

"Roe v. Wade 30 Years Later: How Have Abortion Practice, Policy, Politics, and Public Opinion Changed?"
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[BEGIN TAPE]

TINA HOFF: I'm Tina Hoff with the Kaiser Family Foundation. And thanks for coming to our program. I think most of you have been to one of our briefings before, but for anybody who hasn't, this is part of an ongoing series we do for journalists on emerging issues in reproductive health. And we'll give issues in the news, emerging issues in today's case, we're looking ahead to the third anniversary of Roe versus Wade in January.

And this is a topic that's certainly not new. At least two generations of young women have come of age now in a time when they have known abortion, not as a legal right in this country, but far from resolved. And we just this past week in fact that the Supreme Court once again had another abortion case among its docket that abortion continues to be a hotly debated

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and too much discussed in the public.

Laws have been passed that regulate how and when abortions are performed. And Americans continue to express divided use of this issue.

During the last 30 years, while we've seen medical advances that have allowed women greater control over their reproductive lives with seeing the AIDS epidemic come into play, which has certainly affected how many young people and adults like have thought about protecting themselves against pregnancy and disease, yet unintended pregnancy remains a significant problem in this country, and so too access to safe and legal abortions.

Today, we're going to look back at the three decades since abortion has been legalized in this country. And to help us do that, we've got a panel of experts representing different views from political, social, and looking ahead to

the new generation.

And hoping to frame our discussions, I'm very happy to have with us today Rachel Jones, a senior research associate with the Alan B. Parker Institute, who's going to sharing with you new data about who has abortions today.

And there's a more complete bio for Rachel in your kits, as well as for all of our speakers. So I'm going to keep my introduction somewhat brief, but if you want more detail, it's in there.

But in short, Rachel holds a Ph.D. in sociology and specializes in national research on abortion, gender and sexuality and is a lead author on the study you're going to be hearing about today.

Also with us today, to help get behind these numbers and trends and better understand the different variables that are affecting it are Dr. William Harrison, an OB/GYN from Fayetteville, Arkansas who

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has been providing medical services, including abortions to women in the community for more than 30 years. So here's here to give us a very up close perspective on how trends in abortion have changed over the years, and what he's seen in his private practice.

He has also serving in leadership positions in medical divisions in various area hospitals in Arkansas.

We also have Katherine Ann Colbert, whose been our [unintelligible] before. She's a senior research administrator at the Annenberg Public Policy Center at the University of Pennsylvania. She's a lawyer by training and has argued cases before the Supreme Court on reproductive health matters and abortions.

In 1992, she co-founded the Center for Reproductive Law and Policy. And in addition to her academic career, she is also the executive producer of

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Justice Talking, which is a program on
NPR.

And then last but not least, we
have Sarah Brown, who is the director of
the National Campaign to Prevent Teen
Pregnancy. She is a leading voice on
issues, sexual health issues, affecting
adolescent women, and has been active in
public health for many years, and also
holds a masters in public health. And
she's here to help share with us some of
the views about the generation that's
coming of age today, and their views on
abortion, and how some of the changes in
sexual behavior have affected some of the
rates we're going to here about today.

So I want to turn it over to
Rachel to share with you the new data.
We'll take a quick break and take some
questions from you on the study. And then
we'll open it up for discussion with our
program.

If anybody has questions, just

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raise your hand and I'll call on you. And also, just want to know, we're - when the camera's in the back of the room is a webcast that we're doing of this event. So you'll be able to go online in the next couple of days on Kaiser Network and log on and pick up anything that you might have missed in this discussion.

So Rachel?

RACHEL JONES: All right, well, thank you everyone for being here today. And thank you also to the Kaiser Family Foundation for providing us with a forum to talk about this very important issue.

Before I launch into the findings from the research that I've done, I wanted to recognize that the research that I'm going to talk about today is part of a larger project that AGI is working on, looking at unintended pregnancy and contraceptive effectiveness.

I also wanted to acknowledge that in the last two years, AGI has undertaken

several projects looking at abortion in the United States. I'm just reporting on one facet of that body of work.

Within the next few months, between now and the 30th anniversary of Roe v. Wade in January, we're going to release findings from other research that we've done on this topic.

The information that I'm going to present today is about the characteristics of women who have abortions. The information was gathered from self administered surveys collected from over 10,000 women in over 100 abortion facilities across the United States. The facilities consisted of doctors offices, hospitals, and abortion clinics.

The research I'm going to be presenting today also makes use of unpublished or currently unpublished data collected by AGI. My colleagues there have collected information from all nine abortion providers in the United States to

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find out the number of abortions that were performed in 2000.

A lot of that research, those numbers are still being finalized, but they did perfect or finalize the total number of abortions performed in 2000, which is \$1.3 million. And we make use of that information in this article looking at characteristics of women who have abortions.

And then just one more thing to acknowledge, because I know you've got fact sheets on abortion that made use of CDC data. In addition to AGI, the Centers of Disease Control also collects information about abortion in the United States.

But AGI's research on abortion, and particularly when you look at numbers of abortions in the United States, AGI's information is more accurate for several reasons.

First off, CDC doesn't collect

data from four states, whereas AGI collects information from all 50 states plus D.C. And additionally, the CDC relies on, in many states, relies on providers to self report numbers of abortions or characteristics of women having abortions. And we know at AGI, from our conversations with people at CDC, conversations with health authorities in difference states, and with the providers themselves, that a lot of times providers don't provide this information, that there's no penalty if they don't. It's just another piece of paper they have to fill out.

But because AGI approaches the individual providers and asks for this information, our accounts in this regard are more accurate than those put out by CDC.

Okay, so those are all the - that's all the background information I wanted to give you. Now I just wanted to

focus on the findings from the article
looking at characteristics of women who
have abortion.

Now if you read the article,
there's actually a lot of information in
there. It's very dense. And rather than
walk through all of the findings, I wanted
to focus today on the ones that we were
going to be most important or most
prominent.

And in particular, I wanted to
answer three questions. First off, I
wanted to answer the question of who has
abortions. The second question I wanted
to answer is what's happened to abortion
rates in the second half of the 1990s?
And then the third question I want to
answer is what are some striking patterns
in these changes in abortion rates over
time?

So in regards to the first
question of who has abortions, the
majority of women who have abortions are

in their 20s and specifically, 56 percent of women having abortions are between the ages of 20 and 29.

Two-thirds of women having abortions are never married. 88 percent live in a city or live in a metropolitan area. 57 percent of women having abortions are poor or low income, which means they have a family income of less than 200 percent of poverty.

Three-quarters of women having abortions have a religious affiliation. 43 percent are Protestant, 27 percent are Catholic, and 8 percent identify with an "other" religious affiliation.

One finding that a lot of people find interesting when they hear about this research is the fact that the majority of women having abortions are mothers, that 61 percent of women having abortions have at least one child.

And then finally, no racial or ethnic group makes up a majority of women

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having abortions. Instead, 41 percent are white. 32 percent are black. 6 percent are Asian. 1 percent are Native American. And 20 percent are Hispanic.

Now perhaps the most important thing to recognize or that comes out of this research is the fact that women from all backgrounds have abortions, that women from all social groups are represented among women who have abortions.

And I also want to point that, you know, I just went to this list of the majority of women are 20s, the majority of women are unmarried, but that doesn't mean that the majority of women having abortions are both in their 20s and unmarried, that there is some overlap in these characteristics, but there's also a lot of diversity as well.

Okay, so the second question I wanted to answer is what happened to abortion rates in the second half of the 1990s or specifically between 1994 and

2000, '94 being the last year that AGI did this survey of women.

Well, abortion rates declined between 1994 and 2000. And specifically, they declined by 11 percent. In 1994, there were 24 abortions per 1000 women. And in 2000, there were 21 abortions per 1000 women.

