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Heather D. Boonstra
Rachel Benson Gold
Cory L. Richards
Lawrence B. Finer

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Executive Summary

The ability to determine whether and when to bear children has become a prerequisite for women's full participation in modern life. To understand the role that abortion plays in women's lives, it must be placed within the larger context of unintended pregnancy.

- The typical American woman wants to have two children. To do so, she will spend roughly five years pregnant, postpartum or trying to become pregnant and three decades trying to avoid pregnancy.
- Virtually all U.S. women have used contraceptives; however, neither people nor contraceptive methods are perfect. Nearly half of all women have faced an unintended pregnancy, and one in three will have an abortion at some point in their life. About half of women who unintentionally become pregnant turn to abortion.
- Women who make the decision to have an abortion understand the responsibilities of parenthood and family life. Six in 10 are already a parent. More than half say they want a child or another child at a later point in their life. Most cite concern or responsibility for someone else as a factor in their decision.

Abortion Before Legalization

Both the history of our own country and a look around the world today amply demonstrate that the legal status of abortion has a far greater impact on the circumstances under which the procedure is obtained than on its incidence.

- Abortion in the United States was severely restricted in the decades before *Roe v. Wade.* The continuing toll of illegal abortion on the health and lives of women and their families made decriminalization a moral imperative for many in the medical, legal and pastoral professions.
- Poor American women and their families were disproportionately affected by the illegality of abortion. Although some adult women with financial means had access to a safe procedure, less affluent women often had few options aside from a potentially dangerous clandestine abortion.
- Abortion was a leading cause of maternal mortality in pre-*Roe* America, and it remains so today in many developing countries in which abortion is illegal.

Three Decades of Legal Abortion

Thirty years of legal abortion since *Roe v. Wade* have brought about significant advances for the lives and health of women.

- Induced abortion in the United States is now an extremely safe procedure; injuries and deaths from abortion are rare.
- The proportion of abortions performed after the first trimester dropped rapidly after *Roe.* Today, nearly nine in 10 women who have an abortion do so within the first trimester, and about six in 10 do so within eight weeks. New medical and surgical technologies increasingly enable women to obtain abortions earlier in pregnancy.
- Legal abortion has gone hand-in-hand with sharp increases in contraceptive use, which in turn have been a major factor in declining abortion rates.

The Long-Term Safety of Abortion

Although abortion rights opponents continue to allege that abortion is dangerous to women's physical and mental health over the long term, a considerable body of credible evidence contradicts that assertion.

- Abortions performed in the first trimester pose virtually no long-term risk of such problems as infertility, ectopic pregnancy, spontaneous abortion, congenital malformation, or preterm or low-birth-weight delivery.
- Exhaustive reviews by panels convened by the U.S. and British governments have concluded that there is no association between abortion and breast cancer. Moreover, the available evidence indicates that abortion is not a risk factor for other types of cancer and may even be protective against some types.
- The question of the psychological impact of abortion has been extensively and repeatedly examined since the early 1980s. Each time, leading experts have concluded that abortion does not pose a hazard to women's mental health.

Lingering Disparities

Over the last several decades, much progress has been made in the ability of American women and their partners to control their childbearing; however, not all American women are sharing equally in this progress.

- Declines in the national rate of unintended pregnancy that occurred in the 1980s and 1990s have stalled, and some key groups appear to be losing ground.
- Women of color and those who are young, unmarried or poor have lower levels of contraceptive protection than do other women, leading to higher levels of unintended pregnancy in these groups.
- Accordingly, although women from all walks of life have abortions, the procedure is becoming increasingly concentrated among disadvantaged women.
- Young, poor, black and unmarried women are more likely than other women to experience a delay in obtaining an abortion. At the same time, the majority of all women who have had an abortion say they would have preferred to have had the procedure earlier than they did.

Recommendations for Policies and Programs

As long as women become pregnant unintentionally, some who feel unable to raise a child or another child at that point in their life will turn to abortion. As a matter of social justice, every woman in the United States should have equal access to abortion services, regardless of economic status; therefore, public funding of abortion for indigent women should be restored nationwide. Efforts to restrict women's access to abortion—which fall hardest on young and poor women and women of color, and primarily have the effect of causing them to delay having the procedure—should be rejected or repealed. Women's right to give informed consent to abortion based on the receipt of unbiased, medically accurate information should be protected, and abortion providers should be afforded the respect and legal support bestowed on other members of the medical profession.

Although the national debate over abortion may never be resolved, one obvious path toward lowering the decibel level lies in increasing support for policies and programs that help women and couples to avoid unintended pregnancy. This complex task includes guaranteeing young people access to comprehensive sex education that teaches both the benefits of delaying intercourse and the importance of using contraceptives. It means structuring public and private insurance coverage so that women and men can choose freely the contraceptive method that best suits their needs. And it requires streamlining the delivery of contraceptive care, both in public programs and the private marketplace, so as to make obtaining and using contraceptives as convenient as possible.

Taking these steps would do much to jump-start our stalled national progress in minimizing women's need for abortion by helping them to avoid unplanned pregnancies in the first place—even as we guarantee that all women who need abortion services are able to obtain a timely, safe procedure and to do so with dignity. If women across the United States were afforded the education, services and rights they need to manage their reproductive lives, they would benefit as individuals, as partners and as parents, and the life of the nation would benefit as well.

Chapter 1

Abortion in Women's Lives

For two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail.

The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.[1]

—Justice Sandra Day O'Connor

The ability to determine whether and when to bear children has become a prerequisite for women's full participation in modern life. Yet, unplanned pregnancy remains a reality. And as long as women become pregnant unintentionally, some who feel unable to fulfill the responsibilities of parenting a child or another child at that point in their life will turn to abortion. Justice O'Connor acknowledged these undeniable facts of life in 1992, when the Supreme Court reaffirmed the central holding of its 1973 landmark decision in *Roe v. Wade*.[2]

It is likely, given experiences throughout history and from around the world, that abortion will always exist. More important, where unplanned pregnancy is a common occurrence, abortion also will be common, regardless of its legal status. As a society, we can and must shape the conditions under which abortions take place to ensure that women who seek an abortion are able to obtain a safe procedure and to do so with dignity. At the same time, we must recognize that abortion is a matter on which people of conviction can and do sharply disagree, and that the longstanding, highly polarized debate over abortion has been both unproductive and corrosive to the body politic. If for no other reason, we must do whatever we can to reduce the number of abortions in this country by addressing the root cause—unintended pregnancy.

Although most women use contraceptives, unintended pregnancy remains common

Too often in the public discourse, abortion is talked about in isolation from its precipitating event, unplanned pregnancy. And as a political matter, it is too often treated as though it were the centerpiece of women's reproductive behavior rather than as a last resort, when other options fail. But if we are ever to understand abortion, it must be placed squarely within the context of women's lives. It must be seen in terms of the challenges that women and couples face in realizing their goals and in giving their children the start in life they deserve.

Americans want small families, as is increasingly the case around the world (see Lessons From Abroad). The typical American woman today wants two children over the course of her lifetime and practices contraception to achieve that goal. The Centers for Disease Control and Prevention (CDC) describes contraceptive use as "virtually universal among women of reproductive age."[3] Indeed, 98% of sexually experienced American women have used a contraceptive method at some point in their lives.

But achieving this goal is no easy task. A woman typically spends roughly five years pregnant, postpartum or trying to become pregnant and three decades trying to avoid pregnancy (Figure 1.1).[4] Contraceptives can be difficult to use consistently and correctly, and 30 years is a long time for a woman or a couple to do so flawlessly. One in four

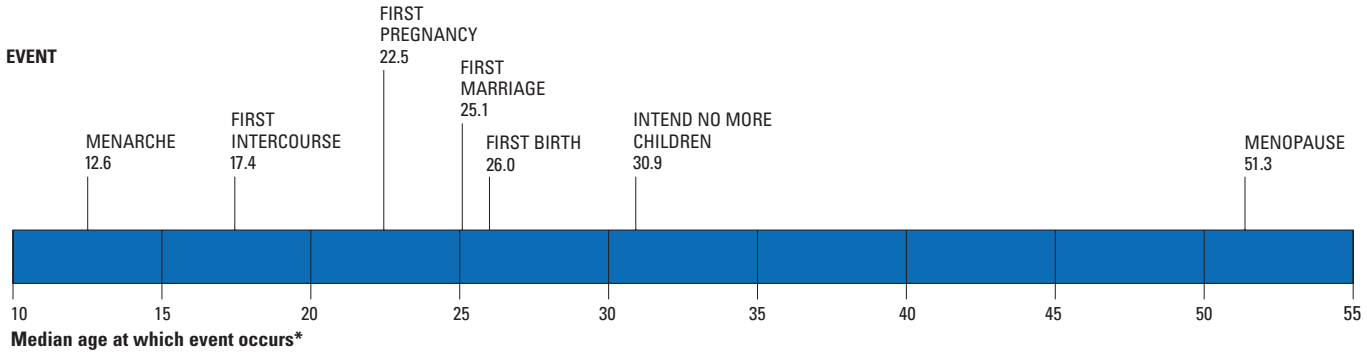
women at risk of unintended pregnancy (i.e., women who are sexually active and able to get pregnant, but who are not trying to do so) report having had at least a one-month gap in their contraceptive use in the last year.[5] But no contraceptive method is perfect, even if used correctly and consistently.

Thus, unintended pregnancy can occur both among those using and those not using a contraceptive method; however, the pregnancy rates of these two groups are very different.[6] A woman's chance of becoming pregnant in the absence of contraception is so great that 52% of the unplanned pregnancies each year occur to the 11% of women at risk who report not using a method the month they became pregnant (Figure 1.2, page 8).[7] The other 48% occur to the 89% of at-risk women who report that they used a contraceptive method at some point during the month they became pregnant, but may not have used it consistently or correctly.

Each year, more than six million American women—one in every 10 women of reproductive age (15–44)—become pregnant, and almost half of those pregnancies are unintentional.[8] In fact, if current rates continue, nearly half of all American women will face an unintended pregnancy at some point in their lives.[9] And although unplanned pregnancy affects all types of American women, a greater proportion of women from certain groups than from others become pregnant unintentionally: women of color and those who are young, unmarried or poor (Figure 1.3, page 9).[10]

FIGURE 1.1

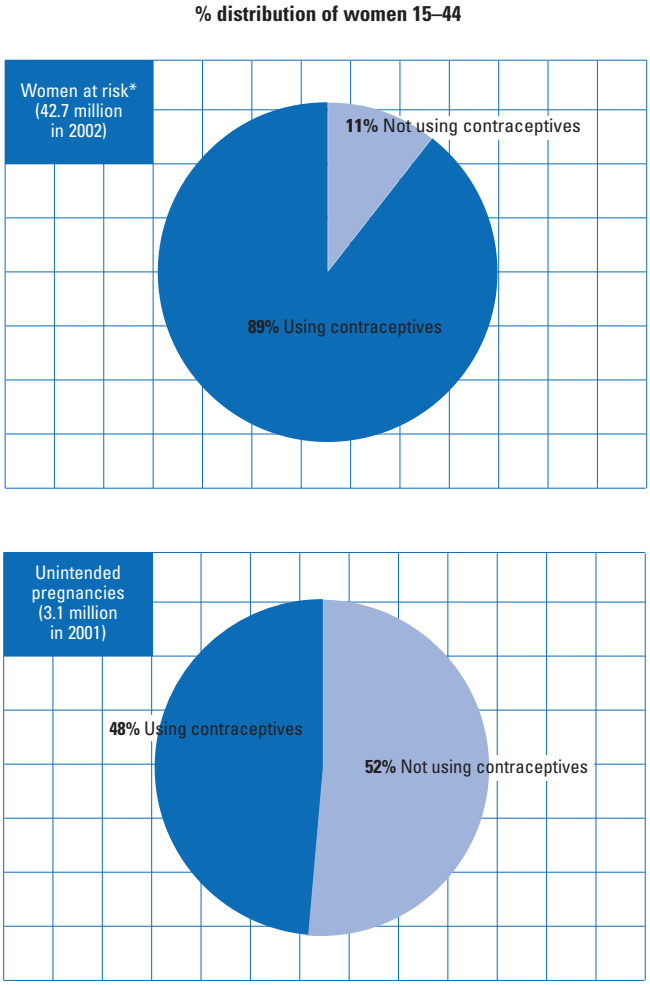
The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years avoiding pregnancy.



Note *Age by which half of women have experienced event.
Source Reference 4.

FIGURE 1.2

Half of unplanned pregnancies occur among the small proportion of women at risk not using a contraceptive method during the month they became pregnant.



Note *Women are at risk if they are sexually active, able to become pregnant and not currently pregnant, postpartum or seeking pregnancy.
Source Reference 7.

A woman's decision often rests on whether she feels she can care for the child at that time

Some women can adapt to an unintended pregnancy and avoid any serious negative consequences for themselves or their families. A woman in a stable relationship, for example, may be more likely than a single parent or a couple struggling to get their relationship or finances stabilized to have the resources to raise a child that had not been anticipated. In fact, about half of the three million women who become pregnant unintentionally each year make the decision to carry their pregnancy to term;[11] a small number of such women (about 14,000 a year) place the child for adoption.[12] The remaining 1.3 million women facing an unplanned pregnancy turn to abortion, as do a small number of women whose pregnancies were wanted but whose life circumstances have drastically changed—for example, because the woman or her fetus has been diagnosed with a dangerous medical condition, or because her marriage or family finances has suddenly become unstable.

The reasons women express for deciding to have an abortion, as well as the people they consult and the way they talk about how they made their decision, make it clear that women carefully consider the realities of their lives and their ability at that time to be the kind of parent they want to be to their current and future children. For most women, the decision to end a pregnancy—even a very early pregnancy—is a complex and deliberative one. The reasons women give for ending a pregnancy underscore their understanding of the serious consequences of

TABLE 1.1

The reasons women most frequently give for having an abortion are that being a parent would limit their ability to meet their current responsibilities and that they cannot afford a child at this point in their lives.

