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The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible?

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Background: During the 1990s the rates of pregnancy, birth and abortion among adolescents in the United States have declined. Taken in composite, these declines are the first in several decades. The question remains: What factor or factors are most responsible for the declines?

Approach: The data on adolescent pregnancy and birth rates, abortion, contraceptive use, and sexual behavior and attitudes were analyzed in order to ascertain correlation and possible cause-and-effect relationships.

Findings: The specific factors and the exact interrelationship of the factors responsible for the decline in teen pregnancy, birth and abortion rates cannot be precisely determined. However, the contention that these declines are due to increased contraceptive use by teenagers does not withstand critical analysis and review. Out-of-wedlock birthrates to sexually experienced female teens rose 29% from 1988 to 1995, despite a 33% increase in the use of condoms at last intercourse.

Decreased rates of pregnancy, abortion and births among the entire adolescent cohort seem to correlate with a corresponding decrease in teenage sexual activity. Because of the difficulty in precisely determining the cause of these positive trends, the issue as to why adolescents have become increasingly involved in abstinent behavior should be the subject of further study.

Summary: Abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for the decline during the 1990s in adolescent pregnancy, birth and abortion rates. Attributing these declines to increased contraception is not supported by the data. Intervention programs focused on abstinence may have significantly contributed to the decline in sexual activity, but further research is needed to test this hypothesis.

Background

Beginning in the 1960s and 1970s, various statistical measures confirmed a dramatic increase in sexual activity by adolescents as reflected by the consequences.

- The birthrate among unmarried females aged 15 to 19 years increased 90% from 22.4 per 1,000 in 1970 to 42.5 per 1,000 in 1990.
- The abortion rate among females aged 10 to 19 years rose 94% from 9.7 per 1,000 in 1972 to 18.8 in 1990.

With few period-to-period exceptions through the late 1980s, these consequential statistics reflected a steady increase in teens having sex. However, in recent years the trend in the measures of these consequences has begun to moderate and even reverse.

The birthrate declined 4.2 percent for unmarried female teens and 11.9 percent for all female teens from 1991 to 1996 (Table A).

Table A	1991	1996	% change
Birthrate per 1,000 females aged 15 to 19			
Total	62.1	54.7	-11.9%
Unmarried	44.8	42.9	-4.2%

Abortions were not responsible for the drop in the birthrate. In fact, rate of abortions for teens dropped during a similar period (Table B).

Table B	1990	1995	% change
Abortion rate per 1,000 females aged 10 to 19 years	18.8	13.5	-28.2%

Correspondingly, the rate at which teenagers became pregnant fell 9.1 percent between 1992 and 1995 (Table C).

Table C	1992	1995	% change
Teenage pregnancy rate per 1,000 females	99.7	90.6	-9.1%

An Increase in Contraception?

Immediately after the data above were released in May and June of this year, advocates of safer-sex programs pointed to increased condom use by teens as a principle reason for the declines in pregnancy and birth rates. Consider the following:

"Contributing to this decline in [birthrates] are indications that... sexually active teenagers are more likely to use contraception." Centers for Disease Control
"Those [teens] who do have sex are using contraceptives more reliably." Washington Post
"Their [female teens] likelihood of pregnancy has decreased. Increases in contraceptive use by adolescent females contribute to this change." HHS
"Increased contraceptive use-especially condoms- was a major factor in the decline of unintended pregnancies." NARHP

And their claims were not without some statistical support. After all, condom use at last intercourse increased significantly by both teenage males (+21%) and females (+33%) from the late 1980s through the mid 1990s (see Table D). Condom use increased even more among specific high-risk teenage demographic groups, such as black females, a cohort that also experienced a significant increase in the use of Norplant and Depo-Provera.

The decline in pregnancy and birth rates and increase in condom use led to the premature conclusions that total contraception rates increased and were responsible for the declining birthrates. But, in matters of statistical and behavioral research, formulating conclusions during the initial review of data is a careless practice.

Contraception-Use Rates Have Not Increased

A more complete review of sexual practices by teenagers from 1988 to 1995 is not compatible with the view that contraception-use rates increased. Total contraception-use rates not only did not increase- the data indicate that they may have actually declined slightly (Table D).

		1988			1995		
Table D Contraceptive use during last intercourse by sexually active teens	Condoms	Oral	Combined	Condoms	Oral	Combined	Change in combined contraceptive use, '88 to '95
Males, 15-19 (and partner)	53%	37%	90%	64%	28%	92%	+2.2%
Females, 15-19 (and partner)	27%	42%	69%	36%	23%	59%	-14.5%

In order to compare 1995 with 1988, the data for oral and condom contraceptive use was added in Table D to yield combined contraceptive use at last intercourse. This calculation includes only oral and condom contraceptives for two reasons. First, these two methods represent the dominant contraception of choice by teens in both comparison years. Second, data for injectable and implantable contraception is not available for 1988.

The combined data show that while condom use did increase, the rise was more than offset by a decrease in the use of oral contraceptives. From 1988 to 1995, sexually active adolescents females increased their use of condoms at last intercourse by 33 percent (36% vs. 27%), but decreased their use of oral contraceptives by 45 percent (23% vs. 42%).

Thus, these females were 14.5 percent less likely to use condoms or oral contraception in 1995 compared to 1988. This fact led Joyce Abma from the National Center for Health Statistics and Freya L. Sonenstein from the Urban Institute to make the following statement:

"Between 1988 and 1995 there has been little change in the proportion of currently sexually active teens reporting that they used no method of contraception at the last intercourse."

This combined calculation ignores two factors that could influence the data on the proportion of female teens protected against pregnancy.

The first factor is that the combined calculation assumes no dual use. But, dual use at last intercourse among never-married young people aged 14 to 19 is relatively small at 5.8 percent of females and 4.1 percent of males. Further, the combined calculation was performed in the same manner for both 1988 and 1995. Therefore, combined data without an adjustment for dual use is valid as a relative comparison of contraceptive use in 1995 to 1988.

The second factor is that injectables/implantables are not included in the combined calculations. However, even if the use of injectable/implantable contraception was included for this cohort on Table D (7% usage rate at last intercourse in 1995}, total contraception use still fell.

The decline in the use of contraception by female teens has been confirmed in other research literature. In the January/February 1998 issue of Family Planning Perspectives ("Trends in Contraceptive Use In the United States: 1982-1995," Table 1), authors Piccinino and Mosher included data that indicate a slight drop from 1988 to 1995 in the proportion of sexually experienced U.S. females aged 15-19 reporting use of any method of contraception. The data on Table E show that the use of any method of contraception (including injectables and implantables) by sexually experienced female teens dropped from 61.0 to 60.1 percent.

Table E	1988	1995
A. Percent of all females aged 15 to 19 currently using any contraceptive method	32.1%	29.8%
B. Percent of females aged 15 to 19 who are sexually experienced	52.6%	49.6%
C. Proportion of sexually experienced females aged 15 to 19 who are using any method (C=A/B)	61.0%	60.1%

Safer-sex advocates may claim that even without a net increase in contraceptive use teens are better protected against the risk of pregnancy because of the effectiveness of injectables/implantables. But it is important to note that the sizable shift from oral contraception to condoms represents a shift to less efficacious protection against pregnancy.

It is possible to statistically calculate the change in protection from pregnancy among female teens by the switch from oral contraception to condoms and injectables/implantables. To make this calculation it is necessary to factor the percentage

of teens using different methods of contraception by the accepted levels of effectiveness for each method.

Table F provides a risk-adjusted contraceptive protection index. For example, in 1988, 69 percent of sexually active females aged 15 to 19 used condoms and/or oral contraception at last intercourse. But adjusted for method effectiveness, the percentage index dropped to 65 percent. Using the same formula for 1995, the percent of the cohort using contraception (including l/l) dropped from 66 percent to 61 percent after the adjustment for effectiveness.

Table F Sexually Active Females 15-19	Condom	1988 Oral	l/l	Total	Condom	1995 Oral	l/l	Total
A. % usage at last intercourse	27%	42%	N/A	69%	36%	23%	7%	66%
B.Method effective ness	85%	99%			85%	99%	99 %	
C. Hypothetic al Protection Index (C=AxB)	23%	42%		65%	31%	23%	7%	61%

Thus, the use of injectable/implantable contraception in 1995 did not offset the reduced protection represented by the switch from birth control pills to condoms. This is yet another reason why contraception would not account for reduced pregnancy and birth rates.

In summary, based on lower reported contraceptive use and a switch to a less effective prevention method (condoms vs. oral), sexually active adolescent females in 1995 were less protected against pregnancy than in 1988. The claim that the drops in pregnancy, birth and abortion rates are due to increased contraceptive use is inconsistent with the data.

Non-Marital Birthrates Among Sexually Experienced and Active Teens Have Risen Sharply

The out-of-wedlock birthrates to sexually experienced female teens (have ever had sex) and sexually active teens (sex in past 3 months) have increased sharply during the 1990s.

