"...a must-read for anyone who cares about the lives of women and children."

— Diana Mason, President,
American Academy of Nursing

A WOMAN'S RIGHT TO KNOW

How Women's Health Became a Political Pawn — and the Surprising Alliances Working to Reclaim It

CAROL ROYE, EdD, RN

ENDORSEMENTS

"Carol Roye draws on public health and history to tell the story of abortion and contraception in America, a story which needs retelling for younger Americans inheriting the country's battles over these topics. Through depiction of the changing stances and shifting moral interpretations of different churches and groups, she reveals that the harsh moment in which we find ourselves stuck is not inevitable, and that the contest is fundamentally a political one."

—**Wendy Chavkin**, MD, MPH, Professor of Clinical Population and Family Health and Obstetrics-Gynecology; Heilbrunn Dept of Population and Family Health and Dept Obstetrics-Gynecology; Mailman School of Public Health and College of Physicians and Surgeons; Columbia University

"Pitch perfect! Roye tells it all and tells it extremely well. Grounded in her own experience as a nurse, hard data and her skills as a researcher this short easy-to-read book documents the horrific consequences of denying women the right to contraception, abortion and control over their own bodies. Roye moves beyond descriptions to reveal how women's health was sacrificed to the interests of power, politics and professional interests. *A Woman's Right to Know* is a must read for anyone interested in preventing maternal deaths and child abuse, reducing health care costs and otherwise ending the war on women's reproductive rights."

—**Mimi Abramovitz**, Bertha Capen Reynolds Professor of Social Policy, Silberman School of Social Work at Hunter College and The Graduate Center, CUNY

"Drawing on her extensive clinical experience as a nurse and educator, Professor Carol Roye makes an impassioned case for the benefits of safe and accessible contraception and abortion to American women and their families. Drawing on the long and often tortured political history of this issue, she also reminds us that advancing reproductive health and rights is not just a moral obligation to protect women rights but also a fundamental tool to fight poverty and promote overall well-being."

—**Ellen Chesler**, author of *Woman of Valor: Margaret Sanger and the Birth Control Movement in America*

"How did we get to a place where even family planning is a controversial issue, despite the indisputable evidence showing that it saves and improves the quality of lives of women and children? *A Women's Right to Know* lays out this evidence and an explanation of why women's rights to abortion and family planning are under siege. As a researcher and women's health nurse practitioner, Dr. Roye has written a compelling story of the history of the politicization of reproductive rights for women in the U.S. that is filled with surprises and is a must-read for anyone who cares about the lives of women and children."

—**Diana Mason**, President of the American Academy of Nursing

"Did you know that early feminists opposed abortion? Or that doctors were more likely to perform the procedure on unmarried women? Can you remember when most of the abortion debates were between doctors, over matters of technique? This book is bound to deepen your understanding of the abortion wars and humanize an issue surrounded by partisan fury."

—**Corinna Barnard**, editor, *Women's eNews*

"Carol Roye has provided critical documentation and analysis of the history and current realities and barriers to reproductive health. Interweaving her own complex experience of compassionate care, compelling case illuminations of how forces outside of the lives and bodies of real girls and women constrain choice, and a comprehensive retelling of what was and what is at stake in reproductive justice, this book is a must read for all of us."

—**Deborah Tolman**, EdD, Professor of Social Welfare and Psychology, Silberman School of Social Work at Hunter College

"*A Women's Right to Know* provides a comprehensive picture of the politics behind the increasing number of assaults on reproductive freedom. Roye's book not only shines a light on the untold story of women's health, but shows us a way forward on steps we can take to reclaim it."

—**Vicki Breitbart**, EdD, LCSW, Director, Health Advocacy, Graduate Studies at Sarah Lawrence College, Professor, Perspectives on Reproductive Health at New York University

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By Carol Roye

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Dedication

This book is dedicated to my six children, their spouses and
my twelve grandchildren who are truly the joys of my life.
And to my husband, David, whose support enables me to do what I do.

Contents

Disclaimer

Although all events reported in the book are real, all names and identifying details about my patients have been changed to protect the privacy of the people involved. Some of the situations presented are amalgams of multiple women who had similar situations.

Introduction

No Moral Imperative

I love children. I have six of them. The first five arrived via the usual biological route. The sixth arrived via Swiss Air from Romania. That delivery, while less painful, was my longest—one year of paperwork, fingerprinting, notarizing and waiting.

Why would a woman who has never terminated a pregnancy, and indeed adopted a little girl who under different circumstances might not have been born, write a book that explains why a woman's right to choose is fundamental to the health of women and children?

Twenty-five years ago I had an awakening.

