GUTTMACHER INSTITUTE

Fact Sheet

September 2016

Induced Abortion in the United States

• Nearly half of pregnancies among American women in 2011 were unintended, and about four in 10 of these were terminated by abortion.

• Twenty-one percent of all pregnancies (excluding miscarriages) in 2011 ended in abortion.

• In 2011, approximately 1.06 million abortions were performed, down 13% from 1.21 million in 2008. From 1973 through 2011, nearly 53 million legal abortions occurred.

• The abortion rate in 2011 was 16.9 per 1,000 women aged 15–44, down 13% from 19.4 per 1,000 in 2008. This is the lowest rate observed since abortion became legal in the United States in 1973.

• In 2011, 1.7% of women aged 15–44 had an abortion. Half of these women had had at least one previous abortion.

WHO HAS ABORTIONS?

• Twelve percent of U.S. abortion patients in 2014 were teenagers: Those aged 18–19 accounted for 8% of all abortions, 15–17-year-olds for 3% and teenagers younger than 15 for 0.2%.

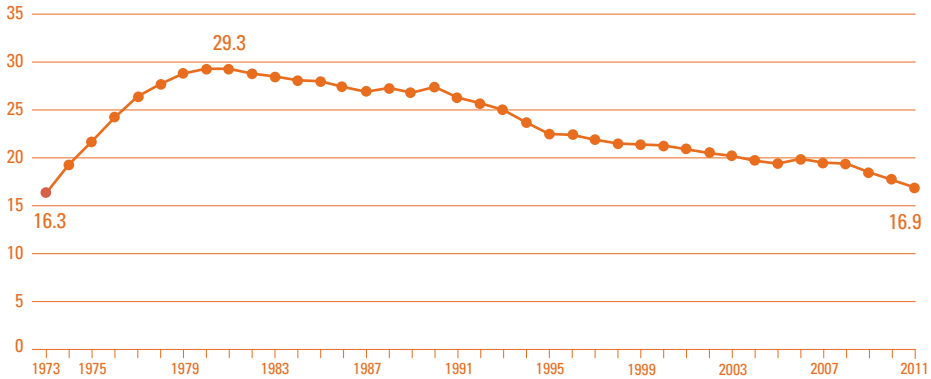
• More than half of all abortion patients in 2014 were in their 20s: Patients aged 20–24 obtained 34% of all abortions, and patients aged 25–29 obtained 27%.

• White patients accounted for 39% of abortion procedures in 2014, blacks for 28%, Hispanics for 25% and patients of other races and ethnicities for 9%.

• Seventeen percent of abortion patients in 2014 identified as mainline Protestant, 13% as evangelical Protestant and 24% as Catholic; 38% reported no religious affiliation.

• In 2014, some 46% of all abortion patients had never married and were not cohabiting.

In 2011, the U.S. abortion rate reached its lowest level since 1973



Number of abortions per 1,000 women aged 15–44

• Fifty-nine percent of abortions in 2014 were obtained by patients who had had at least one previous birth.

• Forty-nine percent of abortion patients in 2014 had incomes of less than 100% of the federal poverty level ($11,670 for a single adult with no children).*

• Twenty-six percent of abortion patients in 2014 had incomes of 100–199% of the federal poverty level.

• The reasons patients gave for having an abortion underscored their understanding of the responsibilities of parenthood and family life. The three most common reasons—each cited by three-fourths of patients—were concern for or responsibility to other individuals; the inability to afford a child; and the belief that having a baby would interfere with work, school or the ability to care for dependents. Half said they did not want to be a single parent or were having problems with their husband or partner.

• Fifty-one percent of abortion patients had used a contraceptive method in the month they got pregnant, most commonly condoms (27%) or a hormonal method (17%).

PROVIDERS AND SERVICES

• The number of U.S. abortion providers declined 4% between 2008 and 2011 (from 1,793 to 1,720). The number of clinics providing abortion services declined 1% over this period (from 851 to

*Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 USC 9902(2).

839). Eighty-nine percent of all U.S. counties lacked an abortion clinic in 2011, and 38% of women of reproductive age lived in those counties.

• Forty-six percent of abortion providers offer very early abortions (before the first missed period), and 95% offer abortion at eight weeks from the last menstrual period. Sixty-one percent of providers offer at least some second-trimester abortion services (at 13 weeks or later), and 34% offer abortion at 20 weeks. Only 16% of all abortion providers perform the procedure at 24 weeks.

• In 2011–2012, the average amount paid for a nonhospital abortion with local anesthesia at 10 weeks' gestation was $480. The average paid for an early medication abortion before 10 weeks was $504.

