

Abortion Reporting: Promoting Public Health, Not Politics

By Joerg Dreweke

On issues related to abortion care in the United States, public health experts have at their disposal reliable data and research to inform and monitor the impact of public health policies and practices. Still, the current system that generates these data—while effective and among the most comprehensive in all of public health—faces two main challenges that should be addressed.

First, three states do not report any basic data on abortion incidence and patient characteristics to the U.S. Centers for Disease Control and Prevention (CDC), and in some other states, the reporting is incomplete and unreliable. These gaps in state abortion surveillance have hampered efforts by the CDC to compile complete abortion statistics at the national level.

Second, opponents of abortion rights have seized on abortion reporting requirements as yet another way to subvert legitimate public health policy and advance their political agenda. In doing so, they are exploiting reporting requirements that exist for public health purposes to create a legal and political tool to monitor compliance with state abortion restrictions aimed at impeding access to care and deterring women from seeking abortion services.

To address these challenges, abortion surveillance systems should be strengthened as needed in states where they are already in place and created in states where they are not; the federal government should facilitate this process through technical and financial assistance. Given the particular personal and political sensitivities surrounding the

HIGHLIGHTS

- *Reliable data on U.S. abortion incidence and patient characteristics are available; however, state surveillance is not always complete and some states do not report at all. Guttmacher Institute researchers have supplemented government data collection efforts since 1973.*
- *The federal government should assist states that currently have no abortion surveillance systems to create them and help some of those that already have systems in place to collect better data and release them in a more timely manner.*
- *Antiabortion lawmakers are subverting abortion reporting systems in some states to stigmatize abortion care, harass providers and patients, and advance a political agenda. Abortion reporting is an important public health tool that must be used—at both the state and federal levels—only to advance public health.*

issue of abortion in the United States, however, any moves to improve state abortion surveillance have to safeguard the privacy, rights and needs of abortion patients and providers. Governmental public health reporting systems must be limited to collecting basic incidence and demographic data for legitimate public health purposes. Official governmental reporting systems that go beyond this limited scope have the effect of stigmatizing women obtaining abortions or harassing abortion providers for the purpose of promoting an antiabortion policy agenda. Using a public health surveillance system for this purpose cannot be justified on any grounds.

Roles and Responsibilities

The incidence of induced abortion is an important public health indicator. On its own, the understanding of abortion levels, rates and trends is key to documenting the success of efforts to help women avoid unintended pregnancy, the precursor to most abortions. As a component of other statistics, abortion incidence data are essential to calculating levels and rates of pregnancy overall, teen pregnancy and unintended pregnancy.

Data from ongoing abortion surveillance also inform public health in two other key areas. Data on basic demographic characteristics of abortion patients (e.g., age, race and ethnicity, and marital status) are needed to identify disparities in reproductive health outcomes and help tailor public health interventions to groups at particular risk of having an unintended pregnancy. Also, surveillance of factors such as gestational age and abortion procedure used provides important insights into the safety of abortion and changes in clinical practice.

Ideally, state and federal governments would work with nongovernmental entities to fulfill distinct and complementary roles as part of a robust national abortion surveillance system:

- The states and the District of Columbia—through their vital statistics offices or other central health agencies—should have in place abortion reporting systems for the collection of basic data on abortion incidence and patient characteristics that are similar to the existing systems for other vital statistics, such as births and deaths.
- In turn, the federal government—through the CDC—should collect and tabulate the basic incidence and patient characteristic data gathered by the states into aggregate state and national statistics. The federal government should also make available funding and technical expertise to help states institute and maintain robust abortion reporting systems.
- All statistics compiled by the state and federal governments should be made available to the public, including academic and other nongovernmental researchers; appropriate protections must

be made for patient and provider privacy. Private researchers could then build on the government-generated basic surveillance data to help answer important questions that are too intrusive, as well as unnecessary, for the government to collect itself. For example, nongovernmental entities could use voluntary surveys of abortion providers and patients to investigate the reasons women have abortions or the cost and logistics of arranging for an abortion.