I had been a typical housewife and mother. I married two months after graduating from college, earned my master's degree in special education and became a teacher. I left the classroom during the middle of my second pregnancy and stayed home until my fourth child (my youngest at the time) was in nursery school, when I went back to school to become a nurse. I became a pediatric nurse practitioner working in adolescent health, providing primary care and reproductive health care to adolescent girls in New York City. Mother, teacher, nurse…clearly *Feminism* was not my raison d'être.

In the late 1980s, in the waiting room of an abortion/colposcopy suite in an inner-city hospital, my world view changed. One of my adolescent patients had an abnormal Pap smear and needed a follow-up procedure called a colposcopy, a special type of examination of the cervix. I knew that she would not go for the necessary procedure alone, so I went with her. The clinic waiting room was filled with women in flimsy hospital gowns, nervous about the procedure they were about to undergo—abortion for

some, colposcopy for others. Some women had sisters or girlfriends with them. Others were alone.

Looking around, I suddenly realized there was not one man in the room. Yet every woman was there because of a man. It was a man who gave her HPV, a sexually transmitted virus which caused her abnormal Pap, or who gave her a pregnancy; but no men were there now to provide comfort. I realized, actually for the first time, that life for women, especially women with few resources, is simply unfair. Oddly enough, I had never thought about that before. These issues had never affected me or my friends.

I had been raised to believe that men came first; that a woman should do what she can to make life easier for her husband. But as I looked at that room without men, who should have been there supporting their wives and lovers, my attitude shifted. I vowed to do what I could to help women overcome the obstacles to gaining control over their reproductive health.

I had no idea at the time what that would entail.

Too often, I have delivered a diagnosis of pregnancy to a girl for whom that diagnosis was a tragedy. My own heart sank each time those two pink lines appeared on a pregnancy test. For over a decade, this scene repeated itself. Then in the late 1990s, I attained professional nirvana. For the two years after emergency contraception (EC), commonly known as Plan B or "the morning after pill" became available, not one of my patients became pregnant. I gave all of my sexually active patients a prescription for EC at routine health visits, always emphasizing that the only 100 percent sure way to avoid both pregnancy and infection is to abstain from sex. I would also tell them they should use condoms as well as a hormonal method of contraception, such as birth control pills. For the first time in my nursing career, many teenage girls in my practice graduated from high school on time. Quite a few even went to college—and graduated. Some were making plans for graduate school.

Then far right-wing "morality" started creeping into our world.

After two years of no unwanted pregnancies, one of my patients, who I'll call Madalena, came in for a pregnancy test. The last time she had sex the condom broke. She went to the pharmacy to get her EC, but the pharmacist refused to give it to her. He had moral objections to her using it. Madalena had already been accepted to college. She was to be the first in her family to attend a university. I felt sick as I watched the pregnancy test develop. It was positive.

I gave the news to a tearful Madalena. She was torn about what to do but was pretty sure she would terminate the pregnancy. She wanted to get an education so she would be in a better position to raise a child later on. I told her to discuss it with the people she was close to: her mother, her boyfriend, her best friend, or whomever she chose. I asked her to come back next week to let me know how she wanted to handle the pregnancy.

It turned out that Madalena's boyfriend wanted her to have the baby. So she abandoned her plans to attend college, and left my office with an appointment for her first prenatal visit.

I never saw her again. I hope she went back to school, but many girls find it uncomfortable to go to school when they are visibly pregnant. Once the baby was born, she was likely to have trouble finding adequate childcare. The barriers only multiply after that.

There are thousands of Madalenas in this country. Why should a pharmacist get to decide that the education of a woman he has never met should be interrupted and her life irreparably altered because he refused to fill her legal prescription for contraception?

I was then and continue to be outraged.

As the mother of four daughters, and as a nurse practitioner who takes care of young women in poverty, I see only too clearly what is happening to our reproductive rights. I see the injustice inherent in the ease with which my middle-class daughters access contraception, when contrasted to the difficulty that many of my patients, teens and young adults from some of

the poorest neighborhoods in New York City have filling their birth control prescriptions.

Alarmingly, more and more women are losing control over their reproductive lives and thus their health. Bills designed to erode women's access to abortion and birth control are presented almost daily in state legislatures. The political viewpoints of a majority of the Supreme Court Justices threaten all women of childbearing age. Women's health is being forced backward to a time when contraception was not always or readily available and abortions were dangerous. Now more than ever, we need to know the facts about the public health consequences of these policies, the historical saga that led them to be indelibly intertwined in our political fabric, and remind ourselves that human lives are in the balance.

This book will provide readers with the knowledge they are entitled to, so they can take steps to improve women's health. As the book demonstrates, when women's health improves, so does the health of children and communities. My awakening in that clinic many years ago has led me to write this book—so more people know the real story. Women's health *is* a family value we can and should all support.

1

Anatomy of a Health Problem

"Indeed, the field of bioethics holds the belief that all humans are diminished when a person dies a preventable death. Therefore, to do nothing about maternal and infant deaths is morally intolerable. To take actions which facilitate these deaths is clearly immoral."