• Eighty-four percent of clinics reported at least one form of antiabortion harassment in 2011. Picketing was the most common form of harassment (80%), followed by phone calls (47%). Fifty-three percent of clinics were picketed 20 times or more in a year.

EARLY MEDICATION ABORTION

• In September 2000, the U.S. Food and Drug Administration approved mifepristone to be marketed in the United States as an alternative to surgical abortion.

• In March 2016, the Food and Drug Administration updated the mifepristone label to reflect the scientifically proven regimen that was already being used by most health care providers. The new regimen allows patients to take lower doses and make fewer provider visits, and also allows for medication abortion up to 10 weeks' gestation.

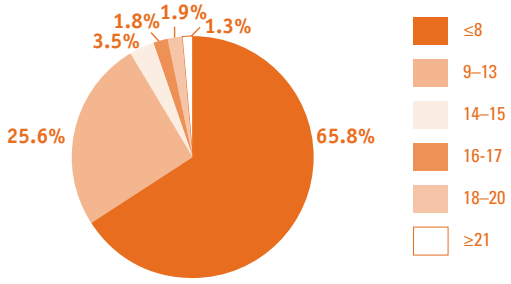
• In 2011, some 59% of abortion providers—1,023 facilities—provided one or more early medication abortions. At least 17% of providers offered only early medication abortion services.

• Medication abortion accounted for 23% of all nonhospital abortions in 2011, and for 36% of abortions before nine weeks' gestation.

• Early medication abortions increased from 6% of all abortions in 2001 to 23% in 2011, even while the overall number of abortions continued to decline. Data from the Centers for Disease Control and Prevention show that the average time of abortion has shifted earlier within the first trimester; this is likely due, in part, to the availability of medication abortion services.

When women have abortions*

Two-thirds of abortions occur at eight weeks of pregnancy or earlier; 91% occur in the first thirteen weeks, 2012



*In weeks from the last menstrual period.

SAFETY OF ABORTION

• A first-trimester abortion is one of the safest medical procedures and carries minimal risk—less than 0.05%—of major complications that might need hospital care.

• Abortions performed in the first trimester pose virtually no long-term risk of problems such as infertility, ectopic pregnancy, spontaneous abortion (miscarriage) or birth defect, and little or no risk of preterm or low-birth-weight deliveries.

• Exhaustive reviews by panels convened by the U.S. and UK governments have concluded that there is no association between abortion and breast cancer. There is also no indication that abortion is a risk factor for other cancers.

• Leading experts have concluded that among women who have an unplanned pregnancy, the risk of mental health problems is no greater if they have a single first-trimester abortion than if they carry the pregnancy to term.

• The risk of death associated with abortion increases with the length of pregnancy, from 0.3 for every 100,000 abortions at or before eight weeks to 6.7 per 100,000 at 18 weeks or later.

INSURANCE COVERAGE AND PAYMENT

• Most abortion patients had health insurance in 2014. Thirty-five percent reported that they had Medicaid coverage, while 31% had private insurance. However, insurance does not necessarily cover abortion services, and even if it does, patients may not use their coverage for a variety of reasons (e.g., because they do not know their plan covers it, they are concerned about confidentiality or their provider does not accept their plan).

• Overall, 53% of abortion patients paid out of pocket for their procedure in 2014.

• Medicaid was the second-most-common method of payment, reported by 24% of abortion patients. The overwhelming majority of these patients live in the few states that allow state funds to be used to pay for abortion.

• Fifteen percent of patients used private insurance to pay for the procedure. Most patients with private insurance (61%) paid out of pocket.

• In 2004, 58% of abortion patients said they would have liked to have had their abortion earlier in the pregnancy. Nearly 60% of women who experienced a delay in obtaining an abortion cited the time it took to make arrangements and raise money.

LAW AND POLICY

• In the 1973 *Roe v. Wade* decision, the Supreme Court ruled that women, in consultation with their physician, have a constitutionally protected right to have an abortion in the early

stages of pregnancy—that is, before viability—free from government interference.

• In 1992, the Court reaffirmed the right to abortion in *Planned Parenthood v. Casey*. However, the ruling significantly weakened the legal protections previously afforded women and physicians by giving states the right to enact restrictions that do not create an "undue burden" for women seeking abortion.

• Congress has barred the use of federal Medicaid funds to pay for abortions, except when the woman's life would be endangered or in cases of rape or incest. States can fund abortion with state dollars, and about one-third of states do so voluntarily or by court order.

• As of April 1, 2016, at least half of the states have imposed excessive and unnecessary regulations on abortion clinics, mandated counseling designed to dissuade a woman from obtaining an abortion, required a waiting period before an abortion, required parental involvement before a minor obtains an abortion or prohibited the use of state Medicaid funds to pay for medically necessary abortions.

