# ABORTION IN THE UNITED STATES: A RIGHT NOT GUARANTEED

by

**Corinne DeBoer**

BS, University of Massachusetts-Amherst, 2016

Submitted to the Graduate Faculty of

the Department of Behavioral and Community Health Sciences

Graduate School of Public Health in partial fulfillment

of the requirements for the degree of

Master of Public Health

University of Pittsburgh

2018

UNIVERSITY OF PITTSBURGH

GRADUATE SCHOOL OF PUBLIC HEALTH

This thesis was presented

by

**Corinne DeBoer**

It was defended on

April 16th 2018

and approved by

**Thesis Director**:
Martha Ann Terry PhD, Associate Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

**Committee Member:**
Jessica Burke PhD MHS, Associate Professor
Behavioral and Community Health Sciences
Graduate School of Public Health
University of Pittsburgh

**Committee Member:**
Jeremy Martinson DPhil, Associate Professor
Infectious Diseases and Microbiology
Graduate School of Public Health
University of Pittsburgh

Martha Ann Terry PhD

**ABORTION IN THE UNITED STATES: A RIGHT NOT GUARANTEED**

Corinne DeBoer, MPH

University of Pittsburgh, 2018

## ABSTRACT

The practice of abortion was legal in the United States under British Common Law until the mid-1800s when states started to make their own laws and made it illegal. Abortions were performed using methods such as knitting needles and household cleaners, many times resulting in excessive bleeding, internal damage, and even death. Women did not stop having abortions even when they were illegal, the procedure just became more dangerous. Since abortion became legal, public acceptance has varied and rates of abortions differ significantly depending on the state.

A variety of perspectives surrounding abortion come from organizations and institutions. The American Medical Association, American Public Health Association, medical professionals, and anti-choice institutions all have their own ideas on how the practice of abortion should be handled. Consequently, abortion policy goes far beyond the landmark Supreme Court case of *Roe v Wade.* There are federal and state policies that limit a woman's access to abortion because of restrictions on funding, insurance coverage, access to clinics, and availability of providers. Moving forward measures need to be put in place to ensure that a woman's right to an abortion is not infringed upon. The public health significance for having access to safe, legal abortions is that without it, women will seek abortions despite increased risk of injury and death. A woman who does not want to continue with her pregnancy should not be forced to and have an undue burden placed upon her.

**TABLE OF CONTENTS**

## LIST OF TABLES

## LIST OF FIGURES

## PREFACE

I would like to thank all of my committee members for their support through the thesis writing process. Dr. Martinson, your guidance on this topic from a different perspective reminded me the importance of stepping back, especially when it is a topic you are passionate about. Dr. Burke, thank you for helping me through my first semester and reminding me why I came to the school. Dr. Terry, thank you for everything. Your guidance and continued support is the reason I am here with more passion than ever for the field of public health.

# 1.0 INTRODUCTION

The policy surrounding abortion in the United States (U.S.) has been fraught with controversy. However, this controversy is a fairly recent development in the history of the practice overall. The present analysis intends to elucidate this and demonstrate that the majority of problems surrounding the issue arise from infringement of the rights of the individual. Today in spite of landmark legal precedents, this infringement exists institutionally, from the letter of federal and state laws to the whims of individual doctors and practices.

When the United States was founded, under English law birth control and abortion were mostly legal, acceptable, and used (Sanger, 2005). During this time, abortions did not need to be done in secret. When abortions were done in secret, they were performed under harmful conditions that were not sterile and put the lives of women at risk. The humanity of an unborn child corresponded with the time a women could first confirm she was pregnant, which often was not until the fourth or fifth month of pregnancy. This meant that under the early Christian doctrine, abortion was not a sin since there was no “human being” (Sanger, 2005).

The Comstock Act was passed in 1873, which prevented the sale, possession, and publishing of print material that contained information about sex, sexually transmitted diseases, birth control, and abortion (Hillstrom, 2008). The act also made it a criminal offense to provide an instrument or medicine that would prevent conception or induce abortion (Hillstrom, 2008). This law was in place until 1936 and had ramifications for research as well as access to

contraceptives and abortions (Schoen, 2005). Massachusetts was the first state to enact a law making abortion a criminal offense in the mid 1800s (Leverich, 2010). Over the course of the next 50 years, all states had some type of law in place making abortion in various circumstances a crime, the most extreme example being Pennsylvania, in which abortions in all cases were prohibited (Leverich, 2010).

*Roe v Wade* is the 1973 landmark Supreme Court decision that made first trimester abortion legal in all 50 states (Leverich, 2010). In the early 1970s a woman's access to a legal abortion depended on the state in which she lived. For example, Texas law permitted abortion only when a woman's life was in danger (Leverich, 2010). In March 1970 a young woman in Texas under the pseudonym Jane Roe filed a class action suit against Henry Wade, a district attorney in Dallas County. The claim was that Texas statutes restricting abortion were unconstitutional because they violated the personal right to privacy which is protected by the First, Fourth, Fifth, Ninth, and Fourteenth amendments (Leverich, 2010). The case determined that a state cannot inhibit a woman's right to have an abortion during the first trimester; during the second trimester, states are permitted to regulate the process for procurement of abortions, but are not able to prohibit abortions entirely. During the third trimester, all abortions are prohibited unless the life of the mother is threatened (Leverich, 2010).

The phrase "induced abortion" is used to describe the expulsion of an embryo or fetus from a woman by a procedure before it is able to survive. The act of abortion has different classifications depending on the reason for the induced abortion. A therapeutic abortion is performed to prevent injury or death to the pregnant woman (Palmer and Palmer, 2014). The decision for a woman to be able to have a therapeutic abortion was made by hospital committees before abortions could be legally performed (Palmer and Palmer, 2014). An elective abortion

occurs when a woman has an abortion though her health or the health of the fetus is not at risk (Palmer and Palmer, 2014). An abortion that is performed to prevent the birth of a child with birth defects is called a eugenic abortion (Palmer and Palmer, 2014).

Two different abortion methods are used, depending on how far along in the pregnancy a woman is. A medication abortion, also known as a pill abortion, was approved by the U.S. Food and Drug Administration (FDA) in 2000 and brought new options in abortion access (Marecek, Macleod, and Hoggart, 2017). In 2016 medication abortions accounted for about 25% of all abortions in the United States (Marecek, Macleod, and Hoggart, 2017). Many women use this type of abortion because it is noninvasive and can be completed at home (Guttmacher Institute, 2018). In 2016, the FDA updated its protocol on using medication abortions, expanding the time span from 49 days to 70 days after a woman's last menstrual period and reduced the dosage from 600 milligrams to 200 milligrams (Guttmacher Institute, 2018).

The second form of abortion is the surgical method, which has two different types of procedures. Suction curettage is used before 13 weeks while dilation and evacuation is used after 13 weeks. The methods are similar, but dilation and evacuation is done in an operating room while suction curettage can be done in a many medical settings (Strubblefield, Carr-Ellis and Borgatta, 2005). Suction curettage is done in the early stages of pregnancy so that only suction is needed but during dilation and evacuation the suction is used to only remove amniotic fluid and forceps remove other tissue (Prager and Oyer, 2009). In 2000, dilation and evacuation was used in 99% of abortions between 13 and 15 weeks and 95% of abortions between 16 and 20 weeks (Strubblefield, Carr-Ellis and Borgatta, 2005). Almost all of abortions were conducted using one of the surgical methods until the pill abortion was approved in the United States.

The practice of abortion started long before the passage of *Roe v Wade.* Illegal abortions were performed with significant complications for a woman, many times resulting in death. After the passage of *Roe v Wade*, the global and domestic gag rule impacted how funding could be used and the public acceptance of legal abortion in any circumstance was low. The rates of legal abortion vary significantly by state because of policy that restrict women's access to safe, legal abortions. Abortion practices, policies, and views today have been shaped by the history of organizations, principles, and people who fought for and against abortion. The American Medical Association (AMA), which has opposed the legalization of abortion, the same organization who was working to have the best medical practices put in place, is one such example.

