Youth who took a virginity pledge reported a similar level of sexual intercourse to that of closely matched nonpledging youth in a longitudinal study that assessed outcomes five years after pledging.1 Three-fourths of both pledgers and nonpledgers had had intercourse by the five-year follow-up, and the mean age at first sex for both groups was 21. Smaller proportions of pledgers than of nonpledgers said that in the past year, they had always used a condom (24% vs. 34%) and always used some birth control method (46% vs. 52%), and had used a method at last sex (67% vs. 72%). Furthermore, 82% of pledgers denied having ever taken a pledge.

The study used data from the National Longitudinal Study of Adolescent Health, which surveyed a sample of students in grades 7–12 over three waves (1995, 1996 and 2001). Students who in 1995 were 15 or older, had never had sexual intercourse and had never taken a virginity pledge, and who had been interviewed in all three waves, were included in the analysis. In contrast with earlier studies, which used regression analysis to compare pledgers and the general population of nonpledgers, this study was unique in matching 289 youth who had pledged in 1996 with 645 nonpledgers on 112 prepledge factors that may influence sexual behavior (e.g., pubertal development, religiosity, and attitudes toward sex and birth control). Outcomes, measured in 2001, were self-reports of sexual behavior and of contraceptive use within the last year and at last sex, as well as STD diagnoses (from urine tests). Outcomes for the two groups were compared using t tests, and Cohen’s effect size was computed for significant differences.

After matching, the mean age of both pledgers and nonpledgers at the 1995 interview was 16, and 61% were female; six in 10 lived with both biological parents. Nearly six in 10 respondents were white, and the rest were evenly divided among Latino, black and Asian backgrounds. At Wave 1, two-thirds of the youth attended weekly church or youth group meetings, and four in 10 were born-again Christians. About half said they would not have sex without using birth control, and two-thirds said they would feel guilty if they did have sex.

In 2001, similar proportions of pledgers and matched nonpledgers reported having had sexual intercourse either before or after marriage (73% and 76%, respectively), and having had premarital intercourse and still being unmarried (53% and 57%, respectively). They did not differ on most measures of sexual behavior (e.g., number of times they had had intercourse in the past year, experience of anal or oral sex, and number of lifetime partners) or on any STD diagnosis, and the mean age at first sex for both groups was 21. Pledgers reported slightly fewer partners in the last year than did nonpledgers (1.1 vs. 1.2), and were less likely to have ever been paid for sex (1% vs. 3%), but these differences were small and possibly attributable to random error.

Among respondents who were unmarried and sexually experienced in 2001, lower proportions of pledgers than of nonpledgers reported always having used a condom in the past year (24% vs. 34%) and having used one at least half the time (51% vs. 62%); a higher proportion of pledgers than of nonpledgers had never used a condom over this period (28% vs. 20%). Pledgers were also less likely to have always used any birth control method in the past year (46% vs. 52%) or to have used one at least half the time (70% vs. 76%). Similarly, pledgers reported a lower rate of birth control use at last sex than did nonpledging youth (67% vs. 72%). Notably, five years after taking a virginity pledge, 82% of pledgers denied that they had ever made such a commitment.

The researcher points out that this study has several possible limitations. At Wave 1, the matched sample was more religious and sexually conservative than the general adolescent population, and consequently at Wave 3, the sample reported more conservative sexual behavior than did most adolescents. Additionally, pledgers may have underreported their sexual activity, and some youth classified as nonpledgers at Wave 2 reported having taken a pledge at the last interview. Furthermore, the analysis did not assess whether taking a pledge had any causal association with later sexual activity. Given that pledgers were less likely than comparable nonpledgers to use birth control, the researcher recommends that federal abstinence-only funding “be shifted to evidence-based sex education programs that teach birth control and have been demonstrated to delay sexual initiation and increase safer sex practices,” and that virginity pledges themselves “not be used as a measure of abstinence...program effectiveness.”—J. Thomas

