CORRECTIONS:

Chart 4.5, page 28

The colors of two bars in this chart are incorrect. The bar for Mexico should be orange, indicating that the rate is an estimate; the bar for Turkey should be yellow, indicating that official statistics are available but are incomplete.

Appendix Table 1, page 51

The data in Table 1, Column 9 are incorrect for two reasons: The decimal place was inadvertently dropped and a programming error made the values slightly lower than they should have been. The correct data appear at right.

Appendix Table 1, Column 9

Country and survey year	Mean diesired family size[4]
Sub-Saharan Africa	
Botswana, 1988	4.7
Burkina Faso, 1992-1993	5.8
Burundi, 1987	5.4
Cameroon, 1991	6.7
Central African Rep., 1994-1995	6.3
Cote d'Ivoire, 1994	5.5
Ghana,1993	4.5
Kenya, 1993	3.8
Liberia, 1986	6.0
Madagascar, 1992	5.6
Malawi, 1992	5.2
Mali, 1987	6.7
Namibia, 1992	5.1
Niger, 1992	7.9
Nigeria, 1990	5.9
Rwanda, 1992	4.3
Senegal, 1992-1993	5.9
Tanzania, 1991-1992	6.1
Togo, 1988	5.3
Uganda, 1995	5.3
Zambia, 1992	5.8
Zimbabwe, 1994	4.3
North Africa, Middle East	
Egypt, 1992	3.5
Morocco, 1992	3.9
Sudan, 1989-1990	6.0
Tunisia, 1988	3.7
Yemen, 1991-1992	5.6
Asia	
Bangladesh, 1993-1994	2.9
India, 1992-1993	3.2
Indonesia, 1994	3.6
Pakistan, 1990-1991	5.3
Philippines, 1993	3.2
Sri Lanka, 1987	3.3
Thailand, 1987	2.8
Turkey, 1993	2.5
Latin America	
Bolivia, 1993-1994	2.8
Brazil, 1996	2.3
Colombia, 1995	2.5
Dominican Republic, 1991	3.2
Ecuador, 1987	3.1
El Salvador, 1985	3.7
Guatemala, 1987	4.2
Mexico, 1987	3.2
Paraguay, 1990	4.1
Peru, 1996	2.6
Trinidad & Tobago, 1987	3.0
Developed Countries	
France, 1994	2.3
Japan, 1992	2.5
United States, 1995	2.2

[4]Women who say their desired family size is "up to God" are assumed to want six children.

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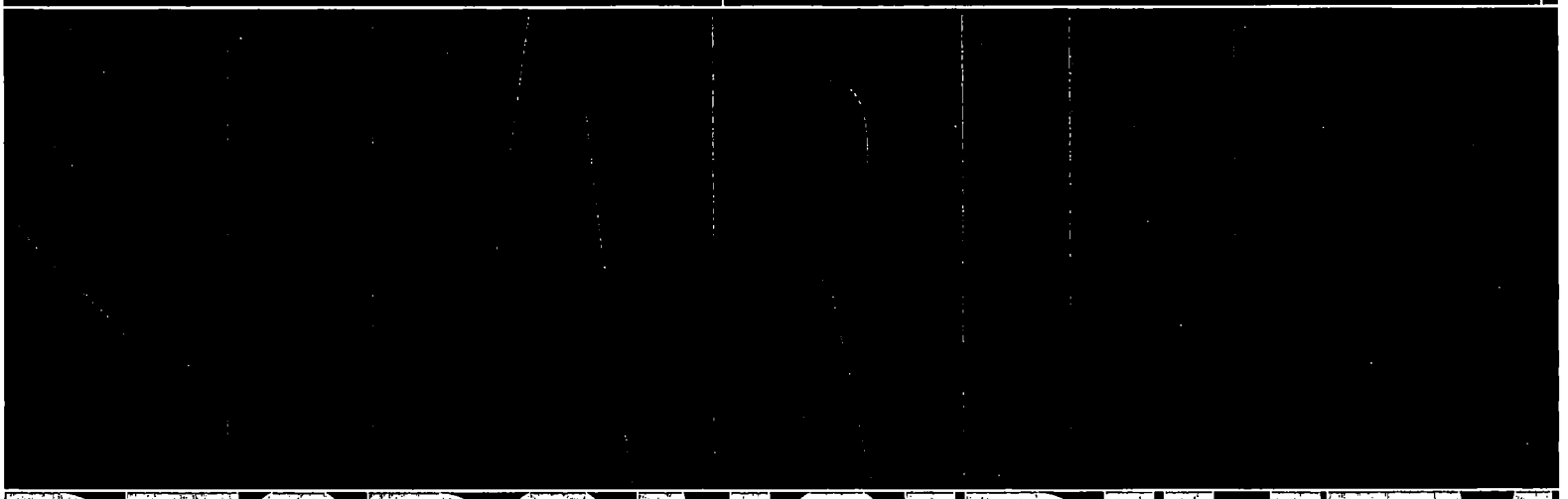

RESPONSIBILITY

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Embargoed until 12/11

Abortion Incidence and Services in the United States, 1995–1996

By Stanley K. Henshaw

Context: *In the 1980s, the number of abortion providers in the United States began to decline, and more recently, so has the number of abortions performed. Whether the decline in service providers, which was last documented in 1992, is continuing and whether this influences the availability and number of abortions is of public interest.*

Methods: *In 1997, the Alan Guttmacher Institute conducted its 12th survey of all known abortion providers in the United States. The number and location of abortion providers and abortions were tabulated for 1995 and 1996, and trends were calculated by comparing these data with those from earlier surveys. Limited data were also gathered on types of abortion procedures.*

Results: *Between 1992 and 1996, the number of abortions fell from 1,529,000 to 1,366,000, and the abortion rate decreased from 26 to 23 per 1,000 women aged 15–44. The number of providers fell 14%, to 2,042, with the greatest decline among hospitals and physicians' offices rather than clinics. Eighty-six percent of counties had no known abortion provider, and 32% of women aged 15–44 lived in these counties. Of the country's 320 metropolitan areas, 89 had no known abortion provider, and for an additional 12, fewer than 50 abortions each were reported. Seventy percent of abortions were performed in specialized clinics and only 7% in hospitals. In the first half of 1997, early medical abortions were being offered in about 160 facilities, virtually all of which were also providers of surgical abortions.*

Conclusions: *While abortion services in some areas of the country have declined since 1992 and many women continue to have limited access to providers, other factors have probably had more influence on the level of abortions performed. Early medical abortion methods are too new to be a measurable factor in abortion access.*

Family Planning Perspectives, 1998, 30(6):263–270 & 287

Reduced access to abortion services in the United States was last documented by data from 1992.[1] These data showed a decrease in the number of abortion providers, more limited availability of abortion services in some geographic areas and a shift of services away from hospitals to specialized clinics. Between 1988 and 1992, the number of abortion service providers fell by an average of 65 a year, and in 1992, 30% of women lived in a county without an abortion provider.

In addition, between 1990 and 1992, the number of abortions and the abortion rate declined slightly. Analysis suggested that reduced availability of abortion services may have been responsible for part of the decline, although other factors, including a reduced rate of unintended pregnancy,[2] may have been more important. From 1992 to 1995, the abortion rate fell by an additional 13%, according to data compiled by the Centers for Disease Control and Prevention (CDC) from state health department reports and its own surveys.[3] However, no information has been available since 1992 on changes in the number or geographic distribution of abortion providers or their possible influence on the abortion rate.

Along with the prevalence of abortion services, the development of methods of early medical (nonsurgical) abortion has the potential to affect the availability and utilization of these services. By 1995, mifepristone, in combination with a prostaglandin, was offered on a limited basis under experimental protocols up to 63 days from the woman's last menstrual period; however, this method has not been approved by the Food and Drug Administration (FDA), and its future availability is unknown. In 1996, the effectiveness of a second medical method to induce abortion early in pregnancy, methotrexate (also used with a prostaglandin), began to gain attention;[4] methotrexate has FDA approval, but for uses that do not include abortion. The availability of these methods may have encouraged more physicians to provide abortions, may have increased the number of women seeking abortion or simply may have replaced surgical procedures.

This article provides new information on the number and geographic distribution of abortion providers as of 1996, and updates national and state-level data on the number of abortions performed and abortion rates. The availability of abortion services by state, metropolitan area and county is documented and compared with past years. Also described are trends in the types of providers, the extent to which early medical abortion is used, the frequency of dilation and extraction abortions, and the other services offered by abortion providers.

The data are derived from the 12th national survey by The Alan Guttmacher Institute (AGI) of all known abortion providers. These surveys are the only national source of information on the number and type of providers and their geographic distribution. In addition, for almost all states and for the United States as a whole, the AGI surveys are the most complete source of information on the number of abortions performed. While abortion statistics are collected by most state health departments and are compiled annually by the CDC,[5] comparison of the 1992 CDC report[6] with the results of the AGI survey for that year[7] indicates that the reporting of abortions is incomplete in most states. In addition, few states publish information about abortion providers.

Methods

Beginning in July 1997, we mailed questionnaires to all hospitals, clinics and physicians' offices thought to have provided abortions during 1995 or 1996. The mailing list included all facilities surveyed by AGI in 1993, excluding those that did not perform abortions in 1992, those that informed AGI in 1993 that they no longer performed abortions and those that were known to have closed before 1995. Added to the list were the names of possible new providers, obtained from the telephone yellow pages for the entire country, Planned Parenthood affiliates, the chapters of the National Abortion and Reproductive Rights Action League, the membership directory of the National Abortion

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Table 1. Number of reported abortions, abortion rate and abortion ratio, United States, 1973–1996

Year	Abortions (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	(1,575.0)	(28.5)	(30.4)
1984	1,577.2	28.1	29.7
1985	1,588.6	28.0	29.7
1986	(1,574.0)	(27.4)	(29.4)
1987	1,559.1	26.9	28.8
1988	1,590.8	27.3	28.6
1989	(1,566.9)	(26.8)	(27.5)
1990	(1,608.6)	(27.4)	(28.0)
1991	1,556.5	26.3	27.4
1992	1,528.9	25.9	27.5
1993	(1,500.0)	(25.4)	(27.4)
1994	(1,431.0)	(24.1)	(26.7)
1995	1,363.7	22.9	26.0
1996	1,365.7	22.9	26.1

*Abortions per 1,000 women aged 15–44. †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). *Note:* Figures in parentheses are estimated by interpolation of numbers of abortions. *Sources:* All data, 1973–1992: reference 1. Abortion data, 1993–1996: AGI Abortion Provider Survey. Population data, 1993–1996: U.S. Bureau of the Census, U.S. population estimates, by age, sex, race, and Hispanic origin: 1990 to 1994, PPL-21, March 1995, Table 1 [for 1993 and 1994]; and U.S. Bureau of the Census, Estimates of the population of the U.S., regions, divisions, and states, by 5-year age-groups and sex: annual time series, July 1, 1990 to July 1, 1996, ST-96-11, Dec. 18, 1997 [for 1995 and 1996]. Birth data, 1993–1997: National Center for Health Statistics (NCHS), Advance report of final natality statistics, *Monthly Vital Statistics Report*, 1995, Vol. 44, No. 3, Supplement [for 1993]; 1996, Vol. 44, No. 11, Supplement [for 1994]; 1997, Vol. 45, No. 11, Supplement [for 1995]; 1998, Vol. 46, No. 11, Supplement [for 1996]; and NCHS, Births, marriages, divorces, and deaths for August 1997, *Monthly Vital Statistics Report*, 1998, Vol. 46, No. 8 [for Jan.–June 1997].

Federation and other miscellaneous sources. Our updated list included a total of 2,948 possible providers.

During the follow-up of nonrespondents and mail returns, 84 additional potential providers were identified and surveyed. Sixty-three others were identified from state health department information but were not surveyed, as health department data for these facilities could be used.

