Approved: January 30, 1995

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Carlos Mayans at 1:30 p.m. on January 26, 1995 in Room 423-S of the State Capitol.

All members were present.

Committee staff present: Emalene Correll, Legislative Research Department
Bill Wolff, Legislative Research Department
Norman Furse, Revisor of Statutes
Lois Hedrick, Committee Secretary

Conferees appearing before the committee:
Lorne Phillips, Director, Center for Health and Environmental Statistics
Representative Bruce Larkin
Pat Goodson, Right to Life
Kathy Ostrowski, from Topeka
Jeanne Gawdon, Kansans for Life
Sharon Stringfellow, Concerned Women for America of Kansas
Peggy Jarman, Pro-Choice League
Darlene Greer Stearns, League of Women Voters
Douglas Johnston, Planned Parenthood of Kansas
Kay Mettner, Now Organization for Women

Others attending: See Guest List, Attachment 1.

HB 2083 - Reporting termination of pregnancies.

Chairperson Mayans opened the hearing on the bill and noted that a memo from Emalene Correll, dated January 23, 1995, on **HB 2083** and the concerns expressed by Peggy Jarman, has been distributed to members.

Dr. Lorne Phillips, Director and State Registrar for the Department of Health and Environment, presented written testimony about the reporting system now in place, and the department's pledge to ensure a comprehensive reporting system (see Attachment 2). Dr. Phillips stated that the Allen Guttmacher Institute nationally gathers statistical information on abortions and that the last report (1992) published a 17% discrepancy in the data Kansas has and what the Institute has. Nationally the range in discrepancies is from 2% to 30-40%. All Kansas hospitals must report all induced terminations of 350 grams or larger (about a 20-22 week gestation period). (See report form, Attachment 3). All other reports of terminations are voluntarily reported.

Representative Bruce Larkin, one of the bill's sponsors, explained the bill is pure raw data gathering and expands the list of those who must report. He said there is no hidden agenda to ferret out the names of those who perform abortions.

Pat Goodson, of Right to Life of Kansas, Inc., presented testimony in support of **HB 2083** (see Attachment 4). Kathy Ostrowski, from Topeka, spoke in support of the bill (see Attachment 5). Jeanne Gawdon, representing Kansans for Life, stated support of **HB 2083** (see Attachment 6). Sharon Stringfellow, volunteer lobbyist for Concerned Women for America, presented testimony in support of the bill (see Attachment 7).

Representative Goodwin expressed the point that in small communities, usually with one medical practitioner, privacy is questionable. There is some apprehension on the part of practititioners that the bill will cause investigations of their medical records and privacy will not be preserved.

Peggy Jarman, representing ProChoice Action League, spoke in opposition to **HB 2083**, expressing the opinion that requiring physicians to report will serve as a means of intimidation to stop abortions (see

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES, Room 423-S State Capitol, at 1:30 p.m. on January 26, 1995.

Attachment 8).

Darlene Greer Stearns, representing the League of Women Voters, distributed testimony in opposition to **HB 2083** (see Attachment 9) stating it is the League's belief that the bill would place physicians and their patients at risk of harm.

Douglas Johnston, Lobbyist for Planned Parenthood of Kansas, testified in opposition to **HB 2083** (see Attachment 10), stating that the additional reporting requirement is not worth the danger to constituents.

Kay Mettner, Now Organization for Women, spoke in opposition to **HB 2083**, stating she agreed with the testimony already given in opposition to the bill.

Representative Kirk stated that in urban areas it is more difficult to identify providers; whereas in the rural areas they could be more easily identified. Ms. Jarman replied that as new methods of medical abortions are administered by physicians, that **HB 2083** may cause more violence, making physicians generally known and a target. She said she did not believe doctors, who are told that they must report medical abortions performed in their offices, would be willing to provide that service.

Representative Freeborn asked if the protocol for RU 486 and metholtrexate was available. Ms. Jarman replied she would attempt to get that information for the committee.

The hearing on **HB 2083** was closed.

Chairman Mayans reported that the committee members have been handed a copy of the Consumer Report that Dr. Dennis Tietze spoke about at yesterday's meeting. Also, members have been handed a copy of written testimony of Patricia Joyce, RN, on **HB 2004** (chiropractors authorized to peform health assessments of school pupils) (see Attachment 11).

The meeting was adjourned at 3:04 p.m.

The next meeting is scheduled for January 30, 1995.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES GUEST LIST

DATE: JANUARY 26, 1995

NAME	REPRESENTING
Barb Fisher	Planned Parenthood GKC
Barbara Holzmark	NATIONAL COUNCIL OF JEWISH WOMEN
Darlene Greer Stearns	League of Women Voters of Ks
Lisa Froese	Leadership Arkansas City Arkansas City Chamber
Peggy Jarman	PCAL
Cleta Renyer	Right to Life of Ks
Pat Goodson	" " " " "
Bob Wunsch	KUMC
Jeanne Gawdun	Kansans for Life
Stacey Empson	Hein, Ebert & Weir
Chip Wheelen	KS Medical Soc.
Rich Guthrie	Health Midwest
Sharon Stringfellow	CWA of Ks
CHERYL LYN HIGGINS	LEADERSHIP ARKANSAS CITY, KANSAS
Shannon Peterson	KBA
Jeff Bottenberg	Bottenberg & Associates
LORNE PHILLIPS	KDHE
Harold Riehm	KAOM
[illegible]	KAOM

Joseph Kroll — KDHE

GREG HANSEN — SEN. HARRINGTON

Travis Carr — A.P.

HOUSE H&HS COMMITTEE
1-26-1995
Attachment 1-1

HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES GUEST LIST

DATE: JANUARY 26, 1995

NAME	REPRESENTING
Nathalie Scharf	KHA
Douglas Johnston	Planned Parenthood

State of Kansas

Bill Graves Governor

Department of Health and Environment

Bob J. Mead, Acting Secretary

Testimony presented to
House Health and Human Services Committee
by
The Kansas Department of Health and Environment
House Bill 2083

K.S.A. 65-445 currently requires that hospitals keep records of induced terminations of pregnancy that are performed and report them to the Secretary of Health and Environment. At the time that this statute was passed, hospitals were most likely the provider of choice for legal terminations. Over time the increasing demands for such procedures has contributed to the evolution of the specialized clinic. These facilities now provide the majority of the terminations and hospitals currently provide a small proportion of the procedures.

Even though these specialized clinics are not required to report to KDHE, we have been fortunate in being able to secure the cooperation of these providers to voluntarily report. We have worked very hard to contact any provider that is made known to us and request their cooperation and assure them that the confidentiality they desire will be maintained.

We believe that the information that is provided by these clinics is an essential component of any consideration of such problems as teenage pregnancy. A mandatory reporting requirement would help ensure that KDHE would continue to receive these data regardless of any change in ownership, management philosophies, etc. that could occur and change the current status of cooperation. On the other hand, a mandatory reporting requirement proposed at a time when cooperation is extremely high could be viewed as unnecessary government intervention.

It is the goal of KDHE and the Center for Health and Environmental Statistics to provide high quality information for program staff, the legislature and the public in general. We will therefore continue our efforts to ensure that we have a comprehensive reporting system as a mandatory or a voluntary effort.

HOUSE H&HS COMMITTEE
1 - 26 - 1995
Attachment 2

Testimony presented by: Dr. Lorne A. Phillips
Director and State Registrar
Center for Health and Environmental Statistics
January 26, 1995

Center for Health and Environmental Statistics, 900 SW Jackson, Room 152, Topeka, KS 66612-1290
Telephone: (913) 296-1415——Fax: (913) 296-8075

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TYPE
OR PRINT
IN
PERMANENT
INK

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
Office of Research and Analysis
Topeka, Kansas 66620-0001
913-296-5645

REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

INSTRUCTIONS SEE HANDBOOK

1. FACILITY NAME (If not clinic or hospital give address)

2. CITY, TOWN, or LOCATION OF PREGNANCY TERMINATION

3. COUNTY OF PREGNANCY TERMINATION

4. PATIENT'S IDENTIFICATION NUMBER

5. AGE LAST BIRTHDAY

6. MARRIED? ☐ Yes ☐ No

7. DATE OF PREGNANCY TERMINATION (Month, Day, Year)

8a. RESIDENCE - STATE

8b. COUNTY

8c. CITY, TOWN, OR LOCATION

8d. INSIDE CITY LIMITS? ☐ Yes ☐ No

9. ANCESTRY--CUBAN, MEXICAN, PUERTO-RICAN, VIETNAMESE, HMONG, ENGLISH, GERMAN, ETC.

Specify_______________

10. RACE

1. ☐ White
2. ☐ Black
3. ☐ American Indian
4. ☐ Other (Specify)
____

11. EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5 +)

CONFIDENTIAL RECORD
Copy for Research Purposes Only
Per K.S.A. 65-2422

12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

13. CLINICAL ESTIMATE OF GESTATION (Weeks)

14. PREVIOUS PREGNANCIES (Complete Each Section)

LIVE BIRTHS

14a. Now Living
Number ___
None ☐

14b. Now Dead
Number ___
None ☐

14c. PREVIOUS INDUCED ABORTIONS
Number ___
None ☐

14d. ALL OTHER TERMINATIONS (DO NOT INCLUDE THIS TERMINATION)
Number ___
None ☐

15. TERMINATION PROCEDURES

15a. PROCEDURE THAT TERMINATED PREGNANCY

(Check only one)

TYPE OF TERMINATION PROCEDURES

15b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY

(Check all that apply)

1.___........................Suction Curettage..___1.
2.___........................Sharp Curettage..___2.
3.___........................Dilation & Evacuation (D&E)..................................___3.
4.___........................Intra-Uterine Saline Instillation..........................___4.
5.___........................Intra-Uterine Prostaglandin Instillation...............___5.
6.___........................Hysterotomy..___6.
7.___........................Hysterectomy...___7.
8.___........................Other Specify_______________..............................___8.

____

17. NAME OF PERSON COMPLETING REPORT (Type or Print)_______________

VS-213
Rev. 6/92

HOUSE H&HS COMMITTEE
1-26-1995
Attachment 3

701 S.W. Jackson St., Suite 203, Topeka, KS 66603-3729 (913) 233-8601

TESTIMONY - HOUSE BILL 2083
KANSAS HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES
JANUARY 26, 1995

BACKGROUND AND PURPOSE OF THE BILL:

House Bill 2083 is simply an update of an existing statute. **It entails no policy changes.** In 1970 the Kansas Legislature deemed **abortion reporting of such importance that they made abortion reporting mandatory.** I do not believe that the legisature then, had a hidden agenda or that their intent was to harrass or intimidate abortion providers, any more so than that is the intent of the sponsors of this bill. In 1970 abortions were restricted to hospitals so that was the language of the statute. **This bill simply extends the reporting to those who are performing abortions today**. As you will note this is statistical information only. **The patients name is specifically excluded**. A penalty fine is provided for in another section of the statute not included in the bill for failure to file any required report.

In drafting the original bill several years ago, we faced the problem of defining who would be required to report. An abortion clinic should fall

under the statutory category of a medical care facility, as an ambulatory surgical center (ASC). **Providers, however, have refused to accept that definition since it would require them to have a license and conform to ASC regulations**. KDHE has continually refused to enforce the licensing statute, a refusal which **leaves abortion clinics in the legal category of physicians offices.** This is the reason for including physicians in the bill. **If the abortion clinics want to obey the licensing law and place themselves in the category of a medical care facility or find some other language which would accomplish the goal of mandating abortion reporting, Right To Life would have no objection to such an amendment.**

This is a reasonable and minimal attempt to provide accurate information and statistics regarding the practice of abortion. Those who want to complain might do well to consider what some other states require. I have included with my testimony a copy of the current reporting requirements in Missouri. For instance, any Missouri physician who sees a patient with complications from an abortion is required to file a report. Perhaps the committee would even want to expand House Bill 2083 to include some of the Missouri reporting provisions.

NEED FOR THE BILL

Abortion statistics compiled by the KDHE are included in the Annual Summary of Vital Statistics about which KDHE writes; "**The facts contained in this report are essential for effictive health policy decisions and program planning."**

Abortion statistics are an integral component of fertility rates. Without accurate abortion stats you will not have accurate fertility rates on which to base population projections essential to planning decisions. As the KDHE also states; **"The quality of the analyses in the Annual Summary of Vital Statistics depends on the accuracy of the Kansas vital statistics data."** Underreporting of abortion by the KDHE **not only affects Kansas, but the entire nation because the Centers for Disease Control (CDC) which compiles national health data uses KDHE information for their analyses.**

As we are learning more and more, for instance with breast cancer, that abortion and particularly multiple abortions, do have an effect on the future health of women and babies. Another issue of vital concern, escalating teenage pregnancy rates, cannot be accurately assessed unless we have accurate abortion rates.

ACCURACY OF THE KANSAS DATA

Opponents will tell us that most abortions are reported voluntarily. Ten years ago when this bill was introduced for the first time the health department claimed that 90 % of abortions were being reported then. Yet for the past few years increases in reported abortions have been attributed to increased voluntarty reporting. **Even if the underreporting actually was insignificant we would still need this bill!**

I believe the attached chart demonstrates conclusively the problem with relying on voluntary reporting. I have charted two sets of stats for

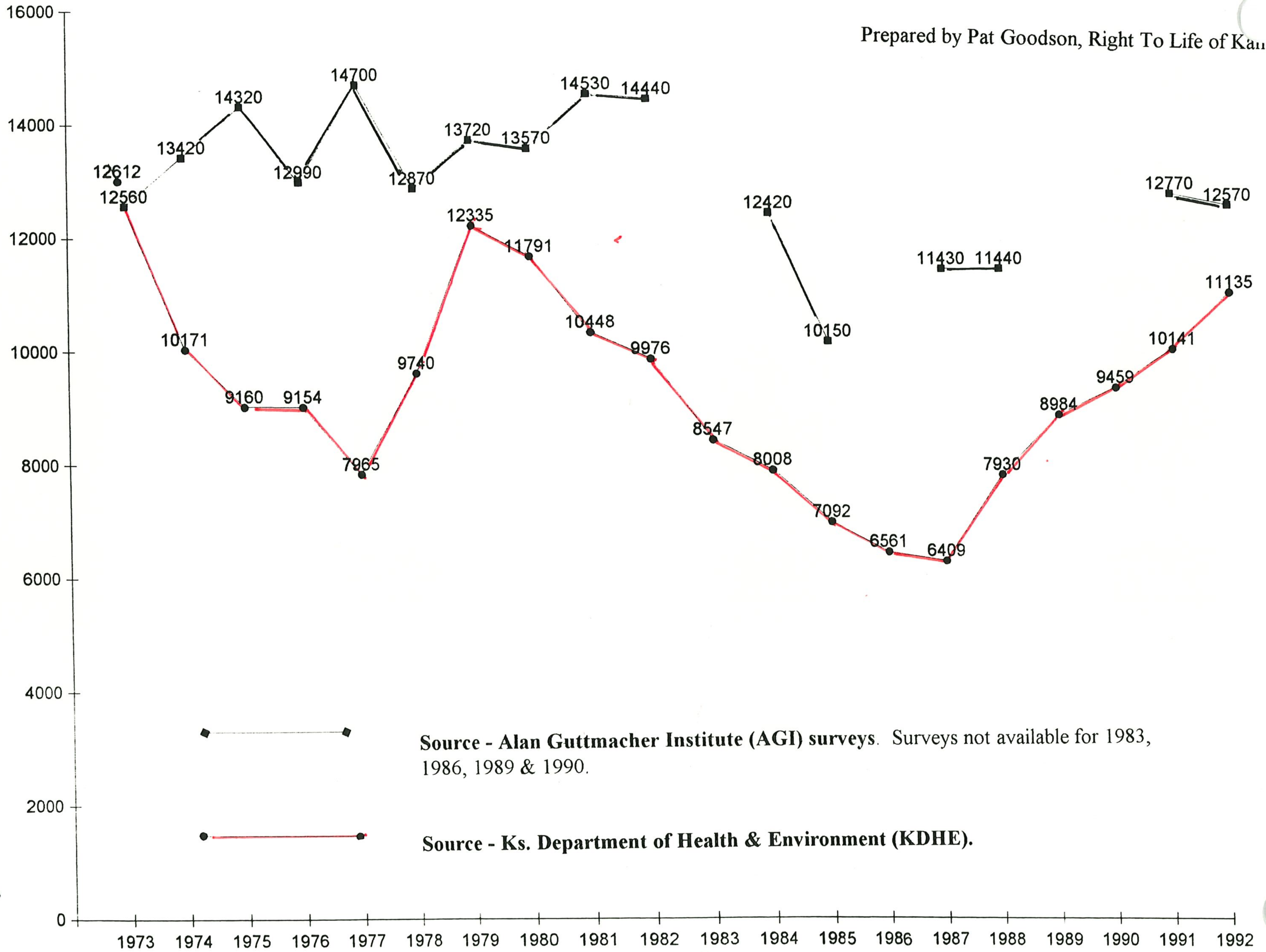
abortions in Kansas. The first set is from surveys made by AGI (Planned Parenthood). The second (in red) is from KDHE reports. **The significant annual discrepancys range from over 65 hundred to over 14 hundred abortions. The only way to ensure any kind of accurate reporting is to make it mandatory.**

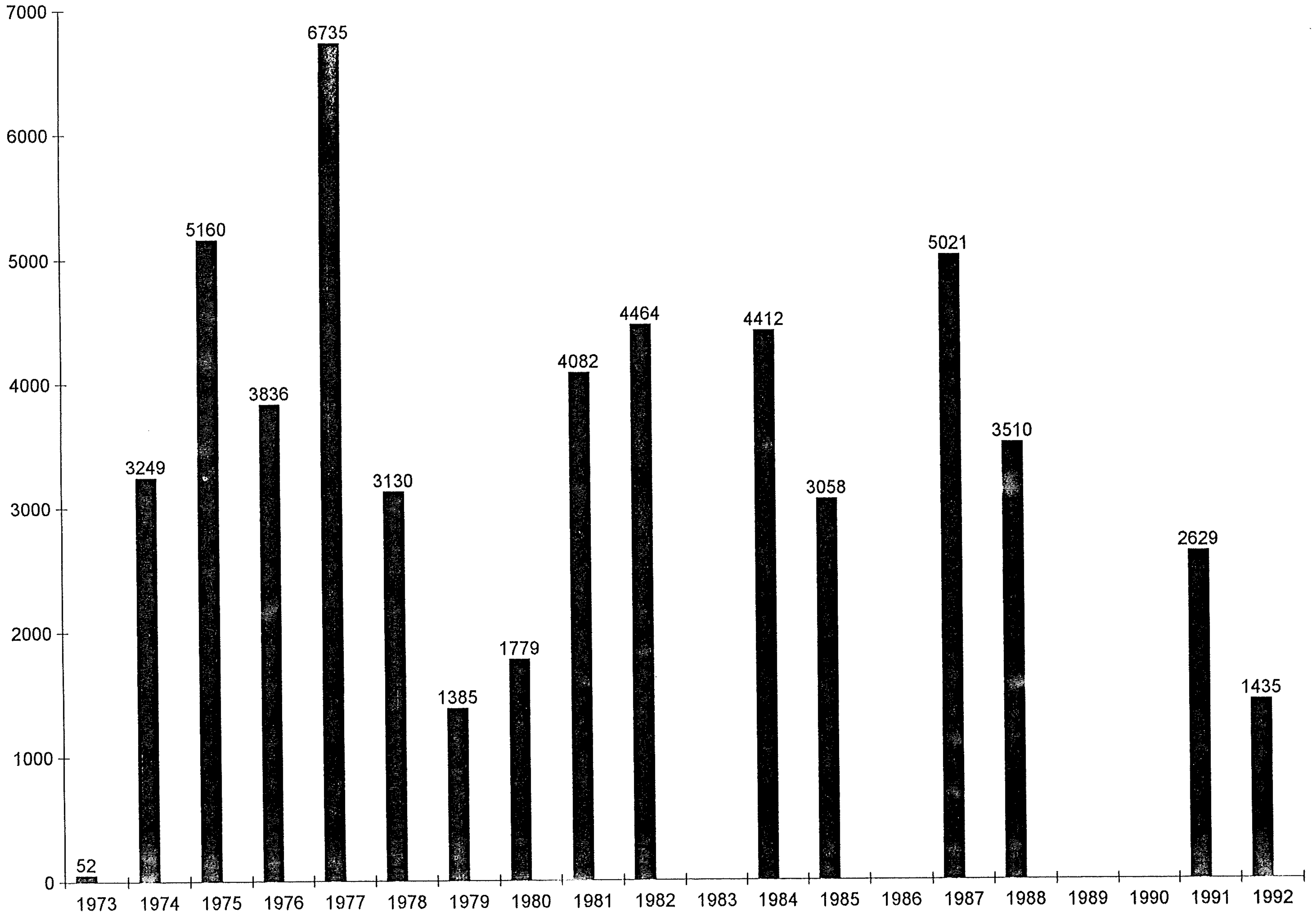
CONCLUSION

Opponents have called this an intimidation bill. Members of the committee, I submit, it is they who are engaging in intimidation. Lacking facts or reasonable arguments they are conducting a paranoic campaign of misinformation, confusion and innuendo. It is time for the Kansas legislature to quit pandering to the grisly self interests of the abortion industry.

The taxpayers of this state are investing a considerable sum of money in the collection of abortion data. At least one full time employee has been engaged since 1992 to monitor abortion reporting. This bill will at last give us some value for those bucks.

