☞ 11hr_SC-Ed_sb0237_ pt02

☞

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2011-12
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Education...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (December 2012)

Staudenmayer, Suzanne

From: Dipesh Navsaria [dipesh@navsaria.com]

Sent: Tuesday, October 18, 2011 10:52 PM

To: Sen.Olsen; Sen.Darling; Sen.Grothmann@legis.wisconsin.gov; Sen.Vukmir; Sen.Jauch; Sen.Vinehout; Sen.Larson

Cc: Kia LaBracke

Subject: SB 237 Statement from Wisconsin Chapter of the American Academy of Pediatrics

Attachments: Wisconsin AAP Sexuality Education Statement.pdf

To the Members of the Wisconsin Senate Education Committee —

The Wisconsin Chapter of the American Academy of Pediatrics **opposes** SB 237 on the grounds that it is harmful to the health and safety of Wisconsin's adolescents. Attached is our formal statement on this issue, including supporting documentation which provides extensive detail.

If we can be of any assistance with clarification or providing further information, please do not hesitate to contact me.

Peace and Prosperity,
Dipesh Navsaria, MPH, MSLIS, MD, FAAP
Wisconsin Chapter of the American Academy of Pediatrics
dipesh@navsaria.com

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Wisconsin Chapter | **POSITION STATEMENT**

WIAAP
563 Carter Court, Suite B
Kimberly, WI 54136
Phone: 262.490.9075
E-mail: KLaBracke@wiaap.org

Chapter Officers

President
James A. Meyer, MD, FAAP
Department of Pediatrics
Marshfield Clinic
Adolescent Section
1000 North Oak Avenue
Marshfield, WI 54449
Phone: 715.387.5240
E-mail:
meyer.james@marshfieldclinic.org

Vice President
Jeffrey W. Britton MD, FAAP
2414 Kohler Memorial Drive
Sheboygan, WI 53081-3129
Phone: 920.457.4461
E-mail: jeffrey.w.britton@aurora.org

Secretary/Treasurer
Mala Mathur, MD, MPH, FAAP
1321 Redan Drive
Verona, WI 53593-7820
Phone: 608.497.0441
Fax: 000/000-0000
E-mail: mmathur@charter.net

Chapter Executive Director
Kia K. LaBracke
563 Carter Court, Suite B
Kimberly, WI 54136
Phone: 262.490.9075
E-mail: KLaBracke@wiaap.org

Immediate Past President
Jeffrey H. Lamont, MD, FAAP
Department of Pediatrics
Marshfield Clinic, Wausau Center
2727 Plaza Drive
Wausau, WI 54401
Phone: 715.847.3575
E-mail:
lamont.jeffrey@marshfieldclinic.org

Chapter Web Site
www.wiaap.org

AAP Headquarters
141 Northwest Point Blvd
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Fax: 847/434-8000
E-mail: kidsdocs@aap.org
www.aap.org

The Wisconsin Chapter of the American Academy of Pediatrics opposes Senate Bill 237, legislation to repeal the Healthy Youth Act.

According to the American Academy of Pediatrics' (AAP) policy statement on *Sexuality Education for Children and Adolescents*, "children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults."

The AAP's review of the available scientific evidence of the effectiveness of sexuality education programs indicated the following points:

- To delay the onset of sexual debut, it is necessary to present programs to fifth and sixth graders.
- Abstinence-only programs have not demonstrated successful outcomes with regard to delayed initiation of sexual activity or use of safer sex practices.
- Effective programs tend to provide practical skills, such as exercising control and increasing communication and negotiation skills through role playing or interactive discussion.
- Programs that encourage abstinence are the best option for adolescents in general, but those which also offer a discussion of HIV prevention and contraception are the best approach for adolescents who are already sexually active. Comprehensive education of this nature has been shown to delay the initiation of sexual activity and increase the proportion of sexually-active adolescents who reported using birth control.
- Programs that have linked educational curricula with access to reproductive health services and comprehensive community-based interventions have also documented reductions in pregnancy rates.

Finally, they specifically state that one should "Encourage schools to begin sexuality education in the fifth or sixth grade as a component of comprehensive school health education and to use curricula that provide effective and balanced approaches to puberty, abstinence, decision-making, contraception, and STD and HIV prevention strategies and information about access to services."

Additionally, the statement on *Contraception and Adolescents* states:

- "To date, the evidence regarding the efficacy of [abstinence-only programs] in the reduction of risky sexual behaviors, including risk of sexually transmitted infections, has not been proven."
- "Several published studies and evaluations have suggested that comprehensive sexuality education is an effective strategy for helping young people delay initiation of sexual intercourse. In addition, research has shown that these programs do not hasten the onset or frequency of sexual intercourse and do not increase the number of partners that sexually active teens have.

- "The AAP supports a comprehensive approach to sexuality education for adolescents. Abstinence should play a part in any comprehensive discussion of sexuality…"
- "Adolescents need to know about other contraceptive options before (or if) they decide to have intercourse."

Accordingly, the Wisconsin Chapter of the American Academy of Pediatrics **opposes** SB 237 because:

- It dilutes the components of comprehensive sexuality education by omitting the requirement for items 3 (puberty, pregnancy, parenting, body image and gender stereotypes) and 6 (benefits, side effects and proper use of FDA-approved means of contraception).
- It removes the requirement that information provided be from sources which are reviewed by recognized and accepted medical organizations of scientific information which may distinguish published items which are carefully designed and analyzed from those which are not.
- It adds abstinence-only language to the statute, despite the scientific evidence that such education does not result in improved health.
- It bans health care providers from teaching health classes that include sex education, despite their broad and comprehensive knowledge and experience.

SB 237 would be a step backwards from appropriately addressing the issues of teenage pregnancy and sexually-transmitted diseases through comprehensive education.

References (Policy Statements of the American Academy of Pediatrics):

Contraception and Adolescents. *Pediatrics*, Vol. 120 No.5, 1 Nov 2007, pp 1135–1148. http://pediatrics.aappublications.org/content/120/5/1135.full

Sexuality Education for Children and Adolescents. *Pediatrics*, Vol. 108 No.2, 2 Aug 2001, pp 498–502 (reaffirmed 2005) http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/2/498

PEDIATRICS
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Contraception and Adolescents

Committee on Adolescence

Pediatrics 2007;120;1135
DOI: 10.1542/peds.2007-2535

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

POLICY STATEMENT

Contraception and Adolescents

Committee on Adolescence

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

ABSTRACT

Although adolescent pregnancy rates in the United States have decreased significantly over the past decade, births to adolescents remain both an individual and public health issue. As advocates for the health and well-being of all young people, the American Academy of Pediatrics strongly supports the recommendation that adolescents postpone consensual sexual activity until they are fully ready for the emotional, physical, and financial consequences of sex. The academy recognizes, however, that some young people will choose not to postpone sexual activity, and as health care providers, the responsibility of pediatricians includes helping teens reduce risks and negative health consequences associated with adolescent sexual behaviors, including unintended pregnancies and sexually transmitted infections. This policy statement provides the pediatrician with updated information on contraception methods and guidelines for counseling adolescents.

INTRODUCTION

Pediatricians have an important role in adolescent reproductive health care. Their long-term relationships with patients and families allow them to help promote healthy decision-making around sexuality and include abstinence as a way to avoid the negative consequences associated with risky sexual behaviors. As advocates for the health and well-being of young people, pediatricians communicate their recommendation to adolescent patients to postpone sexual activity until they are ready, because any sexual activity for which the adolescent is ill prepared may have emotional, physical, and financial consequences. However, clinicians recognize that some of their adolescent patients are sexually active or will choose to become so. Recent studies indicate that, for some adolescents, even participating in formal programs that advocate abstinence and signing abstinence pledges do not result in abstinent behavior.[1,2] Pediatricians can have an active role in encouraging their adolescent patients to use contraception to reduce the risk of unintended pregnancies and to prevent sexually transmitted infections (STIs). In previous publications, the American Academy of Pediatrics (AAP) has addressed issues of adolescent sexuality, unwanted pregnancy, STIs, and contraception.[3] This policy statement provides the pediatrician with updated information on adolescent sexual behavior, which may lead to pregnancy, including guidelines for counseling adolescents about available methods of contraception. Current methods available are discussed, as are methods in development.

ADOLESCENT SEXUAL BEHAVIOR AND USE OF CONTRACEPTION

Reported contraceptive use by adolescents has increased in recent years. From 1991 to 2005, the percentage of sexually active high school students who reported using a condom the last time they had sexual intercourse increased from 46.2% to

www.pediatrics.org/cgi/doi/10.1542/peds.2007-2535

doi:10.1542/peds.2007-2535

Key Words
contraception, adolescents, pregnancy, sexually transmitted infections

Abbreviations
STI—sexually transmitted infection
AAP—American Academy of Pediatrics
OCP—oral contraceptive pill
FDA—Food and Drug Administration
DMPA—depot medroxyprogesterone acetate
BMD—bone mineral density
VTE—venous thromboembolism
IUD—intrauterine device

PEDIATRICS Volume 120, Number 5, November 2007

62.8% in 2005.[4] Despite this increase, consistent use of any contraceptive method remains a challenge for most adolescents.

Levels of reported sexual intercourse by adolescents in the United States decreased during the 1990s for both sexes after increasing for the previous 2 decades.[4–6] The Centers for Disease Control and Prevention's 2005 Youth Risk Behavior Surveillance Summary indicated that less than half (46.8%, down from 49.9% in 1999) of all high school students reported having had sexual intercourse in their lifetimes, and approximately one third (34.3%, down from 37.5% in 1991 and 36.3% in 1999) of all students reported having sexual intercourse during the 3 months preceding the survey and are considered currently sexually active.[4–6]

Each year, almost 850 000 adolescent girls become pregnant. The adolescent pregnancy rate has dropped steadily over the past decade. As of 2004, it was estimated that approximately 41.2% of all pregnancies are to adolescents 15 to 19 years of age.[7] Since 1991, the adolescent birth rate has declined by 33%, the lowest rate ever reported for the nation. The pregnancy rate for 15- to 17-year-olds has dropped by 43% to 22.1% of all pregnancies.[7] Approximately 20% of abortions are in adolescents, although these rates continue to decrease.[8,9] Decreases in pregnancy rates are thought to reflect a decrease in reported rates of sexual intercourse and an increase in reported use of longer-acting, more effective contraceptive agents.[10–12] Over the last decade, evaluations of curricula suggest that those with a comprehensive approach to sexuality education have been effective in improving sexual behaviors and, thus, may also contribute to this trend.[13–15] Despite these declining rates of pregnancies and births, adolescent childbearing (22% of women report giving birth before age 20) is still more common in the United States than in other developed countries such as Great Britain (15%), Canada (11%), and France (6%).[16]

Providing information to adolescents about contraception does not result in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners.[13] In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to experience negative outcomes related to sexual activity.[17] Two school-based studies that demonstrated a delay of onset of sexual intercourse used a comprehensive approach to sexuality education that included a discussion of contraception.[18,19]

Race, ethnicity, age, marital status, education, income, requirements for confidential care, and fertility intentions have all been demonstrated to affect contraceptive choice. Trends in methods of contraception used by adolescents over the past 2 decades show an increase in oral contraceptive pill (OCP) use and an increase in male condom use.[20] In recent years, the number of adolescents reporting OCP use has remained stable at approximately 18% to 20%.[21] Use of injectable contraception by adolescents 15 to 19 years of age has increased from 0% to 13% between 1988 and 1995. A 9% decrease in contraceptive-failure–related pregnancies is attributed to the shift to longer-acting birth control methods.[19]

Factors that contribute to lack of contraceptive use or inconsistent use include issues related to adolescent development, such as reluctance to acknowledge one's sexual activity, belief that one is immune from the problems or consequences surrounding sexual intercourse or pregnancy, and denial of the possibility of pregnancy. Other important factors are lack of education and misconceptions regarding use or appropriateness of contraception. However, an adolescent's level of knowledge about how to use contraception effectively does not necessarily correlate with consistent use. Adolescents may not use or may delay use of contraception for several reasons including lack of parental monitoring, fear that their parents will find out, ambivalence, and the perception that birth control is dangerous or causes unwanted adverse effects such as weight gain.[22–25]

THE ROLE OF THE PEDIATRICIAN

Pediatricians should encourage abstinence and provide appropriate risk-reduction counseling regarding sexual behaviors. Ideally, counseling should include discussion about the prevention of STIs, education on contraceptive methods, and family planning services for the sexually active patient. Such discussion necessarily takes place within the context of an individual patient's physical and emotional development as well as his or her social situation. Although pediatricians are optimally suited for such inquiry, we recognize that not every visit will allow the time required. The demands of comprehensive patient evaluation, counseling, and treatment are daunting, indeed, but are part of the ongoing education of teens and often other family members. This report is intended as a guide and, we hope, is helpful to busy clinicians.

When contraceptive services are provided in the pediatrician's office, policies and procedures that address the provision of such services, including confidentiality, should be developed and then explained to families before the provision of such services is ever needed.[26,27]

Counseling Adolescents About Contraception

Comprehensive health care of adolescents should include a confidential sexual history that should be obtained in a safe, nonthreatening environment through open, honest, and nonjudgmental communication with assurances of confidentiality. During the preadolescent years, the pediatrician can provide anticipatory guidance by discussing puberty and offering health education materials to both the youth and his or her family. At the onset of puberty, the patient's history should include

information on both the family's and the patient's attitudes and knowledge about sexual behaviors and the degree of involvement in sexual activity. General information may be offered or accessible to both the family and patient about methods of contraception and their uses. In addition, around this time, health maintenance visits should begin to include private, confidential time with the adolescent to establish rapport as well as assess degree of involvement in sexual activity. For sexually active adolescents who use contraception, the role of the health care professional is to educate and support compliance, to assist in managing adverse effects or, alternatively, to counsel the patient regarding a new contraceptive method as circumstances require, and to provide referrals and follow-up with periodic screening for STIs. Throughout adolescence, comprehensive sexuality education that includes discussion of abstinence, appropriate contraceptive use, and protection from STIs should be provided as part of healthy sexual development. When initiating any hormonal contraceptive method, the need for consistent protection against STIs (either male or female condoms) should be reinforced.

Confidentiality and Consent

The primary reason that adolescents may hesitate or delay obtaining family planning or contraceptive services is concern about lack of confidentiality.[25,28] It is important for pediatricians to develop office policies that ensure patient confidentiality. State requirements and standards of practice should be reviewed, and the development of clear, concise, and standardized office protocols for confidentiality should be developed for staff, patients, and parents.[29] These policies should include information and education regarding when confidentiality must be waived, guidelines for reimbursement of services, medical chart access, appointment scheduling, and information disclosure.

For those patients whose parents are unaware of their contraceptive use, it may be helpful to discuss with the adolescent patient how the contraceptive method will be consistently used in all circumstances. Consistent adolescent contraceptive use is often derailed during weekends away, family vacations, adolescents' trips to stay with other relatives, and/or visits to noncustodial parents.

