feminists for life of america
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SISTERLIFE

march 1984

THIS ISSUE: GIVING AN EAR TO THE CRITICS OF *IN A DIFFERENT VOICE*

A glance will tell you that this newsletter is dominated by three reviews of the same book, Carol Gilligan's In A Different Voice (Cambridge: Harvard University Press, 1982). In January Ms. magazine named her "Ms. Woman of the Year" for her work on psychological theory and women's moral development.

It's been suggested that Gilligan's In A Different Voice may be for the eighties what Betty Friedan's The Feminine Mystique was for the sixties. We'll see.

The debate on her theories is just getting going and we're excited to jump in with articles from Nancy Koster, Rosemary Bottcher and Wanda Franz reprinted with permission from the February 23 National Right to Life News.

(NRL News is published twice monthly. Subscriptions $15 to: NRL News, Suite 402, 419 - 7th Street NW, Washington, DC 20004.)

GREAT THANKS

We couldn't be more grateful to members and supporters who responded so generously to our desperate December plea for donations and renewals. The notes of encouragement were also appreciated. Thank you all.

FFL TO CAUCUS AT NRL CONVENTION

We plan to hold a FFL caucus at the National Right to Life convention again this year and will be sponsoring a booth featuring information on pro-life feminism. The NRL convention will be held June 7-9 in Kansas City and is featuring the theme: "Bringing Life to the Heart of America...Bringing the Heart of America to Life."

Convention information: NRL Convention '84, P. O. Box 876, Lee's Summit, MO, 64063; (816) 444-4211.

SPEAKERS NEEDED

Pro-life feminist speakers are urgently needed to fill speaking engagements. If you are able and willing to do this, please contact the national address. We've had numerous recent requests that have gone unfilled. It is essential that we develop a speakers bureau to meet these requests. Please consider.

AS WE WENT TO PRESS: PENNSYLVANIA COURT RULES ON ERA AND ABORTION--PAGE 2

COURT RULES THAT ERA REQUIRES FUNDING OF ELECTIVE ABORTIONS

A Pennsylvania court ruled March 9 that the state's Equal Rights Amendment requires Medicaid funding of abortion on demand--a ruling which will have a major impact on prospects for approval of the proposed federal ERA and had an immediate effect in Minnesota where sponsors of a proposed state ERA withdrew the bill in the legislature upon hearing of the Pennsylvania decision.

The ruling came in a lawsuit (Fischer v. Commonwealth of Pennsylvania) filed by Planned Parenthood of Southeastern Pennsylvania and other pro-abortion plantiffs, who argued that the Pennsylvania laws limiting Medicaid funding of abortion to cases of rape, incest, and life endangerment to the mother was a form of "sex discrimination" and thus violated the Pennsylvania ERA (which was enacted in 1971). Legal counsel was provided by the American Civil Liberties Foundation of Pennsylvania, the Women's Law Project, and a number of law professors.

In the March 9 ruling, Judge John MacPhail of the Commonwealth Court in Harrisburg (the court immediately below the state supreme court) accepted the argument that restrictions on abortion are inconsistent with an ERA.

The court said that the ERA/abortion argument "is meritorious and sufficent in and of itself to invalidate the statutes before us in that those statutes do unlawfully discriminate against women with respect to a physical condition unique to women."

Fearful that the proposed federal ERA will be used in the same manner to secure federal funding of abortion, pro-life groups have supported an "abortion-neutralization" amendment to the ERA which states, "Nothing in this Article [the ERA] shall be construed to grant or secure any right relating to abortion or the funding thereof."

The Pennsylvania ERA reads, "Equality of rights under the law shall not be denied or abridged in the Commonwealth of Pennsylvania because of the sex of the individual."

FFL ELECTIONS THIS YEAR

It is not too early to be thinking about new officers to be elected in the fall as the current two-year terms are nearly over. The next newsletter will call for nominations. Anyone needing information on any of the offices to help them in their considerations is encouraged to write us.

IN THE TRUTH-IS-STRANGER-THAN-FICTION DEPARTMENT

A March 2 article in the Minneapolis Star and Tribune reported on a new organization formed to bring issues important to women to the forefront of the 1984 elections. The group has named itself the Gender Gap Coalition and the story featured quotes from co-chair Sue Rockne (who has, it seems, co-chaired more "new" feminist groups in Minnesota than any other single individual). The last two paragraphs of the Tribune report are reprinted here in their entirety:

The coalition is prochoice on the abortion issue and favors federal funding of organizations such as Planned Parenthood. "Women have the right to choose whether or not you will have 6 or 1 child, and when," Rockne said. "That is an economic issue."

Finally, she said, the Gender Gap Coalition will work to cut defense spending and for a nuclear freeze. "We do not wish to have our children sent off to die," she said.

LOVERS OF THE ABSURD TAKE HEART

By Nancy Koster

"I smoke for my health," wrote physician Frank Oski in a 1979 **New York Times** opinion piece. He reasoned that smoking made him cough, preventing pneumonia; it made his heart go faster, eliminating need for exercise; and it curbed his appetite, keeping him thin.

Oski no longer smokes for his health. After suffering a heart attack, he has recanted in another **Times** article. But, lovers of the absurd, take heart. Harvard psychology professor Carol Gilligan will tell you how having abortions promotes women's moral development.

In her book **In A Different Voice,** Gilligan argues that men and women think differently, and that because female thought patterns and ways of reaching moral decisions do not square with males' they have been characterized as abnormal or immature in traditional theories of developmental psychology.

So far, so good. Women are different from men (although it's seldom said aloud by Harvard professors), and different doesn't mean inferior. It also may be true, as Gilligan postulates, that men think in terms of separateness and autonomy and are threatened by intimacy, while women are grounded in connections, protective of relationships and afraid of isolation. After all, since Mother Nature chose women to bear children, it would have been rather short-sighted of her not to have endowed them with the nuturing instincts Gilligan describes.

One might think, then, that Gilligan would view abortion -- a unilateral decision deliberately to shatter the most intimate human bond possible -- as inconsistent with women's nature. On the contrary: she sees choosing abortion as a necessary, responsible-maybe even loving -- act.

Gilligan does not openly proselytize for abortion. In fact, she takes pains to assure her reader that abortion was not an issue in her research, but rather that she studied the "abortion decision" to see how women "think about dilemmas in their lives . . ." But why? Millions of women wouldn't consider aborting under any circumstances, and another contingent will never be pregnant in the first place. So how can the 29 women Gilligan selects to interview (referred by abortion facilities, many of them multiple aborters) possibly reflect the way women think about moral problems?

They can't, especially when only four choose to continue their pregnancies and Gilligan virtually ignores their decision-making processes. Her disclaimer that she did not try to find a sample representative of all women does not negate the fact that her sample is not representative. And, her protestations to the contrary, the book is very much about abortion. One wonders how those heaping praise on it can ignore the fact that many of her conclusions are diametrically opposed to her premises.

For example, there's her repeated assertion that women seek to solve problems in a way that won't hurt anyone and that they are guided by an "ethic of care." Abortion unarguably hurts the unborn child, and while "to care" could have many definitions, at the very least it ought to mean not to deliberately take the life of another human being.

In Gilligan's lexicon, it seems to mean exactly the opposite; that choosing abortion -- for the "right" reasons — is an expression of caring and maturity. Illustrative is her description of Sarah, 25, who "finds a way to reconcile the initially disparate concepts of selfishness and responsibility through a transformed understanding of relationships."

Sarah had her first abortion as "a purging expression of her anger at having been rejected" by her lover. Determined to "take control of my life," she nevertheless became pregnant again when the same man reappeared and she "left my diaphragm in the drawer." Initially "ecstatic" about the pregnancy, Sarah lost her enthusiasm when her lover said he'd leave her again if she had the baby. Viewing the first abortion as "an honest mistake," she was reluctant to keep appointments for the second because it would make her feel "like a walking

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slaughterhouse."

Gilligan says that to choose "between the two evils of hurting herself or ending the incipient life of the child, Sarah reconstructs the dilemma in a way that yields a new priority which allows decision." She begins to develop a concept of "self worth" and to include obligations to herself in her definition of responsibility.

"Instead of doing what I want for myself and feeling guilty over how selfish I am, you realize that that is a very usual way for people to live," Sarah says, "doing what you want to do because you feel that your wants and your needs are important, if to no one else, then to you, and **that's reason enough** to do something that you want to do" (emphasis added).

From this Gilligan reaches the astounding conclusion that "Once obligation extends to include the self as well as others, the disparity between selfishness and responsibilty dissolves." Thus Sarah can say, "This is a life that I have taken, a conscious decision to terminate, and that is just very heavy, a very heavy thing." By exercising her power to choose and accepting "responsibility" for that choice, she is "caring" for everyone involved (although it's not clear how the baby benefits).

Thus released from the "intimidation of inequality," Gilligan says women can enunciate "a morality disentangled from constraints that formerly confused its perception and impeded its articulation . . . Responsibilty for care then includes both self and other, and the injunction not to hurt, freed from conventional constraints, sustains the ideal of care while focusing on the reality of choice."

Translated from the Gilligook, it might go something like this: Sarah had the first abortion out of an instinct for self-preservation; she has qualms about the second but overcomes her guilt by asserting that she owes it to herself -- it will "pay off for me personally in the long run." Although she recognizes that she is taking a life, she has exercised the power to choose and has taken "responsibility" for that choice, thus showing increasing maturity.

This fits nicely with Gilligan's construct of how women's moral development progresses. On the most primitive level, they do something because it will benefit them; on the next level, selfishness is superseded by consideration of needs other than one's own (Gilligan sees women fulfilling traditionally feminine roles centered on "self sacrifice" and "virtue" as operating on this level); but on the most mature plane, women realize they have responsibilities to themselves equal to their obligations to others, and this enables them to make choices.

In practice, level three shakes out to be pretty much the same as level one dressed in educationese and psychobabble.

There used to be a perfectly good word for finding lots of reasons to do what you wanted to do in the first place; rationalization. It's an innately human skill, and Gilligan's interviewees are masters at it. One says she doesn't believe in abortion but fears the damage having a child will inflict on her lover and his wife. Another says she knows abortion takes a life, but her life and that of her husband and son are more important. Others say they must abort to avoid hurting their parents or their careers. And, in the `piece de resistance´, a few insist that what they really want is to have the baby, but since that would be selfish, they will have abortions!

This is not to say that women with untimely pregnancies do not face tragic dilemmas where either choice will cause suffering. But to transform their rationalizations and what used to be called situation ethics into evidence of moral maturity is pure sophistry.

Or try the logic test on this one: Gilligan contrasts Abraham who is "prepared to sacrifice the life of his son in order to demonstrate the integrity and supremacy of his faith" with the woman "who comes before Solomon and verifies her motherhood by relinquishing truth in

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truth in order to save the life of her child." Yet she is perfectly comfortable with an ethic in which women repudiate their motherhood by ignoring truth in order to take the lives of their children.

One feels deeply saddened for the women Gilligan interviews. Most are being used by men who abandon them when their pregnancies make them unusable. Many have been pressured into earlier abortions by irate lovers or embarrassed parents. Others see no support in the social system for a woman dependent because of a child's dependence on her.

Yet they matter-of-factly recognize that the unborn child is a living human being to whom they are connected in a unique and profound way. By Gilligan's own lights, rupturing that connection must surely lead to pain that cannot be eased merely by contending that its cause was freely chosen.

One might even feel a pang for the professor herself. She says her aim is to establish that although men and women think differently, neither is superior. But she seems not really to believe it. Throughout the book she points to dichotomies she perceives between femininity and adulthood, compassion and autonomy, virtue and power. Women of course, have been exemplified by the former, men by the latter. But by exercising the one choice uniquely theirs -- to end the life of another human being -- women can become adult, autonomous and powerful; in other words, like men.

It's too bad that this book should appear when "second stage" feminism has begun to suggest that, just possibly, women do not have to be pseudo-men to gain equality. It's also too bad that when the need is so great to examine how all of us, men and women, reach decisions on vital bioethical issues, someone of Gilligan's stature, bowing to the Great God **Choice**, should insist that the act of choosing is all important, regardless of **what** is chosen.

But worst of all is wondering what equivalent to Dr. Oski's heart attack will be necessary before women like Carol Gilligan realize the extent of the damage being caused by their self-deceptions.

Nancy Koster is editor of the Minnesota Citizens Concerned for Life Newsletter.

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KILLING AS CARING

By Rosemary Bottcher

Hold your noses, ladies and gentlemen! The third wave of feminism is breaking, with far less fury but just as much foam as the first two. Poised on the crest of this low energy wave rides the new standard revised feminist Carol Gilligan, recklessly perched on a dangerously insubstantial surfboard: her "revolutionary" little book, **In a Different Voice.**

The "Different Voice" to which Ms. Gilligan refers is that of many women: she has discovered that women's voices are of a timber different than those of men. (Just like Phyllis and Jerry said.)

Men, according to Ms. Gilligan, tend to view the world in terms of their autonomy while women tend to view it in terms of their connection to others. Men are egocentric; women see themselves as part of a great interdependent web of life. Men are interested in rights; they perceive morality as a matter of respecting the rights of others and define moral conflict as competition among rights. Women, on the other hand, are more interested in responsibility. They see morality as taking care not to hurt others, and they define moral conflict as a problem of deciding which course of action will be the least hurtful. Men are confident that, given the facts, all reasonable people will agree on the proper solution for a given moral dilemma, while women believe that "it all depends;" they practice situational ethics. Men believe in moral absolutes; women believe that there exist Many Truths.

