Approved: June 14, 1991
Date

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY.

The meeting was called to order by Chairperson Senator Wint Winter Jr. at

10:05 a.m. on April 24, 1991 in room 526-S of the Capitol.

All members were present except: Senator Feleciano who was excused.

Committee staff present:
Mike Heim, Legislative Research Department
Jerry Donaldson, Legislative Research Department
Judy Crapser, Secretary to the Committee

Conferees appearing before the committee:
Representative Sandy Praeger
Michael D. Brown, public health nurse
Heather Davis, Baldwin
Patricia Hollomon, Topeka
Kelly Kultala, Kansas National Organization for Women
Melissa Ness, Kansas Children's Service League
Maxine Elmore, Kansas Children's Service League
Azzie Young, Kansas Department of Health and Environment
Pat Turner, Right to Life of Kansas, Inc.
Kenda Bartlett, Concerned Women for America of Kansas

Chairman Winter opened the meeting by announcing if time did not allow for the report by Ben Coates, Executive Director of the Kansas Sentencing Commission, another meeting might be scheduled to receive that report. He added that the bill enacting the Sentencing Guidelines, SB 382, would be recommended for an interim study.

Chairman Winter opened the hearing for HB 2531.

HB 2531-community-based teenage pregnancy reduction program.

Representative Sandy Praeger spoke in support of HB 2531. (ATTACHMENT 1) She added that there is no new fiscal impact since funding for the bill had already been provided in the appropriations for the Department of Health and Environment.

Michael D. Brown, public health nurse, testified in support of HB 2531. (ATTACHMENT 2)

Heather Davis, Baldwin, testified in support of HB 2531. (ATTACHMENT 3)

Patricia Hollomon, Topeka, testified in support of HB 2531. (ATTACHMENT 4)

Kelly Kultala, Kansas National Organization for Women, testified in support of HB 2531. (ATTACHMENT 5)

Melissa Ness, Kansas Children's Service League, testified in support of HB 2531. She stated that their organization is committed to addressing the problems of teen pregnancies and have worked with the Kansas Department of Health and Environment to develop their current program. She deferred to the next conferee to present details of their program.

Maxine Elmore, District Director of the Kansas Children's Service League, testified in support of HB 2531. (ATTACHMENT 6)

Azzie Young, Director of the Bureau of Family Health in the Kansas Department of Health and Environment, testified in support of HB 2531. (ATTACHMENT 7)

CONTINUATION SHEET

MINUTES OF THE SENATE COMMITTEE ON JUDICIARY,

room 514-S, Statehouse, at 10:05 a.m. on April 24, 1991.

Written testimony in support of HB 2531 was received from:
Darlene Stearns, Religious Coalition for Abortion Rights in Kansas (ATTACHMENT 8)
Doug Bowman, Children and Youth Advisory Committee (ATTACHMENT 9)
Barbara Reinert, League of Women Voters of Kansas (ATTACHMENT 10)
Marian Shapiro, Planned Parenthood of Kansas, Inc. (ATTACHMENT 11)
John Kelly, Kansas Planning Council on Developmental Disabilities Services (ATTACHMENT 12)
Beth Powers, Kansas Choice Alliance (ATTACHMENT 13)
Kansas Action for Children, Inc. (ATTACHMENT 14)

The Chairman then called for conferees opposed to the measure.

Pat Turner, Right to Life of Kansas, Inc., testified in opposition to HB 2531. (ATTACHMENT 15)

Kenda Bartlett, Concerned Women for America of Kansas, testified in opposition to HB 2531. (ATTACHMENT 16)

This concluded the hearing for HB 2531.

The Chairman asked for the Committee's pleasure on the bill.

Senator Petty moved to recommend HB 2531 favorable for passage. Senator Kerr seconded the motion. The motion carried.

The Committee's attention was turned to SB 206.

SB 206 - disposition of moneys credited to the juvenile detention facilities fund.

The Chairman noted that the provisions of SB 206 had been amended into HB 2012 by action of this Committee. He suggested that eliminating the bill would save costs of reprinting it as a carry-over into the 1991 Session.

Senator Morris moved to recommend SB 206 be not passed. Senator Yost seconded the motion. The motion carried.

Senator Morris moved to approve the minutes of February 8, February 11, February 12, March 19 and April 8. Senator Parrish seconded the motion. The motion carried.

The Committee's attention was directed to a news-clipping regarding the corrections/prison system. (ATTACHMENT 17)

The meeting was adjourned.

Date 24 April 1991

VISITOR SHEET

Senate Judiciary Committee

(Please sign)

Name/Company	Name/Company
PATRICIA HENSHALL OJA	
Paul Shelby OJA	
Heather Davis - Self (teen mother)	
Michael D. Brown - self (children's advocate)	
Barbara Wilson - self children's advocate	
Jo Wilson "	
Pat Turner RTLK&K	
Michelle Moore KAC	
Doug Bowman - Children & Youth Advisory	
Michelle Sisters/John Peterson & Assoc	
Kelly Kultala - NOW	
Linda Kenney KDHE	
Joyce Markendorf KDHE	
Becci Akin / Ks Children's Service League	
Kenda Bartlett / CWA	
Ben Coates	

STATE OF KANSAS

SANDY PRAEGER
REPRESENTATIVE, 44TH DISTRICT
3601 QUAIL CREEK COURT
LAWRENCE, KANSAS 66047
(913) 841-3554

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
MEMBER: EDUCATION
ELECTIONS
PUBLIC HEALTH & WELFARE

April 24, 199l

TESTIMONY
SENATE JUDICIARY COMMITTEE
Senator Wint Winter, Jr., Chairman

by
Representative Sandy Praeger

Thank you for the opportunity to speak today on behalf of HB2531. I will make only a few comments so that the "experts" on this subject can have the majority of the time. This bill provides for the establishment of community-based teenage pregnancy prevention programs. The need for these programs is obvious. What we are doing now is not working. Nationally, over 1.2 million teenage pregnancies occur every year. About 1 in 10 girls, age 15 - 19 becomes pregnant each year. Nearly 1/2 of Aid to Families With Dependent Children ($4.65 billion annually) goes to households of women who bore their first child while they were teenagers. In Kansas SRS estimates that 900 -1,000 births occur annually to teenage mothers who either become part of the Medicaid system or were already receiving assistance.

This program, modeled after a very successful program in South Carolina, is effective because it involves a broad cross-section of the community. The community works together designing a program that addresses the needs and the social, religious and moral values for that community. It focuses on education and on developing a positive self-awareness. Youth, males and females, learn that abstinence is a viable alternative.

If we can prevent unwanted teenage pregnancies we not only improve the chances for these teen moms and dads to realize their full potential but we stop the flow of new participants into our welfare system. That money can be better utilized in providing a good education for our young people and ensuring that they have a good job waiting for them when they graduate.

Senate Judiciary Committee
4-24-91
Attachment 1

FROM: Michael D. Brown, RN, MS; Children's Advocate
TO: Kansas Senate Judiciary Committee (4/24/91)
SUBJECT: House Bill #2531 on teen pregnancy reduction
(AND DE¢REA$E IN TAXPAYER$' A$$O¢IATED ¢OT)

I am here to ask each of you to help YOUR DISTRICT'S youth AND $AVE YOUR DI$TRI¢T'$ TAXPAYER$ MU¢H MONEY by voting for and carrying House Bill #2531. On April 9 the House passed HB 2531 by a 3-to-1 margin.

Kansas legislators $PEND $150 MILLION OR $O YEARLY on Aid to Families with Dependent Children, Medicaid, and Food Stamps for families begun when the mother was 19 or under.[1] State AND LOCAL officials $PEND MORE OF TAXPAYER$' MONEY on such families through child support collection, housing, education, child care, employment and legal assistance, PLU$ OTHER ¢O$TLY PROGRAM$.[2]

Recently, TWO studies examined TAXPAYER$' $AVING$ DUE TO PUBLI¢LY FUNDED ¢ONTRA¢EPTION $ERVI¢E$.[3,4] Thankfully, their results showed that EVERY DOLLAR TAXPAYER$ $PEND ON ¢ONTRA¢EPTION AVE TAXPAYER$ ABOUT $4.40 OR $7.70 on Aid to Families with Dependent Children, Food Stamps, the WIC nutrition program, and medical care IN ONLY THE FIRST TWO YEARS AFTER A BIRTH.

During 1989, Kansas minor girls had 1,488 babies, including 192 second, THIRD, OR FOURTH babies. That year, minor girls in the state had 12 STILLBIRTHS and 488 abortions, including 38 SECOND OR THIRD abortions.

Attachment 2

Senate Judiciary Committee
4-24-91
Attachment 2

UNMARRIED minors who have had babies helped the PERCENTAGE of Kansas births occurring in a year that were out of wedlock rise for a OTLY 30 YEARS IN A ROW TO 19.7 PERCENT, 7,624 of 38,648 births, in 1989.

HB 2531 is based on a Denmark, South Carolina MOST UNIQUE CIVIC program in which LOCAL CLERGY, a NON-SECTARIAN CHURCH women's group, AND PARENTS helped CUT their school-age pregnancy rate BY 63 PERCENT IN JUST 2 YEARS.[5] Their school-age pregnancy rates for the NEXT 2 years were usually LESS THAN HALF the rates for THREE SIMILAR SOUTH CAROLINA COUNTIES with NO such program.

That program's PRIMARY goal is that adolescents DELAY their FIRST sexual intercourse experience AT LEAST until they COMPLETE HIGH SCHOOL. For the teens AND PRETEENS who DO have intercourse, the program's SECONDARY goal is for them to either (1) STOP having intercourse AT LEAST until they FINISH HIGH SCHOOL or (2) CORRECTLY use EFFECTIVE contraception.[5,6]

Practicing ABSTINENCE is the ONLY 100 PERCENT SURE way minors can avoid problem conceptions. Yet, FIGURES FROM THREE premarital pregnancy prevention programs that advocate JUST abstinence CLEARLY suggest that MANY minors can NOT be PERSUADED to practice ABSTINENCE.[6-8]

Please, help Kansas youth AND KANA TAXPAYER$!!

KANSAS SAVINGS

2-2/11

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1. Waterman, M. K., Scott, V. L., & Nichols, F. H. (1988, February). The public costs of adolescent pregnancy in Kansas. Kansas Nurse, 63, 18-19.
2. Armstrong, E. & Waszak, C. (1990). Teenage pregnancy and too-early childbearing: Public costs, personal consequences (5th ed.). Washington, D.C.: Center for Population Options.
3. Forrest, J. D. & Singh, S. (1990). Public-sector savings resulting from expenditures for contraceptive services. Family Planning Perspectives, 22, 6-15.
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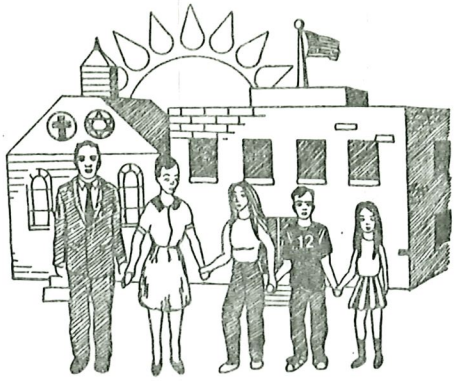
5. Vincent, M. L., Clearie, A. F., Johnson, C. G., & Sharpe, P. A. (1988). Reducing unintended adolescent pregnancy through school/community educational interventions: A South Carolina case study. Atlanta, GA: Centers for Disease Control.
6. Howard, M. & McCabe, J. B. (1990). Helping teenagers postpone sexual involvement. Family Planning Perspectives, 22, 21-26.
7. Sex Respect September 7, 1990 Illinois survey results available from Project Respect, P.O. Box 97, Golf, IL 60029.
8. Teen-Aid, Inc. March, 1989 first year grant results available from Teen-Aid, Inc.; N. 1330 Calispel; Spokane, WA 99201.

2-3/11



The Public Cost of Adolescent Pregnancy in Kansas

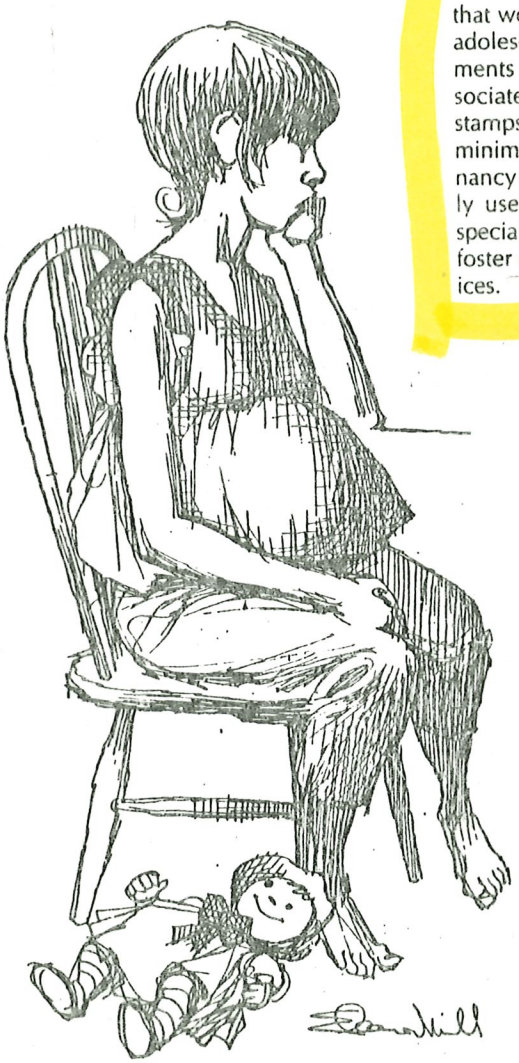
By: Marjory K. Waterman, R.N., B.S.N., Virginia Lynn Scott, R.N., B.S.N. and Francine H. Nichols, R.N.C., Ph.D.

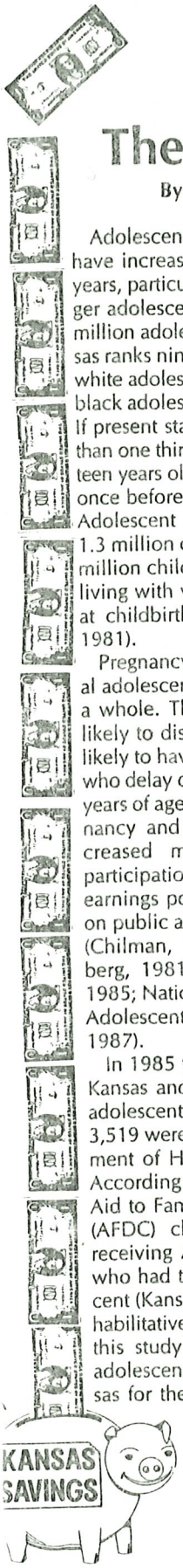
Adolescent pregnancy and parenthood have increased steadily in the last twenty years, particularly among unwed and younger adolescents. Each year more than one million adolescents become pregnant. Kansas ranks nineteenth in the nation in rate of white adolescent pregnancy and seventh in black adolescent pregnancy (Singh, 1986). If present statistical trends continue, more than one third of the girls who are now fourteen years old will become pregnant at least once before they reach the age of twenty. Adolescent mothers are currently rearing 1.3 million children with an additional 1.6 million children less than five years of age living with women who were adolescents at childbirth (Alan Guttmacher Institute, 1981).

Pregnancy affects not only the individual adolescent and her infant but society as a whole. The adolescent mother is more likely to discontinue her education and is likely to have more children than her peers who delay childbearing until at least twenty years of age. Furthermore, adolescent pregnancy and parenthood are linked to increased marital instability, decreased participation in the labor force, decreased earnings potential, increased dependence on public assistance and increased poverty (Chilman, 1980; Dryfoos, 1982; Furstenberg, 1981; Kansas Action for Children, 1985; National Research Council, Panel on Adolescent Pregnancy and Childbearing, 1987).

In 1985 there were 39,418 live births in Kansas and 4,492 of these births were to adolescents. Of these adolescent births, 3,519 were first births (Kansas State Department of Health and Environment, 1986). According to a state-wide survey of Kansas Aid to Families with Dependent Children (AFDC) clients, 52 percent of families receiving AFDC were headed by women who had their first child while an adolescent (Kansas Department of Social and Rehabilitative Services, 1985). The purpose of this study was to determine the cost of adolescent pregnancy to the state of Kansas for the year 1985.

Single year costs: In 1985, the state of Kansas spent **$143.92 million** on families that were started when the mother was an adolescent. This figure includes actual payments as well as administrative costs associated with AFDC, Medicaid, and food stamps. This estimate reflects only the minimal public outlays for adolescent pregnancy in that it does not include frequently used public services such as housing, special education, child protection services, foster care, day care, and other social services.





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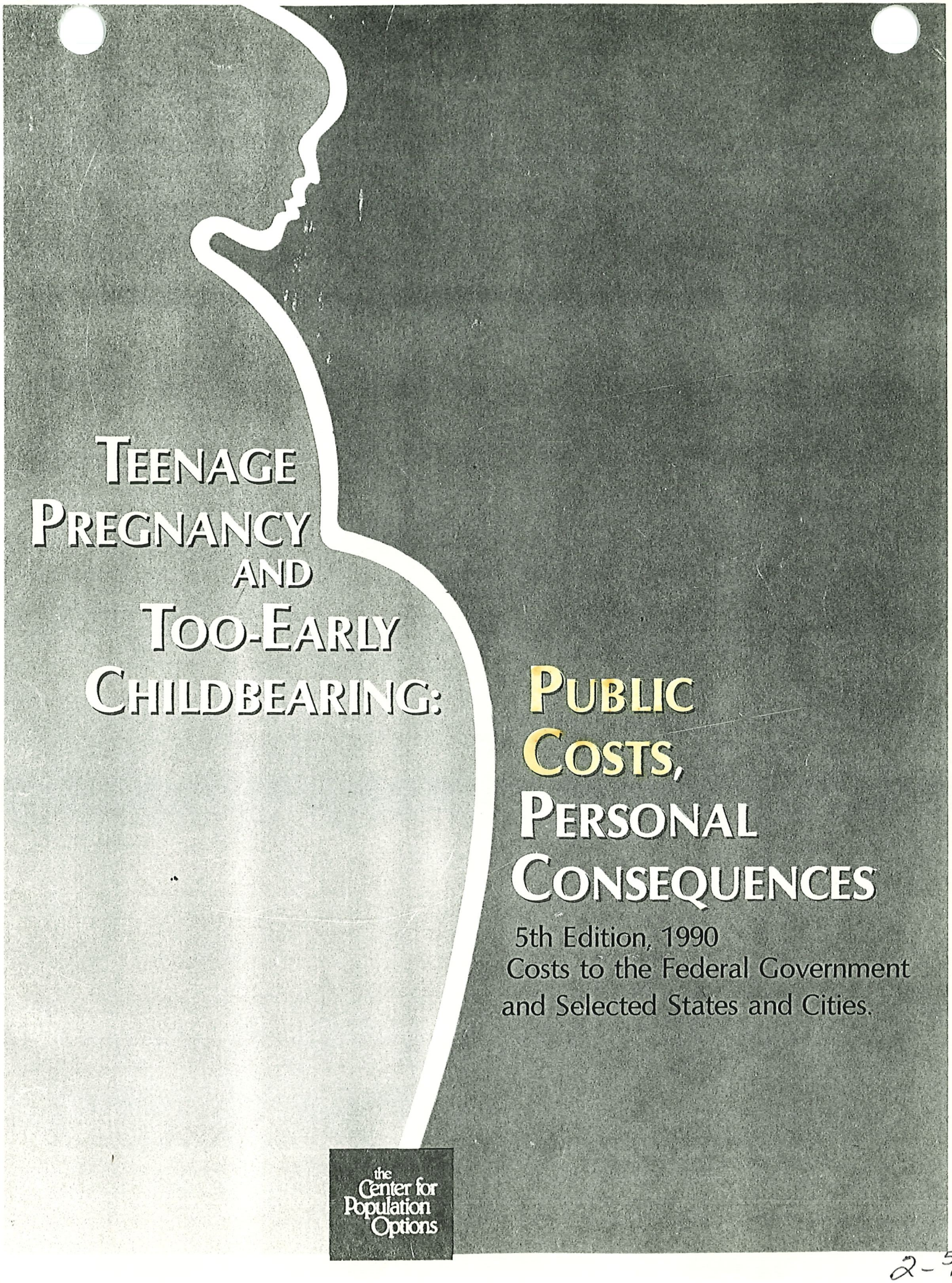


Teenage Pregnancy and Too-Early Childbearing:

Public Costs, Personal Consequences

5th Edition, 1990

Costs to the Federal Government and Selected States and Cities.

the Center for Population Options

2-5/11

Public-Sector Savings Resulting from Expenditures For Contraceptive Services

By Jacqueline Darroch Forrest and Susheela Singh

Summary

Almost one in four U.S. women who use a reversible method of contraception rely on a publicly funded source of care, either a family planning clinic or a private physician reimbursed by Medicaid. According to three scenarios of alternative contraceptive use patterns, if publicly funded services were not available, these women would have between 1.2 million and 2.1 million unintended pregnancies over one year—substantially more than the approximately 400,000 they currently experience. If these women relying on publicly funded services were using no method of contraception, they would be expected to have more than 3.5 million unintended pregnancies in one year.

In FY 1987, federal and state governments spent $412 million on contraceptive services for women who otherwise might not have been able to obtain them. If these services had not been available, the additional public costs for medical care, welfare and supplementary nutritional programs during the first two years after a birth or for publicly funded abortions would have totaled $1.2–$2.6 billion. These savings represent an average of $4.40 saved for every dollar of public funds spent to provide contraceptive services.

Introduction

Since the late 1960s, the U.S. government and most states have subsidized contraceptive services for women who otherwise might not be able to afford such care, both through family planning clinics and through private physicians. However,

Jacqueline Darroch Forrest is vice president for research and Susheela Singh is assistant director of research with The Alan Guttmacher Institute.

