DEPARTMENT OF HEALTH

DEPARTMENT OF HUMAN SERVICES

Summary of Findings: Safety, Effectiveness, and Importance of Abortion Care in Minnesota

PURSUANT TO EXECUTIVE ORDER 22-16

8/1/2022

Pursuant to Executive Order 22-16

A report to Governor, Lieutenant Governor, and Legislature summarizing the safety, effectiveness, and importance of reproductive health care services to people in Minnesota.

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Executive summary

In Minnesota, choosing to have an abortion is a right protected by the Minnesota Constitution.[1] Executive Order 22-16 directed the Minnesota Department of Health and the Minnesota Department of Human Services to present a report to the Governor, Lieutenant Governor, and the Legislature summarizing the safety, effectiveness, and importance of abortion care to people in Minnesota. Abortion care is part of a larger spectrum of reproductive health care services for people of all ages and genders including care during pregnancy, infertility, sexually transmitted infections, voluntary family planning services, and cancers of reproductive systems. Equitable access to affordable, accurate, high-quality, and culturally-congruent information and health care providers is a critical component of reproductive health services.

Abortion care key findings

Abortions are very low-risk medical procedures, and there is a very low risk of serious complications or of potential side effects.[2] Abortions in Minnesota decreased by almost 50% from 19,028 in 1980 to 10,136 abortions in 2021, and the number of abortions stabilized to around 10,000 per year in 2012 through 2021, with more than 90% provided to Minnesota residents. The abortion rate for Minnesota residents is 8.5 abortions per 1,000 women aged 15–44 years compared to the estimated national rate of 11.4 abortions per 1,000 women aged 15-44.[3,4] Terminology used in this report are defined in Appendix 1.

Safety and effectiveness

- The safest time for a person to have an abortion is at or prior to eight weeks after the first day of their last menstrual period, and more than 80% of abortions in Minnesota occur within the first 10 weeks of gestation.[3,5]
- Medication abortions make up more than 50% of abortions in the state, which is 91.9% to 98.1% effective in terminating a pregnancy up to 70 days gestation.[6] The risk of a complication within 24 hours of the procedure requiring medical intervention is 0.2%.[6]
- One-third of abortions performed in Minnesota use dilation and curettage (D&C), which are 99.8% effective in terminating a pregnancy at nine weeks or less.[7] Minor complications following D&C abortions occur in fewer than 2.5% of abortions and serious complications in fewer than 0.5% of abortions. [8,9]
- 10% of abortions in the state occur in the second trimester, and most often use dilation and evacuation (D&E). Complications in second-trimester abortions occur in 0.1% to 8% of abortions, varying by method of abortion.[10]
- There is a low risk for maternal death associated with induced abortions. In the United States in 2018, there were two abortion-related deaths. The national case-fatality rate for legal induced abortions was 0.41 maternal deaths per 100,000 abortions between 2013-2018.[11]
- The risk of death from childbirth is much greater (14-fold) than the risk of death from an abortion.[14]

Importance of abortion

- In Minnesota, at least 50% of all abortions in 2021 were the result of unintended pregnancies, and unintended pregnancies increase the risk of health issues and socioeconomic limitations during and after the pregnancy.[3]
- In 2021, the most common reason for seeking an abortion in the state was because the person did not want children at the time.[3] Also common are economic reasons and emotional and physical health. Although the numbers are small, people seek abortion care for pregnancies related to rape, incest, and fetal anomalies.
- Like most health services in Minnesota, abortion care is less accessible in rural areas and among populations already experiencing non-geographic barriers to health care, including cost, transportation, time off work, and childcare. As of 2017, 61% of women in Minnesota aged 15-44 lived in a county without a known abortion clinic.[12] In 2021, one-third of abortions in Minnesota were paid for out-of-pocket.[3]
- Pregnancy itself is a recognized risk factor for increased abuse, exploitation, and lethality in cases of intimate partner violence and trafficking.[13, 14] Access to reproductive health care, including abortion care, is vital for the prevention of domestic violence, sexual violence, and human trafficking.

Key strategies to prevent and reduce unintended pregnancies include strengthening and expanding family planning services, violence prevention, comprehensive sexuality education, and access to abortion care. Recommendations include:

- Expand person-centered contraception services for all and especially those with barriers to access including young people, victims of violence, LGBTQ+, rural, Black, American Indian, and other communities of color.[15, 16]
- Promote economic supports for women and families that strengthen household financial security, including income supplements, income-generating opportunities, safe and affordable housing, and family-friendly workplace policies such as paid family and medical leave.[17, 18]
- Create safe and equitable environments in schools, workplaces, neighborhoods, and other institutions that promote connectedness and intolerance of violence.[17, 18]
- Support school-based health centers, and other adolescent-friendly service providers, that include reproductive health care.[19]
- Engage parents, health care providers, teachers, and other trusted adults to provide the supportive foundation for young peoples' health and well-being.
- Provide medically-accurate information and patient-centered, non-directive pregnancy options counseling to women, pregnant people, and their families.
- Decrease barriers to reproductive care, including abortion, for Minnesotans and for populations experiencing structural inequities in health care.

