

ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 86 / 2

10205 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

50

Table 6. Unearned Income Received in the Three Months Prior to Interview

Benefit	Percent of Responses	Average Monthly Amount	Standard Deviation
Child Support	18%	\$282	\$240
Adult Public Assistance	16%	\$579	\$285
Cash Gifts	12%	\$660	\$878
Loans	9%	\$8650	\$24,785
Social Security	8%	\$695	\$528
Supplemental Security Income	7%	\$1157	\$2640
Sold Property	5%	\$1613	\$4573
Disability Benefits	5%	\$550	\$588
Workers Compensation	2%	\$1301	\$1975
Retirement Pension	1%	\$780	\$855

Respondents who were Temporary Assistance recipients at the time of the interview were significantly more likely to be receiving state Adult Public Assistance benefits as well (chi-square=92.90, df=3, p<.0001). Figure 38 shows that 25% of respondents who were employed and receiving Temporary Assistance at the time of the interview were also receiving Adult Public Assis-

tance. Forty-two percent (42%) of respondents who were unemployed and Temporary Assistance recipients at the time of the interview received Adult Public Assistance. Six percent (6%) of the non-Temporary Assistance recipients who were employed, and 9% of the non-Temporary Assistance recipients who were unemployed, received Adult Public Assistance.

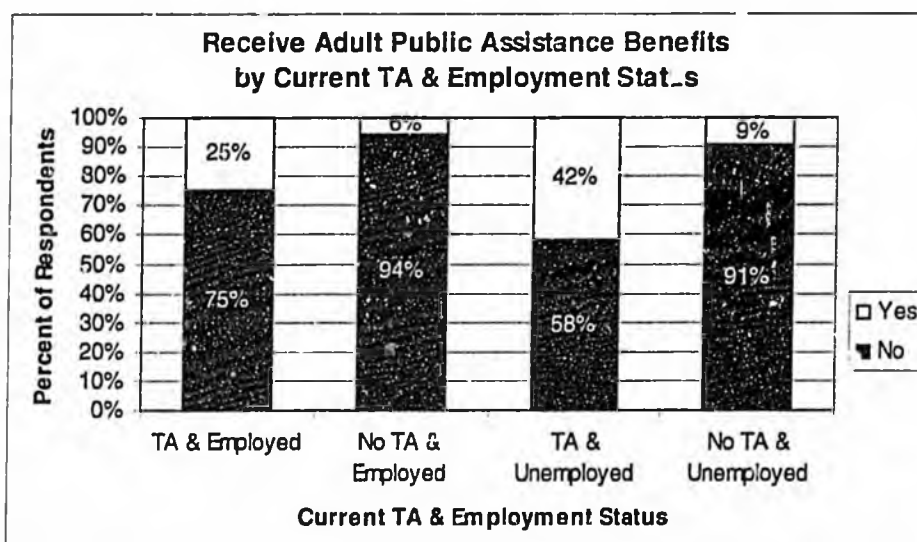


Figure 38

The survey did not include a question about receipt of Unemployment Insurance benefits. Interviewers reported anecdotally that numerous respondents mentioned receiving Unemployment Insurance. Interviewers also reported that some respondents might not have understood exactly how each category of income was defined. Matching the sample against Unemployment Insurance and other administrative data files might lead to a more complete and accurate understanding of the unearned income flowing into these households.

Alaska-Specific Forms of Unearned Income

The Alaska Permanent Fund Dividend (PFD) and Alaska Native Claims Settle-

ment Act (ANCSA) corporation dividends are two types of unearned income that are uniquely Alaskan and may be very important factors in the ability of families to live independent of the Temporary Assistance program. Both types of unearned income are treated specially under Temporary Assistance program policies. PFD payments do not count as income, and the first \$2,000 per year of ANCSA corporation dividends are also disregarded in determining eligibility, and in calculating Temporary Assistance benefits. Nonetheless, these funds are available to many families that leave Temporary Assistance and may constitute a sizeable portion of their annual income. Data on respondent receipt of these funds are displayed in Figure 39.

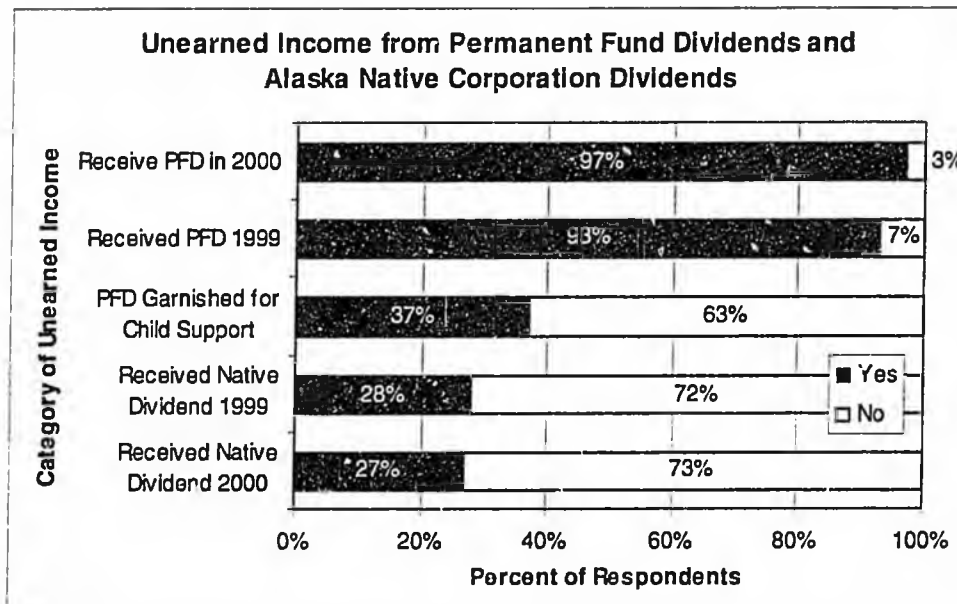


Figure 39

Alaska Permanent Fund Dividends

All Alaska residents who lived in the state for the full previous year are eligible for the annual Alaska Permanent Fund Dividend (PFD) payment. Ninety-three percent (93%) of the people surveyed received PFDs in 1999, with an average of 4 household members receiving the dividend (SD=1.72). Ninety-seven percent (97%) reported that one or more household members will be eligible for dividends in 2000 (mean number of eligible household members=4, SD=1.75).

Respondents were asked whether or not any family member's PFD payment was garnished in 1999 to pay child support, divorce settlements, or other debts. Thirty-seven percent (37%) indicated that a family member's PFD had been garnished for some reason.

While many Alaskans believe that the Permanent Fund Dividend is an important way of reducing the need for Temporary Assistance, many people who left Temporary Assistance had their Permanent Fund Dividends garnished to pay off their debts, suggesting that they were having trouble meeting their financial obligations.

Some of this indebtedness undoubtedly represents past-due child support obligations, possibly reflecting the fact that many Temporary Assistance families are "mixed" families, with the adults having children who do not live with them. Twelve percent (12%) of the respondents reported that someone in the household had paid an average of \$318 per month in child support to a non-household member in the previous three months (SD=\$272 per month).

Alaska Native Corporation Dividends

Twenty-eight percent (28%) of the respondents indicated they had received Alaska Native Corporation dividends in 1999, with an average of \$793 going to an average of 2 family members (SD=1.55). In 1999, corporate dividends ranged from \$7 to \$17,000 (SD=\$1,784). Twenty-seven percent (27%) reported they are eligible to receive Native Corporation dividends in 2000, with an expected range of \$7 to \$8,000 (SD=\$1,029).

The high standard deviation of the mean average amounts of Alaska Native Corporation Dividends demonstrates that the average amounts may be somewhat misleading, because of the very high amounts paid out by a few small corporations.

Use of Transitional Services and Community Help

Anecdotal evidence suggests that the availability and utilization of benefits from non-cash assistance programs may be significant factors in the ability of families to leave Temporary Assistance and remain independent. Non-cash benefits may also be strong contributors to family well-being. Some states have reported a significant tapering-off of the utilization of these benefits after families leave cash assistance, even though many leavers continue to be financially eligible for the benefits. Federal Food Stamp program officials and health care advocates have expressed concern that complex administrative requirements may discourage TANF leavers from using services they are entitled to.

Findings:

- The most frequently cited government service used by respondents after they left the Temporary Assistance rolls was government health insurance, including Medicaid, tribal health care, and Denali KidCare.
- One-third (34%) of respondents said they were not receiving food stamps at the time of the interview. Most of those not using food stamps reported that they did not need or want food stamps, or believed that they were not qualified.
- Some respondents (30%) used food banks, faith-based organizations, family support, or some other form of community support while they were off the Temporary Assistance rolls.

Table 7 shows that, when asked to identify government service that they had used while they were off Temporary Assistance, survey respondents reported a variety of supports they used to help them become

self-sufficient. Health insurance programs, including Medicaid and Denali KidCare, were the most frequently cited programs, with 42% of the leavers receiving health care assistance.

Table 7. Respondent Utilization of Government Services for Low Income People While They Were off Temporary Assistance.

Program or Service	Percent of Responses
Health Insurance /Medicaid, Denali KidCare	42%
Food Stamps	34%
WIC	26%
Heating/Energy Assistance	23%
School Meals	21%
HUD or Alaska Housing	11%
Clothing	2%

Note: some respondents reported more than one service

Food Stamp Utilization

About a third of respondents reported that they were currently receiving food stamps. Respondents who were not participating in the food stamp program were asked why not.

Most of the people who were not using food stamps indicated that they had sufficient income and did not need food stamps (36%), did not want to use them (32%), or thought they did not qualify for food stamps (14%). These data suggest that Alaska's Temporary Assistance leavers have good access to food stamp benefits.

Benefits Provided by Non-Profit Organizations

Nonprofit organizations were helpful sources of support for some of the surveyed leavers. Thirty percent (30%) of respondents indicated that they had received some form of donation of food, clothing, or other necessities from a non-profit organization or family member. Of the respon-

dents who utilized these supports, 21% reported that they had used a food bank after they stopped receiving Temporary Assistance, 9% received some form of assistance from a church, and 2% were helped by a community or village center. In 5% of the cases, respondents reported that they had received food, clothing, or other necessities from their families after leaving Temporary Assistance.

Respondent-Reported Strategies for Getting by While Off Temporary Assistance

All survey participants were asked in an open-ended question how they had managed to get by while they were off of Temporary Assistance in 1999. The results are presented in Table 8, and show that employment was cited in nearly three-quarters of the responses, with utilization of other program benefits second at 12% of the responses. Table 8 includes responses from 694 survey participants.

Table 8. Self-Reported Factors that Allowed Respondents to Get by While off of Temporary Assistance during the Preceding Year

Response Category	N	Percent of Responses
Employment	503	74%
Receiving other program benefits (e.g., SSI, Unemployment Insurance, Disability benefits, Student financial aid)	77	12%
Help from another person	66	10%
Subsistence activities	15	2%
Dividend payments	15	2%
Total	676*	100%

*Note: some respondents did not respond and others reported multiple factors

Services Received by Temporary Assistance Recipients

Temporary Assistance recipients are required to participate in a number of activities that are designed to support their movement into the workforce. The Division of Public Assistance (DPA) provides services either directly or through subcontractors. Sixty-two percent (62%) of respondents indicated that their public assistance caseworker required them to work, look for a job, or go to some kind of job training. Recipients may also participate voluntarily in work transition services that are generally available in the community. An average, 13% of respondents indicated that they had participated in some form of volunteer or unpaid work between 1998 and 1999.

DPA provides services to help recipients search for work, successfully participate in job interviews and in job training, and remain employed once they begin working. Case managers work with individual recipients to develop a plan for achieving self-sufficiency. Case managers may be either DPA employees or DPA work services contractors. The self-sufficiency

Findings:

- Sixty-two percent (62%) of respondents indicated their Public Assistance caseworker had required them to work, look for a job, or go to some kind of job training.
- An average of 13% of respondents indicated they had participated in some form of volunteer or unpaid work between 1998 and 1999.

plan commits the client to engage in specified work-directed activities. The plan also commits DPA or its contractor to provide specified services to support the recipient's transition to work.

Types of Services Used

Table 9 shows a breakdown of some of the DPA-sponsored services survey respondents reported having used while receiving Temporary Assistance.

Table 9. Division of Public Assistance Sponsored Services Used by Temporary Assistance Recipients

Service	Percent
Child Care Assistance	31%
Transportation	26%
Misc. Other Work-Related Expenses (clothing, etc.)	18%

DPA Services Utilization by Returners and Non-Returners

As shown in Figure 40, returners were significantly more likely to use DPA-subsidized child care than non-returners (chi-square = 3.31, df=1, p<.04). Returners also used more DPA-sponsored assistance with

transportation (chi-square=13.63, df=1, p<.0001). Non-returners were likely to use fewer miscellaneous work-related services than returners.

As Figure 41 illustrates, respondents who were employed at the time of the interview were also less likely to have received DPA-sponsored child care while they were working, looking for work, or in training.

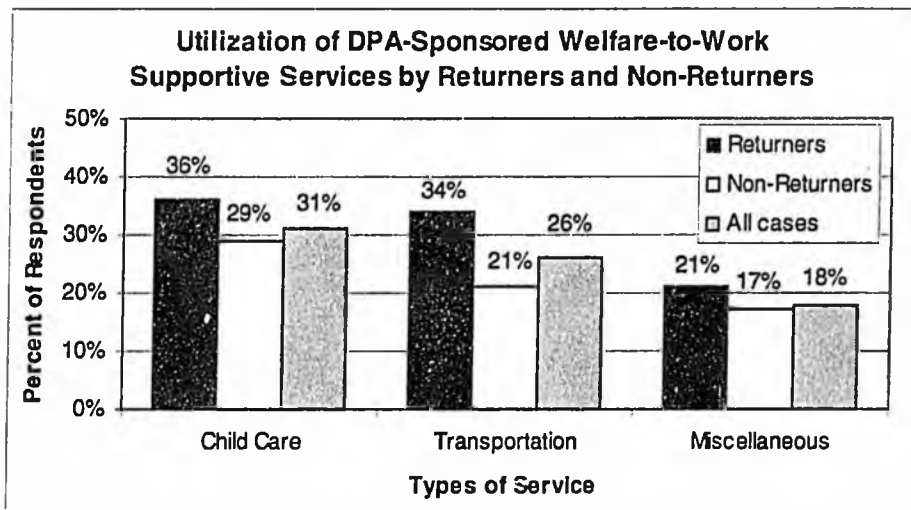


Figure 40

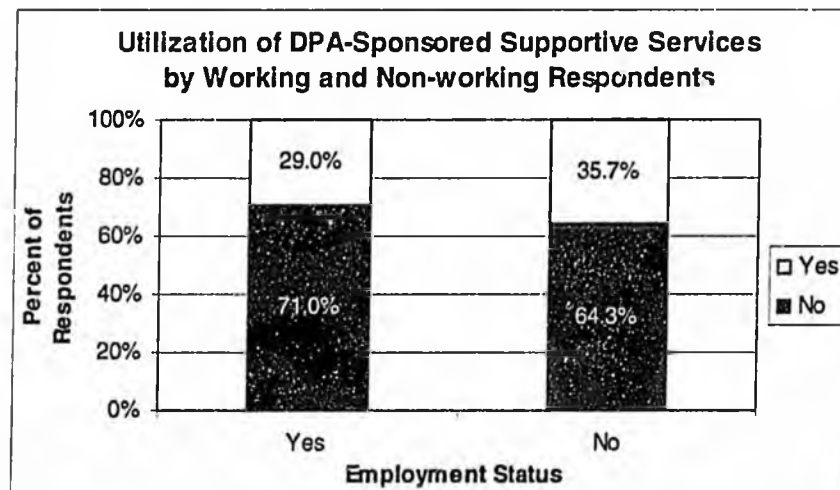


Figure 41

These utilization patterns may appear to indicate that use of these supportive services negatively impacts the success of leavers in staying off the Temporary Assistance rolls and remaining employed. In fact, they probably reflect DPA's accelerating level of effort during the study period as federal requirements to move recipients into employment increased. The non-returners, having left the Temporary Assistance caseload, are less likely to have utilized the supportive services simply because they are much less likely to have been under active case management during the sample period. Returners are more likely to have used these services for two reasons. First, they spend more time as Temporary Assistance recipients who are

required to participate in intensive case management. Second, there has been a steady increase in the proportion of the caseload that participates in work-related activities, and returners are more likely to have been in the caseload in the later months when the likelihood of their being under case management was greater.

For similar reasons, leavers who were employed at the time of the interview were less likely to have received the services because they had been working, and because currently working respondents were more likely to be non-returners, as discussed in the section on earned income and work.

Child Care

Working people with young children, particularly single parents, often need child care while they are working. The scarcity of affordable, appropriate child care is frequently cited as an impediment to stable employment. Forty-seven percent (47%) of the families surveyed reported that they had preschool age children in their households; 33% of those who had preschool age children reported that they used child care for them in order to find or keep a job.

Utilization Rates

Sixty-six percent (66%) of the respondents indicated that, in the past year, they had school age children young enough to require care while they were in training, job hunting, or working. Twenty-four percent (24%) of those who had school age children said they used some kind of extended care, after-school care, or day care after school or when school was not in session.

There was considerable variability in the weekly usage of child care, with the average child in care for 23 hours per week (SD=14 hours/week). Families that paid for child care paid an average of \$121 per week (SD=160).

Types of Care

Figure 42 illustrates that the most frequently utilized forms of child care for people who had young children were child care centers (35%) and family day care homes (15%), with most of the remaining care being provided by friends (10%) and relatives (13%).

Findings:

- One-third of all respondents (33%) reported that a lack of child care had disrupted their ability to look for a job or go to school or training.
- One-third of the respondents (33%) who had preschool age children reported that they used child care for them in order to find or keep a job.
- Twenty-four percent (24%) of respondents who had school age children had used child care for them.
- Three in ten (31%) reported that they had received subsidized child care for training and other work-related reasons before they left the Temporary Assistance caseload, while only 18% said they had received subsidized care after leaving the Temporary Assistance rolls.
- Child care centers and family day care homes were the most frequently mentioned forms of child care used. Friends and relatives provided most of the remaining care.
- Almost nine out of ten (86%) of those who used child care were satisfied with the quality of child care they received.

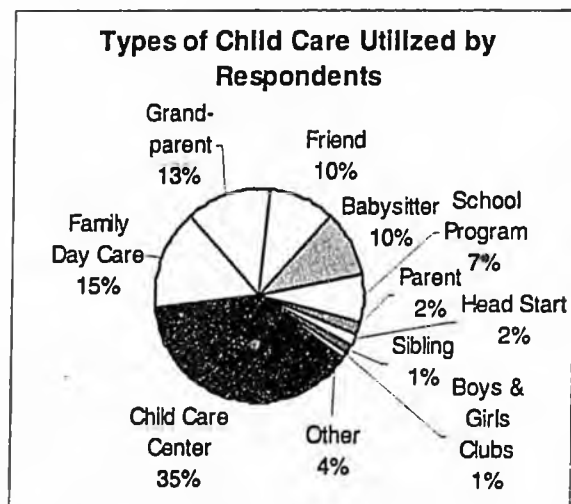


Figure 42

Quality of Care

For the most part, parents were happy with the child care they received. Eighty-six percent (86%) indicated satisfaction with their child care arrangements while working, attending training, or looking for work during the year preceding the interview (see Figure 43). Returner and non-returner status in 1998 and 1999 were not significantly related to satisfaction with child care arrangements for either working or unemployed respondents.

Disruptions for Lack of Care

As Figure 44 illustrates, 33% of those surveyed reported that a lack of child care had disrupted their ability to look for a job or go to school or training in the past year.

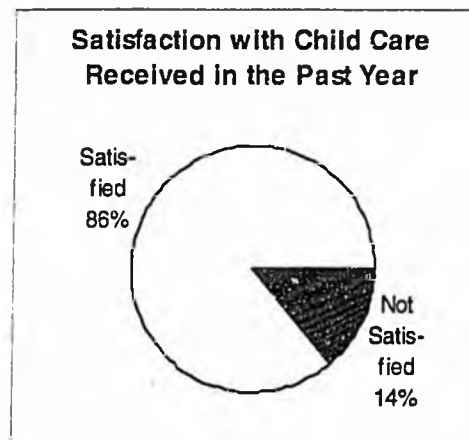


Figure 43

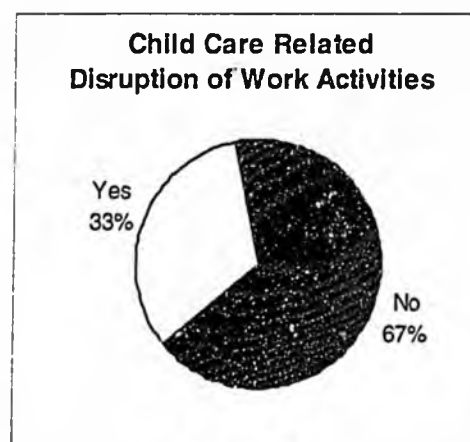


Figure 44

Housing

The transition from welfare to work may both influence and be influenced by the availability of stable and adequate housing. Stable and adequate housing is also a fundamental measure of family well-being. Leavers were asked a series of questions about their living situation at the time of the interview to help gain insight into this fundamental issue.

