DEFENDING HUMAN RIGHTS

Abortion Providers Facing Threats, Restrictions, and Harassment

CENTER FOR REPRODUCTIVE RIGHTS

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OUR MISSION

The Center for Reproductive Rights uses the law to advance reproductive freedom as a fundamental human right that all governments are legally obligated to protect, respect, and fulfill.

OUR VISION

Reproductive freedom lies at the heart of the promise of human dignity, self-determination, and equality embodied in both the U.S. Constitution and the Universal Declaration of Human Rights. The Center works toward the time when that promise is enshrined in law in the United States and throughout the world. We envision a world where every woman is free to decide whether and when to have children; where every woman has access to the best reproductive healthcare available; where every woman can exercise her choices without coercion or discrimination. More simply put, we envision a world where every woman participates with full dignity as an equal member of society.

FOREWORD

As the United Nations High Commissioner for Human Rights from 2004 to 2008, I worked to promote and protect human rights around the world. Fulfilling the promise of the Universal Declaration of Human Rights requires the vigilance of the international community and concerted efforts at the national level. But it also takes the dedication of individuals who fight to protect human rights. Human rights defenders can come in many forms, but they share a commitment to protect, promote, and ensure the rights of others. Because of their work, these courageous individuals put their lives and safety on the line, facing harassment, attacks, and threats of violence. Hostile governments single them out for restrictions and penalties, placing their reputations and livelihoods at risk.

This report brings much needed attention to attacks on a specific group of human rights defenders—physicians and other reproductive healthcare professionals who work to provide abortions in the United States. Despite the Supreme Court's recognition of women's constitutional right to abortion over 35 years ago, the reproductive rights of women in the U.S. remain under attack. While most opponents of reproductive rights lawfully lobby their governments, others resort to extreme, even violent, methods to block women's access to abortion. This report shows how abortion opponents use a variety of tactics to target abortion providers, ranging from violence and harassment to imposing onerous discriminatory restrictions on their right to work. The tactics documented in this thoroughly researched report appear designed to drive providers out of business, and ultimately, to deny women the ability to realize their constitutional right to abortion.

Since the 1994 International Conference on Population and Development in Cairo, the international community has recognized that reproductive rights are human rights. These rights are based on the fundamental rights to health, life, equality, information, education, and privacy that are enshrined in international human rights documents. Cairo's Programme of Action explicitly recognized "the right to attain the highest standard of sexual and reproductive health" and reaffirmed women's right to determine the spacing and timing of children as set forth in the Convention on the Elimination of All Forms of Discrimination against Women.

Yet, fifteen years after Cairo, we continue to see a struggle for the realization of reproductive rights throughout the world. Human rights defenders play a key role in the process of making these rights an everyday reality. They challenge governmental restrictions that undermine women's reproductive autonomy. In China, they battle against forced abortion and sterilization and coercive family planning policies. In the Philippines and Nicaragua, they work to ensure that women have access to reproductive health services, including contraception and abortion, as well as the information necessary to protect their sexual and reproductive health. Because defenders of reproductive rights often challenge gender roles and cultural, religious, and societal norms, they are frequent targets of violence and other attacks, such as slander or smear campaigns. Human rights defenders and the organizations they work for are also often singled out for government interference, including discriminatory penalties and restrictions aimed at discouraging or preventing their work.

As documented in this report, many reproductive healthcare professionals in the U.S. work under extreme circumstances, facing threats to their lives and personal security in order to ensure that woman can access their reproductive rights. They are also singled out for restrictions that substantially burden their ability to provide services. The U.N. has recognized healthcare providers as human rights defenders when they fulfill their professional duties in a way that promotes human rights. Just as the lawyers who bring habeas petitions on behalf of individuals wrongly detained play an instrumental role in ensuring the right to be free from arbitrary detention, doctors and healthcare workers who provide services in the face of severe threats and obstacles play an essential role in ensuring the right to health.

In the reproductive healthcare context, the provision of healthcare services is also necessary to realize women's rights to equality, privacy, and autonomy. Without meaningful access to reproductive health services, women are denied the ability to control their bodies and to make their own decisions about their families. Doctors and reproductive health workers are human rights defenders when they promote women's fundamental rights in the face of personal and professional risks. Indeed, attacks against these providers are also attacks against women themselves.

"This report brings much needed attention to attacks on a specific group of human rights defenders—physicians and other reproductive healthcare professionals who work to provide abortions in the United States." – Louise Arbour

This report is a major step in exposing the broad range of attacks and harassment that abortion providers face because of their work. Like human rights defenders around the world, these defenders are subject to violence and related threats to their personal safety and the safety of their families, including death threats, stalking, and extreme invasions of privacy. Many face daily harassment and intimidation at the facilities where they work and are subject to vicious attacks on their personal or professional reputations. Doctors who perform abortions face professional reprisals and are often pressured by partners, colleagues, and hospital employers not to provide services. This report also highlights government regulations and restrictions targeting abortion providers that infringe upon the physician-patient relationship and make the provision of services more onerous and expensive. As documented by this report, these regulations have little or no medical justification and would be unheard of in any other healthcare context. Indeed, their purpose appears plain: to discourage the provision of reproductive health services and ultimately to deny women access to abortions.

But there is hope. In the face of ever multiplying restrictions and regulations, threats to their safety, and daily harassment, the doctors and healthcare providers documented in this report continue to provide services. Their courage and commitment to women's reproductive health and rights drives them to persevere in the face of incredible obstacles. But they should not be forced to live and work under these conditions. As set forth in this report, the U.S. government has an obligation to protect human rights defenders. Federal, state, and local governments must enforce existing clinic protection legislation and, where necessary, pass new legislation protecting doctors, healthcare workers, and clinics. Targeted governmental restrictions on abortion providers with no health-related purpose should be repealed. Finally, civil society should recognize the crucial role that these brave women and men play in protecting and ensuring women's fundamental rights and honor and support their work.

— **LOUISE ARBOUR**
U.N. High Commissioner for Human Rights, 2004–2008
May 2009

...the Center is indebted to the abortion providers and women seeking abortions who participated in the interviews and very generously shared their time and personal experiences.

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GLOSSARY

40 Days for Life: An anti-choice religious organization that organizes bi-annual campaigns of forty-day long protests outside abortion clinics across the country.

Ambulatory Surgical Centers (ASC): Healthcare centers licensed by states to provide outpatient surgical services. In some states, abortion providers are required to meet burdensome and unnecessary personnel requirements and onerous administrative policies, as well as extensive renovations to physical facilities. These requirements are generally cost prohibitive and cannot be met by clinics or private physicians' offices.

Committee against Torture: A U.N. body charged with monitoring nations' compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Countries that have ratified CAT, including the United States, report to this body every four years.

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (adopted by the U.N. General Assembly in 1984): An international treaty prohibiting torture and other cruel, inhuman or degrading treatment or punishment. The U.S. has signed and ratified CAT.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (adopted by the U.N. General Assembly in 1979): A comprehensive international treaty often described as an international bill of rights for women. It defines what constitutes discrimination against women and sets forth a national action plan for ensuring women's equality — a framework for governmental policy to combat gender inequality. The U.S has signed, but not ratified, CEDAW.

Declaration on Human Rights Defenders (adopted by the U.N. General Assembly in 1998): An international consensus document that does not create new rights, but rather sets forth human rights pertaining to human rights defenders, and government obligations to protect them, as provided in international human rights treaties.

Freedom of Access to Clinic Entrances (FACE) Act: A federal statute, enacted in 1994, that prohibits the use of force to obstruct, intimidate, or interfere with someone who is providing or receiving reproductive health services. The Act includes criminal penalties and provides for civil actions to obtain injunctive relief.

***Harris v. McRae* (1980):** U.S. Supreme Court case that upheld the Hyde Amendment, prohibiting federal Medicaid funding for medically necessary abortions, except in cases of rape, incest, or life endangerment. The Court also held that states are not required to fund abortions under their state Medicaid programs for which federal funds are unavailable.

Human Rights Committee: A U.N. body charged with monitoring nations' compliance with the International Covenant on Civil and Political Rights (ICCPR), one of the foundational international human rights treaties. Countries that have ratified the ICCPR, including the U.S., report to this body every four years.

Human Rights Defenders: Individuals who work individually or with others to promote or protect human rights. Depending on the context in which they work, they frequently put their own lives, safety, and security on the line to defend the human rights of others. Because these courageous individuals often face heightened risks for the work they do, governments have a duty to ensure their protection.

Hyde Amendment: First enacted in 1977, this amendment prohibits federal funding for abortion under the Medicaid program even when an abortion is medically necessary, except in cases of rape, incest, or life endangerment.

International Covenant on Civil and Political Rights (ICCPR) (adopted by the U.N. General Assembly in 1966): An international treaty protecting individuals' civil and political human rights, such as the right to vote and the right to freedom of expression. The U.S. has signed and ratified the ICCPR.

International Covenant on Economic, Social and Cultural Rights (ICESCR) (adopted by the U.N. General Assembly in 1966): An international treaty protecting economic, social, and cultural rights, including the rights to health and education and labor rights. The U.S. has signed, but not ratified, the treaty.

Inter-American Commission on Human Rights (IACHR): As one of the two principal human rights organs of the Organization of American States, monitors human rights activity throughout the Americas, including the U.S. The IACHR has a special unit within its Secretariat dedicated to working with states to improve protections for human rights defenders.

***KL v. Peru* (2003):** Decision from the U.N. Human Rights Committee that found that denying a 17-year-old, who was pregnant with an anencephalic fetus, access to a therapeutic abortion recommended by her doctors and permitted by Peruvian law violated her rights to privacy; to be free from cruel, inhuman or degrading treatment; and to special protections for minors protected by the ICCPR.

Mandatory Delay and Biased Counseling Laws: Mandatory delay refers to a requirement that a woman delay her abortion a certain number of hours or days after receiving or being offered specified state-mandated information (biased counseling). However, abortion providers routinely explain the risks and process of abortion to patients, and assure that women are making an informed decision free from coercion. Mandatory delays and biased counseling requirements serve no actual health purpose and are intended only to discourage abortion provision and decrease women's access to abortion.

Operation Rescue, Operation Save America (which originally used the name Operation Rescue): Anti-abortion organizations that seek to end all abortion in the U.S.

Planned Parenthood: A non-profit organization that engages in healthcare advocacy and provides reproductive health services through affiliates throughout the U.S.

***Planned Parenthood v. Casey* (1992):** U.S. Supreme Court case that diminished the constitutional protections for abortion from the "strict scrutiny" standard for impingements on constitutional rights, replacing it with the "undue burden" test. The Court held that states may regulate abortion as long as the regulations do not place a "substantial obstacle" in a woman's path. This ruling opened the door to a host of previously unconstitutional legal restrictions designed to deter abortion.

Reproductive Rights: Reproductive rights embrace the rights to health, life, equality, information, education, privacy, freedom from discrimination, freedom from violence, and decision-making regarding whether and when to have children. These fundamental rights are found in national laws as well as international human rights treaties and consensus documents.

***Roe v. Wade* (1973):** Seminal case in which the U.S. Supreme Court ruled that a woman's right to obtain an abortion was protected under the due process clause of the Constitution. The core holding of *Roe*, which remains the law today, is that the government may not prohibit a woman from obtaining an abortion prior to fetal viability, but may do so after viability as long as a woman may still legally obtain an abortion to protect her life or health.

Special Rapporteur on Human Rights Defenders: In 2000, following the adoption of the 1998 Declaration on Human Rights Defenders, the UN appointed a human rights expert to encourage compliance with the Declaration and to investigate and publicize the situation of human rights defenders around the world. Since 2008, this expert has been known as the UN Special Rapporteur on Human Rights Defenders.

Targeted Regulation of Abortion Providers (TRAP): Laws that regulate medical practices or facilities that provide abortions by imposing burdensome requirements that are different and more stringent than regulations applied to comparable medical practices. For example, such regulations may require extensive renovations of the abortion provider's physical facility, or require that registered nurses—who are generally in short supply and high demand nationwide—carry out functions outside their normal duties.

EXECUTIVE SUMMARY

For more than 60 years, the United States has joined most countries of the world in formally recognizing and committing to protect the fundamental human rights set out in the Universal Declaration of Human Rights. These include the rights to life, equality, privacy, medical care, information, education, and freedom from discrimination.

The United States has also joined the U.N. General Assembly in recognizing the special challenges faced by those who promote and defend these rights. These courageous people are known as human rights defenders. In the 1998 Declaration on Human Rights Defenders, the General Assembly acknowledged the important role that the governments play in ensuring that they can function effectively and safely.

At the 1994 International Conference on Population and Development, governments explicitly acknowledged that reproductive rights are human rights, grounded in existing human rights instruments, which include the Universal Declaration. These rights include a woman's right to make decisions about her life and family, to access reproductive health services, and to decide when and whether to have children. In the United States, the Supreme Court recognized women's constitutional right to abortion in 1973.

Despite domestic and international recognition of these rights, however, many women in the United States face severe impediments to obtaining abortion services. This report focuses on a key obstacle to the realization of women's reproductive rights, the challenges faced by abortion providers, and recognizes their work as human rights defenders. These challenges come in many forms, from harassment and intimidation of doctors and clinics to legal restrictions that single out abortion providers. But they all have a common purpose: preventing clinics from providing reproductive health services and women from exercising their right to obtain abortions.

