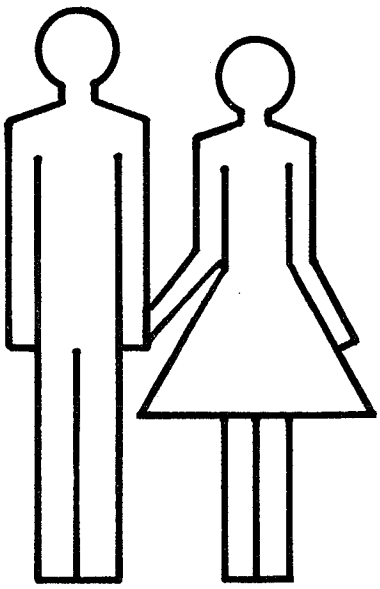
MINNESOTA STATE PLAN
for
FAMILY PLANNING SERVICES



MINNESOTA
STATE BOARD OF HEALTH

May 9, 1974

MINNESOTA STATE PLAN

FOR

FAMILY PLANNING SERVICES

Prepared by

The Technical Advisory Committee
on Family Planning

With Staff Support From
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Adopted by

The Minnesota State Board of Health

May 9, 1974

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I. Purpose of Family Planning

Family planning is defined as voluntary planning and action by individuals to have the number of children they want, when and if they want them. The concept of voluntary planning must be emphasized so that individuals are assured the right to be treated with human dignity and are free from coercion. Family planning concerns itself with not only the problems of fertile individuals to space and control births but also those infertile persons who experience difficulty in conceiving. Under previous laws and practice, the powers of the state and the professions of education, medicine, and law functioned to limit access to information and to hinder contraceptive practice. It is now widely recognized that family planning should be available for all individuals regardless of age, marital status, race, religion, geographic location and income.

According to the 1970 National Fertility Study, 44% of all births to married couples between 1966 and 1970 were reported by the parents as being unplanned at the time of conception. Not all unplanned conceptions have resulted in unwanted children. Many, however, have been denied that basic right to be wanted and physically and mentally well-born. Unwanted births can result in enormous financial, social, health and psychological costs both to the individual and families involved and to society as well.

As a preventive health measure, family planning contributes to a reduction in maternal and infant mortality and morbidity, and premature births. With appropriate counseling, family planning can also contribute to a reduction in mental retardation and congenital defects. Family planning services will reduce the necessity to seek legal or illegal termination of pregnancy. Detrimental health consequences increase when births occur to women younger than eighteen or older than forty years of age, women who have births of birth order four

or more, women who have delivered within the previous fifteen months, women with specific diseases already present or to those who have had abnormalities in previous pregnancies.[1-7]

Family planning has concerned itself with reducing conceptions occurring out-of-wedlock, thus enabling many women and, more significantly, young never-pregnant females, to continue their education, increase their chances for economic success, improve their chances for successful marriage, and eventually, to achieve self-fulfillment.

There is a direct correlation between high birth rates and poverty. Studies have shown that the economically disadvantaged desire no more children than the non-poor, yet, because they lack access to adequate family planning measures, often they do have larger families and become caught up in the poverty cycle.[8] The benefit of preventing unwanted births far exceeds the costs of providing the service. It has been estimated that each public dollar spent on family planning will save

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1 "Family Planning and Infant Mortality: An Analysis of Priorities," Department of Planning and Development and Department of Research, Planned Parenthood/World Population, New York, June 1967.

2 "Relationships Between Family Planning and Maternal and Child Health," Wallace et al., Advances In Planned Parenthood, Vol. 5, Excepta Medica Foundation, New York, March 1970.

3 "Some Estimates of the Potential Reduction In The United States Infant Mortality Rate By Family Planning," Wright, Nicholas, M.D. American Journal of Public Health, August 1972.

4 "The Health and Social Consequences of Teenage Childbearing," Menken, Jane, Perspectives, Vol. 4, No.3, July 1972.

5 "Assessment of Reproductive Risk in Non-Pregnant Women," Perkins, Gordin, M.D., American Journal of Obstetrics and Gynecology, July 1,1968.

6 World Health Organization, "Health Aspects of Family Planning," Report of a WHO Scientific Group, Technical Report Series, No.442, Geneva, 1970.

7 "The Relationship of Family Planning to Pediatrics and Child Health," Helen M. Wallace, M.D., Maternal and Child Health Practices, 1973.

8 "The Role of Family Planning in the Reduction of Poverty," Arthur A. Campbell, Journal of Marriage and the Family, 30:2, 1968.

the public $2.50 in expenses during the next year alone.[9]

Family planning has contributed much in demonstrating new and innovative methods of delivering health care. Family planning, as just one integral part of a comprehensive health care delivery system, enables individuals, who previously have not had access to such services, to enter in to the general health care system. Thus, the family planning service network can and has facilitated the delivery of comprehensive health services.

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[9] "Short Term Costs and Benefits of the Federal Family Planning Program", Center for Family Planning Program Development, Planned Parenthood - World Population, January 3, 1973.

II. The Family Planning Delivery System in Minnesota

A. HISTORY OF SERVICE DEVELOPMENT

The idea of controlling fertility is as old as humanity itself. The manner in which fertility has been controlled has changed from action taken after birth (infanticide), to action before birth (abortion), to action taken to prevent conception (contraception). This relative sophistication became most significant along with the birth control revolution of the 1960s. During that decade, we were witness to the introduction of the "pill" and the IUD on the market, a significant change in the legal status of providing family planning, and the beginning of major federal involvement in family planning.

Minnesota, as well as the rest of our nation, had a law on its books which prohibited "the distribution or display of any article, drug or medicine for the prevention of conception." Ironically, this statute did not make the actual use of contraceptives illegal. This law remained in effect until it was rescinded by the 1965 Minnesota State Legislature.

Federal involvement in family planning with both available funding and statements of policy began in the late 1960s. The following federal statutes reflect the historical development of the most significant legislation which have provided funds, albeit limited, for family planning programs. (The present status of these statutes will be discussed in II, F:1., page 21)

- Title XIX of the Social Security Act (Medicaid, 1965, 1972) has allowed welfare departments to purchase medical care, including family planning services, for recipients of cash assistance

- Title IV-A of the Social Security Act (Public Assistance, 1967, 1972) has required welfare departments to offer and provide family planning services to "appropriate welfare recipients"

- Title V of the Social Security Act (Child Health Act, 1967) provided formula grants to the State Health Department to utilize for family planning services, in addition to other services for mothers and children, and project grants for maternity and infant care and for specific family planning programs

- Title II of the Economic Opportunity Act (1967) gave project grants to local community action agencies to provide family planning services to low income women as a measure to combat poverty

- Title X of the Public Health Service Act (1970) authorized family planning project grants to be utilized by a variety of public or private nonprofit agencies

Along with increasing federal funds being allotted for family planning services, verbal commitments and policies were also evident. The administrations of Presidents Kennedy, Johnson, and Nixon have all supported family planning programs and have made public statements to that effect. In July 1969, President Nixon set as a "national goal the provision of adequate family planning services within the next five years to all those who want but cannot afford them."[10]

The first organized family planning services in Minnesota were those offered through Planned Parenthood services in Minneapolis and St. Paul, beginning in 1931 and 1934 respectively. Despite the prevailing legal and social climate and rather limited budgets, these agencies worked alone in the field to provide family planning services to primarily low-income women until the legal status of family

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[10] Message to the Congress on Population, July 18, 1969

planning changed in 1965. Once family planning became a legal and legitimate component of regular health care, the family planning service network evolved through several phases of which the following developments may be noted:

- the growth of family planning services in the metropolitan area in 1965 - 1966 where the need was most concentrated and resources readily available

- the beginnings of family planning programs in rural Minnesota in 1969 made possible by the Economic Opportunity Act

- the establishment of the National Center for Family Planning Services in 1969 which marked major federal involvement in family planning and contributed significant project funds

- the Minnesota Minors Law of 1971 which enabled family planning agencies to legally serve minors for family planning