• In 2000, a total of 13 states had at least four types of major abortion restrictions and so were considered hostile to abortion rights; by 2015, this category included 27 states. The proportion of women of reproductive age living in hostile states rose from 31% to 56% during this time period.

• In contrast, the number of states that were supportive of abortion rights fell from 17 to 12 between 2000 and 2015. The proportion of women of reproductive age living in supportive states declined from 40% to 30% over this period.

These data are the most current available. References are available in the HTML version: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

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September 2016

CLINICIANS FOR CHOICE

Certified Nurse-Midwives, Nurse Practitioners, and Physician Assistants as Abortion Providers

Certified Nurse-Midwives (CNMs)

A certified nurse-midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, and who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.

Midwifery practice is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the postpartum period, and care of the newborn; family planning and gynecology; and common primary care issues. Certified nurse-midwives practice within a health care system that provides for consultation, collaborative management, and/or referral as indicated by the health status of the client. Certified nurse-midwives practice in accordance with the Standards for the Practice of Midwifery, as defined by the American College of Nurse-Midwives.[1]

Nurse Practitioners (NPs)

A nurse practitioner (NP) is a registered nurse with advanced academic and clinical experience, which enables them to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. A nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications. Working in collaboration with a physician, a nurse practitioner provides high-quality, cost-effective, and individualized care for the lifespan of a patient's special needs.

NPs focus largely on health maintenance, disease prevention, counseling, and patient education in a wide variety of settings. With a strong emphasis on primary care, nurse practitioners are employed within several specialties, including neonatology, pediatrics, school health, family and adult health, women's health, mental health, home care, geriatrics, and acute care.[2]

Physician Assistants (PAs)

Physician assistants (PAs) are health care professionals licensed to practice medicine as part of physician-directed teams. They are educated in accredited graduate-level programs. Physicians may delegate to PAs those medical duties that are within the physician's scope of practice and the PA's training and experience. PAs provide a broad range of diagnostic and therapeutic services, from primary care to surgical procedures. In their work with physicians, PAs routinely perform physical exams and take patient histories, order and interpret laboratory tests, manage and treat illnesses, assist in surgery, write prescriptions, and provide health education and patient counseling.

What is in the Professional Scope of Practice of CNMs, NPs, and PAs?

- CNMs provide health care for women throughout their lives. They provide full-scope care during labor and childbirth, and are competent independent providers of prenatal, postpartum, and newborn care; family planning; and gynecological care.
- CNMs are routinely trained in basic surgical techniques of episiotomy, suturing, and manual removal of the placenta.
- PAs perform approximately 80% of the duties commonly done by primary care physicians
- CNMs, NPs, and PAs diagnose and treat common health problems, order and interpret diagnostic tests, and administer medications.[3]
- CNMs, NPs, and PAs have prescriptive authority in most states.
- When appropriately trained, CNMs, NPs, and PAs perform a variety of procedures, such as endometrial biopsy, intra-uterine device placement, and colposcopy.
- Post-graduate specialty training in anesthesia, surgical assisting, and other advanced procedures, including uterine aspiration, has been an option for members of all three disciplines (depending on state regulations) for many years.

Support for CNMs, NPs, and PAs in Abortion Care

In December 1996, the National Abortion Federation (NAF), with funding from the Kaiser Family Foundation, convened a national symposium to explore how CNMs, NPs, and PAs could participate more fully in abortion service delivery nationwide. The symposium's key findings and recommendations included:

- appropriately trained CNMs, NPs, and PAs possess the skills and expertise to provide this safe and routine elective procedure;
- a very carefully planned state-by-state effort would be needed to overcome legal restrictions limiting

the participation of CNMs, NPs, and PAs in abortion service delivery in some states; and
- education and understanding of all aspects of abortion care, including counseling, pre- and post-abortion care, and abortion techniques must be expanded.[4]

The largest, most influential and well-respected medical and health policy organizations in the United States have issued statements in support of the inclusion of CNMs, NPs, and PAs in abortion care. In 1994, the American College of Obstetricians and Gynecologists stated, "that to address the shortage of health care providers who perform abortions, the College encourages programs to train physicians and other licensed health care professionals to provide abortion services in collaborative settings."[5] Additionally, the American Academy of Physician Assistants, the American College of Nurse-Midwives, the American Medical Women's Association, the American Public Health Association, the Association of Physician Assistants in Obstetrics and Gynecology, the International Confederation of Midwives, the National Association of Nurse Practitioners in Women's Health, and Physicians for Reproductive Choice and Health support the participation of these three professional groups in abortion care provision.* In order to address the lack of access to abortion care and to protect the health and well-being of women of reproductive age, it is essential to increase the number of abortion providers.

