

Study on the Incidence of Teen Pregnancy and Childbearing in West Virginia

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I. Introduction

For more than a decade the births to West Virginia teens had consistently declined, and between 1991 and 2004 teen births had dropped by 24%.¹ Then, in 2006, the rate of teen childbearing in the state increased, with alarming social and economic costs.

The purpose of this report is to 1) highlight the incidences and effects of teen pregnancy and childbearing in West Virginia as compared to the national landscape, and 2) identify strategies and policies aimed at reducing teen pregnancy.

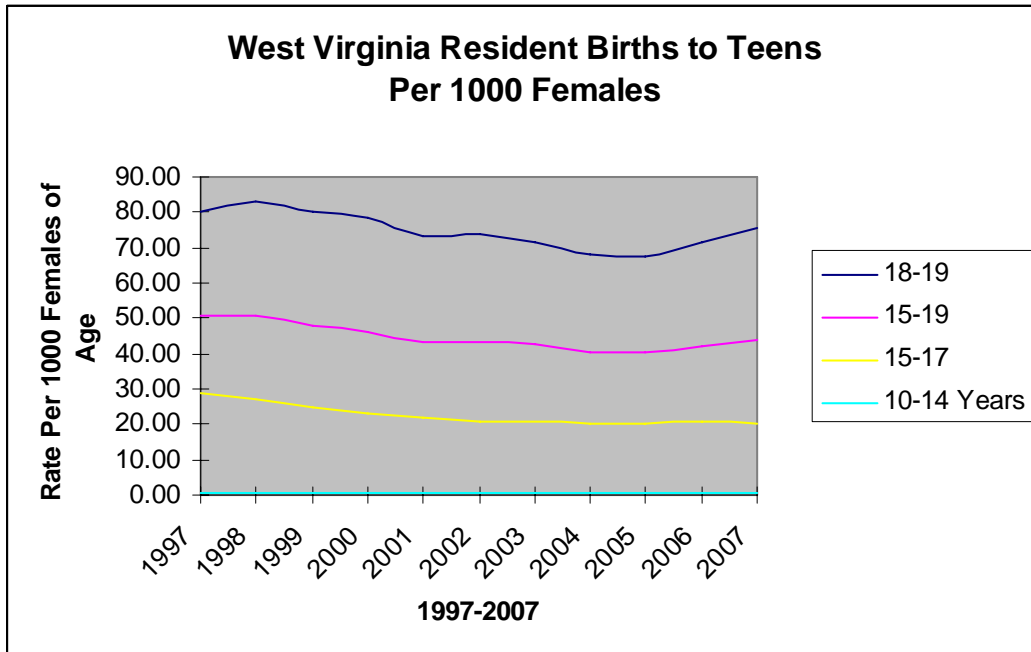
Description of Problem:

Young mothers and their children are more vulnerable to adverse social, economic, and health conditions. Teen mothers are less likely to graduate from high school and more likely to live in poverty, and their children are more likely to suffer from low birth-weight, low literacy, neglect, greater health problems, a 33% higher risk of becoming a teen parent themselves, and 13% higher risk of becoming incarcerated.² The costs of teen childbearing are not only felt by teen mothers and their children, but by society at large. Analysis by the National Campaign to Prevent Teen Pregnancy finds that teen childbearing costs West Virginia taxpayers nearly \$38 million annually, including \$14 million for child welfare and \$4 million for incarceration.³ While it is important to consider teen pregnancy and childbearing within the context of poverty that pervades West Virginia, an exhaustive socioeconomic analysis goes beyond the scope of this paper.

II. Comparison Between National and West Virginia Data

Teens in the United States are more at-risk for unintended pregnancy than in any other industrialized country. The most recent data shows that West Virginia's teen birth rate of 43.4 births per 1,000 women is higher than the national average of 40.5, with 18-19 year olds in West Virginia accounting for the higher rate. The current rate for girls ages 18-19 is 77 in West Virginia, compared to 70 nationally.⁴ Teen pregnancy rates between 1992 and 2000 did not decline in West Virginia as much as the rate decreased nationally. While the teen birth rate decreased 34% nationally between 1991 and 2005, it decreased only 25% in WV during the same period.⁵

The following graph illustrates the birth rate among West Virginia teens from 1997 to 2007:

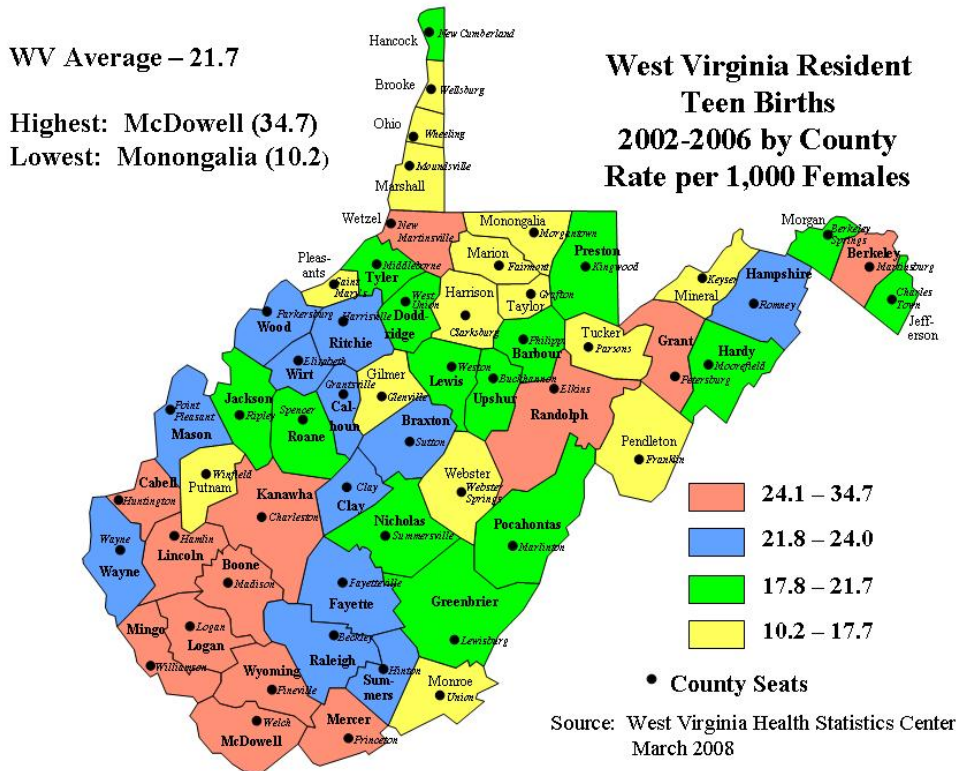


Source: West Virginia Health Statistics Center

Observations:

1. Births to West Virginia teens, for ages 15-19, continued to decline from 1997 through 2005.
2. Births to West Virginia resident teens ages 10-14 has remained fairly stable from 1997 through 2007, ranging 0.3 to 0.6 births per 1000 females of the age group.
3. In 2006 and in 2007 the increase in teen births occurred specifically among the 18-19 year-old age group.
4. Births to West Virginia resident teens ages 15-17 continued a decline during the same time period with a slight one-year increase in 2006, going from 20.0 per 1000 females in 2005 to 20.9 in 2006, but declining again in 2007 to 20.2 births per 1000 females of the age group.
5. Teen girls ages 18 and 19 have the highest proportion of teen pregnancies. They also have a higher teen pregnancy rate as compared to 15 to 17 year-olds in the State. While the majority of teen pregnancies in West Virginia occur to 18-19 year-olds, this paper focuses on teens as a whole because all teen pregnancies have negative consequences.

The following map is a comparison by West Virginia county:



III. Demographics

West Virginia is characterized by an aging population and is predominantly white. The largest minority group is African American, with a growing Latino population.

- Of West Virginia’s 1.8 million people, almost 400,000 are under the age of 18. The majority of youth in West Virginia are white, with fewer than 10,000 non-white youth residents.⁶
- Teen pregnancy in West Virginia is disproportionately higher among the State’s African American population with 103 pregnancies per 1,000 young African American teens vs. 66 pregnancies per 1,000 white teens.⁷

IV. Sexuality Education in West Virginia

West Virginia’s education policies require that public schools teach some form of sex education, as it relates to HIV/AIDS prevention. Abstinence-based education is primarily stressed and contraception may be covered as part of basic sexual education. However there is no mandate for sexual education.⁸ It is important to stress that the West Virginia

Board of Education policies indicate a broader approach to sexual education than what actually may be in effect throughout the state. Health educators anecdotally report that there is no uniform sexuality education curriculum.