Sexual Responsibility

Pediatricians can help adolescents identify their own goals for safe and responsible sexual behavior, including reinforcing and supporting abstinence. The promotion of healthy and responsible sexual decision-making is one of the goals of counseling adolescents about contraception. Successful counseling requires a supportive and nonjudgmental pediatrician who engages in effective dialogue, which includes skillful history taking, careful listening, and repetition of simple educational messages that contain essential information.[26,30]

Sexual Decision-Making

Adolescents should be strongly encouraged to postpone or delay the initiation of sexual activity. For patients who are already engaged in sexual intercourse or who are contemplating having sexual intercourse, a discussion of contraceptive methods and prevention of STIs (including HIV and AIDS) is essential. Condom use should always be reinforced, and teens must be reminded that, for some STIs, condoms are not totally protective. Adolescents should be made aware, in a nonthreatening and nonjudgmental manner, that although condom use is essential and may be life-saving, any individual who engages in sexual contact is at risk of contracting STIs that are transmitted through sexual contact, such as herpes simplex and human papillomaviruses, rather than body-fluid exchange, such as gonorrhea and trichomoniasis. Discussions should address and explore the adolescent's reasons for becoming sexually active and the effect that sexual intercourse may have on relationships with peers, parents, and significant others. Clinicians may also find it useful to explore with the adolescent how he or she believes the sexual experiences will change his or her own self-image. Adolescent sexual decision-making has emerged in recent studies as a complex interplay between an adolescent's perception of peer-group expectations, personal self-image, values, and desires and media influences.[30–33] However, a caring, nonjudgmental yet informative, nonparental adult can wield substantial influence in teens' sexual decision-making; teens cite lack of such a person as a missing key feature of sexuality education.[34] Pediatricians, therefore, may have some influence in adolescent sexual decision-making and are especially well positioned to assess risk-taking behaviors in the area of sexuality.[35]

ADOLESCENTS WITH DISABILITIES

The issue of contraception for adolescents with chronic illness or disability is often forgotten. An estimated 10% to 20% of children and adolescents experience a disability or chronic illness by the age of 20 years.[36] Recent data from the National Longitudinal Study of Adolescent Health has shown that physically disabled adolescents are as sexually experienced as adolescents without disabilities. Attitudes about contraceptives as well as sexuality education and counseling needs within this population should not be overlooked.[37] A list of additional resources for clinicians who desire more information about contraception for adolescents with chronic illness and/or disability is included at the end of this statement.

METHODS OF CONTRACEPTION

Numerous reviews and protocols for prescribing and managing contraception are available. The following section focuses on the appropriateness of various contraceptive methods available for adolescents. The pediatrician should emphasize the need for STI prevention as well as contraception with each patient at each visit.[37,38]

Abstinence

Abstinence is the most effective means of birth control and prevention of STIs and is a viable strategy in the clinician's toolkit for reducing unintended pregnancy and achieve reduction in STI rates. Abstinence education generally focuses on delaying the initiation of adolescent sexual activity until marriage or adulthood. Many schools have adopted abstinence-dominant or abstinence-only education programs for school sexuality curricula. To date, the evidence regarding the efficacy of such interventions in the reduction of risky sexual behaviors, including risk for STIs, has not been proven.[14,39] No data have directly examined how well abstinence counseling works to reduce an individual's pregnancy and STI risk. In practice, many adolescents who intend to be abstinent often fail and have sex. A longitudinal analysis of teens and virginity pledges compared pledgers to nonpledgers and found at a 6-year follow-up that 88% of pledgers reported experiencing premarital sex and had STI rates that, statistically, were no different from those of nonpledgers.[2] A recent article provides some practical tips for abstinence counseling within an office-based setting using a comprehensive perspective including motivational interviewing.[40]

Several published studies and evaluations have suggested that comprehensive sexuality education is an effective strategy for helping young people delay initiation of sexual intercourse. In addition, research has shown that these programs do not hasten the onset or frequency of sexual intercourse and do not increase the number of partners that sexually active teens have.[15]

There is some consensus that sexuality education and interventions with some abstinence-based or "abstinence-plus" curriculum components are most effective when targeted at younger adolescents before they become sexually active.[1,41] Some recent studies demonstrated the importance of youth, parent, physician, and education partnerships for the prevention of health risk behaviors such as early initiation of sexual intercourse.[13,42] One study illustrated that an abstinence-only curriculum had no significant impact on the initiation of sex, the frequency of sex among those students who had ever had sex, or the number of sexual partners among those who had ever had sex. Two other studies produced similar results.[1] The AAP supports a comprehensive approach to sexuality education for adolescents. Abstinence should play a part in any comprehensive discussion of sexuality, and resources should be made available for adolescents who feel pressured, but prefer not, to engage in sexual activity.

For some adolescents, abstinence may be a difficult choice. Adolescents who choose to abstain from sexual intercourse should be encouraged and supported by their parents, peers, and society (including the media) and especially by their pediatricians. Adolescents need to know about other contraceptive options before (or if) they decide to have intercourse.

Male and Female Condoms

The male condom is a mechanical barrier method of contraception. The failure rate at the end of first-year use for the male latex condom is 3% with perfect use and as much as 14% with typical use.[43] Latex condoms significantly reduce the transmission of some STIs and, therefore, should be used by all sexually active adolescents regardless of whether an additional method of contraception is used. Male condoms have several other advantages for adolescents, including involving males in the responsibility of contraception, easy accessibility and availability to minors, use without a prescription, and low cost.[44] Polyurethane condoms can be used by adolescents with a documented latex allergy; however, latex condoms are preferred, because they have a higher efficacy rate with typical use than polyurethane condoms.[43] Some adolescents may have local reactions to condoms that have been pretreated with spermicide and should be counseled that condoms without these agents are also available. Nonoxynol-9 is the only chemical agent in spermicidal products available in the United States; there are nonspermicidal hypoallergenic lubricants available over the counter. Only water-based lubricants may be used with latex condoms, and both water- and oil-based products may be used with polyurethane condoms.[44] Currently, there is a general movement away from products with nonoxynol-9 because of concerns that use increases risk of genital ulceration and irritation, which may facilitate the acquisition of STIs.[44] Condom use reported at most recent intercourse by females was 54% and by males was 71%, which is an increase in the last decade.[20] Surveys of high school students over the last decade indicate that condom use has increased, with condom use at last intercourse increasing from 46.2% in 1991 to 62.8% in 2005.[3]

The female condom, another barrier method of contraception, provides contraceptive efficacy in the same range as other barrier methods, such as the diaphragm and cervical cap (with typical use).[45] One trial of the most widely available female condom on the market yielded a failure rate of 0.8% with perfect use and between 12% and 15% with typical use.[46] The female condom also helps protect against STIs. Adolescents' concerns about using a female condom include difficulty of insertion, higher cost than male condoms, and appearance and noisiness of the device. Female adolescents

have reported that the female condom could be useful if their male partners did not want to use a condom. Further education on using the female condom is needed for both genders. For adolescents who already use male condoms, it is important to market the female condom as an alternative contraceptive choice, because male and female condoms should not be used simultaneously.[47] Male condoms are preferred over female condoms because of higher efficacy rates of preventing pregnancy and STIs and lower cost.

Vaginal Spermicides

Vaginal spermicides are a chemical barrier method of contraception applied intravaginally through a variety of forms: gel, foam, suppository, or film. Spermicides consist of 2 components: a formulation (the gel, foam, suppository, or film) and the chemical ingredient that kills the sperm (eg, nonoxynol-9). As with any barrier method, the effectiveness of spermicides depends on consistent and correct use. The combination of vaginal spermicide and condoms is a very effective means of contraception for adolescents, because it provides effective prevention of pregnancy, reduces the risk of contracting an STI, is available without a prescription, and is inexpensive.[48]

There has been a question as to whether use of nonoxynol-9 alone provides adequate protection against STIs and HIV. In high doses, nonoxynol-9 can irritate the vaginal lining, which makes young women more susceptible to HIV transmission. The Centers for Disease Control and Prevention have concluded that women should be discouraged from using nonoxynol-9 alone for STI and HIV protection, because 1 study found that a product containing nonoxynol-9 did not protect against HIV infection and may have caused an even greater likelihood of transmission as compared with a vaginal lubricant.[49,50] Use of spermicide alone is not advocated as a contraceptive method; condoms must be used in conjunction with vaginal spermicides for protection against STIs

Oral Contraceptives

OCPs are a reliable, effective method for the prevention of pregnancy, are available only by prescription in the United States, and are the most popular method of prescribed contraceptive among adolescents.[21] Of the 2.7 million adolescent women who use contraceptives, 44% rely on the pill.[51] The Youth Risk Behavior Surveillance Summary reported that in both males and females who had sexual intercourse during the 3 months before the survey, the percentage who used birth control pills to prevent pregnancy during last sexual intercourse was 17.6% in 2005, down from 20.8% in 1991.[3]

Three forms of OCPs are currently available: the fixed-dose, monophasic combination (each tablet contains the same dose of estrogen and progestin); the phasic dose (the triphasic and biphasic packs that contain varying doses of estrogen and progestin); and the minipill (which contains progestin only). Many of the newer forms of birth control pills have a low dose of estrogen (20–35 μg) and contain new forms of progestin. These low-dose pills are typically the "first-line" therapy for OCP initiation. There is theoretic potential for lowered efficacy of low-dose OCPs in patients who are taking some medications. Some common medications that increase the metabolism of synthetic steroids by increasing conjugation in the gut and enzyme induction in the liver are listed in Table 1.[52–54] In this clinical situation, prescription of OCPs that contain 50 μg of ethinyl estradiol or switching to a hormonal method that avoids first-pass metabolism, such as injectable progestin, may be indicated; efficacy of transdermal or intravaginal contraceptives with these medications are not known. Generally, the standard 28-day pack of pills (21 days of hormone and 7 days of placebo) is prescribed for teens, and daily compliance is encouraged, particularly over the 21 days of hormone-containing pills to maximize efficacy and minimize bleeding irregularities.[55] The 21-day packs, if available, are better for adolescents who are taking OCPs in continuous or extended cycles.

The US Food and Drug Administration (FDA) recently approved a monophasic 30-μg ethinyl estradiol/0.15-mg levonorgestrel pill for extended cycling called Seasonale (Barr Pharmaceuticals, Woodcliff Lake, NJ). This formulation provides 84 days of continuous hormonally active pills followed by 7 days of placebo. This formulation may be particularly appropriate for adolescents with medical conditions such as anemia, severe dysmenorrhea, endometriosis, dysfunctional uterine bleeding, or Von Willebrand and other bleeding diatheses and adolescents who prefer amenorrhea.[56] In addition, adolescents who frequently miss OCPs may have lower failure rates when using continuous or extended regimens of OCPs with shorter or no placebo intervals.

TABLE 1 Medications That Decrease OCP Efficacy

Antibiotics
Rifampin (Rifadin, Rimactane)
Anticonvulsants
Felbamate (Felbatol)
Ethosuximide (Zarontin)
Primidone (Mysoline)
Phenobarbital (Solfoton, Barbita, Luminal)
Phenytoin (Dilantin, Phenytek)
Carbamazepine (Tegretol)
Oxcarbazepine (Trileptal)
Topiramate (Topamax)
Antidepressants
St John's wort
Antifungal agents
Griseofulvin (Fulvicin, Grifulvin, Grisactin, Gris-PEG)
Anti-HIV drugs
Protease inhibitors
Nonnucleoside reverse transcriptase inhibitors

The noncontraceptive benefits of OCP use include improvement in acne and decreased menstrual cramping, pain, blood loss, and ovarian cysts. OCP use that exceeds 3 years provides significant protection against endometrial and ovarian cancers. Overall, observational data indicate that OCP use does not increase risk of breast cancer. Adverse effects include nausea, breast tenderness, headaches, and breakthrough bleeding. OCPs are one of the best-studied medications ever prescribed and are a safe option throughout a woman's reproductive years, because the method is completely reversible and has no negative effect on long-term fertility.[57]

OCPs have a failure rate of 0.1% when used perfectly. However, failure rates range between 5% and 8% with typical use and for adolescents may reach 15% to 26% because of noncompliance.[58] Adolescents may have difficulty complying with OCPs because of forgetfulness, attempts to hide contraception from parents, and inconsistency of sexual relations, among other reasons. The National Survey on Family Growth reported that as many as 42% of adolescents 15 to 19 years of age missed 2 or more pills in a 3-month period.[57] Adolescent compliance with OCP use may be enhanced by appropriate patient education and problem-solving techniques, which includes careful instruction regarding the use of OCPs; anticipatory guidance about adverse effects and their management; a discussion of correct pill usage (including when the first pill should be taken during the menstrual cycle or what to do if a pill or pills are late or missed); use of emergency contraception; and frequent follow-up and monitoring. Patients should also be encouraged to use condoms in conjunction with OCPs to provide protection against STIs and additional pregnancy prevention. In addition, when possible, involving the patient's mother can greatly enhance compliance with pill taking.[59]

OCPs have few contraindications in healthy female adolescents. Estrogen-containing OCPs are contraindicated for those with a history of thromboembolism or thrombophilia (ie, factor V Leiden mutation or protein C, protein S, or antithrombin III deficiencies); cyanotic heart disease or pulmonary artery hypertension; systemic lupus erythematosus associated with antiphospholipid antibody syndrome or renal disease, particularly associated with hypertension; or hepatic dysfunction. Patients who are taking anticonvulsant medications and HIV medications need to be counseled carefully and may be encouraged to use injectable progestins (Table 1).

Adolescents need not receive a complete gynecologic examination by the pediatrician before initiating OCPs or any other hormonal contraceptive method.[60] In most circumstances, the pelvic examination may be deferred and OCPs may be prescribed if the patient is healthy, is not pregnant, and has no contraindications to taking the pills. An inspection of the external genitalia and either a urine screen or vaginal swab for STIs may be substituted for a pelvic examination as a screening for initiation of contraceptive use. A pelvic examination is indicated for most situations in which abdominal pain is part of the presenting complaint in a sexually experienced adolescent. Sexually active female adolescents should be screened for STIs, especially chlamydia, at least annually and preferably with each new sexual partner.[61] Guidelines from the American Cancer Society and the American College of Obstetricians and Gynecologists recommend initiation of Papanicolaou (Pap) test screening within 3 years of first intercourse (whether consensual or nonconsensual) or by 21 years of age.[62]

Injectable Hormonal Contraception

Depot medroxyprogesterone acetate (DMPA) injection is a long-acting progestin that is given every 12 weeks (11–13 weeks) as a single 150-mg intramuscular dose. This method of contraception, also known by the brand name Depo-Provera (Pfizer, New York, NY), is highly effective in preventing pregnancy. In the first year of use, the probability of becoming pregnant is approximately 0.3%.[63] Available since 1992 in the United States, some experts believe that the use of this method since 1992 among adolescents who are at high risk of becoming pregnant is one factor responsible for the declining rates of adolescent pregnancy in the United States.[17] This method is convenient for women who do not want to have to remember to take their pill each day, cannot use the patch, or cannot use a contraceptive at the actual time of intercourse.[16] Other advantages include lack of estrogen-related adverse effects and, similar to OCPs, protection against endometrial cancer and iron-deficiency anemia.[64]

The major disadvantage of this contraceptive method for adolescents are menstrual cycle irregularities (present for nearly all patients initially), the need for intramuscular administration every 11 to 13 weeks, and potential adverse effects including acne, weight gain, headaches, and bloating. A new formulation, which is administered subcutaneously, contains 104 mg of medroxyprogesterone acetate (Depo-Subq Provera 104 [Pfizer]), and is given on the same dosing schedule as the intramuscular formulation, is now available. The subcutaneous route makes home administration of Depot-Provera possible, although there have been no studies of home use in the adolescent population. The lower dose could decrease suppression of pituitary function and ovarian estradiol production, although no conclusive data are yet available to indicate such an effect.[65] Two large open-label phase-3 studies have found subcutaneous DMPA to be equally effective as intramuscular DMPA; however, the irregular uterine bleeding that many patients complain of after initiating the drug also accompanies subcutaneous use. As with the intramuscular route, this adverse effect largely resolves over the

first year of use: amenorrhea increased from 26% of patients in month 3 of use to 55% during month 12.[66]

In addition to uterine bleeding irregularities, DMPA use over a prolonged period is associated with a delayed return to fertility, typically 9 to 18 months, while the endometrial lining returns to its pre-DMPA state and ovulatory function returns. Both subcutaneous and intramuscular DMPA show similar delays to fertility after injection.[67] However, for adolescent patients, such a delay does not usually pose a major deterrent to using this method. Both intramuscular and subcutaneous DMPA may be safely recommended for adolescents who have chronic illnesses (eg, seizures, sickle cell disease), are lactating, or are at risk of estrogen-related complications.[64]

Pediatricians should discuss potential adverse effects. Studies have shown that patients are more likely to continue DMPA use if they are counseled about potential irregular bleeding before their first injection, but these studies did not target adolescents specifically.[68] Clinicians must also ensure that the patient is not pregnant at the time of the initial injection and at each injection that occurs at an interval greater than 12 weeks.

