P U B L I C H E A R I N G

before

ASSEMBLY EDUCATION COMMITTEE

ASSEMBLY BILL 3345

(Prohibition of certain services in school-based health facilities)

May 7, 1987
Council Chambers, 2nd Floor
City Hall
~~Camden~~, New Jersey
Jersey City

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Joseph A. Palaia, Chairman
Assemblyman Frank J. Gargiulo, Vice Chairman
Assemblyman Gerard S. Naples
Assemblywoman Mildred Barry Garvin

ALSO PRESENT:

Assemblyman Charles J. Catrillo
District 32

David J. Rosen
Office of Legislative Services
Aide, Assembly Education Committee

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Hearing Recorded and Transcribed by
Office of Legislative Services
Public Information Office
Hearing Unit
State House Annex
CN 068
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New Jersey State Legislature
ASSEMBLY EDUCATION COMMITTEE
STATE HOUSE ANNEX, CN-068
TRENTON, NEW JERSEY 08625
TELEPHONE: (609) 984-6843

April 22, 1987

NOTICE OF PUBLIC HEARING

on

The Prohibition on Certain Services in School-Based Health Facilities (A-3345)

The Assembly Education Committee will hold a public hearing on Thursday, May 7, 1987 at approximately 1:30 P.M. (immediately following a meeting of the committee) in the City Council Chamber, City Hall, 280 Grove Street, Jersey City.

Anyone wishing to testify should contact David J. Rosen, aide to the committee, at (609) 984-6843 and should submit copies of their testimony to the committee on the day of the hearing.

ASSEMBLY, No. 3345

STATE OF NEW JERSEY

INTRODUCED OCTOBER 23, 1986

By Assemblymen GARGIULO, PALAIA, Catrillo, Kelly and Assemblywoman Crecco

AN ACT prohibiting the provision of certain health care services by school districts and supplementing chapter 40 of Title 18A of the New Jersey Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. A school-based health clinic or other facility operated in a public school building or operated by a school district shall not provide any of the following health services to pupils: pregnancy testing, prenatal or postpartum examinations, dispensing of contraceptives or abortifacients, abortion or making referrals for abortions, or counseling in regards to family planning or abortion.

2. This act shall take effect immediately.

STATEMENT

This bill prohibits a school-based health clinic from providing to pupils pregnancy tests or prenatal or postpartum examinations, contraceptives or abortifacients, abortions or abortion referrals, or counseling on birth control or abortion.

EDUCATION—GENERAL

Prohibits the offering of health services relating to birth control, pregnancy and abortion by a school district.

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ASSEMBLYMAN JOSEPH A. PALAIA (Chairman): May I have your attention, please? We will begin our hearing at this time on Assembly Bill 3345. I would ask that our Committee Aide, Dave Rosen, call the roll, so we will have on record who is present today.

MR. ROSEN: Assemblyman Catrillo?

ASSEMBLYMAN CATRILLO: Here.

MR. ROSEN: Assemblywoman Garvin?

ASSEMBLYMAN PALAIA: She is present. She is just outside in the hall.

MR. ROSEN: Assemblyman Naples?

ASSEMBLYMAN NAPLES: Yes, present.

MR. ROSEN: Assemblyman Gargiulo?

ASSEMBLYMAN GARGIULO: Present.

MR. ROSEN: Assemblyman Palaia?

ASSEMBLYMAN PALAIA: Present.

At this time, I would like to set a few ground rules for the people who wish to testify. I would ask that your testimony be limited, if at all possible, to five minutes duration. We have a great many speakers who wish to be heard, and we certainly don't want to shut anyone out. That is why we are starting right at two o'clock, so we can get as many people in as we possibly can.

This will will not be voted on today; it will not be voted on today. It will be voted on at the next Assembly Education Committee meeting, which will be held on June 8, in Trenton. The reason why it is not being voted on today is, you cannot have a hearing of this magnitude and digest everything that is heard here today and make a determination. But, we will be having our Assembly Education meeting in a month, at which time we will be taking a vote on Assembly Bill 3345.

At this time, I would like Mr. Rosen to read an introduction to the bill, and then I would ask the sponsor of the bill, Assemblyman Gargiulo, to make an opening statement.

MR. ROSEN: Assembly Bill 3345 would prohibit a school-based health clinic from providing pupils pregnancy tests or prenatal or postpartum examinations, contraceptives or abortifacients, abortions or abortion referrals, or counseling on birth control or abortion.

To assist the Committee in its consideration of this bill, the Chairman has requested that I report briefly to the Committee on a related proposal by the New Jersey Department of Human Services. The Department of Human Services proposes to offer grants to public and nonprofit organizations in approximately 30 communities throughout the State, to establish comprehensive employment, health, and human services programs in local high schools.

The Governor's proposed budget for Fiscal Year 1988 contains a $6 million appropriation to implement this proposal. That budget is now under consideration in the Legislature.

The Department has proposed a statewide effort to foster the establishment of locally designed comprehensive programs to bring certain services to adolescents at or near high schools. Each local program would need a joint application from the school and a public or nonprofit organization. Each local project would be expected to provide teen-agers with a single entry point for a range of comprehensive services. At a minimum, each program would provide employment and job training, health screening and referral, and mental health and family counseling services. Beyond these core services, the local project could provide other economic and social supports to allow teen-agers to complete school, outreach to dropouts, and other services, including, at local option, family planning.

The Department intends to allow each participating local community to determine if, and how, family planning services would be included in the program. Any services

provided under this program would require parental consent. Funds provided by the Department for this program could not be used for the distribution of contraceptives, for the provision of abortions, or for abortion counseling.

ASSEMBLYMAN PALAIA: Thank you, Mr. Rosen. May we have Assemblyman Frank Gargiulo make an opening statement, please?

ASSEMBLYMAN GARGIULO: Thank you, Joe. Human Services Commissioner, Drew Altman, has proposed a school-based youth program. The Fiscal Year 1988 proposed budget contains an appropriation of $6 million for that program. In addition to the Department of Human Services, it is hoped that additional funding will be received from other sources, mainly the Robert Woods Johnson Foundation.

The program will provide grant money to communities to establish at least one site in every county to provide a wide range of services to teen-agers. Sites in or near schools will be considered. A wide range of services will be offered to teen-agers through the program, including job training and employment services, day care services, and instructions in parenting skills, substance abuse counseling, suicide prevention counseling, outreach programs for dropouts, and health services.

The health services component will include physical examinations, immunization, hearing and vision screening, preventative and primary health care services and, as the program is now proposed, family planning. The family planning component of the program was the impetus for this bill.

My bill would prohibit a school-based program from offering services related to contraceptives and abortions. I must emphasize that the Department's program, in total, is a good one. My objection is focused on the family planning services which may be offered through the program. Family planning counseling is not a new concept. In fact, these

programs have been offered to teen-agers across the country. The number of programs is growing. Data compiled by social scientists suggests that family planning for teen-agers may be the cause of the increased abortion rates among teen-agers. The Institute for Research and Evaluation in Salt Lake City has compiled data which shows that teen-age family planning clinics cause a decrease in birth rate among teen-agers, but contribute to the increase in teen-age pregnancies. The conclusion which may be drawn from this data, is that family planning services to teen-agers may, in fact, contribute to a higher rate of abortions among teen-agers.

In my judgment, public funds should not be used or spent on any program which has the effect of increasing teen-age pregnancies and abortions. As a result -- this bill. As a parent -- I have four children -- and as a principal of a high school in Hudson County -- a private high school -- I have other thoughts about the reasons behind this bill. As a parent, it is against my values, and against my very being, that my daughter or son could be in a school and, without my knowing it, be given a contraceptive or abortion information or be sent to an abortion clinic. It almost frightens me that that could happen in this society. Some things are best left to families, and best left to parents. These particular clinics leave the parents out of those things.

My second objection, of course, to the whole program, is that that type of stuff does not belong in the schools, if it belongs anywhere. Education is important to our children. I agree that they have to be educated. But, to be given contraceptives, to be given abortion information, to be sent to abortion clinics, is absolutely uncalled for and, in my opinion, we need a bill like this to put a stop to it.

ASSEMBLYMAN PALAIA: Thank you, Assemblyman Our first speaker will be Assemblywoman Clare Farragher, from the Twelfth Legislative District of New Jersey.

A S S E M B L Y W O M A N C L A R E M. F A R R A G H E R: Thank you, Mr. Chairman. Members of the Committee: This is my first appearance before you since my election in February to the General Assembly. I come here, not only as an Assemblywoman, but also as a parent. I have four daughters, young women -- three young women and one small child -- who I am proud to say have grown up with very good and strong moral values. They have gone through the public school system in our area, and I am proud to say that the values I have taught them at home have carried them through very well so far.

For many of the children in the State of New Jersey, the only place where they get any kind of sense of morality, or what's right and what's wrong, is through the schools, through the example of the teachers and the way the classes work together, and the way the teams work together when they are in sports. I am very concerned that having these types of family planning services available through the school systems is sending the complete wrong message to the children of the State of New Jersey.

I do not feel it is a function of the schools to provide these services. I agree that the program -- the other components -- as far as job training and proper health care, especially hearing and eye examinations, are very worthy, but I do not feel it is right to put a stamp of approval implicitly on family planning services which would include abortion referrals and the distribution of contraceptives.

For that reason, I feel it should not be a part of the school system, and I come here today in support of A-3345.

ASSEMBLYMAN PALAIA: Thank you, Assemblywoman. Mr. Naples?

ASSEMBLYMAN NAPLES: I just want to point out that I was present in New Brunswick when Commissioner Altman held hearings. It was a school workshop. I was there as a principal but, nevertheless, everyone knew I was an

Assemblyman, and this issue was raised. The Department and Commissioner Altman concurred that it would not be a referral system; it would just list abortion and other methods as a range of options. It would not try to influence anyone. We can't just bury our heads in the sand and pretend that certain things will go away. In no way would it say, "You should do this," or "This should be done. This is the address. Go here. Make a right turn on South and turn here, and the person will take care of you." It would only indicate that that was one option. Under no circumstances -- and Commissioner Drew Altman confirmed this -- was anyone to be influenced to exercise the options available. That is important, Clare.

ASSEMBLYMAN PALAIA: I don't know whether the Assemblywoman would like to answer that, or the sponsor of the bill.

ASSEMBLYMAN GARGIULO: The concern is that the program, once you implement it, and you say, "Well, we are not going to perform the abortions--" Someone is going to give that information out. The contraceptive part of the thing -- the schools giving contraceptives out -- is part of the whole family planning process. You cannot separate the two. What is family planning? Family planning is saying, "We want the people to have contraceptives in the schools themselves." So, when my daughter goes there, or my son goes there, the first thing that is going to happen is that they are going to give them contraceptives.

I'll tell you what the problem with the whole thing is. It is like the countries that instituted free drugs because they wanted to take the profit motive out of drugs. What they did was create more drug addicts. If we do what I think Human Services is planning to do, we are going to create more promiscuity and more problems than we have now.

ASSEMBLYMAN NAPLES: Let me just say this, Frank: Rod Frelinghuysen is a sponsor of the bill. I was approached to

sponsor it, but he had already sponsored it. He and I talked about this. We didn't get a chance to meet that day in New Brunswick, but we met on a subsequent date down in Trenton, during an Assembly session. Drew Altman confirmed that it was never to turn into that, that it was to be regulated very, very strongly by the Department of Human Services, to make certain it didn't turn into that.

ASSEMBLYMAN GARGIULO: I thought it was an option for the local communities.

ASSEMBLYMAN NAPLES: It was just an indication of options. It would not direct anyone, or advocate that someone exercise the option. There is a big difference.

ASSEMBLYMAN GARGIULO: Well, that is the point. I don't want them to have that option.

ASSEMBLYMAN PALAIA: Okay. Assemblywoman, are you finished with your testimony?

ASSEMBLYWOMAN FARRAGHER: Yes. (applause)

ASSEMBLYMAN PALAIA: Thank you, Assemblywoman, for your testimony. We appreciate your staying on schedule, too, which is very unusual for most legislators. But, we appreciate what you have done anyway.

At this time, I would like to have-- There are a few speakers who have to leave, and I want to make sure that I get them on. Dolores Grier, Tristate Coalition for Life? Dolores, would you please come forward? I really would appreciate it-- I know you feel good when someone makes a statement on one side or the other, but please hold your applause, because this isn't a popularity contest here. I would appreciate it. A nice smile would be better if you approve of what they are saying.

Yes, Dolores?

D O L O R E S G R I E R: Good afternoon. Thank you very much. I will occasionally have to look down, if you don't mind. (Referring to the fact that the Committee is sitting high above the audience.)

ASSEMBLYMAN PALAIA: That's okay.

MS. GRIER: I am Vice President for the Tristate Coalition for Life. I come before you today to speak in favor of this bill. I come before you especially as a black woman; not as a parent, but as a godparent, and as an aunt. I think I have an understanding, since I work with the youth in my church-- I have an understanding of what the young people will face if such a bill is passed.

I feel the usurping of minority people by the board of education in establishing sex education clinics to distribute contraceptives and abortion information diminishes the people who are still seeking justice and dignity as human beings. I think the lack of respect for our culture and our religious beliefs, and our students and our families, is demonstrated by this bill.

You know, as the plantation owners did in the days of slavery, I think the board of education is saying now that nonwhite children are not human beings with an intellect who can be educated to understand morality, and that the consequences of permissive sexual activity cannot be taught to them, but rather they are animals to be controlled by the chains of contraception and abortion. These are not only minorities -- less in number -- but they are less in humanity. So, we will tell them what to do, and we will do it for them through this program.

The technique of dividing in the story was also used in the time of slavery. By stripping the parents today of their rights and responsibilities to teach their own children discipline, morality, and respect for life, the board of education is destroying family unity. It is initiating family deceptiveness, and is instilling in the students a lack of respect and trust in their parents.

Human sexuality is a gift from God, and sex education is the primary responsibility of the parents. Birth control is

merely a man-made, long-term death plan initiated by the majority to control the minority.

A teen-ager is at a crucial stage in his or her development, and is more vulnerable to emotional and physical injury. Now, contraceptives are going to be a physical danger. The developing bodies of these young people will be-- I can't say definitely, but I understand that contraceptives have -- in the majority of our minority students -- caused sterilization, and the emotional effect of depression. Many of these young people come from Protestant backgrounds, where they go to Sunday School, and they know that contraception is wrong. They know that abortion is murder. They suffer from this very much. Many of them are also coerced by the school systems into doing what is supposedly for their education, for their benefit, and for a better way of life. However, they suffer the emotional trauma a year later, or years later. Much of this has been happening. They have also found now that many of the young people involved in contraception have now gone and turned to coke, because they are looking for an escape from what they have done.

I would just like to end with one statement. I feel the board of education has been mandated to teach academic topics. It has not been asked to handle health facilities or social services. I think health facilities should be handled by health practitioners who have been trained to do this, and that social services should be left in the hands of social workers.

Thank you very much.

ASSEMBLYMAN PALAIA: Thank you, Dolores.

ASSEMBLYWOMAN GARVIN: Thank you.

ASSEMBLYMAN PALAIA: Again, I appreciate your staying right on schedule for us. Our next speaker will be John Tomicki, President, New Jersey Right to Life. John?

J O H N T O M I C K I: Mr. Chairman, with your indulgence-- As I explained to you before, instead of putting the names of our two other witnesses on your list of speakers, I would like to just call them up, because one does have to take an airplane flight back to Washington, and the other one is a nursing mother. I will just give a very quick overview. I will be extremely terse, and I have asked them, likewise, to keep their remarks brief, and to try not to cover each other's ground.

I agree with what Dolores just said before. I happen to know her personally. I know most of the work she does with the Archdiocese in New York. Although this is not a religious issue in and of itself, there is, nevertheless, a significant moral undertone that goes underneath the entire problem.

I think we would have to state -- relative to what was discussed before in the opening parameters -- what the Commissioner -- Drew Altman -- said as to these health clinics which are being discussed and being proposed in the State, that-- This is the best remembrance I have of his statement. I think the Commissioner said he was not going to be held prisoner to the sex-based clinic issue; that it might be a health issue, but they might-- He didn't want to be held prisoner to this very, very sensitive area.

If we look at why we are here now, New Jersey has this history: We had a proposal by the State Education Department in 1981, although it had started somewhat ahead of that time in testimony, stating that we had a teen-age pregnancy problem and a teen-age venereal disease problem. They promulgated three volumes. I have one of them here with me. They talked about the out-of-wedlock pregnancies. What resulted from that was this mandatory sex ed program.

Many of us were disturbed with the program; again, because of the moral values that were going to be absent from the program. We said it wouldn't work. We all saw, at that point in time, that, again, these clinics would eventually

become a potentiality, because that program of mandatory sex education would fail. So, the family planning specialists who told us, "No, don't worry, it will work--" When we came forward to the public hearing in 1985 -- and it was reported in The Newark Star-Ledger -- those of us who were down to appear at that State Board of Education meeting were not only locked out of the meeting, but Dr. Joel Bloom of the Department of Education stated that it was never the goal of the program to lower teen-age pregnancies and venereal disease. Mr. Braun, who was the writer for the paper, was quite shocked by that statement, and so reported on the front page of The Newark Star-Ledger.

At present, we have over 5000 clinics and hospitals administering Title X funds. There are 4.5 million women making themselves available of these Title X programs, and one-third of them are under the age of 20.

Let's look at some history. In 1971, $11 million was spent -- was given out to almost 300,000 teen-age clients. In 1981, we increased to $442 million, with 1.5 million clients. What has happened over that period of time? From 1972 the pregnancy rate went from 95 per 1000 among teen-agers to, now, 113 teen-age pregnancies per 1000. So, has it gone down? No, it has increased. Teen-age abortions from 1973 to 1981 has come up from 190,000 to 430,000.

There are some interesting statements, and I am going to leave a copy of a report done by Robert G. Marshall of the American Life League with the Committee. It mentions school birth control.

I would like to just read some statements of some professionals: Dr. Alan Guttmacher, of Planned Parenthood, reported in The Kickerbocker News on December 6-- He was reported as stating that teen-agers should be provided with birth control information, even though he conceded that such information would bring about an increase in sexual relations

among teen-agers. Dr. Marco Havashum (phonetic spelling), in 1970, told "Redbook" readers: "When the use of contraceptives spreads through a society, one thing that happens is that the age of sexual intercourse and first exposure to unwanted pregnancy drops lower and lower." Dr. Robert Kursner (phonetic spelling) of the Harvard Medical School stated, in 1977: "About 10 years ago, I declared that the pill would not lead to promiscuity. Well, I was wrong." Dr. Min Way Chang (phonetic spelling), who was a co-developer of the birth control pill, is quoted as stating: "I personally feel that the pill has rather spoiled young people. It has made them more permissive."

So, we have a track record which shows us that in 1950, the Center for Disease Control-- The specialists said we had five clinical venereal diseases -- five types of venereal disease. Today, in 1987, we have identified over 50, and this is not a matter of better reporting -- over 50. A quantum shift in the behavior of a society leads to a quantum shift in disease. Abstinence does not breed disease. Abstinence does not cause your death.

Those of us who are speaking here today -- and I have perused the list of the groups-- Our organization represents over 50,000 families in this State. Probably, of the groups that are speaking here today -- the ones I have been able to speak to in the auditorium-- Probably, collectively, we represent over 100,000 families. That is family units, not family members.

I don't think we are here today to usher in a new Jerusalem. I think we are saying, "Don't return to the old Babylon."

With that, I would like to introduce Mr. Maurice Weir. Maurice is from Washington. He has had over 20 years of experience in this particular area. He is involved with a group called Cities and Schools. Mr. Weir?

M A U R I C E W E I R: Thank you. Good afternoon, Mr. Chairman and members of the Committee. As stated, my name is Maurice Weir. I am the Vice President of the organization that has been identified as Cities and Schools. I am also the Director and founder of the Adolescent Health Center in Washington, D.C., which was set up in 1981 specifically to address the problems of pregnant and parenting teens. The clinic and the program still exist. Since that time, it has served an average of 600 kids a year, so at this point, six and a half years later, it has served well over 3000 students.

At the same time, Cities and Schools is a national organization and, as Vice President, I am in charge of all field operations across the country. Currently, we are involved with 65 cities from coast to coast. The organization's specific agenda and charge is to work with average youths, and also to work with, and around, school settings.

So, the idea of services being brought into the schools is not a new one. In fact, it is one we advocate. But, I have taken a position, over the last few years, to specifically oppose the particular services that this bill suggests you leave out of the comprehensive health clinic that may become a part of the public school setting here.

My reasons for that opposition, and for being in support of the bill, relate specifically to my own experience and some research. In running the Adolescent Health Center in Washington, D.C., and looking at our programs across the country, I have dealt with, and continue to deal with, youngsters who have been a part of similar programs. We find increasingly 14-, 15-, 16-, 17-, and 18-year-old girls who come to us who have been through four, five, six, and sometimes as many as seven or eight abortions or previous pregnancies. Someone has made these youngsters think that this is a real easy problem to deal with.

In the course of those various pregnancies, we are charting medical histories from these youngsters of numerous venereal disease encounters they have had, various treatments, and we have seen a number of them now who have diseases that are incurable, including Herpes, which we are forgetting about in the midst of the AIDS crisis.

In a report that came out last week from the American Public Health Association, reporting on recent data from the Center for Disease Control, we found that the next highest risk group for the spread of the AIDS disease is the adolescent population. They are also reporting a fear that it is already rampant, and not yet detected.

Many of the concerns already expressed today about promoting these behaviors-- While our good intentions may be designed to save these youths from the consequences of becoming involved, it has been demonstrated in their implementation over the years that they do not work. Having once been a believer and involved with the implementation of some of these programs in the earlier years -- back through the late '70s and early '80s -- I have seen their failure with my own eyes, to the extent that the programs that once offered these services initially started out with a clear and stated set of goals and objectives that these programs were designed to prevent pregnancies and to reduce the amount of sexual activity among youths-- When those goals and objectives were not achieved, and what we did see after the smoke cleared was that we were only reducing births, we made -- without saying that we did not go into this with our objectives -- we made those our objectives, and reported success.

But, in the wake of what we can no longer deny as the increasing rate of teen pregnancies, with the failure of those services to stop the venereal disease spread in the adult or youth population, we have to -- as I have heard others say -- bite the bullet. But, in this case, I think biting the bullet

is taking a stand with these youngsters and holding fast that we will no longer endorse and surrender to those behaviors with them.

I think, finally, that one of the things I have seen -- and I think we need to be looking at it very carefully -- is where there has been change. In many of our programs where kids have changed many of their behaviors, whether it is their sexual activity, or delinquency, or suicidal interest, or what have you, the thing we have seen that has worked mostly has been human intervention. I think we, as we listen to the experts and hear that youngsters are lacking self-esteem and are looking for love, and these are the underlying causes for their involvement in many of these behaviors, must realize that at the same time they have bought into life styles that seek instant gratification. I think, in some ways, we have modeled those behaviors for them by thinking that we can solve these very serious problems with instant applications of pills, solutions, and other forms of quick fixes. The long, hard work of character building and moral development in our youngsters will not be solved through the revision of these services, and in the long haul, that is where the answer lies.

I think we have to pick up the challenge to begin to be able to face youngsters unarmed with pills and psychosocial curriculums, and bring our hearts and our minds and our caring and our love, in answer to what we have already identified as the real needs. I have seen them respond, and I am waiting for the rest of us to catch up. We cannot wait much longer with this problem. The schools are some of our most precious institutions in society. They have the command presence of their clientele in our youth. I think with that opportunity, it is the one service and the one arena that we need to guard most closely and most carefully.

Thank you.

ASSEMBLYMAN PALAIA: Thank you, Maurice. That was very well done. Mr. Tomicki?

MR. TOMICKI: We have a member of our Board. Ms. Barbiero, please?

If you have any questions at the end, we will be glad to answer them.

Ms. Barbiero is a mother, one of our State Board members, and a well-known lecturer.

ASSEMBLYMAN PALAIA: Please identify yourself.

A D E L T R A U D B A R B I E R O: Thank you. My name is Adeltraud Barbiero. I am originally from Austria. I am not unfamiliar with the problems in this country, because my country shares the same difficulties, and has for a great deal longer than Americans have in general.

I am testifying not just as a Board member of Right to Life, but also as a parent, and also as a taxpayer. This legislation is very necessary, especially to me since I discovered that school-based clinics are not just planned for physicals, laboratory and diagnosis screenings, immunizations, and general health care, but, by their own admission-- I am quoting from the Support Center of School-Based Clinics, which says that all of the clinics are involved, and will be involved in family planning. They suggest that by providing a wide range of services -- as mentioned before -- clinic organizers can achieve a wider community support. In essence, they are deceitful.

Joy Dryfoss of the Center for Population Options stated that respective clinics can avoid local controversy by starting with primary health care, and then later on adding family planning services. Regrettably, this underhanded approach to establishing in-school clinics is apparently quite common. From "Family Planning Perspectives," I quote: "The most common strategy adopted to avoid opposition, was to maintain a low profile, generally by keeping programs out of sight, by staying clear of controversial preventive services -- abortion services -- by relying on word of mouth for

recruitment, and by giving names to programs which obscure their functions, such as Teen Awareness, Access, Services to Young Parents, and so forth.

The same report states that program advocates and service providers are more or less obligated to exaggerate the potential benefits of services, to secure such material and political support. It was argued that teen pregnancy services would combat child abuse, crime in youth, unemployment, sexual abuse, infant mortality, mental retardation, birth defects, drug abuse, and welfare dependency -- a veritable Utopian society.

While no one is opposed for proper health care for our teen-agers, there is little in the literature to suggest that an expansion of the present services for contraception and abortion will be more successful than the history of the birth control movement itself, which dates back to 1970 and the inception of Title X. School-based sex clinics are correctly perceived as an extension of the Federal involvement, which was originally based only on four major premises; that is, it would prevent abortion, eliminate unwanted pregnancies, would not stimulate sexual activity in the much younger population, and would reduce venereal disease.

A review of the statements of proponents shows us that there was little ground for such optimism, and I suggest that their forecast had a little less validity than the general daily weather forecast by our weathermen on television. Lester Kirkendall answered the questions for teachers in his book on sex education. He said, "Of course, to make the elimination of premarital pregnancy and VD the main purpose of sex ed, is to make certain its failure."

When we look at clinic effectiveness, where such clinics do exist, even the Support Center must acknowledge that, and I quote: "Most of the evidence for the success of the program, for instance, in St. Paul, is based on the

clinic's own records and the staff's knowledge of births among students. Reduction of recorded births could also have been a result of an overall drop in the female population at the same time. Fewer girls in a school naturally means fewer pregnancies. Because of the difference in fertility rates and pregnancy rates, we will never know if the latter decreased because of students submitting to abortions."

It is interesting for me as a parent to note that when parents were notified through parental notification, as was done in Minnesota -- it was also done in North Dakota and in Utah -- suddenly the need of teen-agers for pregnancy counseling disappeared or decreased. Abortions decreased by 40%; births declined 23%; and pregnancies dropped 32% statewide overall. I might also add that parental notification is a great deal less expensive, and less likely to lawsuits stemming from damages done to minor children through medication, for which they are ill-equipped. Also, parents do not know the children are receiving that medication.

In the Muskegon Area Planned Parenthood Report, and the Muskegon Heights Public Health Clinic Report in Michigan, they state there was no significant change in the pregnancy rate following their clinics opening, because that was done without parental notification. Another report by the Support Center for School-Based Clinics, which I don't think they are very proud of, says: "Comprehensive programs, despite their many virtues, are not the magic bullets that will solve the problems associated with teen pregnancy and parenthood, nor should they be expected to do so."

School-based clinics, finally, appear to be the latest step in a growing movement to transform public schools into social welfare agencies, which provide services that interfere with academic pursuits, and this despite a dramatic decline in scholastic achievement during the last decade. Myron Lieberman wrote, in the "Journal of Family and Culture," that, "The

educational landscape reveals a mindless commitment of public school resources to the solution of social problems that are beyond their scope and influence. In the long run, the waste of resources, substantial as it is, may be even less important than the loss of respect for public schools engendered by such misguided efforts."

Despite 15 years of effort, and expenditure of more than $500 million to avoid and prevent teen-age pregnancy, abortion, and VD, we know that the statistics are climbing. Teen pregnancy, not unlike teen suicide, is merely the symptom of a far greater problem, and as a mother, and as a speaker in the classroom, I know this is true. It is incomprehensible to me that the only solution is more contraception for teens, or as the Alan Guttmacher Institute Report -- which is a Planned Parenthood adjunct -- seems to suggest, to follow the European role models. Do we really want to increase VD 250% for 16-year-olds, or 400% for 15-year-olds, as we did in Denmark, or 900% in mothers at the age of 14, as we are doing in Sweden? I might add, we are also increasing the infertility of our young people through this intervention.

Instead of relinquishing the authority and prescribing medications and pills, public schools should take the lead in instructing adolescents that there is no safe sex for school children, and that they must learn to say no to fornication, as well as they are told to say no to drugs, to alcohol, and to suicide. Our schools should not be a party to approving behavior that is unhealthy, sometimes illegal, incurs enormous financial liability, and is an offense against the rights of those children and their parents who are taught that nonmarital sex is wrong, dangerous to their health, and above all uncivilized.

Thank you very much.

ASSEMBLYMAN PALAIA: Thank you.

MR. TOMICKI: I would like to close with these two sentences. In the opening remarks by Assemblyman Gargiulo, he referenced the Institute for Research and Evaluation in Salt Lake City. We will give you a copy of the article that Mr. Weed (phonetic spelling) wrote, which appeared in The Wall Street Journal on October 4, 1986, where he very clearly set forth the statistical approach that what you are getting here with these clinics is a reduction in teen-age births, but you are also getting an increase in teen-age pregnancies. Abortion becomes the backup for contraceptive failure.

We will also forward to the Committee a copy of a Washington Post article, which references a "Journal of the American Medical Association" study, which shows that there is a failure rate in contraception among couples who have AIDS or AIDS-related Complex -- a rate of 30%. Initially, it was reported as 10%, but the follow-up report indicates there is a failure rate of 30%.

We commend Assemblyman Gargiulo for sponsoring this bill, seeing into the problem, and his clear thinking on it. We ask that the Committee release the bill.

ASSEMBLYMAN PALAIA: Thank you, Mr. Tomicki. Our next speaker will be Mary DeCillis, New Jersey Coalition of Concerned Parents. Is Mary here? (affirmative response from audience)

While Mary is getting set up, I would just like to thank Mayor Cucci of Jersey City, and his staff, for allowing us to use the facilities here today. They have always been very generous, and always willing to have us here in Jersey City. We appreciate all of their hospitality. Mary?

M A R Y D E C I L L I S: First, I would like to thank all of the members of the Assembly Education Committee for this opportunity.

Once again, the so-called experts are using our children for experimentation. The most recent one, Family Life

Education, was the answer to the increase in adolescent pregnancies. Despite the many hours of testimony, the factual data proving that these programs without moral basis could not be successful, the authoritative figures in government and education proceeded to mandate these programs in New Jersey.

We are now experiencing the results of that decision. These sexologists are now seeking to take us down still another avenue -- school-based health clinics. None of the numerous studies to date -- and many are from the prime movers of this program -- have proven that this course of action will, indeed, curb, or lessen, teen-age pregnancies. In fact, what is said -- and the facts prove it -- is that in reality, the number of live births has decreased. The number of pregnancies, venereal disease, psychological, and other medical problems have increased substantially.

I will never cease to be amazed that these so-called experts are constantly being consulted on their expertise to continue to give their opinions on the very problem they are responsible for. Report after report clearly shows that the solutions they have proposed and implemented have been ineffective. They have had more than 10 years to prove that these programs would, indeed, accomplish what they said they would. Yet, no one questions the credibility of these groups or organizations, when it should be clear to all progressive, thinking adults that the problem has not been addressed effectively.

Therefore, we must conclude the following: They are treating the side effects of this experimentation. They have been somewhat successful in attitudinal acceptance of sexual activities of teen-agers, and an increase in teen-age abortion, especially in white, middle-class teen-agers. Remember, it is not because of a lack of information or access to birth control devices that they are becoming pregnant. It is because they are engaging in sex. If we insist on teaching the glamour of

sex, we must also teach the emotional, moral, and financial responsibilities for such behavior.

Some broad areas to consider are: Guilt manifested in the betrayal of parental trust; the damage to one's self-respect and esteem; the costs related to rearing a child; the sense of loss associated with abortion and adoption; and, the psychological scars and risks of sterility caused by abortion and some contraceptive devices.

Let us ponder some other aspects of this proposed program: How will it impact school budgets? Who will administer this program? Are we going to expect untrained medical personnel to undertake this responsibility? If not, what kind of funds will be needed to support trained medical staffs? Has a feasibility study been presented to answer these questions? If we are going to utilize the school nurse, we must first dissolve present law, which forbids the dispensing of medication or treatment in any form. Has an impact study been made to ascertain the effects this will have on insurance rates when the first lawsuit is filed? Who is going to be responsible for medical and psychological costs incurred as a direct result of misinformation or the incorrect contraceptive being dispensed?

This would be a waste of valuable education dollars and a duplication of government services already in existence. We estimate that the State income tax would have to be substantially increased to meet all these needs, especially if this cannot be fully funded in years to come. What will happen then. Will it become a permanent item in the local school budget?

Another thought to consider is, it is extremely racial in its implications. The public perception of poor and needy -- as the proponents of this program insist are the beneficiaries -- is usually attributed to blacks and Hispanics. On the contrary, the majority of beneficiaries are

white, middle-class people. What are the proponents of this program really telling us? We strongly feel that moneys that would be appropriated for this experimental concept should be diverted to training our teachers, meeting salary increases, improving the academic atmosphere, and updating our curriculum to meet the challenges of the twenty-first century. We feel that instilling a child with self-worth, values that are based on the Christian-Judeo traditions, and occupying their minds and bodies with wholesome, productive activities, will go further than any of the proposed solutions.

When moral values were promoted in all aspects of one's life, a pregnant teen-ager was not looked upon in a very favorable light. Today, it is worn like a badge of honor.

I would like to also add that the Executive Board and our members voted unanimously to support A-3345. Thank you.

ASSEMBLYMAN PALAIA: Thank you, Mary.

ASSEMBLYMAN NAPLES: Mr. Chairman?

ASSEMBLYMAN PALAIA: Yes?

ASSEMBLYMAN NAPLES: I took some notes while the witness was speaking. She mentioned treatment by school nurses. I am going to extend that to principals, teachers, and other school personnel, who are all concerned, and who are trained. There is such a thing in education called the "counselor relationship." I am a principal, but I am not certified in Student Personnel Services, meaning that I do not have a guidance certificate. But, I am a counselor, with a capital C.

On four occasions in my over 20 years in education, I have had young ladies come to me who were pregnant. They could not go to their mothers. They could not evolve a dialogue with their own families. In each case, I indicated that they should go to their mothers and make a decision. In each case, the kid said no. But, I was sworn -- I was sworn -- by my oath of office, if you want to call it that, or by my professional

ethics, to keep that confidential. In three of the four cases, things turned out well, but in one case they did not.

You mentioned a "badge of honor." These kids came into my office with tears in their eyes. There was no badge of honor. It was a traumatic experience, and they needed help. I did not effect treatment. The school nurse did not effect treatment. We tried to provide help as best we could. I think you are totally inaccurate when you say that. I speak from the standpoint of a professional educator who has been at three, four, five schools -- three as principal. I have dealt with school nurses. I have dealt with child study teams. I know the effect of this. I don't think that an extreme, unrealistic point of view here is going to serve any purpose. I certainly did not recognize it as a badge of honor. I certainly did not effect treatment, and I certainly did not disseminate information.

ASSEMBLYMAN PALAIA: Thank you, Assemblyman Naples. Thank you, Mary, for your testimony.

MS. DeCILLIS: Thank you.

ASSEMBLYMAN PALAIA: We will now have William Calvin, President, New Jersey Christian Action Council.

W I L L I A M C A L V I N: Through Assemblyman Palaia, I would like to thank the Committee for having us here today. I am accompanied by John Ball, who is with our Ocean County Chapter, and also David Mercer, the Chairman of our Essex County Chapter. Before I give you my prepared testimony -- I am going to introduce copies of that which you can read later on, because it may not make your five-minute limit -- I would just like to respond to some of the comments I heard earlier.

One, on Mr. Naples' comment about the Frelinghuysen bill versus what Drew Altman said at a meeting, I have here Rodney Frelinghuysen's bill, and I read in it, in section 7-- It says: "A demonstration project shall provide," and then it talks about the services, a. through i. Service e. is family

planning services. So, clearly, it is the intention of Mr. Frelinghuysen, in this bill, to provide family planning services in the schools. Then, under item i., it talks about referrals to social service providers. So, the implication that all that was going to be provided by Rodney Frelinghuysen and the Governor was the local address of an abortion clinic, I think is misleading, if I read this properly.

ASSEMBLYMAN NAPLES: Did you speak to Assemblyman Frelinghuysen?

MR. CALVIN: I am just trying to address what was said earlier, the implication that somehow Frelinghuysen and Altman were not trying to put family planning and abortion into the schoolroom -- which Assemblyman Gargiulo is fighting here today -- I think is misleading.

ASSEMBLYMAN PALAIA: Yeah. I think, though, we are addressing two different issues here. That particular bill you are talking about-- One, it is a part of what is going one but, although it was mentioned by the Assemblyman -- and I understood where the Assemblyman was coming from -- that particular bill right now is, number one, not before the Committee, and two, would really have no impact on what we are talking about.

MR. CALVIN: Okay, but if Mr. Naples brings up things other than Mr. Gargiulo's bill, I think it is important to keep things straight. That's all.

