Approved March 6, 1991
Date

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS.

The meeting was called to order by Representative Kathleen Sebelius at
Chairperson

1:30 ~~a.m.~~/p.m. on Tuesday, February 12, 1991 in room 526-S of the Capitol.

All members were present except:
Representative Arthur Douville - Excused
Representative Sam Roper - Excused
Representative Clyde Graeber - Excused

Committee staff present:
Mary Torrence - Offec of the Revisor
Lynne Holt - Kansas Legislative Research Department
Mary Galligan - Kansas Legislative Research Department
Connie Craig - Secretary to the Committee

Conferees appearing before the committee: HB 2089
Dr. Julie Strickland, OB/GYN, KU Med Center
Joyce Volmut, Clinic Program Director, Shawnee County Health Dept.

PROPONENT - Representative Kerry Patrick, Kansas

OPPONENTS
Joan Upshaw, Clinical Social Work Agency, Overland Park, Kansas
Marilyn Harp, Board President, Planned Parenthood of Kansas
Carla Dugger, ACLU
Beth Powers, Kansas Choice Alliance
Kelly Kultala, National Organization for Women, Kansas
Pat Goodson, Right To Life of Kansas, Inc.
Peggy Jarmen, ProChoice Action League, Kansas
Liane Davis, Ph.D., Kansas Chapter of The National Association of Social Workers
Marsha Burris, Vice-President, BPW, Kansas
Carrie Lindsay, Member of the Kansas Welfare Rights Organization

Chair Sebelius called the meeting to order.

Chair Sebelius entertained requests for bill introduction.

John C. Bottenberg, on behalf of the Kansas Pawnbrokers Association, requested a bill be introduced amending K.S.A. 16-719(b)(2), which would remove the existing limit of $300 maximum loan per transaction, Attachment #1.

Representative Bill Roy moved that the Kansas Pawnbrokers Association amendment to K.S.A. 16-719(b)(2) be introduced as a bill. The motion was seconded by Representative Sherman Jones and the motion carried on a voice vote.

Representative Sherman Jones asked the Committee to introduce a bill to create a historic location at the old Quindaro town site in Wyandotte County, Attachment #2.

The motion to introduce Representative Jones bill was made by Representative James Cates and seconded by Representative Barbara Lawrence. The motion passed on voice vote.

Representative J.C. Long moved that the Committee introduce legislation similar to SB 609, increasing the days that bingo licensees can operate from three days to four days, and increases the daily prize from $1200 to $1500. The motion was seconded by Representative Gjerstad, and passed on a voice vote.

Representative J.C. Long moved that the Committee to introduce legislation that would make it illegal for parents to buy cereal malt beverages for their child or persons for which they have legal guardianship, amending House Bill 2136 (10)(A) subsection c. The motion was seconded by Representative Diane Gjerstad and passed on voice vote.

Representative Betty Jo Charlton made the motion to introduce a bill to take non-alcoholic beer out from the Cereal Malt Beverage law by definition and put restrictions on minor purchasing as there is on tobacco. The motion was seconded by Representative Joan Hamilton, and passed on a voice vote.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS,

room 526-S, Statehouse, at 1:30 a.m./p.m. on Tuesday, February 12, 1991.

Representative Betty Jo Charlton also moved that the Committee introduce legislation that would license and regulate locksmiths as an occupation in the same manner as electricians and plumbers. Representative Joan Hamilton seconded the motion which passed on a voice vote.

Representative Bill Roy moved that the Committee introduce a bill that would include residential mobile home parks in the Kansas Landlord-Tenant Law. The motion was seconded by Representative Betty Jo Charlton and passed on a voice vote.

HOUSE BILL 2089

Representative Kerry Patrick came before the Committee as a proponent of HB 2089. In his testimony, Attachment #3, he explained the bill, the cost of the program, the Norplant contraceptive, as well as giving information on selected Kansas birth statistics, social costs of birth and public policy rationale for the adoption of HB 2089. In regards to the constitutionality of providing financial incentive to use a contraceptive device, he stated that there is no case law in the area of a voluntary program of this nature. He also added that he would support the program if eligibility guidelines were expanded, and that the bill as it is written would allow the addition of a male contraceptive for men, also. He explained that the bill is like a 5-year contract, and that there is no criminal penalty should the recipient decide to have Norplant removed before the five years are up. The recipient would have to pay to have it removed by a health care professional, which would cost the recipient approximately $130, leaving a net profit of approximately $370. In respect to liability due to surgical mishap, Representative Patrick recognized that this would be a tort claim which could cost the state $500,000 a claim. In answer to a question by a Committee member, Representative Patrick stated that S.R.S. has indicated to him that involvement in a contraceptive program would raise almost 44% by AFDC recipients should a monetary incentive be provided.

Dr. Julie Strickland, an obstetrician and gynecologist at the KU Med Center, gave technical information on the Norplant System, Attachment #4, #5, #6 and #7.

Joyce Volmut, Clinic Program Director for the Shawnee County Health Department, gave a brief overview on the Family Planning Program, which began in 1965. Currently, there are approximately 6,500 women enrolled in the program, which makes 12,000 visits a year. Eight percent or between 500 to 600 women are recipients of Medicaid. Eighty-seven percent are at or below 150% of poverty. In addition, 200 to 300 additional women are seen in other services of the health department that provide medical care who are Medicaid eligible or are receiving Medicaid. The patients who are enrolled in Family Planning receive a compliment of services including a comprehensive health history and review; laboratory tests to rule out anemia and sexually transmitted diseases; they have a pap test; education on all contraceptive devices that are available; their blood pressure, height and weight are taken; and at this point they see a physician or an advanced registered nurse. The patient enrolls in a package, receives their contraceptives from that clinic, and it is required that they must maintain these services throughout the course of the treatment or they are no longer eligible for services. That means that they must come back once a year for an annual pap test. If patients don't follow through, they are no longer eligible for contraceptive management, although they may continue to use other health department services or can come back to that clinic for treatment. Patients in our particular program that have medical problems or other problems that do not make them candidates for one of the contraceptive devices, are referred to an OB/GYN specialist; and we also have social work consultation, but that depends on each particular program and county. Currently, S.R.S. pays for a package of services that is divided into three parts: the initial exam which includes all the affair mentioned components, three interim visits per year related to contraceptive problems such as counseling, and the annual exam. Cost for the initial exam is $68 and S.R.S. pays $30. Interim visits cost $41 of which S.R.S. pays $15. Annual visits costs $48 and S.R.S. pays $16.50. That makes about $81 that S.R.S. pays a year for a women who comes to the Clinic for Family Planning. Contraceptive methods are not paid in Family Planning Clinics, although they would be paid if the women went to a private physician. Revenue for services at Shawnee County Health Clinic's Family Planning Program comes from the federal government for family planning services that are contracted to us through the State, patient or third party reimbursement which could be S.R.S., and 50% comes from local tax dollars. When asked if Norplant could be an option, Ms. Volmut stated that it could only if S.R.S.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON FEDERAL AND STATE AFFAIRS,

room 526-S, Statehouse, at 1:30 ~~a.m.~~/p.m. on Tuesday, February 12, 1991

reimbursed for it. She expressed concerns about the transient person who might be difficult to track. She felt that tracking would have to be a very important part of the bill.

Joan Upshaw testified as an opponent to HB 2089, because the bill targets women, because it would push one product as the state approved method of birth control, it could place the state in legal liability and because of the racial implications, Attachment #8.

Marilyn Harp gave testimony opposing HB 2089, as outlined in Attachment #9. She added that this would not address the teenage pregnancy problem as most teens are not AFDC recipients.

Carla Dugger with the American Civil Liberties Union opposed the "Norplant" bill because of serious constitutional questions. No written testimony was available.

Beth Powers handed out written testimony, Attachment #10, which gave argument as to why this bill should not be favorable passed out of committee.

Kelly Kultala with the National Organization for Women, urged the Committee not to support HB 2089, as outlined in her written testimony, Attachment #11.

Written Testimony, Attachment #12, from Barbara Holzmark, National Council of Jewish Women/Greater Kansas City, urged the Committee to not support HB 2089.

Pat Goodson with Right To Life opposed HB 2089 because it is antithetical to traditional moral values and will encourage promiscuity. Other reasons to oppose this bill are in her written testimony, Attachment #13.

Written testimony, Attachment #14, from Peggy Jarmen, Pro Choice Action League, stated various reasons why the Committee should not support HB 2089.

Liane Davis, Kansas Chapter of the National Association of Social Workers offered testimony in opposition to HB 2089 and urged the Committee to kill the bill, Attachment #15.

Marsha Burris offered written testimony opposing HB 2089 and asked the Committee to not favorably pass this bill out of committee hearings, Attachment #16.

Attachment #17 is written testimony from Ruth Macklin, Ph.D., Professor of Bioethics at Albert Einstein College of Medicine of Yeshiva University opposing HB 2089.

Carrie Lindsay came asked the Committee to not support HB 2089. She stated that as a recipient of AFDC, she felt that the money offered as incentive for use of the Norplant System could be better used in other areas such as KanWork. She stated that many times much needed programs that have been brought to the Legislature's attention are turned down due to a lack of money. She handed out to the Committee a "Test Your Welfare IQ" sheet. No other written testimony was available. (Attachment 18)

Committee adjourned at 3:17 p.m..

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE 2/12/91

(PLEASE PRINT) NAME	ADDRESS	WHO YOU REPRESENT
Eric Daigh	Topeka	KSNT-TV
Carel Wheeler	Topeka	KSNT-TV27
Mike Stephen	Chicago	NBC News
Jud Edwards	KCMo	WDAF-TV.
Todd Lakin	Junction City	JC High School
Heather Nunnery	Junction City	JC High School
[illegible] McKean	KC, MO	WDAF-TV
[illegible]	Chicago	NBC News
Will Belden	Topeka	LWVK
Sarah Pirece	Junction City	JC High School
Christopher Marinyese	Fort Riley	JC High School
Aruna Rangarajan	Junction City	Close-up KS. Junction City High School
Christina Culbertson	Junction City	Close up Kansas
Tom Brungardt	"	" " "
Cleta Renyer	Sabetha	Right to Life of Ks.
Laura McClure	Glen Elder	self
Julia McBride	Topeka	[illegible]
Beth Powers	Topeka	KCA
Michelle Liester	Topeka	John Peterson & Associates
Noble Smith	Muscotah Kans	
Amy Smith	" "	
Eileen Koitela	Mission, KS.	W.D.#1
Carrie Lindsey	Wichita	Kansas Welfare Rights Organization
Adele Hughey	4401 W 109th, OP, KS	Kansas Choice Alliance
Joan Millard	4401 W. 109th, OP KS	KS Choice Alliance
Betty Armstrong	4401 W. 109, OP KS.	Comprehensive Health for Women

Page 2

GUEST LIST

FEDERAL & STATE AFFAIRS COMMITTEE

DATE 2/12/91

(PLEASE PRINT)

NAME	ADDRESS	WHO YOU REPRESENT
Carla Dugger	ACLU / 201 Wyandotte #209 KCMO 64105	ACLU of Kansas & W. Missouri
Marian Shapiro	122 E. 12th Hays KS 67601	Planned Parenthood of KS
Darlene Stearns	1248 Buchanan Topeka 66606	RCAR In Ks
Kelly Kultala	KCKS	NOW
Joyce Volmut	3413 Lakeside Topeka 66614	Topeka Shawnee Co. Health
JAN BUEKER	817 S.W. SIXTH 66603	K. NASW
Peggy Jarman	Wichita	PCAL
Diane V Davis	4101 Wimbledon Dr. Lawrence 66047	KNASW
Jennifer Brandeberry	1213 SW. Washburn Ave. Top. Ks. 66604	PCAL
Marilyn Harp	2251 Bramblewood #202 Wichita, KS 67226	Planned Parenthood of Ks.

BOTTENBERG & ASSOCIATES

JOHN C. BOTTENBERG

February 12, 1991

The Honorable Kathleen Sebelius
Chair, House Federal
& State Affairs Committee
State House
Topeka, Kansas 66612

Dear Madame Chair:

On behalf of the Kansas Pawnbrokers Association I am requesting the House Federal and State Affairs Committee introduce a bill amending K.S.A. 16-719(b)(2). The requested amendment would remove the existing limit of $300.00 maximum loan per transaction.

The current limit has been in effect since 1972. The artificially low limit of $300.00 per transaction places an unreasonable burden on Kansas pawnbrokers and hinders their ability to serve their customers. I have attached a copy of the requested amendment to this letter.

If you have any questions, please do not hesitate to contact me. Thank you for your consideration of this request.

Sincerely,

John C. Bottenberg

JCB:kmm
Enc.

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #1 - pg.1

800 SW Jackson • Suite 1120 • Topeka, Kansas 66612 • (913) 235-2324 • FAX (913) 357-3390

16-719. Interest and charges on pawnbroker transactions; applicability of other laws; maximum charges; terms of loans. (a) On and after July 1, 1972, no pawnbroker shall contract for, charge, or receive directly or indrectly on or in connection with any pawnbroker transaction any charges, whether for interest, storage, insurance, service fee, handling, compensation, consideration or expense which in the aggregate are greater than the charges provided and authorized by this act. Any other provisions of law relating to interest, storage and such charges shall not be applicable to any pawnbroker transaction made in accordance with this act.

(b) Whenever any loan is made by a pawnbroker for which goods are received in pledge, the following maximum amounts may be charged:

(1) On any amount a charge may be added in an amount not to exceed ten percent (10%) per month or one hundred twenty percent (120%) per annum of the amount advanced to the borrower; and

~~(2)--The-maximum-amount-of-a-loan-authorized-by-this act-shall-not-exceed-three-hundred-dollars-($300)-per transaction.~~

(c) The term of any loan made under the provisions of this act shall be one (1) month. Loans may be extended or renewed by the payment of the charges herein provided monthly. The charges authorized herein shall be deemed to be earned at the time the loan is made and shall not be subject to refund. On loans under this act, no insurance charges or any other charges of any natue whatsoever shall be permitted.

1RS0614

______ BILL NO. _______

By

AN ACT declaring historic Quindaro town area located in Wyandotte county to possess unusual historical interest; authorizing the state historical society to acquire such area for and in the name of the state of Kansas.