Respectfully submitted
Pat Goodson


KANSAS ABORTION STATISTICS
Prepared by Pat Goodson, Right To Life of Kansas
16000
14000
12000
10000
8000
6000
4000
2000
0
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
12612
12560
13420
14320
12990
14700
12870
13720
13570
14530
14440
12420
10150
11430
11440
12770
12570
10171
9160
9154
7965
9740
12335
11791
10448
9976
8547
8008
7092
6561
6409
7930
8984
9459
10141
11135
Source - Alan Guttmacher Institute (AGI) surveys. Surveys not available for 1983, 1986, 1989 & 1990.
Source - Ks. Department of Health & Environment (KDHE).
5-4



9-7

ANNUAL SUMMARY OF VITAL STATISTICS KANSAS, 1993

Joan Finney, Governor

Robert C. Harder, Secretary
Dept. of Health and Environment

Prepared by:
Center for Health & Environmental Statistics
Office of Research and Analysis
Office of Vital Statistics

December, 1994

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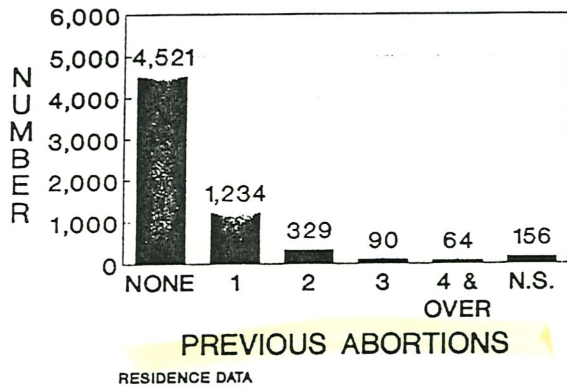
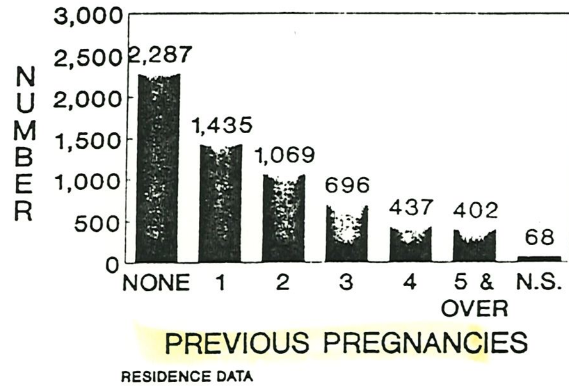
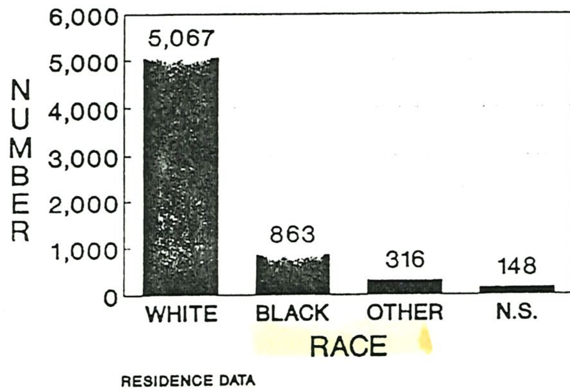
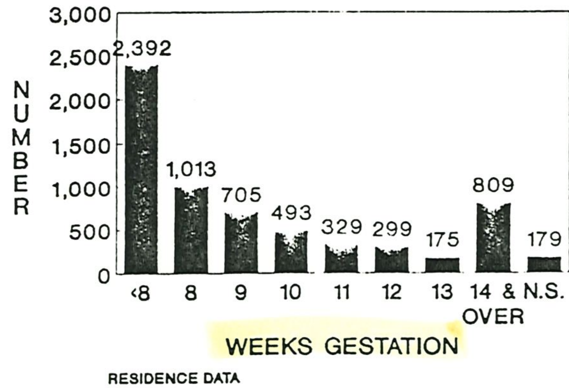
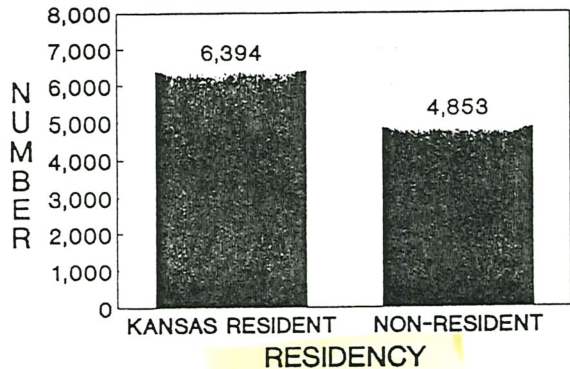
REPORTED INDUCED ABORTIONS
BY SELECTED CHARACTERISTICS
KANSAS, 1993











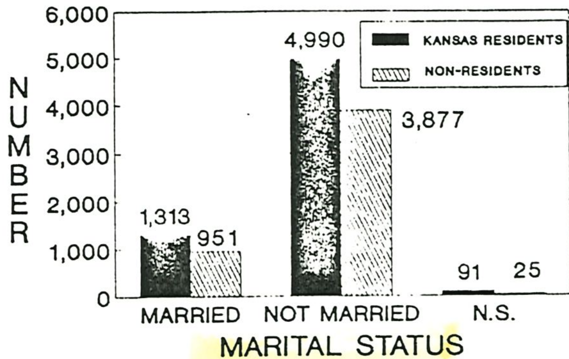


Figure 20

TABLE 18
REPORTED ABORTIONS AND ABORTION RATIOS*
KANSAS AND THE U.S. 1971–1993

Year	Total	Out of State Residents	Kansas Residents	Kansas Ratio	N.S.	U.S. Number	U.S. Ratio
1971	9,472	5,763	3,709	103.0	-	485,816	136.6
1972	12,248	7,736	4,512	136.0	-	586,760	180.1
1973	12,612	7,695	4,917	153.8	-	615,831	196.3
1974	10,171	4,503	5,657	172.9	11	763,476	241.6
1975	9,160	3,565	5,581	165.6	14	854,853	271.9
1976	9,154	3,455	5,686	161.2	13	988,267	312.0
1977	7,965	2,918	5,045	137.0	2	1,079,430	324.5
1978	9,740	3,957	5,722	156.4	61	1,157,776	347.3
1979	12,335	5,042	7,281	187.1	12	1,251,921	358.3
1980	11,791	4,750	7,038	173.0	3	1,297,606	359.2
1981	10,448	4,150	6,291	152.7	7	1,300,760	358.4
1982	9,976	3,823	6,153	151.0	-	1,303,980	354.3
1983	8,547	3,218	5,329	132.0	-	1,268,987	348.7
1984	8,008	2,689	5,319	133.1	-	1,333,521	364.1
1985	7,092	2,447	4,645	117.8	-	1,328,570	353.8
1986	6,561	2,316	4,245	108.4	-	1,328,112	354.2
1987	6,409	2,357	4,052	105.4	-	1,353,671	356.1
1988	7,930	3,161	4,769	123.2	-	1,371,285	352.0
1989	8,984 **	3,270	4,149	107.4	1,565 ***	1,396,658	346.0
1990	9,459 **	3,341	4,175	107.4	1,943 ***	1,429,577	345.0
1991	10,141 **	4,071	6,070	161.3	- ***	1,388,937 ****	339.0 ****
1992	11,135 **	4,904	6,231	164.6	- ***	n.a.	n.a.
1993	11,247 **	4,853	6,394	171.5	- ***	n.a.	n.a.

*Ratio per 1,000 live births
Source for U.S. data: Centers for Disease Control

** The increase in the 1989–1993 figures does not reflect an increase in the number of abortions being performed but rather an increase in the number of providers voluntarily reporting data.

*** Residency data was not available for all abortions in 1989–1990 but due to improved reporting, was obtained for all of the abortions reported in 1991–1993. This improved reporting is also responsible for the increase in the abortion ratio.

**** Provisional

REPEAT ABORTIONS - WHY THE SILENCE?

The phenomenal and steady rise in repeat abortions gives eloquent witness to the fact that making abortion "legal" makes it acceptable. In 1971 1.5% of women having abortions had had a previous abortion. Today, for Kansas women it is nearly one third! The consequences of this phenomen are staggering, both morally and physically.

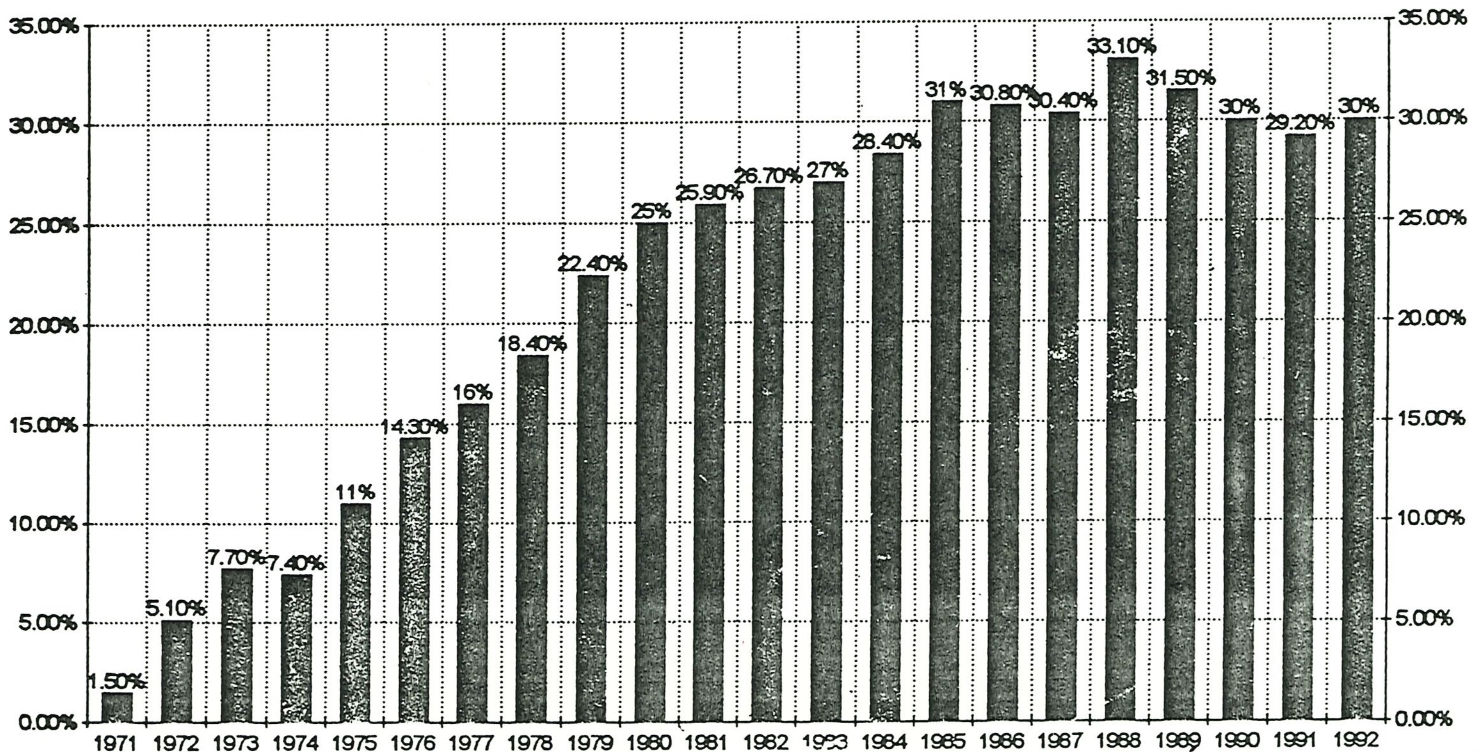
The chart below was prepared from statistics ublished by the Kansas Dept. of Health and Evironment. It represents only abortions reported to the KDHE. For the period from 1971 to 1981 percentages refer to abortions performed in Kansas to both residents and non-residents. For 1982 through 1992 percentages refer to abortions on Kansas residents performed in Kansas and out of state.

Breast cancer is one of the most prolific and rapidly rising cancers in the U. S. and around the world. The incidence of breast cancer in this country has increased 23% since 1973. October is "Breast Cancer Awareness Month" and publicity is aimed at educating women about risk factors for the disease. Yet the one factor that has changed since 1973, the nationwide decriminalization of abortion is never mentioned. The cancer/abortion link is more than a coincidence of timing. It is documented by numerous scientific studies emanating from all over the globe. The risk of breast cancer doubles after one abortion, **and rises even further with two or more abortions.**

A leading cause of infant morbidity and mortality is the low birth weight resulting from premature births. Over the past couple of decades we have listened to public health officials voice concern over high rates of infant morbidity and mortality, yet they have consistently refused to consider the link between abortion and premature births. Ironically, these are the very same people who argued for abortion.

Again, there is ample documentation that abortion dramatically increases the risk of prematurity for a subsequent wanted pregnancy. Dr. John Willke in "Handbook on Abortion" cites European studies finding a 14% increase of premature births after one legal abortion; **18% after two; and 24% after three.**

Why the silence? Is it because the truth would be a threat to the multi-million dollar abortion industry?



4 - 10

Good Afternoon, Ladies and Gentlemen of this Committee.

My name is Kathleen Ostrowski, a Topeka resident. I am speaking as an individual citizen in support of HB2083, a long-overdue measure mandating uniform state collection of abortion statistics. If statistics are to be worth anything, they must reflect reality, not an artificially selected sampling. Certainly this body should not want to jeopardize the future safety of Kansas women by denying them health education and prevention programs grounded in accurate data.

I wonder why the women of this state cannot enjoy the dignity and protection given to Missouri women by their legislature in 1979 in regards to this issue? The State of Missouri abortion reporting statute (188-055) states as its purpose and function

(1.) the preservation of maternal health and life by adding to the sum of medical knowledge through the compilation of relevant maternal health and life data and

(2.) to monitor all abortions performed to assure that they are done only under, and in accordance with, the provisions of the law.

How can it be reasonably argued that similar abortion reporting statutes would NOT serve these genuine governmental purposes? In a phone conversation with Dr. Jack Smith (chief of the CDC stats in the area of reproduction) I learned that this is the ONE health reporting area held hostage by politics, thus denying good scientific data for improving our health.

Opponents of HB2083 will claim they are here to protect women's health.
They can NOT supply any documentation that the abortion reporting statutes of Missouri have been misused over the past 15 years they have been in force. Nor can these opponents point to any other example in the nation where simple statistical reporting eroded medical confidentiality, either actually, intentionally or indirectly. Nor can these opponents provide any documentation of decreased abortion caused by non-invasive statistical registration. Let the wailing cease!

Proponents of HB2083, are promoting the true health concerns of women by providing accurate health data collection.
KDHE's Dr. Steven Pickard writes in the November'94 issue of "Kansas Medicine" that Kansas has defined its state-specific health objectives as the Healthy Kansans 2000 iniative. Its priority is to define the impact of health problems through baseline incidence rate and to identify data needed to monitor progress toward goal achievement. Pickard indicates that HK2000 necessitates state-specific data sources rather than national estimates. HK2000 targeted seven top health issues and, guess what: abortion directly impacts 5 of those top targets! I therefore suggest that HK2000 absolutely requires mandatory abortion statistics.

A large body of reliable studies shows that abortion clearly impacts Alcohol &drug use, Cancer, Heart disease (40% caused by smoking), STDs, Maternal &Infant health. (see colored research newsletters attached) Some highlights:

An eight year study shows teen elective abortion linked to smoking during subsequent pregnancies (a leading cause of low birth rate babies and smoking a leading health negative in itself); 37.8% smoked 10 cigarettes or more per day, compared to non aborted at 20%.

Alcohol consumption for women with 2 or more abortions reported at 98.5% for the entire 9 month gestation as compared to control group, unaborted, at 19%

HOUSE H&HS COMMITTEE
1 -26 - 1995
Attachment 5-1

Alcohol abuse is caused by induced abortion in 15-20% of women aborted.

STDs, unrecognized, are spread by the abortion procedure.; teens are 2 to 5 times more likely than 30 yr.old women to contract complications in this category

Smoking during pregnancy was 18% for the non-aborted, 28.1% for 1 abortion, 31% for 2 abortions, 41.6% for 4 or more abortions

A two year study of hospital admissions showed aborted women smoking rate at 43% as compared to national female rate of 30%

PID (Pelvic Inflammatory Disease) reported 13-37% related to abortion, is experienced by females at least 1 million case per year; acute PID causes infertility, ectopic pregnancies and death.

Maternal Drug Use of Coke, Methamphetamine, Heroin and combinations correlate to number of abortion

Abortion of first pregnancy eliminates of reduces the protective effects of early childbirth against cancer, specifically breast, ovarian, endometrial, and colon

Breast cancer- it's devastating. 180,000 *new* reported cases in the U.S. in 1992. Congress has called this disease a "growing epidemic" since it's the leading cause of death among middle-aged women. Probably everyone here has a friend or relative stricken with it. There are a variety of independent risk factors but international scientific studies show that *abortion* adds 50% to 800% increase in risk for breast cancer!

Using the conservative estimate of 50% increase, 40,000 women annually will contract breast cancer solely because of being aborted; 10,000 of this group will die prematurely and unnecessarily. And that's in *addition* to the annual 10% of American females who will ordinarily be stricken.

In Kansas, 384 women died of breast cancer last year. It may be suggested that an annual abortion rate of 12,000 (with 6,000 done on first time pregnant females) could conservatively yield, solely because of the first abortion, an additional 300 annual breast cancers resulting in 75 more deaths. (see additional materials for explanation of the mechanism of breast cancer)

Cornell Cancer Lab Director Dr. Leon Bradlow feels strongly that it should be more publicized that there is a real risk involving abortions and breast cancer. (Journal of the Nat'l Cancer Inst., Dec.15'93) Pro-choice epidemiologist Dr.Janet Daling published a thorough study (JNCI, Nov.2'94) concluding that abortion adds at least 50% to 90% additional risk for breast cancer. In "Time"magazine she said she was absolutely appalled that politics is entering into the science of this study. I agree; I do not want to demean breast cancer as derivative of a political agenda. However, as a Kansas citizen I have every right to insist that abortion's side effects be known and that a cure for breast cancer (and other health dangers)be pursued free of the abortion ideology. To this end, and as needed to achieve the goals of HK2000, please enact HB2083.

Health issues in Adolescent Pregnancy Decision-Making

Early Child Bearing Provides Protection From Breast Cancer

A womans age at her first full term pregnancy is a critical risk factor for breast cancer. This is an issue of particular interest to adolescents. The longer the length of time from the onset of the first menstrual period to the first full term pregnancy the greater the risk of breast cancer. If one arbitrarily assigns a relative risk of 1.0 to nulliparous women, then a nearly three-fold variation in breast cancer risk can be observed ranging from 0.5 for women who have their first child before age 20 to 1.4 for women who give birth to their first child after age 37. *Etiology of Human Breast cancer*, MacMahon B. et al, J. National Cancer Institute 50:21 (1973). *Diagnosis and Management of Breast Cancer*, Lippman, Marc E. et al, W.B. Saunders Co. (1988) p. 3

Induced abortion, which is usually in the first trimester, does not appear to provide the protective effect of a full-term pregnancy. Thirteen studies have reported that an induced abortion is a risk factor for breast cancer (Relative Risk 1.1-2.7); 4 studies report that an induced abortion provides a slight protective effect against breast cancer and 6 studies report that an induced abortion has no effect on breast cancer risk. *Early Abortion and Breast Cancer Risk Among Women Under Age 40*, H. L. Howe et al, Int'l J. Epidemiology 18(2): 300-304, (1989) citing various studies.

Abortion Increases Risk of Adolescent Infection

Induced abortion by aspiration curettage (the most common method) is directly implicated in post-abortion infections such as endometritis (inflamation of the uterine wall) or (PID) Pelvic Inflammatory Disease (inflammation of the female genital tract). Adolescents are at a particularly high risk especially when unrecognized sexually transmitted diseases (STD) such as chlamydia or gonorrhea are present at the time of the abortion. The abortion procedure stimulates the spread of the unrecognized STD into the uterine cavity causing the infection. Also, instruments used during the abortion procedure may introduce micro-organisms into the uterine cavity or fetal remains following the abortion may also cause infection. *Culture and Treatment Results in Endometritis Following Elective Abortion,* Burkman, et al Am. J. Obstet. Gynecol 128: 156 (1977. *Genital Infections Women Undergoing Therapeutic Abortion,* Avonts and Piot, Europ. J. Obstet., Gynecol. Reprod. Biol, 20: 53 (1985).

Over one million U.S. women annually experience an episode of pelvic inflammatory disease (PID) with 16-20% of cases in teenagers. Acute PID is a major direct cause for infertility, chronic pelvic pain, ectopic pregnancy or even death. *PID and its Sequelae in Adolescents*, Washington et al, J. Adolescent Health Care 6: 298 (1985). The reported incidence of untreated PID following abortion is 0-13% in Scandinavian studies. If chlamydia trachomatis is present at the time of abortion the incidence of untreated PID is 10-37%. *Sexually Transmitted Diseases*, Holmes, Mardh et al, McGraw-Hill (1989) p. 598-599. Women age 15-19 are 2 1/2 times more likely than women 25-29 and five times more likely than women 30-34 to aquire PID when chlamydia or gonorrhea is present in the cervix. *Id.*

A John Hopkins Hospital study found that teenagers 17 years or less were 2.5 times more likely than women 20-29 to aquire endometritis following abortion. The incidence of untreated endometritis following abortion ranges from 3.5% to 14.7% according to John Hopkins Hospital Studies. *Morbidity Risk Among Young Adolescents Undergoing Elective Abortion*, Burkman et al, Contraception , Vol. 30: 99-105 (1984); *Post-abortal Endometrtis and Isolation of Chlamydia, Trachomatis,* Barbacci, M. et al Obstet. Gynecol. 68: 686 (1986).

Adolescent Abortion Risks Increased Maternal Smoking

Women tend to smoke for emotional reasons and as a coping reaction to stress. There is a particular intensification of fear and anxiety in pregnant women who have had previous abortions. Women who have had elective abortions are more likely to smoke during subsequent pregnancies intended to be carried to term compared with women with other reproductive outcomes. A Swedish study of maternal smoking among 4719 women during 1970-78 found that 37.4% of women having prior abortions smoked 10 or more cigarettes per day compared with 21.1% of parity matched controls and 18.9% of all Swedish women. The women with prior abortions were more often teenagers and unmarried at delivery than the control groups. *Outcome of First Delivery After 2nd Trimester Two-Stage Induced Abortion: A Controlled Historical Cohort Study*, Meirik, Nygren, Acta Obstetricia et, Gynecol Scand. 63(1): 45-50 (1984);

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Newsletter

Vol. 5, No. 1, Winter 1993

WOMEN'S HEALTH AND ABORTION I. DETERIORATION OF HEALTH AMONG WOMEN REPEATING INDUCED ABORTION

INTRODUCTION

Approximately one-half of all abortions in the United States are repeat abortions and thus constitute a major portion of all abortions. A number of studies have compared women repeating abortion with women with a history of one abortion or no abortion history. These studies are particularly valuable as the control group includes a woman who has already had one abortion and it is possible to ascertain the trend or direction of the particular aspect of health as the number of abortions increases. This provides the essential information to determine whether or not there is an improvement in health or a deterioration in health.

