

Increase in Obstacles to Abortion: The American Perspective in 2004

Martin Donohoe, MD

This paper summarizes the barriers to abortion in the United States, including the determination of viability, cost and insurance coverage, waiting periods and parental consent laws, restrictions on medical abortion, provider unavailability, harassment, targeted regulation of abortion providers laws, refusal clauses, antichoice laws, and the fetal legal rights movement. Federally subsidized abstinence-only sex education, which has not been shown to decrease the rate of unintended pregnancy (and may increase it), has expanded and access to a full range of contraceptive options has been limited. The policies of the current and past administrations have strengthened barriers to abortion both at home and abroad. Preserving women's right to choose will require improved public and professional education, legislative and legal efforts, and advocacy by physicians and other health care professionals. (*JAMWA*. 2005;60:16-25)

This paper presents barriers to abortion in the United States, although US policies that affect other nations will also be described. Recent trends limiting a woman's right to abortion and other reproductive health services, many of which have been promoted or supported by several administrations, especially the current one, will be analyzed. Because of various infringements on women's right to choose, education, activism, and changes in policy are urgently needed; suggestions are offered at the conclusion of this paper.

Epidemiology

Forty-nine percent of all pregnancies, or 3 million, are unintended per year in the United States.¹ More than 30% of these are in married women, and 58% of women with unintended pregnancies become pregnant while using birth control.¹ This is not surprising, given that 1-year, typical-use contraceptive failure rates are 21% for periodic abstinence (the rhythm method), 7% for oral contraceptive pills, and 1% to 2% for the intrauterine device.²

More than 30 million American women have had abortions since the procedure was legalized in 1973.² There were 1.3 million abortions in the United States in 2000, down from 1.6 million in 1990 and down 27% compared with 1980.³ In 2000, 25% of all pregnancies (excluding miscarriages) ended in induced abortions.⁴ The abortion rate has decreased 11% since 1994.⁴ Forty-eight percent of women obtaining abortions are older than 25, 59% are white, 20% are married, and 56% already have children. By age 45, the average woman will have had 1.4 unintended pregnancies, and 43% will have had induced abortions.¹

Abortion remains one of the safest medical procedures available.⁵⁻⁸ The risk of death from legal abortion is less than that from

Dr. Donohoe is the medical director of the Old Town Clinic and adjunct lecturer in the Department of Community Health at Portland State University in Portland, Oregon.

anaphylaxis resulting from a penicillin shot.⁹ In fact, it is 10 times more dangerous to carry a fetus to term than to abort before 18 weeks.¹⁰ Despite abortion foes' argument that abortion leads to irrevocable psychological harm, most data suggest that only a self-limited sense of loss and guilt occurs, and there are, in fact, few to no long-term emotional and psychological sequelae.¹¹ Indeed, women denied abortions often experience resentment and distrust, and their children may face social and occupational deficiencies.¹²

US public opinion regarding abortion is as diverse as the population itself. Forty-nine percent of citizens consider themselves more "pro-choice" and 46% more "pro-life."³ Some object to these terms, feeling that very few who are for or against a woman's right to choose abortion for herself are, in fact, "anti-life."³ Fifty-five percent of Americans support a woman's right to a first-trimester abortion,³ and 75% favor increased public funding for family planning services and counseling, which should decrease the demand for abortion.¹³

Abortion in the United States is quite safe, especially when compared with many other countries. There are 50 million abortions worldwide each year. Every minute, 380 women become pregnant, 190 face a new unplanned or unwanted pregnancy, and 40 have unsafe abortions. At least 80 000 women die annually from unsafe abortion (8 per hour).¹⁴ For every 1 abortion death, 30 women suffer injuries, severe blood loss, or infection. Unsafe abortion deaths account for 13% of all maternal deaths; in Latin America, they represent from one-quarter to one-half of maternal deaths.¹⁴

Preventing Unwanted Pregnancy

For many women, pregnancy is the result of inadequate or incorrect information about contraceptive options, impaired access to family planning services, and lack of access to emergency contraception. The Bush administration's support of abstinence-only education and cuts to family planning programs will likely increase the number of unwanted pregnancies and thus the number of women seeking to terminate those pregnancies.^{15,16} The 1996 welfare reform legislation allocated \$50 million over 5 years for abstinence-only sex education.¹⁷ Abstinence-only curricula neglect the reality of relatively high rates of ongoing sexual activity among teens. They prohibit any discussion of contraceptives be-

yond failure rates and present worst-case scenarios of sexually-transmitted diseases (STDs).¹⁸ The language in such curricula tends to place responsibility for maintaining sexual abstinence entirely on young women.¹⁹