We created two versions of the questionnaire, one for hospitals and one for clinics and physicians' offices. Both asked the number of induced abortions performed at the location in 1995 and 1996;* in addition, hospitals were asked the number of inpatient and outpatient procedures performed. Nonhospital facilities were asked a number of questions about services provided, the clients, charges, sources of payment, harassment and abortion procedures used. For each of three procedures—early medical abortion, intact dilation and extraction, and other sharp or suction curettage—we asked the number performed in 1996, the number performed from January through June of 1997 and the minimum and maximum gestation limits. We also asked the providers whether they expect to offer early medical abortions within the next 12 months if mifepristone is available and if it is not available.

We sent up to four follow-up mailings. For facilities that did not respond to the mailings, we used health department data on the number of abortions from states that provide information on individual facilities. We contacted the remaining nonrespondents by telephone and asked the number of abortions they had performed; some of the facilities hesitant to cooperate required up to 20 calls before we obtained information or a final refusal.

Of the 3,032 facilities surveyed (including those identified after the initial mailing), 1,279 responded to the mailed questionnaire, 176 faxed or mailed a response after telephone follow-up, 706 provided information by telephone, 123 were determined to have closed and to have not performed abortions during 1995 or 1996, and 80 were found to be duplicates; health department data were used for 365. The remaining 303 facilities either did not respond to requests for data or had closed, moved or could not be located, and we could not confirm that no abortions had been performed at these facilities during 1995 and 1996. For 109 of them, we obtained estimates of the number of abortions performed in 1995 and 1996 from knowledgeable sources in their communities. We made our own estimates for an additional 48 facilities that we knew to have provided abortions; for almost all of them, we were able to project the number of abortions using data from previous years. Of the abortions recorded for 1996, 79% were reported by the providers, 12% were estimated by local experts, 9% came from health department data and 1% were projected from previous years.

No abortions were attributed to the remaining 146 facilities, for which no data or estimates were available; these were not counted as providers in 1995–1996. Forty-two had either moved or lost their physician, and we cannot be sure that no abortions were provided during 1995 and 1996. Among those for which data were available for 1992, a total of 10,000 abortions had been provided in that year.

It has become increasingly difficult to obtain the cooperation of some abortion providers due to fear of antiabortion harassment, even though we assure respondents that we do everything possible to preserve their confidentiality. Response to our mailed questionnaires before telephone follow-up fell from 51% in 1993 to 42% in the current survey. The initial response rate of large abortion providers was above the overall average, and that of newly established providers performing small numbers of abortions was below average. Nevertheless, with extensive follow-up and investigation, we were able to obtain data or estimates for 95% of the facilities identified as possible providers.

Some providers undoubtedly were missed because they could not be identified. These were likely to have been small providers, since facilities that perform large numbers of abortions usually advertise and are known by referral sources such as Planned Parenthood.

The number of providers missed can be estimated by surveying a random sample of physicians and hospitals not on our list of possible providers. For the current survey, we drew a probability sample of 288 such hospitals listed in a directory of hospitals.[8] These hospitals were surveyed with the questionnaire for hospital providers and were telephoned if no response was received after three mailings. Of the sample, nine said they had provided, on average, 34 abortions in 1996, 277 said they had provided no abortions, one refused to respond and one was closed.

Projecting to the universe of unsurveyed hospitals, we estimate that we missed approximately 124 hospital providers and 4,200 hospital abortions in the provider survey. In 1993, a similar sample survey found that 159 hospitals, providing approximately 3,600 abortions, may have been missed in the 1992 study of abortion providers. For the current survey, we were unable to carry out a verification survey of physicians, but a 1993 sample survey of obstetrician-gynecologists indicated that in 1992 we may have missed approximately 1,000 physicians who collectively performed 44,000 abortions.

The results of these methodological studies indicate that the actual number of

*An abortion was defined as "any procedure, including menstrual extraction and menstrual regulation, intended to terminate a pregnancy." Although few menstrual regulations without a pregnancy test are performed today, the wording of the question has been kept consistent since 1974, when the practice was more common. In a majority of such cases, the woman was pregnant (Source: Fortney JA et al., Competing risks of unnecessary procedures and complications, *Studies in Family Planning*, 1977, 8(10):257–269). Some physicians use "menstrual extraction" as a euphemism for early abortion. In states with good abortion reporting, our survey yields about the same number of abortions as the state data system; this indicates that the wording of our question does not inflate the results.

Table 3. Percentage of counties with no abortion providers and with no providers reporting 400 or more abortions, and percentage of women aged 15–44 living in those counties, by metropolitan status, according to year

Provider and metropolitan status	1978	1985	1992	1996
COUNTIES				
No provider	77	82	84	86
Metropolitan	47	50	51	55
Nonmetropolitan	85	91	94	95
No provider of ≥400 abortions	93	92	92	92
Metropolitan	69	65	68	66
Nonmetropolitan	99	99	99	100
WOMEN				
No provider in county	27	30	30	32
Metropolitan	12	15	16	18
Nonmetropolitan	69	79	85	87
No provider of ≥400 abortions in county	43	43	41	41
Metropolitan	25	26	27	27
Nonmetropolitan	96	98	97	98

Note: The classification of counties as metropolitan changed slightly between surveys except in 1996, when the same definition was used as in 1992. *Sources:* 1978—Henshaw S et al., Abortion in the United States, 1978–1979, *Family Planning Perspectives*, 1981, 13(1):6–18, Table 3. 1985—Henshaw SK, Forrest JD and Van Vort J, Abortion services in the United States, 1984 and 1985, *Family Planning Perspectives*, 1987, 19(2):63–70, Table 2. 1992—reference 1. 1996—AGI Abortion Provider Survey.

Florida as well (Table 2). The rate for the District of Columbia (155 per 1,000) was higher than that of any state; relatively high rates are characteristic of central cities generally, and the rate includes large numbers of women from outside the District who seek abortion services there.[9] The census divisions with the highest rates are those on the East and West Coasts: the Middle Atlantic, Pacific, South Atlantic and New England states.

Five states had abortion rates below eight per 1,000: Idaho (6), Mississippi (7), South Dakota (7), West Virginia (7) and Wyoming (3). All of these states are mostly rural, with no large metropolitan areas. Among the census divisions, rates were lowest in the East South Central and West North Central states.

Between 1992 and 1996, the abortion rate declined 12% nationally, and it decreased in 43 of the 50 states (based on state of occurrence). Declines were greatest in the Pacific census division (22%), with a fall of 41% in Hawaii, 24% in Washington and 22% in California. Decreases also were especially large in Mississippi, Wyoming, Maine, and Delaware. In Mississippi and Maine, the largest abortion provider closed between 1992 and 1996, and in Delaware one of the two largest closed. The only two areas that recorded an increase in the abortion rate of more than 10%—New Jersey and the District of Columbia—had more providers in 1996 than in 1992. (Improved reporting may also have been a factor in New Jersey.)

However, abortion rates by state of occurrence should be interpreted cautiously, because they do not always reflect the extent of abortions obtained by residents, who may travel out-of-state for services. For example, in 1992, the most recent year for which such calculations have been made, the number of Wyoming residents who had abortions in other states was more than twice the number of residents who had abortions in the state. In Idaho, Missouri and West Virginia, the abortion rate among state residents was more than 40% higher than the rate based on the abortions occurring in the state. By the same token, abortion rates are inflated in the states that provide services to large numbers of out-of-state women. In 1992, the rates by state of residence were 26–48% lower than the rates by state of occurrence in the District of Columbia, Kansas and Vermont.

Service Availability

The proportion of counties with no abortion providers and the proportion of women who live in a county with no provider are indicators of the availability of abortion services. (These measures are imperfect, of course, because some women live close to a provider in a neighboring county, some providers are not readily accessible because of their high charges or their limitations on the patients they will accept, and some serve only a small number of abortion patients and rarely advertise their services.) Another potentially useful measure is the proportion of counties lacking a provider that is large enough to be likely to advertise and accept self-referred patients (which for this analysis we assume to be a facility that provided 400 or more abortions during the year).

In 1996, 86% of all U.S. counties had no identified abortion provider (Table 3), and 92% had none that performed as many as 400 abortions annually. Thirty-two percent of women of reproductive age lived in counties with no provider, and 41% lived in counties without a large provider. The proportion of counties with no provider was slightly higher than in 1992 (84%), continuing a long-term trend first seen in the late 1970s. However, the proportion of women who lived in a county with no provider of 400 or more abortions changed little between 1992 and 1996, after having declined from 1985 to 1992.

Abortion providers are much less available in nonmetropolitan than in metropolitan counties. Ninety-five percent of nonmetropolitan counties had no abortion services, and 87% of nonmetropolitan women lived in unserved counties. In 1996, only 1% of abortions (14,070 abortions) were reported in nonmetropolitan counties, where 18% of women of reproductive age lived (not shown).

More than half of metropolitan coun-

Table 4. Metropolitan areas reporting no abortions (or fewer than 50), by state, 1996

Alabama
Anniston
Decatur
Dothan
Florence
Gadsden

Arizona
Yuma

Arkansas
Fort Smith
Pine Bluff
Texarkana

California
Merced
Visalia
(Yuba City)

Florida
Bradenton
Fort Walton Beach
Ocala
Panama City

Georgia
(Albany)
Athens
Macon

Illinois
Bloomington
Decatur
Joliet
Kankakee
(Springfield)

Indiana
Anderson
Elkhart
Evansville
Kokomo
Lafayette
Muncie
Terre Haute

Iowa
Davenport
Dubuque
Sioux City

Kentucky
Owensboro

Louisiana
Alexandria
Houma
Lafayette
Lake Charles
Monroe

Maine
Lewiston

Maryland
Cumberland

Michigan
Battle Creek

Minnesota
St. Cloud

Mississippi
Pascagoula

Missouri
Joplin
St. Joseph

New Jersey
(Vineland)

New Mexico
(Las Cruces)

New York
(Elmira)
(Jamestown)
Niagara Falls

North Carolina
Burlington
(Hickory)

North Dakota
Bismarck
Grand Forks

Ohio
(Canton)
Hamilton
Lima
Lorain
Mansfield
Steubenville

Oklahoma
Enid
Lawton

Pennsylvania
Altoona
Beaver County
Erie
Johnstown
Lancaster
Sharon
State College
Williamsport

South Carolina
Anderson

South Dakota
Rapid City

Tennessee
Clarksville
Jackson

Texas
Abilene
Amarillo
Brazoria
Bryan
(Galveston)
Killeen
Longview
San Angelo
Sherman
Tyler
Victoria
Wichita Falls

Utah
Provo

Virginia
(Lynchburg)

West Virginia
Huntington
Parkersburg
Wheeling

Wisconsin
Eau Claire
Janesville
Kenosha
(La Crosse)
Racine
Sheboygan
Wausau

Wyoming
Cheyenne

ties, however, also were unserved, and abortion services were effectively unavailable in one-third of U.S. cities. Of the country's 320 metropolitan areas,* 89 had no known abortion provider and an additional 12 had providers that together reported fewer than 50 abortions in 1996 (Table 4). The states with the most unserved or underserved metropolitan areas were Texas (12), Pennsylvania (eight) and Wisconsin and Indiana (seven each).

Since 1992, however, four metropolitan areas were removed from the list of unserved cities because new clinics were established. In addition, six cities where fewer than 50 abortions had been performed in 1992 moved out of that category, three because of new facilities and three because existing providers increased their level of services. The gain in newly served cities was offset in part by a loss and decline of services in other metropolitan areas.

On the state level, a measure of the availability of services is the proportion of counties without any identified abortion provider (Table 5). In 41 states, a majority of counties had no provider, including 21 states where more than 90% of counties had none. On the other hand, all four counties in Hawaii had physicians performing abortions.

