

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Beth Nolan et al. to POTUS re: Carhart v. Stenberg (3 pages)	03/13/2005	P5
002. memo	John Hitley et al. to POTUS re: "Partial-Birth" Abortion (6 pages)	4/10/1997	P5

COLLECTION:

Clinton Presidential Records
 Domestic Policy Council
 Bruce Reed (Subject File)
 OA/Box Number: 21199

FOLDER TITLE:

Abortion

rs34

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE
WASHINGTON

Date 3/14/00

To: PODESTA, ECHAVESTE, B. REED

Abortion

From: The Staff Secretary

COUNSEL HAS ASKED THAT
PODUS GET THIS BEFORE
THE TRIP. ANY COMMENT?

~~3/14~~

Eric L.

Withdrawal/Redaction Marker

Clinton Library

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**This marker identifies the original location of the withdrawn item listed above.
For a complete list of items withdrawn from this folder, see the
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THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS
HOUSE LIAISON
--FAX COVER SHEET--

Abortion

DATE: 9-9-99

TO: Bruce Reed

FAX: 6-2878

FROM: CHUCK BRAIN
 BRODERICK JOHNSON
 JOSH ACKIL
 BROOKE LIVINGSTON

AL MALDON
 LISA KOUNTOUPES
 JANELLE ERICKSON

(202)456-6620 (TELEPHONE)
(202)456-2604 (FAX)

SUBJECT: This is the base Republican test.

**SUBCOMMITTEE AMENDMENT IN THE NATURE OF
A SUBSTITUTE TO H.R. 2436
[AS APPROVED BY THE SUBCOMMITTEE ON THE
CONSTITUTION 5 AUG 1999]**

Strike all after the enacting clause and insert the following:

1 SECTION 1. SHORT TITLE.

2 This Act may be cited as the "Unborn Victims of Violence Act of 1999".

4 SEC. 2. PROTECTION OF UNBORN CHILDREN.

5 (a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 90 the following:

**7 "CHAPTER 90A—PROTECTION OF UNBORN
8 CHILDREN**

"Sec.
"1841. Protection of unborn children.

9 "§ 1841. Protection of unborn children

10 "(a)(1) Whoever engages in conduct that violates any
11 of the provisions of law listed in subsection (b) and thereby
12 causes the death of, or bodily injury (as defined in section
13 1365) to, a child, who is in utero at the time the conduct
14 takes place, is guilty of a separate offense under this section.
15 tion.

16 "(2)(A) Except as otherwise provided in this paragraph,
17 the punishment for that separate offense is the

1 same as the punishment provided under Federal law for
2 that conduct had that injury or death occurred to the un-
3 born child's mother.

4 “(B) An offense under this section does not require
5 proof that—

6 “(i) the person engaging in the conduct had
7 knowledge or should have had knowledge that the
8 victim of the underlying offense was pregnant; or

9 “(ii) the defendant intended to cause the death
10 of, or bodily injury to, the unborn child.

11 “(C) If the person engaging in the conduct thereby
12 intentionally kills or attempts to kill the unborn child, that
13 person shall be punished as provided under sections 1111,
14 1112, and 1113 of this title for intentionally killing or at-
15 tempting to kill a human being.

16 “(D) Notwithstanding any other provision of law, the
17 death penalty shall not be imposed for an offense under
18 this section.

19 “(b) The provisions referred to in subsection (a) are
20 the following:

- 21 “(1) Sections 36, 37, 43, 111, 112, 113, 114,
22 115, 229, 242, 245, 247, 248, 351, 331, 344(d), (f),
23 (h)(1), and (i), 924(j), 930, 1111, 1112, 1113,
24 1114, 1116, 1118, 1119, 1120, 1121, 1153(a),
25 1201(a), 1203, 1365(a), 1501, 1503, 1505, 1512,

1 1513, 1751, 1864, 1951, 1952(a)(1)(B), (a)(2)(B),
2 and (a)(3)(B), 1958, 1959, 1992, 2113, 2114, 2116,
3 2118, 2119, 2191, 2231, 2241(a), 2245, 2261,
4 2261A, 2280, 2281, 2332, 2332a, 2332b, 2340A,
5 and 2441 of this title.

6 "(2) Section 408(e) of the Controlled Sub-
7 stances Act of 1970 (21 U.S.C. 848(e)).

8 "(3) Section 202 of the Atomic Energy Act of
9 1954 (42 U.S.C. 2283).

10 "(c) Nothing in this section shall be construed to per-
11 mit the prosecution—

12 "(1) of any person for conduct relating to an
13 abortion for which the consent of the pregnant
14 woman has been obtained or for which such consent
15 is implied by law in a medical emergency;

16 "(2) of any person for any medical treatment of
17 the pregnant woman or her unborn child; or

18 "(3) of any woman with respect to her unborn
19 child.

20 "(d) As used in this section, the term 'unborn child'
21 means a child in utero, and the term 'child in utero' or
22 'child, who is in utero' means a member of the species
23 homo sapiens, at any stage of development, who is carried
24 in the womb."

1 (b) CLERICAL AMENDMENT.—The table of chapters
2 for part I of title 18, United States Code, is amended by
3 inserting after the item relating to chapter 90 the follow-
4 ing new item:

“90A. Protection of unborn children 1841”.

5 **SEC. 3. MILITARY JUSTICE SYSTEM.**

6 (a) PROTECTION OF UNBORN CHILDREN.—Sub-
7 chapter X of chapter 47 of title 10, United States Code
8 (the Uniform Code of Military Justice), is amended by in-
9 serting after section 919 (article 119) the following new
10 section:

11 **“§ 919a. Art. 119a. Protection of unborn children**

12 “(a)(1) Any person subject to this chapter who en-
13 gages in conduct that violates any of the provisions of law
14 listed in subsection (b) and thereby causes the death of,
15 or bodily injury (as defined in section 1365 of title 18)
16 to, a child, who is in utero at the time the conduct takes
17 place, is guilty of a separate offense under this section.

18 “(2) The punishment for that separate offense is the
19 same as the punishment provided for that conduct under
20 this chapter had the injury or death occurred to the un-
21 born child’s mother, except that the death penalty shall
22 not be imposed.

23 “(b) The provisions referred to in subsection (a) are
24 sections 918, 919(a), 919(b)(2), 920(a), 922, 924, 926,

1 and 928 of this title (articles 118, 119(a), 119(b)(2),
2 120(a), 122, 124, 126, and 128).

3 “(c) Subsection (a) does not permit prosecution—

4 “(1) for conduct relating to an abortion for
5 which the consent of the pregnant woman has been
6 obtained or for which such consent is implied by law
7 in a medical emergency;

8 “(2) for conduct relating to any medical treat-
9 ment of the pregnant woman or her unborn child; or

10 “(3) of any woman with respect to her unborn
11 child.

12 “(d) In this section, the term ‘unborn child’ means
13 a child in utero.”

14 (b) CLERICAL AMENDMENT.—The table of sections
15 at the beginning of such subchapter is amended by insert-
16 ing after the item relating to section 919 the following
17 new item:

“919a. 119a. Protection of unborn children.”

Bruce --

w/ Q's groups

Jen Palmieri is fine with leaking to Judy Haveman. The paper and q and a are attached. You should also tell her that the Vice President and First Lady are meeting with family planning advocates to discuss the increased family planning money in the budget. The VP's office feels very strongly that we mention this when you do the leak. You should NOT mention that the First Lady will address NARAL. By the way, the actual anniversary is tomorrow, not today.

Jen

Abortion -
Clinic
Violence

Combating Clinic Violence

In the wake of escalating violence against women's health clinics that provide abortions and their doctors and nurses, the President's FY 2000 budget will include \$4.5 million to support additional security for these clinics. Under this proposal, the Department of Justice would make security assessments and enhancements available to clinics deemed to be at high risk of violence. Security enhancements to improve safety and better protect health care providers and their patients might include closed circuit camera systems, improved lighting, motion detectors, alarm systems or bullet-resistant windows.

In recent years, violence against women's health care clinics has intensified. Most recently, Dr. Bernard Slepian was fatally shot through the window of his home. His death followed four non-fatal shootings in western New York and Canada over the last four years. In addition to shootings, between May and July of this year, about 20 health care clinics in three states were splattered with isobutyric acid, and two clinics in North Carolina were the victims of arson and attempted bombings. Clinics in Indiana, Tennessee, Kansas and Kentucky received letters that falsely claimed to contain anthrax.

This FY 2000 budget proposal builds on the Justice Department's National Task Force on Violence Against Health Care Providers announced on November 9 to coordinate the investigation of violence against women's health care clinics nationwide. The Task Force has begun working closely with local authorities and U.S. Attorneys investigating acts of violence against clinics by: coordinating national investigative efforts; creating an investigative clearinghouse for information related to clinic violence; helping to identify clinics at immediate risk and determining whether law enforcement protection is required; and providing training to federal, state and local law enforcement personnel. A key missing piece in preventing clinic violence is funding for greater security. The Task Force will serve in an advisory capacity for the administration of these funds.

496 3936

Q AND A ON CLINIC SECURITY FUNDING

January 14, 1999

Q. What will this money do?

A. The Administration's FY2000 budget request includes \$4.5 million for DOJ's Office of Justice Programs to provide security assessments and, where necessary, security improvements to women's health care clinics at high risk of violence. A security assessment is a review of a facility by a security expert to identify vulnerabilities and recommend ways to address them. Security improvements can include measures like closed circuit camera systems, improved lighting, motion detectors, alarm systems, bullet-resistant windows, and access control systems.

Q. How many clinics will receive security assessments, and how will you choose which ones to review?

A. Initial estimates suggest that \$4.5 million could address security review and improvement needs for approximately 250-300 clinics (approximately 10% of all clinics nationwide). In determining which clinics to review, we will draw upon the threat assessment criteria first developed by the U.S. Marshals Service.

Q. Will the money go directly to clinics themselves?

A. No. Consistent with the approach taken with similar initiatives, the Office of Justice Programs will work with a contractor with expertise in relevant security issues to perform the assessments and provide the security equipment deemed necessary.

Q. How does this relate to the Attorney General's Task Force on Violence Against Health Care Providers?

A. This proposal builds on the Justice Department's National Task Force on Violence Against Health Care Providers announced on November 9 to coordinate the investigation of violence against women's health care clinics nationwide. The Task Force has begun working closely with local authorities and U.S. Attorneys investigating acts of violence against clinics by: coordinating national investigative efforts; creating an investigative clearinghouse for information related to clinic violence; and providing training to federal, state and local law enforcement personnel. A key missing piece in preventing clinic violence is funding for greater security. The new initiative will be administered by the Office of Justice Programs, and the Task Force, given its expertise on clinic violence, will serve as an advisor to the project.

Q. Why are you providing government support for security review and improvements when you don't do the same thing for banks, which are also at risk of criminal activity?

A. Health care clinics' vulnerability to violence is in many ways similar to the recent spate of church arsons. Churches, like clinics, have been the objects of hate-inspired violence, and that is why the Administration has provided support to them. In addition, churches and health care clinics or doctor's offices -- unlike banks, for example -- are not traditionally targets of criminal activity and are not, therefore, designed and built with security concerns foremost in mind.

Second, clinic violence raises additional law enforcement concerns because law enforcement officers have in some clinic cases become targets of secondary devices. For example, the clinic bombing in Birmingham was followed by the detonation of a second bomb -- apparently designed to explode upon the arrival of law enforcement -- which killed an officer.

ABORTION
cc: EK

Status as of: August 5, 1998

ABORTION-RELATED PROVISIONS IN FY 1999 APPROPRIATIONS BILLS

AGRICULTURE/RURAL DEVELOPMENT

Status:

- o Passed the Senate on 7/16/98, 97-2. Passed the House 6/24/98, 373-48.

Provisions:

- o FDA Drug Research Restrictions:
 - House. Section 739 prohibits the FDA from using funds for the testing, development, or approval of any drug for the chemical inducement of abortion (the Coburn (R-OK) amendment). This provision would intervene in the drug safety practices of the FDA and place restrictions on scientific research that can protect women's health and offer safe medical choices. (This is a new provision in the FY 1999 bill.)
 - Senate. The Senate bill contains no similar provision.

COMMERCE/JUSTICE/STATE

Status:

- o Passed the Senate 7/23/98, 99-0. House Full Committee reported the bill 7/15/98.

Provisions:

- o Abortions for Federal Prisoners:
 - House. Section 103 of the House bill would prohibit the Department of Justice (DOJ) from funding abortions except in the case of rape or where the life of the mother is endangered. (This provision is current law contained in the FY 1998 Act.) A DeGette (D-CO) amendment to strike the provision was defeated on the House Floor, 148-271.

- Senate. Section 102 of the Senate bill contains the same prohibition as the House bill on the use of DOJ funds regarding abortions.

o U.N. Arrears/Mexico City:

- House. The House bill includes the requested arrears payment of \$475 million, but the funds remain unavailable subject to authorization. The authorization conference report contains Mexico City family planning language that prohibits international family planning organizations that receive Federal funding from performing or lobbying for abortions even if these organizations use their own funds. (Arrearage payments contained in the FY 1998 Act were also subject to authorization.)
- Senate. The Senate bill contains similar language.

DEFENSE

Status:

- o Passed the Senate 7/30/98, 97-2. Passed the House 6/24/98, 358-61.

Provisions:

- o Forced Abortion:
 - House. The House bill does not address this issue.
 - Senate. An amendment to prohibit visas to Chinese officials involved in forced abortions, forced sterilizations, or religious persecution was adopted on the Floor. (This is a new provision.)

DISTRICT OF COLUMBIA

Status:

- o The bill was reported by the House Committee on July 30th. The bill was reported by the Senate Committee on July 21st.

Provisions:

- o Use of Federal and District Funds:
 - House. Section 132 of the House bill prohibits any of the funds under the Act (Federal or District) from being used for any abortion except where the life of the mother would be endangered if the fetus were carried to term or where the pregnancy is the result of an act of rape or incest. (This is current law contained in the FY 1998 Act.)
 - Senate. Section 129 of the Senate Committee bill contains language identical to the provision of the House bill.

NOTE: The language of the FY 1999 bill is the same language used since FY 1996. In FY 1994 and FY 1995, the restriction on funding for abortions only applied to Federal funds, not local funds.

FOREIGN OPERATIONS

Status:

- o Senate Full Committee reported the bill 7/21/98. House Subcommittee marked up the bill on 7/15/98.

Provisions:

- o "Mexico City" Language:
 - House. As in previous years, it is anticipated that Rep. Chris Smith (R-NJ) will offer an amendment on the House Floor that would prohibit Federal funding to organizations that perform or lobby for or against abortions, even if these organizations use their own funds.

Last year, the President threatened to veto the FY 1998 Foreign Operations bill if it included the "Mexico City" provision. The enacted bill did not include the provision but had a limitation of \$385 million on total population spending from foreign aid accounts and "metering" of obligation of the funds at one-twelfth of the total available per month.

- Senate. The Senate Committee bill has no comparable provision.

o Other Family Planning:

- House. In section 518 of the General Provisions, the House bill contains language that bars the use of funds appropriated in the bill for performance of abortion or involuntary sterilization as a method of family planning, or for lobbying for or against abortion. (This is current law contained in the FY 1998 Act.) The Administration supports this language. There is, however, a limitation of \$385 million on family planing funding.

In Subcommittee, a Pelosi (R-CA) amendment was adopted, 8-7, restoring language to the bill that has been included for many years, concerning "natural family planning." The amendment restores language that requires family planning organizations that do not offer certain types of family planning services to provide referrals for or information on access to such services to any client seeking such information.

- Senate. Section 518 of the Senate Committee bill contains language identical to that of section 518 of the House bill. The Senate bill also contains appropriations language (under the "Development Assistance" heading) requiring that not less than \$435 million of Development Assistance funds be spent on family planning.

o Peace Corps:

- House. The Subcommittee bill would bar any Peace Corps funds from being used to pay for abortions. (This provision is current law contained in the FY 1998 Act.)
- Senate. The Senate Committee bill includes the same language.

LABOR/HHS/EDUCATION

Status:

- o House Full Committee reported the bill on July 14th. Senate action expected in September.

Provisions:

- o Medicare + Choice program:
 - House. A manager's amendment offered by Rep. Porter (R-IL) was adopted in Committee that would prohibit funding for the Medicare + Choice program if HHS excludes health care providers that do not offer abortion services from participating in the Medicare + Choice program. The provision would require the plan to inform enrollees where to obtain information about all Medicare-covered services and would reduce payments to Medicare + Choice program plans not providing these services. (This is a new provision in the FY 1999 bill.)
 - Senate. No action to date.
- o Use of Federal Funds for Embryo Research:
 - House. Funds are prohibited for creation of embryos for research purposes, i.e., research in which a human embryo is destroyed, discarded, or knowingly subjected to risk or injury. (This provision is current law contained in the FY 1998 Act.)
 - Senate. No action to date.
- o Family Planning:
 - House. The House Committee bill requires family planning grantees either to receive written parental consent or provide advance notification to parents before giving contraceptives to minors. Participating clinics are required to certify compliance to HHS. The House bill also requires clinics to follow State laws regarding notification or reporting of child abuse, incest, rape, or other sexual abuse. (The FY

1998 Act did not include provisions regarding parental consent or advance notification. Other provisions regarding compliance certification, and adherence to State laws are current law included in the FY 1998 Act).

- Senate. No action to date.

o Hyde-Amendment Language:

- House. Both sections 508 and 509 of the bill include provisions maintaining current law "Hyde" language barring the use of funds in the Act for abortions. New language extends this ban to all trust fund appropriation accounts in the Act. The bill contains language that prohibits the use of Medicaid funding for abortions except in cases of rape, incest, or when the life of the mother is endangered.

- Senate. No action to date.

TREASURY/GENERAL GOVERNMENT

Status:

o Senate Floor debate on the bill began 7/28/98 but was postponed on 7/30/98 until after the August recess. Passed the House 7/16/98, 218-203.

Provisions:

o Federal Employees Health Benefits Program (abortion):

- House. The House-passed bill includes language (section 508) that prohibits Federal Employees Health Benefits Program (FEHBP) coverage of abortions, with no exceptions. DeLauro (D-CT) amendments to strike the restrictive language were defeated during Committee and Floor consideration. Section 515, the provision of the Committee bill that included exceptions to the restriction (rape, incest, life of the mother), was struck on the House Floor on a point of order for lack of authorization.

- Senate. The Senate bill includes an amendment adopted on the Senate Floor that would reinstate objectionable current law restrictions on FEHBP coverage for abortion services. This amendment also includes a provision allowing for rape, incest, life-of-the-mother exceptions.

- o Federal Employees Health Benefits Program (contraceptives):

- House. A Lowey (D-NY) amendment (section 624 -- similar to section 516 language of the Committee bill but written only as a funding issue) to require FEHBP insurers to cover prescription contraceptives (with exceptions for certain religiously oriented plans) was adopted on the House Floor, 224-198. A Smith amendment to exclude abortion-inducing chemical contraceptive prescriptions from the Lowey amendment was defeated 198-222.

- Senate. A Snowe (R-ME)/Reid (D-NV) amendment requiring FEHBP coverage of prescription contraceptives was adopted during Senate Floor consideration, including a second-degree amendment to clarify that nothing in the amendment is to be construed to apply to abortion or abortion-related services.

Susan Bonfield Herschkowitz

1741 Lanier Place NW * Suite 24 * Washington, DC 20009
202/387-5233

(EK)

MEMORANDUM

To: Friends, Colleagues and Interested Individuals
From: Susan Bonfield
Date: July 25, 1997
Re: Client Statement on the American Medical Association.

Recently, the American Medical Association's House of Delegates reluctantly supported its Board of Trustees endorsement of federal legislation banning dilatation and extraction, a late abortion procedure.

The enclosed statement was prepared on behalf of a client, Physicians for Reproductive Choice and Health, in response to the AMA's endorsement.

Please feel free to share the statement to pro-choice individuals you know who plan to participate in the upcoming elections. And do not hesitate to contact me at 202/387-5233 should you wish additional information.

Hope all is well!

For Bruce
FYI
from
Mickey
Ibarra
7/30/97



Physicians for Reproductive Choice and Health
**Statement On The
American Medical Association Support
of Legislative Efforts
Banning Dilatation and Extraction**

In recent years, the American Medical Association (AMA) has taken critical steps to improve the quality and access of health care for women throughout the nation. Physicians for Reproductive Choice and Health therefore must express its alarm and dismay over recent actions by the AMA that pave the way for a new and growing disrespect for women's reproductive health and lives.

At its June 1997 assembly, the AMA House of Delegates regrettably chose to support the AMA's Board of Trustees endorsement of legislative efforts banning a medical procedure known as dilatation and extraction. A recent in-depth internal study commissioned within AMA recommended the organization reaffirm its current policy on abortion, which stated that abortion is a matter between the patient and her physician. However, the AMA has agreed that elected legislatures have the right to restrict medical care available to women facing health- and life-threatening medical complications.

The AMA's action makes unavailable to physicians and their women patients a safer, less risky medical option during health- and life-threatening events that can occur during pregnancy. Annually, 300 to 600 third trimester post-viability pregnancies are terminated legally for specific medical complications posing severe health and life threats to the woman - including infertility and death. When maternal complications develop, these pregnancies are terminated only after attempts are made to deliver the fetus safely while preserving the health and life of the mother. The severity of these complications may make labor or caesarean section fatal.

Approximately one percent of all legal abortions occur late in the second trimester before fetal viability. Some are performed on women facing medical complications that develop during pregnancy. Other women carry fetuses with serious genetic or developmental anomalies not detected until the second trimester. Some women who lack health insurance and access to healthcare facilities are unaware they are pregnant or unable to terminate the pregnancy earlier. For some of these women, dilatation and extraction is the safest medical option because the fetal head is disproportionately large and trapped in the dilated cervix during delivery.

Banning dilatation and extraction will force competent physicians to choose riskier medical options that increase danger to patients. For women, these options are lengthy and painful, including the placement of surgical instruments into the uterus, increasing the risk of uterine perforation and infertility. Another option uses medication to induce labor, increasing the risk of maternal death from blood clotting failure and hemorrhage.

As physicians, we are ethically obligated to protect, preserve and assure the health of our women patients. We are gravely concerned that our government would prohibit women from choosing the safest and most appropriate medical care during unfortunate, threatening medical circumstances. AMA support of any state or federal legislation that politicizes, criminalizes and restricts access to medical care compromises the medical profession and is truly misguided and irresponsible.

- Steph 230
- 455 Columbus Ave
- New York, NY
- 10017
- TEL: (212) 876-1118
- FAX: (212) 876-1170
- RECEIVED
- Richard J. Berkman, M.D.
- Norm D. Fink, M.D.
- Wanda Finkler, M.D., M.P.H.
- Charles S. D. ... M.D.
- Marcia ... M.D.
- Elizabeth ... M.D.
- Robert ... M.D.
- Bern ... M.D.
- Howard ... M.D.
- Elizabeth ... M.D.
- Marcia ... M.D.
- Stephanie ... M.D.
- Dr. ... M.D., F.R.C.
- William ... M.D.
- Ellen ... M.D.
- Richard ... M.D.
- Christina ... M.D.
- Joseph ... M.D., M.P.H.
- 1st Floor
- Executive Director

(7/97)

THE WHITE HOUSE
WASHINGTON

MEMORANDUM FOR: SYLVIA MATTHEWS
JOHN PODESTA
RAHM EMANUEL
JOHN HILLEY
MELANNE VERVEER
VICKI RADD
CHUCK RUFF

FROM: BRUCE REED
ELENA KAGAN

SUBJECT: LATE TERM ABORTION LETTER

Attached is a draft letter from the President stating his support for the Daschle and Feinstein amendments. Assuming the President signs off, we recommend sending the letter as soon as possible.

Dear Senators Daschle and Feinstein:

I am writing to express support for your amendments prohibiting late-term abortions. If Congress were to substitute either of these amendments for the current H.R. 1122, I would sign the legislation.

As you know, I have long opposed late-term abortions, and I continue to do so except where necessary to save the life of a woman or prevent serious harm to her health. When I was Governor of Arkansas, I signed into law a bill that barred third-trimester abortions, with an appropriate exception for life or health. And last year, I made clear that I would sign such a bill at the federal level.

Your amendments, though differing in detail, both meet the standards I have set for such legislation. The amendments contain exceptions that will adequately protect the lives and health of the small group of women in tragic circumstances who need an abortion at a late stage of pregnancy to avert death or great injury. At the same time, the amendments prohibit any late-term abortions performed for elective reasons. This balance is an appropriate one, which I -- and, I believe, most Americans -- would gladly make the nation's law.

Sincerely,



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 17, 1997

MEMORANDUM FOR SYLVIA MATHEWS
JOHN PODESTA
JOHN HILLEY
✓ BRUCE REED
ELENA KAGAN

FROM: Nancy-Ann Min. *NAM*

SUBJECT: H.R. 929--"Partial Birth Abortion Ban Act of 1997"

There are two items relating to the above bill that may require your attention early this week. First, I have attached a draft Statement of Administration Position (SAP) that OMB's Legislative Reference Division prepared. It is based on the SAP we did on last year's version of this bill, which as some of you will recall, was drafted by the President himself. (I've also attached last year's SAPs for your reference).

If, as was rumored late last week, the bill does go to the House Floor Tuesday or Wednesday, we'll have to decide whether to send a SAP. I have not circulated this draft around to the agencies as we would normally do; instead, I would appreciate your letting me know how you want to handle this.

Second, Chairman Hatch has asked Justice to provide its views on the bill. I have attached a draft letter that Justice would like to send. They have asked for clearance by the end of today. Please let me know how you want to handle this as well.

cc: The Director

~~Did you stop
the DOJ letter?~~
BR
Yes
File:
Abortion

DRAFT -- NOT FOR RELEASE

March 13, 1997
(House)

H.R. 929 - Partial-Birth Abortion Ban Act of 1997
(Rep. Canady and 164 cosponsors)

The President believes that the decision to have an abortion should be between the woman, her doctor, and her God -- not the Government. He believes that legal abortions should be safe and rare. The President has long opposed late-term abortions except where they are necessary to protect the life of the mother or where serious health concerns are involved. The President supports limiting late-term abortions, but opposes H.R. 929 because it fails to provide for consideration of the need to preserve the life and health of the mother, consistent with the U.S. Supreme Court's decision in *Roe v. Wade*.

H.R. 929 contains the same serious flaws as H.R. 1833, a virtually identical bill that was passed during the 104th Congress and vetoed by the President on April 10, 1996.

Pay-As-You-Go Scoring

H.R. 929 would affect both direct spending and receipts; therefore, it is subject to the pay-as-you-go requirement of the Omnibus Budget Reconciliation Act of 1990. OMB's preliminary scoring estimate of this bill is zero.

(Do Not Distribute Outside Executive Office of the President)

This Statement of Administration Policy was developed by the Legislative Reference Division (Pellicci) in consultation with . . .

