

THE BROOKINGS INSTITUTION

IMPROVING OPPORTUNITY THROUGH
ACCESS TO FAMILY PLANNING

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Keynote Address:

JACK MARKELL
73rd Governor, Delaware

Summary of Report: “Why States Matter in the Battle Over Women’s Reproductive Rights”:

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CAMILLE BUSETTE, Moderator
Senior Fellow and Director, Race, Prosperity, and Inclusion Initiative
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PARTICIPANTS (CONT'D):

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Senior Advisor and Former Chief Executive Officer
The National Campaign to Prevent Teen and Unplanned Pregnancy

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Co-Founder/Co-Chief Executive Officer
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GINNY EHRLICH
Chief Executive Officer
Power to Decide

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Panel 3: Research:

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P R O C E E D I N G S

MS. AARONSON: Welcome to Brookings. I'm Stephanie Aaronson, vice president and director of the Economic Studies Program here at Brookings. Thank you for joining us for "Improving Opportunity Through Access to Family Planning."

Before we begin, I want to take the opportunity to thank Isabel Sawhill and our Future of the Middle Class Initiative for organizing today's event. I also want to thank Governor Jack Markell and all of our panelists for their participation, and Morgan Welch and Anna Dawson for helping to coordinate the event.

Nearly half the 6.1 million yearly pregnancies in the United States are unplanned, as are about one-third of all births. These unplanned pregnancies, whether unwanted or mistimed, are associated with a wide variety of negative health, economic, educational, and psychological outcomes for both children and parents.

While the subject remains controversial in some quarters, most people agree that empowering women to have only the children they want has positive benefits for everyone in the form of better pregnancy outcomes, improved child wellbeing, more opportunities for women and their partners, reductions in cost to government, and lower abortion rates. To achieve these improved outcomes, however, we need to base our policies on the latest research and learn from past efforts.

This event brings together a mix of researchers and policymakers to provide us with just such an update. The conference focuses on the release of a new report by Brookings Senior Fellow Isabel Sawhill and Senior Research Assistant Katherine Guyot, "Preventing Unplanned Pregnancies: Lessons from the States," which looks at strategies for reducing unplanned pregnancies and births, especially at the state level.

After Belle provides us with a summary of the report, we will hear from three panels with an all-star cast of experts from around the country, which will focus in turn on state experience with pregnancy prevention, new approaches to reducing unplanned pregnancies, and what the research said about the success of various strategies.

But before that, to get us started here today, it is my great pleasure to welcome our keynote speaker, Governor Jack Markell, who led the path-breaking efforts in Delaware to reduce the rate of unplanned pregnancies. Markell served two terms as Delaware's governor, completing his tenure in 2017. Under his leadership, Delaware won the top spot in President Obama's Race to the Top competition and high school graduation rates saw some of their best increases in the country. Markell also served as chair of the National Governors Association.

His work on unplanned pregnancy began back in 2014. At the time, Delaware had the highest percentage of unplanned pregnancy of any state in the U.S., 57 percent. As you will hear, it subsequently made substantial progress in reducing that rate.

I hope today's event helps to further improve opportunities for women, men, and children by shedding light on the most effective strategies to reduce unplanned pregnancies and births, in part by showing what Delaware and other states have accomplished by ensuring more women have access to the most effective forms of contraception.

On that note, and on behalf of Brookings, I'm delighted to welcome the 73rd governor of Delaware, Jack Markell. (Applause)

GOVERNOR MARKELL: Well, thank you, Stephanie. Wonderful to be here. And I want to start by thanking Isabel Sawhill for the invitation. I think the report that you and your colleague have produced is really excellent and I encourage everybody to read it.

I do appreciate Stephanie characterizing the panels to come as being an all-star cast of experts. And I would just point out that many of them are either from Delaware or with Upstream USA. And since I served as Delaware's governor and I'm on the national board of Upstream USA, I totally agree with the characterization.

You know, most of us who run for office I think do so because we believe that it's all about expanding economic opportunity. I mean, that was the -- if you had to ask

me the single most important reason I ran, it was about helping more people achieve their potential and seize all the opportunities available to them. And that is absolutely why I ran for governor of Delaware.

And through much of my time in office -- I served eight years, two terms, which is the most you can serve in Delaware -- I focused on many of the typical, traditional policy areas. Everything from early childhood education, we made significant strides; better career and technical education, making it possible for more low-income students, but high-performing, low-income students to attend college; focusing on reducing mass incarceration and preparing those who came out of prison to get on a better path. And I'm proud of all of the progress that we made in those areas.

But I also became aware through many conversations in my state that so many women, and for that matter a significant number of men, would tell me about one of the things that would often hold them back from pursuing their own careers and from pursuing their dreams, and that had to do when an unplanned pregnancy came about. And so when Mark Edwards, who you'll be hearing from later, who co-founded Upstream USA, came to talk to me about an opportunity to really empower women in Delaware so that they would be able to have their children when they really were ready for them, when they really wanted them, I was very interested.

And by the way, this was, for me, not just an academic exercise. As I said, I had hundreds and hundreds of conversations during my time in office with women and some men who were in this position, including young people that I knew very well, people that my wife and I -- young men who my wife and I had worked with and mentored over a long period of time told me their own stories, their own personal stories about how their own career opportunities had to be delayed because of this issue. So I really came to realize, and Mark put it to me very well, he basically said he had come to the conclusion that one of the most important things that we could do to help all people achieve their potential is to give women the power to have their babies when they really were ready for them. And as he talked

about it and so much resonated with my own experience and with the conversations that I had had with so many people in Delaware, I agreed.

So in 2011, there were 6.1 million pregnancies in the United States and 45 percent of them were unintended. The unintended pregnancy rate in the U.S. is significantly higher than in any other developed country. And as Stephanie mentioned, the unintended pregnancy rate in Delaware was higher still than the national average by a good margin.

So I saw in Delaware, as Mark and I started to talk about the opportunity to really move the needle in our state, I saw that we had some significant barriers to access to contraception, including a lack of trained providers, health centers that required multiple appointments. This is a very big deal. If a woman said she wanted to access a long-acting, reversible contraceptive, she might have to come back one or two or three times. There was a lot of misinformation. There was poor patient counseling.

In 2015, only 30 percent of publicly funded community health centers nationwide provided same-day access to the full range of contraception. Now, this is really an extraordinary figure. It sounds like I'm in the weeds, but it really speaks to one of the major challenges in the field.

One of the largest federally qualified health centers in my state, in Delaware, told me it had six-month wait list for the most effective methods, the long-acting, reversible contraceptives, specifically the IUDs and the implant. By the way, I've become very comfortable talking about IUDs and implants in settings like this. I did, in fact, in 2016, in my State of State speech talk about this initiative and I did it, you know, 70 percent because I think it's so important for my state and 30 percent because I just wanted in front of all these legislators to talk about IUDs and implants and watch them try to slide under the seats. (Laughter) And I just about succeeded at that.

So address this challenge we launched an effort that we called Delaware Contraceptive Access Now. This is a public-private partnership with Upstream USA. And Upstream USA is a fantastic nonprofit group that provides training and advice to health

centers to improve reproductive healthcare and access to contraception. As I mentioned, after I left my time as governor, I joined the national board of Upstream USA, and I'm thrilled to see other states embracing this opportunity, as well.

But I want to be clear, this is not just about LARCs. This is not just about long-acting, reversible contraceptives. This is about ensuring that women have access and agency over their full reproductive lives, including access to the full range of contraception and preconception care. And this applies to all women.

And essentially what we have done, and I'm sure you'll be hearing more about this from Mark, is we've really tried to change the way the healthcare system interacts with women of child-bearing age in Delaware, so that anytime a woman of child-bearing age interacts with the healthcare system they're asked whether they intend to have a baby in the next year. And if the answer's yes, they're connected to the appropriate preconception and prenatal care. And if the answer's no, they're made aware of the full range of methods.

By the end of 2016, the 160,000 of reproductive age served annually by Delaware CAN health center partners now have access to the full range of methods for free or little cost in a single visit. I mean, that is a really important sentence. And this really speaks to the progress that we have made over these last few years. Colorado pioneered a similar program. In three years, it saw a savings of \$5.85 in Medicaid costs for every dollar that was invested because mothers and babies ended up healthier.

And while this for me was not about -- I didn't get into this because it represented a dollar savings. The fact is this is a win-win-win. This is better when it comes to economic opportunity for the women and many of the fathers, as well. It is about the cost savings, but it's also about the improved birth outcomes because when women are planning for their babies, the chances of having a healthy baby are much higher. So we are already seeing some very promising trends in our state.

Child Trends, which is a nonpartisan, nonprofit research institution that focuses on issues affecting children and youth, have used a simulation model. They call it

FamilyScape. And they estimate a 24 percent reduction in unintended pregnancy amongst a subset of Title 10 patients. And they do so based on the different uptake of various contraceptive methods, and you'll probably be hearing more about that today.

We also believe that this is going to have a significant impact on abortion rates across the country, and we're already seeing it in Delaware. So in Delaware, during the first few years of our initiative, Delaware CAN, abortions by Delaware residents have decreased by 32 percent with no reduction in access to abortion. There should be some ooh's and ah's at that. (Laughter) That is a big a deal.

Teen rates of abortion in Delaware saw an even bigger decrease, 43 percent. So, you know, the national conversation today is just so unbelievably focused on partisanship, bickering, and talking heads talking past each other, but there are so many examples of commonsense, effective solutions at the state and local level across a range of issues, but certainly this one, that increase patient choice and better outcomes for everybody.

So this is good for families, for society, and, most importantly, this is about what women want: to be empowered to make their own decisions about their own lives. And our work in Delaware with Upstream demonstrates the success that a public-private partnership can have in a very short period of time. This only launched a few years ago, and it's replicable and it is sustainable. By empowering women to choose when and if to become pregnant, the ripple effects will benefit generations of people in our state.

And I am really excited, as I mentioned, to see a number of other states embracing this, pursuing this themselves. And I am a huge advocate to future governors and legislators across the country that they have a responsibility to take a step back from the partisan rhetoric and look at what really works and this is a great example of that.

So with that, happy to take questions. I do want to acknowledge a number of -- there are a lot of Delawareans in the room, but a few in particular. Dr. Karyl Rattay, who you'll be hearing about, is the director of the Division of Public Health under Governor

Carney, and she had the same position for all eight years in my administration. And this would never have happened without Dr. Rattay's leadership, so I'm incredibly grateful.

Dr. Janice Tildon-Burton, who you'll be hearing from later, one of the leading providers in our state and role model for so many. So thank you very much, really grateful to you.

And Liz O'Neill, who has run Delaware CAN. And Liz had been in the field sort of broadly speaking for years, and called me several years ago. I'll never forget the call. I was at home and I think a report had come out about the high rate of unintended pregnancy in Delaware, and she called me. And she said, what are we going to do? And I said, you know what, I actually think we may have an idea. And we were successful in recruiting her to lead the effort, and she continues to lead the effort and for that we are very grateful.

So with that, I'm happy to take a few questions.

MS. AARONSON: Okay, it seems like we have six or seven minutes for questions. We have someone who will bring a mic around to you so everyone can hear your question.

SPEAKER: Hi. First of all, thank you so much for speaking on this, especially as governor of Delaware. That's so exciting to hear about this movement.

So there's been a recent movement amongst like younger individuals in this country about recognizing that not only women can get pregnant and that also our trans folks can also get pregnant. So what does contraceptive access look like for them in Delaware? Thank you.

GOVERNOR MARKELL: I'm going to ask Mark or Liz to -- I should have warned them. I may deflect some of the questions that you all may be able to answer better than I can.

MS. O'NEILL: I don't know if it's going to be a satisfactory answer to you, but our philosophy has always been, you know, all individuals, all methods at all of our

health centers, so we use a patient-centered approach for everyone that's counseled. And I would hope and assume that the care would be just optimal across the board given our philosophy and the way we've implemented our program.

And it's also part of, thank you, one of my quality improvement officers just let me know that it's part of our clinical training, you know, curriculum that we deliver to all our health center partners.

MR. EDWARDS: Only just to add that anti-bias training is a central part of the work we do, as well. And so that's just a critical issue that we have to keep in front of us.

MS. AARONSON: Other questions?

MR. CHECCO: Larry Checco. My question has to do with birth control, as we talked about. And it seems that, you know, there's a portion of our society that doesn't want to provide birth control. And at the same time, many of these people are also depriving kids the child care health services, child care in general, school opportunities. What can we do to change this attitude? I mean, if you want kids into this world, provide them with the services that they need to succeed in it or let women use birth control.

GOVERNOR MARKELL: Well, look, I mean, I think, you know, this is an "and-plus." And so our view is that this is very much about empowering women to make the decisions that makes sense for them. And as I mentioned at the beginning, I mean, we focused extensively, you know, when I was governor and the new administration continues to do so, as well, on issues around child care, on programs like the Nurse-Family Partnership, on program like afterschool and summer school activities. I mean, this could be an entire conversation about all the supports that we need to provide in our communities. So, you know, I think this is one piece, but I think it's an incredibly important piece.

MR. CHECCO: Budgets are being decided.

GOVERNOR MARKELL: What's that?

MR. CHECCO: Budgets are being decided.

GOVERNOR MARKELL: Yeah, but they're not -- this is one of the great

things about, you know, as Justice Brandeis said, states are laboratories of democracy. I believe that the states that make these kinds of investments in our children and in our families are going to do better and, over time, other states are going to get that, as well. Sometimes it takes a lot longer than we would like. But I think, you know, elected officials, public servants with foresight and vision will do the right thing and, over time, their constituents will be better served.

MR. CHECCO: I hope you're right.

GOVERNOR MARKELL: I hope so, too.

SPEAKER: Can you address the politics of this program, who opposed it and who supported it?

GOVERNOR MARKELL: Yeah. Thank you for asking that. I was nervous about the politics, I'll be honest with you, and I was wrong. I really had essentially no reason to be nervous about the politics. As I mentioned, I talked about this in my last State of State speech, and I did so, you know, I was nervous because I thought, you know, I sort of -- in fact, when Mark and I started talking about this at the beginning I wanted to fly under the radar because I was concerned about the pushback.

I mean, this is like such an unbelievable win-win-win. And if you frame it appropriately -- and this is not about spin, by the way. If you care about quality birth outcomes, it means you ought to do a better job of connecting prospective mothers with the appropriate preconception and prenatal care. If you care about creating better opportunities for women and men to achieve their dreams, it means that let's put them in a position where they can really have their babies when they're ready for them. And if you want to save taxpayer money -- you know, the healthy Medicaid labor and delivery in Delaware is \$12,000. Now, a lot of these delivers are not healthy because they were unplanned. And so if you want to also do the right thing for taxpayers, this makes a whole lot of sense.

And so I advise -- this should work -- you know, Delaware is a blue state, I will grant you that. You know, it's red in certain places, but overall it's a blue state. But

North Carolina is going to implement this program. I mean, and this should work equally well in blue and red states. And my experience is that if you get out there and you explain yourself to the voters, whether they agree with you or disagree with you, they will give you the benefit of the doubt. And I think this is exactly what's going to happen on this issue.

MS. AARONSON: We have time for one last question.

MS. GANDAL-POWERS: Hi. Mara Gandal-Powers from the National Women's Law Center.

To your last point about working equally in red and blue states, I'm curious how a program like this is implemented in a state like North Carolina where there's a not-so-distant history of reproductive coercion.

GOVERNOR MARKELL: Yeah.

MS. GANDAL-POWERS: And where certain folks and providers may be particularly interested in preventing certain unintended pregnancies or pregnancies generally.

GOVERNOR MARKELL: Right. This is an incredibly important question and it's one of the reasons that I'm so proud of the work that Upstream has done in terms of reaching out to advocates across the country and particularly groups who are especially concerned about exactly that. And so I think we really have to focus on this being something that is available to all women. And there's no question, with the history that we have in this country around that issue, we've got to be incredibly concerned and we have to raise it from the beginning.

And I think it's true in our training and we all of us need to be held accountable for that. Because I think we have a really sad history, you know, in many ways around this issue. And, you know, it's something that has come up with some of the activists not so much in Delaware, but some elsewhere, and I know that Upstream is working really, really hard to try to make sure that we address those issues appropriately. But thanks for raising the question.

MS. AARONSON: Okay, I'm afraid that's all the questions we have time for. Please join me in thanking Governor Markell.

GOVERNOR MARKELL: Thank you. (Applause)

MS. SAWHILL: Good morning, everyone. I want to start out by offering a few really well deserved thank-yous here. First and foremost to the governor. That was just a terrific talk. And we're now going to call you not just the education governor and the jobs governor, but the IUD governor. (Laughter)

But I also want to thank all the panelists who are here today. Some of them have come from a very far distance. We have someone here from Washington state, we have someone here from Utah, we have someone here from Texas. And they're all really smart, involved people, so I'm really, really happy about that.

I also owe a big thank-you to my co-author of our report, Katie Guyot. Unfortunately, she's sick today or I'd make her stand up. And she did a terrific job and she did all the heavy lifting on the paper. She was nice enough to let me put my name on it.

I also want to thank Richard Reeves. Richard, are you here? I don't see -- oh, good, way back there. Richard is our fearless leader of the Future of the Middle Class. And unlike a lot of people who work in this space, he really cares about these issues and was willing to sponsor this event.

So let me then tell you what I'm going to do, which is try to give you a bit of a roadmap. It is based on our paper, but I think it will also, hopefully, set up the more detailed conversations to come.

So let me start with a few concepts and numbers just so we are all on the same page. If there were 100 pregnancies, about 55 of them would be intended and about 45 would be unintended or unplanned. What do we mean by unintended or unplanned? We mean that the woman herself said that she did not want to have a baby or didn't want to have it right now. And this is based on national data and it's a survey that's been conducted many times.

Of the 45 that are unintended, some will be aborted, some will be carried to term. And in the end, we have about a third of all children in United States right now who are either unwanted or mistimed.

So why does all of this matter? Well, I think you've already heard why from the governor. Like the governor, I think that this is not just a triple win, it's a home run. This is going to be better for children, better for adults. We're going to have healthier babies, happier moms, and better life outcomes for both children and their parents. We're also going to see far fewer abortions and we're also in the process going to reduce government cost.

So what's the good news here? The good news is that unintended pregnancy rates are falling and have been for quite a while. Now, there's a lag in the data, but as far as we know they're still going down.

Why are they going down? Well, there's no smoking gun that I can point to in the literature, but as an economist I'm going to frame it as there's a demand side story and there's a supply side story. On the demand side, new roles for women as workers and as breadwinners really means that the need and desire to control your childbearing is higher than ever. And on the supply side, we do have better access and more effective forms of contraception than ever.