This article is based on research funded by The Prospect Hill Foundation and The James Irvine Foundation. The authors gratefully acknowledge the assistance of Ina Jedeikin, Asta Kenney, Joseph Picciano and two anonymous reviewers.

"For every government dollar spent on family planning services, from $2.90 to $6.20 (an average of $4.40) is saved as a result of averting [short-term] expenditures on medical services, welfare and nutritional services."

The Impact of Public-Sector Expenditures For Contraceptive Services in California

By Jacqueline Darroch Forrest and Susheela Singh

Summary

A methodology previously used to calculate the number of unintended pregnancies averted nationally through publicly funded contraceptive services has been adapted for a state-level analysis in California. An estimated 136,800 unintended pregnancies—which would result in approximately 36,000 births, 85,100 abortions and 15,700 miscarriages—are averted each year because publicly funded contraceptive care is available from clinics and private physicians in California. Federal and state expenditures of $46 million for contraceptive services in California in FY 1989 resulted in an estimated savings of $232–$509 million in public costs for abortions, for prenatal and maternity care and for medical care, welfare and supplementary nutritional programs during the first two years after a birth. These savings represent an average of $7.70 saved for each dollar spent to provide contraceptive services. This savings/cost ratio is 75 percent higher than that previously estimated for the United States as a whole.

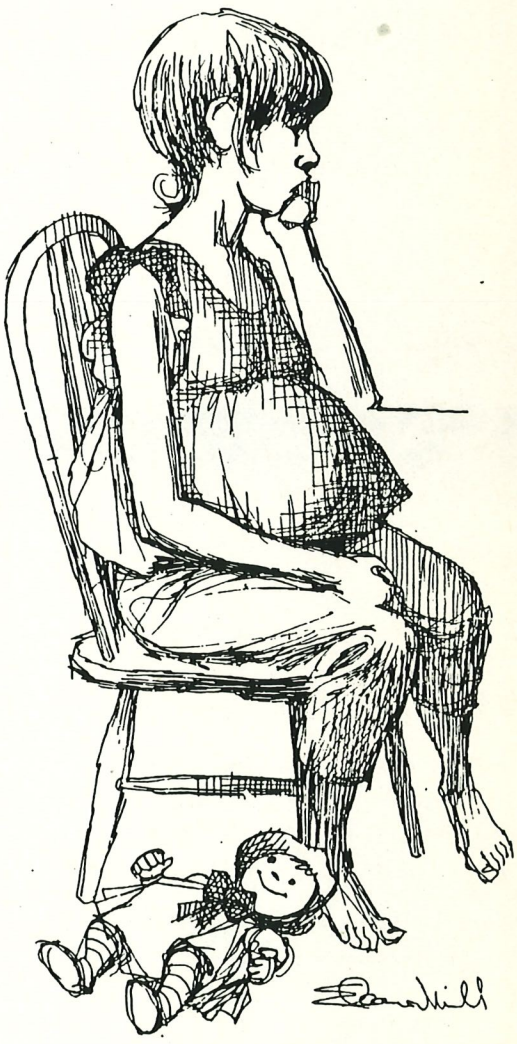
Introduction

The federal government provides the largest proportion of the public funds used for family planning in the United States. The

Jacqueline Darroch Forrest is vice president for research and Susheela Singh is assistant director of research with The Alan Guttmacher Institute.

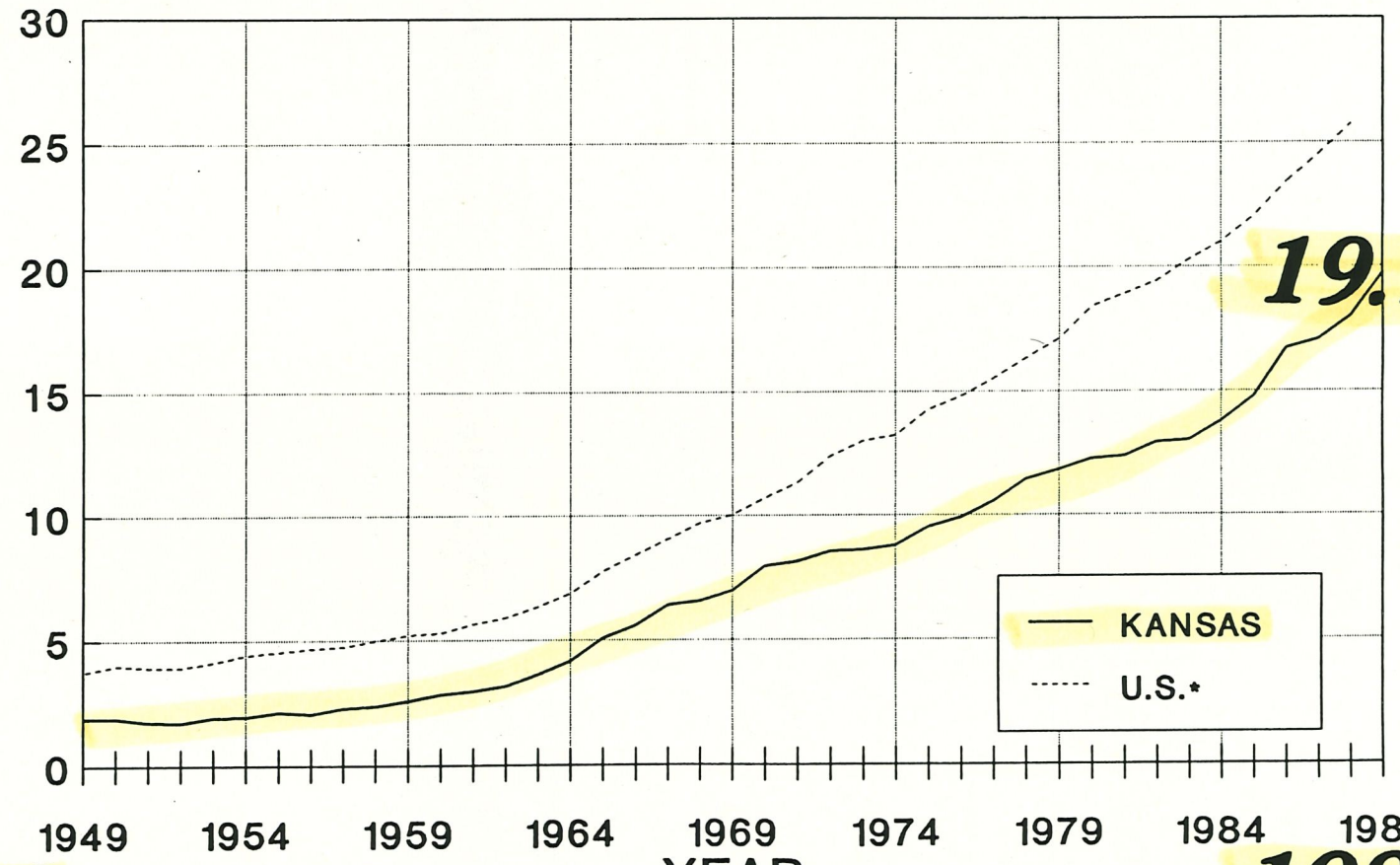
The authors gratefully acknowledge the assistance of Claire Brindis and Carol Korenbrot of the Center for Reproductive Health Policy Research at the Institute for Health Policy Studies, University of California, who provided data for many of the variables used and offered ongoing consultation; Jerry Hansen and other staff of the California Office of Family Planning and Thomas Kring and other staff of the Los Angeles Regional Family Planning Council, who provided computer data tapes for family planning clinic patients; Aida Torres, who assisted with analysis; and Ina Jedeikin and Joseph Picciano, who helped with data processing. This project was funded by grants from The James Irvine Foundation and The Prospect Hill Foundation.

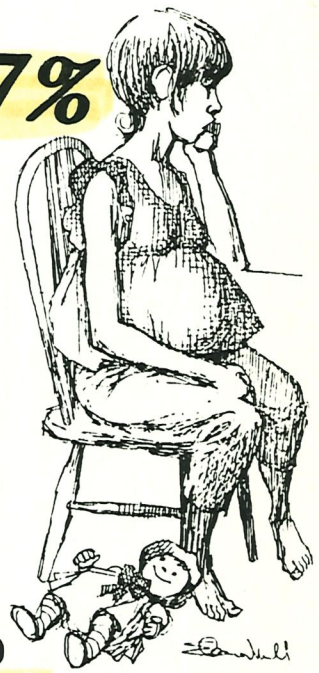
"Should funding for contraceptive s withdrawn, the additional unintende resulting births and abortions—wou already overburdened health and we



2-6/11

OUT-OF-WEDLOCK BIRTH RATIOS
KANSAS AND THE U.S., 1949-1989





19.7%

1949

1989

*DATA NOT AVAILABLE FOR 1989
RATIO PER 100 LIVE BIRTHS
RESIDENCE DATA

Figure 15

2-7/11

GURE 2. School/Community Program Intervention Model.

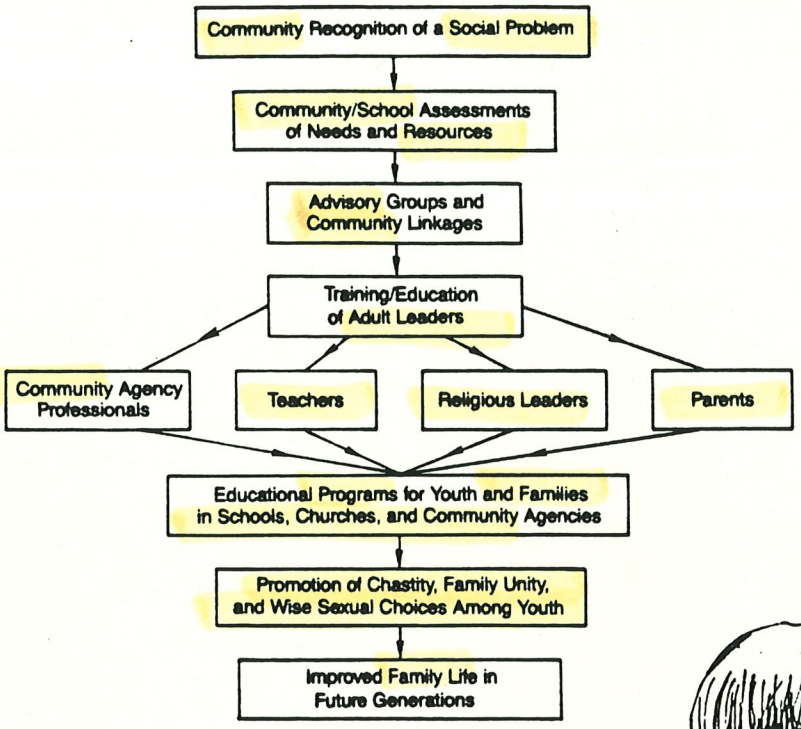
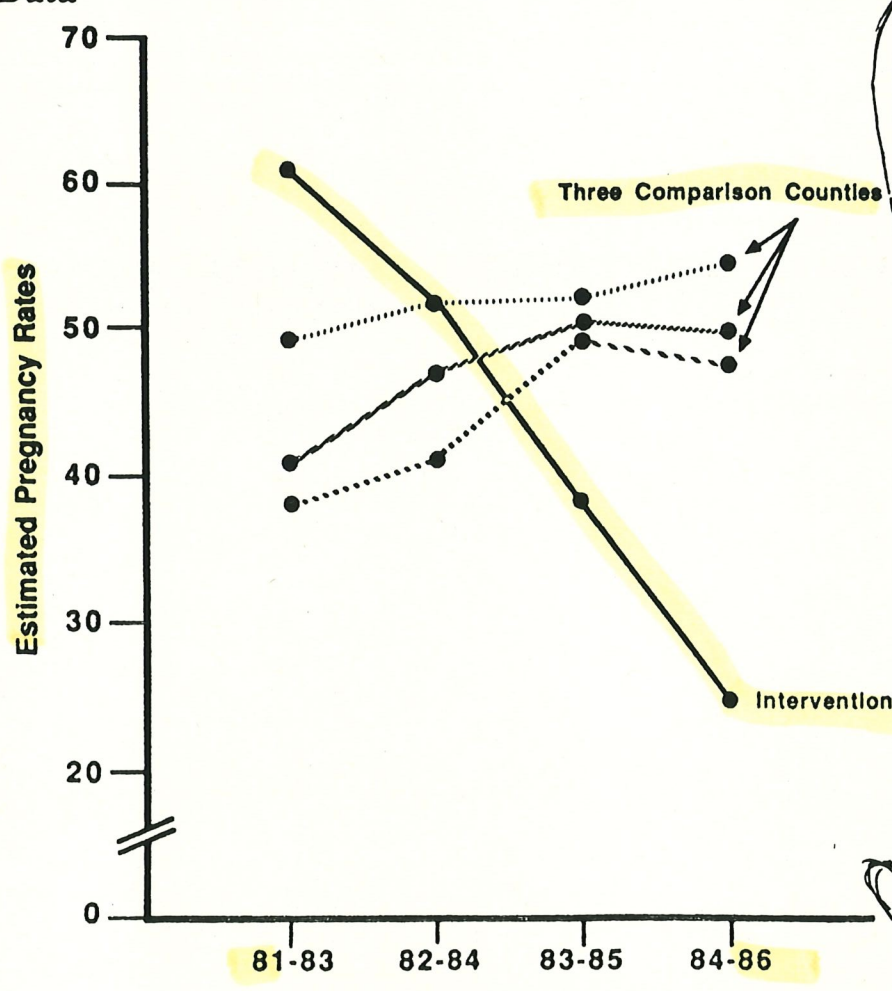
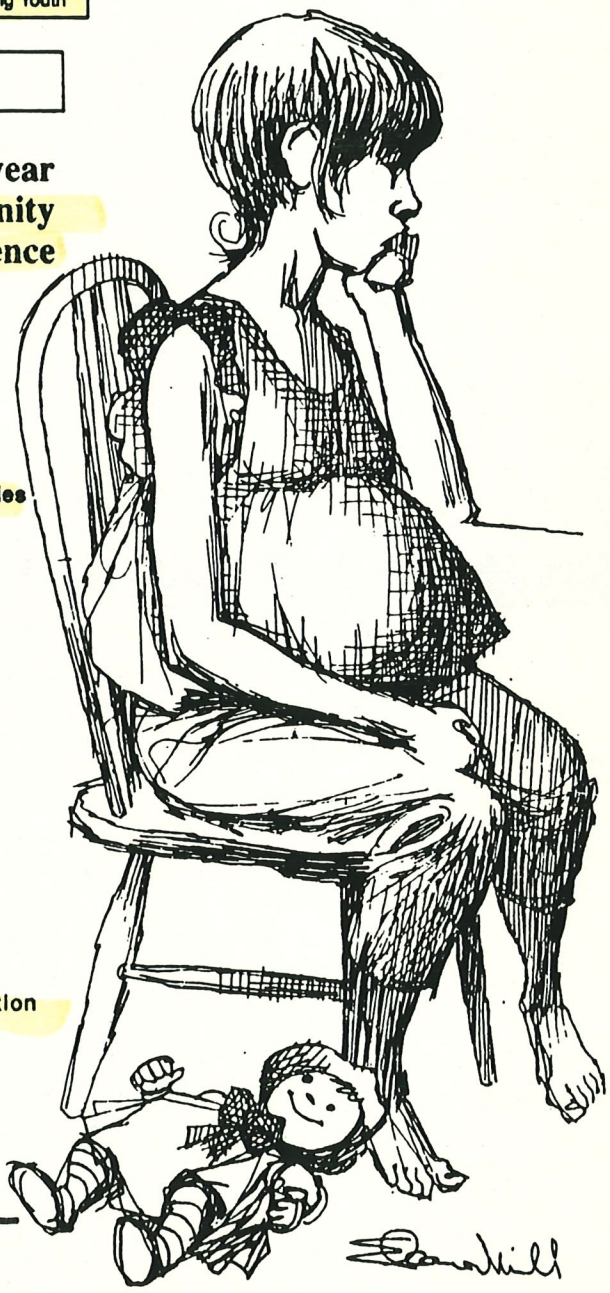


FIGURE 1. Estimated Pregnancy Rates (Three year average), Females Ages 14-17, Intervention Community and Three Comparison Counties, 1981-1986 Residence Data





2-8/11

GOAL

Improved social and health status through long-term sociocultural/health behavior change

OUTCOME OBJECTIVE

To reduce over time unintended pregnancy among never-married teens and preteens

PRIMARY BEHAVIORAL OBJECTIVE

To postpone initial sexual intercourse

SECONDARY BEHAVIORIAL OBJECTIVE

To appropriately use effective contraception

PRIMARY EDUCATIONAL OBJECTIVE

To postpone initial sexual intercourse

SECONDARY EDUCATIONAL OBJECTIVE

To appropriately use contraception

EDUCATIONAL SUBCOMPONENTS

Five core topic areas

1. BETTER PARENT-ADOLESCENT COMMUNICATION
2. VALUE SYSTEM BASED ON FAMILY INFLUENCES
3. IMPROVED SELF-ESTEEM
4. BETTER DECISION-MAKING
5. SEXUALITY AND CONTRACEPTION

PROCESS OBJECTIVE

Recruiting, educating, and training target audiences

2-9/11

He[illegible]ng Teenagers Postpone Sexual Involvement

By Marion Howard and Judith Blamey McCabe

Summary

In 1983, the Henry W. Grady Memorial Hospital in Atlanta began a family planning–based outreach program for eighth graders in a local school system. The program is led by older teenagers and focuses on helping students resist peer and social pressures to initiate sexual activity. Evaluation of the program, based on telephone interviews with 536 students from the hospital's low-income population, revealed that among students who had not had sexual intercourse, those who participated in the program were significantly more likely to continue to postpone sexual activity through the end of the ninth grade than were similar students who did not participate in the program. Because of their lower rate of sexual activity, program students also experienced comparatively fewer pregnancies than no-program students.

Table 2. Percentage of students who initiated sexual activity after eighth grade, by program status

Grade and gender	Program (N=256)	No program (N=109)
End of eighth		
Total (N=365)	4	20*
Boys (N=125)	8	29*
Girls (N=240)	1	15*
Beginning of ninth		
Total (N=365)	12	27*
Boys (N=125)	22	42**
Girls (N=240)	7	18**
End of ninth		
Total (N=365)	24	39*
Boys (N=125)	39	61**
Girls (N=240)	17	27**

*p<0.01. **p<0.05.

Some parents and educators have wondered whether giving young people information about contraceptives along with support for postponing sexual involvement is too confusing a message. Our data suggest that the two messages are not incompatible. Young people who received instruction from family planning counselors about human sexuality, including family planning, and advice from student leaders about postponing sexual involvement used information from each component of the program. Students involved in the program were more likely both to postpone sexual involvement and to use contraceptives when they did have sex than were the no-program group.

"SEX RESPECT" PROGRAM

09/07/90 FINAL TALLY FOR ALL ILLINOIS SCHOOLS NUMBER OF STUDENTS: 4,093

AVERAGE AGE: 13.6

	BEFORE PROGRAM COMPLETION	AFTER PROGRAM COMPLETION
18. THE BEST WAY FOR YOUNG PEOPLE TO AVOID AN UNWANTED PREGNANCY IS TO WAIT UNTIL THEY ARE MARRIED BEFORE HAVING SEX.		
A. STRONGLY AGREE	32%	52%
B. AGREE	35	32
C. NOT SURE	14	8
D. DISAGREE	19	8
39. SINCE YOU HAVE HAD THIS CLASS, ARE YOU NOW WILLING TO SAY "NO" TO SEX BEFORE MARRIAGE?		
A. YES		72%
B. NO		17%
19. THE BEST WAY FOR YOUNG PEOPLE TO KEEP FROM GETTING AIDS OR SOME OTHER SEXUALLY TRANSMITTED DISEASE IS TO WAIT UNTIL THEY ARE MARRIED BEFORE HAVING SEX.		
A. STRONGLY AGREE	29%	50%
B. AGREE	4	30
C. NOT SURE	17	10
D. DISAGREE	25	10
29. I WOULD NOT HAVE SEXUAL RELATIONS BEFORE MARRIAGE BECAUSE OF FEAR OF VD, AIDS, HERPES, SYPHILIS, ETC.		
A. AGREE	65%	77%
B. DISAGREE	33	21
32. A TEEN WHO HAS HAD SEX OUTSIDE OF MARRIAGE WOULD BENEFIT BY DECIDING TO STOP HAVING SEX AND WAIT UNTIL MARRIAGE.		
A. ABSOLUTELY TRUE	19%	34%
B. VERY TRUE	19	24
C. SOMEWHAT TRUE	47	33
D. NOT TRUE AT ALL	14	8
23. IS THE SEX ACT ALL RIGHT FOR UNMARRIED TEENS AS LONG AS NO PREGNANCY RESULTS OF IT?		
A. NO	38%	58%
B. YES	28	17
C. DON'T KNOW	34	24
13. DO YOU THINK SEXUAL URGES ARE CONTROLLABLE?		
A. ALWAYS	25%	43%
B. NEVER	5	4
C. SOMETIMES	55	46
D. DONT'T KNOW	16	7

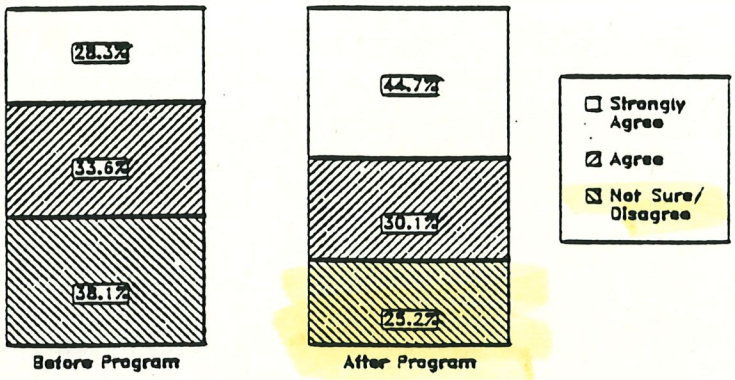
67%<

33%<

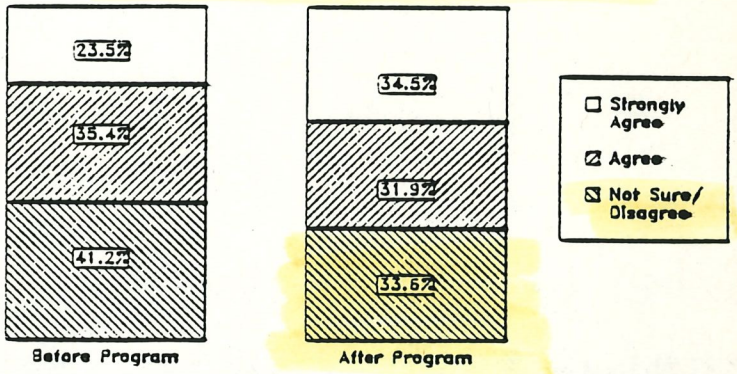
38%<

2-19/11

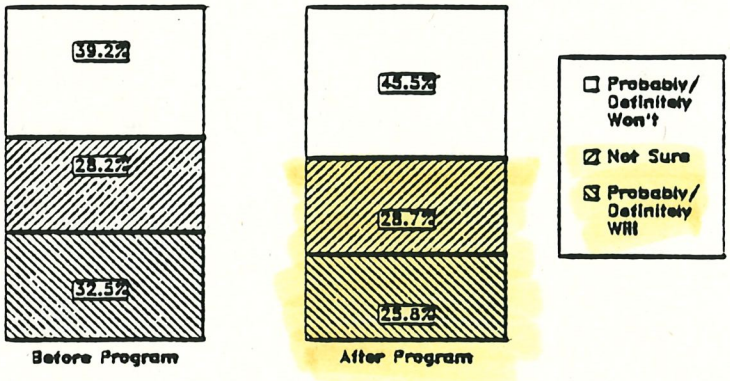
The best way for young people to avoid and unwanted pregnancy is to wait until they are married before having sex.