Although the body of medical and social literature on repeat abortion is relatively small compared to abortion literature in general, it is much more consistent. The available studies all demonstrate that repeated abortion tends to be detrimental to health. There are no studies that purport to demonstrate that repeated abortion improves health. The following summary identifies at least 30 health areas in which the repeating of abortion is detrimental to the health and well-being of women.

ASSOCIATION ANNUAL MEETING

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INCREASED ISOLATION

A Danish study compared 50 women undergoing abortion for the first time with those undergoing abortion a second abortion and found that 57% of the first time women reported having a partner compared to only 33% of those having a repeat abortion.[1]

LOWER SELF-ESTEEM

An analysis of the National Longitudinal Study of U.S. Youth of a total of 5295 women in 1987 who were assessed for well-being based upon self-report found that women with repeat abortions were significantly more likely to say that they did not have much to be proud of than were women who had either one or no abortions.[25]

PERSONAL DISSATISFACTION

A study at four abortion clinics in the Atlanta, Georgia area in 1974 found that women repeating abortion were more likely to want to

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PSYCHIATRIC HOSPITAL ADMISSIONS
DANISH WOMEN-1973-74

Number of Live Births	Age Adjusted Percent with Psychiatric Hospital Admissions
None	2.27%
One	2.56
Two	1.97
Three	2.15
Four	2.01
Number of Prior Induced Abortions	
None	1.90
One	3.42
Two	4.06
Three	6.00
Marital Status	
Married	1.49
Single	2.38
Separated	4.21
Divorced	5.16

Source: R. L. Somers, Risk of Admission to Psychiatric Institutions among Danish Women Who Experienced Induced Abortion: An Analysis Based Upon Record Linkage, PhD Thesis, UCLA (1979) p. 41

* *

change themselves a lot (29.5% v. 19.7%), more likely to say that things go wrong for them (24.6% v. 14.8%), and more likely to feel negatively about their current abortion (27.9% v. 13.1%) compared to women undergoing abortion for the first time.[2]

LACK OF RELIGIOUS AFFILIATION

In a study of repeat abortion patients in Atlanta, Georgia in 1974, 21% of those repeating abortion reported no religious affiliation compared to only 8% of women who were aborting for the first time. The disparity was particularly evident in the private clinic population. (20% vs. 2.5%).[2]

PERSONAL DISTRESS

In a study of 413 women outpatients at the University of Pennsylvania Hospital in 1977-78 women repeating abortion showed significantly higher distress scores on personal sensitivity, paranoid ideation, phobic anxiety and sleep disturbance than women undergoing abortion for the first time.[3]

LESS STABLE RELATIONSHIPS

A study .by researchers at Yale University Medical School of 345 women undergoing abortion at a New York clinic in 1972-73 found that fewer women in the repeat abortion group

were pregnant by husbands (23.7% v. 16.8%') and unmarried women having repeat abortions had been in relationships of shorter duration than unmarried women having first abortions.[4]

A Los Angeles study of 404 women followed through medical records over a 5 year span found that women repeating abortion were more likely to be single or living without a spouse and have less stable relationships with their partners than women undergoing abortion for the first time.[5]

In a study of white women who delivered between 1984-1987 in urban counties of Washington State, 33.5% of women with 4 or more abortions were unmarried compared with 24% of women with one abortion and 20.5% of women with no history of abortion.[12]

A Finnish study found that among women repeating abortion, the men took less responsibility for contraception even though the women had left them greater responsibility in that respect, the solidarity of the relationship with the male was weaker even though the women in the repeated abortion group felt greater admiration for the male partner compared to women with only one abortion.[6]

POORER LIVING CONDITIONS

A Finnish study in 1975 which compared women repeating abortion with women who successfully used contraception following a first abortion found that women repeating abortion had lower net household income, held less prestigious jobs, a lower level of housing and less satisfaction with their living environment as well as poorer competence in building up the socioeconomic framework of their lives.[6]

IMPULSIVENESS

A study conducted at Mount Sinai Hospital and the City Hospital Center using a standard test of "impulsiveness" (the Porteus Maze test) found that women repeating abortion had significantly higher impulsiveness scores than women seeking a first abortion. It was concluded that repeat abortion patients as a group are characterized as having impulsive behavior patterns, absence of reflectiveness, an inability to foresee consequences and a reduced capacity to plan ahead in directed tasks.[7]

INCREASED SEXUAL ACTIVITY

In a study of 1505 women obtaining abortions at a freestanding clinic in western New York during 1975, women repeating abortion were more likely to be using contraceptives but were more erratic in their use and were significantly more sexually active than women who underwent abortion for the first time.[29]

INCREASED RATE OF ABORTION

A study of the rate of abortion in the U.S. from 1974-76 found that the repeat abortion rate among women was approximately 3.5 times higher than women having an abortion for the first time in each of the years of the study.[8]

A study of adolescents in New York City in 1984 found that a single previous pregnancy which ended in abortion greatly increased the likelihood of a subsequent pregnancy ending in abortion. Overall, the increase was 4-6 times greater.[9]

INCREASED FAILURE TO RESPOND

In a follow-up study of women who underwent abortion at two outpatient clinics in metropolitan Philadelphia in 1975, those who failed to respond to a questionnaire survey 4 months later were more likely to have repeated abortions compared to those who did respond (24% vs. 14%). It was suggested that those who failed to respond had more emotional difficulties with their abortions.[30]

INCREASED INCIDENCE OF WELFARE

Women undergoing abortion at the Yale-New Haven Hospital during 1974-75 had an overall incidence of welfare of 25.8% for those women having an abortion for the first time compared to a welfare incidence of 38.2% for women repeating abortion. Among black women 55.6% of the first abortion group were on welfare compared to 65.6% of the repeat abortion group Among white women the figures were 12.3% (first abortion) and 19.3% (repeat abortion).[10]

In a study of women patients entering Boston Hospital for Women during 1976-78,

16.9% of the women with no prior abortions were welfare recipients compared to 26% for women with one prior abortion and 27% for women with 2 or more prior abortions.[11]

INCREASED SMOKING RATES

A study of women entering Boston Hospital for Women during 1975-77 found that among women who had 2 or more abortions 51. 7% smoked compared with 40.3% for women with a history of 1 abortion and 31.7% for women with no history of abortion.[11]

A study conducted by researchers at the Fred Hutchinson Cancer Research Center and the Department of Epidemiology at the University of Washington among 6541 white women during 1984-87 found that 18.0% of the women smoked during pregnancy where there was no history of a prior abortion compared with 28.1% (one abortion), 31.0% (two prior abortions, 29.8% (three prior abortions and 41.6% (four or more prior abortions).[12]

INCREASED DRUG USE

A study of Boston Inner-City women enrolled for prenatal care found that women with a history of two prior abortions were more than twice as likely to be using cocaine during pregnancy (19% v. 9%) and three times more likely to 'use cocaine with a history of 3 or more abortions (9% v. 3%) compared with non-cocaine using controls.[13]

A study on maternal drug use at UCSD Medical Center in San Diego found that women who used cocaine and/or methamphetamine averaged 1.7 abortions compared with 1.2 abortions for non-drug using controls. Women who used heroin or methadone had an average of 2.4 prior abortions and women who used both heroin and either cocaine or methamphetamine had an average of 2.7 prior abortions.[14]

DRINKING DURING PREGNANCY

In a California study of smoking and drinking practices of over 12,000 pregnant women during 1975-77, women reporting a history of two or more abortions nearly all (98.5%) reported consuming alcohol during the entire 9 months of subsequent pregnancy intended to be carried to term. This was a much higher level than women who reported their health as good or excellent (19.7%).[31]

INCREASED INCIDENCE OF PSYCHIATRIC ADMISSIONS

A Danish study during 1973-74 of psychiatric hospital admissions based upon an age adjusted percentage found that the psychiatric hospital admission rate was 1.9% for women with no prior abortions, 3.4% for women with one prior abortion, 4.1% for women with two prior abortions, and 6.0% for women with three prior abortions.[15]

INCREASED INCIDENCE OF SUICIDE ATTEMPTS

In a study of 71 women at the Medical College of Ohio in a post-abortion support group who had poorly assimilated the abortion experience, among women with multiple abortions 50% made post abortion suicide attempts compared with 16% post abortion suicide attempts among women with a history of a single abortion.[16]

INCREASED DEPRESSION

In a study of 71 women in a post-abortion support group who had poorly assimilated their abortion experience those with multiple abortions scored higher on the Beck Depression Inventory Scale (9.4) compared to women with one abortion (4.7).16

COMPULSIVE RE-ENACTMENT

A woman with severe bulimia used repeated pregnancies and abortions to achieve the same calming function as repeated binge eating and vomiting. It was suggested that her behavior was compatible with the view that bulimics use their own bodies as transitional objects and that the cycle of incorporation and expulsion is central to affect regulation. The woman was suicidal and pre-occupied with death.[32]

OBSESSIVE - COMPULSIVE BEHAVIOR

An in-depth clinical study described a young woman who developed a severe obsessive - compulsive disorder after a routine medical procedure. It was suggested that the medical procedure brought back repressed guilt from three prior abortions. She was very fearful of

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SMOKING DURING PREGNANCY AND ABORTION HISTORY

Washington State Women

1984- 1987

Abortion History	Number of Women	Percent Smokers
None	1999	18.0%
One Prior Abortion	1999	28.1%
Two Prior Abortions	1850	31.0%
Four or More Prior Abortions	173	41.6%

Source: MT Mandelson, CB Maden, J. R. Daling, Low Birth Weight in Relation to Multiple Induced Abortions, Am. J. Public Health 82(3): 391, March, 1992

* *

getting pregnant again and that she would make a mistake which would jeopardize her fourth marriage.[33]

MASOCHISTIC TENDENCIES

Masochism or self-punishment has been identified as a factor in some repeat abortions. "I hated myself", said a professional who had undergone three abortions. "I felt abandoned and lost... And I felt guilty about killing something. I couldn't get it out of my head that I'd just killed a baby."

Another 30 year old single woman recalled: "I was totally irresponsible about birth control. It was like I was just waiting to be punished... I didn't go out to do it, but I didn't do anything not to make it happen."[34]

MORAL DETERIORATION

A study by researchers at Yale University Medical School of women having an abortion at a New York clinic in 1973 found that women having first abortions were generally more concerned with moral and ethical issues than were women having repeat abortions.[4]

COMMUNICATION BREAKDOWN

A Canadian study found that among women repeating abortion more had made the decision by themselves compared to women aborting for the first time. (45% v. 33%)[17]

A Hungarian study found that those women who were having a repeat abortion were less likely to be in a happy marriage and more likely to have an abortion independently of her husband.[18]

IRREGULAR MENSTRUAL SYMPTOMS

A survey of Japanese women aged 20 to 44 compared the characteristics of menstruation among women with and without a history of induced abortion reported a significantly higher incidence of cramps, swelling and nervousness compared to women with one abortion or no abortions. A psychic component was suggested by which women with an abortion history view their menses differently than non-abortion women.[24]

INCREASE IN LOW BIRTH WEIGHT AND SHORT GESTATION

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COCAINE USE AMONG BOSTON INNER-CITY WOMEN ENROLLED FOR PRE-NATAL CARE-1984

	Cocaine Users	Non-Users
Number of Women	117	562
Elective Abortions		
One	21%	21%
Two	19%	9%
Three or More	9%	3%

Source: D. A. Frank, et al, Cocaine Use During Pregnancy, Prevalence and Correlates, Pediatrics 82(6):888, Dec. 1988

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A study by the World Health Organization of legalized abortion in Great Britain, Europe, Korea and Scandinavia concluded that repeat abortion is associated with a 2 to 2 1/2 fold increase in low birth weight and short gestation when either compared with one live birth or one abortion.[19]

In a study of white women who delivered between 1984-87 in Washington state , the unadjusted proportion of infants born with a birth weight of less than 2500 grams was 4.4% among women with no abortion history, 5.7% for women with one prior abortion, 7.7% for women with two prior abortions, and 9.6% for women with 4 or more prior abortions.[12]

INCREASED RISK OF PREMATURE BIRTH

A Danish study conducted in 1974-75 concluded that women with a history of 2 or more abortions had twice the risk of a premature infant compared to women with one past abortion.[20]

INCREASED RISK OF MISCARRIAGE OR INCOMPLETE ABORTION

A Boston Hospital for Women study conducted in 1976-78 concluded that women who had two or more induced abortions were 2.7 times more likely to have future first trimester spontaneous abortions (early miscarriage) and 3.2 times more likely to have a second trimester incomplete abortion than were women with no history of induced abortion.[11]

INCREASED INCIDENCE OF SECONDARY INFERTILITY

A 1987-88 study of women in Athens, Greece admitted for secondary infertility found that women with 2 or more prior abortions had a relative risk of 2.3 for secondary infertility, and women with one abortion had a relative risk of 2.1 compared to women with no abortion history. Secondary infertility was defined as, (1) the patient had a previous conception, (2) the patient had been trying to become pregnant for at least 18 months, and (3) if the patient was married and her husband had a normal semen analysis.[28]

INCREASED RISK OF ECTOPIC PREGNANCY

A study of women at the Boston Hospital for Women found that the relative risk of ectopic pregnancy to be 1.6 for women with one prior abortion (reduced to 1. 3 after control of confounding factors) and 4.0 for women with two or more prior abortions (reduced to 2.6 after control of confounding factors.)[21]

INCREASED BREAST CANCER RISK

An upstate New York study matched 1451 cases of breast cancer in women under 40 which were reported to the Cancer Registry with 1451 population controls by year of birth and by residence using zip codes. An odds ratio of 4.0 (CI 1.5-13.6) was associated with a history of repeated interrupted pregnancies with no intervening live births. Ten cases and no controls had a history of two consecutive induced abortions. Six cases and no controls had two or more spontaneous abortions.[22]

A Danish study found that abortion in the first and second trimester was significantly associated with a breast cancer risk of 1.43 (one abortion) and 1.73 (two or more abortions) compared with those without an abortion history after adjustment for age, residence and age at first birth.[27]

INCREASED LIVER CANCER RISK

A study of reproductive factors and the risk of primary liver cancer conducted in Northern Italy between 1984-91 found a 2.1 relative risk for liver cancer for two or more induced abortions and 1.6 relative risk for one abortion compared to women with no abortion history.[23]

INCREASED RISK FOR CANCER OF THE CERVIX

A case-control study published in 1984 in France showed a 2.3 relative risk for cancer of the cervix for women with one abortion and a 4.92 relative risk for women reporting two or more induced abortions compared with women with no prior abortion history.[26]

Compiled by Thomas W. Strahan, Editor

REFERENCES

1. Repeat Abortion in Denmark, Osler, Morgall, Jensen, Osler, Danish Medical Bulletin 39: 89-91, 1992

2. The Repeat Abortion Patient, Judith Leach, Family Planning Perspectives 9(1):37, Jan./Feb. 1977

3. Emotional Distress Patterns Among Women Having First or Repeat Abortions. E. Freeman, Rickels, Huggins, Garcia, Polin, Obstetrics and Gynecology 55(5):630, May, 1980

4. First and Repeat Abortions: A Study of Decision-Making And Delay, M. Bracken and S. Kasl, J. Biosocial Science 7 473-491, 1975

5. Incidence of Repeat Abortion, Second Trimester Abortion, Contraceptive Use and Illness Within A Teenage Population, Rena Bobrowsky, UCLA, PhD Thesis (1986)

6. The First Abortion-And the Last? A Study of the Personality Factors Underlying Repeated Failure of Contraception, P. Niemela, P. Lehtinen, L. Rauramo, R. Hermansson, R. Karjalainen, H. Maki, C-A Stora, Int. J. Gynaecol. Obstet. 19:193-200, 1981

7. Abortion Recidivism, A Problem in Preventive Medicine, J. Rovinsky, Journal of Obstetrics and Gynecology 39(5):649, May, 1972

8. Repeat Abortions- Why More?, C. Tietze, Family Planning Perspectives 10(5):286, Sept./Oct. 1978

9. The Social and Economic Correlates of Pregnancy Resolution Among Adolescents in New York City by Race and Ethnicyit: A Multi-Variate Analysis, Theodore Joyce, Am. J. Public Health 78(6):626, June, 1988

10. Contraceptive Practice and Repeat Induced Abortion: An Epidemiological Investigation, M. Shepard and M. Bracken J. Biosocial Science 11:289-302, 1979

11. Association of Induced Abortion With Subsequent Pregnancy Loss. A. Levin, S. Schoenbaum, R. Monson, P. Stubblefield, K. Ryan, JAMA 243(24): 2495, June 27, 1980

12. Low Birth Weight in Relation to Multiple Induced Abortions, M. Mandelson, C. Maden, J. R. Daling, Am. J. Public Health 82(3) 391-394, March, 1992

13. Cocaine Use During Pregnancy, Prevalence and Correlates D. A. Frank et al, Pediatrics 82(6):888, December, 1988

14. Prenatal Cocaine and Methamphetamine Exposure: Maternal and Neo-Natal Correlates, A. S. Oro and S. D. Dixon, J. Pediatrics 111: 571, 1987

15. Risk of Admission to Psychiatric Institutions among Danish Women Who Experienced Induced Abortion: An Analysis Based Upon Record Linkage, R. L. Somers, PhD Thesis, UCLA (1979) p.41

5 - 10

16.Psychological Profile of Dysphoric Women Postabortion, K. Franco, MB Tamburrino, N. B. Campbell, J. E. Pentz, S. G. Jurs, Journal of the American Medical Women's Association 44(4):113, July-August 1989

17.Repeat Abortion: Is It A Problem?, C. Berger, D. Gold, D. Andres, P. Gillett, R. Kinch, Family Planning Perspectives 16(2):70. March/April 1984

18.Pilot Surveys of Repeated Abortion E. Szabady and A. Klinger, International Mental Health Research Newsletter 14:6, 1972

19.World Health Organization, Special Program of Research, Development and Research Training in Human Reproduction: Seventh Annual Report, Geneva, Nov. 1978

20.Pregnancy Complications Following Legally Induced Abortion With Special Reference to Abortion Technique, E. Obel, Acta Obstet Gynecol Scand 58:147-152, 1979

21.Ectopic Pregnancy and Prior Induced Abortion, A. Levin, S. Scheonbaum, P. Stubblefield, S. Zimicki, R. Monson, K. Ryan, Am. J. Public Health 72(3):2530256, March, 1982

22.Early Abortion and Breast Cancer Risk among Women Under Age 40, H. L. Howe, R. T. Senie, H. Bzduch, P. Herzfeld, Int'l Journal of Epidemiology 18(2):300, 1989

23.Reproductive Factors And The Risk of Hepatocellular Carcinoma in Women, C. LaVecchia, E. Negri, S. Franceschi,
B. D'Avanzo, Int'l J. Cancer 52:351, 1992

24.Increase Reporting of Menstrual Symptoms Among Women Who Used Induced Abortion, L. H. Roht et al, Am. J. Obstet. Gynecol, 127:356, 1977

25.Abortion, Childbearing and Women's Well-Being, N. Russo and K. L. Zierk, Professional Psychology: Research and Practice 23: 269-280, 1992

26.Oral Contraceptive Use and Breast or Cervical Cancer:Preliminary, Results of a French Case-Control Study, M-G,Le et al in Hormones and Sexual Factors in Human Cancer Etiology, Ed. JP Wolff, J. S. Scott, Excerpta Medica:New York (1984) pp.139-147

27.Risk of Breast Cancer in Relation to Reproductive Factors in Denmark, M. Ewartz, Br. J. Cancer 58:99-104, 1988

28.Induced Abortions, Miscarriages, and Tobacco Smoking as Risk Factors for Secondary Infertility, Tzonou et al, J. Epidemiology and Community Health, 47:36, 1993

29.Repeat Abortions: Blaming the Victims, B. Howe et al, Am. J. Public Health, 69(12):1242, Dec. 1979

30.Influence of Personality Attributes on Abortion Experience, Ellen W. Freeman, Am. J. Orthopsychiatry, 47(3):503, July, 1977

31.Patterns of Alcohol and Cigarette Use in Pregnancy, Kuzma and Kissinger, Neurobehavioral Toxicology and Terotology, 3:211-221, 1981

32.Recurrent Abortions in a Bulimic: Implications Regarding Pathogenesis, RS El-Mallakh and A. Tasman, Int'l. J. Eating Disorders, 10(2):215-219, 1991

33.Obsessive - Compulsive Disorder Apparently Related to Abortion, Ronald K. McCraw, Am. J. of Psychotherapy, Vol. XLIII, No 2, pp 269-276, April, 1989

34.Aborted Women: Silent No More, David C. Reardon, Loyola Univ. Press: Chicago, 1987

ASSOCIATION ANNUAL MEETING AND PAPER SESSION

The Annual Meeting of the Association for Interdisciplinary Research in Values and Social Change will be held on Wednesday, June 23, 1993 at the Milwaukee Hyatt Regency Hotel (downtown), 333 West Kilborn Avenue, Milwaukee, Wisconsin, from 8:00pm to 10:30pm. The general public is invited and there is no charge to attend. The presenters will be:
Joel Brind, PhD, Abortion - Breast Cancer Link
Lee Ellen Gsellman, M.A., NCC, Post Abortion Research - Akron Pregnancy Services
David C. Hanley, M.S.W., A.C.S.W., Induced Abortion in Mental Health Outpatients
*George Mulcaire - Jones, M.D., Critique of American Medical Association Position on Abortion *Tentative

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Newsletter

Vol. 5, No. 2, Spring 1993

WOMEN'S HEALTH AND ABORTION II. RISK OF PREMATURE DEATH IN WOMEN FROM INDUCED ABORTION: PRELIMINARY FINDINGS

INTRODUCTION

A major factor in the abortion issue that has received very little attention is the increased likelihood of premature death due to the detrimental health effects of abortion. Induced abortion is a direct cause of alcohol and drug abuse in a substantial number of women which may result in early death. It also is a risk factor and is likely to be a direct cause for increased smoking rates in women. Deaths of U.S. women attributable to smoking exceed 100,000 annually. Induced abortion, particularly of the first pregnancy, eliminates or reduces the protective effects of early childbirth. This increases the risk and likelihood of breast, ovarian, endometrial and possibly other cancers.