OMB/LA Clearance: _____

H.R. 929

As reported by the House Judiciary Committee on March 12th, H.R. 929 would ban under most circumstances a certain type of late-term abortion procedure, which the bill calls a "partial-birth abortion." H.R. 929 defines the term "partial-birth abortion" to mean any "abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."

H.R. 929 would allow a "partial-birth abortion" in cases where it is needed to "save the life of a mother whose life is endangered by a physical disorder, illness, or injury" This exception, however, is permitted only when no other procedure would suffice. This bill does not include an exception for cases in which the women's health is threatened.

H.R. 929 would subject doctors and others who perform the procedure to criminal fines and/or up to two years of imprisonment. The bill would exempt women who obtain such abortions from any criminal penalties.

Congressional Action on H.R. 1833

Last year the House passed H.R. 1833 by a vote of 288-139 and the Senate passed the bill by a vote of 54-44. The House voted to override the President's veto by a vote of 285-137; the Senate failed to override the President's action by a vote of 57-41.

LEGISLATIVE REFERENCE DIVISION DRAFT
03/13/97 - 2:00 P.M.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

December 6, 1995 (SENT)
(Senate)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

H.R. 1833, Partial-Birth Abortion Ban Act of 1995
(Rep. Canady (R) FL and 115 others)

The President believes that the decision to have an abortion should be between a woman, her conscience, her doctor, and her God. He believes that legal abortions should be safe and rare. The President has long opposed late-term abortions except where they are necessary to protect the life of the mother or where there is a threat to her health, consistent with the law. The Supreme Court has ruled that "Roe forbids a state from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." Therefore, the Administration cannot support H.R. 1833 because it fails to provide for consideration of the need to preserve the life and health of the mother, consistent with the U.S. Supreme Court's decision in Roe v. Wade. If the bill is not amended to rectify these constitutional defects, the Attorney General and the White House Counsel will recommend that the President veto the bill.

* * * * *



U. S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

The Honorable Orrin G. Hatch
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This letter sets forth the views of the Justice Department on S. 6, the "Partial-Birth Abortion Ban Act of 1997," which would ban a particular method of performing an abortion. The bill would criminalize performance of the procedure except where the procedure is "necessary to save the life of a mother" and "no other medical procedure would suffice for that purpose."

In our view, the bill, as currently drafted, suffers from at least two flaws, each of which is sufficient to render the bill unconstitutional. First, with regard to post-viability abortions, the bill does not contain an exception for performance of the procedure in order to preserve the woman's health. Second, with regard to pre-viability abortions, the bill is likely to impose a substantial obstacle to a woman's constitutional right to choose an abortion.

In Planned Parenthood v. Casey, 505 U.S. 833, 846 (1992), the Supreme Court "confirm[ed] . . . the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health." See also id. at 879 (plurality) ("subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."), (quoting Roe v. Wade, 410 U.S. 113, 164-65 (1973)). This means, first, that the government may not deny access to an abortion where necessary to preserve the life of the woman or to preserve the health of the woman. It also means that the government may not regulate access to abortions in a manner that effectively "require[s] the mother to bear an

The procedure described by the bill appears to be a form of "dilation and extraction" abortion, sometimes abbreviated as "D&X." See Women's Medical Professional Corp. v. Voinovich, 911 F. Supp. 1051, 1065-67 (S.D. Ohio 1995).

increased medical risk" in order to serve a State interest. Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 768-69 (1986) (citation omitted) (invalidating requirement that doctor use abortion procedure most protective of fetal life "unless . . . [that procedure] would present a significantly greater medical risk to the life or health of the pregnant woman" because that would require some degree of "trade-off" between woman's health and fetal survival). See also Jane L. v. Bangerter, 61 F.3d 1493, 1502-04 (10th Cir. 1995) (striking down provision that physician use abortion method that "will give the unborn child the best chance of survival" unless that method would cause "grave damage to the woman's medical health," because "Thornburgh's admonition that a woman's health must be the paramount concern remains vital in the wake of Casey") (citations omitted), sum. rev'd in part on other grounds sub nom. Leavitt v. Jane L., 116 S. Ct. 2068 (per curiam), and judgment reinstated in relevant part on remand, 102 F.3d 1112, 1114 n.1 (10th Cir. 1996). In short, even where survival of a viable fetus is at stake, the government may neither prohibit abortions without a health exception nor make them more dangerous to a woman's health.

The government's ability to regulate abortions in the pre-viability context is far more circumscribed. The Supreme Court held in Casey that government regulation before the fetus becomes viable is unconstitutional if it imposes an "undue burden" on a woman's ability to obtain an abortion. See, e.g., Casey, 505 U.S. at 895; id. at 877 (plurality). "Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." Id. at 846.² Under the approach taken in Casey, a regulation is unconstitutional on its face whenever, "in a large fraction of the cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." Id. at 895. This means that the constitutionality of a prohibition must be judged "by reference to

²As the plurality explained:

A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.

Id. at 877.

those for whom it is an actual rather than an irrelevant restriction." Id. at 894-95.³ Applying that test here, the relevant group of cases should be limited to women who would have had their physicians perform the procedure at issue but for the prohibition in S. 6. If, in a large fraction of these cases, the prohibition on the use of the procedure poses a substantial obstacle to the woman's election of an abortion, the prohibition is rendered unconstitutional.

Under S. 6, physicians would face criminal prosecution for using this method of abortion even when they believed it was the safest procedure to use for a particular woman or when it was the only procedure available in the woman's geographical area.⁴ The women for whom S. 6 operates as a relevant prohibition, then, would be prevented from using this procedure where they would otherwise have chosen it, presumably, in consultation with their physicians as the most medically appropriate method for their situations. Therefore, it would appear that the bill is likely to impose an undue burden on not just a "large fraction" but most, if not all, women upon whom it operates as a relevant restriction.

Thank you for the opportunity to present our views on S. 6. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget advises us that

³Casey considered, among other things, the constitutionality of a provision allowing married women to obtain abortions only if their husbands had been notified, with certain exceptions, such as when, for example, the husband could not be located. The Court rejected the State's argument that the provision was not invalid on its face because only "one percent of the women seeking abortions who are married would choose not to notify their husbands of their plans." 505 U.S. at 894. The Court explained that the State had selected the wrong "controlling class" based on which to measure the impact of the restriction. The "real target is narrower . . . it is married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement." Id. at 895. Because for a "large fraction of the[se] cases", the notification requirement imposed a "substantial obstacle" to choosing an abortion, the Court held that it was facially invalid. Id.

⁴In Women's Medical Professional Corp., the District Court concluded, after receiving sworn testimony from several physicians, that physicians were performing D&X abortions because this method appeared to pose less of a risk to a woman's health than any alternative procedure. 911 F. Supp. at 1070.

There is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,

Andrew Foia

cc: The Honorable Patrick J. Leahy
Ranking Minority Member
Committee on the Judiciary

The Honorable John Ashcroft
Chairman
Subcommittee on the Constitution,
Federalism, and Property Rights
Committee on the Judiciary

The Honorable Russ Feingold
Ranking Minority Member
Subcommittee on the Constitution,
Federalism, and Property Rights
Committee on the Judiciary



Abortion
 '97 JAN 13 PM 12:18

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; and
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

continued . . .

STATEMENT ON INTACT DILATATION AND EXTRACTION (continued)

Page Two

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the only option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

Approved by the Executive Board
January 12, 1997

Bruce —

Here's The final ACOG
Statement on partial-
birth. It turned out
a ten better than
expected. I'll let
you know in person
what happened.

Elena

Abortion

WHITE HOUSE STAFFING MEMORANDUM

DATE: 06/23/95 ACTION/CONCURRENCE/COMMENT DUE BY: _____

SUBJECT: PRESIDENTIAL RADIO ADDRESS FOR 06/24 -- VERSION A, B, AND C

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	<input type="checkbox"/>	<input type="checkbox"/>	McGINTY	<input type="checkbox"/>	<input type="checkbox"/>
PANETTA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	NASH	<input type="checkbox"/>	<input type="checkbox"/>
McLARTY	<input type="checkbox"/>	<input type="checkbox"/>	QUINN	<input type="checkbox"/>	<input type="checkbox"/>
ICKES	<input type="checkbox"/>	<input type="checkbox"/>	RASCO	<input type="checkbox"/>	<input type="checkbox"/>
BOWLES	<input type="checkbox"/>	<input checked="" type="checkbox"/>	SEGAL	<input type="checkbox"/>	<input type="checkbox"/>
RIVLIN	<input type="checkbox"/>	<input type="checkbox"/>	SOSNIK	<input type="checkbox"/>	<input type="checkbox"/>
EMANUEL	<input type="checkbox"/>	<input type="checkbox"/>	STEPHANOPOULOS	<input type="checkbox"/>	<input checked="" type="checkbox"/>
GEARAN	<input type="checkbox"/>	<input checked="" type="checkbox"/>	TYSON	<input type="checkbox"/>	<input type="checkbox"/>
GIBBONS	<input type="checkbox"/>	<input type="checkbox"/>	WEBSTER	<input type="checkbox"/>	<input type="checkbox"/>
GRIFFIN	<input type="checkbox"/>	<input type="checkbox"/>	WILLIAMS	<input type="checkbox"/>	<input type="checkbox"/>
HALE	<input type="checkbox"/>	<input type="checkbox"/>	CURRY	<input type="checkbox"/>	<input checked="" type="checkbox"/>
HERMAN	<input type="checkbox"/>	<input type="checkbox"/>	REED	<input type="checkbox"/>	<input checked="" type="checkbox"/>
HIGGINS	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
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MIKVA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
McCURRY	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

REMARKS: _____ FYI

RESPONSE:

JOHN D. PODESTA
Assistant to the President
and Staff Secretary
Ext. 2702

VERSION A

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS TO THE NATION
PINE BLUFF, ARKANSAS
JUNE 24, 1995

95 JUN 23 P7:51

Good morning. Today I'm talking to you from Pine Bluff, Arkansas. I'm proud to have Dr. Henry Foster, who was born here, with me. Just under five months ago, I nominated this good, fine man to be Surgeon General. This week, a majority of the United States Senate was prepared to confirm him as Surgeon General. But he was not confirmed. The Senate was never even allowed to vote on his confirmation because they were blocked by a group of willful Senators who abused procedure for their own political ends.

Let me tell you a little bit about Dr. Foster. He has been a doctor for 38 years, including 3 years in the Air Force. This is a man who has delivered thousands of babies. He has trained hundreds of young doctors. He has ridden dusty country roads in Alabama to bring health care to people who would never have gotten it otherwise.

This is a man who has labored to reduce teen pregnancy, to reduce the number of abortions, to tell kids, without other role models, in a disciplined way: You should not have sex before you're married; you should stay off drugs, stay in school, and do a good job with your life. Dr. Foster's efforts were recognized first, not by me, but by my predecessor, President Bush. Let me tell you something: If more people in America lived their lives like Henry Foster, there would be fewer kids on drugs, fewer abortions, fewer broken families. This is a man America should be very, very proud to call her own.

So why was a group of Senators determined to stop Dr. Foster anyway they could? I'll tell you why. A minority of the Senate blocked a vote on Henry Foster in a calculated move to showcase their desire to take away a woman's right to choose. Dr. Foster has faithfully performed his duty as a doctor for 38 years. And, when the law allowed, the patient requested it, and after counseling when appropriate, he performed an average of about one abortion per year.

The extreme right wing, which wants to impose its moral views on us all, killed this nomination with the help of the Republican leaders, who did as they were told. Now, I know that many Americans oppose abortion. Everyone agrees it's a tragedy. The position I have expressed time and time again is simple: I believe it should be rare, safe, and legal.

This is a difficult and sensitive issue. I just don't think the government has any place in the middle of it. I believe that

most people want the right to make their own choices without politicians telling them what to do.

Unfortunately, some people in this country want the government involved in this intensely personal choice. The outrageous thing is, they're the same people who can usually be found railing against everything that government does.

But even more than their inconsistency, I am troubled that these people seem determined to use this narrow issue to divide Americans one from another. At this moment in our history, facing the challenges and opportunities we face, we need to come together, now more than ever. We are going up or down together, and we cannot let anyone divide us for their own political ends.

It was wrong for people to slur the reputation and distort the record of Dr. Foster in pursuit of their own narrow agenda. They should be ashamed of themselves. Dr. Foster has dedicated his life to better the lives of others. Those who blocked his right to be considered by the Senate did him a disservice, and they did America a disservice.

If people spent less time using abortion to divide the country, and more time following Dr. Foster's example of fighting serious problems like teen pregnancy, we'd all be better off. We need more men and women like Henry Foster, willing to commit their time and energy and love, fighting for our children, our families, and our future.

Thanks for listening.

VERSION B

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS TO THE NATION JUN 23 P7:51
PINE BLUFF, ARKANSAS
JUNE 24, 1995

Good morning. Today I'm talking to you from Pine Bluff, Arkansas. I'm proud to have Dr. Henry Foster, who was born here, with me. Just under five months ago, I nominated this good, fine man to be Surgeon General. This week, a majority of the United States Senate was prepared to confirm him as Surgeon General. But he was not confirmed. The Senate was never even allowed to vote on his confirmation because they were blocked by a group of willful Senators who abused procedure for their own political ends.

Let me tell you a little bit about Dr. Foster. He has been a doctor for 38 years, including 3 years in the Air Force. This is a man who has delivered thousands of babies. He has trained hundreds of young doctors. He has ridden dusty country roads in Alabama to bring health care to people who would never have gotten it otherwise.

This is a man who has labored to reduce teen pregnancy, to reduce the number of abortions, to tell kids, without other role models, in a disciplined way: You should not have sex before you're married; you should stay off drugs, stay in school, and do a good job with your life. Dr. Foster's efforts were recognized first, not by me, but by my predecessor, President Bush. Let me tell you something: If more people in America lived their lives like Henry Foster, there would be fewer kids on drugs, fewer abortions, fewer broken families. This is a man America should be very, very proud to call her own.

So why was a group of Senators determined to stop Dr. Foster anyway they could? I'll tell you why. A minority of the Senate blocked a vote on Henry Foster in a calculated move to showcase their desire to take away a woman's right to choose. Dr. Foster has faithfully performed his duty as a doctor for 38 years. And, when the law allowed, the patient requested it, and after counseling when appropriate, he performed an average of about one abortion per year.

The extreme right wing, which wants to impose its moral views on us all, killed this nomination with the help of the Republican leaders, who did as they were told. This isn't the end of their assault on a woman's right to choose. They're just getting started.

This same week, the House passed an outrageous bill which would prevent women in the military, or at a military base with their servicemen husbands, from getting an abortion at a base hospital -- even if they pay for it themselves. Imagine a servicewoman in a foreign country, in a remote location, without good medical

facilities or a safe blood supply. The House would tell her: Spend thousands of dollars of your own money -- if you can -- and fly back to the U.S. for a safe and legal procedure or risk your life in a hospital far from home. Why? Because she voluntarily enlisted to serve her country. The very suggestion that a woman who is willing to risk her life for her country should have to risk her life for a legal medical procedure is offensive in the extreme.

In a few days, the House will actually try to cut off federal funds for abortions arising from rape or incest. Rape or incest. That's unbelievable. A poor woman could be raped on the street by a vicious criminal and the House wants to deny our help to pay for an abortion even under those circumstances.

The extremists want every woman in every corner of America to toe their line and live by their rules. They'll stop at nothing until they get their way. After this week, it looks like Republican leaders have given these extremists the keys to the store. It seems they'll vote for any bill, oppose any nomination, and allow any intrusion into peoples' lives if they get an order from these extremist groups.

Many Americans oppose abortion. Everyone agrees it's a tragedy. The position I have expressed time and time again is simple: I believe it should be rare, safe, and legal. I know that most people want the right to make their own choices without politicians telling them what to do. If people in Washington spent less time using abortion to divide the country, and more time following Dr. Foster's example of fighting serious problems like teen pregnancy, there would be far fewer abortions in America.

We need more men and women like Henry Foster, willing to commit their time and energy and love, fighting for our children, our families, and our future.

Thanks for listening.

VERSION C

PRESIDENT WILLIAM J. CLINTON,
RADIO ADDRESS TO THE NATION
PINE BLUFF, ARKANSAS

JUNE 24, 1995

95 JUN 23 P7:51

Good morning. I am speaking to you this morning from Pine Bluff, Arkansas. It was here in my home state that I began my quest for the presidency. I ran for President for two big reasons. First, because I wanted to restore the American Dream. I wanted to get the economy going. I wanted to lift stagnant wages, create jobs, and fix the education system so that people could have a way to make the most of their lives. And second, I wanted to bring the country together.

Back in Washington, we're in the midst of a big debate about the best way to do that. Some people argue that America's problems are all social and cultural in origin. They don't think government should play any role in solving them. They want to turn out government's lights and put a "going out of business" sign on the door. They believe that if everybody would just get up, go to work, and obey the law, all our problems would be solved.

On one level, they're absolutely right. No government program can get you out of bed and in to work. No government program can make you good parents. Our problems will never be solved through purely political means -- we must demand more responsibility in America, from all Americans. The old way of looking for a government-sponsored solution to every problem isn't good enough anymore -- and it shouldn't be.

At the same time, it is also true that no one in America -- no one -- got where he or she is today alone. To believe otherwise is foolishness. We must make America stronger so we can make individuals stronger.

I believe we must look beyond this debate, to transform government into a partner with the American people. We must get government out of places where it doesn't belong. But we must also continue to doggedly pursue the things that make America stronger.

For the past two and a half years, I've worked to get this economy going, to deal with the problems of the moment, and to keep our eyes on the long run. When I took office, the government was running a huge deficit and the budget was grossly out of whack. Members of both political parties share the blame for that.

Now, my Administration is already cutting the deficit by over \$1 Trillion over seven years. The budget would be in balance today if it weren't for the interest we pay on the debt run up in the 12 years before I took office. And we're cutting in a way that allows us to increase our investment in the American people:

Expanding education, creating incentives for R&D, encouraging medical research.

Today, we're on the verge of a historic breakthrough. For the first time in a very long time, the leaders of both political parties share the will to balance the budget. The task ahead is for us to seize that will, cast partisanship aside, and get the job done.

We do have real differences. There is no question in my mind that we must balance the budget -- but I don't agree with those who believe we should do it with no regard to the consequences. First of all, there is nothing we can do to help people make the most of their own lives that is more important than education. So even while my plan cuts spending, I increase education -- and I make no bones about it.

Second, I want to control health care costs and strengthen Medicare, not gut it with no thought about how it hurts the elderly. Third, I want to cut taxes for middle-class Americans to help them pay for education and college -- but I won't cut education to pay for a tax cut for wealthy Americans who don't need it. Fourth, I want to save money by cutting welfare and moving people to work, but I don't want to just cut people off or hurt children. That will cost far more money down the road than it will ever save.

Finally, I want to balance the budget over ten years. We could do it in seven years, as some in Congress want. But there's no reason to run the risk of a recession or to sacrifice important investments when we can avoid that by doing it in ten years.

Now don't kid yourselves: balancing the budget won't be a cakewalk. There will be real cuts, and they will cause real pain for just about everybody. But the difference between my plan and congressional plans is the difference between necessary cutbacks and unacceptable pain.

Remember the goal: Restore the American Dream. Promote better jobs and higher incomes. Strengthen families and demand responsibility. If we work together, we can balance the budget the right way, in a way that will be good for all our people.

Thanks for listening.

ABORTION

Child Trends, Inc.

4301 Connecticut Avenue, N.W., Suite 100
Washington, DC 20008
(202) 362-5580
Fax: (202) 362-5533
Bitnet/Internet: childtrends@attmail.com

FAX TRANSMISSION COVER SHEET

Date: 6/23/95

To: Bruce Reed

Fax: 456 - 5557

Tele: _____

Re: _____

Sender: Kris Moore

Project: 135

YOU SHOULD RECEIVE _____ PAGE(S), INCLUDING THIS COVER SHEET.
IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL (202) 362-5580.

Notes: Abortion data are attached.
If you do not have the reports
we just completed for ASPE/DHHS,
I'll be happy to send them over.

*Adolescent Sex,
Contraception, and Childbearing:
A Review of Recent Research*

Kristin A. Moore, PhD
Brent C. Miller, PhD
Dana Gleib, MA
Donna Ruane Morrison, PhD

June 1995

CHILD TRENDS, INC.

4301 Connecticut Avenue, N.W., Suite 100, Washington, DC 20008

Vol. 43, No. 11(S) • May 25, 1995

Monthly Vital Statistics Report



Final Data From the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

Trends in Pregnancies and Pregnancy Rates: Estimates for the United States, 1980-92

by Stephanie J. Ventura, AM; Selma M. Taffel; William D. Mosher, Ph.D., Division of Vital Statistics; Jacqueline B. Wilson, MPH, Division of Health Interview Statistics; and Stanley Henshaw, Ph.D., Alan Guttmacher Institute

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Highlights

An estimated 6,484,000 pregnancies ended in 1992, 3 percent less than the number estimated in 1990 (6,668,000), when U.S. pregnancies were at the highest level since national estimates were first prepared in 1976. The number of pregnancies increased steadily from the mid-1970's to the early 1980's, and

then stabilized through 1987. Between 1987 and 1990, the number of pregnancies rose 8 percent, and then declined through 1992.

The pregnancy rate in 1992 was 109.9 pregnancies per 1,000 women aged 15-44 years, 3 percent lower than the 1990 peak, 113.8. Except for 1990, the pregnancy rate has ranged from 107 to 111 since 1980. Between 1980 and 1992, the number of women of reproductive age, defined as 15-44 years of age, increased 12 percent, while the number of pregnancies rose 10 percent. Thus, during this period, the changes in the number of pregnancies and the population at risk were roughly parallel.

Between 1980 and 1992, the rate for live births (also called the fertility rate) increased very slightly—by 1 percent—from 68.4 live births per 1,000 women aged 15-44 years in 1980 to 68.9 in 1992. The abortion rate declined 12 percent during this period, from 29.4 to 25.9. This decline reflects mainly the changes in age distribution of women in the child-

bearing ages. The proportion of the child-bearing population aged 18-29 years, the ages at which abortion rates are highest, declined from 47 to 39 percent. The fetal loss rate rose 7 percent, from 14.1 to 15.1. This increase also reflects the shifting age distribution of women of reproductive age, to ages at which fetal losses are relatively more likely.

As indicated, the pregnancy rate is the sum of three components, the live birth rate, the induced abortion rate, and the fetal loss rate. Although the net change in the pregnancy rate from 1980 to 1992 was very small, the rate declined by 5 percent from 1980 to 1986, and then rose by 7 percent from 1986 to 1990 before falling by 3 percent in 1992. Rates for the three components also declined from 1980 to 1986, with the largest decline measured for the abortion rate (7 percent). Between 1986 and 1990, the birth rate increased 8 percent and the fetal loss rate rose 11 percent, but the abortion rate did not change. Recently, between 1990 and 1992, the birth and fetal loss

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rates declined by 3 and 2 percent respectively, while the abortion rate fell 5 percent.

Pregnancy rates for Hispanic and black non-Hispanic women in 1991 were substantially higher than rates for white non-Hispanic women, 82 percent higher for Hispanic women and 90 percent higher for black non-Hispanic women. This disparity is observed among all age groups. The overall pregnancy rates for Hispanic and black non-Hispanic women were similar. However, rates by pregnancy outcome differed considerably. The birth rate for Hispanic women was much higher than the birth rate for black non-Hispanic women although the induced abortion rate was much higher for black non-Hispanic women.

Overall, about two-thirds of pregnancies among Hispanic and white non-Hispanic women ended in live births in 1991, compared with just half of pregnancies among black non-Hispanic women. The section "Factors associated with pregnancy rates" cites information on sexual activity and contraceptive use that helps to explain these findings.

Introduction

Detailed national data on the number of live births and live birth rates, based on information derived from live birth certificates, are published annually by the National Center for Health Statistics (NCHS). There has been continued and growing interest in the total number of pregnancies and pregnancy rates in the United States. These data are not as readily available, however, because it is more difficult to assemble timely data on the remaining two types of pregnancy outcome, induced abortions and fetal losses.

This is the fourth in a series of reports that estimate the number of pregnancies and pregnancy rates by outcome, age, and race of the woman for the United States. The first of these studies covered the period 1976-81 (1), the second covered the period 1976-85 (2), and the third covered the period 1980-88 (3). Although data on pregnancies and pregnancy rates for 1976-92 are included in this report, information for 1976-79 is included principally for historical reference. The focus of this report is on

changes in the overall number of pregnancies and pregnancy rates and their components from 1980 to 1992, and on variations by age, race, and Hispanic origin for 1991, the most recent year for which detailed information on induced abortion is available. Estimates of pregnancy rates (exclusive of fetal losses) and birth and abortion rates for teenagers by State in 1980 and 1990 have been published (4).

Sources and methods

The estimates of pregnancies in this report are the sum of the three outcomes, live birth, induced abortion, and fetal loss.

- The live birth data are not estimates. They are counts of all live births tabulated from the birth registration system, published annually by NCHS (5-8). More than 99 percent of births occurring in this country are registered (5).
- Estimates of the numbers and rates of induced abortions are derived from published and unpublished reports by the Centers for Disease Control and Prevention (CDC) and the Alan Guttmacher Institute (AGI) (9-12). The AGI estimates the national number of abortions from surveys it conducts of all known abortion providers (10). The AGI national estimates are distributed by age and race according to estimates prepared by CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), based on reports from most State health departments (11,12). In 1991, for example, information on the age of abortion patients was available from 41 States, the District of Columbia, and New York City (12). States with no data or incomplete data, however, included California, Florida, and Illinois, which means that the characteristics of a large proportion of abortion patients are not known. Several other States have data that are known to be incomplete. The estimates shown here attempt to correct for these deficiencies in the abortion data. Detailed information on these estimates and the limitations of the data are provided in the Technical notes.

- Estimates of fetal loss rates are based on sample survey data from the 1982 and 1988 National Surveys of Family Growth (NSFG), conducted by NCHS (13,14). National samples of women aged 15-44 years were asked to report the dates and outcomes of each of their pregnancies, including spontaneous fetal losses from recognized pregnancies. Estimates of fetal loss rates for individual years are based on averages for the 5 years before the 1982 and 1988 surveys. (See Technical notes.) The rate of fetal loss is highest in the early weeks of gestation. Most fetal losses reported here therefore are miscarriages; relatively few are stillbirths occurring late in pregnancy. Because some women are not aware of their early fetal losses, the estimates in this report are estimates of fetal losses from recognized pregnancies. For women under the age of 15 years and for women aged 35 years and older, estimates of fetal loss are based on small numbers of sample cases and should, therefore, be interpreted with caution.

Data shown by age of woman refer to the age at outcome. Some studies of abortion have used age at conception (9).

Beginning in 1990, NCCDPHP has been obtaining information on the race and Hispanic origin of abortion patients from the State health departments. Therefore, pregnancies for 1990 and 1991 are shown for white non-Hispanic women, black non-Hispanic women, and Hispanic women separately. Prior to 1990, information on induced abortion was available only for white women and women of all other races combined. Trend data, therefore, are limited to the white and "All other" categories.

