ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672
10273 HOUSE JUDICIARY

ALASKA STATE LEGISLATURE
JOINT MEETING
ADMINISTRATIVE REGULATION REVIEW
March 27, 2001

DAVID PREE, Resident of the Anchorage Pioneer Home, informed the committee that he was the last First Assistant Attorney General during statehood and he was also the Statehood Election Commissioner. Therefore, he is very familiar with statutory construction and the relationship between the executive and judicial branches and the executive and legislative branches of government. Mr. Pree asked if Commissioner Cohen had requested an opinion from the Attorney General regarding the Department of Administration's interpretation of the various statutes involved.

MS. ELGEE answered that all regulation development promulgated by any program or department is done so with the legal advice and review of the Department of Law. The department worked directly with an attorney from the Department of Law on the drafting of these regulations. Then another attorney within the Department of Law reviews the regulations before the department is allowed to promulgate the regulations and conduct public hearings. Upon completion of the public hearing process, there is a final review of the regulations by the Department of Law before the regulations become effective.

MR. PREE remarked that Ms. Elgee's answer refers to the legal ease of the regulations with which he is not interested. Mr. Pree clarified that he is interested in the intent of the legislature. He said:

> What was the intent that the legislative body had in enacting the Pioneer Homes and the cost entailed thereof. We have a co mangling (ph) of the capital expenses here, maintenance of the existing facility, and then you have operating expenses. If ... the administrative agency, who is to administer these laws interpret these statute one way and it's inconsistent with the legislative intent, then you've created a lot of mess for the state and for the individual agency. If the commissioner hasn't requested an Attorney General's opinion on the question of legislative intent and your proposed increases here and use of the money, I respectfully submit that the administrator or the executive branch of government is not willing to ... have the Attorney General look at this aspect, then I respectfully submit that the legislative attorney should look at it. There are a number of questions that I have involved in this whole mess.

CHAIR McGUIRE clarified that the role of Joint Committee on Administrative Regulation Review is to review proposed regulations in order to determine whether those regulations comport or do not comport with legislative intent. She said, "That's precisely the reason why we are holding this hearing." Chair McGuire noted that Senator Lincoln had requested the ability to respond in writing. Chair McGuire said, "We respectfully request that the Lieutenant Governor doesn't sign these yet." She pointed out that these regulations don't go into effect until July 1st and the public comment period is now.

HB 158--EXAMPLES OF IMPACTS UPON REGULATORY ACTIVITIES

- The Real Estate Commission adopts regulations to carry out the real estate broker licensing statutes. One such regulation requires real estate brokers to keep separate trust accounts for money collected in trust, such as earnest money deposits or purchase money. The statutes do not say who should receive the interest if a trust account earns interest, or whether the broker must disclose it. However, Commission has written regulations to require disclosure of whether a trust account bears interest and at what rate, and they provide that any interest earned does not belong to the broker. If HB 158 became law, the validity of new regulations in this area would be called into doubt.

- Alaska's surface coal mining statute, AS 27.21, lets the Department of Natural Resources (DNR) adopt regulations "pertaining to surface coal mining and reclamation." DNR has used this general authorization to gain "primacy," thus replacing federal jurisdiction. The statute, however, does not specify which topics DNR can address by regulation or how they are to be treated. Primacy must be maintained by frequent regulatory amendments required by the federal Office of Surface Mining. HB 158 would prevent adoption of these amendments, and DNR would lose primacy.

- The Board of Fisheries has general authority to adopt regulations as needed to conserve, develop, and utilize fisheries. Other statutory provisions address bag limits, but to enforce these limits realistically for sport-caught fish, the Board must also set possession limits. Otherwise, if a fish and wildlife enforcement officer discovered someone with 15 sockeye salmon in an icebox, despite a bag limit of three fish per day, the person might claim that the fish were caught on earlier days. Enactment of HB158 would invite lawsuits as to whether the authority to set new possession limits was "clearly expressed."

- The Department of Environmental Conservation (DEC) may adopt regulations to control, prevent, and abate pollution, but DEC's statutes are silent about relaxing water quality standards. By regulation DEC currently allows site-specific water quality criteria for sites where the safe dispersion of pollutants allows standards to be relaxed. With implied authority, DEC can respond quickly, flexibly, and effectively to foster development in an environmentally safe manner by enacting these site-specific criteria. Without implied authority, new regulations of this kind would be vulnerable to litigation from parties opposed to the proposed development. At a minimum, such litigation would be an effective vehicle to create project delays, and, indeed, the litigation might overturn the special regulation entirely.

- DEC may also adopt drinking water standards, as well as regulations for constructing, improving, and maintaining public water systems. DEC's statutes do not address monitoring of systems for contamination, notice to the public about potentially unsafe water, or streamlined approvals for small systems that serve few people. Nonetheless, DEC's regulations require monitoring and notification, so that the state follows the federal Safe Drinking Water Act and avoids a federal takeover. Additionally, DEC has streamlined its approvals for small systems, which has eased regulatory burdens on owners and operators. These initiatives would be jeopardized by HB 158.

Prepared by Department of Law *March 26, 2001*

Resource Development Council
for Alaska, Inc.

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APR 1 0 2001

April 2, 2001

Representative Norman Rokeberg
Alaska State Legislature
State Capitol
Juneau, Alaska 99801-1182

Re: HB 158

Dear Representative Rokeberg:

On behalf of the Resource Development Council for Alaska, Inc. (RDC), I am writing to express our serious concerns with HB 158. While RDC believes the intent of this legislation is well meaning, its application would create extreme obstacles to the regulated community. As such, we have no choice but to oppose this bill.

RDC is a private, membership-funded trade association representing individuals and companies from the mining, timber, oil and gas, fishing and tourism industries. We are active in the regulatory and statutory arenas of local, state and federal government. Our mission is to grow Alaska's economy through responsible resource development.

HB 158 would create an even more cumbersome regulatory system in Alaska. It would generate increased litigation and damage the state's business climate. RDC urges you to pull this bill from the Judiciary Committee schedule.

Thank you for your consideration and please don't hesitate to contact me if you have any questions.

Sincerely,

RESOURCE DEVELOPMENT COUNCIL
for Alaska, Inc.

Tadd Owens

Tadd Owens
Executive Director

ALASKA MINERS ASSOCIATION, INC.

3305 Arctic #202, Anchorage, Alaska 99503 • (907) 563-9229 • FAX: (907) 563-9225 • www.alaskaminers.org

April 2, 2001

The Honorable Norman Rokeberg, Chairman
House Judiciary Committee
Alaska State Legislature
State Capitol, Mailstop 3100
Juneau, Alaska 99801-1182

APR 04 2001

Re: HB 158

Dear Representative Rokeberg:

I am writing to express the concerns the Alaska Miners Association has with HB 158. Although we appreciate your ongoing support of the mining industry in Alaska and the intent of this bill, we feel it would statutorily eliminate critical permitting aspects that currently exist that are important to the mining industry in Alaska today. Therefore, we cannot support this bill.

Our primary concern relates to the implications this bill would have on site specific criteria. Within the current regulations, site specific criteria allows unique characteristics of various projects to be addressed on a case-by-case basis. This approach provides flexibility in allowing how each operation can ensure that proper environmental protections are in place. This is an important component of the operating permits for many mining projects in Alaska today. HB 158 could create situations where these site specific criteria could be legally challenged unless each specific case was addressed in statute, which would be cumbersome, at best. In addition, existing site specific situations could be legally challenged leading to costly and lengthy litigation.

Therefore, even though we appreciate the intent of the bill to formulate a more responsible regulatory framework, we cannot risk losing the site specific aspect of the current regulatory scheme.

Once again, your ongoing support of the mining industry is greatly appreciated. Thank you for the opportunity to comment on this important issue.

Should you have any comments or questions, please do not hesitate to contact me.

Sincerely,
Alaska Miners Association

Stanley T. Foo
(Acting) Executive Director

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Alaska Oil and Gas Association

AOGA

121 W. Fireweed Lane, Suite 207
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Email: brady@aoga.org
Judith Brady, Executive Director

April 2, 2001

APR 02 2001

The Honorable Norman Rokeberg
Chair, House Judiciary Committee
Alaska State House of Representatives
State Capitol, Room 118
Juneau, Alaska 99811

Dear Representatives Rokeberg:

Thank you for the opportunity to comment on HB 158.

The Alaska Oil & Gas Association (AOGA) is a private, non-profit trade association whose member companies represent the majority of oil and gas exploration, production, transportation, refining and marketing activities in Alaska.

The members of AOGA have a strong interest in the State of Alaska's regulatory framework. As the committee is aware, the oil and gas industry in Alaska is the subject of literally hundreds of regulations based on local, state and federal law. At the state level the oil and gas industry is governed by regulations adopted and administered by numerous agencies, including the Department of Natural Resources, the Department of Environmental Conservation, the Department of Fish & Game, the Department of Revenue, the Department of Labor, the Division of Governmental Coordination for the Alaska Coastal Management Program and the Alaska Oil & Gas Conservation Commission. Each year the Association and its member companies review and provide comment on proposed new or amended regulations from several of these Departments, Commissions and Divisions. As an example, at the present time AOGA is participating in public comment on a full review of the Consistency regulations for the Alaska Coastal Management Program (6 AAC 50) conducted by the Division of Governmental Coordination.

It is in this context that we express both our appreciation and our concerns regarding HB 158. We recognize and appreciate the sincere and appropriate desire of the sponsors to open the dialogue on improving Alaska's regulatory framework. However, we are concerned that HB 158, as proposed, may go too far in reducing the flexibility necessary to write reasonable regulations.

The challenge for the Legislature is ensuring sufficient flexibility to allow regulators to fill in the gaps resulting from the unanticipated or the ambiguous that occur during the creation of new law, while at the same time including safeguards to prevent disregard of clear legislative intent. The need for flexibility is a crucial point; if it is not addressed, HB 158 could have the unintended consequence of creating worse problems.

As HB 158 recognizes, the power to create and alter the statutory law of Alaska is vested in the Legislature. The function of the executive branch is to implement the laws which the Legislature enacts. Regulations and administrative rule-making enter this picture because legislation often requires them. Sometimes there are details in legislation which the Legislature intentionally leaves for the executive branch to fill in. Sometimes there are gaps between the scope of one legislative provision and another and the executive branch has to fill in or narrow these gaps. Sometimes the Legislature has a particular kind of situation in mind but chooses words to deal with that situation which can also be read as extending to other situations which the Legislature never even considered. There are infrequent situations when two statutory provisions are in conflict with each other and the executive branch must try to reconcile those provisions to give reasonable effect to both.

In these circumstances the agency administering such a statute needs some flexibility to exercise discretion in deciding how to draft regulations that are covered by the statute, but which the Legislature did not expressly consider. The problem with the wording of HB 158, as proposed, is that some of this needed flexibility may be lost.