The proportion of women in a state living in a county without a provider (another measure of the availability of services) varied from 0% to 84%. In Mississippi, North Dakota and West Virginia, 80% or more of women lived in unserved counties; in contrast, the percentage of women living in unserved counties was very low in California, Massachusetts and New Jersey as well as Hawaii. The East South Central and West North Central states had the highest proportion of women living in counties without providers (65% and 57%, respectively); this proportion was lowest on the coasts, in the Pacific, New England and Middle Atlantic states.

The proportion of women aged 15–44 who lived in counties with a provider is highly correlated with abortion rates according to state of occurrence (r=0.82). (The correlation with the abortion rate by state of *residence* would be lower, since women from unserved states travel to service providers in other states.)

In 1996, abortion services were provided in 2,042 facilities, a decline of 14% since 1992. This represents a decrease of 85 providers per year, compared to a drop of

*As defined by the U.S. Office of Management and Budget, June 30, 1990.

Table 5. Number of counties and number and percentage of counties without an abortion provider, and percentage of women aged 15–44 living in a county without a provider, 1996; and number of providers, 1982, 1992 and 1996, and change in number between 1992 and 1996; all by census division and state

Census division and state	Counties				No. of providers			
	N	Without provider, 1996			1982	1992	1996	Number change, 1992–1996
		N	%	% of women*				
Total	**3,139**	**2,696**	**86**	**32**	**2,908**	**2,380**	**2,042**	**–338**
New England	**67**	**27**	**40**	**12**	**205**	**162**	**141**	**–21**
Connecticut	8	2	25	10	46	43	40	–3
Maine	16	9	56	39	39	17	16	–1
Massachusetts	14	2	14	0	78	64	51	–13
New Hampshire	10	5	50	26	18	16	16	0
Rhode Island	5	3	60	37	5	6	5	–1
Vermont	14	6	43	23	19	16	13	–3
Middle Atlantic	**150**	**78**	**52**	**16**	**516**	**458**	**421**	**–37**
New Jersey	21	2	10	3	100	88	94	6
New York	62	26	42	8	302	289	266	–23
Pennsylvania	67	50	75	37	114	81	61	–20
East North Central	**437**	**392**	**90**	**43**	**255**	**197**	**161**	**–36**
Illinois	102	92	90	30	58	47	38	–9
Indiana	92	86	93	61	30	19	16	–3
Michigan	83	67	81	28	83	70	59	–11
Ohio	88	80	91	50	55	45	37	–8
Wisconsin	72	67	93	62	29	16	11	–5
West North Central	**618**	**595**	**96**	**57**	**110**	**63**	**51**	**–12**
Iowa	99	95	96	69	25	11	8	–3
Kansas	105	100	95	48	23	15	10	–5
Minnesota	87	83	95	57	20	14	13	–1
Missouri	115	110	96	53	29	12	10	–2
Nebraska	93	90	97	47	8	9	8	–1
North Dakota	53	52	98	80	3	1	1	0
South Dakota	66	65	98	79	2	1	1	0
South Atlantic	**591**	**478**	**81**	**37**	**515**	**435**	**361**	**–74**
Delaware	3	1	33	15	7	8	7	–1
District of Columbia	1	0	0	0	14	15	18	3
Florida	67	49	73	22	140	133	114	–19
Georgia	159	143	90	49	82	55	41	–14
Maryland	24	13	54	15	52	51	47	–4
North Carolina	100	74	74	39	114	86	59	–27
South Carolina	46	37	80	58	15	18	14	–4
Virginia	136	108	79	48	81	64	57	–7
West Virginia	55	53	96	84	10	5	4	–1
East South Central	**364**	**347**	**95**	**65**	**116**	**70**	**48**	**–22**
Alabama	67	62	93	58	45	20	14	–6
Kentucky	120	118	98	75	11	9	8	–1
Mississippi	82	79	96	82	13	8	6	–2
Tennessee	95	88	93	54	47	33	20	–13
West South Central	**470**	**440**	**94**	**42**	**177**	**115**	**96**	**–19**
Arkansas	75	73	97	78	13	8	6	–2
Louisiana	64	59	92	60	18	17	15	–2
Oklahoma	77	73	95	54	18	11	11	0
Texas	254	235	93	32	128	79	64	–15
Mountain	**280**	**243**	**87**	**35**	**211**	**156**	**127**	**–29**
Arizona	15	12	80	19	37	28	24	–4
Colorado	63	50	79	34	73	59	47	–12
Idaho	44	41	93	67	15	9	7	–2
Montana	56	50	89	41	20	12	11	–1
Nevada	17	14	82	12	25	17	14	–3
New Mexico	33	29	88	47	26	20	13	–7
Utah	29	27	93	49	7	6	7	1
Wyoming	23	20	87	75	8	5	4	–1
Pacific	**162**	**96**	**59**	**7**	**803**	**724**	**636**	**–88**
Alaska	25	19	76	23	14	13	8	–5
California	58	21	36	3	583	554	492	–62
Hawaii	4	0	0	0	51	52	44	–8
Oregon	36	29	81	38	60	40	35	–5
Washington	39	27	69	15	95	65	57	–8

*Population estimates are for 1995. *Sources:* 1982 and 1992—reference 7. Abortion and provider data, 1996—AGI Abortion Provider Survey. Population estimates—Market Statistics, New York.

Table 6. Number and percentage distribution of abortion providers and of abortions obtained, by type of facility, according to caseload, 1996

Caseload*	Total		Hospitals		Abortion clinics		Other clinics		Physicians' offices†	
	N	%	N	%	N	%	N	%	N	%
Providers	**2,042**	**100**	**703**	**34**	**452**	**22**	**417**	**20**	**470**	**23**
<30	648	32	406	20	0	0	37	2	205	10
30–390	656	32	249	12	15	1	127	6	265	13
400–990	284	14	36	2	81	4	167	8	na	na
1,000–4,990	426	21	10	‡	333	16	83	4	na	na
≥5,000	28	1	2	‡	23	1	3	‡	na	na
Abortions	**1,365,730**	**100**	**92,890**	**7**	**951,610**	**70**	**282,970**	**21**	**38,260**	**3**
<30	8,320	1	4,490	‡	0	0	620	‡	3,210	‡
30–390	89,750	7	31,190	2	3,600	‡	19,910	1	35,050	3
400–990	167,880	14	22,300	2	61,600	5	103,980	8	na	na
1,000–4,990	880,790	64	20,640	2	718,050	53	142,100	10	na	na
≥5,000	198,990	15	14,270	1	168,360	12	16,360	1	na	na

*Here and in Table 7, caseloads are rounded to nearest 10. †Here and in Table 7, physicians' offices reporting 400 or more abortions a year are classified as clinics (either abortion clinics or "other clinics"). ‡Fewer than 0.5%. Notes: na=not applicable. Percentages may not add to 100 due to rounding.

51 per year between 1988 and 1992. The number of providers has been declining since 1982, when it was at a high of 2,908.

Between 1992 and 1996, the number of identified providers fell in all census divisions and in all states except the District of Columbia, New Jersey and Utah, which experienced increases, and New Hampshire, North Dakota and South Dakota, where there was no change. The largest decrease occurred in California (62), which nevertheless continued to have more providers (492) than any other state. Decreases of 20 or more also occurred in New York, North Carolina and Pennsylvania. The percentage decline was greater in the East South Central states (31%) than in other census divisions (not shown). The number of providers fell by one-third or more in Tennessee (39%), Alaska (38%), New Mexico (35%) and Kansas (33%). In Tennessee, New Mexico and Kansas, the loss of providers continued declines that were evident between 1982 and 1992.

Types of Providers

An abortion provider was defined as a place where abortions are performed, whether a hospital, clinic or physician's office. If an organization offered abortion services at more than one location, each service site was counted as a provider. The number of providers is different from the number of physicians who perform abortions, because one physician could be responsible for services in several facilities, and several physicians could perform abortions in a single setting.

• *Hospitals.* The 2,042 abortion providers in 1996 included 703 hospitals where one or more abortions were performed during the year (Table 6). As a proportion of all providers, hospitals declined from 36% in 1992 to 34% in 1996 (not shown); in 1973, 81% of all providers had been hospitals.[10] Similarly, the number of abortions performed in hospitals fell from 110,000 in 1992 to fewer than 93,000 in 1996, although the proportion of all abortions that were performed in hospitals remained at about 7%.

Abortions were performed in only 14% of short-term, general, nonfederal hospitals (16% if Catholic hospitals are excluded). These proportions are two percentage points lower than in 1992. Private (including voluntary) hospitals were somewhat more likely to offer abortion services (18%, excluding Catholic hospitals) than were public hospitals (10%, not shown).

In many of the hospitals classified as providers, only a few abortions are performed. Hospitals that allow abortions to be performed only when a woman's life or health are threatened by the continuation of her pregnancy are counted as abortion providers, even if only one abortion was performed at the facility. A majority (58%) of the hospitals that reported abortions provided fewer than 30 abortions each; these facilities together accounted for only about 4,500 procedures. In 1996, only 12 hospitals performed 1,000 or more abortions.

In keeping with the national trend toward day surgery, a large majority of hospital abortions are performed as outpatient procedures. In 1996, the proportion of inpatient abortions fell to 9%, down from 11% in 1992 (not shown). Of all abortions, fewer than 1% involved hospitalization of the woman (excluding cases where the woman may have been hospitalized for treatment of complications).

• *Nonhospital facilities.* Most abortions are performed in the country's 452 abortion clinics (defined as nonhospital facilities in which half or more of patient visits are for abortion services).* The proportion of abortions that are performed in abortion clinics increased from 60% in 1985 to 69% in 1992 and 70% in 1996, although only 22% of all providers are abortion clinics.

"Other clinics" include group practices with clinic names, surgical centers, health maintenance organizations, family planning clinics and other facilities with clinic names. (In addition, physicians' offices where 400 or more abortions were performed in 1996 were counted as "other clinics" if they did not fit our definition of abortion clinics.) The "other clinics" accounted for 20% of all abortion providers and 21% of abortions in 1996. Four out of five performed fewer than 1,000 abortions a year, compared with only one of five abortion clinics.

Physicians' offices comprise both solo and group practices where fewer than 400 abortions were performed in 1996. (However, some similar providers were counted as clinics because they had adopted clinic-like names.) Approximately 44% of physicians' offices reported 30 or fewer abortions in 1996, and the group as a whole performed only 3% of the country's abortions, down from 4% in 1992.

• *Trends in numbers of providers.* While the overall number of providers dropped by 14% between 1992 and 1996, the loss was greater among hospitals (18%) than among nonhospital facilities (12%), and was greater among public hospitals (23%) than among private ones (16%) (Table 7). This pattern of change was the same between 1982 and 1992, when the number of public hospital providers fell from 331 to 180. There are now only 42% as many public hospital providers as in 1982 and 53% as many private ones.

The change in the number of nonhospital providers has been much less pronounced and has occurred almost entirely among physician practices. In 1996, there were 20 fewer clinics than in 1992, but 80 more than in 1982. From 1992 to 1996, the number of abortion clinics increased by 11, while the number of other clinics providing abortions decreased by 31 (not shown). At the same time, abortion services provided by physicians' offices declined 26%. The decline was greater among

*These facilities may or may not be licensed as surgical centers, abortion clinics, ambulatory care centers or other types of clinics. Self-defined clinics that did not provide information about the percentage of patient visits made for abortion were classified as abortion clinics if they reported 1,000 or more abortions during 1996. Facilities self-defined as a physician's office (i.e., a facility that had not adopted a clinic name) had a cutoff of 1,500 abortions.

physicians' practices that provided 30–390 abortions, possibly because some practices moved from the larger category to the smaller one (fewer than 30 abortions) as a consequence of falling caseloads.