In 1991 the proportion of "All other" births that were to black women was 78 percent, compared with 84 percent in 1980. This reflects the growing proportions of American Indian and Asian or Pacific Islander births in the United States (8). Although comparable trend data are not available for induced abortions, the proportion of "All other" abortions that were to black women in 1991 was 88 percent.

In this report, the racial designation of all pregnancy outcomes is that of the

woman. Previous reports had tabulated live births according to the race of the child. In keeping with recent NCHS changes in tabulation of birth data by race, birth data for all years included in this report have been re-tabulated by race of mother (8,15).

Data are shown by age and race in the tables and figures. Race differentials primarily reflect differences in income, educational levels, and access to health care and health insurance. These are substantially lower for black and Hispanic women than for white women (16-19). (See Technical notes.) Other studies have shown that groups with low levels of income and education have higher birth rates than groups with higher levels of education and income (20,21). Statistics on abortion are not collected by education, income, occupation, or other socioeconomic indicators. Thus, pregnancy rates by these measures of socioeconomic status cannot be computed.

Trends

There were an estimated 6,484,000 pregnancies that ended in 1992, the third highest number since national estimates were first prepared in 1976 (tables 1 and 2). The 1992 total was 3 percent lower than the peak number reported in 1990 (6,668,000), but still 30 percent higher than the number in 1976. Except for declines in 1983 and 1986, the number of pregnancies rose annually between 1976 and 1990.

Although the number of pregnancies was much higher in 1992 than in 1976, most of the increase is due to the 21 percent rise in the number of women in the childbearing ages; the pregnancy rate rose much less, by 7 percent (table 1) (22,23). Much of the population increase is attributable to the baby-boom generation. Women who were born in the peak birth years 1946-64 were aged 28-46 years in 1992. Because the number of births declined sharply beginning in the early 1970's, the number of teenagers and women currently in their early twenties is considerably smaller than the number from the baby-boom generation. Thus, the total population in the childbearing ages is projected to stabilize over the next several years with relatively fewer women in the age group 15-24 years, a

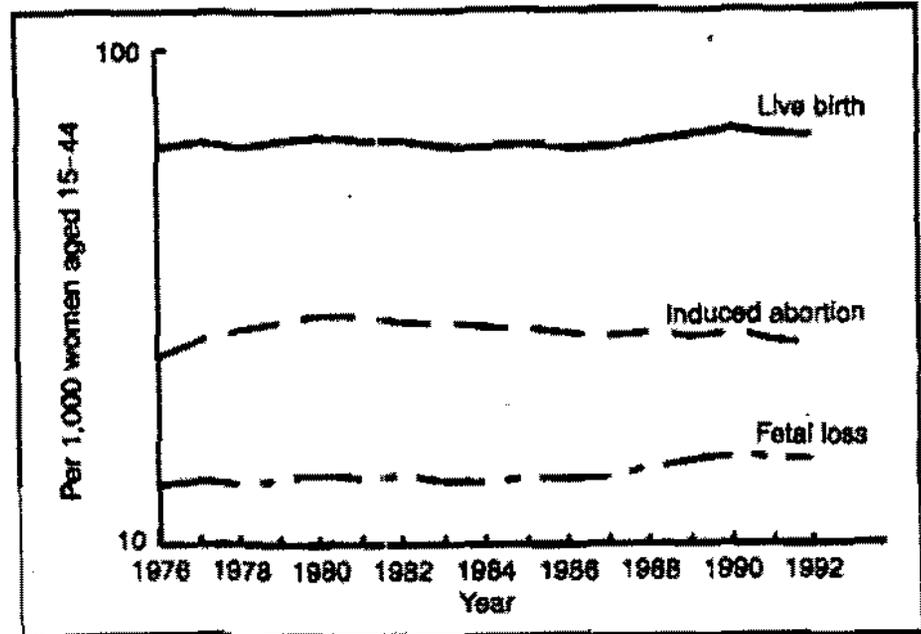


Figure 1. Estimated rates of live birth, induced abortion, and fetal loss: United States, 1976-92

factor that will likely exert a downward pressure on the number of pregnancies during the next several years (24).

The overall pregnancy rate in 1992 was 109.9 pregnancies per 1,000 women aged 15-44 years, 2 percent lower than the rate in 1980 (111.9). Although the net change in the pregnancy rate between 1980 and 1992 was very small, the rate declined by 5 percent from 1980 to 1986, and then rose 7 percent by 1990 before falling by 3 percent to 1992 (table 1 and figure 1). All components of pregnancy rates, i.e., live births, induced abortions, and fetal losses, declined from 1980 to 1986, but the decline was greatest for the abortion rate (7 percent). The birth rate fell 4 percent and the fetal loss rate declined 1 percent.

Between 1986 and 1990, when the pregnancy rate rose 7 percent, the birth rate increased 8 percent and the fetal loss rate rose 11 percent; the induced abortion rate did not change. In the most recent period, from 1990 to 1992, when the pregnancy rate declined 3 percent, all three components declined as well, with the birth and fetal loss rates dropping 3 and 2 percent, respectively, and the abortion rate falling 5 percent.

Age

Pregnancy rates were higher in 1991 than in 1980 for all age groups. For

women in age groups 15-29 years, rates for 1991 were 2-5 percent higher than in 1980 (table 3). However, the increases were not continuous. Rates generally declined in each year for all age groups from 1980 to 1986. Between 1986 and 1990, however, rates increased for all groups, but most rapidly for women in their twenties (the ages at which pregnancy rates are highest) and women aged 30 years and older. Rates for women in their thirties were the only ones to rise almost continuously from 1980 to 1990. Pregnancy rates for almost all age groups in 1991 were lower than in 1990.

The changes in birth rates were very similar to those for the pregnancy rates, except that the overall increases in birth rates between 1986 and 1991 were considerably greater than for pregnancy rates for teenagers and for women in their late thirties and older. Much of the increase for women in their thirties is associated with the ongoing tendency for these women to make up for previously postponed childbearing (6,7,15,25).

Changes in induced abortion rates by age were very different from those in live birth rates. Rates for teenagers aged 15-19 years and women in their forties were lower in 1991 than in 1980. For teenagers, rates changed little from 1980 to 1987, increased in 1988, and then fell between 1988 and 1991 by 10-20 percent. For women in their forties, the rate

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declined through 1986, and then increased to 1990 before declining again in 1991.

Abortion rates for women in age groups 20–39 years were higher in 1991 than in 1980. Rates for women aged 20–29 years also changed little during the period 1980–87; rates then rose between 1987 and 1990 but changed little in 1991. The abortion rates for women in their thirties rose almost continuously throughout the 1980's, more rapidly in the latter part of the decade, but then dropped in 1991.

The changes in the age distribution of women in the childbearing years is an important factor in the overall decline in the abortion rate during the 1980's. The proportion of all women aged 15–44 years who were in age groups 18–29 years, the ages at which abortion rates are highest, declined from 47 to 39 percent between 1980 and 1991 (22). Although the proportion of women aged 30–44 years increased from 42 to 52 percent and abortion rates for these women increased during this period, their rates are much lower, so they account for relatively few abortions, about 1 in 5 in 1991.

Race

Pregnancy rates declined by 1 percent for white women and by 5 percent for women of all other races between 1980 and 1991. Rates for both groups declined from 1980 to 1986, by 4 to 8 percent and then increased by 6 and 5 percent, respectively, to 1990 before falling in 1991 (table 3). The trends in live birth rates by race were similar to those for pregnancy rates, except the increases since 1986 were greater for live births. The abortion rate for white women in 1991 was 17 percent lower than the rate in 1980, and the rate for all other women was 6 percent lower.

Marital status

Pregnancy rates by marital status and race have been estimated for 1980 (26), 1990, and 1991, and are shown in table 4. Pregnancy rates, birth rates, and abortion rates for married women declined between 1980 and 1991, with the declines for pregnancy and birth rates slightly greater for all other married women than for white married women. In contrast, the

pregnancy and birth rates for unmarried women both increased, by 14 percent for the pregnancy rate and by 54 percent for the birth rate. The abortion rate declined. The increase in the birth rate for unmarried women was largely concentrated among white unmarried women, for whom the rate increased 91 percent (from 18.1 to 34.6). The relative decline in the abortion rate was more than twice as great for white as for all other unmarried women.

Rates in 1991

Age

The pregnancy rate for women aged 20–24 years has consistently been higher than for any other age group (table 3). In 1991 the rate was 193 pregnancies per 1,000 women aged 20–24 years. To put this another way, 19.3 percent of all women aged 20–24 years had a pregnancy ending in 1991. The rates for women aged 18–19 and 25–29 years were nearly as high: 171 per 1,000 for women aged 18–19 years (or 17.1 percent) and 174 per 1,000 women aged 25–29 years (equivalent to 17.4 percent). The rate for women aged 30–34 years was 118. Rates for other ages are considerably lower, ranging from 11 per 1,000 for women in their forties to 75 for young teens aged 15–17 years.

The patterns of rates by age differ for live births and induced abortions, with induced abortion rates having a younger age pattern than live birth rates. The birth rates were highest for women aged 20–24 and 25–29 years (116 and 118 per 1,000, respectively), while induced abortion rates were highest for women aged 18–19 and 20–24 years (56 and 57, respectively).

Race and Hispanic origin

Data for Hispanic and white and black non-Hispanic women were available for the first time for 1990, and are shown separately for 1990 and 1991. However, the text focuses on variations in 1991. There are substantial differences in pregnancy rates and pregnancy outcomes among the three groups (tables 5 and 6 and figures 2 and 3). The overall pregnancy rates for Hispanic and black non-Hispanic women in 1991 were rela-

tively similar, 167 and 175 per 1,000, respectively, both substantially higher than the rate for white non-Hispanic women, 92 (table 5).

Although the pregnancy rates for black non-Hispanic and Hispanic women were similar, there were sharp differences between the two groups in the rates by pregnancy outcome (table 5 and figure 2). The birth rate for Hispanic women (108 per 1,000) was 23 percent higher than the rate for black non-Hispanic women (88 per 1,000). In contrast, the abortion rate for black non-Hispanic women (66 per 1,000) was nearly twice the rate for Hispanic women (36 per 1,000). In other words, black non-Hispanic and Hispanic women were about equally likely to become pregnant in 1991, but differed considerably in how their pregnancies were resolved, whether they ended as live births or induced abortions. Birth and abortion rates for white non-Hispanic women (61 and 18, respectively) were substantially lower than rates for either black non-Hispanic or Hispanic women.

The pregnancy rates for black non-Hispanic and Hispanic women were highest for women aged 20–24 years (table 5 and figure 3). The rate for black non-Hispanic women was 337 per 1,000 and the rate for Hispanic women was 286. In other words, one-third of black non-Hispanic women aged 20–24 years and more than one-quarter of Hispanic women of this age group had a pregnancy that ended in 1991. The highest rate for white non-Hispanic women was reported for ages 25–29 years, 155 per 1,000, followed closely by the rate for women aged 20–24 years, 151.

Pregnancy rates for women under 30 years of age were highest for black non-Hispanic women, while rates for women aged 30 years and older were highest for Hispanic women. The differential by race and Hispanic origin was greatest for teenagers under 15 and 15–17 years of age and declined with advancing age up to ages 30–34 years, and then increased for older ages.

Teen birth and abortion rates were highest for black non-Hispanic women. For women aged 20 years and older, birth rates were highest for Hispanic women, and abortion rates were highest for black non-Hispanic women.

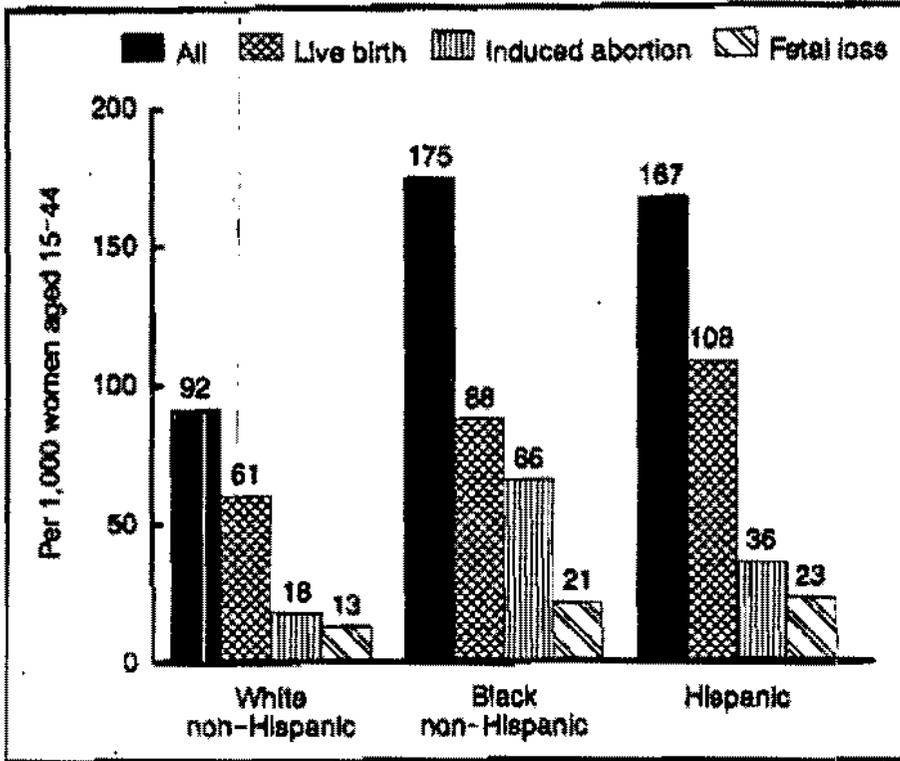


Figure 2. Estimated rates of pregnancy, live birth, induced abortion, and fetal loss by race and Hispanic origin of woman: United States, 1991

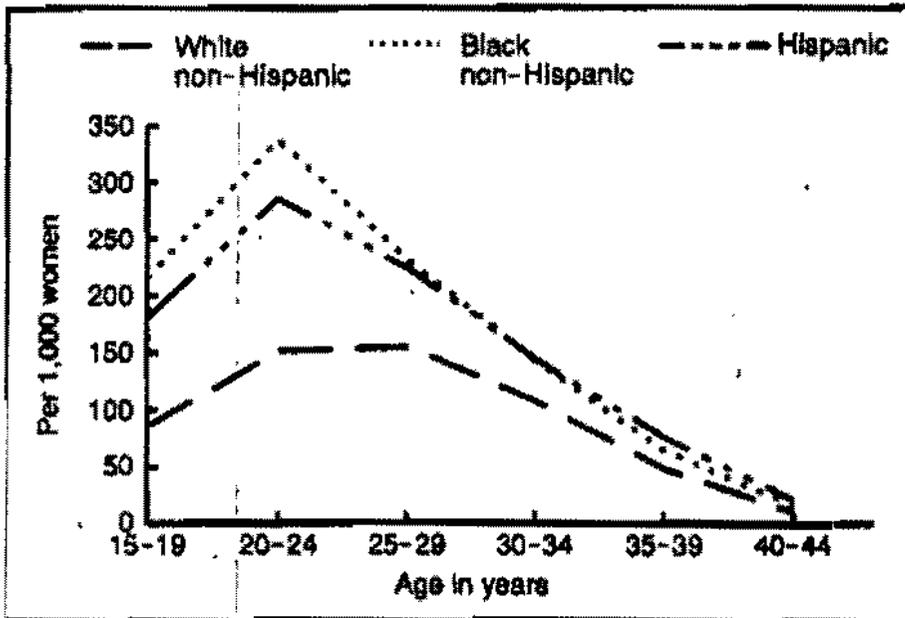


Figure 3. Estimated pregnancy rates by age, race, and Hispanic origin of woman: United States, 1991

Marital status

The pregnancy rate for married women was 118 per 1,000 in 1991, 15 percent higher than the rate for unmarried women, 103 (table 4). The birth rate

for married women was double that for unmarried women (90 compared with 45 per 1,000). In contrast, the abortion rate for unmarried women was about six times as high as for married women (48 compared with 8). The patterns of the

rates for white women were similar to those for women of all races, but the differential by marital status was greater. For example, the birth rate for married white women was 91 per 1,000, 2.6 times the rate for unmarried white women, 35.

Pregnancy rates for all other women differed considerably from those for white women (table 4). The rate for unmarried women of all other races was more than a third greater than the rate for married women, 174 per 1,000, compared with 128. In sharp contrast to the pattern for white women, the birth rate for married women of all other races was only 9 percent higher than the rate for unmarried women. The abortion rate for unmarried all other women (76 per 1,000) was nearly four times that for married women (21 per 1,000).

The birth rate for married women of all other races was slightly lower than for white women (86 and 91 per 1,000, respectively). However, the induced abortion rate for married all other women (21 per 1,000) was three times that for married white women (7 per 1,000).

The overall pregnancy rate for unmarried women of all other races (174 per 1,000) was more than double that of unmarried white women (81 per 1,000). This differential is reflected in sharply higher rates for both live births and induced abortions among all other women.

Lifetime fertility

The total fertility rate (TFR), is the average number of lifetime births that women would have if the age-specific birth rates in a given year continued through their reproductive years. The TFR has been published routinely by NCHS to suggest the implications of current age-specific birth rates for completed family size (5-8,15). By extension, a total abortion rate and a total fetal loss rate can also be calculated. Summing these rates would yield a total pregnancy rate, or the number of lifetime pregnancies per woman. (Method of computation is described in Technical notes.) The figures shown represent the average number of lifetime pregnancies, live births, and

induced abortions per woman implied by the 1991 age-specific rates for each group:

	Preg- nancies	Live births	Abor- tions
Total	3.3	2.1	0.8
Non-Hispanic:			
White	2.6	1.8	0.6
Black	5.1	2.6	1.8
Hispanic	4.7	3.0	1.0

On the average, given these assumptions, black non-Hispanic women would have slightly more than 5.0 pregnancies during their lifetimes, somewhat more than Hispanic women, 4.7; both groups would have substantially more pregnancies than white non-Hispanic women, 2.6. The differential in lifetime births is considerably smaller, and the number is highest for Hispanic women at 3.0 births per woman, compared with 2.6 for black non-Hispanic women and 1.8 births for white non-Hispanic women. The differential in lifetime abortions is larger: black non-Hispanic women would have 1.9 abortions each, compared with 1.0 for Hispanic women and 0.6 for white non-Hispanic women.

Outcomes in 1991-92

Pregnancies in 1992 were slightly more likely to end as live births (63 percent) compared with 1980 (61 percent). There was a concurrent decline in the proportion ending in induced abortion, from 26 to 24 percent. These changes reflect the small increase in the birth rate (from 68 to 69 per 1,000), which occurred concurrently with the decline in the abortion rate (from 29 to 26) (table 1).

Age

Consistent with the wide variations in birth and abortion rates by age, there are substantial differences in the distribution of pregnancy outcomes by age (figure 4). More than two-thirds of pregnancies among women aged 25-34 years ended as live births in 1991, the highest proportion of any age group. About half of the pregnancies among teenagers ended in live births. The proportions of pregnancies ending in induced abortion were highest for women under 25 years of age and aged 40 years and over (29-45 percent), and lowest for women aged 25-39 years (16-20 per-

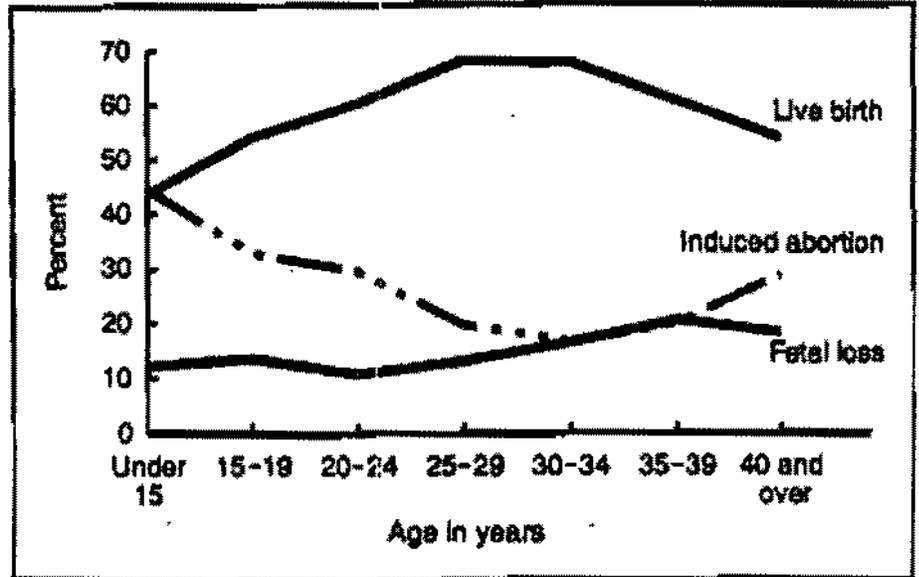


Figure 4. Percent of pregnancies ending as a live birth, induced abortion, or fetal loss, by age of woman: United States, 1991

cent). Generally, the proportions of pregnancies ending in fetal loss increased with advancing age. Among women in their thirties, pregnancies were equally likely to end in induced abortion or fetal loss.

Race and Hispanic origin

As noted earlier, the substantial disparities in pregnancy rates and rates for each pregnancy outcome are reflected in the very different pregnancy outcomes for white non-Hispanic and Hispanic women compared with black non-Hispanic women. Overall, about two-thirds of pregnancies among white non-Hispanic women and Hispanic women ended as a live birth, one-fifth in induced abortion, and 14 percent in fetal loss (table 6). In contrast, about half of the pregnancies to black non-Hispanic women ended as live births, with 38 percent ending in induced abortion, and 12 percent ending in fetal loss (table 6).

Among pregnancies to women aged 20 years and older, the proportions ending in live birth were similar for Hispanic and white non-Hispanic women at each age, and similar to the pattern for all ages combined. The proportion ending in induced abortion was highest for black non-Hispanic women in each age group. There was little difference in fetal loss proportions by race and origin.

Among pregnancies to teenagers 15-19 years of age, there were considerable variations in the distributions of pregnancy outcomes by race and origin. The proportion ending in live birth was highest for Hispanic teenagers (57-61 percent), followed by black non-Hispanic teenagers (55 percent), and white non-Hispanic teenagers (46-54 percent). The proportions of pregnancies ending in induced abortion were similar for white non-Hispanic and black non-Hispanic teenagers (33-39 percent), but were much lower for Hispanic teenagers (20-24 percent).

Factors associated with pregnancy rates

Information on trends in contraceptive use, the effectiveness of contraceptive use, patterns of marriage and divorce, sexual activity, and unwanted childbearing from the National Survey of Family Growth (NSFG), conducted by NCHS, can be used to help explain the trends and differences described in this report.

Data from NSFG have been used to calculate contraceptive failure rates, which show the probability of having an unintended pregnancy within the first year of use of a given contraceptive method (27). In this analysis, a contraceptive "failure" may result from the

failure of the method despite correct and consistent use, or more often, from incorrect or inconsistent use. For example, inconsistent use occurs if a woman forgets to take her oral contraceptive pills for 1 or more days, or if a condom or diaphragm was used at some but not all acts of intercourse. A previous report from the 1990 NSFG showed that, whether condoms are being used for contraception or for disease prevention, fewer than half of condom users use condoms at every act of intercourse in a given month (28).

NSFG data show that for women 15-44 years of age, the failure rate for the pill is 8 percent, and for the condom, 15 percent (27). Although a switch away from the pill to the condom would tend to reduce sexually transmitted diseases (STD), it would also tend to increase the pregnancy rate. According to the same analysis, the contraceptive failure rate for all contraceptive methods combined for teenagers in 12 months of use was 26 percent, compared with 18 percent at ages 20-24 years, 13 percent at ages 25-29 years, and 10 percent at ages 30 years and over.

Trends

NSFG data show three principal trends in contraceptive use between 1982 and 1990: intrauterine device (IUD) use decreased when the IUD was withdrawn from the U.S. market by its principal distributors; use of female sterilization increased among women aged 25 years and over; and there was an increase in condom use among young and unmarried people from 1982 to 1990, in response to the concern about STD, including human immunodeficiency virus (HIV) (29).

The overall trend in pregnancy rates was driven primarily by trends in pregnancy for women under 30 years of age because, in 1991, women under 30 years of age accounted for about 70 percent of all pregnancies and live births in the United States. In general there were slight decreases in pregnancy rates for ages under 30 years from 1980 until the mid-1980's. But each of the rates increased between 1986 and 1991, to levels slightly higher than in 1980 (table 3). For example, the rate for teenagers aged 15-19 years was 110.0 in 1980, 104.7 in

1986, and 115.0 in 1991; the rate for women aged 20-24 years was 183.5 in 1980, 178.2 in 1986, and 192.6 in 1991.

A recent report showed changes in contraceptive use that shed light on the recent increases in pregnancy rates among young women (29). NSFG surveys were done in 1982, 1988, and 1990. These surveys show that between 1988 and 1990, the proportion of women 15-24 years of age who:

- had ever had intercourse increased from 70 to 74 percent;
- had intercourse in the last month while not using any contraceptive method and not intending pregnancy increased from 4 to 12 percent;
- were using oral contraceptive pills dropped from 30 to 24 percent; and
- were using the condom increased from 10 to 14 percent.

An increase in the proportion who ever had intercourse, an increase in the proportion who were currently having intercourse and not using any method of birth control, and a shift from oral contraceptive use to condom use would tend to increase the pregnancy rates among young women. That appears to be what happened in the late 1980's.

Increases in the pregnancy rates for women 30-34 and 35-39 years of age throughout the 1980's are reflected primarily in increasing birth rates at these ages (table 3). For example, the birth rate per 1,000 women aged 30-34 years was 61.9 in 1980 and 79.5 in 1991. These changes in birth rates to women in their thirties appear to be due to the continuation of a trend toward making up for previously delayed childbearing (25). The percent of women reaching age 35 years who were still childless increased from 15 percent in 1980 to 21 percent in 1991 (30,31). The increases in birth rates at ages 35-39 years are of interest because women aged 35 years and over are exposed to elevated risks of infertility (32), pregnancy loss (33), and cesarean delivery (34). Their use of infertility services and other expensive medical care may also be of public interest (35). Despite a sharp relative increase in birth rates at ages 35-39 years, births to women aged 35 years and over still accounted for only 9 percent of all births in 1991, up from 5 percent in 1980.