— Institute of Medicine of the National Academies

One Woman's Story

It is easy for us to forget what life was like for women confronting an unwanted pregnancy before Roe v. Wade was decided. However, many accounts of those nightmares are still in print. When reading these stories, remember to bear in mind that these women were so desperate to terminate their pregnancies that they were willing to risk their lives. For example, one book[1] about illegal abortion describes what happened to a young woman from West Virginia who had recently graduated from high school and found a job as a secretary in Pennsylvania.

1 Adapted from *The Worst of Times: Illegal Abortion-Survivors, Practitioners, Coroners, Cops, and Children of Women Who Died Talk about Its Horror*, by Patricia G. Miller. Copyright (c) 1993 by Patricia G. Miller. An Aaron Asher Book.

She was still a virgin when she left West Virginia. She eventually met a man and began her first sexual relationship. She depicts, in excruciating detail, the panic she felt waiting, hoping for her period to come—even just a little bleeding. It did not, and her boyfriend arranged for her to have an abortion. She was driven at night to a rundown house in another state where an old man, the abortionist, awaited her. His "ministrations" caused pain, and after several days she hemorrhaged and miscarried.

This left her terribly weak, but she returned to work after three weeks, thin and pale. However, unfortunately but certainly not surprisingly, she subsequently developed a severe infection. Although the abortionist had told her not to go to the doctor, she did go when she developed this complication, because the odor was so rancid she just couldn't stand it. The doctor realized what had happened, even though she hadn't told him about the abortion. He was able to treat her successfully.

Despite all this, she never regretted having the abortion. Her concern was that she was a bad person because she had broken the law.

You will see echoes of this story in the pages of this book. Whether their experiences were terrible like the one described here, or safely performed by a licensed provider, most women who had abortions did not regret having them.

This woman, whose story is true, was one of the "lucky" women. She survived her abortion. Other women paid for their abortion with their lives. Dr. Curtis Boyd, a physician during the pre-Roe years, told me that although most women did survive abortions in those years, many did not. Typically those women, usually young women, suffered ghastly, painful deaths.

As we seek common ground on the issue of reproductive health, we must not forget that at the center of every statistic is a human story. A discussion of abortion inherently involves the issue of preventing unwanted pregnancies. While the current debate about abortion began in the seventies—a history to

be discussed later in the book—increasingly those who seek to ban abortion today also seek to limit women's access to comprehensive reproductive health care, including contraception.

Until now, restricting access to reproductive health care and the impact it has on public health and well-being have not been extensively examined. This chapter will show that the best way to improve maternal and child health, and thereby community health, is to give women complete and unrestricted access to reproductive health care. This includes access to abortions, education, support and family planning services.

This chapter examines data assessing the intersection of policies affecting women's access to contraception and abortion, and public health as determined by infant and maternal mortality rates. These are two fundamental measures of the health of a population. This chapter will demonstrate that the intrinsic health advantages of safe, legal abortions belie anti-abortion talking points.

Before going further, it is important to note that the Affordable Care Act, aka "Obamacare," seeks to ensure that women with insurance can obtain a birth control method with no cost sharing or co-pay. However, some object to this, including religious institutions that do not want to pay for contraception. Some of these religious institutions are huge, such as universities and hospitals. People who work for these institutions could be denied contraceptive coverage. Furthermore, the House of Representatives has voted many times to repeal Obamacare. They have not succeeded because the current Senate will not do the same, and hopefully they never will. However, that threat still hovers and any Congressional election could jeopardize the contraceptive provisions provided by the Affordable Care Act.

Reproductive Health Policy Impacts Infant and Maternal Mortality

The infant mortality rate (IMR)[2] is the statistic that experts generally agree reveals the most about the health of a given community. This is because infants, more than any other age group, depend completely on their environment for survival. The IMR concisely measures how well a society meets the needs of its people. Mothers are integral to ensuring the health and well-being of the next generation, therefore alongside IMR, and no less important to determining community health, is the Maternal Mortality Rate (MMR).

As a nurse and health researcher, I am used to talking about data on IMR and MMR, as if they were any other statistics—such as rates of measles immunization or percentage of people who use hand sanitizers. But IMR and MMR are not like other statistics. They refer to painful deaths of young people. I suffered a miscarriage with my first pregnancy. I was only two months pregnant, but already looking forward to delivery and thinking about what my much-wanted little boy or girl would look like, and what he or she would do in life. I had only two months to think about it, but I was devastated when I lost the pregnancy. It took me months to regain any sense of joy in life. I can only imagine what it is like when a baby is born and loved; and then is taken by death in its first year of life. IMR is not just a statistic. Every data point represents a precious infant who will never grow up.