Because DMPA suppresses circulating estradiol concentrations, it causes reductions in bone mineral density (BMD), which has generated some concern regarding the long-term effects. A prospective cohort study of adolescents aged 12 to 18 years found that BMD decreased 3.1% after 2 years of DMPA use, whereas BMD increased 9.5% in the controls who were using no hormonal method of contraception.[69] Some other studies have indicated an adverse impact on biochemical markers of bone formation and resorption as well as the decreased BMD.[70–72] In response to these concerns, the FDA issued a "black-box" warning regarding the risk of decreased BMD among DMPA users in November 2004.[73] Currently, the warning recommends limiting the use of DMPA to 2 years and using DMPA as long-term contraception only if other methods are inadequate. The warning also emphasized the lack of certainty regarding peak BMD attained later in life among users of DMPA, but experts think such a restriction may be unwarranted, especially for patients with no other alternatives for contraception. A recently published study of teens and young adult women documented complete recovery of BMD after DMPA use, thus offering some degree of reassurance about use not affecting long-term skeletal health of adolescent patients.[74] In addition, an increased incidence of fractures has not been reported in adolescents using DMPA.

It is important to consider other risk factors for osteoporosis and to tailor counseling and recommendations to each patient. Factors such as small body habitus, chronic alcohol or tobacco use, eating disorders, or illness that necessitates chronic use of corticosteroids may lead a clinician to recommend against DMPA use more strongly. All patients should be encouraged to include foods and/or supplements to ensure intake of at least 1300 mg of calcium each day along with 400 IU of vitamin D, to participate in weight-bearing exercise regularly, and to stop smoking as important measures to promote skeletal health. Using supplemental estrogen has been observed to prevent loss of BMD in 1 study of teens, whereas the use by teens of antiresorptive medications prescribed for postmenopausal women is definitely not recommended.[75] As with all hormonal methods of contraception, condoms should be used in conjunction with DMPA for protection from STIs.

Another injectable hormonal contraceptive (known by the product name Lunelle [previously manufactured by Pharmacia & Upjohn, Kalamazoo, MI]) combined estrogen and medroxyprogesterone acetate. Lunelle was made available in the United States after confirmation of safety in clinical trials in the United States and internationally. However, Lunelle was voluntarily withdrawn from the market by its manufacturer in September 2002 because some doses may not have contained enough hormone to prevent pregnancy. Women who used Lunelle required monthly clinic visits for the injection of medications. Adverse effects were similar to those of Depo-Provera and included weight gain, menstrual irregularity, headaches, and breast tenderness, although adverse effects were fewer than in trials with DMPA alone.[76,77] A general acceptance of and overall satisfaction with Lunelle by women in clinical trials suggested that this method was widely accepted, but its return into the market is not expected in the future.

Progestin Implants

Levonorgestrel implants, also known by the brand name Norplant (previously manufactured by Wyeth-Ayerst Laboratories, St Davids, PA), were highly effective long-acting progestin-only contraceptives that provided pregnancy prevention for up to 5 years. These implants required insertion of subcutaneous polymeric silicone capsules into the upper arm by a trained health care professional. The 6-rod Norplant system was the first progestin implant available in the United States but has been permanently removed from the US market.[78] Implanon (Organon USA, Roseland, NJ), a single-rod implant that contains etonogestrel, the active metabolite of desogestrel, has been used in Europe since 1998 and is now available in some areas of the United States. Highly effective (in clinical trials, no unintended pregnancies were reported in ~73 000 cycles), Implanon may remain in place for 3 years, but it is associated with irregular bleeding in many users, especially during the first year of use.[63]

Levonorgestrel implants are ideal for adolescents who desire an extended length of protection, feel unable to remember to take OCPs, or have already had 1 preg-

nancy. It is also an excellent contraceptive option for females who may have difficulty remembering to use a contraceptive on a daily basis or at the time of intercourse. The major disadvantages for use in the adolescent population include high initial cost and potential adverse effects such as breakthrough bleeding and headaches. The drugs listed in Table 1 also impair the efficacy of levonorgestrel implants. The difficulty of removal of the implant, in combination with these other disadvantages, made Norplant an unpopular form of contraception for adolescents, and although Implanon is easier to remove, it shares many of Norplant's adverse effects. In addition, condoms must be used in conjunction with progestin implants for protection against STIs.[63]

Other Combined Hormonal Contraceptive Methods (NuvaRing and Ortho Evra)

The vaginal ring (NuvaRing [Organon USA]; 15 μg ethinyl estradiol/120 μg etonogestrel) is a round, flexible device that measures 54 mm in outer diameter and 4 mm cross-sectionally; it is inserted in the vagina and stays in place for 3 weeks, with removal for 1 week to induce menstruation followed by insertion of a new ring. This soft silicone vaginal ring releases both estrogen and progestin hormones that protect against pregnancy for 1 month. The ring has been shown to have greater than 99% efficacy when used correctly by adult women. However, trials with adolescent populations have not been conducted. Compliance with the ring is high, and few adverse effects are experienced. Adverse effects would be the same as other combined hormonal methods, which include breast tenderness, headaches, nausea, and some breakthrough bleeding/spotting and an increased risk of the more serious condition of thrombotic events; local adverse effects may include vaginal symptoms of discharge, discomfort, and device problems.[55]

The combination hormonal transdermal adhesive skin patch (Ortho Evra [Ortho-McNeil Pharmaceutical, Raritan, NJ]) can be applied to the abdomen, upper torso, upper outer arm, or buttocks weekly by using 1 patch for each of 3 weeks in a row, followed by 1 week off the patch, during which a withdrawal bleed usually occurs. While in place, the 4.5-cm^3 contraceptive patch delivers 150 μg of norelgestromin and 20 μg of ethinyl estradiol daily. Efficacy rates from 1 study suggested that the overall annual probability of pregnancy was 0.8%, whereas the method failure probability was 0.6%, similar across age and racial groups.[55]

One study reported that women who use the patch are no more likely to become pregnant than women who use a combination OCP. At least 1 study indicated a higher rate of local adverse effects with adolescents who use the patch than with older patients; these effects include patches dislodging as well as irritation and hyperpigmentation.[79–81] Very concrete counseling regarding patch placement with adolescent patients, and perhaps even demonstration of initial placement, is helpful.[81]

Although compliance with using the patch is improved compared with OCPs, the risk of pregnancy with correct use of the patch was higher for women who weigh more than 198 pounds (0.9% in first 12 months of use) compared with women who weigh less (0.3%).[82,83] Obviously, the risks of pregnancy must be discussed as methods are considered; a pregnancy rate of 1% at the end of 1 year in a patient who weighs more than 200 pounds, refuses other methods, and chooses to remain sexually active is a more acceptable alternative than a pregnancy risk of 85% with no protection. For issues related to compliance, the added value of the patch should be considered. It has demonstrated increased compliance, which results in fewer contraceptive failures. Other possible adverse effects of combined hormone methods include temporary irregular bleeding, temporary breast discomfort, weight gain or loss, and nausea.

The most concerning possible adverse effect of transdermal contraception or any combined hormone method is risk of thrombotic events. In the large clinical trials of the transdermal contraceptive patch, 1 case of nonfatal pulmonary embolism occurred during use of the patch, and 1 case of postoperative nonfatal pulmonary embolism was reported. Recently, the higher bioavailability of estrogens delivered transdermally has prompted Ortho McNeil Pharmaceutical to issue a warning specifically related to risk of thrombotic events in Ortho Evra users.[84] An increased risk of venous thromboembolic disorders has been associated with the use of combination hormonal oral contraceptives compared with nonusers; generally, increases in rates by a factor of 3 to 6 have been reported in studies that evaluated healthy young women who had no other risk factors. A review of studies compared the risk of nonfatal venous thromboembolism (VTE) among different OCPs. The authors found that users of OCPs containing desogestrel, a third-generation progestin, had an increased risk compared with users of OCPs containing levonorgestrel.[85] Thus, a baseline risk for VTE of 1 per 10 000 person-years is increased to 3 to 4 per 10 000 person-years during the time when oral contraceptives are being used.[85] The risk is much greater in those over age 35 and those who smoke, especially if cigarette use equals or exceeds 15 cigarettes daily. Although smoking should be discouraged for teens and young adults, smoking and use of combined hormone methods of contraception are not contraindicated in this age group.[86] Whether the patch places teens and women at increased risk of VTEs compared with combined hormone OCPs is not known, because 2 different studies with different methodologies had different outcomes.[87] No studies to date have directly examined whether the patch increases the risk of

thrombotic events compared with other types of estrogen-containing methods. The risk of VTE is slightly elevated but still quite low for anyone on an estrogen-containing method compared with not being on a method. The risk of VTE associated with pregnancy should be weighed against the risks of the patch or any combined hormone method. Compared with the risk of VTE during pregnancy, risk of VTE associated with combined hormone methods is considered lower in healthy young women.[55]

As with oral or transvaginal combined contraceptives, condoms must be used in conjunction with each method for protection against STIs.

Intrauterine Devices

Intrauterine devices (IUDs) are inserted into the uterus and release hormones, ions, or enzymes that prevent sperm from fertilizing the ova or prevent implantation. The effectiveness of IUDs is influenced by several factors, including size of the IUD surface area and the type of IUD used. When used appropriately, IUDs are generally safe, effective methods of contraception with a failure rate of less than 1%. Condoms must be used in conjunction with IUDs for protection against STIs. IUDs have previously not been recommended for adolescents; risk of infection in teens (who often have multiple partners or are serially monogamous) and liability concerns (a patient who has not conceived before using an IUD may attribute future infertility to IUD use) have contributed to clinicians' reluctance to prescribe this method for adolescent patients. IUDs have not been shown to affect fertility in the absence of infection; however, STI rates in adolescent populations are certainly cautionary. In some cases, however, an IUD may be appropriate for an adolescent who already has children and is taking precautions to protect against STIs. Mirena (Berlex, Montville, NJ), a newly developed IUD that contains the progestin levonorgestrel, gradually releases the progestin over an effective period of 5 years and has a failure rate of 0.3%. This IUD may be particularly useful for adolescents with severe menorrhagia and dysmenorrhea, as has been shown in adult women. Also available is the copper IUD called ParaGard, which releases a small amount of copper that kills or immobilizes sperm before they can fertilize an egg. The ParaGard can be removed at any time but should be replaced after 10 years.[88]

Diaphragm and Cervical Cap

The diaphragm and cervical cap are barrier methods of contraception that also require use of a spermicide. Diaphragms are flexible latex cups that are inserted into the vagina before intercourse and must remain in place for 6 hours after intercourse. Cervical caps are latex or silicone cups with a firm rim that adhere to the cervix and provide continuous contraceptive protection for up to 48 hours. Because of risk of toxic shock syndrome, caps should not remain for more than 48 hours.[89] Consistent, correct use of these methods is critical for achieving a high rate of effectiveness. The failure rate of the diaphragm with perfect use is 6% and with typical use is 20%; for the cervical cap, the failure rate is 26% with perfect use and 40% with typical use.[89] These contraceptive methods may not be feasible for some adolescents, because they require a prescription and visit with a health care professional for a fitting, because 1 size does not fit all. The adolescent must also be comfortable and skilled with insertion. Incidence of urinary tract infection increases over baseline with both diaphragms and cervical caps; in addition, condoms must be used in conjunction with these devices for protection against STIs.[89]

Withdrawal

The withdrawal method, which involves the male partner's attempt to withdraw the penis before ejaculation, is still widely used by adolescents in sexual relationships. Adolescents should receive counseling that emphasizes the high failure rate of withdrawal for pregnancy prevention. On average, of every 100 women whose partners use withdrawal, 19 will become pregnant during the first year of typical use. It is important to stress that preejaculatory fluid can contain enough sperm to cause pregnancy. Pregnancy is also possible if semen or preejaculate leaks out onto the vulva. In addition, providers should stress that this contraceptive method does not provide protection against STIs.[90]

Fertility Awareness and Other Periodic Abstinence Methods

Using fertility-awareness methods as a contraceptive option depends on several factors and requires a strong knowledge of the menstrual cycle and reproductive fertility. This method involves the identification of fertile days within each menstrual cycle when intercourse is most likely to result in pregnancy. Couples can abstain during the fertile times of a woman's cycle or use a combination of either barrier or withdrawal methods. As many as 25% of users of these methods will experience an unintended pregnancy within the first year of use, with some estimates of the pregnancy rate even higher.[91] To optimize method efficacy, users of this method should track their menses on a calendar for 3 months while also checking and recording their basal body temperature daily and should check their cervical mucus consistency to track when they ovulate. Pediatricians should be prepared to teach adolescents about the menstrual cycle but should emphasize that ovulation may not be predictable in the first few year(s) after menarche. Thus, abstinence or more reliable methods should be recommended for adolescents. In addition, health care professionals should stress that this contraceptive method provides no protection against STIs if no barrier methods are used during periods of sexual activity.

Emergency Contraception

Emergency contraception can be administered in 2 ways: by orally administering hormones or by inserting a copper-releasing IUD. An IUD can be inserted to prevent pregnancy up to 5 days after unprotected intercourse but is usually not recommended for adolescents (see IUD section).