There have been instances when AOGA has gone on record that a proposed regulation is outside the intent and scope of the enabling statute and we want to express appreciation for your focus on improving Alaska's regulatory framework. However, this bill as proposed, may have unintended consequences. HB 158 attempts to offer a single solution for a broad set of regulatory problems. We offer to work with you and the rest of the regulated community to identify specific problems which then could be legislatively resolved.

Thank you for your consideration of these comments.

Sincerely

Judy Brady

JUDITH M. BRADY
Executive Director

Cc; Representative Lesil McGuire
Members of the House Judiciary Committee

Representative McGuire
State Capitol
Juneau, AK 99801
Re: HB 158

Representative McGuire,

Our industry association has been lobbying ADF&G for years to clarify policy on on-bottom aquaculture, now we are trying to stop the adoption of regulations that will kill the development of the industry. Everything they are doing is directed at department problems, they are doing nothing to address industry problems. Now we have the added problem of killer regulations. Apart from the content of the regulations I will focus on the structural tactics and abuses being used to change the intent of the statutes. I will be using examples from my first-hand experience in the application process that may get confusing. The facts are confusing because the department is attempting to apply the proposed regulations to applications that I made over two years ago; it is therefore difficult to keep the two sets (existing and proposed) of regulations separate.

Summary

1) The department told me/us, at the end of the application process, that they are using principles that will be embodied in regulation, they will be adopting at some point in the future, as the basis for the issuance of my permits. This is expo-facto rulemaking. They are not only going to apply these regulations to me/us after they are adopted, they have in fact apply them to us before they were adopted.
2) In order to receive a permit I would have to agree to these principles in advance.
3) One of these principles is that the proposed renewal criteria will contain all of the original issuance criteria. In other words we will have to re-apply every five years. This is contrary to the renewal statute AS 16 40.110.
4) The net effect of this regulatory scheme is to prevent farmers from acquiring the status referred to in statute (AS 16 40.105b) as "existing use", even after five years. We would always have to go to the bottom of the list of users and start over.

Example 1

Proposed regulation 5 AAC 41.280 (c) adds the issuance criteria of AS 16 40.105 to the renewal criteria in this section. I see something fundamentally wrong with this. The renewal statute outlines what is needed to renew a current permit. It seems to me that the regulatory process is limited to implementing, clarifying, interpreting, and making specific that intent. For example, setting the referred to fees. Regulations should not be adding criteria that do not come under one of the requirements addressed in the statute. I can only assume that if it were the Legislature's intent to use issuance criteria as renewal criteria they would not have passed statutes addressing them independently.

Example II

Proposed regulation 5 AAC 41.290 (a) expands the use of Stock Acquisition Permits (SAP) to include stocks removed from the farm. Statutory language limits the use of a SAP for stocks to the farm.

THE PROBLEM

The APA already restricts these kinds of activities (consistency with statute) by agencies. They continue to do it anyway. They seem to think that as long as they meet the public notice and comment requirements* they can write whatever they want into law. There needs to be some sanction on regulators who violate this law. Is this any different than breaking other laws? Making regulations is an expensive cost to the public. Making illegal regulations is more expensive as it burdens the State's court system. I think that punitive damages to litigants who have to bare the burden of correcting these violations in courts of the State are appropriate. What about the public that does not know or is unable to bare the burden? They are forced to live under the application of countless regulatory abuses.

*We were told at the last Mari-culture Panel meeting that we would not see the proposed regulations again until the Lieutenant Governor signed them. I consider this an insult to the public process. I cannot complain to you effectively about these regulations because I do not know what the final language is.

Over use of the term "may" tends to transform any section of a regulation into departmental deference. This "due deference" refers to areas were actions are dependant on the special expertise of the department. We could use some statutory definition of these deferential functions that restricted agencies from using it to justify any action they take. "May" leaves the door open for selective application of the regulations that tends to be arbitrary and discriminatory, i.e. unequal application of the law. Proper use of the term "may" is described in the "Drafting Manual For Administrative Regulations".

This manual sets out procedure to be followed in adoption of regulation. A problem we encountered in the process is that DOL is not telling ADF&G what is legal but vise versa. We have a legal history of statements and opinions that dates back to Statehood from DOL on these issues. We have references from ADF&G staff that assistant attorney general Steve White says everything is Constitutional with the Aquatic Farm Act. When conflicts between Steve White and the department became irresolvable the department basically fired him and got a new lawyer that had no experience in fisheries law who would tell them what they wanted to hear. All applications are currently under appeal, in all likelihood will end up going to the State Supreme Court on Constitutional issues that Steve White had no problem with. The department is challenging the constitutionality of their own statutes against DOL advice. Statute that used to be regulations before they where lifted into statute in 1988.

Definition, the department, means the Director of Commercial Fish, Doug Mecum.

THE NET RESULT

The cumulative affect of these regulations is not consistent with the statutory framework. The statutes require the department to evaluate each farm application for suitability, conflicts with existing use and operational and technical feasibility before issuing a permit. Therefore, if the proposed site is suitable, there are no existing conflicts, and the applicants have presented a plan that is technically feasible and they are capable of implementing it, the department will issue a permit. All of these conditions must be met before the department can turn the land and the resource over to private hands.

Under the proposed regs the issuance criteria for an aquatic farm operations permit gets expanded to include all of the statutes and regs applicable to renewal of existing farms including wether or not some commercial fishery, five years from now, decides to fish for the same species of shellfish you are growing, and the issuance criteria for a SAP. This is the extent that the Director had to torture the regulatory process in order to subvert the plain meaning of the word "existing". Soon he will have a quagmire all law that allows him to deny permits based on future potential conflict and criteria designed for a SAP instead of the statutory directive of existing use. When in place no court will be able to sort out all the confusion. Of course the point is mute because no potential applicant would be foolish to fight this regulatory deadbolt. The Director wins. Now he does not have to issue on-bottom aquatic farm permits in areas outside of the critical habitat areas either. Mission accomplished.

HB

160

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: April 4, 2001 **FURTHER REFERRALS: Finance**

Date of Committee Action: 4-27-01

The JUDICIARY Committee considered: **HB 160**

HOUSE BILL NO. 160 **REPORTING OF ABORTIONS**

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

Recommends it be replaced with CS HB 160 (JUD) [✓] **Same Title** [ ] **New Title**

For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____

[ ] attach amendments

[ ] add new referral to _____ Committee

[ ] Letter of Intent _____ Committee

List of Abbrev. For Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LAA
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

***NEW* FISCAL NOTES**
*For Chief Clerk's Office Use Only

FN# *	List by Dept(s):	Fiscal	Indet.	Zero
	HSS	✓		

***PREVIOUS* FISCAL NOTES**

List by Dept(s):	FN #	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Berkowitz			✓	
	Coghill	✓			
	Egan	✓			
	James	✓			
	Kookesh	✓			
	Meyer	✓			
Chair:	Rokeberg			✓	
Chair:					

moved by Rokeberg - ADOPTED

22-LS0457\J.1
Lauterbach
4/27/01

AMENDMENT #1

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 160(HES)

Page 2, line 11, following "section":

Insert ", except that the statistical report may not identify or give information that can be used to identify the name of any physician who performed an induced termination of pregnancy, the name of any facility in which an induced termination of pregnancy occurred, or the name of the municipality or community in which the induced termination of pregnancy occurred."

Page 2, following line 21:

Insert a new bill section to read:

"***Sec. 2.** AS 18.50.310(a) is amended to read:

(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. **Regulations issued under this chapter may not authorize inspection, disclosure, or copying of all or part of any report or record received under AS 18.50.245, except that the statistical report prepared under AS 18.50.245(d) may be copied and distributed.**"

Renumber the following bill sections accordingly.

Alaska State Legislature

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Session:
State Capitol, Room 102
Juneau, AK 99801
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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.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS HB 160 (HES)
( ) Publish Date:

Revision Date/Time (Note if correction): 4/5/2001
Dept. Affected: Health & Social Services
Title: An Act requiring the reporting of induced terminations of pregnancies
BRU: State Health Services
Component: Bureau of Vital Statistics
Sponsor: Coghill et.al.
Requester: House (JUD)
Component Number: 961

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	15.8	16.1	16.4	16.8	17.1	17.4
Travel	3.0	1.0	1.0	1.0	1.0	1.0
Contractual	44.0	3.0	3.0	3.0	3.0	3.0
Supplies	0.5	0.5	0.5	0.5	0.5	0.5
Equipment	8.5				4.5	
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	71.8	20.6	20.9	21.3	26.1	21.9
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF	71.8	20.6	20.9	21.3	26.1	21.9
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	71.8	20.6	20.9	21.3	26.1	21.9

Estimate of any current year (FY2001) cost: 0.0

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal: [ ]

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The Department anticipates 2000 - 2500 reports per year.
Personal Services: one 1/2-time Administrative Clerk II to process reports of induced termination.
Travel: first year - travel to each provider to establish procedures, install programs and train staff
succeeding yrs travel to oversee system functionality.
Contractual: first year
(a) 30k Build an Induced termination of pregnancy subsystem in the new vital statistics information system
(b) 4k lay-out and print reporting form
(c) 10K develop and adopt regulations succeeding yrs Print forms
Supplies: standard office supplies - (Yearly cost)
Equipment: first year Computer and furniture for new Admin Clerk succeeding yrs Replace computer

Prepared by: Karen E. Pearson, MS
Phone 465 3092
Division: Public Health
Date/Time
Approved by: Elmer A. Lindstrom, Special Assistant
Date 4/10/01 12:12 PM
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

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Legal Induced Abortion Reporting in the United States

Why is legal abortion reporting important?

Legal induced abortion data are used to

- Define characteristics of women at high risk for unintended pregnancy.
- Monitor trends in the number, rate, and ratio, of abortion, types of procedures used, and gestational age (in weeks) when abortions are performed.
- Calculate pregnancy rates (in conjunction with births and fetal deaths).
- Evaluate the effectiveness of family planning programs and programs to prevent unintended pregnancy.

Reporting issues

- 47 states, New York City, and the District of Columbia collect data on legal induced abortions.
- 44 reporting areas collect abortion data as required by state statute/regulation or law.
- Every hospital, Medicare facility, or licensed clinician in required areas must report each induced abortion performed to the central department of health by means of a standardized form for that reporting area.
- The time period for filing reports after legal induced abortion varies widely by state.

Abortion Reporting, by Reporting Area and Type of Reporting—United States, 2000

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

Source: Reporting of medical abortions: Information for providers. *Am J Obstet Gynecol*, 2000: 183:S24-S25

September, 2000

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 proc[illegible]ire	(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
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 surveillance 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.

