Abortion Funding:

A Matter of Justice

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The National Network of Abortion Funds (NNAF) was established in 1993 as a nationally coordinated response to harmful government restrictions on abortion funding. Founded by 24 community-based funds, NNAF is now a consortium of 102 grassroots organizations in 42 states and the District of Columbia. NNAF provides support to member funds and advocates on the national level for every woman's right to abortion and full reproductive health care, regardless of ability to pay. Member funds raise money to directly assist low-income women and girls seeking abortions and advocate for increased abortion access for those most in need.

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Abortion Funding: a Matter of Justice

Executive Summary

While a second term for the Bush administration heightens the threat to legal abortion, the right to choose is already an empty promise for many women and girls. Every year, tens of thousands of poor women and teens are forced to carry a pregnancy to term because they cannot afford to pay for an abortion. Many thousands more would be denied this fundamental human and constitutional right if not for the National Network of Abortion Funds (NNAF), an association of 102 community-based funds in 42 states and the District of Columbia that help women pay for abortions.

The central problem is the denial of funding for abortion in government health programs for low-income people. When abortion first became legal in 1973, poor women who qualified for healthcare through the Medicaid program were covered for abortion just as they were for other medical care. But only three years later, Congress passed the Hyde Amendment, banning federal Medicaid funding for abortion. No other medical procedure was singled out for exclusion. Today, 33 states have followed suit, prohibiting state Medicaid funding as well.

> As many as one in three low-income women who would have an abortion if the procedure were covered by Medicaid are instead compelled to carry the pregnancy to term.

Bans on Medicaid funding for abortion burden some of the most disadvantaged women in our society – those who rely on the government for healthcare. Given racial inequalities, women of color disproportionately depend on such coverage, making abortion funding a matter of racial justice as well as economic justice and women's rights. Young women and rural women are also hard hit by funding bans. In addition, Congress denies abortion coverage to many other women who rely on federal health plans: women in the U.S. military and Peace Corps, federal employees, disabled women, residents of the District of Columbia, federal prisoners, and women covered by the Indian Health Service. As many as one in three low-income women who would have an abortion if the procedure were covered by Medicaid are instead compelled to carry the pregnancy to term.

This report illustrates the real costs to women of funding bans. Case studies of selected grassroots abortion funds show the hardships women endure as they struggle to carry out their reproductive decisions. Women who come to abortion funds for help are usually already mothers and may be unable to care for another child. Often they have been raped or battered and they may be suffering from an illness made worse by the pregnancy. Because it takes so long for poor women to find the money for an abortion, they tend to have later and thus more costly abortions. In order to raise the necessary funds, women must frequently use money meant for food, rent, or utilities. In many cases, they face ever-spiraling costs that prove to be insurmountable and are unable to obtain an abortion. As a result, women often cannot complete their educations, escape violence, or climb out of poverty.

The restoration of Medicaid funding for abortion is critical to ensuring access to abortion for all women. At the same time, additional steps must be taken to fully support low-income women's right to abortion. Even in states that provide Medicaid funding, many women fall through the cracks. The working poor and uninsured who do not qualify for Medicaid, as well as women with health plans that have steep deductibles or exclude abortion, also

face enormous barriers. Other obstacles to abortion access that burden poor women include mandatory waiting periods, mandatory parental involvement laws, and the shortage of abortion providers. Many women need help from abortion funds to cover not only the procedure but also travel to clinics in distant cities and other states.

Today, the Bush administration is escalating efforts to limit reproductive rights, with new measures that will take a particularly heavy toll on disadvantaged women. The recently passed Weldon Amendment, also known as the Women's Health Care Denial Law, will give publicly funded institutions new discretion to refuse to provide abortion services and even referrals. The law will most seriously harm poor women, young women, rural women, and women of color, who already have insufficient access to reproductive healthcare. The administration has also signaled its intention to work towards overturning *Roe v. Wade*, the Supreme Court decision that legalized abortion. If a new Supreme Court does reverse *Roe*, abortion will likely be outlawed in many states, exponentially increasing the financial burden on poor women who would need to find money to travel to those states where abortion remains legal.

The National Network of Abortion Funds calls on policy makers and the public to reject harmful policies and support real reproductive choices for all women. Every woman, regardless of her economic resources, should have the right to decide whether and when to have a child. The member funds of NNAF raise and distribute over two million dollars each year to help approximately 20,000 women and girls who would otherwise be unable to obtain an abortion. Yet our efforts can never fill the enormous gap created by the denial of federal and state funding. Women need public support and public resources in order to exercise their right to abortion, as well as their right to have and care for their children with dignity.

By taking the following actions, Congress and state legislatures can facilitate both the prevention of unintended pregnancy and women's access to affordable and timely abortion services:

- Restore full Medicaid funding for abortion by repealing the Hyde Amendment and all other federal and state bans on Medicaid funding.
- Include abortion in all government health programs, including those that provide coverage to women using the Indian Health Service, federal prisoners, women in the military and Peace Corps, disabled women, federal employees, and residents of the District of Columbia.
- Repeal state laws that create needless and harmful delays, such as mandatory waiting periods, mandatory parental involvement, and clinic regulations unrelated to patient safety. All of these restrictions disproportionately burden low-income women.
- Guarantee all women, regardless of immigration status, access to the full range of reproductive healthcare through an expanded Medicaid program or universal healthcare plan.
- Cover abortion and contraception in all private insurance plans, until an expanded or universal plan is put in place.
- Require all institutions that receive public monies, including religiously affiliated institutions, to provide a basic standard of care that includes full reproductive health services.
- Require that accurate reproductive health information be widely distributed in schools, posted on government websites, and included in social service programs.
- Allow emergency contraception to be sold over the counter and make sure it is affordable and widely accessible to all women.
- Provide welfare benefits that respect women's choices and that permit poor mothers to care for their young children at home. Provide adequate healthcare and childcare, as well as education and job-training opportunities that can lift low-income parents out of poverty. These measures will ensure that no woman feels compelled to have an abortion because she lacks the financial resources to care for a child.

We hope the experiences documented in this report will help persuade legislators, judges, and the general public that low-income women deserve the same reproductive rights as women with greater resources. As a matter of justice, we urge the removal of state and federal restrictions that push legal abortion out of reach for so many women.

Introduction

Abortion is a safe, extremely common medical procedure. In fact, it is the most common ob/gyn surgical procedure in the United States. At current rates, about one in three U.S. women will have an abortion by the time she reaches age 45.[1] A broad cross section of women have abortions, including women from every racial and ethnic group and of every religious affiliation.

In 1973, when abortion became legal across the country, poor women who were eligible for health care under the federal Medicaid program were covered for abortions as part of medical care. In that first year of legalized abortion, federal Medicaid funds paid for approximately 270,000 abortions out of a total of 615,800 performed in the U.S. During the next several years, federal and state Medicaid funding similarly paid for about one-third of all abortions, a clear demonstration of women's need for public funding.[2]

In 1976, however, Congress passed the Hyde Amendment, banning the use of federal Medicaid for abortion. The original amendment prohibited all funding except to save a woman's life; since 1993 it has permitted Medicaid funding only in cases of rape, incest, or to save a woman's life when endangered by a physical disorder, injury or illness. Most states followed suit, and today only 17 states provide Medicaid funding for women and girls seeking abortions.

The Supreme Court upheld the Hyde Amendment in 1980, ruling that federal and state governments are not obligated to pay even for medically necessary abortions despite the rights guaranteed to women in *Roe v. Wade*. Abortion funding is also denied to many other women who receive health care through the government, including federal employees, women in the military and the Peace Corps, disabled women, residents of the District of Columbia, Native women using the Indian Health Service, and federal prisoners.

> Abortion access is an important matter of racial justice as well as economic justice and women's rights.