Be it enacted by the Legislature of the State of Kansas:

Section 1. Historic Quindaro town area located in Wyandotte county, Kansas, is hereby declared to possess unusual historical interest. This town evolved through the cooperation of the Wyandot Indian landowners, white free-staters and black freedmen. It is the site of the only safe port-of-entry for the free-state abolition sympathizers that came to settle Kansas territory to insure free statehood status for Kansas, and it served as an "underground railroad station" for slaves to realize their deliverance to freedom. In addition, this area is the locale of the Freedman's university, one of the state's first educational facilities. It is further declared to be in the state's interest to preserve the natural beauty of the Quindaro town area by the development of a park and nature area at the site of Quindaro town area.

Sec. 2. (a) The state historical society is authorized and empowered to acquire by gift, purchase or by condemnation proceedings in fee simple in the name of the state from moneys appropriated for such purpose all or part of the historic Quindaro town area located in the northwest quarter of section 29 and the northeast quarter of section 30, township 10 south, range 25 east, Wyandotte county, Kansas, as may be specified by appropriation act of the legislature. Before any agreement is made to purchase such land, three disinterested appraisers shall be appointed in accordance with the provisions of K.S.A.

75-3043a, and amendments thereto, to determine the market value thereof, and no agreement shall be entered into nor purchase made of the land so appraised for a consideration greater than such market value appraisal. If the state historical society is unable to negotiate an agreement to purchase the lands herein described, the society may discontinue negotiation and proceed to acquire the fee simple title to such land by exercising the power of eminent domain and the attorney general, upon request from the state historical society or its authorized designee, shall immediately exercise the power of eminent domain in the name of the state for the acquisition of such property.

(b) The land described in subsection (a) shall be acquired in the name of the state of Kansas. If an agreement is reached to acquire the land by gift or to purchase such land, the agreement shall not become effective and the state historical society shall not take title to such land acquired by gift or issue a voucher in payment thereof for such land purchased until the attorney general has examined the abstract of title and deed to such land and has determined that such conveyance will convey such land in fee simple to the state of Kansas. Tracts of such land may be acquired separately either by gift, negotiation or condemnation.

Sec. 3. Upon acquisition of the property as authorized by this act, the same shall be placed under the control and management of the state historical society. The property shall be developed by the state historical society in cooperation with other state agencies within appropriations therefor. The state historical society shall have power to adopt rules and regulations relating to the use, preservation, development, improvement, control and maintenance thereof.

Sec. 4. This act shall take effect and be in force from and after its publication in the Kansas register.

KERRY PATRICK
REPRESENTATIVE, TWENTY-EIGHTH DISTRICT
JOHNSON COUNTY
10009 HOWE DRIVE
LEAWOOD, KANSAS 66206

STATE OF KANSAS

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: ENERGY AND NATURAL RESOURCES
LABOR AND INDUSTRY
LOCAL GOVERNMENT
JOINT COMMITTEE ON SPECIAL CLAIMS AGAINST THE STATE

To: House Federal and State Affairs Committee

Date: February 12, 1991

From: Kerry Patrick

Re: HB 2089

<u>I. Overview</u> -This Bill;

1. would create a new state program to provide **free of charge** to public assistance recipients, a payment of $500 if they are implanted with the Norplant contraceptive drug and a payment of $50 annually at checkup time to see that the drug is still working and to see how they are doing healthwise.
2. The program would be strictly **<u>voluntary</u>** and would also provide for annual checkups to the volunteer.

<u>II. Cost of Program in and of itself, per person, over the five year period is expected to be no greater than $1450. The average cost of providing the contraceptive chosen by the public assistance recipient over the same five year period is $1200.</u>

1. <u>First Year cost is projected to be $1050</u> . The cost of the Norplant drug and the physician to implant the drug is projected to be $480. The cost to administer a health exam to determine if the recipient can safely take the medication is expected to be $75. The public assistance recipient will receive $500 after the physician determines that the recipient can take the drug.
2. <u>Cost over next four years is projected to be $400</u>. The payment of $50 to the welfare recipient and $50 for the cost of the annual checkup.
3. According to SRS and the Legislative Research Department the cost to provide the contraceptive known to a public assistance recipient would cost the state at least $1200 **over a five year period.**

   a. When you look at the figures provided to you by SRS, as to the fiscal note and projected cost, they only look at the cost of the Pill for one year and not the cost of providing it for 5 years.

b. SRS fiscal note assumes **a 5% increase** in the number of individuals participating in this program than are participating in the current contraceptive program. I believe that this is too low a figure but I will accept it for purposes of the argument which I intend to make.

III. What is Norplant?

Dr. Julie Strictland, an obstetrician and gynecologist the KU Med Center, will be testifying after me in an informational role only, to tell you about the advantages and disadvantages of using this new drug. I've also provided for your reading an article from the December 24, 1990,***Time*** Magazine which gives you some additional information on the drug. Two key points from that article are;

1. Norplant has 1/10th to 1/20th the failure rate of other oral contraceptives which fail 3% of the time. In other words, Norplant is 200 to 300 times more effective than other oral contraceptives!

2. 3.5 million unwanted pregnancies occur each year in the U.S.

IV. Selected Kansas Birth Statistics

1. In 1989, there were **38,848 live births** to Kansas residents, representing a birth rate of 15.4 per 1000 population. Of those almost 39,000 births;

a. about 11,200 of them were births that required some form of "public assistance" with about 5500 of them being births to those individuals who are on AFDC.

1. 3731 of those deliveries were to individuals 21 and under. SRS statistics do not break out how many of these births are out of wedlock births but it safe to assume that a significant majority of these births were such.

2. about 1/3 of **all** births in Kansas are from individuals :eligible for some form of public assistance.

b. about 7700 of the 39,000 births, or 20% of all Kansas births, are out of wedlock pregnancies.

1. 71.5% of the births in this category occurred to women in the 15-24 age bracket.

2. Of the births to teenage women in 1989, 79.2% were white and 18.3% were black.

2. In 1989, 89% of Kansas live births were to white mothers, 8.4% were to black mothers and 2.6% were to other races. SRS statistics do not break out the racial demographics of the deliveries.

V. Social Costs of Births

1. **The cost of giving a public education,** according to Legislative Research, to a child born today through age 18 is projected to cost the taxpayers of the state of Kansas about **$80,000**. This assumes that they do not require any special education or any form of special educational services.

a. The education of 7700 out of wedlock births in Kansas public schools will cost the Kansas taxpayers, assuming that they all remain Kansas residents and that they all live until they turn 18, is **$616 million**.

b. The expense of educating 5500 AFDC births in Kansas public schools will cost the Kansas taxpayers, assuming that they all remain Kansas residents and that they all live until they turn 18, is **$440 million**.

c. The expense of educating 3731 under 21 Medicaid deliveries in Kansas public schools will cost the Kansas taxpayers, assuming that they all remain Kansas residents and that they all live until they turn 18, is **$299 million**.

2. According to Legislative Research, the cost of maintaining one child in a two person unit through 18 years is estimated to cost the taxpayers $205,000 in public assistance. This estimate does not assume any child care expenditures or other emergency or utility assistance which the family might receive from the state.

a. Assuming that all 5500 AFDC mothers and their children stay on welfare for the next 18 years, it will cost the Kansas taxpayers, assuming that they all remain Kansas residents and that they all live until the child turns 18, **$1.13 billion**.

b. The expense of educating 3731 under 21 Medicaid deliveries in Kansas public schools will cost the Kansas taxpayers, assuming that they all remain Kansas residents and that they all live until they turn 18, is **$765 million**.

c. Based on current federal participation rate, Kansas taxpayers would pay about $86,000 of the $205,000 so the cost to Kansas taxpayers out of their state taxes, using the above assumption, is about **$473 million**.

3. Without taking into account the increased effectiveness of Norplant over the Pill, a 5% increase in the number of AFDC individuals participating in a contraceptive program because of the financial incentive, and assuming a static AFDC population, should equate into a reduction by 275 in the number of AFDC births based on FY 1990 statistics. The savings to the Kansas taxpayer then is;

a. Educational expenses-**$22 million**

b. Public Assistance expenses -**$56.38 million**; and the cost to Kansas taxpayers out of their state taxes; **$9.9 million**.

(All of the above figures have been obtained from and through Legislative Research Department)

VI. Public Policy Rationale for Adoption of HB 2089

In addition to the obvious savings to the taxpayers of Kansas as a result of the enactment of HB 2089, there are many social and humanitarian reasons for doing so.

Since first elected to the Kansas Legislature 10 years ago, I have listened to many debates the availablity to all segments of our society any and all forms of contraceptives. The result of listening to those debates caused me to introduce HB 2089.

The cost to a public assistance recipient to use the Norplant device is staggering. It would cost them upfront $550 of their meager resources. Unless we provide it to them, the public assistance recipient would simply be unable to obtain this kind of contraceptive device. **Why should the latest in medical advancements in technology be available only to the wealthy?**

Norplant is more effective than any other contraceptive device available to the public assistance recipient today. Some recent social research has shown that those individuals on AFDC that have a second pregnancy, depending upon the geographical region in which you reside, **80 to 90% of those individuals will be on some form of public assistance for the rest of their lives.** By making Norplant available to public assistance recipients, we reduce the number of unwanted pregnancies and we give those mothers and potential mothers, a better chance to break the cycle of poverty and despair. Vote for HB 2089 if you care about the woman.

The availability to the poor of safe long term contraception coupled with a financial incentive to promote it's usage is nothing to be ashamed of. All kinds of government programs at the Federal and the State, level provide incentives both financial and otherwise to persuade individuals to act in a sort of socially desirable behavior. For example, we give certain non profit organizations tax exempt status and we give donors to these groups tax deductions because we believe groups like the Salvation Army or Planned Parenthood provide worthwhile social services.

What HB 2089 does is take that concept and applies it on a personal level. We let the public assistance recipient make a choice to be involved or not in this program. I believe that they are intelligent enough and wise enough to make that decision for themselves. Some of the opponents to this bill are saying in effect that we know better, that we can do a better job of taking care of them than they can take care of themselves. I believe that it is time to do away with these kind of patronizing attitudes.

This bill empowers female public assistance recipients in giving them more control over their future. It gives them a greater chance to break the cycle of despair and poverty. If we will approach HB 2089 with an open mind to the evidence, we will no doubt see that the long range benefactors of such a plan will be the women of Kansas who will better be able to avoid the terrors of unwanted pregnancies,the children of Kansas whose future is in our hands today and lastly, the taxpayers.

enditure Detail — House Bill No. 2089

FY [illegible]

Program	Item	Total AFDC	Participation Rate	Participating Persons	Cost	AF	SGF
AFDC	Initial $500 payment	80,263	16.43%	13,187	500	6,593,592	6,593,592
Reg Med Assist	Cost of Implant	80,263	16.43%	13,187	550	7,252,850	725,285
	Offseting Cost of Current Contraceptive [1]	80,263	11.43%	9,174	240	(2,201,770)	(220,177)
	New Participants Health Care Exams	80,263	5.00%	4,013	75	300,986	30,099
	Total					11,945,657	7,128,798

Assumption
1. Current family planning participation rate = 11.43%. A 5% participation increase is assumed with Norplant

FY 1993

Program	Item	AFDC Entrants	70% of Prior Year AFDC	Participation Rate	Participating Persons	Cost	AF	SGF
AFDC	Initial $500 payment (30% New entrants)	24,323		16.43%	3,996	500	1,998,149	1,998,149
	Annual $50 payment [2]		56,184	16.43%	9,231	50	461,551	461,551
Reg Med Assist	Cost of Implant — new entrants	24,323		16.43%	3,996	550	2,197,964	219,796
	Cost of Removal (20% of prior year) [3]				2,637	100	263,740	26,374
	Offseting Cost of Current Contraceptive	24,323	56,184	11.43%	9,202	240	(2,208,472)	(220,847)
	Health Care Exams	24,323	56,184	5.00%	4,025	75	301,902	30,190
	Total						3,014,833	2,515,214

Assumption
2. Assumes 30% AFDC turnover
3. 20% is a rough assumption
4. The number of births that would not occur as a result of the Norplant contraceptive cannot be determined at this time.

Recurring Cost [5]

Program	Item	AF	SGF
AFDC	Initial $500 payment (30% New entrants)	2,078,075	2,078,075
	Annual $50 payment	480,013	480,013
Reg Med Assist	Cost of Implant — new entrants	2,285,882	228,588
	Cost of Removal (20% of prior year)	274,290	27,429
	Offseting Cost of Current Contraceptive	(2,296,811)	(229,681)
	Health Care Exams	313,978	31,398
	Total	3,135,427	2,615,822

Assumption
5. Recurring cost reflects FY 1993 cost inflated by 4% per year.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

Room 545-N – Statehouse

Phone 296-3181

January 29, 1991

TO: Representative Kerry Patrick Office No. 174-W

RE: Public Assistance Clients

This letter is in response to your request for information concerning the public assistance program and certain pregnancy related expenditures.

1. Specifically, you requested information concerning an estimate of how much would be expended on one child from birth-age 18 on public assistance.

   As you are aware, the Aid to Families with Dependent Children (AFDC) is an assistance program to certain families with dependent children. Thus, a single individual without dependent children is not eligible for the program. This scenario assumes that a child is born to a single parent who has no other children. The benefits to the family unit from birth of the child to age 18 would be estimated to total $204,441, including $2,500 for a normal delivery and newborn hospital stay and $201,941 for 18 years of public assistance benefits for the two-person (parent and child) family unit. Based on the current federal participation rate, the state share would equal approximately $86,834. This scenario is based on escalation of the current average cash grant for a two-person family with a 2 percent inflation factor annually; the escalation of the current average household food stamp benefit by a 6 percent annual inflation factor; and the escalation of the current average medical benefits for a two-person family by an 8 percent inflation factor. It should be noted that these inflationary increases assume no specific action on the part of the state to curtail expenditures. For each additional child in the family unit, it is estimated that an additional $82,846 would be expended over 18 years. Based on the current federal participation rate, the state share would equal $35,624. These costs do not assume any child care expenditures or other emergency or utility assistance which the family might receive.

   Thus, in summary, the cost of maintaining one child in a two-person family unit through 18 years is estimated to total $201,941; for an additional child the cost would rise by $82,846.

2. You also asked about the costs to the medical assistance program for pregnancies and pregnancy related admissions. Summary data is provided below for your review.