In a number of ways, current abortion surveillance efforts by the states and the federal government already reflect what a robust national surveillance system would ideally look like.

Role of Federal and State Governments

The CDC has long partnered with the states to collect statistics on abortions. States are responsible for collecting and managing data in accordance with their own policies and systems. As a result, states ultimately determine the quality and availability of national, government-generated abortion data. States are not required to submit abortion data to the CDC, but almost all do so on a voluntary basis.

The latest CDC abortion surveillance report—compiling data for 2011 and published in late 2014—is based on reporting from 47 states (excluding California, Maryland and New Hampshire), as well as the District of Columbia and New York City (which reports abortion data independently of the rest of New York State).¹ However, even among jurisdictions that report data to the CDC, the quality and timeliness of reporting are variable, which is another reason why the CDC cautions that its abortion incidence totals are incomplete.

As part of this abortion surveillance process, the CDC each year requests information from each state's central health agency on the number and characteristics of women obtaining abortions.¹ These health agencies—usually vital statistics offices—provide aggregate numbers to the CDC, without individual-level records. The CDC does not share in the cost of state data collection, but to facilitate the process and encourage uniform reporting, it sends suggested templates to the states for compilation of aggregate abortion data. As the

CDC notes, however, the level of detail it receives on the characteristics of women obtaining abortions can vary considerably by year and reporting area.

Most of the states, for their part, require that abortions be reported, although these requirements differ significantly in scope and detail. As of June 2015, 46 states require hospitals, clinics and physicians providing surgical and medication abortions to submit regular and confidential reports to the state.² Of the four states that do not require reporting, California and Maryland have no reporting in place at all, while abortion providers report on a voluntary basis in New Hampshire and New Jersey, as well as in the District of Columbia. Of the latter three, only New Jersey and the District of Columbia report aggregate statistics to the CDC.

To collect individual-level data, most state vital statistics agencies have designed a form that abortion providers use for reporting to the state. States update these forms as needed in response to changes in medical practice or technological advances. For instance, after the U.S. Food and Drug Administration (FDA) approved the abortion drug mifepristone in 2000, most states—in an effort led by the CDC—adjusted their forms to include questions about medication (nonsurgical) abortion. Over time, states have also updated their systems so that reporting for abortion—as well as for other public health surveillance data—is increasingly done via the Internet.

State abortion reporting forms are often modeled after a template (“U.S. Standard Report of Induced Termination of Pregnancy”) designed by public health experts at the CDC’s National Center for Health Statistics.³ The CDC template asks for the following basic public health information:

- identification of the facility (name, city/town and county) at which the abortion was performed, and names of the physician performing the procedure and person completing the form;
- patient’s basic demographic characteristics (age, race, ethnicity, marital status, educational attainment, and previous pregnancies and their outcomes);

- patient’s residence (state, county, city/town and zip code);

- date the procedure was performed;

- date of last menstrual period and clinical estimate of gestational age; and

- abortion procedure used (e.g., suction curettage or medication).

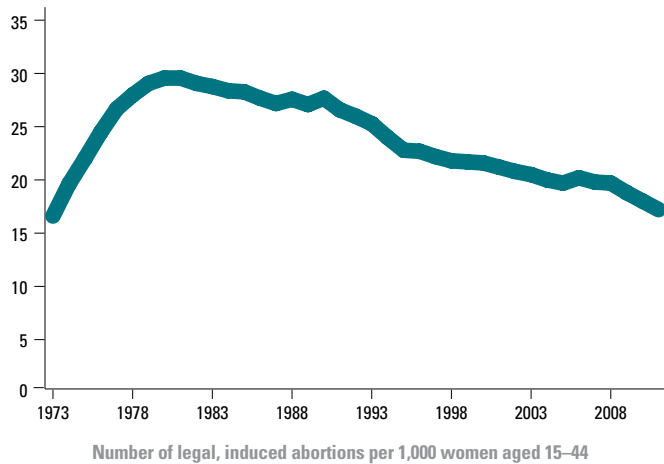
The CDC makes explicit that this form “is designed to collect information for statistical and research purposes only” and that “data that are gathered from these reports are presented in aggregate statistics, not individually, so that specific individuals may not be identified.”³ The CDC further notes the need to protect patients’ and abortion providers’ identities, stating “hospitals, clinics, and physicians are assured that extensive legal and administrative measures are used to protect individuals from unauthorized disclosure of personal information contained on the reporting form.”