Although the total number of providers for whom abortion services are an important activity has changed little, there is always some turnover between surveys: Clinics close or stop offering services, and new clinics are established. Fifty-one clinics that reported 400 or more abortions in 1992 reported none in 1996, while 98 of those reporting 400 or more abortions in 1996 began their abortion services after 1992.

We reviewed our records for any information that might explain why clinics that had provided more than 400 abortions in a year no longer provided any. Two continued to exist, but no longer offered abortion services. Twenty-seven had closed, and while we do not know why, several of them mentioned antiabortion harassment when they were surveyed in 1992 in answer to a question about factors that made it difficult to provide abortion services. In nine instances the physician retired or died, in five the physician lost his or her license, in three the clinic moved to a different county, two had difficulty finding a physician to perform abortions, one closed in bankruptcy, one burned down and no information could be found for one.

•*Services offered.* Abortion providers usually do far more than simply perform abortions. To obtain a fuller understanding of the types of facilities where abortions are performed, we asked nonhospital providers whether they offered general medical care, general gynecologic care and contraceptive services to nonabortion patients. Of nonhospital providers, abortion clinics were the most specialized; nevertheless, 83% offered contraceptive services independently of their abortion services, 74% provided gynecologic care and 20% provided general medical care. Almost all of the other clinics offered contraceptive services (97%) and gynecologic care (94%), and 53% provided general medical care. More than 99% of the physicians' offices provided gynecologic and contraceptive care, and 69% served general medical patients.

•*Medical abortion.* The advent of early medical abortion in recent years is a potentially important development. In our survey, 82 nonhospital facilities said they had performed one or more early medical abortions during 1996, and 114 said they had done so in the first half of 1997. Assuming that nonrespondents offered medical abortion services in the same proportions as respondents with similar abortion caseloads, approximately 117 clinics and doctors' practices were performing medical abortions in 1996 and 163 in 1997. The 1997 estimated number represents 12% of all nonhospital providers. An even larger percentage (44%), including most of the current providers, responded that they will probably provide medical abortions within the next 12 months if mifepristone becomes available, and 29% said they would do so even if it is not available.

Table 7. Number of abortion providers in 1982, 1992 and 1996, and change between 1992 and 1996, by type of facility

Type of facility	1982	1992	1996	Change, 1992–1996	
				N	%
Total	**2,908**	**2,380**	**2,042**	**–338**	**–14**
Hospital	**1,405**	**855**	**703**	**–152**	**–18**
Public	331	180	139	–41	–23
Federal	4	1	1	0	0
State	43	34	33	–1	–3
Hospital district	135	68	46	–22	–32
County	88	42	34	–8	–19
City or city/county	61	35	25	–10	–29
Private	1,074	675	564	–111	–16
Voluntary, church	63	39	35	–4	–10
Voluntary, other	806	529	443	–86	–16
Proprietary	205	107	86	–21	–20
Nonhospital	**1,503**	**1,525**	**1,339**	**–186**	**–12**
Clinics	789	889	869	–20	–2
<30	14	45	37	–8	–18
30–390	118	154	142	–12	–8
400–990	218	237	248	11	5
1,000–4,990	408	410	416	6	1
>5,000	31	43	26	–17	–40
Physicians' offices	714	636	470	–166	–26
<30	180	215	205	–10	–5
30–390	534	421	265	–156	–37

Note: Hospitals are classified by type of administrative entity; nonhospital providers are classified by annual abortion caseload. *Sources:* 1982—Henshaw SK, Forrest JD and Blaine E, Abortion services in the United States, 1981 and 1982, *Family Planning Perspectives*, 1984, 16(3):119–127, Table 5; 1992—reference 1; 1996—AGI Abortion Provider Survey.

The likelihood that early medical abortions were performed was strongly related to the size of the abortion caseload. Among those who reported fewer than 400 abortions in 1996, only 7% performed medical abortions in the first half of 1997, compared with 16% of those providing 400–990 abortions and 17% of providers of 1,000 or more abortions. Expectations for the future, however, are much less associated with provider size; the proportion expecting to offer medical abortion, even without mifepristone, ranges from 26% of the smallest to 31% of the largest providers.

Respondents were asked how many early medical abortions they had performed. Assuming that nonrespondents provided them at the same rate as respondents, approximately 4,200 medical abortions were performed in 1996 and 4,300 in the first half of 1997, indicating a rapid increase in the use of the method.

Respondents also were asked if they were aware of physicians in their community who did not provide surgical abortion services but who had begun to perform medical abortions. The few who answered in the affirmative were recontacted and asked the names of the physicians. In many cases, the respondents had misunderstood the question and did not in fact know of any such providers. Only one respondent named a physician whose office confirmed that medical abortions were provided, and one named a physician who denied performing any abortions. Six respondents had reason to believe physicians in their community performed medical abortions, but refused to supply the names because they felt they would be betraying a confidence if they told us. Six others said they had heard rumors but did not know the names of the physicians. Seven could not be reached.

•*Dilation and extraction procedures.* In view of the ongoing controversies around so-called partial-birth abortions, we wanted to shed light on the number of such abortions that were actually performed. "Partial-birth" abortion, however, is a nonmedical term that has been variably described in the popular press and in legislation, and would be difficult for respondents to interpret. On the questionnaire, therefore, we used the medically accepted term, intact dilation and extraction (D&X), as defined by the American College of Obstetricians and Gynecologists (ACOG),* which is the only procedure that approximates the various descriptions of "partial-birth" abortion.

Eight respondents reported that they had performed a total of 363 D&X abor-

*1. Deliberate dilatation of the cervix, usually over a sequence of days; 2. instrumental conversion of the fetus to a footling breech; 3. breech extraction of the body excepting the head; and 4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus. (See: American College of Obstetricians and Gynecologists (ACOG), *ACOG Statement of Policy: Statement on Intact Dilatation and Extraction*, Washington, DC: ACOG, Jan. 12, 1997.)

tions in 1996 and 201 during the first half of 1997, and one other physician reported using the procedure. But several of them reported that they had difficulty estimating the exact number of abortions they had performed that met all components of the definition. Some D&X abortions were undoubtedly performed in facilities that did not return our questionnaire;* if nonrespondents used the procedure at the same rate as responding facilities, we can project that 14 providers performed a total of about 650 D&X abortions in 1996. However, projecting from such a small number of cases can result in a wide range of possible error.

Respondents were asked the minimum and maximum gestation at which they perform D&X abortions. The most common minimum gestation was 20 weeks (counting from the last menstrual period), and the most common maximum was 24 weeks. Only two of the nine respondents used the procedure before 20 weeks, one as early as 16 weeks and another 18 weeks. Similarly, only two said their maximum gestation was more than 24 weeks, one 26 weeks and one 33 weeks.† Thus, the large majority of D&X abortions were performed at 20 to 24 weeks.

Discussion

Although the abortion rate in the United States has declined in recent years, at 23 per 1,000 women of reproductive age in 1995 and 1996, it is still high compared with other Western developed countries. For example, in 1995, the abortion rate was 16 per 1,000 in Canada, 15 per 1,000 in England and Wales, six per 1,000 in the Netherlands and 18 per 1,000 in Sweden. The 1995 rates are higher, however, in some countries of the former Soviet Union and eastern and central Europe: 35 per 1,000 in Hungary, 87 per 1,000 in Romania and 68 per 1,000 in Russia.[11] (The rates for Romania and Russia may be undercounts because reporting is believed to be incomplete.)

The U.S. abortion rate declined each year between 1990 (when it was 27 per 1,000) and 1995, and remained the same for 1996. A factor contributing to the decline was the aging of the "baby boomers" into their late 30s and 40s, ages when there are fewer pregnancies and abortions.[12] If the age-specific abortion rates had been the same in 1996 as in 1992, there would have been 38,000 fewer abortions in 1996 than in 1992. This amounts to 23% of the actual decline of 163,000 abortions. Thus, the changed age structure of the U.S. population accounts for some but not most of the decline in the number and rate of abortions. The abortion ratio should be affected even less by the changing age distribution, because birthrates as well as abortion rates are lower among women in their 30s and 40s.

Much of the drop in the abortion rate probably reflects a decreasing rate of unintended pregnancy, which fell among all age-groups between 1987 and 1994.[13] The fall in the abortion rate was especially great among teenagers, some of whom began using effective, long-acting contraceptive methods that were not available before 1992. In 1995, 10% of contraceptive users aged 15–19 were using the injectable and 3% were using the implant.[14]

The abortion rate among teenagers was also affected by a decrease in the proportion of unintended pregnancies terminated by abortion—that is, more teenagers continued their unintended pregnancies in the 1990s than was the case in the mid-1980s. Among women aged 20 and older, in contrast, the proportion of unintended pregnancies resulting in abortion increased.[15] It is unclear whether the increase in the proportion of teenagers continuing their unplanned pregnancies was a result of changes in their preferences or their reduced ability to obtain abortion services.

The reason the abortion rate stopped falling in 1996 is also unclear. One contributing factor may be declining use of the contraceptive implant, a method that received negative publicity about removal problems and product liability lawsuits. There is no way to predict whether the abortion rate will resume its fall, remain stable for some time or increase.

The fall in the U.S. abortion rate is probably not an artifact of declining survey coverage and reporting, although it has become somewhat more difficult over the years to obtain information from abortion providers. The AGI national abortion count exceeded the CDC's by 13% in 1995,[16] about the same amount as in 1992 when the difference was 12%. (At this time, CDC data for 1996 are not yet available.) The CDC relies primarily on reports to state health departments, many of which do not receive reporting from all providers and some of which have voluntary reporting.[17]

Trends in the availability of abortion services are mixed. The number of abortion providers continued its sharp decline between 1992 and 1996, the proportion of counties with no identified provider rose slightly and the proportion of women who live in unserved counties increased as well. The decline in the number of providers was concentrated among hospitals and physicians' practices, however, where only a few abortions are performed. The high costs of small-scale abortion provision[18] and possibly antiabortion sentiment or pressure may have discouraged some hospitals and physicians who had been performing abortions for their own patients but for whom abortion services were not a major commitment or source of revenue; as a consequence, they may have found it more attractive to refer their patients to specialized providers.

The number of nonhospital providers performing 400 or more abortions has not declined, however. Slightly more metropolitan areas had services in 1996 than in 1992, and the number of abortion clinics increased slightly. Thus, facilities that are focused on making abortion services available have held their own in the face of continuing harassment and declining rates of unintended pregnancy.

Nevertheless, many women still have limited access to abortion services. Almost a third of metropolitan areas have no provider, and a similar proportion of women live in unserved counties. Two states—North and South Dakota—have only one provider each. Abortion rates by state of occurrence closely reflect the availability of services within the state.

Early medical abortion has the potential to expand the availability of abortion services in areas without surgical abortion providers and reduce the need for interstate travel, but as of 1997 this potential had not been realized. A few physicians who were not formerly abortion providers are performing medical abortions for some of their private patients, but most do not want their names to be widely known. While these medical abortion services may be valuable to the few patients who have access to them, they do not represent an important expansion of service availability, and because the number of abortions performed by these physicians is small, would not impair the accuracy of our 1996 abortion data.

Early medical abortion may become more common in the future, however. (The company with the rights to the dis-

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*Facilities interviewed by telephone were asked a limited number of questions; they were not asked questions about D&X.

†It was beyond the scope of our survey to ask physicians the medical indications for which they terminate late pregnancies; presumably, the higher limits would encompass abortions considered medically necessary to preserve the health and safety of the woman or for gross fetal anomalies.

1, *Population Research and Policy Review*, 1990, 9(2):151–160.

7. Lundberg S and Plotnick RD, Effects of state welfare, abortion and family planning policies on premarital childbearing among white adolescents, *Family Planning Perspectives*, 1990, 22(6):246–251 & 275; and Ohsfeldt R and Gohmann S, Do parental involvement laws reduce adolescent abortion rates? *Contemporary Economic Policy*, 1994, 12(2):65–76.