ASSEMBLYMAN PALAIA: Yes. Well, we appreciate that. The Chair fully recognizes what you are trying to do, but, nevertheless, the bill you are referring to is not relevant to what we are doing here. Go ahead.

MR. CALVIN: Fine. Okay, thank you. Another point I would like to make is, I have been a member of the Morris Township Board of Health for 11 years, and in the local boards of health we have some of these options that were addressed. For example, family planning is not a core activity under the

laws that you gentlemen and ladies have passed, and it is optional. Our Board of Health -- a number of years ago -- did take the option of removing family planning as one of our activities, for this very reason.

The New Jersey Christian Action Council represents thousands of Protestant families here in New Jersey. We are basically concerned about restoring our State and Federal laws to being more consistent with the Judeo-Christian ethic. We are here today to enthusiastically support Assemblyman Gargiulo's bill -- A-3345 -- to keep school-based sex clinics out of our public schools. We do not believe referring for abortions, contraception, and sex education need to be in our school system. The evidence from some of the earlier witnesses, like Mr. Weir from Washington and others, has brought out the fact that where these clinics have been introduced, they have actually increased sexual activity, increased teen-age pregnancy, increased teen-age abortion, and increased some horrible sexually transmitted diseases among teen-agers.

Also, these clinics tend to usurp parental authority. Once again, the example cited by Assemblyman Naples was a fine one, of a principal saying to the child, "Go see your parents." But, the tendency of these family planning services has been to develop confidentiality between adolescents and government and private agencies. A lot of those people do not have the professional ethics that Mr. Naples spoke about, and they don't go to the parents. If the girl is going to continue to carry the baby, she can't keep that a secret. At some point, it is going to be clear that she is pregnant. But, if she has an abortion, that could often be a deep, dark secret, which many years later could come back to haunt her.

Eleven years ago, Planned Parenthood published an article called "Eleven Million Teen-agers: What Can be Done About the Epidemic of Adolescent Pregnancy in the United

States?" That indicated that 11 million teen-agers in our country are sexually active, and that over a million 15- to 19-year-olds become pregnant every year in the United States. It is these alarming statistics that have been repeated over and over that have brought us to this room today in many ways.

I would like to first spend a couple of minutes talking about some of the realities -- what some of the facts are -- because I think there is a lot of exaggeration in this area. First of all, the levels of sexual activity: Studies by the National Institute of Child Health show that the frequency of intercourse and the number of sexual partners of female teen-agers who say they are sexually active, are often exaggerated. Half of the so-called sexually active girls who they interviewed had not had intercourse for more than four weeks. Another half of the sexually active girls had only had one partner, and 14% had experienced sexual intercourse only once. They also came up with a concept they called "Secondary Virginity." That is kind of a humorous word, but their idea was a girl who had sex once, and then didn't repeat it during her premarital days. They found that is not that rare among teen-agers. It is often very common. Overall, they concluded that an appreciable percentage of unmarried teen-agers have had some sexual experience, but they are not sexually active, as that word would imply. It means that some of this alarm that has been raised about the risk of teen-age pregnancy is not a universal factor.

Another important point was brought out by some of the earlier speakers -- the difference between teen pregnancy and teen birth rates. In the United States every year, there are about a million teen-age girls -- 15 to 19 -- who become pregnant, but less than half have live births. What has really happened, as the earlier speakers indicated, is that the abortion rate has taken off. The abortion rate has about doubled in the last 10 years in this country. Actually, the

birth rate to teen-age mothers is down in the United States over the last 10 or 15 years.

Another important point is what we are talking about when we say teen-agers. Teen-agers covers a broad range here, up to 19 years of age. Some of us were married when we were 19 years of age.

There was a House committee study in this area. The House committee found that groups that promote widespread family planning programs for all grade levels in public schools, often use this phrase "teen-agers" too loosely. Dr. Jacqueline Kasen at Humboldt University said: "Much of the discussion is on the terrible problems of 11- to 15-year-olds, without pointing out that less than 2% of all births to teen-age mothers occur to girls under the age of 16. Less than four out of 15- to 17-year-olds, and only one out of 1000 girls aged 15 or below in the United States gives birth in a typical year. Sixty-one percent of teen births are to 18- and 19-year-olds, most of whom aren't even in the schools we are talking about today. So, only 39% of the so-called teen-age pregnancies that are bandied about occur to school-age adolescents.

Another interesting point is when we talk about a teen-age mother -- and we just had a little by-play about whether it was a badge of honor or a disgrace to be an unwed mother-- The teen-age mother phrase, once again, varies the implication of an unwed mother. Well, actually, in 1982, of the 513 live births to teen-age mothers, half of those mothers were married at the time the baby was born. So, unwed teen-age mothers account for only half of this number.

Another point is whether the pregnancy was intended or not intended. Dr. Harriet McAdoo, the Acting Dean of Howard University School of Social Work, points out that adolescents sometimes have a highly romanticized view of what a baby can bring into their lives. They found that 28% of the pregnancies

to teen-agers that they studied were intended. So, it is not clear what providing family planning services in the schools is going to do to these women who already decided they wanted to become pregnant.

Another important point is, it is often suggested -- and in Mr. Frelinghuysen's bill in one of the findings it is mentioned -- that there is a great risk to the health of the mother and the baby in these teen-age pregnancies. Well, that is not really the case. It is really a myth in many areas. Fetal mortality for mothers under the age of 20 is actually the same as for mothers aged 30 to 34, and lower than for mothers aged 35 to 39.

Another myth is that somehow teen-age women give birth to less healthy babies. When any differences are taken out due to prenatal care and economic level, it turns out that teen-age mothers under the age of 20 have less low-birth-weight infants than mothers over the age of 20. Maternal mortality rates are lower for teen-agers than they are for women aged 25 to 29.

So, to summarize, half of the teen-age girls in school are still virgins. Many of those who are not, are not as sexually active as one would like us to think. The pregnancy rate hasn't increased, and the birth rate has been decreasing. Most teen-age pregnancies are to 18- and 19-year-olds, who are not in the school system. Most births to teen-age mothers are to married women. Twenty-eight percent are intended, and teen-age mothers and their infants are at a lower health risk than most older mothers. That is one area -- the true nature of this problem -- that I wanted to bring to your attention.

The one other area I want to get into is the failure of these contraceptive programs for teen-agers. For the past 15 years, the cure for teen pregnancy has been government and private organizations providing more money, more sex education programs, more confidentiality between adolescents and various agencies, and easy access to contraceptives. Reacting to the

failure of these programs, the experts are back, giving us the new and approved version -- school-based sex clinics. Just as the past programs failed to reduce sexual activity, failed to reduce pregnancy, failed to reduce venereal disease, these new programs will do the same thing.

There are four areas where these programs have failed: One, wherever Federal funding has increased, teen pregnancy has increased. Contraceptives have been proven statistically not to reduce teen-age pregnancy. Contraceptives do not reduce teen-age abortions, and they do increase teen-age promiscuity. Data from the U.S. Department of Health, the Census Bureau, and the Alan Guttmacher Institute, show that from 1971 to 1981, Federal spending on family planning went up 306%. In the same time, teen-age pregnancies went up 48%, and teen-age abortions went up 133%. This is also true on a state-by-state basis. The states with the highest per capita public spending on contraception have the highest teen-age pregnancy and abortion rates. In one study of 15 states chosen for similar social and demographic characteristics, the states with similar rates of pregnancy in 1970 -- those with the highest spending between '70 and '79 on family planning -- also had the highest increase in abortion rates and the highest rate of premarital pregnancies of teen-agers.

Furthermore, as sociologist, Philip Cutrite (phonetic spelling) says, "Areas with weak or no programs in family planning had smaller increases in pregnancy, or actual declines, compared to areas with the strongest contraceptive programs."

Another important point is--

ASSEMBLYMAN PALAIA: Excuse me, Bill--

MR. CALVIN: Yeah?

ASSEMBLYMAN PALAIA: Your time is--

MR. CALVIN: Okay, let me just try to wrap up quickly. The other important point is, contraceptives do not

work for teen-agers. Between '76 and '79, the number of premarital sexually active teen-agers who always used contraceptives increased from 28% to 34%. In the same time, their pregnancy rate went from 9-1/2% to 13-1/2%. Among teens who use oral contraceptives regularly and follow the ideal pattern prescribed by Planned Parenthood, the pregnancy rate is 5.8%. Although the failure rate for oral contraceptives is reported to be 1% among all women, clearly, for whatever reason, it does not work as well for teen-agers. Planned Parenthood, in 1973, published a study showing the ineffectiveness for young women using oral contraceptives was four or five times higher than for older women. In light of this, one wonders why they insist that their programs are effective.

Just to sum up, government funding of family planning has increased, and pregnancies have also increased; so have abortions and so have teen pregnancies. Regular use of the most sophisticated contraceptives has not reduced teen-age pregnancies or abortions. Rather, it has increased teen-age promiscuity. In view of these facts, one has to wonder about the intellect or the intentions of the promoters of these programs. If matters had turned out otherwise -- if teen-age pregnancies were down as contraceptives became more available to minors -- then Planned Parenthood would be here to demand credit for that great achievement. Let them and their allies now accept responsibility for the tragedies their programs have brought about. Let them stop trying out their misguided theories on our young people. Teen pregnancy is the symptom of a greater problem -- premarital, adolescent sexual activity. Public and private programs should focus on reducing sexual activity before marriage. Rather than presuming teen-agers are going to have sex anyway, our collective strategy for combating teen pregnancy should be the same as our approach to curbing adolescent drug addiction. We should encourage them to say no.

Our children are our nation's greatest resource. Their behavior will determine the world that will exist for future generations. We must not abandon them to sexual promiscuity via school-based sex clinics. Rather, we must renew our efforts to mold their character in such a way that they reflect virtue, self-control, self-sacrifice, and service to others.

Thank you.

ASSEMBLYMAN PALAIA: Thank you, Bill. We appreciate it. Yes, Gerry?

ASSEMBLYMAN NAPLES: Mr. Chairman, it is obvious that a philosophical difference exists, and that is the understatement of understatements. With all due respect to the point of view you have promulgated, Bill, let me just say two things-- I apologize for interrupting you, Mr. Chairman, you were right in ruling me out of order.

Rod Frelinghuysen, when I spoke to him in the chamber-- He came over to my desk; he chatted with me, and he said he had looked for me in New Brunswick, but couldn't find me. I don't want to talk for Rod, but I would suggest that you talk to him. Also, Dr. Altman and I talked in the Senate Chamber. I went down there to see my colleague, Senator Stockman, about another bill, and the Commissioner and I talked. I would suggest you talk to him, too.

But, let me say this. The point you raised-- I don't doubt the accuracy of the statistics you have presented here; however, I would say they are not only omne dignum, they are not only parenthetical, but in a lot of ways they are tangential to the issue.

We in professional education -- and I can't separate the principal from the Assemblyman -- are trained to recognize social problems, and these are social problems. They are moral problems, too; I don't doubt that. But, they are social problems. That does not mean that an approach to solve a

social problem is per se immoral if one disagrees with that approach. We are trained to recognize problems. That is very true. But, the issue still comes down to this. There is a certain confidentiality, and we, as professional educators, are sworn to that confidentiality, or are sensible enough to know where to direct people. We are not out to influence a kid to have an abortion. I certainly never have.

But, schools come in contact with these kids. Schools are cognizant of these things. A teacher might notice something. A teacher's aide might notice something. It might be called to the attention of the assistant principal, or the vice principal, or the school nurse. Then it would have to go up the line, and it would come to our attention as chief school officers. Then, we would take it from there. Child study teams would talk about this. For the life of me, we are not as far apart as we would believe here, because no one is advocating abortion on demand; no one is advocating promiscuity. No one wants to see a young teen-ager subjected to an unwanted pregnancy.

I think there is a lot of emotion here. That does not mean that you are not well-intentioned, but I don't think we are going to solve this problem if we approach it from the standpoint of emotion. I am glad that this is being put in proper perspective. Normally at a public hearing, most of you know that I don't speak as much; I listen. Perhaps I am evincing my point of view -- no perhaps, I am -- but I have to be convinced here. No one has convinced me that the efforts of school personnel are in any way irreconcilable with those views you have promulgated here today. I strongly feel that, Mr. Calvin.

MR. CALVIN: Okay, but your whole history has been in a school system where things like the school-based clinics have not been a part of the school structure. This week, I spoke to the attorney for the Morris County Vo-Tech School. Ironically,

they sent a girl to an abortion clinic in Jersey City last week, and now their Board is struggling with, "What should we do? Do we tell the parents?" So, everybody doesn't have the same ethics that you have, sir.

ASSEMBLYMAN NAPLES: I admit that is a big detail that has to be worked out. Rod and -- I forget the individual's name with whom I spoke in New Brunswick; he is one of Commissioner Altman's Deputy Commissioners -- and Commissioner Altman himself, feel the question of jurisdiction has to be resolved here. That I agree with; I'll buy that, certainly.

MR. CALVIN: Thank you.

ASSEMBLYMAN NAPLES: Okay, thanks a lot.

MR. CALVIN: Mr. Mercer is not going to add anything, but John Ball has a short statement.

ASSEMBLYMAN PALAIA: Yes, go ahead, sir.

R E V E R E N D J O H N H. B A L L: Thank you. My name is Reverend John H. Ball. I am a Presbyterian minister, and the President of the Christian Action Council of Ocean County. For six years, I served as an instructor in a parochial school classroom. For the last two years, I have been an instructor in a public school classroom on the high school level.

My comments are brief. They will start -- by way of warning -- with a broad sweep, and then narrow to the question, but I assure you they are brief.

This year, of course, we celebrate the 200th anniversary of our Constitution, an anniversary to be a token remembrance of the greatness of our land and our humble and yet noble beginnings, and yet we sense that all is not right. The President has declared this very day a national day of prayer, and that is timely, for where is integrity, where is honesty, where is kindness, and where is the clear sense of right and wrong? Many have clamored, "Let's make America great again," but what is the formula, and, yea, what is first the proper diagnosis of our ills?

I suggest that the godless media culture spawned over the last three decades is causing a tragic change in our perspective on things. The public square, once the home of sound judgment and wisdom, the quorum of the wisdom of our elected officials, has, with our other institutions, become, as Richard John Newhouse (phonetic spelling) has called it, "The naked public square, stripped of all mention of morality."

Public education -- and I tremble because of the august Committee I sit before -- aided by commercial television and forgetting who are the teachers and who are the taught, is helping to reinforce certain anti-family, anti-American ideas, for too often sex is mistaken for love. Too often anarchy is mistaken for freedom, and grades are mistaken for education. We seek to turn out morally responsible citizens from our high schools, and yet we treat morality as if it were irrelevant, illegal, or both. We seek ethical behavior in business and politics, and yet we teach situationalism in the classroom. We seek high standards from our elected officials, and yet we deny the existence of the moral imperatives of our Judeo-Christian heritage. Yea, we seek to forget that heritage in our textbooks. We send a young lady to a school nurse for an aspirin. She returns empty-handed. She lacks the parental consent. Yet, that same child has had two abortions. I know it; the school knows it; the nurse knows it. Her parents do not.

Do we want the schools directly involved in that process by means of referral and parental deception? Do we want a child risking her very life on the abortionist's table, while mother and father think she is in an English class? Is that an excused absence with our State's attendance policy? If she has a note, is it an excused absence? Is that lawsuit material? Will the school become Big Brother? The Orwellian and Huxlarian (sic) threats becloud the horizon. The cure offered by the clinic-minded lobbyists is counterproductive,

for despite 15 years and millions of dollars worth of promiscuous sex education, increased confidentiality between adolescents and these agencies, and easy access to contraceptives and abortion, teen pregnancy rates -- pregnancy rates, though not birth rates -- continue to climb. Let's not buy into more of the same.

The poll used by the Planned Parenthood people to foist the clinics upon us is badly flawed. Benefiting from the research of my colleague, who sits at my right, I conclude with three statements: The study in Planned Parenthood's own "Journal of Premaritally Sexually Active Females Ages 15 to 19," found that as sexual activity increases, the probability of pregnancy also increases, even when contraceptives are consistently used. The Planned Parenthood "Family Planning Perspective" states, and I quote: "More teen-agers are using contraceptives and using them more consistently than ever before, yet the number and rate of premarital pregnancies continues to rise."

Mr. Calvin has already commented from sociologist Philip Cutrite, who has noted that where programs do not exist-- In those municipalities, sometimes the increase is less in pregnancy rates, and sometimes there is actually a larger decline.

In conclusion, Professor Kingsley Davis, who is a Board member of the Zero Population Growth Committee, says this, and I quote: "The current belief that illegitimacy will be reduced if teen-age girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraceptive use was becoming more, rather than less, widespread and respectable."

The establishment of school-based clinics is certainly not the answer to our ills. I respectfully disagree with Assemblyman Naples, for neutrality among teachers is also a myth. Many -- I heard it myself this week -- strongly advocate abortions. So, I speak in obvious support of Assembly Bill 3345.

I would also like to thank you, gentlemen, for your endurance and patience this afternoon.

MR. CALVIN: Thank you.

ASSEMBLYMAN PALAIA: Thank you, Reverend. Thank you, Mr. Calvin, and thank you, Mr. Mercer.

Our next three speakers in order, so you can get an idea of where we are, will be Toni Mullins, New Jersey School Boards Association; Marc Gaswirth, New Jersey Department of Education; and Mr. William Bolan, Executive Director, New Jersey Catholic Conference. May we have Toni first, and then the others will know they will be up right after that?

T O N I M U L L I N S: Thank you very much for having me. I appreciate being able to speak to you -- Assemblyman Gargiulo and Assemblyman Catrillo, especially you -- because the New Jersey School Boards Association certainly respects your intentions and your concerns with these bills. But, NJSBA opposes them, at any rate.

We oppose these bills for many reasons. I am not going to read from my position statement. Too many things have been said today which I want to quickly address before I leave. One thing is, NJSBA is not taking a moral or ethical stand on this issue. We are looking at this as needs at a local level -- student needs and community needs. In addition, I have heard a lot of statistics being brought out. With statistics, you can find pros and cons. There are a lot of variables in any study, which make statistics very hard to prove with direct correlations.

Also, as was just stated, much of what has been discussed and talked about has nothing at all to do with community-based health clinics or services that are utilized in these clinics. Much of what has been said goes on in the schools today.

NJSBA would support school-based health clinics and services that the community believed it needed for several reasons, and I will go through them very briefly. One is, we believe in having the professional staff working very closely with the school staff. That is what happens in community-based health services, regardless of what types of services are going on. We believe in a link between family life education in the school and the clinic services. We have policy looking toward giving teen-agers who are mothers, or who are pregnant, the care they need. We would rather have that care, if the community so desires, in a community-based health clinic, which only means that that clinic is reserved nearby or inside that particular school. That is pretty much the school's responsibility in community-based health clinics.

In addition, there has been a concern about parental consent. When there is a community-based health clinic supported by professional staff and school staff and the community, there is always parental consent before any student can use those facilities. In addition, most require, or request that the parents visit the facilities to become familiar with them.

So, for these reasons, I would like you to think about some of the other issues, and some of the support that a community-based health clinic could provide and the types of services that are needed. Again, this is a very emotional issue, and I happen to be the first one to come up in opposition.

ASSEMBLYMAN PALAIA: There will be others.

ASSEMBLYMAN NAPLES: It is nice to have company.

MS. MULLINS: There are a lot of statistics we could send you supporting the reasons why we think certain services would be viable in certain communities. We are not condoning outright services everywhere. We just want the communities and the people in the communities and the students in the communities to have choices. I am hearing here today that many people do not want the students in the local communities to have choices.

Thank you very much.

ASSEMBLYMAN PALAIA: Thank you, Toni. The Vice Chairman of this Committee will now take over.

ASSEMBLYMAN GARGIULO: Thank you, Joe. Assemblyman Catrillo would like to say something.

ASSEMBLYMAN CATRILLO: I have to leave for another appointment. I am not a regular member of this Committee. I was pressed into service today on an emergency basis, to make sure we would have a quorum for the Committee part of this meeting. I will not be voting on this bill to release it from Committee when it comes up in June, so I don't want anyone to think I am leaving experiencing only partially the testimony to be presented today.

If this bill is released from Committee, however, I will look forward to voting for it on the Assembly floor. I think it is a good bill. One of the reasons I have to leave is because I have to pick up my daughter from school. She is 10 years old, and she will be in high school, I guess, in another three years. I just can't imagine someone giving her birth control devices or abortion counseling without letting me know about it, or even having those services available to her. As far as I am concerned, she is my kid, and I will make those decisions, and nobody else. (applause)

ASSEMBLYMAN GARGIULO: The next speaker will be Marc Gaswirth, New Jersey Department of Education.

Before Marc speaks, I would like to say something about this. This fellow in front of me here-- During my first

term in the Assembly, it was a pleasure, Marc, to work with you, and I want to wish you the very best. I know you are going to be a great superintendent. Thanks for your help.

ASSEMBLYMAN NAPLES: He's a good man, even if he does disagree with us from time to time.

M A R C G A S W I R T H: Thank you very much. I appreciate that.

I would like to thank you for the opportunity to testify. For the record, my name is Marc Gaswirth. I am Legislative Liaison with the State Department of Education.

I can full appreciate how this bill could produce very strong feelings on both sides of the issue, but I really want to be very clear, inasmuch as I am representing the Department's position on this bill. The Department has problems with the bill. In taking this position, I want to be absolutely clear in indicating that the Department is not encouraging abortions or the distribution of contraceptives in the public schools. Our position is simply that within existing law and public policy, these kinds of decisions ought to be made by the appropriate public policy-making apparatus, namely the local school board.

That local school board should determine appropriately what health care services, if any, are to be provided, and what the specific content of health/family education is to be. In short, this issue, in our judgment, is most appropriately handled at the local level.

I would point out, just by way of sharing some information with you, Assemblyman Gargiulo and the other members of the Committee, that there are two existing statutes which provide, I think, further guidance in this area. N.J.S.A. 18A:35-4.6 states, in effect: "No pupil whose parent or guardian objects to such pupil receiving medical treatment or medical examination or physical examination shall be compelled to receive such treatment or examination." In

effect, what I am saying, by virtue of reading this law to you, is that parents can, and sometimes do, retain control over the extent to which their children are required to use school-based health services, through the provisions of the law I just read.

There is another law I would like to identify for the Committee and for the individuals sitting here. N.J.S.A. 18A:35-4.7 provides that: "Parents or guardians may request that their children be excused, without penalty, from any part of instruction in health, family life education, or sex education, which conflicts with their sincerely held moral or religious beliefs."

In view of existing statutory protections, the Department would again like to restate its position that the issues that this bill seeks to address can best be addressed at the local school district level, where the appropriate policy-making apparatus is already in place, and where the public can, and should, be heard on this very important issue.

I thank you very much, Assemblyman Gargiulo.

ASSEMBLYMAN GARGIULO: Bill Bolan, Executive Director, New Jersey Catholic Conference?

W I L L I A M F. B O L A N, J R.: Thank you, Assemblyman Gargiulo. For the record, my name is Bill Bolan. I am the Executive Director of the New Jersey Catholic Conference.

The New Jersey Catholic Conference supports your bill. While the Catholic bishops of our State support providing health care to young people, especially in urban areas where families are often unable to purchase these services, they strenuously object to services relating to contraception and abortion, which might be made available in these clinics. The Conference is as interested as others in curtailing teen-age pregnancies which have had such a devastating effect on the lives of young people, their offspring, and society. But we submit that the problem is not solved by technology, but rather by approaching the solution from a moral perspective.

Our public schools teach more eloquently by what they do than by what they say. The distribution of contraceptives in schools clearly says that the schools support, or at least acquiesce in, the alleged right of a child to engage in sexual activity, so long as it does not result in pregnancy. It suggests that adults view sexual activity by teen-agers as ordinary or inevitable. In short, it legitimatizes such activity. We also believe that counseling regarding abortion and contraception directly interferes with the right of parents to transmit their religious and moral values to children.

To say that contraceptives are necessary because teen-agers will be sexually active, is to tailor legislation to human frailties. We certainly don't do this in other areas of human behavior. Teen-agers drink alcoholic beverages, but we do not facilitate it by lowering the drinking age. If our public schools were to warn against drug abuse in one classroom, but hand out narcotics paraphernalia in another part of that school building, one can imagine how seriously the students would take the counsel not to use drugs. So, too, schools should accept the responsibility to teach students that they should not engage in sexual activity, which can bring with it not only pregnancy, but also venereal disease, AIDS, and other long-term health and social damage.

We believe that schools ought to be promoting sexual abstinence and chastity for teen-agers. Certainly, sexual abstinence is the only certain way not to become pregnant. We urge the Committee, by releasing your bill, to say no to those who would advocate the teaching of contraception and abortion.

Thank you, Assemblymen.

ASSEMBLYMAN GARGIULO: Thank you, Bill. William J. White, Associate Executive Director, Jersey City Medical Center. Is Mr. White here? (affirmative response)

W I L L I A M J. W H I T E, J R.: Good afternoon. I have additional copies of my testimony, which I will be pleased to distribute to the members of the Committee.

Mr. Chairman, members of the Committee: I am present today to testify in opposition to Assembly Bill 3345. My name is William J. White, Jr., and I am the Associate Executive Director of the Jersey City Medical Center.

I testify in opposition to this legislation because it takes from the parent and students of this community the ability to decide on the range of health care services which will meet their health care needs.

Underlying this legislation is the concern that services relating to reproductive health care, including pregnancy testing, prenatal, post partum, abortion referral, contraceptive services, and counseling about family planning, will encourage young men and young women to begin sexual intercourse.

The facts are that nationally more than 1 million pregnancies occur among the approximate 10 million teen-age females each year. About one-half of the 15- to 17-year-old males and one-third of the 15- to 17-year-old females are already sexually active. Teen-age pregnancies are unplanned, and 38% of those pregnancies end in abortion each year.

No one in the fields of health or education, that I know, believes that immature adolescents, men or women, should initiate a sexual relationship. The State of New Jersey mandated a family life education curriculum because this State finds that its young people need to understand the complexities of adolescent growth and development, the facts of human reproduction, and the responsibilities of being a parent. Unfortunately, the mandate did not bring funds to assure that family life education programs would be comprehensive and implemented by specially trained staff. International evaluations funded by the U.S. Public Health Service have found that the lack of quality information and the lack of accessible counseling and health services are major contributors to teen-age pregnancies and high infant mortality rates.

The Council of State Policy and Planning Agencies -- a unit of the U.S. Governors' Association -- in its 1986 report, reported that program options which work to reduce teen-age pregnancy include: Improving knowledge and attitudes about sex and contraception; making birth control services and devices conveniently and confidentially available; improving family relationships or developing positive relationships between teen-agers and adult figures.

In its Executive Summary, the report says: "Teen-age pregnancy is a preventable social problem." States can play an important role in developing strategies that enable local communities to provide services that will reduce pregnancies. Denying access to services will not resolve the dilemma of teen-age pregnancy. Comprehensive services in school-based clinics, as outlined in the attached program, is a community's effort to provide support and assistance to an underserved group -- its youth.

The Jersey City Medical Center, in cooperation with the Board of Education, and in consultation with parents, students, and representatives of civic and religious organizations in Jersey City, submitted an application to the Robert Wood Johnson Foundation to seek funds for a school-based clinic.

The school-based clinic is a resource to serve teens through counseling and health services to complete school and to provide them better future opportunities. The successful clinic requires support from parents, students, teachers, and the community at large. The successful clinic provides for orientation of the family and opportunities for parents to make appointments with clinic staff to discuss the services and their role in the clinic, while assuring students that services are confidential.

The school clinic, consistent with responsible health care practice, will provide accessible and affordable

comprehensive preventive health services and treatment for acute and chronic illnesses to underserved adolescents. These services include treatment of simple injuries, dental health services, mental health and substance abuse counseling, nutrition services, and pregnancy-related care.

To ignore pregnancy-related care services is to ignore responsible health care practice and the incidence of teen-age pregnancy in Jersey City. One of the goals of the school-based clinic is to decrease the number of adolescent pregnancies. Too often, many misinformed people assume that the availability of services encourages adolescents to become pregnant or sexually active.

Assembly Bill 3345 will not make teen-age sexual intercourse disappear. Assembly Bill 3345 will deny teens information and counseling that will assist them in making decisions about their expressions of intimacy and sexuality; it will deny services that will prevent teen-age pregnancies; it will deny health care providers the ability to discuss choices with teens about continuing or terminating a pregnancy; it will deny services and will encourage pregnant teens to stay in school and to return to school; and, it will deny parents access to professionals who can assist them in talking with their sons and daughters.

As a health professional, as a parent, and as one who sees the teen-ager in the Medical Center's Maternity Unit, I am concerned about the opportunities and services available to the adolescents of Jersey City. At the Medical Center, the physicians see the pregnant teen-ager too often, too young, and too late to salvage the life of the mother and the baby. School-based clinics can help to reach young people earlier and give them a chance for a better future.

Thank you.

ASSEMBLYMAN GARGIULO: Mr. White, I have a few questions, if I may.

MR. WHITE: Yes, sir.

ASSEMBLYMAN GARGIULO: Does the Jercey City Medical Center have a family planning site?

MR. WHITE: Do we have a family planning site?

ASSEMBLYMAN GARGIULO: Yeah, right.

MR. WHITE: We have an Ambulatory Care Program which is funded under the U.S. Public Health Service which, in addition to providing a full range of services to adolescents and children and pregnant women, does provide family planning services.

ASSEMBLYMAN GARGIULO: You talked about confidentiality. If a teen-ager came in to you, would the parents be informed?

MR. WHITE: The parents are not informed if the teen does not desire to have them informed. They are provided the opportunity to bring their parents in to talk with the medical staff, with the nursing staff, or with the other counselors, if they so desire.

ASSEMBLYMAN GARGIULO: So, if a 13-year-old girl came in to your clinic, and said to you, "I'm pregnant, and I want an abortion," and if you gave her the information and sent her for an abortion, would that be kept confidential?

MR. WHITE: Unfortunately, Mr. Assemblyman, the 13-year-old girl often comes to us too late in her pregnancy to even consider the option as to whether or not she would desire to terminate the pregnancy. I am not advocating the termination of her pregnancy; we are not advocating that. What we are saying is, we desire an opportunity to be involved earlier so we can assist them in making appropriate decisions in areas which involve their families -- making appropriate decisions and judgments about how they choose to carry forward their lives -- not decrease their options, but increase their options.

ASSEMBLYMAN GARGIULO: What I am trying to determine is, do you involve the parents?

MR. WHITE: Do we involve the parents?

ASSEMBLYMAN GARGIULO: Do you involve the parents?

MR. WHITE: We involve the parents in the sense that if the adolescents desire their parents to know they are there getting health services, they may choose to do so.

ASSEMBLYMAN GARGIULO: There is another point I would like to bring up. I mentioned earlier about the Salt Lake City study. Are you aware of that study?

MR. WHITE: I am aware of components of that study. It has been discredited by most social researchers who have a degree of credibility, including individuals at Columbia University and the University of Pennsylvania. Unfortunately, a variety of social studies have an opportunity to aggregate large masses of data, run sophisticated correlations and regression analyses, and come up with findings that are generally not consistent with what one observes on a day-to-day basis.

ASSEMBLYMAN GARGIULO: I guess my last comment is: Are you willing to state, then, that if these clinics are established, pregnancies will go down? Is that what you're saying?

MR. WHITE: Am I willing to state that pregnancies will go down?

ASSEMBLYMAN GARGIULO: In other words, if you have these clinics based in the high schools in Jersey City, and the schools in Jersey City, are you saying that the pregnancy rate will go down in Jersey City?

MR. WHITE: I am saying that without access to information and services, the pregnancy rate will not change. With adequate access to information and services it is possible that the pregnancy rates will go down. In opposition to statistical data you heard earlier, there is a recent study

produced by the Center for Disease Control of the U.S. Public Health Service, which does indicate that in the period of time between 1976 and 1982 there has been a decrease in adolescent pregnancies nationwide; not just a decrease in the birth rate, but a decrease in adolescent pregnancies. That rate has gone down fairly consistently over the last seven to eight years.

ASSEMBLYMAN GARGIULO: Thank you, Mr. White. Vera Roche, State Chairperson, Eagle Forum? Did I pronounce your name correctly?

V E R A R O C H E: Yes, that's right. Thank you, Mr. Chairman. We are opposed to the school-based clinics, either with or without the contraceptive information. We are very grateful to Assemblyman Gargiulo for sponsoring this legislation.

I won't take up too much of your time, because I really agree with the excellent testimony that has already been given. It was very much what I was going to say, so I just won't repeat it.

It just seems to us -- the Eagle Forum -- that a great deal of this just simply has to do with funding. The Department of Education is already being funded to the tune of $5 billion in order to teach academics and skills and, failing to do this, they are now going into the health care business. They are not going to stop there. We really feel that the mandate from the Legislature in Trenton to the Department of Education is to teach academics, and that is what they should be doing.

I attended a hearing -- an Appropriations Committee hearing -- over at Greystone Hospital in Morris Plains on health and human services. At that time, the Commissioner of Human Services, Drew Altman, spoke. He was asked by one of the Assemblymen, "What can we do about this teen-age pregnancy problem with unwed mothers?" He said, at that time, that when we ask these unwed mothers why they are getting pregnant --

one, two, three, four babies -- invariably, he said, they say, "Well, we just can't do anything else." What he was saying, in effect, was that they have low self-esteem. They don't have the skills, they don't have the academics to give them -- to put them in the position of being able to express themselves in other ways. So, how does giving them pills solve the problem? We have to get back to the basics, and that means education.

Assemblyman Kavanaugh, at that same hearing, brought out the fact that 80% of the children who graduate from the eighth grade in the public school system in Jersey City, cannot pass the eighth grade test. Now, how can the Department of Education be asking for more money to go into health care services, when they are not teaching the children academics?

The only other thing I would like to point out is, 90% of the money that is used in the St. Paul school-based clinic program is used for salaries and benefits. That is what this is all about -- funding.

Thank you.

ASSEMBLYMAN GARGIULO: Just one slight correction. The funding is coming through the health and human services office, not the Department of Education, although it does add to the educational package altogether. Thank you, Ms. Roche.

Cecilia Zalkind, Government Relations Coordinator, Association for Children of New Jersey?

C E C I L I A Z A L K I N D: Thank you. Assemblyman Gargiulo, Assemblyman Naples: I represent the Association for Children of New Jersey, which is a State-based child advocacy organization. We are interested in any of the programs and policies that affect children and their families in the State of New Jersey today. Health care has been a traditionally important issue to our Association, and I am here today to talk about our concern about health care services to certain segments of our population, as well as to talk about the adolescent pregnancy problem in our State.

Before I begin, I would just like to comment that it is always a pleasure to come before this Committee. I think each of you has demonstrated your dedication to children's issues in terms of the bills you have sponsored and in the issues you bring before the Committee. It is also an easy Committee to come to to express your concern. You usually provide a very open forum for a lot of diverse opinions.

With that preamble, I will go on to say that I am appearing here today to oppose this Assembly bill, at least some provisions of the Assembly bill that we are very concerned about.

As I mentioned, ACNJ has long been concerned with health issues in our State, particularly for economically disadvantaged families, who really do not have the access to health care or the money to pay for health services. We are very strongly supportive of this as one of many initiatives which seek to improve health care delivery for the citizens of New Jersey.

We have also been increasingly concerned about the problem of adolescent pregnancy in our State. In cooperation with the New Jersey Network on Adolescent Pregnancy, we completed a year-long look at the problems of teen pregnancy and the services available to teen parents in this State. I have brought some additional copies of our report, "No Easy Answers," which I will distribute to you later. This is a comprehensive look at what types of services are available for pregnant teens and teen parents, in terms of health care, education, and child care.

Based on our report and our research on the State, we have come to two conclusions which we feel are very important: One, New Jersey has a significant adolescent pregnancy problem. School-cased health clinics across the country have been very instrumental in dealing with that problem. Second and an even greater concern of ours which I will address in a

few moments, is the issue of infant mortality, and the fact that in New Jersey, our infant mortality rate is very high, as compared to other states in the United States. Part of the contributing factor to low birth weight and children born at risk is the age of the mother and the health care available to the mother during the pregnancy.

In our report, "No Easy Answers," we noted that in 1984 there were over 10,000 births to children under the age of 19 -- and these are children in our State. This figure accounted for almost 10% of the total infants born in New Jersey that year. Of this figure, 850 were born to single mothers who were aged 15 or younger. I have heard testimony which raised some issues about whether these were single or married parents. According to statistics from the State Department of Health, 73% of these mothers were unmarried. So, we are looking at a significant proportion of unmarried teen parents.

The pregnancy rate is even higher than the birth rate. In New Jersey, almost 30,000 teen-agers a year become pregnant. A large number of these pregnancies end in abortion. The national average on abortion is one out of two pregnancies end in abortion. In New Jersey right now, two out of three pregnancies end in abortion.

Now, in our look across the country and in the work we have done with the Children's Defense Fund, which is a national advocacy organization, there has been a lot of research that supports the idea that school-based clinics do help in reducing the teen-age pregnancy rate. There have been some startling statistics out of other school-based clinics. Again, I have to acknowledge that one can look at statistics and data in many different ways, and make an argument pro and con on the same issue.

Out of some of the Children's Defense Fund research, however, there are indications that in St. Paul, Minnesota --

which had one of the earliest school-based clinics -- teen birth rates declined by 50% from 1977 to the present. In Dallas, Texas, there was a 25% reduction in teen births, and a 90% reduction in infant mortality. In other clinics, pregnancy-related dropouts have also been reduced considerably.