Guttmacher’s Role

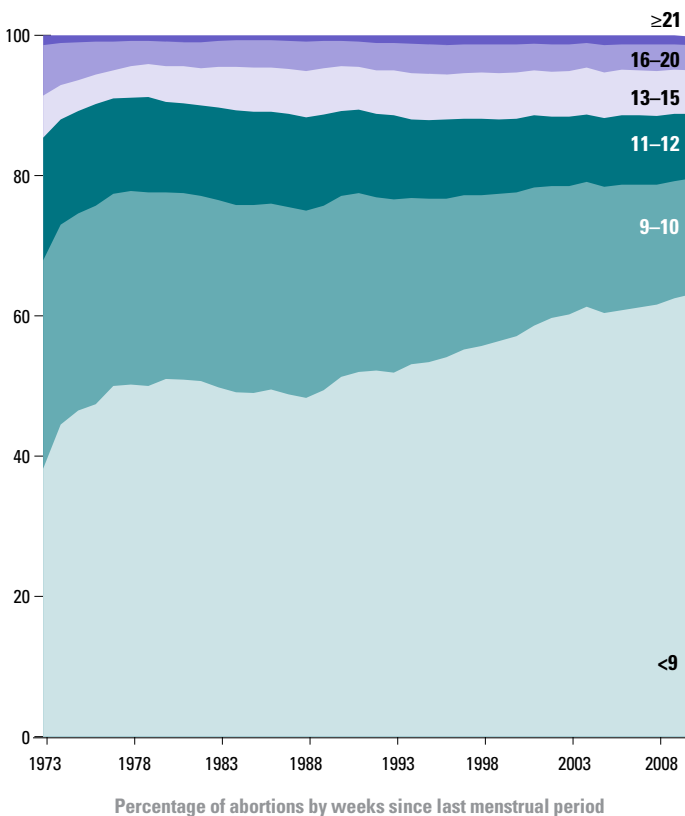
Government abortion surveillance efforts have long been known to be incomplete. When abortion was legalized nationwide in 1973, the Guttmacher Institute—recognizing the importance of obtaining complete and reliable information about abortion care in the United States—initiated a research program to periodically survey all known abortion providers. The 16th and most recent abortion provider census (compiling data for 2010 and 2011) was published in February 2014.⁴ Providers’ participation in the census is voluntary, as is respondents’ participation in all research conducted by Guttmacher. The Institute goes to significant lengths to protect the identity and privacy of respondents, which—combined with its long track record and reputation for conducting research that advances public health programs and policies—contributes to its ongoing ability to successfully do this work on such a politically charged issue. As part of the census, Guttmacher researchers first attempt to identify any potential new providers to add to the pool of known providers. All potential respondents are sent a questionnaire; nonrespondents receive two follow-up mailings and then are contacted by phone.

WEALTH OF DATA

More is known about abortion than perhaps any other surgical procedure. Among many other trends, we know that in 2011, the U.S. abortion rate reached its lowest level since 1973...



... and that an increasing proportion of abortions are taking place earlier within the first trimester.



Sources: Guttmacher Institute and the Centers for Disease Control and Prevention.

Because Guttmacher contacts abortion providers directly, and conducts multiple follow-ups for nonrespondents, it is able to compile reliable abortion incidence data that are significantly more comprehensive than what is published by the CDC. State reports compiled by the CDC typically capture about 68% of the abortions counted by Guttmacher.¹⁴ The Institute's abortion incidence data are, therefore, routinely recognized as the most reliable—including by the CDC, as well as by all sides in the often contentious U.S. abortion debate.