Race and Hispanic origin

The differences in pregnancy rates between non-Hispanic white women and other women (table 5) are substantial. Overall, the pregnancy rate in 1991 was 92 per 1,000 non-Hispanic white women, compared with 167 per 1,000 Hispanic women and 175 per 1,000 non-Hispanic black women. These differences may be related to the following factors: Despite some convergence in the last two decades, non-Hispanic black women are still substantially more likely to begin intercourse before age 18 than Hispanic or non-Hispanic white women (36, 37); both Hispanic and black women are less likely to use a contraceptive method at their first intercourse than non-Hispanic white women (29, 38); and during contraceptive use, Hispanic women and non-Hispanic black women have higher rates of contraceptive failure than non-Hispanic white women (27). It is known that births to never-married women are much more likely to be unwanted than births to ever-married women. This was true for white and black women in both 1982 and 1988 (39). Black women spend fewer of their reproductive years as part of a married couple than white women (40), which may help to explain the higher rates of abortion and unwanted births among black women than among white women. There are several demographic reasons why black women spend fewer of their reproductive years in marriage than white women:

- On average, black women marry at later ages than white women. The average (mean) age at first marriage in 1988 was 26.0 years for black women and 23.9 years for white women (41).
- Black women are also less likely to have ever been married than white women. In 1988, 47 percent of black women and 67 percent of white women 15-44 years of age had ever been married (42).
- Among those who do marry, the marriages of black women were more likely to end in separation, divorce, or death. For example, 39 percent of black women's marriages had dissolved within 10 years compared with 28 percent of white women's marriages (42).

• Among those divorced, black women were much less likely than white women to remarry (40,42).

There are substantial differences by race and Hispanic origin in unwanted pregnancies and births. A pregnancy is defined as "unwanted" in the NSFG if, for example, a woman already had one child, and wanted no more, but became pregnant with her second; or if a woman had two children and did not want to have any more, but then became pregnant with her third child (43). Similarly, if a childless woman wants to remain childless permanently but becomes pregnant, then her first pregnancy would be unwanted. Whether a pregnancy is unwanted is defined at the time the pregnancy was conceived, and is designed to determine the number of pregnancies that would occur if contraceptive use was completely effective and each pregnancy was planned. Births that were unwanted at conception do not necessarily become unwanted children. Mothers who report a pregnancy as unwanted at the time of conception nonetheless may cherish the child born as a result of that pregnancy.

In 1983-88, 14.2 percent of births to Hispanic women, 29.8 percent of births to non-Hispanic black women, and 8.5 percent of births to non-Hispanic white women were unwanted. If it is assumed that these percents unwanted still applied in 1991, a 1991 wanted total fertility rate (TFR), expressed as wanted births per woman, can be computed by multiplying the TFR for 1991 by the proportion of births that were wanted as follows:

	1991 TFR	Percent wanted	Wanted TFR
Total	2.1	87.6	1.8
NH White	1.8	91.5	1.6
NH Black	2.6	70.2	1.8
Hispanic	3.0	85.8	2.6

Among non-Hispanic women, black women want about the same number of births as white women (1.8 compared with 1.6), but have substantially more births than white women (2.6 compared with 1.8 per woman). Thus, most of the difference in birth rates between non-Hispanic black and white women is due

to unwanted births. By contrast, the difference between Hispanic and non-Hispanic white women is primarily due to a difference in wanted births: Hispanic women want and have substantially more births than non-Hispanic white women.

These data show striking differences in marital patterns, contraceptive use, contraceptive effectiveness, unwanted births, and abortion rates among women of different racial and ethnic backgrounds. These differences reflect the relationships of race and ethnicity with education, occupation, access to health care (19,44), income (17,18), and the neighborhoods in which these groups live (45-48). These factors, in turn, affect many of the behaviors described above. It is beyond the scope of this report to discuss these issues in further detail, but they are clearly important to an understanding of the pregnancy and health patterns of minority women, and deserve further study—particularly the relationship of economic opportunities for both men and women to marriage and pregnancy patterns (38,45-48).

Teenage pregnancy

The rate of teenage pregnancy can be broken into two parts: the rate of sexual activity, and the rate of pregnancy per 1,000 sexually experienced women. Thus, the teenage pregnancy rate can be calculated two ways: per 1,000 teenage women; and per 1,000 sexually experienced teenage women.

The table below shows that the rate of teenage pregnancy stayed about the same in the 1980-88 period, despite a sharp increase in the proportion having intercourse. The pregnancy rate per 1,000 sexually experienced teenage women dropped from 235 to 207, a 12-percent decrease. The pregnancy rate increased between 1988 and 1991 for all teenagers and for sexually experienced teenagers.

Rates of pregnancy per 1,000 women 15-19 years of age have been estimated for 1991 for Hispanic, non-Hispanic black, and non-Hispanic white women. Data on the percent who had ever had intercourse (sexual experience) for 1988 were used because the percent sexually experienced was virtually identical for white teenagers in 1988 and 1990, but the

sample size in 1990, particularly for Hispanic teenagers, was not large enough to produce reliable estimates. (See Technical notes for an explanation.)

The pregnancy rates per 1,000 sexually experienced teenaged women in 1991 are, then, estimates, but their pattern is striking. The rates for Hispanic and non-Hispanic black teenagers (379 and 357 pregnancies per 1,000 sexually experienced women, respectively) are substantially higher than the rate for non-Hispanic white teenagers (161 per 1,000).

Compared with non-Hispanic white teenagers, the differences in the overall teenage pregnancy rates (rates per 1,000 women aged 15-19 years) are associated with the higher rates of sexual experience (36,37) and less effective contraceptive use (29,36,38) among black teenagers. Among Hispanic teenagers, less effective contraceptive use (29,36,38) is the principal factor. Further studies of the factors affecting teenage sexual activity and contraceptive use would be helpful in understanding how these patterns can be changed.

As data on abortion are reported to CDC separately for black and Hispanic women over a period of years, it will be possible to determine with more certainty what the trends and levels in pregnancy rates are among black and Hispanic teenagers, and thus to state whether efforts to reduce teenage pregnancy are having their intended effect on Hispanic, non-Hispanic white, and non-Hispanic black teenagers.

	Preg-nancy rate per 1,000 women 15-19 years	Percent who ever had inter-course*	Preg-nancy rate per 1,000 sexually experi-enced
All races			
1980	110.0	46.0	235
1988	109.4	62.9	207
1991	115.0	64.0	209
Non-Hispanic white			
1991	84.7	62.7	161
Non-Hispanic black			
1991	216.7	60.7	357
Hispanic			
1991	180.2	47.5	379

*The 1980 pregnancy rates use 1982 NSFG data on sexual activity because no NSFG was done in 1980. Rates for 1991 for all races combined are based on 1990 NSFG data. The 1991 rates by race and origin are based on 1988 NSFG data on sexual activity. See "Sexual experience" in Technical notes for explanation.

Future research

National statistics of high quality on pregnancy are essential to adequately monitor U.S. fertility patterns. Increasing the completeness of abortion statistics reported to CDC, particularly by those States that do not currently report abortions at all or do not report the race, age, or Hispanic origin of the woman would be useful. Information on the educational attainment of women who have had abortions would be very helpful in interpreting differences among groups. In addition, further research to shed light on the connections between unwanted pregnancy and such characteristics as economic opportunities and access to family planning services and other health care is needed. Future Cycles of NSFG as well as the birth registration data can be useful in performing some of that research.

References

- Ventura SJ, Taffel S, Mosher WD. Estimates of pregnancies and pregnancy rates for the United States, 1976-81. *Public Health Rep* 100(1):31-34. 1985.
- Ventura SJ, Taffel SM, Mosher WD. Estimates of pregnancies and pregnancy rates for the United States, 1976-85. *Am J Public Health* 78(5):506-11. 1988.
- Ventura SJ, Taffel SM, Mosher WD, Henshaw S. Trends in pregnancies and pregnancy rates, United States, 1980-88. *Monthly vital statistics report; vol 41 no 6, supp.* Hyattsville, Maryland: National Center for Health Statistics. 1992.
- Spitz AM, Ventura SJ, Koonin LM, et al. Surveillance for pregnancy and birth rates among teenagers, by State, United States, 1980 and 1990. In: *CDC Surveillance Summaries*, December 17, 1993. *MMWR* 1993; (No. SS-6):1-27.
- National Center for Health Statistics. *Vital statistics of the United States, vol I, natality*. Washington: Public Health Service. Annual issues, 1976-89.
- National Center for Health Statistics. *Advance report of final natality statistics, 1990*. *Monthly vital statistics report; vol 41 no 9, supp.* Hyattsville, Maryland: Public Health Service. 1993.
- National Center for Health Statistics. *Advance report of final natality statistics, 1991*. *Monthly vital statistics report; vol 42 no 3, supp.* Hyattsville, Maryland: Public Health Service. 1993.
- Ventura SJ, Martin JA, Taffel SM, et al. *Advance report of final natality statistics, 1992*. *Monthly vital statistics report; vol 43, no 5, supp.* Hyattsville, Maryland: National Center for Health Statistics. 1994.
- Henshaw SK, Van Vort J, eds. *Abortion factbook, 1992 edition: Readings, trends, and State and local data to 1988*. The Alan Guttmacher Institute. 1992.
- Henshaw SK, Van Vort J. *Abortion services in the United States, 1991 and 1992*. *Fam Plann Persp* 26(3):100-12. 1994.
- Centers for Disease Control and Prevention. *Abortion surveillance: Preliminary data—United States, 1992*. *MMWR* 43:930-39. 1994.
- Koonin LM, Smith JC, Romic M. *Abortion surveillance—United States, 1991*. *CDC Surveillance Summaries*, May 1995. *MMWR* 1995; 44(No. SS-2):23-53.
- Judkins DR, Mosher WD, Botman S. *National Survey of Family Growth: Design, estimation, and inference*. National Center for Health Statistics. *Vital Health Stat* 2(109). 1991.
- Pratt WF, Mosher WD, Bachrach CA, Horn MC. *Understanding U.S. fertility: Findings from the National Survey of Family Growth, Cycle III*. *Popul Bull* 39(5). 1984.
- National Center for Health Statistics. *Advance report of final natality statistics, 1989*. *Monthly vital statistics report; vol 40 no 8, supp.* Hyattsville, Maryland: Public Health Service. 1991.
- U.S. Bureau of the Census. *Poverty in the United States: 1988 and 1989*. *Current population reports; series P-60, no 171*. Washington: U.S. Department of Commerce. 1991.
- Bennett CE. *The Black population in the United States: March 1990 and 1989*. U.S. Bureau of the Census. *Current population reports; series P-20, no 448*. Washington: U.S. Department of Commerce. 1991.
- Garcia JM, Montgomery PA. *The Hispanic population in the United States: March 1990*. U.S. Bureau of the Census. *Current population reports; series P-20, no 449*. Washington: U.S. Department of Commerce. 1991.
- National Center for Health Statistics. *Health, United States, 1993*. DHHS (PHS) 94-1232. Hyattsville, Maryland: Public Health Service. 1994.
- Lewis C, Ventura S. *Birth and fertility rates by education: 1980 and 1985*. National Center for Health Statistics. *Vital Health Stat* 21(49). 1990.
- Bachu A. *Fertility of American women: June 1992*. U.S. Bureau of the Census. *Current population reports; series P-20, no 470*. Washington: U.S. Department of Commerce. 1993.
- U.S. Bureau of the Census. *United States population estimates, by age, sex, race, and Hispanic origin: 1980 to 1991*. *Current population reports; series P-25, no 1095*. Washington: U.S. Department of Commerce. 1993.
- U.S. Bureau of the Census. *U.S. population estimates, by age, sex, race, and Hispanic origin: 1992*. *Census file RESP0792*. Washington: U.S. Department of Commerce. 1994.
- Day JC. *Population projections of the United States, by age, sex, race, and Hispanic origin: 1993 to 2050*. U.S. Bureau of the Census. *Current population reports; series P-25-1104*. Washington: U.S. Department of Commerce. 1993.
- Ventura SJ. *Trends and variations in first births to older women, 1970-86*. National Center for Health Statistics. *Vital Health Stat* 21(47). 1989.
- Henshaw SK, Binkin NJ, Blaine E, Smith JC. *A portrait of American women who obtain abortions*. *Fam Plann Persp* 17(2):90-96. 1985.
- Jones EP, Forrest JD. *Contraceptive failure rates based on the 1988 NSFG*. *Fam Plann Persp* 24(1): 12-20. 1992.
- Mosher WD, Pratt WF. *AIDS-related behavior among women 15-44 years of age: United States, 1988 and 1990*. *Advance data from vital and health statistics; no 239*. Hyattsville, Maryland: National Center for Health Statistics. 1993.
- Peterson LS. *Contraceptive use in the United States: 1982-90*. *Advance data from vital and health statistics; no 260*. Hyattsville, Maryland: National Center for Health Statistics. 1995.
- National Center for Health Statistics. *Vital Statistics of the United States, 1980, vol I, natality*. Washington: National Center for Health Statistics. 1984.
- National Center for Health Statistics. *Vital Statistics of the United States, 1991, vol I, natality*. In press.
- Mosher WD, Pratt WF. *Fecundity and infertility in the United States, 1965-1988*. *Advance data from vital*

- and health statistics; no 192. Hyattsville, Maryland: National Center for Health Statistics. 1990.
33. Mosher WD, Pratt WF. Fecundity, infertility, and reproductive health in the United States, 1982. National Center for Health Statistics. *Vital Health Stat* 23(14). 1987.
34. Taffel SM. Caesarean delivery in the United States. 1990. National Center for Health Statistics. *Vital Health Stat* 21(51). 1994.
35. Chandru A, Mosher WD. The demography of infertility and the use of medical care for infertility. *Infertility and Reproductive Medicine Clinics of North America* 5(4):283-296, April 1994.
36. Forrest JD, Singh S. The sexual and reproductive behavior of American women, 1982-1988. *Fam Plann Persp* 22(5): 206-214. Sept-Oct 1990.
37. Family Growth Survey Branch. *Practical issues concerning adolescent women—United States, 1970-1988.* MMWR 39 (51-52):929-932. 1991.
38. Mosher WD, McNally, JW. Contraceptive use at first premarital intercourse: United States, 1965-1988. *Fam Plann Persp* 23(3):108-116. 1991.
39. Williams LB, Pratt WF. Wanted and unwanted childbearing in the United States: 1973-1988. Advance data from vital and health statistics; no 189. Hyattsville, Maryland: National Center for Health Statistics. 1990.
40. Bachrach CA, Horn MC. Married and unmarried couples. National Center for Health Statistics. *Vital Health Stat* 23(15). 1987.
41. National Center for Health Statistics. Advance report of final marriage statistics, 1988. Monthly vital statistics report; vol 40 no 4, supp. Hyattsville, Maryland: Public Health Service. 1991.
42. London KA. Cohabitation, marriage, marital dissolution, and remarriage: United States, 1988. Advance data from vital and health statistics; no 194. Hyattsville, Maryland: National Center for Health Statistics. 1991.
43. Piccinino LJ. Unintended Pregnancy and Childbearing. In Marks JS and Wilcox LS, editors, *From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children.* Centers for Disease Control and Prevention. 1994.
44. Ries P. Health care coverage by socio-demographic and health characteristics: United States, 1984. National Center for Health Statistics. *Vital Health Stat* 10(162). 1987.
45. Wilson WJ. *The truly disadvantaged: the inner city, the underclass, and public policy.* University of Chicago Press: Chicago, 1987.
46. Brewster KL. Neighborhood context and the transition to sexual activity among young black women. *Demography* 31(4):603-614. 1994.
47. Brewster KL. Race differences in sexual activity among adolescent women: the role of neighborhood characteristics. *American Sociological Review* 59:408-424. 1994.
48. Brooks-Gunn J, Duncan PJ, Klebanov PK, Sealand N. Do neighborhoods influence child and adolescent development? *American Journal of Sociology* 99(2):353-395. 1993.
49. Smith EE, Lawson HW, Smith JC. Legal abortion in the United States: trends and mortality. *Contemp Ob Gyn* 35:58-69. 1990.
50. Koonin LM, Smith JC, Ramick M. Abortion surveillance—United States, 1990. CDC Surveillance Summaries, December 17, 1993. MMWR 1993; 42(No. SS-6):29-57.
51. Koonin LM, Smith JC, Ramick M, Lawson HW. Abortion surveillance, United States, 1989. In: CDC Surveillance Summaries, September 1992. MMWR 1992; 41(No. SS-5):1-33.
52. Ventura SJ. Births to unmarried mothers: United States, 1980-92. National Center for Health Statistics. *Vital Health Stat* 21(53). 1995.
53. Kochanek KD. Induced terminations of pregnancy: reporting States, 1988. Monthly vital statistics report, vol 39 no 12, supp. Hyattsville, Maryland: National Center for Health Statistics. 1991.

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Symbols

- Data not available
 - ... Category not applicable
 - Quantity zero
-

Table 1. Estimated number of pregnancies and pregnancy rates, by outcome of pregnancy, and number of women: United States, 1976-82

Year	All pregnancies				All pregnancies				Women aged 15-44 years
	Total	Live births	Induced abortions	Fetal losses ¹	Total	Live births	Induced abortions	Fetal losses ¹	
	Number in thousands				Rate per 1,000 women aged 15-44 years ²				
1992	6,484	4,065	1,529	890	109.9	65.9	25.9	15.1	58,020
1991	6,563	4,111	1,557	895	111.1	66.6	26.3	15.2	60,079
1990	6,668	4,158	1,609	902	113.8	70.9	27.4	15.4	58,619
1989	6,480	4,041	1,567	873	111.0	69.2	26.8	15.0	58,367
1988	6,341	3,910	1,501	840	109.1	67.3	27.4	14.5	58,120
1987	6,183	3,809	1,569	815	108.8	65.8	26.9	14.1	57,801
1986	6,129	3,757	1,574	798	108.7	65.4	27.4	13.8	57,430
1985	6,144	3,761	1,589	796	108.3	66.3	28.0	14.0	56,716
1984	6,019	3,669	1,577	773	107.4	65.5	28.1	13.8	56,001
1983	5,977	3,639	1,575	763	106.0	65.7	28.5	13.8	55,369
1982	6,024	3,681	1,574	769	110.1	67.3	28.8	14.1	54,700
1981	5,958	3,629	1,577	751	110.5	67.3	29.3	13.9	53,928
1980	5,912	3,612	1,584	746	111.9	68.4	29.4	14.1	52,833
1979	5,714	3,494	1,498	722	109.9	67.2	28.8	13.9	52,016
1978	5,433	3,333	1,418	682	106.7	65.5	27.7	13.5	50,821
1977	5,331	3,327	1,317	687	107.0	66.8	26.4	13.8	49,814
1976	5,002	3,168	1,178	656	102.7	65.0	24.2	13.4	48,721

¹ Spontaneous fetal losses from recognized pregnancies of all gestational periods as reported by women in the 1982 and 1988 National Survey of Fertility Growth conducted by the National Center for Health Statistics. The rate of pregnancy loss depends on the degree to which losses at very early gestations are detected.

² Rates computed by dividing the number of events by women of all ages to women aged 15-44 years.

NOTE: Due to rounding, figures may not add to totals.

Table 2. Estimated number of pregnancies by outcome of pregnancy, age, and race of women: United States, 1976 and 1980-81

Pregnancy outcome and year	Age of women										Race	
	Total	Under 15 years	15-19 years			20-24 years	25-29 years	30-34 years	35-39 years	40 years and over	White	All other
			Total	15-17 years	18-19 years							
Number in thousands												
All pregnancies												
1981	5,563	28	963	362	600	1,814	1,706	1,310	549	101	4,901	1,062
1980	6,068	27	1,002	369	632	1,818	1,678	1,315	532	96	5,013	1,055
1989	5,400	25	1,001	375	626	1,777	1,646	1,249	462	88	4,661	1,019
1988	5,341	27	988	369	619	1,775	1,620	1,195	456	79	4,776	1,071
1987	6,180	28	957	366	571	1,794	1,783	1,136	424	71	4,986	1,406
1986	6,129	29	954	365	579	1,828	1,765	1,091	399	82	4,683	1,446
1985	6,144	30	961	366	586	1,801	1,764	1,045	373	88	4,733	1,411
1984	6,019	30	953	378	576	1,804	1,718	993	343	88	4,657	1,362
1983	5,877	29	1,020	382	638	1,813	1,682	947	319	87	4,628	1,249
1982	6,024	27	1,059	405	653	1,870	1,696	919	288	85	4,882	1,142
1981	5,858	26	1,103	424	679	1,845	1,669	907	268	85	4,813	1,045
1980	5,912	29	1,148	446	709	1,858	1,628	944	259	84	4,885	1,027
1978	5,002	32	1,073	438	636	1,644	1,381	882	214	86	3,871	1,131
Live Births												
1981	4,111	12	620	188	331	1,090	1,220	885	331	35	3,241	670
1980	4,158	12	622	183	326	1,094	1,277	886	318	35	3,280	678
1989	4,041	11	607	181	325	1,078	1,269	842	294	34	3,188	653
1988	3,910	11	478	177	302	1,067	1,239	804	270	34	3,102	607
1987	3,809	10	462	173	283	1,078	1,218	761	246	36	3,044	564
1986	3,757	10	462	168	283	1,102	1,230	721	230	31	3,018	547
1985	3,781	10	467	168	300	1,141	1,231	686	214	30	3,036	523
1984	3,689	10	470	167	300	1,142	1,198	659	198	28	2,967	520
1983	3,639	10	469	173	317	1,160	1,148	635	180	27	2,946	509
1982	3,661	10	514	181	323	1,208	1,152	606	168	28	2,965	496
1981	3,629	10	527	187	340	1,212	1,128	581	148	28	2,946	483
1980	3,612	10	560	186	334	1,199	1,108	553	141	28	2,911	471
1978	3,168	12	559	215	343	1,092	972	382	118	28	2,594	474
Induced abortions												
1981	1,567	12	314	118	198	533	486	213	107	66	1,028	274
1980	1,600	13	351	130	221	532	380	216	108	66	1,028	282
1989	1,582	13	371	139	232	509	345	206	99	66	1,008	280
1988	1,591	14	383	138	234	520	347	197	98	66	1,038	283
1987	1,559	14	382	141	221	516	337	182	83	65	1,017	282
1986	1,574	16	389	145	224	513	336	182	82	65	1,045	280
1985	1,589	17	388	146	234	548	336	181	87	65	1,071	279
1984	1,577	17	398	161	238	551	332	178	82	65	1,060	280
1983	1,575	18	411	168	245	548	328	172	78	65	1,084	281
1982	1,574	18	419	168	250	532	309	168	73	65	1,060	280
1981	1,577	15	433	178	257	565	316	167	70	65	1,108	269
1980	1,554	15	446	183	261	548	304	153	67	65	1,074	280
1978	1,179	18	383	153	210	388	221	110	57	65	788	201

Table 2. Estimated number of pregnancies by outcome of pregnancy, age, and race of woman: United States, 1976 and 1980-81—Con.

Pregnancy outcome and year	Age of woman										Race	
	Total	Under 15 years	15-19 years					30-34 years	35-39 years	40 years and over	White	All other
			Total	15-17 years	18-19 years	20-24 years	25-29 years					
Fetal losses ¹		Number in thousands										
1981	896	3	128	56	73	191	231	213	111	18	678	218
1980	932	3	128	56	73	192	241	213	106	17	684	217
1989	873	3	123	56	66	190	238	203	98	15	639	208
1988	840	3	117	54	63	188	233	194	91	14	612	209
1987	815	3	113	53	61	186	229	184	83	12	579	197
1986	798	3	113	51	62	194	226	174	77	10	619	190
1985	795	3	114	51	63	201	226	188	72	10	620	176
1984	773	3	114	51	64	201	220	159	66	9	608	176
1983	763	3	119	53	66	205	218	151	61	9	597	167
1982	769	3	125	55	70	213	217	146	56	9	602	167
1981	751	3	142	67	91	178	216	148	53	9	558	166
1980	746	3	149	66	84	180	214	140	51	9	586	162
1976	655	4	122	70	52	160	168	100	42	9	492	163

¹Spontaneous fetal losses from recognized pregnancies of all gestational periods as reported by women in the 1982 and 1988 National Survey of Family Growth conducted by the National Center for Health Statistics. The rate of fetal loss depends on the degree to which losses at very early gestations are detected.

NOTE: Due to rounding, figures may not add to totals.

