Approved 2-22-89 Ginger Barr, Chm
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Representative Ginger Barr at
Chairperson

1:35 ~~a.m.~~/p.m. on February 14, 1989 in room 526-S of the Capitol.

All members were present except:
Representative Charlton
Representative Peterson - Excused

Committee staff present:
Mary Torrence, Revisor of Statutes' Office
Mary Galligan, Kansas Department of Legislative Research
Juel Bennewitz, Secretary to the Committee

Conferees appearing before the committee:

Mike Brown, Kansas Registered Nurse & Children's Advocate, Lawrence, KS
Barbara Bradley, Department of Pediatrics, K.U. School of Medicine; Wichita, KS
Karen Rowinsky, Teen Speakers Bureau, Topeka, KS
Brigette Newman, Teen Mother, Topeka, KS
Grace Heckard, Teen Mother, Topeka, KS
Margot Breckbill, Board Member, Kansas Action for Children, Wichita
Judy Reno, Director of Personal Health, Wichita-Sedgwick County Department of Community Health
Representative Alex Scott, M.D.
John Pierpont, Coordinator, Children and Youth Advisory Committee
Belva Ott, Director of Governmental Affairs and Community Relations, Planned Parenthood of Kansas, Inc.

The meeting was called to order at 1:35 p.m.

Mike Brown advocated informing boys regarding teen pregnancy especially with their potential for procreation being greater than girls, Attachment No. 1. He also distributed copies of a pamphlet for young men which is available at USPHS Indian School Health Center, Attachment No. 1A.

Barbara Bradley provided statistics regarding incidences of diseases and costs associated with teen sexual activity, Attachment No. 2.

Karen Rowinsky described the creation and function of the Teen Speakers Bureau and advocated legislative support of the effort, Attachment No. 3. She introduced teen mothers, Brigette Newman and Trace Heckard, who gave the speech they make at presentations to middle and high school students, Attachment No. 3A.

Brigette spoke about the responsibilities of male and female in making choices about sex and the duties of a teen mother.

Grace also addressed the responsibility and points to be considered before engaging in sex. She emphasized the average living expenses of a teen fmaily and issued a challenge to teens to evaluate things of importance to them and be responsible for their sexuality.

Margot Breckbill described the Northcentral Teenage Health Station near North High School in Wichita. She advocated increased funding for the Maternal and Infant Care Porgram and the Healthy Start Home Visitor Program, Attachment No. 4.

Judy Reno described issues relating to maternal and child health, Attachment No 5. Letters from Earl and Jane Griffith, Attachment No. 5A and Susan Osborne-Howes, Attachment No. 5B, parents in support of the health station are attached to Ms. Reno's testimony.

Representative Alex Scott, M.D. related consequences of teen pregnancies and suggested some remedies, Attachment No. 6.

John Pierpont encouraged expansion of the Healthy Start/Home Visitor and Maternal and Infant Care Programs statewide, Attachment No. 7.

Belva Ott noted the rise in teen sexual activity and presented statistics regarding health care cost differences between teen and older mothers. She advocated sex education in the schools and suggested some solutions, Attachment No. 8.

Committee discussion elicited the following:

1. The health station at North High School was established on a one year grant of $74,000.00, matched with private donations of furniture and equipment from private sources. K.U. pediatric faculty donates 1½ - 2 hours per week. Rent is paid for the facility housed across the street from the school.

2. Sports physicals could be obtained for $5.00 as opposed to $65.00 per visit to a private physician. Approximately 501 students at North High School might have been precluded from participating in sports because they could not afford medical care. Approximately 30% of urban teens might not have access to medical care.

3. The teenage group is concrete in their thinking and believe pregnancy won't happen to them.

4. Staff was directed to investigate whether the state funds any other local initiatives such as the teenage health station.

5. The Can Be Healthy Program serves children through the age of 18 years. Outreach to adolescents is usually through local health departments.

6. Teenage pregnancy is a systemic problem due to many things though there is a direct relation to substance abuse. Many teens engage in other high risk activities "sometimes at the same time and sometimes because of". A broad based approach is recommended.

7. The teenage health station requires parental consent for any service and for birth control, the parent must appear in person and give on-site witnessed consent. The school nurse only refers to the health station if the child has a parental consent form on file.

8. In the case of a sexually transmitted disease, by state law, the health department can diagnose and treat without parental consent or knowledge.

Attachment No. 9 is "Preventing Teen Pregnancy: The State Role" and Attachment No. 10 is "Adolescent Pregnancy and Parenting", a handout from SRS.

The meeting adjourned at 3:15 p.m.

The next meeting of the committee will be February 15, 1989, at 1:30 p.m. in Room 526-S.

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE February 14, 1989

(PLEASE PRINT)

NAME	ADDRESS	WHO YOU REPRESENT
Karen Rowinsky	3010 Harland Ct Topeka, KS 66604	Teen Speakers Bureau
Brigitte Newman	3225E Lime Topeka, KS 66607	Teen Speakers Bureau
Chuck Ditzler	1244 Tennessee, Apt 1 Lawrence, KS	Rep George Dean
Valerie Goens	1121 MacVicar Topeka Ks	Kansans for Life
Jane Marie Barlow	1429 W. 19th St. Lawrence, KS. 66045	Univ. Kansas Social welfare.
Dawn Schneider	115-S	Rep. David Miller
Jim M. Barnett	Topeka	observer
BARBARA REINERT	"	MYSELF
Peggy Jarman	5107 E Kellogg, Wichita, Ks	WHCS
Belva Ott	Wichita	Planned Parenthood of Ks., Inc.
Margot Brockbill	618 N. Doreen Ct Wichita, Ks. 67206	Kansas Action for Children
Jerry Larson	701 Jackson B-2 Topeka	Kansas Action For Children
Barbara Bradley	UKSM-W 1010 N. Kansas, Wichita	67214 UKSM-W, Pediatrics
Judy RENO	1900 E. 9th Wichita 67214	Wichita-Sedg Co. Health Dept.
Kim Kastman	3925 Twilight Dr. #108 Topeka 66614	Washburn University social work
Jenny Gregory	2045 SW. MacVicar #33 Topeka 66604	Washburn University, social work Children & Youth Advisory Committee
John Pierpont	300 S W Oakley	
Chip Wheeler	Topeka	Kansas Medical Society
Kristin Barry	9000 Elk Creek Rd. Manhattan, KS. 66502	Parent
Peter L Wolf	4101 Topeka Blvd., Topeka	KDHR.
Becky Linquist	5235	Intern for Sen. Pelly
Kay Eland	1427 W19th Lawrence, KS	Intern for Joan Wagnon KU Social Welfare Student
Jay Wade	300 S.W. Oakley	Topeka, Ks.
Bob Bam	300 " "	" "
Tarri Roberts	Topeka	Kansas State Nurses' Assoc.

Michael D. Brown, RN, BSN; 2424 Sunset Court; Topeka, KS 66604
February 14, 1989

Testimony on teen-preteen pregnancy in Kansas

Members of the House Federal and State Affairs Committee, my name is Michael Brown. I am a Kansas registered nurse and a children's advocate. I have published articles on teen-preteen pregnancy and related topics in several periodicals plus the Topeka Capital-Journal and Kansas City Star newspapers.

Your Chairperson asked me to give your Committee a presentation on teen-preteen pregnancy in Kansas. Before I get into that discussion, however, I want to explain why I chose the format I did for giving my testimony.

It frustrates me when I make presentations or publish articles about pregnancies occurring among Kansas children. Most people that hear those presentations or read my articles focus on the fact that I said what I said instead of zeroing in on the children I am discussing. In an effort to help you focus on the children who need your help and not focus on me, I will give most of the rest of my testimony primarily from the perspective of Kansas children 17 years old or younger.

*HELP US NOT TO BECOME CHILD PARENTS: THE TOO-LONG-IGNORED PROBLEM OF TEEN-PRETEEN PREGNANCY IN KANSAS

We, the girls and boys of Kansas, are tired of so many of us becoming child parents every year. We hope to persuade you to consider better helping us prevent pregnancies from occurring among us.

First, we will give you an idea of how badly we need our parents and adults like you to help us more. By the way, we will be citing mostly numbers for the 1987 year from the Kansas Department of Health and Environment--not the National Enquirer, for instance. Second, we will give you a few suggestions on how our parents and adults like you can help us more effectively.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 1
February 14, 1989

*TEEN-PRETEEN PREGNANCY IN KANSAS: A MUCH WORSE PROBLEM THAN YOU REALIZE

(From The Music Man by Meredith Wilson--Harold Hill: "Well-ll-ll, ya got trouble, my friends, right here--I say, trouble right here in River City!")

Our girls had 562 induced abortions in 1987. An 11-year-old had an elective abortion after she had two prior pregnancies. During 1986, a 16-year-old had at least her fourth abortion. In 1987, seven girls 14-17 years old obtained abortions in the 24th week (sixth month) of their pregnancies.

Among the 1,471 babies born to our girls were 162 second babies, 15 third babies, and 2 fourth babies. Two girls 14 or younger had babies after having another baby. We have a lot to do with the fact that the percentage of babies born to single mothers increased for the last 28 years to 17 percent in 1987. Nationally, girls our age have made grandmothers out of their mothers who were at least as young as 22 years old.

Mothers-to-be among us had to cope with the unexpected losses involved in miscarriage and stillbirth.

In addition, over 1,000 of our girls and boys were treated for incurable and fatal AIDS, gonorrhea (which can cause sterility), incurable genital herpes, chlamydia (that can cause sterility), syphilis, and other serious sexually transmitted diseases. For instance, 18 of our boys and girls only 1-3 years old and 5 of us just 4-6 years old were treated in 1987 for genital herpes, chlamydia, and other sexually transmitted diseases not including gonorrhea and syphilis. During 1986, seven of us 0-3 years old and six of us 4-6 years old were treated for gonorrhea. Nationally, pregnant girls our age are getting such serious diseases and passing them, including the AIDS virus, to their babies.

Each teen-preteen pregnancy's commonly negative effects can last lifelong for the girl, her sex partner, their baby(ies), the couple's immediate families, their extended families, and their friends. Please take a few moments to picture the current situations and the futures for a couple of us mentioned in

the figures we cited earlier.

*EFFECTIVE PREVENTION OF TEEN-PRETEEN PREGNANCY

(From "Dear Mr. Jesus" by Richard Klender on the casette tape PowerSource: Shelter From The Storm--

Children's Choir: "Please, don't let them hurt your children.
We need love and shelter from the storm.
Please, don't let them hurt your children.
Won't you keep us safe and warm?")

We know of a public school district in South Carolina that works with students' parents, 27 local churches, elected government officials, plus other concerned civic leaders and groups to reduce teen-preteen pregnancy. That school system's pregnancy rate dropped by 63 percent in just two years. That program promotes abstinence (and other effective contraception methods).

That local area's pregnancy rate per 1,000 girls 14-17 years old fell from 67.1 during 1982 to only 25.1 in 1984. Their pregnancy rate stayed at 25.1 during 1985 and fell to 22.5 in 1986. During each of the years 1984 through 1986, the pregnancy rate for the rest of the target county and each of three similar South Carolina counties was usually at least 100 percent higher than that school district's rate.

Details on that South Carolina school system's proven program and its history are the subject of the 1988 U.S. Department of Health and Human Services booklet "Reducing Unintended Adolescent Pregnancy." The 40-page publication can be ordered for $3.50 from Murray Vincent, Ed. D.; Professor; School of Public Health; University of South Carolina; Columbia, South Carolina 29208.

Also, the potential of boys helping in the prevention of teen-preteen pregnancy is largely untapped now. Adolescent girls release only one sex cell (ovum or egg) once every 28 days or so. Although only one male sex cell (sperm) usually fertilizes a human egg, adolescent boys can produce four billion sex

cells during those same 28 days. Ignoring special techniques like test-tube babies and surrogate mothers, girls can possibly participate in a conception only once every 28 days or so for just a 15- to 18-hour block of time. Boys can possibly participate in a conception once every 2 or 3 days. Girls can participate in a full-term pregnancy only once every year or so, no matter how many times they have intercourse. Boys can participate in many more full-term pregnancies in a year if they have intercourse every 2 or 3 days with different fertile females!

True, we presented those sexual facts about girls and boys in ways they are not usually presented. We just want to make a point: Why do adults really talk to only girls about preventing teen-preteen pregnancy? The reproductive capacity of boys is actually much greater than that of girls.

A boy can take effective precautions by practicing abstinence, using condoms, or helping his sex partner with her birth control method. By the way, the boy correctly using a spermicidal condom while his sex partner uses spermicide can be 99 percent effective against pregnancy.

Society could encourage men 18 and over not to have intercourse with our girls (or at least to have only protected intercourse).

Incidentally, many effective actions children can take to avoid pregnancy can help prevent sexually-spread AIDS and other sexually transmitted diseases.

SUMMARY

As the figures on teen-preteen pregnancy we mentioned earlier suggest, we are long overdue for better help from our parents and adults like you to prevent pregnancies among us. The successful South Carolina project we cited earlier could serve as a good model for an effective approach to help us. Boys and men should be motivated and educated to help effectively prevent teen-preteen pregnancies.

Michael D. Brown

Michael D. Brown, RN, BSN

TABLE 9
LIVE BIRTHS BY AGE-GROUP OF MOTHER BY AGE-GROUP OF FATHER
KANSAS, 1987

Age-Group of Father	Total	Age-Group of Mother									
		Under 18	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45 & Over	N.S.
Total.....	38,435	1,471	58	4,271	11,681	12,949	7,107	2,110	237	20	2
10 - 14...	1	1	-	1	-	-	-	-	-	-	-
15 - 19...	1,061	409	12	830	197	18	3	1	-	-	-
20 - 24...	7,438	348	6	1,669	4,880	752	108	20	2	1	-
25 - 29...	12,073	55	-	340	4,067	6,660	898	99	8	1	-
30 - 34...	9,029	12	2	66	915	3,847	3,802	381	15	1	-
35 - 39...	3,803	7	-	20	214	817	1,668	1,041	42	1	-
40 - 44...	1,027	1	-	4	52	186	303	375	103	3	1
45 & Over.	313	-	-	3	14	48	89	96	51	12	-
N.S.....	3,690	638	38	1,338	1,342	621	236	97	16	1	1

Residence data

What Are Sexually Transmitted Diseases?

Sexually transmitted diseases (STDs) infect your reproductive sexual organs. The most common major STDs are gonorrhea, genital herpes, chlamydia, syphilis, and AIDS. STDs can be serious and painful.

What Is AIDS?

AIDS harms the body's immune system so it cannot fight off infections and cancers that now kill all people who get AIDS. AIDS is caused by a germ called the Human Immunodeficiency Virus (HIV). **There is no cure or vaccine for AIDS.**

How Are AIDS and Other STDs Spread?

STDs are spread during close sexual activity like sexual intercourse, oral sex, and anal sex. AIDS is spread through the exchange of blood, semen, and vaginal fluids. It is certainly spread through sexual intercourse! Although American gay and bisexual men are at high risk for getting AIDS, more and more "straight" (heterosexual) men and women are getting AIDS. (Over 1,500 American males likely got AIDS from sexual contact with females.)

The AIDS virus can be passed from mother to baby during pregnancy, in childbirth, or maybe from breastfeeding. It can be passed along when an IV drug abuser uses a needle after it was used by someone infected with HIV. The AIDS virus is not known to spread through everyday contact like living in the same house, shaking hands, being coughed or sneezed on, "dry" kissing, or sharing dishes or food with a person infected with HIV.

What If You Think You May Have An STD?

If you may have an STD, you need to get tested and treated soon. Treatment and information are available from your doctor or health clinic without an appointment.

If you have an STD, tell your partner(s) so they can be tested and treated. If they are not treated, they can spread the disease. They may give it to you again!

How Can You Protect Yourself From STDs?

The only 100% effective prevention is not to have sex. If you choose to be sexually active now, you can protect yourself by:

- **Having Few Partners** (Safer if Just One).
- **Using Condoms.** ***When used properly, spermicidal condoms*** protect you well, but not 100%, from many STDs, even AIDS.
- **Having Your Partner Use Spermicide.** Spermicides help prevent many STDs.
- **Knowing the Signs** of STDs. If you notice that you have penis discharge, burning when you urinate, pubic rash/sores/itching, or other genital symptoms that worry you, see a doctor soon.
- **Not having Sex,** If You Have An STD, Until Your Doctor Says You Are Cured.
- **Seeing A Doctor** Immediately If You Find Out That You Had Sex With Someone With An STD. **Do not let the disease** that you may have lead to complications for you or anyone else. Gonorrhea and chlamydia can cause sterility in you and your sex partner(s). **GENITAL HERPES AND AIDS HAVE NO CURE.**

Do Many Native Americans Get STDs?

STDs are more common among American Indians than those same diseases are among the general U.S. population. The numbers of Native Americans found to have AIDS in each of the last several years have steadily increased at a significant rate!

Where Can You Get More Information?

If you want to talk with a well-informed person about STDs and birth control, visit your health clinic or doctor. You can get written handouts from your doctor or health clinic and books from your public or school library or a bookstore. Sex education courses are being offered in some places.

To ask questions by telephone almost anytime, the ***toll-free*** numbers are 800-223-AIDS (Native American AIDS), 800-342-2437 (U.S. AIDS), and 800-227-8922 (Other STDs).

Remember, the best protection is prevention. So, do not have sex until you finish your education and marry. If you have sex now, protect yourself as well as possible!

USPHS Indian School Health Center
Haskell Indian Junior College
Lawrence, KS 66046 (December, 1988)

INDIAN SINGLE YOUNG MEN:

HAVING SEX NOW IS RISKY!!

Tough Decisions

This can be a great time in your life! Being on your own more and making your own choices is what you've always waited for. Yet, it can be confusing to make decisions about school, work, partying, and dating.

Sexual decisions may be quite difficult. Pressures from TV, your girlfriend, other friends, popular songs, movies, videos, and magazines add to the confusion of choosing what is right for you. If you would like help in deciding what is best for you sexually, then talk over your concerns and questions with adults you feel comfortable with such as an older brother, a family friend, a doctor, your parents, your minister, a tribal elder, your school counselor or coach, or a family planning nurse.

Deciding not to be sexually active may be the best choice for you now. The decision to become sexually involved is yours. It's your choice to say "yes" or "no." Remember, it's okay to say "no"! If you decide to have sex now and wish to avoid unintended pregnancy, there are a few things you should know and think hard about.

What Are The Risks?

If you choose to be sexually active, you and your partner are taking chances like:

- *Becoming Parents Before Both of You Are Ready and Want To Be Parents.*
- *Getting AIDS, Which Now Is Epidemic and Fatal.*
- *Getting Other Sexually Transmitted Diseases.*

Why Should You Care About Birth Control?

Roles and attitudes about sex are changing. Birth control is no longer considered to be the responsibility of only women and girls. You play a big part in whether and when your girlfriend becomes pregnant and you become a father.

Avoiding unintended pregnancy together helps a couple build a feeling of trust. Women appreciate men who care enough about them to discuss sexual decisions. Talking about those choices, even if you're embarrassed, could bring you closer together.

What Birth Control Choices Do you Have?

There are two effective birth control methods you can use with little or no help from your girlfriend:

- *You Can Decide Not To Have Sex Until You Both Complete Your Educations and Marry.*
- *If You Have Sex Now, Use Condoms.*

Not having sex is the only 100% reliable birth control method. Show affection toward your girlfriend without having intercourse. Pleasant activities like talking, touching, holding hands, caressing, hugging, dancing, kissing, or just being close provide warm, loving, and safe intimacy.

Condoms, or "rubbers," are the only devices young men can use to prevent pregnancy. Condoms can be at least 88% effective ***when used correctly.*** They can be up to 99% reliable when you use **Spermicidal Condoms** while your partner uses spermicide.

Condoms are safe (**No Side Effects**), inexpensive, plus easy to buy and use. They have another key benefit. Condoms protect both you and your partner well, but not 100%, from many sexually transmitted diseases. Spermicidal and plain condoms are available at many clinics and drug stores.

What Other Methods of Birth Control can Your Girlfriend and You Use?

Several other methods are available that you and your girlfriend may choose from:

- **Birth Control Pills** - The Pill contains agents which prevent a female from releasing eggs and protect her almost 100% against pregnancy.
- **Diaphragm** - A rubber shield is placed in the woman's vagina to block sperm and works well when used with spermicide.
- **Sponge** - A synthetic sponge about two inches across containing spermicide is inserted into the woman's vagina to effectively block and kill sperm.
- **Spermicide** - A sperm-killing foam/cream/jelly/tablet/suppository placed in the woman's vagina before having sex works reliably without a condom or diaphragm.
- **Natural Family Planning** - Having sex when your partner is not likely fertile requires much cooperation within a couple.
- **Poor Methods** - The man pulling his penis out of the woman's vagina before he "comes" helps little to avoid pregnancy since sperm are released throughout inte[illegible]. Your girlfriend douching after sex is not reliabl[illegible] (IntraUterine Devices) were common, but most doctors now consider them unsafe.

The Pill and diaphragm require a doctor's examination. Natural family planning needs to be explained in detail to you and your partner by a doctor or nurse. Those methods are available from health clinics and doctors: You likely need an appointment.

All methods work best when you help each other. If your girlfriend is scared to see her doctor, you can go with her. Your being in the waiting room can reassure her and let her know you care. If getting condoms embarrasses you, she can go with you.

What If Your Girlfriend Gets Pregnant?

In a recent year, 39% of Native American babies were born to single females. Indian females have many abortions each year.

Those situations were not just the girl's or woman's problem. Their sex partners had hard questions and choices to deal with.

Does the young man want to marry the woman and help raise their child?

Will he have to drop out of school and go to work to support her and their child?

Does he want and can he afford to raise their child by himself?

How does he feel about abortion and adoption?

How does he come up with the money to pay for the abortion or child support until his child reaches 21?

When a young man's girlfriend becomes pregnant, h[illegible] he answers such questions can have lifelong effects on [illegible]s partner, their baby, their families, and others.

Your having sex without using birth control is a decision that gives you an 89% chance of making a baby within a year!

The University of Kansas Medical Center
School of Medicine-Wichita

Pediatrics

TO: STATE AND FEDERAL AFFAIRS COMMITTEE

FROM: BARBARA BRADLEY, COORDINATOR, ADOLESCENT SERVICES
DEPARTMENT OF PEDIATRICS, UNIVERSITY OF KANSAS SCHOOL OF MEDICINE-WICHITA

SUBJECT: TESTIMONY, FEBRUARY 14, 1989

It is my concern that the most overlooked of our children: our adolescents, not be ignored when formulating a child and family health policy for our State.

Adolescents today are less functionally literate than 15 years ago yet have been thrust into a more sophisticated and demanding environment. Though much more sophisticated themselves, teens are not as mature as twenty years ago. Health and social problems for this population are intensifying rapidly.

Adolescents are the only age segment of the population experiencing an increase in morbidity and mortality. Those rates are, in fact, 11% higher today than they were twenty years ago. The three leading causes of death among teens are accidents, homocides and suicides. Each of these causes is entirely preventable.

Nationally, the data compiled by the American Medical Association show:

SUBSTANCE ABUSE

-2/3 of American youth use drugs before they finish high school, and one in five high school seniors smoke cigarettes daily
-One in 16 high school seniors drinks alcoholic beverages daily, and 41% report that they have consumed five or more drinks on one occasion

SEXUALITY AND PREGNANCY

-Teen mothers account for 46% of all births to unmarried women and 1/3 of all abortions
-2/3 of all sexually active adolescent girls do not routinely use any method of birth control
-Maternal mortality is 2.5 times higher in girls under age 15 than in women in their twenties

VICTIMIZATION

-24% of all fatalities and 41% of all serious injuries in reported cases of physical abuse involve persons aged 12-17
-6% of all boys and 15% of all girls experience sexual abuse by the age of 16
-1/2 of all rape victims are less than 18 years of age
-600,000 teen girls and 300,000 boys work as prostitutes; their average age is 15

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 2
February 14, 1989

1010 N. Kansas • Wichita, Kansas 67214-3199 • (316) 261-2631
Main Campus, Lawrence • Medical Center, Kansas City and Wichita

PSYCHOLOGICAL DISORDERS AND SUICIDE

-5,000 persons under age 19 commit suicide each year, and 50,000 attempt it
-Up to 10% of teenage girls suffer severe eating disorders such as anorexia

VIOLENCE AND TRAUMA

-80% of deaths in 15-24 year olds are secondary to accidents, suicides and homocides
-Adolescents commit 1/3 of all violent crimes

AIDS

-It is anticipated that sexual activity, drug use, and prostitution will burgeon the number of adolescents becoming infected with AIDS. The death rate among AIDS victims in their twenties suggests, considering the latent diagnosis of the disease, that adolescence is a primary age for infection

Past approaches are insufficient to cope with these mushrooming social ills. Education regarding the consequences of high risk behavior must be conducted so teens make educated decisions regarding their lives.