Since the passage of *Roe v Wade,* 1,193 state abortion restrictions have been enacted (Nash, Gold, Mohammed, Ansari-Thomas, Cappello, 2018). Policies such as waiting periods and physician-only laws make it more difficult for women to access abortions, especially in more rural areas. We should not be fooled into thinking that abortion is still legal if it so restricted that it is available only to rich women or to women whose lives are endangered by pregnancy or whose pregnancy is the result of rape (Reagan, 2008). Millions of women across the United States are restricted from getting an abortion because of the state policies that are enforced. There is a limitation on what health care insurance funds can be used to pay for an abortion and more than half of all abortions are paid for out-of-pocket. Consequently there is still progress to be made to ensure that these essential services are available to women across socio-economic backgrounds.

Women having access to safe, legal abortions is of great public health significance. The year after the legalization of abortion, the maternal mortality in New York City dropped by 45%

and similar improvement was seen in California and North Carolina (Reagan, 2008). The number of abortions performed each year is now more accurately recorded so there can be a greater understanding if programming around family planning and abortion services is working. Having access to safe, legal abortions has been recognized as a fundamental right of women so that they can make decisions about their bodies and medical care.

## 2.0 A HISTORICAL PERSPECTIVE

The history of abortion is complex and begins long before *Roe v Wade*. As noted above, while still under British Law, abortion was legal in the United States. The laws started to change when individual states wanted to make their own decisions on abortion. Women from all backgrounds have been having abortions, even when it was illegal (Lowe, 1966; Henry, 1981).

### 2.1 BEFORE *ROE V. WADE*

Historically the parameters of abortion law were nebulous at best; for example, under British Common Law abortion was permitted until "quickening," the time when the woman was first able to physically feel the fetus move (Francome, 1986; Simon, 1998). Writing law based on the subjective nature of sensation of fetal movement is impractical. However, this approach remained in the United States until 1845, when states began passing their own laws that made various forms of abortion illegal. However, women continued to end their pregnancies during this period (Schoen, 2005) using methods that can be grouped into three categories: noninvasive techniques, ingestion of chemicals or herbal supplements, and invasive surgical techniques (Schoen, 2005). The use of these methods by the woman herself were usually unsuccessful, which is when abortionists would be used. These abortionists often inserted a catheter into the

woman's uterus and immediately removed it or left it in for a period of time until the fetus was expelled (Schoen, 2005).

Illegal abortions were performed by individuals such as an automotive mechanics and boatyard workers while self-abortions were done using Lysol, iodine douches, and inserting knitting needles (Jaffe, Lindheim, and Lee, 1981). These abortions did not happen in a medical space, and they put the lives of the women at risk. The ways that illegal abortions were done had the potential to cause permanent damage to the women's reproductive system as well as pelvic infections, hemorrhage and shock (Henry, 1981). Insertion of objects such as knitting needles and coat hangers could cause cervical or uterine perforation, infection, and an incomplete abortion which could lead to even more complications (Henry, 1981). The consumption of household cleaners could cause bleeding, poisoning, and dehydration (Henry, 1981). In 1930, abortion was listed as an official cause of death for 18% of maternal deaths recorded that year (Leverich, 2010). The death toll from illegal abortion decreased significantly from the 1940s to the 1970s, largely from the introduction of antibiotics that allowed for the treatment for infection from those abortions (Leverich, 2010).

Women from all religious backgrounds have had abortions, but the age at procedure depends on religious denomination. A study done in 1930 with working women from New York found similar rates of abortion among Catholic, Jewish, and Protestant women. What differed was that Catholic and Jewish women had babies early in life and aborted later in life, while Protestant women aborted earlier pregnancies and had babies later in life (Reagan, 2008). Religious institutions have long been vocal about their stance against abortion as well as birth control. The Roman Catholic Church and Southern Baptist Convention oppose abortion in all circumstances (Masci, 2016). Reform and Conservative Judaism allows a woman the right to

choose with few to no exceptions while the Episcopal Church, a protestant denomination, supports abortion only in extreme circumstances (Masci, 2016). The number of women who received abortions while still being affiliated with a religious institution demonstrates that women were still willing to do what was in their best interest, even if they were told it was morally wrong.

A 1934 study of 10,000 women who attended the Margaret Sanger Birth Control Clinic in New York found that between 1925 and 1929 there were 11,172 abortions, two thirds of them illegal. The average number of abortions per woman was 2.23 (Callahan, 1973). During the Depression in the United States, many officials looked the other way even when they knew that clinics were performing these procedures (Caron, 2010). During this time abortions were illegal so officials could have shut the clinics down.

A common practice during a therapeutic abortion was coercive sterilization. Between 1932 and 1941, 18,000 abortions were performed in Chicago. In 1939 Chicago physicians reported that sterilization during therapeutic abortion was necessary to prevent additional abortions in the future (Reagan, 1997). At the hospital Chicago-Lying In, in an eight year period, 67% of women who had therapeutic abortions were sterilized at the same time (Reagan, 1997). This practice meant that in order for women to get the abortion they needed, they had their ability to have children permanently revoked.

## *2.2* AFTER *ROE V. WADE*

### 2.2.1 Global and Domestic Gag Rule

Ronald Reagan implemented the global gag rule during his first term in 1984, and he decided to extend this to the domestic family planning clinics in 1987 during his second term (Feldt and Fraser, 2004). The global gag rule restricts non-governmental organizations (NGO), that receive aid from the U.S., from educating women on legal abortion services, providing legal abortion services to women, or advocating for legal abortions even when the NGO is using its own money (Planned Parenthood, n.d.). The rule compels health care providers in these countries to choose between U.S. family planning aid and the ability to provide their clients with a range of safe and legal reproductive options (Planned Parenthood, n.d.).

The domestic gag rule prohibited clinics who receive Title X grants from providing referrals and counseling regarding abortion by the order of the Department of Health and Human Services (Feldt and Fraser, 2004). Title X is the only federal grant program that is dedicated exclusively to family planning and related preventive health services (Office of Population Affairs, 2018). It has been providing services for millions of low-income or uninsured individuals for around 40 years (Office of Population Affairs, 2018). The grants are given to individual clinics on a yearly basis with specific rules on how the funds can be used. The global gag rule also required that Title X funded services had to be conducted in a different location from the abortion clinics. When Bill Clinton took office in 1993 the gag rule, global and domestic, was suspended and the domestic gag rule has not been reinstated (Feldt and Fraser, 2004). This has been a step towards giving women access to the services that they require.

### 2.2.2 Legal Abortion Rates and Characteristics

Data from the Alan Guttmacher Institute (AGI) indicate that the number of abortions doubled between 1973 and 1979 with the rate also increasing significantly (Francome, 1986). After the passage of *Roe v. Wade* in 1973 illegal abortions were being performed less and AGI was able to track down abortion providers with greater accuracy and efficiency (Francome, 1986). AGI's mission is to advance sexual and reproductive health and rights in the United States and globally so knowing who and where the abortion providers are is important. It is difficult to address disparities in access when they cannot even be identified.

The rate of legal abortion in states in 1981 varied significantly. Table 1 lists 18 states with some of the highest and lowest rates of abortion compared to the federal average (29.1 abortions per 1,000 women). These data come from the Centers for Disease Control and Prevention (CDC) abortion surveillance system and the AGI national survey. In 1981, 81% of the legal abortions were obtained by unmarried women (Henshaw, Binkin, Blaine, and Smith, 1985). Six percent of women had their abortions out of their state of residence in 1981. The District of Columbia had the highest rate of abortion due to a number of factors. There were a disproportionate number of women who were in groups with high abortion rates such as students and poor black women and a large number of women who traveled to the area to have an abortion due to their state having highly restrictive abortion laws (Francome, 1986). Half of all abortions performed in the District of Columbia were among women from other states (Francome, 1986). The rate of legal abortion in England and Wales during 1981 was 12.5 abortions per 1,000 women aged 15-44 and in Italy the rate was 16.3. The right to a legal abortion was granted to women in England and Wales in 1967 and to women in Italy in 1978.

