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HIV Risk Behaviors among Women Living in Low-Income, Inner-City Housing Developments

Kathleen J. Sikkema, PhD, Timothy G. Heckman, PhD, Jeffrey A. Kelly, PhD, Eileen S. Anderson, EdD, Richard A. Winett, PhD, Laura J. Solomon, PhD, David A. Wagstaff, PhD, Roger A. Roffman, DSW, Melissa J. Perry, ScD, Victoria Cargill, MD, Denise A. Crumble, R. Wayne Fuqua, PhD, Ann D. Norman, PhD, and Mary Beth Mercer, MPH

ABSTRACT

Objectives. This study describes the prevalence and predictors of human immunodeficiency virus (HIV) risk behaviors among women living in low-income, inner-city housing developments.

Methods. Anonymous questionnaires were administered to 671 women living in 10 inner-city, low-income housing developments in five US cities to determine their levels of HIV risk behavior and predictors of HIV risk practices.

Results. Approximately one third of women were at high risk for HIV because of the risk behavior of their sexual partners. HIV risk was highest among women who accurately perceived themselves to be at increased HIV risk, held strong beliefs about barriers to condom use, and reported weak behavioral intentions to reduce risk. Women at higher risk were also younger and reported higher rates of alcohol and substance use.

Conclusions. HIV prevention efforts are needed for inner-city women. Interventions should focus on overcoming women's barriers to condom use, strengthening their intentions to change behaviors, and managing the risk related to their use of substances. (*Am J Public Health.* 1996;86:1123–1128)

Introduction

Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) is now the fourth leading cause of death among adult American women under the age of 45.[1] As with the historical pattern of HIV infection among men, risk for the disease is not equally distributed across the entire population of women but is disproportionately high among impoverished minority women in our inner cities. Approximately 77% of female AIDS cases diagnosed in the United States in 1994 occurred among African-American and Hispanic women, although African-American and Hispanic women make up only 21% of all US women.[2] The epidemiology of HIV infections among women is also changing, with heterosexual transmission rather than a woman's own injection drug use now accounting for the majority of new infections.[3] Recent sentinel seroprevalence studies show increasing levels of HIV infection among inner-city women seen in sexually transmitted disease clinics, reproductive health clinics, and urban primary health care programs.[4,5]

A large number of studies have identified the prevalence of HIV sexual risk behaviors among gay or bisexual men and have examined factors predictive of gay men's risk behavior. Across studies with various samples, such factors as age, perceived self-efficacy of behavioral change, intentions to practice safer sex, perceived norms among peers and sexual partners concerning condom use, sexual negotiation or assertiveness skills, and use of alcohol or recreational drugs in association with sexual activity have emerged as salient predictors of gay men's sexual risk behavior.[6–12]

Much less is known about the prevalence and nature of such risk behavior and predictive factors among inner-city women.[13] Jemmott and Jemmott[14] have found that normative beliefs concerning condom use are salient influences on minority women's intentions to use condoms, while Nyamathi and her colleagues have reported an active coping style, high self-esteem, and less drug use as determinants of low levels of HIV risk behavior among homeless and drug-addicted minority women.[15,16] Sexual communication skills between partners and enjoyment of condom use have been shown to influence condom use among sexually active urban women.[17] A number of writers have also noted that social and cultural factors such as patterns of traditional sex role socializa-

Kathleen J. Sikkema, Timothy G. Heckman, Jeffrey A. Kelly, David A. Wagstaff, and Denise A. Crumble are with the Center for AIDS Intervention Research (CAIR), Medical College of Wisconsin, Milwaukee. Eileen S. Anderson and Richard A. Winett are with Virginia Polytechnic Institute and State University, Blacksburg. Laura J. Solomon and Melissa J. Perry are with the University of Vermont, Burlington. Roger A. Roffman and Ann D. Norman are with the University of Washington, Seattle. Virginia Cargill and Mary Beth Mercer are with Case Western Reserve University, Cleveland, Ohio. R. Wayne Fuqua is with Western Michigan University, Kalamazoo.

Requests for reprints should be sent to Kathleen J. Sikkema, PhD, Center for AIDS Intervention Research, Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Rd, Milwaukee, WI 53226.

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tion, lack of power in dyadic sexual relationships, social and economic dependence on a male relationship partner, male resistance to condom use, and life chaos associated with impoverishment all constitute barriers to a woman's ability to take protective steps against sexually transmitted HIV infection.[18–20] In addition, and in contrast to patterns observed among men in which sexual HIV risk is often conferred through having very large numbers of different partners, women may be more often at risk because of their main partner's extrarelationship sexual or drug use activity.

The purpose of the present study was to characterize the nature and prevalence of HIV risk characteristics in a large sample of low-income adult women living in inner-city housing developments. In contrast to previous research, which has often relied on small convenience samples drawn from a single city, the present research surveyed low-income women in five American cities. Within the population of low-income women, considerable variability in levels of HIV risk was expected, with some women at very high risk and others at little or no risk. Consequently, a second purpose of the research was to determine the extent to which social and psychological characteristics such as HIV risk knowledge, substance use patterns, perceived HIV risk, intentions to change behavior, perceptions of safer sex norms, and beliefs about condoms predicted HIV risk behavior in community samples of low-income women.

Methods

Setting and Participants

This research was conducted in spring 1994 in 10 inner-city, low-income housing developments in Milwaukee, Wis; Roanoke, Va; Cleveland, Ohio; Rochester, NY; and Tacoma, Wash. These cities were selected because, based on local HIV seroprevalence studies, they are typical of middle-sized cities in the United States that are now encountering an increase in HIV infections among impoverished women. Housing developments were selected primarily because they had female heads of household, were of moderate size with relatively stable tenant populations, and were located in disadvantaged areas of the city. Two matched housing developments were identified in each of the five cities. Each development had 65 to 150 households, and all were located in central urban areas with high rates of poverty, sexually transmitted disease, and drug use.