The majority of people surveyed were living in rental property. Figure 45 shows the breakdown of living arrangements.

Housing Stability

Thirty percent (30%) of respondents reported having moved in the past year. Of these, 40% moved from one community to another. Living arrangements have been fairly stable for some leavers, with the average length of residence in the current home being four years and three months (SD=6.6). However, many respondents made multiple moves. Of the people who were in their homes for less than one year, the average family moved twice in the past year (SD=1.3).

Housing Costs and Subsidized Housing

The average cost of housing for respondents was \$430 per month (minimum 0 to maximum \$1,600, SD=324), with utilities costing \$133 per month (minimum 0 to maximum \$1,500, SD=146). Only 14% were receiving housing subsidies from a federal, state, or local government program. Another 14% were living in a public housing project owned by a local housing authority, Alaska Housing, or other agency.

Findings:

- Housing arrangements were stable for 70% of respondents in the year preceding the interview, with 30% reporting at least one move in the last year.
- The average housing cost for respondents was \$430 per month, and their average utility cost was \$133 per month.
- Twenty-eight percent (28%) of the respondents were living in either subsidized housing or a public housing project.
- Over one-third (36%) reported being unable to pay rent, housing, or utility bills at least once in the past year, with people not on Temporary Assistance less likely to have this experience.

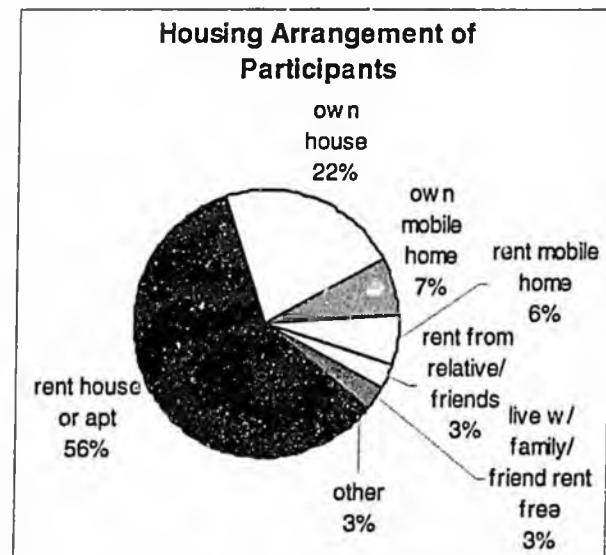


Figure 45

Respondents were asked whether they had experienced problems paying their housing costs during the past 12 months. Almost two thirds (64%) were able to pay their housing costs, with 36% reporting that there had been a period within the past year when they had not been able to pay the mortgage, rent, or utility bills.

Temporary Assistance recipients were more likely than non-recipients to have had problems in paying their mortgage, rent, or utility bills at some point in the past year (chi-square=11.94, df=3, p<.008).

Figure 46 shows the distribution of responses to this question, relative to the respondents' Temporary Assistance recipient status and employment status at the time

of the interview. Forty-six percent (46%) of employed Temporary Assistance recipients reported that at some point they had not been able to pay their mortgage, rent, or utilities within the past year. Forty-five percent (45%) of unemployed Temporary Assistance recipients had also had this problem. In contrast, 31% of non-recipient employed respondents had not been able to meet housing financial obligations in the past year; and 30% of non-recipient unemployed respondents had this problem.

Housing Quality

As Figure 47 illustrates, a substantial majority of respondents indicated that their housing arrangements were satisfactory.

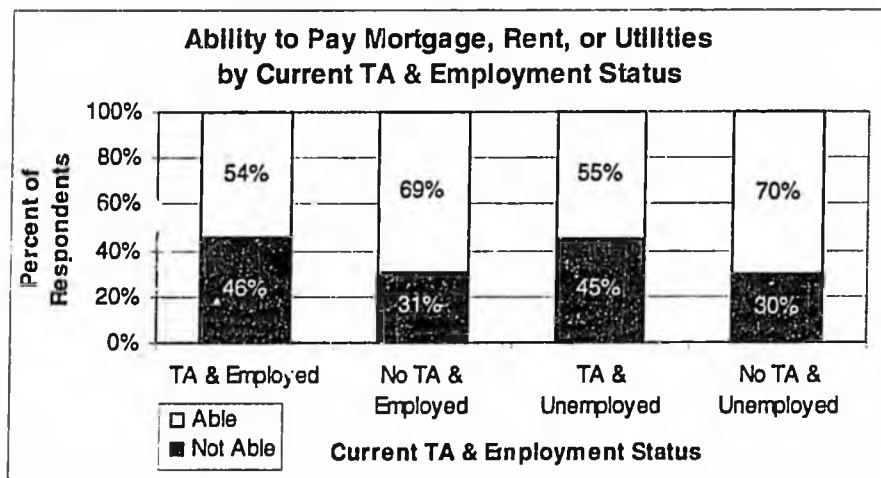


Figure 46

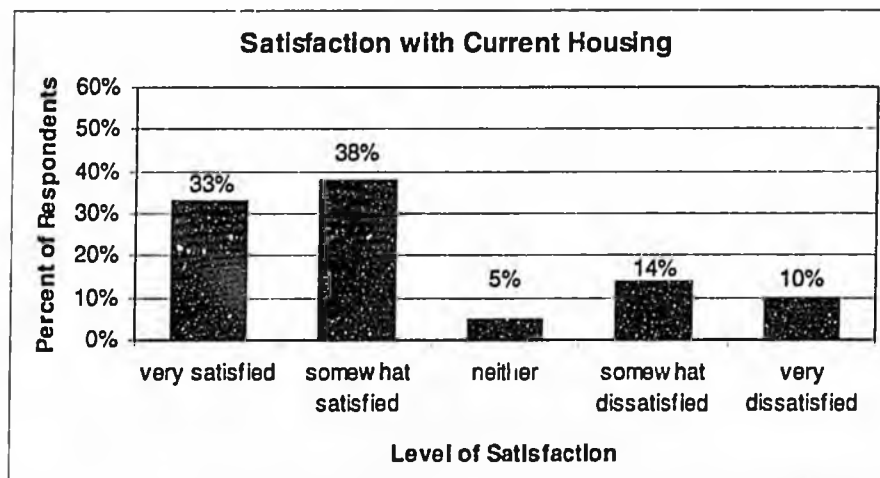


Figure 47

Transportation

Transportation to work is an integral element of employment success. Reliable, affordable, and efficient transportation is necessary for most working parents to find and maintain stable employment. For many, children must be transported to and from child care before, after, and sometimes during the workday. The amount of time consumed in getting back and forth between home, work, shopping, and child care may significantly affect the ability of families to move from welfare to work. During the interview, survey respondents were asked a series of questions about their current transportation situation.

Findings:

- Three quarters (75%) of respondents reported having adequate transportation to get to work, training, or child care.
- Personally owned vehicles were the most common form of transportation.
- People with reliable transportation were significantly more likely to be off Temporary Assistance and employed at the time of the interview.

Types of Transportation

Most people (61%) relied on their own car, truck, motorcycle, or van to get around. Other forms of transportation included: walking and bicycling (11%); riding snow-machines, boats, or ATVs (10%); sharing a ride (9%); and public transportation (9%). These data are shown in Figure 48.

Commute Time

Participants reported an average of 22 minutes each way to commute to work, including time to drop children off at child care (SD=20). The longest reported commute time was 150 minutes.

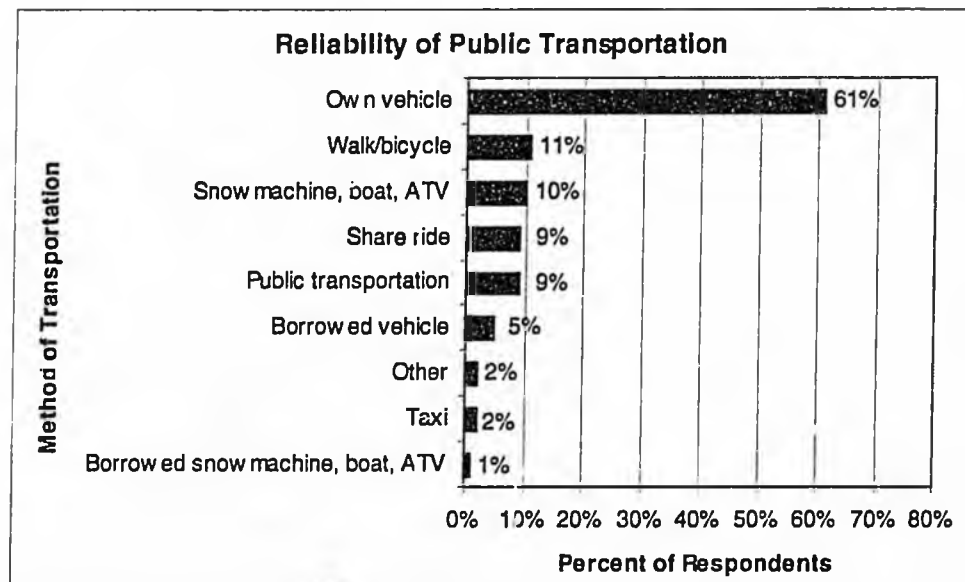


Figure 48

Access to Reliable Transportation

Figure 49 shows that a majority (75%) of the individuals surveyed had reliable transportation to get to work, training, or child care at the time of the interview.

Returners were significantly less likely to have reliable transportation at the time of the interview than non-returners (chi-square=3.78, df=1, p<.03). Figure 50 compares the rates of reliable transportation for the two groups.

Figure 51 shows the distribution of respondents who reported that they had reliable transportation with respect to their recipient

and employment status at the time of the interview. People who were employed and not receiving Temporary Assistance at the time of the interview reported the highest rate of reliable transportation (chi-square=22.94, df=3, p<.0001).

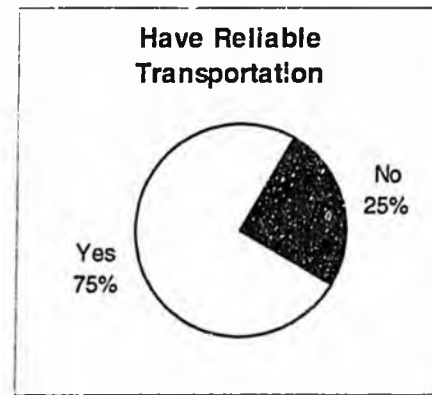


Figure 49

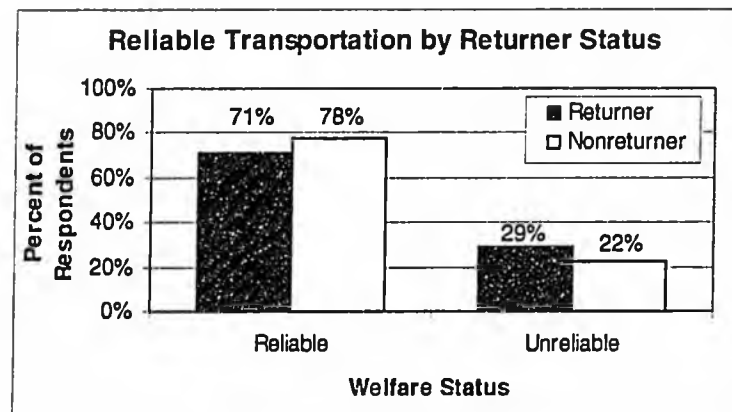


Figure 50

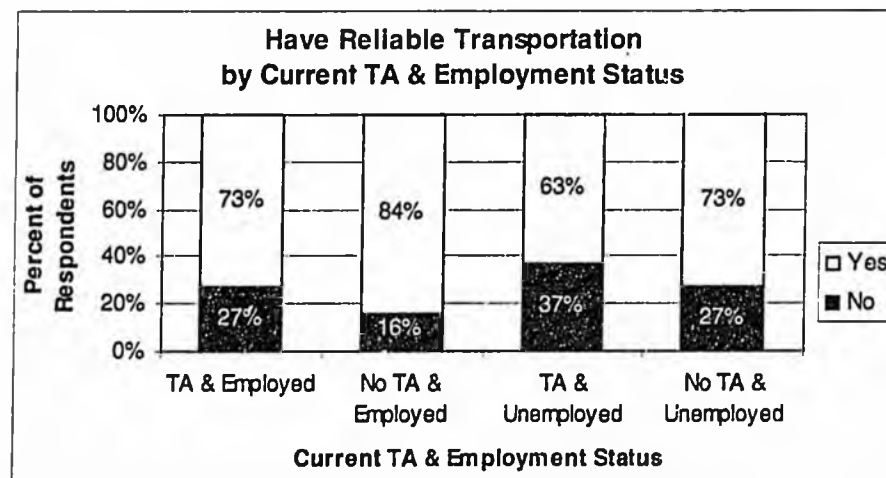


Figure 51

Respondents who were employed and not receiving Temporary Assistance at the time of the interview reported the highest rate of reliable transportation (84%), while 73% of respondents who were both employed and back on Temporary Assistance had reliable transportation. The same percentage (73%) of the people who were neither on Temporary Assistance nor employed at the time of the interview said they had reliable transportation. Sixty-three percent (63%) of those who were both unemployed and back on Temporary Assistance had reliable transportation. This information is displayed in Figure 51.

Reliance on Others for Transportation

Figure 52 shows that, generally, people were self-reliant for transportation, with a small group consistently needing help with transportation.

Reliability of Public Transportation

Figure 53 shows that respondents generally believed the public transportation available in their community was reliable. However, 37% reported that there was no public transportation in their community.

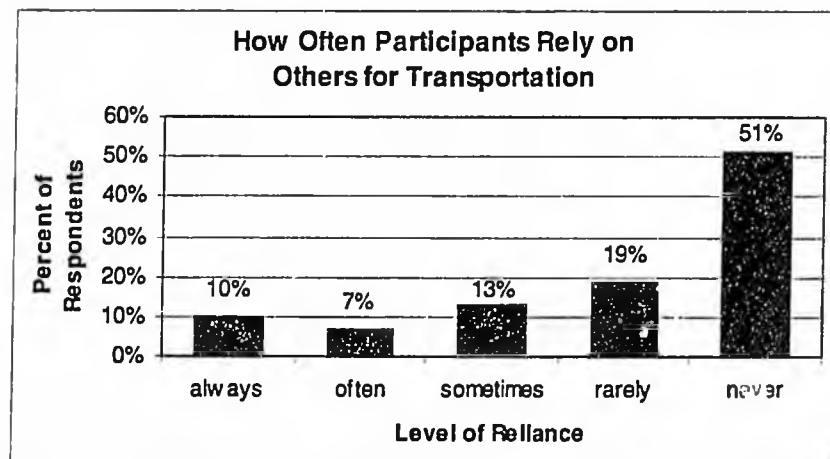


Figure 52

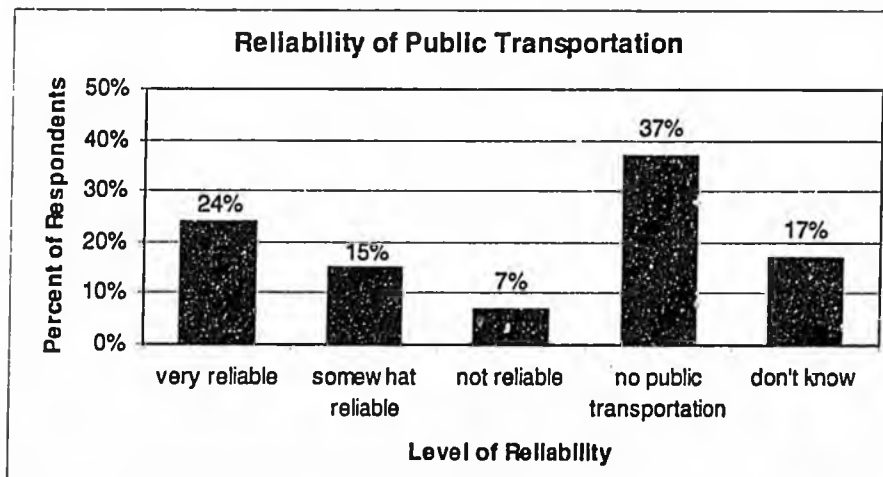


Figure 53

Health Issues

Health status and accessibility to health-related services are significant factors in a family's life. Any member of a family who is experiencing health-related difficulties creates unique stresses and responsibilities for the entire family.

Chronic conditions, such as a physical disability, mental illness, diabetes, heart conditions or developmental concerns take a daily toll on the resources of a family, both emotionally and financially. Acute problems are also realities for families, and without adequate access to care these events can become catastrophic. Often, acute illnesses go untreated in families that do not have access to health insurance.

Poor health can affect Temporary Assistance leavers in two ways. First, adults may be directly prevented from working due to their own health problems. Second, adults may be prevented from working because they must be home to care for a family member with poor health.

Findings:

- Eighty-nine percent (89%) of the respondents reported that their current health was fair or better, with 11% indicating poor health. Their spouses and children were reported to be in comparably good health.
- Thirty percent (30%) of respondents reported at least one family member with no medical coverage.
- Seventeen percent (17%) of respondents said that someone in their household had not received needed health care during the past year, most often due to financial constraints.

Health Status

Most respondents reported that their own health status and that of their families was "excellent" or "good" at the time of the interview and one year prior to the interview. Figure 54 shows that 89% of the respondents reported that their current health was fair or better, with 11% indicating poor health. Their spouses and children were reported to be in comparably good health.

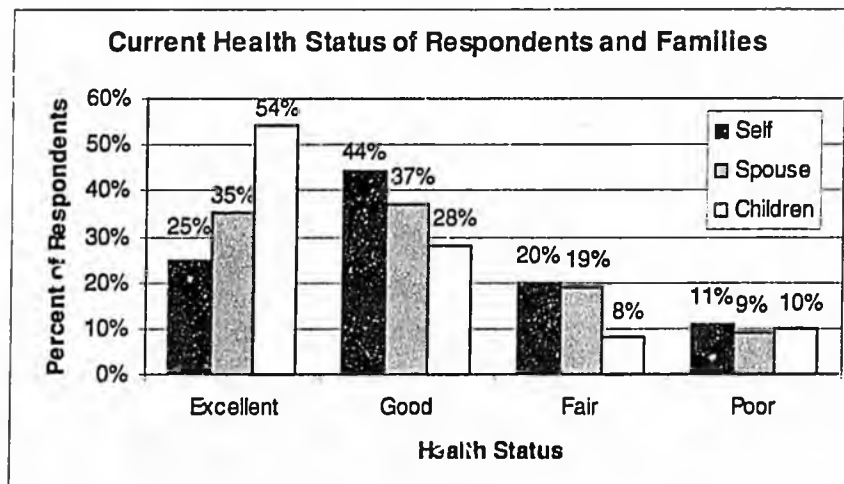


Figure 54

Health Care Coverage

Respondents were asked to identify sources of medical coverage for the household. The results are shown in Figure 55. Medicaid and Denali Kid Care were the most commonly reported forms of medical coverage, with 66% reporting that at least one family member had such coverage. Thirty percent (30%) reported at least one family member receiving Indian Health Service or Native medical benefits, and 26% had employer-paid medical insurance.

Individuals without Health Care Coverage

Figure 56 shows that fully 30% of the respondents indicated that they had at least one family member who did not have any medical coverage.

Figure 57 shows that 17% of the respondents stated that a member of the household had not received care in the past year when it was needed.