The most commonly prescribed and best-studied methods of emergency contraception are the combined estrogen-progestin (also called the Yuzpe regimen) and progestin-only regimens. There is now only 1 dedicated product for emergency contraception: Plan B (DuraMed Pharmaceuticals, Pomona, NY). Plan B, a progestin-only regimen that contains levonorgestrel, is widely available as 2 hormone pills that are taken within 72 hours of unprotected intercourse. The most recent data support extending the time limit of use to 120 hours after unprotected intercourse; however, emergency contraception's efficacy diminishes as hormonal administration becomes more remote from the unprotected intercourse event.[92–94] Adolescent patients especially should be counseled that Plan B is 90% effective if used within 24 hours, 75% effective if used within 72 hours, and approximately 60% effective if used within 120 hours. The Plan B regimen can now be simplified to give both tablets at one time without sacrificing efficacy or resulting in more adverse effects.[94] Combination OCPs may be used for emergency contraception when Plan B is not readily available; the dose depends on the specific product chosen.[95] A recent study found that combination OCPs with progestin norethindrone can also be used effectively for emergency contraception. This study found that even a single dose of the oral contraceptives or combined hormone method was effective for emergency contraception.[96] Adverse effects may include nausea, vomiting, and changes in the menstrual cycle during the month of use. The progestin-only regimen is generally preferred, because it is more effective and causes fewer adverse effects.[97,98] Overall, emergency contraceptives reduce the risk of pregnancy after unprotected sex by at least 74%.[99,100]

Most women who need emergency contraception can use it safely. If the patient or practitioner suspects pregnancy, a pregnancy test can be administered; however, pregnancy testing before emergency contraceptive use is not necessary. It is important to note that emergency contraception does not cause abortion and it is not teratogenic if taken in early pregnancy. Women who are already pregnant should not use emergency contraceptives because they are ineffective at terminating established pregnancies; however, using them inadvertently will not have an adverse effect on the fetus.[99] Six studies have found that providing emergency contraception in advance increases the likelihood of women using it when it is needed and does not increase sexual or contraceptive risk-taking behavior.[101–106]

As the AAP states in its policy statement on emergency contraception, reduction of unintended pregnancy is best achieved by strategies that include developing and implementing programs to help delay and reduce sexual activity and increasing the use of effective contraceptives.[95] However, the AAP continues to support improved availability of emergency contraception to adolescents and advocates clinicians' consideration of advance emergency contraception prescription to sexually active adolescents, recognizing that in some cases, emergency contraception may be quite valuable in preventing unintended pregnancy and that emergency contraception is most effective when used soon after unprotected intercourse.[95] Recently, the FDA approved over-the-counter access for Plan B for women 18 years and older, but Plan B still requires a prescription for those younger than 18 years.[107] In view of the potential value of emergency contraception, pediatricians should inform adolescents about the availability of emergency contraception; however, it should not be advocated as a routine method of contraception.

Newer Forms/Formulations of Contraception

The FDA recently approved the first chewable OCP, Ovcon 35 (Bristol Myers Squibb Company, Princeton, NJ), a spearmint-flavored, 28-day regimen pill that contains the same hormones used in standard OCPs. Women who chew the pills instead of swallowing them should drink 8 oz of liquid afterward to ensure that the full dose reaches the stomach.[108] Another method recently approved by the FDA is the FemCap, a soft silicone dome that covers the cervix. FemCap will be available by prescription in 3 sizes and is designed to last 48 hours per use.[89,109] New forms of contraception for males are also being studied, including an implantation system similar to Norplant, weekly and monthly hormone injections, and a contraceptive patch.[110] A progestin-only vaginal ring is being developed, and Norplant II (a 2-rod system as opposed to the 6-rod system in Norplant) is awaiting FDA approval. Condoms must be used in conjunction with these new forms of contraception for protection against STIs.

COMPLIANCE AND FOLLOW-UP

Frequent follow-up is important to maximize compliance for all methods of contraception, to promote and reinforce healthy decision-making, and to screen periodically for risk-taking behaviors and STIs. Follow-up visits should include periodic examinations, reassessment for contraception method, STI surveillance, and cervical cytologic screening (Papanicolaou test) when appropriate. The timing and frequency of reassessment will vary depending on the contraceptive method. In general, sexually active adolescents should have annual STI screening with consideration for repeat screening for chlamydia 3 to 6 months after a positive test result and

treatment and/or with each new partner.[111] Regularly scheduled visits need to occur to assess contraceptive issues such as use, compliance, adverse effects, and complications. Adolescents should receive ongoing support, personal guidance, and reinforcement to enhance effective and consistent contraceptive use, parental support (when possible), and couples counseling or the opportunity for couples interaction with the health care professional. In addition, condom use at each sexual intercourse must be advised and reinforced at every visit.

RECOMMENDATIONS

1. Pediatricians should encourage sexual abstinence as part of comprehensive sexuality education and services offered to their adolescent patients.
2. Pediatricians should be prepared to offer confidential, nonjudgmental education and risk-reduction counseling around issues of sexuality for adolescent patients, including teens with chronic illnesses and/or disabilities.
3. Pediatricians should be aware that extensive information regarding contraceptive choices and decisions for adolescents with chronic illness or disability are available in references and texts on adolescent medicine (see "Additional Resources").
4. Pediatricians should update each patient's sexual history regularly to counsel about and determine risk of STIs as well as needs for contraceptive initiation and management.
5. Time to counsel, educate, and solve problems regarding contraceptive needs and/or management needs to be a part of any given visit, or arrangements need to be made for a separate visit for contraceptive follow-up.
6. Pediatricians should encourage the consistent and correct use of latex condoms with every event of sexual intercourse.
7. Pediatricians should know that it is appropriate to prescribe contraceptives without a "first pelvic examination," but screenings for STIs, especially chlamydial infections, should not be delayed.
8. Pediatricians should ensure access to basic contraceptive services for their teen patients either within their office setting or by referral to appropriate services and/or sites.
9. Pediatricians who offer contraceptive services to adolescents should provide appropriate follow-up to ensure compliance and monitor for adverse effects and complications.

REFERENCES

1. Haignere CS, Gold R, McDanel HJ. Adolescent abstinence and condom use: are we sure we are really teaching what is safe? *Health Educ Behav.* 1999;26:43–54
2. Brückner H, Bearman P. After the promise: the STD consequences of adolescent virginity pledges. *J Adolesc Health.* 2005; 36:271–278
3. Klein JD; American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy: current trends and issues—2005. *Pediatrics.* 2005;116:281–286
4. National Youth Risk Behavior Survey: 1991–2005. Trends in the prevalence of sexual behaviors. Available at: www.cdc.gov/healthyyouth/yrbs/pdf/trends/2005_YRBS_SexualBehaviors.pdf. Accessed May 18, 2007
5. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance: United States, 1999. *MMWR Surveill Summ.* 2000;49(SS-5):1–32
6. Eaton DK, Kann L, Kinchen S, et al. Youth Risk Behavior Surveillance: United States, 2005. *MMWR Surveill Summ.* 2006;55(5):1–108
7. Hamilton BE, Martin JA, Ventura SJ, Sutton PD, Menacker F. Births: preliminary data for 2004. *Natl Vital Stat Rep.* 2005;54: 1–17
8. Alan Guttmacher Institute. Facts on induced abortion in the United States 05/2006. Available at: www.guttmacher.org/pubs/fb_induced_abortion.html. Accessed May 18, 2007
9. Jones RK, Darroch JE, Henshaw SK. Patterns in the socioeconomic characteristics of women obtaining abortions in 2000–2001. *Perspect Sex Reprod Health.* 2002;34:226–235

10. Singh S, Darroch JE. Trends in sexual activity among adolescent American women: 1982–1995. *Fam Plann Perspect.* 1999; 31:212–219
11. Alan Guttmacher Institute. *Fulfilling the Promise: Public Policy and US Family Planning Clinics.* New York, NY: Alan Guttmacher Institute; 2000
12. Santelli JS, Lindberg LD, Finer LB, Singh S. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *Am J Public Health.* 2007;97:150–156
13. Sexuality Information and Education Council of the United States. *Issues and Answers: Sexuality Education Fact Sheet.* New York, NY: Sexuality Information and Education Council of the United States; 2001. Available at: www.siecus.org/pubs/fact/FS_issues_answers.pdf. Accessed May 18, 2007
14. Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy.* Washington, DC: National Campaign to Prevent Teen Pregnancy; 2001. Available at: www.teenpregnancy.org/about/announcements/campaign_update/sum01/default.asp. Accessed July 6, 2007
15. Kirby DB, Laris BA, Rolleri LA. Sex and HIV education programs: their impact on sexual behaviors of young people throughout the world. *J Adolesc Health.* 2007;40:206–217
16. Darroch JE, Singh S, Frost JJ. Differences in teenage pregnancy rates among live developed countries: the roles of sexual activity and contraceptive use [published correction appears in *Fam Plann Perspect.* 2002;34:56]. *Fam Plann Perspect.* 2001;33:244–250, 281
17. Guttmacher S, Lieberman L, Ward D, Freudenberg N, Radosh A, Des Jarlais D. Condom availability in New York City public high schools: relationships to condom use and sexual behavior. *Am J Public Health.* 1997;87:1427–1433
18. Kirby D, Barth RP, Leland N, Fetro JV. Reducing the risk: impact of a new curriculum on sexual risk-taking. *Fam Plann Perspect.* 1991;23:253–263
19. Zabin LS, Hirsch MB, Smith EA, Streett R, Hardy JB. Evaluation of a pregnancy prevention program for urban teenagers. *Fam Plann Perspect.* 1986;18:119–126
20. Abma JC, Martinez GM, Mosher WD, Dawson BS. Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. *Vital Health Stat 23.* 2004;(24):1–48
21. Santelli JS, Lindberg LD, Abma J, McNeely CS, Resnick M. Adolescent sexual behavior: estimates and trends from four nationally representative surveys. *Fam Plann Perspect.* 2000; 32:156–165, 194
22. Brooks-Gunn J, Furstenberg FF Jr. Adolescent sexual behavior. *Am Psychol.* 1989;44:249–257
23. DiClemente RJ, Wingood GM, Crosby R, et al. Parental monitoring: association with adolescents' risk behaviors. *Pediatrics.* 2001;107:1363–1368
24. Moore PJ, Adler NE, Kegeles SM. Adolescents and the contraceptive pill: the impact of beliefs on intentions and use. *Obstet Gynecol.* 1996;88(3 suppl):48S–56S
25. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. *JAMA.* 2002;288:710–714
26. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence. Sexuality education for children and adolescents. *Pediatrics.* 2001;108:498–502
27. Beach RK. Contraception for adolescents: part I. *Adolesc Health Update.* 1994;7:1–10
28. American Medical Association, Council on Scientific Affairs. Confidential health services for adolescents. *JAMA.* 1993;269: 1420–1424
29. English A, Kenny KE. *State Minor Consent Laws: A Summary.* 2nd ed. Chapel Hill, NC: Center for Adolescent Health & the Law; 2003
30. Pete-McGadney J. Differences in adolescent self-concept as a function of race, geographic location, and pregnancy. *Adolescence.* 1995;30:95–105
31. Robin L DP, Whitaker D, Crosby R, et al. Behavioral interventions to reduce incidence of HIV, STD, and pregnancy among adolescents: a decade in review. *J Adolesc Health.* 2004; 34:3–26
32. Escobar-Chaves SL TS, Markham CM, Low BJ, Eitel P, Thickstun P. Impact of the media on adolescent sexual attitudes and behaviors. *Pediatrics.* 2005;116:303–326
33. Paradise JE, Cote J, Minsky S, Lourenco A, Howland J. Personal values and sexual decision-making among virginal and sexually experienced urban adolescent girls. *J Adolesc Health.* 2001;28:404–409
34. DiCenso A, Borthwick VW, Busca CA, et al. Completing the picture: adolescents talk about what's missing in sexual health services. *Can J Public Health.* 2001;92:35–38
35. Martyn KK, Martin R. Adolescent sexual risk assessment. *J Midwifery Womens Health.* 2003;48:213–219
36. Blum RW. Sexual health contraceptive needs of adolescents with chronic conditions. *Arch Pediatr Adolesc Med.* 1997;151: 290–297
37. Cheng MM, Udry JR. Sexual behaviors of physically disabled adolescents in the United States. *J Adolesc Health.* 2002;31: 48–58
38. Donovan P. School-based sexuality education: the issues and challenges. *Fam Plann Perspect.* 1998;30:188–193
39. Trenholm C, Devaney B, Fortson K, et al. *Impacts of Four Title V, Section 510 Abstinence, Education Programs—Final Report.* Princeton, NJ: Mathematica Policy Research Inc; 2007
40. Ott M, Labbett R, Gold M. Tips for clinicians: counseling adolescents about abstinence in the office setting. *J Pediatr Adolesc Gynecol.* 2007;20:39–44
41. Jemmott JB III, Jemmott LS, Fong GT. Abstinence and safer sex HIV risk-reduction interventions for African American adolescents: a randomized controlled trial. *JAMA.* 1998;279: 1529–1536
42. Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Arch Pediatr Adolesc Med.* 1999; 153:226–234
43. Frezieres RG, Walsh TL, Nelson AL, Clark VA, Coulson AH. Evaluation of the efficacy of a polyurethane condom: results from a randomized, controlled clinical trial. *Fam Plann Perspect.* 1999;31:81–87
44. Warner L, Hatcher RA, Steiner MJ. Male condoms. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology.* 18th Revised ed. New York, NY: Ardent Media Inc; 2004:331–353
45. Masters T, Everett S. Intrauterine and barrier contraception. *Curr Obstet Gynaecol.* 2002;12:28–34
46. Trussell J. Contraceptive efficacy of the Reality female condom. *Contraception.* 1998;58:147–148
47. Haignere CS, Gold R, Maskovsky J, Ambrosini J, Rogers CL, Gollub E. High-risk adolescents and female condoms: knowledge, attitudes, and use patterns. *J Adolesc Health.* 2000;26: 392–398
48. Emans SJ, Laufer MR, Goldstein DP. *Pediatric and Adolescent Gynecology.* 5th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2005
49. Centers for Disease Control and Prevention. CDC statement on study results of product containing nonoxynol-9. *JAMA.* 2000;284:1376
50. van Damme L. Advances in topical microbicides (abstract

