Guttmacher Policy Review
Winter 2007 | Volume 10 | Number 1
GPR

Remember Her Words: The Analysis and Advocacy of Cynthia Dailard, 1998–2006

Editor's note: In her eight years with the Guttmacher Institute, Cynthia Dailard wrote dozens of articles for the Guttmacher Policy Review *and its predecessor publication,* The Guttmacher Report on Public Policy. *Her writings touched on nearly every major issue and controversy in the realm of sexual and reproductive health. What follows is but a small sample of her impressive body of work.*

Pressures on Family Planning Providers

Thirty years after its enactment, the Title X program remains the centerpiece of the U.S. family planning effort.…Title X has been enormously successful in helping American women plan their births and avoid one million unintended pregnancies each year.…Yet despite these significant accomplishments, the Title X program…has been besieged both politically and financially for most of its life.…In fact, taking inflation into account, the $254 million in FY 2000 funding is 58% *lower* than the $162 million appropriated in 1980.…[1]

As a result, family planning providers have struggled on shoestring budgets for two decades to maintain their ability to provide high-quality contraceptive and related preventive health care to as many lower-income women as possible.…Perhaps the greatest difficulty facing the clinics today is maintaining contraceptive choice—as required by the Title X statute and by medical ethics—in the face of rapidly escalating costs.…Skyrocketing costs associated with new pharmaceuticals and screening and diagnostic technologies also hamper clinics' efforts to offer their clientele state-of-the-art care.…[T]he increasing number of uninsured clients places a particularly tight squeeze on Title X dollars, since many uninsured women, including most women who lose their Medicaid coverage, are eligible by virtue of their low incomes for subsidized—and in many cases, entirely free—services under Title X.…

A key obstacle to surmounting these financial and programmatic difficulties has been the enormous political challenges that have long threatened the very existence of the program.… Opponents of Title X have long argued that providing confidential services to teenagers encourages them to be sexually active, despite the fact that the average teenager does not visit a family planning provider until 14 months *after* she has become sexually active.…Title X opponents also charge that the availability of publicly funded contraceptives results in more abortions by encouraging sexual promiscuity, and that family planning providers have a vested interest in encouraging women facing unintended pregnancies to seek abortions. These attacks persist despite the evidence that subsidized family planning services—and Title X in particular—help *reduce* the need for abortion by enabling women to avoid unintended pregnancies.…

[I]n order for family planning clinics to meet the challenges of the present and future—and indeed to just maintain the gains of the past 30 years—there is a need to move beyond the politics that have plagued the program for so long and to acknowledge Title X's distinct and important role in improving the public health by reducing rates

1. By FY 2006, inflation-adjusted funding had fallen further, by 61% from the FY 1980 level.—*Editor.*

of unintended pregnancy, abortion and teen pregnancy. Equally important is to acknowledge those aspects of the program that have led to its success—namely, the national standards and patient protections that ensure that women visiting Title X–supported clinics receive a broad package of confidential, high-quality, affordable services and a full choice of contraceptive methods. Such a renewed political and financial commitment to publicly funded family planning services is long overdue.

From "Challenges Facing Family Planning Clinics and Title X," April 2001.

The Abstinence-only Education Debate

The word "sex" is commonly acknowledged to mean different things to different people. The same can be said for "abstinence." The varied and potentially conflicting meanings of "abstinence" have significant public health implications now that its promotion has emerged as the Bush administration's primary answer to pregnancy and sexually transmitted disease (STD) prevention for all people who are not married.

For those willing to probe beneath the surface, critical questions abound. What is abstinence in the first place, and what does it mean to use abstinence as a method of pregnancy or disease prevention? What constitutes abstinence "failure," and can abstinence failure rates be measured comparably to failure rates for other contraceptive methods? What specific behaviors are to be abstained from? And what is known about the effectiveness and potential "side effects" of programs that promote abstinence? Answering questions about what abstinence means at the individual and programmatic levels, and clarifying all of this for policymakers, remains a key challenge. Meeting that challenge should be regarded as a prerequisite for the development of sound and effective programs designed to protect Americans from unintended pregnancy and STDs, including HIV....

[W]hen the president suggests that abstinence is 100% effective, he is implicitly citing its perfect-use rate—and indeed, abstinence is 100% effective if "used" with perfect consistency. But common sense suggests that in the real world, abstinence as a contraceptive method can and does fail. People who intend to remain abstinent may "slip" and have sex unexpectedly....To promote abstinence, its proponents frequently cite the allegedly high failure rates of other contraceptive methods, particularly condoms. By contrasting the perfect use of abstinence with the typical use of other contraceptive methods, however, they are comparing apples to oranges. From a public health perspective, it is important both to subject abstinence to the same scientific standards that apply to other contraceptive methods and to make consistent comparisons across methods....