8. Trussell J et al., 1980, op. cit. (see reference 5).

9. Kane TJ and Staiger D, Teen motherhood and abortion access, *Quarterly Journal of Economics*, 1996, 111(2):467–506.

10. Lichter DT, McLaughlin DK and Ribar D, Welfare and the rise in female-headed families, *American Journal of Sociology*, 1997, 103(1):112–143; Moffitt RA, Welfare effects on female headship with area effects, *Journal of Human Resources*, 1994, 29(2):621–636; Ellwood DT and Bane MJ, The impact of AFDC on family structure and living arrangements, *Research in Labor Economics*, 1985, 7:137–207; and Winkler AE, The determinants of a mother's choice of family structure: labor market conditions: AFDC policy or community mores? *Population Research and Policy Review*, 1994, 13(3):283–303.

11. Matthews S, Ribar D and Wilhelm M, 1997, op. cit. (see reference 2).

12. U.S. House of Representatives, Committee on Ways and Means, *Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means*. Washington DC: GPO, 1990; U.S. Office of Family Assistance, *Characteristics of State Plans for Aid to Families with Dependent Children Under the Social Security Act, Title IV-A*, Washington DC: GPO, 1980; unpublished data from the U.S. Department of Agriculture, Food and Nutrition Service and U.S. Department of Health and Human Services, Health Care Financing Administration.

13. Lichter DT, McLaughlin DK and Ribar D, 1997, op. cit. (see reference 10).

14. Ibid.; Moffitt RA, 1994, op. cit. (see reference 10), Lichter DT, McLaughlin DK, and Ribar D, 1997, op. cit. (see reference 10); and Blank RM et al., 1996, op. cit. (see reference 3).

15. Levine PB, Trainor AB and Zimmerman DJ, The effect of Medicaid abortion funding restrictions on abortions, pregnancies and births, *Journal of Health Economics*, 1996, 15(5):555–578; Matthews S, Ribar D and Wilhelm M, 1997, op. cit. (see reference 2); and Lundberg S and Plotnick RD, 1990, op. cit. (see reference 7).

16. Matthews S, Ribar D and Wilhelm M, 1997, op. cit. (see reference 2).

17. Kane TJ and Staiger D, 1996, op. cit. (see reference 9).

18. Klerman J, 1996, op. cit. (see reference 1).

19. Ibid.

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tribution of mifepristone expects to have the drug approved and on the market in 1999.[19]) Although medical abortion is offered by few physicians who did not already provide surgical abortions, existing providers appear to be adopting it rapidly. As many medical abortions were performed in the first half of 1997 as in all of 1996, and the number of providers increased 39%. Many other surgical providers say they will probably offer methotrexate in the future, and even more say they intend to provide medical abortions when mifepristone is available.

In the controversy concerning so-called partial-birth abortions, the factual question given most attention is the number of such abortions performed. It is impossible to give a definitive answer to this question because of the vagueness of the term, which has no medically accepted definition. However, intact D&X, as defined by ACOG, is rarely performed, accounting for only about 0.03–0.05% of all abortions in 1996. The large majority of D&X abortions were performed at 20–24 weeks of gestation.

Efforts to reduce the number of abortions can best be focused on reducing unintended pregnancy by improving contraceptive use. The fall in the abortion rate up until 1995 probably resulted in large part from more effective contraceptive use among teenagers. Women of all ages could achieve lower pregnancy rates if they used more effective methods and had better access to family planning services. That lower abortion rates are possible is clear from the examples of other developed countries.

At the same time, women who have an unwanted pregnancy need to be aware of and have access to abortion services; otherwise, they cannot freely decide whether to continue the pregnancy. At present, more than one-fourth of women who live in metropolitan areas have no abortion provider in their county large enough to be well-known in the area, and a majority of women in nonmetropolitan counties live far from any provider. More effort is needed to make services accessible to these women. Short of that, the local health care community needs to ensure that women are able to obtain referral to providers and gain assistance in making arrangements, and receive appropriate follow-up care.

References

1. Henshaw SK and Van Vort J, Abortion services in the United States, 1991 and 1992, *Family Planning Perspectives*, 1994, 26(3):100–106 & 112

2. Henshaw SK, Unintended pregnancy in the United States, *Family Planning Perspectives*, 1998, 30(1):24–29 & 46.

3. Koonin LM et al., Abortion surveillance—United States, 1995, *Morbidity and Mortality Weekly Report*, 1998, Vol. 47, SS-2, pp. 31–68.

4. Schaff EA et al., Combined methotrexate and misoprostol for early induced abortion, *Archives of Family Medicine*, 1995, 4(Sept.):774–779; and Creinin MD et al., Methotrexate and misoprostol for early abortion: a multicenter trial. I. Safety and efficacy, *Contraception*, 1996, 53(6):321–327.

5. Koonin LM et al., 1998, op. cit. (see reference 3).

6. Koonin LM et al., Abortion surveillance—United States, 1992, *Morbidity and Mortality Weekly Report*, 1996, Vol. 45, SS-3, pp. 1–36.

7. Henshaw SK and Van Vort J, 1994, op. cit. (see reference 1).

8. American Hospital Association (AHA), *American Hospital Association Guide to the Health Care Field*, 1996–97 Edition, Chicago: AHA, 1996.

9. Glendinning ST, *Induced Terminations of Pregnancy (Abortions) in the District of Columbia: 1995*, Washington, DC: D.C. State Center for Health Statistics, Commission of Public Health, 1996.

10. Henshaw SK and Van Vort J, *Abortion Factbook, 1992 Edition: Readings, Trends, and State and Local Data to 1988*, Alan Guttmacher Institute, New York, 1992, p. 190.

11. Henshaw SK, Singh S and Haas T, The incidence of abortion worldwide, *International Family Planning Perspectives*, 1998 (forthcoming).

12. Ventura SJ et al., Trends in pregnancies and pregnancy rates: estimates for the United States, 1980–1992, *Monthly Vital Statistics Report*, 1995, 43(11), Supplement.

13. Henshaw SK, 1998, op. cit. (see reference 2).

14. Abma JC et al., Fertility, family planning, and women's health: new data from the 1995 National Survey of Family Growth, *Vital and Health Statistics*, 1997, Series 23, No. 19.

15. Henshaw SK, 1998, op. cit. (see reference 2).

16. Koonin LM et al., 1998, op. cit. (see reference 3).

17. Saul R, Abortion reporting in the United States, *Family Planning Perspectives*, 1998, 30(5):244–247.

18. Henshaw SK, Factors hindering access to abortion services, *Family Planning Perspectives*, 1995, 27(2):54–59 & 87.

19. Haney DQ, First formal US study finds abortion pill 92 percent effective, *Boston Globe*, April 29, 1998.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release January 22, 1997

REMARKS BY THE FIRST LADY AT NATIONAL ABORTION RIGHTS ACTION LEAGUE LUNCHEON

MRS. CLINTON: I am pleased to be here with all of you. And I know that it took a little longer to get into the room than usual, but let me reassure you about the events of this morning. We do not know what the facts are, but law enforcement, as the President said this morning, is working hard to get the bottom of it, and it does not, at least so far as we know at this time, appear to be anything serious that should concern us.

I am very pleased to be here for a number of reasons. One is to join all of you in honoring Robin Chandler Duke. We will hear more about her as the program goes on. But I wanted to thank her publicly for her tireless work on behalf of family planning here at home and particularly internationally, on her advocacy of safe motherhood and other issues critical to women, children and families. She has always understood that these are not marginal concerns. They relate to political and economic progress, human rights, and peace and prosperity here in our country and around the world.

So I wanted to raise my voice with all of yours in commending her for all of her work in raising awareness about family planning and her many other contributions that she has already made and that I know she will continue to make into the future. (Applause.)

I also wanted to come and recognize and thank my friend, Nancy Rubin, for her energy, her wisdom and all of her efforts on behalf of causes relating to women and families. She is a clear and articulate voice for women's rights around the world and has worked to strengthen education, economic opportunities, legal protections and political rights, and has helped from one corner of the world to the next to bring women's issues to the forefront of international and national concerns. (Applause.)

And I know that I speak for all of us and for many others who are not here in thanking Kate Michelman for over a decade of service leading this organization and doing so much to promote and protect a women's right to choose. It has not been an easy mission. And she has

out against policies of forced abortion and sterilization where the government made the choice for women, and traveling to Romania that under the previous communist regime had a policy of enforcing birth -- five children per woman. And I spoke with women who told me of every month being taken as part of their work units to local hospitals where they were forcefully examined to determine whether or not they were pregnant so they could then be monitored by the secret police to be sure they had the child.

Two extremes -- government, on the one hand, saying you cannot have children; government, on the other hand, saying you must have children. What we have tried to do in promoting choice is to say that this most difficult of all intimate choices for women and men must be made by the individual in the privacy of her consultation with her conscience, her God, her family, her physician -- (applause.)

Thank you for continuing to try to get that message across. Please join in helping us make these difficult decisions rarer. Help us support women in all their needs. Help us support families.

And I appreciate greatly the devotion and dedication that so many of you have given to this over the years, and look forward to working with you into the future. Thank you very much. (Applause.)

END

FIRST LADY HILLARY RODHAM CLINTON
TALKING POINTS FOR DROP-BY AT NARAL LUNCHEON
WASHINGTON, DC
JANUARY 22, 1997

I knew you were all gathered here so I couldn't resist stopping by before I leave for New York to say hello and to thank you for all of your hard work on behalf of women and families across America.

But first let me reassure you about the events of this morning. As the President said earlier today, federal officials are working with local law enforcement to get to the bottom of what happened at Planned Parenthood and in this hotel. They will investigate the matter, catch who is doing it, and make sure they are punished. Acts of violence against people who are trying to exercise their constitutional rights are acts of terror. They are illegal. They are wrong. As to the incidents this morning, they are still under investigation. The facts are still unfolding. But as the President said, whatever happened, there is never an excuse for an act of violence against someone exercising a constitutional right.

And I am heartened to see that nothing will deter this group from an important celebration.

I am delighted to join you in honoring my friend Robin Chandler Duke. She has worked tirelessly to promote strong families here and around the world. I am especially grateful for her efforts on behalf of international family planning, safe motherhood, and other issues critical to women, children, and families. She understands that these are not marginal concerns. They relate to political and economic progress, human rights, and to the peace and prosperity of our country and others. So I join in commending her for years spent raising awareness about family planning issues and for the many contributions she will continue to make for years into the future.

I also want to thank my friend Nancy Rubin for the energy, wisdom and vision she has lent to causes relating to women and families. Nancy has been a clear and articulate voice for women's rights around the world. She has worked to strengthen education, economic opportunities, legal protections and political rights. She, too, has helped bring so-called "women's issues" to forefront of international and national concern.

Finally, I know I speak for all of us in thanking Kate Michelman for over a decade of service leading this organization and for doing so much to protect a woman's right to choose. She has continued to speak up and speak out, even in difficult times.

I'm delighted that the Vice President and Tipper Gore are here representing the Administration at this important gathering. I only wish I could stay longer but, unfortunately, I had a previous engagement that requires me to leave for New York this afternoon.

Thank you.

As delivered

FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO THE SIXTH CONFERENCE OF
WIVES OF HEADS OF STATE AND OF GOVERNMENTS OF THE AMERICAS
LA PAZ, BOLIVIA
DECEMBER 3, 1996

President and Mrs. Sanchez de Lozada, First Ladies and special envoys representing the nations of the Western Hemisphere, and distinguished guests:

It is a great pleasure for me to be in La Paz and to join you for this annual conference. I particularly want to thank Mrs. Sanchez de Lozada for her leadership on behalf of women -- especially her work to promote safe motherhood, education, and to reduce domestic violence -- and for extending to all of us a warm welcome this week.