- the expansion of family planning services in rural Minnesota in late 1971

- the growth of community-based clinics since 1972

The Historical Development of Family Planning Services in Minnesota

Year	Family Planning Project	Family Planning Scope of Project	Remarks
1931	P.P. - Minneapolis	provided to low-income women of Mpls. and surrounding areas	funded by private money
1934	P.P. - St. Paul	provided to low-income women of St. Paul and surrounding areas	funded by private money
1965	Minneapolis Health Department	available to women for a period of one year who had received maternity services through the MIC Project	funded by DHEW-MIC project grant
1966	F.P. Clinic of St. Louis County	provided in Duluth	private funding with support from P.P.M. allowed for a weekly f.p. clinic in the local hospital
	Bloomington City Health Department	available for residents of Bloomington and surrounding areas	monthly f.p. clinics were started with help of P.P. and its mobile van.
1967	Hennepin County General Hospital	available to all women of Hennepin County	funded by DHEW-Children's Bureau grant through the M.D.H.
	St. Paul-Ramsey Hospital	available to all women of Ramsey County	a separate f.p.clinic was started and supported by the county and by patient fees
	Model Cities Clinic	available in St. Paul's Model Cities area	funded by OEO project grant
1969	St. Paul Bureau of Health	available for women living in St. Paul	funded by DHEW-NCFPS project grant
	Mpls. Health Department	available for women living in Mpls.	funded by DHEW-NCFPS project grant
	St. Paul-Ramsey Hospital	provided to women for a period of one year who had received maternity services through the MIC project	funded by DHEW-MIC project grant through the St. Paul Bureau of Health
	Bloomington City Health Department	available for residents of Bloomington and surrounding areas	fiscal responsibility for clinic was taken over by the City of Bloomington
	Lakes and Pines CAC, Inc.	available for low-income women of Aitkin, Carlton, Chisago, Isanti, Kanabec, Mille Lacs, and Pine Counties	funded by OEO project grant
	Southeastern Minn. CAC, Inc.	available for low-income women of Fillmore, Houston, and Winona Counties	funded by OEO project grant
	F.P. Clinic of St. Louis County	available for residents of St. Louis County	DHEW-Children's Bureau grant, through the St. Louis Co. Health Dept, took over funding for the project

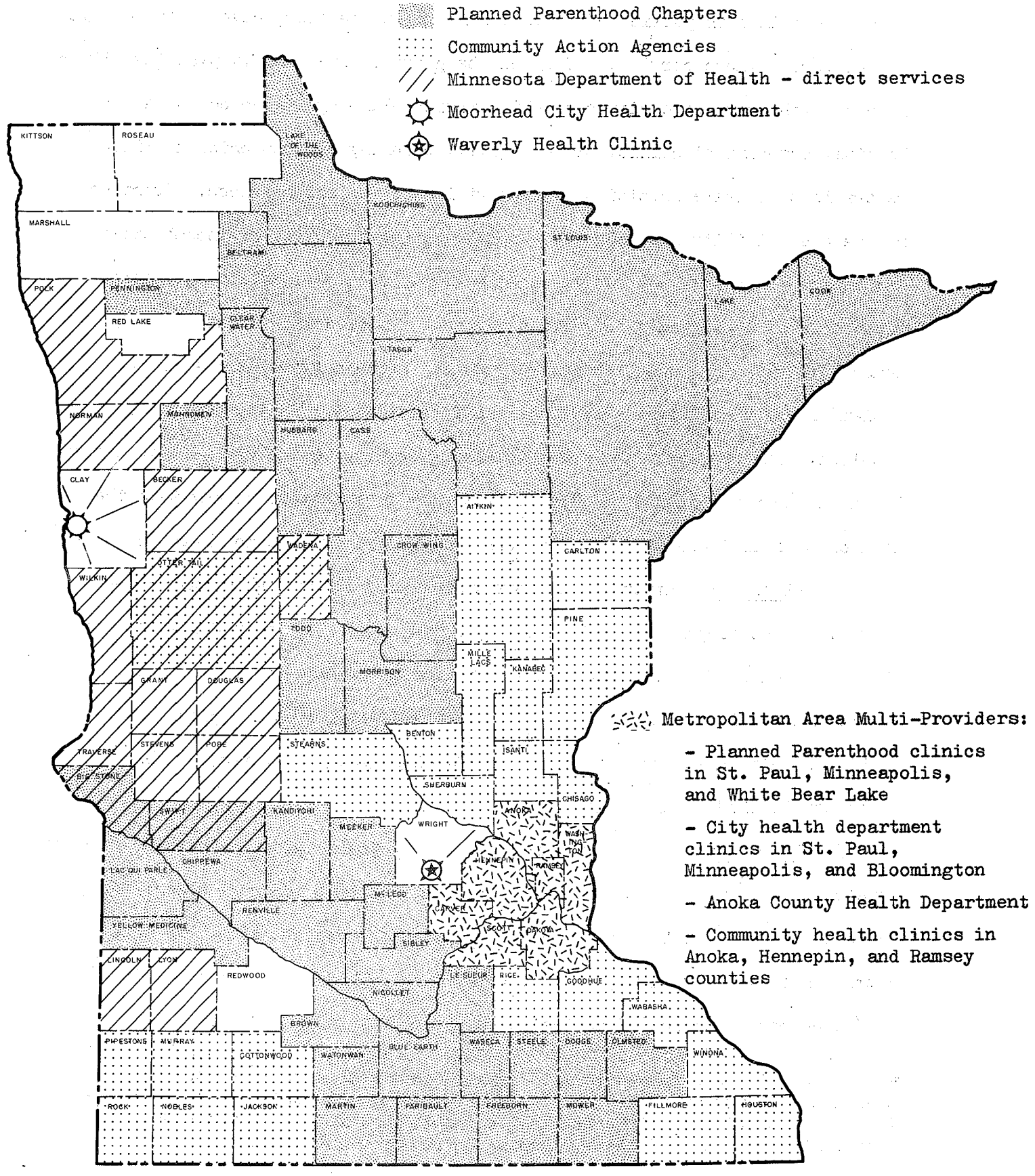
Year	Family Planning Project	Family Planning Scope of Project	Remarks
1969 Cont.	West Side Community Health Center	available for residents of St. Paul's West Side	supported by private foundation money, St. Paul Ramsey & St.Paul Bureau of Health
	Model Cities Clinic	Project area remains focused on St. Paul's Model Cities Area	project was relocated at St. Paul Bureau of Health which took over funding for the project
1970	University of Minnesota-Dept. of Ob &Gyn.	available for all students and staff of the University	services were provided through a special gynecological clinic
	Teen-Age Medical Service	available for young adults in the metropolitan area	MCHS grant, through the MDH, began to provide support for newly structured f.p. clinic
	Pilot City Health Center	available through ob-gyn & general clinics for Mpls. Pilot City residents	MCHS grant, through the MDH, began to provide major funding for the project
	Bloomington City Health Department	available for surrounding residents of Bloomington	MCHS grant, through the MDH, allowed for expansion of program
	Ottertail-Wadena CAC, Inc.	available for low-income women of Ottertail & Wadena Co.	funded by OEO project grant
	Southwestern Minn. Opportunity Council, Inc.	available for low-income women of Murray, Nobles, Rock, and Pipestone Counties	funded by OEO project grant
	Goodhue, Rice and Wabasha CAC, Inc.	available for low-income women of Goodhue, Rice, and Wabasha Counties	funded by OEO project grant
	Lincoln-Lyon Parent-Child Center	available to residents of Lincoln & Lyon Counties	funded by MCHS through the MDH
	Beltrami Health Clinic, Inc.	available to residents of northeast Mpls.	privately funded along with some county and federal funds
1971	Moorhead City Health Department	available for residents of Clay and surrounding counties	funded by MCHS grant through the MDH
	Tri-CAP, Inc.	available for low-income women of Benton, Sherburne, and Stearns Counties	funded by OEO project grant
	Northcentral P.P.	available for medically indigent women of Beltrami, Cass, Clearwater, Hubbard, Itasca, Koochiching, Lake of the Woods, Mahnomen and Pennington Counties	funded by NCFPS project grant through P.P.M.
	Southeast P.P.	available for medically indigent women of Dodge, Freeborn, Mower, Olmsted, and Steele Counties	funded by NCFPS project grant through P.P.M.
	Southcentral P.P.	available for medically indigent women of Blue Earth, Brown, Faribault, LeSueur, Martin, Nicollet, Sibley, Waseca and Watonwan Counties	funded by NCFPS project grant through P.P.M.
	MDH - County welfare and nursing services	available for medically indigent women of Becker, Douglas, Ottertail, Pope and Stevens Counties	MCH funds support medical services, local county welfare and nursing services provide remainder of program support