Reasons	% of women giving each reason
Concern for/responsibility to other individuals*	74
Cannot afford a baby now	73
A baby would interfere with school/employment/ ability to care for dependents	69
Would be a single parent/ having relationship problems	48
Has completed childbearing	38

Note *Includes financial, partner and relationship problems resulting in the inability to care for or support a (or another) child; possible problems affecting the health of the fetus; difficult family situations, such as a current child's chronic illness; financial impacts on existing children; and the need to care for other dependents.
Source Reference 13.

unplanned childbearing for themselves and their families. Most abortion patients—regardless of their age, marital status, income, education, ethnicity or number of existing children—cite concern or responsibility for someone else as a factor in their decision to have an abortion (Table 1.1);[13] two-thirds say that inability to care for a child or concern for the kind of life they could provide for a child (or another child) was a factor.[14] In addition, six in 10 say that they consulted with someone, most often their husband or partner, in making their decision.[15]

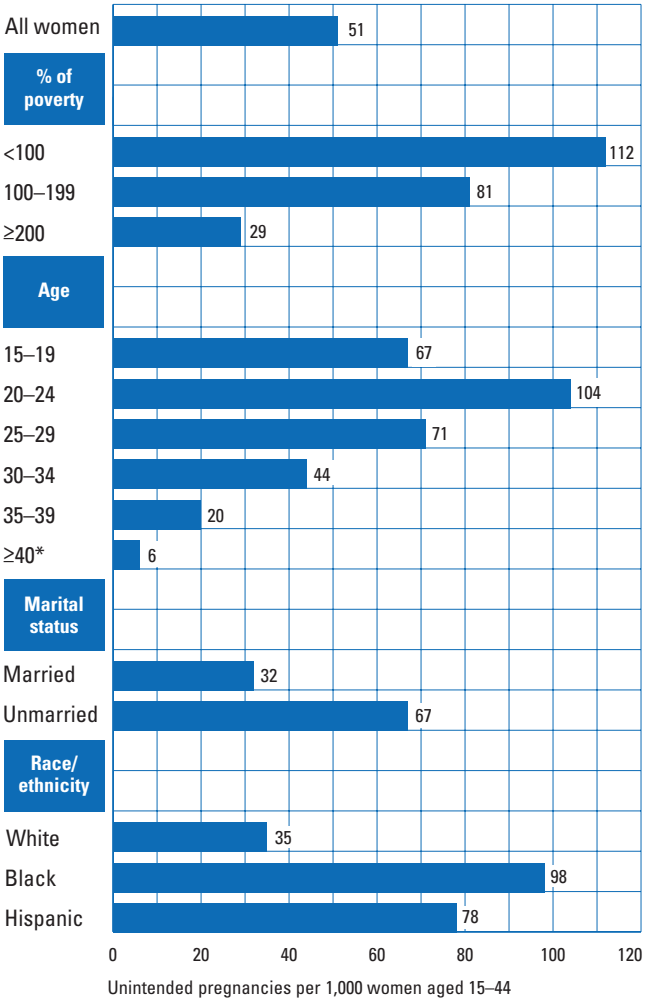
Although women who have abortions and women who have children are often perceived as two distinct groups, in reality, they are the same women at different points in their lives. Six in 10 women who have an abortion are already a parent.[16] Moreover, 52% of women having an abortion intend to have children or more children in the future.[17]

In short, most women who choose to have an abortion are not opposed to accepting parental responsibility. Instead, they are making a well-considered decision—often after becoming pregnant, even though a contraceptive was used—not to bring a child into the world at that time. They understand the commitment of parenthood and judge themselves unable, given their circumstances, to fulfill that responsibility as they would like or to provide the kind of family they believe their children deserve.

This report seeks to increase the understanding of the role abortion has played and continues to play in the larger context of the lives of American women. In Chapter 2, we review the history of abortion in the United States, paying special attention to the obstacles women faced in obtaining an abortion prior to *Roe v. Wade* and the devastating consequences of illegal abortion in pre-*Roe* America and around the world today. Chapter 3 describes the significant individual and public health gains that have accrued in the three decades since abortion became legal nationwide. In Chapter 4, we address the persistent allegations that abortion has long-term, negative consequences for women's physical and psychological health. Chapter 5 examines the societal factors that cause large groups of American women to be at a disadvantage in obtaining an abortion and in accessing the information and services they need to prevent unintended pregnancy. And finally, in Chapter 6, we make recommendations on how we as a society can do a better job of helping women prevent unintended pregnancy, while simultaneously ensuring that women who need abortions are able to obtain procedures safely and with dignity.

FIGURE 1.3

Some groups of women have higher rates of unintended pregnancy than others.



Note *Denominator is women 40–44.
Source Reference 10.

Lessons from Abroad: Legal or Illegal, Abortion Rates Are High Where Levels of Unintended Pregnancy Are High

The longtime trend of wanting and having smaller families has become a global phenomenon. It is likely both a reflection of and a response to the opportunities and demands of modern society.[1] For several decades, women in the United States, like those in many European countries, have typically wanted no more than two children. And now, women in most of Latin America, Asia, the Middle East and North Africa generally want just two or three children as well. Women and couples in much of Sub-Saharan Africa still desire larger families, but even there, women want fewer children than did their mothers or grandmothers and want to space the children they do have at healthy intervals. Historically and around the world, this trend reflects the pervasive desire to time the birth of a child to attain the best outcome for the child, mother and family.

Ideally, this desire for greater control over fertility would be matched by widespread availability of and support for modern contraceptives. Otherwise, there would be an inevitable rise in unplanned pregnancies, many of which would end in abortion, whether it is legal or not (Table 1.2).[2] Put simply, levels of abortion are much less directly tied to the legal status of abortion than to the incidence of unintended pregnancy, which is itself related to the level of sexual activity, the age at which women marry, the number of children they want and the extent to which they know about and practice contraception. In Uganda and the Philippines, for example, the desired family size has fallen sharply since the 1980s.[3] Yet in both countries, the levels of modern contraceptive use remain very low, leading to high rates of unintended pregnancy. As a result, both countries' abortion rates have surpassed that of the United States, despite each having strict abortion bans and strong religious and cultural traditions condemning the procedure.

Indeed, abortion rates are often highest in many of the countries where the procedure is most severely restricted. For example, abortion is banned in Bangladesh, Brazil, Colombia, the Dominican Republic, Nigeria and Peru. However, in these countries, clandestine abortion is reported to be widespread and illegal abortion is estimated to occur more than twice as often as legal abortion does in the United States.[4] At the other end of the spectrum, some of the world's lowest abortion rates can be found in countries with the most liberal abortion laws. In the Netherlands, abortion is legal, free and widely available; however, the abortion rate is less than half of the U.S. rate. Dutch women, like American women, want small families, marry late and experience high rates of premarital sexual activity. However, unlike in the United States, unintended pregnancy in the Netherlands is rare because of comprehensive sex education programs, easy access to contraceptives (including through a national health insurance program), effective contraceptive use and the high value society places on contraceptive use among sexually active people.[5]

TABLE 1.2

Abortion rates are often far higher in countries where abortion is illegal than in countries where it is legal.

Country and year	Abortions per 1,000 women aged 15–44
Abortion is broadly permitted	
Belgium, 2003*	8
England/Wales, 2003	17
Finland, 2003	11
Germany, 2003	8
Netherlands, 2004	9
United States, 2002	21
Abortion is severely restricted	
Brazil, 1991	41
Chile, 1990	50
Colombia, 1989	36
Dominican Republic, 1990	47
Mexico, 1990	25
Nigeria, 1996	25
Peru, 1989	56
Philippines, 2000	27

Note *Includes abortions obtained in the Netherlands.
Source Reference 2.

Chapter 2

Abortion Before Legalization

The history of abortion in the United States clearly shows that making abortion illegal does not eliminate the procedure, because it does nothing to reduce the underlying cause—unintended pregnancy. In fact, making abortion illegal has a far greater impact on the circumstances under which the procedure is obtained (and, therefore, the consequences for the woman, her family and society) than on its incidence.

Abortion was severely restricted before *Roe,* often with harsh penalties for violating the law

At the nation's founding, abortion was generally permitted in each state under common law. The procedure began to become criminalized in the mid-1800s, and by 1900, almost every state had enacted a law declaring most abortions to be criminal offenses.[1] This process was driven in no small measure by doctors concerned about the safety of abortions performed by untrained midwives or other traditional abortion providers[2] (similar to those still found in many developing countries today). Yet, even after the procedure was criminalized, unsafe abortion continued to be an all too common fact of American life, eventually leading doctors who treated women with abortion complications to become involved in efforts to liberalize abortion laws.

In the early 1960s, a decade before the Supreme Court handed down *Roe v. Wade* in 1973,[3] 44 states still allowed abortion only in cases where the woman's life would be endangered if she carried the pregnancy to term.[4] Alabama, Colorado, New Mexico, Massachusetts and the District of Columbia permitted abortion if the life or physical health of the woman was in jeopardy, and Mississippi allowed the procedure in cases of life endangerment or rape; Pennsylvania prohibited all abortions.

Violation of these laws could have serious repercussions for all involved. Physicians feared not only loss of licensure and professional reputation, but criminal prosecution. Most states had statutes allowing for the imposition of fines or prison sentences for those convicted of providing illegal abortions; in 15 states, the sentence could be up to 10 years' imprisonment.[5] Nine states considered it a criminal offense to aid, assist, abet or counsel a woman seeking an illegal abortion.[6] Fourteen states explicitly made obtaining as well as performing an abortion a crime that could be punishable by a fine, imprisonment or both. Abortion patients were rarely prosecuted under these statutes; more often, prosecutors used the threat of prosecution to pressure women into testifying against the person who performed their procedure.

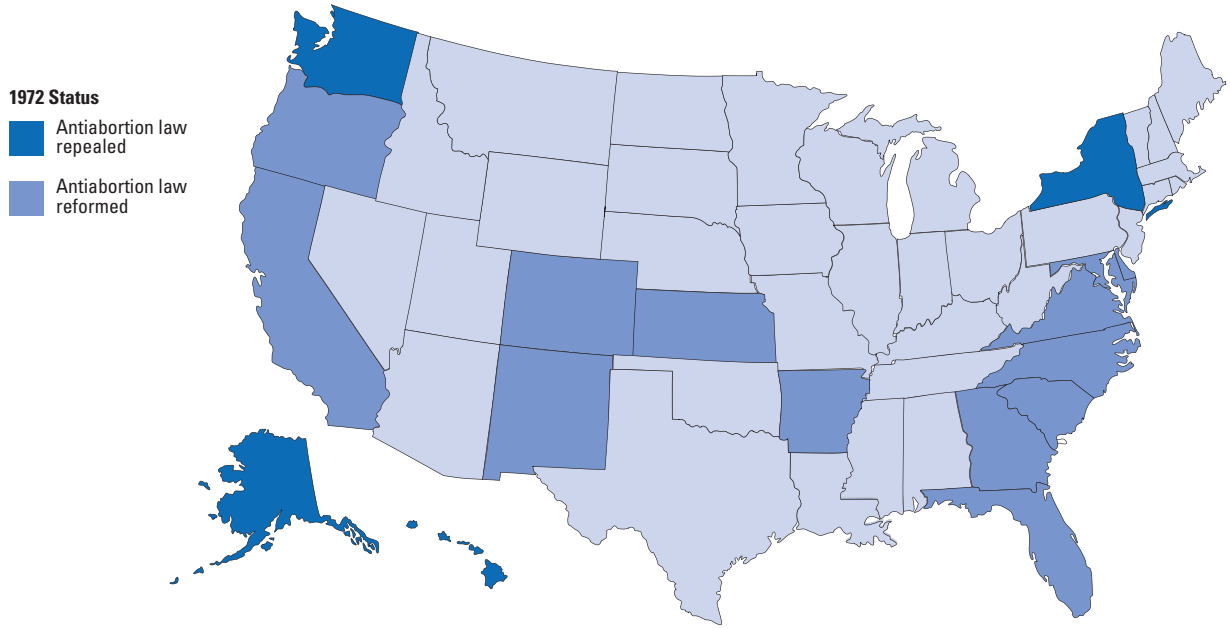
Medical, legal and religious leaders led the way to make abortion legal

The continuing toll of abortion morbidity and mortality on women and families made the issue a moral imperative for many in the medical, legal and pastoral professions, and their efforts eventually convinced policymakers to take up the cause. One of the first national calls to decriminalize abortion came in 1962 from the American Law Institute (ALI), a prestigious panel of lawyers, scholars and jurists that develops model statutes on a range of topics. In its model penal code on abortion, the ALI called for abortion to be legal when the woman's life, physical health or mental health would be at risk if the pregnancy were carried to term; when the pregnancy resulted from rape or incest; or when the fetus had a severe defect.[7]

Some of the most powerful activists supporting the legalization of abortion were members of the clergy. In 1967,

FIGURE 2.1

Seventeen states had already reformed or repealed their antiabortion laws before the 1973 *Roe v. Wade* decision.



Source Reference 14.

Howard Moody, a Baptist minister, joined with 25 other ministers and rabbis to create the Clergy Consultation Service, a counseling service for women with unwanted pregnancies.[8] According to the organization's statement of purpose, "Confronted with a difficult decision and the means of implementing it, women today are forced by ignorance, misinformation and desperation into courses of action that require humane concern on the part of religious leaders. Belief in the sanctity of human life certainly demands helpfulness and sympathy to women in trouble and concern for living children many of whom today are deprived of their mothers, who die following self-induced abortions or those performed under sub-medical standards."[9] Within a year of its founding, the clergy service had 1,400 members, who counseled over 10,000 women during its three years of operation.[10]

In addition to lawyers and clergy, doctors who treated women suffering abortion complications were also a strong force for liberalizing abortion laws. In 1967, the House of Delegates of the American Medical Association endorsed liberalization of state abortion laws, and in the following year, the American Public Health Association urged the repeal of restrictive abortion statutes.[11] And many other national organizations called for the reform or repeal of laws: A 1965 resolution by the American Ethical Union urging the reform of abortion laws was followed by similar action by the American Baptist Churches (USA), Church of the Brethren, Lutheran Church in America, National Council of Jewish Women, Presbyterian Church in the United States, Unitarian Universalist Association, United Methodist Church, United Presbyterian Church (USA) and the United Synagogue of America.[12]

In 1967, Colorado became the first state to reform its abortion law based on the ALI recommendation.[13] The new statute permitted abortion if the pregnant woman's life, physical health or mental health were endangered; if the fetus would be born with a severe physical or mental defect; or if the pregnancy had resulted from rape or incest. Other states began to follow suit, and by 1972, 13 states had statutes patterned after the ALI model (Figure 2.1).[14] In addition, four states, including New York, had repealed their antiabortion laws completely, substituting statutes permitting abortion when judged to be necessary by a woman and her physician.[15] During the debate over New York's law, state legislator Albert Blumenthal painted the repeal as a moral imperative. Citing the nearly 400 women who had died from an unsafe abortion in New York City over the previous decade, Blumenthal asked "Isn't that the ultimate morality? Could we have saved 367 young women from dying if we had not imposed on them our own sense of morality and condemned them…to the butchery of the side streets of Harlem or Riverside Drive in my district?"[16]

By 1973—the year the Supreme Court handed down its decisions in *Roe v. Wade* and *Doe v. Bolton*[17]—four in 10 U.S. women of reproductive age lived in a state that had already repealed or reformed its abortion laws,[18] and

abortion reform legislation had been introduced in all but five states (Alabama, Louisiana, South Dakota, West Virginia and Wyoming).[19] The Court held in *Roe v. Wade* that a woman's right to choose whether to obtain an abortion, in consultation with her physician, is constitutionally protected, but not absolute. After viability (i.e., the point in pregnancy when a fetus can survive outside the womb), states may restrict or prohibit abortions unless the procedure is necessary to protect the life or health of the woman. By so doing, the Court effectively overturned the remaining laws criminalizing abortion, making the procedure legal nationwide. Almost 20 years later, in 1992, the Court reaffirmed that central holding, but held that state regulations that do not impose an undue burden on a woman's ability to obtain an abortion are permissible.[20]

Far from ending abortion, criminalization placed many women and their families at risk

The criminalization of abortion did not eliminate the procedure, but instead put many women's lives in jeopardy by forcing them to seek clandestine procedures. In the 1950s and 1960s, it is estimated that 200,000 to 1.2 million women each year had illegal abortions in the United States, many of which were under unsafe conditions.[21] According to another estimate, which extrapolated data from North Carolina, 699,000 illegal abortions occurred nationwide in 1955 and 829,000 illegal procedures were performed in 1967.[22]

Although estimates of the number of illegal abortions that were performed each year in the United States vary, one stark indication of their prevalence is the death toll. Despite improvements over time in the safety of abortion and the adequacy of postabortion care, as late as 1965, illegal abortion still accounted for an estimated 201 deaths—17% of all officially reported pregnancy-related deaths that year (Figure 2.2).[23] Epidemiologists believe the actual number was likely much higher,[24] but that many deaths were officially attributed to other causes, perhaps to protect women and their families.[25]

Poor and minority women and their families were disproportionately affected by the criminalization of abortion, because even where abortion was illegal, women with financial means often had access to a safe procedure. For example, a woman could obtain a legal abortion by getting the approval of a hospital committee established to review abortion requests—an option generally only available to the well-connected.[26] Less affluent women, however, had few options aside from a dangerous, illegal abortion.