In 2002, the countries of the United Nations sought to determine the highest priorities for promoting health and reducing poverty globally. As a result, they agreed to a broad set of targets—the Millennium Development Goals. Of the eight goals, one addresses reducing child mortality and a second addresses reducing maternal mortality. To put that in other terms,

2 The IMR indicates how many infants die between the second and twelfth months of life, per 1,000 live births. For example, if 5000 infants were born alive in Perfectville, and 5 of those infants died, the IMR for Perfectville would be 5 per 5000, or 1 per 1000.

if you were feeling charitable and had $100 and you wanted to donate it as wisely as you could, you would donate $25 just to reducing IMR and MMR!

Clearly, policy makers should do whatever they can to reduce the IMR. This can be done many ways, but one simple and effective method does not get the attention it should today. That solution is provision of reproductive health services. Fertility control, or a woman's ability to time her pregnancies, is widely considered a vital element in reducing infant (and maternal) mortality.

Three critical factors that influence pregnancy outcomes are: 1) the age at which women conceive, 2) the length of the interval between pregnancies and 3) the number of children a woman bears.

Maternal Age
For biological reasons, teenage mothers and mothers in their forties are more likely than women in their twenties and thirties to have infants who do not survive.

Frequent Births
The chance of dying in infancy increases by about 60 percent to 70 percent for children born less than two years apart.

More Than Four Children
Children born fourth or higher in birth order have, on average, a three-fold greater risk of dying than those lower in birth order. Among the reasons are resource scarcity, and higher exposure to infectious diseases.

It is no surprise that research has found that access to contraception is a key factor in reducing infant mortality. Women who use contraception are significantly *less* likely to have children die during infancy. In fact, when researchers conducted a study in Bolivia, one of the poorest nations in South America, they found that infants whose mothers had not used any birth control prior to their conception were 50 percent more likely to die during

their first two years of life than infants whose mothers used contraceptives. The implications of this and other studies are obvious. Provision of family planning methods to women in poor countries is an integral part of decreasing infant mortality.

While many major infrastructure and educational changes are needed to improve quality of life, providing the conditions for fertility control are relatively simple, achievable, affordable and very effective.

Here's the bottom line: improving women's access to contraception and safe abortions will result in fewer infant deaths.

Infant Mortality in the U.S.

It is no surprise then, that when we look at the United States, we see that family planning services are needed to reduce the IMR. It's true that the IMR in the United States is much lower than it is in the world's poorest countries, but it is still far too high. Despite recent improvements, in 2008 the United States ranked 27th in infant mortality among the thirty countries in the Organization for Economic Cooperation and Development. A number of the former Soviet republics have a lower IMR than we do. Furthermore, we continue to see stark racial differences in infant death rates in the U.S. For instance, the IMR for non-Hispanic blacks is more than two times higher than the rate for whites.

For a variety of reasons, researchers often focus on IMR in developing nations, so not much research has been conducted to explore the relationship between access to birth control and the IMR in the U.S. Curious, I did some research of my own.

Using publicly available data, I analyzed the statistics on infant mortality in the U.S. comparing access to birth control. In each state, I defined access to birth control as whether or not a state pays for comprehensive contraceptive services for poor women through Medicaid. I found that a state's failure to allow Medicaid to pay for comprehensive contraceptive services is a statistically significant predictor of a high infant mortality rate in that state.

In addition, of the twenty states with the highest IMR, sixteen do not have comprehensive Medicaid coverage for contraception.

I then tested the validity of these findings by looking at additional data. The Alan Guttmacher Institute, a widely respected institution that produces objective research on reproductive health, ranked states on their efforts to help women avoid unwanted pregnancies. I found that a high ranking for family planning services correlates significantly with a low IMR. The evidence clearly suggests that in the U.S., as in developing countries, providing women with access to contraception improves the IMR.

Researchers as early as the 1980s began to note a striking decrease in the IMR since the 1960s. They conducted analyses on the relationship between abortion policy and IMR. One interesting study sought to understand this precipitous decline by analyzing the role of four public policies: Medicaid, subsidized family planning services for poor women, maternal and infant care projects and the legalization of abortion. They found that the increase in legal abortions was the single most important factor in reducing infant mortality rates.

The increase in legal abortions was the single most important factor in reducing infant mortality rates.

Child Abuse and the Lack of Family Planning

I was struck recently by several horrific news stories about violent child deaths as a result of abuse. In each story, the dead children had many siblings. Knowing firsthand how trying it can be at times to take care of children, even with financial resources and plenty of social support, it occurred to me that lack of contraception resulting in repeated, unwanted childbearing might well put children at risk for abuse. So I did some investigating.