Guttmacher also periodically conducts nationally representative surveys of abortion patients; again, respondents participate on a voluntary basis and are assured anonymity.⁵ This work supplements the CDC's efforts to publish demographic characteristics of women having abortions. Guttmacher is able to collect information on a wider range of background characteristics than is necessary for government reporting systems (e.g., religious affiliation, disruptive life events or whether the man with whom the patient became pregnant knows about the pregnancy), but which can be important for informing public policy.

Because of its mission to advance evidence-based policies that promote reproductive health and rights, the Guttmacher Institute has a long-standing commitment to this work, which is supported exclusively by private sources.

Clear Picture

The complementary efforts of the states, the CDC and Guttmacher provide a comprehensive overview of access to abortion care in the United States: High-quality data are available on the number, rates and trends of induced abortion, along with demographic data for abortion patients and information on changes in clinical practice. Among many other important insights, these ongoing efforts have documented the increase in legal induced abortion rates in the 1970s, the plateau through the 1980s and a steady decline starting in the early 1990s (see chart). Abortion and unintended pregnancy have become more concentrated among poor women, and significant disparities in the incidence of abortion and unintended pregnancy exist across racial, ethnic and income

groups.⁶ Among teens, pregnancy and abortion rates are known to have declined substantially, a tremendous public health success that has been attributed primarily to better contraceptive use.⁷ Further, the steady increase in the proportion of medication abortion since the approval of mifepristone in 2000 is well documented, reaching 23% of all nonhospital abortions in 2011—a shift that has contributed to abortions taking place earlier within the first trimester (see chart, page 43).

Most important, the evidence base gathered by the states, the CDC and Guttmacher yields valuable insights to inform public health policy. For instance, in its latest abortion report, the CDC notes that “because unintended pregnancies are rare among women who use the most effective methods of contraception, increasing access to and use of these methods can help further reduce the number of abortions performed in the United States.”¹ Guttmacher experts have similarly concluded that the decline in abortions between 2008 and 2011 was likely the result of fewer pregnancies overall, with increased use of long-acting, reversible contraceptive (LARC) methods as a contributing factor.^{4,8} Such evidence is invaluable, for example, in understanding the potential of the Affordable Care Act’s contraceptive coverage guarantee to further reduce unintended pregnancy and abortion rates; that guarantee, which started to benefit large numbers of women in 2013, now allows millions more women to choose the contraceptive method that works best for them—including LARC methods that often have high upfront costs—without cost as a barrier to use.⁹

Other abortion surveillance activities by the CDC have likewise informed public policy in crucial ways. For instance, a large-scale cohort study conducted in the 1970s led to major changes in clinical practice, after finding suction curettage to be safer than sharp curettage.¹⁰ Suction curettage is now the norm for first-trimester surgical abortions in the United States.

Finally, abortion surveillance efforts by the CDC, along with university-based researchers working independently, have demonstrated that legal induced abortion is a very safe medical procedure, with low mortality and complication rates for

patients. A first-trimester abortion has minimal risk—less than 0.05%—of major complications that might need hospital care.¹¹ CDC surveillance of abortion-related maternal mortality documented a sharp decrease in abortion-related deaths after safe and legal abortion services started to become widely available in the United States in the early 1970s;¹⁰ ongoing abortion mortality surveillance by the CDC has consistently affirmed this fact.¹ Likewise, independent studies published as recently as 2015 continue to demonstrate low rates of complications following legal induced abortion.^{11,12}

In short, although government surveillance systems need to be strengthened, the current patchwork is working. There are no major aspects of abortion care in the United States that are unknown.

