parental consent is necessary before medical care can be provided to a minor; otherwise the care constitutes an unauthorized touching - the tort or wrong against the person called battery. But there have always been exceptions to this rule. Harriet Pilpel and Nancy Wechsler review these exceptions in their two excellent articles on this subject in Family Planning Perspectives, Spring 1969 and July 1971. Since many of us fall into the trap of saying that parental consent is always necessary before medical care can be provided to a minor, let me review the exceptions:

- in cases of emergency (one might view lack of contraception for a sexually active minor as an emergency)

- when the minor is emancipated, which is a question of fact (e.g., married, in the armed forces, living away from home, self-supporting)

- in cases of parental neglect (one might view refusal or failure of parents to consent to contraception for a sexually active minor as parental neglect)

- when the minor is a 'mature' minor, the procedure is for the benefit of the minor, and the minor can understand its nature and consequences (increasingly the emerging doctrine of the mature minor is being recognized by courts in varying circumstances)." (Legal Aspects of Access to Family Planning Services)

There is a clear intent on the part of some family planning agencies and clinics to subvert the long-standing rule of law relating to parental consent. The only argument that can be made in support of this position is that "the end justifies the means". This attitude is always dangerous, but it is especially so when a third party is interjected into the relationship between the child and his parents.

Family planning information and counseling may be given to a minor without the parent's consent or knowledge; however, upon the state permitting such an intrusion into parental authority the state then assumes the responsibility to assure that those persons providing such informational and counseling services are sufficiently trained in accordance with statewide standards established by the Department of Health. A minor child is permitted to obtain contraceptive devices from trained medical personnel without obtaining parental consent upon such medical practitioner determining that there is a likelihood of conception unless such device is provided. A minor child may obtain prescriptive contraceptives provided they are prescribed by a licensed doctor, if he finds the prescription is necessary to prevent conception. The use of prescriptive contraceptives may continue subject to the parent's right to modify or terminate such course of treatment.

Ideally, parents should take responsibility for initiating ongoing discussion of this very sensitive and important subject with their children. This lost opportunity on the part of parents and the information void, from the standpoint of the children, is being partially filled by family planning clinics.

What is clear is that in recent years there has been a substantial increase in the availability of birth control information to children and adults alike. This service is provided through a vast number of public and private agencies funded through the use of donated funds and tax funds. It is also clear that this information resource will continue to undergo significant expansion in the coming years. A further aid to expansion is the fact that under the new Social Service Regulations published by the United States Department of Health, Education, and Welfare in May 1973, family planning (birth control) is one of those services which is mandated and will receive more favorable funding consideration.

The Board supports the broad availability of birth control information services to adults as well as children under certain circumstances. In this context, however, the Board is concerned about two important points. First, there are insufficient standards or guidelines to define and assure the provision of quality services in all types of public and private birth control information programs. Most responsible public and private agencies have established their own independent guides and standards; however, such a fragmented approach does not provide adequate protection to the public. The California State Department of Health, as the appropriate state agency, should develop guidelines and standards for birth control services and take the necessary steps to ensure that these requirements are met by providers of birth control services throughout the state.

The second major problem in the viewpoint of the Board is the fact that there are essentially no qualifications which individuals providing birth control information services are required to meet. This state and/or its political subdivisions licenses doctors, teachers, psychologists, contractors and barbers as well as a host of other professional individuals and craftsmen, many of whom are engaged in activities having far less significant social impact than do those persons involved in disseminating birth control information.

Many individuals currently providing birth control information services are highly qualified professional persons who have adequate background and training to provide such services. It is the Board's contention, however, that the significant and rapid growth in the family planning field has resulted in a substantial number of people with notably little background or experience being placed in the position of providing such services. There is a need to establish some basic qualifications in terms of education, experience or training which the individual purveyors of family planning services would have to meet.

The California Business and Professions Code Section 17800 et seq. governs the licensing of persons engaged in marriage, family or child counseling. A legal interpretation of this section reveals that the provisions do not apply to persons engaged in providing family planning services. It is the Board's viewpoint that this section of the Business and Professions Code should be amended to provide for licensing of family planning practitioners and that the basic qualifications as suggeste above, when met, should represent a prerequisite for state licensing.

D. Psychological Vulnerability in Birth Control

Earlier sections of this report have primarily dealt with the dissemination of birth control information to children and the importance of this factor as it relates to their protection, especially during the time of the child's awakening sexuality. In fact, there are a number of circumstances and stages which occur during the individual's lifetime which have been found to have a significant affect on the individual's motivation with respect to birth control protection. Dr. Miller has reported on his research of women who were seeking a therapeutic abortion. He was interested in determining why these women got pregnant, their subsequent behavior (request for abortion) indicating that the pregnancy was rejected and they did not want to have the baby. He identified a number of situations and circumstances which resulted in psychologically vulnerable stages in the life of the fertile woman which affected her motivation to properly utilize birth control techniques and devices. These stages of vulnerability as identified by Dr. Miller are as follows:

I. During early adolescence,

a. when fecundity is absent or low, but increasing, and as a consequence, contraceptive diligence is infrequently developed.

II. At the start of the sexual career,

a. at the time of the first few intercourses, for which there is typically no contraceptive preparation;

b. during the six months afterwards, until the woman recognizes and acknowledges the beginning of her sexual career.

III. In relation to a stable sexual partner,

a. while the relationship is in the stage of development, before a stable sexual and contraceptive pattern has been established;

b. during conflict or separation, when patterns of communication and cooperation are disrupted and the sense of interpersonal loss may be acute;

c. after breakup with the partner with whom a particular sexual and contraceptive pattern have been established;

(1) when situationally reexposed to the old partner, but without access to the previous contraceptive method;

(2) when exposed to new partners with different sexual and contraceptive styles.

IV. After geographic mobility,

a. when there are major changes in social fields such that sexual contraceptive norms and opportunities change;

(1) after moving away from home and family;

(2) after moving to a new socio-cultural area.

V. In relation to marriage,

a. just before or just after, a contraceptive diligence is relaxed;

b. during conflict or separation;

c. after separation or divorce.

VI. After each pregnancy,

a. during the postpartum period, when there is subfecundity, altered sexual activity and, often, the use of interim contraceptive methods;

b. when a new level of contraceptive diligence is required as a result of the demand brought about by a new baby.

VII. In relation to the end of child bearing,

a. when the decision to stop having children is being dealt with.

VIII. During menopause,

a. when fecundity is decreasing and as a consequence, contraceptive diligence is waning.

A significant part of the activity and resources of public and private family planning agencies is directed toward providing birth control information to teen-agers. The youthful age groups have been identified as a target group within which there is a significant need for these services. The Board generally concurs with this viewpoint; however, it suggested that such agencies need to recognize other factors which affect conception vulnerability and to broaden their program to include these target groups as well. It is suggested that the kinds of research summarized above, can serve to identify such other target groups which should be included in the expanded programs.

E. The Moral Issue in Family Planning

Another major issue in agency rendered family planning services is the method of presentation of the material. Basic to this issue is the concern that the simple presentation of cold factual information to the child without some moral frame of reference ... a possibility which can more easily arise in a clinical environment than in a parent-child relationship ... will represent nothing more than a "how-to-do-it" approach. There are those family planning advocates who tend to deny that they have a responsibility beyond simply providing information and permitting the child to make his own choices.

This attitude is similar to providing a young person with the knowledge required to fire a rifle without acquainting him with safety measures and the legal and moral implications of injuring another person or taking a human life. It is a question that has been much debated, but never resolved. Family planning agencies must come to grips with this issue now in order for their credibility to be accepted by the public. Since these agencies are injecting themselves into a subject matter which has a very deep and lasting social and family significance, they must go far beyond the mere providing of cold clinical information.

Consider one comment on the related subject of sex education:

> "If indeed, a person by understanding what I like to call education for human sexuality rather than just sex education, goes ahead and engages in sexual activity, is this harmful? We have never been able to find any kind of proof that if we remove the telltale symptoms, such as pregnancy and venereal disease, that sexual activity is harmful. If there is no venereal disease, because we are so educated that we know how to prevent it, if we have no pregnancies, because we are also educated to prevent pregnancy, what indeed is the harm of sexuality?"

This statement is not only simplistic, but it is inconsistent with family attitudes upon which our social norms are based. The attitude expressed in the above few sentences represents the nub of the problem associated with providing birth control and sex information to minors.

A common feature of relatively new and rapidly developing social programs is that they tend to draw together those individuals who are prone to express what they view as the advanced thinking of the profession. While the Board certainly favors creative thinking and innovation, it suggests that in the area of birth control, especially as related to minors, the public expression of extreme viewpoints does a disservice to the profession as a whole, particularly in such a sensitive area as birth control.

It is suggested that one way in which the public and private family planning agencies can encourage greater acceptance of their service would be to recruit the membership of their policy making boards from among interested citizens and concerned parents residing in their service area. With citizen input into their policies, such agencies might better reflect community attitudes on sexuality, particularly in the area of service to teens.

F. Other Considerations in the Delivery of Birth Control Services

At the present time, birth control services are provided throughout the State of California by a host of public and private agencies on a drop-in basis. In spite of the fact that such services have reached vast numbers of people in this state, those persons served thus far represent only a small part of the target or vulnerable groups which need such family planning services.

Family planning services should also be offered on a voluntary basis to other target groups who do not now have these services generally available to them. For example, reference is made to the number of women who are residents in public and private medical and psychiatric hospitals and in county and state penal facilities. In many instances, the contraceptive program used by women are seriously disrupted when they enter such institutions are either on a temporary or longer term basis. Their release and return to normal family relationships without adequate provision for birth control information and resumption of their contraceptive program makes them particularly vulnerable.

Early efforts to provide family planning services, particularly to women incarcerated in county and state penal institutions have met with much success. Some progressive county jails have permitted the development of voluntary family planning programs operated by local volunteers and the acceptance of these programs by female inmates has been enthusiastic. Another example of such an innovative approach on a broader scale is a highly regarded family planning program directed toward young men functioning within California Youth Authority facilities. The significance of these kinds of programs points out the need for public and private family planning agencies to develop approaches for bringing these services to men and women who are facing a time of high vulnerability.

Another important concern relates to the role and responsibility of the welfare system for providing information and referral services to their clients needing family planning services. At present, family planning services to current, former and potential recipients of welfare in California are provided by local health departments under a contract between the State Department of Benefit Payments and the State Department of Health. Local welfare staff has responsibility for providing information and referral services and local agencies outside the welfare department are responsible for providing the birth control services. Too often, local welfare staff members have not received sufficient training and experience in family planning services to feel comfortable in raising this issue with their recipient-clients. In too many instances, information and referral services to a family planning resource means simply providing the recipient with the name, address and telephone number of the service agency. The same kinds of motivational problems exist with respect to the woman making her way to the family planning agency as exists in the woman using birth control information and devices once they have been provided. Welfare staff needs to be sufficiently informed and trained about family planning considerations so they will be able to speak comfortably about this subject and further consideration must be given to follow-up activities to ensure that the recipient actually reaches the family planning agency to which she has been referred.

Motivating the individual to recognize the need for birth control services and effectively utilizing such services remains a significant problem. Motivational considerations require that the presentation of birth control

Information must go far beyond the mere presentation of factual clinical data. The entire conception process must be explained in sufficient detail and understood so that the recipient of these services, male or female, will have a clear concept of his vulnerability and need for protection.

There is ample research to demonstrate that, for the most part, conceptions of unwanted pregnancies result more from human failing than from ineffectiveness of a particular birth control device or method. For example, in the Board's two-county survey of 259 paternity cases (Appendix 6i), 46% of the mothers had received some type of training in birth control and a larger percent had an awareness of the subject matter. However, 88% of the mothers in these cases failed to use any protective device or method during the period of conception.

Effective pregnancy prevention requires planning and self-discipline. Many young girls are reluctant to consider consciously the possibility of intercourse in advance and, consequently, do not take adequate precautions. Unfortunately, the female has had to assume major responsibility for guarding against conception due to the relative ease and increased use of the pill. In the minds of many males, they are relatively free of responsibility. They tend to relate the use of the condom more to venereal disease prevention than to pregnancy prevention. As stated earlier, when researchers asked a group of young unwed fathers why they had not used this form of protection, the usual response was, "She's not that kind of a girl." This attitude places an unequal and an unfair burden on the woman.

Birth control services have the potential of resulting in great public good. The broad and effective dissemination of this information can help childless couples with their problems; can assist other couples in determining the number and spacing of the children they will have; and assist others, particularly teen-agers, by providing protective information as a means of preventing conception outside of marriage. There are many serious unresolved problems connected with the providing of these services, and there continues to be a heated controversy over many of the issues. Although the proposals suggested herein by the State Social Welfare Board do not purport to address themselves to all of the problems, the Board suggests that the adoption of these principles and recommendations will represent significant progress toward the development of a rational public policy on this sensitive matter.

VIII. ABORTION

In 1971 the State Social Welfare Board was requested by James Hall, Secretary of the California Human Relations Agency, to make a study of abortion. Therefore, testimony on the subject and its possible impact on society was sought at the public hearings on illegitimacy. This section deals with information gleaned from the hearings, related extensive research, and observations gained from both.

Abortion is the termination of pregnancy via expulsion of the fetus or an embryo from the uterus. There are two types of abortion: spontaneous, commonly referred to as miscarriage, and induced. Between 10 and 15 percent of all pregnancies end in spontaneous abortion. Over 116,000 legally induced abortions were performed in California in 1971. The terms legal and therapeutic are used interchangeably in this report to describe certain induced abortions. This specific type of induced abortion is the subject of this section.

A. Philosophical and Historical Perspective

As was stated in the earlier section on family planning, legal abortions became more socially acceptable as a result of the merging of previously divergent viewpoints with respect to women's rights, population control, the problem of illegal abortions, and the attitudes of certain segments of the medical profession. This was not an easy transition. The passage of legal abortion acts in states across the country did not occur without heated debate and the subsequent court decisions related to these statutes served to spark additional dialogue.

The fact that California enacted its Therapeutic Abortion Act on November 8, 1967, has not quelled the debate in this state. Essentially, the pro-abortionists defended the act and sought further liberalization based upon their protestations that every child should be a wanted child; that parents should be able to determine the number of children and the spacing of their children; and, it is the right of every woman to determine whether or not she will bear children. Birth control techniques and devices had come into increased use. However, not all of these proved to be totally effective and most require planning and self-discipline which tend to be inconsistent with the timing and emotional nature of sexual relations.