Section 1: Introduction

Purpose of the report

The purpose of this report is to summarize the safety, effectiveness, and importance of abortion care to people in Minnesota, as directed by Executive Order 22-16.[20] Abortion care is part of a larger spectrum of vital reproductive health care services that encompasses information, education, and health care services for people of all ages and genders including but not limited to: care during pregnancy, infertility, sexually transmitted infections, comprehensive and voluntary family planning services, and cancers of reproductive systems. Reproductive health care helps people maintain optimal health throughout their life, have children, or choose not to have children. Equitable access to affordable, accurate, high-quality, and culturally-congruent information and health care providers is a critical component of reproductive health services.

This report focuses on induced abortion, which is defined as the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth.[21] This definition includes elective abortions for unintended pregnancies, complications during pregnancy (e.g., severe early preeclampsia, fetal demise), and for medical necessity (e.g., worsened health of the pregnant person). This definition excludes spontaneous abortions (i.e., miscarriages) or stillbirths. Definitions and medical terminology used in this report are included in Appendix 1. This report provides a description of abortion care in Minnesota (Section 1), summarizes evidence on safety and effectiveness (Section 2), and discusses the importance of abortion care to people in Minnesota (Section 3).

The contents of this report focus on anyone who can become pregnant including women, non-binary, and trans people.

Health equity and intersectionality

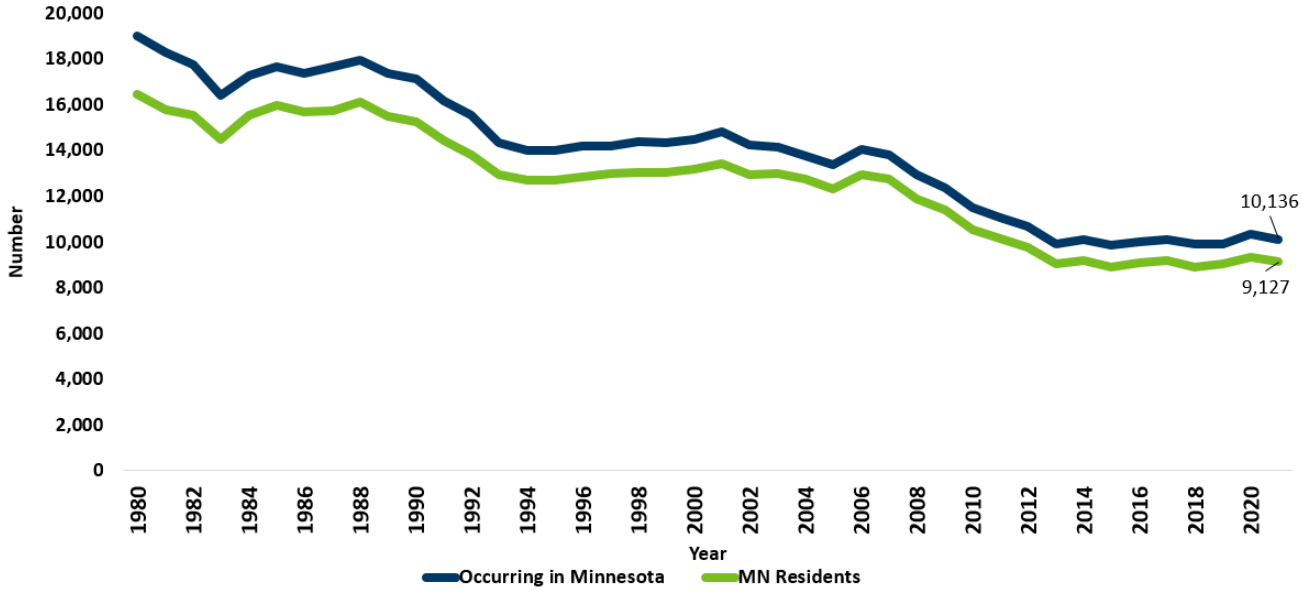
The Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) acknowledge that structural (social, economic, political, and environmental) inequities typically have a greater influence on health outcomes than individual choices or a person's ability to access health care, and not all communities are impacted in the same way. We also acknowledge that the topic addressed in this report does not exist in isolation. There are also intersecting processes and systems through which power and inequity are produced, reproduced, and actively resisted. All people living in Minnesota benefit when we reduce health disparities.

Background

Each year, as required by law, MDH publishes a report to the Minnesota Legislature on the previous year's abortion data. The statute requires all licensed physicians who perform abortions in Minnesota, and all Minnesota facilities in which abortions are performed, to report information on the abortion procedure, and any complications annually to MDH (Minn. Stat. § 145.4131). This data is the basis for the annual report to the Legislature, with the most recent report detailing 2021 abortion data published on July 1, 2022.

From 1980 to 2021, abortions occurring in the state decreased almost 50% from 19,028 to 10,136 abortions per year (Figure 1) even as the state's population grew. Demand for abortions occurring in the state stabilized to around 10,000 per year in 2012 through 2021. The abortion rate for Minnesota residents is 8.5 abortions per 1,000 women aged 15–44 years compared to the estimated national rate of 11.4 abortions per 1,000 women aged 15-44. [3,4]

Figure 1. Abortion procedures by year and residence, MN 1980-2021



Source: MCHS Induced Abortions in Minnesota

Most abortions (≥ 90%) that occurred within the state in the past five years were provided to Minnesota residents (Table 1). Residents from surrounding states also received abortion care in Minnesota with the largest numbers residing in Wisconsin (634) and South Dakota (158). The number of out-of-state residents seeking abortions will likely increase in 2022 and beyond as other states enact abortion restrictions and prohibitions.