CIGARETTE SMOKING

Induced abortion, including legalized abortion, is a risk factor for smoking in women. A study of women patients entering Boston Hospital for Women during 1976-78 found that 31.7% smoked if there was no history of abortion compared to 40.3% (one abortion) or 51.7% (two or more abortions).[1] A large scale study conducted by the World Health Organization on Arab and Jewish women found that among current smokers, 12.3% reported a prior induced abortion compared to only 6.3% among women who had never smoked.[2] A Swedish study conducted during 1970-78 found that 37% of women reporting prior abortion smoked 10 or more cigarettes per day compared to only 21.1% for parity matched controls and 18.9% for Swedish women generally. The Swedish study also reported that women who had prior abortions were more often teenagers and unmarried at a subsequent delivery than controls, and were also more likely to be smoking during pregnancy.[3]

Induced abortion appears to be a direct cause of increased smoking in women

The results of these earlier studies have been recently confirmed in a study of 6541 white women in the major urban counties of Washington state who delivered during 1984-87. Among women with no abortion history only 18.0% smoked during pregnancy compared with 28.1%(one abortion) or 41.6% (four or more abortions).[4] The mean average smoking rate during pregnancy for women with a history of one or more abortions was 30%. This is significantly higher than the results of a 1989

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TABLE 1
IMPACT OF SMOKING ATTRIBUTABLE TO INDUCED ABORTION ON MORTALITY OF U. S. WOMEN IN A SINGLE YEAR

Percent Smoking Increase Attributable to Abortion	Annual Number of Women Who Would Begin to Smoke	Annual Number of Women Who Would Have Lung Cancer	Estimated Annual Number of Premature Deaths From Smoking: Lung Cancer Alone	Estimated Annual Number of Premature Deaths From Smoking: All Causes
2%	31,180	4,310	3,750	11,250
5%	77,950	10,780	9,380	28,140
10%	155,900	21,560	18,760	56,280
15%	233,860	32,240	28,135	84,405

Sources: Abortion Statistics, Alan Guttmacher Institute, 1987[22]
Cancer Facts & Figures - 1993, American Cancer Society[23]
Lung Cancer and Smoking Trends in the United States, May/June 1991[11]
Smoking - Attributable Mortality and Years of Potential Life Lost , CDC, 1984[9]

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Centers for Disease Control (CDC) national survey reporting that only 19% of U.S. women smoke during pregnancy. The CDC survey also found that 64% of women will continue to smoke during pregnancy.[5] If this figure is applied to the women who smoked with a history of abortion, then the weighted average smoking rate of the Washington state women when they were not pregnant is approximately 47%. This figure is very similar to the weighted average smoking rate of 43.5% for non-pregnant women with a history of abortion who entered the Boston Hospital for Women during 1976-78.[1]

This figure of 43.5%-47% is significantly higher than the 30% figure for U.S. women in general which was reported in 1989 by the CDC. The difference might be thought to be accounted for from the differences in personality characteristics and habits of women who seek abortion and not from the effects of abortion itself. However, it appears that personality characteristics of women who may obtain abortions because they have an "unwanted" pregnancy does not account for a major portion of the difference. A British study found that attitude toward pregnancy is a factor in smoking rates among women, Among women who said they wanted to be pregnant 30.3% were smokers, while 36.8% smoked when they said they did not want to be pregnant.[6]

There is other evidence that induced abortion is a major direct or indirect factor in smoking. It is known that women frequently smoke for emotional reasons to attempt to relieve depression or anxiety or as an attempt to cope with stress.[7] The available evidence , particularly with respect to emotional problems as abortion is repeated, is a strong indicator that abortion does not relieve stress and anxiety over the long run but instead increases it. Induced abortion is also frequently a direct cause or result of the breakup the relationship of the womans partner. This factor may increase smoking due to bereavement or grief from the loss of the relationship. A University of New Hampshire study linked high levels of social stress with high cigarette consumption and respiratory cancer deaths. There was a stronger stress - lung cancer connection among women than men. The researchers concluded

that many of the indicators to measure stress such as divorce and abortions could have a greater effect on women.[8]

In 1984, it was reported by the Centers for Disease Control that 106,063 women died from the effects of smoking with a loss of 288,273 years of potential life prior to the age of 65. This was an average loss of 2.71 years of life for each woman prior to age 65.[9] In 1987, 42,748 women died of lung cancer in the U. S. 5116 deaths were in women between the ages of 35-54; 26,228 deaths were between 55-74, and 11,290 were at age 75 or greater.[10]

If induced abortion accounted for only a small increase in smoking among women , thousands of U.S. women will die prematurely each and every year.

According to the most recent figures women smokers are 10.8 times more likely to die from lung cancer than women non-smokers.[11] Women smokers are 3.32 times more likely to die from lung cancer than women in general.(130.4 per 100,000 vs. 39.3 per 100,000). At current figures, which are rising, about 1 in 24 U.S. women will have lung cancer in their lifetime; about 1 in 7.2 women who smoke will have lung cancer in their lifetime.

Women smokers are 10.8 times more likely to die from lung cancer than non-smoking women

If the effects of induced abortion only increased smoking rates in post abortion women 2%, then 4310 additional women would have lung cancer each year and 3750 of these women would die each year from lung cancer at the present mortality rate of 87% If all smoking related deaths were taken into account the 2% smoking increase in post abortion women would lead to approximately 11,250 deaths annually. If smoking were increased 5% in post abortion women, then approximately 28,140 women in the U.S. would die annually from all causes attributable to smoking. If smoking rates were increased 10% in post abortion women, the death figure would reach approximately 56,280 women annually. And if induced abortion increased smoking rates 15% the annual death rate would be approximately 84,405.[22,24]

DRUG ABUSE

Induced abortion is a direct cause of drug abuse in 15-20% of the women who have abortions.[12] Women with a history of abortion are frequently able to recall that the onset of drug abuse or increased drug abuse occurred as a direct result of their abortion experience and have stated that drugs were used to attempt to repress the abortion experience or to overcome nightmares or insomnia as a result of their abortion.[13] In New Jersey and New York during 1987 the leading cause of death among black women aged 15 to 44 was from HIV/AIDS. The death rate for black women(10.3 per 100,000)was nine times that for white women(1.2 per 100,000) Among the death certificates that included any mention of HIV/AIDS among these black women ,27% also included drug abuse as a contributing cause.[14] Induced abortion and particularly repeat abortion, has been found to be a risk factor for cocaine, heroin or methamphetamine use in women. A study of Boston inner-city women enrolled for prenatal care at a Boston hospital found that among those women with a history of two abortions they were twice as likely (19% v. 9%) to be using cocaine compared to non-cocaine using controls and three times more likely to be using cocaine (9% v.3%) if they had a history of three abortions.[15] A San Diego study found that women who used both heroin and either cocaine or methamphetamine had an average of 2.7 abortions compared to 1.2 abortions for non-drug using controls.[16]

ALCOHOL-RELATED FATAL CRASHES

Induced abortion is a direct cause of alcohol abuse in 15-20% of women who have abortions.[12] Since women who have had abortions have a higher incidence of alcohol abuse compared to women without any abortion history, they have a higher risk of a fatal crash in a motor vehicle. For example, a 1976 study of women seen at a detoxification center in King County, Washington found that women who were considered problem drinkers or secondary alcoholics were likely to have experienced abortions in the same year as their alcohol-related problem. Driving while intoxicated was an alcohol-related problem for both secondary

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Type of Cancer	Estimated New Cases U. S. Women-1993	Estimated Deaths-U. S. Women-1993
Breast	182,000	46,000
Ovary	22,000	13,300
Uterine Corpus	31,000	5,700
Colon & Rectum	75,000	28,200

Source: American Cancer Society, Cancer Facts and Figures-1993

* *

alcoholics(33%) and problem drinkers(19%).[17] A 1981 random survey of U.S. women found that women with a history of abortion were more than twice as likely to be heavy drinkers (13%) compared to U.S. women in general(6%).Driving while intoxicated was a problem for 45% of the heavy drinkers but only 17% of women drinkers generally.[18]

A study by the Insurance Institute for Highway Safety based upon 1986-87 data found that each 0.02% increase in the blood alcohol content nearly doubles the risk of being in a single vehicle fatal crash. The risk of a female 21-24 years at a blood alcohol level of 0.05%-0.09% of dying in a single vehicle accident was 35 times higher compared to a blood alcohol level of 0.00-0.01%. Females at similar blood alcohol levels had a generally higher risk of death than males.[19] A separate North Carolina study based upon data from 1975-1984 also found that arrest rates for driving while intoxicated increased among women along with single vehicle nighttime crashes. Males showed a substantial decrease in crash rates while females demonstrated almost no change.[20] The Centers for Disease Control reported that from 1982 to 1990, the number of female drivers involved in fatal crashes increased 28%, while the number of male drivers involved in fatal crashes remained essentially unchanged. Decreases in the estimated numbers of alcohol involved drivers in fatal crashes were greater for males(15%) than for females(4%).[21]

DELAYED CHILDBIRTH

Induced abortion is a major factor of delayed childbirth in the U.S. According to the statistics of the Alan Guttmacher Institute for 1987 1,559,110 women in the U.S. had an induced abortion. 52.7% of these women reported no prior live births. 26.1% were under 20 years of age at the time of the abortion and 59.1% were under age 25.[22] There are several major types of cancer which increase the risk of premature death in women if childbirth is delayed or is non-existent. These are breast cancer, ovarian cancer, cancer of the endometrium or uterine corpus. Several studies have also found that not having children is a risk factor for cancer of the colon and rectum. However this has not been definitely been established and may reflect a lifestyle issue. The above table lists the estimated number of new cases and estimated number of deaths for U.S. women in 1993 .

Breast Cancer

Delayed childbirth or carrying a child to full-term increases the risk of breast cancer. A large international collaborative study published in 1970 of breast cancer and reproductive experience found that women having their first child under the age of 18 have only about one-third the risk of breast cancer of those whose first birth is delayed until age 35 or more.[24] The U.S. Public Health Service and the National Institutes of Public Health have concluded that the risk of breast cancer for women who have never had children and women who have a first child after age 30 have

a risk about three times greater than women who have a first child before age 18.[25]

It is not yet fully established whether induced abortion is a contributing cause for breast cancer independent of nulliparity. Some well designed studies have found that induced abortion does not provide the protective effect of childbirth against breast cancer, but tends to increase the risk of death from breast cancer at an early age. A case-control study in 1972-78 of young women in Los Angeles, County, California age 32 or less found that a first trimester abortion before a first full term birth was associated with a 2.4 fold risk of breast cancer.[26] A case-control study in up-state New York of cases of breast cancer in women under 40 years of age reported to the Cancer Registry during 1976-80 and matched by year of birth and by residence using zip codes, found an elevated risk of 1.9 among those with an induced abortion.[27]

Induced abortion of a first pregnancy eliminates or reduces the protective effects of early childbirth against cancer

Based upon the figures of the Alan Guttmacher Institute, 821,650 women in 1987 who had abortions of the their first pregnancy, increased their risk of dying from breast cancer at sometime within their lifetime.[22] It is estimated by the National Cancer Institute that approximately one out of nine women will have breast cancer in her lifetime.[28] If there is no elevated risk from delayed childbirth, approximately 91,295 women out of the 821,650 women who aborted their first pregnancy would be expected to have breast cancer sometime in their lives. If the risk from delayed childbirth due to early abortion was 2.0, then an additional 91,295 women would subsequently have breast cancer from delaying childbirth due to induced abortion of their first pregnancy. Out of these additional 91,295 women about 18,260- 22,820 would die prematurely from breast cancer from their 1987 abortion at the current mortality rate of 20-25%. These figures are only preliminary and may change as additional data, especially over the long term, is available. However, the data is based only upon the loss of the protective effect from no childbirth and is treated as if the woman were nulliparous. This is a conservative approach and does not treat induced abortion as having a separate increased risk compared to nulliparity which it may indeed have and some studies conclude.

Breast cancer is a major cause of premature death in women. In 1987, 40,899 U. S. women died of breast cancer. 688 women died between the ages of 15-34, 8489 died betweeen the ages of 35-54, 20,071 died between the ages of 55-74, and 11,648 died at age 75 or greater.[10]

Women who have never had children are twice as likely to develop ovarian cancer as those who have children

Ovarian Cancer

Studies of ovarian cancer in women have also found that childbirth exerts a strong protective effect against ovarian cancer which increases with the number of live born children. One study found that women who had no children were 2.45 times more likely to develop malignant ovarian tumors than women who had been pregnant three or more times.[29] A study of borderline ovarian tumors in women in Washington state between 1980-85 found that the risk was 0.7 among women who had given birth to one or two children and 0.4 for three children compared to nulliparous women. A similar proportion of cases and controls reported a history of induced abortion which would tend to indicate that induced abortion does not have a protective effect.[30] The U.S. Public Health Service and the National Institutes of Health have concluded that, " childbearing is the most important known factor in preventing ovarian cancer suggesting that hormones play a role in its development... Breast cancer may also increase a woman's chance of developing ovarian cancer."[25] The American Cancer Society states, " Women who have never had children are twice as likely to develop ovarian cancer as those who have. Early age at first pregnancy, early menopause, and the use of oral contracep-

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TABLE 2

ANNUAL NUMBER OF DEATHS FROM SPECIFIED CANCER IN U. S. WOMEN: PRELIMINARY ANALYSIS

Type of Cancer	Relative Risk*	Annual Number of Cases Attributable to Delayed Childbirth Due to Abortion	Annual Number of Deaths Attributable to Delayed Childbirth Due to Abortion
Breast	2.00	91,295	22,820
Ovarian	2.00	12,640	7,836
Uterine Corpus	1.67	9,960	1,693

Sources: Alan Guttmacher Institute, 1987, Abortion Statistics,[22]
Cancer Facts and Figures - 1993, American Cancer Society[23]

*Compared to one live birth

* *

tives, which reduces the frequency of ovulation, appear to be protective against ovarian cancer. If a woman has had breast cancer, her chances of developing ovarian cancer double."[23]

If 821,650 women abort their first pregnancy and have a risk of 2.0 for ovarian cancer and approximately one out of 65 women will have ovarian cancer, in her lifetime, then approximately 12,640 additional women will have ovarian cancer. At the present mortality rate of 62% , then 7,836 women would die prematurely from ovarian cancer. In 1987, there were 12,020 U. S. women who died of ovarian cancer. 1,666 deaths occurred between the ages of 35-54, 6,462 occurred between 55-74 and 3,753 at age 75 or greater.[10]

Endometrial Cancer or Cancer of the Uterine Corpus

It is estimated that U.S. women will have 31,000 new cases of endometrial cancer in 1993. Several studies have determined that a risk factor for endometrial cancer or cancer of the uterine corpus is few or no children. The U.S. Public Health Service and the National Institutes of Health state, "A risk factor for endometrial cancer is few or no children... Women of high socioeconomic status have an increased risk of developing endometrial cancer; diet and lifestyle may be contributing factors.[25] "A case-control study in Los Angeles County, California between 1972-79 among white women concluded the relative risk for one full pregnancy was 0.54 and for two full term pregnancies was 0.22 compared to no full term pregnancy. Incomplete pregnancies, including both spontaneous and induced abortions, were associated with a slight decrease in relative risk. 5.6 incomplete pregnancies were concluded to be equivalent to one full term pregnancy in terms of risk reduction.[31] In another study published in the Journal of the National Cancer Institute in 1977, women with 1 or 2 full term pregnancies had a 0.6

relative risk, and women with three or four full term births had a 0.3 relative risk of endometrial cancer compared with nulliparous women.[32]

At present rates the risk of endometrial cancer in U.S. women is approximately 1 in 55 women, then 14,940 out of the 821,650 women would be expected to have endometrial cancer. If the relative risk for endometrial cancer is 1.67 due to abortion of the first pregnancy and loss of the protective effect of childbirth, then 9960 additional cases of endometrial cancer would result. At a mortality rate of 17% the annual number of deaths from the increased incidence would be 1,693.

Cancer of the Colon or Rectum

Although the evidence is less certain, cancer of the colon and rectum may increase in women who delay childbirth. A Washington state study in 1976-77 found that the incidence of colon cancer in women with one or two children was reduced by 30% and for women with 3 or more children was reduced by 50% compared to nulliparous women.[33] A Canadian study found a strong protective effect of early age of first pregnancy for both colon and rectal cancers with little or no effect based upon the total number of pregnancies.[34] The data suggested that non-birth outcomes may be a risk factor for both colon and rectal cancer. A large Norwegian study of 63,090 women from 1956-1980 found a relative risk of 1.29 for colon cancer among women with 2 or more abortions and a 1.72 relative risk for cancer of the rectum also among women with 2 or more abortions compared to women with no history of abortion. Most of the abortions in the Nowegian study were thought to be spontaneous abortions.[35]

At present rates approximately 1 out of 23 women in the U.S. will have colon or rectal cancer in her lifetime. Based upon 821,650 U.S. women who abort their first pregnancy annually then 35,725 women would be expected to have colon or rectal cancer in their lifetime. If the risk of delayed childbirth due to abortion was 1.5 then approximately 17,860 additional women would have colon or rectal cancer as a result of the increased incidence. At the present mortality rate of 43% the annual number of premature deaths would be 7680. In 1987, 28,445 women in the U. S. died of cancer of the colon or rectum. 1,998 were between the ages of 35-54, 11,846 were between 55-74 and 14,443 were over 75.[10]

Thomas W. Strahan, Editor

REFERENCES

1. Association of Induced Abortion with Subsequent Pregnancy Loss, Levin, et al., JAMA, 243:2495-2499, June 27, 1980

2. Characteristics of Pregnant Women Reporting Previous Induced Abortions, Harlap and Davies, Bulletin of the World Health Organization, 52:149, 1975

3. Outcome of First Delivery After 2nd Trimester Two-Stage Induced Abortion: A Historical Cohort Study, Meirik and Nygren, Acta. Obstet. Gynecol. Scand., 63(1):45-50, 1984

4. Low Birth Weight in Relation to Multiple Induced Abortions, M. T. Mandleson, C. B. Madden, J. R. Daling, Am.J. Public Health 82(3):391-394, March, 1992

5. Cigarette Smoking Among Reproductive Aged Women-Behavioral Risk Factor Surveillance System, 1989, MMWR, 40(42):719-725, Oct.25, 1991

6. Smoking in Pregnancy, Maternal Blood Pressure, Pregnancy Outcome, Baby Weight and Growth, and Other Factors: A Prospective Study, Russel et al., Br. J. Prev. Soc. Med., 22:119-126, 1968

7. Personality Variables Associated with Cigarette Smoking, R. W. Coan, J. of Personality and Social Psychology, 26(1):86-104, 1973

8. Stress and Smoking, Medical Times, Vol. 114, No. 12, p.44, Dec 1986

9. Smoking - Attributable Mortality and Years of Potential Life Lost, United States, 1984, JAMA, 258(19):2648, Nov 20, 1987

10. Cancer Statistics, 1991, C. S. Boring, T. S. Squires, T. Tong, CA - A Cancer Journal for Clinicians, 41(1):19, Jan/Feb 1991

11. Lung Cancer and Smoking Trends in the United States Over the Past 25 Years, L. Garfinkel and E. Silverberg, CA - A Cancer

Journal for Clinicians, 41(3):137, May/June, 1991

12.The Incidence and Effects of Alcohol and Drug Abuse in Women Following Induced Abortions, T. W. Strahan, Assoc. for Interdisciplinary Research Newsletter, 3(2):1-8, Summer, 1990

13.Aborted Women:Silent No More, David C. Reardon, Loyola Univ. Press: Chicago (1987)

14.Impact of the HIV Epidemic on Mortality in Women of Reproductive Age, Chu et al., JAMA, 264(2):225, July 11, 1990

15.Cocaine Use During Pregnancy, Prevalence and Correlates, D. A. Frank, et al., Pediatrics, 82(6):888, Dec. 1988

16.Perinatal Cocaine and Methamphetamine Exposure, Maternal and Neo Natal Correlates, A. S. Oro and S. D. Dixon, J. Pediatrics 111:571, 1988

17.Stressful Life Events and Alcohol Problems Among Women Seen at a Detoxification Center, E. R. Morrissey and M. A. Schuckit, J. Studies on Alcohol, 39(9):1559, 1978

18.Sexual Experience and Drinking Among Women in a U.S. National Survey, A. Klassen and S. Wilsnack, Archives of Sexual Behavior, 15(5):363, 1986; Women's Drinking and Drinking Patterns from a 1981 National Survey, R. Wilsnack, S. Wilsnack, A. Klassen, Am.J. Public Health, 74(11):1231, Nov. 1984

19.Alcohol-Related Relative Risk of Fatal Driver Injuries in Relation to Driver Age and Sex, Paul L. Zador, J. Studies Alcohol, 52:302-310, 1991

20.Female Drinking and Driving:recent trends in North Carolina, C. L. Popkin et al., Accid. Anal. Prev., 20:219-225, 1988

21.Trends in Alcohol-Related Traffic Fatalities, by Sex-United States, Centers for Disease Control, MMWR, 41:189, 195-197, 1992; reported in JAMA, 268(3):313, July 15, 1992

22.Characteristics of U.S. Women Having Abortions, 1987, S. K. Henshaw, L. M. Koonin, J. C. Smith, Family Plaaning Perspectives 23(2):75, March/April, 1991

23.Cancer Facts & Figures-1993, American Cancer Society, 1599 Clifton Rd NE, Atlanta, GA, 30329, (1993)

24.Age at First Birth and Breast Cancer Risk, B. MacMahon et at., Bulletin of the World Health Organization, 43:209-221, 1970

25.Cancer Rates and Risks, U.S. Dept. of Health and Human Services, NIH Publication No. 85-691, 3rd Edition, (1985)

26.Oral Contraceptive Use and Early Abortion as Risk Factors for Breast Cancer in Young Women, M. C. Pike et al., Br. J. Cancer, 43:72, 1981

27.Early Abortion and Breast Cancer Risk among Women under Age 40, H. L. Howe et al., Int'l Journal Epidemiology, 18(2):300, 1989

28.The Epidemiology of Breast Cancer, J. L. Kelsey and M. D. Gammon, CA-A Cancer for Clinicians, 41(3):147, March, 1991

29.The Woman at Risk for Developing Ovarian Cancer, L. McGowan et al., Gynecologic Oncology, 7:325-344, 1979

30.Case-Control Study of Borderline Ovarian Tumors:Reproductive History and Exposure to Exogenous Female Hormones, B, L, Barlow et al., Cancer Research, 48:5849-5852, Oct.15, 1988

31.The Epidemiology of Endometrial Cancer in Young Women, B.E. Henderson et al., Br. J. Cancer, 47:749-756, 1983

32.Epidemiology of Endometrial Cancer, JNCI, 59:1055-1060, 1977

33.Incidence of Cancer of the Large Bowel in Women in Relation to Reproductive and Hormonal Factors, N. S. Weiss et al., JNCI, 67(1):57, July, 1981

34.Age at First Pregnancy and Risk of Colorectal Cancer:A Case-Control Study, G. R. Howe et al., JNCI, 74(6):1155, June, 1985

35.Is the Incidence of Colorectal Cancer Related to Reproduction? A Prospective Study of 63,000 Women, G. Kvale and I. Heuch, Int'l J. Cancer, 47:390-391, 1991

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Induced Abortion as an Independent Risk Factor for Breast Cancer

The following article is an expanded version of a paper presented by Joel Brind, PhD at the annual meeting of the Association of Interdisciplinary Research in Values and Social Change, Milwaukee, Wis., June, 1993. Dr. Brind is a breast cancer researcher and professor of biology and endocrinology at Baruch College, The City University of New York.