Comprehensive sex education programs, on the other hand, incorporate abstinence education with information about condoms, contraception options, and life skills for resisting peer pressure.¹⁷ These programs have been shown to delay sexual intercourse by teens, reduce the frequency of intercourse, decrease the number of sex partners, increase condom and contraception use, reduce the number of unwanted pregnancies, and lower rates of STDs.^{16,18} They are supported by the scientific community²⁰ and by a large majority of Americans.^{18,21,22} The diversion of government funds to abstinence-only programs represents a diversion of financial resources away from effective measures to reduce the need and demand for abortion.¹⁵

In 1988, only 2% of US schools relied solely on abstinence-only sex education; by 1999, 23% did.¹⁶ The Bush administration has extended the 1996 program by appropriating money directly to organizations that fund community-based abstinence-only education programs,²³ many of which are run by faith-based conservative religious groups.²⁴ The budget for this program has grown from \$20 million dollars in 2000 to \$75 million in 2004. The administration is seeking \$186 million for the program for 2005. Between this program and "welfare reform" funding, the amount of money allocated to abstinence-only education is approaching the Title X budget. All states except California accept federal abstinence-only monies.²³ In late 2001, the administration redefined "success" for these programs as "completion of a course" or "a commitment to abstain from sexual activity," rather than actual outcomes such as delayed onset of sexual activity or decreased teen pregnancy rates.^{15,25,26}

On the other hand, since 1988, 21 states have passed comprehensive laws or regulations ensuring equity in private insurance coverage for prescription contraception.²⁷ Some state legislators have introduced "Freedom of Choice" bills, designed to improve sex education and affirm women's rights to abortion.

The Food and Drug Administration's (FDA) recent approvals of prescription emergency contraception (EC), Preven (ethinyl estradiol and DL-norgestrel) in 1998 and Plan B (levonorgestrel) in 1999, have increased women's options

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for preventing unwanted pregnancy.^{28,29} EC, which has been available (as levonorgestrel and other agents) for many years through gynecologists and family planning clinics, is highly effective in preventing unwanted pregnancy, with generally minor side effects.^{28,29,30} Directions for use are easy to understand, and data show that women with ready access to EC used condoms more often, had intercourse without condoms less often, and used more efficacious methods of contraception more often than other women did.³¹ However, only one-quarter of reproductive age women in the United States have heard about EC,²⁶ and some pharmacists refuse to fill prescriptions for it.³²

The FDA rejected Barr Pharmaceuticals' petition to sell levonorgestrel EC (Plan B) over-the-counter (OTC), even though its own advisory panel voted 23 to 4 to approve it and the FDA staff approved of the switch. Levonorgestrel EC is available OTC in South Africa, the United Kingdom, France, and other European countries.^{32,33} OTC EC is also currently available in 3 Canadian provinces, and the national government has approved it for all provinces, pending formal review by Health Canada, the nation's chief health care regulatory agency.³⁴ As with cheaper prescription drugs, this may provide encouragement for Americans to cross the border to obtain pharmaceuticals.

Only 4 US states (California, Washington, New Mexico, and Alaska) allow drug stores to sell EC OTC.³⁵ California and Hawaii have passed bills allowing willing pharmacists to directly prescribe EC; other states are considering similar legislation.^{26,32} The American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics support OTC availability of EC.³⁶ Only 5 states (New York, California, Illinois, Washington, and New Mexico) mandate that EC be made available to rape victims.^{26,32}

Religious hospitals (13% of US hospitals) have been granted special exemptions by the federal government to use religious doctrine to guide patient care while retaining government health care funding.³⁷ Catholic hospitals prohibit provision of contraception, sterilization, and abortion services. Despite opposition from a majority of American Catholics, church doctrine states that these services are at odds with the purpose of sexual intercourse, ie, procreation.^{34,37}

Barriers to Abortion

Point of Viability

*Roe v Wade*³⁸ protects the privacy and availability of abortion for pregnancies of less than 24 weeks, the point of legal viability.³⁹ After viability, states can ban abortion, except where necessary to protect the woman's life or health. This means that abortion may be denied in cases involving an anencephalic fetus, for example, when, in fact, there is no hope of a viable outcome.