   -- The number of pregnancy related hospital admissions paid for by the medical assistance program (Medicaid and the state funded MediKan program) has grown from 3,323 in FY 1986 to 6,848 in FY 1989 to over 11,000 in FY 1990. The increase is primarily attributable to expansion of the pregnant women and children program eligibility to 150 percent of the federal poverty level. However, the number of AFDC pregnancies has also increased.

   -- In FY 1990, hospital claims paid relating to pregnancy and delivery totaled $30.3 million, of which approximately $13.9 million was from state funds. This represented approximately 26 percent of the total hospital budget

   -- Pregnancy and delivery related claims accounted for approximately 46 percent of all claims submitted by volume.

3. I have requested more specific information concerning teen and single parents and "crack" babies and will forward this information to you upon its receipt.

4. A statewide map of Medicaid expenditures by county in FY 1990 is enclosed.

If you have questions or need additional assistance, please contact me at the Research Department.

Laura Howard
Senior Fiscal Analyst

Enclosure

91-87/LH/jl

A Pill That Gets Under the Skin

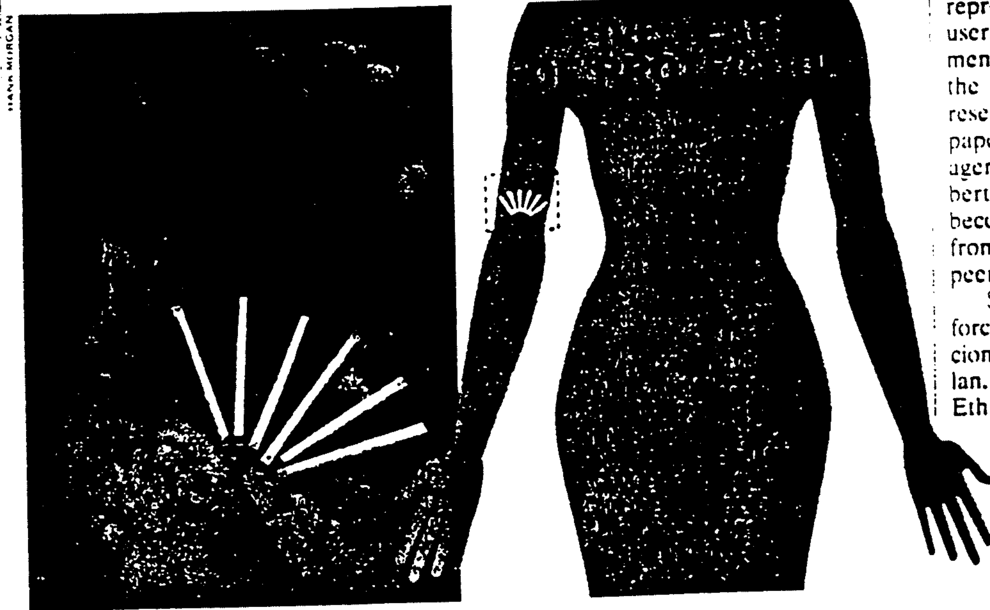
Norplant could spur birth control—and stir controversy

By ANDREW PURVIS

For a country in which medical breakthroughs occur with dizzying regularity, the U.S. has been disturbingly backward in the field of contraception research. Not a single fundamentally new birth-control method has been introduced since the Pill and the IUD, or intrauterine device, came out in the early 1960s. Meanwhile, in several European countries, a series of contraceptive innovations has broadened the range of methods far beyond what is available in the U.S.—and sharply reduced the number of unwanted pregnancies.

Thus many American health experts were delighted last week when the Food and Drug Administration finally approved Norplant, a long-lasting contraceptive that is implanted under the skin. Already available in 16 other countries, the method not only is highly effective but also provides five years of protection against pregnancy with a single implant. How American women will respond to this new alternative, though, is not clear, since Norplant's long-term safety has yet to be fully studied, and it does have a few side effects. Some critics fear that the five-year implant will be used by policymakers as a way of forcing contraception on women deemed unfit for motherhood.

Norplant is essentially an old contraceptive in a new package. Developed by the Population Council, an international nonprofit research group, and Wyeth-Ayerst Laboratories, a division of American Home Products Corp. of Philadelphia, the method prevents pregnancy by using the hormone progestin, which with estrogen is the active ingredient in most birth-control pills. Norplant consists of six progestin-filled silicone tubes, each about the size of a matchstick. In a simple 15-minute procedure, a doctor inserts the tubes just beneath the skin in a woman's upper arm. Once in place, the tiny cylinders start releasing progestin into the bloodstream. The flow continues until the hormone is depleted—usually in about five years. If a woman wishes to become pregnant earlier, she can have the tubes removed, and fertility will be restored in less than 48 hours. In clinical trials Norplant was remarkably effective. During the first two years the implant had one-tenth to one-twentieth the failure rate of oral contraceptives, which fail 3% of the time. Surveys of women who have used Norplant—a total of 350,000 worldwide—show that 80% are willing to stick with the contraceptive for at least one year.



HANK MORGAN

The method does have drawbacks. Progestin causes irregular menstrual bleeding in 75% of women who use it. Women may get their periods at odd intervals, such as 3 or 7 weeks apart, and some could miss one altogether. The periods themselves can also be longer, an average of 8 days of bleeding or spotting as opposed to the normal 5 days. These effects diminish after the first two years, according to the manufacturers. In addition, the cost, although less than that of oral contraceptives, will be considerable. Wyeth-Ayerst officials will not reveal the price until marketing begins in February, but some experts have estimated that the implant and the medical procedure together will run to about $500, as opposed to an average of $900 for five years of the Pill.

Norplant's biggest advantage over other contraceptives is that it requires only one birth-control decision every five years. The method will be useful to young women who want to delay their first pregnancy and to older women who want a reversible alternative to sterilization, which is now the most common method of contraception in the U.S.

But the same advantages that recommend Norplant to many women also raise the specter of abuse. Some health experts fear that legislators and judges will try to use the method as a way of restricting the reproductive freedom of teenagers, drug users, convicted child abusers or even the mentally ill. Economist Isabel Sawhill at the Urban Institute, a Washington-based research organization, recently published a paper in which she suggested that all teenagers be encouraged to use Norplant at puberty. "The decision to have a child would become a conscious choice—decoupled from the dictates of biology, hormones and peer pressure," she wrote.

Sawhill is not recommending the use of force, but some experts believe that coercion is an inevitable next step. Arthur Caplan, director of the Center for Biomedical Ethics at the University of Minnesota, points to a handful of cases in the past five years in which judges have tried to require women to take oral contraceptives or to force men to take drugs that lessen their sexual drive. "There are judges out there who will try to use Norplant," says Caplan. Others worry that some developing countries will force the contraceptive on women without their full consent in a misguided attempt to keep population growth down.

The controversy over Norplant highlights a general dissatisfaction with the state of contraception research in the U.S. Numerous other methods are being studied around the world, including a hormone-releasing IUD, a hormonal badge that is taped to the arm and releases a contraceptive through the skin, a female condom and a hormone-emitting vaginal ring, which a woman can insert and remove at will. The French abortion pill, RU-486, is being actively considered for approval in several other European countries but has not been approved in the U.S. Thanks in part to political skittishness about funding contraception in the U.S., American women still have a paltry array of birth-control choices. Many experts see this contraceptive gap as the chief reason why 3.5 million unwanted pregnancies still occur each year in the U.S. Policymakers are a long way from stopping that national tragedy, but the approval of Norplant may be a start. ■

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #3 - pg.9

EVERY DAY DURING 1989*

Each day Kansas residents experienced approximately....

106 Live births
21 Out of wedlock live births
1 Infant death
1 Fetal death

21 Heart disease deaths
14 Cancer deaths
4 Cerebrovascular disease deaths
3 Chronic obstructive pulmonary disease deaths
3 Accidental deaths
2 Pneumonia and influenza deaths

Each day in Kansas there occurred approximately....

61 Marriages
34 Marriage dissolutions
and
20 Abortions

*BASED ON 365 DAYS IN A YEAR

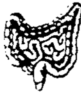
Figure 1

FY 1990 MEDICAID DELIVERIES by AGE 21 and under

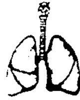
RECIPIENT AGE	# OF DELIVERIES
13	8
14	26
15	82
16	180
17	352
18	676
19	896
20	800
21	711
	3,731

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #3 - pg. 12

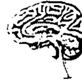
DRUG ABUSE IS CHILD ABUSE



The effects of cocaine abuse have been directly linked to certain congenital anomalies in infants, including intestinal atresia, limb reductions, and brain disruptions. These infants are also at a greater risk for congenital heart, urinary tract, ...



Approximately 80% of the offspring of heroin-dependent women who receive no prenatal care experience serious medical problems such as intracranial hemorrhages and respiratory distress syndrome.



Neonates exposed to cocaine in utero have been documented to experience neurobehavioral abnormalities. They tend to be irritable and easily overstimulated.

The use of amphetamines during pregnancy may increase the occurrence of cardiovascular defects in the offspring.

If your patients are abusing drugs, tell them the facts, counsel them, recommend treatment programs...help them.

Source: ACOG and American Council for Drug Education

WS 0964A

Partnership for a Drug-Free A

Contact: Lobsenz-Stevens
Chris Tatarian
Laurie McGrane
(212) 684-6300

The Population Council
Sandra Waldman
(212) 644-1692

Wyeth-Ayerst Laboratories
Audrey Ashby
(215) 971-5823

WYETH-AYERST INTRODUCES NORPLANT® SYSTEM (levonorgestrel implants) AN ALTERNATIVE TO STERILIZATION

New York, NY, December 10, 1990 -- Today, the FDA has announced market clearance for the Norplant® System (levonorgestrel implants), a reversible, five-year, low dose, progestin-only contraceptive for women. This eagerly awaited medical advance is the most innovative contraceptive in 30 years. It not only provides a long-term contraceptive option for many women of reproductive age but also may provide an alternative to sterilization. The Norplant System prevents pregnancy for five years. Unlike sterilization, the Norplant System is easily reversed at any time upon removal, allowing the woman to return to her previous level of fertility.

The Norplant System has been tested worldwide for more than 20 years. It has been used by 500,000 women in 46 countries. The Norplant System consists of six small flexible capsules (each 1.3 inches long) that are placed under the skin in the upper arm and continuously release a low dose of the progestin -- levonorgestrel. The Norplant System becomes effective within 24 hours when placed during the first seven days of the menstrual cycle.

"The Norplant System has proven to be highly effective in clinical use," says Dr. Marc W. Deitch, Vice President of Medical Affairs and Medical Director of Wyeth-Ayerst Laboratories. "During the full five years of use, the chance of becoming pregnant averages less than 1 percent a year. The Norplant System is well tolerated. The most common side effect is irregular menstrual bleeding which varies from woman to woman, but tends to decrease within six to nine months after placement. Overall, women are highly satisfied with the Norplant System. In fact, in one major U.S. study population, 94% of current users said they were satisfied and would use Norplant again."

"The Norplant System is another important milestone in Wyeth-Ayerst's continued commitment to bringing medical advances to American women," said Fred Hassan, President of Wyeth-Ayerst. "The Norplant System broadens the contraceptive options for women. Today, many couples resort to sterilization, and it is rewarding for us to know that many of them will not have to choose this surgical procedure."

The female sterilization procedure, tubal ligation, can be a major operation that requires anesthesia and a hospital stay. In comparison, placement of the Norplant System is a 10 to 15 minute procedure performed with a local anesthetic in a doctor's office. It involves a small incision -- stitches are not needed -- covered by a small bandage that is removed within a few days.

"The Population Council, developer of the Norplant System, has emphasized the importance of accurate information and sensitive counseling for women who wish to use the Norplant System," says George Zeidenstein, President of the Population Council. "And we're pleased that Wyeth-Ayerst shares our commitment to proper instruction and counseling as the Norplant System is introduced to American women."

-more-

Wyeth-Ayerst Laboratories is a worldwide leader in the research and development of products for contraception and hormone replacement therapy. The Philadelphia, Pennsylvania-based company has a Female Healthcare Products Division to provide healthcare professionals with innovative, quality pharmaceuticals.

The Population Council, an international, nonprofit organization established in 1952, undertakes social and health science programs and research relevant to developing countries; and conducts biomedical research to develop and improve contraceptive technology.

# # #

*Norplant® is the registered trademark of the Population Council for subdermal levonorgestrel implants.

FACTS ABOUT THE NORPLANT® SYSTEM (levonorgestrel implants)

- o The Norplant System is a reversible, five-year, low dose, progestin-only contraceptive providing an effective option in family planning.

- o The Norplant System represents an innovative concept of continuous-release contraception that is highly effective yet does not require daily action on the part of the user.

- o Comprised of six thin, flexible Silastic® capsules (each 1.3 inches long) that release the hormone levonorgestrel, the Norplant System is placed under the skin in the upper arm in a fan-like configuration under local anesthesia. After insertion, levonorgestrel is continuously released at low doses through the capsule walls.

- o The Norplant System provides contraceptive protection within 24 hours of insertion. To ensure that the woman is not pregnant at the time of insertion, the capsules should be inserted within the first seven days of the menstrual cycle.

- o The Norplant System provides protection for up to five years. The Norplant System can be removed at any time prior to five years, returning a woman to her previous level of fertility. If a woman wants to continue using the Norplant System after five years, a new set of capsules can be placed at the time the existing set is removed.

- o Although the Norplant System may be used as a contraceptive option by many women of reproductive age, it is particularly suited for those who are considering the long-term contraceptive advantage of sterilization for themselves or their partners, yet would like the reversibility the Norplant System provides.

- o The Norplant System, which has an average annual pregnancy rate over five years of less than 1 percent, is one of the most effective forms of contraception available.

-more-

o The Norplant System prevents pregnancy through a combination of mechanisms, primarily ovulation inhibition and thickening of the cervical mucus.

o The Norplant System continuously delivers a low dose of the progestin levonorgestrel.

o The Norplant System contains only progestin and no estrogen, thereby making the Norplant System well suited to women for whom estrogens are not recommended.

o Released and successfully used in 17 countries, the Norplant System has undergone more than 20 years of extensive research and testing and was used by more than 55,000 women in 46 countries in preintroduction trials. The most frequently reported side effect is irregular menstrual bleeding. Irregularities vary from woman to woman and, for many women, tend to lessen within six to nine months of insertion.

o Wyeth-Ayerst, exclusive marketer of the Norplant System in the United States, is implementing an instructional program for physicians and consumers.