So here's a little data. On the right-hand side is the shift in attitudes. These shifts have been really dramatic and attitudes about women's roles. Given my age I can remember what things were like in the '50s and '60s, and, believe me, it was very, very different. I have to keep explaining this to my younger colleagues because they don't recognize what a huge transformation this has been in women's lives, all to the good as far as I'm concerned. And one of the effects has been that people of desired family size or intended family size has dropped a lot.

On the left-hand side are just a few well-known statistics on how women's lives have actually changed. They're obviously working a lot more. They're going to get a

lot more education because they know they're going to need to have careers. And most importantly, I think, is that top number there, that 41 percent of breadwinners now, primary breadwinners, either sole or primary breadwinners, are women. So, you know, women have huge family responsibilities nowadays that they didn't used to have.

On the supply side, we do have more access to contraception than in the past. Some of you, again, who may not remember what it was like in the '60s, it wasn't even legal to buy contraception, to buy birth control back then. We had to have a Supreme Court case about that. Everybody knows about *Roe v. Wade*, but they don't know about *Griswold v. Connecticut*.

So this shows that there has been some shifts over time. And I think the most important story here or the most interesting one is that you can see that there has been a big increase recently in LARCs. What are LARCs? They are long-acting, reversible contraceptives, mainly the IUD that the governor already spoke about and also implants. There's been some substitution away from sterilization, especially amongst older women, and away from condoms on the pill amongst younger women.

Now, why does that substitution matter? Well, I think this chart tells you a lot. This is telling you that if you have been sexually active for five years, which most young people in their late teens and twenties will have been, long before they are settled in the job market or have a steady partner, that your probability of getting pregnant if you use the condoms is 63 percent, on the pill it's about 38 percent, and on an IUD it's less than 4 percent.

Now, that's not because condoms and pills aren't effective when they're carefully and consistently used. But the problem is that we're not all perfect. We forget to take our pills. We forget to get our prescription refilled. We don't always use condoms the way they're supposed to be used. So there's user failure. And with an IUD, you set it and forget it and you don't have to worry about user failure.

I certainly would emphasize, as has already been said, that we should give

women the full range of choices. But they do need to know what all of their options are and how they differ. I have had young scholars here at Brookings come up to me in the cafeteria or in the elevator after they read my book that came out a few years ago called *Generation Unbound*, saying, oh, my god, I never knew. And these are young women with master's degrees and Ph.D.'s.

So what's the bad news? The bad news is that these newer approaches are under attack or threat right now, not just newer approaches, but the Title 10 program which provided funding for clinics that serve low-income women. And also, the provision in the Affordable Care Act that we call the Contraceptive Mandate sometimes, that's also under attack. So this is going to be particularly troublesome for low-income women and women of color. They're the most likely, by the way, to say that they don't want a child or don't want one right now, and the least likely to have access, especially to more expensive forms, of birth control. Keep in mind that a LARC can cost \$500 to \$1,000. And what 22-year-old has \$1,000 to spend up front on a LARC?

We have also the fact that there's not enough information out there, and what you're going to hear about today is efforts to get more information out, as in Delaware. And too many providers that are not trained or not well equipped to provide all of the various forms of birth control. And then we have the political issues, which you've already recognized in your questions.

So some states are really showing the way here. And, you know, I really want to congratulate Delaware and my friends at Upstream. Mark Edwards, I think, was the first one who came to me and said, oh, my god, I never knew how powerful this approach could be for improving opportunity. He had been the executive director of a national organization that's mission was to improve opportunity in America. And he looked at all the data and all of the evidence and experience and he said this is a much better way, or at least an important way, not the only way, as the governor said, to work on providing social services of various kinds, as well. But this he felt -- oh, I think I lost my charts.

Oh, there it is, okay. So this is just a summary. You're going to hear a lot more about this, of what some of these states are doing: training providers, offering patient-centered counseling and information, providing same-day access. You've already heard from the governor how important that is. Screening for pregnancy intentions, that doesn't mean just in the family planning clinic. That means whenever you go to a doctor, including your general practitioner for your annual checkup, he or she asks you, well, do you want to have -- if you're of reproductive age, do you want to have a baby in the next year? If yes, we're going to help you get good preconception counseling. If no, we're going to talk to you about birth control. Offering all FDA-approved methods, which includes all of the stuff I showed you a moment ago, and sometimes these states are also subsidizing cost, which can be very important.

Now, you're going to hear a lot more about the research on whether these approaches at the state level have been effective or not later on. I just want to show you this one study because I think it's so interesting and impressive. This was a randomized controlled trial, you know, the gold standard as my friend Ron Haskins would say, of evidence-based policymaking. And it was in 40 clinics in 15 states around the country. And all they did in the treatment group was offer provider training. They didn't even subsidize the cost. And as you can see, it had a big impact on the take-up of LARCs and it halved the pregnancy rate at the end of year one. And this is an RCT.

This is a little descriptive data that we put together on two states: Colorado and Delaware. As the governor said, this all began in Colorado, but it's being imitated in many other states now. And I think what we're all hoping, at least I'm hoping, is it's going to spread and every state is going to find their way of doing this well, right for their audience.

So let me conclude. Unintended pregnancies are declining, but access to the clinics, especially amongst lower income women, and access to the most effective forms of birth control are now being challenged at the federal level. We need to keep in mind that unintended pregnancies are the primary driver of abortions.

Imagine the following through experiment. If we could eliminate all unintended pregnancies -- granted, that's just an aspiration -- we would basically eliminate virtually all abortions. Instead, where we seem to be headed is towards a movement to outlaw abortion. If we outlaw abortion, we will still have unwanted and mistimed children and we'll have even more of them than we have now. So which would you rather do? I understand this is a very fraught issue, but I do think that it's important to keep not just women's reproductive rights in view here, as important as they are, but the wellbeing of children and families.

So we have some challenges still and I'm sure we're going to talk about them in the upcoming panels. And I really, really look forward to hearing all of that discussion. I think we really have a chance now to dig in.

So thank you all very much for listening. (Applause)

Any questions, comments? Yes?

SPEAKER: You said that Title 10 is under attack. Do you think you could go into detail?

MS. SAWHILL: Can you speak up a little bit?

SPEAKER: Sure. You said that Title 10 is under attack. Do you think you could go into detail about how and how they are attacking this and how it's going to be --

MS. SAWHILL: Well, the funding for the program is, you know, part of the usual congressional appropriation. And in the process of trying to cut back spending, government spending, it's been on the chopping block. But there have been court cases about all of this and efforts to maintain the spending and the program.

The person who is here who knows more about this than anyone in the world is Andrea Kane or Ginny Ehrlich. Do one of you want to say a word about that?

SPEAKER: Sure. There's a couple of different paths in addition to the fact that funding has not increased for many, many years until actually this year when the House just passed a bill that increased the program for the first time in many years. But I think

more difficult is the fact that the administration has actually changed some of the grant requirements and it's for the first time actually sending money to organizations that actually don't believe in modern birth control, and also adding restrictions and limits saying you can't send money to -- Title 10 money can't go to organizations that also provide abortion, though they have never provided abortion with the Title 10 money.

So that's just at a very simple level a number of both these legislative and executive level attacks. Those are all pending in court as we speak, although there was a very disappointing ruling from the 9th Circuit just late last week that would allow some of these very disturbing things that are called the domestic gag rule to go into effect immediately, although they will continue to be challenged.

So access to family planning through Title 10 is under attack as we speak with potentially devastating consequences for millions of women.

MS. SAWHILL: This story changes, you know, basically every week or two because there are so many challenges and court cases, can't keep up with it.

Anyone else? Okay, well, thank you very much and will the first panel please come up? (Applause)

MS. BUSETTE: So, good morning, everybody. While we are getting seated and arranged here, I just want to, again, thank Governor Markell for his very, very illuminating remarks. I want to thank Belle, not only for an excellent forethought in putting together this event, but also for her very educational slides and her discussion to start us off.

What we're going to do now, is we're going to turn to state experiences. And as you saw from Belle's first couple of slides, the number of unwanted pregnancies has gone down, and there are a number of states that have been leading in that particular area.

And so, we're going to hear today from the State of Washington, Delaware and Utah, and we're going to be able to have, not only presentations about what what's happened in those states, but also a question and answer, which will then be followed by, again, question and answer from the colleagues -- from the audience.

But before we get started, I want to welcome everybody who is, clearly, and everybody who is following us online as well.

The format for this particular panel will be, I will introduce each speaker as he or she speaks, and that way that will give you a chance to sort of reflect on what each speaker has said prior.

So, let me start off with John Wiesman, who is the Secretary of Health for the State of Washington. He was appointed by Governor Jay Inslee in April 2013. Welcome. He is an accomplished Transformational Leader with more than 22 years of local public health experience, and focuses on whole systems approaches to improving health.

John has been passionate about public health since reading a 1983 *Time Magazine* article about disease -- detectives tracking Legionnaires' disease, toxic shock syndrome, and HIV, and through that that was his impetus for entering the profession. He has worked in four local public health departments in Washington and Connecticut, and of course now serves as the Washington State Secretary of Health.

Thank you very much. Welcome. And we are looking forward to your remarks. (Applause)

MR. WIESMAN: Great. Thank you, Camille, and it's really a pleasure to be here and speaking on this topic with you all. I know one of the things that you often like to start out with, is some audience partnership. And so I thought I would do that and ask you: what do you think that is?

I think, yeah, Mark has got -- so what is that Mark? A sports jacket, yes, and it would actually go with this outfit, and that would be back in condominium in Tacoma, which is why I have come dressed to you in formal West Coast wear, but casual East Coast wear. So, if there was any confusion about that, I just wanted to clear things up from the beginning.

So with that; in Washington State over one-third of our pregnancies are unplanned, and while that is better than the national average of 45 percent, as you heard

earlier, our rate really is still too high.

So, a few years ago we launched a multiagency work group to develop strategies to reduce unintended pregnancy. Now, not anticipating significant new resources at that time, we set a modest goal to decrease the percentage of unintended pregnancies from 38 percent in 2015, to 32.4 percent by 2022 for a 15 percent decrease.

Now, to help achieve this decrease we're employing a mix of strategies including education, health system changes, and policy changes.

So, starting first with education: our educational strategy is focused on implementing evidence-based, comprehensive sex education in our highest risk areas, we are using the Personal Responsibility Education Program, called PREP, and employing that in schools, juvenile detention centers and community-based organizations like the Boys and Girls Club; currently we have resources to implement this in 15 of our 39 counties with the highest teen birthrates.

Our next strategy, health care systems change, is garnering the majority of our attention. This includes one partnership with Upstream USA, and another with the Washington State Hospital Association.

The partnership with Upstream, as you've already heard, focuses on solving one specific problem within the health care delivery system, ensuring that all women have access to the birth control choice of their choice at a single visit.

Upstream has identified five barriers to women receiving birth control of their choice in a single visit, and those are: a lack of trained providers, lack of screening for pregnancy intention by medical assistants, issues with billing, coding and stocking of LARCs, clinic workflows that ensure efficient operations for same-day access, and the lack of patient awareness about the types of birth control available, or where to access them.

Upstream, like all of us, keeps patient choice as a core value within a patient counseling model. The Upstream model has four distinct components, training the whole care team about the latest information contraceptive choices, LARC placement and

management and counseling approaches and skills.

The second is quality improvement and technical assistance, and that is delivered actually across the health care system, and at each clinic location, to truly support the specific changes needed to support the transformation we're looking for.

The third being: a data-driven reporting to ensure that our interventions are working at each clinic, and to make sure we are having the intended consequences; and the last being consumer marketing, to share information about the method availability, once we actually have sufficiently trained providers.

Upstream Washington, we're proud to have in our state, is providing four years of sustainable training and technical assistance to approximately 300 public and private health centers, helping them provide care to a projected reach of over 0.5 million Washingtonians.

Currently many Washington health centers don't keep Long-Acting, Reversible Contraceptives, or LARC, in stock, and they're not necessarily fully trained to provide them. In fact, 14 out of our 39 counties in the state either have only one site or don't have any publicly-funded sites offering LARCs. This requires women to travel long distances, or make more than one appointment in order to get the care they choose.

Now, the long-term sustainability of Upstream Washington's work in Washington State is possible because of Governor Jay Inslee's policy leadership in areas like enhanced LARC reimbursement for Medicaid, and Medicaid Expansion.

Our second health care system partnership is with the Washington State Hospital Association, which is sponsoring the development and implementation of a bundled set of best practice care recommendations for pre-pregnancy, pregnancy labor management and postpartum care.

This is called the safe deliveries roadmap, and the adoption of these recommendations are being promoted statewide for both public and private care settings, and the bundles have been adopted as part of our health care reform in Washington State.

Our last strategy is that of policy change. Washington State's policymakers understand the importance of equal access to and affordability of reproductive health care, and are putting into law reproductive health care access.

In 2017, the Legislature passed a bill requiring that any health plan issued or renewed on or after July 1, of 2018 that covers contraceptive drugs, must also provide reimbursement for a 12-month refill obtained at one time by the enrollee, and the plan must allow that enrollee to obtain it at the site of their provider's office, if available.

This increases convenience and reduces chances of missed doses by not requiring the person to head to the pharmacy every month to access birth control or submit a mail order.

In 2018 the Reproductive Parity Act addressed affordability and access, and it codifies that health plans offered on or after July 1 of 2019, be required to cover all FDA-approved contraceptive, contraception and prohibits co-pays, deductibles and cost sharing.

And this year, the Reproductive Healthcare Act for all requires health plans and student plans beginning in 2021, to cover condoms, screening following a sexual assault while a person visits medically necessary services following a sexual assault, prenatal vitamins for pregnant persons, and breast pumps for persons expecting a birth or an adoption.

And these expansions; to the question earlier is coverage regardless of gender, or how one identifies their gender.

In closing, I have two things, one, is our Governor's support for this, and I think standing up again for a woman's right for reproductive health at the State of the State Address, in which he said: at a time when a woman's health care rights are under attack through our nation, let's leave a legacy that ensures full access to contraception and allows women to chart their own course. That includes access to long-acting reversible contraceptive, contraction and reproductive parity.

And I also want to say in closing that the work I have described is not done

in isolation. As a public health agency working to achieve health equity, we are committed to the broad work of reproductive justice.

This includes things like addressing inequitable impacts of environmental threats to our air, water, food, shelter, clothing and reproduction, addressing personal security and health, addressing racism, discrimination, social connection and support, along with self-esteem and bringing the lived experience of the people we serve.

I know this is a tall order, and we continually strive to meet it. Thank you very much. (Applause)

MS. BUSETTE: Thank you, Secretary Wiesman. We're now going to hear from Dr. Karyl Rattay, who is the Director of the Delaware Division of Public Health. Welcome.

She's a Board-certified Pediatrician, and also specializes in preventive medicine, and prior to her appointment, she worked at the Nemours Health & Prevention Services where, since 2004, she led its Childhood Obesity Initiative, and efforts to prevent overweight in primary care settings. Dr. Rattay also provides weight management clinical care at the Alfred I. duPont Hospital for Children in Wilmington, Delaware.

Between September 2001 and June 2004, Dr. Rattay served as a Senior Public Health Advisor the Surgeon General and Assistant Secretary of Health in the Office of Disease Prevention and Health Promotion at the Department of Health and Human Services here in Washington, D.C.

We're very much looking forward to your remarks. Thank you, Director Rattay. (Applause)

DR. RATTAY: Thank you so much. It's truly a pleasure to get to be here with all of you today. I feel incredibly fortunate to have the opportunity to do the work I do as the health official for Delaware. And thank you, Governor Markell for giving me that opportunity.

As you can see I'm very lucky to have been able to serve under Governor

Markell and his leadership, and also very fortunate that our now Governor Carney is also very supportive of this initiative.

You're going to hear a lot more about Upstream, but the work that we have done in Delaware is just clearly not possible without a partnership like the partnership that we with Upstream in our state, and we also have many other wonderful, necessary great partnerships in the State of Delaware.

So, kind of, as I walk through memory lane with this, our discussions around increasing access to, and at that time we called it LARC, began in 2014 when several of us came together here in Washington, D.C., under a HRSA-sponsored initiative, the CoIN Initiative, focused on improving birth outcomes.

And our Medicaid Director was with us, which was really great, and we have -- you've already heard from Governor Markell -- very high unintended pregnancy rates in the State of Delaware, we also have very high infant mortality and pre-term birth rates in the State of Delaware.

And have tried a number of approaches, and we've seen some decreases, but given high numbers of poor birth spacing, we started really planting seeds, and saying at that collective learning collaborative here in D.C., that this needs to be one of, if not our highest priorities in the State of Delaware.

So, we went back to Delaware. Even our Medicaid Director was really excited about this. And then a few weeks later got an email from the Governor saying, with an attachment that included a proposal from Mark Edwards, and I don't think Upstream existed at that time.

But the Governor said: Can we do this? And we came together, I got to meet Mark Edwards shortly thereafter, and we -- I knew immediately this was going to be a great partnership. And we got back to the Governor saying, oh, yeah, we can do this. But we're going to need some help.

And I also just really want to add at this point, through the next few years,

the leadership of our Governor and being able to break through barriers was so helpful to us, and in fact Governor Markell I think did a lot of great things in Delaware including, you know, establishing one of the best trail networks in our states.

So, as it relates to public health we made some strides forward, but this was the one where, I mean, I had never received weekend calls before from the Governor, and in the winter of 2015, and would go: So how are we doing? What do we need to do to make progress on this? He was so committed, and it was clear.

So, Mark and I started taking a Delaware tour and we met with a number of health providers throughout the state. I think Mark was in Delaware, at least five, six, times over a six-month period where we were traveling, and really hearing from providers across the state, including Dr. Tildon-Burton who you'll hear from, and others, you know, what they thought about an initiative to increase access to IUDs and implants, and what were the barriers?

I also want to add, simultaneously, Liz O'Neil who worked for our largest birth hospital, also brought together a number of folks, and my guess is that probably it was a larger turnout than you expected where there were way more than 100 people in a room learning about St. Louis, and learning about Colorado.

And the reason I bring all of this up, is there was clearly momentum in our state, people wanted to do this work, but there was no such thing as same-day access at that time.

And when Mark and I would talk to people they were like, ah, you know, we like this idea, but we don't think that's possible. Or we would hear myths and misperceptions like, well, you know, you can't use IUDs with teenagers, or with somebody who has not had a baby, or even from health care providers, we were hearing things.

