# 2003-04 SESSION COMMITTEE HEARING RECORDS

*Committee Name:*

*Senate Committee on Health, Children, Families, Aging and Long Term Care*

*(SC-HCFALTC)*

Sample:

Record of Comm. Proceedings … RCP

- 03hrAC-EdR_RCP_pt01a
- 03hrAC-EdR_RCP_pt01b
- 03hrAC-EdR_RCP_pt02

- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Committee Hearings … CH*
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Hearing Records … HR*
- *03hr_sb0186_pt16*

- *Miscellaneous … Misc*
- **

- *Record of Comm. Proceedings … RCP*
- **

Dec. 2003


**PRO-LIFE WISCONSIN**

19270 North Hills Drive
P.O. Box 221
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**Matt Sande**
**Director of Legislative Affairs**

www.prolifewisconsin.org
*Your 100% pro-life voice.*

Sen. Roessler
JH

DEC 01 2003

Sent update letters 12/2

Dear State Senator Carol Roessler and State Representative John Townsend

I urge you to support AB 383 and SB 186, legislation that would eliminate minor children's access to free, taxpayer-funded birth control and other "family planning" services under the *Medicaid Family Planning Demonstration Project.*

Federal law prohibits parents from being notified that their 15, 16 and 17 year-old sons and daughters are receiving free contraceptives under this *Project.* This undermines parental authority and increases underage pregnancy and abortion by encouraging sexual promiscuity. Oral contraceptives offer no protection against sexually transmitted diseases (STDs), which have become a full-blown epidemic among our teens.

**Please support AB 383 and SB 186.** This common-sense legislation respects parents and protects our kids. Thank you for your consideration.

Sincerely, Ann Fontecchio from Fond du Lac County.

I would like to be contacted about your position on these bills.

My address is: N8817 Hwy 151
Fond du Lac, WI 54935

Sen. Roessler
JH

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Sincerely, Donald Fontecchio from Fond du Lac County.

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Donald Fontecchio
N 8817 U.S. Highway 151
Fond du Lac, WI 54935-9525

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Sincerely, Priscilla A Drew from FDL County.

I would like to be contacted about your position on these bills.

My address is: 630 W. ARNDT ST #214
FOND DU LAC, WI 54935

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Sincerely, Donna Beck from Winnebago County.

I would like to be contacted about your position on these bills.

My address is: 1360 E. Scott St.

Omro, WI 54963

WISCONSIN STATE SENATE

# Carol Roessler
STATE SENATOR

December 2, 2003

Priscilla Drew
630 West Arndt St. #214
Fond du Lac, WI 54935

Dear Priscilla,

Thank you for your contact on Senate Bill 186 relating to a Medical Assistance family planning demonstration project minimum age eligibility limitation change.

On September 23, 2003 the full Senate voted 29-4 to send this bill to the Senate Committee on Health, Children, Families, Aging and Long Term Care, which I chair. A public hearing was held on October 14, 2003.

Thank you again for sharing your views on this issue. Please feel free to contact me further with questions or concerns.

Sincerely,

Carol

CAROL ROESSLER
State Senator
18th Senate District

CR/jh S:\DOCS\Jennifer\11-13-03 family planning update.doc

**CAPITOL ADDRESS:** State Capitol • P.O. Box 7882, Madison, WI 53707-7882 • **PHONE:** 608-266-5300 • **FAX:** 608-266-0423
**HOME:** 1506 Jackson Street, Oshkosh, WI 54901 • **TOLL-FREE:** 1-888-736-8720
**E-MAIL:** Sen.Roessler@legis.state.wi.us • **WEBSITE:** http://www.legis.state.wi.us/senate/sen18/news/

WISCONSIN STATE SENATE

**Carol Roessler**
STATE SENATOR

December 2, 2003

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N8817 Hwy 151
Fond du Lac, WI 54935

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WISCONSIN STATE SENATE

**Carol Roessler**
STATE SENATOR

December 2, 2003

Ann Fontecchio
N8817 Hwy 151
Fond du Lac, WI 54935

Dear Ann,

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WISCONSIN STATE SENATE

**Carol Roessler**
STATE SENATOR

December 2, 2003

Donna Beck
1360 East Scott Street
Omro, WI 54963

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## Halbur, Jennifer

**From:** Asbjornson, Karen
**Sent:** Wednesday, December 03, 2003 2:10 PM
**To:** Halbur, Jennifer
**Subject:** FW: Article on the health care services provided by Planned Parenthoo

