NLWJC - Kagan
DPC - Box 068 - Folder-003

Women's Issues-Family Planning

Women's issues –
family planning

[redacted]

Nicole R. Rabner

12/17/98 01:48:28 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc: Jennifer L. Klein/OPD/EOP
Subject: Title X and FMLA

I spoke with the women's groups as we discussed, and, as we suspected, they agreed that an extra $10 million in the Title X budget would make a huge difference. I reported to Dan Mendleson that we strongly recommend a $10 million increase, and he said that he would do all he could to make it happen. Since the last time he and I spoke, it sounds as if the budget contraints may have gotten worse, but Dan said he would do all he could to meet that mark. He also said that if this recommendation were to emerge on the DPC Initiatives list, it would be guaranteed the funding. While I told Dan I thought that would be difficult to do, I promised to raise it with you.

On the Title X program uses (i.e. the male involvement and abstinence programs), I think that the problems may be quite entrenched, as it sounds as if the women's groups and HHS have not seen eye to eye on grant awards for some time. I'll report further soon.

On FMLA, I understand that there was some concern raised at the New Initiatives meeting about pushing for FMLA expansion in the context of the SOTU or another venue. Jen and I think it might be useful for you to call a Deputies meeting soon on FMLA expansion, bringing in a few relevant agencies and WH Leg. Affairs to discuss strategy. Do you agree?

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION

Women's issues - family planning

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

FACSIMILE TRANSMITTAL SHEET

TO: Elena Kagan

FROM: Judith DeCarno, Marcia Greenberger

COMPANY:

DATE: 12/18/98

FAX NUMBER:

TOTAL NO. OF PAGES INCLUDING COVER: 6

PHONE NUMBER:

RE:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

NOTES/COMMENTS:

FYI Re Title X FY 2000 language.

language + background requested by Nicole Lehrer.

Thank you.

NFPRHA 122 C Street, NW • Suite 380 • Washington, DC 20001-2109 • TEL: 202-628-3535 • FAX: 202-737-2690 • E-MAIL: info@nfprha.org

Background on Title X Funding
FY98 and FY99 increases

Our national rate of unintended pregnancy is on the decline, in part due to the availability of clinical reproductive health services to low-income Americans through the title X family planning clinic network and in part because of the introduction of long-acting methods of contraception. At the same time however, our national rate of sexually transmitted disease remains extraordinarily high. The Title X system is facing severe financial pressures and continues to serve as a critical provider of primary care services to uninsured and underinsured Americans. Title X clinics are increasingly unable to make long-acting methods of contraception available to all women who need them, to use new pap technologies critical for services to at-risk populations nor new urine-based screening tests for sexually transmitted infections for men and women. For example, chlamydia, remains the most commonly reported infectious disease in the U.S. and it is assumed that half of new cases occur among men. In addition, it is critical to retain the nurse practitioners who serve as the backbone of the system.

For the past two fiscal years, overall increases to the Title X program have not translated into the same percentage increase in funding for clinical services. While the providers of family planning and reproductive health services did not expect to receive the entire program increase, there was widespread expectation both among the Title X providers, the advocates of women's health and Congressional supporters that this key infrastructure would see some relief from the escalating costs of providing clinical services. In addition, as Title XX of the SSBG was drastically cut, it was hoped that for those states which relied heavily on Title XX funds to provide family planning services, that the increase would help offset those devastating cuts. (This was particularly true in Pennsylvania as articulated by Senator Specter.)

In FY98, Title X funding was $203 million - a $5 million increase over FY97. the clinical service delivery program did not receive the same increase as the program increase. At that time, a nearly $2 million new male involvement program was introduced that with few exceptions ignored the male-oriented programs that were sponsored by the Title X provider network with or without the use of Title X funds. No requirement was made that these new male involvement grants be linked with Title X clinical service programs.

Thus far in FY99, the federal health regions have only a 3% increase, despite the program overall increase of 5%, with no provision that even the 3% increase be passed along to the clinical service program.

Therefore, while the program has received increases over the past two appropriation cycles, the clinical provider network has been effectively level-funded and when the increased costs of contraceptives, better screening devices for cervical cancer and sexually transmitted infections are taken into account, they have actually lost ground.

TITLE X LANGUAGE TO ACCOMPANY THE PASSBACK

The funding increase for the Title X family planning program should, first and foremost, be spent on contraceptive services to reduce unintended pregnancy With any remaining funds, priority will be given to education, counseling, and medical services to males within the clinical service delivery system, or through community-based programs directly linked to Title X service providers.

NATIONAL
FAMILY
PLANNING &
REPRODUCTIVE
HEALTH
ASSOCIATION

December 9, 1998

Denese Shervington, M.D., M.P.H.
Deputy Assistant for Population Affairs
4340 East West Highway, Suite 200
Bethesda, MD 20814

Dear Dr. Shervington:

Thank you for meeting with representatives from the National Family Planning and Reproductive Health Association on November 18, 1998. As a first step in our mutual commitment to ongoing communication, we are requesting information regarding implementation of legislative language included in the introductory paragraphs to section 101(f) of the omnibus spending bill (P.L. 105-277) passed by Congress on October 19. This language incorporates by reference a provision included in Senate Report 105-300 that mandates the following:

> In order to assure that all low-income women have access to comprehensive family planning services, the Committee expects that no less than 90 percent of the total Title X appropriation must be allocated to the regional offices to be awarded to grantees who provide clinical family planning services as defined by law.

The language further provides that all funds available for family planning services be made available no later than 60 days (December 18, 1998) after passage of the bill. This timely release is especially vital to grantees whose funding cycles begin on January 1.

For FY 1999, total funding for the Title X family planning program is $215 million, with 90% totaling $193.5 million. We would appreciate receiving, prior to the Congressional deadline of December 18, 1998, a funding breakdown reflecting the dollars actually allocated to each of the ten regions. If that total is less than $193.5 million, we would like to know the release date for the remaining funds.

Thank you very much for your assistance with this matter which is of critical importance to the provision of family planning to low-income clients.

Sincerely,

Judith M. DeSarno
President/CEO

Margie Fites Seigle
Chairperson
National Family Planning and
Reproductive Health Association

Gloria Feldt
President, Planned Parenthood
Federation of America

Joanne Baker
Chair, State Family Planning Administrators

Frank Bonati
Chair, Family Planning Councils of America, Inc.

Enclosures
cc: The Honorable Donna Shalala

Conference agreement compared with:	
New budget (obligational) authority, fiscal year 1998	−3,842,000
Budget estimates of new (obligational) authority, fiscal year 1999	−162,606,000
House bill, fiscal year 1999	+616,147,000
Senate bill, fiscal year 1999	+447,945,000

SECTION 101(f): DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS ACT, 1999

The conferees on H.R. 4328 agree with the matter inserted in this subsection of this conference agreement and the following description of this matter. This matter was developed through negotiations on the differences in the House and Senate versions (H.R. 4274 and S. 2400) of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, by members of the appropriations subcommittee of both the House and Senate with jurisdiction over H.R. 4274 and S. 2440.

In implementing this agreement, the Departments and agencies should comply with the language and instructions set forth in House Report 105–635 and Senate Report 105–300. In the case where the language and instructions specifically address the allocation of funds, the Departments and agencies are to follow the funding levels specified in the Congressional budget justifications accompanying the fiscal year 1999 budget or the underlying authorizing statute and should give full consideration to all items, including items allocating specific funding included in the House and Senate reports. With respect to the provisions in the House and Senate reports that specifically allocate funds, each has been reviewed and those which are jointly concurred in have been included in this joint statement.

The Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriations Act, FY 1999, put in place by this bill, incorporates the following agreements of the managers:

TITLE I—DEPARTMENT OF LABOR

EMPLOYMENT AND TRAINING ADMINISTRATION

TRAINING AND EMPLOYMENT SERVICES

The conference agreement appropriates $5,272,324,000, instead of $4,000,873,000 as proposed by the House and $5,409,375,000 as proposed by the Senate.

The agreement includes language inserting a legal citation to the Workforce Investment Act of 1998 as proposed by the Senate to fund a specific project authorized by the new law. It also includes language proposed by the Senate modified to identify funds for youth job training activities, making the funds available for the period April 1, 1999 through June 30, 2000, and specifying an amount and a legal citation for youth opportunity grants. It includes language proposed by the Senate providing that job training funds may be used for transition to, and implementation of, the provisions of the Workforce Investment Act of 1998. The House had no similar provisions.

The agreement also in
demonstration funds under
Act (dislocated workers) for
entrants in the workforce a
the Senate. It also includes
ing service delivery areas to
training and summer youth
ernor. The House had no sim

The conference agreeme
priation of $250,000,000 for
ate for youth opportunity gr
$250,000,000 for fiscal year
proposed by the Senate and
Funding for fiscal year 200
2000 appropriations bill.

The Labor Department
and provide technical assist
emy Demonstration Program

The conference agreeme
the following projects and ac

Dislocated Workers

—$5,000,000 for Special
—$1,500,000 for Special
—$500,000 for a high-te
land of Maui in Hawaii
—$500,000 for the Bethe
to provide high technology
Natives
—$1,000,000 for U. of
retraining
—$1,000,000 for the Iow
—$1,000,000 for Twin C
Worklink to plastics employr
—$1,000,000 for the Yor
—$1,000,000 to continue
—$300,000 ($900,000 o
quate performance), for a d
the University of Wisconsin-
Studies Center.

Native Americans

—$4,000,000 for co-loca
Workforce Investment Act of

Pilots and Demonstrations

—$3,000,000 for Samoa
—$675,000 for the Sout
Job Training Program
—$2,500,000 for traini
adults in Hawaii
—$1,250,000 for Ilisaqui
—$250,000 for Koahni
Alaska

and to ensure, as much as possible, that no individual with HIV receives suboptimal therapy due to the lack of health care provider information.

Family planning

The Committee recommends $215,000,000 for the title X family planning program. This is $3,077,000 below the administration request and $12,097,000 above the 1998 level. Title X grants support primary health care services at more than 4,000 clinics nationwide. About 85 percent of family planning clients are women at or below 150 percent of poverty level.

Title X of the Public Health Service Act, which established the family planning program, authorizes the use of a broad range of acceptable and effective family planning methods and services. The Committee believes this includes oral, injectable, and other preventive modalities.

The Committee remains concerned that programs receiving title X funds ought to have access to these resources as quickly as possible. The Committee, therefore, again instructs the Department to distribute to the regional offices all of the funds available for family planning services no later than 60 days following enactment of this bill.

The Committee is pleased with recent data indicating a reduction in the rate of teenage pregnancy in the United States. In order to assure that all low-income women have access to comprehensive family planning services, the Committee expects that no less than 90 percent of the total title X appropriation must be allocated to the regional offices to be awarded to grantees who provide clinical family planning services as defined by law.

Rural health research

The Committee recommends $11,713,000 for the Office of Rural Health Policy. This is $57,000 more than the fiscal year 1998 level and $22,000 above the administration request. The funds provide support for the Office as the focal point for the Department's efforts to improve the delivery of health services to rural communities and populations. Funds are used for rural health research centers, grants to telemedicine projects, the National Advisory Committee on Rural Health, and a reference and information service.

Health care facilities

The Committee provides $30,000,000 for health care facilities, which is $2,043,000 above the 1998 level and $30,000,000 above the administration request. Funds are made available to public and private entities for construction and renovation of health care and other facilities.

Sufficient funds are available to contribute to the construction of a pediatric dental facility serving medically underserved inner city neighborhoods. The Committee is aware that the University of Pennsylvania School of Dental Medicine has many meritorious characteristics that make it well-suited for this important task, and urges the full and fair consideration of its proposal.

Funds are also available to contribute to the upgrade of existing facilities dedicated to women's health that emphasize support of homeless and medically underserved women. The Committee is aware that Magee-Womens Hospital of Pittsburgh, PA, is one of a few specialty hospitals in the country providing services exclusively for women and infants, and urges that its proposal receive full and fair consideration.

Funds are available to contribute to the upgrading of an osteopathic facility dedicated to medically underserved areas in an inner city area. The Committee is supportive of the efforts of the Philadelphia College of Osteopathic Medicine and urges its proposal receive high priority in funding.

Funds are available to contribute to the modernization and upgrade of a medium-sized medical facility that coordinates health services within a county. The Committee is supportive of the proposal by the Fulton

Women's issues –
family planning

FIRST LADY HILLARY CLINTON AND VICE PRESIDENT GORE UNVEIL NEW INVESTMENT IN SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN

January 22, 1999

Today, in honor of the 26th anniversary of Roe vs Wade, First Lady Hillary Rodham Clinton and Vice President Gore met with representatives from the reproductive health community to unveil a series of new steps to prevent unintended pregnancy, including a new multi million dollar initiative to ensure access to safe, high quality family planning services for American women.

MILLIONS OF AMERICAN WOMEN NEED FAMILY PLANNING SERVICES

More than 3 million unintended pregnancies occur every year in the United States. Women who use no contraceptives account for almost half of these pregnancies (47%), while the 39 million method users account for 53%. Unintended pregnancies among women who do not use contraception are almost as likely to end in abortion as they are in a birth.

NEW STEPS TOWARDS PROVIDING SAFE, EFFECTIVE FAMILY PLANNING SERVICES FOR AMERICAN WOMEN. This initiative reaffirms the Clinton-Gore Administration's committment to expanding and enhancing the quality of reproductive health services for all American women. Today, the First Lady and Vice President announced that the Administration is:

- **Unveiling the Largest Increase in Family Planning Services in 15 Years.** The Clinton/Gore Adminstration's FY 2000 budget includes $240 million for family planning, a $25 million increase, and the largest increase in 15 years. These grants fund family planning clinics providing reproductive health services and clinical care to over 5 million low income women. These new funds will be used to prevent over a million unintended pregnancies year by improving the delivery of comprehensive reproductive health services, including STD and cancer screening and prevention, and HIV prevention, education and counseling; providing educational programs that encourage adolescents to postpone of sexual activity; increase the accessibility of contraceptive counseling and services; increasing efforts to provide effective contraceptives to those in need; and developing partnerships with other community based providers to conduct outreach to adolescents at risk.

- **Preventing violence at women's health clinics.** In the wake of escalating violence against women's health clinics that provide abortions, the First Lady and the Vice President will announce the the FY 2000 budget includes $4.5 million for support additional security enhancements, such as including closed circuit camera systems, improved lighting, motion detectors, alarm systems and bullet-resistant windows for these clinics in order to protect their doctors and nurses. Under this proposal, the Department of Justice would make security assessments and enhancements available to clinics deemed to be at high risk of violence. This Administration is committed to fighting this form of domestic terrorism that has threatened so many clinics and providers. While emphasizing the importance of family planning services to prevent unintended pregnancies, the First Lady and Vice President also emphasized that those women who choose to have an abortion do not have to fear violence.

- **Contributing $25 million to the UNFPA.** Today, the First Lady and Vice President will announce that the President's FY 2000 budget proposes a $25 million voluntary contribution to the UNFPA, $5 million more than the President's FY 1999 budget proposal. The UN Population Fund is the largest multilateral donor organization in the population sector and concentrates its assistance to countries in the areas of reproductive health and voluntary family planning, population policy and advocacy.

- **Ensuring that Federal employees have access to comprehensive family planning services.** The FY 2000 budget also continues to ensure that the Federal government leads the way as a model health plan by assuring that Federal employees and their families participating in the 300 Federal Employees Health Benefit Program (FEHBP) have access to contraceptive coverage. This policy provides coverage to approximately 1.2 million women of childbearing age and reduces unwanted pregnancies and the need for abortions by requiring most FEHB plans to offer the full range of contraceptive services. Before this requirement, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all.

Women's issues - family planning

January 21, 1999

MEETING WITH THE VICE PRESIDENT AND THE WOMEN'S CHOICE GROUPS

Date:	**January 22, 1999**
Time:	**10:00 am - 10:45 am**
Location:	**The Map Room**
	The White House
From:	**Neera Tanden**

I. PURPOSE

To discuss a common agenda on women's reproductive health issues over the coming year, and to announce a series of proposed budget increases for family planning as well as a new initiative to combat clinic violence as part of the Administration's FY 2000 budget.

II. BACKGROUND

Overview

This meeting will allow you and the Vice President to discuss a series of initiatives related to women's reproductive health and outline a strategy to move this debate forward in the future. The Vice President will discuss the Administration's proposed increase in the domestic family planning budget and a new effort to combat clinic violence. You will then announce two proposed funding increases in international family planning and move to a general discussion on family planning and other reproductive health issues. (See attached talking points.)