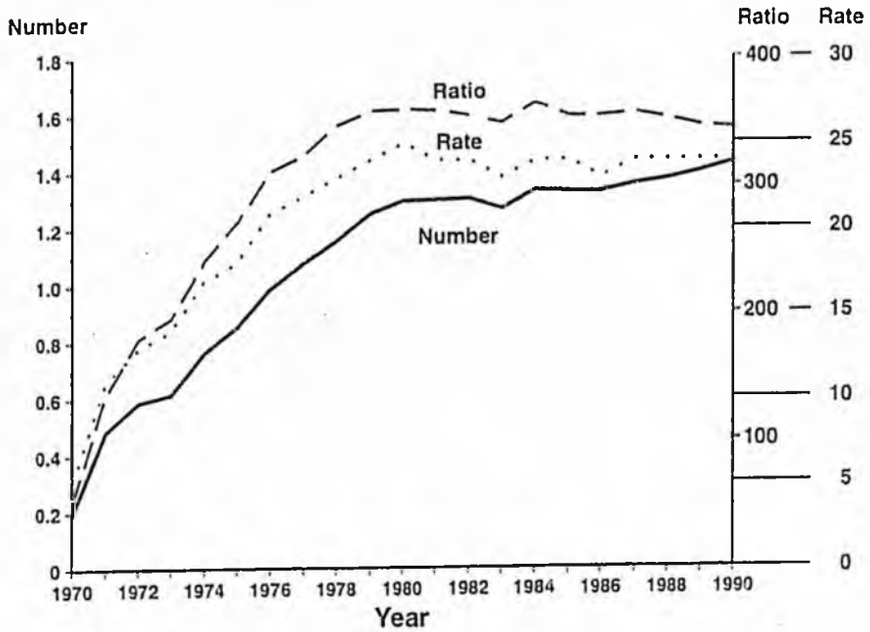
Most reported legal abortions are performed before 8 weeks of gestation, and more than three fourths are done before 13 weeks. Approximately 4% of abortions are performed at 16–20 weeks of gestation, and 1% at ≥21 weeks. Approximately 99% of legal abortions are performed by curettage (which is consistent 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.

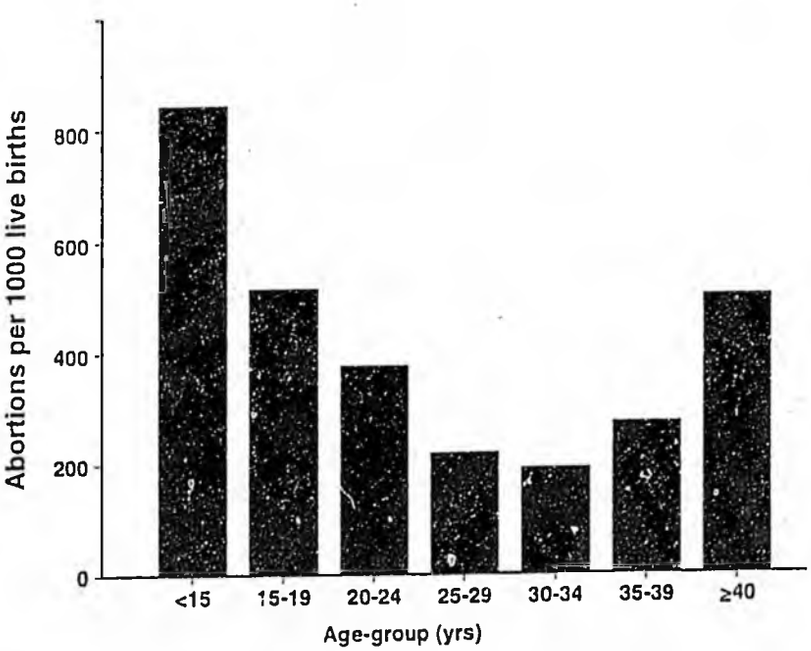
FIGURE 1. Legal abortions — United States, 1970–1990*



* 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

	Race					
	White†		Black and other races		Total	
Age-group* (years)	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	206,677	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 reported 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*	Ratio†	Rate§	Abortions obtained by out-of-state residents (%)¶
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*	Ratio†	Rate§	Abortions obtained by out-of-state residents (%)¶
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†††	24	8.2

* Abortion data from central health agency unless otherwise noted.
† Abortions per 1,000 live births (live-birth data from central health agency unless otherwise specified).
§ Abortions per 1,000 women aged 15–44 years (from Bureau of the Census, Current Population Survey, March 1990).
¶ Based on number of abortions for which residence status of women was known.
** Reported from hospitals and/or other medical facilities in state.
†† CDC estimate.
§§ Live births reported by NCHS (*16*).
¶¶ >1,000 abortions per 1,000 live births.
*** >1,000 abortions per 1,000 women aged 15–44.
††† Excludes 330 Kansas residents obtaining abortions in other states.
§§§ Reported from New York City Health Department.
¶¶¶ Differs from the preliminary ratio (344) published in MMWR (*1*).
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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FAMILY PLANNING PERSPECTIVES

Volume 30, No. 5, September/November 1998

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

compared Tennessee abortion data reported by providers to the Tennessee Department of Public Health with data reported for the state by The Alan Guttmacher Institute (AGI), which collects abortion data by surveying providers directly.[5] For 1974, the Tennessee Department of Public Health reported only half the number of abortions that AGI reported.

The authors concluded that "underreporting, or more specifically, nonreporting, by some facilities in Tennessee, has occurred because clinic and hospital administrators did not know that they were responsible for reporting abortions performed at their facilities and they have relied on physicians to do so." In subsequent years, according to the authors, department of health staff informed nonreporting clinics of the law, and by 1976 the department reported 74% of the number of abortions that AGI reported.

The second study illustrates the problems that arise both from measuring rare events and from human error: A few misrecorded abortions in Georgia dramatically altered the state's data on third-trimester abortions. The authors analyzed the accuracy of data on reported third-trimester abortions in Georgia by comparing the reported information with actual medical records for each case.[6] Upon reviewing 86 third-trimester induced abortions reported to the Georgia Department of Health and Human Services in 1979 and 1980, the authors found that the vast majority of the abortions were misreported. Only three procedures could be verified as actual third-trimester induced abortions; 58 of those reported were actually fetal deaths in utero, and 15 more were first- or second-trimester abortions that had been misclassified as third-trimester. The researchers concluded that the correct rate of third-trimester abortions for Georgia in 1979 and 1980 was 4.3 per 100,000 total abortions, rather than the rate of 123.1 per 100,000 abortions reported by the state's department of health.

Abortion Reporting

As of January 1998, 48 states, the city of New York* and the District of Columbia collect data on induced abortions.† The two nonreporting states, California and Oklahoma, have abortion reporting statutes on the books that are not currently in effect due to legal actions taken against related abortion statutes.

Laws

While 40 states and New York City collect abortion data as required by state statute, these laws vary. In 35 states and New York City, induced termination of pregnancy reporting is required specifically by statute (see Table 1). Overall, the laws are similar; by and large, they require every hospital or facility, or attending physician, to file a report regularly on each abortion performed, usually within a few days of the procedure or on a monthly basis. These laws mandate that abortion reports be submitted to the state department of health, state registrar or state vital statistics officer, and that the agency in turn publish the statistics on a regular basis.

Table 1. Abortion reporting, by jurisdiction

Jurisdiction	Type of reporting			
	Mandatory			Voluntary
	Abortion statute	Fetal death statute	Regulatory policy	
Alabama	X			
Alaska				X
Arizona			X	
Arkansas	X*			

California				
Colorado		X†		
Connecticut			X	
Delaware	X			
District of Columbia				X
Florida	X*			
Georgia	X*			
Hawaii		X		
Idaho	X*			
Illinois	X*			
Indiana	X			
Iowa	X*			
Kansas	X			
Kentucky	X			
Louisiana	X			
Maine	X			
Maryland				X
Massachusetts	X			
Michigan	X			
Minnesota	X*			
Mississippi	X*			
Missouri	X*			
Montana	X			
Nebraska	X			
Nevada	X*			
New Hampshire				X
New Jersey				X‡
New Mexico	X*			
New York		X		
New York City	X			
North Carolina	X*			
North Dakota	X*			
Ohio	X*			
Oklahoma				
Oregon	X*			
Pennsylvania	X			
Rhode Island		X*		

South Carolina	X*			
South Dakota	X			
Tennessee	X			
Texas	X*			
Utah	X			
Vermont	X			
Virginia		X*		
Washington			X	
West Virginia				X‡
Wisconsin	X			
Wyoming	X			

*A regulatory policy guides abortion data collection in addition to state statute. †Abortion reporting is done in accordance with the state's death certification statute. ‡A broad health statute provides legal authority for abortion-related data collection.

Approximately half of the state laws specify that the department of health or a related agency will prescribe and provide the abortion reporting form, and several states require that the form be similar to the U.S. standard suggested by CDC. Virtually all of the statutes include a confidentiality provision—either emphasizing that the data collected are for statistical use only and may be published in aggregate only, or, at a minimum, mandating exclusion of the patient's or provider's name on the reporting form or in the published report.

Four additional states—Hawaii, New York, Rhode Island and Virginia—are legally obligated to collect abortion data under broader fetal death reporting statutes, rather than under laws specific to abortion. The Colorado vital statistics agency, meanwhile, collects abortion data in accordance with its death certification statute, which does not single out fetal death or abortion.

Regulations

Three states—Arizona, Connecticut and Washington—are obligated to collect abortion data solely by regulations issued by their state health agencies (Table 1). Regulations in all three echo the typical reporting statute. Nineteen more states have regulatory policies that accompany their abortion or fetal death reporting statutes. Such regulations typically reinforce the provisions put forth in the state statute and provide administrative guidance for the reporting system. For example, regulations might enumerate exactly what is required on the reporting form, discriminate between requirements for different types of medical facilities or elaborate on confidentiality provisions.

Voluntary Reporting

Five states and the District of Columbia collect abortion data on a voluntary basis, and their health departments provide forms and publish the data—even though no statute or regulation requires that abortions be reported (Table 1). New Jersey and West Virginia cite broad state health statutes as providing legal authority for a state health official to collect abortion-related data, while in Alaska, Maryland, New Hampshire and the District of Columbia, the health departments do not rely on legal authority.

State Data Collection

All states that collect abortion data utilize standardized forms, and most require a separate form for each procedure. The forms largely solicit the same baseline data as does the U.S. Standard Report of Induced Termination of Pregnancy: information on the facility (name or address, city and county); demographic information on the patient (her age, marital status, race, general educational level, and city, county and state of residence); medical information on the patient (date of last normal menses and number and results of previous pregnancies); information on the procedure itself (date of termination, clinical estimate of fetal gestation and method of termination[‡]) and the names of the attending physician and person completing the report.[§]

However, state forms tend to deviate from the U.S. standard in two ways. Many states do not require the same level of detail as the standard form on those items that might identify the facility, patient or attending physician—only 23 states[**] and New York City, for example, require the patient's residential zip code, and only 28 states[††] and New York City request information identifying the attending physician. While all but three reporting areas[‡‡] request information on the type of procedure used, only 17 states,[§§] New York and the District of Columbia include "medical (nonsurgical)" in the list of abortion procedures.

