



Abortion is Health Care

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I. Brief History of Abortion in the United States

The United States did not always have a history of [imposing restrictions on abortion](#). Until the early 1800s, abortion was legal before a [pregnant person felt fetal movement](#), known as “quickeening.” Midwives and other healers largely supervised and assisted with abortion care.

The shift towards banning abortions was born out of racism, misogyny, and the desire for control. [In the mid-1800s](#), the United States experienced a shift towards criminalizing abortion. This was [followed by](#) a move away from midwifery and traditional medicine typically performed by women in their communities in favor of the relatively new, profitable, and male-dominated Western medicine model in the early 1900s. [Black midwives and healers](#) were condemned for performing abortions as well as for their care of pregnant people. The desire for control over pregnancy and reproduction was motivated in part by the [declining birthrates](#) of white Protestant American women in the late 1800s and increased migration. During this time, abortions continued but in much more unsafe conditions unless one was able to [travel to and pay](#) the few providers who performed abortions safely.

In 1973, the Supreme Court decision in *Roe v. Wade* confirmed that the decision to [terminate a pregnancy is a constitutional right](#). Three years later, Congress passed an appropriations bill rider known as the [Hyde Amendment](#) in order to block federal funds from being used to pay for abortion outside of the narrow scope of rape, incest, and life endangerment. The Hyde Amendment and many other restrictions that followed have severely limited coverage for abortion for those enrolled in Medicaid and other federal programs. Since then, [states have enacted a maze of abortion-related laws](#) that limit when, where, and under what circumstances one can obtain an abortion.

II. Abortion is Health Care¹

Abortions are common medical interventions that end pregnancies. Abortions occur regardless of whether it is legal or not to obtain one. [The Guttmacher Institute](#) reports that in 2017 the abortion rate in countries that prohibit or limit abortion was 37 per 1,000 people and that the abortion rate was 34 per 1,000 people in countries that broadly allow for abortion. [The World Health Organization](#) (WHO) confirms that criminalizing abortion does not stop abortions but only makes them less safe; unsafe abortions lead to 4.7 percent to 13.2 percent of maternal deaths.

Various abortion methods can be used to end pregnancies, including medication abortion and surgical abortion. The different procedures for abortions depend on personal preference, length of pregnancy, availability, and access. According to data from the Centers for Disease Control (CDC), in 2016, [almost two-thirds](#) (65.5 percent) of abortions occurred at eight or less weeks of gestation and most (91.0 percent) occurred in the [first trimester](#) or up to thirteen weeks of pregnancy.

Medication abortions involve taking two medications: mifepristone and misoprostol. Mifepristone [blocks progesterone](#), which is a hormone needed for a pregnancy to grow normally. The second medication, [misoprostol, is taken up to 48 hours later](#). Misoprostol causes the uterus to empty, typically resulting in what [feels like a heavy menstruation](#). Medication abortions work up to [70 days](#) or eleven weeks after the first day of the last menstrual cycle. Mifepristone is included by the WHO on their [Model List of Essential Medicines](#). The U.S. Food and Drug Administration (FDA) [allows patients](#) to take mifepristone and misoprostol at home with the choice of self-assessment or clinical follow-up to determine success of the medication abortion.

Mifeprex, the brand name of mifepristone, is subject to regulations known as the [Risk Evaluation and Mitigation Strategy](#) (REMS). Under the REMS requirements, healthcare providers must be certified in the REMS Program and Mifeprex must be dispensed at certain healthcare settings. [The American College of Obstetricians and Gynecologists \(ACOG\)](#) [opposes these restrictions](#) and [research shows](#) that there is no significant need for them; for example, there is no difference between self-assessment and clinical follow-up in determining that medication abortion was successful. ACOG also recognizes that medication abortions can be safely provided through [telemedicine](#). The [use of telemedicine](#) can greatly increase access to abortion for those without access to a health care provider. In fact, in an [analysis](#) of nearly 20,000 medication abortions, the rare occurrence of adverse reactions did not differ between in-person care and telemedicine.