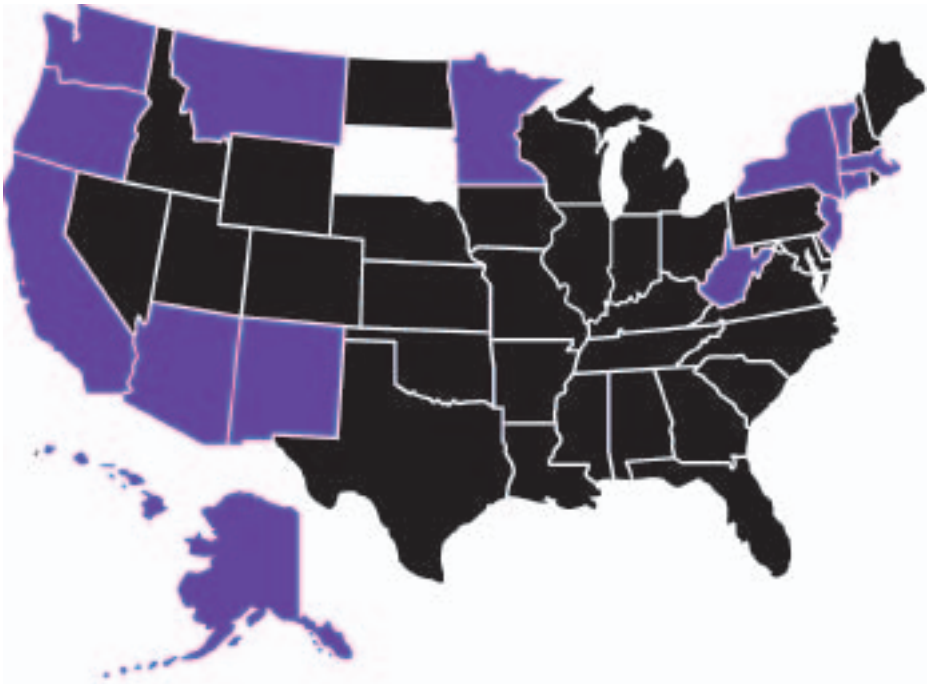
By definition, the Hyde Amendment and other bans on abortion funding burden some of the most disadvantaged women in our society – those who depend on the government for health care. Given racial inequalities in the United States and the resulting racial distribution of poverty, women of color disproportionately rely on public sources for health care, making abortion access an important matter of racial justice as well as economic justice and women's rights. Young women, who typically have few financial resources of their own, are also disproportionately burdened by state and federal bans on funding.

While it is clear that low-income women, women of color, and young women are the most severely affected by policies denying access to abortion, their needs have not been at the forefront of the pro-choice agenda. Access for poor women has frequently taken a back seat to defending the legal right to abortion. By focusing on issues of funding and by providing direct assistance to women in need, NNAF fills a critical gap in pro-choice organizing and action. This report is part of our work to increase awareness among policymakers and the general public of the harmful impact of funding bans on women's lives. The experiences documented from the frontline perspective of our grassroots member funds demonstrate the important role abortion funds play in securing abortion access – and how great the unmet needs of women and girls remain.

Medicaid Coverage and Access to Abortion

Some six million women of reproductive age (15-44) depend on Medicaid for their health care.[3] Because of the Hyde Amendment and state bans on Medicaid funding, the majority of these women are denied coverage for abortion. In 33 states and the District of Columbia, women have virtually no access to Medicaid-funded abortions, unless their pregnancy is a result of rape or their doctors will

Medicaid Funding in the U.S., 2003



States that pay for abortions only in cases of life endangerment, rape or incest

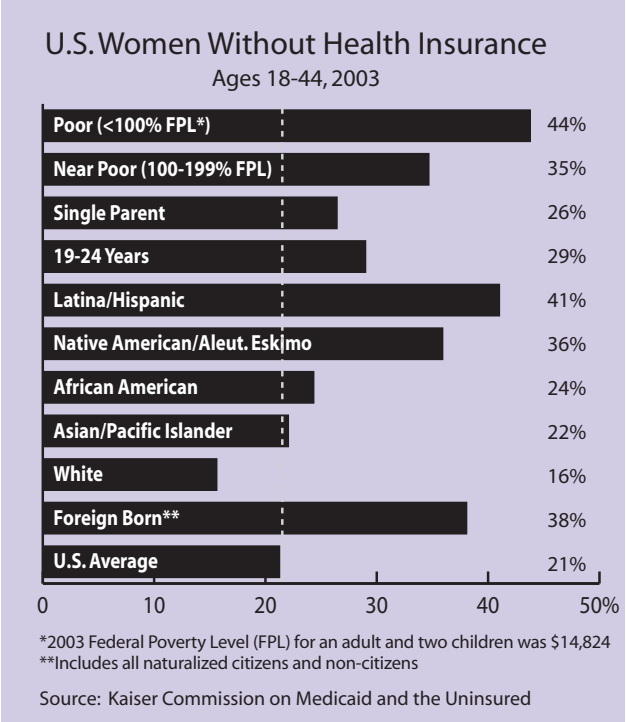
States that pay for abortions in most cases

States that pay for abortions only in cases of life endangerment

attest that continuing the pregnancy endangers their life. Even women in these circumstances are frequently denied coverage because of hostile state agencies, bureaucratic barriers, and misinformation. In these 33 states, Medicaid pays for less than 1% of abortions. By contrast, in the 17 states that provide coverage, Medicaid pays for 27% of abortions.[4]

Women of color are disproportionately represented among low-income women and therefore among Medicaid recipients. Abortion funding bans have a disproportionate impact on this group, and on black women in particular. On average, about one-third (31%) of births are unintended, but for black women, one-half of births (51%) are unintended. It is likely that restricted access to abortion services accounts for at least part of this discrepancy.[5]

Strict Medicaid eligibility rules further limit low-income women's access to abortion. While one-third (35%) of poor women are enrolled in Medicaid, poor women are still more likely to lack any type of coverage (41%) than to be covered by the program, and women of color are far more likely than white women to be uninsured.[6] Some uninsured women are among the working poor, earning too much for Medicaid but not enough to buy health insurance; others are ineligible for Medicaid for different reasons, including immigration status. Prior to 1996, legal immigrants and U.S. citizens were equally eligible for Medicaid. The 1996 welfare reform law, the "Personal Responsibility and Work Opportunity Reconciliation Act," mandated that almost all new legal immigrants wait five years before becoming eligible to apply for Medicaid. Less than half the states opt to use their own funds to provide any coverage during the five-year waiting period, and nine states permanently deny eligibility to non-citizen residents. By 2001, more than 60% of poor immigrant women of reproductive age were uninsured, long-term residents as well as those who had recently arrived. This suggests that their access to basic reproductive health services – abortion, family planning, prenatal and postpartum care – is severely curtailed.[7]



Even women with private insurance often find that abortion is excluded from their coverage. Private insurance accounts for only 19% of abortion payments in Medicaid states and only 8% in states without Medicaid coverage.[8]

The result is that most women must pay out of pocket for an abortion; almost three-quarters of all women who have abortions (74%) pay for the procedure themselves.[9] On average, they pay about $468 for a first-trimester abortion. The vast majority of abortions (88%) take place within the first trimester, but for those that take place later, the cost climbs sharply. At 16 weeks, the average cost increases to $774, and at 20 weeks to $1,179. Twelve percent of women receive abortions at reduced fees or free of charge, with clinics absorbing part of the cost. Many of these women receive support from community-based abortion funds that help to pay for abortions, as well as negotiate discounts with clinics for the low-income women they assist.

Obstacles for Native Women and Women in Prison

In addition to Medicaid bans and insurance restrictions, federal policies also single out and deny abortion funding to specific groups of disadvantaged women, including Native women and women in prison. As a matter of policy, the Indian Health Service (IHS) denies women abortions except in cases of life endangerment, rape, or incest. Even in these cases, however, the agency rarely pays for abortion. IHS paid for only 25 abortions during a 21-year period, and a survey of IHS units found that 62% reported that they do not provide abortion services or funding even when a woman's life is in danger.[10] Beyond the problems of IHS policy and practice, Native women who live on reservations tend to be geographically isolated. Not only are abortion services often far away in urban centers, but tribal lands may not be served by public transportation or private bus lines.

