2003-04 SESSION COMMITTEE HEARING RECORDS

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- Appointments ... Appt
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THE GUTTMACHER REPORT ON PUBLIC POLICY

Issues & Implications

JAN 07 2004

Lessons Learned From Uganda's Experiences In Preventing HIV

Abstinence: Is It Really 100% Effective Against Pregnancy and Disease?

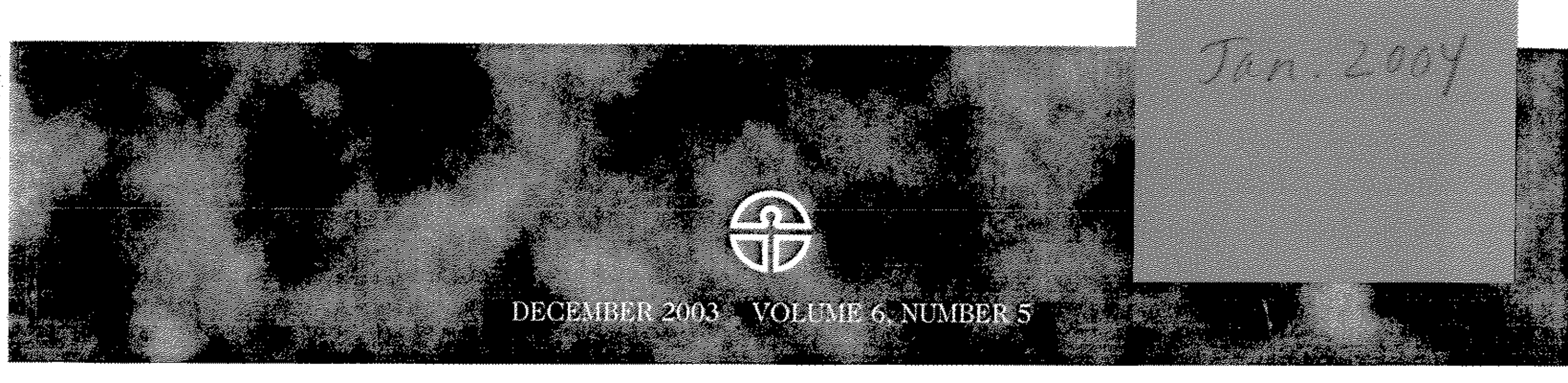
Special Analysis

Meeting the Need for Publicly Supported Contraception

Legislative Reviews

State Action in 2003; Congress and 'Partial-Birth' Abortion

Plus: Bringing the ABC Approach Home to the Title X Family Planning Program



In this Issue:

Issues & Implications

Beyond Slogans: Lessons From Uganda's Experience With ABC and HIV/AIDS 1

Understanding 'Abstinence': Implications for Individuals, Programs and Policies 4

Special Analysis

Preventing Unintended Pregnancy: The Need And the Means 7

Legislative Reviews

Key Reproductive Health–Related Developments in the States: 2003 11

Federal Abortion Procedures Ban Heads to Court; Abortion Foes Pledge More Bills in 2004 12

For The Record

Title X Program Announcement Articulates New Priorities for Nation's Family Planning Program 13

The Guttmacher Report on Public Policy
A review from The Alan Guttmacher Institute's policy analysts

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Beyond Slogans: Lessons From Uganda's Experience With ABC and HIV/AIDS

By Susan A. Cohen

Between the late 1980s and mid-1990s, at a time when HIV/AIDS was well on its way toward ravaging Sub-Saharan Africa, Uganda achieved an extraordinary feat: It stopped the spread of HIV/AIDS in its tracks and saw the nation's rate of infection plummet. As word of the "Uganda miracle" spread, journalists, researchers, policymakers and advocates all descended to try to ascertain how it was accomplished.

By now, Uganda's success story has become virtually synonymous with the so-called ABC approach to HIV/AIDS prevention, for *A*bstain, *B*e faithful, use *C*ondoms. And, indeed, it is clear that some combination of important changes in all three of these sexual behaviors contributed both to Uganda's extraordinary reduction in HIV/AIDS rates and to the country's ability to maintain its reduced rates through the second half of the 1990s. Beyond that, however, the picture becomes considerably less clear.

ABC refers to individual behaviors, but it also refers to the program approach and content designed to lead to those behaviors. Researchers and public health experts continue to study both and to delve into the many and varied complex relationships among them. This information is critical to determining to what extent the Uganda experience really is replicable and what from that experience productively might be exportable to other countries. At the same time, much more research is needed into the relevance of the ABC approach for the prevention of other sexually transmitted diseases (STDs) as well as unintended pregnancy and the abortions or unplanned births that inevitably follow, both in Sub-Saharan Africa and in other parts of the world.

Meanwhile, U.S.-based social conservatives in and out of government—even as they pay homage to the ABC mantra—continue to confuse all of these issues. For them, ABC has become little more than an excuse and justification to promote their long-standing agenda regarding people's sexual behavior and the kind of sex education they should receive: A for unmarried people, bolstered by advocacy of B, but for most people, "anything but C."

Uganda and ABC

Measuring sexual behavior change. Among public health experts, it is by now generally agreed that during the critical time period between the late 1980s and mid-1990s, positive changes in A, B *and* C behaviors occurred and that all of these changes played a role in reducing HIV rates. Uganda's HIV prevalence steadily increased until about 1991, when it peaked at about 15% (30% among pregnant women in urban areas). It then turned sharply downward through the mid-1990s and reached 5% (14% for pregnant urban women) by 2001.

The findings of an analysis released by The Alan Guttmacher Institute in November 2003, *A, B and C in Uganda: The Roles of Abstinence, Monogamy and Condom Use in HIV Decline,* are consistent with the current consensus. Between 1988 and 1995, the time period during which HIV prevalence was declining, key changes in behavior occurred.

- Fewer Ugandans were having sex at young ages. The proportion of young men who had ever had sex decreased substantially and the median age at which young women began having sex rose from 15.9 in 1988 to 16.3 in 1995. Importantly, however, among those people who were having sex, overall levels of sexual activity did not decline.

- Levels of monogamy increased. Sexually active men and women of all ages, particularly the unmarried, were less likely to have more than one sexual partner in a 12-month period in 1995 than in 1989. Other research has found that the proportion of men reporting three or more sexual partners also fell during the period.

- Condom use rose steeply among unmarried sexually active men and women. Among unmarried women who had had sex in the last four weeks, the proportion who used condoms at last intercourse rose from 1% in 1989 to 14% in 1995; among unmarried men, condom use rose from 2% to 22%.

Additional risk factors and epidemiological impact. The relationship between individual sexual behavior and HIV risk is further complicated, however, by many other factors that overlay a simple A, B and C analysis. The risk of exposure is greater, for example, in the presence of other STDs and it appears to be lower for circumcised men. The number of a man or woman's sexual partners matters, but so does the duration of relationships, the extent to which relationships might overlap, frequency of sex, specific sexual practices, how consistently and correctly condoms are used with different partners, and the stage of infection of an HIV-positive partner.

In high-prevalence settings, ascertaining exactly which behavior change or combinations of changes can have the most impact in reducing HIV infection among the population as a whole is the focus of more recent studies. Indeed, based on the Uganda experience and drawing on an understanding of the epidemiology of STDs more generally, scientists are now concluding that other things being equal, even if absolute monogamy is not attained, having fewer sexual partners, especially concurrently, may be the most significant behavior change for a population overall. (Whether this is always the most significant protective factor at the *individual* level may be another matter.)

Creating behavior change. It is not possible to make a direct and simple link between the changes that took place in Uganda and the policies or programs that may have caused them to happen. The widely held view among Ugandans and outside analysts, though, is that increases in all three of the ABC behaviors led to reduced HIV rates following a comprehensive national message that HIV prevention was of the utmost importance to the country and the responsibility of all of its citizens. The message was delivered in different ways through a multiplicity of approaches, programs and types of organizations and was buttressed by a level of political commitment to forthrightly addressing the AIDS crisis that was unique among African governments. President Yoweri Museveni himself exhorted Ugandans, and still does, to practice A, B and C. Further, as Harvard medical anthropologist Edward Green observed recently, "ABC is far from all that Uganda has done." Uganda, he noted, "pioneered approaches towards reducing stigma, bringing discussion of sexual behavior out into the open, involving HIV-infected people in public education, persuading individuals and couples to be tested and counseled, improving the status of women, involving religious organizations, enlisting traditional healers, and much more."

