

## Repeat Abortion, Repeat Unintended Pregnancy, Repeated and Misguided Government Policies

By Susan A. Cohen

About half of all U.S. women having an abortion have had one previously. This fact—not new, but dramatically underscored in a recent report from the Guttmacher Institute on the characteristics of women having repeat abortions—may surprise and concern some policymakers, even prochoice ones. However, policymakers should be more disturbed by the underlying fact that the unintended pregnancy rate in the United States is so high, and that so many women experience repeat unintended pregnancies. Some of these pregnancies end in abortion and some end in unintended births. Indeed, it is not uncommon for a woman to experience both of these outcomes, as well as one or more planned births, during her lifetime.

Reducing repeat abortion must start with reducing repeat unintended pregnancy, which goes back to the basic challenge of helping women prevent unintended pregnancies in the first place. In that regard, the almost 7,500 family planning clinics across the country certainly are doing their share, given that unintended pregnancy prevention is their primary mission. Beyond that, both abortion providers and providers of services to women giving birth also contribute, since contraceptive counseling and the provision of a birth control method upon request are standard components of high-quality postabortion and postpartum care.

Strengthening the linkages between services and between providers would seem to be key, however, if the overall goal is to enable women to better manage their reproductive lives and better plan whether and when to have a child or another

child. But fostering continuity of care between abortion clinics and contraceptive services programs might be easier said than done. The contentious politics of abortion and the culture wars associated with it have led to the isolation of abortion as a medical service and to the stigmatization of both abortion clients and providers. Indeed, particularly for young and low-income women among whom unintended pregnancy and recourse to abortion are especially common, state and federal government policies over the last 25 years have only exacerbated the situation, by consciously driving wedges between providers of publicly subsidized contraceptive services and facilities providing abortions.

### Abortion vs. Repeat Abortion

Although not widely recognized, the U.S. abortion rate reached its height in the early 1980s and has been drifting downward ever since. Over the last few years, however, the decline would appear to have stalled. At the current rate, about one-third of all U.S. women will have had an abortion by age 45. Certain groups are overrepresented among women having abortions: those who are young, poor or near-poor, black, Hispanic or unmarried, and those who already have had one child. Fifty-four percent of women having abortions used some method of contraception during the month they became pregnant. The tiny sliver of all sexually active women not practicing contraception (11%) accounts for the remaining half of all abortions.

According to the 2006 Guttmacher Institute report *Repeat Abortion in the United States*, women having a second or higher-order abortion are substantially different from women having a

first abortion in only two important ways: They are more than twice as likely to be age 30 or older and, even after controlling for age, almost twice as likely to already have had a child. (Among all women having an abortion, six in 10 are mothers.)

Just as with women having their first abortion, however, the majority of women having their second or even their third abortion were using contraceptives during the time period in which

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they became pregnant. In fact, women having a repeat abortion are slightly more likely to have been using a highly effective hormonal method (e.g., the pill or an injectable). This finding refutes the notion that large numbers of women are relying on abortion as their primary method of birth control. Rather, it suggests that women having abortions—especially those having more than one—are trying hard to avoid unintended pregnancy, but are having trouble doing so.

Moreover, according to the Guttmacher analysis, women at risk of having a repeat abortion share many of the same characteristics as women at risk of having a repeat unintended birth, including age, number of prior births, and race and ethnicity. The associations with race and ethnicity, as well as poverty, are particularly striking among women having repeat unintended births: Almost half of black women and about 40% of poor and low-income women have had at least one unintended birth.

Indeed, unintended births are as common among U.S. women as is abortion: Almost one-third of all women aged 15–44 report having had at least one unintended birth. A minimum of four in 10 women of reproductive age have had at least one unintended pregnancy, whatever the outcome. Accordingly, as stated in the Guttmacher report, “it is possible, if not likely, that women who have had a prior abortion have also had other unintended pregnancies, some of which they carried to term.”

Clearly, more effective contraceptive use would help women reduce their risk of unintended pregnancy, which in turn would lead to fewer abortions (including fewer repeat abortions) and fewer unintended births. To improve contraceptive use, a woman first needs good counseling, which will increase her chances of selecting the contraceptive method that is right for her at that particular time in her life. Then she needs easy and affordable access to her chosen method and to the necessary services to support her choice

over time. Although having good access to contraceptive services is important for all sexually active women, it seems especially important for women having abortions and women giving birth (whether intended or unintended), who constitute a self-selected group—perhaps a high-risk one at that.