Because men have so long dominated the disciplines of pyschology and philosophy, the male view has been regarded as the correct one, and the female view dismissed as arrested and immature, evidence of a failure of development. Ms. Gilligan rightly challenges this assumption of male superiority. She insists that both kinds of understanding -- male and female -- have value. One is not better than the other; they are different but equal.

Because the adult world of intellectual activity has been almost exclusively a male world, girls soon come to believe that their world view is flawed; they begin to lose confidence in their perceptions, and, tragically, in themselves. Because of this failure of confidence, women are reluctant to speak up and make their voices heard, so the human community is deprived of the wisdom of these voices.

Judging from the rave reviews granted Ms. Gilligan's book (albeit by those women's movement groupies who tend to rave at the most insignificant stimulus), one would think that all this were an original idea. It's not exactly. More mellow feminists have been saying pretty much the same thing for years.

Groups such as Feminists for Life (motto: We are homemakers, and the world is our home) suggested, long before Ms. Gilligan wrote her book, that the world does not need women who are more like men; it desperately needs men who are more like women. One of the stated goals of Feminists for Life has been to help more men realize that the traits of loving, caring and nuturing should not be considered evidence of weakness because they have been traditionally associated with women; they are immensely valuable traits that should be recognized as strengths in any human being.

Unfortunately, Ms. Gilligan's fairly agreeable point -- that "female" morality of responsibility and care has merit and deserves consideration -- utterly self-destructs in the second section of her book. The irony is incredible. Ms. Gilligan attempts to prove her thesis by examining how women reach the decision to abort.

Twenty-nine women were interviewed twice, first during the time they were making the decision and again at the end of the following year. Ms. Gilligan concludes from these interviews that women define the moral problem of abortion as "one of obligation to exercise care and avoid hurt. The inflicting of hurt is considered selfish and immoral in its reflection of unconcern, while the expression of care is seen as the fulfillment of moral responsibilty."

This ethic of care "evolves around a

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central insight, that self and other are interdependent" and recognizes that "the incidence of violence is in the end destructive to us all, so the activity of care enhances both others and self . . . the abortion decision affirms both femininity and adulthood in its integration of care and responsibilty."

The abortion decision presents an opportunity for growth by reminding women that the injunction against hurting can include themselves, and they are "able to assert a moral equality between self and other and to include both in the compass of care." Abortion, by "provoking a confrontation with choice" encourages women to "claim the power to choose and accept responsibility for choice." She concludes that "the abortion study demonstrates the centrality of the concepts of responsibility and care in women's constructions of the moral domain" and that "compassion and tolerance repeatedly . . . distinguish the moral judgements of women."

One would never guess from Ms. Gilligan's discussion that abortion is one of the most volatile, flammable, even explosive issues of the century. We are given not a clue. Ms. Gilligan is as calm as the eye of a hurricane, and the eye is blind. She seems blissfully unaware of the heartbreaking irony of her total failure to consider the responsibility and care that women owe to their unborn children and of the enormous, irremediable hurt that the decision to abort always inflicts upon these children. Although she claims that women's unique talent is their awareness of the interdependence of lives, and their special virtue is the seeking to include everyone in a great web of mutual care and responsibility, she herself has arbitrarily excluded the unborn child from her circle of concern.

This is not simply a failure of understanding. Gilligan herself repeatedly refers to the pregnancies in terms of "baby" and "child" and the women she interviewed frequently referred to abortion as ending a life, "killing" and even "murder." These women obviously have an inkling.

Ms. Gilligan defines the abortion dilemma as an "issue of justification for taking a life." The aborters see their choice as one of "choosing the victim." Parents and lovers are frequently mentioned as "significant others" who would be harmed were the child to live, even though "the sacrifice of the fetus compromises the altruism of an abortion motivated by concern for others." These women further justify the "sacrifice" of abortion by presenting it as a conflict between morality and their own survival. "I felt very much to save my own life I had to do it," and "I am concerned with my survival first, as opposed to the survival of the relationship or the survival of the child, another human being . . . I am setting my needs to survive first."

Understandably, this posture causes considerable confusion: "I am saying that abortion is morally wrong, but the situation is right and I am going to do it. But . . . eventually they are going to have to go together. I'm going to have to put them together somehow." Asked how this could be done, she replies, "I would have to change morally wrong to morally right."

During the second interview, in the year following the abortion, many women reported a sense of loss, grief, sorrow and even mourning. The decision to abort was rationalized not only as essential to the woman's survival, but as an act of kindness for the child as well; "I am sure I did the right thing. It would have been hell for that poor kid and me too."

But an uneasy ambivalence continues to nag: "The reasons just don't fill up the whole . . . there is just something that happens when you put it all together that is not there when you take it apart and try to put it together and I don't know what that is." In thinking of her two abortions this women says, "If someday I have three children I will also feel that I have three children and two others not with us right now. I have five and here

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are three of them."

There is clearly great anguish involved in the abortion decision, but because most of the women interviewed eventually came to believe that their lives had imporved after the abortion, Ms. Gilligan concludes that abortion itself was a positive experience, a catalyst for moral growth.

Even though Ms. Gilligan and I are both women, my interpretation of the interviews and my judgement of the moral maturity of her subjects is vastly different from hers. Where she sees careful reflection, altruistic sacrifice, self-realization, assertiveness and moral growth, I see irrationality, narcissistic cowardice, self-deception, confusion and moral incoherence.

Ms. Gilligan never entertains the possibility that the reason the women are so distressed is that abortion is morally wrong, and they know this is true.

Their convoluted rationalizations to justify the evil are pathetic but fatuous; for example, nearly all the women described abortion as an act of self-defense, essential to their survival, when in fact the risk was only to their lifestyles, not their lives, and the survival they sought was for relationships, education, jobs, reputations, the status quo -- certainly not survival in the literal sense.

If these women had actually reasoned in the manner suggested by Ms. Gilligan's hypothesis, if they had really taken the grand view and tried to act in a way that would cause the least hurt, I think that they would have let their babies live and perhaps relinquished them for adoption. This choice would have spared the child's life and brought much happiness to the lives of one of the millions of childless couples in this country. By Ms. Gilligan's own definition, that would have been the most morally correct choice. Expedience was the standard for the abortion decision, not morality.

I suspect that Ms. Gilligan's theory is becoming so popular (she is **Ms.'** Woman of the Year) because it justifies muddled thinking, ambivalence, passivity and cowardice by reclassifying these traits as "a reluctance to hurt." Such a judicious definition of "hurt" allows one to "make morally right that which is morally wrong."

It is uncanny how closely Ms. Gilligan's description of the minds of women matches all the old stereotypes that feminists have been battling so long: women as irrational, emotional, intuitive, passive and dependent. She recommends replacing the double standard with what amounts to one standard for men and none for women. If women are incapable of the crisp, elegant logic that we admire in men, we will just have to excuse them. Women often fail to distinguish the difference between right and wrong, good and bad, in the way that men do, so long as women mean well, we'll give them credit for being good. Sort of a social promotion.

Ms. Gilligan did not explain the reasons for the differences in male and female viewpoints. For example, is it rearing, education, diet, hormones? Is there any hope of evolving an androgynous standard or morality upon which we can all agree and by which we can all be judged? Or are we forever condemned to the company of macho men and wishy-washy women?

Also, are Ms. Gilligan's women capable of maturing enough to admit that which they already know, that abortion hurts children and unravels that web of interdependent life which they hold so dear? We'll see what treasures the next wave brings.

Rosemary Bottcher is a chemist and a member of Feminists for Life.

IN AN IMMATURE VOICE: THE CASE OF CAROL GILLIGAN

By Wanda Franz, PH.D.

Professor Gilligan's ideas are dangerous because they give academic credibility to a philosophy of selfish hedonism which lends support to the abortion mentality. It might be hoped that the impact of the book would be limited by the incredibly ponderous style. However, the abortion proponents are so hungry for academic support, this book will undoubtedly be used to support policy far beyond what is merited by its academic value.

Gilligan's attack is aimed principally at Lawrence Kohlberg's analysis of the moral reasoning of boys as they mature into adulthood. In critiquing Kohlberg, Gilligan errs on two levels. First of all, she interprets Kohlberg incorrectly. Second, she applies her view with a feminist bias which seriously distorts the data and raises questions about her conclusions.

Kohlberg's research confirms Jean Piaget's original formulation of a 3-stage developmental process. The stages are defined as: 1) egocentric (moral decisions are based on self-involvement), 2) social (moral decisions are based on awareness of social others), and 3) principled (moral decisions are based on univer-sal concepts of justice).

Kohlberg's analysis of moral reasoning and decision-making in males is the basis for much of our understanding of moral development, and it has been extremely influential. However, researchers frequently observe that young women respond to moral dilemmas at the level of "social awareness," at an age when young men are moving into the "principled level." Gilligan attacks these findings as unfair because, she argues, Kohlberg is using male standards to judge women who reason differently; women use a "different voice."

This contention is based on a series of four small studies which evaluate the moral reasoning of women. None of these is discussed in this book in a way that would make it possible to evaluate the methodology. For only two of the studies is there even an attempt made to present the methodology. Thus, the academic credibility of this work is very weak.

Data from the "college student study" and the "rights and responsibilities study" is entirely anecdotal. The "images of violence study" used a group of adult men and women in a "motivational class." The context of the class and the reasons for the attendance are never explained. The entire study consists of 51 men and 50 women, all of whom may be professionals (although this is never stated). The findings indicate that men see violence in settings of close human relationship, whereas women see violence in settings of individual accomplishment and achievement. From this, Gilligan argues that the women are threatened by separation and isolation, and fear a loss of "connectedness" with others.

The implications are that women are naturally oriented toward these types of fears and that these represent universal patterns for all womanhood. However it is equally likely that these women are affected by real circumstances of vulnerability and that their responses are culturally conditioned. This is particularly likely since the research subjects were all attending a class on "motivation." Gilligan's inferences are simply not supportable by the findings she presents.

Her data on the "abortion-decision study" go beyond being unsupportable to being truly ludicrous. Her sample consists of 29 pregnant women between the ages of 15 and 33 years of age who have been referred to a special counseling facility under circumstances of extreme conflict. In order to be referred, they had to demonstrate great difficulty with the abortion decision or they had to have had repeat abortions, suggesting possible psychological problems. To use 29 women as the basis for generalizing to women as a class is inexcusable for a competent researcher.

However, in addition, this particular sample is hardly representative of American women. While no exact data are given, there are at least six teenagers

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who failed to use contraception, four of the women are in their 20's and 30's and pregnant by their married lovers. Only one woman is identified as married. Religion is never mentioned except in two cases, where the women claimed to be Catholics.

A couple of the women are seeking second abortions of children fathered by the same man. A few additional subjects are seeking second abortions by different partners. To argue that these women are capable of adequate decision-making is absurd. Had Kohlberg used such a sample, he would have been laughed out of the profession. Their statements are full of pathology, self-hatred, and guilt.

Twenty-one of these women choose abortion as the "right" solution. it is quite clear that this book is intended to support such decisions and help to prevent women from being condemned by society (men in particular) when they "choose" abortion.

Gilligan's methods for defining the new stages are equally suspect. She simply asserts that women's answers are of a higher level than Kohlberg claims. She never provides an outside test of actual competency that would help us to know whether the women in her studies really **are** functioning at higher levels.

Furthermore, she never provides a systematic developmental structure that includes the range and type of answers that will qualify a person for each stage. Indeed, the answers the women give look very much like stage 2 answers; and I cannot see why we should up-grade them without some evidence to support the change.

Gilligan's most talked-about contention is that Kohlberg's stage system of moral development doesn't apply to women: men and women think differently and reason differently about moral issues. In particular, Gilligan argues that the stage 3 level of principles is uniquely male.

This stage three male concept of justice is based on the principle of equality in which individuals are viewed as separate, aggressive, and as unique

entities, whose rights can be balanced on a scale of justice weighted by rules, at the expense, we're told, of valuing human relationships. Her thesis is that women do not view themselves as separate entities, but as units, which are always locked in relationship to others.

Therefore, the woman is not able to see justice in terms of weighing rights, but, rather, in terms of caring for others and avoiding pain. For women the ultimate value is an "ethic of care." The "principled" level simply cannot account for women's way of reasoning.

She is clearly wrong in asserting that women don't tend to use principles. Even Gilligan herself uses them. For example she uses the principle of "contextualism," arguing that all decisions must take into account the context. In the abortion decision, this is devastating because the social context is much more meaningful and powerful than the implicit right of the unborn child to life. A couple of her subjects state that they did the "loving thing" for everyone else in their lives by destroying the child.

There is very compelling evidence that for women the process of reasoning may be different. Women do tend to be "field dependent," that is, they are more apt to evaluate visual events in terms of themselves; they tend to use their own body as a reference for resolving visual conflicts. They are more apt to see the "global" or big picture, and they do tend to synthesize ideas, by pulling separate segments together.