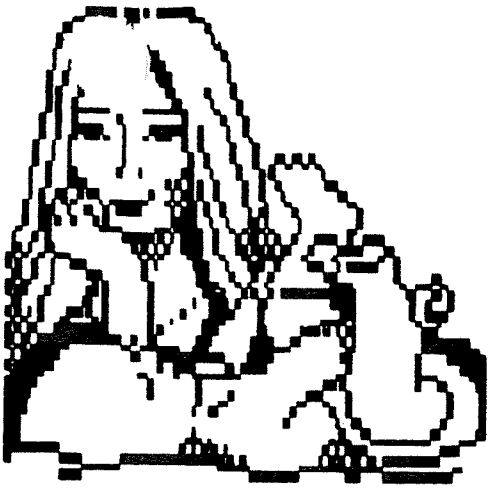


With all the problems of a possible pregnancy and the dangers of AIDS and other sexually transmitted diseases, it just doesn't make sense for teenagers to have sex before they're married.



How likely do you think it is that you will have sexual intercourse at any time before you get married.





House Bill No. 2531

The House Federal and State Affairs Committee

To The Committee:

Hi, my name is Heather Davis and I am a single teen mother. Yes, it is possible that you may be looking at me right now saying "Well she looks like she's handling life okay, where is the problem, and why do you need us?" Things like patience, love, kindness, and gentleness, just to name a few, can't be seen by looking on the outside. And I'm not up here showing you my bank statement either. What I am here to present to you though, is the reality to all of the statistics and a teen parent's inside struggles.

As a junior in high school I thought I had everything. I was popular, the class president and involved in everything a high school student could be involved in. But nobody said enough to stop me in my tracks and make me think about where my life was going, and I became pregnant with my son Brett. I can't blame one soul for what happened, but by knowing that if someone would have said something and I might have stopped gives me hope for those young people out there today searching for someone to say to them "NO, not everybody is doing it and you ARE someone, you can say NO!"

Senate Judiciary Committee
4-26-91
Attachment 3

Everyday I struggle with the choice I made by keeping my son, but no matter what choice any girl makes, it stays with them for the rest of their life. Brett's father has never shown any concern for Brett's well being. What will go through Brett's mind when he realizes that his father doesn't really care about him? Will he hate me for doing this to him? All of these questions will someday be answered, but my goal is to prevent these questions from even having a chance to be questioned. Now, it is up to us to make a difference, we need to give our kids a stable foundation for them to base their decisions on whether it would be giving them the courage to say "No", or educating them about birth control but most importantly, showing them the true to life devastating consequences.

Thankyou!!

Heather Davis
Peer Educator with the Teen Speakers Bureau
905 King St.
P.O.Box 861
Baldwin City, KS. 66006

3-2/2

TESTIMONY ON HOUSE BILL No. 2531---Arpil 24, 1991
Patricia Hollomon, 4758 SW 17th Terrace, Topeka

I am in favor of this bill for a number of reasons: First I am a Pastor's wife and have had the opportunity to counsel with several girls either before or after an abortion. I see the agony this has caused in their lives; even years later. I am strongly opposed to abortion. If there were no pregnancies, there would be no abortions. I only favor the use of contraceptives as a last measure for those who are already sexually active and REFUSE TO ABSTAIN.

Secondly: The savings for the tax payers would be great. We would have less on Welfare rolls. Since large numbers of girls do keep their babies and then have to have help from the state to support them.

Third: The program would also encourage them to do something with their lives; to stay in school, to help them make decisions about other things in a productive manner.

Fourth and finally, but not least of all. I had a daughter who became pregnant at age 16. The anguish that it caused for her and for the family was tremendous. She chose to carry the baby to term. As her mother, I watched her make painfully grown up decisions. It took her the entire nine months to know what to do. Most of that time she planned to keep the child. We had bought baby furniture, clothes etc. A week before his birth she decided to place him for adoption. A most unselfish decision for a teenager. That was four years ago.

Senate Judiciary Committee
4-24-91
Attachment 4

I have watched her struggle to put her life back together. I have seen the father of the child reappear in her life just six months ago and have seen them deal with the sorrow of knowing that they have a little boy out there that they will never see.

As Christian parents we taught her abstinence, but unfortunately the young people today get a totally different message at schools that hand out condoms and will help girls get abortions without their parent's knowledge. The music, movies, books that vie for teenage's money mostly promote sexual activity at an early age. We have to give our young people, both boys and girls a challenging option to the norm.

I am also the Youth Director at our church and I see these young people, Christian Youth struggling with sexuality. There is so much pressure on them to become sexual active. I feel strongly that the churches must work hand in hand with the parents, schools and government to encourage our youth to fight the prevalant patterns of their peers. This has to be a joint effort by all concerned individuals. It is obvious that the scare of veneral diseases, aids and pregnancy has not slowed down teen pregnancies.

I think that house bill # 2531 could be the tool that would start Kansas on the road to fewer teenage pregnancies, less monies spent in aid for dependent children, less abortions, and hopefully give our youth the ability to be independent from their peers in making life changing decisions.

KANSAS

To: Senate Judiciary Committee

From: Kelly Kultala - National Organization for Women

Re: Support of H.B. 2531

The National Organization for Women rises in support of H.B. 2531. This bill provides an excellent opportunity for pro-choice and anti-choice forces to combine and work towards a dialogue that could only benefit our teenagers.

I have three daughters, ages 11, 7 & 4, who want to grow up to be a teacher, a doctor and a ballerina, respectively. As parents, my husband and myself, try to teach our daughters values and sex education, however, they don't always listen to us, nor do we always know the answers. Therefore, we fully understand the pragmatic need for this program.

The educational and behavioral objectives of H.B. 2531 will help young people across the state learn to believe in themselves, enabling them to make decisions that will effect them the rest of their lives. Our young people deserve the opportunity to be able to use the tools they will receive in this program to make their dreams come true, whether it is to be a teacher, a doctor or a ballerina.

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Attachment 5

KANSAS CHILDREN'S SERVICE LEAGUE

OUTLINE OF TESTIMONY ON BEHALF
OF SENATE BILL 170
by
Maxine Elmore, LMSW, ACSW
District Director
Kansas Children's Service League
April 24, 1991

I. BACKGROUND

I am Maxine Elmore, District Director of the Kansas City Office of Kansas Children's Service League. I will be discussing one of the services provided by the Kansas City office, the **Black Family Preservtion Project**, a teenage pregnancy project.

II. PROGRAM INFORMATION

A. Need for Program

1. High incidence of teenage pregnancy in Wyandotte County and state of Kansas.
2. Consequences of Early childbearing.

   a. Health consequences include premature birth babies, low birth weight, increased chances of birth injuries, birth defects and pregnancy complica tions.

   b. Social consequences include diminished or interrupted education, lack of marketable skills, unemployment, public assistance or low paying jobs.

3. Early childbearing affects not only the teen parent and child but also the family and community in which they reside.

B. Implementation

1. The Black Family Preservation Project was initiated by the agency in the fall of 1984 with funding from the Kansas Department of Health and Environment.
2. In 1985 a community outreach to Black youth was developed and implemented.
3. Implementation of program at Northwest Middle School in 1986:

   a. Development of profile of students by school planning committee prior to implementation:
      -majority low income/poverty level homes
      -appeared to have low self esteem and few successful Black role models
      -minimal parental involvement with the school
      -high risk for sexual activities because of few after school activities and too much free time.

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b. Faculty Leadership Team
-plan program activities
-provide feedback on activities and impact.

C. Goals of the Program

1. To preserve and strengthen Black families by decreasing the incidence of pregnancy.
2. Implement a program that promotes adolescent, parent and family awareness of responsible sexuality and parenting.

D. Description of Program

1. Provide information on the consequences of early child-bearing and how to develop alternatives to early sexual activity. Approaches used include: Labs, Mini-Labs and Self Concept groups.
2. Community Networking.

E. Clients Served

1. All students at Northwest Middle School and their parents are invited to participate.
2. 972 persons were served in 1990.
3. 1991 Spring - 2 labs will be presented at West Middle School targeting Black males.
4. Services are not limited to Black students only. Service recipients include Caucasian and Hispanic students at Northwest and West Middle School.

F. Program Statistics

-No pregnancies in 1989 and 1990 at Northwest Middle School.

G. Staffing

1. Project Director
2. Project Coordinator
3. Volunteer Coordinator
4. Secretary

H. Funding

1. Kansas Department of Health and Environment
2. United Way of Wyandotte County
3. Contributions

III. CLOSING REMARKS

1. The decision to delay early sexual activity by stressing abstinence as the method to prevent teenage pregnancy is programmatic reflecting the prevailing community values and does not reflect agency's policy.

2. Community's acceptance of program - increased volunteer involvement.

3. Teen pregnancy continues to be a social problem in Kansas and KCSL remains committed to find innovative ways to try to solve the problem.

4. Our agency has proven on a small scale that teem pregnancy prevention can work.

5. Kansas Children's Service League strongly encourages the legislature support in the development of programs in this area to reduce the rate of children having children in the State of Kansas.

State of Kansas
Joan Finney, Governor

Department of Health and Environment
Division of Health

Stanley C. Grant, Ph.D.,
Acting Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

FAX (913) 296-6231

Testimony Presented to

Senate Judiciary Committee

By

Kansas Department of Health and Environment

H.B. 2531

The Problem of Teen Pregnancy High adolescent birthrates and pregnancy rates in the U.S. relative to those of other developed countries have well-documented serious and adverse consequences for the teenagers themselves, for their children and for society. Among these adverse consequences are: medical, educational, social, and vocational risks to adolescents; medical and developmental risks to infants and children; developmental risks to young parents; risks to the community; and public costs for supportive programs.

The reasons for teenage pregnancy are many and complex and are only partly understood. These include among others: the media; peer influence; religion; the family; proclivity of this age group toward risk-taking behaviors; and access to prevention and intervention services. All these effect adolescent decision-making or nondecision-making regarding their reproductive health needs.

As professionals we believe that since very few pregnant teenagers report that they wanted to get pregnant, it should not be difficult to develop interventions to prevent adolescent pregnancy. Nevertheless, despite considerable public attention given to the problem and despite the development of numerous programs designed to deal with it, adolescent pregnancies continue each year. Teens and their children become statistics of concern to those hard pressed to find cost-effective means of delivering services with limited resources.

In 1989 in Kansas, there were 4,576 births to adolescent mothers with 78 to minors under age 15. Teenagers accounted for 12% or 1/8 of live births in the state. More than one in four adolescent births represented a repeat birth during the teenage years.

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KDHE Programs In Kansas as in other states, professionals have long since discarded the idea of a "magic bullet" program to cure adolescent pregnancy. Rather, a variety of health, education and social services programs address the complex needs of adolescents, their parents and communities. Many of these approaches are interdependent both at the state and local levels as, for instance, when KDHE collaborates with KSDE in developing adolescent educational curricula, or when local health departments provide educational programs to community groups or when, within communities, groups concerned about the number of pregnancies in the high school convene to develop community strategies.

In Kansas, the Legislature has, since 1988, clearly demonstrated support for adolescent health by allocating funding specifically for demonstration projects.

Specific adolescent health projects funded by KDHE in SFY 91, all of which are comprehensive approaches requiring collaboration/integration of multiple community providers, include:

- Adolescent Primary Health Care - Projects in Geary, Johnson and Sedgwick counties provide a full range of medical and educational services to adolescents in clinic settings in the communities.

- Adolescent Health Risk Appraisal - Projects in Shawnee and Wyandotte counties provide health risk appraisals, counseling and followup to adolescents in schools regarding lifestyle and behavioral risks.

- Adolescent Community-Based Education - Projects in Wyandotte and Sedgwick counties provide health education programs to African American adolescents and their families focusing on teen pregnancy prevention, responsible parenting and consequences of too early childbearing.

- Adolescent Repeat Pregnancy Prevention, Maternity Centers - Projects in Douglas and Sedgwick counties provide repeat pregnancy prevention education with community linkages to assure prenatal services and continuing education.

Planning Considerations These and other adolescent pregnancy prevention efforts will require long-term, multi-generation investment in services. Services need to sensitive to community needs with community acknowledgement of the problem and willingness to intervene on behalf of their adolescents. Resources should be targeted for communities with consistently high demonstrated need and priority should be given to evaluation of the effectiveness of approaches. Approaches should include, at a minimum, encouragement of responsible decision-making including postponement of early sexual activity, education about the consequences of unintended pregnancy, and not exclude contraceptive education and medical services when these may be needed. Programs should strive for maximum parental and adolescent involvement in design, implementation and ongoing evaluation of services.

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Public Costs It is estimated that the public will pay an average of $13,902 over the next 20 years for the family begun by each first birth to a teenager. It is further estimated that if U.S. teenage births were delayed until the mother was at least 20 years old, the potential public savings over 20 years would be $5,560 for each birth delayed. Based on these estimates, if each of the 4,576 teen births in Kansas in 1989 had been postponed, the potential public savings can be estimated at $25 million over 20 years. Another study provides the estimate that for every $1 investment in services to help avoid unintended pregnancies, about $4.40 is saved.

RECOMMENDATION

Kansas Department of Health and Environment supports the concept of teen pregnancy prevention. This initiative was not included in the Governor's FY92 budget.

Testimony presented by: Azzie Young, Ph.D.
Director, Bureau of Family Health
Kansas Department of Health and Environment
April 24, 1991

Appendices

1. Reported Teenage Pregnancies by Age-Group and Component, Kansas, 1989 Source: Kansas Department of Health and Environment
2. Teen Pregnancy Rates by Age-Group by County of Residence, Kansas 1985-89 Source: Kansas Department of Health and Environment

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Teen Pregnancy Rates* by Age-Group
By County of Residence, Kansas 1985-1989

County of Residence	Year											
	1985		1986		1987		1988		1989		5-year Rate*	
	Age-Group		Age-Group		Age-Group		Age-Group		Age-Group		Age-Group	
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-1
ALLEN	-	85.7	1.9	63.9	-	51.8	-	55.4	-	73.8	0.4	66.
ANDERSON	-	52.6	-	54.2	-	63.4	-	50.9	-	47.3	-	53.
ATCHISON	1.6	64.2	-	51.8	3.1	60.1	1.6	66.1	1.6	51.3	1.6	58.
BARBER	-	96.0	-	89.3	-	90.4	-	52.4	-	31.4	-	71.
BARTON	-	75.3	-	64.6	-	45.5	-	52.6	-	57.7	-	59.1
BOURBON	3.8	64.0	1.9	71.3	-	63.0	-	68.8	-	88.8	1.1	71.
BROWN	-	97.0	-	51.9	2.4	76.9	2.4	65.8	-	74.0	1.0	73.1
BUTLER	0.6	45.3	-	53.7	-	46.2	-	37.8	0.5	48.1	0.2	46.
CHASE	-	78.7	-	24.7	-	51.3	-	92.1	-	13.2	-	52.0
CHAUTAUQUA	-	46.4	-	98.6	-	34.2	-	72.8	-	33.1	-	57.0
CHEROKEE	-	65.6	-	105.4	1.2	83.1	1.2	82.5	-	83.9	0.5	84.1
CHEYENNE	10.3	51.7	-	67.3	-	-	-	62.5	-	31.3	2.1	42.6
CLARK	-	74.6	-	113.2	-	37.7	-	18.2	-	72.7	-	63.3
CLAY	-	74.2	-	55.7	-	58.2	-	59.8	-	36.5	-	56.9
CLOUD	3.1	33.2	-	55.2	-	48.6	-	51.9	3.1	43.2	1.2	46.4
COFFEY	-	57.5	3.1	42.7	-	49.5	-	34.6	-	37.7	0.6	44.4
COMANCHE	-	21.7	-	-	-	62.5	-	12.3	-	49.4	-	29.2
COWLEY	-	70.3	0.8	80.9	-	68.3	-	92.2	-	87.2	0.2	79.8
CRAWFORD	0.9	44.8	1.0	67.1	-	59.7	1.0	52.5	2.1	52.5	1.0	55.3
DECATUR	-	41.7	-	39.2	-	30.9	-	31.9	-	31.9	-	35.1
DICKINSON	1.5	45.5	1.5	42.9	-	51.4	-	48.3	-	45.1	0.6	46.6
DONIPHAN	2.7	89.8	-	44.5	-	51.1	-	29.9	-	41.8	0.5	51.4
DOUGLAS	2.2	37.1	1.7	36.3	0.6	35.9	0.5	41.6	1.6	41.4	1.3	38.5
EDWARDS	8.8	70.8	-	52.6	-	53.8	-	108.7	-	32.6	1.8	63.7
ELK	-	47.6	-	79.2	-	50.5	-	61.9	-	72.2	-	62.3
ELLIS	-	16.7	-	20.3	-	23.7	-	25.2	-	22.3	-	21.6
ELLSWORTH	-	37.4	-	62.1	-	33.9	-	67.0	-	27.9	-	45.7
FINNEY	0.0	116.4	2.5	120.9	2.4	86.6	6.3	106.2	-	118.4	2.4	109.7
FORD	1.2	107.4	1.2	97.8	-	120.6	-	99.0	-	126.3	0.5	110.2
FRANKLIN	5.2	77.6	-	64.4	-	74.6	3.9	77.5	1.3	77.5	2.1	74.3
GEARY	2.3	122.3	4.5	95.6	2.3	103.4	2.3	121.6	1.2	106.7	2.5	109.9
GOVE	-	53.8	-	24.6	-	-	-	8.8	-	26.3	-	22.7
GRAHAM	-	55.0	-	63.2	-	22.0	-	44.4	-	22.2	-	41.4
GRANT	-	66.9	-	95.1	-	65.6	-	58.4	3.4	66.1	-	70.4
GRAY	-	38.0	-	60.8	-	79.5	-	12.7	4.3	69.6	-	52.1
GREELEY	-	92.6	-	22.2	-	88.9	-	65.2	-	43.5	-	62.5
GREENWOOD	-	80.5	-	69.2	-	50.6	-	50.6	-	62.3	-	62.6

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Teen Pregnancy Rates* by Age-Group
By County of Residence, Kansas 1985-1989