Year	Family Planning Project	Family Planning Scope of Project	Remarks
1971 Cont.	Helping Hand Health Center, Inc.	available for low-income women of Ramsey County	funded by OEO project grant and private money
	Southside Medical	available to residents of Mpls. south side	project support from Abbott Hospital
	Fremont Community Clinic, Inc.	available to residents of north Mpls.	privately funded along with some county and federal funds
1972	Southeastern Minn. CAC, Inc.-Tri-CAP, Inc. - Ottertail-Wadena CAC. Inc. - Lakes and Pines CAC, Inc.	projects remain focused on medically indigent within the same project areas	project grant transferred from OEO to NCFPS. NCFPS funds channeled through P.P.M.
	West-Suburban Teen Clinic, Inc.	available for young adults of the western suburbs of Mpls.	private and county funds are supporting clinic
	Family Tree, Inc.	available to persons in the metropolitan area	clinic support is primarily from private funding
	Face to Face, Inc.	available for youth in the metropolitan area	clinic support is primarily from private funding and St. John's Hospital
	Central Minn. P.P.	available for medically indigent women of Crow Wing, Morrison & Todd Counties	funded by NCFPS grant through P.P.M.
	MDH - County welfare and nursing services	available for medically indigent women of Big Stone, Grant, Polk, Traverse, Wadena, and Wilkin Counties	MCHS funds support medical services; local county welfare and nursing services provide remainder of program support
	University of Minnesota Student Health Service	available for all University students	services were included as part of the Health Service's regular care
	Model Cities Community Health Clinic	focused on St. Paul's Model Cities area	project was relocated in Martin Luther King Center; funded by Model Cities and St. Paul Division of P.H.
1973	MDH - County Nursing Service	available for medically indigent women of Swift County	MCHS funds support medical services; local county nursing service provides remainder of program support
	Northeastern Minn. P.P.	project area expanded to include medically indigent women of Cook and Lake Counties	formerly known as F.P. Clinic of St. Louis County (project became a P.P.M. chapter in late 1972)
	Anoka County Comprehensive Health Department	available for residents of Anoka County	funded by MCHS through the MDH

Year	Family Planning Project	Family Planning Scope of Project	Remarks
1974	Waverly Health Clinic Project	available for residents of Wright County	funding by MCHS through the MDH
	Region VI - P.P.	available for medically indigent women of Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, McLeod, Meeker, Renville, Swift, and Yellow Medicine Counties	funded by NCFPS project grant through P.P.M.
	Southwestern Minn. Opportunity Council, Inc.	projects remain focused on medically indigent in project areas; project areas in southwest expanded to include Cottonwood and Jackson Counties	project grant transferred from OEO to NCFPS. NCFPS funds channeled through P.P.M.
	Goodhue, Rice and Wabasha CAC, Inc.	projects remain focused on medically indigent in project areas	project grant transferred from OEO to NCFPS. NCFPS funds channeled through P.P.M.

C.A.C. or C.A.P. = Community Action Council (Program)
DHEW = Department of Health, Education, and Welfare
f.p. = family planning
M.C.H.S. = Maternal and Child Health Service
MDH = Minnesota Department of Health
MIC = Maternity and Infant Care
NCFPS = National Center for Family Planning Services
OEO = Office of Economic Opportunity
P.P.(M.) = Planned Parenthood (of Minnesota)

THE CURRENT SYSTEM OF ORGANIZED FAMILY PLANNING SERVICES



B. CURRENT DELIVERY SYSTEM

1. Services: Organized, subsidized family planning services in Minnesota, established in both public and private non-profit agencies, have multiple ways of delivering these services. They may be provided in a family planning clinic, in a comprehensive care clinic of which family planning is one component, a hospital out-patient clinic, or in a family planning program which utilizes referrals to private physicians for provision of medical services. Programs may have eligibility requirements, such as age, geographic, or income criteria, established by either the funding agency or through local policy decisions. Support for the program's activities may come from federal, county or city funds, private donations, foundation grants, third-party reimbursements, patient fees or donations, volunteer staff, and donated space, equipment and/or supplies. The charge for the family planning service to the participant may be based on the participant's ability to pay, may be a flat rate, may take the form of a minimal donation, or, in some cases, there may be no charge whatsoever.

2. Planning: Various means have been used in planning for the present system. These components include the Family Planning Advisory Committee* to the State Board of Health originally established on July 13, 1971, (see appendix 1 for 1974 membership), areawide comprehensive health planning agencies, working relationships between agencies, funding agency policies, or through goals established by the agency itself.

3. Coordination: Coordination within the family planning service network exists through funding mechanisms, formal affiliation, informal association, advisory committees, bulk-purchasing arrangements, cross-agency referrals, common in-service training, working relationships, administrative meetings and/or common standards of medical care.

*This Committee was formed in accordance with a recommendation made to the Minnesota Department of Health as part of the "Recommendations for Action - Improving Parent and Infant Health," a report of the Comprehensive Health Planning Program of the State Planning Agency in March of 1970.

C. STANDARDS OF CARE

The following two pages are standards of care, developed by the Advisory Committee on Family Planning to the State Board of Health and adopted by the State Board of Health. It is further recommended that the following be incorporated into each agency's program in providing complete family planning services:

1. Each patient should receive instruction on the physiology of reproduction and comprehensive instruction on all methods of family planning, including the advantages and disadvantages, the relative effectiveness, and an explanation of how each method works.

2. The agency should make an effort to educate each patient as to the necessity of maintaining good health care.

3. The agency should educate each patient as to the relationship and continuity of family planning to comprehensive health care.

4. The agency should familiarize itself with other agencies in the community and make appropriate referrals when indicated.

Minnesota Department of Health Guidelines for Providing
Family Planning Services in Minnesota

I. Guidelines on services to be offered

A. Minimal laboratory services to be offered should include:

1. hemoglobin or hematocrit
2. Urinalysis when indicated
3. pregnancy testing on selective basis
4. GC culture
5. smears for monilia and trichomoniasis diagnosis on selected basis
6. Pap smear
7. serology
8. urine culture when indicated

B. A minimal physical examination will include:
Blood pressure, height, weight
A pelvic and abdominal examination and examination of the breasts with a preceding careful evaluation of the patient's past medical and surgical history
Where staff is available a general physical examination is recommended.

C. A wide range of birth control methods should be available for the patient's voluntary selection, though not all need be available in clinic. Accepted methods include:

1. oral contraceptives
2. intra-uterine devices
3. diaphragms
4. foams and jellies
5. condoms
6. calendar and/or basal temperature rhythm
7. sympto-thermic prediction of ovulation
8. other

D. Where surgical methods such as tubal ligation and vasectomy are indicated and requested, referral to an agency to provide these should be made and funding should not be a barrier to the patient.

E. Arrangements for treatment should be made for those patients in which a diagnosis of vaginitis or venereal disease is made.

F. Since Family Planning is a part of interconceptual care, general advice and counseling must be available to the patient and family. It is recommended that this service include:

1. social services
2. genetic counseling
3. nutritional counseling

G. A family planning agency should be able to perform fertility workups for the infertile patient or have a source to whom the patient may be sent for this evaluation.

H. Since the Department favors family planning services of a comprehensive nature, a local agency is encouraged to include other services that it may feel are indicated.

II. Guidelines on patient scheduling of visits following initial health examination

A. When oral contraceptives are provided, a follow-up visit should be made at six months, or sooner if indicated.

At twelve months a repeat minimal physical examination and Pap smear must be performed if the prescription is renewed.

B. When an intra-uterine device is inserted it is suggested that the patient be re-examined at six weeks; at twelve months a repeat Pap smear and minimal physical examination should be done.

C. When a diaphragm has been used there should be an annual minimal physical examination and Pap smear.

D. The patient should be encouraged to return to the agency for re-evaluation whenever symptoms arise which may be related to use of a contraceptive device or prescription.

III. Guidelines on clinical personnel

A. The initial examination should be performed by a physician.

B. There must be general physician supervision during clinic operation.

C. There should be additional clinic personnel with proper training as required to provide a satisfactory level of service.

D. Use of outreach workers may be indicated.

IV. Guidelines on facilities

The clinic or service should have reasonable hospital back-up for:

1. extensive workups
2. complications
3. laboratory services as necessary, etc.

V. Guidelines on service accessibility

A. Service hours should be such as to provide reasonable accessibility to all patients.

B. The State Health Department will not consider residence site, age, sex, race, marital status, economic status, etc. as barriers to service availability.

VI. Policy on reporting of services to the Minnesota State Board of Health.

A. Periodic reports, as indicated by HEW, will be required, in addition the Department of Health may request other information and statistics.

B. At least one site visit will be made by a representative of the State Board of Health annually. When indicated, more frequent visits will be made.