The evidence, therefore, points to the existence of a range of complementary messages and services delivered by the government and a wide diversity of nongovernmental organizations. To be sure, those messages included the importance of both young people delaying sexual initiation and "zero grazing" (monogamy). But contrary to the assertions of social conservatives that the case of Uganda proves that an undiluted "abstinence-only" message is what makes the difference, there is no evidence that abstinence-only educational programs were even a significant factor in Uganda between 1988 and 1995.

Beyond Uganda

Encouraging signs also are beginning to emerge from other countries where HIV/AIDS had become a generalized epidemic. In Zambia, for example, HIV rates appear to be declining, at least among urban youth. The U.S. Agency for International Development (USAID) notes that "clear, positive changes in all three ABC behaviors" have taken place. Indeed, it would seem that the HEART (Helping Each Other Act Responsibly) program, a major USAID-funded media campaign there, may deserve much of the credit. This program, which was designed for and by youth, promotes both abstinence and condom use. One year after the campaign's initiation, indications are that young people exposed to its comprehensive messages are 46% more likely to be delaying or stopping having sex and 67% more likely to have used a condom the last time they had sex, compared with those who were not exposed.

In Jamaica, where HIV rates are still relatively low but sexual activity at early ages is prevalent, a similar media campaign is beginning to show results. According to a recent summary from the USAID-sponsored YouthNet project, "More than half of the youth who recalled the ads said the ads had influenced how they handle boy/girl relationships through abstaining from sex, not giving into sexual pressure, and always using a condom/contraceptive when having sex."

HIV/AIDS rates also are declining in Cambodia, Thailand and the Dominican Republic, three other countries where various combinations of ABC behavioral changes appear to have played an important role. In Cambodia and Thailand, the epidemic spread mainly through prostitution. Both countries are adopting a "100% condom use" policy in brothels, and it is yielding positive results. In the Dominican Republic, meanwhile, the infection rate has slowed mainly due to men having fewer sexual partners as well as to increased condom use.

Finally, Brazil has so successfully stemmed the tide of HIV/AIDS that only half the number of Brazilians are infected today as the World Bank had predicted only a few years ago. Brazil's case may be atypical in one sense because of the government's decision to make free antiretroviral drugs available to anyone who qualifies for AIDS therapy. But it is equally atypical within Latin America because of the government's decision to promote frank talk about sex as well as condom distribution programs. Indeed, the Brazilian Health Ministry announced plans in August 2003 to distribute condoms to sexually active high school students in five Brazilian cities to prevent not only HIV/AIDS but also teenage pregnancy. Officials are particularly concerned about preventing HIV-positive teenage girls from becoming pregnant and then transmitting HIV/AIDS to their newborn infants.

Beyond HIV and ABC

Despite the evidence from Uganda and these other countries, U.S. HIV prevention policy is focused on promoting abstinence. Indeed, Global AIDS Coordinator Randall Tobias personally endorsed a provision in recently enacted U.S. law requiring that at least one-third of all U.S. assistance to prevent HIV/AIDS globally be reserved for "abstinence-until-marriage" programs ("U.S. AIDS Policy: Priority on Treatment, Conservatives' Approach to Prevention," *TGR*, August 2003, page 1). In effect, this makes "abstinence-until-marriage" advocacy the single most important HIV/AIDS prevention intervention of the U.S. government.

Social conservatives pressed for this result because, at least with regard to the general population, they dismiss the effectiveness of risk-reduction strategies such as those that promote correct and consistent condom use. Some, like Joseph Loconte of the Heritage Foundation, go further, denouncing even those programs that target particular high-risk groups with risk-reduction messages on the grounds that they "legitimize promiscuity, prostitution and illegal drug use." Instead, he and others advocate a strict "risk elimination" approach—which itself must be regarded as a risky strategy, given that risk elimination depends on 100% compliance 100% of the time (see related story, page 4).

Conservatives further assert that the availability of condoms has a "disinhibiting" effect on people's sexual behavior. By that logic, what could be more disinhibiting than the promise, and increasing reality, of HIV treatment? Certainly, correct and consistent contraceptive and condom use is difficult for ordinary people to maintain over long periods of time. But if reports on the recent rise in HIV incidence in the United States pointing to "prevention fatigue" as one of the contributors have merit, should not strict "abstinence fatigue" be considered a clear and present danger?

To be sure, living in the midst of high HIV/AIDS prevalence can be a strong motivator for behavior change. As Harvard's Green wrote recently, in countries "where infection rates exceed 30% and funerals for family and friends are held several times a week, abstinence and faithfulness are attractive alternatives to death." Presumably, more and more-careful condom use would be an attractive alternative in the face of these circumstances as well—and the experience of high-prevalence communities in the United States from roughly the same time period during which Uganda turned its rates around indicates that, indeed, this was so. The critical questions, therefore, become: What behaviors may be more or less realistic for individuals to both achieve and sustain—especially as the imminent crisis begins to ebb? And how best can they be encouraged to do so?

Finally, that Brazil and Jamaica, to name just two countries, have linked HIV/AIDS prevention strategies with the prevention of unintended pregnancy is a reflection of the complex realities of life and sexual relationships. Women, especially, often are trying to prevent both simultaneously. How useful or relevant is the ABC approach for the broader range of reproductive health–related conditions individuals face in everyday life—especially a segmented approach that targets different messages to different groups of people rather than recognizing that the same people may need different messages at different stages of life? Even if a woman abstains until marriage, for example, she is likely to still want and need "C"—be it Condoms or other Contraception—in order to be able to plan her childbearing. Alternatively, how can a married woman who wants to become pregnant protect herself from the risk of HIV/AIDS from her husband who may have other sexual partners? And for a young woman who has so far abstained from sex altogether, must she wait until she is already sexually active until she is entitled to the full and accurate information necessary to protect herself from unplanned pregnancy and disease? These are just some of the questions raised by the ABC approach to sexual risk reduction.

"What happened" in Uganda between the late 1980s and mid-1990s happened in a specific place and time and under very specific circumstances. There is much to be learned from it. But advocates and policymakers seeking the simplicity of a single program model to replicate should be cautioned that Uganda's experience may have limited implications—even for making further gains in that country, let alone for other countries, other time periods and the range of reproductive health concerns beyond HIV that women and men face. Public health experts and researchers, meanwhile, have a special responsibility to recognize and explicate the complexities of these questions, even as they redouble their efforts to answer them. ⊕

This is the third in a series of articles examining emerging issues in sex education and related efforts to prevent unintended pregnancy and sexually transmitted diseases. The series is supported in part by a grant from the Program on Reproductive Health and Rights of the Open Society Institute. The conclusions and opinions expressed in these articles, however, are those of the author and The Alan Guttmacher Institute.

Understanding 'Abstinence': Implications for Individuals, Programs and Policies

By Cynthia Dailard

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.

CONTRACEPTIVE EFFECTIVENESS RATES FOR PREGNANCY PREVENTION*

Contraceptive Method	Perfect Use	Typical Use
Abstinence	100	???
Female Sterilization	99.5	99.5
Oral Contraceptives	99.5–99.9**	92.5
Male Condom	97	86.3
Withdrawal	96	75.5

*Percentage of women who successfully avoid an unintended pregnancy during their first year of use. **Depending on formulation. *Sources:* Perfect use–Hatcher, RA, et al., *Contraceptive Technology*, 17th ed., 1998, page 216. Typical use–AGI, *Fulfilling the Promise: Public Policy and U.S. Family Planning Clinics*, 2000, page 44.