And just to put this in context, an abortion rate of 21 abortions per 1000 women means that in 2000, 2.1 percent of women between the ages of 15 and 44 had an abortion.

So overall, abortion rates declined between 1994 and 2000, but there are important variations in abortion rates among some groups of women.

A decline in abortion rates between '94 and 2000 were larger than average for several groups. They were larger than average for adolescents. And in particular, for adolescents between the ages of 15 and 17, abortion rates declined

by 39 percent for adolescents in this age group.

Other groups that experienced larger than average declines in abortion include women with no previous births, higher income women, or those with family incomes higher than 300 percent of poverty, white women. And then among women age 20 and older, those with college education showed a larger than average decline in abortion rates between 1994 and 2000.

Now of all the groups of women that we examined, we only found two groups that showed an increase in abortion rates between '94 and 2000, or two groups that showed a substantial increase in abortion rates between 1994 and 2000. And these were women on Medicaid and poor and low income women.

In both of these groups of women, those on Medicaid, and poor and low income women are economically disadvantaged

women. So one important finding from our research is that economically disadvantaged women experienced or showed increases in their rates between 1994 and 2000.

A lot of interesting findings in the research. There's two that I want to elaborate on. And the first is the decrease in abortion among adolescents. We're particularly interested in understanding what factors and what conditions contributed to the larger than average decline in adolescent abortion rates.

One commonly asked question people have when we've told them, you know, given them a preview of these findings a common question that they have is well, are kids having more babies? You know, has the abortion rate gone down because teenagers are having more babies?

And the answer to that question is no, that adolescent birth rates have

declined, along with abortion rates. And also for this piece of research, something else that we did, in addition to looking at abortion, is we tracked information about birth rates for different groups of women. And then we combined information about birthrates and about abortion rates, and were able to estimate the proportion of all pregnancies ending in abortion.

And we found in 2000, that 25 percent of pregnancies ended in abortion. And we found among adolescents, that this proportion was slightly higher, that 33 percent of all pregnancies to adolescents ended in abortion.

Now previous AGI research has also looked at this issue of proportion of pregnancies ending in abortion in 1994. And we found then that a similar - for adolescents, a similar proportion of pregnancies ended in abortion, that one-third of pregnancies to adolescents in 1994 also ended in abortion.

So these patterns just confirm that the decrease in adolescent abortion rates isn't due to an increase in births, or isn't due to kids having more babies, but it's due to fewer pregnancies among adolescents.

Now what we're unable to determine in this research is why pregnancy rates declined among adolescents. We know that two factors are contributing to this.

One is contraceptive use. Perhaps adolescents are using contraception more often. More adolescents are using birth control, using it more effectively, and are using more effective methods.

Or it could be that reduced levels of sexual activity are responsible or contributing to the declines in adolescent pregnancy.

Now again, previous AGI research looked at this issue, well, and also let

me acknowledge here that adolescent

abortion rates have been declining since the late 1980s. This isn't a new trend. This is something that started in the late 1980s.

And previous AGI research looked specifically at the decline in adolescent pregnancy rates between 1988 and 1995, and what factors were contributing to that.

And what we found is that 75 percent of the decline in adolescent pregnancies between 1988 and 1995 was due to contraceptive use, that more teens were using contraception in 1995 than '88, and they were using more effective methods.

And when we found that 25 percent of the decline in teen pregnancy was due to reduced levels of sexual activity.

Now again, we don't know the extent to which contraceptive use and changes in adolescent sexual activity are responsible for the decline in adolescent pregnancy between 1994 and 2000, but we

are expecting to address that issue in the next couple of years as data that will allow us to explore those questions becomes available.

We're also interested in gaining a better understanding of why abortion rates have increased for economically disadvantaged women, especially given that these women have typically had high abortion rates to begin with. And also in this context, that their abortion rates were increasing while they were going down for everyone else.

And also, just to give you an idea of what we mean when talk about poor and low income women, in 2000, a family of three was considered poor if they had an income of less than \$14,150. And a family of three, which you know, can be a mother and her two kids, was considered poor if they had - or was considered low income if they had a family income less than \$28,300.

So you can tell from those numbers that when we talk about economically disadvantaged, that these are people who more than likely have a hard time making ends meet.

Okay. And again, we don't have any definitive explanation as to why abortion rates increased for economically disadvantaged women, but we can - we have looked at some potential social conditions that subsequent research, either by HI or by other folks should explore.

One condition, one factor that may have contributed to the increase in abortion for these women were changes in welfare policy. Welfare reform was enacted in 1996. And it's possible that some of the conditions of welfare reform may have made less feasible for economically disadvantaged women to carry pregnancies to term.

One unintended consequence, importantly one intended consequence of

welfare reform was a decrease in Medicaid coverage, that many groups of individuals, and certainly women of reproductive age were less likely to - well, there were lower levels of Medicaid coverage in 2000 relative to 1994.

Medicaid coverage automatically provides someone with access to contraceptive services, and pays for prescriptive methods.

So the fact that fewer women had access to Medicaid coverage in 2000 could mean that fewer of these women had access to contraceptive services during this time period.

And it's also - I also want to acknowledge that while there was this decrease in Medicaid coverage, there was no increase in Title X funding. Title X is the main program, the main government program that provides low cost family planning services to women.

So the combination of these two

factors, again, may have made it harder for economically disadvantaged women to act with contraceptive services. And in turn, more likely to experience an unintended pregnancy.

And then a third factor that you can contribute to the increase in abortion rates for economically disadvantaged women is just the general economic climate of the late half of the 1990s. It was a time of increased employment opportunities, and perhaps a time of increased educational opportunities for economically disadvantaged women.

Women in this situation may have felt that they couldn't take advantage of these employment or educational opportunities if they had a baby at this time in their life. And so, it may have been more likely to have an abortion during this time period.

Okay, so that's what the information that I wanted to present.

Just to highlight for you again the three questions that I hope I answered over the course of the last couple of minutes in regards to who has abortions.

Everyone has abortions. Women from all groups and all backgrounds are represented among the population of women having abortions.

In regards to what happened to abortion rates between 1994 and 2000, well they decreased. And specifically, they decreased by 11 percent.

And then finally, there's two patterns in particular that are striking. The first is the substantial decrease in abortion rates for adolescents. And then the second is the increase in abortion rates for economically disadvantaged women.

And then finally, just to conclude, in 1994, just under 49 percent of all pregnancies were unintended, slightly more than one-half of all

unintended pregnancies ended in abortion.

So the fact that in 2000 there were 1.3 million abortions is a strong indication that unintended pregnancies still a serious social problem in the United States. And so, we need to continue and we need to increase efforts to prevent this particular problem.

TINA HOFF: Thanks, Rachel. I'm going to open it up to your questions [unintelligible] clarify. And you know, AGI's data has looked at those in the late '80s, mid '90s and again in 2000. I know there's how far you can go back, but I wonder if you can talk a little bit about what we know about how just the make up of 2000 [unintelligible] shaped over time, how it looks different in proportional make up, as well as the - accounting for the decline in [unintelligible]?

RACHEL JONES: Right, well if you look at, I guess I can speak to - from 1987 to 2000, is we have fewer young women

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having abortions. We have more poor women having abortions. And we have more women of color having abortions.

TINA HOFF: And prior to when AGI survey collecting this data in the late '80s, what sort of data is available that could take effect farther? So anything that allows for any comparison or sort of look into that time period?

RACHEL JONES: I know the CDC collects - the CDC also collects information on women having abortions. It's a lot more limited than the information we have. I'm not sure how far back they go. I'm pretty sure it's at least through the early '90s. It might be to sometime in the early '80s, but I'm not sure on that.

TINA HOFF: And just two quick points on some of Rachel's remarks, too. When - as you heard her talk about, rarely do these data existence [unintelligible] and you have to look at where it sits

relative to certainly unintended pregnancy rates, sexual activity level for young people, other sort of factors that might give you sense, sort of what's really changing, how it compares.