While federal legislation passed in the 1990s has curtailed some of the most violent forms of harassment, attacks, threats and violence continue to this day. The recent murder of Dr. George Tiller at his church in Wichita, Kansas makes all too clear that the long and tragic history of violent attacks on doctors who perform abortion and clinics is not over. By terrorizing providers and their patients, attackers seek to impede others' fundamental rights.

Governments at all levels are frequently part of the problem. Government officials often fail to enforce protective laws. State regulations and restrictions single out abortion providers for disfavored treatment, requiring that they meet expensive, unnecessary, and onerous regulatory requirements in order to impose significant barriers to the provision of services. States have also passed legislation requiring mandatory delays and biased counseling that is specifically designed to deter women from seeking abortions. The net result of these attacks is a shortage of abortion providers that threatens women's ability to obtain services.

This report documents the heroism of abortion providers whose dedication to women's reproductive health compels them to act despite severe personal and professional sacrifices. It describes attacks, harassment and discriminatory legal restrictions imposed on abortion providers in six states: Mississippi, Alabama, Texas, North Dakota, Missouri and Pennsylvania. It also details the pervasive stigma against abortion within the medical and general communities that allows private and government attacks to persist.

The physicians and healthcare workers documented in this report are human rights defenders. They persevere despite threats to their personal safety, harassment, attacks on their reputation, economic reprisals, and discriminatory restrictions, and they actively work to minimize the harm of these burdens on the women they serve.

SHORTAGE OF PROVIDERS. Human rights defenders should be protected and aided by the government in the promotion of fundamental rights. Unfortunately, the harassment, legal restrictions, and persistent stigma documented in this report deter physicians from providing abortions, resulting in a shortage of doctors. In addition to concerns about their safety, physicians are fearful of the professional, economic, and personal implications of being targeted by abortion opponents. Laws and regulations singling out abortion providers among medical caregivers impose significant financial costs and other administrative and resource burdens on providers.

In the six states included in the investigation, physicians and clinics are few or concentrated unevenly in a few areas of the state. Most clinics rely on a very small number of physicians and often share doctors with other clinics and with the physicians' own private or hospital-based practices. Women travel to clinics from extraordinary distances and the harmful impact of the distances is exacerbated by state laws imposing mandatory 24-hour delays and "counseling." Women with few resources, and those who have difficult personal circumstances, are not able to easily access services in a timely way—or not at all. As a result of delays, women may only be able to obtain more costly, and potentially riskier, later abortions. Or they may pass a clinic's gestational limit altogether and be forced to travel even farther to find services, assuming they are available.

INTIMIDATION AND HARASSMENT. Like other human rights defenders throughout the world, abortion providers face intimidation, harassment, and violence in the course of carrying out their work. Anti-abortion activity at clinics runs the gamut, from peaceful First Amendment-protected activities to civil and criminal offenses, with many behaviors in a legally contested area in between. While outright violence has decreased at most facilities, the legacy of past murders, bombings, arsons, and assaults is well-known, prompting clinics to take new threats seriously. Despite the government's obligation to provide specific and enhanced protection to abortion providers, local law enforcement at many sites is uninformed, unresponsive, or even hostile. As a result, clinics make a significant investment in time and resources to protect their staff and patients. Clinic staff and physicians also experience picketing, stalking, smear campaigns, and harassing leafleting at their residences and other threats to themselves and their families.

LEGAL RESTRICTIONS. Governments should make it easier, not more difficult, for individuals to realize their human rights and defend the rights of others, including reproductive rights. Often, they do not. This report documents discriminatory restrictions aimed at prohibiting abortion providers from exercising their profession and providing services. In many states, providers face legislation designed to deter the provision of abortion services.

- **Mandatory Delay and Biased Counseling.** Each of the states in this report requires a "waiting period" of 24 hours between the time a woman receives "counseling" and/or state-mandated information and obtains an abortion. Across the board, providers agree that there is no medical reason for these requirements. Laws requiring two in-person visits particularly burden women and providers and have the worst effects where there is a severe shortage of providers. Women who have the fewest financial resources, are geographically most isolated from providers, or have later pregnancies are most at risk of being harmed by the barriers that these restrictions impose.

- **Medical Practice and Facilities Requirements.** Abortion clinics are singled out in many states for discriminatory medical practice and facilities requirements. These laws and regulations bear no relationship to medical evidence concerning the safety of abortion services and are not imposed on other healthcare services that carry similar medical risks. Although the regulations have no medical purpose, they impose a significant burden on providers and on women's access to abortion. These regulations often require extensive renovations of existing facilities or entail building a new, custom-designed facility, which can cause providers to temporarily close or stop providing services altogether. Inconsistent and arbitrary enforcement of regulations by state health departments also creates uncertainty, increases workloads for clinic staff, and takes time away from patient care.

- **Funding Prohibitions.** While Medicaid covers medically necessary services for poor women, federal funding restrictions explicitly prohibit coverage of medically necessary abortions except in cases of rape, incest, or life

Anti-choice protestor, Florida 2003

LIKE OTHER HUMAN RIGHTS DEFENDERS THROUGHOUT THE WORLD, ABORTION PROVIDERS FACE INTIMIDATION, HARASSMENT, AND VIOLENCE IN THE COURSE OF CARRYING OUT THEIR WORK

endangerment. Lack of funds frequently causes women to delay an abortion while they raise the money to pay for it. These delays can result in later abortions, potentially increasing risk to the woman's health. A significant percentage of poor women, unable to afford and access the service, forgo abortion altogether.

STIGMA. Stigma creates needless obstacles for human rights defenders and can erode the number of active providers in a community. Stigma related to abortion is widespread in all six states, in both the medical and general communities. Stigma legitimizes harassment and intimidation, permitting them to take place with impunity. Legal restrictions on abortion promote and reinforce abortion as a stigmatized service, distinct and marginalized from other healthcare services.

Stigma results in economic pressure on physicians not to perform abortions, including by the presence or threat of anti-abortion activity at their private practices. Many medical practices and institutions prohibit doctors from performing abortions, even outside of the practice or hospital. Physicians may refuse to refer patients for abortions, or for other services performed by physicians who are abortion providers. Patients in several states expressed apprehension about their regular physician finding out that they had an abortion because they know that the doctor disapproves. The negative attitude of medical professionals contributes to women's fear, lack of information, and negative experiences when seeking to obtain an abortion.

General community stigma affects clinics that provide abortions in a number of ways. Many landlords and service vendors are unwilling to enter into business relationships with providers because they do not want to be associated with abortion. Towns use zoning restrictions to harass or prevent clinics from locating there. Often stigma is intertwined with safety and economic concerns about being targeted by protestors. Lack of evident support for clinics in turn enhances stigma and endorses impunity for abortion opponents who seek to harm providers.

GOVERNMENT'S OBLIGATION TO PROTECT HUMAN RIGHTS DEFENDERS. The United States and many other nations have recognized that it is government's responsibility to protect human rights defenders and create an environment where they can work safely and effectively. Harassment of and attacks on abortion providers violate the rights of both providers and the women they serve. Private attacks and harassment by abortion opponents violate providers' human rights, including their right to work, to promote human rights, to life and health, to be free from violence and unlawful attacks on reputation, and to receive and impart information. Government restrictions targeting providers violate their right to be free from discrimination on the basis of the medical services that they provide.

THIS REPORT DOCUMENTS THE HEROISM OF ABORTION PROVIDERS DEDICATED TO WOMEN'S REPRODUCTIVE HEALTH

The limited availability of abortion services that results from the targeting of abortion providers infringes upon women's fundamental human rights to life, health, equality, freedom from discrimination, privacy, education and information.

The U.S. has an affirmative obligation to protect abortion providers such as those profiled in this report—both because of their status as human rights defenders, and because of the key role they play in ensuring that women are able to vindicate their reproductive rights.

Recommendations

Urgent action is required to recognize abortion providers as human rights defenders, to protect their rights, and to hold those who perpetrate violations accountable.

- Government at all levels should adopt and enforce measures to improve the safety of providers.
- Discriminatory legal restrictions that impede providers' work should be repealed, including biased counseling and mandatory delay laws, discriminatory medical practice and facilities requirements, and funding restrictions.
- The international human rights community should work with the U.S. government to publicize and condemn reproductive rights violations as a human rights issue and to recognize and protect abortion providers who act as human rights defenders.
- The medical community should strongly condemn attacks on abortion providers and the singling out of abortion for different requirements and restrictions than other medical care.
- Steps must be taken by government at all levels and by the medical community to reverse the marginalization of abortion services and to create opportunities for new providers to train and practice.
- Significant efforts must be made by non-governmental organizations at the community level to educate both policymakers and the public to reduce stigma around abortion, and to increase recognition that access to reproductive health services is a fundamental component of basic human rights and that abortion is an essential part of women's reproductive healthcare.

INTRODUCTION

Abortion providers are critical to ensuring that women are able to exercise their fundamental rights, which include access to reproductive healthcare as a component of the right to health. Yet, as this report documents, physicians and clinic personnel are subject to infringements on their personal, professional, and financial security because they provide abortions.

For many doctors and clinic staff, harassment and intimidation, legal restrictions intended to interfere with the availability of abortion, and persistent stigma in the medical and general communities are routine obstacles to their work. Moreover, the government at all levels frequently fails to enforce protective laws, while at the same time enacting restrictions that impinge on the ability to provide services and perpetuate stigma and the marginalization of abortion providers. These attacks, discriminatory treatment, and impunity for perpetrators contribute to a scarcity of providers and make it difficult for women to obtain abortions.

Despite these abuses, providers respond with an extraordinary level of resources, resilience, and dedication to assist women to overcome the many barriers to a critical, and commonplace, reproductive health service.

Objectives of the Report

The goal of this report is to consider the challenges abortion providers face as defenders of women's human rights in the U.S. today. The report documents the range of harassment, attacks, and restrictions experienced by healthcare workers in the provision of abortion services in six states. It identifies the harmful impact of the attacks and legal burdens on providers and on women's right to access reproductive health services.

It is evident from the results of this investigation that firm action to remedy violations of providers' rights and hold perpetrators accountable is badly needed on the local, state, federal, and international levels.

Abortion rights rally, NYC 1986

Method and Scope of the Investigation

The Center for Reproductive Rights conducted semi-structured interviews with 83 abortion providers and 29 women seeking abortions in Alabama, Mississippi, Missouri, North Dakota, Pennsylvania, and Texas from November 2008 to February 2009. The states were chosen for geographic diversity and because they met all or most of the following criteria: 1) significant, recent anti-abortion activity; 2) legal restrictions on women's access to abortion; 3) regulations that single out abortion providers; and 4) unresponsive or inadequate law enforcement.

Clinics and individual providers were recruited to the study from the pool of Center for Reproductive Rights clients, National Abortion Federation and Abortion Care Network members, and Planned Parenthood affiliates. A diversity of locations and settings was sought, where such diversity exists within a particular state. At the same time, we sought to interview providers and women seeking abortions at the clinics who had experienced significant burdens in the provision of abortion. All interviews were conducted privately; participants gave written informed consent in advance of the interviews.[1] •

BACKGROUND

Abortion in the U.S.

Abortion is one of the most common surgical procedures performed in the U.S.[2] and remains one of the safest medical procedures available.[3] Forty percent of unintended pregnancies in the U.S. each year end in induced abortion.[4] Roughly one in three women will have an abortion during her reproductive lifetime.[5] Nearly 90 percent of abortions are performed during the first 12 weeks of pregnancy, a proportion that has been consistent since legalization.[6]

Despite the steady level of abortions performed in the U.S., the population of abortion providers has decreased by at least 37 percent since 1982.[7] As a result, 87 percent of U.S. counties and 97 percent of non-metropolitan counties have no provider, and these counties are home to one-third of women of reproductive age.[8] It is estimated that 24 percent of women having abortions must travel 50 miles or more for services.[9] The consequence is that women in the U.S. increasingly find it harder to obtain necessary services—a problem that is unlikely to be remedied in the near future, as the majority of abortion providers are at least 50 years old, and nearly one-third are over age 55.[10]

At the same time, the majority of medical schools and residency programs do not provide adequate education and training in abortion procedures, reducing the ranks of potential providers to replace those who may soon be retiring (see box: *Lack of Training Opportunities for Potential Abortion Providers*).[11]

The majority of abortions are performed in specialized clinics; these clinics provided 69 percent of all abortions in 2005.[24] Eighty percent of abortions take place in facilities that perform 1,000 or more abortions per year.[25]

SPOTLIGHT

Lack of Training Opportunities for Potential Abortion Providers

Many new doctors are not equipped with the skills they need to provide women with comprehensive reproductive healthcare, including abortion, due to lack of training in the procedure in medical school and residency.[12] Only five percent of abortions are performed in hospitals, where most medical students and residents are trained,[13] and most medical students will graduate without ever seeing an abortion performed.[14]

National standards for medical student education recommend that all medical school curricula include training in family planning and abortion.[15] Only a minority, however, appear to offer a detailed lecture or clinical experience.[16] Reproductive health organizations have attempted to augment medical school training in abortion through the development of extracurricular or elective experiences.[17] Still, medical schools often prevent students from participating in externship clinical rotations in abortion training or from organizing workshops or guest lectures on campus.[18]

Since 1996, accreditation guidelines require that residency education for doctors training to be obstetricians/gynecologists (OB/GYNs) must include experience with induced abortions; however, programs with religious or moral objections may opt out.[19] In a 2006 survey, only about half of OB/GYN program directors reported routine instruction in elective abortion; 39 percent reported optional training and ten percent reported no training.[20] In general, large programs, those located in the Mid-Atlantic, New England or on the West Coast, and programs without a religious affiliation were significantly more likely to provide routine abortion training.[21] The Council of Residency Education also recommends that family practice physicians should be trained in pregnancy risk-assessment and family planning, including voluntary termination up to 10 weeks.[22] Yet, of the 450 family practice residency programs in the U.S., only 25 offer abortion training as part of their integrated curriculum.[23]

U.S. Legal Framework on Abortion

The constitutional right to abortion was recognized in *Roe v. Wade* in 1973.[26] The Supreme Court's subsequent rulings, however, permit myriad restrictions that impede women's ability to obtain the procedure, especially for low-income women.