Abstinence and Individuals

What does it mean to use abstinence? When used conversationally, most people probably understand abstinence to mean refraining from sexual activity—or, more specifically, vaginal intercourse—for moral or religious reasons. But when it is promoted as a public health strategy to avoid unintended pregnancy or STDs, it takes on a different connotation. Indeed, President Bush has described abstinence as "the surest way, and the only completely effective way, to prevent unwanted pregnancies and sexually transmitted disease." So from a scientific perspective, what does it mean to abstain from sex, and how should the "use" of abstinence as a method of pregnancy or disease prevention be measured?

Population and public health researchers commonly classify people as contraceptive users if they or their partner are consciously using at least one method to avoid unintended pregnancy or STDs. From a scientific standpoint, a person would be an "abstinence user" if he or she *intentionally* refrained from sexual activity. Thus, the subgroup of people consciously using abstinence as a method of pregnancy or disease prevention is obviously much smaller than the group of people who are not having sex. The size of the population of abstinence users, however, has never been measured, as it has for other methods of contraception.

When does abstinence fail? The definition of an abstinence user also has implications for determining the effectiveness of abstinence as a method of contraception. The president, in his July 2002 remarks to South Carolina high school students, said "Let me just be perfectly plain. If you're worried about teenage pregnancy, or if you're worried about sexually transmitted disease, abstinence works every single time." In doing so, he suggested that abstinence is 100% effective. But scientifically, is this in fact correct?

Researchers have two different ways of measuring the effectiveness of contraceptive methods. "Perfect use" measures the effectiveness when a contraceptive is used exactly according to clinical guidelines. In contrast, "typical use" measures how effective a method is for the average person who does not always use the method correctly or consistently. For example, women who use oral contraceptives perfectly will experience almost complete protection against pregnancy. However, in the real world, many women find it difficult to take a pill every single day, and pregnancies can and do occur to women who miss one or more pills during a cycle. Thus, while oral contraceptives have a perfect-use effectiveness rate of over 99%, their typical-use effectiveness is closer to 92% (see chart). As a result, eight in 100 women who use oral contraceptives will become pregnant in the first year of use.

Thus, when 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. Research is beginning to suggest how difficult abstinence can be to use consistently over time. For example, a recent study presented at the 2003 annual meeting of the American Psychological Society (APS) found that over 60% of college students who had pledged virginity during their middle or high school years had broken their vow to remain abstinent until marriage. What is not known is how many of these broken vows represent people consciously choosing to abandon abstinence and initiate sexual activity, and how many are simply typical-use abstinence failures.

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. However, researchers have never measured the typical-use effectiveness of abstinence. Therefore, it is not known how frequently abstinence fails in the real world or how effective it is compared with other contraceptive methods. This represents a serious knowledge gap. People deserve to have consistent and accurate information about the effectiveness of all contraceptive methods. For example, if they are told that abstinence is 100% effective, they should also be told that, if used correctly and consistently, condoms are 97% effective in preventing pregnancy. If they are told that condoms fail as much as 14% of the time, they should be given a comparable typical-use failure rate for abstinence.

What behaviors should be abstained from? A recent nationally representative survey conducted by the Kaiser Family Foundation and *seventeen* magazine found that half of all 15–17-year-olds believed that a person who has oral sex is still a virgin. Even more striking, the APS study found that the majority (55%) of college students pledging virginity who said they had kept their vow reported having had oral sex. While the pledgers generally were somewhat less likely to have had vaginal sex than nonpledgers, they were equally likely to have had oral or anal sex. Because oral sex does not eliminate people's risk of HIV and other STDs, and because anal sex can heighten that risk, being technically abstinent may therefore still leave people vulnerable to disease. While the press is increasingly reporting that noncoital behaviors are on the rise among young people, no research data exists to confirm this.

Abstinence is 100% effective if 'used' with perfect consistency. But common sense suggests that in the real world, it can and does fail.

Abstinence Education Programs

Defining and communicating what is meant by abstinence are not just academic exercises, but are crucial to public health efforts to reduce people's risk of pregnancy and STDs. For example, existing federal and state abstinence-promotion policies typically neglect to define those behaviors to be abstained from. The federal government will provide approximately $140 million in FY 2004 to fund education programs that exclusively promote "abstinence from sexual activity outside of marriage" ("Abstinence Promotion and Teen Family Planning: The Misguided Drive for Equal Funding," *TGR*, February 2002, page 1). The law, however, does not define "sexual activity." As a result, it may have the unintended effect of promoting noncoital behaviors that leave young people at risk. Currently, very little is known about the relationship between abstinence-promotion activities and the prevalence of noncoital activities. This hampers the ability of health professionals and policymakers to shape effective public health interventions designed to reduce people's risk.

There is no question, however, 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. Research by The Alan Guttmacher Institute (AGI) indicates that 25% of the decrease in the U.S. teen pregnancy rate between 1988 and 1995 was due to a decline in the proportion of teenagers who had ever had sex (while 75% was due to improved contraceptive use among sexually active teens). A new AGI report also shows that declines in HIV-infection rates in Uganda were due to a combination of fewer Ugandans initiating sex at young ages, people having fewer sexual partners and increased condom use (see related story, page 1).

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 pro-

grammatic interventions. In fact, significant declines in U.S. teen pregnancy rates occurred prior to the implementation of government-funded programs supporting this particularly restrictive brand of abstinence-only education. Similarly, informed observers of the Ugandan experience indicate that abstinence-only education was not a significant program intervention during the years when Uganda's HIV prevalence rate was dropping. Thus, any 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 (see related story, page 13).

To date, no education program focusing exclusively on abstinence has shown success in delaying sexual activity.

Accordingly, key questions arise about how to measure the success of abstinence-promotion programs. For example, the administration is defining program success for its abstinence-only education grants to community and faith-based organizations in terms of shaping young people's intentions and attitudes with regard to future sexual activity. In contrast, most public health experts stress the importance of achieving desired behavioral outcomes such as delayed sexual activity.

To date, however, no education program in this country focusing exclusively on abstinence has shown success in delaying sexual activity. Perhaps some will in the future. In the meantime, considerable scientific evidence already demonstrates that certain types of programs that include information about both abstinence and contraception help teens delay sexual activity, have fewer sexual partners and increase contraceptive use when they begin having sex. It is not clear what it is about these programs that leads teens to delay—a question that researchers need to explore. What is clear, however, is that no program of any kind has ever shown success in convincing young people to postpone sex from age 17, when they typically first have intercourse, *until marriage,* which typically occurs at age 25 for women and 27 for men. Nor is there any evidence that the "wait until marriage" message has any impact on young people's decisions regarding sexual activity. This suggests that scarce public dollars could be better spent on programs that already have been proven to achieve delays in sexual activity of any duration, rather than on programs that stress abstinence until marriage.

Finally, there is the question of whether delays in sexual activity might come at an unacceptable price. This is raised by research indicating that while some teens promising to abstain from sex until marriage delayed sexual activity by an average of 18 months, they were more likely to have unprotected sex when they broke their pledge than those who never pledged virginity in the first place. Thus, might strategies to promote abstinence inadvertently heighten the risks for people when they eventually become sexually active?

Difficult as it may be, answering these key questions regarding abstinence eventually will be necessary for the development of sound and effective programs and policies. At a minimum, the existing lack of common understanding hampers the ability of the public and policymakers to fully assess whether abstinence and abstinence education are viable and realistic public health and public policy approaches to reducing unintended pregnancies and HIV/STDs. ⊕

This is the fourth in a series of articles examining emerging issues in sex education and related efforts to prevent unintended pregnancy and sexually transmitted diseases. The series is supported in part by a grant from the Program on Reproductive Health and Rights of the Open Society Institute. The conclusions and opinions expressed in these articles, however, are those of the author and The Alan Guttmacher Institute.

Preventing Unintended Pregnancy: The Need And the Means

In 2000, 34 million women—half of all U.S. women of reproductive age—were in need of contraceptive services and supplies to help prevent unintended pregnancy, and half of those were in need of public support for such care. In the absence of a national health insurance program, the United States relies on a patchwork system of public insurance and subsidized clinics to provide care to those in need. Holes in this patchwork, however, are becoming increasingly evident, threatening the system's ability to provide needed services and heightening political interest in more comprehensive solutions.

