County Partisanship and Adolescent Pregnancy Prevention Policy

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Abstract

The United States has the highest adolescent birth rate of any developed country. On the federal level, the debate over how to prevent adolescent pregnancy tends to follow partisan lines. Republicans are proponents of abstinence-only education, while Democrats tend to endorse a clinical approach that includes information on contraception. This project uses New Mexico as a case study to see if county policy follows the same partisan lines. I run a cross tabulation comparing county partisanship to three different approaches to prevention: an educational approach, a clinical approach, and an adolescent development approach. For all three approaches, there was no significant relationship between county partisanship and the type of programs allowed in the county. There could be a variety of reasons for this; the school board typically makes decisions on what policies are allowed in the school. It seems that, on the county level, individuals play a more influential role in the debate rather than school boards simply following partisan lines.

In modern society, teen pregnancy is widely recognized as a social problem. Adolescents who have children tend to be less likely to finish high school, have lower paying jobs, and use more public assistance programs (Hotz et all 2008); the child of an adolescent is also more likely to have behavioral problems and face incarceration later in life (Grogger 2008). It is estimated that teen pregnancy costs the United States $9.6 billion per year (Hoffman 2006).

The United States as a whole saw a decline in teen pregnancy from 1991 to 2005 (Ventura et al 2008). However, from 2006-2007, that trend was reversed, and rates began to rise again (Hamilton et al 2009, Alan Guttmacher Institute 2010). New Mexico has had an especially high teen birth rate; in 2005, it had the highest adolescent birth rate in the United States (Alan Guttmacher Institute 2010).

Because of these abnormally high rates in the state, New Mexico uses five types of programs to prevent teen pregnancy: comprehensive sexual education, family planning services, service learning programs, male involvement programs, and adult-teen communication (New Mexico Department of Health 2010). These five types of programs represent three different approaches to teen pregnancy prevention: an educational approach, a clinical approach, and an adolescent development approach.

At the federal level, the debate over how to deal with teen pregnancy tends to evoke a type of morality politics. Since 1981, the Republican platform has supported the policy preferences of conservative groups, which stress an abstinence as the best way to prevent pregnancy. The Republican Party calls for federal funding for family planning services to be instead devoted to abstinence-only education. It opposes school-based health centers that distribute or give counseling about contraceptive methods (Republican

National Committee 2008). Federal funds have been devoted to programs that are aimed more at instilling acceptable morals and sexual behavior rather than those that have been tested and shown to most effectively lower birth rates.

At the local level, however, it is unclear whether partisanship plays any role in the debate; the policy debate may play out very similar to how it does on the federal level. There are a variety of actors in the policy debate; the school board usually makes the decision as to what types of programs are appropriate for the community. This study will attempt to understand if there is a partisan debate on the county level over what types of pregnancy prevention services are offered.

Literature Review

Consequences of Early Pregnancy

Approximately 82 percent of adolescent pregnancies in the United States are unintended (Alan Guttmacher Institute 2011). These unintended pregnancies have a variety of consequences for the mother, father, and child, as well as the public sector. High birth rates tend to affect some demographics more severely than others; Hispanic and black adolescent birth rates tend to be notably higher than non-Hispanic white adolescent birth rates.

The United States has the highest teen birth rate of all industrialized countries (Alan Guttmacher Institute 2010). From 1990-2005, the United States as a whole saw a decline in the teen birth rate. However, in 2006, it saw a 4 percent rise, to 41.9 births per 1000 women ages 15-19. The Hispanic teen birth rate followed a similar pattern,

dropping from 169.7 per 1000 in 1992 to 124.9 per 1000 in 2005. In 2006, it also saw a rise, to 126.6 per 1000.

[Figure 1]

There are many intermediate steps that lead to teen parenthood. Teens engage in sexual intercourse, refrain from or ineffectively use contraception, carry the pregnancy to term, and assume the role of parent rather than adoption (McFarlane and Meier 2001). Interventions efforts focus on these stages to prevent a birth to an adolescent.

Many teenage mothers will experience a variety of social and economic disadvantages. They have lower graduation rates than those who delay pregnancy, spend more years as a single parent, bear more children, and earn less in the labor market. Additionally, they tend to receive more public assistance than those who delay pregnancy (Hotz et al 2008). Hotz et al point out, however, that comparing teen mothers to those who delay pregnancy may be an unfair way to assess the situation; teen mothers tend to come from a socioeconomically disadvantaged background. A teen mother from a higher socioeconomic status is less likely to experience these problems. However, it is likely that those from a lower socioeconomic background will find that their socioeconomic problems are exacerbated by an early pregnancy (Hotz et al 2008, Gortzak-Uzan et al 2001, Chen et al 2007).

The child of a teen pregnancy is more likely to face a variety of disadvantages. They are at higher risk for a low birth weight, low health assessment scores, and low cognitive abilities. Additionally, they exhibit more behavioral problems and score lower on standardized tests. They are also less likely to graduate high school (Manlove et al 2008). The child is also 2.2 times more likely to be placed in foster care and is twice as

likely to face abuse (Goerge et all 2008). Children of teen parents are also twice as likely to spend time incarcerated (Grogger 2008).

Because teen mothers tend to be low income, the cost of teen pregnancy to the public sector is very large. Figure 2 shows an estimate of the cost to the public sector resulting from a teen pregnancy compared to if the pregnancy had been delayed to age 20-21 in 2004.

[Figure 2]

Lost tax revenue is a result of the lower income that is typical for teen parents. If the pregnancy had been delayed to age 20-21, larger earnings are typically reported for the parents (Hoffman 2006).

