talk about ways that we can help these families, and I have been to home visits, and by the way I probably won't talk about that a lot, but if you want to help these mothers and their children, we have found at least in Virginia, and I think in other places, that if we can get into the home and help them get back on track, that this is one of our best investments. And we're actually looking at that concept in the Commonwealth of Virginia.

So how do we take this data, and move it into the policy area? And that's my other life, and that is making laws in the Commonwealth of Virginia. There's a diversity, or two different concepts, if you will, that makes it somewhat challenging policy wise. And personally I feel that if we want to bend that curve of poverty, if you will, if we want to decrease the rate of unplanned pregnancies, if we want to decrease the number of abortions, the best way to do that is through education and through access to healthcare; i.e., and this is why we're here this morning to talk about LARCs.

But I just wanted to talk a little bit about the reality of policymaking in Virginia. And we're not here to throw stones this morning, but I did want to talk about

what the philosophy is, or the approach of some other individuals, who are policymakers. And if you've been keeping up with the news in Virginia over the last couple of years, in 2012 we had the infamous virginal ultrasound bill. And that was to, I think most people would agree, to deter or to make it more difficult for women who had chosen that avenue to have abortions. And the way that Ralph got in the middle of that discussion is that I'm the only practicing physician, only physician period in the senate.

So when it came time for someone to get up and debate the issue, what better person that a pediatric neurologist, right, to talk about vaginal ultrasound. So it was a little bit of a learning curve for me, Ron, but we made it through. And we actually were able to educate folks and say that the purpose and the response from having a vaginal ultrasound really didn't add a whole lot. It was very costly. So we had that bill, and we took care of that.

And then we have a bill that was proposed too, that women that had miscarriages should report that miscarriage to the police. It was like, "Really?" (Laughter) How about reporting it to your provider, or your physician? We've also had the infamous personhood bill, which is not only a state bill, but it's also been a national piece of legislation. And the personhood bill says that life starts with conception.

And so the concern over the personhood bill, and I don't know if we'll get into how contraceptives work, but it possibly could make most forms of contraception unlawful in the Commonwealth of Virginia. And it also would make in vitro fertilization unlawful.

And then we had the TRAP laws that were intended to shut down some of the women's reproductive health clinics in Virginia.

So it's one approach, education and access to healthcare versus the other pieces of legislation. And the trick is how to bring these folks together, sit down at the table and come up with a consensus. And so what happened in Colorado and St. Louis is just very powerful data.

And over a five-year period, at least in Colorado, and I will quote that study, the number of unplanned pregnancies went down 40% in the 15 to 19 year age group. And the number or abortions when down 42%. And those are good numbers. And so I think the message that I try to give my colleagues in Richmond is that let's at least agree that the less abortions the better. And so if we can agree on that, then we can move forward. And then I will start talking about some of the date from St. Louis and Colorado, to hopefully make the case that this is actually a good direction to go in.

So that's what we're involved in. Two last points I'd like to make, and I certainly don't want to go over the time limit. I see these cards over here: one minute, three minutes, five. I feel like I'm in a debate. And I start having flashbacks. (Laughter) But I did want to make two --

MR. HASKINS: If you go over the time limit, we will be in a debate. (Laughter)

DR. NORTHAM: Well I promise you, I don't want to do that. But there's two more issues I just want to talk briefly. The first is the Affordable Care Act, which as you know, covers all forms of contraception. And as part of the Affordable Care Act, we have Medicaid expansion, which is an option for states. Unfortunately, in my opinion, Virginia has chosen not to expand Medicaid. And what that does, we have all paid in through our taxes to the federal system to support the Affordable Care Act, really all we're trying to do is bring that money back to individual states, in this case Virginia, to provide coverage for up to 400,000 working Virginians. And I would underline the word working. These are individuals had maybe one, two, three jobs, but the cost of healthcare have gone up much faster than their salaries, so they don't have coverage.

And these folks that don't have coverage are women who end up not being able to make choices for LARCs, for example. They are our mentally ill, who don't have access to providers. Don't have access to their medications. End up in the emergency room or in the jail and penitentiary system. And believe it or not our veterans.

And having, I know Ron and I both served. He's a Marine and I'm Army, but it's good service nonetheless. (Laughter) But these are our veterans coming home from Afghanistan and Iraq. And I tell people the least that we can do is to provide those folks that have risked their lives for our freedoms that access to quality healthcare.

And from a business perspective, just very quickly, about $4.5 million the Commonwealth of Virginia is contributing to surrounding states who we compete with over politics. And since January of 2014, when we had the option to expand Medicaid, we have given away more than $2.8 billion with a B, and that's a lot of money that we could use for education and healthcare and transportation.

So, finally, what are we doing in Virginia, and then I will come to a close and take questions. We are very committed to the health and wellbeing of our children and families. And for the first time in administrations in Virginia the governor formed a Children's Cabinet. And there're several individuals that sit on that. But within the Children's Cabinet we have, and I know this is a mouthful, but the Commonwealth Council for Childhood Success. And we're looking at several areas, the first of which is pre-K education.

We feel very strongly, and that, by the way, is a non-partisan issue. The Chambers are very enthusiastic. But we know there's a tremendous learning potential in our children before they ever reach Kindergarten, so we applied for a grant. We received a grant of about $70 million over four years. So we're using that to provide access to pre-K across the Commonwealth of Virginia.

We're also looking at childcare. As you all know in our economy, most parents are both working, so it's important to have accessible, and affordable, and quality childcare for our families. And then we want to make sure that our children are healthy. That their immunizations are up to date. And they have good nutrition. So all of these issues are being looked at.

But one of the areas, and I'll close on this, that we're really, and I spoke

about it just a minute ago, are home visits. And so when one goes into the home and sees a single mother who has perhaps two or three children and I have gone into the homes, how can we help that family? And, again, we help that family through education and we help them with access to medical care; i.e., contraception, to really try to get them out of that rut, if you will, or that vicious cycle of poverty. And that's where the use of LARCs comes in.

And when you talk about different types of contraception, whether you use oral contraception, the birth control pills, whether you use condoms, whether you use LARCs, I mean the data is clear that these are very effective up to 99%, which in medicine you don't get to 99% very often. They are becoming more affordable. There's now an IUD for $50.00 that will help with the cost of healthcare. And also they're reversible. So what a great opportunity to help single mothers get on a path of taking care of their current children, becoming educated, being able to obtain a job and be productive members of society. So the LARC is a great concept.

Anyway, so that's kind of my background, as a clinician, as a policymaker, and maybe just a few quick comments on what we're trying to do in the Commonwealth of Virginia to again, and I think Ron mentioned this, to decrease the number of unintended, or unplanned pregnancies. To decrease the number of abortions, and to make it healthier for our children and their family.

So thank you, Ron, for allowing me to say just a few words. And I look forward to your comments and your questions. Thank you very much. (Applause)

MR. HASKINS: Thank you, Lieutenant Governor, that was very nicely done. I can tell from talking to you before and knowing about your background and talking to people who know you, and listening to your presentation, that you're a person of substantial reason. And you appear to be willing to give some credit to people who don't see things the way you do.

