NO. 03-20884

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA,

Appellant,

v.

FRANK LAFAYETTE BIRD, JR.,

Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS

ADDENDUM TO THE BRIEF FOR *AMICI CURIAE* IN SUPPORT OF APPELLANT, UNITED STATES OF AMERICA, ON BEHALF OF AMERICAN CIVIL LIBERTIES UNION, CENTER FOR REPRODUCTIVE RIGHTS, NATIONAL ABORTION FEDERATION, NOW LEGAL DEFENSE AND EDUCATION FUND, AND PLANNED PARENTHOOD FEDERATION OF AMERICA SUPPORTING REVERSAL OF THE DISTRICT COURT

Maria T. Vullo
Andrew Gordon
PAUL, WEISS, RIFKIND,
WHARTON & GARRISON LLP
1285 Avenue of the Americas
New York, New York 10019-6064
(212) 373-3000

Of Counsel:
Jennifer K. Brown
NOW LEGAL DEFENSE AND
EDUCATION FUND
395 Hudson Street
New York, NY 10014
(212) 413-7536

EXHIBIT A

Chronological History of Arsons and Bombings

DATE	STATE	TYPE	EST. DAMAGE	CASE STATUS
3/1976	Oregon	ARSON	$19,000	Joseph C. Stockett was convicted and served two years in prison.
2/1977	Minnesota	ARSON	$250,000	Closed - statute of limitations.
5/1977	Vermont	ARSON	$100,000+	Closed - statute of limitations.
8/1977	Nebraska	ARSON	$35,000	Closed - statute of limitations.
11/1977	Ohio	ARSON	$4,000	Closed - statute of limitations.
2/1978	Ohio	ARSON	$100,000+	Closed - statue of limitations. (Man entered clinic, blinded a technician by throwing chemicals, and set center on fire, destroying it. Clinic was full of patients at the time; they escaped without injury).
2/1978	Ohio	ARSON	$200,000	Closed - statute of limitations.
2/1978	Ohio	BOMB	$3,000	Closed - statute of limitations.
2/1978	Ohio	ARSON	Unknown	Closed - statute of limitations.
5/1978	Vermont	BOMB	Unknown	Closed - statute of limitations.
6/1978	Ohio	BOMB	Unknown	Closed - statute of limitations.
6/1978	Iowa	BOMB	Unknown	Closed - statute of limitations.
2/1979	New York	ARSON	$100,000+	Peter Burkin entered clinic during working hours, set it on fire and injured himself, risking staff & patients' lives. Acquitted of attempted murder and arson; found not guilty by reason of insanity on charges of arson and reckless endangerment.
4/1981	Michigan	ARSON	$30,000	Closed - statute of limitations.
1/1982	Illinois	ARSON	$100,000+	Closed - statute of limitations.
5/1982	Florida	ARSON	$122,000	Don Benny Anderson & Matthew Moore convicted in state court. Both pled guilty and received 30 years, to be served consecutively with 30-year sentence received by Anderson, Matthew Moore and brother Wayne Moore for kidnapping of Illinois physician and his wife.
5/1982	Florida	ARSON	$340,000	Don Benny Anderson & Matthew Moore convicted in state court. Both pled guilty and received 30 years, to be served consecutively with 30-year sentence received by Anderson, Matthew Moore and brother Wayne Moore for kidnapping of Illinois physician and his wife.
6/1982	Virginia	BOMB	$18,000	Don Benny Anderson & Matthew Moore convicted in state court. Both pled guilty and received 30 years, to be served consecutively with 30-year sentence received by Anderson, Matthew Moore and brother Wayne Moore for kidnapping of Illinois physician and his wife.
10/1982	New Jersey	ARSON	$100,000+	Closed - statute of limitations.

5/1983	Virginia	ARSON	$250,000	Joseph Grace convicted in state court. Regarding this and other arson charges, he was sentenced to 10-20 years in Virginia state prison. Scheduled for release: April, 1999.
12/1983	Washington	ARSON	$45,000	Curtis Beseda convicted in U.S. District Court; received two consecutive 10-year terms, 5 years probation, and ordered to pay $295,000 in restitution.
1/1984	Delaware	ARSON	$100,000	Kenneth Shields & Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and $55,000 in restitution. Michael Bray entered Alford plea, in which the defendant does not admit guilt but acknowledges he would be found guilty if tried, and was sentenced to six years.
2/1984	Virginia	ARSON	$1,000	Kenneth Shields & Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and $55,000 in restitution. Michael Bray entered Alford plea, in which the defendant does not admit guilt but acknowledges he would be found guilty if tried, and was sentenced to six years.
2/1984	Maryland	ARSON	$100,000	Kenneth Shields & Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and $55,000 in restitution. Michael Bray entered Alford plea, in which the defendant does not admit guilt but acknowledges he would be found guilty if tried, and was sentenced to six years.
3/1984	Washington	ARSON	$55,000	Curtis Beseda convicted in U.S. District Court; received two consecutive 10-year terms, 5 years probation, and ordered to pay $295,000 in restitution.
3/1984	Washington	ARSON	$70,000	Curtis Beseda convicted in U.S. District Court; received two consecutive 10-year terms, 5 years probation, and ordered to pay $295,000 in restitution.
3/1984	Washington	ARSON	$10,000	Curtis Beseda convicted in U.S. District Court; received two consecutive 10-year terms, 5 years probation, and ordered to pay $295,000 in restitution.
5/1984	Oregon	ARSON	$1,000	Closed - statute of limitations.
6/1984	Florida	BOMB	$200,000	Matthew Goldsby and James Simmons were arrested. U.S. Attorney declined to prosecute because of changes in insanity law. Both men and their girlfriends were prosecuted and convicted in district court. See 12/84 Florida cases.
7/1984	Washington, DC	BOMB	$40,000	Kenneth Shields & Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution.

7/1984	Maryland	BOMB	$50,000+	Kenneth Shields and Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution.
8/1984	Texas	ARSON	$30,000	Closed - statute of limitations.
9/1984	Texas	ARSON	$10,000	Closed - statute of limitations.
9/1984	Texas	ARSON	$90,000	Closed - statute of limitations.
9/1984	Texas	ARSON	Minimal	Closed - statute of limitations.
9/1984	Texas	ARSON	Minimal	Closed - statute of limitations.
9/1984	Georgia	ARSON	$5,000	Closed - statute of limitations.
9/1984	California	ARSON	$125,000+	Closed - statute of limitations.
9/1984	Georgia	ARSON	$8,000+	Closed - statute of limitations.
11/1984	Texas	ARSON	$400,000	Closed - statute of limitations.
11/1984	Maryland	BOMB	$50,000	Kenneth Shields and Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution.
11/1984	Washington, DC	BOMB	Minimal	Kenneth Shields and Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution. Michael Bray entered Alford plea, in which the defendant does not admit guilt but acknowledges he would be found guilty if tried, and was sentenced to six years.
11/1984	Maryland	BOMB	$300,000	Kenneth Shields and Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution.
12/1984	Maryland	BOMB	$150,000	Kenneth Shields and Thomas Spinks pled guilty to conspiracy in connection with this and 9 other cases. Shields received 15 years and was ordered to pay $55,000 in restitution. Michael Bray entered Alford plea, in which the defendant does not admit guilt but acknowledges he would be found guilty if tried, and was sentenced to six years.
12/1984	Florida	BOMB	$100,000+	Matthew Goldsby and James Simmons convicted in U.S. District Court; sentenced to 10 years in prison and $353,073.66 in fines. (Assessed only $350). Kathren Simmons and Kaye Wiggins convicted for conspiracy, received 5 years probation and $2,000 in fines.
12/1984	Florida	BOMB	$225,000+	Matthew Goldsby and James Simmons convicted in U.S. District Court; sentenced to 10 years in prison and $353,073.66 in fines. (Assessed only $350). Kathren Simmons and Kaye Wiggins convicted for conspiracy, received 5 years probation and $2,000 in fines. (Assessed only $50).

12/1984	Florida	BOMB	$100,000+	Matthew Goldsby and James Simmons convicted in U.S. District Court; sentenced to 10 years in prison and $353,073.66 in fines. (Assessed only $350). Kathren Simmons and Kaye Wiggins convicted for conspiracy, received 5 years probation and $2,000 in fines. (Assessed only $50).
1/1985	Washington, DC	BOMB	$100,000+	Kenneth Shields and Thomas Spinks.
2/1985	Texas	ARSON	$1,500,000	Closed - statute of limitations.
3/1985	California	ARSON	$10,000	Shane Cameron arrested. Convicted on unrelated arson charges.
10/1985	North Carolina	ARSON	$75,000	Closed - statute of limitations.
10/1985	Louisiana	ARSON	$300,000	Brent Paul Braud, Derrick James Jarreau, John David Newchurch, and Charles Albert Cheshire Jr. each pled guilty to one count. Braud and Jarreau were sentenced to 2 years in prison and a $50 special assessment. Newchurch was sentenced to 5 years, subject to review after a psychiatric exam. Cheshire was sentenced to 5 years and ordered to pay $314,000 in restitution.
10/1985	Louisiana	ARSON	$20,000	Brent Paul Braud, Derrick James Jarreau, John David Newchurch, and Charles Albert Cheshire Jr. each pled guilty to one count. Braud and Jarreau were sentenced to 2 years in prison and a $50 special assessment Newchurch was sentenced to 5 years, subject to review after a psychiatric exam.
12/1985	Ohio	ARSON	$75,000+	John Brockhoeft pled guilty to one count arson in connection with multiple cases. Sentenced to 7 years in prison. Released in 1995.
12/1985	Ohio	ARSON	$20,000	Marjorie Reed pled guilty to this and multiple other arson charges in 1992. She served 5 years in prison and was released in September 1997.
12/1985	New York	BOMB	Minimal	In connection with this and other NY bombings, Dennis John Malvasi pled guilty to 3 counts and received 5 years in prison; Carl Cenera pled guilty and received 3 years in prison; Frank Wright, Jr., pled guilty and received 2 years in prison. Donald C. pryor, Jr. pled guilty but died before sentencing.
12/1985	Ohio	ARSON	$35,000	John Brockhoeft pled guilty to one count arson in connection with multiple cases. Sentenced to 7 years in prison. Released in 1995.
5/1986	Ohio	ARSON	$200,000	Marjorie Reed pled guilty to this and multiple other arson charges in 1992. She served 5 years in prison and was released in September 1997.
6/1986	Kansas	BOMB	$100,000	Closed - statute of limitations.
6/1986	Missouri	ARSON	$100,000	Closed - statute of limitations.

10/1986	New York	BOMB	$10,000	In connection with this and other New York bombings, Dennis John Malvasi pled guilty to 3 counts & received five years in prison; CarlCenera pled guilty and received three years in prison; Frank Wright, Jr., pled guilty and received two years in prison.
11/1986	Illinois	ARSON	Minimal	David Holman pled guilty. Received 18 months imprisonment and 3 years probation.
12/1986	Illinois	ARSON	Minimal	David Holman pled guilty. Received 18 months imprisonment and 3 years probation.
12/1986	Michigan	ARSON	$750,000	Closed - statute of limitations.
12/1986	New York	BOMB	Minimal	In connection with this and other New York bombings, Dennis John Malvasi pled guilty to 3 counts & received five years in prison; Carl Cenera pled guilty and received three years in prison; Frank Wright, Jr., pled guilty and received two years in prison.
12/1986	California	ARSON	$35,000	Frederick Gordan Tipps arrested. Pled guilty to arson to cover burglary.
1/1987	Illinois	ARSON	Minimal	David Holman pled guilty. Received 18 months imprisonment and 3 years probation.
1/1987	Minnesota	ARSON	$1,500	Mark J. Bundlie confessed to arson. Committed indefinitely to state institution.
3/1987	Ohio	ARSON	$1,000	Marjorie Reed pled guilty to this and multiple other arson charges in 1992. She served 5 years and was released in September 1997.
6/1987	Ohio	ARSON	$1,000	Marjorie Reed pled guilty to this and multiple other arson charges in 1992. She served 5 years and was released in September 1997.
7/1987	California	BOMB	Minimal	Dorman Owens, Joanne Kreipel, Cheryl Sullinger, Randy Sullinger, Chris Harmon, Robin Harmon and Erick Svelmoe were convicted of conspiracy and were given sentences ranging from 149 days to five years.
8/1987	North Dakota	ARSON	$500	Scott Garman pled guilty. Sentenced to 2 months in prison, 2 years probation, and $215 fine. A juvenile was tried in state court and sentenced to two years deferred sentence and 100 hours community service.
9/1987	Minnesota	ARSON	Minimal	Closed - statute of limitations.
9/1987	Minnesota	ARSON	$5,000	Closed - statute of limitations.
9/1987	Minnesota	ARSON	Minimal	Closed - statute of limitations.
10/1987	Minnesota	ARSON	Minimal	Closed - statute of limitations.
12/1987	Alabama	ARSON	Minimal	Closed - statute of limitations.
6/1988	California	ARSON	Minimal	Shannon Taylor convicted and sentenced to 8 years in prison.
10/1988	California	ARSON	$50,000	Shannon Taylor convicted in state and

				sentenced to 8 years in prison.
12/1988	Texas	ARSON	$25,000	Closed - statute of limitations.
12/1988	Texas	ARSON	$65,000	Closed - statute of limitations.
12/1988	Texas	ARSON	$2,000	Closed - statute of limitations.
3/1989	Florida	ARSON	$50,000	Closed - statute of limitations.
3/1989	Florida	ARSON	$50,000	Closed - statute of limitations.
3/1989	Florida	ARSON	$60,000	Closed - statute of limitations.
3/1989	Tennessee	ARSON	$12,000	Closed - statute of limitations.
7/1989	New Hampshire	ARSON	$1,000	Closed - statute of limitations.
9/1989	Pennsylvania	ARSON	$5,000	Closed - statute of limitations.
9/1989	Michigan	BOMB	$300	Closed - statute of limitations.
10/1989	New Jersey	ARSON	Minimal	Marjorie Reed pled guilty to this and multiple other arson charges in 1992.
12/1989	Missouri	ARSON	$100,000	Two juveniles arrested on state juvenile charges for vandalism.
3/1990	Arizona	ARSON	Minimal	Closed - statute of limitations.
5/1990	Oregon	ARSON	$15,000	Daniel J. Carver indicted by state 6/1/90. Apprehended and pled guilty. Sentenced to three years in prison.
5/1990	New York	ARSON	Minimal	Shari DiNicola, arrested 5/28/90. Self-committed to mental institution. State will not prosecute
7/1990	California	ARSON	Minimal	Closed - statute of limitations.
7/1990	California	ARSON	$30,000	Closed - statute of limitations.
8/1990	Washington	BOMB	$400	Closed - statute of limitations.
9/1990	California	ARSON	$50,000	David Brian Martin arrested for burglary; authorities ruled case not abortion-related.
9/1990	Massachusetts	ARSON	Minimal	Closed - statute of limitations.
11/1990	Indiana	ARSON	$10,000	Closed - statute of limitations.
2/1991	Ohio	BOMB	$10,000	Remains open
2/1991	Arizona	ARSON	$300	Remains open
2/1991	Ohio	ARSON	$250,000	Remains open
3/1991	North Carolina	ARSON	Minimal	Robert Hugh Farley arrested 3/91. Committed to mental institution.
3/1991	North Carolina	ARSON	$100,000	Robert Hugh Farley arrested 3/91. Committed to mental institution.
3/1991	New Jersey	ARSON	$500,000	Alan Weiselberg pled guilty to insurance and mail fraud. It was a prosecutorial decision not to prosecute on the arson charges.
5/1991	Alabama	ARSON	$80,000	Remains open
8/1991	North Carolina	ARSON	$50,000	Remains open
11/1991	Florida	ARSON	Minimal	Remains open
1/1992	Montana	ARSON	$75,000	Attributed to Richard Andrews though he was not charged due to statute of limitations.

1/1992	Texas	ARSON	$300,000	Remains open
3/1992	Ohio	ARSON	$1,000	Remains open
3/1992	Oregon	ARSON	$225,000	Rachelle Shannon pled guilty on 6/7/95 to 6 arson incidents and 2 acid incidents. Shannon was convicted of attempted murder of Dr. Tiller of Wichita, KS.
3/1992	North Dakota	ARSON	$2,000	Remains open
5/1992	Toronto	ARSON		Remains open
6/1992	California	ARSON	$70,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.
7/1992	California	ARSON	$9,000	Remains open
8/1992	Oregon	ARSON	$2,500	Rachelle Shannon pled guilty on 6/7/95 to 6 arson incidents and 2 acid incidents. Shannon was convicted of attempted murder of Dr. Tiller of Wichita, KS.
8/1992	California	ARSON	$5,000	Rachelle Shannon pled guilty on 6/7/95 to 6 arson incidents and 2 acid incidents. Shannon was convicted of attempted murder of Dr. Tiller of Wichita, KS.
8/1992	Nevada	ARSON	Minimal	Michael Andrew Fix was arrested on 9/28/92 by NV State Police. He was convicted in state court and sentenced to 2 years in prison.
9/1992	Oregon	ARSON	$1,000+	Rachelle Shannon pled guilty on 6/7/95 to 6 arson incidents and 2 acid incidents. Shannon was convicted of attempted murder of Dr. Tiller of Wichita, KS.
9/1992	Nevada	ARSON	$600	Michael Andrew Fix was arrested on 9/28/92 by NV State Police. He was convicted in state court and sentenced to 2 years in prison.
9/1992	New Mexico	ARSON	$500	Remains open
9/1992	Virginia	ARSON	$25,000	Remains open
9/1992	Nevada	ARSON	$5,000	Michael Andrew Fix was arrested on 9/28/92 by NV State Police. He was convicted in state court and sentenced to 2 years in prison
11/1992	Illinois	ARSON	$2,500	Remains open
11/1992	California	ARSON	$175,000	Rachelle Shannon pled guilty on 6/7/95 to 6 arson incidents and 2 acid incidents. Shannon was convicted of attempted murder of Dr. Tiller of Wichita, KS.
12/1992	California	ARSON	$50,000	Remains open
2/1993	Florida	ARSON	$70,000	Remains open
2/1993	Texas	ARSON	$625,000	Remains open
3/1993	Montana	ARSON	$100,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.
5/1993	Oregon	ARSON	$5,000	Remains open
5/1993	Idaho	ARSON	$100,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.