By Adam Sonfield

The typical American woman has intercourse for the first time at age 17 and reaches menopause at age 51. If she wants only two children, as most American women do, she will spend three decades being sexually active but trying to avoid unintended pregnancy. This is not an easy goal for an individual woman to meet.

Even though the Centers for Disease Control and Prevention in 1999 declared family planning to be one of the 10 most significant U.S. public health achievements of the 20th century, half of all pregnancies in the United States are still unintended. And the consequences of unintended pregnancy can be serious, even life-altering, particularly for women who are young or unmarried, have just recently given birth or already have the number of children they want. An unplanned pregnancy can be a barrier to obtaining timely prenatal care because it may take weeks or months for a woman to realize or accept that she is pregnant. Lack of prenatal care—along with poor birth-spacing, or giving birth before or after one's childbearing prime—can pose health risks for the woman and for her newborn. In addition, an unintended pregnancy can interfere with a young woman's education, limiting her employment possibilities and her ability to support herself and her family. Largely for reasons such as these, half of women who become pregnant unintentionally decide to have an abortion, which can be a serious decision in itself.

Assessing the Need

Contraceptive use drastically reduces the chances of unintended pregnancy. Over the course of a year, only 8% of women using the pill will become pregnant, compared with 85% of sexually active women not using contraceptives. This fact alone helps explain why the 7% of U.S. women at risk of unintended pregnancy who do not practice contraception account for almost half of the country's unintended pregnancies.

According to new data from The Alan Guttmacher Institute (AGI), 34 million U.S. women in 2000 were in need of contraceptive services and supplies—that is, they were of reproductive age, sexually active, able to have children and not pregnant or seeking to become pregnant (see table, page 8). These women constituted just over half of all U.S. women aged 13–44.

For individual women who need contraception over long periods of their life, the costs can be significant. According to Planned Parenthood Federation of America, oral contraceptives can cost $15–35 per month, not counting an annual exam; the contraceptive patch, contraceptive ring and the one-month injectable have costs at the high end of that range. Some of the most effective methods require concentrated payments: $50–115 for the three-month injectable and $175–400 to insert an IUD. Not all women in need can afford to purchase these services and supplies on their own. This is problematic because it may dissuade women from using the method that is most effective or appropriate for them. Also, cost may lead women to delay getting a refill or an injection, which in turn could lead to unintended pregnancy among those nominally using a method (see related story, page 4).

Private health insurance helps to lower and limit the cost of many women's medical care. Yet, 12.1 million U.S. women—20% of all women aged 15 to 44—were uninsured in 2002, and that proportion has increased by 10% since 1999. At the state level, the rate of being uninsured ranged from about 9% in Wisconsin to about 31% in Texas in 2001–2002 (see table, page 9). Moreover, researchers have found serious gaps in private coverage of prescription contraceptive methods; policymakers and advocates have worked over the past decade through legislatures, government agencies, the courts, the media and employers to improve this coverage ("Federal Law Urged as Culmination of Contraceptive Insurance Coverage Campaign," *TGR*, October 2001, page 10). And even when private insurance does pay for contraception, women may be required to contribute high copayments: According to the Kaiser Family

WOMEN IN NEED OF CONTRACEPTION, 2000

State	Overall, # in 000s	With public support	
		% of all	# in 000s
U.S. Total	**33,983**	**48.2**	**16,396**
Alabama	496	55.6	276
Alaska	72	44.4	32
Arizona	606	52.0	315
Arkansas	280	58.9	165
California	4,281	49.3	2,111
Colorado	537	42.6	229
Connecticut	438	36.8	161
Delaware	93	43.0	40
District of Columbia	85	48.2	41
Florida	1,699	49.9	848
Georgia	988	47.8	472
Hawaii	138	44.2	61
Idaho	141	56.7	80
Illinois	1,568	44.3	694
Indiana	735	48.6	357
Iowa	325	52.0	169
Kansas	309	50.8	157
Kentucky	442	54.3	240
Louisiana	520	59.4	309
Maine	152	52.0	79
Maryland	637	38.1	243
Massachusetts	880	38.0	334
Michigan	1,215	46.3	562
Minnesota	598	42.3	253
Mississippi	310	62.6	194
Missouri	665	51.4	342
Montana	89	61.8	55
Nebraska	197	51.8	102
Nevada	239	46.0	110
New Hampshire	158	39.9	63
New Jersey	1,101	35.9	395
New Mexico	207	61.4	127
New York	2,557	46.7	1,195
North Carolina	924	49.2	455
North Dakota	72	58.3	42
Ohio	1,369	48.1	658
Oklahoma	372	58.3	217
Oregon	390	50.5	197
Pennsylvania	1,528	46.8	715
Rhode Island	143	46.2	66
South Carolina	458	53.3	244
South Dakota	82	57.3	47
Tennessee	646	51.2	331
Texas	2,469	52.8	1,304
Utah	292	50.3	147
Vermont	72	52.8	38
Virginia	835	43.8	366
Washington	708	45.1	319
West Virginia	182	60.4	110
Wisconsin	634	46.4	294
Wyoming	51	56.9	29

Source: The Alan Guttmacher Institute (AGI), *Women in Need of Contraceptive Services and Supplies, 2000*, AGI, 2003, <www.guttmacher.org/pubs/win/index.html>.

Foundation, the average copayment for a "nonpreferred" drug (such as a brand-name drug that has generic substitutes) averaged $29 per refill in 2003, up from $17 in 2000.

Poor and low-income women (those below 250% of poverty) are particularly unlikely to have the out-of-pocket resources to pay for contraception. Private health insurance (if it covers contraception) might help, yet among poor women, such coverage is especially rare: Only 23% of women 15–44 with incomes below the poverty level had any private insurance in 2002 (see chart, page 10). Poor and low-income women are also especially likely to find the required cost-sharing to be unaffordable. Adolescent women have all of these problems and more, because they are more likely than older women to have a need and desire for confidentiality that precludes use of their family's resources or insurance.

For these reasons, low-income and adolescent women in need of contraception are also in need of public support for that care. In 2000, 16.4 million U.S. women needed publicly supported contraceptive services and supplies, including 11.5 million poor and low-income adult women and 4.9 million women younger than 20. Nationally, 48% of women in need of contraceptive services and supplies also need public support; however, the proportion varies widely by state: from 36% in New Jersey to 63% in Mississippi (see table).

Meeting the Need

Rather than having a well-structured, nationwide system that guarantees insurance coverage for all Americans, the United States relies on a patchwork system in which most people obtain private insurance through their employer, while some of those without private insurance obtain government-subsidized care. The federal and state governments attempt to provide this care in two primary ways: by extending publicly funded health insurance coverage to specific categories of low-income individuals (primarily through Medicaid) and by providing grants, either through state and local health departments or directly to community-based "safety-net" providers.

Medicaid and the State Children's Health Insurance Program (SCHIP) together covered 6.5 million women 15–44 in 2002, 11% of the age-group. That proportion was an 18% increase from just two years earlier. Coverage at the state level ranged from about 4% in Nevada to about 19% in Tennessee in 2001–2002 (see table, page 9). Medicaid is especially important for poor women, covering 35% of those who are of reproductive age.

Medicaid has been required to cover family planning services and supplies since 1972. Moreover, Congress

has prohibited states from imposing cost-sharing on family planning services under Medicaid and has guaranteed most enrollees—even those in Medicaid managed care plans—freedom in their choice of family planning providers. The requirements for SCHIP are not always as strict, but almost every state covers a broad range of contraceptive services and supplies. Over the past decade, 18 states have extended the role of Medicaid in providing contraception by creating special family planning initiatives for women who are ineligible for the broader Medicaid program ("Medicaid Family Planning Expansions Hit Stride," *TGR*, October 2003, page 11).