The less-than-educated decisions teens are making are costly to us all. To look at teen pregnancy as one example of those costs is startling. The infant mortality rate for children of mothers under the age of 18 is twice as high in Sedgwick County as Kansas overall. The incidence of low-birthweight babies, physical malformations, learning disabilties and prematurity are also much more prevalent among infants born to teen mothers. Yet these same women are the population group most likely not to receive adequate prenatal care. Estimates for average initial hospitalization costs of a low-birthweight baby range from $20,000-30,000. The costs do not stop there. Low-birthweight babies are twice as likely to suffer one or more handicaps. Such handicaps drive costs for social services, educational services and medical services upward.

In 1985, a study conducted by SRS determined that over 52% of the Aid to Dependent Children recipients in Kansas were first mothers while still in their teens. One local study found that the average single birth cost in Kansas (that is, the public cost for a single family begun by an adolescent birth for twenty years following that birth) was $13,600. The single year cost (the public cost in a single year to support all families begun by a birth to an adolescent in that year) was $143.92 million in Kansas! The potential savings, if we were to prevent the 930 teen pregnancies in Sedgwick County during 1986 alone, would be $3,774,397!

Of course, the costs of teen pregnancy are not just economic. Great emotional costs are exacted from the teen parents, their parents and the children themselves.

New networks and alliances must be formed between existing resources. A case in point is the partnership forged between USD 259, the Wichita/Sedgwick County Department of Community Health and the Departments of Pediatrics and Psychiatry at the University of Kansas School of Medicine-Wichita, to develop an Adolescent Health Station located across the street from a public high school. The first of its kind in Kansas, the health station provides quality medical care which is accessible and affordable to teens. Mental health

and much needed emotional support is available from trained professionals who deeply care about the problems young people are facing. It has been said that today's teen sees no reason to carry on, no hope of a future. We hope that the one-on-one contact made possible by a health station devoted to the care of teens, will send a message to our troubled teens that they are a valued resource and that many people care. The health station has been developed with a small grant from the Kansas Department of Health and Environment. Three pediatricians, whom I represent, and a psychiatrist donate their time to provide primary medical care at the station.

It is hoped that preventative intervention and health education efforts will receive funding priority by the legislature. The need is great.

Questions may be directed to:

Barbara Bradley, Coordinator
Adolescent Services, Department of Pediatrics
UKSM-W
1010 N. Kansas
Wichita, Kansas 67214
(316) 261-2631

Eagle Beacon 8-23-88

Teen health station needed

THERE currently are five health stations throughout the city — Southeast, Stanley, Evergreen, Colvin and Orchard Park, each staffed with nurses, providing a range of health services for the community. Patients pay on a sliding scale. Now, the Wichita-Sedgwick County Health Department plans to open a Northcentral Teen Health Station, similar in concept to the other community health stations, but also a bit different.

The Northcentral Teen Health Station will provide clinical health services exclusively for students from North High and Horace Mann and John Marshall Middle Schools who need immunizations, health assessments or physicals, screenings, medical treatments and counseling. Unfortunately, some members of the community feel that this clinic, because it is exclusively for teens, will provide minors with birth control and abortion counseling. That's simply not true.

The policy of the Wichita-Sedgwick County Health Department is that minors must be accompanied by their parent to give written permission for birth control, and that signature must be witnessed by a staff member. Federal funding and regulation denies this clinic the right to offer abortion counseling; it never has been offered in the other clinics and it won't be offered at Northcentral.

Instead, the North-central station will offer teens physician services for episodic illnesses, unlike the other clinics, for a $5 annual fee or $10 a family.

Many North High, Horace Mann and John Marshall students — and their working parents, no doubt — will benefit a great deal from having nearby access to such a clinic. It's unfortunate when the fears of a vocal minority whip up opposition to a welcomed and much-needed service, especially when those fears are completely unfounded. Let us hope the fears and opposition to the Northcentral Teen Health Station finally are put to rest.

Eagle Beacon 9/26/88

Public Forum

Teenagers' needs justify health station

Morbidity and mortality rates for adolescents are 11 percent higher today than they were 20 years ago. The American Medical Association (AMA) cites:

Substance abuse:

- Two-thirds of American youth use drugs before they finish high school, and one in five high school seniors smoke cigarettes daily.
- One in 16 high school seniors drinks alcoholic beverages daily and 41 percent report that they have consumed five or more drinks on one occasion.

Victimization:

- Twenty-four percent of all fatalities and 41 percent of all serious injuries in reported cases of physical abuse involve persons aged 12-17.
- Six percent of all boys and 15 percent of all girls experience sexual abuse by the age of 16.
- One half of all rape victims are younger than 18 years of age.
- Six hundred thousand teen girls and 300,000 boys work as prostitutes; their average age is 15.

Psychological disorders and suicide:

- Five thousand persons under age 19 commit suicide each year, and 50,000 attempt it.
- Up to 10 percent of teenage girls suffer severe eating disorders such as anorexia.

Violence and trauma:

P. Kolsti

- Eighty percent of deaths in 15-24 year olds are attributed to accidents, suicides and homicides.
- Adolescents commit one-third of all violent crimes.

Perhaps less dramatic are health impairments, which range from vision or hearing problems to chronic illnesses. Such problems tend to be more common among low-income teens, in part because conditions are more likely to be untreated or even undetected during childhood. One Kansas City school found close to 20 percent of the student body in need of eyeglasses.

Compounding teens' health care problems is their remarkable low utilization of health-care services. According to virtually every measure, they use health care less than any other age group. They have the lowest physician-visit rate of any age group. Nationally among all children 12-18, 14 percent were insured for only part of the year and 7 percent were completely uninsured in 1980. Teens often cannot get to the services they need. Finally, teens who do use health services often find that providers are not prepared to deal with their special needs for guidance and structure.

The adolescent health station near North High School is critically needed. We should not lose sight that health concerns facing teens involve much more than sexuality.

GERARD VANLEEUWEN, M.D.
Professor and Chairman
Department of Pediatrics
The University of Kansas
School of Medicine
Wichita

Push Congress ... help fix

The Teen Speakers Bureau was established as a result of the Teens Are Concerned Conference in the spring of 1987. This conference, sponsored by the Topeka Youth Project, the Shawnee County Teen Pregnancy Coalition and other area agencies brought together teams of teens and adults from schools, community groups and churches. It was a "working" conference whose focus was to identify unique and creative strategies to cope with the problem of teen pregnancy. Teens were involved from the beginning in the planning and execution of the conference which offered exciting possibilities to explore new ways to address this ever increasing problem. The premise was that teens and their behaviors were the cause of the problem, hence, teens could give insights into ways adults could work with them towards solutions.

A presentation during the conference involved a panel of teen mothers sharing their experiences being pregnant as teens and discussing the impact that their pregnancies had on their lives. Their moving and realistic remarks had a visible impact on their peers in the audience and revealed quite clearly the implications and consequences of early and unprotected sexual activity.

The Teen Speakers Bureau grew out of this original panel presentation. It was funded by the Junior League of Topeka in the spring of 1987. The mission of the Bureau is to prevent the incidence of teen pregnancy by providing panels of teens and young adults to schools, churches and community agencies to speak on the impact and consequences of sexual activity. The Teen Speakers Bureau goes beyond "just saying no" to giving teens a realistic view of the consequences of this behavior. It does not stress abstinence but does stress responsibility. It does not advocate adoption, abortion or parenting, but does present the decisions one has to make after choosing to become sexually active. Above all, the Teen Speakers Bureau speaks to teens on their own level about their own lives--their dreams, their choices and most importantly their responsibilities.

Members of the Teen Speakers Bureau are here today to give you an example of a creative way to address this very difficult issue. We hope that as you look at ways the State of Kansas can tackle this problem, you consider funding working conferences like the original Teens Are Concerned Conference and projects like the Teen Speakers Bureau, utilizing the teens themselves as vital resources to address this problem.

Submitted by Karen Rowinsky to
The House Federal and State Affairs Committee
February 14, 1989

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 3
February 14, 1989

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'EEN MOTHER TESTIMONY: 02-14-89 Hearing

Brigette Newman - 18 years old
- 2 year old child
- has completed GED

When I volunteer to speak, I speak about male/female responsibility and making choices about sex. First of all, before you say yes, both male and female, you need to ask yourself if you are both physically and emotionally ready for it. One reason, is because it changes your life afterwards. You also have to ask yourself if you are ready to become a parent if you should get pregnant or get a girl pregnant. If you're not ready to become a parent, take precautions and use birth control or choose abstinence. While I cannot tell you to not have sex, I can tell you the consequences and realities if you do. Like for instance, Gerber babies. I don't know of anyone who has one. T.V. doesn't show babies crying at 3:00 a.m., they don't show the messy things that come in diapers, they don't say that you have to be this child's maid, chauffeur, teacher etc.

Do you know what it is like to have to teach another human being how to walk, how to talk and how to potty in the big pot? To know what is hot or just how to share with the other kids? Unless you have incredible patience or don't care whether your child dies or not, it is very hard. In one life-stage teaching can be fun, but not when you would rather be at the mall, or at the movies or out with your friends and continuing on with your own education, not staying at home all day taking care of a child. My life as a teen was full of friends and full of sports. Now all I do is stay at home all day and watch soap operas and be a wife and mother. At 18 it is a little too much, but I don't really have a choice right now.

I love my daughter and I always will, but if I had to do it all over again, I would wait. And something else you have to think about is the diseases and sex partners he or she had before you because you are having sex with them too. I think that is enough right there that should have scared me to death, but the problem is I didn't think about the gravity of being pregnant and realize it was that important. In case you are going to ask me why I am pregnant again, I was on birth control but it doesn't always work.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 3A
2/14/89

Grace Heckard - was a teen mother
- currently a student at Washburn
- 4 year old child

I am here to talk about responsibility - the responsiblity that every time you have sex there is the possiblity of getting pregnant. Not just the first time, not if you're having sex just twice a week or three times a week, but every time you have sex. The first time, the fifth time and the twenty-sixth time there is a possibility of a pregnancy. With the possibility of a pregnancy, there are things that both the male and female have to think about. If his partner becomes pregnant, he may be left out of the choice. If she decides to have an abortion and he really wants to keep the baby, he didn't really have a say in it. If she wants to keep the baby and he is not ready to be a father, he doesn't have a say in that either. The female has to think that she might miscarry or she has to choose between abortion, adoption or whether to keep that baby. All those things involve losses, but they also involve losses in your dreams and also respect of others. If you lose a dream, maybe as a male you want to play on the varsity football team. The time you would take to practice after school you would have to take to have a job to pay for that baby. Either that or how are you going to pay for someone to watch that baby while you practice? Maybe it is music that you are interested in, but music costs money too. The instrument costs money and the lessons cost money too. Or maybe it is further schooling. Who is going to take care of that baby and how are you going to afford to pay someone to take care of that baby while you pursue your dreams.

Let's look at the money issue. If you graduate from high school, which some of the students I have talked to have - from either Junior High or High School - you might start at $5.00 an hour if you have some kind of skill - a secretarial skill, a mechanical skill or something like that. At $5.00 an hour you would bring home $800 a month, which is $600 a month after taxes and insurance, which are standard deductions in any job. $250 for a very cheap apartment, $50 for a very cheap electric and gas bill, $180 for very cheap childcare - that is in someone's home and not at a daycare center - $40 for gas in your car, $120 for food. That leaves out McDonalds, Pizza Hut and formula for your baby. After

$40 for diapers you are $80 in the hole. I left out items such as toilet paper, toothpaste, radio, T.V. and stereo, being able to pay for childcare so you might be able to have fun. I left out car payments, I left out a lot of things.

With the money issue discussed, how can you prevent having to deal with these tough decisions? Of course, there is birth control and also, you can say I'm not ready. I'm not ready to give up my dreams of varsity football or being in a rock band, whatever is important to you right now. I'm not ready to quit what is important to me so I can support a child. So, why are teens getting pregnant? One reason, like me, is that they want to be accepted by friends or they want to be loved. Both those things are very natural and nothing is wrong with that, except sex is not love. Sex is responsibility, a great responsibility. Love is when you are interested in someone and they are interested in you, in what you are doing and not in what you can give them. So I challenge teens to respect themselves, their dreams, what is important to them now and to respect their sexuality.

Because all children need someone who cares . . .
Kansas Action for Children, inc.
A non-profit, tax-exempt organization.

701 Jackson, B-2
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TESTIMONY FOR THE FEDERAL HOUSE AND STATE AFFAIRS COMMITTEE
FEBRUARY 14, 1989

Hello. I appreciate this opportunity to speak with you. I am Margot Breckbill. I am a volunteer child advocate and board member of Kansas Action for Children which is a statewide child advocacy group. We have many concerns for today's vulnerable children. Nationally:

One in four is poor
One in three is non=white, 40% are poor
One in five is at risk for becoming a teenage parent
One in seven is at risk for dropping out of school.

We are here today to discuss health issues. One solution I see to accessing young people to good medical care is through adolescent health stations. I am a member of the Advisory Board of the Northcentral Teenage Health Station which is located close to North High School. The health station is operated by the Wichita/Sedgwick County Department of Community Health. Students at North High, Horace Mann Middle School, and John Marshall Middle School are eligible for enrollment at the health station. In the six months since the clinic opened, 15% of the population of the three schools has enrolled (338 students). Fees are $5.00 per student per year or $10.00 per family. Most of the teens enrolled have met the guidelines for scholarships indicating that the station is serving the population intended.

Adolescents tend to get the least adequate health care of any age group. A Children's Defense Fund study reported that 28% of children aged 12-18 do not visit a doctor in the course of a year. Among their special health needs are drug and alcohol abuse, emotional illness, teen pregnancy (in 1986, 4,490 babies were born to Kansas teens), and suicide (during the 1985-1986 school year, there were 40 suicides and 317 suicide attempts among Kansas teens-984 considered suicide).

I would really like to thank Governor Hayden and the Legislature for funding the Adolescent Health Care Program in 1988. These funds made our Northcentral Teenage Health Station possible. I hope that the funding will

be expanded in 1989 so that more adolescent health stations can be added in Sedgwick County and across the state. Present funding is $100,000. We would like to see this expanded to $290,000.00 with $50,000.00 added to the C level budget to fund an adolescent health care specialist and secretary. Our teens are definitely at risk. Since they represent the future of this country, we had better do all that we can to help them!

The Northcentral Teenage Health Station opened amidst some controversy in August of 1988. Some members of the community feared that family planning would be the thrust of the services. However, the Health Department guidelines are very specific about family planning services. **Family planning services are offered to minors only if a consent form is signed by the parent in the presence of a staff member.** Of 179 students seen thus far in 389 visits, only 8 have requested family planning services (3 already had children), 7 have had pregnancy tests and 3 have enrolled in prenatal services. The main services requested have been treatment for acute illnesses and sports physicals. Up to now, sports physicals have been a luxury many families could not afford and students cannot participate in sports, cheerleading, or pom pon squads without them. This has given many students access to sports for the first time in their school experience. This leaves less time for less productive activities and teaches skills which can be used later in life. Through the Health Station, eleven teens were placed on medication which they would not have gotten otherwise.

I would like to mention a couple of specific cases in which the health station has dramatically affected teens' lives. A teen male appeared at the health station who had never been able to do much of anything because he always got so short of breath. He had never been to a doctor about this problem. Jacquie, the nurse clinician, examined the young man and felt that he had exercise induced asthma. This diagnosis was confirmed by a pediatrician from the University of Kansas School of Medicine-Wichita. The young man was put on medication and the quality of his life dramatically improved! Another boy came in who had never been able to participate in sports because of a heart murmur. The nurse clinician could not hear the murmur, the pediatrician could not hear the murmur and neither could the pediatric cardiologist who was called in. At some point in the boy's life, the hole in his heart causing the murmur had closed up but he had been labeled a cardiac cripple. The doctors at the clinic were able to remove that

label and he is now able to lead a normal life. What a happy kid! His mother walked over a mile to participate in the exam and supply background information through an interpretor supplied through the clinic. A 16 year old girl came in who was seven and a half months pregnant. She had had no prenatal care nor had she understood its importance. She was enrolled in prenatal services. She has now delivered a normal baby and is back in school. Her baby is seen at the health station for medical care and immunizations. 32 students have been referred for counseling for depression and other emotional disorders. One mother has been in to see the social worker for advice on how to communicate with her daughter. It's obvious that needs are being met in the North High community through the Health Station which had not been addressed before.

Another measure of success is that the teens have been very consistent in keeping both their initial and follow-up appointments -- a good indication of satisfaction with the service. I think that the secret is that the teens know that the people at the Northcentral Teenage Health Station really care about them!

I am Co-Chair of the Sedgwick County Adolescent Pregnancy Network and have done a lot of work with pregnant and parenting teens. I firmly believe in the Maternal and Infant and the Healthy Start Home Visitor Programs.

KAC would like to see the funding for the Maternal and Infant Program raised from $500,000 to $700,000 which Governor Hayden, also, recommends. For each added $500.00, another woman in the project area could receive prenatal care. We all know that money spent on prevention saves money in the long run. Inadequate prenatal care is costly in human and economic terms. Lack of sufficient prenatal care can result in low birthweight babies. The average cost of prenatal care is $600.00. One day in the newborn intensive care unit is $1000.00 and the average stay is 20 days. Low birthweight babies are three times more likely to suffer from birth defects and ten times more likely to be mentally retarded. Providing special education to a handicapped child costs three times more than educating a normal child.

In 1986, 5,700 Kansas women did not receive adequate prenatal care. This program has made inroads in assuring more women access to prenatal care.

KAC would like to see the Healthy Start Home Visitor Program expanded to all 105 counties. The Healthy Start program offers help to high risk families who are pregnant or have children up to one year. The service is delivered by carefully selected and highly trained lay visitors who are mothers themselves. They work with public health nurses who will make visits if needed. They provide in-home support and information about available services. Parenting skills and child growth and development are discussed. The thrust is the prevention of child abuse and neglect and the growth of self-esteem for mother and child. KAC would like to strongly support a raise to the funding level of $489,543.00. The current level is $340,685.00. Only $104,000. is state money. The balance comes from two federal block grants. Please invest in the children - they are our future.

Also, KAC hopes that the $1,500,000. for implementing the Human Sexuality/AIDS Education Mandate of the State Board of Education will remain in the budget.

Thank you for this opportunity to share my concerns.

Margot A. Breckbill
618 North Doreen Court
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Medicine & Health

PERSPECTIVES

December 12, 1988

SCHOOL-BASED CLINICS SPAWN CONTROVERSY

Some public health officials have gotten tired of trying to get low-income teenagers into clinics. Instead, with the help of educators, providers, and others, they're bringing the clinics to the schools. Controversy -- usually concerning family planning services -- hasn't stopped these school-based clinics; they keep multiplying as the idea of linking health care and school gains ground nationwide and attracts new funding sources.

The first school-based clinic set up shop in Dallas TX in 1971. Since then, 120 clinics have entered public schools in 30 states, according to *School-Based Clinics: 1988 Update*, a publication of the Support Center for School-Based Clinics in Houston TX. By the end of 1988, at least 150 clinics should be open, says the Center for Population Options (CPO) in Washington DC, which sponsors the Support Center. The clinics typically offer a range of services from sports physicals and psychological counseling to immunizations and family planning. All services are free to students, regardless of family income. Although on school grounds, the majority of clinics are not run by the schools themselves, but by community health agencies, hospitals, or outside clinics.

Some educators and health professionals say the clinics provide just the right link between public schools and the medical community needed to improve adolescent health, especially for poor, inner-city, minority youth with limited access to health care. And, supporters say, the clinics show promise in helping students stay in school because they address problems related to adolescents' total well-being. The clinics have attracted financial support from 12 state governments, and the concept has spread to rural and suburban schools.

"We don't know of any other means of helping adolescents that shows as much promise of changing people's lives," says Julia Lear, codirector of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program. The clinics also have received support from -- among others -- the National Academy of Sciences, the National PTA, the American Academy of Pediatrics, the American College of Obstetricians & Gynecologists, and the Committee for Economic Development.

But school-based clinics also are the target of criticism, including opposition from the National Right to Life, the Eagle Forum, and former Education Secretary William Bennett, who says they represent an "abdication of moral authority." Critics generally oppose the provision of birth control services in the clinics and the perceived lessening of parental control. Some educators are wary of the clinics because they can spawn controversy or take up resources they think should be spent in the classroom.

KEY WORD: COMPREHENSIVE

School-based clinics generally share these characteristics:

- They are designed to meet the needs of adolescents within a specific community.
- Outside agencies -- not the school -- operate them.

- They are on or next to school grounds.
- Students must get parental consent before the clinics will serve them.
- All clinics maintain patient confidentiality.
- Services are comprehensive, including physical examinations and screenings, treatment of minor injuries, mental health services, and education services such as nutrition counseling.
- They employ health care providers -- typically doctors, nurse-practitioners, and social workers or psychologists -- trained to work with teens.
- They work with local hospitals, clinics, or other health care providers and refer youth to other community services if necessary.
- Some provide reproductive health care services and/or counseling or referral.
- Student clinic enrollment is voluntary.
- Many are open all year, with evening and weekend hours.

Although most are in high schools, 15 clinics are in middle schools or junior high schools. Middle schools are less likely to dispense contraceptives and more likely to have pediatric specialists on staff. They also tend to involve students' families to a greater degree, according to a recent report from the Carnegie Council on Adolescent Development.

CHANGING EMPHASES

Concern over teenage sexuality -- especially teen pregnancy -- was an original impetus behind school-based clinics. A good example is the clinic program in St. Paul MN, one of the first programs of its kind and a model for others. In 1973, after two years of community discussion, Ramsey County Medical Center opened St. Paul's first school-based clinic at Mechanic Arts High School. Originally conceived as a prenatal and day care program for teen parents, the clinic soon grew to provide comprehensive health services. The number of St. Paul clinics grew to five with much of the focus on contraception and sexually transmitted disease.

Early evaluations were promising. In a study done several years after the first clinic opened, the number of births among students at the school declined by half. "Certainly, our reputation is about pregnancy prevention, but our work extends to all health areas," says K.C. Spensley, president of Health Start, the nonprofit corporation set up two years ago for the clinic program. Health Start now is studying eating disorders, she notes.

Many other programs have shifted their focus from contraception to a broader range of health services. "Once we got in, we discovered there was a tremendous array of need," explains Claire Brindis, codirector of the Center for Population & Reproductive Health Policy at the University of California at San Francisco. Research indicates that only 10-to-20 percent of visits concern contraception. Reasons for visits vary from clinic to clinic; many directors say about half the visits are for general health care and education -- including sports physicals, prenatal care, and treatment for illness and injury -- and about half are for psycho-social counseling.

Why so many? Before the clinics, many students didn't get regular medical attention. At one California clinic, 70 percent of enrolled students had no health insurance. At THAT (Teen Health Assessment and Treatment) Place in Baltimore MD, 80 percent of the 150 junior high school students enrolled in the clinic had no primary physician, says medical director Barry Lachman, MD. This fall's data showed half those enrolled hadn't received medical help in over a year, and 20 percent had behavior or substance abuse problems. "In one month, we uncovered five kids with high blood pressure who weren't being treated," says Lachman.

Clinic supporters say adolescents generally get less health care than other age groups in spite of having more problems. Teenagers often don't get health care because their families can't afford it -- private sports physicals can run $150 -- or because they lack transportation or know-how about the medical system. Thus, many students need the clinics for primary health care. The alternative is a hospital emergency room, clinic supporters say, and then only when need is acute. School-based clinics take the care where the kids are, Lachman says.

FOUNDATIONS TAKE ON BIGGER ROLE

Estimates of the number of clinics vary. At the high end: 160 with another 65 in the planning stage. Estimates of the number of students served range from fewer than 200,000 to as many as 500,000 -- out of a total U.S. adolescent population (ages 10 to 19) of 35 million. According to a spring 1988 CPO survey, about half the students in 70 schools were enrolled in the reporting clinics.

Only a few schools take on total responsibility for funding their clinics. Typically medical schools and affiliated hospitals, local health centers, and nonprofit youth agencies started and administered the earliest programs. Sources of funding for clinics have shifted in the past two years, as private foundations and states provided larger shares. Many hospitals and clinics have dropped out for financial reasons, while more public health agencies have become involved in the clinics. Overall, 41 percent of funds now come from private foundations; 24 percent from public sources; 19 percent from states; 14 percent from federal maternal and child health block grants; and 2 percent from other sources. Virtually all clinics are nonprofit. The average cost of running one is $165,000 a year, says CPO.

Foundations' share of support has increased from 31 percent in 1986 to 41 percent now. The largest private source is the Robert Wood Johnson Foundation, which is funding clinics as part of a $16.8 million demonstration project. Clinics at 24 sites get up to $200,000 a year from RWJ for salaries and operating expenses for two years and $400,000 for the next four. School districts and communities provide clinic space and other contributions; a community-based drug program, for example, might loan a clinic a counselor two days a week.

SEEKING FEDERAL AND STATE FUNDS

Every year since 1985, school-based clinic advocates have tried to interest Congress in providing school-based clinic demonstration funds, but no bill ever has moved out of committee. At the state level, however, school-based clinics have won increasing support. In 1985, Oregon became the first state to establish and fund a clinic demonstration project. In 1987, the state legislature increased its two-year allocation from $235,000 to $537,000; the money helped five existing clinics and paid to open one new one. In 1985, the Michigan Dept. of Health adopted a five-year plan to set up teen health centers. In the program's second year, the legislature appropriated $1.25 million for six existing and five new centers. In FY89, 16 centers will get $2 million.