Conversely, many states require more information than that required in the U.S. standard form. Twenty-seven states,[*†] for example, inquire about abortion-related complications, and several ask for additional information on the fetus, such as fetal viability, abnormality, length or weight. Nine states[*‡] ask the reason for the abortion, and seven[*§] request information on the woman's contraceptive history.

Six states and the District of Columbia do not use a separate form for each procedure. Colorado, New Jersey, Texas and West Virginia, which require the same basic information on each abortion as does the U.S. standard form, record abortions in logs that are submitted to the state agency on a regular basis. In Florida, Massachusetts and the District of Columbia, abortions are reported to health agencies in aggregate on a monthly or quarterly schedule.

National Data Collection

Annually, CDC contacts state vital statistics agencies to request certain data tabulations from the previous year. On a voluntary basis, states then submit aggregate data to CDC in the form of the requested tabulations, or as closely as possible, based on the state's available data. In 1995, the most recent year for which CDC data are available, the agency requested data on age of woman (younger than 15, 15, 16, 17, 18, 19, 20–24, 25–29, 30–34, 35–39, and 40 and older), weeks of gestation (less than or equal to 6 weeks, 7 weeks, 8 weeks, 9–10 weeks, 11–12 weeks, 13–15 weeks, 16–20 weeks, and 21 weeks or greater), type of procedure (suction curettage, all curettage, intrauterine saline instillation, prostaglandin instillation, hysterectomy or hysterotomy, other, unknown), race, Hispanic ethnicity, marital status, previous live births and abortions, and state of residence. As in previous years, CDC surveyed abortion providers in nonreporting states to estimate the number of abortions performed in those states.

Discussion

To a great degree, a national system for collecting data on induced termination of pregnancy is in place, and, by and large, states have moved to adopt federal standards that aim to make data complete and comparable across state lines. However, there remains considerable variability among state laws, policies, forms and systems, and this variability inevitably affects CDC's ability to determine accurately even the total number of abortions performed each year. While state reporting has improved over the years—and three states installed reporting systems for the first time in 1997—AGI reported 13% more abortions nationwide than did CDC in 1995,[7] the latest year for which comparable abortion data are available.

This variability also exacts a toll on CDC's ability to answer specific questions about abortion in the

United States. As demonstrated by the review of state reporting forms, there are considerable differences among states that do require abortion reporting in terms of the information they actually collect. Furthermore, for the information reported to the states, there often are problems with data completeness. For example, in CDC's 1995 state-level surveillance report, data on specific variables are missing for a number of states. To better assess the quality of state data, especially for small or sensitive groups, more research like the Georgia study is needed.

At the same time, it is important to understand that the information available to CDC is limited to the specific pieces of data that the agency requests from the states. For example, in 1995, in keeping with past years, the agency requested aggregated tabulations on nine variables, with some limited cross-tabulations. Therefore, the agency does not have access to state-collected abortion data in a record-by-record format, and it cannot then spontaneously answer questions about individual cases or new variables.

As a result of these data limitations, much of the information recently sought by decision-makers engaged in the "partial birth" abortion debate is currently out of CDC's grasp. Detailed information on late-term abortions is unavailable because the relatively small number of abortions beyond 20 weeks are aggregated into one gestational category. Data on certain procedures—including dilation and extraction, the medical procedure that most closely approximates characterizations of "partial-birth" abortion—are also unavailable because states and CDC collect data under broader categories.

Similarly, current limitations cast doubt on the federal government's ability to rely on existing data to responsibly award the "illegitimacy bonuses" authorized in the federal welfare reform law: Doing so would presumably require accurate, complete and consistent data that is comparable across the years—which simply do not now exist.

Finally, the existing abortion surveillance system poses challenges to public health officials in their quest to accurately trace the use of new, nonsurgical abortion techniques. Inclusion of the new techniques on a significant number of state forms demonstrates a sensitivity to the issue on the part of many state vital statistics officers. However, ensuring reporting by all new providers will undoubtedly require increased education and outreach efforts.

While some data limitations may be intrinsic to abortion—and no system is perfect—the quality of CDC's information is primarily compromised by the unevenness of reporting in the states. Policymakers need to assess the value they place on accurate abortion statistics and match information needs with resources. If accurate abortion data are as necessary to policymaking as recent debate suggests, steps need to be taken to bolster the existing systems. Doing so first requires further research into the limitations of the current systems and data, and a significant will to improve state-level data collection and management.

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*New York City maintains its own vital statistics systems and policies, which are separate and distinct from the rest of New York State.

†In 1996 and 1997, The Alan Guttmacher Institute (AGI) compiled state abortion reporting requirements under grant no. 000057 from the Department of Health and Human Services (DHHS), as part of the department's interest in assessing the accuracy of pregnancy data in the United States. To obtain reporting information from the states, AGI sent state vital statistics officers a copy of the state reporting law from AGI files and asked the officers to verify that the law is current, and, if not, to send AGI a copy of current law. The officers were also asked to send AGI a copy of any current regulations and reporting forms. Parts of this article are based on information gained during that effort; however, this report is neither funded by nor represents the views of DHHS.

‡Suction curettage; medical (nonsurgical) abortion; dilation and evacuation; intrauterine instillation; sharp curettage; hysterotomy or hysterectomy; and any other method.

§A chart detailing which of the 25 elements from the U.S. Standard form are used by each of the 52 jurisdictions examined in this article is available from the author.

**AL, AR, CO, DE, GA, ID, IL, IN, MD, MO, NC, ND, NH, NY, NV, OH, OR, SC, SD, TN, UT, VT, VA.

††AL, AZ, CT, GA, HI, ID, IL, IA, IN, KS, LA, ME, MI, MS, MO, MT, ND, NE, NV, NY, OH, PA, RI, SD, TN, UT, VT, WA.

‡‡IL, IA, WI.

§§AK, DE, KS, KY, ME, MI, MO, NC, NE, NH, NJ, OH, SD, TX, UT, WA, WY.

*†AZ, CT, GA, HI, ID, IL, IN, LA, MA, MD, MI, MN, MS, MT, NC, ND, NE, NY, OH, OR, PA, RI, SD, UT, WA, WI, WY.

*‡AZ, FL, IL, LA, NE, NY, PA, UT, WV.

*§LA, MN, NE, NH, OH, OR, UT.

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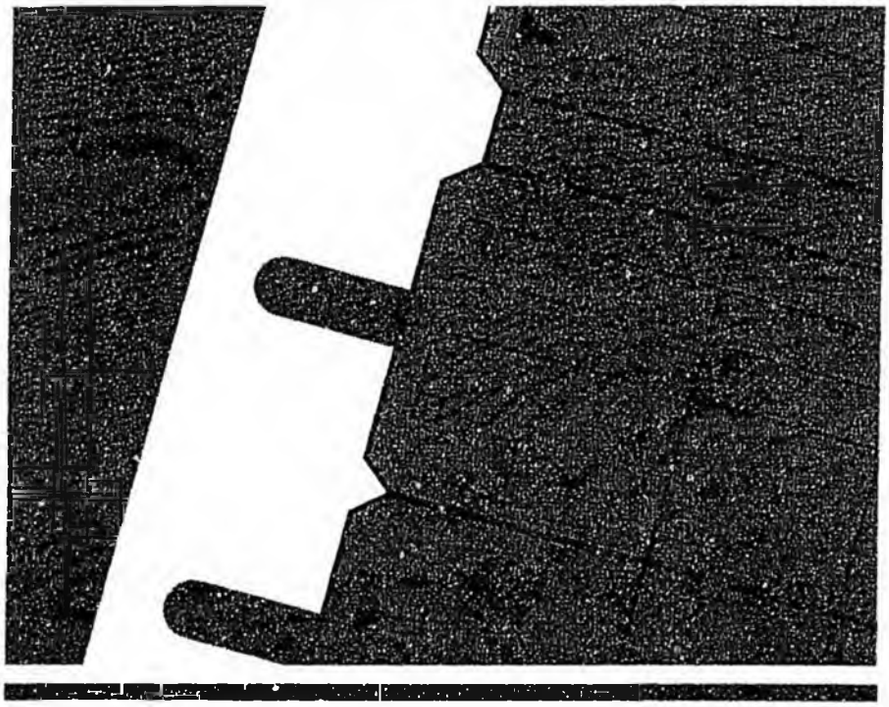
Handbook on the Reporting of Induced Termination Of Pregnancy

Reprinted from 1988, Includes Revised Instructions and Reporting Form, 1997



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics

Hyattsville, Maryland
April 1998
DHHS Publication No. (PHS) 98-1117

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Preface

This handbook is prepared by the National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and contains instructions for persons with responsibilities for completing and filing reports of induced terminations of pregnancy (induced abortions). It pertains to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy as modified in 1996 by the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion and the 1992 revision of the *Model State Vital Statistics Act and Regulations*. This handbook is intended to serve as a model for adaptation by any vital statistics registration area.

Other handbooks available as references on preparing and registering vital records are:

- *Hospitals' and Physicians' Handbook on Birth Registration and Fetal Death Reporting*
- *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting*
- *Physicians' Handbook on Medical Certification of Death*
- *Funeral Directors' Handbook on Death Registration and Fetal Death Reporting*
- *Guidelines for Reporting Occupation and Industry on Death Certificates*
- *Handbook on Marriage Registration*
- *Handbook on Divorce Registration*

Contents

Introduction

Purpose

This handbook is designed as an aid to acquaint hospital and clinic personnel, physicians, and others with responsibilities related to completing and filing reports of induced termination of pregnancy (induced abortion). Background information is included on the importance of these documents for statistical purposes and specific instructions for recording entries.

The purpose is to achieve improved reporting by promoting better understanding of the forms and of the uses of information entered on them.

Although State laws vary in specific requirements, generally the person in charge of the institution or facility where the induced abortion is performed has the overall responsibility for obtaining the required data, preparing the report, and filing the report with the State registrar. For abortions performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for preparing and filing the report.

Importance of induced termination of pregnancy reporting

Reports of induced termination of pregnancy are not legal records and are not maintained permanently in the files of the State office of vital statistics. However, the data they provide are very important from both a demographic and a public health viewpoint.