The US Congress has pinned the label, "growing epidemic" on breast cancer, now the single most frequent cause of death among middle-aged American women. To put it in quantitative perspective, 18,000 American women contracted AIDS in the first ten years of that epidemic (1981 - 1991), but this is merely one-tenth number of new cases of breast cancer diagnosed in 1992 alone. Although most breast cancer researchers readily admit that a majority of patients do not fit any known risk profiles, many risk factors have been identified which seem to be related to some form of excess exposure to the predominant female sex steroid hormone, estrogen.

There is, of course, a monthly estrogen surge with the menstrual cycle, and it is well recognized that those women who spend more of their lives cycling, because of early menarche, and/or late menopause and/or having fewer or no children, are at greater risk. But next to the hormonal awakening of puberty, the greatest surge in circulating estrogen occurs in early pregnancy, during which the cells of the breast are again stimulated to undergo a burst of proliferation. This explosive growth is counterbalanced by several hormones of late pregnancy, which serve to differentiate the breast tissue for the task of milk production and to eliminate unneeded growing cells.

There is direct evidence of the ill effects of abortion vis-a-vis breast cancer. Russo and Russo's laboratory studies in rats as far back as 1980 at the Michigan Cancer Foundation showed that **full-term pregnancies protected rats from breast cancer, while aborting the pregnancies guaranteed the cancer's occurrence.**[1] Histological examination of the rats' breasts also established the necessity of full-term pregnancy for full differentiation of the breast tissue for the function of lactation, while early pregnancy serves to stimulate growth of both normal and abnormal, potentially cancerous cells.

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In 1983 at the same Michigan Cancer Foundation, Ownby and coworkers also looked at histological differences between surgically removed breast tumors from patients who had had any abortions (spontaneous or induced) and those who had never aborted. Those with any abortions were only half as likely to have well differentiated types of tumors (associated with slower growth and better prognosis). More statistically significant and directly relevant was the finding that among 238 patients diagnosed with primary breast cancer with no metastases or lymph node involvement, twice as many (20.5 vs. 10.5%) of the 39 patients who had had one abortion and three times as many (32.3 vs. 10.5%) of the 26 patients who had had two or more abortions had a recurrence of the cancer within three years, in comparison to the 174 patients who had had only live births.[2]

Premenopausal breast tumors were more frequent among young woman who aborted

More disturbing data have recently emerged from studies of 175 young women with premenopausal human breast cancer in the laboratories of Olsson and coworkers at the University of Lund, Sweden. They found that tumors from patients who had aborted (induced or spontaneous) before first full-term pregnancy had a significant, 49% higher index of cellular proliferation (which signifies fast tumor growth and poorer prognosis) compared to patients with no abortions.[3] The same group subsequently reported results of a study of genetic markers in premenopausal breast tumors. They found that tumors from patients with any abortions before first full-term pregnancy were (significantly) 26 times more likely to show amplification of the INT2 gene, another indicator of faster tumor growth and lower survival.[4]

Although the association of abortion and breast cancer is mostly a matter of the disease being a latent, (by years or decades) side-effect of the procedure, there also sometimes occurs a clinical situation in which the two may come together, namely, when the diagnosis of breast cancer occurs during a pregnancy. In 1989, Clark and Chua published the results they compiled on a series of 154 cases of coincidental breast cancer in Toronto, Canada. They found not only a clear difference in survival between those patients who aborted and those who did not, but also between those who aborted spontaneously and those who received a "therapeutic" abortion. Thus, while only 20% of the 116 patients who carried their babies to term were ultimately cured of the cancer, 40% of the 13 who spontaneously aborted were cured. With the fetus out of the way, of course, the cancer can be more aggressively treated. However, of the 21 patients who received "therapeutic" abortions, none escaped death from the breast cancer.[5]

It has also long been established, since the classic series of World Health Organization sponsored studies under Brian MacMahon in 1970, that **an early, full term pregnancy (the earlier the better) affords a woman a measure of lifetime protection against breast cancer.**[6]

In like agreement with known female physiology and endocrinology, pregnancies which are interrupted by spontaneous abortion have, with few exceptions[7-11] consistently been associated with increased risk in studies going back as far as 1957.[12-22] In 1981, Malcolm Pike and colleagues at the University of Southern California (USC) extended the finding of the risk-enhancing effect of interrupted pregnancy to induced abortion. Specifically, they found that young (less than 33 years of age), white women in southern California were 2.4 times more likely (i.e., relative risk = 2.4) to get breast cancer if they

UNDERSTANDING THE MEANING OF RISK FACTOR

The subtle maneuvers and statistical somersaults some scientists use to "prove" what they want to prove are not obvious to the uninitiated. However, the tricks in the bag are few and well worth the effort to recognize. Here is a brief primer in the principles and pitfalls of epidemiological study design and reportage:

Most studies are of the retrospective, case-control type. The researchers identify (usually from computer records) some hundreds or thousands of recently diagnosed cases of breast cancer. Then they try to identify (either from the same hospitals or from the same local population) women who closely resemble the breast cancer patients (especially for characteristics that are known to affect breast cancer risk) except that they don't have breast cancer. Cases and controls are then subjected to questionnaires and/or interviews to determine important elements of their reproductive history, such as children born and children aborted. Then the frequency of abortion (or abortion at a particular time, such as before the first live birth) is compared in the cases versus controls, and that ratio generates a number known as relative risk. A "relative risk = one" means that the factor (e.g., abortion) does not affect the risk of getting disease; a relative risk of two means the factor doubles the risk; and so on. A relative risk value less than one indicates a protective or risk-lowering affect.

Published relative risk values are generally adjusted for other factors affecting risk that controls are not matched for. This is poor substitute for good case-control matching, and it reduces the statistical power of the study. Statistical power refers to the adequacy of the study to show up small relative risk values, and it is dependent both on the closeness of matching and on the number of subjects in the study. Two studies may find the same result, say, a relative risk of two for subjects with a prior abortion, but a study with lower statistical power may ignore it totally in the summary of their findings. Unfortunately, no real relative risk value above one can be considered small for a common disease like breast cancer, even though relative risk values less then two are generally considered small or slight. For example, a relative risk of 1.5 may mean increasing one's chances of getting the disease from 10% to 15% (a 50% increase)! The point here is that there is ample opportunity for researchers with a pro-abortion bias (and/or financial support) to design studies of deliberately low statistical power. Thus, increases in breast cancer risk due to factors such as abortion can be made to disappear!

Not all studies are of the retrospective case-control type. Some are cohort studies, in which large segments of a population are followed for many years, and the incidence of breast cancer and other significant life events are recorded as they occur. At any given time, individuals who have developed breast cancer can be studied and compared to those in the cohort who have not, or to the general population. Since such studies usually rely on computerized records, they cannot be affected by possible recall bias, to which questionnaire-based studies may be subject. However, the lack of a bona fide control group permits considerable distortion, if desired!

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had any history of either spontaneous or induced abortion in the absence of a full-term pregnancy.[23]

What has since followed the Pike study at USC in the largely "pro-choice" world of epidemiological research, appearing in over a dozen publications from around the world, is a curious mix of studies designed to either prove or disprove the USC study. Most support Pike's 1981 findings, even though many of the researchers showed a pro-abortion bias in designing their studies or presenting their data in ways that would minimize or eliminate the evidence of an increased risk of breast cancer due to abortion, or even show an alleged protective effect. As one recent reviewer, Larissa Remennick put it: "An initial attitude of researchers towards abortion usually determines the way they interpret results".[24]

One oft-cited study claiming to refute Pike's 1981 findings, published the following year in the same British Journal of Cancer by Vessey and colleagues at Oxford, cites the Pike study in the abstract, which then continues: "Data are presented on 1176 women aged 16-50 years with breast cancer... The results are entirely reassuring, being, in fact, more compatible with protective effects than the reverse." But this is clearly inconsistent with the authors results section of the paper which admits that their data includes "only a handful" of women having a termination (induced or spontaneous) before their first term pregnancy.[25]

A year later, in the same journal, Brinton and colleagues at the National Cancer Institute (NCI) reported data on 1362 breast cancer cases from 29 screening centers around the US. In their discussion they concluded: "Contrary to Pike, et al. (1981), but in common with Vessey et al. (1982), we observed no excess risk associated with having a first trimester abortion prior to a full-term birth". Actually, from their data they obtained a relative risk estimate of 1.34, but the small number of cases rendered this number statistically insignificant. They also reported that, "al-

though based on small numbers, the finding of excess risk among nulliparous women who experienced an induced abortion is noteworthy". In fact, their relative risk estimate for nulliparous women was 5.5, and close to the statistically significant level.[26] And if the Brinton study had tabulated their data in the same manner as the Pike study, there would have been a close corroboration. Later, in the very same British Journal of Cancer in 1988, Ewertz and Duffy reported their results of a study on 1486 breast cancer cases in Denmark to be "in agreement with the studies of Pike, et al. (1981) and Brinton et al., (1983)", i. e., that first trimester induced abortions significantly increased breast cancer risk in nulliparous women (relative risk = 3.85).[27]

Even associates of Pike at USC have downplayed the adverse affects of abortion on breast cancer. In 1988, Henderson et al. of USC, in collaboration with the University of Shanghai, published the results of their study on Chinese breast cancer patients. They reproduced their own 1981 results exactly, i. e., relative risk = 2.4 for women under 40 years old with a history of induced or spontaneous abortion before first full-term pregnancy. But strangely, this remarkably reproduced statistic, which did not quite achieve statistical significance, was not even mentioned in the article's abstract in the American journal, Cancer Research.[28]

Meanwhile, the preoccupation with disproving Pike's risk increase of 2.4 with abortion before the first full term pregnancy was carried to a new extreme in 1988, when Rosenberg and colleagues, in discussing their finding of a (non-significant) relative risk estimate of 1.3 among nulliparous women from the northeastern U.S. who had had any induced abortions, stated that "the results suggest that an approximate doubling among nulliparous women who had had an induced or spontaneous abortion can be ruled out with 95% confidence". However, a look at the relevant data table shows the contrary: that the upper limit of the 95% confidence interval is 2.6 for women with on induced abortion and 2.2 with women with any number of induced abortions.[29]

Control for age has been a widespread problem

There are other serious problems with the Rosenberg study, most notably the eggregious age mismatch between patients and controls: 52 v. 40 years respectively. Yet despite this extreme bias in study design, wherein both age and cohort effects served to lower relative risk estimates, their relative risk estimates for both parous and nulliparous women with any induced abortion history still exceeded unity (1.2 and 1.3, respectively), although there was no trend of increasing risk with increasing number of abortions. The authors did adjust for age in the statistical treatment, but only by 5 year intervals, and the result of such a large adjustment renders statistically weak a study with even so large a patient population (3200) as this one.

Age adjustment is, in fact, a widespread problem in this area of epidemiological research. With few exceptions, controls are not age-matched, and the age differences are adjusted for by grouping in 5-year age strata. This is inappropriate for any study dealing with breast cancer in younger patients, since the age-incidence curve is so steep. For example, the incidence of breast cancer among 35 year old women is about 2.5 times higher than that among 30 year olds. Thus the median age of a randomly selected patient population in the 31-35 age range with be 34+, while that of a control group in the same range will be 33. The net effect is a reduction in the resulting relative risk estimate.

In their classical 1959 paper on epidemiological study design, on which the statistical models used in this area are

based, Mantel and Haenszel specifically warned against this pitfall: "It can be shown, for instance, that within a given age interval the average age of individuals with cancer of certain sites will be greater than the average age of individuals from the general population in the same age interval. This can arise when incidence increases rapidly with age and may pose a serious problem with broad age intervals. This effect can be offset by close matching of cases and controls on age in drawing of samples, even though they are classified by a broad age category in the analysis".[30]

Age matched studies show the clearest association between abortion and breast cancer

It is therefore not surprising that the clearest association between induced abortion and breast cancer emerges from studies where controls were age matched to patients. Thus, Le, et al. were able to show a statistically significant relative risk of 1.17 for one abortion and 1.64 for two or more in their 1984 study of French breast cancer patients,[31] and Howe, et al. found a statistically significant relative risk of 1.9 among upstate New York women with any abortion history (4.0 among those with two consecutive abortions) in their 1989 study that was based entirely on computer registry data.[32] A Japanese age matched study also showed a highly significant, continuous increase in risk with number of induced abortions, from 2.45 for one abortion to 4.90 for four or more.[33] This echoed the finding of Dvoirin and Medvedev in their 1978 study in the former Soviet Union (where abortion has been legal since 1955), where one or two abortions produced a relative breast cancer risk of 2.0, and 3.4 for three or four abortions.[34]

It is also important to note that correction for parity and age at first full-term pregnancy has been the general rule in this area of research, which helps to demonstrate the independent effect of abortion in addition to the delay of first full-term pregnancy. Moreover, as noted above, the largest and most consistent risk elevations have been observed among nulliparous women who have had any abortions, compared to nulliparous women who have never been pregnant.

Studies attempting to show abortion is protective are poorly designed

It is indeed rare in the epidemiological literature to find any potential risk factor so universally associated with any disease as induced abortion has been with breast cancer. There are, in fact, as of this writing, only two reports which go the other way, i. e., which claim to report a slight but statistically significant protective effect of induced abortion, one in Sweden[35] and one in Northern Italy.[39]

The former study, published by Lindefors-Harris et al. in 1989, is a computer registry study (rather than a questionnaire or interview based study) in which a study sample was selected from the Swedish abortion registry, and compared for the incidence of breast cancer with the general Swedish population. There was no explanation for the failure to select an appropriate control group from the general population registry, nor for limiting the study cohort to women who had an abortion before age 30, but enough data are presented to show that correcting either of these defects in study design would have abolished the 23% "protective" effect.

Most noteworthy in this regard is the difference in the proportion of nulliparous women (known to be at higher risk) in the study cohort (41%) compared to the general population (49%). This statistic alone is enough to account for most if not all of the "protective" effect. Simply put, in this study the protective effect of parity masquerades as a protective effect of abortion. Significantly, in comparing women who were nulliparous at the time of

abortion (i. e., abortion before first full-term pregnancy) to those who were parous, even this study found a relative risk of 1.9, thus corroborating a lengthening list of worldwide studies.[35]

The not-so-hidden agenda of Lindefors-Harris study is even more obvious in their subsequent 1991 study on "response bias", which appeared in the American Journal of Epidemiology.[36] Their attempt to discredit the general finding of increased risk due to abortion appears therein as the literal bottom line: "this bias may in fact explain the tendency of increased risk of breast cancer associated with induced abortion in many case control studies". The hypothesis the authors supposedly supported with their data was essentially that breast cancer patients would be more prone to remember and report events in their reproductive history (like abortions) accurately, while healthy (control) women would be more likely to be forgetful or dishonest. Thus they compared the results of their earlier, computer registry study discussed above with another earlier study they had conducted using standard questionnaire methods, also on a Swedish population.[36,37] Since the computer registry includes everyone, these patients were also included in the computer registry study, so the accuracy of their responses could be compared. They found that a relative risk of 1.5 (statistically significant) could be explained by "under reporting of previous induced abortions among controls relative to over reporting among cases". That last phrase means, of course, that patients made up abortions that never happened! And the controls were from a young group of control subjects which had in fact been deleted inexplicably from the case control study under consideration. How such a poorly designed study could find its way into a prestigious, peer-reviewed journal is a good question.

Yet more chicanery is revealed by this "tale of two studies" in Sweden. The case-control study, which supposedly should have shown an exaggerated risk due to abortion, actually reported no risk elevation due to abortion before first full term pregnancy. But it was the computer registry study which, as noted above, evidenced a 90% increased risk among women who aborted when nulliparous. The explanation lies in the small print footnote of the data table of the case-control study which shows no risk increase: "nulliparous excluded". It is easy to see why as 50% exaggeration of a 90% increase translates to a relative risk of 2.4 for abortion before first full-term pregnancy, just as Pike had reported in 1981 and so many others had confirmed.

The Italian study is a continuing study of hospital patients in greater Milan. It suffers from the widespread deficiency of control patients tending to be younger than breast cancer patients and crude, 5-year age adjustment. Nevertheless, Parazzini et al. reported in 1991 that induced or spontaneous abortion increased breast cancer risk by 20% (relative risk = 1.2).[38] However, their most recent report, published in 1993, negates this finding, instead showing no increase in risk with a single abortion, and a significant, 20% decrease in risk with a history of two or more abortions.[39]

Closer scrutiny of these two studies reveals trends in the study population that underlie the shift in results. The 1991 study of 2,394 breast cancer cases (of which 18% were nulliparous) and 2,218 control patients (of which 20% were nulliparous) is already a very atypical population, since nulliparous women are, in the general population, over represented among breast cancer patients. (Nulliparity raises risk.) Thus, although the relative risk data are corrected for parity, the correction is essentially nil, since parity appears to provide no protection in this study population. That helps explain the relatively low risk elevation reported in 1991. However, in the 1993 report, while the breast cancer population had been increased by

43% to 3,415 cases (18.8% nulliparous), the control population had been increased by 153%, and 23.3% of controls are now nulliparous. The data tables reveal the strange effect of packing the control population in this way: women with two children appear have a 40% higher risk of breast cancer than nulliparous women. Add to this the fact that the vast majority of Italian women who have abortions already have children, the proverbial "bottom line" is another case of the protective effect of parity masquerading as the protective effect of abortion.

Since breast cancer is such a common disease, and induced abortion such a common procedure, the public health impact of the latter on the former must be devastating by even the most conservative estimation. If we consider only the increased risk associated with abortion in the absence of full-term pregnancy (800,00 induced abortions per year in the US on nulliparous girls and women), ignoring the effect of delaying pregnancy, we may assign the modest, minimum relative risk value of 1.5. If we then assume and average lifetime risk in the absence of abortion of 10% then we can expect abortion to be responsible for at least 40,000 excess cases of breast cancer every year, by the time the cohort of American women who were in their twenties in 1973 reach their eighties in the 2030's. Clearly, many thousands have already been afflicted with breast cancer due to previous abortions, and tens or hundreds of thousands more will be, also from abortions that have already taken place!

There is an opening from some skepticism here, however, when we consider that, of necessity, most of the data linking induced abortion to breast cancer has been gathered on young patients. It may thus be argued that the increased risk may only last during the premenopausal period. After all, the risk of contracting breast cancer by age 50 is only about 2%. Even so, a relative risk of 1.5 would raise incidence by 1% of 800,000, or 8,000 excess per year. But there is every reason to be less optimistic. The many early studies on spontaneous abortion that showed increased risk made no age distinctions among patients. More recently, a most careful and thoroughgoing analysis of a cohort of 3,315 parous women in Connecticut who gave birth between 1946 and 1965, was published by Hadjimichael et al. in 1986. They found not only a significant, independent relative risk of 3.5 for women who had any abortions (all presumed spontaneous in the absence of legally induced abortion), but also a much steeper rise in incidence with age among these women, compared to those with no abortions.[40]

The good news about abortion and breast cancer, in fact, the only good news - is that induced abortion is an elective procedure; a matter of choice, as it were. A woman can simply elect not to have one. The worst news about the link between abortion breast cancer is that it is news at all, considering the one-sided evidence that has been piling up around the globe for decades now. Even as late as July, 1992, Harris et al. published an apparently thorough, three-part review on breast cancer in the New England Journal of Medicine (perhaps the most quoted source of medical news for the popular media) that was totally devoid of any mention of abortion whatsoever, even as a potential risk factor.[41] Aware of the evidence, one of the authors even claimed, as recently as April of this year that "this information has not been suppressed".[42] A change in the informational climate in that direction would be most welcome.

Joel Brind, PhD.