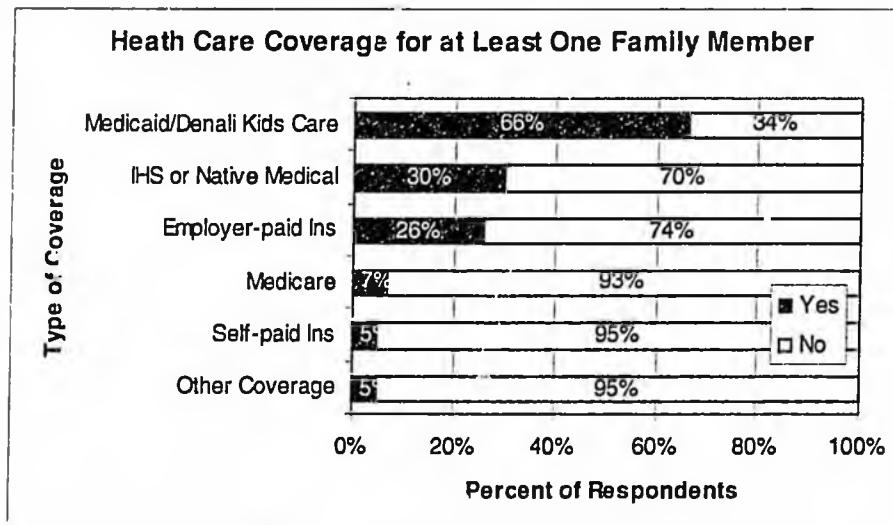


Figure 55

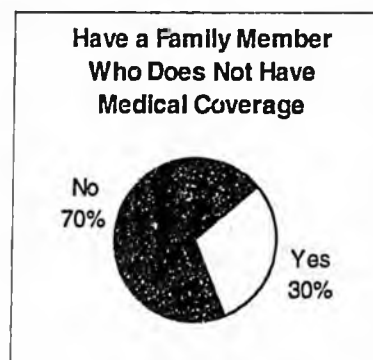


Figure 56

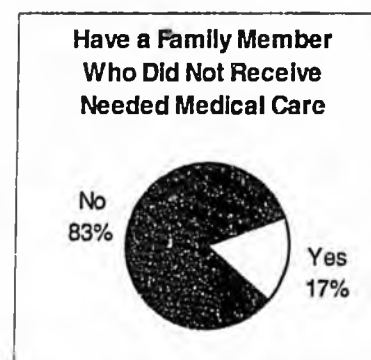


Figure 57

Financial constraints was the most common reason given for not receiving needed medical care (75%). Smaller numbers of respondents indicated that the medical services they needed were not available in their community, or that they did not seek

medical care for themselves or a family member because of the poor quality of medical care available, time constraints, and transportation constraints (see Figure 58).

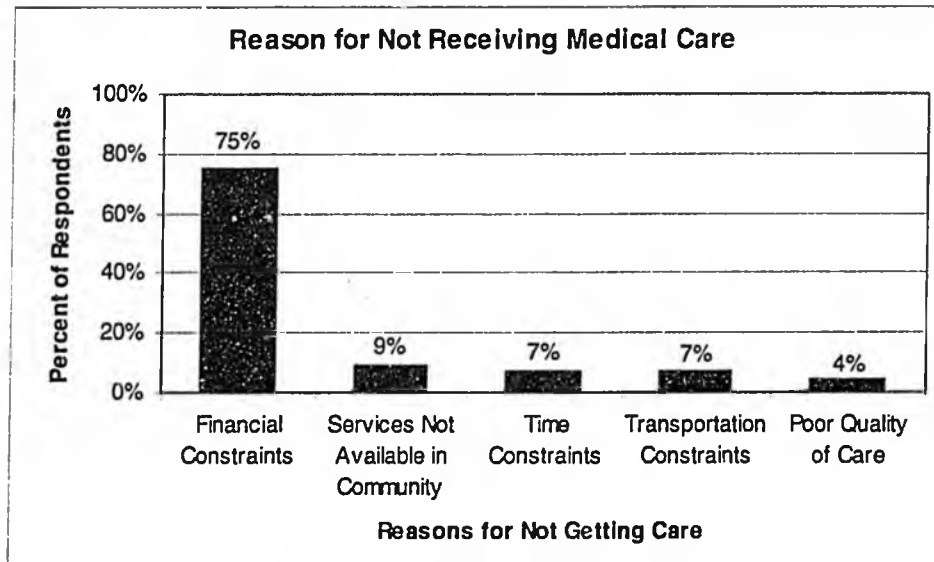


Figure 58

Client Perceptions and Attitudes

The beliefs and emotions of respondents are both indicators of family well-being and sources of information about the quality of their experience after leaving the Temporary Assistance rolls. Differences in perceptions and attitudes between returners and non-returners may correlate with the individual's success in achieving financial independence, as well as help shape policies that will maximize success.

At least two states have reported that, despite the fact that many of them may have been receiving less income since leaving the Temporary Assistance rolls, the preponderance of survey participants disagreed with the notion that they had been better off when they were on Temporary Assistance.

The "Work-First" message of the Temporary Assistance program may have moved some recipients to embrace the work and education ethic of mainstream America.

Survey respondents were asked a number of questions designed to measure their perceptions and attitudes. In general, the majority had accepted the welfare-to-work message and were satisfied with the services they received from their Temporary Assistance caseworkers.

Attitudes about Work and Welfare

Survey respondents indicated their level of agreement or disagreement with several statements that were designed to learn about their attitudes regarding employment and Temporary Assistance. Strong

Findings:

- More than nine out of ten (96%) people interviewed reported that they would rather work than receive Temporary Assistance.
- More than half (55%) of the respondents said that their lives were better while they were off the Temporary Assistance rolls.
- About seven out of ten (71%) respondents agreed with the appropriateness of Temporary Assistance time limits, with half of them (50%) strongly agreeing.
- Over eight out of ten (85%) respondents agreed that people on Temporary Assistance should be required to find a job and work.
- More than six out of ten (62%) people interviewed believed that their Temporary Assistance caseworker was interested in their well-being and gave them good advice and support.

positive responses about preferring work over welfare indicate that access to quality employment, rather than unwillingness to work, is the primary issue for most Temporary Assistance recipients.

Figure 59 shows that almost nine out of ten people interviewed (88%) agreed strongly that they would rather work than receive Temporary Assistance, and an additional eight percent agreed somewhat with the statement.

were receiving benefits versus when they were off assistance. Figure 60 shows that fifty-five percent (55%) disagreed strongly or disagreed somewhat with the statement "My life is better while I'm on Temporary Assistance than when I'm off of Temporary Assistance."

Similarly, the majority of respondents felt that their lives were not better while they

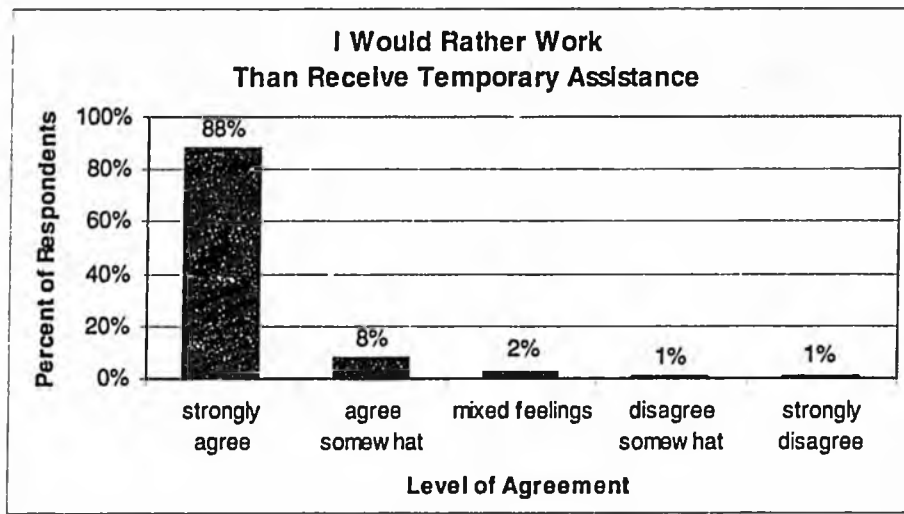


Figure 59

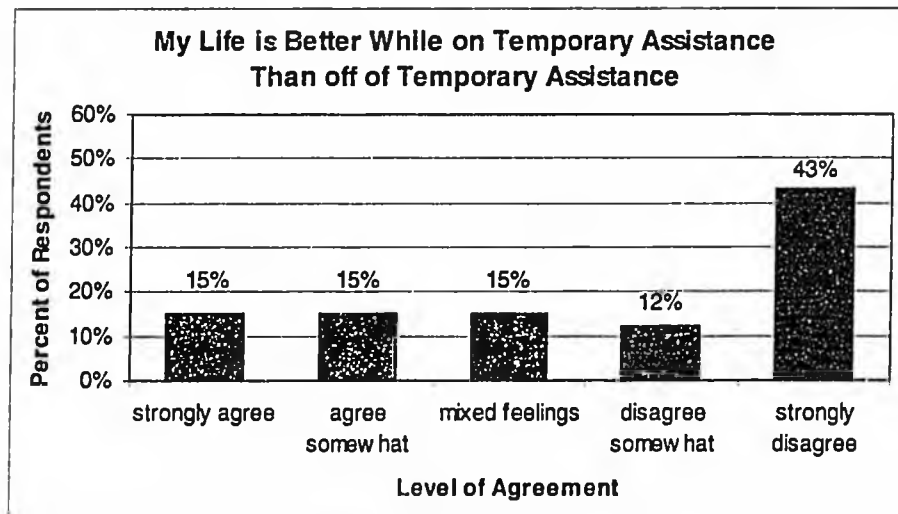


Figure 60

Forty-six percent (46%) of respondents indicated that they worry about not being eligible for Temporary Assistance benefits should they need them in the future (see Figure 61).

Figure 62 shows that the majority of respondents agreed with time limits for Temporary Assistance benefits. Figure 63 shows that respondents also agreed that people who receive Temporary Assistance should be required to find a job.

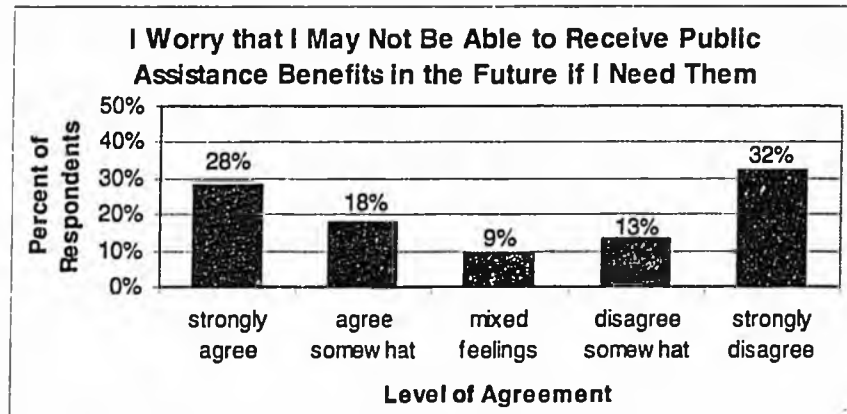


Figure 61

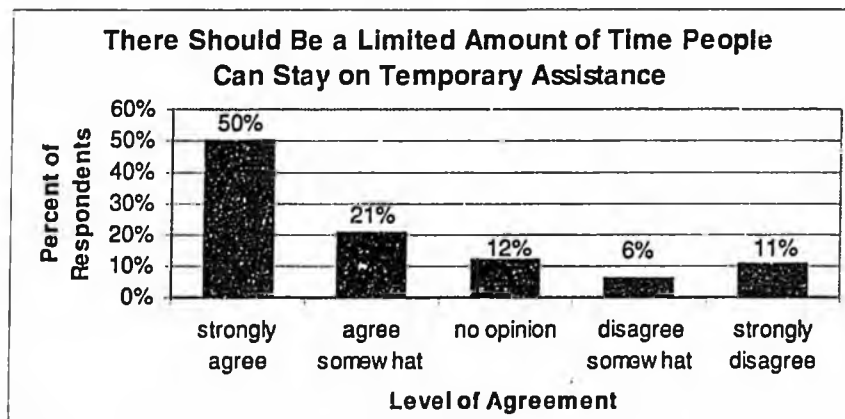


Figure 62

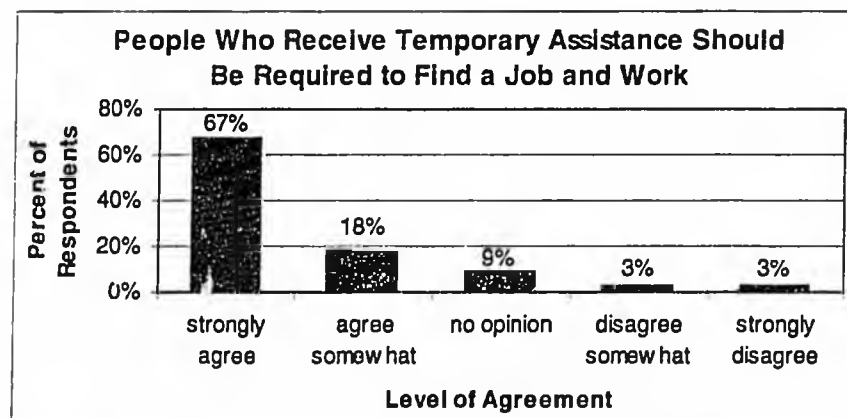


Figure 63

Perceptions of Availability of Education and Training

Lack of access to job training did not appear to be an issue for most of the people interviewed. Figure 64 illustrates that the majority indicated that they could receive the job training they needed in their com-

munity. Two thirds (67%) agreed that needed job training was available locally.

Access to high school equivalency courses and adult education can facilitate preparation for the job market. Most respondents believed that adult education and GED programs were available to them in their area (see Figure 65).

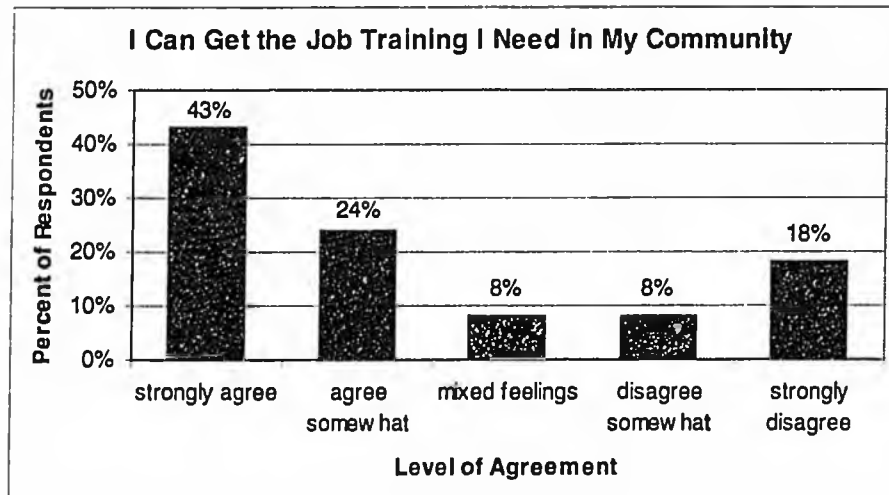


Figure 64

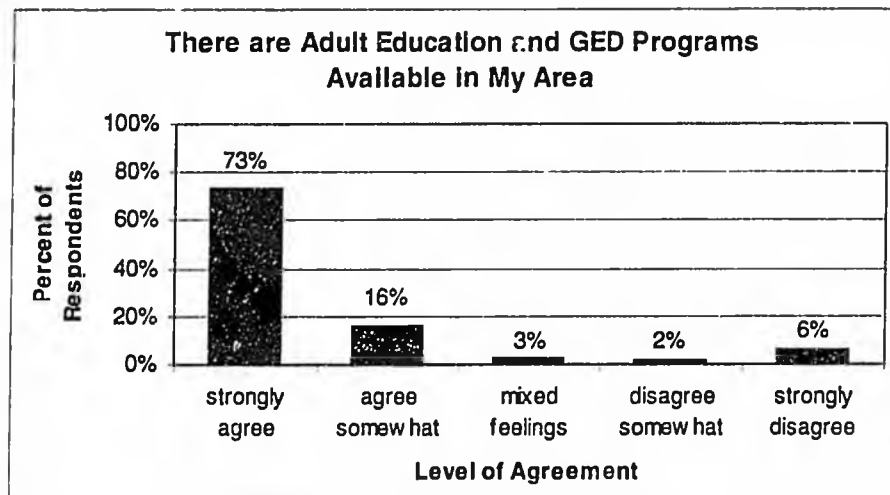


Figure 65

Attitudes about Temporary Assistance Caseworkers

Beliefs and emotions about the quality of services received from the Division of Public Assistance are important for understanding the impact of transitional services for people as they work toward self-

sufficiency. Leavers were asked to give their opinion about the services they received from DPA staff. Figures 66 and 67 show that the majority of leavers felt their caseworker was interested in their well-being and gave them good advice and support.

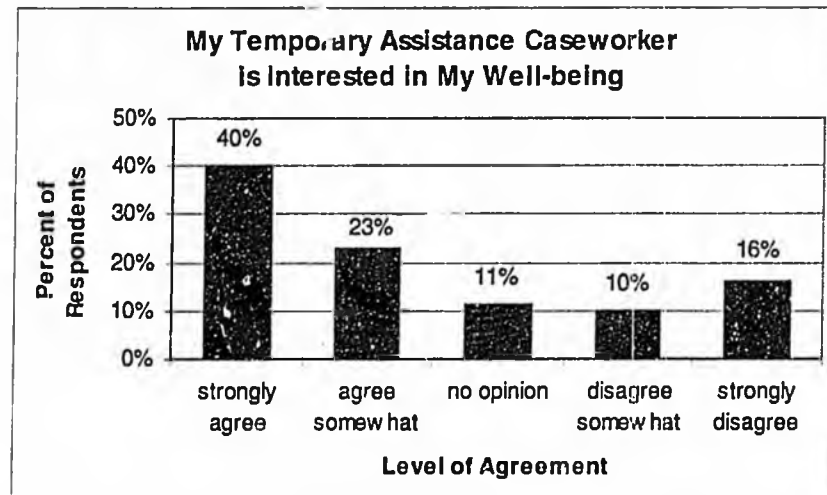


Figure 66

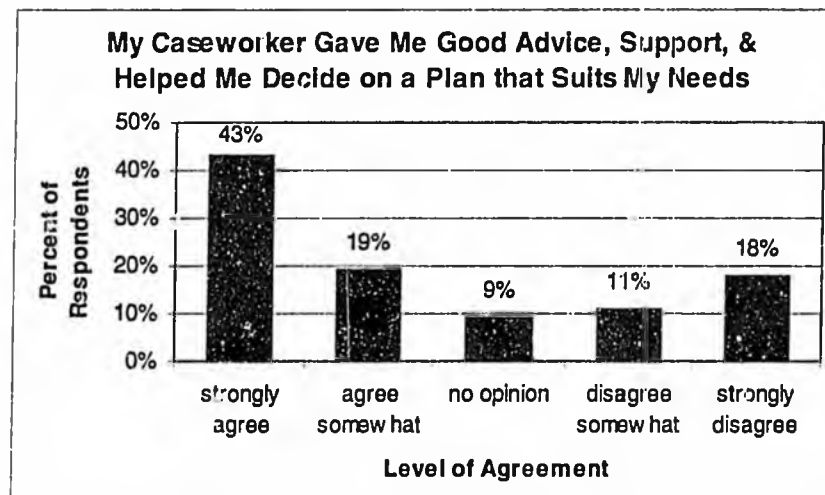


Figure 67

Rural Issues

The scattered distribution and rich diversity of Alaska's population are fundamental factors in the state's labor market and economy. The success of welfare reform is to some extent dependent on the availability of jobs to Temporary Assistance recipients. Smaller rural communities present particular challenges. Analysis of the differences between rural and urban communities may give insight into what programmatic approaches might best serve rural Temporary Assistance recipients in their quest for financial independence.

(See the Demographics and Basic Family Characteristics section of this report for a description of the geographic distribution of the sample population, and the basis for categorizing the sampled cases as either urban or rural.)

Ethnic Distribution

The rural caseload is predominantly Alaska Native; 88% of the rural cases surveyed were Alaska Native. Figures 68 and 69 show the urban/rural ethnic distribution of the study sample.

Findings:

- Almost nine out of ten rural Temporary Assistance recipients (88%) were Alaska Natives. There were significantly more respondents with two-parent families in rural Alaska (52%) than in urban Alaska (20%); this is consistent with the overall geographic distribution of the Temporary Assistance caseload.
- The higher cost of living and seasonal and temporary employment patterns probably offset higher wage levels in rural Alaska.
- Rural respondents believed that the available jobs were of lower quality and harder for them to find than their urban counterparts believed.
- Rural residents were less willing than urban residents to relocate to find employment.

Notwithstanding the high proportion of Alaska Native respondents living in Rural Alaska, rural residents represented only about 23% of the sampled leavers. Forty-five percent (45%) of the Alaska Natives in the survey sample lived in urban areas.