Politicizing Reporting

Opponents of abortion rights have long sought to subvert public health concepts and tools as part of their campaign to restrict women’s ability to obtain abortion care and providers’ ability to offer such services. For instance, abortion opponents have undermined the principle of informed consent by requiring patients to undergo mandatory counseling that includes biased or outright false information to deter them from obtaining an abortion.^{13,14} Abortion opponents have also successfully pushed laws requiring the use of an outdated FDA protocol in the provision of medication abortion, despite the availability of a newer, evidence-based regimen with fewer side effects.^{15,16} And they have used patient safety as a pretext to target abortion providers with unnecessary, onerous regulations—forcing a number to shut down.^{17,18}

In the same vein, abortion rights opponents have co-opted abortion reporting to advance their political agenda by requiring information that has no discernible public health purpose, can be highly intrusive into patient privacy and can risk patient confidentiality. For instance, nine states require providers to report whether state-mandated counseling was provided, and 13 states require providers to report whether state requirements for parental involvement were met (see map, page 45).² Although states should ensure compliance with their laws, there is no justification for singling out

abortion providers for special surveillance for this purpose, or using a public health tool to do so.

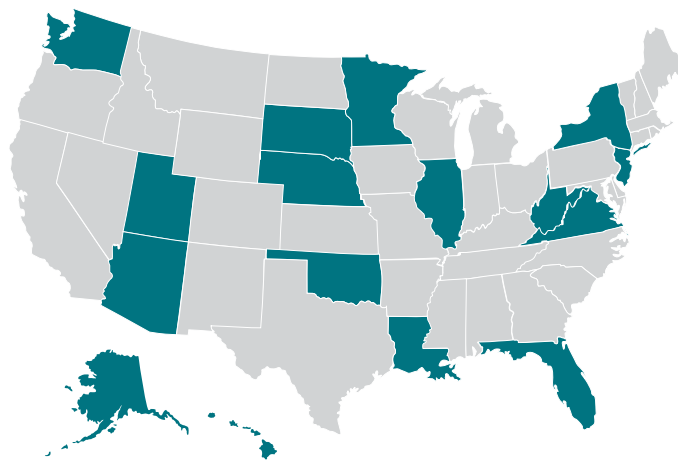
Another example where state reporting requirements veer into political territory involves forcing abortion providers to query women about their reasons for terminating a pregnancy. This crosses the line between public health and politics because it injects the government into the provider-patient relationship and intrudes upon the woman's right to privacy. Sixteen states currently require providers to give some information about the woman's reason for seeking the procedure (see map).² Fifteen states ask whether the abortion was performed because of a diagnosed fetal abnormality, and 10 inquire whether the pregnancy posed a threat to the woman's health or life; beyond medical indications, nine states ask whether the abortion was performed for other reasons, such as the woman's economic or familial circumstances.

Unquestionably, understanding the specific medical or socioeconomic reasons women have abortions is of value to public health experts and researchers. For that reason, nongovernmental entities, including the Guttmacher Institute, have conducted surveys of abortion patients to learn more about why women obtain abortions.¹⁹ However, it is far different for researchers from a private entity to ask women to fill out a questionnaire on a voluntary and anonymous basis than for a state to require abortion providers to ask their patients such questions. Abortion is a constitutionally protected right, and requiring that women be queried about their reasons for obtaining an abortion comes dangerously close to making them justify why they are availing themselves of this right.

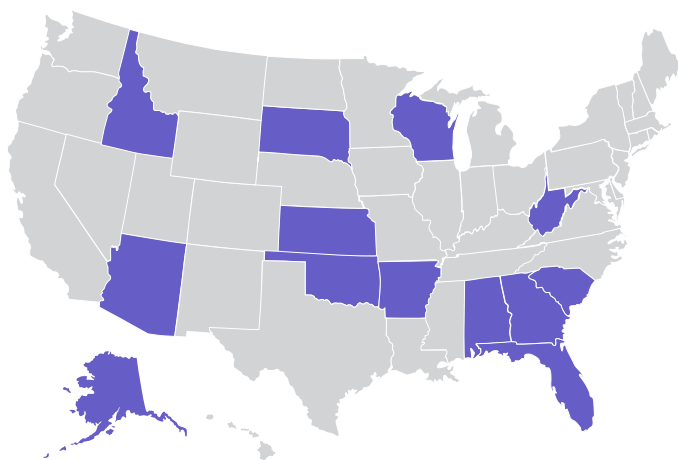
Oklahoma is a particularly egregious example of a state that has crossed the line into politicizing abortion reporting. The state's abortion reporting form—designed not by public health experts, but by abortion opponents who dominate the state legislature—is significantly more expansive than the CDC's template, both in scope and in spirit. The form itself is daunting, with 30 questions for adult patients and 38 for minors, many of them with multiple sub- and follow-up questions.²⁰ In comparison, the CDC's template has 17 questions and few sub-questions.