Federal policy also specifically bars funding for women in federal prisons, and many state prisons and local jails refuse to fund abortions as well. These government institutions are even more restrictive than the Medicaid program; only two states have a clear policy to pay for abortions for women in prison who have been raped. In addition, they often require women to pay the costs of transportation and the guards' time to take them to a clinic – a heavy, sometimes impossible, burden, given how many prisons are located in rural areas.[11]

Provider Shortages and Restrictive Policies Compound Barriers

The declining number of abortion providers and the concentration of abortion services in urban centers increase the economic barriers for low-income women, who incur additional costs from travel, lost time at work, and childcare. The Alan Guttmacher Institute, an organization that conducts reproductive health research, reports that the number of abortion providers fell 37% between 1982 and 2000.[12] As of 2000, only 3% of non-metropolitan counties had an abortion provider, and 87% of counties overall had no provider.[13] In 2000, 24% of women traveled at least 50 miles – and 8% of them traveled more than 100 miles – to reach abortion services. In certain regions of the South and Midwest, much higher proportions of women have to travel these distances.[14] Mergers of religious and secular health care institutions may be one factor driving down the number of providers, in addition to hostile state regulations, harassment, and violence.

Restrictions on the state level further burden low-income women and girls. For example, 22 states impose mandatory delays, typically of 24 hours, between abortion counseling and the abor-

tion itself, even though an estimated 93% of women are certain of their decision by the time they come for their appointment.[15] Five of these states require women to receive counseling in person instead of over the phone or Internet. This means they must make at least two trips to the clinic. Four states specifically prohibit insurance policies from covering abortion unless employers or policy-holders pay extra for an optional rider, and eleven states prohibit or severely limit abortion coverage for public employees and their dependents.

Teenagers contend with all of these restrictions and more if they are under age 18; some form of parental consent or notification policy is in effect in 32 states.[16] Laws mandating parental involvement force girls who cannot tell their parents, as well as those whose parents say no, to petition a court for permission. These policies severely burden girls in foster care and those who live with relatives acting as parents but without legal custody.

Funding cuts and conservative attacks on family planning services deny low-income girls and women the resources to prevent unwanted pregnancies in the first place. Congress under-funds such vital public programs as Title X, which provides contraceptive care to low-income women and young women. In real terms, funding today is 57% lower than in 1980.[17] As a consequence, an estimated 11.5 million poor and low-income women remained in need of contraceptive services in 2000, as well as 4.9 million women under age 20.[18] While effective family planning programs have been cut, the government has spent nearly a billion dollars on ineffective abstinence-only programs, often delivered with overtly religious messages and blatant misinformation.[19] Last year, the FDA rejected a petition to make emergency contraception available over the counter, denying women greater access to this important method of pregnancy prevention.

"Welfare Reform" Exacerbates the Lack of Real Choices

"Welfare reform" has also put extreme pressure on low-income women, further constraining their ability to make meaningful reproductive choices. While low-income women are the least able to pay for abortions, since the advent of "welfare reform" in 1996 they nonetheless appear to be seeking abortions at higher rates. A study conducted by the Alan Guttmacher Institute found that while the overall abortion rate fell by 11% between 1994 and 2000, abortion rates rose among economically disadvantaged women.[20] This may be the result in part of punitive policies that have made it more difficult than ever for poor women to take care of their children. These policies include strict time limits for assistance, the child exclusion policy or "family cap" that denies additional support to women who have another child while on welfare, and stringent work requirements even for women with very young children. In addition, as many women lost welfare benefits during the 1990s, they also lost Medicaid coverage.[21]

New Threats in the Second Term of the Bush Administration

From the very beginning of their second term, the Bush administration has intensified attacks on the reproductive rights of low-income women. Passage of the 2004 Weldon Amendment, also known as the Women's Health Care Denial Law, is jeopardizing poor women's already insufficient access to reproductive health information and basic services; this policy gives publicly funded institutions new discretion to refuse to provide abortion services and even referrals for care.

Other threats include the proposed Child Interstate Abortion Notification Act, also known as the Teen Endangerment Act, which would criminalize family members and others who assist young women who travel out of state for an abortion. Poor young women in crisis would be especially burdened by the law and would be deprived of the support of trusted adults.

And, if the Supreme Court overturns *Roe v. Wade*, states would once again have the power to outlaw abortion. Women in 21 states would be at greatest risk of losing the legal right to abortion within the first year.[22] Low-income women in over half the country would need to find the money to travel to those states where abortion remains legal. The demands for funding – for transportation, motel stays, childcare, and food – would increase exponentially. This would put the right to abortion even further out of reach for low-income women.

In addition, increased poverty for women over the next four years – virtually guaranteed if Congress approves proposed cuts to Medicaid, Title X, food stamps, student loans, and welfare – will

also drive up the need for abortion, as it has among poor women and girls over the last several years.

Documenting the Harsh Impact of Funding Bans

The case studies of grassroots abortion funds in this report provide a firsthand look at the harsh impact of abortion funding bans on women and girls across the country. Additional perspective on the magnitude of the problem comes from studies conducted in the years after the Hyde Amendment went into effect. Findings show that a significant number of Medicaid-eligible women – between 18% and 35% – who would have had abortions if funding had been available, instead carried their pregnancies to term.[23] The studies also demonstrate the great personal cost for many low-income women who did manage to obtain abortions. They often scraped together the money for an abortion by borrowing from several people, postponing bills, and even skimping on food and other basic necessities for themselves and their families. Moreover, these women had abortions two to three weeks later than other women.[24] Because later abortions cost more money, lower-income women found themselves – as they do today – in a vicious cycle. By the time they raise enough money for a first-trimester abortion, they may be in the beginning of the second trimester, and need to raise yet more money.

States that use their own funds to provide Medicaid coverage for abortion substantially increase access for low-income women. Nearly one quarter (24%) of all women who obtained abortions in 2000 were Medicaid recipients, but approximately one-third of them – those in non-Medicaid states – paid out of pocket for their abortion. Had those 33 states provided abortion coverage, it is likely that many more women would have been able to obtain the abortions they needed.[25]

Historically, many women who could not obtain legal abortions have paid with their lives. The first such documented case connected with the Hyde Amendment is that of Rosie Jiménez, a young mother who crossed the border into Mexico in 1977 in search of an affordable illegal abortion when denied Medicaid funding at home. She died of sepsis in a hospital in Texas, with a college scholarship check, uncashed, still in her purse.

Organizing to Assist Women

Abortion Funds in the U.S.

In the years since Rosie Jiménez's death, activists in many communities have united to create community-based funds to help women and girls who would not otherwise be able to obtain abortions. By the end of the 1980s there were at least a dozen abortion funds in the U.S.; in 1993, the National Network of Abortion Funds was founded with 24 charter members. As of the end of 2004, NNAF had 102 member funds located in 42 states and the District of Columbia.

Between July 2002 and July 2003, NNAF member funds distributed $2,031,522 to help 19,590 women and girls – women and girls who wanted a safe, legal abortion and had nowhere else to turn for assistance. These community- and volunteer-based groups helped pay for abortions for 18,040 women and provided other essential "practical support" services, such as transportation and temporary housing, to 1,550 additional women.

In 2003 NNAF surveyed its member funds – 98 at the time – in order to profile the funds themselves and to assess the collective impact of their services. Eighty-five funds responded. We also asked member funds that kept data electronically about the women they helped to contribute their databases after deleting all identifying information. The information that follows comes from these two sources.[26]

Many member funds of NNAF are independent organizations, while others are affiliated with independent or feminist women's clinics, Planned Parenthood clinics, or other reproductive rights organizations. Some are sponsored by churches. Most funds take referrals from abortion and family planning clinics, hotlines, and other social service agencies, as well as from women who hear about them by word of mouth. At most funds, application for assistance is usually made by telephone (77%). One in five funds reports taking requests for help by e-mail, and thirteen funds conduct in-person interviews with women.

Nearly all the funds provide direct funding of abortion procedures. The majority of funds also provide financial help for additional services, including lodging and meals, transportation, pregnancy tests, contraception and emergency contraception, and/or ultrasound to assess gestation of pregnancy. A few funds focus solely on providing support for transportation, lodging, childcare and meals. A number of funds provide intensive advocacy for women and girls, including providing support and referrals for women who have been raped or battered. Funds also play a critical role in assisting women in prison and often work with legal advocates to ensure that women gain access to abortion services.