County of Residence	Year											
	1985		1986		1987		1988		1989		5-year Rate*	
	Age-Group		Age-Group		Age-Group		Age-Group		Age-Group		Age-Group	
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19
HAMILTON	-	58.8	-	39.2	-	39.2	-	48.5	-	48.5	-	46.8
HARPER	-	101.5	-	81.9	-	11.7	-	96.6	4.0	45.5	-	67.4
HARVEY	1.1	52.2	-	41.8	-	44.7	-	46.6	1.0	44.6	0.4	46.0
HASKELL	-	75.8	-	37.3	-	141.8	-	73.5	-	20.4	-	71.6
HODGEMAN	-	25.3	-	49.4	-	64.9	-	27.8	-	83.3	-	50.1
JACKSON	4.8	42.3	-	60.1	-	66.1	-	68.7	-	76.9	1.0	62.8
JEFFERSON	-	40.4	-	64.4	-	38.1	-	52.9	-	52.9	-	49.7
JEWELL	-	19.9	-	20.3	-	6.9	-	21.3	-	14.2	-	16.5
JOHNSON	1.1	43.6	1.1	50.0	-	52.4	0.7	54.3	0.7	53.5	0.7	50.8
KEARNY	14.6	61.7	-	93.8	-	64.1	-	73.3	-	86.7	2.9	75.9
KINGMAN	-	38.3	-	46.3	-	24.8	-	45.1	-	27.8	-	36.5
KIOWA	-	8.5	-	52.6	-	26.5	-	26.3	-	52.6	-	33.3
LABETTE	1.1	70.9	-	43.2	-	63.7	2.2	73.0	1.1	96.2	0.9	69.4
LANE	-	41.7	-	35.3	-	36.1	-	24.7	-	24.7	-	32.5
LEAVENWORTH	0.5	61.5	0.5	62.3	-	63.6	0.9	70.9	3.0	79.4	1.0	67.5
LINCOLN	-	-	-	13.0	-	12.0	-	10.8	-	53.8	-	17.9
LINN	-	63.6	6.9	72.0	-	52.8	6.6	56.0	-	74.6	2.7	63.8
LOGAN	-	48.5	-	11.1	-	-	-	44.9	-	-	-	20.9
LYON	1.7	42.6	0.8	50.1	3.2	44.3	1.6	46.9	-	36.2	1.5	44.0
MARION	-	39.4	-	36.3	-	34.6	-	29.6	-	29.6	-	33.9
MARSHALL	-	67.7	-	81.2	-	69.4	-	79.8	-	79.8	-	75.6
MCPHERSON	-	25.7	-	23.2	-	28.3	-	39.2	-	33.8	-	30.0
MEADE	-	81.1	-	36.0	-	37.7	-	38.5	-	38.5	-	46.4
MIAMI	1.2	53.7	1.1	65.1	-	79.1	-	54.3	1.0	73.2	0.7	65.1
MITCHELL	-	30.3	-	26.6	-	19.8	-	36.9	-	16.4	-	26.0
MONTGOMERY	1.4	87.5	1.4	87.0	-	92.4	-	81.1	1.5	81.9	0.9	86.0
MORRIS	-	35.7	-	46.3	-	60.2	-	41.3	-	73.4	-	51.4
MORTON	-	26.5	-	69.6	-	33.6	-	40.0	6.7	24.0	-	38.7
NEMAHA	-	55.2	-	23.3	-	23.8	-	42.0	-	21.0	-	33.1
NEOSHO	-	66.1	1.4	58.5	-	63.2	-	55.6	-	50.8	0.3	58.8
NESS	-	42.0	8.1	49.2	-	25.9	-	18.2	-	18.2	1.6	30.7
NORTON	-	24.2	-	22.0	-	44.4	-	5.5	-	38.7	-	27.0
OSAGE	-	51.2	-	50.8	-	39.4	-	57.6	-	64.6	-	52.7
OSBORNE	-	40.8	-	42.0	-	58.0	-	52.2	-	67.2	-	52.0
OTTAWA	-	48.1	-	66.7	-	5.7	-	52.9	-	35.3	-	41.7
PAWNEE	-	47.4	-	50.5	-	18.7	4.5	39.1	-	43.0	0.9	39.7
PHILLIPS	4.8	43.3	-	43.0	-	60.8	-	44.7	9.0	44.7	2.8	47.3

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Teen Pregnancy Rates* by Age-Group

By County of Residence, Kansas 1985-1989

County of Residence	Year										5-year Rate*	
	1985		1986		1987		1988		1989			
	Age-Group		Age-Group		Age-Group		Age-Group		Age-Group		Age-Group	
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19
POTTAWATOMIE	1.8	51.2	3.4	86.9	-	60.0	-	48.2	-	38.5	1.0	57.0
PRATT	3.2	78.5	3.3	66.9	-	31.8	-	30.0	-	36.0	1.3	48.6
RAWLINS	-	39.7	-	50.8	-	25.2	-	24.8	-	41.3	-	36.4
RENO	1.4	65.7	1.9	58.0	1.4	57.0	1.4	65.3	0.9	54.3	1.4	60.1
REPUBLIC	-	27.2	-	58.8	-	30.9	-	12.8	-	19.2	-	29.8
RICE	2.8	58.3	-	48.1	-	49.0	-	68.7	-	54.9	0.6	55.8
RILEY	0.7	40.3	1.4	32.2	1.4	39.2	1.4	43.8	0.7	46.9	1.1	40.5
ROOKS	-	98.4	-	69.4	-	58.5	-	57.8	-	46.2	-	66.1
RUSH	8.9	11.6	-	14.7	-	44.8	-	58.0	-	58.0	1.8	37.4
RUSSELL	-	71.1	-	55.3	-	40.8	-	50.8	-	10.2	-	45.6
SALINE	1.2	64.3	1.9	52.8	1.3	51.0	0.6	72.2	1.9	60.6	1.4	60.2
SCOTT	-	44.4	-	52.3	-	41.7	-	29.9	-	53.9	-	44.4
SEDGWICK	1.5	78.6	1.0	79.3	1.2	81.0	1.2	85.5	2.0	80.6	1.4	81.0
SEWARD	1.4	120.0	2.8	109.8	-	117.8	-	137.8	2.7	105.6	1.4	119.8
SHAWNEE	2.1	77.7	2.1	78.0	1.1	71.9	1.9	78.4	2.7	87.7	2.0	78.7
SHERIDAN	-	8.8	-	19.4	-	29.4	-	0.7	-	38.8	-	21.2
SHERMAN	4.0	55.2	-	43.6	-	59.2	-	61.4	-	50.5	0.8	54.0
SMITH	-	49.3	-	39.1	-	31.5	-	47.2	-	47.2	-	42.9
STAFFORD	-	53.3	-	43.8	-	51.0	-	25.6	-	51.3	-	45.0
STANTON	-	34.5	-	21.1	-	43.0	-	33.0	-	65.9	-	39.5
STEVENS	10.4	58.2	-	62.2	-	51.3	-	97.4	-	35.9	2.1	61.0
SUMNER	2.2	58.9	1.1	65.2	-	56.5	-	59.6	2.2	62.0	1.1	60.4
THOMAS	3.2	33.5	-	54.8	-	45.9	-	35.5	-	41.9	0.6	42.3
TREGO	-	73.4	-	50.0	-	10.4	-	31.9	-	21.3	-	37.4
WABAUNSEE	4.0	61.5	-	46.0	-	37.7	-	41.7	-	33.3	0.8	44.0
WALLACE	-	13.7	-	92.3	-	59.7	-	56.3	-	70.4	-	58.5
WASHINGTON	-	17.2	-	53.9	-	20.0	-	24.9	-	34.8	-	30.2
WICHITA	9.7	95.2	-	20.2	-	41.2	-	21.1	-	42.1	1.9	44.0
WILSON	2.5	50.9	-	48.7	-	63.6	-	56.4	-	51.5	0.5	54.2
WOODSON	-	129.0	-	31.7	-	67.8	-	27.0	-	27.0	-	56.5
WYANDOTTE	3.7	109.1	4.1	114.5	3.3	115.5	3.6	123.1	4.7	122.0	3.9	116.8
KANSAS	1.5	64.2	1.2	64.8	1.0	63.5	1.1	67.6	1.4	67.0	1.2	65.4

*Rates per 1,000 age-group population

**The 1984 age-group population estimates were provided by the U.S. Census Bureau. Estimates for 1985 and 1990 were provided by the Kansas University Institute for Public Policy and Business Research. 1986, 1987 and 1988 estimates were derived by KDHE staff from the previously mentioned estimates.

Source: Kansas Department of Health and Environment

7-6/9

Reported Teenage Pregnancies by Age-Group* and Component
Kansas, 1989

County of Residence	Live Births		Stillbirths		Abortions		Total Pregnancies		Teenage Pregnancy Rates**		Teenage Preg. Rates**
	Age-Group		Age-Group		Age-Group		Age-Group		Age-Group		Age-Group
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-19
ALLEN	-	32	-	3	-	5	-	40	-	73.8	38.0
ANDERSON	-	11	-	-	-	2	-	13	-	47.3	21.5
ATCHISON	-	30	-	-	1	8	1	38	1.6	51.3	28.5
BARBER	-	6	-	-	-	-	-	6	-	31.4	13.0
BARTON	-	49	-	-	-	8	-	57	-	57.7	28.0
BOURBON	-	41	-	-	-	8	-	49	-	88.8	45.5
BROWN	-	21	-	-	-	6	-	27	-	74.0	34.2
BUTLER	-	75	-	3	1	6	1	84	0.5	48.1	23.1
CHASE	-	1	-	-	-	-	-	1	-	13.2	6.5
CHAUTAUQUA	-	5	-	-	-	-	-	5	-	33.1	16.0
CHEROKEE	-	53	-	-	-	9	-	62	-	83.9	39.9
CHEYENNE	-	2	-	-	-	1	-	3	-	31.3	14.7
CLARK	-	3	-	-	-	1	-	4	-	72.7	23.5
CLAY	-	10	-	-	-	1	-	11	-	36.5	16.9
CLOUD	1	13	-	-	-	2	1	15	3.1	43.2	23.9
COFFEY	-	12	-	-	-	-	-	12	-	37.7	18.9
COMANCHE	-	3	-	-	-	1	-	4	-	49.4	25.6
COWLEY	-	92	-	-	-	12	-	104	-	87.2	42.7
CRAWFORD	-	59	-	-	2	16	2	75	2.1	52.5	32.2
DECATUR	-	3	-	-	-	-	-	3	-	31.9	13.3
DICKINSON	-	23	-	2	-	3	-	28	-	45.1	21.7
DONIPHAN	-	12	-	-	-	2	-	14	-	41.8	20.3
DOUGLAS	1	81	-	-	2	94	3	175	1.6	41.4	29.3
EDWARDS	-	2	-	1	-	-	-	3	-	32.6	12.9
ELK	-	7	-	-	-	-	-	7	-	72.2	33.0
ELLIS	-	23	-	-	-	7	-	30	-	22.3	13.0
ELLSWORTH	-	4	-	-	-	1	-	5	-	27.9	12.5
FINNEY	-	120	-	-	-	16	-	136	-	118.4	56.0
FORD	-	85	-	-	-	12	-	97	-	126.3	58.5
FRANKLIN	1	46	-	-	-	12	1	58	1.3	77.5	38.9
GEARY	1	161	-	-	-	4	1	165	1.2	106.7	69.2
GOVE	-	3	-	-	-	-	-	3	-	26.3	11.8
GRAHAM	-	2	-	-	-	-	-	2	-	22.2	9.8
GRANT	1	16	-	-	-	1	1	17	3.4	66.1	32.6
GRAY	1	9	-	-	-	2	1	11	4.3	69.6	30.6
GREELEY	-	2	-	-	-	-	-	2	-	43.5	14.8
GREENWOOD	-	13	-	-	-	3	-	16	-	62.3	28.4

7-7/9

Reported Teenage Pregnancies by Age-Group* and Component
Kansas, 1989

County of Residence	Live Births Age-Group		Stillbirths Age-Group		Abortions Age-Group		Total Pregnancies Age-Group		Teenage Pregnancy Rates** Age-Group		Teenage Preg. Rates** Age-Group
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-19
HAMILTON	-	4	-	-	-	1	-	5	-	48.5	25.1
HARPER	1	8	-	-	-	-	1	8	4.0	45.5	21.2
HARVEY	1	41	-	-	-	3	1	44	1.0	44.6	22.7
HASKELL	-	4	-	-	-	-	-	4	-	29.4	13.0
HODGEMAN	-	6	-	-	-	-	-	6	-	83.3	46.9
JACKSON	-	22	-	-	-	6	-	28	-	76.9	35.1
JEFFERSON	-	20	-	-	-	8	-	28	-	52.9	24.6
JEWELL	-	2	-	-	-	-	-	2	-	14.2	6.4
JOHNSON	3	270	-	3	5	292	8	565	0.7	53.5	25.4
KEARNY	-	11	-	-	-	2	-	13	-	86.7	38.0
KINGMAN	-	8	-	-	-	-	-	8	-	27.8	12.2
KIOWA	-	6	-	-	-	-	-	6	-	52.6	22.1
LABETTE	1	79	-	2	-	6	1	87	1.1	96.2	48.6
LANE	-	1	-	-	-	1	-	2	-	24.7	10.6
LEAVENWORTH	1	109	-	-	6	49	7	158	3.0	79.4	38.2
LINCOLN	-	3	-	-	-	2	-	5	-	53.8	22.0
LINN	-	16	-	-	-	4	-	20	-	74.6	35.1
LOGAN	-	-	-	-	-	-	-	-	-	-	-
LYON	-	52	-	-	-	16	-	68	-	36.2	21.6
MARION	-	11	-	-	-	-	-	11	-	29.6	14.3
MARSHALL	-	10	-	-	-	5	-	15	-	79.8	25.1
MCPHERSON	-	29	-	-	-	8	-	37	-	33.8	19.6
MEADE	-	4	-	-	-	-	-	4	-	38.5	15.3
MIAMI	-	41	-	-	1	17	1	58	1.0	73.2	33.8
MITCHELL	-	3	-	-	-	1	-	4	-	16.4	8.1
MONTGOMERY	2	108	-	-	-	4	2	112	1.5	81.9	41.5
MORRIS	-	13	-	-	-	3	-	16	-	73.4	35.2
MORTON	1	2	-	-	-	1	1	3	6.7	24.0	14.6
NEMAHA	-	7	-	-	-	-	-	7	-	21.0	9.3
NEOSHO	-	25	-	-	-	7	-	32	-	50.8	24.5
NESS	-	2	-	-	-	-	-	2	-	18.2	8.1
NORTON	-	7	-	-	-	-	-	7	-	38.7	19.0
OSAGE	-	25	-	-	-	12	-	37	-	64.6	31.1
OSBORNE	-	8	-	-	-	1	-	9	-	67.2	28.1
OTTAWA	-	5	-	1	-	-	-	6	-	35.3	17.4
PAWNEE	-	11	-	-	-	-	-	11	-	43.0	22.9
PHILLIPS	2	8	-	-	-	-	2	8	9.0	44.7	24.9

7-8/9

Reported Teenage Pregnancies by Age-Group* and Component
Kansas, 1989

County of Residence	Live Births		Stillbirths		Abortions		Total Pregnancies		Teenage Pregnancy Rates**		Teenage Preg. Rates**
	Age-Group		Age-Group		Age-Group		Age-Group		Age-Group		Age-Group
	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-14	15-19	10-19
POTTAWATOMIE	-	19	-	-	-	1	-	20	-	38.5	17.8
PRATT	-	10	-	-	-	2	-	12	-	36.0	17.9
RAWLINS	-	5	-	-	-	-	-	5	-	41.3	18.1
RENO	2	92	-	-	-	26	2	118	0.9	54.3	27.6
REPUBLIC	-	3	-	-	-	-	-	3	-	19.2	8.4
RICE	-	20	-	-	-	-	-	20	-	54.9	28.6
RILEY	-	101	-	2	1	66	1	169	0.7	46.9	33.6
ROOKS	-	8	-	-	-	-	-	8	-	46.2	17.9
RUSH	-	4	-	-	-	-	-	4	-	58.0	21.9
RUSSELL	-	1	-	1	-	-	-	2	-	10.2	4.2
SALINE	1	82	-	2	2	10	3	94	1.9	60.6	31.0
SCOTT	-	9	-	-	-	-	-	9	-	53.9	24.3
SEDGWICK	22	929	1	6	5	109	28	1044	2.0	80.6	39.9
SEWARD	2	66	-	-	-	6	2	72	2.7	105.6	52.1
SHAWNEE	11	312	-	2	3	149	14	463	2.7	87.7	45.4
SHERIDAN	-	3	-	-	-	1	-	4	-	38.8	16.3
SHERMAN	-	14	-	-	-	-	-	14	-	50.5	27.8
SMITH	-	5	-	-	-	1	-	6	-	47.2	21.1
STAFFORD	-	8	-	-	-	-	-	8	-	51.3	23.2
STANTON	-	5	-	-	-	1	-	6	-	65.9	32.6
STEVENS	-	6	-	-	-	1	-	7	-	35.9	16.6
SUMNER	1	44	-	-	1	6	2	50	2.2	62.0	30.0
THOMAS	-	12	-	-	-	1	-	13	-	41.9	19.4
TREGO	-	1	-	-	-	1	-	2	-	21.3	7.8
WABAUNSEE	-	5	-	-	-	3	-	8	-	33.3	16.3
WALLACE	-	5	-	-	-	-	-	5	-	70.4	33.3
WASHINGTON	-	7	-	-	-	-	-	7	-	34.8	14.0
WICHITA	-	2	-	1	-	1	-	4	-	42.1	20.5
WILSON	-	20	-	-	-	1	-	21	-	51.5	25.9
WOODSON	-	3	-	-	-	-	-	3	-	27.0	14.4
WYANDOTTE	21	586	-	10	8	140	29	736	4.7	122.0	63.0
KANSAS	78	4,498	1	39	38	1,219	117	5,756	1.4	67.0	~~33.3~~ 33.4

*Rates per 1,000 age-group population

**The 1984 age-group population estimates were provided by the U.S. Census Bureau. Estimates for 1985 and 1990 were provided by the Kansas University Institute for Public Policy and Business Research. 1986, 1987 and 1988 estimates were derived by KDHE staff from the previously mentioned estimates.

***County of residence for one abortion unknown.

Source: Kansas Department of Health and Environment

7-9/9

RCAR in KANSAS

Religious Coalition for Abortion Rights in Kansas

Madam Chair woman and Members of the Committee:

I am Darlene Stearns, State Co-ordinator for the Religious Coalition for Abortion Rights in Kansas, which is supported by the ten faith groups listed on the reverse of this testimony.

RCAR is committed to the protection of religious and reproductive freedom, we support sex education and birth control and we are very concerned about the rise in teen pregnancies.

So, we are delighted to support HB 2531. What a pleasure to have before us legislation that addresses, and offers solutions to, serious problems in our communities.

Any program that holds the promise of reducing teen pregnancy, reducing the spread of sexually transmitted disease and involves the entire community is worthy of support. on those merits alone, but is also, surely, cost effective. Prevention is always less expensive than a cure, and in this case, encompasses savings in dollars as well as preventing the physical, emotional and educational stresses accompanying teen pregnancy.

RCAR has in place clergy who are trained counselors and educators and I can assure you that, all over the state, you will find those clergy ready and willing to support and work with these programs.

Who can oppose this concept? In a period of tight money we are all searching for ways to reduce tax expenditures and RCAR believes this is one way to do just that. Please support HB 2531. We pledge our help in implementing this legislation.

Darlene Greer Stearns
State Co-Ordinator RCAR in Kansas

Darlene Greer Stearns

Senate Judiciary Committee
4-24-91

1248 BUCHANAN TOPEKA, KANSAS 66604 913 354 4823

Attachment 8

POLICY COUNCIL FOR RELIGIOUS COALITION FOR ABORTION RIGHTS IN KANSAS

BOARD OF CHURCH & SOCIETY, KANSAS EAST CONFERENCE UNITED METHODIST CHURCH

UNION OF AMERICAN HEBREW CONGREGATIONS, MID-WEST COUNCIL

PRESBYTERY OF NORTHERN KANSAS, PRESBYTERIAN CHURCH USA

UNITED CHURCH OF CHRIST, KANSAS-OKLAHOMA DISTRICT

COMMITTEE ON WOMEN'S CONCERNS, SYNOD OF MID-AMERICA, PRESBYTERIAN CHURCH USA

UNITARIAN UNIVERSALIST, PRAIRIE STAR DISTRICT

NATIONAL FEDERATION OF TEMPLE SISTERHOODS

TOPEKA YOUNG WOMEN'S CHRISTIAN ASSOCIATION

UNITARIAN UNIVERSALIST SERVICE COMMITTEE

KANSAS EAST CONFERENCE, UNITED METHODIST CHURCH

8-24

A Nonbearing Account

BY NOEL PERRIN

Sometime in 1987 world population hit 5 billion. Sometime a little before 2000 it will hit 6 billion. Sometime around 2010 . . . Obviously growth like this can't continue indefinitely. We'll run out of parking space for all the cars. We'll run out of flight paths for all the airplanes. We'll eventually run out of essentials like food. A country like Nepal has already run out of firewood.

But how do you stop the relentless increase of humanity, currently proceeding at the rate of almost 2 million a week? Well, the most interesting idea I've heard is to do it with money. More specifically, bank accounts. One for every woman in the world. Forget the rest of the world for a minute: here is how the plan would work in the United States. Every girl, when she reached puberty, would notify her local population center. (These sunny offices had better be staffed entirely by women—well-paid ones, too.) At that moment a financial clock would start ticking.

If the girl went the next year without having a baby, she would get a government check for $500, placed in the bank account the center now opened for her. She could take it all out and spend it on angora sweaters, if she wanted. She could leave it in as the beginning of a fund for college. Whatever she liked. The next year, if she still hadn't had a baby, the government would increase the sum by a hundred, so that her second check would be for $600. The year after, $700. A young woman reaching the age of 20, and still not having had a child, would receive a check for around $1,200. No fortune, but worth having. Available without any discrimination of any kind. A Miss du Pont, an ordinary kid in Topeka, an intending nun, a teenage prostitute, all would get their checks.

Suppose the young woman *wants* a child, though. There's nothing to stop her, except a little financial self-interest. If at 21 she proceeded to have a baby, fine. Let's have a baby shower. The government payment, however, would abruptly drop to zero. But then, if she did not have another baby the next year, back would come a check for $500. If she went two years, she'd get $600, and so on up the modest pay ladder. A pleasant little extra income for the sex that has historically been underpaid.

Great bargain: What would all this cost? In the case of women who never do have children, plenty. Start at 13 with a check for $500 and by the time you reached menopause at 53, the check would be $4,500. To that point, you would have received a total of almost $100,000. A lot of money. But still a bargain. A great bargain. The same hundred thousand is about half the cost of bringing up one abandoned child in New York City. It's less than a fifth the cost of bringing up one psychologically disturbed child in a group home in the District of Columbia. The total cost the first year would be about a billion dollars in payments to girls, maybe 2 or 3 billion to set up the centers. The total cost the fifth year would be around $10 billion. The cost wouldn't level off for about 40 years—and when it did, it would still be under what we now pay as welfare. And most of the money would flow back out immediately to stores or get turned over somewhat later to happy bursars at colleges.