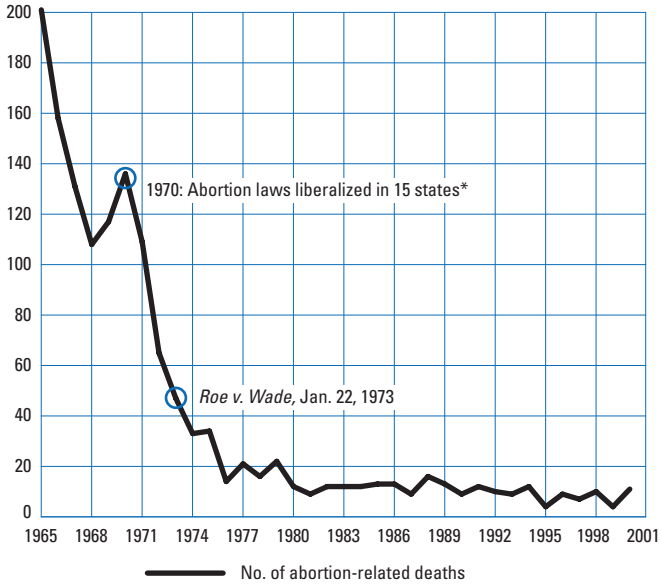
Rep. Constance Cook, the author of the 1970 legislation to repeal New York State's antiabortion law, painted a powerful picture of the statute's cruel inequities during the legislature's debate over the reform bill:

> There are many who say that this bill is abortion on demand. I submit that it is not. I submit that we have abortion on demand in the state of New York right now. Any woman that wants an abortion can get one. And the real difference is how much money she has to spend. If she has $25, she has it done here under the most abominable circumstances. If she has more money, she can go abroad. But the fact remains, that she can get it. We have abortion on demand. And if she doesn't have the $25, please don't forget that she can abort herself. And regretfully, regretfully, this is happening more often than you or I like to admit.[27]

In that context, it is hardly surprising that, according to a study of abortions performed at a large New York City hospital from 1950 to 1960, the incidence of abortion was much higher among patients with private physicians than among women without their own doctor.[28] In addition, low-income women were more likely than more affluent women to be admitted to hospitals for postabortion care following an illegal abortion in New York City in the 1960s.[29] And in a separate study of low-income women in New York from the same time, one in 10 said they had attempted to terminate a pregnancy illegally, almost always with a self-induced abortion.[30] Furthermore, one of every two childbirth-related deaths among nonwhite and Puerto Rican women in New York City in the 1950s

FIGURE 2.2

Deaths from abortion declined dramatically after legalization.



Note *By the end of 1970, four states had repealed their antiabortion laws, and 11 states had reformed them.

Source Reference 23.

Lessons from Abroad: The Consequences of Illegal Abortion Are Still Visible Today

Looking back in time is one way to reflect upon what women faced in a world without access to safe, legal abortion; looking beyond the borders of the United States is another. One in four of the world's women live in countries that severely restrict or ban induced abortion.[1] Even so, abortion is common in most of these countries. In 2000, the World Health Organization estimated that of the 46 million abortions that occur each year worldwide, 19 million are illegal.[2] Some women in countries where abortion is largely illegal may be able to afford a safe, although clandestine and illegal, procedure performed by a physician, as was the case in the United States before Roe. *Not so, however, for the vast majority who live in extreme poverty. Moreover, many women in poor countries live in rural areas without access to hospital care for the complications that often follow an abortion performed using crude and dangerous traditional methods.*

Each year, more than a half million women worldwide die of pregnancy-related causes; 13% of those deaths are attributable to unsafe abortion (the proportion is as high as 17% in Latin America and the Caribbean, and 12% in Africa).[3] Indeed, in the large urban hospitals of some developing countries, complications of illegal abortion take up two out of three maternity beds and consume as much as half of the obstetrics and gynecology budgets.[4]

In country after country, just as was true in the United States, legalizing abortion and bringing it into the open has had a direct and immediate impact.[5] For example, six months after abortion was legalized in Guyana in 1995, hospital admissions for septic and incomplete abortion had dropped by 41%. In Romania, the criminalization of abortion in 1966 led to soaring maternal death rates that continued until the procedure was again made legal in 1990. And in South Africa, six months after legal abortion became available in 1997, the number of incomplete abortions at one large hospital in Port Elizabeth had declined from an average of 18 each week to approximately four.[6]

and early 1960s were due to abortion, compared with one in four among white women.[31] This sad reality, as well as the consequences for women and their families, is as true today in nations around the world where abortion is illegal as it was in the United States for a significant part of our history (see Lessons From Abroad).

In the late 1960s, a new alternative emerged, but again, only for those with considerable financial resources.[32] England liberalized its abortion law in 1967 to permit a woman to have an abortion with the written consent of two physicians. More than 600 American women made the trip during the last three months of 1969 alone, and by 1970, package deals were advertised in the popular media. Furthermore, although four states repealed their antiabortion laws in 1970, New York was the only one without a residency requirement, making travel to New York an option for those who could afford the cost of both the procedure and the travel.[33] (Low-income New York residents could obtain procedures through Medicaid, an option not available to nonresidents.) The year before *Roe,* more than 100,000 women left their own state to obtain a legal abortion in New York City;[34] about 50,000 traveled more than 500 miles, nearly 7,000 traveled more than 1,000 miles and some 250 traveled more than 2,000 miles, from as far as Arizona, Idaho and Nevada.

The need to travel often resulted in a delay in obtaining an abortion, increasing the risk of complications. One in four women traveling to New York City from nonneighboring states had their abortion after 12 weeks' gestation, compared with only one in 10 New York City residents (procedures after 12 weeks' gestation have a higher risk of complications than do earlier abortions).[35] Moreover, a woman who made her way to New York had to undergo the rigors of travel shortly after the procedure. If a complication arose, she most likely would be unable to receive care from the physician who performed the abortion, and might even be unable to receive care from a physician with significant abortion experience.

Chapter 3

Three Decades of Legal Abortion

The three decades of legal abortion since *Roe v. Wade* have brought about significant advances for the lives and health of women. Today, abortion is a medically supervised and extremely safe procedure, and women overwhelmingly are able to obtain an abortion early in pregnancy. (For a portrait of abortion provision in the United States today, see page 20.) Moreover, after rising during the years immediately following *Roe,* the U.S. abortion rate stabilized and has been declining steadily since 1980.[1] This decline is in large part the result of increased contraceptive use and the availability and use of more effective methods.[2]

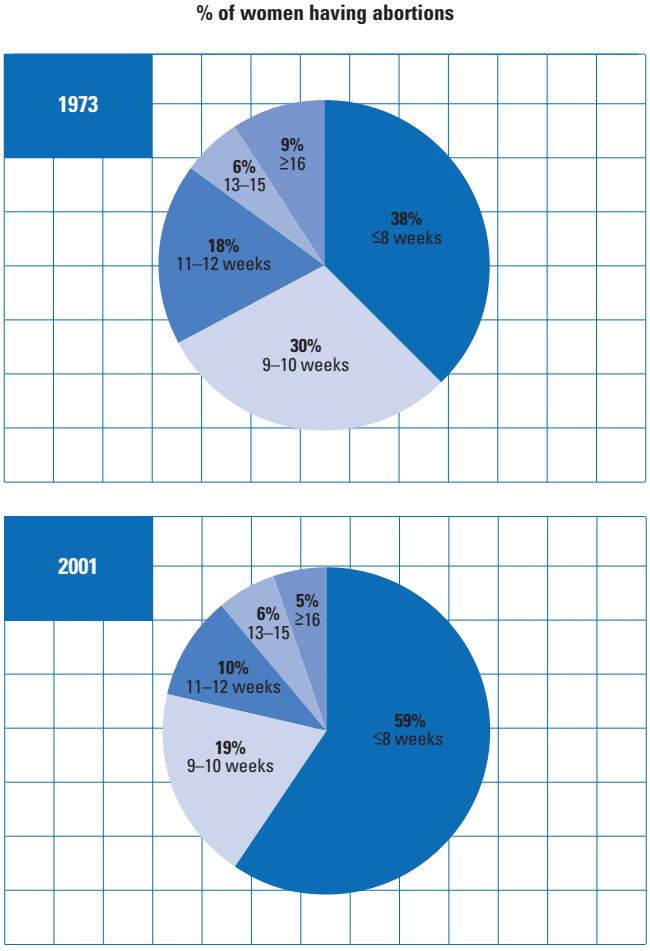
Women do not risk death or severe injury to end an unwanted pregnancy as they did in the past

Legalization in the United States meant that women across the country could terminate unwanted pregnancies knowing that the procedure would be performed by a skilled health professional in a clinical setting. Professionals formed networks of providers, training improved, and safer and simpler abortion procedures evolved: Vacuum aspiration rapidly replaced dilation and sharp curettage in the first trimester, and dilation and evacuation replaced labor induction for later abortions.[3] At the same time, local anesthesia largely replaced general anesthesia,[4] and free-standing clinics began to perform outpatient abortion procedures safely and less expensively.[5]

As safe and legal options became available to women, injuries and deaths from abortion plummeted and are now rare. According to estimates from the National Hospital Discharge Survey, the number of women hospitalized because of abortion-related complications declined between 1970 and 1977, with a sharp decrease in 1973.[6]

FIGURE 3.1

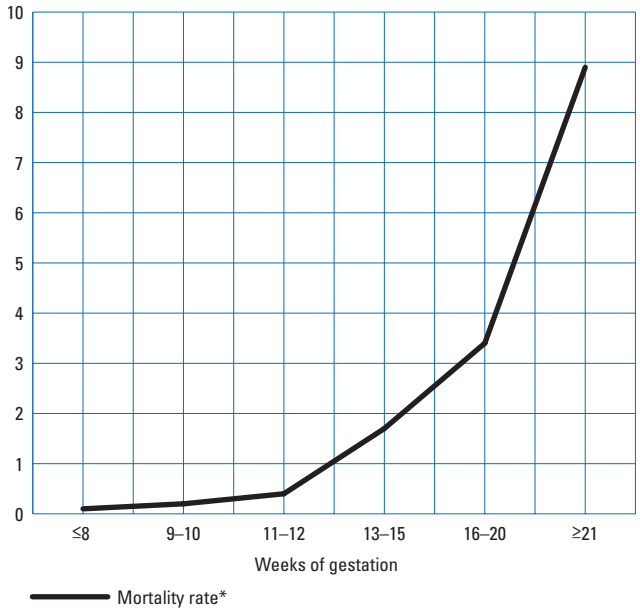
U.S. women have abortions substantially earlier in pregnancy today than they did three decades ago.



Note Percentages do not add to 100 because of rounding.
Source Reference 14.

FIGURE 3.2

The earlier an abortion is performed, the safer it is for the woman.



Note *Number of reported deaths per 100,000 abortions, 1988–1997.
Source Reference 17.

More recently, 1995 data indicate that fewer than 0.3% of abortion patients have complications requiring hospitalization.[7] Moreover, deaths from illegal abortion virtually disappeared after *Roe v. Wade:* In 1972, when four in 10 women aged 15–44 lived in a state where abortion was legal,[8] the Centers for Disease Control and Prevention reported that 41 women died from illegal procedures[9] (compared with around 400 in 1960);[10] that number fell to seven in 1974. Similarly, deaths associated with legal abortion are extremely rare: Since 1976, the overall rate has been less than one death per 100,000 legal abortions.[11]

Today, having an abortion in the United States involves far less short-term risk than carrying a pregnancy to term.[12] Moreover, there is a considerable body of credible evidence that abortion is safe over the long term. The state of the research is addressed in detail in Chapter 4.

American women want and increasingly are able to obtain an abortion early in pregnancy

These days, abortions overwhelmingly occur early in pregnancy. The proportion of all abortions performed at or before 12 weeks' gestation (calculated from the beginning of the last menstrual period) grew from 85% in 1973 to 90% by 1976 (see box).[13] The proportion of women seeking abortion in the first eight weeks of pregnancy increased dramatically after legalization: In 1970, only one in five abortions were performed at or before eight weeks' gestation, compared with one in two by 1977. Now, three in five abortions occur at or before eight weeks' gestation (Figure 3.1, page 15).[14] As a result, the proportion of women seeking abortion at or beyond 16 weeks' gestation has been reduced by almost half, from 9% in 1973 to 5% in 2001.

New technologies in the mid-1990s, including medication abortion and vacuum aspiration with ultrasound, further accelerated the trend toward earlier abortions (see box, page 18). In 2000, 37% of facilities that offered abortion services provided either surgical or medication abortions at or before four weeks' gestation—a five-fold increase from the 7% that did so in 1993.[15] Partly as a result of these developments, the proportion of abortions performed at or before six weeks' gestation has increased steadily, from 14% of abortions in 1992 to 25% in 2001.[16]

These trends are important for women's health, because an abortion is safer the earlier in pregnancy it is performed (Figure 3.2).[17] Although the risk of death from abortion is extremely small, it increases exponentially with increased gestational length, from a rate of 0.1 deaths per 100,000 legally induced abortions at or before eight weeks' gestation to 8.9 deaths after 20 weeks. Similarly, the risk of serious but nonfatal complications, such as a pelvic infection or hemorrhage requiring a blood transfusion, increases throughout gestation. In 1986 (the last year in which these data were collected), the risk of

When Does Pregnancy Begin?

According to the American College of Obstetricians and Gynecologists, a pregnancy takes several days to become established and this process is not completed until a fertilized egg is implanted in the lining of the woman's uterus.[1] The process has many steps. First, ovulation (the monthly release of an egg) occurs, and then the egg must be fertilized. Fertilization describes the process by which a single sperm penetrates the layers of an egg to form a new cell (called a zygote). This usually occurs in the fallopian tubes and can take up to 24 hours. There is only a short window during which an egg can be fertilized: The likelihood of fertilization is greatest if intercourse takes place in the six days leading up to and including the day ovulation occurs. If fertilization does not occur during that time, the egg dissolves and hormonal changes trigger menstruation. If fertilization does take place, the zygote grows and differentiates into a "preembryo" on its way through the fallopian tube toward the uterus. Typically, implantation of the preembryo in the uterine lining begins five days after fertilization and is completed 14 days after fertilization, although it can be completed as early as eight days or as late as 18 days after fertilization. Between one-third and one-half of all fertilized eggs, however, never fully implant.

When discussing pregnancy, the convention among medical professionals is to date a pregnancy from the first day of the woman's last menstrual period, because that is the date most women can pinpoint. Accordingly, a pregnancy of normal gestational length is considered to last approximately 40 weeks from the beginning of a woman's last menstrual period.