And one health care provider said, yeah, we think that it would be beneficial to train APRNs and physicians, but we don't think the whole practice transformation is necessary for us.

Interestingly, right around that time, Medicaid had really, you know, creatively looked at how can they increase access to immediate postpartum, LARC, and so by using a pharmacy benefit we were able to increase access to immediate postpartum IUDs and implants. And also through federally-qualified health centers, user pharmacy benefit.

But what we were finding was that none of them implemented it, and the reason being there's more to practice transformation by far, than just a policy change.

Nonetheless, Mark and I worked on developing our plan, and I like to call it a public health approach because, you know, public health, that's what we call things. But a multifaceted approach which includes policy change, system change, practice transformation, but also increasing awareness, meaning, we really wanted women to know about different contraceptive methods, to know the pros and cons of different methods, and also know where to access them.

But we wanted to make sure that they had the access before we went out there with that piece. It was also very important in our plan that we built and evaluation so we knew and -- we knew if we were making progress and we were learning from our progress along the way.

And also we knew from the beginning that we had to think about sustainability. And I'll circle back around to that. Being a public health state government agency that was still really functioning in the time after the recession, finances were low, staff was stretched very thin, but Mark really convinced me that we had to have this, go big or go home kind of approach to this.

You know, I kept saying, well, I think we can do this. And he's like, oh, we've got to do this big. And so we did, thanks to Upstream we did, and we have trained in our state -- and when I say the "we" that's really Upstream -- has been in over 100 sites, about 142 sites, reaching nearly 700 clinicians, and almost 3,000 staff in our little state.

Our state has shy of a million people. So, a tremendous amount of people,

and in fact more than 126,000 women of reproductive age, are served annually by clinicians and staff who have now been trained under the Delaware CAN Initiative.

And I just have to say, in my years as a medical and public health professional, I have never seen an initiative that has had such dramatic impact on practice change in such a short period of time.

As the Governor mentioned, in Title X, our IUD and implant, our LARC usage increased from 13.7 percent to 31.5 percent in our family planning clinics for those 20 to 39, and we have a simulated estimated reduction in unintended pregnancies of about 24 percent in our state.

I also was kind of snooping around this morning on the way here, to see how we are doing on preterm birth rates, and our latest data from 2018 actually show finally a reduction on pre-term birthrates while the rest of the nation has seen an increase, and we believe -- we don't like using annual data because our numbers are so low in Delaware, nonetheless, this is the first real promising sign around birth outcomes that we've seen.

So, you're going to hear more about practice change, but the practice change and the whole practice transformation is so hugely important, but the policy pieces are very important as well. Having Medicaid at the table all along has been incredibly important, so working with federally qualified health centers to carve out IUDs and implants to make them available -- affordable and available, has been critical.

I want to make a mention around immediate postpartum LARC usage, because Medicaid was able to tackle that pretty early in our state as in other states. We've been a part of a learning collaborative led by -- run by ASTHO, the Association of State and Territorial Health Officials, and learn from really pretty much all states are dealing with not being able to provide immediate postpartum IUDs and implants for privately-insured individuals. And that creates a two-tiered system.

Now, one of the great policies that was enacted in our state -- and I really want to give a shout out to Liz O'Neil who spearheaded this and spent a lot of time in our

legislative hall last year -- was really codifying the Affordable Care Act birth control benefits.

So now in Delaware State code birth control coverage is required with no out-of-pocket cost, as well as a 12-month supply of the pill, and over-the-counter emergency contraception and, this is the big "and", mandating private coverage for immediate postpartum LARC, we were the first state to do that, and we're very proud. That was signed into law by our Governor, Governor Carney in 2018.

And, oh, I am over time. Sorry, I wasn't even looking at you.

Okay, very quickly, sustainability was key, and so last week our House approved a budget that for the first time in my tenures in my role, actually puts a line in public health's budget for a mission-important initiative like this, the budget lines as Delaware CAN, and through the sustainability effort we're going to be able to continue to provide contraception for uninsured and underinsured individuals, and have staff to continue some of the training, as Upstream moves on to other states. So, thank you so much.

(Applause)

MS. BUSETTE: Thank you, Director Rattay. Now, we're going to hear from Dr. David Turok, who's an Associate Professor at the University of Utah, Department of Obstetrics and Gynecology. He's also a Board-Certified Obstetrics and Gynecology, and Family Practice Doctor.

He received his M.D. from Tufts University School of Medicine, and his residency training in Obstetrics and Gynecology was accomplished at the University of Utah where he stayed on as a Faculty Member. His areas of clinical interests and expertise include all aspects of women's health care, particularly for family planning. Welcome, and thank you. (Applause)

DR. TUROK: Thank you very much. And thanks to Belle Sawhill and Brookings for the opportunity, and thanks to the team in Utah that I represent, who, none of which, what I'm going to tell you about, would have happened without them.

As a not young OB-GYN, I have been present over 10,000 times when

women have trusted me to care for them, at critical times during pregnancy. I have seen, heard, and felt elation, exhaustion, pain, grief, and plain relief from women undergoing natural childbirth, cesarean sections, abortions and miscarriages. And from these experiences I have learned to trust women.

A few years ago, I vividly remember walking out of a clinic room in Downtown Salt Lake, and I had just placed an IUD for a patient who I knew very well, and I had been there when she had come way too close to dying at the birth of her twins, and we had done some pretty unusual things to get her and IUD that she very much wanted but didn't have insurance for, and couldn't afford.

And I stood outside of her room thinking: why are we making it so hard for people to plan their families? So, we got to work building a team to expand contraceptive care for the people who are the most underserved in our neighborhood, and in our community. And now it is very exciting to share some progress about two Utah-based contraceptive initiatives.

The HER Salt Lake Contraceptive Initiative began in 2015 as a plan to make IUDs and implants highly effective, reversible, or HER contraceptive methods, available to people in Salt Lake without cost. And colleagues help me realize that it wasn't just about IUDs and implants, some people just do not want a piece of plastic in their body, and for some people the pill works perfectly well.

So, the project grew to embrace reproductive justice, the simply decent notion that basic human rights involved three principles around reproduction: the human right to have a child, to not have a child, and parent your children in safe and healthy environments.

And I nod in appreciation to the Women of Color led by Loretta Ross and her colleagues who developed the framework, and to the young women who are continuing this work today.

Reproductive justice needs to be in this conversation about increasing

opportunity through access to family planning. We do our best as health care providers when we give non-directive counseling, and offer the full range of methods, and when we don't create obstacles for removing IUDs and implants, and we don't over-encourage their use.

So, HER Salt Lake changed, and HER became emphatic support for women's autonomy to access all methods, not just the highly effective ones. And in our community there is clearly one provider who provides the most care to women in need, the best contraceptive care at the least cost, and that's Planned Parenthood, so we partnered with them.

And in March 2016, anyone coming to one of their four clinics in Salt Lake County could walk out with any method of contraception they desired without cost, and clients could return as many times as they wanted over the next three years to get the next method, if that was required.

And we served 7,402 people over the course of a year, and we enrolled 4,425 in a three-year study to rigorously assess how people made decisions about contraception and how these choices influence reproductive autonomy, wellness, sexual satisfaction, as well as health, education and financial outcomes.

And this graph tells the story of what happened with the contraceptive method mix during the course of HER Salt Lake. This red vertical line represents March 2016 when we shifted to no cost contraceptive care.

The purple line at the bottom that ascends is the proportion of people who walked out of the clinics with IUDs and implants over time. The aqua line at the top that starts at the top and drops represents the proportion of people who left with pills, patch, ring, and Depo-Provera shots. At the baseline about one in five people walked out with and IUD or an implant, and that rose to one in three.

Even more importantly, this occurred in a welcoming place where each client could get the contraceptive method that she decided worked best for her, and people

knew they could come back and get the next best thing, if the first choice didn't work.

So HER Salt Lake provided us with some key takeaways. These results demonstrated there was real demand to expand services, and the data were used to support a family planning Medicaid waiver, legislation sponsored by Republican Utah House Representative, Ray Ward, and now more than ever rational, disciplined, dedicated public servants like Ray Ward, are way too rare and highly cherished community.

We also learn the importance of building relationships with elected officials, and coalitions with advocacy groups.

And finally, HER Salt Lake created a platform to expand services statewide, and that is where our second contraceptive initiative, Family Planning Elevated, comes in.

Family Planning Elevated applies what we learned at Planned Parenthood clinics in Salt Lake to community health centers across the state so they can make an additive contribution.

Family Planning Elevated addresses three Ps, for patients it means that people with an income below 250 percent of the Federal poverty level can get the contraceptive method they want at no cost at participating clinics, and that includes undocumented immigrants who are not included in Medicaid.

Secondly, FPE trained community health center providers and staff so that they can offer the full range of methods, and third Family Planning Elevated assists policymakers in passing evidence-based legislation.

So between these two programs we are on track to serve 28,000 people with person-centered care that promotes their autonomy. And of course this will save Utah taxpayers' money, a lot, more than \$28 million through Medicaid savings alone.

And this is a benefit but not the only one, and not the most significant, together, these two projects for Salt Lake and Family Planning Elevated create a platform for a state-wide network to maximize contraceptive coverage that allows federally qualified community health centers to make a contribution on top of the one that allows Planned

Parenthood to provide care for 47,000 people a year in our state.

HER Salt Lake and Family Planning Elevated are unique among contraceptive access projects, we've used our bold optimism to gather a broad base of support from community members, pharmaceutical companies, local and national foundations, the NIH and the Society of Family Planning, who've also focused on reproductive autonomy. And we have a specific policy target at the beginning, Medicaid Expansion.

So as an OB-GYN, I trust women to make the best decisions about sex and reproduction, and I'm not intoxicated by the idea that IUDs and implants alone are going to fix poverty. Contraception is important, but IUDs don't improve opportunities for children in Utah when they're living in a state that spends fiftieth among states on per-pupil expenses on education, and contraceptive implants don't improve opportunities for their moms when they're living in the state with the greatest gender-based wage gap.

We have no more time for polarization along the pro-life/pro-choice battle lines. It's time to collectively embrace reproductive justice, and focus on opportunity, which includes the opportunity for safe pregnancy care, and infertility treatment, and abortion access, educational opportunities, and the opportunity to live without police violence and environmental injustice.

We have the power to shift the ugly, mean-spirited shaming and blaming we are seeing across the country with an example from Utah that demonstrates what real, pro-women, pro-family, pro-autonomy care and policy look like. Thanks. (Applause)

MS. BUSETTE: Thank you, Dr. Turok. I want us to give our panelists, who have been absolutely stellar, a really warm round of applause. (Applause)

So, I will be asking the panelists a few questions before we get into audience Q&A. And so to start off, and what I'm going to say is that we've heard some very interesting reflections and perspectives on how to provide access, information and better training through an equity lens in order to promote family planning choices.

So, I'm going to just -- any of you can answer this, or you're going to have to -- there are going to be other questions, so you're welcome to forego this one as well. But given the policy landscape currently for family planning, and the experiences your offices have had, what additional scope is there for states to play a leading role in this area?

DR. RATTAY: I'll go ahead and jump in. I think states have a very important role to play in women having access to the full range of contraceptive methods. That being said, I think it's also important that when we think about access to contraception we are thinking it in the context of, you know, a broader range of health improvements, or whether it's substance abuse or mental health access, access to support for social determinants of health, et cetera.

But within that context I think it's important for states to be thinking about a multifaceted approach, as I called it, the public health approach to ensuring that women have the -- all women have access to the full range of contraception. We certainly have a role to play in supporting policies that ensure that access is there.

But also in many of our states, and in our divisions, or departments of health, we oversee the Title X Program. For our states, we've been relying heavily on the Title X Program for the work we're doing, and certainly for the sustainability efforts, and so it's important that we maximize Title X. And then finally, I think that states have a role to also invest in reproductive health care for women.

MS. BUSETTE: Thank you.

MR. WIESMAN: I think I would add that states have this particular power as well to be either the first mover in a state around setting policy and thinking about what it is -- what are influences with the public funding we have. And so one of those, certainly, is around health care and health care reform, and the purchasing power we have with Medicaid, with public employee benefits, and setting that stage.

And so, to the extent that through policy, and through how it -- what it is we choose, choose to purchase, what services is incredibly powerful. And I'd mention the safe

deliveries roadmap from the Hospital Association, and the sort of suite of things in their bundle, if you look at the pre-pregnancy care recommendations, for example, they have things from hypertension, diabetes, sexually transmitted disease, violence and abuse, screening, but as well as things like toxic environmental exposure.

So, exposures to toxins at home, or in the community in which they might live, so through those kinds of efforts, I think we in states can be incubators for trying new policies, which is certainly what we've heard today with all of the Upstream work. I mean, Washington is benefitting from all of your work in Delaware.

So I think that's a really important place that states have in the ability to experiment and think about what it is we purchase with our budgets and how we want to change things, and then hopefully drive also the private sector into the directions where we find evidence-base.

MS. BUSETTE: Thank you, Secretary Wiesman. David?

DR. TUROK: And in places where the leaders don't lead, sometimes the people need to. So, I think it's been pointed out several times that in the current -- with the current administration really, solutions do need to come at the state level, and preservation as well.

But our state didn't expand Medicaid until 2019, and only did so when there was a ballot initiative, and then the Legislature eviscerated that, cut the Federal poverty level limit on it, and added some additional restrictions.

So, our approach in Utah, as researchers and clinicians, has been to not just wait around for some opportunity to come along that we could fill, but to actually get out ahead of it, and demonstrate what could be done, and then encourage legislators to follow and address the demand once we've established it.

MS. BUSETTE: You know, I'm sure we could spend a whole afternoon on that. And also these excellent, really excellent suggestions about, making sure that we maximize Title X, really optimizing what services we buy, et cetera, at the state level, and of

course, you know, taking the bull by the horns, and just going forward if there isn't a lot of state action at the top level.

So, I have a second question which is around the tensions that this kind of work tends to incur, and some of them political, some of them are policy; some of them are actually around transforming practice, clinical practice. So, I want you to reflect on those tensions. And Dr. Turok, we'll start with you.

DR. TUROK: Yes, I might be living in a little more tense environment than my colleagues. I mean, obviously the main tension in a conservative state like Utah, is about abortion. And there is just no denying it. There is also no denying that there are imperfections, humans are complicated, and we are imperfect about picking our sexual partners -- not myself but --

MS. BUSETTE: All except for you?

DR. TUROK: Yes, right, right. Imperfect about -- I'm headed for my 25th Anniversary with my wife after this, so you know -- (laughter). So, there are imperfections in partner choice, there's imperfections in contraceptive methods, none of these things work perfectly, and there is imperfection in biology. So, we need to get to a place where we can just acknowledge that abortion will never go away. It will exist. It has existed in every society, forever.

And from that point we've got to also understand, it's incredibly common, over a million women a year have this in the United States, and most of them are mothers, and that is not something we hear or talk about.

So, I think we can -- once we acknowledge that, we can try to find some actionable common ground, and I think we've heard a bunch about that today, in people being able to plan their families is a critical part of that. So let's acknowledge the tension, and then move past it to the place where we can work together and actually do some good.

MS. BUSETTE: Great. Thank you. Are there others?

DR. RATTAY: Reproductive coercion has come up several times today,

and I want to recognize how important it is that we are sensitive to this as an issue, and that we acknowledge the dangerous history of reproductive repression and coercion across the country targeted at women, and people of color and low-income individuals.

All along we have with our Delaware CAN Initiative, focused on all methods for all women, and the transformation that has taken place in the practice has been supportive of all methods, all payer types and ensuring that, you know, there's no wrong door for any women, and that all women across the state have access. And in fact during a period of time, all methods were free across our state for any woman.

And also there has been a real intentional effort to ensure that there are no barriers to removing IUDs and implants, which we feel is very important as well, once of the things that Upstream partners have done is surveying women as they depart, or after their visits, and finding that 99 percent of women have indicated that they have either made their own choices about contraception or shared decision-making with their providers is very important to us.

We think that it's critical that we continue to strive for all women feeling empowered regardless of their insurance type.

And that being said, that two-tiered system I mentioned about immediate postpartum and private insurers not covering it, is problematic.

MS. BUSETTE: Thank you.

MR. WIESMAN: I think I agree with everything my colleagues have said, and I would just add, I think the tensions around uncertainty with the Federal Government, and the rules and regulations around these programs is really high right now.

In Washington State, actually, voters way back in 1991, passed and initiative which is state law that said, every individual will have the fundamental right of privacy with respect to personal reproductive decisions, that every women will have the right to choose or refuse to have an abortion, and that the state shall not deny or interfere with a woman's right to choose abortion. We won't discriminate against those rights through

regulation or benefits, facilities, services or information.

And so we find ourselves right now in Washington State at this tension with the current Title X rules and the Ninth Circuit as was just mentioned, that if that holds, we will be forced to withdraw from the Title X Program, because it will be against state law for us to participate.

And again, I think the health care, the reproductive health care that this purchases, you know, the state puts in something like \$9 million a year, in our own State funding, and about 4 million in Federal funding just, again, sort of limits access, it hurts the folks who have the least access, can least before this, and it just simply isn't right.

So, that tension of patients who are in Washington, well, what do we do? Is it safe to go to a provider, or not? Where do we stand? Is something that I think we can underestimate, and once again these are populations who have been historically traumatized, who have been discriminated against. And they see it, I think playing it out again in their governments.

MS. BUSETTE: Thank you very much. You know, you have all started your presentations by talking about the statistics that sort of drove the efforts behind improved family planning and reproductive services. One of the questions I have for you is around navigating the policy space. So first you start from a position of: okay, here are the facts, and the facts are not what we would like them to be, and now we're going to move forward with some policies and programmatic approaches.

As you have done that, the family planning landscape keeps changing. It changes at the State level, as you mentioned it changes at the Federal level. Have you made any changes to the ways in which you are rolling out programs as those changes have occurred at the policy level, both at the State and the Federal level?

MR. WIESMAN: I guess I would say, we're looking at what it is we feel we need to put in state laws to protect what's already there, such that if the Federal Government does change either the rules, or laws, or the ACA, that at least in Washington State we've

got in state law are expectations.

So, that's definitely been a change, as well as I think just the time and effort to fight law suits around this, not to get political about this but, you know, we're trying to protect reproductive health care in this country, and it's under attack. And so we are having to think about what we do along those lines, and some of that is: how do we assure what's there now is going to stay in our state regardless of what happens?

MS. BUSETTE: Great. Thank you very much. Director Rattay?