There is no question…that increased abstinence—meaning delayed vaginal intercourse among young people—has played a role in reducing both teen pregnancy rates in the United States and HIV rates in at least one developing country....But abstinence proponents frequently cite both U.S. teen pregnancy declines and the Uganda example as "proof" that abstinence-only education programs, which exclude accurate and complete information about contraception, are effective; they argue that these programs should be expanded at home and exported overseas. Yet neither experience, in and of itself, says anything about the effectiveness of programmatic interventions....[A]ny assumptions about program effectiveness, and the effectiveness of abstinence-only education programs in particular, are misleading and potentially dangerous, but they are nonetheless shaping U.S. policy both here and abroad....

Common sense suggests that in the real world, abstinence as a contraceptive method can and does fail.

A January [2006] grant announcement for the Bush administration's pet abstinence education program contains a bold, new articulation of federal abstinence-promotion policy. The guidance defines abstinence as "voluntarily choosing not

to engage in sexual activity until marriage." It then goes on to broadly define sexual activity as "any type of genital contact or *sexual stimulation* between two persons including, but not limited to, sexual intercourse" (emphasis added).... [T]hese definitions make clear that the activities the federal government expects unmarried people to abstain from go well beyond "traditional" intercourse....

Given current patterns of teenage sexual activity, it is probably safe to say that efforts to prevent teenagers—let alone all unmarried people—from engaging in anything potentially sexually stimulating are at best unrealistic. At worst, such efforts may have harmful public health consequences, by failing to prepare young people for the time they, almost inevitably, will become sexually active. To date, there is no sound scientific research suggesting that abstinence-only education delays the initiation of sexual activity. There is evidence, however, that such programming, which either precludes information about condoms and contraception entirely or permits only negative information, may be making it harder for young people to effectively engage in protective behaviors down the road....These findings [also] raise the possibility that virginity pledges, which are a centerpiece of many abstinence education programs, may be affecting the sequencing of sexual behaviors and may be prompting some young people to engage in behaviors such as oral sex to technically preserve their virginity—behaviors that many teenagers themselves consider to be less intimate than vaginal sex.

[M]ore progressive researchers and advocates [also] may bear some responsibility for divorcing sex from intimacy. Based on evidence that a key risk factor for having intercourse is being in a serious dating relationship, many such experts exhort parents and others to discourage adolescents from having such relationships. Yet this too may be having unintended consequences, because it may be deterring the relationships but not the sex....

All of this suggests that the U.S. emphasis on stopping young people from beginning intercourse—almost at any cost—may be directly and indirectly harming American youth. It is clearly hindering important conversations about sex and childbearing; the shared responsibility that couples have to protect themselves from unwanted pregnancy and disease; and perhaps most important, the value of relationships, intimacy and commitment, as they relate to sex among not only adolescents, but adults as well.

From "Understanding 'Abstinence': Implications for Individuals, Programs and Policies," December 2003, and "Legislating Against Arousal: The Growing Divide Between Federal Policy and Teenage Sexual Behavior," Summer 2006.

The Promise of an HPV Vaccine

Because [the human papillomavirus (HPV)] is easily transmitted through sexual contact, the vaccine's full promise may only be realized through near-universal vaccination of girls and young women prior to sexual activity—a notion reflected in recently proposed federal guidelines....Experts believe that such an approach has the potential to significantly reduce cervical cancer deaths [and] the approximately 3.5 million abnormal Pap results experienced by American women each year [along with the accompanying] follow-up care, ranging from additional Pap tests to more invasive procedures such as colposcopies and biopsies....Finally, widespread vaccination fosters "herd immunity," which is achieved when a sufficiently high proportion of individuals within a population are vaccinated that those who go unvaccinated—because the vaccine is contraindicated for them or because they are medically underserved, for example—are essentially protected....

A large body of evidence suggests that the most effective means to ensure rapid and widespread use of childhood or adolescent vaccines is through state laws or policies that require children to be vaccinated prior to enrollment in day care or school. These school-based immunization requirements, which exist in some form in all 50 states, are widely credited for the success of immunization programs in the United States. They have also played a key role in helping to close racial, ethnic and socioeconomic gaps in immunization rates....