So far, New Jersey is the most ambitious state. The state is providing $6.2 million for 29 school-based clinics which provide job training and recreation as well as comprehensive health services. The program covers 75 percent of operating costs, up to $250,000 a year per clinic; the school districts, selected on the basis of need and geographic distribution, contribute the rest. The clinics "have greatly improved services to kids," says Neil Sternberg, director of the state School-Based Youth Services Program, which oversees them. But the state won't pay for contraceptives, although the school districts may provide them on an optional basis. "We can only refer and educate," says Steinberg. "That's the only way we got dollar one."

CONTRACEPTION: KEY TO CONTROVERSY

New Jersey's school-based clinics haven't attracted conservative opposition, but other clinics have. For example, a local Catholic church has organized parents and others to picket the San Fernando High School clinic. "Some parents think that if you talk about sex and provide birth control, kids will have sex," says clinic director Rena Shpegel. Opposition in the close-knit, largely Latino community has focused on birth control and worries that "birth control means abortion, and that we do them," she says. "But we don't even do referrals for abortion."

Clinic supporters agree that the charge that clinics are an abortion pipeline is pervasive and damaging. In *School-Based Clinics, The Abortion Connection*, National Right to Life Education

Director Richard Glasow writes: "Without question the most creative and invidious ploy ever by abortion partisans to multiply the number of abortions secured by teenagers is the rise of the so-called school-based clinics. Packaged as a good faith effort to provide comprehensive health-care services . . . in reality, SBCs represent a wish come true for abortion proponents and others who for decades have dreamt of direct access to the minds and bodies of impressionable teenagers." Clinic supporters say abortions are not performed at the clinics, and abortion counseling and referrals are made only when the school board and community give clinics the go-ahead.

Another source of conflict is parental consent. Clinic directors report that many parents are afraid that their teenagers will seek contraceptive, abortion, or drug-related services without their knowledge or consent. And since clinics generally are bound by state laws to maintain patient confidentiality, some parents fear their rights are being taken away. To assuage that fear, many clinics urge students to talk to their parents about health problems. They also have parental consent forms that list specific services; if parents don't want children to receive contraceptive counseling or prescriptions, for example, they note that on the consent form.

The clinics' capacity to raise controversy is reason to be wary of them, says Scott Thomson, executive director of the National Assn. of Secondary School Principals. Controversy can affect school budgets and school bond issues, he says. Other educators disagree. "I saw a clinic as a godsend from the beginning," says Diana Cagle, principal of Far Rockaway High School in Queens NY. "The only negative is that it's a tremendous amount of work" to plan a clinic, apply for grants, and sell the idea to staff, students, and community.

FACING THE FUTURE

"Most clinics have adopted the policy that they are guests in the schools," says Brindis, and they try to avoid controversy. An increasing number of schools are leaning toward providing all health services -- except those related to contraception, she says; only 15 percent of clinics now provide contraceptives. Another trend is for clinics to provide more and more services.

Although the number of clinics keeps growing, it's uncertain if they'll become standard in secondary schools. Some experts believe they'll continue to open in inner-city schools with the greatest need. Others predict their spread to more rural schools, where access to health care is a particular problem. In any case, most agree that although the need for better adolescent health care may be universal, clinics will become concentrated in lower-income areas first.

Evaluations of existing programs will help determine just how widespread the clinics become. Most evidence so far is anecdotal. An exception is pregnancy prevention research. An evaluation of a three-year school and clinic demonstration project in Baltimore, for example, showed that students in the program postponed first intercourse, were more likely to use birth control, and had lower pregnancy rates that students who weren't in the program. Brindis, who is studying the impact of clinic programs in eight California schools through measures such as substance abuse, school attendance, and teen pregnancy and birth, says more long-term research is necessary. Supporters say future funding could depend on the results of such evaluations. Although federal funding isn't likely in the near future, states have shown a willingness to fund pilot programs. But even while the long term support of school-based clinics is in question, they continue to gain advocates. Next on the agenda, in states such as New Jersey, is promoting the clinic concept for middle and elementary schools; then, clinic advocates believe, they can reach younger students and do even more with preventive health care and education. -- *Kathleen McCormick, contributing writer.*

Editorial:
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Metro-Midtown Alternative High School
Wichita Public Schools
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Wichita, Kansas 67214

Feb. 13, 1989

Dear Chairperson Barr and the Federal House
and State Affairs Committee Members:

This letter is in support of the North Central Teenage Health Station in Wichita. As the School Nurse at the three Metro High Schools and the Transitional Learning Center at Marshall Junior High School it has become a very useful and needed resource. Many of my students do not receive adequate medical care and is is extremely helpful to know that there is a place for them. Parents are unable to pay for and transport their children during working hours. With a resource so close I will be able to help these students get immediate medical care.

Many of my students are emancipated teenagers, living on their own and attending school while holding down a job. The Health Station helps these students receive medical care at an affordable price.

I certainly appreciate knowing that this resource is available and I intend to use it more in the future. I deal with many sexually active teenagers, some pregnant and some with children. Teenagers with adult health problems need a special place to go. I strongly support the North Central Teenage Health Station.

Sincerely,

Cynthia Ellsworth, RN.

Cynthia Ellsworth, R.N.
Metro High School
School Nurse

WICHITA HIGH SCHOOL NORTH
Wichita Public Schools
1437 Rochester
WICHITA, KANSAS 67203

To: Ms. Ginger Bass, Chairman
House and State Affairs Committee

From: Gwendolyn B. Stanley RN
School Nurse
Wichita High School North

The Wichita/ Sedgwick County Health Department has opened a Health Station in the vicinity of North High to provide services to adolescents. In addition to care for acute illness, all services usually provided by the Health Department are offered at this facility. Specific procedures have been developed in cooperation with the School District to facilitate referral and care of teenagers. Written parental consent is required for care.

This service is filling a need for medical care in the community. Many of the teenagers using the Health Station do not have access to medical care through the usual routes. Some parents have neither health insurance or a medical card and many are not in a position to take time off from work to take their children to the doctor. By utilizing the services of the health station, students are able to have acute illnesses evaluated with no delay and thus diminish the severity of the illness and the length of absence from school. Since routine health assessments are also provided, some students have had chronic problems diagnosed and treated. The staff has provided dietary counseling for obesity, as well as counseling for depression and other adolescent concerns.

It is the philosphy of health services that "a healthy child learns best". This facility is providing services that restore the health of youngsters, identifies and treats chronic health problems and gives adolescents the information needed to practice a healthy lifestyle.

WICHITA
PUBLIC SCHOOLS

February 13, 1989

Office of
Area I Superintendent

Ms. Ginger Barr, Chairperson
Federal House & State Affair Committee
State Capitol Building
Topeka, Kansas 66612

Dear Ms. Barr:

As the Wichita Public Schools' Area I Superintendent, I assure you that the school district is most pleased that the Sedgwick County Health Department, in cooperation with the University of Kansas Medical School has provided a health care station. We have worked to include a number of programs to assist students in their educational endeavors. However, it is my firm belief that without health care for adolescents, the educational efforts will wane.

The students in many of our high school areas have a high risk of health problems. One survey shows that thirty per cent of them are not receiving any health care as far as we can determine. Any kind of referrals, whether small health problems or major health concerns, do not get referred to a medical physician.

For many reasons, I was most happy when I heard that Governor Michael Hayden had established funding for adolescent health care and that funds were allocated to Wichita. If you will check the communications to Governor Hayden, you will note that I sent a letter on August 1, expressing my appreciation for this program. I have also sent a letter to Mr. Ed Flentje on August 23 reiterating our support of this program.

Superintendent Stuart Berger is aware of the apparent concern of some individuals about health stations near schools. He has reiterated the district's support of this project and its tremendous benefit to students. That really is our bottom line--benefit to students.

If I can be of any assistance to you, either talking directly to the Governor or testifying to the need for adolescent care, I would be most happy to do so. I again emphasize my support of the health station and the Governor's program for adolescent care. I would go on record to state that we need more, not less programs, and I would be most happy to convey this message to others as you see the need.

Sincerely,

Diana Cubbage

Diana Cubbage
Area I Superintendent

sd

pc: Dr. Stuart Berger
Ms. Margo Breckbill of the Northcentral Health Association

ISSUE: ADOLESCENT HEALTH CARE PROGRAM

POSITION: Kansas Action for Children supports funding the Adolescent Health Care Program of the Department of Health and Environment.

COST:

FY 1989 Funding Level:	$100,000	
Governor's recommendation:	$100,000	(subject to verification)
Proposed Funding Level:	*$290,000	
	**$ 50,000	

BACKGROUND: This program was established to promote access for adolescents to health care. The first functioning adolescent health care station has been established in Wichita. State funds are channeled through the local health department to:

1) provide preventative health care including school physicals, education, immunizations, human reproductive counseling;
2) refer pregnant teens to Maternal & Infant programs for prenatal care;
3) increase adolescent male participation in health programs;
4) reduce the negative effects of teen pregnancy;
5) provide early intervention of high risk behavior; and
6) fund diagnostic and referral services.

RATIONALE: Adolescents have special health needs but are less likely to seek adequate health care than any other age population. A Children's Defense Fund study reported that 28% of children aged 12 - 18 do not visit a doctor during a year. Among their special health needs are drug and alcohol abuse, emotional illness, teen pregnancy (in 1986, 4,490 babies were born to Kansas teens), and suicide (during the 1985-86 school year, there were 40 suicides and 317 suicide attempts among Kansas teens; 984 considered suicide).

* Kansas Department of Health and Environment C level budget request.

** This is C level request for an additional $50,000 (approximately) to fund an adolescent health care specialist and secretary.

ISSUE: HUMAN SEXUALITY/AIDS MANDATE OF THE STATE BOARD OF EDUCATION

POSITION: Kansas Action for Children supports the State Board of Education's recommendation of $1.5 million for human sexuality and AIDS education.

COST:

FY 1989 Funding Level:	$ 1,500,000
Governor's Recommendation:	$ 1,500,000
Proposed Funding Level:	$ 1,500,000

BACKGROUND: The State Board of Education, in May 1987, mandated human sexuality and AIDS education in Kansas schools. The policy is the result of several efforts including: the survey of sex education programs in public schools conducted by the Governor's Committee on Education for Parenthood; Recommendations from the State-wide Planning Conference on Adolescent Pregnancy; and public awareness of the threat of AIDS in Kansas.

The $1.5 million state appropriation is apportioned to the districts on a per pupil basis and is used to cover their expenses in implementing and maintaining programs relating to human sexuality and AIDS education. Plans are being made to expand the training to elementary level school teachers.

RATIONALE: Human sexuality education is an integral part of a strategy to reduce teen pregnancy. In Kansas during 1985, teens accounted for 11.4% (4,492) of all live births in Kansas. During 1986, there were 4,490 live births to teenagers and preteens. Of these births, 700 were to teens 16 years of age and under.

Unmarried teen mothers are more likely to have more children, less education, more unemployment and be in poverty than mothers who delayed childbirth. In Kansas, nearly 20% of all fetal deaths occur to mothers aged 14 to 19.

Pregnant teens are less likely to receive adequate prenatal care and often have low birth weight babies. The average cost of prenatal care is $600. One day in the newborn intensive care unit costs $1,000 with an average stay of 20 days. Low birth weight infants are three times more likely to suffer from birth defects and ten times more likely to be mentally retarded.

Children of adolescent parents are more likely to be raised in poverty, have poorer health, often are abused and neglected, and are more likely to become teen parents themselves. Children growing up in poverty suffer deficits in language, curiosity, self-direction, attention span and coordination.

NOTE: Human Sexuality/AIDS education is part of the 1989 Children's Coalition legislative package.

ISSUE: FUNDING FOR MATERNAL & INFANT PROGRAMS

POSITION: Kansas Action for Children supports an increase in state funds for Maternal and Infant Care Programs.

COST:

FY 1989 Funding Level:	$ 500,000
Governor's recommendation:	$ 700,000
Proposed funding level:	*$ 700,000

BACKGROUND: In 1986, the Legislature approved $500,000 to fund 14 Maternal/Infant Projects with outreach to 27 counties. Facing severe budget constraints, the 1987 Legislature decreased state funding by $100,000. The 1988 Legislature restored this program to the original funding level. The $500,000 level enabled the Department of Health and Environment to expand maternal and infant care projects to 39 counties serving 5,770 women and 3,408 babies. In 1987 only 3,098 women and 1,700 babies were served.

RATIONALE: The Maternal/Infant Projects provide the best chance for infants to be born healthy by assuring that no pregnant women in project areas are denied access to comprehensive prenatal care for financial reasons. High risk mothers and babies with access barriers to health service are specific target populations.

Inadequate prenatal care is costly in human and economic terms. Lack of sufficient prenatal care can result in low birth weight babies. The average cost of prenatal care is $600. One day in the new born intensive care unit costs $1,000 with an average stay of 20 days.

Low birth weight infants are three times more likely to suffer from birth defects and ten times more likely to be mentally retarded. Providing special education to a handicapped child costs three times more than educating a normal child.

In 1986, nearly 5,700 Kansas women did not receive adequate prenatal care. This program has made inroads in assuring more women access to adequate prenatal care.

* $700,000 is the Department of Health and Environment's C level budget request for FY 1990. It is estimated that each $500 in new state money will result in one more woman being served by this program.

NOTE: M & I programs are among the top four priorities of the Governor's Commission on Children and Families. M & I program funding is also part of the Children's Coalition 1989 legislative package. It would be possible to fund M & I without additional state money if:

1) Medicaid eligibility limits would be extended to 185% of poverty; AND
2) Social and Rehabilitation Services (SRS) and Kansas Department of Health and Environment (KDHE) would work out a method of Medicaid reimbursement for comprehensive perinatal services.

ISSUE: STATEWIDE HEALTHY START HOME VISITOR SERVICES

POSITION: Kansas Action for Children supports expanding the Healthy Start Program to all 105 counties.

COST:

FY 1989 Funding Level:	*$	340,685
Governor's Recommendation:	$	365,685
Proposed Funding Level:	**$	489,543 or $472,264

BACKGROUND: The Healthy Start Home Visitor Program is available in 49 counties and serves approximately 15,000 high risk parents of children under one year of age. (37 counties are funded by KDHE and 11 are funded by Children & Youth Trust Fund.) The program offers help to families expecting babies or with newborn babies. This service is delivered by carefully selected and trained lay visitors who are themselves mothers. (These visitors work with public health nurses who will make home visits if needed.) The Healthy Start home visitor provides in-home support and information about available services to new and expecting parents.

RATIONALE: A chief reason for child abuse and neglect is the parents lack of developmentally appropriate knowledge about their children. Abuse and neglect are most likely to occur to children of high risk parents. Early intervention through education and skill enhancement has been shown to reduce this likelihood.

* Currently only $104,926 is state money; the balance comes from two federal block grants. The Governor is proposing $25,000 in new state money.

** $489,543 would have been the total Department of Health and Environment's C level budget request if the FY 90 C level request of $149,000 would have been granted. This amount would extend KDHE funded counties from 37 to 59.

$472,264 would be the cost of the proposal of the Governor's Commission on Children and Families for year one of a three-year phase in. The first year would add no new counties but would add dollars to the existing counties and more staff in preparation for the second year. The recommendation for year two would serve 59 new counties, and for year three, it would serve all 105 counties.

NOTE: Healthy Start is one of the four top legislative priorities of the Governor's Commission on Children and Families.

Testimony Before

House

Federal and State Affairs Committee

on

February 14, 1989

by

Judith M. Reno, R.N., B.S., C.N.A.

Director of Personal Health

Wichita-Sedgwick County Department of Community Health

Chairperson Barr and members of the committee - Thank you for the opportunity to share concerns as they relate to issues regarding maternal and child health. My purpose today is to relate some of the real experiences that are happening in this state but more specifically in Sedgwick County. The issues are not necessarily listed in priority order.

I. Immunizations

In Kansas, we are experiencing outbreaks of mumps and measles and in the not-too-distant past, there was also whooping cough. These are diseases that can be prevented by immunizations. Local health departments receive the vaccine for the immunizations from the State Health Department. Every year, the State Health Department runs out of money for vaccines and the local health department robs Peter to pay Paul to buy the vaccine. We believe if a parent is motivated to bring the child for immunizations we cannot send them away without the immunization. They may never come back until the child is school age. It is the preschool-aged population that is not adequately immunized.

II. Prenatal Care/Infant Mortality

It has been demonstrated that women who receive adequate prenatal care have less complications and a healthier baby. In Sedgwick County, birth certificate data demonstrates that over 600 women a year have less than adequate care. I believe there are several reasons for this but availability of care and knowledge of importance of prenatal care have to be the leading factors. We have had a Maternal and Infant Project in Sedgwick County for 14 years. Only within the last two years have we been able to expand its services. In 1988, the project served 470 pregnant women. Of these, 56% had incomes at the poverty level or less. In January, we served a 13-year old. Last summer we provided care to her 14-year old sister. Both are believed to be victims of incest. This project

needs money to educate all women and their significant others about the importance of care.

III. Prematurity/Infant Mortality

In 1982, our department developed and was funded for an innovative program to prevent prematurity, the leading cause of why our babies die before they reach their first birthday. Funding has never increased for that project so we serve only 1200 women, not the 7200 plus that are pregnant every year. The project has contributed to the decrease of prematurity as the cause of infant death from 52% in 1981 to 39% in 1987.

IV. Homeless

Our department entered into a project with five other agencies to provide health care to the homeless. In 1988, the project served 2024 persons. Of these, 17.7% were less than 14 years old. Preschoolers totaled 9.7%. They demonstrate both acute and chronic illnesses. Many communicable diseases were seen. The children were inadequately immunized. It is estimated there are 3500 homeless persons in Sedgwick County. Based on last year's data, 620 are children under the age of 14. These children are not having a HEADSTART!

V. Black Infant Mortality Project

Sedgwick County is no different than the remainder of the State in that infants of our African-American community have a 2-to-3-times greater chance of dying than infants of the rest of the community. Issues relating to this problem, as with other women at high risk,include sexual decision-making; availability and usage of prenatal care and access to birth control. It is not that simplistic, nor would I want to imply that it is. Communities must have the opportunity and resources to work on the problem. The legislature has allowed that by appropriating money to Sedgwick County for that purpose. Thank you.

VI. Teenagers

And last but not least, I am going to discuss teenagers. Those humans in an almost-adult body with almost adult thinking and feelings. These are the humans that think themselves omnipotent and impervious to harm. At one of our high schools

last year, as is found nationwide, 30% of the students that presented ill to the school nurse did not receive medical care. This was because the parent could not leave work or even if they could they could not afford the medical care. When an opportunity for funding to address these problems was given by the legislature, we took it. A health station was opened in September 1988 across from the high school. To date, parents have given consent for 338 students to receive care at the station. Since the station's opening, there have been 421 visits by students for care. These visits have been for school and athletic physicals; upper respiratory infections; ear infections; strep throat; urinary tract infections; sexually-transmitted diseases; prenatal care and infant care to name a few reasons. Are we doing what the project was developed to do? I think so. An example is the young student who came to the station in December because his ears had been draining for four months. He stated his parents did not have money for either a doctor or medicine. After two rounds of medicine, the ear drums closed. Did we save his hearing? Did it help his school work? Will he stay in school? Only time will tell, certainly not just nine months of a project. The station is a pilot project and it must be given time to have a proper evaluation, one way or another.

In Sedgwick County, over 1100 teenagers each year become pregnant. For 1987, the number was 1327. Studies show that teens are sexually active 23 months before seeking birth control - certainly the presence of birth control has not been the motivator for sexual activity. What is the answer? I don't have one. We must teach every child how to be a parent for in doing that we'll teach them how to communicate their values and preferred lifestyle.

VII. The "Uninsured" and "Underinsured" Women and Children of Kansas

The "uninsured" and underinsured" women and children of Kansas is not the issue in health care. Being insured does not give you access to the doctor's office or the pharmacy for a sore throat and a fever of 104°. Illness care that does not require hospitalization is the issue. To intervene early in an illness is to prevent complications that require hospitalization. Persons of limited income must decide between illness care and food or housing. That is a decision we should not force Kansans to make. Too often, the decision has been costly not only to the person but to The State of Kansas in excessive hospital bills, special education and lifelong financial support. We cannot afford not to support Kansans in their health care.

1523 Woodland
Wichita, KS 67203
February 12, 1989

Federal and State Affairs Committee
Kansas House of Representatives
Topeka, KS

Ladies and Gentlemen:

We thank you for the opportunity to have our views put before this committee. Previous commitments prevent us from attending in person.

Many words have been said and written about the teen health station located near North High School in Wichita. Regrettably, very few of them have come from parents of North High students and it is in this capacity that we wish to speak. Our oldest daughter is a freshman at North; a younger daughter will attend in two and one half years. Therefore, we have a current and future interest in the North High community.

North High School has a large proportion of low income and disadvantaged youth in attendance. Medical care is a luxury beyond the means of too many North High families. We are trusting that health care officials will inform you of the diseases that have gone untreated and the needless pain and suffering that have resulted. The Health Station represents an escape from hurting and a restoration to health so that students may concentrate upon their education.

For medical treatment to be comprehensive, it must embrace all biological aspects of the human organism including sexuality. Unfortunately, a small but vocal group has seized upon this one aspect of treatment and distorted its purpose and application. The objectors have misrepresented the Health Station, its objectives, and the intentions of the staff and management. They have suggested that control of the Health Station does not rest with local officials but with "other" groups that have the promotion of abortion as their goal. The objectors' efforts to rally support for their cause with North High community has come to no avail. At an August 1988 meeting attended by over two hundred parents of incoming freshmen, Dr. Ruth Taylor spoke against the Health Station. Not one parent in the group arose in support of her position. A second person at the meeting, who was not a parent, tried to equate the Health Station with abortion and contraception. This appeal was not supported by the parents either. A similar meeting for parents of incoming sophomores produced the same lack of response.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 5A
February 14, 1989

St. Patrick Parish held a meeting to discuss the Health Station. The only North High parents who attended the meeting were in support of the Health Station. The North High Community wants and needs this Health Station. Parents have had several opportunities to voice their objections. The objections are coming, not from North High parents, but from people who are not a part of the community.

Many parents we have spoken with are supportive of the Health Station and the work that is carried on there. The North High nurse says that these health services are needed. Please extend your help by keeping these services available to the low income and disadvantaged student in the North High School area.

Respectfully,

Earl & Jane Griffith

Earl Griffith
Jane Griffith

February 13, 1989

Chairperson
Federal & State Affairs Committee
Kansas House of Representatives

As a parent of a North High student, I am writing this letter in support of the North Central Teenage Health Station located at 438 W. 15th in Wichita, Kansas and serving North High School, John Marshall Junior High and Horace Mann Middle School. The Teenage Health Station was opened in September 1988 in order to provide health care to adolescents--particularly those who were financially disadvantaged.

After first learning of the new health station I reviewed research on the subject of teen health stations and the status of adolescent health care--not only determine my own opinion about the station but also in conjunction with my membership on a school district committee on middle school implementation. I soon learned that the status of adolescent health care is a national crisis--teenagers are less likely to have access to health care and physicians than any other age group. School districts around the nation are recognizing that healthier students are better students.

Financially disadvantaged students face an additional handicap when they become ill in that they are less likely to receive proper medical attention in order to recover. I discovered this fact first hand when volunteering to assist students in "in-school detention" at John Marshall Junior High. Many of the students in the "I.C.E." room were continually ill, and my suggestion that their parents take them to their doctor was often met with blank stares. I learned from the school's administration that many of these students had no doctor. In fact, North High School administration estimates that one-third of their students have no doctor! The school nurse is not able to assist these students--she must simply have them call their parents to take them home when they are ill. Administrators recall that only last year a student who was continually ill with bronchitis was finally taken to a doctor only after teachers chipped in for his care--his parents had been financially unable to seek medical care for him. This year, students such as this young man are receiving medical attention thanks to the North Central Teenage Health Station.

Since I also serve as North High School's Parent Representative to the school district, I am aware of the administration and staff support of the Health Station. Mel Johnson, North High's principal, has indicated his support of the Health Station "because it offers a means for our indigent students to receive medical care which they might not otherwise receive."

I also strongly endorse the North Central Teenage Health Station's organizational structure (ie: operating under the direction of the Sedgwick County Health Department).

In closing, I might add that any expressed opposition that I am aware of does not originate from North High parents, and is not based on any supported facts.

Thank you for your concern about adolescent health care. Please feel free to contact me if you have any addtional questions.

Sincerely,

Susan Osborne-Howes

Susan Osborne-Howes
839 Wiley
Wichita, Kansas 67203
316-264-8192

THANK YOU MADAME CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I AM REPRESENTATIVE ALEX SCOTT OF THE 65TH DISTRICT, HOUSE OF REPRESENTATIVES. I SPEAK TO TODAY'S ISSUE FROM OVER THIRTY YEARS OF GENERAL PRACTICE AS A PHYSICIAN, AN EXPERIENCE IN WHICH I HAVE SEEN MUCH JOY AND SOME SORROW. I SPEAK AS THE FATHER OF THREE DAUGHTERS AND I HAVE ONE STEPSON. I CAN SAY,HAPPILY FOR ME, THAT I AM PROUD OF THEM ALL, BUT I REALLY CAME TO SPEAK ABOUT TEENAGE PREGNANCIES.