Table 3. Estimated pregnancy rates by outcome of pregnancy and age and race of women: United States, 1970 and 1980-91
(Rate per 1,000 women in specified group)

Pregnancy outcome and year	Age of woman										Race	
	Total ¹	Under 15 years ²	15-19 years					40 years and over ³	White	All other		
			Total	15-17 years	18-19 years	20-24 years	25-29 years				30-34 years	35-39 years
All pregnancies												
1991	111.1	3.2	115.0	78.6	171.9	192.5	174.2	117.6	51.1	19.8	101.2	126.7
1990	113.8	3.3	115.0	75.5	165.6	192.6	176.8	119.9	52.1	18.7	101.6	128.7
1989	111.0	3.4	113.2	75.4	161.8	191.6	171.9	114.7	50.1	19.2	101.1	127.9
1988	109.1	3.4	109.4	74.0	158.7	183.2	167.9	111.2	47.5	2.6	99.2	125.3
1987	108.8	3.5	104.8	70.9	154.8	179.9	163.6	107.7	45.1	2.0	97.5	122.0
1986	106.7	3.6	104.7	69.8	157.1	178.2	161.6	105.0	42.4	2.5	97.8	120.6
1985	106.3	3.6	106.8	71.1	152.9	179.4	163.0	103.7	41.8	2.4	98.5	120.9
1984	107.4	3.5	105.8	70.4	154.4	177.2	166.2	101.1	40.1	2.3	98.3	120.4
1983	106.0	3.3	107.2	72.2	153.5	177.8	166.0	98.4	39.9	2.8	99.6	121.9
1982	110.1	3.1	107.6	72.1	156.7	182.4	163.4	97.3	37.9	2.8	101.7	124.9
1981	110.5	3.1	109.2	72.6	158.6	180.0	164.3	94.6	36.8	2.8	101.3	129.9
1980	111.9	3.2	110.9	73.2	162.2	181.5	166.7	95.0	38.4	3.1	102.4	134.4
1979	102.7	3.2	101.4	69.4	148.8	168.1	158.6	92.2	35.9	2.9	92.6	121.6
Live births												
1991	89.6	1.4	92.1	38.7	94.4	115.7	118.2	79.5	32.9	5.7	67.6	81.6
1990	90.9	1.4	89.9	37.5	85.8	118.0	123.2	80.8	31.7	5.4	68.2	82.2
1989	90.2	1.4	87.3	36.4	84.2	115.8	117.6	77.9	29.9	5.3	68.4	82.7
1988	87.3	1.3	83.0	32.6	79.9	118.2	114.4	74.8	28.1	5.0	64.5	80.0
1987	85.3	1.3	80.8	31.7	78.5	107.9	111.6	72.1	26.3	4.6	63.3	77.9
1986	85.6	1.3	80.2	30.5	79.6	107.4	109.8	70.1	24.4	4.2	63.1	78.6
1985	86.3	1.2	81.0	31.0	78.6	108.3	111.0	69.1	24.9	4.1	64.1	77.3
1984	85.5	1.2	80.8	31.0	77.4	106.8	108.7	67.0	22.9	4.0	63.2	77.9
1983	85.7	1.1	81.4	31.8	77.4	107.6	108.5	64.9	22.8	4.0	63.4	77.6
1982	87.3	1.1	82.4	32.0	79.4	111.6	113.0	64.1	21.2	4.1	64.6	80.3
1981	87.3	1.1	82.2	32.0	80.6	112.2	114.5	61.4	20.8	4.0	64.6	81.1
1980	88.4	1.1	83.0	32.5	82.1	115.1	112.9	61.9	19.8	4.1	65.6	82.7
1979	85.6	1.2	82.6	34.1	80.5	110.3	116.2	53.6	19.8	4.5	62.2	82.0
Included abortions												
1991	26.3	1.8	37.6	24.3	55.9	56.6	33.7	38.1	13.4	2.0	20.3	33.8
1990	27.1	1.5	40.3	25.5	67.9	56.7	33.6	37	13.8	3.2	21.6	34.6
1989	26.8	1.6	42.0	26.0	66.0	53.8	32.2	36.6	13.1	3.0	20.9	34.7
1988	27.1	1.7	43.5	30.2	62.0	52.8	32.0	34.4	13.9	5.0	21.4	35.2
1987	28.8	1.9	41.8	29.6	59.8	62.0	31.0	32	9.9	2.9	21.2	36.1
1986	27.4	2.0	42.3	29.9	69.8	61.8	31.1	30	9.7	2.8	21.6	36.1
1985	25.9	2.0	43.5	30.6	62.0	62.0	31.1	27.8	9.7	2.9	22.7	34.8
1984	26.1	2.0	42.3	25.9	65.8	61.6	31.0	27.8	9.4	2.8	22.2	33.6
1983	26.5	1.9	43.2	30.7	58.8	60.9	31.0	27.8	9.5	3.2	22.3	35.2
1982	29.9	1.5	42.7	30.0	59.7	61.1	31.5	27.8	9.2	2.3	22.8	35.3
1981	29.3	1.7	42.9	30.1	66.8	61.4	31.3	27.7	9.3	2.4	24.9	36.8
1980	29.4	1.7	42.7	30.1	68.6	61.6	31.0	27.2	9.4	3.5	24.4	37.0
1979	24.2	1.8	34.3	24.2	49.3	38.6	24.1	15.0	8.0	3.7	18.8	28.3

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Table 3. Estimated pregnancy rates by outcome of pregnancy and age and race of woman: United States, 1976 and 1980-91—Con.
 (Rates per 1,000 women in specified group)

Pregnancy outcome and year	Age of woman										Race		
	Total ¹	Under 15 years ²	15-19 years							40 years and over ³	White	All other	
			Total	15-17 years	18-19 years	20-24 years	25-29 years	30-34 years	35-39 years				
Fetal losses⁴													
1991	15.2	0.4	15.4	11.5	20.7	20.3	22.3	19.1	10.7	1.9	14.0	23.4	
1990	15.4	0.4	14.8	11.5	19.9	20.4	22.7	19.4	10.9	1.9	14.2	20.8	
1989	15.0	0.4	14.0	11.1	17.7	23.1	22.2	19.7	10.1	1.8	13.8	20.4	
1988	14.5	0.4	13.0	10.2	18.6	19.4	21.5	18.1	9.4	1.7	13.4	19.8	
1987	14.1	0.4	12.4	9.8	18.5	19.0	21.0	17.4	8.8	1.5	13.0	19.1	
1986	13.9	0.4	12.3	9.3	18.7	19.0	20.7	16.9	8.2	1.4	12.9	18.7	
1985	14.0	0.4	12.4	9.4	18.7	19.1	20.9	16.7	8.1	1.4	13.1	18.7	
1984	13.9	0.4	12.3	9.5	18.2	18.9	20.5	16.2	7.7	1.4	12.8	18.6	
1983	13.8	0.3	12.5	9.7	18.2	19.0	20.4	15.7	7.4	1.4	12.6	18.5	
1982	14.1	0.3	12.7	9.8	18.7	19.7	20.9	15.5	7.1	1.4	13.1	19.3	
1981	13.9	0.4	14.1	10.5	19.0	18.5	21.8	15.7	7.2	1.4	12.2	23.0	
1980	14.1	0.4	14.3	10.6	19.5	18.8	21.8	15.8	7.2	1.5	12.4	23.7	
1976	13.4	0.4	14.4	11.1	19.1	16.2	20.5	12.6	6.9	1.6	11.8	23.3	

¹Rates computed by relating the number of events to women of all ages to women aged 15-44 years.

²Rates computed by relating the number of events to women under 15 years to women aged 10-14 years.

³Rates computed by relating the number of events to women aged 40 years and over to women 40-44 years.

⁴Quotations fetal losses from recognized pregnancies of all gestational periods as reported by women in the 1982 and 1986 National Survey of Family Growth conducted by the National Center for Health Statistics. The rate of fetal loss depends on the degree to which losses of very early gestations are detected.

Table 4. Estimated pregnancy, live birth, and induced abortion rates by marital status and race: United States, 1980, 1990, and 1991
 [Rates per 1,000 women aged 15-44 years in specified group]

Marital status and measure	All races			White			All other		
	1980	1990	1991	1980	1990	1991	1980	1990	1991
Married									
All pregnancies ¹	126.9	121.2	117.6	124.4	120.7	116.1	145.3	129.7	127.6
Live birth	97.0	93.2	89.9	97.5	94.1	90.6	93.5	87.4	85.6
Induced abortion	10.5	8.8	8.4	8.6	7.1	6.6	24.7	20.4	20.8
Unmarried									
All pregnancies ¹	90.6	103.6	100.3	68.9	81.0	80.9	179.7	177.4	174.3
Live birth	29.4	43.8	45.2	18.1	32.9	34.6	75.2	79.7	78.8
Induced abortion	64.4	49.8	47.8	47.4	41.3	39.1	82.7	77.7	75.8

¹Includes pregnancies ending in fetal loss, not shown separately.

Table 5. Estimated number of pregnancies and pregnancy rates, by outcome of pregnancy by age, race, and Hispanic origin of women: United States, 1990 and 1991

Pregnancy outcome and race and Hispanic origin	Age									
	Total ¹	Under 15 years ²	15-19 years							40 years and over ¹¹
			Total	15-17 years	18-19 years	20-24 years	25-29 years	30-34 years	35-39 years	
1991										
Number in thousands										
Non-Hispanic										
White:										
All pregnancies	3,954	8	489	172	318	1,007	1,145	884	368	33
Live births	2,835	3	290	79	171	637	834	840	235	36
Induced abortions	774	4	164	61	103	284	163	106	88	16
Fetal losses ⁴	359	1	75	32	43	187	148	138	78	11
Black:										
All pregnancies	1,344	14	272	114	150	439	320	202	81	15
Live births	873	8	149	63	86	218	188	98	37	6
Induced abortions	507	7	101	40	61	178	119	67	39	7
Fetal losses ⁴	184	1	22	12	19	46	41	37	15	3
Hispanic ⁵										
All pregnancies	865	9	177	71	105	306	250	149	84	14
Live births	823	2	166	41	64	199	179	100	38	8
Induced abortions	209	1	40	14	28	73	60	28	13	4
Fetal losses ⁴	134	1	32	16	16	33	30	22	12	2
Rate per 1,000 women										
Non-Hispanic										
White:										
All pregnancies	91.8	1.3	64.7	51.3	139.8	151.4	154.7	107.6	47.3	8.6
Live births	61.0	0.5	43.4	23.8	70.5	85.7	112.7	77.8	30.2	4.8
Induced abortions	17.9	0.7	28.4	18.1	42.8	38.8	22.8	12.9	7.4	2.2
Fetal losses ⁴	12.9	0.2	13.0	9.5	17.7	18.0	20.0	16.8	9.7	1.8
Black:										
All pregnancies	174.8	11.0	216.7	157.5	297.9	337.2	232.3	142.7	63.9	14.4
Live births	87.6	4.9	118.9	66.7	103.1	195.1	118.3	62.2	26.4	5.7
Induced abortions	86.9	3.1	80.5	54.2	115.7	136.4	86.3	47.1	23.0	6.2
Fetal losses ⁴	21.8	0.9	17.2	15.8	19.1	34.7	29.7	26.3	12.1	2.4
Hispanic ⁵										
All pregnancies	167.4	4.8	180.2	123.9	261.3	295.6	224.3	143.9	74.8	19.8
Live births	166.1	2.4	166.7	70.6	158.5	196.3	152.8	95.1	44.9	11.1
Induced abortions	36.2	1.4	40.4	24.7	63.0	65.1	44.4	27.1	15.5	5.2
Fetal losses ⁴	23.2	1.0	33.1	28.5	39.8	31.2	27.1	20.7	14.4	3.6

Table 5. Estimated number of pregnancies and pregnancy rates, by outcome of pregnancy by age, race, and Hispanic origin of women: United States, 1980 and 1991—Con.

Pregnancy outcome and race and Hispanic origin	Total ¹	Age								
		Under 15 years ²	15-19 years							40 years and over ³
			Total	15-17 years	18-19 years	20-24 years	25-29 years	30-34 years	35-39 years	
1980										
Non-Hispanic										
Number in thousands										
White:										
All pregnancies	4,123	8	532	181	351	1,009	1,227	897	358	61
Live births	2,711	3	259	79	180	663	890	648	227	33
Induced abortions	844	5	198	71	125	277	179	111	80	17
Fetal losses ⁴	568	1	77	32	45	109	158	138	73	11
Black:										
All pregnancies	1,345	14	299	118	184	432	327	201	79	14
Live births	874	8	130	62	88	214	165	98	38	6
Induced abortions	507	7	108	42	85	173	119	68	29	6
Fetal losses ⁴	184	1	22	11	10	45	49	37	15	2
Hispanic ⁵										
All pregnancies	919	4	187	86	100	288	243	144	61	13
Live births	587	2	98	37	81	190	167	88	36	7
Induced abortions	185	1	38	14	24	67	46	27	12	3
Fetal losses ⁴	127	1	30	15	15	32	30	21	12	2
Non-Hispanic										
Rate per 1,000 women										
White:										
All pregnancies	85.6	1.4	87.6	58.6	130.2	155.7	158.9	110.0	47.4	8.8
Live births	62.8	0.5	42.6	23.1	66.9	87.9	115.3	79.2	29.9	4.8
Induced abortions	19.6	0.8	32.3	21.0	48.5	41.5	23.1	13.7	7.8	2.4
Fetal losses ⁴	13.2	0.2	12.7	9.4	15.8	16.4	20.4	17.1	8.8	1.5
Black:										
All pregnancies	177.6	11.4	216.5	168.0	237.4	332.8	234.0	144.3	64.0	14.5
Live births	99.0	5.9	146.2	84.9	137.5	185.2	118.3	70.2	28.8	5.8
Induced abortions	87.0	5.4	85.5	57.7	117.4	133.1	85.4	47.5	23.5	6.4
Fetal losses ⁴	21.6	0.9	18.8	15.5	18.5	34.6	30.2	25.8	11.9	2.4
Hispanic ⁵										
All pregnancies	185.7	4.5	170.3	185.7	244.1	274.5	222.4	148.5	75.2	20.3
Live births	107.6	2.4	100.2	65.8	147.6	180.6	152.8	98.1	45.2	11.4
Induced abortions	38.1	1.1	38.1	24.3	58.5	62.4	42.6	27.2	15.4	5.2
Fetal losses ⁴	23.0	1.0	31.0	28.8	37.0	30.3	27.1	21.2	14.6	3.7

¹ Rates computed by relating the number of events to women of all ages to women aged 15-44 years.

² Rates computed by relating the number of events to women under 15 years to women aged 10-14 years.

³ Rates computed by relating the number of events to women aged 40 years and over to women aged 40-44 years.

⁴ Excludes fetal losses from recognized pregnancies of all gestational periods as reported by women in the 1982 and 1991 National Survey of Family Growth conducted by the National Center for Health Statistics. The rate of pregnancy loss depends on the degree to which losses at very early gestation are detected.

⁵ Women of Hispanic origin may be of any race.

NOTE: Due to rounding, figures may not add to totals.

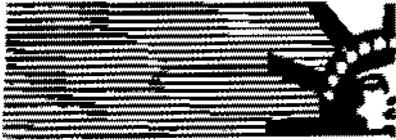
Table 6. Estimated percent distribution of pregnancies by outcome of pregnancy, according to age, race, and Hispanic origin of women: United States, 1990 and 1991

Pregnancy outcome and race and Hispanic origin	Total	Age								
		Under 15 years	15-19 years			20-24 years	25-29 years	30-34 years	35-39 years	40 years and over
			Total	15-17 years	18-19 years					
1991										
Non-Hispanic										
White:										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	65.5	35.4	51.2	46.1	63.9	63.2	72.9	72.4	63.6	55.3
Induced abortions	19.5	59.3	21.5	35.3	32.5	28.2	14.2	12.0	15.6	25.5
Fetal losses	14.0	14.3	15.3	18.6	13.5	10.8	12.9	15.6	20.5	18.1
Black:										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	50.1	45.0	54.9	55.1	54.7	48.2	50.1	48.6	45.2	40.0
Induced abortions	37.7	48.7	37.2	34.9	38.8	40.5	37.1	33.0	36.0	33.3
Fetal losses	12.2	6.2	8.0	10.1	6.4	10.3	12.6	18.4	18.9	16.7
Hispanic¹										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	64.6	50.5	59.2	57.0	60.7	65.2	69.1	65.8	60.6	56.0
Induced abortions	21.5	29.1	22.4	20.0	24.1	23.8	18.6	18.8	20.7	25.0
Fetal losses	13.8	20.4	18.4	23.0	15.2	10.9	12.1	14.4	19.3	18.6
1990										
Non-Hispanic										
White:										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	65.7	32.4	48.7	43.4	51.4	62.8	72.8	72.0	63.1	54.9
Induced abortions	26.5	54.5	38.9	39.1	35.7	28.6	14.6	12.4	18.6	27.4
Fetal losses	13.8	13.1	14.5	17.5	12.9	10.5	12.9	15.5	20.3	17.7
Black:										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	50.1	44.3	53.7	53.7	53.7	49.6	50.6	45.6	44.7	39.8
Induced abortions	37.7	47.5	38.6	36.5	40.0	40.0	38.5	32.9	36.6	43.4
Fetal losses	12.2	8.1	7.8	9.8	6.9	10.4	12.6	18.4	18.7	16.5
Hispanic¹										
All pregnancies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Live births	64.9	53.4	58.9	56.4	60.5	65.9	66.7	67.0	60.1	56.3
Induced abortions	21.2	25.6	23.0	20.8	24.4	23.1	19.2	18.6	20.5	25.6
Fetal losses	13.9	21.6	18.2	22.8	15.2	11.0	12.2	14.5	19.4	18.1

¹Persons of Hispanic origin may be of any race.

NOTE: Based on unrounded frequencies.

NARAL Promoting Reproductive Choices



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ARTICLES

Abortion Services in the United States, 1991 and 1992

By Stanley K. Henshaw and Jennifer Van Vort

According to a survey by The Alan Guttmacher Institute, 1,529,000 abortions were performed in 1992, the lowest number of abortions since 1979. The abortion rate has gradually declined, from a high of 29 per 1,000 women of reproductive age in 1981 to 26 per 1,000 in 1992. The number of hospitals, clinics and physicians' offices that provide abortions—2,380 in 1992—has been declining at a rate of about 65 a year. Most of the decline has occurred among hospitals; the number providing abortions decreased by 18% between 1988 and 1992. Most U.S. counties (84%) have no known abortion provider, and in nonmetropolitan areas, 94% of counties have no provider. Among metropolitan areas, 33% have either no abortion provider or none that serves at least 50 women per year. Among states, North Dakota and South Dakota have only one provider each. Most abortions (69%) are performed in abortion clinics, and only 7% are performed in hospitals. Fewer than 1% of women who have an abortion are hospitalized for the procedure.

(Family Planning Perspectives, 26: 100-106 & 112, 1994)

In recent years, health care providers have become concerned about an apparent decline in the number of physicians willing to perform abortions and, consequently, a decrease in the availability of abortion services.¹ Between 1982 and 1987 the proportion of births that resulted from unintended pregnancies increased, while the proportion of unintended pregnancies that ended in abortion decreased.² These findings suggest that abortion services may be less accessible.

To obtain data on the availability of abortion services, The Alan Guttmacher Institute (AGI) conducts periodic surveys of all known abortion providers in the United States. These surveys are the most complete source of state and national information on the number, type and geographic distribution of abortion providers. For most states, and the United States as a whole, these surveys provide the most

complete information on the number of abortions performed. While abortion statistics are also collected by most state health departments and compiled by the Centers for Disease Control and Prevention (CDC),³ abortion reporting is incomplete in most states, and few states publish information about abortion providers.

The 10th AGI survey gathers information on the availability of abortion services in 1987 and 1988.⁴ In this article, we present the results of the latest AGI survey, which includes information about abortions provided in 1991 and 1992. We describe trends in abortion numbers and rates nationally and by state, geographic availability of abortion services, and trends in the numbers of abortion providers, according to type of provider and case load.

Methodology

In February 1993, we mailed questionnaires to all hospitals, clinics and physicians' offices thought to have provided abortions during 1991 and 1992. The mailing list included all facilities surveyed by AGI in 1989, excluding those that did not provide abortions in 1987 and 1988 and those that informed AGI in 1989 that they had stopped

to the list the names of possible new providers, obtained from affiliates of Planned Parenthood and chapters of the National Abortion Rights Action League. We included other new providers from the telephone yellow pages of all major cities; the membership directory of the National Abortion Federation; newspaper articles from a national clipping service; and, for the first time, a list purchased from a commercial mailing list vendor. Our updated list includes 3,156 possible providers.

Two versions of the questionnaire were used—one for hospitals and one for non-hospital facilities. Both versions asked for the number of induced abortions, including menstrual regulation and excluding spontaneous abortions, performed at the location in 1991 and 1992. Hospitals were asked for the number of inpatient and outpatient abortion procedures performed, and nonhospital facilities were asked for the proportion of patient visits for abortion services. Other questions (not analyzed in this study) asked about the distance patients live from the facility, patient scheduling policies, charges for services, and harassment by antiabortion activists.

If we did not receive a response within three weeks of the mailing, we sent as many as three follow-up mailings. For the facilities that still did not respond, we used health department data in states that provide information on individual facilities. We contacted the remaining nonrespondents by telephone and asked for the number of abortions they had performed; some of the facilities, reluctant to respond because of fear of antiabortion activity, required up to a dozen calls for us to obtain information or a final refusal.

We used data from state health departments for 66 facilities that were not included in the mailing. Among these, 43 were newly identified providers and 23 were listed on AGI's old mailing list.

Stanley K. Henshaw is deputy director of research and Jennifer Van Vort is research associate for The Alan Guttmacher Institute, New York. The authors would like to thank senior research assistant Theresa Camelo and clerical research assistants Jessica Black and Lisa Genetian for their invaluable assistance with this project. The research on which this article is based was funded in part by the Robert Sterling Clark Foundation and the General Services Foundation.

U.S. Abortion Services, 1991-1992

The changing age distribution of women in their reproductive years could be affecting the abortion rate: Women in the baby-boom generation, currently in their 30s and 40s, will have fewer abortions than

they did at younger ages. When the 1988 age-specific abortion rates are applied to 1992 population estimates, the number of abortions expected in 1992 would be 10,000 fewer than the number in 1988. This

amounts to one-sixth of the actual decline of 62,000 abortions. The abortion ratio should be affected less by the changing age distribution, because birthrates, as well as abortion rates, decline among women older than 30 years.

As Table 2 shows, the largest numbers of abortions are performed in the most populous states: California (304,000 abortions in 1992), New York (195,000) and Texas (97,000). These states plus Florida and Illinois account for almost half (49%) of all abortions in the country. At the other end of the spectrum is Wyoming, the state with the fewest abortions; only 460 were performed there in 1992.

Abortion rates by state of occurrence should be interpreted cautiously because they do not always reflect the extent of abortions obtained by residents, who may travel to other states for abortion services. In 1987 (the most recent year for which data are published), the number of Wyoming residents who had abortions in other states was greater than the number of residents who had abortions in Wyoming. In Indiana, South Dakota and West Virginia, the abortion rate for state residents was more than 35% higher than the rate based on the abortions occurring in the state.⁷ By the same token, abortion rates are inflated in the states that provide services to large numbers of out-of-state women. In 1987, the rates by state of occurrence were more than 60% higher than the rates by state of residence in the District of Columbia, Kansas and North Dakota.⁸

Other factors that can cause abortion rates according to state of occurrence to vary widely include the proportion of the population that is nonwhite, Hispanic or unmarried (characteristics associated with above-average abortion rates); the degree of urbanization (large cities tend to have higher rates); the extent of subsidies for abortion services for low-income women; and the availability of abortion services. New York and Hawaii have the highest rates, at 46 abortions per 1,000 female residents aged 15-44, and rates are also higher than 40 in California and Nevada. The rate of 138 abortions for the District of Columbia is higher than that of any state. Relatively high rates are characteristic of central cities; the rate for the District of Columbia includes large numbers of women from outside the District who obtain abortion services there. The census divisions with the highest abortion rates are on the East and West Coasts: Pacific (39 abortions per 1,000 women), Middle At-

Table 2. Number of reported abortions, rate per 1,000 women aged 15-44 and percentage change in rate, by state of occurrence, 1988, 1991 and 1992

State	Number			Rate			% change, 1988-1992
	1988	1991	1992	1988	1991	1992	
Total	1,590,760	1,558,510	1,528,930	27.3	26.3	25.9	-5
New England							
Connecticut	57,450	62,760	78,360	27.9	26.5	25.2	-10
Maine	4,620	4,210	4,200	16.2	14.7	14.7	-9
Massachusetts	43,720	44,150	40,660	30.2	30.2	28.4	-6
New Hampshire	4,710	4,260	3,890	17.3	15.7	14.6	-17
Rhode Island	7,190	7,500	6,990	30.8	31.5	30.0	-2
Vermont	3,590	3,110	2,900	25.6	22.7	21.2	-18
Middle Atlantic							
New Jersey	299,710	297,990	300,450	34.0	33.9	34.6	2
New York	63,900	55,800	55,320	35.1	30.9	31.0	-12
Pennsylvania	183,980	190,410	193,390	43.2	44.5	46.2	7
Maryland	51,830	51,780	49,740	18.9	18.2	18.6	-2
East North Central							
Illinois	223,180	204,270	204,810	22.4	20.6	20.7	-8
Indiana	72,570	64,990	66,420	26.4	24.1	25.4	-4
Michigan	15,760	15,840	15,840	11.9	12.1	12.0	1
Ohio	63,410	55,800	55,580	29.5	25.1	25.2	-11
Wisconsin	53,400	52,030	48,520	21.0	20.4	19.5	-7
Minnesota	18,040	15,510	15,450	16.0	13.6	13.5	-15
West North Central							
Iowa	69,550	61,830	57,340	16.7	15.3	14.3	-15
Kansas	9,420	7,200	6,970	14.6	11.7	11.4	-22
Minnesota	11,440	12,770	12,570	20.1	22.9	22.4	11
Missouri	16,560	16,880	16,160	18.2	18.3	15.6	-14
Nebraska	19,490	15,770	13,510	16.4	13.5	11.6	-29
North Dakota	6,490	6,230	5,580	17.7	17.5	15.7	-11
South Dakota	2,230	1,600	1,490	14.9	11.4	10.7	-28
South Dakota	800	920	1,040	5.7	6.4	6.9	19
South Atlantic							
Delaware	275,640	271,010	269,200	27.7	26.2	25.9	-7
District of Columbia	5,710	5,720	5,730	35.7	34.9	33.2	-1
Florida	28,120	21,510	21,320	163.3	135.1	132.4	-15
Georgia	82,850	81,570	84,660	31.5	29.9	30.0	-5
Maryland	30,720	39,720	39,680	23.5	24.2	24.0	2
North Carolina	32,670	33,000	31,260	29.6	27.5	26.4	-8
South Carolina	39,720	37,210	36,180	25.4	23.2	22.4	-12
Virginia	14,180	13,520	12,190	18.7	15.8	14.2	-15
West Virginia	35,420	35,170	35,020	23.7	22.8	22.7	-5
West Virginia	3,270	2,590	3,140	7.5	6.3	7.7	2
East South Central							
Alabama	55,950	53,670	54,060	15.6	14.9	14.9	-4
Kentucky	18,220	17,400	17,450	16.7	16.2	16.2	-3
Mississippi	11,520	8,270	10,000	13.0	9.5	11.4	-12
Tennessee	5,120	6,160	7,550	8.4	13.3	12.4	48
Tennessee	22,090	19,840	19,060	16.9	16.9	16.2	-14
West South Central							
Arkansas	130,400	126,140	127,070	21.3	19.6	19.6	-1
Louisiana	6,250	7,190	7,130	11.6	13.6	13.5	16
Oklahoma	17,340	13,930	13,600	18.5	13.7	13.4	-18
Texas	12,120	9,130	8,940	16.2	12.6	12.5	-23
Texas	100,690	95,930	97,400	24.8	23.0	23.1	-7
Mountain							
Arizona	69,410	71,530	69,660	21.9	21.5	21.0	-1
Colorado	23,070	19,690	20,600	28.6	23.2	24.1	-16
Idaho	18,740	21,010	19,680	22.4	25.3	23.6	6
Montana	1,920	1,740	1,710	8.2	7.6	7.2	-12
Nevada	3,050	3,660	3,200	16.5	20.6	18.2	11
New Mexico	10,190	14,450	13,300	40.3	49.0	44.2	10
Utah	6,810	6,190	6,410	19.1	17.2	17.7	-7
Wyoming	5,030	4,250	3,940	12.8	10.4	9.3	-27
Wyoming	600	620	460	3.1	4.8	4.2	-16
Pacific							
Alaska	373,460	394,710	368,040	41.5	40.8	39.7	-7
California	2,390	2,400	2,370	16.2	16.9	16.5	-10
Hawaii	311,720	320,980	304,330	43.9	44.4	42.1	-6
Oregon	11,170	12,130	12,190	43.0	43.0	46.0	7
Washington	18,960	18,590	18,050	23.9	24.9	23.9	0
Washington	31,220	32,640	33,190	27.6	27.6	27.7	0

Note: In this and subsequent tables, numbers of abortions are rounded to the nearest 10. Sources: 1988—see reference 4; 1991-1992—see sources to Table 1.

The lowest abortion rates were in Wyoming (four abortions per 1,000 women), South Dakota (seven per 1,000), Idaho (seven), West Virginia (eight) and Utah (nine). All of these states except Utah are largely rural, with no large metropolitan areas. Among the census divisions, abortion rates are lowest in the East South Central (15 per 1,000 women) and West North Central (14).