REFERENCE
West Indian Immigrants, U.S.-Born Blacks Have Different STD Risk Profiles

West Indian–born black men attending two New York City STD clinics were less likely than U.S.-born black men to report a number of behaviors that potentially increase the risk of acquiring STDs, including having casual and onetime partners. Among black women, by contrast, West Indian immigrants appeared more vulnerable to STD risk than those born in the United States, because they were less confident that they could persuade regular partners to use condoms or undergo STD screening. These findings, and others from the same study, shed light on the risk profile of an immigrant group that represents a substantial proportion of black New Yorkers.

The study used baseline data from an assessment of an intervention aimed at improving partner STD notification. Participants were sexually active men and women aged 18 and older who had had chlamydia or gonorrhea diagnosed at one of the clinics in 2002–2004. In face-to-face interviews, they pro-
vided information on their participation in a wide range of risk-related behaviors during the past 90 days, as well as attitudes toward and beliefs about condom use and notifying partners of STD infection. Researchers conducted bivariate and multivariate analyses to examine overall and gender-specific comparisons between immigrant and native-born participants.

A total of 587 men and women were included in the analyses. In both the immigrant and the U.S.-born subgroups, women were about 25 years old, on average, and men were 28; roughly three-quarters of women and half of men in each group reported an income of less than $18,000. West Indians had less schooling than U.S.-born blacks; the majority of immigrants had lived in the United States for more than four years.

Bivariate gender-specific comparisons revealed no differences by place of birth in participants’ STD histories. In each subgroup, approximately one-half of participants had ever had an STD, nine in 10 had been tested for HIV and no more than 4% were HIV-positive. Immigrants’ and U.S.-born participants’ reports of risky sexual behaviors in the past 90 days were largely similar, but a few significant differences emerged. U.S.-born women were more likely than West Indians to have had five or more partners (4% vs. 0%) and to have had a onetime partner—someone they had had sex with once and did not plan to have sex with again (18% vs. 9%). Among the small numbers who had had anal sex, native-born women were more likely than immigrants to say that they had never used condoms on these occasions (75% vs. 14%). Among men, participants born in the United States were more likely than immigrants to have had a casual partner (56% vs. 43%), to have had a onetime partner (43% vs. 33%), to have had anal sex (26% vs. 15%) and to have used drugs other than marijuana (6% vs. 1%). However, native-born black men also were more likely than their West Indian counterparts to report one protective behavior: Forty percent and 26%, respectively, had declined to have sex because they did not have a condom or their partner did not agree to use one.

Although most measures of condom use did not vary by participants’ place of birth, adjusted analyses suggested that differences in condom-related beliefs and intentions may leave U.S.-born blacks less vulnerable to risk than West Indian immigrants. Overall, the former were more likely than the latter to view consistent condom use with regular partners extremely favorably (odds ratio, 1.6). Furthermore, women born in the United States had higher odds than immigrant women of feeling extremely confident that they could convince a regular partner to use condoms (2.4), but they had lower odds of saying that they were extremely likely to use condoms consistently with casual partners (0.2). Men’s responses were not related to their place of birth.

U.S.-born and West Indian participants overall did not differ in their beliefs about STD screening and notification with regard to regular and casual partners. However, U.S.-born women were more likely than West Indian women to feel extremely confident that they could convince regular partners to undergo screening (odds ratio, 1.9) and less likely to feel extremely favorably toward discussing screening with casual partners (0.1). Native-born men had lower odds than immigrant men of feeling extremely confident that they could discuss STD screening with a regular partner (0.5). Although the numbers were small, it appeared that participants who were born in the United States had reduced odds of feeling that they could probably convince a onetime partner to undergo STD screening and of feeling extremely favorably toward discussing screening with such a partner.