Do I possibly exaggerate when I say that when the plan was in full operation, and every woman in the country between puberty and menopause receiving her check, the cost would still be less than that of the current welfare system? I don't think I do. Try looking in the "Statistical Abstract of the United States." The current figure is $770 billion a year—$298 billion in state and local money, $472 billion from the federal government. That table covers many things, including VA hospitals. So turn to a more modest table, the one called "Cash and Noncash Benefits for Persons With Limited Incomes." Here the total is $114 billion, all federal money.

Why not stem the population explosion by paying women not to have babies?

Such a plan would be much harder to implement in, say, India, where most people don't have bank accounts and where the government would be hard pressed to find the funds. But it wouldn't be impossible. Such payment could be the first-ever democratic foreign aid—putting money directly in the hands of women, rather than in the pockets of businessmen and bureaucrats. Furthermore, India has already found ways to pay men to have vasectomies.

Of course there are problems with such a plan. Men will object to all this money going to women, money being power. There are bound to be accusations of racism, even though the offer would be voluntary, universal and totally color blind. There being no precedent (though there's plenty of precedent for the opposite case: governments paying women to *have* children), it would be hard to get started. The more stolid type of politician will call the plan impossible, utopian, dreamy, absurd.

But consider the alternatives. One, of course, is to go on exactly as we are—adding a billion people every few years until there is no more tropical forest, no more oxygen-carbon dioxide balance, no more space, and our world collapses in disaster. Another is nuclear war. A third (the likeliest, I expect) is mandatory birth control, starting one country at a time, with all the repression that implies. The repression is already there in China. And with the rigid immigration restrictions imposed by those countries that have started early against those that start late. Maybe even with population wars. How much more graceful to do it all with checks.

Perrin, who has written for The New Yorker and New York magazine, is professor of English at Dartmouth College.

8-3/4

Teen pregnancies cost U.S. $16.6 billion in '85

WASHINGTON (AP) — Teen-age childbearing cost the nation $16.6 billion last year, and the 385,000 children who were the firstborn of adolescents in 1985 will receive $6 billion in welfare benefits over the next 20 years, said a study released Tuesday.

The first baby born to a teenager last year will receive $15,620 in welfare payments and other government support by the time the child reaches age 20, according to the study released by the privately financed Center for Population Options.

By the time these babies reach age 20, the government will have spent $6.04 billion to support them through Aid to Families with Dependent Children, Medicaid and food stamps, said the report, titled "Estimates of Public Costs for Teen-age Childbearing."

The center, founded in 1980, is dedicated to preventing unwanted teen-age pregnancies. It favors increased access to family planning and sexual education services for teenagers. The center also operates the International Clearinghouse on Adolescent Fertility, as well as a resource center on sex education.

The report said a third of the welfare total — $2.4 billion — could have been saved had teen-age mothers waited until they had reached age 20 to have their first baby.

The study estimated the government spent $16.5 billion last year in welfare costs to support the families started by teen-age mothers. This estimate includes payments for AFDC, Medicaid and food stamps as well as the costs of administering these programs.

"This figure represents minimal public costs in that it does not include other services such as housing, special education, child protection services, foster care, day care and other social services," the report's summary said.

A study by the Urban Institute estimated that in 1975, teen-age childbearing cost the nation $8.5 billion in welfare payments and administrative costs.

Echoing a study recently released by the House Select Committee on Children, Youth and Families, the center's report recommended that more money be spent on programs to prevent teen-age pregnancy.

8-4/4

STATE OF KANSAS

CHILDREN AND YOUTH ADVISORY COMMITTEE

SMITH-WILSON BLDG.
300 S.W. OAKLEY
TOPEKA, KANSAS 66606-1898

(913) 296-2017

KANS-A-N 561-2017

TESTIMONY BEFORE THE SENATE JUDICIARY COMMITTEE
Senator Wint Winter, Jr. - Chairperson
HB 2531 - April 25, 1991

Mr. Chairperson and members of the committee, thank you for the opportunity to testify today. My name is Doug Bowman, and I represent the Children and Youth Advisory Committee.

Programs which encourage teenagers to delay parenthood have a positive impact upon them as prospective parents, as well as their potential children. Teen pregnancy has been correlated with many other social problems: dropping out of school, unemployment, child abuse, low birth-weight babies, and long-term reliance on public assistance programs.

Several features of this proposal are of particular interest to us. The initial emphasis on abstinence from sexual behavior of teenagers is a positive goal, and requires a strong educational component. We are also pleased to see the development of a multi-faceted, community advisory group. This group will work to develop a program that fits into their community context.

The Children and Youth Advisory Committee will gladly assist the Department of Health and Environment in the administration of these grants. We have a decade of experience in oversight of the Kansas Family and Children's Trust Fund. This expertise should serve us well in the establishment of these proposed programs.

Teenage pregnancy is a complex, social problem requiring the creation of innovative solutions. These programs can be seen as pilots projects which might be replicated in other communities. Subsequent benefits could include the strengthening of our young people, our families, and our communities.

Senate Judiciary Committee
4-24-91
Attachment 9

LEAGUE OF WOMEN VOTERS OF KANSAS

919½ South Kansas Avenue Topeka, KS 66612 (913) 234-5152

April 24, 1991

Senator Winter and members of the Senate Judiciary Committee:

I am Barbara Reinert, representing the Kansas League of Women Voters. The League gives enthusiastic support to HB 2531 and all it aims to achieve.

For years, we have been urging for interagency, intergovernmental, interfamily, intermedia, interprofessional, interschool, interanybody approach to the problem surrounding teenage pregnancy. So, of course, we endorse HB 2531 and applaud its authors.

Some of you will remember a presentation made to this committee a few years ago by a Topeka panel of teenage moms. All of us hearing those young women were greatly moved and impressed by the manner in which they re-told their experiences. During the committee discussion, the wish was expressed that all teenagers could hear the panel.

In Topeka, District 501, all the high schools and middle schools have had the chance to see and listen to "The Teen Moms". Last school year, in 501, the number of teen pregnancies dropped, considerably, below the number recorded in the previous year. This pleasant circumstance leads us to suggest that a greater emphasis be placed on the participation of teenage persons throughout the grant proposal process; the implementation of the program; the follow-up evaluation.

We also suggest seeking out teens from at-risk populations, from various types of schools, experiences, ages, economic levels, etc. And, whenever possible, involve young men because improving responsible behavior is best when shared.

Many thanks for giving the League a chance to boost a great idea.

Barbara Reinert

Barbara Reinert
LWVK Lobbyist

Senate Judiciary Committee
4-24-91
Attachment 10

Planned Parenthood®
Of Kansas, Inc.

Testimony in support of House Bill 2531

I am Marian Shapiro, director of the Planned Parenthood family planning clinic in Hays, and associate director of Planned Parenthood of Kansas. I am certified as a sexuality educator by the American Association of Sex Educators, Counselors and Therapists and have been active in the field of sex education for the past 18 years and pregnancy counseling for the past 15 years.

I am submitting written testimony in support of H.B. 2531, a very sound and sensible approach to reducing teenage pregnancy in our state. We can gain understanding about the causes and solutions of the problem of teenage pregnancy by looking at a 1981 study of teenage pregnancy done by the Alan Guttmacher Institute comparing the United States with five other industrialized countries. You can see on the accompanying graph that the U.S. has a much higher teen pregnancy rate than any of the other countries – 96 out of every thousand female teens aged 15 - 19 gets pregnant each year. In England, Wales and Canada they have about half of the teen pregnancy rate that we do, and of course, half the abortion rate. France has 41 per thousand, Sweden 35 per thousand, and the Netherlands 14. **We have seven times the pregnancy rate of the Netherlands, and five times their abortion rate!**

Why are they doing so much better than we are? One might assume that the much lower pregnancy rates were the result of less sexual activity due perhaps to closer families, less drug use, less sex in the media, and stronger religious and moral values. Researchers, however, did **not** find this to be true. The sexual activity rate was about the same in those countries as it was here, that is that roughly half of high school students have had sexual intercourse. So what made the big difference? Those countries had much better comprehensive and mandatory sex education K - 12, birth control was much more accessible to teens, and the society was more open and honest in the way sex was treated.

The educational program set forth in H.B. 2531 has all the components of an excellent comprehensive approach to human sexuality. I would like to focus for a moment on one important aspect of this program with which I have extensive personal experience, and that is the requirement of doing Parent/Son and Parent/Daughter programs. I have presented these programs through several churches in Hays for the past ten years, and have learned a few things which you might find interesting.

1. The parents often tell me afterwards that they feel **they** learned as much as the kids did. (Especially Dads say this.) This says something about why parents may be reluctant to educate their children about sexuality. Besides feeling uncomfortable about discussing

Senate Judiciary Committee
4-24-91
Attachment 11

Wichita — 2226 East Central, Wichita, Kansas 67214-4494 316 263-7575
Hays — 122 East 12th, Hays, Kansas 67601 913 628-2434

this very private and sensitive topic, parents obviously feel they don't have current, factual information.

2. The stricter the religious background of the parents, the more appreciative they are for help in opening up communication about a subject that has long been associated with guilt, sin and embarrassment.

3. Parents report that it is much easier to discuss sexuality with their children after attending a program **together**, because they've both heard the same program and the kids feel that "**now** their parents know about this stuff!"

I think it is much easier to support a program if you know what is being taught. Since H.B.2531 calls for a **community-based** teen pregnancy reduction program and stipulates the integration of community values, morals and standards, each model program will necessarily be custom-made, and one can't tell apriori the exact content. I can share with you, however, what we teach in our Parent/Child Programs. Father Bob Wichael from St. Michael's Church in Hays, who co-facilitated the most recent Father/Son program with me, told the boys that their bodies were made by God and that no parts of their bodies were bad or dirty, that all people have God-given sexual feelings of attraction to others and that these feelings aren't bad, but that we all have to learn how to handle them and be prepared for those strong feelings. We want to reassure kids who are beginning puberty, a time of upheaval, change and awkwardness, that they are normal; that all of us went through the same confusing, embarrassing time. Good comprehensive sexuality education teaches kids the importance of high self-esteem. We want to help them feel good enough about themselves and feel strong enough in their own family values that they can resist peer pressure and exploitation, and that they won't exploit others. They also learn correct, factual information about how the reproductive system works, about the transmission of sexually transmitted diseases, about the full-time, life-long responsibility of bringing a child into the world, and how to prevent an unwanted pregnancy once they become sexually active. Students who have had such a comprehensive sexuality education tend to postpone first intercourse, and when they do become sexually active, are much more likely to use reliable contraception, thereby reducing teen pregnancy and abortion.

I have one small concern, and that is how to accurately ascertain the pregnancy rate in the community for the past five years. Many pregnancies among teens go undetected, especially those who deliver a baby out of town or out of state, or who have abortions. I understand the need for this data to demonstrate the effectiveness of the educational intervention. Aside from this small concern, I wholeheartedly support the community-based teen pregnancy prevention program. Please let me know if I can provide assistance in any way. Thank you.

Marian Shapiro

11-2/5

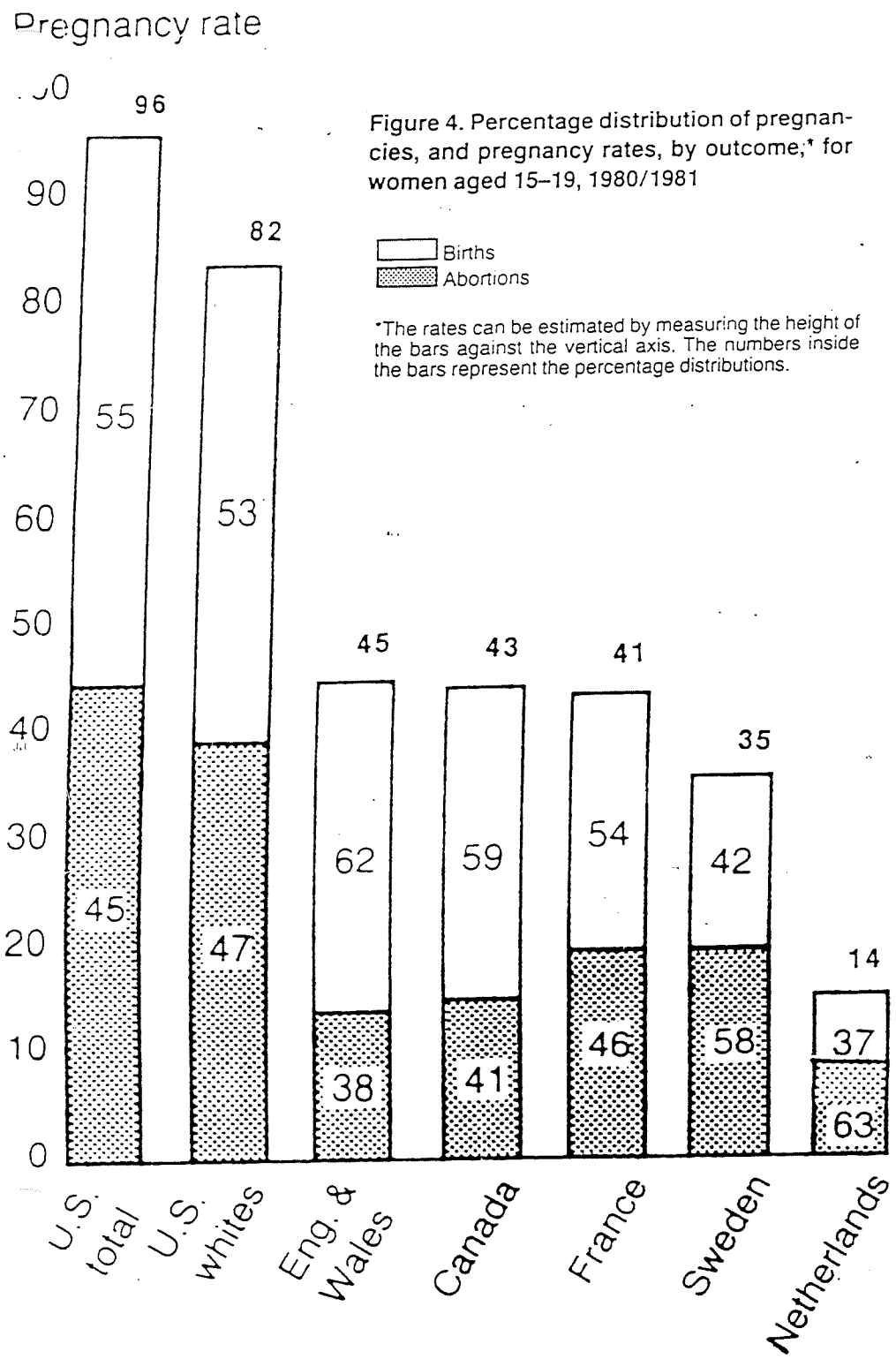


Figure 4. Percentage distribution of pregnancies, and pregnancy rates, by outcome,* for women aged 15–19, 1980/1981

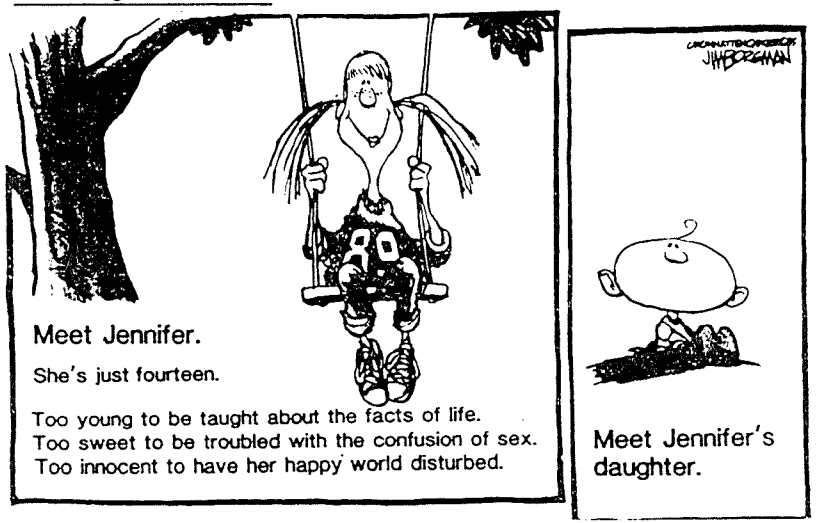
Births
Abortions

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

The bar graph at the right is from an Alan Guttmacher Institute study of teenage pregnancy released in 1985. You can see that the U.S. has a much higher teen pregnancy rate than any of the other countries — 96 out of every thousand female teens aged 15 - 19 gets pregnant each year. England, Wales and Canada have about half of the teen pregnancy rate that we do, and of course, half the abortion rate. France has 41 per thousand, Sweden 35 per thousand, and the Netherlands 14. We have seven times the pregnancy rate of the Netherlands.

Why are they doing so much better than we are? One might assume that the much lower pregnancy rates were the result of less sexual activity due to closer families, less drug use, less sex in the media, and stronger religious and moral values. Researchers, however, did **not** find this to be true. The sexual activity rate was about the same in those countries as it was here, that is that roughly half of high school students have had sexual intercourse. So what made the big difference? Those countries all had much better mandatory sex education K - 12, birth control was much more accessible to teens, and the society was more open in the way sex was treated.

Jim Borgman's View:



PARENTS AND SONS TOGETHER

LEARNING AND SHARING FEELINGS ABOUT BECOMING A MAN

For 6th to 9th grade boys and their parents

- What it means to be male in our society
- The changes of puberty
- Male and female anatomy
- Understanding the feelings or emotions that accompany body changes
- Am I normal? a question everybody asks
- Different rates of growth
- Reproduction - how it works
- Family and church values concerning sex
- Becoming more secure about your own values
- Knowing how peer pressure and self-esteem can affect decisions

Program designed and coordinated by:
Marian Shapiro
Certified Sexuality Educator
Hays Planned Parenthood

Co-facilitated with:
Fr. Bob Wichael
Pastor
St. Michael's Church

To enroll call: **628-2434** Monday -Thursday, 9-5, or **628-8537** evenings

Enrollment fee: **$12** per couple (Scholarships available for low-income families)

Two Sunday afternoons: Nov.26 and Dec. 3, 1:30 to 4:30

Another Planned Parenthood program to encourage family communication

11-4/5

PARENTS & DAUGHTERS TOGETHER

LEARNING & SHARING FEELINGS ABOUT BECOMING A WOMAN

For girls & their moms or dads (or other adult)

- **The changes of puberty**
- **Male and female anatomy**
- **Understanding the feelings or emotions that accompany body changes**
- **Am I normal? a question everybody asks**
- **Different rates of growth**
- **Reproduction - how it works**
- **Family and church values concerning sex**
- **Becoming more secure about your own values**
- **Knowing how peer pressure and self-esteem can affect decisions**

Program designed and presented by:
Marian Shapiro, Certified Sexuality Educator

To enroll call: 628-2434 Monday -Thursday, 9-5, or 628-8537 evenings
Enrollment fee: $12 per couple (Scholarships available for low-income families)

Two part program: Saturday, Nov. 4 and Sunday Nov. 12, 1:30 to 4:30 pm

Another **Planned Parenthood** program to encourage family communication

11-5/5

JOAN FINNEY
Governor

WENDELL LEWIS
Chairperson

JOHN KELLY
Executive Director

KANSAS PLANNING COUNCIL on DEVELOPMENTAL DISABILITIES SERVICES

Tenth Floor West
Docking State Office Building
Topeka, Kansas 66612-1570
VOICE-TDD
(913) 296-2608

April 10, 1991

SENATE WAYS AND MEANS

COMMITTEE

HOUSE BILL 2531

H.B. 2531 - PILOT PROJECT - REDUCTION OF TEENAGE PREGNANCY

Chairperson Bogina and members of the Senate Committee on Ways and Means, my name is John Kelly, and I am representing the Kansas Planning Council on Developmental Disabilities Services (KPCDDS).

The KPCDDS supports H.B. 2531 and see this initiative a worthwhile and significant step for Kansas. My remarks concern the bleak future often faced by young mothers and their children.

Young maternal age is a significant concern when addressing issues surrounding pregnancy. The babies of adolescent mothers are at risk for low birth weight and this risk increases with each pregnancy which occurs during the teen years (McAnarney, 1989). **Adolescent mothers often do not receive early (first trimester) prenatal care.** According to the March of Dimes, they are almost three times as likely as older mothers to receive late to no prenatal care.

Pregnancy complications in very young mothers (under age 15) may include toxemia, anemia, prolonged labor and premature labor (Boham and Placek, 1978). According to Alan Guttmacher Institute, (1981) the maternal death rate of mothers under 15 years of age is 2.5 times that for young adult mothers (age 20-24). Poor eating habits, use of cigarettes, alcohol and drugs increase many teens' risk for a poor pregnancy outcome.

The National Center for Health Statistics data demonstrates that the number of births to girls under 20 years of age reached a peak during the 1970's and has shown a reduction in the last decade (cited in Hayes, 1987). Kansas Department of Health and Environment records show 4,396 live births to mothers under 20 years of age in 1988 (Kansas Department of Health and Environment, 1989). This accounts for approximately 11% of all live births in the state. There were 4,344 live births to mothers between 15-19 years of age and 52 live births to mothers 10-14 years of age.

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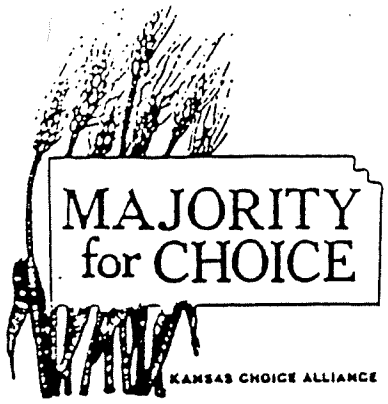
Birth outcomes are only one concern for children born to adolescent mothers. The development of a child who is raised by an adolescent mother is often problematic. Responsibilities of child rearing make it difficult for many adolescent mothers to complete their high school education. **Hofferth (1987) observed that these children face increased risks of reduced intellectual and school achievement in addition to problems with self-esteem and social behavior.** There also appears to be a correlation between the number of years of school that an adolescent mother fails to complete and her child's I.Q. and other achievement scores (Hayes, 1987).