In a couple of states, including Colorado, and at the federal level, there

appears to be politics that are extremely difficult. And people's minds are made up and they are in cement. And in the case of Colorado, it resulted in not funding a program that had pretty strong evidence of success. Now, it's my understanding that a private foundation or individual has picked up the slack, but they might not do it permanently. So here's my question to you, you're on the frontline here. You just described your involvement with several issues having to do with birth. So how do you approach people on the other side who are against policies that would spread birth control?

DR. NORTHAM: That's a great question and it's a challenge that we have. Because in Virginia we have 40 senators and a hundred delegates and they come from very diverse parts of the Commonwealth of Virginia, and they bring with them, you know, I guess different attitudes, different experience. And so, I think one of the ways that we're gonna plan to move forward with this, is to use the data from Colorado and St. Louis and look at what it's done for the wellbeing of families and children. And also what it has done financially.

And so sometimes when we talk to our fellow legislators they don't always believe in science, which we talked about that a little bit earlier, but if you put it to them in a manner where you talk about the data and also how it can be cost saving to the Commonwealth of Virginia. Virginia's a very conservation state. We balance our budget each year, which is a good thing. So I want to give you a quick analogy of how I've done this, or how we have done this before. But back in 2008 the governor asked me to patron a bill to eliminate smoking in restaurants.

And if you can imagine Virginia being very conservative, tobacco being a big part of our economy in the past, that was my first year in the senate. It's like, well thank you very much governor for asking me to do that. (Laughter) But I talked about the science, as a pediatrician of what secondhand smoke the ill effects of that. And also to our healthcare of people that are exposed to secondhand smoke.

And so the first year it passed in the senator. It was defeated in the

house. The second year I reached out, just kind of like we're talking, and continued to education folks on both sides of the aisle and we were able to get that passed the second year.

One of the things though that helped with that, politicians like to be reelected, as you all may realize. And so every two years in Virginia the delegates run for reelection, every four years the senators. And so we actually did some polling talking to individuals across the Commonwealth and in that case 70% of the population said that they would like to be able to go into a restaurant and not be exposed to secondhand smoke. And so we presented data as well, and so we were able to move forward.

So I think you use creative thinking perhaps. Maybe changing semantics when you have that opportunity. But coming at it from different angles. And things happen in policymaking in small steps. So you take one small step at a time. But this is what I plan to do this year. And I didn't mention, and I don't mean to be so long-winded, but part of our Commonwealth Council for Childhood Success, we have offered about 25 recommendations to the governor, that we will be acting on this year in the general assembly. And one of those recommendations is to increase funding for access to LARCs across the Commonwealth of Virginia. So I will be taking this message on the road, if you will. And also to my fellow legislators.

MR. HASKINS: One of the arguments that when I first stated understanding and read studies, that appeared to show, and let me say many of these studies are not random assignment, so we always have to be a little bit cautious about the results. But having said that, the big studies, Iowa, Colorado, St. Louis, and how a big study by the Bixby Center, at the University of California at San Francisco, that is random assignment, randomly assigned 40 clinics around the country, 20 each for a month, 20 control. And the ones that emphasized LARCs cut the birth rate in half compared to --

MS. SAWHILL: Unplanned pregnancy.

MR. HASKINS: I'm sorry, unplanned pregnancy in half compared to the centers that didn't. So that's pretty good evidence. Three of those four studies, I don't know what they found in the Bixby study, but they show reduction in abortions.

DR. NORTHAM: Correct.

Mr. HASKINS: And some of them were quite substantial. So do you think that's an effective argument? I, by the way, have used it often and discussed it with my Republican colleagues, and didn't seem to be all that impressed by reductions in abortions, which really surprises me. You'd think that that would be a leading argument.

DR. NORTHAM: I would, Ron, I would hope that it will be. And I think that whether you want to talk about gun control, or gun violence or the number of abortions, I think that's your first step, is you have to reach out to your colleague and say, "Do you agree with me that we have too many abortions? And the less abortions in the Commonwealth of Virginia would be better? And if we do, if we can agree on that, then how can we change that curve or that number?"

And so it's almost, in my mind, hypocritical if one says that they want to decrease the number of abortions, but they're opposed to contraception. So you can't have it both ways. So my first question would be let's decrease the number of abortions. And, if so, one of the best ways of doing that is to provide women with education, as I said earlier, but access to quality and affordable healthcare. To be able to make the decision whether they want to take a long acting reversible contraceptive. So that's the way we'll move forward.

MR. HASKINS: I have another --

MS. SAWHILL: Can --

MR. HASKINS: Yeah. Go ahead.

MS. SAWHILL: I just want to follow up on that, because it's on the same wavelength, which is I would think the other argument that you might start with is what about the government costs.

DR. NORTHAM: Absolutely.

MS. SAWHILL: And I'm wondering do you have any data in Virginia even rough data on how much you can save in Medicaid and other programs, if you can reduce unplanned pregnancies? You mentioned the very high cost --

DR. NORTHAM: Yes.

MS. SAWHILL: -- of these babies that are born at very low birth weight. And that's very interesting, but I'm wondering about bigger numbers on Medicaid generally.

DR. NORTHAM: No, we do have those numbers. And, you know, you mentioned I think a great figure that I think people can hang their hat on for every dollar that we invest in access and education, you save five to seven dollars. And that's a pretty good investment I would think. And so that will be something that we -- a piece of data that we use.

And the point you made, Belle, and I probably didn't articulate it as well as I could have, but to have let's say a 23 or 25 week infant that has been in the hospital for let's say five or six months that has cost the taxpayers several million dollars, that's just the start.

MS. SAWHILL: Right, right.

DR. NORTHAM: And we do have numbers of what it costs to take care of that individual. Especially if they have problems like, if they have ventriculoperitoneal shunts. And they have epilepsy and cerebral palsy, all of those things are very costly. And the other thing, morally, is it fair to a child? And what does that do to a family? And so all of these are I think strong facts that we can use to try to make our point.

But the last point that I would say is that, and we have this discussion often, it is the people that ultimately will make the decisions. Just like we did in the smoking ban in restaurants, it's the people that will tell their representatives that this is the direction that we want society to go in. And you are either gonna be part of the plan,

or we're gonna vote for someone else. And that's the good thing about democracy.

MS. SAWHILL: Yes. I think that one the things that the National Campaign to Prevent Teen and Unplanned Pregnancy has done, is a very interesting, Andrea Kane, who is our public policy director, and will be speaking later may say more about this, and I'm glad to see our new CEO, Jennie Erlick here -- hi, Jennie -- is that if you ask Republican women how they feel about these issues, especially younger Republican women, they're in favor of birth control. The issue there is that they think it's already available. They don't see what the problem is.

DR. NORTHAM: Right.

MS. SAWMILL: Andrea, you can correct me, but I that's my summary of it.

DR. NORTHAM: Yes, ma'am.

MS. SAWMILL: And I think that fits in with what you're saying about go to the public and find out what they want and what they think.

DR. NORTHAM: Right.

MR. HASKINS: So audience, we have time for a couple questions from the audience. Would someone like to ask the Lieutenant Governor a question? Yes, right there near the back. Please, tell us your name, stand up tell us your name, and ask a question with a minimum comment, okay. Thank you. (Laughter)

MS. TROID: My name's Megan Troid I'm wondering, Lieutenant Governor, you talked about the importance of home visits, as a social worker who's moving into policy, I agree with you they're very important. But what do you think about increasing training and just education for the people that are going into the homes talking about this? It's often a really hard conversation. There a lot of religious and moral objections to birth control for teens, so just wondering what you would do for the people that are actually providing that?