In 1980, in *Harris v. McRae*, the Supreme Court upheld the Hyde Amendment, which prohibits federal Medicaid funding for medically necessary abortions, except in cases of reported rape or incest and a narrowly defined category of life endangerment.[27] Only 17 states currently use state funds to pay for all or most medically necessary abortions for Medicaid recipients, 13 under court order.[28]

In 1992, in *Planned Parenthood v. Casey*,[29] the Court replaced the highest level of judicial review, "strict scrutiny," applied to restrictions of constitutional rights, with the determination that states may regulate abortion provision so long as the regulations do not place an "undue burden" in the path of women seeking abortions. It upheld 24-hour mandatory delay and physician-only biased counseling requirements.

Since *Casey*, dozens of state laws have restricted abortion in ways that had been previously struck down as unconstitutional. These include biased counseling laws that require women seeking abortion to receive state-mandated information intended to discourage abortion prior to the procedure; mandatory delay restrictions that force women to wait for a specific period of time, usually 24 hours, after receiving the biased counseling information and prior to obtaining an abortion; and statutes that mandate parental consent or notification before a minor can have an abortion. Many of these laws carry criminal penalties for violations.[30]

In addition, 44 states and the District of Columbia have passed legislation targeting abortion providers for regulation that does not apply to comparable medical practices or facilities.[31] Targeted regulation of abortion providers—or "TRAP"—laws regulate everything from the physical plant requirements of abortion facilities to staffing levels and qualifications.[32] Failure to comply with these often stringent requirements can result in substantial criminal sanctions, civil penalties, or loss of medical licensure. These excessive and unnecessary government regulations impede abortion provision and access[33] by increasing the cost and scarcity of abortion services, thereby harming women's health and inhibiting their reproductive choices.[34]

Since *Casey*, dozens of state laws have restricted abortion in ways that had previously been struck down as unconstitutional. These include biased counseling laws; mandatory delay restrictions; and statutes that mandate parental consent or notification before a minor can have an abortion.

History of Harassment, Intimidation, and Violence against Abortion Providers in the U.S.

Much of the anti-abortion activity at clinics is peaceful, non-threatening speech and conduct protected by the First Amendment. However, there is a long history of violence at clinics, such as arson and massive blockades, and violations to the physical security of doctors who provide abortions—including murder, attempted murder, assault and battery, and stalking—without adequate government protection.[35]

In 1994, the Freedom of Access to Clinic Entrances (FACE) Act made it a federal offense to use "force, the threat of force or physical obstruction" to intentionally "injure, intimidate or interfere" with individuals obtaining or providing reproductive health services, or to intentionally damage a facility because it provides reproductive health services.[36] The frequency of severe clinic violence[37] declined after the enactment of FACE and its substantial penalties, particularly for multiple offenses. Nevertheless, murders of physicians occurred after the implementation of FACE, including the 2009 murder of Dr. George Tiller. Far from being eradicated, violence, threats, harassment, and intimidation continue today.[38]

Moreover, law enforcement is often unresponsive to providers. In 2008, 72 percent of the 274 clinics participating in a national survey conducted by the Feminist Majority Foundation reported being subjected to intimidation tactics. According to this survey, harassers routinely approach and block cars, take photos or videos of patients, and record license plates.[39] In 2008, the National Abortion Federation compiled reports of 13 bomb threats, 8 clinic blockades, 19 stalkings, 193 incidents of trespassing or vandalism, and 374 incidents of harassing phone calls or hate mail, though the actual number of incidents for most categories likely goes underreported.[40]

The intimidation tactics employed by abortion opponents are also evolving. In recent years, for example, a number of harassing lawsuits have been filed against local governments and abortion providers by clinic protestors.[41] •

HUMAN RIGHTS FRAMEWORK

HUMAN RIGHTS AND HUMAN RIGHTS DEFENDERS. In 1948, the United Nations General Assembly adopted the Universal Declaration of Human Rights, which recognized the inherent dignity and human rights of every human being. In adopting the Universal Declaration, countries around the world committed to securing human rights at the national level.

Since then, the international community has recognized that protecting human rights requires the dedicated work of individuals and organizations, as well as commitments by governments. Commonly known as "human rights defenders," these individuals put their own lives, safety, and security on the line to defend and promote the human rights of others. Recognizing the crucial role that human rights defenders play in protecting the rights of others, international law requires that governments take measures to protect and ensure defenders' rights.

In 1998, on the 50th anniversary of the Universal Declaration, the U.N. General Assembly adopted the Declaration on Human Rights Defenders ("the Declaration")[42] with the full support of the U.S.[43] The Declaration recognizes the central role that human rights defenders play in promoting the realization of human rights. It sets forth the rights of human rights defenders to engage in peaceful activities to promote human rights and government obligations to protect human rights defenders.

The rights and obligations in the Declaration are based on human rights standards set forth in international human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR), which was ratified by the U.S. Senate in 1994.[44] Ratification confers an international legal obligation on the U.S. to respect, protect, and fulfill the rights contained in the treaty[45] and to create the conditions necessary to ensure that all persons are able to enjoy rights in practice.[46] The U.S. has also signed (but not ratified)

...challenges come in many forms, from harassment and intimidation of doctors and clinics to legal restrictions that single out abortion providers.

REPRODUCTIVE RIGHTS INCLUDE A WOMAN'S RIGHT TO MAKE FUNDAMENTAL DECISIONS ABOUT HER LIFE AND FAMILY

several other important human rights treaties, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which also require that governments act to promote the realization of the human rights identified in the treaties.[47]

As a signatory to these treaties, the U.S. has an obligation not to take any action that would defeat their object or purpose.[48] In 2009, the U.S. government also issued a pledge restating its commitments to human rights, including that "The United States recognizes and upholds the vital role of civil society and human rights defenders in the protection and promotion of human rights[.]"[49]

REPRODUCTIVE RIGHTS ARE HUMAN RIGHTS. Reproductive rights include a woman's right to make fundamental decisions about her life and family, to access the reproductive health services necessary to protect her health, and to decide whether and when to have children. Reproductive rights are based on a number of fundamental human rights, including the rights to health, life, equality, information, education and privacy, as well as freedom from discrimination.[50] In particular, the right to health includes "the right to attain the highest standard of sexual and reproductive health."[51]

The right to reproductive health also requires that reproductive health services, goods, and supplies be made widely available, economically and physically accessible, and evidence-based.[52] International law provides strong support for the right to access safe abortion as a component of reproductive healthcare. Because illegal and unsafe abortion leads to high rates of maternal mortality, lack of access to abortion can threaten a woman's right to life.[53] Several international bodies—including the U.N. Human Rights Committee, which monitors compliance with the ICCPR—have linked the rights to health and life and called on governments to ease restrictive abortion laws.[54]

International law also recognizes the right to access healthcare free from discrimination based on race or gender, as required by the International Convention on the Elimination of Racial Discrimination,55[55] which was ratified by the U.S. in 1994, and CEDAW.[56] Women also have a right to information and education to ensure they are able to make informed decisions about their reproductive capacity and lives.[57] Moreover, in *KL v. Peru*, the Human Rights Committee found that denial of a 17-year-old's right to receive a legal abortion violated her rights to privacy; to be free from cruel, inhuman or degrading treatment; and to special protections for minors protected by the ICCPR.[58] In the U.S., the constitutional right to privacy provides the framework for protection of women's reproductive rights and the constitutional right to abortion.[59]

REPRODUCTIVE RIGHTS ACTIVISTS ARE HUMAN RIGHTS DEFENDERS. Women's rights defenders include individuals who stand up to defend women's rights, including those who put themselves at risk to enable women to exercise fundamental human rights, such as the right to reproductive health.[60] Following the 1998 Declaration on Human Rights Defenders, the U.N. appointed a human rights expert to encourage compliance with the Declaration and to investigate and publicize the situation of human rights defenders around the world. In 2008, this expert became known as the Special Rapporteur on Human Rights Defenders.[61]

The Special Rapporteur and her predecessor have called attention to a particular group of women's rights defenders: those who assert that reproductive rights are a fundamental aspect of women's equality.[62] These experts have taken action to address attacks on reproductive rights advocates targeted for campaigning against forced sterilizations and forced abortions[63] and coercive family planning policies.[64] They also have raised concern that reproductive rights advocates are often targeted for particular types of rights violations, including smear campaigns.[65] In addition, the Committee Against Torture, which monitors compliance with the Convention Against Torture, has also urged governments to combat systematic harassment and death threats against defenders of women's human rights, specifically reproductive rights.[66] Worldwide, attacks on reproductive rights defenders vary from discriminatory government actions aimed at preventing their work, such as legislation in Ethiopia prohibiting funding to organizations that promote gender equality issues, including reproductive rights, to harassment and death threats against reproductive rights advocates in Nicaragua (see box: *Reproductive Rights Defenders in Nicaragua and the Philippines*).[67]

SPOTLIGHT

Reproductive Rights Defenders in Nicaragua and the Philippines

Around the world, human rights defenders experience myriad violations based on their work advocating for reproductive rights or promoting rights through the provision of reproductive healthcare services. Many of the underlying factors that contribute to stigma and violence against abortion providers in the U.S., notably hostility to women's claims for reproductive rights, also motivate the attacks against reproductive rights defenders elsewhere. Like the U.S. government, other governments have further restricted defenders' rights rather than bolstering protection for defenders.

The government of Nicaragua banned abortion with criminal penalties even for healthcare providers who perform the procedure when necessary to save a woman's life or health. The ban endangers women's lives by deterring reproductive healthcare providers from their professional and ethical duties to treat women and to protect their lives.[68] The resulting stigma and marginalization of providers has spurred systematic harassment and death threats against reproductive rights advocates in Nicaragua.[69]

The government of Manila, the capital of the Philippines, denied renewal of a health clinic's license, forcing it to close down. The clinic was accused of violating an executive order issued by the former mayor of Manila that prohibits the distribution of contraceptives. Because of the order, organizations that have attempted to provide family planning information and services have suffered harassment, including denial of renewal of permits to operate, dismissal of government doctors who provide referrals to organizations that make contraceptives accessible to women, censorship of family planning information, and withdrawal of support for the distribution of contraceptives in health centers.[70]

HEALTHCARE PROVIDERS ARE HUMAN RIGHTS DEFENDERS. U.N. expert reports have recognized that healthcare providers can be human rights defenders where those individuals fulfill their professional duties in a way that promotes human rights, such as the right to health.[71] These include a diverse range of medical professionals, such as physicians treating civilians in the Occupied Territories,[72] a medical doctor working to provide access to healthcare for extremely marginalized communities in India,[73] a medical professional providing assistance to victims of torture and violence in Egypt,[74] and healthcare professionals assisting people living with HIV/AIDS in China.[75] In addition, the Inter-American Commission on Human Rights, which monitors and protects human rights in the Americas, has explicitly condemned laws that restrict the ability of healthcare professionals to provide reproductive health services because such laws directly undermine women's right to health.[76]

U.S. ABORTION PROVIDERS ARE HUMAN RIGHTS DEFENDERS. The Declaration on Human Rights Defenders makes it clear that the rights of all human rights defenders must be ensured, even where the rights they are defending are evolving or socially contested.[77] Although women's right to abortion is constitutionally protected in the U.S., it remains highly controversial. Because opponents of abortion cannot legally ban abortion, they resort to attacking healthcare professionals to make abortion difficult or impossible to obtain. The reproductive healthcare professionals profiled in this report—which include physicians, nurses, owners and administrators of reproductive health clinics, counselors, clinic volunteers, and outreach workers—are some of the least recognized and most vulnerable of all human rights defenders. This report documents the need for special protection and details measures that the U.S. can take to ensure the rights of these human rights defenders are respected, protected, and fulfilled in accordance with international human rights standards. •

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> [I]n many countries, persons and organizations engaged in promoting and defending human rights and fundamental freedoms are facing threats, harassment, and insecurity as a result of those activities[.]
>
> - Declaration on Human Rights Defenders, Article 7

APPLICATION OF HUMAN RIGHTS FRAMEWORK TO SELECTED FINDINGS

VIOLATIONS OF REPRODUCTIVE RIGHTS. As is evident from the findings of this investigation, the targeting of abortion providers directly infringes on women's fundamental human rights. These include:

- violating the **right to health** by decreasing the availability and economic and physical accessibility of abortion, a reproductive healthcare service;
- violating the **rights to health and life** by placing women at risk of seeking unsafe abortions;
- violating the **right to information** by mandating biased counseling that impacts informed decisions about care and reproduction;
- violating the **right to privacy** by interfering with the decision to have an abortion through biased counseling, mandated delays, and a failure to protect women from exposure and identification as part of the intimidation and harassment activities of protestors at abortion clinics; and
- violating the **rights to equality and freedom from discrimination** by singling out a woman's reproductive health service—abortion—for targeted regulation and restriction and failing to reduce the stigma surrounding it.