Men, on the other hand, are "field independent," that is, they are capable of evaluating visual events independent of their own bodies. They tend to think abstractly by separating out the elements of the whole and evaluating independent events. It is quite likely that they approach moral problems in different ways.

Gilligan could have reasonably argued that all people go through similar moral stages but that modes of reasoning at each level could be different. She could have argued that both men and women

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function at the principled level but emphasize different principles. But she does neither of these.

Instead, she argues that for men to mature, they must learn to accept human relationships as an enhancement of identity and give up their heavy reliance on their self needs. Women's maturity comes in realizing that the standard of care they apply to others must also be applied to themselves, thus engaging in "enlightened self interest." The interesting paradox occurs here in that, mature men must set aside self-interest, but mature women may embrace it whole-heartedly.

This attitude clearly explains the ability today of many feminists who condemn male sexual exploits but simultaneously offer women the "option" of extramarital affairs. The same actions in men condemned by the traditional morality, suddenly become "maturing experiences" for women. Are we not behaving in a condescending way to allow women to act out their worst behavior patterns without condemning them as we would men? We as a society appear to be saying that we don't --perhaps cannot -- expect any better from women.

Gilligan cannot maintain a consistent theoretical or moral frame of reference because her feminist bias appears to force certain conclusions on her. For example, if women see themselves as connected to others in a holisitic way, how can they argue for hurting their husbands by having an "affair." Or how could they argue for abortion of the child to whom they have the greatest "connection."

This paradox can be understood by realizing that Gilligan's underlying concern is not with connectedness but with concreteness. She focuses on the concrete human relationships and denigrates abstractions as the formulation of the rational, "principled" male. But this is a total distortion of the concept of justice based on "right principles." By allowing her analysis to take this direction, she displays an appalling immaturity and concreteness of thinking.

In fact, she appears to be cognitively incapable of understanding what principled thought is all about.

Gilligan emphasizes that men are willing to go to war for "principles" while recognizing that members of families will die. Women tend to object to war because the "principles" aren't worth the pain to the individual and to his family. The focus appears to be on the concrete reality of family and human relationships. While this is surely a valid concern, maturity demands that we come to recognize those over-riding principles that support all human relationships.

A great deal of attention has been paid to the claim that the "feminist" approach to moral issues would work better than the male emphasis on "Justice." The proof for this according to the feminists is that the world is male-dominated but is in a terrible mess. Therefore, we need Gilligan and the feminist orientation to return a humanizing orientation. Obviously, the reason that justice has failed in this world is because it isn't being used. Most people don't function on the principled level.

Indeed, it has failed in Gilligan's own data. The comments of the women making abortion decisions are riddled with hypocricy and inconsistency. They talk about the need to make responsible judgements, but they quite easily avoid feeling any responsibility for the unborn child that they have produced through their irresponsible behavior. Many of the younger subjects complained that the problem was not their fault. They blamed the boyfriend (or mother) for failing to provide contraceptives, which relieved the girl of the responsibility for sexual intercourse.

To make truly responsible decisions requires abstract reasoning. It is necessary to "imagine" possible outcomes that are not concrete realities. It is necessary to anticipate the possible bad outcome and modify behavior in order to avoid it. This requires that the woman deal with possibilities, which are abstract and, by definition, not concrete.

Some of the subjects talk about it

(continued, next page)

being kinder to abort the baby rather than running the risk of abusing it later. Abusing the child is much more concrete in their minds than the very abstract notion of the pain and suffering the baby feels during an abortion. The unborn baby is a complete abstraction to these women, and they cannot imagine applying the normal patterns of thinking to the unborn child. Certainly an abstract notion like justice applied to an abstract notion like an unborn baby, must be the ultimate in abstractions. Neither Gilligan nor her subjects appear to be capable of dealing with it.

Thus, the concept of care and connectedness is a bankrupted notion when it is used to apply only to concrete, adult human relationships. When it fails to protect the most connected and defenseless human, the unborn child, then it clearly fails to function as a standard of mature morality.

Gilligan misrepresents Kohlberg's theory and then compounds the problem by introducing feminist rhetoric, which further distorts and biases the entire presentation.

Her book appears to be an elaborate justification for allowing women the luxury of responding to immediate concrete gratification; that is, they may enjoy sexual gratification without taking responsibility for the results. It further encourages women to remain immature by not encouraging universal patterns of justice and goodness for everyone. Thus women are encouraged to remain at level 2, and this is touted as a great accomplishment.

Finally, women are being encouraged to avoid taking responsibility for behaviors which create major moral dilemmas. A principled way of thinking would demand responsible behavior. Gilligan demeans women by providing them a concrete, immature level of functioning. We expect better of men and the feminists should expect better of women.

Wanda Franz teaches at West Virginia University.

DEADLINE FOR NEXT NEWSLETTER IS MAY 8

ADDRESS CORRECTION REQUESTED

SISTERLIFE EDITOR: PAULETTE JOYER

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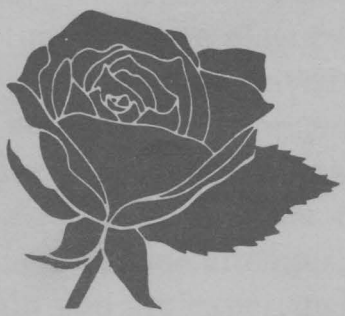
SURVIVING ABORTION

Help for the aborted woman



NEBA

Prepared by Patti McKinney and Jill Lessard

You are hurting. Perhaps you have a vague ache somewhere in your being that is frequently referred to as the "heart". Perhaps it is worse than that. Your abortion may have left you more or less psychologically incapacitated. Your self-esteem may be at an all-time low. You may be suffering depression, anger, fear of punishment. Many women have discovered following their abortions that they are plagued by nightmares; pre-occupied by the baby's perceived would-be birth-date or its age; a need to become pregnant with another baby — an "atonement" baby. Many undertake self-destructive behavior ranging from drug or alcohol abuse to anorexia to suicide attempts.

Whatever pain you are experiencing, you are not alone. Many women are suffering as you do; some of us have worked through our pain. This booklet is an attempt to shed some light on a subject about which little has been written and little is known by anyone except women like us — the surviving victims of abortion.

DON'T ALLOW ANYONE TO TRIVIALIZE OR DISMISS YOUR GRIEF.

Your grief is a healthy sign — a sign that you are facing realities rather than internalizing or burying them where they fester and become morally and spiritually malignant. Tears are cathartic. The first step to being healed of emotional wounds is to admit that the wounds exist and to acknowledge the cause of those wounds.

You have a right to grieve. If you lost an infant to disease or accident, society would not deny your right to grieve; miscarriage of a planned or wanted child is recognized as a legitimate reason for grief. Many women are surprised to find themselves grieving an aborted child because the abortion was — more or less — a voluntary act; but that is all the more a reason to grieve — the added dimension of responsibility — or guilt — intensifies the grief.

You may be led to believe, by doctors, abortion facility counselors or other "family planning" personnel, by other women who have had abortions, psychiatrists, parents, husband or boyfriend that your grief is illegitimate. This frequently leads women to feel foolish, selfish or guilty about their grief and that just makes their already confused state more stressful and makes them fear they are "going off the deep end."

Your grief is not only justifiable, it is normal. When pregnancy occurs, all the hormonal changes designed to change a woman into a mother begin. The body machinery gears up to produce a child; the maternal mind-set begins to establish. Any thwarting of this natural process (such as abortion) upsets the body ecology and scars the psyche of the would-be mother. TO *FAIL* TO EXPERIENCE A SENSE OF LOSS, OF EMPTINESS, OF GRIEF IS *ABNORMAL*. Recognize then that you are responding normally to a tragic life experience. The fact that you cooperated in the bringing about of that tragedy *does not negate* but rather may add to your need to grieve.

DON'T BE TOO HARD ON YOURSELF.

One doctor has stated that ambivalence in early pregnancy is so universal as to be a symptom of pregnancy. You were called upon to make an important life decision at a time when your decision-making abilities were hampered by the hormonal changes going on in your body. In addition, it is likely you did not make your decision in a vacuum.

Perhaps the baby's father was unwilling or unable to be supportive and accept responsibility for his child. He may have suggested abortion — perhaps even used emotional and/or financial leverage to persuade, pressure or coerce you to abort.

Frequently parents, in a desire to protect their child from embarrassment, pain or disruption of plans (education, etc.) by an untimely pregnancy, urge abortion as a "solution" to a "problem" to a "problem" pregnancy. If a woman is unmarried, she may feel that because her sexual behavior has been somewhat irresponsibile that she has abdicated her right to make a decision to bear her child against her parents' expressed wishes. She feels she has no right to further embarrass her parents and postpone their plans for her future. In an earnest desire to end their pain, many women mistakenly view abortion as a way to expedite a situation causing pain to those who love her most.

Your relatives, your clergyman, your best friend might have all suggested — even urged — that abortion was truly a viable solution to a difficult situation.

The counsellors at the family planning or abortion facility may not have disclosed enough information to help you make an informed, intelligent and therefore truly voluntary decision. Verbal gymnastics denied humanity to your unborn child. They called it "a few cells adhering to the uterine wall" or "the products of conception." They told you little of the possible physical complications; less of the emotional ones. They told you little about the procedure by which they would abort your child and nothing of the pain your child would suffer. It is likely that you did not make your decision based on adequate information.

Finally, perhaps you equated what is legal with what is right. After all, the Supreme Court did declare abortion to be a "right" and 1.6 million women a year can't be all wrong, can they? You have a right to expect the law-makers of our nation to be prudent. Usually you can trust the law as a guideline for conducting your life. It isn't your fault you didn't perceive the tragedy of this misapplication of justice until it hurt you. It is society's failure — not yours alone.

The issues may seem unmistakably life-or-death now. That doesn't mean they were so clear then. It was a tragically unfortunate decision — but it was *not* a totally "un-understandable" one.

FORGIVE THOSE YOU MIGHT BE FEELING BITTER TOWARD BECAUSE OF THEIR IMPLICATION IN YOUR ABORTION.

It is natural to feel anger toward people close to you who should have been supportive at a difficult time in your life but who seemed to fail you so miserably. But anger that is nurtured and allowed to live on in your heart soon becomes rage or bitterness. You cannot heal emotionally while harboring those destructive feelings.

Realize that your child's father may have felt himself to be between the "rock" and the proverbial "hard place," also. Perhaps he reneged on every spoken and unspoken committment made between you. You have been generous to yourself — now be generous to him. Abortion frequently ends the relationship that produced the pregnancy. If this has happened to you, so be it. But forgive him.

Forgive your parents, friends, clergyman. They were wrong, but sincerely so. Your best interest was at heart; unfortunately their judgments were faulty. That's a shame — but not a crime.

Forgive the health-care professionals whom you may feel lied to you or who failed to give you the pertinent information that may have changed your decision. There is a paternalistic attitude in the abortion field that seems to promote an opinion that an *uninformed* decision is a less painful one. We know that the opposite is true, but it is all water under the bridge. Some of us are fighting for laws to change that — to require disclosure of the facts to a woman making this vital decision. If you'd like to add your voice to that fight, contact us at the address on the back cover.

SEEK HEALING IN GOD.

Many women have expressed to me that they feel unworthy of God's forgiveness; that, indeed, they are awaiting, or feel that they are under, God's judgment. But read what God says: "For God SO LOVED the world, that He gave His only begotten Son, that WHOSOEVER believeth in Him SHOULD NOT PERISH, BUT HAVE EVERLASTING LIFE." (John 3:16) "Whosoever" includes anyone who has sinned

and Romans 3:23 says "For *all* have sinned."

Abortion is not just a misguided act, a carrying out of an unfortunate decision. It is sin. Confess it to God as sin, and "... He is faithful and just to forgive us our sins, and to cleanse us from all unrighteousness." (John 1:9)

Listen, God is not an angry, exacting tyrant demanding from you a pound of flesh to atone for your mistake. His Son, Jesus, has already given His life to pay for your guilt. And God stands, arms outstretched, longing to soothe your hurting heart and heal your wounded emotions. He declares, "Yea, I have loved THEE with an EVERLASTING LOVE: therefore with loving kindness have I drawn thee." (Jeremiah 31:3)

Don't allow the Enemy of your soul to tell you that your sin was too great, or too premeditated, or too selfish or too destructive for God to forgive. There is no sin too great, premeditated, selfish or destructive that God is not *eager* to forgive if He is only asked!

After my abortion in 1969, I was so filled with regret, remorse and self-recrimination that I become anorexic and nearly starved myself to death. When my weight dropped below 80 pounds and I developed a potentially fatal heart condition (at 20 years of age!) I was hospitalized. I spent 32 weeks in the psychiatric unit of a hospital where I had a series of shock treatments and learned to appreciate the emotional anesthesia induced by certain prescription drugs. Upon my release I began to abuse drugs, then alcohol. Several years passed during which time I was treated for drug overdoses and attempted suicide twice. I married but was so emotionally ill, I could not sustain a relationship and after only a month my husband left me.

It was apparent that unless there was a supernatural force outside of me that could order my life far better than I myself could, my life would never be worth living. I had tried astrology and other occult religions to no avail. Finally, in utter despair and desperation, I turned to God. In the early hours of a morning that followed an anguished night, I fell on my knees and cried out, "If there is a God, and if He cares for me, I beg Him to do something to ease my hurt and straighten out my life." What followed was a miracle. Somewhere deep inside of me I felt a sense of relief begin to grow: I sensed a warmth, a security such as a child feels when his mother washes his fevered brow with a cool cloth. Somehow I knew my life was going to be different from this time on.