Many funds are also centers of activism in their communities and in their states. They sponsor events to educate the public and policymakers about the need for abortion funding, organize rallies in coalition with other groups on related reproductive health care issues, and engage in clinic defense (escorting individual patients past anti-abortion protesters at women's health clinics). They often work with other pro-choice organizations and women's health groups, as well as with allies organizing for racial justice, welfare rights, and broad social justice.

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A majority of abortion funds are operated solely by volunteers. Of these, 18% report more than 20 volunteers, 29% report between six and ten people involved, and one quarter are run by five or fewer activists. Only 16 funds have paid staff employed by the fund (including casual or part-time), but 24 more had part-time staff employed by a supporting organization (i.e., a clinic, church or coalition).

Most of the funds within the Network assist women primarily in a specific geographic area such as a county or state. Six funds are considered "national funds," based locally in terms of fundraising, but providing more than half their money to women out of state. They are located in Massachusetts, California, Washington, and Minnesota.

Most abortion funds list individual donors as their primary source of income and 40% receive some income from foundation grants, often from local family or community foundations.

While most funds provide grants to women seeking assistance, 26 funds provide "loans" instead of grants. Because most of the women helped have incomes below the poverty level, none of the funds expect full repayment. In all cases the payments are voluntary. In fiscal year 2003, three-quarters of the funds that gave loans received up to 10% back from the women they helped; four funds received total repayments of 20% or more.

Case Studies of Abortion Funds

The following case studies highlight the difficult circumstances of women and girls assisted by abortion funds. The individual funds profiled were chosen because they represent the diversity of funds within the Network, including differences in geographic scope, whether or not the fund is located in a state that pays for abortions under Medicaid, and the existence of additional restrictive policies such as mandatory delays and parental involvement laws. The funds profiled are: the Women's Reproductive Rights Assistance Project, our largest national fund; the Women's Medical Fund, a large urban fund in a non-Medicaid state with many restrictive laws; the Delaware Pro-Choice Medical Fund, a statewide fund in a non-Medicaid state; and the Community Abortion Information and Resources Project, a regional fund in a Medicaid state serving many rural women.

Each fund gathers different kinds of information about the women and girls it assists. For example, some funds record information about age, income, race/ethnicity, number of children, and experience of violence or sexual assault. Other funds may collect data on one or more of these elements but not all. Thus, the data are not entirely comparable across funds. Taken together, however, these case studies provide a picture of the situations and hardships experienced by women and girls who must turn to abortion funds for help because federal and state governments fail to provide it.

Women's Reproductive Rights Assistance Project

Helping Women and Girls Nationwide

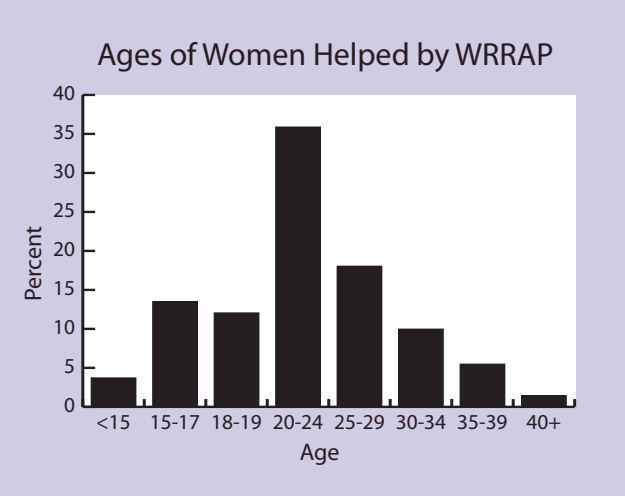
The Women's Reproductive Rights Assistance Project (WRRAP), founded in 1991 and based in Los Angeles, is the largest of our national funds. WRRAP provides assistance for women anywhere in the country and often supplements efforts by local funds and clinics when they cannot raise enough to cover a woman's abortion. Thus, WRRAP provides an overview of the national problem of women's unmet need for abortion funding.

The women helped by WRRAP are often further advanced in their pregnancies than the national average of women obtaining abortions. Many have already raised significant sums of money by the time they turn to the fund, but are still unable to raise enough on their own. These low-income women from across the country are routinely forced into later, costlier abortions because they are denied Medicaid funding and must struggle to find help elsewhere; this is especially notable for younger women.

"Christa" was 14 and had never had a period when she had unprotected sex. She did not realize she was pregnant until her second trimester. Her parents were strict Christian Scientists who would not help her, but her older siblings raised $900. By the time she reached a clinic, Christa was nearly 21 weeks pregnant and needed $1,600. Abortion funds provided $525.

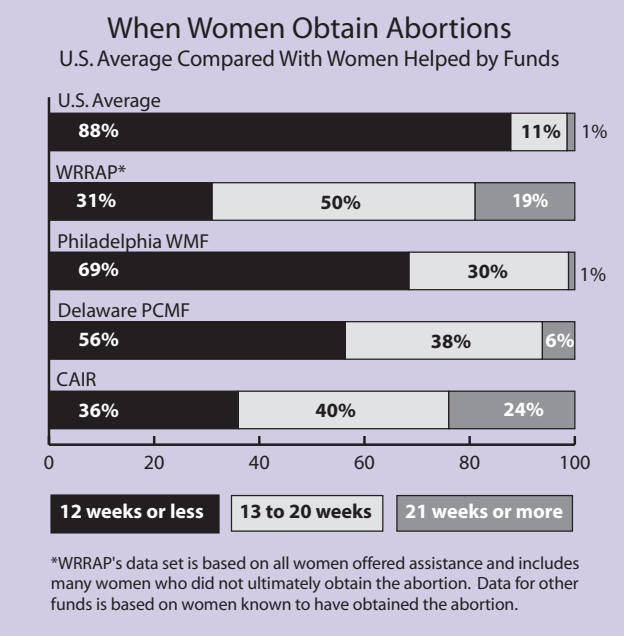
WRRAP authorized grants to 1,550 women in fiscal year 2003, with total spending of $142,413. WRRAP takes calls directly from clinics; a single staff person and a small number of volunteers make all funding decisions.

WRRAP clients came from 45 states and Bermuda: 41% came from seven states (Florida, Illinois, Michigan, Ohio, Pennsylvania, Texas and Wisconsin), with the highest numbers from Ohio (15%) and Texas (16%). All but one of these states deny Medicaid coverage for abortion; Illinois is under court order to fund medically necessary abortions, but in practice so few women are able to obtain coverage that the state resembles non-Medicaid states.



The average age of women helped by WRRAP was 23 years. Girls from ten to 15 accounted for 5%, as did women aged 36 to 44. Two-thirds of clients were mothers as compared to the national average of 61%: 28% had one child, 20% had two children and 19% had three or more (see chart, p. 14). Over three-quarters (78%) reported that this was their first abortion, and 17% reported one prior abortion; one in 20 reported two or more.

WRRAP's clients were dramatically more advanced in their pregnancies compared to national trends. Fewer than one third (31%) were 12 weeks or less, compared with 88% nationally.[27] One quarter were between 13 and 16 weeks, and 24% were 17 to 20 weeks. Nineteen percent were 21 or more weeks pregnant, compared with just 1% nationally. Many of the women who were 21 weeks and over had pregnancies that were intended, but fetal anom-



alies were diagnosed late in the second trimester. Even in these situations, the states that ban Medicaid coverage for abortion offer virtually no assistance to low-income women, despite the possible health risk from continuing such pregnancies, as well as the risk of late-term miscarriage, stillbirth, or birth of a profoundly disabled child for whom there is little social support.

WRRAP's data shows a strong association between youth and later abortions, with girls 10-17 years of age having the highest proportion of abortions at over 20 weeks, usually because the pregnancies were diagnosed very late. Young women may not be aware of the signs of pregnancy and thus realize they are pregnant later than older women. Other factors include little access to confidential healthcare and fear of telling their parents. In many of these cases, the young woman and her family were faced with raising funds for a costly procedure in a matter of days or weeks before reaching the legal abortion limit (22 to 25 weeks in most states).