CR email

Karen Asbjornson
Office of Senator Carol Roessler
(608) 266-5300/1-888-736-8720
Karen.Asbjornson@legis.state.wi.us

-----Original Message-----
**From:** Taylor, Chris [mailto:Chris.Taylor@ppwi.org]
**Sent:** Wednesday, December 03, 2003 2:08 PM
**To:** schultz; breske; chvala; (sen.cowles@legis.state.wi.us); darling; decker; ellis; erpenbach; hansen; harsdorf; jauch; moore; panzer; risser; robson; roessler; zien; Brown, Ron; Carpenter, Tim; coggs; Fitzgerald, Scott; Kanavas, Theodore; Lasee, Alan; Lassa; Lazich, Mary; Leibham, Joseph; Meyer, Mark; Plale; Reynolds, Tom; welch
**Subject:** Article on the health care services provided by Planned Parenthoo d

Dear Senators:

Attached please find an article from the Racine Journal Times from November 30, 2003 regarding the basic and important health care services and comprehensive, abstinence plus sexuality education provided by Planned Parenthood. As indicated in the article, the information which Planned Parenthood of Wisconsin provides to patients so that they may make responsible choices about their health is greatly needed. Over this holiday season, I urge you to consider the health care needs of your constituents who we serve every day.

http://www.journaltimes.com/articles/2003/11/30/local/iq_2564777.txt

Thank you.

Chris Taylor, J.D.
Legislative Director
Planned Parenthood of Wisconsin
111 King St., Suite 23
P.O. Box 2566
Madison, WI 53701
(608) 256-7549
(800) 261-2464
(608) 256-3004 Fax
chris.taylor@ppwi.org

# Health and sex

*By Mary Beth Danielson*

I worked one summer as a day camp director in an extravagantly diverse neighborhood in Chicago. The program, hosted by two churches and funded by the federal government, had about 70 children - with 18 neighborhood teenagers as their counselors. To say we were a little rough around the edges would be a whopper of an understatement.

Half the kids had a non-English first language. The playground was eight (long, dangerous) blocks away. It was a record-breakingly hot summer. Several of teens were perilously vague on the concept of keeping track of children.

Fridays were reserved for outings and programs for the teenagers. After inventing the week's curriculum for all 70 kids, now I was supposed to invent more stuff for the big kids? It was, as they say, nuts.

I'd heard Planned Parenthood of Chicago had speakers who would present free programs for teens. Anyone willing to keep my big kids occupied for a few hours sounded great to me. I called and scheduled a speaker.

The day arrived. Into the basement of that old church walked an elegant woman with a good haircut and a well-cut suit. My heart sank. I knew there was no way this lovely, refined, suburban matron was going to engage my gang. The teens shared my opinion as they slouched and snickered.

The woman smiled coolly and pulled out some flip charts.

Guess what they were of and guess how quickly those smart aleck boys sat up straight? She never raised her voice. She never blushed. She never chided or shushed - but within minutes she had transformed those kids into attentive, knowledge-hungry students. She explained the human reproductive system in simple, correct terms - and the kids listened so hard you could almost see their ears move. Talk about a "teaching moment." It was astounding to witness.

Then she upped the ante. She told the kids they could write questions anonymously, put them in a basket, she'd pull them out one by one and answer them.

"Is it true a girl will drown if she goes swimming during `that' time of the month?" "I can't get a girl pregnant if I'm not in the usual position, right?" And other stuff to make you shudder and weep.

When she described, in her unflappable way, various methods of birth control, including abstinence - it was if a bomb of understanding went off among them. In a world gone mad hustling sex, no one had offered these things so clearly.

Real information about how sex works. True respect for their minds, bodies and stories. The alluring idea that mature lovers are responsible. That it's sexy to value yourself so deeply you wait.

* n n There is a Planned Parenthood clinic in Racine. (It's at 834 Main St., and its phone number is (262) 634-2060.) I spoke with the director, some staff people, two (elegant and refined) volunteer board members. I told them that when I hear people dismiss the mission and work of Planned Parenthood, I flip back to the morning I saw it in action.

Did you know this? One in four women in the United States have used the services of Planned Parenthood at some point in their lives. Maybe that's because the organization does so MUCH stuff.