Cost and Coverage

An average patient was charged \$372 for a surgical abortion at 10 weeks and between \$438 and \$490 for a medical abortion in 2001, and most patients pay out of pocket.^{2,40} Second-trimester surgical abortions are 2 to 3 times more expensive than first-trimester surgical abortions. Only 26% of abortion clients have services billed directly to public or private insurance.

Most insured patients are reluctant to file claims because of concerns about confidentiality. Most health plans today cover almost all forms of contraception, due in part to state mandates.⁴¹ Some cover sterilization but not abortion, leaving poor women in the position of having to choose sterilization if they lack the resources for adequate contraception.^{28,42,43} Efforts to improve equity in contraceptive coverage are ongoing at the state level.^{16,27}

The 1978 Hyde Amendment prohibits federal Medicaid dollars from being spent on abortion except to preserve a woman's life or in cases of rape or incest.⁴⁴ Even so, 22 states have decided to allocate a portion of their share of Medicaid funding to cover abortion. The Hyde Amendment was applied to Medicare in 1998. It bans federal funding for abortions for disabled women except in cases of life endangerment, rape, or incest. There is no state funding of the Medicare program to make up for this gap.

Title X Family Planning Clinics cover women from low-income households, including a disproportionate number of women from ethnic minorities, and are prohibited from using federal and nonfederal funds for any abortion.^{15,26} They were subject to the domestic gag rule, which prohibited providers from even discussing abortion, from 1988 to 1992.²⁶ Many fear that the current administration will reinstitute this rule.^{15,26}

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The Defense Department provides health care coverage to 8.3 million military personnel and their families⁴⁵ and has instituted a permanent ban on abortion, except when the life of the woman is endangered.³⁹ Uniformed personnel serving abroad and their dependents are prohibited from obtaining abortions at military hospitals, except in cases of rape or incest, even if they pay for the procedure with personal funds.⁴⁶ Their only alternatives are to travel long distances, which can be expensive and requires permission to take leave, or to have the abortion in a local, nonmilitary hospital, a particularly risky undertaking in many Middle Eastern and other countries.

Federal health insurance programs do fund a full range of prenatal diagnostic procedures, including maternal serum screening, ultrasonographic fetal anatomic survey, amniocentesis, and fetal blood sampling. This could conceivably create a significant psychological conflict for a couple who are offered genetic counseling, request and receive diagnostic prenatal interventions, but then face a harsh economic reality: One option for management of an anomalous fetus, namely abortion, is denied them by the Hyde Amendment.

Other federal health insurance programs similarly limit coverage of abortion.³⁹ The 1.5 million American Indians and Alaskan natives covered by the Indian Health Service are subject to the Hyde Amendment.⁴⁷ The Federal Employees Health Benefits Program covers over 8.5 million federal employees, their dependents, and retirees, 45% of whom are women.⁴⁸ Since 1983 (except for a brief period in 1994), abortions have been paid for only in cases of life endangerment, rape, or incest. Since 1987 (except for the brief hiatus in 1994), women in federal prisons (11 250 today) have been allowed access to abortion only when their lives are endangered or when the pregnancy is the result of rape,⁴⁹ which may be difficult to prove. Finally, the 4453 female Peace Corps volunteers are not covered for abortion under their government-provided insurance plan, even in cases of rape or when their lives are endangered.⁵⁰

Women of color are more likely to be poor, to lack health insurance, and to rely on government health care programs than are white women. Thus, they are disproportionately harmed by prohibitions on public funding for abortions.^{51,52} The National Network of Abortion Funds, a 10-year old group

linking 96 funds in 42 states helped pay for 1.6% of abortions in 2001.⁵³

Legal Barriers

Today 22 states have mandated waiting periods for women wishing to obtain abortions, most lasting 24 hours.⁵⁴ Mandatory waiting periods augment patients' exposure to antichoice harassment and increase gestational age, thereby also increasing the risk associated with the procedure.⁵⁵ No

other common, accepted medical procedure carries such a waiting period. Alabama goes a step further, requiring a sonogram before termination, ostensibly to determine fetal age.