Now, again, we are looking at data which deals directly with the use of contraceptives in school-based clinics. Not all school-based clinics do their own prescriptions for contraceptives or dispense contraceptives in the clinic. There are no school-based clinics right now that do abortions, but most clinics do refer for family planning outside the school-based clinic. We believe that in the context of the adolescent pregnancy problem in our State, this is appropriate. The Department of Human Services' proposal, as it now reads, contains two very important issues. One is local community input. The Department looks at the local contribution, not only from the school district, but from parents, in terms of what they are looking for in their particular clinic. We believe that legislation which restricts local community input would not serve the needs of New Jersey's youth.

Secondly, it is true that parental consent is needed in most school-based clinics. Again, according to the Children's Defense Fund, any service a child seeks through a school-based clinic, whether it is reproductive services, health care, sports exams, for example, needs parental consent. There has to be permission for a child to seek those services. We feel that that provides adequate protection for the child and the family.

Again, as other speakers have noted, this is a very controversial issue, and one that is really ingrained with one's own personal and family values. We have to acknowledge that this is controversial. It is not an issue that is going to be easily resolved. We do, however, have very serious

concerns about the infant mortality rate, and specifically the provisions of the bill which exclude prenatal and post partum services to children at school-based health clinics.

There was an article in a women's magazine about a year ago that had the headline that a baby born in Singapore has a better chance of surviving to his first birthday than one born in the United States. The United States infant mortality rate is very high in comparison to other countries. New Jersey's infant mortality rate is higher than the United States rate at the present time. There have been a lot of programs in New Jersey to address this issue of infant mortality. Some of their findings indicate that infant mortality is closely connected with teen pregnancy, that the age of the mother at the time of birth, as well as her prenatal health care, contribute significantly to the health of the baby upon birth.

In 1984, for example, almost 20% of infants born to New Jersey teen-agers under the age of 15, and 11% of those born to mothers aged 15 to 19, were in the low-birth-weight, under-five-and-a-half-pound category. This is a baby at risk. This leads to lifelong problems -- can lead to lifelong problems -- of disability, mental retardation and, in some cases, even death.

Because of this known risk, early prenatal care is a necessity. However, in 1984, only 41% of the State's pregnant adolescents under 15, and 55% of those 15 to 19, received care in the first three months of pregnancy. There are a lot of health professionals who believe that the first three months are very critical. We are looking at half of the population of the teens who become pregnant who do not seek prenatal care. Even more alarming, there is a significant number of teens in both categories, those under 15 and those 15 to 19, who receive no care at all during their pregnancies. We believe that one of the strongest features of the school-based clinic is the ability to provide prenatal care services to the child there.

It provides the child with medical services; it provides the child with nutrition services to protect her and her unborn baby during her pregnancy, and can follow through with some post partum medical services afterwards.

Additionally, we believe that this gives the message, and some support, to the idea that the child should stay in school. I keep saying child because our adolescent pregnancy data is about children. We are talking about girls who are very young -- under the age of 19.

A lot of the bills you have considered over the last session -- for example, your school-based child care bill, which this Committee endorsed -- look at how to keep these teen mothers in school, so that they don't wind up on the welfare rolls; they don't wind up pregnant a second time; they don't wind up dependent -- they and their families -- dependent on the State.

Providing prenatal care and postnatal care is a message that we will provide services to keep these girls in school. That also has been documented as highly successful in terms of reducing future pregnancy and enabling girls to finish school and go on to self-support for themselves and their infants.

In closing, I would like to stress that I want to thank you again for the opportunity. It is not easy to come out and oppose legislation, especially legislation that is very controversial and personal to many people. I do appreciate the opportunity to be here this afternoon.

ASSEMBLYMAN GARGIULO: Thank you. I have a few questions, if I may. Your testimony was very good, by the way; very informative. You did a good job.

Just this past week, to let you know, the Governor-- I am very much concerned about that prenatal part of the bill myself I worry about it. I don't want people to get the wrong impression that we are against babies, because we are not. This week the Governor signed a $22 million--

MS. ZALKIND: Yes. Health Start was a program we very strongly supported.

ASSEMBLYMAN GARGIULO: --prenatal bill, and I thought that was sufficient to take care of that area. That is why I really didn't address it in the bill as it is.

You make some other points about the declining birth rate in the Minnesota studies, but you didn't mention the fact that there actually was an increase in pregnancies, which means that there had to be an increase in abortions. I don't want people to be misled by that.

MS. ZALKIND: I think that is a very valid point. It is very difficult to make the connection between contraceptives and abortion and an increase in birth rate. There are a lot of factors involved in teen pregnancy and why a girl becomes pregnant during her teen-age years. Again, I think it is very easy to pick out the pieces of the data that support your argument.

ASSEMBLYMAN GARGIULO: I don't want to get into a controversy about data. I am looking for information; that is why I am really reaching out to you. I am looking for data.

MS. ZALKIND: If I may just make a very brief comment-- As I mentioned, we supported the Governor's Health Start Program. We thought that was a significant program. We are very disappointed that the Medically Needy Program was not a success. That was also a program that we were very interested in. Both of those programs are targeted to families which do not have the financial ability to provide medical care for themselves; those families which live below the poverty level, but are not eligible for Medicaid. We feel that school-based clinics go beyond that. It is true they will reach children who are financially unable to get health care, but they will also provide access to health care for children who maybe have the financial means -- they and their families have the financial means for health care -- but who are

afraid. It is difficult for teen-agers to go to a doctor, to find a doctor, to talk about a problem as personal as teen pregnancy, especially if they can't initially go to their parents to talk about it. Having the clinic at school, having some of the services provided there, with the parental permission, provides some access that goes beyond the financial issues.

ASSEMBLYMAN GARGIULO: Thank you very much.

MS. ZALKIND: Thank you.

ASSEMBLYMAN GARGIULO: Jean Belsante, New Jersey Representative, Concerned Women for America?

J E A N B E L S A N T E: Good afternoon. My name is Jean Belsante, the New Jersey State Representative for Concerned Women for America, an organization of over one-half million nationally. I thank you, too, for the opportunity to be here today.

In addressing this issue, I prefer to call these "sex clinics," simply because the attendees at their Chicago-based convention in October, 1985, confessed that the whole program was aimed at how to get contraceptives into the hands of all junior and senior high schoolers.

My message today encompasses three major points. Point one: So-called family planning programs for teen-agers simply don't work. These programs have not only failed to reverse the tide of teen pregnancy, they have seen a drastic increase in nearly every area they were designed to reduce.

In the first 10 years of government-financed family planning programs, the number of teens served by them increased 400%. During this same period, the number of illicit pregnancies doubled among 15- to 19-year-olds. Many of them, in fact, became pregnant while participating in family planning programs. One study showed, for example, that in 1976, teens who used contraceptives were more likely to become accidently pregnant than non-contracepting teens.

As Planned Parenthood's own magazine acknowledged, "More teen-agers are using contraceptives and using them more consistently than ever before, yet the number and rate of premarital pregnancies continues to rise."

Teen abortions, as well, have increased steadily, despite these programs. From 1974 to 1982, the percentage of teen-age pregnancies terminated by abortion rose nearly 70%. I am going to skip through some more statistics to support the fact that I stated earlier, just to save some time.

In contrast, the most dramatic decline in teen pregnancies in many years followed passage of the 1981 Minnesota law requiring parental notification of teen abortion. Between 1980 and 1983, teen-age pregnancies declined in Minnesota by 32%, births by 23%, and abortions by 40%, among 15- to 17-year-olds. It would seem wise, then, gentlemen, to pursue the course that has demonstrated success, rather than to open the floodgates for sex clinics in our schools -- a concept that is, as demonstrated, a proven failure.

Point two of my address is that the underlying current of this issue is largely political, the hidden agenda being the desire by school-based sex clinic proponents to establish a very dangerous eugenics policy in the United States.

Planned Parenthood, for example, is a leading advocate of school-based sex clinics -- an indisputable statement. In looking behind the facade of the supposed humanitarian purpose of Planned Parenthood, we find a consistent focal point centered on eugenics -- a fact perhaps undetected by the average Planned Parenthood member.

It cannot be denied, for example, that Planned Parenthood's founder, Margaret Sanger, was obsessed with establishing a eugenics policy in the United States. Let's examine several copies of the magazine, "Birth Control Review," which she edited for many years:

The May, 1919 copy, in which she wrote, "More children from the fit, less from the unfit. That is the chief issue of birth control."

The December, 1921 issue, whose motto on the masthead touted that the purpose of birth control, according to Sanger, was, "To create a race of thoroughbreds."

A 1923 issue, which advertised a birth control conference held that year in Chicago, whose banquet address was titled, "Eugenics -- the Super Race."

Margaret Sanger openly collaborated with contemporary eugenicists in promoting her ideas, having invited Adolf Hitler's advisor on race hygiene to the United States. Moreover, Margaret Sanger's close associate, Lothrop Stoddard, looked favorably on Adolf Hitler's eugenic views. In fact, his book, "The Rising Tide of Color Against White World Supremacy," was given a glowing review in Margaret Sanger's October, 1920 issue of "Birth Control Review."

But, even more incriminating, Planned Parenthood founder, Margaret Sanger, once revealed her own birth control plan for the black community. She envisioned: "Three or four colored ministers, preferably with social service backgrounds and with engaging personalities" to promote birth control throughout the South. She wrote further, and I quote, "The most successful educational approach to the Negro is through a religious appeal. We do not want word to go out that we want to exterminate the Negro population, and the minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members."

It should, therefore, come as no surprise that over 80% of all school-based sex clinics in America are positioned in the inner-city school districts.

My third and final point is the most cogent, that being that there is a very obvious conflict of interest in this incredible scheme; namely that school-based sex clinics, whose

aim is to distribute contraceptives to teen-agers, are being railroaded into our schools, as well, by people who manufacture contraceptives!

A case in point is the earlier-mentioned Robert Wood Johnson Foundation -- I heard it mentioned several times today -- which is openly committed to funding some 20 clinics in America as a starter, and whose major assets are Johnson and Johnson stock -- the same Johnson and Johnson that manufactures condoms. Equally ominous is the fact that our New Jersey Commissioner of Human Services, Dr. Drew Altman, is a former Vice President of the Robert Wood Johnson Foundation, while claiming that school-based clinics will be, "A priority for my administration." An obvious question here, gentlemen, is, does Dr. Altman currently hold stock in the Robert Wood Johnson Foundation or perhaps Johnson and Johnson?

In closing, I, therefore, strongly urge your support of A-3345 as the New Jersey State Representative of Concerned Women for America, and respectfully request that you release this bill from Committee in order that our General Assembly may promptly act on it.

As with drugs, as with alcohol, and as with smoking, let's just teach our teen-agers to redefine the boundaries, and to just say no.

If possible, I would like to just rebut a comment that was made earlier, unless you would rather ask questions first.

ASSEMBLYMAN GARGIULO: That's okay; go ahead.

MS. BELSANTE: I heard it said that no one would advocate, you know, encouraging sexual immorality among teen-agers. I have something here which I am sure is well-documented, and I will trace it further for you, if you would like, to the effect that at the National Conference on School-Based Health Clinics, held in October, 1985, in Chicago, they recommended the book, "Changing Bodies and Changing Lives," written by Planned Parenthood, to be made available in

these sex clinics. I would like to point out that on pages 98 and 99 of this book, it instructs teens on how to have oral sex. On pages 82 and 83, it gives them techniques to reach sexual orgasms. It tells them on page 94 that the more sexual partners these teen-agers have, the more they will learn about sex. If that isn't encouraging them, I don't know what is.

Furthermore, I would like to mention that Planned Parenthood, as we know, is very heavily involved in the promotion of these clinics and, in fact, plans to be there with bated breath, to be available to teach the kids anything they are given the privilege of teaching. I have one of their pamphlets here called "How Pregnancy Happens." Actually, it is called "Basics of Birth Control." I'm sorry, I gave you a subtitle. You can see right here for yourselves-- For example, what they give out to the teens is a description of every known contraceptive device, what it is, how it works, features of its use, chances of pregnancy if you use it, other facts, and so on. I ask you, if that is not encouraging promiscuous sex--

Furthermore, as far as the New Jersey State Department of Health is concerned, they publish a pamphlet that I understand is being used in sex education programs in our State, called "Am I Ready?" Right on the inside cover, it asks "What are my rights?" It answers that the teen-agers' rights are to seek information and services about birth control. Their rights are to expect confidentiality -- in parenthesis, "(No one will know)" -- and their rights are to obtain education, information, and guidance from home, school, church, and health centers, like Planned Parenthood. I say these are open commitments to promulgating teen-age sexual activity.

Thank you, again, for the privilege of being here today.

ASSEMBLYMAN NAPLES: Frank, this really has nothing to do with the testimony, but I just want to say this for my own

benefit. Outside before, a young lady named Marie, who is one of the persons who respectfully disagrees with me-- I missed her last name. She is from the Camden County area. She criticized me, and I hope that some of you will listen to what I have to say. Several times, it was indicated -- and I feel badly about this -- that I hit this microphone as a gesture of disrespect toward the people with whom I disagreed. That is not true. There are microphones all over the place.

Once I crumpled up papers, for which Mildred Garvin gave me hell. I didn't realize it. On another occasion, I leaned back as though I wasn't paying attention. That is not true. I leaned back to think. If it was anything else, I have a very, very bad migraine headache right now. I get them about two or three times a year. My aide is going to drive home. So, I am here, and certainly there was no disrespect intended. Any time I walked out there, it was to get information from my aide, or to get information relative to this issue. So, if anyone shares that viewpoint, please understand that there was no disrespect intended.

MS. BELSANTE: Thank you, Mr. Naples. I will accept that apology. I think if there is any issue that can give one a headache, it's this.

ASSEMBLYMAN GARGIULO: Thank you very much.

ASSEMBLYMAN NAPLES: Thanks a lot.

ASSEMBLYMAN GARGIULO: We have a lot of speakers yet to come, so I am going to enforce the five-minute rule. Please be as brief as you can. Councilwoman Frances Thompson.

C O U N C I L W O M A N F R A N C E S T H O M P S O N: Good afternoon. I would like to say one thing first, to the Assemblyman who just spoke. The microphones in this Council Chambers -- I am part of this Jersey City Council, and these are our Chambers -- are brand-new. They were just put in last Wednesday. So, that is one reason for the intense sound that is coming from them. Normally you wouldn't hear the rattling of papers, and everything else.

Before I begin, I would like to let everyone clearly know that I have been fighting for social issues in Jersey City for 22 months. To relate my background, I have a master's degree from Rutgers University; I have been Vice President of Rutgers Alumni; I have been a counselor at Rutgers University, Hudson County Community College, and several other places.

This bill, as far as I am concerned, is blatant, outright racism to major urban cities. That is just the way I feel about it. I am going to explain in detail. I am not saying the act was racist by the Assemblyman who placed it into effect, because I really believe Assemblyman Gargiulo believes it is going to work. However, as a legislator, one cannot just devise bills because of his emotions or how he feels about it. Legislators represent large groups of people. I, myself, have 37,000 constituents, and I am also a legislator of 250,000 people in this community. We are the second largest city in the State of New Jersey. The population of school children in the public school system is astronomical in size. The majority of them are minority students; minority not just meaning black, but Asian, Hispanic, and poor whites. These youngsters, for whatever reason -- be it economic or social -- have come into a situation where they have not been blessed with the guidance, many times, of a parochial education, where religion is a very integral part of their education.

Wherever you find a parochial school system -- my son went to both public and parochial schools -- where religion exists in the school, there is a teaching that exists from the Bible that assists them with abstention from drugs, abstention from sex, abstention from negative behavior. Because of our system in the United States, religion has been taken out of the schools, so they function as social ball parks to adhere to, and make some of these changes. Most of the youngsters in the public school system are not in the upper middle class. Unfortunately, Jersey City is not in Ocean County; it is not in

Morris County. The children are not from the upper middle class portions of the State of New Jersey.

We have a crisis in the urban cities; that is, we have a large proportion of youngsters who, at this particular point in time, are babies having babies. It has been going on for a long time.

I would like to say this, and I am not pointing at any particular individual or at anyone who has spoken before: How many women sitting in this audience can say -- I am 45; I feel good about being 45; I just became 45 -- they were not pregnant when they got married in 1950, or 1960? You know, we advocate a lot of new things in 1987 which were not advocated in 1952, when we were in the back seats of those cars, doing the same things these kids are doing. But, we were forced to get married. Our parents wanted us to get married, and we were in love. So, those things passed.

Today, the morality has deteriorated because of people who are our age -- 45, 55, 65. We have allowed the morality to destroy itself to such an extent that it is not necessary for one to get married if one is pregnant. So, teen-age pregnancy tends to increase, and we tend to keep having children. The welfare rolls keep increasing. The welfare rolls are not necessarily controlled by blacks, but by minorities and poor whites. We also have a problem now with homelessness.

I am in a situation on the Municipal Council where problems continuously and perpetually come into my office. I am supposed to be a part-time Councilperson. I work 18 hours a day, six days a week -- no less than 12 -- because of the social problems and ills which exist in this city. Many, many times, young women -- 21, 22 years old -- come in here with four children, homeless, with nowhere to go, uneducated. Their children will be uneducated. It is not one generation; it is two generations and three generations.

I beg to tell you, gentlemen and ladies of the Legislature, when you make a law, don't look at a select population. Look at the total population, and what exists in our major cities. Yes, there are things that, maybe, I don't know if you can do it by law-- There should be laws set up to deal basically in the urban cities where the problems exist. I don't know if you can make those kinds of restraints, but there must be something done in the urban cities.

I look at this bill as a racist, targeted situation to perpetuate pregnancy, perpetuate the poor, perpetuate homelessness, perpetuate the uneducated. I am not -- and I am going to say this for the third time -- saying that that was the intent of the bill, but that is the way the bill looks to me.

The people you hear speaking in defense of this bill are people who are employed in a social service system, or people who have been inundated with this kind of a situation, or know that this situation exists. It appears to me that those who are fighting on behalf of this do not come from these big urban cities, where the situation continuously grows and grows and grows.

I am very glad for you, Assemblyman Gargiulo, that you have that much control in your home with your youngsters, but many of us do not. We talk to our youngsters, but they still function from peer pressure. If they learn from peer pressure, and peer pressure says, "Active sex," if a child comes from a situation where the parents sometimes are professionals and do not give them the time they need, they involve themselves in sex for attention and love. They end up becoming pregnant from that situation.

If you can, within yourselves, maintain that kind of rapport with your family, whereby you can maintain your children, give them guidance, explain to them the truth of sex, and the education of sex, I applaud you, but many, many, many

people throughout the country are not able to do that. One, because of ignorance, because babies are still having babies, and this has been going on for the last 15 or 20 years, and they are uneducated and can't teach them; two, they do not have the religious background to understand the structure of the family, abstention from sex, and what that is all about; and three, the economic situation that exists for them -- just grappling for survival and to eat -- does not allow them to clearly do those things that are necessary to be a strong family structure.

I have been blessed. I come from a strong family structure. My grandmother was a minister; my grandfather was an entrepreneur; my great-grandfather did something; my father was an engineer; my mother was involved in politics and education. But, I fight for those in my community and those in my city who did not come from the family structure that I came from. Someone must fight for them; someone must clearly make everyone understand that there is a problem that exists here. We need help in this city. We need help in all of the major cities in this State. The small towns, where there is a control mechanism, where families work together, churches work together, schools work together-- God bless them. They are doing a good job. That control does not exist in the urban cities.

I am against this bill. I look at this bill as a racist tool to continue to perpetuate the destruction that exists in the urban cities.

Thank you.

ASSEMBLYMAN GARGIULO: Assemblyman Joseph Doria, from Legislative District 31. Assemblyman, if you would.

A S S E M B L Y M A N J O S E P H V. D O R I A, J R.: Thank you, Mr. Chairman. I appreciate the opportunity to be able to testify on this very important piece of legislation. I would like to begin by thanking the Committee -- the Committee

Chairman and Vice Chairman, Assemblyman Palaia and Assemblyman Gargiulo -- for coming here to Jersey City to hear testimony on this very important bill. I just want to emphasize that I think this bill is very important. I also want to thank the Vice Chairman, Assemblyman Gargiulo, for allowing me to be a cosponsor of this piece of legislation.

I feel this legislation provides for something that is important in our society today. I think the morality in our society, unfortunately, is not what it should be. I also feel there is a need to provide health services to young people. I do not support doing away with that. But, I think, at the same time, we should not provide them with information on something such as abortion. To me, that is a form of genocide. Unfortunately, I think it is a form of genocide directed at specific populations in our cities.

We don't encourage abortion among the upper middle class, or the middle class, in many instances, but yet, in our inner-city schools, this is something that is encouraged. We are encouraging our young people, especially in many instances our minority young people, to take advantage of this opportunity. Obviously, this is a form of genocide upon this population.

So, I feel it is very important that we pass this piece of legislation to allow for the protection of the rights of the individual. If someone wants to have an abortion, well, they can have an abortion. If someone wants to use birth control, they can use birth control. Our society allows it. We may not always agree with that, but our society does allow it. However, I do not think that public moneys -- in this instance, the school systems' moneys -- should be encouraging it to take place within the context of the schools. Rather, if this is taking place, it should be done outside the context of the school environment.

I don't think it is necessarily something I would encourage, but yet I do think there are other facilities in our environment, in our social structure, where this information is provided. What I am saying here is, the concept of the bill is a very good one. I think it is important for us to realize that, unfortunately, and for all good intentions-- I think there are a lot of people with a lot of good intentions who say, "Well, we should be providing this information within the schools, especially our inner-city schools." As I say, I think that a lot of times what we are doing here is seeming to direct this toward one group of people -- one particular area. We seem to encourage that to take place in that area because, unfortunately, those are the people who have no other choice, have no other opportunity.

I disagree with some of the statements made earlier concerning morality. I think morality is as important today as it was 30 years ago; as it was 60 years ago. Obviously, some people do not live up to that context, but I think we have to demand that our society fulfills certain types of standards. I do not think our schools should be encouraging the opposite of the standards that are part of our basic society, part of our basic culture.

For that reason, I strongly support this piece of legislation. I will be working with the sponsor and with the members of the Committee who support it, to see that it becomes law.

I want to thank Assemblyman Gargiulo for giving me this opportunity, and Assemblyman Naples, and I will be seeing you in Trenton. Thank you.

ASSEMBLYMAN GARGIULO: Thank you, Joe; thank you very much. Joseph Gonzalez? Mr. Gonzalez, are you affiliated with any organization?

J O S E P H G O N Z A L E Z: No, I am a citizen from Bayonne.

ASSEMBLYMAN GARGIULO: Great.

MR. GONZALEZ: I would like to take about 30 seconds of my testimony time to call on the Lord to bless this hearing here today.

Heavenly Father, these are ordained ministers of yours. Father, I ask that you give them the wisdom to ferret out all of the information, so that they may make the decision that will fulfill thy will. I ask that in Jesus' name. Amen.

Now, I am here as a foster parent, as a grandparent, as a concerned citizen. I believe, from my personal experiences with the public schools-- Normally a person of my age -- I am 57 years old -- would not be involved in the public school system, because my children are all grown now. But, being a foster parent, I have been involved. I don't like what I see. I believe the public schools to be the biggest child abuser in this nation. They are involved in snooping; they are involved in counseling where they do not belong. I had a case just three days ago where a parent called me. She was crying because she had a child who was interrogated -- a sick child who was interrogated in the school -- without parental permission. So, I have very little confidence in the public educational system to safeguard my rights.

I have been locked out of a public school. I was only allowed to enter after they put a gag on me. They told me I could not speak, nor ask questions, because I was not a member of the PTA. I attempted to form a group in Bayonne -- the Bayonne Action Organization -- to counter some of the things we thought were happening in family life education. We ran into all kinds of opposition. So, I really do not have any confidence in the public schools in safeguarding my rights.

I would just like to read a letter; I've got it right here. This letter is entitled, "Family Life Education Means Death to the Family." It is related to this issue: "On October 9, 1985, a group of parents who refused to be silent about their concern for their children and this nation, stood

outside one of the Bayonne Public Schools handing out a questionnaire designed to encourage other parents to take a second look at the Family Life Education Program.

"Along with the questionnaire, a critique of the program was given to parents as they were entering that school for the first monthly PTA meeting of the season. Even though it was within our rights as taxpayers and residents with children in the system to be on school property, we were told to leave the school grounds and to hand out our materials from the sidewalk, and we complied.

"As concerned parents, we tried to attend this meeting in order to learn more about the distict's Family Life Education Program, to ask questions, and to speak, but we were refused entry. After some disquieting discussion with the principal and an administrator, only my wife and I were permitted to attend the meeting, because we had a foster child in the school and we had an invitation." We had a written invitation to come.

"The other parents were escorted out of the building. We were told that we could not speak nor ask questions, because we were not paid-up members of the PTA." Imagine that! "Paid-up members, however, were permitted to speak and ask their questions. Must one be a paid-up member of a PTA to have a voice in our government's schools?

"The Family Life Education Program is actually a misnomer for family death education. This program teaches our children the advantages and disadvantages of early sexual activity. Now, you are a parent. I ask you, what advantage do you see for your child being involved in early sexual activity? None. I cannot see any."

Abortion as an acceptable alternative to pregnancy and homosexuality as an alternate life style-- As a result of these violations of God's natural order of things, a natural penalty is exacted -- AIDS. That has risen to epidemic

proportions, and abortions are recorded at the alarming number of a total of 20 million thus far.

ASSEMBLYMAN GARGIULO: Mr. Gonzalez, would you please sum up? Your five minutes are up.

MR. GONZALEZ: Okay, then I won't take any more time. I would just like to show you one picture. One picture spells a thousand words. May I just turn it around to the audience?

ASSEMBLYMAN GARGIULO: Sure.

MR. GONZALEZ: We have here a picture of Uncle Sam on his knees. He is being struck down by a bolt of lightening. From the cloud, we read from the II Chronicles 714: "If my people which are called by my name shall humble themselves and pray and seek my face and turn from their wicked ways, then will I hear from heaven and I will forgive their sin, and will heal their land."

Thank you very much.

ASSEMBLYMAN GARGIULO: Thank you, Mr. Gonzalez. Ann Wilson, Assistant Professor, Graduate School of Social Work, Rutgers University; Director, New Jersey Network on Adolescent Pregnancy.

A N N W I L S O N: Good afternoon.

ASSEMBLYMAN GARGIULO: Good afternoon.

MS. WILSON: I am very pleased to be here. I am the Director of the New Jersey Network on Adolescent Pregnancy. I met Assemblyman Naples before, and I am pleased to meet you, sir.

The Network was formed in 1979. It is a consortium of some 3000 individuals around the State who are concerned about adolescent pregnancy, teen parenting, and prevention. I am here today, unfortunately, to oppose the bill. I say that because I think we are at a juncture in New Jersey now with a model program in family life education that is looked to by the rest of the nation as something to be replicated. I say that because we are at the juncture of welfare reform efforts, which

include teen parent programs in Camden and Newark. I see this bill as really mitigating those very positive efforts.

I have been looking at what is called -- I guess the Youth Demonstration Centers is what they have been calling them -- in terms of developing 30 of these around the State of New Jersey. I would like to just tell you some of the experience of the 71 school-based clinics around the nation. I think you know they were begun in 1973 -- at least the conceptualization, the model for this -- by the Robert Wood Johnson Foundation. I have heard them rather slandered, I think, this afternoon. You know they are the second largest foundation in the entire country. They are the largest foundation that is concerned about health issues. Their understanding and their beginning to look at the problem were based on the fact that teen-agers have the worst demographics of any age group in the nation. Most of us in this room will live longer, and will live healthier lives than teen-agers. They have the highest rate of suicide; the highest rate of homicides; overweight; anorexia; and pregnancy. Because of this, Robert Wood Johnson took a look, and said they needed health care.

I would also suggest that we now know that teen-agers are notoriously reluctant to seek services. While there are existing services in the State, the fact that they could be offered on-site in school-based clinics could really make a difference; could really make a dent in terms of some of those other issues.

The whole issue of access is very important; again, remembering that teen-agers are reluctant to seek services. Having them on-site and non-stigmatized-- In other words, a school-based clinic is where the football player goes to get a physical examination. A school-based clinic is where a youngster goes if he has a cut, a scratch, a scrape, whatever. It is primary, general medical care. They are not sex clinics. All the data from the last 14 years of experience

around the nation points out that less than 25% of the services are for reproductive health services. Rather, they are for primary medical care.

I would also like to say that in terms of developing the model, the Robert Wood Johnson Foundation, to its credit, insists upon family planning services, and let me tell you why. Again, with a comprehensive approach to health care, and knowing with whom they deal -- mainly teen-agers, and sometimes older teen-agers, 16-, 17-, and 18-year-olds -- they knew that a number of them were sexually active. In terms of reducing, or preventing, teen pregnancy, they feel that family planning should be a part of the component of comprehensive care.

What I would like to suggest in terms of the bill is that it be left a local option, in the sense that we have this for family life education, and it seems to have worked. In other words, we have a precedent now in terms of local communities taking a look at their own local needs, their own local resources, and moving towards making their own local plans.

I have some other material, but I realize you are under a time constraint. The model around the nation has been that none of them -- by the way, I support the testimony of Ceil Zalkind -- none of them provides abortion services. So, really, that is a moot issue in terms of this legislation. It is just not provided. It was never in the design; it was never in the planning. Rather, because of numbers, and because of concerns, it has turned out to be an alternative parallel system of health care for a group that does not get health care.

Thank you very much.

ASSEMBLYMAN GARGIULO: Thank you very much. Gaye Hodges, Healthy Mothers/Healthy Babies.

G A Y E H O D G E S: Hello. My name is Gaye Hodges. I am the Coordinator for Healthy Mothers/Healthy Babies. The Chairperson for the Healthy Mothers/Healthy Babies Coalition,

Madeline Brown, had to step out for a minute, so I will begin to read her prepared statement.

To the Chair and members of the Assembly Education Committee: I am here this afternoon to express my thoughts with you and as a representative of the Jersey City Healthy Mothers/Healthy Babies Coalition.

The Coalition is very concerned regarding the legislation as proposed here today. The decision to request funds for a school-based clinic is excellent. To have a school-based clinic deal with the major health issues among teens in our community is even better. Preventing unwanted pregnancies is a major health issue. Unfortunately, in our community this is a major problem which must be addressed realistically. In one of the elementary schools in this community right now, I know a sixth-grader who is pregnant. There were 68 pregnancies in one of the high schools alone in the 1985-1986 school year. You are familiar with the expression "babies having babies." Jersey City has been designated as one of the 10 target cities allocated moneys to deal with the high infant mortality rate. I have attached a data sheet for your perusal. Please examine it and know there is an association with teen pregnancy, high-risk pregnancy, and infant mortality.

Parental input is vital for this concept of health care in the school setting to be most effective. As a parent myself of three teens, I certainly would never agree or support any service which would circumvent parental guidance and decisions. Therefore, the decision of what services are made available to the students in the school-based clinic should be addressed by the parents and the local community, not legislated by a body on a State level. Why? Because different communities have different needs. This community needs this major issue of teen pregnancy addressed from all aspects. It is a multifaceted problem, and it needs a multifaceted

approach. Home, church, school, and community need to combine efforts and energies to address this issue.

Please, do not make a law which is not relevant to the community it is to serve.

I presented the statement, but the person who prepared it is Madeline Brown. This is Madeline Brown, who is the Chairperson of the Healthy Mothers/Healthy Babies Coalition.

D O R I S M A S S E Y: And I am Doris Massey, parent, Snyder High School, Jersey City, where the clinic will be located. Madeline, is there something you would like to say?

M A D E L I N E B R O W N: I have listened very, very intently to the testimony and the words that were spoken today. It is very interesting. There seems to be a great deal of controversy. There also seem to be a lot of issues which those opposing the bill and those supporting the bill are in agreement on.

The point I really want to make is, the issue seems to be with parental consent and the abortion factor. The clinics are being referred to as sex clinics, and that is not their intent, to my understanding. The clinics are to service teens. Teens need, and will function well in a setting that is designed with them in mind.

As my statement said, I am the parent of three teens, and I certainly would not support any legislation that would take away my right to supervise my teens. But, we have to be realistic. In this community where we live and service people, we do not have homes which are two-parent oriented. We do not have homes where health care and services are provided to a standard that we would like to see them provided. So, legislation designed which is not applicable, must be given more thought.

ASSEMBLYMAN GARGIULO: Are you aware that this bill deals with a very small segment of the whole package that is being proposed? It does not wipe out the health care per se. It deals with just specifics.

MS. BROWN: Yes, I am very aware of that. That is why I think it should be dealt with on the community level. I think the community should decide. If referrals are needed, then they should be allowed to be given. I am not saying-- I think this community needs it.

ASSEMBLYMAN GARGIULO: Okay.

MS. BROWN: I do.

ASSEMBLYMAN GARGIULO: Your community, though-- The fellow from the Medical Center has testified that when your child -- that sixth-grader -- walks into the clinic--

MS. BROWN: See, you know, I can't even identify with that--

MS. MASSEY: I can't identify with that either.

MS. BROWN: --because I don't think my child would be going to that.

ASSEMBLYMAN GARGIULO: I know, but that is a Jersey City-based clinic. That is what I am telling you; that is what I am saying to you. You're telling me that is what you don't want. I'm telling you that is what you have.

Ladies, anything else?

MS. MASSEY: I am Doris Massey, a parent of a student at Snyder High School, where the clinic would be based.

I sat here today and I noticed that even for the people who were for the program, or for those who were against it legislative-wise, it was terribly unbalanced. Okay? Quite naturally, I saw where more people came out in support of you, but I don't think it was open to the public so you could balance it out. I felt that was unjust, for one thing.

For another thing, there is a lot of misunderstanding, and a lot of inaccurate quotes were made here today. Most of the time, when a child has a problem in the school, the parent is informed regardless of what it is. All right? But, I have to look back at the legislative laws that were passed in Jersey City that gave that student the right to withhold information

from the parent. So, you're saying on one hand that they should be notified, and on the other hand, you're saying that they shouldn't be notified. As a matter of fact, President Reagan tried to enforce a law where a parent should be informed, and I think almost all of the United States fought against it.

So, you're damned if you do, and you're damned if you don't. Okay? My concern is, this health clinic should be not only for health services, but also for prenatal care. I will give you an example. I work at night, and I spend three-quarters of my time in the school during the day. I have had numerous students approach me, because I have developed this type of a rapport with the students in the high school. They came to me and asked me to help them to seek out some type of prenatal care, or they asked me for information on contraceptives.

The average student is afraid or ashamed to go to the drug store. Even though they have that right, and can purchase contraceptives over the counter, they are ashamed to do it. They are ashamed to ask their parents, or to inform their parents that they are having sex. I know for a fact that, not only in high schools, but this is starting in the elementary schools. Okay? They are actually having sex from the fourth, fifth, sixth, seventh grades. By that time, a young lady may not have come around, but by the time she reaches high school, she has, which would lead her, more than likely, into pregnancy.

Actually, these children have nowhere to go, and have no one to turn to, to ask questions. I have left myself open for the children to come to me to explain their needs and to see what should take place. Also, in high school -- freshman year, sophmore year, junior year, senior year -- they are afraid to walk through the doors of a Planned Parenthood office. It is like advertising to the world, "I am on contraceptives." Okay?

So, if they were able to go to the nurse on a more intimate basis, and the availabilities were there, it would help to a large degree.

Again, I felt this hearing today was a little one-sided, because you are mentioning communities where the people can afford to send their kids to private schools, and where most of the homes have two parents. I happen to come from an area where the majority of the families -- more than three-quarters of them -- are single-parent families, or the parents are working. I happen to be one of those who left room, who left time open for my kids to come to seek help, if they needed it. I sat down and I spoke to them, but not every parent is going to do that. Every parent -- even you -- sits back and hopes and prays that she has raised her kids to a degree where they won't do this, or, if they do get in trouble, they will go to the parent, but more than likely they won't. You have to keep your fingers crossed all the time -- okay? -- all the time, that this won't happen to your child.

But, in the meantime, in our community, it is happening. It is happening fast. I know for a fact that there are five seniors getting ready to walk down the aisle who have conceived -- who are carrying. In Snyder High School right now, you have anywhere from 30 to 40 students pregnant. I also know of a young lady who was pregnant and didn't tell her mother. She was heading toward her fifth month of pregnancy. She had no prenatal care, although she knew she was pregnant. Toxemia had started to set in. Her parent, in a panic, who could not afford to have another child come into the house, took her for an abortion. Do you know what type of an abortion she had? The salt -- one of the most vicious, one of the most dangerous procedures in abortion. But, if this had been caught in time, if the parent of the child had been informed-- If she had gone for prenatal care, maybe she might not have had the abortion. Maybe toxemia might not have set in.

So, where does the controversy end? Where does the reality of it all come into existence? I see this as a political ball game for and against. I don't see the gut emotional feeling involved in any of this.

ASSEMBLYMAN GARGIULO: I am going to have to cut the time off, but-- Assemblyman, do you want to say something?

ASSEMBLYMAN NAPLES: I have to agree with you. I am thinking back to the four young ladies who approached me over the years. Three turned out well. In fact, one of them had me over to her house for supper a couple of months ago, with my girlfriend. She is in her 30s now. One of the girls didn't turn out well. She had the same type of abortion you talked about. Her girlfriend told me she would never conceive again because of the abortion she had. She didn't talk to me until it was too late. She finally did talk to the school nurse, and to medical personnel, but it was too late. She went to New York, and a butcher worked on her. Now, that is the fault of the State of New York. That is my personal opinion. Although I realize I am responsible for New Jersey, I have my own opinion about that.

At this point, I would like to excuse myself, Mr. Chairman. I have to get back to Mercer County. I am going out tonight. Believe it or not, I am going out with a conservative Republican girl, who always says I am too liberal. If she were here now, she wouldn't go out with me.

Thank you all very much for your testimony.

ASSEMBLYMAN GARGIULO: Okay, Gerry.

MS. BROWN: May I just make one point?