To calculate the birthrate among adolescents, the government uses the total number of births by female teens as the numerator and the total number of female teens

as the denominator. This formula is misleading because it does not recognize that abstinent female teens do not become pregnant.

The convention of reporting on birthrates within the entire cohort of 15 to 19 year-old females has masked the steady increase in the out-of-wedlock birthrate among sexually experienced and sexually active teens.

A more revealing way to consider the data is to calculate the out-of-wedlock birthrate among sexually experienced and sexually active female teens. This calculation would allow researchers to more accurately determine the impact of national interventions aimed at reducing non-marital births.

Table G shows the out-of-wedlock birthrate to sexually experienced females aged 15 to 19. The birthrates per 1,000 unmarried females, aged 15 to 19, are from the National Center for Health Statistics. The percent of females 15 to 19 who have had premarital sex is from the National Survey of Family Growth. See footnote (a) for a more complete discussion on calculating birthrates to sub-groups of teens.

This calculation shows that the long-term trend of out-of -wedlock birthrates to sexually experienced female teens has increased substantially during the 1990s. Based on this data, the out-of-wedlock birthrate to sexually experienced females aged 15 to 19 increased 41.8 percent from 1976 to 1995 and 29.3 percent from 1988 to 1995.

Table G Year	Birthrate per 1,000 unmarried females aged 15 to 19	% of females 15 to 19 who have had premarital sex (sexually experienced)	Non-marital birthrate per 1,000 sexually experienced females 15 to 19
1976	24,6	39.0%	63.1
1982	28.7	45.2%	63.5
1988	36.4	52.6%	69.2
1995	44.4	49.6%	89.5
Percent change '76 to'95 '88 to '95			+41.8% +29.3%

a) The calculation of non-marital birthrates to sexually experienced female teens was performed by using the total out-of-wedlock birthrate to females aged 15 to 19 as the numerator and the proportion of female teens who reported premarital sex as the denominator. For example, the non-marital birthrate of 89.5 per 1,000 sexually experienced female teens in 1995 was calculated by dividing 496 (number of female teens per 1,000 who reported premarital sex) into 44.4 (births per 1,000 unmarried females aged 15 to 19).

The birthrate to sexually active female teens were calculated in the same manner.

For a more complete discussion on calculating birthrates by adolescent sub-groups, see the discussion in the article "The Decline in US Teen Pregnancy Rates, 1990-1995," Pediatrics, Vol.102, No.5, November 1998.

The Pediatrics article concluded that the pregnancy, abortion and birthrates among sexually experienced and sexually active teens have held steady or declined significantly since the 1980s. However, authors Kaufmann, et al. used data for all teen births. The calculation of out-of-wedlock birthrates among sexually experienced and sexually active teens, as shown herein, leads to a dramatically different conclusion.

Table H shows the same analysis for sexually active females, aged 15 to 19.

Table H Year	Birthrate per 1,000 unmarried females aged 15 to 19 (Entire teen female cohort)	% of females 15 to 19 who are sexually active (sex in past 3 months)	Non-marital Birthrate per 1,000 sexually active females 15 to 19
1988	36.4 (53.0)	42.7%	85.2
1995	44.4 (56.8)	39.7%	111.8
Percent change '88 to '95			+ 31.2%

Based on this data, the out-of-wedlock birthrate to sexually active females aged 15 to 19 increased 31.2% from 1988 to 1995.

The increases shown in Tables G and H occurred despite sharply higher condom usage, as illustrated in Graph 1.

From 1982 to 1995, the out-of-wedlock birthrate per 1,000 sexually experienced females aged 15 to 19 increased 40.9 percent, from 63.5 to 89.5 (Table G).

During the same time span the proportion of teenage females who reported using contraceptives increased their use of condoms 76 percent (from 21% to 37%). The implications of the data in Table G and H and Graph 1 should not minimized- out-of-wedlock birthrates have increased among sexually experienced and sexually active female teens despite an increased use of condoms.

It should be noted that the proportion of female teens who reported premarital sex was used as a proxy for unmarried female teens in Table G. It is possible that some females who reported having had premarital sex were married at the time of reporting.

However, the authors believe that the use of specific data limited to never-married female teens would not significantly alter the results shown. This is because (1) the proportion of married teens in this age category is low (4.5% in 1995 NSFG), and (2) the proportion of never-married female teens who have ever had sex is not much different than the proportion of all teens who have ever had sex.

For example, in 1995, 48.1 percent of never-married female teens reported having had sex compared to 50.4 percent of all teens. So while the exact calculations of out-of-wedlock birthrates to sexually experienced and sexually active female teens might change if a pure data set limited to never married teens was used, the pattern of the results would remain the same. The authors encourage other researchers to further expand the study of out-of-wedlock birthrates.

Declining Sexual Activity Rates

Obviously, programs in safer-sex education and condom distribution have not reduced out-of-wedlock birthrates among sexually experienced teens. On the other hand, there has been a decrease in the overall teen birthrate. The following data suggest reasons why. Tables I and J confirm that more teens are choosing abstinence.

Table I % teens 15-19 who have ever had sex	1988	1995	% change '95 vs. '88
Never-married Males-NSAM	60.4%	55.0%	-8.9%
Females-NSFG	52.6%	49.6%	-5.7%

Table J % high school teens 15-19 who have ever had sex	1990	1997	% change '97 vs. '90
Males-YRBS	60.8%	48.9%	-19.6%
Females-YRBS	48.0%	47.7%	-.6%

Sexually experienced teen males have become less sexually active and have fewer partners (Table K).

Table K % H.S. teens	1990	1995	1997	% change '97 vs. '90
Had intercourse in past 3 months	39.4%	37.9%	34.8%	-11.7%
Males	42.5%	35.5%	33.4%	-21.4%
Females	36.4%	40.4%	36.5%	+.3%
Had four or more partners-	19.0%	17.8%	16.0%	-15.8%
Males	26.7%	20.9%	17.6%	-34.1%
Females	11.8%	14.4%	14.1%	+19.5%

A very strong trend is reflected in Tables I, J and K. The positive correlation between the reductions in teen sexual activity and teen pregnancy rates may be mostly due to more abstinent behavior by male, rather than female, adolescents. From 1990 to 1997 there was a 19.6 percent decline in the proportion of adolescent males who have ever had sex compared to a .6 percent decline among adolescent females (Table J). From 1990 to 1997 there was a 21.4 percent drop in the proportion of adolescent males who have had sex in the past three months compared to a .3 percent increase among adolescent females (Table K). And, from 1990 to 1997 there was a 34.1 percent decline

in the proportion of adolescent males who have had four or more partners compared to a 19.5 percent increase among adolescent females (Table K). So while the percent of all female teens who have ever had sex has declined, those females remaining sexually active have become increasingly promiscuous. A discussion of this phenomenon is not within the scope of this paper, but should be the subject of further study.

Promotion of Abstinence

Tables I, J and K show that there has been a significant overall decline in teen sexual activity from 1988 to 1995 and beyond, simultaneous with an overall decline in teen pregnancy, birth and abortion rates (Tables A, B, and C). Increased condom use has been invoked to explain the latter, yet increased condom use is outweighed by a shift away from using more efficacious oral contraceptives. Tables G and H show that the non-marital birthrate to sexually experienced and sexually active female teens actually increased sharply from 1988 to 1995.

Thus we find it more reasonable to suggest reduced sexual activity as the hypothesis capable of explaining reduced pregnancy, birth and abortion rates. In fact, the decline in the overall birthrates among adolescents females during the 1990s is due primarily to teens that have never had sex or are not currently having sex.

Abstinence-only programs may be playing an increasing role in bringing about reduced teen sexual activity. In the remainder of this publication, therefore, we present: 1.) Observations on the history and nature of abstinence programs; 2.) Societal factors that support the choice of abstinence; and 3.) Promising preliminary results of abstinence-only programs.

1.History and Nature of Abstinence Programs

Abstinence component of comprehensive sexuality programs. In the early 1990s comprehensive sexuality programs began emphasizing abstinence as the preferred choice for teenagers. Such programs are called "abstinence-based" While abstinence-only advocates accuse abstinence-based education of sending a confusing dual message, it is likely that the abstinence component has influenced some adolescents. All of this raises a very interesting question: If comprehensive sexuality education has contributed to the decline in teen pregnancy, might it be due primarily to the abstinence component? This is a very real possibility since, as shown earlier in this research study, contraceptive use is not associated with reduced unintended out-of-wedlock births.

Abstinence-only programs. There has been an explosive growth in privately funded abstinence-only programs during the 1990s. An indication of that growth is shown in Table L.

Table L Abstinence-only category	# of students reached 1986	# of students reached - 1989	# of students reached- 1997
Pledge card based	0	0	750,000
Crisis pregnancy centers	12,164	69,918	620,250
Private curriculum/speakers	234,950	572,656	1,676,032
Total	247,114	642,574	3,046,282

As a result, there has been a 12-fold increase in the number of teens reached by privately funded abstinence programs in the span of a decade.