And it was. My marriage was restored by God and now, nearly 10 years later, is strong and happy. I have three beautiful children and a productive, balanced life.

Jesus picked up the pieces of my life and put it back together again. Sure, sometimes I still grieve for my aborted child. I wonder what he (or she) would have been like and I sorrow that I denied myself the joy of nurturing him. But I know one thing for certain: Someday soon when Jesus comes in the clouds of glory to claim the faithful of all ages, my child will be restored to me and I will rear him in that Place where there is no grief or death.

You can have that assurance, too. Right now. If you don't know Jesus as your Savior, Healer and Friend, pray in your own words a prayer of repentance and acceptance, or pray the following prayer:

Father in Heaven, I come to you now, confessing my sins. Lord, seeking my own way and living by my own rules has resulted in death and torment for my child and myself. Forgive me. I thank you that you were willing for Your Son to die to redeem me. I accept His great sacrifice in my behalf.

Father, I lay at your feet all my feelings of guilt, grief, remorse and regret. Cleanse me and heal me by the blood of Your dear Son.

Today is the first day of my new life — a life I commit to You. Teach me to live according to Your will.

In Jesus' Name, Amen.

If I knew then
What I know now,
You never would have died.
I'd have held you close
And nurtured you
And kept you by my side.
I'd have sung you songs
And treasured you
More than silver,
More than gold:
But this song is all I'll give
To the Babe I'll never hold.

I've never written poetry
That hasn't been a praise
To the Lord Who wept with me
And held me through those days.
Jesus, now I'm asking,
I know You hear my plea,
Won't You take that child in Your Hands,
And hold my Babe for me.

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June 13, 1984

TO : Participant Providers - Minnesota Abortion Surveillance

FROM: Ruth Algren, Counseling Consultant
Family Planning/Reproductive Health Unit
(612) 623-5267
and
Susan Bedard-Johnson SBJ
Minnesota Center for Health Statistics
(612) 623-5353

Enclosed for your reference is the "Reported Induced Abortions, 1982." This report is the data compiled from the "Report of Induced Abortion" forms voluntarily submitted to the Minnesota Department of Health by providers participating in the Minnesota Abortion Surveillance.

Once again we want to thank you and your staff for the time and effort contributed to making the Minnesota Abortion Surveillance a success.

If you have any technical questions please direct them to Ruth Algren and statistical questions may be directed to Sue Bedard-Johnson. We would be willing to answer any questions you may have.

SBJ

Enclosure

REPORTED INDUCED ABORTIONS

1982

MINNESOTA CENTER FOR HEALTH STATISTICS
MINNESOTA DEPARTMENT OF HEALTH

REPORTED INDUCED ABORTIONS

MINNESOTA, 1982

Report No. 8

Minnesota Abortion Surveillance

December, 1983

Minnesota Center for Health Statistics
Minnesota Department of Health
717 Delaware Street S.E.
P.O. Box 9441
Minneapolis, MN 55440

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PREFACE

This report is the eighth in a series of analyses of data gathered during the Minnesota Abortion Surveillance. These data were collected, analyzed and prepared by the staff of the Minnesota Center for Health Statistics. Address correspondence to:

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INTRODUCTION

The Minnesota Abortion Surveillance is a statewide reporting system monitored by the Center for Health Statistics within the Minnesota Department of Health. Since introduction of the surveillance in 1974, data on abortions have been gathered through voluntary reporting by provider facilities throughout Minnesota. Continuous facility recruiting has been conducted to enlist all possible sources of abortion data, yielding the present 25 data providers enrolled on the system.

Analysis of data received through the surveillance has provided current public health information on abortions including demographic profiles of the abortion patients.

Since, by definition, a voluntary surveillance is subject to partial and incomplete reporting of events, this report and the data collected do not imply the complete and comprehensive status of legal abortion in Minnesota. The intention of this report is to describe as accurately as possible the situation as it was reported during the Surveillance period.

HISTORICAL RELATIONSHIP OF THE MINNESOTA ABORTION SURVEILLANCE TO NATIONAL ABORTION DATA

Although continuous reporting of induced abortions was initiated nationally by the Centers for Disease Control (CDC) in Atlanta during 1969, data on Minnesota women did not appear in CDC's "Surveillance Report" until 1972. In that year, 2,227 abortions to Minnesota resident women were reported by agencies outside Minnesota.[1] Abortion services first became available in Minnesota in 1973.[2] In 1973 and 1974, the CDC solicited reports of induced abortions from several hospitals and clinics in Minnesota. In 1974, the Minnesota Abortion Surveillance was established by the Center for Health Statistics, Minnesota Department of Health, for the voluntary reporting of abortions performed in the state. The first year "testing phase" of the Surveillance provided CDC with three (3) months of survey data which CDC published in lieu of its solicited abortion data. 1975 marked the first complete year of the Minnesota-based Surveillance and since then annual abortion data have been supplied to CDC, as well as to other federal, state, and private agencies.

In 1980, the last year for which national data are available, CDC reported 1,553,890 abortions performed in the fifty (50) states and the District of Columbia. The national abortion ratio for that year was 430 abortions per 1,000 live births.[3] The Minnesota resident abortion ratio in the same year was 243.1 abortions per 1,000 live births.

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1 Centers for Disease Control: "Abortion Surveillance, 1972," issued April, 1974.

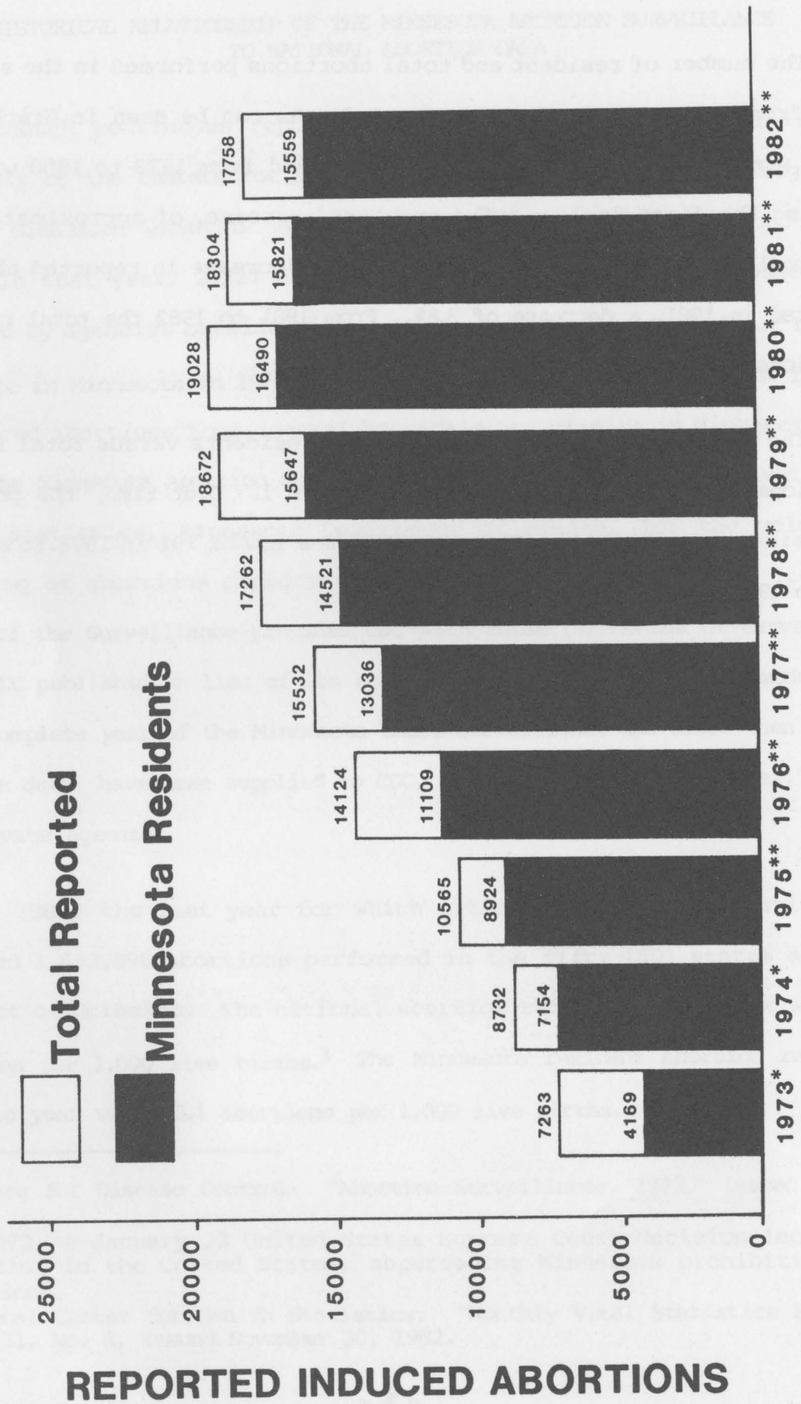
2 In 1973, a January 22 United States Supreme Court decision legalized abortion in the United States, superseding Minnesota prohibitions on abortions.

3 National Center for Health Statistics: "Monthly Vital Statistics Report." Vol. 31, No. 8, Issued November 30, 1982.

The number of resident and total abortions performed in the state per year from 1973-1982 is shown in Graph 1. As can be seen in Graph 1, the total number of reported abortions increased from 1973 to 1980 with 1981 showing the first decline. The greatest increase, of approximately 34%, occurred between 1975 and 1976. The first decrease in reported abortions occurred in 1981, a decrease of 3.8%. From 1981 to 1982 the total number of abortions decreased 3%.

The proportion of abortions to state residents versus total reported abortions in Minnesota is also shown in Graph 1. Over time, the proportion of resident abortions has fluctuated from a low of 79% in 1976 to a high of 88% in 1982.

GRAPH 1
REPORTED INDUCED ABORTIONS
MINNESOTA 1973 to 1982



*Center for Disease Control data
**Minnesota Abortion Surveillance data

SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

Minnesota facilities reported 17,758 abortions in 1982, a 3.0% decrease from the 18,304 reported in 1981. The number of Minnesota resident women receiving abortions in Minnesota facilities showed a 1.7% decrease from 15,821 in 1981 to 15,559 in 1982.

The ages of Minnesota women receiving abortions was 12 to 51 years. Women under 20 years accounted for 28.0% of all reported procedures, while women 40 and over comprised 1.1% of the total. As shown in Table 1 (page 9), the proportion of abortion recipients under age 20 decreased from 36.1% reported in 1978 to the 1982 figure of 28.0%. During this period, the proportion of abortion recipients aged 40 and over stayed about the same, while there was an increase in the proportion of recipients 20-39 years old.

Never married women represented 70.7% of the resident women having abortions. Although 14.4% of all abortion recipients indicated they were married, only 2.2% of those younger than 20 years specified "currently married."

The race and ethnic distribution of Minnesota resident women receiving abortions in 1982 was 90.4% = White, 4.7% = Black, 1.0% = Indian, 0.8% = Hispanic, 2.7% = Other Races. These data reflect no major changes from 1981.

Prior abortions were reported in 28.9% of the overall resident reports, and by 34.9% of the women aged 20-39 years. One or more previous births was reported by 31.8% of all clients and by 93.8% of those aged 40 and over.

1980 was the first full year in which five category choices relative to abortion recipients' "contraceptive use at the time of conception" were available for reporting by Minnesota facilities. Prior to July, 1979,

facility coders categorized abortion recipient's contraceptive - use responses as: 1) Never used, 2) Have used but discontinued, 3) Was using at conception, or 4) Contraceptive use unknown. In July of 1979, a fifth category, "Interrupted use of usual method" was added to the reporting form. This new category means that the abortion recipient indicated regular contraceptive use, but during the cycle in which the pregnancy was conceived, missed a pill or two, did not always use a condom, did not use her diaphragm on one or two occasions, did not abstain during her fertile period, etc. Addition of the new category allows for clearer differentiation between contraceptive method failure and human error. However, these data are subjective since reporting relies on client recall, etc. During 1982, "interrupted use" was associated with 12.5% of the reported resident abortions.

As shown in Table 1 approximately three quarters of the 1982 Minnesota resident abortion recipients reported some prior contraceptive experience. Approximately one quarter reported contraceptive use at the time of conception. As this figure is subject to reporting error it may reflect more than mechanical failures of the contraceptive method. It very likely includes use failures; that is, the method was used carelessly or without knowledge or understanding of proper use. No prior use of contraception was indicated in approximately one in five of reported resident abortions.

As in previous Surveillance years, first trimester clients ($\leq$12 weeks gestation) accounted for the majority of all women receiving abortions (88.5%). Table 1 indicates that abortions in 1982 were done at an earlier gestational age than in previous Surveillance years. The proportion of abortions performed after 15 weeks gestation decreased from 5.6% in 1978 to 4.9% in 1982.