…by supporting legislation that restricts women's access to abortion, abortion opponents may be preventing women from obtaining early procedures and raising the safety risks for women whose procedures are seriously delayed.

major complications was about 0.2% for abortions performed at seven or eight weeks' gestation, 0.6% at 13 or 14 weeks, and 1.5% after 20 weeks.[18]

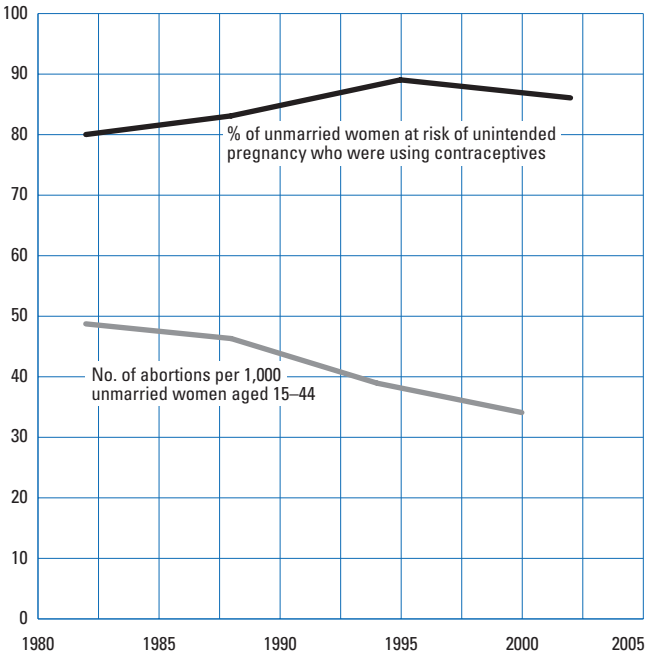
For a woman who has made the decision to end an unintended pregnancy, an early abortion is clearly preferable. But many factors can delay her from obtaining the procedure, including lack of awareness of her pregnancy, lack of money, difficulty finding a provider, the distance to the nearest provider, the inability to leave work and the need to arrange for child care.[19] (For more on this topic, see Chapter 5.) In addition, her situation can be further complicated by a range of governmental restrictions on abortion, such as waiting periods and mandated parental consent or notification. Thirty-four percent of women who have had an abortion at or before six weeks' gestation would have preferred an earlier procedure; this proportion increases to 74% at 9–12 weeks and 92% at or beyond 13 weeks.[20] Therefore, by supporting legislation that restricts women's access to abortion, abortion opponents may be preventing women from obtaining early procedures and raising the safety risks for women whose procedures are seriously delayed.

Sharp increases in contraceptive use have been a major factor in declining abortion rates

Following the nationwide legalization of abortion, the reported U.S. abortion rate increased, peaking in 1980 at 29 abortions per 1,000 women.[21] A number of factors may have contributed to this increase; however, one certain explanation is that illegal abortions, which were largely unreported, were replaced with legal procedures, which were reported.[22] Legalization, of course, also meant better access for women denied a safe abortion in the past. As the number of physicians who were trained and experi-

FIGURE 3.3

The increase in the proportion of unmarried women at risk who were using contraceptives contributed sigificantly to the decrease in abortion rate among unmarried women.



Source Reference 24.

New Technologies and Earlier Abortion

Recent technological advances have made it possible for women to have an abortion more safely and earlier in pregnancy than ever before. And perhaps no new technology was more anticipated than the early abortion pill, mifepristone (commonly known as RU-486). Mifepristone, which was first approved in France in 1988, is given under the supervision of a physician, and the resulting abortion can be completed in the privacy of a woman's home. The U.S. Food and Drug Administration (FDA) approved mifepristone in September 2000—a decision hailed by health professionals, abortion rights activists and women's health groups as a momentous step, because it allowed American women the option of a safe, early and nonsurgical abortion long available to women in Europe. In addition, FDA approval spawned hopes that a range of providers who had not offered abortion before would begin providing medication abortion, resulting in women's increased access to abortion outside urban areas and more generally in areas with few or no clinics. Proponents predicted a reduction in the violence directed toward abortion clinics and, ultimately, some defusing of the abortion debate.

There are indications that the use of mifepristone for early abortion is growing in the United States, although mainly at sites that also provide surgical abortion. The proportion of early abortions performed with mifepristone at Planned Parenthood clinics, for example, has increased steadily from 9% of eligible women in 2001 to 24% in 2004.[1] At the same time, nearly one-fifth of mifepristone sales are to providers that are not abortion clinics.[2] A decade of experience with nonsurgical abortion in Europe indicates that integration of the procedure into a country's medical care system is generally slow and gradual. Moreover, that experience strongly suggests that the introduction of mifepristone in the United States will not noticeably increase the country's abortion rate but, instead, may well increase the proportion of abortions taking place very early in pregnancy. In European countries where mifepristone is available, a larger proportion of women are now having abortions at or before nine weeks than did so before the drug was introduced.[3]

In addition to mifepristone, other technologies have made it possible for women to have safe early abortions. Highly sensitive at-home urine pregnancy tests and the use of transvaginal ultrasonography allow women and providers to confirm and date a pregnancy earlier. Furthermore, during the 1990s, before mifepristone was available in the United States, health care providers and patients became interested in the prospect of early terminations, spurring the development of new surgical techniques: For example, innovations in the way that vacuum aspiration is performed, such as with a handheld syringe, offer the possibility of earlier abortion, and also reduce the risk of complications.

Because of these technological advances, women can end an unwanted pregnancy within days of a missed menstrual period, whereas in the past, women presenting with a pregnancy of less than eight weeks' gestation were typically asked to wait for their procedure. In addition, now women have a choice of procedures when seeking an early abortion.

enced in the procedure increased, and as a nationwide network of outpatient abortion clinics developed, women who previously did not have access to even a clandestine abortion were able to receive a legal procedure in a medical facility.

The U.S. abortion rate began to fall after 1980, dropping more steeply after 1990 until it reached a rate of 21 abortions per 1,000 women in 2002—the lowest since 1974.[23] Although the abortion rate among married women remained consistently low between 1981 and 2000, the rate for unmarried women fell sharply, from 50 per 1,000 women in 1981 to 34 in 2000 (Figure 3.3, page 17).[24] A key factor behind this trend was increased contraceptive use. The proportion of unmarried women at risk of unintended pregnancy who were using contraceptives increased from 80% in 1982 to 86% in 2002;[25] this increase was accompanied by a decline in unmarried women's unintended pregnancy rate (which is in turn a key determinant of the abortion rate) over the same period.[26] Thus, the increase in contraceptive use contributed significantly to the decrease in abortion rates among unmarried women.

In short, although opponents argue that making abortion legal encourages women to use abortion instead of contraceptives as their primary method of family planning, this has emphatically not been the case in the United States. Moreover, experience from around the world demonstrates that women who are determined to have smaller families and to control the timing of their childbearing will resort to abortion—even illegal abortion—if necessary; however, where contraceptive services are readily available and accessible, levels of contraceptive use will increase and will be accompanied, over time, by falling abortion rates (see Lessons From Abroad).

Lessons from Abroad: Reducing Abortion Takes Time

When the desire for small families takes hold in a society, the initial result is often an increase in both contraceptive use and abortion. Over time, however, increasing levels of contraceptive use are accompanied by falling abortion rates. The experiences of South Korea, Hungary and Russia are cases in point.

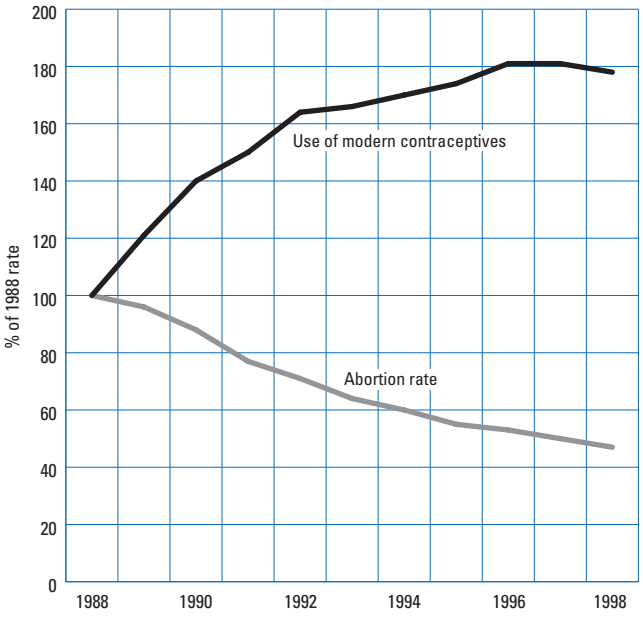
South Korea experienced a dramatic decrease in desired family size beginning in the 1960s, and the average number of children a woman had fell by more than half over a 20-year period. As women's motivation for small families intensified, abortion and contraceptive prevalence rates rose. Eventually, the country's total fertility rate began to stabilize, the abortion rate plateaued and then began to fall, and contraceptive use continued to increase.[1]

In Hungary in the late 1950s, most women were relying on abortion rather than contraception to limit the size of their families. The country's contraceptive use rate hovered at about 20%, and the abortion rate was around 70 per 1,000 women (more than three times the U.S. rate today).[2] *Then, in the mid-1960s, an increase in the availability of contraceptives led to a gradual rise in their use. Abortion rates reached a peak of 90 per 1,000 women in the late 1960s,*[3] *and then dropped sharply once the shift to pregnancy prevention took hold and contraceptive use began to increase. Today, the rate of contraceptive use is 68%,*[4] *and the abortion rate stands at about 35 per 1,000 women.*[5]

The abortion rate in Russia historically has been among the world's highest. Although small families have long been the norm, modern contraceptives have not been widely available. In fact, until quite recently, the only contraceptive options available to Russians were largely low-quality condoms and diaphragms. Russia legalized abortion in 1955 in response to the public health problem of illegal procedures. From that time until the 1980s, it was not uncommon for a woman wanting only two children to have 10 or more abortions in her lifetime; as late as 1990, Russia's abortion rate was well over 100 per 1,000 women of reproductive age. The situation began to change in the late 1980s, when free market reforms opened the door to foreign-made modern contraceptives. And in 1992, the Russian government, which had always subsidized abortion services, began subsidizing family planning programs and promoting contraceptive use by distributing free contraceptives. The results have been dramatic: In the ensuing decade, contraceptive use rose and the abortion rate plummeted (Figure 3.4).[6]

FIGURE 3.4

Between 1988 and 1998, as modern contraceptive use increased in Russia, the abortion rate declined by 53%.



Source Reference 6.

Abortion in the United States Today

Wanted and unwanted pregnancies

- *Most U.S. couples want only two children. To achieve this goal, the typical woman spends roughly five years pregnant, postpartum or trying to become pregnant and three decades trying to avoid unintended pregnancy.*[1]
- *Among women who are at risk of an unintended pregnancy,* 89% are currently using a contraceptive method.*[2]
- *Nearly half of pregnancies are unintended, and about half of women aged 15–44 have experienced an unintended pregnancy.*[3]
- *Half of unintended pregnancies occur among the 11% of women at risk who were not using a contraceptive method during the month they became pregnant.*[4]

Incidence of abortion

- *In 2002, 1.3 million abortions took place in the United States. Each year, two out of every 100 women aged 15–44 have an abortion.*[5]
- *Half of unintended pregnancies and one in five pregnancies overall end in abortion.*[6†]
- *Each year, 46 million abortions occur worldwide; 19 million of those are illegal procedures. About 3%—virtually all legal—occur in the United States, which has 5% of the world's reproductive-aged women.*[7]

Women who obtain abortions

- *At the current rate, more than one-third (35%) of American women will have had an abortion by the time they reach age 45.*[8]
- *More than half of abortions in the United States are to women in their 20s—33% to women aged 20–24 and 23% to women aged 25–29.*[9]
- *Two-thirds of all abortions occur among never-married women.*[10]
- *The abortion rate among women living below the federal poverty level (i.e., $9,570 for a single woman with no children) is more than four times that of women living above 300% of the poverty level (44 vs. 10 per 1,000 women).*[11]
- *Black women are more than twice as likely as women overall to have an abortion, and Hispanic and Asian women have abortion rates slightly higher than average: Five percent of black women have an abortion each year, compared with 3% of Hispanic women, 3% of Asian women and 1% of white women.*[12]
- *Among women having an abortion, 43% identify themselves as being Protestant and 27% as being Catholic. The abortion rate for Protestant women is slightly lower than that for Catholic women (18 vs. 22 per 1,000), and substantially lower than those for women of other religions and women who do not identify with any religion (31 and 30 per 1,000, respectively).*[13]
- *More than 60% of abortions occur among women who have had one or more children.*[14]
- *Forty-eight percent of women having abortions have had at least one previous abortion.*[15]
- *Among women who have had an abortion, 59% did so at or before eight weeks' gestation, and 89% at or before 12 weeks' gestation. One percent of women who have had an abortion did so at or after 21 weeks' gestation.*[16]

**Women are at risk if they are sexually active, able to become pregnant and not currently pregnant, postpartum or seeking pregnancy.*

†The proportion of unintended pregnancies ending in abortion excludes miscarriages and other fetal losses.

Contraceptive use and abortion

- *Among women who have had an abortion, 54% used a contraceptive method during the month they became pregnant. Of those, 76% of pill users and 49% of condom users reported using the methods inconsistently, but 13% of pill users and 14% of condom users reported becoming pregnant despite using their method perfectly.*[17]
- *Forty-six percent of women who have had an abortion did not use a contraceptive method during the month they became pregnant. Of those women, 33% perceived themselves to be at low risk of becoming pregnant, 32% had concerns about contraceptive methods, 26% had unexpected sex and 1% were forced to have sex.*[18]
- *Among women having an abortion, 8% had never used a contraceptive method; never-use is greatest among those who are young, poor, black, Hispanic or poorly educated.*[19]
- *Family planning clinics funded under Title X of the federal Public Health Service Act have helped women prevent 20 million unintended pregnancies over the last 20 years; an estimated nine million of these pregnancies would have been expected to end in abortion.*[20]

Providers and services

- *In 2000, there were 1,819 abortion providers in the United States. Eighty-seven percent of all U.S. counties lacked an abortion provider, and 34% of women of reproductive age lived in a county that did not have a provider.*[21]
- *Thirty-seven percent of providers offer abortion at four weeks' gestation, and 97% offer abortion at eight weeks; 33% offer abortion at 20 weeks. After 20 weeks' gestation, the number of providers offering abortion services drops off sharply. Only 2% of all abortion providers offer abortions at 26 weeks' gestation.*[22]
- *The vast majority of abortions (93%) are performed at clinics, even though clinics represent only 46% of providers. The remainder are performed at hospitals (5%) and physicians' offices (2%).*[23]
- *In 2000, the cost of a nonhospital abortion with local anesthesia at 10 weeks' gestation ranged from $150 to $4,000; the average was $370.*[24]
- *Three-fourths of abortions are paid for out-of-pocket by women, and 13% are paid for by private insurance. About 13% of abortions are paid for with public funding*[25]*—virtually all of which comes from the 17 states that use their own Medicaid funds to cover the cost of abortion for poor women.*[26]
- *Sixteen percent of patients travel between 50 and 100 miles to obtain an abortion. Eight percent travel more than 100 miles.*[27]
- *Fifty-six percent of all abortion providers and 82% of large providers experienced some kind of harassment in 2000, including picketing of clinics and staff members' homes, physical interference with patients, vandalism and bomb threats. Of large abortion providers, 61% had 20 or more picketing incidents.*[28]

Chapter 4

The Long-Term Safety Of Abortion

In the last 30 years, researchers have considered the long-term implications of terminating a pregnancy. And despite challenges in all stages of the research process—from study design, through data collection and analysis, to the interpretation of results (see box)—the preponderance of evidence from well-designed and well-executed studies indicates that abortion is safe over the long term and carries little or no risk of fertility-related problems, cancer or psychological illnesses. However, this has not stopped abortion opponents from insisting that abortion is dangerous to women's health.

Leaders in the antiabortion community have attempted to document a link between abortion and fertility issues, breast cancer and a phenomenon they call "postabortion traumatic stress syndrome," something they claim has traits similar to posttraumatic stress disorder but which is not recognized by either the American Psychological Association (APA) or the American Psychiatric Association. They have founded organizations to promote quasi-academic studies supporting these claims, and although these studies remain on the fringe of the scientific community, they have influenced policy at the state level. Antiabortion policymakers in several states have passed legislation requiring women seeking an abortion to be counseled that abortion can increase their risk of certain health issues. Also, abortion opponents have initiated high-profile public education campaigns on the purported health risks—initiatives that are clearly designed to discourage women from obtaining an abortion.