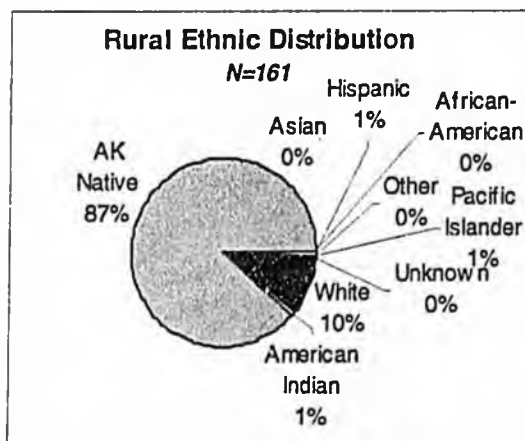


Figure 68

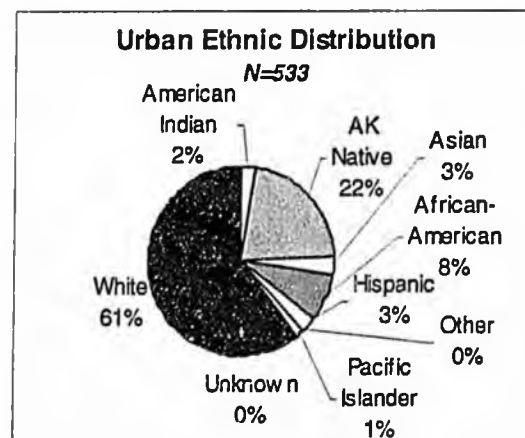


Figure 69

Family Types

Rural cases in the survey were significantly more likely to be two-parent families than urban cases. Twenty percent (20%) of urban respondents represented two-parent families, while 52% of the surveyed rural families were of the two-parent type. This is consistent with the overall distribution of the Temporary Assistance caseload (see Figures 70 and 71).

Urban and Rural Wage Levels

As Figure 72 shows, urban and rural respondents reported different average wage levels. Rural workers earned significantly more per hour than people in urban areas in both 1998 and 1999. In 1998, the average rural worker earned \$11.24 per hour (SD=4.64), while the urban worker earned \$9.35 per hour (SD=4.06). In 1999, earnings increased to an average rural wage of \$12.08 per hour (SD=4.73) and urban wage of \$10.13 per hour (SD=4.64). The 1999 average wage increase was significant only for urban workers.

It is important to note that although rural hourly pay was significantly higher during the study period, this does not in itself indicate that rural families had more total

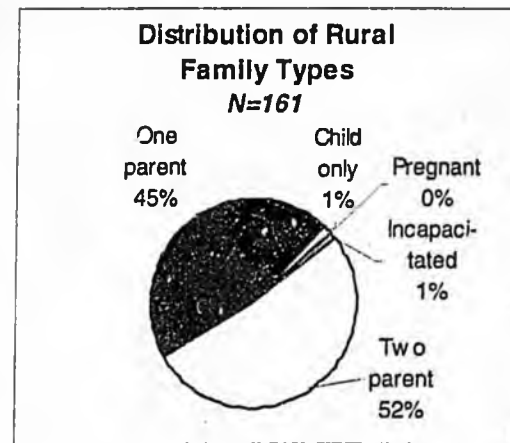


Figure 70

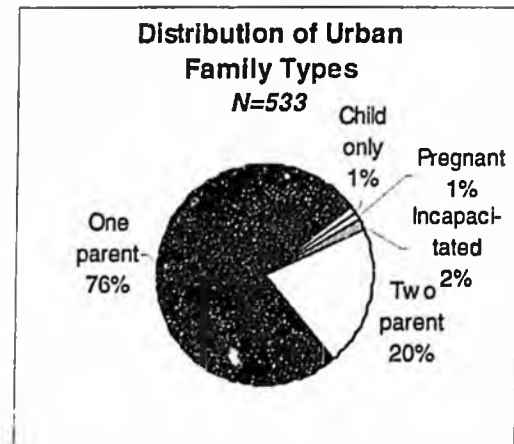


Figure 71

earned income. Comparative information on the relative employment rates of urban and rural respondents was not available at this writing.

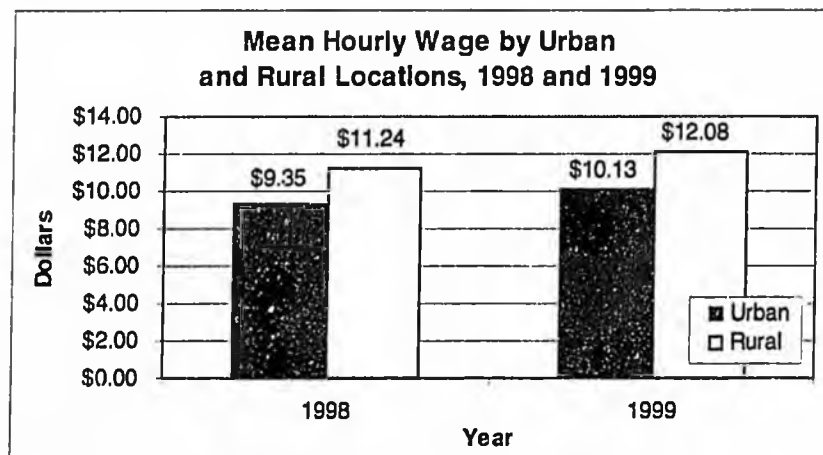


Figure 72

Vehicle Ownership, Temporary Assistance Status, and Urban/Rural Residency

Figure 73 illustrates that, in urban areas, 77% of the non-returners and 61% of the returners owned vehicles at the time of the interview. People in rural areas depended upon more varied sources of transportation, including cars, trucks, boats, sleds, snowmachines, and ATVs. In rural areas, 62% of the returners and 71% of the non-returners owned their own transportation.

Community Perceptions of the Job Market

Rural respondents differed from urban respondents in their beliefs about work opportunities. When asked if they thought jobs were available in their community for which they were qualified, 89% of urban subjects responded affirmatively. This is significantly greater than the 67% of rural residents who believed that work was available to them in their communities.

There were also significant differences between the responses of urban and rural respondents who were asked how hard it was to find work in their community; 42% of the urban respondents said jobs were ei-

ther very hard or fairly hard to find, while 75% of the rural respondents expressed the same belief.

Urban and rural respondents also differed in their perception of the quality of jobs available to them. Although 41% of each group said the quality of jobs they could get was average, 32% of the urban residents felt they could get fairly high quality or very high quality work in their community, while only 17% of the rural residents said they could get fairly high quality or very high quality work in their community.

Willingness to Relocate

When asked to respond to the statement, "I would have to move to a different community to get a good job," 51% of the rural subjects agreed strongly or agreed somewhat, compared to 24% of their urban counterparts. Only 48% of the rural subjects said they would be willing to move to another community to get a good job, while 57% of the urban respondents said they would move for a better job. This suggests that despite their perceptions of a less favorable local job climate, other aspects of the rural way of life may strongly influence the decisions that rural residents who leave Temporary Assistance make about where they choose to live and work.

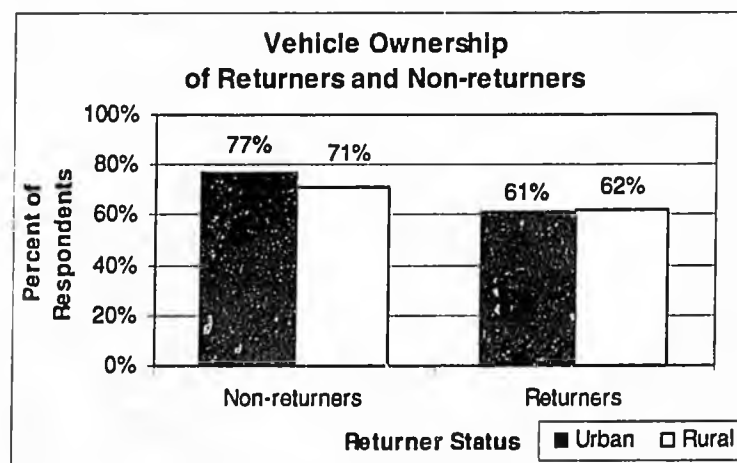


Figure 73

Appendix A

Survey Instrument

University of Alaska Anchorage
Institute for Circumpolar Health Studies

Alaska Temporary Assistance Program Evaluation Spring 2000 Survey

Survey Instructions

PLEASE USE A BLACK OR BLUE PEN TO FILL OUT THIS FORM

For optimum accuracy, please print carefully and avoid contact with the edges of the box. The following will serve as an example:

Mark choice boxes like:



NOT like:



1	2	3	4	5	6	7	8	9	0
---	---	---	---	---	---	---	---	---	---

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z

Additional Notes:

1. Do not mark, disfigure or remove the survey cornerstones or the recognition code located in the lower left hand corner.
2. Complete ALL items per instructions. Do not use "see attached", "see above", ditto marks or arrows to refer to earlier, duplicate or other answers.
3. For question #3a_(all) only the first names are recorded.
4. For question #3c_(all) record ages of less than one year as a decimal.
For example: a 6 month old baby is .5 years old
5. For all questions regarding dollar amounts other than hourly wage (question #20) record values as the nearest whole number.
6. For question #92 round the months value to the nearest whole number.

Interviewer name: _____

Interview date: / /
mm dd yy

Interview type: face to face telephone

Interview location (city): _____

Read Informed Consent Text to Subject

I want to start with some basic information about your family and your experience with the Alaska Temporary Assistance Program, also called Temporary Assistance or ATAP.

The Temporary Assistance Program is the program that replaced the old AFDC program in 1997. It provides monthly cash assistance to low-income families with children, along with other services that are designed to help people find work and keep jobs so they can live independent of Temporary Assistance.

1. Please give me the following information:

a) your full name

b) date of birth

/ /
mm dd yy

c) current mailing address

_____ street or PO box

_____ city state zip

d) current residence address

_____ street

_____ city state zip

e) home telephone number

() -

2. State records show that you stopped receiving Temporary Assistance benefits for at least two consecutive months since October 1997. Is that correct? YES NO

Now, I'd like to know about the general health of each member of your household. I'd like to list everyone who currently lives in the household and I would like you to tell me how they are related

3. Let's start with you. What is your age? How do you rate your current health, excellent, good, fair or poor? On the same scale, how was your health one year ago?

Record responses in the chart on the next page.

Now, tell me about the other people who live with you, starting with the youngest. What is this person's name? What is their relationship to you? How old is he/she? How do you rate his/her current health, excellent, good, fair or poor? And on the same scale, how was his/her health one year ago?

**Record responses in the following chart for each family member.
If more than 10, list only the first 10.**

	FAMILY MEMBER (name)	Relationship to you, (child, spouse, unmarried partner, etc.)	AGE	HEALTH STATUS				
				excellent	good	fair	poor	
1st				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2nd				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3rd				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10th				Today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				A Year Ago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Do you or does anyone in your household have any of the following kinds of medical coverage?

Read this list

- Employer-paid medical insurance..... YES NO
- Self-paid medical insurance..... YES NO
- Medicaid or Denali KidCare..... YES NO
- Medicare..... YES NO
- Indian Health Services or other Native medical benefits..... YES NO
- Other health coverage _____ YES NO

specify

5. Is there anyone in your family who has no medical coverage?..... YES NO

6. In the last year, has any member of your household not received any kind of medical attention that they needed?..... YES NO

If yes, why? *Do not prompt*

- Cost is too high/Couldn't afford
- Needed services not available
- Quality of care or provider
- Time
- Transportation
- Other _____

specify

Now I want you to respond to some statements about the Temporary Assistance Program. Please tell me if you agree strongly, agree somewhat, disagree somewhat, or disagree strongly with each statement I read.

7. My life is better while I'm on Temporary Assistance than when I'm off of Temporary Assistance.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Agree
strongly | Agree
somewhat | Have mixed
feelings | Disagree
somewhat | Disagree
strongly | N/A /
have no opinion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

8. I'd rather be employed than receive Temporary Assistance benefits.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Agree
strongly | Agree
somewhat | Have mixed
feelings | Disagree
somewhat | Disagree
strongly | N/A /
have no opinion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. I can get the job training I need in my community or village.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Agree
strongly | Agree
somewhat | Have mixed
feelings | Disagree
somewhat | Disagree
strongly | N/A /
have no opinion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. I worry that I won't be able to receive future Temporary Assistance payments if I need them.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Agree
strongly | Agree
somewhat | Have mixed
feelings | Disagree
somewhat | Disagree
strongly | N/A /
have no opinion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

11. There are adult education and GED programs available in my area.

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Agree
strongly | Agree
somewhat | Have mixed
feelings | Disagree
somewhat | Disagree
strongly | N/A /
have no opinion |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Now I want to ask you about any work that you've done and what those jobs were like. I'd like to measure the results to this question separately for each of the four quarters of the year. First, let's start with last year.

Winter = 1st Qtr = JAN-MAR; spring = 2nd Qtr = APR-JUN; summer = 3rd Qtr = JUL-SEP; fall = 4th Qtr = OCT-DEC

Questions #16 through #25	Fall 1999 / 4th Qtr 1999 a	Summer 1999 / 3rd Qtr 1999 b	Spring 1999/ 2nd Qtr 1999 c	Winter 1999/ 1st Qtr 1999 d	Fall 1998/ 4th Qtr 1998 e	Summer 1998/ 3rd Qtr 1998 f	Spring 1998/ 2nd Qtr 1998 g	Winter 1998/ 1st Qtr 1998 h
16. Last year (1999), did you do any work for pay? enter Y = YES N= NO, by quarters								
17. The year before last (1998) did you do any work for pay? enter Y = YES N= NO, by quarters								
If subject answers YES for either #16 or #17, get information by quarters, proceeding through question #22 for each quarter. If NO for both years, skip to question #23.								
18. Was your employer for your main job? G= government P= private company N= non-profit organization S= self (complete #19) T= temporary employment service O= other								
19. If self employed, what type of work did you do? U= unskilled labor/service work C= construction/skilled trades A= arts/crafts P= professional/technical F= fishing/farming O= other								
20. What was your hourly wage for your main job during that quarter? (If subject quotes rate per day, week, month, so report)								
21. In your main job, did you work: A= more than 40 hours p/week B= 31 to 40 hours/week C= 21 to 30 hours/week D= 11 to 20 hours/week E= 1 to 10 hours/week?								
22. Was your work seasonal, temporary, or permanent? S= seasonal T= temporary P= permanent								
23. Did you subsistence hunt or fish or gather subsistence foods last year (1999)? The year before last (1998)? Enter Y = YES, N= NO, by quarters								
24. Did you do any unpaid community service or volunteer work last year (1999)? The year before last (1998)? Enter Y= YES, N= NO, by quarters								
25. Last year (1999), did any other adult member of your household (anyone over 18) do any work for pay? The year before last? (1998) Enter Y= YES, N= NO, by quarters								

26. Are you permanently disabled or unable to work for health reasons?..... YES NO
If YES, skip to question #37

27. Are you working NOW?..... YES NO
If NO, AND subject did not work at all in 1998 or 1999 (questions #16 and 17), skip to question #37

Now I am going to ask you a series of questions about your current job or, if you are not working now, about the last job you had.

29. Did you receive any education or training for your job that was NOT provided by your employer?..... YES NO

28. Did you have the skills you needed to do your job when you started?..... YES NO

If YES, Was this education or training before or after you started the job?..... BEFORE AFTER

30. Did you receive any on-the-job training from your employer?..... YES NO

31. Have you received an increase in salary while working in this job?..... YES NO

32. Were there opportunities for promotion in this job?..... YES NO
"NO", skip to Q.36

33. (IF YES TO Q.32...) Did you receive a promotion while working your current job, or during the last job you worked?..... YES NO

34. (IF YES TO Q.32...) Did you need additional education or training to be eligible for promotion?..... YES NO

35. (IF YES TO Q.32...) Did your employer offer or provide education or training that could lead to promotion? YES NO

36. During the past year (1999), what has been the longest period of time that you were without work?..... (# of weeks)

Now I have some general questions about what kind of work is available in your community or village. If you are currently working, please think about what work would be available if you were NOT working.

37. Are there jobs available in your community or village that you believe you are qualified for?..... YES NO

38. How hard is it to find work in your community or village? Would you say jobs are very easy to find, fairly easy to find, fairly hard to find, or very hard to find?

Very easy to find	Fairly easy to find	Neither easy nor hard to find	Fairly hard to find	Very hard to find	N/A / no opinion?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. How would you rate the quality of the jobs you could get in your community or village? Would you say jobs are very high quality, fairly high quality, fairly low quality or very low quality?

Very high quality	Fairly high quality	Average quality	Fairly low quality	Very low quality	N/A / no opinion?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. Please tell me whether you agree strongly, agree somewhat, disagree somewhat or disagree strongly with the following statement: I would have to move to another community to get a good job.

Agree strongly	Agree somewhat	Mixed feelings	Disagree somewhat	Disagree strongly	N/A / no opinion?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. Would you move to another community to get a good job?..... YES NO

42. In the last 12 months, have any of the following services made it possible for you to find work in your community or village?

Read this list

- Public Assistance work search programs..... YES NO
- Dept. of Labor employment services or job centers..... YES NO
- Temporary job agency..... YES NO
- Tribal or community job assistance program..... YES NO
- Newspaper ads..... YES NO
- Friends or family..... YES NO
- Other services _____ YES NO

specify

43. In the last 12 months, has anything made it difficult for you to find or keep a job?..... YES NO

If YES, What made it difficult? **Do not prompt**

44. In the past year, has your involvement in any of the following made it difficult for you to find or keep a job?

Read this list

- DFYS Child Protection programs..... YES NO
- Tribal Child Protection programs..... YES NO
- Juvenile Justice program..... YES NO
- Involvement with the criminal justice system..... YES NO
- Court restraining orders..... YES NO
- Child custody disputes..... YES NO
- Other family issues or problems..... YES NO

_____ specify

This next series of questions applies to unearned income (money you receive that is not from salary, wages, or self-employment).

45. Did you or other household members receive Permanent Fund Dividends last year (1999)? YES NO

If YES, how many household members received dividends?.....

46. Was anyone's Permanent Fund Dividend garnished last year to pay child support, divorce settlements, or other debts?..... YES NO

47. Will you or other household members receive Permanent Fund Dividends this year (2000)?..... YES NO

If YES, how many household members will receive dividends?.....

48. Did you or other household members receive Native corporation dividends last year (1999)?..... YES NO

If YES, how many household members?.....

How much did each person get last year (1999)?.....

49. Will you or other household members receive Native corporation dividends this year (2000)?..... YES NO

If YES, how many household members?.....

How much do you expect each person to get this year (2000)?.....

The following is a list of certain types of benefits you may or may not receive. Please tell me if you or any other household members have received any of the following payments in the last three months, and remember, your responses are completely confidential and will not under any circumstances result in any loss of benefits:

50. Regular disability pay?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....
51. Worker's compensation?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....
52. SSI (Supplemental Security Income)?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....
53. Social Security benefits (Retirement, survivors, or disability)?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....
54. Retirement payments?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....
55. State Adult Public Assistance benefits?..... YES NO
If YES, how many household members receive it?.....
If YES, what is the total monthly payment for the household?.....

The next five questions also apply to the past three months.

56. Do members of your household receive regular child support payments?..... YES NO
If YES, how much total child support does your household receive each month?.....
57. Do you or other household members pay child support?..... YES NO
If YES, how much child support is your household required to pay each month?.....

58. Have you (or other household members) sold property or other belongings in the last three months to help pay expenses?..... YES NO
If YES, how much money did your household make selling these belongings or property?.....

59. Have you (or other household members) taken out loans in the last three months to help pay expenses?..... YES NO
If YES, how much money was borrowed?.....

60. Have you (or other household members) received cash support in the last three months from family, friends or community groups?..... YES NO
If YES, how much support did you receive?.....

Now I'm going to ask you some questions about education or training that you may have had to help you look for a job, train you for a job or career, or stay

61. What is the highest grade you have completed (including college)?.....
If LOWER than grade 12, do you have a GED?..... YES NO
If NO, are you working on your GED?..... YES NO

62. Have you been involved in any training classes that help teach people how to look for a job, prepare a resume, or how to act in job interviews and talk to employers?..... YES NO

63. (IF "YES", THEN ASK...) Were any of these classes sponsored by Public Assistance or a Public Assistance case management contractor?..... YES NO

The next series of question applies to your education and training services DURING THE PAST 3 YEARS

64. Have you taken any workshops or training that help people understand what their skills are and what kinds of jobs are best for them?..... YES NO

65. Have you been involved in any classroom training that teaches job skills?..... YES NO

66. Have you had a job that provides training while you work?..... YES NO

67. Have you taken a course in English as a second language?..... YES NO

68. Have you taken any correspondence courses where you study at home with materials you get in the mail?..... YES NO

69. Have you had an apprenticeship through a trade union?..... YES NO

In the past three years.....