The researchers conclude that the use of traditional, broad racial and ethnic categories in public health research obscures “significant heterogeneity” among black subgroups living in the United States and that place of birth is an important characteristic to include in studies of STD-related risk among black immigrants. Moreover, given their findings of West Indian women’s relative reluctance to discuss condom use and STD screening with regular partners, the investigators stress the need “for interventions that target gender norms and behaviors among West Indian immigrants.”—D. Hollander

REFERENCE

Sexual Partnerships in Britain: Characteristics Differ By Gender and Predict Likelihood of Condom Use

Men and women in Britain report many differences in the characteristics of their heterosexual partnerships, and some differences in partnership characteristics are reflected in the likelihood of risky behavior. For example, men are more likely than women to have casual partners, and they are less likely than women to have partners of roughly their own age. Condom use is more likely in casual partnerships than within marriage; even so, the level of use in casual relationships suggests that many men and women are inadequately protected against the risk of STD infection. Additionally, condom use the first time a couple has sex is more likely if the partners are about the same age than if the male is five or more years older than the female. In nearly one-quarter of men’s new partnerships, but only one in 10 of women’s, first sex with a new partner occurs within 24 hours after the couple’s meeting. These are among the findings of an analysis based on data from Britain’s 1999–2001 National Survey of Sexual Attitudes and Lifestyles.¹

The survey was based on a stratified probability sample of more than 11,000 British residents aged 16–44, who participated in face-to-face interviews and computer-assisted self-interviews. A total of 9,598 respondents reported having had at least one heterosexual partner in the past year; investigators used data on this subsample to study partnership formation, and they employed logistic regression to assess associations between partnership characteristics and condom use.

Men and women differed significantly in both the number and the types of heterosexual partners they reported for the previous year. On average, men reported 1.8 partners, whereas women reported 1.3; some 6% of men, but only 2% of women, had had five or more partners. The largest proportion of men’s relationships (39%) were with a casual—or, in the survey’s term, “not (yet) regular”—partner; 25% were with a spouse, 22% with a regular partner and 14% with a cohabiting partner. By contrast, women’s relationships were most frequently with a spouse (36%); 25% were with a regular partner, and 20% each with a cohabiting and a casual partner.

Condom use was reported in a minority of partnerships but was more common outside
than within marriage. Overall, 37% of men’s partnerships and 29% of women’s involved condom use at last intercourse. Regular partnerships were more likely than marital relationships to include such use (odds ratios, 3.1 for men and 2.5 for women). Use was even more likely in casual partnerships (5.1 for each gender); nevertheless, the prevalence of use in these partnerships was only 56% among men and 52% among women.

More than half of reported new partnerships occurred among respondents in their teens and early 20s, and the older respondents were, the less likely they were to have used a condom the first time they had sex with a new partner. The odds of this behavior were 70% lower in new partnerships among 35–44-year-old men than in those reported by male teenagers, for women’s partnerships, the odds dropped by 80% from the youngest to the oldest age-group.

In the majority of new partnerships reported by both genders, the man was within five years of the woman’s age, but this situation was more common among men than among women (73% vs. 63%). Women more often than men reported that the male was five or more years older than the female (25% vs. 20%). Same-age partners were more likely than couples in which the male was at least five years the female’s senior to use a condom the first time they had intercourse (odds ratios, 2.2 for males and 1.7 for females); no difference was observed if the man was younger than the woman.

Men’s and women’s reports of where they had met recent new partners were largely similar. The most common places were pubs or restaurants, work, school and social events organized by friends. About three in five respondents of each gender reported that new partners lived in their city or town.

Men had first had sex with a new partner sooner than women had. Twenty-three percent of men’s new partnerships had included sexual activity within the first 24 hours; in another 14%, the couple had had sex within one week after meeting. Among women’s partnerships, 11% had included intercourse within 24 hours, and by one week, sexual activity had begun only in another 10%. Men who had had sex within 24 hours of meeting a new partner were more likely to have used a condom at that time than were men whose first sexual encounter with a new partner had occurred after a day or more.