I know that, as in the past, this gathering will provide new insights and fresh inspiration as we work to expand opportunities for women, children, and families in North, Central, South America and the Caribbean region. I am also pleased to note that Vice President Gore will be in Santa Cruz in a few days representing the United States government at what promises to be a significant hemispheric meeting on sustainable development.

This is my first trip to Bolivia, but I have long felt a special connection to this country. Little Rock, the capital of my home state of Arkansas, is a sister-city of Santa Cruz in what is called the Eastern Bolivia-Arkansas partnership. This partnership has initiated cultural, professional and health exchanges that have benefitted the people in both of our countries. So I am especially delighted finally to be in Bolivia after all these years.

Many Bolivians have made their mark on my country. I am proud to say that President Clinton named a woman who was born and raised here in La Paz, Maria Otero, to be the Chair of the

Board of the Inter-American Foundation. That foundation funds grassroots development in the region, and Maria is with me today.

I'm also pleased to be here at a time of such hope and promise for women, children and families across the Americas and around the world. A few days ago, I returned from a trip with my husband to Australia, the Philippines and Thailand, and at each stop I had the chance to talk to diverse groups of women -- from government leaders to grassroots activists to teenage school girls. And I was reminded once again, no matter where we find ourselves in the world today, our aspirations and concerns are fundamentally the same.

Thanks in part to the agenda set at the United Nations Fourth World Conference on Women in Beijing, as well as the conferences of this group in Miami, and Asuncion and elsewhere, the status of women is improving in many countries.

In the Philippines last week, I had the opportunity along with Mrs. Frei to speak to 15,000 women and girls in Manila. Some had traveled for days by boat and car to celebrate the Beijing Agenda and just as we are doing today, they came together to renew their commitment to women's rights -- and to ensure that every woman and girl has access to the tools of opportunity: health care, education, jobs and credit, legal protections and the right to participate fully in the political life of their countries.

In the 15 months since Beijing, we have seen advances on every continent. In country after country, governments, non-governmental organizations, businesses and corporations, and individual citizens are beginning to recognize that elevating the status of women and girls in society is essential to progress and prosperity. That is the same whether we are talking about the East, the West, the North or the South; there is a growing appreciation of women's contributions inside and outside of the home - and a greater understanding that everyone in society benefits when women are allowed to claim the political, economic, social, and civic power they are due.

The Western Hemisphere is no exception. In Panama, the family code has been reformed, giving women more say in alimony, child support and child custody cases. The country's new Law 27

on Intra-Family Violence criminalizes certain forms of domestic violence. In Colombia, men and women now have equal weight in determining divorce. In El Salvador and Peru, new institutions have been established to address issues relating to women's development. In Guatemala, a national university has created scholarships for indigenous women to study political science.

Jamaica's Gold Street Program, which addresses teen violence and adolescent pregnancy, has become a model that the United States is using to confront the same issues in the city of Baltimore. In Brazil, women are now entitled to free breast and uterine exams. And in Chile, the government has committed itself to tackling AIDS and adolescent pregnancies and to expanding educational opportunities for girls. And here in Bolivia, as part of the President's plans, the Plan *de Todos*, special efforts are being made to reach out to the indigenous population.

From the northernmost reaches of Canada to the southern tip of South America, women are pushing governments to lift the veil of secrecy that for too long has concealed the tragic crime of domestic violence. I mentioned the legal advances in Panama. Another ground-breaking domestic violence law was passed in Ecuador, creating Family Courts that are empowered to separate an abusive spouse from the home. In Costa Rica, police officers receive special training on how to handle domestic violence cases. In my own country we recently launched a national hotline for victims of domestic violence which has already received 50,000 calls.

Looking across our region, we also see progress on the goals that this group outlined at our previous meetings. Those goals to eliminate measles from the hemisphere, reduce maternal mortality, and promote education reform are making progress. Since 1995, our region has witnessed a 63 percent decline in measles. We have seen the Partnership for the Revitalization of Education in the Americas launch new efforts to expand educational opportunities in six countries. And while the tragic problem of maternal mortality continues to haunt us, we know that progress will come if we focus more energy and resources on this issue.

It is clear that pioneering efforts are underway across the Americas to improve conditions for women and girls. Earlier

today in La Paz, I visited with Ximena, Banco Sol, the only commercial bank in the world and the largest that specializes in microenterprise right here. I spoke to women whose lives had been transformed because they had received a modest loan to start selling vegetables in the market, to start making skirts. Not only had they become economically self-sufficient, they had begun to lift their families out of poverty and improve the economies of their communities. We met one woman in the market who is caring for her six orphan grandchildren because of the loans that she had received. I have seen the same encouraging results at FINCA, a micro-lending enterprise that I visited in Managua, Nicaragua. I've visited a comparable enterprise in Santiago and I have seen it in my own country.

In La Paz today I also visited new and expectant mothers at a primary health care center run by an NGO, PROSALUD. The 28 PROSALUD clinics offer prenatal care and family planning services that have resulted in safer pregnancies and deliveries and, in some cases, have saved lives.

This is but one piece of the nationwide effort here in Bolivia to promote safe motherhood and family planning so that women and girls are educated about their own health and their own reproductive options.

Although the rate is far too high, Bolivia's success over the past five years at reducing maternal mortality offers a model for the world of how one nation has responded to a serious health crisis and galvanized the government, non-governmental organizations, and the medical communities. I wish to commend the President and the Vice President for their leadership in this very important effort.

It is worth noting that Bolivia undertook this campaign not only as a way to reduce maternal mortality, but also to reduce the increasing rate of abortion. Without access to family planning, women often turn in desperation to illegal, unsafe abortion procedures that account for half of all maternal deaths in this country. Deaths from abortion complications are responsible for from 30 to 70 percent of maternal mortality in our hemisphere, depending on the country.

Here, in Brazil, and in other places around the globe, I have seen examples of how investments in family planning improve maternal health and the well-being of families as well as reduce the number of abortions. The United States has supported family planning efforts, including Bolivia's. However, as you may know, some members of the United States Congress have voted to limit American support for family planning initiatives. My husband's Administration remains committed to encouraging a continuation of these investments, which represent a sensible, cost-effective and long-range strategy for improving women's health and for lowering the rate of abortion. And for my part, I will certainly remember and share the powerful stories I have heard around the world to explain why these programs are critical.

Education is also critical. It is inextricably tied to how women and children achieve progress. Children of illiterate mothers are twice as likely to die as those with mothers who are educated. So our efforts across the Western Hemisphere to educate girls and mothers will have a profound and concrete effect on women's health. The better educated a girl or woman is, the healthier she is. The healthier she is, the healthier her family is. And all of society stands to gain.

While some may dismiss the achievements of this conference and the conferences before or of the Beijing Agenda as merely "women's issues" that have no place on the front-burner of global politics, I believe that you here in Bolivia, and certainly your President and Vice President understand how they are part of sustainable development and progress. They represent a balancing of power that is just as crucial to the endurance of democracy as issues like trade, diplomacy and national security. Democracy, after all, requires the full participation of all citizens, including women.

And today, we can take heart knowing that democracy has replaced dictatorship around the world and virtually throughout our own hemisphere. Building and sustaining democracy has always required a balance of power, a balance of public power, private economic power, and the power of civic society, those formal and informal networks that bring people together. It is the balance of power that Bolivia has incorporated into its Popular Participation Law, and by doing so, insured the further success of democracy. Whether we succeed at achieving the balance of

power is particularly important for women who despite the strides we have made, still find their voices silenced and their potential stymied in too many parts of the world. In country after country -- from the most advanced democracies to those newly emerging, from the most dynamic free market economies to those struggling in the face of rapid global change -- women are still striving to define and attain their rightful place in government, the economy, the civil society and throughout their lives.

Women are seeking balance in their lives and in their societies, and I am heartened that civic education is on the agenda of this conference. Teaching people about democratic values and the importance of their participation in the political process is critical to sustaining democracy. When we look at what is happening in our hemisphere, when I look at what is happening in my own country, I see that the voices and votes of women can make a difference. If all of us believe in the God-given potential of each human being, then all of us should do what we can in our own ways and our own roles to further those voices and that potential.

For all of the challenges that confront us on the eve of this new century I am optimistic about our future. I am optimistic about our hemisphere and about our capacity to meet those challenges. And certainly, if there is one vision that should guide us, it is that of the young people who rely on us to leave them a world that encourages their dreams, nurtures their talents and respects their choices. That is really why we are gathered today -- most of us in this auditorium have made most of the choices we will make that will determine the course of our lives. It is up to us to determine how we provide the same opportunities for all of our sons and daughters.

Building a better future for children, women, men, and families in the Western Hemisphere is not just the opportunity of government, it is the responsibility of all of us. And I thank you very much for being part of meeting that responsibility and challenge.

FIRST LADY HILLARY RODHAM CLINTON
NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION
VIDEOTAPED REMARKS FOR SILVER ANNIVERSARY
FEBRUARY 27, 1996

Good evening. I wish I could be with all of you tonight to celebrate the Silver Anniversary of the National Family Planning and Reproductive Health Association. Through your work, NFPRHA [NIF-rah] is educating and empowering people to be the best parents possible. This starts with giving them the means and the encouragement to plan their pregnancies and better support their children.

I'm particlarly pleased to join you for this special tribute to Justice Harry Blackmun, who is receiving the Silver Anniversary Award for Lifetime Achievement. Justice Blackmun's career has been about bettering people's lives, and about bettering our country in the process. Always wise, always humble, he never let his 24 years of service on the United States Supreme Court distance him from the experiences of his fellow Americans. And he never has lost his sense of humor -- no mean feat for someone who has lived in Washington that long.

Today, we all celebrate Justice Blackmun's legacy of courage, compassion, integrity and faith in our legal system to do right by our citizens. Justice Blackmun's imprint is on almost every major Supreme Court case of the past generation. I wish we had time to review all of his contributions and accomplishments. But let me just mention one: Justice Blackmun's leadership on the case known as *Roe v Wade,* which inspired a whole generation of law school students at the time, including me.

Justice Blackmun's opinions for the Court in Roe and Doe recognized not only the rights of American women, but also the professional obligations of America's doctors.

On behalf of the President and all Americans, I offer congratulations to Justice Blackmun and thanks for his example of wisdom, leadership, and dedication to our country.

I also would like to join all of you in recognizing two other Silver Anniversary Award winners -- Congressman Henry Waxman of California and Congressman John Porter of Illinois, both of whom are being honored for their leadership in the public policy arena.

No current member of Congress has done more to assure access to family planning services for low income women than my friend, Congressman Waxman. From the California legislature to the U. S. Congress, Henry Waxman has been a champion of family planning. He has led the charge to ensure that women are able to get needed services and to know about the options available to them.

Congressman Waxman has provided the leadership, tenacity and moral courage to ride out the storm on one of our nation's most emotional issues. As one of his friends once said, Henry's not a rock. He's a river. He keeps going until he changes the ground.

It is also fitting that tonight you honor Congressman Porter for his leadership in Congress, not only for his work on family planning issues but for his commitment to universal access to health care and medical research. Congressman Porter has fought hard to ensure that women get the counseling they need at federally funded family planning clinics. He understands that federal support for scientific research and discovery is what has made our health care system second to none. Dedication and courage are the hallmarks of Congressman Porter's tenure in Congress, and I am pleased to join in this tribute to him.

I wish NFPRHA [NIF-rah] and your member organizations continued success and courage and I congratulate the other honorees here this evening. Thank you, and happy anniversary.

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First Lady Hillary Rodham Clinton

Remarks to the World Health Organization Forum on Women and Health Security

Beijing, China
September 5, 1995

MRS. CLINTON: Thank you very much. Thank you Dr. Nakajima, Mrs. Mongella, all of the panelists, delegates to this important conference, and guests from all over the world. I am honored to be here this morning among women and men who are committed to improving the health of women and girls everywhere in our world.