Table 1. Country/State of residence (number), 2017-2021

Residence	2017	2018	2019	2020	2021
Minnesota	9,193	8,897	9,057	9,366	9,127
Other States					
Iowa	51	58	66	59	56
Michigan	32	17	14	9	20
North Dakota	88	73	51	52	84
South Dakota	71	111	99	157	158
Wisconsin	637	705	616	637	634
Other States	57	48	41	56	57
Canada	1	-	-	1	-
Other Foreign Countries	1	2	1	2	-
Total	10,131	9,911	9,945	10,339	10,136

Source: MCHS Induced Abortions in Minnesota

Over the past five years, most women and pregnant people who received abortion care in Minnesota were over 20 years old, with the highest percentage (28.2%) being 25-29 years old, followed by people aged 20-24 (27.5%), 30-34 (18.4%), and 35-39 years of age (13.7%). Most had at least some college education (28.8%), followed by high school graduates (21.3%), and college graduates (19.5%). While the highest percentage of women and pregnant people reported no previous live births (39.7%), 23% had one previous live birth, 19.8% had two previous live births, and 17.3% reported three or more previous live births.[22]

In 2021, among Minnesota residents, 50% of abortion care was paid for through public assistance, 27% was paid for out of pocket, and 22% was paid for through private insurance coverage.[3] Abortion care is covered under Minnesota's public health care programs when medical necessity requirements are met (see Appendix 1 for more details). These programs include the Minnesota Medicaid program (also known as Medical Assistance) and the MinnesotaCare program. Services provided within the standard of care for a public program member are covered when rendered by an enrolled provider. Federal funding applies to abortion services only where the pregnancy is a result of rape or incest, or if a woman or pregnant person suffers from a life-threatening physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself.

Section 2: Safety and efficacy of abortion care

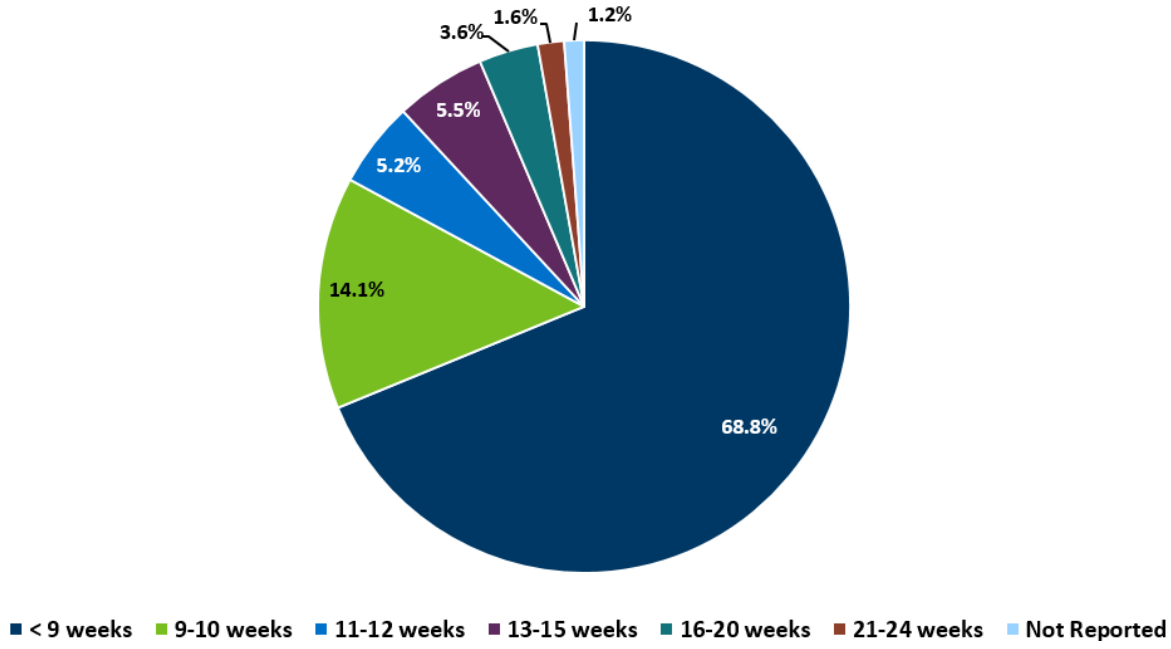
Abortions are very low-risk medical procedures, and there is a very low risk of serious complications or of potential side effects.[2] Method of abortion is selected based on a combination of factors including gestational age, patient preference, availability and skill of providers, and medical contraindications. Clinical providers evaluate each of these factors to determine if the patient is a candidate for a medication abortion or a surgical abortion

(definitions found in Appendix 1). The safest time for a person to have an abortion is at or prior to eight weeks after the first day of their last menstrual period.[5] The overall risk of complications increases with advancing gestational age.