70. Did the Public Assistance office or a Public Assistance case management contractor require you to work, look for a job, or go to some type of job training class?..... YES NO

71. Did the Public Assistance office or a Public Assistance case management contractor help you pay for child care while you went to work, looked for a job, or attended some type of job training class?..... YES NO

72. Did the Public Assistance office or a Public Assistance case management contractor help you pay for transportation to work, look for a job, or attend some type of job training class?..... YES NO

73. Did the Public Assistance office or a Public Assistance case management contractor help you pay for any other expenses (for example: tuition, car repair, tools, work clothes) to help you work, look for a job or attend some type of job training class?..... YES NO

Now, please tell me whether you agree strongly, agree somewhat, disagree somewhat or disagree strongly with the following statements about the Public Assistance office and your Public Assistance caseworker.

74. My Temporary Assistance caseworker is interested in my well-being.

Agree strongly	Agree somewhat	Have mixed feelings	Disagree somewhat	Disagree strongly	N/A / have no opinion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

75. My caseworker gave me good advice and support and helped me decide on a plan that suits my needs.

Agree strongly	Agree somewhat	Have mixed feelings	Disagree somewhat	Disagree strongly	N/A / have no opinion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

76. There should be a limited amount of time people can stay on Temporary Assistance.

Agree strongly	Agree somewhat	Have mixed feelings	Disagree somewhat	Disagree strongly	N/A / have no opinion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

77. People who receive Temporary Assistance should be required to find a job and work.

Agree strongly	Agree somewhat	Have mixed feelings	Disagree somewhat	Disagree strongly	N/A / have no opinion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now I want to ask you about your child care arrangements.

78. Are there preschool children in your household?..... YES NO
 If NO, skip to #80

79. In the past year, did someone take care of your children while you were training, looking for work, or working?..... YES NO N/A

If YES, who provided this care? Was this caregiver paid to care for children? How many hours per week is care provided? (If they are paid...) How much did you pay per week for this caregiver?

Mark all that apply in chart below
 If NO, skip to # 80

CAREGIVER	Is caregiver paid to care for child(ren)? y=yes n=no	How many hours per week is care provided?	How much did you pay per week?
Friend			
Child's other parent or stepparent			
Grandparent or other adult relative			
Child's brother or sister			
Babysitter			
Child Care Center			
Family Day Care Home			
Head Start Program			
School or school-sponsored Program			
Boys and Girls Clubs			
Church or other Faith-based organization			
_____ Other specify			

80. Are there school-age children in your household?..... YES NO
 If NO, skip to #82

81. Now, thinking about children living in your household who are in school, do you have some kind of extended care, after-school care, or daycare during school vacations for them while you are at work, looking for a job, or going to school that you have used during the past year?..... YES NO N/A

If YES, who provided this care? Was this caregiver paid to care for children? How many hours per week is care provided? (If they are paid...) How much did you pay per week for this caregiver?

Mark all that apply in chart below
 If NO, skip to # 82

CAREGIVER	Is caregiver paid to care for child(ren)? y=yes n=no	How many hours per week is care provided?	How much did you pay per week?
Friend			
Child's other parent or stepparent			
Grandparent or other adult relative			
Child's brother or sister			
Babysitter			
Child Care Center			
Family Day Care Home			
Head Start Program			
School or school-sponsored Program			
Boys and Girls Clubs			
Church or other Faith-based organization			
_____ Other specify			

82. (IF THEY HAVE HAD CHILDCARE...) During the past year, have you been satisfied with your childcare arrangements?..... YES NO N/A

83. During the past year, was there ever a time you could not look for a job or go to school or training because you lacked child care?..... YES NO N/A

Now, I want to ask you about services you received after you stopped receiving Temporary Assistance. If you have started receiving Temporary Assistance again, think about when you stopped getting Temporary Assistance for a while.

84. While you were off Temporary Assistance, did you get any government assistance for your family needs?..... YES NO

If YES, check all that apply.

- Read this list
- Day care assistance
 - Health insurance, such as Medicaid or Denali KidCare
 - Transportation
 - WIC
 - Free or low-cost school
 - HUD or ASHA housing
 - Heating Assistance or Home Energy Assistance programs
 - Food
 - Clothing
 - Other services from Public Assistance _____
specify
 - Services from other government programs _____
specify

85. Did you get donations of food, clothing, or other necessities from anyone else such as a food bank, church, family, or a community center?..... YES NO

If YES, check all that apply.

Do not prompt.

- food bank
- church
- family
- community or village center
- other _____
specify

86. Are you receiving food stamp benefits right now?..... YES NO

If NO, why not?

87. Does anyone give you subsistence foods?..... YES NO

88. Do you receive help from a heating assistance or home energy assistance program to pay for home heating?..... YES NO

89. In the past year (1999), what did you do to get by when you weren't receiving Temporary Assistance?
Open-ended.

90. Let's think about the time you were off Temporary Assistance. Was there some kind of help you needed to help you stay off of assistance?..... YES NO

If YES, what kind of help?

If YES, did you get the help you needed?..... YES NO

Now, let's talk about your housing situation.

91. What type of housing do you live in now?:

Check the one that applies.

OK to prompt.

- Live in a house or condominium that you own
- Live in a mobile home, motor home, or trailer that you own
- Rent a house, condominium, or apartment
- Rent a mobile home, motor home, or trailer
- Live with family or friends and not pay rent
- Live with family or friends and pay part of the rent or mortgage
- Live in a group shelter
- Live in a shelter for the homeless
- Live in some other situation.
- Have nowhere to live _____ specify

92. How long have you lived where you are now?.....

If one year or MORE, skip to #93

years months

If LESS than one year:

a) How many times did you move in the past year?.....

b) Why did you move the last time? *Open-ended.*

c) Did you move from one community or village to another?..... YES NO

82. (IF THEY HAVE HAD CHILDCARE...) During the past year, have you been satisfied with your childcare arrangements?..... YES NO N/A

83. During the past year, was there ever a time you could not look for a job or go to school or training because you lacked child care?..... YES NO N/A

Now, I want to ask you about services you received after you stopped receiving Temporary Assistance. If you have started receiving Temporary Assistance again, think about when you stopped getting Temporary Assistance for a while.

84. While you were off Temporary Assistance, did you get any government assistance for your family needs?..... YES NO

If YES, check all that apply.

Read this list

- Day care assistance
- Health insurance, such as Medicaid or Denali KidCare
- Transportation
- WIC
- Free or low-cost school
- HUD or ASHA housing
- Heating Assistance or Home Energy Assistance programs
- Food
- Clothing
- Other services from Public Assistance _____
specify
- Services from other government programs _____
specify

85. Did you get donations of food, clothing, or other necessities from anyone else such as a food bank, church, family, or a community center?..... YES NO

If YES, check all that apply.

Do not prompt.

- food bank
- church
- family
- community or village center
- other _____
specify

86. Are you receiving food stamp benefits right now?..... YES NO

If NO, why not?

87. Does anyone give you subsistence foods?..... YES NO

93. Last month, how much did you pay for rent or mortgage on your home?.....

94. Last month, about how much did you pay for utilities, including electricity, heating fuel, water, sewer, waste disposal but not telephone or cable?.....

95. Are you paying reduced rent because the federal, state, or local government or a tribal organization is paying part of the rent?..... YES NO

96. Do you live in a public housing project owned by a local housing authority, ASHA, another public agency, or a nonprofit agency?..... YES NO

97. In the past year, was there a time when you or you and your family were not able to pay your mortgage, rent or utility bills?..... YES NO

98. How satisfied are you with your current living situation, very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied? Very satisfied Somewhat satisfied Neither Somewhat dissatisfied Very dissatisfied

Now let's talk about how you get around.

99. Do you have reliable transportation to get to work, training, or childcare (for example, a car, snowmachine, ATV, or boat)?..... YES NO

100. When you travel from one location to another, be it for work, shopping, or childcare how do you usually get there?
If more than one, check all that apply.
Do not prompt.

- Drive own automobile/motorcycle/truck/van
- Drive own snowmachine / ATV/boat
- Drive someone else's automobile/motorcycle
- Drive someone else's snowmachine/ATV/boat
- Walk or ride a bicycle
- Get a ride (other than public transportation or taxi)
- Ride public transportation
- Taxi
- Other _____
specify

101. If you are working, how long does it usually take you to get to work, including time needed to drop children off at child care?.....
minutes

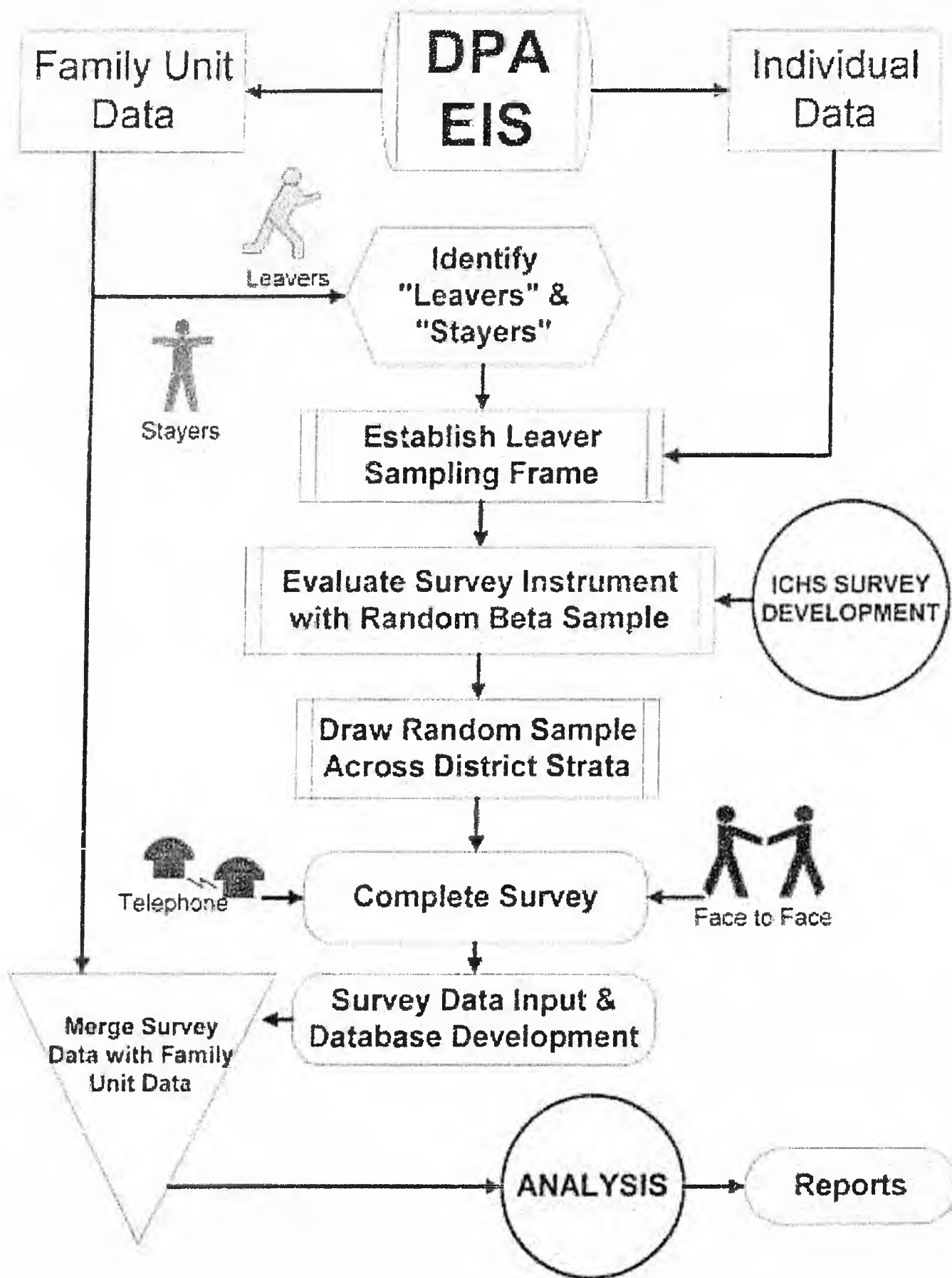
102. How often do you rely upon others for transportation to work, training, or child care, always, often, sometimes, rarely or never? Always Often Sometimes Rarely Never

103. How reliable is the public transportation where you live, very reliable, somewhat reliable or not at all reliable? Very reliable Somewhat reliable Not at all reliable No public transportation Don't know

Appendix B

**Flow Chart: Selection of Respondents
and EIS and Survey Data**

Selection of Respondents and EIS and Survey Data



Appendix C

**Food Stamp Program
Urban/Rural Cities List**

ALASKA FOOD STAMP MANUAL

ADDENDUM 1

FOOD STAMP PROGRAM CITY AND VILLAGE CLASSIFICATION

URBAN: Geographic Area - URBAN (CU, NU, SU)

Adak	Douglas	Indian	Saxman
Alexander Creek	Eagle River	Juneau	Seward
Anchor Point	Eielson AFB	Kasilof	Sitka
Anchorage	Eklutna	Kenai	Skagway
Auke Bay	Elmendorf AFB	Ketchikan	Soldotna
Beluga River	Ester	Kodiak	Spenard
Big Lake	Fairbanks	Metlakatla	Sterling
Broad Pass	Fort Greely	Moose Pass	Susitna
Canyon City	Fort Richardson	Mountain View	Sutton
Chase	Fort Wainwright	Mt Edgecumbe	Talkeetna
Chena Hot Springs	Fox	Nikishka	Trapper Creek
Chickaloon	Fritz Creek	Nikiski	Trappers Creek
Chugiak	Girdwood	Nikolaevsk	Two Rivers
Clam Gulch	Glen Hwy West	Ninilchik	Valdez
Cohoe	Gruen	North Pole	Ward Cove
Cold Bay	Haines	Palmer	Wasilla
College	Halibut Cove	Petersburg	Willow
Cooper Landing	Homer	Peters Creek	Wrangell
Craig	Hope	Portage	
Curry	Houston	Port Chilkoot	
Delta Junction	Hyder	Salcha	

RURAL I: Geographic Area - RURAL I (CM, NM, SM, NN)

Akhiok	False Pass	Mentasta Lake	Siana
Angoon	Funter Bay	Meyers Chuck	Tanacross
Annette	Gakona	Nabesna	Tatitlek
Cape Yakataga	Glen Hwy East	Nanwalek	Tenakee
Chenega	Glennallen	Nenana	Tetlin
Chicken	Gulkana	Northway	Thorne Bay
Chiniak	Gustavus	Old Harbor	Tok
Chistochina	Hawk Inlet	Ouzinkie	Tokeen
Chitina	Hollis	Paxson	Tonsina
Coffman Cove	Hoonah	Pelican	Tuxekan
Copper Center	Hydaburg	Point Baker	Tyonek
Cordova	Kake	Port Alexander	Whale Pass
Dot Lake	Karluk	Port Bailey	Whittier
Eagle	Kasaan	Port Graham	Yakutat
Edna Bay	Kenny Lake	Port Lions	
Elemar	Klawock	Portlock	
Elfin Cove	Klukwan	Port Protection	
Evans Island	Larsen Bay	Seldovia	
Excursion Inlet	McCarthy	Skwentna	

RURAL II: Geographic Area - RURAL II (CR, NR, WR)

Akiachak	Diomedes	Kwethluk	Pribilof Island
Akiak	Dunbar	Kwigillingok	Quinhagak
Akutan	Dutch Harbor	Levelock	Rampart
Alakanuk	Eek	Lime Village	Red Devil
Aleknagik	Egegik	Livengood	Ruby
Allakaket	Ekuk	Manley Hot Springs	Russian Mission
Ambler	Ekwok	Manokotak	Saint George
Anaktuvuk Pass	Elim	McGrath	Saint Marys
Anderson	Emmonak	Medfra	Sand Point
Aniak	Flat	Mekoryuk	Savoonga
Anvik	Fort Yukon	Miller House	Scammon Bay
Arctic Village	Fortuna Ledge	Minchumina Lake	Selawik
	Galena	Minto	Shageluk
Atka	Gambell	Mt Village	Shaktolik
Atkasuk	Georgetown	Naknek	Sheldon Point
Atmautluak	Golovin	Napaimiut	Shishmaref
Barrow	Goodnews Bay	Napakiak	Shungnak
Barter Island	Grayling	Napaskiak	Sleetmute
Beaver	Haycock	Nelson Lagoon	Solomon
Belkofski	Healy	Newhalen	South Naknek
Bethel	Holikachuk	New Stuyahok	Squaw Harbor
Bettles	Holy Cross	Newtok	Stebbins
Birch Creek	Hooper Bay	Nightmute	Stevens Village
Brevig Mission	Hughes	Nikolai	St Michael
Buckland	Huslia	Nikolski	St Michaels
Candle	Igiugig	Noatak	Stony River
Cantwell	Illiamna	Nome	St Paul Island
Canyon Village	Ivanoff Bay	Nondalton	Takotna
Central	Kaktovik	Noorvik	Tanana
Chalkyitsik	Lower Kalskag	Northeast Cape	Telida
Chaniliut	Upper Kalskag	Nuiqsut	Teller
Chefornak	Kaltag	Nulato	Togiak
Chevak	Kasigluk	Nunapitchuk	Toksook Bay
Chignik	Kiana	Nyac	Tuluksak
Chignik Lagoon	King Cove	Ohgsenakale	Tuntutuliak
Chignik Lake	King Salmon	Oscarville	Tununak
Chuathbaluk	Kipnuk	Pauloff Harbor	Twin Hills
Circle	Kivalina	Pedro Bay	Ugashik
Circle Hot Springs	Kobuk	Perryville	Unalakleet
Clarks Point	Kokhanok	Pilot Point	Unalaska
Clear	Kokrines	Pilot Station	Unga
Coldfoot	Koliganek	Pitka's Point	Usibelli
Council	Kongiganak	Platinum	Venetie
Crooked Creek	Kotlik	Point Hope	Wainwright
Deering	Kotzebue	Point Lay	Wales
Denali Natl Park	Koyuk	Port Alsworth	White Mountain
Dillingham	Koyukuk	Port Heiden	Wiseman

HB

160

22-LS0457AF
Lauterbach
4/2/01

CS FOR HOUSE BILL NO. 160()

IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTY-SECOND LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Dyson, James, Kott, Wilson, Meyer

A BILL

FOR AN ACT ENTITLED

1 "An Act requiring the reporting of induced terminations of pregnancies."

2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 * Section 1. AS 18.50 is amended by adding a new section to read:

4 Sec. 18.50.245. Report of induced termination of pregnancy. (a) A
5 hospital, clinic, or other institution where an induced termination of pregnancy is
6 performed in the state shall submit a report directly to the state registrar within 30 days
7 after the induced termination is completed. The report may not contain the name of
8 the patient whose pregnancy was terminated but must contain the information required
9 by the state registrar in regulations adopted under this section.

10 (b) When an induced termination of pregnancy is performed by a physician
11 outside of a hospital, clinic, or other institution, the physician shall submit the report
12 required under this section within 30 days after the induced termination of pregnancy
13 is completed.

14 (c) For purposes of this section,

15 (1) an induced termination of pregnancy is considered to be performed

1 where the act interrupting the pregnancy is performed even if the resultant expulsion
2 of the product of conception occurs elsewhere;

3 (2) prescription of a medicine by a physician who knows that the
4 medicine will be taken with the intention of inducing termination of a pregnancy is
5 considered to be the act that interrupts the pregnancy even if the medicine is taken
6 outside of the physician's presence; and

7 (3) an induced termination of pregnancy is considered to be completed
8 when the product of conception is extracted or expelled.

9 (d) The state registrar shall annually prepare a statistical report based on the
10 reports received under this section. The report must include the types of information
11 required under (e) of this section. The data gathered from the reports received under
12 this section may only be presented in aggregate statistics, not individually, so that
13 specific individuals may not be identified. After preparation of the annual report, the
14 state registrar shall destroy the reports received under this section.

15 (e) The state registrar shall adopt regulations to implement this section. The
16 regulations that establish the information that will be required in a report of an induced
17 termination of pregnancy must require information substantially similar to the
18 information required under the United States Standard Report of Induced Termination
19 of Pregnancy, as published by the National Center for Health Statistics, Centers for
20 Disease Control and Prevention, United States Department of Health and Human
21 Services, in April 1998, as part of DHHS Publication No. (PHS) 98-1117.

22 * Sec. 2. AS 18.50.310(b) is amended to read:

23 (b) The bureau may permit the use of data contained in vital statistics records,
24 other than reports of induced terminations of pregnancy, for research purposes.

25 * Sec. 3. AS 18.50.310(e) is amended to read:

26 (e) The department may by regulation provide for the release of information,
27 other than information in reports of induced terminations of pregnancy, to
28 authorized representatives of organizations or foundations that counsel the next of kin
29 of victims of sudden infant death syndrome.