From 1975-1981 the highest resident abortion complication rate was 5.71 in 1975. The lowest resident abortion complication rate was 1.15 in 1979. A gradual increase in this rate was noted from 1979 to 1981. During 1979 data privacy regulations eliminated major channels through which staff of the Minnesota Center for Health Statistics previously verified complication reports, creating a greater margin of error relative to the reporting of actual abortion-related complications from that year forward. In 1982, 6.7 complications per 1,000 resident abortions were reported compared to 2.5 per 1,000 in 1981.

During 1982, the Minnesota Department of Health provided technical assistance to providers relative to the reporting of complications. Confusion among some providers was found relative to the types of complications to be reported on the "Report of Induced Abortion" form. The categories provided on the form do not differentiate between possible minor side effects of abortion and possible complications of abortion requiring treatment. In 1982, side effects experienced by abortion recipients were for the first time reported as complications, increasing the resident abortion complication rate from 1981 to 1982. In 1982, some facilities reported as complications minor side effects such as, heavy bleeding (not considered hemorrhage), uterine cramping, and elevated temperatures lower than 38 degrees C.

Abortion-related complications include any of the following factors: 1) Hemorrhage (500 ml. or greater), 2) Pelvic infection, 3) Fever (> 38^0 C.), 4) Cervical injury, 5) Uterine perforation, 6) Retained tissue, 7) Continuing pregnancy (incomplete abortion), and 8) Any other medical complication related to the abortion procedure.

The abortion rate (number of abortions per 1,000 women aged 15-44) has fluctuated in the eight years of reporting. The Minnesota abortion rate in 1982 was 16.2 events per 1,000 women aged 15-44 as compared to the rate of 10.3 events observed in 1975.

Conclusion

For the second year in a row the number of Minnesota resident women receiving abortions in Minnesota facilities decreased. The total decrease since 1980 is 5.9% (16,490 events in 1980; 15,559 events in 1982). The proportion of women between the ages of 20-39 who had an abortion increased by 24.8% between 1978 and 1982 while the proportion of women under the age of 20 who had an abortion decreased 8.1%. The overall abortion rate increased by 57.3% between 1975 and 1982. In 1975 the rate was 10.3 events per 1,000 women aged 15-44, in 1982 the rate was 16.2 events per 1,000 women aged 15-44.

Most women who had an abortion at a Minnesota medical facility in 1982 were white residents, had never been married, had never had a previous abortion, were first trimester clients (less than 12 weeks gestation), had previous contraceptive experience, and experienced no complications.

Table 1

REPORTED INDUCED ABORTIONS
SELECTED SURVEILLANCE RESULTS AND COMPARISONS
MINNESOTA, 1978-1982

	1978[1]	1979	1980	1981	1982	Percent Change 1981-1982	Percent Change 1978-1982
Reported Induced Abortions[2]							
Total Reported Abortions	17,262	18,672	19,028	18,304	17,758	-3.0	+2.9
Minnesota Resident Abortions	14,521	15,647	16,490	15,821	15,559	-1.7	+7.1
Total Monthly Average	1,438	1,556	1,586	1,525	1,480	-3.0	+2.9
Resident Monthly Average	1,210	1,304	1,374	1,318	1,297	-5.8	+7.2
Gestational Age[2]							
Proportion <9 weeks	35.4%	36.4%	38.1%	45.6%	47.9%	+5.0	+35.3%
Proportion <13 weeks	86.4%	88.4%	86.9%	88.5%	88.5%	0	+2.4%
Proportion ≥16 weeks	5.6%	4.1%	5.4%	4.8%	4.9%	+2.1%	-12.5%
Client's Age[2]							
Proportion <Age 16	2.6%	2.2%	2.3%	2.1%	1.9%	-9.5%	-26.9%
Proportion <Age 20	36.1%	35.8%	34.6%	30.9%	28.0%	-9.4%	-22.4%
Proportion ≥Age 40	1.0%	1.1%	1.1%	1.1%	1.1%	0	+10.0%
Contraception[2]							
Proportion "Never Used"	25.9%	24.0%	22.4%	20.6%	20.6%	0	-20.5%
Proportion "Have Used but Discontinued"	45.5%	44.8%	40.7%	44.9%	42.0%	-6.5%	-7.7%
Proportion "Was Using at Conception"	21.6%	25.3%	25.9%	22.5%	22.0%	-2.2%	+1.9%
Proportion "Interrupted Use of Usual Method"[3]	N.A.	2.7%	6.7%	8.7%	12.5%	+43.7%	N.A.
Complications[2]							
Total Per 1,000 Procedures	2.90	1.18	2.52[4]	2.57	6.25		
Resident Per 1,000 Procedures	3.17	1.15	2.30[4]	2.53	6.68		
Resident - Suction Curettage	2.84	0.82	1.71[4]	2.30	6.97	(See footnote [5])	
Resident - All Other Methods	5.39	3.07	5.69[4]	4.21	4.24		

[1] Data from earlier years are available from MDH.

[2] Note: All data are Minnesota resident abortion statistics unless "Total" is indicated.

[3] Category was added July 1979.

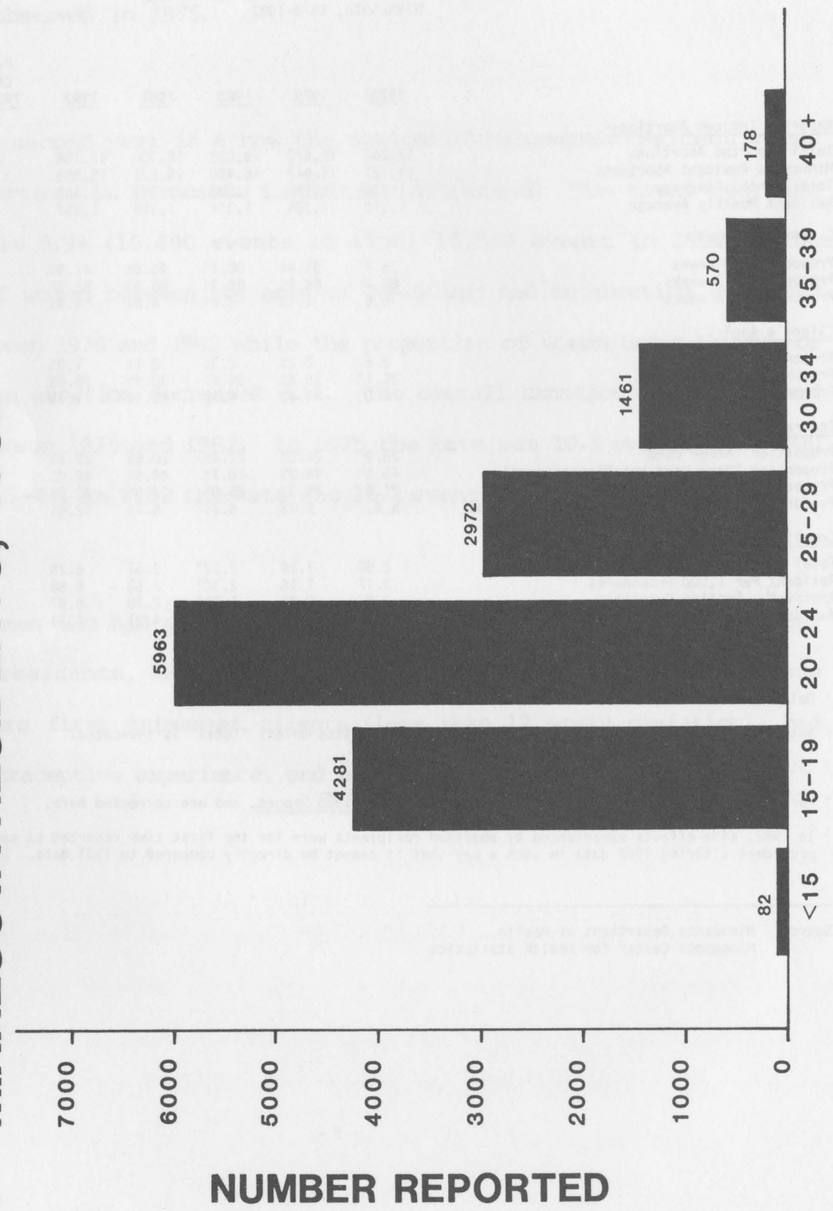
[4] Percentages for 1980 were incorrectly reported in the 1980 Report, and are corrected here.

[5] In 1982, side effects experienced by abortion recipients were for the first time reported as complications by some providers altering 1982 data in such a way that it cannot be directly compared to 1981 data. See page 7.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 2

REPORTED INDUCED ABORTIONS
NUMBER REPORTED BY RECIPIENT's AGE
MINNESOTA RESIDENTS, 1982



SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

Table 2

REPORTED INDUCED ABORTIONS
BY AGE GROUP AND RESIDENCE

MINNESOTA, 1982

Age Group	Total Reported Abortions		Minnesota Resident Abortions		Resident Percentage*
	Number	Percentage	Number	Percentage	
<15	97	0.5	82	0.5	84.5
15-19	4,982	28.1	4,281	27.5	85.9
20-24	6,826	38.4	5,963	38.3	87.4
25-29	3,292	18.5	2,972	19.1	90.3
30-34	1,636	9.2	1,461	9.4	89.3
35-39	665	3.7	570	3.7	85.7
40+	201	1.1	178	1.1	88.6
Unknown	59	0.3	52	0.3	88.1
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions (age X)}}{\text{Total Reported Abortions (age X)}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 3

REPORTED INDUCED ABORTIONS
BY INDIVIDUAL AGE FOR TEENAGE PATIENTS
AND BY SELECTED AGE GROUP BY RESIDENCE

MINNESOTA, 1982

	Total Reported Abortions			Minnesota Resident Abortions			
Age	Number	Percentage of Teens	Percentage of Total	Number	Percentage of Teens	Percentage of Residents	Resident Percentage*
<12	0	0.0	0.0	0	0.0	0.0	0.0
12	3	0.1	0.0	2	0.0	0.0	66.7
13	20	0.4	0.1	16	0.4	0.1	80.0
14	74	1.5	0.4	64	1.5	0.4	86.5
15	252	5.0	1.4	216	5.0	1.4	85.7
16	609	12.0	3.4	516	11.8	3.3	84.7
17	849	16.7	4.8	750	17.2	4.8	88.3
18	1,559	30.7	8.8	1,345	30.8	8.6	86.3
19	1,713	33.7	9.6	1,454	33.3	9.3	84.9
10-19	5,079	100.0	28.6	4,363	100.0	28.0	85.9
20-29	10,118	-	57.0	8,935	-	57.4	88.3
30-39	2,301	-	13.0	2,031	-	13.1	88.3
40+	201	-	1.1	178	-	1.1	88.6
Unknown	59	-	0.3	52	-	0.3	88.1
TOTAL	17,758	-	100.0	15,559	-	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions}}{\text{Total Reported Abortions}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 4

REPORTED INDUCED ABORTIONS
BY RACE/ETHNIC GROUP AND RESIDENCE

MINNESOTA, 1982

	Total Reported Abortions		Minnesota Resident Abortions		
Race	Number	Percentage	Number	Percentage	Resident Percentage*
White	16,153	91.0	14,061	90.4	87.0
Black	761	4.3	732	4.7	96.2
American Indian	184	1.0	156	1.0	84.8
Hispanic	126	0.7	118	0.8	93.7
Other	449	2.5	418	2.7	93.1
Unknown	85	0.5	74	0.5	87.1
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions (race X)}}{\text{Total Reported Abortions (race X)}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 5

REPORTED INDUCED ABORTIONS
BY MARITAL STATUS AND RESIDENCE

MINNESOTA, 1982

Marital Status	Total Reported Abortions		Minnesota Resident Abortions		Resident Percentage*
	Number	Percentage	Number	Percentage	
Never Married	12,546	70.6	11,005	70.7	87.7
Married	2,580	14.5	2,247	14.4	87.1
Divorced	1,575	8.9	1,393	9.0	88.4
Separated	613	3.5	541	3.5	88.3
Widowed	83	0.5	72	0.5	86.7
Unknown	361	2.0	301	1.9	83.4
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions}}{\text{Total Reported Abortions}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 6