> "Abortion, then, appeared as the surgically certain way of eliminating accidents, the completely effective way of preventing unwanted children. Through abortion, the individual's control of the consequences of his sexual freedom was affirmed." The Morality of Abortion

In discussing this "backstop" concept of abortion, Dr. Kingsley Davis has stated:

> "In current thinking, legalized abortion is also often regarded as a preventive measure. In my view, it is likely, at least in the short run, to be more effective than stepped-up contraceptive programs in reducing the number of children with inadequate parents. Since sexual intercourse is an ephemeral

> activity engaged in under many kinds of situations and under varying degrees of emotional rationality, it is not always compatible with a systematic utilitarian use of contraception. Further, the best contraceptives from the standpoint of female health (the condom and spermicidal jellies) are not necessarily the best from the standpoint of birth control. Abortion, on the other hand, is a back-up measure that can be used when, for whatever reason, unwanted pregnancy has ensued. There is plenty of time to seek objective advice and to make a careful decision. If the girl has taken a chance and lost, abortion allows her to avoid the full penalty of having an unwanted child."

This "backstop" concept, cited by Davis and others, is held as justification for aborting the unwanted child and, in many cases, has replaced the former practice of giving life to the child and then placing it in an adoptive home where it is wanted.

Antiabortionists plead for the right to life of the fetus and express concern about the moral and social consequences to the individual and members of a society which legitimize pregnancy termination on a wholesale and "demand" basis. In support of their argument that the fetus is an unborn child endowed with life, they point out that the fetus has a heartbeat within 18 to 25 days; has human brain waves within six weeks; moves within six weeks; and, breathes within 12 weeks.

The debate continues to rage at both the state and national level, and there is every reason to believe that it will continue into the future. A constitutional amendment banning most abortions has been proposed by a member of Congress. The proposal in effect defines life as beginning at the moment of conception, a position which is disputed in medical circles and among abortion advocates. Also, on this particular subject, welfare laws and regulations have coped with an issue which has, so far, been sidestepped by law makers and social planners. As soon as a female welfare recipient has a verified pregnancy, her grant may be increased to account for the additional "person" (the unborn child). This factor suggests that two realities must be faced: That life begins at the time of conception and that abortion is, in fact, the taking of a life. With this in mind, more rational decisions should be made with respect to public policy on the important question of abortion.

It is clear that societies in western civilization have long demonstrated a moral, social, legal and religious abhorrence toward abortion. Generally, the only recent exception to prohibiting abortions was in those cases when the procedure was necessary to save the life of the expectant mother. The exception has now become the rule, changes have been made in abortion statutes tending to overlook moral, legal and religious considerations and without a basis of facts on social consequences, good or bad.

It was in the midst of this controversy and debate that the California Legislature enacted the California Therapeutic Abortion Act which became Section 25950, et seq., of the Health and Safety Code. The particular provisions of these sections, the court decisions affecting them, the particular applications and misapplications of this law will be the subject of this section.

B. Statistical Perspective

The year 1968 was the first year of full implementation of California's Therapeutic Abortion Act. In that year, there were 5,018 abortions performed under the provisions of this act and within four years, this number had increased 23-fold to more than 116,000 therapeutic abortions in the year 1971. The increasing number of abortions performed each of the four years is shown in the following chart.

Therapeutic Abortions Performed in California

1968	5,018
1969	15,339
1970	65,369
1971	116,749

Appendix 10 describes some of the selected characteristics of the women having abortions in California during the years 1968 through 1971. Some of the significant characteristics shown in Appendix 10 are the fact that over half the women receiving abortions in 1971 had never been married. Over 31 percent of the abortions performed in that year were performed on women under the age of 20 years. Ninety percent of the abortions performed in 1971 were performed in private hospitals as opposed to county medical facilities, and more than 30 percent of these surgical procedures were paid for at public expense. Another significant feature is the increased representation of black women in the population receiving abortions from 7.2 percent of the total in 1968 to 13.7 percent of the total in 1971.

Of the 116,749 abortions performed in the year 1971, 104,844 were performed on women who were residents of the State of California. The startling fact is that over 1,100 of these abortion procedures were performed on young girls between the ages of 10 and 14 years. These children are included in the 31 percent of the abortions performed in California in 1971 on girls age 19 and under. The following chart reflects the numbers of abortions performed in the various age groups.

Therapeutic Abortions Performed in California in 1971
By Age Groups

Age Groups	Number
10-14 years of age	1,166
15-19	31,806
20-24	35,988
25-34	27,940
35-44	7,944

As stated in the section "Dimensions of the Illegitimacy Problem", there seems little doubt that the increased use of therapeutic abortions in California has had an effect on illegitimate births. For example, of the 65,529 abortions performed under California's law in 1970, 48,205 were performed for unmarried women (never married, widowed, divorced or separated). Further, Berkov and Sklar point out certain parallels between the characteristics of mothers of illegitimate children and those who receive abortions. In 1971, the age group between 20 and 24 had the largest drop in the illegitimate birth rate. This age group also had the highest therapeutic abortion rate in 1970.

C. Relationship of Therapeutic Abortions to Illegal Abortions

A significant feature of the increased number of legal therapeutic abortions in California is its estimated effect on illegal abortions. For obvious reasons, the number of illegal abortions performed in California at any given time is not known. However, a recent study of both spontaneous and illegal abortions in urban North Carolina indicates that in the 18 to 44 age group, it was estimated that the proportion of white women having induced abortions was 13.9 per 1,000 and the proportion of nonwhite women was 68.1 per 1,000. The Board expresses a note of caution on the applicability of this data to California, especially in view of the sparcity of other research information.

The California Department of Public Health has applied these rates to the number of California women ages 15 to 44, and estimated there were over 80,000 illegal abortions in the state in 1967. Thus, it was not until 1971 that therapeutic procedures exceeded the previous level of illegal abortions. From 1968 through 1970, it appeared that therapeutic abortions were replacing illegal ones. This indicates that despite the increases in therapeutic procedures, the rate of total induced abortions (illegal plus therapeutic) did not really change until 1971 when the rate for therapeutic abortions was greater than that estimated for illegal procedures in 1967.

Public attitudes about illegal abortions as reflected in the various California legal codes are quite clear. For example, Business and Professions Code Section 601 provides that advertising for producing or facilitating an abortion is a felony. Business and Professions Code Section 2377, provides that aiding or abetting or attempting or agreeing or offering to procure a criminal abortion constitutes unprofessional conduct by a physician. Under Section 2761, a nurse may be the subject of disciplinary action for being involved in a criminal abortion. The license of a vocational nurse may be suspended or revoked for similar conduct under Section 2878. Similar action can be taken against a psychiatric technician under Section 4521. Penal Code Section 187-a defines murder as the unlawful killing of a human being or a fetus with malice aforethought, but further qualifies the definition of murder involving a fetus so as to be consistent with the provisions of the California Therapeutic Abortion Act. Several other sections of the Penal Code describe the punishment for soliciting the use of or supplying chemicals and/or instruments designed for the purpose of inducing a miscarriage. From this, it can be seen that public policy took a clear and opposing view of criminal abortions.

D. The Therapeutic Abortion Act in Practice

California's Therapeutic Abortion Act was passed in November 1967. Essentially it provides that the holder of a Physician's and Surgeon's Certificate may perform an abortion if each of the following requirements is met:

1. The abortion is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

2. The abortion is approved in advance by a committee of the medical staff which is established and maintained according to the standards of the Joint Commission and if such committee consists of no more than three licensed physicians, the unanimous consent of all committee members is required to approve the abortion.

3. The committee of the medical staff finds that one or more of the following conditions exist:

   a. There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother;

   b. The pregnancy resulted from rape or incest.

The law also provides that the above-described committee must consist of not less than two licensed physicians, but three are required if the pregnancy is to be terminated after the thirteenth week and in no event shall the termination be approved after the twentieth week of pregnancy.

The California Department of Public Health estimates that prior to 1967, there were fewer than 600 legal abortions per year performed in all California hospitals. It is presumed that most of these abortions were performed because of the danger to the mother's physical health and relatively few were performed following rape or incest. Only four years later, in 1971, the number of therapeutic abortions performed in this state jumped to 116,749. It is estimated that an excess of 90 percent of these abortions were performed under Health and Safety Code Section 25951(c)(1) holding that the continuance of the pregnancy would gravely impair the mental health of the mother.

The term "mental health" as used in Health and Safety Code Section 25951 is defined in Section 25954 and means "mental illness to the extent that the woman is dangerous to herself or to the person or property of others or in need of supervision or restraint." This definition appears to be even more stringent than that contained in Welfare and Institutions Code Section 5150. This section describes the individual's psychiatric condition in circumstances when she may be involuntarily detained for evaluation and treatment. That definition reads "When any person as a result of mental disorder, is a danger to others, or to himself, or gravely disabled..." The enactment of California's Therapeutic Abortion Act opened the door and from that time on, relatively little attention was paid to the specific requirements of the statute by a number of large-scale abortion facilities in the state.

In many facilities, the pregnant woman simply makes written application for an abortion, indicating that unless the abortion is approved her mental health will be impaired and the abortion is approved solely on the basis of the unverified written application.

The law specifically requires the establishment of a committee structure maintained in accordance with standards promulgated by the Joint Commission on Accreditation of Hospitals. An accreditation surveyed by the Joint Commission involves a detailed study of the administrative and medical-psychiatric practices in each accredited institution. California's law has been in effect for six years and it is curious that the Joint Commission has not publicly raised questions about the informal functioning of the Therapeutic Abortion Committee in a large number of public and private facilities across the state.

The California State Department of Public Health reports that in 1970, 17 hospitals, each performing over 1,000 abortions, accounted for over 27,000, or 42 percent of the total 65,369 procedures. In 1971, the number of institutions performing more than 1,000 abortions each increased to 22 and they did more than half (51 percent) of the 116,749 abortions that year. The distribution of therapeutic abortions among medical facilities in this state is quite interesting. Appendix II reflects the number of therapeutic abortions reported by county and individual hospitals throughout California in 1971, as well as the abortions performed in these facilities, other than those in Los Angeles County, in the first quarter of 1972. This information reveals that reports on therapeutic abortions performed were received from 351 public and private hospitals in 48 counties. It is interesting, however, to note that four hospitals in Los Angeles County (Avalon Memorial, Los Angeles-University of Southern California, Parkwood, and San Vincente) accounted for over 29,000 abortions which represented 25 percent of the total abortions performed in the State of California in the year 1971.

In its Report to the 1972 California Assembly on the Effects of Therapeutic Abortion Law on the Medical Profession, Patient-Doctor Relationships, Relationships Between the Medical Profession and General Public, the California Department of Public Health stated on Page 2: "Within the medical community, therapeutic abortions have changed from a rare operation in 1967 to the most common surgical procedure in the state in 1971." As mentioned earlier, in relation to the subject of family planning or birth control, a whole new medical industry has been created with significant fiscal ramifications. The average cost of a therapeutic abortion is $250 Applying this amount to the 116,749 abortions in 1971 reveals that the fees for this service totaled almost $30 million during that year, approximately 40 percent of which was reimbursed by public tax-supported medical care programs.

Misapplication or misuse of the California Therapeutic Abortion Statutes is not restricted to the abortion procedure itself, but rather includes other aspects as well. The same problems identified earlier with respect to birth control also exist in relation to abortion counseling, but are considered to be more serious because of the possible consequences. There are no statewide guidelines which require that individuals or agencies meet certain standards of quality for the service they perform, nor are

there requirements that the individuals performing pregnancy counseling and referral services must meet certain qualifications in terms of their education and experience. Obviously for the protection of pregnant women, standards of service and educational and experience criteria must be established by a responsible agency of state government and then enforced on a uniform statewide basis.

At one of its public hearings, the Board received testimony from Stewart Knight who alleged that there exists in the State of California the practice of referral payments between pregnancy counselors and medical centers which provide abortion services. The magnitude of this particular problem is unknown, but the possibilities could be substantial considering the number of therapeutic abortions performed in California. In that 40 percent of the abortions performed in this state are financed through Medi-Cal funds, the improper expenditure of public funds also raises serious questions. As a part of the effort to develop standards for quality service and minimum qualifications for individuals engaged in pregnancy counseling, legislation should also be enacted to prohibit the soliciting or payment of a fee for referral to an abortion service. The Board is concerned about the apparent conflict of interest involved in such a situation in which implications of such counseling and referral services may exert influence on the emotional young women to seek an abortion.

In the face of the turmoil and emotional debate the United States Supreme Court, in a seven to two decision, overruled all state laws that prohibit or restrict the woman's right to obtain an abortion during her first three months of pregnancy. An analysis of the key features of the ruling are as follows:

1. For the first three months of pregnancy, the decision to have an abortion lies with the woman and her doctor, and the state's interest in her welfare is not "compelling enough" to warrant any interference.

2. In the second trimester of pregnancy, a state may regulate the abortion procedure in ways that are reasonably related to maternal health, such as licensing and regulating the persons and facilities involved.

3. For the last ten weeks of pregnancy, the period during which the fetus is judged capable of surviving if born, any state may prohibit abortion, if it wishes, except where it may be necessary to preserve the life or health of the mother.

The California State Supreme Court in December 1972 threw out all requirements for abortions in California except that they be performed by licensed physicians in accredited hospitals before 20 weeks of pregnancy. The U. S. Supreme Court decision went beyond this and threw out all requirements in the first trimester (12 weeks) except that the abortion be performed by a licensed physician. Further, the decision provides for abortion up to 24 weeks as compared with California's 20-week restriction.

The force and effect of both the California Supreme Court decision and the United States Supreme Court Decision on this state was not that significant. Essentially, what the courts have done was to simply legitimize a practice which already existed in California resulting from the misuse of this state's therapeutic abortion statutes.

Even the United States Supreme Court decision of January 22, 1973 and a February 26 denial of petitions for rehearings by Texas and Georgia failed to settle the social issue or quell the debate. By the end of February at least nine states had introduced legislation that would bring their laws into conformity with the decision and an equal number were working on new legislation. One state legislature which had acted by that time, the State of Virginia, rejected a bill that would have brought its law into line with what the court said. In more than a dozen states, attorneys general or local courts have declared existing abortion laws null and void, but in at least five states legal or judicial authorities have supported the old restrictive laws. However, despite actions of the court, various efforts are being made to nullify the recent Supreme Court decision:

1. A constitutional amendment was introduced in Congress which would call for legal protection of life from the moment of conception.