Although we surveyed Puerto Rico, we could not determine the number of abortions performed there because the response to our questionnaires was very low. However, a recent study estimated that 17,000 abortions were performed in Puerto Rico in 1991, for an abortion rate of 20 per 1,000 women aged 15-44.⁹

Between 1988 and 1992, abortion rates decreased in 36 states and the District of Columbia, as well as in the country as a whole. The largest declines occurred in the West North Central states, where the abortion rate decreased by 15%, and in one of that region's states, Missouri, by 29%. Other states in the country where the abortion rate declined by more than 25% include North Dakota (28%) and Utah (27%). In North Dakota, two physicians stopped performing abortions, leaving only one provider. At the end of 1988, Michigan and the District of Columbia stopped funding abortions for Medicaid patients; both experienced greater declines in their abortion rates between 1988 and 1991 than did the United States in general.¹

The abortion rate increased in only one census division, the Middle Atlantic. The 2% increase was entirely the result of a 7% increase in New York. Five states in the country experienced increases of more than 10%: Mississippi (48%), South Dakota (19%), Arkansas (16%), Kansas (11%) and Montana (11%). Mississippi gained three providers, increasing from five providers in 1988 to eight in 1992. It is not surprising that an expansion of services in Mississippi resulted in an increase in abortions, since 32% of Mississippi residents in 1987 had gone to other states for abortions. The other states with higher abortion rates, however, had no change in the number of providers or experienced a net loss.

Service Availability

The distance a woman has to travel for abortion services can be an important determinant of her success at obtaining services. One measure of the availability of abortion services is the proportion of counties that have abortion providers and the proportion of women who live in those counties. The presence of a small provider,

however, may not represent true availability of services because small providers often do not want a large abortion caseload, and they usually do not advertise; hence, women may have difficulty finding out about and obtaining services from these providers. In 1992, 84% of all U.S. counties had no identified abortion provider, and 92% had none that performed at least 400 abortions. Thirty percent of women of reproductive age lived in counties that had no abortion provider and 41% lived in counties with no large provider. The number of counties with a provider declined from 714 in 1978¹⁰ to 495 in 1992, a decrease of 31%.

The scarcity of providers is much greater in nonmetropolitan than in metropolitan counties: Ninety-four percent of nonmetropolitan counties have no abortion services, and 65% of nonmetropolitan women live in unserved counties. Even among metropolitan counties, however, 51% have no abortion services. While many of the unserved metropolitan counties border counties with services, of the country's 320 metropolitan areas,¹¹ 91 have no identified abortion provider and another 14 have providers who together performed fewer than 50 abortions in 1992; thus, 33% of metropolitan areas are underserved.

These numbers have increased since 1988, when 70 metropolitan areas had no provider and 20 had providers that had performed fewer than 50 abortions. The increase of 15 underserved areas, from 90 to 105 includes nine that were newly created when population estimates were revised; that is, they were not considered metropolitan areas in 1988. However, 13 areas lost providers they had in 1988, while only five areas acquired new providers. As Table 3 shows, the states with the most underserved metropolitan

Table 3. Metropolitan areas reporting no abortions or fewer than 50, by state, 1992

Alabama Ariston Decatur Daman Florence Gadsden	Iowa Davenport Dubuque Sioux City	New Mexico Las Cruces*	Tennessee Clarksville Jackson
Arkansas Fort Smith Pine Bluff Texarkana	Kentucky Owensboro	New York Jamestown* Niagara Falls	Texas Abilene Amarillo Brazoria Bryan Galveston Longview Midland San Angelo Sherman Tyler Victoria Waco Wichita Falls
California Maricopa Visalia Yuba City*	Louisiana Alexandria Houma Lafayette Lake Charles Monroe	North Carolina Burlington	Utah Provo
Colorado Pueblo	Maine Lewiston	Ohio Canton* Hamilton Lima Lorain Mansfield Steubenville	Virginia Danville* Lynchburg*
Florida Bradenton Ocala Panama City	Maryland Cumberland*	Oklahoma Enid Lawton	Washington Bromfield
Georgia Albany* Athens Macon	Michigan Battle Creek Jackson*	Oregon Salem*	West Virginia Huntington Parkersburg Wheeling
Illinois Bloomington Decatur Joliet Kankakee Springfield	Minnesota St. Cloud	Pennsylvania Allentown Beaver County Erie Johnstown Lancaster Sharon Williamsport	Wisconsin Eau Claire Janesville Kenosha La Crosse Shobogan Wausau
Indiana Anderson Bloomington* Elkhart Evansville Kokomo Muncie Terre Haute	Mississippi Joliet* Pascagoula	Missouri Joplin St. Joseph	South Carolina Anderson Florence*
	Nebraska Lincoln*	New Jersey Vineland	South Dakota Rapid City
			Wyoming Cheyenne

* Reported fewer than 50 abortions. Note: No abortions were reported in metropolitan areas without an asterisk.

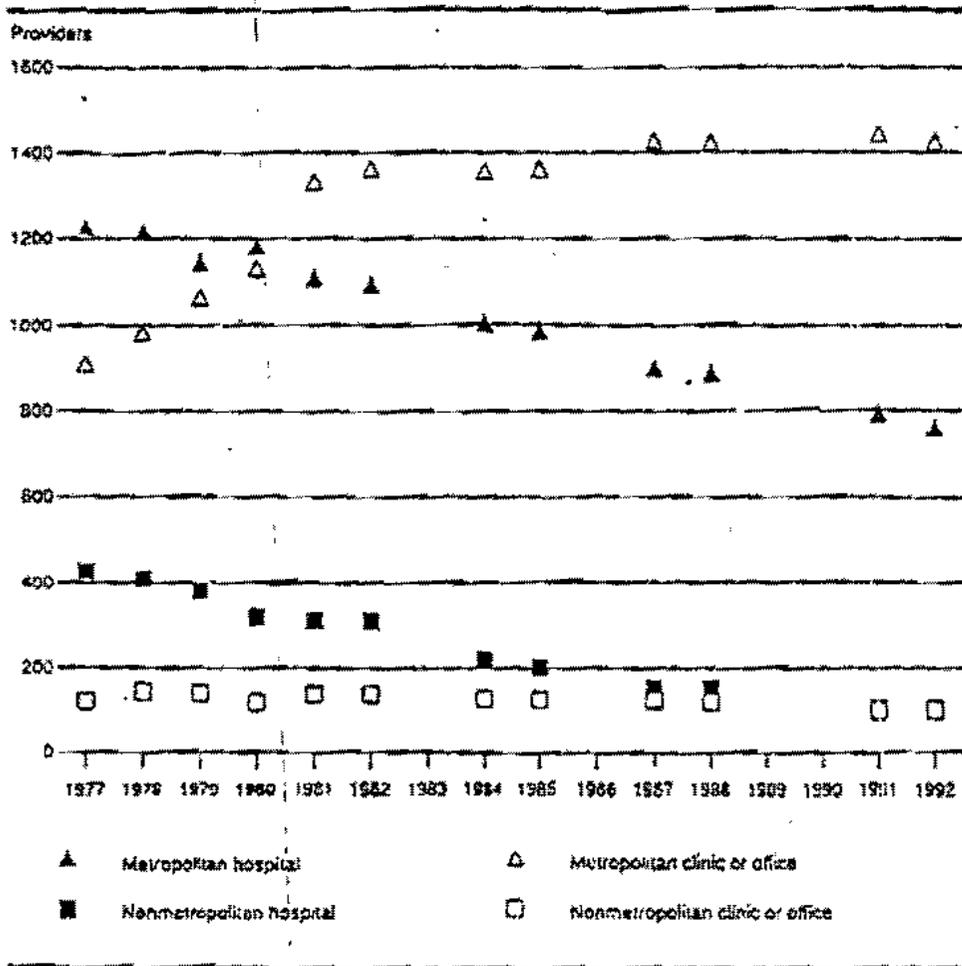
areas are Texas, with 13 underserved areas, and Indiana, Pennsylvania and Wisconsin, each with seven.

The number of underserved metropolitan areas is only one indication of wide state-to-state differences in the availability of abortion services. Another measure of availability is the number of counties in a state that have an abortion provider (Table 4, page 105). In 22 states, no more than five counties have a facility that reported providing at least one abortion in 1992, and in only 11 states do as many as half the counties have any abortion services. In eight states, fewer than one-third of women live in a county with a provider.

* The Office of Management and Budget defines a metropolitan area as a county containing a central city with a population of 50,000 or more, along with any contiguous counties with close economic ties to the central county.

U.S. Abortion Services, 1991-1992

Figure 1. Number of providers, by type of provider and metropolitan status, 1977-1982, 1984-1985, 1987-1988 and 1991-1992



In 1992, abortion services were provided by 2,380 facilities in the United States, a decline of 202 since 1988. The number of abortion providers declined by 18%, from a high of 2,908 in 1982. The loss of providers accelerated in the most recent survey period, from an average of 33 lost per year from 1985 to 1988, to an average of 51 providers per year from 1988 to 1992. The loss in the latest period was greater than appears in these figures because in 1992, 42 new providers were identified through special sample surveys of hospitals and physicians that were not conducted for 1988. Moreover, use of a commercial mailing list yielded 17 providers that might not have been located using 1988 procedures. When these new providers were excluded, the rate of loss in the 1988-1992 period approached 65 providers, or about 3%, per year.

Another indication of service availability is the number of identified abortion providers in a state, although this measure may be misleading if the facilities provide only a few abortions, which is often the case. All states except North Dakota and South Dakota have at least four

but several states experienced a distinct loss of providers since 1988. The greatest numerical losses occurred in California (which had a net loss of 54 providers), New York (16), Texas (12), North Carolina (11) and Florida (10). Large proportionate changes took place in several states in the middle of the country, including Indiana, Iowa, Kansas, Missouri and Tennessee, each of which lost 20-40% of its providers. Since 1988, North Dakota has lost two of its three providers and has joined South Dakota in having only one facility where women can obtain abortion services.

Nationally, there are 4.0 providers for each 100,000 women aged 15-44 in the population. Ten states appear to be especially underserved by this standard, with fewer than 1.5 providers per 100,000 women. The abortion rates of these states are 7-14 abortions per 1,000 women, well below the median rate of 18 for all states. Hawaii, which has the highest ratio of providers to population (19.5), also has the second highest abortion rate in the country. Reliance on private physicians

its abortion services contributes to Hawaii's high provider ratio. The abortion rates of the seven states with more than six providers per 100,000 women of reproductive age range from 17 to 45; all but two of these are above the median rate.

Because many providers serve only a few women, the relationship between the provider ratio and the abortion rate is not necessarily entirely causal; rather, the level of public acceptance of abortion may have influenced both the provider ratio and the abortion rate. All of the states on the East and West Coasts, except Georgia, Rhode Island and South Carolina, are above the national average in their provider ratios, while the only noncoastal states with above-average abortion ratios are Vermont and five western states (Colorado, Montana, Nevada, New Mexico and Wyoming).

Types of Facilities

The 2,380 facilities providing abortion services in 1992 included hospitals, abortion clinics, other nonhospital clinics and physicians' offices (Table 5, page 106). As a proportion of all providers, hospitals decreased from 40% in 1988 to 36% in 1992; in 1973, 81% of all providers were hospitals.¹¹ The 855 hospital providers accounted for 110,000 abortions, or 7% of the 1992 total. The proportion of abortions performed in hospitals has declined steadily since 1973, when hospitals provided more than half of all abortions. This trend has continued since 1988, when 10% of abortions were performed in hospitals. The decline in the number of hospital abortions has occurred because fewer abortions are performed in each hospital and because fewer hospitals offer abortion services.

In 1992, only 16% of the country's short-term, general hospitals provided abortion services, down from 19% in 1988. When Catholic hospitals are excluded, the proportion is 18%, down from 21%. Abortion services are available in 20% of private (excluding Catholic) hospitals, compared with only 13% of public hospitals.

Hospitals that offer abortion services tend to provide few abortions. Hospitals that allow abortion only when a woman's life or health is threatened by the continuation of her pregnancy are counted as abortion providers even if only one abortion was performed there. A majority (51%) of the hospitals that reported abortion services provided fewer than 30 each; these facilities together accounted for only 3,000 abortions. Only 20 hospitals performed 1,000 abortions or more. In 1992, only 12% of hos-

Most abortions are performed in the country's 441 abortion clinics, defined as nonhospital facilities in which half or more patient visits are for abortion services.* The largest of these (those that reported providing 5,000 or more abortions in 1992) together provided 325,000 abortions, or 21% of all abortions performed during the year. The proportion of all abortions performed in abortion clinics increased from 60% in 1985 to 64% in 1988 and 69% in 1992.

The category called "other clinics" includes group practices with clinic names, surgical centers, health maintenance organizations and other facilities with clinic names. Physicians' offices were included in this category if they provided 400 or more abortions in 1992 and did not indicate that at least half of patient visits were for abortion services; however, if they provided 1,500 abortions or more and did not indicate that fewer than half of patients were seeking abortion services, they were classified as abortion clinics. While there are as many "other clinics" as abortion clinics, they provide only 20% of all abortions. About 79% of other clinics perform fewer than 1,000 abortions a year, compared with 18% of abortion clinics.

The category of physicians' offices is made up of solo practitioners or group practitioners who performed fewer than 400 abortions in 1992. Two-thirds of the physicians' offices provide 30-350 abortions, and together they provide 4% of all abortions.

As Figure 1 shows, the decline in abortion providers since 1977 is substantial among both metropolitan and nonmetropolitan hospitals. The percentage change is greatest among hospitals in nonmetropolitan counties, where the number of providers fell from 427 in 1977 to 96 in 1992, a 78% decline, compared with a 38% decrease in metropolitan hospitals (1,227 to 759). The number of clinics and physicians' offices providing abortion services in nonmetropolitan areas also fell, from 145 in 1978 to 100 in 1992, although these types of facilities have increased in metropolitan areas since 1977 and have held steady at slightly more than 1,400 since 1987.

In the most recent four-year interval, 1988-1992, the total number of hospital providers fell by 185 or 18% (Table 6, page 106). In 1992, public hospitals constituted about one-fifth of all hospital providers, and the percentage decline among public

hospitals was slightly greater (22%) than among private hospitals (17%). Public hospitals under city and county control experienced a greater percentage reduction in providers than did those controlled by hospital districts and state agencies.

The number of nonhospital clinics offering abortion services was virtually unchanged between 1988 and 1992, but the

number of clinics that reported 1,000-4,990 abortions annually declined by 22, and was offset by increases in other size categories. The number of abortion clinics increased by 32 between 1988 and 1992 (not shown), while the number of clinic providers that do not specialize in abortion services declined by 28. The number of physicians' offices decreased slightly

Table 4. Measures of the availability of abortion services at the county level and provider level, by state, 1992

State	Counties			Providers			
	N	With a provider		N	Change since 1988	Per 100,000 women 15-44*	
		N	%	% of women*			
Total	2,199	495	16	70	2,390	-202	4.0
Alabama	67	6	9	44	20	0	2.1
Alaska	25	7	28	77	13	1	9.0
Arizona	15	4	27	84	28	-1	3.3
Arkansas	75	3	4	26	8	-2	1.5
California	58	39	67	96	554	-54	7.7
Colorado	53	15	24	86	59	-2	7.0
Connecticut	8	7	88	96	43	0	3.7
Delaware	2	2	87	85	8	-2	4.8
District of Columbia	1	1	100	100	15	-2	9.7
Florida	67	21	31	83	133	-10	4.7
Georgia	159	22	14	36	55	0	3.3
Hawaii	4	4	100	100	82	-1	19.6
Idaho	44	5	11	42	9	0	3.8
Illinois	102	9	9	68	47	-5	1.7
Indiana	92	9	10	45	19	-5	1.4
Iowa	89	4	4	30	11	-5	1.8
Kansas	105	6	6	53	15	-4	2.7
Kentucky	120	2	2	26	9	0	1.0
Louisiana	64	5	8	41	17	4	1.7
Maine	16	8	60	64	17	-4	6.0
Maryland	24	12	50	87	51	-2	4.3
Massachusetts	14	12	86	83	64	0	4.5
Michigan	83	18	22	75	70	-8	3.2
Minnesota	87	4	5	45	14	1	1.4
Mississippi	82	4	5	21	8	3	1.3
Missouri	115	5	4	48	12	-8	1.0
Montana	56	7	13	56	12	-1	6.6
Nabraska	93	3	3	52	9	0	2.5
Nevada	17	3	16	87	17	-3	3.6
New Hampshire	10	5	50	74	16	1	6.0
New Jersey	21	16	76	94	88	-1	4.9
New Mexico	33	6	18	36	20	-4	5.5
New York	62	37	60	93	289	-10	6.8
North Carolina	100	34	34	69	86	-11	5.3
North Dakota	53	1	2	19	1	-2	0.7
Ohio	88	9	10	54	45	-6	1.8
Oklahoma	77	4	6	45	11	-2	1.5
Oregon	36	9	25	73	40	-5	6.0
Pennsylvania	97	20	30	66	81	-9	3.0
Rhode Island	6	2	40	64	6	0	2.6
South Carolina	46	10	22	49	18	3	2.1
South Dakota	66	1	2	21	1	0	0.7
Tennessee	95	10	11	53	33	-8	2.8
Texas	254	19	7	67	79	-12	1.9
Utah	29	2	7	52	6	-2	1.4
Vermont	14	8	57	76	18	0	11.7
Virginia	136	34	25	57	84	-9	4.1
Washington	39	11	28	81	65	-3	5.4
West Virginia	58	2	4	17	5	-1	1.2
Wisconsin	72	5	7	39	16	-1	1.4
Wyoming	23	2	13	25	5	-2	4.6

* Population data from the 1990 census were used to calculate the percentage of women living in a county with a provider.

U.S. Abortion Services, 1991-1992

Table 5. Number and percentage distribution of abortion providers and abortions, by type of facility, according to caseload, 1992

Caseload*	Total		Hospitals		Abortion clinics		Other clinics		Physicians' offices†	
	N	%	N	%	N	%	N	%	N	%
Providers	2,380	100	855	36	441	19	448	19	636	27
<30	699	29	439	18	0	0	45	2	215	9
30-399	926	39	351	15	13	1	141	6	491	18
400-999	282	12	45	2	53	3	169	7	na	na
1,000-4,999	428	18	18	1	318	13	92	4	na	na
≥5,000	45	2	2	1	42	2	1	1	na	na
Abortions	1,528,930	100	109,950	7	1,067,800	68	367,020	20	54,460	4
<30	6,480	0.4	2,390	1	0	0	510	1	2,580	0.2
30-399	111,970	7	35,170	2	2,740	0.2	22,180	1	51,880	3
400-999	183,970	12	26,640	2	49,810	3	107,720	7	na	na
1,000-4,999	877,430	57	26,940	2	679,980	44	166,610	11	na	na
≥5,000	348,080	23	13,910	1	325,170	21	10,000	1	na	na

*In this table and Table 6, caseloads are rounded to nearest 10. †In this table and Table 6, physicians' offices reporting 400 or more abortions a year are classified as clinics (either abortion clinics or "other clinics"). ‡Fewer than 0.5%. Note: na is not applicable. Percentages may not add to 100 because of rounding.

(3%), and these providers tended to have smaller abortion caseloads.

Each survey finds that some facilities have initiated abortion services since the prior survey; that some have discontinued services and that some have changed provider category. Between 1988 and 1992, 275 hospitals stopped providing abortion services and 90 hospitals initiated services, for a net loss of 185 hospital providers. The 90 new hospital providers reported an average of only 28 abortions in 1992, compared with an average of 140 among hospitals that had been providers in 1988.

Between 1988 and 1992, 54 new abortion clinics began providing services and 63 were reclassified from other clinics or physicians' offices to abortion clinics; these were partially offset by 39 abortion clinics that ceased offering services and 46 that were reclassified. About half of the 32 abortion clinics gained, therefore, resulted from other clinics focusing on abortion services and about half from the creation of new clinics. Turnover was greater among other clinics and physicians' offices; 21% of the former and 24% of the latter were new providers that had reported no abortions in 1988. The caseloads of the new providers are much smaller, on average, than those of facilities that had offered services since 1988.

Discussion

Two very different strategies have been advocated for reducing the level of abortion in the United States: making it difficult or impossible for pregnant women to obtain abortion services, and reducing the level of unintended pregnancy and therefore the number of women seeking services. The latest data indicate that abor-

tion levels, whether measured by the rate per 1,000 women of reproductive age or the ratio of abortions to pregnancies, have decreased slowly but persistently since the early 1980s. A small part of the decline in the abortion rate may be attributable to the changing age-structure of the population, but the cause of most of the decline is not clear. Other reasons why abortion rates might have declined are that the number of unintended pregnancies may have decreased, that attitudes may have changed toward less acceptance of abortion or more acceptance of childbirth outside of marriage, or that services may have become less accessible.

What support can be found for these theories? Between 1981 and 1987, the rate

Table 6. Number of abortion providers in 1988 and 1992, and change between 1988 and 1992, by type of facility

Type of facility	1988	1992	Change 1988-1992	
			N	%
Total	2,582	2,380	-202	-8
Hospital	1,040	855	-185	-18
Public	230	180	-50	-22
Federal	1	1	0	0
State	39	34	-5	-13
Hospital district	22	98	+14	+17
County	58	42	-16	-28
City/county	50	35	-15	-30
Private	810	675	-135	-17
Voluntary, church	48	39	-9	-19
Voluntary, other	615	529	-86	-14
Proprietary	147	107	-40	-27
Nonhospital facility	1,542	1,525	-17	-1
Clinics	885	889	4	0
<30 abortions	33	45	12	38
30-399 abortions	147	154	7	5
400-999 abortions	233	237	4	2
1,000-4,999 abortions	432	410	-22	-5
≥5,000 abortions	40	43	3	8
Physicians' offices	637	635	-2	-0
<30 abortions	181	215	34	19
30-399 abortions	476	421	-55	-12

* Less than 0.5%.

of unintended pregnancy and unplanned births actually increased.¹² Since 1987, data on the intention status of births have not been available, but the rate of unintended pregnancy may have begun to decline, given that recent survey data show the proportion of women at risk of unintended pregnancy using no method of contraception is decreasing and the proportions using oral contraceptives and the condom are increasing.¹³ Nevertheless, it seems unlikely that most of the decline in abortion levels is attributable to reduced numbers of unintended pregnancies.

The possible effect of public attitudes toward abortion is even more difficult to measure. According to special tabulations of data from the General Social Survey (National Opinion Research Center, Chicago), public approval of legal abortion in six circumstances fell from 67% of those surveyed in 1980 to 62% in 1985; but by 1993, the proportion had returned to 67%. Personal attitudes toward abortion for oneself, however, may be distinctly different and may follow different trends.

Evidence that nonmarital childbearing has become more acceptable may be seen in the soaring birthrate of unmarried women, which was 30 births per 1,000 unmarried women of reproductive age in 1981, 39 per 1,000 in 1988 and 45 per 1,000 in 1991.¹⁴ Further, between 1981 and 1988, the proportion of pregnancies ending in abortion declined by 14% among unmarried women, compared with a 5% decline among married women.¹⁵

Regarding accessibility of abortion services, the declining number of providers suggests that services are becoming more difficult to obtain, especially for women living in nonmetropolitan areas, in smaller cities or in the Midwest. The proportion of nonmetropolitan counties with no abortion provider has continued to increase,

(continued on page 112)

Two very effective reversible contraceptives, the implant and the injectable, were introduced too recently to have affected pregnancy rates in 1992.

Condom Breakage and Slippage

14. ———, 1992, op. cit. (see reference 5).
 15. K. Tanfer, "National Survey of Men: Design and Execution," *Family Planning Perspectives*, 25:33-64, 1993.
 16. *Ibid.*
 17. M. Steiner et al., 1993, op. cit. (see reference 6).
 18. M. A. Leeper and M. Conzardy, 1989, op. cit. (see reference 3); J. Trussell, D. L. Warner and R. A. Hatcher, 1992, op. cit. (see reference 1); ———, 1992, op. cit. (see reference 5); and M. Steiner et al., 1993, op. cit. (see reference 6).

19. J. O. G. Billy et al., "The Sexual Behavior of Men in the United States," *Family Planning Perspectives*, 25:52-61, 1993.
 20. W. R. Cundy et al., 1993, op. cit. (see reference 2).
 21. M. Steiner et al., 1993, op. cit. (see reference 6).
 22. W. H. Greene, *Econometric Analysis*, Macmillan, New York, 1990.
 23. M. A. Leeper and M. Conzardy, 1989, op. cit. (see reference 3); and "Can You Rely....," 1989, op. cit. (see reference 9).

24. J. Trussell, D. L. Warner and R. A. Hatcher, 1992, op. cit. (see reference 1).
 25. *Ibid.*
 26. M. Steiner et al., 1993, op. cit. (see reference 6).
 27. J. Trussell, D. L. Warner and R. A. Hatcher, 1992, op. cit. (see reference 5).
 28. ———, 1992, op. cit. (see reference 1).
 29. M. Steiner et al., 1993, op. cit. (see reference 6).

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as has the number of unserved metropolitan areas. North Dakota, like South Dakota, now has only one provider in the entire state.

Decreases in the numbers of providers have been especially steep among hospitals. Among several explanations for this change, the most important is the relatively high cost of hospital abortion services.¹⁶ Changes in hospital policies in response to pressure from antiabortion groups may also be a factor. Even where nonhospital services are available, however, the presence of hospital abortion services is vital to the minority of women whose health status requires overnight postoperative observation or emergency equipment that only a hospital can provide.

Other women may be unable to obtain services from their personal physician if that physician prefers not to perform abortions in the office and is unable to use the local hospital for this purpose. A 1983 study found that 9% of obstetrician-gynecologists said they did not provide abortion services because they did not have access to a hospital that permitted the procedure.¹⁷ Abortion services in hospitals are also important as backup for clinics and for training gynecologic residents in performing abortions; if hospitals do not provide the service, residents will be less likely to receive training.¹⁸

The reduction in the number of providers has been accompanied by increasing concentration of services in specialized abortion clinics, where 69% of all abortions are now performed. Thus, abortion services are becoming even more isolated

from the mainstream of medical care, leaving physicians who provide these services vulnerable to stigmatization within the medical community. While the option of seeking abortion services that are organizationally separate from other medical care may be important to some women concerned about preserving their confidentiality, abortion services should also be available in the same facilities as other gynecological care.

References

1. D. A. Grimes, "Clinicians Who Provide Abortions: The Thinning Ranks," *Obstetrics & Gynecology*, 80:719-721, 1992; and National Abortion Federation, *Who Will Provide Abortions?* Washington, D. C., 1991.
 2. J. D. Forrest and S. Singh, "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives*, 22:206-214, 1990.
 3. L. M. Koonin et al., "Abortion Surveillance—United States, 1990," *Morbidity and Mortality Weekly Review, CDC Surveillance Summaries*, Vol. 42, No. 55-6, Dec. 17, 1993, pp. 29-57.
 4. S. K. Henshaw and J. Van Vorst, "Abortion Services in the United States, 1987 and 1988," *Family Planning Perspectives*, 22:102-108 & 142, 1990.
 5. American Hospital Association, *American Hospital Association Guide to the Health Care Field, 1992 Edition*, Chicago, 1992.
 6. S. K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, 22:74-89, 1990.
 7. S. K. Henshaw, L. M. Koonin and J. C. Schulz, "Characteristics of U.S. Women Having Abortions, 1987," *Family Planning Perspectives*, 23:75-81, 1991.
 8. *Ibid.*
 9. Women's Studies Project, Caysey University College, *Abortion in Puerto Rico: Current Practice and Policy Recommendations*, University of Puerto Rico, Caysey, 1993.
 10. S. K. Henshaw et al., *Abortion 1977-1979: Need and Services in the United States, Each State and Metropolitan Area*, Alan Guttmacher Institute, New York, 1981, Table V-4, p. 32.
 11. S. K. Henshaw and J. Van Vorst, eds., *Abortion Factbook, 1992 Edition: Readings, Trends, and State and Local Data to 1988*, Alan Guttmacher Institute, New York, 1992, p. 190.
 12. J. D. Forrest and S. Singh, 1990, op. cit. (see reference 2).
 13. J. D. Forrest and R. R. Fordyce, "Women's Contraceptive Attitudes and Use in 1992," *Family Planning Perspectives*, 24:—, 1992.