8/1993	Florida	ARSON	$500,000	Remains open
9/1993	Illinois	ARSON	$7,500	Remains open
9/1993	California	BOMB	$1,000	Remains open
9/1993	Pennsylvania	ARSON	$130,000	Remains open
9/1993	California	ARSON	$1.4 million	Remains open
10/1993	Texas	ARSON	$20,000	On 3/14/94, Joshua Graff pled guilty & was sentenced to 39 months in prison.
11/1993	Pennsylvania	ARSON	$500	Remains open
12/1993	New York	ARSON	$150	Janet Smith was arrested for throwing two molotov cocktails.
7/1994	Virginia	ARSON	$10,000	Remains open
8/1994	Minnesota	ARSON	$373,000	Remains open
8/1994	Ohio	ARSON	$100	Remains open
10/1994	California	ARSON	$3,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.
10/1994	California	ARSON	$35,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.
10/1994	Montana	ARSON	$100,000	In October 1997, Richard Thomas Andrews was indicted for setting three fires to clinics in Redding and Chico.
10/1994	California	ARSON	$500	Remains open
11/1994	California	BOMB	Minimal	Remains open
12/1994	Virginia	ARSON	$400	Jennifer Spearle and Ryan Clark Martin were convicted.
12/1994	Kansas	ARSON	$3,000	Remains open
12/1994	South Dakota	ARSON	$1,000	Remains open
1/1995	Pennsylvania	ARSON	unknown	Remains open
1/1995	New Mexico	ARSON	Minimal	Ricky Lee McDonald arrested by ATF 2/24/95 and convicted.
2/1995	California	ARSON	$300	Remains open
2/1995	California	ARSON	$500	Remains open
2/1995	California	ARSON	$50,000	Remains open
2/1995	California	ARSON	Minimal	Remains open
2/1995	New Mexico	ARSON	$5,000	Ricky Lee McDonald arrested by Services ATF 2/24/95 and convicted.
2/1995	California	ARSON	$1,000	Remains open
2/1995	Virginia	ARSON	$500	Remains open
3/1995	Virginia	ARSON	under $5,000	Jennifer Spearle and Ryan Clark Martin were convicted.
5/1995	Ohio	BOMB	Minimal	Remains open
8/1995	Oregon	ARSON	$200	Remains open
8/1995	Florida	ARSON	$100,000	Remains open
8/1995	Florida	ARSON	$40,000	Remains open
9/1995	Wyoming	ARSON	$50,000	In October 1997, Richard Thomas Andrews was indicted for setting three

				fires to clinics in Redding and Chico.
11/1995	Florida	ARSON	$100	Remains open
11/1995	Florida	ARSON	$400	Remains open
5/1996	Idaho	ARSON	$400	Remains open
7/1996	Idaho	ARSON	$50,000	Remains open
7/1996	Washington	BOMB	$50,000	Brian Rattigan, Verne Jay Merrell, Charles Barbee and Robert Berry were convicted of conspiring in the bombing of the clinic and a bank robbery.
9/1996	Oklahoma	BOMB	$1,000	A juvenile was convicted in this and other arsons and bombings. Name sealed due to age.
11/1996	Missouri	ARSON	$75,000	A juvenile was convicted in this and other arsons and bombings. Name sealed due to age.
1/1997	Oklahoma	BOMB	$2,500	A juvenile was convicted in this and other arsons and bombings. Name sealed due to age.
1/1997	Georgia	BOMB	$90,000+	2 explosions. Eric Rudolph has been charged with the bombing but remains at large.
1/1997	Oklahoma	ARSON	$7,000	A juvenile was convicted in this and other arsons and bombings. Name sealed due to age.
2/1997	Virginia	ARSON	$25,000	James Anthony Mitchell of VA pleaded guilty and was sentenced to ten years in jail in September 1997.
3/1997	North Carolina	BOMB	$50,000	Remains open
3/1997	Montana	BOMB	$2,000	JohnYankowski apprehended at clinic; convicted and sentenced to 5 years in prison.
3/1997	California	ARSON	Unknown	Peter Howard, a local activist, put 13 gas cans and 3 propane tanks in his truck and drove it thru the clinic door. He was caught on the scene, pled guilty and was sentenced to 15 yrs in prison and fined $16, 320.87 for damages and restitution.
3/1997	California	BOMB	$1,000	Container of flammable liquid thrown through the window.
3/1997	Iowa	BOMB	Unknown	Remains open
5/1997	Washington	ARSON	$1,500	Remains open
5/1997	Oregon	ARSON	$400,000	Remains open
8/1997	Alabama	ARSON	$250,000	Remains open
10/1997	Oregon	ARSON	$5,000	Remains open
12/1997	New York	ARSON	Minimal	Remains open
3/1998	California	ARSON	$5,000	Remains open
9/1998	North Carolina	ARSON	$200	Remains open
9/1998	North Carolina	ARSON	$7,000	Remains open
9/1998	North Carolina	ARSON	$17,000	Remains open
3/1999	South Dakota	ARSON	Minimal	Martin Uphoff was convicted of using explosives during a felony, and

				vandalism to a facility providing health care services (a FACE charge). Uphoff was sentenced to 60 months for the felony and 6 months for the FACE charge, to be served concurrently.
3/1999	Wisconsin	ARSON	Minimal	Peter Quinn, 17 admitted to this arson. He is being charged in state court as an adult.
3/1999	Wisconsin	ARSON	$1,000	Peter Quinn, 17 admitted to this arson. He is being charged in state court as an adult.
3/1999	North Carolina	BOMB	Minimal	Remains open
3/1999	New Mexico	ARSON	$3,000	Ricki Lee McDonald has been arrested for this arson and is being held pending trial. The previous Albuquerque arson is still being investigated.
4/1999	Wisconsin	ARSON	$500	Remains open
5/1999	New Mexico	ARSON	$5,000	Ricki Lee McDonald has been arrested for this arson and is being held pending trial. The previous Albuquerque arson is still being investigated.
7/1999	California	ARSON	Minimal damage to the clinic. Approx $100,000 damage to the building housing the clinic.	Benjamin Matthew Williams and James Tyler Williams pled guilty and were sentenced to 21-30 years in jail for this fire and three synagogue arsons.
8/1999	New Hampshire	ARSON	Approx. $20,000	Remains open
4/2000	Kentucky	ARSON		Remains open
4/2000	Florida	ARSON	$2-3,000	Remains open
5/2000	New Hampshire	ARSON	$20,000	Remains open
4/2001	Kentucky	ARSON		Remains open
6/2001	Washington	ARSON		Remains open
6/2001	Washington	BOMB	$6,000	Remains open
6/2002	Texas	ARSON		Remains open
1/2003	Illinois	ARSON		Remains open
5/2003	Florida	ARSON		Remains open
9/2003	Indiana	ARSON	$2,000	Remains open
1/2004	Florida	ARSON		Remains open

EXHIBIT B

Butyric Acid Attacks

Butyric acid is a clear, colorless liquid with an unpleasant, rancid, vomit-like odor. Anti-choice extremists bagan using butyric acid as a weapon against abortion facilities in early 1992. The goal of introducing butyric acid into a clinic is to disrupt services, close the clinic, and harass patients and staff. Depending on the amount used and how it is introduced into the clinic, butyric acid can cause thousands of dollars of damage, requiring clinics to replace carpeting, furniture, and conduct extensive cleanup of the facility. In addition, even after cleanup, butyric acid's smell leaves a reminder of the incident for months and often years to come.

There have been about 100 butyric acid attacks throughout the United States and Canada, causing in excess of $1 million in damages.

The table below contains less than 100 entries. This is because in many cases multiple clinics were targeted in the same city on the same day.

DATE	STATE	EST. DAMAGE
1/1991	Ontario	$1,000
3/1992	Colorado	$15,000
3/1992	Texas	$25,000
4/1992	Michigan	$5,000
4/1992	Michigan	$1,000
4/1992	Kentucky	$800
5/1992	Tennessee	$200,000
6/1992	Illinois	$5,000
6/1992	Illinois	$2,000
6/1992	Kansas	$500
6/1992	Illinois	$1,500
7/1992	Michigan	$3,000
7/1992	Ohio	$20,000
9/1992	California	$7,000
9/1992	Michigan	$40,000
9/1992	Michigan	$13,000
9/1992	Michigan	$7,000
9/1992	Michigan	$60,000
9/1992	Texas	$500
9/1992	Nevada	$2,000
10/1992	Louisiana	$28,000
10/1992	Texas	$3,000
10/1992	Alabama	$25,000+
10/1992	Louisiana	unknown
10/1992	Florida	$3,000
10/1992	Louisiana	unknown
11/1992	Texas	$750
12/1992	Florida	$5,000
2/1993	Texas	$10,000
3/1993	California	$100,000+

3/1993	Kansas	$5,000
5/1993	Indiana	$150,000
8/1993	Wisconsin	$10,000
8/1993	Wisconsin	$40,000
10/1993	Colorado	$1,000
2/1994	Indiana	Minor
2/1994	Wisconsin	$1,000
4/1994	New York	$60,000
4/1994	Nebraska	$1,000
5/1994	Texas	$1,000
5/1994	New York	$10,000
11/1996	Alberta	
5/1998	Florida	$3,000
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
5/1998	Florida	Unknown
7/1998	Louisiana	Unknown
7/1998	Louisiana	Unknown
7/1998	Louisiana	$13,000
7/1998	Louisiana	Unknown
7/1998	Louisiana	Unknown
7/1998	Texas	Unknown
7/1998	Texas	Unknown
7/1998	Texas	Unknown
7/1998	Texas	Unknown

EXHIBIT C

1999 NATIONAL CLINIC VIOLENCE SURVEY REPORT

Conducted by the Feminist Majority Foundation

Prepared by

Tracy Sefl, PhDc
Amy Hennessy, BA
Elizabeth Gavrilles, MFA
Jennifer Jackman, PhD

Released January 19, 2000

KEY FINDINGS

- **One in five clinics experienced severe anti-abortion violence in 1999.** The percentage of clinics reporting one or more types of severe anti-abortion violence (including death threats, stalking, bom arsons, blockades, invasions, chemical attacks, bomb threats, and arson threats) declined slightly fr in 1998 to 20% in 1999.[1] [2]

- **Fewer clinics were free from violence in 1999, reversing a trend from previous years.** Anti-ab violence and harassment appears more widely distributed, as the percentage of clinics reporting no vandalism, or harassment has declined from 64% in 1998 to 54% in 1999. For the first time, the ga between the percentage of clinics experiencing no violence and those facing moderate violence has narrowed. **Moreover, the percentage of clinics experiencing high levels of concentrated anti-al violence is relatively unchanged at 5% in 1999 compared with 4% in 1998.**

- **Vandalism at clinics has more than doubled; bomb threats are slightly up.** A major increase ir vandalism is detected. Over one-third of clinics (34%) reported one or more forms of vandalism, a more than doubled from 16% in 1998. In 1999, 13% of clinics were the target of bomb threats, whi small increase from 11% in 1998.

- **Measured in this survey for the first time, 18% of clinics report harassment via the Internet o** Abortion clinic providers are open targets in cyberspace. With ever-increasing access to computer technology, clinic staff, providers, and patients have become vulnerable to this form of harassment, may include divulging personal information such as home address and phone numbers, or advocatii targeting of specific abortion providers.

- **Anthrax threat attacks were prevalent in 1999, with 11% of clinics affected.** Clinics in every the country have been subjected to these disruptive threats (newly measured in the 1999 National C Violence Survey), all of which have thus far proved to be hoaxes. Additionally, in early January 2(alone, over thirty clinics in twenty-two states have also received anthrax threats.

- **All levels of law enforcement received higher "excellent" ratings in 1999, with local law enfor yielding the largest net increase.** This year, 52% of clinics rated local law enforcement as excelle 15% from 1998. Federal law enforcement excellent ratings increased from 21% to 35%, a 14% inc Excellent ratings for state law enforcement also went up, rising 8% in 1999 to 20%. In addition, cli reported much stronger enforcement of buffer zones and injunctions. **The percentage of clinics th identified "strong" enforcement of their buffer zones nearly tripled from 14% to 39% in 1999**

- **Lower levels of violence are again associated with higher law enforcement response ratings. I** example, of those clinics that rated local law enforcement response as "excellent," only 16% experi high violence. Conversely, one-third of clinics rating local law enforcement poorly were subjected levels of anti-abortion violence.

1999 NATIONAL CLINIC VIOLENCE SURVEY REPORT

METHODOLOGY

The seventh annual National Clinic Violence Survey measured anti-abortion violence and harassment over the past twelve months. This survey is one of the

most comprehensive studies of anti-abortion violence and harassment directed at clinics, patients, health care workers and volunteers in the United States and includes abortion providers of various organizational affiliations as well as independent clinics.

In September 1999, surveys were mailed to 839 clinics in the United States. The universe of clinics was compiled by the Feminist Majority Foundation's National Clinic Access Project. Follow-up telephone and fax contacts were made from mid-October to December. Three hundred and sixty abortion providers responded, yielding a response rate of 43%.[3] Participants in this survey were assured that their individual responses would remain confidential.

PROFILE OF RESPONDENTS

This sample of 360 clinics includes clinics and private doctors' offices in 47 states and the District of Columbia. (See Appendix A for a list of respondents by state.) Types of facilities in this sample included non-profit (41%), for-profit (36%) and doctor's offices (23%).

While 62% of the clinics were affiliated with Planned Parenthood and/or the National Abortion Federation, the remaining 38% were unaffiliated with either organization. The majority of facilities are free-standing (64%) and have uncovered parking lots (84%). On-site, volunteer clinic escorts assist patients at 29% of all reporting facilities.

The percentage of clinics' practices devoted to abortion services ranges from 10% or less (23% of all clinics) to over 76% (45% of all clinics). Virtually all facilities (99%) offer a variety of other women's reproductive health care services. These include birth control services (96%), pregnancy counseling (90%), emergency contraception (84%), adoption counseling and referral (67%), cancer screening (67%), and HIV/AIDS testing (60%).

Methotrexate, a method of early medical abortion, is administered at 27% of responding clinics. Also, clinics' interest in offering mifepristone (formerly known as RU-486) once it becomes available in the United States continues to grow (up 3% to 65% in 1999). Consistent with previous reports, non-profit clinics are most enthusiastic about offering mifepristone (75%).

1999 NATIONAL CLINIC VIOLENCE SURVEY REPORT

RESULTS

ONE IN FIVE CLINICS EXPERIENCE SEVERE ANTI-ABORTION VIOLENCE

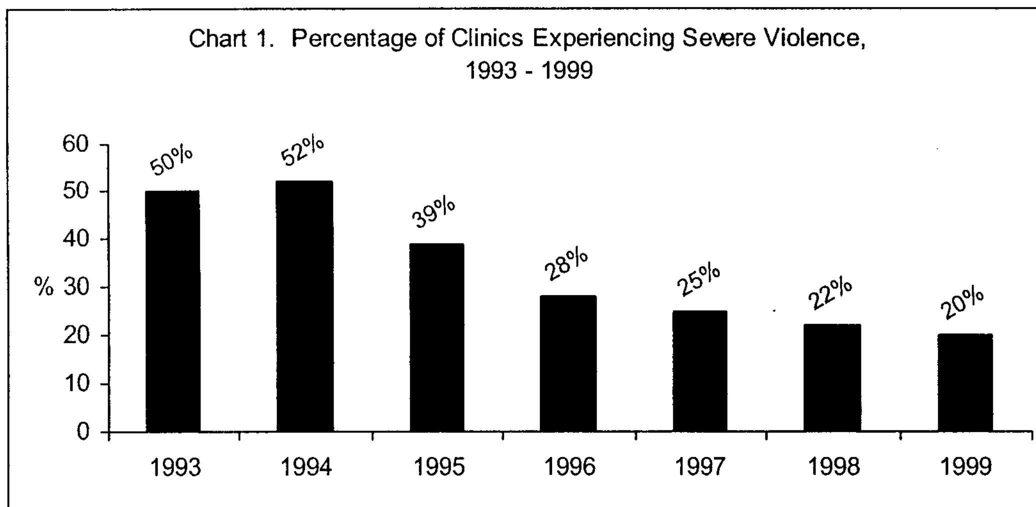
Compared to 1998, which began with a fatal bombing at an abortion clinic and ended with the murder of a doctor who performed abortions, 1999 seemed like a relatively quiet year at our nation's women's health clinics. Yet, even with the combined and ongoing efforts of the pro-choice community and local, state, and federal law enforcement, the overall level of violence directed at abortion clinics remained essentially the same as in 1998. In 1999, as shown in Chart 1 below, **one in five clinics suffered severe anti-abortion violence**.

The percentage of clinics reporting one or more types of severe violence (which includes bombings, arsons, blockades, invasions, chemical attacks, death threats, stalking, bomb threats, and arson threats) dropped slightly from 22% in 1998 to 20% in 1999.[4] While anti-abortion violence plagued clinics across the United States, ten states bore the brunt of the severe violence: Alabama,

Arizona, California, Florida, Michigan, New York, North Carolina, Pennsylvania, Texas, and Virginia (Appendix B).

This decline is part of a trend over the past five years. In 1994, with anti-abortion extremists emboldened by the January 1993 U.S. Supreme Court decision in *Bray, et al. v. Alexandria Women's Health Clinic, et al.,*[5] severe clinic violence reached an all-time high of 52%. However, the sustained efforts of pro-choice mobilization combined with the federal Freedom of Access to Clinic Entrances (FACE) Act and U.S. Supreme Court decisions in *Madsen v. Women's Health Center*[6] and *NOW, et al. v. Scheidler, et al.*[7] sent a strong deterrent message to anti-abortion extremists in 1994. Overall levels of severe violence dropped significantly to 39% in 1995. Since 1996, when severe violence was reported at 28%, there continues to be a small and slow decline in severe violence.

Yet 20% of clinics still suffering from anti-abortion violence indicates an enduring problem at our nation's women's health clinics.



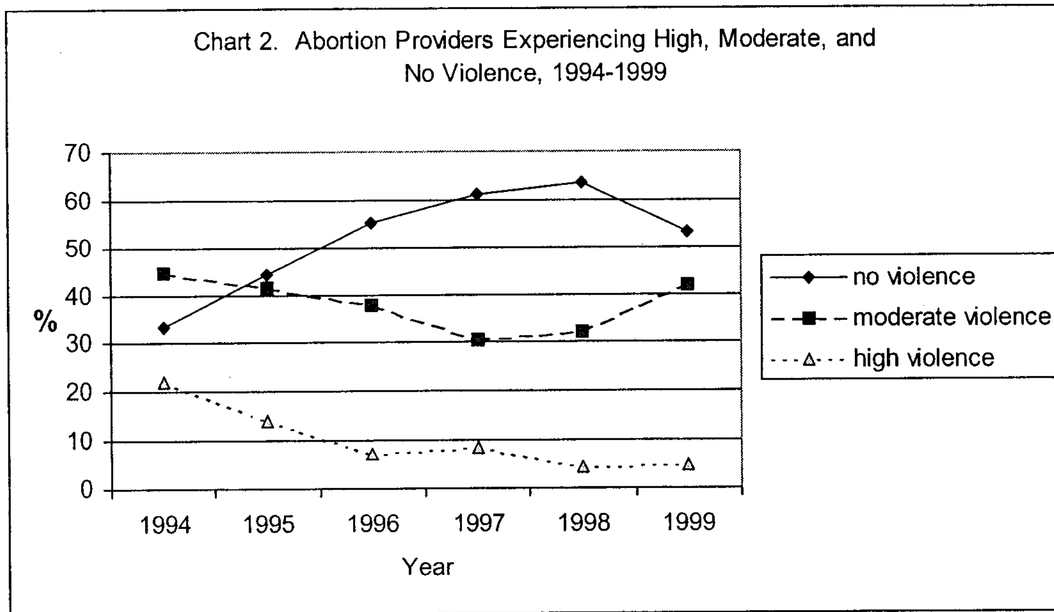
HIGH VIOLENCE STILL CONCENTRATED; FEWER CLINICS FREE FROM VIOLENCE

The 1999 National Clinic Violence Survey data reflect the greater dispersion of harassment, intimidation and violence throughout the overall clinic population, with more clinics affected by at least one or two types of violence (Chart 2). **As well, high levels of violence remain concentrated on a small percentage of clinics (5%) in 1999, akin to 4% in 1998.**

And for the first time since 1995 in the National Clinic Violence Survey, the gap between those clinics experiencing no violence and those experiencing moderate and high violence has narrowed. This gap is revealed in the analysis of indexed variables measuring the total number of violent and harassing tactics all clinics experienced. This indexed measure combines tactics of violence, intimidation and harassment. This measure was then divided into three levels: clinics experiencing no violence (zero types), moderate violence (1-2 types) and high violence (3 or more types).[8]

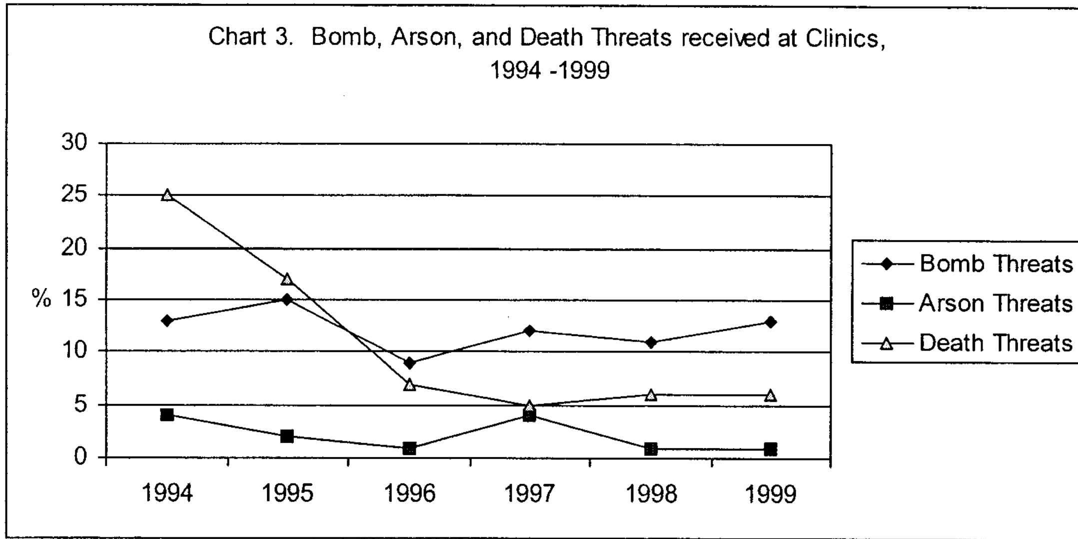
Reversing a trend from previous years, this year's findings reveal that the gap between clinics facing moderate violence and no violence has diminished (Chart 2). In every survey prior to 1999, more and more clinics were reporting no violence, peaking with 64% of clinics free from violence in 1998. In 1999, however, that trend noticeably reversed as the percentage of clinics free from violence

declined to 54%. In 1998, 64% of clinics reported no violence, harassment, or intimidation and 32% experienced moderate levels – for a gap of 32%. The gap this year between clinics facing moderate and no violence narrowed considerably to 13%, as 54% of clinics reported no violence and 41% reported moderate levels of violence. This redistribution is illustrated in comparing the "no" and "moderate" violence trend lines in Chart 2.