According to the West Virginia Board of Education's *Health Content Standards and Objectives for West Virginia Schools* (Policy 2520.5), effective November 13, 2005, "a major focus has been given to what the Center for Disease Control recognizes as adolescent risk behaviors," including "sexual behaviors that result in HIV infection/other STDs and unintended pregnancy." Starting in the seventh grade, students should be able to "analyze the difference between safe and risky behaviors, including methods for preventing pregnancy and STDs (e.g., abstinence and methods of birth control)."⁹

Over the past eight years there has been an emphasis on abstinence-only education. West Virginia followed the national trend and created its own program, the West Virginia Abstinence Education Project. In 2006, West Virginia received over \$385,000 in federal Title V funding for abstinence-only education, and in 2007, the State received \$600,000 in Community-Based Abstinence Education funds.¹⁰ However, recent studies have found such programs ineffective at reducing teen pregnancy or delaying sexual activity.¹¹

A State program with a broader approach to sexuality education is the West Virginia Department of Health and Human Resources' Adolescent Pregnancy Prevention Initiative. This program includes abstinence and family planning education and is driven by a group of youth advocates including religious leaders, social workers, teachers and school nurses. Another program, the Adolescent Pregnancy Prevention Task Force, is a voluntary network of individual and group programs that addresses adolescent pregnancy prevention, sexuality and reproduction, decision-making, and risk reduction.¹² The group, while inactive for several years, is in the early stages of reorganization.

V. Teen Sexual Activity in West Virginia

According to the Centers for Disease Control and Prevention, positive indicators regarding high school teens' sexual behavior and contraceptive use across the country are reversing. Presently, more than one-third of teens are sexually active, with less than two-thirds of them reporting using a condom the last time they had sex, indicating a 2% increase of sexual activity between 2005 and 2007 and a 2% decrease of condom use during the same time period.¹³

These trends that the Centers for Disease Control and Prevention call "more sex, less contraception" are especially relevant in light of the fact that the teen birth rate has recently increased – the first increase in fifteen years. A survey of West Virginia high school students shows a higher rate of sexual activity than the national average – 53 percent vs. 47 percent.¹⁴ Reported condom use for this group matches the national average at 61% using a condom at last intercourse.¹⁵

VI. Family Planning Services in West Virginia

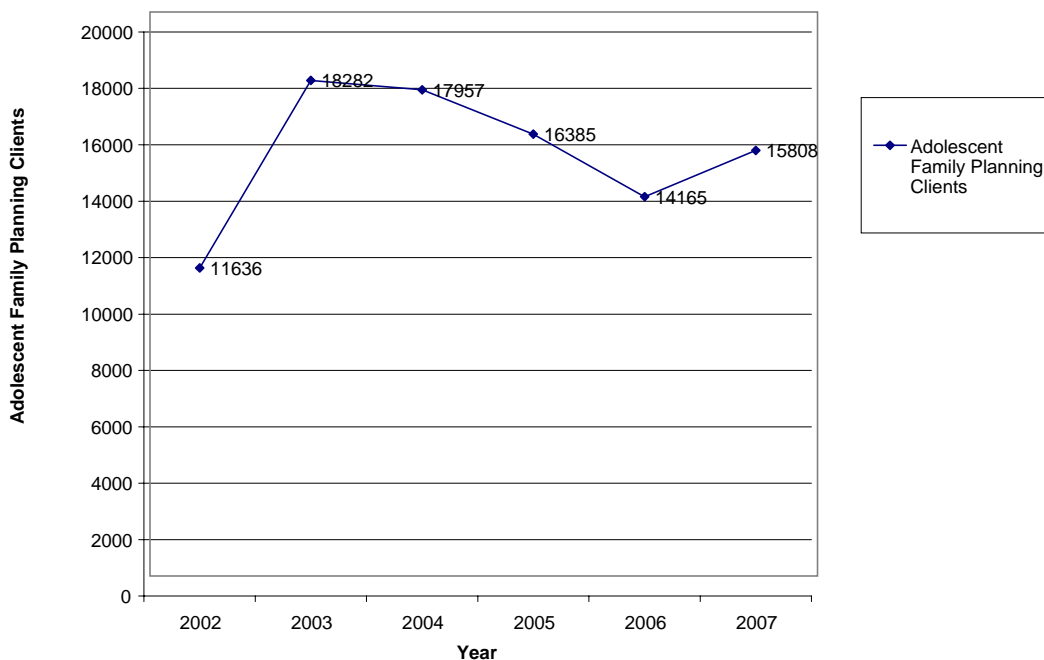
Family planning clinics help women plan and space their pregnancies and avoid mistimed, unwanted or unintended pregnancies, reduce the number of abortions, lower rates of sexually transmitted diseases, and significantly improve the health of women, children and families.¹⁶

The West Virginia Department of Health and Human Resources Family Planning Program, despite limited funding, has been ranked sixth nationally in service availability. Services are available confidentially at low or no cost at 145 clinics throughout the state. Any female or male capable of becoming or causing pregnancy whose income is at or below 250% federal poverty level is eligible to receive services. No one is denied services because of inability to pay.