And then also with regard to the other data that's available, there's fact sheets in your packets from both AGI and the Foundation that detail this. The green fact sheet also discusses some of the differences in the data sets that Rachel mentioned between what the CDC collects and what AGI collects, which is also important in how you think about what you're presenting.

Are there any specific questions on this data? Yes, so if you could identify yourself, so -

ERIC GOLDWIN: Sure. I'm Eric Goldwin, "OB/GYN News." I'm wondering if you collected data on the number of physicians or facilities providing abortions through this time period. Has

that changed?

RACHEL JONES: Right, AGI has, since before Roe v. Wade, AGI has collected information on abortions in the United States from providers. And we're actually going to be releasing information on abortion in 2000 in January.

ERIC GOLDWIN: So you can't say anything about that at this point?

RACHEL JONES: Yeah, the numbers haven't been finalized for that yet. So I can't present - I don't have any information to present on that one, unfortunately.

TINA HOFF: Yes?

MARLA DIAMOND: Hi, I'm Marla Diamond with WCS Radio. Can you discuss - you say that abortion rates declined for most women, but increased among the economically disadvantaged. By what percentage and can you tell me the racial make up of these women?

RACHEL JONES: Okay, abortion

rates increased 25 percent for poor women and 23 percent for low income women. Poor women had a family income less than 100 percent of poverty. So - and low income had the family income within 100 and 199 percent of poverty.

So for economically disadvantaged women, it decreased by, you know, about 25 percent. And then also, women on Medicaid showed a 14 percent increase in abortion rates between 1994 and 2000.

Now you ask about their racial and ethnic make up. You mean of all women having abortions or of economically disadvantaged women?

MARLA DIAMOND: Economically disadvantaged?

RACHEL JONES: Yeah, I don't have that information on hand. Certainly if you contact me afterwards, I can run a few cross tabs and get that information for you.

TINA HOFF: And again, like

[unintelligible] with a question like
that, you'd need [unintelligible] and
racial make up among women who are
economically disadvantaged -

RACHEL JONES: Right.

TINA HOFF: -- but there is -

RACHEL JONES: Oh, well actually,
I take that back. There is - I do have
information. We did look at - do you want
abortion rates among economically
disadvantaged women by race and ethnicity?
And I don't want to sit here and read
numbers off the tables. So maybe if you'd
follow up with me afterwards, I can pass
on the information to you, but I do
actually have abortion rates and changes
in abortion rates by those
[unintelligible].

TINA HOFF: Such a popular
program, everybody wants to call in. Yes?

FEMALE SPEAKER: Something that's
really striking me is this statistic about
the 88 percent live in metropolitan areas.

Could you talk a little bit about that?

RACHEL JONES: Right, well first off, the majority of adult women live in metropolitan areas. And I'm tracking that down right now.

79 percent of women between the ages of 15 and 44, women of reproductive age, live in metropolitan areas. It's a little bit higher, you know, we have a proportion of women having abortions in metropolitan areas. One very likely reason for this is because abortion services are much accessible in metropolitan areas. So women in non-metropolitan areas might not have access to abortion.

TINA HOFF: And actually with that, I want to turn over to Dr. Harrison now, who is a physician in practice performing abortions over the past 30 years, and to talk a bit about what kind of changes he's seen with his own practice, how these compare with what

we've seen on the national level and some of the numbers that Rachel shared with you.

So maybe we could start there and perhaps you could tell us a little bit about your practice to start with, and then share with us some of your observations?

DR. HARRISON: Well, I know from my youthful appearance that most of you won't believe that I've been in practice for more than 30 years.

I started by OB/GYN residency in 1968. Of course, that was six years before Roe v. Wade was - five years before Roe v. Wade was determined. The numbers of abortions that were done back then are estimated by the CDC, were estimated by the CDC.

I have no idea, and neither does anyone else, exactly how many abortions were done pre Roe v. Wade in this country. But from 1968 until 1972, when I finished

my residency in my hospital, which is a very small metropolitan hospital, university hospital in Little Rock, Arkansas, we saw about 5,000 women during that four years who were in the emergency room or admitted or had surgical procedures because of complications of illegal abortions.

Oddly enough, in 1969, the abortion laws were liberalized in Arkansas. Most people don't believe that, but it was - Arkansas was a very progressive state back in those days in certain areas.

The numbers of abortions that were done legally were relatively small until after Roe v. Wade. In my hospital, we started providing abortions in 1970. And we did about 30 abortions a month, somewhere around there.

In those patients, there were almost no complications. In fact, I don't ever remember seeing a complication from

one of our abortion patients during that time. At the same time, we were seeing four, five, six young women every night in our emergency room still, even though the abortion laws were liberalized with illegal abortions.

Of course, this all changed in 1973. And it changed in really, really good ways. I haven't seen an abortion complication now with one exception and - excuse me, and with two exceptions over almost 30 years.

By the time I became the only physician in my town providing abortions, there were about 13 within a 25 mile radius of Fayetteville, Arkansas, where I practice. In 1983, that suddenly changed. And I suddenly became the only abortion provider in my part of the state. Abortions generally available in two areas in my states: in Fayetteville, where I do them, and in Little Rock, where there are three practitioners who provide abortions,

a few in practice.

I stopped doing OB about 10 years ago, but I still GYN. And GYN makes up the bulk of my practice.

The number of abortions that I do per year in my town is about 700. Prior to that to '93, I did about 12 to 20 abortions because my associate did most of the abortions in our practice. And there were, as I said, 13 other physicians who were providing abortions.

Something really, really dangerous is happening, as I see it. In my state, we have a Baptist preacher, who's our governor. A large percentage of our legislature now is very right wing. Some of them are Democrats, some of them Republicans. There are a large percentage of the House of Representatives in our legislature is now pro-life.

And in the Senate, we've been protected somewhat because the committee that has to pass on anti-abortion

legislation has been made up of a majority of people who were pro-choice.

But we have term limits in Arkansas now. And the nature of our Senate's changed. In the next election, excuse me, in the next legislative session, I expect they'll be six or seven laws that will come in front of this committee. And I don't expect that the committee will turn them down, as they have in the past.

And these laws will make it much, much more difficult to provide abortions. It's increased almost exponentially in Arkansas. Whereas harassment from protestors and pro-life groups has decreased markedly -

[AUDIO GAP]

-- in 1984 prior to the presidential election.

I was talking about what I saw as the dangers of a Republican president being elected again, Ronald Reagan. And

that letter elicited a tremendous response from the pro-life folks.

For the next several years, I had anywhere from 10 or 12 or 500 people in front of my office marching around. And that continued for several years until 1989. After I wrote my letter, I began to speak out publicly in all sorts of forums. And that changed slowly over the years. And now I haven't had a protestor in front of my office, with very rare exceptions, since 1989.

So the climate in my state has been relatively calm. In 1985, my office was firebombed. In 1991, the first shots were fired in the abortion wars. About 90 miles from home in Springfield, MO, two women were shot.

And by 1994, of course, the war started really in a significant way. A fellow from "OB/GYN News" asked how many physicians provide abortions. The National Abortion Federation has abject

information about this. And now about
2000 physicians that provide abortions,
about 1000 of them are OB/GYNs.

The vast majority of abortions
are provided in clinics that are dedicated
strictly to abortion and the associated
reproductive services. Most of the
OB/GYNs who provide abortions do so in
tiny, tiny numbers. For instance in my
city, there are three other physicians who
sometimes provide abortions. They two or
three among them in a year's period.

And almost all of them are done
either for significant fetal anomalies,
because the physicians go and do another
surgical procedure on the mother.

In my state, if Roe v. Wade's
overturned, if George Bush has his
opportunity to afford a pro-life justice
to replace one of the justices who have
protected on Roe v. Wade, in my state
there will be a special legislative
session called, and abortion will

immediately become illegal. That's a
fact.