> I think that anyone who has dedicated part of her career to making sure that constitutional rights are upheld, anyone who has devoted herself to a position where there is some threat, believes very strongly that this is a right that needs protection.[79]
>
> - Pennylvania clinic administrator

RECOGNITION OF ABORTION PROVIDERS AS HUMAN RIGHTS DEFENDERS. This report documents unequivocally that the healthcare workers interviewed for the investigation are human rights defenders. Many of the providers recognized, and asserted, their role in promoting fundamental human rights for women. As one explained, "I think that healthcare is a human right, and that abortion is healthcare. … [T]he ability to control your reproductive destiny is essential to controlling destiny. The ability to control your body is the most basic freedom."[80] Abortion providers make a significant contribution toward creating a culture of human rights in the U.S. by respecting and facilitating the exercise of the rights of women to life and health, equality and non-discrimination, information, privacy, and decision making regarding childbearing. They treat women with dignity under circumstances of stigmatization and marginalization. As a result of their dedication to women's human rights, abortion providers are subjected to violations of their own rights as human beings and as women's human rights defenders. These violations in turn restrict women's ability to realize their right to reproductive healthcare, including safe abortion.

> **"Some days [I think I am a human rights defender] and some days I feel like I need defending.[81]"**
>
> **- El Paso, Texas clinic administrator**

IMPUNITY FOR HARASSMENT AND INTIMIDATION. Like other human rights defenders throughout the world, abortion providers face intimidation, harassment, and violence in the course of carrying out their work, which government at all levels, contrary to its obligations, often permits with impunity.

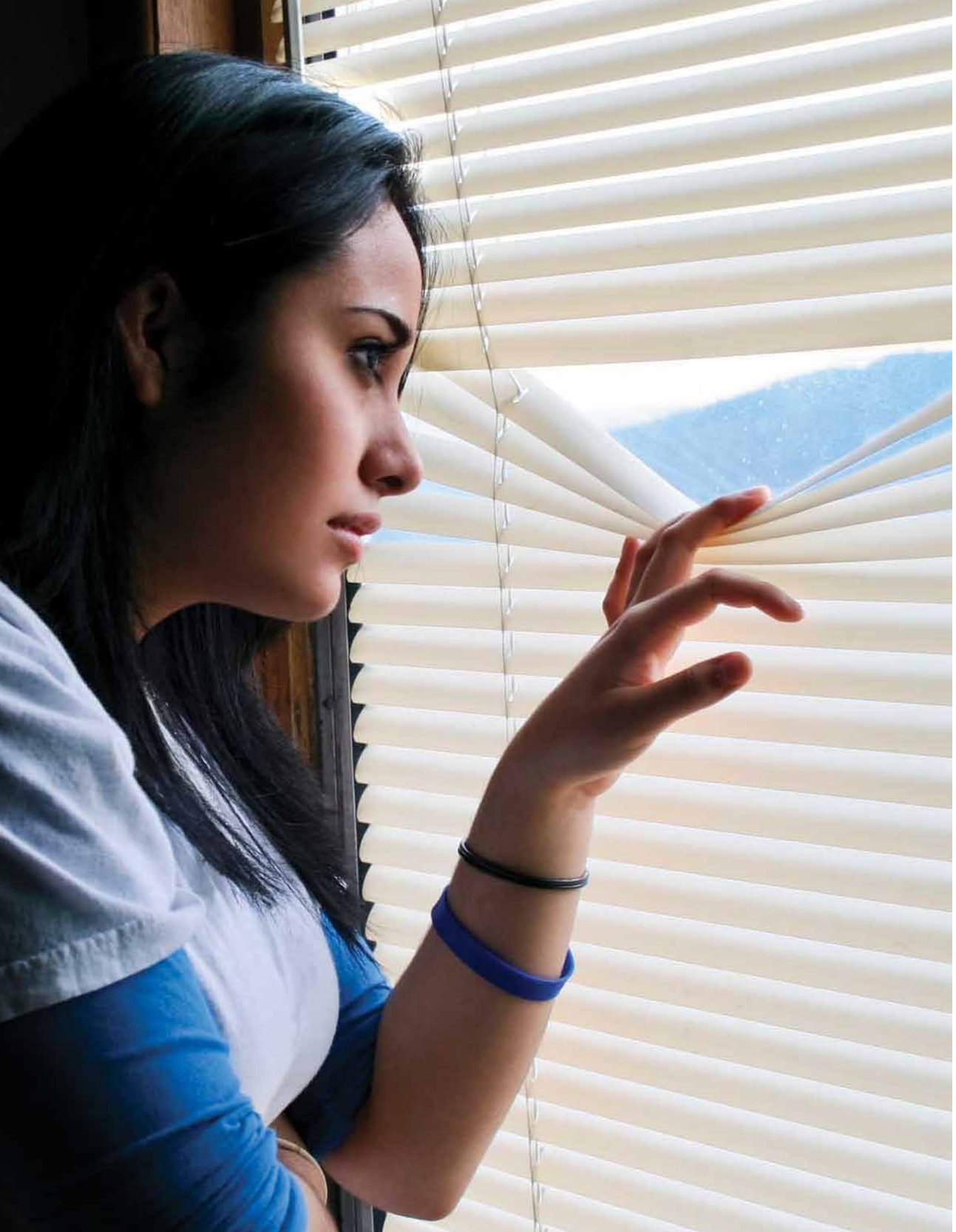
In each of the six states included in the investigation, staff members at abortion clinics face a working environment that is insecure, threatening, and demeaning, due to the unlawful activities of abortion opponents. Despite the obligations of the government to provide specific and enhanced protection to abortion providers, local law enforcement is uninformed, unresponsive, or hostile. As a result, providers are forced to be self-reliant. While outright violence has decreased at most facilities, the legacy of past murders, bombings, arsons, and assaults is intimately known to many of those performing abortions, creating an atmosphere of fear and easy intimidation. As one physician with decades of experience declared, "I provide a service at the risk of my life."[82]

Beyond verbal and physical harassment and intimidation, providers are subject to smear campaigns (for example, email barrages or home leafleting labeling a provider a "serial killer," or television ads falsely claiming that a facility is unlicensed or fails to sterilize instruments). Abuse of the judicial system through frivolous lawsuits by protestors is another increasingly prevalent form of harassment.

> **"[W]omen's rights are human rights, I definitely agree with that. I've read a lot of books and met physicians who were providing when abortion was not legal, and talked to them about septic abortions, things that they saw in that time period. We are fighting a human rights battle, because the consequences of illegal abortion are so great … we are constantly fighting …[83]"**
>
> **- Bryan, Texas clinic administrator**

DISCRIMINATORY LEGAL RESTRICTIONS ON ABORTION. Restrictions aimed at prohibiting the exercise of providers' right to practice a legal profession also violate defenders' rights. Mandatory delay and biased counseling laws place burdens on providers that force them to expend time and financial resources, retain additional staff, and change the ways they practice their profession in order to comply. Physicians and clinic staff are forced to become "agents of the state" in promulgating biased or misleading information to patients, depriving women of their right to information and privacy and compromising trust in the physician-patient relationship. ASC requirements and other discriminatory facility regulations imposed only on providers of abortions reduce the availability of abortion services by making it prohibitively costly and administratively burdensome to perform abortions for the vast majority of providers. Inconsistent and arbitrary enforcement of these regulations by state health departments creates uncertainty and increases workloads for clinic staff and takes time away from patient care.

> **"I think the termination of pregnancy encompasses so many rights—body, choice, mind, voting, allowing a woman to make a decision right for her and for me to defend the decision and not judge it.[84]"**
>
> **- Philadelphia, Pennsylvania clinic staff member**



FAILURE TO REDUCE ABORTION-RELATED STIGMA. By failing to address the deeply rooted stigma that surrounds abortion in both the medical and general communities, governments tacitly condone and even encourage the targeting of providers for harassment and legal restrictions on their work, and endorse gender discrimination.

Stigma itself, like those other burdens, deters both new and trained providers, reducing the availability of abortion services. In order to defend themselves, and the women they serve, abortion providers undertake extensive efforts of education, building community and institutional relationships, and patient counseling.

Failure to support these efforts by actively condemning and taking steps to address abortion-related stigma does not just harm healthcare workers. It also harms women in fundamental ways. It decreases the availability of physicians and services and reduces access to reproductive health services. It results in the segregation of one reproductive healthcare service from the mainstream healthcare system, again reducing women's ability to obtain that service. It encourages incomplete and false information about abortion and abortion providers, undermining women's ability to make decisions with informed consent. As a 36-year-old woman and mother of three stated, "[Clinic staff] give you all the information needed. … [I]f they were to stop this, it's taking away my right. In this climate, it's very hard to raise a child. It's my human right to decide this."[85]

> **"I know people who have tried all sorts of things to hurt themselves to end a pregnancy. …Here they prevent you from hurting your body, they help me protect my body, and there are no judgments, they don't judge you here."[86]** - Pennsylvania woman

DISCRIMINATORY FUNDING PROHIBITIONS AND FAILURE TO PROTECT VULNERABLE WOMEN. Legal prohibitions on funding for abortion, such as the Hyde Amendment and similar state restrictions, single out one category of medically necessary services for elimination. These restrictions in no way promote or protect women's health and lack any evidentiary basis in medicine. In fact, they frequently curtail essential care because women have to delay abortions to raise the necessary funds. These delays result in later procedures, potentially increasing risk to the woman's health, additional financial costs for travel, additional child care and wage loss, and a higher fee for an abortion later in pregnancy. For women who are already the most vulnerable to rights violations—poor women, homeless women, minors, and those with later pregnancies—restrictions make it logistically and financially harder to obtain abortions and may deny their rights altogether. •

FINDINGS ACROSS STATES

The findings of this investigation fall into four categories: lack of availability of abortion services, intimidation and harassment of abortion providers, legal restrictions on abortion, and abortion-related stigma in the medical and general communities.

1. Lack of Availability of Abortion Services

In the six states, physicians and clinics are either absent or few (as in Mississippi, Missouri, and North Dakota), or concentrated unevenly in a few areas within the state (as in Alabama, Pennsylvania, and Texas). Most clinics rely on a very small number of physicians, and often share doctors on a part-time basis both with other clinics providing abortions and with the physicians' own private or hospital-based practices. With few new, young doctors entering the field, the supply of physicians is dwindling almost across the board, with a few exceptions where clinics have been able to initiate partnerships or collaborate with residency programs at local hospitals, as has been the case in St. Louis, Missouri and Houston, Texas.

Because of the shortage in abortion providers, women are forced to travel extraordinary distances to clinics, both within state borders and from neighboring states. Women with few resources—transport, child care, funds, flexible work schedules—face steep challenges in obtaining services in a timely way, if they can obtain them at all (see box: *The Hyde Amendment Limits Availability of Abortion*). Many women must borrow money, leave bills unpaid, find a private ride, give up a day's wages, or even lose their job in order to make the trip to a provider.

For some women, a delay may lead to a later, more risky and costly procedure. Or they may pass a clinic's gestational limit altogether and be forced to go even farther from home to find services, if these are available at all.

Most women interviewed by the Center for Reproductive Rights were not aware of another clinic or location providing abortion if their current provider did not offer abortion services, illustrating both the scarcity of facilities and the challenges women face in finding them.

INVESTIGATIVE SPOTLIGHT

The Hyde Amendment Limits the Availability of Abortion

The Hyde Amendment prohibits federal Medicaid funding for abortion, with narrow exceptions for cases of rape, incest, and life endangerment. Outside of these exceptions, abortion is excluded from the medically necessary services that states are required to cover, which generally include inpatient and outpatient medical services; physician, midwife and nurse practitioner services; and family planning services and supplies.[87] This restriction makes it extremely difficult for women with low incomes to finance abortion services. Coupled with the shortage of abortion providers, the Hyde Amendment severely limits a woman's fundamental right to reproductive healthcare. In 2005, the median charge for an abortion at 10 weeks was $430, and at 20 weeks, it rose to $1,260.[88] The income ceiling for pregnant women to be eligible for Medicaid in the six states is either 133% ($23,408) or 185% ($32,560) of the federal poverty level for a family of three.[89] Even with financial assistance for the procedure itself, the costs of arranging an abortion—primarily transport, child care and loss of wages—are significant at this income level. The findings from the investigation confirm other studies demonstrating that the Hyde restrictions result in significant delays, raising the cost of an abortion to the point where many women forgo it altogether.[90]

Women are able to obtain limited financial assistance from some clinics. This funding significantly improves access, but the financial barrier remains for many women. In Pennsylvania and Texas, women identify financial barriers as the greatest obstacle to abortion services. Even with funding assistance, one Texas woman had to delay her appointment two weeks so she could scrape together the $200 she needed. "I'll have to give up paying other bills this month," she said.[91] Moreover, the majority of women in other states report borrowing funds, requesting assistance from the clinic to pay the costs, relying on family, foregoing bills, and/or depleting savings. One North Dakota woman, who would have been eligible for Medicaid funding absent the Hyde Amendment, received some financial assistance through the clinic, but still had to borrow from her family to pay her $150 share. "When I get home," she said, "I'll have twenty dollars for the rest of the month. I'll probably rely on family to get through."[92] Another, who has two children and borrowed money from a cousin to pay for transport and the abortion, said "[i]f [the state will] pay for a baby for 18 years for low-income people, they should help with covering the costs of an abortion."[93]

2. Intimidation and Harassment of Abortion Providers

ANTI-ABORTION ACTIVITIES. As human rights defenders, physicians and abortion clinic staff in each of the six states routinely face serious harassment and intimidation by abortion opponents.