14. National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1981," *Monthly Vital Statistics Report*, Vol. 32, No. 2 Supplement, 1983, Table 15; ———, "Advance Report of Final Natality Statistics, 1988," *Monthly Vital Statistics Report*, Vol. 39, No. 4 Supplement, 1990, Table 16; and ———, "Advance Report of Final Natality Statistics, 1991," *Monthly Vital Statistics Report*, Vol. 42, No. 2 Supplement, 1993, Table 16.
 15. S. K. Henshaw and J. Van Vorst, 1992, op. cit. (see reference 11), pp. 176-177.
 16. S. K. Henshaw, "The Accessibility of Abortion Services in the United States," *Family Planning Perspectives*, 23:246-253, 1991.
 17. M. T. Orr and J. D. Forrest, "The Availability of Reproductive Health Services from U.S. Private Physicians," *Family Planning Perspectives*, 17:63-69, 1985, Table 5.

¹⁶As long ago as 1976, the failure of most hospitals to provide abortion services and the small abortion caseloads in many teaching hospitals were cited as causes of inadequate training of residents in performing abortions (B. L. Lindheim and M. A. Couerill, "Training in Induced Abortion by Obstetrics and Gynecology Residency Programs," *Family Planning Perspectives*, 10:24-28, 1978).

NARAL Promoting Reproductive Choices**Privately Funded Abortions at Military Hospitals**

Department of Defense (DOD) appropriations bills have prohibited the use of funds to perform abortion at military hospitals in almost all cases since 1979. The ban was made permanent by the DOD Authorization Bill of 1985. From 1985 until 1988 women stationed overseas were able to use their own funds to obtain abortion services at military hospitals. In 1988, DOD issued an administrative order - without Congressional consultation - extending the funding ban to prohibit women from obtaining abortion services at military facilities overseas, even if paid for with their own private funds.

President Clinton lifted the ban by Executive Order in January, 1993, permitting abortion services to be provided at U.S. military hospitals overseas if paid for with private, non-DOD funds. Congressman Robert Dornan (R-CA), Chairman of the National Security Subcommittee on Military Personnel has included language reinstating the ban in the DOD reauthorization bill.

The Executive Order does nothing to change the language in the DOD Authorization Bill which says that no federal funds may be used for abortion at military hospitals overseas. The President's Executive Order deals exclusively with the personal funds of women who require abortion services.

The Executive Order reinstated a policy that had been in place from 1985 through 1988, allowing abortions to be made available at military medical facilities overseas within the framework set up in *Roe v. Wade*, and in keeping with other laws and regulations governing military medical care.

This ban discriminates against women who have volunteered to serve their country by prohibiting them from exercising their legally protected right to choose simply because they are stationed overseas. While DOD policy respects host nation laws regarding abortion, to the extent feasible and consistent with legal obligations, Service women stationed overseas should have the same access to abortion services as do women in the U.S.

Prohibiting women from using their own funds to obtain abortion services at overseas military facilities endangers their health. Women stationed overseas depend on their base hospitals for medical care, and are often situated in areas where local facilities are inadequate or unavailable. This policy may cause a woman facing a crisis pregnancy to seek out an illegal, unsafe procedure.

National Abortion
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Action League

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This ban may cause a woman stationed overseas who is facing an unintended pregnancy to be forced to delay the procedure for several weeks until she can travel to a location where safe, adequate care is available. For each week an abortion is delayed, the risk to the woman's health increases.

All three branches of the military have "conscience clause" provisions which permit medical personnel who have moral, religious or ethical objections to abortion not to participate in the procedure. These "conscience clauses" remain intact.

NARAL
5/18/95

Second-Class Soldiers

The House National Security Committee yesterday launched the first of several expected Congressional efforts to overturn President Clinton's abortion policies. In approving a measure that would restore a ban on abortion services in military hospitals, it effectively voted to return military women (and servicemen's wives and daughters) to second-class citizenship.

In 1988 the Department of Defense banned most abortions in American military hospitals, even though no Federal funds have been used for such procedures since 1979. In 1993 Mr. Clinton lifted the ban by executive order, permitting abortion services to be provided at military hospitals if paid for by the patient.

Good medical care, not Federal funding or constitutional right, is the primary issue here. If a female soldier or member of a serviceman's family

lives in the United States, getting a safe, legal abortion is relatively simple. But it is not if they are stationed in countries where abortion is illegal or the blood supply unsafe, needles are not routinely sterilized and there are few reliable physicians. Such circumstances may force postponement or travel to a safer place. The longer an abortion is delayed the greater the risk and possible consequences to the woman's health.

In voting 32 to 20 to incorporate this punitive policy in the Department of Defense reauthorization bill, the committee has sent a clear message to America's military women. They can fight for their country. They can die for their country. But they cannot get access to a full range of medical services when their country stations them overseas. When the bill comes to the floor for a vote, the House should reject this callous proposition.

NY Times

pg. A28

5/25

A Bad Abortion Rule Revived

WITHIN DAYS of his inauguration, President Clinton delivered on a campaign promise by issuing a series of executive orders reversing Reagan-Bush-era policies on abortion. One of these overturned a 1988 regulation prohibiting the use of military hospitals abroad for abortions. The regulation was particularly burdensome on servicewomen and military dependents and had been fought by Congress but preserved by presidential veto or threat of veto. President Clinton's action was welcomed at the time, but now abortion opponents in Congress propose to turn the tables once again and reinstate the old policy by statute. This week, they won an important first victory, when Rep. Robert Dornan's military personnel subcommittee of the House National Security Committee voted for this backward step.

This is not an abstract or unusual problem for military families, but one that affects real people serving their country abroad often under difficult conditions. Although the government has never paid for military abortions, it had, before 1988, allowed service personnel and dependents who paid their own way, to use military hospitals

abroad for this procedure. The availability of these American facilities is of importance in parts of the world where abortions are illegal, or where local sanitary and medical conditions pose a substantial risk of infection. Armed forces doctors have terrible stories about problems that arose when the old policy was in force. A young military wife whose eagerly awaited first child was found to suffer from fetal abnormalities incompatible with life was forced to carry the child for 10 weeks after receiving this devastating news, until it died. Young servicewomen either had to wait weeks for space available on aircraft headed home or spend hundreds of dollars for transportation to Japan, where the procedure typically costs another \$2,500. There is absolutely no reason to impose these conditions on service personnel and families abroad.

It won't be easy to stop this return to a harsh policy. The full National Security Committee will mark up the defense authorization bill, of which this is a part, on Wednesday, and Mr. Dornan's forces expect another win. Legislators with an ounce of concern and a sense of responsibility for Americans serving abroad should resist.

WASHINGTON POST

page A22

5/20/95

NARAL Promoting Reproductive Choices



THE CHRISTIAN COALITION'S CONTRACT: AN ASSAULT ON WOMEN'S REPRODUCTIVE HEALTH

The Christian Coalition's "Contract with the American Family" is a significant first step in a broader campaign by the radical right to enact a political agenda that will infringe on the liberties of millions of Americans. The Contract is a dangerous document cleverly designed to hide the radical right's goal of criminalizing abortion in the United States. The carefully scripted Contract uses code words to describe an abortion ban when it states:

We support constitutional and statutory protection for the unborn child. . . .
We urge Congress to take the following action as a beginning toward that end. . . .

This statement is a call for a very extreme and unpopular goal -- to make abortion illegal. Legal protection for "the unborn child" would criminalize abortion in every state in this country. The "Contract with the American Family" attempts to disguise this reality by supporting an abortion ban, and then calling for three preliminary measures that would have serious consequences for women's health: (1) permit states to deny rape and incest victims Medicaid funding for abortions; (2) severely restrict all third trimester abortions and outlaw the D&X procedure; (3) eliminate funding for family planning programs.

1. Permit States to Deny Rape and Incest Victims Medicaid Funding for Abortion

The Christian Coalition's call to eliminate abortion from the Medicaid program is particularly callous and cruel because it is directed at low income women who are victims of rape or incest.

- It is important for victims of rape and incest have some control over a resulting pregnancy. The failure to provide abortion coverage could force a woman to bear the child of her rapist against her will.
- Once a state elects to participate in the Medicaid program, it must comply with federal standards. In 1993, Congress authorized federal reimbursement for the termination of pregnancies resulting from rape or incest. The Medicaid program has always required states to fund pregnancy terminations for which federal reimbursement is available.

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2. Severely Restrict All Third Trimester Abortions and Outlaw the D&X Procedure

Abortion late in pregnancy occurs under the most dire circumstances -- when a woman's life or health is in danger or there is severe fetal abnormality. When an abortion is needed, the physician's decision about which procedure to use should be based on the health needs of the woman. The D&X procedure that opponents of choice want to ban is often the safest available for late abortions. Which abortion method to use is a medical decision that should be made by a physician, not the government.

- Abortion late in pregnancy occurs under tragic circumstances including when a woman is carrying a fetus with no spinal cord and therefore no chance of survival, and in cases of Tay-Sachs disease or anencephaly.
- The onset or worsening of a disease or medical condition may create the need for an abortion which did not exist at the beginning of pregnancy. Among the medical conditions that present increased risks to women's health are diabetes, cardiovascular disease, cancer (including cervical, ovarian and breast cancer), high blood pressure, kidney disease and immunity disorders.¹
- Late abortions are rare: one one-hundredth of one percent of abortions are performed after 24 weeks. Only three doctors in the United States, located in California, Colorado and Kansas, are known to offer abortion services during the last three months of pregnancy.²
- In *Roe v. Wade*, the Supreme Court held that, prior to viability -- the point at which a fetus is potentially able to live outside the womb -- states may not interfere with a woman's right to make her own decision regarding abortion. After viability, which usually occurs at approximately 24 to 28 weeks of pregnancy, states may prohibit abortions unless the procedure is necessary to protect a woman's life or health.³

3. Eliminate Funding for Family Planning Programs

The Christian Coalition suggests that Congress should eliminate the cornerstones of federal family planning efforts: the Title X Program and expenditures for family planning under Medicaid and International programs. Title X of the Public Health Services Act is dedicated primarily to funding family planning and other services including contraceptive care, pregnancy and STD/HIV testing, sterilization services and diabetes and anemia screening for low-income women. The Medicaid program is the largest source of federal funds for family planning services. If funding for these programs were to continue, the Contract signals that a gag rule should be imposed.

- One of every five women receiving family planning services depends on a clinic funded at least in part by Title X. Eighty-three percent of these women rely on clinics funded by Title X as their only source of family planning services. In 1987-1988, eighty-four percent of the women who received family planning services at Title X clinics received medical contraceptive services.⁴
- Eliminating funding for family planning programs would endanger the health and lives of women, men and children by denying many people access to necessary reproductive health care.
- A gag rule would prohibit medical professionals at clinics that receive federal funds from counseling or referring for abortion. The rule would endanger women's lives and health by denying them complete and accurate information about their reproductive choices. It would also interfere with the doctor-patient relationship by requiring physicians to compromise their best medical judgment as to what information or treatment is in the best interests of their patients.

In a veiled attempt to begin the process of eliminating a woman's right to choose, the "Contract with the American Family" calls for punitive policies that would endanger women's lives and health. If they are successful there is no doubt that the radical right will seek to move Congress further down this road until they reach their desired end -- to make abortion illegal. The policies promoted by the "Contract with the American Family" are inherently dangerous and are designed to lull policy makers into endangering women's health while chipping away at a woman's right to choose. Instead, America should pursue policies that improve women's health and reduce the need for abortion, including improved access to family planning services, prenatal care and reproductive health services and programs to reduce teen pregnancy.

ENDNOTES

1. F. Gary Cunningham, M.D., Paul C. MacDonald, M.D. and Norman F. Gant, M.D., Williams Obstetrics, 18th ed. (Norwalk, Connecticut: Appleton & Lange, 1989), 656-857; Hunter, "Position Paper/Time Limits on Abortion," 110.
2. Rachel Benson Gold, *Abortion and Women's Health: A Turning Point For America?* (New York: Alan Guttmacher Institute, 1990), 23.
3. *Roe v. Wade*, 410 U.S. 113 (1973).
4. *Title X Family Planning Clinic Network: Final Analysis*, Sept. 16, 1992 (New York: Alan Guttmacher Institute).

NARAL Promoting Reproductive Choices



FAX COVER SHEET

DATE: 6/21/95

TO: Bruce Reed

OFFICE: White House

FROM: Katja PHONE: 973-3053

THIS IS PAGE ONE OF 21 TOTAL PAGES

COMMENTS:

Hope this information is helpful - please call if we can be of additional assistance.

- 1 HJRes18 Emerson (R-MO) 01/04/95
Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.
(BILLTRACK; No digest information available)
Item Key: 359

- 2 HR222 Dickey (R-AR) 01/04/95
A bill to prohibit the secretary of Health and Human Services from finding that a state medicaid plan is not in compliance with title XIX of the Social Security Act solely on the grounds that the plan does not cover abortions for pregnancies resulting from an act of rape or incest if coverage for such abortions is inconsistent with state law.
(BILLTRACK; No digest information available)
Item Key: 517

- 3 HR231 Dornan (R-CA) 01/04/95
A bill to amend the Internal Revenue Code of 1986 to deny the deduction for medical expenses incurred for an abortion.
(BILLTRACK; No digest information available)
Item Key: 526

- 4 HJRes23 Volkmer (D-MO) 01/04/95
Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.
(BILLTRACK; No digest information available)
Item Key: 364

- 5 HJRes26 Dornan (R-CA) 01/04/95
Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.
(BILLTRACK; No digest information available)
Item Key: 367

- 7 HR237 Emerson (R-MO) 01/04/95
A bill to prohibit the use of federal funds for abortions except where the life of the mother would be endangered.
(BILLTRACK; No digest information available)
Item Key: 532

*** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES ***

MEASURE: HJRes18

SPONSOR: Emerson (R-MO)

OFFICIAL TITLE: Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.

*NO UNBORN LIFE PERSON
WOULD NULLIFY
ROL
PREVENT DEATH OF
MOM*

INTRODUCED: 01/04/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

*Should be
deprived of
life by
ANY PERSON*

COMMITTEES: House Judiciary

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on the Judiciary (CR p. H175)

*** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES ***

MEASURE: HR222

SPONSOR: Dickey (R-AR)

OFFICIAL TITLE: A bill to prohibit the secretary of Health and Human Services from finding that a state medicaid plan is not in compliance with title XIX of the Social Security Act solely on the grounds that the plan does not cover abortions for pregnancies resulting from an act of rape or incest if coverage for such abortions is inconsistent with state law.

INTRODUCED: 01/04/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

COMMITTEES: House Commerce

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on Commerce (CR p. H169-H170)

***** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES *****

MEASURE: HJRes26

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: Joint resolution proposing an amendment to the
Constitution of the United States with respect to the
right to life.

INTRODUCED: 01/04/95

COSPONSORS: 5 (Dems: 0 Reps: 5 Ind: 0)

COMMITTEES: House Judiciary

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on the Judiciary (CR p. H175)

01/04/95 Original Cosponsor(s): 5

Burton, D. (R-IN)

Hyde (R-IL)

Vucanovich (R-NV)

Hancock (R-MO)

Smith, C. (R-NJ)

***** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES *****

MEASURE: HR237

SPONSOR: Emerson (R-MO)

OFFICIAL TITLE: A bill to prohibit the use of federal funds for
abortions except where the life of the mother would be
endangered.

INTRODUCED: 01/04/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

COMMITTEES: House Commerce

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on Commerce (CR p. H170)

***** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES *****

MEASURE: HR231

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A bill to amend the Internal Revenue Code of 1986 to deny the deduction for medical expenses incurred for an abortion.

INTRODUCED: 01/04/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

COMMITTEES: House Ways and Means

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on Ways and Means (CR p. H170)

***** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES *****

MEASURE: HJRes23

SPONSOR: Volkmer (D-MO)

OFFICIAL TITLE: Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.

INTRODUCED: 01/04/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

COMMITTEES: House Judiciary

LEGISLATIVE ACTION:

01/04/95 Referred to Committee on the Judiciary (CR p. H175)

5/31/95

- 1 HJRes90 Dornan (R-CA) 05/23/95
A joint resolution proposing an amendment to the Constitution of the United States to protect the right to life.
(BILLTRACK; no CRS information available)
Item Key: 3023

- 2 HR1623 Dornan (R-CA) 05/12/95
A bill to amend the Public Health Service Act to repeal family planning programs under title X of the Act.
(BILLTRACK; BillWatch 05/26/95; CRS 05/18/95 -- digest 4 lines)
Item Key: 2885

- 3 HR1624 Dornan (R-CA) 05/12/95
A bill to modify the jurisdiction of the federal courts with respect to abortion.
(BILLTRACK; no CRS information available)
Item Key: 2886

- 4 HR1625 Dornan (R-CA) 05/12/95
A bill to protect the right to life of each born and preborn human person in existence at fertilization.
(BILLTRACK; CRS 05/18/95 -- digest 3 lines)
Item Key: 2887

1 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** BILLWATCH REPORT -- QUICK REFERENCE, BRIEF, INSIGHT ***

MEASURE: HJRes90

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A joint resolution proposing an amendment to the
Constitution of the United States to protect the right to
life.

QUICK REFERENCE: None

INTRODUCED: 05/23/95

CQ BILLWATCH BRIEF:
None

CQ BILLWATCH INSIGHT:
None

2 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** BILLWATCH REPORT -- QUICK REFERENCE, BRIEF, INSIGHT ***

MEASURE: HR1623

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A bill to amend the Public Health Service Act to repeal
family planning programs under title X of the Act.

QUICK REFERENCE: End family planning programs

INTRODUCED: 05/12/95

CQ BILLWATCH BRIEF:

One of the most ardent foes of abortion in Congress, Rep. Robert K.
Dornan, R-Calif., introduced a bill (HR1623) that would repeal family
planning programs under Title X of the Public Health Service Act.

Title X long has been a vehicle for anti-abortion legislation, even
though no federal family planning funds can be spent on abortion.

Enacted in 1971, the law provides grants to public and nonprofit private organizations to offer services that include contraception; referrals for pre-natal care and abortion; infertility screening; treatment of sexually transmitted diseases; and screening for cervical cancer, breast cancer and HIV infection. Most of the nation's 4,000 clinics also provide basic primary care such as blood pressure checks and screening for anemia and diabetes.

CQ BILLWATCH INSIGHT:

No action has been scheduled on HR1623, which was referred to the House Commerce Committee.

3 of 4 items

CQ's WASHINGTON ALERT 05/31/95

***** BILLWATCH REPORT -- QUICK REFERENCE, BRIEF, INSIGHT *******MEASURE:** HR1624**SPONSOR:** Dornan (R-CA)**OFFICIAL TITLE:** A bill to modify the jurisdiction of the federal courts with respect to abortion.**QUICK REFERENCE:** None**INTRODUCED:** 05/12/95**CQ BILLWATCH BRIEF:**
None**CQ BILLWATCH INSIGHT:**
None

4 of 4 items

CQ's WASHINGTON ALERT 05/31/95

***** BILLWATCH REPORT -- QUICK REFERENCE, BRIEF, INSIGHT *******MEASURE:** HR1625**SPONSOR:** Dornan (R-CA)

OFFICIAL TITLE: A bill to protect the right to life of each born and preborn human person in existence at fertilization.

QUICK REFERENCE: None

INTRODUCED: 05/12/95

CQ BILLWATCH BRIEF:

None

CQ BILLWATCH INSIGHT:

None

1 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** COSPONSOR REPORT -- CURRENT COSPONSORS IN ALPHABETICAL ORDER ***

MEASURE: HJRes90

SPONSOR: Doman (R-CA)

OFFICIAL TITLE: A joint resolution proposing an amendment to the Constitution of the United States to protect the right to life.

INTRODUCED: 05/23/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

CURRENT COSPONSORS:

No reported cosponsors

2 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** COSPONSOR REPORT -- CURRENT COSPONSORS IN ALPHABETICAL ORDER ***

MEASURE: HR1623

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A bill to amend the Public Health Service Act to repeal family planning programs under title X of the Act.

INTRODUCED: 05/12/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

CURRENT COSPONSORS:

No reported cosponsors

3 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** COSPONSOR REPORT -- CURRENT COSPONSORS IN ALPHABETICAL ORDER ***

MEASURE: HR1624

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A bill to modify the jurisdiction of the federal courts with respect to abortion.

INTRODUCED: 05/12/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

CURRENT COSPONSORS:

No reported cosponsors

4 of 4 items

CQ's WASHINGTON ALERT 05/31/95

*** COSPONSOR REPORT -- CURRENT COSPONSORS IN ALPHABETICAL ORDER ***

MEASURE: HR1625

SPONSOR: Dornan (R-CA)

OFFICIAL TITLE: A bill to protect the right to life of each born and preborn human person in existence at fertilization.

INTRODUCED: 05/12/95

COSPONSORS: 0 (Dems: 0 Reps: 0 Ind: 0)

CURRENT COSPONSORS:

No reported cosponsors

***** FULL REPORT -- DIGEST, LEGISLATIVE ACTION, COSPONSORS, SPEECHES *******MEASURE:** HJRes72**SPONSOR:** Oberstar (D-MN)**OFFICIAL TITLE:** Joint resolution proposing an amendment to the Constitution of the United States with respect to the right to life.**INTRODUCED:** 03/01/95**COSPONSORS:** 5 (Dems: 1 Reps: 4 Ind: 0)**COMMITTEES:** House Judiciary**RELATED BILLS:** See HJRes18, HJRes23, HJRes26**LEGISLATIVE ACTION:**

01/04/95 *** Related measure (HJRES18) introduced in House. ***

01/04/95 *** Related measure (HJRES23) introduced in House. ***

01/04/95 *** Related measure (HJRES26) introduced in House. ***

03/01/95 Referred to Committee on the Judiciary (CR p. H2487)

03/01/95 Original Cosponsor(s): 4

Burton, D. (R-IN) Smith, C. (R-NJ)
Lipinski (D-IL) Young, D. (R-AK)

03/08/95 Cosponsor(s) added: 1

Bunn, J. (R-OR)

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DISCUSSION DRAFT

JUNE 13, 1995

4:30 p.m.

104TH CONGRESS
1ST SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. HOKKSTADT (for himself, Mr. CONYER, (see attached list of other cosponsors)) introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Public Health Service Act to prohibit governmental discrimination in the training and licensing of health professionals on the basis of the refusal to undergo or provide training in the performance of induced abortions, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

15-JUN-95 15:42 FROM: Cong. Pete Hoekstra-Vash. DC ID: 2022260779

PAGE

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[DISCUSSION DRAFT]

2

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Medical Training Non-
3 discrimination Act of 1995".

4 **SEC. 2. ESTABLISHMENT OF PROHIBITION AGAINST ABOR-**
5 **TION-RELATED DISCRIMINATION IN TRAIN-**
6 **ING AND LICENSING OF PHYSICIANS.**

7 Part B of title II of the Public Health Service Act
8 (42 U.S.C. 238 et seq.) is amended by adding at the end
9 the following section:

10 **"ABORTION-RELATED DISCRIMINATION IN GOVERN-**
11 **MENTAL ACTIVITIES REGARDING TRAINING OF PHY-**
12 **SICIANS**

13 **"SEC. 245. (a) IN GENERAL.—**The Federal Govern-
14 ment, and any State that receives Federal financial assist-
15 ance, may not subject any health care entity to discrimina-
16 tion on the basis that—

17 "(1) the entity refuses to undergo training in
18 the performance of induced abortions, to provide
19 such training, to perform such abortions, or to pro-
20 vide referrals for such abortions;

21 "(2) the entity refuses to make arrangements
22 for any of the activities specified in paragraph (1);
23 or

24 "(3) the entity attends (or attended) a post-
25 graduate physician training program, or any other
26 program of training in the health professions, that

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(DISCUSSION DRAFT)

3

or arrange for

1 does not (or did not) require, ~~or~~ provide training in
2 the performance of induced abortions.

3 "(b) ACCREDITATION OF POSTGRADUATE PHYSICIAN
4 TRAINING PROGRAMS.—

5 "(1) IN GENERAL.—With respect to the govern-
6 ment involved, restrictions under subsection (a) in-
7 clude the restriction that, in granting a legal status
8 to a health care entity (including a license or certifi-
9 cate), or in providing to the entity financial assist-
10 ance, a service, or another benefit, the government
11 may not require that the entity be an accredited
12 postgraduate physician training program, or that the
13 entity have completed or be attending such a pro-
14 gram, if the applicable standards for accreditation of
15 the program include the standard that the program
16 must require, ~~or~~ ^{or arrange for} provide training in the performance
17 of induced abortions.

18 "(2) RULE OF CONSTRUCTION.—With respect
19 to subsections (I) and (II) of section 705(a)(2)(B)(i)
20 (relating to a program of insured loans for training
21 in the health professions), the requirements in such
22 subsections regarding accredited internship or resi-
23 dency programs are subject to paragraph (1) of this
24 subsection.

25 "(c) DEFINITIONS.—For purposes of this section:

SCN: [REDACTED] FROM: Cong. Pete Hoekstra-Wash. DC ID: 2022260779

PAGE

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[DISCUSSION DRAFT]

4

1 “(1) The term ‘financial assistance’, with re-
 2 spect to a government program, includes govern-
 3 mental payments provided as reimbursement for the
 4 provision of health-related services.

Handwritten:
 10/1/95
 M. J. [unclear]
 [unclear]

5 “(2) The term ‘health care entity’ includes an
 6 individual physician, a postgraduate physician train-
 7 ing program, and a participant in a program of
 8 training in the health professions.

9 “(3) The term ‘postgraduate physician training
 10 program’ includes a residency training program.”

PROPOSED CHANGE IN OBSTETRICS-GYNECOLOGY PROGRAM REQUIREMENTS
 ACGME MEETING OF JUNE 13, 1995

Experience with induced abortion must be part of residency training, except for programs and residents with moral or religious objections. This education can be provided outside the institution. Experience with management of complications of abortion must be provided to all residents. If a residency program has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs must have mechanisms which ensure that 1) not impede residents in their program who do not have a religious or moral objection receive from receiving education and experience in performing abortions at another institution; and 2) must publicize such policy to all applicants to the residency.

Post-It™ brand fax transmittal memo 7671 # of pages >

To <u>J. A. M.</u>	From <u>Shirley W. ...</u>
Co.	Co.
Dept.	Phone #
Fax # <u>973 3070</u>	Fax #

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H.L.C.