Opponents of abstinence-only programs point out that the effectiveness of such programs has not been documented. This may be based more on philosophical opposition to the abstinence-only message than on an objective consideration of all the facts. Accordingly, four observations are worthy of note.

First, very little research has been conducted on abstinence-only programs. Douglas Kirby in his booklet "No Easy Answers" stated that "more research should be done on these programs...very few such programs have been well evaluated, and, thus there is little evidence to determine whether or not abstinence-only programs can delay intercourse." In other words, the jury is still out.

Second, the abstinence-only programs that have been evaluated in peer-reviewed research journals have been very narrowly defined in scope and low in intensity. An example is an abstinence program in Philadelphia recently declared as ineffective in JAMA. The entire abstinence message therein studied was delivered during just two Saturday sessions. Researchers have concluded that any intervention program, in order to be effective, must be multifaceted and of adequate intensity and duration.

Third, some of the abstinence programs that have been evaluated do not meet the standards set by abstinence-only education experts. An example is Education Now and Babies Later (ENABL), the well publicized program in California. ENABL was a limited scope program. But more importantly, ENABL was never fully endorsed by abstinence-only education experts. From the onset, abstinence-education advocates did not acknowledge ENABL as a true abstinence program because of its limited duration, use of values-clarification methods and reliance on teachers who were not trained in or did not philosophically agree with an abstinence-only message.

Philosophical buy-in by teachers to a message correlates highly with the impact of the message upon students. In a 1994 study researchers reported "that teachers are a vital and important ingredient in the successful implementation of these programs [meaning] that an abstinence sex education program may succeed or fail not simply because of the merit of the program but because of the lack of either teacher commitment to implementation or support for the program objectives or both.

Finally, abstinence-only advocates also claim that a much higher standard of research protocol is applied to abstinence-only programs than to comprehensive sexuality programs. One example of this apparent double standard is the research on condom

availability in Los Angeles area high schools. In that study there was a 41 percent pre-to-post test participant-dropout rate due to parental opposition.

Another example of the double standard is the Center for Disease Control's "Programs That Work" initiative. "Programs That Work" features five interventions that CDC claims are quite effective. Not one of the five has data measuring a reduction in teen pregnancy or STD rates. Yet, these programs were developed to reduce pregnancy and STD rates.

2.Societal Factors That Encourage Abstinence

A number of societal factors also encourage abstinence.

HIV/AIDS Education. Perhaps not since the polio crisis of the 1950s has the national consciousness on a medical issue been so raised as it has been for HIV/AIDS. Almost all teens now receive instruction on HIV/AIDS: 92 percent of males and 94 percent of females. The HIV/AIDS scare has likely impacted the sexual behaviors of many adolescents. in favor of abstinence.

Instruction on Refusal Skills. As equally common among females as HIV/AIDS information is instruction on how to say "no" to sex. In fact, 93 percent of adolescent females received instruction on refusal skills in 1995. Three quarters of adolescent males received similar instruction.

Generational Changes in Attitudes. There are several theories of generational sociology. One view holds that generational history is seamless-each new generation simply builds upon the foundation established by its predecessors. Another view holds that generational history is cyclical- attitudes abandoned by one generation often reappear after a skip of two or more generations. If the latter theory is true, then the recent declines in teen sexual activity may, in some part, be due to generational factors. Teenagers today could be rejecting the view of sexual behavior held by their baby-boomer parents (who are widely credited with the sexual revolution of the 1960s and 70s) in favor of the traditional view held by today's more senior citizens. If this observation is valid, then an unambiguous abstinence message should be quite well received by the next few generations.

A recent article in Family Planning Perspectives confirms the link between more conservative attitudes among teens and declining sexual activity rates. In the article, "Understanding Changes in Sexual Activity Among Young Metropolitan Men: 1979-1995," authors Ku, et al. state "More permissive attitudes about premarital sex were far less likely to have had sex recently than were those who approved of it." The study also demonstrates that "religiosity is part of reason for the shift in attitudes."

The article suggests that these attitudinal "changes reflect a growing trend and not merely a unique fluctuation in the sexual beliefs of American youth."

Generational Societal Attitudes. There have been a number of studies in recent years showing that society in general has embraced an abstinence-until marriage viewpoint.

A survey of nearly 4,980 people by Wirthlin Worldwide found that 71 percent of the national respondents believe couples should wait to have sex until marriage. A New York Times poll found that nearly half of teens polled said sex before marriage is always wrong. In an Emory University survey of 1,000 sexually active teen girls, 84 percent said they would like to learn how to say no to sex. In a 1994 Roper-Starch study, 54 percent of students who have already tried sex indicated they should have waited. In a study commissioned by the National Campaign to Prevent Teen Pregnancy, 95 percent of both adults and teens stated that it is important for high school students to be given a strong abstinence message from society.

3. Promising Results of Abstinence-Only Programs

There is increasing evidence that an unambiguous abstinence message shows promise in changing the behavior of teens.

Add Health Study. The September 10,1997 issue of JAMA published an article on the first wave of findings from the National Longitudinal Study on Adolescent Health (Add Health)-the most extensive study on adolescent risk behavior ever conducted. The study showed that the factor most strongly associated with a delay in the onset of sexual activity was a pledge of abstinence. In fact, the pledge of abstinence was three times more strongly associated with a delay in sex than the next most positively correlated factor. A pledge of abstinence is the cornerstone of a program popular among many church youth groups called True Love Waits. Nearly 16 percent of all female teens and 10 percent of all male teens have signed pledge cards and joined peer support groups through True Love Waits and similar programs.

Simply signing a pledge of abstinence-in and of itself-is probably not the sole reason signers significantly delay sexual activity. There are likely a number of familial, religious and personal risk-protective factors that lead an adolescent to sign the pledge. Nevertheless, the signing itself does represent a point of decision and commitment, which the Add Health data show is highly significant as a singular risk-protective factor. Further research is needed to more thoroughly understand the dynamics of the abstinence pledge.

Other factors reported by Add Health as significantly associated with a delay in the age of sexual debut are parental disapproval of adolescent contraception and parental disapproval of adolescent sex.

STARS. "Students Aren't Ready for Sex" began in 1994 as a pilot project in Multnomah County, Oregon in four middle schools that served about 1,000 students. In 1998/99 STARS will reach all but five of Oregon's 36 counties and serve more than 33,000 students through its peer-mentoring abstinence program. In December 1997 the Oregon STARS Foundation contracted with the Oregon Health Policy Institute to evaluate STARS. The evaluation concluded in July 1998. Among the results:

-70 percent of students said STARS helped them decide to abstain from sex.

-77 percent of students said the program helped them understand their personal rights to set limits.

-Rates of sexual involvement among participating middle school students surveyed dropped from 9.7 percent before to 5.3 percent after STARS.

The Michigan Abstinence Partnership. In the early 1990s the State of Michigan began a major campaign called "The Michigan Abstinence Partnership." The partnership has provided communities with technical assistance, education materials and promotional items. Each participating community has developed a coalition which develops and implements unique abstinence activities, such as youth rallies, educational sessions for parents, abstinence curricula, family activity days, recreational events and peer education sessions.

Importantly, the partnership has had a goal of making teen abstinence the culturally accepted norm. The result has been a decline in teen birthrates far exceeding the national average. From 1991 to 1996 the teen birthrate in Michigan declined 19.1 percent from 58.7 to 47.5 births per 1,000 females aged 15 to 19. This compares to a national decline of only 11.9 percent during the same period (see Table A).

Tennessee Study. Of the 10 largest counties in Tennessee with statistics on pregnancy broken-down among black and white adolescents, research indicates that teen pregnancies in the three that taught abstinence-only in schools declined between 14 and 38 percent from 1991 to 1996. By comparison, the four that taught safer-sex education or had no system-wide sex education experienced a maximum decline of only 7 percent.

Table M. Teen Pregnancy Rates in Counties with Populations over 50,000 and Black and White Statistics, 1991 to 1996

County	Sex Ed	1991 (per 1,000)	1996 (per 1,000)	% change
Madison	Abstinence	79.9	49.3	-38.3%
Hamilton	Abstinence	69.6	52.1	-25.1%
Shelby	Abstinence	92.1	79.1	-14.1%
Davidson	Community initiatives	74.3	64	-13.9%
Knox	Mixed Message	46.2	40.5	-12.3%
Summer	Teachers guide	49.2	44.5	-9.6%
Williamson	Safer-sex education	23.9	22.2	-7.1%
Montgomery	Safer-sex education	47.8	45.3	-5.2%
Rutherford	No systematic sex ed	41.0	39.9	-2.7%
Wilson	No systematic sex ed	36.3	36.5	+0.5%

Best Friends. The Best Friends mentoring and abstinence education program in Washington, D.C. has been highly effective. Only 10 percent of Best Friends girls reported having sexual intercourse compared to 37 percent of D.C. middle school girls.