The researchers comment that ambiguity in the wording of survey questions about when and where respondents first met their partners may have influenced some of the findings. On the other hand, they emphasize that the study improved on earlier work by using an analytic approach that permitted them to draw conclusions about the entire population of partnerships in the past year, rather than current or most recent ones. This approach, they maintain, contributes to a greater understanding of “who has sex with whom, and how partnership characteristics relate to condom use and thus [STD] risk.”

—D. Hollander

REFERENCE
Abortion or Pill Access Is Associated with Lower Birthrates Among Minors

The existence of state-level restrictions on minors’ legal ability to obtain abortions or oral contraceptives in the 1960s and 1970s appears to have influenced their fertility, according to a study of birthrates among 15–21-year-olds during this period. Increased access to abortions was associated with declines in birthrates among both white and nonwhite young women; expanded access to the pill also was related to birthrate reductions among whites. The differences were accounted for mainly by changes in the rate of first births to unmarried women.

Earlier studies of birthrates did not consider younger minors’ legal access to the pill and to abortion in the late 1960s and the 1970s; this shortcoming is critical, because such access may affect women’s short- and long-term fertility, in addition to career and labor force outcomes. A host of children’s outcomes—such as educational attainment, welfare use and fatal injury rates—may be affected as well. This study was the first to assess whether birthrates were influenced by access to the pill or by state laws that were in place prior to the 1973 Roe v. Wade decision and that allowed minors to obtain an abortion without parental involvement. Fertility and population data were drawn from U.S. vital statistics (1968–1979) and Census Bureau (1970–1980) databases, and state-level policy variables for 1968–1978 were collected from a variety of sources.

Legal access to the pill was defined by whether a minor could obtain the method without parental consent in the year prior to giving birth, and legal access to abortion was defined similarly. Ordinary least-squares regression analyses controlled for age, state and year fixed effects, as well as for state-year fixed effects. In light of racial differences in response to these policies, the analyses assessed the birthrates of whites and nonwhites separately. Nonmarital births were also analyzed separately, because minors who were married or who had children were usually legally emancipated and so already had access to the pill and abortion in most states.

Among white minors, having had access to the pill was associated with a 9% drop in the overall birthrate and an 8% drop in the rate of nonmarital first births. In this same group, access to an abortion was correlated with a 17% decline in the nonmarital birthrate and a 16% decline in the rate of nonmarital first births. Only one association was found among nonwhite women: Access to abortion was associated with an 8% decrease in the nonmarital birthrate. Where significant differences in birthrates were found between white and nonwhite minors, access to the pill and access to abortion were confirmed to have stronger relationships with white women’s birthrates. Robustness tests supported the association between access to abortion and decreased birthrates, while the relationship between access to the pill and birthrates received less support.

The researcher believes that the smaller decline in birthrate seen with access to the pill than with abortion access may be explained by the pill’s inherent failure rate and the fact that its use requires continual action on the woman’s part. She asserts that “changes in minors’ abortion and oral contraceptive access brought about by the changes in state and national laws in the late 1960s and early 1970s” were instrumental in reducing minors’ birthrates, particularly among unmarried women experiencing their first birth. Although these findings are based on data collected several decades ago, the researcher argues that the results “can inform contemporary debate on minors’ access to reproductive control.” —J. Thomas

REFERENCE
Heterosexual Anal Sex Is Common Among STD Clinic Clients, but Is Frequently Not Protected by Condom Use

During the year following a visit to one of three public STD clinics, clients who returned for follow-up visits frequently engaged in heterosexual anal sex, mostly without using condoms. Multivariate analyses identified several characteristics that were positively associated with the odds of having anal sex during a three-month period, including: being a partner of the opposite sex at baseline and were sexually active during the follow-up period; together, they contributed data on more than 6,000 three-month intervals and more than 9,000 partnerships.