CNMs, NPs, and PAs Involvement in Abortion Care

CNMs, NPs, and PAs are involved in all aspects of abortion care. Listed below are some key aspects of abortion care that may be provided by appropriately trained CNMs, NPs, and PAs:

- provide method-specific counseling and screening;
- determine gestational age and size using patient historical data, and physical exam, as well as ultrasound diagnosis when indicated;
- provide medications for the purpose of inducing abortion, and manage the process of medical abortion including collaborative management of complications, as necessary;
- dilate the cervix;
- assist with vacuum aspiration and surgical procedures;
- perform uterine aspiration for purposes of pregnancy termination or management of abortion complications; and
- provide post-abortion care, including evaluation and collaborative management of complications.

The potential scope of CNM, NP, and PA practice currently varies depending upon each state's regulations, rather than on capacity, training and competency. Unnecessary obstacles to scope of CNM, NP, and PA practice contribute to the rising costs and inaccessibility of health care including abortion care.[6] To expand access to abortion care NAF and Clinicians for Choice (CFC) work with other professional and advocacy groups to increase the number of CNMs, NPs, and PAs who provide medical and surgical abortion.

Clinicians for Choice (CFC) is a membership organization affiliated with the National Abortion Federation (NAF), representing pro-choice certified nurse-midwives, nurse practitioners, and physician assistants working to increase access to comprehensive reproductive health care.

Acknowledgements
Thank you to the 2005 Clinicians for Choice (CFC) Advisory Committee for contributing to the development of this fact sheet.

Endnote
*For a complete list of professional organizations' statements on CNMs, NPs, and PAs in abortion care, please visit the CFC web pages at http://www.prochoice.org/cfc/

Citations
[1] American College of Nurse-Midwives. "Definition of Midwifery Practice." June 2004. <http://www.acnm.org/display.cfm?id=457>.
[2] American College of Nurse Practitioners. "What is a Nurse Practitioner?" October 2005. <http://www.nurse.org/acnp/facts/whatis.shtml>.
[3] Strategies for Expanding Abortion Access: The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions. Washington, DC: National Abortion Federation, 1997.
[4] Id.
[5] Id.
[6] Supra n. 2.

For More Information
For referrals to abortion providers who offer quality care, call NAF's toll-free hotline: 1-800-772-9100. Weekdays: 8:00A.M. - 9:00P.M. Saturdays: 9:00A.M. - 5:00P.M. EST

To order *Strategies for Expanding Abortion Access: The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions* visit https://www.nafresources.org/cgi-bin/ccp51/cp-app.cgi

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MODULE ONE: UNDERSTANDING ABORTION CARE

One of the goals of the *APC Toolkit* is to present abortion care as a normal part of primary care and to provide the evidence for abortion care as a natural extension of the work of APCs, who care for women at risk for or experiencing an unintended pregnancy.

Module One presents evidence regarding the safety of abortion, the need for more abortion providers, and the role of CNMs, NPs, and PAs in providing abortion in the United States. In addition, it describes the multiple barriers that APCs face in becoming abortion providers, including lack of clinical training opportunities, professional and abortion politics, isolation of abortion care from professional credentialing or legal/regulatory mechanisms, and the wide variation in state practice and regulatory environments.

SECTION I. ABORTION IN CONTEXT

OBJECTIVES:

1. Provide background information about the need for abortion in the United States.
2. Describe the range of abortion care, and provide evidence of the safety and efficacy of early abortion procedures.
3. Explain how terminology impacts interpretations of scope of practice.
4. Provide an overview of abortion providers in the United States.

A. AN OVERVIEW OF THE ABORTION CARE SPECIALTY

As noted earlier, about half of all pregnancies in the United States are unintended (Finer & Henshaw, 2006). *Healthy People 2010,* an initiative of the U.S. Department of Health and Human Services, established a national goal to reduce unintended pregnancy (U.S. Department of Health and Human Services, 2000). Access to reproductive health care, including pregnancy options counseling and contraceptive counseling, is critical for reaching this goal.

Differences in adolescent and adult sexual and reproductive health indicators between the United States and other countries shed light on the important role of primary and secondary prevention strategies in reducing unintended pregnancies. Figure I.1 compares reproductive health outcomes in the United States with those in Sweden, France, Canada, and Great Britain.