Data were collected from 671 women in the 10 developments (range: 89 to 207 women per city). All women over the age of 18 in each development were approached by female research staff and asked to participate in the study. Based on the housing management's census from each development, approximately 80% of all adult women living in each development completed the survey. The demographic characteristics (age, race, number of children, income, and educational level) of the respondents were comparable to those of all adult female residents in each of the housing developments. For completing the assessment, women were compensated $15, part of which was intended to cover the cost of child care.

Assessment Measure

Women completed the assessment in small groups that met in community rooms within each housing development. Because interview data collection methods may promote inaccurate reports of sexual or drug use behaviors owing to social desirability,[21] each woman anonymously recorded her responses on a printed survey questionnaire. To ensure that women with low reading levels understood assessment measures and to provide an opportunity to explain each question in more detail if necessary, research staff used an overhead projector to display a facsimile of the questionnaire and read aloud each item while participants privately marked responses on their own form. Content of the questionnaire was adapted from previous research on factors related to HIV risk.[7,22,23] The survey measure was pilot tested with 100 women from other housing developments to ensure that questions were clear and easily understood and to establish psychometric indices of multi-item scales. The measure, which took approximately 30 minutes to complete, assessed the following variables:

Demographic characteristics. Women indicated their age, race/ethnicity, education, income, number of children, history of HIV testing and treatment for sexually transmitted diseases, and current relationship status.

HIV risk behavior knowledge scale. Practical understanding of AIDS risk behavior and risk reduction steps was assessed using a 12-item true–false scale. Sample items included the following statements: "Latex is the best material a condom can be made of for protection against the AIDS virus" and "Most people who carry the AIDS virus look and feel healthy." This scale demonstrated adequate internal consistency (Cronbach's alpha = .74).

Sexual and substance use behavior. Women were instructed to think about their sexual behavior during the past 2 months. They were then asked to report the number of their male sexual partners, the total number of times they had intercourse, and the number of times they used condoms during intercourse over this specified time period. This format has been extensively tested, and the "past 2 months" time frame was used because it elicits reliable reports of sexual behavior.[24] Women described their sexual behavior with both their regular sexual partner and any other sexual partners. Regular partners were defined as a man with whom the respondent had a current or long-term relationship; other partners were defined as any other man with whom the respondent had sex within the past 2 months. Additionally, each woman indicated the number of days in the past 2 months when she used alcohol, marijuana, cocaine or crack, and injection drugs.

Risk level of male sexual partners. Women may be at risk for HIV infection if they have multiple sexual partners or if they have an exclusive sexual relationship with a man who either injects drugs or has unprotected sex with other people. Therefore, participants completed items assessing the HIV risk behavior of their regular partner and any other sexual partner. Using 4-point Likert ratings (from 1 = "sure he did not" to 4 = "sure he did"), women were asked to rate how sure they were that their regular and other sexual partners had ever injected an illegal drug or had sex with anyone else in the past year.

Personal risk estimation. Based on her behavior over the past 2 months, the respondent was asked to indicate her perceived risk for getting the AIDS virus. Responses to this question ranged from 1 = "no risk at all" to 5 = "a lot of risk." The time frame for risk self-estimation was the same as for sexual behavior self-reports to permit comparison of risk behavior with risk estimation over the same period. In addition to its face validity, this measure has exhibited predictive validity in previous investigations of HIV risk among gay men.[12,25]

Risk reduction behavioral intentions. Women completed a three-item scale assessing their intentions to use condoms

during their next intercourse occasion. Each item consisted of a statement (e.g., "I will say no to sex with a male partner if he will not use a condom") and a 4-point Likert scale to indicate her level of agreement (from 1 = "strongly disagree" to 4 = "strongly agree"). This scale yielded scores ranging from 3 to 12, with higher scores indicative of stronger intentions to engage in safer sex, and it demonstrated satisfactory internal consistency (Cronbach's alpha = .82).

Safer sex peer norms. Respondents completed a four-item scale to assess perceptions of peer norms concerning condom use. Each item consisted of a statement (e.g., "Most of my closest women friends use condoms when they have sex with a man") and a 4-point Likert scale to indicate level of agreement (from 1 = "strongly disagree" to 4 = "strongly agree"). This scale produced scores ranging from 4 to 16 (Cronbach's alpha = .82).

Condom barrier beliefs. Four items were used to assess beliefs about barriers to condom use. The four items included the following statements: "Sex is not as good with a condom," "Using condoms means you don't trust your partner," "I do not have a need to use condoms," and "My partner would react badly if I suggested the use of a condom." Women again indicated their level of agreement with each statement using a 4-point Likert scale (from 1 = "strongly disagree" to 4 = "strongly agree").

Conversations with male partners about condoms and AIDS concerns. To assess the salience of AIDS concerns and safer sex, communication between the woman and her partner about condoms and health, and negotiation efforts concerning risk reduction, the women reported the number of times in the past 2 months when they had talked with their partners about condoms and, separately, about AIDS concerns.

Statistical Analysis

To identify factors predictive of high HIV risk among inner-city women, respondents were classified into high or low risk groups, and the classification was modeled with logistic regression. High-risk women were defined as those who (1) had multiple male sexual partners in the past 2 months and reported any unprotected intercourse; (2) had unprotected intercourse with a partner believed to have injected illegal drugs or to have had sex with other people in the past year; (3) had unprotected intercourse with an HIV-positive man; (4) had used injection drugs in the past 2 months; (5) had been treated for a sexually transmitted disease in the past 2 months and reported any unprotected intercourse; or (6) had unprotected intercourse with a regular partner with whom she had been sexually involved for less than 1 year and was uncertain whether that partner had injected drugs or had sex with other people. Low-risk women were those who reported no intercourse, no occasions of unprotected intercourse (i.e., no intercourse occasions when condoms were not used), and involvement in a mutually monogamous relationship with a man who she reported had tested negative for HIV and who she believed did not inject illegal drugs or have sex with other people. This classification scheme yielded 319 low-risk women and 206 high-risk women. The remaining women in the sample could not be reliably categorized as high or low in risk either because of missing responses on items used to determine risk categorization or because they reported relationships with regular male partners who did not have known risk characteristics but were not described as monogamous. Given uncertainty concerning their risk level, these women were not included in the risk-level group comparisons.