TuPpC1171). Presented at: the 13th International AIDS Conference; July 9–14, 2000; Durban, South Africa
51. Alan Guttmacher Institute. *Facts in Brief: Contraceptive Use—Who Needs Contraception?* New York, NY: Alan Guttmacher Institute; 2000. Available at: www.agi-usa.org/pubs/fb_contr_use.html. Accessed May 18, 2007
52. Back DJ, Breckenridge AM, Crawford FE, et al. The effect of rifampicin on the pharmacokinetics of ethinylestradiol in women. *Contraception.* 1980;21:135–143
53. Mattson RH, Cramer JA, Darney PD, Naftolin F. Use of oral contraceptives by women with epilepsy. *JAMA.* 1986;256:238–240
54. Szoka PR, Edgren RA. Drug interactions with oral contraceptives: compilation and analysis of an adverse experience report database. *Fertil Steril.* 1988;49(5 suppl 2):31S–38S
55. Hatcher RA, Nelson A. Combined hormonal contraceptive methods. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology.* 18th Revised ed. New York, NY: Ardent Media Inc; 2004:391–460
56. Sucato GS, Gold MA. Extended cycling of oral contraceptive pills for adolescents. *J Pediatr Adolesc Gynecol.* 2002;15:325–327
57. Abma JC, Chandra A, Mosher WD, Peterson LS, Piccinino LJ. Fertility, family planning, and women's health: new data from the 1995 national survey of family growth. *Vital Health Stat 23.* 1997;(19):1–114
58. Burke AE, Blumenthal PD. Successful use of oral contraceptives. *Semin Reprod Med.* 2001;19:313–321
59. Grimes DA. Contraception and adolescents: highlights from the NASPAG Conference. *Contracept Rep.* 1995;6:4, 7, 10–11, 14
60. Stewart FH, Harper CC, Ellertson CE, Grimes DA, Sawaya GF, Trussell J. Clinical breast and pelvic examination requirements for hormonal contraception: current practice vs evidence. *JAMA.* 2001;285:2232–2239
61. US Preventive Services Task Force. Screening for chlamydial infection: recommendations and rationale. *Am J Prev Med.* 2001;20(3 suppl):90–94
62. Smith RA, Cokkinides V, Eyre HJ. Cancer screening in the United States, 2007: a review of current guidelines, practices, and prospects. *CA Cancer J Clin.* 2007;57:90–104
63. Hatcher RA. Depo-Provera injections, implants, and progestin-only pills (minipills). In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology.* 18th Revised ed. New York, NY: Ardent Media Inc; 2004:461–494
64. Scholes D, Lacroix AZ, Ott SM, Ichikawa LE, Barlow WE. Bone mineral density in women using depot medroxyprogesterone acetate for contraception. *Obstet Gynecol.* 1999;93:233–238
65. Depot Subq Provera 104. Medroxyprogesterone acetate injectable suspension: 104 mg/0.65 mL—physician information. Available at: www.pfizer.com/pfizer/download/uspi_depo_subq_provera.pdf. Accessed May 18, 2007
66. Jain J, Jakimiuk AJ, Bode FR, Ross D, Kaunitz AM. Contraceptive efficacy and safety of DMPA-SC. *Contraception.* 2004;70:269–275
67. Jain J, Dutton C, Nicosia A, Wajszczuk C, Bode FR, Mishell DR Jr. Pharmacokinetics, ovulation suppression and return to ovulation following a lower dose subcutaneous formulation of Depo-Provera. *Contraception.* 2004;70:11–18
68. Canto De Cetina TE, Canto P, Ordonez Luna M. Effect of counseling to improve compliance in Mexican Women receiving depot-medroxyprogesterone acetate. *Contraception.* 2001;63:143–146
69. Cromer BA, Blair JM, Mahan JD, Zibners L, Naumovski Z. A prospective comparison of bone density in adolescent girls receiving depot medroxyprogesterone acetate (Depo-Provera), levonorgestrel (Norplant), or oral contraceptives. *J Pediatr.* 1996;129:671–676
70. Cromer BA, Stager M, Bonny A, et al. Depot medroxyprogesterone acetate, oral contraceptives and bone mineral density in a cohort of adolescent girls. *J Adolesc Health.* 2004;35:434–441
71. Lara-Torre E, Edwards CP, Perlman S, Hertweck SP. Bone mineral density in adolescent females using depot medroxyprogesterone acetate. *J Pediatr Adolesc Gynecol.* 2004;17:17–21
72. Rome E, Ziegler J, Secic M, et al. Bone biochemical markers in adolescent girls using either depot medroxyprogesterone acetate or an oral contraceptive. *J Pediatr Adolesc Gynecol.* 2004;17:373–377
73. DepoProvera 150 mg and Depo SubQ Provera 104 [package inserts]. Cambridge, MA: Pfizer; 2005
74. Scholes D, LaCroix AZ, Ichikawa LE, Barlow WE, Ott SM. Change in bone mineral density among adolescent women using and discontinuing depot medroxyprogesterone acetate contraception. *Arch Pediatr Adolesc Med.* 2005;159:139–144
75. Cromer BA, Lazebnik R, Rome E, et al. Double-blinded randomized controlled trial of estrogen supplementation in adolescent girls who receive depot medroxyprogesterone acetate for contraception. *Am J Obstet Gynecol.* 2005;192:42–47
76. Freeman S. Nondaily hormonal contraception: considerations in contraceptive choice and patient counseling. *J Am Acad Nurse Pract.* 2004;16:226–238
77. Kaunitz AM. Current options for injectable contraception in the United States. *Semin Reprod Med.* 2001;19:331–337
78. US Food and Drug Administration. *Update on Advisory for Norplant Contraceptive Kits.* Rockville, MD: US Food and Drug Administration; 2002. Available at: www.fda.gov/bbs/topics/ANSWERS/2002/ANS01161.html. Accessed May 18, 2007
79. Rubinstein ML, Halpern-Fisher BL, Irwin CE. An evaluation of the use of the transdermal contraceptive patch in adolescents. *J Adolesc Health.* 2004;34:395–401
80. Keder LM. New developments in contraception. *J Pediatr Adolesc Gynecol.* 2002;15:179–181
81. Harel Z, Riggs S, Vaz R, Flanagan P, Dunn K, Harel D. Adolescents' experience with the combined estrogen and progestin transdermal contraceptive method Ortho Evra. *J Pediatr Adolesc Gynecol.* 2005;18:85–90
82. Audet MC, Moreau M, Koltun WD, et al. Evaluation of contraceptive efficacy and cycle control of a transdermal contraceptive patch vs an oral contraceptive: a randomized controlled trial. *JAMA.* 2001;285:2347–2354
83. Zieman M, Guillebaud J, Weisberg E, Shangold GA, Fisher AC, Creasy GW. Contraceptive efficacy and cycle control with the Ortho Evra/Evra transdermal system: the analysis of pooled data. *Fertil Steril.* 2002;77(2 suppl 2):S13–S18
84. US Food and Drug Administration. FDA updates labeling for Ortho Evra contraceptive patch [press release]. Available at: www.fda.gov/bbs/topics/news/2005/NEW01262.html. Accessed May 18, 2007
85. Vandenbroucke JP, Rosing J, Bloemenkamp KWM. Oral contraceptives and the risk of venous thrombosis. *N Engl J Med.* 2001;344:1527–1535
86. World Health Organization. Medical eligibility criteria for contraceptive use. Available at: www.who.int/reproductive-health/publications/med/med.pdf. Accessed July 6, 2007
87. US Food and Drug Administration, Center for Drug Evaluation and Research. Questions and answers: Ortho Evra (norelgestromin/ethinyl estradiol). Available at: www.fda.gov/cder/drug/infopage/orthoevra/qa20060920.htm. Accessed May 18, 2007
88. Grimes DA. Intrauterine devices (IUDs). In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology.* 18th Revised ed. New York, NY: Ardent Media Inc; 2004:495–530

89. Cates W, Stewart F. Vaginal barriers. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology*. 18th Revised ed. New York, NY: Ardent Media Inc; 2004:365–389
90. Kowal D. Coitus interruptus (withdrawal). In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology*. 18th Revised ed. New York, NY: Ardent Media Inc; 2004:311–315
91. Jennings VH, Arevalo M, Kowal D. Fertility awareness-based methods. In: Hatcher RA, Trussell J, Stewart F, et al, eds. *Contraceptive Technology*. 18th Revised ed. New York, NY: Ardent Media Inc; 2004:317–329
92. Ellertson C, Evans M, Ferden S, et al. Extending the time limit for starting the Yuzpe regimen of emergency contraception to 120 hours. *Obstet Gynecol*. 2003;101:1168–1171
93. Rodrigues I, Grou F, Joly J. Effectiveness of emergency contraceptive pills between 72 and 120 hours after unprotected sexual intercourse. *Am J Obstet Gynecol*. 2001;184:531–537
94. von Hertzen H, Piaggio G, Ding J, et al. Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial. *Lancet*. 2002;360:1803–1810
95. American Academy of Pediatrics, Committee on Adolescence. Emergency contraception. *Pediatrics*. 2005;116:1026–1035
96. Ellertson C, Webb A, Blanchard K, et al. Modifying the Yuzpe regimen of emergency contraception: a multicenter randomized controlled trial. *Obstet Gynecol*. 2003;101:1160–1167
97. Piaggio G, von Hertzen H, Grimes DA, Van Look PF. Timing of emergency contraception with levonorgestrel or the Yuzpe regimen. Task Force on Postovulatory Methods of Fertility Regulation. *Lancet*. 1999;353:721
98. Task Force on Postovulatory Methods of Fertility Regulation. Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. *Lancet*. 1998;352:428–433
99. Grimes DA. Switching emergency contraception to over-the-counter status. *N Engl J Med*. 2002;347:846–849
100. Stewart F, Trussel J, Van Look PFA. Emergency contraception. In: Hatcher RA, Trussell J, Stewart F, et al. *Contraceptive Technology*. 18th Revised ed. New York, NY: Ardent Media Inc; 2004:279–303
101. Ellertson C, Ambardekar S, Hedley A, Coyaji K, Trussell J, Blanchard K. Emergency contraception: randomized comparison of advance provision and information only. *Obstet Gynecol*. 2001;98:570–575
102. Glasier A, Baird D. The effects of self-administering emergency contraception. *N Engl J Med*. 1998;339:1–4
103. Gold MA, Wolford JE, Smith KA, Parker AM. The effects of advance provision of emergency contraception on adolescent women's sexual and contraceptive behaviors. *J Pediatr Adolesc Gynecol*. 2004;17:87–96
104. Jackson RA, Bimla Schwarz E, Freedman L, Darney P. Advance supply of emergency contraception: effect on use and usual contraception—a randomized trial. *Obstet Gynecol*. 2003; 102:8–16
105. Lovvorn A, Nerquaye-Tetteh J, Glover EK, Amankwah-Poku A, Hays M, Raymond E. Provision of emergency contraceptive pills to spermicide users in Ghana. *Contraception*. 2000;61:287–293
106. Raine T, Harper C, Leon K, Darney P. Emergency contraception: advance provision in a young, high-risk clinic population. *Obstet Gynecol*. 2000;96:1–7
107. The emergency contraception web site. Available at: http://ec.princeton.edu/news/8-24-06-FDA-press-release.html. Accessed July 7, 2007
108. US Food and Drug Administration. FDA approves Ovcon 35 as the first chewable contraceptive tablet for women. Available at: www.fda.gov/bbs/topics/ANSWERS/2003/ANS01260.html. Accessed May 18, 2007
109. US Food and Drug Administration, Center for Devices and Radiological Health. New Device Approval: FemCap—P020041. Available at: www.fda.gov/cdrh/mda/docs/P020041.html. Accessed May 18, 2007
110. Gonzalo IT, Swerdloff RS, Nelson AL, et al. Levonorgestrel implants (Norplant II) for male contraception clinical trials: combination with transdermal and injectable testosterone. *J Clin Endocrinol Metab*. 2002;87:3562–3572
111. Centers for Disease Control and Prevention. Sexually transmitted disease treatment guidelines 2006. Available at: www.cdc.gov/std/treatment/2006/urethritis-and-cervicitis.htm#uc4. Accessed July 26, 2007

ADDITIONAL RESOURCES

Canobbio MM. Contraception for the adolescent and young adult with congenital heart disease. *Nurs Clin North Am*. 2004;39:769–785

Gittes EB, Strickland JL. Contraceptive choices for chronically ill adolescents. *Adolesc Med*. 2005;16:635–644

Heroux K. Contraceptive choices in medically ill adolescents. *Semin Reprod Med*. 2003;21:389–398

Laurence V, Gbolade BA, Morgan SJ, Glaser A. Contraception for teenagers and young adults with cancer. *Eur J Cancer*. 2004;40: 2705–2716

Logsdon-Pokorny VK. Epilepsy in adolescents: hormonal considerations. *J Pediatr Adolesc Gynecol*. 2000;13:9–13

Miller LJ. Sexuality, reproduction, and family planning in women with schizophrenia. *Schizophr Bull*. 1997;23:623–635

Murphy N. Sexuality in children and adolescents with disabilities. *Dev Med Child Neurol*. 2005;47:640–644

Owens K, Honebrink A. Gynecologic care of medically complicated adolescents. *Pediatr Clin North Am*. 1999;46:631–642

Sciscione AC, Callan NA. Congenital heart disease in adolescents and adults: pregnancy and contraception. *Cardiol Clin*. 1993;11: 701–709

Shorvon SD, Tallis RC, Wallace HK. Antiepileptic drugs: coprescription of proconvulsant drugs and oral contraceptives: a national study of antiepileptic drug prescribing practice. *J Neurol Neurosurg Psychiatry*. 2002;72:114–115

Sucato G, Gerschultz KL. Extended cycle hormonal contraception in adolescents. *Curr Opin Obstet Gynecol*. 2005;17:461–465

Zurawin RK, Paransky OL. The role of surgical techniques in the treatment of menstrual problems and as contraception in adolescents with disabilities. *J Pediatr Adolesc Gynecol*. 2003;16: 51–54

Contraception and Adolescents
Committee on Adolescence
Pediatrics 2007;120;1135
DOI: 10.1542/peds.2007-2535

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

AMERICAN ACADEMY OF PEDIATRICS

Committee on Psychosocial Aspects of Child and Family Health and Committee on Adolescence

Sexuality Education for Children and Adolescents

ABSTRACT. **Children and adolescents need accurate and comprehensive education about sexuality to practice healthy sexual behavior as adults. Early, exploitative, or risky sexual activity may lead to health and social problems, such as unintended pregnancy and sexually transmitted diseases, including human immunodeficiency virus infection and acquired immunodeficiency syndrome. This statement reviews the role of the pediatrician in providing sexuality education to children, adolescents, and their families. Pediatricians should integrate sexuality education into the confidential and longitudinal relationship they develop with children, adolescents, and families to complement the education children obtain at school and at home. Pediatricians must be aware of their own attitudes, beliefs, and values so their effectiveness in discussing sexuality in the clinical setting is not limited.**

ABBREVIATIONS. STD, sexually transmitted disease; HIV, human immunodeficiency virus; AIDS, acquired immunodeficiency syndrome; AAP, American Academy of Pediatrics.

BACKGROUND

Recent federal surveys for the Department of Health and Human Services have found a decline in sexual activity among adolescents 15 to 19 years of age in the United States during the last decade.[1] However, initiation of sexual intercourse during adolescence remains the norm for American youth.[1] Rates of hormonal contraception and condom use have risen throughout the last 5 years and adolescent birth rates have been decreasing,[2] yet the percentage of births to unmarried women of all ages, including adolescents, remains high.[2,3] Among women 15 to 19 years of age, most pregnancies are unintended,[3,4] and approximately 1 in 3 end in abortion.[3]

Overall rates of sexually transmitted diseases (STDs) in the United States are among the highest in the industrialized world. Every year, an estimated 1 in 4 (approximately 3 million) sexually active adolescents acquire an STD.[5] Additionally, only 57% of the 1 in 3 adolescents who reported having been sexually active in the past 3 months reported that they had used barrier contraception the last time they had intercourse.[6]

Children most likely to engage in earlier sexual activity include children with learning problems or low academic attainment; children with other social, behavioral, or emotional problems (including mental health disorders and substance abuse); those from low-income families; children of some ethnic minorities; victims of physical and sexual abuse; and children in families with marital discord and low levels of parental supervision.[7,8] Risky sexual behaviors, defined as having multiple partners, having sex with strangers, or having intercourse without a latex condom, are also associated with alcohol consumption.[7,8] Many gay, lesbian, and bisexual youth are also at high risk because of unsafe sexual practices with same or opposite sex partners and because of increased rates of depression, dropping out of school, homelessness (running away or being thrown out of the home), and substance abuse.[9]

In the Youth Risk Behavior Surveillance survey conducted by the Centers for Disease Control and Prevention, almost all (>90%) adolescents reported having received human immunodeficiency virus (HIV) prevention education in school in 1997, and many also reported discussing HIV and acquired immunodeficiency syndrome (AIDS) with a parent or guardian.[6] However, the content of such discussions may not provide complete information. Additionally, school-based interventions do not provide confidential opportunities for individual risk assessments or targeted preventive counseling. Although as many as two thirds of adolescent patients reported wanting information about STDs and pregnancy from their physicians, many fewer have ever discussed these issues with their physician.[10] In fact, fewer than half of primary care providers routinely ask adolescents about their sexual activity, and far fewer ask specifically about STDs, condom use, sexual orientation, number of partners, or sexual abuse,[11] despite the fact that care guidelines universally recommend obtaining comprehensive sexual histories from adolescents.[12–14] Slightly more than half of adolescents who reported having a health care visit reported that they had an opportunity to talk alone (without a parent or other adult present) with their physician,[15] and fear of disclosure was a major reason for adolescents having missed care they believed that they needed.[16]

SOURCES, CONTENT, AND EFFECTIVENESS OF SEXUALITY EDUCATION PROGRAMS

Sexuality education classes have become a routine part of junior high and high school curricula in many parts of the country.[1] Sexuality education is also often a component of community-based programs targeting pregnancy prevention, substance abuse prevention, violence reduction, youth development,

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

or reproductive health services. Several sexuality education programs that were evaluated using quasi-experimental or experimental designs had impact on the sexual behavior of adolescents.[17] To delay onset of sexual debut, it is necessary to present programs to fifth and sixth graders. Abstinence-only programs have not demonstrated successful outcomes with regard to delayed initiation of sexual activity or use of safer sex practices.[8,17] Effective programs tend to provide practical skills, such as exercising control and increasing communication and negotiation skills through role playing or interactive discussion. Programs that encourage abstinence as the best option for adolescents, but offer a discussion of HIV prevention and contraception as the best approach for adolescents who are sexually active, have been shown to delay the initiation of sexual activity and increase the proportion of sexually active adolescents who reported using birth control. Programs that have linked educational curricula with access to reproductive health services and comprehensive community-based interventions have also documented reductions in pregnancy rates.[18–20] Despite these findings, among the 69% of public schools that provide district-wide sexuality education, 14% treat abstinence as an option for adolescents, 51% teach abstinence as the preferred option for adolescents but permit discussion about contraception as an effective means of protection against unintended pregnancy and STDs (an abstinence-plus policy), and more than 1 in 3 (35%) teach abstinence only, with discussion of contraception prohibited or limited to discussion of its lack of effectiveness.[21]

ROLE OF THE PEDIATRICIAN

The American Academy of Pediatrics (AAP) has published policy statements about sexuality and adolescence.[22–24] Pediatricians are in an ideal position to provide longitudinal sexuality education to children and adolescents as part of preventive health care, and many tools are available to guide their efforts.[22–24] Additionally, pediatricians' efforts may be useful in complementing school or community-based programs.