2. Another proposed constitutional amendment was introduced in Congress to give states the unqualified right to make their own abortion laws.

3. Several state legislatures have introduced (and one state passed) resolutions to endorse a federal constitutional amendment to supersede the Supreme Court decision.

E. The Process and Procedures

There has been a rapid growth of pregnancy counseling services since the Therapeutic Abortion Act became effective. Preliminary survey data from the California State Department of Health indicates about half the women obtaining abortions in 1971 used counseling services. The effect of such services tends to limit the physician's role to a medical assessment of the patient and the application of his technical skills. Pregnancy counseling and, in particular, abortion counseling represents a new and unique service. The Department has identified 110 pregnancy counseling agencies in California. The following kinds of organizations are providing these services: Planned Parenthood-World Population, county health and welfare departments, The Children's Home Society, University Hospital and Health Services, free clinics, Community Crisis Centers, Women's Liberation, Zero Population Growth, and the Association to Repeal Abortion Laws. Private individuals are also offering pregnancy counseling services.

The Board has previously expressed its viewpoint on the need for criteria to assure quality service and the establishment of qualifications for individuals providing pregnancy counseling services.

The pregnancy counseling agency is acting as an intermediary between the patient and the doctor. There is no specific legal authority for this practice. After the patient makes the decision as to whether or not the pregnancy will be continued, she is referred to the appropriate medical resource for either prenatal care or therapeutic abortion. The exchange of information about pregnancy alternatives, assessment of emotional needs, and even the institution of follow-up, if any, is carried out largely by the counseling service. The role of the physician is limited to the physical assessment of his patient and implementing the medical procedures whether it be abortion, prenatal care, or contraception. The Board has also expressed its position that such pregnancy counseling agencies should be prohibited by statute from soliciting or collecting a fee for their service from the medical practitioner or the medical facility to which the client is referred.

Essentially, at the time the pregnant woman reaches the doctor or hospital, her decision has already been made with respect to the abortion. It is interesting that pregnant women seeking a therapeutic abortion tend to use medical facilities other than those that they would use for normal procedures. Although there has been a marked increase in the number of therapeutic abortions, with over 300 hospitals in California reporting one or more procedures. For example, in 1970, 24,000 abortions, nearly 40 percent of the total, were performed in only 17 hospitals and these same 17 hospitals accounted for less than seven percent of all total births. These figures make it clear that many women are not obtaining abortions in the same hospitals in which they receive their obstetric care.

The above information also implies that a greater number of women are not seeking abortions from the physician usually providing them obstetric or general medical care. It is not known if this situation stems basically from the patient's desire for anonymity, from a reluctance of many obstetricians and general practitioners to perform abortions, or whether it's simply a function of patients going to the place where services are available. It is clear that therapeutic abortions are frequently obtained in a manner distinct from all other medical surgical services even though as pointed out earlier abortions have become the most common medical procedure in this state.

Assuming that the pregnant woman visits an accredited medical facility which provides an active therapeutic abortion program and her pregnancy is in the first trimester (12 weeks), the entire procedure can be completed in four to five hours including a one-hour counseling session.

Some facilities conduct their preabortion counseling sessions in a group setting with from three to five abortion patients in attendance. Generally, the "counselor" is a nonprofessional from the peer group who devotes a substantial part of the counseling hour to a discussion of the specifics of the medical procedure and to birth control techniques which the patients may have used in the past and which they plan to use in the future. Considering the fact that half of the women attending have had no prior counseling, such sessions are completely inadequate in comparison to general psychiatric or medical practice, and, when witnessed, completely destroy the illusion that the decision to abort is arrived at in a

considered, confidential, doctor-patient conference. The "counseling" session becomes an emotionally-charged experience with each of the women generally offering information about the circumstances which brought her to this point. This hour-session is virtually the last opportunity the woman has to change her mind, and it is also the key point at which the staff has an opportunity to identify the woman who is insecure in her decision.

If the woman's pregnancy is 12 weeks or less, the abortion is normally performed by use of a vacuum aspirator. The placenta is drawn out of the uterus through suction created by an electric pump. Major facilities performing these services advertise that patients flying into metropolitan areas can easily be admitted by 11 a.m. and be released from the hospital in order to make plane connections home that evening.

Women whose pregnancies are more advanced than the first trimester generally are required to rely on the "amnio" method of abortion. This is a more extensive procedure than that described above and requires at least an overnight stay in the hospital. Essentially, a saline solution is injected through the abdominal wall into the uterus and this process induces labor in much the same fashion as normal childbirth. The cost of this procedure is substantially higher than the aspiration method and there is also an increased risk.

Compared to the extensive prenatal and postnatal laboratory and diagnostic testing now common in normal childbirth, some facilities seem lax in this regard. There is generally little, if any, medical follow-up, expecially since a substantial number of women do not live in close proximity to the medical facility they use for abortion services. Some facilities advertise no charge for medical complications, but from the patient's standpoint, this is normally impractical. These factors combine to cloud the whole issue of specifically what kinds of medical and psychiatric complications do, in fact, result from abortions. It also becomes impossible to determine resultant death rates with any precision.

F. The Consequences

There is the potential for deep individual and social significance connected with a society's headlong rush into liberalized abortion. One is forced to wonder how much consideration was given to these factors in the development of legislation. It would also appear that lawmakers and the courts have gone beyond what the majority of people will support with respect to abortion. Davis reports that seven opinion studies taken since 1962 showed only 33 percent of the public believes there should be no legal restraints on abortions. The latest survey taken in late 1972 indicates that ten percent opposed any legal abortion, 19 percent opposed if an expected child was deformed, 55 opposed for financial reasons, and 67 percent opposed abortions on women who just didn't want more children.

The specific effect of abortions on individuals is relatively unclear at this point in time. Most studies involve a relatively small sample of women and the inability of the medical-psychiatric profession to accurately measure cause and effect is a very real problem. Another

compounding element is the fact that a substantial number of women go elsewhere for abortions and are, therefore, very difficult to follow for study purposes. Having obtained her abortion in a metropolitan area, major and minor complications are most likely seen by the family physician near the patient's home and as a result are not reported to the abortion facility.

Dr. Robert Pasnaugh reports the viewpoint that most normal women were found to react to abortions with mild feelings of depression without serious after-effects. Most women who were psychiatrically ill were found to respond with improved mental attitudes. Some were found to respond with increased symptoms. No study has been able to determine in advance which women will react adversely to pregnancy and which to abortion. He states that at present, there is no evidence to suggest that the risk of psychiatric complications in induced abortions constitutes a contraindication to the procedure in either normal or psychiatrically ill women. He does, however, propose three specific steps that should be taken to reduce the risk of psychiatric complications: (1) there should be routine psychiatric consultation; (2) psychiatric evaluation should be requested if patient exhibits symptoms of major psychiatric illness, history of postpartum psychosis, exhibits ambivalence or is passively compliant; and, (3) all patients should be seen in routine follow-up visits. Although the evidence is unclear, there are studies which identify guilt reactions and lowered self-esteem following abortion.

Perhaps the most ambitious study and certainly one which involved a substantial sample is one conducted by the Joint Program for the Study of Abortions (JPSA). This study was based on a total of 72,988 abortions performed from July 1, 1970 to June 30, 1971 as reported by 66 institutions participating in the JPSA study sponsored by the Population Council. The JPSA study also noted that abortions were performed on 164 women who were not pregnant. It is suggested that this document should receive careful consideration as it represents a significant contribution toward assessing postabortion medical complications. Some of the conclusions reached by JPSA with respect to medical complications are as follows:

1. The incidence of early medical complications, including minor complaints, during the first trimester of pregnancy was on the order of one in twenty abortions; the incidence of major complications as defined in the report, was one in two hundred abortions.

2. The risk to health associated with abortions was three to four times as high in the second trimester of pregnancy as in the first trimester.

3. Complication rates were higher for abortions performed at six weeks gestation or less than at seven to ten weeks gestation, especially for major complications. However, the major complication rates were far lower for the earliest abortions than for abortions in the second trimester.

The above study should represent a significant contribution to assessing postabortion medical complications and it is suggested that this document should receive careful consideration.

It is extremely doubtful that any amount of statistical data received through studies will ever totally erase the atmosphere of emotion which surrounds the subject at the present time. It can only be hoped that through proper counseling and education men, women, boys and girls will come to realize the burden of responsibility they place upon themselves and society with the creation of unwanted pregnancies.

State Social Welfare Board
Analysis of Mail
Preliminary Position Statement on Illegitimacy
Published March 1972

A total of 139 letters were received by the State Social Welfare Board following publication of its preliminary position statement on the subject of illegitimacy. Every letter received a personal reply and in instances where the writer seemed to be reacting to a news report only, a copy of the statement accompanied the letter. Writers were urged to study the problem and then to suggest alternatives. In only two cases did the Board receive follow-up letters containing alternative suggestions.

Persons requesting a copy of the statement	44
Persons expressing a position on the statement	95
	139

Positions Expressed

Of the 95 writers who expressed a position, those who supported the Board's position were as likely to react emotionally as were those who opposed the position:

Support of the Board's position	51	53%
Opposed to the Board's position	44	47%
	95	100%

Basis for Criticism

A number of writers opposed to the Board's position simply reacted on an emotional level and did not propose alternative solutions. There were 83 critical responses contained in the 44 letters of opposition. The breakdown of these responses is as follows:

Interference with mother's rights	32	39%
Excessive governmental power	25	30%
Illegitimacy not criteria for inadequacy	10	12%
Unconstitutional	9	11%
Motivated by cost savings	5	6%
Insufficient adoptive homes	1	1%
Will not promote greater use of Civil Code Section 232	1	1%
	83	100%

Alternative Proposals

Generally, writers making suggestions were inclined to propose more than one. Most of the following 95 suggestions came from writers who opposed the Board's position.

1.	Increased emphasis on family planning and expand availability of contraceptive devices.	17	18%
2.	Increased emphasis on education for family life and responsibility.	13	14%

3.	Provide for sterilization on males and females and consider bonus for voluntary sterilization.	10	10%
4.	Liberalize abortion laws and broaden the availability of information on this subject.	7	7%
5.	Enforce the support obligation of the father.	7	7%
6.	Give recognition to social changes which condone other family life styles.	7	7%
7.	Find some means of getting at the inadequate or unfit parents who are married.	5	5%
8.	Provide more social services during and following the pregnancy.	4	4%
9.	Provide child care so young mothers can complete education and obtain training.	4	4%
10.	No increase in grant following birth of certain number of illegitimate children (usually two).	4	4%
11.	Develop program to assist the young mother to complete her education.	3	3%
12.	Increase the grant level to improve mother's ability to provide good home for child.	3	3%
13.	Evaluate grandparents' home for suitability to avoid repeating mistakes they may have made before insisting that the young mother remain in their home.	3	3%
14.	Provide for financial responsibility on the part of the grandparents of one/both unwed parents.	3	3%
15.	Provide equal job opportunities for women.	2	2%
16.	Use income tax incentives to limit the number of births.	2	2%
17.	Provide for state-run institutions as alternatives to unfit or inadequate parents.	1	1%
		95	97%

Survey Opinion Questions

Following is a summary of responses to survey opinion questions reported in Illegitimacy: Law and Social Policy, by Harry D. Krause, Bobbs-Merrill Co., Inc., App. B, pp 307-322. Refer to the text for a breakdown of responses by characteristics of the respondents and for information on the conduct of the survey and drawing of the sample.

1. Do you agree or disagree that in general, the illegitimate child should have the same legal relationship (rights and duties) with its mother that a legitimate child has with its mother?

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
95%	3%	2%	100%	2,031

2. Which one of these statements best reflects your opinion?

   a. The father of an illegitimate child should have no legally recognized and enforceable responsibilities to his illegitimate child.

   b. An illegitimate child should be entitled to the same amount of support as a legitimate child.

   c. An illegitimate child should not be in as good a position as a legitimate child, but it should be entitled to receive enough support from its father to take care of its basic needs.

a.	b.	c.	Total	Number of Cases
4%	78%	18%	100%	2,031

3. Which one of these statements best reflects your opinion?

   a. Unless the father leaves a will in which he specifically gives his illegitimate child an inheritance, the illegitimate child should have no right to inherit from its father.

   b. If the father does not leave a will, the illegitimate child should inherit from its father the same inheritance to which the child would be entitled if it were of legitimate birth.

   c. If the father does not leave a will, the illegitimate child should inherit from its father enough to cover support needs until the child is able to go to work and earn its own living.

a.	b.	c.	Total	Number of Cases
5%	64%	31%	100%	2,031

4. If the father is fit, willing, and paying adequate support, and if a family court considers this in the best interests of the child, the father of an illegitimate child should be allowed to visit his child periodically, even if the mother objects.

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
82%	14%	4%	100%	2,031

5. The illegitimate child should have the same rights involving the payment of benefits for the death or disability of the father (for example, workman's compensation) as a child of legitimate birth.

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
87%	9%	4%	100%	2,031

6. In each case of an illegitimate birth, appropriate legal authorities should investigate the fitness of the mother to bring up the child and if the mother is considered unfit, should ask the courts to determine whether the child should be given into foster care or into adoption.

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
86%	10%	4%	100%	2,031

7. Unless the child is given up for adoption by its mother, appropriate legal authorities should investigate the identity of the father in each case of an illegitimate birth and should ask the court to hold the father responsible for his child.

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
86%	10%	4%	100%	2,031

Do you agree or disagree with the following statements?

8. If the father cannot be found or cannot contribute to the support of his illegitimate child, the welfare authorities should give the mother (if she is a fit person) enough money to make a decent home for her illegitimate child.

9. The discrimination imposed by our law on the illegitimate child is an effective way to discourage sexual intercourse between unmarried persons.

10. Making fathers financially responsible for their illegitimate children would seem to be a more effective way to discourage promiscuous sexual intercourse than imposing no obligation or a limited support obligation on fathers of illegitimate children.

	Agree	Don't Know or Disagree/No Opinion
Question 8	79%	21%
Question 9	20%	80%
Question 10	75%	25%

11. The law should not disadvantage the illegitimate child for the misdeed of its parents that brought it into the world. Do you agree or disagree?

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
96%	3%	1%	100%	2,031

12. Fathers and mothers of illegitimate children should be punished by the criminal law for bringing them into the world. Do you agree or disagree?