A series of univariate logistic regressions was conducted to identify individual predictor variables of risk classification. To establish the relative contributions of predictor variables, many of which were intercorrelated, a forward stepwise logistic regression analysis was conducted. The odds ratio was used to assess the strength of bivariate associations.[26]

Results

The mean age of surveyed women was 33.2 years (SD = 11.8, range = 18 to 76), and the average level of education completed was 11.5 years (SD = 1.9, range = 3 to 17 years). Eighty-two percent of the women were African American, 10% were White, 5% were Hispanic/Latina, and 3% were of other ethnicities. Sixty-three percent of women had household incomes below $700 per month, and 93% of women had children (mean = 3.1 children, SD = 2.0 children).

HIV Risk Behavior Knowledge

As Table 1 shows, the women's knowledge of HIV risk behavior varied; the mean score for correct answers on the 12-item knowledge measure was 72%. While most of the women were aware of HIV risks related to injection drug use and heterosexual transmission, there were also important areas of misconception. For example, most of the women did not know that people with HIV often look and feel healthy and that latex condoms

TABLE 1—Percentage of Inner-City Women (n = 655) Correctly Answering Each of 12 Items Constituting an HIV Risk Knowledge Test[a]

Item	% Responding Correctly
Birth control pills protect against the AIDS virus (F)	90
If a man pulls out right before orgasm (cumming), condoms don't need to be used to protect against the AIDS virus (F)	89
Most people who have the AIDS virus look sick (F)	80
Vaseline and other oils should not be used to lubricate condoms (T)	56
Latex is the best material a condom can be made of for protection against the AIDS virus (T)	46
Cleaning injection needles with water is enough to kill the AIDS virus (F)	89
Most people who carry the AIDS virus look and feel healthy (T)	46
Hand lotion is not a good lubricant to use with a condom (T)	60
A woman is not likely to get the AIDS virus from having sex with a man unless he is bisexual (F)	87
Condoms cause men physical pain (F)	74
If you're seeing a man and he agrees not to have sex with other people, it is not important to use a condom (F)	85
Always leave some room or "slack" in the tip of the condom when putting it on (T)	62

[a]Percentages are based on women who provided responses to all 12 HIV risk knowledge scale items.

TABLE 2—Percentage of Women (n = 671) Living in Low-Income Housing Developments Reporting Various HIV Risk-Related Sexual Behaviors in the Past 2 Months[a]

Risk Behavior	% (No.) Women Reporting the Behavior
Intercourse with two or more sexual partners	14 (97/671)[b]
Intercourse with a regular sexual partner believed to have injected drugs	6 (29/499)[c]
Intercourse with a regular sexual partner believed to have had sex with others in the past year	40 (199/503)[c]
Intercourse with a regular partner whose HIV serostatus is unknown	60 (304/510)[c]
Intercourse with other sexual partners believed to have injected drugs	9 (9/95)[d]
Intercourse with other sexual partners believed to have had sex with others in the past year	68 (63/93)[d]

[a]Denominators vary because all items do not pertain to every participant or because some data were missing. Belief about partner risk was based on women reporting that they were "sure" or "pretty sure" of their partner's risk characteristics.
[b]Pertains to all women.
[c]Pertains only to women with at least one sexual partner.
[d]Pertains only to women with more than one sexual partner.

TABLE 3—Logistic Regression Analysis of High vs Low HIV Risk among Inner-City Women (n = 494)

	Univariate Effect		Multivariate Effect	
	OR	95% CI	OR	95% CI
Age, in decades	0.68	0.6, 0.8	0.74	0.6, 0.9
HIV risk behavior knowledge score[a]	1.3	0.6, 3.1		
Personal risk estimation score	2.0	1.6, 2.4	1.8	1.4, 2.2
No. conversations about condoms, past 2 months[b,c]	1.7	1.1, 2.9	1.1	0.5, 2.1
No. conversations about AIDS concerns, past 2 months[b,c]	2.2	1.4, 3.7	1.3	0.7, 2.5
No. days in past 2 months alcohol or illegal substances were used[b]	2.2	1.6, 3.1	1.7	1.2, 2.5
Safer sex peer norms score[c]	0.92	0.88, 0.97	0.98	0.3, 3.3
Risk reduction behavioral intentions score	0.86	0.8, 0.9	0.88	0.8, 0.9
Condom barrier beliefs score	1.1	1.0, 1.2	1.1	1.1, 1.2

Note. OR = odds ratio; CI = confidence interval.
[a]Variable not used in multivariate model because of nonsignificant OR.
[b]$\log_{10}(x + 1)$ transformation applied to variable.
[c]Variable did not enter in multivariate stepwise analysis.

afford the best protection against the AIDS virus. Large proportions of the women believed that Vaseline, hand lotions, or oils are good lubricants for condoms, and more than one quarter of them believed that use of a condom causes men pain.

Sexual Behavior Patterns

Table 2 summarizes findings with respect to HIV sexual risk behavior. During the previous 2 months, 77% of all respondents reported at least one male sexual partner and 14% had two or more. A substantial proportion of the women were at increased risk of exposure to HIV because of the risk behavior of their sexual partners. For example, 40% of the women with a regular sexual partner and 68% of the women with other sexual partners believed that their partners had had sex with someone else during the past year. Nine percent of the women with casual sexual partners were either "sure" or "pretty sure" that their partners had injected illegal drugs at sometime in the past. Condom use varied by partner type; 33% of intercourse occasions with regular partners were protected while 60% of intercourse occasions with other partners were protected (data not shown). Underscoring the issue of increased HIV risk because of partner risk behavior, only 36% of intercourse occasions with regular partners who were believed to have had sex with others or to have injected drugs were protected.