**Table 1: Rate of Abortions by US state in 1981**

| State | Rate of abortion per 1,000 women aged 15-44 |
|---|---|
| Kentucky | 10.9 |
| Utah | 11.4 |
| West Virginia | 12.1 |
| South Dakota | 12.4 |
| North Dakota | 12.9 |
| Mississippi | 13.6 |
| Arkansas | 15.4 |
| Idaho | 15.8 |
| Oklahoma | 17.9 |
| Minnesota | 18.4 |
| Alabama | 22.1 |
| Federal | 29.1 |
| Delaware | 30.8 |
| Massachusetts | 31.4 |
| Maryland | 41.0 |
| Nevada | 41.3 |
| New York | 43.7 |
| California | 44.9 |
| District of Columbia | 92.7 |

(Francome, 1986)

The race and ethnicity of women obtaining abortions changed over time. When abortions first became legal the majority (about 70%) of women obtaining abortions were white (Henshaw and Kost, 2008). Over the next 10 years, into the early 1980s, the number of nonwhite women getting abortions began to increase gradually. In 2004 non-Hispanic white women accounted for 34% of the abortions, 37% were black women, and 22% were Hispanic women (Henshaw and Kost, 2008). The reason for the change in demographics is partially due to the increasing size of minority populations in the United States (Henshaw and Kost, 2008). However, it is important to remember that early on in the collection of abortion data there were only two ethnic classifications, “white” and “nonwhite,” with many Hispanic women being classified as “white” (Henshaw and Kost, 2008).

A total of 337 women died from complications from legal induced abortion between 1972 and 1997, but the mortality rate decreased from 4.1 to 0.6 per 100,000 abortions during the same time period (Bartlett et al., 2004). The reduction in mortality rate was most significant from 1972 to 1976 when it decreased by 73% (Bartlett et al., 2004). Women who had abortions between 1972 and 1979 were three times more likely to die from complications compared to women who had abortions between 1988 and 1997 (Bartlett et al., 2004**).**

A 2004 survey sent to women who decided to have an abortion found that the two main reasons cited were not being able to afford the baby and that having a child would interfere with their current lifestyle (Finer et al., 2005). This same survey was given to women in 1987 and there are significant differences in certain answers. The number of women who chose to have an abortion because they had their desired number of children increased from 28% in 1987 to 38% in 2004 (Finer et al., 2005). Conversely, 38% of women in 2004 reported that having a baby would interfere with their career compared to 50% in 1987 (Finer et al., 2005).

In depth interviews were conducted with 29 women who were seeking abortion services in Michigan and New Mexico to understand barriers to care and the consequences. Out of those 29 women, 19 received an abortion at a later gestation, 17 experienced negative mental health outcomes, and six considered performing an abortion on their own (Jerman, Frohwirth, Kavanaugh, and Blades, 2017). Another study found that a woman who is denied a legal abortion took three and a half years longer to gain the financial and employment status than a woman who was able to access an abortion (Foster et al., 2018). A woman who is denied a legal abortion is more likely to experience financial hardships compared to a woman who is able to get a legal abortion (Foster et al., 2018).

In 2014 about 60% of abortions were performed on women in their 20s (Jerman, Jones, and Onda, 2016). This could be because women in their 20s are not in a position to raise an unplanned baby compared to women in their 30s who may be more financially stable. During their early 20s, women may still be on their parents' health insurance, which could help with access to abortion services but there are still many barriers. Also in 2014, half of all women who received abortions were 100% under the federal poverty level (FPL), an increase of 6% from 2008. When the women were 100-199% under the FPL that increases to 76% (Jerman, Jones, and Onda, 2016). The high rate of abortions among women in poverty has many influences.

Between 2011 and 2014 abortions declined by an average of 4.5% per year and in 2014 the rate of provider abortions was 14.6 abortions per 1,000 women, the lowest since 1973 (Jones and Jerman, 2017). In 2008, about 1% of women report using misoprostol, the medication used for medication abortion, while another one percent report using other substances such as vitamin C and herbs to self-induce an abortion (Jones, 2010). Since 2008 abortions have been on a steady decline, which has been linked to the increase in the number of long acting contraceptives (LARC) such as the IUD and implant (Jones and Jerman, 2017). Table 2 displays the rate of abortion in 2014 in the same 18 states from Table 1. The rate of abortion in most states has decreased by more than 50%. The most drastic change is in the District of Columbia which went from a rate of 92.7 to 32.7 but still has the highest rate. The decrease in the number of abortions because of fewer unintended pregnancies is positive, but there is also a negative reason for the decline: access.

**Table 2- Rate of Legal Abortions by US State in 2014**

| State | Rate of abortion per 1,000 women aged 15-44 |
|---|---|
| South Dakota | 3.5 |
| Mississippi | 3.8 |
| Idaho | 4.2 |
| Utah | 4.6 |
| West Virginia | 6.0 |
| Oklahoma | 7.0 |
| Arkansas | 8.0 |
| Alabama | 8.3 |
| Kentucky | 8.3 |
| North Dakota | 8.7 |
| Minnesota | 9.3 |
| Massachusetts | 14.6 |
| Delaware | 16.7 |
| Nevada | 19.4 |
| California | 19.5 |
| Maryland | 23.4 |
| New York | 29.6 |
| District of Columbia | 32.7 |

(Guttmacher Institute, 2018)

### 2.2.3 Public Perception of Abortions and Stigma

After the passage of *Roe v. Wade* in 1973 abortion was legalized but the public approval rate of abortion varied depending on the circumstance. The Gallup Organizations all over the world linked with survey research centers to understand the public attitudes towards abortion. Called the World Values Survey, it started in 1981 and is carried out every four to six years in over 100 countries across the world (Who We Are, 2017). Sampling is based on the number of individuals over the age of 18 living in a private household in that country no matter their

language, citizenship or nationality (Fieldwork and Sampling, 2017). These individuals are then interviewed using face to face interviews with a paper questionnaire or Computed Assisted Personal Interview (Fieldwork and Sampling, 2017). The information that follows comes from surveys conducted from 1981 through 1984 and then again from 1990 through 1994. In the United States the first survey received 2325 responses and the second received 1839 responses (Simon, 1998). There is a high rate of approval for safe, legal abortion if a the woman's life is endangered but significantly lower rates of approval if the reason is the woman is unmarried or the child will be handicapped (Simon, 1998). If a couple decides that they do not want any more children, the approval of abortion is only 25% (Simon, 1998).

Table 3 displays percentages of approval for abortion in three different circumstances divided by gender. There is high approval for abortion if the mother's health is in danger but little support if the only reason is that the mother is unmarried (Simon, 1998).

**Table 3 : Acceptance of Abortion by Gender, 1991-1994**

| Gender | Mother's Health | Child Handicapped | Mother unmarried |
|---|---|---|---|
| Male | 85.4 | 54.0 | 28.2 |
| Female | 86.5 | 54.2 | 29.9 |

(Simon, 1998)

Table 4 displays percentages of approval for abortion based on the number of children that the respondent has. There is a difference for respondents who have no children compared to those who have two or more children (Simon, 1998).

**Table 4: Acceptance of Abortion by Number of Children, 1991-1994**

| Number of Children | Mother's Health | Child Handicapped | Mother unmarried |
|---|---|---|---|
| None | 86.7 | 59.4 | 38.7 |
| One | 87.6 | 57.3 | 33.5 |
| Two or More | 85.0 | 51.8 | 24.3 |

(Simon, 1998)

Table 5 presents the differences in respondents' approval based on their religion. Approval for abortions when the mother's health is in danger varies by religion but is still relatively high. The approval of abortion significantly declines when the reason for abortion is that a woman is not married (Simon, 1998).