BOMB, DEATH, AND ARSON THREATS CONTINUE TO PLAGUE CLINICS

As severe violence continues its slight but steady decline, the frequency of severe threats remains near-constant overall. **As in 1998, this year slightly less than one in five clinics (18%) received bomb, arson, or death threats.** More bomb threats were reported than in 1998, rising slightly from 11% to 13% in the current reporting period (Chart 3). Death and arson threats remained stable between 1998 and 1999, at 6% and 1% respectively.



Clinics where abortion constitutes more than three-fourths of all services (45% of all clinics), however, receive the bulk of these threats. Notably during this reporting period, clinics whose primary service is abortion received 61% of bomb threats and just over half of all death threats (52%).

Chart 4 provides a longitudinal view of changes in frequency of types of violence from 1997 to 1999. In addition to the increases in vandalism, bomb, death, and arson threats noted above, other interesting findings are illustrated. **Chemical attacks and gunfire have both declined from 1998, whereas stalking, break-ins, blockades and invasions are slightly higher.** From 1998 to 1999, chemical attacks and gunfire both declined from approximately 1% to less than 1%. There were small increases in reports of stalking, break-ins and invasions. Stalking and break-ins both increased from 5% in 1998 to 6% in 1999; facility invasions went up from 2% to 3%. Reports of blockades, while small in total number, more than doubled from 2% to 5%.

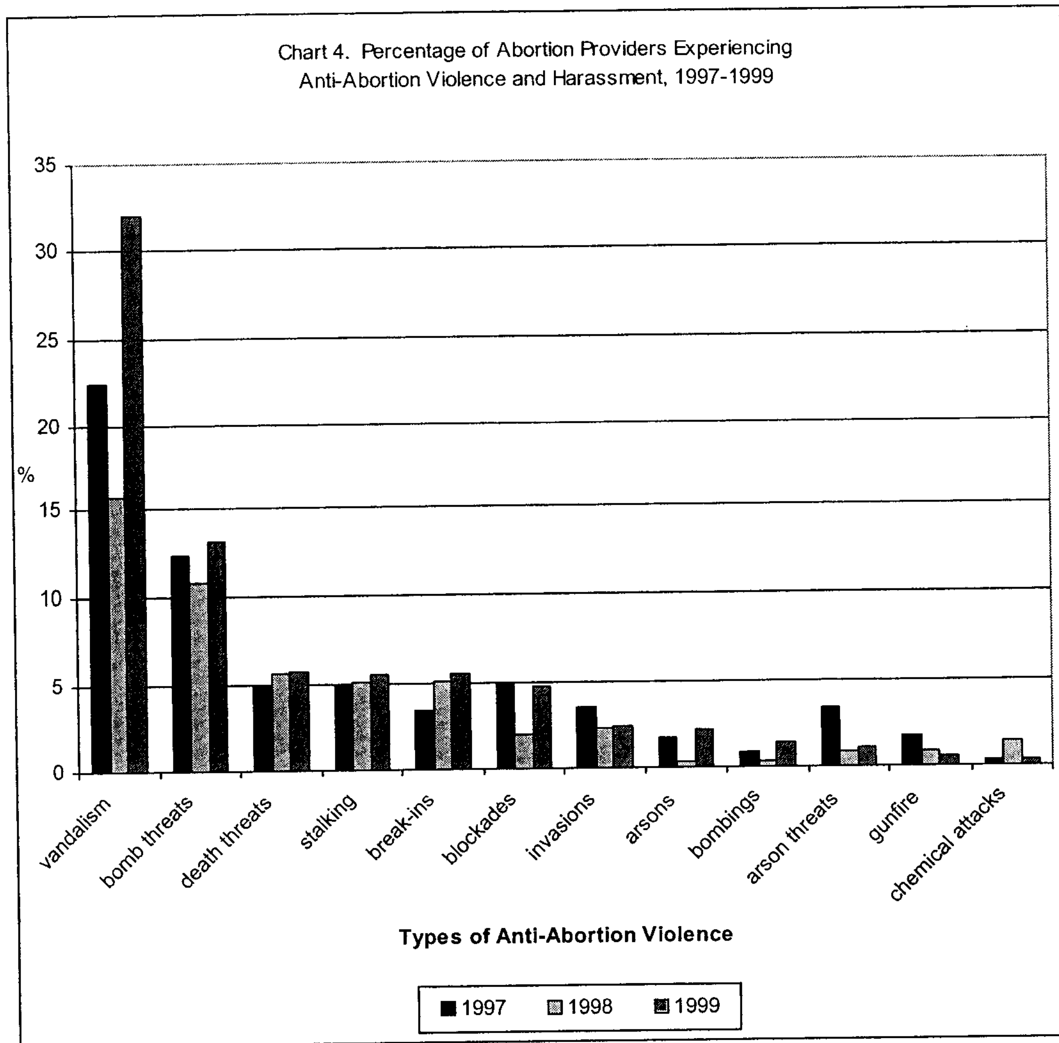


Chart Note: In 1999, arsons and bombings measures included attempted events as well as actual events.

Finally, because the 1999 National Clinic Violence Survey collapsed attempted bombings and arsons into the bomb and arson variables (to represent the severity and potential fatalities present even in *attempts*), slight increases are noted here as well. In 1999, 1% of clinics reported bombings and 2% reported arsons, compared to 1998 where less than 1% of clinics reported either.

MAJOR INCREASE IN CLINIC VANDALISM

Over one-third of all clinics (34%) were subjected to one or more forms of vandalism, making vandalism the most frequently reported type of anti-abortion harassment or intimidation. This finding has more than doubled since 1998, when only 16% of all clinics experienced one or more forms of vandalism. Anti-abortion extremists continue to barrage clinics with an increasingly widespread vandalism campaign. Their methods are diverse, attacking building structures, adjacent property, and even staff members' personal property.

The increase in clinic vandalism is also reflected in another manner: the previously reported finding that fewer clinics are free from violence (see Chart 1). Anti-abortion extremists have broadened their campaign against clinics and more clinics were vulnerable to vandalism in 1999 compared to 1998.

When examining the multiple forms of vandalism directed at clinics, graffiti remains the most commonly reported tactic (31%), though this is a decline from 38% of vandalized clinics in 1998. Despite that decline, graffiti is the most widely reported form of structural vandalism, as reports of broken windows and paint splattering have declined from 1998.

New in this year's questionnaire, clinics were asked to report any garbage dumpster tampering at their facility. Seventeen percent (17%) of vandalized clinics reported this form of vandalism. Phone call and line tampering has increased, occurring at one-fourth (25%) of vandalized clinics, compared to 18% of vandalized clinics in 1998.

Notably, 27% of vandalized clinics provided open-ended responses as to additional forms of vandalism directed at their clinics. These supplemental tactics included tampering with septic tanks and building ornaments, broken glass strewn in clinic driveways, malicious corruption of outdoor power sources, torn siding, slashed tires on staff members' cars, and the smearing of human excrement on exterior walls.

Anti-abortion vandalism is affecting a larger proportion of clinics, which in large part explains the narrowing gap between clinics experiencing no violence and those experiencing one or two types of violence.

ABORTION PROVIDERS FACE INTERNET HARASSMENT

The seventh annual National Clinic Violence Survey measured Internet and Web-based harassment for the first time. **Data suggest that abortion providers are open targets in cyberspace, with 18% of clinics reporting this form of harassment.** Such harassment may include divulging personal "profiles" including home addresses and telephone numbers; death threats; or even advocating murder of specific abortion providers. This harassment occurs in various electronic forms: on Web sites, in Internet chat rooms, and through email. Recourse for such forms of harassment is complicated by the often-veiled identities of persons posting such information.

The most infamous example of this tactic was anti-abortion extremist Neal Horsley's "Nuremberg Files" Web site[9], where, amidst graphics of dripping blood, hundreds of abortion providers and abortion rights advocates' names were listed. Many of those persons' names were hyper-linked to personal information profiles including home addresses and type of car driven. This form of harassment has been found to constitute "true threats," and in *Planned Parenthood v. American Coalition of Life Activists*, a jury ordered several anti-abortion extremists to pay $107.5 million in damages to abortion providers who had been targeted and threatened by the defendants.

Unlike bold and prominent "WANTED" posters distributed in communities with abortion providers' names, photos, and addresses (posters which 6% of clinics report appearing in their communities in 1999), the evolving nature of cyberspace may leave clinic staff and abortion providers unaware that cyber-threats are even being circulated.

ANTHRAX ATTACKS THREATENED AT 11% OF CLINICS

Thirty-nine clinics nationwide (11%) received threatened anthrax attacks in this year's reporting period. Anthrax, an infectious and potentially fatal bacterial disease, has no indication of exposure: there is no cloud, color, smell, taste, or effective treatment for unvaccinated victims.[10] Clinics in the Midwest and Northeast received the bulk of the threats, measured for the first time in the 1999 National Clinic Violence Survey. When asked to compare the frequency of anti-abortion violent tactics from 1999 to 1998, clinics report that the frequency of threatened anthrax attacks increased 13%, much more than all other tactics.

Clinics who receive threatened anthrax attacks are subjected to extensive evacuation, testing, and safety procedures. Such attacks are also disruptive to the larger community, evidenced in a recent anthrax threat at a Toledo OH abortion clinic where law enforcement officials closed a ten-block area. Although the FBI reports that a spate of letters received in 1999 contained only a sticky substance or dark powder, clinic staff and abortion providers are nonetheless disrupted by the necessary evacuation, decontamination, and testing procedures.

In the first two weeks of January 2000, over thirty clinics in twenty-two states have also received anthrax threats.[11] Investigations are ongoing.

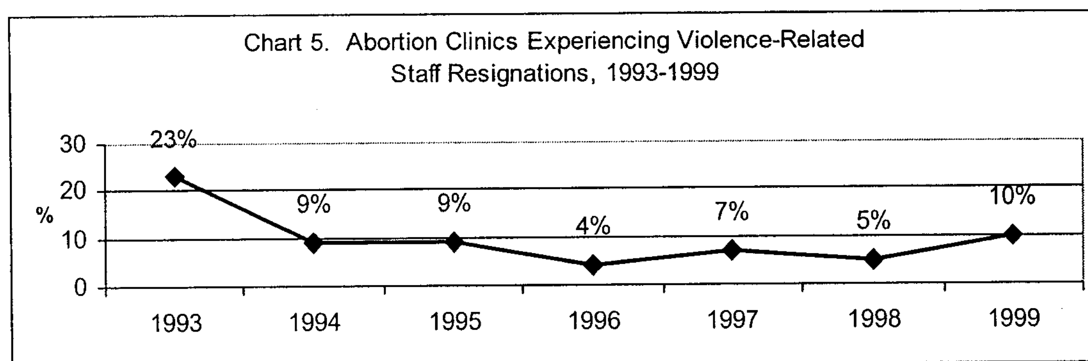
FOLLOWING A VIOLENT 1998, MORE STAFF RESIGNATIONS REPORTED

Overall, Clinic Staff and Administrators Prove Resilient to Campaign of Violence

The percentage of clinics reporting staff resignations as a result of anti-abortion violence

increased. Following a violent 1998, with a fatal clinic bombing in Birmingham AL and the murder of Dr. Barnett A. Slepian in his Amherst NY home, **10% of clinics reported staff resignations due to anti-abortion violence, an increase from 5% of clinics in 1998.** Of those few clinics reporting violence-related resignations, 32% lost a physician, 29% lost a receptionist, 26% lost a lab technician, 23% lost a counselor, and 20% lost a nurse. Clinic administrators proved most resilient, with only 6% resigning.

These resignations can be understood in the broad context of severe clinic violence and persistent harassment. Indeed, the longitudinal trend displayed below (Chart 5) reflects increases in staff resignations that correspond with horrific acts of violence like the murders of doctors, clinic staff, and volunteers in 1993 and 1994.



Within this overall picture, as well, is a strong relationship between violence-related staff resignations and the level of violence at a given clinic. **In 1999, 22% of clinics experiencing high violence lost staff members; in fact, twice as many clinics experiencing high violence lost staff compared with clinics not subjected to high violence.** In the wake of a year that saw a fatal clinic bombing and a physician murdered in his own home, staff vulnerability at "high violence" clinics, while intuitive, is disturbing.

REMEDIES TO VIOLENCE: BUFFER ZONES AND OTHER LEGAL PROTECTIONS

More clinics were protected by buffer zones in this year's reporting period, nearly one-third (114 clinics, 32%) compared with 27% of clinics in 1998. Buffer zones are areas determined by courts, legislatures, or municipal officials in which distance is specified between demonstrators and their intended targets. Buffer zones may apply to clinic facilities as well as staff members' homes. This year, ten clinics reported home buffer zones for staff members or physicians, compared with 1998, when only five clinics reported such protections.

More clinics conferred positive law enforcement ratings for their buffer zones and injunctions in 1999 than in 1998. **A significant portion of clinics (35%) reported that their buffer zones and injunctions were strongly enforced.** This finding is dramatically higher than 1998, when buffer zones were strongly enforced at only 14% of clinics and injunctions strongly enforced at 11% of clinics.

Clinics' perceptions of stronger buffer zone and injunction enforcement are also reflected in lowered "poor" ratings. **Fewer clinics in this reporting period reported weak or no enforcement of buffer zones and injunctions compared to 1998.** In 1999, 23% of clinics rated their legal protections as weakly or not enforced. In 1998, buffer zones were weakly or not enforced at 28% of clinics, and injunctions weakly or not enforced at 36% of clinics.

Nine percent (9%) of clinics turned to the legal system for legal remedies other than buffer zones, consistent with 10% of clinics seeking legal remedies in 1998. Temporary restraining orders and permanent injunctions were the most frequently sought remedies, with eighteen (5%) and fourteen clinics (4%) seeking such measures respectively.

Nearly half of those clinics with buffer zones or injunctions (46%) believe that these legal protections have prompted improved law enforcement responses to anti-abortion violence and harassment at their facilities.

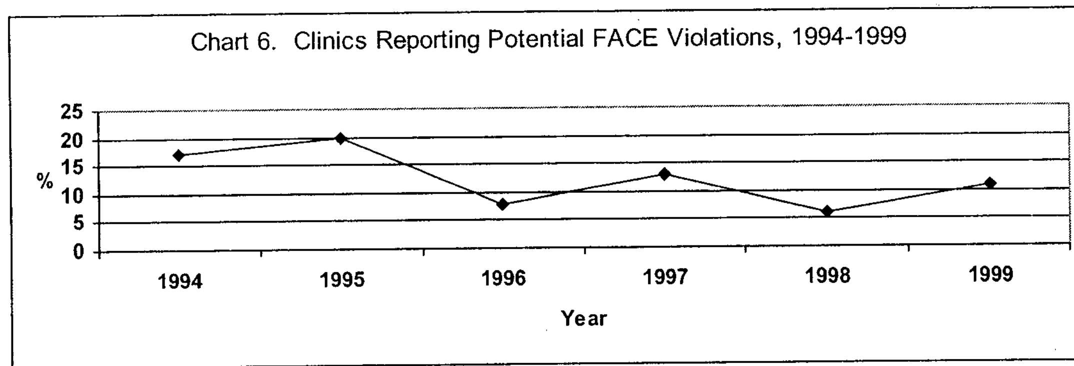
In addition to legal remedies sought, legal victories in this reporting period were also analyzed. Thirteen clinics won temporary restraining orders (4%), five won preliminary injunctions (1%), and nine won permanent injunctions (3%). Twenty-nine clinics (8%) were awarded money damages as a result of anti-abortion activities, though less than one in five of those clinics (17%) have yet to collect monies owed to them.[12]

Even though, for the most part, clinics have not been able to collect judgments, they have not given up and are still pursuing anti-abortion extremists. At the end of 1999, four of the twelve anti-abortion defendants in the high-profile *Planned Parenthood v. ACLA* filed for bankruptcy just prior to their federal court-ordered depositions in an effort to avoid disclosing financial information in the post-judgment phase of the lower court proceeding. Increasingly, anti-abortion extremists are using bankruptcy filings in an effort to avoid paying damage awards.

MORE CLINICS REPORT POTENTIAL FACE VIOLATIONS; LAW ENFORCEMENT FOLLOW-UP DECLINES

Thirty-nine clinics (11%) contacted law enforcement officials to report potential violations of FACE. These numbers have essentially doubled from the 20 clinics contacting law enforcement regarding potential FACE violations in 1998 (Chart 6). Although the number of clinics making FACE-related law enforcement contacts has increased, clinics report that the handling of such contacts by law enforcement officials has declined.

Several indices of authorities' responses to FACE complaints suggest that more aggressive investigations and prosecutions are necessary. Of those clinics initiating contact with officials, the majority (66%) did <u>not</u> receive clear direction for pursuing their complaints. This is an increase from 1998, when 55% of clinics did not receive clear directions from officials. Fifteen percent (15%) of clinics were advised that authorities would not prosecute their cases, a slight increase from 11% in 1998. A greater percentage of clinics were advised to refer complaints to local law enforcement this year (45%) compared with 30% in 1998. Moreover, in relatively few cases (23%) did federal officials even conduct official interviews with involved parties.

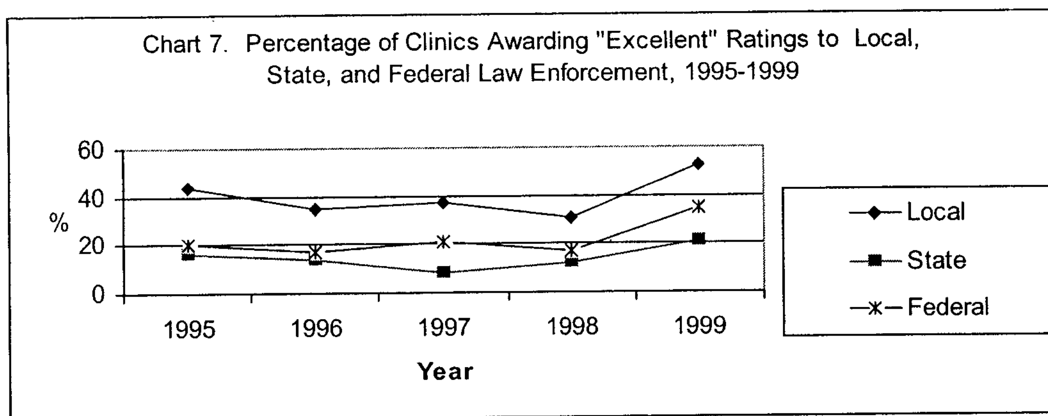


The percentage of clinics with FACE violations that reported federal officials had initiated criminal FACE actions was cut in half from 10% in 1998 to 5% in 1999. A slight decrease – from 10% to 8% – occurred in the proportion of clinics reporting that civil FACE actions had been initiated. These 1999 reports reverse a trend between 1997 and 1998, where more civil and criminal FACE actions were initiated.