Although spousal notification and consent are not required for abortion, parental consent and notification laws for teens are common. Twenty-one states require parental permission; another 14 require parental notification.^{56,57} Notification can be dangerous for the teen if a pregnancy results from incest or if the adolescent's home environment is abusive or otherwise unstable. Reddy et al⁵⁸ have shown that

parental consent and notification laws could prevent up to half of teens from using Planned Parenthood services, including contraception, while only stopping 1% from having sex.

Congress is currently considering the Child Custody Protection Act, which would prohibit anyone other than a parent, including other relatives and religious counselors, from accompanying a young woman across state lines for an abortion without complying with the home state's parental involvement statutes.^{59,60} This would delay abortion for a woman determined to have one but unable to draw on her parents' assistance, increase its cost, and place additional physical and emotional burdens on the teenager.

More than 20 states have biased counseling laws.^{61,62} These initiatives, often labeled "mandated informed consent" or "women's right to know" laws, employ scare tactics to convince women that abortion is much more dangerous than it really is. The laws mandate reading of a lengthy list of possible but very rare complications from abortion, but not of a corresponding list of benefits.

Similar biased information is distributed at up to 4000 "crisis pregnancy centers" nationwide, some of which receive federal and state funding.⁶³ These clinics are listed in the phone book under pregnancy services or abortion services. Staff members try to dissuade clients from having

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abortions through exaggeration of risks, myths, and fetal photographs/body scans.

Pseudoscience

Crisis pregnancy centers and abstinence-only education constitute 2 manifestations of the federal government's political and ideological influence on medical decision making. The current administration has supported many misuses of science.^{25,64} For instance, in response to political pressure, the National Cancer Institute (NCI) removed information on the findings of its Early Reproductive Events and Breast Cancer workshop from its Web site, refuting the idea that abortion can cause breast cancer.^{3,65} The NCI later replaced this information, but only by posting a statement saying that data were "controversial." In similar fashion, the NCI and the Centers for Disease Control and Prevention removed information regarding the effectiveness of condoms and comprehensive sex education curricula from their Web sites.^{25,64,66,67}

Appointments to key scientific bodies relevant to women's health have also been based more on ideology than on candidates' experience and expertise in a given area. For instance, David Hager, MD, and Joseph Stanford, MD, were nominated for membership on the FDA's Reproductive Health Drugs Advisory Committee.^{15,68} Dr. Stanford refuses to prescribe oral contraceptives.⁶⁹ Dr. Hager, an obstetrician/gynecologist whose track record as a researcher was described by the *Lancet* as "sparse,"⁷⁰ authored *As Jesus Cared for Women*, in which he advocates Bible reading and prayer for premenstrual syndrome.⁷¹ Dr. Hager has condemned the birth control pill and reportedly refuses to provide contraceptives to unmarried women.^{72,73}

Availability of Mifepristone

The current administration has asked the FDA to reconsider its approval of mifepristone. Drs. Hager and Stanford are both outspoken opponents of this agent, which was approved for medical termination of pregnancies 49 days or less from the last menstrual period. Despite its approval, many women cannot obtain this drug because they are unaware of it, because providers don't know how it is used (and fear prescribing it), and because of cost. Medicaid restricts funding for mifepristone to cases of rape, incest, or to preserve the pregnant woman's life. Legislation has been pro-

posed at both state and federal levels to curtail availability of mifepristone and limit the number of doctors who can prescribe it.⁷⁴

Provider Availability

More than one-third of US women live in the 87% of counties, including 30% of metropolitan areas, that have no abortion provider.⁷⁵ The situation is worst in rural areas, where women may have to travel more than 100 miles to obtain abortions.^{40,76} Only 1800 physicians provide abortion services today, down from 2400 in 1992.³ Most do not perform abortions every day of the week,⁷⁷ and 57% are 50 years old or older.⁷⁸ Only 12% of obstetrics/gynecology residency programs required abortion training in the mid-1990s, down from 25% in 1985.⁷⁹⁻⁸² By 1998, 46% of programs offered abortion training routinely, an increase from the mid 1990s, but still lower than the 70% of programs offering training in 1991-1992.⁸³ Forty-four states bar nonphysicians from performing abortions.⁸⁴