DR. NORTHAM: It's a wonderful question and I thank you for bringing it

up, because when we talk about going into homes, do we have the manpower, if you will, the number of social workers, and nurses, and whoever we choose to take into the homes. And the answer to that is no. We're very underfunded for that. And so just to give you an example in Hampton Roads, where we have a program, CHIP is actually the name of the program. And that's actually a statewide program where we go into homes. For every one home that we visit, there are ten others that need our help.

So we're chipping away really by what we're doing right now. But you're exactly right. And not just in that area, but mental health issues that we're working on in Virginia. We're very much underfunded and understaffed with psychologists, social workers. So it's all about priorities and all about where we want to make our investments. But your point is well taken and we do need to make sure that we have more individuals that are trained to do that, and able to get into these homes and help. Again, as I say try to bend that curve of poverty, that's what our intentions are.

MR. HASKINS: Right here on the aisle. Wait till I get the mic.

SPEAKER: Thank you, I am a Virginia voter, so thank you for being here and your service.

MR. HASKINS: That sounds like a warning to me. (Laughter)

SPEAKER: No. It's not. But I would suggest that the smoking analogy is slightly off, since most religions didn't think that smoking was a sin. And there are still a number or religions who think sex outside of marriage is wrong.

DR. NORTHAM: Yes.

SPEAKER: So there's that difference there.

DR. NORTHAM: Good point.

SPEAKER: But the political, the question I would actually like to pose to you is that you say the people will ultimately choose. But the people that are actually the people who vote who choose to come to local elections and state elections, and not just national elections. And in the state of Virginia women between the ages I would say of 21

and 35, do not necessarily come out to vote. I'm not a politician, or a pollster, but it's pretty obvious.

DR. NORTHAM: You're on the right track, you're doing very well.

SPEAKER: So I would ask you to comment on the need or the role for outreach to the voters who don't vote in local and state elections in states like Virginia regarding issues like this?

DR. NORTHAM: Your point is so well taken. And I think a lot of us if we remember back to when we were 25 years old, politics and policymaking was not real high on our radar screen. So one of the things that we're doing and we're very active, at least in Virginia, I can't speak for other areas, but is going to our colleges and universities, or community college systems and talking to those individuals and talking about these very issues just like with LARCs. And whether legislators, most of whom are men by the way, should be telling women what they should and shouldn't be doing with their bodies, whether legislators should be telling people who they should love, who they should live with. And that is all part of the process as we move forward to make our young folks -- and the reason I'm so interested in this is I have a 27 and a 24-year-old. And I see their friends. I see what's important to them. And I am working as hard as I can and a lot of other folks are, as well, to make sure that we do reach out to that population if -- just as a follow up and a conclusion of that, when we do do polling, when I ran in 2013 for lieutenant governor we knew that the people that would be voting were elderly and women. Those were the two big areas. And that's who the folks that were heavily targeted.

Does that mean that we should ignore the rest of the folks? No. And so that's our job now is to get out and make sure that in the next election, that it's not just the elderly and the women, but it is young folks who are educated and in colleges and universities, so that's all part of the overall plan. But you make a great point.

And if you, I don't know what your career's in, but politics and polling may

be good for you. (Laughter)

MR. HASKINS: Another question. Over here in the middle up here. And then the next, and last one, will be on the back aisle there.

SPEAKER: Lieutenant Governor, I'm also a Virginia resident and voter, and I want to congratulate you on whatever role you had in turning around the bogus regulations of clinics. But there have to be some challenges for the next several steps to make sure that it sticks. So what do you see as the challenges? Where are they coming from? And what is your approach going to be?

DR. NORTHAM: Well, yes, ma'am. That's a great question. And you're referring to the TRAP laws. And those changed the structural regulations for women's reproductive clinics. And I won't get into -- I certainly don't want to get off on a tangent, but that was done in the guise of making it safer for women. And the data is not there to support that. And my concern, as a pediatric neurologist, and as physician, I mean we have people like me that are doing procedures. In our office, for example, I do lumbar punctures. You have gastroenterologists, plastic surgeons, dermatologists, that are doing procedures that are much more dangerous than an abortion, if you look at the data.

And so my question to them when they introduced and then unfortunately passed this legislation, "Am I next?" If you're worried about the safety of our patients, what's gonna happen if you think this out?

So right now we have been able to kind of stop the progress of closing down our women's clinics. And that's all through what we call an executive order. That's done through the governor and the Board of Health. But what needs to happen, if we're gonna make those changes permanent, is we need to change some of the seats in the legislature. Right now the Republicans have the majority in both the house and the senate. So it's difficult to go back on laws that have been passed. But that's down the road, what we would need to do and what we would hope to do, to I think to keep Virginia moving in a positive direction.

I would just tell you that a big part of my job, as lieutenant governor, is in economic development. We want to bring businesses, manufacturers, jobs to Virginia, because that's what pays for all of the things that we like to talk about. And if we're gonna do that, we need to have the lights on, as they say. We need to welcome people. We don't want to deter women from coming to the Commonwealth and folks like LGBT community, we want to accept anybody that would like to come and live in Virginia. So that's the direction we need to go in, I believe, to move Virginia forward.

MR. HASKINS: So Governor, before we end this panel, I have a suggestion for you about how you can --

DR. NORTHAM: I'm always open to suggestions.

MR. HASKINS: Well good. So this is a suggestion about how to advance the debate on LARCs. And that is that we mentioned the Colorado situation where they had a big fight and Republicans were opposed to paying for LARCs, or extended birth control. And they won. Despite the fact that one of their most conservative members, a guy named Don Coram, led the fight against his own party. So I suggest you invite him to Virginia to come down to talk to Republicans in your legislature.

DR. NORTHAM: I think that's a great suggestion and we'll take you up on that.

MR. HASKINS: Good. Great. Well invite me to come, because I want to hear what happens when you do that. (Laughter)

DR. NORTHAM: All right.

MR. HASKINS: So join me in thanking the Lieutenant Governor. (Applause) Thank you so much.

DR. NORTHAM: Thank you. I appreciate it.

MR. HASKINS: Okay. If you just bear with us for a minute, we're gonna bring up more opinions.

Okay. Thank you very much. Now we have a disguised panel of people with lots of views on these issues. I hope, you probably all memorized my last slide about all the advantages we could get if we were more successful in ending or at least reducing the number of unplanned pregnancies, and for almost every issue on there, someone on this panel has studied it, written about it, thought about it, so I'm hoping that we'll really dig into some of these issues.

So let me just introduce the whole panel and then we'll proceed. So this is Andrea Kane, Belle's already basically introduced here. She's the head of policy at the National Campaign to Prevent Teen and Unplanned Pregnancy. I worked with Andrea for many, many years, and my typical response to her is, yes, ma'am. That's what I'm going to do. It's amazing how much she knows about what's going on in the Hill. I really like people like that that keep up on the Hill. I've been able to have contacts through lots of staffers on issues I was (inaudible). Because I called Andrea and she tells me who to call, so that's very good. To the extent possible it would be great if you could reflect things that you have heard about on the Hill in your remarks.