# # #

QUESTIONS AND ANSWERS ABOUT
THE NORPLANT ® SYSTEM (levonorgestrel implants)
PLACEMENT AND REMOVAL

Q. Where in the body is the Norplant System placed?

A. Studies have shown that the optimal site for the Norplant System is the inside part of the upper arm, where the capsules are placed just under the skin.

Q. Does placement of the Norplant System require a surgical procedure?

A. The placement of the Norplant System requires an office-based procedure that usually takes 10 to 15 minutes. The procedure is performed with a local anesthetic and no stitches are required.

Q. Specifically, how is the Norplant System placed under the skin?

A. The six Silastic ® capsules that comprise the Norplant System are placed under the skin of the upper arm in a fan-like configuration through a 1/8-inch incision using a hollow instrument called a trocar. Once the capsules are in place, the incision is covered with a small bandage and protective gauze. No stitches are required; since the incision is small, scarring is minimal.

Q. Who can insert the Norplant System?

A. The Norplant System is placed under the skin of the upper arm by healthcare professionals. Wyeth-Ayerst, exclusive marketer of the Norplant System in the United States, is conducting a nationwide physician education and instruction program.

Q. Can you see the capsules once they've been placed under the skin?

A. The capsules usually cannot be seen unless the woman is very thin or muscular. The site of insertion, the inner part of the upper arm, is discreet and the capsules are not easily noticed.

-more-

Q. Do the Norplant System capsules migrate?

A. The capsules remain where they are placed in the upper arm and should not migrate.

Q. How is the Norplant System removed?

A. The capsules are removed by a healthcare provider by a procedure similar to insertion. Capsules are removed under local anesthesia through the same incision in which they were placed. The removal procedure usually takes 15 to 20 minutes. The patient will then return to her previous level of fertility.

Q. When should the Norplant System be removed?

A. The Norplant System must be removed after five years; however, it can be removed sooner if desired. If continuing contraception is desired, a new set of capsules can be placed under the skin at the time of removal.

# # #

QUESTIONS AND ANSWERS ABOUT THE NORPLANT® SYSTEM
(levonorgestrel implants)

Q. What is the Norplant System?

A. The Norplant System -- a reversible, five-year, low dose, progestin-only contraceptive -- is an innovation in family planning. The long-term contraceptive provides women with an effective method of contraception for up to five years, broadening existing family planning choices.

Q. Who can use the Norplant System?

A. The Norplant System may be used as a contraceptive option by many women of reproductive age. It is particularly suited for women who are considering the long-term contraceptive advantage of sterilization for themselves or their partners, yet would like the reversibility the Norplant System provides.

Q. How effective is the Norplant System?

A. Aside from sterilization, the Norplant System is one of the most effective forms of contraception. The Norplant System has an average annual pregnancy rate over a five-year period of less than 1 percent.

Q. How does the Norplant System work?

A. Consisting of six thin, flexible Silastic® capsules (each 1.3 inches long) that contain the synthetic hormone levonorgestrel, the Norplant System is placed under the skin of the upper arm. A low dose of levonorgestrel is then continuously diffused through the walls of the capsules into the body. The Norplant System prevents pregnancy through a combination of mechanisms including ovulation inhibition and thickening of the cervical mucus. The Norplant System is convenient and, unlike the diaphragm and other "barrier" methods, does not require any action prior to intercourse.

-more-

Q. How does the Norplant System differ from oral contraceptives containing levonorgestrel?

A. Most oral contraceptive pills are "combination pills" containing both an estrogen and a progestin. The Norplant System contains only the progestin levonorgestrel. The Norplant System contains no estrogen, making the Norplant System a good option in women for whom estrogens are not recommended.

Q. How is the Norplant System inserted?

A. The Norplant System is placed under the skin of the upper arm by a healthcare professional in an office-based procedure, which usually takes 10 to 15 minutes and is performed under local anesthesia. The capsules are inserted in a fan-like configuration through a 1/8-inch incision. Once the capsules are in place, the incision is covered with a small adhesive bandage and protective gauze. No sutures are required and most women will have only minimal scarring.

Q. How safe is the Silastic material?

A. The Silastic material has been used since the 1950s. It is the same material currently used in heart valves and in other medical devices.

Q. When is the Norplant System inserted and when does it become effective?

A. To ensure that the woman is not pregnant at the time, the Norplant System should be placed under the skin within seven days after the onset of menstrual bleeding. As long as the Norplant System is inserted within this time period, a woman is protected from risk of pregnancy within 24 hours of insertion.

Q. Does the Norplant System cause any side effects?

A. The most frequently reported side effect experienced by Norplant System users is irregularity in the menstrual bleeding pattern. These irregularities vary from woman to woman and tend to lessen within six to nine months.

Q. Has the Norplant System been studied in the United States?

A. The Norplant System has been studied extensively in the United States. More than 1,000 women volunteered to take part in three U.S. clinical trials. The major investigators in the United States are Dr. Daniel Mishell (University of Southern California), Dr. Philip Darney (University of California at San Francisco) and Dr. Samuel Pasquale (University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School).

Q. What if a woman decides to become pregnant, or wishes to have the Norplant System removed for any other reason?

A. Should a woman decide to become pregnant or wish to discontinue use of the Norplant System, she should visit her healthcare provider to have the capsules removed. The capsules are removed by a procedure similar to insertion and can be removed through the same incision in which they were placed under the skin, under local anesthesia. Once the capsules are removed, a woman will then return to her previous level of fertility.

Q. How soon can a new set of capsules be inserted if a woman wishes to continue with the Norplant System at the end of five years?

A. Should a woman wish to continue using the Norplant System after five years, a new set of capsules can be placed under the skin at the same time the initial set is removed.

Q. How will the women obtain the Norplant System?

A. A woman interested in the Norplant System should contact her physician for information on the system and its availability.

# # #

Testimony before Kansas Legislative Committee
House Bill 2089
February 12, 1991

My name is Joan Upshaw. For fourteen years I worked in health care at a Kansas City area hospital both as a direct service worker serving clients/patients by delivering social work services and as a department director. For the last three years, I have owned a business in Overland Park that among its programs furnishes social workers to health care and mental health facilities in metropolitan Kansas City and Eastern Kansas area. In these experiences, I have worked with clients directly and in supervising health care social workers that serve persons this proposed bill targets for change.

I wish to state that I am speaking for myself, ~~the populations that my social work agency serves~~ as well as a significant number of health care social work directors within the Kansas City area.

My remarks before you will be brief and are intended to respect the difficult dilemma that all Kansans struggle with on a daily basis --- how to contain costs --- whether it be to maintain a minimal level of quality in our homes or to pay for the state programs we prioritize as essential.

It is my personal hope that you as legislators and decision makers will not decide to further House Bill 2089 (the Norplant Bill, as it is commonly known), will be one of those bills that you deem "essential" for the following reasons.

Point I: A family planning program should be comprehensive and not single out a particular sex or population.

For any state to be involved in family planning, the progam should be comprehensive and available to all men and women of its state.

House Bill 2089 arbitrarily selects "public assistance recipients" and further targets women as its intended population for changed behavior through financial incentives. This intended very targeted focused population raises questions of discriminatory and sexist nature even though I am sure that Representative Patrick did not intend such to happen.

Point II: The state would be seen as advancing Norplant or its equivalent as a famlly planning method of choice.

To build on the point that a state needs to provide a comprehensive program, this bill advances Norplant (or another functionally equivalent contraceptive) as what would be interpreted as the state approved method of contraception. All methods of proven safe and effective birth control as well as family planning options need to be advanced and available as a product or practice. Along with this, educational services and the monitoring of product use must also be provided.

Point III: Leading as a form of legal liability.

In social work practice, I advance options for client decision making sure to avoid choosing a course of action for a client. This practice is not just used because it validates a person's dignity, self direction, and their decision making right BUT also because I know that I can be sued for leading or directing a client to a product, practititioner or agency where an undesirous or damaging outcome is experienced. Had the state advanced or promoted IUD's in a legislative bill and law, the question becomes what legal liability and commitant tax dollar drain would the state have faced by now. Too many medical products are touted as efficient and safe, only to find out years later that they have serious side effects and damage to those who use them. Why not leave those type of decisions for personal decision making and not place the state in legal jeopardy on this product or its equivalence?

Point IV: Racial Implications

Another issue in this bill deliberation is one of race. Because approximately 28% of persons on public assistance in Kansas are persons of color (according to Kansas SRS 1988 statistics, the latest statistics readily available from SRS), all the fears, apprehensions, and oppressions felt by this population of Kansans will undoubtedly be intensified and at the very time that many of the nation's serious race issues are again surfacing across the nation. I hope you will obtain multi-sourced, advised feedback from various minority residents if it is not forthcoming today on this issue.

In summary, to single out women as adverse to men and women; to single out the poor who in this state are overrepresented racially within the public assistance population; to single out one method of birth control and advance its use through the seduction of money; to place the state in a leading position that may have legal ramifications; and not be sensitive to religious, ethnic, gender, and class issues is not prudent.

As a social worker, as an experienced health care service provider, as a woman, as a mother who was never enticed with money for not conceiving or bearing a child, as a Kansas resident and as a hard hit taxpayer, I ask that you deliberate this bill very carefully and hopefully decline to further advance its course.

Thank you.

Joan K. Upshaw, LSCSW

Joan Upshaw & Associates
Clinical Social Work Agency
10680 Barkley, Suite 200
Overland Park, Kansas 66212
(913) 648-2888

Testimony of Marilyn I
Board President.
Planned Parenthood of Kansas

Testimony on House Bill 2089

I would like to begin with some numbers. Kansas has 75,000 women, living at 150% of poverty or less, who are at risk of unintended pregnancy. (1987 report by the Alan Guttmacher Institute). 125,000 women at risk, if you increase this to 200% of poverty. What is Kansas currently doing to decrease the risk of pregnancy for these women?

First, Federal Title X family planning services are available through the Ks. Department of Health and Environment. However, women in 33 counties do not have these services available. In all counties, the money available does not fully meet the need.

Second, the state, through the Medical Assistance Program, makes contraceptives available to persons on ADC.

Now, we have a new type of contraceptive- Norplant. Only recently approved by the FDA, it is providing new opportunities for women and their medical providers. At present, only about 1,000 physicians are trained in the US to implant Norplant. The drug is not available on the market. When it becomes available, the cost is estimated to be about $350. for enough Norplant to last for 5 years. This is the first 'new' contraceptive in 20 years and is welcomed by many.

Unfortunately, legislation like H.B. 2089 is the one thing that could block the effectiveness of Norplant forever. Therefore, I speak in opposition to this bill.

I agree with the idea that Norplant should be available to public assistance recipients. A legislative requirement that Norplant be included in the list of drugs approved for Medical Assistance would be a welcome thing. It would insure that in the face of a tight budget, SRS did not ignore this new technology and that poor women have the same contraceptive options as other women.

The part of this bill I object to is the incentive payment. I do so for the following reasons:

1. It shows a total disre[illegible]rd for the ability of women to m[illegible] the right choices for themselves. Made available, I believe many women will take advantage of it, due to the convenience of the implant. It is very premature to think that an incentive payment is needed to encourage women to have children at appropriate times in their lives.

2. The incentive will limit the number of people who could be served. With 20,000 women in ADC households, the cost of the incentive would be high. Unless the state will guarantee full funding for all who request this program, the incentives limit by 2 each, the number of women who could use this contraceptive.

3. The incentive program is clearly coercive and is meant to be that way. To offer a women who monthly lives on less money than she needs, a $500 bonus to choose a particular form of contraceptive is coercion. In India, they offered the women radios to accept contraceptives. In Kansas, Representative Patrick thinks it will take a little bit more.

Is this really the way we want women to chose their form on contraceptive? Unfortunately, Norplant has many of the same risks that birth control pills do. Women who smoke and use Norplant greatly increase their risk of cancer. Women over 40 who use Norplant put their lives at risk. We would be asking these women to chose between a healthy contraceptive and this incentive payment. We should not ask Kansas women to make such a choice.

4. This program is limited to those on ADC, those who already have one child. The drug has the greatest potential for young women, before they have any children. This bill does not deal with those women.

5.. Finally, this bill risks rejection of Norplant by the very community that we hope will choose to use it. I spoke recently with Oretha Faust. Mrs. Faust has long been a worker in the black community in Wichita. While I don't always agree with her, I find her a good barometer of her community. She spoke of this bill as a great danger to this community. It reminded her of the days when sterilization was forced on poor black women. She promised that she was working hard to see that no one in her community chose to use Norplant. That is not the reputation Norplant deserves. It has too much promise to brighten the lives of so many people. But, it cannot be forced on anyone.

Like all decisions about reproductive choices, the decision about Norplant must be left to the woman. This must be about availability and choice - not about threats, stereotypes of large, welfare families and bribes.

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #10 pg. 3

Title X Family Planning Services

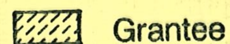
Kansas Department of Health and Environment

FY 91

CHEYENNE, RAWLINS, DECATUR, NORTON, PHILLIPS, SMITH, JEWELL, REPUBLIC, WASHINGTON, MARSHALL, NEMAHA, BROWN, DONIPHAN
SHERMAN, THOMAS, SHERIDAN, GRAHAM, ROOKS, OSBORNE, MITCHELL, CLOUD, CLAY, RILEY, POTTAWATOMIE, JACKSON, ATCHISON, JEFFERSON, LEAVENWORTH, WYANDOTTE
WALLACE, LOGAN, GOVE, TREGO, ELLIS, RUSSELL, LINCOLN, OTTAWA, DICKINSON, GEARY, WABAUNSEE, SHAWNEE, DOUGLAS, JOHNSON
ELLSWORTH, SALINE, MORRIS, OSAGE, LYON, FRANKLIN, MIAMI
GREELEY, WICHITA, SCOTT, LANE, NESS, RUSH, BARTON, RICE, McPHERSON, MARION, CHASE, COFFEY, ANDERSON, LINN
HAMILTON, KEARNY, FINNEY, HODGEMAN, PAWNEE, RENO, HARVEY, BUTLER, GREENWOOD, WOODSON, ALLEN, BOURBON
GRAY, FORD, EDWARDS, STAFFORD, PRATT, SEDGWICK, KINGMAN, WILSON, NEOSHO, CRAWFORD, ELK
STANTON, GRANT, HASKELL, KIOWA, BARBER, SUMNER, COWLEY, MONTGOMERY, LABETTE, CHEROKEE
MORTON, STEVENS, SEWARD, MEADE, CLARK, COMANCHE, HARPER, CHAUTAUQUA

Direct Support

Region VII Funded

 Grantee

REPRINT FROM *THE LOS ANGELES TIMES* -- JANUARY 13, 1991

PERSPECTIVE ON RACE AND POVERTY

Using Birth Control as Coercion

To compel or deny contraceptive use, such as Norplant, is immoral, inhuman and it targets the poor.