Announcements

The Largest Increase in Family Planning Services in 15 Years

The Vice President will announce that the Administration's FY 2000 budget includes $240 million for family planning through Title X, a $25 million increase, and the largest increase in 15 years. These grants fund family planning clinics providing reproductive health services and clinical care to over 5 million low income women. These new funds will be used to prevent over a million unintended pregnancies a year by improving the delivery of comprehensive reproductive health services, including STD and cancer screening and prevention, and HIV prevention, education and counseling; providing educational programs that encourage adolescents to postpone of sexual activity; increase the accessibility of contraceptive counseling and services; increasing efforts to provide effective contraceptives to those in need; and developing partnerships with other community based providers to conduct outreach to adolescents at risk. The Administration has increased funding in Title X by 60% since 1992.

More than 3 million unintended pregnancies occur every year in the United States.

Women who use no contraceptives account for almost half of these pregnancies (47%), while the 39 million method users account for 53%. Unintended pregnancies among women who do not use contraception are almost as likely to end in abortion as they are in a birth.

New Initiative to Prevent Violence at Women's Health Clinics

The Vice President will announce that the FY 2000 budget includes $4.5 million for support additional security enhancements for clinic deemed at risk of violence. This initiatives will help respond to the escalating violence against women's health clinics and providers. Under this proposal, the Department of Justice would make security assessments and enhancements, including closed circuit camera systems, improved lighting, motion detectors, alarm systems and bullet-resistant windows, available to these clinics deemed to be at high risk of violence.

U.S. Contributions to the UN Population Fund

The UNFPA is the largest multilateral donor organization in the population sector and concentrates its assistance to countries in the areas of reproductive health and voluntary family planning, population policy and advocacy. Congress eliminated funding for this program last year because it continues to fund efforts in China (though the Fund did not fund abortion). You will announce that the President's FY 2000 budget proposes a $25 million voluntary contribution to the UNFPA, $5 million more than the President's FY 1999 budget proposal.

Bilateral International Family Planning Programs

You will announce that the FY 2000 budget includes a $15 million increase over FY 1999 enacted funds in international family planning assistance. The United States, through US AID, is the largest bilateral donor for international family planning services. US AID supports a wide range of family planning programs in key developing countries, including direct services and commodities (though U.S. funds are prohibited by law and Administration policy from paying for abortions. The FY 2000 budget requests a total of $400 million for international family planning assistance.

Access to Comprehensive Family Planning Services by Federal Employees

You or the Vice President may refer to the fact that the FY 2000 budget will also continue to ensure that the Federal government leads the way as a model health plan by assuring that Federal employees and their families participating in the 300 Federal Employees Health Benefit Program (FEHBP) have access to contraceptive coverage. This policy, which was passed in the last Congress with the leadership of Representative Lowey and others, provides coverage to approximately 1.2 million women of childbearing age and reduces unwanted pregnancies and the need for abortions by requiring most FEHB plans to offer the full range of contraceptive services. Before this requirement, only 19% of federal health plans covered prescription contraceptives and 10% of the plans offered no contraceptive coverage at all.

Background

A recent study, *Declines in Teenage Birth Rates: National and State Patterns 1991-97*, reports that while teenage birth rates have declined substantially during the 1990s, the most dramatic decline is in the birth rate for young women who have already had one child. While there was a 6 percent decline in first births to teenagers, the rate of second births for teens was down by 21 percent between 1991 and 1996. In addition, it found that the overall teen birth rate dropped 15 percent from 1991 through 1997. Rates are down more for younger teens (15-17) than older teens (18 and 19). In addition, teenage childbearing is down in all race and ethnic groups, but the largest declines documented are for black teenagers, especially younger black teens.

Recent Action by the Administration

Providing family planning services to low income women. The Administration has granted Medicaid waivers to expand access to family planning services in 11 states in order to reduce the number of women with mistimed or unwanted pregnancies. These waivers extend family planning services to low-income women of childbearing age who would not otherwise be eligible for Medicaid family planning services, including low-income women who are eligible for Medicaid while pregnant but who lose their eligibility at the end of pregnancy, and low-income women who would become eligible for Medicaid if pregnant, even if they've never been pregnant or Medicaid eligible.

Stopped the Coburn Amendment Prohibiting the FDA from Approving RU-486. On January 22, 1993, President Clinton reversed the ban on the importation of Mifepristone or RU-486; RU-486 is currently under review by the Food and Drug Administration (FDA). Unfortunately, the FDA's scientific drug approval process became under assault in the 105th Congress. President Clinton threatened to veto a provision that would have prevented the FDA from using government funds to test, develop or approve drugs that may induce medical abortion, including RU-486. Because of the President's veto threat, Republicans backed down and decided not to attach this provision to any funding bill.

Defeated Parental Consent Restrictions on Contraceptives for Minors. The House voted to require minors to obtain parental consent prior to receiving any Title X family planning services (this has also been referred to as the Istook amendment). The President's veto threat helped to keep it out of the final bill.

Stopped the So-Called "Child Custody Protection" Act. The Administration threatened to veto this bill which would have made it illegal to transport a minor across State lines for the purpose of avoiding parental consent or notification laws. The bill did not protect close family members --including grandmothers, aunts and siblings --from criminal and civil liability, and did not protect persons that only provide information,

counseling, referral or medical services to the minor from liability. Under a veto threat, the Senate failed to invoke cloture (or end debate) on the Child Custody Protection Act.

Upheld the Late Term Abortion Veto. This year, the House of Representatives voted to override President Clinton's veto of a bill banning certain late-term abortions, known by proponents of the ban as "partial birth abortions." While the House voted to override the President's action, the Senate sustained the veto by a vote of 36-64 --just three votes short of the required two-thirds majority needed to override the veto. President Clinton vetoed the measure in October 1997 because it did not contain an exception that protected the health or life of the woman.

Continued to Fight Restrictions on International Family Planning. The FY99 Omnibus Appropriations Act does not contain the so-called "Mexico City" policy, a provision that denies U.S. funds to international family planning organizations that use their own resources to perform abortions or lobby on abortion policy. However, the Mexico City restrictions were also included in the Foreign Affairs Reform and Restructuring Act. President Clinton vetoed this legislation because it contained these unacceptable restrictions.

Issues and Concerns:
Recently, HHS has created a male initiative project as part of Title X, the goal of which is to involve men in reproductive health issues. This new initiative has created some consternation among providers, who fear that it will divert funds away from clinics who have traditionally received Title X funds. However, this effort only receives 1.24% of funds now and will only receive that share of the proposed increase. Therefore, the groups are basically supportive of the program and its priorities as they now stand.

III. PARTICIPANTS

See attached list.

IV. SEQUENCE OF EVENTS

- You will make very brief welcoming remarks and then introduce the Vice President;
- The Vice President will make remarks and announce the budget increase in Title X (domestic family planning) and the clinic violence initiative, and then turn back to you;
- You will make your remarks and then open up discussion.

V. PRESS PLAN

Closed press.

VI. REMARKS

Talking points to come.

Confirmed Participants to Pro-Choice Group Meeting
January 22, 1999 10:00 am

1. Susan Cohen, Senior Policy Associate
   Alan Guttmacher Institute

2. Nancy Zirkin, Director of Government Relations
   American Association of University Women

3. Kim Gandy, Executive Vice President
   National Organization for Women

4. Marcia Greenberger, Co-President
   National Women's Law Center

5. Gloria Feldt, President
   Planned Parenthood

6. Kate Michelman, President
   National Abortion and Reproductive Rights Action League

7. Vicki Saporta, Executive Director
   National Abortion Federation

8. Ellie Smeal, President
   Feminist Majority

9. Judy DeSarno, President/CEO
   National Family Planning and Reproductive Health Association

10. Judy Lichtman, Director
    National Partnership for Women and Families

11. Amy Coen
    Population Action International

12. Brian Dixon, Director of Government Relations
    Zero Population Growth

13. Sarah Brown, Director
    National Campaign to Prevent Teen Pregnancy

14. Sana Shtasel, Incoming President
    Center for Reproductive Law and Policy

15. James Wagner, Executive Director
Advocates for Youth

16. Kim Parker, Interim Lobbyist for Reproductive Rights Issues
American Civil Liberties Union

17. Julia Scott, President
Black Women's Health Project

18. Francis Kissling, President
Catholics for Free Choice

19. Reverend Carlton Veazey, President
Religious Coalition for Reproductive Choice

20. Beverly Malone, President
American Nurses Association

21. Dr. Renee Jenkins, Professor of Pediatrics
Howard University, American Academy of Pediatrics

22. Dr. Deborah Smith, Howard University, Chair
American Medical Women's Association Reproductive Health Committee

23. Ralph Hale, Executive Vice President
American College of OBGYN

Women's issues - family planning

December 10, 1998

MEMORANDUM

TO: **Elena**
FROM: **Nicole**
SUBJECT: **Title X Update**

Following my e-mail to you yesterday about funding for Title X in the FY 2000 budget, I spoke with Judy Appelbaum at the National Women's Law Center, who raised a recent concern shared by a variety of women's advocates and outlined in an attached letter to Sylvia Matthews. In the letter, the advocates state that it is their understanding that the Administration intends to devote the entirety of our FY 2000 Title X increase of $15 million to programs other than clinical reproductive health services, planning instead to expand efforts that involve males or promote abstinence among non-sexually active teens. The advocates naturally object strongly to this strategy, but it is not in fact our position.

In its budget justification document, HHS did single out these programs as warranting added dollars, but also recommended that the increase be used to augment the delivery of clinical reproductive health services. In its passback notes, OMB concurred with HHS' recommendation, writing:

> OMB staff stated that the FY 2000 passback level for HRSA includes $229.952 million for Family Planning activities at HRSA, an increase of $14.952 million (+7%) over the FY 1999 enacted level. OMB concurred with HHS' proposal to expand and augment the following two existing initiatives: 1) reaching adolescents before they become sexually active; and 2) expanding "male involvement" grants that provide family planning services to young men.

It is clear that the women's groups obtained this passback language and read it as targeting the totality of our recommended increase to these two programs. I spoke with the Title X budget examiner at OMB, who stressed that this was not OMB's intention. OMB then spoke with the HHS budget staff, who said that they also did not read the passback language in that way.

The women's groups, however, may oppose targeting any new dollars to these purposes, given the great need for the basic services that Title X provides and given that these other efforts are supported through a number of other funding streams. Further, the women's groups will likely urge a greater budget commitment to Title X. OMB points out, however, that HRSA, which administers Title X, was cut as a whole, and Title X was one of only two programs that received any increase in HRSA's budget.

I called Marsha Greenberger to discuss this, but have not yet reached her. My view is that

we should touch base soon with one of the signatories to the letter, explain that the advocates misunderstood the passback language, and gauge their level of opposition to targeting any of the new funding to the programs suggested by HHS. Please let me know if you would like to handle this; otherwise, I will try to reach Marsha next week.

Attachments
12/9/98 letter to Matthews
HHS Title X budget justification
OMB Title X passback
12/9/98 e-mail

December 9, 1998

Ms. Sylvia Mathews
Deputy Director, Office of Management and Budget
Room 252
Old Executive Office Building
Washington, DC 20503

Dear Sylvia:

Thank you again for meeting with the undersigned representatives of national women's organizations on November 25th. We are writing to express our continued concern that the Administration's budget request for Title X remains low. Further, we would like to call your attention to an additional problem involving family planning funding that we have learned of since our meeting.

As you recall, we discussed the proposed funding level for the Title X family planning program and learned that the Office of Management and Budget had included an increase of $14.9 million for the program for FY 2000, for a total proposed funding level of just under $230 million. This falls far short of the HHS requested increase of $38 million, which itself did not meet the needs of the program. We request that you find additional funds to support these basic clinical reproductive health services for women funded by the Title X program before the President's Budget is finalized.

Since our meeting, we have learned that the OMB passback also included language drafted by HHS which directs that the *entire* proposed increase be spent on programs other than clinical reproductive health services. Specifically, language contained in the passback calls for every penny of that increase to be spent on programs to involve males or to promote abstinence among non-sexually active teens. Even given low inflation, this proposal to level fund women's health services effectively constitutes a cut.

Moreover, the impact of this proposed cut would be compounded by increasing service costs, further hampering clinics' abilities to effectively serve women. Right now, rates of chlamydia are skyrocketing among teens and excellent but expensive urine-based tests to screen for certain sexually transmitted diseases have come onto the market. In addition, new technologies such as the ThinPrep Pap test, and long-acting methods of contraception, such as Depo-Provera and Norplant have the potential to expand the health care options of women served at Title X clinics, but still remain out of the reach of many Title X providers. We believe that this proposal will therefore weaken the clinic

infrastructure and reduce access to basic health care services for the growing ranks of low-income Americans who are uninsured or underinsured.

Although supporters of Title X recognize the value of additional programs dedicated to involving males, as well as the value of postponing sexual involvement, we question the wisdom of funding these programs at the expense of Title X—an already cash-strapped program that is one of the vital safety nets for health care in this country. In the case of male involvement, many Title X providers *already* operate such programs. However, the separate programs funded in recent years through the Office of Family Planning have not even required linkage to the existing clinic system to provide reproductive health services to those who need them. In addition, it is our understanding that a proposal is being developed with HHS that calls for a vastly expanded new male involvement program that would establish an entirely *separate* health care system within community-based organizations that have not historically provided health services.

Title X is, first and foremost, a *family planning* program. While Title X providers discuss abstinence with patients when appropriate, abstinence-specific dollars are made available through the Adolescent Family Life program. In addition to the $17 million allocated for FY 1999 for the Adolescent Family Life program, the federal government will spend close to $50 million per year to implement the abstinence-only programs required by the 1995 welfare reform legislation.

We would like to schedule a meeting as soon as possible to continue our discussion on how best to advance a women's health agenda for the coming year.

Sincerely,

Judith M. DeSarno, National Family Planning and Reproductive Health Assn.

Marsha Greenberger, National Women's Law Center

Jacquelyn Lendsey, Planned Parenthood Federation of America

Kate Michelman, National Abortion and Reproductive Rights Action League

Cory Richards, The Alan Guttmacher Institute

Nancy Zirkin, American Association of University Women

Family Planning Program

Authorizing Legislation--Title X, Section 1001 of the Public Health Service Act.

	FY 1998 Budget	FY 1999 President's Budget	FY 1999 House	FY 2000 Estimate
BA	$202,903,000	$218,077,000	$202,903,000	$253,113,000
FTE	42	42	42	46

FY 2000 Authorization.....Expired

RATIONALE FOR BUDGET REQUEST

The FY 2000 request of $253,113,000 is an increase of $35,036,000 over the FY 1999 President's budget and $50,210,000 over the FY 1999 House level. This proposed increment will further strengthen the Title X health infrastructure for families, women and adolescents, as well enable the program to continue providing a comprehensive range of family planning services and to better meet the increasing demand for these services. The proposed increment will enhance partnerships with other health and social service organizations. It will allow an expansion of services to hard to reach populations, including males and adolescents, as well as research on the mix of services most appropriate and effective for these populations. The program will continue its quest for newly developed technologies aimed at improving its ability to function efficiently and effectively.

Investment in family planning services is essential in averting unintended pregnancies which are costly, in both human and dollar terms, to society. Both the Administration and the Department have clearly targeted adolescent pregnancy prevention and male responsibility in preventing unintended pregnancy as major policy issues. Effective pregnancy prevention efforts must include men and adolescent boys, as well as women and adolescent girls. Moreover, particularly in the case of adolescents, these efforts should not only provide education and services but also expand opportunities for their futures. Although the program is already working in these areas, this proposed increment will substantially expand existing initiatives.

- Increasing the program's ability to reach adolescents before they become sexually active and providing interventions to encourage continued postponement greatly enhance the potential for reducing adolescent pregnancy.

- Further expanding male involvement initiatives which provide family planning/reproductive health education and services to young men:

  Supporting additional demonstration projects designed to employ young men from the surrounding community while providing them with job training, career counseling and family planning education, counseling and services.

Supporting community-based organizations in developing, implementing and testing family planning education and service components for inclusion in programs that provide other health, education and social services to young males.

- Current and ongoing advances in electronic communication technologies (distance learning) will be used to increase the efficiency and effectiveness of the Title X health infrastructure.