Best Friends girls also were found to have a one-percent pregnancy rate, compared to a 26-percent rate among all high school-aged D.C. girls. Graph 2 reports on other aspects of the effectiveness of Best Friends.

Denmark, SC Community Program. Between 1982 and 1987, a program was implemented in Denmark, SC. The community-based program had multiple components- classroom abstinence education, adult education, motivational speakers, newspaper articles, intensive teacher training, and faith community and civic leadership involvement. Prior to the implementation of the program, the area had an adolescent pregnancy rate of 61 out of every 1,000 adolescent girls aged 14 to 17. In the second and third years of the program, the adolescent pregnancy rate dropped to 25 out of every 1,000 girls, while comparison schools not participating in the program remained at more than twice that rate.

Several years after the completion of the Denmark program, some researchers claimed that the study was flawed because a school nurse had been distributing condoms. In 1998 the U.S. Department of Health and Human Services, which funded the program, reiterated that the community intervention was designed from the onset and funded as abstinence-only and that an official HHS investigation was unable to attribute the decline in the pregnancy rate to the activities of the school nurse. The controversy raises an interesting question: Should the results of a contraceptive-based intervention be invalidated if it is later determined that an abstinence-only message existed within the intervention community?

Conclusion

The evidence points to sexual abstinence, not increased contraceptive use, as the primary reason for the decline in teen pregnancy and birth rates throughout the 1990s. It appears possible that programs aimed at producing abstinent behavior have been more successful than programs aimed at increasing safer-sex practices in reducing unintended births to adolescents. Douglas Kirby, a noted sex education researcher, was prophetic in 1991 when he noted that "it may actually be easier to delay the onset of intercourse than to increase contraceptive practice.

The increase in teen abstinence is likely due to a combination of factors- the HIV/AIDS epidemic, the growth of abstinence-only programs, generational changes and increased cultural acceptance of abstinence.

The authors believe that the correlation between increased condom usage and higher out-of-wedlock birthrates among teens has significant public health policy implications. In 1997/98 a new federal program was implemented to promote an abstinence-only message. The timing of the federal Title V abstinence program seems well placed. Educational and youth programs should increase their emphasis on the abstinence-until-marriage message. Further research should be conducted into what components within an abstinence program contribute most to overall effectiveness.

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A Perspective on the Medical Implications of the Virginity Pledge among Teens

The Physicians Consortium

January 5, 2001

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A Perspective on the Medical Implications of the Virginity Pledge among Teens

John R. Diggs, Jr., M.D.; Hall Wallis, M.D.; Joanna K. Mohn, M.D.; and Kent Jones, M.D., Ph.D.
The Physicians Consortium, January 5, 2001

Background

The January 2001 issue of the *American Journal of Sociology* published the results of an extensive research project on the effect of the virginity pledge in delaying sexual initiation among teens. The paper titled, "Promising the Future: Virginity Pledges as they affect the Transition to First Intercourse," is the result of research conducted by Dr. Peter S. Bearman, Director of the Institute for Social and Economic Research and Policy at Columbia University, and Dr. Hannah Brückner, Assistant Professor of Sociology at Yale University. The data examined by Bearman and Brückner came from the National Longitudinal Study on Adolescent Health (AddHealth)—the most-extensive-ever longitudinal research study of adolescent behavior and the factors that reduce risk-taking by teens.

AddHealth included a question on whether or not teens had ever taken a pledge of virginity. The answer to this question—as well as data gathered on familial, school and social contexts—made it possible for the authors to greatly extend the social scientific understanding of the relationship of the virginity pledge to teen sexual behavior.

The authors found the following:

- *"Adolescents who pledge, controlling for all of the usual characteristics of adolescents and their social contexts that are associated with the transition to sex, are much less likely than adolescents who do not pledge to have intercourse."*
- *"The delay effect is substantial and almost impossible to erase. Taking a pledge delays intercourse for a long time....Pledging decreases the risk of intercourse substantially and independently."*
- *"The pledge effect is not a selection effect. It is real and it is substantial."*

The authors found that the delay in sexual debut among pledgers is very long.

- The median age of transition for non-black female pledgers was 19.9 years, versus 16.7 years for their non-pledging counterparts. At age 19.6 years, only 25 percent of non-black male pledgers had experienced first intercourse. About 25 percent of male non-black non-pledgers had sex by the age of 17.1 years.
- According to the authors, *"For both black females and males, the difference in median age between pledgers and others is slightly above 2 years (27 months)."*

A delay in sexual debut among pledgers remained intact when the authors controlled for all of the usual determinants (factors) associated with the transition to first sex and the determinants associated with pledging. The authors also compared those pledgers and non-pledgers who were still virgin at the time of the second wave of the AddHealth study. Here too, the pledge effect was apparent—non-black pledgers delayed sex about one and a half years longer than did non-pledgers.

The pledge study authors did qualify the pledge effect in several respects.

- *"The pledge identity is relatively fragile and meaningful only in contexts where it is at least partially non-normative."*
- *"The pledge effect is strongly conditioned by age. Pledging does not work for adolescents at all ages. It works the most for younger adolescents."*

- *"The pledge identity is induced and sustained through interacting with other pledgers in the community who distinguish themselves from non-pledgers by their public pledge and commitment to the group. The pledge movement, in this sense, is an identity movement."*

- At first intercourse, pledgers are about one-third less likely to use contraceptives than non-pledgers. [We will discuss this finding below.]

Introduction

At first glance, the finding that pledgers are one-third less likely to use contraception at first intercourse than are non-pledgers would seem to indicate that pledgers are less protected against the risks of unmarried teen childbearing and STDs. Does this decreased condom use among pledge-breakers put all pledgers, as a group, at statistically higher risk for STDs and childbearing? The answer is an unqualified no! As a group, pledgers are at far less risk than are non-pledgers. There are two reasons for this.

1. Pledger-breakers are really not one-third less likely to use contraception at first intercourse.

The finding by the authors of the pledge that pledger-breakers are one-third less likely to use contraception at first intercourse than are non-pledgers might seem to indicate that pledger-breakers are more likely to experience unmarried teen childbearing and STDs.

Pledgers are people who have other characteristics that make them more likely to use contraception at first intercourse. In the complex research model used for the pledge study, the authors quite correctly "washed-out" these characteristics in order to isolate the effect of the pledge itself. So the finding that pledge-breakers are less likely to use contraception is true in what researchers call a "multivariate model." When these characteristics are not "washed-out," and the comparison is just contraception use by pledgers and non-pledgers at first intercourse, it cannot be said that pledgers are one-third less likely to use contraception. In fact, in this context pledgers may be more likely to use contraceptives.

2. The delay in having first intercourse among pledgers has important health implications.

Pledgers experience sexual debut at a significantly older age than do non-pledgers. Whatever the reason for this delay—the pledge itself, certain factors in the lives of pledgers, or a combination of the two—the fact remains that pledgers, as a group, experience first intercourse at an older age. Research exists from which one can make certain inferences regarding the health risks associated with the age of sexual debut. This is the focus of the Consortium's review.

The Perspective of the Physicians Consortium

As practicing physicians, we encounter the results of teenage sexual "experimentation" in the forms of unwed teenage parenthood, pregnancy scares, STDs and requests for abortion. Even many years later, the consequences can be as fatal as AIDS, as permanent as incurable herpes, and as heartbreaking as infertility.

Our conclusion is that it is best for teens to refrain from sexual involvement until marriage. This is not only the best choice from a health perspective, but also for the purpose of a successful marriage. A delay to just a "later age" of sexual initiation is not a satisfactory target for us. Nevertheless, the pledge study research identified a delay in the median age of sexual initiation by pledgers, and this has important health implications.

Teens who begin sex at an earlier age are at greater risk for STD infection for four reasons.

A. An earlier age of first intercourse is linked to a greater number of sexual partners and a greater number of sexual partners is linked to greater STD risk.
B. Condom use generally declines with length of sexual activity.
C. The number of sexual acts unprotected against STDs and teen pregnancy is likely to be greater among teens who begin sex at an earlier age.
D. Contraceptives do not provide significant protection against certain widespread STDs

A. Age of first intercourse and number of sexual partners.

Age of sexual debut is correlated with number of sex partners. Table A compares the median age of sexual debut for pledgers with that of non-pledgers. At the median age, 50 percent of a group has had sex and 50 percent has not. The use of median age as a comparison point is somewhat arbitrary because it represents a slice in time. But, while the difference in the age of debut between pledgers and non-pledgers may be greater or less at different quartiles, the pattern would likely be similar. Pledgers have an older age of sexual debut at every point of comparison.