"EXCELLENT" RATINGS RISE FOR ALL LEVELS OF LAW ENFORCEMENT

The role of law enforcement is an important variable both in the continued, although slight, decline of severe violence and the improved ratings of legal protections like buffer zones and injunctions. The combined efforts of pro-choice advocacy on behalf of clinics, along with increased judicial and legislative penalties against anti-abortion extremists are contributing to law enforcement's increasingly high-quality responses to clinics' needs.

Clinics were asked to rate their overall experience with the law enforcement response to clinic violence and harassment in the reporting period. **All levels of law enforcement received more "excellent" ratings in 1999 than in 1998 (Chart 7), with local law enforcement yielding the largest net increase.** In 1999, 52% of clinics rated local law enforcement as excellent, up 15% from 1998. Federal law enforcement excellent ratings increased from 21% to 35%, a 14% increase. Excellent ratings for state law enforcement went up 8% in 1999 to 20%.



An additional measure of law enforcement response examines a comparison of this reporting period to 1998. Most clinics report that local, state, and federal law enforcement response has remained the same. Yet notably, several clinics said that local and federal law enforcement improved this year, 14% and 15% respectively. Both of these ratings reflect increases from 1998, up 1% for local and 7% for federal law enforcement. Nine percent of clinics (9%) said state law enforcement had improved, up from 6% in 1998.

This study also examines the type of interactions that clinics have with law enforcement officials. As local law enforcement officials provide the first response to the majority of anti-abortion incidents, clinics necessarily report the most contact with this level of law enforcement (80%). Just over half of all clinics (53%) contacted federal law enforcement officials and 32% contacted state officials. The majority of clinics have designated contact persons or liaisons with local (65%) and federal (60%) law enforcement officials.

Seventy-four percent of clinics (74%) report that law enforcement officials had visited their facilities for a variety of reasons, including responding to anthrax threats or complaints, or in the course of an investigation. Overall, clinics most frequently report that local law enforcement has visited their clinic to discuss security issues (51%).

Nine percent (9%) of clinics reported arrests on-site, with misdemeanors being the most frequently reported type of arrest (82%). This is consistent with arrest rates in 1998 (9%). Eleven

clinics also noted that anti-abortion arrests occurred off-premises (i.e., at a staff member's home or neighborhood). These off-premises arrests were also largely misdemeanor arrests (64%). Only 3% of these arrests, both on- and off- premises, resulted in criminal prosecution. This figure is slightly lower than both 1997 and 1998, where 4% of all arrests resulted in criminal prosecutions.

LOWER LEVELS OF VIOLENCE AGAIN ASSOCIATED WITH BETTER LAW ENFORCEMENT RESPONSE

As reported in 1998, the quality of local and federal law enforcement is associated with the level of violence at clinics nationwide. In 1999, 185 clinics rated their local law enforcement as excellent. Of these clinics, 39% were free from violence and only 16% reported high violence. Few clinics rated their local law enforcement as poor. Nonetheless, of those 19 clinics, 32% experienced high violence compared with 21% who were free from violence.

Federal law enforcement was rated as excellent by 111 clinics. Of those clinics, 29% were free from violence, compared to 17% who faced high violence. Similar to local law enforcement ratings, very few clinics rated federal law enforcement as poor. Of those 11 clinics, the majority (45%) faced high anti-abortion violence compared to 27% who faced none.

These findings indicate that excellent law enforcement response was more likely to be associated with no or low violence. Poor law enforcement ratings appeared to be related to higher levels of violence.

These relationships largely mirror the law enforcement/violence relationship in the 1998 findings. In 1998, of clinics reporting "excellent" federal law enforcement response, only 6% experienced high violence. Of clinics describing poor federal law enforcement response, 20% had high levels of violence.

CONCLUSIONS

Despite the fact that there were no anti-abortion fatalities in 1999, one in five clinics remains plagued by severe violence. This level of severe violence at abortion clinics remains essentially unchanged, at 20% of all clinics in 1999, down slightly from 22% in 1998. The trend for declines in categories of severe violence continues, though the declines are modest. These declines are offset by slight increases in types of severe violence like bomb threats, death threats, blockades, and stalking.

The war of attrition against clinics continues. As in 1998, a small percentage of clinics (5%) is again besieged with multiple, and often simultaneous, types of violence as anti-abortion extremists continue to try to force clinics out of business.

Notably, our survey further revealed that the percentage of clinics experiencing no violence has declined, meaning that fewer clinics are free from anti-abortion violence, harassment, and intimidation. In 1999, 54% of clinics were free from violence, an appreciable decline from 64% in 1998. Moreover, the gap between clinics experiencing no violence and those experiencing moderate levels of violence has narrowed. Given the stability of the percentage of clinics facing high violence, this narrowed gap suggests a greater dispersion of anti-abortion violence, intimidation, and harassment at clinics nationwide.

Another new and disturbing finding in the 1999 National Clinic Violence Survey is the prevalence of Internet and Web harassment by anti-abortion extremists. Eighteen percent of clinics (18%) reported cyberspace harassment and threats. These cyberspace threats may take many forms, from privacy-invading profiles of physicians to overt death threats against specific abortion providers. This form of harassment is alarming for providers both because the identities of persons making threats are often veiled, and because the nature of cyberspace allows instantaneous diffusion among anti-abortion extremists nationwide.

An additional new finding in 1999 was that 11% of clinics nationwide were the targets of anthrax threat letters. These threats (which, to date, have been hoaxes) have the potential for wide disruption to clinics and larger communities. The frequency of these hoaxes – including over thirty incidents in the first weeks of January 2000[13] – suggests that anthrax hoaxes are an increasingly preferred tactic for anti-abortion extremists. Recent security advisories from the Feminist Majority Foundation, Planned Parenthood Federation of America, and the National Abortion Federation have aided clinic administrators in intercepting several of these hoax letters.

In this context of violence – and following a year that included a fatal clinic bombing and the murder of a physician in his home – staff resignations as a result of anti-abortion violence doubled in 1999, up from 5% to 10%. Of those clinics with violence-related resignations, those facing high levels of violence were twice as likely to lose a staff member or physician.

Perhaps the most encouraging findings of our study are the increasingly high ratings that clinics awarded law enforcement responses to clinic violence. This year, all levels of law enforcement (local, state, and federal) received notably higher "excellent" ratings than in 1998. This finding demonstrates that the role of law enforcement is a vital element in the continued slight decline of severe anti-abortion violence. Not only has the law enforcement response to violence improved, but 80% of clinics also reported regular contact with local law enforcement officials. This suggests that the interrelationships of clinics and law enforcement are valuable in combating anti-abortion violence.

Moreover, this survey shows a relationship between the quality of law enforcement response and the level of violence at clinics. In one telling finding, only 16% of clinics that rated local law

enforcement response as "excellent" faced high levels of anti-abortion violence. Conversely, one in three clinics that rated local law enforcement as "poor" experienced high violence.

This year's data also showed that 32% of clinics now have legal protections such as buffer zones and injunctions (a 5% increase from 1998), and that the strong enforcement of such protections dramatically increased from 14% in 1998 to 40%.

Although the overall law enforcement response to clinic violence has demonstrably improved, our survey contained less optimistic news about specific law enforcement responses to clinics' claims of potential FACE violations. Twice as many clinics contacted law enforcement officials to report potential violations of FACE (the 1994 Freedom of Access to Clinic Entrances Act), forty clinics in 1999 compared with twenty clinics in 1998. Yet clinics reported that the law enforcement follow-up to these FACE-related contacts has declined. Two out of three clinics did not receive clear direction for pursuing their complaints, up from 55% in 1998. Our 1999 findings show a reversed trend from 1997 and 1998, in that fewer civil and criminal FACE actions have been initiated by federal law enforcement.

The diminishing trend line of anti-abortion violence at women's health centers is encouraging. But neither the law enforcement community nor the pro-choice community can become complacent. One-fifth of women's clinics besieged by severe anti-abortion violence is an unacceptable level of violence for a civil society or for providing accessible health care to all American women.

APPENDIX A
Number of Respondents by State

State	Respondents
Alabama	08
Alaska	02
Arizona	10
Arkansas	04
California	50
Colorado	06
Connecticut	08
Delaware	02
Florida	33
Georgia	06
Idaho	01
Illinois	08
Indiana	06
Iowa	05
Kansas	03
Kentucky	01
Louisiana	03
Maine	03
Maryland	06
Massachusetts	07
Michigan	17
Minnesota	04
Mississippi	02
Missouri	03
Montana	05
Nebraska	02
Nevada	02
New Hampshire	03
New Jersey	07
New Mexico	01
New York	28
North Carolina	13
North Dakota	02
Ohio	15
Oklahoma	01
Oregon	06
Pennsylvania	12
Rhode Island	04
South Dakota	01
Tennessee	06
Texas	19
Utah	02
Vermont	04
Virginia	10

Washington	11
West Virginia	02
Wisconsin	04
District of Columbia	02
TOTAL	360

APPENDIX B

States with Highest Reported Levels of Anti-Abortion Violence

ALABAMA

One of the eight participating Alabama clinics reported that its facility was the target of an attempted arson. One clinic reported that members of their staff or physician(s) were stalked. Likewise, one clinic reported that members of their staff or physician(s) received death threats. One clinic received an anthrax threat.

ARIZONA

One of the ten participating Arizona clinics reported that it was invaded. Three clinics reported anthrax threats.

CALIFORNIA

Of the 50 participating California clinics, four clinics reported blockades at their facilities. Three clinics were the targets of attempted arson. Two clinics reported that members of their clinic staff or physicians (s) were stalked. Three clinics received death threats targeted at clinic staff or physician(s). One clinic received an anthrax threat.

FLORIDA

Three of the thirty-three participating Florida clinics reported blockades at their facilities. Three clinics also reported that their facilities were invaded. One Florida clinic reported an attempted bombing. One clinic reported an attempted chemical attack. One clinic reported that members of their clinic staff or physican(s) were stalked.

MICHIGAN

One of the seventeen participating Michigan clinics reported that their facility had been invaded. One clinic reported an attempted arson. One clinic reported death threats against clinic staff or physician(s). One clinic received an anthrax threat.

NEW YORK

One of the twenty-eight participating New York clinics reported a blockade in front of their facility. One clinic reported that their facility had been the target of an attempted arson. Three clinics reported that members of their clinic staff or physician(s) were stalked; two clinics reported having received death threats against clinic staff or physician(s). Two clinics received anthrax threats.

NORTH CAROLINA

On March 13, 1999, a bomb partially exploded outside of one of the thirteen participating North

Carolina clinics. One clinic was blockaded. One clinic reported that members of their staff or physician (s) received death threats. One clinic received an anthrax threat.

PENNSYLVANIA

Three of the twelve participating Pennsylvania clinics reported that members of their clinic staff or physician(s) were stalked. One clinic reported an attempted bombing. One clinic reported receiving death threats against clinic staff or physician(s). Two clinics received anthrax threats.

TEXAS

Two clinics of the nineteen participating Texas clinics reported blockades at their facilities. One clinic reported being invaded by anti-abortion extremists. Two clinics were the targets of attempted bombings. One clinic reported that members of their staff or physician(s) were stalked; one clinic received an anthrax threat.

VIRGINIA

Three of the ten participating Virginia clinics reported that members of their staff or physician(s) were stalked; two clinics reported death threats against their staff or physician(s). One clinic was blockaded. One clinic received an anthrax threat.

APPENDIX C

Anthrax Hoax Letters Received January 1-15, 2000

STATE	LOCATION(S)
AL	Birmingham, Tuscaloosa
CT	Manchester
DC	District of Columbia
DE	Wilmington
FL	Naples
GA	Atlanta, Savannah
IL	Chicago, Peoria
IN	Ft. Wayne, Portland
KY	Louisville
ME	Portland
MI	Detroit
NC	Asheville
NJ	Morristown, Hackensack
NY	Bronx, Manhattan
OH	Toledo
PA	Pittsburgh
RI	Providence
SC	Columbia
TN	Knoxville
VA	Roanoke, Richmond
VT	Williston
WI	Milwaukee

[1] This reported comparison reflects adjustments over survey reporting periods (seven months reported in 1998; twelve mon reported in 1999).

[2]. All reported percentages are rounded to the nearest whole number.

[3] Response rate calculated using the American Association of Public Opinion Research Best Practices Guidelines (1998). Questionnaire data were analyzed with SPSS (Statistical Package for the Social Sciences) using univariate and bivariate techniques.

[4] This comparison reflects adjusted rates for the different survey reporting periods (7 month reporting period in 1998; 12 month reporting period in 1999).

[5] In *Bray*, the U.S. Supreme Court struck down the ability of federal judges to use the Ku Klux Klan Act of 1871 as the legal basis for injunctions against clinic blockades.

[6] In *Madsen*, the U.S. Supreme Court upheld lower courts' freedom to establish buffer zones.

[7] In *NOW*, the U.S. Supreme Court ruled that federal RICO statutes could be applied in abortion violence cases.

[8] Variables in this index measure include: blockade, invasion, bombing/bomb attempt, bomb threat, arson/arson attempt, arson threat, chemical attack, death threat, stalking, vandalism, and gunfire.

[9] Neal Horsley's original "Nuremberg Files" Web site, while no longer accessible at his Web address, has at various times

been copied – or " mirrored" – on others' Web sites.

[10] Anthrax Report, Office of the Army Surgeon General, Falls Church VA, November 1999.

[11] See Appendix C for a list of states targeted in the rash of January 2000 anthrax hoax attacks.

[12] Due to difficulties measuring the *duration* of legal battles, we do not know whether these victories were for legal remedies sought during the survey reporting period or victories stemming from older legal proceedings.

[13] These incidents were outside the reporting period for this year's survey.

EXHIBIT D

Abortion Incidence and Services In the United States in 2000

By Lawrence B. Finer and Stanley K. Henshaw

Lawrence B. Finer is assistant director of research, and Stanley K. Henshaw is senior fellow, both with The Alan Guttmacher Institute, New York.

CONTEXT: *Nearly half of unintended pregnancies and more than one-fifth of all pregnancies in the United States end in abortion. No nationally representative statistics on abortion incidence or on the universe of abortion providers have been available since 1996.*

METHODS: *In 2001–2002, The Alan Guttmacher Institute (AGI) conducted its 13th survey of all known U.S. abortion providers, collecting information for 1999, 2000 and the first half of 2001. Trends were calculated by comparing the survey results with data from previous AGI surveys.*

RESULTS: *From 1996 to 2000, the number of abortions fell by 3% to 1.31 million, and the abortion rate declined 5% to 21.3 per 1,000 women 15–44. (In comparison, the rate declined 12% between 1992 and 1996.) The abortion ratio in 2000 was 24.5 per 100 pregnancies ending in abortion or live birth, 5% lower than in 1996. The number of abortion providers decreased by 11% to 1,819 (46% were clinics, 33% hospitals and 21% physicians' offices); clinics provided 93% of all abortions in 2000. In that year, 34% of women aged 15–44 lived in the 87% of counties with no provider, and 86 of the nation's 276 metropolitan areas had no provider. About 600 providers performed an estimated 37,000 early medical abortions during the first six months of 2001; these procedures represented approximately 6% of all abortions during that period. Abortions performed by dilation and extraction were estimated to account for 0.17% of all abortions in 2000.*

CONCLUSIONS: *Abortion incidence and the number of abortion providers continued to decline during the late 1990s but at a slower rate than earlier in the decade. Medical abortion began to play a small but significant role in abortion provision.*

Perspectives on Sexual and Reproductive Health, 2003, 35(1):6–15

Induced abortion, one of the most frequently performed surgical procedures in the United States, is experienced by a substantial proportion of American women. More than one-fifth of all pregnancies end in abortion,[1] a reflection of the fact that almost half of U.S. pregnancies are unintended.[2] Trends in abortion may reflect a number of factors, such as variations in the underlying incidence of unintended pregnancy and changes in how women resolve unplanned pregnancies and in the availability or accessibility of abortion services. Therefore, regular and accurate estimates of abortion incidence and service provision are essential for monitoring trends in reproductive behavior.

After remaining fairly steady for most of the 1980s, the number of abortions in the United States declined from a high of 1.61 million in 1990 to 1.36 million in 1996, the last year for which comprehensive abortion incidence data were collected. The abortion rate declined from 29.3 per 1,000 women aged 15–44 in 1980 and 27.4 in 1990 to 22.4 in 1996. The abortion ratio (the proportion of pregnancies ending in abortion) also fell during the early and mid-1990s. These declines meant that in the mid-1990s, measures of abortion reached the lowest levels since the 1970s.[3]

Several major developments since 1996 may have had an impact on unintended pregnancy levels and, therefore, abortion levels. Declines in teenagers' level of sexual activity[4] and continued increases in their use and effective use of contraceptives[5] could have reduced adolescent pregnancy and abortion rates and, thus, the overall abortion rate (although only one-fifth of abortions are provided to women younger than 20).[6] Some states have expanded eligibility for family planning services under Medicaid;[7] however, Title X funds for free and low-cost family planning services have increased only enough to match inflation.[8] In addition, the number of women of reproductive age covered by Medicaid declined in the late 1990s, while the number with no health insurance increased;[9] these factors could have inhibited women's access to both family planning and abortion services.

Meanwhile, a continuing decline in the number of providers could result in more limited access to abortion services. The number of U.S. abortion providers fell from a high of 2,900 in 1982 to about 2,000 in 1996, and the proportion of counties without a provider increased from 77% in 1978 to 86% in 1996.[10] A 1997 survey of obstetricians and gynecologists who perform abortions indicated that 57% were aged 50 or older,[11] fueling the perception that the number of providers will decline drastically as current providers reach retirement age. However, some evidence

indicates that training opportunities for providers have begun to increase.[12]

A development that may have facilitated access to abortion was the introduction of a new method of early medical abortion. Mifepristone (formerly known as RU 486) was approved by the Food and Drug Administration (FDA) in September 2000, giving women seeking early abortion a nonsurgical option. Some providers have also used the cancer drug methotrexate to provide early medical abortion, but mifepristone is the first drug approved specifically for that purpose. Information about the extent of mifepristone utilization has only recently become available and still is quite limited.[13]

Between 1997 and 1998, the Centers for Disease Control and Prevention (CDC) reported a 2% decrease in the number of abortions performed in the United States and no change in the abortion rate. However, CDC data are compiled from state reports, and in 1998, four states did not report data to the CDC. These states (primarily California) accounted for 18% of all abortions tallied by The Alan Guttmacher Institute's (AGI's) 1997 data collection effort.[14] More recent CDC statistics on national abortion incidence are not available.

Thus, new data on nationwide abortion incidence and the number, types and locations of abortion service providers are needed. To obtain this information, AGI fielded a national survey of U.S. abortion providers (its 13th) in 2001 and 2002, collecting data primarily for 1999 and 2000. In this article, we present information from this survey on the number of abortions performed and national, regional and state abortion rates. We also examine the number and distribution of providers by location, type and caseload. Furthermore, we include data from previous AGI surveys to permit examination of trends over time. To obtain baseline estimates of mifepristone use in the United States, we report on medical abortions occurring during the first half of 2001. Finally, we report on findings regarding the incidence of abortion by dilation and extraction, a procedure that is the primary target of many efforts to ban so-called partial-birth abortions.*

METHODS

Questionnaire Development

Our survey questionnaire was modeled on the one used in AGI's previous round of data collection, in 1997. We created versions of the questionnaire for each of three major categories of providers: clinics, physicians and hospitals. The clinic and physician questionnaires were virtually identical. All questionnaires asked the number of induced abortions performed at the provider's location in 1999 and 2000. In addition, we asked hospitals the number of inpatient and outpatient procedures performed. We requested information from all providers on minimum and maximum gestations at which both surgical and medical abortions are performed, and we asked nonhospital† providers about fees charged, sources of payment, distance traveled by clients and antiabortion harassment; results from these questions are presented elsewhere.[15]

In regard to early medical abortions and intact dilation and extraction abortions, we asked nonhospital providers the number of procedures performed in 2000 and during the first six months of 2001. We also asked whether they anticipated providing early medical abortions within the next year (if they were not already doing so). For nonhospital providers offering early medical abortion, we ascertained whether they used mifepristone or methotrexate.