As would be expected, the costs of these second-trimester abortions were much higher than the average, despite discounts from many clinics that called WRRAP on behalf of their clients. The average fee for WRRAP's clients was $913, but the most advanced 1% of pregnancy terminations ranged from $4,240 to $12,000. WRRAP's median grant amount was $100, with 5% at the $250 level, but amounts ranged from $25 to $600. Women who needed help from WRRAP had raised what for them were very significant amounts of money by the time the clinics appealed to WRRAP; the average raised was $365, and five percent had raised $1,000 or more. In addition to what they raised themselves and received from WRRAP, exactly half of the women were counting on money from other abortion funds in amounts ranging from $25 to $8,000; occasionally, women were also relying on donations from clinic staff.

Despite these massive efforts, for the majority of women, large gaps remained between the amount they had raised themselves and from abortion funds, and the cost of the abortion. For nearly one in five, the gap was $500 or more. In some cases, clinics absorbed the difference in order for women to obtain the abortion; in other cases, fund members believe that women eventually gave up and never received an abortion.

"Gina," a 28-year-old mother with one child, had just left a violent relationship. She was receiving therapy and medication for depression. Her ex-partner was in prison for beating her. She relied on Medicaid and had not been able to raise money for the abortion on her own. The fund provided the $350 she needed.

Women seeking help from WRRAP were pregnant as a result of rape or incest at much higher rates than women nationally. Nine percent of women helped by WRRAP were pregnant because of rape and incest (the youngest was ten years old), as compared to 1% of women having abortions nationally.[28] WRRAP asked clinic personnel whether rapes had been reported to the police and whether Medicaid money was available to cover the abortion. They noted many cases – especially where the assailant was known – where women or girls were afraid to report the rape and states would not accept claims for rapes not reported to police. Other funds also report that abortions are rarely covered in cases of rape because of onerous reporting requirements or other red tape that make it all but impossible for women to receive Medicaid funding.

The Women's Medical Fund

Multiple Barriers and Discriminatory Impact

Founded in 1985, the Women's Medical Fund (WMF), formerly called the Greater Philadelphia Women's Medical Fund (GPWMF), represents one of the Network's largest urban funds. It operates in one of the states that denies Medicaid to women for abortion care, except in cases of life endangerment, rape or incest. Even in these cases, Pennsylvania rarely pays for abortions. The state also has many other restrictive anti-abortion laws, all of which disproportionately affect low-income women.[29] These laws include parental consent for minors, as well as mandatory "counseling" designed to discourage women from getting an abortion, followed by a 24-hour waiting period.

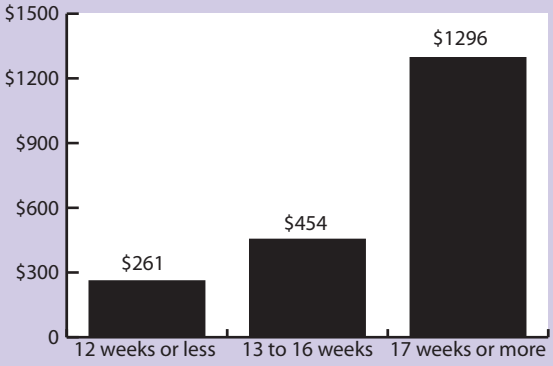
The circumstances of women seeking assistance from WMF reveal the impact of these multiple barriers and show their disproportionate effect on young women, poor women, and women of color. In contrast with overall state and regional figures of women obtaining abortions, women turning for help to this abortion fund were younger, more often uninsured or relying on Medicaid for their health care, and more likely to be African American. They were also more likely to be mothers and to have larger families, to have a pre-existing medical condition that would be complicated by the pregnancy, and to be further along in their pregnancy when they obtained the abortion. They also suffered from a great deal of violence in their lives.

The Women's Medical Fund distributed $55,462 in loans to women and girls in 2003. They offered assistance to 600 women, with most loans in the first four months of the year, before the fund ran out of money and temporarily suspended its services.[30] Staff and volunteers conduct short screening interviews with women calling for assistance and issue "loan vouchers" directly to one of 15 abortion providers with which the fund has arranged discounted fees. The fund had one paid staff person in 2003.

The fund assists women in the Philadelphia metropolitan area, which includes a large population living in poverty. Residents of the area account for more than half (52%) of the abortions performed in the state.[31] Before Pennsylvania eliminated abortion funding in 1985, state Medicaid covered one in three abortions. If Medicaid still covered abortion services at the same rate, it would have paid for abortions for 4,500 Philadelphia women in 2003 – seven times the number WMF was able to help that year.

Assistance provided by WMF averaged $141 and ranged from $20 to $2,000; almost all the loans were under $200. Nearly all the women and girls (98.5%) were Pennsylvania residents and 86% lived in Philadelphia.

Nearly two-thirds of the women and girls helped by WMF were covered under the Medicaid program and had very low incomes. Fewer than 4% had private insurance and the rest (31%) were uninsured. The women's average family income was $344 per month. Only 14 women (2%) met or exceeded the federal poverty threshold of $14,824 for a family of three.[32] Despite their very limited resources, most women worked hard to raise a significant share of



"Marie," a young mother with two children, found out she was pregnant in late December. She needed to collect two paychecks before she could pay for the abortion. By the time she had enough money and got an appointment for February 3, she had just missed the first trimester cutoff. WMF provided the extra $200 she needed.

the cost of their abortion. Half raised $200 or more, and 25% raised $300 or more.

Women helped by WMF ranged in age from 13 to 42, with an average age of 23. Teenagers under the age of 18 represented a high percentage of women assisted – 16%, compared with 6.7% of women from the metropolitan area obtaining abortions. Of the 97 teenagers helped by the fund, 15 were already mothers. Where parental consent status was known, the great majority obtained a parent's consent (83% of 70 girls). Of the 12 who did not, ten obtained judicial approval and had the abortion in Philadelphia. Only two traveled to New Jersey, which does not require parental consent. For young women who don't have family support or money to pay for an abortion, the need to travel to another state is a major hurdle.

Women helped by the fund were significantly more likely to be mothers than the statewide and national average, and they also had more children. Seventy-three percent of women helped were already mothers, in contrast to the state and national average of 61% of women obtaining abortions.

Health Complications, Violence, and Rape

Eleven percent of women reported a serious health problem that would be complicated by the pregnancy, compared with less than 1% in the state overall. Health conditions reported by clients included asthma, high blood pressure, substance addictions, mental health conditions (especially depression), kidney ailments, epilepsy, HIV, and a history of high-risk pregnancy-related problems such as pre-eclampsia, a condition that can lead to seizures and even death.

Many callers to WMF reported domestic abuse and sexual assault. Forty-three women felt their lives were at risk; of these women, about half cited fear of extreme violence from a partner or ex-partner. Nearly 14% of women said they were currently in an abusive relationship or had become pregnant as a result of one. Some cited fear of continuing violence if they did not have an abortion, while others said they had been threatened because they wanted the abortion.

Federal Medicaid rules require that states pay for abortions in cases of rape or incest, or when the woman's life is endangered. Over 11% of women (66) helped by WMF said their pregnancy was a result of rape (one of these rapes was incest). Twenty-eight of these women had Medicaid, but only one in this group was eventually able to obtain a Medicaid-funded abortion. Obstacles include misleading and difficult to obtain forms that must be filled out by women and their doctors and misinformation from Medicaid HMOs. While WMF tries to advocate for women seeking Medicaid funding in the case of rape, most often Pennsylvania does not pay and the fund must work to cover the cost.