Anti-abortion activity runs the gamut, from peaceful First Amendment-protected activities to civil and criminal offenses. While providers recognize that abortion opponents have free speech rights, "[t]hey should be able to express themselves without terrorizing people."[94] Abortion providers contend daily with opponents engaging in a range of protected and unprotected activities, including praying, distributing leaflets and holding signs, taking photographs or video of patients, staff, and license plates, trespassing on private property and blocking access to entrances, using bullhorns, touching patients, taunting with epithets, identifying employees by name and shouting racist or homophobic slurs, spreading false information about the nature and risks of abortion and the safety of the clinic, luring patients from the clinic by promising "free" ultrasounds and other services, sending physical or verbal threats to the staff and doctors, stalking, and vandalizing clinic and personal property.

Away from the clinic, photographs, threats and personal information also appear on websites run by abortion opponents; some physicians are targeted at their private practices or institutions; and clinic staff and physicians experience picketing, stalking, harassing, leafleting, and threats to themselves and their families at their residences.

Experiences at clinics range from mild to acute. All of the clinics participating in the study had at least a few regular protestors; many had dozens, particularly on weekend procedure days and during staged anti-abortion events, such as the biannual "40 Days for Life" campaign and the anniversary of the *Roe v. Wade* decision, when national groups such as Operation Save America, Operation Rescue, and local Catholic dioceses and schools, bus in abortion opponents for large rallies or long "sieges." An individual clinic often has several different groups of anti-abortion activists, each with their own routines and tactics. Many providers report steady activity year in and out; others have seen drastic changes in dynamics and behaviors (see box: *The Evolving Nature of Intimidation and Harassment: Lawsuits by Protestors*).

INVESTIGATIVE SPOTLIGHT

The Evolving Nature of Intimidation and Harassment: Lawsuits by Protestors

Protestors are increasingly turning to legal action to justify their acts of intimidation and threats against abortion providers. In Bryan, Texas and York, Pennsylvania, abortion opponents have repeatedly sued local authorities for alleged violations of their First Amendment rights at clinics. These lawsuits burden municipalities with high costs and long processes, and, in some cases, have contributed to the failure of police to enforce the law and protect clinics facing severe anti-abortion activity.

Emblematic of this new strategy, two lawsuits were brought in 2004 by abortion opponents against the City of Allentown, Pennsylvania claiming violations of constitutional rights related to the arrests of protestors at the Allentown Women's Center.[95] The Center has been the target of extreme anti-abortion activity since it opened its doors in 1978.[96] Since relocating in 2003, the clinic has been faced with increasingly aggressive harassment from anti-abortion groups and individuals, including trespass, impeding access, racist and sexual taunting, and residential picketing.[97] A settlement reached by the City, without the participation of the clinic, paid each of 13 protestors $10,000 in exchange for an agreement circumscribing the location of protestors; this agreement has been repeatedly violated.[98]

Fear of lawsuits has undermined local authorities' resolve to curb protestor harassment and violations of the agreement and enforce criminal laws. At the conclusion of the second lawsuit in 2007, the Allentown City Solicitor told the clinic's executive director that the City would not prosecute any complaints from the clinic about anti-abortion activity or enforce the settlement agreement "unless there is a threat to life or person."[99] In June 2008, a third lawsuit was filed against the City, Allentown Women's Center, and the clinic's director.[100] Meanwhile, intimidation, harassment, and obstruction continue unabated and unpunished, emboldened by the settlement and the lack of law enforcement.[101]

LACK OF LAW ENFORCEMENT. Clinics without adequate law enforcement protection report worse levels of anti-abortion activity and acts of harassment and intimidation. In Alabama, Mississippi, Pennsylvania, and Texas, providers describe an acute lack of law enforcement response, permitting protestors to violate laws with impunity. Factors that contribute to inadequate protection by local law enforcement include lack of knowledge of the applicable laws, lack of institutional or political leadership, personal opposition to abortion, fatigue with having to confront daily acts of "less serious" offenses, and an assumption that harassment is part of the expected cost of providing abortion (see box: *Legal Remedies and Law Enforcement: Challenges and Recommendations*).

INVESTIGATIVE SPOTLIGHT

Legal Remedies and Law Enforcement: Challenges and Recommendations

FACE and other legal restrictions on anti-abortion activities can help protect clinics and providers, but their effectiveness is limited by the willingness of federal, state, and local authorities to enforce the law.

FACE violators may be criminally prosecuted by the U.S. Department of Justice, potentially resulting in prison sentences and fines. They may also be sued in civil court by federal or state governments, or injured individuals or clinics, for injunctive relief, damages, and civil fines.

Local and state police are often unfamiliar with FACE and misunderstand it as applying only to complete blockades across entrances, or refuse to enforce it because it is a federal statute. One clinic administrator commented, "I don't believe [FACE] has ever been used successfully in Alabama. So often when the police have to witness something, they tend to [diminish it]. It's not the blockades of the '80s. I think they want to wait until there's chaining to the clinic door to do anything."[102] Local FBI offices may be similarly unresponsive. Whole Woman's Health in McAllen, Texas has unsuccessfully tried to educate the local FBI office about the continuum of violence, "from intimidation to threat to physical violence," that constitutes a FACE violation.[103]

Despite the current lack of enforcement, FACE can be very effective when enforced. A Planned Parenthood clinic in Houston successfully used FACE to imprison a frequent protestor who drove a van through the clinic doors several years ago, his second FACE violation.[104] An infamous central Pennsylvania protestor who advocates violence against abortion doctors was permanently enjoined to stay off the internet in a Pennsylvania FACE case.[105] However, if a clinic has a civil injunction in a case brought by the U.S. under FACE, it may be unable to adequately enforce it if the government is unresponsive, as this requires returning to court for a finding of contempt; this is the case in Jackson, Mississippi.[106]

Many clinics benefit from the passage of local laws, obtaining injunctions, and dedicated enforcement efforts by local police. Signage, permit, and noise ordinances can also benefit individual clinics. Nearly all interviewed were in favor of some form of buffer zone (a delineated area around a health facility, and/or around individuals entering or leaving it, in which anti-abortion activity is restricted). Based on experiences from some clinics, these zones, whether arising from injunction, as was more common in the 1990s or local ordinances, like the one that came into effect in Pittsburgh at the end of 2005, can decrease the level, aggression, and effects of anti-abortion activity. However, by all accounts, law enforcement leadership, vigilance, and periodic training are necessary to counter lack of awareness and lax enforcement on the ground.

COSTS OF INTIMIDATION AND HARASSMENT. Anti-abortion activity, particularly as it crosses over from free speech to intimidation and harassment, is very burdensome to many abortion clinics. In addition to large investments in security and alarm systems, clinics—particularly those without adequate police protection expend thousands of dollars annually on security guards to protect staff and patients. Time is taken away from patient care to counsel patients affected by anti-abortion activity, and time and resources are invested in making staff feel safe and to train them in security matters.

Providers also report that many trained physicians are deterred from performing abortions by the economic pressures placed on them in their private practices by the presence, or threat, of protest activity. Some are deterred by the stigma associated with being known as an abortion provider, or the effects harassing protestors will have on their patient caseload or receipt of referrals from other physicians. Others are prohibited by their partners or institutions from performing abortions, even outside the practice, because of these concerns.

Not only are abortion providers themselves targeted by abortion opponents, landlords who rent to them and vendors who provide them with cleaning, maintenance, technology, and other services have also been the focus of harassment and threats to their livelihoods.

When the new Planned Parenthood clinic was being built in Austin in 2004, a local opponent and owner of a concrete company organized a boycott of local suppliers that delayed construction of the building for several months. The clinic ultimately had to obtain concrete from sympathetic anonymous sources and pour the foundations for its buildings at midnight on a Sunday.[107] Other clinics have experienced difficulties in finding insurers who will cover their facilities after an incident of arson[108] or will provide them with comprehensive business liability insurance.[109]

PERSONAL TOLL ON STAFF AND WOMEN SEEKING ABORTIONS. On a personal level, working at an abortion clinic takes a daily toll on the well-being of clinic staff and physicians. In particular, walking a gauntlet of ugly epithets and personal targeting, apart from fears for their physical safety, is demeaning and depleting. Staff and owners in Alabama, Pennsylvania, and Texas discussed how clinic owners or administrators "put themselves out there" as the face of the clinic to the media and abortion opponents in order to protect their staff.

While staff turnover was infrequently reported, many staff report feeling anger and frustration on behalf of patients, as well as concern that the patients' confidence in providers and their care is shaken by hearing the slurs and lies of protestors. Staff report that many women are frightened and anxious when they come into the clinic, or reschedule appointments in an effort to avoid protestors, which sometimes results in delaying a procedure beyond the gestational limits of the clinic.

AWAY FROM THE CLINIC, STAFF AND PHYSICIANS MAY EXPERIENCE HARASSMENT AND INTIMIDATION ON THE INTERNET, IN PUBLIC PLACES, OR AT THEIR HOMES

A staff member who works at the front desk in the Fargo, North Dakota clinic on procedure days is the first person patients see: "They always ask if the protestors are always there, will they be there when I leave," she said. "…Always, some are so shaky they can't hold the pen when they have to register."[110]

TARGETING AWAY FROM CLINICS. Away from the clinic, staff and physicians may experience harassment and intimidation on the internet, in public places, or at their homes (see box: *Harassment and Intimidation on the Internet*). While anti-abortion activity at residences is less widespread than in the 1980s and 1990s, some providers interviewed for this study are currently facing protest activity targeting their homes or families. This is particularly true of physicians in Pennsylvania.

One doctor who has been providing services in and around Philadelphia for two decades was protested at his home when he started working in the town of West Chester. In the past ten years, protestors have followed him from home to home, finding out where he lives each time he moves.[111] In each place he has lived, he has been told by the police that there is nothing they could do until the protestors trespass or become violent.[112] Another physician who faced threatening phone calls at home was advised to protect himself and get a gun.[113] At least one Pennsylvania physician stopped providing altogether because "she was hunted down by protestors"[114] at her home in rural New Jersey. She was attacked on the internet, had dead animals placed at her home, and had her house broken into.[115] She was forced to stop practicing entirely as an OB/GYN because she could not maintain her private practice.[116]

EXTENSIVE PRECAUTIONS TO PROTECT PHYSICIANS. Many clinics and doctors take extra precautions to safeguard physicians' identities and physical security. Physicians everywhere have unlisted phone numbers. They have property or utilities listed in their spouses or partners' names. They park away from the clinic and are picked up by staff. They rent cars, remove license tags, or keep an old car to take to the clinic. At least one out-of-state physician registers at the local hotel under an assumed name. Several doctors keep loaded guns in the car and have bulletproof vests. Doctors in nearly all locations use back doors and vary their practice schedules or driving routes. Some physicians avoid pro-choice and patient advocacy work to keep a lower profile. Others only perform medical abortions in order to be less known and avoid the clinic on procedure days when protestors are more likely to be present.

INVESTIGATIVE SPOTLIGHT

Harassment and Intimidation on the Internet

Abortion opponents use the internet to disseminate photos and personal information to harass, threaten, and violate the privacy of physicians providing abortions and women going into clinics. Several clinics have staff time dedicated to monitoring anti-abortion websites. Most clinics report that protestors take photos and video of staff and patients, and their cars and license plates, causing fear that their identities will be exposed on the internet and they will be targeted for further harassment or harm.

In Texas protestors have used car registry information to send mass emails to the A&M campus and to patients' parents, identifying by name women who have gone to the Planned Parenthood in Bryan, allegedly for abortions.[117] They have also sent community-wide emails labeled "public advisory," including graphic depictions, and identifying particular clinic staff as "abortionists."[118] One protestor has set up a website called "Austin Abortion Exposed" with personal information on clinic owners and landlords and photos of clinics and individuals, including a cleaner at one of the clinics ("it freaked him out").[119]

In Alabama protestors at the two abortion clinics in Birmingham routinely film patients and clinic staff entering the facilities and put the video on a dedicated channel on YouTube.[120] Recently, a 17 year-old girl came to New Woman with her elderly parents: "On the way out, the protestors barraged them, and took her picture and put it on the internet with a caption: 'What father would allow…?'"[121]

> **It's a brilliant strategy, to hammer away at access through smaller and larger legal paths, so that the idea of *Roe* becomes an idea and not a reality for large groups of women in the U.S. Many pro-choice [women] are not aware [of the restrictions] unless they go through it, because when they read about it in the paper, it sounds relatively benign and makes sense.**[122] **- Philadelphia, Pennsylvania clinic administrator**

3. Legal Restrictions on Abortion

MANDATORY DELAY AND BIASED COUNSELING

Mandatory delay and biased counseling laws take a variety of forms in the six states, some more burdensome than others.

Each of the states included in the fact-finding require a "waiting period" of 24 hours between the time a woman receives information and obtains an abortion. State laws vary on whether they require counseling to be in-person, whether mandated information must be given orally and/or in writing, whether state-produced written materials must be offered or given, if the information must be given by a doctor or other specific medical professional, whether they require an ultrasound to be performed, and the degree and content of irrelevant, unnecessary, misleading, or medically inappropriate information mandated. Mississippi requires two in-person visits for patients, a particular burden for both women and providers. States that mandate that physicians perform the biased counseling—Mississippi, Missouri, Pennsylvania, and Texas—or narrowly limit the list of permitted persons, such as Alabama, force the most onerous adaptation of operations and resource expenditure by providers.