Agree	Disagree	Don't Know or No Opinion	Total	Number of Cases
20%	70%	10%	100%	2,031

Appendix 3

NUMBER OF LIVE BIRTHS BY LEGITIMACY STATUS
RACE OF MOTHER AND AGE OF MOTHER
CALIFORNIA 1966 - 1972

LEGITIMACY STATUS AND YEAR		ALL RACES					WHITE[1/]					BLACK[1/]				
		All Ages	15-19	20-24	25-34	35+	All Ages	15-19	20-24	25-34	35+	All Ages	15-19	20-24	25-34	35+
Illegitimate	1972	40,171	17,499	12,806	7,917	1,277	26,821	11,243	8,620	5,644	950	12,420	5,928	3,865	2,044	297
	1971	39,912	16,726	13,222	7,887	1,419	26,522	10,685	8,930	5,514	1,041	12,450	5,738	3,950	2,145	341
	1970	45,593	18,888	15,615	8,793	1,676	31,052	12,345	10,996	6,187	1,222	13,602	6,231	4,277	2,396	404
	1969a/	42,085	17,348	14,557	8,009	1,600	29,371	11,517	10,742	5,683	1,156	11,924	5,537	3,571	2,120	406
	1968a/	38,053	15,587	13,110	7,177	1,614	27,141	10,597	9,963	5,143	1,162	10,393	4,818	2,972	1,905	416
	1967	35,215	14,440	11,658	6,841	1,740	24,987	9,636	8,943	4,873	1,262	9,750	4,630	2,590	1,839	429
	1966	31,804	12,819	10,303	6,582	1,627	22,204	8,531	7,712	4,582	1,167	9,124	4,138	2,450	1,860	418
Legitimate	1972	266,204	34,830	97,833	118,362	14,991	239,217	32,075	88,890	105,264	12,821	14,450	2,134	5,630	5,785	883
	1971	289,914	36,989	111,955	123,422	17,410	260,919	33,954	101,919	109,935	14,987	16,595	2,404	6,569	6,470	1,142
	1970	317,059	42,125	121,668	133,234	19,863	286,116	38,597	111,107	119,122	17,144	18,531	2,842	7,206	7,158	1,311
	1969a/	310,822	41,406	118,842	129,442	20,978	280,823	37,498	108,765	116,232	18,228	18,700	3,209	7,104	6,970	1,381
	1968a/	301,168	42,135	115,476	121,488	21,923	272,618	38,129	106,248	108,953	19,193	18,113	3,375	6,667	6,680	1,351
	1967	301,369	44,168	114,939	117,963	24,165	272,862	40,048	105,784	105,642	21,282	18,746	3,568	6,770	6,862	1,523
	1966	305,819	46,698	112,520	119,869	26,610	276,287	42,587	103,274	106,867	23,465	19,723	3,647	6,910	7,458	1,690
All Live Births	1972	306,375	52,329	110,638	126,279	16,268	266,038	43,318	97,510	110,908	13,771	26,870	8,062	9,495	7,829	1,130
	1971	329,826	53,715	125,177	131,309	18,829	287,441	44,639	110,849	115,449	16,028	29,045	8,142	10,519	8,615	1,483
	1970	362,652	61,013	137,283	142,027	21,539	317,168	50,942	122,103	125,309	18,366	32,133	9,073	11,483	9,554	1,715
	1969	352,907	58,754	133,399	137,451	22,578	310,194	49,015	119,507	121,915	19,384	30,624	8,746	10,675	9,090	1,787
	1968	339,221	57,722	128,586	128,665	23,537	299,759	48,726	116,211	114,096	20,355	28,506	8,193	9,639	8,585	1,767
	1967	336,584	58,608	126,597	124,804	25,905	297,849	49,684	114,727	110,515	22,544	28,496	8,198	9,360	8,701	1,952
	1966	337,623	59,517	122,823	126,451	28,237	298,491	51,118	110,986	111,449	24,632	28,847	7,785	9,360	9,318	2,108

1/ For 1966-1969, births by race of mother were estimated from births by race of child using 1970 ratios. Prior to 1970, California births were classified by race of child only. Since 1970, they have been classified by race of mother, race of father and race of child.

a/ Figures for illegitimate and legitimate births adjusted for comparability with coding rules applied for 1966-67 and 1970-71.

Note: Totals include births to mothers under age 15 and of unknown age.

Source: State of California, Department of Public Health, Birth Records.

ESTIMATED BIRTH RATES BY LEGITIMACY STATUS, RACE OF MOTHER, AND AGE OF MOTHER: CALIFORNIA RESIDENTS, 1966-1972

Type of Birth Rate and Year	All Races					White[a]					Black[a]				
	15-44[b]	15-19	20-24	25-34	35-44[c]	15-44[b]	15-19	20-24	25-34	35-44[c]	15-44[b]	15-19	20-24	25-34	35-44[c]
Illegitimate															
1972	22.0	20.7	31.3	23.5	5.4	17.4	15.3	24.9	20.7	5.0	65.4	85.5	101.6	42.7	8.5
1971	22.6	20.4	32.8	25.4	6.1	17.7	14.9	26.2	21.9	5.5	69.1	87.6	106.3	49.2	10.0
1970	27.0	24.1	41.3	29.9	7.2	21.6	17.9	34.2	26.0	6.4	80.1	102.0	123.5	58.5	12.2
1969	26.0	22.8	41.6	28.9	7.0	21.2	17.1	36.1	25.1	6.1	74.5	95.9	112.2	55.6	12.6
1968	24.6	21.1	41.0	27.8	7.1	20.4	16.2	36.5	24.2	6.2	69.2	88.8	102.6	54.0	13.2
1967	23.8	20.0	40.3	28.2	7.7	19.6	15.0	36.1	24.5	6.7	69.2	90.1	99.4	56.2	14.0
1966	22.5	18.2	40.4	28.8	7.3	18.1	13.5	35.2	24.2	6.3	69.2	84.8	107.5	60.8	14.1
Legitimate															
1972	98.4	333.8	194.2	102.8	15.9	99.2	342.2	195.5	102.8	15.3	92.3	286.4	192.3	83.9	17.4
1971	109.5	354.7	220.3	114.1	18.3	110.2	364.2	221.3	114.0	17.7	109.7	330.2	223.2	101.0	22.6
1970	122.1	409.6	247.9	127.6	20.7	122.8	418.1	249.5	127.4	20.0	126.4	405.2	254.4	117.0	26.2
1969	120.1	390.8	248.2	126.6	21.4	120.6	392.7	249.9	127.0	20.7	128.9	449.5	255.8	117.3	27.2
1968	117.7	388.9	249.8	122.6	22.0	118.1	388.9	252.3	122.6	21.3	127.4	473.9	248.4	117.0	26.5
1967	119.1	399.2	259.3	122.5	23.8	119.1	395.6	261.7	122.0	23.1	134.4	495.0	263.0	124.6	29.6
1966	122.4	410.6	272.9	127.0	25.8	121.9	410.6	274.6	125.7	25.1	144.5	504.8	287.8	139.4	32.7
All Live Births															
1972	67.6	55.2	121.2	84.9	13.8	67.3	52.2	121.8	85.6	13.4	77.5	105.0	141.1	67.0	13.8
1971	74.7	58.2	137.4	94.3	15.9	74.3	55.1	138.4	94.9	15.4	87.6	111.8	157.9	80.0	17.6
1970	84.6	68.8	158.0	106.1	18.1	84.1	65.1	159.3	106.8	17.5	101.6	133.2	182.4	93.6	20.6
1969	83.9	67.6	161.1	105.8	18.6	83.5	63.7	163.1	106.8	18.1	100.4	134.8	179.1	93.1	21.5
1968	82.7	68.2	164.4	103.0	19.2	82.4	64.6	167.5	103.6	18.7	97.5	133.4	172.7	92.9	21.4
1967	83.9	70.5	172.8	103.6	20.9	83.5	66.7	176.0	103.8	20.4	101.6	139.9	180.7	99.1	23.8
1966	86.3	72.7	184.1	107.9	22.5	85.5	69.5	186.5	107.2	21.9	107.5	139.0	200.0	110.8	26.0

NOTE: Rates are per 1,000 unmarried (illegitimate), married (legitimate), and total women. Unmarried women are those single, widowed, divorced, or separated.

a/For 1966-1969, births by race of mother (numerators for rates) were estimated from births by race of child using 1970 ratios. Prior to 1970, California births were classified by race of child only. Since 1970, they have been classified by race of mother, race of father, and race of child.

b/Rates computed by relating total births, regardless of age of mother, to estimated number of women aged 15-44.

c/Rates computed by relating births to mothers aged 35 and over to estimated number of women aged 35-44.

Source: State of California, Department of Public Health, Birth Records; State of California, Department of Finance, population estimates prepared December 1971 and November 1972; 1970 Census of Population, General Population Characteristics, California, Tables 19, 22; 1960 Census of Population, Vol. 1, Part 6, Table 105 and Subject Reports PC(2)-1C, Table 19.

Illegitimate Birth Rates by Rank Order for 46 Countries
Number of Illegitimate Births per 1000 Unmarried Women 15-44

Rank Order	Country	Latest Year Date	Rate
1	Guinea	1955	209.9
2	Angola	1960	209.4
3	El Salvador	1961	206.6
4	Venezuela	1961	190.3
5	Jamaica	1960	189.5
6	Honduras	1961	185.1
7	Panama	1960	170.4
8	Ecuador	1962	136.3
9	Peru	1961	125.8
10	Mexico	1960	112.6
11	Puerto Rico	1960	78.4
12	Iceland	1950	76.7
13	Colombia	1951	60.3
14	Congo, D.R.	1957	49.4
15	Chile	1960	48.3
16	Argentina	1947	26.4
17	Yugoslavia	1961	26.0
18	Austria	1951	25.4
19	Bulgaria	1956	24.9
20	New Zealand	1961	24.1
21	United States	1965	23.5
22	Portugal	1960	22.2
23	England and Wales	1964	20.2
24	Sweden	1960	19.7
25	Canada	1961	17.9
26	Australia	1961	17.8
27	China-Taiwan	1956	17.7
28	Denmark	1960	17.1
29	Poland	1960	15.3
30	France	1962	14.5
31	West Germany	1961	13.0
32	Hungary	1960	12.4
33	Norway	1960	9.2
34	Finland	1960	8.5
35	Ryukuy Islands	1960	8.2
36	Switzerland	1950	7.2
37	Belgium	1947	5.4
38	Spain	1960	4.9
39	Italy	1961	4.2
40	Albania	1955	3.6
41	Ireland	1951	3.6
42	Netherlands	1960	3.6
43	Greece	1961	2.2
44	Philippines	1960	1.9
45	Japan	1964	1.6
46	Israel	1961	1.3

Sources: Computations from the number of births by legitimacy and total births, numbers of unmarried women 15-44, from the United Nations, Demographic Yearbook, 1959, 1962, 1963 and 1965.

Characteristics of Persons Involved in Welfare Paternity Actions
Based on 259 Interviews in Two Counties, August 1972

Column one describes the characteristics of persons involved in cases in which the district attorney made a decision to proceed with the action. Column two are those cases in which the district attorney decided not to proceed. Column three represents a combined total of both types of cases.

1. Of the 259 cases interviewed, a decision was made to proceed with the paternity action in 162 (62%) of the cases. The mother, or expectant mother, was asked to indicate if she could identify the putative father.

2. The present residence of the putative father was indicated by the mother to be:

3. The present living arrangement of the mother in these cases is as follows:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Yes	162	100	81	84	243	94
No	0	0	16	16	16	6
In county	115	71	22	23	137	52
In state	28	17	7	7	35	14
Out of state	10	6	42	43	52	20
Unknown	9	6	26	27	35	14
Parents/Relative	76	47	28	29	104	40
Alone	55	34	48	50	103	40
Friends	21	13	15	15	36	14
Husband	3	12	6	6	9	3
Common-law husband	7	4	0	0	7	3

4. The education level of the mother and putative father were determined to be:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Mother:						
Less than 8 years	1	1	10	10	11	4
8 through 11 years	98	60	37	38	135	52
High school graduate	45	28	37	38	82	32
Some college	15	9	11	12	26	10
College graduate	3	2	2	2	5	2
Father:						
Less than 8 years	3	2	6	6	9	3
8 through 11 years	78	48	21	22	99	38
High school graduate	45	28	30	31	75	29
Some college	23	14	10	10	33	13
College graduate	4	2	0	0	4	2
Unknown	9	6	30	31	39	15

5. The present age of the mother and putative father is as follows:

Mother:						
Under 15	0	0	0	0	0	0
15-17	31	19	5	5	36	14
18-19	45	28	19	20	64	25
20-24	59	37	35	36	94	37
25-29	15	9	17	18	32	12
30-34	9	6	15	15	24	9
35 and over	2	1	6	6	8	3

Appendix 6c

6. At the time of conception, the age spread of the mother and putative father was as follows:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Father:						
Under 15	0	0	0	0	0	0
15-17	18	11	1	1	19	7
18-19	17	10	7	7	24	9
20-24	70	44	28	30	98	37
25-29	29	18	24	25	53	20
30-34	16	10	12	12	28	10
35 and over	12	7	11	11	33	12
Unknown	0	0	14	14	14	5
Mother:						
Under 15	4	2	1	1	5	2
15-17	58	37	15	16	73	28
18-19	39	24	26	27	65	25
20-24	49	30	39	40	88	34
25-29	10	6	11	11	21	8
30-34	2	1	5	5	7	3
35 and over	0	0	0	0	0	0

Appendix 6d

7. The present marital status of the mother and putative father is as follows:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Father:						
Under 15	0	0	0	0	0	0
15-17	27	17	6	6	33	13
18-19	25	15	15	16	40	15
20-24	64	39	34	35	98	38
25-29	32	20	21	22	53	20
30-34	13	8	5	5	18	7
35 and over	1	1	3	3	4	2
Unknown	0	0	13	13	13	5
Mother:						
Never married	101	63	43	44	144	56
Married to another	17	10	21	22	38	15
Divorced from putative father	2	1	0	0	2	1
Divorced from another	20	12	14	14	34	13
Separated from putative father	11	7	2	2	13	5
Separated from another	11	7	16	17	27	10
Widowed	0	0	1	1	1	0