Medicaid's reach, however, is limited. People may think of Medicaid as covering "the poor," but it only covers a subset of the poor, both by design and in practice. Medicaid coverage is available in all states to very young children and to pregnant women up to 133% of poverty, and to older children up to 100% of poverty; many states cover children and pregnant women at higher incomes, through Medicaid or SCHIP. Yet, parents of Medicaid-enrolled children are only eligible at state-set income levels that are typically far lower, averaging 71% of poverty in 2003, according to the Center on Budget and Policy Priorities. Medicaid also includes other eligibility tests, including one that prohibits coverage for many immigrants. Even if they are eligible for coverage, low-income Americans may not enroll because of a perceived social stigma, lack of knowledge about the program or bureaucratic hassles in applying for and maintaining coverage. For all of these reasons, poor women are more likely to be uninsured than on Medicaid (40% vs. 35%).

Although some poor women obtain their contraceptive and other health care from private doctors, as a group, they are heavily dependent on local clinics. There are more than 7,000 clinics located in 85% of U.S. counties that provide free or subsidized family planning services and supplies. These clinics are typically designed to meet the needs of low-income members of their communities and to link their clients with other public health and social services programs.

The federal and state governments provide funding for these clinics through a wide variety of sources. Medicaid is the largest public source of funding, as it pays for the services its enrollees receive from clinics. Yet, much of clinic funding—and the most flexible portion of it—is through grants to providers. The largest federal source of such grants is the Title X program, which was appropriated $273 million in FY 2003. State governments collectively spend a similar amount of their own money in grants, and they spend smaller sums from several federal health and social services block grants.

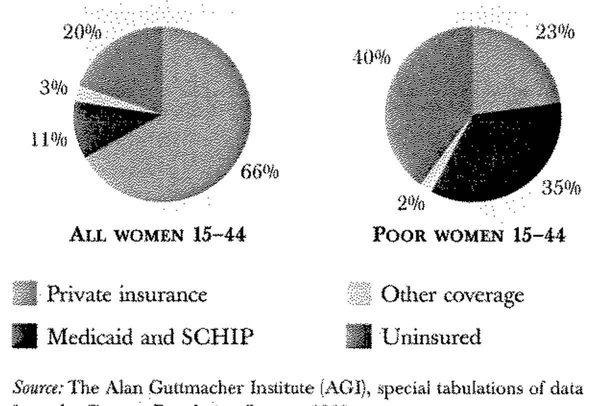
WOMEN ON MEDICAID AND UNINSURED

State	% of women 15–44, 2001–2002	
	Medicaid or SCHIP	Uninsured
U.S. Total	**10.3**	**19.2**
Alabama	9.9	16.9
Alaska	11.9	19.3
Arizona	11.7	20.9
Arkansas	10.8	24.8
California	11.3	22.9
Colorado	4.6	19.1
Connecticut	8.5	13.7
Delaware	10.7	11.1
District of Columbia	18.6	14.0
Florida	8.3	23.7
Georgia	7.3	21.9
Hawaii	10.3	12.2
Idaho	11.2	20.8
Illinois	8.8	17.6
Indiana	5.9	16.2
Iowa	7.8	11.5
Kansas	6.9	16.2
Kentucky	10.7	17.0
Louisiana	11.6	28.2
Maine	16.9	12.8
Maryland	4.7	15.0
Massachusetts	15.2	10.1
Michigan	10.7	15.4
Minnesota	9.6	9.5
Mississippi	17.6	21.2
Missouri	12.0	15.8
Montana	10.8	18.6
Nebraska	9.3	11.1
Nevada	3.9	21.8
New Hampshire	4.6	12.9
New Jersey	8.7	16.4
New Mexico	14.4	30.6
New York	14.5	20.3
North Carolina	10.5	21.6
North Dakota	10.6	11.4
Ohio	9.7	14.1
Oklahoma	8.3	22.8
Oregon	13.6	18.4
Pennsylvania	10.3	13.3
Rhode Island	16.8	11.3
South Carolina	14.2	17.6
South Dakota	7.8	14.5
Tennessee	19.3	13.0
Texas	7.5	31.4
Utah	8.8	15.0
Vermont	17.8	12.3
Virginia	5.4	15.4
Washington	12.9	17.6
West Virginia	15.6	21.9
Wisconsin	11.2	9.3
Wyoming	6.5	23.8

Source: The Alan Guttmacher Institute, special tabulations of data from the Current Population Survey, 2002 and 2003.

Coverage Gaps

While two-thirds of American reproductive-age women have private insurance, those who are poor tend to be on Medicaid or uninsured.



Source: The Alan Guttmacher Institute (AGI), special tabulations of data from the Current Population Survey, 2003.

This public funding has a demonstrable impact. Publicly funded clinics provided contraceptive services and supplies to 6.5 million women in 1997, serving about one-quarter of women who obtain family planning services from a medical provider, and half of such women who are poor or adolescent. These clinics provide women with a broad choice of methods on a confidential basis. Moreover, they do so at a price that women can afford; for Title X–supported clinics, this means providing services for free to poor women and on a sliding scale for low-income women.

The contraceptive services and supplies provided by Title X–supported clinics have prevented 20 million pregnancies and nine million abortions over the past two decades. Publicly funded family planning clinics also provide their clients with other vital reproductive health services, including prenatal care, cervical cancer screening, and screening and treatment for sexually transmitted diseases. Furthermore, publicly funded contraceptive services are cost-effective: Every $1 spent saves an estimated $3 in expenditures for pregnancy-related and newborn care for Medicaid alone.

Challenges to Public Funding

Despite these successes, the need for publicly supported contraceptive services and supplies goes unmet for many women. The nation's official health goals, *Healthy People 2010,* include 13 objectives for future progress in this area, toward the overall goal of improving pregnancy planning and preventing unintended pregnancy. Given the patchwork system of care that exists in this country, however, progress will be difficult.

Medicaid costs have been rising rapidly, and the program now accounts for two of every 10 dollars spent by the states. Part of this increase is due to higher prices for medical services and supplies, a trend that has affected private insurance coverage as well. Yet, much is the result of increased enrollment in Medicaid (and in SCHIP) that is the natural consequence of the recent economic stagnation. Medicaid is designed as a safety-net program—there to catch people who fall out of work and off of their insurance plans. However, because the federal and state governments are struggling with low revenue and tight budgets, policymakers have been forced to make tough decisions about containing costs ("States Eye Medicaid Cuts as Cure for Fiscal Woes," *TGR,* August 2002, page 6). A September 2003 analysis by the Kaiser Commission on Medicaid and the Uninsured found that every state imposed cost-containment measures in FY 2003 and planned to do so again in FY 2004. These measures ranged from freezing or cutting provider payments (in all 50 states in FY 2003) to restricting eligibility (25 states) to increasing copayments (17 states).

Publicly funded clinics are feeling these cost pressures. According to a 2002 AGI investigation, clinics are facing serious problems paying for even their current caseloads because of the rising costs of contraceptive supplies and other medical care, new and more expensive contraceptive and screening technologies, inadequate reimbursement from Medicaid, rising staff salaries and the need for multilingual services ("Nowhere But Up: Rising Costs for Title X Clinics," *TGR,* December 2002, page 6). These problems have been compounded by the cost of caring for new clients driven to the clinics by the sluggish economy.

These circumstances have helped to illuminate the limitations of our nation's patchwork approach to health care and to revive the movement for more universal health coverage. Many of the 2004 Democratic contenders for president have released detailed proposals to substantially decrease, if not eliminate, the number of uninsured Americans. Maine enacted a law in June designed to provide universal health care in the state by 2009, and California enacted a law in October that will require large employers to provide health insurance or pay into a state insurance fund. It is, of course, uncertain whether universal health care will ever become a reality in the United States, and whether it will include contraceptive and other reproductive health services. In the meantime, the programs that are struggling to provide assistance to needy Americans today are increasingly in need of assistance themselves.

Tabulations of data from the Current Population Survey were done by Rachel K. Jones, senior research associate, The Alan Guttmacher Institute. This article was supported in part by the U.S. Department of Health and Human Services under grant FPR000072. The conclusions and opinions expressed in this article, however, are those of the author and The Alan Guttmacher Institute.