FOOTNOTES

1. Russo J, Russo IH (1980) Susceptibility of the Mammary Gland to Carcinogenesis II. Pregnancy Interruption as a Risk Factor in Tumor Incidence, Am J Pathol, 100:497-451

2. Ownby HE, Martino S, Roi LD, Howard L, Russo J, Brooks S, Brennan MJ, (1983), Interrupted Pregnancy as an Indicator of Poor Prognosis in T1, 2, No, Mo Primary Breast Cancer, Breast Canser Res Treat, 3:339-344

3. Olsson H, Ranstam J, Baldetorp B, Ewers S-B, Ferno M, Killander D, (1991), Proliferation and DNA Ploidy in Malig-

nant Breast Tumors in Relation to Early Oral Contraceptive Use and Early Abortions, Cancer, 67:1285-1290

4. Olsson H, Borg A, Ferno M, Ranstam J, Sigurdsson H, (1991), Her - 2/neu and INT2 Proto-oncogene Amplification in Malignant Breast Tumors in Relation to Reproductive Factors and Exposure to Exogenous Hormones, J Nat Cancer Inst, 83:1483-1487

5. Clark RM, Chua T, (1989), Breast Cancer and Pregnancy: The Ultimate Challenge, Clin Oncol Royal Coll Radiol, 1:11-18

6. MacMahon B, Cole P, Lin TM, Lowe CR, Mirra AP, Ravnihar B, Salber EJ, Valaoras VG, Yuasa S, (1970), Age at First Birth and Breast Cancer Risk, Bull World Hlth Org, 43:209-221

7. Salber EJ, Trichopoulos D, MacMahon B, (1969), Lactation and Reproductive Histories of Breast Cancer Patients in Boston, 1965-66, J Nat Cancer Inst, 43:1013-1024

8. Lowe CR, MacMahon B, (1970), Breast Cancer and Reproductive History of Women in South Wales, Lancet, i:153-156

9. Ravnihar B, MacMahon B, Lindtner J, (1971), Epidemiologic Features of Breast Cancer in Slovenia, 1965-1967, Eur J Cancer, 7:295-306

10. Herity BA, O'Halloran MJ, Bourke GJ, Wilson-Davis K (1975), A Study of Breast Cancer in Irish Women, Brit J Prev Soc Med, 29:178-181

11. Paffenbarger RS, Jr, Kampert JB, Chang H-G, (1980), Characteristics that Predict the Risk of Breast Cancer Before and After the Menopause, Am J Epidemiology, 112:258-268

12. Segi M, Fukushima I, et al, (1957), An epidemiological Study on Cancer in Japan, GANN, 48 Suppl:1-43f

13. Wynder EL, Boss IJ, Hirayama T, (1960), A Study of the Epidemiology of Cancer of the Breast, Cancer, 13:559-601

14. Valaoras VG, MacMahon B, Trichopoulos D, Polychronopoulou A, (1969), Lactation and Reproductive Histories of Breast Cancer Patients in Greater Athens, 1965-67, Int J Cancer, 4:350-363

15. Yuasa S, MacMahon B, (1970), Lactation and Reproductive Histories of Breast Cancer Patients in Tokyo, Japan, Bull World Hlth Org, 42:195-204

16. Lin TM, Chen KP, MacMahon B, (1971), Epidemiology Characteristics of Cancer of the Breast in Taiwan, Cancer, 27:1497-1504

17. Mirra AP, Cole P, MacMahon B, (1971), Breast Cancer in an Area of High Parity, Sao Paulo, Brazil, Cancer Res, 31:77-83

18. Stavraky K, Emmons S, (1974), Breast Cancer in Premenopausal and Postmenopausal Women, J Nat Cancer Inst, 53:647-654

19. Soini I, (1977), Risk Factors of Breast Cancer in Finland, Int J Epidemiology, 6:365-373

20. Choi NW, Howe GR, Miller AB, Matthews V, Morgan RW, Munan L, Burch JD, Feather J, (1978), An Epidemiological Study of Breast Cancer, Am J Epidemiology, 107:510-521

21. Toti A, Piffanelli A, Pavanelli T, Buriani C, Nenci I, Arslan-Pagnini M, (1980), Possible Indication of Breast Cancer Risk Through Discriminant Functions, Cancer, 46:1280-1285

22. Kelsey JL, Fischer DB, Holford TR, Livoisi VA, Mostow ED, Goldenberg IS, White C, (1981), Exogenous Estrogens and Other Factors in the Epidemiology of Breast Cancer, J Nat Cancer Inst, 67:327-333

23. Pike MC, Henderson BE, Casagrande JT, Rosario I, Gray GE, (1981), Oral Contraceptive Use and Early Abortion as Risk Factors for Breast Cancer in Young Women, Br J Cancer, 43:72-76

24. Remennick L, (1990), Induced Abortion as a Cancer Risk Factor: A Review of Epidemiological Evidence, J Epidemiol Community Health, 44:259-264

25. Vessey MP, McPherson K, Yeates D, Doll R, (1982), Oral Contraceptive Use and Abortion Before First Term Pregnancy in Relation to Breast Cancer Risk, Br J Cancer, 45:327-331

26. Brinton LA, Hoover R, Fraumeni JF Jr, (1983), Reproductive Factors in the Aetiology of Breast Cancer, 47:757-762

27. Ewertz M, Duffy SW, (1988), Risk of Breast Cancer in Relation to Reproduction Factors in Denmark, Br J Cancer, 58:99-104

28. Yuan J-M, Yu MC, Ross RK, Gao Y-T, Henderson BE, (1988), Risk Factors for Breast Cancer in Chinese Women in Shanghai, Cancer Res, 48:1949-1953

29. Rosenberg L, Palmer JR, Kaufman DW, Strom BL, Schottenfeld D, Shapiro S, (1988), Breast Cancer in Relation to the Occurrence and Time of Induced and Spontaneous Abortion, Am J Epidemiol, 127:981-989

30. Mantel N, Haenszel W, (1959), Statistical Aspects of the Analysis of Data From Retrospective Studies of Disease, J Nat Cancer Inst, 22:719-748

31. Le M-G, Bachelot A, Doyon F, Kramar A, Hill C, (1984), Oral Contraceptive Use and Breast or Cervical Cancer: Preliminary Results of a French Case-control Study, in Hormones and Sexual Factors in Human Cancer Actiology, Wolff J-P and Scott JS, eds, Elsevier, Amsterdam, 139-147

32. Howe HL, Senie RT, Bzduch H, Herzfeld P, (1989), Early Abortion and Breast Cancer Risk Amoung Women Under Age 40, Int J Epidemiol, 18:300-304

33. Nishiyama F, (1982), The Epidemiology of Breast Cancer in Tokushima Prefecture, Shikoku Ichi (Shikoku Med J), 38:333-343 (Tr. Frank C, Farnham Co., Philadelphia)

34. Dvoirin VV, Medvedev AB, (1978), The Role of Reproductive History in Breast Cancer Causation, in Methods and Results of Studies of Breast Cancer Epidemiology, Tallinn, 53-56 (in Russian, reported by Remennick, 1990 [ref. #24])

35. Lindefors-Harris B-M, Eklund G, Meirik O, Rutgvist LE, Wiklund K, (1989), Risk of Cancer of the Breast After Legal Abortion During the First Trimester: A Swedish Register Study, Br Med J, 299:1430-1432

36. Lindefors-Harris B-M, Eklund G, Adami H-O, Meirik O, (1991) Response Bias in a Case-control Study: Analysis Utilizing Comparative Data Concerning Leagal Abortions From Two Independent Swedish Studies, Am J Epidemiol, 134:1003-1008

37. Adami H-O, Bergstrom R, Lund E, Meirik O, (1990), Absence of Association Between Reproductive Variables and the Risk of Breast Cancer in Young Women in Sweden and Norway, Brit J Cancer, 62:122-126

38. Parazzini F, La Vecchia C, Negri E, (1991), Spontaneous and Induced Abortions and Risk of Breast Cancer, Int J Cancer, 48:816-820

39. La Vecchia C, Negri E, Franceschi S, Parazzini F, (1993), Long-term Impact of Reproductive Factors on Cancer Risk, Int J Cancer, 53:215-219

40. Hadjimichael OC, Boyle CA, Meigs JW, (1986), Abortion Before First Livebirth and Risk of Breast Cancer, Br J Cancer, 53:281-284

41. Harris JR, Lippman ME, Veronesi U, (1992), Breast Cancer (first of three parts), N Engl J Med, 327:319-328

42. Coia DA, (1993), Having Abortion Increases the Risk of Breast Cancer, The Washington Times, April 2, 1993

82 - 5

A first pregnancy permanently changes the structure of a woman's breasts. Before she is pregnant, her breasts cannot produce milk, as the gland cells are immature and underdeveloped. When she becomes pregnant, estrogen and other hormones flood her system. This results in rapid growth in size, while the internal structure undergoes dramatic change.

Cells, previously dormant, rapidly grow into a system of branching ducts and gland cells capable of producing milk. Once this growth, change and maturing is complete, there is no further significant change the rest of her life. Once mature, the chance of the breast developing cancer is much less.

When these cells are changing and transitional, they are less stable and have much greater potential of becoming cancerous. If she completes her first pregnancy, this unstable period passes and her gland cells mature and stabilize.

But --- if she interrupts her pregnancy, in its early phase, and 90% of abortions are done in the first trimester, she in effect stops the development of the cells at this unstable, transitional phase. It seems apparent that cancerous changes can and do occur more frequently among these transitional cells of a woman who has terminated her pregnancy. If she aborts more than once before completing a pregnancy, her chance for cancer increases even more. A subsequent full term pregnancy helps, but sadly never removes the sharply increased threat of

- There are 1,600,000 abortions each year, 56% are first abortions, 44% second or more.
- One woman in ten will develop breast cancer, and 25% of them will die.

Increase - how much?
Women who carry their first baby to term cut their chance for breast cancer almost in half. Women who abort their first pregnancy almost double their chance. With 2 or more abortions, there is a 3-4 fold increase.

For instance
A 15 year old American girl has a 10% lifetime risk of breast cancer. If she gets pregnant in her teens and has the baby she reduces her risk to 7.5%. However, if she has an abortion, her risk rises to 15% (assuming she has at least one child in her 20's). If the abortion sterilizes her and/or for other reasons, she never has another pregnancy, her risk rises to 30%.[14]

10,000 added deaths?
Over 800,000 women abort their first pregnancy each year. Of these, 10% or 80,000 would have developed breast cancer. But, because of their abortions, the number of cancer cases will increase to 120,000. Of these extra 40,000 cases, 25%, or 10,000 additional women will die of breast cancer every year.

Abortion mortality
The abortion industry claims 1 per 100,000 or 16 maternal deaths per year. If, however, we add these 10,000 deaths, a total of 10,016 die annually, or 834 deaths per 100,000. Mortality from childbirth is about 6/100,000, plus the fact that childbirth prevents over 500 deaths from cancer for every 100,000 first pregnancies carried to term.

Scientific Studies

- Multi-national WHO studies and MacMahon et al[1] clearly established that the younger she has a full term pregnancy the less chance she has of developing breast cancer.
- Pike et al[2] found a 2.4 times increased risk of breast cancer among women under 32 years of age who had aborted their first pregnancy.
- Henderson et al[3] found the same risk in Chinese women.
- Additional confirmation came from studies in U.S.[4,5,6], Japan[7], Denmark[8], Italy[9], and Russia[10,11] as well as showing that multiple abortions sharply increase the risk of breast cancer.
- Meanwhile a series of other studies were done in the hope of disproving this link. Most of these were flawed by: inappropriately crude age matching or adjusting of controls (the main problem); interpreting as statistically insignificant some retrospective case controls with low statistical power; minimizing the actual results obtained in their conclusions; and attributing results to patient's "recall bias" even though a close exam refutes such a claim.
- Dr. Remennick[10] concluded "an initial attitude of researchers toward abortion usually determines the way they interpret results." e.g. The New England Journal of Medicine[13] reviewed risk factors and didn't even mention abortion. An 8 page TIME magazine (1-14-91) analysis ignored abortion and only mentioned in passing "delayed child bearing" as a risk factor.
- Dr. Howe et al[6] in a well matched study (New York State Department of Health) found a 1.7 times increased risk from one abortion and 4.0 for 2 abortions if there were no intervening live births.
- Olsson et al[12] recently demonstrated that pre-menopausal breast cancers grow faster and are more invasive and lethal than those occurring after menopause, and patients who have had abortions have the most invasive and lethal types. The rise in the rate of this, more lethal cancer, directly parallels the use in abortions in the U.S.

[1]MacMahon B, Cole P, Lin TM, Lowe CR, Mirra AP, Ravnihar B, Salber EJ, Valaoras VG, Yuasa S (1970) Bull. Wld. Hlth. Org. 43:209-21.

[2]Pike MC, Henderson BE, Casagrande JT, Rosario I, Gray CE (1981) Brit. J. Cancer. 43:72-6.

[3]Yuan J-M, Yu MC, Ross RK, Gao Y-T, Henderson BE (1988) Cancer Res. 48:1949-53.

[4]Brinton LA, Hoover R, Fraumeni JF, Jr. (1983) Brit. J. Cancer. 47:757-62.

[5]Rosenberg L, Palmer JR, Kaufman DW, Strom BL, Schottenfeld D, Shapiro S (1988) Am. J. Epidemiol. 127:981-9.

[6]Howe HL, Senie RT, Bzduch H, Herzfeld P (1989) Int. J. Epidemiol. 18:300-4.

[7]Hirohata T, Shigematsu T, Nomura AMY, Horie A, Hirohata I (1985) Nat. Cancer Inst. Monogr. 69: 187-90.

[8]Ewertz M, Duffy SW (1988) Brit. J. Cancer. 58:99-104.

[9]Parazzini F, La Vecchia C, Negri E (1991) Int. J. Cancer. 48:816-20.

[10]Remennick LI (1989) Int. J. Epidemiol. 18:498-510.

[11]Remennick LI (1990) J. Epidemiol. Commun. Health 44:259-64.

[12]Olsson H, Ranstam J, Baldetorp B, Ewers S-B, Ferno M, Killander D, Sigurdsson H (1991) Cancer 67:1285-90.

[13]Harris JR, Lippman ME, Veronesi U, Willett W. (1992) New Engl. J. Med. 327:319-328.

[14]J. Brind, Baruch College, 1-27-93, letter to David Kessler, FDA Commissioner

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January 26, 1995

Mister Chairman and Members of the Committee:

Thank you for the opportunity to speak. My name is Jeanne Gawdun and I am a lobbyist for Kansans for Life, the state's largest pro-life organization.

Kansans for Life supports House Bill 2083 because with an issue as controversial as abortion, the state is entitled to know the <u>facts</u>. Currently, the majority of facilities performing abortions in the state of Kansas are not required by law to report the number of abortions they perform.

According to the Alan Guttmacher Institute, a research arm of Planned Parenthood, in 1973, 81% of abortion providers were hospitals and they performed over 50% of all abortions. However, in 1992, only 36% of providers were hospitals and they performed only 7% of all abortions in the U.S.

In the state of Kansas, we allow the <u>majority</u> of abortion providers to "voluntarily" report the number of abortions they perform. In no other industry does the state settle for this type of reporting. Even waiters and waitresses are required by law to accurately report their income from tips! Certainly, it is not unreasonable to require accurate reporting from an industry such as abortion which deals primarily in cash. There is great temptation for under-reporting in a cash business and settling for "voluntary" reporting does not encourage truthfulness.

In the past, we have consistently seen discrepancies in the number of abortions reported to the Kansas Department of Health and Environment as compared to those reported by abortion providers to the Alan Guttmacher Institute. There have been under-reports as high as 5,021 abortions to the KDH&E.

The state must set a standard of accuracy in reporting and send the message that false reporting will not be tolerated. Thank you.

Kansas affiliate to the National Right to Life Committee

HOUSE H&HS COMMITTEE
1-26-1995
Attachment 6-1

TABLE 18
REPORTED ABORTIONS AND ABORTION RATIOS*
KANSAS AND THE U.S. 1971–1993

Year	Total	Out of State Residents	Kansas Residents	Kansas Ratio	N.S.	U.S. Number	U.S. Ratio
1971........	9,472	5,763	3,709	103.0	–	485,816	136.6
1972........	12,248	7,736	4,512	136.0	–	586,760	180.1
1973........	12,612	7,695	4,917	153.8	–	615,831	196.3
1974........	10,171	4,503	5,657	172.9	11	763,476	241.6
1975........	9,160	3,565	5,581	165.6	14	854,853	271.9
1976........	9,154	3,455	5,686	161.2	13	988,267	312.0
1977........	7,965	2,918	5,045	137.0	2	1,079,430	324.5
1978........	9,740	3,957	5,722	156.4	61	1,157,776	347.3
1979........	12,335	5,042	7,281	187.1	12	1,251,921	358.3
1980........	11,791	4,750	7,038	173.0	3	1,297,606	359.2
1981........	10,448	4,150	6,291	152.7	7	1,300,760	358.4
1982........	9,976	3,823	6,153	151.0	–	1,303,980	354.3
1983........	8,547	3,218	5,329	132.0	–	1,268,987	348.7
1984........	8,008	2,689	5,319	133.1	–	1,333,521	364.1
1985........	7,092	2,447	4,645	117.8	–	1,328,570	353.8
1986........	6,561	2,316	4,245	108.4	–	1,328,112	354.2
1987........	6,409	2,357	4,052	105.4	–	1,353,671	356.1
1988........	7,930	3,161	4,769	123.2	–	1,371,285	352.0
1989........	8,984 **	3,270	4,149	107.4	1,565 ***	1,396,658	346.0
1990........	9,459 **	3,341	4,175	107.4	1,943 ***	1,429,577	345.0
1991........	10,141 **	4,071	6,070	161.3	– ***	1,388,937 ****	339.0 ****
1992........	11,135 **	4,904	6,231	164.6	– ***	n.a.	n.a.
1993........	11,247 **	4,853	6,394	171.5	– ***	n.a.	n.a.

*Ratio per 1,000 live births
Source for U.S. data: Centers for Disease Control
** The increase in the 1989–1993 figures does not reflect an increase in the number of abortions being performed but rather an increase in the number of providers voluntarily reporting data.
*** Residency data was not available for all abortions in 1989–1990 but due to improved reporting, was obtained for all of the abortions reported in 1991–1993. This improved reporting is also responsible for the increase in the abortion ratio.
****Provisional

... changing age distribution of women in their reproductive years could be affecting the abortion rate: Women in the baby-boom generation, currently in their 30s and 40s, will have fewer abortions than they did at younger ages. When the 1988 age-specific abortion rates are applied to 1992 population estimates, the number of abortions expected in 1992 would be 10,000 fewer than the number in 1988. This amounts to one-sixth of the actual decline of 62,000 abortions. The abortion ratio should be affected less by the changing age distribution, because birthrates, as well as abortion rates, decline among women older than 30 years.

As Table 2 shows, the largest numbers of abortions are performed in the most populous states: California (304,000 abortions in 1992), New York (195,000) and Texas (97,000). These states plus Florida and Illinois account for almost half (49%) of all abortions in the country. At the other end of the spectrum is Wyoming, the state with the fewest abortions; only 460 were performed there in 1992.

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 to other states for abortion services. In 1987 (the most recent year for which data are published), the number of Wyoming residents who had abortions in other states was greater than the number of residents who had abortions in Wyoming. In Indiana, South Dakota and West Virginia, the abortion rate for state residents was more than 35% higher than the rate based on the abortions occurring in the state.[7] By the same token, abortion rates are inflated in the states that provide services to large numbers of out-of-state women. In 1987, the rates by state of occurrence were more than 60% higher than the rates by state of residence in the District of Columbia, Kansas and North Dakota.[8]

Other factors that can cause abortion rates according to state of occurrence to vary widely include the proportion of the population that is nonwhite, Hispanic or unmarried (characteristics associated with above-average abortion rates); the degree of urbanization (large cities tend to have higher rates); the extent of subsidies for abortion services for low-income women; and the availability of abortion services. New York and Hawaii have the highest rates, at 46 abortions per 1,000 female residents aged 15–44, and rates are also higher than 40 in California and Nevada. The rate of 138 abortions for the District of Columbia is higher than that of any state. Relatively high rates are characteristic of central cities; the rate for the District of Columbia includes large numbers of women from outside the District who obtain abortion services there. The census divisions with the highest abortion rates are on the East and West Coasts: Pacific (39 abortions per 1,000 women), Middle Atlantic (35 per 1,000), South Atlantic (26) and New England (25).

Table 2. Number of reported abortions, rate per 1,000 women aged 15–44 and percentage change in rate, by state of occurrence, 1988, 1991 and 1992

State	Number			Rate			% change, 1988–1992
	1988	1991	1992	1988	1991	1992	
Total	1,590,750	1,556,510	1,528,930	27.3	26.3	25.9	–5
New England	87,450	83,760	78,360	27.9	26.5	25.2	–10
Connecticut	23,630	20,530	19,720	31.2	26.7	26.2	–16
Maine	4,620	4,210	4,200	16.2	14.7	14.7	–9
Massachusetts	43,720	44,150	40,660	30.2	30.2	28.4	–6
New Hampshire	4,710	4,260	3,890	17.5	15.7	14.6	–17
Rhode Island	7,190	7,500	6,990	30.6	31.5	30.0	–2
Vermont	3,580	3,110	2,900	25.8	22.7	21.2	–18
Middle Atlantic	299,710	297,990	300,450	34.0	33.9	34.6	2
New Jersey	63,900	55,800	55,320	35.1	30.9	31.0	–12
New York	183,980	190,410	195,390	43.3	44.5	46.2	7
Pennsylvania	51,830	51,780	49,740	18.9	19.2	18.6	–2
East North Central	223,180	204,270	204,810	22.4	20.6	20.7	–8
Illinois	72,570	64,990	68,420	26.4	24.1	25.4	–4
Indiana	15,760	15,940	15,840	11.9	12.1	12.0	1
Michigan	63,410	55,800	55,580	28.5	25.1	25.2	–11
Ohio	53,400	52,030	49,520	21.0	20.4	19.5	–7
Wisconsin	18,040	15,510	15,450	16.0	13.6	13.6	–15
West North Central	68,550	61,430	57,340	16.7	15.3	14.3	–15
Iowa	9,420	7,200	6,970	14.6	11.7	11.4	–22
Kansas	11,440	12,770	12,570	20.1	22.9	22.4	11
Minnesota	18,580	16,880	16,180	18.2	16.3	15.6	–14
Missouri	19,490	15,770	13,510	16.4	13.5	11.6	–29
Nebraska	6,490	6,230	5,580	17.7	17.5	15.7	–11
North Dakota	2,230	1,600	1,490	14.9	11.4	10.7	–28
South Dakota	900	980	1,040	5.7	6.4	6.8	19
South Atlantic	276,640	273,010	269,200	27.7	26.2	25.9	–7
Delaware	5,710	5,720	5,730	35.7	34.9	35.2	–1
District of Columbia	26,120	21,510	21,320	163.3	136.1	138.4	–15
Florida	82,850	84,570	84,680	31.5	29.9	30.0	–5
Georgia	36,720	39,720	39,680	23.5	24.2	24.0	2
Maryland	32,670	33,000	31,260	28.6	27.5	26.4	–8
North Carolina	39,720	37,210	36,180	25.4	23.2	22.4	–12
Sourth Carolina	14,160	13,520	12,190	16.7	15.8	14.2	–15
Virginia	35,420	35,170	35,020	23.7	22.8	22.7	–5
West Virginia	3,270	2,590	3,140	7.5	6.3	7.7	2
East South Central	56,950	53,670	54,060	15.6	14.9	14.9	–4
Alabama	18,220	17,400	17,450	18.7	18.2	18.2	–3
Kentucky	11,520	8,270	10,000	13.0	9.5	11.4	–12
Mississippi	5,120	8,160	7,550	8.4	13.5	12.4	48
Tennessee	22,090	19,840	19,060	18.9	16.9	16.2	–14
West South Central	136,400	126,140	127,070	21.3	19.6	19.6	–8
Arkansas	6,250	7,150	7,130	11.6	13.6	13.5	16
Louisiana	17,340	13,930	13,600	16.3	13.7	13.4	–18
Oklahoma	12,120	9,130	8,940	16.2	12.8	12.5	–23
Texas	100,690	95,930	97,400	24.8	23.0	23.1	–7
Mountain	69,410	71,530	69,600	21.9	21.9	21.0	–4
Arizona	23,070	19,690	20,600	28.8	23.2	24.1	–16
Colorado	18,740	21,010	19,880	22.4	25.3	23.6	6
Idaho	1,920	1,740	1,710	8.2	7.5	7.2	–12
Montana	3,050	3,680	3,300	16.5	20.6	18.2	11
Nevada	10,190	14,450	13,300	40.3	49.0	44.2	10
New Mexico	6,810	6,190	6,410	19.1	17.2	17.7	–7
Utah	5,030	4,250	3,940	12.8	10.4	9.3	–27
Wyoming	600	520	460	5.1	4.9	4.3	–16
Pacific	372,460	384,710	368,040	41.5	40.6	38.7	–7
Alaska	2,390	2,400	2,370	18.2	16.9	16.5	–10
California	311,720	320,960	304,230	45.9	44.4	42.1	–8
Hawaii	11,170	12,130	12,190	43.0	45.9	46.0	7
Oregon	15,960	16,580	16,060	23.9	24.9	23.9	0
Washington	31,220	32,640	33,190	27.6	27.6	27.7	0

Note: In this and subsequent tables, numbers of abortions are rounded to the nearest 10. *Sources:* 1988—see reference 4; 1991–1992—see sources to Table 1.