A combination of funds from the U.S. Department of Health and Human Services, Office of Population Affairs, and West Virginia state budget appropriations support most of the services, which include:

- Pregnancy testing
- Fertility awareness information
- Free contraceptive methods and supplies
- Breast, cervical and testicular cancer screenings
- Surgical sterilizations for women and men

The following graph illustrates the number of adolescents served through West Virginia Family Planning Program:



Source: West Virginia Family Planning Program, July 2008

The difference by sex of teens served in Family Planning Clinics is shown in this table:

Number of Teens Served by WV Family Planning Program		
Year	Males	Females
2002	517	11,119
2003	586	17,696
2004	574	17,383
2005	737	15,648
2006	774	13,391
2007	748	15,060

VII. Unintended Pregnancy and Abortion in West Virginia and Nationwide

Nearly half of pregnancies among American women are unintended, and four in 10 of these are terminated by abortion.¹⁷ The West Virginia Health Statistics Center collects information on all abortions performed in the state as does Alan Guttmacher Institute.¹⁸ However, this data is problematic because it does not account for women traveling out of state to procure services. The Health Statistics Center reports that after years of a decline in the abortion rate, there was an increase in 2006, the most recent year with available data.¹⁹

There is a shortage of abortion providers in West Virginia. In 2005, there were 4 abortion providers in the state. This represents a 33% increase from 2000, when there were 3 abortion providers. In 2005, 96% of West Virginia counties had no abortion provider. 84% of West Virginia women lived in these counties. The only two clinics that currently provide elective abortion care are located in Charleston.²⁰

West Virginia law mandates that a minor must inform a parent or guardian twenty-four hours before having an abortion. This can be a barrier for teens who need confidential services, as some young women cannot involve their parents due to physical or emotional abuse at home or because their pregnancy is a result of incest.

The Office of Medical Services will pay for pregnancy termination upon certification by the physician that a) a general medical necessity exists for the pregnant women related to the following conditions: physical, emotional, psychological, familial, or age, or because of a combination of the above relative to the wellbeing of the patient; or b) a specific medical necessity condition exists such as * rape, * incest * or endangerment of the woman's life if the fetus is carried to full term.

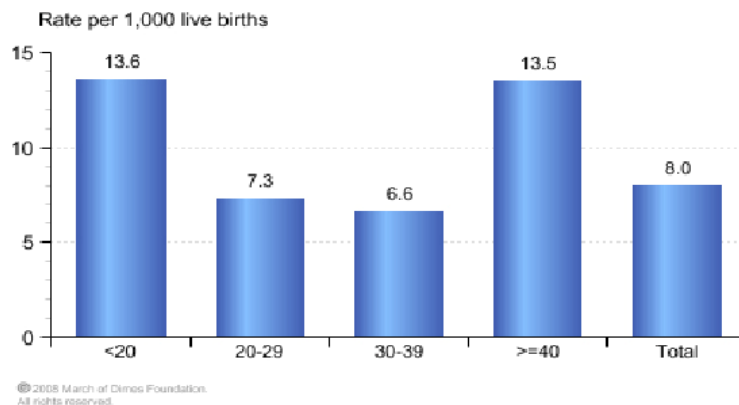
VIII. Understanding the Medical Costs of Teen Birth

Teen pregnancy leads to poor birth outcomes. Teen childbearing often results in later entry into prenatal care and lower likelihood of breastfeeding. Children born to teen mothers are at greater risk of:

- Low birth-weight and pre-term birth, both of which increase the likelihood of infant mortality
- Having mothers *and* fathers who suffer from depression and relationship conflict
- Lower cognitive scores on a range of measures in early childhood
- Childhood health problems
- Child abuse and neglect²¹