Table A - Median age of sexual debut for pledgers and non-pledgers, by race and gender

	Pledgers (age in years)	Non-pledgers (age in years)
Females		
Non-blacks†	19.9	16.7
Blacks†	18.6	16.3
All (weighted to pop.) ‡	19.7	16.6
Males		
Non-blacks†*	19.6 (lowest quartile) 20.5 (median age – estimated)‡	17.1 (lowest quartile) 17.4 (median age - estimated)‡
Blacks†	17.7	15.4
All (weighted to pop.) ‡	20.1 (based on median ages)	17.1 (based on median ages)

*The pledge study authors compared the transition for non-black male pledgers and non-pledgers in the lowest quartile because fewer than 50 percent of non-black male pledgers had experienced sexual debut before age 20.
†Data from the pledge study.
‡Data so noted represent calculations or estimates by the Consortium.

From a mature adult's perspective of the world, a teen is not always a rational decision-maker. Any person who has parented teens knows this to be true. For example, what 16-year-old high school sophomore girl does not think that the present love of her life will not always be the love of her life? But we know that high school romances are generally short-lived. Our experience is that many teens who begin sex at an early age will remain sexually active throughout all subsequent relationships. While the teen may view his or her behavior as monogamy (only having sex with someone they "love"), the medical description is nothing short of promiscuity.

Our experience is that teens who begin sex at an earlier age engage in riskier activities. There is research that supports our observation that an early age of debut is strongly correlated with the number of sexual partners. The number of sexual partners, in turn, is correlated with the risk of STD infection.

Non-pledgers, as group, transition to sex at a younger age. This means, for example, that on a median-age basis, non-pledging non-black females have more than three years of sexual experience before non-black female pledgers have their first intercourse. By age 20, non-pledgers are more likely than are pledgers to have had multiple partners.

Table B shows the probability of multiple partners based on age of sexual debut.

Table B – Probability of multiple partners, by age of sexual debut, females 15-44

Age of sexual debut	Females - four or more sexual partners, past 12 months[i]	Females - six or more sexual partners, lifetime-to-date[ii]
17 years (median age of sexual debut for female non-pledgers = 16.6 years, estimate by Consortium)	9.4%	31.9%
20 years (median age of sexual debut for female pledgers = 19.7 years, estimate by Consortium)	3.3%	10.5%

Females who began sex at age 17 were 2.8 times more likely to have had four or more partners in the previous year and three times more likely to have had six or more partners lifetime-to-date than were females who began sex at age 20. The data in Table B is for all females (pledgers and non-pledgers). Some pledgers transition to sex at an age earlier than the median age of debut for non-pledgers just as some non-pledgers transition to sex at an age later than the median age of debut for pledgers. The Consortium believes that the data in Table B might be considered an estimate for pledgers and non-pledgers, relative to their respective median ages of debut.

Table C provides a percent distribution of all 19-year-old teens, by number of lifetime-to-date sexual partners.

Table C – Probability of lifetime sexual partners, all teens, age 19, by gender[iv]		
Number of lifetime partners	All males, age 19	All females, age 19
0[iv]	15%	23%
1	16.4%	22.6%
2 to 3	25.1%	21.4%
4 to 5	10.8%	14.4%
6 or more	32.7%	18.6%

By age 20, about 50 percent of pledgers remain virgins. Contrast this figure with the data on Table C showing that only 15 percent of all males age 19 are virgins and 68.6 percent have had at least 2 partners. For all females age 19, only 23 percent are virgins and 54.4 percent have had at least 2 partners.

The probability of contracting an STD increases with the number of sexual partners. For example, consider chlamydia. Females who acquire an average of about one new partner per year, compared to those who acquire about one new partner every 10 years, are 16 times more likely to contract chlamydia.[v] This is a vitally important statistic given that there are four million new cases of chlamydia per year,[vi] and that chlamydia increases HIV transmission probability by between 3.6- and 5-fold.[vii] Chlamydia is also a major cause of infertility.

B. Condom use declines the longer a teen is sexually active.

We have experienced this time and time again in our practices. Teens are people who believe they will never die or even suffer consequences from bad decisions. They may be very conscientious about using contraception when they first have sex, but over time they tend to throw caution to the wind. The data confirm our observations. A number of research studies indicate that contraceptive use declines with increased sexual experience. One study showed that the proportion of sexually active men ages 17-22 who used a condom with their most recent partner declined from 53 percent the first time they had intercourse with that partner to 44 percent at the most recent episode.[viii] The same study showed that condom use declined in each successive relationship.

Another study showed the likelihood of contraceptive use among women of every age group declined as the number of lifetime partners rose.[ix]

It must be pointed out that only condoms—of all forms of contraception—offer any, albeit inadequate, protection against STDs. So the reduction in condom use over time is a pertinent consideration when determining the risk for STD infection. According to a study by the research firm Child Trends, condom use declines sharply following sexual debut. While 63 percent of females, ages 15-19, reported condom use at first sex, only 28 percent of sexually active females reported condom use at most recent sex.[x]

C. By beginning sex at a younger age, non-pledgers are likely to accumulate many more sexual acts as teens compared to pledgers.

Based on data included in a report by the Alan Guttmacher Institute, the Consortium calculated that the average teen female has about 218 acts of sex during her teen years.[xi] The low condom use at most recent sex means that non-pledgers are at far greater risk for STDs than are pledgers. Based on a rate of 28 percent for condom use at most recent sex, the average non-pledging teen female is likely to have about 157 acts of "unprotected" sex. Despite intensive and expensive campaigns to increase condom use among teens, the use rates are low.

D. Contraceptives do not provide significant protection against certain widespread STDs.

As physicians, we are greatly concerned that all of the talk about "safe sex" will give sexually active teens a false sense of security. Condoms have marginal effectiveness rates against genital herpes (HSV) and chlamydia, and little or no effectiveness against human papillomavirus (HPV). These are the three most common STDs. The sum of these three diseases dwarfs the number of cases of remaining STDs by several orders of magnitude. Consequently, condom use or, non-use, would not be expected to produce an appreciable difference in the occurrence of these STDs.

The major determinants of the acquisition of these diseases are the number of different sexual partners and the prevalence of the diseases within the population. Thus, for these three STDs, non-pledgers are at far greater risk because they begin sex at an earlier age and are more apt to have multiple partners.

Teen birthrates.

Chronologically, teen childbearing is only possible for a teen female who transitions to sexual debut prior to age 19.25 years. After this age, childbearing would occur beyond the teenage years.

According to the pledge study, only 50 percent of female pledgers had transitioned to first intercourse by this benchmark age. In contrast, a study released by the National Campaign to Prevent Teen Pregnancy showed that 77 percent of all 19-year old females were sexually experienced.[xii] Thus, not controlling for other factors (contraceptive use, frequency of sex, and the usual factors associated with transition to first sex and with pledging), non-pledgers, as a group, could be 52 percent more likely to experience unmarried teen childbearing.

Other risky behaviors.

When we find out that a teen patient is sexually active at an early age, often we discover that the teen is involved in additional risky behaviors, such as tobacco or alcohol use. Age of sexual debut is strongly associated with a variety of psychosocial risks. Sexually experienced adolescents are significantly more likely than virginal teens to engage in other risky behavior. For example, non-virginal girls were found to be 10.4 times more likely than were virginal girls to have used marijuana and 6.3 times more likely to have attempted suicide.[xiii] We are offended by the idea that sexually active teens should be given condoms and sent on their way. Not having instruction on and access to condoms are far from the most important things sexually active young people need. The real problem is teen sex, not the non-use of contraception.

Cumulative evidence.

The cumulative evidence is quite weighty: as a class, pledgers have a significantly lower risk for STDs and teen childbearing than do non-pledgers. This is because non-pledgers, as a group, begin sex at a far earlier age than pledgers, as a group. In our practices, we have observed that a teen who begins sex at an early age is very likely to contract an STD or become involved in a non-marital pregnancy.

Optimum Model for Sexual Health

Sexual activity among unmarried teens is a major problem in the United States. The twin epidemics of unwed pregnancy and sexually transmitted diseases (STDs) among teenagers carry enormous social, medical, educational and emotional costs. It is estimated that the direct and indirect cost to society of children bearing children exceeds $29 billion per year.[xiv] Additionally, STDs carry a direct and indirect cost to society of $16.6 billion annually.[xv] The precise proportion of the STD cost attributable to teens or older women who contracted an STD as teens is not known, but is likely sizable.

Teen sexual activity is a highly controversial topic, as might be expected of any major social problem (especially one with a strong moral component). Everyone recognizes the problem, but not everyone agrees about the solution.

Generally, there are two perspectives on addressing the problem. The first view, generically termed "abstinence plus safer-sex" believes that teens must be educated about and provided with condoms and other forms of contraceptives because the overwhelming majority of teens will experiment with sex before marriage.

The second view, called "abstinence until marriage," believes that teens should receive an unambiguous message that sex should be reserved for marriage.

As a group of more than 2,000 physicians who deal daily with the ravages of STDs and teen pregnancy, we see a simple solution: abstinence until marriage with an uninfected partner and monogamy thereafter. This is the lifetime prescription for optimum sexual health.