Logistic Regression Analysis Identifying Factors Differentiating Low- and High-Risk Women

To identify factors associated with HIV risk level, we compared the high- and low-risk groups using a forward stepwise logistic regression analysis.[26] Table 3 summarizes the univariate and multivariate logistic regression results. Of the nine predictor variables investigated, eight were statistically related in univariate analyses to risk-group classification and were used in the regression analysis: (1) respondent's age, (2) personal risk estimation score, (3) number of conversations in the past 2 months with male sexual partners about using condoms, (4) number of conversations in the past 2 months with male sexual partners about AIDS concerns, (5) number of days in the past 2 months in which alcohol or illegal substances were used, (6) safer sex peer norms score, (7) risk reduction behavioral intentions score, and (9) condom barrier beliefs score. The HIV risk behavior knowledge score did not relate in univariate analyses to risk-group classification and was not used in the regression analyses. To ensure that regression analysis assumptions were satisfied, a $\log_{10}(x + 1)$ transformation was applied to the two conversation indices to reduce distribution skew, decrease the number of outliers, and improve the normality of residuals.[26]

The multiple logistic regression analysis was used to evaluate all the variables that were significant in the univariate analysis. As shown in Table 3, five variables entered the multivariate model: (1) personal risk estimation score, (2) condom barrier beliefs score, (3) risk reduction behavioral intentions score, (4) age, and (5) substance use during the past 2 months. Women who were at high risk of HIV infection accurately perceived themselves to be at increased HIV risk. High-risk women perceived stronger barriers to condom use, such as the belief that sex is not as good if condoms are used and that their male sexual partner would react badly if condom use were suggested, and they reported weaker intentions of engaging in safer sex. Women at high risk were also younger and reported greater

rates of alcohol and other substance use during the past 2 months. HIV risk-group classification was not statistically associated with the number of conversations in the past 2 months about condoms or AIDS concerns, or with safer sex peer norms scores.

Overall, of the women included in the regression analysis, the five-variable model correctly classified 69% into their respective HIV-risk category. Specifically, the model correctly identified 81% of the women at low risk of HIV infection and 52% at high risk of HIV infection.

Discussion

Many women living in inner-city, low-income housing developments are at risk of contracting HIV infection. Women are at high risk because of their involvement in sexual relationships with regular partners who have extrarelationship sex or have injected drugs, or because of their multiple partners. High rates of recent treatment for sexually transmitted disease and low rates of condom use with regular partners substantiated this risk for many of the women in our study. A large proportion of these women reported knowing that their regular sexual partners had sex with other people, injected drugs, or were of unknown serostatus, and not using condoms in more than two thirds of intercourse occasions with these partners. These findings underscore that women may be at risk for HIV because of their main partner's extrarelationship activities, their own practice of having unprotected intercourse with multiple male partners, or their use of injected drugs. At the same time, not all the women were at risk; a relatively large proportion of participants were not sexually active in the past 2 months, had only a single regular partner not known or believed to be at elevated risk, or consistently used condoms.

Women in this sample exhibited high overall levels of HIV risk knowledge; however, they also had knowledge deficits related primarily to proper condom and lubricant use, and misconceptions about the physical appearance of most people with HIV infection. A large number of women had been treated for a sexually transmitted disease in the past 2 months, confirming the HIV vulnerability of these inner-city poor women.

Social and psychological characteristics predicted the HIV risk level of women in the sample. Women at high risk for HIV were younger, held weak behavioral intentions to engage in condom-protected intercourse, perceived greater relationship barriers to condom use, and had higher rates of substance use. However, high-risk women also reported accurate perceptions of HIV risk. These findings are consistent with social-cognitive[27,28] and reasoned action[29] theories that identify beliefs, skills, self-efficacy, and social norm characteristics as determinants of HIV risk behaviors. However, the regression analysis used in this sample correctly classified 81% of the low-risk women as compared to 52% of high-risk women. This suggests that while the assessed variables are strongly predictive of risk-related behavior, additional and unassessed factors may influence high-risk sexual behavior.

These findings support the social-cognitive HIV prevention approaches that emphasize the strengthening of behavioral intentions and self-efficacy through skill development of proper condom use, behavioral self-management, and sexual negotiation and communication appropriately tailored for low income, inner-city women. Group interventions that focus on increasing accurate perceived risk of contracting HIV infection, identifying and managing factors (especially substance use) related to high-risk behavior, developing problem-solving skills related to changing risk behavior, learning sexual communication and negotiation skills, and receiving social support for behavior change efforts have proven effective with other populations.[30–32] However, interventions for women must also incorporate prevention messages and skills focused on partner relationships and the issues of power imbalance in traditional sexual relationships, social and economic dependence on a male partner, and the priorities of daily life for impoverished women.

Inner-city housing developments are an appropriate and important setting for HIV risk reduction interventions as they constitute identifiable and accessible communities in which to reach adult and adolescent women at risk for HIV infection. Characteristics of housing developments, such as their accessibility, the potential for multiple contacts, and the formulation of resident-controlled intervention components, increase the likely efficacy of such preventive programs. With the changing epidemiology of HIV infection among women and the competing life stress priorities encountered by impoverished women, innovative HIV preventive approaches integrated into health, social service, and residential activities within housing development communities are urgently needed. □

Acknowledgments

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It is the mission of the Center for AIDS Intervention Research (CAIR) to conceptualize, develop, conduct, and scientifically evaluate the effectiveness of new intervention strategies to prevent HIV infection in populations vulnerable to the disease.

CAIR's research also seeks to identify improved strategies to promote health and alleviate adverse mental health consequences of HIV among persons with the disease and among their loved ones.

Bridging the Gap Between Science and Service

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Center for AIDS Intervention Research (CAIR)

Department of Psychiatry and Behavioral Medicine
Medical College of Wisconsin
2071 North Summit Avenue
Milwaukee, WI 53202
Telephone: 414-456-7700 ◦ 1-800-644-1615
Fax: 414-287-4209
Web: www.cair.mcw.edu

MEDICAL COLLEGE OF WISCONSIN

Center for AIDS Intervention Research (CAIR)

Department of Psychiatry and Behavioral Medicine
Medical College of Wisconsin

Evergreen Missionary Baptist Church

1138 W. Center Street • Milwaukee, WI 53206
Office: (414) 265-0400

Rev. Joseph H. Jackson Jr., Pastor

YOU DON'T HAVE TO BE PRO-ABORTION, HOWEVER YOU DONT HAVE BE AGAINST PLANNED PARENTHOOD. LET'S NOT BE SO NARROW MINDED AND MISS OUT ON QUALITY HEALTH TESTING / SCREENING AT AN AFFORDABLE COST IN A COMMUNITY THAT COULD GREATLY BENEFIT FROM THIS MUCH NEEDED CARE.