Abortion does not impair women's future fertility

About half of women having an abortion plan to have children in the future, and another one in five are unsure of their intentions.[1] Thus, any negative effect of abortion on women's future fertility would be an important concern. Researchers have investigated whether fertility-related problems could be related to infections or injuries caused by abortion, even if undetectable at the time of the procedure.

Several reviews of the available scientific literature affirm that vacuum aspiration—the modern method most commonly used during first-trimester abortions—poses virtually no long-term risks of future fertility-related problems, such as infertility, ectopic pregnancy, spontaneous abortion or congenital malformation.[2] Although the evidence is less extensive, the literature also suggests that repeat abortion, in and of itself, poses little or no risk.[3]

Some studies suggest that second-trimester abortion using dilation and evacuation may pose some increased risk of complications in future pregnancies, such as premature delivery and low birth weight in future pregnancies (as it does for short-term mortality and morbidity).[4] However, advances in the way second-trimester abortions are performed appear to have reduced complications: For instance, use of laminaria (a small, rod-shaped piece of dried seaweed), rather than metal instruments, dilates the cervix more gradually and less traumatically.[5]

Despite the preponderance of evidence that abortion does not impair women's future fertility, abortion opponents have continued to assert a definitive link between abortion—even in the first trimester—and preterm or low-birth-weight deliveries. Studies that report an increased risk of such adverse outcomes[6] typically fail to control for all the important confounding factors (e.g., having a sexually transmitted infection at the time of delivery). Others compare women having a first birth after abortion with women having a second birth, which is not a fair compar-

ison because first births are known to be riskier for the infant than later births.[7] Several well-designed studies have found no connection to pregnancy-related outcomes: For example, a large prospective study comparing women who had had an abortion with a carefully matched control group found no link between abortion history and poor pregnancy outcomes.[8] Furthermore, according to two recent studies of mifepristone by researchers in Asia, there is no significant difference between women who had had a medication abortion, a surgical abortion or no abortion, in terms of their risk of preterm or low-birth-weight delivery.[9]

Abortion is not associated with an increased risk of cancer

For several decades, researchers have extensively studied the potential connection between abortion and breast cancer, paying specific attention to whether abrupt hormonal changes after a pregnancy is terminated alter a woman's breasts in a way that leaves her vulnerable to cancer later in life. Until the mid-1990s, the evidence was inconsistent. Abortion opponents seized upon a 1996 analysis, which combined the results of multiple studies and reported that women who had had an abortion had a significantly elevated risk of breast cancer.[10] Other researchers and medical groups, however, found this study to be flawed, largely because the data were collected only after breast cancer had been diagnosed. The study was further flawed because women's histories of abortion were not collected from medical records, but rather were self-reported by the women themselves—a methodology that typically results in more complete reporting of past abortions by women with cancer than by women without cancer.[11]

Since then, exhaustive reviews by panels convened by the U.S. and British governments have consistently found no association between abortion and breast cancer. In February 2003, the U.S. National Cancer Institute convened a workshop of more than 100 of the world's leading experts to consider the issue. The following month, a joint meeting of the institute's boards of scientific advisors and counselors unanimously approved the workshop's conclusion that "induced abortion is not associated with an increase in breast cancer risk," saying that the evidence for that conclusion was "well established," the agency's highest standard.[12] Another exhaustive literature review and analysis published in 2004 by a panel convened by the British government came to the same conclusion.[13] According to that analysis, only studies that relied on women's reports of abortion found a cancer risk, and the panel concluded that such studies "cannot be trusted." In contrast, studies that relied on medical records found no increased risk of breast cancer. For example, one of the most highly regarded of such studies used the medical records of 1.5 million women in Denmark born between 1935 and 1978, and linked data from national registries for abortion and for cancer, thereby avoiding the pitfalls of self-reporting; it found no indication of risk of breast cancer following an induced abortion.[14]

As for the possibility that abortion may be linked to other types of cancer, the available evidence indicates that abortion is not a risk factor and may even be protective against some cancers; however, the literature is sparse and drawing any conclusions is difficult. Four studies have focused on thyroid cancer, two studies on colorectal cancer and three studies on cervical cancer. Some report a positive association, but are flawed in a number of ways that can lead to unreliable results; better-designed studies show no association. Research on endometrial and ovarian cancer suggests either no association or a protective effect.[15]

Abortion does not pose a hazard to women's mental health

According to studies of the reasons women give for choosing to have an abortion, the decision to terminate a pregnancy is often complex and sometimes difficult.[16] Most women feel relief after their abortion, but some experience short-term feelings of anger, regret, guilt or sadness; some women experience more serious psychological problems, although these cases are relatively rare.

Methodological Issues in Abortion Research

There are a number of challenges that make it difficult to study the possible long-term physical and psychological sequelae of abortion and that have the potential to lead to incorrect answers. To overcome these difficulties, researchers must use methods that take into account confounding factors, defined as risk factors associated with both the outcome of interest and the measured variable that may explain or contribute to that outcome.[1]

Certain factors are more common among women with a history of unwanted pregnancy and abortion than among other women, and health outcomes that might be more common among women with a history of abortion may be the result of these unmeasured factors that preceded the abortion. For example, a history of childhood sexual abuse, emotional problems, intimate partner violence or high levels of stress may be more common among women who have unintended pregnancies (and thus abortions), and may also lead to later psychological problems.[2] Similarly, among women giving birth, a history of sexually transmitted infection or poor prenatal care may be associated with both a history of abortion and with premature delivery or other complications of pregnancy.[3] In addition, patients with infertility, depression or other health problems may be more likely than healthy women to admit having had an abortion and to blame it for their present condition. Such reporting bias is a common problem in studies that rely on retrospective interviews, as opposed to studies that collect data from abortion patients prospectively over time or from medical records.

Most abortion, however, occurs in the context of an unwanted pregnancy, and it is very difficult to tease apart the effects of these two events. Psychological problems that develop after an abortion may not be caused by the procedure itself, but instead may reflect other factors associated with having an unwanted pregnancy, or those unrelated to either the pregnancy or the abortion, such as a history of emotional problems or intimate partner violence. Even so, the mental health of women who have had an abortion appears to be no worse than that of women who have carried their unintended pregnancy to term or of same-aged women overall.[17]

Since the early 1980s, abortion opponents have claimed that a large number of women who have had an abortion experience severe emotional problems as a result of the procedure. Each time the question of the psychological impact of abortion has been extensively examined, however, leading experts have concluded that there is no evidence to support a connection.

In 1987, President Ronald Reagan directed Surgeon General C. Everett Koop to prepare a report on the health effects of abortion. Because Koop was a vocal, longstanding foe of abortion, activists on both sides of the issue expected his report to conclude that abortion is associated with long–term dangers. After an exhaustive 15-month study, however, Koop declined to release the report. In March of 1989, he told the Human Resources and Intergovernmental Relations Subcommittee of the Committee on Government Operations that most of the research in this area had serious methodological flaws, making it impossible to support the premise that abortion does or does not cause psychological problems for a given individual, but that the psychological effects are "minuscule" from a public health perspective.[18] (In addition, he told the panel that "obstetricians and gynecologists had long since concluded that the physical sequelae of abortion were no different than those found in women who carried pregnancy to term or who had never been pregnant."[19])

Koop's findings did not quell the debate on the psychological aspects of abortion. In 1989, the APA convened a panel of experts to examine the evidence. The panel identified the studies that met the minimum criteria for scientifically valid research, and on the basis of those studies—which had diverse samples, different measures of response and different times of assessment—concluded that legal abortion of an unwanted pregnancy "does not pose a psychological hazard for most women." Although some women experience severe distress or psychopathology after abortion and require the intervention of a mental health professional, these reactions are "rare and can best be understood in the framework of coping with normal life stress." For example, women who are terminating pregnancies that are wanted or who lack support from their partner or parents for the abortion may feel a greater sense of loss, anxiety and distress. For most women, however, the time of greatest distress is likely to be before an abortion; after an abortion, women frequently report feeling "relief and happiness."[20]

Since the APA panel's review of the scientific literature, there has been a new wave of analyses that report correlations between a history of abortion and a range of conditions, including psychiatric treatment, depression, anxiety, substance abuse and death. (Commonly, these studies are by David Reardon, director of the Elliot Institute, an Illinois-based organization that opposes abortion, and Priscilla Coleman, assistant professor in the School of Family and Consumer Sciences at Bowling Green State University.) Many of these studies, however, have methodological shortcomings that make it impossible to infer a causal relationship. None adequately control for factors that might explain both the unintended pregnancy and the mental health problem, such as social or demographic characteristics, preexisting mental or physical health conditions, childhood exposure to physical or sexual abuse, and other risk-taking behaviors. (Childhood exposure to physical or sexual abuse, for instance, is known to be associated with unintended pregnancy and abortion, and also with risk for a psychological disorder.[21]) Because of these confounding factors, even if mental health problems are more common among women who have had an abortion, abortion may not have been the real cause. In some of the articles, the authors suggest that abortion caused the later conditions, but concede that the data do not prove causality. For example, the authors of a study on abortion and subsequent substance abuse acknowledge that "various factors alone or in combination, as opposed to the abortion itself, may have been the critical variables that were related to the discrepant rates of substance use that was revealed in this report."[22]

Well-designed studies conducted since the APA review continue to find no causal relationship between abortion and mental health problems. One study that has come close to the ideal research design is a long-term prospective cohort study sponsored by the Royal Colleges of Obstetricians and Gynaecologists and of General Practitioners in the United Kingdom. This study followed more than 13,000 women in England and Wales over an 11-year period and compared two groups of women facing an unintended pregnancy: those whose pregnancy was terminated and those who delivered a baby. When the women's history of psychiatric illness was taken into account, the two groups did not differ in the rate at which psychiatric treatment was required in the years following the pregnancy outcome. If anything, the women who delivered appeared to be at higher risk: Among women without a history of psychiatric illness, those who delivered had a significantly higher likelihood of having a psychotic episode than those who had an abortion.[23]

Chapter 5

Lingering Disparities

Over the last several decades, much progress has been made in the ability of American women and their partners to control their childbearing. As discussed in Chapter 3, increased contraceptive use has enabled women to better avoid unintended pregnancies, and as a result, the abortion rate has decreased. Moreover, those abortions that do occur are taking place early in pregnancy, when the procedure is safest.

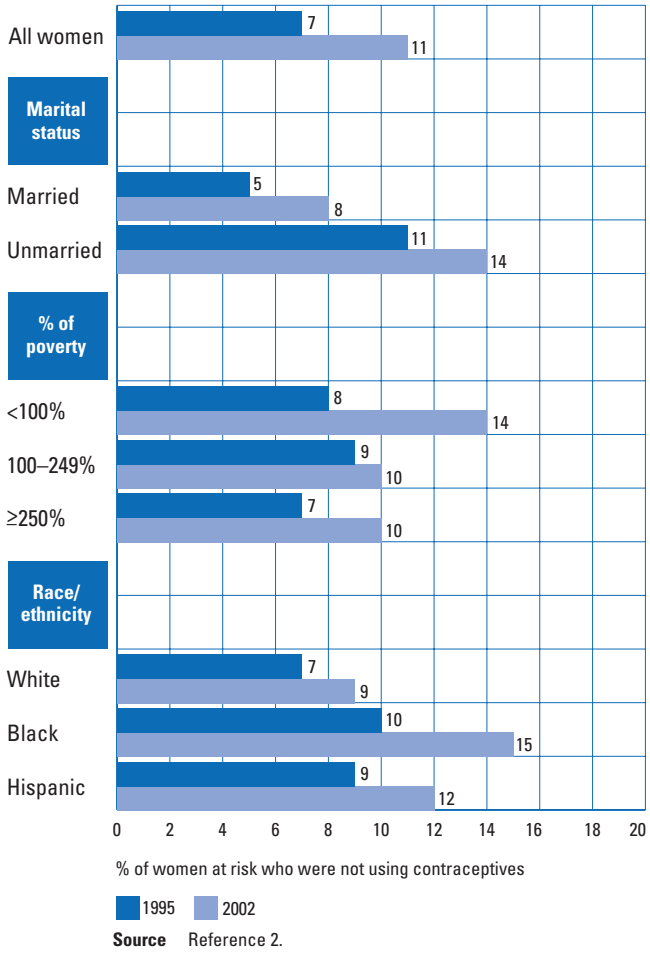
Although this progress is notable and vitally important, not all American women are sharing in it equally. Too many young, poor and unmarried women, as well as women of color, have not benefited from many of these gains. These groups of women have lower rates of contraceptive use than others, which increases their risk of unintended pregnancy, which in turn leads to higher levels of abortion. And even when seeking an abortion, the disadvantage continues, as these groups of women are more likely than others to experience a delay in obtaining the procedure.

Disparities in contraceptive use persist among poor women and women of color

Half of unintended pregnancies in the United States occur to the 11% of women at risk who do not practice contraception;[1] therefore, expanding contraceptive use remains the most effective way to further reduce unintended pregnancy among sexually active women (see Chapter 1). But again, the steady progress in the reduction of unintended pregnancy rates that occurred in the 1980s and 1990s seems to have stalled, and in fact, some key groups now appear to be losing ground. Nationwide, the proportion of women at risk of unintended pregnancy not using a contraceptive method fell from 12% in 1982 to 7% in 1995,

FIGURE 5.1

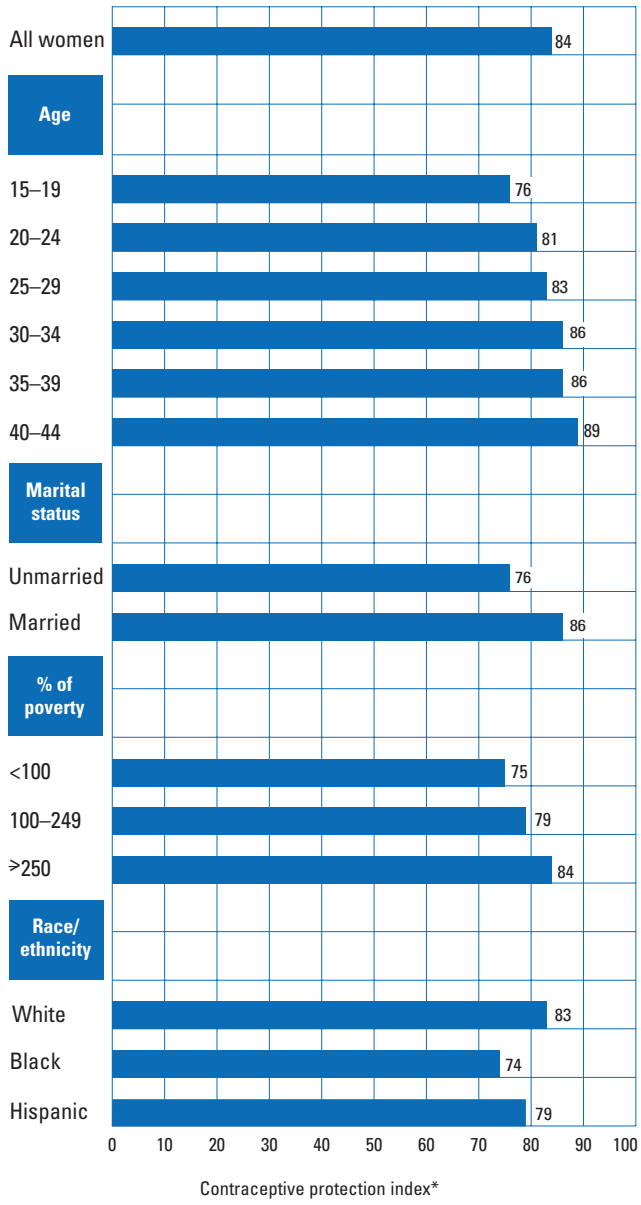
Among women at risk of unintended pregnancy, a greater proportion in 2002 than in 1995 were not using contraceptives, and some disparities in use grew during that time.