Additionally, 60 percent of children born to teen parents use public sources of health care, compared to 50 percent of children born to older parents. The child of a teen mother is estimated to use $145 more per year in public health care funds than the child of an older mother (Wolfe and Rivers 2008).

Many factors can contribute to a high teen birth rate. Engaging in sexual intercourse as an adolescent has been positively associated with being Black, living in a single parent home, and being male. Low income and low parental education level has also been associated with engaging in sexual activity at an early age (Blum et al 2000, Ventura et al 1998, Gold et al 2001, Singh et al 2001, Santelli et al 2000, Kapinus and Gorman 2004). Consistent contraceptive use has been inversely associated with having less than a college education. Additionally, one is more likely to use contraceptives if she has firmly decided to avoid pregnancy and has parental involvement in her decisions (Frost et al 2007, Frisco 2005).

Policy Options for Adolescent Pregnancy Prevention

The New Mexico Department of Health's five strategies for preventing teen pregnancy (family planning services, comprehensive sexual education, service learning programs, male involvement programs, and adult-teen communication) represent an attempt to use combination of approaches to combat the problem. The National Research Council (1987) identified three different types of strategies that were proven effective in teen pregnancy prevention. The first was increased contraception use; both knowledge of and increased access were shown to lead to lower birth rates. The second was school-based health centers clearly defining a goal of reducing the fertility rate among students. The third was a teen outreach program.

The Clinical Approach

In New Mexico, family planning services represent a clinical approach. Public health offices and school-based health centers are usually used to provide these services. Comprehensive sexual education is a type of educational approach that involves teaching contraceptive methods. The last three, service learning programs, male involvement programs, and adult-teen communication programs are a type of adolescent development approach to the problem.

School-based health centers have been in existence since the early 1970s. They offer no- or low-cost primary and preventative care to students. The local community usually gets to decide what services the clinic can offer to students via the school board. Services typically include treatment of illness, physicals, lab tests, prescriptions, and mental health. Additionally, they offer a variety of health promotion services, such as

prevention of tobacco use, drug and alcohol use, pregnancy, and violence (Dryfoos 1985, Dailard 2000, Schlit et al 2008).

Family planning services in school-based health clinics tend to be a controversial area. Clinics began appearing in the 1970s; many believed they were a masked attempt at getting contraceptive to teens. With the emergence of HIV/AIDS, however, the issue of providing contraceptives became especially important. Many communities began to realize that teens were sexually active, and contraceptives were key to preventing the spread of HIV/AIDS (Dailard 2000).

According to 1998-1999 survey, about one quarter of school-based health centers were allowed to distribute contraceptives; 77 percent were prohibited from dispensing contraceptive materials. Many (55-82 percent) offered some types of reproductive services, including pregnancy testing and counseling (Remez 2003). A 2001 survey found that one third of centers were allowed to prescribe emergency contraceptives (McCarthy et al 2005).

In general, a school-based health center is more likely to dispense contraceptives if its charter is older. 41 percent of centers that have been in existence for over 10 years can provide contraceptives, while only 21 percent of newer centers are permitted to do so. This is usually attributed to older centers being more established in the community; once parents start to trust the clinics, they tend to allow it to offer more services (Dryfoos, 1985, Dailard 2000).

Furthermore, high school clinics are more likely to offer reproductive health services than clinics for younger students, likely because parents do not believe sexual health is an issue for younger students (Dailard 2000). Clinics in urban settings are more

likely to be able to offer reproductive health services. Rural clinics tend to offer less, perhaps because they operate in more conservative areas or because of limited staff (Remez 2003, McCarthy et al 2005).

The Educational Approach

Comprehensive sexual education involves giving teens information about contraception methods. In contrast, abstinence-only education gives no information about contraception. It instead focuses on abstaining from sex as the only guaranteed way to avoid adverse consequences. The debate over what subjects should be taught takes place at the federal level, as well as the local level.

The federal government used a clinical approach to preventing teen pregnancy until 1981. Previously, the government had funded contraceptive and abortion services through the Adolescent Health Services and Pregnancy Prevention Care Act of 1978. Schools, however, were teaching sexual education without federal funding and influence. The Christian Right, however, vehemently opposed these policies, claiming that it promoted bad morals and inappropriate sexual activity. They wanted sex education out of the classroom. By the late 1970s, however, it became clear that this topic would not be eliminated from school, so conservative groups began pushing for education that promoted Christian values. In 1981, Senators Hatch (R-Utah) and Denton (R-Alabama) helped the Christian Right to gain its first victory with the Adolescent Family Life Act (AFLA) (Doan and Williams 2008).

AFLA was designed to promote programs that encouraged chastity and self-discipline and were family-oriented (Adolescent Family Life Act 1981). Adoption was promoted as the best option for pregnant teens. It went through Congress without

hearings or floor votes (Saul 1998, Dailard 2000, McFarlane and Meier 2001, Doan and Williams 2008).

Another round of abstinence-only education made its way through Congress in the Personal Responsibility and Work Opportunity Reconciliation Act (1996). $50 million was directed at sexual education programs that promoted abstinence from sexual activity and emphasized marriage as the appropriate relationship for sexual activity (McFarlane 2006). By this time, studies on abstinence-only education had concluded that it was not an effective way of reducing teen pregnancy, suggesting that it was passed for ideological reasons rather than for its efficacy (McFarlane and Meier 2001). When Clinton signed the bill, he emphasized that he was signing it because it changed many problematic aspects of welfare. However, he had serious objections to some of the non-welfare measures, including the abstinence-only education provisions (Doan and Williams 2008).