Appendix 6e

8. At the time of conception, the marital status of the mother and putative father was as follows:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Father:						
Never married	86	53	32	34	118	45
Married to another	18	11	11	11	29	11
Divorced from mother	2	1	0	0	2	1
Divorced from another	23	14	7	7	30	12
Separated from mother	11	7	2	2	13	5
Separated from another	9	6	2	2	11	4
Widower	1	1	1	1	2	1
Unknown	12	7	42	43	54	21
Mother:						
Never married	123	79	65	67	188	73
Married to another	12	7	10	10	22	8
Divorced from putative father	0	0	0	0	0	0
Divorced from another	15	9	13	14	28	11
Separated from putative father	2	1	0	0	2	1
Separated from another	10	6	8	8	18	7
Widowed	0	0	1	1	1	0

9. Based on the knowledge of the mother, the putative father's present occupation is:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Father:						
Never married	100	61	54	56	154	59
Married to another	14	9	7	7	21	8
Divorced from mother	0	0	0	0	0	0
Divorced from another	20	12	8	8	28	11
Separated from mother	2	1	0	0	2	1
Separated from another	14	9	2	2	16	6
Widowed	1	1	1	1	2	1
Unknown	11	7	25	26	36	14
Professional	7	4	1	1	8	3
Proprietor, manager	0	0	0	0	0	0
Clerical	4	2	2	2	6	2
Craftsman	9	6	1	1	10	4
Armed Forces	5	3	7	7	12	5
Operatives	29	18	12	12	41	16
Farm laborer	1	1	0	0	1	0
Service worker	6	4	2	2	8	3
Household worker	0	0	0	0	0	0
Unskilled worker	36	22	18	19	54	22
Retired	0	0	0	0	0	0
Unemployed	25	15	6	6	31	12
Student	19	12	3	3	22	8
Unknown	21	13	45	47	66	25

Appendix 6g

10. Also based upon the knowledge of the mother, the putative father's present monthly income is:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
None	43	26	7	7	50	19
Under $200	5	3	1	1	6	2
$200 - 399	17	11	4	4	21	8
$400 - 599	12	7	5	5	17	7
$600 - 799	17	11	1	1	18	7
$800 - 999	4	2	0	0	4	2
$1000 - 1199	1	1	1	1	2	1
$1200 - 1399	0	0	0	0	0	0
$1400 - 1599	0	0	1	1	1	0
$1600 and over	0	0	0	0	0	0
Unknown	63	39	77	80	140	54

11. At the time of the interviews, there were 169 other children in the custody of the mothers, 65 (38%) of whom were born out of wedlock. Distribution by family size and legitimacy status is as follows:

	Prosecutable	Nonprosecutable	Combined Total
Legitimate:			
Families with 1 child	24	25	49
Families with 2 children	9	6	15
Families with 3 children	0	5	5
Families with 4 children	1	0	1
Families with 6+ children	1	0	1
Illegitimate:			
Families with 1 child	26	12	38
Families with 2 children	4	5	9
Families with 3 children	1	0	1
Families with 6+ children	1	0	1

12. An effort was made to determine what had been the outcome of any earlier conception, if any, involving this mother and this, or any other, putative father, in addition to the 169 legitimate and illegitimate children presently in the custody of this mother. There had been at least 39 other conceptions, the outcome of which was as follows:

	Prosecutable	Nonprosecutable	Combined Total
This putative father - placed for adoption	3	0	3
By another father - placed for adoption	1	9	10
This putative father - aborted	4	1	5
By another father - aborted	11	10	21

13. The putative fathers represented in this group of 259 cases had 171 children among them. Distribution by family size and legitimacy status is as follows:

Legitimate - with this mother:			
Cases with 1 child	2	2	4
Cases with 3 children	0	1	1
Illegitimate - with this mother:			
Cases with 1 child	11	4	15
Children by another mother:			
Cases with 1 child	23	10	33
Cases with 2 children	19	4	23
Cases with 3 children	6	2	8
Cases with 4 children	2	0	2
Cases with 5 children	2	2	4
Cases with 6+ children	3	0	3

Appendix 6i

14. We attempted to determine the living arrangment of the two parties at the time of conception:

	Prosecutable				Combined	
	Yes		No		Total	
	#	%	#	%	#	%
Lived together during conception	44	27	17	18	61	24
Did not live together during conception	118	73	80	82	198	76

15. We attempted to learn the level of knowledge on the part of the mother with respect to birth control techniques. Forty-six percent of the mothers had received some type of birth control training, although many more had some knowledge of the subject:

Formal training	18	11	8	8	26	10
Home training	7	4	3	3	10	4
Informal training	56	35	27	28	83	32
None	81	50	59	61	140	54

16. Although 46 percent of the mothers had some type of birth control training, and an additional percentage had an awareness of the subject and techniques, 88 percent of the mothers used no form of contraception during the period of conception:

Yes	23	14	9	9	32	12
No	139	86	88	91	227	88

Appendix 6j

17. Within the 259 cases, expectant mothers most often (83%) told the putative father of the pregnancy. This percentage was higher (95%) among those 162 cases in which the district attorney decided to proceed with a paternity action. The question of whether or not the father was told of the pregnancy was answered as follows:

18. Putative fathers most often admitted paternity to the mother or to another person, or both. Of the 354 responses in the 259 cases, only 11% denied paternity and in 6% of the cases the mother was not aware of the admission or denial by the father.

19. Although the father admitted paternity in an overwhelming number of cases, this fact did not appreciably influence the financial arrangements for the birth of the 259 children. In these cases 82% were delivered, or to be delivered, under the Medi-Cal program.

	Prosecutable				Combined	
	Yes		No		Total	
	#	%	#	%	#	%
Yes	154	95	62	64	216	83
No	8	5	35	36	43	17
Admitted to mother	143	56	45	42	188	53
Admitted to another	94	37	12	11	106	30
Denied paternity	7	3	31	28	38	11
Unknown	11	4	21	19	22	6
Medi-Cal delivery	138	85	74	76	212	82
Non-Medi-Cal delivery	24	15	23	24	47	18

20. Some of the fathers did assist the mother in limited ways. However, again, 75% of the fathers assumed no part of the financial burden:

	Prosecutable				Combined Total	
	Yes		No			
	#	%	#	%	#	%
Paid any medical expenses	14	9	3	3	17	7
Made cash contributions	12	7	2	2	14	5
Made in-kind contribution	27	17	7	7	34	13
None	109	67	85	88	194	75

21. We sought to determine if before or after delivery the mother received any type of abortion, adoption or birth control counseling. Of the 259 mothers, 187 had received none (112 prosecutable cases + 75 nonprosecutable cases). Of the 72 mothers who had received counseling, the following agencies were involved:

	Prosecutable	Nonprosecutable	Combined Total
Welfare	8	9	17
Public Health	19	9	28
Probation	2	0	2
Private social agency	10	2	12
Private family planning	11	2	13

22. Mothers sometimes received counseling on more than one subject. The 72 mothers had a total of counseling contacts spread among the three subjects as follows:

Abortion	21	5	26
Adoption	12	9	21
Birth control	33	15	48

23. In 97 of the 259 cases, the district attorney determined that prosecution of the paternity action was not feasible. This decision was based on the following primary reasons:

Reason	Number	Percent
Incarceration of father	3	3
Death of father	0	0
Disability of father	1	1
Absence of father from state	37	38
Too many potential fathers	29	30
Incomplete evidence	17	18
Absolute marital presumption (child of legal husband)	3	3
Mother refused to cooperate	1	1
Child nearing age of emancipation	2	2
Child has limited life expectancy	1	1
Application for public assistance withdrawn	1	1
Mother is an illegal alien	2	2
TOTAL	97	100%

TABLE 32.--AFDC FAMILIES, BY NUMBER OF ILLEGITIMATE CHILDREN, 1971

CENSUS DIVISION AND STATE	TOTAL FAMILIES	NUMBER OF ILLEGITIMATE RECIPIENT CHILDREN						
		NONE	1 CHILD	2 CHILDREN	3 CHILDREN	4 CHILDREN	5 CHILDREN	6 OR MORE CHILDREN
TOTAL:								
NUMBER.	2523900	1426000	559600	262400	129600	71700	37300	37300
PERCENT	100.0	56.5	22.2	10.4	5.1	2.8	1.5	1.5
CENSUS DIVISION:								
NEW ENGLAND	134000	66.7	21.3	7.2	2.4	0.9	0.9	0.6
MIDDLE ATLANTIC . . .	560100	51.8	21.9	12.1	6.7	4.1	1.5	1.9
EAST NORTH CENTRAL. .	363500	51.9	23.9	12.2	5.6	2.8	1.9	1.7
WEST NORTH CENTRAL. .	136600	63.1	20.2	8.2	3.4	2.4	1.4	1.2
SOUTH ATLANTIC. . . .	321800	48.0	24.1	13.5	7.3	3.7	1.9	1.6
EAST SOUTH CENTRAL. .	161900	48.7	25.0	12.4	5.9	3.4	2.2	2.5
WEST SOUTH CENTRAL. .	183000	51.0	21.4	12.5	6.7	3.7	2.2	2.6
MOUNTAIN.	87600	66.4	21.0	6.3	3.1	1.5	1.0	0.7
PACIFIC	517000	65.3	21.9	6.9	3.0	1.5	0.8	0.6
SELECTED STATES:								
ALABAMA	42600	43.2	27.2	12.9	6.3	4.2	3.1	3.1
CALIFORNIA.	440000	63.3	22.7	7.4	3.2	1.8	0.9	0.7
FLORDIA	70200	47.7	22.6	13.8	8.7	3.7	1.1	2.3
GEORGIA	75100	47.3	27.2	14.0	6.3	2.8	1.5	1.1
ILLINOIS.	120300	44.9	22.8	15.4	7.5	4.1	2.7	2.7
KENTUCKY.	37600	64.4	20.2	8.8	2.7	1.9	0.5	1.6
LOUISIANA	54100	43.4	19.0	13.7	8.1	6.1	3.7	5.9
MARYLAND.	40900	39.4	24.0	18.6	7.6	4.6	3.7	2.2
MASSACHUSETTS	72300	67.9	21.2	7.3	1.7	0.8	0.6	0.6
MICHIGAN.	94700	55.2	25.1	10.2	4.5	2.5	1.1	1.3
MISSISSIPPI	34600	38.7	25.4	15.0	9.0	4.6	3.2	4.0
MISSOURI.	48500	53.6	20.0	10.5	6.6	4.1	2.7	2.5
NEW JERSEY.	86200	48.7	23.9	12.6	7.0	3.8	1.5	2.4
NEW YORK.	332600	49.0	22.6	12.8	7.2	4.7	1.8	1.9
NORTH CAROLINA. . . .	39200	50.3	24.0	11.7	6.1	4.1	2.6	1.3
OHIO.	91500	55.5	23.3	11.8	4.7	2.0	1.6	1.1
PENNSYLVANIA.	141300	60.3	18.9	9.9	5.4	3.0	0.9	1.6
TENNESSEE	47100	48.6	26.5	12.7	5.7	3.0	1.9	1.5
TEXAS	84000	52.7	22.7	12.5	6.9	2.1	1.9	1.1
WASHINGTON.	42500	76.9	17.4	3.1	1.9	0.2	0.2	0.2
PUERTO RICO	57800	84.8	9.0	3.6	0.9	0.9	0.2	0.7

Source: Findings of the 1971 AFDC Study, Part I, U.S. Department of Health, Education, and Welfare Publication No. (SRS) 72-03756.

Questions Planned Parenthood speakers must be able to answer. Also questions that pregnancy counselors say, "If the girl had known the answer she probably wouldn't be pregnant."

1. How soon can a pregnancy be determined by a urine test or pelvic exam?

   By urine test, 5-7 days after a missed period. By a pelvic, after six weeks.

2. Why does a female become pregnant when withdrawal is the method of contraception used?

   Often there are sperm down in the penis before the male ejaculates.

3. Can a female become pregnant if there is no penetration?

   Yes - Sperm are mobile and can travel up the entire length of the vagina.

4. If a female has been raped, had unexpected intercourse or had a condom break and is fearful of this resulting in pregnancy, what can be done for her?

   Take the "morning after pill" which can only be prescribed by a physician.

5. Is it possible for conception to occur during a menstrual period?

   Yes

6. How soon after delivery, miscarriage or abortion can a new pregnancy occur?

   2 - 3 weeks.

7. Why do some young girls who have had sexual relations for 3 or 4 years after puberty without using any form of birth control find themselves pregnant when they are in their teens?

   They have not ovulated regularly.

8. How does the pill compare in numbers of fatalities to pregnancy?

   Pregnancy is about 15 times more dangerous than the pill.

9. At what age of the mother are birth defects most likely to occur?

   Early teens and after 35.

Questions (Continued)

10. Name the symptoms of German measles.

    Fine rash, swollen glands behind the ears and symptoms similar to a cold.

11. When does a girl become old enough to have an abortion without her parents' consent?

    At any age that she becomes pregnant.