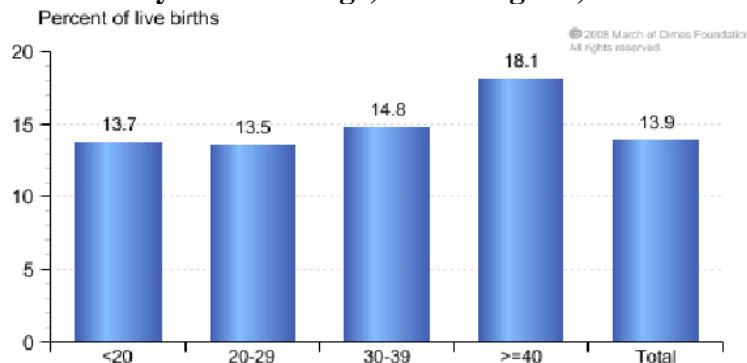
In West Virginia during 2002-2004, on average, infant mortality rates (per 1,000 live births) were highest for women under age 20 (13.6), compared to 8.0 for all live births.²²

Infant Mortality Rates by Maternal Age, West Virginia, 2002-2004 Average



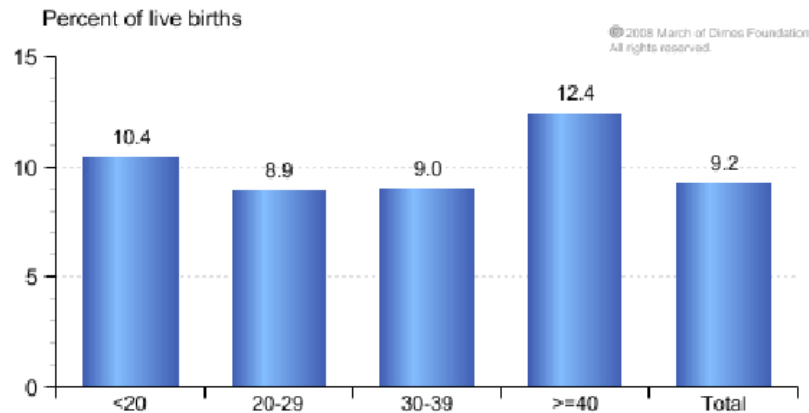
Maternal age is a risk factor for pre-term birth, with higher pre-term birth rates found among the youngest and oldest mothers.²³

Pre-term Births by Maternal Age, West Virginia, 2003-2005 Average



In West Virginia during 2003-2005, the low birth-weight rates were highest for women ages 40 and older (12.4%) and under age 20 (10.4%).

Low Birth-weight by Maternal Age, West Virginia, 2003-2005 Average



IX. Understanding Social and Fiscal Costs of Teen Childbearing

Teen childbearing results in higher incidences of the following social problems:²⁴

- Foster children
- Children experiencing trouble in school
- High school drop-outs
- Adolescent mothers from one generation to the next
- Incarceration of people raised by teen parents
- Welfare dependency
- Father absence

Teen mothers are also more likely to have subsequent births during their adolescence. Of the 2,450 teen births in West Virginia in 2005, 2,000 were first births and 450 were subsequent births. Of all the teen births in the State that year, 7% were to girls ages 15-17 who already had a child and 23% were subsequent births to girls ages 18-19.²⁵

Teen childbearing has tremendous fiscal implications for taxpayers of West Virginia. The National Campaign to Prevent Teen and Unplanned Pregnancy conducted a study assessing the costs and found:

- In 2004 alone, teen childbearing cost West Virginia taxpayers \$38 million. Of that, 39% was covered by federal dollars; the remaining 61% came from State and local dollars.
- Because children born to teen mothers are more likely to be dependent on state assistance, there are great costs to West Virginia's social and health welfare programs. In 2004, an estimated \$11 million was spent on public health care (like Medicaid and CHIP) and \$14 million for child welfare programs.
- The 45,300 teen births that occurred in West Virginia between 1991 and 2004 cost taxpayers a total of \$0.8 billion.²⁶

X. Factors Affecting Access to Family Planning Services and Pregnancy Care

▪ Primary Care and County Health Departments' Hours of Operation

While the State Family Planning Program serves a great number of West Virginia teens, access to services is restrictive due to limited hours of operation for primary care centers and county health departments. The vast majority of primary care centers are open from 8 to 5, with occasional evenings and Saturday hours, making it prohibitive for teens and for those who work during normal business hours to access services. Some county health departments offer family planning services only a few days a month.

▪ Limited Access to Abortion Care

As noted above, there is a shortage of abortion providers in West Virginia. Parental notification policies for minors seeking abortion care create another hurdle for youth seeking abortion care.