Women who sought help from WMF were on average farther along in their pregnancies than the overall population of women having abortions in Pennsylvania and nationally. Many women reported delaying the abortion in order to raise enough money to pay for it, only to find that as their pregnancy passed the 13-week mark the price increased steeply. Although over half of WMF clients, those in the first trimester, needed only to raise $250 for a reduced-fee abortion, that amount nearly doubled in the early second trimester to $480. The top 8% of procedures cost $1,000 or more. The average stage of pregnancy at the time of the abortion was 12 weeks. Two-thirds had their abortion at 13 weeks or less, compared with the statewide average of 92.6%. Ten percent were 18 weeks or more, compared with 3.9% statewide (see chart, p. 11).

Disproportionate Impact on African American Women

African American women are hardest hit by the state of Pennsylvania's denial of abortion funding and are also helped in higher numbers by WMF. In the city of Philadelphia, while black women represent 41% of all adult women, they represent 83% of women helped by WMF.

Delaware Pro-Choice Medical Fund

Later Abortions and Larger Families

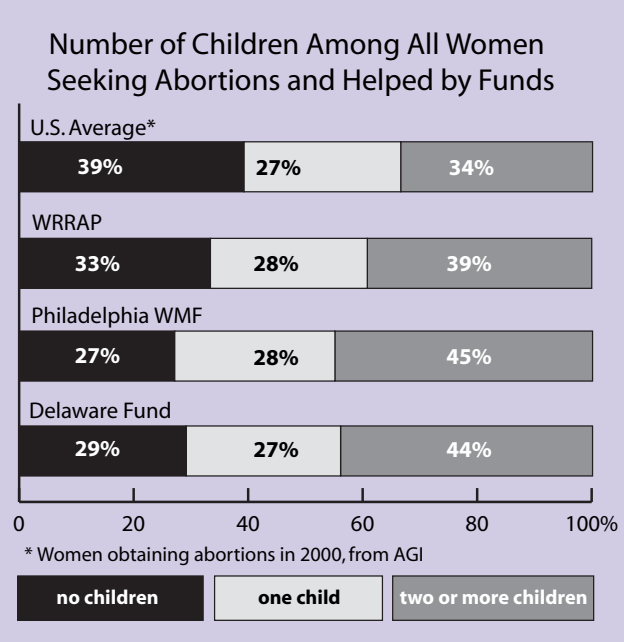
Founded in 1990, the Delaware Pro-Choice Medical Fund serves women across the state who need abortion funding. Like Pennsylvania, Delaware denies Medicaid funding for abortion, except in cases of life endangerment, rape, or incest. Also like Pennsylvania, Delaware makes it virtually impossible for women pregnant because of sexual assault to secure Medicaid funding for abortions. In addition, parents of minors under 16 must be notified before an abortion is provided. The experience of women seeking assistance from the Delaware fund illustrates pervasive problems, including the harmful effect of multiple barriers and the higher costs of later abortion caused by Medicaid bans. Compared with national averages for women having abortions, the women were more likely to be teenagers, to have larger families, and to be pregnant as a result of rape.

Delaware's fund, which is run entirely by volunteers, raised and distributed $69,000 in grants to 342 women in 2003, helping to pay for over 5% of the state's abortions. Abortion providers screen clients who cannot afford the cost of the procedure and call the fund on the woman's behalf with a request for funding. In addition, approximately 12% of the women helped by the fund are from outside Delaware.

Ten percent of the women helped by the fund were minor teenagers 17 and under, and half of these were 15 or younger. In contrast, 7.2% of abortions nationally are obtained by women 17 and younger.[33] The average age of all the women helped was 23.

Most of the women (71%) were mothers, as compared to the national average of 61%. A significant number had larger families than the national average. Forty-four percent had two or more children, as compared with the national average of 33.5% with two or more children.[34]

While the majority of women (56%) helped in Delaware were in the first trimester, with a median abortion cost of $350, the average cost for an abortion was $642, driven up by the 10% of women whose procedures cost between $1,100 and $8,000. The fund's grants ranged from $15 to $1,000; the average was $203. As with every other abortion fund profiled, the number of second trimester and late second trimester abortions exceeded the national average; 6% of the women were 21 weeks pregnant or more, compared with about 1% nationally.



Delaware Pro-Choice Medical Fund's data also revealed that few poor women and girls were receiving financial help from a male partner. Comments in the data show that for those women who talked about their situation, 178 (52% of all the women helped) said that they were receiving no assistance toward the cost of the abortion from their male partner. Only 55 women said that they were receiving such help. In many cases, the couple was no longer together and/or the man had left when the woman told him she was pregnant. Fourteen women (4%) reported pregnancies because of rape and six said they were experiencing domestic violence (the question was not routinely asked).

The CAIR Project

Northwest Regional Fund in a Medicaid State

Founded in 1998, the Community Abortion Information and Resources Project (CAIR) is a regional fund based in Seattle. Because Washington provides abortion coverage for women with Medicaid, the state covers abortions for many of its very poor women. Washington also covers immigrants who do not have legal status and allows pregnant women who are eligible for Medicaid to enroll in the program in as little as 24 hours. This means that CAIR can focus on assisting the working poor in Washington state, as well as women from other states primarily in the Northwest region.

CAIR's clients demonstrate the great needs of women who are not poor enough to qualify for Medicaid, yet have no way to pay for an abortion on their own. Other women who turn to CAIR for help are non-citizens from other states, even from neighboring Medicaid states; for example, Oregon's Medicaid program refuses abortion coverage to undocumented women. In addition, CAIR assists many young women too scared to use their parents' insurance, non-English speakers, those who depend on the military for their medical care, and women from rural areas or small towns who must travel long distances to obtain an abortion.

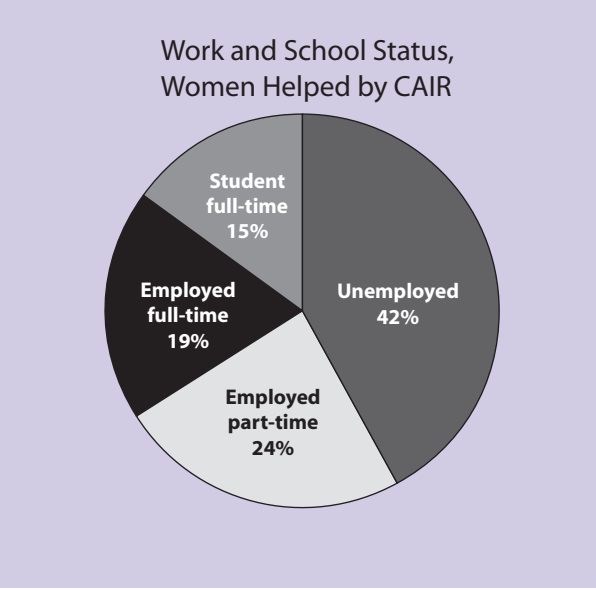
This all-volunteer group takes calls directly from women in need over the telephone and also responds to clinics or other funds that have run out of money. CAIR volunteers frequently take on "case management" for women, which means that they make calls to other funds on behalf of the woman if CAIR itself cannot come up with what is needed. Half of the calls to CAIR are for information and referrals only; many are from women and girls who need help getting the care to which they are legally entitled.

Over a two-year period, 2002 and 2003, CAIR gave grants totaling $24,382 to 192 women from 21 states. The majority of these women (83%) came from six states: 15% from Washington, 5% from Alaska, 25% from Idaho, 11% from Oregon, 18% from Texas, and 9% from Ohio. As noted, Oregon is a Medicaid state. However, not only does it deny coverage to non-citizens but enrollment in its program is also difficult and slow.

"Sarah," a 31-year-old Alaska mother, worked full time, making $1,000 a month. She had no health insurance. At 15 weeks, she was unable to get an abortion in Alaska and had to use her rent money to fly to Washington. A friend provided a place to stay in Seattle; CAIR and two other funds provided the money she needed for the abortion.

Like WRRAP, CAIR's client profile included a majority of women in the second trimester (65%). Of the youngest group needing financial assistance, ages 12-17, 80% were in the second trimester. Nationally, only 12% of all abortions occur beyond the first trimester.

Forty-three percent of CAIR's clients were women with paid employment, but their jobs did not pay enough for them to afford an abortion.