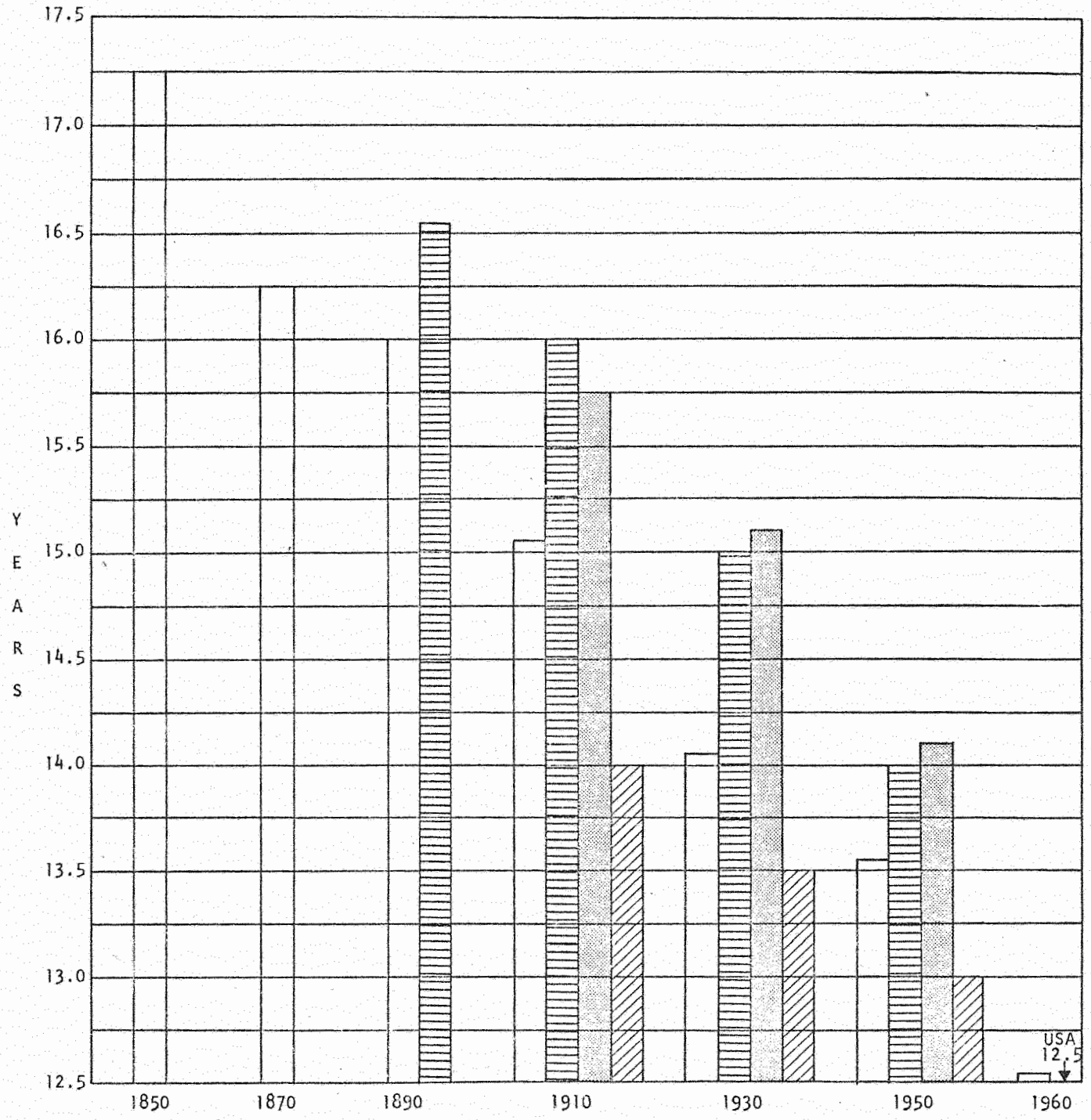
12. What, if any, responsibilities are involved when a minor fathers a child?

    Legally, the boy's parents are financially responsible until the boy is 18; after 18 he is responsible.

13. At what age can a girl get contraceptives without parental consent if she might become a welfare recipient?

    Age 15 and above.

AGE AT ONSET OF MENSTRUATION
PAST 100 YEARS



Menstrual Disorders & Sterility - 1959 Mazer & Israel Gynecology Text

PERCENT DISTRIBUTION OF SELECTED CHARACTERISTICS OF WOMEN HAVING ABORTION

California, 1968-1971

CHARACTERISTIC	YEAR			
	1968	1969	1970	1971
Total: Number	5,018	15,339	665,369a/	116,749a/
Percent	100.0	100.0	100.0	100.0
Ethnic Group				
White	89.1	85.8	81.5	80.0
Black	7.2	9.5	11.8	13.7
Other and Not Reported	3.6	4.7	6.7	6.3
Marital Status				
Married	30.1	25.2	25.4	26.3
Never Married	53.0	57.5	55.0	51.0
Other and Not Reported	16.9	17.2	19.6	22.7
Pregnancy Number				
1	51.4	54.5	49.0	47.8
2-3	23.4	24.2	26.8	30.1
4 or More	23.9	20.6	18.4	19.3
Not Reported	1.4	0.8	5.8	2.8
Age				
Under 20 Years	29.1	31.6	31.7	31.4
20-29	44.4	47.3	49.5	50.9
30-39	21.6	17.8	15.5	15.5
40 and Over	4.7	3.1	2.4	2.2
Not Reported	0.2	0.2	0.9	0.1
Source of Payment				
Medi-Cal	7.8	19.5	35.8	38.5
Other and Unknown	92.2	80.5	64.2	61.5
Type of Hospital				
County	10.5	14.1	9.4	10.0
Private and Other	89.5	84.9	90.6	90.0

a/: Number of therapeutic abortions adjusted for late reports.

Note: Percents calculated independently and may not add to 100.

Source: State of California, Department of Public Health, Bureau of Maternal and Child Health, Therapeutic Abortion Reports.

THERAPEUTIC ABORTIONS REPORTED BY COUNTY AND INDIVIDUAL HOSPITAL

California, 1971, January-March 1972

HOSPITAL	NUMBER REPORTED[1/] 1971	NUMBER REPORTED[1/] January-March, 1972
Alameda	7,638	2,142
Alameda Hospital 2070 Clinton Avenue, Alameda	189	50
Albany Hospital 1247 Marin Avenue, Albany	1[A/]	0
Alta Bates Community Hospital Webster & Regent, Berkeley	879	160
Civic Center Hospital 390 & 420 Fortieth, Oakland	2,623	911
Doctors Hospital of San Leandro 13855 East 14th Street, San Leandro	98	14
Eden Hospital 20103 Lake Chabot Road, Castro Valley	88	22
Herrick Memorial Hospital 2001 Dwight Way, Berkeley	422	117
Highland General Hospital 1411 East 31st Street, Oakland	181	44
Kaiser Foundation Hospital 27400 Hesperian Boulevard, Hayward	266	73
Kaiser Foundation Hospital 280 West MacArthur Boulevard, Oakland	857	194
Laurel Grove Hospital 19933 Lake Chabot Road, Castro Valley	573	69
Levine Hospital 1030 Levine Court, Hayward	163	24
Memorial Hospital of San Leandro 2800 Benedict Drive, San Leandro	627	282
Oak Knoll Naval Hospital 8750 Mountain Boulevard, Oakland	0	--
Oakland Hospital 2648 East 14th Street, Oakland	43	31
Peralta Hospital 450 - 30th Street, Oakland	50	8
Providence Hospital 3012 Summit Street, Oakland	0	0
Samuel Merritt Hospital Hawthorne & Webster, Oakland	269	80
St. Rose Hospital 27200 Calaroga Avenue, Hayward	0	0
Valley Memorial Hospital 1111 Stanley Boulevard, Livermore	111	26
Washington Hospital 2000 Mowry Avenue, Fremont	198	37

1/ Reports received as of September 12, 1972.
A/ Incomplete reporting. Estimates made from reports received.

Source: State of California, Department of Health.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Amador	1	--
Amador Hospital 810 Court Street, Jackson	1	0
Butte	98	38
Feather River Hospital 5974 Pentz Road, Paradise	1	1
Medical Center Hospital of Oroville 2767 Olive Highway, Oroville	45	22
N T Enloe Memorial Hospital West 5th Esplanade, Chico	52	15
Calaveras	2	--
Mark Twain Hospital El Dorado and Pope, San Andreas	2	0
Colusa	12	5
Colusa Memorial Hospital 119 East Webster Street, Colusa	12	5
Contra Costa	1,845	399
Brookside Hospital Vale Road and San Pablo, San Pablo	266	38
Concord Community Hospital 2540 East Street, Concord	133	22
Contra Costa County Hospital 2500 Alhambra Avenue, Martinez	799	166
Doctors Hospital of Pinole 2151 Appian Way, Pinole	40	28
John Muir Memorial Hospital 1601 Ygnacio Valley Road, Walnut Creek	120	24
Kaiser Foundation Hospital 1425 South Main Street, Walnut Creek	388	85
Martinez Community Hospital 20 Allen Street, Martinez	2	0
Pittsburg Community Hospital 550 School Street, Pittsburg	40	25
Richmond Hospital 23rd and Gaynor Avenue, Richmond	57	11
El Dorado	63	25
Barton Memorial Hospital 4th and South Streets, Tahoe Valley	9	3
El Dorado Community Hospital 935 Spring Street, Placerville	9	2
Marshall Hospital Marshall Way, Placerville	45	20

HOSPITAL	NUMBER REPORTED 1971	NUMBER REPORTED January-March, 1972
Fresno	983	275
Clovis Memorial Hospital 88 Norte DeWitt, Clovis	74	14
Coalinga District Hospital Sunset and Washington, Coalinga	6	1
Fresno Community Hospital Fresno and R Streets, Fresno	202	53
Valley Medical Center 445 South Cedar Avenue, Fresno	701	207
Humboldt	265	64
General Hospital Harris and H Streets, Eureka	83[A/]	22
Humboldt Medical Center 2200 Harrison Avenue, Eureka	182[A/]	37
Trinity Hospital 14th and C Street, Arcata	0	5
Imperial	54	22
El Centro Community Hospital Ross at Imperial, El Centro	54	22
Inyo	36	11
Northern Inyo Hospital 150 Pioneer Lane, Bishop	25	10
Southern Inyo Hospital 501 East Locust, Lone Pine	11	1
Kern	622	175
Greater Bakersfield Memorial Hospital 420 - 34th Street, Bakersfield	332	84
Kern County General Hospital 1830 Flower Street, Bakersfield	146	39
North Kern - South Tulare Hospital 1330 Jefferson, Delano	0	1
Physicians Hospital 901 Olive Drive, Bakersfield	13	5
Ridgecrest Community Hospital 1081 North China Lake, Ridgecrest	45	14
San Joaquin Community Hospital 2628 Eye Street, Bakersfield	82	31
USAF Hospital Edwards AFB, Edwards	4	1

A/ Incomplete reporting. Estimates made from reports received.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Kings	5	4
Corcoran District Hospital 1310 Hanna Avenue, Corcoran	3	4
Hanford Community Hospital 450 Greenfield Way, Hanford	2[A/]	0
Lake	3	2
Lakeside Community Hospital Lakeshore Drive, Lakeport	3	2
Lassen	27	6
Lassen Memorial Hospital HSP Lane and West Street, Susanville	27	6
Marin [C/]	487	109
Marin General Hospital 250 Bon Air Road, San Rafael	211	39
Novato General Hospital Hill and Canyon Roads, Novato	16[A/]	7
Ross General Hospital 1160 Sir Francis Drake, Ross	260	63
Mendocino	2	3
Mendocino State Hospital Talmadge	1	0
Ukiah General Hospital 564 South Dora Street, Ukiah	1	3
Merced	14	3
Merced General Hospital 290 East 15th Street, Merced	3	0
USAF Hospital Castle Air Force Base, Merced	11[A/]	2
West Side Community District Hospital 151 South Highway 33, Newman	0	1
Mono	6	3
Mono General Hospital Twin Lakes Road, Bridgeport	6	3

A/ Incomplete reporting. Estimates made from reports received.

C/ Los Angeles County, see page 133.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Monterey	970	227
Alisal Community Hospital 333 North Sanborn Road, Salinas	17[A/]	4
Community Hospital Monterey Pennisula Pacific Grove Carmel Highway, Carmel	146	89
General Hospital of Monterey County Natividad Road, Salinas	39[A/]	7
George L. Mee Memorial Hospital 300 Canal Street, King City	15	7
Monterey Hospital Limited 576 Hartnell Street, Monterey	477	58
Salinas Valley Memorial Hospital 450 East Romie Lane, Salinas	132	51
US Army Registrar's Division Medical Records, Fort Ord	144[A/]	11
Napa	--	1
St. Helena Sanitarium and Hospital Sanitarium Road, Sanitarium	0	1
Nevada	32	19
Tahoe Forest Hospital Tahoe Drive and Pine Street, Truckee	32	19
Orange	3,015	862
Anaheim General Hospital 3350 West Ball Road, Anaheim	54	77
Anaheim Memorial Hospital 1111 West La Palma, Anaheim	4	0
Beach Community Hospital 5742 Beach Boulevard, Buena Park	5	2
Chapman General Hospital 2601 East Chapman Avenue, Orange	48[A/]	36
Costa Mesa Memorial Hospital 301 Victoria Street, Costa Mesa	1	--
Doctors Hospital of Santa Ana 1901 College Avenue, Santa Ana	15	20
Fullerton Community Hospital 100 East Valley View, Fullerton	125	35
Garden Park General Hospital 9922 Gilbert Street, Anaheim	307	30
Hoag Memorial Hospital 301 Newport Boulevard, Newport Beach	321	76
Huntington Intercommunity Hospital 17772 Beach Boulevard, Huntington Beach	6[A/]	5

A/ Incomplete reporting. Estimates made from reports received.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Orange (Continued)		
Lincoln Community Hospital 6850 Lincoln Avenue, Buena Park	381	226
Los Alamitos General Hospital 3751 Katella Avenue, Los Alamitos	19	38
Martin Luther Hospital 1825 West Romneya Drive, Anaheim	28	10
Orange County Medical Center 101 Manchester, Orange	890	151
Palm Harbor General Hospital 12860 Palm Street, Garden Grove	113[A/]	45
Riverview Hospital 1901 North Fairview Street, Santa Ana	52	37
Santa Ana Community Hospital 600 East Washington, Santa Ana	365	8
South Coast Community Hospital 31872 Coast Highway, South Laguna	132	28
Stanton Community Hospital 7770 Katella Avenue, Stanton	23	7
West Anaheim Community Hospital 3033 West Orange Avenue, Anaheim	118	29
Westminster Community Hospital 200 Hospital Circle, Westminster	8	2
Placer	46	15
Auburn Faith Hospital Highway 49 & Education, Auburn	3[A/]	2
Roseville Community Hospital 333 Sunrise Avenue, Roseville	43	13
Plumas	90	16
Plumas District Hospital Meadow Valley Road, Quincy	90	16
Riverside	1,456	390
Circle City Hospital 730 Old Magnolia, Corona	31	11
Corona Community Hospital 812 South Washburn Street, Corona	2	0
Desert Hospital 1151 North V Miraleste, Palm Springs	186	49
Hemet Valley Hospital 1116 East Latham Street, Hemet	19	5
Indio Community Hospital 47-111 Monroe Street, Indo	59	13

A/ Incomplete reporting. Estimates made from reports received.