**Table 5-Acceptance of Abortion by Religion, 1991-1994**

| Religion | Mother's Health | Child Handicapped | Mother unmarried |
|---|---|---|---|
| None | 88.9 | 67.7 | 41.6 |
| Catholic | 84.9 | 47.5 | 24.8 |
| Protestant | 88.3 | 58.0 | 28.2 |
| Other | 78.7 | 43.2 | 22.6 |

(Simon, 1998)

The 2008 Abortion Patient Survey by the Guttmacher Institute was a survey of 4,188 women who had received an abortion between April 2008 and May 2009. The survey contained five items that were intended to measure perceived and internalized stigma. Two thirds of the women felt that other people would look down on them if they knew about the abortion and 58% reported that they needed to keep their abortion a secret from family and friends (Shellenberg and Tsui, 2012). Also, 40% of women responded that they felt their family and friends would think less of them if they knew about the abortion (Shellenberg and Tsui, 2012). There were substantial differences in perceived stigma by racial and ethnic groups. White women were most likely to perceive stigma from the general public, while Hispanic women were most likely to perceive stigma from family and friends (Shellenberg and Tsui, 2012). Although black women were the least likely to report perceived stigma, they had higher odds of perceiving stigma from other people if they lived in southern or western regions of the US (Shellenberg and Tsui, 2012). The results from a 2016 Gallop Poll based on 1,025 phone interviews from adults across the country showed that acceptance of legal abortion is still low. In May of 2016, 43% of

respondents said that abortion is morally acceptable, 29% said that abortion should be legal under any circumstance, and 50% thought abortion should be legal but only in certain situations (Saad, 2016).

## 3.0 ORGANIZATION AND PROVIDER PERSPECTIVES

There are many perspectives surrounding abortion and its legalization. The American Medical Association is an organization with a long history against legal abortion. By contrast, the American Public Health Association argues that abortion should be legal and works to create guidelines for safe abortion practices. The practice of abortion can take place only if there are doctors to do the procedure. Doctors are on both sides of the issue and their beliefs influence the way that they care for their patients around abortion. Anti-choice organizations believe that abortion should never be the option and influence women to choose another route.

### 3.1 AMERICAN MEDICAL ASSOCIATION

The American Medical Association was founded in 1847. Its goals were to advance science, set standards in medical education, improve public health, and establish a program of medical ethics. Since its formation, the AMA has played one of the biggest roles in the development of medicine as a field. With the increase in standards and quality comes control over the medical field, which can have negative consequences, specifically in women's health and abortion.

In 1912, the AMA's first president, Abraham Jacobi, advocated for the prevention of reproduction by people who were "degenerate, imbecile, and criminal" (Stormer, 2015, pg. 159). The use of abortion was not explicitly stated as a strategy, but Jacobi was the first AMA

president to introduce reproductive control. One of AMA's first orders of business was to put reproduction in physicians' hands by pushing irregulars (eg. midwives) out of business (Sanger, 2005). Up until this time midwives were responsible for providing healthcare to women as well as helping them give birth. With the introduction of the AMA, power was taken away from midwives, who were mostly women, and handed to the doctors, mostly men. Even when there were more women physicians, a culture already existed that medicine was a field for men. Women physicians found the need to distance themselves from abortion because their male colleagues had long been criticizing them as abortionists.

The AMA's campaign to criminalize abortion took the issue out of the private domain and made it a public problem. It also positioned physicians as morally and scientifically superior to pregnant women, which "legitimized physicians as moral authorities about female sexuality and reproduction" (Freedman, 2010, pg.10). The campaign named doctors, mostly males, as the experts on women's bodies, helping to discredit the voices of women. This supported the AMA's action to criminalize abortion because the opinions of the male physicians speaking out against abortion were considered superior.

The association with abortion threatened the medical profession overall but was especially dangerous to docototrs whose status was more insecure such as female physicians, physicians of color, and new physicians (Reagan, 2008). The status of female physicians was always more insecure, which prevented them from being able to provide abortions and speak out as supporters of a woman's right to choose. This put female physicians in a difficult place because in some circumstances they were looked at as a resource for providing women's health but male physicians still always had more control.

## 3.2 AMERICAN PUBLIC HEALTH ASSOCATION

The American Public Health Association was founded in 1872, and its mission is to improve the health of the public and establish health equity across the population. As an organization it influences federal policy and impacts the health of the public through that policy. APHA supported the creation of accessible, safe and legal abortion services and in 1968 called for an all-out repeal of abortion laws (Freedman, 2010; Halfmann, 2011). This support is in direct opposition to the AMA, and was important for improving policy but not in training on and providing abortion services.

In 1973 the APHA adopted a Comprehensive Program Guide for Abortion Services, which stressed the need for the full implementation of Supreme Court decisions. The guide covered education, referral, consent, safety factors, and the standards of practice (Jaffe, Lindheim, and Lee, 1981). This further showed that APHA was in support of women being able to have access to legal abortion services.

## 3.3 ANTI-CHOICE INSTITUTIONS

Catholic hospitals treat patients following the "Catholic moral principles" and do not offer certain reproductive health services like abortion (Freedman, 2010). Doctors were prevented from practicing medicine in accord with their professional judgment because of the municipal hospital policies that were based on sectarian doctrines, specifically when it came to birth control (Jaffe, Lindheim, and Lee, 1981). These policies prevented doctors from making decisions that they felt were in the best interest of their patients. A perinatology doctor who worked at a

Catholic hospital in the late-1990s said," it was in my contract that if I discussed birth control, abortion, did an abortion, a tubal ligation that it was grounds for immediate termination of employment" (Freedman, 2010, pg. 53).

Operation Rescue, an anti-abortion organization, was founded in 1986 by Randall Terry. The organization is well known for its confrontational protesting strategies. During protests the members use screaming and force to prevent women from entering aborting clinics (Hillstrom, 2008). In 1988 the organization gained national attention when 1,200 protestors were arrested in Atlanta during the Democratic National Convention (Inrig, 2008). Terry was arrested in Atlanta in 1989 for trespassing and criminal assembly and declared that preventing the murder of innocent children was not a crime (Hillstrom, 2008). In 1994 Randall Terry left the organization and Flip Benham became the new director, changing the name of the organization to Operation Save America (Hillstrom, 2008). Today, a number of organizations exist with the names Operation Save America and Operation Rescue. Each has its own website, but from the histories of the organizations, they are all linked together.

## 3.4 PROVIDER PERSPECTIVES

Many doctors do not perform abortions because of the clinical environment in which they practice or because they feel that their safety would be threatened if they were to perform abortion (Freedman, 2010). Abortions were illegal and could not be performed by doctors before *Roe v. Wade* was passed in 1973. Doctors who were willing to perform abortions asked permission from hospital committees on a case-by-case basis (Lowe, 1966). In the beginning of this practice, therapeutic abortions were conducted more regularly, for women who had certain

medical conditions like heart disease, diabetes or tuberculosis (Lowe, 1966). As medical technology improved, pregnancy was less likely to threaten a woman's life and the justification for therapeutic abortions declined.

Even after *Roe v. Wade* was passed and abortion became legal there are many doctors who do not want to perform abortions because of personal beliefs or fear of stigmatization. Residents are allowed to opt out of training on abortion; one resident said the reason she opted out was because she was a practicing Catholic while another said that she did not want to be a part of ending a life (Freedman, 2010). There are doctors who go through training to perform abortions and then become morally conflicted on the procedure (Freedman, 2010). Some physicians feel that it is acceptable for a woman to have one abortion but having more than that is insupportable (Freedman, 2010). An infertility specialist stated that he went through the training to perform legal abortions but after getting into his specialty, he could no longer work with patients who were struggling with infertility as well as perform abortions (Freeman, 2010). A hospital administrator expressed that if it was too easy for a woman to get an abortion that she would use it is as her primary method of birth control and use it every three months (Halfmann, 2011).

# 4.0 STATE AND FEDERAL POLICIES

Abortion policy goes far deeper than the single well known case of *Roe v. Wade*. Federal policies like the Hyde Amendment restrict how women can pay for their abortion services. The continuous introduction of bills into the House of Representatives and Congress changes abortion laws constantly for better and worse. Many state policies restrict a woman's access to abortion as well as the procedures she has to go through before she is able to have an abortion. Waiting periods and physician-only laws have been successfully implemented in most or all states with varying language and implications. Implementation of human life amendments has been attempted in many states with little success. Texas and Pennsylvania are two states that have implemented laws that restrict a woman's access to abortion. Regulations resulted in the closure of clinics in Texas and waiting periods in Pennsylvania making it almost impossible to get an abortion in one day.