"Barbara" and "Gerard" had been married and trying to have children for ten years. After treatment for fertility, Barbara became pregnant. At 22 weeks, the fetus was diagnosed with a genetic disorder and given little chance of survival. They traveled from Montana to Seattle for the abortion, which Gerard's military insurance would not cover. CAIR helped them raise the $500 they needed.

Twenty-four percent were employed part-time and 19% worked full-time. Over half of the callers (57%) could not afford health insurance but may not have been poor enough to qualify for Medicaid. Overall, CAIR clients' median earnings were $12,000 per year among women who reported some income; the average cost of their abortions was $1,020, about one month's wages. Even some who had medical insurance through their jobs had such high deductibles – up to $1,000 – that they were still forced to pay the entire cost of the procedure.

Nearly 10% of CAIR's callers, and 6% of women who received grants, were covered by military insurance, which does not pay for abortions. In some cases women were separated from their husbands and collecting minimal support; several times, they were sufficiently poor that CAIR was able to help them enroll in the Medicaid program.

The racial and ethnic profile of CAIR's clients reflected the low-income population in the Pacific Northwest. (The information was recorded for 60% of women helped by the fund.) More than half of women who reported their race were white (62%), 17% were Latina, 10% were African American, 3% were Native or Alaska Native and 2% were Asian/Pacific Islander; the remaining 6% answered "other."

Five percent of CAIR's clients were married and another 18% reported that they were "partnered"; 38% were single and 23% were separated or divorced (the status was unknown for 16%). Like women turning to funds elsewhere, CAIR's clients also reported domestic violence (4%) and high rates of rape (8%).

Beyond the Cost of Abortion

Transportation, Lodging, and Childcare

Many poor women seeking abortions confront economic barriers beyond the cost of the procedure itself. In order to obtain an abortion, they often need assistance with transportation, lodging, and childcare. Twelve NNAF member funds provide "practical support" services to help women overcome these barriers.

"Mariana" had been raped in Mexico before she and her husband came to California and found work as farm laborers. Distraught about the pregnancy, she asked for help at a local hospital, which referred her to ACCESS. The fund provided referrals, paid for a hotel room, and found a volunteer to drive Mariana and her husband back home after the procedure, a journey of a few hours. Mariana continued to use ACCESS referrals for sexual assault counseling and other services.

Practical support funds either offer services through a network of volunteers or provide funding for those services. Funds such as the Haven Coalition in New York City open their homes to women who travel long distances, often from states where second-trimester abortions are not available. Others, such as the New Mexico Religious Coalition for Reproductive Choice, pay for transportation and lodging for women who must travel within or out of the state.

ACCESS/Women's Health Rights in Oakland, California combines elements of both: volunteer labor as well as funding for needs that volunteers cannot meet. ACCESS serves northern and central California – covering about two-thirds of the state geographically and 40% of its population.[35]

On the abortion access spectrum, California represents one of the best-case scenarios, with a variety of legal protections that include minors' privacy rights, no waiting period, Medicaid funding, and services for undocumented immigrants. California's Medicaid program, MediCal, makes care available to all pregnant women with incomes up to 200% of the poverty level. Enrollment in MediCal's pregnancy-related program takes seven to ten days, but can sometimes be expedited. Applicants must have a photo ID proving California residence.

Yet even with these policies, not every woman or girl is able to obtain an abortion. ACCESS notes that many low-income women, particularly those in rural areas, lack access to transportation and accurate information about abortion availability. It is not uncommon for misinformed MediCal workers to deny help to women on the basis of immigration status. In addition, many undocumented immigrants do not apply for MediCal coverage because they do not know they are eligible and/or fear they will be deported. ACCESS is able to help many undocumented women to enroll in the program.

An additional problem is the state's low MediCal reimbursement rate, which has contributed to a loss of abortion providers in rural and semi-rural areas and reluctance among remaining providers to take MediCal patients. This problem is particularly acute for women in their second trimester, because clinics often take a loss on these later procedures. As this burden is absorbed by fewer and fewer clinics, more women are forced to travel long distances to reach a provider.

One MediCal policy change has improved access: women no longer need to show official pregnancy verification from a clinic in order to sign up. As a result, enrollment is faster and women obtain earlier abortions. In addition, this change means that fewer women are likely to go to crisis pregnancy centers run by anti-abortion activists. In the past, many women inadvertently ended up at such sites in their effort to get pregnancy confirmation.

A review of 4,615 records from 2000-2002 shows that about 70% of calls to the ACCESS hotline concerned abortion, with requests for information, referrals, insurance advocacy, and options counseling, as well as practical support. The other 30% concerned birth control, prenatal care, sexually transmitted infections, infertility, and general questions about reproductive health.

Of the 85% of callers for whom health coverage was known, 39% were covered by MediCal, 25% had private insurance, 1% had military coverage, and less than 5% had "other" coverage. The remaining 31% had no coverage of any kind.

ACCESS has a network of about 100 volunteers who provide women with rides to and from clinics and bus stations, overnight housing, and sometimes childcare. Others provide translation for non-English-speaking immigrants and deaf women. Although fewer than 10% of callers to ACCESS need practical support, about 25 to 35% of their staff time is spent coordinating practical support services for these women. In 2003-2004, ACCESS spent $8,500 to provide practical support for 70 women. More than three-quarters of this money was spent on overnight lodging in motels.

There is a growing movement in California for a universal, single-payer health care plan. A single-payer system would cover abortion for all women in the state at the same level of care, and thereby eliminate discrepancies in reimbursements and uneven access to information. It could also potentially encourage more rural providers to offer abortion services.

> Founded in 2001, the Haven Coalition is a network of New York City residents who provide free overnight housing to women coming to the city for second-trimester abortions. A woman from Maine, for example, who discovers a serious fetal anomaly during amniocentesis at 15 weeks, would not be able to get an abortion in her own state. Haven has hosted 236 women and girls, as well as their mothers or other support people.[36]

Abortion Funding: Conclusions and Policy Recommendations

Abortion access is a matter of justice. As the case studies make clear, the Hyde Amendment and state bans on Medicaid funding deny abortion rights and reproductive freedom to some of the most disadvantaged women in our society – those who depend on the government for their health care. Given the racial distribution of poverty in the United States, funding bans discriminate against women of color, from African American women in large cities to Native women on rural reservations. In addition, federal funding bans unfairly penalize immigrants, disabled women, and women in the military, as well as women in prison. Young women, who tend to have few financial resources of their own, are also especially burdened by policies that deny abortion funding.

The case studies in this report reveal the concrete, negative effects of such policies on poor women's ability to exercise their right to abortion. Overall, because of funding bans, the women helped by abortion funds have experienced significant delays in obtaining an abortion; as a result, they have later and more expensive procedures. They struggle to scrape together money for an abortion, often sacrificing other essentials in the process. In many cases, despite their own efforts and those of abortion funds, poor women are unable to secure an abortion. They are denied the basic right to make their own decision about bearing a child and the right to decide how best to care for the families they already have. Other barriers, including mandatory waiting periods, mandatory parental involvement, and burdensome restrictions on providers, compound the hardships imposed on poor women.

The stories of women helped by abortion funds also reveal the difficult life circumstances of poor women seeking assistance. Abortion funds help women and girls who, compared with the average woman who has an abortion, are more likely to be mothers and to have larger families, more likely to suffer from chronic illness, and more likely to have experienced violence in their lives. A disproportionate number are pregnant as a result of sexual assault. Even in this case, where federal law requires coverage, they are routinely denied funding for abortion.

In 2005, we also face significant new threats to the reproductive rights of poor women. The Bush administration and emboldened anti-choice legislators have renewed attacks on reproductive freedom – with policy initiatives that will most severely affect low-income women, women of color and young women. If *Roe v. Wade* is overturned, the financial burden on poor women will increase exponentially. Poor women in over half the country would need to raise money to travel to those states where abortion remains legal. In addition, proposed measures to cut essential health and welfare programs will impoverish more women and further deny reproductive rights to poor women.