Unlike school-based instruction, discussion of sexuality with pediatricians provides opportunities for personalized information, for confidential screening of risk status, and for health promotion and counseling. Children and adolescents may ask questions, discuss potentially embarrassing experiences, or reveal highly personal information to their pediatricians. Families and children may obtain education together or in a separate but coordinated manner. Prevention and counseling can be targeted to the needs of youth who are and those who are not yet sexually active and to groups at high risk for early or unsafe sexual activity.[7,8]

Recommendations for pediatricians are as follows:

1. Put sexuality education into a lifelong perspective. Actively encourage parents to discuss sexuality and contraception consistent with the family's attitudes, values, beliefs, and circumstances beginning early in the child's life. Do not impose values on the family. Be aware of the diversity of family circumstances, such as families with same-sex parents. Guide these families or refer them to agencies or clinicians that can help them if they report difficulties or if you are not comfortable assisting them.
2. Encourage parents to offer sexuality education and discuss sex-related issues that are appropriate for the child's or adolescent's developmental level.
   - Use proper terms for anatomic parts.
   - Discuss masturbation and other sexual behaviors of all children, even those as young as preschool age, openly with parents.
   - Initiate discussions about sexuality with children at relevant opportunities, such as the birth of a sibling or pet. Encourage parents to answer children's questions fully and accurately. Offer parents resources to assist their communication efforts at home.
3. Provide sexuality education that respects confidentiality and acknowledges the individual patient's and family's issues and values.
   - Promote communication and safety within social relationships between partners.[25] Ask about special friendships and relationships and explore their character. Complement school-based sexuality education, which typically emphasizes unintended pregnancy, STDs, and other potential risks of sex. When appropriate, acknowledge that sexual activity may be pleasurable but also must be engaged in responsibly.
   - Address knowledge, questions, worries, or misunderstandings of children and adolescents regarding anatomy, masturbation, menstruation, erections, nocturnal emissions ("wet dreams"), sexual fantasies, sexual orientation, and orgasms. Information regarding availability and access to confidential reproductive health services and emergency contraception should also be discussed with early adolescents and with parents. During these discussions, also be open and nonjudgemental toward those with homosexual or bisexual experiences or orientation (see the AAP statement "Homosexuality and Adolescence"[9]).
   - Acknowledge the influence of media imagery on sexuality as it is portrayed in music and music videos, movies, television, print, and Internet content.
   - Obtain a comprehensive sexual history from all adolescents, including knowledge about sexuality, sexual practices, partners and relationships, sexual feelings and identity, and contraceptive practices and plans.
   - In discussing reasons to delay sexual activity or use contraception, frame the suggestions in terms of the individual's development, language, motivation, and history. Be sensitive to cultural and family norms, values, beliefs, and attitudes, and integrate these factors into health promotion or behavior change counseling. Also be aware of the potential for, and ask about,

abuse or coercion in relationships or sexual activity.

- Counsel parents about sexuality. Suggest opportunities for them to provide guidance about abstinence and responsible sexual behavior to their children. Encourage reciprocal and honest dialogue between parents and children. Counsel parents and adolescents about circumstances that are associated with earlier sexual activity, including early dating, excessive unsupervised time, truancy, and alcohol use.[7,8] Ensure that adolescents have opportunities to practice social skills, assertiveness, control, and rejection of unwanted sexual advances.[17]

4. Provide specific, confidential, culturally sensitive, and nonjudgmental counseling about key issues of sexuality.
   - ***General counseling***. Counsel children and parents about normal sexual development before the onset of sexual activity, and encourage parent-child communication about sexuality. Parents should be encouraged to discuss explicit expectations for abstinence, for delaying sexual activity, and for responsible expression of one's sexuality. Advise children and adolescents to discontinue high-risk sexual behavior and avoid or discontinue coercive relationships.[26] Discourage alcohol and other drug use and abuse not only for the direct benefits to the adolescent's health but also to prevent unwanted sexual activity or adverse consequences of sexual activity. Some pediatricians may want to consider the use of established curricula to ensure that all major points are covered.[27] Additionally, handouts to reinforce safe sex practices and responsible decision-making should be available in the office or clinic. Pediatricians may directly provide this counseling, and other members of the office staff, such as nurses, social workers, or health educators, may also provide counseling and health education.
   - ***Preventing unintended pregnancy***. Discuss methods of birth control with male and female adolescents ideally before the onset of sexual intercourse (see the AAP statement "Contraception and Adolescents"[22]). Barrier methods should always be used during intercourse in combination with spermicide or with hormonal contraceptives. Providing access to contraception for adolescents who are sexually active is an important method of reducing pregnancy rates.[26]
   - ***Strategies to avoid STDs, including HIV infection and AIDS***. Abstinence should be promoted as the most effective strategy for preventing HIV infection and other STDs as well as for prevention of pregnancy. Adolescents who become sexually active need additional advice and health care services. Adolescents should be counseled regarding the importance of consistent use of safer sex precautions. Pediatricians should assist adolescents in practicing communication and negotiation skills regarding use of condoms in every sexual encounter[28] and should consider providing adolescents with information and demonstrations about how condoms should be used. Comprehensive recommendations for HIV counseling, testing, and partner notification are addressed in detail in the AAP statement "Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention."[29]
5. Provide appropriate counseling or referrals for children and adolescents with special issues and concerns.
   - ***Gay, lesbian, and bisexual youth***. Maintain nonjudgmental attitudes and avoid a heterosexual bias in history taking to encourage adolescents to be open about their behaviors and feelings (see the AAP statement "Homosexuality and Adolescence"[9]).[30,31] If adolescents are certain of homosexual or bisexual orientation, discuss advantages and potential risks of disclosure to family and peers, and support families in accepting children who identify themselves as gay, lesbian, or bisexual. Adolescents who are homosexual should be screened carefully for depression, risk of suicide, and adjustment-related mental health problems. Similar issues are important to children unsure of their sexual orientation.
   - ***Children and adolescents with disabilities***. Rates of sexual activity for adolescents with disabilities are the same as those for adolescents without disabilities.[32] However, children in special education may not receive sexuality education in school. Children and youth with disabilities should be provided developmentally appropriate sexuality education. Parents may need reassurance and support in getting sexuality education for children and adolescents with disabilities. Discussions should be initiated with parents or guardians of children with disabilities at a young age to encourage self-protection and acceptable forms of sexual behavior. Community resources and support groups may also be of assistance.
   - ***Other children at risk***. Identify children at risk for early or coercive and unintended sexual behaviors at an early age. Children who have been victims of physical or sexual abuse or have witnessed sexual violence or physical abuse; children with precocious puberty; and children with social risk factors, such as learning problems, drug or alcohol use, and antisocial behavior, may be at increased risk. Provide or arrange for counseling about sexuality for these children or adolescents. Refer to mental health services if appropriate.
6. Routine gynecologic services should be provided to female adolescents who have become sexually active. Screening for cervical cancer and STDs should be performed for sexually active females, and screening for STDs should be performed for sexually active males, as recommended in *Guidelines for Health Supervision III*.[12]

7. Become knowledgeable about sexuality education offered in schools, religious institutions, and other community agencies. Encourage schools to begin sexuality education in the fifth or sixth grade as a component of comprehensive school health education and to use curricula that provide effective and balanced approaches to puberty, abstinence, decision-making, contraception, and STD and HIV prevention strategies and information about access to services. Because nearly one third of school districts do not provide any information about contraception regardless of whether students are sexually active or at risk,[21] pediatricians should consider presenting material at the school. The American College of Obstetricians and Gynecologists publishes the *Adolescent Sexuality Kit: Guides for Professional Involvement*.[33] This series addresses AIDS, date rape, contraceptive options, and other topics that may be useful to pediatricians who plan to provide sexuality education. Participate in community activities to monitor the effectiveness of prevention strategies and revise approaches to decrease the rate of untoward outcomes. Consider serving as a referral source for students who need comprehensive reproductive health services.
8. Work with local public planners to develop a comprehensive strategy to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.

RECOMMENDATIONS

1. Every pediatrician should integrate sexuality education into clinical practice with children from early childhood through adolescence. This education should respect the family's individual and cultural values.
2. Educational materials, such as handouts, pamphlets, or videos, should be available to reinforce office-based educational efforts.
3. Pediatricians should be knowledgeable about community services that provide appropriate high-quality sexuality education and additional services that children, adolescents, or families need.
4. Pediatricians should consider participating in the development and implementation of sexuality education curricula for schools or in public efforts to decrease the rates of unsafe adolescent sexual behavior and adverse outcomes.
5. Linguistically appropriate materials could be provided in the office or the pediatrician should have a way of helping children, adolescents, and their families get information in their language of choice.

REFERENCES

1. Abma JC, Chandra A, Mosher WE, Peterson LS, Piccinino LJ. Fertility, family planning and women's health: new data from the 1995 National Survey on Family Growth. National Center for Health Statistics. *Vital Health Stat*. 1997;23:1–114
2. Amini SB, Catalano PM, Dierker LJ, Mann LI. Births to teenagers: trends and obstetric outcomes. *Obstet Gynecol*. 1996;87:668–674
3. Ventura SJ, Mathews TJ, Curtin SC. Declines in teenage birth rates, 1991–97: national and state patterns. *Natl Vital Stat Rep*. 1998;47:1–17
4. Spitz AM, Ventura SJ, Koonin LM, et al. Surveillance for pregnancy and birth rates among teenagers, by state—United States, 1980 and 1990. *MMWR CDC Surveill Summ*. 1993;42:1–27
5. Cooper LG, Leland NL, Alexander G. Effect of maternal age on birth outcomes among young adolescents. *Soc Biol*. 1995;42:22–35
6. Kann L, Kinchen SA, Williams BI, et al. Youth Risk Surveillance—United States, 1997. *MMWR CDC Surveill Summ*. 1998;47:1–89
7. Donovan P. *The Politics of Blame: Family Planning, Abortion, and the Poor*. New York, NY: Alan Guttmacher Institute; 1995
8. Alan Guttmacher Institute. *Sex and America's Teenagers*. New York, NY: Alan Guttmacher Institute; 1994
9. American Academy of Pediatrics, Committee on Adolescence. Homosexuality and adolescence. *Pediatrics*. 1993;92:631–634
10. Kapphahn CJ, Wilson KM, Klein JD. Adolescent girls' and boys' preferences for provider gender and confidentiality in their health care. *J Adolesc Health*. 1999;25:131–142
11. Millstein SG, Igra V, Gans J. Deliver of STD/HIV preventive services to adolescents by primary care physicians. *J Adolesc Health*. 1996;19:249–257
12. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. *Guidelines for Health Supervision III*. Elk Grove Village, IL: American Academy of Pediatrics; 1997

13. Green M, ed. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. Arlington, VA: National Center for Education in Maternal and Child Health; 1994
14. Elster AB, Kuznets NJ, eds. *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale*. Baltimore, MD: Williams & Wilkins; 1994
15. Klein JD, Wilson KM, McNulty M, Kapphahn C, Collins KS. Access to medical care for adolescents: results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *J Adolesc Health*. 1999; 25:120–130
16. Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *JAMA*. 1999;282:2227–2234
17. Frost JJ, Forrest JD. Understanding the impact of effective teenage pregnancy prevention programs. *Fam Plann Perspect*. 1995;27:188–195
18. Zabin LS, Hirsch MB, Streett R, et al. The Baltimore pregnancy prevention program for urban teenagers. I. How did it work? *Fam Plann Perspect*. 1988;20:182–187
19. Zabin LS, Hirsch MB, Smith EA, et al. The Baltimore pregnancy prevention program for urban teenagers. II. What did it cost? *Fam Plann Perspect*. 1988;20:188–192
20. Vincent ML, Clearie AF, Schluchter MD. Reducing adolescent pregnancy through school and community-based education. *JAMA*. 1987; 257:3382–3386
21. Landry DJ, Kaeser L, Richards CL. Abstinence promotion and the provision of information about contraception in public school district sexuality education policies. *Fam Plann Perspect*. 1999;31:280–286
22. American Academy of Pediatrics, Committee on Adolescence. Contraception and adolescents. *Pediatrics*. 1999;104:1161–1166
23. American Academy of Pediatrics, Committee on Adolescence. Adolescent pregnancy: current trends and issues: 1998. *Pediatrics*. 1999;103: 516–520
24. American Academy of Pediatrics, Committee on Adolescence. Counseling, the adolescent about pregnancy options. *Pediatrics*. 1998;101: 938–940
25. Ruusuvaara L. Adolescent sexuality: an educational and counseling challenge. *Ann N Y Acad Sci*. 1997;816:411–413
26. Peckham S. Preventing unintended teenage pregnancies. *Public Health*. 1993;107:125–133
27. Card JJ, Niego S, Mallari A, Farrell WS. The program archive on sexuality, health & adolescence: promising "prevention programs in a box." *Fam Plann Perspect*. 1996;28:210–220
28. Darrow WW. Condom use and use-effectiveness in high-risk populations. *Sex Transm Dis*. 1989;16:157–168
29. American Academy of Pediatrics, Committee on Pediatric AIDS and Committee on Adolescence. Adolescents and human immunodeficiency virus infection: the role of the pediatrician in prevention and intervention. *Pediatrics*. 2001;107:188–190
30. Harrison AE. Primary care of lesbian and gay patients: educating ourselves and our students. *Fam Med*. 1996;28:10–23
31. Ryan C, Futterman D. *Lesbian and Gay Youth: Care and Counseling*. New York, NY: Columbia University Press; 2000
32. Suris JC, Resnick MD, Cassuto N, Blum RW. Sexual behavior of adolescents with chronic disease and disability. *J Adolesc Health*. 1996;19: 124–131
33. American College of Obstetricians and Gynecologists, Committee on Adolescent Health Care. *Adolescent Sexuality Kit: Guides for Professional Involvement*. 2nd ed. Washington, DC: American College of Obstetricians and Gynecologists; 1992

ERRATUM

In "Tobacco's Toll: Implications for the Pediatrician" by the AAP Committee on Substance Abuse, Catherine A. McDonald, MD, was omitted from the list of consultants due to an oversight. The statement was published in the April 2001 issue of *Pediatrics*. (*Pediatrics*. 2001;107(4):794–798.)