Analyses examined the sexual behavior of clients attending clinics in Denver, Long Beach, California; and Newark, New Jersey. Trials participants were recruited in 1999–2000, during a clinic visit for an STD examination; to be eligible for the study, clients had to be 15–39 years old and HIV-negative. Those who enrolled received prevention counseling and agreed to return for follow-up visits every three months for a year. During each visit, they used audio computer-assisted self-interviewing to provide information on their sexual behavior with up to three partners during the preceding three months. The analytic sample was restricted to the 2,357 men and women who reported at least one partner of the opposite sex at baseline and were sexually active during the follow-up period. Together, they contributed data on more than 6,000 three-month intervals and more than 9,000 partnerships.

Participants reported heterosexual anal sex in 18% of three-month intervals following their baseline clinic visit. Virtually all of these intervals also included vaginal sex; on average, participants reported 4.7 occurrences of anal sex and 38.0 episodes of vaginal sex per interval. In multivariate analyses, the likelihood that anal sex occurred during a given interval was elevated if the participant reported more than one partner (odds ratio, 1.5), 13 sex acts (2.1–3.8) or any unprotected vaginal sex (1.3) during that interval; it was also elevated if the participant reported having bought or sold sex (1.5). Age, gender and race—which have been identified as predictors of heterosexual anal sex in the general population—were not significant for this sample.

Fourteen percent of all reported partnerships included at least one episode of heterosexual anal sex. Main partnerships were more likely than casual ones to involve anal sex (odds ratio, 1.4), and the odds of this activity were elevated if either partner had been high on alcohol or other drugs during sex (1.4). Compared with partnerships that had included 1–13 episodes of sex during a three-month period, those that had included 14 or more had higher odds of involving anal sex (2.2–3.5). New and established partnerships were equally likely to involve anal sex, and reports of anal sex were not related to whether a partner had been treated for an STD.

Condom use during heterosexual anal sex was rare. Only 27% of intervals in which anal sex occurred contained reports of consistent use; 63% contained no reports of use. The strongest predictor of consistent use was protective behavior during vaginal sex. Intervals in which condoms were always used for vaginal sex were considerably more likely to involve consistent use for anal sex than were intervals marked by inconsistent condom use for vaginal sex (odds ratio, 17.4). Only one other characteristic included in a multivariate analysis was associated with consistent condom use: Participants were more likely to report consistent use during intervals in which they had had multiple partners than in periods in which they had had only one (1.6).

Of all partnerships that had included heterosexual anal sex, 30% had involved consistent condom use. This protective behavior was more likely in main partnerships than in casual ones (odds ratio, 2.1), and was more prevalent in new partnerships than in established ones (1.4). No other partnership characteristics included in the analysis predicted consistent condom use during anal sex.

The researchers acknowledge that because of possible underreporting and the select nature of their sample, the findings should be interpreted with caution. Nevertheless, they note, the results “suggest that clinicians should ask their patients about anal sex, tell them unprotected anal sex is an efficient path for HIV/STD transmission, and recommend consistent condom use for both anal and vaginal sex.” Commenting on the broader implications of the study, the author of an accompanying editorial writes, “At a minimum,
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Pediatricians’ Support Of Breast-Feeding Is Linked To Their Experience with It

Pediatricians’ attitudes toward breast-feeding have worsened over time, according to a national study. Although a higher proportion of pediatricians surveyed in 2004 than in 1995 recommended exclusive breast-feeding (74% vs. 65%), lower proportions believed that all mothers could successfully breast-feed and that the benefits of breast-feeding were worth the potential inconvenience. However, in 2004, pediatricians who had breast-fed their children were more likely to provide support for breast-feeding than were those with no personal experience.