Source Reference 2.

FIGURE 5.2

Some groups of women have lower levels of contraceptive protection than others.



Note *The contraceptive protection index takes into account the proportion of women at risk of unintended pregnancy who are using contraceptive methods and the effectiveness of those methods. If 100% of women used a method that was 100% effective (an impossibility because all methods have some risk of failure), the contraceptive protection index would be 100. If 90% of women used oral contraceptives, which are 92% effective over one year, the index would be 90% x 92%, or 83.

Source Reference 5.

but then rose to 11% in 2002 (see Figure 5.1, page 25).[2] And nonuse has risen more sharply among poor women and women of color—those most likely to become pregnant without wanting to be—than among more affluent and white women.[3]

But whether a woman uses contraceptives is only one piece of the puzzle; another critical element is the effectiveness of the method she uses. Contraceptive methods that are long-acting and require minimal user intervention, such as the injectable and the IUD, have very low failure rates—typically, less than 3% of women who use such methods will become pregnant during a year of use.[4] Other methods such as the pill or condoms, which are more dependent on the consistency and correctness with which they are used, are effective but have somewhat higher failure rates.

When both the likelihood of using a contraceptive method and the effectiveness of the methods used are considered, large disparities emerge between groups of women, with women of color and those who are young, unmarried or poor having a lower level of contraceptive protection* against unwanted pregnancy than others (Figure 5.2).[5] As one would expect, these are also the same groups of women with high levels of unintended pregnancy, and those for whom the consequences of unwanted childbearing are likely to be particularly severe—not only for themselves, but for their children and their families as well.

Disadvantaged women bear a disproportionate burden of unintended pregnancies and abortions

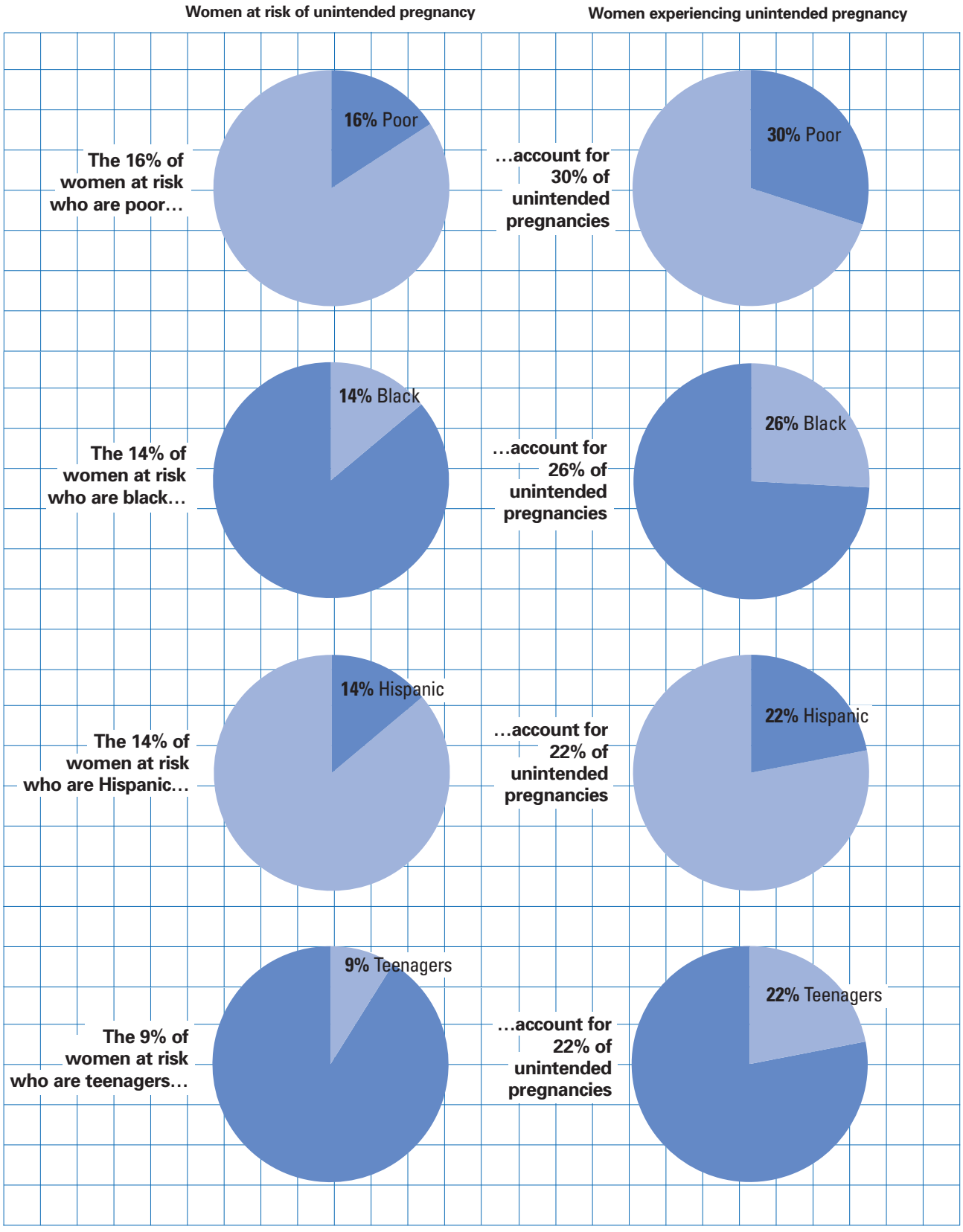
Between the early 1980s and the mid-1990s, American women made great strides in reducing unintended pregnancy, with incidence falling 18% in just over a decade.[6] But between 1994 and 2001, the overall unintended pregnancy rate remained unchanged, and now it stands at 51 per 1,000 women of reproductive age.[7] The lack of a change in the overall rate, however, hides significant trends by subgroup.

Most significantly, unintended pregnancy is becoming increasingly concentrated among poor women. Between 1994 and 2001, the unintended pregnancy rate rose 29% among women living below the poverty level and 26% among women living between 100% and 200% of the poverty level, but fell 20% among more affluent women.[8] The 16% of women at risk of unintended pregnancy who live in poverty[9] now account for 30% of unintended pregnancies nationwide (Figure 5.3).[10]

*We use a contraceptive protection index to account for the proportion of women at risk of unintended pregnancy who are using a contraceptive method and the effectiveness of the method used. If 100% of women used a method that was 100% effective (an impossibility since all methods have some risk of failure), the contraceptive protection index would be 100. If 90% of women used oral contraceptives, which are 92% effective over one year, the index would be 90% x 92%, or 83.

FIGURE 5.3

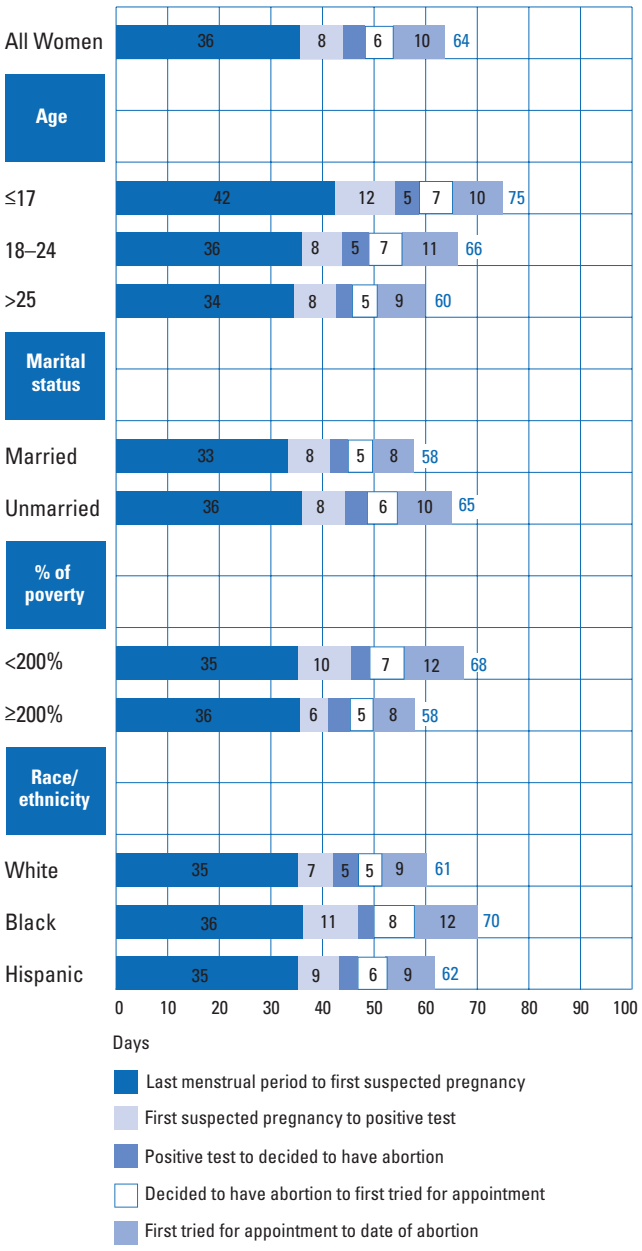
Some groups of women are disproportionately likely to experience an unintended pregnancy.



Note Based on women 15–44. **Source** Reference 10.

FIGURE 5.4

Young, unmarried, poor and black women experience delays in obtaining an abortion.



Note Segments may not add up to totals because of rounding.
Source Reference 28.

Black women saw some progress in recent years: The unintended pregnancy rate among blacks fell 3% between 1994 and 2001.[11] Nonetheless, it remains almost twice the national rate (98 vs. 51 per 1,000 women). This is likely because of a combination of factors, including the fact that black women are disproportionately poor and unmarried. Two-thirds of pregnancies to black women are unintended,[12] and although black women make up 14% of women at risk,[13] they account for 26% of all unintended pregnancies.[14]

The story is different for Latinas. Although the overall pregnancy rate for Hispanic women fell by 10% from 1994 to 2001, the decline was entirely because of a drop in intended pregnancies. The unintended pregnancy rate remained unchanged, leading to an increase in the proportion of pregnancies that are unintended. The unintended pregnancy rate for Latinas is 75% higher than for non-Hispanic women.[15]

The unintended pregnancy rate among teenagers decreased substantially from 1994 to 2001, because of decreased sexual activity and higher levels of contraceptive use among sexually active adolescents.[16] But by Western standards, unintended pregnancy among U.S. teenagers is still too high: More than four-fifths of pregnancies to teenagers are unintended, and teenagers account for more than one in five unintended pregnancies nationwide.

It is not surprising that unmarried, black and poor women are among those most likely to have an abortion. Although the nation's overall abortion rate has fallen in recent years, these women have effectively been left behind. They are disproportionately likely to be faced with an unintended pregnancy, which leads them to turn to abortion more often.[17]

Although single women are less likely than married women to become pregnant, they are more likely to become pregnant unintentionally and to end their unintended pregnancies in abortion.[18] Thus, the abortion rates for previously married and never-married women (29 and 35 per 1,000, respectively) are much higher than for married women (eight per 1,000).[19] Unmarried women living with a partner bear a disproportionate burden of abortions: Although they account for 17% of unmarried women, cohabiting women have 31% of the abortions among unmarried women.[20]

The abortion rate among black women decreased between 1994 and 2000; nevertheless, it remains more than twice the national average.[21] The high abortion rate reflects both the high rate of unintended pregnancy and the fact that black women are less likely than other racial and ethnic groups to carry their unintended pregnancies to term.[22] Often, these factors are driven by socioeconomic circumstances: For example, black women of reproductive age are more likely than other women to be poor[23] and less likely to be married,[24] characteristics associated with higher unintended pregnancy rates.[25]

Low-income women experienced an increase in abortion rates between 1994 and 2000, and now they account for a greater proportion of abortions than they did in the mid-1990s.[26] In 2000, the 34% of reproductive-age women who live below 200% of the poverty level accounted for 57% of all abortions.[27] The high abortion rate among economically disadvantaged women is mainly because of their high rate of unintended pregnancy, but it may also be related to the fact that they feel ill-equipped to deal with an unplanned birth.

Particular groups of women experience delays in obtaining an abortion

Of women who have had abortions, most are able to obtain the procedure fairly quickly—that is, once they know that they are pregnant and decide to terminate the pregnancy. Research on women who have had an abortion indicates that, on average, a woman first suspects she is pregnant a few days after missing her menstrual period. Then, she takes one week to confirm the pregnancy with a test and another four days to decide to have an abortion; it takes about 16 days from the time she decides to have an abortion to the date of the procedure (Figure 5.4).[28] Thus, most women are able to have an abortion early in pregnancy: Six in 10 women obtain an abortion in the first eight weeks of gestation, and nearly nine in 10 women do so in the first 12 weeks.[29]

Even so, 11% of women who obtain an abortion do so after the first trimester.[30] Women who have an abortion at or after 13 weeks take longer than other women at every step in the process, but there are some groups of women who take longer at certain stages. On average, minors take a week longer than other women to recognize that they are pregnant or to determine how far along they are, and two weeks longer overall to obtain an abortion.[31] This may be a reflection of teenagers' lack of awareness of the early physiological signs of pregnancy or of their state of denial about the pregnancy. Alternatively, it may be that minors are scared about social repercussions from their family or partner or are unsure about where to seek assistance. Or they may have histories of irregular periods and do not recognize when their cycles have been altered by pregnancy.

Making arrangements to obtain an abortion is a particular problem for low-income women. Compared with more affluent women, those living below 200% of the poverty level (i.e., $19,140 for a single woman with no children[32]) take an average of six days longer from the time they decide to have an abortion to the date of the procedure and obtain an abortion 10 days later in pregnancy.[33] Six in 10 economically disadvantaged women report preferring to have had their abortion earlier;[34] more than half of those experienced delays in arranging an abortion, usually because they needed time to raise the money.[35] And even when poor women are able to raise the money needed for an abortion, they often do so at a great sacrifice to themselves and their families, frequently forced to divert money that would otherwise be used to pay daily expenses. Some use money that could otherwise have been spent on rent, utility bills, food and clothing for themselves and their children.[36]

Youth and economic disadvantage are not the only factors associated with delayed access to abortion. For example, compared with married women, unmarried women (single or cohabiting) typically take three or four days longer from the time they decide to have an abortion to the date of the procedure, and obtain an abortion about one week later in pregnancy. Furthermore, black women deliberate about abortion for as long as Hispanic or white women do, but take significantly longer from the time they decide to have an abortion to the time they obtain one, even when controlling for age, marital status and income.[37]

However, delayed access to abortion is not just a problem among women who are young, poor, black or unmarried; it is something experienced by the majority of women who have an abortion. Some 60% of all women who have had an abortion report that they would have preferred to have had the procedure earlier than they did. More than one-third of women who wished they had had an earlier abortion were delayed because they did not realize they were pregnant or how far along they were. And nearly 60% of women who experienced a delay in obtaining an abortion said it was because it took some time to make arrangements—including 26% who needed time to raise money. Indeed, in in-depth interviews with women who felt delayed, needing to raise money was the most common reason for a delay.[38]

Chapter 6

Recommendations for Policies and Programs

Abortion has been legal throughout the United States since 1973, when the Supreme Court ruled that a woman's constitutional right to privacy includes her right to decide, in consultation with her physician, whether to terminate a pregnancy. The subsequent three decades of legal and relatively accessible abortion have brought about significant benefits to women and society. Today, abortions are openly performed in medical settings by highly trained practitioners. In addition, the vast majority of women who have an abortion do so within the first trimester, when it is safest.[1] And as new technologies have become available in the United States, women have increasingly been able to obtain abortions earlier and earlier in pregnancy: More than one in four abortions occur at or before six weeks' gestation.[2] As a result, induced abortion in the United States is now extremely safe for women, in both the short term and the long term, and injuries and deaths from abortion are a rarity.