The illustration shows that adolescents in the United States initiate sexual activity at basically the same age as their European and Canadian counterparts (Darroch, Singh, & Frost, 2001). However, U.S. adolescents are much less likely to use a form of contraception and far more likely to experience an unintended pregnancy. France has the lowest rate of adolescent pregnancy, 20.2 per 1,000 women aged 15–19, with Sweden just slightly higher at 25 per 1,000. Canada and Great Britain report 45.7 and 46.7 pregnancies per 1,000 women aged 15–19, whereas the United States reports 83.6 pregnancies per 1,000 women 15–19, a much higher rate than the other countries in the comparison.

Broadening the focus to include adult women further highlights the importance of preventing unintended pregnancies. For example, in the Netherlands, only 3% of pregnancies

are unplanned, compared with 57% in the United States (Sedgh, Henshaw, Singh, Bankole, & Drescher, 2007). With its low rate of unplanned pregnancies, the Netherlands also has a much lower abortion rate than the United States: 9 abortions per 1,000 women aged 15–44, compared with 21 per 1,000 in the United States (Delbanco, Lundy, Hoff, Parker, & Smith, 1997; Sedgh et al., 2007). Ensuring and expanding access to contraception and comprehensive reproductive health care can help the United States achieve its goal of reducing unintended pregnancies.

FIGURE I.1

Sexual and Reproductive Health: Comparison Among Sweden, France, Canada, Great Britain, and the United States

	Sweden (1996)	France (1995)	Canada (1995)	Great Britain (1995)	United States (1996)
Median age at first sex	17.1	18	17.3	17.5	17.2
Percent who used at least one method of contraception at last intercourse	93.5	89.1	86.8	95.9	80
Pregnancies per 1,000 women aged 15–19	25	20.2	45.7	46.7	83.6
Abortions per 1,000 women aged 15–19	17.2	10.2	21.2	18.4	29.2
Births per 1,000 women aged 15–19	7.8	10	24.5	28.3	54.4

Adapted from: Darroch et al., 2001

Although abortion rates among adolescent and adult women in the United States have decreased somewhat since the late 1990s, approximately 1.2 million abortions were provided in the United States in 2005, making abortion one of the most common procedures women of reproductive age experience (Jones et al., 2008). The Guttmacher Institute estimates that approximately one-third of all women will have an abortion at some point in their lives (Boonstra et al., 2006).

FIGURE I.2

Number of Abortions per 1,000 Women Aged 15–44 in 2003

	Number per 1,000
Switzerland	7
Belgium	8
Germany	8
Netherlands	9
Denmark	15
England and Wales	17
France	17
United States	21

From: Sedgh et al., 2007

Despite the great need for abortion care, most women face multiple obstacles when accessing abortion. A scarcity of clinicians trained and empowered to provide abortions is one such obstacle. Women in rural areas are particularly affected; 35% of women in the United States live in counties without an abortion provider (Jones et al., 2008). Ninety-nine percent of all facilities that perform more than 400 terminations per year are located in metropolitan areas (Jones et al., 2008). Many states also have laws mandating that only physicians may perform abortions ("physician-only" laws). These laws further impede access to abortion care by denying appropriately trained APCs the opportunity to serve their patients' needs.[4]

FIGURE I.3

"Aspiration" versus "Surgical": What's in a Name?

This *APC Toolkit* uses the term *aspiration abortion* when discussing first trimester abortion care because it more accurately depicts a first trimester abortion than does *surgical abortion*. *Surgical* "implies incision, excision and suturing and is associated with the physician subpopulation of surgeons" (Weitz, Foster, Ellertson, Grossman, & Stewart, 2004, p. 78).

Most abortions performed during the first trimester use electric or manual suction to empty the uterus. These simple procedures require only local or oral analgesics and can easily be performed in a primary care setting. Using the term *surgical abortion* to describe both less invasive aspiration procedures as well as more invasive procedures blurs the boundary between these very different types of procedures (Weitz et al., 2004).

Not only does the term *aspiration abortion* clarify the important differences between types of abortions, its use can assist with efforts to challenge the thinking that only physicians should provide abortion care. Surgeons perform surgery. Aspiration abortion is not surgery. Primary care providers, including APCs, provide a wide range of procedures, including intrauterine device (IUD) insertion, endometrial biopsy, management of early pregnancy loss, and abortion. Use of the term *aspiration,* rather than *surgical,* abortion to refer to these procedures is a small but important step that all of us can take to help de-mystify early abortion techniques.

B. BASIC TYPES OF ABORTION PROCEDURES

An important first step in advocating for APCs as abortion providers involves education about the abortion procedure itself. Politicians and regulators as well as clinicians are often unaware of the basic training that is required to become a provider of medication or early aspiration abortion. This lack of understanding can lead to misinformed decisions that unduly restrict training and access.