ASSEMBLYMAN GARGIULO: Go ahead; go ahead.

MS. BROWN: I feel that you are absolutely right. These issues should not even be dealt with in the schools -- abortion, preventing pregnancy, teen-age sex, etc. They should be dealt with at home, with the mother and the father. But the point is, there are many homes in this community that do

not have mothers and fathers functioning in the capacity that we would like to see them function in.

The point is, this group of children does need some other support system; does need some other mechanism in place to assist them with these decisions they are going to make. I don't think there would be anyone in any type of school-based clinic who would tell a young woman 14, 15 years old, "Have sex, and if you get caught you can have an abortion." I do not think that is the intent at all. It would be educating. In a sense, it would be parenting. It is sad that we have to have that take place in a school, but we do.

MS. MASSEY: We have no other option.

MS. BROWN: Realistically, in some communities, we do.

MS. MASSEY: We have no other option in this community. Unfortunately, the school has to take the place of adviser, parent--

MS. BROWN: It shouldn't be, but it--

MS. MASSEY: It has come to that point because we are losing them. Also, I don't condone abortion, but it is taking place. There is no sense of us turning our backs to it. What we do is shut it out. When young ladies are pregnant, if they feel ashamed to go to the public facilities, like Planned Parenthood, and what have you--

MS. BROWN: Or, if the parenting is not there, they need someone to talk to. That is why I say I don't think my 13-year-old would be there discussing the fact that she was pregnant, because hopefully I would be there to talk to her. Or, she could go to her father. But, what does the 13-year-old do who does not have this mechanism in place? Wouldn't it be better for her to go to the school nurse? Wouldn't it be better for her to go to the nurse practitioner?

MS. MASSEY: Wouldn't it be better for her to receive those services there?

MS. BROWN: Can't you tell that I am a nurse, and therefore I am going to send her to a nurse? But, wouldn't it be better?

ASSEMBLYMAN GARGIULO: Ladies, I hear you. You have made some very good points. Thank you very much.

MS. BROWN: Thank you for your time.

ASSEMBLYMAN GARGIULO: Listen, there will be consideration on June 8, in Trenton, so if you are interested-- That is the day the bill is going to be voted on.

MS. BROWN: All right, thank you.

MS. MASSEY: Thank you.

ASSEMBLYMAN GARGIULO: You're welcome. Thank you.

Mary Kay Smith, National Coalition of Clergy and Laity?

M A R Y K A Y S M I T H: Good afternoon, gentlemen. I am very happy to be here. I am representing the National Coalition of Clergy and Laity. That is a grass-roots group of organized Catholics who are firmly in support of the Holy Father and the magisterium and, also, most, most definitely concerned with areas regarding chastity and the teaching of chastity in our public and Catholic schools.

Now, as for my prepared statement, I will read it: Proponents of the school-based comprehensive health clinic concept have produced numerous studies purporting to show the success of these clinics in reducing teen pregnancy. However, what their studies really show -- when reviewed in concert with related works on adolescent sexuality -- is that the school-based sex clinic phenomenon may well be creating greater problems than it set out to resolve.

School health/birth control clinic proponents claim that school clinics facilitate close, daily clinic/student contact to ensure contraceptive compliance, thereby allegedly reducing the incidence of teen pregnancy. But they do not even address the question of how such contact is maintained during school breaks and vacations.

The premier school clinic in St. Paul, Minnesota, reports that contraceptive continuance among clinic student/clients was 87% after four years use -- rates matched nowhere else in world birth control literature, with the possible exception of the forced birth control program of Mainland China. Yet, the mean age of entrance into the program was 16.2 years, and tracking of students does not continue beyond age 18 or graduation.

Among the procedural flaws common to the reports reviewed is that school-based clinic proponents have purposely used teen live birth rates, rather than teen pregnancy rates as a yardstick, in order to inflate their "successes." An analysis of this substitution shows that reductions in teen birth rates have been achieved by an increase in teen abortion rates -- not a reduction in teen pregnancy rates. Since this is not the outcome school-based clinic proponents promised, school-based clinic studies routinely ignore or finesse the abortion rate.

Typical of studies that have claimed school-based clinics' successes is one that purported to show a reduction in teen pregnancy rates in a Baltimore school. Buried in the footnotes, however, is the fact that one-third of the females in the study could not be located for the final survey -- an omission that would include all the girls who dropped out of school due to pregnancy.

Claims of cost benefits -- primarily due to savings in welfare and medical benefits to young, unmarried women -- continue to be one of the major attractions of the school-based clinic concept. However, school-based clinic proponents universally ignore the downstream economic costs of widespread birth control usage among adolescents.

Studies have shown that there is a direct relationship between adolescent birth control usage and increased sexual activity. What that points out, ladies and gentlemen, is, this

type of a program does not work. If the young people are encouraged to engage in sex, there is a higher risk of them becoming pregnant. It is a very simple analysis there. There is well-documented direct relationship between premarital sexual activity and the incidence of venereal disease. The estimated current economic cost of just one of these diseases -- pelvic inflammatory disease -- is $2.5 billion, and that is expected to increase to $3.5 billion by 1990. Teens between the ages of 15 and 19 now account for over 15% of pelvic inflammatory disease cases.

Sexually inexperienced adolescents are routinely given birth control, including the pill. This happens all the time.

The initiation and continuation of sexual activity -- both frequency and number of contacts -- increases among adolescent birth control users.

The use of birth control enhances resorting to abortion.

Birth control proponents do support legal restraints as effective behavior modification techniques for teen seat belt use and smoking, but denounce parental consent for birth control users.

Teens are not adequately warned about the venereal disease consequences of their sexual behavior. Pill use is associated with higher rates of pelvic inflammatory disease, and cost the American people $192,000 alone in direct medical costs during the year 1984. This was the last figure I could dig up on that.

Birth control clinics and medical personnel are not a major source of information concerning pill side effects. Medical misinformation is routinely given to adolescents about the pill. The pill is prescribed even for young women who smoke. Family medical history for cancer is routinely ignored or incompletely ascertained. Pill use is promoted in violation of Food and Drug Administration guidelines.

ASSEMBLYMAN GARGIULO: Excuse me, Ms. Smith. Would you please sum up?

MS. SMITH: Okay. I'll sum it up by saying that the program doesn't work. I can put my statement aside, but there is one thing I did want to bring up that I think is very important. When we say costs-- These programs have proven not to be cost-effective. It is proven by Planned Parenthood literature itself. But, the greatest cost is the liability factor. Schools that dispense contraceptives to students may be held financially liable for venereal disease, sexually transmitted disease, or physical or emotional trauma from a botched abortion conducted without parental knowledge.

Schools may be held accountable for wrongful births, physical side effects of contraceptives, or even the death of a teen-age girl from the use of the pill, either by itself or in combination with other medications the girl is using, which the clinic operators have failed to discover. The insurance costs are going to skyrocket for these schools. I don't know how much study school boards have put into this, but I think they have put themselves into an impossible position, because all you need -- and you will find them -- is one outraged parent to go after his or her local school board, and that board is contingently liable for what happens to the child on the school premises under their control, whether the clinics are being operated by school personnel or non-school personnel. I think that is a major consideration the schools should take into account.

Also, as you brought up, we do have $42.4 million going as of Tuesday, to help young people and people who are in financial distress to carry their babies to healthy deliveries. I think it is a complete duplication of services, unnecessary, and a total usurpation of parental rights. Thank you.

I would like to ask Mr. Rosen to provide the members of the Assembly Education Committee-- I have a little packet prepared here, which I would ask that you please-- If you read nothing else, please read this one, "School-Based Sex Clinics: The Facts." It is a question and answer format, very quick; everything is in it. Thank you.

ASSEMBLYMAN GARGIULO: I will read it. Thank you, Ms. Smith.

Is Ernie Lettieri here?

UNIDENTIFIED SPEAKER FROM AUDIENCE: He had to leave.

ASSEMBLYMAN GARGIULO: He had to leave. Sherry Thompson?

S H E R R Y T H O M P S O N: My name is Sherry Thompson. I am from Millville. I am the mother of four children. I would like to thank you for the opportunity to come and address you today on this issue.

First, I would like to go on record as being against health clinics in any form in the public schools. I greatly fear it is just one more giant step toward socialized medicine. Also, these clinics may well lay the groundwork for providing sexually related health care services at a future date, even if they are prohibited now. I ask you to consider the wisdom of providing these clinics in any form in the schools.

At issue today is whether or not these proposed health clinics will provide health care services relating to birth control, pregnancy, and abortion. As a citizen who ascribes to Judeo-Christian principles, I must vociferously protest the use of my tax dollars to aid and abet children in fornication, which is exactly what these services would be promoting.

We would, in effect, be destroying our children with our own money. I pray that the elected officials of this State, in whom we have placed our trust, will not effectively sanction fornication among our children by permitting these services in our schools.

Why would the children go to these clinics instead of to their own family doctor, who would be familiar with, and therefore better able to treat the patient? One answer is, these clinics would facilitate children's sexual activity by providing easy access to contraceptives through an avenue which excludes parental consent or knowledge. This does not permit healthy relationships between parents and children. It is easy to see, however, where it would encourage deceit. Most parents do, indeed, provide their children with the information about sex they want them to have. If there are parents who want their children to use birth control, then it is up to those parents, and not the State and the taxpayers, to provide it. If parents have taught their children that premarital sex is wrong, is it the place of the State or the school to help the children to circumvent the wishes and teachings of their parents?

Teen pregnancy is a problem of great concern to us all. Several years ago, the experts claimed that mandated sex education in the schools would solve the problem. Our children are now being taught how to have sex, about deviate sexual practices and how to perform them, and why it is okay to make your own decisions about sexual activity before marriage and disregard the teachings of your parents and of your church.

Their solution has only exacerbated the problem. More kids are sexually active than ever before. VD is up and teen pregnancy is up, although statistics do not always accurately reflect that due to the skyrocketing abortion rate. Are we expected to again sacrifice our children to one of their solutions?

Please give the following careful consideration: What is the goal of these clinics? Is the goal to eliminate sexual activity among teens, or merely to use their sexuality more creatively, or to enjoy sex without getting caught? Logically, if sex educators and health clinic personnel were to

successfully inculcate a high standard of morality into their charges, they would simultaneously eliminate the need for their own services.

Conversely, the greater the teen-age promiscuity, the greater the alleged need for their services. In order to stay in business, is it not logical that they need to propitiate the need for their own services? We must understand that teen-age sexuality and sex ed is big business. It is safe to estimate that there are thousands of opportunists who are now directly or indirectly panning the teen-age sexuality gold mine. We have the sexperts, the family planning specialists, psychologists, counselors, sex ed teachers, teachers to teach and desensitize the sex ed teachers, and courses and services for sex ed teachers; writers, publishers, printers, and distributors of sex ed books, pamphlets, movies, etc.; makers and distributors of contraceptives the kids are encouraged to use; family planning clinics, abortion clinics, abortionists; the fashion industry, and it goes on and on. They have created a veritable empire, complete with unions and PR people. It is frightening to imagine just how far the tentacles of this insidious cancerous monster have spread, and to estimate the damages already done to the lives and souls of its victims, and what is yet to come?

The success of these clinics depends upon duping parents and taxpayers into accepting them as a necessary service and promoting and propitiating the need for their own services. In order to get the public to accept mandated sex ed in schools, its proponents waged a brilliant public relations campaign and convinced -- deceived might be a better word -- many that this was a good thing. Many of us were asleep, or just didn't realize the disastrous implications of this. The same arguments are now being used again with the school-based clinics. Have we learned anything? Sex ed, and its associated in-school health clinics, are a cruel hoax perpetrated on the

American public, whose consequences are the shattered hearts and lives of our children, deterioration of our families, and further erosion of the morals of our nation as a whole.

ASSEMBLYMAN GARGIULO: Ms. Thompson, would you please sum it up now?

MS. THOMPSON: Yes, I will. Our children expect their elders to uphold a standard of honor and decency. If we expect them to do wrong, and even help them to do wrong, we must share in their culpability when they commit the wrong. To approve A-3345 is to send a strong signal, not only to the youth of New Jersey, but to all New Jeseyans, that you expect and endorse moral behavior among young people. To approve this bill would be to prevent the usurpation of the God-given and constitutionally upheld authority of parents to raise their children in the way they should go, without undue interference from the State.

School health clinics ostensibly held students to avoid the immediate consequences of their sin, while simultaneously providing them with the resources to continue in their sin. Teen pregnancy is not an educational problem. It is a moral problem. Since our school system has repeatedly stated they cannot teach morals, it is obvious that we should look elsewhere for the solution to this problem.

Thank you for listening. I trust the course of action you choose will be the honorable one.

ASSEMBLYMAN GARGIULO: Thank you very much. Cindi Berry?

C I N D I B E R R Y: Good afternoon. My name is Cindi Berry. I am from Deerfield Township, Cumberland County. Thank you for giving me the opportunity to speak. I regret that Assemblyman Naples left, because I feel I have a fresh angle about all of this.

I am a child birth educator with the Child Birth Education Association. For the past seven years, I have taught

prenatal classes at Bridgeton Hospital, which boasts one of the highest teen-age birth rates nationwide. I have also taught prenatal classes at a local public high school. I have seen firsthand the tragedy of teen-age pregnancy and its devastating effect on the young couples involved, their families, and the community. No one wants to stop this problem more than I do, but school-based health clinics are not the answer.

Free and easy access to contraceptives does not guarantee that the students will use them properly. I have worked with pregnant girls ranging in age from 12 to 18 years old. One thing I have learned is how terribly irresponsible they are. Giving out a contraceptive, even after carefully explaining how to use it, does not guarantee that the teen-ager will follow through on the information received.

It seems ironic to me that here in the State of New Jersey we require that a young person must be at least 17 years old before receiving a driver's license. We have a good reason for such a law. The teen-ager needs to be mature enough to consistently obey traffic laws. Yet, we are considering giving our young people a license to experiment with sex through the encouragement of school-based health clinics. Would we allow a 13- or 15-year-old to test drive our car after explaining how to drive? Of course not. Can we really expect a 13- or 15-year-old to consistently follow and practice birth control methods? No.

Girls forget to take the pill each and every day. Boys do not use condoms correctly. Birth control methods are designed for adults, yet we are unfairly expecting children to behave like responsible adults.

I also feel it is extremely unfair to lead these students into the false assumption that if contraceptives are used, there will not be a pregnancy. My husband and I have three children, two of whom were conceived despite carefully following birth control measures. We cannot promise that there absolutely will be no pregnancy if contraceptives are used.

I can give you several examples of married couples in my child birth classes who were faithfully practicing various birth control methods, and still ended up conceiving a child. What do we tell the 14-year-old girl who was given pills through our school clinic and conceived anyway? "I'm sorry, but you are included in that fraction of people for whom the pill is not effective." Now we can offer her the stress of abortion counseling and cause her more emotional and physical damage. Perhaps she doesn't get pregnant, but ends up with VD. I fear these health clinics will only spawn scores of emotionally and physically crippled young women.

The places where the students are conceiving do not lend themselves to effective birth control. The sexual act for the adolescent is often a spur of the moment occurrence. Popular places include the back of a van, an empty house, outside a building where a dance is going on. I know one girl who conceived under the school steps. Do you really think that either of them thought about birth control at the time? Do you really think that even if the boy had a condom in his pocket that he would have taken the time to use it? There is a passion for the moment mind-set with many of our young people. They just don't think about the consequences. The knowledge of birth control is there and, in many cases, the means for birth control is also there. I feel that our State mandate requiring sex ed has contributed to the problem. All we have reaped from the sex ed effort is a heightening of interest in sex that is already there, thanks to overactive adolescent hormones. Just check the statistics on pregnancy before and after the sex ed classes were instituted statewide.

Whatever happened to encouraging abstinence? That would be teaching morals, someone might say. Well, we teach them not to steal, don't we? We tell them not to stab each other. Why can't we tell them not to engage in sex? Our schools are making premarital sex socially acceptable, when in

reality such a stance is reaping devastating effects on the children. As AIDS so graphically illustrates, free sex can kill.

I am angry; I am angry that we have short-changed our kids. Lives have been ruined because we have not had the backbone to tell the kids to abstain. School-based health clinics are not the answer. They will only open a Pandora's box to greater problems than we already have. Therefore, I urge you to approve Assembly Bill 3345.

Thank you.

ASSEMBLYMAN GARGIULO: Thank you. Cynthia Scott, Hudson Health Services?

L I B B Y H U T C H I N S O N: Let me first thank you for the opportunity to speak to you, and secondly say I am not Cynthia Scott. I am Libby Hutchinson from Hudson Health Services. I am going to be very brief. It is hard to imagine that more could be said to the point, so I will definitely stay within my five-minute limit.

I have three points to make. The first is, of course, we would all prefer to have our teen-agers deal with their parents about subjects that are family issues. Secondly, that does not happen. This community in which we live has a higher rate of immigrants and refugees than most other places in the United States. We have over 32 different ethnic populations represented in Jersey City. I cannot speak to the issue of your bill in the entire State, but I would like to speak to it locally.

We are an inner-city, urban area, with a high population of non-English-speaking, unemployed, and poverty-stricken minorities. To think that health care is readily available and accessible to a high risk group -- teen-agers -- is simply not the case. School-based clinics for our local community need to incorporate a comprehensive set of services, and not exclude any.

I would like to call your attention to a questionnaire taken of New Jersey citizens on behalf of the Family Planning Association of New Jersey in October, 1986, which found that-- In response to the question, "Do you have any moral or religious objections to the use of contraceptives by teen-agers?" the answer among New Jersey citizens was-- Seventy-nine percent believed that teen-agers should be allowed the free use of contraceptives. In response to the question, "Which is a more effective way to reduce the problems of teen pregnancy, to widen the availability of sex education and contraceptives, or to restrict the availability of sex education and contraceptives?" 85% said that widening the availability of sex education and contraceptives was preferable.

So, on behalf of many of the parents of New Jersey, and many of the residents of New Jersey, I think that while your bill is certainly well-intentioned, it does not apply locally here to the needs of Jersey City, and it certainly does not represent the opinions of the majority of the residents of New Jersey.

Thank you.

ASSEMBLYMAN GARGIULO: Thank you. Patricia Daly, Catholics United for Life?

P A T R I C I A D A L Y: Thank you very much for allowing me to come. For the record, my name is Patricia Daly. I am a Christian and, by divine providence, a citizen of the United States protected by the Constitution of this free land, whose founding document acknowledges a divine creator.

In fulfillment of my duties toward this nation and its people, I am a pro-life activist, a side-role counselor, a member of Catholics United for Life, the Vice President of Monmouth County Right to Life, and County Coordinator for the New Jersey Coalition of Concerned Parents. This tells you where my heart, mind, and action is. So, for me to say anything at all is to be redundant. And, if I must be redundant, it will be to emphasize these two truths.

One, the contraceptive mind is the precursor of violence and abortion. Two, there is inherent falseness in the teaching of sex outside the framework of the existence of sin, which truth negates the integrity of health clinics and invalidates the reason for their being at all; that is, the reason for their existence.

In conclusion, my own personal finding is that the sex ethic of health clinics is the pornography bible of our youth. Worse even than drugs, are young Americans are being hooked on lust and violence in our own schools.

Thank you very much.

ASSEMBLYMAN GARGIULO: Thank you. Dr. Paul Morrissey, Director, National Coalition to Prevent the Spread of AIDS? Hello, Doctor.

P A U L M O R R I S S E Y: Good afternoon, gentlemen. I am in favor of the bill. I am not a doctor; I don't know who put me down as a doctor. I would like to make the point that I am not a doctor, because I feel that one of the problems we have here is that we have, for far too long in American society, listened to the so-called experts, particularly in the medical profession, particularly in relationship to sexually transmitted diseases, prevention of pregnancy, encouragement of pregnancy, and so on.

I am, of course, referring to diseases such as DES, which was promoted-- It was not a disease actually. It was a pill, a formula to prevent miscarriage. What it did, in actual fact, was, of course-- The net result of this was vaginal cancer to the females who were conceived during the application of DES. We listened to the experts, and the experts got us into trouble.

When women wanted to become pregnant 20 years ago, they took thalidomide and, once again, the experts got us into trouble. When Noah built the ark, he was an amateur wood-carver, and the ark floated very well. The experts gave

us the Titanic, and said it could never sink. The experts in this scenario are Planned Parenthood. Planned Parenthood, as many of the speakers here have already stated, has given us abortion on demand. They have promoted the pill, the pill which increases the chances of cervical cancer by an unbelievable rate, particularly in teen-agers. We are talking here adolescent teen-agers, giving the pill to adolescent teen-agers. We are talking about giving IUDs. Well, fortunately, IUDs, except, I believe, for one, have been outlawed in the United States, but it was Planned Parenthood -- the experts -- who, in 1930, introduced American to the IUD. How many women have died from applications of IUDs? Thousands, tens of thousands of women, and invariably they have not been documented. Babies have been born with IUDs inside of them, proving very clearly that they simply do not work.

We are deceiving our youth if we are telling them that contraception works. We know, from statistics all over the world-- Great Britain has had sex clinics and sex education for the last 20 years. In Scandinavia, sex education has been around for the last 30 years. Conception is up, abortion is up, so births are down. So what? What's the difference? All we are doing is annihilating the next generation here.

What I say is this: Apply common sense to the problem here. We have listened to experts on this subject long enough. Let us listen to the man in the street, the person who can apply simple common sense to the problem, and say, once and for all, if you want to solve the drug problem, the answer is, don't take drugs. If you want to solve the smoking problem, the answer is no to cigarettes. No to alcohol. We keep on saying no, no, no, but when it comes to sex, oh, wait a minute, you can't say no to sex. People have to have sex.

Let's give the message to our youth here that the word, indeed, is no, before marriage. And, now, for a very strong reason, the incurable, deadly disease -- AIDS. We have

now reached a plateau here, where we can no longer really joke about sex any more. We have the horror story of AIDS. You could have one sexual relationship, pick up AIDS, and die a horrible deadly death in the next five years. We have to look at this problem extremely seriously. This has to be a national program, probably directed from the White House, actually. Certainly not in our schools, where it's almost a casual, "Well, look, if you don't feel like it, don't have it. But, listen, we know you are going to have sex. Hey, we know you are going to have it."

Nonsense, you know they are going to have it. I have an 18-year-old daughter. She hasn't gone out on her first date yet.

ASSEMBLYMAN GARGIULO: Your time is just about up.

MR. MORRISSEY: Okay. Well, on that-- The last point I would like to make, actually, just in closing here -- and someone did touch on it -- is the financial standpoint. The Robbins Corporation has just gone Chapter 11 because they tried pushing IUDs, and every man and his God sued them to the ninths. The same thing has to happen to the school system. You don't think people will sit around and say, "Hey, wait a minute, you never told my daughter about the complications of the pill. I am suing you"? You know, "I didn't even know about it," and bong!

So, the bottom line is, if you want to, you know, be in real financial trouble, just embrace the sex clinic program, and, phew, I'll give you maybe three years and you will be financially down the hole.

Thank you.

ASSEMBLYMAN GARGIULO: Thank you. George Jeffrey, Decency and Virtue in Democracy Society?

G E O R G E J E F F R E Y: Thank you, gentlemen. I am going to be brief because I am sure you want to get home to your children and your families.

Before I start my very brief presentation, I want to confirm what the young man before me has said. In fact, there are suits now going on in the Midwest United States, where societies have brought civil suits against school boards for just this type of a program. If you want, you may contact me later and I will give you the details.

My name is George Jeffrey. I am a resident of Middletown, New Jersey. I have been there for 15 years. I am a refugee from a major city -- Brooklyn, New York. I am married, and I have two teen-age children here in New Jersey. One of them goes to a public high school, and the other one goes to a parochial high school. I am a member of the Middletown Task Force on Drug Abuse, and President -- I hope you don't mind -- of the local Republican Club. However, I have come here today as a parent, and as Chairman of the DAVID Society, which is a group of 300 citizens, laity, clerics, and pastors actively involved in promoting Decency and Virtue in Democracy.

The DAVID Society and I strongly support Assembly Bill 3345, and we want to give you our reasons for doing so.

Before I tell you our reasons, I would like to give you some background on our organization and our programs, and some research in the area with which the bill deals. Our campaigns deal with promoting positive recreational activities for youth -- for example, the Monmouth Teen Center in Monmouth, New Jersey -- and their families, and funds and clothing drives for those organizations which work with the abused and castaway children of our society. The Covenant House is an example. Additionally, we are heavily involved in fighting the negative forces of our soceity, the teen-age sexual abuse, pornography, suicide, and drug abuse, which we all find is very much interrelated.

In researching factors which adversely affect the sexual habits of our children, we ran across a survey done by a

Dr. Victor Strasberger, Director of Adolescent Medicine, Bridgeport Hospital, Bridgeport, Connecticut, and a member of the Task Force on Children and Television of the American Academy of Pediatrics. He did a survey on TV influence and, among other things, children's sexual behavior. According to this survey, by the time the average American child graduates from high school, he or she will have spent about 15,000 hours watching TV, as compared to only 11,000 hours of education in high school or grammar school.

Dr. Strasberger also concluded that these depictions of sex, especially sex in casual relationships, have increased dramatically in the TV medium, and that the number of sexual references jumped sevenfold between 1975 and 1979. In our opinion, the conclusion is that TV is changing the moral behavior of our children by a constant barrage of improper instruction regarding sexual behavior.

We have also studied the effects of the advertising -- an estimated $90 billion industry today -- on our children's sexual attitudes and subsequent behavior. We have found that the advertising industry, over the last 20 to 30 years, has -- consciously and unconsciously -- promoted sexual promiscuity to our children and our adults by their constant drive to sell clothes, food, drinks, alcohol, and cigarettes. This, too, in our opinion, is changing the moral attitudes of our children.

And then there are the effects of pornography. The pornography industry is another multi-billion-dollar industry bent on the moral destruction of our children and our adults when and wherever possible -- through the United States mails, the X-rated home video, the X-rated movie house, the pornographic magazines, the pornographic telephone service hyped by several radio announcers, pornographic computer services, and pornographic literature on the T-shirts of our young and on the walls of public bathrooms. There seems to be no safe haven for our children, other than our homes and our schools.

With all these messages from our society promoting sexual promiscuity, someone in authority has to have the guts to now say no to having schools used as sex clinics dispensing contraceptives and prescriptions for killing off our posterity. And, this is what this bill will do.

Before I close, I would like to refer to an article written by Ray Kerrison. I will leave copies of this article with you, and I ask that you look it over. Ray Kerrison writes for The New York Post, and he wrote an article on the sex education system in New York City. As you may already know, the New York City Board of Education has tried engaging in dispensing contraceptives and prescriptions for abortion, which some felt was the correct thing to do. It was this type of philosophy that made New York City one of the major sex capitals of the world, and one of the leaders in the number of AIDS cases in the nation.

If I may just have a few more minutes, I would like to quote from one of these books on sex education. The book was called, "Learning About Sex: The Contemporary Guide for Young Adults." The book tells the reader: "There is no specific medical dangers associated with oral or anal sexual contact." Ray Kerrison says: "This, of course, violently contradicts the truth about AIDS."

Let me go on a little bit further. The book says: "A few research studies have indicated that a fair percentage of people probably have some sort of sexual contact with animals during their lifetime, particularly boys who live on farms. There are no indications that such animal contacts are harmful, except for the obvious danger of poor hygiene, injury by the animal or to the animal, or guilt on the part of the human being."

ASSEMBLYMAN GARGIULO: Mr. Jeffrey, I am going to ask you to please sum up.

MR. JEFFREY: Yes, I will sum up. Gentlemen, I ask you-- We have been talking in very general attitudes about this issue. I ask you to get much more specific into what sex education really means. We want to start delivering a different message to our children. In the organization to which I belong, we deal strictly with the sending of messages. As far as the law is concerned, it sends a message. So, if you intend to send a message to the youth of this great State by saying no to sexual promiscuity, the DAVID Society fully supports you.

I thank you for your time and effort in listening to me.

ASSEMBLYMAN GARGIULO: Thank you very much. Carol Breen, St. Gerard Guild?

C A R O L B R E E N: My name is Carol Breen. I come from Highlands, New Jersey. I am a blue-collar worker, and I live in a low-income town. I am a member of the St. Gerard Guild, a Guild which believes in strong family values and also in helping the poor and needy in various instances. We do various charity works.

I am here speaking for the Guild and for myself. I am for Assembly Bill 3345, which would prohibit the school-based health clinics from the various -- rather than name everything, because we have mentioned them already today.

I would like to take a look inside the school at how a teen-ager may view the implementation of such a clinic. The above-mentioned services are already in the community; they are available to young people. These services are well-advertised in many forms, such as newspapers and phone books, so it would only be a duplication of tax money to have these facilities within the schools.

Providing these services to students in schools would only rob the individual student of valuable education time. After all, they are in school to learn. I know with the

education I had -- 12 years of school and two years of college -- I certainly wished I could have gone back and learned a little more. I am certainly glad I wasn't distracted by the presence of school-based sex clinics at the time.

Now, peer pressure among the students would develop. They would want to find out about the health clinic services. For many students, it would be an excuse to congregate with other students at the nurse's office, causing groups of students to miss out, again, on more valuable education time. The presence of these health services in school clinics would only encourage a permissive environment for students who, in turn, would act irresponsibly, knowing that these services were available for them at the school. The services would become a backup for the students' permissive behavior. The presence of these services in our schools would have a homogenizing effect on students, drawing those students who would normally act responsibly into using the services just through peer pressure alone. The students who would normally say no to sexual involvement, would involve themselves with the clinic services just to be part of a group. I think that is something you must understand here. Look in and see. Remember when you were in school how you were drawn into various things because you were part of a group.

Also, who is going to pay for these expanded health services when the grants run out? Of course, the taxpayers are going to pay.

In conclusion, I ask you, where is the responsible parenthood that would make these clinics unnecessary? The line must be drawn. The stand must be taken. It is not up to the State, through the schools, to provide a dismal solution, at best, for the increasing promiscuity of our young people. It rests with the parents and other responsible adults standing up and being counted on to give their children vigilant, moral training which would render even the thought of these services in school clinics obsolete.

I ask your support of Assembly Bill 3345.

ASSEMBLYMAN GARGIULO: Thank you, Carol. Peggy Switch, Concerned Women for America?

P E G G Y S W I T C H: I am Peggy Switch, a new member of the Concerned Women for America group, I am very proud to say. I want to start out by saying that sex clinics are not the answer to the teen-age problem in our State, or any state, since according to the Lead Olson (phonetic spelling) report, which was a two-year, exhaustive study of teen pregnancy in the United States-- Their findings were that the opening of clinics in various cities and states throughout the nation has only resulted in a much higher rate of pregnancy and abortion, and, of course, the abortion rate escalated three times as much. These clinics will only compound the mess we are already in by increasing not only abortion and pregnancy, but also sexually transmitted diseases, depression, suicide, etc.

Our problem is the result of the sexual liberation taught in sex education courses in the public schools, which promote promiscuity, and which are an abomination. Until there is a reevaluation and a reformation of sex educational courses taught, with emphasis on abstinence until marriage, self-control, and self-respect, and also respect for sex-- Only then will the teen-agers have the true sexual freedom that they deserve.

New Jersey already has the highest percentage in the nation of the deadly AIDS disease among young women in the age bracket between 25 and 30, who caught the AIDS virus in their teens. This was in The Daily Record a few weeks ago. The American Medical Society has stated that three out of ten promiscuous persons who engage in sex will get AIDS, even though they use condoms faithfully.

Secretary of Education Bennett was on the "Cross Fire" show on Saturday on cable. He places great emphasis on abstinence. He said, "You have to give children good reasons

for avoiding sexual promiscuity, as it is a very important part of sexual education. It is a parental concern and their responsibility, but when parents send their children to school, they expect them to also be taught about morality, about right and wrong, and that is a belief as old as the nation itself. If you institute a course in sex education about AIDS, you better emphasize morality and restraint, as that is the only prudent, safe, and responsible course."

Well, I was just thinking sitting there, if you were going down a road and you had to cross a bridge, and you were told, "If you go over that bridge, three out of ten people will be killed," I think you would turn around and wouldn't go over that bridge. You would be pretty crazy to go over that bridge. Well, young people are looking for guidance of this sort.

A group of young women in a pregnancy center in a hospital in Atlanta were interviewed, and nine out of ten said, "No one ever talked to us about restraint. All they ever said was, 'Well, we know how you girls behave, so try to be careful.'" Well, what happened was, the advice was not effective, and no one gave them good reasons for restraint, such as to defer their sex, not to deny their sexuality, but to master it and control it. You know, no one ever died from not having sex.

AIDS is a killer disease. It is as bad, or worse, than rabies. Surgeon General Koop should have a warning on packages of condoms -- "Condoms are dangerous to your health. Three out of ten will get AIDS and die."

I think it is very sad that we have to sit here and beg the legislators -- the Assemblymen -- for our rights -- our God-given rights. We have no say. It is still a free country -- it is supposed to be -- but it's very sad.

Thank you.

ASSEMBLYMAN GARGIULO: Thank you very much.

MS. SWITCH: Oh, there are a lot of new-- Like, this is a book, "Sex Respect: The Option of True Sexual Freedom." They have this guide for parents; there is one for children, and one for teachers. There are about 10 hours of study in these books. There are a lot of other new programs coming out like this which should be looked into.

Thank you.

ASSEMBLYMAN GARGIULO: Thank you. Judy Armento (phonetic spelling)?

J U D Y A R M E N T O: For the record, my name is Judy Armento. I live in Teaneck, New Jersey. I was born and raised in this State. I am a product not only of the public school system through twelfth grade, but I also attended Montclair State College here in New Jersey, where I received a degree in Home Economics, with a concentration in Family Living and Child Growth and Development. As a part of the courses which I took in my teacher training-- I almost hang my head in shame, and I wish Mr. Naples were here to hear this -- Assemblyman Naples -- to say that I am a teacher, because I feel that teachers have abrogated the responsibility they have to the children, not only of this State, but of the entire nation, in the way in which we are not educating our young people today.

I want to commend the gentlemen and the lady on this Committee for having the inner fortitude to come forward and support the amendment that you are putting forth, that has been discussed here today. There are many things I could say to you, but I would like to share a few personal things. Most of the statistics have been presented. I pray to God Almighty, which I do every day -- not as faithfully as I should, and I am ashamed to admit that -- that what you have heard will have an impact on you people about what these clinics truly are.

I speak this to you as a former member of a Board of Planned Parenthood. I sat on the inside, and I know what goes on. The name of the game with Planned Parenthood is protect

your job, create new jobs, and get as much funding as you can from the Federal government to support the agenda, which is the taking over of the human family from the aegis of the parents, and making it the concern of the State. It does not belong with the State. God Almighty ordained the institution of marriage to bring forth children -- to procreate on this earth. We take a gift of God, the gift we have of human sexuality, and we blantantly display it in the meanest places. We have pornography throughout every pore of the fiber of this society. We allow it on radio, on television, on our telephones.

I pray for the people of the State Legislature; I pray for the judges; I pray for the President. I am not the only one. I am a member of Concerned Women for America, and I am an alien on a strange planet. I don't like where this country has gone. It happened in the early 1920s, when we allowed Dewey and other "educators" to come in and begin to corrupt the fiber of the education in this nation, which was founded by men of God, in the name of God Almighty, to educate people to be able to read God's holy word, and stand for righteousness.

There is a Scripture I live by: "Righteousness exalts a nation, and sin is a reproach to any people." We play with words. We take words, and we say, "Oh, the new morality." The new morality is nothing more than the old immorality, which is a three-letter word -- sin. We have to call it what it is. I don't care if it is on the steps of a school, where a teen-ager unfortunately conceives a baby she never wanted to have, or if it is someone who is indulging in acts of sodomy, which are still against the law -- thank the good Lord -- in 27 states in this country. I am ashamed to say that New Jersey rescinded it in the '60s with the all new morality. We should bring it back, gentlemen. If you want a charge and a challenge, put forth a bill on sodomy to protect the citizens of the State of New Jersey from the plague of AIDS, because it is a plague, and

we are going to be faced more and more and more with the consequences of immorality and of sin.

A black lady sat here today and said, "I cross my fingers," and I said, "No, you've got to cross your legs." Unfortunately, I have to be gross enough to say something like that publicly. When I received my training to teach sex education in the public schools of this State, the training was, "Anything from soup to nuts, from A to Z. If it feels good, kids, do it." That is the message we are giving to our teen-agers when instituting sex education, and it is education clinics. The program which was referred to here today -- Family Life Curriculum, which is the predominant program that is being put forth throughout our nation by Planned Parenthood, the Alan Guttmacher Institute, and the people who followed Mary Calderone's teachings and Margaret Sanger's teachings -- okay? -- is teaching children in kindergarten. I didn't bring chapter and verse, but I will send it to your Committee. But, from kindergarten to twelfth grade, homosexual practices, teaching our children how to masturbate. The word "family" -- and that is the title of the curriculum -- is not mentioned once in all the pages of that curriculum, from kindergarten through twelfth grade -- 13 years of teaching. Shame on this State; shame on the teachers; shame on the educators; shame on Mr. Naples; shame on me.

We had a gentleman who came here and quoted the Scripture, and I cannot go over it surface-wise: "If my people," God's people, "who are called by my name, will humble themselves--" Humble themselves -- not somebody else doing it for you. You go before Almighty God. I thank the Lord that this hearing was on this day -- the National Day of Prayer for this country, to thank Almighty God for the blessings he has given to this nation. We are living on our laurels. We are living on the prayers that the founding fathers of this country, the men who sat and signed the Declaration of

Independence and pledged their lives, their fortunes, and their sacred honor-- Sacred honor? Today, we have Marines who go to Russia and screw around -- there is no other way of putting it; pardon me for putting it in the vernacular -- with KGB agents, and subvert the security of this nation. What are we doing to our children?