Staudenmayer, Suzanne

From: WI Family Action [info@wifamilyaction.org]
Sent: Thursday, October 06, 2011 9:53 AM
To: WI Family Action
Subject: Legislative memo re LRB 2088/1, the "Strong Communities.Healthy Kids Act"
Attachments: image001.jpg; strong_communities_healthy_kids_100611.pdf

Attached and included below is a memo regarding co-sponsorship of LRB 2088/1, the "Strong Communities... Healthy Kids Act," authored by Sen. Mary Lazich with Rep. Joel Kleefisch as lead sponsor in the Assembly. Co-sponsorship is open through this Friday, October 7.

If you have questions, please feel free to call me.

Julaine

Julaine K. Appling, President
Wisconsin Family Action
PO Box 1327 ✯ Madison WI 53701
1-866-849-2536 (toll-free) ✯ 608-268-5074
jkappling@wifamilyaction.org
www.wifamilyaction.org
✯ ***Strengthening and preserving marriage, family, life and liberty in Wisconsin*** ✯

Check out WFA's blog, ***Wisconsin Family Voice—Speaking Up for Wisconsin's Families!***

Wisconsin Family Action

PO Box 1327 • Madison WI 53701-1327
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
Email: info@wifamilyaction.org
Blog: http://blog.wifamilyaction.com
Web site: www.wifamilyaction.org

LEGISLATIVE MEMORANDUM

To: Members, Wisconsin State Legislature

From: Julaine K. Appling, President

Date: October 6, 2011

Re: Co-sponsorship of LRB-2088/1, "Strong Communities...Healthy Kids Act"

Wisconsin Family Action (WFA) urges you to co-sponsor LRB 2088/1, the "Strong Communities...Healthy Kids Act," a bill that restores local control for Wisconsin's school districts in the area of Human Growth and Development and emphasizes the partnership of parents and schools in the "optimal health and well-being" of students.

Current law forces any Wisconsin school district that elects to have a Human Growth and Development program to have one that is rigidly prescribed by the state. Such an approach presumes that the state legislature knows what is best for all school districts and that all school districts/communities want the same type of Human Growth and Development program.

The "Strong Communities...Healthy Kids Act" recognizes that students are best served when those closest to them are making decisions that affect them, especially in important areas such as Human Growth and Development. This bill will allow school districts to make, with input from parents and other stake-holders in the community, the best decisions to ensure the "optimal health and well-being" of their students, including implementing abstinence-centered programs, if they so choose. Currently, school districts do not have such options; it's "one-size-fits-all," whether or not that size fits what a community believes is best for its children.

Rather than issue mandates such as requiring schools to teach "proper use of contraceptives and barrier methods," the "Strong Communities...Healthy Kids Act" makes ***recommendations*** in key areas such as parent/student communication, the benefits of abstinence and the skills necessary to remain abstinent, reproductive and sexual anatomy and physiology, adoption resources, and the positive connection between marriage and parenting, among others.

Significantly, the "Strong Communities...Healthy Kids Act" prevents groups such as Planned Parenthood of Wisconsin with their volunteer health care providers from teaching, with immunity as agents of the state, any aspect of a school district's Human Growth and Development program.

The "Strong Communities...Healthy Kids Act" is a responsible and reasonable approach to Human Growth and Development. It respects the right of local schools to determine their own program, while still keeping an appropriate emphasis on presenting abstinence until marriage as the only reliable way to prevent pregnancy and sexually transmitted infections, an emphasis that is all about the health and future of students.

Wisconsin Family Action thanks you for your careful consideration of this bill. We encourage you to co-sponsor this legislation that restores local control so that communities can make wise choices to achieve healthy young people. Co-sponsorship of this bill (lead sponsors, Sen. Mary Lazich and Rep. Joel Kleefisch) is open through this Friday, October 7. Please contact Senator Lazich to be added to the bill (LRB 2088/1).

If you have questions, please feel free to contact me at 608-268-5074.

Wisconsin Family Action
Strengthening & Preserving Marriage, Family, Life & Liberty

PO Box 1327 • Madison WI 53701-1327
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
Email: info@wifamilyaction.org
Blog: http://blog.wifamilyaction.com
Web site: www.wifamilyaction.org

LEGISLATIVE MEMORANDUM

To: Members, Wisconsin State Legislature

From: Julaine K. Appling, President

Date: October 6, 2011

Re: Co-sponsorship of LRB-2088/1, "Strong Communities...Healthy Kids Act"

Wisconsin Family Action (WFA) urges you to co-sponsor LRB 2088/1, the "Strong Communities...Healthy Kids Act," a bill that restores local control for Wisconsin's school districts in the area of Human Growth and Development and emphasizes the partnership of parents and schools in the "optimal health and well-being" of students.

Current law forces any Wisconsin school district that elects to have a Human Growth and Development program to have one that is rigidly prescribed by the state. Such an approach presumes that the state legislature knows what is best for all school districts and that all school districts/communities want the same type of Human Growth and Development program.

The "Strong Communities...Healthy Kids Act" recognizes that students are best served when those closest to them are making decisions that affect them, especially in important areas such as Human Growth and Development. This bill will allow school districts to make, with input from parents and other stake-holders in the community, the best decisions to ensure the "optimal health and well-being" of their students, including implementing abstinence-centered programs, if they so choose. Currently, school districts do not have such options; it's "one-size-fits-all," whether or not that size fits what a community believes is best for its children.

Rather than issue mandates such as requiring schools to teach "proper use of contraceptives and barrier methods," the "Strong Communities...Healthy Kids Act" makes ***recommendations*** in key areas such as parent/student communication, the benefits of abstinence and the skills necessary to remain abstinent, reproductive and sexual anatomy and physiology, adoption resources, and the positive connection between marriage and parenting, among others.

Significantly, the "Strong Communities...Healthy Kids Act" prevents groups such as Planned Parenthood of Wisconsin with their volunteer health care providers from teaching, with immunity as agents of the state, any aspect of a school district's Human Growth and Development program.

The "Strong Communities...Healthy Kids Act" is a responsible and reasonable approach to Human Growth and Development. It respects the right of local schools to determine their own program, while still keeping an appropriate emphasis on presenting abstinence until marriage as the only reliable way to prevent pregnancy and sexually transmitted infections, an emphasis that is all about the health and future of students.

Wisconsin Family Action thanks you for your careful consideration of this bill. We encourage you to co-sponsor this legislation that restores local control so that communities can make wise choices to achieve healthy young people. Co-sponsorship of this bill (lead sponsors, Sen. Mary Lazich and Rep. Joel Kleefisch) is open through this Friday, October 7. Please contact Senator Lazich to be added to the bill (LRB 2088/1).

If you have questions, please feel free to contact me at 608-268-5074.

Staudenmayer, Suzanne

From: Wisconsin Right To Life [legis@wrtl.org]
Sent: Wednesday, October 05, 2011 12:41 PM
To: Wisconsin Right To Life
Subject: LRB 2088 Strong Communities - Healthy Kids Legislation

TO: State Legislators

FROM: Susan Armacost, Legislative Director
Wisconsin Right to Life

RE: Wisconsin Right to Life urges you to co-sponsor LRB 2088 (Strong Communities - Healthy Kids
Legislation)

Senator Mary Lazich is circulating LRB 2088 for co-sponsors. Wisconsin Right to Life hopes you will co-sponsor this legislation that is centered around restoring local community control and generating healthy kids.

Wisconsin Right to Life believes that local school districts should have the freedom to choose a sex education curriculum that reflects local community standards. Senator Lazich's legislation restores that freedom to local communities.

Under LRB 2008, regardless of the curriculum a local school district would choose, abstinence would be presented as the only reliable method to avoid pregnancy and sexually transmitted diseases. There will be students who will take that provision to heart. As a result, those students would not face incidences of pregnancy, abortion and sexually transmitted diseases. That is an outcome everyone should wholeheartedly support.

LRB 2008 would also end the practice of outside volunteer health care providers coming into Wisconsin's schools to provide instruction in sexual education. Planned Parenthood, the state's largest abortion provider, is one of the organizations who has been teaching sex education in our schools for many years. Wisconsin Right to Life believes that organizations like Planned Parenthood, who have a vested financial interest in promoting abortion in our state, should not be given that privilege and access to our young people.

Wisconsin Right to Life urges you to co-sponsor LRB 2088. The deadline for co-sponsorship

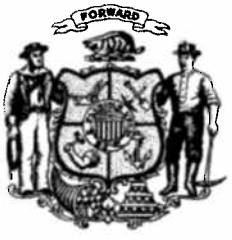
is this Friday, October 7. Please contact Senator Lazich's office to become a co-sponsor.

Thank you.

Wisconsin Right to Life
9739 W. Bluemound Ave., Suite 200
Milwaukee, WI 53226
414 778-5780 Ext. 202
Email: legis@wrtl.org
http://www.wrtl.org

Follow us on Facebook and Twitter!


WISCONSIN STATE LEGISLATURE


FORWARD

WISCONSIN LEGISLATIVE COUNCIL

Terry C. Anderson, Director
Laura D. Rose, Deputy Director

TO: REPRESENTATIVE TAMARA GRIGSBY

FROM: Anne Sappenfield, Senior Staff Attorney

RE: 2011 Senate Bill 237, Relating to Providing Instruction in Human Growth and Development, and Use of Instructional Methods and Materials That do not Promote Bias Against Certain Pupils

DATE: October 18, 2011

You have asked how 2011 Senate Bill 237 affects a provision of current law under which instruction in human growth and development in elementary and high schools must use instructional methods and materials that do not promote bias against certain pupils. Senate Bill 237 repeals the provision.

Under current law, a school board may provide an instructional program in human growth and development in grades Kindergarten to 12. If provided, the instructional program must meet the requirements for such instruction as set forth in the statutes. One of these requirements is that the program must use instructional methods and materials that do not promote bias against pupils of any race, gender, religion, sexual orientation, or ethnic or cultural background, or against sexually active pupils, or children with disabilities. [s. 118.019 (2) (b), Stats.]

Senate Bill 237 makes various changes to the requirements for instruction on human growth and development. Among those changes, the bill repeals the requirement that the instructional methods and materials that do not promote bias against pupils based on various factors. The bill instead provides that instruction on human growth and development must conform to the current pupil non-discrimination statute which broadly prohibits pupil discrimination. Specifically, current state law provides that:

> ...[N]o person may be denied admission to any public school or be denied participation in, be denied the benefits of or be discriminated against in any curricular, extra-curricular, pupil services, recreational or other program or activity because of the person's sex, race, religion, national origin, ancestry, creed, pregnancy, marital or parental status, sexual orientation or physical, mental, emotional or learning disability.

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

(OVER)

[s. 118.13 (1), Stats.]

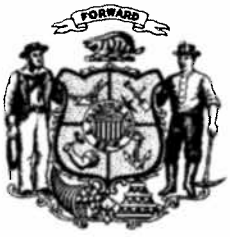
Regarding instructional materials, each school board must provide adequate instructional materials, texts, and library services which reflect the cultural diversity and pluralistic nature of American society. [s. 121.02 (1) (h), Stats.]

The extent to which repealing the specific bias provision in the human growth and development instruction law effects such instruction is not clear in light of other pupil non-discrimination laws. However, Senate Bill 237 does eliminate the prohibition against bias in that instruction against sexually active students, as that is a status that is not protected in current discrimination laws. In addition, the current provision in the statute relating to human growth and development instruction is a clearer directive to school boards regarding such instruction than the broader non-discrimination laws and, arguably, interprets those broader laws in the context of human growth and development instruction.

If you have any questions, please feel free to contact me directly at the Legislative Council staff offices.

AS:ty

WISCONSIN STATE LEGISLATURE



Testimony against 237: FILE

Ertel, Lindsi

From: Elizabeth Wendt [emwendt@wisc.edu]
Sent: Tuesday, October 18, 2011 4:50 PM
To: Sen.Olsen

18 October 2011
Testimony in Opposition to Senate Bill 237 From Elizabeth Wendt Hello,

My name is Elizabeth, and I am a 19-year-old freshman at the University of Wisconsin-Madison majoring in English with a pre-health/surgical oncology intention. In my free time I am a teen educator with the Wisconsin Adolescent Health Care Communication Program (WAHCCP) and an intern with the Wisconsin Alliance for Women's Health. I am also highly involved with St. Paul's Catholic Church on campus and consider myself a practicing Catholic. One may ask, how can this girl support both of these causes? She works for an organization that supports medically accurate and available reproductive health care AND believes in a religion that advocates abstinence. And I can answer you this:

Yes, I believe in abstinence in my personal life. But the place where my personal life intersects the rest of the world is where practicality sets in. Through my experiences with WAHCCP, I have met a group of dynamic, engaging, and wonderful peers. We have open discussions, and I know that some of them are engaging in sex. I also come from a school district where I did not have a health education class until I was a sophomore in high school. I saw many of the devastating effects of this through a rise in teen pregnancy, less open conversations about sexual health topics, circulation of misinformation, and a lack of confidence to seek the treatment and advice needed to be safe and healthy amongst my high school peers. This was absolutely disheartening to see. As a future health professional, I can see the importance of medically accurate reproductive health information and the devastating effects if it is not present. Beyond that, I know that my friends would continue to engage in risky sexual behaviors whether they were well informed of the risks or not. I love my friends and my colleagues at WAHCCP, and I would never want to see them hurt or see them make a poor decision simply because they were misinformed or uninformed. Regardless of my personal beliefs, my desire to have safe, healthy, responsible, and happy friends as well as my desire (and future responsibility as a health professional) to provide accurate health care drives me to oppose Senate Bill 237.

If Senate Bill 237 is passed, I anticipate a rise in sexually transmitted diseases, teen pregnancy, and a breakdown of communication between parents, health care providers, and youth.
Most teens are going to engage in risky sexual behaviors at some point during their teenage years, and even those who do not plan to, like myself, deserve to be informed. Teenage sexuality and identity is fluid. My beliefs could change tomorrow, and would it not be better for me to be informed so that I can make healthy and safe decisions for myself than uninformed, curious, and at risk? I say yes.

Because of my unique beliefs, I felt that my opinion was one you needed to hear in order to make a well-informed decision on Senate Bill 237. Simply because someone believes in abstinence in his or her personal life does NOT, by any stretch of the imagination, mean that abstinence is what should be taught. Teens deserve to receive medically accurate and comprehensive information regarding sexual health. It is, put simply, INJUST to deny anyone the right to information that will help him or her be the safest, healthiest, and happiest he or she can be.

Thank you for your time.
VOTE NO on SENATE BILL 237!!