By FAYE WATTLETON

Acts of bigotry committed out of stupidity or senselessness are no more acceptable than those motivated by malice. Last month the Philadelphia Inquirer ran an editorial suggesting that Norplant, the new, long-term contraceptive implant, could be a useful tool for "reducing the underclass." A storm of well-deserved criticism erupted, focused on two points: the usage throughout the editorial of "underclass" and "black" as synonyms; and the proposal that black women on welfare be paid not to have children.

The Inquirer published a retraction, correctly labeling the editorial "misguided and wrongheaded." Unfortunately, the racist philosophy it espoused will surely rear its ugly head again.

The editors' first mistake was to blame the poor for poverty and brand all poor families as "dysfunctional." They added insult to injury by focusing this blame on African-Americans. By using "black," "poor" and "underclass" interchangeably, they left no doubt about whom they hold responsible for America's social ills.

Equally offensive was their call for a concerted societal effort "to reduce the number of children" born to poor black women. The editors pointedly avoided the term *unintended pregnancy*. Can it be that they do not care whether pregnancy among "the underclass" is intended or not? After all, they wrote, "these women already have one or more children." Do the editors deem "these women" unfit to make their own decisions about childbearing?

Even if we give the Inquirer editors the benefit of the doubt and assume that they were referring to unintended pregnancy, they were wrong to ascribe this problem uniquely to "underclass" African-Americans. The burden of unintended pregnancy falls heaviest on the disadvantaged, who lack access to the health care and other resources available to the affluent. But the problem is not confined to any one race or class.

The Inquirer hastened to reassure readers that increasing the welfare benefits of women who agree to use Norplant "is not [like] Indira Gandhi offering portable radios to women who agree to be sterilized." Where is the difference? In both cases, financial benefits are offered to induce contraceptive practice. Any successful incentive, by definition, undermines the individual's ability to make reproductive decisions free from interference. True, as the Inquirer pointed out, women taking Norplant "can change their minds at any time"—but surely any plan for "incentives" to become infertile would also include disincentives from becoming fertile. And to whom must poor women turn for removal of Norplant—to the same ethically questionable medical facility that may have conspired to "push" contraception in the first place?

For African-Americans who already fear that family planning efforts are thinly disguised eugenics, the Inquirer amply validated their fears. Its retraction will not set those fears to rest. Neither will the shocking and coercive action of a judge in Visalia, Calif. Earlier this month the judge (who is white) told a 27-year-old black woman who had pleaded guilty to child abuse that she must use Norplant as a condition for her probation. Because her lawyer was unable to attend the hearing, the defendant did not fully understand what she was agreeing to do.

As an African-American, I have spent 20 years fighting to ensure that no person is forced into any reproductive decision through societal pressures, through denial of comprehensive health services or by force of law. I have struggled against the few misguided zealots who claim that voluntary family planning amounts to genocide.

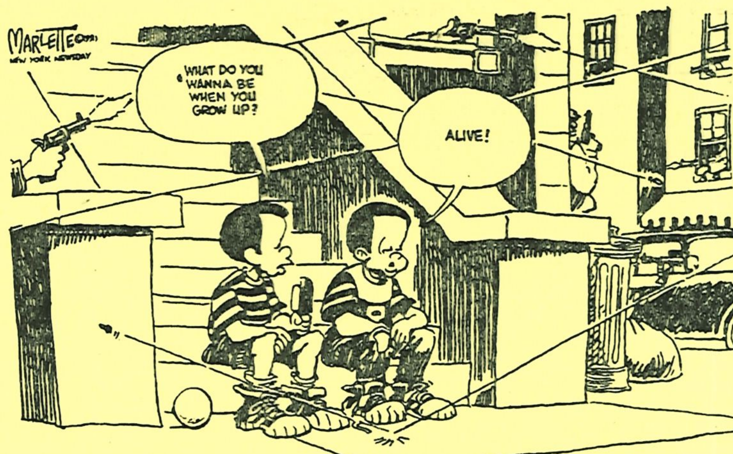
Fortunately, most Americans of all races recognize that voluntary family planning is their birthright and a precious tool for self-determination. But for poor people and young people, access to birth control is woefully inadequate—so inadequate, in fact, that one could argue that poor and young women are effectively coerced to have children.

Since 1978, federal Medicaid funds have been unavailable for abortion unless the woman's life is endangered; only 13 states use their own revenues to provide medically necessary abortions for low-income residents. Meanwhile, the contraceptive services that help reduce the need for abortion are under siege. The federal family planning program, has limped along without congressional reauthorization since 1985.

The Reagan and Bush administrations have tried to further cripple the program through a "gag rule" imposed in 1988. The "gag rule" (now under injunction pending a decision from the Supreme Court) would prohibit Title X-funded clinics from providing counseling or referral for abortion services—even if a patient asks for such information, and even if her health depends upon it.

Publicly funded clinics annually serve 4.1 million clients (mostly poor or near-poor) and help prevent 1.2 million unintended pregnancies and 512,000 abortions. Most of these clinics would forgo federal funding—and be obliged to turn away needy clients—rather than become partners in government-mandated malpractice. A health-care system in which the poor are denied information and services readily available to the affluent is unconscionable.

It is immoral and inhuman to coerce the childbearing decisions of any individual—either by compelling the use of contraception or by denying it. American or not, wealthy or not, white or not—every woman and man deserves the knowledge and the means to make healthy, private choices, free from bribery and manipulation.



Faye Wattleton is president of Planned Parenthood Federation of America.

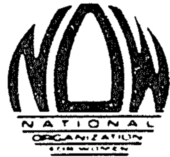
TESTIMONY FOR HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE
HB 2089
February 12, 1991

The Kansas Choice Alliance is a coalition of groups from accross the state of Kansas. Our mission is to maintain reproductive freedom for women in the state of Kansas. This freedom includes the freedom to choose or not choose to use birth control according to each woman's personal beliefs and desires.

HB 2089 suggests that the state should establish a greater interest in family planning than heretofore seen. We applaud this interest but seek to alter the approach mentioned in this bill. Aside from the legal and practical problems of implementing such a bill into law, the Alliance asks you to consider the ethical problems this bill presents. In offering women on public assistance a $500 "financial assistance grant" the state seems to be offering an incentive to such women not to reproduce with added financial bonuses yearly for continuing not to reproduce. Unfortunately, this approach perpetuates a paternalistic view of individuals deemed less fortunate than you or I.

If we truly want to help such women we can begin by offering them the full range of birth control devices at minimal cost, as well as education about responsible family planning.

Beth Powers KCA
Adele Hughey Co-chair KCA



To: House Federal & State Affairs Committee

From: Kelly Kultala - National Organization for Women

Re: Opposition to H.B. 2089

The National Organization for Women (NOW) maintains a committment to reproductive freedom for all Kansas women.

Statistics compiled by our national office in Washinton D.C. have shown that fifteen per cent of American women live below the poverty line and that the average annual income for women in the United States is about $16,000. Subsequently, the costs of birth control devices and pills often limits access of low-income women and girls to contraceptives.

NOW proposes that instead of paying women and girls to implant the Norplant contraceptive, which NOW sees as a form of coercion to women, the secretary of social and rehabilitation services should provide information on family planning and distribute birth control devices and pills to all men, women, girls and boys in the state of Kansas free of charge.

As a family planning bill, H.B. 2089 might have some merit. However, in its' current form, H.B. 2089 is regarded as oppressive to women and the legislature should expend as little time and energy as possible on it.

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #11

NATIONAL COUNCIL OF JEWISH WOMEN
GREATER KANSAS CITY SECTION

STATEMENT of NATIONAL COUNCIL OF JEWISH WOMEN
Greater Kansas City Section

Barbara Holzmark, Immediate Past President and Kansas Legislative Chair
Submitted to the Kansas House Federal and State Affairs Committee

February 12, 1991

In absence of a verbal testimony, please accept this written testimony on behalf of the Greater Kansas City Section of the National Council of Jewish Women (NCJW) in opposition to House Bill 2089; an Act concerning social welfare; establishing a program of special financial assistance grants to certain public assistance recipients who implant certain long-lasting contraceptives; prescribing powers, duties and functions for the secretary of social and rehabilitation services.

Established in 1893, NCJW is the oldest Jewish Women's organization in America with 100,000 active volunteers in 200 communities nationwide. In the greater Kansas City area, we are 1300 members strong. NCJW has been concerned with the rights, needs and quality of life of our nation's children and youth. We have been a major force among voluntary organizations that engage in public education, community service programming and advocacy on behalf of Children and Families. To quote from our National Resolutions, the National Council of Jewish Women believes that:

1. "Individual well-being, acceptance of the diversity of families and respect for human dignity are fundamental to a healthy society."

2. "Individual liberties and rights guaranteed by the constitution are keystones of a free and pluralistic society. Inherent in these rights is our responsibility to protect them."

3. "A strong system of quality public education is essential to American democracy. Inherent in the concept of public education is a strong belief in and strict adherence to the separation of church and state. Access to quality education is a fundamental right for all individuals."

4. "A free, secure and ordered society depends upon just laws and their equitable enforcement. Violation of the law should result in appropriate and expeditious action with proper regard for the protections of constitutional rights".

We therefore Endorse and Resolve to work for the following:

1. "Quality physical and mental health services, affordable and accessible to all, which emphasize prevention and health maintenance."

2. "Confidential family planning and reproductive health services for all, regardless of age and ability to pay."

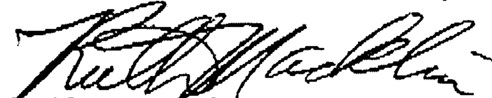
2310 W. 75th STREET, #LL1
SHAWNEE MISSION, KANSAS 66208-3508
(913) 677-0747

A third ethical problem lies in the fact that as a long-acting contraceptive, Norplant is a more restrictive means of birth control than other existing methods. A less restrictive measure for the state to adopt would be to support contraceptive education for women and free choice among contraceptive alternatives, including Norplant.

A final ethical consideration is the danger of setting a precedent for broader and more sweeping governmental control of citizens' reproductive lives. Potential future actions could include offering people incentives not to have children because of heritable genetic diseases; offering people with low incomes incentives not to have children because of their generally poorer health status; and preventing alcohol and drug users from reproducing because of the possibility of intrauterine damage.

This country witnessed one of its darker moments in the 1920s and 1930s, when zealots obtained many involuntary sterilizations of women, based on eugenic considerations. Trying to reduce the number of children born to welfare recipients appears to have an economic rationale rather than a eugenic one. At bottom, however, both amount to an ethically unacceptable intrusion into reproductive freedom.

Respectfully submitted,



Ruth Macklin, Ph.D.
Professor of Bioethics

3. "Family Life education, under the aegis of the public schools and other community institutions and agencies, which includes helping individuals deal responsibly with their sexuality".

4. "Funding for AIDS research, prevention and support services and treatment for individuals with the HIV-virus, AIDS-related complex and AIDS-related diseases".

5. "Enactment and enforcement of laws and regulations which protect civil rights and individual liberties".

6. "A constitutional amendment guaranteeing that equality of rights shall not be denied or abridged on the basis of gender".

7. "Affirmative action programs which ensure equal opportunity for all".

8. "The right to know and to have free access to public information".

9. "Prevention of the invasion or disclosure of personal records without the individual's consent".

10. "Protection of the right to privacy in sexual relations between consenting adults".

11. "The rights of patients, in consultation with medical personnel and without government interference, to make informal decisions about their own health care".

12. "A separate system of justice for children which provides for due process and takes into account their special needs and vulnerability.

13. "The development and implementation of early childhood education programs".

14. "Measures which ensure access to public education for children without a permanent address".

15. "A comprehensive human sexuality program to be taught by trained personnel in the public schools.

NCJW develops and implements programs which affect the lives of people of all ages, races, religions and economic backgrounds. NCJW focuses on family issues with a special emphasis on women and children. Our resolutions enable us to take action at the national, state and local levels. I have cited 4 out of 10 resolutions and many of the resolves that relate to HB 2089 directly or indirectly. In reviewing the bill utilizing the "Norplant contraceptive" there seems to be many questions unanswered as well as many abuses toward the individuals well-being, rights and liberties, lack of sexual education or family planning, and a free and secure society in which the "public assistant recipient" must endure. Please look for the answers to the following questions within HB 2089:

1. NCJW, being Pro-Choice, does not see where "choice" is a possibility in this bill. Are we educating these recipients as to the many contraceptive choices available and their duration of prevention?

2. There has been no reference as to the age of the recipient. Is she in need of notice or consent from someone in the immediate family if she is a minor?

3. Are the recipients children as well as mothers? Are one or both recipients on public assistance?

4. If the recipients are families, why has no consideration gone into the prevention on behalf of the father?

5. What are the side affects of the usage of the Norplant contraceptive and what would happen if a female could not continue its usage? If added expenses are involved, who is responsible?

6. In reference to the financial grant assistance, who is responsible for paying the grant, monitoring the grant records, and monitoring the recipient for abuse or neglect of the implant? Will the grant be given up front or half way through the first year? How will the additional grant for each successive year thereafter be awarded?

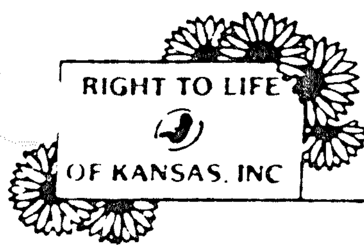
7. Who will be responsible for the procedure? Will the recipient receive the best qualified care by a licensed doctor?

8. Who will be privy to the confidential information on each recipient?

9. Will there be follow-up education for the remainder of the family?

These questions are unknown factors to the importance of HB 2089. I am in hopes that you will see that usage of the Norplant contraceptive is not a workable solution and that the rights and liberties of all would be better addressed through many other significant avenues such as confidential family planning and family life education. Thank you for your attention. If you have any questions, please feel free to contact me.