HOSPITAL	NUMBER REPORTED 1971	NUMBER REPORTED January-March, 1972
Riverside (Continued)		
Knollwood Hospital 5900 Brockton Avenue, Riverside	14	9
Palo Verde Hospital 250 North First Street, Blythe	30	B/
Parkview Community Hospital 3865 Jackson Street, Riverside	346	99
Riverside Community Hospital 4445 Magnolia Avenue, Riverside	183	45
Riverside GH University Medical Center 9851 Magnolia Avenue, Riverside	496	127
San Gorgonio Pass Memorial Hospital 600 North Highland Spr, Banning	10	2
US Air Force Hospital March AF Base, Riverside	78	30
Valley Memorial Hospital 82 - 485 Miles Avenue, Indio	2	0
Sacramento	4,202	1,153
American River Hospital 4747 Engle Road, Carmichael	1,079	271
Community Memorial Hospital 2251 Hawthorne Street, Sacramento	117	233
Kaiser Foundation Hospital 2025 Morse Avenue, Sacramento	371	146
Sacramento Medical Center 2315 Stockton Boulevard, Sacramento	865	172
Sutter Memorial Hospital 52nd and F Streets, Sacramento	1,724	323
Twin Lakes Community Hospital 223 Fargo Way, Folsom	21	2
US Air Force Hospital Mather AF Base, Sacramento	9	5
Woodside Community Hospital 3201 Del Paso Boulevard, North Sacramento	16	1
San Bernardino	4,232	4,089
Hi Desert Memorial Hospital 8515 Cholla Avenue, Yucca Valley	2	3
Kaiser Foundation Hospital 9961 Sierra Avenue, Fontana	258	89
Loma Linda University Hospital 11234 Anderson, Loma Linda	24	3
Montclair Memorial Hospital 5050 San Bernardino, Montclair	3,103	3,620
Ontario Community Hospital 550 North Monterey, Ontario	16	4

B/ No report received

HOSPITAL	NUMBER REPORTED 1971	NUMBER REPORTED January-March, 1972
San Bernardino (Continued)		
Redlands Community Hospital 350 Terracina Boulevard, Redlands	58	19
San Antonio Community Hospital 999 San Bernardino, Upland	447	179
San Bernardino County General Hospital 780 East Gilbert Street, San Bernardino	160	131
San Bernardino Community Hospital 1500 West 17th Street, San Bernardino	163	41
US Air Force Hospital George AF Base, Victorville	1 1/	0
San Diego	5,829	1,290
Bay General Hospital 435 H Street, Chula Vista	98	61
Childrens Hospital 8001 Frost Street, San Diego	14	0
Clairemont General Hospital 5255 Mount Etna Drive, San Diego	923	250
Community Hospital of Chula Vista 553 F Street, Chula Vista	2	0
Donald N. Sharp Memorial Community Hospital 7901 Frost Street, San Diego	2,589	577
Fallbrook Hospital 624 East Elder Street, Fallbrook	16	1
Grossmont Hospital 5555 Grossmont, La Mesa	195	37
Kaiser Foundation Hospital - La Mesa 8010 Parkway Drive, La Mesa	256	91
Oceanside Community Hospital 1100 Fifth Street, Oceanside	184	51
Palomar Memorial Hospital 550 East Grand Avenue, Escondido	71	20
Paradise Valley Hospital 2400 East 4th Street, National City	362	29
Scripps Memorial Hospital 9888 Genesee Avenue, La Jolla	152	21
Tri City Hospital 4002 Vista Way, Oceanside	14	5
University Hospital of San Diego Center 225 West Dickinson, San Diego	838	120
US Naval Hospital Camp Pendleton, Oceanside	47	9
US Naval Hospital Park Boulevard, Balboa Park	68	18

1/ Reports received as of September 12, 1972.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
San Francisco	11,052	3,335
Childrens Hospital of San Francisco 3700 California Street, San Francisco	1,081	245
Chinese Hospital 835 Jackson Street, San Francisco	49	10
French Hospital 4131 Geary Boulevard, San Francisco	828	172
Golden Gate Community Hospital 1065 Sutter Street, San Francisco	648	745
Hahnemann Hospital 3773 Sacramento, San Francisco	62	17
Harkness Community Hospital & Medical Center 1400 Fell Street, San Francisco	4A/	8
Kaiser Foundation Hospital 2425 Geary Boulevard, San Francisco	1,032	257
Letterman General Hospital Presidio of San Francisco, San Francisco	135	16
Mount Zion Hospital 1600 Divisadero Street, San Francisco	632A/	116
Presbyterian Hospital Pacific Medical Center Clay & Webster, San Francisco	477A/	B/
San Francisco Eye & Ear 1801 Bush Street, San Francisco	2,689A/	1,096
San Francisco General Hospital 1001 Potrero Avenue, San Francisco	456	125
St. Francis Memorial Hospital 900 Hyde Street, San Francisco	815	159
St. Lukes Hospital 1580 Valencia, San Francisco	499	170
UC San Francisco Medical Center 3rd and Parnassus, San Francisco	1,377	139
Unity Hospital 2356 Sutter Street, San Francisco	268A/	60
San Joaquin	767	226
Dameron Hospital 525 West Acacia, Stockton	411	147
Lodi Community Hospital 800 South Lower Sacramento, Lodi	43	5
Lodi Memorial Hospital 975 South Fairmont Avenue, Lodi	32	16
Manteca Hospital 300 Cottage Avenue, Manteca	7	2
Oak Park Community Hospital of North Ca 2510 North California, Stockton	7	1
San Joaquin General Hospital Hospital Lane Highway 50, French Camp	265	54
Stockton State Hospital 510 East Magnolia, Stockton	2	1

A/ Incomplete reporting. Estimates made from reports received.
B/ No report received.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
San Luis Obispo	411	116
San Luis Obispo General Hospital 2180 Johnson Street, San Luis Obispo	314	90
Sierra Vista Hospital 1010 Murray Street, San Luis Obispo	97	26
San Mateo	1,633	403
Church of St. Matthew Mills Memorial Hospital 100 South San Mateo Drive, San Mateo	202	48
H. D. Chope Community Hospital 222 West 39th Avenue, San Mateo	895	246
Kaiser Foundation Hospital 1150 Veterans Boulevard, Redwood City	65	34
Peninsula Hospital & Medical Center 1783 El Camino RL, Burlingame	320	52
Sequoia Hospital Whipple & Alameda, Redwood City	151	23
Santa Barbara	604	93
Goleta Valley Community Hospital 351 South Patterson, Santa Barbara	20	9
Lompoc District Hospital 508 East Hickory, Lompoc	16	3
Register Office (MSR) USAF Hospital, Vandenberg AFB	54[A/]	16
Santa Barbara Cottage Hospital 320 West Pueblo, Santa Barbara	328	25
Santa Barbara County General Hospital P.O. Box 3650, Santa Barbara	117	16
Santa Ynez Valley Hospital 700 Alamo Pintado, Solvang	57	13
Valley Community Hospital 505 East Plaza Drive, Santa Maria	12	11
Santa Clara	5,047	1,270
Campbell Community Hospital 1650 Winchester, Campbell	8	10
Community Hospital Los Gatos Sar 815 Pollard, Los Gatos	482	156
El Camino Hospital 2500 Grant Road, Mountain View	892	224
Kaiser Foundation Hospital 900 Kiely Drive, Santa Clara	639	170

A/ Incomplete reporting. Estimates made from reports received.

HOSPITAL	NUMBER REPORTED 1971	NUMBER REPORTED January-March, 1972
Santa Clara (Continued)		
San Jose Hospital & Health Center 675 East Santa Clara, San Jose	B/	227
Santa Clara Valley Medical Center 751 South Bascom Avenue, San Jose	300A/	43
Stanford University Hospital 300 Pasteur Drive, Palo Alto	1,307	192
The Good Samaritan Hospital 15825 Samaritan Drive, San Jose	1,023	182
The Park Alameda Hospital 976 Lenzen Avenue, San Jose	354	49
Wheeler Hospital 651 - 6th Street, Gilroy	42	17
Santa Cruz	2	3
Watsonville Community Hospital Green Valley Holohan, Watsonville	2	3
Shasta	11	--
Memorial Hospital of Redding East & Butte Streets, Redding	11	0
Siskiyou	50	6
Mount Shasta Community Hospital 203 Eugene Street, Mount Shasta	22	6
Siskiyou General Hospital 818 South Main Street, Yreka	28A/	B/
Solano	767	234
Broadway Hospital 525 Oregon Street, Vallejo	428	123
David Grant USAF Hospital Travis AF Base, Fairfield	204A/	54
Intercommunity Memorial Hospital 1800 Pennsylvania, Fairfield	40	29
Kaiser Foundation Health & Rehabilitation Center 2600 Alameda Street, Vallejo	93	28
Vallejo General Hospital 510 Los Cerritos, Vallejo	2	0

A/ Incomplete reporting. Estimates made from reports received.
B/ No report received.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Sonoma	857	246
Community Hospital of Sonoma County 3325 Chanate Road, Santa Rosa	439	90
Hillcrest Hospital Hayes Street & El Rose, Petaluma	115	34
Palm Drive Hospital 501 Petaluma Avenue, Sebastopol	15	2
Santa Rosa General Hospital 465 A Street, Santa Rosa	138	97
Sonoma Valley District Hospital 347 Andrieux Street, Sonoma	146	23
Warrack Medical Center Hospital 2457 Summerfield Road, Santa Rosa	4	0
Stanislaus	602	105
Doctors Hospital of Modesto 333 West Orangeburg A, Modesto	34	22
Emanuel Hospital 825 Delbon Avenue, Turlock	18	7
Memorial Hospital Stanislaus County P.O. Box 942, Modesto	12	3
Modesto City Hospital 730 - 17th Street, Modesto	16	28
Scenic General Hospital 830 Scenic Drive, Modesto	520	43
Turlock Community Hospital 222 South Thor Street, Turlock	2	2
Sutter	121	28
Fremont Hospital 970 Plumas Street, Yuba City	70	28
Sutter County General Hospital 1965 Live Oak Boulevard, Yuba City	51	B/
Tulare	133	38
Alta Local Hospital 500 Adelaide Way, Dinuba	2	0
Kaweah Delta District Hospital 400 West Mineral King, Visalia	56	17
Lindsay District Hospital City Park, Lindsay	2	0
Tulare County General Hospital 1062 South K Street, Tulare	1	0
Tulare District Hospital 869 Cherry Avenue, Tulare	72	21

B/ No report received.

HOSPITAL	NUMBER REPORTED 1971	January-March, 1972
Tuolumne	4	1
Sierra Hospital 179 South Fairview Lane, Sonora	3	1
Tuolumne General Hospital 101 East Hospital Road, Sonora	1	0
Ventura	787	168
Community Memorial Hospital S Buenaventura 2800 Loma Vista Road, Ventura	155	35
General Hospital Ventura County 3291 Loma Vista Road, Ventura	513	93
Los Robles Hospital 215 West Janss Road, Thousand Oaks	61	17
Ojai Valley Community Hospital 1306 Maricopa Highway, Ojai	25	4
Oxnard Community Hospital 540 South H Street, Oxnard	32	19
Simi Valley Adventist Hospital 2975 Sycamore Drive, Simi	1	0
Yolo	253	46
Davis Community Hospital Road 31 & Road 99, Davis	119	30
Woodland Memorial Hospital 1325 Cottonwood Street, Woodland	93	16
Yuba	69	26
Rideout Memorial Hospital 726 Fourth Street, Marysville	69	26

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Alhambra Community Hospital 206 South Garfield Ave. Alahambra	5
Antelope Valley District Hospital 1600 West Avenue J Lancaster	90
Avalon Memorial Hospital 5862 South Avalon Boulevard Los Angeles	10,021
Bay Harbor Hospital 1437 West Lomita Boulevard Harbor City	11
Behrens Memorial Hospital 446 Piedmont Avenue Glendale	89
Bel Air Memorial Hospital 2311 Roseomare Road Bel Air	2,515
Bella Vista Community Hospital 5425 East Pomona Los Angeles	3,640
Bellflower Community Hospital 9542 East Artesia Bellflower	46
Belvedere Hospital 127 South Utah Street Los Angeles	4A/
Beverly Glen Hospital 10361 West Pico Boulevard Los Angeles	162A/
Beverly Hills Doctors Hospital 10390 Santa Monica Los Angeles	770

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Beverly Hospital 309 West Beverly Boulevard Montebello	61
Bon Air Hospital 250 West 120th Street Los Angeles	86
Broadway Community Hospital 9500 South Broadway Los Angeles	577
Burbank Community Hospital 466 East Olive Avenue Burbank	173
Canoga Park Hospital 20800 Sherman Way Canoga Park	934
Carson Intercommunity Hospital 23621 South Main Carson	324
Cedars Lebanon Hospital 4833 Fountain Avenue Los Angeles	1,251
Centinela Valley Community Hospital 555 East Hardy Street Inglewood	531
City of Hope 1500 East Duarte Duarte	2
City View Hospital 3711 Baldwin Street Los Angeles	24
Community Hospital North Hollywood 6421 Coldwater Canyon North Hollywood	1,541
Community Hospital of San Gabriel 218 South Santa Anita San Gabriel	7

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Community Hospital of Gardena 1246 West 155th Street Gardena	51
Community Hospital of Huntington Park 2623 East Slausen Huntington Park	148
Community Hospital of Los Angeles 4081 East Olympic Boulevard Los Angeles	4
Compton Phys. & Surg. Hospital 4200 East Compton Compton	16[A/]
Doctors Hospital 325 West Jefferson Los Angeles	1,755
Dominguez Valley Hospital 3100 South Susana Road Compton	50
Downey Community Hospital 11500 Brookshire Downey	2
Encino Hospital 16237 Ventura Boulevard Encino	15[A/]
Fox Hills Community 5525 West Slausen Avenue Los Angeles	151[A/]
Gardena Medical Center Hospital 2315 West Compton Boulevard Gardena	117
Garfield Hospital 123 Hilliard Monterey Park	139

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Glendale Adventist Hospital 1509 Wilson Terrace Glendale	47
Glendale Community Hospital 800 South Adams Street Glendale	25
Granada Hills Community Hospital 10445 Balboa Granada Hills	232
Hartland Hospital 14148 East Francisqto Baldwin Park	157
Hawthorne Community Hospital 11711 Grevillea Avenue Hawthorne	111
Hollywood Pres. HP Olmsted 1322 North Vermont Los Angeles	12
Holly Park Hospital 2501 West El Segundo Hawthorne	90A/
Hollywood Community Hospital 6245 De Longpre Hollywood	142
Hospital of Good Samaritan 1212 Shatto Street Los Angeles	49A/
Huntington Memorial Hospital 100 Congress Street Pasadena	217
Imperial Hospital 11222 Inglewood Inglewood	9