Across the board, providers agree there is no medical reason for mandatory delay and biased counseling restrictions. Typically, trained counselors explain to patients the risks and process of an abortion, the steps of their appointment, and instructions for post-abortion and follow-up care. They also counsel women to ensure that they understand their options, are comfortable with their decision, and have made it without coercion. As one physician who provides abortions in North Dakota, South Dakota, and Minnesota explains, "I have said for years that abortion is the most highly consented procedure that we do in medicine, even before the restrictions."[123] The laws are simply intended to make it difficult for abortion providers to stay in business and harder for some women to obtain abortions. One physician in Texas commented on the intimidating nature of the requirements, which place yet another obstacle in the path of women seeking abortions: "There is no patient who wants to wait that we force to have a procedure that day, and there is no medical reason to wait if they want it right away."[124]

Mandatory delay and biased counseling provisions impose on providers the burdens of establishing new processes, rescheduling existing staff and/or hiring additional personnel, documenting compliance, obtaining and distributing state-mandated materials, and accommodating an additional volume of appointments. Moreover, providers are mandated to act as agents of the state, conveying information that may be (at best) redundant and unnecessary, and (at worst) false, frightening, and confusing to patients.

All providers take steps to ameliorate the effects of the laws on their patients. These include waiving fees and assisting with transportation, scheduling additional or flexible sessions, hiring additional physicians or obtaining volunteers to do counseling, creating videos and tapes of counseling messages (where permitted), and turning a mandated visit into an opportunity to provide additional information and make the woman feel welcome and respected by the clinic.

> **We've taken lemons and made lemonade: we add what we think is important for women's health and give the appointment extra value for women… The tough thing is that clinics like ours, ethical providers, will try not only to make it work, but improve upon it to help the women. Pretty soon people will say it's not a barrier, you made it work.**[125] **- Missouri clinic staff member**

Unfortunately, the restrictions do the most harm to the most precarious providers and the most vulnerable women. Where providers must rely on a single or very few physicians, their time is very valuable. Clinics that provide abortions only once a week plan carefully to try to avoid delaying women who miss the cut-off for the next available appointment, but the interaction of the mandated delays and the clinic's schedule may result in routine delays of weeks. Women who have the fewest financial resources, are geographically most isolated from providers or have later pregnancies are most at risk of being unable to overcome the barriers erected by the restrictions. For women who are seeking a second trimester abortion, a mandated visit can add a third trip to an already two- or three-day abortion procedure (see box: *Limited Options for Women Seeking Second Trimester Abortions*).

INVESTIGATIVE SPOTLIGHT

Limited Options for Women Seeking Second Trimester Abortions

Due to legal restrictions and the need for physicians and clinical staff with specific expertise, the majority of clinics in the investigation have gestational limits on abortion provision at the end of the first or early second trimester. As a result, many women seeking abortions after the first trimester must travel a significant distance to find a provider. Young women, women with complicated physical or mental health issues, and women living in shelters or dangerous situations are at greater risk for needing a second trimester abortion. In addition, women with intended pregnancies who seek an abortion for fetal anomalies routinely find out about these conditions later in pregnancy.

Getting a second trimester abortion is particularly a problem for indigent women, who often end up having later abortions because of the time it takes to raise the fees. By the time they have obtained the money, they may face an even more costly procedure, in addition to the additional expenses of having to travel a long distance or out-of-state to a clinic that provide services at a later gestational age. Many of these procedures require at least two days to complete, resulting in an additional cost of a second trip or overnight accommodations and posing greater financial and logistical burdens on women who may already be in dire situations.

In the two states with a single abortion clinic, North Dakota and Mississippi, women seeking abortions past 15 or 16 weeks, respectively, must travel out-of-state. Women seeking abortions in the mid-second trimester in other states have very few providers, if any, to choose from. In Missouri, for example, there is one provider, Planned Parenthood in St. Louis, which performs abortions after 14 or 15 weeks, up to 22 weeks. In Pennsylvania, two providers participating in the investigation, in Pittsburgh and Philadelphia, provide services to the mid-second trimester.

Targeted Regulations Including Ambulatory Surgical Center Standards

Abortion providers are singled out in many states for discriminatory regulation because of the service they provide, or because they offer the service after the first trimester.[126] All six states in the investigation have a variety of laws that regulate medical practices or facilities that provide abortions that are different and more stringent than regulations applied to comparable medical practices (TRAP). For example, clinics in Alabama and Texas, unlike other doctors' practices, are subject to inspection by their states' departments of health (see box: *Arbitrary Department of Health Inspections*).

These rules bear no relationship to medical evidence concerning the safety of abortion procedures and care. Like the mandatory delay and biased counseling restrictions, they are meant to raise the costs of providing abortion services for clinics, limit the availability of these services, and consequently reduce women's access to abortion. Unlike mandatory delays and biased counseling provisions, however, TRAP requirements are often very difficult for providers to ameliorate due to the often prohibitive expenses imposed, in particular, renovating an existing facility or obtaining a new, custom-designed building.

In particular, ambulatory surgical center (ASC) requirements applied to abortion clinics can have a serious, even fatal, effect on a provider's practices. These state licensing requirements for healthcare centers providing out-patient surgical services usually include staffing requirements and onerous administrative policies as well as stringent physical plant requirements (such as those regulating widths of stairs and hallways) that generally cannot be met without exceedingly expensive renovations. Moreover, these requirements are often applied to abortion procedures and not to other comparable gynecological surgeries or more serious non-gynecological procedures, such as treatment of miscarriage, vasectomy, and minor ear surgery.

Three states in the investigation—Mississippi, Missouri, and Texas—currently have ASC laws of some kind. The clinic in Mississippi was built to meet ASC requirements, in anticipation of a restriction.[127] In Missouri, should a currently enjoined ASC licensing law go into effect, at least one and perhaps two of the state's three providers would have to stop performing abortions altogether, leaving the state with a single clinic. In Texas, there are only two clinics in the state qualified under the law to perform abortions for pregnancies of 16 weeks or later. Prior to 2004, when the ASC law took effect, seven out of the nine clinics participating in the investigation, located throughout the state, performed abortions past 16 weeks.

> It's overwhelming because we never know how [regulations] are going to be interpreted. One time everything's in order and the next time they change...So, you are really at [the inspectors] mercy.
>
> - Huntsville, Alabama clinic administrator

INVESTIGATIVE SPOTLIGHT

Arbitrary Department of Health Inspections

State departments of health are responsible for enforcing regulations of abortion facilities through inspections. Providers in Alabama and Texas report that inconsistent and arbitrary inspections of abortion facilities in those states have created heavy burdens on their clinics. Uncertainty is created and clinic resources are consumed when clinics are forced to comply with unanticipated changes in the way rules are interpreted or an arbitrary exercise of discretion by inspectors.

In Alabama, providers attribute the conduct of the inspectors to the political climate and the power that abortion opponents have within the agency,[128] as well as to external pressure on the agency.[129] As one administrator commented, "It's overwhelming because we never know how [regulations] are going to be interpreted. One time everything's in order and the next time they change. We had to change the cover procedure sheet three times. …. So you're really at their mercy."[130] Because cited deficiencies can lead to a clinic being placed on probation, or even closed down, clinics believe they lack recourse to complain: "The bottom line is that they have the power, to continue to close me and to ruin us financially."[131]

In Texas, the power of individual inspectors and the lack of uniform training mean that clinics—even those that have the same owners and identical physicians, policies, and protocols—have different rules to meet from inspection to inspection. In 2006, when an inspector from the health department's Tyler, Texas bureau was assigned to inspect Whole Woman's Health in Beaumont and Bryan Planned Parenthood, each clinic experienced a long and disruptive process because that inspector "changed the rules."[132] In Bryan, she rejected all of the policies the clinic had been adhering to for eight years.[133] One of the citations wrongly alleged that the doctor did not examine patients or review histories because there was no checkbox on a form for this step.[134] The inspector also wanted to take personnel records and patient records off the premises.[135] The local anti-abortion coalition used the inspector's public report as a basis for a television attack ad falsely claiming that the clinic failed its inspection.[136]

The Beaumont clinic's license was briefly revoked after inspection by the same individual for "endangering women" and it was closed for ten days. The inspector also reported the clinic and one of the doctors to the state boards of pharmacy and medical inspectors, respectively. The clinic was given 116 citations to address, which occupied two to three staff full-time for six weeks and required flying the Beaumont doctor to Austin.[137] Eventually, the Tyler inspector was disciplined and the citations were reduced to three, but they will stay on the state's website for two years.[138] "It's a strategy … to do things that they can't do legislatively through the inspection process: they propose a bill, it gets shot down, so they give a mandate to the inspectors to [carry it out]."[139] Some clinics go beyond the letter of the law, for fear of being deemed non-compliant, creating additional burdens for women seeking abortions or for themselves.[140]

4. Stigma in the Medical and General Communities

Stigma related to abortion is widespread in all six states, in both the medical and general communities. Stigma legitimizes harassment and intimidation and permits it to take place with impunity. Legal restrictions on abortion stem from, promote and reinforce abortion as a stigmatized service, distinct and separate from other healthcare services. Overcoming stigma—which often colors women's own views of their choice of abortion—is an additional obstacle for women attempting to obtain an already scarce and restricted medical procedure.

Even where the general community is perceived to have a mixed population of supporters and opponents of abortion services—in Philadelphia, for example—stigma persists among physicians and other healthcare workers. Because abortion is not integrated into mainstream healthcare, it is marginalized and perceived as "dirty" and outside of normal medical practice. Due to stigma, many trained physicians do not perform abortions or will not serve as back-up emergency providers to clinics; some refuse to refer patients for abortions or for other services performed by physicians who also provide the procedure.

Many physicians who do not provide abortions improperly criticize the care women have received as "botched" and often give misinformation to women who seek post-abortion care in hospital settings. Patients in several states express apprehension that their regular physician will be able to tell that they had an abortion. The condemnatory perspective of medical professionals contributes to women's fear, lack of information, and negative experiences in seeking to obtain a socially stigmatized service, and reinforces that stigma.

General community stigma affects clinics that provide abortions in a number of ways. Local officials use zoning restrictions to harass or prevent clinics from locating in their towns.[141] Many landlords and service vendors are unwilling to enter into business relationships with providers because they do not want to be associated with abortion.

Often stigma is intertwined with a reluctance to be subject to targeting by protestors. The only clinic in Huntsville, Alabama, could not find a landlord willing to lease to them "as soon as word got out" that they would be performing abortions; they ended up spending two years and $100,000 to renovate the private office space of one of the clinic partners.[142] In Mississippi, the sole clinic has difficulty finding medical equipment, as well as repair, waste management, computer, and heating/cooling services.[143] In Columbia, Missouri, the only local provider is stymied in seeking bidders for potential renovations to the facility to meet ASC requirements: "People call and say the Catholic Church is our client and we have to drop you."[144]

VIGOROUS AND VOCAL COMMUNITY SUPPORT CAN HAVE THE EFFECT OF DECREASING STIGMA AND EASING THE BURDENS ON CLINICS

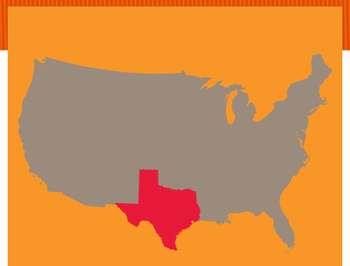
Where stigma is prevalent and accepted, particularly in the South, in smaller, more isolated communities and in towns or cities that identify as predominantly Catholic, some clinics find it hard to attract or retain staff. Individuals who want to work for the clinics find it difficult to do so in the face of opposition from their families and communities. This is the case in Midland, Texas, where staff members "are forced constantly to defend where they work."[145] In McAllen, Texas, a community that is "very conservative and baby-oriented," it is difficult to find staff because many potential workers live at home and most families do not support working at the clinic.[146]

Vigorous and vocal community support can have the effect of decreasing stigma and easing the burdens on clinics. Many clinics undertake extensive, long-term efforts to make their presence known in positive ways by building relationships with local businesses and academic and medical institutions, the police, and community members, to decrease stigma and "humanize" clinic staff and patients.

Longevity can mean building a community of former patients and their families, as in Fargo, North Dakota: "half the people in town have been patients, since it's been thirty years that we're there."[147] The administrator of a clinic in El Paso, Texas explained, "They may not like us, but they respect us … we earned it long and hard" through participation in community health education campaigns and other local work outside the clinic.[148] Yet over and over again, even in communities where providers report that they believe there is support for abortion services, they remark that the support is discrete, silenced by stigma and largely dwarfed, at least in appearance, by the loud denunciations of abortion opponents. •

FINDINGS BY STATE

TEXAS



Key Findings

Clinics in Texas serve large populations of women with limited access to abortion services, particularly those seeking abortions at a later gestational age. The Center for Reproductive Rights interviewed twenty-one individual providers at nine clinics in eight locations and four women in three locations.[157] All clinics participating in the investigation experience harassment and intimidation, ranging from modest to extremely burdensome.

Anti-abortion activity is extreme and a chief challenge for some clinic administrators. Texas is also an incubator for novel intimidation and harassment strategies, which are particularly robust in smaller, more conservative cities. The most harmful legal restriction on abortion is the ambulatory surgical center requirement, which creates barriers for provision and access that are difficult to ameliorate. The 24-hour mandatory delay and biased counseling law drains clinic resources and often causes delays for women, resulting in more costly and riskier procedures.