Barbara Holzmark
8504 Reinhardt Lane
Leawood, Kansas 66206
913/381-8222



Crosby Place Mall 717 S. Kansas Ave. Topeka, Ks. 66603 (913) 233-8601

TESTIMONY HOUSE FEDERAL AND STATE AFFAIRS

February 12, 1991

We appear in opposition to House Bill 2089. We oppose this bill for the following reasons;

NORPLANT is not just a contraceptive. It sometimes acts as an abortifacient to abort a tiny living preborn human child.

House bill 2089 is antithetical to traditional moral values and will encourage promiscuity.

The safety of NORPLANT is highly questionable.

Contrary to saving the state money, it could cost the state a great deal of the taxpayer's money.

NORPLANT provides no protection against sexually transmitted diseases.

This bill is coercive and violative of the rights of minorities.

NORPLANT is being sold as a contraceptive -- either as suppressing ovulation or preventing conception by inhibiting sperm migration. Nevertheless, its mode of action includes a prominent abortifacient effect. While surgical abortions may be avoided in women using NORPLANT, early chemical abortions will occur. The abortifacient effect occurs when the lining of the womb (endometrium) is made adverse to the implantation of the developing human after fertilization. In a test of NORPLANT, 24 women had a suppressed womb lining, 12 were irregular and only 5 were normal.

NORPLANT has the same side effects as the pill, but is being promoted as safer than the pill. However these claims must be viewed with suspicion, since women with contraindications that would prevent them from taking the pill were excluded from the testing.

of the highest damage awards ever, have been made to women who have suffered severe damage from contraceptive use. A few multimillion dollar lawsuits from this inadequately tested drug would cost more than the money it is supposed to be saving in welfare costs.

It has been proven that women taking the pill are at a substantially increased risk of contracting a venereal disease. Since the action of this drug is similar to that of the pill. We presume the same is true of NORPLANT.

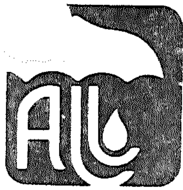
Can we foresee an increase in promiscuity and therefore as well as in venereal diseases and AIDS? Undoubtedly. We do not believe the people of Kansas are prepared to abandon the Judeo Christian ethic on which this nation was founded or to supplant morality with technology.

Finally we object to the coercive nature of this legislation. Kansas once led the nation in forcefully sterilizing patients in our institutions and prisons. House bill 2089 is a step back toward those days.

We urge the committee to report this bill adversely.

Respectfully submitted

Pat Goodson



American Life Lobby, Inc.
National Headquarters:
P.O. Box 490 / Stafford, VA 22554 / (703) 659-4171
Metro D.C. (703) 690-2510 — Fax (703) 659-2586

FACT SHEET
NORPLANT

New "Under the Skin" Abortifacient-Birth Control Drug/Device Implant

INTRODUCTION

An Advisory Committee to the U.S. Food and Drug Administration (FDA) has unanimously recommended FDA approval of NORPLANT, an "under-the-skin" birth control drug/device. Norplant consists of six hormone-filled Silastic rubber capsules surgically placed (using local anesthesia) under the skin of a woman's upper or lower arm, where they can sometimes be seen. The capsules release a synthetic progesterone called 'levonorgestrel' directly into the blood stream. The anti-fertility effect lasts for five years. NORPLANT is being developed by the Population Council, which was founded by the late John Rockefeller III.

[Editor's Note: The Food and Drug Administration approved NORPLANT on December 10, 1990.]

The FDA Committee found NORPLANT to be effective and at least as safe as the combined Pill. Committee member Dr. Paul G. McDonough said,"I think we could say safer." [1] Dr. Wayne Bardin of the Population Council added that "The only side effect is that menstrual bleeding can be irregular." [2] NORPLANT is said to be 99.8% effective in preventing pregnancy in women who weigh less than 110 pounds and 91.4% effective in women weighing more than 153 pounds.

It is being touted as revolutionary because it requires only a single decision, not constant motivation as with the Pill. [3]

Proponents see it as useful in the developing nations and in the U.S. "where teen-age pregnancy is a major problem circumscribing the lives of young girls and leaving too many single-parent families in poverty, as a single decision that could postpone childbearing for a critically important five years.

"Americans have widely divergent views on the morality of abortion, but on one thing there is unanimity: the fewer abortions the better." [4]

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #13 - pg.3

ANALYSIS AND CRITIQUE—HEALTH EFFECTS

The only new thing about NORPLANT is its "under-the-skin" mode of administration. NORPLANT is a member of the class of anti-fertility products which contain a single synthetic hormone. Other members of this class in the United States include the progestasert IUD and the Mini-Pill. [5] The progestin-containing Mini-Pill has never been popular, comprising only 1% of the U.S. birth control pill sales. [6] And as a progestin variant, NORPLANT can be expected to have many of the same problems.

NORPLANT, like the Mini-Pill, does not contain estrogen, "the hormone believed to be responsible for the most serious potential side effects of birth control pills like heart attack and stroke." [7] This is identical to the reason for introducing the Mini-Pill in the early 1970s. [8]

Nevertheless, Physician's Desk Reference lists the same warnings, contraindications, precautions, drug interactions, adverse reactions and carcinogenesis criteria for the Mini-Pill as the combined Pill! [9]

Moreover, women who were part of NORPLANT pre-marketing safety and health tests were excluded if they had contraindications that would prevent them from taking the combined or progesterone (Mini) Pill:

A. China—"Histories or current clinical evidence of contraindications to the use of steroid contraceptive hormones precluded admission." [10]

B. Indonesia—"Acceptors in the study met the following criteria.... no contraindications to progestin-only [Mini-Pill] contraceptives." [11]

C. Chile—"Women enrolled in the study were all healthy....None had contraindications for the use of hormonal methods." [12]

D. India—"Healthy women volunteers....with no contraindications to steroidal hormone treatment." [13]

Thus, the claims of fewer side effects must be viewed with some suspicion, even though NORPLANT proponents state that less of the progesterone is present in a woman's blood plasma than the typical progesterone Mini-Pill. As shown, the manner of testing does not include women who might have succumbed to side effects since they were excluded before the testing took place.

NORPLANT IN THE SYSTEM

Ordinarily, women swallow the Pill which is then broken down in the stomach and intestines. The hormones then enter the blood stream and eventually affect the organ targeted to produce a dysfunction and the ensuing anti-fertility effect. However, NORPLANT is released directly into the blood from the six implants, so less is needed. But there has to be enough of the hormone to produce the same anti-fertility effects as the higher dosage progesterone [Mini] Pills.

And it is at those levels that women have the physical problems.

"Obviously, women must be given large enough amounts of hormones reliably to block ovulation and to prevent endometrial bleeding. A truly low dose Pill is a myth" [14]

Furthermore, there are reports in the current medical literature of "side effects" similar to those experienced by women on the combined or progesterone Pill. One from Singapore notes that after one year of use women "may have an increased predisposition to thrombosis as evidenced by significant increase in platelet count and aggregability.

; results also show that NORPLANT acceptors may have an enhanced potential for hypercoagulatio..... ' [15]

Another study documented that NORPLANT, after a year's use, produced a significant [58%] increase in bilirubin, thus demonstrating that it causes some degree of liver dysfunction. [16]

In a Chilean study two women died while part of a NORPLANT test, one from a cerebral aneurism three months after NORPLANT insertion, and the other, who had NORPLANT inserted for 27 months, died from cardiac arrest after gallbladder surgery. The authors claim that the relationship of NORPLANT "to the cause of death in the two subjects who died within the study is a matter of speculation." [17] Yet, both of these "side effects" are known complications of the Pill.

And NORPLANT produces "side effects" that need no clinical verification. NORPLANT does alter the rhythm, duration, volume, and spotting associated with the menstrual cycle. A common effect is that some women experience long intervals without bleeding. Such women are "counseled" that these events do not mean pregnancy or ill health or a threat to femininity. [18] While such disturbance is a known "side effect" of NORPLANT, by the exclusion of major problems by observations and tests, women may be led to believe nothing is wrong when in fact there is something wrong.

There is very little data on what happens to children conceived in women using or previously using NORPLANT.[19]

And there is a possible increased AIDS risk among NORPLANT users. This derives from the insertion of NORPLANT through the use of equipment improperly or not sterilized. [20] And its subsequent use may pose an AIDS hazard because of an increase in menstrual-bleeding-days associated with the progestin hormones in NORPLANT. [21]

ANALYSIS AND CRITIQUE—MODE OF ACTION

NORPLANT is being sold to the public as a contraceptive—either as suppressing ovulation or preventing conception by inhibiting sperm migration. [22] Nevertheless, its mode of action includes a prominent abortifacient effect.

The Planned Parenthood Federation of America, in its recent brief to the U.S. Supreme Court, objected to a Missouri law because its wording reaches "those methods of contraception which can operate after fertilization but prior to the implantation of the fertilized ovum....progestogen-only oral contraceptives (the Mini-Pill)...." [23]

In a test of 113 women using NORPLANT, the rate of "anovulation varied between 25 and 80%....The highest rate was observed during the first year of treatment." [24] Thus, from 20 to 75% of menstrual cycles are ovulatory. The abortifacient effect occurs when the lining of the womb [endometrium] is made adverse to the implantation of the developing human after fertilization. In a test of NORPLANT, 24 women had a suppressed womb lining, 12 were irregular and only 5 were normal. [25] Thus, cyclic development has a clear abortifacient potential in 70% of the cycles measured. The cervical mucus in NORPLANT users may reduce but not completely inhibit sperm passage, thus allowing fertilization to take place. [26]

And while surgical abortions may be avoided in women using NORPLANT, mini-abortions will occur. Further, it is unlikely that women will use NORPLANT for the rest of their fertile days. And former contraceptors resort to induced abortion in greater rates than women never using birth control. In Taiwan only 3.5% of never-users of birth control had an induced abortion versus 24.8% of ever-users of birth control. [27]

NORPLANT'S TAINTED DATA: IMPLICATIONS FOR FDA ETHICAL DRUG APPROVAL

The testing of NORPLANT overseas leaves open the question of whether true informed consent was obtained from experiments on women using the implant. For example, NORPLANT has been tested in Indonesia for The Population Council on women who have only an elementary education and who equate the NORPLANT implant

.. a native medical practice—"susik"—believed to give supernatural powers to the user. [28]

Further, the Population Council has given the coercive Red Chinese "One Child, One Couple" mandatory birth control program money to test NORPLANT as part of its government imposed crash population control program. From September 1984 through June 1988, $233,000 was given to the Red Chinese Birth Control Agency to "evaluate the acceptability of NORPLANT implants in the interest of considering extension of their use to a wider acceptor population." [29]

In the Chinese compulsory program, Irvin Sivin, a principal NORPLANT researcher for the Population Council, is listed as co-author of an important research article from Red China. The article describes how "More than 90 percent of women had only one living child at admission. Less than one percent had three or more children....acceptors live in urban centers of the People's Republic of China where completed family size is low." [30] More than 82% of the "volunteers" were under 35 years of age and fertile. This is quite telling as "in 1982 the Chinese Communist Party issued a directive calling on every urban couple to give birth to only one child." [31]

The UN acknowledges that the Chinese birth control program incorporates social and economic measures at the national and provincial level including income bonuses, health care subsidies, higher pensions, gardens, and other prizes to those who only have one child. Violators will lose 10 percent of their pay, will not receive ration coupons, and will be taxed for their "excess" children. [32]

The authors also note that the size of the present study exceeds other Population Council studies in size and detail permitting "more precise evaluation of problems associated with the method than has hitherto been possible." [33] They indicate that: "Loss to follow-up is not a contaminant or contributor to downward bias in this study because there was virtually none." This is unheard of in truly voluntary studies. Sivin writes in the Population Council's own journal that the "Chinese experience with implants is well documented". [34] Of course it is, with pregnancy police in every factory checking women for "fertility violations." In assessing international NORPLANT experience, more than half of the data on second-year pregnancy rates comes from Red China. When gross cumulative "continuation" rates for the six capsule implant system were contrasted, Red China had the lowest rates: 1.2% for first and 3.8% second year drop outs, contrasted to 8.2% for first and 15.7% for second year drop outs in the U.S. [35]

No reputable researcher has utilized data gained from the infamous Nazi experiments because of the manner in which it was derived. Why should this standard be abandoned now?

CONCLUSION

The U.S. Food and Drug Administration should reject the Population Council's petition to approve use of NORPLANT in the United States because:

First: The suspicions, created by the manner in which data from the coercive Chinese program were used, are such that the entire collection of that data as it pertains to this program should be discounted totally.

Second: There is an apparent absence of informed consent from Indonesian women who might not have participated in the clinical trials had they been fully informed. Thus, the data collected through this manner should be discounted totally.

Third: Should the Food and Drug Administration approve of this surgical implant, and define same as a contraceptive, even though it is obviously abortive in action? Would unemancipated minor children be subjected to the insert, even though it does require surgery? NORPLANT, as indicated in our research, is inapproriate for minor children.

Finally, American Life Lobby seeks a Congressional Committee hearing which would look into all of these questions, preferably before NORPLANT is approved, but certainly in any case so that the data collection procedures used can be examined in full.