I want to start by commending the World Health Organization for making women's health a top priority and for establishing the Global Commission on Women's Health.

I am also proud that in the preparatory meetings for this Fourth World Conference on Women, the United States took the lead with other countries in highlighting the importance of a comprehensive approach to women's health. That approach builds on actions taken at previous women's conferences and the recent conferences at Cairo and Copenhagen, whose goals to promote the health and well-being of all people were endorsed by 180 nations.

Cairo was particularly significant as governmental and non-governmental participants worked together to craft a Program for Action which, among other things, calls for universal access to good quality reproductive health care services, including safe, effective, voluntary family planning; greater access to education and health care; more responsibility on the part of men in sexual and reproductive health and childbearing; and reduction of wasteful resource consumption.

Here at this conference, improving girls and women's health is a priority of the draft Platform for Action. It includes such goals as: Access to universal primary health care for all people -- a goal not yet achieved in many countries, including my own. The promotion of breast feeding. The provision of safe drinking water and sanitation. Research in and attention to women's health issues, including: environmental hazards, prevention of HIV/AIDS and other sexually transmitted diseases, encouragement for adolescents to postpone sexual activity and childbearing, and discouragement of cultural traditions and customs that deny food and health care to girls and women.

Goals such as these illustrate a new commitment to the well-being of girls and women and a belief in their rights to live up to their own God-given potentials.

At long last, people and governments everywhere are beginning to understand that investing in the health of women and girls is as important to the prosperity of nations as investing in the development of open markets and trade. The health of women and girls cannot and must not be divorced from progress on other economic and social issues.

Scientists, doctors, nurses, community leaders and women themselves are working to improve and safeguard the health of women and families all over

the world. If we join together as a global community, we can lift up the health and dignity of all women and their families in the remaining years of the 20th century and on into the next millennium.

Yet, for all the promise the future holds, we also know that many barriers lie in our way. For too long, women have been denied access to health care, education, economic opportunities, legal protection and human rights -- all of which are used as building blocks for a healthy and productive life.

In too many places today, the health of women and families is compromised by inadequate, inaccessible and unaffordable medical care, lack of sanitation, unsafe drinking water, poor nutrition, insufficient research and education about women's health practices, and coercive and abusive sexual practices.

In too many places, the status of women's health is a picture of human suffering and pain. The faces in that picture are of girls and women who, but for the grace of God or the accident of birth, could be us or one of our sisters, mothers or daughters.

Today, at least fifteen percent of pregnant women suffer life threatening complications and more than one-half million women around the world die in childbirth. Most of those deaths could be prevented with basic primary, reproductive and emergency obstetric health care. In some places, there are 175,000 motherless children for every one million families. Many of those children don't survive. And of those who do, many are recruited into a life of exploitation on the streets of our world's cities, subjected daily to abuse, indignity, disease, and the specter of early death.

There must be a renewed commitment to improving maternal health. The World Health Organization launched in 1987 a Safe Motherhood Initiative to have maternal mortality by the year 2000. To reach that goal, more attention must be paid to emergency medical care as well as primary prenatal care. Providing emergency obstetric care is a relatively cheap way of saving lives -- and along with family planning services is among the most cost effective interventions in even the poorest of countries.

The commitment of the World Health Organization and its Global Commission on Women's Health to make childbearing and childbirth a safe and healthy period of every woman's life deserves action on the part of every nation represented here.

In addition, one hundred million women cannot obtain or are not using family planning services because they are poor, uneducated or lack access to care. Twenty million of these women will seek unsafe abortions -- some will die, some will be disabled for life. A growing number of unwanted pregnancies are occurring among young women, barely beyond childhood themselves. As we know, when children have children, the chance of schooling, jobs, and good health is reduced for both parent and child. And our progress as a human family takes another step back.

The Cairo document recognizes "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so." Women should have the right to health care that will enable them to go safely through pregnancy and childbirth and provide them with the best chance of having a healthy infant.

Women and men must also have the right to make those most intimate of all decisions free of discrimination, coercion and violence, particularly any

coercive practices that force women into abortions or sterilizations.

On these issues, the US supports the provisions in the Beijing Platform for Action that reaffirm consensus language that was agreed to at the Cairo Conference about a year ago. But I also want to emphasize what the Cairo document said on a particularly sensitive issue to many represented here. It declared that "in no case should abortion be promoted as a method of family planning" -- and that too should be reaffirmed loudly and clearly. The Platform asks governments "to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services."

As Mrs. Mongella reminded us, violence is also a health issue. It is about time we recognized it as such and began to move against it whereever it occurs. Violence against women remains a leading cause of death among girls and women between the ages of 14 and 44 -- violence from ethnic and religious conflicts, crime in the streets and brutality in the home. For women who survive the violence, what often awaits them is a life of unrelenting physical and emotional pain that destroys their capacity for mothering, homemaking or working and can lead to substance abuse, and even suicide.

Violence against girls and women goes beyond the beatings, rape, killings and forced prostitution that arise from poverty, wars and domestic conflicts. Every day, more than 5,000 young girls are forced to endure the brutal practice of genital mutilation. The procedure is painful and life-threatening. It is degrading. And it is a violation of the physical integrity of a woman's body, leaving a lifetime of physical and emotional scars.

HIV, AIDS, and sexually transmitted diseases threaten more and more women -- and you will hear more about that poignantly and personally later. Experts predict that by the end of this decade more than half of the people in the world with HIV will be women. AIDS, which threatens whole families and regions, demands the strongest possible response. Governments and the international community must address head-on the growing number of women who are being infected -- and that means refusing to deny the extent of the problem and beginning to deal with it in order to start solving it and preventing it whereever we can.

More than 700,000 women worldwide face breast cancer each year -- and over 300,000 die of it. It's the leading cause of death for women in their prime in the developed world. In the time I speak to you today, 25 women around the world will die of breast cancer. In my own country, it is hard to find a family, an office, or a neighborhood that has not been touched by this disease. My own mother-in-law struggled against breast cancer for four years before losing her battle. That is another disease that all of us must join forces together to combat.

Tobacco use is the number one preventable cause of death. Some might think that is doesn't rank up there with the other serious problems that will be discussed, AIDS/HIV -- and of course it does not have the extraordinarly painful image and effects that other threats to health do -- but is is a killer and it causes great anguish among those who are struck down. Ninety percent of women who smoke began to smoke as adolescents -- leading to high rates of heart disease, cancer, and chronic lung disease later in life -- that are not only a burden to the individual and the family -- but to the health care system that are trying cope with diseases such as AIDS and breast cancer.

As the World Health Organization points out, we also need to recognize and

effectively address the fact that women are far more likely to be exposed to work-related and environmental health hazards. Policies to alleviate and eliminate such health hazards associated with work in the home and in the workplace also demand action.

Research indicates further that certain communicable diseases affect women in greater numbers. Tuberculosis, for example, is responsible for the deaths of one million women each year and those in their early and reproductive years are most vulnerable.

When health care systems around the world don't work for women; when our mothers, daughters, sisters, friends and co-workers are denied access to quality care because they are poor, do not have health insurance, or simply because they are women, it is not just their health that is put at risk. It is the health of their families and communities as well.

Like many nations, the United States brings to this conference a serious commitment to improving women's health. We bring with us a series of initiatives which represent the first steps to carrying out this Conference's Platform for Action.

We are continuing to work for health care reform to ensure that every citizen has access to affordable, quality care.

We are proposing a comprehensive and coordinated plan to reduce smoking by children and adolescents by 50 percent.

We are working to address the many factors that contribute to teenage pregnancy, our most serious social problem, by encouraging abstinence and personal responsibility on the part of young men and women; improving access to health care and family planning services; and supporting health education in our schools.

We are pursuing a public policy agenda on HIV/AIDS that is specific to women, adolescents, and children.

We are continuing to fund and conduct contraceptive research and development.

We are addressing the health needs of women through initiatives such as:

- The National Action Plan on Breast Cancer -- a public, private partnership working with all agencies of government, the media, scientific organizations, advocacy groups and industry to advance breast health and eradicate breast cancer as a threat to the lives of American women.

- An Expansion of the National Breast and Cervical Cancer Early Detection Program -- we hope will ensure that women who need regular screening and detection services have access to them, and that those services meet quality standards.

- The inclusion of women in clinical trials for research and testing of drugs or other interventions that probe specific differences between men and women in patterns of disease and reactions to therapy.

- The specific health needs of older women will be addressed through educational campaigns about osteoporosis, cancer and other diseases.

- And the United States is conducting the largest clinical research study ever undertaken to examine the major causes of death, disability and frailty in post-menopausal women.

We come prepared to be partners working together on behalf of women's health security -- which must be a priority of all people and governments working together. Without good health, a woman's God-given potential can never be realized. And without healthy women, the world's potential can never be realized.

So I hope that through this conference we renew our commitment to join together to ensure that every little boy and girl that comes into our world is healthy and wanted; that every young woman has the education and economic opportunity to live a healthy life; and that every woman has access to the health care she needs throughout her life to fulfill her potential in her family, her work, and her community.

If we care about the futures of our daughters, our sons, and the generations that will follow them, we can do nothing less.

I want to thank so many of you in this room for the work you do everyday to bring better health to women, men, children, and families throughout world. Thank you for helping governments and citizens understand that we cannot talk about equality and social development without also talking about health care.

Most of all, thank you for being part of this historic and vital discussion. It holds promise for our future, if we act and continue to work together. I was pleased to find this declaration on women's health and health security and to see in it goals with measurable targets. That is what we must commit ourselves to. Rhetoric alone, recognition of the problems alone, will not save another girl child, will not prevent the disease that cuts down too many women in their prime, will not ease the passage of women in their older years who have worked so hard all their lives. It is only by combining the rhetoric and recognition with a commitment to specific actions that will bring about the changes we want to see. I commend and thank you for being part of that effort. Thank you very much.

United Nations Fourth World Conference on Women

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release
September 5, 1995

First Lady Hillary Rodham Clinton
Remarks to the United Nations Fourth World Conference on Women
Beijing, China

MRS. CLINTON: Thank you very much Gertrude Mongella, for your dedicated work that has brought us to this point.

Distinguished delegates and guests, I would like to thank the Secretary General of the United Nations for inviting me to be part of this important United Nations Fourth World Conference on Women. This is truly a celebration -- a celebration of the contributions women make in every aspect of life: in the home, on the job, in the community, as mothers, wives, sisters, daughters, learners, workers, citizens and leaders.

It is also a coming together, much the way women come together every day in every country.

We come together in fields and in factories. In village markets and supermarkets. In living rooms and board rooms.

Whether it is while playing with our children in the park, or washing clothes in a river, or taking a break at the office water cooler, we come together and talk about our aspirations and concerns. And time and again, our talk turns to our children and our families.

However different we may appear, there is far more that unites us than divides us. We share a common future. And we are here to find common ground so that we may help bring new dignity and respect to women and girls all over the world -- and in so doing, bring new strength and stability to families as well.

By gathering in Beijing, we are focusing world attention on issues that matter most in the lives of women and their families: access to education, health care, jobs, and credit, the chance to enjoy basic legal and human rights and to participate fully in the political life of their countries.

There are some who question the reason for this conference. Let them listen to the voices of women in their homes, neighborhoods, and workplaces.

There are some who wonder whether the lives of women and girls matter to economic and political progress around the globe. ... Let them look at the women gathered here and at Hairou.... the homemakers, nurses, teachers, lawyers, policymakers, and women who run their own businesses.

It is conferences like this that compel governments and peoples everywhere to listen, look and face the world's most pressing problems.

Wasn't it after the women's conference in Nairobi ten years ago that the world focused for the first time on the crisis of domestic violence?