Although there are multiple types of abortion procedures, this *APC Toolkit* focuses on the two methods most commonly used during the first trimester of pregnancy: aspiration and medication.[5] (See Figure I.3 for a discussion of why the language used to describe these procedures is important.) The vast majority of women seeking abortion care do so in the first trimester, and this is the time when early intervention by an APC is most advantageous. Nationally, APC providers are most likely to perform abortions during this time frame.

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[4] To determine whether you are practicing in a physician-only state, contact the Abortion Access Project at http://www.abortionaccess.org or the National Abortion Federation at http://www.prochoice.org. To see an overview of state laws relating to abortion, visit the Guttmacher Institute's website at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf

[5] See Janet Singer's article—***Share with women. Early termination of pregnancy.*** J Midwifery Womens Health 2009;54:93-4—which provides evidence-based information on early termination of pregnancy that can be used during the essential clinician–patient options counseling for a woman with an unintended pregnancy who is considering abortion or pre-abortion counseling for a woman who has chosen that option.

Medication Abortion

Medication abortion is a method of pharmacologic termination of the early first trimester of pregnancy. Depending on the agent(s), the regimen, and the provider, medication abortion may be initiated as soon as a woman finds out she is pregnant, through 7–9 weeks (49–63 days) of gestation (via menstrual dating). Together, these methods account for 13% of all abortions in the United States (Jones et al., 2008).

In the United States, three medications are available for use as abortifacients: (1) mifepristone, (2) methotrexate, and (3) misoprostol. Both mifepristone and methotrexate are only acceptably effective in terminating intrauterine pregnancy when used in combination with misoprostol (Creinin, 2000; Pymar & Creinin, 2000). Mifepristone is the only one of these agents that has been specifically labeled by the FDA for use as an abortifacient. It blocks the uptake of progesterone by receptor cells in the uterus. Without this essential hormone, the lining of the uterus begins to break down, and the cervix softens. Methotrexate, by contrast, interferes with the DNA synthesis of rapidly dividing cells—in this case, the developing embryo. Misoprostol is a prostaglandin analogue that stimulates uterine contractions and softens the cervix, facilitating uterine emptying. It is most effective when used following either mifepristone or methotrexate. Where neither methotrexate nor mifepristone is available, regimens for misoprostol alone may be used, although efficacy is lower, and the risk of side effects is higher (Carbonell et.al. 2003; Singh et.al. 2003)

FIGURE I.4

Abortion Method Terminology

Medication abortion refers to termination of pregnancy using one or more of the pharmacologic agents mifepristone, methotrexate, and/or misoprostol. Medication abortion may sometimes be referred to as RU486 (its original European name), "the abortion pill," or as "medical" abortion.

Aspiration (or *suction,* or *surgical*) *abortion* refers to procedures that terminate a pregnancy by using manual or electric suction to empty the uterus. These procedures are also known as manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA).

Dilation and evacuation (D&E) and *dilation and extraction* (D&X) describe abortion procedures performed with instrumentation of the uterus and fetus. These procedures are generally used in second trimester abortion care.

Medication Abortion Regimens

Medication abortion regimens are based on the most current clinical research evidence. The World Health Organization (WHO), the American College of Obstetricians and Gynecologists (ACOG), and several other general and specialty health organizations have described safe and effective regimens of early medication abortion (American College of Obstetricians and Gynecologists, 2005; Cheng, 2008; Chien & Thomson, 2006; Grossman 2004; Odusoga & Olatunji, 2002).

As professional organizations that together represent the majority of abortion providers in the United States, the National Abortion Federation (NAF) and the Planned Parenthood Federation of America (PPFA) offer their members continuously revised protocols for safe and effective administration of abortifacients in the first 9 weeks of pregnancy (National Abortion Federation, 2008a). Figure I.5 summarizes the most common regimens (NAF, 2008a).

Early Aspiration Abortion in the U.S.

In the first trimester, abortion can be performed as a simple office procedure using a vacuum aspirator. The designator *aspiration abortion* more accurately describes this procedure (see Figure I.3) than the traditional appellation *surgical abortion*. In aspiration abortion, the cervix usually is gradually stretched with tapered rods. After the cervix is dilated sufficiently, a plastic cannula attached to the suction apparatus is inserted into the uterus. Gentle suction (<60 mmHg) is applied to empty the contents of the uterus. Local anesthesia by means of paracervical and/or intracervical injection is almost universally used, and many clinics offer various other medications for relief of anxiety and pain management. General anesthesia is less commonly used in early abortion but may be offered in some facilities that have specialized equipment and dedicated anesthesia services.