In January 1973, the U.S. Supreme Court ruled that the restrictive abortion laws in two States were unconstitutional and that, within the first two trimesters after conception, whether an abortion was to be performed or not was a matter between the woman and her doctor (Roe v. Wade, 410 U.S. 113 (1973); and Doe v. Bolton, 410 U.S. 179 (1973)). The net result of this ruling is that induced abortion under these criteria is legal in all States. In July 1976, the Supreme Court ruled that it is legal for States to require the reporting of certain information about induced abortions performed in that State (Planned Parenthood of Central Missouri v. Danforth, 96 Supreme Court 2831 (1976)). As a result of these two rulings, many States have established mandatory induced abortion reporting systems.

Data from reports of induced termination of pregnancy provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with induced abortion at various lengths of gestation and by the type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. The data also help measure the role that induced abortion plays in birth prevention as compared with contraception. Because these abortion data provide information necessary to promote and monitor health, it is important that the forms be completed carefully.

State reporting requirements

In those States requiring the reporting of information on induced abortions, various methods are used to collect the data. Some States include induced abortion reporting as a part of their fetal death reporting system by collecting additional information on induced terminations on their fetal death report. A majority of the States use a separate form, usually called Report of Induced Termination of Pregnancy, for the reporting of induced abortions. In a few States, a combination system is used whereby induced abortions above a certain gestational age are reported on the fetal death report and those below that gestational age are reported on the induced termination of pregnancy report. However, regardless of the reporting system used, all States with reporting systems require the reporting of all induced abortions regardless of length of gestation.

Because of the variations that exist from State to State, it is imperative that those persons having responsibilities in the reporting of induced abortions familiarize themselves with the procedures and forms used in their State.

Live birth

Although unlikely, the induced abortion procedure may result in a live birth. Should this occur, the report of induced termination of pregnancy is not to be completed and filed. Rather, a certificate of live birth is to be prepared for the infant. In the event the infant should later die, a death certificate would also have to be prepared and filed.

U.S. Standard Report of Induced Termination of Pregnancy

The National Center for Health Statistics, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services has historically provided leadership and coordination in the development of the

Standard Report of Induced Termination of Pregnancy to serve as a model for use by States. This report has been revised periodically in collaboration with State health officials, registrars, and statisticians; Federal agencies; local registrars, and medical record personnel. In these revisions, each item is evaluated thoroughly for its registration, statistical, health, and research value.

In recent years, responsibility for the collection of abortion data from the official files of the States has rested with the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. In 1996, in response to the emerging use of medical procedures to induce abortion, the Division of Reproductive Health, in consultation with a working group of experts, revised Item 15: *Type of Termination Procedure.* The instructions for completing several sections of the form were also revised at this time. This Handbook reflects those revisions.

Each State is encouraged to adopt the recommended standard report as a means of developing a uniform national induced abortion reporting and statistics system. Although many States use the recommended standard report, some States modify it to comply with State laws and regulations or to meet their own particular needs for information.

State health department

The State health department administers the induced termination of pregnancy reporting system under the laws and regulations of the State. The State health department is responsible for developing forms and procedures and for ensuring adherence to the requirements of the laws and regulations. It also publishes statistical data derived from the reports of induced termination of pregnancy it receives.

Local registrar

Generally, the Report of Induced Termination of Pregnancy is filed directly with the State registrar. In a few States, however, these reports are filed with the local registrar who then forwards them to the State registrar.

Confidentiality

The Report of Induced Termination of Pregnancy is designed to collect information for statistical and research purposes only. These reports are not maintained permanently in the official files of the State health department. The data that are gathered from these reports are presented in aggregate statistics, not individually, so that specific individuals may not be identified.

Hospitals, clinics, and physicians are assured that extensive legal and administrative measures are used to protect individuals from unauthorized disclosure of personal information contained on the reporting form.

Specific responsibilities

Hospital or clinic

The hospital, clinic, or other institution or facility where the induced abortion is performed is responsible for obtaining the necessary data, completing the form, and filing it with the State registrar within the time period specified by law. To ensure the proper performance of these responsibilities, it is preferable that one staff member be given the overall responsibility and authority to see that the reports are completed and filed on time. Specifically, the hospital, clinic, or other institution should:

- Develop efficient procedures for prompt preparation and filing of the reports.
- Collect and record the information required by the report.
- Prepare a correct and legible report, making certain that every item is completed.
- File the report with the proper official within the time specified in the vital statistics laws of the State.
- Cooperate with State or local registrars concerning queries on report entries.
- Call on the State or local office of vital statistics for advice and assistance when necessary.

Physician

For induced abortions performed in a hospital, clinic, or other institution, the physician performing the abortion is responsible for providing the medical information required by the report. When an induced abortion is performed outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for obtaining all of the necessary data, completing the form, and filing it with the State registrar within the time period specified by law.

Part I. General instructions for completing reports

The data necessary for preparation of the induced termination of pregnancy report are obtained from the:

- Patient
- Attending physician
- Hospital or clinic records

Reports of induced termination of pregnancy are not permanent records and are used only for statistical purposes. However, the data obtained from these reports are very important from both a demographic and a public health viewpoint. Therefore, it is essential that these reports be prepared accurately. These general rules should be followed:

- File the original report with the registrar. Reproductions or duplicates are not acceptable.
- Avoid abbreviations except those recommended in the specific item instruction.
- Spell entries correctly.
- Refer problems not covered in these instructions to the State office of vital statistics.
- Use the current form designated by the State.
- Type all entries whenever possible. Do not use worn typewriter ribbons.
- If a typewriter cannot be used, print legibly in black ink.
- Complete each item following the specific instructions for that item.
- Do not make alterations or erasures.

Part II. Completing the report of induced termination of pregnancy

These instructions pertain to the 1989 revision of the U.S. Standard Report of Induced Termination of Pregnancy.

1–3 PLACE OF TERMINATION

1. FACILITY NAME *(If not clinic or hospital, give address)*

Enter the full name of the hospital or clinic where the induced termination of pregnancy occurred.

If the induced termination of pregnancy occurred in a hospital or a clinic that is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital.

If the induced termination of pregnancy occurred in a freestanding clinic, a clinic that is physically and administratively separate from a hospital, enter the full name of the clinic.

If the induced termination of pregnancy occurred in a physician's office or some other place, enter the number and street name or name of the place.

2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

Enter the name of the city, town, or location where the pregnancy termination occurred.

3. COUNTY OR PREGNANCY TERMINATION

Enter the name of the county where the pregnancy termination occurred.

Item 1 provides information about the types of facilities where induced terminations are performed. Items 2 and 3 provide information that is used in the planning of health facilities and health education programs.

4. PATIENT'S IDENTIFICATION

Enter the hospital, clinic, or other patient identification number. This number must be one that would enable the facility or physician to access the medical file of this patient.

This information is used with Items 1 and 2 for querying for missing information without identifying the patient.

5. AGE LAST BIRTHDAY

Enter the age of the patient in years at her last birthday.

This information permits analysis of health risks related to length of pregnancy and type of procedure among different age groups. It is also used to study the impact of induced terminations on the fertility rates of different age groups.

6. MARRIED?

☐ Yes ☐ No Specify: _____

Check "Yes" if the patient was legally married (including separated) at the time of conception, at the time of termination, or at any time between conception and the termination. Otherwise, check "No."

This information is used to study the health risk of induced terminations by marital status. It also helps determine the impact of induced terminations on the fertility rates of married and unmarried women and aids in planning for and evaluating the effectiveness of family planning programs.

7. DATE OF PREGNANCY TERMINATION (*Month, Day, Year*)

Enter the exact month, day, and year of the pregnancy termination.

The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun. *Exception*: For termination procedures performed by medical (nonsurgical) methods, the date of the termination should be recorded as the actual date the *initial* dosage of the medication was given—not the actual date of termination of pregnancy.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

This information is used to determine when the pregnancy termination occurred and to determine the length of gestation. Length of gestation is an essential element in the study of risks associated with induced terminations.

8a–e RESIDENCE OF PATIENT

The patient's residence is the place where her household is located. This is not necessarily the same as her "home State," "voting residence," "mailing address," or "legal residence." The State, county, and city should be that of the place where the patient actually lives. Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is *not* considered temporary and should be entered as the place of residence of the patient on the report.

If the patient has been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, this facility should be entered as the place of residence.

8a. RESIDENCE—STATE

Enter the name of the State where the patient lives. This may differ from the State in her mailing address. If the patient is not a resident of the United States, enter the name of the country and the name of the unit of government that is the nearest equivalent of a State.

8b. RESIDENCE—COUNTY

Enter the name of the county where the patient lives.

8c. RESIDENCE—CITY, TOWN, OR LOCATION

Enter the name of the city, town, or location where the patient lives. This may differ from the city, town, or location in her mailing address.

8d. RESIDENCE—INSIDE CITY LIMITS? *(Yes or no)*

Enter "Yes" if the location entered in item 8c is incorporated and the patient's residence is inside its boundaries. Otherwise, enter "No."

8e. RESIDENCE—ZIP CODE

Enter the ZIP Code of the place where the patient lives.

These items provide data for the analysis of induced termination by residence of the patient. This information is used with the city and county of termination to provide information on the amount of movement occurring within a State or between States to obtain an induced termination of pregnancy. This type of information is useful in planning the location of health care facilities.

9. OF HISPANIC ORIGIN?

(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ No ☐ Yes Specify: _____

Check "No" or "Yes." If "Yes" is checked, enter the specific Hispanic group as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, Puerto Rico, Cuba, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining Hispanic origin. A patient may report Hispanic origin based on the country

of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry. Although the prompts include the major Hispanic groups of Cuban, Mexican, and Puerto Rican, other Hispanic groups can also be identified in the space provided.

If a patient indicates that she is of multiple Hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a patient indicates that she is Mexican American or Cuban American, enter the Hispanic origin as stated.

This item is not a part of the Race item. A person of Hispanic origin may be of any race. Each question, Race and Hispanic origin, should be asked independently.

Hispanics comprise the second-largest minority in this country. This item provides data to measure differences in pregnancy outcome and variations in health care for people of Hispanic and non-Hispanic origin. Without collection of data on persons of Hispanic origin, it is impossible to obtain valid demographic and health information on this important group of Americans.

Some States may wish to obtain data on other groups or may have a very small Hispanic population. Therefore, they may opt to include a general Ancestry item on their report instead of a specific Hispanic origin item. Instructions for the general Ancestry item follow:

ANCESTRY—Mexican, Puerto Rican, Cuban, African, English, Irish-German, Hmong, etc. *(Specify)*

Enter the ancestry as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For purposes of this item, ancestry refers to the nationality, lineage, or country in which the patient or her ancestors were born before their arrival in the United States. American Indian or Alaskan Native ancestry should be entered as such.

There is no set rule as to how many generations are to be taken into account in determining ancestry. A person may report ancestry based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry.

Some persons may not identify with the foreign birthplace of their ancestors or with a nationality and may report "American." If, after clarification of the intent of this item, the patient still feels that she is an "American," enter "American" on the record.