Availability of Abortion in Texas

Clinics in Texas are distributed unevenly throughout the state, with the majority of providers clustered around the cities of Austin, Houston, and Dallas-Fort Worth. The only two providers in the state that provide abortions at or after 16 weeks are located in Austin and Houston. Most of the clinics surveyed provided abortions up to 15 weeks, 6 days, on a variety of schedules ranging from one day every other week at the sole clinic in Bryan, to six days per week in Houston at Planned Parenthood's Fannin location.

Given the large size of the state, and the restrictions on abortion in some of the border states, Texas clinics serve women from a dispersed geographic area. Each clinic serves specific populations that would suffer if that clinic closed. For example, women come to El Paso Reproductive Services (El Paso Repro) from all of southern New Mexico because they do not have the money to travel to Albuquerque, which is five hours away,[158] and from "little country towns" in West Texas.[159] Thirty to 45 percent of the clinic's patients come from Mexico and New Mexico.

Texas Information

Demographics: The state population is 24,326,974.[149] Texas is the eighth poorest state in the country, with 16.3 percent of its population living below the poverty level.[150]

Pregnancy and abortion: 17.3 per 1,000 women aged 15–44 obtained abortions in Texas in 2005, representing 15 percent of all pregnancies in the state that year.[151]

Selected state law restrictions on abortion:

- 24-hour delay and biased counseling law requires that mandated information be given by the performing or referring physician, including possible increased risk of breast cancer. [152]
- State-published materials, including enlarged color photographs of fetal development, must be made available to the woman 24-hours in advance should she choose to view them.[153]
- Abortions at 16 weeks or later must be performed in a licensed ambulatory surgical center or hospital.[154]
- Abortion facility licenses are required for providers of 10 or more abortions per month or 100 or more abortions per year. [155] Licensure requirements include minimum standards, inspection, and reporting.[156]

These are the locations of the clinics where the Center for Reproductive Rights conducted interviews

There are other clinics in Texas, located primarily in the Dallas-Fort Worth area

FEAR OF THE PERSONAL PROFESSIONAL, AND FINANCIAL CONSEQUENCES OF PROTEST ACTIVITY AND MEDICAL COMMUNITY STIGMA ARE BLAMED FOR THE SCARCITY OF PROVIDERS

Mexican women come not only from the border city of Juarez, but from Guadalajara, Acapulco, and Aguas Calientes, 24 hours away by bus.[160] Women from Mexico often call from the homeless shelter in downtown El Paso because they have nowhere to stay.[161] The clinic also sees women from military bases in Texas and New Mexico.[162] Women come to Midland Planned Parenthood from Amarillo, 300 miles away.[163] Women come to Bryan Planned Parenthood from as far as Lufkin, more than two hours away.[164] Women travel to Whole Woman's Health (Whole Woman's) in McAllen from up to three hours away; 20 percent of the patients come from Mexico, as the border is 50 minutes away.[165] Women frequently come from Louisiana to Houston Planned Parenthood.[166]

With the exception of the Planned Parenthood clinics in Houston and Austin, all of the providers have difficulty finding physicians to provide surgical abortion and rely primarily on physicians who travel. One doctor travels 1,500 miles per week, working at Waco Planned Parenthood, Whole Woman's in Austin and McAllen, and a clinic in Harlingen.[167] Whole Woman's relies primarily on five doctors to provide surgical abortions shared among its three sites in Austin, McAllen, and Beaumont.[168] Physicians must drive four to eight hours to McAllen.[169] In addition to working locally at El Paso Repro,[170] that clinic's physician travels 300 miles to the Midland clinic, a seven to eight hour drive, one day per week. The other Midland physician providing surgical abortions at the time of the Center's visit commuted from Oregon; he retired in May 2009.[171] According to the CEO for the Midland affiliate, Planned Parenthood of West Texas: "if we didn't have [the El Paso doctor] to replace [the retiring doctor], we'd shut down."[172]

Fear of the personal, professional, and financial consequences of protest activity and medical community stigma are blamed for the scarcity of providers. A doctor who provides only medication abortion said, "No one wants to be seen as an abortion provider in the community," even doctors providing the procedure to their private patients.[173] The Bryan clinic has never had a local physician—their current doctor lives in San Antonio. He had to stop working at the clinic for a period of time after Bryan protestors pressured his employer to prohibit him from providing abortions.[174] Until he found a new position and began providing at Bryan again, clinic administrators "had to beg" to find a substitute physician.[175] Although Houston Planned Parenthood is an hour and a half away, the doctors there refuse to come to Bryan because the anti-abortion activity at the clinic is extensive and they fear being targeted.[176]

Economic pressure and stigma are factors even in progressive cities: physicians are often constrained by the anti-abortion views of their partners.[177] Indeed, a doctor who currently practices in three Texas communities for Whole Woman's thought that fear of losing income was most doctors' chief concern regarding protestors.[178] One physician in Austin accepted the role of back-up for Whole Woman's; her practice group subsequently had a meeting "in secret" and told her that she could not take on that role.[179]

The lack of training for new providers and the onerous effects of the restrictions on abortion provision and practice have resulted in the "graying" of providers. Dr. Alan Braid, who has provided for twenty years at Reproductive Services of San Antonio and is now its owner, remarked that he is one of only a few doctors in that city who has expertise in abortion.[180] He knows all of the other providers who, like him, will be in their 70s in seven to eight years: "I don't know any young doctors doing abortions or who want to. I spoke with a few young doctors, and they're supportive but not interested."[181]

The medical director of Austin Planned Parenthood, who lives locally, as does the only second trimester provider at the clinic, attributed the lack of local providers in Austin in part to trained physicians being deterred by feeling ignorant of the legal requirements and fearing that they will violate them.[182] El Paso Repro reported similar factors for the scarcity of physicians in El Paso.[183]

Harassment and Intimidation

All of the clinics participating in the investigation are subject to harassment and intimidation by protestors, although the volume and level of aggression ranges. Anti-abortion activity is most threatening and burdensome at the clinics in Midland, McAllen, and Bryan. Bryan is the incubator for novel forms of harassment and intimidation, which then spread to Houston and other parts of the country (see box: *Bryan, Texas as an Incubator for Opposition Tactics*). Potential factors worsening anti-abortion activity appear to be conservative communities (where general and medical community stigma around abortion is rampant), facilities that are physically vulnerable and where it is difficult to control access to patients and staff, and lack of law enforcement by local police.

INVESTIGATIVE SPOTLIGHT

Bryan, Texas as an Incubator for Opposition Tactics

The Bryan clinic has been the site of new and aggressive strategies of harassment and intimidation. Bryan is the home of David Bereit, the founder of the "40 Days for Life" campaign, an anti-choice group that organizes 40-day protests targeting abortion clinics around the U.S.

Protestors have used patient car registry information to send mass emails to the A&M campus and to the parents of patients, alleging that specific young women have gone to the clinic for an abortion.[194] The Brazos Valley Coalition for Life sponsors smear ads about the clinic that play often on local television.[195] The police have been sued numerous times by one of the protestors.[196] Nearly all staff members have been targeted as "abortionists" by email or postcards to their neighborhoods under the heading "public advisory" with graphic depictions.[197] From mid-2007 to May 2008, the health center director received six threats to her life at her home, at the clinic, on her car, in the mail, and in her yard.[198] Each one was more overt and detailed than the last.[199] One spoke of her daughter being "better off" left without a mother; another said that she would be seeing her grandfather soon—he had recently died.[200] The last one was a 40-day "countdown" on her life, which had already begun.[201] The case remains unresolved.[202]

The culture of impunity is also evident in the police response in Bryan. Officers have been told that they cannot write a ticket without permission from a lieutenant or assistant chief.[203] A new chief of police was initially very positive; after a first meeting he promised to call back in a week. That was in late 2007; the clinic has never heard back from him.[204]

As a result of the intimidation, the clinic has had two complete turnovers of staff. "At this facility, it can't just be a paycheck, because you have to deal with too much."[205]

Anti-abortion activities at the Midland, McAllen, and Bryan clinics include shouting, praying and/or singing, blocking a sidewalk[184] or walking across an entrance to block access and approach cars,[185] and seeking to persuade women to go a nearby crisis pregnancy center[186] or an anti-abortion physician's office.[187] Around Halloween 2008 in Midland, forty protestors wore frightening masks and costumes.[188] There are anti-abortion billboards near the clinic and a "mock gravesite" for the unborn across the street.[189] In McAllen, protestors take pictures of staff members' cars and plates and bait the partners or companions of patients; they walk with patients from their cars to the door[190] staying on the public sidewalk, but getting "up in the faces" of women and following them step-by-step.[191] There has also been vandalism at the clinic, including spray paint on the wall and repeated theft of the clinic name and street numbers from the building.[192] In Bryan, protestors climb on the clinic's fence at the edge of the parking lot and shout and leaflet false information (that the instruments are not sterilized; "You know they are going to take your baby parts and dissect them").[193]

Police in Bryan, McAllen, and Midland do not enforce the law and have a negative or blaming attitude toward providers. In Midland, the clinic's relationship with the police has deteriorated since the mid-1990s; the attitude of individual officers runs from not supportive to strongly opposed.[206] The current chief of police does not permit off-duty officers to work security at the clinic;[207] this is also the case in McAllen.[208] Whole Woman's in McAllen has difficulty getting support from the police: "[t]he police tell us to go to the city and the city then tells us to talk to the police."[209] Police do not enforce an ordinance requiring signs to be held not propped, unless "the peace is being disturbed," and they argue over what property is private and what is easement.[210] "Very little is accomplished. The police do [come to the clinic when called] but they aren't receptive. They need the law explained to them constantly."[211]

In Bryan, the attitude of the police is that the clinic brings the harassment and intimidation upon itself. The authorities have been inconsistent in enforcement—to the point where the clinic administration prefers to handle protestors themselves.[212]

Most clinics in the investigation undertake extensive security measures to ensure the safety of staff and patients. These include employing armed security guards, installing cameras and security systems, restricting access to the facility, having volunteer escorts, and conducting regular trainings for staff. Security guards are costly, but have the effect of curtailing anti-abortion activities.

Houston Planned Parenthood pays $5,000 to $6,000 every two weeks for Harris County deputy sheriffs to serve as armed security guards; they also have a full-time security manager.[213] Waco Planned Parenthood has an armed security guard for both the abortion and family planning clinics, costing them approximately $45,000 to $50,000 annually.[214] Some clinics choose not to have guards in order not to intimidate patients: "There is a fine line—we don't

want to scare people and we don't want them to get complacent."[215] Bryan Planned Parenthood has volunteer escorts who check patient identification, nine cameras, an alarm system, and access doors, but they do not want it to be too intimidating for patients—"We don't want it to be like Fort Knox in here."[216] The clinic does have a mesh, chain link and barbed wire fence they installed in 2008 at a cost of $10,000; a lot of consideration was given too whether it would look too ominous.[217]

Legal Restrictions on Abortion

Abortion providers' abilities to provide women with health services—and women's access to reproductive healthcare—is impeded by unnecessary and, at times, arbitrary legal restrictions. In the 2009 legislative session in Texas, 23 bills restricting abortion were introduced. Providers in Texas report that their ability to make abortion available is limited by the ambulatory surgical center (ASC) restriction and burdened by the 24-hour mandatory delay and biased counseling requirement.

Ambulatory Surgical Center Requirement

Interviewees singled out the ASC restriction on facilities providing services at or after 16 weeks as the most harmful one to women in Texas.[218] Clinic administrators and physicians were unanimous in finding no medical reason for the restriction.

Two doctors reported that they previously performed abortions up to 20 weeks in the clinic setting and had no greater number of problems or hospitalizations.[219] A surgical center is not necessary, just more expensive for the clinic.[220] The administrator of El Paso Repro attributed the legislation to the large "right to life" contingency, which ignored medical experts in favor of imposing their moral view on others.[221] The CEO of Whole Woman's linked it with the stigma against abortion and the marginalization of poor and young women who are more likely to have second trimester abortions.[222]

There are only two facilities in the state which meet ASC standards. Seven of the nine clinics participating in the investigation[223] stopped providing abortions after 15 weeks, 6 days, after the law went into effect on January 1, 2004. El Paso Repro used to offer the service until 22 weeks, but has stopped providing those services. Instead, the clinic refers patients to Albuquerque, Wichita, or the two surgical centers in Texas, "but they're priced as high as going out of state."[224]

The increased financial burdens on women severely limit their option to have an abortion. "You're going to have a person that time is going to get away from, and it's almost a punishment. In more cases than not, I see forced parenting. They can't come up with $3,000-4,000."[225]

Abortion providers' abilities to provide women with health services—and women's access to reproductive healthcare—is impeded by unnecessary and, at times, arbitrary legal restrictions.