Our position on the matter of marriage is based on medical experience as well as science. Research overwhelmingly documents the fact that abstinence until marriage is the optimum medical model regarding sexuality. Individuals who remain sexually abstinent until marriage are better off medically, socially, educationally, economically and psychologically than those who have sex outside of marriage. Groups that attempt to discredit abstinence until marriage as a religious message apparently ignore a vast body of science. It is our opinion that those who oppose the concept of abstinence from a medical point of view have been greatly influenced by the fraudulent "research" of Alfred Kinsey, a zoologist who has been completely discredited by mainstream science. As physicians, we are concerned about the health of our patients. Abstinence until marriage to an uninfected partner, and monogamy thereafter, is the optimum health message. This fact is not altered because some people may choose not to marry or others do not believe that sex and marriage should be linked.

The challenge for medical professionals, parents, public health workers, educators and other youth leaders is to create a compelling vision for this goal and direct teens toward it.

There are several significant failings with basing a teen sexual health model on contraceptive and/or condom use.

1. Sexual monogamy, not contraceptive use, is the most direct path for optimum sexual health.
2. Condoms provide marginal protection against the three most prevalent STDs.
3. Condom use rates decrease with age and sexual experience.
4. Teens—by their very nature—are inconsistent and unreliable users of contraception.

The role of the virginity pledge

The Consortium identifies several components that contribute to the pledge's success.

1. The pledge acknowledges that sexual activity is controllable.
2. The pledge places the locus of control upon the individual.
3. The pledge requires a conscious, purposeful decision, in contrast to the "if it happens, it happens" outlook of many teens.

The questions, now, are straightforward. How can we extend the effect of the pledge as we move culture back towards the abstinence until marriage model? What types of programs or messages result in sexual postponement until marriage among teens and young adults?

Research on the virginity pledge is beginning to provide revealing answers.

The pledge of virginity study offers proponents of the abstinence movement much to cheer about. In fact, the entire public and private health community should be greatly encouraged by the pledge study.

Some groups may pronounce that pledgers would be better prepared for sex with more sex education and access to condoms. On the matter of sex education, pledgers presently receive the exact same classes as non-pledgers on such topics as human biology, STDs (including HIV/AIDS) and health. On the matter of condom instruction and availability, the opinion of the pledge study authors is that, *"It is hard not to imagine the dissonance that would arise if they [pledgers] were contraceptively prepared."* The Consortium recognizes that teens who abstain from sex need support to help them to continue to abstain until marriage, rather than having their resolve undermined by messages that may promote sexual activity.

Fans of the pledge movement must also recognize that the pledge study researchers found limitations of the pledge. The pledge effect is complex. Just getting a bunch of kids in a classroom to sign a pledge would ignore where the pledge gets its power. We believe that the pledge would be most effective when there is a supportive social structure. The vision for a successful marriage and family must be instilled by all components of society—parents, educators, youth workers, media, government and others.

All those concerned about teaching adolescents the optimum health model must view the pledge study as a starting point for understanding.

Editor's note: The quotations from the authors are from the draft submitted to the *American Journal of Sociology*. The published paper may be edited from the submitted draft.

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About the Physicians Consortium

The Physicians Consortium is a network organization of nineteen state Physicians Resource Councils (PRCs). State PRCs represent over 2,000 physicians who bring their medical experiences into forums where public opinion is framed and public health policy is formed. Because the physician members have direct clinical care of their patients, they bring a unique and needed perspective to the debate on medically related health policies.

The Physicians Consortium was organized in 1999 to enable state PRCs to speak as one voice on public health issues of national significance.

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Testimony of Matt Sande, Director of Legislative Affairs
Pro-Life Wisconsin (PLW)

Suspension of Emergency Rule re: MA Family Planning Demonstration Project *(Clearinghouse Rule 03-021)*
Joint Committee for the Review of Administrative Rules (JCRAR)
April 30, 2003

Introduction

Good morning Chairman Grothman and committee members. Pro-Life Wisconsin appreciates the opportunity to express our opposition to the Medical Assistance (MA) Family Planning Demonstration Project. We strongly urge suspension of the Department's emergency rule effectuating this program, not only because the rule works to undermine parental authority in the sensitive area of child contraception but also because family planning is not a proven method of reducing underage pregnancies or abortion rates. In fact, a family planning study conducted in Britain and recently published in the Journal of Health Economics indicates that family planning services may have the *opposite* effect of increasing underage pregnancies and abortions by promoting sexual activity. I will highlight the conclusions of this study later in my testimony.

To begin with, Pro-Life Wisconsin questions whether an "emergency" truly exists; certainly this short-term demonstration project is not "necessary for the immediate preservation of the public peace, health, safety or welfare" of Wisconsin. Nevertheless, we would like to point out some concerns about the emergency's rules language specifically and about the effectiveness of family planning generally.

Parental Notification

Several provisions in the emergency rule strongly appear to intentionally eliminate parental notification of an underage child who applies for services under the family planning demonstration project. These provisions also appear to conflict with current law as evidenced by the Legislative Council's Rules Clearinghouse technical analysis of the rule. For example, Section HFS 102.01 (5)(e) of the rule states that the department will determine the eligibility of a person who applies solely for benefits under the family planning demonstration project and is under the age of 18 "without regard to the person's parent or parents." Legislative Council comments that "This appears to conflict with s. 49.45(24r), Stats., which requires that the woman's family income does not exceed 185% of the poverty line for a family the size of a woman's family, and thus generally appears to require taking into account parental income for women who are under the age of 18, regardless of whether the woman is under the care of the parent for the purposes of s.49.19(1), Stats." Legislative Council also points out three other sections of the rule which appear to conflict with current law in a similar manner – by eliminating the need to consider parental income in determining eligibility for minor children.

We are also concerned about section HFS 104.02(7) of the rule entitled "Financial Responsibility of Spouse or Responsible Relative." Under current law, the parent of a Medicaid applicant under the age of 18 "shall be charged with the costs of medical services before MA payments shall be made." However, the rule makes a conspicuous exception for the parent of an applicant under the age of 18 who is eligible for services under the Family Planning Demonstration Project.

We cannot help but conclude that the above provisions appear designed to evade parental notification of underage applicants for the Family Planning Demonstration Project. Whatever the Department's intentions, the rule as drafted effectively eliminates any parental involvement in a minor child's access to family planning services under the project. Pro-Life Wisconsin strongly believes that parents must be involved in the health care of their minor children, especially in the sensitive and consequential area of sexuality.

Contraceptive drugs and devices pose serious health risks to women. For example, the standard birth control pill, which is an oral drug consisting of synthetic hormones (progestin and estrogen), has been proven to produce blood clotting defects. These have resulted in thrombophlebitis (a vein inflammation related to a blood clot), pulmonary embolisms (blood clots which lodge in the lung and may be fatal), strokes, heart attacks and blindness. A more complete listing in the FDA patient warning brochure lists 18 other diseases or health problems that have been associated with the Pill, including cancer. The mortality risks for taking the Pill are higher than those for pregnancy. The Pill also offers no protection against sexually transmitted diseases including AIDS.

One need only read the patient package insert included with the Pill to verify its health risks. Some of the side effects include:

- Bacterial infections and increased susceptibility to the AIDS virus (HIV), because the Pill weakens the immune system;
- Pelvic inflammatory disease (an infection of the Fallopian tubes that can sickness or sterility);
- Infertility;
- Cervical cancer;
- Breast cancer;
- Endometrial atrophy (shrinking of the womb)
- Ectopic pregnancy;
- Mood swings and depression;
- Weight gain.

In sum, what parent would not want to know that their minor child is ingesting such potentially life threatening drugs? Should we not ensure that moms and dads are involved in the sexual health of their sons and daughters, not to mention their moral development? The very least we can do as a state is to respect parental authority; to recognize the love and concern that parents have for the children. To do otherwise is to adopt a very cynical, and threatening, attitude toward parents.

The Paton Study

Dr. David Paton of Nottingham University Business School in the United Kingdom recently authored a study entitled, "The Economics of Family Planning and Underage Conceptions." Published in the March 2002 issue of the prestigious Journal of Health Economics, the study's conclusions debunk Planned Parenthood's theory that the provision of contraceptives to teens will reduce underage pregnancies.

Paton, a senior lecturer in industrial economics, investigated the impact of family planning on teenage conceptions and abortions by testing data from 16 UK regions over a 14-year period. The focal aim of Paton's research was to explore the impact of the 1984 "Gillick ruling" which drastically reduced attendance by teen-agers at family planning clinics in the UK until it was overturned. It did so by forcing health professionals to inform parents before providing contraceptives to females under the age of 16 (the UK age of consent). Paton explained that "This ruling provided us with a useful natural experiment involving a change in public policy." Contrary to forecasts, the Gillick ruling did not lead to an increase in underage pregnancies.