Identifying Providers

Before fielding the survey, we conducted an extensive update of our list of facilities in the United States (excluding Puerto Rico and U.S. territories) where abortions are performed. We began with all of the providers‡ known to have performed abortions in 1996, excluding those that stopped providing abortions or closed before January 1, 1999. To this list, we added possible new providers obtained from a variety of sources, including telephone yellow pages for the entire country, Planned Parenthood affiliates, the membership directory of the National Abortion Federation and World Wide Web listings of abortion providers. The updated list contained 2,287 possible providers.

In addition, the clinic and physician questionnaires inquired whether providers knew of facilities not offering surgical abortion that had begun offering medical abortion. Another question asked about hospital satellite facilities that performed abortions. During follow-up of these questions and of survey nonrespondents, as well as the investigation of mail returns, 155 additional possible providers were identified and included in the survey universe, bringing the total to 2,442. Seven of the additional providers were identified through the question about providers who performed only medical abortion; however, all seven reported performing surgical abortions as well.

Survey Fielding

In July 2001, we mailed questionnaires to all potential providers. Those who did not respond were sent two additional mailings at three-week intervals; a fourth mailing was sent to doctors' offices and hospitals. In addition, we contacted state health statistics agencies, requesting all available data reported by providers to each state health agency on the number of abortions performed in 1999 and 2000. For the states that supplied us with data by provider, we used the health agency figures for providers who did not

*In June of 2000, the Supreme Court rebuffed Nebraska's (and, by implication, other states') attempts to outlaw a broad range of abortion procedures that the state gathered under the rubric of "partial-birth abortion" (source: *Stenberg v. Carhart,* 120 S. Ct. 2597, 2000). Despite this ruling, efforts to ban some procedures continue. H.R. 4965, the Partial-Birth Abortion Ban Act of 2002, was introduced by Rep. Steve Chabot (R-OH) on June 20, 2002, and was passed by the House on July 24, 2002, by a vote of 274–151.

†We asked hospitals a more limited set of questions because their administrative structures make it more difficult to obtain information beyond abortion counts and gestation limits.

‡For the purpose of our survey, a provider is defined as a site where abortions are performed. Several physicians providing abortions at one location would count as one provider; a health agency with several clinics would be counted as multiple providers.

TABLE 1. Number of reported abortions, abortion rate and abortion ratio, United States, 1973–2000

Year	No. (in 000s)	Rate*	Ratio†
1973	744.6	16.3	19.3
1974	898.6	19.3	22.0
1975	1,034.2	21.7	24.9
1976	1,179.3	24.2	26.5
1977	1,316.7	26.4	28.6
1978	1,409.6	27.7	29.2
1979	1,497.7	28.8	29.6
1980	1,553.9	29.3	30.0
1981	1,577.3	29.3	30.1
1982	1,573.9	28.8	30.0
1983	(1,575)	(28.5)	(30.4)
1984	1,577.2	28.1	29.7
1985	1,588.6	28.0	29.7
1986	(1,574)	(27.4)	(29.4)
1987	1,559.1	26.9	28.8
1988	1,590.8	27.3	28.6
1989	(1,567)	(26.8)	(27.5)
1990	(1,609)	(27.4)	(28.0)
1991	1,556.5	26.3	27.4
1992	1,528.9	25.7	27.5
1993	(1,495)	(25.0)	(27.4)
1994	(1,423)	(23.7)	(26.6)
1995	1,359.4	22.5	25.9
1996	1,360.2	22.4	25.9
1997	(1,335)	(21.9)	(25.5)
1998	(1,319)	(21.5)	(25.1)
1999	1,314.8	21.4	24.6
2000	1,313.0	21.3	24.5

*Abortions per 1,000 women aged 15–44 as of July 1 of each year. †Abortions per 100 pregnancies ending in abortion or live birth; for each year, the ratio is based on births occurring during the 12-month period starting in July of that year (to match times of conception for pregnancies ending in births with those for pregnancies ending in abortions). *Notes:* Figures in parentheses are estimated by interpolation of numbers of abortions. Number of abortions for 1993–1996, abortion rates for 1992–1996 and abortion ratios for 1994–1996 are revised from previously published figures on the basis of a corrected 1996 abortion incidence figure and revised 1992–1996 populations. *Sources:* **Number of abortions, 1973–1996; population data, 1973–1990; and birth data, 1973–1991:** reference 1. **Number of abortions, 1997–2000:** 2001–2002 AGI Abortion Provider Survey and interpolations. **Population data, 1991–2000:** U.S. Census Bureau, Estimates for the population of the U.S., regions, divisions and states, by five-year age-groups and sex: time series estimates, July 1, 1990 to July 1, 1999 and April 1, 1990 census population counts, 2000, <http://eire.census.gov/popest/ archives/state/st-99-08.txt> [for 1991–1999], accessed Jun. 28, 2002; and Campbell PR, *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*, Washington, DC: U.S. Bureau of the Census, 1996 [for 1999 and 2000]; both adjusted to 2000 U.S. census figures. **Birth data, 1992–2000:** National Center for Health Statistics, Advance report of final natality statistics, *Monthly Vital Statistics Report,* 1994, Vol. 43, No. 5, Suppl. [for 1992]; 1995, Vol. 44, No. 3, Suppl. [for 1993]; 1996, Vol. 44, No. 11 [for 1994]; Report of final natality statistics, *Monthly Vital Statistics Report,* 1997, Vol. 45, No. 11, Suppl. [for 1995]; 1998, Vol. 46, No. 11, Suppl. [for 1996]; Births: final data, *National Vital Statistics Reports,* 1999, Vol. 47, No. 18 [for 1997]; 2000, Vol. 48, No. 3 [for 1998]; 2001, Vol. 49, No.1 [for 1999]; and 2002, Vol. 50, No. 5 [for 2000].

respond to any of our mailings.

The remaining nonrespondents were contacted by telephone and asked to complete and return the questionnaire. Providers who could not or would not do so were asked a small number of key questions, including the number of abortions they had performed and gestational limits. To obtain facility data or record a final refusal, staff members made up to 35 attempts to contact each provider by phone, mail or fax. In total, staff members made more than 6,000 attempts to reach more than 900 providers. Follow-up continued through June 2002.

Of the 2,442 facilities surveyed, 962 responded to the mailed questionnaire, and 662 faxed or mailed a response or provided information during telephone follow-up; health department data were used for 449. (Each of these three groups of respondents included both providers who reported having performed abortions during the survey period and those who did not.) After additional follow-up with other sources, we determined that 32 more providers had closed or performed no abortions during the survey period, and that 14 were providers for whom we had already obtained data. For 71 of the remaining 323 potential providers, we obtained estimates of the number of abortions performed in 1999 and 2000 from knowledgeable sources in their communities, and for an additional 183 facilities that we knew had provided abortions, we made our own estimates. For three-fifths of these 183 estimates, we projected the number of abortions using data from previous surveys; such projections were almost always based on past information from the facilities themselves (and not on previous estimates).

We did not attribute any abortions to the remaining 69 facilities, for which no data or estimates were available; therefore, we did not count them as providers in 1999 or 2000. However, we cannot be sure that no abortions were provided at these facilities, although we were unable to obtain any indication that they were. For 15 of these providers, data were available for 1996; these providers performed a total of 1,594 abortions in that year.

Of the abortions reported for 2000, 77% were reported by the providers, 10% came from health department data, 11% were estimated by knowledgeable sources and 2% were projections or other estimates. These figures were similar to 1996 results. Out of 2,442 potential providers, a total of 1,931 performed abortions at some time between January 1999 and June 2001. Of those that did not, 245 indicated that they were not abortion providers, 82 had stopped providing abortions before the survey period began or had begun providing after the survey period ended, 76 had closed completely and 39 were duplicates; as indicated above, we were unable to ascertain whether 69 provided any abortions in the study period.

Some providers were undoubtedly missed because we were unable to identify them; the number can be estimated by surveying a random sample of physicians or hospitals not on our list of possible providers. Results from past underreporting surveys of this kind suggest that the actual number of abortions in 2000 might have been 3–4% greater than the number we counted and that we may have missed as many as half of the providers of fewer than 30 abortions.[16] (We did not adjust the number of abortions or providers for this estimated undercount.) The number of abortions missed could be greater if our list omitted facilities with large abortion caseloads, but such omissions are unlikely, since large providers usually advertise and are known by referral sources. It is unlikely that we missed providers who were offering only medical abortion, because mifepristone became available only in November 2000, and because distributor reports suggest that the bulk of mifepristone shipments have been to existing providers.[17]

The state, regional and national data reported here are based on the location at which abortions occurred. In some cases, data based on women's place of residence may be quite different. For example, according to the most recent CDC data, 36% of abortions performed in Delaware in 1998 and 64% of abortions performed in the District of Columbia were obtained by nonresidents.*[18]

RESULTS

Abortion Incidence

The number of abortions in the United States declined 3% between 1996 and 2000, from 1.36 million to 1.31 million (Table 1). This was the lowest number of abortions since 1976. The abortion rate also declined through 2000, reaching 21.3 abortions per 1,000 women 15–44 in that year. This figure represents a 5% drop over the four-year interval and is the lowest rate since 1974. The abortion ratio declined to 24.5 abortions per 100 pregnancies ending in abortion or live birth in 2000; this also represents a 5% drop since 1996 and the lowest figure since 1974. Including estimated miscarriages, 21% of all pregnancies in 2000 ended in abortion (not shown).†

The number of abortions and abortion rates vary widely by region and state of occurrence (Table 2). Six states that account for 40% of women aged 15–44–California, Florida, Illinois, New Jersey, New York and Texas–accounted for 55% of all abortions in 2000. Rates were highest in New Jersey and New York, and were relatively high (above 30 per 1,000 women 15–44) in California, Delaware, Florida and Nevada. The states with the fewest abortions–South Dakota, North Dakota and Wyoming–are largely rural states and have relatively small populations. The lowest rates were in Kentucky, South Dakota and Wyoming; Idaho, Mississippi, Missouri, Utah and West Virginia also had low rates (seven or fewer per 1,000 women 15–44). Among the 25 states with the largest populations of women 15–44, the lowest abortion rate was in Kentucky.

Between 1996 and 2000, the abortion rate declined in every region of the country, but changes varied by region and, even more so, by state. The abortion rate declined in 35 states and the District of Columbia; the greatest percentage decreases occurred in Kentucky and Wyoming. Percentage changes are most meaningful in states with the greatest number of abortions, since small absolute changes in states with few abortions can result in large percentage shifts. Among the states reporting at least 10,000 abortions in 1996, the largest declines occurred in Massachusetts and Missouri. The abortion rate increased in 15 states. The largest percentage increase occurred in Delaware, and the largest increase among states with at least 10,000 abortions

*The District of Columbia's abortion count and rates are not strictly comparable to those of states; they are more typical of urban areas.

†For the purposes of this calculation, miscarriages are estimated as 10% of abortions plus 20% of births. These proportions attempt to account for pregnancies that end in miscarriage after lasting long enough to be noted by the woman, typically 6–7 weeks after the last menstrual period. (Source: Leridon H, *Human Fertility: The Basic Components,* Chicago: University of Chicago Press, 1977, Table 4.20.)

TABLE 2. Number of reported abortions and abortion rate, 1992, 1996 and 2000; and percentage change in rate, 1996–2000, by region and state in which the abortions occurred

Region and state	No.			Rate*			
	1992	1996	2000	1992	1996	2000	% change 1996–2000
U.S. total	**1,528,930**	**1,360,160**	**1,312,990**	**25.7**	**22.4**	**21.3**	**–5**
Northeast	**378,810**	**341,500**	**325,540**	**31.8**	**29.1**	**28.0**	**–4**
Connecticut	19,720	16,230	15,240	25.9	21.9	21.1	–4
Maine	4,200	2,700	2,650	14.8	9.8	9.9	1
Massachusetts	40,660	41,160	30,410	28.1	28.8	21.4	–26
New Hampshire	3,890	3,470	3,010	14.6	12.9	11.2	–13
New Jersey	55,320	63,100	65,780	30.5	34.9	36.3	4
New York	195,390	167,600	164,630	45.7	39.7	39.1	–2
Pennsylvania	49,740	39,520	36,570	18.6	15.0	14.3	–5
Rhode Island	6,990	5,420	5,600	29.5	23.3	24.1	3
Vermont	2,900	2,300	1,660	21.5	17.3	12.7	–27
Midwest	**262,150**	**238,710**	**221,230**	**18.8**	**16.9**	**15.9**	**–6**
Illinois	68,420	69,390	63,690	25.2	25.3	23.2	–8
Indiana	15,840	14,850	12,490	12.0	11.1	9.4	–15
Iowa	6,970	5,780	5,970	11.3	9.3	9.8	5
Kansas	12,570	10,630	12,270	22.4	18.6	21.4	15
Michigan	55,580	48,780	46,470	25.1	22.1	21.6	–2
Minnesota	16,180	14,660	14,610	15.6	13.7	13.5	–2
Missouri	13,510	10,810	7,920	11.5	9.0	6.6	–27
Nebraska	5,580	4,460	4,250	15.6	12.2	11.6	–4
North Dakota	1,490	1,290	1,340	10.7	9.2	9.9	7
Ohio	49,520	42,870	40,230	19.5	17.1	16.5	–3
South Dakota	1,040	1,030	870	6.9	6.5	5.5	–15
Wisconsin	15,450	14,160	11,130	13.5	12.2	9.6	–21
South	**450,330**	**424,740**	**418,630**	**21.8**	**19.8**	**19.0**	**–4**
Alabama	17,450	15,150	13,830	18.1	15.5	14.3	–8
Arkansas	7,130	6,200	5,540	13.5	11.2	9.8	–12
Delaware	5,730	4,090	5,440	34.9	24.0	31.3	31
District of Columbia	21,320	15,220	9,800	134.6	104.5	68.1	–39
Florida	84,680	94,050	103,050	29.3	30.7	31.9	4
Georgia	39,680	37,320	32,140	23.7	20.8	16.9	–19
Kentucky	10,000	8,470	4,700	11.4	9.5	5.3	–44
Louisiana	13,600	14,740	13,100	13.5	14.5	13.0	–10
Maryland	31,260	31,310	34,560	26.2	26.2	29.0	11
Mississippi	7,550	4,490	3,780	12.4	7.1	6.0	–17
North Carolina	36,180	33,550	37,610	22.2	19.5	21.0	8
Oklahoma	8,940	8,400	7,390	12.5	11.6	10.1	–13
South Carolina	12,190	9,940	8,210	14.2	11.4	9.3	–18
Tennessee	19,060	17,990	19,010	16.2	14.6	15.2	4
Texas	97,400	91,270	89,160	23.0	20.2	18.8	–7
Virginia	35,020	29,940	28,780	22.6	19.0	18.1	–5
West Virginia	3,140	2,610	2,540	7.8	6.6	6.8	3
West	**437,640**	**355,210**	**347,600**	**33.9**	**26.6**	**24.9**	**–6**
Alaska	2,370	2,040	1,660	16.6	14.2	11.7	–18
Arizona	20,600	19,310	17,940	23.4	19.2	16.5	–14
California	304,230	237,830	236,060	41.8	32.8	31.2	–5
Colorado	19,880	18,310	15,530	23.6	19.9	15.9	–20
Hawaii	12,190	6,930	5,630	46.4	26.8	22.2	–17
Idaho	1,710	1,600	1,950	7.3	6.1	7.0	15
Montana	3,300	2,900	2,510	18.5	15.4	13.5	–12
Nevada	13,300	15,450	13,740	43.0	41.7	32.2	–23
New Mexico	6,410	5,470	5,760	17.7	14.1	14.7	4
Oregon	16,060	15,050	17,010	23.9	21.2	23.5	11
Utah	3,940	3,700	3,510	9.2	7.5	6.6	–11
Washington	33,190	26,340	26,200	27.7	20.9	20.2	–3
Wyoming	460	280	100	4.4	2.6	1.0	–64

*Abortions per 1,000 women aged 15–44. *Notes:* Abortion rates for 1996 are revised from previously published fiugres on the basis of revised population data. Figures for the District of Columbia in 1996 are corrected from data originally published in 1998. Numbers of abortions are rounded to the nearest 10. *Sources:* see Table 1.

TABLE 3. Number of providers, 1992, 1996 and 2000, and percentage change between 1996 and 2000; and number of counties, percentage of counties without an abortion provider and percentage of women aged 15–44 living in a county without a provider, 2000—all by region and state

Region and state	No. of providers				Counties, 2000		
	1992	1996	2000	% change 1996–2000	Total	Without a provider	
						% of counties	% of women*
U.S. total	**2,380**	**2,042**	**1,819**	**-11**	**3,141**	**87**	**34**
Northeast	**620**	**562**	**536**	**-5**	**217**	**50**	**16**
Connecticut	43	40	50	25	8	25	9
Maine	17	16	15	-6	16	63	45
Massachusetts	64	51	47	-8	14	21	7
New Hampshire	16	16	14	-13	10	50	26
New Jersey	88	94	86	-9	21	10	3
New York	289	266	234	-12	62	42	8
Pennsylvania	81	61	73	20	67	75	39
Rhode Island	6	5	6	20	5	80	39
Vermont	16	13	11	-15	14	43	23
Midwest	**260**	**212**	**188**	**-11**	**1,055**	**94**	**49**
Illinois	47	38	37	-3	102	90	30
Indiana	19	16	15	-6	92	93	62
Iowa	11	8	8	0	99	95	64
Kansas	15	10	7	-30	105	96	54
Michigan	70	59	50	-15	83	83	31
Minnesota	14	13	11	-15	87	95	58
Missouri	12	10	6	-40	115	97	71
Nebraska	9	8	5	-38	93	97	46
North Dakota	1	1	2	100	53	98	77
Ohio	45	37	35	-5	88	91	50
South Dakota	1	1	2	100	66	98	78
Wisconsin	16	11	10	-9	72	93	62
South	**620**	**505**	**442**	**-12**	**1,425**	**91**	**45**
Alabama	20	14	14	0	67	93	59
Arkansas	8	6	7	17	75	97	79
Delaware	8	7	9	29	3	33	17
District of Columbia	15	18	15	-17	1	0	0
Florida	133	114	108	-5	67	70	19
Georgia	55	41	26	-37	159	94	56
Kentucky	9	8	3	-63	120	98	75
Louisiana	17	15	13	-13	64	92	61
Maryland	51	47	42	-11	24	67	24
Mississippi	8	6	4	-33	82	98	86
North Carolina	86	59	55	-7	100	78	44
Oklahoma	11	11	6	-45	77	96	56
South Carolina	18	14	10	-29	46	87	66
Tennessee	33	20	16	-20	95	94	56
Texas	79	64	65	2	254	93	32
Virginia	64	57	46	-19	136	84	47
West Virginia	5	4	3	-25	55	96	83
West	**880**	**763**	**653**	**-14**	**444**	**78**	**15**
Alaska	13	8	7	-13	27	85	39
Arizona	28	24	21	-13	15	80	18
California	554	492	400	-19	58	41	4
Colorado	59	47	40	-15	63	78	26
Hawaii	52	44	51	16	4	0	0
Idaho	9	7	7	0	44	93	67
Montana	12	11	9	-18	56	91	43
Nevada	17	14	13	-7	17	82	10
New Mexico	20	13	11	-15	33	88	48
Oregon	40	35	34	-3	36	78	26
Utah	6	7	4	-43	29	93	51
Washington	65	57	53	-7	39	74	17
Wyoming	5	4	3	-25	23	91	88

*Population counts are for April 1, 2000. *Note:* Numbers of abortions are rounded to the nearest 10. *Sources:* **Providers, 1992 and 1996:** reference 1. **Providers, 2000:** 2001–2002 AGI Abortion Provider Survey. **Population data, 2000:** U.S. Census Bureau, American fact finder, summary file 2, detailed table PCT3, <http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=DEC_2000_SF2_U&_lang=en&_ts=55786803406>, accessed May 21, 2002.

in 1996 occurred in Kansas (15%).

There was no clear state or regional pattern in time trends in abortion rates. Some states with rate increases between 1992 and 1996 had declines in the later period, and vice versa. The correlation between changes in state abortion rates in these two periods was low (r=–0.10).