These significant individual and public health gains, however, have taken place against a backdrop of escalating hostility toward abortion by some groups that now threatens the procedure's very legality. For now, *Roe v. Wade* remains the law of the land, but what it will actually mean for women in the future is in question. In Congress and state legislatures, antiabortion advocates are pressing for increased impediments to abortion services. And given the undeniable shift toward a more conservative judiciary at all levels, it is increasingly likely that a wider range of restrictive abortion laws will be upheld.

The extent to which antiabortion laws block substantial numbers of women from obtaining abortions is unclear. What is clear, however, is that the restrictions they impose make abortion more costly—financially and in terms of women's health and safety, as they delay women having the procedure. Moreover, restrictions on abortion access fall hardest on young and poor women and women of color, who are already disadvantaged in a host of other areas, including in their access to the information and services necessary to prevent unplanned pregnancy in the first place.

A woman facing an unplanned pregnancy needs unbiased information about her legal medical options. Whatever her decision, she needs access to the appropriate medical services as early in pregnancy as possible. It is cruel and ultimately self-defeating for society to make it more difficult for a woman to obtain an abortion that she has already decided she must have. At the same time, society can do a much better job of supporting those women who decide to carry an unplanned pregnancy to term (see box).

Abortion remains an emotionally charged and politically divisive issue, and that divisiveness is a problem that warrants attention in and of itself. Some Americans consider abortion immoral and unacceptable under all or virtually all circumstances. For others, the decision to terminate a pregnancy is an ethical and responsible decision that is a woman's alone to make. Although this debate may never be resolved, one obvious path toward lowering the decibel level lies in increasing support for policies and programs that enhance a woman's ability to avoid or postpone having a child by helping her do a better job of preventing unintended pregnancy.

Although the U.S. abortion rate is at its lowest level since 1974, it remains significantly higher than in many European countries.[3] Furthermore, it has declined more slowly in recent years: Between 2000 and 2002, annual declines in the abortion rate averaged just 0.8%, compared with 3.4% in the early 1990s.[4] For abortion levels to decline more steeply, we must redouble our efforts to help women prevent unintended pregnancy—and to do that, we must make a genuine effort to improve contraceptive use.

It is essential that we maintain and improve access to abortion

Although most women who decide to have an abortion are able to obtain one fairly quickly and early in pregnancy, some women have to overcome substantial obstacles before they are able to access a procedure. For example, in many parts of the country, a woman has to travel a long distance to find a provider, which can pose significant problems if she has limited resources, or has work or family responsibilities. Only 13% of U.S. counties have an abortion provider, and nearly one in four women travel at least 50 miles to obtain the service.[5] In addition, many states require that at least 24 hours elapse between when counseling is provided and when an abortion is performed. In states that require counseling to be provided in person, a woman is effectively required to make two trips to the health care provider to obtain an abortion. Once a woman has decided to end her pregnancy, a waiting period unnecessarily draws out what can already be an emotionally draining experience. Also, it may pose serious difficulties for a woman who has to take time away from school or work, or arrange for child care or transportation. We must ensure women more timely access to abortion services across the United States, especially outside major metropolitan areas, and enable women to obtain an abortion in a single visit by doing away with waiting periods for abortion.

Legal requirements that mandate parental consent or notification before a teenager can obtain an abortion may likewise do more harm than good. Even without specific parental involvement laws, six in 10 teenagers who have an abortion report that at least one parent knew about their procedure.[6] There is no evidence to suggest parental involvement laws improve family communication or relationships; on the contrary, research suggests that forcing teenagers to inform their parents that they are pregnant or seeking an abortion may place some at risk of physical violence or being forced to leave home.[7] In addition, minors typically detect their pregnancies and have abortions later than do adults;[8] legal obstacles are likely to cause further delays, increasing teenagers' risk of complications.[9] Of course, a young woman who is considering having an abortion should be encouraged to talk to her parents or, if that is not possible, to another responsible adult; however, mandatory parental involvement laws are bad public policy and should be repealed.

As a matter of social justice, every woman in the United States should have the same access to reproductive health care options, regardless of her economic status; unfortunately, this is not the case. Although abortion may be generally well covered in private insurance plans, nearly eight in 10 poor women aged 15–44 are not privately insured.[10]

In addition, nearly four in 10 poor women receive coverage under Medicaid, but Medicaid funds may be used for an abortion only in cases of rape and incest, or if the woman's life is endangered;[11] only 17 states use their own funds to pay for abortions beyond the federal requirement (although most do so as a result of a specific court order). The average cost of an abortion at 10 weeks' gestation is nearly $400.[12] Lacking insurance coverage, a poor woman often requires a considerable amount of time to come up with the money to pay for an abortion, if she is able to do so at all. And given that Medicaid-eligible women take an average of 2–3 weeks longer than other women to have an abortion[13] and that the cost of the procedure only increases with the gestation, many poor women become trapped in a vicious cycle, exacerbating their difficulties and increasing

Support for Pregnant Women and Parents Of Young Children Is Vital

Women who make the decision to carry an unplanned pregnancy to term deserve society's help and respect. A variety of federal and state programs—notably, Medicaid, the Maternal and Child Health Block Grant and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)—are available to assist with medical and nutritional needs. These efforts should receive sufficient funding to care for all women who need assistance during this critical time and eligibility and enrollment processes should be streamlined to the maximum extent possible.

Overwhelmingly, women who carry an unplanned pregnancy to term will opt to parent their child. According to the National Center for Health Statistics (NCHS), placing children for adoption has never been common and has been declining in recent years. The most recent estimates suggest that only 1% of babies born to never-married women are placed for adoption.[1] Moreover, according to NCHS, the availability of legal abortion "is not a significant factor in lower prevalence of relinquishment." Instead, the downward trend in the willingness of women to choose adoption parallels a steady rise in nonmarital births, which itself may be a function of greater societal acceptance of single parenthood.

Whether it is possible or desirable to go back to a time when single parenthood was shunned is a debatable proposition. Regardless, we should ensure that women who become pregnant unintentionally have the unbiased counseling and support they need to consider adoption as a positive option so they can go on to implement that decision if they so choose. In this regard, it is significant that a 2002 Department of Health and Human Services assessment of Title X family planning and other public health programs concluded that "infant adoption as part of a course of non-directive counseling to pregnant women is an accepted and adhered-to standard among clinicians at federally funded health clinics."[2]

At the same time, our obligation to families ought not to end with childbirth. We should work to ensure that young mothers have access to the educational and support services necessary to enable them to reach their full potential as adults while caring for their families. We should promote family-friendly workplaces that allow mothers and fathers to balance work and parenting and ensure high-quality care for children while their parents are working. And we should guarantee access to safe housing and adequate medical care for families in need. We should do these things for all parents, whether or not their pregnancy was planned—not as a means to influence individual decisions around abortion, adoption or parenting, but because it is the right thing to do.

Ten Ways to Facilitate Access to Early Abortion

- Launch a public education effort emphasizing the importance of early pregnancy detection and timely medical intervention for both prenatal care and abortion.
- Increase the number of qualified abortion providers by making abortion a routine part of medical training programs for obstetricians, gynecologists and other physicians and midlevel practitioners providing women's health care.
- Allow midlevel practitioners to provide early abortion services.
- Eliminate waiting period requirements that, by definition, delay women from obtaining timely care.
- Make training in medication abortion available to primary care physicians and other health care providers who have not traditionally offered abortion services.
- Guarantee confidential access to abortion services for minors, while encouraging young women to talk about their pregnancy with a parent or, if that is not possible, another responsible adult.
- Restore Medicaid funding for abortion to help poor women obtain abortion services early in pregnancy.
- Ensure that private insurance plans cover abortion services and overturn state policies that limit abortion coverage in insurance plans for public employees.
- Increase penalties for making threats against abortion providers, patients and facilities.
- Overturn excessive and medically unnecessary regulations on facilities providing early abortion services.

their health risks. Worse yet, funding restrictions have forced some women to carry their unintended pregnancies to term: Some 18–37% of women who would have obtained an abortion if the government would have paid for it instead carried the pregnancy to term because they lacked the money to pay for the procedure themselves.[14]

Even with expanded efforts to ensure access to early abortion, some abortions will necessarily take place later in pregnancy. About 4% of abortions are performed between 16 and 20 weeks' gestation, and 1% are performed after 20 weeks[15]—the midpoint in a typical pregnancy. A woman may seek abortion later in pregnancy because her life or health is in danger, or because her life circumstances have changed. For example, since becoming pregnant, she may have separated from her husband, lost her job, discovered that the fetus she is carrying has a serious genetic anomaly or learned that she herself has a serious, even life-threatening illness. As a society, we need to acknowledge that, although these abortions should not be undertaken lightly, they must always be available to women. But at the same time, many late abortions could be avoided. We need to do more to help women access abortion early in pregnancy (see box).

Women have the same right to receive medically accurate information prior to an abortion as they do before any other medical procedure. In addition, they deserve to be treated with dignity and respect. Yet, many states undermine the informed consent process by making women who seek abortion listen to a lecture designed to scare them into rethinking their decision. Some states require providers to show women pictures of fetuses at various stages of development. Other states require providers to give women discredited information on a purported link between abortion and breast cancer. And as if that were not bad enough, women often face a gauntlet of antiabortion protesters when seeking services. It is unethical to give biased or inaccurate information to women seeking abortion, and it is wrong to harass and shame them.

Furthermore, abortion providers deserve the respect bestowed on other members of the medical profession. The federal government and several states have passed legislation designed to protect clinics under siege, and since 1996, most forms of harassment have become less common. Nevertheless, 56% of providers experienced antiabortion harassment in 2000.[16]

Contraceptive use is a key part of a successful strategy to reduce unintended pregnancy

After nearly two decades of steady progress, the decline in unintended pregnancy in the United States seems to have stalled. Even more worrisome, unintended pregnancy is becoming increasingly concentrated among poor women.[17] It is essential to further reduce the unintended pregnancy rate to reduce the abortion rate. Doing so, however, is a complex task that will require a multifaceted strategy.

The recent proliferation of abstinence-only programs that either ignore the topic of contraception entirely or discuss it only in the context of health risks and failure rates does a huge disservice to young people by leaving them ill-prepared to protect themselves when they eventually begin to have sex. Instead, we need to encourage comprehensive sex education—programs that teach youth about both the benefits of delaying intercourse and the importance of using contraceptives. And education should not stop with our young people. Contraceptive use may be nearly universal among American women, but misunderstandings about the risks of various methods persist, and many women are confused about the implications of individual methods for their own health. Our society would be well-served to explore ways to expand understanding of the risks and benefits of contraceptive methods among adults as well as youth. Moreover, efforts need to be made with both parents and their children to encourage communication about issues of reproductive health, human sexuality, values and relationships.

With the recent introduction of new methods to the U.S. marketplace, American women and men now have the same contraceptive choices that Europeans have long enjoyed. The new challenge is to make the full range of options available to low-income women, as well as to those who are more affluent, so that every woman can choose the method or methods that best fit her health needs and life circumstances—which, of course, will change over the many years in which she will try to avoid pregnancy. In that regard, much more work is needed to ensure that every person who wants a contraceptive method is able to obtain one. For example, we have made great strides in mainstreaming contraceptive coverage into private insurance plans, but every plan still does not cover every method. As a result, a woman may find herself choosing a method that best suits her budget, instead of the one that best suits her needs. Moreover, increases in the copays for prescription drugs required by plans may put covered services out of reach of some women.

Ensuring coverage under private insurance plans could facilitate access for many women; however, the sad fact remains that two in 10 women of reproductive age—and four in 10 reproductive-age women living in poverty—have no insurance coverage whatsoever.[18] For these women, as well as for teenagers, Medicaid enrollees and privately insured women who cannot afford the out-of-pocket costs that their plans require, publicly funded family planning services are essential. Publicly funded family planning services prevent an estimated 1.3 million unintended pregnancies each year, and in the absence of such services, the U.S. abortion rate would likely be 40% higher than it is.[19] But support for these efforts has not kept pace with the need. In just two years (2000 to 2002), an estimated 400,000 more women joined the ranks of those needing publicly subsidized family planning care.[20] Nonetheless, when inflation is taken into account, family planning funding declined or stagnated in half the states between 1994 and 2001. In addition, inflation-adjusted funding for the Title X national family planning program is 59% lower today than it was a quarter century ago.[21] At the same time, the cost to clinics of providing the high-quality care women deserve is rising. Compared with older methods, many of the new contraceptive methods cost more for clinics to provide; half of the agencies that operate family planning clinics are unable to offer certain methods because of their cost.[22]

Over the last decade, 23 states have initiated innovative efforts to expand eligibility for Medicaid-covered family planning services to cover individuals who otherwise would not qualify. These efforts have been shown to expand access to care while reducing taxpayer costs overall.[23] In addition, they appear to have a real impact on reducing unintended pregnancy and improving maternal and child health. Therefore, any bureaucratic obstacles impeding the remaining states from establishing these programs should be cleared.

At the same time, we need to look carefully at what else can be done to help women improve the consistency of their contraceptive use. More research is needed to better understand why women experience gaps in their protection due to inconsistent contraceptive use. And because half of unintended pregnancies occur among women who report using a contraceptive method in the month that they became pregnant,[24] it is vital that we discover how to improve the effectiveness of women's contraceptive use.

Part of the answer may lie in streamlining the delivery of contraceptive services so as to make obtaining and using contraceptives as convenient for women as possible—including by deregulating and demedicalizing contraceptive access, where appropriate. For example, delinking the dispensing of contraceptives from other health care services (e.g., no longer requiring women who want to initiate oral contraceptive use to have a pelvic exam) could remove barriers for some women. Along the same lines, policies in place in several states that permit pharmacists, under certain circumstances, to dispense emergency contraception to women without first getting a prescription from a physician should be expanded and replicated. Furthermore, the possibility of making emergency contraception, as well as regular birth control pills, available over the counter should be seriously explored.

If all of these steps were taken, we would do much to jump-start our stalled progress in minimizing the need for abortion by reducing unintended pregnancy. And this could be done even as we improve access to abortion for all women, and especially for those who have the most difficulty obtaining timely abortion services.

To be sure, helping women achieve greater control over their childbearing addresses only one aspect of their complex lives, and fertility control is only one area in which women—especially women of color and those who are young or poor—need and deserve greater societal support. Poverty, violence, lack of education and inadequate access to health care are factors that shape too many women's lives in our country. But these factors, which themselves predispose disadvantaged women to unintended pregnancy and, thereby, high levels of recourse to abortion, also can be ameliorated by enabling women to exercise greater personal control over the timing and spacing of their children. If all women were given the education, services and rights they need to manage their reproductive lives, they would benefit as individuals, as partners and as parents. And, as Supreme Court Justice Sandra Day O'Connor acknowledged almost 15 years ago, the "economic and social life of the Nation" would benefit as well.