Key Reproductive Health–Related Developments in the States: 2003

By Rachel Benson Gold

As this issue of *The Guttmacher Report* goes to press, the legislatures in all but five states (Massachusetts, Michigan, New Jersey, Ohio and Pennsylvania) had adjourned for the year, and lawmakers across the nation had taken a variety of final actions related to reproductive and sexual health issues.* As has been the case consistently over the last many years, abortion was a major topic of interest in state legislatures, with 18 new measures enacted this year alone. While lawmakers addressed a range of abortion-related topics, including so-called partial-birth abortion (see related story, page 12), 2003 is notable for the attention given mandatory counseling and waiting periods for women seeking an abortion. Meanwhile, efforts to impose state-level "gag rules" on family planning funds continued, with two state legislatures taking extreme actions under this rubric that could have devastating consequences for young and low-income women needing subsidized contraceptive services. On a more positive note, five states took important steps this year to increase women's access to emergency contraception.

Abortion Counseling and Waiting Periods

In 2003, four states—Minnesota, Missouri, Texas and West Virginia—enacted new laws requiring women seeking an abortion to receive state-directed counseling, while three others—Arkansas, South Dakota and Virginia—expanded their existing laws; Missouri's new law was enjoined pending a legal challenge. This year's actions bring to 27 the number of states with state-directed counseling requirements in effect.

Under these provisions, physicians must provide material on possible alternatives to abortion and services available to women who continue their pregnancy. Physicians must offer women state-prepared materials, which often detail the psychological effects of abortion, fetal development and fetal pain. Notably, Minnesota and Texas require information about a purported link between abortion and an increased risk of breast cancer, although the National Cancer Institute has found that no such link exists.

All three of the new laws, as well as the enjoined Missouri statute, require women to wait 24 hours after receiving the counseling before having the abortion. In all, 21 states have mandatory waiting period laws in effect.

State-Level Gag Rules

For several years, conservative activists' attempts to condition the receipt of public family planning dollars on what a private-sector organization does with its nongovernmental funds have played out both in U.S. foreign policy and in state capitals across the country. Internationally, debate has centered around a U.S. government requirement (often referred to as the "Mexico City" policy) that developing-country nongovernmental organizations receiving U.S. family planning funding pledge that they will not use any of their *other* funds for abortion-related services or advocacy ("Global Gag Rule Revisited: HIV/AIDS Initiative Out, Family Planning Still In," *TGR*, October 2003, page 1). On the state level, the issue has centered on requirements that agencies receiving state family planning funds be financially and physically "separate" from any privately funded activities related to abortion ("Efforts Renew to Deny Family Planning Funds to Agencies That Offer Abortions," *TGR*, February 2002, page 4).

This year, Texas enacted a restriction more akin to the international version than what has generally been implemented at the state level. The measure flatly prohibits the receipt of federal family planning funds—including Title X and Medicaid—by any organization in the state that provides or contracts with another entity to provide "elective" abortions—notwithstanding the degree to which the two activities may be separated. The funding prohibition was immediately challenged and its enforcement enjoined.

Meanwhile, this year, a long-running saga in Missouri also took a potentially devastating turn for women in need of publicly subsidized family planning. For several years, litigation has swirled around increasingly stringent state requirements that family planning providers be separate from agencies providing abortion. With enforcement of the separation requirement appearing to be finally blocked as a result of the litigation, the Republican leader of the state Senate moved to "make this a moot issue," according to press accounts. Rather than continue the wrangling, the legislature terminated *all* state funding for family planning services. With the demise of the Missouri program, and the ongoing challenge in Texas, four states—Colorado, Michigan, Ohio and Pennsylvania—have abortion-related

*More detailed information on state policy on key sexual and reproductive health issues is available at <www.guttmacher.org/statecenter>.

restrictions on family planning funds, commonly regarded as state gag rules, in effect.

Emergency Contraception

Although much of the legislative attention in 2003 was on restricting access to reproductive health services, five states moved to increase access to emergency contraception, taking two different approaches to the issue.

Three states—New Mexico, New York and Oregon—enacted new laws pertaining to hospital emergency room provision of emergency contraception to women who had been sexually assaulted. The New Mexico and New York measures require hospital emergency rooms both to provide information about emergency contraception and to dispense the medication on request. The Oregon law authorizes state payment when emergency contraception is dispensed to women who have been assaulted, although it does not mandate treatment or information. With these enactments, six states (not including Oregon) now require hospital emergency rooms to provide services related to emergency contraception.

None of the three measures enacted in 2003 includes a provision allowing hospitals to refuse to comply because of moral or religious objection to emergency contraception. However, the New York law does not require hospitals to provide emergency contraception to any woman who is "pregnant," a clause added to reflect current practice at many Catholic hospitals. These hospitals administer a pregnancy test that, if used within the window of time that emergency contraception is effective, would only determine whether the woman had been pregnant prior to the rape.

Also this year, two states passed measures aimed at facilitating the ability of pharmacists to dispense emergency contraception without a prescription, bringing to five the number of states taking this approach. A Hawaii law allows pharmacists to dispense emergency contraception under a collaborative practice agreement with a physician. California, which previously had a law similar to the Hawaii measure, became the first state to give pharmacists the option of dispensing the medication either under a collaborative practice arrangement or in accordance with a specific, state-established protocol.

Christopher Guttridge, Elizabeth Nash and Chinue Richardson also contributed to this article.

Federal Abortion Procedures Ban Heads to Court; Abortion Foes Pledge More Bills in 2004

By Amy Deschner

President Bush's signing of the Partial-Birth Abortion Ban Act on November 5, 2003, was not just a moment of political triumph for abortion opponents, who had seen almost identical legislation vetoed twice by President Clinton. It was also, in the words of the Family Research Council's former president, Kenneth L. Connor, part of social conservatives' long-term strategy of dismantling, "brick by brick, the deadly edifice created by *Roe v. Wade.*" The law represents the first federal ban on an abortion procedure since the Supreme Court legalized abortion nationwide more than 30 years ago, setting the stage for a court challenge that could redefine the scope of abortion rights in the United States.

Issues in Contention

Three years ago, the Supreme Court struck down by the narrow majority of 5–4 a similar ban that had been enacted in Nebraska. In *Stenberg v. Carhart,* the Court cited two distinct constitutional problems with the state law: that the language used to define a "partial-birth" abortion was so broad as to potentially outlaw a range of abortion procedures and that the law lacked an exception that would allow a physician to employ such procedures when necessary to protect the health of the woman. Congressional supporters of the bill claim to have addressed these problems.

Supporters argue that they have sufficiently narrowed the definition of a "partial-birth" abortion by describing it as the performance of an "overt act" intended to kill the partially delivered living fetus. Opponents say that the language is still too imprecise and could cover a much broader category of procedures, including the dilatation and evacuation (D&E) procedure that is commonly performed during the second trimester of pregnancy—well before fetal viability, the point at which the Supreme Court has said states may act to restrict or prohibit abortion. The procedure that comes closest to what antiabortion groups say they want to criminalize is known as dilation and extraction (D&X). To avoid confusion, the bill's authors could have used that medical term and given the corresponding *medical* definition in the legislation. Instead, they chose to use the *political* term "partial-birth" abortion and create their own definition, purposely leaving the door open to broad interpretation.

(Continued on page 14)

Title X Program Announcement Articulates New Priorities for Nation's Family Planning Program

In July 2003, the Office of Population Affairs (OPA) at the U.S. Department of Health and Human Services formally requested applications for $49 million for family planning service delivery under the Title X program for FY 2004. The request for applications was in some respects routine, affecting the 24 competitive grants supporting service delivery that are up for renewal that year. (The rest of the FY 2004 appropriation will support the remaining 64 grants, which are not open to competition in FY 2004.) However, the announcement contains a number of new program priorities (affecting the 24 grants this year and, presumably, the remaining grants in subsequent years) that will affect the delivery of subsidized family planning services for millions of low-income women and teenagers in the years to come.

While continuing to acknowledge Title X's statutory mission of assuring access to a broad package of high-quality family planning and related preventive health services, the OPA announcement identifies several new overarching goals for the program that reflect the Bush administration's broader social agenda but do not appear in statute. Specifically, it stresses that the broad range of services includes "extramarital abstinence education and counseling" designed to "encourage abstinence outside a mutually monogamous marriage or union" (see related story, page 4). Building on the long-standing requirement to encourage family participation in the decision of minors to seek family planning services, funded programs will now also be required to include activities that promote positive family relationships. Finally, emphasis is placed on partnering with faith-based organizations, which, the announcement also notes, are eligible to apply for Title X grants in their own right.