And that will happen at about 32
other states. In places like New York,
Chicago, New York, California, Colorado,
maybe Kansas and a few other states,
abortions will be protected and will still
available, but there's no state that
touches Arkansas in which abortions will
be available.

When that happens, people like me
are going to have a real tough choice.
Will I continue to provide abortions
illegally? I don't know. But most
physicians won't because most physicians
don't provide them illegally.

I looked around the room for a
minute, there are about 22 or 23 women in
this room. Given the statistics of
abortion, about 8 of you either have or
will have had an abortion within the next
20 years, if it remains legal.

It will still be available for

those of you who have physicians on which you can bring emotional guilt to bear. Those of you who have an emotional tie with a physician, a father or family member or a very good friend will still be able to have abortions legally, even if you weren't in New York, because abortions were done for all sorts of reasons prior to Roe v. Wade, but they were done surreptitiously. They were done because someone had had "incomplete" abortion, because no way that a hospital can determine whether a woman's had an abortion because of incomplete abortion or because of some other complication of the pregnancy, and whether it's done electively.

And so physicians prior to Roe v. Wade did provide abortions, but they didn't - in small numbers and with people that they knew very well.

That's what I see coming down the pike. And given George Bush's

predilection for appointing the right wing ideologues to the federal courts, I think it's a high probability.

TINA HOFF: Thanks for those comments. I see that data you referenced from the National Abortion Federation is available on their website or by contacting NAF.

DR. HARRISON: Yes.

TINA HOFF: It'll be on the resource list that you have there in the fact sheet. There's also some reference to gathering of [unintelligible] through their study of abortion providers. This Foundation has well as previous points in time looked at who makes up abortion providers. And in fact, what we've seen is that many of those performing abortions, and they are over the age of 50 or 65, and we're seeing an aging of abortion providers that's going on, I wonder if you can just comment maybe on what you see from your younger colleagues

in terms of sort of a likelihood that they'd be operating this service and kind of where they're being performed, so people who really need specialize in towns like - be an abortion provider today in many ways, given where they're being performed?

DR. HARRISON: Well, in the Midwest and the South and the Mountain West, it's very difficult for a young physician coming into practice to provide abortions, because in most practices, their partners are going to prevent them from providing abortions.

In my city, I had a young woman who wanted to come in with me about four years ago. She had grown up in Fayetteville. And I knew her, and I knew her parents since she was a child. And she was very anxious to come in with me.

She was finishing up her residency two years ago. And by the time she got to her second year of the

residency, she was beginning to change her mind. And even though Fayetteville right now at least is an extremely safe place to provide abortions, she was still afraid to do so. She's got two small children. And she was afraid of how her children would be treated at school.

Her husband was afraid for her life. She joined a group that won't allow her to provide abortions, even though she's very, very pro-choice. Of all the young physicians who have come into Arkansas in the last 15, 20 years, none of them provide abortions. A significant number of these physicians are women.

So the fact that a majority of OB/GYNs finishing residency now are women doesn't really mean that they're going to provide abortions to any greater extent than men have.

There are three physicians in my state that provide abortions now. One is about 56 or 57, I'm 67, the other one's

about 66. He has severe diabetes and is probably going to retire in the next year or so.

FEMALE SPEAKER: [unintelligible]
you said three in the state?

DR. HARRISON: Three in the state. I had six bypasses two years ago. So there are no guarantees for either one of us. And eventually, that may lead to one physician in the state to provide abortions.

There have been several physicians who have tried to come into the state to provide abortions as local tenants for one of the physicians in Little Rock. They've been unable to be licensed because the majority of the state medical board has been appointed by our Baptist preacher governor. And these folks won't grant licenses, even though these people have no malpractice or no ethical or no professional problems.

And they're doing it for all

sorts of stated reasons, but the real reason is because the physicians who were applying wanted to provide abortions at one of the Little Rock clinics.

TINA HOFF: Thanks very much.

Well, I could keep asking questions, and I am sure everybody else is, but I want to get the rest of our panelists in, and then we'll open it up for all of you.

Katherine [unintelligible], it'd be great for you to pick up on some of [unintelligible] references to some of the policy changes that's been going on, and what we're seeing in terms of trends and - that's happening in Arkansas, as well as other states. Now that's affecting the last [unintelligible] future of abortion in this country.

FEMALE SPEAKER: If you don't mind, I'm going to stand up just because I'm a lawyer and it's easier for me to talk when I stand. So if you can't hear me, let me know, but it's just force of

habit, I think.

I understood one of my tasks this morning was to try to give you an overview of what's happened legally over the last 30 years, and then to be a bit of a prognosticator of what we're likely to see in the future.

And so, what I wanted to do is to just give you a sense of what types of restrictions and other regulatory efforts have been underway since the adoption of Roe and what we've seen in that 30 year period.

And I think the easiest way - I always like to think of ways to capture the - what's going on. And I think on the abortion front politically and legally, it's really been a question of what missiles have been lobbed in our way over the course of the years.

Now that's an analogy to war, but I think it's really because I've broken it down into three categories. Restrictions

on access, [unintelligible] on abortion,
and restrictions of methods of abortion.
If we put those together, we've got ABM.
And so that's a good missile analogy for
you.

Let's start with access, because
primarily the restrictions on access came
in the years following Roe in the '70s and
in the '80s, and continue to this very
day, but we've seen more cumulative effect
of all of these things.

And I break those down into
really five major restrictions on access.
There have been what I think of as
regulatory restrictions. Access limited
because states have adopted laws which
regulate the performance of abortion. And
as for decades have continued, those
regulations have turned into - they
started as health restrictions. They
started as ways in order to improve the
performance of abortions, to make it more
healthy for women who are adopting it.

And as we have progressed, they have become more and more restrictive, so that they are regulating the width and size of the doorways and the kinds of materials that have to be kept at clinics, but they've become more and more restrictive as a way to limit the performance of abortion.

The second major category started as restrictions on married women. Efforts by states to say to women, in order to get an abortion, if you are married, you must get the permission or notify your spouse of the performance of abortion. Those who have been struck down by the Supreme Court of the United States in all instances, but many efforts over the years have been to try to restrict access by requiring the consent in notification of spouses.

And a variation of that, which started as spousal notification turned in very quickly to parental notification for young women obtaining abortions. Now

again, the history of the Supreme Court has varied on these questions, but basically, starting in about the mid '70s, we saw restrictions on minors trying to obtain abortions, requiring either consent or notification.

And let me just say from a perspective of a young woman, whether you have to obtain the consent of your mother or father, where they need one or two parents consent, or whether you just need to tell them that you're having an abortion, makes very little difference.

That is, notification and consent to a young woman is really the same thing because the difficulty is informing the parent of the fact that their sexually active, and the fact that they're pregnant.

So it really - even though there's lots of variation in laws, the effect of these laws are pretty much the same thing. And the courts have varied

over the years on whether they would strengthen down or uphold them, but basically the bottom line is today we see more and more and more states adopting parental notification and consent laws. And we see the courts for the most part upholding them as long as there are what I think of as bypass procedures or ability of the young woman to go to court, obtain a court order to have that procedure without notifying parents of the pregnancy.

Okay, so we've got regulations. They turned more restrictive. We've got spousal consent and notification requirements. We've got minor notification and consent requirements. We have restrictions on indigent women's ability to obtain Medicaid abortions and other funding for abortion procedures.

And those started in the mid '80s - actually the late '70s with the passage of the federal Hyde Amendment and went to

- on the state level, more and more
restrictions on state funding for
abortion, and in some instances, family
planning and contraceptive services.