### **Walls of Separation**

From the time that the U.S. Supreme Court legalized abortion nationwide in 1973, antiabortion activists inside and outside government turned their attention to making abortion services harder to obtain, rather than on making the unintended pregnancies that precede almost all abortions less likely. A central component of that effort, based on the notion that family planning clinics serve as funnels for abortion clinics, has been a doggedly pursued campaign to erect “walls of separation” between the two. At both the state and federal levels with varying degrees of success, antiabortion activists have sought to block organizations that receive public funds for family planning from providing problem pregnancy counseling that includes any discussion of the option of abortion, making abortion referrals even upon direct request, engaging in abortion rights advocacy and providing abortion services at all.

A spate of such separation requirements were enacted at the state level in the late 1970s but were blocked by the courts. With the election of Ronald Reagan in 1981, activists turned to the

## State 'Walls of Separation' Between Abortion and Contraceptive Services: Laws Currently in Effect

### Colorado, Ohio and Pennsylvania

*These three states have similar laws that ban the use of state funds for abortion counseling or referral. But they go far beyond that: They also disqualify entities from receiving any state family planning funds unless strict physical and financial separation exists between the family planning services and any abortion-related services. In*

*Pennsylvania, hospitals and physicians participating in the Medicaid program are exempt from the requirement, however, leaving the law to apply mainly to Planned Parenthood affiliates.*

### Michigan

*Michigan, likewise, bans any state funds from being used to counsel or refer for abortion, but Michigan has employed a unique twist to punish entities that use other funds for these purposes. Under Michigan's separation law, recipient agencies are ranked according to how many abortion-related "demerits" they*

*have, with state and federal funding priority going to those with the fewest demerits. The offending activities include: providing abortion services (except to save a woman's life or in cases of rape or incest), providing abortion referrals, or maintaining in writing that "abortion is considered part of a continuum of family planning or reproductive health services."*

### Texas

*In December 2006, the Texas Department of State Health Services received approval from the federal government to increase access to and participation in family planning services under the state's Medicaid program. The Texas legislature authorized the health department's waiver application, but not before adding a condition prohibiting any providers from participating in the Medicaid family planning expansion program that also "perform or promote elective abortions."*

federal government and set their sights first on U.S. foreign policy, over which the president is given significant discretion. In 1984, the Reagan administration unveiled the "Mexico City" policy (named for the location of the international population conference at which it was first announced), which did not require congressional approval or even authority. The policy disqualifies indigenous organizations in developing countries from eligibility for U.S. family planning aid if they use other, non-U.S. government funds to provide abortions or abortion-related counseling, referrals or advocacy. In 1993, President Clinton rescinded the policy, which has come to be widely known as the global gag rule, but President Bush reimposed it in 2001.

Having successfully restricted international family planning programs, the Reagan administration in

1987 issued a similar gag rule for the Title X domestic family planning program. That regulation banned the "nondirective" problem pregnancy counseling that had been required in Title X programs, as well as abortion referrals for women who request them; it also called for physical and financial separation between a federally funded contraceptive services program and any privately funded abortion service. The courts blocked the domestic gag rule from going into effect until the U.S. Supreme Court upheld its constitutionality in 1991. The policy, however, was never fully implemented, and on his first day in office in January 1993, Clinton cancelled it (along with its international counterpart).

Just before leaving office, the Clinton administration replaced the Reagan-era regulation with guidelines that restored Title X's mandate to provide nondirective counseling and abortion referrals on request, but even these

guidelines require Title X project activities to be "separate and distinguishable" from abortion-related services. In the intervening years, moreover, several states—notably, Colorado, Michigan, Ohio, Pennsylvania and Texas—have picked up where the federal government left off and have enacted laws or polices going much further than the Title X guidelines (see box).

### Realities on the Ground

The putative goal of federal and state separation requirements is to sever ties going from family planning clinics to abortion providers. Indisputably, however, the consequences—both direct and indirect—have meant severed ties going in the other direction as well.

Both the National Abortion Federation (NAF) and Planned Parenthood Federation of America make

clear through their respective clinical guidelines that an integral component of postabortion care includes the provision of information about contraception, as well as a contraceptive method, if requested. However, most free-standing abortion clinics (as opposed to Planned Parenthood clinics that also provide abortions), are not set up to provide ongoing, comprehensive contraceptive care. Rather, they have come to specialize in providing abortion-related care in response to the need that has arisen for this single-service approach. The reasons for this are several and interrelated, including the historic isolation of abortion services and providers by the “mainstream” health care system; the stigma associated with abortion, which deters women from wanting to return for ongoing health care; and the long distances many women must travel just to find an abortion provider.