Trends in Provider Numbers

A total of 1,819 providers performed at least one abortion in 2000—11% fewer than in 1996 (Table 3). In comparison, the number of providers declined by 14% from 1992 to 1996. The number of providers in 2000 was 37% lower than the all-time high of 2,908 in 1982 (not shown).

Between 1996 and 2000, the number of providers grew in nine states and fell in 38 and the District of Columbia; in the remaining three states, the number of providers did not change (Table 3). California and New York—the states with the largest numbers of providers—saw the largest absolute decreases between 1996 and 2000. The biggest absolute increases were in Connecticut, Hawaii and Pennsylvania. The increase in Pennsylvania may have resulted from the use of state health department data to identify hospitals that performed small numbers of abortions. In Connecticut, most of the increase was due to the identification of several physicians who performed a small number of abortions in 2000; some of these may have performed abortions in 1996, although we did not record them at that time. In Hawaii, most of the new providers were physicians as well.

Provider changes may be reflected in state abortion occurrence rates, especially if the number of abortions in a state is relatively small, but the impact may be exaggerated or muted by the size of the state (area and population), by the size of providers that discontinue or initiate services and by other factors. For example, a small net increase of two providers in Delaware is probably reflected in the parallel increase in the number of abortions that occurred in that state. However, it is hard to tell whether the latter change was a real increase or a shift in where Delaware residents had abortions because the change was small compared with changes in abortion levels in nearby areas. And while the number of providers decreased in both Kansas and Missouri from 1996 to 2000, a shift in service provision within the Kansas City area from Missouri to Kansas contributed to a sizable decrease in the abortion rate in Missouri and an increased rate in Kansas, although the same population was probably being served. The state-level correlation between the percentage change in the abortion rate between 1996 and 2000 and the percentage change in the number of providers during the same period was only –0.02 (not shown). In addition, the state-level percentage change in provider counts between 1996 and 2000 was not highly correlated (r=–0.08) with the change between 1992 and 1996.

Geographic Distribution of Providers

Abortion providers were located in 404 of the 3,141 U.S. counties in 2000. Overall, 87% of counties had no provider of abortions (Table 3). More than 90% of counties in the

Midwest and South had no abortion provider; outside of these regions, the only states with no provider in at least 90% of counties were Idaho, Montana, Utah and Wyoming.

Although the vast majority of counties had no provider, only 34% of women aged 15–44 in 2000 lived in counties with no abortion providers, because many of these have relatively small populations. However, nearly half of women in the Midwest (49%) and South (45%) lived in counties that lacked abortion services. In 19 states in these regions, at least half of women lived in counties without an abortion provider. However, in six states in the same regions—Delaware, Florida, Illinois, Maryland, Michigan and Texas (and the District of Columbia)—fewer than one-third lived in counties with no provider. Fewer than one in five women in the Northeast and West lived in counties without an abortion provider; the proportion was less than one-third in 13 states in these regions and more than one-half in only three.

These measures may overestimate or underestimate the availability of services. On the one hand, many counties with no provider are adjacent to others where services may be available. On the other hand, facilities that perform few abortions may not be well known to the general public, so the existence of a small provider in a county does not guarantee the availability of services. Thus, additional useful indicators of service availability are the presence or absence of providers in an entire metropolitan area* and the proportion of counties without a provider large enough to be likely to advertise its services and accept self-referred patients.[19] (For the purposes of this analysis, we use 400 or more abortions provided per year as the criterion for this category of provider.)

Between 1990 and 1999, the number of counties defined as metropolitan grew as some cities and urbanized areas became large enough to qualify as metropolitan areas.† In Table 4, where we present analyses by metropolitan status, we show figures for 2000 using two definitions of metropolitan status. This allows us to give accurate figures for 2000 (based on the 1999 metropolitan classification), while also showing true trends since 1978 (based on the 1990 classification).

The proportion of counties with no abortion provider in 2000 (87%) changed little compared with that in 1996 (86%), but remained higher than the proportion in 1978 (77%). In addition, the proportion of counties with no provider of 400 or more abortions per year has changed little over time, indicating that the drop in counties with providers has been concentrated in those where providers perform fewer than 400 abortions per year.

Most abortion providers are located in metropolitan areas: 94% of all providers and 99% of those who performed 400 or more abortions in 2000 (not shown). Even so, 61% of counties in metropolitan areas had no abortion provider, and 70% had no large provider (Table 4). Of nonmetropolitan counties, 97% had no provider, and virtually all lacked a provider of at least 400 abortions per year.

Overall, the proportion of women living in a county without a provider increased from 27% in 1978 to 30% in 1985 and 34% in 2000. However, figures based on comparable metropolitan classifications indicate that the proportion of women with no provider in their county increased from 1978 to 1996 in both metropolitan and nonmetropolitan counties, but changed only slightly between 1996 and 2000. There was no change during the 1990s in the proportion of women in metropolitan areas living in counties with no large provider, although the levels were slightly greater than those in 1978 and 1985. Almost all women in nonmetropolitan counties have lived without a large abortion provider.

TABLE 4. Percentage of counties with no abortion providers and with no large providers, and percentage of women aged 15–44 living in those counties, by metropolitan status, selected years

Provider and metropolitan status	1978	1985	1992	1996	2000	
					Based on 1990 status	Based on 1999 status
COUNTIES						
No provider	77	82	84	86	87	87
Metropolitan	47	50	51	55	57	61
Nonmetropolitan	85	91	94	95	96	97
No large provider*	93	92	92	92	92	92
Metropolitan	69	65	68	66	67	70
Nonmetropolitan	99	99	99	>99	>99	>99
WOMEN						
No provider in county	27	30	30	32	34	34
Metropolitan	12	15	16	18	19	21
Nonmetropolitan	69	79	85	87	86	91
No large provider in county*	43	43	41	41	41	41
Metropolitan	25	26	27	27	27	29
Nonmetropolitan	96	98	97	98	94	99

*Provider of at least 400 abortions per year. *Note:* The classification of some counties as metropolitan areas changed between 1990 and 1999. Figures for 1978–1996 use 1990 definitions. *Sources:* **1978–1996:** reference 1. **2000:** 2001–2002 AGI Abortion Provider Survey.

The 856 metropolitan counties make up 276 metropolitan areas (on the basis of the 1999 metropolitan classification). Eighty-six of these areas (31%) have no abortion provider, and an additional 12 reported fewer than 50 abortions in 2000 (not shown). If women in these areas sought abortions at the same rate as the overall U.S. population, as many as 250–2,640 women in each metropolitan area would seek abortion services. The two largest areas without a provider are within 100 miles of each other in eastern Pennsylvania (Scranton–Wilkes-Barre–Hazleton and Lancaster), and have 124,000 and 99,000 women aged 15–44, respectively. Three other areas have populations of 80,000 or more women 15–44: Provo-Orem, Utah; Lafayette, Louisiana; and Canton-Massillon, Ohio. However, all re-

*A metropolitan area is defined by the Office of Management and Budget as "a core area containing a large population nucleus together with adjacent communities having a high degree of economic and social integration with that core" (source: National Institute of Standards and Technology, FIPS 8–6: metropolitan areas, <http://www.itl.nist.gov/fipspubs/fip8-6-0.htm>, accessed May 14, 2002). Metropolitan areas consist of one county or two or more that are contiguous.

†Under the 1990 definition, 745 counties were in metropolitan areas; in 1999, the number rose to 856. Our previous analyses through 1996 used the 1990 metropolitan definition, but our current analyses use the 1999 definition. As a result, trends in measures broken down by metropolitan status may show change even if changes did not occur in individual counties.

TABLE 5. Number and percentage distribution of all abortion providers and all abortions, and number and percentage of providers and abortions represented by each type of facility, by caseload

Caseload	All		Abortion clinics		Other clinics		Hospitals		Physicians' offices*	
	No.	%	No.	%	No.	%	No.	%	No.	%
Providers	**1,819**	**100**	**447**	**25**	**386**	**21**	**603**	**33**	**383**	**21**
1–29	523	29	1	<1	33	2	332	18	157	9
30–399	599	33	19	1	112	6	242	13	226	12
400–999	264	15	91	5	154	8	19	1	na	na
1,000–4,999	405	22	313	17	82	5	10	1	na	na
≥5,000	28	2	23	1	5	<1	0	0	na	na
Abortions	**1,312,990**	**100**	**927,200**	**71**	**292,710**	**22**	**65,590**	**5**	**27,490**	**2**
1–29	5,340	<1	0	0	470	<1	2,970	<1	1,900	<1
30–399	78,240	6	4,840	<1	19,440	1	28,370	2	25,600	2
400–999	177,450	14	65,150	5	100,920	8	11,390	1	na	na
1,000–4,999	858,340	65	701,900	53	133,570	10	22,860	2	na	na
≥5,000	193,620	15	155,310	12	38,310	3	0	0	na	na

*Physicians' offices reporting 400 or more abortions a year are classified as clinics (either abortion clinics, if at least half of patient visits are for abortion services, or other clinics). *Notes:* na=not applicable. Abortion counts may not sum to totals and percentages may not add to 100 because of rounding.

gions of the country are represented on the list of metropolitan areas with no provider of 50 or more abortions.* Ten of these metropolitan areas are located in or include Texas, seven are in Pennsylvania and six each are in Alabama, Indiana and Ohio. In some cases, active community opposition has made it difficult to establish abortion facilities in unserved cities. For example, when a provider in Lancaster, Pennsylvania, made plans to offer abortions in September 1998, antiabortion advocates initiated legislation that led the local zoning board to reverse its initial stance and deny the clinic a permit for surgical procedures.[20]

Types of Providers

• *Clinics.* In 2000, clinics made up 46% of all abortion providers (Table 5); this proportion was up from 43% in 1996 (figures cited here and below for 1996 are not shown in the table). Most abortions in 2000 were performed at clinics (93%); this figure increased from 90% in 1996. (Physicians' offices where more than 400 abortions were provided have been categorized as clinics.)

Slightly more than half of clinics (25% of all providers) were specialized abortion clinics, defined as those where at least half of patient visits are for abortion services. Such clinics provided 71% of abortions in 2000, about the same proportion as in 1996 (70%). Caseloads are largest at abortion clinics: Three-fourths provided at least 1,000 abortions in 2000, while only 7% of other providers did so. The remaining clinics, in which the majority of patients receive services other than abortion, made up 21% of providers and performed 22% of all abortions in 2000.

• *Hospitals.* One-third of abortion providers in 2000 were hospitals, nearly the same proportion as in 1996. However, the proportion of abortions performed in hospitals decreased from 7% to 5% during the four years. More than half of hospitals performing abortions (18% of all providers) performed fewer than 30; 24% performed five or fewer abortions (not shown—these hospitals were most likely performing abortions only in cases of fetal anomaly or serious risk to the woman's life or health).

Four-fifths (82%) of hospitals that provided abortions were private; 69% were nonprofit and 13% were for-profit. The remaining hospital providers were under the jurisdiction of either a state (5%), a county (5%), a city (3%) or a hospital district, a public entity created by a state and covering a specific community (6%). Eighty-eight percent of hospital abortions were outpatient procedures, nearly the same proportion as in 1996 (91%) and 1992 (89%). In 2000, some 8,000 abortions involved hospitalization (not shown).

• *Physicians.* One-fifth (21%) of providers were physicians' offices (defined here as providers that appear from their name to be physicians' offices and reported performing fewer than 400 abortions in 2000), representing a decline from 23% in 1996. Forty-one percent of these practices (9% of all providers) performed fewer than 30 abortions in 2000. In total, these offices performed 27,500 abortions, and their share of abortions fell from 3% in 1996 to 2% in 2000.

Provider Caseloads and Types of Procedures

A majority (62%) of abortion providers performed fewer than 400 abortions in 2000. However, most abortions were obtained at large facilities where 1,000 or more abortions were performed (80%), nearly the same proportion as in 1996 (79%). Large providers were predominantly abortion clinics; 65% of abortions in 2000 were performed in abortion clinics that had caseloads of 1,000 or more procedures per year. Between 1996 and 2000, the number of providers declined in each size category except the largest (5,000 or more); thus, abortions were increasingly concentrated among a small number of very large providers.

• ***Early medical abortion.*** Mifepristone received FDA approval in September 2000, and distribution of the drug to providers began in November 2000.[21] Thus, the first six months of 2001 represent the initial period in which the method was available to American women outside of clin-

*The full list of metropolitan areas with no provider of 50 or more abortions is available from the authors.

TABLE 6. Estimated number and percentage of providers performing early medical abortion; and among nonhospital abortions, number and percentage that were medical, and percentage of medical abortions that used mifepristone—all by selected characteristics of providers, January–June 2001

Characteristic	Providers		Nonhospital abortions		
	No.	%*	No. that were medical†	% that were medical	% of medical that used mifepristone
Total	**603**	**33**	**35,300**	**6**	**72**
Provider type					
Abortion clinics	229	51	25,900	6	75
Other clinics	174	45	8,600	6	77
Hospitals	112	19	u	u	u
Physicians' offices	88	23	800	6	54
Region					
Northeast	201	38	9,800	6	81
Midwest	82	44	6,000	6	70
South	148	33	13,300	7	64
West	173	26	6,200	4	73
2000 abortion caseload					
1–29	74	14	200	18	57‡
30–399	138	23	1,300	5	u
400–999	128	48	6,200	7	75
1,000–4,999	245	60	22,900	6	78‡
≥5,000	19	68	4,600	5	u

*The denominator is the provider universe for the year 2000. †Rounded to the nearest 100. ‡Caseload category 1–29 includes 30–399, and category 1,000–4,999 includes ≥5,000, because cell sizes are too small to break them out individually. *Note:* u=unavailable.

ical trials. During that period, one-third of all abortion providers in the 2000 provider universe performed at least one early medical abortion–that is, an abortion in the first trimester using mifepristone or methotrexate (Table 6); medical abortions with mifepristone and methotrexate are always prescribed with misoprostol.

About half of abortion clinics (51%) and nonspecialized clinics (45%) provided early medical abortion, as did one in five (19%) hospital abortion providers. Large providers were the most likely to offer early medical abortion during this initial time period: At least 60% of those performing 1,000 or more abortions per year offered medical abortion, compared with at most 23% of providers performing fewer than 400 abortions. All of the providers offering early medical abortions during our survey period also performed surgical abortions.

Nonhospital facilities made up 81% of sites where early medical abortions were provided in the first half of 2001 (not shown). These sites provided an estimated 35,000 early medical abortions in that time period; 72% of these were performed with mifepristone, and the rest with methotrexate (Table 6). Roughly three-quarters of medical abortions were provided at abortion clinics.

Early medical abortions represented an estimated 6% of abortions performed in nonhospital facilities during the first half of 2001. Providers with annual caseloads of fewer than 30 abortions reported a higher proportion of medical abortions than those with larger caseloads (although larger providers reported a greater number of early medical abortions). We did not ask hospitals the number of medical abortions they provided, but if 6% of all abortions at hospitals were early medical abortions, an estimated 2,000 additional early medical abortions were performed, for a total of 37,000 early medical abortions in the first half of 2001.

Of providers performing medical abortions, 54% used only mifepristone, and 18% used only methotrexate (not shown). A smaller proportion of physician offices (54%) than of clinics (75–77%) performed medical abortions with mifepristone; larger providers were more likely than smaller ones to perform medical abortions with mifepristone.

Among nonhospital facilities that did not offer medical abortion in the first half of 2001, 30% reported that they "probably will" offer it in the future, 23% said "maybe" and 47% said they "probably won't" (not shown). Providers with larger caseloads were more likely than those with smaller caseloads to report that they would offer the method, as were providers in the Northeast and Midwest.

• *Dilation and extraction abortions.* Abortions performed by dilation and extraction* are quite rare: Eighteen providers reported 1,274 such abortions in 2000, and 16 providers reported 742 for the first half of 2001; an additional provider reported performing dilation and extraction abortions in both 2000 and 2001, but could not say how many. Assuming that the provision of dilation and extraction abortions by providers who responded to the question reflects the experience of nonrespondents of similar type and size, an estimated total of 31 providers performed the procedure 2,200 times in 2000, and 0.17% of all abortions performed in that year used this method. While these data confirm that the absolute number of abortions performed by dilation and extraction is very small, this figure should be interpreted cautiously, because projections based on such small numbers are subject to error.[22]

DISCUSSION

Between 1996 and 2000, the U.S. abortion rate fell 5%, a decline less than half as steep as that seen between 1992 and 1996 (12%). The number of abortion providers continued to decline between 1996 and 2000, at a rate slightly lower than that during 1992–1996. The 1996–2000 period saw the continuing consolidation of abortion provision at clinics, particularly specialized clinics; only 7% of abortions in 2000 were performed in nonclinic facilities. This trend may be partially due to increasing legal constraints on the circumstances under which abortions may be performed, such as zoning rules and state licensing and inspection requirements. Specialized clinics may be better

*The definition of dilation and extraction, as printed on the questionnaire, was as follows: deliberate dilation of the cervix, usually over several days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus (source: American College of Obstetricians and Gynecologists (ACOG), ACOG statement of policy: statement on intact dilatation and extraction, Washington, DC: ACOG, Jan. 12, 1997).

able to deal with new restrictions than physicians' offices and nonspecialized clinics, which may not be willing or able to undertake the expenses and time required to comply with them. This factor may be most relevant in South Carolina and Mississippi, where new licensing laws have created burdensome requirements for small providers; at least one South Carolina provider has reportedly closed in response to the new regulations.[23]

Another factor that may have contributed to the decline in the number of providers since 1996 is harassment. Despite the reported decline in severe forms of harassment of abortion providers,[24] several high-profile incidents of violence have occurred since 1996. In addition to the murder of Buffalo abortion provider Barnett Slepian and the death of a police officer in a Birmingham, Alabama, clinic bombing in 1998, two doctors were shot and wounded in 1997.[25] These incidents may have increased providers' fear of physical threats and, thus, contributed to the drop in the number of providers.

With more than one in five U.S. pregnancies ending in abortion, it is clear that American women are becoming pregnant far more often than they desire.

The decrease in providers was concentrated among those with small caseloads. Because many hospitals and physicians who did not perform abortions in 2000 performed few abortions in 1996, this decline probably had little impact on abortion incidence nationally, although it may have had a significant impact on abortion accessibility for residents of some rural areas and small towns.

For most American women, access to abortion is directly tied to where they live. Only 3% of nonmetropolitan counties have a provider, and almost none of those providers performed more than 400 abortions in 2000. Of metropolitan counties, only 30% have a large abortion provider. Surprisingly, although the proportion of nonmetropolitan counties with a provider has declined, the proportion of women in nonmetropolitan counties with a provider appears to have increased slightly, probably because of population shifts toward counties with providers. In metropolitan areas, the proportion of women living in counties with providers has changed little.

The Northeast and West are characterized by higher abortion rates and greater access to providers than are the Midwest and South, and also by more supportive laws regarding abortion.[26] In some states, abortion decreases may be due to regulatory requirements placed on women seeking abortion. For example, in Wisconsin, the imposition of a two-day delay law may have contributed to the 21% decline in the abortion rate (although women there may increasingly have gone to Illinois, particularly Chicago, to obtain abortions). In other states, rates may decline because many women travel out of state to have abortions.[27] This may occur when the barriers to obtaining an abortion–such as gestational limits or other restrictions, or expense–are lower in neighboring states.

During the first six months of 2001, early medical abortion (largely mifepristone) accounted for a small but nonnegligible proportion of all abortions. As of April 2002, 69% of National Abortion Federation members offered the method.[28] The growing acceptance of mifepristone raises the possibility that the decrease in surgical abortion providers may be offset by an increase in the number of providers that offer medical abortion, particularly in areas with no current providers. However, the information available from this early phase of provision suggests that the availability of this new procedure has not reduced travel distances for abortions[29] or increased the overall abortion rate. In addition, our findings show that mifepristone is being used mostly by existing (surgical) abortion providers rather than by new providers.