DR. RATTAY: You know, to add to what John said, I mean, it's the same for us, we've been working to preserve, for example, what's in the Affordable Care Act, and the new Title X rules, quite frankly, are devastating to us and to the work that we have been doing. It's beyond disruptive to the system that we have been building with providers.

And even just, who it is that can do counseling? Well, in our initiative in our state medical assistants and nurses are doing a lot of the counseling, so the new Title X rules are very problematic for that.

So, the unacceptable restraints on health care providers with the new Title X rules are really quite devastating to the program that we've been working so hard to build.

MS. BUSETTE: Okay. Thank you. And Dr. Turok?

DR. TUROK: You know, no policy by itself just increases access or care. So, you know, it's interesting to hear that you all are, I think, working from a somewhat defensive posture from the national effects. And obviously, we are too. But I think it's also important to acknowledge that, you know, a policy by itself doesn't create the opportunity, it's got to involve some hands-on interactions for actual care delivery to occur and differences to be made.

And it's just -- you know, so much comes down to, like this is a solvable problem. This is not some, you know, unsolvable thing. It's very simple, and it's about resource allocation, and Title X provides this incredible example about that.

So if you look at the national Title X expenditures for 2019 for all the states,

it's \$260 million. A single state, Mississippi spends more than that on just delivering pregnancy care for people who have Medicaid and had unplanned births. So that it's not a totally fair comparative, but it gives you an idea of what the balance of resource allocation is.

MS. BUSETTE: Great. Thank you very much. We are now going to move to Q&A from the audience. So, the way I tend to do this is we'll take about three questions at a time, and then you're free to answer one, all, you know, it's up to you. And then we'll also be able to accommodate more questions. So, our first question, we have a gentleman in purple here, a gentleman with the red check shirt, and this young lady in the leopard -- cheetah skin jacket. Here we go. (Laughter)

MR. HATHAWAY: I'm Mark Hathaway, in the purple shirt, from Washington, D.C., unfortunately not a state yet, but perhaps someday. But thank you to everyone for the leadership and the work on this is fantastic, lots and lots of great, great things. I'm curious about, if one of you might address the issue of, you know, we know that the lower social economic quintiles have the highest rates of everything terrible, smoking, obesity, access to good food, access to family planning services.

So, I'm wondering if you can talk a little bit about how you've been able to draw them into clinic care, where there's mistrust and, you know, men don't understand that when you have sex you might get pregnant, women perhaps understand it better, but at the same time, even once you recognize that, getting into a clinic, and getting access to care, or making that step to get to care, to a clinic setting is a hurdle. And so I'm wondering if you can talk a little bit about how you've addressed that to getting folks over that hurdle, getting to a site to get care? Thanks.

MS. BUSETTE: All right, thanks. Thanks Mark. We'll take our second question here?

QUESTIONER: Can you expand, can the panel expand on their comments regarding the revisions to Title X, and the impact that's having on the programs?

MS. BUSETTE: Thank you.

QUESTIONER: Kay Osho, I'm a retired Federal employee. My question is for Dr. Turok. And I just wondered whether the LDS leadership had a position or a reaction to your two programs you mentioned.

MS. BUSETTE: Thank you. Okay, so we have a first question on how do you get folks who do not trust medical care into clinics. And then a second question on: what exactly are the revisions to Title X? And then of course the third question for Turok on the LDS reaction to your work. Okay, Dr. Rattay.

DR. RATTAY: So, we can choose whichever question?

MS. BUSETTE: Mm-hmm.

DR. RATTAY: So, the first question is a great question, and the barriers that we understand include lack of access, lack of affordability and lack of awareness. And so certainly, and our efforts include tackling all of those. So, whether it's the policy barriers, or for all methods free approach, ensuring that women can afford access is important, but also making sure that our providers that are serving them, have transformed their practice so that they can provide the all methods free, same-day access, has been critical.

But the social marketing work that we've been doing across socioeconomic classes, I mean, certainly, increasing awareness and really empowering women and telling them, how do access these services has been really important to reach women.

MS. BUSETTE: Great. Thank you. Dr. Turok?

DR. TUROK: I'm going to tag onto that. You know, we've basically gone to where people are, and then tried to augment that by -- with a media campaign, so I didn't get to talk about that, but was an aspect of what we did in HER Salt Lake, and we learned some things there, and we'll try to improve upon them, for Family Planning Elevated with the media campaign that's currently in development.

MS. BUSETTE: Great. Thank you. Did you want to answer that other question?

DR. TUROK: Yeah, yeah, yeah, please. So, you know, obviously the LDS

Church yields some considerable power at the Legislature, you know, in Utah. And the church, to my understanding, is supportive of people planning their families, and that's the actionable common ground.

And, you know, people vote with their feet, the LDS membership. And I can remember a very specific patient I saw at Planned Parenthood, where I walked into the room, and started to -- I knew she was there for an IUD insertion, and I started to talk to her about that, and she said, listen, I know all about this. I just had my sixth kid, and this will be my sixth IUD, and they've all been spaced three years apart.

And this is not like an incredibly uncommon thing. People have big families, but they have spaced families, and it represents their values. So, I think that's, again, you know, that's the place where we can meet people and have meaningful discussions.

MS. BUSETTE: Great. Thank you. Secretary Wiesman?

MR. WIESMAN: I would just add on the lower socioeconomic piece. I think, and again, this is sort of broader, I think, health care what we're working on and needing to do. It's one, hiring people who actually look like the community we serve, who are from the community we serve, who speak the language of the community being served, both in terms of the sort of professional staff as well as models looking at community health workers, who are those trusted folks from the community who can help folks navigate very complex systems. And again, speak their language, come from their culture, and I think those are important in terms of health care systems competency and being able to provide culturally appropriate and relevant health care. So, I would just add that piece.

On the Title X impacts, so some of the things happening is that the rules immediately actually prevent the health care provider in a Title X Program from talking about abortion.

If a patient wants an abortion they cannot give a list of providers that are identified as someone who might provide an abortion, they have to give a list of actually primary care providers, and they can't indicate whether they provide abortions or not. And

they can't indicate whether they provide abortions or not, and they can actually choose to give a list of providers that they know nobody provides abortions.

So that's what we call the "gag rule" and really very devastating, and frankly we believe interferes with the provider and patient relationship, and full medical appropriate information, and is really harmful to -- again, if we're talking patient-centered, that is not at all a patient-centered approach.

And then there are provisions that go into effect later that require things like a physical wall separation, you know, a provider who might provide both abortions and other contraceptive care; that they have to be physically separate sites, separate entrances. And so those kinds of things make it incredibly difficult to operate a program that is fully inclusive.

MS. BUSETTE: Thank you.

DR. TUROK: I was going to say, in our state Planned Parenthood is the lone Title X grantee, and has been for a very long time, and has done a phenomenal job on an incredibly tight budget. And they've committed to continuing to provide the services and planned for this, and we are prepared, and have, you know, we'll use funding from other sources to get it done until this can be clarified.

MS. BUSETTE: Great. Thank you. You know, I hate to do this, but it looks like we are running out of time. So, what I wanted to do was invite each of our panelists, to give us one statement about one thing we should remember as we think about family planning and family reproductive services, in this policy environment. And I'm going to start with you, David.

DR. TUROK: How much time do we have? (Laughter) You know, I sincerely hope that we are at the nadir of civility on discussions of sexual and reproductive health in our country, and I think it would be really extraordinary if the same policy, rational policy from a very conservative state that respected people's autonomy, served as an example. And you know, let me be frank here, Utah is saying like: that's crazy. (Laughter)

MS. BUSETTE: Director Rattay?

DR. RATTAY: I think it's important that we do keep our eye on policy solutions, especially in this complicated time, there's definitely things that states can do. Again, the Medicaid policy opportunities, for example, with federally qualified health centers, and ensuring that there are carve outs or support for all methods, whether in the clinic as well as -- that methods are available in birth hospitals, is certainly work that we can continue doing that the state level.

MS. BUSETTE: Thank you. And Secretary Wiesman?

MR. WIESMAN: And again, I think emphasize that states are this place where we can experiment, and try things, and learn from each other, and that's incredibly important, as our local communities, frankly, in this work.

And I think the last thing would be that this work is not in isolation of the larger context of societies, of the social determinants of health, of the historical traumas, racism, discrimination, and that certainly as public health agency, it's my responsibility to look at that broad picture, and work with partners on that. And to work, frankly, with community-based organizations who know the best.

MS. BUSETTE: Great. Thank you. You all have given us a lot of food for thought. Please join me in giving them a very warm round of applause. (Applause) Thank you. And we are moving on to our next panel.

MS. BROWN: Welcome to Panel 2. We're not taking a break here. We're just going to keep on going. This wonderful panel is going to continue the exploration of some new approaches to reducing unplanned pregnancy.

My name is Sarah Brown, and four colleagues to my left join me in -- this morning. Mark Edwards is the co-founder and co-CEO of Upstream USA, that you've heard so much about this morning. Ian Rowe, next to him, is the CEO of the Public Prep Network of Charter Schools, in the New York City area. Ginny Ehrlich, next to him, is the CEO of Power to Decide, and Dr. Janice Tildon-Burton is the leading OB-GYN in Delaware. Now, I am not going to go through their wonderful resumes because I do believe you have them.

Yes?

MALE SPEAKER: Can you bring your microphone way closer?

MS. BROWN: Much closer?

MALE SPEAKER: Yes.

MS. BROWN: Is that better?

MALE SPEAKER: Yeah, really.

MS. BROWN: Thank you, Richard. I'm not going to go through their wonderful biographical statements. They're in your materials, but suffice it to say these are all rock stars, and we are thrilled to have them all here together. The theme of this Panel, and indeed this entire meeting, really, is showcasing new approaches to providing high quality family planning.

Now, as an old warhorse in this field, I must say that it's about time. In 1995, when Bell Sawhill and I, and many other people in this room, began to put together the National Campaign to Prevent Teen Pregnancy, which is now Power to Decide, led by Ginny Ehrlich, I went on what I called a listening and learning tour, to try and see what was fresh and new in the pregnancy planning and prevention sector.

I had last worked in family planning, and in community programs, in the late '60s and early '70s, in several different states, and I was sure that by the mid-1990's there would be many, many new practices, and programs and models of clinic, flow, and provider training, even new materials, that would be inspirational, wonderful, and that our group should probably disseminate, and others as well.

In truth, though, I returned home from my travels, unimpressed, and even puzzled. I remember saying to a few colleagues that next to nothing seem to have changed, on the ground, in almost 30 years, that is, from the late '60s and '70s, and that if ever there was a sector that needed a little bit of reinvention and reimagining, maybe even disruption, family planning was it.

The good news, as this event has already showcased, is that the picture

today is significantly different. There are now numerous efforts underway, doing wonderful things in family planning, some at the system level, some at the personal one on one level, some in billing offices, and everything in between. So, without further delay, let's hear some more about what's current in choice, and we begin with Mark Edwards, and I'm going to allow each person to either sit down or stand up, as they choose.

MR. EDWARDS: Thank you, Sarah. Thank you very much, and I want start by thanking Bell, and Ron, and Richard, for hosting this event. I think you have been on the forefront of pushing us all, about how to think about opportunity in this country, and I'm just grateful for that. Secretary Wiesman, of course, Karyl Rattay, from Delaware, Dr. Rattay, Janice Tildon-Burton, whom I'm thrilled is here, really a leading provider from Delaware, who just can take this, sort of, conceptional conversation, and bring it quite real, down to the real experiences of real patients. Sarah Brown, of course, for introducing me to the whole history of family planning, and Governor Markell. Thank you for your leadership in this important area.

You've heard a lot today about what Upstream does, and, so, I won't spend a lot of time rehashing all that. At its simplest, all we're really trying to do is ensure that women are empowered to choose the contraceptive methods of their choice. We're really trying to bring the healthcare practice to best in class care, and I also want to thank all of my Upstream colleagues who are here today, here, as well as the hundred plus Upstreamer's around the country.

We're really excited about some of the work that's been happening in Delaware. When we came to Delaware, quite frankly, we saw a mixed healthcare landscape. There were health providers who were only offering their patients the pill, patch and ring. They weren't offering them the most effective methods. There were others that were doing a better job, and people often ask, you know, what are the issues? Why aren't people being offered the full range of methods, and what we find is that it's not just about training providers. Of course, if providers can't place and or move the full range of methods,

that can happen, but if you don't stock the methods, if you don't bill and code for them properly, if you can't work -- make your work flow work, so that women can come in, and, believe me, and offer the full range of methods, they won't be able to get them in a single visit, and being able to get those methods in a single visit is really the key thing here.

What we know is that it requires two or three visits, which, for many places, is really the standard of care. Women won't come back, and what we also know is that, for example, if you don't stock the methods, and by definition, it's going to require multiple visits, and, so, what I think we found, which is quite interesting, is that, while the policy changes are critical, and we've heard a lot about those policy changes, as Dr. Turok said, it's not just about the policy changes. We have to actually change practice, and, so, there are many times where we found that the policy was saying women should get all these methods. They should be able to have great counseling, and get all those methods, but the practice was simply not translating into that, and that's really the place that Upstream is trying to work in.

As an Organization, we're thrilled about some of the progress in Delaware. We're now expanding our work to other states, so that we can reach Health Centers that serve about a million women, or more, over the next several years, but I also want to acknowledge that our work takes place in a very important context, and that is the context of extraordinary oppression and reproductive coercion in this country.

I want to thank Merritt Gendle-Powers, from the National Women's Law Center, for raising that question in the very first Panel. This is not just ancient history. This is ongoing today, that women and people of color, around this country, are being targeted for forced sterilization, and we are deeply, deeply aware of the context that we work in, which is one of the reasons that, as an Organization, we regularly survey patients, to ensure that the experiences they're having are excellent experiences.

Dr. Rattay spoke about what was happening in Delaware, that 99% of patients are saying that they were in charge of choosing their own methods. We also know that 98% plus are saying that they felt listened to in the contraceptive conversations, that

99% are saying they didn't feel pressured. We regularly do that because it's just a central foundational part of what it means to deliver best in class care, and we're grateful for women of color around this country, who have held these issues up. They have every right to ask questions; organizations, like ours, and others, to make sure that we're doing a good job, and we're grateful, grateful for their partnership.

So, we are very excited about how this work is taking place, around the country, and, at the end of the day, all we're trying to do is make sure that people have the education, the choice, and the access. It's really an equity issue, and if you take this out of reproductive healthcare, for just a moment, I mean, imagine, what the data show is that IED's and implants are 20 times more effective at preventing unplanned pregnancy than the pill, patch, or ring.

Imagine if there was a stent that was 20 time more effective than another stent, and we allowed a healthcare system that didn't make that stent available. It'd be an outrage, and that's really all we're trying to do here today, is to make sure that women have access, people have access to all methods of birth control with great patient centered counseling, so they can choose what really works best for them.

So, I'm thrilled that Dr. Janice Tildon-Burton is here because she's going to talk to us about, in Delaware, about what is actually happening among real -- with real patients, in her practice, and that's at the core of the work we're doing. I just want to emphasize one other thing that Dr. Rattay said, which is that, at the end, we really are trying to ensure that all women have access to all methods.

So, in Delaware, someone asked a question earlier, about what do we do about women who -- people who live, you know, not near a Health Center? We actually partnered with Uber, to make sure that wom -- that patients could get free rides to the Health Center of their choice, as part of that work. We know that transportation is a huge barrier for many people, and, so, that's another aspect of trying to ensure -- recognize that this is not just what happens in the Health Center. It's also what happens to get people there in the

first place.

So, in the end, I think, empowering women to choose when and if they become pregnant is really one of the most important things that we can do. I think it's something that we all can get behind, and I'm excited about what this can mean for our country. Thank you.

MS. BROWN: Thank you, Mark. We now turn to Ian Rowe.

MR. ROWE: Good morning. Okay. Good morning. My name is Ian Rowe. It's a great honor to be here. Bell, thank you very much for the opportunity to speak, and I'm also proud to represent The World of Public Education, and how we have to think differently about educating the next generation to think about how to navigate these issues, and to get into a position to make the best decisions for their individual lives. These are some of our graduates.

I do run Public Prep, which is the Nation's first and oldest network of single gender public charter schools in New York City. We have about 2,000 students across our five campuses in the heart of the South Bronx, and the lower eastside of Manhattan. About 90% of our students are from low income communities, and nearly 100% are black or Hispanic. We're very proud of the fact that our first cohort, that started in girls' prep, way back in 2005, in kindergarten and first grade, they are now freshman and sophomores at some of the finest colleges and universities in the country.

So, we're very proud of that, but we know that our kids face enormous challenges, and in New York City, the need for more great schools is huge, and, so, back in 2015 and '16, we were thinking about our growth, and we decided to make a decision to focus all of our growth in the Bronx, particularly in the South Bronx, and, so, we made a decision to move our headquarters from Tribeca, in Manhattan, to a 148th Street in the heart of the South Bronx, and we decided to go on a walking tour to get to know the neighborhood, and on that walking tour, we saw a 27 foot, baby blue, Winnebago Truck, and all these folks were excited to see this truck, and it turned out, it had graffiti lettering on it,

and the lettering said, "Who's your daddy?" and it was almost like the ice cream truck, in terms of how excited people were to see it.

It turned out that "Who's your daddy?" is a Mobile DNA Testing Center that charges low-income folks, between \$350-500 to answer questions, such as, you know, "Is she my sister?" "Could you be my father?" and it was really profound moment for me. It was an epiphany moment, for me, because the normalcy of that truck, the acceptance of that, made it clear to me that the environments, in which our kids are being raised, there's a break that we have to effect in the world of public education, if we want different outcomes for our kids.

That lead me on a journey to start doing research, particularly related to the non-marital birth rate, what has transpired in our country over the last five decades. As many of you know, there's an explosion in non-marital births, from, you know, 5% in the '60s to now, consistently, about 40% of all births in the United States are outside of marriage, and that has had a profound impact on the family structures in which children are raised; something we don't speak about, but I think it's very important that those of us, again, particularly in public education, think about, not only the causes, but how do we stop this cycle from repeating in the first place.

Just to give you a snap shot, in 2017, and I've particularly focused on women 24 and under, and, by the way, it would be great to have the same data for men, but it's only tracked for women, but, for women 24 and under, you know, in the black community, nine out of ten births are outside of marriage.

It's a staggering number, and in sort of a depressing thing of how the racial achievement gap is closing. In the white community, it's 61%, and across all of these, 41% of women, 24 and under, who had a baby in 2017, were having their second thru their eighth child. So, that has profound impacts for the ensuing family structures because you have large numbers of very young women raising very young children.