A TEENAGE PREGNANCY (PREGNANCY BEFORE CHRONOLOGICAL AGE 18) IS AN UNHAPPY MEDICAL EVENT; AND, IF THE GIRL IS UNMARRIED IT IS A SOCIALLY TRAGIC EVENT BECAUSE IT OPENS FOUR OPTIONS:

(1) CARRY THE PREGNANCY TO TERM AND KEEP THE INFANT.

(2) CARRY THE PREGNANCY TO TERM AND PLACE THE INFANT FOR ADOPTION.

(3) BE ABORTED OF THE EMBRYO.

(4) HOPE THAT A SPONTANEOUS ABORTION WILL OCCUR AS IT DOES IN ONE OF ABOUT SEVEN PREGNANCIES. PERHAPS GOD HAS CONCERN FOR THE SINGLE GIRL AND IN ABOUT 17% OF CASES GIVES HER A SECOND CHANCE. THIS IS TANTAMOUNT TO TELEPHONING THE TOOTH FAIRY.

NONE OF THE OPTIONS ARE REALLY SATISFACTORY IN A SOCIETAL SETTING WHERE PERMANENT PAIR BONDING BETWEEN A MAN AND WOMEN IS BIOLOGICALLY AND SOCIALLY MOST SATISFACTORY, AND ECONOMICALLY ABOUT THE ONLY WAY A FAMILY CAN EXIST SINCE TWO INCOMES APPEAR NECESSARY FOR FAMILY SURVIVAL AND PROGRESS.

LET US EXAMINE THE PICTURE OF THE SCHOOL GIRL WHO BECOMES PREGNANT, IS UMNARRIED, AND KEEPS HER BABY:

(1) SHE FINDS IT DIFFICULT TO COMPLETE EVEN A HIGH SCHOOL EDUCATION AND MUST EITHER ACCEPT A MINIMUM WAGE JOB, HOPE FOR THE SUPPORT OF HER PARENT OR PARENTS, AND THEY MAY BE HOSTILE AS OFTEN AS SUPPORTIVE DESPITE WHAT THEY AVOWED BEFORE THE BABY WAS BORN; OR,

(2) SHE CAN ACCEPT A WELFARE SUBSISTENCE AND STRIKE OUT ON HER OWN. SHE MAY BE ABLE TO SATISFY HER LONELINESS BY RE-ESTABLISHING A LIAISON WITH THE CHILD'S FATHER OR ANOTHER MALE.

IF THE SECOND ALTERNATIVE IS ADOPTED, SHE HAS TO RUN THE RISK OF CHILD ABUSE WHEN THE CHILD IS LEFT WITH THE LIVE-IN BOYFRIEND. INCIDENTALLY, THE MALE MUST KEEP HIS SUPPORT HIDDEN FROM SOCIAL WELFARE AND REHABITATION SERVICES OR THE WOMAN LOSES HER SUPPORT FROM THAT AGENCY. IN THIS SITUATION SHE MUST WORRY ABOUT WELFARE FRAUD AND HE HAS TO WORRY ABOUT BEING NAMED AS THE CHILD's PARENT (AS HE MAY HAVE WITH PROUD FOOLISHNESS ALLOWED HIS NAME ON THE BIRTH CERTIFICATE) IN WHICH CASE HE IS PURSUED FOR SUPPORT. I CAN ASSURE YOU HIS NAME WILL ONLY APPEAR ON THE BIRTH CERTIFICATE FOR THE FIRST BIRTH.

WHAT IS THE REMEDY?

(1) EDUCATION: MARRIAGE AND THE FAMILY COURSES ARE TAUGHT MUCH TOO LATE, AND USUALLY IN COLLEGE. IF TAUGHT AT ANY TIME BEFORE PUBERTY THE COURSE WORK IS SO SANITIZED THE CHILDREN FAIL TO COMPREHEND THE CONNECTION BETWEEN A FROG EGG AND A FROG SPERM CELL AND WHAT THEY SEE ON NOT SO LATE NIGHT TELEVISION OR IN AN R-RATED MOVIE. DO THEY HAVE X-RATED MOVIES ANYMORE?

EDUCATION MUST BE IN THE SCHOOL SYSTEM SINCE PARENTS CANNOT TALK TO THEIR CHILDREN ABOUT SEX BECAUSE THEY DO NOT WANT THEIR CHILDREN TO HEAR FOUR LETTER WORDS - THE ONLY ONES MANY PARENTS KNOW FOR BODY FUNCTIONS. HEARING THOSE WORDS FROM THEIR PARENTS WOULD ONLY CONFUSE THEM SINCE THEY USUALLY HEAR THEM ON THE PLAYGROUND.

WE MUST LOOK TO THE TYPE OF "TOUGH LOVE" EDUCATION ADVOCATED BY THE SURGEON GENERAL OF THE UNITED STATES PUBLIC HEALTH SERVICE, DR. EVERETT KOOP. HE IS ONE OF THE MOST MORAL MEN I HAVE EVER MET, BUT HE ALSO IS A PRAGMATIST. HE ALSO IS SUPPORTED REPETITIVELY BY THE INFLUENTIAL COLUMNISTS ANN LANDERS AND DEAR ABBY. IT IS HIGH TIME WE RESPOND TO THE TEENAGE PREGNANCY PROBLEM. DISPENSING ORAL CONTRACEPTIVES IS NOT ENOUGH ANYMORE NOR WAS IT EVER THE ANSWER. SINCE THE AQUIRED IMMUNE DEFICIENCY DISEASE COMMONLY CALLED AIDS HAS APPEARED, MANKIND FOR THE FORESEEABLE FUTURE MUST CHOOSE BETWEEN MORALITY OR MORTALITY.

WHEN DON QUIXOTE SET OUT ON HIS QUEST HE MAY HAVE BEEN SENILE BUT HE WAS SMART ENOUGH TO SAY - -
"TOO MUCH SANITY IS MADNESS: THE MADDEST OF ALL IS TO SEE LIFE AS IT IS, RATHER THAN AS IT SHOULD BE."

IT IS OUR TASK, MY FRIENDS, TO LEGISLATE NOT TO PRESERVE LIFE AS IT IS BUT HOPEFULLY TO MAKE LIVING "AS IT SHOULD BE."

ALEX SCOTT
Representative, 65th District

TESTIMONY ON PRENATAL HEALTH
February 14, 1989
Federal and State Affairs Committee
Representative Ginger Barr, Chairwoman

Madam Chairwoman and Members of the Committee, thank you for the opportunity to testify today. My name is John Pierpont, and I represent the Children and Youth Advisory Committee.

For many years the Advisory Committee has been committed to the enhancement of prenatal and perinatal health services. In "Seeking Friends for Kansas Children", a report issued jointly with Kansas Action for Children last summer, we called for expansion of Healthy Start/Home Visitor and Maternal and Infant Projects. We hope to see both programs expanded statewide. You have already heard much about the M & I Projects; therefore, I will limit most of my testimony to the Healthy Start/Home Visitor Program.

A 1987 document on maternal and child health sponsored by the Southern Legislative Conference reports that **two to ten dollars are saved for every dollar spent on prenatal care; that the cost of treating five high-risk premature babies can pay for providing prenatal care for as many as 149 women; a person's best chance to be a healthy adult is to have been a healthy child; and that, as study after study concludes, prenatal care is the single most significant factor in determining a newborn's health, and postnatal care is the second most significant factor.**

In Kansas, approximately 6,000 mothers do not obtain adequate prenatal care; one in 16 babies is a low-birthweight baby; fewer than half of the children and pregnant women eligible for the WIC program actually receive services; and fewer than half of the eligible medical assistance clients use EPSDT (Early and Periodic Screening, Diagnosis and Treatment) services. **The public health operated Maternal and Infant Program is available in only one-third of 105 Kansas counties. Healthy Start/Home Visitor Programs are available in only 49 counties.**

Healthy Start/Home Visitor Programs promote newborn and child health by providing information, referrals, support, and often transportation, to parents with or expecting a newborn. Parents receive information on pregnancy and delivery, child health needs, nutrition, and child development. They learn about WIC and EPSDT services, and they have contact with a supportive person who is knowledgeable about parenting and child care.

Healthy Start Programs are operated by local health departments on the county level where home visitors are recruited, trained, and supervised. The Kansas Department of Health and Environment provides technical assistance, quality control, and partial funding for local programs. (Local and county agencies pay 53% of costs and KDHE pays 47%). KDHE funds for Healthy Start/Home Visitor Programs come from federal grants and state appropriations.

The Governor's Commission on Children and Families recommended expansion of Healthy Start. Two of that Commission's three committees supported Healthy Start as a first or second priority. Unforunately, **the proposed budget for Health and Environment would not expand Healthy Start. The 25,000 additional dollars allocated for Healthy Start would enable KDHE to pick up those programs now funded by the Family and Children Trust Fund.** No new Healthy Start programs would be implemented. We do not believe this is the intent of the Governor's Commission. It certainly is not in the best interest of our children and families.

The Department of Health and Environment has drawn up a three-year plan for the implementation of Healthy Start Programs in every county in Kansas by 1991. The Children and Youth Advisory Committee fully supports this plan and urges you to use whatever measure of influence you have to assure its funding and implementation.

In closing, I will leave you with two facts about Healthy Start/Home Visitor Programs. **First, Home Visitor Programs, when properly executed, have been shown to reduce the incidence of child abuse to infants; the incidence of preventable childhood diseases; and the number of serious childhood injuries in the families served.**

Second, Healthy Start Programs begin near the end of pregnancy. They do not replace prenatal care programs. They extend the benefits begun by Maternal and Infant Programs. **Both programs are vital to our children's health. The Children and Youth Advisory Committee urges you to support these pre and postnatal care programs, and to ensure that, in Kansas, they reach every child in need.** Thank you.

John Pierpont, Coordinator
Children and Youth Advisory Committee
296-4656

Planned Parenthood®
Of Kansas, Inc.

TO: House Federal and State Affairs Committee
FROM: Belva Ott, Director of Governmental Affairs and Community Relations, Planned Parenthood of Kansas, Inc.
RE: Teen Pregnancy and other issues concerning our Children
DATE: February 14, 1989

Thank you for the opportunity to come and share thoughts regarding the "Caring for our Children," which I hope to bring to you today.

Planned Parenthood has been dedicated to eradicating unintended pregnancy since its inception and remain committed to that goal. Efforts must be made to reach that group of Kansans who suffer most from the consequences of unintended pregnancy -- Kansas teenagers, and America's teenagers.

In recent years, we have seen:

- an escalation of sexually active teens: 1.1 million teens become pregnant every year; one out of every 4 young women will become pregnant while still in her teens.

- a dramatic - but still inadequate - expansion of family planning services to sexually active teens.

A. KANSAS HAS THE 19TH HIGHEST WHITE TEEN PREGNANCY RATE IN THE U.S.

KANSAS HAS THE 7TH HIGHEST BLACK TEEN PREGNANCY RATE NATIONALLY.

B. KANSAS SPENT $143.9 MILLION DOLLARS ON FAMILIES STARTED WHEN THE MOTHER WAS AN ADOLESCENT...1985 latest figures available. This includes only money spent on AFDC, Medicaid and food stamps. IT DOES NOT INCLUDE OFTEN USED SERVICES OF HOUSING, SPECIAL EDUCATION, CHILD PROTECTION SERVICES, FOSTER CARE, DAY CARE AND OTHER SOCIAL SERVICES.

HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 8
February 14, 1989

Wichita — 2226 East Central, Wichita, Kansas 67214-4494 316 263-7575
Hays — 122 East 12th, Hays, Kansas 67601 913 628-2434
Cowley County — P.O. Box 176, Strother Field, Winfield, Kansas 67156
Winfield: 316 221-1326 Arkansas City: 316 442-0050

A study completed in October, 1987, by faculty at Wichita State University in Maternal-Child Nursing, calculated the costs of adolescent pregnancy to the state of Kansas for the year 1985. The information showed:

$13,600.....AVERAGE SINGLE BIRTH COST - KANSAS
(Public cost for a single family begun by an adolescent birth for 20 years following that birth.)
$17,670 for Kansas mothers under age 14;
$17,636 for Kansas mother 15-17 years old;
$11,174 for Kansas mother 18 & 19 years old.

$143.92 million....SINGLE YEAR COST TO STATE OF KANSAS
(Public cost for 1 year to support all families begun by a birth to an adolescent that year.)
TWO OUT OF THREE ADOLESCENT MOTHERS DO NOT RECEIVE PUBLIC ASSISTANCE THUS ACTUAL PUBLIC COST OF A SINGLE BIRTH IS CONSIDERABLY HIGHER THAN THE ESTIMATED AVERAGE COST.

$47.86 million....SINGLE COHORT COST FOR KANSAS
(Public cost for all families begun by a teen birth in a single year for the 20 years that family may require public assistance.)

KANSAS COULD HAVE SAVED $19.14 MILLION DOLLARS IF THESE BIRTHS HAD BEEN DELAYED UNTIL THE MOTHER WAS TWENTY YEARS OF AGE OR OLDER. (See Packet)

Additional consequences of unintended pregnancy are:

- increased poverty, unemployment, divorce rates and socioeconomic polarization and a rise in the number of female headed households;

- a growing consensus about the solutions to these problems, but half-hearted attempts to implement them.

Education is a well known factor in future earnings potential and the likelihood of subsisting in poverty. In Kansas, almost 50% of the mothers with a high school diploma were in poverty, WHILE 75% OF THOSE WITHOUT A HIGH SCHOOL EDUCATION WERE IN POVERTY.

* Teen mothers staying in school have fewer children. One study has shown that 40% OF MOTHERS WHO QUIT SCHOOL AFTER THE FIRST CHILD HAD AT LEAST 2 MORE PREGNANCIES. In contrast, only 25% of mothers completing school had at least 2 more.

* In Kansas 24% of the 15-19 year olds giving birth in 1985 had experienced a previous pregnancy. Five percent had been pregnant twice. Five percent of the 10-14 year olds had been pregnant previously.

Early parenthood reduces future employment opportunities. Young women without children were 6 times more likely to be in the labor force. In a study tracking teen mothers from 1966 through 1972, 43% of the young mothers with only one child had been employed steadily in the last two year of the study compared to only 10% of those teens with more than one child.

A KANSAS SURVEY OF ADC CLIENTS DURING 1985 CONFIRMS THAT 52.3% HAD THEIR FIRST CHILD BEFORE AGE 20. CHILDREN BORN TO UNMARRIED ADOLESCENT MOTHERS ARE 4 TIMES MORE LIKELY TO BE POOR AS OTHER CHILDREN.

There must be added a definitive health risk in addition to the disproportionate financial and emotional cost of early parenthood. THE YOUNGER THE MOTHER THE MORE LIKELY THE BABY WILL DIE. The mortality rate for infants of black teen mothers in Sedgwick County during 1985 was a stunning 100 for 10-14 year olds and 20.8 for 15-19 year olds. Even white teens experienced a rate of infant mortality half again as high as the overall rate in Kansas.

The well-documented consequences of adolescent pregnancy and childbearing are so pervasive that a coordinated, comprehensive and fully funded program of prevention is needed to address the problem.

SEXUALITY EDUCATION AND BIRTH CONTROL HELP DECREASE THE NUMBER OF TEEN PREGNANCIES. In one year alone, Title X, the federal family planning program, helped avert more than 400,000 pregnancies among teens. TEEN PREGNANCY, ABORTION AND CHILDBEARING RATES IN THE U.S. STILL REMAIN HIGHER THAN THOSE IN OTHER DEVELOPED COUNTRIES. WHY IS THE RATE SO MUCH HIGHER IN THE U.S.? THE PROBLEM OF TEEN PREGNANCY WAS RESEARCHED IN THE U.S. AND 5 OTHER COUNTRIES: ENGLAND & WALES, CANADA, FRANCE, SWEDEN AND THE NETHERLANDS. The other countries have a much lower pregnancy rate. Researchers found the level of sexual activity was not less, but the same. THE BIG DIFFERENCES WAS THAT THE 5 COUNTRIES ALL HAD MUCH BETTER MANDATORY SEX EDUCATION AND BIRTH CONTROL WAS MUCH MORE ACCESSIBLE TO TEENAGERS. THIS DID NOT CAUSE MORE OR FEWER TEENS TO BE SEXUALLY ACTIVE, BUT DEFINITELY RESULTED IN FAR FEWER PREGNANCIES AND FAR FEWER ABORTIONS.

See Attachment 1

Kansas has taken the lead in educating our children regarding sexuality education, AIDS...however, too many areas continue to pay lip service to a comprehensive sexuality education curriculum. This comes when a Louis Harris Poll, completed in May 1988, and commissioned by PPFA, shows that:

* 89% OF AMERICANS FAVOR SEX EDUCATION BEING TAUGHT IN THE SCHOOLS; (up from 85% in 1985.)

* 80% FAVOR ALLOWING SCHOOL HEALTH CLINICS TO REFER SEXUALLY ACTIVE STUDENTS TO OUTSIDE FAMILY PLANNING CLINICS.

* 73% SUPPORT MAKING BIRTH CONTROL INFORMATION AND CONTRACEPTIVES AVAILABLE IN SCHOOL HEALTH CLINICS.

* 53% THINK MAKING CONTRACEPTIVES MORE DIFFICULT FOR TEENAGERS TO OBTAIN WOULD RESULT IN MORE TEEN PREGNANCY.

* 78% THINK THAT TV SHOULD PRESENT MESSAGES ABOUT BIRTH CONTROL AS PART OF THEIR PROGRAMMING. (See attachment III.)

PRACTICAL SOLUTIONS:

1. SEXUALITY EDUCATION STATUTORILY MANDATED K-12 AND FULLY FUNDED AS A CORE CURRICULUM COURSE...LIKE MATH, SCIENCE.

Our children's information and attitudes are presently coming from peers, the media, home, school, and community organizations...and hopefully our churches/synagogues. WHEN SEXUALITY EDUCTION IS WELL-TAUGHT AND INCLUDES CONTRACEPTIVE EDUCATION...PREGNANCY DECREASES AND ABORTIONS DECREASE. Sexuality education needs to be broad...as a relationship between people, including the teaching of self-esteem, respect for other human beings, acceptance of respnsibility for one's actions, and the importance of human relationships. Besides teaching anatomy and physiology, information about contraception and where to obtain contraceptives must be included. Facts about sexually transmitted diseases (STDs), pregnancy (including the early signs of it), must also be emphasized. Children must be told it it okay to say "No" but if they are going to be sexually active, be responsible. Most teens are sexually active for 1 year prior to getting birth control info.

2. MAKE SOCIETY'S ATTITUDES ABOUT SEX RATIONAL

The issues in the debate over parental involvement in adolescent decision making about birth control go far beyond law, medicine and education. They involve the rights of the individual and the balance between minor children

and their parents rights. IN THE MIDST OF THESE STRUGGLES, THE HEALTH AND WELL-BEING OF OUR CHILDREN ARE BEING SACRIFICED. Our children aren't immune to the pervasiveness of sexual messages..TV, radio, pictorially, recordings, advertising. However, they are receiving these messages conflictingly...some want to punish for sexual activity...at least the minor female should be punished. Again, look at our higher rate of pregnancy compared to the other 5 developed countries and ask "WHY?"

3. ESTABLISH A HOTLINE WHICH WILL GIVE NEEDED INFORMATION, AS WELL AS THE SERVICES AVAILABLE AND WHO TO CALL.

It may be necessary to begin by establishing 2-3 regional Hotlines...to find out what questions are most on teens minds as well as coordinating the availability of agencies which can respond.

4. BEGIN STATE FUNDING OF FAMILY PLANNING SERVICES.

The WSU study has shown how the State of Kansas can save millions by preventing pregnancy in the first place. The study did not go into the additional savings in less child abuse, sexual abuse, or supporting early childhood education, quality child care and enrichment programs of human sexual development for our children. However, children well-endowed with self-esteem and a conviction of self-worth are at less risk of adolescent pregnancy. IF YOU CAN DEVELOP THE PROGRAM THAT WILL ENABLE KANSAS CHILDREN TO DELAY CHILDBEARING UNTIL THE MOTHER IS 20 YEARS OLD, YOU WILL SAVE APPROXIMATELY $19.14 MILLION YEARLY, AS WELL AS GIVING THOSE INDIVIDUAL YOUNG WOMEN A FUTURE, A REALLY MEANINGFUL FUTURE. ASSURE EVERY TEEN THAT SHE WILL BE ABLE TO RECEIVE FAMILY PLANNING SERVICES, REGARDLESS OF ABILITY TO PAY.

In Colorado, teens are being paid $1.00 per day to not get pregnant. That is much less expensive than the cost of teen pregnancy is to the State of Kansas now.

5. PARENTING CLASSES -- PARENT'S AS SEX EDUCATORS

Parents may feel uncomfortable or are unknowing or uneducated themselves. Make available to them educational opportunities to better insure they can communicate with their child(ren)...United Methodist Sex Ed course for parent and child, etc.

6. SPECIALLY TRAINED SEXUALITY EDUCATION TEACHERS SHOULD BE UTILIZED.

There are a number of specially trained sexuality education/counselors in the State. Use them...in the classroom and to teach additional teachers outside the universi

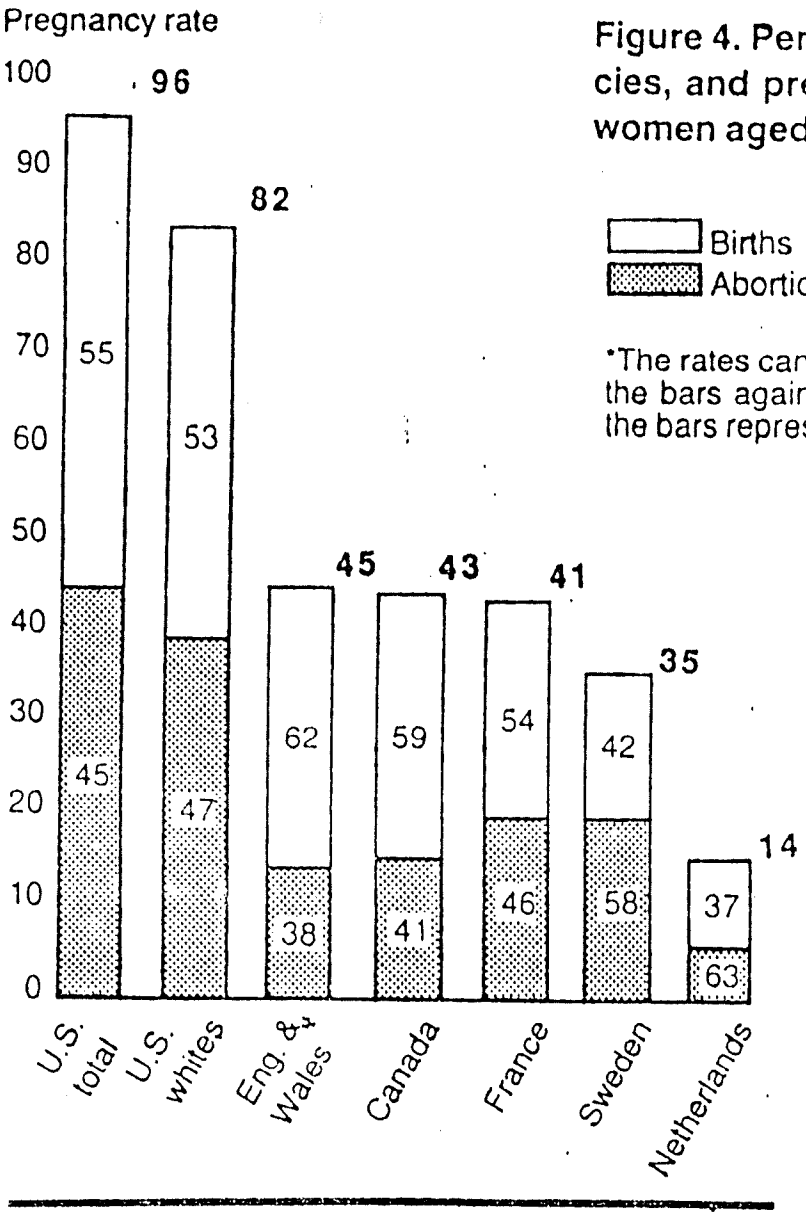


Figure 4. Percentage distribution o. gnancies, and pregnancy rates, by outcome,* for women aged 15–19, 1980/1981

Births
Abortions

*The rates can be estimated by measuring the height of the bars against the vertical axis. The numbers inside the bars represent the percentage distributions.

WHY IS THE TEENAGE PREGNANCY RATE SO MUCH HIGHER IN THE UNITED STATES THAN IN OTHER DEVELOPED COUNTRIES?

The problem of teenage pregnancy was researched in the U.S. and five other countries which have similar standards of living to ours. The other countries have a much lower pregnancy rate. One might guess that this would be due to less sexual activity by teens in those countries, but that was not the case. Researchers found that the level of sexual activity was the same in those countries as it was in the U.S. What then made the big difference? Those five countries all had much better mandatory sex education, and birth control was much more accessible to teenagers... In some cases it was available free at school. This did not cause more or fewer teens to be sexually active, but definitely resulted in far fewer pregnancies and far fewer abortions.