Since the mid-1990s, the proportion of U.S. mothers who ever breast-fed and the number of initiatives aimed at promoting breast-feeding have increased substantially. To examine whether pediatricians’ support of breast-feeding also has changed, researchers analyzed data from surveys conducted by the American Academy of Pediatrics (AAP) in 1995 and 2004. Each survey used a closed-ended questionnaire mailed to a random sample of academy members. Respondents provided information on their demographic characteristics (including their number of children and personal breast-feeding experience) and their pediatrics practice. Pediatricians who provided primary care for children up to two years old were asked about their counseling and management practices for breast-feeding and their opinions of breast-feeding’s benefits. The final sample consisted of 1,133 pediatricians in 1995 and 875 pediatricians in 2004.

Pediatricians surveyed in 2004 were generally similar to those surveyed in 1995. They were, on average, 42 years old; 58% were

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female (compared with 46% in 1995). In both years, about eight in ten worked in a group practice, hospital, clinic or medical school. In 1995 and 2004, four in ten pediatricians had patients aged 0–2, and seven in ten were parents. The two samples diverged on the proportion whose children were ever exclusively breast-fed. The 2004 proportion was about twice that of 1995 (72% vs. 37%).

Pediatricians in 2004 were more likely than those in the earlier sample to have had professional breast-feeding training; 68% and 58%, respectively, had been instructed on this topic during medical school or residency. Interestingly, far higher proportions of pediatricians in 2004 than in 1995 indicated that they would recommend against breast-feeding for “unnecessary reasons,” including the mother’s immaturity (26% vs. 7%) and the inconvenience of breast-feeding (15% vs. 4%).

The researchers also assessed how consistent breast-feeding recommendations were with the World Health Organization’s breast-feeding policies among pediatricians with patients who were 0–2 years old. A higher proportion of pediatricians in 2004 than in 1995 correctly counseled mothers to breast-feed exclusively (74% vs. 65%) and had mothers and infants stay in the same hospital room to make breast-feeding easier (71% vs. 51%). Moreover, smaller proportions in 2004 than in 1995 made recommendations not supported by the AAP—supplementing breast-feeding with formula (8% vs. 13%) or water (8% vs. 12%), or giving exclusively breast-fed infants multivitamins (29% vs. 41%) or fluoride (9% vs. 34%).

Similarly, higher proportions of pediatricians in 2004 than in 1995 gave advice matching the AAP’s 10 criteria for successful breast-feeding in hospitals, even though only 12% were aware of the policies. For example, more than two-thirds encouraged breast-feeding within one hour of delivery and unrestricted feeding thereafter, compared with no more than three in five of those surveyed in 1995.

Though some positive changes occurred, pediatricians’ attitudes toward breast-feeding deteriorated overall between surveys. For example, smaller proportions of respondents in 2004 than in 1995 agreed that formula-fed and breast-fed babies would be equally healthy (26% vs. 35%), and that pediatricians had little influence on breast-feeding initiation (6% vs. 18%). In contrast, just 58–62% in 2004 believed that breast-feeding’s benefits offset its potential difficulty or that almost any mother could successfully breast-feed—lower proportions than in 1995.

In 2004, personal experience with breast-feeding, while not significantly related to most attitudes, was linked to pediatricians’ decision to teach or counsel their patients to do the same. For example, much higher proportions of those who had breast-fed their children than of others had managed breast-feeding problems (80% vs. 64%) or taught breast-feeding techniques to a new mother (47% vs. 20%) at least five times in the last year.

Although pediatricians may have supported breast-feeding using methods not covered by the surveys, the results of this analysis indicate that knowledge was often not enough to overcome “concerns about the sustainability of breast-feeding,” according to the investigators. Many pediatricians surveyed in 2004 had little clinical experience with breast-feeding, the researchers observe, but personal breast-feeding experience was associated with improved practices. Noting that new educational materials have been developed since 2004, the researchers suggest that these resources, combined with support in the workplace for pediatricians choosing to breast-feed and early training, could help change attitudes and create “a culture in which breast-feeding is the norm.”—S. Ramashwar

REFERENCE