So, what do we do about that, and obviously, for -- many of you know, the

emerging brain science and cognitive development, kids in these situations are at much higher risk of having adverse childhood experiences, which then severely impacts the learning foundation that happens even before our kids enter formal schooling. So, we, at Public Prep, we thought a lot about this, what can we do, both on the front end, and the back end, to address these issues.

So, we've created a concept called, Eighteen to Eighteen, where the first eighteen is eighteen months, which I'll describe to you, and the second eighteen is eighteen years, and we feel it's important that we, in the -- providing a model. Hopefully, that can be replicated by other public schools across the country, to both break the firewall on the front end of schooling. So, we actually have now started a partnership with The Parent Child Home Program, which is a two-year home visiting program, for the eighteen-month-old younger siblings of our current Boys Prep and Girls Prep Scholars.

So, because they are guaranteed entry into our schools, when they enter our lottery, two or three years from now, those kids will receive two years of home visits by an Early Learning Specialist, two times per week, 30 minutes per visit. An Early Literacy Specialist sits with the caregiver and her child, typically a single mom, to help that parent build their capacity to be the at home reading coach. How do reduce screen time? How do you create a library at home? How do you take advantage of walks to the local bodega, as an opportunity to build vocabulary?

We are very, very confident that that will have a huge impact on the levels of school readiness that we achieve for our kids. We also created a partnership with Sesame Workshop, around pre-K. So, we're now one of the largest providers of pre-K in New York City, in terms of Charter Schools, but the key is that, even before formal schooling begins, at four years old, we have a really well integrated pre-K that's aligned with our elementary school.

This is some data which shows that the readiness levels of kids who go through our pre-K, is at 93% versus kids who've just come in straight, into our lottery, only at

23%. So, again, all of these efforts, around aligned early childhood education, we think is really important. This is our Parent Child Home Program, a picture of our parent with a caregiver. Each week, the parent or the caregiver gets a new book. So, by the time -- the end of the two years, you've got a hundred book library, and we've just normalized education and literacy within the home.

PCHP, which is now actually now called Parent Child Plus, they just changed their name, has an incredible track record, longitudinal data about the positive impacts of kids who went through this kind of experience. Starting early, it's necessary, but not deficient. For us, you know, we go through eighth grade. So, what is it that we can to help our graduating eighth graders, really have an understanding of the series of life decisions that are most correlated to life success?

Thanks to the work of Bell Sawhill, Ron Haskins, a few years ago, I came across the data associated with the success sequence, which is the name of a series of decisions, education, full time work, marriage, then children. The data shows, and it's descriptive, not prescriptive, but the data shows, that when those series of decisions are made, somewhere between 97 -- 94 to 97% of the time, you're going to land into the middle class, or upper class, or beyond.

That's important information that our graduating eighth graders need to know. So, we've made that a part of a codified class called Pathways to Power, which is to ensure that, as our kids leave eighth grade and enter high school, college, in the first four years of young adulthood, they know the series of life decisions that, more likely, will lead to life success, and, then, just finally, I think, in the same way we're talking about unplanned pregnancies, we do need to have the courage to talk about the ensuing family structure, non-material birth rates because that's all part of this discussion.

Invest in district and early intervention, so we break, what is typically a firewall between K to 12 education, and early childhood education. Teach the next generation about the series of life decisions most correlated to success, and then, finally,

actually measure academic outcomes, not only by the usual suspects of race, class, and gender, but also incorporate family structure because, I think, we'd start to see that that's a factor that transcends many of these other elements. Thank you.

MS. BROWN: Thank you, Ian, so much. Our next speaker is Ginny Ehrlich, the head of Power to Decide.

MS. EHRLICH: Thanks. Good morning, everybody. As we're getting my slides setup, I want to thank Bell, Ron, and Richard for the opportunity to be here.

At Power to Decide, we work to ensure that all young people, no matter who they are, or where they live, have the power to decide, if, when, and under what circumstances to get pregnant, and have a child, and we focus our work, specifically, on those most impacted by unplanned pregnancy: women of color and low-income women.

We recognize that the inequities that still persist around rates of unplanned pregnancy are, by and large, systems inequities, and not about the women, themselves, and for that reason, we recognize that we -- the work is very intersectional, and our piece of that work is really focused on leveling the playing field around good quality sexual health information, access to services, and agency and opportunity for women, and really the nexus between those is what really matters, in terms of really having everything come together.

Today, I'm going to talk about our digital online property, called Bedsider. Bedsider really is an example and an emulation of all of these concepts of information, access to agency, and opportunity to come together. We launched Bedsider, in 2011, to fill the voids that existed then, and currently still exist, in serving up relevant, resonant, and accurate information to young people and specifically focused on young women from 18 to 29 years old.

Bedsider works to ensure that women have, and all people have, access to quality sexual health information, on their own terms, on their own timeline, and that they have access to knowing where to find services. They have access to user tools, to use

contraception effectively. We also have a series of provider tools, and clinical education tools that are used in thousands of clinics across the country.

So, you might be asking, “Why are we talking about this in the New Panel?” and we’re talking about this in the new Panel because the magic of Bedsider is that we’re constantly reinventing it. We’re constantly making it that so that the users drive content, and we’re driving the needs through the users. We see it as an opportunity to provide sex education before, during, and after a clinic visit, and outside of the classroom, on women’s own terms, and on their own timeline. We think of it as sex-ed for the 21st Century, and as you can see, it doesn’t look like a typical DC website. It’s a little edgier, a little catchier, and cuts through the noise and politics that we’ve been talking about today.

We also know that Bedsider has impact, and it’s worked. A randomized control trial study, published in 2015, found that women who accessed Bedsider at least four times, by comparison to a control group, were less likely to have a pregnancy scare, less likely to have unprotected sex, less likely to report an unplanned pregnancy, and they were more likely to use a more effective method of contraception. Colleen Kay, who’s one of the authors of that study, is in the room today. So, Colleen, thanks for your work on this.

So, in the spirit of reinvention, and our focus on health equity, we set out, in 2017, to answer the question: can we ensure that Bedsider is serving those most impacted by unplanned pregnancy, young women of color, and low-income young women? At the time, only about a third of the most engaged Bedsider users, comprised of that population. So, we decided to look at how we could optimize Bedsider to really serve the needs of women most impacted.

We did ethnic graphic interviews with women, and their girlfriends, through girlfriend groups. We explored how they use their devices to access sexual health information, how they think about conversation, or decisions about contraception in the context of their lives, how they talked with their girlfriends about these issues, and we learned a lot about it. We learned that, by and large, and actually to a person of the women

who are part of those ethnic graphic interviews, that they described some sort of sexual violence in their past.

They didn't use the words, but they talked about the experiences. We discovered that they do plan, but they plan for the next day, or the next hour, because that's a luxury that they're working within. We discovered that they care about these issues, and because of their experiences, they were trying to figure out in their 20's, early 20's, how to navigate their relationships in a way that was healthy and a little different than, maybe, they've navigated them in the past, because they all wanted to go forward, and move forward in some direction.

We identified four archetypes, stuck, looking for love, living in the now, and in control, and we shifted Bedsider from a functional perspective, as well as a content perspective, to really meet the needs of the young women, and really in ways that we hope resonated with these women. You see the content kind of emulated here. You got this. It might be, you know, walking out the door, it might be getting to a class, or going to work, but it was that sense of agency that was so important for these young women.

We shifted the content to assume, to really talk about sense of agency, next steps, not long term planning, and we shifted the functionality of Bedsider, so that short form articles were more accessible for the short amount of time women had to, really, look up information, and we made it much more mobile friendly. To date, 84% of Bedsider's traffic is mobile. That was not the case in 2011. So, it really requires that new and reinvention.

In 2018, alone, just to give you a sense of numbers, 7.3 -- Bedsider had 7.3 million unique visits, and, now, 63% of the most engaged users, for Bedsider, are African American and Latina, and 23% are women whose incomes are below \$50,000. So, we saw some tremendous increased reach and impact for those most needing information through the development of this approach.

We also found impact on knowledge, attitudes, and beliefs. We've found statically significant increases in knowledge, in behavioral intent amongst all users, to use

hormonal or LARC methods of contraception, statistically significant increases among African American, new users, to use hormonal or LARC methods of contraception, and statistically significant increases in intent to use LARC methods among women, who's income were between \$25 and \$50,000 a year.

We also found that they found it easier to find information, and felt like they could find a method that was right for them. We found some contend data, related to improvements in Latino women, intending to use hormonal or LARC methods, and feel -- and among all users, feeling more confident in talking about these issues with partners, and really navigating those decisions. We constantly reinvent ourselves. We use these data. We use ongoing user data to do new content.

Bedsider serves up eight to ten different new articles every week. That's because 18 to 29-year-olds refresh their phones about every 45 seconds, and, so, if we want to be relevant, we have to do that. We've talked a lot about access to contraception today, and what we're looking at, now, in terms of how we leverage the power of Bedsider's Platform, is to really look at contraceptive access. This map represents, before last week, what the contraceptive access looked like by county, across the country.

More than 19.5 million women live in what we call contraceptive deserts, or counties in which there's not reasonable access to the full range of contraceptive methods; reasonable access being one clinic to 1,000 women, eligible for publicly funded contraception. That's not okay. We know we need to systemic solutions, policy solutions, and we're working hard alongside our sister organizations to make those happen, but this means that, every day, those that you see in the yellow and pink parts of this map, are trying to decide how they're going to use their transportation dollars.

Are they going to work, or are they going to drive or transport themselves, a long way, to access basic healthcare? How are they going to pay for that extra child care, if they already have children? How are they going to address unpaid time off, if they don't have PTO? These are real tradeoffs for real women, and, so, on to Bedsider's, what we've

launched is BC Benefits, a contraceptive access fund, a fund that will support the unreimbursed, unrealized costs associated with accessing contraception.

It's up and running in its first form, whereby we're able to offer telehealth prescriptions, as well as prescription delivery for women whose incomes are at or below 250% of the poverty level for hormonal methods. By the end of the summer, we'll be adding transportation, and support for unreimbursed costs for all methods. We see this as something that really addresses an immediate need, and gives women what they need to make the decision that's right for them, and we're really excited about being able to add this to Bedsider, as the next iteration, in terms of what's new. So, thank you, very much.

MS. BROWN: Thank you, Ginny. That was wonderful, and our last speaker is, not last, but not least, is Dr. Tildon-Burton, and I have seen her on video, but I've never seen her in in the flesh, and I know her reputation precedes her. Thank you for being here.

DR. TILDEN-BURTON: Thank you so much, and thank you for inviting me. I said, when I came earlier, and I don't recall who I said it to, but I never thought I would be in the Brookings Institute. So, I'll add that on my little Instagram and Twitter today, as I go out.

So, I feel like there is a lot pressure here. People, "Oh, you're going to hear from Janice Tildon-Burton." I'm like, "I'm not all that." I'm a practicing Obstetrician and Gynecologist, and have been for about 30 years. I've done a little bit of everything. I've been in solo practice. I've been a Hospital Generalist. I've been in a group practice, and, so, I have a breadth of understanding of what it is to be on the ground, and I'm still on the ground. I deliver babies still. I do general gynecology. So, I'm considered a generalist because there are so many sub-specialists, now, in my field.

I deal with a wide, diverse population. So, I have very young women. I have girls. My youngest patient is 11, and she has some menstrual problems, and, so, her pediatrician wasn't comfortable, and had invited me to try to help with managing her. So, that's my youngest. My oldest is 88, and I just got a call from her, this past week, to see if

she should come in for an exam, to which I said, "It really is up to you. At 88, I'll go by whatever you decide you need for me to do, and if you want to come in, I'll be happy to see you." She made an appointment, but the reason I'm here is because of the work that Upstream has done in the state of Delaware, in conjunction with our Governor and Karyl Rattay, Dr. Rattay, over at Health and Human Services, and it's been a fantastic journey, I think. Having -- being in private practice, I can tell you, I try always, or have had tried always to give a breadth of information to patients when they come in, but, as a realist, there's times when I just don't have enough time to do what I would consider an adequate job, to give information to patients that need it.

So, this question that we now have in my electronic record, do you plan to become pregnant this year, has really forced everyone in the office to become engaged, and it helps me to help the patients because once they've entered the office, and they've checked in, and they've filled out some information for us, and we see that they're planning to be pregnant, we know how I'm going to address them.

When I find out they're not, and they're in the age group of reproduction, then I know what I'm going to do when I see them, and even before that, my receptionist knows what she is going to do. So, if they're not interested in pregnancy, we have Bedsider, and I can't believe I'm sitting next to Bedsider. I'm just -- that's really great, and, so, we have the little cards, it gives them all the choices, in all of my exam rooms, I had that oops, and the one, two, three, four are the best practices, and, so, they get it from all directions.

The whole premise of offering all options, I think, is real important. It's not just LARCs. It is -- believe it or not, I have a few patients that use diaphragms, and they're really good at it, but not very many women are, but then we have the IUD, so, like, the full gamut, and you try to come to each patient, where they are. Some patients are not ready for LARCs. They just aren't. They've not even thought about birth control, and now you're talking about a foreign body that just doesn't sit well with many patients, but you can take them along that progression, and if you have patient that's ready, then you're ready, and

that's where I am now. When they're ready, I'm ready, and I'll take them to each step as they need to be taken.

During this last few years, when we've been dealing with the Can Program, I -- and those of you that have seen the video, I'll make it very concise, but there was a moment when I had a young lady come in to see me. It was her first visit, and we were talking about birth control, and she just didn't seem as though she felt as though there was a need for her to use birth control. She was sexually active, but that wasn't the big thing in her mind, and if she said, "Well, you know, if I get pregnant, I get pregnant." and I kind of looked at her, and, "Well, yeah, but do you want to get pregnant?" and "Well, no, I don't want to, but if I do, I do." So, my question to her is, "Well, what do you want to do? Who do you want to be? Where do you want to go?" and this young woman, about 19 years old, turned and looked at me and said, "Well, what do you mean what do I want to do? Who cares what I want to do?" I'm like, "Well, I care. That's why we're having this conversation." and she had this look on her face that I will never forget, never forget. She said, "Nobody ever asked me that question."

That's why I do what I do because the question has to be asked. We have to give direction to our young people, many of whom don't have an adult in their life that they're comfortable with speaking with, and, so, for many, I'm the first person that they've sat with and had an honest discussion about what it is they want to do, where they want to go, and how they want to do it, and, so, if I can help in any way, I'll try to do that.

I will often bring, particularly, my young patients in. They will come with their mother or a guardian or their grandmother, and, you know, we'll sit and talk, and then I'll look at whoever that adult in the room is and say, "Well, at this time, I'm going to have you just step outside because we have to have a discussion that only the two of us can have." because that's important, and I always emphasize to all my young adults and my young adolescents that, unless they're going to tell me something that will do them physical harm, I won't break their trust.

So, I walk around with a lot of stuff up here that I try to give up, but I think

it's important for the patients to know that they can trust us, and they can share with us, and, so, when you have a patient, and I think it came up about abuse, when you have a patient in the room with you that you know has been or is in an abusive situation, you have to be able to have resources to go to in order to get them help, and it's very difficult for these young women to come in and let you know that they need that type of help.

I digressed a little, but it all goes back to this whole issue of giving a breadth of information and just trying to do the things that are necessary to meet patients where they are, and do for them what they need, and that's what I try to do. I'm really glad that I was able to be here today.

MS. BROWN: That was just spectacular. Thank you so much. It puts human feeling and the reality of the individual right at the center of all this. Thank you.

DR. TILDON-BURTON: Thank you.

MS. BROWN: I'm going to pose a couple of questions to this group, as we did in the last panel, and then we will have time for questions from the audience. The first question I want to ask is: what gets you in trouble, and how do you respond?

I mean, everything that's been mentioned, at least from my point of view, is creative. It's reasonable. It's good. It's evidence based. It has deep humanity and heart, but I also know that this field brings out the worst in people, you know? You, sometimes, you're trying to do your best, and you still get in trouble. So, I would just like to ask each of you what gets you in trouble, and how do you respond? Have -- we could -- yeah.

DR. TILDON-BURTON: I'll jump right in.

MS. BROWN: Please.

DR. TILDON-BURTON: I'm known to speak my mind. I have really interesting patients who come to me because they know I'm going to tell them like it is, and if you don't want to hear the truth from me, you shouldn't come to me because I think that's my obligation, to be honest. So, I'm honest with the patient, but then, sometimes, if I have a mother who has decided that what I've told the patient is not the way they're going to go, we

have some conflict, and I will, generally, say, "I can't get in the middle of this. I've given your daughter the information. This is what she would like to do. You disagree with what I've recommended. The two of you will have to have that discussion, and whatever you decide, I will move in that direction."

MS. BROWN: Hmm.

MS. EHRLICH: So, I think that Power to Decide has always been grounded on meeting our audiences where they're at, and that means that what is in Bedsider, what is in some of the other work that we do with the entertainment industry, et cetera doesn't necessarily resonate with everybody, and might feel a little out there, and a little too edgy, and that can get us in trouble every once in a while. It might not be technical enough, or did we really use this language, et cetera, and, you know, it comes back to, you know, the mantra that we use a lot, and sometimes, when I review content, I say, "I'm not the audience." and I think that that's really important, that if we really want to touch the lives of young people, meet people where they're at, we need to recognize that. We need to do that with some humility, and really listen to who we're trying to serve.

MS. BROWN: Hmm. Thank you.

MR. ROWE: I guess I would say what probably gets me in the most trouble is, as I said from my presentation, you know, part of our focus is on non-marital birth rates in the role of marriage. So, that, certainly, I think, raises tension, but when we think about ensuring, you know, young people or young women understand all of their options, it's also important that they understand information about what has transpired with other young women and men, and how they have achieved success in their own life, and if there is data, for example, around this series of decisions, around education, work, marriage, then children, in that order, 97% of the time, lands you in the middle class or beyond, that should be part of the toolkit of the information that young people have, but it seems to, you know, cause tension.

I mean, generally, even though we are making progress in this area, the

truth is the numbers are still big enough that there are very young children being raised -- being born and then being raised in environments that are likely putting our kids on a treadmill that they will repeat the same outcomes as their parents, and we just have to be honest to talk about these things.

MR. EDWARDS: I have a long list of things that get me in trouble. I think the first is that we are working with a healthcare system that is a big bureaucracy that is under stress and under resourced, and we are trying to bring this topic into the center of primary healthcare, rather just being in specialty care, and, so, trying to move that mountain is very hard, and there are many disincentives along the way.