In recent months, some commentators have noted that as a sexually transmitted infection, HPV is "different" from other infectious diseases such as measles, mumps or whooping cough, which are easily transmitted in a school setting or threaten school attendance when an outbreak occurs. Some socially conservative advocacy groups accordingly argue that the HPV vaccine does not meet the historical criteria necessary for it to be required for children attending school.…This position reflects only a limited understanding of school-based vaccination requirements. These requirements do not exist solely to prevent the transmission of disease in school or during childhood. Instead, they further society's strong interest in ensuring that people are protected from disease throughout their lives and are a highly efficient means of eradicating disease in the larger community.…[S]tates currently require vaccination against certain diseases, such as tetanus, that are not "contagious" at all, but have very serious consequences for those affected. And almost all states require vaccination against Hepatitis B, a blood borne disease which can be sexually transmitted.…

Solutions to the various challenges presented by the HPV vaccine are likely to have relevance far beyond cervical cancer. In the coming years, scientific breakthroughs in the areas of immunology, molecular biology and genetics will eventually permit vaccination against a broader range of acute illnesses as well as chronic diseases. Currently, vaccines for other STIs such as chlamydia, herpes and HIV are in various stages of development. Also under study are vaccines for Alzheimer's disease, diabetes and a range of cancers. Vaccines for use among adolescents will also be increasingly common. A key question is, in the future, will individuals across the economic spectrum have access to these breakthrough medical advances or will disadvantaged individuals be left behind?…

If the HPV vaccine is indeed "the first of its kind," as some have characterized it, it has the potential to prompt communities across the nation to reconsider and perhaps reconceive the philosophical justification for school entry requirements.…School entry requirements might… provide an important opportunity to deliver public health interventions that, like the HPV vaccine, offer protections to individuals who have the potential to become disconnected from health care services later in life.…Meanwhile, the cost and affordability issues raised by the HPV vaccine may help draw attention to the need to reform the vaccine-financing system in this country.

From "Achieving Universal Vaccination Against Cervical Cancer in the United States: The Need and the Means," Fall 2006.

Equitable Coverage of Contraceptives

The bipartisan [Equity in Prescription Insurance and Contraceptive Coverage Act (EPICC), introduced in 1997,] would require health insurance plans to provide the same level of coverage for prescription contraceptives and contraceptive services that they provide for other prescription drugs and outpatient health services. The enormous political and popular appeal of this approach was readily evident on several levels. …EPICC demonstrated the potential to stake out "common ground" by emphasizing the role that contraceptives play in preventing unintended pregnancy and reducing the need for abortion; it provided a simple remedy to an easy-to-understand, well-documented problem; and it addressed a "middle class" issue that had great potential to tap into women's anger over gender inequities. Finally, it provided prochoice advocates, who were becoming increasingly beleaguered by a series of political losses on the abortion front, with the beginnings of a proactive vision for the future on a national scale.…

It was not until the spring of 1998, however, that two events would jumpstart the legislative strategy for achieving contraceptive coverage, making the issue a subject of debate in state legislatures across the nation. First, and perhaps most importantly from a public relations standpoint, the male-impotency drug Viagra was approved by the Food and Drug Administration; press reports that insurers were flocking to cover the drug prompted considerable indignation among women who believed that insurers were eager to accommodate men's prescription drug needs while ignoring important needs of their own. Second, [the

Guttmacher Institute] issued an analysis concluding that the cost to employers of providing contraceptive coverage would be minimal, thus refuting the then–commonly heard argument that requiring such coverage would impose significant financial burdens on employers.

In 1998, Maryland became the first state in the nation to actually enact a contraceptive coverage mandate. Within six short years, a total of 20 states would have such laws in effect.[2]….As the movement to secure contraceptive coverage through state legislation gathered steam, advocates simultaneously began using tools already at their disposal to apply pressure directly on employers—namely, litigation under existing gender discrimination laws. In June 2001, they celebrated a landmark victory in litigation alleging that an employer who excluded contraceptive coverage from an otherwise comprehensive prescription drug plan violated Title VII of the Civil Rights Act of 1964….A[nother] particularly momentous victory came when [Congress adopted] an amendment to a pending annual appropriations bill requiring contraceptive coverage in insurance plans participating in the Federal Employees Health Benefits Program (FEHBP)….As the largest employer-sponsored health plan in the world, FEHBP often serves as a bellwether for private employers shaping their employee health plans. President Bush would attempt to eliminate the FEHBP requirement in his fist budget proposal to Congress in the spring of 2001….However, there was no turning back the clock. Congress resoundingly rejected the President's proposal to eliminate contraceptive coverage, and since then has renewed the requirement on an annual basis without debate.