REPORTED INDUCED ABORTIONS
BY AGE GROUP AND MARITAL STATUS

MINNESOTA RESIDENTS, 1982

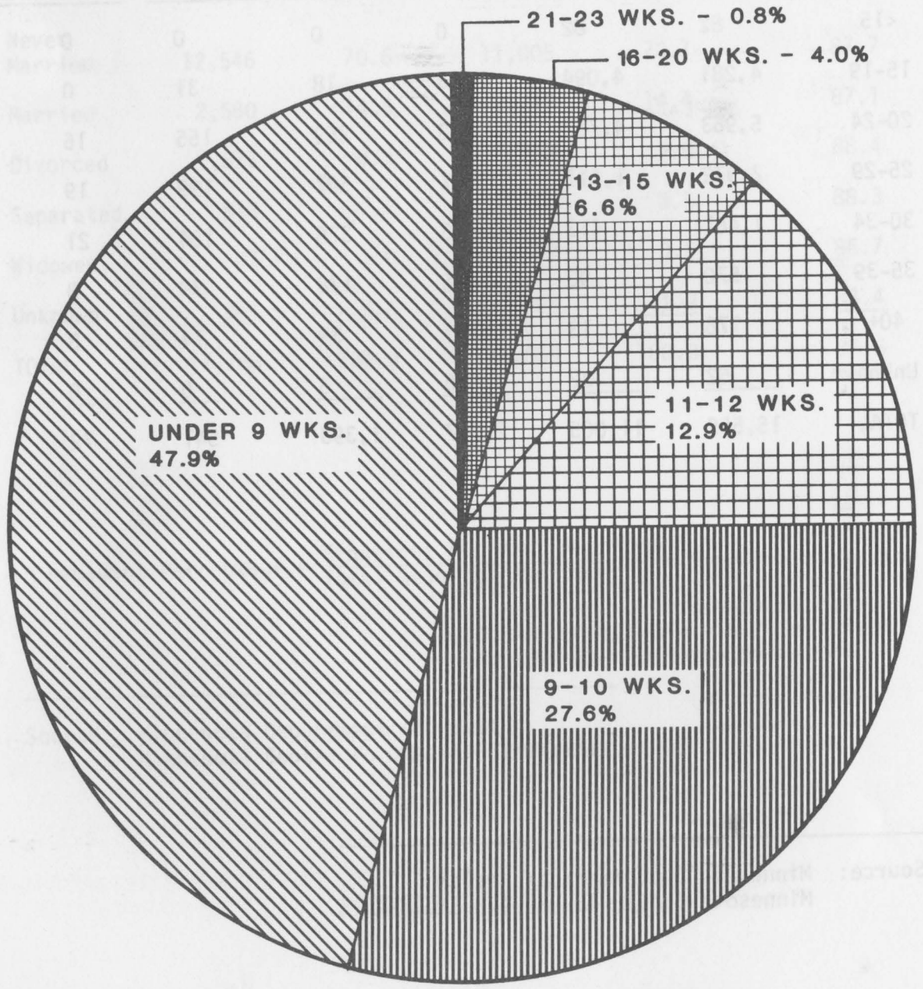
Age Group	Reported Resident Abortions	Marital Status					
		Never Married	Currently Married	Divorced	Separated	Widowed	Unknown
<15	82	82	0	0	0	0	0
15-19	4,281	4,094	93	18	31	0	45
20-24	5,963	4,767	632	269	155	16	124
25-29	2,972	1,511	667	507	199	19	69
30-34	1,461	413	503	376	104	21	44
35-39	570	93	245	178	38	8	8
40+	178	13	101	39	14	8	3
Unknown	52	32	6	6	0	0	8
TOTAL	15,559	11,005	2,247	1,393	541	72	301

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 3

REPORTED INDUCED ABORTIONS

PERCENT OF TOTAL RESIDENT ABORTIONS BY WEEKS OF GESTATION MINNESOTA, 1982



SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

Table 7

REPORTED INDUCED ABORTIONS
BY GESTATION AND RESIDENCE

MINNESOTA, 1982

Weeks of Gestation[1] (Post LMP)	Total Reported Abortions		Minnesota Resident Abortions		Resident Percentage[2]
	Number	Percentage	Number	Percentage	
<9	8,188	46.1	7,453	47.9	91.0
9-10	4,841	27.3	4,298	27.6	88.8
11-12	2,305	13.0	2,014	12.9	87.4
13-15	1,235	7.0	1,033	6.6	83.6
16-20	962	5.4	629	4.0	65.4
21-23	227	1.3	132	0.8	58.1
TOTAL	17,758	100.0	15,559	100.0	87.6

[1] Weeks of gestation as reported by the physician using uterine size and/or LMP indicated by the patient.

[2] Resident Percentage = $\frac{\text{Minnesota Resident Abortions (week X)}}{\text{Total Reported Abortions (week X)}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 8

REPORTED INDUCED ABORTIONS
BY AGE GROUP BY WEEKS OF GESTATION

MINNESOTA RESIDENTS, 1982

Age Group	Reported Resident Abortions	Gestation in Weeks* (LMP) <9	9-10	11-12	13-15	16-20	21-23
<15	82	26	22	12	14	6	2
15-19	4,281	1,626	1,213	717	399	268	58
20-24	5,963	2,955	1,636	741	380	206	45
25-29	2,972	1,636	779	324	140	81	12
30-34	1,461	793	409	138	70	45	6
35-39	570	313	165	49	22	14	7
40+	178	80	56	27	7	7	1
Unknown	52	24	18	6	1	2	1
TOTAL	15,559	7,453	4,298	2,014	1,033	629	132

* Weeks of gestation as reported by the physician using uterine size and/or LMP indicated by the patient.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 9

REPORTED INDUCED ABORTIONS
BY NUMBER OF PRIOR ABORTIONS
AND RESIDENCE

MINNESOTA, 1982

Number of Prior Abortions	Total Reported Abortions Number	Percentage	Minnesota Resident Abortions Number	Percentage	Resident Percentage*
0	12,182	68.6	10,616	68.2	87.1
1	2,765	15.6	2,472	15.9	89.4
2	1,781	10.0	1,554	10.0	87.3
3	654	3.7	581	3.7	88.8
4	202	1.1	176	1.1	87.1
5+	174	1.0	160	1.0	92.0
Unknown	0	0.0	0	0.0	0.0
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions}}{\text{Total Reported Abortions}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 4

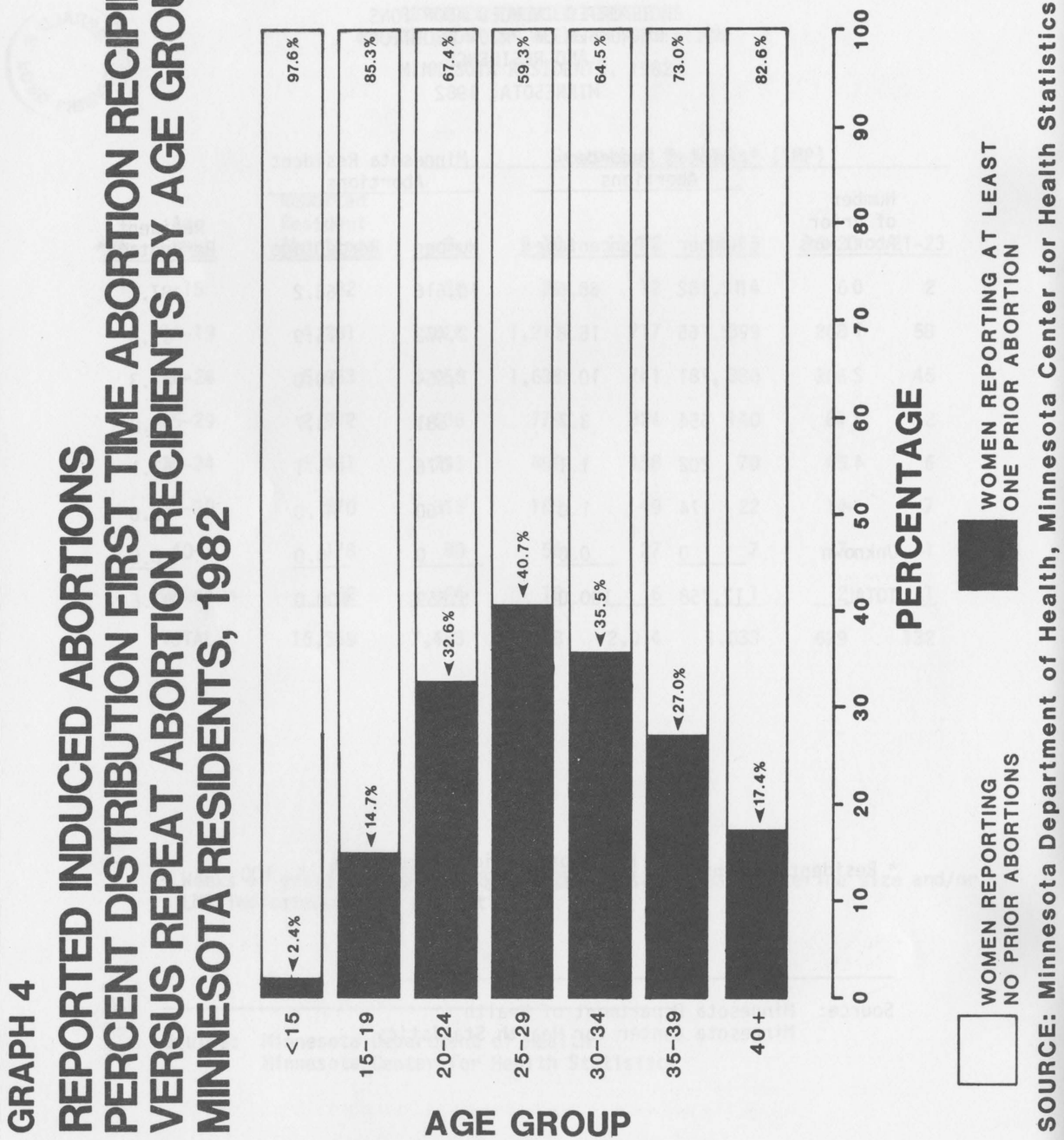


Table 10

REPORTED INDUCED ABORTIONS
PATIENTS REPORTING PRIOR ABORTIONS
BY AGE GROUP AND RESIDENCE

MINNESOTA, 1982

Age Group	Total Reported Abortions			Minnesota Resident Abortions		
	Number	Abortions[1]	%[2]	Number	Abortions[1]	%[2]
<15	97	2	2.1	82	2	2.4
15-19	4,982	694	13.9	4,281	631	14.7
20-24	6,826	2,164	31.7	5,963	1,941	32.6
25-29	3,292	1,320	40.1	2,972	1,210	40.7
30-34	1,636	580	35.5	1,461	518	35.5
35-39	665	172	25.9	570	154	27.0
40+	201	33	16.4	178	31	17.4
Unknown	59	14	23.7	52	12	23.1
TOTAL	17,758	4,979	28.0	15,559	4,499	28.9

[1] Number of women who reported at least one prior abortion.

[2] Percentage of women within each age group who reported having had at least one prior abortion.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 11

REPORTED INDUCED ABORTIONS
BY NUMBER OF PRIOR LIVE BIRTHS
AND RESIDENCE

MINNESOTA, 1982

Number of Prior Live Births	Total Reported Abortions		Minnesota Resident Abortions		Resident Percentage*
	Number	Percentage	Number	Percentage	
0	12,182	68.6	10,616	68.2	87.1
1	2,765	15.6	2,472	15.9	89.4
2	1,781	10.0	1,554	10.0	87.3
3	654	3.7	581	3.7	88.8
4	202	1.1	176	1.1	87.1
5	82	0.5	72	0.5	87.8
6	38	0.2	36	0.2	94.7
7	19	0.1	19	0.1	100.0
8	15	0.1	14	0.1	93.3
9+	20	0.1	19	0.1	95.0
Unknown	0	0.0	0	0.0	0.0
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions}}{\text{Total Reported Abortions}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 12

REPORTED INDUCED ABORTIONS
PATIENTS REPORTING PRIOR LIVE BIRTHS
BY AGE GROUP AND RESIDENCE

MINNESOTA, 1982

Age Group	Total Reported Abortions			Minnesota Resident Abortions		
	Number	Prior Live Births[1]	%[2]	Number	Prior Live Births[1]	%[2]
<15	97	1	1.0	82	0	0.0
15-19	4,982	452	9.1	4,281	402	9.4
20-24	6,826	1,739	25.5	5,963	1,555	26.1
25-29	3,292	1,525	46.3	2,972	1,361	45.8
30-34	1,636	1,127	68.9	1,461	998	68.3
35-39	665	530	79.7	570	448	78.6
40+	201	188	93.5	178	167	93.8
Unknown	59	14	23.7	52	12	23.1
TOTAL	17,758	5,576	31.4	15,559	4,943	31.8

[1] Number of women who reported at least one prior live birth.

[2] Percentage of women within each age group who reported having had at least one prior live birth.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 13

REPORTED INDUCED ABORTIONS
BY METHOD BY WEEKS OF GESTATION
MINNESOTA RESIDENTS, 1982

Method[1]	Reported Resident Abortions	Gestation in Weeks[2] (LMP) <9	9-10	11-12	13-15	16-20	21-23
Suction Curettage	13,908	7,181	4,120	1,867	700	38	2
Laminaria & Curettage	1,030	27	14	11	261	587	130
Combination	592	219	163	136	71	3	0
Prostaglandin	0	0	0	0	0	0	0
Sharp Curettage	3	2	1	0	0	0	0
Hysterectomy Hysterotomy	0	0	0	0	0	0	0
Saline	0	0	0	0	0	0	0
Menstrual Extraction(-)[3]	16	14	0	0	1[4]	1[4]	0
Menstrual Extraction(+)[3]	10	10	0	0	0	0	0
TOTAL	15,559	7,453	4,298	2,014	1,033	629	132

[1] See definitions of methods in index.

[2] Weeks of gestation as reported by the physician using uterine size and/or LMP indicated by the patient.