In the past, the U.S. abortion rate has been distinctly higher than the rate in other industrialized countries. Although the U.S. rate (21.3 per 1,000 women 15–44) is still higher than those in many western European countries, it is now within the range of rates in a few other developed countries, such as Sweden (18.7) and Australia (22.2).[30] Furthermore, U.S. rates vary by women's ethnicity and socioeconomic standing; the rate among white non-Hispanic women is in the middle range of other developed countries, but other ethnic groups have higher rates. Moreover, poor and near-poor women have rates roughly twice as high as their wealthier counterparts.[31]

This article has documented current levels of abortion and abortion service provision. More research needs to be done both to understand why abortion service provision is changing and the impact on women of the small number and geographic concentration of providers. In addition, further work is needed to determine the causes of declines in the abortion rate. Increasing use of emergency contraception appears to have been a major contributor in recent years: An estimated 51,000 pregnancies were averted by emergency contraception in 2000, accounting for 43% of the decrease in abortions since 1994.[32] Contraceptive use trends through 1995–improvements in use (e.g., a shift to greater use of long-acting, highly effective methods) and reductions in the proportion of women using no method–may have continued. The abortion rate decline between 1994 and 2000 was greatest among teenagers.[33] Both a decline in sexual activity among adolescents and increased use of contraceptives at first intercourse contribute to decreasing pregnancy and abortion rates among adolescents.[34]

It is also important to understand better the societal and personal factors that can have an impact on sexual and contraceptive behavior and the ways women deal with unintended pregnancies, as well as the factors that affect women's ability to obtain abortions when they seek them. The impacts of various influences may also change over time. For example, one previous study found no consistent relationship between economic conditions (as measured by income, employment and government benefits) and abortion rates at the state level.[35] However, new data indicate that trends in abortion rates were similar among lower- and higher-income women between 1987 and 1994, but have diverged since then.[36] This may indicate that increased economic pressures are discouraging greater numbers of lower-income women from having children, or that it is more difficult for them to avoid unintended pregnancy because of

decreased access to contraceptive services.

With more than one in five U.S. pregnancies ending in abortion, it is clear that American women are becoming pregnant far more often than they desire. More than half of these pregnancies occur among women who had difficulty using contraceptive methods effectively or who experienced method failure, and nearly half occur among the minority of sexually active women who use no contraceptives, reflecting the high rate of pregnancy among this group.[37] The challenge of reducing U.S. abortion rates without increasing unintended births requires action on several fronts, but foremost among these are increasing (and increasing the effectiveness of) contraceptive use by sexually active women and their partners, improving access to contraceptive services for those who are disadvantaged and ensuring the availability of a broader range of more-effective and user-friendly contraceptive methods.

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Author contact: *lfiner@guttmacher.org*

EXHIBIT E

The Accessibility of Abortion Services In the United States, 2001

By Stanley K. Henshaw and Lawrence B. Finer

Stanley K. Henshaw is senior fellow, and Lawrence B. Finer is assistant director of research, both at The Alan Guttmacher Institute, New York.

CONTEXT: *A woman's ability to obtain an abortion is affected both by the availability of a provider and by access-related factors such as cost, convenience, gestational limits and the provision of early medical abortion services.*

METHODS: *In 2001–2002, The Alan Guttmacher Institute surveyed all known abortion providers in the United States, collecting information on their delivery of abortion services and on the number of abortions performed.*

RESULTS: *A minority of abortion providers offer services before five weeks from the last menstrual period (37%) or after 20 weeks (24% or fewer), but the proportions have increased since 1993. Providers estimate that one-quarter of women having abortions in nonhospital facilities travel 50 miles or more for services, and that 7% are initially unsure of their abortion decision. The majority of providers (59%) say that these clients usually receive abortions during a single visit. An average self-paying client was charged $372 for a surgical abortion at 10 weeks in 2001, up from $319 in 1997; only 26% of clients receive services billed directly to public or private insurance. Early medical abortions are becoming increasingly available but are more expensive than surgical abortions. More than half (56%) of providers experienced antiabortion harassment in 2000, but types of harassment other than picketing have declined since 1996.*

CONCLUSIONS: *Abortion at very early and late gestations and early medical abortion are more available than before, but charges have increased and antiabortion picketing remains at high levels. Thus, many women still face substantial barriers to obtaining an abortion.*

Perspectives on Sexual and Reproductive Health, 2003, 35(1):16–24

Unintended pregnancies and induced abortions are common and occur among women of all social and economic groups.[1] Yet the availability and accessibility of abortion services have long been a concern for reproductive health professionals, as women seeking an abortion have a fairly narrow time period during which they can obtain the procedure. Measures of availability have generally declined since 1982: The number of abortion providers in the United States has fallen by 37%, and the proportion of women who live in counties with no abortion provider has increased from 28% to 34%.[2] In 2000, 86 of the country's 276 metropolitan areas and almost all nonmetropolitan areas had no abortion provider.[3]

Accessibility is harder to measure than availability, because of the variety of possible barriers, both tangible and intangible. Besides distance from a provider, cost is the most obvious tangible barrier. The provision of specific services, such as second-trimester pregnancy termination, can determine accessibility for individual women. Among the barriers that are less tangible, and therefore more difficult to quantify, are women's lack of accurate information about the legality of abortion and about where and how to obtain abortion care, misinformation about abortion, intimidation by protesters, state-required waiting periods and mandated counseling topics that may not be relevant to a woman's personal situation, and antiabortion attitudes among family or friends.

Although it is difficult to measure the impact of the accessibility of abortion services on abortion incidence, lack of access likely prevents some women from terminating unintended pregnancies. An estimated 46% of unintended pregnancies in 1994 were carried to term, excluding those ending in miscarriage.[4] While many women who continued such pregnancies undoubtedly came to want to give birth, others may have been deterred from having an abortion by the difficulty of obtaining one. For example, distance from services may help to explain why the abortion rate among nonmetropolitan women is half that of women who live in metropolitan areas.[5]

In addition, as with other types of health care, women are likely to be more satisfied with their abortion-related care if they have access to the types of services that best meet their physical and personal needs. Thus, for a woman who decides early in pregnancy that she wants an abortion, quality of care may be enhanced if she can choose between a medical and a surgical procedure, and if she is not required to wait for one or more weeks to meet minimum gestation limits.

This article documents the current status of abortion service accessibility in the United States, on the basis of data collected in a survey of all known U.S. abortion providers conducted in 2001–2002 by The Alan Guttmacher Institute (AGI). (Information on availability from the same survey is presented elsewhere.[6])

METHODS

The 2001-2002 AGI Abortion Provider Survey was the 13th such survey of all known abortion providers in the United States. This survey is the only national source of information on the numbers and types of providers and their geographic distribution. In addition, for the United States as a whole and for most states, the AGI survey produces the most complete data available on the numbers of abortions performed.

The survey methodology has been described in detail elsewhere.[7] Briefly, we identified potential providers, beginning with facilities found to be offering abortion services in 1996 through the prior AGI Abortion Provider Survey. Possible new providers were added on the basis of information from a variety of sources (e.g., telephone yellow pages, Planned Parenthood affiliates and World Wide Web listings), and past providers that had closed or that no longer offered abortion services were purged from the list. After four mailings and extensive telephone follow-up of nonrespondents, we identified 1,819 facilities where abortions were performed in 2000; this article analyzes information from these providers.

All respondents were asked about the number of abortions provided at their facility in 1999 and 2000, the minimum and maximum gestational ages at which abortion services were offered, the availability of early medical abortion (using either mifepristone or methotrexate) and the conditions under which this service is provided.

We classified providers into four types: hospitals; abortion clinics (defined as nonhospital facilities where half or more of patient visits are for abortion services); other clinics (all other nonhospital facilities with names suggesting a clinic structure, as well as physicians' offices where 400 or more abortions were performed in 2000); and physicians' offices (or facilities with names suggesting that they are physicians' private practices) where fewer than 400 abortions were performed. Facilities were also classified according to the number of abortions provided, rounded to the nearest 10.

As in the earlier surveys, we asked nonhospital providers how far they thought abortion clients lived from the facility, how much they charged for abortions at various gestations, what sources women used to pay for services and whether the facility experienced any antiabortion harassment. To track trends in these aspects of accessibility, we compare the results of the current survey with data from AGI surveys covering 1992-1993[8] and 1996-1997.[9] (Information on the latter survey's methodology has been published elsewhere.[10])

We obtained more detailed information from nonhospital providers that offered early medical abortions: the number performed during the first half of 2001; gestational limits; for mifepristone abortions, the dosage used; and practices regarding home administration of misoprostol, counseling and follow-up. Other new questions for nonhospital providers were whether services were provided in a single visit and what proportion of clients they thought were initially unsure about the abortion decision.

While two questions rely on providers' impressions, rather than on records or policies, both involve information that staff are likely to be aware of, because it is relevant to their service provision. The distance of clients' homes from the facility is known from their addresses and from planning for follow-up care; additionally, providers know what area they have targeted, and often advertised in, as their service area. Similarly, staff typically have an impression of the proportion of clients who are unsure of their abortion decision when they arrive, because assessing the firmness of a woman's decision is part of abortion counseling, and the administrators and physicians who completed the questionnaire would be aware of when extra counseling has been required and when women have left without having an abortion.

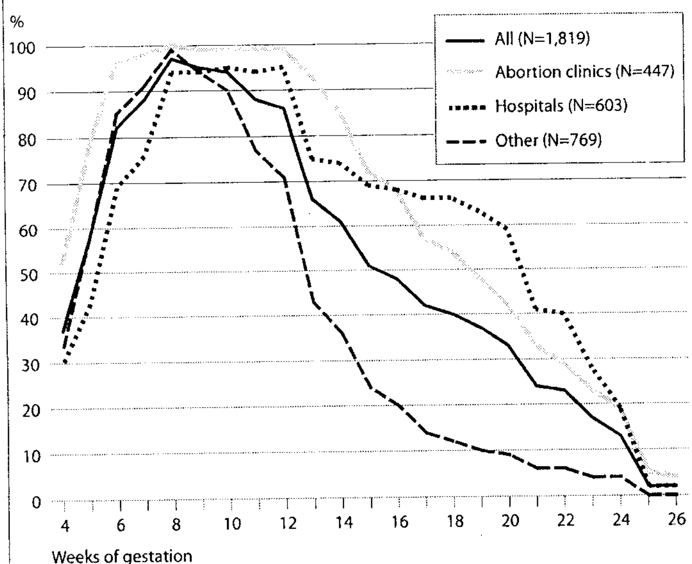
Most survey questions were worded in the present tense and referred to the time at which the survey was completed. For convenience of presentation, we considered questions asked in the present tense to refer to 2001, since the large majority of responses arrived in that year. The questions about harassment, however, referred specifically to providers' experiences in 2000.

Other than the number of abortions, gestational limits and the provision of early medical abortion, the items reported here were asked only of nonhospital facilities, because the medical records staff who completed many of the hospital questionnaires are unable to answer questions about the functioning of the abortion service. The results nevertheless represent the experience of most women having abortions, since nonhospital providers performed 95% of all abortions in 2000.[11]

We obtained information on gestational limits from 77% of the 1,216 nonhospital abortion providers surveyed in 2000, information on charges from 72% and data on other items from 52–55%. The large majority of providers with missing data did not return the questionnaire; through follow-up telephone calls to the facility or from other sources, we were able to obtain information on the number of abortions performed, gestational limits and charges, but not on most other questions.

Response rates were higher for nonhospital facilities and for facilities with large caseloads than for hospitals and smaller facilities. For example, information on gestational limits was obtained for only 35% of hospitals, compared with 77% of nonhospital providers, and for 81% of facilities performing 1,000 or more abortions, versus 65% of those performing fewer than 30. We therefore weighted all results to reflect the correct national proportions according to facility type and caseload. To account for item-specific nonresponse, we used different weights for each variable. Most data presented here refer to the characteristics of providers. However, where the focus is on the experience of the typical woman obtaining an abortion, we also weighted the results by the number of abortions reported by each facility in 2000, since numbers of abortions in 2001 were not available.

FIGURE 1. Percentage of facilities performing abortions, by gestational age at which abortions are performed, according to type of facility, 2001



FINDINGS

Gestational Limits

Providers typically set a minimum and maximum gestation at which they are willing and able to perform an abortion. These limits are expressed as the number of weeks since the woman's last menstrual period (LMP). Thirty-seven percent of facilities that offer abortion services provide either surgical or medical abortions at four weeks or less LMP (Figure 1), often for any pregnancy that can be confirmed by ultrasound or even a pregnancy test. This represents a sharp increase from the level of 7% reported in 1993 (not shown). Eighty-two percent of abortion facilities perform abortions at six weeks LMP (Figure 1). Abortion clinics are more likely than other types of facilities to offer abortions at five and six weeks LMP.

More than 90% of all abortion providers offer services at 8–10 weeks LMP. However, the proportion drops with each additional week of gestation after eight weeks LMP (typically four weeks after the woman's first missed period) and declines steeply after 12 weeks. At 20 weeks, for example, only 33% of all providers offer abortion services, and at 21 weeks, 24% still do so.

Hospitals and abortion clinics are much more likely than other providers to offer services past 12 weeks. At 13–15 weeks LMP, a higher proportion of abortion clinics than of hospitals perform abortions, while at 17–23 weeks LMP, the reverse is true. (Many hospitals, however, provide very few abortions and do so only in extraordinary circumstances, such as when the fetus has an abnormality or the pregnancy poses severe health risks to the woman.) After 24 weeks LMP, the number of providers offering abortion services again drops off sharply. Only 2% of all abortion providers (approximately 11 hospitals and 19 abortion clinics) provide abortions at 26 weeks.

The proportion of all facilities offering abortion services at 20 weeks increased from 22% in 1993 and 25% in 1997 to 33% in 2001, for a 50% increase over the period. However, because the overall number of abortion providers has declined, the number offering such services increased only 16%, from 524 in 1993 and 511 in 1997 to 607 in 2001. A majority of facilities providing abortions at 17–24 weeks LMP are hospitals, although a majority of abortions at each gestational age are probably performed in abortion clinics (not shown).

Distance Traveled

Respondents estimated that 8% of women having abortions in nonhospital facilities travel more than 100 miles to obtain this service, and that an additional 16% travel 50–100 miles.* Travel patterns appear to have changed little over time. In both 1993 and 1997, providers also reported that 24% of clients traveled at least 50 miles, including 8% and 7%, respectively, who traveled more than 100 miles.

The proportion traveling long distances varies by geographic region. In the East South Central and the West North Central states, 43% and 37%, respectively, of women travel at least 50 miles to obtain an abortion, including 14–15% who travel more than 100 miles. In contrast, only 11% of women in the Middle Atlantic states travel 50 miles or more.†

In general, clients of large providers are the most likely to travel great distances. Only 6% of clients of providers that perform fewer than 30 abortions a year travel 50 miles or more, compared with 26% of clients of providers that perform 1,000–4,990 abortions and 18% of women see-

TABLE 1. Mean, median and range in charges for nonhospital surgical abortion, by weeks of gestation, according to type of facility, 2001

Weeks of gestation and charge	All	Abortion clinics	Other clinics	Physicians' offices
6 weeks				
Mean charge	$461	$362	$440	$599
Median charge	375	340	375	500
Range	150–4,000	170–1,380	150–4,000	150–1,765
10 weeks				
Mean charge	468	364	426	632
Median charge	370	350	370	500
Range	150–4,000	170–1,380	150–4,000	200–1,765
16 weeks				
Mean charge	774	720	758	855
Median charge	650	650	632	700
Range	250–4,000	300–2,200	250–4,000	300–3,000
20 weeks				
Mean charge	1,179	1,290	1,178	1,051
Median charge	1,042	1,100	1,100	1,000
Range	300–3,000	675–3,000	450–2,500	300–2,000

*We weighted these responses by the number of abortions provided in 2000.

†The East South Central region consists of Alabama, Kentucky, Mississippi and Tennessee; the West North Central states are Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota; and the Middle Atlantic states are New Jersey, New York and Pennsylvania.

TABLE 2. Mean charge for nonhospital surgical abortion at 10 weeks of gestation, by caseload, according to type of facility, 2001

Caseload	All	Abortion clinics	Other clinics	Physicians' offices
<30	$787	$ *	$827	$782
30–390	488	353	434	528
400–990	368	362	372	na
1,000–4,990	369	365	381	na
≥5,000	356	350	*	na

*Too few cases to produce reliable statistics. *Note:* na=not applicable, because physicians' offices responsible for 400 or more abortions are classified as clinics.

ing providers that perform 5,000 or more abortions annually. Some 26% of clients of abortion clinics (which tend to have larger caseloads than other providers) travel at least 50 miles to obtain an abortion, compared with 16–18% of clients of other types of facilities.

Traveling a long distance to a provider can be difficult for women who need to make two or more trips to the abortion facility. In 2001, four states* had legislation requiring most or all clients to receive specified in-person counseling at least 24 hours before the procedure is performed. Such requirements usually necessitate two trips to the abortion provider. In other states, most women can obtain abortion counseling and medical services in a single visit.

Fifty-nine percent of nonhospital providers nationally and 60% of providers in states that do not require in-person advance counseling said that their clients usually obtain abortions in a single visit, while 15% and 14%, respectively, said that this never happens. Single-visit service is highly associated with caseload: All facilities that provided 5,000 or more abortions in 2000 usually perform abortions in a single visit, compared with only 20% of facilities providing fewer than 30 abortions (not shown).

Distance may also be a barrier for women who are uncertain about how to resolve a pregnancy and who first seek counseling about that decision at an abortion facility. They may then need time to consider the decision before having an abortion, if that is their choice. Nonhospital providers estimate that 7% of their clients arrive unsure; this proportion is slightly lower at larger clinics. Since some women presumably decide against an abortion, the proportion of all women having an abortion who were unsure of their decision when they first visited an abortion provider is probably lower than 7%.

Charges

We asked each nonhospital provider to indicate the usual charges that a woman would incur at that location for an abortion (with local anesthesia) at various gestations, including fees for any services always required for an abortion client, even if these are not billed through the provider (e.g., laboratory tests). On average, surveyed facilities charge $468 for a surgical abortion at 10 weeks LMP (Table 1).† The lowest average charge ($364) is reported by specialized abortion clinics, and the highest average charge ($632) is reported by physicians' offices. The range of charges is wide (from $150 to $4,000), and the median ($370) is lower than the mean, which is influenced by a few facilities that have very high charges.

As a pregnancy advances into the second trimester, the abortion procedure becomes more complex, because it requires more time and more skill on the part of the clinician, and charges increase. At 16 weeks, the mean and median charges ($774 and $650, respectively) are more than half again the amounts at 10 weeks (Table 1). At 20 weeks, the mean and median charges increase to $1,179 and $1,042, respectively. In the second trimester, charges vary relatively little by type of provider, but the range remains wide, with some providers charging 2–5 times the average.

We also examined mean charges for abortions at 10 weeks LMP by the provider's caseload (i.e., the number of abortions performed). Charges are approximately twice as high in facilities that perform fewer than 30 abortions per year as in those that perform 400 or more. Caseload has little relationship to charges among abortion clinics or among other types of clinics that perform 400 or more abortions per year (Table 2).

By weighting the survey responses by caseload, we determined the amount paid by the average self-paying client, rather than the amount charged by the average facility. The mean amount paid by clients ($372) is lower than the mean amount charged by the typical provider, since larger providers (especially abortion clinics) tend to charge lower fees. Clients at abortion clinics and other types of clinics pay about the same as the average ($367 and $376, respectively), but clients obtaining an abortion at a doctor's office pay substantially more ($471).

In current dollars (the amount paid at the time), the average self-paying client's payment for an abortion at 10 weeks LMP has increased steadily over time—from $200 in 1983 to $319 in 1997, and to $372 in 2001 (Figure 2, page 20). When inflation in the cost of living (as measured by the Consumer Price Index for all items) is taken into account, the amount changed little between 1983 and 1997, but increased by 9% ($30) from 1997 to 2001. When compared with the amounts paid for other medical care, the amount paid for abortion services fell from 1983 to 1997, and then increased by 5% ($17) between 1997 and 2001.

*Louisiana, Mississippi, Utah and Wisconsin required in-person counseling with the attending or referring physician at least 24 hours before the abortion is performed. Only 2% of all providers, and none of those that performed 5,000 or more abortions in 2000, were located in these states. (Ten other states required a delay after mandatory counseling, but permitted the counseling to be delivered by telephone or another means that did not require a visit.) In some cases, it may be permissible, but often not practical, for a woman to receive the mandatory counseling without visiting the abortion facility. (Source: NARAL Foundation, *Who Decides? A State-by-State Review of Abortion and Reproductive Rights,* 10th ed., Washington, DC: NARAL Foundation, 2001.)