## 4.1 FEDERAL POLICIES

### 4.1.1 *Roe v. Wade*

By the time *Roe v. Wade* made its way to the Supreme Court in 1970, abortion was illegal in all cases in 30 states, legal in certain circumstances (rape, incest, danger to health) in 16 states, and

totally legal in only four (Alaska, Hawaii, New York, and Washington) (Kogan, 2015). The Supreme Court issued its decision on *Roe v. Wade* on January 22, 1973, in which the justices ruled 7-2 that abortion was a fundamental right protected by the United States Constitution (Kogan, 2015). It is considered one of the most controversial and politically significant cases in the history of the United States Supreme Court (Leverich, 2010). This was a landmark decision for women and for their right to make choices about their bodies. The Supreme Court Decision made first trimester abortion legal in all 50 states regardless of what previous state policies stated (Leverich, 2010). However, since that decision in 1973 hundreds of policies have chipped away at the victory making it more and more difficult for women to obtain abortions in many states. Between the years of 2009 and 2014 alone, 288 state policies existed that restricted abortion access (Jerman, Jones, Onda, 2016).

### 4.1.2 Hyde Amendment

The Hyde Amendment prevents the use of federal Medicaid dollars for abortion services except in the case of rape, incest, or life threatening circumstances (Jerman, Jones and Onda, 2016). Women who are insured with Medicaid are limited in their options, especially in states where the expansion of Medicaid did not occur. Women who are insured under Medicaid cannot pay for an abortion with their health insurance. Although federal Medicaid dollars can be used in limited circumstances, 15 states including California and New York allow state Medicaid dollars to be used on abortion services no matter the circumstance (Jerman, Jones and Onda, 2016). These 15 states also have a large number of providers who will perform these services. States where women cannot use their Medicaid to pay for an abortion are considered hostile or very hostile to abortion services. The number of states labeled hostile or very hostile has grown significantly

since 2006. In 2006 only two states were considered very hostile, but in 2016 the number had risen to 22 (Figure 1) (Nash et al., 2017). The states considered very hostile in 2016 were largely considered hostile in 2006 but some states like Arizona went from supporting abortion to being very hostile in only 10 years (Figure 1) (Nash et al., 2017).

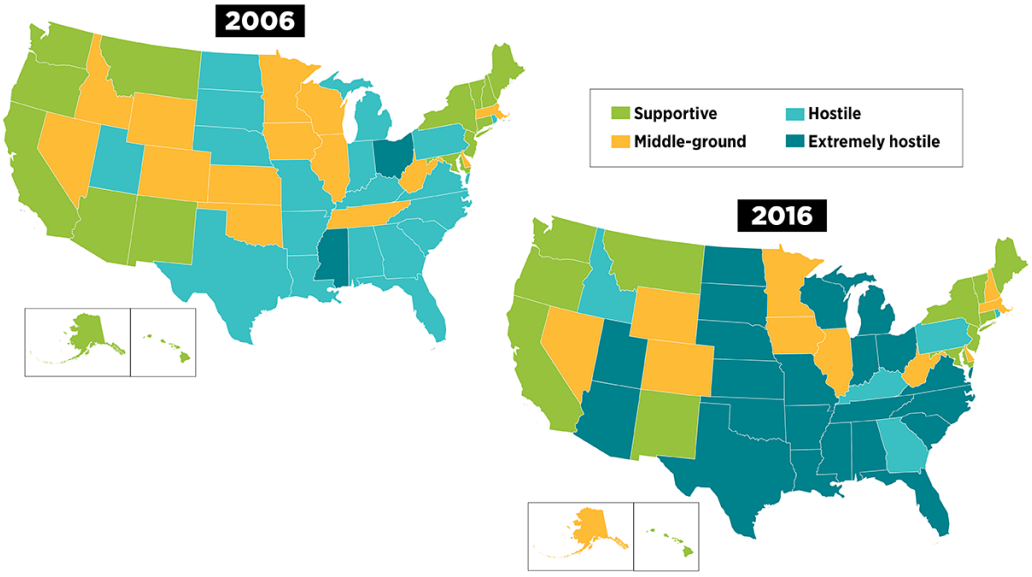


**Figure 1: Change in Hostile States over the Past 10 Years**

(Nash et al., 2017)

### 4.1.3 Affordable Care Act

The Affordable Care Act (ACA) aimed to get all Americans to have health insurance through private and public insurance expansions. At the time, the Supreme Court ruled that states had the option to be able to expand Medicaid eligibility to allow more individuals to have coverage (Salganicoff, Beamesderfer, Kurani, and Sobel, 2014). In September 2014, only 27 states had

expanded their Medicaid eligibility, which left almost two million women without health insurance coverage because of the gap (Salganicoff et al., 2014). This is a significant improvement from before the ACA when 11.8 million women were uninsured. In 2014, 5.8 million women gained access to abortions without restriction, 4.3 million have restricted coverage for abortion with Medicaid or private insurance, and 1.7 million fall in the coverage gap for Medicaid or Tax credits (Salganicoff et al., 2014). As of April 2018, 33 states have expanded their Medicaid coverage through the ACA and the number of women who are in the Medicaid gap has been reduced to about one million (KKF). As of April 2015, 25 states banned abortion coverage in private health insurance plans that were offered through the marketplace (Figure 2) (Hasstedt, 2015). In 2017, Texas became the 26th state to ban abortion coverage through private health insurance plans offered through the marketplace (Guttmacher Institute, 2018).

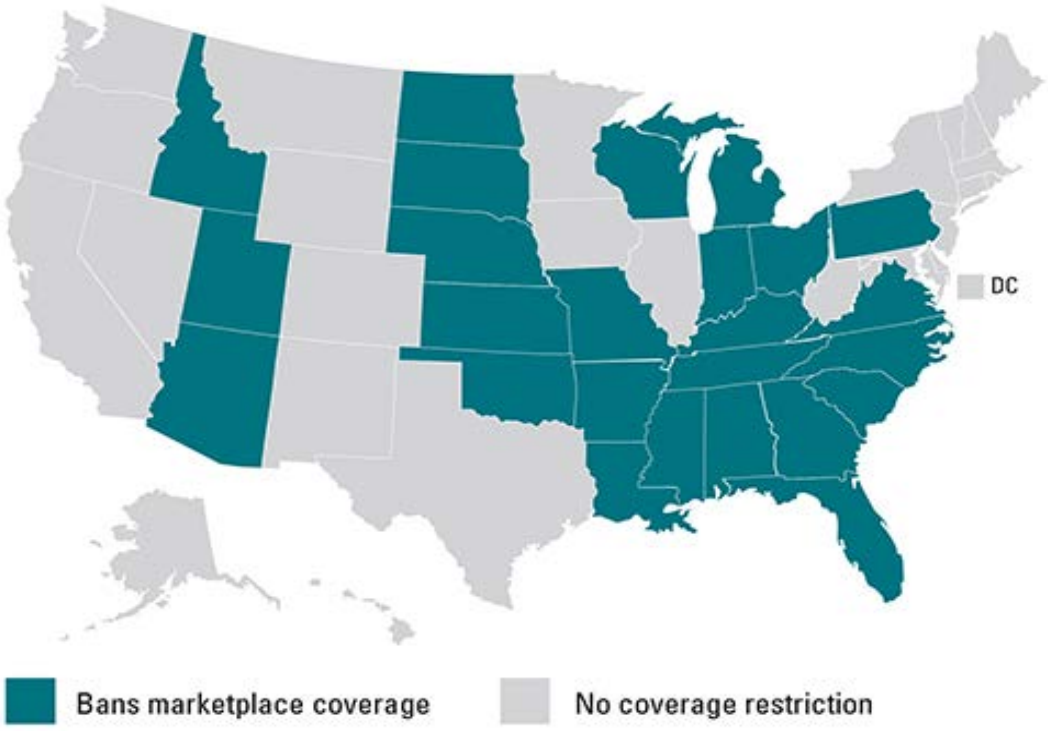


**Figure 2: States that Ban Abortion Coverage in Private Insurance Plans**
(Hasstedt, 2015)

Since 2008 there has been a significant increase in the number of policies that make it more difficult for women to pay for their abortion and for clinics to keep their doors open (Jones and Jerman, 2017). Since 2011, 25 states have experienced a decrease in the number of its abortion clinics. In 2014, Mississippi, Missouri, North Dakota, South Dakota, and Wyoming each had only one clinic that provided abortion services (Jones and Jerman, 2017). Furthermore while 5% of women in California lived in a county with no access to an abortion clinic 90% of women in West Virginia did not have access and Indiana at 77% (Jones and Jerman, 2017).