The Title X Family Planning Program will continue its focus on providing family planning and reproductive health services through existing program priorities:

- increasing outreach to persons not likely to seek services, including males and adolescents;

- emphasis on comprehensiveness of reproductive health services, including STD and cancer screening and prevention, HIV prevention, education and counseling,
increased involvement of male partners, substance abuse screening and referral;

- emphasis on services to adolescents, including community education, emphasis on postponement of sexual activity, and more accessible provision of contraceptive counseling and services for those adolescents who are sexually active;

- elimination of disincentives to provide high cost but effective contraceptives to serve high risk (and high unit cost) clients, and to provide non-revenue generating services such as community education and prevention services; and

- emphasis on activities involving women's health nurse practitioners particularly minority nurse practitioners and nurse practitioners serving disadvantaged and medically underserved communities.

Outputs:

	FY 1998 Enacted	FY 1999 President's Budget	FY 2000 Estimate
No. of Service Grantee	83	83	95
No. of Clinics	4,790	4,790	4,950
Clients Served	5,050,000	6,135,000	7,135,000
Community Partnership Projects:			
No. Male Initiative Grants	10	15	25
No. Other Hard to Reach Population Grants	25	35	50
Service Delivery Improvement Grants	4	8	12

OMB PASSBACK NOTES -- FAMILY PLANNING

Family Planning. OMB staff stated that the FY 2000 passback level for HRSA includes $229.952 million for Family Planning activities at HRSA, an increase of $14.952 million (+7%) over the FY 1999 enacted level. OMB concurred with HHS' proposal to expand and augment the following two existing initiatives: 1) reaching adolescents before they become sexually active; and 2) expanding "male involvement" grants that provide family planning services to young men.

[redacted]

Nicole R. Rabner

12/09/98 03:14:47 PM

Record Type: Record

To: Elena Kagan/OPD/EOP

cc:
Subject: Title X

Title X family planning seems to be in fairly good shape. First, the history:

FY98 Enacted	FY99 Request	FY99 Enacted
$203 mil	$218 mil	$215 mil

This year's OMB/HHS budget negotiations:

FY00 HHS Request	FY00 Passback
$253 mil	$230 mil

While OMB did not grant HHS its full requested increase for Title X, the passback does represent a 7 percent increase over the FY99 enacted level and the same dollar increase ($15 million) that we requested for FY99. HHS has not appealed the passback -- in large measure because the Health Resources and Services Administration (HERSA), which administers Title X, was cut in other, unrelated areas. In fact, Ryan White and family planning were the only two HERSA programs that were given any increase in passback. HHS/HERSA plans to spend any Title X increase in three areas: (1) augmenting current programs; (2) targeting adolescents before they become sexually active, and (3) strengthening male responsibility.

I understand that Sylvia Mathews met with the women's groups the day after passback, and the women's groups were already aware of the passback level. While they did press Sylvia for a larger increase for family planning, they were pleased with our continued commitment to increasing the program.

Women's issues -
family planning

Cynthia Dailard 09/30/98 04:16:03 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Title X -- ugly scene on Hs Labor-HHS bill

It looks like the House Labor HHS bill will go to the Rules Committee tomorrow, and to the floor on Tuesday, along the following lines:

Currently, the bill contains an Istook provision which requires parental consent for Title X family planning.

1) Greenwood will be allowed to strike the Istook language and offer his friendly substitute which emphasizes that Title X providers should encourage minors to abstain from sexual activity and involve their parents in their decision to seek family planning services. Unfortunately, anti-choice members will be able to second degree this amendment with whatever they want. This is a bad procedural situation -- the vote on the second degree will come first, so if it passes Greenwood does not get a vote.

2) Brady will be allowed to offer an amendment saying that states can pass their own legislation requiring parental consent, thus overriding existing federal requirements guaranteeing confidential services to teens. The pro-choice side apparently will be allowed to offer a substitute (the groups are drafting language and talking to Castle about offering it).

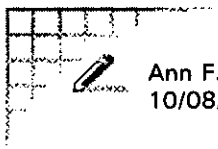
3) Tihart will be allowed to offer an amendment saying that Title X clinics which perform abortions must have both financial and physical separation between the title X and abortion services. Currently, there must be financial separation. The pro-choice side apparently will be allowed to offer a substitute (the groups are drafting language and talking to Nancy Johnson about offering it).

So this means that there will be at least 6 votes on family planning, and a lot of opportunity for confusion among members.

Message Sent To:

Jennifer L. Klein/OPD/EOP
Neera Tanden/WHO/EOP
Nicole R. Rabner/WHO/EOP
Laura Emmett/WHO/EOP
Elena Kagan/OPD/EOP
Peter G. Jacoby/WHO/EOP
Daniel N. Mendelson/OMB/EOP

Women's issues -
family planning



Ann F. Lewis
10/08/98 02:20:11 PM

Record Type: Record

To: Cynthia Dailard/OPD/EOP

cc: See the distribution list at the bottom of this message
Subject: Re: family planning issues

IN reverse order:

-- the parental consent/family planning provision --which can be called the Increase Teen Pregnancy Bill -- is one of the most dangerous ideas in a long time. We have a positive record of working to decrease teen pregnancy --this would reverse those gains. It's very bad policy and -- with such strong support for family planning --bad politics. Has to be a priority to oppose.

- I would like to be equally strong about adding in the FEHBP contraception and hope we can be,This was a congressional initiative : we should support it every step of the way --- but its hard to put it in the same category.

Message Copied To:

Elena Kagan/OPD/EOP
Laura Emmett/WHO/EOP
Daniel N. Mendelson/OMB/EOP
Jennifer L. Klein/OPD/EOP
Neera Tanden/WHO/EOP

Women's issues - family planning

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
LEGISLATIVE AFFAIRS

PHONE: 395-4790 / FAX: 395-3729

TO: Elena Kagan

DATE:

FROM: URGENT

____ CHUCK KIEFFER ____ ~~CHUCK~~ KONIGSBERG

____ ELIZABETH GORE ✓ KATE DONOVAN

____ NANCY BRANDEL ____ LISA ZWEIG

____ BRIAN MASON

Comments: Please let me know if you have any more changes.

Thanks

FAX #:_____ PAGES: 2
PHONE NUMBER:_____ (includes cover-page)

SUMMARY OF AMENDMENTS TO BE MADE IN ORDER TO H.R. 4274, THE LABOR/HHS/EDUCATION APPROPRIATIONS BILL, 1999

Porter	10 minutes	Manager's amendment.
Greenwood/Castle	30 minutes	Strikes the language mandating parental consent or notification for Tile X programs, and it substitutes parental involvement and an emphasis on abstinence for minors seeking contraceptive drugs or devices. Provides Title X counselors with state of the art training on how to effectively intervene with minors to encourage abstinence, parental involvement and to avoid coercion, and it requires the Secretary of HHS to develop protocols in these areas, especially as they relate to younger adolescents.
Istook/Barcia/ Manzullo	30 minutes	Substitute amendment to the Greenwood/Castle amendment, consisting of the Istook Title X language already in the bill and the Greenwood/Castle abstinence language.

Women's issues - family planning

Kate P. Donovan
10/01/98 07:19:33 PM

Record Type: Record

To: Elena Kagan/OPD/EOP, Laura Emmett/WHO/EOP, Daniel N. Mendelson/OMB/EOP, Gina C. Mooers/OMB/EOP

cc:
Subject: family planning lang.

Dan Mendelson prepared this language for the Labor/HHS/Ed House Floor SAP. We'll be circulating it tonight for WW clearance but wanted to run it by you first. Please let me know if you're ok or need changes. Thanks.

The Administration strongly objects to language in the House Committee bill, and to any related potential amendments, that would have the effect of requiring family planning or other health care grantees to ~~receive~~ obtain parental consent or provide advance notification to parents before giving contraceptives to minors. Mandating parental consent discourages minors from seeking health care and reproductive services and thus leads to more unintended pregnancies, abortions, and sexually transmitted diseases, including HIV. ~~Federal health program costs could also increase if this amendment interferes with the prevention of teen pregnancy.~~ The Administration urges the House to adopt the proposed Castle/Greenwood amendment, which will ensure that grantees will encourage minors to seek their family's participation in family planning decisions.

The Administration adamantly opposes the proposed Tiahrt amendment that would mandate onerous and ~~ill-defined~~ physical separation requirements between Title X supported family planning projects and non-Title X activities related to abortion. The Department of Health and Human Services already provides safeguards, as well as performs periodic rigorous site reviews, to ensure that no Title X funds are used to conduct abortions or abortion related activities.

[redacted]

AMENDMENT TO H.R. 4274, AS REPORTED

OFFERED BY _____

Page 52, strike line 8 and all that follows through page 53, line 8, and insert the following:

(b)(1) The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall require that each family planning project under section 1001 of title X of the Public Health Service Act—

(A) expressly informs all minors who seek the services of the project that abstinence is the only certain way to avoid pregnancy, sexually transmitted diseases, and infection with the human immunodeficiency virus; and

(B) ensures that all individuals who provide counseling services to minors through the project are trained to provide to minors counseling that encourages the minors—

(i) to abstain from sexual activity;

(ii) to avoid being coerced into engaging in sexual activities; and

(iii) to involve their parents in the decision to seek family planning services;

(2) The Secretary, acting through the Deputy Assistant Secretary for Population Affairs, shall carry out the

following with respect to family planning projects referred to in paragraph (1):

(A) The Secretary shall develop and disseminate to the projects protocols for providing the counseling described in paragraph (1)(B), including protocols for training individuals to provide the counseling.

(B) The Secretary shall ensure that such protocols include protocols specific to younger adolescents.

(C) In developing protocols under subparagraphs (A) and (B), the Secretary shall consider the results of research under title XX of the Public Health Service Act.

From Dan,
Mendelson
55178
Cynthia Dailard offered
to draft stronger language

Excerpt from SAP

Committee bill that would suspend two HHS rules pertaining to organ donation: a HCFA rule that seeks to expand the number of organs available for donation through more vigorous procurement efforts; and, a Health Resources and Services Administration rule that would require the national organ transplant network to develop policies that would allocate organs based on patients' medical need, not their geographic location.

Other troublesome HHS-related funding and language issues, with which the Administration has serious concerns, include the following:

- National Household Survey on Drug Abuse. The Committee mark eliminates funding for data collection activities of the Substance Abuse and Mental Health Services Administration, including the National Household Survey on Drug Abuse, which is our single best source of information on youth drug use and youth smoking and is important for evaluating the impact of substance abuse prevention, treatment, and enforcement efforts.

- Family Planning. The Committee bill requires family planning grantees either to receive written parental consent or provide advance notification to parents before giving contraceptives to minors. Mandating parental consent could discourage sexually active minors from seeking health care and reproductive counseling services and thus lead to more unintended pregnancies, more abortions and more sexually transmitted diseases, including HIV, among our nation's youth. We understand an amend will be offered striking Parental Notice & Supporting Counseling.

- Needle Exchange. The Committee includes a total ban on the use of funds appropriated in this Act for needle exchange programs rather than making the use of funds for such programs conditional upon the certification of the Secretary of Health and Human Services.

- Health Care Financing Administration (HCFA). Although the Committee has fully funded the President's program level request for HCFA Program Management (with the exception of the Medicare+Choice information campaign), no action has been taken on the $265 million in new discretionary HCFA user fees. We urge the House to enact the President's requested user fees to finance HCFA activities and to ensure that sufficient resources remain available for education and other priorities.

- Bio-Terrorism. The Administration urges the House to provide the full $111 million requested to improve HHS' ability to respond to attacks of biological and chemical terrorism.

- Health Disparities. The Committee has failed to include $30 million requested for demonstration projects to address racial and ethnic health

Women's issues -
family planning

Charles E. Kieffer 08/03/98 06:43:24 PM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP

cc: Jacob J. Lew/OMB/EOP, Sylvia M. Mathews/OMB/EOP, Martha Foley/WHO/EOP, Elena Kagan/OPD/EOP

Subject: parental notification and the Castle-Greenwood amendment

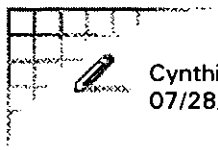
Obey's staff called this evening to report that the treatment of amendments related to family planning is now the central outstanding issue with the Republican leadership as they wrestle with what amendments to make in order in the rule for Labor/HHS/Education. Istook is insisting that a motion to strike his language from the Committee bill be allowed but that the rule not allow a substitute. He clearly thinks he can win on an up or down vote but would lose if Castle-Greenwood were made in order.

Obey is following the general strategy of keeping this bill as ugly as possible and therefore does not want our Rules SAP to support Castle-Greenwood ("providing a roadmap to a better bill"). Obey's staff (Mioduski) is hoping that we will just oppose Istook's Committee language in the Rules SAP and be silent on the compromise. If the Rules Committee makes in order the compromise, then we could support it in the floor SAP.

Rules is scheduled for 2:30 pm Tuesday. We need to make a decision early Tuesday.

thoughts?

Women's issues - family planning



Cynthia Dailard
07/28/98 11:56:56 AM

Record Type: Record

To: Elena Kagan/OPD/EOP, Laura Emmett/WHO/EOP, Jennifer L. Klein/OPD/EOP, Peter G. Jacoby/WHO/EOP

cc: Nicole R. Rabner/WHO/EOP
Subject: Title X -- DC Appropriations Vote

Senator Brownback is circulating an amendment to the DC appropriations bill which would require organizations receiving Title X funds to provide adoption counseling and referral services to pregnant teens. Current Title X guidelines require Title X providers to provide non-directive counseling for the following three options: prenatal care, adoption, and abortion. Brownback's amendment would codify only adoption. His language says:

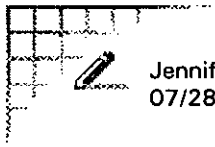
"Notwithstanding any other provision of law, a family planning organization that is conducting operations in the District of Columbia and that receives funds under Title X of the Public Health Service Act may use such funds to provide adoption services as described in [the Adolescent Family Life Program Act]".

The pro-choice community is torn over this amendment. Some of the groups (AGI, Planned Parenthood) believe that this puts adoption on a higher plane than the other options, and that it sets a bad precendent for the entire Title X program. (But practically speaking, this amendment should not have any effect on the program, since the clinics already provide adoption counseling). They want a second-degree amendment offered to Brownback's which says that nothing in the Brownback language is intended to negate the obligation of providers to provide non-directive counseling which includes the three options mentioned above. They will probably go to Boxer to offer this amendment (she is ranking member on the subcommittee).

NFPRHA (National Family Planning Assn) doesn't think it a second degree amendment is a good idea. They don't want anyone reminded that Title X clinics provide abortion referrals, because that could plant gag clause ideas in the minds of anti-choice members. I agree with this line of thinking.

Apparently, Boxer has tried to talk to Brownback to find out whether his intentions are evil (ie. he wants to undermine the entire Title X program) or benign. While she wasn't able to elicit that information, she did find out that he is adamant about bringing this up for a vote -- he wants the Senate to be on record regarding adoption.

FYI. Any thoughts?



Jennifer L. Klein
07/28/98 12:49:08 PM

Record Type: Record

To: Cynthia Dailard/OPD/EOP

cc: See the distribution list at the bottom of this message
Subject: Re: Title X -- DC Appropriations Vote

I think it's hard for us to be against that. I also tend to think that we shouldn't get involved in second order amendments, but I could be convinced otherwise.

Message Copied To:

Elena Kagan/OPD/EOP
Laura Emmett/WHO/EOP
Peter G. Jacoby/WHO/EOP
Nicole R. Rabner/WHO/EOP
Neera Tanden/WHO/EOP

Women's Issues – family planning

PRESIDENT CLINTON:
INCREASING SUPPORT FOR FAMILY PLANNING

January 22, 1998

" I will continue to do everything I can to make sure that every child in America is a wanted child, raised in a loving, strong family. Ultimately, that is the idea the anniversary of Roe v. Wade celebrates."

President Bill Clinton
January 22, 1998

Today, marks the 25th anniversary of Roe v. Wade, the landmark Supreme Court decision that affirmed every woman's right to choose whether and when to have a child. President Clinton is committed to ensuring this right, and in doing so, to protecting two of our nation's most deeply-held values, personal privacy and family responsibility.

PREVENTION AND FAMILY PLANNING. During the last five years, the Administration has worked hard to reduce the need for abortions and to prevent unintended pregnancy by making comprehensive family planning and sex education programs more widely available. The President's FY 1999 budget calls for:

- **Increased Funding for Title X.** The proposal will increase Title X Family Planning grants by $15 million -- a 46% increase since FY1992.