Footnotes

[1] Susan Okie, "FDA Urged to Approve Birth Control Implant," *The Washington Post*, April 28, 1989, A-1, 18.
[2] "U.S. Panel Backs a Contraceptive," *The New York Times*, April 9, 1989, p. 8.
[3] Ibid.
[4] Editorial, "The Five Year Contraceptive," *The Washington Post*, May 2, 1989, A-14.
[5] Robert A. Hatcher, et al., *Contraceptive Technology: 1988-89*, 14th Revised Edition, Irvington Publishers, New York, New York, 1988, 251-252.
[6] Howard I. Shapiro, *The New Birth Control Book*, Simon and Schuster, Inc., New York, New York, 1988, 32.
[7] Susan Okie, loc. cit.
[8] Howard I. Shapiro, loc. cit.
[9] *Physician's Desk Reference*, 43rd Edition, 1989, Medical Economics Company, Oradell, New Jersey [see, "Ovrette" Norgestrel Tablets].
[10] Gu Sujuan, Irvin Sivin [Population Council] et al., "A Two Year Study of Acceptability, Side Effects, and Effectiveness of NORPLANT and NORPLANT-2 Implants in the People's Republic of China," *Contraception*, December 1988, Vol. 38, No. 6, 641-657.
[11] B. Affandi, et al., "Five-Year Experience With NORPLANT," *Contraception*, October 1987, Vol. 36, No. 4, 417-434.
[12] S. Diaz, et al., "Long-Term Follow-Up of Women Treated With NORPLANT Implants," *Contraception*, June 1987, Vol. 35, No. 6, 551-567.
[13] N. Chaudhury, et al., "Phase III—Clinical Trial With NORPLANT—(Covered Rods) Report of a 24 Month Study," *Contraception*, December 1988, Vol. 38, No. 6, 659-673.
[14] Ellen Grant, "Cancer and the Pill," *The Ecologist*, Vol. 14, No. 2, 1984, 68-76.
[15] O. A. C. Viegas, et al., "The Effects of NORPLANT on Clinical Chemistry in Singaporean Acceptors After 1 Year of Use: Haemostatic Changes," *Contraception*, September 1988, Vol. 38, No. 3, 313-323.
[16] O. A. C. Viegas, et al., "The Effects of NORPLANT on Clinical Chemistry in Singaporean Acceptors After 1 Year of Use: Metabolic Changes," *Contraception*, July 1988, Vol. 38, No. 1, 79-89.
[17] S. Diaz, et al., loc. cit.
[18] Irvin Sivin, "International Experience With NORPLANT and NORPLANT-2 Contraceptives," *Studies in Family Planning*, Vol. 19, No. 2, March/April 1988, 81-94.
[19] Irvin Sivin, loc. cit.
[20] Laurie Liskin, et al., editor, "Hormonal Contraception: New Long Acting Methods," *Population Reports—Injectibles and Implants—Series K*, No. 3, March-April 1987, K58-K87.
[21] Robert A. Hatcher, loc. cit.
[22] Susan Okie, loc. cit.
[23] Brief for Apellees, Planned Parenthood Federation of America, in re: *Webster v. Reproductive Health Services Inc.*, No. 88-605, March 30, 1989, 21-22.
[24] Horacio B. Croxatto, et al., "Plasma Progesterone Levels During Long Term Treatment with Lovonorgestrel Silastic Implants," *Acta Endocrinologica*, 1982, Vol. 101, 307-311.
[25] Horacio B. Croxatto, et al.,"Histopathology of the Endometrium During Continuous Use of Levonorgestrel," 290-295, from *Long Acting Contraceptive Delivery Systems*, ed. Gerald I. Zatuchini, et al., Harper and Roe Publishers, New York, New York, 1984.
[26] Dale N. Robertson, "Implantable Levonorgestrel Rod Systems: In Vivo Release Rates and Clinic Effects," 133-144, from *Long Acting Contraceptive Delivery Systems*, ed. Gerald I. Zatuchini, et. al. Harper and Roe Publishers, New York, New York, 1984.
[27] Malcolm Potts, et al., *Abortion*, Cambridge University Press, Cambridge, 1977, 478-479.

[28] B. Affandi, et al., "Five-Year Experience With NORPLANT," *Contraception*, October 1987, Vol. , No. 4, 417-428.

[29] *Inventory of Population Projects in Developing Countries Around the World: 1986/87*, United Nations Population Fund, Vol. 2, "China," 105-115, 114.

[30] Gu Sujuan, Irvin Sivin, loc. cit.

[31] *Inventory of Population Projects...*, loc. cit.

[32] Ibid.

[33] Gu Sujuan, Irvin Sivin, loc. cit.

[34] Irvin Sivin, loc. cit.

[35] Irvin Sivin, loc. cit.

Prepared for distribution by Mrs. Judie Brown, President, American Life Lobby Inc.
and Robert G. Marshall, Director of Research, Castello Institute of Stafford.
©1989 American Life Lobby

roChoice Action League ★ P.O. Box 3622, Wichita, KS 67201 ★ 316-681-2121

Dedicated★Determined★Decisive

TO: Members of the House Federal and State Affairs Committee

FROM: Peggy Jarman, Pro Choice Action League

REGARDING: House Bill 2089

DATE: February 12, 1991

Since the beginning of time women have wanted, and tried, to control their fertility. Margaret Sanger, the founder of the birth control movement in this country, understood the need and the desire of women to determine when and whether to have children. She watched women of her generation endure pregnancies often numbering twelve, fifteen, and more. She smuggled diaphragms into this country when contraceptives were illegal in an effort to reduce the deaths of women from self-induced abortion and to give them a modicum of control over their reproductive lives. Almost fifty years passed before birth control pills were available and legal for married people, and it was 1968 before birth control was legal for the unmarried. Thirty more years passed before another breakthrough in contraceptives gave women another significant option. That breakthrough is Norplant.

Norplant is believed to be effective, easy to use and long-lasting, although temporary. All of that is good news. Sometimes good news turns to bad. "Easy, long-lasting, and effective" can be perverted by government interaction and used to determine who should and should not have children. It has happened before. Thousands of women were sterilized with government funds without their knowledge or consent in the early 1970's. Others were coerced with threats of withholding welfare payments, and other penalties. We must be absolute in our determination that we do not revisit those years via Norplant.

The state must not make decisions for women about when or whether she should have a baby. This is fundamental and an absolute human right. A decision of this magnitude, importance, and of such long term implications should not be a matter for the government to decide. The decision to have a child, or not have a child, is a personal one. For some, birth control is a religious issue. The state must respect the religious nature of reproductive decisions. The state, therefore, must not compel a woman to complete or terminate a pregnancy and the state must not mandate, coerce, threaten or intimidate women to use or not to use birth control. There can be no compromise on these issues.

Is there a role for government in family planning? The answer is a resounding yes. Government supported family planning programs can provide safe, low-cost, accessible, comprehensive birth control services through health departments and local family planning clinics. That means more than birth control devices.

Comprehensive programs are a key to prevention of disease and death through screening and other testing and through quality education programs.

Contraceptives alone are not the answer. Education is critical. Education about sexuality, transmission of disease, and accurate information about jobs, job training, budgeting, parenting and other life skills are essential in comprehensive family planning. Accurate and comprehensive information must be an integral part of any family planning program.

For the state to pay women to use a particular birth control device is coercive and therefore, immoral and inhuman. Most Americans recognize that voluntary family planning is their birthright and a precious tool for self-determination. For poor people and young people, access to birth control is woefully inadequate-so inadequate. Every woman and man deserves the knowledge and the means to make healthy, private decisions about reproduction. The state can help to provide that knowledge and those means without resorting to bribery and manipulation.

Copyright (c) 1990 The Washington Post

December 29, 1990, Saturday, Final Edition

SECTION: EDITORIAL; PAGE A18; LETTERS TO THE EDITOR

LENGTH: 639 words

HEADLINE: The Purpose of Norplant

SERIES: Occasional

BODY:

As the originator of implant contraception, and director of the international team of scientists that developed Norplant, seeing this new contraceptive win approval from the Food and Drug Administration was the culmination of 24 years of exciting and satisfying work. But the best of scientific and technological advances often are also bent to immoral and destructive purposes. The thrill of success has been dampened by some of the suggested uses of Norplant that have appeared in the print and electronic media.

I was appalled by The Post's account ["Inquirer's Birth Control Bomb," Style, Dec. 18] describing how editorial writers at the Philadelphia Inquirer saw Norplant as a way of reducing the welfare burden resulting from high fertility among the underclass. A radio talk show host suggested that Norplant offers a "solution" to the problem of teenage pregnancy. His proposal was that all young girls reaching puberty should be required to use Norplant, so that in the years ahead they could not become pregnant unless they took the positive step of going to a clinic to have the implants removed.

It has been suggested, also, that Norplant provides the judiciary with a weapon to impose forced sterilization as a punishment for crimes such as child abuse. Some family planning advocates in the United States see in Norplant a powerful addition to the "contraceptive armamentarium," as they call it, for poor countries. "A dream method for birth control programs," they explained, "because once Norplant is inserted, a woman cannot become pregnant unless she is motivated enough to take the positive step to have it removed."

Hold everything! Norplant should never be used for any coercive or involuntary purpose. It was developed to enhance reproductive freedom, not to restrict it. My colleagues and I worked on this innovation for decades because we believe in human dignity and believe that women should have the opportunity to have the number of children they want, when they want to have them -- not just educated and well-to-do women, but all women.

Those who suggest using Norplant for involuntary or coercive sterilization or birth control will find me leading the opposition. Our purpose in improving contraceptive technology is to enrich the quality of human life. Using Norplant, in this country or abroad, to toss aside rights and trample human dignity would be an intolerable perversion.

SHELDON J. SEGAL New York

The writer is director of Population Sciences at the Rockefeller Foundation in New York City.

TESTIMONY OF LIANE V. DAVIS, PH.D,
KANSAS CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS
BEFORE THE KANSAS HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE,
FEBRUARY 12, 1991

I am pleased to have the opportunity to speak out in opposition to House Bill 2089. I am speaking today on behalf of the Kansas Chapter of the National Association of Social Workers. I am also speaking on my own behalf. My name is Liane Davis. I am an Associate Professor at the School of Social Welfare at the University of Kansas. I am licensed as a clinical social worker in the State of Kansas. I serve on the Committee on Women's Issues of both the National Association of Social Workers and its Kansas Chapter.

I am here today to debunk some historic myths about women and public welfare and to prove to you that the bill you have before you is sexist and racist. It is a piece of legislation that continues a sad tradition in this country of controlling the behavior of poor women, instead of providing opportunities for them to take charge of their own lives.

To put this bill into perspective I'd like to share a little personal history. My mother, now in her 80s, was one of the first public welfare workers in this country. Back in those days, the 1930s to be exact, it was common practice for public welfare workers to make early morning visits to women on assistance, in the hope of surprising them in bed with some man. When their raids were successful, they would then cut the women off of public assistance. The explicit rationale was that any man allowed into her bed had an obligation to get out and support her and her children. Implicit in these early morning raids was the belief that women who were supported by the government didn't have the same rights as other women. They didn't have the right to privacy. And they certainly didn't have the right to an ongoing sexual and emotional relationship with a man. My mother was a woman ahead of her times. Even in the 30s, she believed that poor women, even poor women on welfare, had the same rights as other women. And so she refused to participate in those early morning raids. Surprise visits slowly disappeared. But the distrust of public welfare workers they created among the poor remains to this day.

By the time I became a social worker in the late 1960s, we no longer made surprise home visits; we had developed different means to control poor women. My first job as a social worker was in the obstetrical and gynecological clinic of a large city hospital. It was 1967, before Roe v Wade. So women were denied safe and legal abortions. For many poor women, safe contraceptives were also unavailable. Instead <u>we</u> convinced large numbers of poor women, primarily poor women of color, that the only safe way to protect their own health was for them to not have any more children. And the only way for them to do that was to be sterilized. I say <u>we</u> because a major part of my job as a social worker was to cajole and convince women to be sterilized and to secure their "voluntary" consent to this permanent form of birth control. I was 23 years old and naive. It wasn't until some years later that I understood how I, in the guise of providing medical care, had contributed to efforts to control the numbers of children that poor women of

color brought into this world.

And that brings us to the present. When Representative Kerry Patrick first began to talk about his legislation, I experienced deja vu. In the intervening years I had become far wiser. This time I knew that what was being proposed was legislation to control the behavior of poor women.

At face value HB 2089 may seem like an innocuous piece of legislation. After all it simply makes a new form of contraception available to poor women and even gives them an incentive to use it. But that is just a thin veneer, a very thin veneer. Under the surface are myths about poor women and beliefs about the state's right to control what women do with their bodies. Let me bring some of those myths and beliefs to the surface so that we can examine them openly and perhaps more honestly.

#1. First, is the myth that AFDC mothers have too many children.

If we look at the data we find that women on AFDC have the same numbers of children as women who are not on AFDC (U.S. Department of Health and Human Services, 1988.)

40.4% of Kansas AFDC recipients have only one child.
31.9% of Kansas AFDC recipients have two children.
18.7% have 3 children.
5.2% have 4 children
2% have 5 children
1% have 6 children

0.8% have 7 or more children
More than 70% of all women on AFDC in the state of Kansas have two children or less. In this regard women on AFDC are no different than women who are not receiving AFDC. This legislation continues the lie that the average welfare recipient is a woman with a large family who chooses to have children in order to obtain an ever-increasing welfare check. Is this lie something you, as legislators, want to add your name to?

#2. Second, is the myth that poor women remain on AFDC for long periods of time. The typical single mother stays on AFDC for about 2 years at any one time. She may return at some later time, when she is once again without a viable means of support. But she will exit again when she is able (Dornbusch and Gray, 1988).

#3. Third, is the myth that poor women need incentives to limit their family size. To the contrary, there is every indication that poor women, teenage girls included, willingly and effectively use birth control <u>when it is available to them</u>.

#4. Four, is the belief that the government has a right and responsibility to control and monitor the reproductive behavior of poor women. The state of Kansas has been clear on this issue: it is a woman, in consultation with her physician, who makes all decisions surrounding her reproductive behavior. This certainly includes the choice of which

contraceptive method, if any, she will use.

#5. Five, is the belief that this is a voluntary program. To a woman struggling to support herself and her children on a little over $400 a month, $500 is a small fortune. It is certainly sufficient to induce many women to do something they would not ordinarily choose to do of their own free will.

Further, if this becomes SRS policy, workers may cajole and coerce, just as I as a hospital social worker, cajoled and coerced, poor women to cooperate.

#6. Six, is the belief that it is ethical to offer women money to control their fertility. As I was preparing this testimony, I talked with a number of colleagues. One challenged my contention that offering financial incentives for using Norplant was unethical. I thought about this issue a lot.

As a scholar at The University of Kansas, I am required to submit all plans for research to a group of my peers who determine whether it meets ethical guidelines. Similar boards throughout the country have long recognized that people, if paid enough, can be induced to do a lot of things they would not voluntarily choose to do. Therefore, payments to human subjects are considered ethical only when they are sufficiently low to not coerce people to do something they would not freely choose to do. It is acceptable to pay a participant $25 for her time, perhaps to cover the cost of a babysitter, the cost of transportation, or to make up for lost income. Five hundred dollars, however, is unacceptable. It is coercive and such coercion is unethical.

I began by saying that this bill is sexist and racist. One need merely to look at whose lives will be affected to demonstrate its inherent sexism and racism.

This bill is sexist because it is directed solely at controlling the behavior of women; it is totally silent about men.