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Inter Community Hospital 275 West College Street Covina	62
Inter-Valley Community Hospital 21704 West Soledad Court Saugus	10
John Wesley Co. Hospital 2826 South Hope Street Los Angeles	946
Kaiser Foundation Hospital 9400 East Rosecrans Bellflower	489
Kaiser Foundation Hospital 4867 Sunset Boulevard Los Angeles	1,316
Kaiser Foundation Hospital 13652 Cantara Street Panarama City	369
Kaiser Foundation Hospital 1100 West Pacific Coast Highway Harbor City	407
Los Angeles County - Harbor 1000 West Carson Street Torrance	278
Los Angeles County - Olive View 14445 Olive View Drive Sylmar	2
Los Angeles County - U.S.C. Medical Center 1200 West State Street Los Angeles	6,184[A/]
La Mirada Community Hospital 14900 East Imperial Highway La Mirada	73

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Lincoln Hospital 443 South Soto Street Los Angeles	2
Long Beach Community Hospital 1720 Termino Avenue Long Beach	739
Los Altos Hospital 3340 Los Coyotes Long Beach	369
Memorial Hospital of Glendale 1420 South Central Glendale	91
Memorial Hospital of Hawthorne 13300 South Hawthorne Hawthorne	140
Memorial Hospital of Long Beach 2801 Atlantic Avenue Long Beach	842
Memorial Hospital of Panorama City 14850 Roscoe Boulevard Panorama City	260A/
Memorial Hospital of Southern California 13828 Hughes Avenue Culver City	103
Memorial Hospital of Gardena 1145 Redondo Beach Gardena	186
Methodist Hospital of Southern California 300 West Huntington Arcadia	206
Midvalley Community 7533 Van Nuys Boulevard Van Nuys	109

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Midway Hospital 5925 San Vicente Los Angeles	12
Mission Hospital 3111 East Florence Huntington Park	2
Monte Sano Hospital 2834 Glendale Boulevard Los Angeles	14
Morningside Hospital 8711 South Harvard Boulevard Los Angeles	727
Mt. Sinai Hospital and Clinic 8720 Beverly Boulevard Los Angeles	71A/
North Glendale Hospital 1401 West Glenoaks Glendale	12
Northridge Hospital Foundation 183 Roscoe Boulevard Northridge	149A/
Norwalk Community Hospital 13222 Bloomfield Norwalk	19
Pacific Glen Hospital 712 South Pacific Avenue Glendale	816
Pacific Hospital of Long Beach 2776 Pacific Avenue Long Beach	158
Pacoima Memorial Lutheran Hospital 11600 Eldridge Avenue Pacoima	372

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
Palmdale General 1212 East Avenue South Palmdale	6
Park View Hospital 1021 North Hoover Street Los Angeles	34[A/]
Parkwood Community Hospital 7011 Shoup Avenue Canoga Park	6,906
Pasadena Community Hospital 1845 North Fair Oaks Pasadena	3
Pico Rivera Community Hospital 5216 South Rosemead Pico Rivera	45
Pioneer Hospital 17831 South Pioneer Artesia	64
Pomona Valley Community Hospital 1798 North Garey Avenue Pomona	263
Presbyterian Intercommunity Hospital 12401 East Washington Whittier	116[A/]
Rancho Los Amigos 7601 Imperial Highway Downey	2
Rio Hondo Memorial Hospital 8300 Telegraph Road Downey	289
San Fernando Hospital 732 Mott Street San Fernando	1

A/ Incomplete reporting. Estimates made from reports received.

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
San Gabriel Valley Hospital 115 East Broadway San Gabriel	28
San Pedro and Peninsula Hospital 1305 West 6th Street San Pedro	61
San Vicente Hospital 6000 San Vicente Los Angeles	6,524
Santa Monica Hospital Medical Center 1225 - 15th Street Santa Monica	104
Sherman Oaks Community Hospital 4929 Van Nuys Boulevard Sherman Oaks	13
South Bay Hospital 514 North Prospect Avenue Redondo Beach	211
Southeast Doctors Hospital 5900 Pine Avenue Maywood	432
St. Michaels 1845 Pacific Coast Highway Hermosa Beach	120
Studebaker Community Hospital 13100 South Studebaker Norwalk	1
Suburban Hospital, Inc. 3164 Southern Avenue South Gate	2
Temple Hospital 235 North Hoover Los Angeles	191

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
The California Hospital 1414 South Hope Street Los Angeles	201
Torrance Memorial 1425 Engracia Torrance	345
U.C.L.A. Medical Center 10833 Le Conte Los Angeles	144
University Hospital 3787 South Vermont Los Angeles	28
Valley Hospital 14500 Sherman Circle Van Nuys	15
Valley Doctors 12629 Riverside Drive North Hollywood	1,897
Valley Presbyterian 15107 Van Owen Street Van Nuys	405
Viewpark Community Hospital 5035 Coliseum Street Los Angeles	9
Washington Hospital 12101 West Washington Los Angeles	119
West Hills Hospital 23023 Sherman Way Canoga Park	19
West Park Hospital 22141 Roscoe Boulevard Canoga Park	78

THERAPEUTIC ABORTIONS REPORTED BY INDIVIDUAL HOSPITAL

LOS ANGELES COUNTY, 1971

Hospital	Number Performed
West Valley Community Hospital Fd. 5333 Balboa Boulevard Encino	827
Westside Hospital 910 South Fairfax Avenue Los Angeles	6
White Memorial Medical Center 1720 Brooklyn Avenue Los Angeles	73
Whittier Hospital 15151 Janine Drive Whittier	4
Woodruff Community Hospital 3800 Woodruff Avenue Long Beach	90

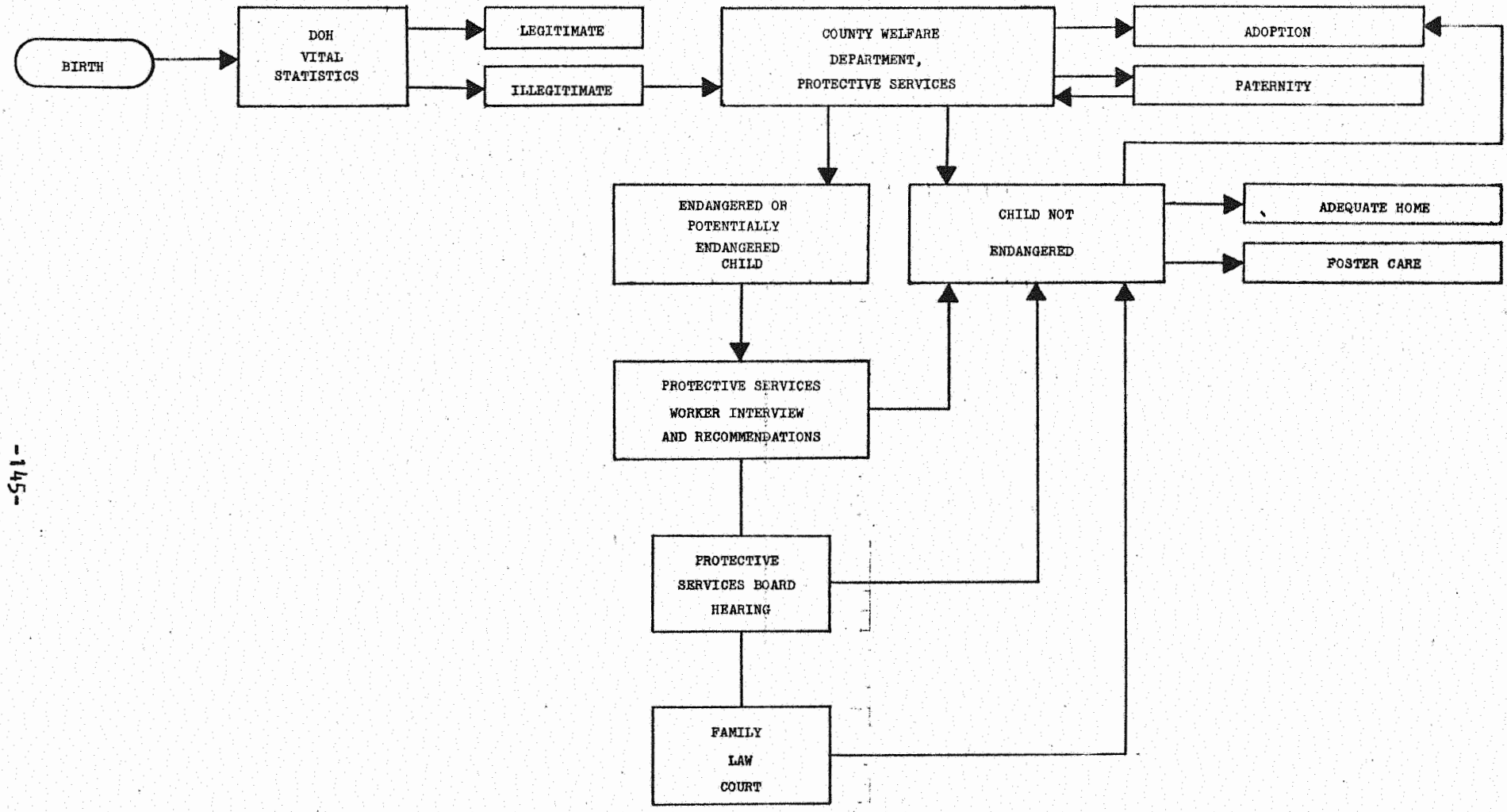
STATE OF CALIFORNIA
STATEWIDE ADOPTIONS
Fiscal 55-56 through Fiscal 70-71

Fiscal Year	Relinquishment Adoptions		Total Public and Private Relinquishment Adoptions	Independent Adoptions	Total Relinquishment and Independent Adoptions	Stepparent Adoptions
	Public	Private				
1955-56	1243	914	2157	4101	6258	3276
1956-57	1271	1147	2418	4214	6632	3644
1957-58	1326	1144	2470	4265	6735	3524
1958-59	1436	1216	2652	4552	7204	3870
1959-60	1758	1508	3266	4994	8260	3862
1960-61	2135	1506	3641	4872	8513	3911
1961-62	2669	1659	4328	4827	9155	4362
1962-63	3207	1531	4738	4890	9628	4605
1963-64	3832	1739	5571	4912*	10483	5019
1964-65	4611	1729	6340	4772	11112	5002
1965-66	5059	1951	7010	4683	11693	5639
1966-67	5410	2200	7610	4370	11980	6453
1967-68	6055	2337	8392	3995	12387*	6369
1968-69	6301	2366	8667*	3390	12057	6433
1969-70	5718	2037	7755	3115	10870	5951
1970-71	4121	1438	5559	2603	8162	7088

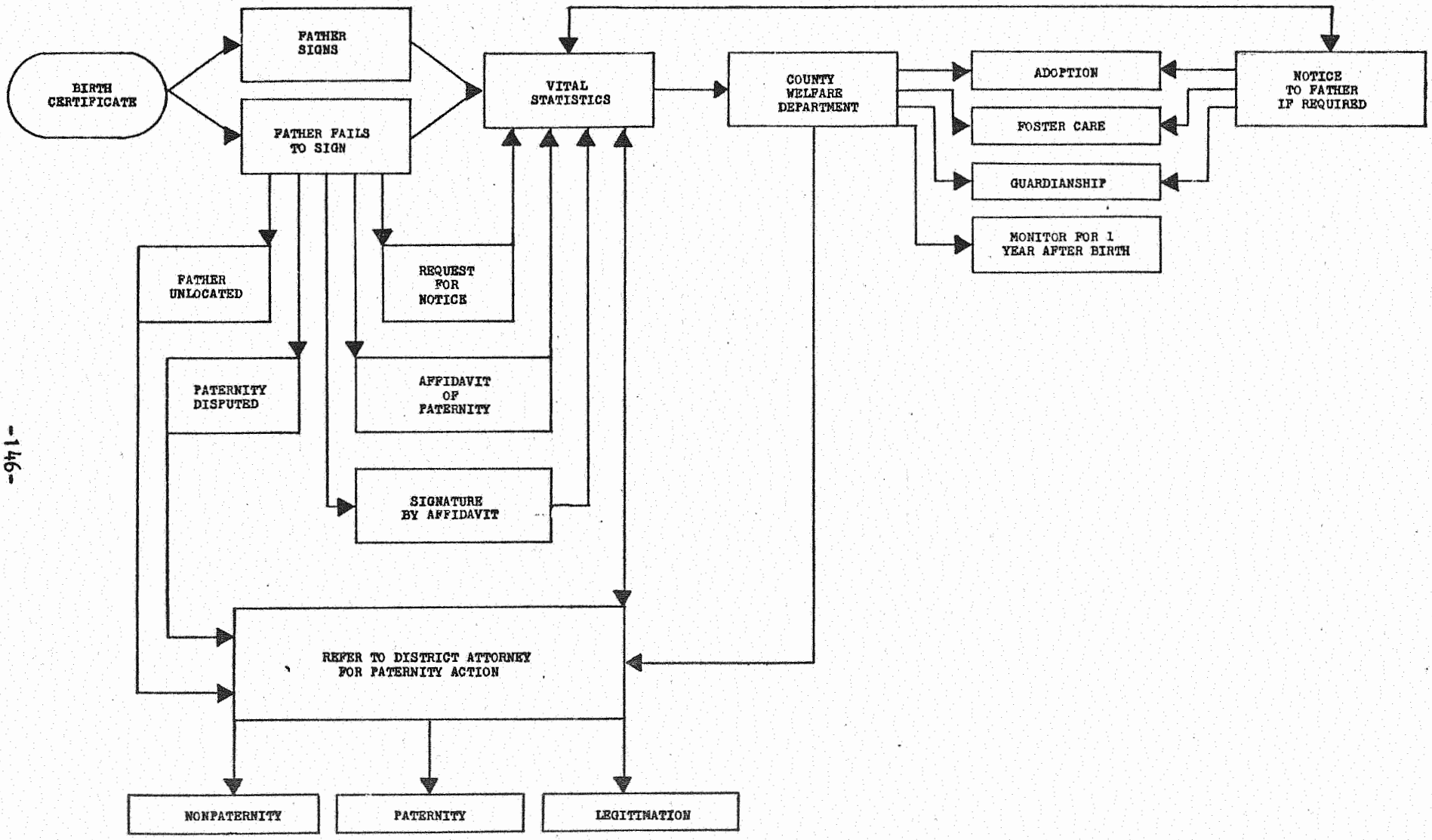
* Peak year followed by decrease.

Source: State of California, Department of Benefit Payments.

PROTECTIVE SERVICES FOR ILLEGITIMATE CHILDREN



ESTABLISHMENT OF PATERNITY AND NOTIFICATION OF INTERESTED FATHER



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