Those types of Hyde Amendment
restrictions were upheld by the Supreme
Court in 1980. And as a result, the kinds
of restrictions the government has been
able to place on federal funding programs
have expanded today, not only as our
Medicaid requirements such that women
cannot use those monies for abortion, but
similarly, federal health insurance plans
are limited, the ability to get abortions
and overseas funding programs for
contraception and other kinds of
international programs are limited in
their ability to provide abortion
services.

Okay, and then the last - what I
think of as access development really
comes in what I think of as and what Dr.
Harrison has talked about, the violence

and other kinds of efforts that has been brought upon providers of the service at the local level.

For the most part, individual violence against individuals, but at the same time, in many instances policies by states, which either permit the violence to continue or refuse to stop it in any kind of organized fashion.

Up until the mid '90s, with the passage of the FACE Act in Congress, we saw very little effort to stop the violence by individual abortion providers. And I think that the FACE legislation, that's the Freedom of Access of Clinic Entrances Act that was passed in Congress has done some to stop violence, but it still remains - and the fear of violence still remains a very significant impediment to the beginnings of the provision of abortion services by doctors at the state level.

Okay, so that's my access. We

now have bans. And if you think of the access issues, they started in the late '70s and have continue today. Almost all of those kinds of restrictions, except for spousal, have continued. And more and more states have adopted them.

Okay, so almost all states now have restrictions on minors, restrictions on poor women, restrictions on waiting periods or other kinds of regulations that are mapped.

But somewhere in the mid '80s, and I think this came about because of the change in the United States Supreme Court, we began to see state efforts to restrict abortion by banning the procedure altogether.

And I think that the history of that effort to ban abortion really started in Congress with the passage and the discussion of the passage of the Human Life Amendment, which came very close to passage in the late '70s, and to bans on

abortion being passed at the state level.

And frankly, the effort was spurred on by a perceptions on political front that the Supreme Court had changed significantly. And was likely to uphold or at least undermined the rulings of Roe so significantly that bans will continue to be constitutional.

We saw that change begin. I did a case - I heard a case in the Supreme Court in 1985. It was decided in 1986. It was the first case that changed the number of Roe. Roe was originally passed by a 7 to 2 majority. By Thornburg versus Acock (Misspelled?) in 1986, it as a 5 to 4 majority in support of the continued reaffirmation of Roe.

And there began, and it was actually a really interesting event for me, because here I have status. I won a case in the Supreme Court. The Court called. They give us the moves. It was 5 to 4. And every newspaper in the country

reported it as a significant loss to Roe, because the number changed on the Court from 6 to 3 to 5 to 4 . And that meant that only one vote had to change.

And the politics from that day on, despite the fact that I had the picture in the paper with the bottle of champagne celebrating victory, from that day on, we began to see major efforts to A, change the composition of the Supreme Court, and B, continue to push legally for the overruling of Roe versus Wade.

And the way that that happened is at the state level, you began to see the adopting of bans on abortion or other restrictions that were so onerous, that in fact the underlying rationale of Roe had to change.

I'd like to say that that ban effort, again, it's a peek and a stop, or at least we hope it's a stop. In 1989, the Court in the Webster case probably the case that most of America remembers as the

big abortion case, considered the question of the validity of Roe. The court in that case was divided. Justice O'Connor very thankfully did not feel that she could cast the deciding vote to overrule Roe.

So what that what they said is, I don't need to reach that question. And we had another three years of continued efforts to ban abortion. States like Idaho and let me think here.

FEMALE SPEAKER: Louisiana and Mississippi.

FEMALE SPEAKER: Thank you, Louisiana and Mississippi voted to ban abortion in those cases. Went up to the Supreme Court. The Court decided to decline to take it.

And it wasn't until 1992 in another case that I was involved in, called Planned Parenthood versus Casey, where the court had to re - to question what was the validity or the continuing viability of Roe.

Is it a doctrine that remains?

Is it one that the court will reaffirm?

And the court in that case said yes, Roe
remains the law of the land.

We're going to change what Roe
means. We're going to change the standard
by which we review abortion restrictions.
We're going to give states more
flexibility to restrict abortion. In many
ways, we're going to change the burdens of
proof. We're going to make it much more
difficult for litigators to win their
cases, because we're going to make them
prove that abortion restrictions interfere
with the ability of women to actually
obtain procedures, totally different way
of thinking about the right.

But at the same time, the court
said legalized abortion will remain. It
is a precedent of our court. And we are
not going to overrule that precedent.

Now Casey in many ways meant that
as a political matter, the efforts to ban

abortion stopped. No longer were we seeing a tax on the right altogether.

We began to see, however, that isn't to say that the political opposition went away. Political opposition remained, but the tact had changed. And what we see in since cases, since 1992, is not so much an effort to restrict access on abortion. That has continued. Not so much an effort to ban abortion, but most importantly an effort to try to change what types of methods of abortion can be provided.

Now the reason for this change really goes way back. This is a theory and a strategy that has been part of the anti-abortion movement for many, many years.

But I think the important part is that the choice movement won primarily as a matter of public opinion by saying to America, who should make this decision? Who should decide? Is this a matter of privacy between a woman and her doctor?

And what the new strategy has been, since '92, is to say the methods that the doctors are using are unsafe. They're not appropriate. They are infanticide. They should be curtailed, and to really focus on how abortions are performed, as opposed to who could get them, and who could make those decisions.

And so we've seen, for example, the passage in Congress twice with the partial birth abortion restrictions, and other efforts to interfere with the ability of doctors to make medical judgments for their patients.

That's my ABM. We've access. We've go bans. We've got methods.

Let me just turn quickly to the future and see if I can give you some sense of where I think we're going.

I think the future - I used to do a lot of work in state legislatures. I was the person at the ACLU who would travel from legislature to legislature to

help the coalitions looking at new
abortion restrictions.

I think I was in 45 states in
less than a two year period in the '90s.
You know, early '90s, late '80s. And I
used to say that lobbying about abortion
was a lot like Sesame Street. You had to
be - you had to learn to count.

In those cases, it was learning
how to count the votes at the state
legislative level. I think counting is
still critically important for the future
of abortion. And let me just give you two
sentences on why I think that's true.

First, I think that there's
really three critical questions that we
have to look at. Dr. Harrison very
eloquently described the situation in
Arkansas.

The first number that's
absolutely critical for the future of
abortion is the number of abortion
providers. Okay? And those numbers are

determined by a variety of factors, both from who's being trained, provide abortions, how old providers have become, who's replacing those old providers, what kinds of restrictions?

So we've got things of age. We've got issues of training. We have issues of insurance.

I mean, the question is not necessarily who's providing abortions, but who's providing OB/GYN care? Because we're now seeing many, many efforts in states to make malpractice insurance so difficult to obtain that the number of OB/GYNs has gone way down.

So that's a trend we want to look at. Those are the numbers. Who's providing abortions?

The second critical number is really a political number to me. And that is the number, not who supports abortion, or who doesn't support abortion. Not the number of where we are in the support

versus opposition, but the saliency

number. How important is this issue as a matter of politics? How many people will vote on the question of abortion?

Because for politicians, the saliency number is much more important than the general support or non support. They want to know who's going to be out there working on their campaigns, who's going to be out there targeting them for [unintelligible]?

And so, I think that's the second thing you're going to need to look at. So one number is how many abortion providers. The second number is the saliency number, how important is the issue generally in the public? And lastly I think, the number that we have all been prognosticating about for years and years and years, is the number of pro-choice justices [unintelligible].

What's that [unintelligible]?

And who's retiring? And who is replacing?

And frankly, I don't want to get into that prognostication because I don't think we know. The reality is, there are several justices, some of whom are pro-choice and some of whom are not, who are very elderly, who could potentially retire at any given year.

About May of every year, you will hear rumors about every single justice retiring. I've been hearing rumors about Justice O'Connor stepping down since about 1988. We've heard rumors about Justice Stephens repeatedly. It keeps getting worse every year. Justice Rehnquist, that problem.