The offer low-cost, routine gynecological exams and care. If you personally have a great health insurance plan, maybe you don't know what this means. Would you be able to pay a couple hundred dollars for your annual exam? Planned Parenthood provides, also often for the least expensive costs available anywhere, birth control services. In Wisconsin, 47,000 women per year get their contraceptives in PP offices. Locally, each of these women, by their second appointment, also receives a physical exam from a nurse practitioner. If the exam raises questions, the woman is referred to doctors and clinics in the community.

A woman facing an unexpected pregnancy is offered an array of services and support. Locally, that woman walks back out of the clinic with a hand-out that has 39 phone numbers. While she's making up her mind what to do, she has at her fingertips numbers that will connect her to financial aid, programs to help her obtain prenatal care and a healthy birth, resources for adoption, child care referrals, resources for parenting. And safe, licensed places for abortion.

Robin Davis, Racine Center administrator, adds this.

"We can and do respect and protect the privacy of our patients. If a young woman doesn't know how to tell her folks that she's pregnant, we will do it for her, if she wants us to. We believe in families as much, if not more, than anyone. But not every girl comes from a wonderfully supportive family. We deal with that. We are here first and foremost, for the women who come to us for all kinds of medical help and issues."

The local Planned Parenthood Health Center saw 8,000 patients last year - which was a 20 percent increase over the previous year. Sixty-four percent of those visits were for health exams, 74 percent of the visits were for contraceptive services, 50 percent were for pregnancy testing or counseling, 47percent were to test for STD (sexually transmitted diseases). Eighty people were tested for HIV infection.

This week is designated as the Week of the Family. For 70 years, Planned Parenthood has devoted itself to the health and care of women and their young children. This strong heritage continues in our community.

Write to Mary Beth Danielson c/o The Journal Times, 212 Fourth St., Racine, WI 53403.

State of Wisconsin
**Department of Health and Family Services**

DEC 08 2003

Jim Doyle, Governor
Helene Nelson, Secretary

**DATE:** December 4, 2003

**TO:** **Senator Carol A. Roessler**
**Committee on Health, Children, Families, Aging and Long Term Care**

**FROM:** **Diane Welsh**
**DHFS Executive Assistant**

**SUBJECT:** **Follow-up to Public Hearing**

At the public hearing on AB383, you asked Dr. Murray Katcher to provider your committee with evidence-based responses to several questions. Attached are those responses. Gary Radloff may have sent you a version of these responses earlier. Because I am uncertain, however, I am sending these to you now. If my Department can be of further assistance, please let me know.

cc: Dr. Murray Katcher

**Senate Bill 186 and Assembly Bill 383 Hearing**
**October 14, 2003**
**Follow-up to DHFS Testimony Presented by Murray Katcher, MD, PhD**
**Questions Raised during the Hearing**

1. **Do family planning and related health services available under the Medicaid Family Planning Waiver prevent abortions?**

2. **Do family planning and related health services available under the Medicaid Family Planning Waiver prevent teenage pregnancy?**

**Pregnancies Averted Among U.S. Teenagers By the Use of Contraceptives.** By James G. Kahn, Claire D. Brindis and Dana A. Glei.

**Results:** Current levels of contraceptive use averted an estimated 1.65 million pregnancies among 15–19-year-old women in the United States during 1995. If these young women had been denied access to both prescription and over-the-counter contraceptive methods, an estimated one million additional pregnancies (ranging from 750,000 to 1.25 million) would have occurred, assuming some decrease in sexual activity. These pregnancies would have led to 480,000 live births, 390,000 abortions, 120,000 miscarriages, 10,000 ectopic pregnancies and 37 maternal deaths

.

**Conclusion:** Contraceptive use by teenage women prevents pregnancies and negative pregnancy-related health consequences that can disrupt the lives of adolescent women and that have substantial societal costs. Continued and expanded access to contraceptives for adolescents is a critically important public health strategy.

Family Planning Perspectives. Volume 31, No. 1, January/February 1999: Pages 29-34.
http://www.guttmacher.org/pubs/journals/3102999.html

**Impact of Publicly Funded Contraceptive Services On Unintended Pregnancies and Implications For Medicaid Expenditures By Jacqueline Darroch Forrest and Renee Samara**

Of U.S. women who use a reversible method of contraception, 24% each year obtain family planning services from a publicly funded clinic or a private doctor reimbursed by Medicaid. If these subsidized contraceptive services were not available, women who currently use them would have an estimated 1.3 million additional unplanned pregnancies annually, of which 29% would involve women aged 15-19, 67% would involve never-married women and 61% would involve women with a household income below 200% of the federal poverty level.