Other types of abortion procedures are considered [surgical abortions](#). There is [no standard terminology for these types of abortion](#) which include methods like [uterine aspiration](#),

¹ This report will occasionally use the terms “women” or “woman” as well as other gendered language where the research data or laws cited uses those specific terms. We recognize that people of all genders, gender identities, and expressions require access to abortion and have tried to otherwise limit our use of gendered language where possible.

aspiration curettage, suction curettage, dilation and curettage, dilation and evacuation. Surgical abortion options depend on the stage of pregnancy, geographical location, and what tools are used, e.g. if curettage instrument is not used, it would not be included in the name. [Uterine aspiration abortion](#) is common. According to the CDC, in 2016, approximately 59.9 percent of abortions were surgical and performed at or before 13 weeks of pregnancy. Aspiration is usually [performed in the first trimester](#). The procedure typically involves a mechanical or medication cervical dilator followed by a [mechanical vacuum aspirator](#). In the second trimester, [dilation and evacuation](#) is the most commonly used method in the United States. This method entails dilation of the cervix with medication or mechanical dilators followed by the evacuation of the contents of the uterus with suction, forceps, or curettage to empty the uterus; this method is usually used after sixteen weeks [since the last menstrual cycle](#). The [CDC reports](#) that only 1.2 percent of abortion are performed at 21 weeks or later.

The National Academies of Science, Engineering, and Medicine confirmed in 2018 that [abortions are safe and low-risk interventions](#). Also according to [ACOG](#), the risk of death from abortion is lower than one in 100,000 and the risk of dying in childbirth is fourteen times greater than the risk of dying from an early abortion. Complications from medication abortion are rare as well, occurring in [less than one percent](#) of patients. Similarly, complications are also rare in aspiration abortions. One study analyzed Medicaid claims data in California and found that 0.16 percent of approximately 35,000 patients were found to have experienced serious complications. With dilation and evacuation methods, the risk is increased due to increased stage of pregnancy. Despite this increase, the [rate of complication is still low](#), ranging from 0.05 to 4 percent.

Physicians are not the only providers who are able to perform or assist in an abortion. Nurse practitioners, certified nurse-midwives, and physician assistants can perform abortions and increasingly are legally permitted to do so. A six year study, [Health Workforce Pilot Project](#), demonstrated that these providers can safely and competently provide early abortion care. In 2003, [the WHO recommended](#) that abortion services can be provided at the lowest appropriate level of health care systems, stating specifically that aspiration abortion can be completed up to twelve weeks of pregnancy by mid-level health providers like midwives, nurse practitioners, clinical officers, physician's assistants, and others with the appropriate training. [ACOG encourages](#) abortion education expansion to increase the number and types of trained providers who can improve access to safe abortions.

People from all demographics get abortions, regardless of income, sex and gender, race, geographic location, disability, or marital status. Abortions are not limited to cisgender heterosexual women. [The Guttmacher Institute](#) shows the racial demographics of abortion patients in 2014 was as follows: 39 percent were white, 28 percent Black, 25 percent Latinx, 6 percent Asian/Pacific Islander, and 3 percent were "Other." In addition, 62 percent of abortion patients were religiously affiliated, 59 percent were women with children, and 60 percent were people in their 20s. The Guttmacher Institute [also estimates](#) that in 2017, approximately 462 to 530 transgender and non-binary individuals obtained abortions and 23 percent of surveyed abortion clinics provided transgender-specific health services. [People with disabilities](#) often face more barriers to clinician access and reproductive and sexual health care in addition to enduring the double stigma of disability and stigma related to sexuality and abortion.

Many motives lead individuals to end their pregnancies. [One study](#) found that the most cited reasons for seeking an abortion were that having a child would interfere with a person's education, work, or ability to care for dependents (74 percent) that she could not afford a baby (73 percent), that she did not want to be a single parent or was having relationship issues (48 percent). In addition, four in ten women said that they had completed their childbearing, and about one-third of participants said they were not ready to have a child.

The organizations, [Shout Your Abortion](#) and [We Testify](#) compile accounts of people who have had abortions and their stories. These stories show the complexity and diversity of people who get abortions while helping to destigmatize the intervention.¹

We Testify, in particular, elevates the voices of people of color, queer-identified people, those with varying abilities, and different citizenship statuses. One person, describes her experience with abortion as [a Black woman, HBCU graduate, and Christian](#): “*I want fellow Christians to know that having abortions won't separate you from the love of God. My faith played a major role in choosing abortion and being able to feel firm in my decision. [...] I want people to know that you don't have to choose between your faith and your decision to have an abortion. For me, having an abortion actually strengthened my spiritual relationship.*”

[Another storyteller](#) describes having an abortion at 20 as a “*poor undergraduate student in a crumbling relationship with poor mental health... Making the decision to have an abortion wasn't difficult, but accessing it was. I'm an AfroLatinx person with no health insurance. The medicinal abortion route was a smooth \$500 out of pocket and the whole time I was paying I was kissing my rent, textbooks, and groceries goodbye. [...] It wasn't just the physical and logistical aspects of having a medicinal procedure, but the emotional labor of navigating a space where I was constantly misgendered. [...] I've made it a personal goal to shed light on how trans and gender nonconforming people are also very much affected by restrictive and oppressive anti-choice legislation.*”