Then Rachel Gold is from Guttmacher Institute. She just wrote a wonderful paper. I shouldn't say just, but on coercion, and that's an issue that we're very concerned about that some women may feel -- the Lieutenant Governor brought up the issue of males telling women what they should do, and they we throw racial issues and ethnic issues into the match. This is an area that we ought to anticipate and be sophisticated about or we could really cause some problems or even worse we could do things that are wrong.

Then Mark Edwards. Mark is a wonderful story. Mark was on the board of directors at the National Campaign to Prevent Teen and Unplanned Pregnancy, and talk about turning someone into a true believer. He quit his job and moved to another city so he could start an organization called Upstream, and he now flies all over the country and he tells people how they can bill the federal government to pay for birth control

measures. Is that right?

MR. EDWARDS: Something like that.

MR. HASKINS: Rachel's reaction was, oh god. Anyway, Mark really knows a lot about this because he teaches states how to set up these clinics and train their personnel and all the issues having to do with what it takes to do a good job, especially with regard to having a good program that makes (inaudible) available.

Then I've asked Belle to stay on the panel, and I won't introduce her again. So now they each have a chance for an opening statement, and then I'm going to try to stump them, and then you get a chance to try to stump them. So we're going to begin with Mark.

MR. EDWARDS: I've been introduce in lots of ways, Ron, I'm sure ever that way. But I really do want to thank Belle and Ron for today and for your incredible work. Part of that story's actually true which is that the two of you really have inspired me to change what I'm doing to work on this important issue. I remember when I read the Creating Opportunities Society, which was an extraordinarily powerful book and, of course, I think this volume here is fabulous.

I will admit my bias. I think that helping women achieve their own goals and become pregnant when they want to is one of the most powerful things we can do increase opportunity and economic mobility. Upstream USA delivers training and technical assistance to health centers so they can offer their patients the full range of contraceptive methods, particularly the most effective ones. We've done work in about half a dozen states around the country.

One thing we didn't talk about as much in the beginning here is that the government -- all the governing bodies in the medical field now are really behind these methods, so the CDC sort of talks about how important it is to have access to these methods. The American College of OB-GYNS, and most recently the American Academy of Pediatrics has come out with a definitive committee opinion saying that IUDs

and implants should be the methods of choice for all women, including all adolescents. So this is really sort of middle of the road sort of modern contraceptive methods. These are not, sort of, wacky things at all.

Part of what we do is acknowledge that there's a big gap between what the policy may say and then what actually happens in health centers. What happens more often than not is that women are given a false choice when they go to a health center. They're told you can get the pill today or it'll take you two or three visits to get one of these other methods of contraception. As an aside, only in women's health would this kind of a false choice be available. I mean, if there was a really good stent that was 20 times more effective than a regular one there would be law suits if you couldn't get those methods the same day, but we can't. And so when women are faced with that choice they will either use the pill, and we know that the failure rate in the pill is really quite high, or they'll say they'll come back for one of these other methods. They don't come back and they often will come back pregnant.

So we've had a couple examples that illustrate, I think, what can happen. The very first health center we did some work in was in Amarillo, Texas. A place that has incredibly high rates of unplanned pregnant, teen pregnancy, premature birth, and this is a health center that just wanted to do best in class medicine for their patients. They are now, after the training, making sure that the entire health center is aligned to make these methods available same day. That means not only training clinicians and providers on how to place IUDs and implants, but also ensuring that they can bill for them, code for them. They can schedule properly and they can be counseled properly. I mean, too often patients aren't counseled. They don't know the difference in the efficacy rates between these various methods.

What the data shows that when you tell patients about this, and you make them aware of the various efficacy rates they will often, on their own, chose IUDs and implants for themselves. I think my colleague Rachel's' going to talk a lot about

coercion, which I think is a really important piece of this here. We should not be forcing women to do anything. They should be given a true choice, and unfortunately, the choice they have right now is not a true choice.

But at this health center now they're doing six times as many IUDs and implants as they were before the training. What's most interesting though is that also their revenue is up about 400%, and it's largely because of word of mouth. Because when women know that they can get these methods they are then tell their friends. Patient volume is way up. Satisfaction is way higher. We also are measuring volunteerism. So we asked patients who chose the method? Did you choose it? Did you choose it with your provider or did your provider choose it for you? I think it's a really important question because we want to make sure women are not being forced into this. What we're finding is that upwards of 95% of the women are saying they chose the method. When you give women full information they make great choices.

Another area where we're seeing a real issue is -- one of the background pieces of information here is that most of this unplanned pregnancy, of course, occurs to women who are using a contraceptive method, but it's using a method that's not working well for them. I mean, these really are accidental pregnancies. These are pregnancies that are often occurring to women who know this is not a good time to get pregnant. They know this is not when they want to get pregnant, but the pill, as a method, is simply not that effective unless you're really good about taking it. So this is really an opportunity to help women achieve their own goals.

What we're also seeing is that in many health centers women are not even being screened for pregnancy intention as a regular part of their well care. And so women are actually in these health centers, (inaudible) these federally qualified health centers for a whole range of other health issues, but no one is asking them about pregnancy intention. And so one of the things that we do with our training is to ensure that that becomes a standard part of their intake, and so women are asked the question,

"Do you want to become pregnant in the next year?" It's sort of a standard part of their intake. If the answer is no then we should have a conversation about contraceptive counseling. If the answer is yes, then let's get you into preconception care right away: folic acid, multivitamins.

But unfortunately, that is a question which is not a standard part of care. We're doing a project at a large health center in Massachusetts. Only 18% of the women of reproductive age are considered contraceptive clients. The other 82% are there in the health center for a whole variety of other reasons, but no one is asking about pregnancy intention, and as a result some of the same women are coming back just a few months later accidentally pregnant with this whole set of negative outcomes that the Lieutenant Governor was just speaking about because no one thought about this. This is not a central piece of women's care, as I really believe it should be.

Finally, just speaking to the notion of costs. We're doing a state-wide project in Delaware. Delaware's really interested. It actually has one of the highest rates of unintended pregnancy in the country. We crossed Medicaid data with PRAMs data, the pregnancy risk assessment monitoring system data, and discovered that 74.6% of the Medicaid births were unplanned, three out of four Medicaid births were unplanned. This isn't what women want themselves. It is extraordinarily expensive for the state, just in health outcomes alone. So it really is, I think, unusual opportunity to both help women achieve their own goals, and also to save money at the same time.

I just want to close with three quick points. One is that this really has to be all about patient choice. I know Rachel's going to be talking about this, but that is such a central part of this. We cannot force women to use any methods at all, but true choice means that they really ought to be offered the full range of methods same day. That's what the data shows, how critical that is. Not that they can get some methods some days and takes you two or three visits for another, but rather all methods same day. That's really important.

Second, is that IUDs and implants, they're not a panacea. We know that that's not the solution to the cycle of poverty, as the Lieutenant Governor spoke about. But we also know that last year there were 1.4 million unplanned births in this country. My own view is that if we want to increase opportunity, if we want to make sure that children can achieve their full potential we really need to include this as part of what we think about as an opportunity continuum. We can't just simply start the conversation once children are born. We have to ensure that the children are born to parents that want them, who plan for them, and who think this is a good time to have them.