When George W Bush became president in 2001, he brought another federal abstinence-only education plan, the Community Based Abstinence Education under Title V of the Social Security Act. Those who receive CBAE funding are require to stress that abstinence is the only way to prevent pregnancy and STDs and that premarital sex will likely have harmful physical and psychological effects. Under President Bush, federally funded abstinence-only education increased from $80 million to $200 million (McFarlane 2006, Doan and Williams 2008).

Abstinence-only education legislation has consistently had support from the Republican Party. The Party's platform supports more conservative approaches to sexual education, asserting that funding for family planning programs should be replaced with

funding for abstinence-only education (Republican National Committee 2008) Because the last two were enacted after strong evidence against the curriculum's efficacy (Institute of Medicine 1995), it seems that they do so based on ideology and morals rather than the effectiveness of the program.

Public opinion, however, does not match the policies being made. A 2004 survey by the National Campaign to Prevent Teen Pregnancy showed that three quarters of adults wanted to see contraception taught in addition to abstinence. Only 15 percent of adults indicated they would like to see abstinence-only education in schools. Only 68 percent of adults and 77 percent of teens believed information about contraceptives sends a mixed message (Albert 2004). A similar survey by NPR, Kaiser, and the Kennedy School of Government found that 87 percent of Americans think how to use and where to buy contraceptives is an appropriate subject for sexual education curriculum. 46 percent favor an "abstinence-plus" approach, which teaches abstinence as the best option, but also gives information on contraceptives (NPR et al 2004).

The Adolescent Development Approach

The adolescent development approach is intended to promote a sense of independence and relatedness with other students and the community in adolescents. It combines aspects of volunteer work with classroom discussion (Allen et al 1997). A 1987 report by the National Research Council finds that the teen outreach program is one of three proven effective ways of preventing teen pregnancy. Because it focuses on volunteer work and adolescent development, there is a relatively low amount of controversy around these programs (Allen et al 1994).

Since 1981, Republicans have tended to favor teen pregnancy prevention policies

that follow the moral beliefs of the conservative Christian Right. The party's national platform clearly promotes abstinence-only education while opposing information and access to contraception in the school. Therefore, I predict that a similar debate will take place on the county level. Counties with high Republican vote levels and high Republican voter registration will be less likely to support clinical programs that distribute contraceptives. Abstinence-only education programs will also most likely be in predominately Republican counties. Adolescent development programs will be unaffected by partisan level.

Methods

Partisanship levels are measured using the New Mexico Secretary of State's (NMSOS) 2011 Voter Registration Report (NMSOS 2011). Any county with a plurality of registered Republicans are assigned a dummy variable of 1; those without receive a 0. The SOS's results from the 2008 Presidential election are the second measure of partisanship (New Mexico Secretary Of State 2008). Again, those counties with a Republican plurality receive a value of 1, and those without receive a value of 0. Data from the presidential election is used because voter turnout is typically higher for these elections.

Information on which counties have received abstinence-only education funding comes from SIECUS' report on grants given to New Mexico (SEICUS 2008). This report shows that the only CBAE grant given in New Mexico was to Socorro General Hospital (SGH), which extends from 2008-2013, meaning it is still current. In total, the program

receives $1,349,883. Counties where SGH operates are assigned a dummy variable of 1; counties without the funding receive a 0.

The number of adolescent development programs is my own data, collected for the New Mexico Teen Pregnancy Coalition in the summer and fall of 2010. Counties with adolescent development programs are given a dummy variable of 1, and those without are given a 0.

Data on which school-based health centers distribute contraceptives is also my own. I contacted the program coordinators initially by email asking for information on the center's family planning program. I called those who did not respond to email.

Family planning policies vary greatly from center to center. First, the data will be run looking at which centers can distribute contraceptives, regardless of restrictions. Centers that are allowed to dispense any kind of contraceptive will be assigned a dummy variable of 1; those who are not allowed to dispense will receive a 0.

The second run will consider county partisanship in relation to centers that can distribute contraceptives but have restrictions. Centers that have restrictions on what they are able to do (require parental consent, allow condoms but no pill, etc) receive a dummy variable of 0; those with no restrictions receive a 1.

All variables will be analyzed using a cross tabulation, as well as looking at the correlation between the variables. The cross tabulation will be used to calculate a chi-2 value and a p-value, which will determine if there is a significant relationship between the variables.

In relation to CBAE funding, I believe that I will find that counties that receive funding will be more likely to have both a Republican voting and registration plurality.

Adolescent development programs will have no relationship to partisanship. In regards to SBHCs, centers not allowed to dispense any type of contraceptive will be more likely to have a Republican voting and registration plurality. Clinics with restrictions on distribution will be more likely to be in a Republican county.

Results

76 percent of counties had a registered Democrat plurality, and 24 percent had a registered Republican plurality. 69 percent of counties had a Democrat vote plurality, while 31 percent had a Republican vote plurality. A p-value is significant at less than 0.05.

[Figure 3]

[Figure 4]

[Figure 5]

[Figure 6]

Figures 3 and 5 show the cross tabulation between abstinence-only education and political party. Contrary to my expectations, there is no significant relationship between a county's abstinence-only education funding and the partisanship of the population. Abstinence-only funding was received in one county with a plurality of Republican votes and registration and in one with a Democrat voting and registration plurality. Because there were only two counties that SGH worked in, the sample size may have been too small.