Telling stories sheds light on how experiences with abortion are varied and depend on one's circumstances, intersecting identities, and where one lives. Some people describe uncertainty in deciding to get abortions while others were positive from the moment they found out they were pregnant that they wanted an abortion. During and after the abortion experiences range from relief, to joy, to freedom, and sometimes sadness. One person describes [their decision to seek an abortion](#): “*It was never a hard decision for me and I'd do it again. There was no pain, no tears, or feeling conflicted. I was pregnant and did not want to be. Simple as that and it was a valid reason. [...] Having autonomy over my own body is joyful and it is my right [...]*” [Another story](#) states that “*Abortion make (sic) me the person that I wanted to be.*” In this story, the author describes their abusive relationship, and that for them, having a child would mean letting go of their dreams and raising a child with their abuser.² Another person describes feeling both relief and grief during their abortion: “*In the days that followed I was surprised by the degree of sadness and loss I felt despite knowing it was the best possible outcome and something I actively chose. Grief and relief seemed a contradictory pairing, yet there they*

² The singular they/them is used here as the pronouns of the storytellers are not available.

were, filling my heart together. I learned to give myself time and space to sit with this duality, to remind myself I can be pro-choice and thankful to no longer be pregnant while simultaneously mourn the loss of something I wanted under different circumstances.” These stories show that people seek abortions for many reasons and for many the ability to decide when to have a child is freedom, joy, and key for both their health and a potential child’s health.

III. Abortion Restrictions are a Public Health Crisis

Restricting access to abortion has consequences for the mental, physical, and social health and well-being of people who can become pregnant. Restrictions happen through laws and policies that limit access, force clinics to close, make abortion unaffordable, spread misinformation about abortions, and stigmatize abortion.

[The Hyde Amendment](#) was introduced in 1976 and continues to be renewed by Congress every year. This appropriation bill rider prohibits coverage of abortion except in limited cases of rape, incest, or when a pregnancy is life endangering. The Hyde Amendment applies to crucial health coverage programs like Medicaid and Medicare as well as to individuals who receive health care coverage through the federal government like federal employees, military personnel and veterans, Indigenous people receiving health care through the Indian Health Service, and more.

Due to the Hyde Amendment, it is estimated that 7.4 million women ages 15-49 who are enrolled in Medicaid cannot use their insurance to cover the cost of abortion except in [very narrow circumstances](#). However, Medicaid does cover other services related to pregnancy such as prenatal care, treatment of complications after a medically unsupervised abortion, treatment of ectopic pregnancies, and post-abortion contraception. Similar restrictions can be found in some states’ Marketplace plans, private insurance plans, and employer plans. [Sixteen states](#) go beyond the Hyde Amendment to cover all abortions in their Medicaid programs using state funds.

Without insurance coverage of abortion, those seeking abortions must pay for it out-of-pocket. The cost varies based on location, type, and other factors but on average a first trimester abortion can [cost between \\$500 to over \\$1,000](#). In addition to out-of-pocket costs for the abortion itself, there are also costs associated with travel, childcare costs, and time off from work. Partly as a result of unnecessary restrictions on abortion care, the number of abortion providers is in [decline](#).

Many patients must travel long distances to obtain abortions. For example, even in a state with increased insurance coverage of abortion like California, abortion patients have travel burdens associated with abortion because providers are concentrated in urban areas. [One study](#) found that among women seeking an abortion in California who are enrolled in Medicaid, 11.9 percent traveled 50 miles or more. In addition, individuals obtaining second trimester or later abortions as well as rural residents have to travel 50 miles or more to obtain an abortion. [One study examined 6,022 telemedicine requests](#) for self-managed abortion services over ten months. They found that while approximately 76 percent of requests were from states with

hostile restrictions, the majority (60 percent) reported a combination of barriers to clinic access and preference for self-management of abortion for privacy and convenience.

The legal framework set forth in *Planned Parenthood of Southeastern Pennsylvania v. Casey* has allowed states to place some limitations on abortion after the first trimester. Nevertheless, some state bills, such as those that restrict abortions when there is cardiac activity, have been blocked by federal courts because they are unconstitutional. The reality is that cardiac activity, which can be detected around six weeks, happens before many people even know they are pregnant. In effect, these bills would ban most abortions and are primarily designed to test the current Supreme Court's willingness to undermine or overturn *Roe v. Wade*.