An estimated 632,300 of these pregnancies would end in induced abortion, an increase of 40% over the current national level. Another 533,800 pregnancies would result in unintended births. Some 76,400 of these would be births to families already receiving public assistance, and 64,100 would be to families that would become eligible for public assistance because of the birth; another 197,000 would be to women whose families would not receive public assistance, but would be eligible for Medicaid coverage of pregnancy, delivery and newborn care.

In FY 1987, public-sector expenditures for contraceptive services totaled an estimated $412 million. If subsidized services had not been available, the federal and state governments would have spent an additional $1.2 billion through their Medicaid programs for expenses associated with unplanned births and abortions. Thus, for every dollar spent to provide publicly funded contraceptive services, an average of $3.00 was saved in Medicaid costs for pregnancy-related health care and medical care for newborns.

Family Planning Perspectives, **28:**188-195, 1996.
http://www.guttmacher.org/pubs/journals/2818896.html

**Medical Care Cost Savings from Adolescent Contraceptive Use**

**By James Trussell, Jacqueline Koenig, Felicia Stewart and Jacqueline E. Darroch**

An analysis of the economic benefits of adolescent contraceptive use utilizes information from a national private payer database and from the California Medicaid program to compare private- and public-sector costs and savings. The study estimates the costs of acquiring and using 11 contraceptive methods appropriate for adolescents, treating associated side effects, providing medical care related to an unintended pregnancy during method use and treating sexually transmitted diseases (STDs) and compares them with the costs of using no method. The average annual cost per adolescent at risk of unintended pregnancy who uses no method is $1,267 ($1,079 for unintended pregnancy and $188 for STDs) in the private sector and $677 ($541 for unintended pregnancy and $137 for STDs) in the public sector under the most conservative assumptions. At one year of use, private-sector savings from adolescent contraceptive use range from $308 for the implant to $946 for the male condom; public-sector savings rise from $60 for the implant to $525 for the male condom. Both the use of male condoms with another method and the advance provision of backup emergency contraceptive pills provide additional savings.

*Family Planning Perspectives,* **29:**248–203 & 295, 1997.
http://www.guttmacher.org/pubs/journals/2924897.html

**Contraceptive Use Among U.S. Women Having Abortions in 2000-2001** by Rachel K. Jones, Jacqueline E. Darroch and Stanley K. Henshaw.

A substantial proportion of the 11% decline in abortion rates between 1994 and 2000 resulted from women's use of emergency contraception (EC), according to a new analysis of contraceptive use among more than 10,000 U.S. women having abortions in 2000-2001. Forty-six percent of women surveyed were not using a contraceptive method in the month in which they became pregnant, whereas 54% were using a method. The analysis, conducted by The Alan Guttmacher Institute (AGI), estimates that 51,000 abortions were prevented by EC use in 2000--47,000 more than in 1994, when only 4,000 abortions were averted through EC. Overall, 110,000 fewer abortions occurred in 2000 than in 1994; increased use of EC may account for up to 43% of the total decline.

Published in the November/December 2002 issue of *Perspectives on Sexual and Reproductive Health.*

Family Planning Perspectives. http://www.guttmacher.org/pubs/archives/nr_340602.html

3. **Do family planning and related health services available under the Medicaid Family Planning Waiver prevent sexually transmitted diseases and infections?**

**The Use of Condoms with Other Contraceptive Methods Among Young Men and Women. John S. Santelli, Charles W. Warren, Richard Lowry, Ellen Sogolow, Janet Collins, Laura Kann, Rachel B. Kaufmann and David D. Celentano**

"Because the contraceptive methods most effective in preventing pregnancy and those most protective against sexually transmitted diseases (STDs), including HIV, are not the same, experts in reproductive health care now recommend that couples who wish to minimize both risks use two methods—an effective non-barrier contraceptive such as the pill or the IUD and a barrier method, usually the condom.[1]

Health care practitioners and health educators have essential roles in promoting the appropriate use of dual protection. A previous report among women in Baltimore suggested that counseling provided in family planning clinics may be contributing to increased dual use.[29]

(*Family Planning Perspectives*, **29:**261–267, 1997).
http://www.guttmacher.org/pubs/journals/2926197.html