[3] (-) Negative tissue pathology (not pregnant)
(+) Positive tissue pathology (pregnancy confirmed)

[4] Reported gestational data may be inaccurate, however data privacy regulations make it difficult to trace individual report forms for correction.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 14

REPORTED INDUCED ABORTIONS
BY METHOD BY COMPLICATIONS AND RESIDENCE
MINNESOTA, 1982

Method[1]	Total Reported Abortions: Procedures	%	Complications	Rate/1000[2]	Minnesota Resident Abortions: Procedures	%	Complications	Rate/1000[2]
Suction Curettage	15,493	87.2	102	6.58	12,908	89.4	97	6.97
Laminaria & Curettage	1,521	8.6	6	3.94	1,030	6.6	6	5.83
Combination	715	4.0	2	2.80	592	3.8	0	0
Prostaglandin[3]	0	0	0	0	0	0	0	0
Sharp Curettage	3	0.0	0	0	3	0.0	0	0
Hysterectomy Hysterotomy	0	0	0	0	0	0	0	0
Saline	0	0	0	0	0	0	0	0
Menstrual Extraction(-)[4]	16	0.1	0	0	16	0.1	0	0
Menstrual Extraction(+)[4]	10	0.1	1	100.00	10	0.1	1	100.00
TOTAL	17,758	100.0	111	6.25	15,559	100.0	104	6.68

Reported complications include the categories hemorrhage (≥500 ml), pelvic infection, fever, cervical injury, uterine perforation, retained tissue and other procedure related conditions. In 1982, minor side effects experienced by abortion recipients were for the first time reported as complications. These minor side effects included heavy bleeding (<500 ml), uterine cramping, and elevated temperatures lower than 38° C.

[1] See definitions of methods in the index.

[2] Rate is reported complications per 1,000 abortion procedures.

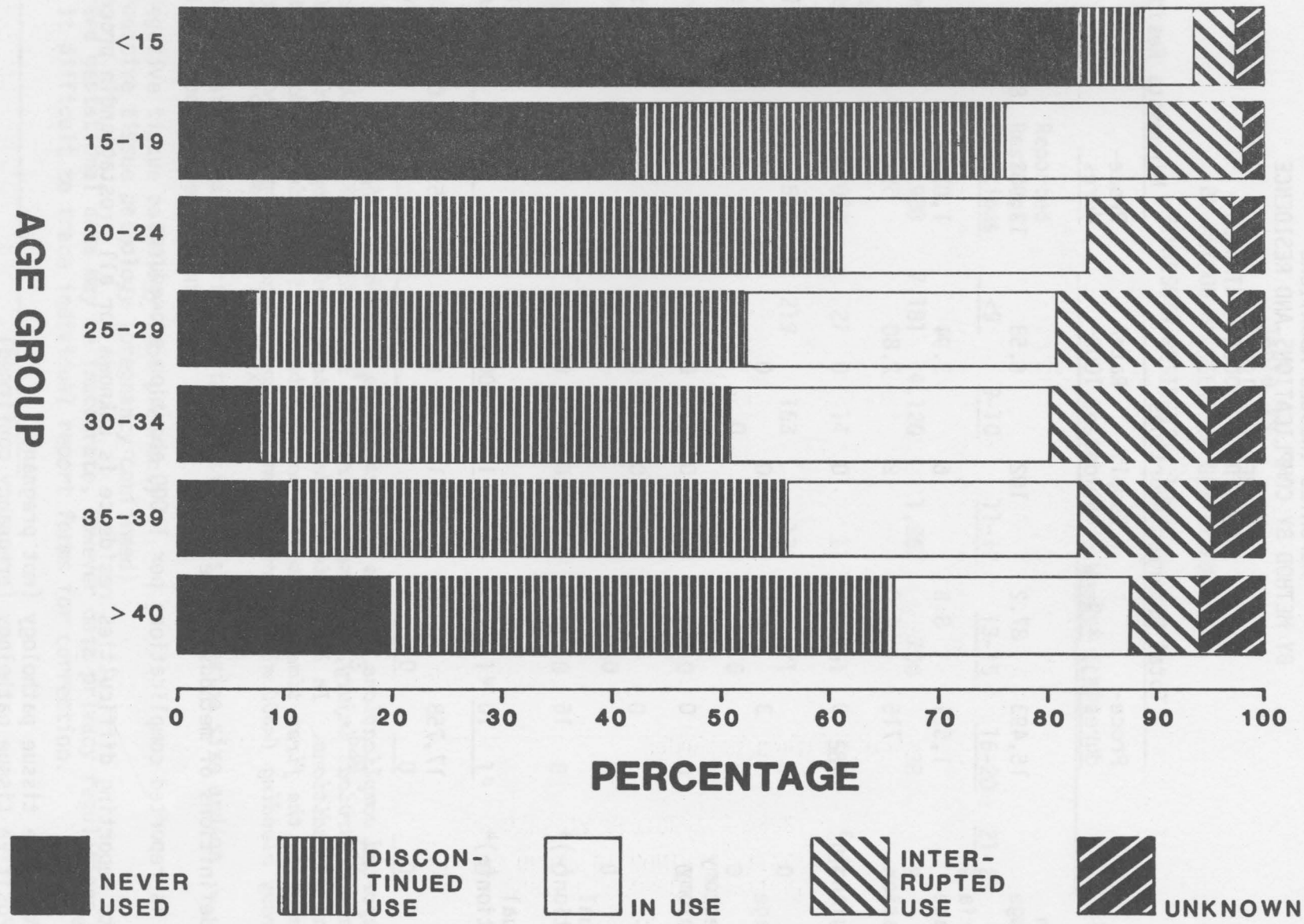
[3] Due to reporting difficulties residence is unknown for all prostaglandin procedure patients.

[4] (-) Negative tissue pathology (not pregnant)
(+) Positive tissue pathology (pregnancy confirmed)

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 5

REPORTED INDUCED ABORTIONS LEVEL OF CONTRACEPTIVE USE BY AGE GROUP MINNESOTA RESIDENTS, 1982*



*The data relative to contraceptive use are subjective as reporting relies on client recall, reporting, etc.

SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

Table 15

REPORTED INDUCED ABORTIONS
BY AGE GROUP BY CONTRACEPTIVE USE[1]
MINNESOTA RESIDENTS, 1982

Age Group	Reported Resident Abortions	Reported Contraceptive Use[2] Never Used	%[3]	Discontinued Use	%[3]	In Use	%[3]	Interrupted Use	%[3]	Unknown	%[3]
<15	82	68	82.9	5	6.1	4	4.9	3	3.7	2	2.4
15-19	4,281	1,795	41.9	1,476	34.5	560	13.1	365	8.5	85	2.0
20-24	5,963	945	15.8	2,692	45.1	1,366	22.9	801	13.4	159	2.7
25-29	2,972	196	6.6	1,359	45.7	857	28.8	473	15.9	87	2.9
30-34	1,461	103	7.0	637	43.6	433	29.6	218	14.9	70	4.8
35-39	570	55	9.6	263	46.1	154	27.0	70	12.3	28	4.9
40+	178	34	19.1	83	46.6	39	21.9	11	6.2	11	6.2
Unknown	52	8	15.4	22	42.3	17	32.7	1	1.9	4	7.7
TOTAL	15,559	3,204	20.6	6,537	42.0	3,430	22.0	1,942	12.5	446	2.9

[1] These data relative to contraceptive use are subjective as reporting relies on client recall, reporting, etc.

[2] Responses given--
Never used - I've never used any form of birth control.
Discontinued use - I've used some type of birth control but not when I became pregnant.
In use - I was using contraception when I became pregnant.
Interrupted use - I usually use a method of contraception but through human error it was not effective (missed a pill or two, forgot to check for my IUD, did not use my diaphragm once or twice, etc.)

[3] Percent is read horizontally to equal 100%, i.e., each percent is the proportion of women in that age group reporting any contraceptive use.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 16

REPORTED INDUCED ABORTIONS
MARITAL STATUS BY REPORTED CONTRACEPTIVE USE[1]
MINNESOTA RESIDENTS, 1982

Age Group	Reported Resident Abortions	Reported Contraceptive Use[2] Never Used	% [3]	Discontinued Use	% [3]	In Use	% [3]	Interrupted Use	% [3]	Unknown	% [3]
Never Married	11,005	2,823	25.7	4,423	40.2	2,163	19.7	1,347	12.2	249	2.3
Married	2,247	211	9.4	942	41.9	686	30.5	319	14.2	89	4.0
Divorced	1,393	75	5.4	713	51.2	384	27.6	181	13.0	40	2.9
Separated	541	48	8.9	307	56.7	107	19.8	61	11.3	18	3.3
Widowed	72	13	18.1	38	52.8	14	19.4	4	5.6	3	4.2
Unknown	301	34	11.3	114	37.9	76	25.2	30	10.0	47	15.6
TOTAL	15,559	3,204	20.6	6,537	42.0	3,430	22.0	1,942	12.5	446	2.9

[1] These data relative to contraceptive use are subjective as reporting relies on client recall, reporting, etc.

[2] Responses given--
Never used - I've never used any form of birth control.
Discontinued use - I've used some type of birth control but not when I became pregnant.
In use - I was using contraception when I became pregnant.
Interrupted use - I usually use a method of contraception but through human error it was not effective (missed a pill or two, forgot to check for my IUD, did not use my diaphragm once or twice, etc.)

[3] Percent is read horizontally to equal 100%, i.e., each percent is the proportion of women in that marital status reporting any contraceptive use.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 17

REPORTED INDUCED ABORTIONS
BY AGE GROUP BY TYPE OF CONTRACEPTION AT CONCEPTION*
MINNESOTA RESIDENTS, 1982

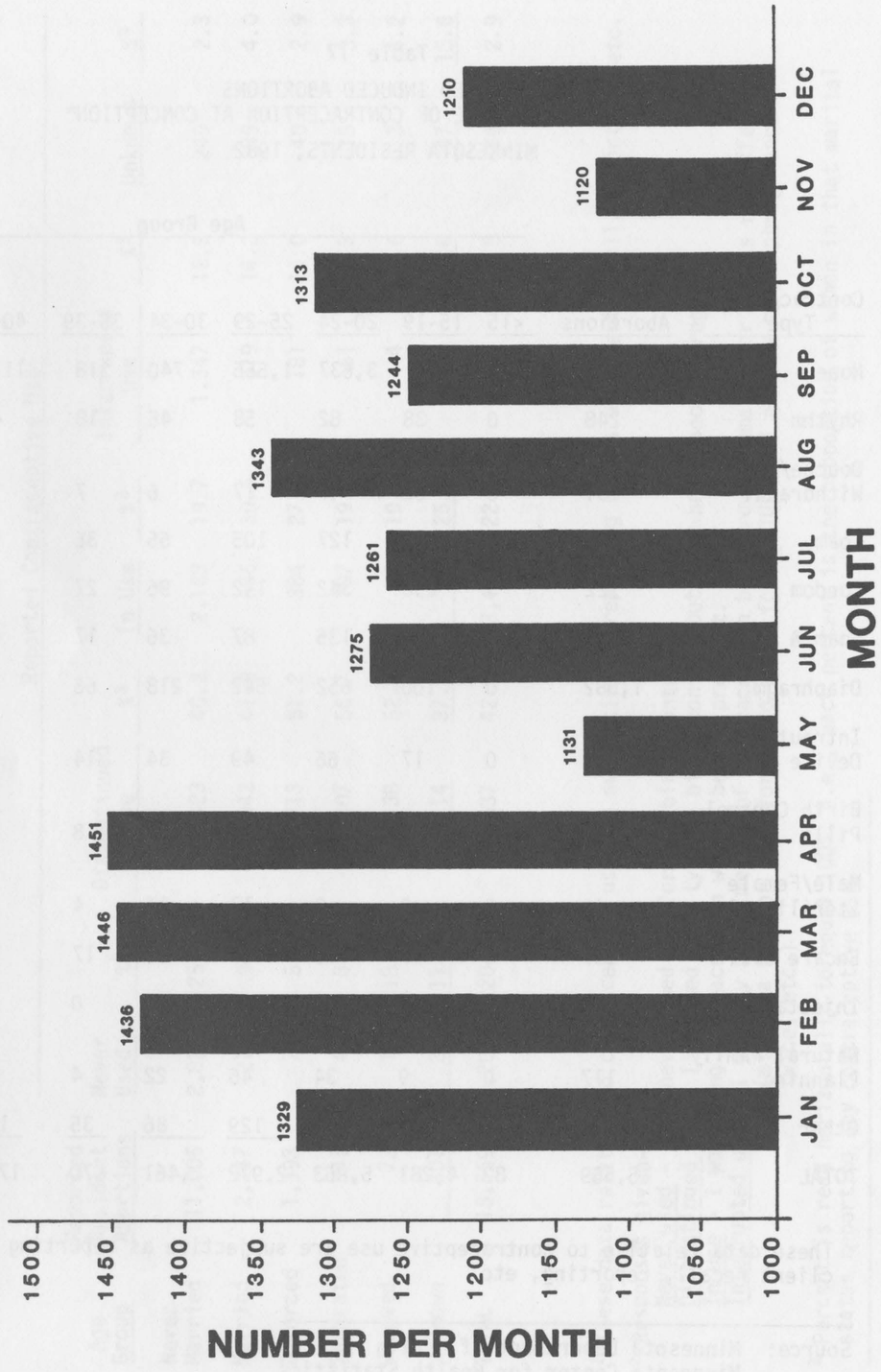
Contraceptive Type	Reported Resident Abortions	Age Group <15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
None	9,741	73	3,271	3,637	1,555	740	318	117	30
Rhythm	248	0	38	82	58	45	18	4	3
Douche/ Withdrawal	131	0	52	47	17	6	7	1	1
Foam	396	1	52	127	105	65	35	9	2
Condom	922	5	298	342	142	96	27	9	3
Foam & Condom	333	0	53	135	87	36	17	5	0
Diaphragm	1,582	0	100	652	542	218	66	4	0
Intrauterine Device	182	0	17	66	49	34	14	1	1
Birth Control Pills	959	0	239	477	165	63	8	3	4
Male/Female Sterilization	49	0	0	8	17	14	4	5	1
Encare Oval	297	0	47	130	59	36	17	6	2
Injectable	4	0	1	2	1	0	0	0	0
Natural Family Planning	117	0	9	34	46	22	4	2	0
Other	598	3	104	224	129	86	35	12	5
TOTAL	15,559	82	4,281	5,963	2,972	1,461	570	178	52