Finally, I just want to say that this basic idea that women should be able to plan their pregnancies and have children when they want them -- in my view, this is not about 'those women.' This is what I would want for my own children. I mean, I have three college-aged girls, myself. My new occupation has certainly changed the conversation around the dining room table in my household, as you can imagine. But I want them to become pregnant only when they want to, and not a minute before. So this is really why wouldn't I want them to have access to the most effective methods of contraception? If those methods don't work then we can move on to something else, but, you know, my oldest is now 23 was never offered these methods. She just didn't even know about them, and yet we know the failure rates are so different.

I think it's important as we have this conversation to recognize that this is not -- we focus a lot on poor women and low income women where the rates of unplanned pregnancy are actually going up. This is important and best class medicine for all women. Thanks.

MR. HASKINS: Thank you, Mark.

MS. GOLD: I could not agree with Mark more about the importance of enabling women to make free judgements and free decisions about their child bearing. I think that is an absolutely critical goal. I could not agree with Mark more about the potential of LARC methods. They have amazing potential. You look at the numbers,

they have amazing potential. I think that means several things. I think that means that we have an obligation to remove any and all barriers to use of these methods. We have to make sure that women can afford them. We have to make sure that they are available and accessible in the places that women go for care. I think we need to make sure that women who have just had a baby, who have just delivered have access to LARC methods that day. I think we need to pay a whole heck of a lot more attention to the availability of LARC methods for women who have just had an abortion. I think that's something we don't talk about a whole lot. We don't think about a whole lot. I think that's a really important missing piece of this whole debate.

Having said all of that, I think we have to, as we go down this road, be mindful every single minute of going too far. In the guise of making sure that we are removing barriers and leveling the playing field we absolutely cannot go too far and end up titling that playing field in the other direction, and end up being directive. I think that is something we have to constantly keep in our minds as we go forward.

In that regard, I think it's important to look at history and learn the lessons of history. I guess one lesson for me is once a history major, always a history major, so let's think about the history and some of the history having to do with contraception in this country unfortunately is not great. Some of the history specifically having to do with LARC methods in this country is not great. I think that means we have an obligation to learn those lessons. Within days of when the initial LARC method, or one of the initial LARC methods, the contraceptive implant was approved by the FDA in 1990, within days there started to be proposals to offer financial incentives to women if they agree to get a contraceptive implant. That instantly embroiled this method in an incredible controversy. A controversy from which I don't think it ever recovered.

Just within a couple of years, in 13 states legislators had introduced provisions that were not adopted. They were not enacted, but they were introduced, offering women financial incentives if they agree to get a contraceptive implant. That was

in 13 states. In seven states legislators introduced measures mandating use of contraceptive implants for women on welfare, women who had recently given birth to a drug exposed infant, and at least in one case mandating use of contraceptive implants to women who had had a publicly funded abortion. Again, none of these were passed, none of these were adopted, but they were proposed.

We also in five states had judges handing down decisions or offering deals to people who had been convicted of child abuse, offering reduced sentences if they agreed to get a contraceptive implant. What this did was it took this method, that had such potential, and completely engulfed it in controversy, and especially engulfed it in controversy in those very communities that we, as family planning programs, were seeking to serve, and moved this method from having enormous potential to being a source of controversy. It was an incredibly unfortunate event.

Even more unfortunate is that we're starting to see some ripples of this come back. Just this year there was a bill proposed in the legislature in Arkansas, again proposed, not adopted but proposed, that would have offered women $2,5000 to a woman on Medicaid who already had a child, a $2,500 payment if she agreed to a LARC method. Again, didn't go anywhere, but it was considered by a committee. The district attorney in Nashville, Tennessee, you know, which is like not a foreign place. That's where my son lives, Nashville, Tennessee. The district attorney went so far as to formally ban the prosecutors that worked for him from offering reduced sentences to people who had been convicted of child abuse if they agreed to sterilization. Apparently, according to media reports, the DA took this action after four reports in the last five years of these deals being offered to people.

Not widespread, but I think something we just have to keep in our minds constantly. So I think while these methods have enormous, enormous potential while we have an obligation to remove any and all barriers that could possibly stand in the way of women getting access to these methods. I think these are some minefields that we have

to be mindful of. That was not a great sentence. We need to be careful to remember these minefields. We need to remember that the principle of giving women voluntary and informed choice of the full range of contraceptive methods has been at the heart of family planning programs in this country for decades. That principle has served us incredibly well and we need to remember that principle.

I think, frankly, we need to remember that for some women the choice of a contraceptive method is not solely about efficacy. It's about what choice this woman wants to make and what she feels is going to be best for her life. Because at the end of the day the method that the woman chooses voluntarily, the one that she thinks is going to best fit into her life is going to be the method that she can use most effectively to avoid a pregnancy that she doesn't want to have. Thank you.

MS. KANE: I feel like when we talk about this issue we're sort of talking almost on two levels. There's so much progress. There's so much momentum. The conversations that we're having around the country. The research that's coming out of places like Colorado and Iowa and St. Louis are so exciting, and there's so much potential, as Rachel said, and then there's also a lot of landmines, as Rachel said. What I want to do is just try to put some of this in policy and political context based on the experience that National Campaign has had in talking to a lot of people from diverse viewpoints around the country, on the Hill, and state governments, local communities.

I think one of the most encouraging things is there is potential for, sort of, broad bipartisan support on this. I think as the Lieutenant Governor said, you know, if you look at the list of arguments that Ron put up or the list of potential outcomes that Ron put up if we reduce unintended pregnancy. There's something there for everyone, and it happens to be true which helps too. But, you know, reducing unintended pregnancy, in particular, through the use of effective contraception does reduce abortion. It does save money. It improves child outcomes. It empowers women to achieve their goals, and there's something there really for everybody.

I think what we can learn from are some of the places where people have come together to find ways to talk about this. It doesn't mean that it's all perfect. I think Colorado's worth just spending a little bit of time on because it is an exciting, but also cautionary tale. Don Coram, the legislature there who Ron mentioned is a very conservative, pro-life, self-proclaims redneck Republican who saw the value of making IUDs and implants available to women in the state. They weren't the only methods available, as Rachel said, but it reduced the barriers to those methods being available by extra education and counseling so that women could choose those as well as other things. And guess what? When good counseling was available, when the barriers were removed lots of young women did choose those methods.

That initiative was privately funded, as Ron said, and when it came time for the State of Colorado to try to step up and continue the initiative at a very modest sum of $5 this Republican was one of the champions, and he -- you should look him up. You should Google him because he quotes are really priceless. But I want to just mention a couple of them because I think for a state like Virginia they could be very helpful. He said, "If you are like I am and you do not support abortion, you want to break the cycle of poverty, you want young people to have a better life, you want to save tax payer dollars why would you not support this legislation?" He really thought that the cost argument, especially the cost savings to Medicaid would be the way to bring some of his colleagues along.

I think the fact that he was only able to get, I think it was three Republicans, to join him is extremely telling and cautionary. I think the reason that he gave for that, I think, is extremely important. He said it was fear. He said behind the scenes, and this is very similar to what we hear on the Hill, Ron asked me to talk about that. Behind the scenes, he said, most of his colleagues said, I get it. I'd love to support this bill. The research is there. The arguments are there. It's fantastic policy, but I'm afraid. I think there's political liability for my doing that. Good politicians don't give up.