**Contraceptive Use Elevates the Odds of Barrier Method Use for Disease Prevention**
Low-income women with a high risk of acquiring a sexually transmitted disease (STD) are more likely to use condoms or spermicides for STD prevention if they have been using contraceptives, particularly barrier methods, than if they have not been practicing birth control, according to results of a study conducted in an urban Alabama STD clinic.[1] However, all women--including those originally using no contraceptive--increased their use of barrier methods after participating in an intensive program promoting the use of such methods for STD prevention. The proportion reporting consistent use of a barrier method rose from 46% to 48% among those who had been using barrier contraceptives, from roughly 20% to 40% among users of other contraceptive methods and from 7% to 33% among women who had been using no birth control.

Family Planning Perspectives **Volume 33, Number 2, March/April 2001**
http://www.guttmacher.org/pubs/journals/3309301b.html

**California Program Shows Benefits of Expanding Family Planning Eligibility** By Rachel Benson Gold

In recent years, several states have moved to make large numbers of individuals whose incomes are above the very low, state-set levels for regular Medicaid enrollment eligible for Medicaid-funded family planning services. A newly released evaluation concludes that California's effort in that regard has been successful at increasing the use of effective contraceptive methods, as well as at improving access to other reproductive health services, such as sexually transmitted disease (STD) screening and treatment, among low-income women and men in the state.

Alan Guttmacher Report Volume 3, Number 5, October 2000
http://www.guttmacher.org/pubs/journals/gr030501.html

**4. What percentage of teenagers is sexually active prior to their first clinic visit?**

**Does the Timing of the First Family Planning Visit Still Matter? By Lawrence B. Finer and Laurie Schwab Zabin**

**Context:** The timing of a first family planning visit relative to first intercourse can affect the likelihood of an early unintended pregnancy.
**Results:** The proportion of women who waited a month or more after their first intercourse to see a provider grew slightly between 1978 and 1995, from 76% to 79%; women waited a median of 22 months after first intercourse in 1991-1995. Any contraceptive use at first intercourse increased among both women who delayed a first visit (from 51% to 75%) and among those whose first visit occurred before their first intercourse or within the same month (from 61% to 91%). Cox proportional hazards analysis suggests that the protective effect of a first family planning visit decreased over the period studied, due in part to the increase in early contraceptive use.
**Conclusions:** The importance of the first family planning visit appears to be declining, as sexually active young women who delay their first visit increasingly do so because they are already using a provider-independent method (primarily the condom). Thus, a multifaceted approach to providing family planning may now be needed, in which independent method use and visits to providers both play a role.

As 76-83% of young women who initiated sexual activity did not see a provider before or in the same month as when they first had intercourse, the growth in contraceptive use at first intercourse among women who delayed their first visit should mirror the increase for the population as a whole, an increase that has been previously described....The increase in method use at first coitus among women who had not seen a provider--from 51% to 75%--was almost entirely due to an increase in condom use, from 26% to 67%. However, a small proportion (2-4%) reported using the pill at first intercourse.

Family Planning Perspectives, 1998, 30:(1)30-33 & 42
http://www.guttmacher.org/pubs/journals/3003098.html

**Preventing Sexual Risk Behaviors and Pregnancy Among Teenagers: Linking Research and Programs By Debra Kalmuss, Andrew Davidson, Alwyn Cohall, Danielle Laraque and Carol Cassell**
Recent trends in adolescent sexual behavior offer mixed messages. It is very encouraging that teenagers' overall rates of sexual activity, pregnancy and childbearing are decreasing, and that their rates of contraceptive and condom use are increasing.[1] However, the proportion of young people who have had sex at an early age has increased.[2] Moreover, while adolescent females' contraceptive use at first sex is rising, their use at most recent sex is falling.[3]

**Family Planning Perspectives Volume 35, Number 2, March/April 2003**
http://www.guttmacher.org/pubs/journals/3508703.html

**5. Do family planning and related health services available under the Medicaid Family Planning Waiver promote or contribute to sexual activity among teenagers?**

**Pregnancies Averted Among U.S. Teenagers By the Use of Contraceptives.** By James G. Kahn, Claire D. Brindis and Dana A. Glei.