D. CURRENT FINANCING OF FAMILY PLANNING SERVICES

Source of Funds	Fiscal Agency	Project	Other Significant Funding/Support
Department of Health, Education, and Welfare- National Center for Family Planning Services	Planned Parenthood of Minnesota	Southcentral Mn. P.P.	private funds
		Southeast Mn. P.P.	private funds
		North Central Mn. P.P.	private funds
		Central Mn. P.P.	private funds
		Northeastern Mn. P.P.	private funds
		Region VI P.P.	private funds
		SEMCAC, Inc.	"in-kind" services
		Lakes and Pines CAC, Inc.	"in-kind" services
		Ottertail-Wadena CAC, Inc.	"in-kind" services
		Southwestern Opportunity Action Council, Inc.	"in-kind" services
		TRI-CAP, Inc.	"in-kind" services
		Goodhue, Rice, and Wabasha CAC, Inc.	"in-kind" services
	Minneapolis Health Dept.	Minneapolis Health Dept.	city funds, county funds
	St. Paul Division of Public Health	St. Paul Division of Public Health	city funds, county funds
Department of Health, Education, and Welfare- Maternal and Child Health Services	Minnesota Department of Health	Anoka Co. Comp. Hlth. Dept.	county funds
		Blmgtn. City Hlth. Dept.	city funds, patient fees
		Hennepin Co. General Hosp.	Co. & city funds, pt. fees
		Moorhead City Hlth. Dept.	city funds, pt. donations
		Pilot City Hlth. Center	patient fees, county funds
		Teen-Age Medical Service	NFCC grant, Co. funds, pvt. funds, pt. donations
		Waverly Health Care Clinic	
Department of Health, Education, and Welfare- Maternity and Infant Care Projects	Minneapolis Health Dept.	Minneapolis Health Dept.	city and county funds
	St. Paul Division of Public Health	St. Paul Division of Public Health	city and county funds
Office of Economic Opportunity	Ramsey Action Program	Helping Hand Health Center	private foundation grant, University of Minnesota, & United Hospitals support
Model Cities	St. Paul Division of Public Health	Model Cities Community Health Clinic	city funds

Source of Funds	Fiscal Agency	Project	Other Significant Funding/Support
St. Paul-Ramsey Hosp.		St. Paul-Ramsey Hospital Family Planning Project	patient fees
Abbott Hosp.		Southside Medical Clinic	NFCC grant
private funds		Beltrami Health Clinic	Hennepin County, National Free Clinic Council(NFCC) grant, patient donations
		Face to Face Crisis Center, Inc.	NFCC grant, patient donations, city funds
		Family Tree, Inc.	NFCC grant, patient donations
		Fremont Community Clinic, Inc.	Hennepin County grant, NFCC grant, patient donations
		West Suburban Teen Clinic, Inc.	Hennepin County grant, NFCC grant, patient donations
		St. Paul Planned Parenthood	
		Mpls. Planned Parenthood	

E. WHO IS IN NEED OF SUBSIDIZED FAMILY PLANNING SERVICES

Unplanned pregnancies may result when individuals lack the means and understanding to allow for the control of their fertility. Not only do some individuals lack the financial resources to obtain family planning services but psychological misuse or nonuse of contraception or an inherent failure in the contraceptive itself may also result in unplanned pregnancies.

Joy G. Dryfoos, Director of Planning, Center for Family Planning Program Development, Planned Parenthood -- World Population, has estimated the need for subsidized family planning services based on recent fertility research and census data for the United States for each state and county. These data represent estimates of the number of women of reproductive age and the number and percent projected to be in need of family planning services in 1973 for the state and at 1975 levels for each county (see Appendix 2) for three age groups and for two income-family size thresholds -- at or below 150 percent of the federal poverty index, and at or below 200 percent of the federal poverty index.* The following table reflects the need for the state:

*The federal poverty index is a schedule of income and family size thresholds below which individuals are classified as poor. It is adjusted each year according to the Consumer Price Index. Since the data on which this study was based was from the 1970 Census, the applicable poverty thresholds are based on income reported during 1969. For a nonfarm family of four, this amounted to $5,615 at 150% of poverty and $7,486 at 200%.

ESTIMATED NEED FOR FAMILY PLANNING SERVICES, MINNESOTA, 1973

Age	Total Number	Estimated Need			
		150% of Poverty		200% of Poverty	
		Number	% of Total	Number	% of Total
15-19	186,831	13,825	7.4	21,131	11.3
20-29	310,057	37,207	12.0	64,988	21.0
30-44	322,979	31,878	9.9	59,816	18.5
15-44	819,867	82,910	10.1	145,935	17.8

Source:

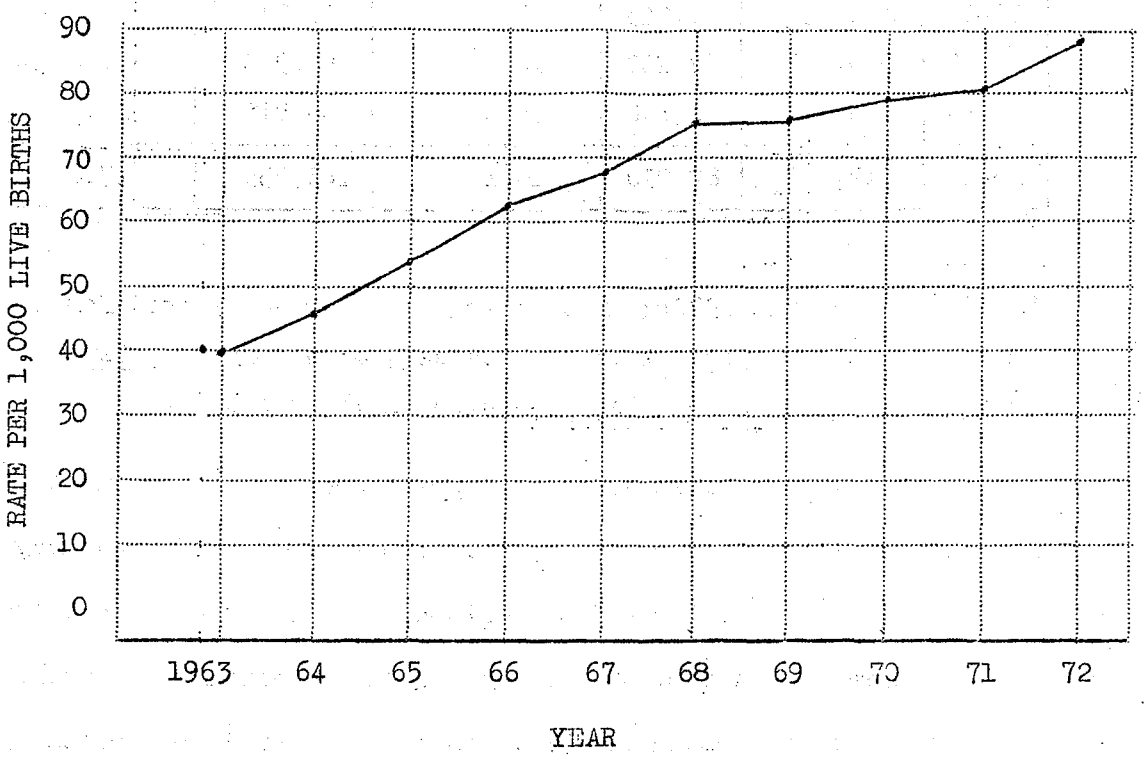
"A Formula for the 1970s: Estimating Need for Subsidized Family Planning Services in the United States", J. G. Dryfoos, Family Planning Perspectives. Vol. 5, No. 3, 1973, Table 34.

In early 1973, the United States Supreme Court and subsequent Minnesota Supreme Court rulings allowed for the legal performance of pregnancy terminations. As facilities became equipped and personnel became trained to perform these procedures, the numbers of legal terminations performed in Minnesota increased monthly. If present rates continue, currently available data indicate that Minnesota would be experiencing around 10,000 legal terminations each year. Termination of pregnancy is clearly not a mechanism of controlling fertility and could and should be averted through voluntary use of effective contraceptive techniques. Hopefully, as more effective and available family planning measures are utilized, the need for pregnancy termination procedures will be greatly reduced.

Another indicator of need for family planning services are out-of-wedlock births. An out-of-wedlock birth will result when an unmarried female is exposed to the risk of pregnancy and does not have control over conception, gestation, nor legitimation by marriage before such birth occurs. The rate of out-of-wedlock births, computed as the number of out-of-wedlock births per 1,000 live births, has increased alarmingly over the last decade, as the following graph indicates:

OUT-OF-WEDLOCK RATE PER 1,000 LIVE BIRTHS, MINNESOTA RESIDENTS

1963 - 1972



Source: Minnesota Department of Health, Section of Health Statistics, special tabulations.