But perhaps most striking is the new language spelling out requirements for the integration of family planning and HIV prevention services. Achieving such integration has been a priority for many family planning providers for several years. While noting that "HIV/AIDS education, counseling and testing either on-site or by referral should be provided in all Title X funded programs," the announcement states that HIV/AIDS education "should incorporate the 'ABC' message"—explaining further that "for adolescents and unmarried individuals, the message is 'A' for abstinence; for married or individuals in committed relationships, the message is 'B' for being faithful; and, for individuals who engage in behavior that puts them at risk for HIV, the message is 'C' for condom use."

This represents the first time that the administration has imported the ABC approach, derived from the international context and guiding U.S. policy for HIV prevention efforts overseas, to a domestic public health program (see related story, page 1, and "U.S. AIDS Policy: Priority on Treatment, Conservatives' Approach to Prevention," *TGR*, August 2003, page 1). It also represents the first time that the ABC message will shape counseling provided to individuals within the context of a medical family planning visit, rather than public education messages designed to respond to high rates of HIV.

Putting the ABC requirement into practice will pose key challenges for Title X providers, largely because the grant announcement leaves many questions unanswered. While it spells out different HIV prevention messages to be provided to different subgroups, to what extent are these populations actually separate and distinct? Specifically, should "adolescents and unmarried individuals" who are also sexually active and, therefore, "engag[ing] in behavior that puts then at risk for HIV," be given messages about abstinence, condom use, or both? And, if HIV prevention and pregnancy prevention services are to be integrated within a family planning visit, does the ABC approach also become the primary strategy for pregnancy prevention? In other words, how are Title X providers expected to reconcile the new requirement to provide abstinence messages to all unmarried individuals for HIV prevention with the program's historic mandate to provide contraceptive methods and services to sexually active individuals, including teenagers? These are only a few of the questions confronting Title X providers that will be further explicated over time as the administration seeks to implement its new Title X program priorities. —*C. Dailard*

Erratum:

The October 2003 issue incorrectly reported that the Arkansas Medicaid family planning waiver had an eligibility ceiling of 133% of the federal poverty level (page 12). In fact, the ceiling was increased to 200% of poverty when renewal of the state's waiver was approved by the Centers for Medicare and Medicaid Services. Corrected information on state programs may be found at <http://www.guttmacher.org/pubs/spib_MFPW.pdf>.

Federal Ban...
Continued from page 12

Proponents also say they have addressed the health issue by including in the legislation itself congressional "findings" that "partial-birth" abortion is never necessary to preserve a woman's health, that it poses serious risks to a woman's health and that it lies outside the standard of medical care. Critics cite a substantial body of medical opinion to the contrary and argue that according to Supreme Court precedent, only a doctor evaluating an individual woman's particular circumstances can determine the best way to protect that woman's health.

'You Can Weave Them Together'

President Bush has stated that the country in not "ready" for a total ban on abortion. Republican leaders have already served notice that they hope to move the country closer to that day by bringing up for congressional consideration a number of other abortion-related bills in 2004. The election-year legislative agenda prominently includes the Unborn Victims of Violence Act, which, while not affecting abortion legality per se, would create a separate crime for harm to an "unborn child" caused while committing a crime against a pregnant woman; alternative proposals that carry the same penalties as the Unborn Victims of Violence Act but would not, however, grant the fetus legal rights independent of the woman have already been rejected. Other likely candidates include the RU-486 Suspension and Review Act, which would remove mifepristone from the U.S. market, as well as a bill requiring parental notification for minors seeking an abortion on military bases. "Each of these issues can stand on their own," Sen. Sam Brownback (R-KS) recently remarked. However, "you can weave them together."

Meanwhile, it will be up to the Supreme Court to determine the final outcome of the "partial-birth" abortion ban. Challenges filed by Planned Parenthood Federation of America, the American Civil Liberties Union and the Center for Reproductive Rights have already resulted in temporary restraining orders blocking the law from enforcement throughout much of the country. The Justice Department has appealed these rulings, and hearings are slated in all three cases in March 2004, although the legal battle could take several years to play out.

Proponents of the measure are hopeful that by the time the case reaches the Court, President Bush will have had an opportunity to appoint at least one new justice, who could tip the balance in their favor. With this in mind, both sides agree: The 2004 presidential election will likely play a pivotal role in defining the scope of abortion rights in the future. ⊕

December 2003

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Division of Integrated Health Systems, Family and Children's Health Programs Group, CMSO

OCT 15 2003

Representative Glen Grothman
State Capitol - 15 North
P.O. Box 8952
Madison, WI 53708-8952

Dear Representative Grothman:

We recently received your inquiry regarding information on states with family planning 1115 demonstrations that cover ages 18 and older. There are currently two approved family planning 1115 demonstrations that cover ages 19 and older which include New Mexico and Illinois. Oklahoma's family planning 1115 demonstration proposal, which is currently under review, would cover men and women over 19 years old, while a North Carolina proposal, which is also under review, would cover all men and women over 18. If Wisconsin were to request to amend its current section 1115 demonstration to exclude individuals under age 18, we would review the request and, in all likelihood, the exclusion of the lower age group should not impact coverage of the higher age group under the demonstration.

If you have any further questions, please contact Julie Jones of my staff at (410) 786-3039. I wish you continued success with Wisconsin's family planning 1115 demonstration.

Sincerely,

Michael Fiore
Director

Wisconsin Right to Life NEWS RELEASE

10625 W. North Avenue, Milwaukee, WI 53226
414-778-5780 or toll free: 877-855-5007

For immediate release: Thursday, January 8, 2004

Contact: Susan Armacost, Legislative Director

Assembly Committee Approves Bill to Regulate New Federal Family Planning Waiver Dollars

Today, the Assembly Family Law Committee approved Assembly Bill 634, legislation that would regulate the new pot of $38 million federal dollars coming into the state via the Family Planning Waiver.

Wisconsin Right to Life supports AB 634 which is authored by Rep. Glenn Grothman (R-West Bend). Sen. Joe Leibham (R-Sheboygan) is the Senate author.

Assembly Bill 634 would limit the use of the $38 million dollars to "service" women over the age of 17. The legislation would not, however, prevent adult women from being provided with family planning services with the new federal funds nor would it affect the other state and federal tax dollars that are currently being used to provide family planning services to minor girls and adult women.

"Wisconsin Right to Life supports regulating the use of these new federal funds because there is a connection between the use of these funds and the bolstering of Planned Parenthood's abortion operations," said Susan Armacost, Legislative Director for Wisconsin Right to Life. **"Planned Parenthood uses their family planning clinics as sites from which they refer pregnant women and girls of all ages right over to their own profit-oriented abortion clinics. With this new pool of federal dollars, they will have access to an even larger pool of women and girls who will enter their family planning clinics. Not only will Planned Parenthood be receiving more federal dollars via the family planning waiver dollars, they will also receive additional income from the increasing number of abortions they will be able to generate via their family planning clinics."**

Today in Madison, Planned Parenthood opened their third abortion clinic in Wisconsin. Armacost said that the combination of the new federal family planning dollars and an additional abortion clinic will translate into huge profits for Planned Parenthood. Even prior to the opening of their third abortion clinic, Planned Parenthood had the onerous distinction of being the state's leading promoter and provider of abortion.

"This is a blatant conflict of interest that should be very disturbing to every single state lawmaker regardless of where that lawmaker stands on the issue of abortion," said Armacost.