Most abortions occur early in pregnancy, within the first 10 weeks of gestation (Figure 2). Most early abortions are performed using either dilation and curettage (D&C) or medication abortion (Table 2). Surgical abortions by D&C make up one-third of all abortions performed in Minnesota, and they are 99.8% effective in terminating a pregnancy at 9 weeks or less.[7] Medication abortions make up more than 50% of abortions provided in Minnesota, and they use a United States Food and Drug Administration (FDA) approved regimen and are performed up to 70 days after the first day of the last menstrual period. Medication abortions are between 91.9% to 98.1% effective in terminating a pregnancy, depending on the gestational age and route of medication administration.[6]

Risk, including the risk of death, associated with either of these common methods of early abortion is very low. Cramping and vaginal bleeding are expected after completion of an abortion. Complications following D&C abortions are infrequent, and they can include infection, missed or incomplete abortion, cervical tear, uterine perforation, and hemorrhage requiring transfusion.[9] Minor complications following D&C abortions are estimated to occur in fewer than 2.5% of abortions and serious complications, those which require hospitalization, in fewer than 0.5% of abortions.[8,9] Surgical abortion techniques may increase the risk of a preterm birth in a future pregnancy, and this risk is not seen with medication abortions.[23, 24, 25] For medication abortions, the risk of needing medical intervention for any complication within 24 hours of the procedure is 0.2%, including the risk of hemorrhage requiring medical attention is less than 1% and the risk of hemorrhage requiring blood transfusion is rare (>0.1%).[6]

Figure 2. Clinical estimate of fetal gestational age at the time of abortion occurring in MN, 2021



Source: MCHS Induced Abortions in Minnesota

Abortions occurring in the second trimester, between 13-26 weeks gestation, can be completed by a surgical technique such as dilation and evacuation (D&E) or through medication for induction abortions, also known as medical induction. D&E is associated with fewer complications (up to 4%) compared to induction abortions when performed in the second trimester.[10] Cramping and vaginal bleeding are expected after completion of an abortion. There is a low incidence of complications in second-trimester abortions, and these include: postabortion hemorrhage (occurs in 0.1%-0.6% of D&E; 0.7% of induction abortions), retained products of conception (>1% of D&E; at least 8% of induction abortion), uterine atony (2.6% of D&E), uterine rupture (1 in 1,002 second trimester induction abortions), disseminated intravascular coagulation, infection (0.1%-4%), and embolism (10-20 per 100,000 abortions).[10] History of multiple prior cesarean deliveries may increase some complication risks including hemorrhage, uterine atony, and uterine rupture.[10] Other abortion methods, including inter-uterine instillation and hysterectomy, are rare in Minnesota, representing between 0.05% and 0.3% of all abortions between 2017-2021 (Table 2).

Table 2. Abortion procedures occurring in MN by method, 2017-2021

Occurring in Minnesota	2017	2018	2019	2020	2021
Surgical					
Dilation and Curettage (D&C)	5,418	5,547	5,510	3,958	3,365
Dilation & Evacuation (D&E)	696	683	690	687	611
Hysterectomy/Hysterotomy	-	1	1	-	-
Other surgical	2	3	2	4	1
Medication					
Mifepristone	3,991	3,594	3,592	5,210	5,894
Misoprostol	24	81	121	457	260
Other medication (includes labor induction)	1	2	26	23	3
Intra-Uterine Instillation	1	-	3	-	1
Unknown	1	-	-	-	1
Total	10,134	9,911	9,945	10,339	10,136

Source: MCHS Induced Abortions in Minnesota

In Minnesota in 2021, 10,017 abortions were performed with no intraoperative complications. In this reporting period, 118 abortions had at least one intraoperative complication that occurred during the procedure including seven instances of cervical lacerations requiring suture or repair, 12 instances of heavy bleeding/hemorrhage with estimated blood loss more than 500 cubic centimeters, and 99 other complications not defined in the required state reporting. In 2021, complications that occurred after the procedure, or postoperative complications,

occurred in 87 cases including 43 failed termination of pregnancy (continued viable pregnancy), 27 incomplete termination of pregnancy (retained products of conception requiring re-evacuation), and four reports of heavy bleeding/hemorrhage with estimated blood loss more than 500 cubic centimeters.[3]

Abortion-related mortality

Mortality and morbidity related to abortion have been exceedingly rare in recent years. In 2021, the Centers for Disease Control and Prevention (CDC) released its updated abortion surveillance report for 2019, which includes data voluntarily reported from 49 states and jurisdictions including Minnesota. Using Pregnancy Mortality Surveillance System data, the report includes all maternal deaths related to legal induced abortions in 2018, the most recent year for which data is available. According to this report, in the United States in 2018, there were two abortion-related deaths. Because the annual number of maternal deaths related to legal abortions is small, the CDC uses consecutive six-year periods to calculate case fatality rates during 2013-2018. The national case-fatality rate for legal induced abortions was 0.41 deaths per 100,000 abortions.[4] The CDC concludes that because all national case-fatality rates for legal induced abortion since the 1970s has been fewer than one maternal death per 100,000 abortions that there is "low risk for death associated with legal induced abortions".[4]

Safety of childbirth

When comparing the risks related to abortion, it is important to also consider the risks associated with continuing a pregnancy. There is an estimated 14-fold difference in risk of death between abortion and childbirth, and abortion is associated with less pregnancy-related morbidity than childbirth.[11] Abortions most often occur early in pregnancy, and there is less time for pregnancy-related complications, such as pregnancy-induced hypertension, to occur.[11]