- **Medicaid and Other Services.** The proposal will provide almost $500 million in federal funds to Medicaid to support family planning services. Additionally, the Maternal & Child Health Block Grant, the Social Services Block Grant, and the Preventive Health Block Grant will provide $100 million to state and local communities for family planning services.

- **Prevention Education and Research.** The proposal will provide about $200 million for the National Institutes of Health's research on infertility, contraception, and related matters, and CDC's programs to educate teenagers about sexual development and abstinence. Additionally, Health and Human Service's teen pregnancy prevention and related youth programs will continue to engage the Girl Power! education initiative in sustained efforts to promote pregnancy prevention among girls 9- to 14-years-old.

A COMPREHENSIVE APPROACH TO FAMILY PLANNING. Under the President's proposal nearly 5 million clients each year at more than 4,700 family planning clinics nationwide, would have access to a comprehensive set of family planning services including contraceptive services, pregnancy testing, sexually transmitted disease screening and treatment, and education and outreach.

SUPPORTING INTERNATIONAL FAMILY PLANNING. The Administration is strongly committed to international family planning efforts. The President has blocked several Congressional attempts to prohibit funding for international family planning groups that use their own funding to lobby on behalf of abortion rights or perform abortions. Under the President's Budget, bilateral assistance provided through AID and assistance to the United Nations Population Fund will grow to $425 million in FY 1999, a 32% increase over FY 1992.

Women's issues - family planning

The Alan Guttmacher Institute
New York and Washington

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education

1120 Connecticut Avenue
Suite 460
Washington, DC 20036
Telephone: 202 296-4012
Fax: 202 223-5756
e-mail: policyinfo@agi-usa.org

MEMORANDUM

TO: Friends of Family Planning
FROM: Susan Cohen
DATE: January 22, 1998
RE: Promoting Prevention of Unintended Pregnancy

In light of the discussion on January 20th with the First Lady and the Vice President about the Administration's priority on making abortion less necessary by promoting family planning, I thought you would find the attached materials useful.

It is self-evident to most Americans that increased access to effective family planning services and information is the most effective and responsible way to reduce abortion. It is not only a winning message – it is also supported by the data and experiences of women both in the United States and in other countries. The recent AGI study that provoked interest during the meeting reveals the dramatic decline in the unintended pregnancy rate in this country and finds that much of that success is attributable directly to improved contraceptive use. The fact that the abortion rate also dropped steeply during this same time period, then, is not surprising. The data make clear that a large factor in explaining the reduction in the abortion rate is, indeed, the success of family planning.

In addition, "The Role of Contraception in Reducing Abortion" highlights some of the major evidence – from the United States and abroad – that contraception works.

Please feel free to contact me with any questions or to further discuss these issues. I could not agree more with the First Lady and the Vice President that we must work together to promote this unified front to take back the moral and political high ground.

News

A Not-for-Profit Corporation
for Reproductive Health
Research, Policy Analysis
and Public Education
120 Wall Street
New York, NY 10005

The Alan Guttmacher Institute
New York and Washington

Contact: Susan Tew
212/248-1111 (x2208)
info@agi-usa.org

EMBARGOED FOR RELEASE:
SATURDAY. JAN. 17, 1998—6 PM

U.S. UNINTENDED PREGNANCY RATE FALLS 16% SINCE 1987

Improved Contraceptive Use a Major Factor

The rate of unintended pregnancy among women of reproductive age (15–44) in the United States dropped 16%—from 54 to 45 pregnancies per 1,000 women annually—between 1987 and 1994, according to a new study **"Unintended Pregnancy in the United States,"** by The Alan Guttmacher Institute (AGI). As reflected in the overall drop in the unintended pregnancy rate during this period, the abortion rate declined 11% from 27 to 24 abortions per 1,000 women annually (continuing its downward trend since 1980), as did the unintended birth rate, which declined 22% from 27 to 21 births per 1,000 women. (Unintended pregnancies are estimated as the sum of abortions and of births resulting from pregnancies reported as having been unplanned.)

Another measure of unplanned pregnancy—the proportion of all pregnancies that are unintended—dropped 14% between 1987 and 1994. In 1987, 57% of all pregnancies were unplanned; *in 1994, 49% of 5.4 million pregnancies in the United States were unplanned.* Unintended pregnancy is highest among women aged 18–24, and those who are unmarried, low-income, black or Hispanic.

The dramatic decline in unplanned pregnancy has occurred to a large extent as a result of higher contraceptive prevalence and use of more effective methods. For example, condom use has increased significantly and the proportion of women at risk of an unplanned pregnancy using no contraceptive method has gone down. The decline may also begin to explain why all measures of abortion in the United States (rates, ratios and numbers) are falling. It is important, however, to note that unplanned pregnancy in this country continues to be much higher than in most comparable developed countries.

The new study shows how widespread unplanned pregnancy is among U.S. women: 48% of women (15–44) have had at least one unplanned pregnancy in their lives. Twenty-eight percent have had at least one unplanned birth, 30% have had one or more abortions and 11 % have had both. At 1992 abortion rates, 43% of women will have had an abortion by age 45.

"The drop in unintended pregnancy in this country is good news, but half of pregnancies is still half. Whether they end in abortion or unplanned birth, unintended pregnancies come at a cost

both to the people involved and to society. The key to reducing unplanned pregnancy further will be to decrease risky behavior, promote the use of effective contraceptive methods, including emergency contraceptive pills, and improve the effectiveness with which all methods are used," comments study author Stanley K. Henshaw, deputy director of research at AGI.

The study, published in the forthcoming January/February 1998 issue of *Family Planning Perspectives*, presents 1994 estimates of the percentage of births and pregnancies that were unintended, the intended and unintended pregnancy rates, and the proportion of women who have had an unintended birth, an abortion or both. It also provides estimates of the proportion of women who will have had an abortion by age 45 (cumulative first-abortion rate).

The analysis is based on several sources of the most current available data on reproductive behavior, including AGI's 1992 survey of all known abortion providers in the country, AGI's 1994 survey of nearly 10,000 women having abortions and the 1995 National Survey of Family Growth (a periodic nationally representative survey of U.S. women of reproductive age conducted by the National Center for Health Statistics).

The full study presents detailed demographic characteristics of women who have unintended pregnancies, distributed by age, marital status, poverty status, race and ethnicity (see attached tables 1-4). Among key findings:

- 1 in 11 (9%) U.S. women have a pregnancy each year
- 51% of all pregnancies to U.S. women end in planned births, 23% end in unplanned births (either mistimed or unwanted conceptions) and 27% end in abortion
- nearly 5% of women have an unplanned pregnancy each year
- 54% of unintended pregnancies end in abortion and 46% end in birth
- nearly one-third of all births (31%) are unplanned (21% are mistimed and 10% unwanted)
- 60% of women in their 30s have had an unplanned birth or an abortion
- two-thirds of pregnancies to 30–34-year-old women end in planned births
- 15% of 30–39-year-old women have had an unplanned birth and an abortion
- 6 in 10 unintended pregnancies to both women under 15 and over 40 end in abortion
- never-married women have more than twice the unintended pregnancy rate of married women
- low-income women have nearly three times the rate of unintended pregnancy as higher-income women, but are less likely to end their unplanned pregnancies in abortion
- black and Hispanic women have considerably higher rates of unplanned pregnancy than other women but are only somewhat more likely to end these pregnancies in abortion
- 58% of women who had an abortion had been using a contraceptive during the month they became pregnant, as had 48% of those who had an unplanned birth

###

The Alan Guttmacher Institute is a not-for-profit organization for reproductive health research, policy analysis and public education with offices in New York City and Washington, D.C.

Unintended Pregnancy in the United States

by Stanley K. Henshaw

Context: *Current debates on how to reduce the high U.S. abortion rate often fail to take into account the role of unintended pregnancy, an important determinant of abortion.*

Methods: *Data from the 1982, 1988 and 1995 cycles of the National Survey of Family Growth, supplemented by data from other sources, are used to estimate 1994 rates and percentages of unintended birth and pregnancy and the proportion of women who have experienced an unintended birth, an abortion or both. In addition, estimates are made of the proportion of women who will have had an abortion by age 45.*

Results: *Excluding miscarriages, 49% of the pregnancies concluding in 1994 were unintended; 54% of these ended in abortion. Forty-eight percent of women aged 15–44 in 1994 had had at least one unplanned pregnancy sometime in their lives; 28% had had one or more unplanned births, 30% had had one or more abortions and 11% had had both. At 1994 rates, women can expect to have 1.42 unintended pregnancies by the time they are 45, and at 1992 rates, 43% of women will have had an abortion. Between 1987 and 1994, the unintended pregnancy rate declined by 16%, from 54 to 45 per 1,000 women of reproductive age. The proportion of unplanned pregnancies that ended in abortion increased among women aged 20 and older, but decreased among teenagers, who are now more likely than older women to continue their unplanned pregnancies. The unintended pregnancy rate was highest among women who were aged 18–24, unmarried, low-income, black or Hispanic.*

Conclusion: *Rates of unintended pregnancy have declined, probably as a result of higher contraceptive prevalence and use of more effective methods. Efforts to achieve further decreases should focus on reducing risky behavior, promoting the use of effective contraceptive methods and improving the effectiveness with which all methods are used.*

Family Planning Perspectives, 1998, 30(1):24–29 & 46

The relatively high rate of unintended pregnancy in the United States[1] has received increasing attention as the immediate cause of both abortion and unplanned birth. For example, the Institute of Medicine recently published a report that summarized the consequences of unintended pregnancies that are carried to term and urged the adoption of a new national goal that all pregnancies be planned.[2] Improved fertility control would allow women and couples to have children when they feel best prepared socially and financially to assume the responsibilities of parenting.

The most accurate national estimates of unplanned birth have been based on the National Surveys of Family Growth (NSFG), a series of nationally representative surveys that collect detailed reproductive and contraceptive histories and related information from women of reproductive age. A study based on the 1988 NSFG estimated that 57% of pregnancies in 1987 (excluding miscarriages) were unintended; that is, they ended in induced abortion, the woman had wanted no children at that time or she had wanted no more children ever.[3] A study of births to ever-married women found that the proportion of births that were unplanned decreased from 38% in 1969–1973 to 32% in 1978–1982, then increased again to 35% in 1984–1988.[4] Another study comparing the 1982 and 1988 NSFG survey results found that there had been no change in the unintended pregnancy rate between 1982 and 1987, but that the unintended birth rate had increased from 25 per 1,000 women aged 15–44 to 27 per 1,000, while the abortion rate fell by a similar amount.[5] An earlier study based on the 1982 NSFG concluded that 46% of women aged 15–44 at the time of the survey had experienced one or more unintended pregnancies and that at 1982 rates, 46% would have at least one abortion by age 45.[6]

The publication of data from the 1995 NSFG[7] provides information on the intendedness of births during the five years preceding the 1995 survey interviews, and can be used as the basis of an updated report on unintended pregnancy. In this article, we assess the prevalence of unintended pregnancy during this period, the changes from 1987 to 1994 and the effect of changes in unintended pregnancy rates on rates of abortion and unplanned birth.

Data and Methodology

Data from the 1995 NFSG and from other sources are used to present estimates, for 1994, of the percentage of births and pregnancies that were unintended, the intended and unintended pregnancy rates, and the proportion of women who have ever had an unintended birth, an abortion or both. In addition, we have calculated the proportion of women who, at 1992 rates, will have had an abortion by age 45. For this analysis, unintended pregnancies were estimated as the sum of abortions and of births resulting from pregnancies reported as having been unintended.

Births

The most recent national data on the planning status of births come from the NSFG, a periodic fertility survey. In addition to the 1995 survey, we also use data from NSFGs conducted in 1982 and 1988.

The 1995 NSFG interviewed a nationally representative probability sample of 10,847 civilian women aged 15–44.[8] Interviews were conducted between January and October 1995 and included questions on the planning status of each pregnancy experienced by a respondent. Following the NSFG definition, births were categorized as unplanned if the woman had been practicing contraception when she became pregnant, if she had not wanted to become pregnant until a later time or if she had wanted no more children ever. The pregnancy was considered intended if the woman had not been practicing contraception and reported that she had not cared whether she became pregnant. The small number of births for which intention status was undetermined (0.3%) were distributed proportionally.

Stanley K. Henshaw is deputy director of research with The Alan Guttmacher Institute, New York (AGI). The research on which this article is based was funded by the Andrew W. Mellon Foundation and The Rockefeller Foundation. The author thanks his colleagues in the research department of AGI: Haishan Fu, for calculations of contraceptive use; Suzette Audam, for programming; and Yvette Cuca, Taylor Haas and Shelby Pasarell, for research assistance.

This information was used to determine the proportion of unplanned births among NFSG respondents in the five years preceding the interview. We chose the five-year period to ensure that the sample size would be large enough to yield a stable proportion. We estimated the number of unplanned births in the United States by multiplying the resulting proportion with the number of births reported in 1994 by the National Center for Health Statistics (NCHS).[9]

We also estimated unplanned births for 1994 according to the mothers' age, marital status, poverty status, race, ethnicity and contraceptive use during the month of conception. Since the number of births by poverty status is not published by the NCHS, we used the poverty distribution of births, as tabulated from the NSFG. Births to unmarried women are reported by the NCHS, but we used NSFG tabulations to further categorize these women as formerly married or never-married.

For 1981 and 1987, the proportions of unplanned births were taken from published 1982 and 1988 NSFG results[10] and applied to the numbers of births in 1981 and 1987.[11] While the NSFG coded the woman as married or unmarried for each birth, it did not include a category for formerly married women. For this reason, we were unable to calculate marital status for 1981.

Finally, using the 1995 NSFG data, we estimated the proportion of U. S. women in 1994 who had ever had an unplanned birth. In the interests of simplicity and comparability with other published data, the results for all analyses are presented according to the age and marital status of the woman at the time of the birth or abortion, rather than her age and marital status at the time of conception. Similarly, the year shown is the year of pregnancy outcome, not the year of conception.

Abortions

In calculating the number of unintended* pregnancies, it was assumed that all pregnancies ending in abortion were unwanted, although a small proportion of abortions may have occurred among initially wanted pregnancies. This may have happened for any number of reasons, including health problems experienced by the woman or the fetus or changes in the woman's circumstances, sometimes resulting from the loss of her partner or lack of support.[12]

To calculate the number of unintended pregnancies in 1994, we needed an estimate of the total number of abortions that occurred during the year and data on the characteristics of women who had abortions. The total number of abortions performed nationally is compiled through periodic surveys of abortion providers conducted by The Alan Guttmacher Institute.[13] However, this provided abortion estimates only through 1992, the most recent year covered by the surveys. For 1993 and 1994, we projected totals from trends in the number of abortions in published and unpublished reports from state health statistics agencies. We used information only from states with consistent data collection procedures in the two adjacent years (42 states and the District of Columbia to project 1993 totals from the 1992 data, and 43 states and the District of Columbia to project 1994 totals from the 1993 data).

The age, marital status, race and ethnicity of women who had had abortions were based on percentage distributions compiled from state health department reports by the Centers for Disease Control and Prevention (CDC),[14] with adjustments for year-to-year changes in the reporting states.† For 1994, we separated unmarried women who had had abortions into subcategories of never-married and formerly married women and derived the distribution of abortions by women's poverty status according to data from a 1994–1995 national survey of 9,985 abortion patients.[15] For 1987, we took the distribution of abortions by marital status from a similar survey of 9,480 abortion patients in that year.[16]

Because abortions are underreported in population surveys,[17] we decided not to use NFSG data on the number of women in each age-group who had ever had an abortion, a procedure that would have resulted in a serious underestimate. Instead, we made estimates from national abortion statistics, a complicated task since a woman aged 35 in 1994 could have had an abortion in any year since 1973, placing her in a number of possible age-groups. In addition, we wished to avoid counting more than once the many women who have had more than one abortion.

The first step in estimating the number of women in each age-group who have had an abortion was to estimate the number of abortions that occurred in each year according to single year of age. We started with the number of abortions by five-year age-groups (with single-year groupings for teenagers) for each year during 1973–1994, derived from CDC reports with adjustments as described above. To distribute the five-year groups to single years of age, we used microdata tapes compiled by the NCHS for 1980, 1983, 1985, 1986 and 1988–1992.‡ Each tape contains data on more than 280,000 abortions in 12 or more states. We used tabulations of these abortions by single year of age to break down national five-year age-groups into single-year categories. For years lacking an NCHS tape, we interpolated or projected figures.