I think the other thing I would say is that, you know, too often, this conversation gets reduced down to a conversation about LARC, and it's not about that, and I think we're going to hear from the folks at Child Trends, a little bit later on, and I think much of the progress we've seen in reducing unintended pregnancy, or the estimation of that. In Delaware, it's actually been about -- we've been choosing all kinds of other methods as well. It's just something, more access to more methods. It's not really all about LARC, and, so, that's an important thing for us also.

MS. BROWN: Okay. I have another question that I used to get asked a lot, and I just want to ask it of this group as well. It's always "What about the men?" There'd be a sort of -- we'd be two thirds of the way through a meeting, and someone would say, "What about the man?" and I would often say, "Well, look, it's women who get pregnant." It's often women who do the majority of childrearing, especially in early years, and, you know, most of the birth control methods, except for the male condom, are female centered. So, it's no accident that we talk a lot about women, but they would say, "Yeah, but it takes two to Tango." and I'd go, "That's right. I've heard that."

So, I would just like to ask this group what do you do and say with and for and about men in all of this? Do we leave them out, or -- and they're often not in family planning clinics. Sometimes, they are, but I'd be interested in -- what about the men?

DR. TILDON-BURTON: Well, I'll -- I had a little vignette I was going to share, and then I said, "No, I don't have enough time." but I will because you've asked that question. I had a young woman come in, who we went over the whole scope of birth control, and she decided on a pill, after going over everything, and she had looked at the Bedsider chart, and she said, "Would you mind if I come back? My boyfriend's out here. Can I come back in? I know you have other patients. I'll wait."

So, she had to wait for a few minutes, but she came back in, and he came in, and she said, "Would you just go over what you've gone over with me because I think it's important that he hear this." and I just thought that was so, so nice, that he was interested. She wanted him to hear, and he was very receptive, and we talked about how the various methods and the things that he could do to ensure that they were effective, and he said he was going to have an app on his phone.

MS. EHRLICH: We get this question a lot, as well, and I'll answer it in a few ways. On Bedsider, and within our materials, we do -- we have the Guy's Guide to Birth Control, on Bedsider, video content, very fun, very funny, and we do work to ensure that men and young men, in particular, have what they need to be a part of the conversation and a part of the partnership that it requires to reduce unplanned pregnancy.

That being said, going back to our audience research, we have an answer that people might not want to hear, and that is: to get to the men, you need to get to their women. That's what we keep learning over and over, and that's because men say that they find the most reliable source of information around sexual and reproductive health to be the women in their lives, and that doesn't necessarily need to be a romantic partner. It's just that they say, "Well, women know. I'm not going to talk to other guys about it, or, you know, because women know more." and they're kind of right, but they also, you know, do, by and large, believe that. They're like, "Well, it's really her call, what method she chooses, things like that. That's really her call." and, so, those two things combined make it so that some of the best interventions we might be able to do, for men, is to really support women to

influence men in a positive way, while also working on the longer term responsibility component.

MR. ROWE: So, this is definitely a huge area. Even in my presentation, I said, you know, the data I showed was all focused on non-marital birth rates for women, and I said, because that data isn't even tracked, we should be collecting information related to men, non-marital birth rates, unintended pregnancy rates to show that this responsibility is shared. It is solely not focused on women.

You know, in our own class, Pathways to Power, which we teach as the last semester of eighth grade, our boys' school, we're not yet up to eighth grade, but we will be teaching -- we'll be having that class for boys as well. The way that we frame that class is that we use The Seven Habits of Highly Effective Teens as our anchor texts. We have our eighth graders create, essentially, a 10 to 12-year plan about what it is that they want to achieve in their life. What are the obstacles that they think are going to stand in the way, and what are their plans to overcome those hurdles, especially in the next 12 years of their life, where they're making some of the biggest decisions that will have positive or negative consequences. We want girls to have that same sort of future orientation and plan. We want boys to have that same future orientation and plan.

I mean, even in this room, I'd probably say it's about 90% women versus men. So, just generally, guys are not part of this discussion, and we really need to be.

MR. EDWARDS: So, as part of the regular training that we do, that has taken place all across Delaware and the other states that we're working in, it's -- obviously, we focus on dual method use. It's very important, and, you know, there are methods that are great for reducing unintended pregnancy. They're great -- other methods that are really important for reducing STIs, STDs, and, so, what many people in this room may not know is that there are -- actually are 12 steps to putting on a condom appropriately. I would like to do a little pop quiz, but I won't do it here, about how many -- also, I'll note -- but it's important to know how to do that, even that, appropriately -

MS. BROWN: Yeah.

MR. EDWARDS: -- and well.

MS. BROWN: You know, I just remembered, years ago, there was an area of research and demography on this issue of intendedness, un-intendedness, which, as Bill mentioned at the beginning of this meeting, is a question asked of women, at the time you became pregnant, were you planning, in which in a small group of people, they were also able to ask the male partner, was this pregnancy intended, and there was quite a bit of dissonance between what the women reported, with regard to intendedness, and what the men reported, with regard to intendedness, and I've often just thought about that and remembered it as one more complicating factor in getting this all lined up.

I have another question I'd like to invite you all to speak about. In essence, it -- the question is: how can all of us, here, not just you all in your programs, but how can all of us bring family planning in from the cold, and by that I mean how can we, this field, be more included and supported by all these other fields that we work so closely with and support so warmly. You know, the Head Start, Early Childhood Education, Home Visiting for At Risk Families, you know, this whole social services network that, you know, they're right next door to us, and we always say if we do our job well, it will help you in your work, but my experience has been that there's a separation between all the good social welfare stuff, Maternal and Child Health, all that good stuff, cement wall, and then family planning. I don't know. We're too hot to handle, or something, because we're not all working together.

I mean, I think, for example, wouldn't it be amazing if the Title X Program were reauthorized, and there was a big hearing, and most of the people testifying in favor of family planning were from these other agencies, not just family planning providers who, of course, their funding is at stake, but why don't we have the housing people, and the job training people, and the childcare people all saying, "This work that Title X supports is critical to who we see down the road." So, I would just like to invite anybody, here, or when we get to Q and A with the audience, how can we bring all of these together, and in particular, bring

family planning in from the cold?

MR. ROWE: I mean, one thing that I would say, and I mentioned it in my presentation, the -- in the world of education, if you're looking at education data, you can see information sliced and diced by race, class, gender, geography, but you almost never see that data sliced in terms of family structure -

MS. BROWN: Hmm.

MR. ROWE: -- and one of the reasons I am a big proponent of including that as a new metric or a new category of measurement is that I think we would see, start to see over time, that there is more than a correlational relationship between family structure and ultimate academic outcomes for kids. We're already seeing in healthcare. National Center for Health Statistics, they put out reports, where they have seven different categories of family structure, and they show what the relationship is to long-term health outcomes for kids. If you were to show relationship to family structure, in terms of incarceration data, poverty, it's pretty massive. It's pretty -- some would say causal. I would say more than correlational, but that's important data that, if we were to make family structure a common metric of measurement across sectors, I think there would be more of a realization that family planning is a critical element to strengthen the family structure, that then has such a huge relationship to all these other social outcomes that we're all fighting to address.

MS. EHRLICH: Just to add to that, I think that it's measuring on the front end and the back end, but it's also putting performance measures in place that are integrated in nature -

MS. BROWN: Yeah.

MS. EHRLICH: -- right, because what gets measured gets done, and having worked a lot of my career in an educational setting, as the health person, I know that, you know, and having talked to a lot of administrators, they will say, "Yeah, it's such a priority, but this is what the state's asking us to do, and this is what's being reported." So, I think, in addition to collecting the data to make the case, and to make the case in terms of

outcomes, I think it's also important for us to really think about how we create blended performance metrics, so that we are all incented to work together.

MS. BROWN: Mm-hmm. Yeah.

MR. EDWARDS: You know, it just strikes me that the whole conversation about opportunity in this country really begins after children are born. We say, "This child is here. What do we do, now, to make sure this child achieves its full potential?" which is a really important conversation to have, of course, but we haven't, Sarah, to your point -

MS. BROWN: Yeah.

MR. EDWARDS: -- included the conversation we're having here, in this room, and I do think that Brookings has done an extraordinary job of bringing family planning into the opportunity dialogue, and it's events like these, in fact, which I think go a long way. I do think that, you know, and it struck me in my previous job, when I was working at Opportunity Nation, the college board put together a panel on one of these events. There were eight young people, between the ages of 25 and 30, just talking about their life story, and long before I'd ever even thought about Upstream, you know, seven of the eight began their stories with some version of, "Well, I got my girlfriend pregnant and this happened." or "I found myself pregnant and this happened." I mean it just -- unaided, just -- that topic is there. So, it is real. It is a part of the conversation, or it should be more a part of the conversation, and, I think, until we stop thinking about opportunity, exclusively, as starting at the province of once this child is here, we're not going to make the kind of progress we need to.

MS. BROWN: And -- friendly amendment to that, it's actually once that -- there's a positive pregnancy test. There's all this emphasis on prenatal care, which I love. I get that. It sort of starts with prenatal care forward, early, you know, intervention, support to high risk pregnancies, and so forth, but you can't back up that little bit a bit.

DR. TILDON-BURTON: Can I just add a -

MS. BROWN: Yeah. Oh, Please -

DR. TILDON-BURTON: Oh, no.

MS. BROWN: No, finish up on your thought.

MR. EDWARDS: I'm just -- oh, no, no. You go ahead. Go ahead.

DR. TILDON-BURTON: You're asking how to get other people -- come and testify when testify -- we need to do that. I think of some of the things that, done at a local level, going into a correction institute or working -- going to the girls' reform school, and actually giving classes there, I've done that, going into my church, and giving a class there, done that, but I don't think many of us have thought about, when time comes, to go back to those same places, and say, "We need your help now. This is what we've been doing with you. Can you not come and support us?" So, I think we have an ask.

MR. EDWARDS: I just think -- I have just one last thing, which is that I do think that it's possible to both deliver best in class contraceptive care and not -- in a non-coercive and entirely voluntary manner, and I think that that's middle ground that actually can work -

MS. BROWN: Mm-hmm.

MR. EDWARDS: -- but until we've, sort of, recognized that, and this is going to continue to be sort of such a topic outside of that.

MS. BROWN: The too hot to handle.

MR. EDWARDS: Yeah.

MS. BROWN: Yeah.

MR. ROWE: And just one last thing. Yesterday, I presented at the Beulah Church on East Gun Hill Road, in the Bronx, on this topic, and, well, it was just really interesting. There are many allies within the faith community that have -- that are given the permission to have these conversations, and sometimes we don't invite that community in. I think that would be another -

MS. BROWN: Mm-hmm.

MR. ROWE: -- huge population to really tap into.

MS. BROWN: Very helpful. I think it's time to invite questions from the audience. We look forward to them. So, do I -- am I the chooser?

MR. EDWARDS: I would think so. You're in charge.

MS. BROWN: Who has a microphone? How about right up here, in the leopard print dress?

MS. FISSEL: Thank you so much for your presentations. My name is Kaitlyn Fissel. I work for USAID, and I work in International Family Planning Programming. More specifically, I work in the Research Division at USAID. So, I have two questions. The first, for Ian, you talked about births outside of marriage, and you talked a little bit about a class that you have in your charter school. I would like to hear a little bit more, and I wonder if you talk to your students about body literacy, about puberty, about fertility, and how that comes about during puberty, and then my second question is to Ginny. I love Bedsider. When I first discovered it, I shared it on my Facebook page. I shared it everywhere, and I got some pushback, and, so, one piece of pushback that I got is -- on your chart of family planning methods, where fertility awareness is, it's very, very low, and in our International Programming, we have disentangled the rhythm method from things, like the standard days method. So, I appreciate hearing that you are constantly revising things because we just published some research from a clinical trial of the dynamic optimal timing method, which is an app, and it's 95% effective, and it's just women tracking their cycle, and abstaining or using a condom during days when they are fertile.

So, I love Bedsider. I love that it's, you know, client-based, and I think there's a little bit of tension in the communication of the effectiveness of methods because we do know that there are some fertility awareness methods that are highly effective. So, when we put them off to the side, like very low effectiveness, I think we do a disservice to women who -- for whom that method is going to be the right method. So, sorry there's not a question there. There should be.

MR. ROWE: In terms of -- so, what we -- so, our schools go through eighth

grade, and, so, we do some of the things that you just talked about, in terms of fertility, body awareness. Those are things that we teach, pretty much, in our hygiene and, sort of, our social worker advisory. So, that is intact, and I think something that's relatively normal in most schools.

We think we've gone one step further to create a new class, called Pathways to Power, and, there, the frame isn't exclusively around sexual behavior. It's really around this idea of creating a plan for your life, right, of which sexual activity is a component, but there are other key elements, or other key rites of passage, that we want to ensure, or, again, our graduating eighth graders know about before they embark upon the next 12 years, high school, college, and the first four years of young adulthood, because the decisions that are made in those 12 years -

MS. BROWN: Hmm.

MR. ROWE: -- can have fundamental impact, so, positive or negative. So, that's why, again, the data associated with the success sequence, we think, is so empowering because it's, again, it's not a prescription. It is a description of what other young people, who have faced series of decisions, these were the outcomes. We did a presentation, last year, related to the economic success of black men in America that, basically, mimicked many -- much of the data that came out of the original success sequence data that, basically, said, "Eh, hey, big story. There's a, actually, a thriving population of middle- and upper-class black men." So, the question was: how do you get there? How did that group get there? It turns out that education, work, marriage, then children was usually a common set of decisions that this group had made, in addition to elements related to church participation, some related to military involvement, and then, this last idea, personal agency, that they felt that their individual decisions had greater influence over all the forces that might be arrayed against them.

So, the class that we create, in Pathways to Power, is all about that. It's all about creating this plan for your life, and learning from the experience of those who, again,

came from very similar circumstances, but were able to overcome the inevitable challenges that our kids are going to face.

MS. BROWN: Mm-hmm.

MS. EHRLICH: And I'll just say thank you for your feedback, and we are constantly improving and reinventing. You will find some more recent content; actually, if you go to Bedsider, on fertility awareness, for our consumers. In terms of our clinical materials, we work in partnership with UCSF Bixby to, you know, constantly update those materials. That process takes a little more time, based on new data that are available, but we are looking at revising them in many ways, based on learning, so, but that cycle, from just the perspective of really getting it through different review processes, et cetera, takes a little longer.

MS. BROWN: Other questions? We -- Alex, in the red shirt, here.

MR. JACKOW: Thank you very much. Larry Jackow, Senior Advisor to Serve USA. Planned Parent -- sorry family planning, how do we get family planning not to be anti-religious? How do we -- I mean, what role does religion play in your work? We're seeing what's going on with Planned Parenthood, for example, and the struggle it's having to do exactly the kind of work that you want to do. Look at what's going on in states, like Alabama and Missouri. So, I mean, it sounds like you're fighting a battle, here, with religious institutions. How do we get beyond that, to show people that this is a real -- your future? You keep saying it, you know? These decisions that you make are going to go right -- not only through your future, but all the generations that follow you. How do we get that message through to people?

MR. ROWE: Well, in my case, literally, I was at a church yesterday, because I think they're more receptive audiences that we might imagine because, certainly, these parishioners, yesterday, were very concerned, and we were right in East Gun Hill Road, in the Bronx, where these issues are very prevalent, and, so, the pastors and the leadership there were very interested to hear how we are constructing this course for our

own kids in our schools, and, so, I would not assume that there's opposition. I think there's a lot of opportunity for collaboration.

MS. BROWN: Other questions? In the white shirt.

ISABELLE: Hi. My name's Isabelle, and I'm from the UN Foundation, and I'm really curious if any of you have explored telemedicine, as far as, you know, whether it's in an OBGYN Practice, or, you know, with schools, and bringing access, or just online, and providing resources.

MS. EHRLICH: Sure. We actually work pretty closely with the emerging telehealth companies that are offering online prescribing, as well as deliver to your door services for most hormonal methods of contraception. There is actually a directory, as well as some editorial content, on Bedsider, to really educate our audience about those resources. One of the things we're learning is that, while it's an amazing option, it's not yet democratized. Most are for -- actually, the companies would love to democratize it, but given a lot -- for a lot of different reasons, it's usually pay to play, at this point in time, and, so, that is still an access barrier, but for those women who do have insurance, and it's a great option. It eliminates, you know, transportation costs, and we are working closely with them, and we see a real opportunity, actually, to really address some of the access barriers we've all talked about, with these companies emerging.

MS. BROWN: I think we have time for one more question, if there's one.
Mark Hathaway?

MR. HATHAWAY: Thank you very much. This could be addressed to many of you, but I'm going to direct it more towards Mark. I'm wondering if you could talk a little bit about the upfront costs and how you calculate that in a place, like Delaware or other states, and then how you trend down, and transition to the sustainability of, you know, weaning yourselves out of a state.

MS. BROWN: Mm.

MR. EDWARDS: Just to add just a little more context to Mark's question,

one of the things that we've found, which is exciting, is that when you really approach this work from a systems perspective, it really has, as Dr. Rattay said, everyone from the, sort of, the front desk staff through the Chief Medical Officer, it really becomes embedded in practice, and, so, it just becomes the way care is offered, and it's not about the individuals there. It's really about the entire system, and, so, in Delaware, you know, when we started, back in 2014, it really grew to a staff of, really, almost 20, and primarily providing quality improvement and training technical assistance across the healthcare system, really in public, private hospitals, inpatient, outpatient, I mean, really, any place that women get their care, and, now, the vast majority of the state is in what we refer to as sustainability mode, which, really, is that we're no longer delivering active care, but, really, we are -- we're monitoring, and we gather data to allow us to ensure that women are getting same day access to the full range of methods with great counseling, and as a result, our staff is actually beginning to -- it's actually -- be reduced because there's simply no need for us to be there.

Women are getting asked about their pregnancy intention, and they're getting great experiences, and, so, and we have ongoing data supporting that, and, so, from a budgeting perspective, there is this ramp down, and to the point where, pretty soon, we will be, essentially, really ending the work. There's just no reason for us to be there, which is exciting, from both sort of a sustainability point of view, and, obviously, also from a cost point of view because we're not going to -- there are existing insurance flows. Dr. Rattay spoke about some of the new legislation that ensures that even uninsured women will get -- continue to get access, and that's just sort of built into the system going forward.

MS. BROWN: I think we're out of time. Will you join me in thanking this wonderful group of panelists? We got -- yeah, and, so, we're now going to bring on panel three.