The first time, as the Lieutenant Governor said, and I think there is every expectation that a Don Corman, other people in Colorado will come back at this next year and maybe they'll have more success. I think they've learned some things about how to tweak the approach, how to talk about it that could be instructive.

I think one of the other landmines is when we talk about IUDs and implants and teens. I think I find it a little bit unfortunate that so many of the headlines coming out of Colorado were, Colorado's giving IUDs to teenagers. No, Colorado was making IUDs and implants available to women, including teenagers. But the headline of IUDs for teenagers just grabs peoples' attention and I don't think it has been helpful. So I think it's, again, a cautionary tale for how to talk about this and work on it in a political and a policy space. We definitely find that on the Hill when we talk to Republicans. When we talk about making contraception available to women of all ages you get a very different response than when you focus on in teens. That doesn't mean teens have to be excluded, but it's sort of who you lead with and I just think it's really important.

I think the cost argument is very, very powerful. But it also can be, you know, there's some landmines there. I think the Arkansas one is a good one. I think that legislator was very motivated by the idea of saving government money, and we can give people this incentive which will help save money, but, perhaps, you know, that has some unintended consequences that we have to be really, really careful about.

We definitely have to get the policies in line. I think the Affordable Care Act, the contraceptive coverage requirement making all methods of contraception available with no cost sharing to women who have private plans is a huge step. Medicaid is a huge step, but we can't forget that there's still a number of states where people don't have access to Medicaid and Medicaid expansion, including Virginia. There are still a lot of low income women who don't have that choice, as Rachel said, and that's still a big policy barrier. So I think we can't look just at the national picture on this. We've really got to look at specific states and the kind of work that Mark is doing to help improve

access in some states is really important.

Even if we can get the financing and the policies all aligned and sort of the supply side is all perfect I think we have a lot of work to do both politically and on the ground in terms of the demand side and patient education. If we want to voters to be the ones that help make the decision we have a lot of work to do to educate voters about this, and to educate the consumers. The patients that we're talking about. The National Campaign recently just finished qualitative research with the target audience, with young women 18 to 30 who would benefit from IUDs and implants. We learned a lot about how to talk about LARC, how not to talk about LARC. The first insight was don't use the word LARC, and I think that's something we all have to learn from. So we have to listen to the patients and we also have to listen to both the patients, but also as voters and look at what they want.

A couple of important research findings from public opinion data. Knowledge about the IUD and implant is very limited, and so what people do know is often incorrect, inaccurate, out of date, confused. For example, we found that 77% of adults say they know little or nothing about the implant, and 68% say they know little or nothing about IUDs. So how can they communicate their desires to their elected officials if they don't even have good knowledge themselves about these issues? I think we have a lot of education to do there.

We often talk about sex education for teens. That's often where the debate goes, and it does often become a debate, but we can't stop at teens. I think there was a fantastic policy initiative announced in New York City this week that I would encourage you to check out, I guess it was last week. Where they are now educating college students about the potential for IUDs, and I think they will move on to other methods in time as well, because this is a college completion strategy. That is a way of framing this issue that I think is very inviting, and appealing, and powerful. And, again, happens to be true. So it's not just about reducing non-marital births. It's about helping

people get through college.

Maybe in sort of surprising news we've seen great success in states like Mississippi and Arkansas around the idea of education college students, particularly community college students about unplanned pregnancies. Sort of sex education for college students which helps those students learn about the full range of contraceptive methods and how that can help them achieve their educational goals. Again, I think that's partly happened in those pretty conservative states because we're talking about adults and not teens, so I want to just again caution us to think about how we talk about this, who people have in mind when we're talking about these policy ideas.

Is that my time up sign? Okay. So we will have more discussion now.

MR. HASKINS: Yes, we will. (inaudible) of the overall state of financing for birth control in general, and Mark in particular, in the states where you've been. Is financing a big problem or can they figure it out and mostly get the federal government to pay their share?

MR. EDWARDS: I think I would probably toss this also to Andrea who I think has a better sense of the national sense, but our experience to date has been that many health centers in a wide variety of states think they're losing money when they offer these methods, but when they actually do the data and look at it they actually are not. They're actually making money. In part, because this is now considered a procedure, so they make more money there. And so cost is actually less of a barrier than --

MR. HASKINS: But you're not talking about benefit cost here. You're talking about actual it brings in more money to operate their center.

MR. EDWARDS: Yes. We've seen those data from a lot of the health centers we've been working with, so this notion that somehow these methods are so expensive. We're going to lose money on them.

MR. HASKINS: If you tell that to the next clinic you work with do they believe it, and say, oh, wow, all the more reason?

MR. EDWARDS: Again, we have not been in every state in the country, and there certainly are places that that is not the case, but in many cases cost does not seem to be the primary -- I mean, there's a lot of good policy which has been done. There's some important areas that we need to work on. For example, the post-partum access to ideas, post-abortion as you mentioned, but in the middle of that bell curve, in most places that we have worked, cost is actually not the barrier here.

MR. HASKIN: Go ahead, add to this, and Belle, jump in any time.

MS. GOLD: I want to make two points. I think one thing that we hear from family planning centers all the time is in addition to cost it's being able to have that upfront money so that you can have that, you know, the IUD, the implant sitting in a closet there waiting for a woman to come in and want it. So that it is available, as you said, on that same day, so it's being able to have that upfront money to make that investment.

I think, as Andrea said, we've made a lot of progress on the insurance side. On Medicaid and expanding Medicaid in many states, unfortunately, not Virginia, although Virginia is one of the several states that has a specific Medicaid expansion specifically for family planning. Then we've made a lot of progress, again as Andrea said, on the Affordable Care Act making sure that women have the choice of contraceptive methods and their private coverage.

What we still have though is the gap between Medicaid and private coverage, and we have low income women who don't qualify for Medicaid. We have immigrants, recent immigrants who don't qualify for Medicaid. We have people who are going on and off coverage, so we can't just look at the insurance side. We have to make sure that there is a pot of funding available to provide coverage for people who are between and without insurance coverage. That's where federal programs like the Federal Title X, National Family Planning program can step in to provide that sort of flexible funding to meet the needs of women who don't have insurance coverage on the

day they come in.

MS. KANE: And just to jump in on that, I mean, I think that's where there's a perfect store between the politics and the policy here because the Title X program, which is often what provides that flexible funding, and there's good research that shows when a clinic gets that Title X funding it tends to provide better quality family planning, care, including access to the full range of methods. That program has been proposed for elimination by the House Appropriations Bill and cut by 10% in the Senate really for political reasons which just makes no sense when it's very clear that it helps reduce abortion and save money. But, again, that's the political reality that we face.

MR. EDWARDS: Can I just add one thing?

MR. HASKINS: Yes.

MR. EDWARDS: Rachel talked about I think an important issue which is the question of if health centers can't stock the methods, you know, have them right now, can't offer them same day. Many health centers, we've found, don't realize that you actually can get 90 to 120 terms when they actually can get these methods. And so one of the pieces of quality improvement that we do is renegotiate those contracts so they can actually get 120 day terms which then gives them the cash flow to be able to have the methods right there. So I think there are ways that we can work within the system to ensure the cost is not the barrier.