We also used the tape tabulations to calculate for each year during 1973–1994 the proportion of first-time abortions within each single-year age-group. First, we multiplied the number of abortions by the proportions we had derived from the tapes in order to arrive at an initial estimate for each year of first abortions for each single year of age. We then adjusted the numbers of first abortions in each single-year age category so that the sum for each year was equal to the total number of first abortions previously estimated for that year from CDC data. To estimate the cumulative number of first abortions that took place during 1973–1994 for each age cohort, we added together the number of first abortions that each age-group would have experienced for each year during this period. We then divided this total by the number of women in that age-group in the population in 1994 to arrive at the proportion of U. S. women in each age-group who had ever had an abortion.

Our estimates of the number of first abortions are subject to several possible sources of error: The states included in the NCHS tapes may not have been completely representative of all women having abortions; some women may not have reported their prior abortions to the abortion provider; some of the women who had first abortions died before 1994 and should not have been counted; and some immigrants may have had abortions before coming to the United States.§ Nevertheless, the results provide an approximate picture of the past abortion experience of U. S. women since the 1973 *Roe* v. *Wade* decision.

Unintended Pregnancy

We estimated the proportion of women who have ever had an unintended preg-

*"Unintended" and "unplanned" are used interchangeably in this article.

†For a detailed description of the methods for estimating the number of abortions according to women's characteristics, see Henshaw SK and Van Vort J, *Abortion Factbook, 1992 Edition: Readings, Trends, and State and Local Data to 1988*, New York: The Alan Guttmacher Institute, 1992, p. 164.

‡For a description of the 1988 data file, see Kochanek KD, Induced terminations of pregnancy: reporting states, 1988, *Monthly Vital Statistics Report*, 1991, Vol. 39, No. 12, Supplement. The NCHS used the same procedures to compile each data file.

§The number of immigrants exceeded the number of deaths, resulting in an increase by 3–4% of the number of women in each age cohort between 1980 and 1990.

Table 1. Estimated number of pregnancies (excluding miscarriages), percentage distribution of pregnancies, by outcome and intention, and selected measures of unintended pregnancy, all by characteristic, 1994

Characteristic	No. of pregnancies	% distribution of pregnancies				% of births that were unintended	% of pregnancies that were unintended	% of unintended pregnancies that ended in abortion	Pregnancy rate*		
		Intended births	Unintended births	Abortions	Total				Total	Intended	Unintended
Total	**5,383,800**	**50.8**	**23.0**	**26.6**	**100.0**	**30.8**	**49.2**	**54.0**	**90.8**	**46.1**	**44.7**
Age at outcome											
<15†	25,100	18.3	33.2	48.5	100.0	64.5	81.7	59.4	13.7	2.5	11.2
15–19	781,900	22.0	42.7	35.3	100.0	66.0	78.0	45.3	91.1	20.0	71.1
15–17	306,100	17.3	46.5	36.2	100.0	72.9	82.7	43.8	59.0	10.2	48.8
18–19	475,800	25.0	40.2	34.8	100.0	61.7	75.0	46.4	140.3	35.1	105.2
20–24	1,479,500	41.5	26.2	32.3	100.0	38.7	58.5	55.2	164.1	68.1	96.0
25–29	1,405,200	60.3	17.2	22.5	100.0	22.2	39.7	56.7	147.0	88.7	58.4
30–34	1,111,400	66.9	14.6	18.4	100.0	18.0	33.1	55.7	100.0	66.9	33.1
35–39	482,400	59.2	17.9	23.0	100.0	23.2	40.8	56.3	43.7	25.9	17.8
≥40‡	98,300	49.3	17.9	32.8	100.0	26.7	50.7	64.7	9.9	4.9	5.0
Marital status at outcome											
Currently married§	3,003,900	69.3	19.3	11.3	100.0	21.8	30.7	37.0	95.2	66.0	29.2
Formerly married	356,700	37.5	21.8	40.7	100.0	36.8	62.5	65.1	64.7	24.3	40.4
Never-married	2,023,100	22.3	31.0	46.7	100.0	58.2	77.7	60.1	91.0	20.3	70.8
Poverty status**											
<100%	1,358,000	38.6	31.3	30.1	100.0	44.8	61.4	49.0	143.7	55.4	88.3
100–199%	1,292,500	46.8	27.7	25.4	100.0	37.2	53.2	47.9	115.2	53.9	61.2
≥200%	2,733,200	58.8	15.9	25.4	100.0	21.3	41.2	61.5	70.8	41.6	29.2
Race											
White	3,981,700	57.1	21.2	21.6	100.0	27.1	42.9	50.4	82.7	47.3	35.5
Black	1,130,700	27.7	28.6	43.7	100.0	50.8	72.3	60.4	136.7	37.8	98.9
Other	271,400	50.0	22.0	28.0	100.0	30.5	50.0	56.0	93.9	46.9	46.9
Ethnicity											
Hispanic	900,200	51.4	22.4	26.1	100.0	30.4	46.6	53.8	143.0	73.5	69.4
Non-Hispanic	4,483,600	50.7	22.6	26.7	100.0	30.9	49.3	54.1	84.6	42.9	41.7

*Pregnancy rates for this category are expressed as per 1,000 women aged 15–44, except for rates for age-groups. †Denominator for rates is women aged 14. ‡Numerator for rates is women aged 40 and older; denominator is women aged 40–44. §Includes separated women. **Percentage of federal poverty level at time of interview. In 1994, the federal poverty level was $17,020 for a family of four. *Note:* Intention status of births is based on births in the five years before the 1995 interview.

nancy by first adding the number of women who had had an unplanned birth to the number who had had an abortion, and then subtracting those who were counted twice because they had had both an unplanned birth and an abortion. Tabulations of the NSFG indicate that the proportion of women who have had an unintended birth and also reported having had an abortion ranged from 9% among women aged 15–19 to 28% among women aged 30–34. Since comparisons with national data indicate that the actual number of abortions experienced is about 56% higher than the number reported in the NSFG for the period 1976–1994,[18] we used this figure as a correction factor and adjusted the proportion experiencing both unintended birth and abortion upward for each age-group. Since the rate of abortion underreporting was the same for women younger than 35 and those aged 35–44, we used the same correction factor in all age-groups.[19]

Miscarriages

Except where otherwise specified, we excluded miscarriages from all calculations of the number of pregnancies and of pregnancy rates. With miscarriages omitted, the proportion of unintended pregnancies that ended in abortion reflects actual decisions to terminate or continue pregnancies. In addition, it assures that all tables in this article are consistent, since it would be difficult to calculate the proportion of women who have ever had an unintended pregnancy while at the same time taking into account the overlap between women who have had unintended pregnancies that ended in miscarriage, birth and abortion. (However, the number of miscarriages after 6–7 weeks of pregnancy—the point at which miscarriages are likely to be noted by the woman—can be estimated by adding 20% of births to 10% of abortions.[20] Miscarriages may also be estimated using NSFG data.[21])

Results

Rates and Outcomes

Approximately 3.95 million births and 1.43 million abortions occurred in 1994, for a total of 5.38 million pregnancies, not including miscarriages. (Use of the estimation procedure mentioned above produces an estimated 930,000 miscarriages during the year as well.) The largest number of pregnancies occurred among women aged 20–29, among currently married women, among those with an income 200% or more of the federal poverty level, and among white and non-Hispanic women (Table 1).

During the five years preceding the 1995 NSFG interview, 31% of births were reported as unintended—that is, the woman did not want to have children when she did (21%) or wanted no more births ever (10%). Applying the same proportions to 1994 births, we estimated that 1.22 million births resulted from unintended pregnancies. Adding abortions, there were 2.65 million unintended pregnancies, or 49% of all pregnancies for that year. (If we include an estimated 390,000 miscarriages that would have otherwise ended in abortion or unintended birth, we find that a total of 3.04 million unintended pregnancies occurred during 1994.) Of all pregnancies in 1994 (excluding miscarriages), 23% ended in unintended births and 27% in abortions. Thus, among women who experienced an unintended pregnancy in 1994 (excluding miscarriages), 54% had an abortion and 46% carried the pregnancy to term.

Forty-eight percent of the women who had an unplanned birth had been using a contraceptive method during the month

Table 2. Estimated rates of unintended pregnancies, unintended births and abortions per 1,000 women, age and marital status, and percentage of unintended pregnancies ended by abortion, by characteristic, 1981, 1987 and 1994

Characteristic	Unintended pregnancy			Unintended birth			Abortion			% ended by abortion		
	1981	1987	1994	1981	1987	1994	1981	1987	1994	1981	1987	1994
Total	**54.2**	**53.5**	**44.7**	**25.0**	**26.6**	**20.9**	**29.2**	**26.9**	**24.1**	**53.9**	**50.3**	**54.0**
Age at outcome												
15–19	78.1	79.3	71.1	35.2	37.1	38.9	42.9	42.2	32.2	54.9	53.2	45.3
20–24	93.6	102.7	96.0	42.3	50.2	43.0	51.4	52.5	53.0	54.8	51.1	55.2
25–29	60.6	66.1	58.4	29.3	35.4	25.3	31.3	30.8	33.1	51.6	46.5	56.7
30–34	37.0	37.3	33.1	19.3	19.3	14.6	17.7	17.9	18.4	47.8	48.2	55.7
35–39	15.0	18.8	17.8	5.5	9.0	7.8	9.5	9.8	10.0	63.5	52.2	56.3
≥40*	4.3	5.3	5.0	0.9	2.4	1.8	3.4	2.9	3.2	78.2	54.3	64.7
Marital status at outcome												
Currently married†	u	41.5	29.2	u	29.8	18.4	u	11.7	10.8	u	28.2	37.0
Formerly married	u	54.6	40.4	u	19.0	14.1	u	35.7	26.3	u	65.3	65.1
Never married	u	71.5	70.8	u	23.2	28.2	u	48.2	42.5	u	67.5	60.1

*Numerator for rates is women aged 40 and older; denominator is women aged 40–44. †Includes separated women. *Notes:* All measures exclude miscarriages. The intention status of births is based on births in the five years before the interviews in 1988 and 1995 and in the four years before the 1982 interview. u=unavailable.

they became pregnant,* as had 58% of those who had abortions (not shown). For all unintended pregnancies combined, slightly more than half (53%) of the women had been using a method. Of the contraceptive users, 58% ended their pregnancies by abortion, compared with 49% of nonusers who had accidental pregnancies. (When the estimated number of unintended pregnancies that ended in miscarriage is included, the percentage of women who were using a method remains at 53%, but among contraceptive users, we estimate that 51% had abortions, 37% had births and 12% had miscarriages; among nonusers, we estimate that 43% had abortions, 44% had births and 13% had miscarriages.) Thus, contraceptive users appear to have been more motivated to prevent births than were nonusers, although many nonusers did have abortions.

The proportion of all pregnancies that were unintended varied sharply by age, with teenagers younger than 18 having the highest percentage (82–83%). The proportion decreased with rising age, dropping to 33% among women aged 30–34, and then increased again, reaching 51% among women aged 40 and older. Some 44% of teenagers aged 15–17 ended their unintended pregnancies by abortion, the lowest proportion in any age-group. (The relatively high proportion among women younger than 15 is misleading because it excludes the pregnancies of 14-year-olds that ended in births at age 15. It also excludes pregnancies to 14-year-olds that ended in abortion at age 15, but there are relatively few of these.) The proportion was also relatively low for women aged 18–19 (46%), and was highest among women older than 40 (65%).†

The unintended pregnancy rate shows that for every 1,000 women aged 15–44, about 45 had an accidental pregnancy during 1994 (or nearly 5%). Among women aged 15–17, the rate was similar to that for all women. It peaked at 105 per 1,000 among women aged 18–19, then dropped sharply with age. At these rates, a cohort of 100 women will have experienced 142 unintended pregnancies, or about 1.42 per woman, by the time they are 45 (not shown).

The intended pregnancy rate was about the same as the unintended rate (46 per 1,000), having increased from 40 per 1,000 in 1987 and 43 per 1,000 in 1981 (not shown). The age pattern of intended pregnancy, however, was very different from that of unintended pregnancy: Intended pregnancy was much higher than unintended pregnancy among women aged 25–39 and much lower than unintended pregnancy among teenagers. Each year, 1% of all women aged 15–17 had an intended pregnancy.

Among married women, 31% of pregnancies were unintended, compared with 63% among formerly married women and 78% among never-married women. Only 37% of married women who had unintended pregnancies ended them by abortion, compared with 60–65% of unmarried women. The pregnancy rate among never-married women (91 per 1,000) was about the same as that of married women (95 per 1,000). The outcomes of these pregnancies reflect differences in intention status for these groups, however: Almost half of pregnancies among formerly and never-married women ended in abortion (47% and 41%, respectively), compared with only 11% of those among married women.

Women's poverty status (defined as the ratio of family income to the federal definition of poverty)‡ was strongly associated with the unintended pregnancy rate but only weakly associated with the rate of intended pregnancy. Among women in poverty, pregnancies were more likely than among higher income women to be unintended and to end in unplanned births, and were slightly more likely to end in abortions. The overall pregnancy rate declined with increasing income, and this trend resulted mainly from the higher rate of unintended pregnancy among poor women. The proportion of poor women's unintended pregnancies that ended in abortion was similar to the proportion among women living at 100–199% of the poverty level, and was less than that among women whose income was 200% or more of the poverty level.

The differences between white and black women generally paralleled those between high- and low-income women: Compared with white women, black women had a higher pregnancy rate. The higher pregnancy rate for black women resulted from an unintended pregnancy rate that was almost three times that of white women. Because black women's unintended pregnancy rate was so high, the proportion of these women's pregnancies that ended in abortion (44%) was much higher than that of white women (22%).

On all measures, women of other races fell between white and black women, usually closer to white women. Hispanic women had a much higher rate of both intended and unintended pregnancy than

*Based on NPSG tabulations of births that were conceived after January 1, 1991, and that took place before the interview. For abortion data, see reference 15.

†These figures are based on the age of the woman when the pregnancy ended, not her age at conception. Adjustment to age at conception would lower the proportions for women younger than 20 and raise them for women older than 30.

‡In 1994, the federal poverty level was $17,020 for a family of four.

Table 3. Percentage of women who have ever had at least one unplanned birth, abortion or unintended pregnancy, by age-group, 1994

Age	≥1 unplanned births	≥1 abortions*	Both birth and abortion	≥1 unintended pregnancies†
Total	**28.4**	**29.9**	**10.6**	**47.7**
15–19	6.1	7.0	0.9	12.2
20–24	22.5	26.3	7.4	41.4
25–29	28.5	37.3	10.8	55.1
30–34	33.7	40.2	14.8	59.2
35–39	36.6	38.3	14.9	60.0
40–44	38.1	25.0	12.7	50.4

*Since 1973. †Excludes miscarriages.

did non-Hispanic women, but the percentage of unintended pregnancies and births and the distribution of outcomes were almost identical for Hispanic and non-Hispanic women.

Trends

There have been significant changes over time in the frequency of unintended pregnancy and in the resolution of such pregnancies, especially since 1987. Between 1981 and 1987, the unintended pregnancy rate changed little, but from 1987 to 1994, the rate dropped 16%, from 54 per 1,000 to 45 per 1,000 (Table 2, page 27). As a result, the rates of both unintended births and abortions fell between 1987 and 1994, but the drop was greater for unintended births (6 per 1,000) than for abortions (3 per 1,000). Consequently, the proportion of unintended pregnancies ended by abortion increased from 50% to 54%.

The changes differed markedly by age-group, especially when teenagers were compared with women aged 20 and older. Between 1981 and 1987, the unintended pregnancy rate and birthrate changed little among teenagers but increased among all women aged 20 and older, except among women aged 30–34. Changes in abortion rates were very small during this period. From 1987 to 1994, the rate of unintended pregnancy fell among all age-groups, although the change was small among women aged 35 and older. Among teenagers, the drop in unintended pregnancy affected only the abortion rate, which fell by 24% (from 42 per 1,000 to 32 per 1,000), while the rate of unintended births actually increased slightly (from 37 per 1,000 to 39 per 1,000). Among all other age-groups, the abortion rate increased slightly or stayed the same, while the rate of unintended births fell significantly as a consequence of the reduced rate of unintended pregnancy. In 1994, teenage women were less likely than women in any other age-group to end an unintended pregnancy by abortion, whereas in earlier periods teenagers have been similar to other women in this respect.

