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The public health threat of anti-abortion legislation

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What happens when abortion access is severely restricted for 26 million Americans? Texas is about to find out. In July 2013, the Texas legislature passed one of the country's most restrictive laws that not only bans most abortions after 22 weeks and limits the use of medical abortion but also contains several provisions that are likely to lead to the closure of most abortion clinics in the state. The law requires facilities to meet the standards of ambulatory surgery centers (ASCs) and mandates physicians to have admitting privileges at nearby hospitals. Proponents of the law claim it will improve safety, despite overwhelming evidence that abortions provided in outpatient clinics have a very low level of complications [1]. This legislation comes on the heels of measures passed in 2011 that drastically reduced funding for family planning, effectively removed Planned Parenthood from all state-funded family planning programs and required women seeking abortion to make an extra visit at least 24 hours before the abortion in order to undergo an ultrasound and listen to a detailed description of its images.

Texas is only one of several states attempting to regulate abortion out of existence — a trend that should be deeply troubling to the medical community. First, it represents a stunning incursion into the physician's exam room, allowing state representatives to dictate how doctors should practice medicine. Second, it is in blatant contradiction to evidence-based medicine. One of the provisions of the Texas law requires doctors to follow the regimen for medical abortion included in the mifepristone labeling approved by the Food and Drug Administration in 2000, or the dosage included in the American College of Obstetricians and Gynecologists (ACOG) practice bulletin published in 2005. Both of these documents are out of date, and most US providers use a newer protocol that has been widely studied and found to be safe, effective and acceptable to patients [2,3]. Yet even when the ACOG

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bulletin is updated, physicians in Texas will be prohibited from following its revised recommendations.

Most concerning, however, is the effect this law will have on the health of Texas women — especially low-income and young women who lack the resources to travel to clinics in a distant city or out of state — and the potential rise of abortion self-induction. In 2012, we conducted a survey with 318 women seeking abortion in six cities across the state to assess the impact of the 2011 restrictions. We found that 7% of women reported taking something on their own in order to try to end their current pregnancy before coming to the abortion clinic. This proportion was even higher — about 12% — among women at clinics near the Mexican border. Misoprostol and herbs were the methods women more commonly mentioned. By comparison, a nationally representative survey of abortion patients in 2008 found that 2.6% reported *ever* taking something to attempt to self-induce an abortion [4]. The confluence of extremely limited access to abortion in the context of poverty, access to misoprostol from Mexico, as well as familiarity with the practice of self-induction in Latin America, makes it particularly likely that self-induction will become more commonplace in Texas.

Early medical abortion with misoprostol is a safe and effective regimen and is recommended by the World Health Organization in settings without access to mifepristone [5]. But if women do not have accurate information, they may use ineffective dosages and may not realize the abortion failed until much later in pregnancy, forcing them to seek a second-trimester abortion or continue the pregnancy and have a child they do not want or feel they cannot care for. Using misoprostol in the second trimester also increases the risk of hemorrhage that might require surgical intervention or transfusion, as well as the risk of uterine rupture if inappropriately high dosages are used, especially with a history of prior cesarean delivery [6]. And while misoprostol is unquestionably a safe method to self-induce abortion [7], women may use a variety of less effective and more dangerous methods to end a pregnancy on their own, including taking herbs or self-inflicting abdominal trauma [8].

Women’s health may also be negatively impacted by a rise in the number of second-trimester abortions in Texas caused by delays accessing care. Of the 34 abortion clinics that were open in October 2013, twelve closed in November when the law was allowed to go into effect and physicians were unable to secure hospital privileges. Of the clinics open in November 2013, only three are currently licensed ASCs. Although several new ASCs are planned, it will take time—and money — before there is a sufficient number of surgery centers to meet demand in the state, where approximately 70,000 abortions are performed annually. The limited number of providers will undoubtedly result in delays in obtaining an abortion, pushing women later in pregnancy, when the procedure is associated with a higher risk of complication [9] and is more expensive.

As an example, consider what might happen in the Lower Rio Grande Valley, an area of Texas along the Mexican border. The four counties that make up the Valley are home to about 275,000 women of reproductive age, about two thirds of whom are estimated to be in need of subsidized contraceptive services. This area was particularly hard hit by the cuts in public family planning funds mandated by the state legislature in 2011. State funding to

family planning clinics in the Valley dropped from $4.3 million in 2010 to $1.4 million in 2012, resulting in numerous clinic closures, significant reductions in service hours at many remaining locations, and limited availability of the most effective contraceptive methods (e.g., intrauterine devices and implants).

In 2011, 2634 women living in the Valley obtained an abortion. Both of the abortion clinics in the Valley closed in November 2013 because physicians were unable to obtain hospital privileges. The nearest clinic is in Corpus Christi, 150 miles away, and the nearest ASC is in San Antonio, about 250 miles away, adding up to eight hours of travel time to the process of obtaining an abortion. If a woman chooses a medical abortion, state law requires her to make this long journey at least three times. These barriers are likely to be too great for many women.

Evidence from other countries indicates that severely restricting abortion does not reduce its incidence — it simply makes unsafe abortion more common [10,11]. A handful of countries have made abortion illegal for all indications, but most of these countries are either very small and susceptible to external influence, such as the Dominican Republic or Nicaragua, or imposed these restrictions under a dictatorship, as was the case in Chile and Romania. While Texas does not exactly fit into either of these categories, it is notable that the restrictive abortion bill was not able to move out of committee during the regular legislative session, and the governor had to call two special sessions in order to get it passed.

It remains to be seen what will happen in the Valley and throughout Texas. Parts of the new abortion law may be blocked by the courts, and the effect on abortion services may not be as extreme as projected. But one thing is certain: the population of Texas has taken notice of the legislature's actions. For several weeks in June and July, activists swelled the Capitol in Austin and made their voices heard. As the fight for abortion rights in Texas moves from the legislature to the courts, it is critical that reproductive health specialists — both clinicians and researchers — add their voices to this outcry, highlighting the negative impact of these restrictions and demanding that all women have the right to comprehensive health care services.

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