Maternal mortality rates in the United States, compared to other high-income countries, continue to increase, and the increased rate revealed a wide racial disparity with non-Hispanic Black birthing people 2-3 times more likely to die of a pregnancy complication than non-Hispanic white birthing people.[26,27] In Minnesota during 2017-2018, there were 8.8 pregnancy-related deaths per 100,000 live births. While Black birthing people (13%) and American Indian birthing people (2%) are a small percent of births in Minnesota, they are disproportionately represented among the pregnancy-associated deaths, making up 23% and 8% of the deaths respectively. As a result of structural racism, Black and American Indian women and birthing people, along with other under-resourced groups, experience significant barriers to accessing high-quality care during pregnancy and delivery and to receiving fair treatment within the healthcare system. Ultimately, structural racism leads to worse pregnancy and birth outcomes among Black and American Indian women and birthing people and their families, making access to the full range of reproductive health care, including abortion, an important component of health equity.

Section 3: Importance of abortion

Consequences of unintended pregnancy

Unintended pregnancy is a critical public health issue impacting women and pregnant people, children, families, and communities.[28] As of 2011, 45% of pregnancies in the U.S. are unintended, and most are the result of not using contraception or from not using it consistently or correctly.[29,30] In Minnesota, at least 50% of all abortions in 2021 were the result of unintended pregnancies.[3] Unintended pregnancies occur across all age, income, geographic, and racial/ethnic groups. Higher proportions of unintended pregnancies occur among adolescents and young people; American Indian, Black, and Hispanic people; and people with lower levels of education and income.[29] When a pregnancy is unintended, the birthing person and baby are at higher risk for health issues and socioeconomic limitations during and after pregnancy.

Health

Unintended pregnancies are associated with delays in seeking prenatal care, adverse infant health outcomes, and adverse maternal mental health outcomes. Studies have found that unintended pregnancies, specifically pregnancies that were mistimed by more than two years or unwanted, were less likely to be recognized early in pregnancy.[31] Further, unintended pregnancies, specifically pregnancies that were unwanted, were less likely to receive prenatal care in the first trimester, more likely to result in low-birthweight babies, and the infants were less likely to have been breastfed at any time.[31] Additionally, pregnant people are more likely to experience postpartum depression if the pregnancy is unintended.[32]

Socioeconomic impacts

Unintended pregnancies are also associated with limitations in socioeconomic growth such as educational attainment and economic stability. For example, adolescents who have children are less likely to complete high school or pursue higher education later in life compared to their peers who delay having children.[32, 33] Further, the ability to delay and time childbearing contributes to educational and employment opportunities, and delays in childbearing can allow women and birthing persons to contribute to the family's economic stability.[32] Women who were denied an abortion and gave birth may be more likely than peers who received an abortion to experience economic hardship, including higher odds of poverty, less likely to be employed full time and more likely to receive public assistance for up to four years after seeking an abortion.[34] Inability to afford basic necessities such as food or housing, is also a major factor affecting pregnancy intentions.[35]

Legal protection under the Constitution

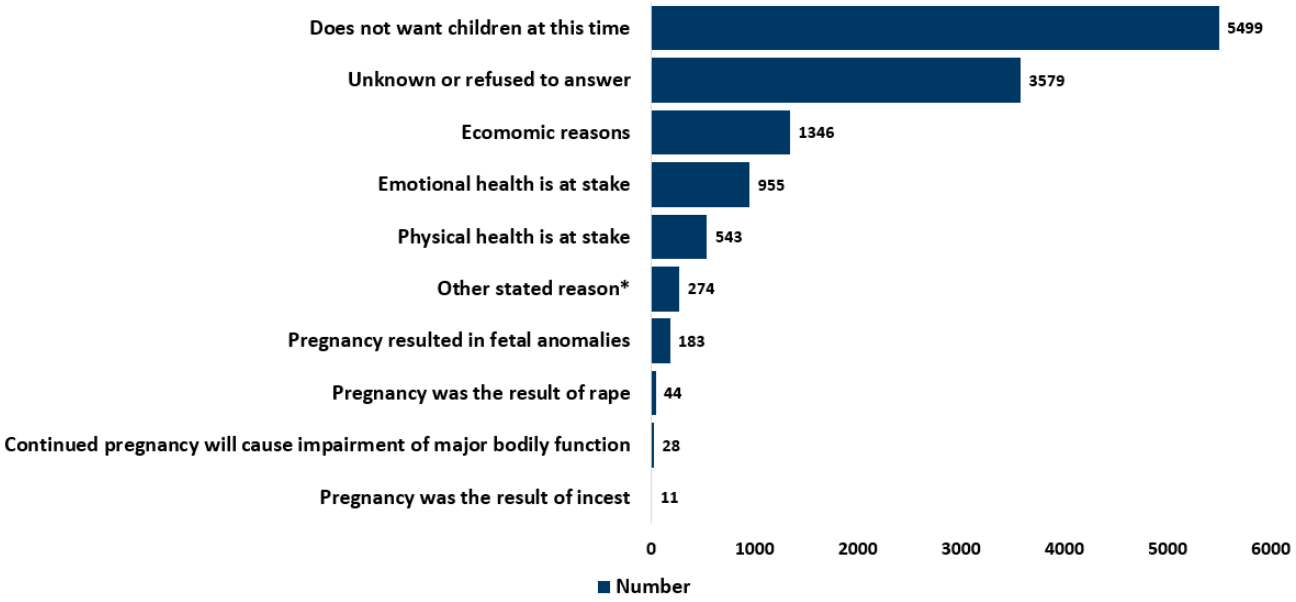
The Minnesota Constitution provides a fundamental right of privacy. In 1995, the Minnesota Supreme Court held that right of privacy encompasses the right to terminate a pregnancy. In that case, Doe v. Gomez, [1] the court explicitly found that the Minnesota Constitution offers broader protection than the United States Constitution of a person's fundamental right to make reproductive healthcare choices without state interference. As a result, any regulation that