30 * Sec. 4. AS 18.50.350 is amended to read:

31 **Sec. 18.50.350. Duty to furnish information.** A person having knowledge of

1 the facts shall furnish the information the person possesses regarding a birth, death,
2 fetal death, induced termination of pregnancy, marriage, or divorce, upon demand
3 of the state registrar.

4 * Sec. 5. AS 18.50.950(8) is amended to read:

5 (8) "fetal death" means death before the complete expulsion or
6 extraction from its mother of a product of human conception, irrespective of the
7 duration of pregnancy, where

8 (A) [AND] the death is indicated by the fact that, after
9 expulsion or extraction, the fetus does not breathe or show evidence of life
10 such as beating of the heart, pulsation of the umbilical cord, or definite
11 movement of voluntary muscles; and

12 (B) the expulsion or extraction is not caused by an induced
13 termination of pregnancy;

14 * Sec. 6. AS 18.50.950(18) is amended to read:

15 (18) "vital statistics" means records of birth, death, fetal death,
16 induced termination of pregnancy, marriage, divorce, adoption, and related data.

17 * Sec. 7. AS 18.50.950 is amended by adding a new paragraph to read:

18 (19) "induced termination of pregnancy" means the purposeful
19 interruption of an intrauterine pregnancy with the intention other than to produce a
20 live-born infant, and that does not result in a live birth, except that "induced
21 termination of pregnancy" does not include management of prolonged retention of
22 products of conception following fetal death;

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: _____
 Bill Version: _____
 (H) Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Health & Social Services
 Title: An Act requiring the reporting of induced BRU: State Health Service
terminations of pregnancies Component: Bureau of Vital Statistics
 Sponsor: Rep. Coghill
 Requester: House HESS Component Number: _____

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2001) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Randall C. Lorenz Phone 465-3759
House HESS Committee Aide

Approved by: _____ Date 4/2/01
 Agency _____

AMENDMENT

OFFERED IN THE HOUSE

BY REPRESENTATIVE COGHILL

TO: HB 160

- 1 Page 3, line 8, following "AS 47.07":
- 2 Insert "or the general relief assistance program established under AS 47.25.120 -
- 3 47.25.300"

Alaska State Legislature



Interim:
119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907) 456-5081 - Phone
(907) 456-8245 - Fax

Session:
State Capitol, Room 102
Juneau, AK 99801
(907) 465-3719 - Phone
(907) 465-3258 - Fax

Representative John Coghill

MEMORANDUM

To: Representative Fred Dyson, Chairman
House Health, Education & Social Services Committee

From: Representative John Coghill *JCB*

Re: Request for hearing - HB 160

Date: March 14, 2001

Please schedule a hearing for House Bill 160 in the House HESS committee at your earliest convenience.

I have attached with the bill a copy of the sponsor statement along with back-up materials. Please contact my legislative aide, Danielle Serino, at extension 5038 if you have any questions. Thank you.

Alaska State Legislature

Interim:

119 N. Cushman, Suite 211
Fairbanks, AK 99701
(907) 456-5081 - Phone
(907) 456-8245 - Fax



Session:

State Capitol, Room 102
Juneau, AK 99801
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(907) 465-3258 - Fax

Representative John Coghill

SPONSOR STATEMENT

HB 160

Currently, the State of Alaska does not monitor or collect any abortion data. This hampers efforts on a state and national level in publishing and evaluating accurate abortion data in relation to important maternal health information.

House Bill 160 would implement a reporting system for abortions in Alaska by requiring physicians to submit an induced termination of pregnancy report within three days after the procedure to the Bureau of Vital Statistics, who would publish the aggregated data in an annual report.

Abortion data in the United States is collected and evaluated by the Centers for Disease Control and the Alan Guttmacher Institute. Data from abortion surveillance is used in conjunction with birth data and fetal death computations to estimate pregnancy rates and other maternal health rates. Abortion data is also used in defining characteristics of women who are at high risk for unintended pregnancy. Moreover, ongoing annual surveillance is used to monitor trends in the number, ratio, and rate of abortions in the United States and provide data for assessing changes in clinical practice patterns related to abortion.

This information is collected by the states, and it is compiled and published at the national level by the Centers for Disease Control and Prevention. However, some states, including Alaska, have no abortion reporting system. The Alan Guttmacher Institute periodically conducts surveys of abortion providers and uses the results together with the CDC data to estimate the number of abortions and the abortion rate.

The Centers for Disease Control and the National Center for Health Statistics advocate the collection of detailed abortion data since it is vital to accurate evaluations of abortion related topics and essential for both health and public policy issues.

The information that House Bill 160 would require to be reported is modeled after the federal guidelines for induced termination of pregnancy reports, established by the National Center for Health Statistics.

Sponsor Statement

Abortion Reporting in the Era of Medical Procedures: Why Is It Important?

LISA M. KOONIN, MN, MPH

Food and Drug Administration approval of mifepristone and the subsequent widespread use of medical abortion will change the patterns and practice of abortion services in this country. Accurate monitoring of new, nonsurgical abortion techniques will be critical as this change takes place. Providers will want to know which women will be the predominant users of medical versus surgical methods. If medical procedures are used widely, the national trend in gestational age at the time of abortion is likely to change because medical procedures are usually performed early (at less than eight weeks' gestation). New and existing abortion providers must be informed about the reporting statutes and requirements in their areas. Information and instructions for reporting abortions are available from the vital statistics offices in each state health department and the health departments of New York City and the District of Columbia. Ongoing comprehensive monitoring of legal induced abortion is needed in all states to determine the number of procedures performed, the characteristics of women who obtain them, and the evolving trends in procedures. (*JAMWA*. 2000;55:203-204)

In 1996, the Food and Drug Administration (FDA) began action to approve the use of mifepristone as an abortifacient in the United States, and final approval is currently pending. Methotrexate and misoprostol have also been studied recently and are currently being used

Ms. Koonin is chief of the Surveillance Unit, Statistics and Computer Resources Branch, Division of Reproductive Health at the Centers for Disease Control and Prevention in Atlanta.

for abortion in many settings across the country.¹ Clinical trials and other studies have demonstrated that the acceptability of medical abortion is high among both patients and physicians, and use of medical abortion is projected to increase after mifepristone is approved.^{2,4} Ongoing comprehensive monitoring of legal induced abortion will be essential to track changes in the patterns and practice of abortion services that will result with these new methods.

Since 1969, the Centers for Disease Control and Prevention (CDC) has compiled and reported legal induced abortion data from 52 reporting areas in the United States: 50 states, the District of Columbia, and New York City.⁵ Although the total number of legal induced abortions is available for all reporting areas, some states do not collect and compile the numbers and characteristics of women who obtain induced abortions within their states. As of early 2000, only two states did not have centralized reporting (California and Alaska). Although reporting requirements vary by state, 44 states and New York City mandate the reporting of abortions (Alan Guttmacher Institute, unpublished data, 2000). The laws require that every hospital, medical facility, or attending physician in a reporting area file a report to the central department of health on each abortion performed, and that the agency in turn publish the statistics on a regular basis.⁶ The CDC then compiles these aggregated data and publishes the state/reporting area statistics annually.

All reporting areas collect abortion data on a standard form, which was last revised by the CDC in 1997 to include "medical (nonsurgical)" as well as the specific medication used.⁷ As of January 2000, 29 states, New York City, and the District of Columbia listed "medical (nonsurgical)" on their reporting

forms. In states where medical is not listed on the reporting form, a category of "other" is available, usually with space to provide information that the abortion was performed by medical methods. Therefore, providers report induced abortions performed by medical procedures on the same form used to report surgical abortions.

Why is reporting of abortions important, especially the reporting of medical abortions? Accurate monitoring of new, nonsurgical abortion techniques will be critical as the use of medical methods becomes widespread in this country. Findings from ongoing national surveillance of all types of legal induced abortion are used for several purposes. First, ongoing surveillance provides data for assessing changes in clinical practice patterns related to abortion. Providers will want to know which women will be the predominant users of medical versus surgical methods. Understanding the demographic characteristics of women who choose medical abortion will be helpful as providers create educational messages about medical abortion.

If medical procedures are used widely, national trends in gestational age at the time of abortion are likely to change because medical procedures are usually performed early (at less than eight weeks' gestation).^{1,2} Studies have shown that the risk of complications from abortion is lower when abortions are performed at eight weeks gestation or earlier.⁸ The widespread availability of medical procedures may also affect gestation patterns related to surgical abortion; when women learn that early abortions are available, they may seek services earlier.

Comprehensive annual surveillance is essential to monitor trends in the number, ratio, and rate of abortions and pregnancies in the United States. At present, complete counts of legal induced abortions are difficult to obtain.⁶ If a sig-

nificant number of medical abortions are not reported, undercounting may result. Statistics on the number of pregnancies ending in abortion are used in conjunction with birth and fetal death statistics to estimate overall pregnancy rates (eg, pregnancy rates among adolescents)⁹ and other pregnancy outcome rates (eg, the rate of ectopic pregnancies per 1000 pregnancies).¹⁰ Data from abortion surveillance are also used to identify characteristics of women at high risk for unintended pregnancy.¹¹ Abortion and pregnancy rates can also be used to evaluate the effectiveness of family planning and other programs for preventing unintended pregnancy. Finally, abortion data are used as the denominator in calculating abortion morbidity and mortality rates.⁸

The potential availability of mifepristone makes it likely that providers who have never performed surgical abortions may offer medical abortions in the near future.^{12,13} New and existing abortion providers must be informed about the reporting statutes and requirements in their areas. Information about and instructions for reporting abortions are available from the vital statistics offices in each state health department and the health departments of New York City and the District of Columbia.

FDA approval of mifepristone and the subsequent widespread use of medical abortion will likely change the patterns and practice of abortion services in this country. Ongoing comprehensive monitoring of legal induced abortion is needed in all states to determine the number of procedures performed, the characteristics of women who obtain them, and the evolving trends in procedures. ■

medical abortion: The view from the clinic. *J Am Med Womens Assoc.* 1999;54:91-96.

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Sec. 18.50.310. Disclosure of records. (a) To protect the integrity of vital statistics records, to ensure their proper use, and to ensure the efficient and proper administration of the vital statistics system, it is unlawful for a person to permit inspection of, or to disclose information contained in vital statistics records, or to copy or issue a copy of all or part of a record, except as provided by this section or as authorized by regulations issued under this chapter.

(b) The bureau may permit the use of data contained in vital statistics records for research purposes.

(c) Information in vital statistics records indicating that a birth occurred out of wedlock may not be disclosed except upon order of a superior court or as provided by regulations.

(d) Appeals from decisions of the custodians of local records refusing disclosure under (a) and (b) of this section shall be made to the state registrar, whose decision is binding upon the custodian of local records.

(e) The department may by regulation provide for the release of information to authorized representatives of organizations or foundations that counsel the next of kin of victims of sudden infant death syndrome.

(f) Notwithstanding the provisions of AS 40.25.120, when 100 years have elapsed after the date of a birth, or 50 years have elapsed after the date of a death, marriage, divorce, dissolution of marriage, or annulment, the records of these events in the custody of the state registrar become public records subject to inspection and copying as provided in AS 40.25.110 — 40.25.140.

(g) The principal health officer of a municipality, or a municipal health officer designated by the principal health officer, may inspect vital statistics records pertinent to the functions of the principal health officer. The state registrar may enter into an agreement with a municipality governing the conditions and purposes of those inspections.

(h) Marriage license applications shall be open for public inspection or examination during normal business hours. The bureau may, in response to a request under AS 25.27.300, disclose to the child support enforcement agency whether the bureau has a record indicating that a person has remarried after the date specified by the agency.

(i) In this section, "principal health officer" means the municipal official who is exercising health powers and who is primarily responsible for public health in the municipality. (§ 27 ch 118 SLA 1960; am § 1 ch 132 SLA 1978; §§ 1, 2 ch 25 SLA 1984; am § 11 ch 200 SLA 1990; am § 1 ch 79 SLA 1997; am § 10 ch 132 SLA 1998)

Revisor's notes. — Subsection (h) was enacted as (i). Relettered in 1997, at which time former subsection (h) was relettered as (i).

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Cross references. — For inspection and copying of public records other than vital statistics records maintained under this chapter, see AS 40.25. For purpose, findings, and nonseverability provisions related to the 1998 amendment to subsection (h), see §§ 1 and 56, ch. 132, SLA 1998 in the 1998 Temporary and Special Acts.

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SITE: ANCHORAGE LIO

COMMITTEE:

House H.E.S.S.

DATE: 3-29-2001

SUBJECT OF MEETING:

HB 160-Reporting of Abortions

HB 164-Grandparents' Rights

Regarding CINA

HB 142-AK Temp. Assistance

Program Amendments

UPDATE #: 1



PLEASE SIGN IN

PLEASE PRINT:

NAME

ADDRESS (MAILING & ZIP)

REPRESENTING

**DO YOU WANT
TO TESTIFY?**

Y or N

NAME	ADDRESS (MAILING & ZIP)	REPRESENTING	DO YOU WANT TO TESTIFY? Y or N
Betty Short		Grandparents Rights	Y - HB 164
Linda Shore		Grandparents Rights	Y - HB 164
✓ Anna Frank		Planned Parenthood	Y - HB 160
✓ Dr. Sharon Smith			Y - HB 160
✓ Jennifer Rudinger		AK CLU <i>Civil Liberties Union</i>	Y - HB 160
✓ Karen Vosburgh		AKRTL	Y - HB 160



Planned Parenthood®

of Alaska

3401 East 42nd Ave., Suite 200, Anchorage, Alaska 99508
(907) 565-7526 Fax (907) 565-7529

DATE: March 29, 2001

TO: House HESS Committee
Reps. Fred Dyson (Chair), Peggy Wilson, John Coghill, Vic Cohring,
Gary Stevens, Sharon Cissna, Reggie Joule.

FROM: Anna Franks, Executive Director

RE: Written/Verbal Testimony for HB 160, "Reporting of induced terminations of pregnancies"

Ladies and Gentlemen:

I am the Executive Director of Planned Parenthood of Alaska and today I speak on behalf of our statewide agency.

It may surprise you to know that Planned Parenthood of Alaska is in support of requiring certain statistics to be required of physicians performing abortions. Indeed, knowing how many abortions are performed, the age of people who receive abortions, and whether or not they already have children or have had other terminations is information we can use to assess whether or not our efforts to REDUCE abortion and provide family planning services are working. Alaska is, I believe, the only state that does not currently have a reporting requirement.

Sadly, however, we must oppose HB 160 as it is currently drafted. The bill is truly unprecedented and very burdensome. No other state requires such specific information. While it reads that the information to be required is "substantially similar" to the information required under the US Standard Report of Induced Termination of Pregnancy, as published by the Centers for Disease Control and Prevention, we see nothing similar about the requirements.

If I could call your attention to Section 1 (e) 2, clearly, the requirements are beyond what the state has a compelling interest to know. Why a woman needs or chooses to have an abortion is none of the state's interest. Whether or not the termination is paid through Medicaid is redundant. Because a physician already files a claim to Medicaid for this



Anchorage Center
3401 E. 42nd Avenue, #201
Anchorage, Alaska 99508
(907) 563-2229 Fax: 563-7419

Sitka Center
P.O. Box 515
Sitka, Alaska 99835
(907) 747-3883 Fax: 747-8282

Soldotna Center
44109 Sterling Hwy., #D
Soldotna, Alaska 99669
(907) 262-2622 Fax: 262-8564

For clinic nearest you 1-800-230-PLAN

procedure if it is therapeutic, the state already has this information readily available and should not be required to track it more than once.

Furthermore, under Section 1 (b), the requirement of the physician to submit the information within three days is, again, burdensome, unprecedented, and in many instances, the physician would be unable to comply. This is because if a physician were providing a medical abortion, known to be safer and done earlier than a surgical abortion, it is likely that the abortion would not be complete within the specified three-day period. What is typical of other states is to require information on an annual or semi-annual basis.

We believe this bill, as written, is in violation of Alaska's Constitution. We would support a redrafted bill that would require information on an annual or semi-annual basis that actually IS similar to the CDC requirements. Those requirements, and I believe you have a sample reporting form in front of you, include a patient ID, age, marriage status, date of termination, residence information, race, education, date of last menstrual period, estimated gestation, previous pregnancies and live births, other terminations, the type of termination procedure, the name of the attending physician, and the name of the person completing the report.

Again, Planned Parenthood of Alaska is pleased that we may be able to know, by aggregate statistics, information associated with induced abortion, information on the characteristics of the women who choose or need an abortion, and information on the role that abortion plays in prevention of unintended births as compared with contraception. The data obtained are very important from both a demographic and a public health viewpoint.

Thank you for your time, and thank you for considering to amend the bill as written to protect women's privacy and keep the state's interest to that which simply protects and promotes women's health.

Appendix A

U.S. Standard Report of Induced Termination of Pregnancy

TYPEPRINT
OR
PERMANENT
BLACK INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

U.S. STANDARD
REPORT OF INDUCED TERMINATION OF PREGNANCY

Part Five (Mandatory)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR DISEASE CONTROL AND PREVENTION — NATIONAL CENTER FOR HEALTH STATISTICS — TERRITORY DIVISION

1. FACILITY NAME (If not clinic or hospital, give address) Merrywood Clinic		2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION Louisville		3. COUNTY OF PREGNANCY TERMINATION Jefferson	
4. PATIENT'S IDENTIFICATION 25466		5. AGE LAST BIRTHDAY 23		6. MARRIED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
7. DATE OF PREGNANCY TERMINATION (Month, Day, Year) November 20, 1997		8. RESIDENCE-STATE Ohio		9. COUNTY Hamilton	
10. CITY, TOWN, OR LOCATION Cincinnati		11. INSIDE CITY LIMITS? (Yes or No) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		12. ZIP CODE 45202	
13. OF HISPANIC ORIGIN? (Specify No or Yes — if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Specify: Puerto Rican		14. RACE <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input checked="" type="checkbox"/> White <input type="checkbox"/> Other (Specify) _____		15. EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) _____ College (1-4 or 5+) _____ 12	
16. DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year) September 5, 1997		17. CLINICAL ESTIMATE OF GESTATION (Weeks) 10 weeks		18. PREVIOUS PREGNANCIES (Complete each section)	
		19. LIVE BIRTHS		20. OTHER TERMINATIONS	
		19a. Now Living Number _____ <input checked="" type="checkbox"/> None		19b. Now Dead Number _____ <input checked="" type="checkbox"/> None	
		20a. Spontaneous Number _____ <input checked="" type="checkbox"/> None		20b. Induced (Do not include this termination) Number _____ <input checked="" type="checkbox"/> None	
21. TYPE OF TERMINATION PROCEDURES (Check only one) <input checked="" type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical (Non-surgical), Specify Medication(s) _____ <input type="checkbox"/> Dilatation and Evacuation (D&E) <input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin) <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (Specify) _____					
22. NAME OF ATTENDING PHYSICIAN (Type/print) Edmund Matthew Stone, M.D.			23. NAME OF PERSON COMPLETING REPORT (Type/print) Julia Lynn Koval		

3/29/01.

Testimony to the House HESS Committee on HB 160

I am astounded that Alaska is currently the only state that does not require mandatory reporting of abortions. These statistics are essential. The National Center for Health Statistics, Centers for Disease Control and US Dept. of Health and Human services have developed a Standard Report of induced termination of pregnancy designed to be a model for use by the states. If each state adopts this standard report, there will be a uniform system of reporting nationwide which can yield very useful and important information to be used in policy making and assessment of current programs. I urge you to adopt this reporting tool for use in Alaska.

Unfortunately, HB 160 requires the mandatory reporting of a different set of statistics, and does not make use of the standard created by the CDC. Many of the statistics required by HB 160 are frankly inappropriate and/or irrelevant. The time table of required reporting is also very short and difficult to comply with.

I urge you to oppose HB 160, and instead draft a bill which would require reporting based on the model provided by the CDC.

Thank you for your attention.

Sharon Smith MD

Abortion Reporting in the Era of Medical Procedures: Why Is It Important?

LISA M. KOONIN, MN, MPH

Food and Drug Administration approval of mifepristone and the subsequent widespread use of medical abortion will change the patterns and practice of abortion services in this country. Accurate monitoring of new, nonsurgical abortion techniques will be critical as this change takes place. Providers will want to know which women will be the predominant users of medical versus surgical methods. If medical procedures are used widely, the national trend in gestational age at the time of abortion is likely to change because medical procedures are usually performed early (at less than eight weeks' gestation). New and existing abortion providers must be informed about the reporting statutes and requirements in their areas. Information and instructions for reporting abortions are available from the vital statistics offices in each state health department and the health departments of New York City and the District of Columbia. Ongoing comprehensive monitoring of legal induced abortion is needed in all states to determine the number of procedures performed, the characteristics of women who obtain them, and the evolving trends in procedures. (JAMWA, 2000;55:203-204)

In 1996, the Food and Drug Administration (FDA) began action to approve the use of mifepristone as an abortifacient in the United States, and final approval is currently pending. Methotrexate and misoprostol have also been studied recently and are currently being used

Ms. Koonin is chief of the Surveillance Unit, Statistics and Computer Resources Branch, Division of Reproductive Health at the Centers for Disease Control and Prevention in Atlanta.

for abortion in many settings across the country.¹ Clinical trials and other studies have demonstrated that the acceptability of medical abortion is high among both patients and physicians, and use of medical abortion is projected to increase after mifepristone is approved.^{2,4} Ongoing comprehensive monitoring of legal induced abortion will be essential to track changes in the patterns and practice of abortion services that will result with these new methods.