Between 1987 and 1994, currently and formerly married women experienced reductions in unintended pregnancy that were reflected in decreases both in the rate of unintended birth and in that of abortion. Among married women, the proportion of unintended pregnancies that ended in abortion increased from 28% to 37%. Never-married women, on the other hand, reported an increase in unintended births that was approximately equal to the decrease in abortions in this group, and the proportion of unintended pregnancies that ended in abortion declined.

All three income groups experienced a decrease in the proportion of pregnancies that were unintended (not shown).[22] The proportion of unintended pregnancies that ended in abortion remained about the same among women in the lowest income group, decreased among those in the middle income group and increased sharply among women in the highest income category.

Lifetime Experiences

Over their lifetime, the proportion of women experiencing an unintended pregnancy is substantial, even when the proportion in any one year is small. Of the women aged 15–44 who were surveyed in the 1995 NFSG, 28% indicated that they had had one or more unplanned births, and based on national abortion statistics, 30% of women had had one or more abortions (Table 3). The probability of having experienced an unplanned birth increased with age, largely because of the increased years of exposure to pregnancy risk. By the time they were 40–44, 38% of the women surveyed had had this experience.

Similarly, the probability of having had an abortion also increased with age, rising from 7% among women aged 15–19 to 40% among women aged 30–34. The proportion was lower among women older than 34 because this research did not attempt to include abortions before 1973, when these women experienced their highest-risk years (ages 15–24). Overall, 11% of all women had had both at least one unplanned birth and at least one abortion. Among women in their 30s, this proportion was 15%.

About 48% of all women aged 15–44 had ever had an unintended pregnancy (either an unplanned birth or an abortion, or both). The percentage increased with age, to a high of 60% among women 35–39. Although the percentage was lower among women aged 40–44, this figure may be understated, again because neither legal nor illegal abortions that occurred before 1973 were counted in this estimate.

Although we know how many women in each age-group had already had an unintended pregnancy, we cannot say exactly how many will have one by age 45, because of the difficulties of estimating the proportion of women having a first abortion who have previously had an unplanned birth and, of those having an unplanned birth, the proportion who have had an abortion. However, we were able to make lifetime abortion estimates at 1992 rates, the most recent year for which data were available (Table 4).*

We estimated the first-abortion rate by applying the 1992 proportion of first abortions for each age-group to the abortion rate for that age-group. The cumulative first-abortion rate indicates the number of women per 1,000, at 1992 rates, who will

Table 4. Abortion rate per 1,000 women and percentage of abortions that were first abortions, and first-abortion and cumulative first-abortion rates, by year, all according to age-group

Age	Abortion rate in 1992	% that were first abortions in 1992	First-abortion rate		Cumulative first-abortion rate*	
			1982	1992	1982	1992
Total	**25.9**	**.530**	**17.8**	**13.7**	**na**	**na**
<15†	7.6	.942	7.8	7.2	7.8	7.2
15–17	23.1	.855	26.0	19.7	85.8	66.4
18–19	53.8	.722	45.4	38.9	176.6	144.1
15–19	35.5	.760	34.1	27.0	176.6	144.1
20–24	56.3	.541	30.3	30.5	328.1	296.5
25–29	33.9	.419	15.7	14.2	406.6	367.5
30–34	19.0	.393	7.1	7.5	442.1	404.8
35–39	10.4	.405	2.8	4.2	456.1	425.9
40–44‡	3.2	.453	0.7	1.4	459.6	433.1

*Number having an abortion by end of specific age-period, per 1,000 women, at current rates. †Denominator for rates is women aged 14. ‡Numerator for rates is women aged 40 and older; denominator is women aged 40–44. *Note:* na=not applicable. *Sources:* **1982 DATA**—See reference 6.

*Information on the proportion of first abortions by age is unavailable for years since 1992. For calculating the lifetime experience of abortion for Table 3, we assumed that the 1993 and 1994 proportions of first abortion were similar to those for 1992, since small errors would have little effect on the results. The cumulative first abortion rate, however, depends entirely on these proportions, which are only accurate for 1992.

have had a first abortion by the time they reach the end of the age range. At these rates, 14% of women can expect to have had an abortion before age 20, 37% by age 30 and 43% by age 45.*

The 1992 cumulative lifetime first-abortion rate was slightly lower than the 1982 cumulative rate (46%),[23] and the rate may be still lower today, since abortion rates fell somewhat between 1992 and 1994. The drop between 1982 and 1992 was almost entirely the result of the lower first-abortion rate among teenagers, which fell by seven percentage points; the first-abortion rate among other age-groups changed by no more than two percentage points.

Discussion

Although it is well known that unintended pregnancy is common in the United States, the statistics presented in this article show just how widespread the experience is: Half of all pregnancies are unintended; 28% of women aged 15–44 have had an unplanned birth and 30% have had an abortion; 60% of women in their 30s have had an unplanned birth or an abortion; and, at 1992 rates, 43% of women will have had an abortion by age 45. Some of the women who are most prone to unintended pregnancy, especially unmarried and low-income women, are those who may have the greatest difficulty caring for an unanticipated child.

In spite of the disruption that can be caused by an unplanned birth, only about half of unintended pregnancies are terminated by abortion. A majority of married women (63%) continue their unintended pregnancies, possibly because they find it easier to accommodate an additional child than do unmarried women. However, 35% of formerly married women and 40% of never-married women also continue their unplanned pregnancies.

Between 1987 and 1994, the rate of unintended pregnancy fell from 54 pregnancies per 1,000 women of reproductive age to 45 per 1,000, a decrease of 16%. A likely explanation for the decline in unintended pregnancy is an increase in widespread and effective contraceptive use. The 1995 NSFG data show that condom use has increased significantly, and that the proportion of contraceptive nonusers among women at risk of unintended pregnancy has gone down.[24] Another possible factor is the availability of two new highly effective contraceptives, the implant and the injectable. In part because Medicaid pays for these methods, many of the women who adopted them were at especially high risk of unintended pregnancy—even when they were using other reversible methods. Therefore, use of the new methods may have prevented a disproportionate number of pregnancies.

Overall, the drop in unintended pregnancy between 1987 and 1994 is reflected in decreases in the rates of both unplanned birth and abortion. Further progress is needed, however. In view of the lower rates of unintended pregnancy in other developed countries,[25] such progress should be possible.

Among women aged 20 and older, the reduction in unintended pregnancy resulted in lower rates of unplanned birth. Abortion rates in this group changed little or increased slightly. Thus, the percentage of unintended pregnancies ended by abortion increased, indicating that women and couples had become less willing to accept unplanned births. One reason for the change is that a higher proportion of women in each age-group were not currently married. Among unmarried women, 60–65% resolved unintended pregnancies by abortion, compared with 37% among married women. Of women aged 25–29, the proportion who were currently married and living with their husband fell from 59% in 1987 to 53% in 1994.[26] Even within the married group, however, more women ended their unintended pregnancies by abortion in 1994 than did so in 1987. One possible reason may be married couples' increased reliance on the woman's earnings.

The pattern among teenagers is remarkably different. Among women aged 15–19 who had an unwanted pregnancy, the proportion who ended these pregnancies by abortion fell from 53% to 45%. The abortion rate declined 24%, while the rate of unplanned birth did not decline at all—and may have increased slightly. In the absence of data, any explanation of the differences between teenagers and other age-groups is speculative. One hypothesis is that teenagers may have been influenced by antiabortion messages. Other possible reasons are decreased access to abortion services, barriers posed by parental involvement statutes, and use of better contraceptive methods (such as the injectable and implant) by those teenagers who are strongly motivated to avoid childbearing, leaving unplanned pregnancies more concentrated among those less motivated to avoid childbearing.

Whether they end in abortion or unplanned birth, unintended pregnancies come at a cost both to the individuals involved and to the larger society. Reduction of unplanned pregnancy can only be achieved by decreasing risky behavior, promoting the use of effective contraceptive methods and improving the effectiveness with which all methods are used. More research is needed on the best ways to accomplish these goals, but we know that sensible strategies are to improve the accessibility of contraceptive services, to dispel misconceptions about the health risks of contraception and to make emergency contraception easily available and widely known.

*In the future, one can expect that for women having abortions at age 35 or older, a lower proportion will be having a first abortion, since a greater proportion of their reproductive lives will have occurred while legal abortion has been available. If we assume that the proportion of first abortions was .35 for women aged 35–39 and .30 for women aged 40–44, the cumulative abortion rate for women aged 45 will be 428 per 1,000, similar to the rate of 433 per 1,000, shown in Table 4.

References

1. Jones EJ et al., *Pregnancy, Contraception and Family Planning Services in Industrialized Countries*, New Haven: Yale University Press, 1989.

2. Brown SS and Eisenberg L, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, Washington, DC: National Academy Press, 1995.

3. Forrest JD, Epidemiology of unintended pregnancy and contraceptive use, *American Journal of Obstetrics and Gynecology*, 1994, 170(5):1485–1489, Table I.

4. Williams LB and Pratt WF, Wanted and unwanted childbearing in the United States: 1973–88, *Advance Data from Vital and Health Statistics*, 1990, No. 189.

5. Forrest JD and Singh S, The sexual and reproductive behavior of American women, 1982–1988, *Family Planning Perspectives*, 1990, 22(5):206–214

6. Forrest JD, Unintended pregnancy among American women, *Family Planning Perspectives*, 1987, 19(2):76–77.

7. Abma JC et al., Fertility, family planning, and women's health: new data from the 1995 National Survey of Family Growth, *Vital and Health Statistics*, 1997, Series 23, No. 19.

8. Ibid.

9. Ventura SJ et al., Advance report of final natality statistics, 1994, *Monthly Vital Statistics Report*, 1996, Vol. 44, No. 11, Supplement.

10. Forrest JD and Singh S, 1990, op. cit. (see reference 5), p. 212, Table 8; and Forrest JD, 1994, op. cit. (see reference 3).

11. National Center for Vital and Health Statistics (NCHS), Advance report of final natality statistics, 1981, *Monthly Vital Statistics Report*, 1983, Vol. 32, No. 9, Supplement; and NCHS, Advance report of final natality statistics, 1987, *Monthly Vital Statistics Report*, 1989, Vol. 38, No. 3, Supplement.

12. Torres A and Forrest JD, Why do women have abortions? *Family Planning Perspectives*, 1988, 20(4):169–176.

13. Henshaw SK and Van Vort J, Abortion services in the United States, 1991 and 1992, *Family Planning Perspectives*, 1994, 26(3):100–106 & 112.

14. Koonin L et al., Abortion surveillance—United States, 1993 and 1994, *Morbidity and Mortality Weekly Report*, 1997, 46(SS-4):37–98, and earlier volumes.

(continued on page 46)

Unintended Pregnancy...

(continued from page 29)

15. Henshaw SK and Kost K, Abortion patients in 1994–1995: characteristics and contraceptive use, *Family Planning Perspectives*, 1996, 28(4):140–147 & 158, Table 1.

16. Henshaw SK and Silverman J, Characteristics and prior contraceptive use of abortion patients, *Family Planning Perspectives*, 1988, 20(4):158–168, Table 2.

17. Jones EF and Forrest JD, Underreporting of abortion in surveys of U.S. women: 1976 to 1988, *Demography*, 1992, 29(1):113–126.

18. Fu H et al., Measuring the extent of abortion underreporting in the 1995 National Survey of Family Growth, unpublished paper, New York: The Alan Guttmacher Institute, 1997.

19. Ibid.

20. Leridon H, *Human Fertility: The Basic Components*, Chicago: University of Chicago Press, 1977, Table 4.20.

21. Ventura SJ et al., Trends in pregnancies and pregnancy rates: estimates for the United States, 1980–92, *Monthly Vital Statistics Report*, 1995, Vol. 43, No. 11, Supplement.

22. Forrest JD, 1994, op. cit. (see reference 3).

23. Forrest JD, 1987, op. cit. (see reference 6).

24. Finer L and Zabin LS, Does the timing of the first family planning visit still matter? *Family Planning Perspectives*, 1998, 30(1):30–33 & 42.

25. Jones EJ et al., 1989, op. cit. (see reference 1).

26. U.S. Bureau of the Census, Marital status and living arrangements: March 1987, *Current Population Reports*, 1988, Series P-20, No. 423, Table 1; and Saluter AF, Marital status and living arrangements: March 1994, *Current Population Reports*, 1996, Series P-20, No. 484, Table 1.

Issues in Brief

The Role of Contraception In Reducing Abortion

Following the 1994 election, which gave social conservatives a majority in the U.S. House of Representatives for the first time in 40 years, emboldened leaders of the antiabortion movement began to campaign openly against government-subsidized family planning programs. In a preview of the legislative assaults to come against both the international and domestic programs, House Pro-Life Caucus Chairman Christopher Smith (R-NJ) declared in January 1995 that he opposed U.S.-supported family planning efforts abroad because they lead to "abortion activism" and, by implication, result in more rather than fewer abortions.

The "evidence" for his claim derives in part from a misunderstanding of the data. Following the introduction of family planning programs, contraceptive use and abortion rates in some countries have initially risen simultaneously; in other countries—including the United States—contraceptive use is nearly universal, but abortion rates have only recently begun to decline significantly. These data have been used to legitimate the assertion that the availability of contraception itself causes more abortions.

In the two and a half years since Smith's comment, the proponents of this view have sowed sufficient doubt among enough policymakers about the role of family planning programs domestically and internationally to disrupt a decades-long political consensus. Previously, all but a very small minority considered self-evident the view that better access to and more effective use of contraceptives are necessary to reduce the incidence of abortion.

Common sense still leads most people to the conclusion that more effective contraception means fewer abortions—and research results point to that conclusion as well. Individual women who use an effective method of contraception simply are much less likely to face an unintended pregnancy and the decision of whether to have an abortion than women who do not. Similarly, the advent of high-quality contraceptive services, both in the United States and elsewhere, has been shown over time to be associated with lower levels of abortion.

Fundamentally, the relationship between contraceptive use and abortion is explained by a single phenomenon: the inexorable and universal trend toward couples' wanting, and having, smaller families and trying to time the birth of their children to best advantage. Acknowledgment of this reality is important, since an individual's decision to practice contraception or to have an abortion stems from this same goal.

This *Issues in Brief* seeks to explain the statistical trends in the context of women's lives, their reproductive goals and the choices available to them. A great deal of information exists, largely from research in the United States, on the likelihood that an *individual* can avoid an unintended pregnancy, and abortion, by practicing effective contraception. Analyses of the effectiveness of contraceptive *programs* in reducing abortion rates come from the experiences of many countries, including the United States.

Contraception Works For Individuals

As more and more couples feel strongly about limiting the number of children they have, and about having those children when they want them, the demand for contraception will be great; in its absence or in the event of its failure, so will the demand for abortion. The choice for societies is whether to facilitate access to contraception or to leave women and their families with abortion, legal or not, as the only means of achieving their childbearing goals.

American women typically want two children, as do women in European countries and many parts of Asia. In Latin America, the average preference is for two or three children. Women in Sub-Saharan Africa still want large families, five or six children on average, but indications are that, as in more developed countries, their desired family size is beginning to decline, too. These numbers represent women's goals, but not necessarily their experience. In most countries of the world, a significant proportion of women reveal that they have actually had more children than they had intended.

To succeed in having the number of children she wants when she wants them, a woman must use contraceptive methods properly for a long time. The

The Alan Guttmacher Institute
New York and Washington

fewer the desired number of children, the longer the period of time. For example, if a woman marries or becomes sexually active at 20, remains sexually active through her reproductive years (roughly until age 45) and wants only two children, she must practice contraception for approximately 240 months, or 20 years (see Chart A).

Data from the United States illustrate how contraception reduces abortion on a personal level. Virtually all American women who are sexually active but wish to avoid becoming pregnant use some form of birth control, since they have concluded that contraception is the most effective way to reduce the likelihood of a crisis pregnancy and the possibility of an unwanted birth or abortion. The facts support them: Women using a method of contraception are only 15% as likely as women using no method to have an abortion. In other words, contraception reduces the probability of having an abortion by 85%.