FIGURE I.5

from NAF (2008a): Comparison of FDA-Approved and Other Evidence-Based Regimens

	FDA-Approved Regimen	Evidence-Based Alternative Regimens (vaginal misoprostol)	Evidence-Based Alternative Regimen (buccal misoprostol)	Evidence-Based Alternative Regimen (oral misoprostol beyond 49 days' EGA)
Mifepristone dose	600 mg orally (three 200 mg tablets)	200 mg orally (one 200 mg tablet)	200 mg orally (one 200 mg tablet)	200 mg orally (one 200 mg tablet)
Misoprostol dose	400 µg orally	800 µg vaginally	800 µg buccally	800 µg orally (given as 2 doses of 400 µg, 2 hours apart)
When misoprostol taken	48 hours after mifepristone	6–72 hours after mifepristone ≤ 56 days' gestation; 6–48 hours after mifepristone ≤ 63 days' gestation	One or two days after mifepristone ≤ 56 days' gestation; 24–36 hours after mifepristone ≤ 63 days' gestation	One day after mifepristone, to be repeated on day 7 (vaginally) if abortion is incomplete
Where misoprostol taken	At the medical office	At home	At home	At home
Gestational age limit	49 days' gestation	63 days' gestation	63 days' gestation	63 days' gestation
Timing of initial follow-up examination	Approximately day 14	Within approximately 4 days (e.g. day 4–14)	Within approximately 14 days (e.g. day 4–14)	One week after mifepristone and at 2 weeks (if still incomplete on day 7)
				A one-week follow-up visit is mandatory. According to one study, 10.4% of women needed to receive more misoprostol at their follow-up visit. This second dose was administered vaginally. These women returned for an additional follow-up visit 1–8 days later. Note: an initial dose of 800 µg of misoprostol orally is less effective than giving the same dose vaginally or buccally for women 53–63 days' gestation.

Efficacy and Safety of Early Abortion

Aspiration abortion is highly effective, with success rates (complete abortion) at 99% (National Abortion Federation, 2009). It is also extremely safe. Both major and minor risks are lowest when women receive abortion care in the first trimester (Boonstra, 2006). One community-based study of 1,132 aspiration abortions reported that 88% of patients had been less than 13 weeks pregnant (Paul, Mitchell, Rogers, Fox, & Lackie, 2002). Of these women, 97% reported no complications, 2.5% had minor complications (e.g., infection, bleeding, incomplete abortion) that were handled at a medical office or abortion facility, and less than 0.5% had more serious complications that required some additional surgical procedure and/or hospitalization. No deaths were reported.

Medication abortion is also an extremely safe procedure, with complications occurring in less than 0.5% of cases when evidence-based mifepristone/misoprostol regimens are used (Grimes, 2005). In less than 2% of medication abortions (using evidence-based regimens), the medications do not successfully terminate the pregnancy and an aspiration procedure is necessary.

Both major and minor risks are lowest when women receive abortion care in the first trimester (Boonstra, 2006). Rarely, excessive bleeding or uterine infection may occur (ACOG, 2005; Soper, 2007; Paul, Lichtenberg, Borgatta et al, 2009). Figure I.6 compares aspiration and medication abortion, describing how each works and the advantages and disadvantages of each method.

FIGURE I.6

First Trimester Abortion: A Comparison of Procedures

Procedure	How It Works	Advantages	Disadvantages
Mifepristone	Mifepristone blocks the action of progesterone, causing uterine lining to thin, the cervix to soften and dilate, and the pregnancy to detach. It also increases prostaglandin production resulting in uterine contractions. Misoprostol, a prostaglandin analogue taken orally, vaginally or buccally within a few days of mifepristone, induces uterine contractions and increases the effectiveness of mifepristone to approximately 95–98%.	- Usually does not require the use of surgical instruments, avoiding risk of cervical or uterine injury. - Anesthesia not required. - High success rate (95–98%) with vaginal or buccal misoprostol up to 9 weeks. - Resembles a "natural miscarriage." - May offer women more privacy. - Can be used very early in pregnancy. - Procedure completed within 24 hours of the misoprostol administration in 90% of women. - Approved by the FDA for early abortion.	- May require at least 2 visits. - Takes hours or, rarely, weeks to complete. - Postprocedure bleeding may last longer than with surgical abortion. - Women may see blood clots and pregnancy tissue.
Vacuum Aspiration	The cervix is opened gradually with tapered rods. A cannula (strawlike tube), which is attached to a suction apparatus (either an electric machine or a hand-held syringe), is inserted into the uterus. The contents of the uterus are emptied by suction.	- Usually requires only one visit to the provider. - Procedure is usually completed within minutes. - Allows for anesthesia and/or sedation if desired. - High success rate (approximately 99%). - Can be used early in pregnancy.	- Is an invasive procedure. - May seem less private to some women than aborting at home.