If a patient indicates that she is of multiple ancestry, enter the ancestry as reported (for example, English-Scottish-Irish, Mexican American).

If she gives a religious group—such as, Jewish, Moslem, or Protestant—ask for the country of origin or nationality.

This item is not a part of the Race item. Both questions, Race and Ancestry, should be asked independently. This means that for certain groups—such as Japanese, Chinese, or Hawaiian—the entry will be the same in both items. The entry should be made in both items even if it is the same. However, an entry of "Black" or "White" should never be recorded in the ancestry item.

10. RACE

☐ American Indian ☐ Black ☐ White

☐ Other *(Specify)* _____

Check the box that describes the race of the patient. The entry in this item should reflect the response of the patient.

If the patient is not American Indian, Black, or White, check "Other" and specify the race on the line provided.

For Asian or Pacific Islanders, enter the national origin of the patient, such as Chinese, Japanese, Korean, Filipino, or Hawaiian.

If the patient is of mixed race, check "Other" and enter both races or origins.

Information on race is needed to study the impact of induced terminations on the birth, fertility, and out-of-wedlock rates of different racial groups.

11. EDUCATION *(Specify only highest grade completed)*

Elementary/Secondary *(0–12)* ____ College *(1–4 or 5+)* ____

Enter the highest number of years of regular schooling completed by the patient in either the space for elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

Count formal schooling. Do not include beauty, barber, trade, business, technical, or other special schools when determining the highest grade completed.

This item is an important indicator of socioeconomic status of the patient. This information is used for studying the effect of induced terminations on the health and fertility of various educational and socioeconomic groups. This information is also useful in planning educational programs that address family planning.

12. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

Enter the exact date (month, day, and year) of the first day of the patient's last normal menstrual period, as obtained from the hospital or clinic record or the patient herself.

Enter the full name of the month—January, February, March, etc. Do not use a number or abbreviation to designate the month.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the patient, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only.

Enter "Unknown" if the date cannot be determined. Do not leave this item blank.

This item is used in conjunction with the date of termination to determine the length of gestation. Gestational age is important in evaluating the effectiveness and safety of the various termination procedures.

13. CLINICAL ESTIMATE OF GESTATION *(Weeks)*

Enter the length of gestation as estimated by the attending physician in completed menstrual weeks. Do not compute this information from the date last normal menses began and date of termination. If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank. *Exception: For termination procedures performed by medical (nonsurgical) methods, gestational age should be recorded as the gestational age of the pregnancy on the actual date the initial dosage of medication was given.*

This item provides a check on the length of gestation as calculated from date of last normal menses. It permits the physician to report an estimate when there is doubt as to the accuracy of the length of gestation or when date of last normal menses is unavailable or misleading.

14a–d PREVIOUS PREGNANCIES (Complete each section)

14a–b LIVE BIRTHS

14a. Now living

Number _____ ☐ None

Enter the number of children born alive to this patient who are still living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are dead.

14b. Now dead

Number _____ ☐ None

Enter the number of children born alive to this patient who are no longer living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are still living.

14c–d OTHER TERMINATIONS

14c. Spontaneous

Number _____ ☐ None

Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. This should not include induced terminations. Check "None" if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

14d. Induced *(Do not include current termination)*

Number _____ ☐ None

Enter the number of previous induced terminations (induced abortions) that this patient has had. Do not include this termination. Check "None" if the patient has had no previous induced terminations.

This information provides a pregnancy history and allows for insight into the use of induced terminations to limit family size. Because this item also collects information on the number of previous induced terminations, it provides some data on characteristics of women who may need alternative methods of family planning.

15. TYPE OF TERMINATION PROCEDURE

(Definitions of certain abortion procedures can be found in Appendix C.)

☐ Suction Curettage

☐ Medical (Nonsurgical), Specify Medication(s) _____

☐ Dilation and Evacuation (D&E)

☐ Intrauterine Instillation (Saline or Prostaglandin)

☐ Sharp Curettage (D&C)

☐ Hysterotomy/Hysterectomy

☐ Other (Specify) _____

Check the box that describes the procedure that actually terminated this pregnancy. Check only one box. If a procedure not listed was used, check "Other" and specify on the line provided.

This item provides information on the frequency of specific procedures and the incidence of terminations involving multiple procedures. When used in conjunction with length of gestation it provides an indication of the safety, appropriateness, and health risks of the various termination procedures at different gestational ages.

16. NAME OF ATTENDING PHYSICIAN *(Type/Print)*

Enter the full name of the attending physician. Be sure to spell it correctly and verify correct spelling. This item is used to query for missing or additional information.

17. NAME OF PERSON COMPLETING REPORT *(Type/Print)*

Enter the full name of the person completing this report.

This is the primary person who is queried for missing information on the report, although the physician is contacted in some instances.

Appendixes

Appendix A

U.S. Standard Report of Induced Termination of Pregnancy

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD
REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

1. FACILITY NAME (If not clinic or hospital, give address)	2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION
Merrywood Clinic	Louisville	Jefferson

4. PATIENT'S IDENTIFICATION	5. AGE LAST BIRTHDAY	6. MARRIED?	7. DATE OF PREGNANCY TERMINATION (Month, Day, Year)
25466	23	☐ YES ☒ NO	November 20, 1997

8a. RESIDENCE-STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. INSIDE CITY LIMITS? (Yes or No)	8e. ZIP CODE
Ohio	Hamilton	Cincinnati	☒ YES ☐ NO	45202

9. OF HISPANIC ORIGIN? (Specify No or Yes – If yes, specify Cuban, Mexican, Puerto Rican, etc.)	10. RACE	11. EDUCATION (Specify only highest grade completed)	
		Elementary/Secondary (0-12)	College (1-4 or 5+)
☐ No ☒ Yes Specify: Puerto Rican	☐ American Indian ☐ Black ☒ White ☐ Other (Specify) _____	12	

12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	13. CLINICAL ESTIMATE OF GESTATION (Weeks)	14. PREVIOUS PREGNANCIES (Complete each section)			
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living	14b. Now Dead	14c. Spontaneous	14d. Induced (Do not include this termination)
September 5, 1997	10 weeks	Number _____ ☒ None	Number _____ ☒ None	Number _____ ☒ None	Number _____ ☒ None

15. TYPE OF TERMINATION PROCEDURE (Check only one)

- ☒ Suction Curettage
- ☐ Medical (Nonsurgical), Specify Medication(s) _____
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- ☐ Sharp Curettage (D&C)
- ☐ Hysterotomy/Hysterectomy
- ☐ Other (Specify) _____

16. NAME OF ATTENDING PHYSICIAN (Type/Print)	17. NAME OF PERSON COMPLETING REPORT (Type/Print)
Edmund Matthew Stone, M.D.	Julia Lynn Koval

7-97R

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR DISEASE CONTROL AND PREVENTION — NATIONAL CENTER FOR HEALTH STATISTICS — 1997 REVISION

PHS-T008
REV. 12/97

Appendix B

Definitions of live birth, fetal death, and induced termination of pregnancy

The following definitions are included in the 1992 revision of the *Model State Vital Statistics Act and Regulations*. The definitions of live birth and fetal death conform to the definitions adopted by the Assembly of the World Health Organization.

Live birth—means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Important—If an infant breathes or shows any other evidence of life after complete delivery, even though it may be only momentary, the birth must be registered as a live birth and a death certificate must also be filed.

Fetal death—means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps.

Induced termination of pregnancy—means 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. This definition excludes management of prolonged retention of products of conception following fetal death.

Appendix C

Definitions of induced abortion procedures

Suction curettage (Also known as vacuum aspiration)—In this procedure the cervical canal is dilated by the successive insertion of instruments of increasing diameter (dilators). When the cervix is sufficiently dilated, a flexible tube (cannula) is inserted into the uterine cavity, and the fetal and placental tissues are then removed using an electric vacuum pump.

Medical (Nonsurgical)—This nonsurgical procedure involves the administration of a medication or medications to induce an abortion. Medications (e.g., methotrexate, mifepristone, misoprostol, etc.) are used most frequently early in the first trimester of pregnancy. However, some medications (e.g., prostaglandin suppositories, injectable prostaglandins, etc.) may be administered during the second trimester of pregnancy to induce abortion. Medications may be administered orally, by injection, or intravaginally.

Dilation and evacuation (D&E)—This procedure, used most frequently in the second trimester of pregnancy (greater than or equal to 13 weeks gestation) involves opening the cervix (dilation) and primarily using sharp instrument techniques, but also suction and other instrumentation such as forceps for evacuation.

Intrauterine instillation (saline or prostaglandin)—This procedure involves either withdrawing a portion of the amniotic fluid from the uterine cavity by a needle inserted through the abdominal wall and replacing this fluid with a concentrated salt solution (known as saline instillation, saline abortion, or saline amniotic fluid exchange) or injecting a prostaglandin—a substance with hormone-like activity—into the uterine cavity through a needle inserted through the abdominal wall (known as intrauterine prostaglandin instillation). The saline instillation process induces labor, which results in the expulsion of the fetus approximately 24 to 48 hours later. The interval between prostaglandin injection and expulsion tends to be shorter than in a saline abortion.

Sharp curettage (D&C) (Also known as dilatation and curettage, D&C, or surgical curettage)—This procedure involves the dilation of the cervix as in the suction curettage procedure, although usually to a larger diameter. The fetal and placental tissues are then removed with a sharp curette.

Hysterotomy/Hysterectomy—Hysterotomy involves surgical entry into the uterus to remove a fetus. Hysterotomy is usually performed only if other abortion procedures fail or if other abortion procedures are not appropriate. Hysterectomy is a procedure in which the uterus is removed (with the fetus inside). It is usually performed only when a pathological condition of the uterus, such as fibroid tumors, warrants its removal or when a woman desires sterilization.

All definitions, except for D&E, are from *Legalized Abortion and the Public Health* (Institute of Medicine, 1975). The definition of D&E is based on NCHS consultation with the Center for Health Promotion and Education, Centers for Disease Control and Prevention.

All other procedures should be shown as "Other" and the specific procedure listed. This category includes procedures using a combination of agents, such as urea and prostaglandin, prostaglandin and oxytocin, or prostaglandin and saline.