Paton stated in a press release that, **"My research casts serious doubt on current government policy. Over the past few years, we have had a massive expansion in family planning services for young people in the UK, yet there is no evidence that this has reduced either underage pregnancy or abortion rates. Although family planning may make sexually active teenagers less likely to get pregnant, it seems that is also encourages others to start having sex. Some of these will get pregnant through contraceptive failure and, *if anything, the overall effect of expanding family planning services for under-16s has been to increase pregnancies and abortion.*"** (press release, Nottingham University, 2/27/02)

Specifically, the study itself concludes that:

> "Using a range of specifications, I find no evidence that greater access to family planning has reduced underage conceptions or abortions. Indeed, there is some evidence that greater access is associated with an increase in underage conceptions in our sample."

The study also emphasizes that:

> "Socio-economic factors are found to be important predictors of underage conception and abortion rates. Rates of unemployment and children in statutory care are positive predictors of underage conception, while participation in post-compulsory education is a negative predictor...(Therefore) measures which improve educational and work prospects of those groups most at risk seem likely to help achieve the stated aim of reducing underage conceptions."

By providing contraceptives to children, family planning clinics have helped fuel teen sexual activity, which leads to pregnancy and abortion. Other studies have shown that greater availability of contraception is linked to increased rates of abortion. **In Maryland, for example, the first state to enact a contraceptive insurance mandate, the number of abortions rose by 1,226 the year after the mandate became effective.** Despite this data, our federal, state and

local governments continue to funnel millions of dollars toward the provision of contraceptives, money which Dr. Paton's study suggests would be better spent on education and job training.

Based on the two empirical studies highlighted today (which raise serious doubts as to the effectiveness of family planning services in reducing underage pregnancies and abortion), Pro-Life Wisconsin is highly suspicious of the estimated cost savings to the State of Wisconsin that DHFS attributes to the Family Planning Demonstration Project.

Conclusion

In conclusion, Pro-Life Wisconsin opposes the Medicaid Family Demonstration Project based on the rule's apparent undermining of parental authority in the area of child contraception and the questionable effectiveness of family planning services in reducing underage pregnancies and abortion. In fact, there is data to suggest that broad contraceptive availability may actually work to increase underage pregnancy and abortion by promoting sexual promiscuity.

Thank you for your thoughtful consideration of the social and financial implications of this powerful rule. I would be happy to answer any questions you may have at this time.

NOTES on Emergency Contraception *(if committee members probe into the abortifacient nature of contraceptive drugs and devices)*

Emergency Contraception

The DHFS Standard of Practice Inventory for Title V/GPR Family Planning and Related Reproductive Health Care includes the provision of emergency contraception as a required contraceptive service.

Section 2, Delivery of Services, reads: "Family planning programs *must* provide immediate contraception to patients at risk of unintended pregnancy. This includes: Emergency Hormonal Contraception (EHC)..."

Although proponents of so-called "emergency contraception" assert that it is not abortion, the fact of the matter is that "emergency contraception" will often act to cause a chemical abortion. Emergency contraception (EC), also known as the morning-after-pill, is basically two high doses of the birth control pill taken within a 72-hour period. It can work in three ways: to inhibit the movement of sperm, to suppress ovulation, and to irritate the lining of the uterus so that a newly conceived child is unable to implant in the womb, thus starving and dying. This last action is chemical abortion.

Two of the most commonly used emergency contraceptive pills are **Preven** and **Plan B**. The websites for both of these drugs clearly indicate that each can work to prevent a fertilized egg from implanting in the uterine wall:

Source: www.preven.com *under "Frequently Asked Questions (FAQ)"*
"How do the PREVEN® emergency contraceptive pills prevent pregnancy?
PREVEN® can stop or delay ovulation (the release of an egg), it can stop sperm from fertilizing an egg if it was already released, **and it can stop a fertilized egg from attaching to the wall of the uterus.** " (emphasis added)

Source: www.go2planb.com *under "Consumers Guide" then go to "What is Plan B"*
"How Does Plan B® Work?
Plan B® (levonorgestrel) may prevent pregnancy by temporarily stopping the release of an egg from a woman's ovary, or it may prevent fertilization. **It may also prevent a fertilized egg from attaching to the uterus.** " (emphasis added)

Supporters of emergency contraception argue that it prevents pregnancy and thereby reduces the need for induced abortion. However, they intentionally define the term "pregnancy" as *implantation* of a fertilized egg in the lining of a woman's uterus, as opposed to "pregnancy" beginning at *fertilization.* **Whether one understands pregnancy as beginning at "implantation" or "fertilization," the heart of the matter is when human life begins. Embryological science has clearly determined that human life begins at fertilization – the fusion of an egg and sperm immediately resulting in a new, genetically distinct human being.** This is not a subjective opinion, but an objective scientific fact. Accordingly, any artificial action that works to destroy a fertilized egg (human embryo) is abortifacient in nature.

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

Ronald Sklansky
Clearinghouse Director

Terry C. Anderson
Legislative Council Director

Richard Sweet
Clearinghouse Assistant Director

Laura D. Rose
Legislative Council Deputy Director

CLEARINGHOUSE RULE 03-021

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated October 2002.]

1. Statutory Authority

a. Section HFS 102.01 (5) (e) states that the department will determine the eligibility of a person who applies solely for benefits under the family planning demonstration project and is under the age of 18 "without regard to the person's parent or parents." This appears to conflict with s. 49.45 (24r), Stats., which requires that the woman's family income does not exceed 185% of the poverty line for a family the size of the woman's family, and thus generally appears to require taking into account parental income for women who are under the age of 18, regardless of whether the woman is under the care of the parent for the purposes of s. 49.19 (1), Stats.

b. Under s. HFS 103.03, persons are required to meet both nonfinancial and financial conditions for eligibility. Section HFS 103.03 (1) (a) and (i) create what is referred to in the title to s. HFS 103.03 (1) as a "family planning waiver" allowing a woman meeting the specified conditions under sub. (1) (i) to be "non-financially eligible" for the family planning demonstration project. Such a woman:

- Under s. HFS 103.04 (10) (b) would meet financial conditions for eligibility if the income for a "fiscal test group," defined in s. HFS 103.04 (11) (b), is no greater than 185% of the poverty line for a family the size of the fiscal test group. This apparently conflicts with s. 49.45 (24r), Stats., which requires that the person's family income (not a fiscal test group's income, which appears to exclude income of parents of a woman under age 18) not exceed 185% of the poverty line for a family the size of the woman's family (not the size of the fiscal test group).

Appendix J

Historical Data on Teen Births in Wisconsin

	Number of Teen Births			
Calendar Year	**15-17**	**18-19**	**Total Births**	**% Change**
1992	2,427	4,622	7,049	
1993	2,481	4,576	7,057	0%
1994	2,497	4,379	6,876	-3%
1995	2,549	4,379	6,928	1%
1996	2,509	4,454	6,963	1%
1997	2,532	4,384	6,916	-1%
	Actual Change from 1992 to 1997			**-2%**

Projection of Wisconsin Teen Births Without the Waiver

The chart below assumes that the Wisconsin Adolescent Pregnancy Committee will be successful in reducing teen pregnancy 15% from the 1995 level.

	Number of Teen Births			
Calendar Year	**15-17**	**18-19**	**Total Births**	**% Change**
1998	2,532	4,378	6,910	0%
1999	2,382	4,243	6,625	-4%
2000	2,230	4,033	6,263	-5%
2001	2,043	3,845	5,888	-6%
2002	2,013	3,816	5,829	-1%
2003	1,985	3,788	5,773	-1%
	Expected Change from 1998 to 2003			**-17%**

Projection of Wisconsin Teen Births With the Waiver

The chart below again assumes that the Wisconsin Adolescent Pregnancy Committee will be successful in reducing teen pregnancy 15% from the 1995 level.

	Number of Teen Births			
Calendar Year	**15-17**	**18-19**	**Total Births**	**% Change**
1998	2,532	4,378	6,910	0%
1999	2,364	4,202	6,565	-5%
2000	2,197	3,906	6,104	-7%
2001	1,953	3,628	5,581	-9%
2002	1,865	3,463	5,327	-5%
2003	1,710	3,319	5,029	-6%
		Expected Change from 1998 to 2003		**-23%**

Appendix K

Organizational charts for Wisconsin's:

1. Department of Health and Family Services (DHFS),
2. Division of Health Care Financing (DHCF), and
3. Division of Public Health (DPH).

ny G. Thompson
rnor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

(608) 266-8922
FAX: (608) 266-1096
www.dhfs.state.wi.us

March 5, 1999

Barbara England
Health Care Financing Administration
105 West Adams, 14th Floor
Chicago, IL 60603

Dear Ms. England:

I am pleased to submit the attached draft copy of the Section 1115(a) demonstration waiver request for the State of Wisconsin to extend family planning services to all women at or below 185% federal poverty level (FPL) for your review.