infringes on the fundamental right to abortion is reviewed under the highest level of court scrutiny available, strict scrutiny. The decision in Gomez has held firm during the ensuing 27 years.

Reasons for seeking abortion care

Women and people who seek abortion care have a variety of interrelated reasons for seeking abortion care (Figure 3). MDH's annual report on induced abortions includes the reasons provided for seeking abortion care, and the person can name more than one reason. From 2017-2021, the most common reason for seeking an abortion was because the person did not want children at the time, followed closely by people who declined to provide an answer. Economic reasons and emotional and physical health were other common reasons given. Although the numbers are small, it's important to recognize that some people seek abortion care for pregnancies related to rape, incest, and relationship issues including abuse. Additionally, people seek abortion care related to fetal anomalies and when continuing the pregnancy may cause impairment of major bodily functions.[22]

Figure 3. Reason for abortion care occurring in MN, 2017-2021



Source: MCHS Induced Abortions in Minnesota
*Other stated reason includes relationship issues including abuse, mental/physical health issues and concerns

Access to abortion care

Access to health care is impacted by household finances, insurance coverage, geographic availability, and timeliness of the services. Like most reproductive health services in Minnesota, abortion care is less accessible in rural areas and among populations who already experience non-geographic barriers to health care. The state has eight clinics providing abortion care, and seven are in metropolitan areas, with five in the Twin Cities metro area. These clinics provide most of the abortion care in the state. However, 7% of abortions are provided by independent physicians, small clinics, or hospitals.[3]

As of 2020, nearly 43% of 15–44-year-old females lived outside of the seven-county metropolitan area.[36] As of 2017, 97% of Minnesota counties were without a known abortion clinic, and 61% of women aged 15-44 lived in a county without a known abortion clinic.[12] Many people living in Greater Minnesota and seeking abortion care must travel to receive care and remain near the clinic or hospital for multiple days for some abortions.

Beyond distance, populations who already experience barriers to health care also have difficulty accessing abortion care. While abortions are covered by public health care programs and by some, but not all private insurance policies, one-third of abortions in Minnesota are paid for out-of-pocket.[3] According to the Minnesota Health Care Access Survey in 2021, 20% of Minnesotans went without health care because of cost, and because people are un- and under-insured, the cost of abortion may cause people to delay or not seek abortion care.[37] In addition to the cost, people also navigate issues like requesting time away from work, local

transportation barriers, and childcare when seeking abortion care. These barriers are part of systemic inequities in the health care system that reflect the social determinants of health and are disproportionately experienced by rural communities, immigrant communities, people with low incomes, and Black, American Indian, and other communities of color in the state.

Telemedicine services for abortion care can be a facilitator to access across the state. Over half of abortion services in Minnesota in 2021 use medication, or non-surgical, abortions. Consultations for medication abortion can be provided remotely by a physician through telemedicine, and the medications can be dispensed by a clinic or mailed directly to a patient's address and taken at home. MDH's current process for collecting abortion data does not capture whether medication abortions occur only through telemedicine. However, evidence suggests that medication abortions can be provided safely with high patient satisfaction, and a study of 19,000 medication abortions found adverse events were rare and telemedicine was not inferior compared to in-person medication abortion.[6, 38]

Reproductive health care as violence prevention

Access to the spectrum of reproductive health care resources, including abortion care, is vital for violence prevention, specifically the prevention of domestic violence, sexual violence, and human trafficking. Victims and survivors of intimate partner violence, sexual violence, and human trafficking may experience unintended pregnancy, sexually transmitted infections (STIs), human immunodeficiency virus (HIV), and other adverse reproductive health outcomes due to the violence they have experienced. Pregnancy itself is a recognized risk factor for increased abuse, exploitation, and lethality in cases of intimate partner violence and trafficking, and 14.9% of U.S. women/people who can become pregnant experience a rape-related pregnancy in their lifetime.[13, 14, 39] Reproductive coercion is a known control tactic used by perpetrators of violence and exploitation, and people who reported a rape-related pregnancy were significantly more likely to experience reproductive coercion than those who do not become pregnant.[17] For victims of human trafficking, unintended pregnancy is a part of the reproductive coercion, and it is both a recurring risk while trafficked and a barrier to exiting the trafficking situation. Restrictive laws or practices around contraception and abortion care limits health professionals and other types of professionals from providing care for victims of human trafficking.[40] Fear of reprisal, recrimination, and stigma also prevent victims of human trafficking, intimate partner violence or other forms of violence from seeking care, including reproductive health care. This is magnified for populations who are marginalized or already disproportionately involved in the criminal justice system as victims or perpetrators.