Sincerely,
Elizabeth Wendt

18 October 2011
Testimony in Opposition to Senate Bill 237
From Elizabeth Wendt

Hello,

My name is Elizabeth, and I am a 19-year-old freshman at the University of Wisconsin-Madison majoring in English with a pre-health/surgical oncology intention. In my free time I am a teen educator with the Wisconsin Adolescent Health Care Communication Program (WAHCCP) and an intern with the Wisconsin Alliance for Women's Health. I am also highly involved with St. Paul's Catholic Church on campus and consider myself a practicing Catholic. One may ask, how can this girl support both of these causes? She works for an organization that supports medically accurate and available reproductive health care AND believes in a religion that advocates abstinence. And I can answer you this:

Yes, I believe in abstinence in my personal life. But the place where my personal life intersects the rest of the world is where practicality sets in. Through my experiences with WAHCCP, I have met a group of dynamic, engaging, and wonderful peers. We have open discussions, and I know that some of them are engaging in sex. I also come from a school district where I did not have a health education class until I was a sophomore in high school. I saw many of the devastating effects of this through a rise in teen pregnancy, less open conversations about sexual health topics, circulation of misinformation, and a lack of confidence to seek the treatment and advice needed to be safe and healthy amongst my high school peers. This was absolutely disheartening to see. As a future health professional, I can see the importance of medically accurate reproductive health information and the devastating effects if it is not present. Beyond that, I know that my friends would continue to engage in risky sexual behaviors whether they were well informed of the risks or not. I love my friends and my colleagues at WAHCCP, and I would never want to see them hurt or see them make a poor decision simply because they were misinformed or uninformed. Regardless of my personal beliefs, my desire to have safe, healthy, responsible, and happy friends as well as my desire (and future responsibility as a health professional) to provide accurate health care drives me to oppose Senate Bill 237.

If Senate Bill 237 is passed, I anticipate a rise in sexually transmitted diseases, teen pregnancy, and a breakdown of communication between parents, health care providers, and youth. Most teens are going to engage in risky sexual behaviors at some point during their teenage years, and even those who do not plan to, like myself, deserve to be informed. Teenage sexuality and identity is fluid. My beliefs could change tomorrow, and would it not be better for me to be informed so that I can make healthy and safe decisions for myself than uninformed, curious, and at risk? I say yes.

Because of my unique beliefs, I felt that my opinion was one you needed to hear in order to make a well-informed decision on Senate Bill 237. Simply because someone believes in abstinence in his or her personal life does NOT, by any stretch of the imagination, mean that abstinence is what should be taught. Teens deserve to receive medically accurate and comprehensive information regarding sexual health. It is, put simply, INJUST to deny anyone the right to information that will help him or her be the safest, healthiest, and happiest he or she can be.

Thank you for your time.
VOTE NO on SENATE BILL 237!!

Sincerely,
Elizabeth Wendt


FORWARD
E PLURIBUS UNUM

Wisconsin Family Action
Strengthening & Preserving Marriage, Family, Life & Liberty

PO Box 1327 • Madison WI 53701-1327
608-268-5074 (Madison) • 866-849-2536 (toll-free) • 608-256-3370 (fax)
Email: info@wifamilyaction.org
Web site: www.wifamilyaction.org
Blog: http://blog.wifamiyaction.com

Testimony in Support of Senate Bill 237
Senate Committee on Education
Julaine K. Appling, WFA President
October 19, 2011

Thank you, Chairman Olsen and committee members, for the opportunity to testify today in support of Senate Bill 237, the "Strong Communities...Healthy Kids Act." I am Julaine Appling, and I am testifying today as president of Wisconsin Family Action, a statewide organization that represents tens of thousands of Wisconsin individuals and families that are concerned about strengthening and preserving marriage, family, life and liberty in our state.

Last session, the state legislature determined that Madison knows best about how to have healthy children and passed the so-called "Healthy Youth Act." That law mandates that any school district that wants to have a Human Growth and Development program, or sex ed program, must use the one-size-fits-all approach. In particular, this law requires, among other mandates, that all school districts with a sex ed program must teach a comprehensive sex ed approach, including the "proper use of contraceptives and barrier methods."

Wisconsin Family Action worked diligently to defeat this legislation because we believed that it wrests most of the decision-making about sex ed from the local school districts and locks them into an "our-way-or-no-way" situation. Further, this loss of local control and decision making makes it even more difficult for parents to have input into the design and implementation of a sex ed program. Since we firmly believe that parents are the ones who truly have the best interest of their children at heart, we find this loss of parental input very problematic.

Within hours of Governor Doyle signing the so-called "Healthy Youth Act" into law last year, the phones in our office began ringing. For months, actually up until early this year with the change in the legislature and the administration, we heard regularly from parents, school board members, concerned community members and members of Human Growth and Development committees from school districts all around this state. Not one of them was happy with the new law. Many were angry; all were seeking ways to remove the heavy foot of Madison from their districts in this area. As an organization we sympathized and advised them as best we could, given the severe limitations in this current law. We traveled many miles to meet with groups of people who wanted to change what was happening in and to their schools. All along we told these folks that we would work tirelessly to restore local control, to give districts real choices, when it comes to Human Growth and Development programs. And that is what we have done.

Senator Lazich's "Strong Communities...Healthy Kids Act" is all about restoring local control—giving parents, communities, and school districts real choices in the type of sex ed programs that they develop and implement. SB 237 makes curriculum recommendations, not mandates. These solid recommendations are truly focused on ensuring the "optimal health and well-being" of the students." SB 237 allows school districts that believe an abstinence-centered curriculum is in line with their communities' values and is the best way to have healthy kids to have such a program. However, it also allows school districts to choose a "comprehensive sex ed" program, if that is what they believe reflects the values of their communities.

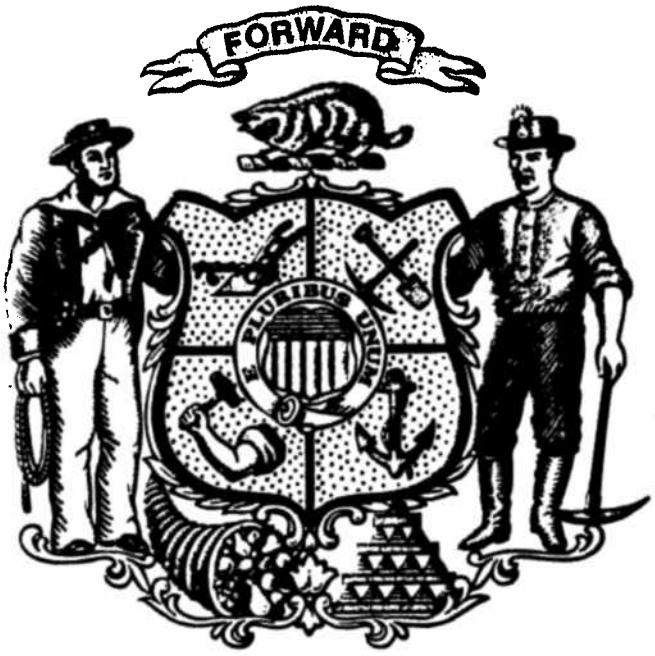
This bill addresses many of the problems we have with the so-called "Healthy Youth Act." We believe it is a reasonable, responsible approach that allows those closest to the students to make important decisions in a critical curriculum area.

You will hear today that taking this approach and allowing parents, communities and school personnel to decide what will be included in their Human Growth and Development programs will result in sky-rocketing teen pregnancy rates and sexually transmitted infections. We categorically reject that argument.

Of course, what the opponents of SB 237 are really concerned about is making sure no school district designs and implements a program that is more abstinence-centered than comprehensive. We contend that is a school district's, a community's right, to make that choice. And further, we know that ultimately such a decision is truly going to help students make healthy choices that will impact their entire future. We find it very difficult to envision a situation where a community that has chosen a strong abstinence program and faithfully implemented this holistic approach ending up with teen pregnancy and sexually transmitted infection rates that come anywhere near what those rates are in Milwaukee, where a comprehensive sex ed program has been in place for the entire 14 years I have been involved with this work. Ultimately, however, it is a school district's right to make the choice.

And that is the essence of SB 237—respecting the right of parents, communities and school districts to make their own decisions as to what will result in healthy kids.

Wisconsin Family Action urges you to support SB 237, the "Strong Communities...Healthy Kids Act" and thanks you for your time today.


FORWARD
E PLURIBUS UNUM

L!fe

WISCONSINRIGHTTOLIFE

Testimony of Susan Armacost
Legislative Director, Wisconsin Right to Life
before the Senate Education Committee
October 19, 2011

in support of Senate Bill 237
Strong Communities-Healthy Kids Legislation

9730 W Bluemond Rd, Ste 200 Milwaukee, WI 53226 Tel: 414-778-5780 Toll Free: 877-855-5007 Fax: 414-778-5785 www.WisconsinRightToLife.org

I am Susan Armacost, Legislative Director for Wisconsin Right to Life. I appreciate the opportunity to testify in favor of Senate Bill 237 - legislation to promote strong communities and healthy kids.

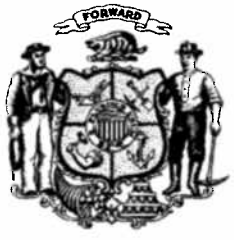
When Act 134, the so-called Healthy Youth Act, was enacted in 2009, Wisconsin Right to Life strongly opposed its enactment because of two areas of concern:

1. Under Act 134, local school districts offering a human growth and development curriculum are prohibited from teaching an abstinence-only approach to sex education. Wisconsin Right to Life believes the education of Wisconsin's young people in this area belongs under local control...not state control. If a local school district wants to teach an abstinence-only approach to their students, they should be able to. Abstinence is the healthiest course for our young people to take and is the only way to insure that sexually transmitted diseases, pregnancy and abortion will not result. Local school districts and parents should have the ability to select an abstinence-only approach to teaching sex education.
2. Under Act 134 organizations, like Planned Parenthood, continue to have the ability to come into Wisconsin's schools to teach within the sex education curriculum. Planned Parenthood is the largest abortion provider in the state and performs most of the abortions in Wisconsin. Wisconsin Right to Life strenuously objects to our public schools subjecting young students to the pro-abortion bias of an organization that has a vested financial interest in promoting abortion in our state.

Senate Bill 237 restores local control to local school districts to determine the approach they wish to take in teaching sex education and stops the objectionable practice of bringing biased and financially motivated abortion providers into our public schools to teach sex education. Wisconsin Right to Life urges you to support SB 237.

Thank you.


WISCONSIN STATE LEGISLATURE


FORWARD

TESTIMONY: **IN FAVOR of SB.237**

Loretta Baughan, N1166 High Ridge Rd, Merrill WI 54452
Wisconsin Senate Committee on Education Hearing, October 19, 2011

SB.237: PRO-FAMILY CHANGES TO HUMAN GROWTH & DEVELOPMENT LAW

Serving on the Board of Education at Merrill since April 2009, I've witnessed community outcry objecting to the sexualizing of children and trampling of family values. We lost our ability to teach abstinence before marriage without forced inclusion of comprehensive sex-ed, as a result of the so-called Healthy Youth Act of 2009. It's not only a contentious, divisive issue at the community level, but also among school board members. I speak today, as an individual and from the perspective of one school board member.

From my observations, those who push hardest for Planned Parenthood style, sex-ed programs often argue they don't want those with high moral values preventing their children from being exposed to comprehensive sex education at school. Yet, they see nothing wrong with imposing their permissive, anything goes beliefs on other people's children. I believe it's a two-way street. Sex education must be presented in a manner which is respectful and fair for all.

A one-size-fits-all approach is a disservice to our youth. Merrill has different needs and concerns than Milwaukee, Green Bay or Madison. Flexibility is always far better than mandates, especially in legislation of a sensitive nature, because local school boards, communities and parents are best equipped to determine what and how their children should be taught.

Changes contained in SB.237 are a welcome improvement to a very troubling law. As a mother of exceptionally challenged children, new "age-appropriate" language alleviates my concern special needs students could be subjected to instruction inappropriate to their capacity of understanding or even damaging to their well-being.

I support an emphasis on abstinence before marriage and equipping students with skills to withstand pressure against sexual activity, while remaining chaste. Personal responsibility, prenatal development, as well as inclusion of adoption add value. Conveying a positive emphasis on marriage, parenting skills and communication within the family unit benefits young people. It's vital they fully understand legal consequences and life-long ramifications of a sex offender conviction. I appreciate the removal of mandatory curriculum topics, especially, what amounted to the promotion of contraceptives and an appearance of endorsing teen premarital sexual activity. It's imperative students know abstinence is the only way to avoid pregnancy or STDs.

No legitimate need justifies outside agencies, individuals or organizations' access to classrooms as "volunteer health care providers" when school districts already pay their own staff to teach Human Growth and Development. Barring outside interests from public school HG&D classes preserves student privacy and prevent an unfair advantage or potential of financial gain for those who may cultivate students' trust while undermining family values. I'm appalled by current law protecting volunteer health care providers from civil liability by the State. Ending taxpayer-funded protectionism demonstrates wisdom and common sense on the part of Legislators who authored and support SB.237.

I whole-heartedly welcome and support limitations related to advisory committee membership in the interest of preventing school districts from unfairly stacking them with past or present school personnel, school board members and their spouses. Such committees must accurately reflect local community standards while granting all viewpoints a fair representation. I humbly urge your support of SB.237.


WISCONSIN STATE LEGISLATURE


FORWARD

JMJ †

Wednesday,
October 19, 2011 p. 1

Modern Catholic Dictionary
by John A. Hardon, S.J.
reprinted and published by Eternal Life
Bardstown, Kentucky
Fourth Printing 2008

p. 96
Chastity. The virtue that moderates the desire for sexual pleasure according to the principles of faith and right reason. In married people, chastity moderates the desire in conformity with their state in life; in unmarried people who wish to marry, the desire is moderated by abstention until (or unless) they get married; in those who resolve not to marry, the desire is sacrificed entirely.

Chastity and purity, modesty and decency are comparable in that they have the basic meaning of freedom from whatever is lewd or salacious. Yet they also differ.

(cont.) Chastity implies an opposition to the immoral in the sense of lustful or licentious. It suggests refraining from all acts or thoughts that are not in accordance with the Church's teachings about the use of one's reproductive powers. It particularly stresses restraint and avoidance of anything that might defile or make unclean the soul because the body has not been controlled in the exercise of its most imperious passion.
(Etym. Latin castus, morally pure, unstained.)

jmj †

Wednesday,
October 19, 2011 p.3

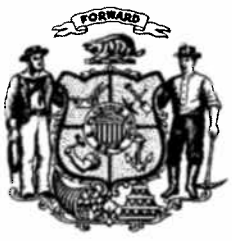
Committee of the Wisconsin State Senate:

Repeal the sex ed bill- law.
SB 237 should replace the word "kids" with "children." "They are not goats!
As a lifelong Wisconsin citizen, my support goes 100% for any legislation which protects children from Planned Parenthood.
Children need virginity taught them, first, at home, then, in their formal education.
all children should be taught that sexual pleasure belongs to the married state, and that "marital embrace" is God's gift on the wedding night, intended always to be open to children, with whom the mother and father intend to share the love they have for each other.

God bless you to do God's will in this matter. God is love. 1 John 4:8,16

Jeanne Breunig
Middleton, WI

WISCONSIN STATE LEGISLATURE



October 19, 2011

To Whom It May Concern:

I am writing to voice my support for Senate Bill 237. As a parent, I believe that it is crucial that we lead our children to make wise decisions about their lives, their sexuality, and the commitment they make to another individual in marriage.

I believe we have not done an adequate job helping kids understand the risks that accompany a promiscuous lifestyle. As a former University of Wisconsin-Madison student, I enrolled in classes that not only promoted a different lifestyle, they bashed the traditional family and some of its members. Thankfully, my conscience urged me out of that type of class - but many young adults were filled with these false truths.

I believe it is our job as adults to protect and to prepare the children. If our goal is to create healthy and responsible adults, then Senate Bill 237 is a step in that direction and should be unanimously supported.

Thank you for your consideration.

Very Sincerely,

Angelique Breuscher

1517 Sandy Rock Rd

Hollandale, WI 53544