I SUPPORT SAFE, QUALITY & AFFORTABLE HEALTH TESTING + SCREENING.

THAT POSSIBILITY EXISTS AT 76TH + HILL RD.

REV. Joseph Jackson, Jr. 02/25/03

"Ever increasing opportunities for many"

February 26, 2003

Dear Milwaukee Community:

I am providing a written support statement in lieu of my attendance at today's meeting due to prior obligations.

Without reservation, I support the creation of a disease prevention health center at 76th Street and Mill Road. I contend that the rising rates of sexually transmitted diseases and the unmarried pregnancy rate of teenage mothers in the Milwaukee community elicit the need for this type of program which will not offer abortion as a service.

Residents in our community need a place to go for reproductive health education. We cannot ignore the facts that Milwaukee has the second highest teen pregnancy rate in the nation, 7,000 teens become pregnant in Milwaukee every year, Milwaukee has the 10th highest national gonorrhea rate, and that every hour a teenager is infected with HIV. Additionally, the percentage of low birth weight babies born in Milwaukee was above the average.

Viewing the problem and assessing the need for a solution, it is clear that disease prevention and reproductive health education is needed to reverse the increasing trends of these negative findings.

Regards,

Chuck Holloway

Rev. Chuck Holloway, MA
President/Executive Director

Corporate Office: 4098 North Elmhurst Road, Milwaukee, WI 53216 Phone (414) 449-5096 Fax (414) 449-5038

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Lutheran Church of the Reformation

2201 North 35th Street
Milwaukee, WI 53208-1404
414.444-0440
Rev. Mick Roschke, pastor
Rev. Mary Rowland, pastor

February 25, 2003

Dear City Officials and Friends,

It is our hope at Reformation and related parishes throughout the city of Milwaukee that any source of health services that can be established for our citizens is given high priority by your Board. If Planned Parenthood is willing and able to provide such a clinic in the proposed neighborhood, and even offer basic health care and only limited reproductive health care, then please grant them – and all of us – the possibility!!

When people were denied medical help at hospitals because of *their race*, people of faith were too often behind that sentiment. We write to say that we are behind you in your decisions to give the people, **all** the people, of your city the possibility of appropriate health care.

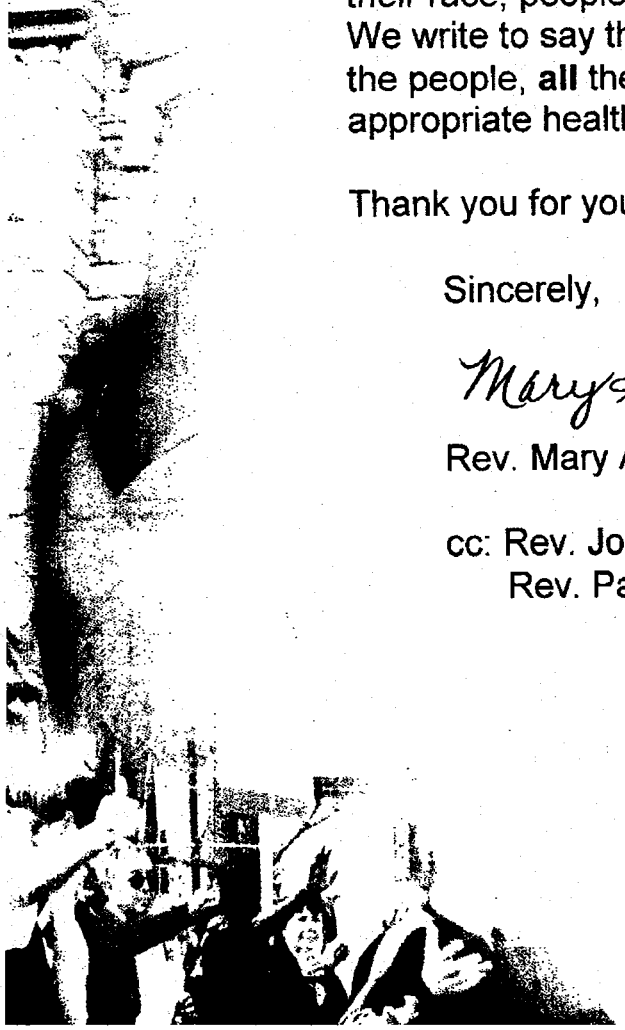
Thank you for your consideration.

Sincerely,

Mary A. Rowland

Rev. Mary A. Rowland

cc: Rev. Joseph Jackson, President, MICAH
Rev. Paul Stumme-Diers, Bishop, ELCA



Don't go through life's journey without a compass.

EVANGELICAL LUTHERAN CHURCH IN AMERICA

I'm writing to support the health care being proposed at 76th and Mill. I have been a clergywoman for 18 years and have pastored numerous women who have found it difficult to receive health care services such as being proposed. The cost of denying access is a cost to our society as a whole - not just in disease, but in the cost of family cohesiveness. Supporting this type of health care is supporting families.

Nancy Bauer-King
Pastor - Native American Ministry
United Methodist Church
ncbk@wi.net

As a resident and a Parish Nurse in the city of Milwaukee, I have utilized the services of the Milwaukee Health Department and Planned Parenthood of Wisconsin. Access to educational materials and health professionals is vital to the health of the residents, and knowing the great work that both the Health Department and Planned Parenthood do, it is a great opportunity for all involved to have a combined clinic in the 76th and Mill Road neighborhood. That area is also out of the reach of the major hospitals and clinics, so again this would be filling a great gap in health care services. I am strongly in support of this clinic and have great faith that all patients would be treated with dignity, with respect for their religious beliefs, and receive great medical care.