That suspicion was confirmed by an examination of the research in this area. Large family size and unplanned pregnancies and births do place

children at risk for physical abuse and neglect. Similar to infant mortality, studies have shown that the risks appear to come not only from having a lot of children, but also from having children too closely spaced. Children from families with two unplanned births are almost three times more likely to experience abuse than children in families with no unplanned births; and children from families with three unplanned births are almost five times more likely to suffer from abuse! Additionally, in 1996 the U.S. Department of Health and Human Services stated in an official study that children in the largest families were almost three times more likely to be educationally neglected, and two and two-fifths times more likely to be physically neglected compared to children in families with two or three children.

Child abuse experts maintain that the best strategy for preventing child abuse and neglect is providing women with family planning services. A Surgeon General's Workshop on Violence and Public Health, convened by Dr. C. Everett Koop, found that "The starting point for effective child abuse programming is pregnancy planning."

Although deaths and child abuse and neglect are the most horrifying consequences of uncontrolled fertility, they are not the only troubling outcomes. Newborns that were not wanted are more likely to be premature and/or have a low birth-weight. Long-term studies followed these children into adolescence, and found that their problems persist. They are more likely to have serious behavioral problems, do poorly in school and the boys tend to feel neglected or rejected by their mothers. When women bear children they do not want, the whole family continues to suffer.

Maternal Mortality in the U.S.

In the United States, we do not often think about maternal mortality, i.e. death from complications relating to pregnancy and childbirth. It seems to me that the teens and mothers I speak to in my office have all heard that hormonal contraceptives such as birth control pills can have fatal side effects.

However, I have never met a woman who is aware that for most women, pregnancy carries a much higher risk of death than birth control pills. The United States saw a seven-fold reduction in maternal mortality in the 20th century. Yet, despite those decreases, preventable deaths related to pregnancy and childbirth persist. And recent evidence shows that maternal mortality is greatly underestimated. The United States ranks only 52nd in maternal mortality rates globally, hardly better than the 65th percentile.

The maternal mortality statistics are sobering. Pregnancy-related causes are the seventh leading cause of death for all women aged 15–34 years of age. Pregnancy is the fifth leading cause of death for black women aged 15–24 years and the sixth leading cause of death for black women aged 25–34. For white women aged 20–24 years, such causes are the tenth leading cause of death. At least five hundred and forty eight women died of pregnancy-related causes in 2007, the most recent year for which data are available.

As with infant mortality, racial discrepancies are a factor in maternal mortality. Mothers who are black, Native American, Hispanic or Asian immigrants are more likely to die of causes related to pregnancy and childbirth than are white women. In the United States, the maternal mortality rate for black women is three and a half times higher than it is for whites. As maternal age increases so do potential complications and here we see another instance where racial inequalities exacerbate the situation. A pregnant African-American woman age 35 or older is six times more likely to die than a pregnant white woman of the same age.[3]

Another predictor of maternal mortality is higher number of previous live births. For both white and black women, pregnancy-related mortality was approximately twice as high for women after delivering a fifth or higher order live birth than for women after a first live birth. And still the racial disparity

3 The risk for pregnancy-related death decreases with increasing levels of education among women aged 25–39 years. However, at all levels of education, pregnancy-related mortality for black women was three to four times higher than for white women.

persists. Overall, a threefold to fourfold disparity exists in pregnancy-related deaths for black women compared with white women for each level of birth order. In addition, women who received prenatal care were less likely to die after a live birth than those who did not. Again racial disparities persist. The reduction in mortality for women who received prenatal care was higher for white women than for black women.

Additional Health Benefits of Contraception

I often hear young women and their mothers express fears that oral contraceptives can lead to increased risk of breast cancer. Therefore, let's clear up a common misperception about the risks posed by contraceptives. No evidence supports the claim that today's low-dose pills pose such a risk. Indeed, the risk of dying from pregnancy-related complications dwarfs the risk of dying from complications of oral contraceptives (and abortion), especially in non-smokers under the age of 35.

In fact, oral contraceptives have a number of *health promoting* effects. Birth control pills also decrease the incidence of ectopic pregnancy and decrease the risk of ovarian cancer. It is not unusual for me to see women, frequently young adolescents, who have very heavy periods, which can result in severe anemia. The treatment for this condition, in addition to treating the anemia, is birth control pills. Oral contraceptives are also a treatment for women who get their periods only rarely, which can pose a risk of endometrial cancer later in life. For women who tend to have a problem with menstrual cramps, the use of birth control pills helps them avoid monthly absenteeism from school or work. Despite these important benefits of hormonal contraceptives, thirteen states allow some health care providers to refuse to provide services related to contraception.

This data points to one clear conclusion: access to comprehensive contraception is essential to the health of women and children. Furthermore,

the well-being of the entire family and thus the community is dependent on the ability of women to take control of their reproductive health.

The Health Impact of Legalized Abortion in the U.S.