It is sexist because it assumes that women bear total responsibility for controlling the number of children brought into this world. It assumes that it is women whose bodies must ingest experimental substances to insure that they will not be impregnated. It is silent about inducing men to similarly control their reproductive behavior. If women are to be paid to take Norplant, why aren't men being paid to take some similar drug to make them sterile?

I have always found strange the amount of money and energy directed at developing substances to control women's fertility, while men's fertility is left untampered with. After all men can impregnate hundreds of women in the nine months it takes for a woman to bring one child into the world.

This bill is sexist because it assumes that the problem needing to be addressed is that women on AFDC have more children than they can support.

Nothing is said about men's responsibility to support the children that they bring into this world.

This bill is racist because it is women of color who are more likely than their white peers to need to fall back on AFDC. In the state of Kansas women of color make up less than 10% of the female population. They make up 35% of women receiving AFDC. Whose lives will be affected? Just as I participated in a program to sterilize large numbers of poor women of color, this program too will disproportionately affect poor women of color.

There is a real problem in this country and in the state of Kansas. The problem is that women need to turn to AFDC to support themselves and their families because they have no other means of support. That is the problem that we should be addressing.

Helping women move out of poverty is a tremendous concern. I do not pretend to have the answers to a problem that has challenged the best policymakers and scholars over the past 50 years. But we do know some things about the directions that need to be taken:

#1. We know that poor women will leave AFDC if they have viable alternatives. This is the underlying assumption of the Federal Family Support Act and its JOBS program.

Women need skills for the jobs that are available in this increasingly technological job market.

Women need jobs that provide them a wage that can support themselves and their children.

Women need jobs that provide them and their children with health insurance.

Women need quality health care.

Women need reliable, accessible, and affordable childcare.
Women need family leave policies that enable them to care for sick children (and other relatives) without endangering their jobs.

Women need support services to enable them to make a successful transition off of AFDC.

#2. We know that fewer women will fall into poverty if fathers provide economically for their own children. Following divorce, women's income drops an average of 73% while that of their ex-husbands rises by 42% (Weitzman,1985). Recent studies reveal that only 58% of families eligible for child support receive an award. Only 50% of those granted child support receive the full amount owed them; while 24% of those granted child support receive no funds at all (Plotnick, 1989.) Furthermore, research shows that noncustodial fathers can afford to pay between 2 1/2 and 3 times what they are ordered to pay (Garfinkel and Oellerich, 1989.) In the state of Kansas, recent changes in the child support laws have made it possible for father to

reduce their contributions to the children of early marriages when they have children in later marriages. Is it surprising that many women become dependent on AFDC because they receive too little child support?

#3. We know that women need to have control over their own lives if they are to get off and stay off of AFDC. In social work we call this empowerment. As a profession, social work is committed to creating conditions that allow all people to make their own decisions about how to run their lives. As professionals, social workers are engaged daily in efforts to enable people to take control of their own lives.

The legislation that is presently before you is diametrically opposed to all that we as social workers believe and work for. The message that it gives to poor women is that once again the state is intervening in yet another area of your life. No longer can we trust you to make ongoing decisions about whether or not to use contraceptives. No longer will we trust you to go to your own doctor and discuss with him or her what form of contraceptive is most appropriate for your health and welfare. Instead we, the state, have determined the contraceptive that is in your best interest to use. And we will pay you to implant it in your body.

As a social worker representing over 1500 social workers in the State of Kansas, I urge you to kill this bill before it does any more damage.

REFERENCES

Dornbusch, S.F. and Gray. K. D. (1988). Single-parent families. In S. M. Dornbusch and M.H. Strober (eds.) Feminism, children, and the new families. New York: The Guilford Press.

Garfinkel, I. and Oellerich, D. (1989). Noncustodial fathers' ability to pay child support. Demography, 26, 219-233.

Plotnik, R.D. (1989). Directions for reducing child poverty. Social Work, 34, 523-530.

U.S. Department of Health and Human Services (1989). 1987 AFDC Recipient Characteristics Study.

Weitzman, L.J. (1985). The divorce revolution: The unexpected social and economic consequences for women and children in America. New York: Free Press.

Marsha M. Burris
BPW/kansas First Vice-President
P. O. Box 345
Iola, Kansas 66749

February 12, 1991

BPW kansas

The Kansas Federation of Business and Professional Women's Clubs, Inc.

Rep. Kathleen Sebelius, Chair
Federal and State Affairs Committee
Capital Building
Topeka, Kansas 66612

The Honorable Kathleen Sebelius:

I submit the following information concerning House Bill No. 2089 for the Federal and State Affairs Committee, which begin hearings on this bill today.

I write to the Committee in opposition to this bill. As a state officer for an organization that promotes "participation, equity and economic self-sufficiency for working women", I see nothing in this bill to promote women. Women who are receiving public assistance need an education to help them become self-supporting. They need to be elevated to being productive citizens in our society. I fail to see where a contraceptive implant will educate them to being a productive citizen.

There are questions this bill leaves unaddressed. What is the liability of the State of Kansas if this implant does not work in a woman? What is the future liability of the State of Kansas in case the woman decides to have the implant removed? What if there are side affects from this implant that have not been discovered? What happens if the woman contracts aids because our state law now allow her to live a loose, carefree life; will this be a liability of the State of Kansas? What forced contraceptive device is being offered to the male population who are public assistance recipients?

As a taxpayer I can see there needs to be something done to stop this "welfare cycle" and producing more babies in this environment will not stop this cycle. I ask your committee to weigh heavily will this stop the cycle? Wouldn't we possibly have better odds to stop this cycle if we try to educate these public assistance recipients to improve their lifestyle? Wouldn't we be better off if we made them work for the check they receive and not hand out more money to encourage the same lifestyle they are living?

I encourage the Federal and State Affairs Committee to not favorably pass this bill out of committee hearings. I feel there are other avenues that need to be explored to prevent unwanted pregnancies and help individuals get off welfare. Thank you for your considerations.

Best Personal Wishes,

Marsha M. Burris

HOUSE FEDERAL AND STATE AFFAIRS
February 12, 1991
ATTACHMENT #16 - pg. 1

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY
JACK AND PEARL RESNICK CAMPUS • 1300 MORRIS PARK AVENUE • BRONX, NEW YORK 10461-1602

DEPARTMENT OF EPIDEMIOLOGY
AND SOCIAL MEDICINE

PHONE: (212) 430-3574
FAX #: (212) 828-9125

February 11, 1991

HOUSE FEDERAL AND STATE AFFAIRS COMMITTEE
STATEMENT ON HOUSE BILL 2089: ETHICAL CONSIDERATIONS

This testimony points up several serious ethical problems surrounding House Bill 2089, which proposes to offer an incentive of $500 to women of reproductive age who are on welfare if they agree to have Norplant implanted as a means of contraception.

The first ethical problem lies in the attempt by government to interfere with the reproductive rights of its citizens. Reproductive liberty is one of the hallmarks of a free society. Nations throughout the world have endorsed international declarations seeking to promote the right of individuals and couples to choose the timing and manner of spacing of their children. Although it could be argued that welfare recipients in Kansas do have a "choice" of whether to accept the $500 and undergo the implant, that is not a fully voluntary choice. It is what William James referred to as a "forced choice." The sum of $500 is likely to be so attractive to poor women that it constitutes a "coercive offer."

In addition, the doctrine of informed consent to medical treatment requires that a patient's agreement to undergo a procedure be fully voluntary. For the reasons just noted, even if the consent of welfare recipients could be properly informed, consent could not be considered voluntary in the requisite sense.

A second ethical problem with the Bill lies in the nature of medical services available to poorer classes in our society. Norplant has been approved by the FDA, but that does not guarantee users a risk-free method of contraception. All medications have side effects, and women who decide to use Norplant should be assured of access to a decent level of health care. People of low income start out with a poorer health status than those who are better off. Until our society provides equitable access to health care for all its members, inducing welfare recipients to undergo five-year implants of a newly approved method of birth control is unjust.

Carrie Lindsey - 682-4517 (316)
Member of the Kansas Welfare Rights Organization

Test Your Welfare I.Q.

by Nancy Amidei

1. Over 35 million Americans are living in poverty. How many do you think get federally supported cash welfare?
   All______ ¾______ ½ ______

2. What is the average period that a poor family gets Aid to Families with Dependent Children (AFDC)?
   12 months______ 2 years______ 3 generations______

3. What is the most common family size of families on AFDC (include adults AND children)?
   2______ 4______ 6______ 8______

4. The average food stamp benefit per person per meal works out to?
   17¢______ 47¢______ $2.00______ Unlimited______

5. The fraud rate in the Food Stamp Program is? (trick question)
   2%______ 10%______ 50%______ 75%______

6. Programs for poor people (all cash welfare, food stamps, medicaid, subsidized housing, education, etc.) take up what portion of federal spending?
   Less than 10%______ ⅓______ Over ½ ______

7. Not counting trust fund programs like Social Security, spending for poor people's programs, as a portion of all federal spending, has been:
   Out of control______ Finally controlled under Reagan______
   Still rising, but slower______ Going down since 1970s______

8. Benefits to families getting AFDC welfare are, in most states:
   Competitive with average wages______ At the poverty line______
   150% of the poverty line______ Substantially below the poverty line______

9. What portion of the poor get one or more subsidized in-kind benefits (e.g. food stamps, medicaid, housing)?
   100%______ 60%______ 40%______ 25%______

—*Nancy Amidei is a contributing Editor for Seeds*

Answers on page 34

nswers

Welfare Test—page 5

. Less than half. Only 16 million Americans get help from federal cash welfare programs—Aid to Families with Dependent Children (AFDC), or Supplemental Security Income (SSI). Of the 16 million:

- 4 million are elderly, blind, or disabled
- 8 million are children
- 4 million are non-aged adults responsible for children

(only 2.6% of all welfare recipients are non-aged, non-disabled men, but all of them must accept work or training to receive welfare.)

Most poor people don't get welfare; they never have.

2. The arithmetical average of time spent on AFDC is about two years. However, that is misleading because:

- half the families coming onto AFDC in a year are off of welfare within the year;
- only about 8% of those on AFDC get welfare for half or more of their income for 7 years or more;
- long-term, heavy dependence on welfare is uncommon (and may be related to having a chronically ill or disabled family member).

For most families, welfare means help during a crisis (serious illness; loss of job; desertion) or as a supplement to low wages. Many of those helped during a crisis never need welfare again; the country is full of "welfare success stories."

3. The most common family size on AFDC is two—one adult and one child. The next most common family is one adult with two children. Together they make up 75% of all AFDC families.

More important, welfare families have been getting smaller since the 1960s. There is no evidence that women become pregnant in order to qualify for welfare, or to get more welfare once on AFDC.

4. Average food stamp benefits work out to 47c per person, per meal. The most anyone can get works out to about $2.15 per person per day. Many elderly and disabled people who get food stamps get only $10.00 a month—which works out to 10c per person per meal.

5. There is NO fraud rate in the Food Stamp program. The reports issued by the Inspector General at the U.S. Department of Agriculture make that clear. They compile an "error rate," but "errors" are not the same as fraud—as anyone who's made a mistake knows.

One estimate of the program dollars involved in deliberate fraud comes to about 1.5%—2% of total program dollars.

Half of the errors in the program are "agency generated," which gives food stamp program employees a better record than the IRS—in which two-thirds of the errors are "agency generated." Errors from all sources have been going steadily down.

6. Programs for poor people now represent only about 7.5% of all federal spending.

Because poor people's programs take up so little of all federal spending, they are not what is driving the deficit. For the same reason, neither can cuts in these programs involve enough dollars to be significant in reducing the deficit.

7. Spending for poor people's programs, as a portion of all federal general revenue spending (that is, not counting self-financed systems like social security), has been going down since 1978.

8. Even when food stamps are included together with cash AFDC benefits, total family income remains below ¾ of the poverty line in ¾ of the states. There is no state in the Continental U.S. where food stamps and welfare are high enough to raise AFDC families out of poverty. People who get welfare and food stamps are still poor.

In recent years, the value of welfare benefits has been eroding. AFDC is not indexed, and so payments do not go up when inflation drives costs up.

9. Roughly 60% of the poor get some help from in-kind benefits, but it may be as little as 10c a meal worth of food stamps. Forty percent get no in-kind benefits at all, not even free school meals or food stamps.

Note: Listed below are sources for the statistics used in each of the answers provided. The information available from these sources was analyzed and/or described by the author of this quiz and other analysts. The answers provided here do not represent direct quotes from the sources indicated.

All of the statistics are publicly available, many from government or congressional publications; most have also been the subject of analyses by a broad range of research groups and individuals, and have appeared in numerous press accounts.

1. Sources: U.S. Department of Commerce, Bureau of the Census, Reports on Consumer Income, Series P-60, No. 147. *Social Security Bulletin*, published monthly by the Office of Research and Statistics, Social Security Admin.

2. Sources: Office of Research and Statistics, Social Security Administration (e.g. SSA Publ. No. 13-11979, February 1982); Institute for Social Research, University of Michigan Panel Study: **Years of Poverty Years of Plenty.**

3. Sources: "AFDC Recipient Characteristics Studies," U.S. Department of Health and Human Services (1967 through 1979); Mary Jo Bane and David Ellwood, "The Impact of AFDC on Family Structure and Living Arrangements," Harvard University, Kennedy School of Government, March 1984.

4. Source: U.S. Department of Agriculture, Food and Nutrition Service Statistical Reports

5. Source: U.S. Department of Agriculture, analysis of Reports from the Office of the Inspector General.

6. Source: Congressional Budget Office, U.S. Congress; and Committee on the Budget, U.S. House of Representatives, Washington, D.C

7. Sources. Same as in number 6, above. See also "The Budget in Brief," from the Office of Management and Budget.

8. Source: Committee on Ways and Means, Subcommittee on Public Assistance and Unemployment Compe[illegible] U.S. House of Representatives.

9. Source: U.S. Dep[illegible]nt of Commerce, Bureau of the Censu[illegible] eport Series P-60, No. 148.

Sources: Executive Office of the President, The U.S. Budget for Fiscal Year 1986, and analyses by U.S. House of Representatives' Committee on the Budget, among others.

Particularly useful is: "Beyond the Myths—The Families Helped by the AFDC Program," Center on Social Welfare Policy and Law, 95 Madison Avenue, New York, NY 10016.