The graph shows that the rate of out-of-wedlock births increased from 40.0 per 1,000 live births in 1963 to 88.6 in 1972. The actual numbers of out-of-wedlock births increased 56% from 3,208 in 1963 to 4,994 in 1972.

F. GAPS IN THE CURRENT SYSTEM

1. Funding: Although federal funding became a major and substantial source for many family planning programs in Minnesota, there have been no increases from either NCFPS (Title X) or MCHS (Title V) funds in the previous three fiscal years. While Title V - MCHS formula funds are continuing, categorically defined Title V project funds will expire on June 30, 1974. The projects originally funded from Title II of the Economic Opportunity Act were transferred to NCFPS funding at their current levels and Title II funding has been phased out. While funding has therefore remained frozen at fiscal year 1972 levels, programs have not. Patient volume and program activities have continued to increase each year while programs have received no new funding.

Programs are currently receiving pressure to gradually decrease their dependence on federal project grants and to beoome self-supporting, primarily through third-party reimbursement mechanisms. While such mechanisms have been proposed through IV-A (Public Assistance) and XIX (Medicaid), the potential to use these programs are minimal because of restrictive guidelines imposed under XIX and proposed under IV-A. In addition to the minimal potential use of these programs, IV-A and XIX would primarily pay for the direct costs of providing the service. The agency is thus still dependent on providing funds for the indirect, supportive costs. Assuming maximum third-party reimbursement, each patient served represents a net loss to the agency.

Most federally funded projects have been required to provide local match for each federal dollar. Some county and city money has been made available for this match, but usually projects have searched out private donations or "in-kind" services. Other projects have relied heavily on private donations or grants for the sole support of their project. The uncertainty of future private donations has meant that those projects have

existed at a survival level from year to year. Unfortunately, no state funds have ever been made available to finance family planning projects.

2. Unserved Areas: Minnesota has done well in making subsidized family planning services geographically accessible. As of January 1, 1974, there were only five counties remaining which have not been linked into any organized family planning program.

3. Underserved Areas: Based upon the 1970 census, there are approximately 83,000 Minnesota women between the ages of 15 and 44 years who have family incomes equal to or less than 150 percent of official Bureau of Labor Statistics poverty levels. All organized family planning programs in Minnesota together probably saw no more than 37,000 women in 1972 - far less than half of those in need. Taking 200 percent of poverty level as another indicator of need, our success falls to merely 25 percent. We cannot take pride in this degree of underservice.

4. Criteria for Program Decision-Making: Most of the agencies offering family planning services do keep data on their program's participants. Experience with feeding this data into a data system has produced few functional uses of that system. Many projects feel their full program's activities are not adequately portrayed because the data system merely reveals "head counts". Many family planning programs are part of a larger data system, such as that of the National Center for Health Statistics. Other family planning programs are not part of any larger information system. This has meant that adequate and uniform data is lacking on the full family planning service network thus hampering current efforts at planning and also evaluating the effectiveness and efficiency of the service system.

5. Community Education: Although many agencies have made substantial progress in establishing programs in the community's schools and in talking to other groups, more efforts could be made in this direction. Emphasis

should be placed on family planning as part of a comprehensive and preventive health service.

6. Training and Manpower Development: There is a demonstrated need for cooperative training of new types of family planning personnel, such as the family planning nurse-practitioner or new paraprofessionals that can proficiently perform services traditionally performed by physicians. In addition, there should be continuing education for all types of family planning workers, including administrators, physicians, nurses, counselors, social workers, educators, and community workers in not only family planning but other related areas such as dealing with problem pregnancies and concerns relating to sexuality.

7. Expansion of Services: Some agencies are anxious to expand their services in order to be able to offer more comprehensive health services including such things as venereal disease screening and treatment, pre-natal care, etc. Some agencies have expressed the need to have better follow-up of patients but have been limited because of not enough staff and funds.

8. Program Restrictions: Many programs have operated under restrictive guidelines imposed by Federal authorities, such as those dealing with sterilization, the morning-after-pill, and injectable contraceptive drugs. Some programs, because of local policy decisions, have been unable to serve minors in the community.

III. Goals

GOAL

To provide high-quality patient-oriented family planning services to individuals throughout the state by:

- assuring availability and accessibility
- maximizing efficiency and effectiveness of existing family planning delivery systems
- promoting coordination among family planning services and between family planning services and other health/social services

SUB-GOALS

The objectives which have been established to move toward this goal, in order of priority, are:

A. to increase the utilization of existing family planning services, especially in those underserved areas of the state

B. to provide adequate and uniform data for program development, administration, and evaluation

C. to provide cooperative training for new types of family planning personnel and continuation training for all types of family planning workers in family planning and related subjects

D. to provide organized, subsidized family planning services in those areas of the state currently without such services

E. to promote public awareness of the availability and benefits of family planning services

IV. Methods for Achieving Goals and Objectives

A. In order to increase the utilization of existing family planning services in those underserved areas of the state, alternative approaches include:

- overcoming community attitudes and social barriers which may prevent those who desire services from receiving them through:
  - the integration of family planning services into the general health care delivery system in timely and appropriate ways
  - public education programs
  - public relations efforts
  - community participation through committees, volunteer systems, etc.
  - cross-agency and professional disciplines, alliances, and referrals
- overcoming problems caused by inadequate staffing through:
  - assessing staffing patterns to use staff more efficiently
  - utilizing volunteers where feasible in the delivery of services
  - coordinating staff resources with other agencies
  - utilizing personnel trained for new roles in family planning to meet manpower needs
  - adding staff when funds allow
- overcoming geographic barriers through:
  - establishing satellite or mobile clinics bringing services closer to clients
  - providing transportation for patients to the service
  - outreach promotion of the program
  - promoting private physician participation

- overcoming limitations of program activities precipitated by inadequate financing through:
  - . securing state and local government appropriations
  - . utilizing third-party reimbursement mechanisms, where cost-effective
  - . exploring and securing funds from private and federal sources
  - . a patient-fee-system, according to ability to pay
- increasing internal efficiencies of programs through:
  - . obtaining contraceptive, consumable medical, and consumable office supplies, where possible, through bulk-purchasing arrangements
  - . providing contraceptive supplies directly through program
  - . contracting for services which can be provided more economically elsewhere
  - . clarifying job functions and staffing patterns

B. In order to provide adequate and uniform data for program development, administration, and evaluation, alternative approaches include:

- continuing the current investigation by the MDH Advisory Committee's task force into the development of a statewide data system
- expanding the present participation in the NCHS data system to include all Minnesota projects
- providing useful reports to local projects based on NCHS data received by the MDH
- continuing to monitor and evaluate various reporting systems operating in other areas of the country

C. In order to provide cooperative training for new types of family planning personnel and continuation training for all types of family planning workers in family planning and related subjects, alternative approaches include:

- encouraging the promotion of family planning related matters into the curricula and programs of institutions of higher education in the state
- encouraging uniform certification of family life education teachers and family planning personnel
- the coordination of cooperative training between agencies to maximize training skills
- exploring and securing funds to provide training programs

D. In order to provide organized, subsidized family planning services in those areas of the state currently without such services, alternative approaches include:

- evaluation of the extent of need in Kittson, Roseau, Marshall, Red Lake, and Redwood counties (as referred to on map on page 10)
- investigation of most efficient mechanism of extending services into the preceding five counties either through:
  - . expanding bordering programs into area in need
  - . creating new programs in area in need

E. In order to promote public awareness of the availability and benefits of family planning services, alternative approaches include:

- build community acceptance and support through:
  - . the development of a coordinated speakers' bureau
  - . coordinating a statewide public awareness program
  - . increasing local agency involvement in public education programs

- informing and educating potential and present recipients of family planning services by:
  - integrating family planning information into general health care delivery programs
  - promoting program activities through the mass media and other resources
  - providing comprehensive patient education within the program's promotional, clinical and follow-up activities

V. Process of Implementation

The Technical Advisory Committee that developed this Plan considered two different options in regard to this implementation process. This section could have delineated specific tasks for various agencies which would have been held responsible for their implementation. This particular course seemed to present problems in that specific tasks may have become soon outdated, workable solutions designed to meet the objectives may have been omitted, specific assignments may have cut across a multitude of agencies, and other unforseeable problems seemed inevitable with this task-specific approach. The Technical Advisory Committee instead chose what seemed to be a more workable course which involved presenting an operational framework within which the Plan would be implemented. This course also seemed most consistent with the original philosophic purpose of the Plan, i.e. "to provide a conceptual framework for the planning, financing, implementation and evaluation of organized family planning services in Minnesota."