The target population for services under this demonstration project includes women who are not eligible for either Title XIX (Medicaid) or Title XXI (BadgerCare), and women who might be eligible for BadgerCare but have chosen not to enroll. Family planning services will be the only services offered to these women.

The primary objective of this demonstration waiver project is to reduce the number of unintended births, thereby controlling specific Wisconsin Medicaid program costs.

We would like to implement this waiver on July 1, 1999. Thank you for your assistance.

Sincerely,

Peggy L. Bartels
Administrator

PLB:vg
CH12203.PO/CHPERM

Attachment

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin
Department of Health and Family Services

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

(608) 266-8922
FAX: (608) 266-1096
www.dhfs.state.wi.us

March 5, 1999

Dear Interested Parties:

I am pleased to submit for your review a draft copy of the Section 1115(a) demonstration waiver request for the State of Wisconsin to extend family planning services to all women at or below 185% federal poverty level (FPL).

Please send your comments to me within the next two weeks so that we can incorporate them into the final version to be submitted to the Health Care Financing Administration.

Sincerely,

Peggy L. Bartels
Administrator

PLB:vg
CH12203.PO/CHPERM

Model Budget Neutrality Worksheet for Wisconsin Proposal SFY 2001-2005					(Revised Version)				
All Costs		**1999**	**2000**	2001	2002	2003	2004	2005	Total
WITHOUT WAIVER									
BASIC FP SERVS – All current eligibles	Persons	48,428	48,428	48,428	47,698	47,426	47,174	46,917	
	Per Capita	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DELIVERIES	Persons	6,247	6,247	6,247	6,153	6,118	6,085	6,052	
	Per Capita	$ 1,978.00	$ 2,037.34	$ 2,098.46	$ 2,161.41	$ 2,226.25	$ 2,293.04	$ 2,361.83	
	Total	$ 12,356,985	$ 12,727,695	$ 13,109,524	$ 13,299,247	$ 13,620,095	$ 13,954,171	$ 14,294,487	$ 68,277,524
FIRST YEAR COSTS	Persons	6,247	6,247	6,247	6,153	6,118	6,085	6,052	
	Per Capita	$ 989.00	$ 1,018.67	$ 1,049.23	$ 1,080.71	$ 1,113.13	$ 1,146.52	$ 1,180.92	
	Total	$ 6,178,493	$ 6,363,847	$ 6,554,762	$ 6,649,654	$ 6,810,078	$ 6,977,086	$ 7,147,274	$ 34,138,854
OTHER CHILD COSTS	Persons				6247	12400	18518	24604	
	Per Capita	$ 718	$ 739.54	$ 761.73	$ 784.58	$ 808.12	$ 832.36	$ 857.33	
	Total	$ -	$ -	$ -	$ 4,901,438	$ 10,020,893	$ 15,413,816	$ 21,093,451	$ 51,429,597
TOTAL BASE YEAR		$ 18,535,478	$ 19,091,542	$ 19,664,287	$ 24,850,338	$ 30,451,066	$ 36,345,072	$ 42,535,212	$153,845,975
WITH WAIVER									
BASIC FP SERVS	Persons	48,428	48,428	48,428	47,698	47,426	47,174	46,917	
	Per Capita	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
VERIES	Persons	6,046	6,046	5659	5,002	4,000	2,710	1,203	
	Per Capita	$ 1,978.00	$ 2,037.34	$ 2,098.46	$ 2,161.41	$ 2,226.25	$ 2,293.04	$ 2,361.83	
	Total	$ 11,958,988	$ 12,317,758	$ 11,874,295	$ 10,811,068	$ 8,905,882	$ 6,213,714	$ 2,841,754	$ 40,646,713
FIRST YEAR COSTS	Persons	6046	6046	5659	5002	4000	2710	1203	
	Per Capita	$ 989.00	$ 1,018.67	$ 1,049.23	$ 1,080.71	$ 1,113.13	$ 1,146.52	$ 1,180.92	
	Total	$ 5,979,494	$ 6,158,879	$ 5,937,148	$ 5,405,559	$ 4,452,961	$ 3,106,857	$ 1,420,883	$ 20,323,408
OTHER CHILD COSTS	Persons				5659	10660	14661	17371	
	Per Capita	$ 718	$ 739.54	$ 761.73	$ 784.58	$ 808.12	$ 832.36	$ 857.33	
	Total	$ -	$ -	$ -	$ 4,439,606	$ 8,614,911	$ 12,203,089	$ 14,892,376	$ 40,149,982
EXPANDED FP	Persons	0	0	12,107	21,309	30,994	40,195	48,428	
	Per Capita	$ 185.00	$ 190.55	$ 196.27	$ 202.16	$ 208.22	$ 214.47	$ 220.90	
	Total	$ -	$ -	$ 2,376,241	$ 4,307,827	$ 6,453,571	$ 8,620,622	$ 10,697,745	$ 32,456,006
SYSTEMS CHANGES		0	0	$ 487,777	$ 512,979	$ 624,759	$ 732,251	$ 835,455	$ 3,193,221
*PUBLIC AWARENESS**		$ -	$ -	$ -	$ -	$ -	$ -	$ -	
*EVALUATION***		$ -	$ -	$ -	$ -	$ -	$ -	$ -	
TOTAL WITH WAIVER COSTS		$ 17,938,482	$ 18,476,636	$ 20,675,461	$ 25,477,039	$ 29,052,083	$ 30,876,533	$ 30,688,213	$136,769,329
DIFFERENCE		$ 596,996	$ 614,906	$ (1,011,174)	$ (626,701)	$ 1,398,984	$ 5,468,539	$ 11,846,999	$ 17,076,646

*$100,000 in TANF funds have been allocated for outreach and education.

**Evaluation of the demonstration project will be done internally within the Department of Health and Family Services, and will be paid for by the Department.

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

Fiscal Estimate — 2001 Session

☒ Original ☐ Updated	LRB Number	Amendment Number if Applicable
☐ Corrected ☐ Supplemental	Bill Number	Administrative Rule Number HFS 101 to 104 and 107

Subject
Family planning waiver.

Fiscal Effect
State: ☐ No State Fiscal Effect
Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.
☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation
☒ Increase Costs — May be possible to absorb within agency's budget. ☒ Yes ☐ No
☐ Decrease Costs

Local: ☒ No Local Government Costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory	3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory	5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory	4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory	☐ Counties ☐ Others ☐ School Districts ☐ WTCS Districts

Fund Sources Affected	Affected Chapter 20 Appropriations
☒ GPR ☒ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S	20.435(4)(b) and 20.435(4)(o)

Assumptions Used in Arriving at Fiscal Estimate

The administrative rule would allow the implementation of a Medicaid expansion of family planning services to single women aged 15 to 44 that have annual incomes below 185% of the federal poverty level. As directed by statute, the Department applied and received federal approval for this expansion of MA eligibility.

Currently, Medicaid and BadgerCare cover women below 185% of the federal poverty level who are either pregnant or have children. However, low-income women without children are not eligible for Medicaid or BadgerCare. Low-income women who do not qualify for these programs are unlikely to have either employer-provided insurance coverage, or sufficient personal funds to purchase family planning and reproductive health services in the private sector. They are therefore at a higher risk of unintended pregnancy. If a woman with an income below 185% federal poverty level becomes pregnant, Medicaid or BadgerCare would pay for birth costs, first year costs of the child, and other costs for the child and mother.

The family planning waiver is a five-year demonstration project that will provide family planning services and ancillary family planning services, on a fee-for-service basis, to any woman between the ages of 15 and 44 whose family income does not exceed 185% of the federal poverty level. Funding for the family planning services will be funded 90% FED and 10% GPR. Funding for covered ancillary family planning services will be funded at the Medicaid matching rate.

By preventing unintended pregnancies and therefore preventing low-income women from becoming eligible for Medicaid or BadgerCare, the cost to Medicaid and BadgerCare is reduced. In the first three years years of operation, it is projected that the cost of providing the family planning services will exceed the savings. However, over the five-year period, allowing low-income women access to family planing services, will save BadgerCare and Medicaid $8,897,500 AF ($1,557,100 GPR). The net cost is $742,100 AF ($129,900 GPR) in FY03; $1,638,100 AF ($286,700 GPR) in FY04; and $1,786,000 AF ($312,500 GPR) in FY05. Projected costs for FY04 and FY05 were included in the Departments's 03-05 biennial budget request for the MA Benefits Re-estimate item. It is estimated that enrollment at the end of the five year demonstration period will reach approximately 47,000 women.

Long-Range Fiscal Implications

Over a five year period the family planning waiver program is projected to save the Wisconsin Medicaid program $8,897,500.

Prepared By:	Telephone No.	Agency
Curtis Cunningham	(608) 266-5362	DHFS - OSF
Authorized Signature	Telephone No.	Date (mm/dd/ccyy)
		01/30/03