Since 1969, the Centers for Disease Control and Prevention (CDC) has compiled and reported legal induced abortion data from 52 reporting areas in the United States: 50 states, the District of Columbia, and New York City.⁵ Although the total number of legal induced abortions is available for all reporting areas, some states do not collect and compile the numbers and characteristics of women who obtain induced abortions within their states. As of early 2000, only two states did not have centralized reporting (California and Alaska). Although reporting requirements vary by state, 44 states and New York City mandate the reporting of abortions (Alan Guttmacher Institute, unpublished data, 2000). The laws require that every hospital, medical facility, or attending physician in a reporting area file a report to the central department of health on each abortion performed, and that the agency in turn publish the statistics on a regular basis.⁶ The CDC then compiles these aggregated data and publishes the state/reporting area statistics annually.

All reporting areas collect abortion data on a standard form, which was last revised by the CDC in 1997 to include "medical (nonsurgical)" as well as the specific medication used.⁷ As of January 2000, 29 states, New York City, and the District of Columbia listed "medical (nonsurgical)" on their reporting

forms. In states where medical is not listed on the reporting form, a category of "other" is available, usually with space to provide information that the abortion was performed by medical methods. Therefore, providers report induced abortions performed by medical procedures on the same form used to report surgical abortions.

Why is reporting of abortions important, especially the reporting of medical abortions? Accurate monitoring of new, nonsurgical abortion techniques will be critical as the use of medical methods becomes widespread in this country. Findings from ongoing national surveillance of all types of legal induced abortion are used for several purposes. First, ongoing surveillance provides data for assessing changes in clinical practice patterns related to abortion. Providers will want to know which women will be the predominant users of medical versus surgical methods. Understanding the demographic characteristics of women who choose medical abortion will be helpful as providers create educational messages about medical abortion.

If medical procedures are used widely, national trends in gestational age at the time of abortion are likely to change because medical procedures are usually performed early (at less than eight weeks' gestation).¹⁻² Studies have shown that the risk of complications from abortion is lower when abortions are performed at eight weeks gestation or earlier.⁸ The widespread availability of medical procedures may also affect gestation patterns related to surgical abortion; when women learn that early abortions are available, they may seek services earlier.

Comprehensive annual surveillance is essential to monitor trends in the number, ratio, and rate of abortions and pregnancies in the United States. At present, complete counts of legal induced abortions are difficult to obtain.⁶ If a sig-

nificant number of medical abortions are not reported, undercounting may result. Statistics on the number of pregnancies ending in abortion are used in conjunction with birth and fetal death statistics to estimate overall pregnancy rates (eg, pregnancy rates among adolescents)⁹ and other pregnancy outcome rates (eg, the rate of ectopic pregnancies per 1000 pregnancies).¹⁰ Data from abortion surveillance are also used to identify characteristics of women at high risk for unintended pregnancy.¹¹ Abortion and pregnancy rates can also be used to evaluate the effectiveness of family planning and other programs for preventing unintended pregnancy. Finally, abortion data are used as the denominator in calculating abortion morbidity and mortality rates.⁸

The potential availability of mifepristone makes it likely that providers who have never performed surgical abortions may offer medical abortions in the near future.^{12,13} New and existing abortion providers must be informed about the reporting statutes and requirements in their areas. Information about and instructions for reporting abortions are available from the vital statistics offices in each state health department and the health departments of New York City and the District of Columbia.

FDA approval of mifepristone and the subsequent widespread use of medical abortion will likely change the patterns and practice of abortion services in this country. Ongoing comprehensive monitoring of legal induced abortion is needed in all states to determine the number of procedures performed, the characteristics of women who obtain them, and the evolving trends in procedures. □

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Legal Induced Abortion Reporting in the United States

	Reporting form includes medical (nonsurgical) procedures	Time for Reporting	Contact state/reporting area office for more info
Alabama *		10 days after end of month	(334) 206-5426
Alaska †	Y	_____	(907) 465-3090
Arizona †		Monthly	(602) 542-1216
Arkansas *		5 days after procedure	(501) 661-2036
California ‡	NA	_____	(916) 323-2662
Colorado §		5 days after procedure	(303) 692-2160
Connecticut *		7 days after procedure	(860) 509-7897
Delaware *	Y	30 days after end of month	(302) 739-4776
Dist. of Col.	Y	_____	(202) 442-5865
Florida *		Monthly	(904) 359-6900
Georgia *		10 days after procedure	(404) 656-4750
Hawaii †		1 month after procedure	(808) 586-4600
Idaho *	Y	15 days after end of month	(208) 334-5992
Illinois *		10 days after end of month	(217) 782-6554
Indiana *		Twice a year	(317) 233-2700
Iowa *		30 days after procedure	(515) 281-5787
Kansas *	Y	Annually	(785) 296-8627
Kentucky *	Y	15 days after end of month	(502) 564-4212
Louisiana *		15 days after procedure	(504) 568-5152
Maine *	Y	10 days after end of month	(207) 287-5445
Maryland		_____	(410) 767-6783
Massachusetts *		30 days after procedure	(617) 753-8624
Michigan *	Y	7 days after procedure	(517) 335-8705
Minnesota *	Y	by April 1 for previous year	1-800-657-3900
Mississippi *	Y	5 days after procedure	(601) 576-7960
Missouri *	Y	45 days after procedure	(573) 751-6381

	Reporting form includes medical (nonsurgical) procedures	Time for Reporting	Contact state/reporting area office for more info
Montana *		30 days after procedure	(406) 444-5249
Nebraska *	Y	15 days after end of month	(402) 471-3121
Nevada *		No time for report specified	(775) 684-4242
New Hampshire ‡	Y	_____	(603) 271-4650
New Jersey **	Y	No time for report specified	(609) 984-6702
New Mexico *	Y	5 days after procedure	(505) 827-2338
New York †	Y	72 hours after procedure	(518) 474-3077
New York City *	Y	5 days after procedure	(212) 788-4520
North Carolina *	Y	Monthly	(919) 733-3526
North Dakota *	Y	30 days after procedure	(701) 328-2360
Ohio *	Y	15 days after discharge ¶	(614) 466-2531
Oklahoma *		_____	(405) 271-3430
Oregon *	Y	5 days after procedure	(503) 731-4108
Pennsylvania *	Y	15 days after end of month	(717) 783-2548
Rhode Island †	Y	7 days after procedure	(401) 222-2812
South Carolina *		7 days after procedure	(803) 898-3324
South Dakota *	Y	by Jan. 15 for previous year	(605) 773-4961
Tennessee *		10 days after procedure	(615) 741-1954
Texas *	Y	by Jan. 31 for previous year	(512) 458-7111
Utah *	Y	10 days after procedure	(801) 538-6105
Vermont *	Y	7 days after procedure	(802) 863-7275
Virginia †	Y	3 days after procedure	(804) 225-5076
Washington *	Y	Monthly for previous month	(360) 236-4313
West Virginia **	Y††	_____	(304) 558-9100
Wisconsin *	Y	by Jan. 15 for previous year	(608) 266-2838
Wyoming *	Y	20 days after procedure	(307) 777-7591

Note: State abortion reporting statutes are subject to modification or change at any time, therefore it is important to verify state reporting requirements with the state's office of vital statistics.

* Induced termination of pregnancy reporting is specifically required by state statute or regulation.

† Reporting is done in accordance with the state's fetal death reporting statute or regulation.

‡ Currently this state does not collect data on induced termination of pregnancy.

§ State collects abortion data in accordance with its death certification statutory law.

¶ Reporting requirements refer to reporting by hospitals.

** A broad health statute provides legal authority for abortion data collection.

†† Category not specified but includes fill-in procedure column.

NA Not available

Source: Reporting of medical abortions: Information for providers. *Am J Obstet Gynecol*, 2000; 183:S24-S25; Unpublished data, Alan Guttmacher Institute, 2000.

For information on the medication, mifepristone, recently approved by the FDA for termination of early pregnancy: <http://www.fda.gov/cder/drug/infopage/mifepristone/>.

For further information on abortion surveillance, or the latest legal abortion statistics reported by CDC: <http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4851a3.htm>.

Legal Induced Abortion

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PUBLIC HEALTH IMPORTANCE

Legal induced abortion is one of the most frequently performed surgical procedures in the United States. Each year since 1980, the number of abortions in this country has remained relatively stable at approximately 1.3–1.4 million abortions per year (1). Recent reports show that in 1991, 339 abortions were provided for every 1,000 live births and that about 24 of every 1,000 females of reproductive age (15–44 years old) had an abortion (1).

Induced abortions usually are linked to unintended pregnancies, which often occur despite the use of contraception (2–4). In the mid-1980s, about 1.2 million of the live births that occurred each year were unintended (either mistimed or unwanted at conception) (5). Improving contraceptive practices as well as access to and education about safe, effective, and low-cost contraception and family planning services may help minimize the need for abortion in this country (6).

Fewer than one woman in 100 develops a major complication from induced abortion, and fewer than one in 100,000 dies (7,8). The risk of morbidity and mortality from legal abortion is directly related to gestational age at the time of abortion—the earlier the gestation, the safer the procedure (9,10).

The surveillance of legal induced abortion is important for numerous reasons. Surveillance is used to identify characteristics of those who have abortions, in particular, women at high risk of unintended pregnancy. Ongoing surveil-

lance is essential to monitor trends in the number, ratio, and rate of abortions in this country.* We need statistics on the number of pregnancies ending in abortion to add to birth and fetal death statistics so that we can accurately estimate pregnancy rates and calculate other outcome rates, such as the rate of ectopic pregnancies per 1,000 pregnancies. In turn, abortion and pregnancy rates can be used to evaluate the effectiveness of family planning and unintended pregnancy prevention programs. This is especially important for teenage pregnancy programs, because a large proportion of teenage pregnancies are terminated by abortion (1). Ongoing surveillance also gives us an opportunity to assess changes in clinical practice patterns related to abortion, such as changes in types of procedure over time. Finally, abortion data are used as denominators to calculate abortion morbidity rates and mortality rates.

Legal abortion rates vary widely among countries—ranging from a high of >100 abortions per 1,000 women of reproductive age in the former Soviet Union to a low of 5 per 1,000 in the Netherlands. The induced abortion rate in the United States (24 per 1,000) is higher than rates reported by Australia, Canada, and most Western European countries; the U.S. rate is lower than rates reported by the former Soviet Union, China, Cuba, and Eastern European countries (11). Abortion rates for teenagers are much higher in the United States than in most Western European countries and in some Eastern European countries (11) (for additional information about related topics and surveillance

* The ratio is the number of abortions per 1,000 live births. The rate is the number of abortions per 1000 females 15–44 years old.

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activities, see the Unintended Pregnancy and Childbearing and the Pregnancy in Adolescents chapters).

HISTORY OF DATA COLLECTION

During the late 1960s and early 1970s, a new reproductive health event, legal induced abortion, was emerging as a result of judicial and legislative changes occurring in this country. At that time, the incidence of induced abortion in the United States was unknown. In 1969, recognizing both the importance of abortion as a public health issue and the need for national abortion statistics, CDC began the continuous epidemiologic surveillance of abortion in the United States.

That same year, CDC published the first report of legal induced abortions. The term **legal** was used to contrast those abortions with illegal procedures or self-induced procedures that still occurred. Since then, reports of annual data for 1969–1990 have been published regularly.

To assess morbidity associated with legal induced abortion from 1971 through 1978, CDC sponsored a multicenter, observational study of complications following legal induced abortion (12). This study, known as the Joint Program for the Study of Abortion (JPSA), continued the initial investigation (JPSA I) sponsored by the Population Council of New York. On the basis of data from about 80,000 abortions performed in 32 institutions between 1971 and 1975 (JPSA II) and 84,000 abortions performed in 13 institutions between 1975 and 1978 (JPSA III), CDC offered the medical community recommendations, which have significantly reduced the number and severity of abortion complications and the number of related deaths in this country.

Today, abortion statistics are compiled by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and National Center for Health Statistics (NCHS) as well as the Alan Guttmacher Institute, an independent, nonprofit research organization. Abortion data compiled by NCHS are collected from participating states and registration areas. Information on each induced abortion is provided to NCHS on magnetic tape as a

part of the Vital Statistics Cooperative Program. In 1988, the last year for which statistics were reported, NCHS reports included data from 14 states† and New York City (13). The Alan Guttmacher Institute conducts periodic direct surveys of abortion providers in the United States (14); however, the institute does not conduct continuous annual surveys or collect information on the characteristics of women obtaining abortions.

CDC SURVEILLANCE ACTIVITIES

NCCDPHP is responsible for national surveillance to document the number and characteristics of women obtaining abortions, and NCHS is responsible for compiling abortion data in selected states. On occasion, NCCDPHP and NCHS collaborate in producing abortion surveillance reports.

A legal induced abortion is defined as a procedure performed by a licensed physician or someone acting under the supervision of a licensed physician, with the intent to "terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age" (9). Data on the reasons for the legal induced abortion are not collected by many states and are not provided to NCCDPHP.

Until the late 1970s, state health departments had independently developed their own abortion reporting forms or had used fetal death reporting forms, which were problematic for reporting induced abortions. In 1977, with the assistance of state health departments, NCHS developed a model abortion reporting form to collect demographic information and data on gestational age and the type of procedure performed; the form does not include personal identifiers of the woman. This reporting form has been modified periodically and serves as the primary tool for collecting abortion statistics in most states.

NCCDPHP compiles tabular data, aggregated at the state and area levels, received from 52 reporting areas: 50 states, New York City, and the District of Columbia. The total number of legal

† States include Colorado, Indiana, Kansas, Maine, Missouri, Montana, New York, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, and Virginia.

induced abortions are available from all reporting areas, most of which provide information on the characteristics of women obtaining abortions. Each year, in about 45 reporting areas, data are provided from the central health agencies.[§] In the remaining reporting areas, data are provided from hospitals and other medical facilities. No patient or physician identifiers are provided to CDC. Data are reported by the state in which the abortion occurred. CDC checks the data for numerical accuracy and for consistency with published state reports and resolves discrepancies by communicating with health department personnel. Data are stored in secured files.

CDC computes abortion-to-live-birth ratios by using the number of abortions in a given category (e.g., by state, age, or race) as the numerator and the number of live births (reported by state and area health departments) in the same category as denominators. Abortion rates are computed by using the number of abortions as numerators and Current Population Survey data for females aged 15–44 years as denominators.

Preliminary annual data on legal induced abortions are published in the *Morbidity and Mortality Weekly Report (MMWR)*, and a final and more comprehensive report is published later in the *MMWR's CDC Surveillance Summaries*. National numbers, ratios, and rates of abortions are presented in each report. State-specific characteristics of women obtaining abortions are presented in the *Surveillance Summaries* only.

GENERAL FINDINGS

From 1970 to 1982, the reported number of legal abortions in the United States increased every year; the largest percentage increase occurred during 1970–1972 (Figure 1). From 1976 to 1982, the annual rate of increase slowed continuously, reaching a low of 0.2% for 1981–1982. Since 1980, the number of abortions has remained relatively stable, with only small (<5%) year-to-year fluctuations. The abortion ratio increased each year from 1970 to 1980, remained relatively stable until 1988,

and since then has decreased somewhat each year (Figure 1).

Women who have abortions in this country tend to be young, white, unmarried, and having the procedure for the first time. Specifically, women 20–24 years of age have approximately one third of all abortions, whereas women younger <15 years of age have about 1%. Abortion ratios are highest for women at the age extremes — <19 years (particularly <15 years) and ≥40 years of age (Figure 2). Women aged 30–34 years have the lowest ratios. Among teenagers, the abortion ratio is highest for those <15 years old and lowest for those 19 years old.

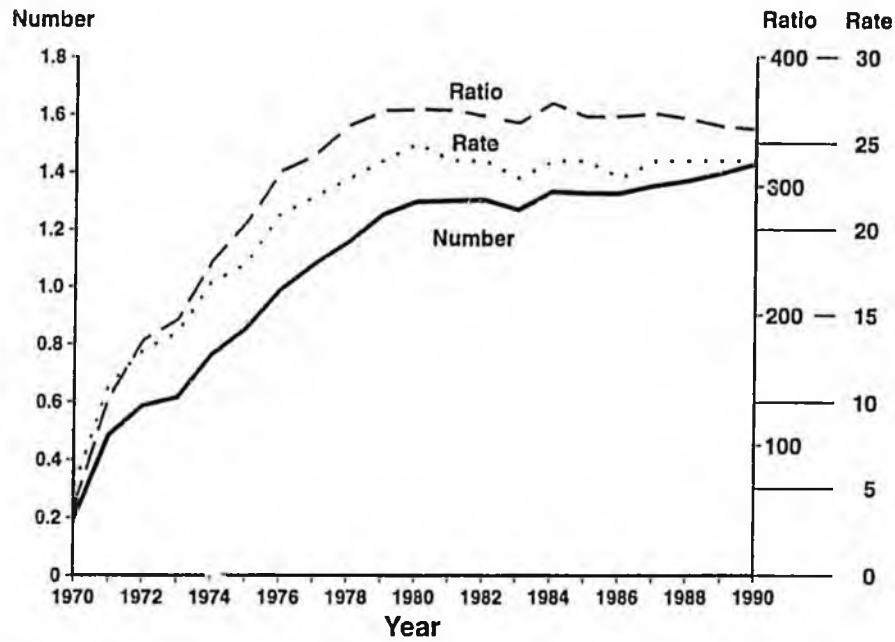
Most reported legal abortions are performed before 8 weeks of gestation, and more than three fourths are done before 13 weeks. Approximately 4% of abortions are performed at 16–20 weeks of gestation, and 1% at ≥21 weeks. Approximately 99% of legal abortions are performed by curettage (which is consistent with the fact that 94% of abortions are performed in the first trimester or early second trimester of pregnancy), and <1% are performed by intrauterine saline or prostaglandin instillation. Hysterectomy and hysterotomy are rarely used to perform abortions.

Abortion ratios vary by race and ethnicity, although these variations are probably related to socioeconomic differences rather than to race per se. Almost two thirds of women obtaining abortions are white; however, the abortion ratio for blacks is about two times higher than that for white women, and the ratio for women of other races (Asian-Pacific Islander, Native American, Alaska Native, or race listed as other) is 1.3 times higher than that for white women. In 1990, the abortion ratios for Hispanics were similar to those for whites. When the proportion of women undergoing legal abortion is analyzed by race and age-group, few differences are found between whites and blacks except among girls <15 years old; the percentage of girls who had an abortion was over twice that of white girls in this age-group (Table 1).

Over three fourths of women who have legal induced abortion are unmarried. The abortion ratio is 11 times higher for unmarried women than for married women.

[§] Agencies include state health departments and the health departments of New York City and the District of Columbia.

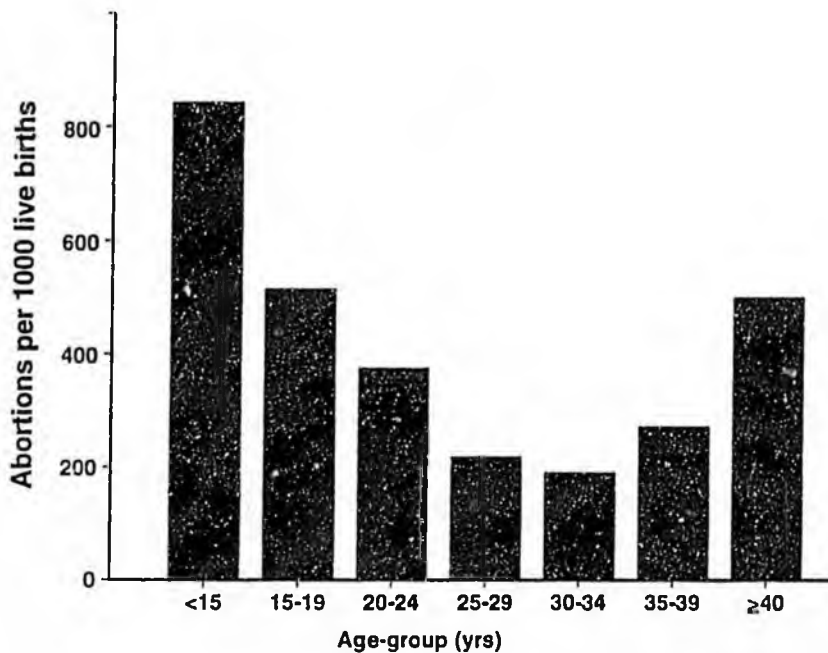
FIGURE 1. Legal abortions — United States, 1970–1990*



* Number of abortions are in millions of women, ratio is number of abortions per 1,000 live births, and rate is number of abortions per 1,000 women aged 15–44 years.