[Figure 7]

[Figure 8]

[Figure 9]

[Figure 10]

Figures 7 and 9 show there is no significant relationship between a county's partisanship and the likelihood of it having adolescent development programs. 10 counties in the state had adolescent development programs, while 23 counties did not. 30 percent of the counties with programs had a both a Republican voting and registration plurality, and 70 percent of the counties with programs had a Democrat voting and registration plurality, which does not vary significantly from overall state trends.

[Figure 11]

[Figure 12]

76 percent of centers that were allowed to distribute contraceptives were in counties with a Democrat registration plurality; 24 percent of centers allowed to distribute were in Republican registration plurality counties. 68 percent of centers allowing contraception were in counties with a Democrat vote plurality; 32 percent were in counties with a Republican vote plurality. Though more centers that are allowed to distribute contraceptives are in Democrat counties than in Republican counties, it does not vary significantly from the number of Democrat counties compared to Republican counties.

[Figure 13]

[Figure 14]

When looking at those centers with restrictions on contraceptive distribution, there was again no significance between the partisanship of the county the center was in

and the presence of restrictions. Only 4 of the centers faced restrictions, so it could be again that the sample size is too small.

Discussion

New Mexico is a very interesting case study because of its unique demographic. The majority of the population is Hispanic (45.6 percent in 2009) (US Census Bureau 2010). Hispanics tend to register and vote as Democrats but are affiliated with Christian faiths (PEW Hispanic Center 2002). Around 42 percent of the population of New Mexico is affiliated with some Christian denomination, and another 26 percent is Catholic (PEW 2008). It is possible that this population registers and votes Democrat in presidential elections, but on the local level, they hold more conservative values in regards to teen sexuality.

Additionally, in the 2008 presidential election, moral values were not seen as the most important issue at stake; the economy, the situation in Iraq, education, corruption in government, health care, energy, terrorism, social security, and the budget deficit were all ranked higher in importance (Gallup Poll 2008). Voters may not have been voting for candidates who held similar moral values; instead, they were more focused on economic issues. New Mexican voters were likely not thinking about which candidate would advance their views on how to decrease the adolescent pregnancy rate; instead, they were more concerned about which candidate would improve the state of the economy.

The Adolescent Development Approach

The finding that partisanship was not a factor in whether or not a county is likely to offer adolescent development programs was not surprising. These programs usually

focus on developing a teenager as a productive member of society, including aspects like community service. They tend to be less controversial because a teen's sexuality is not the focus; the main idea behind the programs is that if adolescents have other foci, such as community service, and have a sense of identity, they will be less likely to engage in risky sexual activity.

A bipartisan effort should be made to expand these programs. Because these programs usually do not evoke a morality politics discussion, support from both conservatives and liberals should be fairly simple to attain. These programs have been shown to be widely effective (Allen et all 1997, Kirby 2002, National Research Council 1987) and are relatively low cost. However, there are only 9 such programs in New Mexico that receive state funding. This approach needs to be considered vital and continue receiving state money.

The Educational Approach

The finding that county partisanship does not affect its likelihood to receive CBAE funding may be inconclusive because there is only one active grant in the state. However, Socorro General Hospital is not the only organization in the state that teaches an abstinence-only approach to sexual education.

For example, schools run by the Archdiocese of Santa Fe and the Diocese of Gallup teach a curriculum that promotes abstinence until marriage. The Archdiocese of Santa Fe operates 17 schools with 5066 students total (Archdiocese of Santa Fe 2011); the Diocese of Gallup has 5 schools with 1300 students and the Diocese of Las Cruces operates 5 schools in the southern section of New Mexico. Clearly, there are more students in the state receiving abstinence-only education that are not accounted for when

looking only at CBAE funding. Unfortunately, the scope of this project does not allow me to find a sound way to account for these other organizations.

The State of New Mexico requires sexual and HIV education in its public schools. The curriculum is supposed to include information on abstinence, as well as contraceptives. Additionally, it should stress healthy life skills, such as avoiding coercion, family communication, and healthy decision-making. HIV education is supposed to stress abstinence but also includes information on contraceptives (Guttmacher Institute 2011).

As a whole, the state seems to favor a sort of abstinence-plus approach to sexual education. Contraceptives are included in the curriculum, as well as the benefits of abstinence. In 2007, Dr Vigil, the state's Health Secretary, rejected Title V abstinence-only education money, citing lack of evidence of the program's effectiveness. He stressed that though the program works for some teens, it also fails many others (Clovis News Journal 2007). Because the state has taken a position that promotes a more comprehensive approach to sexual education, there is less room for county partisanship to play a role in what the school teaches.

Parents are allowed to request that their children not take part in the curriculum, but this may be a flawed measure as well. Students who do not take part in the class may be alienated from their peers, leading their parents to be less likely to request that their child skips the class. Additionally, many parents do not want to be the sole educator for their children on sexual health. The topic is awkward and uncomfortable; many prefer to defer the responsibility to the school.

At the national level, it seems that abstinence-only education has been spearheaded by a few key players. The Republican Party has had several "policy entrepreneurs" who have led the effort towards abstinence-only education. A "policy entrepreneur" is considered to be a person who focuses the public's attention on a problem and offers a solution to that problem through a specific policy (Baumgartner and Jones 1991, Parsons 1995). Senators Hatch and Denton could be indentified as policy entrepreneurs because of their role in the passage of the Adolescent Family Life Act. They identified the problem of teen pregnancy and took the Christian Right's solution of teaching abstinence-only education. George W Bush could also be identified as a abstinence-only education policy entrepreneur. When he took office, he identified teen pregnancy as a problem and offered the solution of using abstinence-only education to prevent adolescents from engaging in sexual activities.