With limited education and poor employment prospects, these young mothers and their children often face a bleak future.

Thank you for the opportunity to present these research findings to you.

FOR MORE INFORMATION CONTACT:
John F. Kelly, Executive Director
Kansas Planning Council on
Developmental Disabilities Services
Telephone 913/296-2608



TESTIMONY ON HB 2531 GIVEN TO THE SENATE JUDICIARY COMMITTEE, APRIL 24, 1991

THE KANSAS CHOICE ALLIANCE
BETH POWERS, SPOKESPERSON

AAUW

ACLU OF KANSAS AND WESTERN MISSOURI

B'NAI B'RITH WOMEN

CHOICE COALITION OF GREATER KC

COMPREHENSIVE HEALTH FOR WOMEN

JEWISH COMMUNITY RELATIONS BUREAU

NCJW, GREATER KC SECTION

NOW (KANSAS)

NOW (KC URBAN)

NOW (SE KANSAS)

NOW (WICHITA)

NOW (CAPITOL CITY)

PLANNED PARENTHOOD OF GREATER KC

PLANNED PARENTHOOD OF KANSAS

PROCHOICE ACTION LEAGUE

RCAR OF KANSAS

WICHITA FAMILY PLANNING

WICHITA WOMENS CENTER

WOMENS HEALTH CARE CENTER

YWCA OF TOPEKA

YWCA OF WICHITA

The Kansas Choice Alliance is in strong support of HB 2531. We are a coalition of groups concerned with responsible reproductive freedom. We recognize that our state's young people are becoming sexually active increasingly early in their development. Many of Kansas' young people are facing decisions about birth control, motherhood and abortion long before these questions should enter into their lives. Unfortunately, our schools and our families do not always succeed in educating teens about the need to delay sexual activity. We support HB 2531 with its goal of providing support for teens who face pressure to prematurely engage in sexual activity. Our teens need to be actively encouraged to become assertive, self-confident people capable of saying no to irresponsible sexual behavior. HB 2531 outlines a plan that can help the teens of Kansas achieve this goal.

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Statement to Senate Judiciary Committee
re: HB 2531

Kansas Action for Children, Inc. is very supportive of efforts to reduce teen pregnancy. In particular, KAC believes that the provisions of HB 2531 (the community-based approach, the local matching requirement, the evaluation component, etc.) are excellent and are likely to lead to effective programs to reduce teen pregnancy.

Since 1981, no state money has been allocated to fund family planning services or to fund primary prevention of teen pregnancy. There are a few local programs in existence, but no comprehensive state plan or consistent program of prevention. KAC believes that HB 2531 is an excellent beginning in assuring that all teens in our state understand the choices before them and the consequences of those choices, and then have the skills they need to make informed decisions.

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GOVERNMENT DOES NOT SOLVE TEENAGE PREGNANCY

The common thread running through almost all of the adolescent-pregnancy debates has been the bland assumption that government has the responsibility somehow to solve or alleviate what a coterie has chosen to consider a malignancy. Even when the disputable nature of the statistics is recognized, there are those who insist that the problem of "children....having children" is such that "it would be irresponsible to ignore teenage pregnancy" and, therefore, that government action is justifiable.[114] One essential question is not only unanswered but unasked - whether, even if you grant that adolescent pregnancy is a problem, government can improve matters.

The record is far from reassuring. During the period between the late 1960s and the early 1980s, the government-subsidized family-planning/sex-education effort expanded at an unprecedented rate.

The adolescent pregnancy rate - that is, the rate of births plus the rate of abortions - had declined between 1957 and 1971, at which time the new federally funded sex programs began to expand in earnest, and at which time there began a step-by-step increase in adolescent pregnancy. Although fertility - that is, live births per thousand women of age 15 to 19 - continued downward, the pregnancy rate - that is, births plus abortions per thousand women - began to increase. [124] The reason, of course, the increasing pregnancies did not result in higher fertility was that the teenage abortions rate increased explosively after 1972, so that by the end of the decade 45 percent of all pregnancies among teenagers were being aborted.

[114] Gilbert Y. Steiner, The Futility of Family Policy (Washington: The Brookings Institution, 1981), pp. 71-88.

[124] Jacqueline R. Kasun, Testimony before the United States Senate Committee on Labor and Human Resources, March 31, 1981.

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id as Table 3, page 4 of attachment "Teenage Pregnancy" and Figure 2, page 3 of the same document show, even these high levels of abortion barely counteracted the upsurge in teen pregnancies so that after 1976 there were no further declines in teenage fertility, despite massive increases in government spending.

Not only did teenage pregnancy increase when the government intervened to control it, but it was subsequently discovered that teenage pregnancy decreased when visits to the government-funded family-planning clinics declined. In 1980 the state of Utah passed a law requiring parental consent for contraceptives given to minors. In the following year there was a decline in clinic attendance by teenagers, and the pregnancy rate - which had been increasing among girls of 15-27 - declined for the age-group, as did abortion and birth rates. [125] The facts are indisputable. For some, they clearly demonstrate the failure of the public programs and the justification for their termination. For those holding this view, the fact that the burgeoning pregnancy rates are joined inexorably to expanding premarital sex activity, which has led to ballooning abortion rates, constitutes the final nails in the coffin for the public programs. The problems the promoters are facing are those they have created, which in turn are defying their stratagems to correct them.

Dr. Jacqueline Kasun states that which has been omitted in most studies is that which is probably the most important determinant of differences amoung young people in levels of premarital sex activity and pregnancy. The analysts have carefully measured and reported the influence of race, religion, education, and family stability, but they omitted the key determinant of demand - the price. What is the "price" of premarital sex activity for a teenager? It is, like any other price, the terms on which it is available.

[125] Press release by United Families of America, March 8, 1983, quoting figures from Utah Department of Health.

15-2/23

youngster who is given free contraceptives by her school birth control clinic without her parents' knowledge and with the promise of a free and confidential abortion in case of pregnancy, faces a low price for premarital sex activity. She can be expected to consume more of it than a girl with less easy access to contraceptives and abortion. Though sociologists may not admit it, it is an established fact well understood by most people that human beings -- and teenagers are human beings--do respond to incentive and disincentives. Her studies show that states which spend most heavily to provide free contraceptives and abortions have the highest rates of premarital teenage pregnancy. And the differences are major. The rate of premarital teenage pregnancy is more than twice as high in California as in Idaho or South Dakota; and California spends more than four times as much per capita as the other two states on "free" birth control.

To people of practical understanding, the relationship between price and demand is obvious. The notion that teenagers can be deterred from becoming pregnant by more and easier access to contraceptives and abortions is like expecting people who are given free gasoline to reduce their driving.

Even if the intention is not to discourage sex activity or pregnancy but only to reduce child-bearing by women under the age of 20 by any means available, including abortion, there is no evidence that government programs of sex education and birth control do the job.

Dr. Jacqueline R. Kasun is Professor of Economics at Humboldt State College, Arcata, CA

4/24/91

Submitted by Pat Turner, 900 Country Acres, Wichita, KS 67212
RIGHT TO LIFE OF KANSAS. INC.
Vice President & Fourth District Coordinator

15-3/23

EFFECTS OF FAMILY PLANNING PROGRAMS ON TEENAGE PREGNANCY

Presented By Stan E. Weed
Institute for Research and Evaluation

Briefing on

"The Impact of Family Planning Services on Teenage Pregnancy"

Organized for the

Congressional Coalition on Population and Development

By the

Population Resource Center,
Population Association of America

March 11, 1987

Room EF 100
Capitol Building
Washington D. C.

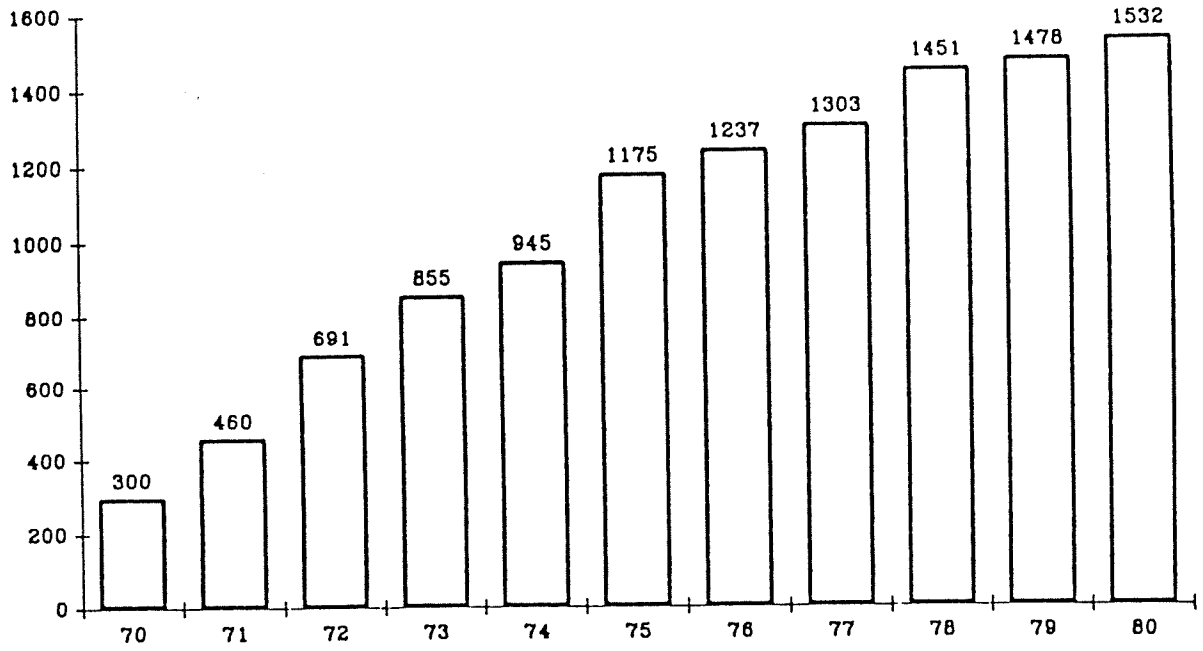
15-4/23

EFFECTS OF FAMILY PLANNING PROGRAMS ON TEENAGE PREGNANCY

During the past decade and a half, a major federal attempt to address the problem of teenage pregnancy has consisted of the provision of family planning services to teenagers through some 5,000 family planning clinics throughout the country.

TEENAGE CLIENTS OF ORGANIZED FAMILY PLANNING PROGRAMS 1970 – 1980

(Clients numbers in 000s)

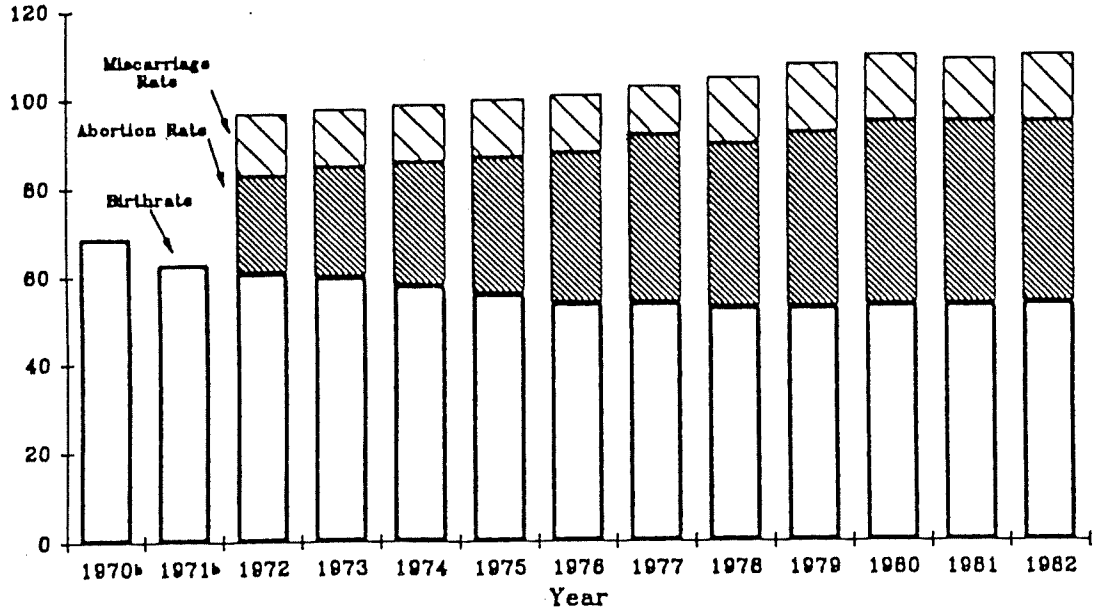


Source: Allen Guttmacher Institute 1982, Current Functioning and Future Priorities in Family Planning Services Delivery. p.32

Currently, about a million and a half teenagers are involved in these clinic programs each year. During this period, there has been a decline in the adolescent birth rate, but a general increase in the abortion rate as well as the overall pregnancy rate.

15-5/23

Adolescent Pregnancy Rate and Outcomes, 1970 - 1982



a The pregnancy rate is the sum of the birth, abortions and miscarriage rates

b Pregnancy, abortions and miscarriage data are not available before 1972 because abortion was not legal in many areas at that time.

SOURCE: Congressional Budget Office. Pregnancy and abortion data from the Alan Guttmacher Institute, unpublished data Birth data from National Center for Health Statistics. Advance Report of Final Natality Statistics: 1982, vol. 33, no. 6, Supplement (September 28, 1984), p. 16

With respect to teenage pregnancy, these national figures give us cause for concern and tell us something about the magnitude of the problem, but they do not tell us if the changes in the national teen pregnancy rate are systematically related to program and policy changes. Even though we see a change in the pregnancy rate that appears to correspond with a change in the number of clients served, this "eyeball" correlation does not necessarily mean that these two factors are directly related to each other. For example, some other factor (or factors) may cause these two things to rise or fall simultaneously.

It is essential that the the other things which also affect teenage birth rates (race, poverty, urbanization, mobility, prior fertility, etc.) be taken into account in estimating program effects. Without attention to these other

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factors which affect the teenage pregnancy rate, one could not legitimately infer program failure as the pregnancy increases or program success if the rate were to fall. Our research was designed to deal with these and other issues, and to provide an accurate assessment of the effects of family planning programs on teenage pregnancy rates. The fundamental question was relatively simple and straightforward; and addresses a very pragmatic question that policy makers and administrators must ask: "How effective are family planning programs in reducing teenage pregnancy rates? Does increasing the availability and accessibility of contraceptive counseling and services to teens reduce their pregnancy rate as was expected?" This effectiveness question was targeted at the societal level. We approached family planning for teenagers as a social policy or public health issue, which required that we look broadly at data from throughout the country rather than relying on results from a few clinics or a small sample of clients. It was the net societal effect that the policy was aimed at.

Using data from all 50 states and the District of Columbia, we examined program impact throughout the 1970's and early 1980's. This time perspective is important because we needed to ensure that there had been enough time for adequate implementation and reach into the target population. It also permitted replication of the basic findings from year to year, and the use of longitudinal models which could examine changes over time in the pattern of results.

REVIEW OF FINDINGS

With this minimal background, let us review briefly the major findings of the research. The details are available in the technical reports and our time is short, so we will simply try to highlight the main results.

Prior to our research, there didn't appear to be any studies which had directly examined the effects of family planning programs on teenage pregnancy rates. However, there were several which had estimated the impact

15-7/23

of teenage participation in family planning programs on adolescent birth rates. One of the significant efforts looking at the impact on birth rates was done by Dr. Jacqueline Forrest (a member of today's panel) and her colleagues and was published in 1981. This study was significant for several reasons:

1. It attempted a comprehensive national assessment of program impact using subunits (counties) in the society of direct interest.
2. It was the first to use age-specific family planning participation rates for teenagers.
3. It used longitudinal as well as cross-sectional analyses.
4. It has served as the basis for estimates of program impact that were widely cited in congressional testimony, as well as in the professional literature and the media.

The study directly estimated program effects on birth rates (for 1975 and 1976), and on the basis of these effects, projections were made concerning the potential effects on overall pregnancy rates. However, since the appropriate abortion figures were not available at the county level, an essential component of the overall teenage pregnancy rate was missing from the study, and therefore a direct estimation of program impact on pregnancy rates was not possible. Additional research was needed to determine the effects on pregnancy rates. Our research and a subsequent study by Susheela Singh (1986) of the Alan Guttmacher Institute have now examined program impact on total pregnancy rates and also on abortion rates.

Pregnancy rates constitute a more appropriate and direct measure of program success than do birth rates, and correspond with the stated intentions and goals of the program--the reduction of unintended pregnancies.

> "If we focus on freedom from unplanned births, then abortion is a means of achieving our goal. If we focus on freedom from unplanned pregnancy, then abortion is a measure of the problem we face. . . The objective of the service program is best measured in terms of preventing unplanned pregnancies, not just unplanned births." (Tyler, 1982:221-223)

Our studies and the 1986 AGI report provide important new information and

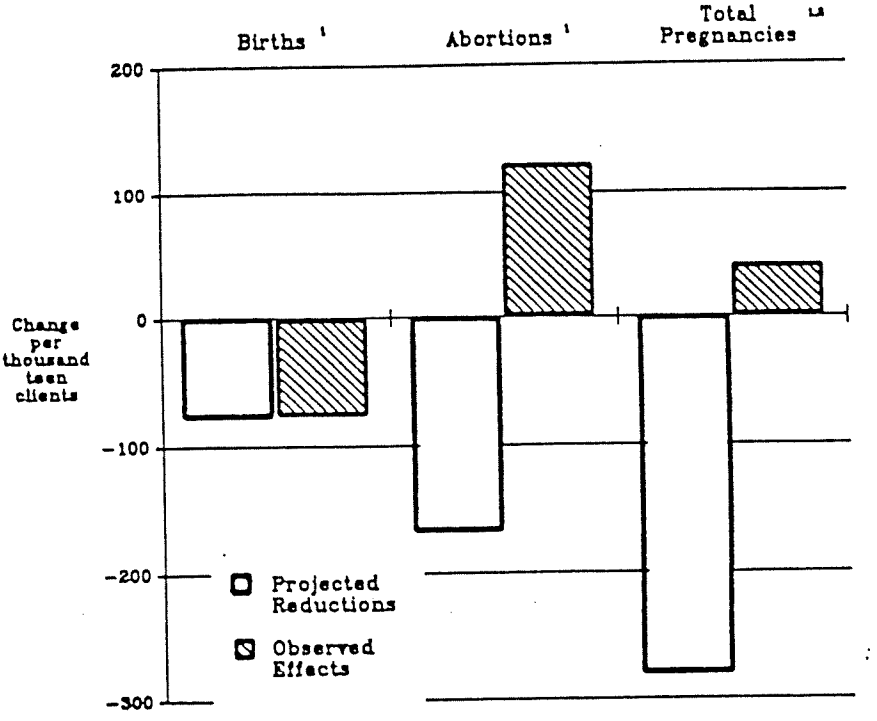
15-8/23

significant corroboration concerning the effects of family planning programs for teenagers on adolescent pregnancy, abortion, and birth rates.

If we compare our results for 1980 birth rates with the projections for that year, we see substantial agreement. Data for other years and other statistical models confirm the same basic finding: where family planning program involvement is greater, one can expect to see lower teenage birth rates. The finding is robust and stable and is found in the 1981 and 1986 AGI studies, as well as our own. The size of that effect is about 80 fewer births for every 1000 teenage clients in organized family planning programs.

IMPACT OF TEENAGE FAMILY PLANNING PROGRAMS

Projected vs. observed change in Births, Abortions, and Total Pregnancies (per 1,000 teen clients, 1980)



2 Total Pregnancy includes miscarriages, which are estimated at 20% of births and 10% of abortions

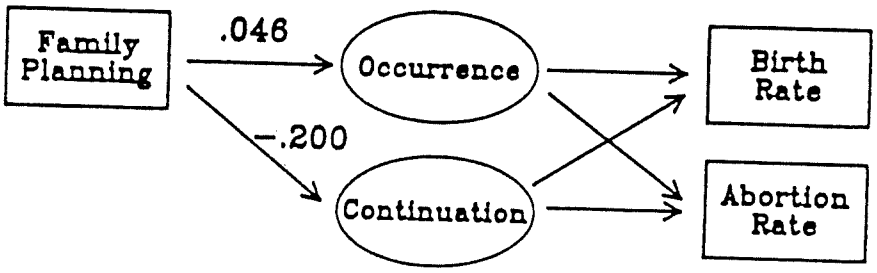
1 These represent the remaining effects after accounting for race, poverty, urbanization, and residential stability

Sources: projected reductions (Forrest, 1984)
observed effects (Weed & Olsen, 1986)

15-9/23

However, rather than the projected reduction of 282 total pregnancies for every 1000 clients, we observe an increase of some 42 pregnancies per thousand clients. The main explanation for the discrepancy between the projected reductions and the effects we observed involves the previously unanalyzed relationship between family planning participation and abortion rates. Instead of the projected reduction of some 170 abortions for every 1000 teenage family planning clients, we see about 120 more abortions per thousand clients. Just as we found with birth rates, these findings hold up for the various years, with abortion data from the Centers for Disease Control as well as for the AGI data, and with both longitudinal and cross sectional analyses.

In addition, we analyzed the data in terms of both the occurrence and the resolution of pregnancy. The observed reduction in birth rate was due not to a reduction in the initial occurrence of pregnancy but to a more frequent termination of pregnancy through abortion.



We have also been able to compare our results with those of the recent 1986 AGI study. This is a little difficult from the published reports since their study reports regression coefficients only in standardized form and the values of some coefficients are not reported. Still, where comparisons can be made, the results are very similar, and provide support for our conclusions.