MR. HASKINS: Welcome to the final session. On the agenda today, the topic of this session is Research on Family Planning and Improving Opportunity which has come up several times today and now we'll focus on it specifically. We have three of the best people in the nation to discuss this vital topic.

Immediately to my left, Martha Bailey who's a professor of Economics and Research Professor at the Population Studies Center at the University of Michigan. She's also a faculty research fellow at the National Bureau of Economic Research. Martha conducts research on issues related to economics of gender and reproductive health.

Kristin Moore is a Senior Scholar at Child Trends where she's been for many years here in D.C. She studies adolescent development including adolescent sexual contraceptive behavior. And then Jason Lindo, one of the people who came from far away. He's at Texas A&M but he came from Bozeman, Montana. He doesn't like the temperature in Texas. I have two offspring in Texas and I was there a couple of weeks ago and I'm on your side. So, Jason is a professor of economics at Texas A&M University and a research associate at the National Bureau of Economic Research. His research focuses on the effects of changes in access to reproductive healthcare.

And there is more information about all the participants in your materials. Each speaker has eight minutes followed by questions from me and then from the audience. And then finally after we're done, Bel will reappear if she's still awake and come on up and give us parting words. I want to remind everybody including the speakers that you need to stay -- these are wonderful mics but you've got to stay close to them. If you're far away like this, it will much more difficult to hear. And the one up there is the same way so you need to be quite close to the mic in order to make it work well. So, let's begin with Bailey.

MS. BAILEY: Hi everyone. Thanks so much for organizing this session. I've been working on reproductive healthcare since I became an economist in 2005 minted with my PhD. But I couldn't be more excited that this topic is kind of entering into the public discussion much more than it was recently. So, a couple of things. We've talked about this everyone has seen this. Almost half of U.S. pregnancies are unintended and those rates are much higher among disadvantaged women.

So, when I started as an economist, I was sort of shocked. When I started thinking about this topic, I was met with a lot of skepticism in economics and I think many of

you know what I'm talking about. Not necessarily in this room but outside of this room, can policy really matter at all. What does this mean? And to put this in the parlance of economists, Bel set me up well to do this. Economists will talk a lot about the demand for children. So, unintended births, all about what women want. And so, contraceptive technology, policy, access just doesn't really matter so much. Unintended pregnancies, this line of thought says is kind of like an unintended speeding ticket. You know, clearly, you were doing something that got you there in the first place.

On the other side of that policy debate are a number of people who say it's about supply. It's about access to services, it's about empowering women to realize what the number of children they want to actually get there. So, given that they want it, how are they going to actually achieve that and that's really what contraceptive technology and a lot of policy can do.

And so, one of the difficulties here and when I entered this discussion, these were basically two different camps fighting with one another arguing about the interpretation of a time series. So, the number of births women were having was it going up, was it going down, how do we know those changes in birth rates are not reflecting demand. How do we know they're reflecting supply and both camps made different arguments about why things were really, really important.

So, my role here, I think on the panel and so and what a lot of my early career was devoted to was how do you find good ways to put numbers on some of the things we've been talking about. I think everyone in this room thinks these things are important but as an economist, how important. How much do these programs cost, how do we quantify some of these benefits that often appear in the sort of doctors' offices and waiting rooms and these personal discussions that don't kind of leak out into the public space. How do you put numbers on those things to try to make sort of think about how cost effective these investments could be.

And notice, I just called these investments which is one of those ways I'm

trying to shift the discussion about the cost of reproductive healthcare instead thinking about them. It's like what are the returns to a dollar spent on reproductive healthcare.

So, a couple of things that researchers do and something I spend a lot of time thinking about. How do we get good control groups right? When you have a policy that rolls out to every place in a state, how do we come up with an adequate comparison group. What would the world have been like in the absence of the policy? That's really what we need to do to try to quantify those benefits.

The other thing is a lot of the evaluations really focus on short term metrics, right? What people are saying at the time they get access to the contraceptives, whether or not they're getting a particular type of contraceptive and one of the things we're really interested in are those downstream outcomes. How does access to a LARC today not just influence your life, your educational attainment, your career, the lives of your children, we want to know all of those things, right, not just contraceptive use. But the reason we often focus on these short term metrics is because that's the data we get. That's what we get in real time and that's easy.

So, a couple of things I want to take you through. I've done a lot of work on this topic. A lot of my work is centered on the '60s and 1970s for two reasons. One, it's because we can come up with some really nice comparison groups to try to get some numbers, very clear numbers out of that. The second reason is we can start to look at a lot of those downstream outcomes. Not just how does this affect your life this year, your pregnancy this year, but your longer term career prospects and importantly the lives of your children, right? So, that's what I'm going to be talking to you about today.

And the other thing I'm going to do is a give applaud for a very large scale randomized control trial that we're doing in Michigan right now that we don't have results for yet. And I think after that, then we'll talk about two of the other more recent things.

So, the first thing I did, so it turns out how much the laws or you say barriers to access matter. You can think about barriers as legal barriers, you can think about them

as transportation barriers, spatial barriers, how much is it going to cost you to go and get contraceptives. Well, it turns out in the 1960s and early 1970s, women who were under the age of 21 and unmarried were not able to legally consent to birth control pills. They couldn't go into their private providers, they couldn't go into their college clinics, they couldn't get them at all. And there were a series of legislative changes that happened across states that altered those barriers.

So, it turns out that allowing young women to legally obtain contraceptives at 18 versus age 21 not only reduces birth rates which is what I'm showing you in this picture right here. You can see it really drives down birth rates between ages say 18 to 21. But one of the things you don't see in this figure and I had to cut a lot out for time. If you're interested, you can go to my website and see all of these things is it increases their educational attainment, increases their labor force participation and their wage rates are about 8 percent higher by the age of 40. So, substantial improvement, that's an annual number.

Another thing that was important, and Bel brought this up this morning. It turns out when the birth control pill was first introduced in the 1960s, about half of the states in the United States made it illegal for physicians to prescribe or pharmacists to sell contraceptives. So, one of the things that happens over the course of the 1960s is that birth rates are declining everywhere in the United States. The baby boom is ending which was sort of the 50 year high in birth rates in the United States. So, birth rates are going down everywhere.

What this figure shows you is that birth rates went down significantly faster in places that did not have those restrictions on contraceptive access allowing me to quantify exactly how much this seems to matter. And something I won't show you but is in a Brookings paper is how much this improves child outcomes.

A final piece is that federal funding for family planning rolled out in the 1960s before Title X and then with Title X to places all over the United States. What impact

did both setting up facilities and reducing the price of contraceptives for a lot of low income women have on birth rates. It turns out that before the program was introduced, the places that eventually got family planning programs and those that didn't, birth rates were changing about the same way.

After the program started, we see a dramatic decline in birth rates. We think it's driven primarily by reductions in unintended births. The other thing that you see is that for the children who were born to mothers with access to contraception is that their household incomes increased dramatically. We see sharp reductions in the share of children that are living in households that are below the poverty line and we also see that children born to mothers with access to family planning are about 12 percent less likely to live in households receiving public assistance. And this turns out to be a really important thing. Because this says that a dollar invested in family planning is going to have a pretty sizeable effect on public outlays for a variety of public programs even though this is just one.

So, coming to the last piece. So, how do these findings generalize to today. What we really want to know is that all of the exciting things that we've discussing today, what types of affects are they going to have on families, what types of affects are they going to have on the lives of children, what about now, what about in the longer term. Well, we need a time machine or a lot of patience. So, those results we don't quite have yet but I think the evidence from the past is very suggestive that a lot of these initiatives should matter.

The last thing that we're doing now is so how do we think about access to reproductive healthcare now. We are starting or we have started, it's currently in the field, a large scale randomized control trial. It's called the Michigan Contraceptive Access Research and Evaluation Study. And this is joint with Planned Parenthood of Michigan and the field work is being is being done by NORC. It's funded by the Laura and John Arnold Foundation. And we're very excited because what this is doing is, we don't have access to the resources to change the provision of healthcare, even change practice in Michigan. So,

all we're doing for this study right now is just making the out of pocket costs zero for about half of the women that walk into the clinics.

The second thing we're doing is, so this gives us a control group that's built in within clinic. The second thing that we are able to do is we're going to survey these women following up in both three and five years and we've also gained their consent to track them in administrative data for the next 30 years. So, we expect that there will be a lot more exciting work to come. Thank you very much.

MR. HASKINS: Kris Moore.

MS. MOORE: Thank you and what a great discussion today. I want to acknowledge that I am the presenter and have done a fair amount of work on teen childbearing over the years but today I'm a presenter. I was a senior advisor on the project but Dr. Jennifer Manlove was the principle investigator. Jenn's daughter has her college orientation today so I'm presenting on behalf of Jenn and Kate Welty. Child Trends cares about kids at all ages.

So, the focus of this presentation is simulated reductions in unintended pregnancy among Delaware Title X family planning client after contraception access intervention. In late 2014, Upstream USA began an initiative, Delaware Contraceptive Access Now known as Delaware CAN, you've heard a lot about it, to provide women with greater access to the full range of effective contraceptives. In 2017, Child Trends was commissioned by Upstream to examine how contraceptive use among family planning clients at Title X clinics in Delaware changed during the implementation of Delaware CAN.

Child Trends study focuses on the time period between 2014 and 2017 as 2017 is the most recent year for which contraceptive use data are available. After examining trends in contraceptive use in Delaware and in the U.S. overall, Child Trends input these contraceptive data into the micro simulation model Family Scape 3.0. To project having unintended pregnancy rate may have changed based on observed shifts in method use.

Approach, Delaware CAN is a statewide initiative. However, Child Trends

analyses had used data for a more limited population. Specifically, the team used the Title X data because Title X grantees consistently collect and submit data on client's primary method use each year to the federal government. And these data are audited and made publicly available. Statewide Title X data were provided by the Delaware Department of Health and Social Services. All national Title X data came from the family planning annual report published by the federal office of Population Affairs.

The analysis was conducted for women ages 20 to 39 because levels are missing data are high for teenagers and because FamilyScape is most accurate for women under age 40. The study team acknowledges that this was not and could not be designed to be a rigorous evaluation that could detect causal impacts. However, the team was able to compare trends and contraceptive use among Delaware Title X clients to trends among Title X clients nationwide to understand whether the findings for Delaware were unique. For instance, we know that the use of long acting reversible contraceptives or LARCs has been increasing over the past decade across the United States. So, the goal was to check whether any changes found in Delaware were simply part of a larger trend.

As I mentioned, after examining the trends in contraceptive use among Title X clients in Delaware and the U.S. overall, Child Trends then used FamilyScape 3.0 to project how the unintended pregnancy rate among this population may have changed. FamilyScape's is an innovative simulation model of pregnancy and family formation. The model was originally developed here at the Brookings Institution and is now a collaborative effort between Brookings and Child Trends.

FamilyScape is designed to replicate real world fertility related behaviors and outcomes among U.S. women of childbearing age. FamilyScape has been widely used by researchers to examine how changes in contraceptive use are linked to reductions in early and unplanned pregnancies, births and abortions and there's more information on the Child Trends website.

Several limitations in the study, of course, deserve mention. First, the Title

X data from Delaware had a substantial number of women who were missing data on contraceptive method. Approximately 40 percent of women in 2014 and about one-quarter in later years. Needless to say, the team excluded these women from analyses. However, based on discussions with staff at Delaware's Department of Health and Social Services, we have no reason to believe that data are missing in a way that might systematically bias the results. Also, Child Trends conducted a number of sensitivity checks, making different assumptions about method choice among women with missing data. In all of these data checks, the findings were similar.

Second, FamilyScape is a useful tool for estimating whether contraceptive use trends could lead to reductions in unplanned pregnancy in the absence of actual pregnancy data. However, FamilyScape is a simulation model so it's not designed to capture causal impacts or replace a rigorous evaluation. And third, findings from this study are for Title X family planning clients so they're not generalizable to all women in Delaware.

So, results. Delaware CAN focused on providing women with access to the birth control method of their choice. However, one of the key findings that we highlight here was an increase in the use of LARCs and this important because LARCs are highly effective contraceptive methods. Among Delaware Title X family planning clients, there was an increase in LARC use from 13.7 percent to 31.5 percent, just between 2014 and 2017. This increase in LARC use was offset by decrease in the use of other methods such as injectables, hormonal methods like the pill, patch or ring, condoms and a modest decline in the percent using no method at all.

Among Title X family planning clients nationwide, the team found a smaller increase in LARC use during this period from 13.6 percent to 19.9 percent. I'd like to note that these percentages are calculated among family planning clients who are considered at risk of unintended pregnancy. That is, they were sexually active and were not pregnant or seeking pregnancy.

On this figure, we show the results of the FamilyScape simulations. The

blue line is the simulated unintended pregnancy rate among Title X family planning clients in Delaware. The orange line is a simulated unintended pregnancy rate among Title X family planning clients nationwide predicted based on the methods used by these women in each year. The study team found a decline of 24 percent in the projected unintended pregnancy rate for Title X clients in Delaware between 2014 and 2017. In the U.S. overall, the projected decline was approximately 3 percent.

In conclusion, while this study cannot determine causality of Upstream's work with Title X providers in Delaware has coincided with a large increase in the use of LARC methods among Title X clients in Delaware. A far more substantial increase than was estimated among Title X clients nationwide. And based on changes in the Title X method mix, the FamilyScape model simulates a substantial decrease in the unintended pregnancy rate in Delaware during this period. Of the national unintended pregnancy rate among Title X clients, it estimated it dropped less notably. Thank you.

MR. HASKINS: Jason Lindo.

MR. LINDO: So, today I'm going to be presenting some joint work with Andrea Kelly who is a PhD student at Texas A&M, also Emily Sapackum who was a PhD student at Texas A&M and is now an assistant professor at Vanderbilt. In this research, we're trying to evaluate the causal effects of the Colorado Family Planning Initiative which has been brought up several times today. One thing I think is important for me to let you all know is that none of us are in any way affiliated with Colorado. In fact, we didn't learn about the Colorado Family Planning Initiative probably until all of you did in 2014 when it made headlines. At the time, these headlines were talking about, you know, 40 percent reduction in teen birth rates in Colorado and what we set out to do was to see well, just how much of that decline could be attributed to this initiative.

A little bit more background is that this initiative involved a \$23 million investment from 2009 to 2015. And all 28 agencies in Colorado operating Title X clinics accepted some of this funding. And the major impetus for this was that this was going to

allow these clinics to offer implants and IUDs in addition to all other methods of contraception to low income women at no cost. Previously, they would have liked to do so and that's their policy but they could only stock so many of these devices and so they would have to ration basically. So, in 2009 after this initiative was underway, we had 20 of these agencies offering IUDs for the first time, 16 offering implants for the first time.

So, the larger goal for our research here is to try understand to what degree does funding of Title X clinics matter in terms of improving access and use of highly effective contraceptive and then affecting women's outcomes. So, how did contraceptive use change in Colorado after this initiative was implemented? This figure gives you a sense of what happened. 2008, only about 5 percent of and this is women who are clients of Title X clinics, only 5 percent were using a LARC. By 2015, as many were using a LARC as were using the pill. So, this is a really massive increase in the share of women who were LARCs following this program.

Of course, as Martha pointed out, to know what the causal effect is we need to have some comparison group to help us learn about what would have happened in the absence of this initiative. And so, this next figure shows what happened in Colorado relative to other U.S. states. And this is again, the share of Title X clinic clients who are using LARCs and you can see that the share rapidly escalated in Colorado. It also increased across the U.S. but at a much slower rate. So, this is indicative of a causal effect of this initiative pretty dramatically increasing the use of LARCs.

Okay so what happened to birth rates? Well, to do this, again we needed to find some good comparison group. And so, what we did is we looked at other counties across the U.S. that had Title X clinics. And we compared their birthrates to Colorado counties with Title X clinics okay and that's what we're doing here. And you can see across the U.S., the teen birth rate fell quite dramatically. And what that tells us is even without the initiative, the teen birth would have fallen pretty dramatically in Colorado but it fell more dramatically in Colorado as a result of this initiative.

So, it's not this entire decline that represents the causal effect of the initiative, it's this gap that emerges after the initiative that represents the causal effect of the initiative. So, the statistical models that we estimate indicate that this initiative reduced the teen birth rate by 6.4 percent over 5 years for counties with these clinics. Not 40 percent as the headlines might have led you to suggest but 6.4 percent. And 6.4 percent, I would say, is pretty big. We don't have to say 40 percent, we could say 6.4 percent and be happy that that's a pretty big number, I think.

Some of our more recent research has looked at data at a finer level looking at zip codes and there we've identified that the effects are really concentrated among women who are living in zip codes within seven miles of these clinics. Okay so for zip codes that are within seven miles, the impact on the teen birth rate is 20 percent. Beyond that seven mile radius around these Title X clinics, we can't detect effects. There may be effects, but we can't detect them if they exist.

It's also the case that we haven't been able to detect effects for women who are older than 20 up until 2014 and 2015 where we start to see significant effects for older women. And that initially was quite a puzzle for us and it is still something that we don't have a definitive answer to but interestingly, what happened in 2014, '15, well in 2014, one year before they were set to run out of funding, Colorado released their report on supposed effects of the initiative. And then this initiative went from under the radar, and I can tell you that there were no newspaper reports about the Colorado Family Planning Initiative until 2014. But then it made international news and then lots of people became aware of it. And then in 2015, there was a very fierce and highly publicized debate about whether or not the state was going to take over the funding of this initiative.

And so, maybe this is why things seemed to change in 2014-15 with the effects reaching women who are more distant from the clinics and also reaching older women. And interestingly here, I've plotted a number of insertions per client and there is this interesting uptick in 2015 which, you know, we can only speculate as to why that might be

the case. But it could be this advertising, this publicity or fear that the clinics would no longer be able to offer these devices in the future without the funding.

So, looked at a lot of other outcomes as well. We found significant effects on relatively costly births. Births involving very low birth weights. Those certainly were reduced by a significant amount by this initiative. We find especially large effects on Hispanics and modest evidence of effects on abortions to teens.

So, wrapping up, you know, I think what we've learned from this research is that funding resources for Title X clinics can have really dramatic impacts on birth rates for women who are living very close to these clinics. It seems like advertising matters but one of the things that I think we need to wrestle with is how do we serve the large number of women who are outside of this seven mile radius around these clinics if that's where the services are being expanded. That's it.

MR. HASKINS: Well believe it or not Jason and I did not plan this but the first question I want to ask is, I like to ask fairly simply straightforward questions. And the first thing I want to ask is how strong is the evidence that links these policy changes to changes in women's use of different kinds of birth control including the more effective kinds. Is that evidence really strong, in some states it is but do we believe it?