CROSSING THE LINE

Some states require reporting that is too intrusive or unnecessary for public health purposes, such as information about the woman's reasons for seeking an abortion...



...and whether state requirements for parental involvement were met.



Source: Guttmacher Institute.

A recurring theme in Oklahoma's form is an unwarranted undercurrent of suspicion that abortion providers are not following the law. Each time they complete the form, providers have to affirm on multiple occasions that they have complied with the state's myriad abortion restrictions. For instance, they have to report compliance with mandatory counseling and parental notice requirements. The state also requires ultrasound images to be submitted electronically along with the reporting form, a provision that serves no discernible public health purpose other than

monitoring compliance with the state's mandatory ultrasound law. Furthermore, under "method of abortion used," the form lists "partial birth abortion," a medically inaccurate term for a procedure that is banned under both federal and state law. And among the possible reasons why the woman is obtaining the procedure, the form includes "wanted a child of a different sex"; performing an abortion for this reason would be a violation of Oklahoma's ban on sex-selective abortion.

This theme of politically motivated harassment and mistrust of abortion providers is mirrored in other states' abortion forms, although not to the same extent as in Oklahoma. For instance, Louisiana also has a mandatory ultrasound law and requires providers to submit ultrasound images.²¹ And Kansas, which bans "partial-birth abortion" except to save the life of the patient, requires providers to indicate whether such a procedure was used, and if so, to justify in detail how the patient's life was endangered.²²

Another theme apparent in Oklahoma's abortion reporting form is the use of politically charged language throughout. The form refers to the fetus as the "unborn child subject to abortion," and lists "forcible rape" among the reasons why the woman might be obtaining an abortion, which suggests that any rape not involving force does not qualify as rape.²⁰ Similar politically loaded language can be found in reporting forms in other states as well: For example, South Dakota asks about the age of the "unborn child's father,"²³ and Texas inquires about the "probable post-fertilization age of the unborn child."²⁴

Making a Good System Better

Abortion is one of the most studied medical procedures in the United States, which leads two prominent public health experts and former CDC officials to conclude that "as a result of this commitment to data collection and their quality, we have come to know more about legally induced abortion than any other operation."¹⁰ Indeed, the quality of available incidence data—especially through Guttmacher's periodic provider census—rivals that for other basic vital statistics, like births and deaths.

Nevertheless, high-quality systems should be created in the states that do not currently have them, including California, which is not only the most populous state and among the most demographically diverse, but also accounts for more abortions than any other. Moreover, the quality and timeliness of existing government data collection systems should be improved in states as needed. Making available federal funding for the CDC to help states strengthen their abortion reporting systems could go a long way toward bolstering the quality and timeliness of data currently being gathered.

However, in the current political climate, merely opening a discussion about creating a more robust government abortion surveillance system could well result in antiabortion policymakers in the states—and potentially even at the federal level—exploiting this issue in pursuit of their increasingly aggressive antiabortion agenda. Hundreds of state laws restricting access to abortion care have been enacted in recent years,²⁵ while a number of antiabortion bills have been introduced in the U.S. Congress, with some of them even passing the House of Representatives.

Responsible approaches to improving reporting depend on responsible intentions to use the information for protecting and promoting women's health, not for interfering with access to abortion care. Meanwhile, until there is a more robust system for abortion reporting in the United States, there exists a very good one that provides a large amount of information that is essential and integral to grounding reproductive health programs and policy in solid evidence. ■

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