The National Network of Abortion Funds calls on policy makers and the public to reject harmful policies and support real reproductive choices for all women. Every woman, regardless of her economic resources, should have the right to decide whether and when to have a child. Every woman should have the right to shape her own life and plan her future. The member funds of NNAF play a critical role by assisting thousands of women and girls every year who would otherwise be unable to obtain an abortion. Yet our efforts can never fill the enormous gap left by the denial of federal and state funding. Women need public support and public resources in order to exercise their right to abortion, as well as their right to have and care for their children with dignity.

By taking the following actions, Congress and state legislatures can facilitate both the prevention of unintended pregnancy and women's access to affordable and timely abortion services:

- Restore full Medicaid funding for abortion by repealing the Hyde Amendment and all other federal and state bans on Medicaid funding.
- Include abortion in all government health programs, including those that provide coverage to Native women using the Indian Health Service, federal prisoners, women in the military and Peace Corps, disabled women, federal employees, and residents of the District of Columbia.
- Repeal state laws that create needless and harmful delays, such as mandatory waiting periods, mandatory parental involvement, and clinic regulations unrelated to patient safety. All of these restrictions disproportionately burden low-income women.
- Guarantee all women, regardless of immigration status, access to the full range of reproductive healthcare through an expanded Medicaid program or universal healthcare plan.
- Cover abortion and contraception in all private insurance plans, until an expanded or universal plan is put in place.
- Defeat the proposed federal Child Interstate Abortion Notification Act, also known as the Teen Endangerment Act, which would criminalize family members and others who assist girls who travel out of state for an abortion.
- Repeal the Weldon Amendment to the Labor-Health and Human Services appropriations bill, also known as the Women's Health Care Denial Law. Require all institutions that receive public monies, including religiously affiliated institutions, to provide a basic standard of care that includes full reproductive health services.
- Require that accurate reproductive health information be widely distributed in schools, posted on government websites, and included in social service programs.
- Make emergency contraception available over the counter and make sure it is affordable and widely accessible to all women.
- Provide welfare benefits that respect women's choices and that permit poor mothers to care for their young children at home. Provide adequate healthcare and childcare, as well as education and job-training opportunities that can lift low-income parents out of poverty. These measures will ensure that no woman feels compelled to have an abortion because she lacks the financial resources to care for a child.

We hope the experiences documented in this report will help persuade legislators, judges, and the general public that low-income women deserve the same reproductive rights as women with greater resources. As a matter of justice, we urge the removal of state and federal restrictions that push legal abortion out of reach for so many women.

Endnotes

[1] *Get "In the Know": Questions about Pregnancy, Contraception, and Abortion*, available at http://www.guttmacher.org/in-the-know/incidence.html, a factsheet published by the Alan Guttmacher Institute (AGI), which is the leading national authority on abortion incidence in the United States. AGI conducts periodic surveys of all known abortion providers.

[2] Patricia Donovan, *The Politics of Blame* (New York: The Alan Guttmacher Institute, 1995), p. 34.

[3] Heather Boonstra and Adam Sonfield, "Rights without Access: Revisiting Public Funding of Abortion for Poor Women," *The Guttmacher Report on Public Policy*, April 2000: 8-11; p. 10.

[4] Medicaid pays for about 13 percent of abortions overall in the United States. See Stanley Henshaw and Lawrence Finer, "The Accessibility of Abortion Services in the United States, 2001," *Perspectives on Sexual and Reproductive Health*, 2003, 35(1): 16-24; p. 20.

[5] Stanley Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives*, 1998, 30(1): 24-29 & 46; p. 26.

[6] Adam Sonfield, "Preventing Unintended Pregnancy: The Need and the Means," *The Guttmacher Report on Public Policy*, December 2003: 7-10; p. 9.

[7] Rachel Benson Gold, "Immigrants and Medicaid after Welfare Reform," *The Guttmacher Report on Public Policy*, May 2003: 6-9; p. 8. See also Elsa Rios and Angela Hooton, *A National Latina Agenda for Reproductive Justice,* National Latina Institute for Reproductive Health, 2004, available at http://www.latinainstitute.org/policy.html.

[8] Henshaw and Finer 2003, p. 20.

[9] Henshaw and Finer 2003, pp. 19-20

[10] Kati Schindler, Anna Jackson, and Charon Asetoyer, *Indigenous Women's Reproductive Rights: The Indian Health Service and its Inconsistent Application of the Hyde Amendment* (Lake Andes: South Dakota: Native American Women's Health Education Resource Center, 2002), pp. 5 and 9.

[11] Rachel Roth, "Searching for the State: Who Governs Prisoners' Reproductive Rights?" *Social Politics*, 2004, 11(3): 411-38; p. 424.

[12] Lawrence Finer and Stanley Henshaw, "Abortion Incidence and Services in the United States in 2000," *Perspectives on Sexual and Reproductive Health*, 2003, 35(1): 6-15; p. 10.

[13] Finer and Henshaw 2003, pp. 10-12.

[14] Henshaw and Finer 2003, p. 18.

[15] Henshaw and Finer 2003, p. 23.

[16] All information from AGI "State Policies in Brief" series, as of January 1, 2003, except for information on restrictions on public facilities, which is from NARAL Pro-Choice America Foundation, "Overview of State Reproductive Rights Laws," in *Who Decides? A State-by-State Report on the Status of Women's Reproductive Rights*, 2004, available at http://www.naral.org/yourstate/whodecides/trends/index.cfm. The AGI "State Policies in Brief" series is updated monthly at http://www.guttmacher.org/pubs/spib.html.

[17] Felicia Stewart, Wayne Shields, and Ann Hwang, "Title X: A Sure Fire Investment with at Least a 300 Percent Return" (editorial), *Contraception*, 2003, 68(1): 1.

[18] Sonfield 2003, p. 8.

[19] U.S. House of Representatives Committee on Government Reform — Minority Staff Special Investigations Division, *The Content of Federally Funded Abstinence-Only Education Programs*, December 2004, Prepared for Rep. Henry A. Waxman. Available at www.democrats.reform.house.gov.

[20] Rachel Jones, Jacqueline Darroch, and Stanley Henshaw, "Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health*, 2002, 34(5): 226-34; pp. 229, 231.

[21] Jones, Darroch, and Henshaw 2002, pp. 233-34.

[22] Center for Reproductive Rights, *If Roe Fell*, 2004, available at http://www.crlp.org/pr_04_1005roerelease.html

[23] Henshaw and Finer 2003, p. 23.

[24] Boonstra and Sonfield 2000, p. 10.

[25] Jones, Darroch, and Henshaw 2002, p. 231.

[26] A questionnaire was sent to member funds in September 2003 as part of NNAF's membership renewal drive. The information provided was voluntary and not a condition of membership. All the data requested covered the fiscal year 2002-03, as defined by the fund. Ten funds also contributed client data, from which we draw our case studies in this report.

[27] Henshaw and Finer 2003, p. 19.

[28] Jones, Rachel, Jacqueline Darroch, and Stanley Henshaw, "Contraceptive Use Among U.S. Women Having Abortions in 2000-2001," *Perspectives on Sexual and Reproductive Health*, 2002, 34(6): 294-303; p. 297.

[29] *Planned Parenthood of Southeastern Pennsylvania v. Casey* 112 S.Ct. 2791 (1992).

[30] Of these 600 women, 408 women were known to have obtained the abortion because their vouchers were redeemed by a clinic, which then billed the fund. Some women may have miscarried before their appointment, changed their mind, or obtained the abortion on their own after raising the full cost. Others may have been unable to pay for the abortion despite help from the fund.

[31] Pennsylvania Department of Health, *2003 Abortion Statistics.* All of the statewide statistics discussed in the WMF section come from this report. http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=175&pm=1&Q=236162.

[32] Jones, Darroch, and Henshaw 2002, p. 228.

[33] Jones, Darroch, and Henshaw 2002, p. 228.

[34] Jones, Darroch, and Henshaw 2002, p. 228.

[35] Interview with Jennifer Parker, Executive Director, ACCESS/Women's Health Rights Coalition (based in Oakland, California), on December 21, 2004.

[36] Lynn Harris, "Shelter from the Storm," *Salon,* June 8, 2004, available at http://archive.salon.com/opinion/feature/2004/06/08/haven_coalition.

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