104TH CONGRESS
1ST SESSION

H. R. 1833

IN THE HOUSE OF REPRESENTATIVES

Mr. CANADY of Florida introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title 18, United States Code, to ban partial-birth abortions.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Partial-Birth Abortion
5 Ban Act of 1995".

6 **SEC. 2. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.**

7 (a) **IN GENERAL.**—Title 18, United States Code, is
8 amended by inserting after chapter 73 the following:

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H.L.C.

2

"CHAPTER 74—partial-birth abortions**"Sec.****"1681 Partial-birth abortions prohibited****2 "§1531 Partial-birth abortions prohibited.**

3 "(a) Whoever, in or affecting interstate or foreign
4 commerce, knowingly performs a partial-birth abortion
5 and thereby kills a human fetus shall be fined under this
6 title or imprisoned not more than two years, or both.

7 "(b) As used in this section, the term 'partial-birth
8 abortion' means an abortion in which the person perform-
9 ing the abortion partially vaginally delivers a living fetus
10 before killing the fetus and completing the delivery.

11 "(c)(1) The mother, father, and if the mother has
12 not attained the age of 18 years at the time of the abor-
13 tion, the maternal grandparents of the fetus, may in a civil
14 action obtain appropriate relief.

15 "(2) Such relief shall include—

16 "(A) money damages for all injuries, psycho-
17 logical and physical, occasioned by the violation of
18 this section; and

19 "(B) statutory damages equal to three times
20 the cost of the partial-birth abortion;
21 even if any party consented to the performance of an abor-
22 tion.

23 "(d) A woman upon whom a partial-birth abortion
24 is performed may not be prosecuted under this section for

004
004

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H.L.C.

3

1 a conspiracy to violate this section, or an offense under
2 section 2, 3, or 4 of this title based on a violation of this
3 section.

4 “(e) It is an affirmative defense to a prosecution or
5 a civil action under this section, which must be proved by
6 a preponderance of the evidence, that the partial-birth
7 abortion was performed by a physician who reasonably be-
8 lieved—

9 “(1) the partial-birth abortion was necessary to
10 save the life of the woman upon whom it was per-
11 formed; and

12 “(2) no other form of abortion would suffice for
13 that purpose.”

14 (b) CLERICAL AMENDMENT.—The table of chapters
15 for part I of title 18, United States Code, is amended by
16 inserting after the item relating to chapter 73 the follow-
17 ing new item:

“74. Partial-birth abortions 1531”.

THE WHITE HOUSE
WASHINGTON

*Called
Okay*

August 31, 1993

MEMORANDUM TO BRUCE REED

From: Reta J. Lewis, Political Affairs

Re: Attorney General's Meetings with Abortion Rights Groups

I have received the attached memo from the Department of Justice regarding potential meetings between the Attorney General and various pro-choice and anti-choice groups.

The DoJ Office of Public Liaison has asked for our input regarding their suggested list of anti-choice groups for these meetings (see attached).

If you have any comments or concerns regarding the proposed list of anti-choice groups -- or the meeting itself -- please contact me at X6257.

Thank you.

Looks fine



Office of Policy Development
U.S. Department of Justice

Office of Public Liaison and Intergovernmental Affairs

Washington, D.C. 20530

August 30, 1993

MEMORANDUM

TO: Rita Lewis, Office of Political Affairs, The White House

FROM: Bob Hussey, Senior Liaison Officer

SUBJECT: The Attorney General's Meeting with Pro-Life Groups

Sometime during the next few weeks, the Attorney General will be holding meetings on the abortion issue. We plan to have her meet with both pro-choice and pro-life groups on the same day but in separate sessions. The date has yet to be determined.

Attached is a list of pro-choice ^{life} groups recommended to us by the National Conference of Catholic Bishops. We asked the Bishops to confine their recommendations to those groups that do not engage in violent activities.

Could you please get back to me with any comments or suggestions you might have concerning this list of attendees. I can be reached at 514-3465. Thanks.



Office of the General Secretary

3211 Fourth Street NE Washington, DC 20017-1194 (202) 541-3100 FAX (202) 541-3166 TELEX 7400424

Most Reverend William H. Keeler, D.D.
Archbishop of Baltimore
President

NCCB Secretariat for Pro-Life Activities
Gail Quinn
202/541-3070

Knights of Columbus
Carl Anderson
202/628-2355

Americans United for Life
Clark Forsythe or Paige Cunningham
312/786-9494

National Right to Life Committee
David O'Steen (or designate)
202/626-8800

Feminists for Life
Susan Gibbs
301/565-5200 (Work)
202/544-0958 (Home)

Women's Coalition for Life
refer to Jeannie French
708/848-5351

Women Affirming Life
Frances Hogan, Esq.
617/523-6655

American Life League
Judie Brown
703/659-4171

Seamless Garment Network
Carol Crossed
716/442-8497

National Council of Catholic Women
Annette Kane
202/682-0334

Christian Coalition
Ralph Reed
804/424-2630

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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002. memo	John Hilley et al. to POTUS re: "Partial-Birth" Abortion (6 pages)	4/10/1997	P5
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**This marker identifies the original location of the withdrawn item listed above.
For a complete list of items withdrawn from this folder, see the
Withdrawal/Redaction Sheet at the front of the folder.**

COLLECTION:

Clinton Presidential Records
 Domestic Policy Council
 Bruce Reed (Subject File)
 OA/Box Number: 21199

FOLDER TITLE:

Abortion

rs34

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

STATES THAT HAVE RECENTLY ENACTED PROCEDURE SPECIFIC BANS

Georgia : "Partial-Birth" Ban (March 1997)

Michigan: "Partial-Birth" Ban (June 1997); legal challenge filed

Mississippi: "Partial-Birth" Ban (March 1997)

Ohio: "Dilation and Extraction" Ban (August 1995); enjoined by Federal district court and appeal filed with 6th circuit

South Carolina: "Partial-Birth" Ban (March 1997)

South Dakota: "Partial-Birth" Ban (March 1997)

Utah: "Partial-Birth" and "Dilation and Extraction" and "Saline Abortion" Bans (March 1996)

Bipartisan Alternative to S. 6/H.R. 1122

S. 6, the "Partial Birth Abortion Ban", would outlaw the procedure physicians call dilatation and extraction (D&X) at any stage of pregnancy — with no exception for the health of the mother — but allow other, sometimes more dangerous abortion procedures to be used in its place.

The bipartisan alternative to S. 6 would ban all abortions after fetal viability (when the fetus can sustain survivability outside the womb with or without life support) unless the mother's life or health is truly endangered. The health exception to the comprehensive ban is being written to cover only very rare situations that arise from complications of the pregnancy itself, such as serious heart damage (cardiomyopathy), severe hypertension (pre-eclampsia), and, as in the cases of some women carrying severely deformed fetuses, uterine rupture and other injuries; from pre-existing conditions that become very dangerous, such as complications from diabetes (blindness, amputation); or from newly diagnosed diseases, such as aggressive cancers (acute leukemia or breast cancer) that require treatment that cannot be given during pregnancy.

Constitutional Parameters Limiting Government Restriction of Abortion

Right To Terminate Pregnancy Prior To Viability: Roe v. Wade held that the Constitution protects "a woman's decision whether or not to terminate her pregnancy." This holding was reaffirmed in Planned Parenthood of Southeastern Pennsylvania v. Casey, in which the Supreme Court held that "it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy."

Viability Defined: According to the Court, "viability is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman." Although the actual point of viability varies with each case, it is generally reached between the 23rd and the 28th week.

Government May Ban Abortion After Viability: In Casey, the Supreme Court reiterated Roe's determination that after viability, the State may ban abortion. Many states have done so, and post-viability abortions comprise less than 0.5% of all abortions (99% occur in the first 20 weeks).

Ban Must Have An Exception When A Woman's Life or Health Is At Risk: According to Roe and Casey, although the State has a legitimate interest in preserving potential life, and may promote this interest by prohibiting abortion once the fetus attains viability, it may not do so when preventing an abortion would endanger the life or health of the mother. The Court has consistently held that "maternal health [must] be the physician's paramount consideration."

Would S. 6 prevent abortions? No. S. 6 would not stop a single abortion; it would merely result in abortion by a different method, such as induction, hysterotomy (pre-term c-section), or dilatation and evacuation (D&E) — all of which pose a greater risk to the mother's health in certain cases.

Can S. 6 become permanent law? No. Even if Congress overrides a Presidential veto, S. 6 is clearly unconstitutional, so it will be struck down by the courts and have no ultimate effect.

Can something be done to stop unnecessary abortions of viable fetuses? Yes. Congress can pass a comprehensive post-viability abortion ban with a narrow life and health exception that will outlaw these very late-term abortions. This will actually reduce the number of abortions in this country without putting women at unacceptable risk. This ban would be constitutional, and the President would sign it.

Abortion

THE WHITE HOUSE
WASHINGTON

May 13, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
ELENA KAGAN

SUBJECT: DASCHLE AND FEINSTEIN AMENDMENTS

As you know, the Senate is taking up the Partial Birth Abortion Act (HR 1122) this afternoon. We expect Senator Daschle and Senator Feinstein to offer substitute amendments during the course of the debate. We recommend that you send a letter to Congress indicating that you would accept either of these substitute proposals. John Hilley and Rahm strongly agree, believing that a letter of this kind will help prevent a veto override on this issue. The proposed letter is attached; if you agree to send it, we will put it into final form for your signature.

Background

Both the Feinstein and the Daschle amendments prohibit post-viability abortions generally. They thus differ in two crucial ways from HR 1122: (1) they apply to all procedures, including but not limited to the "partial birth" procedure, and (2) they apply only to abortions performed after the fetus has become viable.

Both amendments impose civil, rather than criminal, penalties. Feinstein's would fine the physician up to \$10,000 for a violation. Daschle's would result in a fine of up to \$100,000, or suspension or revocation of the doctor's medical license (and in the case of a second or subsequent offense, \$250,000 or revocation of the license).

Most critically, both amendments contain a health exception, though of different kinds. The Feinstein legislation would exempt an abortion if, "in the medical judgment of the attending physician, the abortion is necessary to . . . avert serious adverse health consequences to the woman." This language is essentially identical to the language you have used in calling for a health exception to the Partial Birth Act. The Daschle language is more stringent. It exempts an abortion when the physician "certifies that continuation of the pregnancy would . . . risk grievous injury to [the mother's] physical health." "Grievous injury" is then defined as "a severely debilitating disease or impairment specifically caused by the pregnancy, or an inability to provide necessary treatment for a life-threatening condition."

The five women you spoke with before your last year's veto would fall within even the Daschle exception, assuming the truth of their accounts. Each said that her doctor advised her that an abortion was necessary to prevent a risk of grave physical harm -- for example, of serious

damage to her reproductive system. Daschle himself believes that his bill protects such women, and is willing to refer to these women when he offers his amendment. You should be aware, however, of a slight chance that one of the choice groups will persuade one or more of these women to oppose the Daschle bill on the ground that it would not protect women in her situation.

The American College of Obstetricians and Gynecologists today endorsed the Daschle amendment, stating that it "provides a meaningful ban [on post-viability abortions] while assuring women's health is protected." (ACOG took no position on the Feinsein amendment, which the group rightly views as a less serious proposal.) The AMA has refused to take a position on any of the pending legislative proposals, but yesterday issued a study (1) expressing skepticism about the need to use the "partial birth" procedure, but stating that doctors must retain discretion to use medical judgment in selecting procedures, and (2) stating that post-viability abortions are almost never necessary to save a woman's life or prevent serious harm to her health, given the alternative at this stage of delivering the fetus.

The choice groups (somewhat reluctantly) support the Feinsein language, but oppose the Daschle proposal. They argue that the stringency of Daschle's health exception -- including its limitation to cases of physical harm -- undermines the comprehensive protections announced in Roe regarding the health of the woman. The Office of Legal Counsel of the Justice Department similarly believes that both the Daschle and the Feinsein amendments, properly read, violate Roe because they countenance tradeoffs involving women's health. (OLC thinks, however, that a court might be able to interpret the Feinsein amendment so narrowly as to avoid this problem.)

John Hilley believes that a letter from you supporting the Daschle amendment is of crucial importance in sustaining a veto. He worries that if the Daschle amendment goes down to a decisive defeat, many Senators who previously supported you will switch and vote for HR 1122. He thinks a letter of endorsement from you will strengthen the prospects for the Daschle amendment.

Recommendation

We recommend that you endorse the Daschle amendment in order to sustain your credibility on HR 1122 and prevent Congress from overriding your veto. You have spent many months calling on Congress to pass a bill that contains a sufficiently protective, but also appropriately confined, health exception -- as you said in a letter to the Cardinals, not a health exception that "could be stretched to cover most anything," but a health exception that "takes effect only where a woman faces real, serious adverse health consequences." Especially given ACOG's endorsement of the Daschle amendment, it will be difficult for you to make the case that Daschle's language does not adequately safeguard women's health. In these circumstances, declining to support the amendment will weaken your position and increase the chance that Congress will override your veto.

DRAFT

Dear Senators Daschle and Feinstein:

I am writing to express support for your amendments prohibiting late-term abortions. If Congress were to substitute either of these amendments for the current H.R. 1122, I would sign the legislation.

As you know, I have long opposed late-term abortions, and I continue to do so except where necessary to save the life of a woman or prevent serious harm to her health. When I was Governor of Arkansas, I signed into law a bill that barred third-trimester abortions, with an appropriate exception for life or health. And last year, I made clear that I would sign such a bill at the federal level.

Your amendments, though differing in detail, both meet the standards I have set for such legislation. The amendments contain exceptions that will adequately protect the lives and health of the small group of women in tragic circumstances who need an abortion at a late stage of pregnancy to avert death or great injury. At the same time, the amendments prohibit any late-term abortions performed for elective reasons. This balance is an appropriate one, which I -- and, I believe, most Americans -- would gladly make the nation's law.

Sincerely,

ISSUE OF ABORTION IS PUSHING ITS WAY TO CENTER STAGE

DOZEN BILLS IN CONGRESS

Christian Conservatives Chip Away at Provisions From Clinton's First 2 Years.

By JERRY GRAY

WASHINGTON, June 18 — The politically charged issue of abortion has returned to the Congressional stage, sooner than many abortion rights advocates or some Republican leaders had hoped, but with the strong backing of the Christian conservative movement.

At least a dozen abortion-related bills, many taken directly from the Christian Coalition's political and social manifesto, the Contract With the American Family, are pending in Congress and at least that many more are under discussion.

No proposal carries the weight of an outright ban on abortion. Instead they try to use a variety of avenues — some tried before, some not — to chip away at abortion rights and in particular at the gains its advocates made during President Clinton's first two years in office. In Washington, the clear sense is that the political pendulum is swinging back in favor of the anti-abortion forces.

Last Thursday the Republican-controlled House passed the first of the anti-abortion proposals, a bill to reinstate a ban on abortions at American military hospitals overseas, and a House committee opened debate on the most controversial measure — an unprecedented attempt at Federal legislation to ban and criminalize a particular class of abortions.

Other legislation under consideration would have these effects:

• Repeal or modify Title X of the Public Health Service Act, which has provided family planning programs, including abortion counseling, to low-income women and adolescents.

• Refuse to provide financing to institutions favoring a policy of the Accreditation Council of Graduate Medical Education requiring obstetrics/gynecology programs to provide training in abortion procedures. This was adopted by the council in February.

• Overturn an executive order by President Clinton lifting a Reagan-era ban against using foreign aid money for abortion counseling or referrals.

• End or severely curtail financial support for agencies, like the United

Continued From Page A1

Nations Fund for Population Activities, that offer family planning programs that provide abortions with private money.

• Limit Federal Medicaid money for abortions to only those instances when a woman's life is threatened and end the use of Medicaid financing for abortions when pregnancies result from rape or incest.

The Christian Coalition and other groups have also called for legislation to overturn executive orders that allowed Federal money to be used for fetal tissue research and the clinical testing of the abortion drug RU-486, as well as restoring the Bush Administration prohibition on counseling women about abortion at family planning clinics that receive Federal money.

And anti-abortion forces want Republicans to use their Congressional power in the appropriations process to restore the ban on the use of Federal money for abortions for women in Federal prisons, prohibit the District of Columbia from using local tax revenue to pay for abortions and to restore the Reagan-era policy that prohibited the Federal employees' health benefit plan from covering abortion.

"Some of what we are seeing now is the fact that the tracks are now open," said Douglas Johnson, legislative director of the National Right to Life Committee. "But in most cases, we are just trying to repair the damage to legislation and advancements that we made under the Reagan and Bush Administrations."

But abortion rights groups see a broader agenda. "Their goal, however long it takes them, is to make all abortions under all circumstances a crime," said Kate Michelman, president of the National Abortion and Reproductive Rights Action League, the political organization for the pro-choice movement. "They cannot immediately criminalize all abortions under all circumstances, but they have begun to move us step by step down that road."

Republicans hold majorities in both chambers of Congress and there is enough crossover Democratic support on some issues to assure an override of a veto, abortion rights opponents say.

"That doesn't mean we are going to win on everything, and it certainly doesn't mean that we are going to get everything that we like to see passed into law," said Representative Charles T. Canady, a Florida Republican who is chairman of the Judiciary subcommittee where much of the major abortion-related legislation originates.

Also behind the current debate is the 1996 Presidential campaign. Republicans had recoiled from the issue after George Bush's defeat in 1992, which some moderate Republicans attributed to the stridency of anti-abortion forces. But with the race for the Republican nomination now shaping up as a battle for support from the party's conservative wing, few in the party have been objecting to the issue's return to prominence. Among the nine Presidential candidates, only one, Senator Arlen Specter of Pennsylvania, supports abortion rights.

Many coming abortion fights are perennial skirmishes over appropriations for agencies and programs that provide abortion services. But

the Republican takeover of Congress in last November's elections changed the dynamics of the abortion debate.

"What you are seeing are a series of activities that are, for the most part, not talking about abortion directly, but are talking about ways in which Government is being used to promote abortions or to put abortions in more favorable light," said Representative Ernest Jim Istook Jr., an Oklahoma Republican who helped draft the Christian Coalition's Contract With the American Family.

"We're talking about things that are one step back from the issue of abortion itself," Mr. Istook said. "Part of what you have to do is to be able to get through these second-level issues, have them resolved, elevate public awareness through the debate and clarify the issues that way before people could actually focus on the core issue of abortion."

Beginning last year, shortly after the Republican victory, Mr. Johnson and other leaders of anti-abortion groups — including the Christian Coalition, the United States Catholic Conference and the Traditional Values Coalition — began to hold regular strategy sessions. They drafted much of the legislation and strategy for passing it.

As the opening political shots in the abortion debate were fired last week in the 104th Congress, it gave a preview of the direction and the scope of the coming battle.

In an emotion-charged hearing last Thursday, the House Judiciary Subcommittee on the Constitution opened debate on a bill to outlaw one of the rarest types of abortions — a highly specialized procedure that is used in the latter stages of pregnancy to abort fetuses with severe abnormalities or no chance of surviving long after birth.

Mr. Canady, the Florida Republican, introduced the legislation, which would make a doctor performing the procedure liable in most cases to criminal and civil charges. The proposed law makes exceptions in cases in which it is necessary to save the life of the pregnant woman or when "no other form of abortion would suffice for that purpose."

To drive home their point, abortion opponents used graphic diagrams and pictures of the abortion procedure and plastic models of a womb and a fetus to demonstrate the technique.

Ms. Michelman of the pro-choice movement countered: "Years ago, the whole debate about abortion was about the procedure, about the fetus and there was never a discussion about the women who faced a crisis pregnancy or the circumstances of their lives. We changed that. But now they are trying to come back to the issue of procedure and sensationalize it to distract people from thinking about the women and the fact that the real issue in the debate is who should decide."

Supporters of these measures say their first goal is to roll back the gains of abortion-rights supporters in recent years. But Mr. Johnson said the debate is also timed to try to make abortion one of the core issues in next year's Presidential race.

"We don't think as long as Clinton is in the White House that we will be able to move public policy a great distance in the pro-life direction," he said.

THE NEW YORK TIMES
MONDAY, JUNE 19, 1995

Continued on Page A9, Column 1

Aliens' Melee Closes Center In New Jersey

By RICHARD PÉREZ-PÉÑA

Frustration flared into violence early yesterday at an immigrant detention center in Elizabeth, N.J., that has been buffeted by charges of mistreating the illegal aliens held there. A ragtag band of detainees took over the building, demolished much of the interior and barricaded themselves in for five hours before the center was stormed by law enforcement officers.

Twenty illegal immigrants were injured in a clash that ended the standoff at 6:30 A.M., when 100 baton-wielding officers from the Union County sheriff's and prosecutor's offices, the Elizabeth police and surrounding cities took control of the building at 675 Evans Street.

The siege began with what appeared to be a coordinated attack on guards by some of the aliens in the center, said William Slattery, executive associate commissioner of the Immigration and Naturalization Service. The Elizabeth police said two guards were taken hostage, but the immigration service disputed that. Officials said that none of the guards required medical treatment; the immigrants who were hurt received only minor injuries.

In the 11 months it has been open, the detention center, which is run by Esmor Correctional Services of Melville, L.I., under contract to the immigration service, has gained a reputation among immigrants and their advocates as one of the worst of its kind in the nation.

There have been charges of physical and verbal abuse including racial slurs by guards. More common are tales of detainees being shackled to chairs and tables while conferring

Continued on Page B5, Column 4

Continued From Page A1

with their lawyers, of blazing lights that make sleep difficult even in the middle of the night, of limited exercise and no fresh air, and of inedible food.

Early yesterday, the center erupted in a storm of broken glass, smashed furniture and fear. The detainees captured two guards, though both escaped, and built barricades out of the debris created by their rampage, but it was unclear whether they were trying to escape or merely stage a protest.

"It was a cauldron ready to explode," said Representative Robert Menendez, a New Jersey Democrat who has been one of the center's most-vocal critics. "You can't stand for human rights around the world and treat people like this at home."

Calls to Esmor were not answered yesterday. The company, part of the growing private incarceration industry, had revenues of \$24 million last year. It runs several centers, including the LeMarquis Hotel, a halfway house in Manhattan, and an immigrant detention center in Seattle that has also been the target of abuse charges.

"In the seven months I was there, I was never outside, not once," said Suzanne Kidoni, a Sudanese refugee who was held in the Esmor center in Elizabeth from October through May. "The food is not enough for a human being."

as a mind-numbing routine, lived out in dirty clothes, on insect-infested beds, with no privacy. "We had no way to make complaints," she said. "We had to complain to ourselves."

When asked about the center, immigration service officials would acknowledge only that there had been many complaints and said the agency had investigated the charges over the last two weeks. Mr. Slattery said the investigators had produced a report, but that it had not yet been made public.

Two immigration service agents, speaking on condition of anonymity, described the detention center as a disaster waiting to happen, a place where no one should have had to stay more than a few weeks but where people were often held for several months.

The center, a squat converted warehouse in an industrial area, held about 240 men and 60 women from more than 40 countries who were caught trying to enter the country at area airports without the proper paperwork. They were being held pending hearings on deportation or claims for political asylum.

"These people are not criminals, but they're treated like it," said Stephanie Marks of the Lawyers Committee for Human Rights, who has gone to the center several times and represented people who were being held there. "Many of these people have suffered tremendously in their home countries; that's why they're here. I think what happened today could have been expected. People have to be pretty desperate to resort to those means."

Mr. Slattery of the immigration service said the disturbance began at 1:30 A.M., when two guards in two of the center's eight dormitories were "attacked by a number of inmates," almost simultaneously. He said four to eight ringleaders had been identified, but he would not name them or say whether they were all from the country. Neither would he discuss the prospect of criminal charges against them.

"They were throwing furniture, breaking glass, ripping fire extinguishers" from the walls, Mr. Slattery he said. He said sprinkler pipes were ripped from walls and ceilings, leaving about an inch of water on the floors throughout the building.

Police and immigration officials disagreed on whether guards were taken hostage. Sgt. James McKenna of the Elizabeth police, who, along with the Federal Bureau of Investigation, sent hostage negotiators to the scene, said two guards were held captive by the immigrants but both escaped unharmed. One made his way out of the building, the sergeant said, and another hid in a drop ceiling. The immigration service said there were no hostages.

The Elizabeth police received two distress calls at about 1:30 A.M., one from a pay telephone inside the center, and one by fax, but officials said they did not know if the alerts came from detainees or guards.

Representative Menendez said the immigration service Commissioner, Doris Meissner, had told him that when the unrest began, the guards walked off their jobs, but other agency officials said they did not believe that was so. Donald Mueller, an immigration service spokesman in Washington, said the Commissioner was not available for comment.

One way or another, all but three of the 13 guards on duty were soon out of the building and the illegal immigrants had taken control. They blocked a major corridor with a barricade made of pieces of furniture and any other debris they could collect and were constructing a second barricade in another hallway when the siege ended.

Mary Kabe'au, the Elizabeth police director, said that while there may have been a core of plotters behind the disturbance, she believed it was not a widely organized event or that most of the detainees were involved. "It would have been much more intensive if you had 300 people, all of one mindset," she said.

The guard who escaped to hide in the ceiling was directly over the barricade, said Robert Froehlich, the Union County sheriff. He said the guard had used his hand-held radio to call the police for help, but then his battery died.

Officials said an Elizabeth police lieutenant sneaked into the building through a window and found the hiding guard, whose name was not released, and that they both escaped without the detainees knowing they had ever been there.

Mr. Slattery said another guard, a woman, was trapped in the women's dormitory when detainees cut the building's electrical power, which automatically locked the doors.

As described by law enforcement officials, one element of the standoff — the inability of the police and the detainees to communicate — would have been comical were it not so

tense. Sheriff Froehlich said the detainees were contacted by phone, but "efforts at negotiations failed immediately" not only because of the officials' inability to find someone inside the center who spoke English, but by the detainees inability to talk to each other.

"No individual could come forward and take control," the Sheriff said.

Mr. Slattery said that the aliens did not appear to have any demands.

After a few minutes of frustrated attempts at communication, officials said, someone inside the center smashed the phone.

Meanwhile, the sheriff said, inside the center the detainees were wreaking havoc.

"Every piece of reinforced glass was either broken or taken out," he said. "Even cinder blocks were removed from walls. Bedding, beds, mattresses, everything was destroyed. All the detainees' paperwork and records were destroyed, also. All the televisions were broken. All the furniture was broken. Devastation."

The police officers and sheriff's deputies entered the building at 6:30 A.M., using "flash-bang" grenades to stun the people behind the barricades. Officials said they decided to leave both tear gas and guns outside and go in armed only with batons.

Most of the aliens scattered when the police tore down their barricade, the sheriff said, but some stayed, fought with the officers and were injured. But Mr. Slattery said most of those who were hurt had slipped on wet floors or cut themselves on broken glass.

He said it would take two to four weeks to repair the damaged building. All 300 immigrants were moved from the damaged center to nearby county jails and to immigration service detention facilities in New York, Pennsylvania and Maryland, said Bill Carattini, an agency spokesman.