[T]he Department of Health and Human Services [has] made increasing private-sector insurance coverage of contraceptives an official public health goal for the nation….New [Guttmacher Institute] research shows considerable progress toward that goal: levels of coverage have risen sharply…and disparities in coverage among contraceptive methods have been greatly reduced…. This progress promises to make true method choice a reality for many privately insured women in this country. Yet there is still much work left to be done. The fact remains that only half of all women of reproductive age live in states that require contraceptive coverage….Further, state mandates reach only those covered through employers who purchase from insurers…. Passage of EPICC is necessary to guarantee coverage for women in states without mandates and for individuals in self-insured plans. Similarly, enhanced enforcement of gender discrimination laws, coupled with other efforts to persuade employers to provide coverage, also will play vital roles. In short, in the absence of comprehensive health insurance reform at the federal level, a continued multiplicity of targeted efforts and strategies will likely be necessary to ensure that women have the contraceptive coverage they need to best avoid unintended pregnancy.

Levels of coverage have risen sharply and disparities in coverage among contraceptive methods have been greatly reduced. This progress promises to make true method choice a reality for many privately insured women in this country.

From "Contraceptive Coverage: A 10-Year Retrospective," June 2004.

The Power of Putting Prevention First

[T]o the extent that abortion is deemed a "problem," it is best addressed by helping women prevent unwanted pregnancies in the first place. Indeed, focusing on prevention—not as a way of backing away from abortion rights, but as a means of reducing the need for abortion—constitutes both good policy and good politics. It is good policy because it has the potential to address the root cause of most abortions in a constructive way that responds realistically to the problems that many people face in trying to responsibly manage their reproductive lives. And

2. By February 2007, that number had grown to 26 states requiring contraceptive coverage.—*Editor.*

it is good politics because it is in sync with what Americans say they want from their legislators, and because it promises to diffuse the intensity of the debate over abortion that has raged in this country for far too long....

[T]he U.S. abortion rate remains among the highest of all industrialized nations—more than twice as high, for example, as the Netherlands....There, unlike here, government and social institutions support comprehensive sex education and health care services aimed at helping people, including young people, avoid unintended pregnancy and disease; contraceptive use is widely encouraged and contraceptives are easily available; and national health insurance helps ensure that people have access to timely and affordable care. In short, the abortion rate in the Netherlands—and in other western and northern European countries—is low because unintended pregnancy rates are extremely low due to widespread and effective contraceptive use....

The social conservatives currently in power at the federal level and in many state governments are hostile to the very notion of prevention. Their answer to abortion is to make it illegal; their answer to unwanted pregnancy (or out-of-wedlock births, as they define the problem) is abstinence for all people outside of marriage....From a public health perspective, denigrating contraception as a strategy to help young people delay and refrain from sexual activity is misguided and counterproductive; it may very well deter contraceptive use among people when they do become sexually active. It would be unthinkable as a matter of public health to tell people that because seatbelts do not offer 100% protection against injury from car crashes, they should refrain from driving. Instead, people are strongly advised to use seatbelts each and every time they ride in a car (and driving without a seatbelt is in fact socially, and in most places even legally, sanctioned)....

Prochoice groups, for their part, have been working to advance prevention through federal and state policy for many years and can point to numerous successes that have made a meaningful difference in people's lives. Historically, however, many prochoice leaders have been resistant to the notion of putting prevention *first.* Because they have feared that doing so would cast abortion in a negative light, they have been unwilling to say that contraception, as an intervention, is *preferable* to abortion—for women and for society. This has made the prochoice community seem out of touch with the American public. For years, poll after poll has shown that while Americans want abortion to be legal, they are also uncomfortable with abortion, and want it to be treated as a last resort....

Focusing on prevention—not as a way of backing away from abortion rights, but as a means of reducing the need for abortion—constitutes both good policy and good politics.

Establishing the prevention of unintended pregnancy (through more and better contraceptive use) as a major public health priority will require it to be cut free from the twin political anchors of abstinence and abortion....As for abstinence, there is no question that helping young people to delay sexual activity is a valid and important component of any national prevention strategy. Yet, the fact is that most American women, over most of their lives, rely on contraception...to help them responsibly manage their sexual lives. With regard to abortion, there is also no question that both sides of the debate, unwittingly or not, have relegated prevention to the position of poor stepchild. This subjects those policymakers trying to elevate prevention as the solution to the problem of abortion in this country to criticism that they are trying to "change the subject." In no other area of public health outside of the abortion context would prevention be so denigrated, nor would the motives of those promoting prevention be so called into question. **www.guttmacher.org**

From "Promoting Prevention to Reduce the Need for Abortion: Good Policy, Good Politics," May 2005.