15-10/23

EFFECTS OF TEENAGE FAMILY PLANNING PROGRAM PARTICIPATION ON ADOLESCENT PREGNANCY, BIRTH, AND ABORTION RATES
(STANDARDIZED REGRESSION COEFFICIENTS)

	PREGNANCY	BIRTH	ABORTION
BASIC MODEL			
SINGH	.28	NR	.44
WEED AND OLSEN	.23	-.21	.49
PRIOR FERTILITY CONTROLLED			
SINGH	NR	-.29	.43
WEED AND OLSEN	.24	-.22	.49

NOTE: NR = NOT REPORTED

The negative relationship of family planning involvement with birth rates shown in these studies has been known for some time. However, the positive relationship with abortion and pregnancy rates appears equally consistent across the studies. Although they are new, our own assessment is that these findings are here to stay and have important scientific and public policy implications.

ABORTION AVAILABILITY AND SEXUAL ACTIVITY

As a result of the publication and presentation of these studies, friends, colleagues, and critics have helped us test our thinking and our analyses. We think that the most fundamental question that could be raised about these results is called "model specification" by researchers. This has to do with the kinds of variables included in the analysis, and the relationship these variables have with the outcome of interest (teen pregnancy in this case) and with each other. The basic question is whether including some variable in the model which had previously been omitted might change the observed pattern.

15-11/23

For example, some have suggested that clinics are placed in the high need areas and therefore, one would initially expect to see a positive relationship between family planning and pregnancy until the programs were able to have a detectable impact. However, even after 10 or 12 years, we do not see pregnancy rate reductions. Even when we explicitly control for prior fertility, and use longitudinal models which implicitly control for all stable variables, whether measured or unmeasured, the same results are found.

Some have suggested that including a specific variable, such as abortion availability, non-program sources of family planning services, or sexual activity rates could change the observed positive relationship into the hoped-for negative one. The hypothesis concerning abortion availability was directly tested in the 1986 AGI study. Although abortion availability had an independent effect on the abortion and pregnancy rates, the family planning program effect did not change as a result of including this variable in the model.

With respect to sexual activity, we know that in society generally, teen sexual activity rates have gone up over the years. Some claim that if the analysis controlled for differences in levels of sexual activity, the projected reductions in teenage pregnancy rates would show up. It would help to have the necessary state-level data to test this hypothesis directly. Although we feel that data about sexual activity constitutes a necessary factor in understanding teen pregnancy, there are several basic reasons to believe that this variable would not alter the basic pattern of results found in the recent studies we and AGI have done.

First, neither a general increase in sexual activity nor stable differences among states in levels of sexual activity could account for the observed results. The design of our analysis can discount those possibilities. The changes over time in family planning program involvement would have to have a direct link with corresponding changes in sexual activity

levels. The nature and causal direction of such a link remain to be established.

Second, much of the potential effect of sexual activity on family planning utilization is likely to already be controlled by the variables that have already been included in the models. Just as poverty, race, urbanization, mobility, prior fertility, etc., are strong predictors of teenage pregnancy rates, they also account for much of the variation in sexual activity. Where these and other variables have already been controlled, adding sexual activity is likely to have little effect on model parameters.

Third, the hypothesized effects of sexual activity would have to be extremely large (and inconsistent with other estimates) in order to drastically alter the pattern of our results and fit the prior claims of averted pregnancies. We have estimated what would be necessary to reconcile the previously projected reductions in pregnancy rates with the other information about the effects of sexual activity on family planning utilization and pregnancy among teenagers. This analysis (Weed and Olsen, forthcoming) demonstrates the mathematical and logical inconsistency of the projected teenage pregnancy reductions with the existing data and other information about the effects of sexual activity on clinic use and pregnancy. In summary, including sexual activity when estimating the effect of family planning programs on teenage pregnancy rates may be important and useful, but offers little hope for vindicating the previous projections of pregnancy reductions.

CONCLUSIONS AND RECOMMENDATIONS

What do we conclude about the impact of family planning programs on teenage pregnancy? Our research and that done by others allows us to make four basic statements:

1. Family planning program involvement is related to lower teenage birth rates.

2. Family planning program involvement is associated with higher, not lower, abortion rates among teenagers.

3. Family planning program involvement does not appear to reduce overall teenage pregnancy rates.

4. The reduction in teenage birth rates which can be attributed to family planning program involvement is, in turn, due to its impact on the continuation and not on the occurrence of pregnancy.

What would we recommend in terms of a strategy for successfully dealing with the teenage pregnancy problem? First, we would recommend broadening the options when considering potential interventions. We would have to say that programs which rely on increased accessibility of contraceptive services as the major means of reducing teenage pregnancy are not likely to be effective. Teenage pregnancy is embedded in a complex set of social, psychological, and economic factors that must be taken into account if our efforts are to succeed.

We know more currently about what is not working than why it is not, or what will work. Why has the family planning approach not had the intended impact, and what kinds of interventions will be effective? Our current and future research efforts will focus on both of those latter aspects. We would also recommend more careful and systematic evaluation of program and policy interventions.

> "It is therefore imperative, regardless of which policies are adopted, to evaluate them continuously and carefully in order to be able to change them when and if needed. . . The implemented policies should be evaluated to determine their impact on the incidence of premarital sexual intercourse, use of contraception, unwanted pregnancy, abortion, adoption, and parent-child communication. . . We should not cast our policies and programs in concrete, and should consider changes based on a continuous flow of evaluative information. . ." (Rodman, Lewis, and Griffith, 1984)

Given the drastic consequences of teen pregnancies, sexually transmitted diseases, etc., we can ill afford to go another 15 years assuming that we have an adequate solution in hand.

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TEENAGE PREGNANCY:
MEDIA EFFECTS VERSUS FACTS

By Jacqueline R. Kasun, Ph.D.

This paper is adapted in part from a chapter in American Family and the State, *edited by Fred Glahe and Joseph Peden (Pacific Institute for Public Policy Research, San Francisco, 1986), with the publisher's permission.*

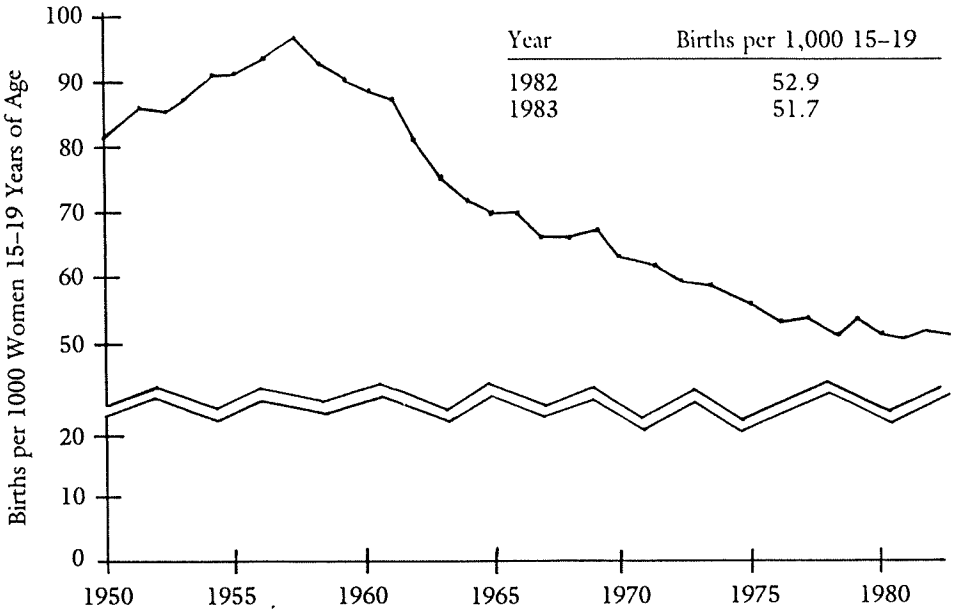
The so-called "Teenage Pregnancy Epidemic" burst upon the national scene in 1976 with the publication of a widely distributed pamphlet by Planned Parenthood: *11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancy in the United States.*

Actually, adolescent child-bearing was at the time in the middle of a steep decline, as Figure 1 shows. Nevertheless, believers in the doctrine of "overpopulation" had observed that **the size of the population could be significantly reduced** by eliminating **all** births to teenage mothers.[1]

Accordingly, teenage pregnancy became a new front in the war on "overpopulation." The media targeted big guns on it, and Congress initiated a multi-million dollar program to stamp it out. Now that respected authorities have seriously questioned the "overpopulation" doctrine and years of low birthrates have reduced the size of the population under age 18 by several million, it is fitting to re-examine the Teenage Pregnancy Epidemic.

The facts differ rather markedly from the rhetoric of the movement. The decline of 46 percent in teenage fertility during the 1957–1983 period, shown in Figure 1, was actually the same as the decline among women of all ages. The decline occurred among both blacks and whites, although black fertility remained higher than for whites. As a proportion of all births, those to women 15 to 19 were actually a bit lower – 13 percent – in 1983 than they had been in 1960.[2] Table 1 shows that not only birth rates but numbers of births to women aged 15

FIGURE 1
LIVE BIRTHS PER 1000 WOMEN 15–19 YEARS OF AGE, 1950–1983



National Center for Health Statistics, *Vital Statistics of the United States,* annual, and *Monthly Vital Statistics.*

TABLE 1
BIRTH RATES, BY AGE OF MOTHER AND NUMBERS OF BIRTHS TO WOMEN AGED 15–19, 1966, 1970 and 1983

Year	(1) Births per 1000 Women 15–19	(2) Number of Births to Women 15–19	(3) Births per 1000 Women 18–19	(4) Births per 1000 Girls 15–17	(5) Births per 1000 Girls Under 15
1966	70.6	621,426	121.2	35.8	0.9
1970	68.3	644,708	114.7	38.8	1.2
1983	51.7	489,286	78.1	32.0	1.1
Percent Change, 1966–83	−26.8%	−21.3%	−35.6%	−10.6%	+22.2%
Percent Change, 1970–83	−24.3%	−24.1%	−31.9%	−17.5%	− 8.3%

Derived from U.S. Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Monthly Vital Statistics Report* for Sept. 8, 1977, and March 29, 1978, and *Vital Statistics of the United States,* annual, and *Advance Report of Final Natality Statistics,* 1983, (PHS) 85-1120, Vol. 34, No. 6, Supplement, Sept. 20, 1985.

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to 19 have been falling, with a decline of more than 155,000 births to women of this age group between 1970 and 1983. A related fact is that marriage is occurring at later ages and rising proportions of both sexes have never married.[3]

Low Early-Teen Birthrate

As Table 1 suggests, births to teenagers are heavily concentrated among women 18 years of age and over. Much of the discussion of teenage pregnancy has reported in painful detail on the alleged problems of girls 11 to 15 years old without stating that less than two percent of all births to women under 20 occur in this younger age group. As Table 1 shows, **less than four out of a hundred girls aged 15 to 17 and about one out of a thousand girls under age 15 give birth in a typical year.**

The very low birth rate for the youngest group varies on a year-to-year basis by as much as 20 percent, most of which must be regarded as random changes in a small number, having little statistical significance.

Although the **proportion** of births out-of-wedlock has risen markedly since 1970, as Table 2 shows the **rate** of child-bearing among single women has risen by less than a percentage point. What this means is that although young women are having fewer babies, they are having a larger proportion of them – more than half – outside of marriage. Nevertheless, Table 2 shows that **fewer than three young women out of a hundred in the unmarried 15 to 19 year age group give birth each year.**

TABLE 2

Estimated Live Births Out-of-Wedlock Per 1000 Unmarried Women 15–19, And As a Proportion of All Births To Women 15–19, 1970 and 1983

Year	Estimated Live Births Out-of-Wedlock per 1000 Unmarried Women, 15–19	Estimated Live Births Out-of-Wedlock as a Percent of All Births to Women, 15–19
1970	22.4	29.5%
1983	29.7	53.4%

Derived from U.S. Department of Health, Education and Welfare, Public Health Service, National Center for Health Statistics, *Monthly Vital Statistics Report,* Sept. 8, 1977, and *Advance Report of Final Natality Statistics,* 1983, (PHS) 85–1120, Vol. 34, No. 6, Supplement, Sept. 20, 1985.

With the exception of the rising proportion of out-of-wedlock births, the facts discussed so far hardly suggest a crisis or "epidemic."

A Different Epidemic

There are, however, other reasons for concern, though these do not necessarily justify the kind of public action which has been taken. Trends in abortion have moved sharply upward since 1970, as shown in Table 3 and Figure 2 (next page). In 1972 less than one fourth of all teenage pregnancies ended in abortion, but by 1981 the proportion was 45 percent.

In some states – such as California, Connecticut, Massachusetts and New York – and the District of Columbia, teenage abortions now outnumber births.

Adding the numbers of abortions to the numbers of births for this age group gives the number of pregnancies. Although there are no data on abortions prior to 1972, it is clear that even if there were no abortions in the 1950s the rate of pregnancy among teenagers during that decade must have been higher than it was in 1972. This means that **the teenage pregnancy rate fell sharply between the late 1950s and 1972 and rose markedly thereafter.**

TABLE 3

FEDERAL EXPENDITURES ON FAMILY PLANNING; BIRTHS AND ABORTIONS TO WOMEN 15–19; PREGNANCIES, BIRTHS AND ABORTIONS PER 1000 WOMEN 15–19, UNITED STATES, 1970–1981

Year	Federal Expenditures on Family Planning ($ thousands)	Births to Women 15–19	Abortions to Women 15–19	Pregnancies per 1000 Women 15–19	Births per 1000 Women 15–19	Abortions per 1000 Women 15–19
1970	–	644,708	–	68.32	68.32	–
1971	80,000	628,000	–	64.66	64.66	–
1972	99,420	616,280	191,000	81.22	62.01	19.22
1973	137,280	604,096	231,890	82.61	59.69	22.91
1974	142,780	595,466	279,700	85.36	58.08	27.28
1975	148,220	582,238	325,780	87.77	56.28	31.49
1976	157,140	558,744	362,680	88.26	53.52	34.74
1977	184,620	559,154	397,720	91.87	53.69	38.19
1978	217,771	543,407	418,790	92.82	52.42	40.40
1979	233,031	549,472	444,600	94.7	52.3	42.4
1980	298,572	552,161	444,780	95.9	53.0	42.9
1981	324,977	527,392	433,000	96.0	52.7	43.3

Figures for 1970–1978 from Susan Roylance testimony before U.S. Senate Committee on Labor and Human Resources, March 31, 1981, based on data from National Center for Health Statistics, U.S. Department of Health and Human Services, U.S. Bureau of the Census, and the Alan Guttmacher Institute; figures for 1979–1981 from National Center for Health Statistics and the Alan Guttmacher Institute. The figures for family planning expenditures are estimates of certain categories of spending only. While they appear to be internally consistent, they are substantially smaller than other estimates of the same kinds of spending.

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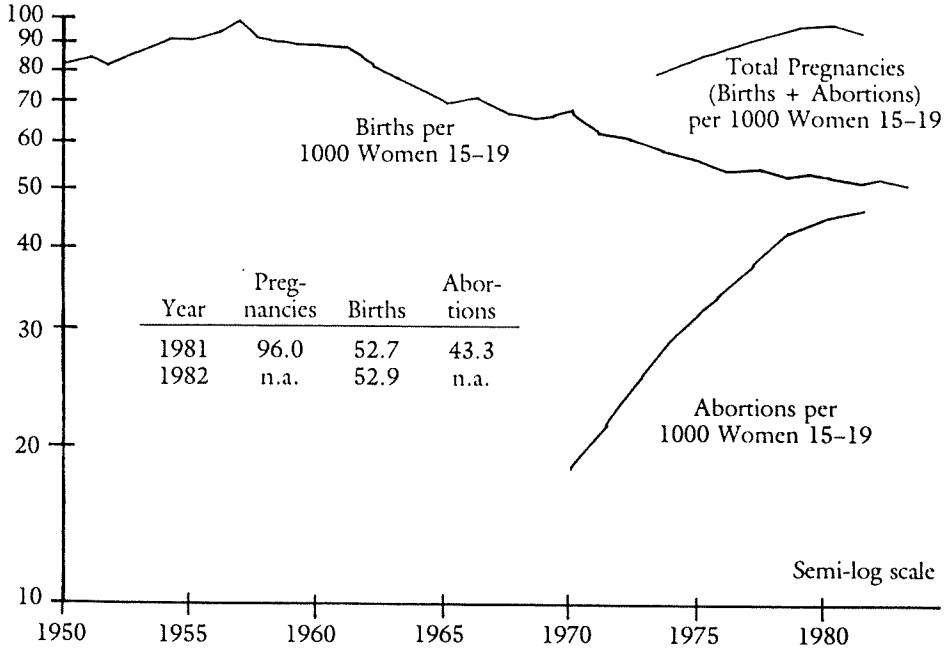
FIGURE 2

PREGNANCIES, BIRTHS AND ABORTIONS PER 1000 WOMEN 15-19 YEARS OF AGE, UNITED STATES, 1950-1982



Year	Pregnancies	Births	Abortions
1981	96.0	52.7	43.3
1982	n.a.	52.9	n.a.

Birth data from National Center for Health Statistics; abortion data from Alan Guttmacher Institute.

The Expenditures Do What?

It should be noted that **this reversal of the previously declining trend in teenage pregnancy coincided precisely with the increase in government funding of the groups proposing to combat teenage pregnancy.**

Spokesman for the teenage pregnancy lobby claim that abortion is the economic "solution" to the problem. Obviously, however, the close correspondence between the increases in abortions and the increases in government grants raise doubts. Susan Roylance found a high statistical correspondence between teenage pregnancy and government expenditures to combat it during the decade of the 1970s.[4]

Although Mrs. Roylance did not make this calculation, her data indicated that in the late 1970s for every additional million dollars being given to family planners by the federal government, an additional 2,000 adolescent pregnancies were occurring two years later.

Even more damaging to the case for public adolescent pregnancy programs was Roylance's demonstration that in 15 states with similar social-demographic characteristics and similar rates of teenage pregnancy in 1970, those with the highest expenditures on family planning showed the largest increases in the abortion rate and the rate of births out-of-wedlock among teenagers between 1970 and 1979.[5]

Reinforcing Roylance's findings, surveys indicated sharp increases in sexual activity among unwed young people. Zelnik and Kantner reported:

"The proportion of U.S. teenage women residing in metropolitan areas who have had premarital sexual experience rose from 30 percent in 1971 to 43 percent in 1976 and to 50 percent in 1979. . ."[6]

They reported also **a greater increase in the rate of premarital pregnancy among teenagers than in sex activity** and a rise between 1976 and 1979 in the proportion of premarital pregnancies occurring among those who reported that they had always used a contraceptive method.[7] These latter, of course, were precisely the sorts of thing that were supposed to be corrected by government-funded family planning.

In addition to these unsettling developments, the reported incidence of gonorrhea among teenage women almost doubled between 1971 and 1980.[8]

Maternal Mortality Down

Though much is clearly amiss, the claims of the government-funded family planners regarding the alleged evils of teenage pregnancy fail to ring true. The claim, for example, that teenagers are at a physical disadvantage in child-bearing is without basis in fact. Maternal mortality is **not,** as is so often claimed, higher among teenagers than other age groups, as Table 4 and Figure 3 (next page) show. It is, in fact, substantially **lower** than the rate for all women and less than half as high as the rate for women in their thirties.

(It should be noted also that the rate for all groups is extremely low, amounting to less than one death per 10,000 live births on the average.) Maternal mortality rates for the years since 1980 are not yet available.

TABLE 4

MATERNAL MORTALITY RATES,[1] BY AGE, UNITED STATES, 1977, 1979 and 1980

Age Group	1977 Rate	1979 Rate	1980 Rate
Total	11.2	9.6	9.2
Under 20 Years	7.0	6.2	7.6
20-24 Years	7.9	7.5	5.8
25-29 Years	9.2	7.6	7.7
30-34 Years	18.8	12.8	13.6
35-39 Years	38.9	33.3	31.3
40-44 Years	66.3	65.2	60.6
45 Years and Over[2]	148.7	414.9	166.7

[1] Maternal death rates per 100,000 live births in specified group.

[2] Rate computed by relating deaths to women 45 years and over to live births to women 45-49 years.

National Center for Health Statistics, *Vital Statistics of the United States.*

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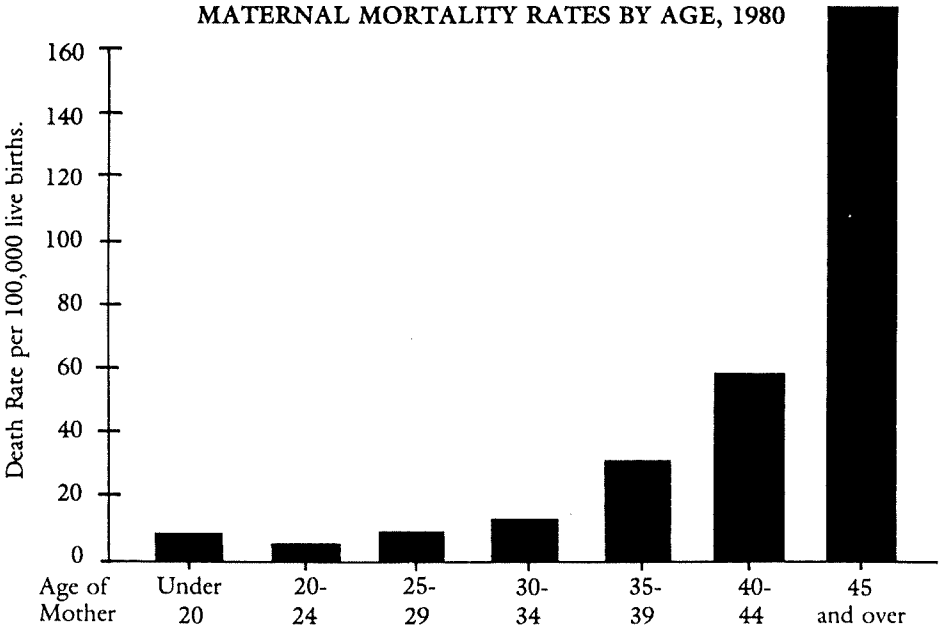
FIGURE 3
MATERNAL MORTALITY RATES BY AGE, 1980



National Center for Health Statistics, *Vital Statistics of the United States.*

The Risk to the Unborn Baby

Fetal death ratios, often reported with alarm by government-funded adolescent pregnancy controllers, appear in Figure 4. Clearly the most marked feature is the increase that occurs after the age of 30. (Teenage pregnancy researchers often leave these high rates for older women off their charts).