In contrast, California law now requires all obstetrics/gynecology residency programs to comply with the Accreditation Council on Graduate Medical Education requirement that they include abortion training, with an opt-out provision for conscientious objectors.^{85,86} Institutions outside California have also established model abortion training programs.⁸⁷

Harassment of Patients and Providers

Since 1977, 80 000 acts of violence or disruption at abortion clinics have been reported.⁸⁸ Although the number of providers reporting severe forms of harassment has been declining for a decade,⁴⁰ the list includes 7 murders, 17 attempted murders, 41 bombings, 166 arsons, 125 assaults, and 654 anthrax threats (480 of them since September 11, 2001).⁸⁹ Patients are often harangued, belittled, defamed, and taunted with verbal and physical threats, despite the federal Freedom of Access to Clinic Entrances Act.^{27,90} Many clinics have bodyguards and alarm systems and provide escorts for patients.⁹¹ Between 55% and 86% of providers report that they have been harassed.² This threatening behavior, which has not received the attention that other threats to US infrastructure and public services have received, is aimed at a legal procedure carried out by licensed health care providers.

The Bush administration's philosophy and antichoice rhetoric have perpetuated the environment in which this ha-

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rassment occurs. For example, when President Bush declared January 20, 2002 National Sanctity of Life Day, he likened abortion to terrorism: “On September 11 [2001], we clearly saw that evil exists in this world and that it does not value life. Now we are engaged in a fight against evil and tyranny to preserve and protect life.”⁹² Some may interpret this rhetoric as permissive of extremism, in that it likens the “battle” against prochoice advocates and abortion providers to that against suicide bombers.³⁹

Sensing a favorable environment, extremist groups (eg, the Army of God) and Web sites that promote violence against providers and recipients of abortion have thrived.^{93,94} In violation of patient confidentiality, the federal government tried to subpoena all the medical records from a family planning clinic in Iowa as part of a murder investigation. Its efforts were blocked, largely because of the courage of Jill June, the President of Planned Parenthood of Greater Iowa, who risked jail time and a fine to preserve the confidentiality of the doctor-patient relationship.⁹⁵

Targeted Regulation of Abortion Providers Laws

Targeted regulation of abortion provider (TRAP) laws have become increasingly common at the local and state level.^{96,97} In effect in 35 states and Puerto Rico, they are designed to add regulations and extra costs to abortion clinics, with the probable underlying motive of putting them out of business altogether. They do not apply to other ambulatory health care centers.^{98,99} TRAP Laws regulate hallway corridor and door-frame width, temperature of operating rooms, and the number of hours of training each staff member must receive, in each case exceeding the usual recommendations and requirements of respected scientific organizations. Increased retrofitting, design, and training costs, combined with increased licensing fees and burdensome documentation requirements, have put some clinics out of business and forced others to close temporarily or reduce services. Zoning ordinances have also been passed to force clinics to move. Some facilities shut down and do not reopen. The overall effects of TRAP laws and unfair zoning ordinances are to decrease access and increase costs of abortion.⁹¹

Refusal Clauses

Shortly after the *Roe v Wade* decision, 45 states enacted “refusal clauses,” which permit certain medical personnel,

health facilities, or institutions to refuse to provide abortion services.¹⁰⁰ As a result, employers can refuse to provide contraceptive coverage in their health plans, pharmacists can refuse to dispense or provide referrals for lawfully prescribed oral contraceptives, and health care professionals can deny patients’ requests for information on or referral for family planning services, regardless of the patients’ health care needs.^{28,29,32}

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Other State Laws

In 2002, states enacted 34 new antichoice measures, bringing the cumulative total to 335 since 1995.^{101,102} South Dakota and Arkansas have passed laws that explicitly protect pharmacists who refuse to fill birth control prescriptions on moral or religious grounds.¹⁰³ Similar legislation has been introduced in 13 other states.⁹⁸ In 2003, 10 states introduced 15 measures that would ban all or most abortions.^{99,100} Today very few states have both a legislature and a governor that favor protecting women’s right to choose. Three states have “choose life” laws that allow motorists to purchase Choose Life license plates.⁹⁹ Proceeds from these sales usually support pregnancy crisis centers.