We have to humble ourselves. We must get on our knees and pray to Almighty God to forgive us for the sins we are perpetrating. We're spending tax dollars, and that money is money that comes from God. I said to my husband, "I don't want to pay my taxes any more, because of the things the money is going for. I would rather go to jail."

We have to humble ourselves and pray, and seek God's face and turn from our wicked ways, because then -- and this is what the word of God says -- then will I hear from heaven: "Forgive their sin, and heal their land." And, this land needs a healing. It needs it from the inside out; from the core of our being; from the clergymen right down to the individual citizen in the street. The answer does not lie in new programs and new clinics that are replecations and duplications of what we already have. It lies in every human being confessing before God the wrongs they have done, the rotten lives we are living, the sins that we commit day by day, and in saying, "God forgive me, and let me do what I can to help to bring America back to the point where she was founded, where people can know such things as the value of human life."

We throw away our babies. We are all getting older. There is no more base to help to support the Social Security system from what we are doing with our children. This, I know. There are just so many factors involved, but know this-- I have been very emotional. I didn't plan on this. This comes from my heart and the spirit of God that is within me. Bless God. I said I would be used by Him as a vessel, and I pray I have. I was the last person, and I think it was the

will of the Lord. I exhort you, but not just to go and speak before the New Jersey Assembly and encourage the Senators to speak before the Senate that this bill will be passed. The whole concept -- the whole premise -- of the health clinics is destruction of the family. It is giving over more control to the State. When a parent signs that innocuous permission that the kid can have a physical to play football, or can see the school dentist because the family is impoverished, most parents don't realize, and are not told-- They don't even have time to read things because of where society is at today, which is unfortunate. But, they sign over that right to know.

I have raised five children. My youngest is 16, and I pray to God she makes it to the point that the older ones have. But, our children are the resource for the future of this country and the world. America has been the hope of the world, and I charge every one of you, when you go into that Assembly, to encourage everyone to vote in support of this bill, to vote against having those health clinics, because of the evil it is. One of the underlying goals of the whole feminist movement-- I was a feminist -- okay? I used to be a feminist, too. I confess that before you.

ASSEMBLYMAN GARGIULO: We have to cut it short, please.

MS. ARMENTO: I just want to make this point: The three areas that they seek to change are the family, the school, and the church. If they can change those three institutions, they will succeed in destroying this country, because it is those three institutions that have accultured our young people to have the values and the moral standards that we have espoused as a nation, and that we are losing.

I thank you for listening. I'm sorry it was so impassioned, but it was from the heart, after listening all day long. God bless you and be with you in the decisions you make. I thank you. (applause)

ASSEMBLYMAN GARGIULO: Thank you, Ms. Armento.

Thank you all for coming, and I want to thank the staff for hanging around.

(HEARING CONCLUDED)

APPENDIX

New Jersey
School Boards Association
Headquarters: 413 West State Street, P.O. Box 909, Trenton, New Jersey 08605
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POSITION STATEMENT

A-3345/S-2451 (Gargiulo/Pallone)

PROHIBITION OF SCHOOL-BASED HEALTH SERVICES

NJSBA opposes S-2451/A-3345, bills which would prohibit local school boards of education from providing certain services to students in school-based health clinics or similar facilities.

NJSBA believes that local school boards should have the option of establishing school-based health clinics with services related to the needs of the students within their community. In addition, these options are best left to the local community's representatives--the people who are both responsible for the students in the district and accountable to their parents and to the other voters and taxpayers of the community.

A school-based health clinic is a primary health care clinic located in or adjacent to either a junior or senior high school. Such clinics are staffed by professionals such as nurses, physicians, nutritionists and social workers. Generally the clinics provide comprehensive multi-health services such as physical examinations, first aid, diagnostic and laboratory screening, weight reduction, immunization, nutrition advice, drug abuse counseling, family planning and other social services such as child abuse prevention and employment preparation.

School-based health clinics are successful, particularly in districts with a large population of "high-risk" students. "High-risk" youths are persons under 21 years of age who are at risk of becoming, or are drug abusers; are victims of physical, sexual or psychological abuse; have dropped out of school; have become pregnant or are economically disadvantaged; have committed a violent or delinquent act; have experienced mental health problems, attempted suicide or are disabled by injury.

New Jersey has many school districts whose major student population is considered "at risk." Of New Jersey's 1,100,000 youth between the ages of 10 and 19, almost 14 percent are living in poverty. The unemployment rate for youth between 16 and 19 is 13.5 percent as compared with a January 1987 adult

-over-

unemployment rate in New Jersey of 4.3 percent. Over 57 percent of high school students have used marijuana, 18 percent have used cocaine and two-thirds of that population abuse alcohol. A report from the New Jersey Office of Adolescent Services predicts that 30,000 New Jersey adolescents between the ages of 10 and 19 will need prenatal care; over 300 will need medical care for syphilis, gonorrhea and AIDS. Typically, teenagers living in poverty have disproportionately high rates of illness. They are not likely to have access to physicians or live in families that have health insurance.

NJSBA believes that local boards of education should cooperate with other social service agencies to develop day care programs, prenatal care and counseling for teenage mothers; provide sites for drug and alcohol prevention programs; family counseling; delinquency prevention; and employment preparation. School-based health clinics can provide the sites for such services and

1. Easy access to medical and health care needs, counseling and information to adolescents who do not have transportation to receive these needed services elsewhere.

2. An environment that encourages improved attendance in schools and decreased rates for student dropouts.

3. Working relationships among the professional health staff and the school nurses, guidance counselors and teachers.

4. A link between health education, family life education and clinic services.

5. The same standards that govern other medical facilities.

Although clinic personnel stress the importance of maintaining confidentiality, school-based health clinics generally require parental consent before they will provide medical services to teenagers. Some clinics require the parent to visit the clinics as part of the student's registration procedure and with permission from the student, will speak to them about their child's problems.

School-based health clinics are places that students will go and where they will accept as useful and relevant services tailored to their needs. If these clinics are prevented from providing the information and counseling that students need most, there usefulness will be forfeited and our children and society will be the poorer--personally, socially, economically and politically.

NJSBA URGES YOU TO <u>OPPOSE</u> S-2451/A-3345.

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and/or psychological problem.

a. by identifying this group of students early

b. by providing appropriate counselling and referral services

c. by running special groups, e.g support groups for teen-agers who have family members with AIDS, alcoholic parents, or are victims of child abuse

Evaluation: Monitor numbers of students identified, types of treatment and referral, and intensity of effort in providing services.

IV. Services and Activities

The Snyder school-based health center will be able to offer a full-range of comprehensive health services, health education, nutrition counselling, psychological support services and mental health treatment programs, drug and alcohol abuse prevention and treatment programs, and family planning programs.

The majority of these services will be offered onsite while some will be offered through referral. The school-based health services will operate as a "satellite" of the Jersey City Family Health Center. While relating primarily to JCFHC for back-up, after-hours and vacation coverage, and most specialty services, the school-based clinic will have a special relationship with two other services in Jersey City: Health Services of Hudson County and Christ Hospital's Community Mental Health Center.

The school-based clinic will be staffed by employees of the JCFHC (see below for staffing), and will have, in addition, the services of a half-time drug and substance-abuse counsellor employed by the board of Ed and a family-planning counsellor from Health Services of Hudson County for two sessions weekly. The entire staff of the school-based clinic will relate closely with several resources already present in the schools: the school nurses (who will functionally become part of the team), the family-life education teachers (staff of the clinic will be used to supplement and augment the already existing curriculum), and the child-study team (whose primary function is to evaluate learning disorders but whose psychologist and social worker are presently

utilized for emergencies).

A. Informed Consent

Before receiving any services through the school based clinic, a student will have to have on file an informed consent signed by a parent or guardian. This consent form will delineate all services offered through the clinic and allow parent(s) or guardian to sign for all services or opt to withhold consent for any particular service.

All parents will be invited to an open discussion of the schoolbased clinic before being asked to sign the consent. Parents will also be offered the opportunity for individual appointments with clinic personnel at the time they are asked for consent.

Any student requesting services whose parent has not signed a consent will be told of several possible alternative sites for receiving health care. These students will be encouraged to discuss with their families their desire for health services.

In some selected cases (rape, child abuse, sexual abuse) the clinic will help the student make the actual appointment with an appropriate referral agency in the absence of informed consent from the parent or guardian.

B. Hours of Services

The clinic will operate during normal school hours and for an hour and one-half after classes are over every school day except Friday. Students will be able to "drop-in" on the clinic during their study periods and lunch hours or after-school. Appointments could be made with health professionals as necessary during regular class time as well as during students' free time. Staff will have designated time for conferencing, record keeping, continuing medical education, etc.

C. Medical Services

A full-time nurse practitioner (NP) will be the the primary medical practitioner at the school. She will be responsible for the primary medical

care of the students and treat common simple illnesses and minor injuries. The N.P. will be responsible for referral and follow-up for serious illnesses and emergencies. In coordination with the school nurses, she will conduct the annual health screening and assessment of all enrolled students as well as the required sports physicals for students who desire this service from the school-based clinic.

A pediatrician with experience and sensitivity in the treatment of adolescents will be at the school-based health clinic two half-days weekly (0.2 F.T.E.). During these sessions the physician will follow-up on those adolescents for whom the N.P. has concerns as well as those with chronic illnesses and conditions which need physician in-put. This pediatrician will also serve as telephone back-up for the nurse practitioner when not on-site.

The clinic will have the ability to perform simple laboratory tests including obtaining cultures, urine and blood specimens, and performing microscopics onsite. Once specimens are collected, they will be transported to JCMC laboratories.

When a student requires further diagnostic testing, radiology or specialty consult services, he/she will be referred to the Jersey City Family Health Center. Similarly, in the case of an emergency, the student will be transported to the Emergency Room at the Jersey City Medical Center. Since the school-based clinic will be a satellite of the JCFHC and therefore a component of the JCMC, coordination between the JCFHC, the JCMC, and the school-based clinic will be constantly maintained.

D. Dental Services

Dental services will be provided by a full-time dental hygienist working at the school and a half-time dentist at the JCMC dental clinic whose time will be designated to student referrals .

The hygienist, working with the school nurses and the health education faculty, will provide education in the classrooms on dental health, nutrition,

and prophylaxis. Most importantly, she will help to allay students' fears of dental treatment through explanation of procedures, high speed drills, local anesthetics, etc. After this orientation session on dental health, an appointment will be made for a class to have dental screening.

During this screening, students will be examined for obvious caries and gum disease. Each student will immediately be given a letter to take home to the parent explaining findings. Because so many students are expected to require dental care, a form of triage will be staged in respect to who is offered treatment through the school-based clinic.

Students with no immediately obvious disease will be referred to their own dentist or to a dental clinic at JCMC in six months for routine care. Students with dental caries or gum disease will be divided into two groups: those needing urgent care (care should be rendered within one month) and emergent care (care should be rendered as soon as possible). Letters home will inform of the screening's findings and offer care at JCMC on a priority basis. Parents or guardians will be asked to sign a consent form for the specific dental treatment needed. Referrals to other dental providers in the area will be made if the parent or student desires.

The emphasis throughout screening and treatment will be to minimize students' fears of dentistry and to encourage students to engage in prophylactic care. By involving parents throughout, hopefully the message about need for prophylactic care as well as regular treatment will be reinforced.

E. Pregnancy Services

An adolescent who suspects she is pregnant can obtain pregnancy testing directly on site. If she desires to continue the pregnancy she will be offered the choice of obtaining her prenatal care at Snyder High School or of utilizing the prenatal program at the JCFHC or at Health Services of Hudson County (women using this service are followed by Obstetricians affiliated with JCMC and are delivered at JCMC).

The on-site prenatal care will be provided by the N.P. and an Obstetrician-Gynecologist who will be present at the clinic one half day a week.

At both JCFHC and Health Services of Hudson, regularly scheduled prenatal education sessions covering such topics as nutrition, body changes, parenting skills, and labor and delivery are available to all pregnant patients. A similar education program will be arranged for adolescents who choose to receive their prenatal care on-site so that all pregnant adolescents will have the advantage of prenatal education tailored for their needs.

Some pregnant adolescents in the Jersey City School system choose at some point in their pregnancies to attend an alternative school arrangement, TEMP (Teen-age Expectant Mother's Program). This program is actually run by the Board Of Education in space at the JCMC and the women attending it receive their prenatal care at the JCFHC. If a student at Snyder chose to leave Snyder for the TEMP program, continuity of medical care will be guaranteed.

A pregnant student opting for termination of pregnancy services will be referred to Health Services of Hudson County, a state licensed medical services provider.

F. Family Planning Services

Family planning will include both family planning counselling and family planning services. While the family planning counselor will take the lead, other members of the clinic staff including the general counselor, the nurse practitioner, the pediatrician, and the obstetrician-gynecologist will be engaged in family planning counselling as well.

The emphasis of the counselling will be to allow an adolescent to make realistic decisions consistent with his/her age, maturity, and circumstances. A major theme of all counselling will be to encourage the adolescent to discuss with his/her family the circumstances and thinking that are entering into decisions around sexuality and family planning.

One of the prime functions of counselling will be to work with an

adolescent who is uncomfortable with or hasn't yet reached a decision to be sexually active. Counselling can serve to help him/her understand alternative ways of expressing intimacy and affection or of asserting independence or of feeling "grown up" other than by engaging in sexual activities. For some students counselling will serve to reinforce abstinence as an active decision.

The Community Advisory Board, during the planning stages of this application, strongly felt that all levels of family planning services, including dispensing of family devices, should be offered on-site. This decision was reached after reviewing parent questionnaires, meeting with parents and students, and many hours of discussion. However, recognizing the sensitive nature of family planning services at school-based health clinics, the Community Advisory Board has agreed to hold several further meetings with parents. Like all policy decisions, the policies on family planning will be reviewed by both the Community Advisory Board and the School Board.

G. Sexually Transmitted Diseases

A student presenting with a suspected sexually transmitted disease will receive any necessary diagnostic testing and treatment onsite. He/she will be asked to voluntarily bring in his/her sexual partner for treatment. The clinic will not engage in any search for contacts. The appropriate state-mandated reporting requirements will be followed.

H. Immunizations

Under New Jersey law, students immunization records are checked yearly by the school nurses. This policy will continue. However, any student requiring vaccination will be able to receive such a service at the school based clinic.

I. Counselling and Mental Health Service

A full-time counsellor will be available to work individually and in rap groups with students to discuss issues crucial to adolescents. These topics range from changes in body image to career choices to parent-child relation. Some students will desire discussion of peer group relations; others will want

to discuss sexual relationships. For most students, the issues will be within the wide range of normal adolescent growth and development. The student advisory group will be asked to help establish the themes for rap groups.

The counsellor will be a friendly and familiar figure to students by virtue of his full-time presence at the school. (S)he will also assist with health education by participating in the Family Life curriculum and helping to organize health fairs, a health newsletter, and parent-student discussion groups.

Certain students will need more specialized psychological services. Each student seen in the clinic for medical reasons will eventually be adminstered a Psychological Risk Assessment. Information obtained from this assessment, plus the Health Assesment will allow for identification of potential special risks. Students with special needs will be receive further evaluation and treatment.

For these students and for self-referred students, a psychologist will be available at the school a half-day weekly. The counselor and psychologist will work closely, as necessary, with the Child Study Team which performs diagnostic work-ups for students with suspected or known learning disabilities. Back-up psychological and psychiatric services will be available through the Community Mental Health Centers and Departments of Psychiatry at Jersey City Medical Center and Christ Hospital and through other community agencies.

The counsellor and the psychologist will work directly with agencies such as Sexual Abuse Victims Agency (SAVA) and DEYFUS when a student has been identified as a victim of sexual or child abuse. Many students in Jersey City are now experiencing the terrible tragedy of a family member with AIDS. Special counselling and support groups will be arranged for these students on an as-needed basis.

J. Alcohol and Substance Abuse Counselling and Treatment

A half-time substance abuse counsellor will be responsible for

individual and group counselling for those students who are at high risk for drug and alcohol abuse, who have just begun experimenting with drugs and alcohol and those for whom substance abuse is threatening their ability to successfully attend school. In addition, the substance abuse counsellor will participate in educational efforts within the classroom and the general school in relation to alcohol and drug usage.

As with all components of this health program, the counsellor will maximize family involvement wherever possible.

The general counsellor and psychologist will also be available to work with students who are getting into difficulty because of alcohol and/or illicit drug usage. He/she will also work with students who were experiencing difficulty because of a family member's use of alcohol or drugs.

The Community Mental Health Center at JCMC will provide additional services for those students whose alcohol or drug-related problems required them.

K. Nutritional Services

A nutritionist will be present two half-days weekly for individual and group counselling and treatment for nutritionally related disorders including obesity, anorexia, bulemia, and diabetes melitus. Equally important, she will be available to answer questions relating to body image and general nutritional concerns.

Because many of the concerns of adolescents are related to body image and therefore to nutrition, the physicians, nurse-practitioner, and the general counselor will all receive additional training in nutrition to supplement their present level of knowledge.

L. Health Education Activities

Since one of the major goals of the school-based clinic is to increase students' ability to assume responsibility for their own health and to participate knowledgeably in decision making regarding their own health, a major

service of the clinic will be health education. All team members will participate in health education augmenting the already existing Family Life and health education curriculums and by creating a series of additional health education activities.

Student advisory committees will be asked to help set the agenda for health education activities. Students from different grades may require different topics. At least twenty-five percent of students would be expected to participate in one health education activity outside the classroom each year.

Activities anticipated include health education campaigns, health newsletters to be distributed in the greater community as well as in the school, participation in health fairs, poster campaigns, etc. The senior high school will also be "paired" with upper elementary school grades and the high school students will be asked to initiate and carry out health education campaigns for students in these grades.

The clinic will maintain an accessible collection of health education material, both written literature and audiovisual aids. Students will be asked to help create additional pamphlets, fliers, and video material for their fellow students' use.

In addition to the targeted education around family planning and substance abuse, several other topics will be targeted including accident prevention, smoking cessation, and health career development

M. Organization and Management

The Jersey City Board of Education and the Board of Managers of Jersey City Medical Center (in conjunction with the Health Council of the JCFHC) jointly share responsibility for policy making. The Board of Education retains ultimate responsibility for issues concerning facilities, security, and hours of operation. The Board of Managers of the JCMC retains ultimate responsibility for medical policy, quality of care, and personnel. The Board of Education and the Board of Managers (JCMC) have created a community advisory board which

establishes and reviews program policies, determines needs, recommends services, solicits community input and support, and establishes criteria for program evaluation.

The Project Director, who is also Medical Director of JCFHC, has management responsibility for operations, quality of care, and personnel. She will serve as the liaison to the community advisory board. The Chief Financial Officer of JCMC will be responsible for financial management. Day-to-day coordination onsite will be the responsibility of the Nurse Practitioner.

N. Community Advisory Board

The Community Advisory Board (CAB) was organized in early Spring, 1986. Ms. Evelyn Bailey, Board of Education, and Dr. Joanne Lukomnik, JCMC, were asked to chair. The CAB includes representatives from the City-Wide Parents Council and Snyder High School Parents Organization, the student body council, Jersey City Department of Public Welfare, N.A.A.C.P., Christ Hospital, PACO, Urban League, Concerned Women, Health Services of Hudson County, the Healthy Mother's/ Healthy Baby's Coalition, the Merchants Council, and the Ministerial Alliance. Representatives of the Board of Education (including a Board Member, superintendent of schools, administrators, Snyder High School Prinicpal, and school nurses) and the Jersey City Medical Center (Mr. William White, Chief Operating Officer, Joanne E. Lukomnik, M.D., Medical Director, and Joan Clark, Project Director) sat with the CAB.

The CAB actively solicited student and parent input. Besides the representation on the CAB, the CAB sent home letters to every parent at Snyder High School explaining the proposed school-based health service and inviting them to an open meeting to discuss the plan, sponsored the meeting, and followed-up with a parental survey which was answered by more than 200 parents. Some parents, including the President of the Parent Council and the mother of the Student Body President, held small meetings with other parents to discuss the proposed health services.

Parents strongly support the idea of the clinic and felt the need for family planning services (onsite counselling was almost unanimously supported and onsite treatment supported by over 80%), general health services, and dental services. They expressed enormous concern over drug abuse, especially over the recent epidemic of crack.

Two class representatives from each of seventy classrooms met with the school principal to provide feedback. These class representatives were invited to (and attended!) the open meeting. During October, every student in the school had a chance to discuss the school-based clinic during health education classes specially devoted to the subject. The students' major concerns centered on confidentiality, and they strongly desired family planning services and counselling services.

Further meetings with students and parents from Snyder High School are planned. A similar process will take place with students and parents from Dickinson.

D. Key Personnel

(Please note: the FTE percentages are written for staffing a single school-based clinic, e.g. either Snyder High School or Dickinson High School. For total staff time devoted to project, please double the FTE percentages except for project director. The identified personnel will be staffing the Snyder High School clinic. The Dickinson High //school clinic staff will be identified during the project's first year.)

Project Director (0.1 FTE)--Joanne E. Lukomnik, M.D., Medical Director, JCFHC. Dr. Lukomnik, an internist, is a former Chief Medical Officer, National Health Service Corps and Bureau Community Health Services (now BCHDA), Public Health Service. She is a medical advisor to the National Association of Community Health Centers and has served as a consultant to many adolescent health centers and family planning clinics. For three years, she had a panel of over 500 adolescent patients at the Martin Luther King Health Center in the South Bronx.

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NEWSLETTER

ACNJ
ASSOCIATION FOR CHILDREN OF NEW JERSEY 17 ACADEMY ST., SUITE 709 NEWARK, NJ 07102 201/643-3876

Special Issue: Adolescent Pregnancy

One Teen Mom's Reality

By Maureen Braun, MSW

The following is the transcript of an interview conducted by Ms. Maureen Braun, former Program Director of the New Jersey Chapter, National Committee for Prevention of Child Abuse's "Parent Linking Project III (PLP)". The young mother, Laticia, now age 17, has a three year old daughter, Tamika, and a six week old son, Duane. Laticia was a participant in the 1985-1986 PLP. (All names have been changed to protect the privacy of the young family).

Q. Were your pregnancies planned?
A. "No"

Q. Did you think you would get pregnant?
A. "I knew there was a possibility of getting pregnant, but I did not want to get pregnant."

Q. Were you using birth control? Both times?
A. "No" (Giggling)

Q. Did you realize you might get pregnant?
A. "Yeah (Giggling)... I hoped not."

Q. Is this embarrassing?
A. "Yeah"

Q. What is it like for you being a parent?
A. (Serious) It really,–I don't know how to say this–with Tamika I had no problems. I took her everywhere. But now that I have got two, I really can't go anywhere. Now I've got to find a job, and a babysitter for both of them.

OK, it's like–if I get a job or go to school–I have to have a babysitter for both of them... Before when I wanted to do things I would just do it.

James (Duane's father) said he would mind Duane. But he said he would have to quit one of his jobs–his morning job–so I could go to school.

If he would quit his job, I would like to go to school. But, I told him not to quit his job, though, because (we need) the money. But he said he is going to do it so I can go back to school.

Photo by Estelle Kobrin

Q. What is it like being a parent in the middle of the night?
A. Oh, God! What is it like?! It's terrible! But then again, if you know what time your baby is going to wake up and want to eat–and you have things ready for him, then it isn't too much of a problem. But, if you don't have his bottle ready and his pamper changed–he is going to give you some *business!* One time I did not have his bottle ready, and he was hollering and hollering and hollering. Then Tamika got up saying, "Mommy, sleepy," and she wanted to go to sleep. I told her to go back to bed and she didn't want to go to bed until I went to bed. So, it's like, she gets up when I get up to feed him.

Q. Are there other problems being a parent?
A. Yes, money. It's a big problem. I have to buy pampers, milk, clothes–everything–doctor bills–everything.

Q. How about time?
A. I get to go out sometimes, but then again, I can't stay like I want to stay because I have to be back to pick up these kids.

Q. Do you remember what you said to me in the hospital?
A. Oh. Yeah!–I feel like I went from being a young kid to being an old lady. I wasn't like that with Tamika but now that I have got two kids–I went from being 17 to 24!

Q. What is your relationship like with the baby's father?
A. It's OK with Duane's father, James, but Tamika's father–we don't have any relationship at all. He had called me because he has a problem right now–so let him solve his problem and do what he has to do. But still, I am not going to go back with him.

Q. When he could see Tamika, did he see her?
A. Not like he is supposed to–he hasn't done what he's supposed to for her... like money and everything. When I was pregnant with her he was happy. But when I had her, he was like, "I have to do this" and "I have to do that." So I was (alone). He was too busy. (Sometimes) he would come by and buy her a whole lot of clothes and shoes, pampers and milk–but then he would disappear. Then he would come back and do the same thing–then disappear again. So, he did some things for her–but not like he was supposed to.

Q. How does Duane's father feel about him?
A. He is so happy and proud of him. We went over to New York to see James' father and mother and grandmother. His father took my baby and started showing him off to all his friends saying, "Look at my grandson". He did not even want to give him back to me! He said, "Go–go to the store..." He did not want to give me my baby! (Laughter). Then we went to see James' mother and she kept the baby (for a while).

His family really likes the baby. They like Tamika too. They want her to spend the night with them–they want both babies to spend the night.

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Teen Mom's Reality

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Q. How about your mother?
A. She wasn't happy about me being pregnant. I don't want to talk about that.

Q. Was she angry both times you got pregnant?
A. The first time, she was, but, then it wore off and it was like, she had her first grandchild. Second child, she was, "uh-uh!" –but then again she couldn't say too much because I was at my grandmother's.

Q. How did your grandmother feel about it?
A. She told me I shouldn't have had another baby so soon. But, she said to do what I thought was best for the baby.

I couldn't have an abortion. Well, I wanted one, but it was too late. So...

Q. What kind of help or services do you need to help you be a good parent and to help you take good care of yourself?
A. I need a day care center so I can go to school or work. Umm...I need money, (even though) James is doing what he's supposed to. I need money for doctor bills and stuff...

Q. Did you think the workshop like we had last year at the Parent Linking Project were any help?
A. They were boring (laughter), but they helped because we were talking about the right things. Like what we need for our careers, birth control, how to take care of your child.

Q. What do you foresee for your future?
A. I know I am going to have a job. And my kids, they are going to be doing alright. I will get my own apartment, and I will be doing things for myself–without asking (my mother) for anything.

Q. So you want to be independent?
A. (I want to)...get married.

Q. What does it mean to you to be married?
A. **TIED DOWN!!** But I won't really be tied down, because James says I can go out and do things. I told him, I'm still young, I am not ready to be tied down. I still want to do a lot of things, but I can't do that much until (the babies) get older.

Q. When we talked about your future, is this the same future you thought about before you had children?
A. Not really, uh-uh–It is not the same. I planned on college, I planned on a lot of things. I did not plan on being married so soon. I didn't think I would have any kids, but gosh, I did. I have two.

Q. What did you plan on going to college for?
A. To be a nurse. I am really good in math. I got A's and B's. I used to be a good student.

Q. Do you think you could do that again?
A. Yeah, I think I could be a good student. If I get a babysitter, believe me, I could be a good student—cause I would go to school.

Q. Do you think you could still be a nurse?
A. I don't know. To be a nurse you have to have an around-the-clock schedule. You have to have a lot of time, cause you have to go to school to train. I have to put that off for awhile until I am 21 or 22. Then I will go back to school.

But I am trying to do what I'm supposed to do now. But since I'm still at my mother's house, I can't do what I want to do.

Q. Do you think programs like the Parent Linking Project are good for teenage moms?
A. Yeah! If you have a program like that to tell you and teach you some things, then you won't be running out having a whole bunch of babies, and getting into a lot of trouble. You think more about going to school —becoming something.

Half these girls out there, they don't know what they want to be—they don't know what they want to do. Now if they had something like (Parent Linking Project) to give them an idea of something or someone, then, maybe they would do something for themselves.

See, if I had had that program a long time ago, I don't think I would have kids. If there was a program for teenagers—where they have things like Planned Parenthood and stuff like that—but if I would have thought about things like that 2 or 3 years ago I would not have any kids. I would be thinking about something else, you know, a career, things like that.

If you had it to do all over again, what would you do?
Oh! I would do a lot. I'd go to school and finish school. I'd go to college and become a nurse or mathematician or something like that.

Do you get sad sometimes?
Yeah. I am sad a lot of times. My girlfriends call me and ask me to go out, and I say, "I can't go anywhere." And I can't, because I had those babies...All I do is sit in the house and watch TV, and talk on the phone. I want to go out—but I can't.

It's like my teenage life went—somewhere. It wasn't with me. It's like I am grown. I feel like I am 30.

School-Based Health Clinics An Aid to Many Teen Problems

By Marge Derrick

Across the country, school based health clinics are becoming an increasingly frequent phenomenon. These clinics, which for the most part offer comprehensive health care to high school and junior high students, have been developed in response to ongoing concern in the health community about the chronic underuse of health services by teenagers. Located within or nearby high and junior high schools, the new clinics are remedying that situation, and producing some remarkable results.

In 1973 the first clinic was begun in Mechanic Arts High School in St. Paul, Minnesota as part of St. Paul's Maternal and Infant Care Project when Laura Edwards, an obstetrician, became concerned about the consequences of the high rate of teenage childbearing. The clinic's staff included a nurse practitioner, a social worker and medical assistant. It provided students with a range of services that included athletic physicals, weight control programs, family planning information (including contraception education and abstinence) and day care for student mothers. Students are referred (with follow-up) to a nearby hospital clinic for contraception.

Clinics in other parts of the country followed the St. Paul model with variations that address the specific needs of their student populations. Services may include immunizations, vision, hearing and dental screening, prenatal care, pregnancy testing, etc. The potential of all these programs is to upgrade the quality of medical care for adolescents, decrease student absenteeism and prevent teenage pregnancy. There are now approximately 71 clinics nationwide with 100 more being developed. Some record upwards of 20,000 visits per year.

The Range of Services

An article in the March/April 1985 issue of "Family Planning Perspective" indicates that among the nine clinics surveyed, all the programs offered:

Physical exams: sports, employment, general health
Treatment for minor and acute illness, accidents and injuries
Individual Counseling: sexuality, gynecological exams, follow-up family planning
Contraceptive information: prescriptions or referral
Perform lab tests
Screen for sexually transmitted diseases
Nutrition information
Referral to social service agencies

Many offer sex education, pregnancy testing, drug and alcohol abuse treatment, weight loss programs, individual and family counseling.

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School-Based Health Clinics

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Caseloads of the various clinics range from 500 to 5,000 students, representing ¼ to ¾ of the student population of the schools they serve. Depending upon the extent of the program, clinics can be staffed by teams that make use of doctors, clinic aides, social workers, dental hygienists and nutritionists, most working part-time. The original school-based clinic concept only covered some specific reproductive services, but soon a wider variety of health services was offered, both to protect the teenagers attending the clinic from being stigmatized, and to meet the broader range of existing need.

When questioned, teenagers reported confidentiality, accessibility and cost as the main factors influencing their use of health services. The staff must be trustworthy and consistently available. Most clinics either charge a minimal $5-$25 annual fee or are free. They are usually located within a school or close to one. Once a clinic visit is made, the student's progress is monitored and follow-up is thorough.

Positive Results

There have been a number of studies on the impact of school based health clinics on the young people they serve. In St. Paul, Minnesota, there has been a continuing decline in the fertility rates, from 59 births per 1000 in 1976-1977 to 26 births per 1000 in 1983-1984. There has also been a decline in positive pregnancy tests and a reduction in recourse to abortion.

In another study comparing clinic users with non-users, those who utilize the services and are sexually active were found to be more likely to use contraception (55% vs. 35%). Teen mothers who received prenatal care had babies who were less likely to experience fetal death or low birthweight. Significantly, in some cases it has also been found that clinic users delayed initiating sexual activity.

In West Dallas, Texas there was a 25% reduction in teen births and a 90% reduction in infant mortality. In Mississippi, pregnancy related dropouts were reduced from 50% to 10%.

In Kansas City, there was a significant decline in absenteeism and suspensions. An estimate was made at one clinic that of 500 visits made, 500 school days were saved. The school saved $8.93 per day for each absence prevented, due to state financial regulations.

Also, through special drug and alcohol treatment programs, of the students who completed treatment, not one was cited again for substance related disciplinary action.

The most successful programs have several common threads:

Accessible location and hours
Staff trained and committed to working with teens
Familiar and supportive staff from several professional backgrounds
Services available without long waits for appointments
Confidentiality
Informed health education
Affordable services
Ability to make referrals and thorough follow-up

On-site and off-site clinics are generally similar, but off-site clinics often offer mental health, job and placement counseling as additional services.

Developing a School Based Health Clinic

Successful development and implementation of school based health clinics is dependent upon several key ingredients. You must have at least one highly motivated individual, preferably from outside the school system. It is often effective for this individual to be affiliated with a public health agency, physicians, or health agency such as Planned Parenthood.

The ideal site for these clinics is in the school or very nearby, but the most successful programs are sponsored by outside providers. Most programs are operated by health service providers such as teaching hospitals, public health services, maternal and child health providers or Planned Parenthood. Many programs, though, have been developed by community organizations like the Junior League and United Way.

All school based clinics have contractual arrangements with a variety of community-based agencies to provide additional services. These often include mental health agencies, Planned Parenthood, dental facilities, social services and others. Most have voluntary advisory boards. A significant advantage to an outside run clinic is that they are outside constraining school regulations, thus permitting them to dispense medication.

Consent slips listing available services, signed by parents or guardians are necessary. A great deal of time should be devoted to public relations and developing community support so that the appropriate perspective of the program is maintained. A good relationship with school administrators, staff and nurses is essential.

There are a variety of potential funding resources for school based health clinics. They include:
Maternal and Child Health
Title X
Grant Foundation-evaluation
Ford Foundation
Harris Foundation-High School
Robert Wood Johnson Foundation
Hewlett Foundation-Junior High
Rockefeller Foundation-initial data gathering

At a time in their lives during which young people are most in need of comprehensive health services, too few are receiving adequate health care. These clinics go where the need is. School based health clinics have provided teenagers the help they need to effectively deal with the physical and emotional difficulties they so often face. With increased community understanding and support we can expect to see, in the not too distant future, a proliferation of this vital service.

Marge Derrick is a member of the Junior League of Montclair-Newark, in which she served as Community Vice-President in 1984-1985 and as Chairperson of the State Public Affairs Committee in 1985-1986. She is presently Chairperson of the Montclair Adolescent Pregnancy Task Force, Secretary to the State Board of Parents Anonymous, and President of the Montclair-based "Parents Place".

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Essex County Network on Adolescent Pregnancy
Association for Children of New Jersey (ACNJ)

The Network's Response

By Ann M. Wilson, Director NJNAP

The publication of *NO EASY ANSWERS: A Blueprint for Action in Working with Pregnant and Parenting Adolescents and Those at Risk*, provides increased support for the continued efforts of the New Jersey Network on Adolescent Pregnancy.

The New Jersey Network on Adolescent Pregnancy (NJNAP) is a voluntary association of organizations and individuals focusing on the issue of adolescent pregnancy and its ramifications. It is a program of the Center for Community Education of Rutgers School of Social Work. The mission of the Center is to provide technical assistance, community organization skills, resources and information on a variety of social issues. The Network was created in 1979. Its activities are carried out on the local level in 18 County Networks. (In Essex County, the Essex County Network on Adolescent Pregnancy is coordinated by Mary-Ellen Mess, the Project Associate and co-author of the report.) The Network provides linkages among existing organizations but is not itself a formal organization with membership as such. It consists of affiliates and subscribers who are seeking ways to share information and ideas, not limiting freedom of choice in the type of service provision; it emphasizes the enrichment of sharing and mutual cooperation, particularly during funding cutbacks; and its seeks to avoid duplication and competition. Currently, some 3,000 people statewide have joined together in activities through the County Networks.

The Network has always focused on the *interrelated* social issues affecting youth and resulting in adolescent pregnancy, alcohol, drugs, suicide, homicide, and auto accidents. It emphasizes the need for systems change to enhance life options for *all* adolescents.

Community development efforts of the Network—as a follow-up to the joint report—will focus on two levels: community education, public information and technical assistance; and cooperative efforts on legislation and policy formulation.

Efforts of the NJNAP will continue to include provision of resources and technical assistance to federal, state and local governmental personnel and elected officials about the interrelated issues affecting youth. EXCHANGES, the quarterly newsletter of NJNAP, will continue to be published and provide "state-of-the-art" information to its 3,000 readers. The Network will provide a second round of its acclaimed training for child welfare workers on adolescent development and sexuality, "Changing Bodies, Changing Lives." Finally, the Center is embarking on a new project on school-community agency linkages that builds on the efforts of the Network.

As a follow-up to the Report, the NJNAP will initiate the following new actions: The Network will sponsor county-wide and/or regional workshops to discuss the findings of this report and its recommendations; initiate meetings with social agency executives and school administrators to discuss implementing the recommendations; advocate for program funding from County Human Service Advisory Councils (adolescent pregnancy is one of the six priority areas of the state HSAC this year); make presentations at County School Superintendent Roundtable meetings; and provide testimony to County Commissions on the Status of Women.

A major mission and expertise of ACNJ is advocacy for programs and policies for children and youth. The Network will work cooperatively with ACNJ to promulgate legislation and to meet with interested county, state and federal legislators in this regard. This will be concurrent with meetings with the Commissioners of the Departments of Health, Education, Human Services and Labor and the Division on Women concerning the recommendations in the report.

The publication of *NO EASY ANSWERS* was a cooperative effort that joined the research and legislative skills of ACNJ with that of the networking and community organizing expertise of NJNAP. Together, ACNJ advocates and affiliates of NJNAP have the opportunity of addressing the issues which impact adversely on the lives of adolescents. The challenge is formidable, but combined efforts can make a difference in the lives of young people in New Jersey.