Basically, free-standing clinics are not comprehensive reproductive health care providers because of the lack of demand from their clients and because the existing providers, for better or worse, are doing all they can to keep up with the demand for abortion services. According to Rachel Falls, who directs NAF’s abortion hotline, “a woman may be very pleased with the care she receives at the abortion clinic, but she is not

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there to build a relationship.” Certainly, the stigma many women feel about having an abortion—emanating from family, friends, church, society at large or even themselves—can be a significant impediment to their wanting to return more than necessary.

Compounding the problem is the fact that the declining number of abortion providers has meant increasing numbers of women must travel longer distances to find one. For example, in the case of the free-standing Hope Clinic for Women in Granite City, Illinois, more than half of the clients travel over 50 miles for abortion services, according to executive director Sally Burgess. The further a woman must travel (or for

confidentiality reasons chooses to travel) to reach an abortion provider, the less practical it would be for her to consider that clinic for her regular source of reproductive health care.

However, comprehensive models do exist, overwhelmingly among Planned Parenthood clinics. The Boulder Valley Women’s Health Center in Colorado is a rare example of a comprehensive clinic not affiliated with Planned Parenthood that provides abortion services as well as Title X–funded contraceptive services. Executive Director Susan Levy observes that some abortion providers who might consider creating a family planning program are dubious about participating in Title X because of suspicion that the government rules would impinge on the quality of their abortion services program. Levy has managed to juggle both, she says, largely because she is operating in a favorable local political climate and because she has been able to garner additional public funding for her family planning program from local sources.

Like the many Planned Parenthoods that both offer abortion services and operate Title X family planning programs, Boulder Valley has a strong commitment to overcoming political obstacles to make the system work for women as much as

possible. Participating in the Title X program, however, does carry a cost. Levy notes, for example, that women who obtain an abortion at her agency must have a separate chart if they later return for ongoing, Title X–funded contraceptive services. The agency must scrupulously segregate the funds it uses for its abortion services and its Title X program.

Clearly, none of this promotes what should be an overriding interest in ensuring continuity of care, especially in the direction of helping a woman decrease her chances of having another abortion. “If only we didn’t have these barriers,” Levy explained, “we would be able to provide a low-income abortion patient with an appropriate and

subsidized method of birth control on the spot, instead of her having to return for another appointment at our Title X clinic. We are operating our abortion clinic from a prevention mindset,” she continued, “and that comes from being a family planning provider at the same time.”

### **Government’s Role, for Good or Ill**

Lebanon Valley Health Services in central Pennsylvania has been operating a prenatal clinic and a Title X–supported contraceptive services program at the same site since 1990. The agency’s goal is two-fold: to facilitate early entry into prenatal care to improve pregnancy outcomes, and to ensure that their prenatal care clients, when returning for their postpartum visits, have direct access to a source of ongoing birth control information, services and support. The American College of Obstetricians and

countries tell us that the United States can do much better than it is doing now. Indeed, it is challenging enough to design an approach to providing preventive health care that makes it easier for women—especially young and disadvantaged women—to be effective contraceptive users when life’s other, more immediate priorities, such as housing, food, jobs and child care, often push contraception to the bottom of the list. The negative political climate surrounding abortion, contraception and sexuality in general in the United States does not help the situation.

Certainly, not every abortion provider needs to become a provider of comprehensive contraceptive services, or of Title X–supported subsidized services for low-income women. But the historic isolation of abortion and abortion providers, which impedes continuity of care from abortion

### ***The historic isolation of abortion and abortion providers, which impedes continuity of care from abortion to contraception and which is reinforced by long-standing government policy, is clearly counterproductive.***

Gynecologists and the American Academy of Pediatrics encourage this approach. The federal Department of Health and Human Services embraces it too, noting in *Healthy People 2010*—the nation’s official public health objectives—that “health care providers can help all new mothers understand that they can become pregnant again soon after delivery and should assist them with contraceptive education and supplies.” By contrast, the federal government insists on separation between abortion and publicly subsidized contraceptive services.

This is short-sighted, at best. The fact is that for many if not most women, using contraceptives consistently and effectively over decades is not easy. But the records of other industrialized

to contraception and which is reinforced by long-standing government policy, is clearly counterproductive. Indeed, to the extent women are able to avail themselves of the services they need to help them prevent an unintended pregnancy, they benefit and society does too. This applies whether it is their first or a subsequent pregnancy and whether they are seeking services at an abortion clinic, in a postpartum care setting or at a family planning clinic. U.S. culture, politics and the health care system are all factors in how well this can ever work, but government has an important role to play as well. Ideally, it should be facilitating the linkages among these reproductive health and pregnancy-related services and providers. At a minimum, it should get out of the way. [www.guttmacher.org](http://www.guttmacher.org)