The cost of abortion varies significantly depending on where the woman is obtaining care and how far along in the pregnancy she is. One study found that a first trimester medication abortion has a median cost of $440 and the median price of an abortion at or after 20 weeks is $1,750 (Roberts et al., 2014). Another estimate is that the average cost for an abortion for women in 2011 and 2012 was $480 for a first trimester procedure (Jones, Ingerick, and Jerman, 2018). This just the cost of the physical procedure. It does not include the lost wages from work or travel cost. In 2014, 53% of women paid for their abortions out of pocket (Jerman, Jones and Onda, 2016). While there are a number of reasons why abortions are paid for out-of-pocket, one of the most significant is lack of insurance coverage.

In the Turnaway study (Roberts et al., 2014), 71% of women received some type of financial assistance for their abortion with the majority being Medicaid (34%) and other organizations (29%). Even with financial assistance, many women still have to pay out-of-pocket costs (Roberts et al., 2014). More than half of the participants reported that their personal costs for their abortion were more than one third of their monthly income. Of the women with private insurance, 77% could not use it or chose not to use it to cover their abortion. Costs range from

$0 to $2,400, with a mean cost of $578. Over half of the women reported that the cost of their abortion delayed their care (Roberts et al., 2014).

### 4.1.4 Acts in Progress Causing Uncertainty

The H.R. 681 Life at Conception Act was introduced into the House Committee on the Judiciary in January 2017. Representative Alexander Mooney from West Virginia is the sponsor on the bill with 136 cosponsors from 37 states and the bill was referred to the subcommittee on the Constitution and Civil Justice. This act defines a human being as "each and every member of the species homo sapiens at all stages of life, including the moment of fertilization, cloning, or other moment at which an individual member of the human species comes into being" (Life at Conception, 2017). This act works in conjunction with the 14$^{th}$ Amendment, to the United States Constitution, which grants citizenship to all persons born or naturalized in the United States. It also prohibits states from depriving any person "life, liberty, or property without due process" or to "deny to any person within its jurisdiction the equal protection of the laws" (Library of Congress, 14th Amendment to the U.S. Constitution). Along with H.R. 681, S. 231 "Life at Conception Act of 2017" sponsored by Senator Rand Paul has been referred to the United States Senate Committee on the Judiciary. It contains the same language as H.R. 681 but with one addition: "Nothing in this Act shall be construed to require the prosecution of any woman for the death of her unborn child, a prohibition on in vitro fertilization, or a prohibition on use of birth control or another means of preventing fertilization" (Life at Conception Act of 2017, 2017). If passed, this bill could open the door for interpretation since it does not specifically contain language addressing the topic of abortion.

### 4.1.5 Acts in Progress Offering Protection

The bill H.R. 1322, Women's Health Protection Act of 2017 was introduced by Representative Judy Chu from California in March 2017. It has 144 cosponsors from 35 states and was referred to the House Subcommittee on Health within Energy and Commerce. The act cites that many state restrictions on abortion are not based in scientific evidence and they make access more difficult for women (Women's Health Protection Act of 2017, 2017). The purpose of this act is to protect women's health by ensuring the availability of abortion services and avoiding0 excess burden preventing women from being able to obtain these services. The bill lists a number of restrictions that are unlawful and singles out abortion services. These include the requirement that the same clinician who performed the abortion also perform all tests needed prior to and after the abortion (Women's Health Protection Act of 2017, 2017). Women who travel hundreds of miles to get an abortion have an undue burden placed on them because of this restriction.

## 4.2 STATE POLICIES

### 4.2.1 Physician-Only Laws

Physician-only laws were enacted shortly after abortions were legalized to prevent unlicensed health care personnel from performing abortions, and currently most states allow only physicians to perform abortions (Jones, Ingerick, and Jerman, 2018). When these laws were put in place, medical professionals such as nurse practitioners, nurse-midwives, and physician assistants were not as common as they are today (Jones, Ingerick and Jerman, 2018). Currently five states allow

physician assistants to perform surgical abortions, and 12 states allow them to administer medication abortions (Jones, Ingerick, and Jerman, 2018). The laws that are in place limit care for individuals in many states where their only access to abortion services through providers other than physicians. A number of studies compare the rates of complications when abortions are performed by trained medical professionals instead of physicians (Templeton Dunn and Parham, 2013). The results of the studies show that the complication rates are the same for each type of provider and medical professionals such as nurse practitioners are capable of performing abortions (Templeton Dunn and Parham, 2013). The increased use of medication abortion is helping to shift into allowing other medical professionals to be able to perform abortions (Jones, Ingerick, and Jerman, 2018).

The use of telemedicine to prescribe abortion pills is still prohibited in the United States so a woman still needs to go see a doctor to get the medication for the abortion (Raymond, Chone, Hyland, 2016). Telemedicine is the real time interactive communication between a practitioner and patient using audio and video equipment ("Telemedicine", n.d.). A study in Iowa compared face to face visits with telemedicine for women seeking an abortion and found similar clinical outcomes (Grossman, Grindlay, Buchacker, Lane, Blanchard, 2011). The women who used telemedicine were significantly more willing to recommend the service to a friend (Grossman et al., 2011).

### 4.2.2 Waiting Periods

Twenty seven states have a waiting period, so women have to wait at least 24 hours and up to 72 hours before they are able to have an abortion after they have received counseling (An Overview of Abortion Law, 2018). Women have to make an appointment at their doctor's office or clinic

where they are going to have the abortion. Once the woman is counseled by the doctor about the procedure, she has to wait the required amount of time and then come back to have the abortion. In some circumstances women have to travel hundreds of miles to get to a clinic that provides abortion services. If a woman has to wait 48 hours for an abortion she may have to stay overnight, may have to take off of work, take more than one day off of school, or she might need to bring her other children, all of which have costs associated with them. This waiting period was enacted to give women the chance to change their minds after they have been educated about the abortion procedure but in many cases it is the reason women do not get an abortion.

### 4.2.3 Human Life Amendments

Some states have tried to pass Human Life Amendments (HLA) since *Roe v. Wade* was passed by the Supreme Court. HLAs state that embryos are human life and that embryos have rights. Based on the 14th Amendment HLAs would prohibit a woman from being able to abort a fetus since it would be protected under the law. Although no specific HLAs have been passed in any state, some have provisions that are comparable (Murphy, 2010).

### 4.2.4 Planned Parenthood v. Casey

In the 1992 decision *Planned Parenthood v Casey, Roe v Wade* was upheld but the ruling changed Pennsylvania state law making access to abortions more restrictive. This decision imposed a rule that requires women to wait 24 hours after medical consultation before receiving an abortion (Leverich, 2017). Part of the bill required women to obtain spousal consent before getting an abortion, although this was ruled to cause undue burden so it was not passed. This

decision of undue burden was important because it was one of the first times it was used in a Supreme Court case on abortion (Leverich, 2017).

### 4.2.5 House Bill Two

In 2013, Texas passed House Bill Two, which resulted in the closure of half of the abortion clinics in Texas. The bill required clinics to meet certain hospital standards such as minimum sizes for rooms and doorways and that abortion providers have admitting privileges at a hospital within 30 miles of the clinic (Grossman et al., 2014). If a clinic could not meet these standards, it had to shut down. These closures increased the distance women needed to travel to receive an abortion and increased the number of abortions that occurred in the second trimester (Moseson, 2017). Texas also has the 20 week abortion ban in place as well as a 24 hour waiting period which already makes it difficult for a women to receive an abortion. After the bill was in place for over a year, it was ruled to be unconstitutional by the U.S. Supreme court. In that time, thousands of women had excess burden put on them, which in some cases resulted in women not be able to have the abortion that they needed (Nash et al., 2018).