MR. LINDO: Well, I guess I would say that's why it's important that some of us researchers get out here and we share it. So, I hope you all believed it. And I think like throughout the day though folks have been presenting figures showing these dramatic increases in LARC use when they are made available to women. And these increases are so dramatic relative to what is happening nationwide that it really has to be a causal effect of the expansion and access.

MS. MOORE: I would agree. I think that the findings are so similar across studies where people are not working together, they're not collaborating but they're getting very similar results and that's not trivial.

MR. HASKINS: All right, so we've established a fact that these policies

have an impact on the states use them and employ them and they have an impact on the service that are delivered. What are the effects on kids?

MS. MOORE: I guess that's for me from Child Trends. I mean, I don't think we have data from any of the available studies on the implications for children. But from everything we know about child development would suggest that children who are born to couples who are committed to one another, committed to their child, planning to have that child and raise it together who are more educated, more financially secure, those children are advantaged in life. And so, that is probably going to be positive and gosh it seems like that should be the next phase of research.

MR. HASKINS: Go ahead.

MS. BAILEY: So, in fact, looking at the effects on kids was one of the important components of what I was showing for the 1960s and '70s, not just health. And so, what I was able to show you is changes in household resources for children that are born after family planning programs began in the United States.

So, how do we interpret that evidence? There are two things that could be going on. One is just a lot of poor women aren't having children anymore. They didn't want to have them, now they're not having them so the income on average of children born after the initiative rises. This is just mechanical. But that doesn't necessarily mean that the resources of any child that's born are actually changing. You're just taking the mean over a more advantaged group. So, how do we actually know whether or not resources have improved for some of the children that are born. In fact, we have evidence on this as well.

So, one of the things we do in our paper is try to bound what we would call the selection effect is versus what is and what I call the empowerment effect when I wrote that paper but the editor made me change it to the resource effect. So, the way I think about the other side of this discussion, it's not just you're sort of eliminating certain children, you're empowering parents to have children and families when they want. How does this actually affect those parents? Does it affect their employment, does it affect their education, does it

affect their receipt of public resources, does it affect their health and how do those resources affect their children once those children are born down the line?

We actually know the answer to that too. So, in the context of the 1960s and '70s, about half of the effects we see are due to the selection, that is they're poor women, poor families who are not having children and the other half of the effect is due to what I call the empowerment effect. I'll say that in this crowd even though the editor wouldn't let me print it. That that is the lives of people who have access to family planning, in particular, Title X clinics that their children are doing significantly better for those families.

So, I do think that that's very, very promising evidence. So, what about, those are childhood resources. How does that translate in the long term into those children's educational attainment, labor force participation, disability, health, those are really hard questions. I cut that slide because I was short on time but we also have some evidence on that.

So, one of the things I was showing you is that we see these sharp reductions or sharper declines in birth rates due to this decrease in unintended pregnancy in places, for instance, that didn't have these restrictions on contraceptive use, right in the United States in the 1960s and '70s. You can look at those cohorts of children and those kids, right, kind of going back in your mind, they're about prime earning age now. So, when we look at those cohorts of children that are born in those states, how much higher is their educational attainment, how much better are they doing in the labor market, it turns out significantly.

So, you see this both for sort of the Griswold paper that I described first and you see this also for the rollout of Title X clinics in the United States over the 60s and 70s. So, I will say both pieces of evidence, so what are the effects on children for Colorado today for Upstream today? That's really hard to say. We need a time machine or a whole lot of patience right, one or the other. But we can tell from evidence from the past that, in fact, it appears that children are doing much better as a result. And measurably better in ways we can see in data.

MR. HASKINS: I'd like to hear from the panel what kind of research should we do? How we can supplement and improve the studies we've done so far to do something like Martha is describing. How can we find out if we agree that they're impacts which everyone on the family does and then their more wide use of effective means of birth control and reductions in pregnancy rates among the women who are using them. How can we more effectively demonstrate the effects on children?

MS. MOORE: Well, I would offer one strategy which is the use of simulation models and FamilyScape is, of course, one simulation model. Child Trends has also worked with Brookings on to develop and now are updating the social genome model which is a child development model. So, it's looking at not just education for children but their social development, their emotional well-being and their physical health and also their relationship quality. And hopefully when that is ready, we will be able to simulate those kinds of findings. I mean, you'd love to see a long term intensive random assignment study done like Assadourian on this kind of project. Maybe you're doing that in Michigan.

MS. BAILEY: That's what we're doing in Michigan.

MS. MOORE: I hand the mic to you.

MS. BAILEY: So, one of the things that's really challenging when you're thinking about outcomes of kids is sort of one, we know that pregnancies are rare. They don't happen to ever single woman. Two, unintended pregnancies are rarer and then if you think there are effects on kids, right, those aren't going to be massive and so you're starting to cut your samples down to be really, really, really, small. So, if you want to look at the effects on kids and you're looking at all the survey data we have, you're really limited in what you can say statistically. You have very, very small sample sizes but really, really rich data.

So, one of the things we're trying to do as part of the M-CARES project and something I think is really important for these evaluations going forward, simulation models are the best we can do without a lot of data sort of now. But if we're trying to actually follow these kids and be able to say quantitatively in five, ten years how well we're doing, using

administrative data. Administrative data is collected on every child. We have birth records on every child. We can say things much more definitively for the universe of kids that we can for a small sample of kids. So, I will encourage you, if you're putting these together and thinking about this, I do think administrative data can really help shed new light on some of these important questions.

MR. LINDO: I'd like to add that I was really excited to potentially evaluate how the Colorado Family Planning Initiative effected kids' outcomes. And along with my co-authors who spent a tremendous amount of time trying to do that using survey data and we can't find anything. And it's because the data are just too sparse. It's not necessarily because there's no effect, it's just because the sample sizes aren't large enough.

The other thing that I would add is that, you know, one of the things that made it possible for us to do our research was that if the state of Colorado was willing to share data with us. It couldn't have been done without that and I think that this is really important for all the organizations who are implementing these sorts of programs. You know, there are different methodologies out there that exist and I think we would have more convincing estimates of the effects of these programs if we have multiple teams out there doing research using different methodologies so that way we can compare and contrast the results.

MS. MOORE: I just want to mention one resource that goes beyond some of the administrative data which is, of course, a wonderful approach. But the National Survey of Children's Health has been done since the early 2000s and it has information across domain's health, education, family and emotional well-being and offers some opportunities. It is cross sectional, that's a liability, but it has huge samples, tens of thousands of children nationwide with state specific samples. So, that's a possibility.

MR. LINDO: Can I add one more thing. Sometimes administrative data can be difficult for researchers to access. One of the things we were hoping to do is to get data from the Colorado Department of Education but they declined to participate in this study

because they thought it was too controversial.

MR. HASKINS: Yes, it's a condition of life in the United States is that states are often very jealous of their data and they will not share it. They won't share it with people at the federal level and won't share it with the Census Bureau. So, we have a lot of work to do there and we could learn more especially about these kinds of what seem to be now correlational issue effects of kids on these policies.

All right, now I want you to be policymakers, okay and apply your research knowledge to, I think, very important policy questions. The first thing is, I think, I've been citing this quite a bit, been involved in it a little bit through the power to decide. And that is the Trump administration seems to have, I don't want to be too critical here but they are doing several things that are reducing funding and support for the programs that are helping the states implement and pay for these policies.

So, the question arises to me, are we going to have to face a situation where the states are going to be not only the main innovators which I think they have been so far. But also, they're going to be the funders of these policies which is going to be difficult as you can see. I want to give you one example. Teen pregnancy prevention which the way I look at things has been a very, very successful policy implemented in sites around the country competition for the money. They would now be in the seventh or eighth year of implementing these programs at the local level. And fortunately, you showed the data on teen pregnancy and you've seen data on teen birth rates, they've both just plummeted, unbelievable. And the teen pregnancy prevention may have played a role in that.

And the Trump administration decided that they were going to use the money for something else. And when I first, I was on The Hill for many years and actually played a role in the funding for this legislation when I was on The Hill. And when I first saw this, I said they can't do that, they cannot do that. This is a law passed by the Congress, has all kinds of stipulations in it. The actions of the (inaudible) meet the stipulations and now they're going to take the money out and use it for other purposes. Well, they did it anyway.

Fortunately, the courts intervened and they stopped the Trump administration but they still took some of the money and, you know, it's a mess.

So, that shows you, I think it shows you the strength that the evidence that the administration is really willing to move on this agenda not just on the abortion front but on many others as well. So, the states are going to have to not just step up with innovation but with money too. How are they going to do that?

MR. LINDO: I don't know where they're going find the money. But one thing I would like to say is, you know, states have innovated in this way in the past. Texas is a great example where in 2011, they cut family planning funding by two-thirds. Eighty clinics in Texas closed and this is because they took the funding away from these clinics. There's really good research out there that has documented the effects of this defunding by Yal Lou, David Selski and Annalise Packam. If you want to look them up, they show that preventive care use among women fell. Teen birth rates rose. So, we don't have to guess about what is likely to happen if we cut Title X funding. We've seen it in Texas.

MS. MOORE: So, I would say that there is another approach which is that the savings can be invested back into these kinds of programs. And I think that's true for evidenced based programs more broadly. They prevented incarceration in Washington. They're not building as many prisons now. But given how rapid some of these changes seem to be happening, they seem likely to generate savings in short order. So, I might propose that as a possible source for states to fund their innovations.

MR. HASKINS: And, in fact, at least one state I know of is actually doing that so that's a good concrete suggestion of how states could fund it is through (inaudible) and I think that is a possibility. Anything else?

MS. BAILEY: So, I think everyone else on the panel has laid out what we know what the costs of these programs are. One of the things that I think has been important is so times are tough, budgets are tight. If you're a policymaker and you want to influence opportunity of kids where do you put your money? So, you can think about this in

lots of ways and so this is the difficult types of decisions that a lot of people are facing and a lot of people are choosing to take it out of reproductive health and put it into other programs.

One of the things I think, so an economist, we tend to think about sort of things or sort of what are the costs but you can also think about these things as investments. So, if you're thinking about what are the returns on dollars put in public education, what are the returns on dollars put in Medicaid. And so, not just sort of how much does that influence say the next generation's opportunities in human capital but also is there very mechanical savings associated with some of those decisions.

And I think in that sense family planning and I've been arguing this for a very long time. I'm on record in multiple papers kind of doing the cost benefit analysis is cheap and it has an extremely, extremely high return. It's improving the environments of children in terms of resources and homes before the public sector ever steps in to help, right. It compliments any investments that's happening in schools, it's also complimenting a lot of the investments that are happening through the healthcare system.

So, in many ways, this is setting kids and families up for success. So, a dollar spent on family planning is maybe the best investment policymakers can make. And I can only think that some of these places that are -- all these cuts are going to increase costs in other programs so much that they may not be sustainable.

MR. HASKINS: I agree with that but it's amazing how many policymakers don't pay attention to benefit cost numbers if they oppose it on other grounds. And this is an area where they oppose things for all kinds of bizarre reasons. Okay audience, time for audience to ask questions. Raise your hand, I'll recognize it, someone will bring you a mic and ask you a question. All the way in the back.

SPEAKER: I can't resist this question. So, if they are not wanting to provide -- they know that family planning, investing every dollar in family planning is a great investment return, what is your personal opinions as to why they will not invest in family planning? And does it have to do with a larger view of just women in society in general or

something like that.

MR. LINDO: I mentioned that Texas experienced with this previously. And there it was very clear that the intent was to deprive funding to organizations associated with abortion providers. And there was -- it was spoken about quite openly.

MR. HASKINS: Other questions? Yes, over here.

MR. HATHAWAY: Thanks again. I'm still Mark Hathaway from Washington, D.C. which is still not a state. I'm curious if any of you are looking into the research. There's a lot of talk these days about maternal mortality rates rising in our country. And it seems to me there's lots of research in low resource countries around the world that if we provide safe, simple, easy access to abortion care and safe, simple access easy access to family planning services, we can tremendously reduce maternal mortality rates. And those numbers are tough to draw down for multiple reasons. But I'm wondering if any of you as researchers or anyone is looking at that link.

MR. LINDO: So, I would say internationally, yeah. There's really good research that's being done. In the U.S., I know of some failed attempts to do it. One of the issues there is this is a really rare outcome. And so, getting any estimates with statistical precision as Martha was pointing out is especially difficult when you're talking about an outcome like this. But perhaps with better access to measures of maternal morbidity I think that's maybe the best shot that we might have. But I haven't seen any research in the U.S. context on this issue.

MR. HASKINS: And there's one more question in front of them.

SPEAKER: It wasn't so much a question it was just is anybody in the room feel we have to cut taxes anymore so that we can, you know, do away with some of these programs, give it to the rich? It's not a question.

SPEAKER: I looked at my notes and Jason, can you say a little bit more about this issue of women living within seven miles of their clinic. I hadn't heard that about the results from Colorado. Does it only pertain to women within seven miles? Can you just

say more about that?

MR. LINDO: Sure. So, you may have seen one of the earlier papers on this that's published and that was an analysis using county level data. So, the next step in our research agenda was to get more granular data and look at zip codes. And so, that's where, it's going to be in our working paper if you're interested, we're sort of focusing down on just how close you have to be in order to observe these impacts. And it seems to be about 7 miles up until 2014 to '15 and then there after that, we see effects out to 12 miles from a clinic.

MR. HASKINS: So, you need an Uber study.

MR. BAILEY: Let me add to this though. And I think that this is really important. When we talk about access to reproductive healthcare, there are the effects we can measure and there are the effects that we can't measure. And a lot of those have to do with sample sizes and a lot of them just have to do that effects are small relative to sample sizes.

So, when Jason is saying, correct me if I'm wrong, that we can't measure effects beyond sort of these certain radiuses, that is we cannot detect statistically that there is an effect. It doesn't mean that women aren't benefiting and driving in. But what it does mean is sort of if you're thinking about transportation, taking the bus to your local Planned Parenthood or how are you going to catch a ride or being locally proximate is actually going to matter a great deal for access. And so, that's something, so it does suggest that the effects are larger so proximity is key to access. We know that but it doesn't mean that there's no effects, we know that women drive a great deal of distance which is also evidence in, of course, these clinics and services matter a great deal.

MR. HASKINS: Mark.

SPEAKER: Thank you. I was just wondering if you could position the or help us understand the scale of the changes that you've seen certainly in Colorado but also Martha, you spoke of this a little bit also, in some sort of a comparative way. In other words,

compared to other kinds of things Jason, you said in Colorado I think it is 6.4 percent reduction in teen pregnancy. I think all of us really care about the opportunity and how do you think about family planning and investments in that against a whole suite of other things that one might do. Whether you're talking about outcomes for kids or outcomes for mothers, just put it in a relative basis.

MS. MOORE: How do you scale this is the question now. And I think if you think about it in relative to the effect size of other interventions, it's hard to change the behavior of human beings. You know, we're kind of a stubborn people. And with a rapid response to this suggests that there is an unmet need that people are ready for this and that making it available certainly the higher barriers the less likely people are to access the services. So, that this is probably but I don't know that we're in the position to calculate an effect size. But it sounds to me like it is potentially quite a large effect size relative to other interventions. And I just might note that prevention is generally more cost effective than amelioration or treatment so it would fit into a very large body of research on that topic.

MR. LINDO: So, I would say that the effect was 6.4 percent for the county, at the county level. 20 percent if you focus on the zip codes nearest to the clinics. And that's happening against a backdrop where across the U.S. say the teen birthrate has fallen by 40 percent. So, you know, 6 percent you can explain 6 percent of that massive decline as being a result of this initiative.

So, other things are going on in the background that are really pushing unintended pregnancies down. Certainly, though these sorts of initiatives appear as if they can push them down even further. But understanding what else is it and what is it that's causing these birth rates to go down all across the U.S. even in places where these initiatives aren't happening is something that I think is really important for researchers to dig into and to better understand.

MS. BAILEY: So Mark, one of the things we did, so we've done a couple of things trying to think about how do you compare the value of a dollar spent on family

planning to say the value of a dollar spent on federal aid for college in terms of increasing college graduation rates. We did a variety of calculations like this in sort of our Brookings piece so you're welcome to take a look at that, that has some hard numbers.

And the other thing that we did is sort of increasing the resources for children. Say, for instance, as a policymaker, you want to target a reduction in poverty, what's your best bet in terms of program. What's the most cost effective way to reduce child poverty by a point, by 5 percentage points, how would you do that. Family planning wins by a lot relative to other public programs that are funding that as well. So, that's also in a paper that I can provide you the link to after this session.

MR. HASKINS: Okay, thank you members of the panel. And now Bel, for the final word.

MS. SAWHILL: I'm going to be very brief. I mainly want to really thank everybody. You all were terrific and I've been so excited about this whole event. And I really think the story that came out is an important one and we are going to do what we can to use our megaphone here to get it out even further.

What was the story, let me try to give you my very quick, short takeaways. On panel one, we learned that there are some states that are doing some great stuff and they seem to be accomplishing their purposes. It takes leadership. That means a governor like Governor Markell. It takes partnerships like between Upstream and the State of Washington or the State of Delaware or wherever. It takes changing practice and changing bureaucracies in the health system. We heard about that. So, it isn't easy, it's hard work. It's got to be kept going, it's got to be sustainable. I'm glad the sustainable question came up but I think this is a very positive story.

Panel two we heard more about what I like to think of as the demand side. As someone in the audience asked early on, how do we get people, get women in particular to come to the clinics to get services that we're able to offer. And I think what you heard in panel two is that if you give people good information such as like through Bedsider for

example, that helps a lot. If on top of that, you say you've got to think about your future, you've got to think about pathways to power as Ian puts it.

You've got to do as Dr. Tildon-Burton said to one of her patients, what do you want to do with your life. That, I thought, was just a wonderful little anecdote that she told that this patient of hers had never had anyone in her life say to her what do you want to do with your life. And if you offer same day services to make it easy for people and if you have OB-GYN's that are as dedicated as Dave Turok or the others we've heard from today it makes a big difference.

And then finally, this research panel, I think, has showcased some of the best research in the country on these issues. As we said earlier, there isn't enough of it and we need more and the data aren't great. But I think we at this stage know enough to know that this kind of approach can work. That if we had more Title X dollars it would be good, if we had more efforts in the states that we've talked about it would be good. And that we don't know as much about the long term effects but as Martha so well pointed out as her research has so well shown, there are likely strong long term effects on both children and adults. So, thank you all for being here and stay tuned.

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