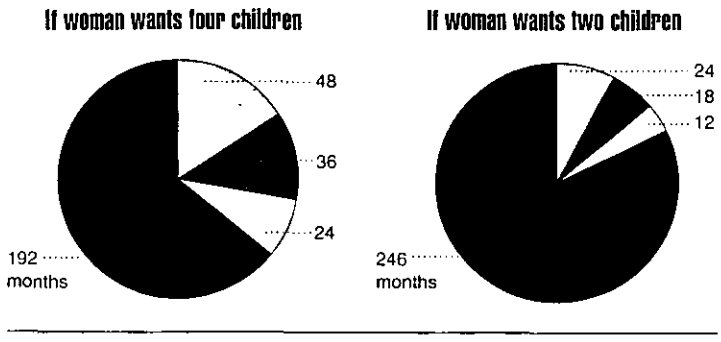
Yet, because of the enormous effort involved in practicing contraception continuously and effectively for more than two decades, almost half of all American women will have had at least one abortion by the time they are 45. It might seem contradictory to some and appear to be the "smoking gun" to others that the U.S. abortion rate (26 abortions per 1,000 women of reproductive age) is high by industrialized-country standards, even though 90% of women use a method. The explanation is that most of the unintended pregnancies and a disproportionate share of the resulting abortions occur among the 10% of women who use no method of birth control (such as teenagers having early sexual experiences) or use one only sporadically. The remaining abortions result among women trying to prevent an unwanted pregnancy whose contraceptive fails.

chart a

The Reproductive Years

The fewer children women want, the more time they spend in need of contraception.

Distribution of 300 months between ages 20 and 45



Note: Distributions assume that women marry at age 20 and remain sexually active between ages 20 and 45. *Source:* Alan Guttmacher Institute, *Hopes and Realities*, New York, 1995, p. 39.

Some of the failure is due to the methods themselves, but most is a result of the difficulties that individual women confront in incorporating the task of contraceptive use into their everyday lives; over half of all women practicing contraception use a method that requires ongoing attention (as opposed to surgical sterilization). They include women who rely on oral contraceptives as well as those using intercourse-related methods such as the condom and the diaphragm. Practicing the prevention of pregnancy, therefore, is at least as difficult as other such preventive health strategies as maintaining a proper diet, exercising and quitting smoking. In this light, perhaps what is surprising is how many women manage to use birth control [illegible]

Reducing Abortion Rates Takes Time

Individual countries have had very different histories in attempting to attain a balance between contraceptive use and reliance on abortion to control fertility. Some of the variation is associated with cultural and socioeconomic differences, but much of it relates to the disparity between actual and desired family size and the extent to which women were relying on abortion—regardless of its legal status—to limit childbearing before the introduction of family planning programs.

Russia's experience presents a stark and contemporary example of a situation where abortion has been legal for a long time, and because modern methods of contraception were unavailable for many years, abortion became the predominant method of controlling fertility for most women. According to the Russian Ministry of Health, the official abortion rate hovered around 109 abortions per 1,000 women of reproductive age in 1990, with only an estimated 19% of Russian women relying on modern contraceptives. By 1994, however, the health ministry reported that contraceptive use had risen to 24%, while the abortion rate had plummeted to 76 abortions per 1,000 women. Even taking into account the possibility of incomplete reporting, there is no doubt that the number of abortions is on the decline.

The desire of Russian women for small families is well established, intense and pervasive. Until now, a typical Russian woman who wanted only two children would have up to four abortions in her lifetime (although it would not be unusual for some women to have more). Even though the Russian abortion rate remains among the world's highest, Russian women are quickly seizing the opportunity they have been given to use modern birth control methods and are doing so relatively successfully.

Unlike Russia, both legal abortion and access to contraception have been available in Hungary, South Korea and the United States. Each country has had a different experience over time, but all have arrived at a point where abortion rates are on the decline.

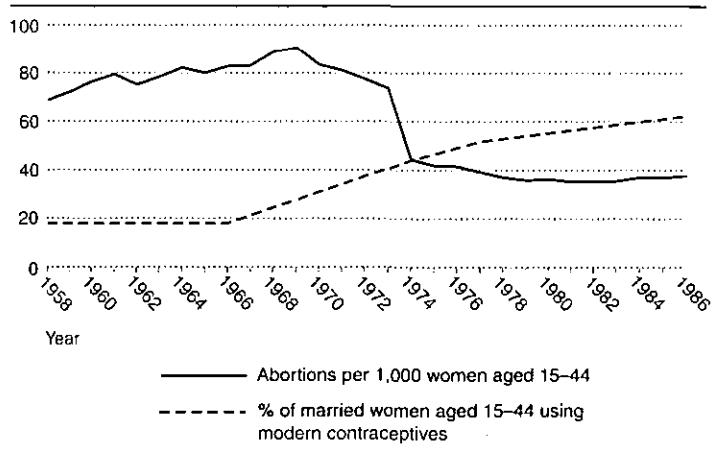
Data from Hungary show the trend in contraceptive use and abortion over a 30-year period. In the late 1950s, most women were relying on abortion rather than contraception to limit the size of their families. Then, in the mid-1960s, an increase in the availability of contraceptives led to a sharp rise in their use, which continued through the mid-1980s. At almost the same time, the levels of abortion began to drop sharply (see Chart B).

In South Korea, the transition took another route but

chart b

Trends in Hungary

As contraceptive use rose, abortion rates dropped.



Sources: S.K. Henshaw and E. Morrow, *Induced Abortion: A World Review, 1990 Supplement*, The Alan Guttmacher Institute, 1990; and United Nations, *World Contraceptive Use*, data diskettes, New York, 1992.

had the same result. When the desire for small families became a cultural norm in the 1960s, both abortion and use of contraceptives initially rose together, creating a period of rapid fertility decline. In the decade between the late 1970s and the late 1980s, however, the abortion rate, which had peaked at 83 abortions per 1,000 women, declined to 54 per 1,000. Meanwhile, contraceptive use tripled, from 24% of married women of reproductive age to 77%.

The number of abortions has not yet dropped further, primarily because a sizable number of South Korean women who practice contraception still rely on some of the less effective methods. In the meantime, the motivation for smaller and smaller families has intensified, and increasingly through use of contraceptive methods, but also abortion, the average number of children per woman has fallen from six to less than two over a 20-year period.

The pattern in the United States is somewhat similar to South Korea's, although less dramatic. Here, the cultural norm of having a small family was well established by the 1960s. Contraceptive use was relatively high also, although so were contraceptive failures, unintended pregnancies, unplanned births and clandestine abortions. With the legalization of abortion nationwide in 1973, the abortion rate increased for a brief time as services became available; by 1980, however, the rate had peaked and then began a gradual decline. The rate has dropped more quickly since 1990, accompanied by an increase in the number of women using contraceptives, using them better and shifting to more effective methods.

In some countries, the provision of abortion remains illegal but the desire for smaller families is rapidly becoming stronger and more widespread, outpacing the availability of the means to achieve family-size goals. Research on the number of Latin American women who obtain clandestine abortions highlights the effect on the abortion rate of the relatively recent introduction of contraceptive services in that region.

By 1990, contraceptive use had risen dramatically throughout Colombia and Mexico, while abortion rates had essentially stabilized at their mid-1970s levels of about 34 and 23 abortions per 1,000 women, respectively. Abortion appears to have played a significant role in containing family size throughout the region, as Latin American women began to shift from having 6–7 children each to only 3–4. Abortion rates in many areas initially rose or were already fairly high—despite laws against the practice of abortion—because contraceptive services were scarce. Although contraceptive use has risen, abortion rates are declining only gradually, partly because of the time it takes for contraceptive services to become widely accessible. Even more difficult is the development of the necessary cultural and behavioral shifts to successfully prevent unintended pregnancy—a goal that still remains elusive for many women in the United States.

A look at the major urban areas in Colombia and Mexico City clearly reflects the underlying trends. Between 1976 and 1990, the abortion rate in Bogotá fell by 40%, while contraceptive use doubled. During the same period, the abortion rate in Mexico City first climbed to a high of about 40 abortions per 1,000 women and then dropped to the mid-20s, while contraceptive use doubled (see Chart C). If the strong family planning programs in these cities can be replicated in small towns and rural areas, the national abortion levels, which have plateaued, are likely to show unmistakable signs of declining soon.

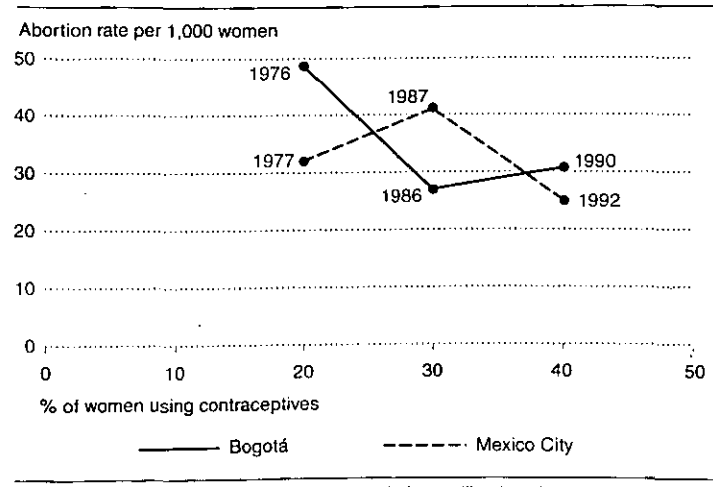
Abortion Laws And Abortion Rates

The data clearly demonstrate the dampening effect of contraceptive use on abortion rates, even though it often

chart c

Trends in Two Cities

The abortion rates in Bogotá and Mexico City fell as contraceptive use doubled.



Source: S. Singh and G. Sedgh, "The Relationship of Abortion Trends to Contraception and Fertility in Brazil, Colombia and Mexico," *International Family Planning Perspectives*, 23:4–14, 1997, Figures 2 and 3.

table 1
Abortion Legality and Rates

Country	Abortion rate per 1,000 women aged 15–44*	Maternal deaths per 100,000 live births
Where abortion is legal		
United States	26	12
England/Wales	15	9
Netherlands	6	12
Finland	10	11
Japan	14	18
Australia	17	9
Where abortion is illegal		
Brazil	38	220
Colombia	34	100
Chile	45	65
Dominican Republic	44	110
Mexico	23	110
Peru	52	280

*Data are for 1990; age-group is 15–49 in countries where abortion is illegal. *Sources:* Abortion rates are from S. Singh and S.K. Henshaw, "The Incidence of Abortion: A Worldwide Overview Focusing on Methodology and on Latin America," paper delivered at International Union for the Scientific Study of Population Seminar on Socio-Cultural and Political Aspects of Abortion from an Anthropological Perspective, Trivandrum, India, Mar. 25–28, 1996; maternal death rates are from P. Adamson, "A Failure of Imagination," *The Progress of Nations: 1996*, United Nations Children's Fund (UNICEF), New York, 1996.

takes time for the impact to be seen. Skeptics remain, however, largely among those whose main strategy for reducing abortion is to criminalize it. But while it may seem paradoxical, the legal status of abortion appears to have relatively little connection to its overall pervasiveness. In some parts of Latin America, for example, the abortion rate is as much as twice that of the United States. Worse, mainly because the procedure must be done clandestinely, it is associated with a high incidence of maternal death and disability. By contrast, in many countries where abortion is legal and performed under safe conditions, abortion rates are among the world's lowest (see Table 1).

The World Health Organization estimates that about 20 million clandestine abortions occur each year, the vast majority in South and Southeast Asia, Sub-Saharan Africa, and Latin America and the Caribbean. Any serious efforts to reduce either the overall number of abortions in these countries or the almost 600,000 maternal deaths each year—about 80,000 as a direct result of unsafe, illegally performed abortions—cannot succeed by making abortion there "more illegal."

If the main effect of abortion's legal status is on its safety, not its likelihood, then abortion rates of various countries must be explained by other factors. The two most important ones are the extent to which women are at risk of unwanted pregnancy (which depends largely on how many children they want and how strongly they feel about it) and the prevalence and effectiveness of contraceptive use. Abortion rates are believed to be low in some Islamic countries, for example, because couples there still want to have large families and because the consequences of sex outside marriage are very severe for women. At the opposite end of the legal and cultural spectrum, the abortion rate is low in the Netherlands, but for completely different reasons. Dutch women want very small families and high rates of premarital sexual activity prevail, but because of widespread reliance on effective contraception, abortion is uncommon.

A Critical Juncture

In much of the world, abortion rates have already declined or are beginning to do so. In most cases, the declines have been made possible by the increased availability, greater acceptance and more effective use of contraceptive services. Sub-Saharan Africa, with the world's fastest growing population, is at a crucial turning point. Although women there still want relatively large families, they too are increasingly expressing the desire to have fewer children than their mothers did. These beginnings of a desire for fewer children and a nascent shift from traditional family planning methods to more modern ones are driving a rising need for contraceptive services. In the absence of stronger contraceptive programs, however, African women may turn more frequently to abortion, even unsafe abortion, if it is the primary means available to limit their childbearing. To avoid this situation, better and more contraceptive services are essential.

Contraception, even under the best of circumstances, cannot end the need for abortion entirely. Contraceptive methods will never be perfect, and women and men will never be perfect users of them. What common sense and research show, however, is that the most effective means of reducing abortion is preventing unintended pregnancies in the first place. No serious effort to achieve this end, and thus reduce abortion, can succeed without contraception.

Information Sources

The Alan Guttmacher Institute (AGI), *Preventing Pregnancy, Protecting Health: A New Look at Birth Control Choices in the United States*, New York, 1991.

S.K. Henshaw, "Abortion Laws and Practice Worldwide," *Choices*, 26:2–6, 1997.

S.K. Henshaw and K. Kost, "Abortion Patients in 1994–1995: Characteristics and Contraceptive Use," *Family Planning Perspectives*, 28:140–147 & 158, 1996.

S. Singh and G. Sedgh, "The Relationship of Abortion Trends to Contraception and Fertility in Brazil, Colombia and Mexico," *International Family Planning Perspectives*," 23:4–14, 1997.

S. Singh and M. Klitsch, "Are Women Achieving Their Childbearing Goals?" *Issues in Brief*, AGI, Nov. 1996.

U.S. Agency for International Development, *The Role of Family Planning in Preventing Abortion*, Washington, DC, 1996.

This report was written by Susan A. Cohen. It was prepared with the support of The Pew Charitable Trusts/Global Stewardship Initiative.

The Alan Guttmacher Institute
New York and Washington

A Not-for-Profit Corporation for Reproductive Health Research, Policy Analysis and Public Education

120 Wall Street
New York, NY 10005
Telephone: 212 248-1111
Fax: 212 248-1951
e-mail: info@agi-usa.org

1120 Connecticut Avenue, N.W.
Suite 460
Washington, DC 20036
Telephone: 202 296-4012
Fax: 202 223-5756
e-mail: policyinfo@agi-usa.org

http://www.agi-usa.org

Women's Issues - Family planning

Support for Family Planning in the Clinton Administration

Under the Clinton Administration, federal support for family planning has been steadily rising, both in programs specially dedicated to family planning and others (e.g., Medicaid) that provide family planning services as part of a broader program.

Title X Family Planning grants will, under the President's proposal, be increased $15 million to $218 million in FY 1999.

- This is a 46% increase since 1992, at a time when total Federal discretionary spending has increased only 6% [however, non-defense discretionary will have risen 32%].
- $15 million would be the largest increase enacted in this administration, and well above the $5m Congress provided last year.

Medicaid provides almost $500 million [est: $475 in FY98] in Federal funds to support family planning services. By FY99, this will represent an increase of almost 20% [19%] over FY 1992.