* These data relative to contraceptive use are subjective as reporting relies on client recall, reporting, etc.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 6

REPORTED INDUCED ABORTIONS NUMBER OF ABORTIONS BY MONTH PERFORMED MINNESOTA RESIDENTS, 1982



SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

Table 18

REPORTED INDUCED ABORTIONS
BY QUARTER AND RESIDENCE
MINNESOTA, 1982

Quarter	Total Reported Abortions		Minnesota Resident Abortions		Resident Percentage*
	Number	Percentage	Number	Percentage	
Jan - Mar	4,827	27.2	4,211	27.1	87.2
Apr - June	4,366	24.6	3,857	24.8	88.3
July - Sept	4,408	24.8	3,848	24.7	87.3
Oct - Dec	4,157	23.4	3,643	23.4	87.6
TOTAL	17,758	100.0	15,559	100.0	87.6

* Resident Percentage = $\frac{\text{Minnesota Resident Abortions (quarter X)}}{\text{Total Reported Abortions (quarter X)}} \times 100$

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

GRAPH 7

REPORTED INDUCED ABORTIONS BY COUNTY OF RESIDENCE MINNESOTA, 1982

SOURCE: Minnesota Department of Health, Minnesota Center for Health Statistics

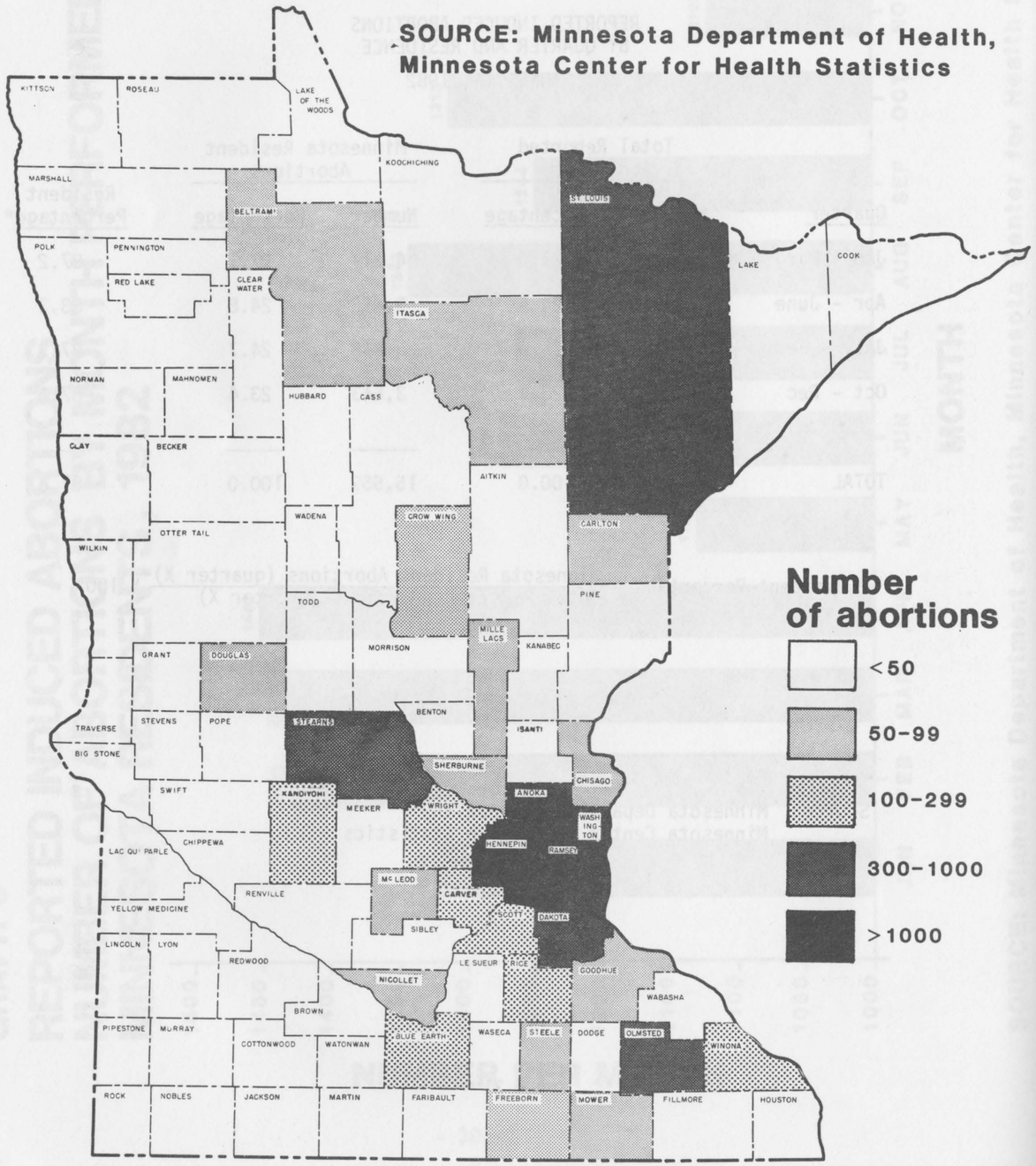


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Table 19

REPORTED INDUCED ABORTIONS
OCCURRING IN MINNESOTA TO NON-MINNESOTA RESIDENTS
BY STATE OR COUNTRY OF RESIDENCE, 1982

State of Residence	Reported Abortions Number	Percentage
Alaska	2	0.1
Arizona	1	0.0
California	5	0.2
Colorado	5	0.2
Connecticut	2	0.1
District of Columbia	1	0.0
Florida	4	0.2
Georgia	1	0.0
Hawaii	2	0.1
Illinois	59	2.7
Indiana	4	0.2
Iowa	144	6.5
Kansas	1	0.0
Maine	1	0.0
Massachusetts	2	0.1
Michigan	52	2.4
Mississippi	1	0.0
Missouri	3	0.1
Nebraska	2	0.1
Nevada	2	0.1
New York	5	0.2
North Dakota	113	5.1
Ohio	2	0.1
Oklahoma	1	0.0
Pennsylvania	1	0.0
South Dakota	268	12.2
Texas	4	0.2
Utah	1	0.0
Virginia	1	0.0
Washington	1	0.0
Wisconsin	1,330	60.5
Wyoming	2	0.1
Country of Residence		
Canada	160	7.3
Mexico	1	0.0
Other & Unknown	15	0.7
TOTAL	2,199	100.0

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

Table 20

NUMBER OF ABORTIONS OCCURRING IN OTHER STATES
TO MINNESOTA RESIDENT WOMEN, 1982*

State	Number
Arizona	1
Arkansas	1
Kansas	2
Nebraska	5
New York	8
North Dakota	583
Oklahoma	1
South Dakota	42
Total	643

* This table is based on data voluntarily provided to the Minnesota Department of Health, by health departments from selected states.

Source: Minnesota Department of Health
Minnesota Center for Health Statistics

DEFINITIONS*

ABORTION, INDUCED:

The intentional, premature removal from the uterus of a non-viable fetus.

ABORTION, RESIDENT:

Abortions to Minnesota residents which occurred in Minnesota and were reported during this Surveillance.

ABORTION RATE:

The number of abortions per 1,000 women in the population aged 15-44 years.

BIRTH RATE:

The number of live births per 1,000 population.

COMPLICATIONS:

Any unfavorable condition related to the abortion as reported by the provider facility including: hemorrhage (≥ 500 ml), pelvic infection, fever, cervical injury, uterine perforation, or retained tissue.

CURETTE:

A spoon-shaped surgical instrument.

CURETTAGE:

The removal of material from the uterine wall with a curette. Also, the induction of endometrial bleeding by administration and withdrawal of any progestational agent.

FERTILITY RATE:

The number of live births per 1,000 women in the population aged 15-44 years.

GESTATION:

The period of development of the fetus, expressed in completed weeks, calculated from the first day of the last menstrual period (LMP).

LAMINARIA:

Sterile, dried marine plant stems which are capable of expanding with fluid absorption.

*As used in this report.

DEFINITIONS*

PREGNANCY RATE:

The number of live births, fetal deaths, and induced abortions per 1,000 women in the population aged 15-44 years.

TRIMESTER:

One third of the total gestational period necessary for a full-term pregnancy. Thirteen weeks are allotted to each trimester. The count of weeks begins with the first day of the last menstrual period.

ABORTION PROCEDURES:

Combination: Two or more abortion methods used simultaneously or sequentially.

Hysterectomy/hysterotomy: Removal of the fetus by means of a surgical incision made in the uterine wall. In the case of hysterectomy, the entire uterus is removed.

Laminaria and curettage (Dilation and Evacuation, D & E): Dilitation of the cervix by insertion of laminaria several hours before removal of uterine contents by suction and sharp curettage.

Menstrual extraction (m. regulation, m. induction): Evacuation of the uterine contents by suction curettage, usually before the 14th day after a missed menstrual period, and before the diagnosis of pregnancy is reliable. Urine pregnancy test may be negative (-) or positive (+).

Prostaglandin: Induction of labor by injection of a prostaglandin (naturally occurring hormone) solution into the amniotic sac. Laminaria are often inserted in the cervix several hours before the injection to aid dilation. Other hormones may be given intravenously to assist labor.

Saline/fluid exchange: Induction of labor by injection of a sterile salt solution into the amniotic sac. Laminaria are often inserted in the cervix several hours before the injection to aid dilation.

Sharp curettage: Mechanical dilation of the cervix with removal of the uterine contents by scraping the uterine wall with a surgical curette.

Suction curettage: Mechanical dilation of the cervix with removal of the uterine contents by low pressure suction created by an electric suction pump.

Complete and return to:

Center for Health Statistics
Minnesota Department of Health
717 Delaware St., S.E.
Minneapolis, Minnesota 55440
(612) 296-5584

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PLEASE PRINT

REPORT OF INDUCED ABORTION

TYPE OF ADMISSION — FACILITY ID CODE [1]

1 = Inpatient 2 = Outpatient 3 = Clinic 4 = Other ____

PATIENT RESIDENCE *(Write in)*

City ____

County ____

State ____

MDH use only
12
16
18
20

AGE IN YEARS *(Birth Date Optional* Month Day Year *)* Years

RACE/ETHNICITY — 22
1 = White 2 = Black 3 = American Indian 4 = Hispanic 5 = Japanese/Chinese/Asian 6 = Other 7 = Unknown

MARITAL STATUS — 23
1 = Never Married 2 = Married Now 3 = Widowed 4 = Divorced 5 = Separated 6 = Unknown

CONTRACEPTIVES USED? — 28
1 = Never used any contraceptive method
2 = Have used but discontinued method
3 = Was using at conception *(Method failure – See 46 below*)*
4 = Unknown
5 = Interrupted use of usual method *(Human error – See 46 below*)*

Total number of prior pregnancies to this woman *(a+b+c below)* — 24
a. Total number of live births
b. Fetal deaths, spontaneous abortions
c. Number of prior induced abortions

DATE OF ABORTION — 29 Month Day Year

DATE OF LAST NORMAL MENSES (LMP) — 35 Month Day Year

GESTATION WEEKS *(Physicians estimate of completed weeks post LMP)* — 41 Weeks

ABORTION METHOD — 43
1 = Suction curettage
2 = Sharp curettage
3 = Saline/fluid exch
4 = Prostaglandin
5 = Hysterectomy/otomy
6 = Combination *(Circle each)*
7 = Menstrual extr (– preg)
8 = Menstrual extr (+ preg)
9 = Laminaria & curettage (Dilation & evacuation)

COMPLICATIONS OR FAILURES *(Was patient hospitalized? Yes No [Circle one])* Briefly Note any other information — 44
0 = None
1 = Hemorrhage (500 ml)
2 = Pelvic infection
3 = Fever (>38° C)
4 = Cervical injury
5 = Uterine perforation
6 = Retained tissue
7 = Continuing pregnancy
8 = Other *(Specify)* ____

Optional

RELIGIOUS PREFERENCE — 45
1 = Prot 2 = Cath 3 = Jew 4 = Other 5 = None 6 = Unk

*CURRENT CONTRACEPTIVE *(As indicated by 28 above)* — 46
0 = None
1 = Rhythm
2 = Douche or Wthdrwl
3 = Foam
4 = Condom
5 = Foam + Condom
6 = Diaphragm
7 = IUD
8 = Pills
9 = Sterilization
A = Suppositories
B = Injectables
C = Natural Family Planning
D = Other ____
E = Combination
F = Unknown

47 (M or F)

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