Table 2. Number of reported abortions, rate per 1,000 women aged 15–44, and absolute change in rate, by state of occurrence, 1985, 1987 and 1988

State	No. of abortions			Abortion rate			Rate change
	1985	1987	1988	1985	1987	1988	1985–1988
Total	1,588,550	1,559,110	1,590,750	28.0	26.9	27.3	–0.7
Alabama	19,360	19,630	18,220	20.2	20.2	18.7	–1.5
Alaska	3,450	2,560	2,390	27.7	19.7	18.2	–9.5
Arizona	22,330	22,130	23,070	29.9	28.2	28.8	–1.1
Arkansas	5,420	7,030	6,250	10.1	13.1	11.6	1.5
California	304,130	300,830	311,720	47.9	46.0	45.9	–2.1
Colorado	24,350	18,850	18,740	28.8	22.4	22.4	–6.4
Connecticut	21,850	22,380	23,630	29.3	29.4	31.2	1.8
Delaware	4,590	5,880	5,710	30.9	35.9	35.7	4.8
District of Columbia	23,910	25,840	26,120	145.9	158.5	163.3	17.4
Florida	76,650	80,560	82,850	31.8	31.2	31.5	–0.3
Georgia	38,340	36,030	36,720	26.1	23.3	23.5	–2.6
Hawaii	11,160	11,290	11,170	43.7	44.1	43.0	–0.7
Idaho	2,660	1,960	1,920	11.1	8.5	8.2	–2.8
Illinois	64,960	72,180	72,570	23.8	26.2	26.4	2.6
Indiana	16,090	14,750	15,760	12.2	11.2	11.9	–0.2
Iowa	9,930	8,900	9,420	15.0	13.8	14.6	–0.4
Kansas	10,150	11,430	11,440	18.2	20.2	20.1	2.0
Kentucky	9,820	11,580	11,520	11.0	13.1	13.0	2.0
Louisiana	19,240	16,560	17,340	17.4	15.4	16.3	–1.1
Maine	4,960	4,950	4,620	18.6	17.7	16.2	–2.4
Maryland	29,480	31,240	32,670	26.9	27.6	28.6	1.7
Massachusetts	40,310	41,490	43,720	29.3	28.7	30.2	0.9
Michigan	64,390	61,060	63,410	28.7	27.3	28.5	–0.3
Minnesota	16,850	17,810	18,580	16.6	17.5	18.2	1.6
Mississippi	5,890	5,430	5,120	9.7	8.9	8.4	–1.3
Missouri	20,100	20,190	19,490	17.3	17.0	16.4	–0.9
Montana	3,710	3,280	3,060	19.0	17.7	16.5	–2.5
Nebraska	6,660	6,580	6,490	18.2	18.0	17.7	–0.4
Nevada	8,910	10,710	10,190	40.5	43.9	40.3	–0.2
New Hampshire	7,030	4,880	4,710	29.0	17.8	17.5	–11.5
New Jersey	69,190	63,570	63,900	39.6	34.9	35.1	–4.5
New Mexico	6,110	6,660	6,810	17.4	18.6	19.1	1.8
New York	195,120	184,420	183,980	47.4	43.3	43.3	–4.0
North Carolina	34,180	37,630	39,720	22.6	24.2	25.4	2.8
North Dakota	2,850	2,560	2,230	18.5	17.0	14.9	–3.6
Ohio	57,360	51,490	53,400	22.4	20.2	21.0	–1.4
Oklahoma	13,100	11,000	12,120	17.1	14.5	16.2	–0.9
Oregon	15,230	14,370	15,960	22.3	21.8	23.9	1.7
Pennsylvania	57,370	51,800	51,830	21.3	18.9	18.9	–2.4
Rhode Island	7,770	7,390	7,190	35.5	31.3	30.6	–4.9
South Carolina	11,200	12,770	14,160	13.7	15.2	15.7	3.1
South Dakota	1,650	860	900	10.6	5.5	5.7	–4.9
Tennessee	22,360	22,060	22,090	19.1	18.9	18.9	–0.2
Texas	100,820	100,210	100,690	25.5	24.7	24.8	0.7
Utah	4,440	4,830	5,030	11.1	12.4	12.8	1.7
Vermont	3,430	3,680	3,580	26.2	26.9	25.8	–0.5
Virginia	34,180	34,410	35,420	24.0	23.3	23.7	–0.3
Washington	30,990	29,840	31,220	28.0	26.8	27.6	–0.4
West Virginia	4,590	2,880	3,270	10.1	6.8	7.5	–2.6
Wisconsin	17,830	18,300	18,040	15.7	16.3	16.0	0.2
Wyoming	1,070	680	600	7.9	5.7	5.1	–2.8

Note: In this and subsequent tables, numbers of abortions are rounded to the nearest 10.

Sources: 1985—see reference 1. 1987–1988—See sources to Table 1.

is nonwhite or Hispanic (characteristics that are associated with above-average abortion rates), the degree of urbanization (rates tend to be higher in large cities) and state policies, especially public payment for abortion services for low-income women. The highest rate in 1988, 46 abortions per 1,000 women of childbearing age in California, was nine times that of Wyoming, which had the lowest rate (5 per 1,000). The other states with rates of 40 or higher were New York (43), Hawaii (43) and Nevada (40). Like other large cities, the District of Columbia has a higher rate (163) than any state. At the other extreme are states with rates below 10 abortions per 1,000 women: Wyoming (5), South Dakota (6), West Virginia (8), Idaho (8), and Mississippi (8). These are rural states with relatively few places where women can obtain abortion services.

In general, rates are highest on the East and West Coasts (not shown). The Pacific and mid-Atlantic census divisions had the highest rates in 1988 (42 and 34 abortions per 1,000 women aged 15–44, respectively), followed by the New England and South Atlantic regions (both 28 per 1,000). The lowest rates occurred in the East South Central and West North Central census divisions (16 and 17 per 1,000).

Table 2 shows the changes in the abortion rates between 1985 and 1988, but because such changes can be strongly influenced by small errors in the data, they should be interpreted with caution. Errors can be introduced by incomplete or inconsistent reporting of abortions by the providers and by inaccurate estimates of the size of the female population aged 15–44. Sharp drops in state abortion rates of 25 percent or more occurred between 1985 and 1988 in six states, all of which already had relatively low rates in 1985: South Dakota (46 percent drop), New Hampshire (40 percent), Wyoming (36 percent), Alaska (34 percent), Idaho (26 percent), and West Virginia (25 percent). In all these states, physicians or clinics that had been providing a large proportion of the abortions in 1985 either retired or discontinued their services. In South Dakota, for example, one of the two physicians who had been performing abortions retired, leaving women in the western and central parts of the state as far as 200 miles from the nearest provider. North Dakota has also been left with only one provider of abortion services since the retirement of a physician in February 1990. The decline in abortions performed in these states may lead to an overestimation of the decline in the number of residents obtaining abortions, since more women may be traveling out of state for abortion services.

The only abortion rate increases of 15 percent or more from 1985 to 1988 occurred in Delaware (16 percent), Kentucky (18 percent) and South Carolina (22 percent). In Delaware and South Carolina, new providers began offering abortion services during this period and established providers increased their caseloads. The increase from 146 to 163 abortions per 1,000 women aged 15–44 in the District of Columbia represents a partial return to a higher rate of 170 abortions reported in 1982; the drop had been caused by the closing of a major clinic. Among the census divisions, the

Dr. Beverly LaHaye
President

Cathy Holthaus
Area Representative

January 26, 1995

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
Carlos Mayans, Chairman
HB 2083

Chairman, members of the Committee:

My name is Sharon Stringfellow. I am a volunteer lobbyist for Concerned Women for America of Kansas. We are a "pro-family" women's organization with over 600,000 members nationwide. We support HB 2083 because it ensures the intent of the current reporting law and the integrity of our state's statistical data that is used to direct policy and programs.

The intent of the law, when it was written, was to know how many abortions were performed each year. At that time abortions were to be performed only in hospitals. Today the majority of abortions are done in offices and are not required to be reported. Since the site of abortions has changed the wording of the law needs to change. The law needs to be worded so as to include all abortions performed. Only with this change will the intent of the law be upheld.

Concerning numbers of abortions it is important to have correct statistical data. One reason we need accurate data is because abortion numbers are used in the compilation of teenage pregnancy numbers. Based on these teenage pregnancy statistics the legislature makes program and funding decisions. If we have incorrect data we are bound to make incorrect assumptions and conclusions and most likely bad decisions, harmful to our children.

I will give you an example of this. During the 1993 interim session the Joint Committee on Children and Families held hearings on the topic of teenage pregnancy and prevention. The committee heard testimony concerning the "Shawnee County Teen Pregnancy Prevention Program" and the assumed great success it had. The presenter boasted in her testimony that "during 1991, 193 Shawnee County Girls between 10 and 17 years of age became pregnant. During the first year of our project the number was reduced to 150... a 23% reduction." This is a truly amazing decrease. This type of reduction is not the custom for comprehensive

Concerned Women for America of Kansas
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teenage sexuality programs. The committee was full of praise for the program. It was not mentioned that coincidentially, that same year, in early 1992 an abortionist opened up his abortion business in Topeka. 43 abortions in a year would have made only a drop in his bucketfull of abortions the abortionist performed that year. This coinciding incident, this coincident, was not mentioned yet it is very peculiar, interesting and significant.

A couple of things need to be addressed and I will do so briefly. We acknowledge that voluntary reporting already occurs. We are not convinced that it is complete nor accurate. But if thorough reporting really was the practice, passing this bill would not be burdensome. If thorough reporting already was the practice, then what hardship are we placing on these abortionists? If thorough reporting was already the practice passage of this bill would merely be a formality and there should be no resistence to this it.

This bill does not affect the confidentiality of the abortionist nor the anonymity of the mother seeking the abortion. These are already protected in the current law. The state and the Department of Vital Statistics are required to keep the name of the abortionist and the abortion facilities completely and entirely confidential. There is no place for the woman's name on the report. The wording of the current law is maintained in this bill where it states, beginning on line 29, "the report shall not include the names of the persons whose pregnancies were so terminated." The purpose of this bill is to get numbers not names, to get information about abortion not the people involved.

Enforceability is a problem that we see. This is a case with many laws that are made. We can only hope that the Executive branch will be responsible in this area and that the Judicial branch and the Board of Healing Arts will correctly prosecute and/or punish those that do not follow the law.

We ask you to pass this bill because you are the ones that legislate. HB 2083 is good law because it corrects the current law to fulfill its intent and it provides for good statistics upon which you make policy and spending decisions. We ask that you pass HB 2083.

P ~Choice Action League • P.O. Box 3622, Wichita, KS 67201 • 316-681-2121

Dedicated • Determined • Decisive

To: Committee on Health and Human Services
From: Peggy Jarman
Regarding: H.B. 2083

Most of you are well versed in the history of harassment in the anti-choice movement. You certainly have heard of clinic blockades. You may also have heard of patients being followed as they leave abortion clinics for further harassment at their homes and businesses. Or about the camera that is focused from the window of the "sidewalk counselors" house onto the clinic next door in Wichita. Or about license plate numbers being recorded as patients enter the clinics. You may know that doctors' homes have been picketed. That protests have been held at their weddings. That family members of doctors who provide abortions have been followed to beauty shops, grocery stores, and about children of doctors who provide abortions being harassed at their schools and in their neighborhoods. I know you have heard about the assassinations and the attempted assassinations. They include the murder of doctors providing abortions. They include a 70 year old man trying to protect a physician's life. They include women answering the phones in offices of doctors who provide abortion services. Perhaps you heard about the group attending the march in Washington who have targeted Dr. Tiller and 11 other abortion providers for further abuse in 1995. Michael Dodds of Wichita is the regional director of that group. Michael Dodds also signed the manifesto calling the murder of physicians providing abortion services justifiable. There has already been an attempt to murder Dr. Tiller just a over a year ago. The aim of this violence is clear. Stop doctors who are providing abortions.

H.B. 2083 asks private physicians to report abortions done in their offices. At the present, physicians are not providing abortions in their private offices. Abortions are being done in abortion clinics. What happens when medical abortions are available? What happens when RU 486 is available to physicians and women in this state? What happens when the trials for methotraxate medical abortions are completed in the very near future and doctors anywhere and everywhere can offer this procedure? Abortions along with physical exams, cancer treatment, removal of warts, treatment of strep throat, blood pressure regulation, and the wide array of medical procedures taking place daily in the offices of physicians around this state will be available all in one place. The anti-choice people will have no idea where to find the doctors providing medical abortions, whose families to target, which offices to picket. They will have no idea where to display their bloody fetus pictures or where to gather to scream at patients. They will have no idea who to target for harassment or with death threats or automatic weapons.

What do people trying to stop abortions do now? Introduce a bill to mandate reporting by physicians in hopes of intimidating them into not providing the service to begin with. To those who say the suggestion that these motives are unfounded because reporting bills have been introduced in the past I say this: The motives of intimidations were the same then as now. What has changed is the increase in violence and the fact that medical abortions are so imminent the anti-choice faction is more desperate than ever to get this bill passed. This bill says join the providers of abortion services and subject yourself to the possibility of the vile behaviors listed above. We dare you to even think about it. Whether they support, defend, abhor, or champion the past harassment and violence of their colleagues, they certainly intend to take advantage of the environment they have created.

H.B. 2083 is an intimidation bill designed to stop medical abortions. If that is your desire, vote to pass this bill.

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Dedicated • Determined • Decisive

H.B. 2083
Stop Medical Abortion
or
The Intimidation Bill

H.B. 2083 has been disguised as a reporting bill. On the surface it looks fairly innocent. After all, all abortion clinics are reporting (except for one very small clinic in Lawrence) and have been doing so for several years.

Then comes Lines 19 through 24. This language calls for private physicians to report abortions performed in their offices. Currently few, if any, physicians are providing abortions in their offices. This likely, hopefully, will change when medical abortions become available.

Anti-choice factions greatly fear medical abortions and the privacy this procedure provides both physician and patient. There would be no way to know who the patients are, who the physicians are, when the procedure takes place. No way to follow patients to their homes, no way to harass them going in, no way to interfere with this very private medical decision.

Now comes H.B. 2083. The obvious plan is for doctors to be so intimidated by the mere thought of turning in a report that they will not provide the service to begin with. And who can blame them. Physicians providing abortion services have been constantly threatened, their families threatened, their homes picketed. They have even been shot to death.

We ask that H.B. 2083 be rejected.

If you have additional questions, I may be reached through the Lobbyist Message Center at 234-5500.

Peggy Jarman, lobbyist for PCAL and Women's Health Care Services

TESTIMONY IN OPPOSITION TO HB 2083
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
THURSDAY 27 JANUARY 1995 1:30 ROOM 423 SOUTH

Chairman Mayans and Members of the Committee,

I am Darlene Stearns, League of Women Voters of Kansas, appearing in opposition to HB 2083.

The League of Woman Voters' position on reproductive choice is as follows: " to protect the constitutional right of individuals to make reproductive choices". We believe this applies to both physicians and their patients, the physicians to practice medicine, lawfully, as they choose, and patients to choose medical treatment they need.

The League believes HB 2083, by requiring reporting of lawfully terminated pregnancies by physicians, in their offices, opens the door to harassment and intimidation to those physicians and their patients by persons opposed to abortion. By identifying physicians performing medical abortions, their offices will be subject to the same terrorist activities presently directed toward clinics.

USA TODAY. Tuesday, January 24,1995,(attached) printed a statement by Paul deParrie, editor of Life Advocate Magazine," Anybody who gives RU-486 can be traced down the same way as people who do surgical abortion." and "people who are not committed won't do them once they find out the pro-lifers can find out who they are."

We believe HB 2083 puts physicians and their patients at risk to bodily harm and even death. It is unacceptable for the state to pass legislation that clearly could harm its citizens.

Darlene Greer Stearns

Darlene Greer Stearns
League of Women Voters of Kansas
112 Woodlawn
Topeka, Kansas 66606
913-235-3757

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COVER STORY

Abortion pill: An answer or new problem?

Backers hope RU-486 ends the violence; foes call it 'a high-tech way to kill babies'

By Anita Manning
USA TODAY

Women who seek an abortion at Des Moines' Planned Parenthood clinic walk past U.S. marshals, a cadre of protesters and an armed guard before being buzzed through a locked door and passing through a metal detector.

The Des Moines clinic is not unusual. Doctors and employees of abortion clinics increasingly are the targets of shootings and death threats. Since 1991, five have been killed and nine others wounded.

What is unusual at this clinic is that it's among about a dozen around the country taking part in medical trials of RU-486, the so-called "abortion pill."

In the aftermath of the speeches and demonstrations Monday marking the 22nd anniversary of the *Roe vs. Wade* ruling legalizing abortion, both sides are watching the trials, debating whether the prospect of non-surgical abortions could help defuse the violence.

"It will make a huge difference," says Dr. Wendy Chavkin, editor of the *Journal of the American Medical Women's Association*. "We now know it is possible to provide a medical abortion within the first two months of pregnancy.

"It opens up the prospect that the majority of abortions can be done privately in a doctor's office without anybody knowing what's going on."

In Des Moines, the trials began three months ago and have not brought added attention from abortion foes, says Jill June, president of Planned Parenthood of Greater Iowa.

"The harassment was already quite awful. I couldn't say it has escalated," she says. "The opposition to legal abortion in Iowa is quite fierce. To them, it is objectionable regardless of what form it takes."

David Crane of the American Coalition of Life Activists agrees. "This is just a high-tech way to kill babies."

Paul deParrie, editor of *Life Advocate Magazine*, says, "Anybody who gives RU-486 can be traced down the same way as people who do surgical abortion."

Many doctors, he says, oppose abortion and won't do them, regardless of methods. And "people who are not committed won't do them once they find out the pro-lifers can find out who they are."

RU-486, the brand name for mifepristone, counteracts progesterone, causing the uterus to let go of the fetal tissue. In the clinical trials, it is given in the form of three pills taken all at once, followed two days later by two more pills.

The second drug, misoprostol, causes uterine contractions that expel the tissue. Patients in the trial, who must be within the first nine weeks of pregnancy, return to the clinic in 15 days for follow-up examina-

RU-486 may reshape abortion fight

tion, to assure that the abortion has been completed.

Eventually, 2,100 women will take part in the trial, and the data gathered will be used to help determine whether the drug will be cleared for marketing in the USA.

In Europe, it has been used by more than 150,000 women.

The trials don't guarantee approval.

"It's not a foregone conclusion that these procedures are safe and are something women are willing to do," says Wanda Franz, president of the National Right to Life Committee.

"There can be severe bleeding, and there's the possibility of women ... not completing the procedure and giving birth to babies with severe deformities. There is also evidence from France that women who have these procedures and expel the baby at home, see the body parts, and have trauma."

RU-486 is not the only drug being used to cause abortion. Methotrexate, already approved as a treatment for cancer and arthritis, and to end ectopic pregnancies, has not been approved by the Food and Drug Administration for abortion, but is being used for that purpose legally, says Dr. Richard Hausknecht, a New York City gynecologist.

He has given the drug to "in excess of 200 women," he says. Hausknecht has been criticized for using methotrexate for abortion outside of clinical trials, but he says it is safe, "close to 100%" effective and offers an alternative to either surgical abortion or RU-486.

Because the drug is already available, he says, "it returns this (procedure) to mainstream medicine. ... The vast majority of ob/gyns in the U.S. are pro-choice, but most don't do abortions. We're afraid. We risk being shot to death."

The Alan Guttmacher Institute says the number of health-care providers who perform abortions dropped 8% between 1988 and 1992, from 2,582 to 2,380. Two states, North and South Dakota, have one each.

One reason for the declining numbers is that only 12% of medical schools require instruction in abortion for ob/-gyn residents, and it's not offered at all in 30% of programs.