> *"I remember having conversations with two [Ob-Gyn doctors] in particular, each of whom was an older, very religiously conservative man, neither of whom were themselves abortion providers. Both came from orthodox religious traditions that didn't approve of abortion. And they both said to me, 'Wendy, if you've seen a 13-year-old dying of gas gangrene[4], you can never really be opposed to abortion after that.'"*
>
> – Wendy Chavkin

Maternal mortality statistics changed radically after the Roe v. Wade decision—for the better. The Centers for Disease Control (CDC) established an abortion mortality surveillance system, which documented the profound and beneficial public health effects of the availability of legal abortion. As the chart below shows, as the availability of legal abortion increased, mortality due to abortion dropped from close to forty deaths per million live births in 1970 to eight deaths per million live births in 1976. Only six years!

In terms of hard numbers, in 1967, six years before Roe v. Wade, 700,000 to 800,000 induced and mostly illegal abortions were performed nationally each year. After 1973, the number of illegal abortions fell sharply while the number of legal abortions increased.

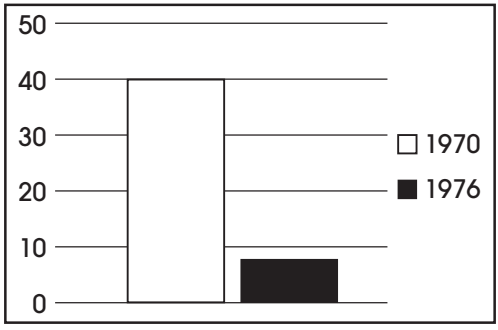
In 1965, almost two hundred women died from illegal abortions,

4 Gas gangrene: Gas gangrene is a severe form of gangrene (tissue death) usually caused by a bacterial infection. The onset of gas gangrene is sudden and dramatic. Inflammation begins at the site of infection with color changes and extremely painful tissue swelling. Gas may be felt in the tissue as a crackly sensation when the swollen area is pressed with the fingers. The infection spreads so rapidly that changes are visible over a few minutes. The involved tissue is completely destroyed. Gas gangrene is progressive and often lethal. Immediate medical attention is required. (Medline, 2006).

and illegal abortions accounted for nearly 17 percent of all deaths due to pregnancy and childbirth that year. When considering the appropriate course for dealing with unwanted pregnancy, women tend to take the safety of pregnancy and childbirth for granted. However, as we have seen, pregnancy carries significant risks, and abortion is by far safer for the mother's health. Today abortion is one of the most commonly performed and safest clinical procedures. It is more than ten times safer than carrying a pregnancy to term.

Maternal Deaths due to Abortion before and after Roe v. Wade

(per million live births)



The American Medical Association (AMA) conducted a study published in 1992, which examined maternal morbidity (disease) and mortality (death) before and after Roe v. Wade. Among the researchers' findings was that gestational age (how far along the pregnancy is) is probably the most significant determinant of risk of death from legal abortion. In 1973, only 36 percent of abortions were performed at or before eight weeks of pregnancy, the safest time. In 2007, 62.3 percent of reported legal abortions were obtained at less than eight weeks' gestation and 91.5 percent at less than thirteen weeks. Only 1.3 percent occurred after twenty weeks. Furthermore the number of abortions that were performed at less than six weeks gestation increased by 65 percent.

Tragically, in restricting and hindering access to abortion providers, current policies in many states are delaying abortions, and thus increasing

the risk. This is especially problematic in a growing number of states where only one or two clinics perform abortions, and those may soon be gone. Nationally, even before the onslaught of state laws constraining abortion facilities and providers in 2013, only 13 percent of counties had an abortion provider. This makes it difficult for poor women in particular to have an early abortion. The lack of safe abortion options puts many women in serious danger.

Today abortion is one of the most commonly performed and safest clinical procedures. It is more than ten times safer than carrying a pregnancy to term.

Another factor that strongly correlates with abortion mortality is physician skill. After Roe was decided, doctors were able to train residents to perform abortions, and they also developed improved abortion procedures. However, today the number of abortion providers is shrinking dramatically and few young doctors are being trained in abortion techniques, leaving more and more women without a trained abortion provider. Luckily, other providers are being trained to perform abortions including nurse practitioners, certified nurse midwives and physician's assistants. Their safety record is equivalent to that of physicians, but they are not permitted to perform abortions in many states.

After Roe v. Wade, the number of maternal deaths fell more sharply than the reduction in live births. And birth rates of women most at risk—older women and teenagers—declined more steeply than rates for other women. That is exactly what the Roe decision had anticipated—it was about saving women's lives.

Poor and minority women probably benefited most from Roe, because it gave them access to safe abortions without an undue cost burden, at least until the Hyde Amendment was enacted in 1976, which excludes abortion

from the health care services provided to low-income people through Medicaid. The affluent always have access to more options and in this case even when abortions were illegal, wealthy women were able to access safer, albeit more expensive, abortion providers. The majority of women who had been harmed by illegal abortions were poor and minority. For example, from 1972 to 1974, the mortality rate due to illegal abortion for nonwhite women was *twelve times* that for white women. Yet white women had more abortions than women of color.