Some laws specifically target abortion providers. Known as [Targeted Regulation of Abortion Providers \(TRAP\)](#), these laws typically apply the state's standard for ambulatory surgical centers on abortion clinics even though abortions are much less risky, invasive, and typically do not use the same high levels of sedation that other surgeries require. Some TRAP laws also require physicians to have admitting privileges at a local hospital. By reducing access through the distance between clinics and the growing closure of abortion clinics, these laws complicate who is allowed to perform an abortion or even dispense mifepristone and misoprostol.

Denying access to abortions negatively impacts people's physical health, mental health, and economic stability. [The Turnaway Study](#) is the largest study that examines women's experiences with abortion and unwanted pregnancy in the United States. In this study, researchers tracked the health of approximately 870 participants who sought abortions. About [160 participants were denied abortions](#) because they exceeded their clinics' gestational limits. Participants who were denied abortions more often reported that their overall health was "fair" or "poor" in comparison to those who had an abortion, who reported that their health as "good" or "very good." In addition, women who were denied an abortion reported [more life-threatening complications](#) of pregnancy like eclampsia and postpartum hemorrhage. Women who were denied an abortion also reported [higher instances of chronic headaches, migraines, and joint pain](#) compared to those that received an abortion.

People seeking abortions experience a [wide range of emotions](#) related to having abortions. However, women denied abortions report their stress and anxiety at the highest levels when they are denied this service. [The Turnaway Study](#) looked at the differences in mental health and the nuance in experiences for those who received an abortion and those who were denied. Mental health harm was not associated with those who wanted and were able to receive abortions. Those who were denied abortions had higher rates of anxiety and low self-esteem approximately one week after the denial. However, those who received abortions and those who were denied had similar rates of depression and both groups reported a reduction in depression over five years. The researchers found that the most significant factors linked with depression after seeking an abortion were an existing history of mental health conditions, history of child abuse, and neglect. Similarly, women seeking abortions after their first trimester did not experience higher rates of depression, anxiety, or other mental health harm than women who were obtaining an abortion in their first trimester, and stress levels between the two groups were similar by six months post abortion.

Abortion denial can also affect [relationship health and the wellbeing of children](#). Women who were denied abortions were more likely to stay in contact with a violent or abusive partner while women who received an abortion experienced less physical violence from their partner. After five years, women who were denied an abortion were more likely to raise their child alone without family members and male partners. The existing children of women who were denied abortions had worse childhood development compared to children of women who received an abortion. Further, an abortion denial is associated with poorer maternal bonding with the next child born, compared to a woman who received an abortion.

Finally, abortion denial is tied to the financial health of women seeking abortions. The Turnaway study also showed that children of women who were denied abortions were more likely to live below the federal poverty level than the next children born to women who received abortions. [Another study on the economic consequences of abortion](#) compared the credit reports of women who received abortions and women who were denied abortions. The researchers found that both groups had [similar financial trajectories](#) prior to seeking abortions. Those who were denied abortions were found to have a “large and persistent increase” in financial distress over several years. The group denied abortions had a 78 percent increase in debt that was 30 day or more past due and an 81 percent increase in negative public records like eviction. This impact can be seen up to five years after the birth for those who were denied abortions.

IV. Conclusion

Abortion is a common, safe, and effective medical intervention. Abortion care is a critical part of the right to body autonomy, and is key to the physical, emotional, and economic health of a person seeking an abortion and that of their current and future families. Restrictions on abortion harm people and have ripple effects that can last for years. It is also important to destigmatize and normalize abortion as well as normalize that transgender, non-binary, gender non-conforming people, lesbian, and bisexual people all have a need for accessible, equitable, and competent care when seeking abortions

[The EACH Woman Act](#) (HR 1692 and S 758), introduced in 2019 by Congresswomen Barbara Lee (D-CA), Jan Schakowsky (D-IL), and Diana DeGette (D-CO), and U.S. Senators Tammy Duckworth (D-IL), Kamala Harris (D-CA), Mazie Hirono (D-HI), and Patty Murray (D-WA) [requires insurance coverage for abortion for every woman, regardless of income or insurance type](#). The enactment of the EACH Woman Act can mark a significant step towards reproduction freedom for all.

The National Health Law Program believes that abortion is health care and should be covered and accessible like any other medical intervention. Abortions are only unsafe when they are inaccessible, restricted, and denied.