The Fetal Rights Movement

The current administration has aggressively attempted to grant rights usually available only to living US citizens to the unborn. For instance, it has extended coverage to fetuses under the State Children’s Health Insurance Program (SCHIP), while failing to extend full prenatal care to all women.^{27,28,29} The mission of the federal Advisory Committee on Human Research Protection, which oversees the safety of human research volunteers, has been expanded to include embryos.¹⁰⁴ Concerns over liability could impede important scientific research and frighten providers away from performing abortions or providing morning-after contraception.

The Unborn Victims of Violence Law criminalizes harming fetuses.¹⁰⁵ Its supporters say it will “help protect victims from domestic violence.” This law could limit women’s freedom to work at certain jobs in which they, and by proxy their fetuses, might be exposed to occupational or environmental hazards. In 2003, 20 states introduced 37 bills criminalizing harm to an embryo or fetus independent of the pregnant woman.^{99,100,102}

The latest addition to antichoice legal measures is the recently signed Partial Birth Abortion Ban. This is actually a misnomer, as there is no such medical term as partial birth abortion.^{39,106} This law criminalizes the rarely performed and often lifesaving (for the mother), procedure known as intact dilation and evacuation (also sometimes referred to as intact dilation and extraction). In fact, dilation and evacuation for termination of pregnancy involves in utero destruction of the fetus. The procedure is specifically exempted from the Partial Birth Abortion Ban, because it is recognized as legal and permissible. The ban makes no exceptions for the health of the woman. A number of law suits have been filed, including one in which a federal appeals court judge in San Francisco blocked the administration from enforcing the ban against Planned Parenthood of America clinics and their doctors, who perform roughly half the nation's abortions.¹⁰⁷ Two other courts have also struck down the ban.¹⁰⁸ Courts have also blocked the US Justice Department's attempts to get confidential medical records as part of their case against opponents of the law.^{109,110} The law may be overturned by the present US Supreme Court in the event of a federal government appeal; the Court ruled that a similar 2000 Nebraska State law was unconstitutional.³

Worldwide Barriers to Abortion

US policy has affected access to abortion and other reproductive health services worldwide. Lack of access to reproductive education, condoms, and contraceptives in the developing world has increased the need for abortion, which has not been matched by appropriate numbers of providers and facilities.¹¹¹ One hundred million women have unmet need for contraception.¹¹² One-third of the developing world's population lives where abortion is prohibited or allowed only in cases of rape or incest or to save the mother's life.¹¹³ The Catholic Church, socially and politically active in most countries, actively opposes contraception and abortion, even in areas suffering from overpopulation and its consequent environmental degradation and social injustice.¹¹⁴

In 2001, President George W. Bush reinstated the global gag rule first adopted by the President Reagan in 1984 and rescinded by President Clinton in 1993.^{15,40,115} This edict pre-

vents US government aid from being used by any organization operating outside the country that discusses, advocates for, or performs abortions. Since the resumption of the global gag rule, 430 organizations in 50 countries have stopped performing abortions or speaking about abortion laws in order to qualify for funding.¹¹⁶ The Senate recently voted to overturn the rule, but the House is unlikely to follow; even if it did, President Bush would likely veto such a measure. Instead the

House recently upheld an amendment to the 2004-2005 Foreign Relations Authorization Act that prevents the United Nations' Population Fund from receiving US government funds.¹¹⁷

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Conclusions

Although many barriers to abortion in the United States are longstanding, many new ones have been enacted since President Bush took office. Many states and conservative religious groups support this effort. At the same time, the administration has limited public access both to scientifically sound sex education and to effective methods of STD prevention and contraception. It has attempted to prevent (or at least delay) the availability of EC. The administration's efforts have been backed by pseudoscience and inflammatory rhetoric. These policies have helped to create an environment in which abortion may be delayed or rendered essentially unavailable.

Preserving women's access to abortion services will require vigilance and legislative efforts at the federal and state levels and in the courts. Efforts to prevent the government from inserting itself into the doctor-patient relationship through legislation should be countered aggressively.¹¹⁸ Advocates should continue to lobby at the state and federal levels for women's access to a full range of reproductive health options. Health care providers and educational institutions should enhance their professional and public education programs to ensure the distribution of scientifically sound information on contraception and abortion and the availability of trained providers for women who choose to exercise their legal right to terminate unwanted pregnancies.

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