It's important to note that not all complications of illegal abortions result in death. Illegal or incompetent abortions can also result in considerable damage to a woman's health that is life-long. The human and financial cost of illegal abortions is staggering in terms of women killed or maimed—often young women; many with young children. Disturbingly, if abortion becomes illegal again, more women may turn to the internet, which already provides dangerous information on self-abortion techniques.

When abortion became more widely available after Roe v. Wade was decided, younger, lower income and unmarried women were able to obtain these procedures closer to home and earlier in their pregnancies. Today, poor and near-poor women account for slightly more than half of all abortions performed in the U.S.

Yet women from higher economic strata still account for a considerable number of abortions today. That figure is telling. It means that even those who have access to birth control have unwanted pregnancies. Birth control is not 100 percent perfect, and neither are those who use it. Although the majority of women having abortions are unmarried, most of them have already had children.

In addition to its other benefits, legalization of abortion allowed physicians to conduct research to develop better surgical techniques for performing abortions, and improve the management of abortion complications, further decreasing morbidity and mortality from legal abortions.

Additionally, rather than having surgery, women can now obtain medical abortions utilizing pills, which are now legal and available during the first seven weeks of pregnancy. Although this option too is now under attack.

Psychological Considerations

Does legalized abortion threaten the emotional health of women, as its opponents sometimes claim? In a word, no. The American Psychological Association cited a rigorous evaluation of the emotional impact of abortion that concluded that "legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women."

Women who did manifest psychological distress after an abortion were generally women who had preexisting psychiatric problems, were ambivalent about having the procedure, had the abortion for medical or genetic reasons, did not make the decision freely, had a second trimester procedure or had wanted to become pregnant.

What is more, *denied* abortion has emotional consequences too, including continued negative feelings toward the child and continuing adjustment problems for years after the procedure was denied. Such negative feelings toward the unwanted child no doubt contribute to the child's increased risk of being abused, which I discussed earlier. Mothers who were unable to obtain an abortion also suffered from higher levels of depression, and their mothering was more punitive and less nurturing than other mothers'. Moreover, the unintended child is not the only one to suffer. The poor quality of mothering affected all the children in the family.

Even C. Everett Koop, an early and passionate pro-life activist who became Surgeon General in the Reagan administration, criticized the research that demonstrated an association between abortion and emotional problems. He noted that emotional problems resulting from abortion are "miniscule from a public health perspective."

Logically, this makes perfect sense. When women are confronted with an unwanted pregnancy, they are often so anguished that they are willing to take sometimes desperate and dangerous measures to terminate the pregnancy. Why then should we expect them to be anything but relieved once the pregnancy has been safely terminated?

I have seen this again and again: patients who have their whole lives in front of them, patients who may be the first in their families to go to college, who are gifted and talented, who acknowledge that they have made a mistake and who don't want to throw everything away because of that mistake. I recounted the story of one of these patients in the introduction to this book, who I called Madalena. Like Madalena, many of these patients often consult their mothers and sisters, or other family members. If they finally decide to undergo abortion, of course, they are relieved to know that they have not given up all their potential and have their life back.

There have been a number of studies designed to determine whether having an abortion adversely affects a woman's mental health. One study conducted in Czechoslovakia after abortion laws were liberalized, found persistent mental health problems for the children born to women who had wanted to terminate their pregnancies. Similarly, an extensive review of the literature by researchers at the American Psychological Association, found no evidence of increased mental health problems after abortion.

Having an abortion does not increase the likelihood of mental health problems compared to having an unwanted birth. Moreover, as the medical research also demonstrates, carrying a pregnancy to term and delivering a baby presents more physical health risks than an abortion.

Economic and Social Benefits

Despite recent innovations in contraceptive technology, almost half of all pregnancies in the U.S. each year are unintended, and about half of these are terminated by medically safe, legal abortions. In 2000, 1.31 million

abortions took place, down from an estimated 1.61 million in 1990. If safe, legal abortion was not available, more women would experience unwanted births with the attendant health and social consequences.

In the United States, a country with tremendous wealth, almost one-fourth of all children live in poverty. Some may argue that the individual adult is responsible for his or her own health and well-being, but all agree that children need to be cared and provided for by society. We must take into account the public health considerations of children living in poverty because infant and child health are a strong determining factor in lifetime success and prosperity.

The health and well-being of women and children are best in states with liberal abortion laws. They also tend to be states that spend more money to help poor children.