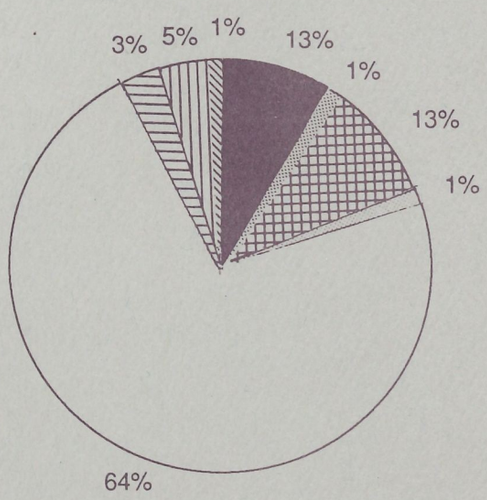
Planned Parenthood® of Kansas

WE BELIEVE . . .

- That reproductive choice is a basic human right.
- In the right of all people, regardless of age, marital or economic status, to determine their own reproduction.
- In the right of all children to be born wanted to parents who can offer them a happy, healthy, loving environment.
- That family planning and responsible parenthood are direct reflections of a respect for life.
- That according to the principles of tolerance and compassion, the moral views of any one group in our society must never be imposed on those who do not share that view.
- That Planned Parenthood does more to effectively reduce the number of unwanted pregnancies and the need for abortion than any other organization.

Financial Report

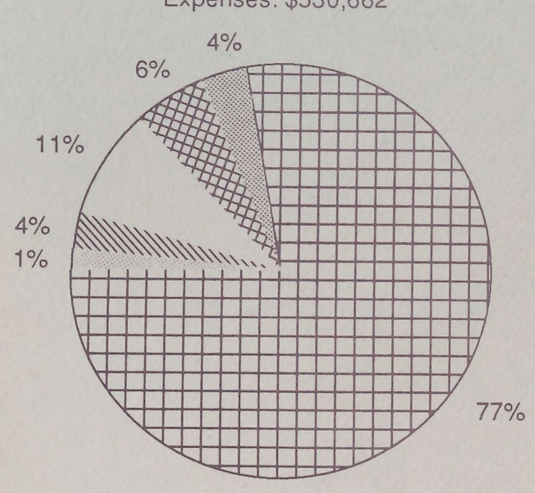
Public Support/Revenue: $513,149



INCOME

Contributions	$66,027
PPFA Grants	1,500
Gov't Programs	69,191
In-Kind Gifts	4,331
Patient Fees	326,779
CDBG	15,692
Special Events	27,439
Interest	2,190
	$513,149

Expenses: $530,662



EXPENSE

Education	$19,087
Patient Services	406,050
Justice Fund	2,107
Public Affairs	15,255
Management	56,429
Fundraising	31,734
	$530,662

ACCOUNTABILITY

HOUSE FEDERAL & STATE AFFAIRS

Attachment No. 8
February 14, 1989

Hays Wichita Winfield/Arkansas City

Planned Parenthood® of Kansas

Annual Report
Fiscal Year
1987

Planned Parenthood® of Kansas

GOVERNING BOARDS

1987 BOARD OF DIRECTORS

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Cheryl Pilate – Vice President of Program
Phyllis McNickle – Vice President of Public Affairs
Patricia Cahill – Vice President of Fundraising
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Planned Parenthood of Kansas, Inc.

Hays Clinic
122 E. 12th Street
Hays, KS 67601
(913) 628-2434

Wichita Clinic
2226 E. Central
Wichita, KS 67214
(316) 263-7575

Winfield/Ark City Clinic
Strotherfield
Winfield, KS 67156
(316) 221-1326
(316) 442-0050

SERVICES PROVIDED

Medical

- Pregnancy Testing
- Pap Smears
- Sexually Transmitted Disease Testing
- Urinalysis
- Blood Pressure
- Blood Count and Anemia Tests
- Prescriptions for Birth Control
- Breast Examinations
- Pelvic Examinations

Education

- Contraceptive Methods
- Teenage Pregnancy Prevention
- Human Sexuality
- Parents As Sex Educators
- Abortion Rights Movement
- Parent–Child Communication
- Sexually Transmitted Diseases
- Decision Making Skills
- Assertiveness Training
- Setting Your Sexual Limits

Medical Services Provided – 1987

	Percentage of Services Provided		
	W	H	C
Pap Smear	7.2	6.9	7.5
Pelvic	7.0	6.7	7.8
Breast Exam.	6.4	6.7	7.7
Blood Pressure	11.9	10.6	7.9
Hgt/Wt	11.7	10.5	7.8
Thyroid	6.5	6.5	7.4
Heart/Lung Aus.	6.2	6.5	7.5
Abd. Palp.	6.1	6.5	7.7
Preg. Test	2.5	0.4	1.9
Gonorrhea Cult.	6.2	6.5	7.0
Serology	0.2	0.1	0.2
Urinalysis	6.2	6.5	7.6
HGB/HCT	6.1	6.5	7.1
Wet Mount	0.7	0.7	0.9
Other Blood	0.1	0.0	- - -
Other Medical	0.6	0.5	0.1
Supply	11.0	9.9	7.4
IUD Insert	0.5	0.0	- - -
IUD Check	0.0	0.1	- - -
Diaphragm Fit	0.1	0.1	0.0
Diaphragm Check	0.0	0.0	- - -
Other	0.1	0.3	0.1
None	0.0	0.0	0.1
Immunization Hx.	- - -	1.3	0.2
Rubella Hx.	2.7	6.2	5.9
Total	100.00	100.0	99.8

W = Wichita
H = Hays
C = Cowley County/Winfield and Arkansas City, Ks.

Educational Services Provided – 1987

	Number of individuals in audience		
Educational Programs:	Wichita	Hays	Total Affiliate
Total presentations	243	87	330
Total people reached	5624	2612	8236
Presentations made to the following:		Number of Presentations	
Jr/Sr High Schools	152	45	197
Elementary Schools	1		1
Colleges	8	21	29
Professional Training	5	4	9
Community/Civic Groups	62	11	73
Religious/Church	11	2	13
Parents/Families	4	4	8

Education services extended to following counties:
Sedgwick, Cowley, Butler, Harvey, McPherson, Ford, Ellis Wallace, Rooks, Sheridan, Finney, Thomas, Rush, Barton.

1986 Comparison

Increase of 35 (11%) presentations and 1279 (18%) number of people reached.

Counseling

- Pregnancy
- Parenthood
- Contraception
- Sterilization
- Infertility
- Medical
- Sexually Transmitted Diseases

Referrals

- Pre and Post-Natal Care
- Infertility
- Sexually Transmitted Disease Treatment
- Male and Female Sterilization
- Psychiatric Services
- Adoption
- Pregnancy Termination
- Other Social and Health Services

Counseling Services Provided – 1987

	Percentage of Services Provided		
	W	H	C
Contraceptive	58.0	40.0	37.9
Sterilization	0.5	0.0	- - -
Infertility	0.1	- - -	- - -
Nutrition	0.9	0.1	0.2
Pregnancy	8.2	0.4	3.6
Medical	12.8	3.4	9.2
Smoking	- - -	0.4	11.4
STD	18.5	24.1	36.7
Other	5.0	30.6	0.5
None	2.0	1.4	0.5
Total	106.4	100.1	100.0

SERVICES

CLIENT PROFILE

Ages	Number of Clients
10–14	37
15–17	686
18–19	911
20–24	1665
25–29	623
30–34	184
35 & over	51
Total:	4157

Contraception Methodology Provided	Number of Clients
Oral	3642
Diaphragm	52
Spermicide/Condom	71
IUD	6
Sterilization	24
No Method	522

Ethnicity	
Caucasian	3891
Black	186
Hispanic	62
Am. Indian	8
Other	10

Initial and Continuing Clients

	Number of New Clients Seen in 1987	Number of Continuing Clients Through 1987
Wichita	1164	1727
Hays	482	668
Winfield/Ark City	150	126
Totals	1796	2521

Income

Percentage of clients according to poverty guidelines:

100% of poverty or below	10%
150% of poverty or below	54%
250% of poverty or below	16%
250% above poverty (100% of changes)	16%
XIX Medical Card	2%

(Percentages may add to more than 100% due to rounding.)

WHILE THIS REPORT DOCUMENTS THE ACHIEVEMENTS OF PLANNED PARENTHOOD OF KANSAS IN 1987, THESE FACTS REMAIN:

Medical Complications:

- The younger the mother, the more likely the baby is to die
- Of the fetal deaths in Kansas, 20% were to mothers 19 and under
- In a Kansas study of infant deaths due to suspected child abuse, over 90% of the parents began parenthood as teens.

Social Implications:

- Two-thirds of all teen pregnancies are unintended
- 94% of teen mothers keep their babies
- Teen divorce rates are almost 8 out of 10 for those who marry because of pregnancy
- Kansas has the 19th highest white teen pregnancy rate in the nation and the 7th highest black teen pregnancy rate nationally
- Kansas State Board of Education (BOE) mandated sexuality education in Kansas, K–12, effective September, 1988. KANSAS IS 4TH STATE IN THE NATION TO MANDATE SEXUALITY EDUCATION.

Economic Impact:

- 8 out of 10 women who become mothers at 17 years or younger never finish school
- Over 60% of all teen mothers are on welfare
- In 1985, the State of Kansas spent $143.9 million public dollars on families started when the mother was an adolescent. This includes only dollars spent on AFDC, Medicaid and food stamps.

PLANNED PARENTHOOD OF KANSAS IS FACED WITH THE CHALLENGES OF REDUCING THESE NUMBERS AND THEIR POTENTIAL TRAGIC CONSEQUENCES, PARTICULARLY FOR TEENAGERS.

MISSION

Planned Parenthood®
Of Kansas, Inc.

FACTS ABOUT FAMILY PLANNING IN KANSAS*

321,460.....Women of childbearing age at risk in KS.
83,690.....Low income women in need of subsidized family planning services in KS.
40,000.....Served by family planning clinics in KS.
43,690.....UNMET NEED OF LOW INCOME WOMEN

EXAMPLES OF COST SAVINGS OF FAMILY PLANNING IN KANSAS

If only 5,000 of these low income women are not served through family planning clinics, become pregnant, deliver their child and enroll on welfare, the cost of public support for them in the first year would be $18,050,000.00, compared with preventive services for 5,000 women at a cost of $485,000. **Cost savings for one year: $17,565,000.00**

CONSEQUENCES OF ADOLESCENT PREGNANCY

Data for Kansas adolescents (ages 10-19) reveal that there were an estimated 48,341 births in the State of Kansas in 1986. Of those, 5,776 were to adolescents: 4,490 live births, 1,245 abortions and 41 fetal deaths. Teenage pregnancy represents:

Medical Complications:
- The younger the mother, the more likely the baby is to die.
- Of the fetal deaths, 17% were to mothers 19 and under.
- In a Kansas study of infant deaths due to suspected child abuse, over 90% of the parents began parenthood as teens.
- U.S. figures indicate that 26% of all low birth weight babies are born to teen mothers.
- Low birth weight is a major cause of infant mortality. It is associated with a host of other problems including neurological defects which can lead to life-long mental retardation.

Social Implications:
- Two-thirds of all teen pregnancies are unintended.
- 94% of teen mothers keep their babies.
- Teen divorce rates are almost 7 out of 10 for those who marry because of pregnancy.
- 53.7% of the total live births to mothers 19 and under were out-of-wedlock.

Economic Impact:
- 8 out of 10 women who become mothers at 17 or younger never finish school.
- 60% of all teen mothers become dependent on public assistance.
- Having a baby before age eighteen reduces the mothers chance of graduating from high school by one-half, resulting in lowered job opportunities and earnings.

* *Annual Summary of Vital Statistics Kansas 1986*, Kansas Dept. of Health and Environment

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Winfield: 316 221-1326 Arkansas City: 316 442-0050

Planned Parenthood®
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Issue Analysis...
Information on Public Policy

PARENTAL CONSENT FOR ABORTIONS

THE ISSUE:
Should minors be forced/required to obtain parental consent prior to obtaining a legal abortion or are they guaranteed the right of individual freedom and therefore have the right to make their own decisions?

BACKGROUND:
In 1973, the U.S. Supreme Court, in its landmark *Roe v. Wade* ruling recognized a woman's constitutional right to an abortion. Prior to abortion being safe and legal, thousands of women sought out dangerous, illicit abortions yearly. Many died. Countless thousands more survived dangerous and painful infections, gangrene or other complications related to unsafe methods...ranging from drinking turpentine or bleach; as well as inserting sharp, unsterilized objects into the uterus.

Approximately one-quarter (1.5 million) of all pregnancies, yearly, are terminated by abortion(1); approximately 27% of these abortions are obtained by unmarried women aged 19 and under(2). Since 1973, women have been obtaining abortions earlier in pregnancy when the health risks to them are minimal. **Today, 91% of all abortions in the U.S., and 88.2% in Kansas, are performed in the first trimester.**

Legalized abortion has dramatically reduced the number of abortion-related deaths in this country --- from 90 in 1972 to 16 in 1980. **Today, legal abortion is five times safer than childbirth.** The U.S. Supreme Court majority reaffirmed abortions rights in the 1986 *Thornburg v. A.C.O.G.* case, with Justice Powell supplying the critical fifth vote.

Anti-choice, anti-abortion extremists have failed in their attempts to criminalize abortion, to this point in time. Many have resorted to misleading and inaccurate propaganda, harassment and violent attacks against family planning and abortion clinics, patients, staff and any funding sources.

Kansas does not provide any funding for the many women who want abortions but can't get them...either because they can't afford a procedure's cost or due to local legislative or regulatory restrictions on access to abortion services. Seven states (AK, HI, NY, MD, NC, WA, WV) and the District of Columbia voluntarily provide Medicaid funding for medically necessary abortions where the woman's life is not endangered. In addition, seven states (CA, CT, MA, MI, NJ, OR, VT) provide such funding under court order.

History has shown that women have sought abortions, since time began ...even when they risk their lives to do so. A return to the Dark Ages, before legalized abortion in this country, would mean a return to widespread, needless suffering and death. Moreover, outlawing abortion would further victimize the troubled poor in our nation; affluent women will simply seek the services they need through expensive, illegal providers in the U.S., or by traveling to countries where the procedure is legal.

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In recent years, anti-choice groups have thrown roadblocks up to minors seeking an abortion. Anti-choice groups have sought to mandate judicial by-pass procedures (forcing teens into court to be declared an "emancipated minor") or force minors to obtain parental permission prior to an abortion...most often one parent.

In recent legislative sessions, the Kansas Legislature has considered several bills seeking to throw up these very roadblocks to Kansas minors....but all legislation has been killed through the 1988 legislative session. Many states have passed judicial by-pass legislation, or enforced parental consent bills...but these are currently tied up in the courts and are not in operation. **Only 9 states have working parental consent laws.**

PLANNED PARENTHOOD PHILOSOPHY:

- **Parental consent laws are not motivated by a desire to help minors. The real goal is to discourage abortions or prevent it altogether.** These laws are not introduced by medical groups, youth advocates, family physicians, family therapists, young women's associations, groups fighting child abuse or groups traditionally concerned about minors and their families. **ALL LEGISLATION INTRODUCED IN THE LAST 15 YEARS WAS DRAFTED BY ANTI-CHOICE G GROUPS. THE MAJOR PROFESSIONAL, MEDICAL AND SOCIAL SERVICE GROUPS HAVE OPPOSED THESE LAWS.**
- **Judicial by-pass laws are a nightmare.**
  - **Minors lose their right to privacy**; going to court forces a minor to go to a public place to obtain consent (sometimes being seen by at least 23 different persons). This is especially true in more rural areas.
  - **Court causes unnecessary delay** which may result in a riskier procedure.
  - The concepts of "maturity" and "best interests" of the minor are meaningless since they may be interpreted differently by each judge.
  - Judges, guardians, lawyers and health professionals testitified in court in Minnesota that there's no apparent positive effect of the judicial by-pass procedure. The law was "disruptive to, and had a negative impact on families." They said, "when a minor feels she can't talk to her parents about an unintended pregnancy...forcing her to court doesn't lead to greater love and parent-child communication."
  - **Few minors are kept from having the procedure by the by-pass laws** according to the Minnesota case.(Hardigan vs. Zbarra). **Over 3,500 minors went through the judicial by-pass procedure and only 4 were turned down.**
- **Parental consent laws are not necessary to insure that minors give informed consent for abortion services.**
  It is standard medical practice for medical providers to explain a procedure and its potential medical risks. Physicians have a legal responsibility to insure patients give knowledgeable and informed consent and to be aware that the patient is capable of giving that informed consent. With the highly litigious society prevalent today, no physician would do otherwise.
  KANSAS STATUTES CURRENTLY AUTHORIZE MINORS TO CONSENT TO TREATMENT FOR SEXUALLY TRANSMITTED DISEASES (STD'S) AND FOR ALL PRENATAL CARE...AFTER THEY BECOME PREGNANT.
- **By-pass laws force motherhood on adolescents by forcing children to have children. (A punishment for their behavior?)**
  At the expense of the life and future of the minor parents, usually the mother, the law is intended to save the fetus' life.
  - **The mothers are more likely not to finish high school;**
  - **The mother will more likely have to depend on welfare; and**
  - **The mother and child are seven times more likely to be poor.**
  - **Statistics are mostly unavailable for minor fathers since the minor mother assumes most of the responsibilities for the child.**
- **Most minors choosing not to involve one or both parents have good reasons for not doing so.**
  These reasons include: psychiatric or physical illnesses of parents, chemical abuse and dependency of a parent; religious or moral anti-abortion or anti-sex views; fear of abuse...either verbal, physical or sexual.

PLANNED PARENTHOOD POLICY:

- The decision to have an abortion is a matter of personal choice.
- All available options should be presented to every woman, regardless of her age (abortion, adoption, keeping the baby).
- No woman should be required to obtain consent from another individual, a court or any person/institution as a prerequisite to obtaining an abortion.
- No one should be denied abortion services solely because of her age or her economic or social circumstances.
- Public funding should be available to subsidize the cost of abortion services for women dependent on the government for their health care.
- The need for abortion can, and should, be reduced by increasing the availability of contraceptive services to all who want them; by expanding sexuality education; by evolving societal attitudes to promote more realistic and accepting attitudes toward sexuality and greater male involvement in, and responsibility for, family planning; and by committing increased funding and support for research to develop new and more effective contraceptive methods. However, even with these advances, abortion will remain necessary under certain circumstances and must remain safe, legal and accessible.

PUBLIC OPINION:

Since the legalization of abortion in 1973, the majority of Americans have consistently supported a woman's right to safe and legal abortion.

- 90% of Americans think abortion should be available under some or all circumstances. (3

- By a margin of more than 2 to 1, Americans think that any woman who is three months or less pregnant should have the right to decide, with her doctor's advice, whether or not to have an abortion.(3)

- A 55% majority of Americans oppose a constitutional amendment to ban abortion; 37% support such an amendment. (3)

Notes

(1) Forrest, J.D., "Unintended Pregnancy Among American Women," *Family Planning Perspectives,* Vol. 19, No. 2, March/April 1987.

(2) Centers for Disease Control, Atlanta, GA. Report issued Aug.23, 1987, as cited in *USA Today,* Aug. 24, 1987, p. D-1.

(3) *Public Attitudes about Sex Education, Family Planning and Abortion in the United States.* Conducted for the Planned Parenthood Federation of America, Inc., by Louis Harris and Associates, Inc., New York, N.Y., Aug.-Sept. 1985.

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A study, completed in October, 1987, by faculty at Wichita State University in Maternal-Child Nursing, calculated the costs of adolescent pregnancy to the state of Kansas for the year 1985.

The information showed:

$13,600.....Average single birth cost - Kansas
This is the public cost for a single family begun by an adolescent birth for 20 years following that birth.

$17,670.....Cost for Kansas mothers under age 14;
$17,636.....Costs for Kansas mothers ages 15 to 17;
$11,174.....Costs for Kansas mothers 18 & 19;

$143.92 million.....Single year cost - Kansas
This is the public cost in a single year to support all families begun by a birth to an adolescent birth in that year.

This figure includes public outlays for Aid to Families with Dependent Children (AFDC), Medicaid, and food stamps for families begun by a teen birth. It include direct payments to service providers, as well as the administrative costs of these programs.This figure represents minimal public costs in that it doesn't include other services such as housing, special education, child protection services, foster care, daycare, and other social services.

Two out of three adolescent mothers do not receive public assistance, thus the actual public cost of a single birth to an adolescent who does receive public assistance is considerably higher than the estimated average cost.

$47.86 million.....Single cohort cost - Kansas
Public cost for all families begun by a teen birth in a single year for the 20 years that the family may require public assistance.

Kansas could have saved $19.14 million if these births had been delayed until the mother was twenty years of age or older.

The more than one million teenage pregnancies that occur in the United States each year are a serious problem for all of society. Not only is teenage childbearing a threat to the health and welfare of the mother and child, but adolescent pregnancy contributes to such societal problems as poverty, unemployment, family disintigration, juvenile crime and school dropouts.

Kansas ranks 19th in the nation in rate of white adolescent pregnancy; and 7th in black adolescent pregnancy. ((Singh, S. (1986). Adolescent pregnancy in the United States: an interstate analysis. Family Planning Perspectives. 18,(5), 210-220.))

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Implications

It is fairly safe to predict, if statistical trends continue, that more than one third of the girls who are now fourteen years old will become pregnant at least once before they reach the age of twenty, according to the WSU study.

Adolescent childbearing results in high expenditures of public funds to support the adolescent families. This is in addition to the negative social, educational and economic consequences to the mother and her child.

Programs to support teenage mothers and their children are essential in order to provide for their health and well-being. However, **programs directed to preventing adolescent pregnancy, or at least reducing its incidence, have the potential to cut these costs dramatically. It is estimated that for every dollar spent on services for a teenage client by the federal family planning program, three dollars can be saved in the next year alone.**

Recommendations

- **Improved access to family planning services as well as sexuality education information for all adolescents**
- **Teenagers must have direct and accurate information about sexuality, including support to delay sexual activity as well as access to convenient, confidential and affordable family planning counseling and medical services.**
- **Teens must perceive real options for their future in order to to be motivated to avoid premature/early childbearing.**
- **Provide access to both quality education and vocational opportunities.**

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WHY DO WOMEN HAVE ABORTIONS?

Women who choose abortion do so for reasons that are as individual as the women themselves. In most cases, they had not intended to become pregnant. On finding that they are pregnant, they deeply feel that continuing the pregnancy and becoming a parent at this particular time is wrong for them, physically or emotionally. Among the most commonly reported reasons are:

- The woman is unmarried or in an unstable relationship.
- She is too young.
- She is too old.
- She is not emotionally prepared for parenthood.
- She would be unable to finish her education.
- She has medical problems that would make pregnancy and childbirth dangerous.
- The fetus is known to be deformed.
- Her pregnancy resulted from rape or incest.
- Her pregnancy resulted from contraceptive failure.

HOW DO WOMEN FEEL AFTER HAVING ABORTIONS?

Some women feel *sad* for a few days or weeks after an abortion, but *sadness* is not the same as *regret*. Most women report relief that the pregnancy is over and are satisfied that they made the right decision. Here are conclusions from some of the more than fifty studies of the emotional effects of abortion that have been done worldwide:

- Up to 98% of women who have had abortions have no regrets and would make the same choice again in similar circumstances.

- Up to 20% of women who have had abortions experience mild, quickly passing depression immediately following the procedure. Similar depression occurs in up to 70% of women following childbirth.

- The women most likely to have severe, lasting psychiatric disturbances after an abortion are women with histories of psychiatric problems or of abnormal pregnancies or births and women who were ambivalent about their decision to have an abortion.

- The mental health of women faced with unwanted pregnancy is at greater risk when they are compelled to go to term than when allowed to choose abortion.

- A woman is more likely to suffer remorse after an abortion if there is a conflict between her religious beliefs and her desire not to have a child at this particular time.

- More than 77% of women who have had abortions express a desire for children in the future.

- Virtually no women who choose to have abortions see it as a preferred or desirable form of birth control.

Sources: Belsey, Elizabeth, M.Sc., "Psychological Consequences of Abortion," *Family Planning Association Newsletter*, April, 1976, 60, p.5/ Osofsky, Joy D. Ph.D., and Osofsky, Howard J., Ph.D., "The Psychological Reactions of Patients to Legalized Abortion," *American Journal of Orthopsychiatry*, January 1972, 42, pp. 48-60/ Hamilton, James Alexander, quoted in "Rip Van Winkle Period Ends for Puerperal Psychiatric Problems," *Journal of the American Medical Association*, April 27, 1984, 251, 16, pp. 2061-2067/ Ashton, J.R., "The Psychological Outcome of Induced Abortion," *British Journal of Obstetrics and Gynaecology*, December 1980, 87, pp. 275-282/ Greenglass, Esther, Ph.D., "Therapeutic Abortion, Fertility Plans and Psychological Sequelae," *American Journal of Orthopsychiatry*, January 1977, 47, pp. 119-126/ Bracken, Michael B., M.P.H., et al., "The Decision to Abort and Psychological Sequelae," *The Journal of Nervous and Mental Disease*, February 1974, 158, pp. 154-162.