"Notwithstanding societal desires to prevent teenage pregnancy, adolescent contraceptive use is often viewed negatively. Some believe that making information regarding contraception available to young people encourages sexual activity. Yet many studies have suggested that contraceptive availability neither encourages the initiation of sexual activity nor increases the frequency of intercourse among teenagers.[2]

2. Kirby D, *No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy*, Washington DC: The National Campaign to Prevent Teen Pregnancy, 1997; Kirby D, *A Review of Educational Programs Designed to Reduce Sexual Risk Taking Behaviors Among School-Aged Youth in the United States,* Washington, DC: U.S. Office of Technology Assessment/National Technical Information Service, 1995; Dawson DA, The effects of sex education on adolescent behavior, *Family Planning Perspectives*, 1986, 18(4):162–170; and Roosa M and Christopher S, Evaluation of an abstinence-only adolescent pregnancy prevention program: a replication, *Family Relations*, 1990, 39(6):363–367.

Family Planning Perspectives. Volume 31, No. 1, January/February 1999: Pages 29-34.
http://www.guttmacher.org/pubs/journals/3102999.html

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**Differences in Teenage Pregnancy Rates Among Five Developed Countries: The Roles of Sexual Activity and Contraceptive Use. Jacqueline E. Darroch, Susheela Singh, Jennifer J. Frost and the Study Team**

**Context:** Adolescent pregnancy, birth, abortion and sexually transmitted disease (STD) rates are much higher in the United States than in most other developed countries. *NOTE regarding significance: access to contraceptive services is greater in most other developed countries compared to the US, however, the level of sexual activity does not significantly vary.*

**Results:** Adolescent childbearing is more common in the United States (22% of women reported having had a child before age 20) than in Great Britain (15%), Canada (11%), France (6%) and Sweden (4%); differences are even greater for births to younger teenagers. A lower proportion of teenage pregnancies are resolved through abortion in the United States than in the other countries; however, because of their high pregnancy rate, U.S. teenagers have the highest abortion rate. The age of sexual debut varies little across countries, yet American teenagers are the most likely to have multiple partners. A greater proportion of U.S. women reported no contraceptive use at either first or recent intercourse (25% and 20%, respectively) than reported nonuse in France (11% and 12%, respectively), Great Britain (21% and 4%, respectively) and Sweden (22% and 7%, respectively).

Large differences in adolescent pregnancy rates were also identified in the early 1980s in a comparative study of developed countries.[3] At that time, differences in sexual activity were not found to account for the variation in pregnancy rates; instead, the limited available information suggested that use of contraceptives, particularly the pill, by teenage women was lower in the United States than in other developed countries.

In addition to having a higher adolescent pregnancy rate, the United States has higher rates of sexually transmitted diseases (STDs) among adolescents than most other developed countries.[5]

*Family Planning Perspectives*, 2001, 33(5):244-250 & 281
http://www.guttmacher.org/pubs/journals/3324401.html

**Access to Adolescent Reproductive Health Services: Financial and Structural Barriers to Care**
**By Linda Hock-Long, Roberta Herceg-Baron, Amy M. Cassidy and Paul G. Whittaker**
Since the early 1970s, adolescent pregnancy rates in the United States, the United Kingdom and other western European countries have dropped significantly, partly because of the availability of more effective contraceptive methods and increases in condom use.[1] Despite this progress, U.S. youth continue to be at greater risk for pregnancy and sexually transmitted diseases (STDs) than their British and other western European peers. Given these disparities, can experiences in other developed countries inform U.S. prevention efforts? We believe that they can, and the results of Stone and Ingham's investigation of when and why British youth seek sexual health services, on page 114 of this issue, provide an instructive starting point.

Differences in young people's age at sexual debut and level of subsequent sexual activity fail to explain why U.S. adolescent pregnancy rates continue to exceed the rates of the United Kingdom and other western European countries.[21] Clearly, the experiences of youth in these countries debunk the popular notion that access to reproductive health services promotes early sexual initiation. Moreover, the disproportionately high adolescent pregnancy and STD rates in the United States, coupled with formidable barriers to reproductive health services, underscore the need to capitalize on lessons learned in other developed countries and to identify innovative strategies to reduce hurdles to care.

**Family Planning Perspectives. Volume 35, Number 3, May/June 2003**
http://www.guttmacher.org/pubs/journals/3514403.html

**Condom availability in New York City public high schools: relationships to condom use and sexual behavior.** S Guttmacher, L Lieberman, D Ward, N Freudenberg, A Radosh and D Des Jarlais

CONCLUSIONS: Condom availability has a modest but significant effect on condom use and does not increase rates of sexual activity. These findings suggest that school-based condom availability can lower the risk of HIV and other sexually transmitted diseases for urban teenagers in the United States.