ADOLESCENT PREGNANCY LEGISLATIVE ACTIVITY

As part of its follow-up to its adolescent pregnancy project and "No Easy Answers", ACNJ will continue to assess, monitor and act upon pertinent legislation. The following are current ACNJ Agenda Bills and are among our priority bills:

BILL #	DESCRIPTION	SPONSOR	COMMITTEE STATUS
S-0792	Establishes a group residence pilot program for unwed pregnant adolescent girls; appropriates $2 million	DiFrancesco (R)	Senate, Revenue Finance & Appr. Committee
S-0795	Directs the Department of Education to conduct a study of alternative education programs for pregnant adolescents and adolescent mothers; appropriates $50,000	DiFrancesco (R)	Senate Instit. Health and Welfare Comm.
S-1316	Establishes a task force on adolescent pregnancy	Lipman (D)	Vetoed by Gov. 10/22/86
S-1722	Establishes a Young Parents Grant program that provides day care services for teenage parents during school hours; appropriates $1 million (Passed in Senate)	DiFrancesco (R)	Out of Assembly Education Comm. (In Assembly Approp. Comm.)
S-1813	Establishes a Teenage Fathers Assistance Program and appropriates $1 million	DiFrancesco (R)	Senate Commit. on Children's Services

No Easy Answers

ACNJ and the New Jersey Network on Adolescent Pregnancy (NJNAP) recently released a report on a joint 18 month study of the problem of adolescent pregnancy in New Jersey. The report was written by Louise Murray, DSW, Project Director and Mary-Ellen Mess, MS, Project Associate and Coordinator of the Essex County Network on Adolescent Pregnancy, and edited by Shirley Geismar, ACNJ Research Coordinator. Ann M. Wilson, Director of NJNAP and Ciro A. Scalera, Executive Director of ACNJ provided overall leadership and guidance to the project and editorial assistance on the report.

"No Easy Answers: A Blueprint for Action in Working with Pregnant and Parenting Teens and Those at Risk" was recently released by ACNJ and the New Jersey Network on Adolescent Pregnancy (NJNAP). The report points out a number of serious problems with the state's ability to provide for this very vulnerable population, and makes strong recommendations for overcoming these shortcomings.

30,000 New Jersey adolescents ages 10 to 19 will become pregnant this year. More than two thirds of these young women will choose to end their pregnancy with an abortion. Of the teen-agers who choose to keep their babies, a majority of them will raise their children as single parents, a choice that often relegates them and their young families to lives of poverty and hardship. "No Easy Answers" reports that the state has failed to develop a comprehensive policy or service system to address these problems. The report states, "present community and state efforts lack coordination, overall planning and systematic evaluation."

An Office on Adolescent Services

As a result of these findings, the report recommends a new approach, one that will coordinate existing services in New Jersey so that they form a comprehensive and complementary whole and develop plans on a state-wide level to improve present prevention and treatment efforts, and at the same time, create new initiatives to satisfy unmet needs. It states all this be done within the context of the adolescent as a member of a distinct age group with specific characteristics, occupying a unique position in today's society.

To achieve these goals, the report recommends that a state department be designated as a lead agency within which an Office of Adolescent Services be developed to deal with the problems of adolescent pregnancy as a whole and develop age-appropriate services for adolescents. This office should:

—Be responsible for coordinating the myriad of health, education, employment and social services required to prevent adolescent pregnancy and to help our youngest families.
—Assume primary responsibility for ensuring that service providers receive appropriate technical assistance.
—Develop a strategic long-range plan.

Prevention and Treatment Recommendations

"No Easy Answers" also makes a number of recommendations to strengthen present prevention and service delivery efforts.

In order to more effectively prevent adolescent pregnancy, the report offers concrete recommendations for strengthening Family Life Education, and school-community linkages. Included is a recommendation that the feasibility of establishing school-based health clinics be explored. Increased funding for family planning services is also called for. Treatment services can be strengthened in a number of ways. The report recommends the enhancement and verification of referrals, and the provision of or reimbursement for transportation for young clients. Also suggested are broader and more targeted outreach efforts; the development of more parenting classes; that Medicaid and the Medically Needy Program be modified to extend to eligible newborns in a more timely fashion. Also recommended was reassessment of Aid to Dependent Children policies which assumes that the entire income of the teen mother's parents is available to the young woman and her child in assessing eligibility. This policy often results in the teen mother setting up her own household in order to receive financial assistance, or dropping out of school in order to support her child.

The report also recommended increased staff training at agencies serving pregnant and parenting teens, and that programs strengthen their monitoring of services and outcomes.

Finally, the report dealt with the numerous unmet needs of the pregnant and parenting teens. Major service gaps were found in housing, infant child care, parenting education and services of teen fathers. Specific recommendations were made regarding each of these issues. ACNJ will use *"No Easy Answers"* as a support to continued advocacy efforts on behalf of pregnant, parenting and at risk teens. Our follow-up, both through the legislative process and administratively, will be directed toward implementation of the recommendations contained in the report.

Copies of "No Easy Answers: A Blueprint for Action in Working with Pregnent and Parenting Adolescents and Those At Risk" are available at the ACNJ offices. Call (201) 643-3876 or (609) 854-2661. They may also be obtained through the New Jersey Network on Adolescent Pregnancy at (201) 932-8636.

Photo by Polly Brown

FACT SHEET

Jersey City Total Births	3,944
New Jersey Total Births	100,950
Ethnic Breakdown	
White	51% (2,011)
Nonwhite	46% (1,814)
Infant Deaths	
Jersey City	65 (16.5 deaths/1000 live birth
New Jersey	1,088 (10.8 deaths/1000 live birth
Babies Born With Physical or Cerebral Anomalies	175*
Low Birthweight Births	
< 2,500 grams; 5½ pounds	390
Children Born To Unwed Mothers	1,658
Children Born To Teenage Mothers	671

* Hudson County Total; Statistic Available by Counties Only.

Statistics Based Upon 1984 Figures.

Source: New Jersey State Department of Health.

Jersey City Healthy Mothers/Healthy Babies

Composed of Representative from the following Agencies:

American College of Nurse Midwives
Christ Hospital
Coalition of 100 Black Women
Division of Health
Division of Youth and Family Services
Girl Scouts of Hudson County
Headstart
Health Services of Hudson County
Hudson County Division of Welfare
Hudson Unit -- ARC
Jersey City Board of Education
Jersey City Medical Center
Jewish Home
Lead Poisoning Prevention Program
Project Self - Sufficiency
Rutgers Cooperative Extension
Urban League of Hudson County
Visiting Homemaker Service
WIC
YMCA

SCHOOL BIRTH CONTROL: NEW PROMISE OR OLD PROBLEM
EXECUTIVE SUMMARY

Proponents of the School-Based Comprehensive Health Clinic concept have produced numerous studies purporting to show the success of these clinics in reducing teen pregnancy. However, what their studies really show--when reviewed in concert with related works on adolescent sexuality--is that the School-Based Sex Clinic (SBC) phenomenon may well be creating greater problems than it set out to resolve.

"School Birth Control: New Promise or Old Problem" reviews the highly publicized reports promoting SBCs and points out their institutional biases, statistical and procedural errors. The study also brings together results of related public health research to present a more complete picture of the real and potential impact of SBCs.

School Health/Birth Control clinic proponents claim that school clinics facilitate close, daily clinic/student contact to ensure contraceptive compliance thereby allegedly reducing the incidence of teen pregnancy. But they do not even address the question of how such contact is maintained during school breaks and vacations.

The premier school clinic in St. Paul, Minnesota, reports that contraceptive continuance among clinic student/clients was 87 percent after four years use--rates matched nowhere else in world birth control literature with the possible exception of the forced birth control program of Mainland China. Yet, the mean age of entrance into the program was 16.2 years and tracking of students does not continue beyond age 18 or graduation.

Among the procedural flaws common to the reports reviewed is that SBC proponents have purposely used teen live birth rates rather than teen pregnancy rates as a yardstick in order to inflate their "successes." An analysis of this substitution shows that reductions in teen birth rates have been achieved by an increase in teen abortion rates--NOT a reduction in teen pregnancy rates. Since this is not the outcome SBC proponents promised, SBC studies routinely ignore or finesse the abortion rate.

Typical of studies that have claimed SBC 'success' is one that purported to show a reduction in teen pregnancy rates in a Baltimore school. Buried in the footnotes, however, is the fact that one-third of the females in the study could not be located for the final survey--an omission that would include all the girls who dropped out of school due to pregnancy.

Claims of cost-benefits--primarily due to savings in welfare and medical benefits to young, unmarried women--continues to be one of the major attractions of the SBC concept. However, SBC proponents universally ignore the downstream economic costs of widespread birth control usage among adolescents.

Studies have shown there is a direct relationship between adolescent birth control usage and increased sexual activity; and there is a well-documented direct relationship between premarital sexual activity and the incidence of venereal diseases. The estimated current economic cost of just one of these diseases --pelvic inflammatory disease, (PID)--is $2.5 billion and expected to increase to $3.5 billion by 1990. Teens between the ages of 15 and 19 now account for over 15 percent of PID cases.

Although often ignored, medical, public health and sociological studies undertaken by birth control proponents, as cited in "School Birth Control: New Promise or Old Problem," clearly document that:

1. Sexually inexperienced adolescents are routinely given birth control, including the pill;

2. The initiation and continuation of sexual activity (both frequency and number of contacts) increases among adolescent birth control users;

3. The use of birth control enhances resort to abortion;

4. Birth control proponents do support legal restraints as effective behavior modification techniques for teen seat belt use and smoking, but denounce parental consent for birth control users;

5. Teens are not adequately warned about the venereal disease consequences of their sexual behavior; pill use is associated with higher rates of chlamydia trachomatis and subsequent involuntary sterility and pelvic inflammatory disease cost American teens (aged 15-19) $192,000 alone in direct medical costs during 1984;

6. Birth control clinics and medical personnel are not a major source of information concerning pill side effects; medical misinformation is routinely given to adolescents about the pill; the pill is prescribed even for young women who smoke; family medical history for cancer is routinely ignored or incompletely ascertained; pill use is promoted in violation of Food and Drug Administration guidelines;

7. School birth control proponents ignore teen contraceptive drop-out, discontinuance and 'non-start' data;

8. As moral guilt inhibits effective adolescent birth control use, moral restraints to sexual intercourse become impediments to a "perfect contracepting society;"

9. Birth control professionals denounce morality and encourage sexual experimentation/promiscuity as this is more compatible with their own life style especially clinic counselors;

10. There are more out-of-wedlock teen pregnancies in those areas that routinely make birth control easily available to teens;

11. There is no scientific evidence that wanted pregnancies fare better than "unwanted pregnancies;"

12. The long-term economic benefit even of a non-marital birth is 3.6 times greater than the present value of public assistance costs for an AFDC mother and child;

The current push to implement SBCs appears to derive from a much-heralded study by the Alan Guttmacher Institute, research arm of the Planned Parenthood Federation of America, published in 1985. The study concluded that the "United States leads nearly all other developed nations of the world in rates of teenage pregnancy, abortion and childbearing." The study 'suggested' freer teen access to birth control, emphasis on sex education in the schools and, of course, extensive government promotion and funding of the teen birth control program.

A study by Jacqueline Kasun, Ph.D., indicated the opposite approach to be more effective. Her study showed that, "states that spend relatively large amounts on government birth control also tend to have high rates of teenage abortions-plus-unmarried births." States which limited teenagers' access to birth control --through reduced funding, as in South Dakota, or requiring parental consent, as in Utah--reduced the rates of teen pregnancy and abortion.

In California, for example, the tremendous growth in state funding for teen birth control programs was accompanied by a soaring rate of teen pregnancies and teen abortions. In 1970 and 1981 California's teen fertility rate was at the same level as the national average. However, as the state boosted its birth control funding to one-fifth of the nation's total, its teen pregnancy rate soared to 30 percent above the national average. California's program, following the blueprint of pro-SBC studies, has been a documented failure.

The problems of SBCs, then, lie not in the execution, but in the basic concept.

* * *

Copies of the report, "School Birth Control: New Promise or Old Problems," are available from the American Life League, PO Box 1350, Stafford, VA 22554, at $5.00 per copy. The report, prepared by Robert G. Marshall, director of research, Castello Institute of Stafford, in collaboration with Mrs. Judie Brown, president of the American Life League, is fully documented and includes related SBC analyses by Jacqueline R. Kasun, Ph.D.

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For Immediate Release — May 7, 1987

SCHOOL BASED SEX CLINICS - THE MYTH OF MORAL NEUTRALITY

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As pointed out so clearly in the Family Research Council report, Teen Pregnancy and School Based Health Clinics, virtually everyone agrees that something must be done to stem the rising tide of children having children. Premature births, abortion, drug and alcohol abuse, suicide, venereal desease, juvenile delinquency, and the perpetuation of the poverty - welfare cycle are but a few of the tragic consequences of teenage pregnancy.

Unfortunately, diagnosing the problem is often easier than finding a cure. For the past 15 years the prescribed"cure has consited of progressive sex education programs, the establishment of confidentially between adolescents and various public and private agencies, and the easy acess to contraceptives.

Despite 15 years of effort and the expenditure of more than $500 million, teenage pregnancy and abortion rates continue to climb. Reacting to the obvious inefficacy of existing programs, the "experts" are now offering the "new and improved" version - school based health clinics. Like past programs,, however, school based health clinics fail to simultaneously reduce pregnancy, sexual activity, abortion, and venereal disease among our young people

more

"You are Peter, and upon this rock I will build my Church, and the gates of hell will not prevail against it." - Mt. 16, 13-19

They fail because they are founded upon the same flawed presuppositions as previous programs: the reliance on birth control to reduce teen pregnancy, the myth of moral neutrality, and the " kids are going to do it anyway " mentality.

School based health clinics should not be funded because they usurp parental authority and involvement, fail to instruct in principles of morality and character development, are promoted under the pretense of providing general medical care when their prime focus is family planning, and represent unnecessary duplication of existing services at added cost to the taxpayer.

Because our children are one of our nations greatest resources and because their behavior will determine the type of world that will exist for future generations, we must not abandon our children to sexual promiscuity. We must renew our efforts to mold their character in such a way that they reflect virtue, self control, and self sacrific in service to others

Teen pregnancy is merely the symptom of a greater problem - premarital, adolescent behavior. Accordingly, public and private programs designe to reduce teen pregnancy should focus on discouraging sexual involvemer among our youth prior to marriage. Rather then presuming that teen-agers are going to have sex anyway, our collective s trategy for combatting teen pregnancy should be similar to the approach we have taken on curbing adolescent drug addiction, alcohol abuse, and smoking - we should encourage teens to say "no".

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A FAMILY RESEARCH REPORT

Teen Pregnancy and School-Based Health Clinics

By Barrett Mosbacker

AUGUST 1986

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Teen Pregnancy and School-Based Health Clinics

Introduction

The sexual revolution of the last two decades has brought about a marked increase in the sexual activity of America's youth. During the 1970s, the percentage of sexually active teens grew nearly 67 percent, and while this growth has begun to level off in recent years, there are still more than 11 million sexually active teenagers in America today.[1]

This increased sexual behavior has spurred a dramatic rise in the pregnancy rate for unmarried teenage females. In fact, more than one million teenagers become pregnant each year.[2]

To combat this growing problem, public health clinics have made birth control counseling and free contraceptives available to minors and many public schools have implemented sex education programs.

Although well-intentioned, these programs have not worked. In fact, they may have actually exacerbated the problem. In a recent report on teen pregnancy, the House Select Committee on Children, Youth & Families found that despite sex education and contraceptive distribution programs

> *there has been no change in the percentage of sexually active teens who become pregnant, but there has been a huge increase in the percentage of teens who are sexually active. And this increase in sexual activity has led to a proportionate increase in pregnancies to unmarried teens.*[3]

Why has teenage sexual activity and pregnancy increased despite the development and implementation of well-intentioned and well-financed programs?

The primary reason these programs have failed is that they are based on three flawed presuppositions:

(1) teenagers will exercise greater sexual responsibility if they have an increased awareness of sexuality and an increased accessibility to contraceptives;
(2) programs that do not explicitly encourage or discourage teen sexual activity are "morally neutral;" and
(3) teens will be sexually active even if encouraged to say "no."

Barrett Mosbacker is the president of Heritage Marketing, a political consulting firm in Charlotte, N.C. He is a member of the Family Research Council's Resource Network.

Contraception is the Answer?

The first presupposition undergirding current pregnancy prevention projects is that adolescents do not have enough information on the proper use of contraceptives. It is assumed that teenage pregnancy will be reduced if teenagers have easier access to contraceptives and better education on responsible sexual behavior and the proper use of birth control.

If the greater availability of contraceptives and sex education is effective in reducing teenage pregnancy, one would expect to see a correlation between increased contraceptive use and decreased pregnancies. But a study of premaritally sexually active females aged 15-19 found that as sexual activity increases, the probability of pregnancy also increases—even when contraceptives are used consistently.[4]

The contraceptive failure rate is largely responsible for this phenomenon. To quote from the Select Committee on Children, Youth & Families:

> *The contraceptive failure rate for teens who always use contraceptives is about 10% (Zelnik and Kantner, 1976 and 1979). Therefore, hypothetically, if sexual activity among teens reached 100% and the constant use of contraceptives 100%, we would still have a pregnancy rate of about 10%.*[5]

Although well-intentioned, these (sex education and contraceptive distribution) programs have not worked. In fact, they may have actually exacerbated the problem.

While teen contraceptive use has increased, so has the sophistication in birth control methods. Accordit to Dr. James Ford and Michael Schwartz of the Free Congress Foundation:

> *At least as significant as the increased regularity of contraceptive use was the increased sophistication in contraceptive methods. By 1976, oral contraception had far outstripped all other methods in popularity among unmarried*

teenagers, having been used by 58.8% of all unmarried teenage contraceptive users.[6]

Thus, the emergence of family planning clinics has coincided with an unprecedented increase in the incidence of premarital teenage pregnancy. This increase in teen pregnancy has occurred even though more teens are using contraceptives, using more effective forms of contraceptives, and are exposed to more instruction on sexual behavior and birth control methods.

Even the largest providers of contraceptives acknowledge that the increased availability and use of contraceptives has not reduced teenage pregnancy. Planned Parenthood's own journal, *Family Planning Perspectives*, states:

More teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital pregnancies continues to rise.[7]

Sociologist Phillips Cutright reaches the same conclusion:

We find no evidence that the programs reduced white illegitimacy, because areas with weak programs or no programs at all experience smaller increases or larger declines (in pregnancy) than are found in areas with strong contraceptive programs.[8]

The anomaly of increasing contraceptive use with a corresponding increase in pregnancy rates is bewildering to researchers Melvin Zelnik and John F. Kantner:

If all other factors had remained the same, the substantial increase in the prevalence of premarital sexual experience among teenage women between 1971 and 1976 might have been expected to result in an increase in premarital pregnancy. Over the same period, however, these same young women reported a dramatic increase in overall contraceptive use, in use of the most effective methods, and in more regular use of all methods—changes which, other things being equal, should have led to a decrease in premarital pregnancy.[9]

Professor Kingsley Davis, a member of the board of Sponsors for Zero Population Growth, summarized the failure of contraceptives to reduce teen pregnancy:

The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraceptive use was becoming more, rather than less, widespread and respectable.[10]

The Moral Neutrality Myth

The second false assumption of current pregnancy prevention projects is that programs that do not explicitly encourage or discourage teen sexual activity are "morally neutral." According to this line of reasoning, teachers and counselors merely act as catalysts of discussion and help students "discover" their own values. No moral judgments are made. While students are told it is OK to say "no" to sex, they are not told they *ought* to say "no."

This increase in teen pregnancy has occurred even though more teens are using contraceptives, using more effective forms of contraceptives, and are exposed to more instruction on sexual behavior and birth control methods.

On the surface, this approach is appealing because it gives the impression of being neutral and objective. It must be pointed out, however, that sex education is neither objective nor neutral. Indeed, it cannot be. It is philosophically and intellectually impossible to be morally neutral. Either sexual activity is presented as having moral parameters, or as having no parameters, but both are equally moral statements.

What is perhaps more striking (if no more harmful) is the inherent contradictions that exist in our approach to questions of right and wrong as they relate to our nation's children. No responsible teacher, parent, school superintendent or counselor would take a "neutral approach" to stealing, lying, cheating on exams or violence. Yet, this is precisely what is being done in the area of sexual activity.

Unfortunately, moral neutrality is not stagnant. Once it is accepted that teenage sexual activity is not a moral issue that can be addressed in sex education programs, there is an inevitable slide into open acceptance of such activity.

The Minority Report of the House Select Committee on Children, Youth & Families asks some very important questions in this regard:

Every generation has inherited the difficult job of bringing children into adulthood, and the same problems have presented themselves. What is so

different now? Why does the problem seem so much more difficult in this generation? . . . Have we really failed in our efforts to prevent pregnancies to unmarried teens? Or is it truer to say that we have abandoned them? Progressively over the last 25 years, we have, as a nation, decided that it is easier to give children pills than to teach them respect for sex and marriage.[11]

Kids are Going to Do It Anyway?

Flowing naturally from the myth of neutrality is the third flawed assumption which is that "kids are going to do it anyway, so we ought to at least protect them from the worst consequences of their behavior."

It is quite true that we will always have sexually active teenagers, and consequently, unintended premarital teenage pregnancies. It is equally true that

No responsible teacher, parent, school superintendent or counselor would take a 'neutral approach' to stealing, lying, cheating on exams, or violence. Yet, this is precisely what is being done in the area of sexual activity.

we will always have prostitutes, drug addicts, alcoholics, wife abusers, rapists, tax evaders and thieves. The fact that some individuals will engage in unhealthy behavior should not discourage society from promoting moral conduct.

The issue is not whether some teenagers will be sexually active, the issue is whether current pregnancy rates can be reduced by discouraging unmarried teenagers from engaging in sexual activity.

In spite of the strong natural desire and propensity toward sexual activity among adolescents, sexual activity can be controlled. When one states that there has been a dramatic increase in teenage sexual activity over the last fifteen years, he acknowledges that sexual promiscuity among teenagers was once much less common than it is today. Obviously, the desire for sexual activity among teenagers has always been great, but the recent increase in adolescent sexual activity has taken place because there is an unwillingness to state in unquivocal terms that sexual activity outside of marriage poses serious risks to one's physical, psychological, spiritual, and emotional well-being.

Teen sex is not inevitable. Indeed, a recent national study found that even today, nearly half of all 18 year-old females have never had premarital intercourse.[12] Moreover 20% of all sexually experienced teenagers aged 15-17 have had intercourse only once.[13]

Although teen sexual activity has shown a dramatic increase during the last two decades, it would be shortsighted to conclude that this is an irreversible trend. Trends can be reversed if society is willing to candidly re-evaluate existing programs and make much-needed changes.

Unfortunately, when current programs are evaluated and found to be ineffective, the proposed solutions are often an expansion and modification of existing concepts rather than a total change in direction. The recent emergence of school-based health clinics epitomizes such a phenomenon.

School-Based Clinics: An Overview

School-based health clinics have received a lot of attention recently, but the concept of offering family planning services in public schools is really not new. The first school-based clinic was opened in Dallas in 1970 by the University of Texas Health Science Center. Three years later, the Maternal and Infant Care Program of the St. Paul Ramsey Hospital opened a clinic in Mechanic Arts High School in St. Paul, Minnesota. Similar clinics in two other St. Paul schools soon followed, and the school-based concept spread to other communities throughout the country as well. Currently, there are at least 43 in-school clinics in operation and another 50 - 60 proposed clinics under consideration.

School-based health clinics vary in size and organizational structure. Some have been set up and managed by hospitals or public health departments, others by community health centers or nonprofit organizations. Almost all have been established in

Progressively over the last 25 years, we have, as a nation decided that it is easier to give children pills than to teach them respect for sex and marriage.

schools which are predominantly comprised of minority students.

A recent report issued by the Support Center for School-Based Clinics notes that "by definition all of the clinics are involved in family planning."[14] While

this is no doubt their primary function, clinics also offer a variety of other health services, including athletic physicals, laboratory and diagnostic screenings, immunizations, nutrition and weight reduction programs, child care, and drug and alcohol abuse programs.

By providing a wide range of services, clinic organizers believe they can not only obtain greater student participation, but that they can achieve wider community support. Indeed, Joy Dryfoos of the Center for Population Options stated in a recent article that prospective clinics "can avoid local controversy by starting with primary health care and then adding family planning services."[15]

Regrettably, this underhanded approach to establishing in-school clinics is apparently quite common. A recent issue of *Family Planning Perspectives* identified ways in which clinics have circumvented potential opposition:

> *The most common strategy adopted to avoid opposition was to maintain a low profile—generally by keeping programs out of sight, by avoiding potentially controversial preventive services, by staying clear of abortion services, by relying on word of mouth for recruitment and by giving names to programs that obscured their functions (Cyesis, Teen Awareness, Access, Services to Young Parents, Healthworks, and Continuing Education to Young Families are some examples).*[16]

Moreover, the report states:

> *Program advocates and service provides are more or less obligated to exaggerate the potential benefits of services in order to secure political and material support. One popular ploy . . . revealed an incredible array of problems that allegedly would be solved by the provision of services for pregnant teenagers and adolescent parents. In claims reminisent of those made for the patent medicine nostrums of the 19th century, it was argued that teenage pregnancy services would combat child abuse, crime, youth unemployment, sexual abuse, infant mortality, mental retardation, birth defects, drug abuse and welfare dependency.*[17]

Evaluating Clinic Effectiveness

In supporting their claim that teen clinics are effective, clinic proponents often cite a study of the St. Paul schools which found that a drop in the number of teen births during the late 1970s coincided with an increase in female patronage of in-school clinics.[18]

But there is reason to question the validity of these findings. The Support Center for School-Based Clinics acknowledges:

> *Most of the evidence for the success of that program (St. Paul) is based upon the clinic's own records and the staff's knowledge of births among students. Thus the data undoubtedly do not include all births.*[19]

Moreover, an analysis of the data conducted by Michael Schwartz of the Free Congress Foundation found that the total female enrollment of the two schools included in the study dropped from 1,268 in 1977 to 948 in 1979.[20] Therefore, the reduction in reported births could be attributable to an overall decline in the female population.

By providing a wide range of services, clinic organizers believe they can not only obtain greater student participation, but that they can achieve wider community support.

Furthermore, it is important to point out that the St. Paul study showed a drop in the teen *birth* rate rather than the teen *pregnancy* rate. Accordingly, it is quite likely that the reduction in the fertility rate was due at least in part to an increase in the number of abortions.

As Michael Schwartz noted in a recent article:

> *We still do not know whether the rate and/or number of pregnancies changed or how many students submitted to abortions.*[21]

In addition to these problems, the St. Paul research design was not replicable and did not control for outside factors. Research analyst Marie Dietz noted:

> *Since its comparisons were done in a cross-sectional way between the school before and after clinic presence, other variables affecting birth rates could have been affecting all school populations. The suggested approach to show whether this occurred or not is to compare the clinic school with other schools or a school which is similar in school demographics (number of students, race of students, and socio-economic status of students) and to see if there is a significant difference between the birth/fertility rates of the school with a clinic and without a clinic. This was not done. Therefore, the widely publicized findings of the teenage contraceptive clinic which supposedly showed a drop in the birth rate are simply not supported by the data presented in the research report.*[22]

It is interesting to note that following the enactment of a 1981 Minnesota law requiring parental notification for abortions, the birth rate among St. Paul teenagers attending schools with clinics reversed itself.[23] This increase in the St. Paul birth rate coincided with a dramatic statewide *decrease* in abortions, births, and pregnancies among teenagers. From 1980 to 1983, abortions to Minnesota teens aged 15-17 decreased 40%, births declined 23.4%, and pregnancies dropped 32%.[24]

Not only are there serious problems with the data presented in support of the St. Paul project, but there is also substantial testimony demonstrating that clinic programs in general are not effective.

A report released by the Muskegon Area Planned Parenthood and the Muskegon Heights Public Schools Health Clinics in Michigan found that: "There was no significant change in the pregnancy rate."[25]

Another report issued by the Support Center for School-Based Clinics acknowledged that there is a poor rate of consistent and proper use of contraceptives by adolescents:

Continued patient compliance poses a real challenge to health clinic practitioners. Many adolescents fail to use properly and continually a method of birth control, even after they have obtained that method.[26]

Still another study which examined 10 localities in four states found that:

The comprehensive model assumes that timely interventions of health, educational, and social service agencies will help young women to make informal decisions about the resolution of their pregnancies (abortion, adoption or parenthood) . . . The scant evidence available on program effectiveness shows these to be optimistic goals.[27]

The report concludes:

Comprehensive programs, despite their many virtues, are not the magic bullets that will solve the problems associated with unintended teenage pregnancy and parenthood. Nor should they be expected to do so.[28]

'Program advocates and service providers are more or less obligated to exaggerate the potential benefits of services in order to secure political and material support.'

Parental Concerns and Other Problems

Not only are school-based health clinics ineffective in thwarting teen pregnancy, but many parents believe that in-school clinics usurp their authority and responsibility for helping children make decisions about sex. Once a parent gives consent for the in-school clinic to provide any health service, all student visits are confidential. Thus, parents who want their child to receive a free sports physical must sign a "blank check" which gives the in-school clinic the freedom to provide other health services (including birth control counseling and prescriptions) without further parental notification or consent.

This particular policy is not accidental. According to the Center for Population Options, it is necessary "to assure minors access to family planning information."[29] In fact, CPO is encouraging in-school clinics to compose parental consent forms so that only forms returned denying registration will be recognized as parental disapproval. Forms not returned will be considered assent.

In addition to these problems, school-based health clinics appear to be the latest step in a growing movement to transform public schools into social welfare agencies which provide a wide range of peripheral services that interfere with academic pursuits. This movement has arisen despite a dramatic decline in scholastic achievement during the last decade—a decline largely caused by the inability of public schools to give proper attention to equipping young people with basic educational skills.

Many parents believe that in-school clinics usurp their authority and responsibility for helping children make decisions about sex.

Myron Lieberman, writing in *The Journal of Family and Culture*, addresses this problem:

The educational landscape reveals a mindless commitment of public school resources to the solution of social problems that are beyond their influence. In the long run, the waste of resources, substantial as it is, may be less important than the loss of respect for public schools engendered by

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such misguided efforts.[30]

School-based health clinics also pose a financial problem. According to the Support Center for School-Based Clinics, the cost of clinics range from about $25,000 to $400,000 per clinic annually.[31]

School-based health clinics appear to be the latest step in a growing movement to transform public schools into social welfare agencies which provide a wide range of peripheral services that interfere with academic pursuits.

A study of a proposed clinic program in Mecklenburg County, North Carolina found that an average of $79,800 would be spent annually for a single clinic to serve an average of six teens per day. That breaks down to $7 388 per student served each school day.[32]

In light of the fact that school-based clinics fail to reduce the pregnancy rate, will be involved in diagnosis rather than treatment, and offer services already available in most communities through private physicians and public agencies, such wasteful expenditures to initiate and sustain the school-based clinic program seems totally unjustifiable from a fiscal standpoint.

Conclusion

Virtually everyone agrees that something must be done to stem the rising tide of children having children.

Premature births, abortion, drug and alcohol abuse, suicide, venereal disease, juvenile delinquency, and the perpetuation of the poverty-welfare cycle are but a few of the tragic consequences of teenage pregnancy.

Unfortunately, diagnosing the problem is often easier than finding a cure. For the past 15 years, the prescribed "cure" has consisted of progressive sex education programs, the establishment of confidentiality between adolescents and various public and private agencies, and the easy access to contraceptives.

Despite 15 years of effort and the expenditure of more than $500 million, teenage pregnancy and abortion rates continue to climb.

Reacting to the obvious inefficacy of existing programs, the "experts" are now offering the "new and improved" version—school-based health clinics.

Like past programs, however, school-based health clinics fail to *simultaneously* reduce pregnancy, sexual activity, abortion, and venereal disease among our young people.

They fail because they are founded upon the same flawed presuppositions as previous programs: the reliance on birth control to reduce teen pregnancy, the myth of moral neutrality, and the "kids are going to do it anyway" mentality.

School-based health clinics should not be funded because they usurp parental authority and involvement, fail to instruct in principles of morality and character development, are promoted under the pretense of providing general medical care when their prime focus is family planning, and represent unnecessary duplication of existing services at added cost to the taxpayer.

Because our children are one of the nation's greatest resources and because their behavior will determine the type of world that will exist for future generations, we must not abandon our children to sexual promiscuity. We must renew our efforts to mold their character in such a way that they reflect virtue, self-control, and self-sacrifice in service to others.

Teen pregnancy is merely the symptom of a greater problem—premarital, adolescent sexual behavior. Accordingly, public and private programs designed to reduce teen pregnancy should focus on discouraging sexual involvement among youth prior to marriage.

Teen pregnancy is merely the symptom of a greater problem—premarital, adolescent sexual behavior. Accordingly, public and private programs designed to reduce teen pregnancy should focus on discouraging sexual involvement among youth prior to marriage.

Rather then presuming that teenagers are going to have sex anyway, our collective strategy for combatting teen pregnancy should be similar to the approach we have taken on curbing adolescent drug addiction, alcohol abuse, and smoking—we should encourage teens to say "no." □

NOTES

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[18]Laural Edwards, et. al., "Adolescent Pregnancy Prevention Services in High School Clinics," *Family Planning Perspectives*, Vol. 12, No. 1, January/February, 1980, pp. 11, 14.

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[21]Ibid., p. 5.

[22]Marie Dietz, Unpublished paper, "St. Paul In-School Sex Clinics," no date.

[23]Select Committee Report, p. 381.

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[25]"Muskegon Heights School-Based Teen Clinic—A Survey," Muskegon Heights Area Planned Parenthood, September 1984—June 1985, p. 2

[26]Kirby, pp.8-9.

[27]Richard Weatherley, et. al., p. 77.

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[29]"Annual Report," Center for Population Options, 1985.

[30]Myron Lieberman, "Sex Education," *Journal of Family and Culture*, Vol. 1, No. 4, Winter, 1986, p.58.

[31]Asta M. Kenney, "School-Based Clinics: A National Conference," *Family Planning Perspectives*, Vol. 18, No. 1, January/February, 1986, p. 45.

[32]Figures are derived from a personal letter to Jerry Blackmon, Board of County Commissioners/County Board of Health from Basil Delta, M.D., M.P.H. Health Director, April 8, 1986.

SCHOOL BASED SEX CLINICS:

THE FACTS

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SCHOOL BASED HEALTH CLINICS: THE FACTS

PART I: SCHOOL BASED SEX CLINICS: THE FACTS

PART II: SCHOOL SEX CLINICS: FINANCIAL AND LEGAL IMPLICATIONS

PART III: SOCIAL AND POLITICAL IMPLICATIONS

PART IV: SCHOOL BASED SEX CLINICS: SUPPORTERS AND OPPONENTS

PART V: PSYCHOLOGICAL IMPLICATIONS

SCHOOL BASED SEX CLINICS: THE FACTS

1. What is the purpose behind the so-called "School Based Health Clinics?"

-- Obstensibly, the purpose of these clinics is to provide "general health care" for junior high and high school students. In fact, however, they are always proposed, backed and operated by the abortion / contraceptives / amoral sex education lobby.

** The only sponsor of the current legislation (August 1986) to establish a "pilot program" of such clinics in California is Planned Parenthood.

** The Center for Population Options, a population control group based in Washington, D.C., was the the chief financial sponsor of both the first and second "National Conference(s) on School-Based Health Clinics." (Asta M. Kenney, "School-Based Clinics: A National Conference," Family Planning Perspectives (FPP), 18:1, Jan/Feb 1986, p.44)

-- The purpose of these clinics is not and never has been general health care for students. They always become School Sex Clinics which hand out contraceptives, refer for abortions, and indoctrinate children in a casual, "recreational" view of sex, and do all of this behind parents' backs.

2. How do we know that the real purpose is to form a School Based Sex Clinic?

-- Planned Parenthood itself in its official publications has been proposing these clinics for almost a decade, and offering its members strategies for getting them approved before parents know what is happening.

** As early as 1976, articles were appearing urging the use of such clinics as a "solution" for teen pregnancy. (eg., Laura Edwards, et. al., "An Experimental Comprehensive High School Clinic," American Journal of Public Health, Vol 67, p. 765-66; and L. Edwards, et. al., "Adolescent Pregnancy Prevention Services in Hign School Clinics, FPP, Vol. 12, No. 1, Jan/Feb 1980, pp. 6-14)

** "Most of these clinics were originated by an individual from outside the school system." (Joy Dryfoos, "School-Based Health Clinics: A New Approach to Preventing Teen Pregnancy," FPP, 17:2, March/April 1985, p. 70-75.)

** "In Muskegon, the local Planned Parenthood affiliate operates a school based clinic. ... (In many other clinics) Planned Parenthood affiliates are also sources of personnel and specialized programs." (ibid.)

** "Usually, when clinic proponents approach a school system with a plan, they should consult school board members, administrators, and superintendents before individual principals, teachers or nurses are brought into the picture. (Kenny, FPP, Vol. 18:1, Jan/Feb 1986, p. 45)

** "It is imperative to have the approval of the school board and school superintendent first, as well as their commitment to defend the decision." (ibid.)

-- The chief corporate and foundation providers of "start-up" and ""pilot" program funds for these clinics have required that they offer "pregnancy related" services.

** "These services must include: ... on site consultation, as well as referral and follow up for pregnancy; ... effective preventative services aimed at pregnancy ..." (Information and application brochure, "The School-Based Adolescent Health-Care Program," for funds from the Robert Wood Johnson Foundation's $16.8 million program for school based clinics, p. 6.)

