

Commentary

Enhancing Maternal and Child Health in Mississippi: Is the One Key Question® (OKQ) Initiative a Potential Solution?

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Background

The birth of an infant is one of the most celebrated moments of life; however, for many, pregnancy comes as a surprise. According to recent estimates, approximately half of all pregnancies in the U.S. (6.1 million) are unintended (Finer & Zolna, 2011). Unintended pregnancies are defined as either unwanted (the pregnancy occurred when no children, or no more children, were desired) or mistimed (the pregnancy occurred earlier than desired) (Division of Reproductive Health, 2015)—and are often the result of not using contraception, inconsistent, or incorrect use of contraceptive methods. Unintended pregnancy rates provide an understanding of the population's fertility and unmet needs (Division of Reproductive Health, 2015).

According to the Guttmacher Institute, approximately 36% of pregnancies in every U.S. state were unintended, with 28 states including the District of Columbia, reporting more than 50% unintended pregnancies in 2010 (Guttmacher Institute, 2016). The highest rates of unintended pregnancy occurred in Southern and Southwestern states, as well as heavily populated areas. Women who are more likely to experience unintended births include: cohabiting women, minority women, and women with less education or income (Division of Reproductive Health, 2015).

In the same year (2010), Guttmacher's Mississippi fact sheet reported 35,000 (62%) unintended pregnancies. Sixty-six percent (62%) resulted in births, 19% ended in abortions; the remainder resulted in miscarriages. Mississippi's teen pregnancy rate was 70 per 1,000 among women aged 15–19 in 2011, an increase from 57 per 1,000 in 2010 and greater than the national rate of 52 per 1,000.

Unintended pregnancy is associated with an increased risk of problems for both mom and baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. For example, women with an unintended pregnancy could unknowingly engage in behaviors that are harmful to an infant's development. These behaviors include smoking, drinking, drug use, not managing chronic illnesses or stress.

“By helping women control the timing, number, and spacing of births, family planning has many benefits for a woman and children she may have in the future. Planned pregnancies—which for most women require contraception—benefit women by allowing them to take steps to optimize their own health before pregnancy and childbirth. An unintended pregnancy may have significant implications for a woman’s health, sometimes worsening a preexisting health condition such as diabetes, hypertension, or coronary artery disease. Planned pregnancies improve the health of children as well, as adequate birth spacing lowers the risk of low birth weight, preterm birth, and small-for-gestational age (Lawrence, III, 2011)”.

Economic Impact

Unintended pregnancies are not only associated with increased health problems for mother and child but also carry a large economic burden. In 2010, over \$267 million was spent on unintended pregnancies in Mississippi. Approximately \$226 million came from federal funding and the other \$40 million paid by the state. The total public cost for unintended pregnancies statewide was \$442 per woman aged 15-44, more than \$200 greater than the national cost (\$201 per woman) {State Facts About Unintended Pregnancy, 2016}.

In 2014, 64% of Mississippi births were financed by the state Medicaid program (The Henry J. Kaiser Family Foundation, 2016). Public programs paid for at least 75% of unplanned births in eight states and the District of Columbia. All but two of the nine jurisdictions are located in the South (as categorized by the U.S. Census Bureau) and in a region with high levels of poverty (Sonfield & Kost, 2015b). “Of the eight states which received public funding for unplanned births, Mississippi had the highest proportion (82%) of pregnancies.” (Sonfield & Kost, 2015; *Strategies to Increase Access to Long-Acting Reversible Contraception (LARC) in Medicaid*, 2016). Since Medicaid spends over \$10 billion dollars on complications accompanying unplanned births, unplanned births in MS account for a large part of Medicaid’s expenditure.

Indirectly, complications from unplanned pregnancies (i.e., preterm birth) add to the economic impact. In 2007, the Institute of Medicine reported that the cost associated with premature birth in the United States was \$26.2 billion each year (Behrman & Stith Butler, 2007).

According to the March of Dimes, preterm births-- a complication of unplanned pregnancies-- cost the Nation (March of Dimes, 2015):

- \$16.9 billion in medical and health care costs for the baby
- \$1.9 billion in labor and delivery costs for mom
- \$611 million for early intervention services. These are programs for children from birth to age 3 with disabilities and developmental delays. They help children learn physical, thinking, communicating, social and self-help skills that normally develop before age 3.
- \$1.1 billion for special education services. These services are specially designed for children with disabilities ages 3 through 21. They help children with development and learning. Children can get these services at school, at home, in hospitals and in other places, as needed.
- \$5.7 billion in lost work and pay for people born prematurely

Preconception Health Care

Per the Centers for Disease Control (CDC), preconception health and healthcare is defined as active steps taken to ensure the health of a baby in the future. It is usually the first step in addressing unwanted pregnancies. One of the goals of Healthy People 2020 is to improve pregnancy planning and spacing, and prevent unintended pregnancy. Family planning efforts that can help reduce unintended pregnancy “include preconception care, increasing access to contraception, particularly to the more effective and longer acting reversible forms of contraception, and increasing correct and consistent use of contraceptive methods overall among those who are sexually active but wish to delay or avoid pregnancy” (Division of Reproductive Health, 2016). Unfortunately, many healthcare providers assume that women share the same desires regarding pregnancy and children and therefore do not offer these services to all patients.