American Journal of Public Health, Vol 87, Issue 9 1427-1433
http://www.ajph.org/cgi/content/abstract/87/9/1427?maxtoshow=&HITS=10&hits=1

**6. What are contributing factors to teenage sexual activity?**

**Risk-Focused Prevention of Early Teen Sexual Activity** by Karen Bogenschneider.
Risk factors for early teen sexual activity include: • history of physical or sexual abuse; • use of alcohol or other drugs; • involvement in deviant behaviors; • earlier puberty; • limited religious affiliation; • unmarried daughters of single parents; • lack of family support or closeness; • poor parent/teen communication about sex; • lower parental education; • poverty; older siblings; • perception of peer involvement; • early and frequent dating; • low academic achievement; • low aspirations; • negative attitude toward school; • few employment opportunities; • low-income and disorganized communities; and • permissive societal attitudes about sex.

Wisconsin Family Impact Seminars. University of Wisconsin Extension. Child and Family Studies. http://www.uwex.edu/ces/familyimpact/reports/fis7two.pdf

**Brook Factsheet: Teenage Sexual Activity, April 2002.**
Factors associated with sexual activity under age 16, as cited by teenagers: curiosity; "in love", and peer pressure. Other factors: early sexual experience; early menarche; lower educational achievement; and friends and media as source of sexual education (rather than school).

http://www.brook.org.uk/content/Fact1_TeenageSexualActivity.pdf

**Preventing Sexual Risk Behaviors and Pregnancy Among Teenagers: Linking Research and Programs By Debra Kalmuss, Andrew Davidson, Alwyn Cohall, Danielle Laraque and Carol Cassell**

**Antecedents of Risky Sexual Behaviors and Pregnancy**
In our literature review for the CDC, we targeted three risky sexual behaviors--early onset of sexual activity, nonuse of contraceptives and nonuse of condoms--and one possible outcome of those behaviors, teenage pregnancy. Major literature reviews on these topics were published in 1987 and 1995;[9] we supplemented and updated them by systematically examining the research published in peer-reviewed journals from 1994 to 2002.

The literature identifies four key sets of factors that have been associated with risky sexual behaviors and pregnancy: race and ethnicity; socioeconomic status; social influences; and attitudes toward contraception, condoms and pregnancy and safer-sex behavioral skills.

Among the socioeconomic indicators that significantly predict risky sexual behaviors and pregnancy are the adolescent's having a parent with low educational attainment and living in a single-parent family.[14] A teenager's own level of academic achievement is positively related to age at sexual debut.[15]

...having friends who are sexually active or who do not use condoms enhances one's own risk of these behaviors.[16] Moreover, teenagers who perceive that their mother disapproves of their having sex or who talked with their mother about condom use before first intercourse are less likely than others to become sexually active or to fail to use condoms.[17]Finally, teenagers who are more actively involved in religious activities and those who avoid general non-sexual high-risk behaviors tend to initiate sex later than other teenagers.[18] In all likelihood, the effects of religiosity and avoidance of risk operate through social influence mechanisms.

Sexual risk behaviors are also related to attitudes and behavioral skills. Adolescents' attitudes toward practicing contraception, using condoms and becoming pregnant predict the likelihood that each will occur.[19]

... age and age at menarche strongly affect the likelihood of sexual initiation and teenage pregnancy.[23]

Family Planning Perspectives Volume 35, Number 2, March/April 2003
http://www.guttmacher.org/pubs/journals/3508703.html#1

**Understanding What Works and What Doesn't In Reducing Adolescent Sexual Risk-Taking**
**By Douglas Kirby**

Given high rates of unprotected sex, unintended pregnancy and sexually transmitted disease (STD) infection among U.S. adolescents, for at least two decades people concerned about youth have developed a wide variety of programs to reduce adolescent sexual risk-taking. Sometimes these programs reduced sexual risk-taking; other times, they did not. Recognizing the varying success of programs, people have tried to identify the critical elements of effective programs.

In *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy,*[1] I attempted to answer at least in part important questions about what works, what doesn't and why. That volume reviewed about 300 studies on risk and protective factors for adolescent sexual risk-taking. The research had examined the relationship between characteristics of communities, families, peers, partners and the adolescents themselves, on the one hand, and initiation of sex, frequency of sex, number of sexual partners, use of condoms, use of contraceptives, pregnancy and childbearing, on the other hand.