In the past, the Democrat Party has lacked a policy entrepreneur that uses an educational approach to combat the teen pregnancy problem. It seems that in the past, Democrat policy entrepreneurs have instead advocated more for a clinical approach. For example, in the 1970s, Senator Kennedy advocated extensively for federal funding for family planning services for teens with the Adolescent Health Services and Pregnancy Prevention Care Act (Doan and Williams 2008, p 26). However, there has not been a definite push towards an educational approach.

President Obama has recently pushed to end federal funding for abstinence-only education and instead to devote those funds to a comprehensive sexual education plan (Cohen 2009). This development in the Democrat's teen pregnancy prevention approach may signal that they are moving towards a more multifaceted approach at the national

level. At the local level, Vigil could be seen as a similar policy entrepreneur when he rejected CBAE grant money.

One of the issues with comprehensive sexual education is the number of different curriculums used. Though various studies have shown that some are effective in delaying onset of sexual activity, there is no consensus on which curriculum should be implemented widely. Kirby (2008) did a review of 48 different types of programs; two thirds had a positive effect on teen sexual behavior. He also reviews nine abstinence programs, finding that only one third of abstinence education programs had any effect on teen sexual behavior.

[Figure 15]

Kirby's report clearly shows that abstinence programs have little effect on adolescent sexual behavior; the amount of funding devoted to them is not scientifically justifiable. However, comprehensive education programs seem to have mixed results as well. Though some have positive effects, many show no significant effect. More research needs to be done on what aspects of comprehensive programs are working, so they can be combined into one effective program. That program can then be implemented on a wide-scale. A comprehensive approach will likely be loudly opposed by conservative religious groups. There must be conclusive scientific evidence that this program is effective.

The Clinical Approach

The finding that there is no significant relationship between partisanship and if a SBHC will distribute contraceptives is rather surprising. For the past three decades, Democrats have spearheaded the effort for more family planning funding, while

Republicans have backed abstinence education. The Republican platform keeps the government away from any clinical decisions; they believe only the family can make these decisions (Republican National Committee 2008).

The decision of what services will be allowed in a clinic is typically made by the school board. Members of the community elect members of the school board. Many of these elections will have lower voter turnout because of their size, which likely indicates that these members are being elected by very active members of the community. School board meetings are open to the public, and members of the community are allowed to speak their views at these meetings.

Parents often play a large role in the debate. When the subject of contraceptives comes up, those who have strong beliefs on the subject often attend the meetings to voice their opinion. They give passionate speeches about how contraceptives are a private, family matter, and the school should have no role in the matter. School board members then are reluctant to pursue the matter further.

One reason partisanship may not be a predictor of a community's tolerance of contraceptives in schools is because of the large number of Hispanics in the state. Many Hispanics identify as Catholic, meaning that their religion teaches contraception is wrong. However, they tend to register and vote Democrat. In 2007, 57 percent of Latinos identified as Democrat, while only 23 percent identified as Republican (Taylor and Fry 2007). This could mean that though much of the population that registers and votes Democrat are not supportive of contraception in schools.

Certain centers had restrictions on what services they were allowed to provide. Clinics that were able to distribute condoms but not birth control often mentioned that

condoms were allowed by the school board in order to prevent disease. The threat of HIV/AIDS is seen as ominous enough to justify contraceptives in schools, as the consequence of the disease will eventually be death.

Teen pregnancy is not considered to be a disease. It is usually viewed and discussed through more of a morality lens rather than a health issue. It is not physically dangerous for a teenager to give birth, so it is more difficult to argue for prevention from a health perspective. The consequences are not fatal, so it appears less threatening. It seems that the social consequences of teen pregnancy are less likely to come up in the public discourse on the matter. Lower economic earning potential for the mother and a higher cost to the state does not carry the same weight as the consequence of death.

In previous studies, there has been a trend of older centers being more likely to allow contraceptives, as trust for the clinic increases. Additionally, urban clinics tend to be more likely to offer contraceptives, as they tend to have more staffing and less conservative students and parents (Dailard 2000). With time, it is likely that more clinics in New Mexico will be allowed to offer contraceptives.

Overall, it seems the issue of teen pregnancy is not strictly partisan on the local level. On the federal level, party positions are much clearer on the matter. However, thus does not mean that all Republicans are opposed to comprehensive education and contraception in school clinics. The individual politicians can be affected by the different needs of the constituents they represent.

Because the debate over adolescent pregnancy prevention can often follow party lines, the adolescent development approach seems to be the most promising for gaining support from both sides of the political spectrum. Though the educational and clinical

approach were not affected by partisanship in this study, there seems to be a sense that ideology of a community is affecting the decisions of the school board. Teen pregnancy prevention activists may have the best chance of achieving their policy goals on the local level.