APPENDIX TABLE 1 **State policies on abortion, as of February 1, 2006**

State	Must be performed by a licensed physician	Must be performed in a hospital at/after:	Second physician must participate at/after:	Allowed only in cases of life/health endangerment at/after:	"Partial birth" abortion banned	Public funding limited to life endangerment, rape and incest	Private insurance plans written in state limited to life endangerment
Alabama	X	Viability	Viability	Viability*	Perm. enjoined	X	
Alaska	X				Perm. enjoined		
Arizona	X		Viability	Viability	Perm. enjoined		
Arkansas	X		Viability	Viability§§	Perm. enjoined	X	
California	X			Viability			
Colorado	X					X	
Connecticut	X	Viability		Viability			
Delaware				Perm. enjoined*†		X	
D.C.						X	
Florida	X		24 weeks	24 weeks	Perm. enjoined	X	
Georgia	X		Third trimester	Third trimester	After viability	X	
Hawaii	X						
Idaho	X	Viability	Third trimester	Viability*†	Perm. enjoined	X	X
Illinois	X		Viability	Viability	Perm. enjoined		
Indiana	X	Second trimester	Viability	Viability*	X‡‡	X*	
Iowa	X			Third trimester	Perm. enjoined	X†	
Kansas			Viability	Viability	After viability	X	
Kentucky		Second trimester		Viability	Perm. enjoined	X	X
Louisiana	X		Viability	Viability	Perm. enjoined	X	
Maine	X			Viability		X	
Maryland	X			Viability†			
Massachusetts	X	12 weeks		24 weeks			
Michigan	X			Viability*†	Perm. enjoined	X	
Minnesota	X	Second trimester	Perm. enjoined	Perm. enjoined			
Mississippi	X				X‡‡	X†	
Missouri	X	Viability	Viability	Viability	Perm. enjoined	X	X
Montana			Viability	Viability*	X‡‡		
Nebraska	X			Viability	Perm. enjoined	X	
Nevada	X	24 weeks		24 weeks		X	
New Hampshire						X	
New Jersey	X	14 weeks			Perm. enjoined		
New Mexico					After viability		
New York			24 weeks	24 weeks*†			
North Carolina	X	20 weeks		20 weeks		X	
North Dakota	X	12 weeks	12 weeks	Viability	X‡‡	X	X
Ohio	X		Perm. enjoined	Perm. enjoined*	Entire pregnancy	X	
Oklahoma	X	Second trimester	Viability	Viability	X‡‡	X	
Oregon							
Pennsylvania	X	Viability	Viability	24 weeks*		X	
Rhode Island	X	14 weeks		24 weeks*†	Perm. enjoined	X	Perm. enjoined
South Carolina	X	Second trimester	Third trimester	Third trimester	X‡‡	X	
South Dakota	X	24 weeks		24 weeks	X‡‡	Life only	
Tennessee	X			Viability	X‡‡	X	
Texas	X			Third trimester		X	
Utah	X	90 days		Perm. enjoined*	Temp. enjoined	X*,†	
Vermont							
Virginia	X	Second trimester	Viability	Third trimester	Perm. enjoined	X†	
Washington				Viability			
West Virginia					Perm. enjoined		
Wisconsin	X	12 weeks		Viability	Perm. enjoined	X*	
Wyoming	X			Viability		X	
Total in effect	**39**	**20**	**18**	**36**	**12**	**32 + DC**	**4**

*Exception in case of threat to the woman's physical health. †Exception in case of fetal abnormality. ‡Fetal pain information is given only to women who are at least 20 weeks' gestation. §The waiting period requirement is waived if the pregnancy is the result of rape or incest, the fetus has grave defects or the patient is younger than 15. **Specified health professionals may waive parental involvement in certain circumstances. ††Both parents must consent to the abortion. ‡‡Unchallenged in court although this policy is presumably unenforceable under the

Providers may refuse to participate		Mandated counseling includes information on				Waiting period after counseling	Parental involvement required for minors	State
Individuals	Institutions	Breast cancer	Fetal pain	Serious psychological effects	Abortion alternatives and support services			
					X	24 hours	Consent	Alabama
X	Private				X		Perm. enjoined	Alaska
X	X						Consent	Arizona
X	X		X‡	X	X	Day before	Consent	Arkansas
X	Religious						Perm. enjoined	California
X	X						Notice	Colorado
X								Connecticut
X	X				X	Perm. enjoined	Notice**	Delaware
								D.C.
X	X						Notice	Florida
X	X		X		X	24 hours	Notice	Georgia
X	X							Hawaii
X	X					24 hours	Temp. enjoined	Idaho
X	Private		X				Perm. enjoined	Illinois
X	Private				X	18 hours	Consent	Indiana
X	Private						Notice	Iowa
X	X				X	24 hours	Notice	Kansas
X	X				X	24 hours	Consent	Kentucky
X	X				X	24 hours	Consent	Louisiana
X	X							Maine
X	X						Notice**	Maryland
X	X					Perm. enjoined	Consent	Massachusetts
X	X				X	24 hours	Consent	Michigan
X	Private	X	X‡		X	24 hours	Notice††	Minnesota
X	X	X			X	24 hours	Consent††	Mississippi
X	X					24 hours	Consent	Missouri
X	Private					Perm. enjoined	Perm. enjoined	Montana
X	X				X	24 hours	Notice	Nebraska
X	Private			X			Perm. enjoined	Nevada
							Perm. enjoined	New Hampshire
X	Private						Perm. enjoined	New Jersey
X	X						Perm. enjoined	New Mexico
X								New York
X	X						Consent	North Carolina
X	X				X	24 hours	Consent	North Dakota
X	X				X	24 hours	Consent	Ohio
X	Private				X	24 hours	Notice	Oklahoma
X	Private							Oregon
X	Private				X	24 hours	Consent	Pennsylvania
X					X		Consent	Rhode Island
X	Private				X	1 hour	Consent	South Carolina
X	X			Perm. enjoined	X	24 hours	Notice	South Dakota
X	X				X	Perm. enjoined	Consent	Tennessee
X	Private	X			X	24 hours	Consent	Texas
X	Private				X	24 hours§	Notice	Utah
								Vermont
X	X				X	24 hours	Consent	Virginia
X	X							Washington
					X	24 hours	Notice**	West Virginia
X	X			X	X	24 hours	Consent**	Wisconsin
X	Private						Consent	Wyoming
46	**43**	**3**	**4**	**3**	**26**	**24**	**34**	**Total in effect**

terms set out in *Stenberg v. Carhart*. §§Exception in case of rape or incest. *†Exception in case of life endangerment only. **Notes:** Perm. enjoined=law not in effect because it has been permanently enjoined. Temp. enjoined=law not in effect because it has been temporarily enjoined. **Source:** Guttmacher Institute, State policies in brief, <http://www.guttmacher.org/statecenter/spib_OAL.pdf>, accessed Feb. 1, 2006.

APPENDIX TABLE 2 State abortion data

U.S./state	% of teenage pregnancies resulting in abortion, 2000	No. of abortions among women 15–19, 2000*	Abortion rate per 1,000 women, by age, 2000*			No. of abortions, 2000†	No. of abortion providers, 2000	% of counties with no abortion provider, 2000	% of women in counties with no abortion provider, 2000	No. of metro areas with no abortion provider, 2000
			15–19	15–17	18–19					
	1	2	3	4	5	6	7	8	9	10
U.S. total	29	235,470	24	14	38	1,312,990	1,819	87	34	98
Alabama	17	2,480	16	9	24	13,830	14	93	59	6
Alaska	19	340	14	8	26	1,660	7	85	39	0
Arizona	20	3,810	21	12	35	17,940	21	80	18	1
Arkansas	13	1,180	12	8	19	5,540	7	97	79	4
California	37	42,230	36	21	58	236,060	400	41	4	2
Colorado	23	2,790	19	12	29	15,530	40	78	26	1
Connecticut	43	3,170	30	21	44	15,240	50	25	9	1
Delaware	34	860	31	24	41	5,440	9	33	17	0
D.C.	43	1,040	55	53	57	9,800	15	0	0	0
Florida	34	16,590	33	19	56	103,050	108	70	19	3
Georgia	19	5,250	18	11	29	32,140	26	94	56	2
Hawaii	37	1,320	34	21	55	5,630	51	0	0	0
Idaho	16	540	10	6	16	1,950	7	93	67	0
Illinois	31	11,480	27	18	40	63,690	37	90	30	2
Indiana	17	2,730	12	7	20	12,490	15	93	62	6
Iowa	22	1,340	12	7	19	5,970	8	95	64	2
Kansas	18	1,260	12	8	19	12,270	7	96	54	1
Kentucky	11	1,170	8	5	13	4,700	3	98	75	4
Louisiana	13	2,050	11	7	18	13,100	13	92	61	5
Maine	29	660	15	9	24	2,650	15	63	45	1
Maryland	41	6,600	38	22	62	34,560	42	67	24	1
Massachusetts	43	5,260	26	14	41	30,410	47	21	7	0
Michigan	32	8,480	24	14	39	46,470	50	83	31	1
Minnesota	25	2,290	13	7	21	14,610	11	95	58	2
Mississippi	16	1,820	16	9	25	3,780	4	98	86	2
Missouri	19	2,840	14	7	25	7,920	6	97	71	3
Montana	24	500	14	9	23	2,510	9	91	43	0
Nebraska	21	810	12	8	19	4,250	5	97	46	0
Nevada	32	2,270	36	22	59	13,740	13	82	10	0
New Hampshire	37	730	17	9	29	3,010	14	50	26	0
New Jersey	53	12,160	47	29	78	65,780	86	10	3	0
New Mexico	21	1,550	22	15	33	5,760	11	88	48	0
New York	51	28,620	46	31	67	164,630	234	42	8	0
North Carolina	23	5,790	22	12	35	37,610	55	78	44	1
North Dakota	19	200	8	5	12	1,340	2	98	77	2
Ohio	23	6,820	17	10	27	40,230	35	91	50	6
Oklahoma	15	1,620	12	8	19	7,390	6	96	56	3
Oregon	32	2,950	25	15	40	17,010	34	78	26	0
Pennsylvania	29	7,210	17	10	28	36,570	73	75	39	7
Rhode Island	35	850	23	12	36	5,600	6	80	39	1
South Carolina	19	2,450	17	13	23	8,210	10	87	66	2
South Dakota	14	220	7	3	13	870	2	98	78	1
Tennessee	18	3,020	16	9	26	19,010	16	94	56	2
Texas	17	13,520	17	9	30	89,160	65	93	32	10
Utah	11	630	6	4	9	3,510	4	93	51	1
Vermont	32	310	14	9	22	1,660	11	43	23	0
Virginia	29	4,880	21	11	34	28,780	46	84	47	1
Washington	34	5,340	26	16	40	26,200	53	74	17	0
West Virginia	15	590	10	6	15	2,540	3	96	83	5
Wisconsin	22	2,370	12	7	19	11,130	10	93	62	4
Wyoming	32	490	25	17	36	100	3	91	88	2

*Number of abortions and abortion rates have been tabulated according to women's state of residence. †Number of abortions have been tabulated according to state of occurrence. ‡Number of abortions includes abortions obtained by Hispanic women; in these states, ≤10% of births to white women 15–19 were to Hispanics. **Notes:** u=unavailable. Abortions rounded to the nearest 10. **Sources:** Column 1: Unpublished list from 2000–2001 Abortion Provider Survey, The Alan Guttmacher Institute (AGI). Columns 2–5: AGI, U.S. teenage pregnancy statistics: overall trends, trends by race and ethnicity and state-by-state information, <http://guttmacher.org/pubs/state_pregnancy_trends.pdf>, accessed Apr. 14, 2006. Columns 6–9: Finer LB and Henshaw

No. of abortions among women 15–19, by race/ethnicity, 2000*			Public expenditures for abortions, FY 2001 (in 000s of dollars)			No. of publicly funded abortions, FY 2001			Abortion rate per 1,000 women 15–44, 2000*	U.S./State
White	Black	Hispanic	Total	Federal	State	Total	Federal	State		
11	12	13	14	15	16	17	18	19	20	
92,830	84,460	45,110	72,707	233	72,473	168,601	83	168,518	21	U.S. total
1,210	1,220	20	1	1	0	5	5	0	13	Alabama
u	u	u	277	3	274	541	5	536	13	Alaska
1,990	240	1,440	0	0	0	0	0	0	17	Arizona
670	460	30	0	0	0	0	0	0	10	Arkansas
u	u	u	27,183	0	27,183	84,381	0	84,381	31	California
2,070	120	520	u	0	u	u	0	u	13	Colorado
u	u	u	u	u	u	3,913	5	3,908	22	Connecticut
420	390	40	0	0	0	0	0	0	22	Delaware
u	u	u	0	0	0	0	0	0	40	D.C.
u	u	u	u	0	u	u	0	u	30	Florida
2,180	2,760	160	13	5	8	23	5	18	17	Georgia
250	50	100	u	0	u	u	0	u	22	Hawaii
480	10	40	27	5	22	39	5	34	10	Idaho
u	u	u	6	0	6	u	0	u	21	Illinois
1,970‡	720	u	0	0	0	0	0	0	11	Indiana
1,140‡	70	u	17	2	15	9	1	8	10	Iowa
860	250	100	u	0	u	u	0	u	11	Kansas
890‡	210	<5	13	13	0	8	8	0	7	Kentucky
950‡	1,070	u	0	0	0	0	0	0	11	Louisiana
610	10	10	3	3	u	u	u	u	11	Maine
u	3,740	u	2,300	0	2,300	3,324	0	3,324	32	Maryland
u	u	u	2,391	0	2,391	5,874	0	5,874	21	Massachusetts
u	u	u	0	0	0	0	0	0	21	Michigan
1,500	420	120	856	3	853	3,241	11	3,230	13	Minnesota
540	1,260	10	0	0	0	0	0	0	14	Mississippi
1,620	1,070	60	1	1	0	1	1	0	14	Missouri
460‡	<5	u	100	0	100	u	0	u	12	Montana
u	u	u	u	0	u	u	0	u	11	Nebraska
u	u	u	0	0	0	0	0	0	31	Nevada
u	u	u	u	0	u	u	0	u	15	New Hampshire
2,690	5,620	1,860	6,000	0	6,000	11,514	0	11,514	36	New Jersey
540	60	810	451	0	451	1,265	0	1,265	18	New Mexico
10,080	12,820	5,410	23,090	0	23,090	36,131	0	36,131	38	New York
u	2,420	u	37	37	0	6	6	0	19	North Carolina
180	<5	10	2	2	0	1	1	0	7	North Dakota
4,210	2,370	170	42	42	0	6	6	0	16	Ohio
u	240	u	0	0	0	0	0	0	11	Oklahoma
2,230	200	290	1,930	0	1,930	4,371	0	4,371	21	Oregon
3,660	3,130	310	0	0	0	0	0	0	15	Pennsylvania
u	120	u	2	0	2	7	0	7	21	Rhode Island
1,350	1,040	30	114	114	0	20	20	0	14	South Carolina
180	<5	10	0	0	0	0	0	0	6	South Dakota
1,700	1,210	50	u	0	u	u	0	u	14	Tennessee
5,580	2,710	4,840	2	2	0	3	3	0	18	Texas
460	20	100	0	0	0	0	0	0	7	Utah
300	10	<5	181	0	181	469	0	469	11	Vermont
u	1,900	u	2	0	2	2	0	2	19	Virginia
u	u	u	7,332	0	7,332	12,397	0	12,397	21	Washington
530‡	50	u	334	0	334	1,043	0	1,043	8	West Virginia
1,640	590	150	u	0	u	6	0	6	11	Wisconsin
u	u	u	1	1	0	1	1	0	20	Wyoming

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Box: Support for Pregnant Women and Parents of Young Children Is Vital

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Guttmacher Institute
120 Wall Street
New York, NY 10005 USA
Telephone: 212-248-1111
Fax: 212-248-1951
E-mail: info@guttmacher.org

1301 Connecticut Avenue NW, Suite 700
Washington, DC 20036 USA

www.guttmacher.org

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