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WHAT HAPPENS WHEN A MINOR NEEDS AN ABORTION?

25 states have laws that restrict access to abortion for girls under the age of 18. These states' statutes require minors who want an abortion to obtain parental consent or agree to have the abortion provider notify one or both parents. But Supreme Court rulings deny parents absolute veto power over a minor's decision. All states are required to provide a judicial bypass for minors—an intimidating procedure whereby minors must go to court to get parental consent or notification regulations waived.

3 states do not have a judicial bypass option, so their parental consent/notification statutes are unconstitutional and inactive. These states are:

Consent	Notification
South Carolina	Idaho
	Montana

10 states are enforcing their apparently constitutional laws requiring minors to get parental consent or notify their parents before they have an abortion. These states are:

Consent	Notification
Alabama	Maryland
Indiana	Utah
Louisiana	West Virginia
Massachusetts	
Missouri	
North Dakota	
Rhode Island	

Another 12 states have parental consent/notification statutes, the constitutionality of which is still in question. Pending the court's decision, these laws are not now being enforced. These states are:

Consent	Notification
Arizona	Georgia
California	Illinois
Kentucky	Nevada
Mississippi	Ohio
Pennsylvania	Minnesota *
Tennessee	
Florida	

* A Federal Court ruled this law constitutional on August 8. 1988. If not appealed to the U.S. Supreme Court, it will be enforced.

Source: Reproductive Freedom Project of the American Civil Liberties Union, August, 1988.

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Sides agree: No abortion study needed

TOPEKA CAP-JOURNAL

WASHINGTON (AP) — Pro-choice and anti-abortion groups, unlikely allies, agreed Tuesday that the government does not need to spend tens of millions of dollars to determine whether abortion damages a woman's physical or emotional health.

Surgeon General C. Everett Koop proposed such a study, he said in an interview with the Associated Press, because "the data simply do not support the premise that abortion does or does not cause a specific, post-abortion psychiatric syndrome."

Koop had been asked by President Reagan to prepare a comprehensive report on the issue, but said he told the president he could not because there is no scientific evidence to support the anti-abortion belief that abortion harms women or the pro-choice stance that abortion is beneficial.

Koop, who said he remains firmly opposed to abortion, told Reagan that a comprehensive study costing from $10 million to $100 million would take five years to complete.

Groups on both sides of the issue said a study was not needed.

Nancy Broff of the National Abortion Rights Action League praised Koop for doing a "fair study" and said the tens of millions he proposes spending on another study could be better used for contraception research.

Nellie Gray of March for Life said Koop is "highly misguided," adding: "We don't need any more studies; what we need is for Koop to retire."

However, one anti-abortion group, National Right to Life, said a study such as the one Koop is proposing is "long overdue." Psychological harm from abortion often surfaces five to 10 years after the abortion, and existing research generally is based on studies of women in their first year after abortion, said Olivia Gans, an official of the group.

The decision on whether such a study should be conducted probably will fall to President-elect Bush, who upset anti-abortion forces with his nomination of Dr. Louis Sullivan to head the Department of Health and Human Services.

Sullivan drew an outcry from anti-abortion forces when he said in a newspaper interview that he supported a woman's right to seek an abortion but opposed federal aid to pay for it. He later said he opposed abortion except in cases of rape, incest and where the life of the mother is threatened, which mirrors Bush's view on abortion.

Sheila Tate, a spokeswoman for the Bush transition team, said she did not know whether the incoming administration would pursue Koop's recommended abortion study.

Reagan administration officials had nothing to say about Koop's decision not to issue a report, a decision he detailed in a letter delivered to the White House on Monday. Presidential spokesman Marlin Fitzwater said Reagan "doesn't have any characterization one way or the other" of the letter.

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WHAT ARE THE CHANCES OF CONTRACEPTIVE FAILURE FOR TYPICAL USERS?

THE PILL	About 3 out of 100 women using it for one year will become pregnant.
INTRAUTERINE DEVICE (IUD)	About 4 out of 100 women using it for one year will become pregnant.
CONDOM	About 14 out of 100 women using it for one year will become pregnant.
DIAPHRAGM	About 18 out of 100 women using it for one year will become pregnant.
CERVICAL CAP	About 18 out of 100 women using it for one year will become pregnant.
VAGINAL CONTRACEPTIVE SPONGE	About 18 out of 100 women using it for one year will become pregnant.
VAGINAL CHEMICAL CONTRACEPTIVE	About 20 out of 100 women using it for one year will become pregnant.
FERTILITY AWARENESS WITH ABSTINENCE	About 24 out of 100 women using it for one year will become pregnant.

Source: Effectiveness rates for the condom are from the Alan Guttmacher Institute. Effectiveness rates for all other methods are from the American College of Obstetricians and Gynecologists.

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America Speaks

PUBLIC ATTITUDES TOWARD TEENAGE PREGNANCY, SEX EDUCATION AND BIRTH CONTROL

Americans are increasingly concerned about the problem of teenage pregnancy.

- **95%** of Americans say that teen pregnancy is a serious problem in the U.S., up 11% since 1985.
- **62%** believe that teen pregnancy is getting worse.

Parents are talking with their children about sex more than they were three years ago.

- **62%** of parents report having discussed the use of contraceptives with their teenage children, and
- **61%** have discussed abortion.
  In 1985, only 33% of parents who talked with their children had talked about sex and included birth control.
- **84%** of parents have talked about sex and pregnancy;
- **81%** have talked about sex and infectious diseases.
- **14%** of parents do not talk with their children about sexuality at all!

There is a growing national consensus on the need for sex education.

- **89%** favor sex education being taught in the schools, up from 85% in 1985.
- **80%** favor allowing school health clinics to refer sexually active students to outside family planning clinics.

- **73%** support making birth control information and contraceptives available in school health clinics.

- **53%** think making contraceptives more difficult for teenagers to obtain would result in more teen pregnancy.

- **77%** say people will be more likely to use condoms to prevent the spread of AIDS as a result of open discussion of sexuality.

- **72%** of all adults report feeling very comfortable talking with their spouses or partners about sex, birth control and abortion, *compared to*

- **59%** of parents who say they are very comfortable talking with their children about sex, birth control and abortion.

- **41%** of the people use condoms currently; 65% report they have used condoms.

- **37%** of the people use birth control pills now; while 63% of people who use contraceptives say they have used the pill.

- **82%** of the public favors government spending on research and development of new birth control methods.

- **53%** of all adult Americans know someone who has had an abortion.

- **78%** think that television should present messages about birth control as part of its programming.

These are findings from a national public opinion poll conducted by Louis Harris and Associates between August and September, 1985, updated in May, 1988. Planned Parenthood Federation of America commissioned the poll.

WOMEN AT RISK

The Need for Family Planning Services: State and County Estimates, 1987

HOUSE FEDERAL & STATE AFFAIRS
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SUMMARY

There were approximately 31.8 million women aged 13–44 at risk of unintended pregnancy in 1987. Of these, 7.9 million had family incomes of less than 150 percent of the federal poverty standard, three million were at 150–199 percent of the poverty standard and 3.2 million were at 200–249 percent of the poverty standard. Four million were teenagers. There were 13.1 million women at risk who were teenagers or were aged 20–44 and had incomes of less than 200 percent of the poverty standard; 3.2 million of these women were black.

The number of women at risk of unintended pregnancy decreased from 33.9 million in 1981 to 31.8 million in 1987. Contributing to the decline were increases in the proportion of women who were over 30 and increases in the use of sterilization as a contraceptive method. These effects were somewhat offset by increases in the proportion of teens and unmarried women who were sexually active. A larger decrease occurred in the number of low-income women at risk of unintended pregnancy, because in 1981 the United States was in a period of recession and therefore the number of women with a low income was particularly high. The decrease is especially significant in the areas of the country in which economic recovery has been the greatest.

The 1987 figures are the latest in a long series of state and county estimates calculated by The Alan Guttmacher Institute (AGI). They update the last estimates calculated for 1981. As is consistent with past methodology, women were considered to be at risk of unintended pregnancy if they had ever had sexual intercourse, if neither they nor their partners had been surgically sterilized or were known to be infecund, and if during at least part of the year they were neither pregnant nor trying to become pregnant. The estimates of the proportions of women who met this definition were based on national surveys and took into account the age, race, marital status, poverty status and state and geographic region of residence of the women in each county.

It should be kept in mind that there are *no* current data on the number or percentages of women who were receiving contraceptive services from clinics or private physicians in 1987. This information was previously collected by AGI under a grant from the U.S. Department of Health and Human Services (DHHS) but has been unavailable since 1983.

INTRODUCTION

Background

In order to estimate the number of women in an area who might need contraceptive services, one must take into account that not all unmarried women are sexually active, that some women are surgically sterilized or unable to become pregnant for other reasons, and that some women have no desire to avoid pregnancy. Detailed information on the numbers of women in need of contraceptive services are available nationally from surveys, but it is not feasible to conduct such surveys at the county level. Therefore, estimates for local areas have been made by applying national or regional data to local area population numbers. The most recent estimates were for 1981, based on the 1976 National Survey of Family Growth (NSFG), the 1976 and 1979 Johns Hopkins Surveys of Young Women and the 1980 census counts updated to 1981. The present report presents 1987 estimates produced by basically the same methodology as was used in 1981 but incorporating data from more recent national surveys and new population estimates. The discussion below outlines the methodology and discusses the differences between the 1981 and 1987 estimates.

Methodology

Women of reproductive age are defined as being at risk of unintended pregnancy during a given year if they (1) are sexually active, that is, have ever had sexual intercourse; (2) are fecund, meaning that neither they nor their husbands have been contraceptively sterilized and they do not believe that they are infecund for any other reason; and (3) are or were neither pregnant nor trying to become pregnant during at least part of the year. The proportions of women at risk have been estimated for a number of population subgroups from national data, mainly the 1982 National Survey of Family Growth, conducted by the National Center for Health Statistics of the U.S. Department of Health and Human Services, which surveyed women aged 15–44. These proportions have been applied to county-level estimates of the number of women in each of the population subgroups.

The methodology for estimating the number of women at risk of unintended pregnancy at the county level has evolved from approaches used in 1973,[1] 1975,[2] 1981,[3] 1982,[4] and 1983.[5] The principle by which the calculations are made has remained basically the same, but the proportions sexually active, fecund and neither pregnant nor trying to become pregnant have been modified according to the latest available data.

The population subgroups used in the estimation procedure are defined by cross-tabulations by age, marital status, race, poverty status and metropolitan status of the county. In some years, region of the country has also been used. For the 1987 estimates, five age groups were used (10–14, 15–17, 18–19, 20–29 and 30–44), two marital status groups (married and living with spouse vs. all other), two race groups (white and "other" races vs. black), five poverty status groups (family income less than 100 percent of the federal poverty standard, 100–149 percent, 150–199 percent, 200–249 percent and 250 percent and over), two metropolitan status groups (metropolitan vs. nonmetropolitan) and four census regions (Northeast, Midwest, South and West). Thus, estimates of the proportion at risk of unintended pregnancy were needed for 5 x 2 x 2 x 5 x 2 x 4 = 800 population subgroups.

Proportions of Women at Risk. The proportions of women in the various subgroups who were sexually active and fecund were calculated from special tabulations of the 1982 NSFG, a survey of about 8,000 women in all parts of the country. Because of the large number of subgroups (800), a stable, separate estimate for each was not possible using cross-tabulation, even with a survey as large as the NSFG. Therefore, another means had to be found to produce reasonable subgroup estimates while taking advan-

tage of the detail available in the NSFG about differences by characteristics in the proportion sexually active and fecund. The method chosen was log-linear analysis, a statistical procedure by which significant relationships can be distinguished from the ones that are relatively unimportant in predicting the dependent variable (i.e., the likelihood of being sexually active and fecund).[6]

Before the log-linear analysis was applied, an initial simplification of the model was made by collapsing the poverty variable into three categories: under 150 percent, 150–249 percent and over 249 percent. This left 480 possible subgroups, still too many to allow individual estimates to be made from the NSFG. Initial cross-tabulation of married teenagers indicated that virtually all were fecund (or not known to be infecund), so these were assumed to be 100 percent fecund and no further analysis was done. Separate log-linear analyses were undertaken for three groups: unmarried teenagers, unmarried adults and married adults.

Age, race and poverty status proved to be important predictors of sexual activity/fecundity in all three groups, and region was also important for unmarried teenagers and married adults. Metropolitan status was a poor predictor and was omitted from the models. For unmarried teenagers, the best model showed the proportion sexually active to range from 12.6 percent among nonblack 15–17-year-olds at or above 250 percent of the poverty level in the Northeast to 84.3 percent among black 18–19-year-olds under 150 percent of poverty in the West. Among nonblack teenagers, the proportion sexually active was about 10 percentage points lower in the Northeast than in the other census regions.

The proportion of unmarried adults who were sexually active and fecund ranged from 48.7 percent of nonblack 30–44-year-old women under 150 percent of poverty to 89.2 percent of black women aged 20–29 at 150–249 percent of the poverty level. Among adult married women, the lowest proportion fecund was 35.2 percent, found among nonblack 30–44-year-old southern women at 150–249 percent of the poverty level, and the highest was 92.3 percent, among nonblack 20–29-year-old northeastern women at or above 250 percent of poverty.

Since these models were based on 1982 data, the proportions sexually active and fecund were adjusted for changes between 1982 and 1987 as indicated by surveys sponsored by the Ortho Pharmaceutical Corporation.[7] The proportion of unmarried women who are sexually active are shown in the Ortho studies to have increased by seven percent over this time period, so this factor was applied to the model results for unmarried women. The Ortho data show no change in the proportion of unmarried women who are infecund or sterilized. Among married couples, the proportion infecund or sterilized increased 13 percent, and the proportions used in the estimates were adjusted by this factor.

From special tabulations of the NSFG, it was estimated that 2.5 percent of women aged 10–14 were sexually active in 1982. It was assumed that the proportion increased by seven percent by 1987 and that all of the sexually active women in this group are aged 13–14. It was also assumed that the proportion sexually active varies by poverty status in the same manner as among women aged 15–17.

In addition to sexual activity and fecundity, the estimating procedure takes into account the proportion of women who during an entire year are either pregnant or trying to become pregnant and are therefore not at risk of unintended pregnancy at any time during the year. Calculation of this proportion has been based on the number of additional births expected by women in each state and the average number of months needed to achieve a birth, including time needed to become pregnant and to carry to term, with an adjustment for fetal loss. The estimates for 1987 have been based on those used for the 1980 and 1981 estimates of women at risk,[8] with adjustments for national changes since then in the number of future births expected, which increased for white women,

especially those aged 30 and over, and decreased slightly for black women. These estimates come from the Census Bureau's Current Population Surveys.[9] As in previous years, it was assumed that adult women would not be trying to become pregnant while unmarried, and that even if they did become pregnant, they would be seeking to avoid pregnancy for the balance of the year. It is known that some unmarried teenagers do seek pregnancy, and the proportion of such women was assumed to be the same as was estimated for 1981. Among married women, the proportion who are either seeking pregnancy or are pregnant throughout a year ranges between seven and 16 percent percent for teenagers, four and nine percent for women aged 20–29 and one and two percent among those over 30. The percentages are somewhat higher in Utah, where a larger family is desired.

County Population Estimates. The estimated percentages at risk were applied to the number of women in each county in age, race, marital status and poverty status subgroups. The population estimates were based on a number of sources.

Estimates of the number of women by age and race were purchased from Market Statistics. The numbers in each age and race group were adjusted by a small factor so that the national totals would equal the population estimates for July 1, 1987, published by the Census Bureau.[10]

The proportion of each age/race group in each county who were married and living with their husbands was estimated from the 1980 census as updated previously to 1981, with adjustments for national trends as reported by the Census Bureau.[11] Each year the Census Bureau obtains information on the marital status of U.S. residents from the Current Population Survey, a large national survey. The survey results show large decreases between 1981 and 1987 in the proportions of women married and living with their husbands, especially for teenagers. For women aged 18–19 of white and "other" races, the proportion married and living with husbands dropped from 14.5 percent in 1981 to 10.2 percent in 1987. The figures were 54.7 in 1981 and 49.5 in 1987 for women aged 20–29, and 76.4 and 73.7 for those aged 30–44. Although the proportions of blacks who are married and living with their husbands were much lower in both years, the proportionate declines were similar to those among women of white and "other" races. Adjustment factors based on these changes within each age/race group were applied to the proportion married in 1981 in each county.

Within each age/race/marital status group, the proportion of women at each poverty level was based on the 1980 census as updated to 1981, adjusted for the county's change in economic status between 1981 and 1987. The adjustment was based on the proportion of households with "effective buying power" under $18,000 in 1987 in comparison with the proportion under $15,000 in 1981. *Effective buying power* is an economic indicator estimated for each county by Market Statistics. The change in criterion from $15,000 to $18,000 approximately adjusts for the amount of inflation between the two years.

The adjustments for each poverty level of each subgroup were calculated by the same procedures as were used for the 1981 estimates.[12] Additional adjustments were made to yield national and regional totals for each poverty group similar to the levels found in special tabulations of the Current Population Survey for March 1987, which reflects income in the calendar year 1986; the result was then further adjusted to account for an overall 0.3 percentage point decrease between 1986 and 1987 in the proportion of all persons living in families under 150 percent of the poverty level.

Women at Risk: Numbers in 1987 and Change from 1981 Estimates

There were an estimated 31.8 million women at risk of unintended pregnancy in 1987 (Table 1). Of these, 7.9 million lived in families with incomes at less than 150 percent of the federal poverty standard. Three million were in families at 150–199

percent of the poverty level, and another 3.2 million were in families at 200–249 percent. Four million of the women at risk were teenagers; they had lower incomes on average than older women. Some family planning programs have targeted all teenagers at risk of unintended pregnancy, plus women at risk aged 20–44 under 200 percent of the poverty level; these women are sometimes considered the group in need of subsidized or organized family planning services. There were 13.1 million women in this target group in 1987.

The estimated number of women at risk of unintended pregnancy was six percent lower in 1987 than in 1981, the last year for which estimates were made (Table 2). The number of low-income women at risk fell by 16 percent, from 9.5 million in 1981 to 7.9 million in 1987, and the target group of women in need, those at risk aged 20–44 under 200 percent of poverty and all teenagers at risk, fell 17 percent. All regions shared in the decline, which ranged from 34 percent in Region I to four percent in Region VI.

All states except Alaska shared in the drop in the number of women in need of subsidized or organized services (Table 3). While the number in Alaska increased by 17 percent, the drop in the other states ranged from just two percent in Texas to 39 percent in Connecticut. Among all women of reproductive age in 1987, the percentage in need of subsidized services ranged from 12 percent in Connecticut and 16 percent in Massachusetts to 32 percent in Mississippi and 31 percent in the District of Columbia. The percentage tends to be above average in the southern states and below average in the northeastern states.

The principal factors that contributed to the change in the estimated number of women in need were changes in the size of the population, the proportion of the population with a low income, the percentage of unmarried women who are sexually active and the percentage of married couples who are infecund. Other less important factors included changes in the age distribution, the proportion married and the number of future births expected.

Table 4 shows the population and income changes between 1981 and 1987. While the population of women aged 13–44 increased seven percent, the number of low-income women (under 150 percent of the federal poverty level) fell by nine percent. It should be remembered that 1981 was a recession year when a relatively high proportion of families had low incomes. The age distribution changed, but not in a way that alone would have had a great effect on the number of women at risk. The age group with the highest proportion of women at risk, women aged 20–29, changed little, while all the population growth occurred among women 30–44, who are less likely to be at risk. Marital status was affected by two trends with opposite effects: delayed marriage and increasing divorce, and growth in the number of women 30–44, who tend to be married. The net result was little change in the proportion married, although the proportion married among low-income women did fall by two percentage points.

All federal regions experienced moderate population growth, especially Regions VI and IX, but the change in the number of low-income women varied more markedly by region. Region I, the New England states, experienced a 37 percent decline in the number of poor women, while Region VI, which includes Texas, had an increase of 12 percent. Region X also had an increase (four percent), and the remaining regions had decreases ranging from one percent (Region VIII) to 23 percent (Region II). Thus, differences in economic changes across areas have had an important effect on the numbers of women who need subsidized services.

The estimated proportion of all women aged 13–44 at risk of unintended pregnancy declined from 59 percent in 1981 to 52 percent in 1987 (Table 5). The decline was greatest for women under age 18 (20 percent) and those aged 30–44 (22 percent). There was relatively little difference between the federal regions in the extent of the de-

cline, which ranged from 10.4 percent in Region II to 13.6 percent in Region V.

The reasons for the decline may be seen in Table 6, which shows the percentage at risk separately for married women living with their husbands and for all other women. The largest change, a decrease from 53.2 to 35.3 percent, occurred among married women aged 30–44. This is mainly the result of the large increase in the proportion of couples who use surgical sterilization. The 1981 calculations were based on data from the 1976 NSFG, and the 1987 estimating procedure was updated with data from 1987, so the change in fecundity reflects 11 years of increasing use of sterilization. The proportion of married women who are infecund was lower in the Northeast than in other census regions in both 1981 and 1987. The decline in the proportions of married women at risk was largest in Regions IV, V, and VI (27 percent) and lowest in Region I (19 percent).

Among unmarried women, the estimates show a significant decline in the proportion of women under age 18 at risk of unintended pregnancy. This change may be largely a methodological artifact. The 1981 calculations incorporated a projected continuation of the trend toward increasing sexual activity of teenagers that had been observed in 1976 and 1979, whereas the 1982 NSFG indicated a slight decrease from 1979. In addition, the increasing income of all women, including teenagers, produced an apparent decline in the proportion of teenagers who are sexually active, since the estimated proportion of those sexually active varies sharply with poverty status. For example, according to the 1987 estimates, the proportion of 15–17-year-olds sexually active is 49 percent among those under 100 percent of poverty as compared with 21 percent among those at or above 250 percent of poverty. Since a larger proportion of teenagers were in the highest poverty group in 1987 than in 1982, the predicted proportion sexually active of all income groups combined declined. However, since only about six percent of women at risk of unintended pregnancy are under age 18, the uncertainty in the estimate for this group has little effect on the overall estimate of women at risk.

Among older unmarried women, the proportion at risk increased slightly. The change is surprisingly small, since the proportions used in 1981 were based on fragmentary data from local surveys, there having been no national survey of this group before 1982.

In conclusion, the overall six percent drop since 1981 in the number of women at risk of unintended pregnancy was caused largely by a sharp increase in the number of married couples relying on either male or female contraceptive sterilization. The number of low-income women at risk of unintended pregnancy has fallen even more—16 percent—because of overall improvement in the economic status of families in most areas of the country.

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Table 1. Estimated number (in 000s) of women at risk of unintended pregnancy, by age, according to poverty status, 1987

Age	Total	% of poverty level				
		<100	100–149	150–199	200–249	>249
Total	**31,847**	**4,977**	**2,972**	**2,965**	**3,180**	**17,753**
13–14	196	51	32	20	24	69
15–17	1,605	400	241	158	171	635
18–19	2,246	522	262	192	205	1,065
20–29	15,954	2,534	1,501	1,580	1,660	8,679
30–44	11,846	1,470	936	1,015	1,120	7,305

Note: Numbers in this and Tables 2–4 may differ slightly from those in the county table because of differences in rounding.