For a list of reports published by the National Center for Health Statistics contact:

Data Dissemination Branch
National Center for Health Statistics
Centers for Disease Control and Prevention
6525 Belcrest Road, Room 1064
Hyattsville, MD 20782-2003
(301) 436-8500
Internet: www.cdc.gov/nchswww/

4/24/01

To the Alaska State Legislature:

I strongly support HB 160. All other physicians in Alaska must provide the statistics of their medical practice. In 48 of the other 49 United States, abortion providers must provide the statistics of their practices. Physician accountability is a crucial element in keeping high the national standards of medical care and health. It is important for **all** Alaskan medical providers to participate in providing the statistics of their practices. The passage of HB 160 moves us toward this end.
Please support HB 160.
Thank you,
Susan Yanish
508 Monroe Street
Fairbanks, Alaska 99701
907-456-2488

HB

164

HOUSE COMMITTEE REPORT

(7)
Date Referred to Committee: April 5, 2001 **FURTHER REFERRALS: Finance**

Date of Committee Action: 4.20.01

The JUDICIARY Committee considered: **HB 164**

HOUSE BILL NO. 164 **GRANDPARENTS' RIGHTS REGARDING CINA**

"An Act prescribing the rights of grandparents related to child-in-need-of-aid hearings; and amending Rules 3, 7, 10, 15, and 19, Alaska Child in Need of Aid Rules."

Recommends it be replaced with _____ **CS** HB 164 (JUD) [✓] **Same Title** [ ] **New Title**
*For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR*_____

[ ] attach amendments
[ ] add new referral to _____ Committee
[ ] Letter of Intent _____ _____Committee

List of Abbrev. For Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
HSS
LAA
LAW
LWF
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *For Chief Clerk's Office Use Only				
FN# *	List by Dept(s):	Fiscal	Indet.	Zero

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN #	Fiscal	Indet.	Zero
HSS	1			✓

Signing with recommendations	**Printed Last Name**	**DP**	**DNP**	**NR**	**AM**
	Berkowitz				—
	Meyer	✓			
	Coghill	✓			
	James	✓			
Chair:	Rokeberg	✓			
Chair:					

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 20, 2001

SUBJECT: CINA hearings/grandparents (CSHB 164(JUD), version "F")

TO: Representative Norman Rokeberg
Attn: Heather

FROM: Terri Lauterbach
Legislative Counsel

Enclosed is a JUD CS for HB 164, including the conceptual amendment you requested.

The main language corresponding to the conceptual amendment appears in the new subsection (e) added in sec. 2 of the bill. There is also conforming language added in subsection (d) of sec. 2 ("Except as provided in (e) of this section") and in sec. 1 of the bill ("**and (e)**" is added on page 1, line 8).

If I may be of further assistance, please advise.

TML:jhb
01-074.jhb

Enclosure

Adopted

Conceptual Amendment #1 to CSHB 164 (HES):

If a grandparent has been convicted of a crime against the child or is subject to a court order of No Contact, the department is relieved from the notification requirements.

This language was suggested to be added to section 3, but it is up to the drafter.

Alaska State Legislature

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FAX (907) 694-1015

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- E-mail -
Representative_Fred_Dyson
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REPRESENTATIVE FRED DYSON

HB 164
Sponsor Statement

"An Act relating to Grandparents

Updated: March 30, 2001
Contact: Representative Fred Dyson's office at (907) 465-2199

Grandparents are often the most stable and healthy influence in the life of a child from a troubled family. HB 164 assures that grandparents will have an opportunity to be heard at; Child in Need of Aid (CINA) hearings and custody hearings when the hearings involve their grandchildren.

Over the past couple of sessions the legislature has focused considerable effort on making our child protection and custody procedures more open, responsive and responsible. We have given foster parents more input and the right to be heard in treatment and in placement decisions and have encouraged more efficient placement procedures.

HB 164 will result in more informed decisions about the treatment and placement of Alaska s abused and neglected children. We also believe this measure will increase the likelihood of children being placed with relatives who may not have otherwise been located, heard, or considered.

The bill specifies that, unless the court specifically finds otherwise, the testimony of parents will be given more weight than a grandparents. This approach protects the primary parental interest while specifically allowing a court to defer to a grandparent for good cause.

Because we recognize that there will be cases where a grandparent is not a suitable option for child placement, HB 164 does not mandate that end. Instead, it requires notification of grandparents who care enough to make themselves known, so they can be part of the process if they will. The intended result is to encourage the department and parents to consider grandparents more frequently as a preferred placement option for children in need.

HB 164 Sectional Analysis
Revised: April 2, 2001 LS0693\C

Section 1: Inserts "Grandparents" into the list of those who must receive notice of court proceedings that could result in termination of parental rights and responsibilities in Child in Need of Aid (CINA) cases. "Grandparents" are included with; parent, tribe, foster parent or other out-of-home care provider, guardian, and guardian ad litem.

Section 2: Defines the parameters defining when the department must give notice to grandparents.

- The department must first be aware that a child has a grandparent. The department is not required to search for grandparents, the grandparent must contact the department.
- Grandparent must make the department aware of their current mailing address.

Section 3: Requires grandparent notification for informal hearings related to a custody petition and gives them the right to be heard. The court may limit the testimony and presence of a foster parent or a grandparent if it is in the best interest of the CINA.

Section 4: Requires grandparent notification of a permanency hearing for a CINA child. "Grandparents" are included with; parent, tribe, foster parent or other out-of-home care provider, guardian, and guardian ad litem.

Section 5: Amends court Rule 17(b) that allows grandparents to be heard at disposition hearings. This rule is a section of HB 164 because there is no statute that specifically addresses disposition hearings, therefore it could be argued that the bill doesn't warrant mention in Section 6.

Section 6: Itemizes the court rules changes that result from this bill: Rules 3, 7, 10, 15, 17 and 19 are changed consistent with the changes made by this act and spells out that a 2/3 majority vote is required.

FISCAL NOTE

STATE OF ALASKA
2001 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSHB 164(HES)
(H) Publish Date: 4/5/01

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services
Title: Grandparents' rights regarding CINA.
BRU: Family and Youth Services Mngmt
Component: FYS Management
Sponsor: Rep. Dyson
Requester: House (HES)
Component Number: 2306

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

Check this box (X) if funding for this bill is included in the Governor's FY 2002 budget proposal:

POSITIONS

Full-time	0					
Part-time	0					
Temporary	0					

ANALYSIS: *(Attach a separate page if necessary)*
In its present form, this bill will have no fiscal impact on the Department if enacted.

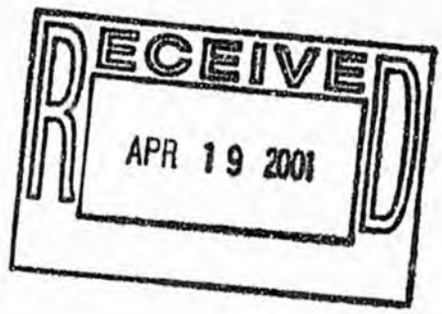
Prepared by: Theresa Tan[illegible]y, Director
Phone 465-3191
Division: Family & Youth Services
Date/Time
Approved by: Elmer A. Lindstrom, Special Assistant
Date 3/26/01 11:44 AM
Agency: Department of Health & Social Services

For distribution information, call the Governor's Legislative Office

(Rev 2/7/2001 OMB)

COMMITTEE COPY

Subject: Grandparents Rights
Date: Thu, 19 Apr 2001 00:44:13 EDT
From: EStroman@aol.com
To: Representative_Norman_Rokeberg@legis.state.ak.us



I am vice president of the Alaska chapter of Grandparents Rights Organization, and I am writing to ask for your support of h.b.164.

There are a great deal of grandparents in Alaska who need your support in the passing of h.b.164 so that they may have the right to get to see their grandchildren.

I have seen time and time again grandparents being denied the right to see their grandchildren because of D.F.Y.S. involvement in the childrens case.

Too many times the grandparents are being denied the right to participate in the placement of children being taken out of a disfunctional family.

Even when the grandparents volunteer to take in the grandchildren, the D.F.Y.S. often disregards their offers because the D.F.Y.S. too often casts blame on grandparents for what the parents have done.

Friday, our grandparents group will have some delegates to participate in the teleconference on h.b.164.

The president of our group, Betty Short, will be in Anchorage for the teleconference, and would be happy to answer any questions you may have regarding our stand on h.b.164.

She will have a few eye opening stories to share with you.

Please give h.b.164 your support as it is our grandchildren that are in need of your help.

Thank you,

Ed Stroman
3224 Linden Dr.
Anchorage, Alaska
estroman@aol.com
907-243-0899 hm. msg.

Alaska State Legislature

APR 25 2001

Please enter into the record my testimony to the House Judiciary
committee name

committee on HB 164 , dated April 20, 2001 .
bill/subject

Please PASS the grandparent's Rights Bill HB164. It is a shame that what should be a logical and resonable action, to allow grandparent's to assist ~~with~~ when their grandchildren come into the system, needs to be defined in our statutes. Let's hope that if this bill becomes law, it will be perform by our legal and social service system and not be pushed aside. Children need love and stability, not isolation, when there is a capable family member is eagerly willing to care (in most cases without costs to the State) for their loved ones. Please pass HB164.

Thank you

Signed: Marei Schmidt
Testifier

Representing (Optional)

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Journal Text

H

05/10/97 House Journal Page 1808
SB 13
Representative Porter brought up reconsideration of the vote on HCS CSSB 13(HES) (page 1781).

The following was again before the House in third reading:

HOUSE CS FOR CS FOR SENATE BILL NO. 13(HES)
"An Act relating to taxes on cigarettes and tobacco products and to the use of the proceeds of those taxes, and increasing by at least 35.5 mills the amount of excise tax levied on each cigarette imported or acquired in the state; and providing for an effective date."

**The presence of Representative Kubina was noted.

Representative Porter placed a call of the House.

**The presence of Representative Therriault was noted.

The call was satisfied.

The question to be reconsidered: "Shall HCS CSSB 13(HES) pass the House?" The roll was taken with the following result:

HCS CSSB 13(HES)--RECONSIDERATION
Third Reading
Final Passage

YEAS: 23 NAYS: 17 EXCUSED: 0 ABSENT: 0

Yeas: Austerman, Berkowitz, Brice, Bunde, Croft, Davies, Davis, Elton, Green, Grussendorf, Hanley, Hudson, Ivan, James, Joule, Kemplen, Kookesh, Kubina, Nicholia, Porter, Rokeberg, Therriault, Williams

Nays: Barnes, Cowdery, Dyson, Foster, Hodgins, Kelly, Kohring, Kott, Martin, Masek, Moses, Mulder, Ogan, Phillips, Ryan, Sanders, Vezey

And so, HCS CSSB 13(HES) passed the House on reconsideration.

05/10/97 House Journal Page 1809
SB 13
Representative Porter moved the effective date clause.