-- In several instances, the backers of these clinics have pulled out, or killed the proposed "health clinic" when handing out contraceptives or referring for abortions was specifically excluded.

** In the predominantly black Anacostia section of Washington, D.C., parents welcomed the proposed "school based health clinic" on the condition that "sex counseling," contraceptive "services" and abortion referral would be specifically and permanently excluded. Backers of the clinc then dropped the whole plan. (William Raspberry, "Birth Control Clinics in Schools? No.", Washington Post, April 14, 1986, p. A-13)

** In Minnesota, State Sen. Linda Berglin, author of a (1986) bill to fund "comprehensive school health clinics" killed the proposal rather than accept amendments which would prohibit the clinic from promoting abortions and prevent abortion providers (like PP) from participating in the program. (NRL News, April 10, 1986, p. 6).

-- Planned Parenthood has even advised its affiliates to downplay or even omit the contraceptives / sex-counseling / abortion-referral part of these clinics at first, in order to avoid opposition. Later, they say, the sex-clinic part can be "added."

** "A midwestern clinic omitted the provision of contraceptives from the clinic's activities in its first year, to establish a clear image of the broad range of health care services provided. In the programs's subsequent year, the advisory board decided to include contraceptive care ..." (FPP Vol 18:1, p. 45, italics added).

--In other words, by Planned Parenthood's own admission the impetus for these clinics comes not from the health needs of students, nor from parents or school personnel, but from "outside" forces: ie., the elitist, sometimes racist, population control / "family planning" / abortion industry.

3. Why is the family planning / abortion industry so interested in starting these sex clinics?

-- Obstensibly, they want to stem the "epidemic" of teenage pregnancies in the United States, and to help make sure these young girls don't ruin their opportunity for a high school education by becoming pregnant and having to drop out of school.

-- In fact, however, it provides these industries with yet another massive

infusion of tax dollars for their business, and enables them to capture a whole new class of clientele.

4. Is there an "epidemic" of teenage pregnancy in the U.S.?

-- Yes, there is.

** Estimates are that the "total number of premarital (teen) pregnancies more than doubled (from 1970 to 1978) from about 300,000 to 700,000." (Michael Schwartz and James H. Ford, M.D., Family Planning Clinics: Cure or Cause of Teeange Pregnancy," Linacre Quarterly, May 1982, p. 143.)

** Overall estimates of teen pregnancy (including married teens, eg., ages 18 and 19) run to 1,100,000 in 1978. (Title XX Adolescent Family Life Demonstration Projects regulations, U.S. Congress, 1983)

** Current estimates run to about 1 to 1.1 million teen pregancies annually, a slowdown in the rate of growth for teen pregnancies, but no cause for relief since the teenage population of the U.S. has been declining for the past several years. (cf. "Children Having Children," Time, 126:78-82+, Dec. 9, 1985.)

-- However, neither the causes nor the effects of this "epidemic" are what clinic backers claim they are.

-- First, clinic supporters claim that the cause of the explosion in the teenage pregnancies is a lack of knowledge among teens about contraceptives. In fact, just the opposite is true!

** "Data indicate that in the late 1970's for every additional million dollars being given to family planners by the federal government, about 2,000 (more) adolescent pregnancies were occuring two years later."

** "In 15 states with similar social-demographic characteristics and rates of 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."

** "Federal Expenditures on Family Planning" grew from $99 million in 1972 to $298 million in 1980, but not only was the total number of teen pregnancies doubling, but the proportion of the births among 15 to 19 year olds which were births to unmarried mothers nearly doubled.

** (Jacqueline R. Kasun, Ph.D, "Teenage Pregnancy: Media Effects Versus Facts," pp. 2-3; Tables 2 and 3, summarizing the testimony of Susan Roylance to the U.S. Senate Committee on Labor and Human Resources March 31, 1981.)

-- After declining for almost fifteen years (1959-1973), the number of teen pregnancies began to skyrocket in 1973. This increase occurred simultaneously with the massive growth of federal government spending on adolescent birth control programs during the 1970's. (Kasun, ibid.)

-- Second, the favorite media incantation of clinic backers is that, as a result of all these pregnancies, we have millions of "Children having children" in the

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U.S. But this claim is factually false.

** The increased resort to abortion by teenagers during the 1970's and early 1980's was so massive that it more than offset the increase in pregnancies. While teen pregnancy rates were skyrocketing, the rate of births to teens was actually dropping.

** In 1976, when the teen pregnancy "epidemic" was already in full swing and first noted by the press, "adolescent child-bearing was at the time in the middle of a steep decline," as figures from the National Center for Health Statistics show.

"Live births per 1,000 women 15-19 years old" declined from a high of 97 births in 1958 to fewer than 59 in 1980. (Kasun, op. cit., p. 1)

** Meanwhile, teenage abortions increased from (about) 90,000 in 1970 to more than 500,000 per year in 1978. (Michael Schwartz and James Ford, M.D., "Family Planning Centers: Cure or Cause of Teenage Pregnancy?", Linacre Quarterly, May 1982, p. 143)

-- Third, clinic backers have focused much of their rhetoric about teen pregnancies on the difficulties faced by girls 11 to 15 years old when they become pregnant and bear children.

** Most births to teenagers, however, "are heavily concentrated among women 18 years of age and older."

"Less than two percent of all births to women under 20 occur" in the 11 to 15 year old age bracket.

"Less than four out of a hundred girls aged 15 to 17, and about one out of a thousand girls under 15 give birth in a typical year. (Kasun, ibid.)

-- In fact, then, two of the major claims of the sex clinic's backers are demonstrably false. First, "children" are not having children; they are aborting them. Second, the majority of "teen pregnancies" occur not among "children" but among young women who are already legal adults, and many of whom are already married.

** More than 500,000 abortions are still being performed annually on U.S. teenagers.

** "In 1972 less than one fourth of all teenage pregnancies ended in abortion, but by 1980 the proportion was 45 percent.

"In some states -- such as California, Massachusetts, and New York -- abortions have recently outnubered live births." (Kasun, op cit., p. 2)

5. But don't these statistics show that it would not only help decrease pregnancies, but help decrease abortions as well, if we provided adolescents with contraceptives in school?

-- No! In fact, the evidence shows just the opposite. Birth control programs evidently just create more pregnancies and more abortions.

-- In October 1980, the lead editorial of Planned Parenthhood's Family Planning Perspectives magazine admitted:

** "More teenagers are using contraceptives and using them more

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consistently than ever before. Yet the number and rate of premarital pregnancies continues to rise." (FPP, 12:5, Sept/Oct 1980, p. 259)

-- Moreover, there was also a "a rise between 1976 and 1979 in the proportion of premarital pregnancies among those who had always reported that they used a contraceptive method." (Melvin Zelnick and John F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979," FPP, Vol 12:5, Sept/Oct 1980, p. 230.)

-- And, as we have just seen (Q. 4, above), there is substantial evidence that the more the states and federal government have spent on teen birth control programs, the greater the number of teen pregnancies has become.

6. So these clinics just don't work as a means of cutting down on teen pregnancy?

-- No, they don't. There is absolutely no evidence that these clinics serve to reduce teen pregnancy. Even the best clinic results in the country can claim only a reduction in birthrates, and not in pregnancies.

** "Whether the decline (at these clinics) was due to a decrease in the number of pregancices, or to an increase in the number of abortions cannnot be discerned." (Asta Kenny, "School Based Clinics, A National Conference," in FPP, Jan-Feb. 1986, Vol. 18:1, pp. 44-46.)

-- "There was no significant change in the pregnancy rate" after three years of operation of a SBC at Muskegon Heights (Michigan) High School. (Muskegon Area PP Report, Muskegon Heights, MI, April 1986)

-- Harvard Medical School researcher Dr. Joanne Cox reports that providing contraceptives and extensive counseling to did not reduce repeat adolescent pregnancies in a program she helped operate in the Boston area.

** "We were naive to think we could alter the repeat pregnancy rate by making contraceptives more accessible." ("Access to Birth Control Doesn't Alter Teen Repeat Pregancy Rate," Pediatric News, Vol 20, No. 1 January 1986

-- "We've been in this business for 13 years and the abortion and pregnancy rate has gone nowhere but up." (Gail Francis, director of a birth control clinic in Virginia, in Washington Post, April 30, 1980.)

-- A "Main Street" program broadcast on prime time by NBC as a propaganda ploy for these clinics (June 16, 1986) had to use the phrase "a reduction in birthrates" and not in pregnancies in lauding these clinincs.

-- Even the highly touted success of a teen clinic in St. Paul, MN can claim absolutely no evidence of a reduced pregnancy rate, but only of a reduced birthrate, which might well be due to an increase in abortions. (FPP, 18:1, p. 45)

** Meanwhile, during the same time of this supposedly highly successful SBC clinic in St. Paul, there was a 13.5% drop in the 15-19

year old population in the state. And thanks to a parental notification/consent law for teenage abortions, there was a 32% decrease in teen pregancies statewide, even in areas where no SBCs were established.

7. But why don't these clinics work?

-- In short, they don't work because teenagers are incapable of the kind of responsiblity necessary to use contraceptives regularly and successfully.

** "Forty percent of the abortions we do are because of contraception that failed." (Vanessa Bedient, Executive Director of Planned Parenthood of Santa Barbara, CA., Santa Barbara News Press, 1/19/86, p. G-1)

** In one study, Planned Parenthood found that 10% of girls using perscription birth control will become pregnant by the end of one year; 24% within two years. (FPP, Jan/Feb. 1984)

** 31.5% of pregnant girls in one PP study were using birth control. (Zelncik/Kantner, FPP, Sept/Oct 1980)

-- Second, teenagers, girls especially, are inherently ambivalent about sexual activity. Hence, it is very difficult to talk them into using contraceptives in advance of actual sexual activity.

** "Because a (young adolescent) girl's genital structures are biologically unready and remain anesthetic to sexual intercourse until much later in life and because her feminine psychology is not completed until late adolescence, the young female has a natural aversion to sexual intercourse.

** "A teenage girl's eroticism may be as intense as the boy's but her desires are not for sexual intercourse, and usually involve fantasies and dreams, kisses and carresses, the wish to love and be loved and sometimes thoughts of having a child."

** Dr. Melvin Anchell, M.D., (psychiatrist), "A Psycholanalytic Look At Today's Sex Education: A Guide For The Perplexed," a report to the Project Sex Respect state conference, Emeryville, CA, May 17, 1986. Cf., also, Anchell, "Psychoanalysis vs. Sex Education," National Review, Vol. 37, No. 1, June 20, 1986, pp. 33,38.

-- Third, pregnancy frequently results in a conscious, or even a subconcious effort to keep a relationship from falling apart.

** "Perhaps as many as 40% of the girls we counsel got pregnant just before or just as a relationship was breaking up. They thought it was a way of bringing clarity to the relationship, and of keeping it going.

** "Sometimes they don't realize their motives until they've had some counseling, but very often, subconsiously they wanted to get pregnant."

** Sr. Paula Vandegaer, M.S.W., Editor, The Living World Magazine, 20 years psychological counseling in teen pregnancy.

-- Fourth, "for many girls in an economically deprived environment, pregnancy is a way to gain maturity and independence." (Dr. Joanne Cox, ibid.)

8. But isn't it better to reduce at least a few teen pregnancies by getting as many students as possible to use contraceptives regularly?

-- No, it is not!

-- First, SCHOOL SEX CLINICS ARE INHERENTLY SELF-DEFEATING because they help increase the very thing they are trying decrease: teen pregnancy.

** Offering teens free access to contraceptives in school, behind their parents' backs and with no effort to discourage sexual activity, puts a direct stamp of public approval on pre-marital teen sex. Such "here's a pill just don't get pregnant" clinics thus encourage and foster even more teens to become sexually active.

** "The proportion of U.S. teenage women residing in metropolitan areas who had premarital sexual experience rose from 30 percent in 1971 to 43 percent in 1976 and to 50 percent in 1979." This is the same time period in which the federal government was vastly increasing its expenditures on family planning. (Zelnick and Kantner, FPP, p. 230.)

** The frequency with which sexually active teens have intercourse has also risen dramatically since contraceptive programs for teens began in 1970, from an average of about once a month to up to five or six times a month. (Cf., Schwartz/Ford, op. cit., p. 144.)

-- Handing out contraceptives in school may help avoid some pregnancies, but by encouraging more and more teens to become sexually active more and more often, these clinincs also cause more pregnancies because they increase the number and frequency of teen sexual activity. By giving the stamp of adult approval to premarital sex, they also increase peer pressure on teens who would otherwise remain abstinent.

-- This is the central reason why these clinics do not and cannot show a decrease in pregnancies no mater how hard they work to provide "contraceptive education." The harder they work, the more pregnancies they cause.

-- "Hundreds of thousands of unplanned pregnancies are inevitable even for couples using contraceptives. ... Young couples, and couples merely trying to delay pregnancy, have failure rates considerably higher than average." (Zero Population Growth pamphlet, "15 Things You Should Know About Abortion.")

-- Second, EARLY AND REPEATED SEXUAL ACTIVITY CAN BE MEDICALLY DANGEROUS for adolescents.

** The link between early and repeated sexual activity and cervical cancer "has been confined to medical journals" but it is an increasingly well documented medical fact which is of "critical importance" for teenage girls to know about. (Rhoda L. Lorand, Ph.D., Psychology, "Betrayal of Youth," Journal of New York State School Nurse Teachers Association," 1979.)

** "Facts appearing in British and American medical journals are being streened out in what is presented to parents and teenagers." (ibid.)

** "This information would strengthen the backbone of (even the most) ultra-modern parents whose greatest dread is to be considered old fashioned." (Jack Mabley, columinist for the Chicago Tribune, March 1979)

-- Third, SEXUALLY TRANSMITTED DISEASES ARE EPIDEMIC in the U.S.

** "The reported incidence of gonorrhea among teenage women almost doubled between 1971 and 1980." (Kasun, op. cit., p. 3; cited from A.L.L. About Issues, Vol. 6, No. 5, May 1984, p. 28, based on reports by the U.S. Center for Disease Control)

** "Chlamydia is the most damaging STD (sexually transmitted disease) and the most prevalent," said Dr. Eugene Washington. Between 3 and 4 million women in the U.S. have a chlamydia infection each year.(A.L.L. About Issues, May 10, 1985, p. 5)

** "Teenagers appear to be at the greatest risk for chlamydia," particularly inner city youths with multiple heterosexual partners. (ibid.)

** Dr. James O. Mason, M.D., Dr. P.H., director of the Center for Disease Control, estimates that the annual costs of STD's are between $2 and $3 billion. One seventh of the CDC budget is devoted to STDs. (ibid.)

** AIDS now poses an increasing threat to heterosexual women. "Up to 20%" of the cases of female AIDS patients now appear to be the result of heterosexual sexual contact. (Newsweek, July 14, 1986)

** "While gonorrhea and syphillis rates dropped in 1984, incidence of carcinoma of the cervix, pelvic inflammatory disease (PID), herpes and ectopic pregnancies are rising" according to CDC statistics. (A.L.L., ibid.)

-- Some barrier methods of contracpetion like condoms and diaphragms may help lessen the chance of sexually transmitted diseases, but they are even less reliable in the hands of teenagers than the pill.

-- "It is the women and children of our society who pay the price of sexually transmitted diseases," says Dr. James O. Mason, M.D., Dr. P.H., director of the Centers for Disease Control. "Sometimes I wonder why the female population doesn't stand up and scream about this." (A.L.L., ibid.)

-- Fourth, CONTRACPETIVES ARE DANGEROUS for teenage girls.

** The pill predisposes girls to pelvic inflammatory disease (PID), sexually transmitted diseases, endrometrial and breasts cancer, liver tumors and gallbladder stones.

** The pill is a powerful artificial hormone which throws the entire endocrine system out of balance, causing blood clotting disorders.

** The pill is a powerful artificial hormone which cannot be metabolized by the liver, causing tumors and also thyroid changes and blood clotting.

** Such hormones also greatly complicate the physical development of teenage girls whose bodies are already struggling to deal with a massive surge of natural hormones during puberty and adolescence.

** The pill adversely affects and depresses pituitary and endrocine functions before they are mature.

** It is not uncommon for a teenage girl not to menstruate for 6 months after discontinuation of the pill and to require up to one year for ovulation to resume.

** (Taken from Dr. Espinoza, Why Are They Lying to Women, and Dr. Hillebrand, nationally recognized expert on the pill and the IUD.)

** Research funds for contraceptive technology has fallen dramatically among drug companies because of massive law suits on behalf of women injured or killed by contraceptives.

"The A.H. Robins Co. filed for bankruptcy after being assesed $395 million in legal judgement and settlements for its Dalkon shield IUD ... (which had resulted) in 21 deaths." ("Contraceptives: On Hold," Newsweek, 107:68, May 5, 1986.)

** 500 women die annually from taking the pill. (Making Choices, Alan Guttmacher Institute, 1983. AGI is the "research" arm of Planned Parenthood.)

-- Fifth, ABORTION IS NOT A "SAFE" ALTERNATIVE.

** Abortion is the 6th leading cause of maternal death according to the Center for Disease Control in Atlanta.

** In a first pregnancy, abortion can cause permanent damage to the muscles of the cervix, causing up to double the rate of miscarriages in future (wanted) pregnancies. (Richards/Dickenson, "Effects of Legal Termination on Subsequent Pregnancy," British Medical Journal, Vol 1, pp. 1303-4, 1976.)

** For teenagers, the increased risk in subsequent pregnancies due to an abortion on the first pregnancy grows substantially.

"The cervix of the young teenager, pregnant for the first time, is invariably small and tightly closed and especially liable to damage upon (forced, aritificial) dilation (by doctor's instruments during the abortion.)

"(Follow up studies on a control group of 50 aborted teens) showed the rather dismal results of 19 spontaneous miscarriages, 1 stillborn, and 6 infant deaths between birth and two years among 53 subsequent pregnancies."

(J. Russell, "Sexual Activity and its Consequences in the Teenager," Clinics in OB, GYN, vol 1., No. 3, Dec. 1974, pp. 683-698.)

** The rate of life-threatening ectopic (tubal) pregnancies has increased 300% in the United States since the legalization of abortion in 1973. (U.S. Dept of Health and Human Serivces, Morbidity and Mortality Weekly Report, Vol. 33, No. 15, April 20, 1984.)

"If the abortionist's currette cuts or scrapes too deeply across the opening of the tubes, there is scar formation, and often (partial) blockage (resulting in an increased chance of tubal pregnacies in the future)." Wilke, Abortion: Questions and Answers, p. 104).

"437 U.S. women died from ectopic (tubal) pregnancies from 1974 to 1983." (Medical Tribune, Jan. 26, 1983)

** Women who have had previous abortions experience a "seven to fifteen fold increased prevalence of placenta previa" in future pregnancies. (Barret, Et. al., "Induced Abortion: A Risk Factor to Placenta Previa," Amer. Journ. OB/GYN, Dec. 1981, pp. 769-772.)

** Permanent sterility is also a risk from an induced abortion.

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"The relative risk of secondary infertility among women with at least one induced abortion and no spontaneous miscarriages was 3-4 times that among non-aborting women." (D. Trichopoulos, et. al., "Induced Abortion and Secondary Infertility," British Journal OB/GYN, Vol. 83, Aug, 1976, pp. 645-650.)

** Among the immediate risks of teen abortion are:

Infection. "Occurence of gential tract infection following an elective abortion is a well-known complication," with rates of up to 19% for second trimester abortions. (Burkman, et al., "Culture and Treatment Results in Endometritis Following Elective Abortion," Amer. Journ. OB/GYN, 128:5, 1977, pp. 556-559.)

PID (Pelivic Inflammatory Disease). PID is one of the most common forms of infection to strike a teenager having an abortion. (British Jour. of Venereal Disease, June 1982, p. 182.)

Perforation of the Uterus.

Tearing of the Cervix.

Hemorrhaging. Up to 9.5% of aborting women need a blood transfusion (J.A. Stallworthy et al., "Legal Abortion: A Critial Assessment of its Risks," The Lancet, Dec. 4, 1971). Among possible complications of a blood transfusion are the transmission of viral hepatitis (in up to 10% of transfusions, Amer. Assn. Blood Banks and Amer. Red. Cross Circular Information, 1984, p. 6), and, increasingly, AIDS.

** Free standing abortion clinics (ie., those not connected with hospitals) are almost totally unregulated in the U.S., and have a safety record much worse than all the averages reported above.

** All of these complications and later consequences increase dramatically after multiple abortions

"After one legal abortion, premature births increase by 14%; after two abortions it is 18%; after three, it increases to 24%. (Klinger, "Demographic Consequences of Legalization of Abortion in Eastern Europe," Internatl. Jour. GYN & OB, Vol. 8, 1977, p. 691.)

** (Data collected in Dr.and Mrs. J.C. Wilke, Abortion: Questions & Answers, Hayes Publishing Co., Cincinnati, 1985)

PART II
SCHOOL SEX CLINICS: FINANCIAL AND LEGAL IMPLICATIONS

1. Where will the money come from to run these clinics?

-- Initially, much of the money for starting up such clinics comes from large private foundations which are heavily involved in "population control" ideology and programs.

** Over $36 million dollars has been targeted by major foundations in the United States for the promotion of School Sex Clinics in 1986-87. (New York Times, May 19, 1986).

** The Robert Wood Johnson Foundation, the nation's largest private philanthropy, expects to provide $16.8 million over the next six years to school based sex clinics. (ibid.)

** The Carnegie Foundation will spend $4 million in two years. (ibid.)

** The Kaiser Family Foundation in California is planning to spend $15 million dollars on "teen age pregnancy." (ibid.)

-- Once schools and communities are hooked on these clinics, however, it will fall to taxpayers to fund these clinincs.

** "Although private funds have played an important part in starting up these programs, almost all of the school programs look to public support for continuation," says Planned Parenthood. (Dryfoos, FPP, 17:2, March/April 1985, p. 73.)

2. How much do these clinics cost?

-- Estimates are that these clinics quickly become very expensive.

** The clinic in St. Paul, MN aparently ran up a $100,000 deficit in the 1984 school year. (Report of Dr. John Stremple, Fresno Superintendent of Education, public school board meeting, April 10, 1986)

** Estimates by one physician are that implementing these clinics in the Los Angeles City School District alone would cost $15 million dollars annually. (Jay Lawrence Sugarman, M.D., "Contraception Clinics at L.A. High Schools," L.A. Times, Mar. 1, 1986)

-- Some programs run as high as $1.9 million annually. The former administrator of a clinic in St. Paul estimated $90,000 per school per year. Others have estimated $100 per pupil per year. (Dryfoos, ibid.)

-- Even from the start, and with foundation support, schools must provide space, light, heating, and other services in kind.

3. What is their cost effectiveness?

-- By Planned Parenthood's own admission, there is absolutely no evidence whatsoever that these clinics are cost-effective.

** "Cost data for school-based clinics are rough estimates only, so their cost-effectiveness is not proven." (Dryfoos, op. cit, p. 75.)

-- In any event, we know that no matter how much money is spent, these clinics will never be cost effective because, by actual experience over 13 years, we find that teen birth control programs have only served to make matters worse.

-- The current, and potential cost of sexually transmitted diseases, which have increased right along with increased spending for teen birth control are potentially catastrophic.

** 20 million American now have incurable genital herpes, which regularly causes great financial loss in lessened or lost work time effectiveness when flare-ups of this painful disease occur.

** Estimates of the cost to fight the AIDS epidemic which threatens the U.S. run into the billions of dollars. With more and more women contracting AIDS (Newsweek 7/14/86), casual resort to sex can no longer

be considered "free."

4. What are the liability costs involved?

-- These may be the greatest costs of all

-- Schools that dispense contraceptives to students may be held financially liable for venereal disease, sexually transmitted disease, or physical or emotional trauma for a botched abortion conducted without parental knowledge.

-- Schools may be held accountable for "wrongful births," physical side effects of contraceptives, or even the death of a teenage girl from use of the pill either by itself or in combination with other medications the girl is using which the clinic operators have failed to discover.

-- Insurance costs for such clinics would skyrocket after the first successful suit by outraged parents or injured children.

** At present (July 1986) the Thermalitos (CA) School district and one of its teachers is being sued for more than $6 million by a parent whose daughter obtained an abortion without the parent's knowledge or consent. The parent discovered that a teacher assisted her daughter in obtaining an abortion, and the daughter later hemorrhaged severely .

-- Some clinic backers have claimed that because many of these clinics are run by non-school personnel (ie., Planned Parenthood employees), that the school will have no liablity.

** But, in fact, "while the child is at school or participating in a school activity, the school has a duty to the child to exercise due care for the child's welfare. ... (The) intervention of well-meaning third parties will not necessarily relieve the school of liability if the school was negligent in not being prepared to provide reasonable assistance to the child."

** William B. Smith, J.D., American Bar Association, Chicago, JAMA, 255:17, May 2, 1985, p. 2357

5. What are the legal implications of School Based Sex Clinics?

-- California Sex Education Code, Sec. 61650, requires written permission from parents before any information may be solicited from a pupil about the pupil's or his parent's beliefs or practices in sex, family life, morality or religion.

** Sex clinics would regularly and egregiously offend against this law.

-- Penal Code 261.5 states that sexual intercourse is unlawful with a minor female under 18 years of age, and carries with it a penalty of 3-8 years in jail.

** Hence, "school personnel who facilitate sexual intercourse" by providing the wherewithal for a minor girl of less than 18 years old to have sex (via contraceptives) could be looked upon as violating Penal Code 272, contributing to the deliquency of a minor, endeavoring or inducing minors to commit illegal acts or conduct whcih incurs penalties

of $2500 and one year in jail.

-- The California State Constitution, Art. IX, Sec. 1 states that legislative policy dealing with education must be to promote the intellectual, scientific, moral and agricultural improvement of the people.

-- Report of Mr. Thomas Burton, Esq., Sex Respect State Conference, Emeryville, CA, May 17, 1986

-- Although it obviously does not matter to backers of these clinics, the entire effort is at odds with some of the most basic California laws regarding schools and minor children.

PART III
SOCIAL AND POLITICAL IMPLICATIONS

1. What are the possible consequences for public schools of the establishment of such clinics?

-- Backers claim that such clinics would aid schools by helping students with their medical needs, but they are badly mistaken.

-- Frist, the clinics represent a danger that more and more parents with strong religious convictions will take their children out of public schools to enroll them in religious schools, even if such schools were of a lesser quality academically.

> ** "At some stage during the program, parents with strong religious convictions will pull their children out of public schools, leaving public schools increasingly the educational servant of children from unstable homes, broken homes, or no homes at all.
>
> "When enough families have abandonned public schools for religious schools, pressure for educational vouchers will become irresistable. The courts, reading the signs of the times, will declare this constitutional.
>
> "Public schools .. will see the quality of their students delcine and their resources diverted" by a citizenry grown hostile to its projects.
>
> (Report of Professor Terrence J. Hughes, University of Maine at Oronto, to the Governor's Task Force on the Prevention of Adolescent Pregnancy and Parenting, Maine Dept. of Human Services, 4/7/86)
>
> ** "This is obviously a local decision. But I would say this to any locality considering it -- you had better be sure, really sure, that you have consulted fully and thoroughly with parents. Otherwise you may find that you have created a full enrollment policy for private schools."
>
> Sec. of Education William Bennett, "Bennett Critiizes Birth-Control Clinics," Washington Post, 4/12/85.

-- Second, such clinics undercut one of the most basic purposes of any educational system: to instill moral values which encourage the sacrifice of

short term pleasure for long term gain, and individual satisfaction for the wider good of family and society.

** School based birth control clinics represent "an abidication of moral authority" on the part of schools which damages their entire ability to instill in students those character traits necessary for achieving a good education. (Sec. of Education William Bennett, ibid.)

2. What are the implications for parents?

-- They are, in a word, frightening.

-- Faye Wattleton, President of the American Planned Parenthood Federation, says that American Society is too "prudish."

** That is the reason that so many parents oppose Planned Parenthood's attempts to put birth control clinics on high school campuses, Wattleton told a 60 Minutes television audience, April 6, 1986.

We need to be more like the Scandanavian countries, she said, which hand out contraceptives to teenagers at will. (And also have rampant pornography; birhtrates declining so catastrophically[1] that they are in the process of committing "demographic suicide," as Pope John Paul II has put it; as well as legalized euthanasia, common infanticide of the handicapped, and a host of other "advanced" social policies.)

Parents are also unable to educate their children properly about sexuality at home, Wattleton said, so that the schools must "take over" such education for them.

-- The ultimate goal of the backers of these clinics is not just to prevent teen pregnancy, then, but to indocrinate American children is a destructively selfish, casual, amoral view of human sexuality, in order to overcome the "prudishness" of their parents. (Cf., below, Part V: The Psychological Implications of More Sex Education: A Dangerous Coverup for a Costly Failure.)

-- It is always the intention and policy of the backers of these clinics to rigorously exclude parents from all information regarding their child's use of these clinics.

** "These clinics work because they are confidential. Students learn that what happens and is said in the clinic stays there."

Report of the St. Paul Adolescent Health Services Project, Maternal and Child Health Program, St. Paul-Ramsey Medical Center, Room 321 - North Building, 640 Jackson Street, St. Paul, MN 55101.

** In California, of course, since there is no law requiring parental notification / consent for teen abortions, nor any requirement for prior approval of the provision of contraceptives, parents would be easily excluded from being informed of what "medical services" were provided to their children in these clinics.

** Cf, also, Part IV, Q. 3, below.

3. What are the implications for our children?

-- They are deadly.

1. Cf. "Rich Nations Have Population Problems," Futurist, 19:61, Oct. 1985

-- Suicide among American teenagers is rampant. 20 million people between the ages of 15 and 34 now suffer incurable genital herpes. Chlamydia, Pelivic Inflammatory Disease (PID), and other sexually transmitted diseases are already a a crisis and already cost up to $4 billion dollars a year to American society.

-- Increasing numbers of people in their late teens and early twenties will never marry, studies show, because they have lost the ability for true emotional intimacy because of constant, frequent sexual intercourse with multiple partners during their teen years.

** "Esteem and affection for the sex partner are essential if human sexual needs are to be fulfilled. When affectionate needs are not met during sexual intercourse, frustrations result.

"A buildup of these frustrastions can result in mental anxiety and depression.

"And, indeed, in the past twenty years or so, the number of adolescents admitted to hospitals for depression has tripled, and adolescent suicide has increased 200 percent."

Anchell, National Review, 6/20/86, p. 60.

-- With teenage abortions running as high as 500,000 per year, and many of these abortions for girls who are having their second or third abortion, the number of teenage girls who face life threatening infections, inablility to bring future ("wanted") pregnancies to term, and permanent sterility is massively increasing.

** In Czechoslovakia, which has had a high (legalized) abortion rate for several decades now, premature biths resulting from previous abortions are so frequent that a woman who has had several abortions and who becomes pregnant again is examined, and:

"If the physician can see scar tissue, they will sew the cervix closed in the 12th or 13th week of pregnancy. the patient stays in the hospital as long as necessary which, in some cases, means many months."

("Czechs Tighten Reins on Abortion," Medical World News, 106 J, 1973; cited in Wilke, op cit., p. 113).

-- All of these social, emotional and medical disasters have occured simultaneously with 20 years of exactly the kind of thing now being pushed further by these school clinics: "free" sex; casual and amoral sex; frequent and uninhibited teen premarital sex; increased government expenditures for birth control programs, even ones aimed at teens (remember, federal courts struck down the so-called "squeal rule" -- which would have required local health agencies to inform parents of the provision of contraceptives for their teenage children -- several years ago now); sex education which implicitly mocks heterosexual monogamy as the healthy norm.

** The policies advocated by school clinic backers are not new. They are just more of the same old failed disasters.

** "Some of the blame for this (rapid) decline in adolescent mental health must fall on the carnal attitudes toward sex, as well as premature sexual activity encouraged by contemporary sex education. ...

"Sex educators seem to be unable to understand that their own programs are partly responsible for the pregnancies, abortions, perversions, suicides, and psychological as well as venereal disease that are epidemic in todays's youth." (Dr. Anchell, ibid.)

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PART IV

SCHOOL BASED SEX CLINICS: SUPPORTERS AND OPPONENTS

1. Who are the major backers of these clinics?

-- As we have seen, (Part I, Q. 1,2; Part II: Q. 1), these clinics are proposed and backed almost exclusively by the family planning / population control / abortion / elitist social planning industry.

** Major foundations will pour $36 million dollars into starting (and not continuing) the financing of school based sex clinics in 1986-87. (NRL News, Vol. 14, No. 11, 6/12/86, p. 1.)

** All these foundations insist that the clinics must provide birth control services if they are to receive foundation grants:

** "These services must include ... on-site consultation as well as referral and follow up for pregnancy, chronic diseases and disorders, and emotional and mental problems; ... on-site care and referral care for drug and alcohol abuse and sexually transmitted diseases; ... effective services aimed at pregnancy ... ." ("The School-Based Adolescent Health Care Program," Robert Wood Johnson Foundation, 111 Michigan Ave. NW, Washington, D.C. 20010).

-- Zero Population Grwoth, the Population Council and other anti-people "population control" groups have targeted the teen population of the U.S. for a massive injection of contraceptives by means of these clinics.

** The Center for Population Options sponsored both the first and second National Conference(s) on School Based Health Clinics, in Houston, Tx, Sept. 28-30, 1984, and in Chicago, IL, Oct. 9-12, 1985.

2. What are some of the other "front" organizations for this movement?

-- The Children's Defense Fund, Education Training Research Associates (Santa Cruz, CA), the Family Life Education Council, the Support Center for School-Based Health Clinics (a front for the Center for Population Options) and others.

-- Unfortunately, even some "mainline" organizations like the March of Dimes and the American Red Cross have gotten caught up in this boondoggle for the family planning industry.

3. But can't these groups be trusted?

-- Sadly, on this issue, they cannot.

-- Readily available printed material shared by backers of these schools reveal a pervasive pattern of deception on the part of those trying to force these clinics into public schools: behind parents' backs if possible, over their heads, if necessary.

** "Initially, maintain a low profile. After the clinic is set up,

find reporters that support the clinic and prepare for them news releases which foucs upon the comprehensive health care of the clinic, its acceptance (and) ... its success ... .

"Beware: some reporters may try to focus on the most controversial aspects of the clinic such as providing contraception."

Center for Population Options brochure on How To Start a School Based Clinic, available from The Support Center for School Based Health Clinics, 1012 14th St. N.W., Suite 12000, Washington, D.C. 20005.)

** In some clinics, the contraceptive aspect of the program has been omitted from the first year or two of the clinic's operation, then later added once the public debate over the clinic had ended, and public attention turned elsewhere. This tacitic was recommend for consideration by Planned Parenthood in its official publication. (Kenny, FPP, 18:1, Jan/Feb 1986, p. 45.)

** Consistently throughout the country, a "blue ribbon" advisory panel is set up to investigate what should be done about teen pregnancy. These panels are always stacked with Planned Parenthood operatives, clinic supporters, and people with contacts in the population control industries.

In San Diego, the advisory panel voted 23 to 3 in favor of the clinics, even though public reponse to the proposal was overwhelmingly negative, and letters ran 20 to 1 against the clinic. Public outcry finally lead the school board to vote down the proposed clinics on 7/9/86.

** The real agenda of the clinics is often supressed, soft-peddled or hidden from parents in the initial planning stages.

In San Jose, CA, the principal of San Jose High School sent home a "Parental Survey" in late 1985 asking parents opinion about a possible "free medical clinic at San Jose High." In the questionaire for the parents, the possiblity of the clinic dealing with "assistance to protect against pregnancy" was mentionned only once, near then end of list of "possible services" to be offered. In the questionnaire for the students, however -- marked "Confidential" at the top -- there wre four sets of questions about sexuality, sexual activity and pregnancy "services."

** Clinic operators repeatedly assert the necessity of going to school boards and directors first, and securing their approval, before involving even school principals and teachers, much less parents.

** See also, Part I, Q. 2.

4. Who opposes these clinics?

-- First, PARENTS oppose school based "health" clinics.

** Not one clinic in the country has been established at the instigation, or demand of parents. Virtually all originated at the suggestions of outsiders.

** All of them have been vigorously opposed by parents once started, or -- if parents heard about them in time -- when they have been proposed.

** "Plans for a school health clinic (in San Diego) fell victim to a

wave of public outcry and were voted down by the San Diego School Board, despite proponents' assurances the clinics wouldn't promote teenage promiscuity." (Associated Press report, quoted in "Parents Block Plans For School Clinic," Fresno Bee, 7/10/86, p. B-2)

** Parents in Chicago, IL launched a major protest when it was publicly reported that a clinic at DuSable High School was dispensing contraceptives. After coming under "strong pressure to reconsider its earlier approval of the clinic," the Chicago School board voted "by a one-vote margin" to "permit the clinic to continue dispensing contraceptives, but also directed the superintendent of schools to prepare guidlines for school clininc." (Kenny, FPP, 18:1, p. 44)

** A bill proposing such clinics was withdrawn from the Delaware State Legislature in late May 1986 after a wave of public protest convinced leading government officials that the public was opposed. (Delaware Right To Life News, June 1986.)

** More than 100 parents at a meeting of the Hollywood High School Community Advisory Council in Los Angeles voted 4 to 1 against a proposed clinic at their school after a Feb. 20, 1986 public debate on the issue. (The Tidings, 2/28/86)

** Parents in the Anacostia section of Washington, D.C. forced school board members to withdraw a proposed clinic in their high school when they discovered that its major purpose was to dispense contraceptives and refer for abortions. (Raspberry, Washington Post, 4/14/86, p. A-13)

** A major controversey erupted in New Gloucester (near Portland) MA, when a mother discovered "graphic sexual material that was originally distributed to a junior high teacher to six eight grade girls in a counseling session on sexual issues." (Portland, Maine, Evening Express, 3/20/86)

-- Second, RELIGIOUS LEADERS oppose these clinics.