Reproductive health care services, including abortion care, provide victim/survivors with options, resources, and autonomy to interrupt and prevent violence. Ensuring access to high-quality reproductive health care services, including abortion care, is particularly important for the health and safety of populations who disproportionately experience sexual violence victimization, including LGBTQ+ communities, Black, American Indian, Latine, Asian, and

multiracial communities. If systems do not support the reproductive health care needs of all populations equitably, then this contributes to the societal structural discrimination and marginalization that creates increased risks for sexual violence victimization in the first place.

Strategies to prevent and reduce unintended pregnancies

Key strategies to prevent and reduce unintended pregnancies include strengthening and expanding family planning services, violence prevention, comprehensive sexuality education, and access to abortion care.

Family planning services

Access to consistent, effective, and affordable contraception is a fundamental component of reproductive health care, and it is key to reproductive autonomy, preventing unintended pregnancies, and reducing abortion rates.[5] The ability to choose from among the full range of contraceptive methods encourages consistent and effective contraceptive use and leads to positive health, social, and economic outcomes. Services provided at publicly supported family planning visits in the U.S. reduced the incidence and impact of preterm and low birth rates, STIs, infertility, and cervical cancer (see Appendix 1 for more information). In addition, adolescent pregnancy rates have declined nationally and in Minnesota due in part because of increased use of highly effective contraceptive methods.[41] Investments in family planning services save the government billions of public dollars, equivalent to an estimated taxpayer savings of $7.09 for every public dollar spent.[43] Public health care programs in Minnesota cover the full range of contraceptive methods with no cost sharing, reducing financial barriers and improving access to affordable, safe, and effective family planning services as well as comprehensive health coverage for low-income individuals and families.

In Minnesota, the Family Planning Special Projects (FPSP) (https://www.health.state.mn.us/people/womeninfants/familyplanning/grant.html) and the Minnesota Family Planning Program (https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/family-planning.jsp) support agencies to provide low- and no-cost family planning services to people in the state. Both programs are essential in providing effective pre-pregnancy family planning services to populations that are at greater risk of unintended pregnancy and have difficulty accessing services because of barriers such as poverty, lack of insurance, geography, or inadequate transportation.

Strategies to strengthening and expanding access to contraceptives include:

- Expanding person-centered, equitable contraception services for all and especially those with barriers to access including young people, victims of violence, LGBTQ+, rural, Black, American Indian, and other communities of color. [15, 16]
- Supporting coverage for an extended supply, or more than one month at a time, of contraception.
- Supporting increased access to hormonal contraception through telehealth policies, pharmacists as prescribers, and encouraging the U.S. FDA to approve over-the-counter access to oral contraceptives without an age restriction.[43, 44]

- Supporting school-based health centers, and other adolescent-friendly service providers, that include reproductive health care.[19]
- Increasing funds allocated to Minnesota's family planning assistance programming.

Violence prevention to reduce unintended pregnancies

As detailed above, sexual violence, intimate partner violence, and human trafficking are traumatic experiences that can result in several health consequences, including unintended pregnancies. Preventing or disrupting these forms of violence through trauma-informed services and support can prevent unintended pregnancies.

Strategies to prevent sexual violence, intimate partner violence, and human trafficking include:

- Promoting economic supports for women and families that strengthen household financial security, including income supplements, income-generating opportunities, safe and affordable housing, affordable childcare, and family-friendly workplace policies like paid family and medical leave.[17, 18]
- Teaching skills to prevent violence, including social emotional learning, healthy relationships education, and comprehensive sexuality education.[17, 18]
- Funding community-driven and culturally-relevant programs that promote social norms to protect against violence, such as less restrictive gender norms.[17, 18]
- Creating safe and equitable environments in schools, workplaces, neighborhoods, and other institutions that promote connectedness and intolerance of violence.[17, 18]
- Providing healing-centered services for victims and survivors to access medical care (including reproductive health care), safety planning, housing, and other support services.[17, 18]

Comprehensive sexuality education (CSE)

People can make informed decisions about sexual and reproductive health, including decisions around childbearing, when they have age-appropriate, medically-accurate education. Comprehensive sexuality education (CSE) supports informed decisions and is a key component of healthy youth development (see Appendix 1 for more information). CSE is consistent with scientific research and best practices, reflects the diversity of student experiences and identities, and aligns with school, family, and community priorities.[45] CSE topics include healthy relationships, consent, anatomy, HIV and other STI prevention, abstinence, sexual health, and identity.[46] Research shows CSE helps young people take steps to protect their health, including delaying sex (abstinence), using condoms or contraception, and being monogamous.[45] CSE programs have been found to help young people succeed academically by helping them to stay in school and achieve higher grades.[47] In addition, adolescents and young men are often left out of the discussion on reproductive health. The behavior of adolescent males is also central to preventing teenage pregnancy and childbearing, and inclusive pregnancy prevention, as part of CSE, includes people of all genders.[48]

Strategies to strengthening and expanding CSE include:

- Creating statewide standards for comprehensive sexuality education in schools that align with Minnesota K-12 Academic Standards and national sex education standards.[49]
- Engaging parents, health care providers, teachers, and other trusted adults to provide the supportive foundation for young people's health and well-being.
- Supporting and expanding parent-focused education on sexuality and healthy development to support parents as educators, including It's That Easy (http://itsthateasy.net/) program.
- Highlighting the role of young men in preventing unplanned pregnancy and challenging harmful attitudes and norms of men's roles and identities. [48]

High-quality, safe abortion care

Choosing an abortion is a right protected by the Minnesota Constitution, and abortion is an important component of reproductive health care, which is essential to the health of women and people who can become pregnant.[50, 51] As with all health care, pregnant people should be provided with medically-accurate information and patient-centered, non-directive pregnancy options counseling from a trusted source including information on parenting, adoption, and abortion. If a pregnant person selects abortion care, access to abortion services should be available, safe, affordable, and meet their comprehensive reproductive health needs.