The viability of this Plan and the achievement of its stated goals and objectives is dependent on the cooperation and action of various agencies and individuals within the state. These include State agencies, such as the Minnesota Department of Health, the Minnesota Department of Public Welfare, the Minnesota Department of Education, and institutions of higher education in the state; the existing network of subsidized family planning service providers; elected state and local officials; the medical community; public institutions; and all other agencies and individuals concerned with improving health thrcugh family planning.

The authority to implement the Plan resides with the Minnesota Department of Health with the assistance, guidance and participation of its technical Advisory Committee on Family Planning. The Advisory

Committee comprises representatives from metropolitan and outstate area providers of family planning services and is appointed by the State Board of Health on an annual basis. The Committee's roles include advising the Minnesota Department of Health on current needs and problems, evaluating projects and programs of the Minnesota Department of Health, and serving as a technical resource to broaden and extend the expertise available to the Department.

The Advisory Committee will provide guidance to and participate with the Department in the following areas:

- review and comment on all applications for federal and state family planning grants according to the State Plan for Family Planning
- serve as an advocate of family planning with appropriate individuals, governmental and legislative institutions, public and private agencies
- make recommendations concerning new methods of educating health providers in the areas of family planning and on issues relevant to family planning
- make recommendations regarding a statewide information system on family planning
- serve as a vehicle to transmit family planning information to other family planning providers in the state

VI. Evaluation

The State Plan for Family Planning was developed with the assumptions that as new data and techniques of delivering services become available and programs are developed and establish their effectiveness, this Plan will require modification. The evaluation of services to enhance their efficiency and to insure the provision of high-quality patient care will also involve an overall assessment of the scope of family planning services and identifying and prioritizing service gaps throughout the state. This review and evaluative function will reside with the Minnesota Department of Health with the assistance of its Advisory Committee on an on-going basis. As gaps are identified and prioritized, a variety of strategies and methods for providing needed services consistent with the Plan will be developed and considered. Necessary program assistance to help in maximizing program efficiency and effectiveness will be provided.

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Appendix 2

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
STATE TOTAL					
15-19	200,089	14,805	7.4	22,824	11.4
20-29	354,331	43,515	12.3	74,153	20.9
30-44	328,273	30,882	9.4	58,642	17.9
15-44	882,693	89,202	10.1	155,619	17.6
AITKIN					
15-19	557	70	12.6	116	20.8
20-29	449	79	17.5	166	36.9
30-44	701	172	24.6	249	35.5
15-44	1,707	321	18.8	531	31.1
ANOKA					
15-19	10,489	409	3.9	703	6.7
20-29	17,140	840	4.9	1,903	11.1
30-44	24,001	1,176	4.9	2,832	11.8
15-44	51,630	2,425	4.7	5,438	10.5
BECKER					
15-19	1,410	182	12.9	255	18.1
20-29	1,312	304	23.2	497	37.9
30-44	1,708	338	19.8	526	30.8
15-44	4,430	824	18.6	1,278	28.8
BELTRAMI					
15-19	1,377	207	15.0	289	21.0
20-29	3,252	956	29.4	1,476	45.4
30-44	1,678	347	20.7	500	29.8
15-44	6,307	1,510	23.9	2,265	35.9
BENTON					
15-19	1,225	102	8.3	162	13.2
20-29	1,681	230	13.7	471	28.0
30-44	1,774	293	16.5	483	27.2
15-44	4,680	625	13.4	1,116	23.8
BIG STONE					
15-19	382	33	8.6	41	10.7
20-29	343	81	23.6	123	36.0
30-44	496	105	21.2	163	32.9
15-44	1,221	219	17.9	327	26.8

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
BLUE EARTH					
15-19	2,490	229	9.2	361	14.5
20-29	9,706	2,038	21.0	2,989	30.8
30-44	3,196	336	10.5	649	20.3
15-44	15,392	2,603	16.9	3,999	26.0
BROWN					
15-19	1,575	143	9.1	232	14.7
20.29	2,218	291	13.1	495	22.3
30-44	1,999	310	15.5	550	27.5
15-44	5,792	744	12.8	1,277	22.0
CARLTON					
15-19	1,511	118	7.8	184	12.2
20-29	1,618	285	17.6	497	30.7
30-44	2,273	261	11.5	518	22.8
15-44	5,402	664	12.3	1,199	22.2
CARVER					
15-19	1,688	71	4.2	132	7.8
20-29	2,108	169	8.0	341	16.2
30-44	2,926	252	8.6	451	15.4
15-44	6,722	492	7.3	924	13.7
CASS					
15-19	885	142	16.0	192	21.7
20-29	766	196	25.6	316	41.2
30-44	1,125	278	24.7	399	35.5
15-44	2,776	616	22.2	907	32.7
CHIPPEWA					
15-19	765	94	12.3	137	17.9
20-29	730	131	18.0	234	32.0
30-44	1,052	186	17.7	320	30.4
15-44	2,547	411	16.1	691	27.1
CHISAGO					
15-19	1,083	97	9.0	154	14.2
20.29	1,067	122	11.4	257	24.1
30-44	1,791	152	8.5	338	18.9
15.44	3,941	371	9.4	749	19.0

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
CLAY					
15-19	2,393	187	7.8	282	11.8
20-29	7,195	1,403	19.5	2,036	28.3
30-44	3,277	305	9.3	636	19.4
15-44	12,865	1,895	14.7	2,954	23.0
CLEARWATER					
15-19	387	70	18.2	99	25.5
20-29	303	92	30.2	134	44.1
30-44	505	122	24.2	193	38.3
15-44	1,195	284	23.8	426	35.6
COOK					
15-19	159	9	5.9	24	15.4
20-29	159	27	16.8	55	34.6
30-44	284	45	15.7	84	29.7
15-44	602	81	13.5	163	27.1
COTTONWOOD					
15-19	710	61	8.6	104	14.7
20-29	692	135	19.5	231	33.4
30-44	1,017	211	20.7	348	34.2
15-44	2,419	407	16.8	683	28.2
CROW WING					
15-19	1,824	168	9.2	263	14.4
20-29	2,314	479	20.7	826	35.7
30-44	2,736	383	14.0	698	25.5
15-44	6,874	1,030	15.0	1,787	26.0
DAKOTA					
15-19	9,601	336	3.5	614	6.4
20-29	14,171	666	4.7	1,474	10.4
30-44	21,456	923	4.3	2,360	11.0
15-44	45,228	1,925	4.3	4,448	9.8
DODGE					
15-19	701	53	7.6	102	14.6
20-29	662	105	15.9	197	29.8
30-44	1,018	197	19.4	310	30.5
15-44	2,381	355	14.9	609	25.6

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
DOUGLAS					
15-19	1,264	186	14.7	239	18.9
20-29	1,482	305	20.6	522	35.2
30-44	1,691	289	17.1	519	30.7
15-44	4,437	780	17.6	1,280	28.8
FARIBAULT					
15-19	981	130	13.3	170	17.3
20-29	964	248	25.7	377	39.1
30-44	1,342	240	17.9	433	32.3
15-44	3,287	618	18.8	980	29.8
FILLMORE					
15-19	1,089	122	11.2	161	14.8
20-29	978	213	21.8	389	39.8
30-44	1,433	294	20.5	438	30.6
15-44	3,500	629	18.0	988	28.2
FREEBORN					
15-19	1,861	140	7.5	249	13.4
20-29	2,381	357	15.0	648	27.2
30-44	2,914	288	9.9	612	21.0
15-44	7,156	785	11.0	1,509	21.1
GOODHUE					
15-19	1,781	128	7.2	214	12.0
20-29	2,020	194	9.6	461	22.8
30-44	2,770	291	10.5	548	19.8
15-44	6,571	613	9.3	1,223	18.6
GRANT					
15-19	370	61	16.6	84	22.7
20-29	278	61	22.0	142	51.0
30-44	459	108	23.5	172	37.5
15-44	1,107	230	20.8	398	36.0
HENNEPIN					
15-19	45,460	2,636	5.8	3,864	8.5
20-29	114,672	11,238	9.8	17,659	15.4
30-44	85,687	4,627	5.4	9,254	10.8
15-44	245,819	18,501	7.5	30,777	12.5