▪ Limited Access to Emergency Contraception (EC)

When used properly and made widely available, EC has the potential to greatly reduce the pregnancy and abortion rate in West Virginia. Many young women either do not know about EC or do not know how or where to get it. Many of the young women *and* health providers who do know about EC have misinformation about it, the most common misconception being that EC is an abortifacient. It is also not widely known that Plan B®, the dedicated EC product, is available over the counter for women 18 and over. Minors still need a prescription to get EC and must visit a doctor or clinic to obtain it.

- **Resistance and Consistency in Contraceptive Usage**

Young women are choosing more traditional methods of birth control over newer methods such as the Nuva-Ring and other implants that are more effective for their age group.²⁷

There is a concern among providers that young women served by family planning clinics and home visiting programs designed to prevent subsequent pregnancies were not using any form of contraception when they became pregnant.²⁸

- **Limited Transportation Options**

As with all health services, lack of access to transportation is a barrier for many West Virginians needing reproductive health care. Most counties lack public transportation, making access especially difficult for teens who may be reliant on others for mobility.

Limited transportation has even greater consequences for teens who have health coverage under a Medicaid HMO plan. Under such plans, they must revisit a pharmacy each month to obtain birth control pills. Teen clients of the Family Planning Program, however, may receive a three-month supply after an initial exam. If they return for a follow-up visit after three months, they may receive multiple months of birth control pills, thereby minimizing transportation needs.

- **Contraceptive Costs**

In West Virginia, nearly 180,000 women need contraceptive services. Over 100,000 women need publicly-funded contraceptive services because they have incomes below 250 percent of the federal poverty level or are sexually active teens. Moreover, a study in one state showed that, in order to prevent pregnancy, women often face out-of-pocket health care expenses as much as 65 percent above the costs men face.²⁹

Twenty-three percent of all women ages 15 to 44 in West Virginia have *no* health insurance. While the State mandates coverage of contraception in all health insurance plans, this does not help the women who have no health insurance. At the same time, publicly-funded family planning clinics serve just over half (56 percent) of all women and 60 percent of teens in the state who need these services.³⁰

- **Limited Funding for Family Planning Program**

In 2007 West Virginia lawmakers appropriated the first increase in funding for the state family planning program in more than twelve years. Those additional funds only enabled the program to covers expenses associated with rising contraceptive costs. There was no programmatic expansion.

- **Inadequate Insurance Coverage of Minors**

According to the WV Insurance Commission, Blue Cross, which covers 70% of insured West Virginians, does not provide pregnancy coverage for dependents. Carelink, the second largest insurance provider in the state, does not provide pregnancy coverage for dependents. While the Public Employees Insurance Agency provides prescription coverage for dependent minors generally, it exempts prescriptions for contraceptives.

XI. Recommendations for Reducing Teen Pregnancy

The findings in this paper clearly demonstrate the need for a multifaceted approach to the rising rate of teen pregnancy and childbearing in West Virginia. Recommended strategies are outlined below.

1. Implement Medicaid Improvements
 - Submit Family Planning Program waiver application that would extend coverage to females 24 months postpartum.
 - Include emergency contraception in Medicaid formulary.
2. Mandate PEIA and private insurance coverage of dependents' pregnancy, abortion and preventive reproductive health care.
3. Implement and enforce uniform comprehensive sexuality education.
4. Assess parental attitudes toward sex education to build support for comprehensive curricular reform.
5. Increase funding for public education surrounding youth pregnancy to both private organizations and government agencies such as the Family Planning Program, incorporating new media technology for outreach. Message-framing should be designed to reach male audiences and youth of color.
6. Support community-wide pregnancy prevention initiatives.
 - Conduct cross-cultural, cross-generational community discussions about teen pregnancy, including faith communities, local leaders, policymakers, communities of color, rural populations and youth serving professionals.
7. Expand hours of operation for primary care, family planning clinics and county health departments.
8. Support school-based health centers.
9. Engage in provider training to conduct outreach to teens who already have one child by providing contraception immediately postpartum and maintaining contact. This includes placing family planning information in the packets new mothers take home

from the hospital and outreach to pediatricians' offices to provide information to new mothers about the importance of child spacing.

10. Support and expand youth development programs that focus on sexual health and risk minimization.
11. Enable timely youth access to emergency contraception. A collaborative practice agreement should be initiated which would permit pharmacists to enter into agreements with physicians in order that the pharmacist may fill prescriptions for EC. Because timely access is vital to EC's effectiveness, pharmacy access for minors in West Virginia would help young women under age 18 have a greater chance to avoid a pregnancy for which they are not physically, emotionally, or financially prepared.

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