The question being: "Shall the effective date clause be adopted?" The roll was taken with the following result:

HCS CSSB 13(HES)--RECONSIDERATION
Third Reading
Effective Date

YEAS: 26 NAYS: 14 EXCUSED: 0 ABSENT: 0

Yeas: Austerman, Berkowitz, Bunde, Croft, Davies, Davis, Elton, Green, Grussendorf, Hanley, Hudson, Ivan, James, Joule, Kelly, Kemplen, Kookesh, Kubina, Moses, Mulder, Nicholia, Porter, Rokeberg, Therriault, Vezey, Williams

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April 20, 2001

STATE OF ALASKA
Judiciary Committee, Legislative Affairs Agency

Reference: HB 164 "An Act prescribing the rights of grandparents related to child-in-need-of-aid hearings and amending Rules 3, 7, 10, 15, and 19 Alaska Child in Need of Aid Rules."

My name is Sharon Lee Shields, and my granddaughter born to my younger daughter in 1994 is "a-child-in-need." My daughter was and still is a single mother, and the father of my granddaughter was [is] military. The father was transferred out of Alaska when my granddaughter was just over a year old, and has recently been transferred back to Alaska after being absent for almost six years.

In the beginning of my granddaughter's life, my daughter and the military-father stumbled through making an effort at being parents, and depended that I supported them along with my granddaughter physically, financially, and emotionally.

Up to that point, my daughter had only babysat one time in her entire life before having my granddaughter. In her teenage years and as a young adult she didn't have time for children and was impatient around them. So, my granddaughter was born to a mother with a days training in childcare. Currently, my granddaughter has lived through six live-in boyfriend relationships of my daughters.

As time went on I knew my granddaughter was a "child-in-need." So I automatically assumed the position of the absent parents, and became a psychological, emotional, physical and financial parent to my granddaughter, and had my granddaughter 80% of her life up to November 5, 2000. That time is well documented, as it started out as a diary of fun days and events with my granddaughter, and then last May 2000 the diary turned into documentation of horrible physical and mental abuses reported to me by my granddaughter.

My granddaughter reported: May 23, 2000 my daughter slapped her across the face so hard it knocked her off her feet. And because she cried too loud, my daughter ordered her to go to the bathroom until she could quit crying. My granddaughter reported: she lay on the bathroom rug until it quit hurting so badly, and she could quit crying. The next morning when my daughter dropped her off to me again, the big red mark (handprint) was still visible; the next reported incident was that my granddaughter was slugged in the back, over her kidneys by my daughter's sixth live-in boyfriend and the red mark across her kidneys was still on her back the next day after school when she came to my home; food has been withheld from my granddaughter and warm clothing not sent to school when the weather was cold.

During the past seven years, my heart has ached each time my granddaughter, as a small child, was dropped off to my home after spending time with her mother, because she acted out so

dramatically: yelling and screaming at other children, it took a few days for her to calm down, again. Her actions and the sadness in my granddaughter's eyes told me of the results of her stay with mommy.

My daughter has a history of violence, and I had suspicions that she wasn't capable of proving my granddaughter with a loving, nurturing environment. But I had always kept hope.

So there I was: I was a brand new grandmother already with "**a-child-in-need.**" I don't know where the years have gone, but during that time, my granddaughter was provided a normal life because of my elder daughter and her family, and me. As the years passed, it just became natural that my granddaughter was apart of my elder daughter's family and my life and included in our plans: plans for the day, the week, the month, and then the years. Time slipped away, and out of loving and caring, the end result of that time was we gave my granddaughter a normal happy life.

At the time my granddaughter started reporting the abuses, I tried addressing those issues with my daughter because I had knowledge of the way the DFYS system operated and I didn't want my granddaughter dumped into an already non-functioning system. And of course, my daughter threatened me with the system I feared, telling me that I better be careful because I have no rights. And from that time on, when I addressed the abuse issues with my daughter she threatened withholding my granddaughter from me, and also threatened my granddaughter to keep secrets about what went on in her home, or she wouldn't be able to see me, grandma again. My granddaughter became confused, because I had always been the person whom she could confide in and depend on, now I was getting her in trouble.

Then when my granddaughter was dropped off on Monday mornings for the week, she would scold me, in her own young-words telling me how disappointed she was in me getting her in trouble with her mommy, and that she couldn't talk to me anymore mommy told her not to tell Grandma what was going on. Perhaps only an hour would lapse, and she'd tell me what was going on because it hurt her and she needed someone to confide in.

So there I was, my granddaughter's guardian angel, handcuffed by the system. I had all the responsibility of my granddaughter for seven years, but no authority. And a daughter very well versed in the fact that I had no rights.

Last year, I took my granddaughter to school almost everyday and volunteered in the classroom at least three times a week. I even got a volunteer award. My elder daughter and I baked cookies for every child who graduated in all the kindergarten classes at Tanaina Elementary School. My granddaughter was one of the top students in her classroom, and she looked forward to and depended on me participating in her learning and her life.

On November 5, 2000, the reports of abuse from my granddaughter got so bad, and the father who had returned to Alaska in August 2000 would do nothing after many pleas for his help from many outside people. He didn't want to get involved, he said. So, I was forced to address this issue with my daughter, knowing how risky it was and the consequences, but I couldn't ignore my granddaughter's pleas for help, seeing her desperation, and knowing her helplessness.

On November 5, 2000, I tried to do an intervention with my daughter. After repeated attempts to sit down and talk with her to no avail. I finally demanded that she meet with me. But the intervention blew-up in my face. She brought the father, and a friend of hers from the Social

Services Department on a Sunday, and their showing up was just an elaborate scheme to squelch any of my efforts to resolve this, and to protect my granddaughter. The Social Service worker, and the father threatened me: Told me to keep my mouth shut. I recorded the intervention and had it transcribed by a court reporter because it proved negligence by both parents and the Social Services worker.

The consequence of my efforts was that my granddaughter was taken out of my life. Immediately, the parents went to the school and revoked all my volunteer privileges, and access to any of the classrooms, and I have not been allowed access to volunteering since that date. I have not allowed me to see or talk to my granddaughter since December 3, 2000, when I was allowed to see her 6 hours. My granddaughter was frantic then, I can't imagine how she is doing now.

Back when my granddaughter started talking, and my daughter would come to take her for the weekend or day, my granddaughter always asked me and made sure by asking me when she was coming back to my house. Now, I can't talk to her on the phone; she can't come to my home; she can't spend the night with me; I can't volunteer in her classroom, all because I tried to protect her. That's not even the beginning: my granddaughter cannot see anyone whom she depended on and loves: her aunt uncle, or new cousin. We, her family, have not been allowed by the parents to have a Thanksgiving, Christmas, celebrated her birthday, or Valentines Day with my granddaughter.

This is not a normal life for my granddaughter. My granddaughter's life has been turned upside down by the parents and they could care less for my granddaughter's welfare or feelings as long as they have control over the family.

My daughter works for the system and lives in the Valley. Palmer/Wasilla is a small community, and my daughter has many friends within the social services departments in the Valley and she has been given confidential information about my contacts with the DFYS in the Valley. That fact alone has been the most damaging factor in my efforts to see and protect my granddaughter.

As so many grandparents have discussed in our Grandparents Rights Organization (GRO), the most hopeless and helpless feeling in the world, after loving, caring and nurturing our grandchildren, is when we are forced by our abusive children to go to the system for help and the response is **ALWAYS**: if the child is not in immediate danger right at that very moment, they tell us the child is safe. Meaning that the child is not in an emergency room with internal damages or broken limbs, or in a morgue waiting to be identified at the time of reporting the abuse, because, "the child is not in immediate danger."

I still struggle with the system, and the parents to see my granddaughter whom I have not seen in 5 months, now. I can't even think about what she's gone and going through. But, according to law, I have no rights to know that.

HB 164 is the beginning effort that should be made in securing rights for Grandparents who have been active in raising their grandchildren, or would like to have the opportunity to know what is happening to their grandchildren. Since when did the family unit not include Grandparents? We are sick of being looked upon as the reason our children, the parents, are the way they are, because that is just not the truth. The majority of Grandparents in our group are educated, loving, and caring people who have loved their children and now their grandchildren. What we

see as the beginning problem was that we were there too much for our children, and supported them and given them too much, and we haven't expected any thing in return for our efforts. We are horrified and bewildered that our children could do this to us and to their own children.

At the least, Grandparents should have the right to raise, or **continue** to raise their grandchildren, and should have knowledge that our grandchildren are "children-in-need-of-aid" and not have them put into foster homes. To me, that would only be common sense.

I understand that morals, scruples, and common sense can't be legislated, but it's time that they are factored in when legislating laws about human beings, "our grandchildren." Remember these grandchildren could be one of yours in another state or another town, and the truth about their welfare withheld from you. I don't know one of you here today who wouldn't want to know that your grandchild was being placed in a foster home by DFYS just so they could get its quota of "child numbers" for state and federal funds.

Go home tonight and look at your grandchildren, or call them on the phone, and when you hear their small voices know that they could be placed in a foster home by DFYS, without your knowledge, or even the system obligated to notify you that your grandchildren are in the system. When DFYS placed little Steven Murray in a foster home, he didn't have a voice, and now he's dead.

Officials from agency level people all the way to Commissioner Karen Purdue know exactly what is going on with my granddaughter, and do nothing because she's only a "Priority 3 case." Well I'm here to tell everyone that my granddaughter is and always has been a "Priority 1 case" with me.

It's time to move DFYS, its rules, and its budge out of the way, gather our morals, scruples, and common sense and put grandparents back into the family picture. Would we have so many children in the system? Would we have so much violence in schools? Would we have the number of school shootings if our children and grandchildren had real families to go home to?

I pray for all our children and grandchildren that we begin to move back to the family unit, and HB 164 will be a step in that direction.

Sincerely,

Sharon Lee Shields

Sharon Lee Shields

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Referencing article Gleason and foster care in Alaska

Letter to the Editor

It's time Alaskans deal with a major reason for the broken-down family structure, which certainly leads to school violence. It's time to move DFYS, its budget, and its drive for numbers (children) out of the way of what is in the best interest of the child[ren]. Foster care is big business in Alaska. A money deal that leaves all family members, including grandparents out of the decision making process when it comes to placing "a child in need of assistance." And believe me tragedies like this happens to the best of families.

There is an upper income, well established couple in Juneau. The woman has a documented history of violence toward children, her own step-children, with police reports, and court proceedings. Astoundingly, shortly after the court proceeding that couple went out and got a foster care license.

The point being made is: Under the current laws DFYS has the right to place your family member or grandchild[ren] who is "in need of assistance" in that foster home or another one just like it, and they are under no obligation to notify or place that child[ren]with family.

Grandparents: The state of Alaska DFYS will place your grandchild[ren] in a foster home and you have no rights whatsoever to your grandchild, either at the time of placement or even after you find out that your grandchildren have been placed and you try to get them out of foster care, and back into your family unit. Under the current laws "family" has no rights to our children and grandchildren. DFYS has a vested interest in keeping your family in the system. Know the facts. Call your representatives immediately and tell them to support HB 164.

Sharon Lee Shields
Palmer, Alaska