Appendix

FIGURE 1: RATES OF BIRTH, PREGNANCY, AND ABORTION PER 1000 GIRLS AGED 15-19 BY RACE, 2005

	Pregnancy Rate			Birth Rate			Abortion Rate		
	Non-Hispanic White	Hispanic	Black	Non-Hispanic White	Hispanic	Black	Non-Hispanic White	Hispanic	Black
United States	43	123	125	26	62	82	11	44	24
New Mexico	44	79	127	30	38	85	7	30	22

SOURCE: Alan Guttmacher Institute 2010

FIGURE 2: PUBLIC SECTOR COST OF A FIRST BIRTH TO A TEEN MOTHER COMPARED TO A FIRST BIRTH AGE 20-21

OUTCOME MEASURES	**1st Birth at Age 17 or Younger**	**1st Birth at Age 18-19**	**1st Birth Age 19 and Younger**
Lost Tax Revenue	**$4.89**	**$1.43**	**$6.32**
Income & Sales Taxes (Mother)	$0.92	$0.65	$0.27
Income & Sales Taxes (Father)	$1.71	$1.45	$3.16
Income & Sales Taxes (Children)	$2.26	$0.63	$2.89
Public Assistance (Mothers)	**-$0.95**	**-$2.62**	**-$3.56**
TANF	-$0.72	-$1.26	-$1.98
Food Stamps	-$0.45	-$0.91	-$1.35
Housing	-$0.22	-$0.45	-$0.23
Health Care Cost (Children)	**$0.92**	**$0.98**	**$1.92**
Child Welfare (Children)	**$1.84**	**$0.46**	**$2.30**
Incarceration of Sons of Teen Mothers (Children)	**$1.90**	**$0.17**	**$2.07**
Total Annual Cost (Billion)	**$8.63**	**$0.42**	**$9.06**

SOURCE: Hoffman 2006

FIGURE 3: ABSTINENCE-ONLY EDUCATION FUNDING IN RELATION TO REPUBLICAN VOTES

	Title V/CBAE Funded Organization? 0=No/1=Yes		
Republican Vote Plurality? 0=No/1=Yes	0	1	Total
0	17 54.84%	1 50.00%	18 54.55%

1	14 45.16%	1 50.00%	15 45.45%
Total	31 100.0%	2 100.0%	33 100.0%

P-Value= 0.894

FIGURE 4

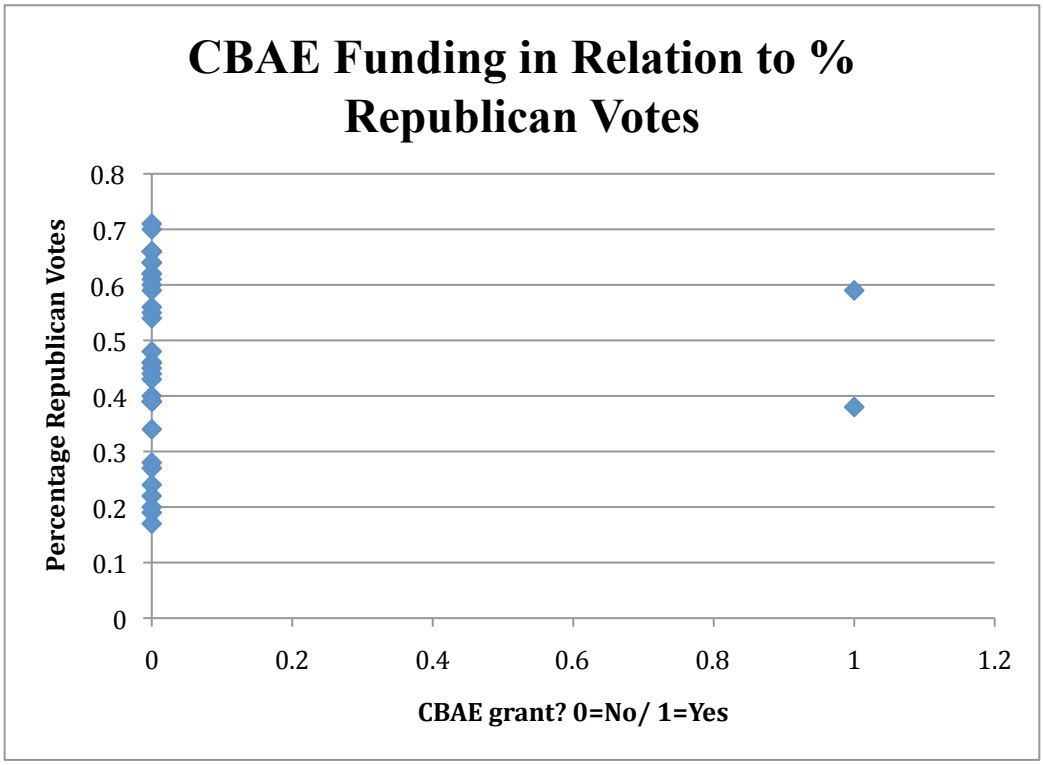

FIGURE 5: ABSTIENCE-ONLY EDUCATION FUNDING IN RELATION TO REGISTERED REPUBLICANS

	Title V/CBAE Funded Organization? 0=No/1=Yes		
Registered Republican Plurality? 0=No/1=Yes	0	1	Total
0	20 64.52%	1 50.00%	21 63.64%
1	11 35.48%	1 50.00%	12 36.36%
Total	31 100.0%	2 100.0%	33 100.0%