Adapted from: National Abortion Federation, 2009

C. WHO CAN PROVIDE ABORTION CARE?

In 2005 the majority of abortions (69%) were performed at specialized clinics that provide a large number of abortions; nonspecialty clinics provided 25% of abortions, and the remainder were performed in hospitals (5%) and private physician practices (2%) (Jones et al., 2008).

Specialist Providers of Abortion Care

Although there are no regulatory or legislative restrictions related to which categories of physician may provide abortion care, most abortions are currently provided by obstetrician-gynecologists. While the inclusion of abortion care education in obstetric/gynecology residency programs has varied over the past 20 years, the most recent study indicates that more than half of residency programs provide routine training in abortion care and another 40% provide opportunities for residents to train in their elective time (Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006). Only 10% of programs do not provide training opportunities in abortion care to their residents (Eastwood, Kacmar, Steinauer, Weitzen, & Boardman, 2006). Obstetrician-gynecologists may be trained in first trimester as well as second trimester procedures (often referred to as D&Es, or dilation and extraction). Recently, the American College of Obstetrics and Gynecology (ACOG) issued a formal Committee Opinion emphasizing the need for all medical school and obstetric/gynecology residency programs to integrate abortion care training into their curricula to ensure the "availability of safe, legal and accessible abortion care" (ACOG, 2009). While obstetrician-gynecologists comprise an important constituency of abortion providers, other clinicians—in particular, those providing primary care services—are well positioned within the health care system to provide abortion care.

Primary Care Providers of Abortion Care

A variety of primary care providers are showing a growing interest in including abortion care among the comprehensive range of services they offer within their practices. Primary care clinicians, a category which includes family physicians, NPs, PAs, and CNMs (IOM Committee & Donaldson, 1996), are much more likely to provide care to women at risk for unintended pregnancy who live in medically underserved areas than are specialists such as obstetrician-gynecologists (Grumbach et al., 2003).

PAs in Vermont and Montana were among the first providers of aspiration abortion after the Supreme Court decision in *Roe v. Wade* legalized abortion in the United States in 1973 (Joffe & Yanow, 2004). In Vermont, PAs and NPs have continued to provide a significant proportion of the state's abortion care services, and their training program for physicians as well as for other APCs is one of the most respected in the nation. Although physician-only laws in other states may be daunting, there has been growing interest in defining abortion care as within the scope of practice of APCs. In a survey conducted in 1992, 52% of CNMs surveyed believed that they should be allowed to perform abortions, 19% said they might be willing to perform aspiration abortions themselves, and 57% indicated that they wanted prescriptive authority for medication abortion (McKee & Adams, 1994). More recently, approximately one quarter of APCs in a California study expressed interest in obtaining medication abortion training (Hwang, Koyama, Taylor, Henderson, & Miller, 2005). At the time of publication of this *APC Toolkit*, APCs are providing medication and/or aspiration abortion care in numerous states in a variety of clinical settings (Berer, 2009). A timeline of important historical events in APC provision of abortion care can be found on the Clinicians for Choice website at http://www.prochoice.org/cfc/resources/timeline.html (National Abortion Federation, 2008b).

SUMMARY

- Approximately half of all pregnancies in the United States were unintended in 2006; a U.S. national health goal to reduce the rate of unintended pregnancy to 30% by 2010 is unattainable.
- Abortion is one of the most common and safe procedures experienced by women of reproductive age; abortion care can be considered a secondary prevention strategy to reduce the rate of unintended pregnancy.
- Despite the great need for abortion care, most women face multiple obstacles when accessing abortion, including a scarcity of clinicians trained and empowered to provide the procedure.
- Most women seeking abortion do so in the first trimester, when abortion is safest and when early intervention by an APC is most advantageous.
- Both medication and aspiration abortion procedures have excellent efficacy and safety profiles, with major complications occurring in less than 1–2% of cases.
- Aspiration abortion is most commonly provided as a simple ambulatory care procedure; medication abortion is commonly completed by the woman in her home following evaluation, education, and guidance by a health care professional.
- Currently, obstetrician-gynecologists provide most abortions, although primary care clinicians (CNMs, NPs, PAs, and family physicians) are much more likely to provide care to women at risk for unintended pregnancy who live in medically underserved areas.
- Primary care clinicians in certain states have been providing safe, effective abortion care since legalization, demonstrating that early abortion combined with continuity of care reduces complications and increases access.

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