The health and well-being of women and children are best in states with liberal abortion laws. They also tend to be states that spend more money to help poor children. By contrast, states with more restrictive laws tend to spend far less money per child on important services for children such as foster care, education, welfare and the adoption of children who have physical and mental disabilities. These states also have fewer mandates requiring insurance providers to cover minimum hospital stays after childbirth. Furthermore, women in states that have the most rigid anti-abortion laws suffer from lower levels of education and higher levels of poverty. It appears that the states most hostile to abortion rights are also the states that are least likely to spend money to provide services for mothers and children once the children have been born.

The unrestricted access to abortion is essential to the health and well-being of any community. In this country, it has drastically reduced maternal mortality rates in the years since it was legalized. Additionally, as with contraception, the termination of unwanted pregnancies leads to better

maternal health and improved well-being for other children in the family. Lastly, *restriction to abortion access does not substantially reduce the number of abortions*. It only serves to increase the burden and the risk of maternal mortality for those already struggling to overcome social and economic disparities and challenges.

Impacting Everyone's Future

This chapter is about protecting and improving the lives of women and children in our society. There are medical challenges and there are public health challenges. They are interrelated.

Direct causes of a maternal or infant death, such as hemorrhage or infection, are medical and must be addressed by medical technology. But many social and economic issues are amenable to policy and public health interventions. These issues include conditions such as a woman giving birth to four children in five years; losing a job and coverage for birth control; living in a state where the nearest abortion provider is a day's drive—and she has no car; or any of dozens of other social/economic matters. These are often barriers that keep women and communities locked in cycles of poverty and hinder them from achieving their full potential. If we can create intelligent public health programs, we can go a long way toward alleviating these grim circumstances.

Well-run family planning programs have a much broader impact than simply preventing unwanted pregnancies, although that is a worthy goal in itself. By preventing unwanted pregnancies, such programs prevent deaths related to pregnancy and childbirth. Homes and communities are strengthened when young women do not die in childbirth. Fewer children grow up without a mother. The World Health Organization has written that family planning is one of the best investments that can be made to help ensure the health and well-being of women, children and communities.

About the Author

Carol Roye is a well-known researcher in reproductive health who specializes in issues pertinent to adolescents, including HIV prevention, teen pregnancy prevention and working with mothers of pregnant and parenting teens to improve outcomes for their daughters. She was also awarded a prestigious research grant from the National Institutes of Health to study HIV/AIDS prevention. Her work has been featured by the National Campaign to Prevent Teen Pregnancy and appears in the National Clearinghouse on Families and Youth. She has appeared on radio and television to talk about adolescent and women's health issues and has spoken at numerous national and international conferences.

Dr. Roye is a Professor of Nursing at Hunter College in New York City and a practicing pediatric nurse practitioner. She splits her professional time between research, teaching and her clinical practice providing reproductive health care to adolescent girls in an inner-city neighborhood of New York. She is the author of many publications on a range of topics in adolescent reproductive health, including *Adolescent Sexual Development and Sexuality: Assessment and Interventions*, a popular book for professionals who work with teenagers around issues of sexuality.

She is the mother of six children, the youngest adopted from a Romanian orphanage, and the grandmother of twelve.

You can learn more about Carol and her work at www.CarolRoye.com.

Discover the surprising history of women's health that everyone deserves to know

Women's health has long been seen as a divisive social issue. But, behind inflammatory news headlines, there's an untold history that every man and woman is entitled to know. This factual and eye-opening story recounts how women's health went from being a medical issue, supported by religious groups, to a divisive political debate.

Author Carol Roye, an academic, longtime nurse practitioner and mother of six, dispels many of the inaccurate political arguments surrounding abortion and reproductive rights and instead shines a light on the real concern at hand — public health. *A Woman's Right to Know* reveals the negative impacts that the "moral imperative vs. women's rights" debate has had on countless women, their children and our society while pointing us toward a solution.

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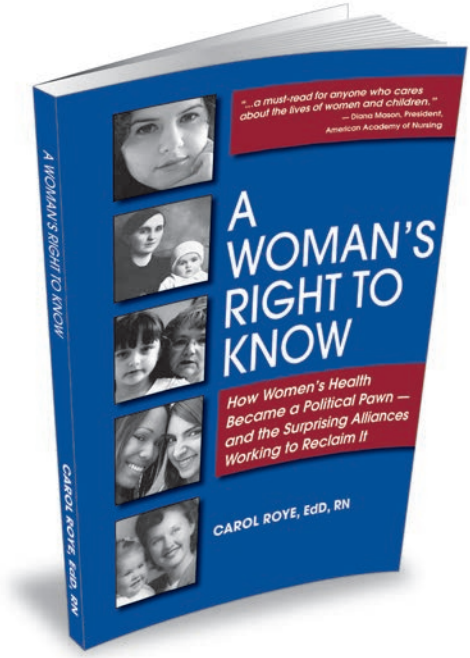

If you would like to learn more about the book and receive timely updates on key women's health issues, please visit www.CarolRoye.com.

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