You will hear every rumor imaginable. There's no way to know who's going to step down, but we do know that at least in the question of whether abortion is a right, the vote is 6 to 3. In the most recent cases on bans on methods of abortion, the vote is 5 to 4. Whoever is appointed to the court is going to make a

significant difference at least in determining whether women's access to procedures is curtailed. And then they ultimately, although not necessarily, determine whether or not the overall right continues to remain a constitutional liberty for all women.

So I thank you. And happy to answer your questions.

I think that there was hope that medical abortion would increase the number of providers because all a doctor had to do was to prescribe a pill, as opposed to provide a surgical procedure. That is requiring less training.

In fact, medical abortion, like other abortion, is an abortion. And despite everybody's hope that more physicians would provide the services, there are two very significant limitations.

One is, is the requirement that there be surgical back-up. And for most

doctors, that's very difficult. And second, the fact that it is an abortion, whether it's done by pill or surgically. And therefore, all of the restrictions that have been passed in states that [unintelligible] 24 hour waiting periods and informed consent requirements and special protocols and other kinds of restrictions on clinics and reporting clinics and the potential for violence attached to these doctors.

And the reality is, is until we get to the point where we have trained more doctors in the performance of medical abortion and solve, excuse me, many of the regulatory programs that have been hatched, I don't think we're going to see a significant increase among non performing physicians.

And I actually have always thought that. I thought that this was a new method. I thought it was a method that was likely to help, but not that

silver bullet that everybody was looking for in technology, which is also - always easy to hope for, but very rarely a reality.

TINA HOFF: Thank you. So [unintelligible] we touched on the population that you represent in all of these discussions, which are adolescents. And the two areas [unintelligible].

One is the other side of abortion and unintended pregnancy. And what you've seen in terms of some of the factors that have resulted in bringing down that rate. And it's probably actually one area where maybe people who have differing views on abortion may agree that at least this is an area that we can focus on, and talk about what's been happening [unintelligible] adolescence.

And then also, looking more at young people's attitudes around abortion today, and how that's changed over time. They do represent the future. And you

heard about the importance of public
opinion on this issue and maybe commenting
a bit on the [unintelligible] about
abortion and your sense of concern over
its availability.

FEMALE SPEAKER: Thank you, Tina.
Good morning to all of you. I feel you
probably want to ask questions and not
hear yet another speaker. Will you bear
with me just a few more minutes?
Everybody okay? All right.

Well, for the teen pregnancy
prevention community, the headline today,
as was mentioned earlier by Rachel, is
that teens posted the steepest decline in
abortions in the last half of the '90s of
the groups studied.

Overall, as you've heard, it was
11 percent. But ponder this. Of the 15
to 17 year olds, it was 39 percent
decline. In public health land, that's an
enormous change. It's very significant,
very impressive.

And I think another important point to underscore is the remarkable decline we've seen in the teen birth rate is because of the decline in the teen pregnancy rate.

There was always this concern, I think, that we might be successful in driving down the teen birth rate, but if we did that by encouraging by abortion, by leading more teenagers to have abortions, that that probably wasn't the right strategy.

And these data today make very clear once again that teen abortion rates are down because teen pregnancy rates are down. And that is enormously good news, because that the national campaign in many other places, of course, as well.

We've always argued that decreasing teen pregnancy is the best way to decrease teen abortion. And that seems to be what we're doing.

So why are the rates of teen

pregnancy going down, which is what Tina just posed, and Rachel touched on as well? Well, clearly, teens are doing less and more of the only two things that can reduce teen pregnancies, and therefore abortion, less sex and more contraception.

I want to give you just a few numbers. You've been drowning in numbers. Let me give you just a couple more from the CDC from their recently released data, from the Youth Risk Behavior Survey of high school teenagers in 2001.

These recent CDC data show that over the last decade, '91 to 2001, sexual activity amongst high school teens declined 16 percent.

The number of high school students reporting four or more sexual partners is also down, 24 percent. Condom use at last sexual intercourse increased 25 percent. So all of these numbers, I think, are going in the right direction. Declines in teen pregnancy, teen abortion,

teen birth, and teen sex, and an increase in contraceptive use amongst those teens who are sexually active.

I think this signals a deep and profound and robust change in adolescent sexual behavior in this country. And I think it's cause for I don't if celebration's the right word, but certainly your full attention.

I think, interestingly, these numbers show the decreasing teen pregnancy does not require the nation to choose between abstinence and contraception. Clearly, both are at play, both work, and we need more of both.

Now the question I'm most often asked by the press, and again that Rachel touched on, is while if kids are being more careful by having less sex and using contraception more effectively, why are they doing that? Why are they being more careful?

Let me give you a few reasons

very briefly. We can return to them in more detail if you wish.

First of all, there is lots of evidence that teens are taking a more cautious attitude towards casual sex. One little data. The annual UCLA survey of incoming freshmen shows that the proportion of college freshmen, remember these are 18, some of them 17, the proportion of college freshmen who agree that "it's all right to have sex if two people have known each other for just a short time" is now at a record low.

In 1987, about 52 percent agreed it was okay. In 1999, the number is down to 40 percent.

Teens also indicate that morals, values and/or religious beliefs affect their decisions about sex more than any other factor, according to a number of national polls.

Secondly, there is real concern over sexually transmitted diseases in

general, and AIDS in particular. And that affects sexual activity.

In our surveys, teens say that fear of STDs is the primary reason why rates of teen pregnancy has declined because of course it's making teens be, as I said earlier, more cautious.

For example, in 2001, when teens aged 12 to 19 were asked to name the primary reason for the decline in teen pregnancy, almost 40 percent said worry over STDs and AIDS.

A third reason is economic prosperity. It may have played a role in the second half of the '90s in lower pregnancy rates, and decreased child bearing. I think perhaps teens also are not immune to the business cycle that we're all very familiar with right now.

Think about it. In good times, the opportunity costs of very early pregnancy, child bearing parenthood are great.

And you know, we have a little natural experiment underway now with the increase in poverty that's being tracked. If we see that there is an uptick in the teen pregnancy rate, cracking the downturn in the economy, I think we'll have more to say about the relationship between economic factors and fertility patterns.

Number four, an increased emphasis on work and less available funds from the public welfare system. Now as was mentioned earlier, the welfare reform law was signed in '96, but there were many states that were experimenting with tightening welfare restrictions even before the passage of the law.

And what teens tell us, apart from the details of the law, is that the neighborhood buzz is that welfare dollars are less available, and work requirements are up. At the margin, that may have changed their behavior a bit.

[unintelligible] I'm almost to

the end. There has clearly been an increase in citizen activism on teen pregnancy prevention. Efforts to reduce this problem in teen pregnancy intensified in the '90s. I can't think of the state I've been to, where I haven't run into a governor's commission or a statewide coalition, or a group of fired up citizens.

By our count, there were about 50 teen pregnancy coalitions in the early to mid '90s. Excuse me, about 30. We're now up to over 50. And I think we don't have a count, but at the local level that's probably true as well.

And note this, in 1990, only 16 states had an official policy requiring or at least encouraging pregnancy prevention programs in public schools.

In 1999, 28 states now do. Finally, I think the media can take a little bit of credit for the decline in teen pregnancy. And I'm not just saying

that because I'm at a press conference. I say it all the time.

We have seen an explosion in attention to the issue of teen pregnancy, teen child bearing, single child bearing, to contraception, to abstinence, to all the parts of - the moving parts of this ongoing, very interesting topic.

Our recent Kaiser Family Foundation study suggests that while sex on TV has increased overall, the only segment of the medium which responsible messages has increased is the teen medium.

Just last week, MTV had a special on the sex education wars. "Teen People" magazine and many others have teen pregnancy prevention and related issues as a constant and enduring theme.

One final data for you. A poll we conducted about a year ago showed that over 80 percent of adults reported noticing more attention on the media to teen pregnancy prevention over the last

five years. So take a bow, or least maybe your colleagues can take a bow.