P-Value= 0.679

FIGURE 6

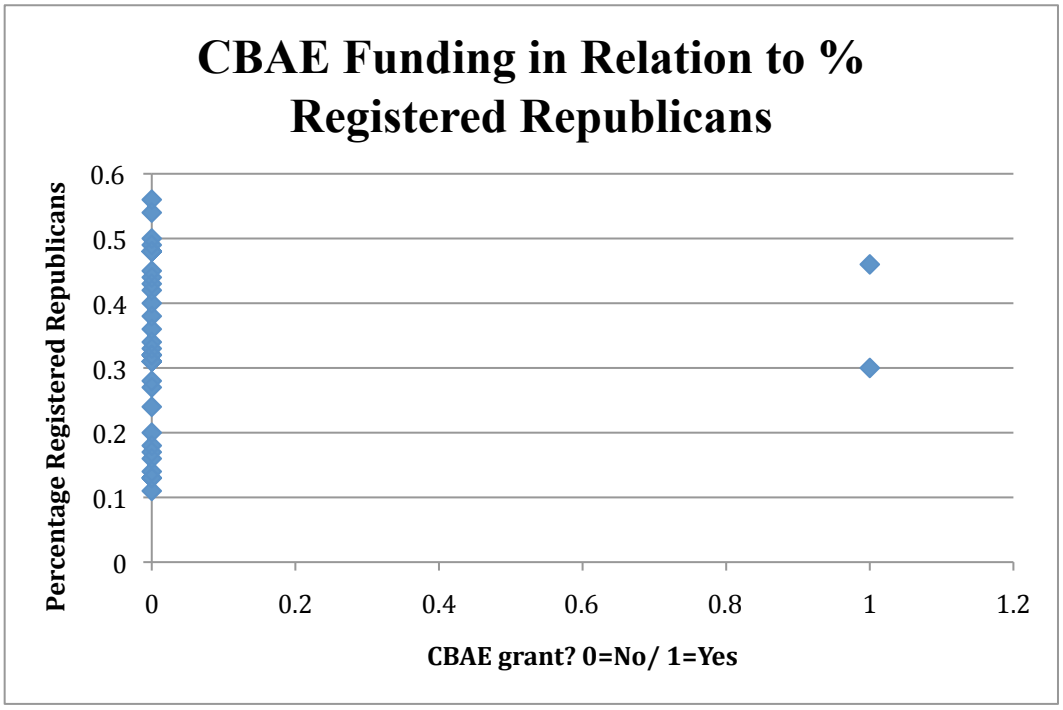

FIGURE 7: ADOLESCENT DEVELOPMENT PROGRAMS IN RELATION TO REPUBLICAN VOTES

	Adolescent Development Program? 0=No/1=Yes		
Republican Vote Plurality? 0=No/1=Yes	0	1	Total
0	11 47.83%	7 70.00%	18 54.55%
1	12 52.17%	3 30.00%	15 45.45%
Total	31 100.0%	2 100.0%	33 100.0%
			P-Value=0.240

FIGURE 8

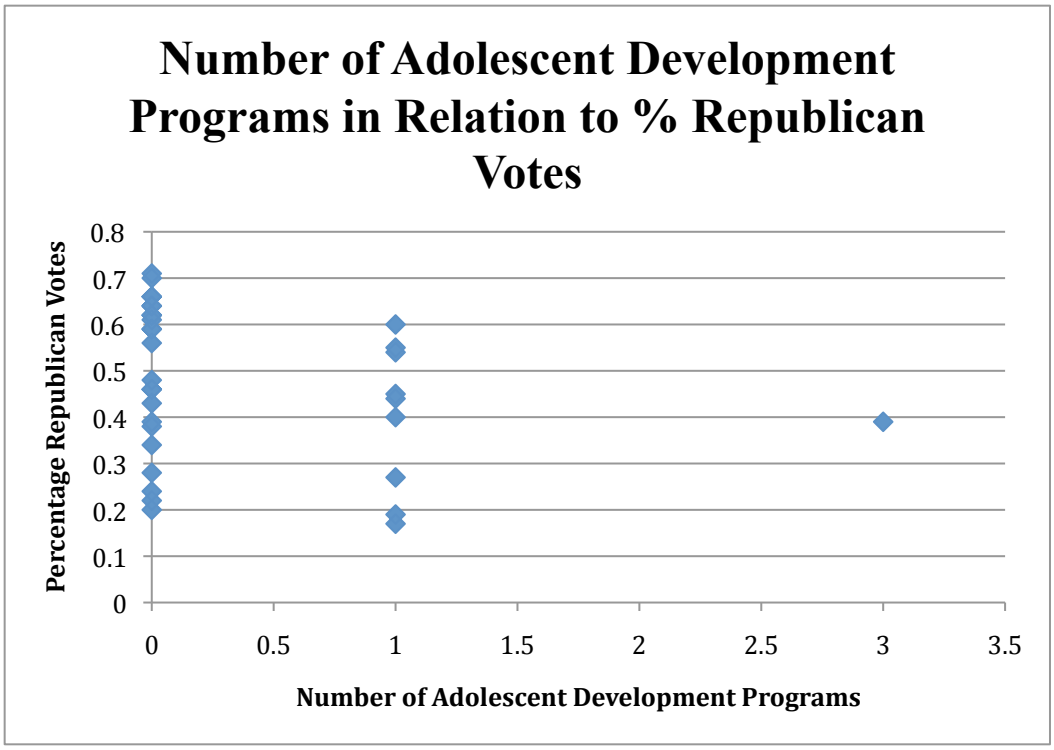

FIGURE 9: ADOLESCENT DEVELOPMENT PROGRAMS IN RELATION TO REGISTERED REPUBLICANS

	Adolescent Development Program? 0=No/1=Yes		
Registered Republican Plurality? 0=No/1=Yes	0	1	Total
0	14 60.87%	7 70.00%	21 63.64%
1	9 39.13%	3 30.00%	12 36.36%
Total	23 100.0%	10 100.0%	33 100.0%
			P-Value=0.616