MR. HASKINS: Bringing up politics, always fascinating and fun to talk about politics here at Brookings and the politics of this issue are especially -- but they're kind of mysterious. You use the word fear that Republicans said in interviews that they would ordinarily support this, I think you said fantastic policy, but they're fearful. What exactly are they fearful of?

MS. GOLD: Becoming unemployed.

MS. KANE: I think they are fearful of primary challenges from the far right, and I think Don Coram said that in the National Journal article. I'm not making this

up. I've certainly heard that from Republicans on the Hill that I've talked to. I don't know if it's true. I mean, I wish one of them would stand up and do what they think is right and test the proposition and we'd find out. Because I think those are extreme views that are not where most voters are, but, obviously, we have very gerrymandered districts and so it depends on where you're from.

We often call this sort of the whack-a-mole problem. On different days they're afraid of different things. I think they're afraid of -- if you're talking about teens they're afraid of saying we're sort of going to encourage every 14 year old to go out and have sex if we make an IUD available to them. Although there's absolutely no evidence that that is true. Or we are afraid that we are condoning sex outside of marriage, or we are afraid that we are doing something that's inconsistent with peoples' religious values, or we're afraid that certain methods of contraception may act as abortificants. Or, or, or, I mean, the argument just changes on different days, but there's a lot of fear.

MS. GOLD: I think the fact that Mark Udall lost in his bid for the Senate in Colorado after having talked about reproductive health and family planning a huge amount, and then being attacked by the Denver Post, which is a liberal newspaper, for being a one issue candidate was probably a big element in Colorado. Don't you think, Andrea?

MS. KANE: I do. And I also think it's fascinating that he was beat be a Republican who went out of his way to show that he supported contraception, said it was a very valuable thing for women. His particular policy solution was different. It was to propose over the counter contraception which, by the way, doesn't help at all with IUDs and implants. But he went out of his way to say, no, no. I'm for contraception too.

MS. GOLD: Mm-hmm. That's true.

MS. KANE: So I think that was a very interesting election, and I think that one has gotten more Republicans to think about ways to be for something when it comes to contraception. I don't think we've seen that yet in terms of IUDs and implants,

necessarily, at the federal level. But certainly a number of Republicans have supported over the counter access.

MS. GOLD: The other issue that I think comes in here and is related to what you said about the number of adults who have very limited knowledge or misinformation about long action forms of contraception is that there's been very little use up until now. I mean, when I first started working on my book the data was saying that only 2% of all women using contraception were using a long acting form. You probably know the data better than I do now, but it's up to something like 12% now. And it's higher than that amongst -- if you look just at young women.

So the word is spreading very rapidly, and I think that will play into the politics. Because once more, and it goes back to your very good question about young women maybe not voting as much, but I think as this becomes better known and as more people are using it, and it remains supported by the medical community that will make a difference politically. But we do have to be patient about that.

MR. HASKINS: Andrea, we haven't talked about about teen pregnancy, which is a great story, most of the audience probably know that the teen pregnancy rate has declined every year since 1991 since two years, total down 60%, and yet we have ten times the teen pregnancy rate of Japan, twice as great as most European countries, so there's room for a lot of progress here.

This administration, right at the beginning, started a program called Teen Pregnancy Prevention which is getting the most thorough evaluation of any program that I know of, and it's at 102 places around the country. We've already talked about all the potential advantages of more effective forms of birth control, especially with you, you know, with teenagers. And yet, the House killed it and the Senate cut it by 80%. Were they fearful? I mean, what's -- I don't understand why this is happening.

MS. KANE: First, I want to be very clear that that program, the Teen Pregnancy Prevention program, TPP, is not a program that provides contraception. It's

an educational program, and I think it's often helpful to divide educating people about why to wait to have children and how to do that from the actual delivery of contraceptive services.

That said, it's an evidence-based program, as you're written about in your book. It's one of the gold standard evidence-based programs and it is mind boggling that it would have been proposed for elimination. I think from everything we've heard it has gotten caught up in politics, shocking. And I think that the larger politics around Planned Parenthood have shifted into putting that TPP program at risk, unfortunately. We're hopeful that it can get restored, and that science and evidence will prevail, but it's at risk.

MR. HASKINS: Science and evidence prevail. That's --

MS. KANE: We can be forever hopeful, right?

MR. HASKINS: That's got a ring to it, right? Well, it's one time that I've been very pleased that the labor age bill is not going to pass. So we're into continuing resolution and maybe we'll get the money for another year because this is a really important program.

This is the last question and then we're going to open it up to the audience, briefly. What is the number one thing we could do that would make these long acting, reversible forms of contraception more available, especially to a woman (inaudible). What's the single most important thing we should do? Go ahead, Rachel.

MS. GOLD: I think it's working at the service delivery level, and I think it's a lot of training. I think it's a lot of the staff at the sites are older and, like me, are schlepping around, you know, baggage from the Dalkon Shield from 20 years ago or the transition to getting to the place where thinking that these methods are appropriate and find for teens and young adults is a long transition. So I think it's the hands-on training of how to do it, but I also think it's just talking to people and helping people understand that this needs to be part and parcel of the service delivery package at every one of these

sites.

MR. HASKINS: Rachel just said that Mark, you're doing the most important thing that needs to be done now.

MR. EDWARDS: I'm just going to keep my mouth shut.

MR. HASKINS: So surely you agree with that. What's the next thing we should do?

MR. EDWARDS: I will take that and raise it one step forward. Thank you. It is the work we do. I would also say that if we could establish quality family planning guidelines of the kind of work that should be going in health centers, and timed Medicaid payments to meeting those guidelines I think that would be a great thing. Because right now we don't have those guidelines. We don't --

MR. HASKINS: So this is a version of training because you'd have good guidelines and then you would --

MS. KANE: Follow the family planning guidelines.

MR. EDWARDS: Tied to family?

MS. KANE: No, not tied to family.

MR. HASKINS: Here. Let me ask a question.

MR. EDWARDS: Sorry.

MR. HASKINS: This is really a version of training that we'd -- first of all, have the guidelines, but then they'd be some way to train clinics on how to follow it?

MR. EDWARDS: Create some incentives that actually made sure these methods are available same day. Okay. Bell, what do you think?

MS. SAWHILL: Well, I very much agree with this. This is the supply side, so since it's already been covered I would say we have to work on the demand side too. I think that educating the public more broadly and getting, especially, young women knowledge about the fact that this is safe, and effective, and hassle free, and so forth is really, really important.

MS. GOLD: I just want to comment on that.

MR. HASKINS: Yes, go ahead.

MS. GOLD: I'm all for the quality family planning guidelines. I get very uncomfortable when we have performance standards where we're, you know, essentially grading people. That's your report card on what the level is of uptake of these methods, and then you tie that to payment which then can have the impact of giving providers a financial stake in the methods that women choose. That makes me really uncomfortable. I'm all for the performance standards where we look at, you know, try to spot low numbers and use performance standards to spot, you know, low uptake as may be a sign of barriers to access.

I get nervous when you have performance standards that end up in this kind of world of pay for performance that is kind of all the rage in healthcare at the moment. I get nervous when we end up in a system where providers have a financial stake in what methods women choose. That makes me nervous.