Last week, a coalition of medical groups called for mandatory training in abortion procedures, with exemption for students who object on moral or religious grounds.

DeParrie says that won't make much difference. "Very few will take the training," he says. "It's too much of a hassle. We may not be able to picket everyone, we may not find everyone, but ... if we can embarrass a doctor into not doing abortions, that means there are babies that don't get killed."

While some doctors have been intimidated or won over to the abortion opponents' point of view, others have become more resolved in their abortion-rights beliefs.

"There has been a groundswell of commitment and interest fueled by the recent tragedies," says David Grimes of the American College of Obstetricians and Gynecologists. "We're going to close ranks ... and carry on. Our patients deserve that."

Medical groups are taking steps to shore up the ranks of abortion providers: The American Medical Women's Association offers seminars to its members on abortion and follow-up care, and is developing a curriculum.

Planned Parenthood of New York City offers training to residents from several area medical centers. Similar programs exist in Seattle and Vermont.

"Abortion has always been here and always will be because women will go to great lengths and personal sacrifice and pain not to bring a child into this world that they don't want," says Alexander Sanger, head of Planned Parenthood of New York City. He predicts within five years, "over half of the abortions will be done through the use of a pill."

Sanger hopes this will lead to "a lessening of the street theater" surrounding the abortion debate and a decrease in violence. "The violent fringe of the anti-abortion movement cannot picket every doctor's office in the country."

CHOICE NEWS

MAJORITY for CHOICE

FROM THE KANSAS CHOICE ALLIANCE

1995 KANSAS LEGISLATIVE SESSION SPECIAL EDITION

The KANSAS CHOICE ALLIANCE is a statewide coalition of diverse organizations dedicated to insuring access to a full range of reproductive choices, including a woman's right to choose abortion, and to the promotion of comprehensive reproductive health care and human sexuality education.

Officers & Staff

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Barbara Holzmark
913-381-8222

Co-President
George Gardner
316-683-4643

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Sue Ledbetter
316-265-5736

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913-642-1614

Treasurer
Barbara Lisher
913-631-6499

Legislative Chair
Erika Fox
816-756-2277

Community Organizer
Ainka C. Kwell
316-431-4563

PRO-CHOICE AND PROUD

From the Co-Presidents

Friends.....you are needed!

The elections are over! We've gained a few new friends and lost many old friends. However, the show must go on.

Governor Bill Graves needs our support as do our many pro-choice legislators in the house and senate. It's up to us to let them know we appreciate their continuing support on our issues.

We expect to see a very interesting session this year with many proposed bills coming to the floor for debate. We urge you to attend as many committee meetings and house and senate sessions as possible. The anti-choice movement will visible. We will be monitoring the following committees and encourage your participation as well: Federal and State Affairs, Education, Judiciary in both the House and Senate.

Your support is especially needed for our "KCA Lobby Days." We urge you to encourage your organizations to keep in contact with your legislators during this critical session. Please join KCA Monday, January 23rd, for our annual "Ring the Bell for Freedom of Choice" lobby day, celebrating the 22nd anniversary of Roe v. Wade. On Wednesday, February 22nd plan to join us. For March and April dates, please feel free to contact any of the officers.

Please put yourselves "ON CALL" and help us by reacting immediately when called. If you have never called a legislator make this a goal for the new year. Encourage friends to get involved and together we can celebrate this 22nd anniversary year of Roe v. Wade, by once again protecting the rights of the women of Kansas to choose.

Your Co-Presidents.....
Barbara Holzmark and Rev. George Gardner

NATIONAL ORGANIZATIONS

The following organizations are active in preserving reproductive rights in the United States. They are a good resource for a variety of tools to assist you -- some offer individual memberships; some can provide you with fact sheets, voting records, research data, and other helpful information. Call or write:.

Alan Guttmacher Institute
2010 Massachusetts Ave., NW
Washington, DC 20036
202/296-4012

American Association of University Women
1111 16th Street, NW
Washington, DC 20036
202/785-7710

American Civil Liberties Union
132 W. 43rd Street
New York, NY 10036
212/944-9800

Catholics for a Free Choice
1436 U Street, NW, Ste. 301
Washington, DC 20009
202/638-1706

Center for Reproductive Law and Policy
120 Wall St., 18th Floor
New York, NY 10005
212/514-5534

Fund for a Feminist Majority
1600 Wilson Blvd., #1102
Arlington, VA 22209
703/522-2214

National Abortion Federation
1436 U Street, NW, Ste. 103
Washington, DC 20009
202/667-5881

National Abortion Rights Action League
1101 14th Street, NW, Ste. 500
Washington, DC 20005
202/408-4600

National Black Women's Health Project
1615 M Street, NW., Ste. 230
Washington, DC 20036
202/835-0117

National Council of Negro Women
1211 Connecticut Ave., NW, Ste. 702
Washington, DC 20036
202/659-0006

National Organization for Women
1000 16th Street, NW, Ste. 700
Washington, DC 20036
202/331-0066

National Women's Law Center
1616 P Street, NW, Ste. 100
Washington, DC 20036
202/328-5160

National Women's Political Caucus
1275 K Street, NW, Ste. 750
Washington, DC 20005
202/898-1100

NOW Legal Defense Fund
99 Hudson Street
New York, NY 10013
212/925-6635

Religious Coalition for Abortion Rights
100 Maryland Ave., NE, Ste. 307
Washington, DC 20002
202/543-7820

Voters for Choice
2000 P Street, NW, Ste. 515
Washington, DC 20036
202/822-6640

THE KANSAS LEGISLATURE

Who is Your Legislator?

To find our who your Senator and Representative is call you local Election Commissioner. If your area does not have an Election Commissioner contact your County Clerk.

How to Contract Your Legislator:

When the legislature is in session, write to the legislator at the State Capitol, Topeka, KS 66612. Or call, Senate Switchboard (to call any Senator) 913 296-7300; House Switchboard (to call any Representative) 913 296-7500. Note: The Senate and House switchboards are in operation only during legislative sessions (regular sessions start the second Monday of January and last approximately 90 calendar days).

To Obtain Copies of Bills:

For copies of bills, calendars, journals, etc., contact Legislative Document Room, Room 145-N, State Capitol, Topeka, KS 66612 or call 913 296-7394.

Membership and Voting:

The House has 125 members. Sixty-three votes required to pass a bill. Eighty-four votes required to propose constitutional amendment or override a Governor's veto.

The Senate has 40 members. Twenty-one votes required to pass a bill. Twenty-seven votes required to propose constitutional amendment or override a governor's veto.

Terms of Office:

HOUSE: 2 years, next election
November 1996
SENATE: 4 years, next election
November 1996.

SUMMARY OF BILLS FILED IN THE KANSAS LEGISLATURE
1995 SESSION

KCA 1/21/95

Anti-Choice Bills

HB2083 **Broadly Expands Abortion Reporting Requirements**
Sponsors: Reps. Bruce Larkin (D-Baileyville), John Ballou (R-Gardner), Darlene Cornfield (R-Valley Center), Michael Farmer (R-Wichita), Laurel McClure (D-Osborne), Kay O'Connor (R-Olathe), Janice Pauls (D-Hutchinson), Ted Powers (R-Mulvane), Bill Readon (D-Kansas City), John Toplikar (R-Olathe), Gene Vickrey (R-Louisburg) and Jack Wempe (D-Little River)

Requires all medical care facilities and physicians to keep records of pregnancy terminations and to submit an annual written report thereof to the Secretary of Health and Environment in the manner and form prescribed by the Secretary, such reports to include number of terminations, type of facility in which performed and such other information as may be required by the Secretary, excluding only the name of women whose pregnancies were terminated. In addition to leaving open to the discretion of the Secretary the scope of information required, the bill would help anti-choice forces target physicians for harassment and violence. There is no provision for confidentiality of these reports.

Status: Assigned to House Health & Human Services Committee chaired by Rep. Carlos Mayans (R-Wichita); Hearing: Thursday, January 26, 1:30PM, Room 423-S

SB 16 **Revises Definition of Human Being in Criminal Statutes relating to Murder, Manslaughter and Vehicular Homicide to include a "Preborn Human Being"**
Sponsor: Senator Don Sallee (R-Troy)

Amends criminal code such that "the killing of a human being" applies to a "preborn human being...in existence from fertilization until birth" in provisions defining murder in the first degree (Sec. 21-3401(b)), voluntary (Sec. 21-3403) and involuntary (Sec. 21-3404) manslaughter, vehicular homicide (Sec. 21-3405) and any amendments to those sections. Although anti-choice legislators and lobbyists deny that this bill was meant to apply to abortion, it is so broadly drawn that it could have that effect. There is no precedent in Kansas law for treating a fetus as a human being from the moment of fertilization and such a law would set a dangerous and confusing precedent. It is not necessary to redefine "human being" in the statutes in order to provide enhanced penalties for the destruction of a fetus during the commission of a crime which injures a pregnant woman.

Status: Assigned to a Subcommittee of the Senate Judiciary Committee chaired by Sen. Mark Parkinson (R-Olathe); Hearing: Monday, January 23, 10:00AM, Room 514-S

THE 1995 KANSAS LEGISLATIVE SESSION

by Peggy Jarman, Pro-Choice Action League

The 1995 legislative session will be a real challenge. The assumption is that regardless of what the House sends, the Senate which is pro-choice will deal anti-choice legislation a swift death. There are problems with the assumption.

One, most of the legislation will not come in just simple anti vs. pro-choice legislation. It will come disguised as Parental Rights and other ultra conservative items.

Two, politicians have interpreted the election as a move to the right and they will likely move to the right to reflect what they now believe is the mainstream. Will we even have a pro-choice, moderate Senate? No one knows until they are put to the test. The test will likely come early in the session.

Three, since there has been a change in the House leadership, it is very possible that we will not only see anti-choice legislation early, but we will see it often and routinely on the floor. The Senate will not only have to resist the pressure from the right once; they will have to resist the pressure often. Many legislators still operate on the "throw them a bone" theory. Or give them something and they will be quiet.

The Senate may have to learn the hard way that it doesn't work that way. The radical right is about taking over. The radical right is about replacing our personal freedom. The Senate will have many opportunities to stand up for democracy, stand firm for individual freedoms, and resist the radical right take over.

You may have guessed by now that we lost our pro-choice majority in the Kansas House of Representatives. The Right to Life PAC of Kansas endorsed in 40 races and won 31 of them. PCAL PAC endorsed in 90 races and 59 of those candidates won. That is probably not enough for us to win anything except a total ban on all abortions with no exceptions. It is unlikely that even the extremists will try that. But everything and anything else is possible.

We've already heard about several bills that are expected to be introduced. They include: a ban on all saline abortions (none are done in this state), fetal vehicular homicide (could be done without impacting abortion services, but it's doubtful that's what they have in mind), parental rights (major attack on public schools, safety of children, and abortion rights for minors), mandatory counseling prior to abortion services for all women (state must protect women from themselves).

We've already heard the criticism that pro-choice people were/are not organized. That's very true. Pro-choice represents moderate, main-stream thought in Kansas. It is always hard to organize around maintaining the status quo. Now, the question is, can we organize around protecting ourselves from the radical right?

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Planned Parenthood®

Of Kansas, Inc.

Testimony by Douglas E. Johnston

Lobbyist, Planned Parenthood of Kansas

Opposition to House Bill 2083

Honored representatives, thank you for this opportunity to testify on House Bill 2083.

I am proud to be here today representing Planned Parenthood. Planned Parenthood is a reproductive health care provider with clinics in Wichita, Hays and Lawrence. Every year we serve thousands of Kansas women and men. Many of our clients are at risk of sexually transmitted diseases and unintended pregnancies. Many are young. Many have low incomes and/or are students. For many we are their only health care provider.

On their behalf I stand before you today opposed to HB 2083. I stand before you today on behalf of the majority of Kansans that believe in safe and legal reproductive choice. I am here also representing the people providing these essential health care services.

Today America stands at a crossroads. Anti-abortion violence has reached unprecedented levels. In the past year five people have been ruthlessly gunned down and six wounded -- all because they worked for and believed in choice. In the past six months alone, seven reproductive health care clinics have been bombed -- and that is not counting the failed attacks. The Chronicle of Violence that I have attached to my testimony deserves your immediate and undivided attention. Please read it.

House Bill 2083 is a problem. Establishing mandatory reporting of all abortions performed in Kansas will <u>with little doubt</u> put the lives of doctors, their patients, health care workers, and their supporters at risk of violence, threats and other forms of intimidation -- bomb threats, fire bomb attacks, hate mail and stalking to name a few tactics.

I ask you: Did Dr. David Gunn deserve to die? Did Dr. John Britton and his escort, James Barrett, deserve their fate? Did Shannon Lowney and Leanne Nichols deserve their early deaths?

Wichita--2226 East Central, Wichita, Kansas 67214-4494 316 263-7575
Hays--122 East 12th, Hays, Kansas 67601 913 628-2434

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These are tough questions. We must all answer NO in the strongest terms. Until we can <u>together</u> put a stop to this violence and intimidation, legislation that would establish mandatory reporting must not be passed.

DEFENSIVE ACTION

P. O. Box 2243, Pensacola, FL 32513-2243

Paul J. Hill, Director
Telephone Number Prior to Jury Selection - (904) 478-0800
Press Number During Jury Selection and Trial - (904) 474-5285
Media Consultant - Gary McCullough; Publicist - Jerry McGlothlin

We, the undersigned, declare the justice of taking all godly action necessary to defend innocent human life including the use of force. We proclaim that whatever force is legitimate to defend the life of a born child is legitimate to defend the life of an unborn child.

We assert that if Michael Griffin did in fact kill David Gunn, his use of lethal force was justifiable provided it was carried out for the purpose of defending the lives of unborn children. Therefore, he ought to be acquitted of the charges against him.

Mike Bray	Pastor, Reformation Lutheran Church, Bowie, Maryland
C. Roy McMillan	Executive Director, Christian Action Group, Jackson, Mississippi
Andrew Burnett	Director, Advocates for Life Ministries, Portland, Oregon
Cathy Ramey	Associate Editor, Life Advocate Magazine, Portland, Oregon
Matt Trewhella	Pastor, Mercy Seat Christian Church, Milwaukee, Wisconsin
Paul J. Hill	Director, Defensive Action, Pensacola, Florida
Paul dePanie	Author of Numerous Titles, Portland, Oregon
Regina Dinwiddie	Christian Pro-life Activist & Producer of Rescue Radio, MO and KS
Michael Dodds	Leader of Wichita Rescue Movement, Kansas
Henry Felisone	Director, Queens Pro-Life Group, Queens, New York
Tony Piso	Pastor, Evangelical Mission Church, Forest Hill, New York
Jacob Miller	Evangelist, Assembly of Yahweh & Pro-life Activist, Tampa, Florida
Dan Bray	Director, Defenders of the Defenders of Life, Bowie, Maryland
David Crane	Director, Rescue Virginia, Norfolk, Virginia
Donald Spitz	Evangelist & Assistant Director for Rescue Virginia, Norfolk, Virginia
Michael Jarecki	Ret, Pastor, Saint Mary's Church, Brushton, New York
Bill Koehler	Director of Project Awareness, North Bergen, New Jersey
Kenneth Arndt	Director, New Hampshire Rescue, Windham, New Hampshire
Dave Leach	Editor, Prayer and Action Weekly News, Des Moines, Iowa
Mike Walker	Leader in National Assoc. of Planned Parenthood Fighters, Alabama
Thomas Carleton	Catholic Priest, Presently Incarcerated in Billerica, Massachusetts
Valerie Zyskowski	Member of Leadership Committee, Rescue Pittsburg, Pittsburgh, PA
Joseph F. O'Hara	Director, Wyoming Valley Rescue Group, Pennsylvania
David Graham	Attorney at Law, Olathe, Kansas
David Trosch	Catholic Priest, Publisher Justifiable Homicide Cartoon & President

HEALING ARTS OR KILLING ARTS???

Wesley Hospital currently hosts, in the residency program, three local abortionists. With a long history of encouraging and protecting childkilling in Wichita, Wesley Hospital stands in the shoes Goliath of old, crying out curses against the Living God and his people. The childkilling empire that exists in Wichita could not stand without the support of HCA Wesley.

On behalf of the Christians of Wichita:

*We are calling on Wesley to repent and turn from its' childkilling ways.
*We are calling on Wesley to live up to its' great evangelical heritage, to return to the faith of the Wesley family.
*We are calling on Wesley to dismiss from the residency program the three documented local childkillers pictured below.
*We are calling on Wesley to announce a public policy that affirms the right to life, and denounces those who harvest preborn human life for a profit.

The Childkillers of Wesley Hospital

M. Joaquin Jessup, M.D.

Robert M. Moore, M.D.

David D. Duke, M.D.

Please join the Wichita pro-life community in;

a. Praying for Duke, Moore and Jessup. Pray specifically that the Lord would reveal to them His love for the children they kill, and that He would grant them mercy and repentance.

b. Notifying women deceived and maimed by the abortion industry that medical, legal, and spiritual help is available. Call 1-800-634-2224.

c. Calling the management of Wesley Hospital to let them know you will no longer be using their services until the above requests are acted upon. Call CEO Jim Biltz, 688-2097, and PR Director Bob Choi, 688-2018.

d. Photocopy this flier and post in churches, public halls, civic organizations and workplaces.

Publically confront the childkillers with their evil, asking, for the sake of the children and women, that they repent.

Prepared and distributed by Kansas YOuth for America, in memory of our slain peers.

distributed at Cross of Life 10-6-91 & at Wesley

Planned Parenthood®
Of Kansas, Inc.
2226 East Central Wichita, Kansas 67214-4494 316 263-7575

PPFA--*ALERT-NET*...12/31/94

July 30, 1994: 12 hours after the Pensacola murders, **Commonwealth Women's Clinic in Falls Church, VA** was firebombed.

August 9, 1994: Firebomb found unexploded **at Planned Parenthood of Northern New England's St. Alban, VT office.**

August 10, 1994: **Planned Parenthood of Minnesota clinic** firebombed.

End of August: Bomb threat at **Planned Parenthood regional office in Chicago.**

October 9, 1994: **Planned Parenthood of Shasta-Diablo, CA** destroyed in arson attack.

90 minutes after Shasta-Diablo attack and 70 miles away, the **Feminist Women's Health Center in Redding, CA** was firebombed.

October 11, 1994: **Kalispell, MT clinic of Dr. James Armstrong** partially destroyed by arson.

November 3, 1994: Pipe bomb exploded in driveway between the headquarters of **Planned Parenthood of Marin, Sonoma & Mendocino Counties, CA** and a building housing an architectural firm.

November 8, 1994: **Dr. Garson Romalis shot in his home in Vancouver, British Columbia.** The physician, who performs abortions, was shot at least 3 times with an AK-47 assault rifle.

December 12, 1994: Evidence discovered of failed arson attack against **Planned Parenthood of Greater Kansas City clinic.**

December 30, 1994 Receptionist Shannon Lowney and Leanne Nichols killed and five wounded at **Planned Parenthood and another clinic in Brookline, Massachusetts**

-30-

10-6

CHRONICLE of VIOLENCE

Since the murders of Dr. John Britton and James Barrett, several providers have received letters containing death threats. "All abortion laws are unjust," the letters say, "therefore all abortionists are fair game. All Hell is going to break loose and you've been targeted for a front row seat."

Donna Bray, sister-in-law of convicted clinic firebomber Michael Bray, and director of "Defenders of Life" in Maryland, has been circulating a petition saying that Paul Hill was justified in shooting Dr. John Britton and James Barrett. She says discussing the use of murder to stop abortion will "strengthen your own position ... and show others why, even if God does not call them to take forceful action, such action is in accordance with biblical principals."

The Ku Klux Klan in Port St. Lucie, Florida, has set up a hotline where people can call to hear justifications for murdering abortion providers. The message calls Paul Hill, murderer of Dr. John Britton and James Barrett, a hero. The message is predictably racist, claiming that abortion is "racial suicide" aimed at eliminating white babies. When questioned about the tape, a spokesperson said, "If you want to raise eyebrows and get attention, you have to take a hard-core line."

The KKK held a march at a Melbourne clinic which drew 8 members and announced its intention to con[illegible] to demonstrate against abortion and against the use of federal marshals to protect cli[illegible].

10 - 5

TESTIMONY ON HB 2004

Presented by Patricia Joyce, MN, RN
House Health and Human Services Committee

January 25, 1995

Thank you for giving me the opportunity to speak to you about House Bill 2004, Child Health Assessment at School Entry. The health of school age children and youth is of paramount concern to me since most of my professional career as a registered nurse has been spent providing nursing services in a school setting. What I have learned is that many children who come to school do not have proper preventive health care and this failure to meet the health needs of children certainly compromises their ability to learn.

While child health assessment at first school entry is not the panacea for correcting all unmet health needs of young children, it is clearly one way of identifying health problems early in a child's life and with proper interventions, remediation can occur. Removal of health related barriers facilitates the learning process.

My concern about HB 2004 is the proposal to allow chiropractors to provide child health assessments at school entry. Until I can be assured that chiropractors are clinically prepared to provide developmentally appropriate preventive health care, I oppose allowing them to assume this responsibility. Emphasis with chiropractic education is on manipulation of the musculoskeletal system. While the musculoskeletal system is an important aspect of child health assessment, it is by no means the only system to be considered when providing a comprehensive child health assessment.

I further have much concern about the position assumed by the American Chiropractic Association on childhood immunizations which promotes, "an individual's right to freedom of choice in health care matters and providing an alternative/elective course of action regarding vaccinations". As a school nurse, I have experienced, the refusal of chiropractors to have their own children immunized. When chiropractors do not philosophically support immunizations as critical to the prevention of childhood disease, it seems most contradictory to then allow them to provide child health assessments where immunizations are considered an integral part of the service. When immunizations are not complete, not only is the individual child unprotected, but this has far reaching implications for the broader population of children who attend school.

We all need to work together to promote excellent preventive health services for young children. Appropriate clinical preparation with a philosophy supportive of disease prevention and health promotion in all aspects is critical to the provision of quality health services for children. I urge you not to compromise on this issue and trust that you will, in the end, not support the provision of child health assessments at school entry by chiropractors.

HOUSE H&HS COMMITTEE
1-26-1995
Attachment 11