** The Roman Catholic Bishop Leo T. Maher of San Diego sent a letter to be read from the pulpits of all the parishes in his diocease, condemning a proposed health clinic as an ill-disguied effort to "find an apparently legitimatized means of providing pregnancy counseling, contraceptives, and abortion counseling for teenage students.

** "Offering contraceptives or abortions to high shoool children is inherently evil, for it tactily encourages them to act promiscuously. It clearly suggests to them ... to behave as though they were married adults, without any awareness of the responsibilities of adulthood or marriage," Maher said. (The Tidings, 4/11/86).

** Bishop Maher also endorsed a "one-day boycott of city high schools to protest the proposed clinic" in San Diego. (Los Angeles Times, 5/24/86, Part II, p. 3)

** Rev. Louis Sheldon, Chairman of the California Coalition for Traditional Values, has condemned the clinics as an attack on the most basic institution of society, the family. (Cal. Coal. Trad Val., 100 S. Ahaheim Blvd., Suite 320, Anaheim, CA 92805)

** Pastor Louis Mimms, of Faith Tabernacle Baptist Church in the South Central (Watts) section of Los Angeles, co-founder of "Parents And Students United of Los Angeles" as a broad-based coalition organized to

fight a proposed series of clinics in Los Angeles: "We know these things are aimed at our people, and we're going to do our part to help fight them."

** Archbishop Roger R. Mahony, Roman Catholic Archbishop of Los Angeles, wrote to Governor George Dukemejian (6/22/86) "urgently" requesting that the Governor delete from the (CA) state budget the "entire $300,000 Planned Parenthood budget for school based clinics." "This appropriation only continues to promote sexual irresponsibility on the part of our young people, rather than teach them sound moral values and moral responsiblity." (The Tidings, 6/27/86, p. 1)

Third, the REAGAN ADMINISTRATION and CONGRESS have opposed these clinics and the philosophy which underlies them.

** Congress, in its Title XX regulations, "Adolescent Family Life Demonstration Projects," to the Public Health Services Act, found:

** "Prevention of adolescent sexual activity and adolescent pregnancy depends primarily upon developing strong family values and close family ties ...; (hence) programs designed to deal with issues of sexuality and pregnancy will be successful to the extent that such programs encourage and sustain the role of the family in dealing with adolescent sexual activity and pregnancy." (Sec. 2001.(a), 10 (A).)"

** "Services encouraged by the federal government should promote the involvement of parents with their adolescent children, and should emphasize the provision of suport by other family members, religious and charitable organizations, (and) voluntary organizations." (Sec. 2001.(a), 10(C).)

** Secretary of Education William J. Bennett has called these clinics "an abdication of moral authority" which undermines the whole educational process. Such clinics give young people the wrong signal by indicating that adults and school authorities "are acknowledging as commonplace what ought not to be commonplace.

"Birth control clinics in school may prevent some births, that I won't deny. The question is: What does it teach (to the students)? What lessons does it teach? What attitudes does it encourage? What behaviors does it foster? ... (Clinics are) a classic bureaucratic response; ...a response which is highly questionable, if not offensive." (Bennett, Washington Post, 4/12/86)

"I believe there are certain kinds of surrender that adults may not make declare in the presence of the young. One such surrender is abdication of moral authority. Schools are the last place that should happen." (Bennett, Washington Post, 4/14/86, p. A-13).

** Secretary of Health and Human Services Otis Bowen has launched a campaign "to combat teenage pregnancy ... that focuses on discouraging sex among unmarried youth, rather than providing information on contraceptives." (Wall Street Journal, 3/26/86)

A HHS Dept. report prepared for Sec. Bowen says, "(The focus will be on) encouraging unmarried teens not to be sexually active. ... We do not want to give, directly or subliminally, a message condoning abortion or 'safe sex.'" (ibid.)

** "Basically, we think it's a terrible idea," says Education Undersecretary Gary Bauer about the school based sex clinics. (ibid.)

Fourth, NEWSPAPERS and SYNDICATED COLUMNISTS oppose these clinics.

** The Chicago Tribune: (These clinics) could be construed as a signal of approval for promiscuous behavior, although the clinic staff argues that promiscuous behavior is already a fact of life. (They) could reduce the number of pregnancies ...; but (they) also seem to tell minors that responsible behavior means, not the exercise of restraint, the hallmark of a civilized human being, but the use of condoms and pills." (Editorial, 9/18/85)

** The San Diego Union: "For starters, the use of contraceptives is a highly personal matter that ought to be left to the students and their parents. ... (Second), however limited its involvement, the school would be sanctioning premarital sex among students." (Editorial, 12/27/85)

"(A clinic) will be seen as societal approval for student sex which will inevitably increase peer pressure on thoe who would otherwise refrain." (San Diego Union, Editorial, 3/14/86)

** The Pittsburgh Courier, the largest black owned newspaper in the U.S.: "Once again, the black community has been targeted for control, decimation and ultimately the destruction of black family traditions and black life. ... Most disturbing is the way the ramrod approach being used by the task force to implement these school-based birth control clinics. Its meetings and discussions have been held outside the purview of the community and have been without community input." (Editorial, "Semantics Aside, Black Community Target of 'Sex Clinics,'" 5/17/86)

** William Raspberry, syndicated coulmnist: "Which view makes more sense: pragmatism in the face of a serious national problem or an effort to hold fast to basic moral standards? ...

"The Rev. Willie Wilson, whose Anacostia church runs one of the city's best youth programs was against the idea. 'Overall health care is positive,' he said, 'but providing contraceptives of any sort condones what we know to be the spirit of the times, which is one of free sex. Contraceptives will not solve the problem. It may even expand the problem.' ...

"Are we ready (to assume that merely avoiding consequences is better than dealing with the real problem)? ... Well, some of us aren't. Some of us will insist, with (Sec. of Ed.) Bennett and Rev. Wilson, that when it comes to sex, the only acceptable instruction the adults can offer to adolescents is: Don't." (Washington Post, 1/14, 86, A-13).

PART V:
PSYCHOLOGICAL IMPLICATIONS OF "MORE" SEX EDUCATION: A DANGEROUS COVER-UP FOR A COSTLY FAILURE

1. Even though opponents of these clinics say they don't work and actually make matters worse, don't we need to have some kind of sex education in our schools to deal with this problem of teen pregnancy?

-- Yes we do. But not the kind proposed by the backers of school-based sex clinics.

2. What's wrong with the kind of sex education promoted by Planned Parenthood, the Center for Population Options and other clinic backers?

-- Sex education as organized and run by Planned Parenthood is not only completely amoral, anti-family, and medically dangerous and irresponsible. It is contradicted by the most basic insights about human sexual development of modern psychology as well.

3. What do you mean, Planned Parenthood's sex education program is amoral?

-- Planned Parenthood's sex education program, widely used and promoted in our public schools, drumbeats the idea that there are no moral considerations whatsoever involved in sexual activity.

** "Do what gives you pleasure and enjoy what gives pleasure and ask for what gives pleasure. Don't rob yourself of joy by focusing on old-fashioned ideas about what's 'normal' or 'nice.' Just communicate, and enjoy." ("The Great Orgasm Robbery," a pamphlet for teens from Rocky Mountain Planned Parenthood, 1852 Vine St., Denver, CO 80206)

** "If you're not suppposed to go after a girl for sex, what are you supposed to do? Well, firstly, you can learn that masturbation is a perfectly acceptable, useful, comforting thing to do with sexual feelings. It cannot possibly hurt you unless you do it in public. You my never feel the need to masturbate, and you may feel the need to masturbate a lot. Both conditions are normal." ("The Problem With Puberty," pamphlet available through Rocky Mountain Planned Parenthood, Denver, CO)

** "If pregnancy happens ... call Planned Parenthood. If you are pregnant, you have several alternatives: you can have the baby and keep it; you can have the baby and give it up for adoption; or you can have an abortion. Planed Parenthood will help you with whatever you decide." "Decisions About Sex," published by Planned Parenthood of Westchester, Inc., 88 East Post Road, White Plains, NY 10601

** In the book Changing Bodies, Changing Lives, by Ruth Bell and Planned Parenthood associates, students are instructed on how to have oral sex (pp. 96-97), masturbate (82-83), how to have sexual intercourse (pp. 98-99), techniques to reach sexual orgasm (pp. 82-83), and that the more sexual partners they have, the more they "learn" about sex. (p. 94).

The book also contains a morally indifferent section on lesbianism, as well as pictures of nude teenage boys sunbathing and girls comparing breast size, and the like.

This book has been widely used in public high school sex education classes. Because of public outcry, Planned Parenthood itself does not distribute the book readily from its offices. Copies for examination can be had through the library of the California Office of Family Planning (which has used the book), 3250 Wilshire Blvd., Los Angeles, CA

-- Second, Planned Parenthood formulated sex education programs for schools regularly disparage religious or moral considerations regarding sexuality.

** At Enka High School in Candler, NC, the sex education class to the 10th grade was run by the Western Carolina Abortion Clinic!

"The young kids were told that abortions were a means of birth control. ... The kids picked up and went over female birth control devices, which was very offensive to the class. The abortion clinic gave their prices, the days and hours they are open for business, and (even said) transportation would be provided, if needed," reported Mr. Herschel Ted Anderson, a parent who attended the session.

"There was not one mention of God, home, husband, wife and keeping themselves until marriage and home. These young people were told about their 'sex partners' and how to use contraceptives, etc.," reported Dr. Ralph Sexton, another parent who attended a later session, in a written report to the local school board.

(Schlafly, Phyllis, "Pro-Abortionist Infiltrates Sex Education Course," Human Events, 5/18/85)

4. What do you mean, "Planned Parenthood's sex education viewpoint is anti-family?"

-- Planned Parenthood's "sex education" literature is absolutely barren of references to the procreative, familial or marital aspects of human sexuality and sexual intercourse.

-- Indeed, their literature for teens disparages marriage and the family as an important consideration in sexual matters.

** "Your great grandfather had a combination for life. It was a winning combination. The loser was your great gandmother. ...

"Don't lie to yourself. Decide honestly what you want from your relationships with women. Do you want a convenient warm body? Buy one. That's right. There are women who have freely chosen that business, buy one. Do you want a virgin to marry? Buy one. There are girls in that business, too. Marriage is the price you'll pay, and you'll get the virgin. Very temporarily."

From "You've Changed The Combination," Rocky Mountain Planned Parenthood Publications (RMPP) 1525 Josephine Street, Denver, CO 80206. pp. 3,18.

** There are certain things you don't want to talk over with your parents. There are certain things they don't want to talk about to you, either. ...

"If you think your parents are great, that's wonderful. If you don't get along, that's too bad but its no lifelong tragedy."

("The Perils of Puberty," RMPP Publications, pp. 8,9.

** "The organizers of the week long seminar stressed repeatedly that one of the ways to get Planned Parenthood's type of sex education into the schools was to avoid dealing with parents. They told us specifically to never meet alone with parents, and to 'follow your Teacher Guidelines which parents don't need to see.'"

Report of Mrs. Pat Reihle, Chairperson, American Family Defense Coalition of California, on a weeklong seminar for junior and high school teachers presented by the "Educational Training and Research Associates" of Santa Cruz on teen sex education. This program was funded by a $750,000grant from the California office of Family Planning. Report sent

to members of State legislature, 6/16/86. Copies available from AFDC of Cal., 500 S. Broadway, Suite 245-B, Santa Maria, CA 93454

5. Why do you say Planned Parenthood's sex education program is medically dangerous and irresponsible?

-- Rarely in any of its sex "education" books or pamphlets for teens does Planned Parenthood -- the primary backer, supplier of personnel and materials for these teen "health" clinics -- discuss with adolescents the serious medical dangers associated with various forms of contraceptives.

-- These sex education materials also regularly deny the serious medical and psychological problems which can accompany teenage abortions.

** "Legal abortion is a relatively safe, uncomplicated procedure." (Planned Parenhood of Santa Cruz Family Life Education Guide, 1979.)

** "An abortion is 10 times safer than childbirth for teens." (Planned Parenthood sex education program for northern New England.)

-- This propaganda continues in spite of the massive evidence that contraceptives and abortion present grave medical risks for teenagers.

6. Why do you claim that Planned Parenthood's sex education program is actually contradicted by the most basic psychological data about human sexual development?

-- First, one of the most dangerous apsects of the campaign to implement these clinics is their backers argument that we need "more and earlier" sex education.

-- But "more and earlier" sex education is directly and dangerously destructive to the health of children.

7. What's wrong with "earlier" sex education.

-- "There is a phase of personality development called the latency period, during which the healthy child is not interested in sex. This interval from about the age of five until adolescence serves a very important biological purpose. It affords a child the opportunity to develop his own resources, his beginning physical and mental strength.

"Premature interest in sex is unnatural and will arrest or distort the development of the personality. Sex education should not be foisted on children; (it) should not begin in grade schools." (William MCGrath, M.D., Psychiatrist, Phoenix, Arizona)

-- The backers of health clinics, however, want earlier sex education as a coverup for their utter failure to stem the wave of teen pregnancies by their "here's a pill, just don't get pregnant" sex education in the high schools.

** Planned Parenthood of Northern New England has developed a grammar school "sex education" program which includes the following:

Kindergarten: Children are asked to outline partners' bodies and verbally label all parts, including genitals and buttocks.

Grade 1: Children are read "The True Story of Where Babies Come From," and are asked to "illustrate" where babies come from.

Grade 2: Children review where babies come from, examine different "types" of families.

Grade 3: Diagrams shown of male/female reproductive systems. Children are asked to make models of reproductive organs using ping pong balls, straw, paper cups, yarn and cellophane bags.

Grade 4: Children are told, then asked to describe the act of sexual intercourse, chromosomes, and the process of fertilization.

Grade 5: Pathways of egg and sperm and described. Mensturation and resproductive systems are described. Children told about contraceptives. "If a female does not want to be pregnant, she can either not have sex or use birth control when she does."

Grade 6: "Dear Diary" movie shown, with questions like, "What are some of the causesof that tingly feelings in the vulva region?" "Do girls masturbate?" Children are also told (in a book) "masturbation is a normal acitivity for males and females of all ages. It means touching, caressing, stimulating one's gneitals. ... Masturbation is one of earliest and most effective ways for children to learn about their bodies."

-- Ironically, and very dangerously, Planned Parenthood and the school based sex clinic lobby are about two decades behind the times in terms of psychological knowledge and development.

** "Twenty-five years ago, I and many other child analysts might have enthusiastically endorsed school sex education ... because we believed at that time that emphasis on sexual knowledge could do no harm, only good.

"We have since learned that it is harmful to force sexual preoccupation on children in the elementary school grades. ... Forcing sexual preoccupation on the elementary school child is very likely to result in sexual difficulties in adulthood, and it can lead to disturbed behavior in childhood."

Dr. Rhonda L Lorand, Ph.D. (Psychologist, New York City)

8. What are some of the psychological dangers of childhood sex education and adolescent premarital sexual intercourse.

-- The dramatic rise in teen suicides can be directly attributed to massive increase of teen premarital sex, according to Dr. Richard Bloom, M.D. (psychiatrist) of Los Angeles.

** "Having extremely active sex lives by the time they're 14, teenagers have lost that feeling of looking forward to a special someone. Most kids have been through every kind of sexual experience by the time they're 16."

(Los Angeles Jewish Community News, 3/21/85)

-- The gross emphasis on "carnality" from kindergarten on in school sex programs can have a devastating effect on the psychosexual development of these children.

** "(V)ery early sex education often consists largely of temptations to linger at one particular stage of development. The sex instruction given to some very young students consists, in part, of repeated demonstrations of nudity, genital anatomy, and how humans and animals mate.

"Three to six year olds who are repeatedly given such instruction may become fixed in the need for exhibitionist and voyeuristic pleasure in their later sex life.

"Freud certainly believed that indulging children in an excess of exhibitionism and voyeurism could impair sexual growth, ... and case histories reported by innumerable practionners since have confirmed this view." (Anchell, National Review, p. 33.)

-- "Particularly dangerous is the sex educators' insistence on teaching overtolerance of perversion. Teaching young people that orgasm achieved by any means is beneficial can break down psychological defenses and lead them into becoming polymorphous perverts -- that is, mechanical robots capable of engaging in any kind of sex acts with indifference and also without guilt." (Anchell, ibid.)

-- "Anyone who would deliberately arouse the child's curiosity or stimulate his unready mind to troubled sexual preoccupations ought to have a millstone tied around hisneck and be cast into the sea." (Dr. William McGrath, Psychiatrist, Phoenix).

9. What are some of the psychological implications of teenage abortions?

-- While some of the short term psychological effects have long been known, studies are also now beginning to indicate the disastrous long term psychological harm that can result from resort to abortion.

-- While extremely rare among pregnant women of any age or marital status, suicide is much more common following an induced abortion.

** Between 1938 and 1958, over 13,500 Sweedish women were refused abortions. Only three committed suicide." (J. Ottosson, "Legal Abortion in Sweeden," Jour. Biosocial Sciences, vol. 3, 1971, p. 173.)

** In Brisbane, Australia, no pregnant woman has ever committed suicide. (Comp. Psychiarty, Vol. 9, No.1, 1968.)

** A state of Minnesota study, Criminal Abortion Deaths, Illegitimate Pregnancy, Deaths and Suicides in Pregnancy, 1960-1965, found that in fifteen years there were only 14 maternal suicides, only four of which were committed during pregnancy. The other ten mothers committed suicide shortly after delivery.

12 of these 14 suicides were psychotic depressives; two were schizophrenic.

Meanwhile, the male suicide rate in Minnesota during the same time period was 16 per 100,000 population. The nonpregnant female rate averaged 3.5 per 100,000. But the pregnant female suicide rate average only 0.6 per 100,000 population.

** (All the above cited from Wilke, Abortion: Questions & Answers, p. 123-24.)

-- Suicide after an induced abortion is a far more common, however, and is a growing phenomenon.

** Suiciders Annonymous of Cincinnati, Ohio reported that during one 35 month period in the late 1970's it counseled 5,620 people who were suffering "deep depression, anxiety, stress, fears they cannot overcome, those who have attempted suicide, often several times, and those who (were) considering suicide." Of these 5,620 people:

4,000 were women
1,800 had had abortions; of whom
1,400 were between 15-24 years old.

** Reports are increasingly common of adolescents in particular who attempt suicide after an abortion on the very date their child would have been born. (C. Tishler, "Adolescent Suicide Attempt: Anniversary Reaction," Pediatrics, Vol. 68, 1981, p. 670671.)

** Cited from Wilke, ibid.

-- More recent studies indicate that the are potentially severe long term psychological problems associated with abortion. Two recent studies showed:

** A great number of women studied experienced deep feelings of grief, sadness, and regret even as much as five or ten years after getting an abortion.

** More than half suffered nightmares involving babies; 23% reported hallucinations related to the abortion; 35% perceived an appearance from the aborted child.

** 65% had considered killing themselves; almost that many reported drinking or taking drugs to stop the pain; 31% had attempted suicide.

** And all these reactions occurred despite the fact that a majority of women in these studies indicated they had no strongly held religious beliefs.

Because these studies are limited in numbers and involved women who had previously indicated some psychological stress regarding their abortions, the percentages cannot be generalized to all women who have had abortions. However, the data collected "is very significant in its documentation of the fact that abortion does act as a stressor event" in the lives of women.

"The Psychological Aspects of Stress Following Abortion," doctoral dissertation of Anne Catherine Speckhard, Ph.D., University of Minnesota. Cf. also, Page Laws, "Post Abortion Syndrome," The Virginian Pilot, 5/28/86. p. B-1.)

-- All the psychological evidence also indicates that the younger a woman/girl is when procurring an abortion, the greater the chance there is for psychological stress or harm.

PART VI
ARE THESE CLINICS RACIST?

1. Why would anyone even raise the question of whether these clinics are racist?

-- First, because almost invariably, these clinics are targeted at schools with a high percentage of minority students.

** "The Pittsburgh School Board's blue ribbon task force, whose ultimate goal is to establish school based birth control clinics has targeted ... Brashear and Westinghouse (high) schools. ...

"(Westinghouse and Brashear have been deisgnated) 'high risk' schools because of their feeder schols, most of which are largely black."

Westinghouse High School has a student population 1,074 black and 7 white. Brashear is 807 black and 1,214 white.

"Once again, the black community has been targeted for control, decimation and ultimately the destruction of black family traditions and black life."

Pittsburgh Courier editorial, "Semantics Aside, Black Community Target of 'Sex Clinics,'" Vol 77, No. 20, 5/17/86. The Courier is one of the largest black-owned newspapers in the country.

** In Washington, D.C., it was the predominantly black secton of Anacostia which was first targeted for a clinic. (Raspberry, Washington Post, 4/14/86)

** Of the eight schools in the Los Angeles School District targeted for clinics in 1986-87, all but one have heavily minority student populations.

-- Second, black, Hispanic and other minority populations have long been the target of population control and "family planning" groups.

** In 1984-85, the California State Office of Family Planning let 28 contracts in more than 20 cities in California, totaling more than $9 million, for birth control programs aimed at minority population groups.

** Among those twenty-eight contracts were:

$66,424 trageted on Hispanic children in Coachella.

$94,074 targeted on Hmong refugees in Fresno.

$95,000 given to the Charles Drew Medical School to do media work to target "Black Youth" in Los Angeles for birth control.

$90,000 given to the Watts Health Foundation to target black churches and public school students for birth control "education" programs.

$103,000 spent in Merced to target farmworkers, Hispanics, and Lao refugees for birth control acceptance.

$93,000 targeted on Hispanic youth and parents in Oakland for Planned Parenthood sex education and birth control.

$267,000 given to Riverside County Health to target Hispanic youths for birth control.

And $6,247,171 was given to the Los Angeles County Regional Family Planning Council to train "counselors" for family planning for Asian/Pacifics, Blacks, Hispanics, and American Indians.

** (Cf. "The Office of Family Planning, Analysis of a Tragic Failure," Report to the Legislature of California by the Center for Documentation, P.O. Box 60087, Los Angeles, CA 90087)

2. Is there any other evidence of the racist/elitist intentions of these clinics or their backers?

-- Yes, there is.

-- Planned Parenthood was founded by a woman whose slogan was, "More children from the fit, less from the unfit."

** Margaret Sanger also proposed that dysgenic groups (those with "bad genes") be given the choice of sterilization or life-long segregation in work camps. (Sanger, "Plan for Peace," Birth Control Review, April 1932, p. 107.)

** Sanger wrote a book, The Pivot of Civilization in which she inveighed against "The Cruelty of Charity," and denounced maternity care given to poor women because it help the "unfit" continue to have children.

** Sanger also had many professional contacts with Adoplh Hitler's advisor on race, Eugen Fischer.

** A book entitled The Rising Tide of Color Against White World Supremecy, authored by another man favorably impressed by Hitler, was given a favorble review in October 1920 Birth Control Review.

-- Planned Parenthood has also opposed recent Reagan administration efforts to cut off family planning funds for China after the U.S. discovered that that nation's Marxist government was performing forced and coerced abortions on hundreds of thousands of Chinese women.

PART VII: ALTERNATIVES

1. Well, if none of the programs tried so far seem to work, and only make matters worse, what is the alternative?

-- There are two parts to the only positive alternative.

-- First, we must regain the moral courage to tell teenagers to say "no" to premarital sexual intercourse.

-- Second, we must begin a sound education program which is based on healthy psychological principles, and which teaches teenagers to respect themselves and their sexuality.

2. Are you saying abstinence is the answer?

-- Yes. And the only realistic one. It was by discouraging premarital and extramarital sexual intercourse that the whole of western civilization as we have known it for 2,000 years was built and sustained.

-- It is a policy with a long record of success in preventing sexually transmitted disease, teen pregnancy, abortion, and the host of psychological problems we see around us today.

-- It does not work perfectly, but it works far better that the mass experiment

in hedonism of the last two decades.

3. But isn't that naive, to try to prevent teen pregnancy by telling adolescents to be abstinent?

-- Not according to the American Medical Association and the California Medical Association.

-- In 1984 both the California and American Medical Associations adopted nearly identical resolutions which said, in part:

** "Whereas, there are 1.5 million legal abortions performed by physicians in this country every year; and

"Whereas, most of these abortions (about 80%) are sought to preclude the prospect of an out-of-wedlock birth; and,

"Whereas prevention as a solution to the problem of unwanted, untimely, or out-of-wedlock pregnancy is superior to abortion, which is frequently an unpleasant experience for the woman, and may have significant physical, social, and emotional sequelae; and

"Whereas, most of these abortions are sought in order to eliminate unwanted pegnancies, which often occur despite studied contraceptive efforts; and therefore, such abortions represent clear-cut instances of contraceptive failure; and

"Whereas, unmarried women as a group, especially when they are very young, have a much higher contraceptive failure rate than married women; and ...

"Whereas premarital abstinence is the only foolproof means of preventing unwanted, out of wedlock pregnancy; and ...

"Whereas the current statutory rape law of California makes it a crime for a male of any age to have sexual intercourse with a female under 18 years of age who is not his wife -- even with the girl's consent; and

"Whereas, the self-evident purpose of this law is to encourage (even if only indirectly) premarital abstinence among teenage girls -- ergo this goal is a long established public policy in this state; and ...

"Whereas, ... the AMA (has) adopted as policy 'the need to encourage the use of all practical ... methods of prevention ... of gonorrhea and other venereal diseases ... including (by means of) fidelity and continence in married couples and abstinence in unmarried individuals;' and

"Whereas, a recent poll reveals (despite the alleged inroads of the sexual revolution) that most American women not only believe in premarital absitence as a good policy and desirable norm, but also strongly disaprove altogether of premarital sex; ...

"Resolved that the California Medical Association recognize that premarital abstinence is an effective means of precluding unwanted pregnancy; and be it further

"Resolved that CMA suggest that the media, appropriate public agencies, and all concerned professional groups in their educational campaigns to the public epmhasize the effectiveness of premarital

70X

abstinence as a mean of reducing the incidence of un-wanted pregnancy. ..."

Resolution 701-84 of the California Medical Association, adopted 2/11/84. (Copies available in booklet form for $1 each from: American Life Lobby, P.O. Box 490, Stafford, VA 22554. Quantity prices available.)

-- And in a poll taken in Glamour magazine (the poll mentionned by the CMA resolution):

** 51% of the women polled considered premarital sex to be "unaccpetable," while only 20% "strongly agreed" that it was acceptable. (cf. Los Angeles Times, Dec. 19, 1982)

4. What kinds of sex education programs do you think are workable, healthy alternatives?

-- There are several.

-- One of the most widely used sex education program which promotes and helps support teenager as decisions to remain abstinent is the Sex Respect program developed by Colleen Kelly Mast

** Sex Respect: And Option for True Sexual Freedom was originally funded by a $300,000 development grant from the U.S. Department of Health and Human Services, Office of Adolescent Pregnancy.

Sex Respect is already in operation in many states and three countries.

The Sex Respect program has been developed specifically for public schools and makes it case for premarital abstinence without reference to religious creed, but solely on the basis of medical and psychological knowledge.

The Sex Respect program provides material for parents, and seeks to include parents in the educational and developmental process regarding their teenagers' sexuality.

For more information, contact: Project Sex Respect, 347 S. Center, Bradley, IL, 60915. (815) 939-0296.

-- Another program designed to encourage healthy, and abstinent, sexual development among adolescents is the Teen Aid program which originated in Spokane Washington.

** Teen Aid was founded in 1981, "on the belief that avoidance of sexual activity and strong family ties provide teens with necessary stability and with increased opportunities for the future."

"Teen Aid stresses the need for adult role models who are willing to encourage abstinence for teens, and who can clearly convey the advantages of a teen lifestyle free from sexual involvement."

Teen Aid has developed a complete high school sex education curriculum which includes a program for teen-parent communication on sexuality and video taped programs and projects as well.

Teen Aid has also opened counseling centers in several cities as a specific alternative to the amoral contraceptive/abortion centers offered by Planned Parenthood.

Teen Aid also runs workshosps in various areas on healthy adolescent sexual development.

For more information, contact: Teen Aid, West 22 Mission, Spokane, WA 99201.

Family Planning Advocates of New Jersey

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TESTIMONY PRESENTED TO THE ASSEMBLY EDUCATION COMMITTEE
MAY 7, 1987
on

A.3345, a bill prohibiting school-based health clinics from providing pregnancy testing, prenatal or postpartum examinations, dispensing of contraceptives or abortifacients, abortion or making referrals for abortions, or counseling in regards to family planning or abortion.

We strongly oppose this bill. The whole purpose of school-based clinics is to provide primary health care, guidance, and counseling to students for whom such services are often out of reach, and who may be relying on hospital emergency rooms for their medical care. They usually include a whole range of support services, such as parenting education and day care services for student parents, as well as career counseling and help with job placement. They are designed to address real problems for real students and sometimes dropouts. To work well, they need strong local community support and input.

What this bill says is that no matter how important a problem teen pregnancy and sexual activity is considered to be in a particular community, the state insists on censoring the information and services that community can offer to its children.

What this bill says is that no matter how important it is to get early prenatal care, or make an early decision about terminating a pregnancy, the state prefers to tell a community it can't provide help in the most accessible place for young people to get such help.

What this bill says is that New Jersey chooses to punish young people who are sexually active rather then help them with accurate information about risks and precautions they can take.

Communities around the country who have started school-based or school-linked health services have overwhelmingly chosen to provide family planning services (80%), the rest do referrals. We think those New Jersey communities making a realistic assessment of the health needs of their students and wishing to provide school-based services, will want to include most of the services this bill would prohibit. A poll taken of New Jersey citizens on behalf of the Family Planning Association of NJ in October of 1986 found, in part, that:

Question: Do you have any moral or religious objections to the use of contraceptives by teenagers?

ALL	Yes: 18%	No: 79%	Don't know: 3%
Catholics	19%	79%	2%

Question: Which is a more effective way to reduce the problems of teenage pregnancy -- to widen the availability of sex education and contraceptives or to restrict the availability of sex education and contraceptives?

ALL	Widen: 85%	Restrict: 7%	Don't know: 8%
Catholics	84%	8%	8%

Question: In general, do you think that free contraceptives should be provided for teenagers who ask for them?

ALL	Should: 67%	Should not: 28%	Don't know: 5%
Catholics	61%	34%	5%

Question: Should contraceptives be provided to all teenagers who ask for them or should they be provided only to teenagers who have permission from their parents?

ALL	Should: 62%	Should not: 32%	Don't know: 6%
Catholics	61%	33%	8%

Question: Some people say that if teenagers must have parental consent to receive contraceptives, those contraceptives will never reach the teenagers who need them the most. Other people say that such parental consent is an important part of a parent's rights over their children. What is your view?

ALL	Teens won't get: 57%	Parent's Rights: 37%	Don't know: 6%
Catholics	53%	42%	5%

Question: If it became more difficult for teenagers to obtain contraceptives, do you think this would lead to more teenagers becoming pregnant, fewer teenagers becoming pregnant, or would this have no effect on teenage pregnancy?

ALL	More: 71%	Fewer: 10%	No effect: 16%	Don't know: 2%
Catholics	67%	12%	19%	3%

Question: Teenage pregnancy is out of control and only a program of education and distribution of contraceptives can reduce the problem?

ALL	Agree: 78%	Disagree: 19%	Don't know: 2%
Catholics	78%	20%	2%

Question: More information on sex and contraceptives will lead to increased pregnancies and abortions?

ALL	Agree: 16%	Disagree: 83%	Don't know: 1%
Catholics	15%	84%	1%

(Note: of the 900 New Jerseyans surveyed, 49% were Catholic)

Opponents of family planning services have lately been citing a recent study (by Weed & Olsen) claiming that the provision of contraceptive services to teens has not decreased teen pregnancies, just the teen birth rate and has lead to more teen abortions. This study is flawed: it does not take into account the great increase in sexual activity among teenagers in recent years, the increased availability of abortion services since legalization in 1973, or the fact that family planning programs are reaching only about 31% of the teens estimated to be at risk of an unintended pregnancy. And it doesn't account for the higher US rates of pregnancy, birth and abortion among teens as compared to comparable developed countries where family life education and access to free or low cost medical contraceptives is far greater than in this

country. ("Teenage Pregnancy in Developed Countries,"by E.F. Jones et al., Family Planning Perspectives, V.17, No.2, March/April 1985: US pregnancy rate, 96 per 1,000 women 15-19; England & Wales, 45 per 1,000; France, 43; Canada, 44; Sweden, 35; Netherlands, 14. Rates are for 1981).

Most teens don't even come into a clinic for nine months to a year after beginning to be sexually active, and often that first visit is for a pregnancy test. And in fact, a study by the Centers for Disease Control has found a six percent decline in pregnancy rates among sexually active teens between 1974 and 1980 (the last year covered by the Weed & Olsen study). More recent statistics from the National Institute of Child Health & Human Development show a seven percent drop between 1974 and 1983. (See attachments for more details and citations).

We urge the committee not to release this bill.

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SOME ANSWERS TO COMMONLY-ASKED QUESTIONS ABOUT TEENAGERS' CONTRACEPTIVE USE AND ITS RELATIONSHIP TO TEEN PREGNANCY

Does Contraception Prevent Teen Pregnancy?

There is no doubt that sexually active teenagers who use contraception are less likely to become pregnant than those who don't. Researchers at Johns Hopkins University studied the effectiveness of teenage contraceptive use in a large national sample. They found that 50 percent of sexually active unmarried teenagers who never used contraception became pregnant within two years, while only 12 percent of those who always used it did so.[1] In fact, 45 percent of all premarital pregnancies among teens are conceived within the first six months of sexual activity -- and 36 percent within the first three months -- during the period before most teenagers have even sought effective contraception.[2] (See next point.)

Is It True That the Availability of Contraception Causes Teens to Become Sexually Active?

Sexual activity among unmarried teenagers has been increasing in the United States and elsewhere for several decades. While reliable national data only became available in the 1970s, earlier studies indicate that sexual activity has been increasing since the 1940s. Attesting to this trend are the high rates of teenage childbearing since 1940, the steady increases in the proportion of births that are premaritally conceived and the high incidence of illegal abortion prior to 1970.[3]

There is no research that shows that the availability of contraception has any influence on teenagers' decisions to become -- or not become -- sexually active. It is known, however, that 88 percent of teenagers who come to family planning clinics do so only after they have become sexually active, and most wait more than a year after first intercourse.[4] If the availability of contraception encouraged young people to become sexually active, most teenagers would be expected to seek contraception before first intercourse.

Are Teens Who Go to Clinics Less Likely to be Effective Users of Contraception Than Teens Who Go to Private Physicians?

The source from which teenagers get medical contraceptive care does not influence the effectiveness of the methods used. In general, young women and poor women -- who are more likely to go to clinics rather than physicians -- experience contraceptive failure more frequently than their older, more affluent counterparts.[5] When this is taken into account, researchers at Johns

Hopkins University found that unmarried teens using clinics were equally effective contraceptive users as those going to private physicians.[6]

Is Teenage Pregnancy Increasing?

Both the number of teen pregnancies and the rate -- i.e., the number of pregnancies per 1,000 women aged 15 - 19 -- increased throughout the 1970s. Since 1980, however, teen pregnancies have been on the decline. The number has dropped from close to 1.2 million in 1980 to just over one million in 1983, partly because of a drop in the teen population. However, the pregnancy rate too has fallen from 111 to 108 over the same time period.[7]

The rise in teen pregnancy in the 1970s was attributable to sharp increases in sexual activity. Between 1971 and 1982, the proportion of women aged 15-19 who were sexually active (and therefore at risk of pregnancy) increased by 28 percent, from 36 to 46 percent.[8] Without increased use of contraceptives by sexually active teens, the teen pregnancy rate might have been expected to rise sharply, along with the rise in sexual activity. In fact, the pregnancy rate increased less sharply than sexual activity. From 1973 to 1982*, the teen pregnancy rate increased only 15 percent, from 96 per 1,000 women aged 15-19 to 110 per 1,000.[9]

The pregnancy rate among teens who are sexually active has actually decreased. A study by the federal government's Centers for Disease Control found a six percent decline between 1974 and 1980, from 204.5 per 1,000 to 193.[10] More recent statistics from the federal government's National Institute of Child Health and Human Development show a seven percent drop between 1974 and 1983.[11]

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* Data on the incidence of teen pregnancy prior to 1973 are unreliable since abortion became legal nationwide only in 1973 and since the number of pregnancies is calculated by adding births, abortions and miscarriages.

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11. Statement of Wendy H. Baldwin, Ph.D., Chief Social Demographer, Demographic and Behavioral Sciences Branch, Center for Population Research, National Institute of Child Health and Human Development, before the Congressional Coalition on Population and Development, April 29, 1986.

26 april 1987

dear assemblyman rocco

i would appreciate your assistance in obtaining the release from the assembly education committee of bill a-3345 which will restrict school health clinics from providing services relating to pregnancy tests, related examinations, abortions or abortion referrals and any related counseling.

it is my understanding that the federal government recommends a complete medical history back at least two generations before birth control pills should be made available and then if certain types of conditions are found in the family no pills should be prescribed. it is also my understanding that birth control bills should not be prescribed until the menstrual period has been fully established.

how many junior and senior high school students can accurately provide the above information? could your daughters have provided this information to a health clinic without first obtaining the specifics from you and your wife?

considering the number of botched abortions we have been hearing about who will be responsible when the school sends or takes a student to a clinic to have an abortion performed and complications set in? will the student be afraid to tell her parents or doctors the reason for her problems was that she had an abortion and thereby delay treatment?

in my opinion this bill needs to be passed as soon as possible and signed by the governor.

i would appreciate your comments and position on this bill.

sincerely

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