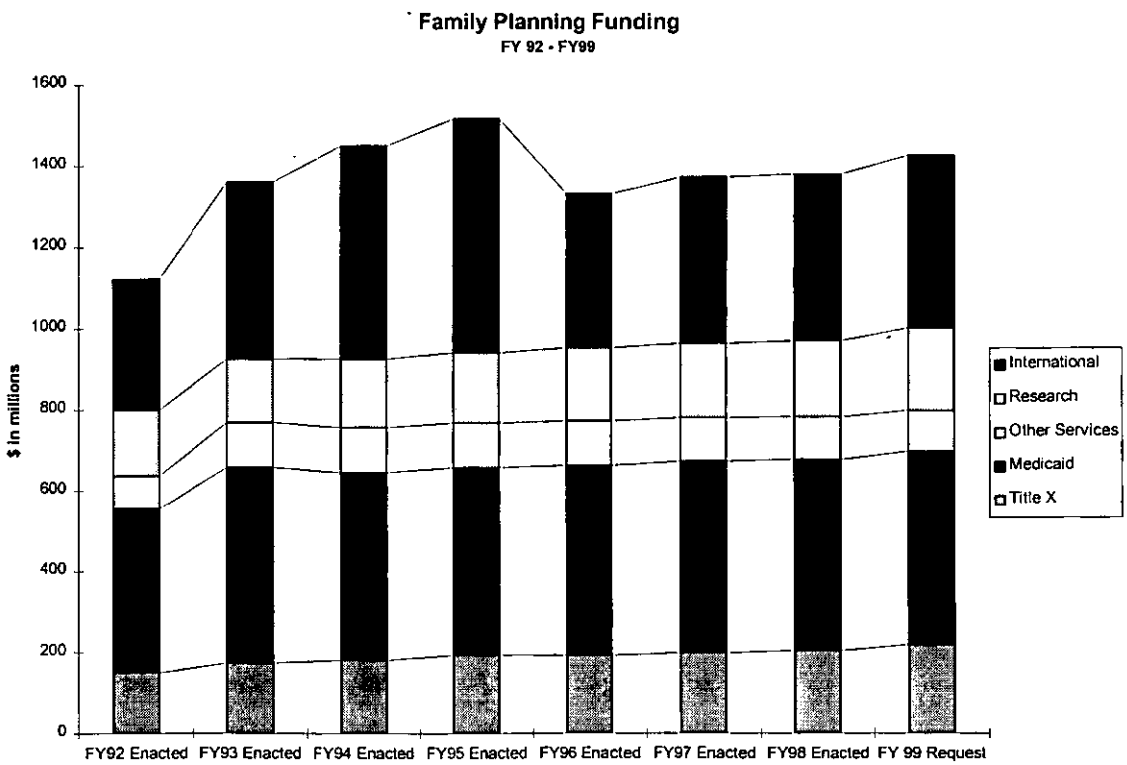
Family planning services are also provided by states and local communities from the Maternal & Child Health Block Grant, the Social Services Block Grant, and the Preventive Health Block Grant and to Native Americans by the Indian Health Service. In FY 1999, we estimate $100 million [actually $101m] in family planning services will be provided under the President's budget, a 21% increase over FY92 [though a 4% decrease from FY98].

Services are provided to nearly 4.4 million clients each year at more than 4,000 family planning clinics nationwide. They include the contraceptive services, pregnancy testing, STD screening and treatment, and education and outreach.

The National Institutes of Health undertake research in infertility, contraception, and related matters. CDC funds programs to educate teenagers about sexual development and abstinence. Under the President's Budget, in FY 1999 these should total about $200 million [$202m], a 25% increase since FY92.

Internationally, the Administration has been a strong supporter of family planning programs. Under the Presidents Budget, bilateral assistance provided through AID and assistance to the United Nations Population Fund will grow to $425 million in FY99, a 32% increase over FY92.

In total, under the President's budget family planning will rise to $1.43 billion in FY 1999, a 27% increase over FY 1992 [$1.1 billion].


Family Planning Funding
FY 92 - FY99
$ in millions
1600
1400
1200
1000
800
600
400
200
0
FY92 Enacted
FY93 Enacted
FY94 Enacted
FY95 Enacted
FY96 Enacted
FY97 Enacted
FY98 Enacted
FY 99 Request
International
Research
Other Services
Medicaid
Title X

FAMILY PLANNING FUNDING ($ in millions)

FY 1992 - FY 1999

	FY 1992 Enacted	FY 1993 Enacted	FY 1994 Enacted	FY 1995 Enacted	FY 1996 Enacted	FY 1997 Enacted	FY 1998 Enacted	FY 1999 Request	% change FY98-FY99	Total % change FY92 - FY99
Title X Family Planning	149	173	181	193	193	198	203	218	7%	46%
Medicaid (Federal share)	405	485	465	465	470	475	475	480	1%	19%
Other Services*	83	111	111	110	111	107	105	101	-4%	21%
Research spending	162	157	169	173	180	183	187	202	8%	25%
International**	322	436	524	575	378	410	410	425	4%	32%
TOTAL FAMILY PLANNING	1,122	1,362	1,450	1,516	1,332	1,373	1,380	1,426	3%	27%

* Reflects estimated family planning expenditures in the Maternal and Child Health Block Grant, Social Services Block Grant, Preventive Health Block Grant, and the Indian Health Service.

** Reflects funding for Agency for International Development (AID) bilateral assistance and the UN population fund.

Fpspread.xl

Message Sent To: _____

Women's issues -
family planning

HEALTH DIVISION
Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Date: 1/16

TO: M. Verveer / E. Kagan / A. Lewis

fax: 6-6244 6-2878 6-2223

FROM: Gotbaum

Number of pages (not including cover): 2

Subject:

Family Planning Charts.

per Gotbaum, he will follow-up over weekend via email.

Please call (202) 395-9188 if there are any problems with this transmission

FAMILY PLANNING FUNDING ($ in millions)

FY 1992 - FY 1999

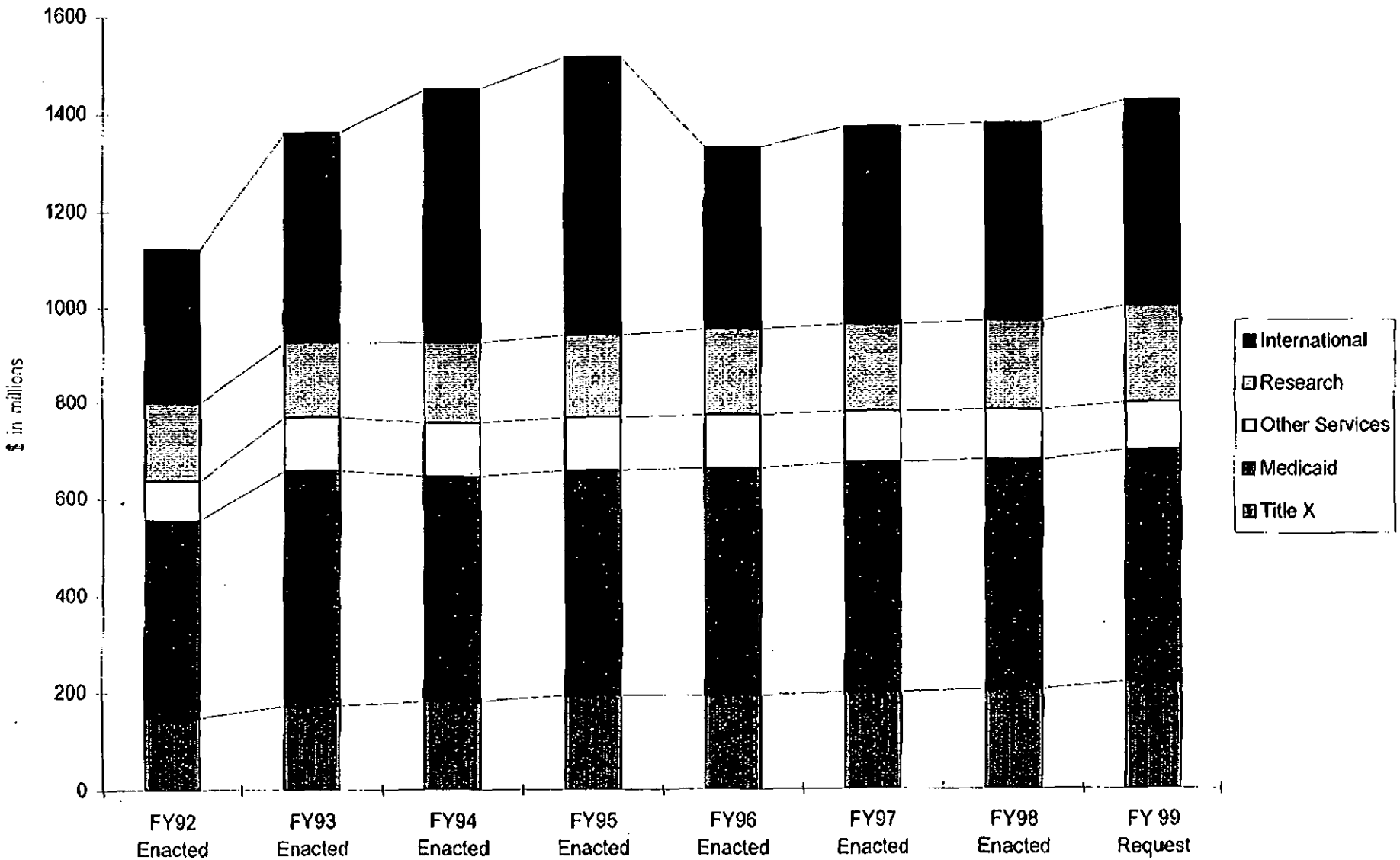
	FY 1992 Enacted	FY 1993 Enacted	FY 1994 Enacted	FY 1995 Enacted	FY 1996 Enacted	FY 1997 Enacted	FY 1998 Enacted	FY 1999 Request	% change FY98-FY99	Total % change FY92 - FY99
Title X Family Planning	149	173	181	193	193	198	203	218	7%	46%
Medicaid (Federal share)	405	485	465	465	470	475	475	480	1%	19%
Other Services*	83	111	111	110	111	107	105	101	-4%	21%
Research spending	162	157	169	173	180	183	187	202	8%	25%
International**	322	436	524	575	378	410	410	425	4%	32%
TOTAL FAMILY PLANNING	1,122	1,362	1,450	1,516	1,332	1,373	1,380	1,426	3%	27%

* Reflects estimated family planning expenditures in the Maternal and Child Health Block Grant, Social Services Block Grant, Preventive Health Block Grant, and the Indian Health Service.

** Reflects funding for Agency for International Development (AID) bilateral assistance and the UN population fund.

Family Planning Funding

FY 92 - FY99



Women's issues —
family planning

Meeting with Family Planning Advocates

January 20, 1998

- I'm glad to have the opportunity to meet with you all as we approach the 25th anniversary of *Roe v. Wade*. I'd like to thank you for all your work to promote and protect a woman's right to choose. I know it has not been an easy mission.

- In fact, this has never been an easy issue. I hope that we will be able to find ways of to increase dialogue, to work together with people of good faith on both sides of this issue, to try to understand how we can continue the progress that has been made in the last five years in decreasing the number of abortions, decreasing teen pregnancy, in working to give women opportunities to make choices that are best for them and their families.

- I think my husband's formulation of it years ago is still the right one: abortion should be legal, safe and rare. We have worked hard in the last five years to maintain legality and safety and to begin to change attitudes, values and policies that will make abortion less necessary. And we are gratified at some of the results we are seeing -- the teen pregnancy rate is down to its lowest level in years, and the abortion rate is declining as well.

- That's why the President's increase in Title X is so important -- we can continue the progress we've made. We must work on behalf of educational opportunities for young women and young men so they know they have better choices and that they should postpone childbearing so that they can avoid the issue of abortion. That's why I think efforts like HHS' Girl Power! Campaign are so important. This pregnancy prevention education initiative is engaging all HHS teen pregnancy prevention and related youth programs in sustained efforts to prevent pregnancy among 9- to 14-year-old girls.

- We must continue to speak out on behalf of family planning here and around the world. As I have traveled around the world, I have seen examples of how our international family planning efforts reduce abortion in country after country [e.g. Brazil]. I have also been to a country where the government forces women to have abortion [e.g. China] and to a country where the government forces women to become pregnant [e.g. Romania]. Two extremes -- government, on the one hand, saying you cannot have children; government on the other hand, saying you must have children. What we have tried to do in promoting choice is to say that this most difficult of all intimate choices for women and men must be made by the individual in consultation with her conscience, her God, her physician and her family.

- I look forward to working with you to meet the challenges ahead. Thank you for all your work.

Women's Issues -
Family Planning

Meeting with Family Planning Groups

Background Facts

January 20, 1998

Under the Clinton Administration, federal support for family planning has steadily increased, both in programs specially dedicated to family planning and in programs providing family planning as part of a broader range of services. Most recently, the President demonstrated his commitment to family planning by refusing to accede to Republican demands that he support a measure to deny federal money to any overseas family planning agency that performs abortions or lobbies to change abortion laws. Congressional Republicans had made the President's support of this effort the price of passage of fast-track trade legislation and legislation that would fund the U.N. and the I.M.F.

A Record of Strong Support for Family Planning

Increasing Funding for Family Planning. In total, under the President's budget support for family planning will rise to $1.43 billion in FY 1999, a 27% increase over FY 1992. These funds provide services to nearly 4.4 million clients each year at more than 4,000 family planning clinics nationwide. Services provided include contraceptive services, pregnancy testing, STD screening and treatment, and education and outreach.

Increasing Funding for Title X. The President's FY 1999 budget proposal will call for an increase of $15 million in Title X Family Planning grants (to $218 million).

- A $15 million increase would be the largest enacted during this Administration, and well above the $5 million Congress provided last year.
- This increase would cap an overall 46% increase since 1992, at a time when total Federal discretionary spending has increased only 6%.

Expanding Medicaid and Other Services. Under the President's proposal, Medicaid will provide almost $500 million in federal funds to support family planning services. This sum represents an increase of 19% over FY 1992. The Maternal & Child Health Block Grant, the Social Services Block Grant, and the Preventive Health Block Grant provide funds to state and local communities for family planning services. In FY 1999, the President's budget will request $100 million in family planning services -- a 21% increase over FY92 (though a 4% decrease from FY98).

Supporting Prevention Education and Research. The National Institutes of Health undertake research in infertility, contraception, and related matters. CDC funds programs to educate teenagers about sexual development and abstinence. Under the President's FY99 Budget, funding for these research and education programs should total about $200 million -- a 25% increase since FY92. In addition, HHS' Girl Power! education initiative is engaging all HHS teen pregnancy prevention and related youth programs in sustained efforts to promote pregnancy prevention among 9- to 14-year-old girls.

Promoting International Family Planning. The Administration has strongly supported international family planning programs. The President has blocked several Congressional efforts to prohibit funding for international family planning groups that lobby on behalf or abortion rights or perform abortions. And under the President's Budget, bilateral assistance provided through AID and assistance to the United Nations Population Fund will grow to $425 million in FY99, a 32% increase over FY92.

A Record of Reducing Unwanted Pregnancy

Reducing Unintended Pregnancy. The Alan Guttmacher Institute, a New York-based organization that conducts research on reproductive issues, recently reported a 16% decrease in unintended pregnancies between 1987 and 1994. The change is primarily a result of improved use of contraceptives, according to the study's author. And according to a recent CDC report, the percentage of pregnancies ending in legal abortions has fallen to its lowest level since the mid-1970s.

Preventing Teenage Pregnancy. After rising steadily from 1986 to 1991, the birth rate for teens aged 15-19 declined for the sixth straight year in 1996. The rate declined 12% between 1991 and 1996 and four percent from 1995 to 1996. All 50 states had a sustained decline in their teen birth rates between 1991 and 1995, and 21 of these states had declines of more than 10% over this period.

Women's Issues - ~~Title~~ Family planning

JOSHUA GOTBAUM
01/20/98 01:48:05 PM

Record Type: Record

To: Neera Tanden/WHO/EOP, Elena Kagan/OPD/EOP

cc: Richard J. Turman/OMB/EOP, Chin-Chin Ip/OMB/EOP
Subject: Title X Funding: Corrected point: FY89 request was Reagan; FY90 was the first Bush Budget

My (careful and competent) staff notes that FY89 was a Reagan submission. See below. Also a typo. Therefore, one should say:

If we look at the President's Budget proposals (vs what Congress enacted), then we can say the following about Title X requests:

- From FY90 to its last budget submission for FY93, the Bush Administration proposed increases in Title X totalling $11 million over 4 years.
- From FY94 to FY97, also 4 years, the Clinton Administration proposed $69 million in increases. [Unfortunately, we didn't get our full proposals.]
- In the FY99 budget, the President will propose an additional $15 million increase. If enacted, it will be the largest increase achieved by this Administration. [Congress, on its own, enacted a larger increase for FY93, to $173 from the previous year's $150m.]

---------- Forwarded by Joshua Gotbaum/OMB/EOP on 01/20/98 01:43 PM ----------

Richard J. Turman
01/20/98 01:30:38 PM

Record Type: Record

To: Joshua Gotbaum/OMB/EOP@EOP

cc: Chin-Chin Ip/OMB/EOP@EOP
Subject: Note: FY89 request was Reagan; FY90 was the first Bush Budget

This is not a big deal, but after we spoke I went and checked the transmittal dates of the FY89 and FY90 Budgets.

FY89 was transmitted by Reagan in January, 1988.

FY90 was transmitted by Reagan on Jan. 9, 1989

FY90, Round II, was transmitted by Bush on Feb. 9, 1989, and superceded the Reagan FY90 Budget.