†We focus on abortions at 10 weeks LMP because almost all providers perform abortions at this gestation. In addition, the charge for a surgical abortion at six weeks (and probably throughout the first trimester) is about the same as at 10 weeks. Charges at 10 weeks LMP are representative of the medical costs for most women having abortions, because 88% of abortions occur within the first trimester (source: U.S. Bureau of the Census, *Statistical Abstract of the United States: 2001,* 121st ed., Washington, DC: U.S. Bureau of the Census, 2001, Table 93).

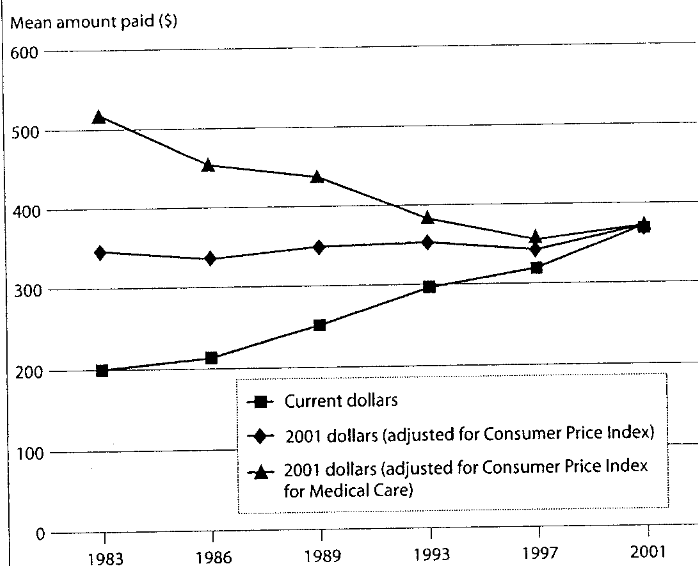


FIGURE 2. Mean amount paid for a nonhospital abortion at 10 weeks LMP, by dollar measure, selected years, 1983–2001

How Women Pay

According to estimates by nonhospital providers, a large majority of women (74%) pay for their abortions with their own money or with funds they obtain from their partner, family or others (Table 3). In an unknown proportion of these cases, the women obtain subsequent reimbursement from health insurance. Included among self-paying clients are women for whom the facility reduces the fee or provides the service without charge (12%); some of these may receive partial support from one of the many funds that subsidize abortions for poor women.[12] The proportion of clients who are charged reduced fees rises with the facility caseload, from 5% at the smallest providers to 15% at the largest (not shown).

Although the federal government pays for abortions through Medicaid only in cases of rape, incest and life endangerment, 16 states cover abortions under their Medicaid programs, either voluntarily or under court order.* Providers reported that about 13% of abortions are reimbursed by Medicaid; almost all of these occur in Medicaid-funding states (Table 3). An estimated 13% of abortions are covered by private insurance billed directly by the facility.

Other payment sources also vary between Medicaid-funding states and nonfunding states. Specifically, 19% of abortions in Medicaid-funding states are billed to private insurance, compared with only 8% in other states. As of December 2000, four states[†] of the 34 that do not fund abortions under Medicaid had legislation prohibiting private insurance from covering abortions except under an optional rider at additional cost, but these could not account for much of the difference between Medicaid-funding and nonfunding states. Evidently, some of the same state characteristics that influence states to cover abortion under Medicaid influence private insurers to cover abortion.

The proportion of providers that bill private insurance for their clients' abortions is higher than average for nonhospital providers performing fewer than 30 abortions per year and for physicians' offices (45% and 27%, respectively—not shown). Direct billing of private insurance is most common in the Northeast (27%) and is least common in the South (5%). The proportion of clients for whom the provider billed private insurance has increased since 1997, when a similar question indicated that only 3% of clients benefited from direct insurance billing (not shown).

Early Medical Abortion

One-third of abortion facilities provided early medical abortions in the first half of 2001, and this proportion was increasing rapidly.[13] An estimated 37,000 early medical abortions occurred in this time period; 35,000 of them were provided by nonhospital facilities. One-quarter of early medical abortions in nonhospital facilities were performed using methotrexate, which was available before the Food and Drug Administration (FDA) approved mifepristone in September 2000. However, 82% of medical abortion providers were using mifepristone—although some of these used methotrexate as well. Both drugs are used in conjunction with misoprostol, a prostaglandin that is administered within several days of the mifepristone or methotrexate to cause contractions and expel the products of conception.

The FDA-approved labeling specifies a fairly restrictive protocol for abortion using mifepristone: use within the first seven weeks of gestation; a mifepristone dose of 600 mg; misoprostol administered orally in the physician's office; and a follow-up visit to the provider for an examination to confirm that the pregnancy has been completely terminated. However, experts who have reviewed published studies have concluded that more convenient and less-expensive procedures are equally safe and effective.[14] How providers structure their early medical abortion services influences the number of locations where the method is

TABLE 3. Percentage distribution of abortions performed in nonhospital facilities, by clients' source of payment, according to whether the facility is in a state that covers abortion under Medicaid, 2001

Source of payment	All (N=637)	State covers (N=360)	State does not cover (N=277)
Self	74	55	91
Full fee	62	43	79
Reduced fee	12	12	12
Medicaid	13	27	<1
Private insurance	13	19	8
Total	100	100	100

Notes: Percentages are weighted to represent women having abortions in nonhospital facilities. Ns are unweighted.

*As of September 2000, the following states funded medically necessary abortions through Medicaid: California, Connecticut, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington and West Virginia. Alaska and Arizona were in violation of court orders to fund medically necessary abortions (source: reference 30).

†Idaho, Kentucky, Missouri and North Dakota.

offered, the proportion of women who are eligible, the charges to clients and the convenience of the method from the client's point of view.

Table 4 shows information on the protocols used and experiences of nonhospital abortion providers offering early medical abortion services, including separate data for providers that performed 50 or more medical abortions from January through June 2001 and those that performed fewer.* Overall, the majority (67%) of medical abortion providers offered the service very early in pregnancy: These providers either set a minimum limit at or before 28 days LMP (45%), required only that the pregnancy be confirmed by a laboratory test (7%) or sonogram (9%), or had no minimum gestation requirement (6%). Seventy-six percent set their maximum gestation limits at or below seven weeks LMP, in line with the mifepristone labeling approved by the FDA; the remaining 24% used the method past seven weeks, on the basis of evidence from clinical studies,[15] following mifepristone practice in Britain and elsewhere.[16] More experienced providers (i.e., those with larger medical abortion caseloads) were more likely than the less-experienced to offer the method before 29 days and after seven weeks LMP.

The great majority of providers of early medical abortion used a dose of 200 mg of mifepristone (83%), and most permitted the client to take the misoprostol at home rather than requiring her to return to the abortion facility to receive it (84%). Both practices were more common among providers that did 50 or more medical abortions than among less-experienced providers.

Most providers (74%) reported that counseling for medical abortion takes more time than does counseling for surgical abortion. A large minority (43%) said that fewer than 10% of early medical abortion clients called with questions or problems, but one-third reported that 20% or more did so. Calls from one-fifth or more of clients were less common among the more experienced providers.

Unlike a surgical abortion, an early medical abortion is not completed during the woman's appointment with the provider, making follow-up important for ascertaining that the abortion has been completed. Therefore, providers usually attempt to contact clients who miss their follow-up appointments, to make sure that they are no longer pregnant. Respondents said that in early 2001, pregnancy termination was confirmed for almost all of their clients—for 91% in a return visit, and for 3% by telephone or other contact. (Six percent of clients were lost to follow-up.)

The mean charges for a mifepristone abortion and for a methotrexate abortion were $490 and $438, respectively, during the first half of 2001 (not shown). Providers who used 600 mg of mifepristone charged $74 more, on average, than providers who used 200 mg. More than two in five providers (43%) charged between $400 and $499 for mifepristone, and 38% charged $500 or more (Table 4). Providers with relatively large medical abortion caseloads were more likely than those who did few procedures to charge $450–499 and were less likely to charge $500 or more.

Sixty-nine percent of providers who offered both surgi-

*We set the division at 50 to separate out providers that are relatively experienced with early medical abortion while maintaining an adequate number of responses in each category. Presumably, providers with relatively large medical abortion caseloads best reflect how services are evolving as providers and women gain experience with early medical abortion.

TABLE 4. Percentage distribution of nonhospital abortion providers, by selected early medical abortion protocols and experiences, according to medical abortion caseload in first half of 2001

Protocols and experiences	Total (N=358)	Caseload	
		<50 (N=218)	≥50 (N=140)
Minimum gestation			
No minimum	6	7	5
Positive pregnancy test	7	4	12
Visible sac on sonogram	9	9	10
≤28 days	45	39	53
>28 days	33	41	20
Maximum gestation			
≤7 weeks	76	83	66
8 weeks	12	10	14
≥9 weeks	12	8	19
Mifepristone dosage used*			
200 mg	83	76	93
600 mg	15	21	7
Other	2	3	0
Permits home administration of misoprostol			
Yes	84	78	93
No	16	22	7
Counseling time required			
More than for surgical abortion	74	80	64
The same as for surgical abortion	24	19	32
Less than for surgical abortion	2	1	4
% of clients who call with problems/questions			
0–4	23	24	21
5–9	20	16	25
10–19	24	21	28
20–100	34	39	26
How pregnancy termination is confirmed†			
By office visit	91	93	88
By other means	3	2	4
Not confirmed	6	5	8
Charge for mifepristone abortion*			
$0–399	19	21	15
$400–449	17	16	18
$450–499	26	20	35
≥$500	38	43	32
Charge for mifepristone vs. surgical abortion at six weeks‡			
Mifepristone costs less	9	14	3
Both are the same	21	22	18
Mifepristone costs $1–99 more	25	19	35
Mifepristone costs $100–199 more	29	29	30
Mifepristone costs ≥$200 more	15	16	14
Charge includes surgical completion when needed			
Yes	80	71	95
No	20	29	5
Total	100	100	100

*Excludes providers who used only methotrexate. †Mean percentages. ‡Among those that provided both surgical and mifepristone abortions. *Note:* Significance tests were not conducted because this is a census, not a sample survey.

TABLE 5. Percentage of large nonhospital facilities that experienced any incidents of harassment, by type of harassment, according to year, 1985–2000; and percentage distribution of facilities, by number of incidents of harassment in 2000, according to type of harassment

Type of harassment	Year					No. of incidents in 2000				
	1985	1988	1992	1996	2000	0	1–4	5–19	≥20	Total
Picketing	80	81	83	78	80	20	12	7	61	100
Picketing plus physical contact with/ blocking of patients	47	46	50	32	28	72	19	4	5	100
Vandalism*	28	34	42	24	18	82	16	2	0	100
Picketing of homes of staff	16	17	28	18	14	86	11	1	1	100
Bomb threats	48	36	24	18	15	85	15	<1	0	100

*Jamming of locks or physical damage. *Note:* Large nonhospital facilities are those that provide 400 or more abortions per year.

cal abortions at six weeks and mifepristone abortions charged more for the latter, while 9% charged less. For 15%, the additional charge was $200 or more. More experienced providers were slightly more likely to charge more for mifepristone, but charges varied little by type of provider (not shown).

For 80% of medical abortion providers, the basic charge for a medical abortion included the cost of a subsequent vacuum aspiration, should an incomplete abortion or continuing pregnancy occur. Providers who performed at least 50 early medical abortions were much more likely than less-experienced providers to include surgical completion in their basic charge (95% vs. 71%).

Harassment

Many women seeking abortion face harassment by antiabortion protesters; this also affects a facility's ability to offer services. Each year, 56% of all nonhospital providers experience at least one of five types of harassment—picketing; picketing coupled with physical contact with or blocking of clients; vandalism (such as jamming of locks or other physical damage); picketing of the homes of staff; and bomb threats. Harassment is much more common in facilities with large abortion caseloads than in smaller facilities: The proportion experiencing one or more incidents ranges from 10% among facilities performing fewer than 30 abortions to 70% among those providing 400–990 abortions and to 100% of clinics providing 5,000 or more.

To avoid distortion caused by facilities with small caseloads (which vary in number from area to area and which affect relatively few women), we limited further analyses of harassment to large providers (those that performed 400 or more abortions in 2000). These providers accounted for 94% of all abortions in 2000.[17] Overall, 82% of these facilities experience any type of harassment in a given year. The proportion experiencing harassment is greatest in the Midwest (91%) and lowest in the West (78%).

Picketing is by far the most common type of antiabortion activity, reported by 80% of large providers (Table 5). Some 14–28% of large providers experience more extreme forms of harassment. A majority (61%) of facilities experience picketing at least 20 times a year. Other types of harassment usually occur fewer than five times per year at any one facility.

Since 1996, all of these forms of harassment except picketing have become less common. The proportions of large providers reporting picketing with physical contact, vandalism and picketing of staff members' homes have fallen by about half since 1992, when these activities were at their height. The proportion of large providers reporting bomb threats has fallen steadily, from 48% in 1985 to 15% in 2000.

DISCUSSION

For many women, barriers to abortion services are significantly more common than are obstacles to other common types of reproductive health care. For example, only 13% of U.S. counties have an abortion provider,[18] while obstetric-gynecologic care is available in half of all counties.[19] In 1997, 85% of counties had at least one publicly funded family planning clinic.[20] Depending on the circumstances of any given woman needing abortion services, she may have to cope with gestational limits, a long distance from a provider (the effects of which may be exacerbated if she needs to make two trips or is undecided about whether to have an abortion), travel and other expenses that may not be covered by insurance, a lack of choice of method of early medical abortion and antiabortion protesters. These are the potential barriers for which we have information; other factors, including restrictive legislation and attitudes, may also pose important problems for some women.

Gestational limits reduce the number of abortion providers available to specific women. Women frequently encounter such barriers when they seek an abortion during the second trimester. Many providers offer services only up to 12 or 14 weeks, because later abortions require more cervical dilation and greater skill on the clinician's part, the risk of complications is greater than with earlier abortions and the demand is less. When a fetal anomaly is discovered late in the second trimester, the woman may find that facilities where the pregnancy can be terminated are difficult to locate and are far from her home. Nonetheless, the number of facilities where second-trimester abortions are performed has increased in recent years.

A woman who discovers an unintended pregnancy at less than six weeks LMP may find that an abortion provider she contacts will not provide services then, but will ask her to wait until six weeks or later. Studies in the 1970s found a higher rate of continuing pregnancies after very early procedures.[21] Recent research has shown, however, that with high-resolution ultrasound and careful examination of the products of conception, early surgical abortions can be performed without an elevated risk of ectopic pregnancy or incomplete abortion,[22] and that an increasing number of providers perform such early abortions. In addition, providers of surgical abortion increasingly are offering early medical abortion.

Distance from a provider continues to affect women's ability to obtain access to abortion services, presumably because of the difficulty and expense of arranging travel

and unfamiliarity with distant facilities.[23] Although a distance of 50 miles may not create any difficulty for some women, for others it may pose a significant problem. Providers estimate that 8% of women who have abortions travel more than 100 miles to do so, a proportion that has not changed in recent years. Women who are able to overcome the barrier of distance may nevertheless suffer consequences. In a survey conducted in 1987–1988, half of a national sample of women who were having an abortion at 16 weeks LMP or later cited difficulty in making arrangements as a cause of delay.[24]

For many women--especially for those who must travel long distances for services--the option of having the abortion in a single visit is important and lowers travel costs. A large majority of nonhospital abortion providers serve at least some clients in one visit. This practice is not permitted, however, in states that require face-to-face counseling by a physician at least a day before the procedure. The result in one state was a decrease in the number of resident women who obtained abortions.[25] Distance is also a factor for women who need to make multiple visits because they are uncertain about their abortion decision. Providers estimate that no more than 7% of clients arrive unsure at their first visit, however, and in such cases additional visits are responsive to the women's needs.

Another factor affecting access is the fee that clients pay, which averages $372 at 10 weeks. This is a minimum figure, because many clients have additional expenses, such as for other services (intravenous sedation or general anesthesia), transportation, time lost from work and increased costs if the pregnancy is at a later gestation. Nonhospital providers directly bill Medicaid or other insurance for only 26% of their abortion clients, and for only 8% in states where Medicaid does not cover abortion. Whether because of Medicaid funding restrictions, a lack of insurance coverage, women's hesitancy to use insurance coverage for abortion or providers' inability to bill directly, most women pay directly for their abortion care.

While the cost of an abortion may seem moderate to some, many low-income women are likely to find it substantial. Between 18% and 35% of Medicaid-eligible women who would have abortions instead continue their pregnancies if public funding is unavailable.[26] The lack of Medicaid coverage may be the public policy that has the greatest impact on the number of women who want an abortion but are not able to obtain one. In addition, a woman's need to secure funds often causes abortions to be delayed; one study found that 22% of Medicaid-eligible women who had a second-trimester abortion would have terminated their pregnancy in the first trimester if Medicaid had covered abortion services.[27]

After a long period of stability, the average amount paid for a first-trimester abortion, adjusted for inflation, increased by 9% in recent years. These increased fees may reflect increased costs for physicians and other staff (to comply with state and federal regulations or to maintain the safety of the facility, staff and clients) or reduced competition among abortion providers. The increased proportion of women whose health insurance is billed directly for abortion services somewhat offsets the effect of the increased fees.

Early medical abortion is a new development that increases women's options and is preferable to some women. Although it has the potential to make services available in geographic areas that were previously unserved, by mid-2001 there was little evidence of providers' offering only early medical abortion.[28] However, the number of surgical abortion providers who also offer early medical abortions has grown rapidly, and as of early 2002, two-thirds of National Abortion Federation members were providing early medical abortion.[29]

The protocols used to provide early medical abortions have an important effect on the cost of the method and the extent to which it meets women's needs. While practices reported in our survey may have changed since then, the results indicate that many providers, using evidence based on clinical studies, are offering mifepristone abortions with variations in the approved protocol. In particular, a large majority of providers use a smaller dose of mifepristone (200 mg rather than 600 mg) and allow the client to administer the prostaglandin herself at home. In addition, a substantial minority of providers use the method beyond the approved gestational limit of 49 days. If these practices prove to be safe and effective in clinical practice and are seen as preferable to providers and clients, almost all providers of medical abortion are likely to adopt them. The finding that the practices were used most by providers with the largest caseloads supports this expectation.

A majority of providers charge more for medical abortion than for surgical abortion at six weeks. This may reflect the cost of the drug, the greater amount of counseling time required for medical abortion than for surgical abortion, the number of calls from clients with problems or questions, and the greater perceived need for active follow-up of medical abortion clients, to ensure that the abortion was completed without complications. As providers gain experience with early medical abortion, however, these services may become more routine, and the additional expenses for medical abortion could fall.

Picketing remains prevalent at abortion facilities, especially at those with large caseloads. Other types of harassment have declined over time but have not disappeared. This decrease may reflect the impact that federal legislation to protect access to medical facilities has had in deterring illegal antiabortion activity, as well as the fact that by September 2000, 15 states had laws protecting access to clinics that provide reproductive health services.[30] Nevertheless, a majority of clinics reported being picketed at least 20 times a year, and many women seeking abortion are exposed to the stress of noisy and sometimes threatening protesters.[31] In addition, we did not ask about new types of harassment, such as anthrax threats and photographing clients and staff for publication on the Internet.

In summary, barriers to abortion services remain substantial for many women. Although services are more avail-

For many women, barriers to abortion services are significantly more common than are obstacles to other common types of reproductive health care.

able at very early and late gestations than in the past and early medical abortion is now available, charges have increased and antiabortion picketing (the type of harassment most likely to affect women directly) remains at high levels. Moreover, because we surveyed abortion providers, we could not address many of the problems that women may face when seeking abortion services, including difficulties in locating services, the prevalence of misinformation about abortion, antiabortion attitudes in some subgroups and in many public forums, and state restrictions such as parental involvement requirements and 24-hour delay laws. Thus, the factors documented in this article present only a partial picture of the barriers women face in seeking abortion services.

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Author contact: *shenshaw@guttmacher.org*