Earlier today, I participated in a World Health Organization forum. In that forum we talked about ways that where government officials, NGOs, and individual citizens are working on ways to address the health problems of women and girls.

Tomorrow, I will attend a gathering of the United Nations Development Fund for Women. There, the discussion will focus on local -- and highly successful -- programs that give hard-working women access to credit so they can improve their own lives and the lives of their families.

What we are learning around the world is that, if women are healthy and educated, their families will flourish. If women are free from violence, their families will flourish. If women have a chance to work and earn as full and equal partners in society, their families will flourish.

And when families flourish, communities and nations will flourish.

That is why every woman, every man, every child, every family, and every nation on our planet does have a stake in the discussion that takes place here.

Over the past 25 years, I have worked persistently on issues relating to women, children and families. Over the past two-and-a-half years, I have had the opportunity to learn more about the challenges facing women in my own country and around the world.

I have met new mothers in Indonesia, who come together regularly in their village to discuss nutrition, family planning, and baby care.

I have met working parents in Denmark who talk about the comfort they feel in knowing that their children can be cared for in creative, safe, and nurturing after-school centers.

I have met women in South Africa who helped lead the struggle to end apartheid and are now helping build a new democracy.

I have met with the leading women of my own hemisphere who are working every day to promote literacy and better health care for the children in their countries.

I have met women in India and Bangladesh who are taking out small loans to buy milk cows, rickshaws, thread and other materials to create a livelihood for themselves and their families.

I have met doctors and nurses in Belarus and Ukraine who are trying to keep children alive in the aftermath of Chernobyl.

The great challenge of this conference is to give voice to women everywhere whose experiences go unnoticed, whose words go unheard.

Women comprise more than half the world's population. Women are 70% percent of the world's poor, and two-thirds of those who are not taught to read and write.

Women are the primary caretakers for most of the world's children and elderly. Yet much of the work we do is not valued -- not by economists, not by historians, not by popular culture, not by government leaders.

At this very moment, as we sit here, women around the world are giving birth, raising children, cooking meals, washing clothes, cleaning houses, planting crops, working on assembly lines, running companies, and running countries.

Women also are dying from diseases that should have been prevented or treated; they are watching their children succumb to malnutrition caused by poverty and economic deprivation; they are being denied the right to go to school by their own fathers and brothers; they are being forced into prostitution, and they are being barred from the bank lending office and banned from the ballot box.

Those of us who have the opportunity to be here have the responsibility to speak for those who could not.

As an American, I want to speak up for women in my own country -- women who are raising children on the minimum wage, women who can't afford health care or child care, women whose lives are threatened by violence, including violence in their own homes.

I want to speak up for mothers who are fighting for good schools, safe neighborhoods, clean air and clean airwaves...

...for older women, some of them widows, who have raised their families and now find that their skills and life experiences are not valued in the workplace... for women who are working all night as nurses, hotel clerks, and fast food chefs so that they can be at home during the day with their kids... and for women everywhere who simply don't have time to do everything they are called upon to do each day.

Speaking to you today, I speak for them, just as each of us speaks for women around the world who are denied the chance to go to school, or see a doctor, or own property, or have a say about the direction of their lives, simply because they are women.

The truth is that most women around the world work both inside and outside the home, usually by necessity.

We need to understand that there is no one formula for how women should lead their lives.

That is why we must respect the choices that each woman makes for herself and her family. Every woman deserves the chance to realize her God-given potential.

We also must recognize that women will never gain full dignity until their human rights are respected and protected.

Our goals for this conference, to strengthen families and societies by empowering women to take greater control over their own destinies, cannot be fully achieved unless all governments -- here and around the world -- accept their responsibility to protect and promote internationally recognized human rights.

The international community has long acknowledged -- and recently affirmed at Vienna -- that both women and men are entitled to a range of protections and personal freedoms, from the right of personal security to the right to determine freely the number and spacing of the children they bear.

No one should be forced to remain silent for fear of religious or political persecution, arrest, abuse or torture.

Tragically, women are most often the ones whose human rights are violated.

Even in the late 20th century, the rape of women continues to be used as an instrument of armed conflict. Women and children make up a large majority of the world's refugees. And when women are excluded from the political process, they become even more vulnerable to abuse.

I believe that, on the eve of a new millennium, it is time to break our silence. It is time for us to say here in Beijing, and the world to hear, that it is no longer acceptable to discuss women's rights as separate from human rights.

These abuses have continued because, for too long, the history of women has been a history of silence. Even today, there are those who are trying to silence our words.

The voices of this conference and of the women at Hairou must be heard loud and clear:

It is a violation of human rights when babies are denied food, or drowned, or suffocated, or their spines broken, simply because they are born girls.

It is a violation of human rights when women and girls are sold into the slavery of prostitution.

It is a violation of human rights when women are doused with gasoline, set on fire and burned to death because their marriage dowries are deemed too small.

It is a violation of human rights when individual women are raped in their own communities and when thousands of women are subjected to rape as a tactic or prize of war.

It is a violation of human rights when a leading cause of death worldwide among women ages 14 to 44 is the violence they are subjected to in their own homes by their own relatives.

It is a violation of human rights when young girls are brutalized by the painful and degrading practice of genital mutilation.

It is a violation of human rights when women are denied the right to plan their own families, and that includes being forced to have abortions or being sterilized against their will.

If there is one message that echoes forth from this conference, let it be that human rights are women's rights.... And women's rights are human rights, once and for all.

Let us not forget that among those rights are the right to speak freely. And the right to be heard.

Women must enjoy the right to participate fully in the social and political lives of their countries if we want freedom and democracy to thrive and endure.

It is indefensible that many women in non-governmental organizations who wished to participate in this conference have not been able to attend -- or have been prohibited from fully taking part.

Let me be clear. Freedom means the right of people to assemble, organize, and debate openly. It means respecting the views of those who may disagree with the views of their governments. It means not taking citizens away from their loved ones and jailing them, mistreating them, or denying them their freedom or dignity because of the peaceful expression of their ideas and opinions.

In my country, we recently celebrated the 75th anniversary of women's suffrage. It took 150 years after the signing of our Declaration of Independence for women to win the right to vote.

It took 72 years of organized struggle on the part of many courageous women and men.

It was one of America's most divisive philosophical wars. But it was also a bloodless war. Suffrage was achieved without a shot fired.

We have also been reminded, in V-J Day observances last weekend, of the good that comes when men and women join together to combat the forces of tyranny and build a better world.

We have seen peace prevail in most places for a half century. We have avoided another world war.

But we have not solved older, deeply-rooted problems that continue to diminish the potential of half the world's population.

Now it is time to act on behalf of women everywhere.

If we take bold steps to better the lives of women, we will be taking bold steps to better the lives of children and families too.

Families rely on mothers and wives for emotional support and care; families rely on women for labor in the home; and increasingly, families rely on women for income needed to raise healthy children and care for other relatives.

As long as discrimination and inequities remain so commonplace around everywhere in the world -- as long as girls and women are valued less, fed less, fed last, overworked, underpaid, not schooled and

subjected to violence in and out of their homes -- the potential of the human family to create a peaceful, prosperous world will not be realized.

Let this conference be our -- and the world's -- call to action.

Let us heed the call so that we can create a world in which every woman is treated with respect and dignity, every boy and girl is loved and cared for equally, and every family has the hope of a strong and stable future.

That is the work before you, that is the work before all of us, who have a vision of the world we want to see for our children and our grandchildren. The time is now. We must move beyond rhetoric, we must move beyond recognition of problems, to working together, to have the common efforts to build that common ground we hope to see.

God's blessings on you, your work and all who will benefit from it. Godspeed and thank you very much.

THE WHITE HOUSE AT WORK

Thursday, January 22, 1998

INCREASING SUPPORT FOR FAMILY PLANNING

I will continue to do everything I can to make sure that every child in America is a wanted child, raised in a loving, strong family. Ultimately, that is the idea the anniversary of Roe v. Wade celebrates.

President Bill Clinton
January 22, 1998

Today, marks the 25th anniversary of Roe v. Wade, the landmark Supreme Court decision that affirmed every woman's right to choose whether and when to have a child. President Clinton is committed to ensuring this right, and in doing so, to protecting two of our nation's most deeply-held values, personal privacy and family responsibility.

Prevention and Family Planning. During the last five years, the Administration has worked hard to reduce the need for abortions and to prevent unintended pregnancy by making comprehensive family planning and sex education programs more widely available. The President's FY 1999 budget calls for:

- **Increased Funding for Title X.** The proposal will increase Title X Family Planning grants by $15 million -- a 46% increase since FY1992.
- **Medicaid and Other Services.** The proposal will provide almost $500 million in federal funds to Medicaid to support family planning services. Additionally, the Maternal & Child Health Block Grant, the Social Services Block Grant, and the Preventive Health Block Grant will provide $100 million to state and local communities for family planning services.
- **Prevention Education and Research.** The proposal will provide about $200 million for the National Institutes of Health's research on infertility, contraception, and related matters, and CDC's programs to educate teenagers about sexual development and abstinence. Additionally, Health and Human Service's teen pregnancy prevention and related youth programs will continue to engage the Girl Power! education initiative in sustained efforts to promote pregnancy prevention among girls 9- to 14-years-old.

A Comprehensive Approach to Family Planning. Under the President's proposal nearly 5 million clients each year at more than 4,700 family planning clinics nationwide, would have access to a comprehensive set of family planning services including contraceptive services, pregnancy testing, sexually transmitted disease screening and treatment, and education and outreach.

Supporting International Family Planning. The Administration is strongly committed to international family planning efforts. The President has blocked several Congressional attempts to prohibit funding for international family planning groups that use their own funding to lobby on behalf of abortion rights or perform abortions. Under the President's Budget, bilateral assistance provided through AID and assistance to the United Nations Population Fund

will grow to $425 million in FY 1999, a 32% increase over FY 1992.

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Fact Sheet V

Promoting Reproductive Health Services for Women

"Certain choices are too personal for politics." **President Clinton and Vice President Gore**

The President is committed to ensuring that all women have access to reproductive health and family planning services, that all women are able to determine the number and spacing of their children, and that abortion is safe, legal and rare.

Reversed the Gag Rule
During his first week in office, President Clinton reversed the previous administration's attempts to prevent federally funded family planning clinics from providing full information on options for resolving unintended pregnancies. A notice of proposed rule making for permanent reversal has been issued.

Supports Reproductive Health and Family Planning
Under President Clinton, the annual budget for the Title X Family Planning Program has increased from $173.4 million to $193.3 million. This program is the primary federal mechanism for direct provision of reproductive health and family planning services to low-income women. It is estimated that subsidized family planning services, such as those provided through Title X, prevent more than 1 million unintended pregnancies and 500,000 abortions each year. In addition, the President reversed the ban, instituted in 1987 by the Reagan Administration, on privately funded abortion services in U.S. military hospitals; and repealed the Mexico City policy, established in 1984 banning U.S. funding support to international organizations that include abortion services in their reproductive health and family planning programs. In 1994, at the International Conference on Population and Development in Cairo, the United States agreed with more than 150 nations to promote reproductive health for all women and to address the threat to women's health from unsafe abortion.

Establishing Clinic Safety
President Clinton signed the Freedom of Access to Clinic Entrances Act to fight the escalating violence against women and doctors at women's health clinics.

Moved Forward with Reproductive Research
President Clinton ordered that the ban on mifepristonne, a drug that terminates pregnancy without surgery, be revisited. Currently, the drug is undergoing clinical trials in the U.S.

Establishing Services for Victims of Rape and Incest
Under President Clinton, the Department of Health and Human Services implemented a congressionally ordered change to Medicaid to include abortion services for women whose pregnancies result from rape or incest, in addition to saving the life of the woman.

Office of Women's Initiatives and Outreach. Phone: 202 456-7300; Fax: 202 456-7311

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