"Sadly, there is not the political will in the state legislature to stop Planned Parenthood and other like-minded organizations from receiving any of these new federal dollars," said Armacost. **"The best that can be done is to limit the use of the funds to women over 18 so that, at least, Planned Parenthood cannot get their hands on additional numbers of vulnerable minor girls."**

Armacost said that both opponents and supporters of AB 634 need to be forthright in describing what the legislation would and would not do. **"Opponents of AB 634 claim the legislation would prevent minor girls from receiving 'health care' services. The only people who claim abortion is 'health care' are the folks who work in the abortion industry and who have a vested economic interest in increasing the numbers of abortions," said** Armacost. **"Likewise, when the supporters of AB 634 talk about the bill, it must be made clear that AB 634 does not solve the problem of minors receiving family planning services without parental consent. There are numerous other pots of state and federal dollars with which minor girls will still receive 'services' and abortion referrals. Wisconsin Right to Life views AB 634 as making an intolerable situation a little less intolerable and for that reason, it deserves our support."**

Armacost commended Rep. Grothman for his authorship of the bill as well as Rep. Lorraine Seratti (R-Spread Eagle) and Rep. Scott Gunderson (R-Waterford) who have provided tremendous leadership on the issue. In addition, Armacost cited Committee Chair Rep. Carol Owens (R-Oshkosh) for her fair and timely action on the bill. She and Reps Peggy Krusick (D-Milwaukee), Steve Kestell (R-Elkhart Lake), Scott Jensen (R-Waukesha), and Don Friske (R-Merrill) voted to approve AB 634. Rep. Therese Berceau (D-Madison) voted against the measure.

"Our thanks go to all of these courageous legislators for their concern for this issue," said Armacost.

Wisconsin Right to Life
10625 W. North Avenue, Milwaukee, WI 53226
414-778-5780 or toll free: 877-855-5007

For immediate release: Thursday, January 8, 2004

Contact: Barbara Lyons, Executive Director
Susan Armacost, Legislative Director

Planned Parenthood Continues to Establish Itself as the Nation's and State's Largest Promoter of Abortion

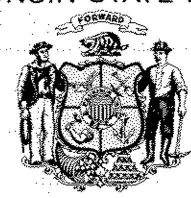
I Opens It's Third Wisconsin Abortion Clinic Today

Today , Planned Parenthood will once again demonstrate that they richly deserve the onerous title of "the state's largest promoter and provider of abortion." After operating abortion clinics in Milwaukee and the Fox Valley for many years, Planned Parenthood will open a third abortion clinic today in Madison. There are a total of six abortion clinics in Wisconsin.

"Planned Parenthood tries to portray itself as an organization that is helping women and reducing abortions," said Barbara Lyons, Executive Director of Wisconsin Right to Life. **"But, in reality, this devious organization takes advantage of women who are at an extremely vulnerable time in their lives. The more women who have abortions, the more money Planned Parenthood makes. It's a business and a very profitable one for Planned Parenthood. But unlike other kinds of businesses, the employees of Planned Parenthood abortion clinics make their living destroying human life for profit. We are very sad that there is yet another abortion clinic in Wisconsin where that tragedy will be played out day after day."**

For years, Planned Parenthood has tried to take credit for the continued decline in the number of abortions performed in Wisconsin. Lyons pointed out the inherent conflict in Planned Parenthood claiming they want to reduce abortions while, at the same time, they open a third abortion clinic to perform more abortions. **"The fact is, we have been successful in reducing the numbers of abortions in spite of Planned Parenthood,"** said Lyons. **"We have accomplished this through the enactment of numerous pro-life state laws, through our extensive public education programs that reach millions of Wisconsinites each year and through assistance provided to pregnant women. So, as Planned Parenthood increases its promotion of abortion in Wisconsin, Wisconsin Right to Life will continue to carry out activities that promote the sanctity of each and every member of the human family."**

WISCONSIN STATE SENATE



Carol Roessler
STATE SENATOR

January 9, 2004

X
X
X

Dear X,

Thank you for your contact on Senate Bill 186 and Assembly Bill 634 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.

On January 8, 2003 the Assembly Committee on Family Law held a public hearing on this bill. An Executive Session was held and the bill passed 5-1. This bill is now available to be scheduled before the full Assembly.

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

Sincerely,

CAROL ROESSLER
State Senator
18th Senate District

CR/jhS:\DOCS\Jennifer\1-9-04 family planning waiver.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/
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SD 18 Roessler

Support Women's Health

Oppose Attacks on the Family Planning Waiver

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As Wisconsin citizens struggle to find affordable health care, programs like the Family Planning Waiver should be supported rather than attacked. This is a very important issue to me.

Please stand up for women's health.
Vote against AB 634/SB 308 and AB 383/SB 186.

JAN 30 2004

Sincerely, Erin
Please print name

Oshkosh, 54901
Home Address

☐ I vote ☐ I pledge to vote in 2004 and will be watching these bills

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JAN 30 2004

Sincerely, Melissa
Please print name

54901
Home Address

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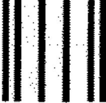
Save the Waiver Coalition



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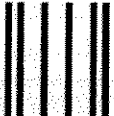

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JAN 30 2004

Sincerely, Tina
Please print name

54902
Home Address

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Please print name

54901
Home Address

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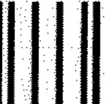

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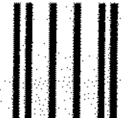

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Please print name

54901
Home Address

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Sincerely, Danielle
Please print name

54902
Home Address

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Sincerely, Annie Melaas
Please print name

Oshkosh, 54901
Home Address

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SD 18 Roessler

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Sincerely, Cherie
Please print name

916 A Wisconsin St, Oshkosh
Home Address

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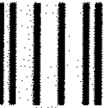

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Roessler JH

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JAN 30 200-

Sincerely, LuAnn Bird LuAnn Bird
Please print name

3037 Bellaire Lane Oshkosh WI 54904
Home Address

(Carol Roessler)

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JAN 30 200-

Sincerely, ANGELA
Please print name

333 W. 11th Ave Oshkosh, WI 54902
Home Address

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Save the Waiver Coalition

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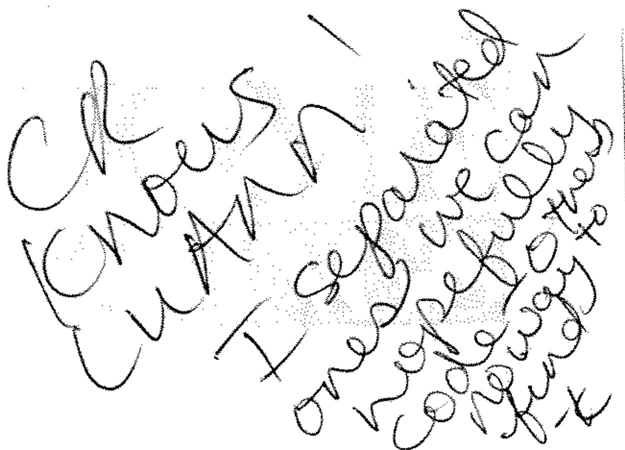

Bruce

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JAN 30 2004

Sincerely, Mary M. Cary
Please print name

43 Westfield Circle – Fond du Lac, WI 54935
Home Address

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SD 18
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JAN 30 2004

Sincerely, Katrina Black
Please print name

975 Freedom Av Oshkosh Wi 54901
Home Address

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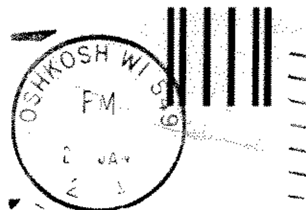
Save the Waiver Coalition



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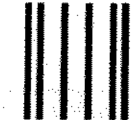

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Sincerely, Kelly Garcia
Please print name

660 Broad St Oshkosh, Wi 54901
Home Address

☒ I vote ☒ I pledge to vote in 2004 and will be watching these bills

SD 18
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Sincerely, Tracy Ryckman
Please print name

2026 B Mt Vernon 54901
Home Address

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Save the Waiver Coalition

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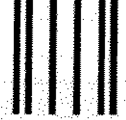

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JAN 30 2004

Sincerely, Jessica Elias
Please print name

762 Prospect ave, Oshkosh WI 54901
Home Address

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JAN 30 2004

Sincerely, BRITTANY WICKET
Please print name

625 ALGOMA BLVD 876 N. SCOTT OSHKOSH WI 54901
Home Address

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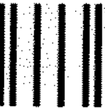

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