With regard, Tina, to the issue of young people's attitudes towards abortion, I don't have data on that. But let me just say that right now, what we're finding is the two important things to understand.

The proportion of teens who elect abortion, once they're pregnant, has not changed. It's about a third. Am I right?

FEMALE SPEAKER: Mm-hmm.

FEMALE SPEAKER: 33, 34 percent over the half decade that we're discussing. So the relative inclination of teens to elect abortion appears quite stable, despite all of the turmoil that has been so eloquently discussed today.

I think the other notable figure is that when you look at the inclination of teens to place their babies for adoption, which really was the way when I was in the dark ages, when I was a young

woman, there was a lot of sort of going to Chicago to Aunt Bessie for sort of six or seven months and placing a child for adoption. That inclination is very, very low.

Current estimates are that only about one percent of babies born to unmarried teenagers are placed for adoption. So I think that's some indication of how young people feel about this mix of single parenthood, abortion, and childbearing.

TINA HOFF: Thank you. Let me open it up to questions from any of you. Again, if you could identify yourselves for our speakers? Any questions?

Yes?

MALE SPEAKER: I'm curious how any of you have been - how do you perceive the pro-life response to all this data? I mean, on the face value of it, you could make a good case that a lot of the right wing policies work. You know, the

abstinence movement works. Restricting
abortion works because people get more
responsible. A lot of the arguments that
you hear coming from the pro-life movement
[unintelligible] by this data.

And I know that's exactly what
you're saying, but how are you anticipate
their response to these comments?

FEMALE SPEAKER: Well, I know one
thing that we're emphasizing is that he
decline in adolescent abortion rate,
again, preceded you know, it's very - at
least in the late 1980s, prior to
abstinence education, not saying that
abstinence education hasn't had an impact,
but that just again, the declines in
adolescent abortion rates started in the
late 1980s.

FEMALE SPEAKER: Let me just say,
I don't think that there's ever an answer
that - or a single answer about why you
see changes occurring. It's very
complicated to track human behavior and

figure out why people have differing attitudes.

So I don't want to minimize the fact that in fact they will make that claim. I think the biggest problem is that I don't think it is appropriate to penalize young women for human sexuality. And I think that's really - in fact, yes, penalizing young women for human sexuality will mean that fewer want to do it.

But the question, as with social policy, is that where do we want to be?

So I - regardless of their claims, I still think it's a question of social policy that we need to address that's much more fundamental than whether or not increasing the penalties on young women are likely to decrease the amount of sexual activity that they have.

FEMALE SPEAKER: Just one additional perspective. It's interesting, again, if we focus just on adolescents, which I understand was only part of the

story here, but I think what adolescents notice is simply, well not simply, but largely, an enormous amount of conversation about these issues, a lot of adult agitation, a lot of discussion.

Sometimes it's very acrimonious. Sometimes they're ugly debates. But what young people find, I think, is that some of these topics of sexual activity, contraception, abortion and so forth, are more out there. They are less taboo as a topic, as I alluded to earlier.

There's more in the more in the media. It may be discussed in environmental stress and disagreement, but I think in all things it's general to have these issues on the table and be talked about, and allow the young people to hear a variety of sides of the argument, to seek information on the Internet, in their schools, in magazines where they do, and to come to their own decisions.

So don't always think that

controversy is inevitably bad. It

sometimes raises issues and airs them in
ways that can be productive.

DR. HARRISON: I think it's also
going to very interesting what happens in
the next [unintelligible] survey. Because
the - under the Republican administration
that we have currently, the abstinence
education only movement has just really
taken off in the last year and a half.

So it's going to be really
interesting to see what happens with
teenage pregnancies.

In my practice, a significant
number of teenagers, and we asked every
woman who has an abortion in my practice
what they were using for birth control.
And a significant number of the teenagers
say abstinence. Well, abstinence works
most of the time, apparently.

FEMALE SPEAKER: [unintelligible]
magazine. I was wondering if you could
project the rate of [unintelligible], as

well as that really high percentage,
about 51 percent of [unintelligible]?

FEMALE SPEAKER: All right.

Well, I mean, I have this table here that
looks at, at least in 1994 is the most
recent year that I have level on well,
unintended pregnancy that includes
unintended births.

I guess if you were wanting to
know about unintended pregnancy, again,
overall 25 percent of pregnancies end in
abortion. These rates are relatively high
for women up through the end of their 20s,
and then they start decreasing.

You know about one-third of women
of adolescents and women through their
early 20s, up to age 24, about one-third
of their pregnancies end in abortion, and
then it decreases until you hit - it
decreases gradually with age, until you
hit women age 40 and older. And then
there's this jump back up to one-third of
pregnancies are unintended.

And men, I guess maybe I'd ask you to clarify on the question about - well the fact that the majority of women having abortions are mothers, this is something that has increased over time.

FEMALE SPEAKER: Well, you know, what I think it also raises maybe you could comment on that [unintelligible], or you Bill, is sort of the complex set of choices that women make in choosing to either bring the pregnancy to term, or have an abortion that isn't - that simply needs to talk about some of the factors that come into play, and how that may differ for a younger woman versus a for woman in a different point in her life?

FEMALE SPEAKER: Right. Well, I mean, certainly a lot of younger women are in less stable relationships. Often either cohabiting or not even in a cohabiting relationship. So there may be more reluctance to carry a pregnancy to term.

And also to acknowledge that almost all pregnancies among adolescents in particular are unintended, even if they are carried to birth, they're typically - they weren't planned births.

But as women get older, first of all, first they're more likely to be planned, but also, older women are more likely to carry an unintended pregnancy to term, because they're going to be in a situation where that's a feasible option.

Maybe we didn't plan to do this, but we have the economic resources. We have a household, you know, a household to support another person. And so, they're more likely to do that.

FEMALE SPEAKER: Remember, too, that unintended includes two categories of pregnancies. Flat out unwanted at any point and mistimed. And I think sometimes when you look at older women, particularly women who are married, what you're finding is a heavier weighing to miss time, rather

than absolutely unwanted.

Now it varies though. When women are over 40 and experiencing unintended and often in that case fully unwanted pregnancies, the question is why is there this blip?

Something I've been interested in for years, and it's not because I'm over 40. It has something to do with the fact that there are a number of women at that age who either think that they themselves might be less fertile, or that their partner may be. Their relationships may be changing. New partners. Has he been sterilized? Am I in menopause approaching sub fertility?

And the net effect of all this instability in sort of peri menopause and incipient middle age has a lot to do with less contraceptive vigilance.

If you look at a 43-year old woman, she says you know, I can try and use contraception carefully, which is very

difficult to do for anybody, teenagers as well as older woman.

I've been at this now for, you know, 20 or 25 years. And the contraceptive vigilance sometimes decreases.

The majority of couples, of course, at that age are relying on sterilization. So this is a rate amongst women who could become pregnant, not all women.

TINA HOFF: Yes.

RACHEL BAUM: I'm Rachel Baum with Covell (Misspelled?) Ogden. Is there any stats comparing women's choices for choosing menopause [unintelligible] or vice versa? Or is it too early to even have a comparison?

FEMALE SPEAKER: Right, this is another issue - well, the survey that we did of women having abortions, we didn't ask what types of abortions, whether it was surgical or medical.

I anticipate the next time we do this, that's something we'll at least consider exploring. The survey that my colleagues are working on right now, perfecting the numbers, the survey of all nine abortion providers in the United States, they did collect information about actual procedures, including medical abortions.

So again, that information, it's being finalized right now, and will be available in January.

FEMALE SPEAKER: I think Janco (Misspelled?), the manufacturer of this [unintelligible] has released some data talking about at least the number of medical abortions that were performed. And I can't recall the exact numbers, but -

FEMALE SPEAKER: 100,000.
100,000 over two years.