Source: CDC abortion surveillance.

FIGURE 2. Abortion ratio, by age-group — United States, 1990



Source: CDC abortion surveillance.

TABLE 1. Number and percentage of reported legal abortions, by race and age-group — United States, 1990

Age-group* (years)	Race				Total	
	White†		Black and other races			
	No.	%	No.	%	No.	%
< 15	2,215	0.6	2,597	1.3	4,812	0.8
15-19	88,731	22.3	41,597	20.1	130,328	21.5
20-24	132,427	33.2	68,922	33.3	201,349	33.2
25-29	87,044	21.8	49,242	23.8	136,286	22.5
30-34	52,741	13.2	28,171	13.6	80,912	13.4
35-39	27,571	6.9	12,919	6.3	40,490	6.7
≥ 40	8,022	2.0	3,229	1.6	11,251	1.9
Total‡	398,751	100.0	206,577	100.0	605,428	100.0

* Excludes persons of unknown ages.

† Includes Hispanics.

‡ Reported by 30 states and New York City.

Source: CDC, National Abortion Surveillance (17).

The abortion ratio is highest for women who had no live births and lowest for women who had one live birth. Approximately half of women obtaining abortions are having the procedure for the first time, whereas approximately 15% have had at least two previous abortions.

Overall, most women obtain abortions during the first 12 weeks of pregnancy. However girls <15 years of age are more likely to obtain abortions later in pregnancy than older women. The proportion of women obtaining an early abortion (<8 weeks) increases with age, and the proportion obtaining a late abortion (≥16 weeks) decreases with age. Black women of all ages tend to obtain abortions later in pregnancy than white women.

About 99% of abortions at <12 weeks of gestation are performed by curettage (primarily suction procedures). Beyond 12 weeks of gestation, the most common procedure again is curettage, which is usually reported as dilatation and evacuation. Most intrauterine instillations involve the use of saline and are usually performed at ≥16 weeks of gestation.

For all racial groups, educational level strongly influences when an abortion is performed (15). For example, in 1988, among white women

who obtained an abortion, 60% of those with college educations (≥16 years of school completed) had an early abortion (≤8 weeks), compared with 46% of those who completed high school only. Among minority women who obtained an abortion, about 53% of those with college educations had an early abortion compared with 42% of those who completed high school only.

Also in 1988, about 88% of women who obtained abortions lived in metropolitan areas (15). For these women, the abortion ratio was about 2.2 times greater than the ratio for women who lived in nonmetropolitan areas (373 vs. 168 abortions per 1,000 live births). This difference varied by race. For example, the abortion ratio for minority women living in metropolitan areas was 2.8 times the ratio for those living in nonmetropolitan areas (599 vs. 210 abortions per 1,000 live births). In contrast, the abortion ratio for white women living in metropolitan areas was 1.9 times that of white women living in nonmetropolitan areas (302 vs. 162 abortions per 1,000 live births).

Areas with the highest incidence of legal induced abortion include California, New York City, Texas, and Illinois; the lowest incidence occurs in Wyoming, South Dakota, Alaska, and Idaho

(Table 2) (16,17). Data on women whose state of residence is known indicate that approximately 92% have the abortion performed within that state.

INTERPRETATION ISSUES

Since the 1970s, legal induced abortion has spurred much public controversy, which has affected national and state surveillance activities. In recent years, the abortion issue has influenced a significant number of public policy decisions, including issues related to the public funding of abortions, fetal tissue research, international family planning program development and support, and the possible availability of certain abortion-inducing medications, such as RU 486.

Despite NCCDPHP's ability to monitor national abortion trends, these data have several significant limitations. In 1990, approximately 28% of the abortions were reported from states that do not have centralized reporting; these areas could provide no information on the characteristics of women obtaining abortions. Representativeness is limited when data from all states are not available. In addition, because the number of states that report such information varies from year to year, we must use caution when making temporal comparisons. Nevertheless, the data available from CDC's abortion surveillance system are particularly useful because national characteristic data of women who obtain abortions are not collected by any other system. Also, because this is a continuous surveillance activity, data for each year since 1969 have been compiled, tabulated, and reported.

Differences in the data reported to NCCDPHP and NCHS also must be considered. For example, legal induced abortion data reported to NCHS contain demographic data—including information on educational level and area of residence (metropolitan or nonmetropolitan)—not available from states that provide data to NCCDPHP. The NCHS data system also enables detailed cross-tabulation of these and other characteristics. Because NCHS data are from a limited number of states, they cannot be used to represent national statistics. In 1988, NCCDPHP received the same number of re-

ported abortions as did NCHS for the selected states in their system—these NCHS abortion data represented approximately 22% of all abortions reported to NCCDPHP in that year.

The Alan Guttmacher Institute reports higher numbers of abortions in a given year than does NCCDPHP. However, the institute does not conduct abortion surveillance annually; in the 1980s, data were not collected for 1983, 1986, and 1989. The number of abortions reported to CDC has consistently been about 19% lower than the number ascertained by the Alan Guttmacher Institute (18). Methodologic differences account for this discrepancy. The institute uses an active survey technique to contact all identifiable abortion providers, whereas NCCDPHP primarily compiles data collected by state health departments. The smaller number of abortions reported to NCCDPHP from health departments is likely the result of inconsistencies among states in abortion reporting requirements and methods. Specifically, the completeness of state health department data varies widely because 1) some states require reporting from all licensed facilities whereas others have a voluntary abortion reporting system, 2) the types of providers that must report vary among states, and 3) the completeness of reporting varies among states. These factors probably contribute to underreporting in some states, which can lead to an underestimation of the national abortion rate and ratio.

Because legal induced abortions are usually performed in licensed medical facilities and most states use a standard abortion reporting form for data collection, we suspect that overreporting of abortions (false positives) is rare. However, the data collection forms filled out by providers may contain incomplete data, which in turn would be submitted to NCCDPHP for inclusion in national statistics.

NCCDPHP's definition of legal induced abortion is very similar to the definitions used by NCHS and the Alan Guttmacher Institute. NCHS uses the term **induced termination of pregnancy** in its reports and defines it as the "purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth . . . and excludes management of prolonged re-

TABLE 2. Reported number, ratio, and rate of legal abortions and percentage of abortions obtained by out-of-state residents, by state of occurrence — United States, 1990

State	Number of abortions ^a	Ratio ^b	Rate ^c	Abortions obtained by out-of-state residents (%) ^d
Alabama	15,012**	237	16	NR
Alaska	1,489**	125	11	NR
Arizona	15,783	229	19	2.5
Arkansas	5,953	163	11	3.2
California	357,579††	585	50	NR
Colorado	12,679	237	16	8.2
Connecticut	18,776	375 ^{§§}	24	NR
Delaware	5,557	500	34	NR
District of Columbia	19,969	NR ^{¶¶}	NR	52.9
Florida	66,071	332	24	NR
Georgia	39,245	349	24	8.3
Hawaii	4,748	232	18	0.8
Idaho	1,390	85	6	9.0
Illinois	67,350	345	25	NR
Indiana	14,351	167	11	3.6
Iowa	7,166**	182	12	NR
Kansas	7,516†††	193 ^{§§}	14	46.5
Kentucky	10,921	202	13	29.3
Louisiana	13,020	181	13	NR
Maine	4,607	266	16	12.6
Maryland	22,425	279 ^{§§}	19	6.8
Massachusetts	39,739	430	27	3.9
Michigan	36,183	236	16	4.2
Minnesota	17,156	252	17	10.7
Mississippi	6,842	157	11	22.7
Missouri	16,366	207	14	10.8
Montana	3,365	290	19	23.6
Nebraska	6,346	260	18	20.2
Nevada	7,226	331	26	11.2
New Hampshire	4,259**	243	16	NR
New Jersey	41,358	337	23	3.0
New Mexico	5,288	194	15	3.9
New York	159,098	545	37	3.4
City	102,202 ^{§§§}	787	NR	2.9
State	56,896	351	NR	4.2
North Carolina	36,494	349	23	8.3
North Dakota	1,723	186	12	38.2
Ohio	32,165	193	13	9.6
Oklahoma	10,708**	225 ^{§§}	15	NR
Oregon	13,658	319	21	9.7
Pennsylvania	52,143	305	19	5.9
Rhode Island	7,782	512 ^{§§}	33	21.7
South Carolina	13,285	227	16	6.1
South Dakota	946	86	6	19.4

TABLE 2. Reported number, ratio, and rate of legal abortions and percentage of abortions obtained by out-of-state residents, by state of occurrence — United States, 1990 — continued

State	Number of abortions ^a	Ratio ^b	Rate ^c	Abortions obtained by out-of-state residents (%) ^d
Tennessee	21,144	282	18	17.4
Texas	92,580	293	23	3.9
Utah	4,786	132	12	15.2
Vermont	3,184	384	23	29.8
Virginia	32,992	334	21	6.0
Washington	31,443	397	27	4.9
West Virginia	2,500	111	6	11.7
Wisconsin	6,848	232	15	6.1
Wyoming	363	52	4	12.4
Total	1,429,577	345 ^{eee}	24	8.2

^a Abortion data from central health agency unless otherwise noted.

^b Abortions per 1,000 live births (live-birth data from central health agency unless otherwise specified).

^c Abortions per 1,000 women aged 15–44 years (from Bureau of the Census, Current Population Survey, March 1990).

^d Based on number of abortions for which residence status of women was known.

^e Reported from hospitals and/or other medical facilities in state.

^f CDC estimate.

^g Live births reported by NCHS (16).

^h >1,000 abortions per 1,000 live births.

ⁱ >1,000 abortions per 1,000 women aged 15–44.

^j Excludes 330 Kansas residents obtaining abortions in other states.

^k Reported from New York City Health Department.

^l Differs from the preliminary ratio (344) published in MMWR (7).

NR: Not reported.

tention of products of conception following fetal death" (19).

Because of multiple levels of reporting—from the facility or doctor to the state health department and then to NCCDPHP—reporting complexity is part of this surveillance system. This complexity is exacerbated by the political sensitivities and legal issues surrounding abortion in every state. This creates a surveillance situation that is dynamic and not completely in the control of the state health agency collecting data.

The timeliness of surveillance data can be described as having two components: 1) the interval between the performance of the abortion and the reporting of the event to the state health department and subsequently NCCDPHP, and 2) the interval between the receipt of such data by NCCDPHP and dissemination of the results of the analysis. Since 1991, the interval between the abortion and publication of a report has been about 3 years.

EXAMPLES OF USING DATA

CDC's need for abortion data at the national level is used by states to justify state legislation requiring abortion reporting. In turn, states compare their data with national data to make and assess policy and program decisions related to abortion. States also use abortion data to monitor teen pregnancy prevention programs and to plan for providing family planning and STD treatment and prevention services to groups at high risk for unintended pregnancies.

FUTURE ISSUES

Although no year 2000 objectives specifically call for reducing the number of legal induced abortions provided in this country, several objectives indirectly address this issue:

- Objective 5.1: Reducing teen pregnancies.
- Objective 5.2: Reducing the proportion of pregnancies that are unintended.

- Objective 5.7: Increasing the effectiveness with which family planning methods are used.

Achieving these objectives will affect the need for abortion services (20) and will require all states to collect abortion data needed to fully assess our progress in reducing abortions.

Not all states have recognized the need for state-based abortion surveillance, and some states have recognized the need but have been unable to gather information because of the sensitivities that abortion generates. Data on the number and characteristics of women having abortions in all states are needed to have an accurate picture of legal induced abortion in this country. Moreover, a larger emphasis must be placed on preventing unintended pregnancy, particularly among teenagers. States that do not have age- and race/ethnicity-specific data on abortions will be in a weak position for assessing their needs, addressing teen pregnancy and unintended pregnancy in high-risk groups, and evaluating the effectiveness of their programs.

Ultimately, recent judicial rulings, executive orders, and legislative changes related to parental consent for abortions for minors, restrictions on the availability of services, the possible availability of RU 486, and the funding of abortion services may affect the number of abortions performed, the characteristics of women having abortions, and the methods used for abortion surveillance. Therefore, ongoing abortion surveillance continues to be a dynamic process that can contribute valuable information about an important public health issue.

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Abortion Reporting in the United States: An Examination of the Federal-State Partnership

By Rebekah Saul

Over the past three years, several events have led policymakers, public health officials and the general public to focus renewed attention on abortion data in the United States. The information that is available on how many abortions are performed, when they take place and what methods are used has contributed to the public policy debate, but it also has proven inadequate in some instances to answer all the questions being asked.

For example, in 1995 Ohio outlawed dilation and extraction abortions, an event seen by opponents of abortion as the first victory in a national campaign to ban procedures they later dubbed "partial birth" abortions. The proposed federal "Partial-Birth Abortion Ban Act" has intensified the debate over abortion procedures, late-term abortions and, ultimately, the incidence and timing of abortions in general. Yet the debaters were often frustrated because specific data on the frequency of late-term abortions are limited, and data on the use of dilation and extraction do not exist either at the state or national level.

Moreover, at around the same time, Congress enacted a federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Among several provisions intended to discourage out-of-wedlock births is the so-called illegitimacy bonus: Every year, for the next four years, the federal government will award \$20 million each to the five states that can demonstrate the largest reduction in out-of-wedlock births and a simultaneous decrease in abortion rates. While the legislation establishes 1995 as the baseline against which reductions and increases will be measured, it does not address the limitations of abortion data collection efforts, which pose a significant challenge for accurately establishing a baseline level of abortion in many states, as well as for establishing accurate subsequent levels.

In 1996, as well, the Food and Drug Administration (FDA) took significant steps toward approving the use of medical (nonsurgical) abortion in the United States, essentially by "preapproving" the use of mifepristone, popularly known as RU 486, as an abortifacient; final approval is pending information on manufacturing and labeling. In addition, FDA cleared the way for clinical study by U.S. health care providers of a combination of two other drugs—methotrexate and misoprostol—used to induce early nonsurgical abortions.

While it remains to be seen to what extent the advent of medical (nonsurgical) abortions will actually change the provision of abortion services in the United States, it is at least possible that such abortions will be administered by health care providers who, for whatever reasons, have been reluctant to provide surgical abortions. If new providers do indeed emerge, incorporating abortion reporting by these providers into current reporting procedures will be critical both to measuring the number of abortions provided in the United States, and to monitoring the drugs' use and safety. Furthermore, because medical abortion is used primarily in the first seven weeks of pregnancy, the provision of nonsurgical abortion may lead to a shift in the timing of abortions. Documenting this shift might prove important to the abortion debate, since many

individuals support early abortion but grow increasingly uncomfortable with the procedure as the pregnancy continues.

The Centers for Disease Control and Prevention (CDC), the government agency currently responsible for compiling U.S. abortion data, has been criticized by some people for its inability to answer all abortion-related inquiries—particularly, detailed questions relating to late-term abortions. However, such criticism does not consider that—in keeping with vital statistics tradition—CDC obtains its data through a voluntary federal-state partnership in which states are responsible for collecting and managing data in accordance with their own policies and systems, and submitting the information to the federal government. As a result, states ultimately determine the quality and availability of national, government-generated abortion data.

Background

History of U.S. Vital Statistics

The maintenance of vital records in the United States dates back to the 1600s, when colonies voluntarily or by law kept registers of births, deaths and marriages. This early recordkeeping was done primarily to protect individual rights; records were regarded as legal documents necessary for posterity and to ensure just administration of inheritance and other laws. During the 17th and 18th centuries, recognition of the utility of vital records as a public health tool grew, and local health boards began using death records to trace epidemics and evaluate community health.¹

In the 1800s, several states and cities adopted laws governing the organization of public health agencies, and government maintenance of vital statistics emerged as an important public health function. Congress created the National Board of Health, which (in conjunction with the U.S. Bureau of the Census) was to spearhead establishment of a national vital statistics system. By 1900, the Census Bureau had developed the first standard certificates of birth and death, and in 1907 submitted the first in a series of model vital statistics bills to the states.

In 1946, responsibility for national vital statistics was transferred from the Census Bureau to the U.S. Public Health Service, which made two significant moves a decade later: It developed and issued the first standard records of marriage and divorce or annulment, and it issued the Certificate of Fetal Death (which later became the U.S. Standard Report of Fetal Death).

The National Center for Health Statistics (NCHS) was established in 1960 to collect statistics on a broad range of health topics, to conduct relevant research and analysis, and to publish vital statistics data. Nevertheless, the primary responsibility for collecting, managing and compiling vital records—records of births, deaths, fetal deaths, marriage and divorce or annulment—lies with the states in accordance with their own laws, regulations and public health agencies. They also submit data to the federal government on a contractual basis, through which the federal government shares in the cost of operating the state system.

Reporting Abortions

The move toward legalization of induced abortion in several states during the late 1960s provided an impetus for distinguishing between spontaneous and induced termination of pregnancy in reporting. As a result, some states began to collect induced abortion data separately, while others continued to record the events as fetal deaths. In 1969, with the original intent of monitoring the safety of abortion, CDC initiated a national abortion surveillance system to compile and analyze state-generated abortion statistics.²

Around the time of the landmark 1973 U.S. Supreme Court decision in *Roe v. Wade*, which legalized abortion in the United States, NCHS stepped up its efforts to obtain abortion data by attempting to install an abortion reporting system on par with other vital statistics data collection. In 1978, as part of that effort,

NCHS introduced a standard form specifically for the reporting of induced abortion—the U.S. Standard Report of Induced Termination of Pregnancy. It was hoped that the NCHS system of collecting abortion data, which utilized micro data sets obtained by NCHS from the states on a contractual basis, would eventually replace the CDC abortion surveillance system, which relies on state-reported aggregate data.

However, NCHS was under severe financial constraint and failed to fund its abortion program adequately. This problem stymied the abortion data system's growth. At its peak, NCHS obtained abortion data from only 15 states, and the program was discontinued altogether after data year 1993.

Today, CDC's abortion surveillance system remains the sole governmental source of abortion data. The primary responsibility for recording, collecting and managing data rests with the states' vital statistics agencies, which submit data to CDC on a voluntary basis. CDC retains the federal role of issuing model legislation, forms and guidelines, as well as compiling and publishing state information; however, CDC does not share in the cost of the state data collection. Most recently, with the advent of medical abortion using such drugs as mifepristone and methotrexate, CDC led the effort to revise the U.S. Standard Report of Induced Terminations of Pregnancy to include medical abortions as a type of procedure.

Challenges to Abortion Reporting

Over time, all 50 states have wrestled with abortion reporting requirements, because, as with all abortion-related issues, reporting has met with controversy. At the heart of the issue is whether induced abortions should be regarded as reportable events paralleling births, deaths and fetal deaths, or rather as health events to be monitored as other surgeries and medical procedures are.

Additionally, some abortion rights supporters have raised concerns about the intent of abortion reporting requirements. They fear that abortion foes will use the laws to deter abortion provision, either by making reporting requirements too onerous or by allowing reported data to be used to harass service providers or women who have obtained abortions. In several states, reporting policies have been legally challenged; two cases argued before the Supreme Court have upheld reporting requirements.

When the Supreme Court heard challenges to Missouri's 1974 abortion law in *Planned Parenthood of Central Missouri v. Danforth*, the justices unanimously upheld the law's requirements that all health facilities and physicians report all abortions to the health departments. The Court concluded that such recordkeeping is useful to the state's interest in protecting the health of its female citizens, and that recordkeeping and reporting requirements "that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible."³

Sixteen years later, the Supreme Court reiterated its position in *Danforth* when it decided on the reporting requirement provisions of the Pennsylvania Abortion Control Act in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. The decision stated that "[t]he collection of information with respect to actual patients is a vital element of medical research, and so it cannot be said that the requirements serve no purpose other than to make abortions more difficult."⁴ These decisions largely affirmed states' moves to institutionalize the reporting of abortion data.

Data Completeness and Quality

While issues related to the quality of abortion data are outside the scope of this article, two studies that examined the completeness and consistency of state abortion data deserve mention. They highlight some of the limitations of abortion data, as well as indicate the potential impact of provider education and outreach, enforcement, follow-up and quality monitoring on state abortion data.

The first points to the underreporting and nonreporting that may occur in some states. The 1980 study