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
HOUSTON					
15-19	1,001	75	7.5	123	12.3
20-29	1,025	177	17.3	259	25.3
30-44	1,296	202	15.6	375	28.9
15-44	3,322	454	13.7	757	22.8
HUBBARD					
15-19	575	79	13.8	118	20.6
20-29	487	151	31.1	199	40.8
30-44	783	193	24.6	289	36.9
15-44	1,845	423	22.9	606	32.8
ISANTI					
15-19	1,070	47	4.4	112	10.5
20-29	1,168	99	8.5	181	15.5
30-44	1,633	131	8.0	299	18.3
15-44	3,871	277	7.2	592	15.3
ITASCA					
15-19	1,996	190	9.5	293	14.7
20-29	1,971	402	20.4	692	35.1
30-44	2,555	424	16.6	718	28.1
15-44	6,522	1,016	15.6	1,703	26.1
JACKSON					
15-19	723	46	6.4	93	12.9
20-29	770	150	19.5	230	29.9
30-44	922	135	14.7	272	29.5
15-44	2,415	331	13.7	595	24.6
KANABEC					
15-19	545	29	5.4	56	10.2
20-29	480	80	16.7	131	27.2
30-44	822	99	12.1	188	22.9
15-44	1,847	208	11.3	375	20.3
KANDIYOHI					
15-19	1,563	166	10.6	233	14.9
20-29	1,997	320	16.0	669	33.5
30-44	2,268	315	13.9	547	24.1
15-44	5,828	801	13.7	1,449	24.9

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
KITTSON					
15-19	320	28	8.8	52	16.2
20-29	281	54	19.3	98	34.7
30-44	423	69	16.3	115	27.2
15-44	1,024	151	14.7	265	25.9
KOOCHICHING					
15-19	937	104	11.1	140	14.9
20-29	1,027	202	19.7	397	38.7
30-44	1,339	179	13.4	347	25.9
15-44	3,303	485	14.7	884	26.8
LAC QUI PARLE					
15-19	566	71	12.6	96	17.0
20-29	399	128	32.0	185	46.3
30-44	650	163	25.1	253	38.9
15-44	1,615	362	22.4	534	33.1
LAKE					
15-19	770	46	6.0	116	15.1
20-29	806	70	8.7	240	29.8
30-44	1,135	112	9.9	317	27.9
15-44	2,711	228	8.4	673	24.8
LAKE OF THE WOODS					
15-19	211	30	14.4	47	22.1
20-29	189	40	21.2	71	37.7
30-44	275	61	22.3	114	41.3
15-44	675	131	19.4	232	34.4
LE SUEUR					
15-19	1,076	76	7.1	136	12.6
20-29	1,286	159	12.4	322	25.0
30-44	1,616	173	10.7	404	25.0
15-44	3,978	408	10.3	862	21.7
LINCOLN					
15-19	377	46	12.1	59	15.7
20-29	300	114	38.0	158	52.5
30-44	495	141	28.4	213	43.1
15-44	1,172	301	25.7	430	36.7
LYON					
15-19	1,310	143	10.9	261	19.9
20-29	2,116	381	18.0	599	28.3
30-44	1,686	258	15.3	445	26.4
15-44	5,112	782	15.3	1,305	25.5

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
MC LEOD					
15-19	1,413	106	7.5	189	13.4
20-29	2,152	228	10.6	454	21.1
30-44	2,408	296	12.3	513	21.3
15-44	5,973	630	10.5	1,156	19.4
MAHNOMEN					
15-19	313	54	17.4	63	20.0
20-29	228	103	45.2	140	61.4
30-44	325	74	22.8	107	32.8
15-44	866	231	26.7	310	35.8
MARSHALL					
15-19	665	101	15.2	134	20.1
20-29	573	148	25.9	219	38.2
30-44	902	244	27.0	351	38.9
15-44	2,140	493	23.0	704	32.9
MARTIN					
15-19	1,101	78	7.1	140	12.7
20-29	1,230	225	18.3	390	31.7
30-44	1,637	203	12.4	404	24.7
15-44	3,968	506	12.8	934	23.5
MEEKER					
15-19	928	80	8.6	131	14.1
20-29	997	210	21.1	377	37.8
30-44	1,349	279	20.7	457	33.9
15-44	3,274	569	17.4	965	29.5
MILLE LACS					
15-19	809	85	10.5	135	16.7
20-29	801	135	16.9	238	29.7
30-44	1,204	206	17.1	361	30.0
15-44	2,814	426	15.1	734	26.1
MORRISON					
15-19	1,642	204	12.4	307	18.7
20-29	1,425	301	21.1	537	37.7
30-44	1,774	380	21.4	663	37.4
15-44	4,841	885	18.3	1,507	31.1

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
MOWER					
15-19	2,395	187	7.8	287	12.0
20-29	2,404	334	13.9	620	25.8
30-44	2,978	337	11.3	593	19.9
15-44	7,777	858	11.0	1,500	19.3
MURRAY					
15-19	687	91	13.2	120	17.4
20-29	507	115	22.7	183	36.1
30-44	783	177	22.6	278	35.5
15-44	1,977	383	19.4	581	29.4
NICOLLET					
15-19	1,270	135	10.6	166	13.1
20-29	2,965	362	12.2	806	27.2
30-44	1,715	223	13.0	353	20.6
15-44	5,950	720	12.1	1,325	22.3
NOBLES					
15-19	1,243	116	9.3	195	15.7
20-29	1,399	260	18.6	474	33.9
30-44	1,654	296	17.9	516	31.2
15-44	4,296	672	15.6	1,185	27.6
NORMAN					
15-19	492	75	15.3	105	21.3
20-29	365	114	31.2	189	51.7
30-44	671	165	24.6	249	37.1
15-44	1,528	354	23.2	543	35.5
OLMSTED					
15-19	4,315	388	9.0	488	11.3
20-29	10,010	1,051	10.5	1,882	18.8
30-44	8,939	661	7.4	1,296	14.5
15-44	23,264	2,100	9.0	3,666	15.8
OTTER TAIL					
15-19	2,325	244	10.5	358	15.4
20-29	2,262	538	23.8	862	38.1
30-44	3,048	570	18.7	939	30.8
15-44	7,635	1,352	17.7	2,159	28.3

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
PENNINGTON					
15-19	688	80	11.7	116	16.8
20-29	1,094	191	17.5	397	36.3
30-44	960	132	13.8	242	25.2
15-44	2,742	403	14.7	755	27.5
PINE					
15-19	875	95	10.8	120	13.7
20-29	678	124	18.3	244	36.0
30-44	1,231	206	16.7	334	27.1
15-44	2,784	425	15.3	698	25.1
PIPESTONE					
15-19	701	103	14.7	142	20.2
20-29	719	153	21.3	250	34.8
30-44	810	198	24.4	298	36.8
15-44	2,230	454	20.4	690	30.9
POLK					
15-19	1,766	143	8.1	251	14.2
20-29	2,020	366	18.1	596	29.5
30-44	2,279	356	15.6	638	28.0
15-44	6,065	865	14.3	1,485	24.5
POPE					
15-19	547	38	7.0	61	11.2
20-29	406	83	20.5	123	30.4
30-44	756	134	17.7	221	29.2
15-44	1,709	255	14.9	405	23.7
RAMSEY					
15-19	23,097	1,224	5.3	1,963	8.5
20-29	52,060	4,842	9.3	8,434	16.2
30-44	39,117	2,308	5.9	5,007	12.8
15-44	114,274	8,374	7.3	15,404	13.5
RED LAKE					
15-19	278	36	12.8	47	17.0
20-29	237	59	24.7	82	34.4
30-44	320	87	27.1	115	36.0
15-44	835	182	21.8	244	29.2

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
REDWOOD					
15-19	995	120	12.1	171	17.2
20-29	926	199	21.5	330	35.6
30-44	1,270	240	18.9	377	29.7
15-44	3,191	559	17.5	878	27.5
RENVILLE					
15-19	1,094	125	11.4	175	16.0
20-29	860	189	22.0	345	40.1
30-44	1,370	248	18.1	448	32.7
15-44	3,324	562	16.9	968	29.1
RICE					
15-19	2,310	148	6.4	231	10.0
20-29	4,804	567	11.8	1,153	24.0
30-44	2,799	299	10.7	543	19.4
15-44	9,913	1,014	10.2	1,927	19.4
ROCK					
15-19	642	66	10.3	96	15.0
20-29	662	95	14.3	169	25.6
30-44	769	127	16.5	224	29.1
15-44	2,073	288	13.9	489	23.6
ROSEAU					
15-19	595	57	9.5	96	16.2
20-29	534	110	20.6	199	37.2
30-44	774	145	18.7	249	32.2
15-44	1,903	312	16.4	544	28.6
ST. LOUIS					
15-19	11,032	938	8.5	1,456	13.2
20-29	16,789	2,468	14.7	4,583	27.3
30-44	15,162	1,592	10.5	3,366	22.2
15-44	42,983	4,998	11.6	9,405	21.9
SCOTT					
15-19	2,093	88	4.2	184	8.8
20-29	2,838	227	8.0	440	15.5
30-44	3,540	301	8.5	658	18.6
15-44	8,471	616	7.3	1,282	15.1