In identifying literally hundreds of different risk and protective factors across those domains, these studies painted a remarkably detailed and complex portrait of the antecedents of adolescent sexual risk-taking. However, 43 seemingly diverse factors appeared to be particularly important.

At the community level, community disadvantage (e.g., low levels of education, employment and income) and disorganization (e.g., the crime rate) predicted measures of sexual behavior or pregnancy. Within the family, levels of education and income had an impact, as did family structure (e.g., having two parents versus one parent).

Family dynamics and attachment also play a role: If parents appropriately supervise and monitor their children, and if the adolescents feel connected to their parents, they are less likely to engage in sexual risk-taking. Family values about sexual behavior and contraceptive use, and family sexual behaviors, also have an impact on the adolescents' behavior. Moreover, peers' norms and behavior regarding sex and contraceptive use affect an individual's sexual and contraceptive behavior, as do adolescents' partners' support for contraception.

Turning to the teenagers themselves, their age and hormone levels, their attachment to school and religious institutions, their engagement in other problem or risk behaviors, their emotional well-being, the characteristics of their relationships with romantic partners, any past history of sexual abuse, and their own sexual beliefs, attitudes, skills and motivations all affect their sexual or contraceptive behavior.

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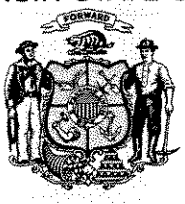
**Family Planning Perspectives. Volume 33, Number 6, November/December 2001**
http://www.guttmacher.org/pubs/journals/3327601.html

Prepared by Michael Vaughn. 11/29/2003.

WISCONSIN STATE SENATE



# Carol Roessler
STATE SENATOR

December 15, 2003

Becky Blarel
337 North Western Drive
Oshkosh, WI 54904

Dear Becky,

Thank you for your contact on Senate Bill 186 relating to a Medical Assistance family planning demonstration project minimum age eligibility limitation change.

On September 23, 2003 the full Senate voted 29-4 to send this bill to the Senate Committee on Health, Children, Families, Aging and Long Term Care, which I chair. A public hearing was held on October 14, 2003.

Thank you again for sharing your views on this issue. Please feel free to contact me further with questions or concerns.

Sincerely,

Carol

CAROL ROESSLER
State Senator
18th Senate District

CR/jh S:\DOCS\Jennifer\11-13-03 family planning update.doc

**CAPITOL ADDRESS:** State Capitol • P.O. Box 7882, Madison, WI 53707-7882 • **PHONE:** 608-266-5300 • **FAX:** 608-266-0423
**HOME:** 1506 Jackson Street, Oshkosh, WI 54901 • **TOLL-FREE:** 1-888-736-8720
**E-MAIL:** Sen.Roessler@legis.state.wi.us • **WEBSITE:** http://www.legis.state.wi.us/senate/sen18/news/

SD18

# Be Part of the Solution.

Dear Legislator: Roessler DEC 18 2003 JH

I am so thrilled the Wisconsin Medicaid Family Planning Waiver Program has finally started! (Wisconsin women have been waiting over 5 years for it!) This prevention program not only helps women avoid unintended pregnancy but also gets them the medical health care they require to prevent cervical cancer and treat STD's. It gives women and families control over their lives, childbearing, education, and careers.

I know you play an important part in making public policy changes like this family planning waiver. Not only does it help women, but everyone in Wisconsin because it saves state taxpayers money.

**WE THANK YOU FOR YOUR SUPPORT!**
(If you are not supporting this program then please begin now!)

Thank you for your help and courageous support of women & families in your district.

Sincerely, Becky Blaul from Winnebago County.

Please send me a response to this message, I would like to know your views on this topic.

My address is: 337 N. Westhaven Dr. Oshkosh, WI 54904

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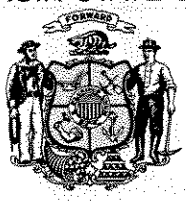

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STATE SENATOR

December 15, 2003

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337 North Western Drive P108
Oshkosh, WI 54904

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CAROL ROESSLER
State Senator
18th Senate District

CR/jh S:\DOCS\Jennifer\11-13-03 family planning update.doc

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JH

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DEC 12 2003

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My address is: 337 N. Westhaven Dr. P108 Oshkosh, WI 54904