# 5.0 MOVING FORWARD

The ruling of *Roe v. Wade* was essential to making abortions available to women across the United States, but it no longer means that all women have that opportunity. State policies have made it more and more difficult in some states for women to have abortions that are easily accessible and affordable. Laws have been put in place that require waiting periods before abortions can be performed and that limit the amount of funds that can be used from Medicaid. This makes it next to impossible for certain women to have the abortion that they need. Since the Supreme Court ruled that access to abortion is a woman's right, access to abortion must be equal across all states.

A national program for sexual health education would ensure that all students will be able to make informed decisions when it comes to their sexual health. A base standardized curriculum would ensure that all students are receiving the same information and supplemental material can be added depending on state resources. This education would include information on how to protect against pregnancy and STIs as well as where to get help in their community. In order to reduce the rate of unplanned pregnancies and abortions, individuals need to be educated and also have the resources to act on that education.

Every four years the United States Department of Health and Human Services (HHS) releases a strategic plan document that outlines the mission, goals, and means of measurement for the next four years. A draft of the strategic plan for 2018-2022 was published for public

comment in October 2017. The final strategic plan was published in February 2018 containing this language. This document stated five times that life begins at conception whereas the previous strategic plan for 2014-2018 never mentioned this. The change in language affects the way that funding is allocated and contradicts ruling of the Supreme Court. The Supreme Court ruled that there is no answer to the question of when life begins. This ruling should prevent the phrase "life begins at conception" from being used in any official government documents.

Physician-only laws and waiting periods are two restrictions that are significantly impacting women's access to abortion and need to be changed. If a woman is a living in an area where she does not have access to a physician that she can meet with face-to-face or there are no physician in her area that are willing to perform a legal abortion, she will not be able to get an abortion. A physician should not be forced to perform abortions if they do not wish to do so. Other willing and able medical professionals can perform safe, legal abortions. If physician-only laws are eliminated, a woman could see a nurse practitioner, physician's assistant, or use telemedicine for a medication abortion. This would significantly increase the number of women who would access to safe and legal abortions. Waiting periods require a woman to wait a certain amount of time after consultation before having an abortion. If she does not have the resources to return to the clinic, she will not be able to get an abortion. Waiting periods have been used to try and change a woman's mind from having a safe, legal abortion. The elimination of waiting periods would allow women to have an abortion with only one trip to the clinic.

Women also need to be educated about all of their family planning options including abortion. Changing the laws is important for women to be able to have access but without knowing the possibilities it will be useless. Providing accurate information to women about what a medication abortion is and when it can be used can help with the misunderstanding

around abortion. There also needs to be education on how to talk about abortion to reduce the stigma. Many women who get an abortion feel that they need to keep their abortion a secret because of stigma, which perpetuates secrecy and shame. If there were more open conversations around abortion and education on how to talk about it, this stigma could be reduced.

# 6.0 CONCLUSION

Abortion in the United States has a complicated history, usually with legality at the center of the discussion. Before the Supreme Court decision on *Roe v Wade* women were having illegal abortions in unsanitary conditions, risking their lives. Instead of the American Medical Association working towards training doctors to perform safe abortions, it was working on a campaign to keep abortion illegal. Once abortion became legal, the fight for a woman to be able to have an abortion without undue burden did not disappear. There are still significant barriers that women face in order to be able to get an abortion. The Hyde Amendment and Title X restrictions make paying for an abortion a burden for some women because of high out-of-pocket costs. Physician-only laws and waiting periods can result in longer travel times and delay in care putting more of a burden on a woman seeking abortion services.

Anti-choice individuals fear that legalizing abortion results in abortion not becoming a choice but rather a duty (Sanger, 2005). This fear is unfounded because the number of abortions that occur when it is legalized is similar to the number that took place when it was illegal; the methods and location of abortion just change. The problem is that even though abortion is legal now, so many laws limit services. Considering the conditions that cause women to need abortions, rather than their access to abortions themselves is the much more important point. If a woman has to make the choice to have an abortion, a decision that is difficult, there has been a

system failure. The fear should be that there is not enough being done so that women never have to make the choice to have an abortion, not that women are able to make the choice.

The passage of *Roe v Wade* was a success in public health policy because it gave women the right to access safe abortions. There was a significant decrease in maternal mortality and complications from women obtaining unsafe illegal abortions. But since the passage of *Roe v Wade* there has been over 1,000 state policies enacted that put the health of women at risk. If a woman does not have access to a safe abortion, she may use unsafe options to terminate her pregnancy. It is a basic human right for a woman to be able to make decisions about her body in a safe way.

There are many layers to abortion access that all need to line up in order for a woman to be able to receive an abortion. She needs to be able to have the right insurance with no restrictions or enough personal funds to cover the procedure. There needs to be a willing and able abortion provider to perform the procedure once she gets to the medical facility. The state in which she is going to get the abortion needs to have laws that allow for the procedure to take place and that do not require her to come back for multiple visits before she can have the procedure. If any of these things is not present, the system breaks down and abortions are difficult to receive. Abortion access is more than *Roe v Wade;* it is medical training, clinic location, insurance plans, financial means, education, local policy, state policy, and federal policy.

Based on *Roe v Wade*, women have the legal right to have an abortion without undue burden put upon them. Policies such as waiting periods and physician only laws are not looked at as illegal, because the law says that women are not prohibited from getting an abortion, even though this is far from the truth. Abortion was not always this way. It used to be legal and

accepted, women were able to get one without any questions because they knew their bodies best. Women were the keepers of their own bodies and pregnancy and birth were women's business. Before *Roe v Wade* many women were forced to be sterilized if they wanted to have an abortion. Doctors, who were considered the experts on women's bodies, thought that a woman who had an abortion did not deserve to have more children. Women were punished for what could possibly happen instead of focusing on how those women could be supported in the present to ensure that no other unwanted pregnancies occurred in the future.

## BIBLIOGRAPHY


An Overview of Abortion Laws. (2018, February 01). Retrieved February 9, 2018, from https://www.guttmacher.org/state-policy/explore/overview-abortion-laws

Bartlett, L., Berg, C., Shulman, H., Zane, S., Green, C., Whitehead, S., & Atrash, H. (2004). Risk Factors for Legal Induced Abortion–Related Mortality in the United States. *Obstetrics & Gynecology*,103(4), 729-737. Retrieved February 26, 2018.

Callahan, D. (1973). *Abortion: law, choice and morality*. New York: Macmillan.

Caron, S. (2010). *Who Chooses? American Reproductive History Since 1830*. University Press of Florida.

Ehrenreich, B., & English, D. (1973). *Witches, midwives, and nurses: a history of women healers*. Brooklyn, NY: The Feminist Press.

Feldt, G., & Fraser, L. (2004). The war on choice: the right-wing attack on womens rights and how to fight back. New York: Bantam Books.

Fieldwork and Sampling. (2017). Retrieved March 14, 2018, from http://www.worldvaluessurvey.org/WVSContents.jsp

Foster, D. G., Biggs, M. A., Ralph, L., Gerdts, C., Roberts, S., & Glymour, M. M. (2018). Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. American Journal of Public Health, 108(3), 407-413. doi:10.2105/ajph.2017.304247

Francome, C. (1986). Abortion practice in Britain and the United States. London: Allen and Unwin

Freedman, L. (2010). *Willing and unable: doctors constraints in abortion care.* Nashville: Vanderbilt University Press.