Sincerely,
Patrice Olin, RNC, MS
Pentecost Evangelical Lutheran Church
olin@execpc.com

Bennker, Colleen

From: RRollefson@aol.com

Sent: Tuesday, February 25, 2003 3:17 PM

To: Bennker, Colleen

Subject: Re: Planned Parenthood Clinic @76th and Mill

Collen,
I don't think I can attend the meeting, but you are welcome to use the following:

Dear Common Council Members,

I am writing in support of the proposed Planned Parenthood Clinic/Milwaukee Public Health Clinic at 76th and Mill Road. There is clearly a need for low-cost reproductive health care in this part of the city and a partership with Planned Parenthood would help to insure its availability for Milwaukee residents.
Sincerely,
Rev. Richard Rollefson
The Village Church
130 E. Juneau Ave.
Milwaukee, WI 53202
(414)273-7617

We provide a service to a community of need not being served by others. The well being of the disenfranchised (no health care) is a basic concern for the faith community.

Rev. Deborah Block
Immanuel Presbyterian Church
deborahblock@mwci.net

Fax: 286-3456

February 25, 2003

Common Council President Pratt
200 East Wells Street
Milwaukee, WI 53202

Dear Alderman Pratt:

I absence of an alderman to speak on my behalf, I am writing to inform you that I support the proposed Planned Parenthood Clinic collaboration with the City of Milwaukee Health Department.

As a mother of 4 children, I know that my children may not always come to me. I would like for them to be able to go to a place that I know they will receive honest and medically accurate information related to sexually activity.

I have live at my address for 5 years and I support Planned Parenthood of Wisconsin.

Sincerely,

Catina Cotton

Catina Cotton
5489 North 69th Street
Milwaukee, WI 53218

Fax: 286-3456

February 25, 2003

Alderman Jim Bohl
5th District City of Milwaukee
200 East Wells Street
Milwaukee, WI 53202

Dear Alderman Bohl:

I am writing to inform you that I support the proposed Planned Parenthood Clinic collaboration with the City of Milwaukee Health Department.

As the Alderperson for my neighborhood, I am asking that you support the proposal also.

Sincerely,

Toni Johnson
5766 North 80th Street
Milwaukee, WI 53218

cc: Planned Parenthood of Wisconsin

My name is Marianne Linane. I am a property owning tax paying resident of the City of Milwaukee. I am a Registered Nurse by profession and have been since 1963.

My objections to the leasing of property owned by the City of Milwaukee to Planned Parenthood center primarily around the objectionable use of my tax dollars being to promote a practice which is morally objectionable to many Milwaukee residents and taxpayers. And while Planned Parenthood will not be performing any abortions in a city owned building, they are the largest provider of abortion in the country and will certainly be referring for abortion from the city owned space which is being proposed for rental to them. Other testimony either has already, or will, elaborate on this referral process.

My second objection is that this arrangement will generate further income for Planned Parenthood from the abortions performed through referral and this constitutes a conflict of interest in that they will be in a position of promoting their own financial gain by referring for abortion at the expense of any other perceived good that may come form the arrangement. This is a conflict of interest being promoted by the City of Milwaukee.

Planned Parenthood does not need to be in a city owned building. They are capable of being, and certainly are, located in a number of places throughout the City of Milwaukee at which locations they can take referrals from any number of agencies including those administered by the City of Milwaukee. They have been able to successfully accomplish this without the use of tax dollars. No one is proposing that this arrangement cease.

But additionally, I would like to raise to question of just what Planned Parenthood actually contributes to the betterment of our society by the practices it promotes. I refer you to one of many recent studies which points, not to a decline in teen pregnancies by the distribution of condoms and other birth control devices to our youth, but to a rise in unwed birthrates despite increased condom use. One of the facts it is important to point out, and which I do point out to the clients of the Pregnancy Help Center where I am a volunteer counselor, is that all contraceptives have a predictable failure rate and many contraceptives rely on proper use for their effectiveness. Teens have never been noted to be especially faithful at following instructions and today's teens are no exception. It is little wonder that with increased condom or other contraceptive use that increased pregnancies will result. It is simply a matter of arithmetic: more contraceptive use results in more sexual activity results in more pregnancies as a matter of mathematical extrapolation. Anyone can do the math.

The cliché that "teens will just do it anyway" may be true to some extent. There have always been unwed teen pregnancies and most likely always be. But to promote an attitude that makes teen sex acceptable is to lower expectations and to insult the capability of the human spirit in its quest to do better and rise above the impulses of our lower human nature. We are not teaching, and our youth are not learning, the valuable lessons of self control and denial to accomplish a higher goal, specifically in this case, that of responsible parenting and citizenship, and, in the long-term scheme, other goals which will enhance their lives as members of the human family. The practices promoted by Planned Parenthood do not accomplish this and are detrimental to a healthy society.

RESEARCH STUDY:

Higher Unwed Birthrates Among Teens Despite Increased Condom Use

Report finds that overall reduction in teen pregnancy is due to abstinence, not increased contraceptive use.

WASHINGTON — On February 10, the Consortium of State Physicians Resource Councils released a report showing that the cause of the overall teen birth rate decline in the 1990s is *not* increased contraceptive use, but a trend toward sexual abstinence. The report also shows that among those teens who are sexually active, the non-marital birth rate has *risen* dramatically.

"Our report challenges the consensus of government funded health agencies that contraceptive training and the increased availability of condoms for teens must play a central role in the prevention of pregnancy," said Dr. John Diggs, Consortium spokesman and member of the Massachusetts Physicians Resource Council. "The findings of our report show that the safe sex approach to teen sexuality is a failure and not at all safe."

According to the report:

> "Programs in safer sex education and condom distribution have not reduced the out-of-wedlock birthrates among sexually experienced teens. It appears possible that programs aimed at producing abstinent behavior have been more successful than programs aimed at increasing safer-sex practices in reducing unintended births to adolescents. The authors believe that the correlation between increased condom usage and higher out-of-wedlock birthrates among teens has significant public health policy implications."

The research report, titled *The Declines in Adolescent Pregnancy, Abortion and Birth Rates in the 1990s: What Factors are Responsible?*, was authored by 11 physicians and commissioned by a network of 13 state organizations representing over 2,000 physicians. Its conclusions are likely to be controversial because they refute statements by the U.S. Department of Health, the Centers for Disease Control (CDC), and other public health organizations which credit increased contraceptive use for the decline in the number of teen pregnancies.