Table 2. Estimated number (in 000s) of women at risk of unintended pregnancy, by age and poverty status, 1981, 1987, and change and percent change 1981–1987

Age/poverty status	1981	1987	Change 1981–1987	% Change 1981–1987
All women 13–44	33,864	31,847	-2,017	-6.0
Women 13–44 at <150% of poverty	9,493	7,949	-1,544	-16.3
All teens; women 20–44 at <200% of poverty	15,808	13,088	-2,720	-17.2
Region				
I	755	500	-255	-33.8
II	1,609	1,194	-415	-25.8
III	1,611	1,260	-351	-21.8
IV	3,031	2,645	-386	-12.7
V	2,911	2,329	-582	-20.0
VI	1,856	1,783	-73	-3.9
VII	772	623	-149	-19.3
VIII	528	451	-77	-14.6
IX	2,149	1,803	-346	-16.1
X	587	502	-85	-14.5

Table 3. Women at risk of unintended pregnancy: all aged 13–19 plus those 20–44 under 200 percent of the poverty level, 1981, 1987, and change and percent change 1981–1987, and percent of population 13–44, 1987

State	1981	1987	Change 1981–1987	% Change 1981–1987	% of Women 13–44 1987
Alabama	318,100	284,300	-33,800	-10.6	27.8
Alaska	28,730	33,740	5,010	17.4	22.1
Arizona	219,110	195,540	-23,570	-10.8	23.2
Arkansas	182,470	150,330	-32,140	-17.6	26.5
California	1,799,720	1,493,710	-306,010	-17.0	21.0
Colorado	219,330	184,400	-34,930	-15.9	20.4
Connecticut	160,870	98,900	-61,970	-38.5	12.3
Delaware	42,620	38,560	-4,060	-9.5	23.3
District of Columbia	60,320	53,330	-6,990	-11.6	30.5
Florida	663,990	577,100	-86,890	-13.1	21.3
Georgia	440,400	375,680	-64,720	-14.7	22.8
Hawaii	75,460	61,860	-13,600	-18.0	22.4
Idaho	76,910	68,360	-8,550	-11.1	27.1
Illinois	701,440	574,580	-126,860	-18.1	19.8
Indiana	365,200	286,000	-79,200	-21.7	20.6
Iowa	187,820	155,690	-32,130	-17.1	22.9
Kansas	149,570	126,620	-22,950	-15.3	21.3
Kentucky	286,060	237,410	-48,650	-17.0	25.6
Louisiana	331,020	318,750	-12,270	-3.7	27.7
Maine	82,630	61,210	-21,420	-25.9	21.3
Maryland	269,770	209,410	-60,360	-22.4	17.3
Massachusetts	355,430	229,440	-125,990	-35.4	15.5
Michigan	594,060	491,740	-102,320	-17.2	21.0
Minnesota	260,650	192,920	-67,730	-26.0	17.9
Mississippi	223,730	208,090	-15,640	-7.0	31.9
Missouri	330,610	256,990	-73,620	-22.3	20.6
Montana	58,280	52,770	-5,510	-9.5	25.7
Nebraska	103,600	83,520	-20,080	-19.4	21.6
Nevada	54,300	51,470	-2,830	-5.2	19.3
New Hampshire	56,290	36,760	-19,530	-34.7	13.7
New Jersey	416,410	290,190	-126,220	-30.3	15.2
New Mexico	115,040	111,610	-3,430	-3.0	28.7
New York	1,192,180	903,400	-288,780	-24.2	20.2
North Carolina	477,680	421,250	-56,430	-11.8	25.7
North Dakota	45,120	36,810	-8,310	-18.4	22.4
Ohio	688,650	548,420	-140,230	-20.4	20.4
Oklahoma	200,270	193,890	-6,380	-3.2	24.1
Oregon	195,270	163,230	-32,040	-16.4	23.8
Pennsylvania	730,780	542,120	-188,660	-25.8	19.0
Rhode Island	59,440	41,680	-17,760	-29.9	17.4
South Carolina	262,700	245,300	-17,400	-6.6	27.6
South Dakota	52,070	46,710	-5,360	-10.3	27.9
Tennessee	358,020	294,310	-63,710	-17.8	23.9
Texas	1,026,830	1,007,020	-19,810	-1.9	23.5
Utah	124,620	101,680	-22,940	-18.4	24.1
Vermont	40,260	31,360	-8,900	-22.1	22.3
Virginia	372,210	300,170	-72,040	-19.4	19.3
Washington	286,310	236,710	-49,600	-17.3	20.6
West Virginia	135,540	115,430	-20,110	-14.8	25.2
Wisconsin	300,870	234,020	-66,850	-22.2	19.8
Wyoming	28,890	27,610	-1,280	-4.4	22.9
Total	15,807,650	13,082,100	-2,725,550	-17.2	21.4

Table 4. Female population aged 13–44 (In 000s), by age, marital status and federal region, 1981, 1987, and change and percent change 1981–1987

Characteristic	1981	1987	Change 1981–1987	% Change 1981–1987
ALL INCOME LEVELS				
Total	**57,356**	**61,158**	**3,802**	**6.6**
Age				
13–19	13,515	12,242	-1,273	-9.4
20–29	20,911	20,849	-62	-0.3
30–44	22,930	28,067	5,137	22.4
Marital status				
Married, spouse present	28,108	29,782	1,674	6.0
Other	29,246	31,376	2,130	7.3
Federal region				
I	3,103	3,217	114	3.7
II	6,187	6,382	195	3.2
III	6,176	6,409	233	3.8
IV	9,759	10,725	966	9.9
V	11,492	11,584	92	0.8
VI	6,488	7,202	714	11.0
VII	2,846	2,909	63	2.2
VIII	1,825	1,986	161	8.8
IX	7,373	8,503	1,130	15.3
X	2,104	2,241	137	6.5
INCOME <150% OF POVERTY				
Total	**15,415**	**14,027**	**-1,388**	**-9.0**
Age				
13–19	4,224	3,217	-1,007	-23.8
20–29	6,009	5,335	-674	-11.2
30–44	5,183	5,475	292	5.6
Marital status				
Married, spouse present	4,907	4,150	-757	-15.4
Other	10,508	9,878	-630	-6.0
Federal region				
I	706	448	-258	-36.5
II	1,631	1,261	-370	-22.7
III	1,547	1,255	-292	-18.9
IV	3,178	2,916	-262	-8.2
V	2,752	2,467	-285	-10.4
VI	1,868	2,089	221	11.8
VII	771	672	-99	-12.8
VIII	487	480	-7	-1.4
IX	1,941	1,889	-52	-2.7
X	533	553	20	3.8

Table 5. Percent of women at risk of unintended pregnancy, by age and federal region, 1981, 1987, and change and percent change 1981–1987

Age and region	1981	1987	Change 1981–1987	% Change 1981–1987
Total	**59.0**	**52.1**	**-6.9**	**-11.7**
Age				
13–14	7.6	6.1	-1.5	-19.7
15–17	36.8	29.6	-7.2	-19.6
18–19	63.0	62.2	-0.8	-1.3
20–29	78.3	76.5	-1.8	-2.3
30–44	54.3	42.2	-12.1	-22.3
Federal region				
I	62.0	55.4	-6.6	-10.7
II	62.6	56.1	-6.5	-10.4
III	60.0	53.5	-6.5	-10.9
IV	57.9	51.4	-6.5	-11.2
V	57.7	49.9	-7.8	-13.6
VI	58.1	50.8	-7.3	-12.5
VII	56.4	49.3	-7.0	-12.4
VIII	57.3	51.3	-6.0	-10.5
IX	60.3	52.9	-7.4	-12.3
X	57.7	51.6	-6.1	-10.5

Table 6. Percent of women at risk of unintended pregnancy, by age, marital status and federal region, 1981, 1987, and change and percent change 1981–1987

Characteristic	1981	1987	Change 1981–1987	% Change 1981–1987
MARRIED, SPOUSE PRESENT				
Total	**64.5**	**48.9**	**-15.6**	**-24.2**
Age				
13–14	na	na		
15–17	86.5	87.0	0.5	0.6
18–19	86.1	86.5	0.4	0.5
20–29	80.9	75.1	-5.8	-7.2
30–44	53.2	35.3	-17.9	-33.6
Federal region				
I	73.8	59.8	-14.1	-19.1
II	73.2	58.7	-14.5	-19.9
III	67.6	51.7	-15.8	-23.4
IV	63.1	46.1	-17.1	-27.0
V	62.3	45.4	-16.9	-27.2
VI	63.5	46.6	-17.0	-26.7
VII	61.9	45.9	-16.0	-25.9
VIII	61.2	48.5	-12.6	-20.7
IX	61.5	48.2	-13.3	-21.6
X	60.7	48.6	-12.2	-20.0
ALL OTHER MARITAL STATUSES*				
Total	**53.7**	**55.1**	**1.4**	**2.6**
Age				
13–14	7.6	6.1	-1.5	-19.7
15–17	35.6	28.7	-6.9	-19.4
18–19	59.6	59.7	0.1	0.2
20–29	75.6	77.7	2.1	2.8
30–44	57.3	58.6	1.3	2.3
Federal region				
I	52.1	51.7	-0.4	-0.8
II	54.5	54.1	-0.5	-0.9
III	53.1	55.1	2.0	3.7
IV	52.5	56.7	4.2	7.9
V	53.2	54.3	1.0	1.9
VI	52.0	55.5	3.5	6.8
VII	50.0	53.2	3.3	6.6
VIII	52.8	54.3	1.6	3.0
IX	59.2	56.8	-2.4	-4.0
X	54.3	54.9	0.6	1.1

*Consists of women who are married, without spouse present; women who are never-married; and women who are separated, divorced or widowed.

DEFINITIONS AND GUIDE TO THE DATA

This document presents estimates of the female population by age and the number of women at risk of unintended pregnancy by age, poverty status and race for 3,135 counties. All numbers have been rounded to the nearest 10.

Columns 1–4 show population estimates as of July 1, 1987. These estimates have been adjusted so that the national totals would approximately (within rounding error) equal the latest Census Bureau estimates.

The remaining columns show the numbers of women who were at risk of unintended pregnancy at some time during the year and would therefore have needed a method of contraception. Column 5 gives the total number of women at risk, and Columns 6–8 show the numbers separately for three age groups: 13–17, 18–19 and 20–44.

Columns 9–14 contain the numbers of low- and marginal-income women at risk of unintended pregnancy. Income is measured in relation to the federal povery standard, which varies according to the number of persons in the family. In 1987, the federal poverty level for a family of four was $11,200. Columns 9 and 10 show the numbers of women at risk whose family incomes were under 150 percent of the poverty standard; for a family of four, for example, the income would have been less than $16,800. The number of teenagers is not shown separately but can be obtained by subtracting Column 10, women 20–44, from Column 9. Columns 11 and 12 give the same statistics for women under 200 percent of the poverty standard, and Columns 13 and 14, for those under 250 percent of the poverty standard. The figures are cumulative; for example, a woman counted in Column 9 would also be counted in Columns 11 and 13.

Column 15 contains a summary figure combining all teenagers at risk with women 20–44 at risk whose family income is under 200 percent of the poverty level. The numbers in this column are the sums of Columns 6, 7 and 12 (although the figures for some counties have slight discrepancies due to rounding error). Column 16 shows the number of white and "other" (nonblack) races who meet these conditions, and Column 17 shows the number of black women. Column 15 is identical to the category called "in need of organized services" in 1981.

The states are arranged in alphabetical order, with each state taking up a two-page spread. (Where there was sufficient room, more than one state was included on a two-page spread.) The counties within each state are also arranged in alphabetical order, with the Federal Information Processing Standards (FIPS) code listed to the left of each county name. The number to the right of each state name is the state FIPS code. In states where independent cities that are the equivalents of counties are included, the cities are listed after all the traditional counties.

Above each state total is the total for the federal region of which the state is a part, as well as the U.S. total (which is, of course, the same in each table).

It should be remembered that the numbers in the table are estimates containing several possible sources of error: the population estimates may be inaccurate seven years after the most recent census, especially for counties with rapid population change; the poverty and marital status distributions are not known exactly; and the estimated proportions of women who are fecund, sexually active and not pregnant or trying to become pregnant are based on national and regional data that may not be accurate for a particular county.

NUMBER OF WOMEN AT RISK OF UNINTENDED PREGNANCY BY AGE AND POVERTY STATUS, 1987

GEOGRAPHIC AREA	AT RISK <150% OF POVERTY		AT RISK <200% OF POVERTY		AT RISK <250% OF POVERTY		AT RISK AND AGE 13-19 OR 20-44 <200% POV. (COL. 6+7+12)		
	TOTAL 13-44 (9)	20-44 (10)	TOTAL 13-44 (11)	20-44 (12)	TOTAL 13-44 (13)	20-44 (14)	ALL RACES (15)	WHITE/ OTHER (16)	BLACK (17)
U.S. TOTAL	7950600	6442390	10914250	9037000	14094600	11816680	13087960	9914240	3173720
REGION 7 TOTAL	364530	293030	514940	424340	651650	542420	623400	548840	74560
KANSAS 20	74350	60090	104930	86940	133430	111570	126800	113360	13440
1 ALLEN	470	370	680	540	860	690	800	770	30
3 ANDERSON	200	150	300	240	380	300	360	360	0
5 ATCHISON	570	450	850	690	1070	860	1040	900	140
7 BARBER	180	150	250	210	320	270	290	290	0
9 BARTON	780	630	1240	1050	1690	1430	1570	1530	40
11 BOURBON	510	400	710	580	870	720	820	790	30
13 BROWN	370	300	520	430	620	510	580	580	0
15 BUTLER	1210	1000	1770	1460	2200	1820	2180	2160	20
17 CHASE	70	50	100	80	130	100	120	120	0
19 CHAUTAUQUA	110	80	180	160	220	190	220	220	0
21 CHEROKEE	770	640	1090	910	1300	1080	1250	1250	0
23 CHEYENNE	90	70	110	100	140	120	140	140	0
25 CLARK	50	40	80	70	100	90	100	100	0
27 CLAY	270	230	380	320	460	390	430	430	0
29 CLOUD	450	3320	620	480	720	550	710	710	0
31 COFFEY	140	110	230	190	360	300	310	310	0
33 COMANCHE	80	60	120	100	140	110	130	130	0
35 COWLEY	840	630	1360	1100	1850	1520	1720	1620	100
37 CRAWFORD	1600	1240	2070	1650	2450	1980	2330	2280	50
39 DECATUR	140	120	200	170	230	190	220	220	0
41 DICKINSON	480	400	750	640	960	810	910	910	0
43 DONIPHAN	320	240	460	360	560	440	530	510	20
45 DOUGLAS	5390	4130	6620	5230	7380	5860	7580	7050	530
47 EDWARDS	150	120	210	180	250	210	230	230	0
49 ELK	80	70	140	120	160	140	160	160	0
51 ELLIS	1190	960	1560	1270	2010	1660	1880	1870	10
53 ELLSWORTH	160	130	250	210	320	270	290	290	0
55 FINNEY	960	810	1420	1190	1870	1570	1720	1710	10
57 FORD	770	610	1140	940	1510	1260	1450	1410	40
59 FRANKLIN	540	440	850	720	1130	960	1050	1030	20
61 GEARY	2140	1680	2650	2120	2930	2360	2900	2060	840
63 GOVE	150	120	200	160	220	170	210	210	0
65 GRAHAM	100	80	180	140	210	170	210	200	10
67 GRANT	220	200	370	340	460	410	450	450	0
69 GRAY	130	110	210	180	280	250	250	250	0
71 GREELEY	70	60	100	80	120	100	110	110	0
73 GREENWOOD	230	200	310	270	370	320	360	360	0
75 HAMILTON	60	50	90	70	110	90	100	100	0
77 HARPER	250	210	320	270	380	320	360	360	0
79 HARVEY	970	720	1290	1000	1740	1390	1560	1520	40
81 HASKELL	170	130	230	190	260	220	240	240	0
83 HODGEMAN	90	70	120	100	140	110	130	130	0
85 JACKSON	290	240	450	380	590	490	540	540	0
87 JEFFERSON	370	300	560	470	690	580	700	700	0
89 JEWELL	140	120	210	180	240	200	230	230	0
91 JOHNSON	4470	3880	6950	6150	11210	9940	10180	9980	200
93 KEARNY	140	100	170	130	210	170	200	200	0
95 KINGMAN	270	220	360	300	460	380	420	420	0
97 KIOWA	110	100	150	130	190	170	180	180	0
99 LABETTE	650	520	1020	850	1300	1090	1230	1130	100
101 LANE	60	60	100	80	120	110	110	110	0
103 LEAVENWORTH	1110	890	1800	1510	2590	2190	2350	1940	410
105 LINCOLN	130	110	180	150	200	170	190	190	0
107 LINN	270	210	350	280	420	340	390	390	0
109 LOGAN	100	80	150	120	180	150	170	170	0
111 LYON	1570	1230	2060	1670	2630	2170	2460	2330	130
113 MCPHERSON	610	480	970	800	1360	1130	1270	1260	10
115 MARION	350	280	510	410	640	520	610	610	0
117 MARSHALL	450	350	620	500	730	590	690	690	0
119 MEADE	150	130	210	180	250	210	240	240	0
121 MIAMI	570	450	860	710	1130	940	1040	970	70
123 MITCHELL	300	230	400	320	470	380	440	440	0
125 MONTGOMERY	1160	960	1760	1460	2230	1860	2080	1840	240
127 MORRIS	190	150	260	210	310	260	300	300	0
129 MORTON	100	80	150	120	190	160	170	170	0
131 NEMAHA	310	230	450	350	550	430	510	510	0
133 NEOSHO	520	430	750	630	950	800	900	890	10

NUMBER OF WOMEN AT RISK OF UNINTENDED PREGNANCY BY AGE AND POVERTY STATUS, 1987

GEOGRAPHIC AREA		AT RISK <150% OF POVERTY		AT RISK <200% OF POVERTY		AT RISK <250% OF POVERTY		AT RISK AND AGE 13-19 OR 20-44 <200% POV.(COL. 6+7+12)		
		TOTAL 13-44 (9)	20-44 (10)	TOTAL 13-44 (11)	20-44 (12)	TOTAL 13-44 (13)	20-44 (14)	ALL RACES (15)	WHITE/ OTHER (16)	BLACK (17)
20 KANSAS	CONTINUED									
135	NESS	110	90	160	130	200	170	180	180	0
137	NORTON	200	160	260	210	310	260	290	290	0
139	OSAGE	350	290	490	410	630	530	630	630	0
141	OSBORNE	200	160	260	210	300	250	280	280	0
143	OTTAWA	130	110	210	170	270	220	250	250	0
145	PAWNEE	140	120	260	220	350	300	310	300	10
147	PHILLIPS	140	120	230	200	300	260	280	280	0
149	POTTAWATOMIE	420	360	630	550	830	730	760	760	0
151	PRATT	250	220	390	330	520	440	480	470	10
153	RAWLINS	140	120	200	170	220	190	210	210	0
155	RENO	2070	1680	2960	2470	3820	3220	3570	3480	90
157	REPUBLIC	170	140	290	240	340	280	320	320	0
159	RICE	240	200	380	320	520	440	500	490	10
161	RILEY	4840	3920	6040	5020	6710	5570	6710	6080	630
163	ROOKS	190	140	270	220	330	270	320	320	0
165	RUSH	100	80	150	120	180	150	160	160	0
167	RUSSELL	200	170	300	240	380	320	340	340	0
169	SALINE	1730	1350	2520	2040	3240	2670	2940	2800	140
171	SCOTT	180	140	240	190	320	260	280	280	0
173	SEDGWICK	10370	8570	14870	12590	19350	16500	18460	14770	3690
175	SEWARD	700	550	960	770	1210	990	1110	1020	90
177	SHAWNEE	3850	3180	5830	4890	7640	6480	7240	6020	1220
179	SHERIDAN	150	110	200	150	210	170	210	210	0
181	SHERMAN	300	240	440	360	510	420	490	490	0
183	SMITH	210	180	290	250	320	270	310	310	0
185	STAFFORD	120	90	190	150	240	200	220	220	0
187	STANTON	100	80	140	110	160	130	150	150	0
189	STEVENS	100	90	170	140	240	210	210	210	0
191	SUMNER	560	450	920	750	1230	1020	1110	1110	0
193	THOMAS	420	310	530	400	640	490	620	620	0
195	TREGO	140	110	210	170	250	200	230	230	0
197	WABAUNSEE	170	130	260	200	340	270	300	300	0
199	WALLACE	110	90	130	110	140	110	140	140	0
201	WASHINGTON	290	210	380	290	410	320	400	400	0
203	WICHITA	100	80	140	120	170	140	160	160	0
205	WILSON	380	290	500	400	620	500	560	560	0
207	WOODSON	130	100	190	140	220	170	210	210	0
209	WYANDOTTE	6440	5250	8560	7090	10440	8710	10080	5630	4450

NUMBER OF WOMEN AT RISK OF UNINTENDED PREGNANCY BY AGE AND POVERTY STATUS, 1987

GEOGRAPHIC AREA	FEMALE POPULATION				WOMEN AT RISK			
	TOTAL 13-44 (1)	13-17 (2)	18-19 (3)	20-44 (4)	TOTAL 13-44 (5)	13-17 (6)	18-19 (7)	20-44 (8)
U.S. TOTAL	61157270	8628060	3613990	48915220	31851950	1803490	2247470	27800990
REGION 7 TOTAL	2908430	415600	185270	2307560	1435870	84170	114890	1236810
KANSAS 20	595170	82330	37320	475520	294990	16410	23450	255130
1 ALLEN	3270	500	220	2550	1570	110	140	1320
3 ANDERSON	1660	320	90	1250	740	70	60	610
5 ATCHISON	4120	670	360	3090	2000	140	220	1640
7 BARBER	1270	190	60	1020	590	40	40	510
9 BARTON	7460	1140	480	5840	3610	220	290	3100
11 BOURBON	3200	480	220	2500	1560	100	140	1320
13 BROWN	2230	350	130	1750	1040	80	80	880
15 BUTLER	11300	1750	630	8920	5170	330	390	4450
17 CHASE	560	90	30	440	250	20	20	210
19 CHAUTAUQUA	870	140	40	690	400	30	30	340
21 CHEROKEE	4870	800	270	3800	2210	180	170	1860
23 CHEYENNE	610	110	30	470	280	20	20	240
25 CLARK	440	90	20	330	190	20	10	160
27 CLAY	1770	280	80	1410	810	60	50	700
29 CLOUD	2330	360	250	1720	1130	80	160	890
31 COFFEY	1990	310	100	1580	940	60	60	820
33 COMANCHE	450	70	20	360	220	20	20	180
35 COWLEY	8490	1210	600	6680	4110	230	390	3490
37 CRAWFORD	8170	1070	690	6410	4100	230	440	3430
39 DECATUR	730	130	30	570	340	30	20	290
41 DICKINSON	4000	670	220	3110	1800	140	140	1520
43 DONIPHAN	2000	340	160	1500	960	80	100	780
45 DOUGLAS	22560	1810	3180	17570	12940	350	2000	10590
47 EDWARDS	760	130	40	590	350	30	20	300
49 ELK	630	100	30	500	280	20	20	240
51 ELLIS	7440	880	750	5810	4010	170	450	3390
53 ELLSWORTH	1230	200	60	970	560	40	40	480
55 FINNEY	7550	1130	470	5950	3750	230	290	3230
57 FORD	6420	900	540	4980	3150	180	330	2640
59 FRANKLIN	4920	740	300	3880	2370	150	190	2030
61 GEARY	8030	1010	670	6350	4360	280	490	3590
63 GOVE	730	160	30	540	330	40	20	270
65 GRAHAM	780	140	50	590	350	30	30	290
67 GRANT	1840	300	90	1450	850	60	60	730
69 GRAY	1240	170	60	1010	600	30	40	530
71 GREELEY	370	70	20	280	160	10	10	140
73 GREENWOOD	1450	250	60	1140	640	50	40	550
75 HAMILTON	470	80	20	370	220	20	20	180
77 HARPER	1370	220	60	1090	620	50	40	530
79 HARVEY	7390	1010	570	5810	3650	200	360	3090
81 HASKELL	920	150	40	730	420	30	30	360
83 HODGEMAN	440	70	30	340	200	20	20	160
85 JACKSON	2620	440	120	2060	1150	90	70	990
87 JEFFERSON	3790	660	160	2970	1650	130	100	1420
89 JEWELL	820	140	40	640	370	30	30	310
91 JOHNSON	89180	11850	3540	73790	41980	1950	2070	37960
93 KEARNY	870	160	50	660	390	30	40	320
95 KINGMAN	1780	300	90	1390	830	70	60	700
97 KIOWA	740	110	40	590	340	20	20	300
99 LABETTE	5470	900	300	4270	2610	180	200	2230
101 LANE	530	100	20	410	230	20	10	200
103 LEAVENWORTH	13960	2090	750	11120	6410	380	460	5570
105 LINCOLN	620	100	30	490	280	20	20	240
107 LINN	1660	290	80	1290	740	70	50	620
109 LOGAN	680	130	30	520	310	30	20	260
111 LYON	9450	950	950	7550	5180	200	590	4390
113 MCPHERSON	6280	840	540	4900	3080	160	320	2600
115 MARION	2510	400	190	1920	1160	90	110	960
117 MARSHALL	2520	470	130	1920	1160	110	80	970
119 MEADE	890	140	40	710	420	30	30	360
121 MIAMI	5090	830	260	4000	2290	170	160	1960
123 MITCHELL	1600	310	90	1200	750	70	60	620
125 MONTGOMERY	9040	1350	560	7130	4340	280	350	3710
127 MORRIS	1180	220	60	900	520	50	40	430
129 MORTON	790	100	40	650	380	20	30	330
131 NEMAHA	2070	410	120	1540	930	90	70	770
133 NEOSHO	3890	610	220	3060	1810	130	140	1540

NUMBER OF WOMEN AT RISK OF UNINTENDED PREGNANCY BY AGE AND POVERTY STATUS, 1987

GEOGRAPHIC AREA		FEMALE POPULATION				WOMEN AT RISK			
		TOTAL 13-44 (1)	13-17 (2)	18-19 (3)	20-44 (4)	TOTAL 13-44 (5)	13-17 (6)	18-19 (7)	20-44 (8)
20	KANSAS CONTINUED								
135	NESS	790	120	40	630	370	30	20	320
137	NORTON	1240	200	60	980	550	40	40	470
139	OSAGE	3450	530	190	2730	1590	100	120	1370
141	OSBORNE	980	180	40	760	460	40	30	390
143	OTTAWA	1170	210	60	900	510	40	40	430
145	PAWNEE	1490	240	70	1180	710	50	50	610
147	PHILLIPS	1320	220	50	1050	570	40	30	500
149	POTTAWATOMIE	3610	540	180	2890	1700	100	110	1490
151	PRATT	2210	300	160	1750	1080	60	100	920
153	RAWLINS	750	120	30	600	340	30	20	290
155	RENO	15430	2130	1030	12270	7510	450	640	6420
157	REPUBLIC	1200	190	70	940	530	40	40	450
159	RICE	2370	360	170	1840	1110	70	100	940
161	RILEY	17330	1300	2240	13790	9930	260	1430	8240
163	ROOKS	1240	230	70	940	560	50	50	460
165	RUSH	740	120	30	590	330	30	20	280
167	RUSSELL	1670	260	80	1330	790	60	50	680
169	SALINE	12700	1680	890	10130	6380	330	580	5470
171	SCOTT	1340	220	60	1060	620	50	40	530
173	SEDGWICK	98840	12930	5380	80530	50890	2500	3370	45020
175	SEWARD	4490	620	290	3580	2260	150	190	1920
177	SHAWNEE	40340	5360	2160	32820	20430	1020	1330	18080
179	SHERIDAN	640	130	30	480	280	30	20	230
181	SHERMAN	1630	260	100	1270	770	60	70	640
183	SMITH	980	140	40	800	440	30	30	380
185	STAFFORD	1040	180	50	810	490	40	40	410
187	STANTON	560	90	30	440	250	20	20	210
189	STEVENS	1140	160	50	930	540	30	40	470
191	SUMNER	5460	870	290	4300	2500	180	180	2140
193	THOMAS	2170	290	260	1620	1100	70	160	870
195	TREGO	860	160	30	670	400	40	20	340
197	WABAUNSEE	1400	250	70	1080	620	60	40	520
199	WALLACE	390	70	20	300	190	20	20	150
201	WASHINGTON	1270	270	60	940	560	70	40	450
203	WICHITA	610	100	30	480	280	20	20	240
205	WILSON	2440	400	120	1920	1130	90	80	960
207	WOODSON	790	140	50	600	370	30	30	310
209	WYANDOTTE	42730	6270	2490	33970	22710	1380	1620	19710

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Issue Analysis...
Information on Public Policy

ADOLESCENT PREGNANCY

THE ISSUE:

Approximately 1.1 million American teenagers become pregnant every year, more than 80% unintentionally(1) The situation represents a tragedy for the young people themselves and for all Americans. For the teens involved it often means having to decide between abortion or dropping out of school, leaving home, or becoming dependent on welfare. For society, it means a staggering federal tax bill --- more than $18 billion in 1986(2). Worst of all, it presents an almost insurmountable obstacle to the creative and productive potential of America's greatest asset, our youth.