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

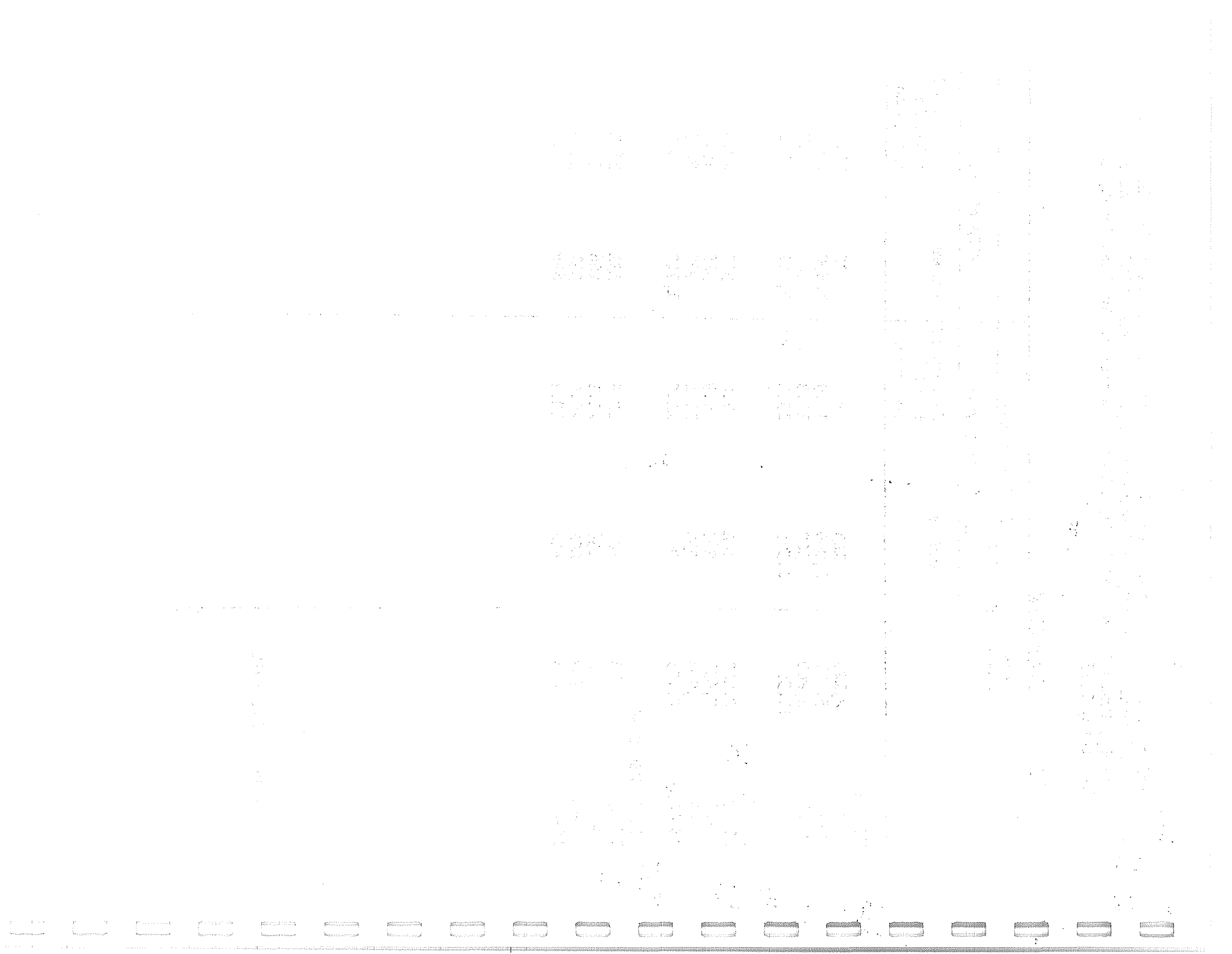
County and age	Women 15-44				
	Total Number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
SHERBURNE					
15-19	1,087	88	8.1	146	13.4
20-29	1,617	212	13.1	395	24.4
30-44	1,770	168	9.5	375	21.2
15-44	4,474	468	10.5	916	20.5
SIBLEY					
15-19	825	63	7.6	94	11.4
20-29	807	109	13.5	195	24.2
30-44	1,175	241	20.5	372	31.7
15-44	2,807	413	14.7	661	23.5
STEARNS					
15-19	5,752	569	9.9	920	16.0
20-29	11,429	2,194	19.2	3,566	31.2
30-44	6,283	1,162	18.5	1,985	31.6
15-44	23,464	3,925	16.7	6,471	27.6
STEELE					
15-19	1,525	113	7.4	191	12.5
20-29	1,975	209	10.6	494	25.0
30-44	2,190	217	9.9	473	21.6
15-44	5,690	539	9.5	1,158	20.4
STEVENS					
15-19	599	75	12.6	100	16.7
20-29	1,046	303	29.0	449	42.9
30-44	694	117	16.9	205	29.5
15-44	2,339	495	21.2	754	32.2
SWIFT					
15-19	687	92	13.4	137	20.0
20-29	540	146	27.0	226	41.8
30-44	813	198	24.4	296	36.4
15-44	2,040	436	21.4	659	32.3
TODD					
15-19	1,159	185	16.0	250	21.6
20-29	970	311	32.1	413	42.6
30-44	1,507	449	29.8	613	40.7
15-44	3,636	945	26.0	1,276	35.1

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤150% of poverty		≤200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
TRAVERSE					
15-19	329	31	9.3	55	16.7
20-29	244	58	23.6	88	36.1
30-44	403	82	20.4	125	31.1
15-44	976	171	17.5	268	27.5
WABASHA					
15-19	917	81	8.8	120	13.1
20-29	885	123	13.9	241	27.2
30-44	1,223	212	17.3	338	27.6
15-44	3,025	416	13.8	699	23.1
WADENA					
15-19	700	72	10.3	98	14.0
20-29	638	175	27.4	256	40.1
30-44	832	171	20.6	264	31.7
15-44	2,170	418	19.3	618	28.5
WASECA					
15-19	882	51	5.8	86	9.8
20-29	1,020	110	10.8	247	24.2
30-44	1,234	155	12.6	283	22.9
15-44	3,136	316	10.1	616	19.6
WASHINGTON					
15-19	5,815	244	4.2	407	7.0
20-29	6,400	371	5.8	877	13.7
30-44	11,307	644	5.7	1,594	14.1
15-44	23,522	1,259	5.4	2,878	12.2
WATONWAN					
15-19	667	58	8.7	95	14.3
20-29	668	71	10.7	146	21.9
30-44	941	190	20.2	310	32.9
15-44	2,276	319	14.0	551	24.2
WILKIN					
15-19	490	67	13.6	94	19.2
20-29	496	86	17.4	166	33.4
30-44	598	148	24.8	218	36.4
15-44	1,584	301	19.0	478	30.2

Projected Number of Women Aged 15-44 and Estimated Number of Low-Income (≤150 Percent of Poverty) and Low and Marginal Income (≤200 Percent of Poverty) Women in Need of Family Planning Services, for Each County in Minnesota, 1975

County and age	Women 15-44				
	Total number	Estimated need			
		≤ 150% of poverty		≤ 200% of poverty	
		Number	Percent of total in age group	Number	Percent of total in age group
WINONA					
15-19	2,126	183	8.6	308	14.5
20-29	5,371	1,069	19.9	1,590	29.6
30-44	2,860	323	11.3	649	22.7
15-44	10,357	1,575	15.2	2,547	24.6
WRIGHT					
15-19	2,347	164	7.0	303	12.9
20-29	2,655	263	9.9	515	19.4
30-44	3,703	533	14.4	922	24.9
15-44	8,705	960	11.0	1,740	20.0
YELLOW MEDICINE					
15-19	813	104	12.8	131	16.1
20-29	644	136	21.1	226	35.1
30-44	989	204	20.6	341	34.5
15-44	2,446	444	18.2	698	28.5



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