Grossman, D., Grindlay, K., Buchacker, T., Lane, K., & Blanchard, K. (2011). Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. Obstetrics & Gynecology, 118(2, Part 1), 296-303. doi:10.1097/aog.0b013e318224d110

Grossman, D., Baum, S., Fuentes, L., White, K., Hopkins, K., Stevenson, A., & Potter, J. E. (2014). Change in abortion services after implementation of a restrictive law in Texas. Contraception, 90(5), 496-501. doi:10.1016/j.contraception.2014.07.006

Guttmacher Institute. (2018). Data Center. Retrieved from https://data.guttmacher.org/states?state=AL&topics=65

Guttmacher Institute. (2018, February 08). Medication Abortion. Retrieved March 06, 2018, from https://www.guttmacher.org/evidence-you-can-use/medication-abortion

Halfmann, D. (2011). *Doctors and demonstrators: how political institutions shape abortion law in the United States, Britain, and Canada*. Chicago: University of Chicago Press

Hasstedt, K. (2016, December 06). Abortion Coverage Under the Affordable Care Act: Advancing Transparency, Ensuring Choice and Facilitating Access. Retrieved March 27, 2018, from https://www.guttmacher.org/gpr/2015/04/abortion-coverage-under-affordable-care-act-advancing-transparency-ensuring-choice-and

Henry, A. (1981). 30 million illegal abortions, 10 million complications. *Off our Backs, 11*, 5. Retrieved from http://pitt.idm.oclc.org/login?url=https://search-proquest-com.pitt.idm.oclc.org/docview/197145055?accountid=14709

Henshaw, S., Binkin, N., Blaine, E., & Smith, J. (1985). A Portrait of American Women Who Obtain Abortions. Family Planning Perspectives, 17, 90-96.

Henshaw, S.K. and Kost, K., Trends in the Characteristics of Women Obtaining Abortions, 1974 to 2004, New York: Guttmacher Institute, 2008.

Hillstrom, L. C. (2008). Roe v. Wade. Detroit, MI: Omnigraphics.

Inrig, S. (2008). Encyclopedia of activism and social justice (G. Anderson & K. Herr, Eds.). Thousand Oaks: Sage Online.

Jaffe, F. S., Lee, P. R., & Lindheim, B. L. (1981). *Abortion politics: private morality and public policy*. New York: McGraw-Hill.

Jerman J, Jones R.K. and Onda T. (2016). Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. Retrieved from: https://www.guttmacher.org/report/characteristicsus-abortion-patients-2014

Jerman, Jenna, et al. Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. Perspective on Sexual and Reproductive Health , 10 Apr. 2017,onlinelibrary.wiley.com/doi/10.1363/psrh.12024/full.

Jones, R. K. (2010). How commonly do US abortion patients report attempts to self-induce? American Journal of Obstetrics and Gynecology, 204(1). doi:10.1016/j.ajog.2010.08.019

Jones, R. K., Ingerick, M., & Jerman, J. (2018). Differences in Abortion Service Delivery in Hostile, Middle-ground and Supportive States in 2014. Womens Health Issues. doi:10.1016/j.whi.2017.12.003

Kogan, M. (2015, October 26). Roe v. Wade: A Simple Explanation Of the Most Important SCOTUS Decision in 40 Years. Retrieved from: https://mic.com/articles/23822/roe-v-wade-a-simple-explanation-of-the-most-important-scotus-decision-in-40-years#.GhXeRFkFK

Leverich, J. (Ed.). (2010). Abortion. Detroit: Greenhaven Press.

Levine, P., Staiger, D., Kane, T., & Zimmerman, D. (1999). Roe v. Wade and American Fertility. *American Journal of Pubic Health*,*89*(2), 199-203. doi:10.3386/w5615

Life at Conception Act of 2017, S.231, 115th Cong., Congress.gov (2017).

Life at Conception Act, H.R. 681, 115th Cong., Congress.gov (2017).

Lowe, D. (1966). Abortion and the law. New York: Simon, Schuster.

Marecek, J., Macleod, C., & Hoggart, L. (2017). Abortion in legal, social, and healthcare contexts. Feminism & Psychology, 27(1), 4-14. doi:10.1177/0959353516689521

Masci, D. (2016, June 21). Where major religious groups stand on abortion. Retrieved from http://www.pewresearch.org/fact-tank/2016/06/21/where-major-religious-groups-stand-on-abortion/

McCann, C. R. (1999). *Birth control politics in the United States, 1916-1945*. Ithaca: Cornell University Press.

Moseson, H., Gerdts, C., Fuentes, L., Baum, S., White, K., Hopkins, K., . . . Grossman, D. (2017). Measuring Texas women's experiences with abortion self-induction using a list experiment. *Contraception, 96*(4), 272. doi:10.1016/j.contraception.2017.07.042

Murphy, T. F. (2010). What Human Life Amendments Mean and Don't Mean. The American Journal of Bioethics, 10(12), 47-48. doi:10.1080/15265161.2010.528517

Nash, E., Benson Gold, R., Ansari-Thomas, Z., Cappello, O., & Mohammed, L. (2017, July 13). Policy Trends in the States: 2016. Retrieved March 27, 2018, from https://www.guttmacher.org/article/2017/01/policy-trends-states-2016

Nash, E., Gold, R., Mohammed, L., Ansari-Thomas, Z., & Cappello, O. (2018, January 02). Policy Trends in the States, 2017. Retrieved February 8, 2018, from https://www.guttmacher.org/article/2018/01/policy-trends-states-2017

Office of Population Affairs. (2017, September 20). Title X Service Delivery Improvement Retrieved March 31, 2018, from https://www.hhs.gov/opa/title-x-family-planning/title-x-service-delivery-improvement/index.html

Raymond, E. G., Chong, E., & Hyland, P. (2016). Increasing Access to Abortion With Telemedicine. *JAMA Internal Medicine, 176*(5),585. doi:10.1001/jamainternmed.2016.0573

Reagan, L. J. (2008). *When abortion was a crime: women, medicine, and law in the United States, 1867-1973*. Berkeley, Calif: University of California Press.

Roberts, S. C., Gould, H., Kimport, K., Weitz, T. A., & Foster, D. G. (2014). Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. Womens Health Issues, 24(2). doi:10.1016/j.whi.2014.01.003

Palmer, L. J., & Palmer, X. Z. (2014). Encyclopedia of Abortion in the United States (2nd ed.). S.l.: McFarland

Planned Parenthood. (n.d.). End the Global Gag Rule. Retrieved from https://www.plannedparenthoodaction.org/communities/planned-parenthood-global/end-global-gag-rule

Prager, S., & Oyer, D. (2009). Second-Trimester Surgical Abortion. Clinical Obstetrics and Gynecology, 52(2), 179-187. doi:10.1097/GRF.0b013e3181a2b43a

Saad, L. (2016, May 25). Americans' Attitudes Toward Abortion Unchanged. Retrieved from http://news.gallup.com/poll/191834/americans-attitudes-toward-abortion-unchanged.aspx

Salganicoff, A., Beamesderfer, A., Kurani, N., & Sobel, L. (2014, September 19). Coverage for Abortion Services and the ACA. Retrieved March 27, 2018, from https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca/

Sanger, A. (2005). *Beyond choice: reproductive freedom in the 21st century*. New York: Public Affairs.

Shellenberg, K. M., & Tsui, A. O. (2012). Correlates of Perceived and Internalized Stigma Among Abortion Patients in the USA: An Exploration by Race and Hispanic Ethnicity. International Journal of Gynecology & Obstetrics, 118. doi:10.1016/s0020-7292(12)60015-0

Simon, R. J. (1998). Abortion: statutes, policies, and public attitudes the world over. Westport, CT: Praeger.

Stubblefield, P. G., Carr-Ellis, S., & Borgatta, L. (2005). Methods for Induced Abortion. Obstetrics & Gynecology, 105(1), 221-222. doi:10.1097/01.aog.0000145753.05624.62

Telemedicine. (n.d.). Retrieved April 01, 2018, from https://www.medicaid.gov/medicaid/benefits/telemed/index.html

Templeton Dunn, J., & Parham, L. (2013). After the Choice: Challenging California's Physician-Only Abortion Restriction Under the State Constitution. UCLA Law Review Discourse, 22-42. Retrieved March 13, 2018, from https://www.uclalawreview.org/pdf/discourse/61-3.pdf.

Who We Are (2017). Retrieved March 14, 2018, from http://www.worldvaluessurvey.org/WVSContents.jsp

Women's Health Protection Act of 2017, H.R.1322, 115th Cong. (2017)