THE CRITICAL FACTS:

- Of the 25 million young people in the U.S. between the ages of 13 and 19, 45% -- seven million young men and five million young women -- have had sexual intercourse(1). Studies show continuing trends toward earlier initiation of sexual activity(3)

- Only 33% of sexually active teens aged 12-17 use contraceptives every time they have sex. Over one-fourth never use them(4).

- Many teens never visit family planning clinics; and of those who do, only 12% do so before they initiate intercourse. **Most wait more than a year after first intercourse**(5).

- One in eight births in the United States occurs to a teenager. Teens account for 27.5% of all abortions annually(6).

- Adolescent childbearing is one of the leading causes of welfare dependency in the U.S.(1).

- Teens at greatest risk of unintended pregnancy--those likely to initiate sexual activity at an early age and not use contraceptive consistently--are those with the least resources: lower socio-economic status, low grades, single-parent homes, parents aren't college graduates, and no defined career plans(4).

U.S. TEEN PREGNANCY RATE HIGHEST IN DEVELOPED WORLD

A 1985 study found the rate of teen pregnancy in the U.S. is 2 to 7 times higher than that in other comparable industrialized nations...despite similar rates of sexual activity(7). Several factors were found to influence lower pregnancy rates in other developed countries: rational and unambivalent societal attitudes toward sexuality and sexual development; families frank discussion of sexual issues and in the media; comprehensive, government-sanctioned school sexuality education; widely available, confidential, low-or no-cost contraceptives. The findings of this study provide a virtual blueprint for soluntions to the adolescent pregnancy problem in America.

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PRACTICAL SOLUTIONS - PLANNED PARENTHOOD'S POSITION:
Although concern about the adolescent pregnancy issue has grown in this country and solving the problem has become an accepted national priority, so far we have seen only a patchwork of sporadic, healfhearted efforts. In line with approaches recommended by the National Research Council, which advises the federal government on scientific and technical matters, Planned Parenthood urges states to address the problem, possibly in coordination with a nationwide program, such as:

- Fully fund and statutorily mandate Kansas' comprehensive sexuality education, K-12.
  Provide new legislation providing grants to educational institutions and public and private non-profit agencies to assist in family life education programs.
- Eliminate all barriers to confidential, inexpensive or free, contraceptive services for teenagers who are sexually active.

- **Provide funding for parents as sexuality educators and other innovative programs which will enable more parents to feel comfortable in communicating with the teen. Teens' suffer from our society's dangerous hypocrisy of hyping sex while repressing frankness and realism about sexuality. Provideing parents the opportunities to learn to be comfortable with their own sexuality is a good and positive beginning.**

PLANNED PARENTHOOD FURTHER BELIEVES THAT:
- <u>Efforts to eliminate teen sexuality rather than teen pregnancy are counterproductive.</u> Sexual development is a normal part of teens' growth. Rather than repressing teens through enforced ignorance, we must help them cope with sexual feelings responsibly and in ways that don't jeopardize their health or their future.

- **Equally destructive are state and federal government policies and societal attitudes favoring punishment over prevention.** Denying services to teens in an effort to change their behavior is punitive...and can only result in more unwanted teen pregnancies, birth and abortions.

- TV, a particularly powerful vehicle for conveying society's mixed message, overly romanticizes sex and uses sexual imagery to advertise virtually every product except contraception, which is banned from network advertising and censored in network programming to a large extent. **A comprehensive solution to the teen pregnancy problem must include the promotion of balanced and realistic treatment of sexual topics in the media, an idea supported by the majority of Americans and a growing number of state and national agencies.**

PUBLIC OPINION:
- 84% of American adults agree that teen pregnancy is a serious problem(8)

- 80% of teens think that more of their peers would use contraceptives if they knew where they could obtain them confidentially(4)

- 70% of parents agree that their teens should be able to buy contraceptives without their knowledge(9).

- 78% of adults think that television should present messages about birth control as part of its programming(8).

- By a margin of 3 to 1, American adults report they would not be offended by contraceptive advertising on TV; 82% believe that contraceptive advertising on TV would encourage more teens to use contraception(10)

- 83% of American adults recognize that TV exaggerates the importance of sex in American life(9); but almost half of American teens think television presents sexual topics realistically(4).

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Issue Analysis...
Information on Public Policy

SEXUALITY EDUCATION AND SEXUALLY TRANSMITTED DISEASES INCLUDING AIDS

THE ISSUE:
Of the 25 million young people in the U.S. between the ages of 13 and 19, 45% -- seven million young men and 5 million young women --- have had sexual intercourse according to The Alan Guttmacher Institute's 1981 report "Teenage Pregnancy: The Problem Hasn't Gone Away."(1)

Although about 85% of all young people receive some school sexuality education, it is usually sketchy and too late to be of much use(2). Fewer than 10% of students nationwide, and only 35% of high school students, are getting a comprehensive sexuality education(3). Only 12 states, Kansas was the 3rd state, require sexuality education from kindergarten through 12th grade. Most of these programs are just now being implemented. In the face of widespread teenage pregnancy and the AIDS crisis, the need for dramatically expanded sexuality education is critical.

Much of what passes for sexuality education is a technical description of the reproductive system, what students call "the organ recital," that omits subjects young people worry about most (communication, relationships, decision making, AIDS, contraception, abortion, masturbation and homosexuality.) Clearly the U.S., and Kansas', spotty sexuality education efforts are dangerously insufficient.

Parents are, and always will be, children's primary educators about sexuality. But many parents feel uncomfortable or unsure discussing sexual issues with their children. Nearly 40% of parents of teens report they have "never at all" or "only a few time" discussed sex openly with their children...and nearly 70% of parents of children 8-12 have never or rarely had such conversations(4). Most parents recognize that school sexuality education programs can help their children in ways they themselves are unable to do.

The claim that sexuality education encourages early and increased sexual activity and results in more pregnancies and abortions has been disproved by several national studies:

- A 1984 study found that **junior high school students who had had sexuality education courses were less likely to have had intercourse(5)**.
- A U.S. government study found that **sexuality education programs increase students' *knowledge* about sexuality but don't change the personal *values* that guide their behavior(6)** 1
- A 1986 poll indicated that among teens who have had intercourse, those who have had a comprehensive sexuality education course in school and who have discussed sex, pregnancy and contraception with their parents are more than twice as likely as others to use birth control...and are therefore far more likely to avoid pregnancy(3).

High rates of teen pregnancy and sexually transmitted diseases in the U.S. testify to the fact that keeping children ignorant doesn't keep them innocent.

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Television, which overly romanticizes sex and uses sexual imagery to sell virtually every product except contraception, constantly barrages teens with sexual titillation, devoid of any information on prevention or consequences. This sends a powerful and misleading message -- that romantic sex means being "swept away," and that glamourous people don't plan for sex or protect themselves -- a message that isn't lost on young people. Two-thirds of teens polled say they were unprepared for their first intercourse experience -- that it "just happened." Even after first intercourse, "unexpected sex" is teens' single most frequently cited reason for not using contraception(3).

PLANNED PARENTHOOD'S POSITION:

- Thorough, timely and appropriate sexuality education is as basic and necessary to our children's health and well-being as food, shelter and nurturance.
- Withholding sexuality information from children can only increase their risk of unplanned pregnancy, sexually transmitted diseases (STDs) and exploitation.
- Funding of comprehensive sexuality education in every school district is necessary, Kindergarten through 12.
- **Comprehensive school sexuality education, in age-appropriate fashion, must include:**
    1. **communication and decision-making skills (discussing values and choices with parents and other respected adults;**
    2. **saying "no" to risky behaviors**
    3. **accepting responsibility for one's actions;**
    4. **sexual development (physical, emotional and social) through the life cycle, with emphasis on pubertal changes, reproductive anatomy, conception and pregnancy; contraception (including where to obtain it and how to use it);**
    5. **abortion;**
    6. **prevention of STDs, including AIDS;**
    7. **childbirth and the responsibilities of parenthood and family life(7).**
- Educators must do more than merely tell young people to "just say no." While it is important to teach that abstinence is the only 100% effective way to avoid pregnancy and STDs, for most, it will not be a life-long choice. And we must acknowledge that million of teens will have intercourse. Young people who don't refrain from activities that put them at risk of unintended pregnancy or STDs must be taught how to minimize the dangers.

PUBLIC OPINION:

- 89 percent favor sex education being taught in the schools.(Harris Poll, 1988)

- 84 percent of Americans would like sexuality education courses to encourage students to use contraception if they engage in sexual intercourse; 89% think sexuality education courses for 12-year-old students should cover birth control(4).

- 83 percent of Americans think children should be taught about AIDS in school; 95% think a sexuality education course for 12-year-old children should include information on the dangers of AIDS(4).

- By a majority of 3.5 to one, Americans recognize that eliminating sexuality education in schools would result in more, rather than fewer, teen pregnancies(8).

- 67 percent of American adults support school-linked clinics that offer students information on sexuality and contraception as well as family planning services along with general health care(8).

- School sexuality education enjoys the support of many respected national organizations, including: the National Council of Churches, the Synagogue Council of America, the joint committee of the National School Boards Association and the American Association of School Administrators, the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

Notes(1) *Teenage Pregnancy: the Problem Hasn't Gone Away.* The Alan Guttmacher Institute, New York, N.Y., 1981.

(2) Sonenstein, Freya L. and Karen J. Pittman, "The Availability of Sex Education in Large City School Districts," *Family Planning Perspectives,* Vol. 16, No. 1, Jan./Feb. 1984.

(3) *American Teens Speak: Sex, Myths, TV and Birth Control.* Conducted for the Planned Parenthood Federation of America, Inc., by Louis Harris and Associates, Inc., New York, NY, Sept.-Oct. 1986.

(4) *Poll on Sex Education.* Conducted by *Time* magazine by Yankelovich Clancy Shulman, Nov. 1986.

(5) Furstenberg, Frank F., Jr., *et al.*, "Sex Education and Sexual Experiences Among Adolescents," *American Journal of Public Health,* Vol. 75, No. 11, Nov. 1985.

(6) Kirby, Doug. "Sexuality Education: An Evaluation of Programs and Their Effects---Executive Summary." Santa Cruz, CA: Network Publications, 1984.

(7) *American Teens Speak: Sex, Myths, TV and Birth Control.* Conducted for the Planned Parenthood Federation of America, Inc., by Louis Harris and Associates, Inc., New York, NY, Sept-Oct. 1986.

(8) *Public Attitudes About Sex Education, Family Planning, and Abortion in the United States.* Conducted for the Planned Parenthood Federation of America, Inc., by Louis Harris and Associates, Inc., New York, N.Y., Aug.-Sept. 1985.

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Issue Analysis...
Information on Public Policy

REPORTING PREGNANCY TERMINATIONS

THE ISSUE...

The emotional fighting over who should be required to report pregnancy terminations has continued in the Kansas Legislature for several years.

The policy to be determined is whether every individual medical doctor in the state of Kansas shall report pregnancy terminations.

Currently all hospitals are required to report pregnancy terminations. Those clinics providing abortions are voluntarily reporting. This leaves only those private physicians, in private practice, who do not report terminations.

BACKGROUND...Proponents argue that Kansas needs an accounting of all pregnancy terminations so state statisitcs are accurate. While promoting accurate statistics, information continues to surface that the real issue is to obtain the names of individual physicians for proponents to target in attempts to dissuade physicians from performing any pregnancy terminations. In the past, physicians performing abortions have been subjected to demonstrations and harassment in front of their own homes as well as their offices. Persons demonstrating harass by carrying signs, yelling to patients and staff while others communicate by bullhorns. Rural areas would provide still easier targets for harassment if the physician reporting pregnancy termination is the only doctor practicing within several counties.

Proponents requested past legislation include a medical form to be given by physicians to their patients. The form requires patients to fill in any medical complications they might have following the procedure. This would attempt to prove their point that abortions are dangerous and have complications.

Opponents site this type of legislation for what it is: **harassment**.

Opponents argue it is an increased and unnecessary expenditure of state funds as reporting compliance is presently 90-95%.

Patient's risk losing confidentiality. When hospitals or medical clinics report, there isn't a means to identify individual patients. Private physicians in rural Kansas have limited patients and become easier targets to pinpoint due to their rural locale. In 1986, Joe Schiedler, head of the Pro-Life Action Network published a scheduled list of activities he'd accomplish that year...this included targeting individual physicians homes, if they terminated pregnancies.

Opponents also point out that a lay-patient would need medical expertise, which most don't have, in order to complete the medical form. In addition, will the patient return the form? If confidentiality is strongly desired, forms would be discarded and the State will have spent taxpayers money unnecessarily.

WHAT IS THE COMPELLING STATE INTEREST: NONE.

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HOUSE FEDERAL & STATE AFFAIRS
Attachment No. 8 2/14/89

Preventing Teenage Pregnancy: The State Role

Implementation of the prevention strategies addressed below would benefit teenagers themselves, state governments and the public. For example, they should yield:

- A reduction in the incidence of abortion among adolescents;
- Possible decreases in other risk-taking behavior;
- Possible decreases in high school drop-out rates; and
- An avoidance of large and continuing costs for welfare and health and social services.

States can play an essential role in the design and implementation of any teenage pregnancy prevention strategy. By targeting services to those most at risk and considering pregnancy prevention strategies in the context of other state initiatives, states can make effective use of scarce resources and realize a significant impact on the reduction of teenage pregnancies. While direct assumption of the responisibility for initiation local programs does not currently appear to be a major role for the state, nor necessarily an appropriate one in most case, state government can play an invaluable role. In most cases, the state role would be one of stimulating, facilitating, and supporting local actions. To this end, the state is in a position to greatly influence the actions of local organizations in preventing teenage pregnancy. Such activities might take the following forms:

- Public articulation of the issue of teenage pregnancy, changing public attitudes about the issue, and directing public attention to methods of prevention
- Statutory, regulatory, and policy changes to cover successful approaches under existing state programs and assistance in coordinating the use of multiple state programs to support local initiatives.
    - Methods of increasing the eligibility of students served in school-based clinics.
    - Methods of extending benefit coverage for services provided in school-based clinics.
        (1) Targeting EPSDT outreach to adolescents.
        (2) Changing the state's periodicity schedule under the EPSDT program to permit more frequent screenings of adolescents.
        (3) Extending coverage under a state's EPSDT treatment plan.
        (4) Extending coverage to targeted services for children.
    - Extending provider certification to school-based health clinics.
    - Improving reimbursement to school-based clinics.
    - Protecting the confidentiality of students.
- Financial support to local prevention efforts. (cont'd)

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(cont'd) States now provide financial support to local prevention efforts through a range of federal/state programs. For example, Medicaid including EPSDT program, Family-planning Services, The Maternal and Child Health Block Grant Program, The Child Welfare Services Program, The programs of the State Employment Service, Elementary and Secondary Education Programs and several others. States can provide financial support for teenage pregnancy prevention programs by targeting funds under federal and state programs to prevention activities.

- Technical Assistance to local providers establishing and operating prevention programs.
- Public information services about successful strategies and connecting local providers with information, funding, and additional technical assistance.

In conclusion, most intervention programs are of necessity locally based. Sex education and clinic services are offered by local service providers. School policies governing sex education and methods of dealing with the marginal student are still largely set by local boards and principals. Parental support programs are largely offered by school, community, and religious organizations. Finally, employment opportunities are primarily determined by local, private sector firms, although most employment programs are state or regionally administered.

On the other hand, the state is the major actor in providing income and in-kind support to the poor. The state can play a significant role in employment policy for low income persons and through financial contributions to a wide range of service programs can directly contribute to local interventions to prevent teenage pregnancy. Furthermore, the state is in a unique position to establish a policy direction and provide assistance to local groups in furthering that direction.

Source: PREVENTING TEENAGE PREGNANCY by Susan E. Foster
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ADOLESCENT PREGNANCY AND PARENTING

Becoming a parent for the first time is a major event for any individual. The changes that occur as a result of parenthood can be monumental, yet they are often unforeseen. For those who become parents while still teenagers, the demands and consequences of parenthood are likely to be more formidable than for those who become parents later in life. Teenage parents put themselves and their children at risk of encountering a variety of problems that can occur at some point in their lives.

The pregnancy rate among teens rose slightly from 1972 to 1982. But, though the proportion of teenage women who were sexually active rose from about 30 to nearly 50 percent in that decade, the proportion becoming pregnant rose from only about 9.5 to 11 percent. During the same period, the birth rate for adolescent teens fell from 62 to 53 births per 1,000. While the teenage birthrate has declined in recent years, a sharply higher share of all children born to teenage mothers are born out of wedlock.

The share of all first born children of adolescents that were born out of wedlock rose from 16 to nearly 50 percent. The rates in Kansas have paralleled national ones. In 1955, approximately 7 percent of all Kansas women who gave birth under 20 were unmarried and this figure increased to 48 percent in 1985. In 1985, nearly 40 percent of all births out of wedlock in Kansas were to adolescents.

In the U.S. the problem is disproportionately high among black teenage females. In 1984, more than one out of every four black babies born was to a teenage mother. In fact, 29 percent of babies born was to a teenage mother. Twenty-nine percent of babies born to white teens was outside of marriage,

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compared to 83 percent for black teens. Infant mortality rate among blacks was also disproportionately high.

Kansas Teens

- In 1985, 72 births in Kansas were to children 10-14 years of ages and 4,420 to teenagers 15-19 years of age.
- In 1985, teens accounted for 11.4 percent (4,492 births) of all live births in Kansas while 15 percent of all low birth weight infants had teen mothers.
- In 1970, 23.1 percent of teenagers giving birth in Kansas were unmarried. In 1985, this figure increased to 48 percent.
- In 1985, 9.7 percent of births to Kansas teenagers under 18 years of age were low birth weight compared to 6.1 percent for all births.
- In 1985, the infant mortality rate in Kansas for children born to mothers under age 18 was 18 percent while the overall infant mortality rate for Kansas was 9.1 percent in 1983.
- In 1985, 35.2 percent of teenage Kansas women receiving Medicaid had inadequate prenatal care as compared to 30.7 percent of older Kansas women receiving Medicaid.

Kansas Ranking Among States

- In 1983, 13 percent of Kansas births were to unmarried mothers. The U.S. average was 20.3 percent and Kansas ranked 42 out of 50 states. The rate tends to be well below the national average in many rural states and well above the national average in Southeastern and Southwestern states and New York. Mississippi was number 1 with 31.2 percent, while Utah ranked last (7.6 percent).

- In 1980, 10.1 percent of female teenagers (15-19) in Kansas became pregnant while the U.S. average was 11.1 percent. Kansas ranked 31 out of 50 states. Nevada was number 1 with 14.4 percent, and North Dakota ranked last (7.5 percent).
- In 1980, 29.6 percent of teen pregnancies ended in abortion in Kansas while the U.S. average was 38.6 percent. Kansas ranked 35 out of 50 states. Massachusetts was number 1 with 55 percent, and Utah ranked last (15.7 percent).
- In 1980, 56.3 percent of teen pregnancies in Kansas ended in birth while the U.S. average was 47.9 percent. Kansas ranked number 16 out of 50 states. Utah was number 1 with 69 percent, and Massachusetts ranked last (32.8 percent).

The consequences of too early childbearing are enormous. Many of the problems are not only related to the parents' youthful age but to their single parent status as well. Below are some of the major consequences:

I. **Education** - Studies of school dropout rates have shown that pregnancy is one of the major reasons why women do not complete high school. In Kansas, statistically, pregnancy and dropout rates would seem to bear this out though there is no reliable data to confirm the extent to which pregnancy is a factor. In a 1985 SRS survey of Kansas families receiving Aid to Dependent Children (ADC) payments, which is the state's largest program for cash assistance, only 51 percent of the teenage mothers had finished high school while 69 percent who delayed childbirth past the age of 19 had finished high school.

II. **Employment** - Employment opportunity is influenced by education level as well as by other factors. Because they are less likely to finish high school, job opportunities for teenage mothers are reduced. Young women who are not yet

mothers also avoid other related barriers to employment, such as day care expenses.

III. **Poverty** - Women who were teenage mothers are more likely to be poor and on public assistance than other mothers. In the 1985 SRS survey of Kansas families receiving ADC payments, approximately one-half of the families were headed by women who had been teenage mothers. A 1978 study by the Urban Institute showed that becoming a parent at an early age increases a woman's chances of being in poverty at some later date. One reason is that teenage mothers are more likely to have larger families than women whose first child was born when they were at least 20 years old. The 1985 SRS survey of ADC clients showed a strong association between teenage childbirth and larger families. For those mothers who were 14 years or younger at the birth of their first child, 71 percent had more than two children, and for those 15-17 year of age at the birth of their first child, 47 percent had more than two children. The rate for women who were 20-24 years of age was only 24 percent, and it dropped substantially, to 9 percent, for women 25-30 years of age at the birth of their first child. Moreover, the Kansas survey data showed that ADC clients who have more children are more likely to have been on ADC for long periods, have less education, are less likely to have had a job for longer periods, and are more likely to have difficulty finding day care.

IV. **Health Problems** - Low birth weight is a key factor in infant mortality. Low birth weight infants are five times more likely than normal birth weight infants to die before they are a year old. They are also more likely to have a neurological impairments, respiratory problems, or mental retardation as well as certain other types of handicapping medical conditions. Unmarried women and teenagers are both more likely to have low birth weight infants, primarily because they are less apt to receive adequate prenatal care.

In Kansas in 1985, 9.7 percent of births to women under age 18 were low birth weight, compared to 6 percent of all births. Teenage mothers are also more likely to have fetal deaths (stillbirths) than older mothers, except those over 35.

V. **Mental Health** - A 1978 study by the National Institute of Mental Health concluded that the greatest increases in depression in recent years have been among young, poor female heads of households.

VI. **Child Abuse and Neglect** - National studies, including those done by the American Human Association and the National Center on Child Abuse and Neglect, have shown that the reported incidence of child abuse and neglect is greatest among families with low incomes. (Most abuse or neglect of children is commited by a parent or guardian.) In Kansas, approximately one-third of all reported abuse or neglect occurs in families receiving public assistance. Because women who were teenage mothers are more likely to have low incomes and be recipients of public assistance, they are also more likely to abuse or neglect their children.

VII. **Child Support** - Teenage fathers are not immune to unanticipated difficulties of their own, even if they never marry or live with the child or the mother. Fathers can be legally liable for child support, and payments may be substantial even when the father is still a teenager.

Thus, pregnancy and childbearing reduces the likelihood a teenager will finish high school, diminishes her chances of future employment, and makes it more likely that she and her children will live in poverty in the future. Her children are more likely to be abused and neglected; to have health problems; to suffer deficiencies in language development, curiosity, and self-education; to have shorter attention spans and less coordination; and, they are more likely to

repeat grades. In addition, the unmarried teenage father may find himself obligated to make substantial monthly child support payments until his son or daughter becomes an adult.

Figure 1

ANTECEDENTS AND CONSEQUENCES OF ADOLESCENT PREGNANCIES