Strategies to support high-quality and safe abortion care include:

- Providing medically-accurate information and patient-centered, non-directive pregnancy options counseling to women and pregnant people.
- Supporting protections, privacy, and safety for women and people who seek abortion care, and clinicians and clinic staff providing abortion care.
- Supporting insurance coverage and clinic support to provide affordable abortion care.
- Increasing the training opportunities for interested health care providers to become skilled providers of abortion care.
- Increasing levers of access to abortion care through a range of telemedicine and physical locations of services, particularly addressing rural communities.
- Decreasing barriers to comprehensive reproductive care, including abortion, for populations who experience structural inequities in health care.
- Providing adequate post-abortion care including contraceptive counseling and prescriptions or referrals for patient-selected contraceptive methods.

Appendix 1: Definitions

Induced abortion[52]

The purposeful interruption of an intrauterine pregnancy with the intention other than to produce a liveborn infant, and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following a fetal death.

Fetal death

Death prior to the complete expulsion or extraction of a product of conception from its mother, irrespective of the duration of pregnancy. The death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Method of abortion[53]

Abortion procedures

- **Dilation & Curettage (D & C):** Abortion procedures performed prior to 14 weeks 0 days gestation are called dilation and curettage (D & C) procedures. Other terms for this type of procedure include aspiration curettage, suction curettage, manual vacuum aspiration, or menstrual extraction. This type of procedure may also be called sharp curettage if a sharp curette is used to confirm complete evacuation of uterine contents. A very early termination by D & C is sometimes called menstrual regulation.
- **Dilation & Evacuation:** Abortion procedures performed after 14 weeks 0 days gestation are called dilation and evacuation (D & E) procedures. This type of abortion procedure typically requires a greater degree of cervical dilation and the use of grasping forceps.
- **Hysterectomy/Hysterotomy:** Termination of pregnancy by removing the fetus through an incision in the uterus or by removing the uterus.

Medication abortion methods

Administration of medication to induce abortion.

- The medicines used for the American College of Obstetricians and Gynecologists-endorsed and FDA-approved protocols include mifepristone (also called RU486 or Mifeprix®).
- Other options for early medication termination of pregnancy include methotrexate (Amethopterin, MTX) and misoprostol (Cytotec®). Each of these medications can be used alone or in combination with each other.

Intra-Uterine Instillation: Termination of pregnancy induced through intra-amniotic injection (amniocentesis-injection) of a substance such as saline, urea, or a prostaglandin.

Induction Abortion: Nonsurgical termination of pregnancy that use medications to induce labor and delivery of the fetus in the second trimester. [2]

Unintended pregnancy

A pregnancy that is either unwanted, such as the pregnancy occurred when no children or no more children were desired, or the pregnancy is mistimed, such as the pregnancy occurred earlier than desired.

Reproductive coercion[54, 55]

Reproductive coercion refers to a wide range of abusive behaviors that have the impact of exerting control over any aspect of another person's reproductive health including their body, their choices, and options. Reproductive coercion is most commonly discussed as occurring in the context of an intimate partner relationship although it occurs in other contexts as well. Examples include but are not limited to refusing to use a condom or other birth control; removing access to birth control; secretly removing condoms during sexual activity; taking the choice away from their partner about when they want to become pregnant; taking the choice away from their partner about whether or not to seek an abortion; actions to increase a partner's chances of contracting a sexually transmitted infection; and not allowing a partner to access reproductive healthcare.

Pregnancy-related deaths

A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

Pregnancy-associated deaths

A death during pregnancy or within one year of the end of pregnancy, irrespective of cause.

Maternal mortality

Deaths of women while pregnant or within 42 days of being pregnant, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes (i.e., neither caused nor complicated by the woman being pregnant at the time of or within one year of death).[56]

Maternal morbidity

Unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health.[57]

Family planning services[58]

Family planning services often include the following core services:

- Providing FDA-approved methods of contraception including long-acting reversible methods.
- Providing sexually transmitted infections (STI) screening and treatment services.
- Offering pregnancy testing and counseling.
- Helping clients who want to conceive.
- Providing basic infertility services.
- Providing preconception health services.

Comprehensive sexuality education[59]

Programs that build a foundation of knowledge and skills relating to human development, relationships, decision-making, abstinence, contraception, and disease prevention. Ideally, school-based comprehensive sex education should at least start in kindergarten and continue through 12th grade. At each developmental stage, these programs teach age-appropriate, medically-accurate, and culturally-responsive information that builds on the knowledge and skills that were taught in the previous stage.

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