In *Addressing potential pitfalls of reproductive life planning with patient-centered counseling*, Callegari et al. (2016) outline many of these assumptions and provide alternatives to fostering the conversation of pregnancy with patients in a way that is patient centered. According to Callegari et al., (2016) women may experience certain pitfalls when discussing reproductive life planning options with their health provider. Some of these pitfalls include: (1) providers assuming that all women share the same intentions in getting pregnant or avoiding pregnancy; (2) providers assuming that all women (married, single, teens) believe that having an unintended pregnancy is a negative consequence; (3) providers assuming that women are interested in pregnancy planning and find it meaningful and relevant to their lives; and (4) providers possibly allowing their personal/implicit biases about women’s reproductive goals and desires to impact their counseling. To avoid some of these pitfalls, Callegari et al. (2016) recommend that providers engage in patient-centered alternatives such as: (1) having an open dialogue with women that allows them to express their feelings (mixed, ambivalent, joy) about pregnancy; (2) recognize that some women irrespective of stage in life may not be interested in pursuing pregnancy, however, they see no problems with an unintended pregnancy; (3) acknowledging that some women are not interested in planning a pregnancy or may believe that planning a pregnancy is unachievable for them due to various social and environmental circumstances; and (4) providers respecting women’s reproductive autonomy by refraining from interjecting their opinion about “appropriate” reproductive health decisions for women.

A preconception care visit can optimize women’s chances of a healthy pregnancy by screening for conditions that adversely affect pregnancy and reducing toxic exposures to the infant. Despite decades of high-quality evidence and several national initiatives, only 33% of women take folic acid daily – a preconception care recommendation (Behrman & Stith Butler, 2007) before conception to prevent major birth defects of the brain and spinal cord. This may be due to the fact that these women are not actively planning on becoming pregnant or that their health providers are not discussing folic intake with them.

Opportunities for Action

Many states and public health organizations have employed various methods to decrease unplanned pregnancy rates, using campaigns and adolescent-focused messaging. Screening women on their pregnancy intentions may prove worthwhile in reducing unwanted pregnancies and improving birth outcomes especially within communities most affected by unintended pregnancies (minority and low-income women).

One program that has shown to be effective at starting the conversation about pregnancy intentions is The One Key Question® (OKQ) Initiative. The OKQ Initiative is preconception care, encouraging primary care health teams to routinely ask women ages 18-50 “*Would you like to become pregnant in the next year?*” Based on the patients’ response, she and her physician would create a plan of reproductive health services suited to her needs. These may include: folic acid supplementation, preconception care, and or contraceptive services.

The trademark question “*Would You Like to Become Pregnant in the Next Year?*” was developed by the Oregon Foundation for Reproductive Health (OFRH) as a part of the One Key Question® Initiative (OKQ). The “question” is a simple solution to making women and families healthier and ensure that more pregnancies are wanted, planned, and as healthy as possible. OKQ encourages primary care providers to routinely ask women about their reproductive health needs; asking women about their pregnancy intentions within the next year reduces stigma and increases comfortability with family planning conversations. In addition, the woman is able to focus her attention on her own life and health (Bellanca & Hunter, 2013).

By asking women “*Would you like to become pregnant in the next year?*” primary care clinicians can more fully support women’s preventive reproductive health needs, such as preventing an unintended pregnancy or preparing for a healthy pregnancy. One Key Question® was part of a unique survey of nearly 2,000 women of childbearing age who receive health care at the nation’s community health centers. It found that 90% of participants reported not actively seeking to become pregnant in the next 12 months. Yet more than 3 out of 10 were not using any preventive measures to avoid pregnancy (Wood et al., 2015).

In a state with birth outcomes such as Mississippi, could asking women of reproductive ages “*Would you like to become pregnant in the next year?*” impact our high rates of unintended pregnancy? We hypothesize that this simple question, if implemented, could yield tremendous results for Mississippi women and their children. This model would start dialogue among women and families and the opportunity to think about and plan for their reproductive future.

Call to Action!

Here are some actions you can take to influence the future directions of family planning in Mississippi: (1) Try asking women the One Key Question® “*Would you like to become pregnant in the next year?*” in your clinic and note its effect on preconception care and contraception services and share your experience with the OFRH. (2) Encourage other professionals and colleagues to pilot the OKQ model. Go to www.onekeyquestion.org to learn more. For more information on OKQ and its implementation in Mississippi, contact the authors.

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