FEMALE SPEAKER: And we've also looked at among physicians who perform

abortions, there's - documenting their chart paths, surveyed about who's offering [unintelligible]. And we're still seeing the percent description pretty well.

I don't know, is it something that you were offering in your practice?

DR. HARRISON: I do, but I usually offer methatrexate, because where methapristone (Misspelled?) recommended dosage is \$270. The dosage of methatrexate is about \$15.

FEMALE SPEAKER: So -

DR. HARRISON: And that makes a significant difference. There's a little bit of difference in the effectiveness rate. But methatrexate's been available for this for a long, long time. So medical abortion is not anything new.

It didn't come in with RU-486. Methatrexate's been used in atopic pregnancies since the early '90s anyway. And we've known for a long, long time that it will induce abortion.

So we've had medical abortions
available for at least 12 years.

FEMALE SPEAKER: And among your
patients, are you seeing a level of
awareness about the availability of medical
abortions in some of the offices and often
when you're counseling them? And how are
they going -

DR. HARRISON: I offer it as an
option, but I'm not wild about the medical
abortion. There are some downsides to
medical abortions because of what
[unintelligible]. It may take two or
three weeks to work.

You don't know when it's going to
work. And the vast majority of women,
when they're presented all the data about
it, will choose in practice anyway, will
choose to have surgical abortion.

But we do surgical abortions in
my practice as soon as she comes in and
asks for it. We have to wait 24 hours,
but I've done abortions for women who

missed a period, because of early
pregnancy tests.

FEMALE SPEAKER: Other questions?

Yes?

MALE SPEAKER: [unintelligible]

I have a question for Dr. Harrison about
Arkansas, and then if Andrea wants to talk
nationally? I mean, the question - I know
there's no hard data on this, but the
question is are there women in your state
who would prefer - who would choose to
have an abortion, who cannot? Or for whom
the obstacles are so hard that there are
women who were - who - too much time goes
by, or for one reason or another, you
know, is abortion still in practice
available to everyone in Arkansas?

DR. HARRISON: No, in practice,
it's not. And this is one of the real
problems with parental notification.
Frequently, a young woman will delay and
delay and delay and delay. And then the
mother notices that her belly's getting

bigger.

And she brings her in desperate.
And the girl's 32 weeks or 34 weeks. This
also happens with young women who come in
to the physician and discuss an abortion.
They find out that the cost is \$400 or
\$300, whatever it is.

And they go away thinking that
they will save the money in order to have
the abortion. They come in six weeks
later or eight weeks later, and the cost
goes up as the pregnancy advances, because
complications go up, and the different
procedure increases.

So eventually, if they wait too
long, the cost may be even more
prohibitive than it was when they first
started. And while most of us give a
break to patients who have economic
difficulties, it's very difficult to tell
who those patients are.

And if all of us get abortions
for free, you know, it's economically not

feasible to do so. And so, you have to be very careful in choosing those patients that you think are economically disadvantaged. And if they need a break or maybe a free abortion, and whose able to pay.

FEMALE SPEAKER: Well, can I add one thing that it used to be that restrictions such as funding restrictions and restrictions on minors, discouraged the performance of abortion, made it more difficult.

And I think that continues to be true. The issue is not so much are they prevented, although there are some women that are prevented, but at what cost attaches? And for poor women especially, and I think that the numbers which are showing an increase in poor women having abortions, the calculus remains the same.

Is it my lifetime important or in my life circumstances important to have an abortion now or to carry to term and the,

obviously, the economics of that. That is, is it a time in time their life when they can afford to have another child or a child at all, are very determinative factors.

But the issue is not can they get the abortion? The issue is you know, what to do to - are they paying the rent? Are they being able to put food on the table for their kids? Are they doing things like prostitution in order to make up the money to do it? All of the downsides of life that are much more hard - much more difficult to capture.

But frankly, when you talk to poor women who are seeking abortions and the women who are going through that, I'm trying to raise enough money to be able to do it fast enough, you will hear story after story after of hardship that is remarkable and very discouraging.

FEMALE SPEAKER: You provide abortion training in their program, all of

them have conscience clauses which let people opt out of them. I'd like to ask Dr. Harrison and others in their opinion that the profession of OB/GYN is going to be able to mandate a change in the number of people who provide abortions?

DR. HARRISON: No, you can't mandate a change. Probably if they made an attempt at - as the American College of OB/GYN. The problem is not really - doesn't really have to do with -- plenty of physicians to provide abortions. And there are only first trimester abortions. It's very similar to doing a D&C or an incomplete abortion.

Every OB/GYN resident, by the time he's finished - she's finished her first year has been trained in doing incomplete abortions or missed abortions. And so, that's really a red herring.

The problem is when a program doesn't offer abortion training, is it sending a not so subtle message to the

physician that abortion's not important, or it's something that you don't want to have anything to do with.

And that's the real problem. And in this country still, the great majority of OB/GYN training programs do not offer abortion training.

I wrote a letter to the - I think there are 135 or 140 OB/GYN training programs in this country. And I wrote a letter to the department heads of each one several years ago about what I saw as the problem.

I got letters back from about oh, 10 or 15 of them, of the department heads, most of whom were already providing abortions.

My letter made no difference in [unintelligible] that were not providing abortions. But the problem is not training. The problem is perception of the resident that this is not important or this is not something that I really want

to be involved in.

FEMALE SPEAKER: Or there's
somebody else there to do it?

DR. HARRISON: Yeah, or there's
somebody else.

FEMALE SPEAKER: I would add one
other tidbit is you have to remember the
history here about why most abortion
providers are in their 50s and 60s and
young doctors don't have that. In some
ways, thank God they don't. But at the
same time, the impetus to provide the
service is less because they don't see the
negative effects of illegal abortion.

DR. HARRISON: I tell my patients
after they've had an abortion, if they
have a problem or if they think they're
having a problem, call me, because the
vast, vast, vast majority of known
physicians today, and of course most of
them are significantly younger than I am,
have never seen a complication of an
abortion.

And if they contact someone or go into an emergency room, in an area in which abortion's not available, they may get put into a situation that costs them thousands of dollars. And then they have all sorts of things done to them that don't really need to be done, either out of ignorance or malice.

And it doesn't matter whether it's ignorance or malice. There are few physicians out there who feel like that they need to punish patients because they've had an abortion.

But most of them are ignorant of what's going on. And they overdiagnose. And the woman may be admitted for a D&C. And rare instances, they may have hysterectomies. In rare instances, they may have multiple days of hospitalization because someone's diagnosed a septic abortion when they've got the flu.

There are all sorts of reasons that women post abortion are admitted to

hospitals nowadays. But the vast majority of those reasons really don't have to do with complications of abortions.

TINA HOFF: Thanks, any final questions?

MALE SPEAKER: Yeah, I just wanted to ask, back to the survey and 61 percent of women who have abortions who already have children. Did you collect any information from them on why they chose to have the abortion the second time?

I mean, I'm guessing that it's probably an economically driven decision, but I don't want to assume that.

FEMALE SPEAKER: Right, no we didn't ask reasons for abortion on this particular survey. It is the case that women having abortions who had a child were older on average than the average abortion patient, poor than the average abortion patient, and there's one other characteristic that I'm not remembering,

but it does suggest that economics might
play a circumstance.

TINA HOFF: Great. Thank you all
for coming today. And if, as you're
working [unintelligible] the next couple
of months, feel free to call on any of us
or any of our panel. There's contact
sheets in your guide.

And we'll be doing one more
program before the end of the year that
you'll be hearing from us on. And I just
want to thank Andrea Miller, and the rest
of the staff for the Public Interest Media
Group, who helped put this together,
Kaiser Media Research Project who's
available here in New York to answer your
questions, and Kristen Leo and my staff,
who helped organize this.

So thank you very much. And
thank you to our panel.

[END TAPE]