MS. SAWHILL: Let me just ask a follow up on that that might be slightly push back which is Mark talked about having a screening question that's on every health care form. When you go to your doctor for, you know, just an annual checkup and you're a woman of reproductive age there should be a screening question there on do you intend to get pregnant or want to get pregnant in the next year. I think that that could be a game changer, but to get doctors and other providers to do that you might have to regulate or provide a financial incentive. Would that be going too far in your view?

MS. GOLD: Where I get uncomfortable is when it affects the choice of method.

MS. SAWHILL: Right, right. I just wanted to clarify.

MS. GOLD: It's absolutely foundational to me is that women should have the unfettered ability to choose the method that they think is best for them.

MR. EDWARDS: I think we all agree about that.

MR. HASKINS: Audience. Let's start up here, Nick Zill. Nick, you can't tell us about your magnificent adoption study, okay?

MR. ZILL: Apart from your mention of the Dalkon Shield you have had no discussion about medical complications of these methods, and also the media coverage of those medical complications. Because it seems to me that the stories that I've seen tend to be very one-sided and talk about the risks, and do not end at the end of the article saying, but, you know, these are the most effective contraceptive methods. And maybe what part of what we need to do is balance what journalists do about the complications and the benefits.

MR. HASKINS: That's an excellent point.

MS. KANE: It's a really good point. And you're right, there tends to be a lot of attention to some of the side-effects and to some of the problems. And we have to remember, and I'm sure the doctor/Lieutenant Governor would remind us of this, that any medical device or pharmaceutical ---

MR. HASKINS: Procedure.

MS. KANE: -- product has risks. But I think the key point is to -- in counseling with women, to talk about that. To talk very honestly about the benefits and the downsides of these methods so they can make an informed choose. And also in our sort of public messaging to put those risks in context. From the qualitative research we've done with young women and also from some national survey work we've done those negative stories, even the fine print that you hear in ads on TV about all the side effects, those loom very, very large in women's minds, and that's often all they know about a method. So I think you're right that's something we have a lot of work to do.

MR. HASKINS: So that makes his point even more important.

MS. KANE: Yes.

MR. EDWARDS: There are a lot of risks associated with unintended pregnancy.

MR. HASKINS: All the way in the back.

MS. HAGLER: Hi. My name is Lauren Hagler. Off that question of the risks and talking about the coercion that there used to be. What about that LARCs weren't that safe when the first came out? There were the bad brands that came out. For instance, like in my personal experience, my mom was like, why would you want to do that? It's really unsafe, basing it on a bad experience that she had, and then in the 90s with the implant, so what do you guys think about that?

MS. GOLD: I think we should just reiterate something that Mark already said which is if the American College of OB-GYNs and the American Academy of Pediatricians have said this is not only safe, but should be the first line of defense for any women who wants to avoid a pregnancy what more medical certitude can you get about safety? Now, it is true, and Mark I'm sure you know more about this than I do, that a lot of providers out there, including existing gynecologists who are in practice and are well-respected, will tell a women when she comes in, oh I don't do that. It's not safe.

I have friends, younger friends obviously, who've gone to their gynecologists --

MR. HASKINS: Good thing she clarified that.

MS. GOLD -- after they read my book and asked for an IUD and have been told by their doctor, oh no, we don't do that. They're not safe. So there is an education job and a retraining job to be done here.

MR. EDWARDS: Yes, absolutely the case. It's just so unfortunate these new IUDs are called the same things as the old Dalkon Shield were, but I think the evidence is really clear. It's also what the research shows, particularly coming out of St. Louis, is that when women choose these methods they tend to like them much more than they do the pill. They tend to stay with them longer which is one of the reasons that it lowers rates of unintended pregnancy. They don't sort of go on and off, and they also return to their original fertility faster than they do with some other methods of

contraception. So there's lots of things about these methods that women like better.

MR. HASKINS: Next question. Up here in the front.

MR. TERRIA: Hello. Thank you. My name is Richard Terria. I was wondering why is it there seems to be hesitation about focusing on teens with the education on these methods they lack and all that? I remember that one of you said that you want to just call it women, not teens, and I have experience in the minority communities. I'm a Ghanaian and in our communities where we talk with the girls they call themselves girls more than women, so when you talk of women's health issues they don't consider it as part of belonging to them. So why do you think there's a hesitation to talk about it in terms of teens rather than -- why don't we help that population out?

MS. HASKINS: Repeat the question, quickly.

MS. KANE: I think the question was why the hesitation to talk about the teens and that sometimes if you talk about women, which includes teens, teens may not hear themselves in that. They think of themselves as girls, not women. Is that the question?

I think it's a good point. I think it's more just a political hesitation than anything else. I mean, as we've heard, from a medical point of view, the American Academy of Pediatrics says IUDs and implants are perfectly appropriate and first-line --

MR. HASKINS: For teens.

MS. KANE: -- option for teens. I think it's more of a messaging issue in terms of sort of the political and policy discussion.

But I also feel like, you know, we sort of were trying to have this conversation on two levels, and we need to. There's how we talk about in a policy and political space, and then there's how we talk about it when we are trying to actually reach girls and women. It'd be nice and convenient, and a lot simpler if we could sort of use the same terms all the time, but I think we do have to kind of tweak our messages.

I just want to go back to the point about LARC. We all are using this

term LARC because it's a convenient way of packaging a couple of categories of contraception. The research we've done with women has shown that packaging makes no sense to them. They don't understand why you would treat something that goes in your arm and something that goes in your uterus as one category of things. They're just so different, so that we've started to now talk about IUDs and implants. It's a little bit few more syllables than saying LARC, but I think that's an example where, sure in a space like this we can talk about LARC to shorthand. But if we were talking to an actual young women who's thinking about getting one of these methods that's probably not the best way to talk about it.

MR. HASKINS: Last question.

MR. EDWARDS: I just wanted to add on to that.

MR. HASKINS: Oh yeah. Sure.

MR. EDWARDS: I think we know this, but the vast majority of unplanned pregnancy occurs to women who are not teens, and so we tend to focus on teens, but it really is single women in their 20s where the heart of it is, and so it is an important thing to keep in mind.

MR. HASKINS: Right in there, second one.

MS. RACINE: Hi. My name is Kirsten Racine. You had mentioned that ACOG's done a lot of great provider education with their membership, but what's being done more on the primary care level? Because I know that a lot of women won't see a gynecologist until their 21 years old, and most women at that point in time are already sexually active, so what's being done at the primary care provider level?

MS. GOLD: Not enough.

MS. SAWHILL: That's where having the screening question becomes important that we talked about.

MR. EDWARDS: The bulk of our work is actually in primary care settings. That is a huge opportunity, because you're right, that's where the volume of

patients are. Where they're seeing them early. There's a big gap between what's best and what's actually happening.

MS. GOLD: Just to add onto that, and not to pick on the pediatrician in the audience. I think it's not just the primary care level. I think we really need to focus much more on the pediatricians, the adolescent care docs, the docs that are seeing women in their teens who can really set them up for being able to make responsible decisions going forward.

MR. HASKINS: At least I hope we've convinced you this is a really, really important issue, and there's plenty of evidence that we could actually do something about it if we got the policies right, and we're moving fairly rapidly in that direction. This is generally a good story. We need to keep going in the same direction. Thank you very much for coming today and join me in thanking the panel. Good day.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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