FIGURE 10

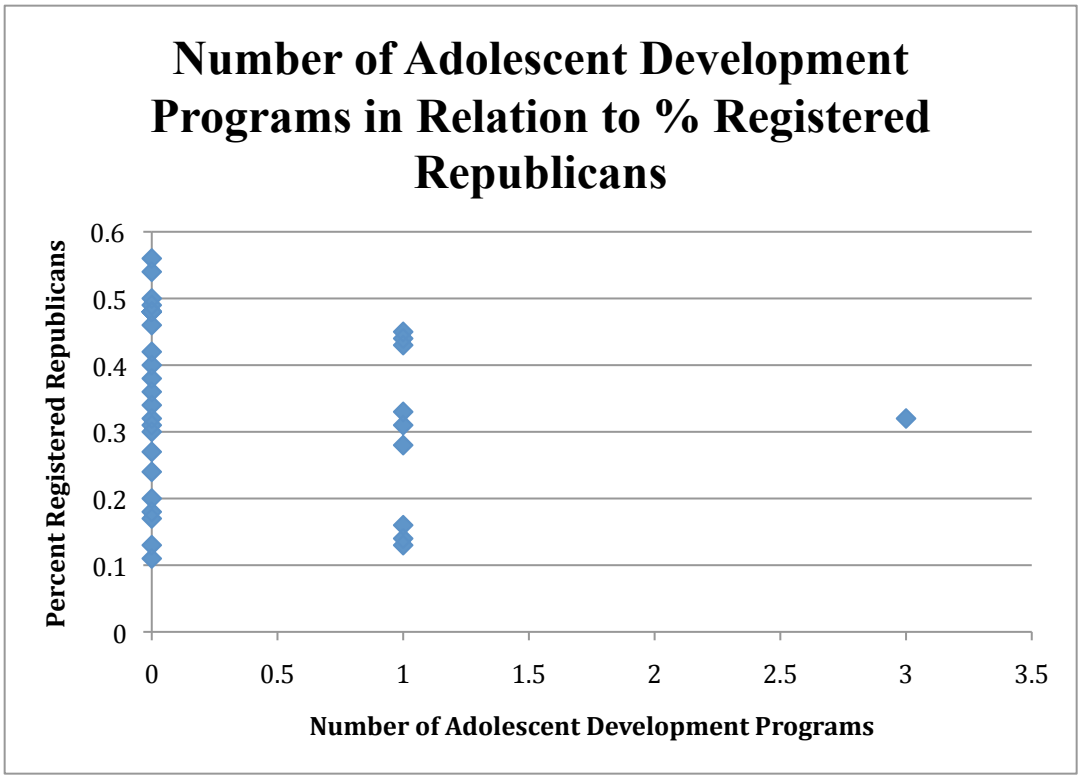

FIGURE 11: SCHOOL-BASED HEALTH CENTERS THAT OFFER CONTRACEPTION IN RELATION TO REGISTERED REPUBLICANS

	SBHC Dispenses Contraceptives? 0=No/1=Yes		
Registered Republican Plurality? 0=No/1=Yes	0	1	Total
0	18 75.00%	29 76.32%	47 75.81%
1	6 25.00%	9 23.68%	15 24.19%
Total	24 100.0%	38 100.0%	62 100.0%
			P-Value=0.841

FIGURE 12: SCHOOL-BASED HEALTH CENTERS THAT OFFER CONTRACEPTION IN RELATION TO REPUBLICAN VOTES

	SBHC Dispenses Contraceptives? 0=No/1=Yes		
Republican Vote Plurality? 0=No/1=Yes	0	1	Total

0	17 70.83%	26 68.42%	43 69.35%
1	7 29.17%	12 31.58%	19 30.65%
Total	24 100.0%	38 100.0%	62 100.0%
			P-Value=0.906

FIGURE 13: SCHOOL-BASED HEALTH CENTERS WITH RESTRICTIONS ON CONTRACEPTION DISTRIBUTION IN RELATION TO REPUBLICAN VOTES

	Restrictions on Contraceptive Distribution? 0=No/1=Yes		
Republican Vote Plurality? 0=No/1=Yes	0	1	Total
0	23 67.65%	3 75.00%	26 68.42%
1	11 32.35%	1 25.00%	12 31.58%
Total	34 100.0%	4 100.0%	38 100.0%
			P-Value= 0.765

FIGURE 14: SCHOOL-BASED HEALTH CENTERS WITH RESTRICTIONS ON CONTRACEPTION DISTRIBUTION IN RELATION TO REGISTERED REPUBLICANS

	Restriction? 0=No/1=Yes		
Registered Republican Plurality? 0=No/1=Yes	0	1	Total
0	25 73.53%	4 100.00%	29 76.32%
1	9 26.47%	0 0.00%	9 23.68%
Total	34 100.0%	4 100.0%	38 100.0%
			P-Value= 0.239

FIGURE 15: ABSTINENCE EDUCATION PROGRAMS VERSUS COMPREHENSIVE PROGRAMS (KIRBY 2008)

Outcomes measured	Abstinence programs (N=9)	Comprehensive programs (N=48)

Initiation of sex	(n=9)	(n=32)
Hastened initiation	0	0
No significant results	7	17
Delayed initiation	2	15
Frequency of sex	(n=6)	(n=21)
Increased frequency	0	0
No significant results	4	15
Reduced frequency	2	6
Number of partners	(n=5)	(n=24)
Increased number	0	1
No significant results	4	12
Reduced number	1	11
Condom use	(n=5)	(n=32)
Reduced use	0	0
No significant results	5	17
Increased use	0	15
Contraceptive use	(n=4)	(n=9)
Reduced use	0	1
No significant results	4	4
Increased use	0	4
Sexual risk taking	(n=3)	(n=24)
Increased risk	0	0
No significant results	3	9
Reduced risk	0	15

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