"The Consortium commissioned this report out of a concern that the interpretation of declining teen pregnancy/birth/abortion rates was dictated more by ideology than an objective review of the data," said Dr. Diggs.

The report's major findings show:

✓ The correlation between condom use and unintended pregnancies is the exact opposite of that claimed by the public health community. The fact is, increased condom use by teens is associated with *increased* out-of-wedlock birth rates. The out-of-wedlock birth rate to sexually-experienced teens did not decline from 1988 to 1995, but actually *increased* 29 percent, despite a 33 percent increase in the use of condoms at last intercourse.

✓ The birth rate decline for all females aged 15 to 19 — from 62.1 births per 1,000 teens in 1991 to 54.7 per 1,000 in 1996 — is due primarily to the decrease in teen sexual activity.

✓ The proportion of teens choosing abstinence has been growing and the majority of that growth has been among teenage *males*. In 1997, 51.1 percent of male teens had never had sex. This figure compares to 39.2 percent in 1990. The increase among female teens has been much less, from 52.0 percent in 1990 to 52.3 percent in 1997.

✓ The abstinence factor in sex education programs is a much more reasonable explanation than the contraceptive component for the lower rates of pregnancy, abortion and births among all teens. A number of successful abstinence-centered programs are highlighted in the report.

"The implications of this research to public health policy are far reaching," said Dr. Joanna Mohn of the New Jersey Physicians Resource Council. "This report documents that increased condom use and higher illegitimacy rates among teens have gone hand-in-hand. Such analysis should go a long way to resolve the current debate about 'safe sex' versus abstinence-centered programs. Abstinence, not 'safe sex,' has proven to be the successful teen health message."

"When Congress decided in 1996 to allocate $250 million to promote sexual abstinence until marriage to teens, the sex education establishment derided the policy, stating that teens needed training in condom use to prevent pregnancy," said Rep. Tom Coburn, M.D. (R-Okla). "This report debunks that theory and appears to land on the side of the abstinence advocates." ❖

— To obtain copies of *The Decline in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors are Responsible?* call 877-236-5772.

The Consortium of State Physicians Resource Councils is an association of more than 2,000 health professionals who are dedicated to bringing accurate medical data to public health officials and policy makers.

— *ENDNOTES, from page 22*

were sexually active, and the annual pregnancy rate was 5.9 percent per year (i.e., 37% x 16%). When the experiment ended two years later, 46 percent of the school's female students were sexually active, and the annual pregnancy rate among these girls was 16 percent, so the school's overall pregnancy rate was 7.4 percent per year (i.e., 46% x 16%, or one-fourth higher than when the experiment started). See 1991 Report, Table 3, p. 11, and Table 8, p. 15.

7. Douglas Kirby, et. al., "The Effects of School-Based Health Clinics in St. Paul on School-Wide Birthrates," *Family Planning Perspectives*, January/February 1993, pp. 12-16. See Table 2, p. 15.

8. At the end of the two-year experiment, 80 percent of the girls in the school that dispensed condoms were sexually active, and the annual pregnancy rate was 11.2 percent per year (i.e., 80% x 14%). By contrast, only 76 percent of the girls in the school that did not dispense condoms had ever engaged in sex, and the annual pregnancy rate among these girls was only 10 percent, so the school's overall pregnancy rate was only 7.6 percent per year (i.e., 76% x 10%). Thus, the overall pregnancy rate in the school that dispensed condoms was 1.47 times the overall pregnancy rate in the otherwise identical sister school that did not dispense condoms. See 1991 Report, Table 3, p. 11, and Table 8, p. 15.

9. James Trussell, et. al., "Condom Slippage and Breakage Rates," *Family Planning Perspectives*, January/February 1992, pp. 20-23. See p. 20 and Table 1, p. 22.

10. Margaret Fischl, et. al., "Heterosexual Transmission of Human Immunodeficiency Virus (HIV): Relationship of Sexual Practices to Seroconversion," Third International Conference on AIDS, June 1987, *Abstracts Volume*, p. 178.

11. Y. Laurian, et. al., "HIV Infection in Sexual Partners of HIV-Seropositive Patients with Hemophilia," *New England Journal of Medicine*, January 19, 1989, p. 183.

12. European Study Group on Heterosexual Transmission of HIV, "Comparison of female to male and male to female transmission of HIV in stable couples," *British Medical Journal*, March 28, 1992, pp. 809-813. See Table 1, p. 810.

13. Isabelle de Vicenzi, et. al., "A Longitudinal Study of Human Immunodeficiency Virus Transmission by Heterosexual Partners," *New England Journal of Medicine*, August 11, 1994, pp. 341-346. See p. 343.

PERSPECTIVES

MCJ EDITORIAL

Common Council needs to get collective head out of the sand and approve Planned Parenthood clinic

One of the reasons Milwaukee has the highest Black teen pregnancy rate in the country is because too many people are hiding their heads in the sand.

Too many parents turn their backs on the sexual activities of their children. Too many children lack the moral foundation, the biological knowledge or the emotional stability to make intelligent decisions.

Too few clerics, community leaders and social engineers are committed to their communal responsibility to provide guidance and consensus leadership on an issue that is undermining the fabric of our community.

And lastly, too few politicians are willing to prioritize, or even address this epidemic.

A case in point was shown again last week when the Milwaukee Common Council tabled, once again, a proposal to lease space at the City Health Department's faculty on 76th and Mill Road to Planned Parenthood of Wisconsin.

The lease agreement, which is supported by the health commissioner, community activists and residents of the area would provide a much needed clinic on the northwest side, and equally important, provide teenagers with easy, confidential access to birth control and sexual education, with an emphasis on abstinence.

The reality is too many children are engaging in unprotected sex. Many are contracting sexually transmitted diseases, and, hundreds are turning up pregnant each week.

Blame it on their parents for not encouraging abstinence, or in many cases refusing to discuss sexuality and its consequences with them.