Many investigators believe that the differences among the younger age groups primarily reflect differences in income and lifestyle. The ratios are higher for non-whites than for whites and for the unmarried than the married in all age groups.

Physicians confirm the impression conveyed by the statistics. The Rochester Adolescent Maternity Project studied predominantly black, inner-city teenagers with an average age at delivery of 16 years and found no greater obstetric or neonatal risks among this group than among women in their twenties.[10] Other physicians have reported similar findings.[11]

One of the most dramatic assertions of the movement is that pregnant teenagers have high suicide rates. This claim originated in two articles which have been misquoted repeatedly in subsequent works. One was a study of 105 pregnant teenagers admitted to the Yale-New Haven Hospital during 1959–1960. There were no suicides in the group but 14 of the young women were reported to have made suicide attempts or threats.[12]

The other was a 1955–59 Swedish study which found the same rate of pregnancy among women under the age of 21 attempting suicide as among all women in that age group.[13]

In other words, **neither study found any evidence of an elevated suicide rate among pregnant teenagers** although both have been repeatedly misquoted to that effect.[14]

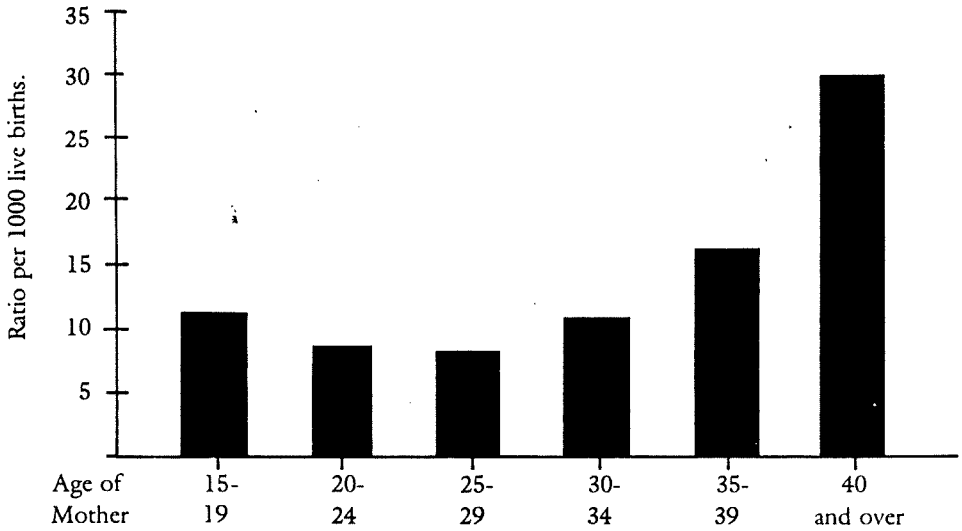
But what about the children of young mothers? Spokesmen for the government-funded family planning movement blame youthful childbearing for a long list of children's disabilities, beginning with the claim that rates of prematurity and low birth weight are higher for the babies of younger mothers and that this adversely affects mental and physical development.

Research on this point, however, has shown that, where no income differences exist, teenage mothers bear a **lower** proportion of low birth-weight infants than mothers over age 20.[15]

A recent study found that ". . . teenage mothers tend to be of small stature and weight. . . The small size of their infants is in proportion to their smaller size and not to their early age at conception."[16]

Moreover, ". . . undesirable pregnancy outcomes are not necessarily more common in teenage pregnancies or in the younger teenage pregnancies . . . some undesirable pregnancy outcomes are actually less

FIGURE 4
FETAL MORTALITY BY AGE OF MOTHER, 1980



National Center for Health Statistics, *Vital Statistics of the United States.*

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frequ... in the progeny of teenage mothers."[17]

Infant Mortality

It is frequently claimed that infant mortality (death under the age of one year) is higher among the children of mothers under 20. No regularly-published national data exist on this point and research results have been mixed, with some studies showing higher rates for the children of teenage mothers and some showing lower.[18] Rates are much higher in all age groups for non-whites and appear to be heavily affected by income and access to medical care.

Studies of the physical and mental development of the children of teenage mothers have failed to discover significant differences between them and other children.

The previously-cited study of birthweight and prematurity found that although the babies of teenage mothers were smaller at birth, by the time the children were seven years of age they did not differ in weight from the children of older mothers.[19]

A major study of the mental and social development of 375,000 children in the United States found that the children of teenage parents showed somewhat less academic aptitude in high school than did other children but that this difference tended to disappear when children of similar family background – that is, matched as to whether they were living with both parents or in some other situation – were compared.

This study followed the same children up to the age of 30 and found that, by that age, although those born to teenage parents had had less formal education, **they were earning as much income as those who had been born to older parents.**[20] The author concluded by commenting that she had found "much smaller consequences for the future lives of the children involved" than previous studies which claimed to discover an "enormous impact" of teenage childbearing.[21]

Another common claim is that the children of teenage parents "repeat the cycle" of poverty and welfare dependence. In fact, as we have just seen, the evidence is that by the age of 30 the children of teenage parents are earning just as high incomes as the children of older parents. This would suggest that they have no higher probability of being dependent on public assistance than any other group.

Further strengthening this conclusion is the fact shown by research at the University of Michigan Survey Research Center that persons whose parents have received public assistance have little higher probability of being themselves dependent than other groups.[22] Indeed, the authors of the latter study refuted a number of often-heard claims regarding the supposedly bad effects of teenage pregnancy:

"Our results do not support the intergenerational arguments of the culture-of-poverty, underclass and welfare-dependence theories. We observe a great deal of income mobility from one generation to the next, even among the poorest households.

"Links between parents' and children's economic circumstances do exist. However, long-term welfare dependency as a child does not cause long-term welfare dependency as an adult, at least among blacks. Parental attitudes and values had little effect on children's later economic outcomes and welfare dependence."[23]

How High Are the Costs, Then?

The essence of the case against teenage childbearing, however, is that it causes "soaring welfare costs," and numerous articles and studies have reported on these. On the face of it the charge is patently untrue because Aid to Families with Dependent Children, the public program principally affected by dependency among teenage mothers, is one of the few government programs whose costs are **not** soaring, and in fact has declined in real dollar cost since the mid-1970s.

It is a relatively small public transfer program directly accounting for about one percent of all public expenditures and for no more than a possible four percent when allowance is made for the addition of food stamps, health care and housing allowances.

About seven percent of the mothers on AFDC are teenagers.[24] It is not known what proportion of women giving birth under the age of 20 become dependent on public assistance. One study found that 70 percent of teenage mothers were living with their own parents at the time of birth.[25]

It has been estimated that perhaps a third become dependent for a time;[26] recent data indicate that this proportion may be much lower, closer to a quarter or a fifth.[27] Another study found that almost two thirds of unwed young mothers married within five years after birth, 60 percent of these within one year after delivery.[28]

Not surprisingly, the sooner the young father found a job, the greater was the likelihood of marriage[29] and, therefore, independence of parental support or public assistance.

These findings suggest the probable importance of economic factors in the rising proportion of teenage births out-of-wedlock. A young couple without much income can avoid the large and rising private medical costs of childbirth by remaining unmarried and qualifying for care under the parents' health insurance or Medicaid.

Once this hurdle has been passed, they have less incentive to remain unmarried. Rising levels of unemployment among young male workers have probably also encouraged illegitimacy.

One study of low-income adolescent mothers found that five years after delivery only 15 percent were totally dependent on public assistance and only half of those on welfare had received it for more than 12 months.[30]

An oft-repeated charge is that "half of all welfare expenditures go to women who were teenagers when

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they first gave birth."[31] The claim stems from an Urban Institute estimate based on data for 1975.[32]

What the estimate, if accurate, actually suggested was that the women receiving AFDC were not very different from the female population at large, because at that time about a third of all first births to American women (and about half of all black first births) were occurring to women under the age of 20.[33] And the same study found **no direct connection between early childbearing and the probability of receiving public assistance.** It suggested that an "indirect role" might exist, however.[34]

It is the poor who constitute the population from which public assistance recipients are drawn and for whom the programs were designed. Although in the past the poor began their childbearing at earlier ages and had somewhat larger families on the average than the higher-income groups, this difference is growing smaller. In 1982 wives 18 to 29 years of age in all income groups had had fewer than two children on the average and expected to have no more than two when their families were completed.[35] Fertility has been below replacement levels in the United States since 1972.[36]

Sensational descriptions of the astronomical public welfare costs supposedly attributable to teenage pregnancy have been widely circulated.[37]

These colossal estimates are the result of several kinds of exaggerations:

(1) Overestimating the proportion of teenage mothers and babies who become dependent on public assistance; for example, instead of the actual proportion of one fifth to one fourth of teenage mothers and babies who become dependent on public assistance, the Center for Population Options in its widely-reported 1986 study added large numbers of additional children; the effect was to multiply the resulting cost estimate by a factor of four;

(2) Overestimating the duration and extent of dependency; for example, the SRC and the Danforth studies both assumed unrealistically long periods of total dependency at maximum allowances instead of the partial dependency for much shorter periods actually observed;

(3) Assuming, without proof or even good evidence, that most poverty and dependency on public assistance are the results of teenage motherhood; for example, the Center for Population Options used this method in its $16 billion estimate of the "single year costs" of teenage childbearing. This is an example of the "false cause" fallacy, assuming that because two events occur together, one causes the other. Scientific research has **not** shown that teenage motherhood is the principal cause of poverty. Economic studies indicate that restricted job opportunities for young workers, resulting from the minimum wage and other labor market restraints, are important causes of unemployment,[38] which in turn leads to poverty, welfare dependence and single parenthood.

Short-Term Dependence

In fact, the typical AFDC family in 1982 consisted of a mother and one child who had received public assistance for less than three years.[39] A ten-year study of welfare dependency conducted by the Survey Research Institute at the University of Michigan found that nearly half of all recipients were on the welfare rolls for no more than two years and that only one in 12 was heavily dependent for more than seven years.[40]

These findings of the actual duration of welfare dependency are considerably lower than those reported or implied in most discussions of teenage pregnancy.[41]

The reports of the alleged "costs of teenage pregnancy" generally do not mention any benefits to be expected from the lives of children born to young mothers. In fact, however, like other children, they grow up to be productive members of society.

Though it is impossible for any human beings to determine the true worth of any others, there is a smaller question and one that is relatively easy to answer; that is whether the **public economic costs** of children born to youthful mothers are greater or smaller than the **public economic benefits** to be expected from those children.

As shown above, these children will grow up and become income producers and taxpayers, with no greater probability of becoming welfare dependent than other children and with the same expected income as other children.

The average baby born in the United States in 1983 will spend about 47 years in the labor force, will earn more than two thirds of a million dollars over his lifetime and will pay more than a quarter of a million dollars in taxes.

The value of these tax payments will greatly exceed the cost of public assistance even for those very rare children (no more than two out of a hundred) who spend their entire childhood on public assistance. For the baby of a typical teenage welfare mother who will spend less than three years on public assistance before marrying or becoming otherwise self-supporting, Table 5 shows that **the present value in 1983 dollars of the expected tax payments to be made by that child during his adult lifetime is 3.6 times as great as the present value of the public assistance costs incurred on his behalf.**

In other words, **the public assistance expenditures made on behalf of these dependent children are investments in human capital that promise high rates of return to the public over long periods of time.**

Even if we use the inflated costs and high ratios and duration of welfare dependence attributed to teenage pregnancy by some of the more alarmist studies, this conclusion holds true.

For example, the Center for Population Options arrived at approximately the same estimate of the public assistance costs per child as shown in Table 5. When compared with the future taxes to be paid by

that child, the benefit-cost ratio is, as shown in the table, between 3 and 4.

In general, any public investment having a benefit-to-cost ratio greater than one is regarded as acceptable since its benefits will pay for its costs.

A Good Investment

In this example, the ratio indicates that the public benefits of teenage births will pay three-and-a-half times over for the public costs which they cause, even when those costs are estimated at very high levels. This is a significantly higher benefit-to-cost ratio than those typically shown for proposed public investments.[41]

Even when the comparison is confined to the small minority of children who spend their entire childhood on welfare, **their** expected taxes will more than pay for their public assistance.

The same reasoning applies to the frequent allegations that abortion is the "economical solution" to teenage pregnancy. Such statements overlook the benefits that would be created by the lives so destroyed. They calculate only the money "saved" by eliminating the costs of staying alive. Since such "savings" would be maximized by abolishing all human life, the statements are patently foolish.

Moreover, they fail even on their own grounds of attempting to put a monetary value on human life. If we subtract from the typical child's future earnings[42] his cost of living over his lifetime[43] and express future dollars at their present values, using a four percent real rate of discount, the net present value of the life of a new baby in 1983 amounted to about $70,000. In dollars of 1986 purchasing power, this would amount to about $75,000.

This is the value of the contribution which this child will make to society's wealth over his lifetime. It is a broader measurement of his net economic contribution than just the taxes he will pay, which were discussed above, because it includes all of his productivity not absorbed by his own maintenance.

TABLE 5

PUBLIC BENEFIT-COST CALCULATION FOR A BABY OF A TEENAGE AFDC MOTHER, 1983

Expected Public Benefits		*Expected Public Costs*	
Expected average annual tax payment during adulthood	$ 5,394	Cost of delivery	2,174[2]
Total expected taxes to be paid during lifetime	253,518	Annual public assistance costs, 1983, for mother and child[3]	
Present discounted value[1] in 1983 of total taxes	56,031	AFDC cash payment	2,567
		Food stamps	971
		Medical costs	906
		School lunch	200
		Housing assistance	834
		Total annual costs	$ 5,478
		Present discounted value[1] of costs of delivery and annual public assistance for 2½ years	$15,451

$$\frac{\text{Benefit}}{\text{Cost}} \text{ Ratio} = \frac{\text{Present value of taxes to be paid}}{\text{Present value of public assistance costs}} = \frac{\$56{,}031}{\$15{,}451} = 3.6$$

[1] Discounted at 4 percent real rate

[2] Estimated from actual Medicaid costs in California, 1980, corrected by 1983 medical care price index.

[3] Estimated from actual payments and numbers of recipients reported in *Statistical Abstract of the U.S., 1984* and *Social Security Bulletin.*

It is the present value of the taxes he will pay together with the personal investments by which he will add to his family's and the nation's wealth during his lifetime. It is the net present value of the financial loss caused by an abortion.

Multiplying this figure by the 430,000 abortions now occurring annually to women under 20, the resultant **net costs** of teenage abortion amount to $32 billion annually. The costs of the 1.5 million abortions to women of all ages amount to $112 billion annually.

It may be argued that the lives destroyed by abortion can be replaced at a later time under more propitious circumstances for both society and the families concerned. Leaving aside the moral objection to this argument, it begs the question by assuming what has not been shown to be the case – that the circumstances of the children in question are "inferior" to those of other children.

It also assumes that abortion has no effects on subsequent fertility, when in fact significant research has shown that abortion reduces subsequent fertility and affects it in various undesirable ways.[44]

Turning the nation's perception of "teenage pregnancy" from a natural phenomenon of young womanhood into a scourge has been a triumph of media effect over fact and one of the most remarkable feats of the war on "overpopulation" that has absorbed so much of the national energy and public treasure in recent years.

Without the multi-million dollar "research" subsidies that have gushed out of the federal treasury into the population network, it could not have been done. These subsidies ensure that, whatever the real facts may be, there will be no lack of alleged "statistics" to show that teenage pregnancy is a plague that ought to be stamped out.

The aging Americans of the future, struggling to extract taxes from a dwindling proportion of productive workers, may look back on it with wonder.

With the wisdom of hindsight they may wonder why we did not correct the economic policies that make it so difficult for young men to enter and stay in the labor force and marry and support their families.

They may wonder why we tried to turn all the would-be young mothers into childless "professional women."

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41. It represents, in fact, an investment promising over a 65-year period approximately an 8 percent per year real rate of return, net of inflation – a substantially higher rate than that promised by most investments.
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15-23/23

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BEVERLY LAHAYE
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KENDA BARTLETT
LEGISLATIVE LIAISON

April 24, 1991

TESTIMONY BEFORE SENATE JUDICIARY COMMITTEE
Senator Wint Winter, Jr., Chairman
HB 2531

Mister Chairman and members of the committee:
Thank you for the opportunity to testify today. My name is Kenda Bartlett, and I am the Legislative Liaison for Concerned Women for America of Kansas. Since this is my first time to testify before this committee, I would like to take a minute to tell you a little about our organization. Concerned Women for America (CWA) is a non-profit, public-policy organization based in Washington, D. C., with chapters in all 50 states and Puerto Rico. We have approximately 700,000 members nation-wide making us the largest women's organization in the United States. We have about 3,000 members in Kansas. CWA's stated purpose is to "preserve, protect, and promote traditional and Judeo-Christian values through education, legal defense, legislative programs, humanitarian aid and related activities". As Legislative Liaison I track legislation that will have an impact on families. I focus on educational issues and issues that have to do with children and youth.

Today I would like to address HB 2531. There are a number of aspects of this bill that we can and will support. We recognize the need to focus our resources and attention to the prevention of teen pregnancy rather than just the treatment of the problem. For too long we have been reacting to this problem; we must begin to look more at prevention. The idea of a community-based program is also desirable to us. It is apparent to anyone that has studied this problem that the programs that have been implemented in our schools and agencies are generally not successful. We also applaud the efforts of this bill to enhance communication between teens and parents; we believe that the answer to most of our social problems is tied to a strengthening of the family. Parents are a teen's primary teacher and must be an active part of any successful program.

The problem that we have with the bill is Educational Objective (3)- "preventing pregnancy by other means when the program has been unable to assist minor females and males in postponing or suspending sexual intercourse". We cannot support this

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objective. Abstinence seems to be the key to this bill, but the teaching of birth control nullifies the abstinence message. Teaching abstinence means teaching in such a way that you change a teenager's attitudes towards his/her sexuality and sexual activity. You teach them that sexual urges are controllable, that everyone is not "doing it", and that abstinence is a healthy choice. If you teach all of this and then say, "but if you can't control your urges, then let us show you how to prevent pregnancy", you have undermined your complete program. Independent research and even Planned Parenthood data shows contraceptive approaches that ignore parents and rely on technology to solve the highly personal problems of teen pregnancy and AIDS do not work. For at least the last 15 years contraceptive information and contraceptive devices have been available to teens on a confidential basis; for the last ten years this information has been provided them through public health departments, public service announcements and in public school sex education courses. Yet we have not seen significant declines in the rate of teen pregnancies. What we have seen is an increase in teen sexual activity. Programs that have been successful in reducing the numbers of teen pregnancies (Grady Program in Atlanta, Project Respect and the Teen-Aid Program) have been programs that have stressed all of the objectives that are enumerated in this bill, but do not include contraceptive education. Dr. Michael Carrera, the director of the Children's Aid Society of New York program for 51 teenagers and 30 parents in central Harlem, says, "We have found that it is not enough to give teenagers a few sessions of sex education to stop the high pregnancy rates in central Harlem, which is 20 times the city average. You have to make kids feel that they are valued as human beings so that they won't become pregnant to fill a void in their lives. You also have to give them job skills and interests so they feel they have a future and will postpone having children until they are ready for them."

Former Secretary of Education, William Bennett, stated, "The most important determinant of teens' actions is their understanding of right and wrong." Eunice Kennedy Shriver, who has been a social worker with children for many years, says, It is time we accorded all teenagers the respect they deserve by recognizing their genuine, if often unspoken, desire to affirm values and standards, and to accept limits on behavior, including sexual behavior...If we want to do something helpful about teenage sex and pregnancy, the need is not for more money for the mechanics of birth control or more value-free sex education. Instead we should support efforts that strengthen family commitment and marriage, and that get at the basic problems that lead adolescents into sexual activity at an early age...We should support programs that shift our priorities from the mechanical to the moral; from the bureaucratic to the familial; from reliance on transitory adolescent notions of sexuality to the timeless values that place our sexual lives within a context of love, marriage and commitment to creation of strong and enduring families."

Any program that CWA would endorse would follow this premise. It must show adolescents that responsible action is a matter of ethical action not simply a matter of person's free choice. Therefore, we would respectfully ask that educational objective (3) be eliminated from this bill.

Thank you for this opportunity to address the committee.

Respectfully submitted,
Kenda Bartlett

16-3/3

Kansas
Wednesday, April 17, 1991

The Topeka Capital-Jou

Sentencing plan could affect suit

The Associated Press

The Legislature's decision on a proposal to overhaul the state's criminal sentencing laws could affect the handling of a 14-year-old prison overcrowding lawsuit, a federal judge said Tuesday.

U.S. District Judge Richard Rogers of Topeka said passage of a plan drafted by the Kansas Sentencing Commission could be a factor he considers in determining when to close a case brought by inmates against the state in 1977.

The litigation led to a 1989 order requiring Kansas to eliminate prison overcrowding by July 1. Supporters of the commission's plan say passage of it or a similar plan is vital to giving the state the ability to control its inmate population.

Rogers said his future handling of the case will hinge on the size of the prison population and the state's plans for managing it. If the passage of new sentencing laws results in fewer criminals going to prison, the state's efforts to settle the case would be aided.

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