Blame it on the media, or blame it on peers. The reality is, most teenagers today are engaging in sexual activity and they, and society will suffer the consequences.

Teen pregnancy is the leading reason for girls dropping out of high school, and it is also a leading contributor to poverty. Most teen mothers are forever trapped in a cycle of despair and frustration.

The Planned Parenthood clinic will not solve the problem of teen pregnancy in Milwaukee.

But it can curb it, and in the process save lives and break the cycle of poverty that often follows an unwanted or unexpected pregnancy.

It's time the Common Council pulled it heads out of the sand and did something proactive to deal with the teen pregnancy problem. Supporting the leasing of the clinic is a positive first step.

My name is Linda Schmidt and I head a group called Citizens for a Pro-life Society-WI. Over the years since Roe v Wade we have seen the devastating effects of Planned Parenthood. Promiscuous sex has soared and sex-related disease has skyrocketed concomitantly. In the fiscal year of 1998, the income of the Wisconsin affiliate of Planned Parenthood was ranked 5th highest in the nation, over $15 million. A large portion of that money comes from grants paid by our own taxes. Why they need money from taxpayers I sincerely don't know because for the last 8 years Planned Parenthood has shown a profit, nationally of over $6 million. Do we honestly want PP to proliferate even more? I don't think so. Most assuredly we do not want them to be operating in a government-owned facility. PP says they want to serve the community better but what they really want is to increase their own coffers.

Why don't we want PP in a government-owned facility? First, it is a conflict of interest for the government to be supplying rental space to such an organization. Secondly, regardless of the supposed good it does for the community, PP is the largest provider of abortions in the nation. We do not want our city government linked to this horrible practice. Even though PP is not planning to perform surgical abortions in this facility, chemical abortions will be given in the form of abortifacient birth control pills and women will be referred to facilities that do perform surgical abortions. This is not a healthy enterprise with which our city government should be connected.

I don't know if many of you have read much about Margaret Sanger, PP's founder. She was a white supremacist and called blacks "the weeds of society." She said that the kindest thing poor people could do is to "kill their offspring." She had something called "The Black Project" in which she laid out a plan to rid society of black people using their churches and ministers. INSIDEOUS! PP might say that this is no longer true but if you look at the figures you can see

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Wisconsin Right to Life, Inc.
10625 W. North Ave., Suite LL
Milwaukee, WI 53226-2331
Ph: 414-778-5780
Fax: 414-778-5785
Toll Free: 877-855-5007
Home Page: www.wrtl.org

Testimony of Susan Armacost, Legislative Director Wisconsin Right to Life

before the
Steering and Rules Committee
Milwaukee Common Council

in opposition to the proposal
to place Planned Parenthood
in a taxpayer-owned building

February 26, 2003

Good morning. I am Susan Armacost, Legislative Director of the statewide organization, Wisconsin Right to Life, one of the largest voluntary membership organizations of any kind in Wisconsin. In the city of Milwaukee alone Wisconsin Right to Life has over 5,000 members.

I am here to testify in oppostion to the plan to place Planned Parenthood in a taxpayer-owned building.

The taxpayers of the City of Milwaukee own and maintain all of the city's public buildings and many of them, including myself – a City of Milwaukee resident – do not want Planned Parenthood, the state's largest abortion provider as our tenant.

Although officials from the City Health Department and Planned Parenthood have said that Planned Parenthood would not refer women for abortions from this site, that is simply untrue.

This project is funded with Title X family planning funds and the current Title X regulations **require** that Title X recipients refer women for abortions. I have attached the pertinent page from the Title X regulations to my testimony.

One of Planned Parenthood's abortion clinics is located in the city of Milwaukee. Planned Parenthood will use the Milwaukee Health Clinic site to refer women right over to their own profit-oriented abortion clinic where women must put their money down first before getting up on the table for an abortion. Selling and performing abortions is a huge money-making endeavor. This proposed "alliance" with the City of Milwaukee would be an extremely profitable venture for Planned Parenthood. Such a conflict of interest, with the potential for financial gain, could result in pregnant women being persuaded into

obtaining abortions and then funneled to the Planned Parenthood clinic. And the City of Milwaukee would then be in the business of promoting the abortion industry.

If the northwest side of Milwaukee, where I live, is in such desperate need of Planned Parenthood's services, then Planned Parenthood can rent space in a private facility. In that way, taxpayers would not be forced to subsidize the activities of the state's largest abortion provider. And it is the taxpayer issue that is at the heart of Wisconsin Right to Life's objection to this proposal.

Wisconsin Right to Life urges you to reject this or any other proposal that would involve Milwaukee taxpayers in subsidizing an organization that provides or promotes abortion.

the grant, including the regulations of this subpart, must sign the application.

(c) The application shall contain—

(1) A description, satisfactory to the Secretary, of the project and how it will meet the requirements of this subpart;

(2) A budget and justification of the amount of grant funds requested;

(3) A description of the standards and qualifications which will be required for all personnel and for all facilities to be used by the project; and

(4) Such other pertinent information as the Secretary may require.

§59.5 What requirements must be met by a family planning project?

(a) Each project supported under this part must:

(1) Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents). If an organization offers only a single method of family planning, it may participate as part of a project as long as the entire project offers a broad range of family planning services.

(2) Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant.[1]

(3) Provide services in a manner which protects the dignity of the individual.

(4) Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

(5) Not provide abortion as a method of family planning. A project must:

(i) Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

(A) Prenatal care and delivery;

(B) Infant care, foster care, or adoption; and

(C) Pregnancy termination.

(ii) If requested to provide such information and counseling, provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.

(6) Provide that priority in the provision of services will be given to persons from low-income families.

(7) Provide that no charge will be made for services provided to any persons from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

(8) Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to persons from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines issued pursuant to 42 U.S.C. 9902(2) will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

(9) If a third party (including a Government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement

[1] Section 205 of Pub. L. 94-63 states: "Any (1) officer or employee of the United States, (2) officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration of any program receiving Federal financial assistance, or (3) person who receives, under any program receiving Federal assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than $1,000 or imprisoned for not more than one year, or both."