Texas State House Dome

There is very little that clinics can do to ameliorate the effects of the gestational limit on women because building a new facility is prohibitively costly for most clinics. One doctor who is trained to perform abortions up to 20 weeks would have to bring patients to an outpatient surgical center in San Antonio, where he practices, increasing the costs by several thousand dollars. There are also problems with scheduling and staffing because some nurses are not willing to assist in abortions, even for patients in his private practice with fetal abnormalities.[226] At best, providers can provide counseling to women, help prepare them for a later procedure, and try to assist them with obtaining funds to go to Austin or Houston.[227]

24-Hour Mandatory Delay and Biased Counseling Requirement

Because the 24-hour delay and state-mandated information could become a serious obstacle for women seeking abortions, clinics have instituted processes and spend additional resources to reduce their effects on women. All of the clinics have recorded a "doctor's message" that women can listen to over the phone at the time they make their appointment to receive the physician-mandated information. The clinics make it clear in the message that the information is required by the state and not based in fact or on scientific evidence—one physician termed it "an infomercial."[228] Waco Planned Parenthood clinic, along with Whole Women's Health and Reproductive Services (owner of the El Paso clinic),[229] initiated this system and it is replicated by clinics throughout the state.[230] This is particularly significant for patients at clinics that serve a large geographic area, like Midland.[231]

Although clinics have been able to cope with the restriction, mandates present a constant challenge because of frequent additions and changes. Clinics train staff and create a new process each time there is a new requirement, but "[o]ne day it will be too much."[232] The biased counseling requirement is also troubling to providers because clinics perceive themselves as being the state's agent of the regulations for their patients, by being forced to convey irrelevant and misleading information. Providers must also obtain each woman's signed certification that she has been told the required information by the physician and informed of her right to review and receive copies of the state-produced written materials.[233] At the Bryan clinic, for example, many patients think it is the clinic's rule requiring them to receive the information, including the alleged potential link to increased breast cancer risk described in the state-produced booklet.[234]

Despite the clinics' efforts, women are harmed by the restriction, particularly those already most affected by the scarcity of providers in Texas. If patients come in and report that they have not listened to the doctor's message, they are turned away.[235] Women in this position may be pushed past the gestational limit.[236] Women from New Mexico are likely to call El Paso Repro the morning before they come in, or the evening before, having made all of their travel and child care arrangements; because of the 24-hour delay, they need to wait for the next clinic, which may be two days later.[237] Clinics that serve large populations of patients from Mexico report that they are the most affected, and require extra efforts by providers in order to obtain abortion services (see box: *Women From Mexico*). Women who work hourly wage jobs, lack a reliable care provider, have language barriers, or need child care are also very vulnerable to delay.[238] In Bryan, if a woman calls on Friday, she has to wait an additional two weeks because the clinic only provides abortions every other Saturday, which may push her past the clinic's gestational limit.[239] Most women end up receiving an abortion, though often a more costly and risky second trimester procedure, which they have to travel to Houston or Austin to obtain; many women lack transport to make the trip.[240]

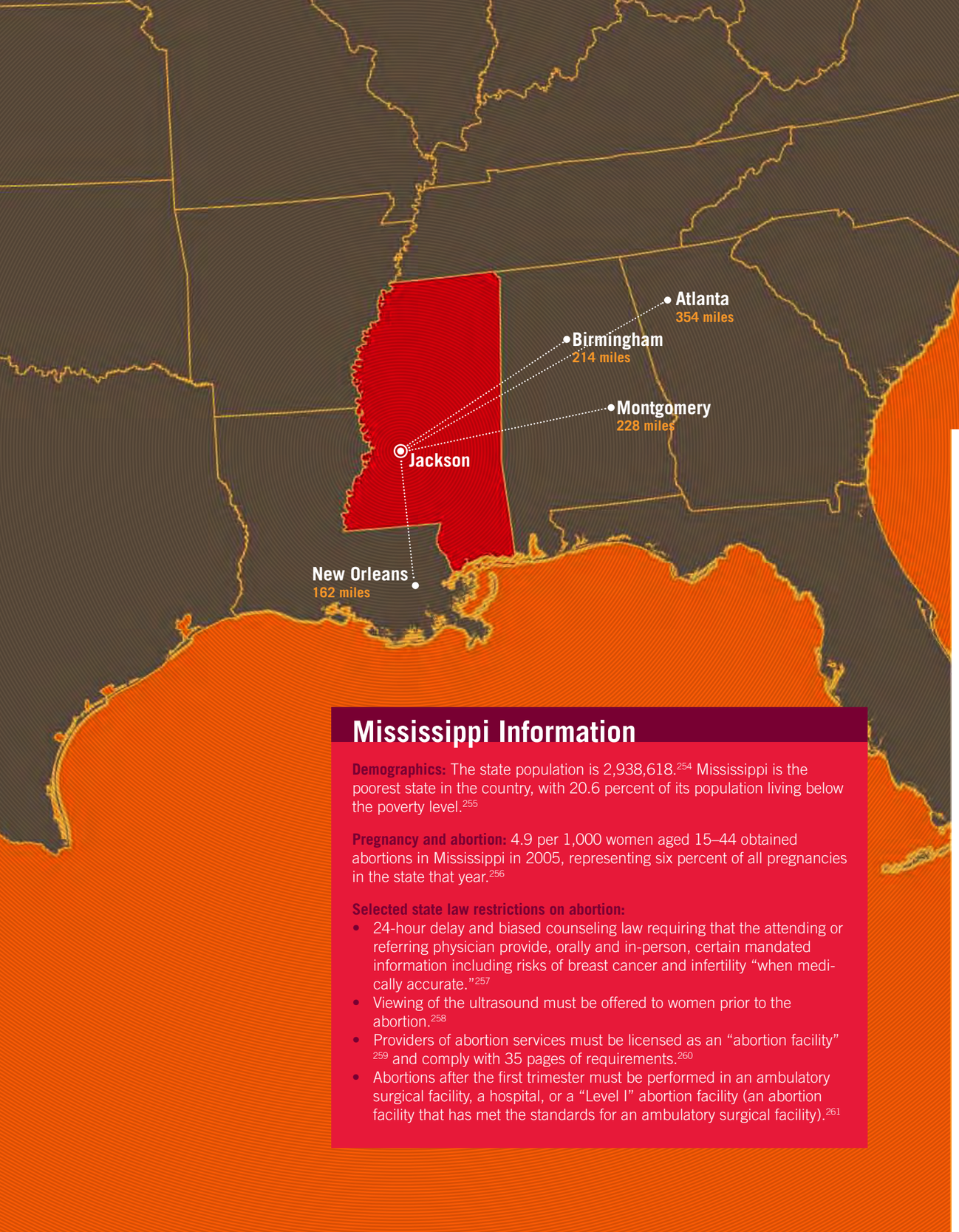
INVESTIGATIVE SPOTLIGHT

Women from Mexico

In El Paso and McAllen, providers report that the women most affected by the mandatory delay and biased counseling law are patients who come from Mexico, some from great distances, often with few financial resources and no place to stay.[241] Patients must obtain medical visas if they are Mexican citizens, a cumbersome process[242] for which they usually only receive a 24-hour pass.[243] El Paso is a port of entry where women can obtain permits; women without passports require a letter from the clinic.[244] Crossing the border can be uncertain and costly for women; at times, immigration agents in El Paso have refused to let women going to a clinic, as opposed to those going to a hospital, pass even if they have a visa or passport.[245] While a permit should cost $6, anti-abortion agents at an El Paso crossing charged women $571,[246] more than the cost of an abortion at the clinic, for a period of a year and a half in 2007 and 2008.[247] After the administrator of El Paso Repro spoke to several supervisors at that particular bridge crossing, the discrimination stopped.[248]

Because of the arbitrary immigration enforcement process, women cannot always make an abortion appointment for a specific day. Prior to the passage of the mandatory delay and biased counseling restriction, patients could walk in;[249] now some are turned away for failing to meet the legal requirements.[250] If women are delayed in obtaining the procedure once they are in the U.S., they must return to Mexico, apply for a second permit, and pay the fee again to attempt to cross the border.[251]

Difficulties in obtaining or affording medical care, as well as lack of information about the legality and availability of abortion in the U.S., causes some women to try to self-abort with medication (cytotec/misoprostol) obtained from Mexico.[252] This was the case with one Hispanic woman interviewed for the investigation, a 22-year-old mother of a 10-month-old, who unsuccessfully tried to self abort with herbs, teas, and "pills" prior to making an appointment at Whole Woman's in McAllen.[253]



MISSISSIPPI

Mississippi Information

Demographics: The state population is 2,938,618.[254] Mississippi is the poorest state in the country, with 20.6 percent of its population living below the poverty level.[255]

Pregnancy and abortion: 4.9 per 1,000 women aged 15–44 obtained abortions in Mississippi in 2005, representing six percent of all pregnancies in the state that year.[256]

Selected state law restrictions on abortion:

- 24-hour delay and biased counseling law requiring that the attending or referring physician provide, orally and in-person, certain mandated information including risks of breast cancer and infertility "when medically accurate."[257]
- Viewing of the ultrasound must be offered to women prior to the abortion.[258]
- Providers of abortion services must be licensed as an "abortion facility" [259] and comply with 35 pages of requirements.[260]
- Abortions after the first trimester must be performed in an ambulatory surgical facility, a hospital, or a "Level I" abortion facility (an abortion facility that has met the standards for an ambulatory surgical facility).[261]

Key Findings

Since 2004, Jackson Women's Health Organization (Women's Health) has been the only abortion clinic in Mississippi, and its situation is precarious. The Center for Reproductive Rights interviewed three clinic staff members, the doctor who works at the clinic, and two patients.

The clinic now relies on one physician and is under siege from anti-abortion opponents in the Legislature – and on the street. Mississippi's biased counseling requirement is particularly onerous because it requires that patients make two visits to the clinic and receive certain state-mandated information from a physician. This restriction depletes clinic resources and makes it more expensive and time-consuming for women seeking abortions, particularly poor women. The clinic's resources are already stretched by the need to respond to and comply with a constant flow of new legislation and restrictions. A daily toll is inflicted on clinic staff by protest activity in a state that is strongly anti-abortion and a "testing ground" for legislative restrictions and anti-abortion tactics. Harassment and threats of violence keep doctors and clinic staff cautious and vigilant. Because the clinic does not provide abortion services after 16 weeks, women seeking abortions at later stages of gestation need to go out of state, traveling as far as Atlanta, about 400 miles from Jackson.

Availability of Abortion in Mississippi

Women come to the clinic from across the state, traveling up to four hours from the Delta, the coastal area and Louisiana.[262] Women go to Memphis, Tennessee from Oxford and the northern part of the state. [263] The majority of patients are poor. Women's Health provides family planning services and abortions up to 16 weeks, six mornings or afternoons per week. For abortions at or after 16 weeks, women must travel out of state several hours to Birmingham, and at or after 18 weeks, to Montgomery, Atlanta, or New Orleans.

Given the long distances women already have to travel to obtain abortions in Mississippi, if Women's Health closed, the harm to women would be severe. If the clinic stopped performing abortions, it would be very difficult to establish another clinic in the state due to the legal restrictions on abortion, pervasive stigma, and persistent anti-abortion activity that any abortion provider would face.[264] When asked if women would go to Alabama or Louisiana, one staff member said, "Shoot, no. They have a hard time enough time coming here."

The clinic's sole physician, Dr. Joseph Booker, is certain that there already are illegal, unsafe abortions taking place in Mississippi, given the lack of providers and the poverty of the population.[265] Without Women's Health, clinic staff predict that there would be an increase in the birth rate[266] and maternal mortality, as a consequence of a greater number of teen pregnancies and unsafe abortions.[267] "It would be awful. We would go back to back-alley abortions, babies being left everywhere, women dying of infections. Especially [women] from … the Delta."[268]

Harassment, Intimidation, and Stigma

All interviewees, both providers and women, reported that harassment, intimidation, and stigma around abortion are strong in the state of Mississippi. This is evidenced by regular anti-abortion activity at the clinic. Staff members are very concerned about safety and feel vulnerable: "Anyone could walk in at any time off of the street. I'm always looking out of the window here and at home. It wears on you, being cautious all the time, looking to see if someone is following you."[269] There is steady anti-abortion activity during the week; it increases on Saturdays and when the clinic is targeted for extensive periods, such as during the "40 Days for Life" campaign and Operation Save America's weeklong event in 2006.[270] Abortion opponents occupy the sidewalk outside the clinic's fenced parking lot and the sidewalk on the main street that runs alongside the clinic, sometimes camping out with folding chairs. "They yell and scream, they are obnoxious, they try to intimidate people. [They yell] 'Babykiller, Murderer, Black Genocide, Butcher, You may die to today."[271]

The clinic has an armed security guard who escorts patients from the parking lot to the door (a path which runs alongside the fence), a metal detector, and security cameras (costing $10,000-12,000) around the perimeter of the clinic.[272] Patients and visitors are not allowed to bring bags into the clinic.[273] Nevertheless, clinic staff members are uncertain about what protestors will do next.[274]

Harassment, intimidation, and stigma make it difficult for the clinic to find physicians to perform abortions. Dr. Booker is 64 years old. He has been a longtime target of threats and intimidation, but throughout, he has continued to provide abortion services.

In 1994, after the murder of Dr. John Britton and his clinic escort by Paul Hill in Pensacola, Florida, Dr. Booker (who practiced at a clinic about 130 miles away in Gulfport, Mississippi at the time) was under federal marshal protection for 18 months.[275] He reports having protestors at his house numerous times, most recently about a year before the interview. They went door-to-door with graphic signs, informing his neighbors that a "baby killer" was living next door.[276] The local police continue to drive by his house occasionally. The doctor has been targeted for over a decade by one abortion opponent in particular – Roy McMillan, who has been arrested numerous times for anti-abortion harassment and intimidation (see box: *Challenges of FACE Enforcement: the Case Against Roy McMillan*). Despite these threats, Dr. Booker reports that he is resolute: "The harder they try to tear me down, it just galvanizes me."[277]

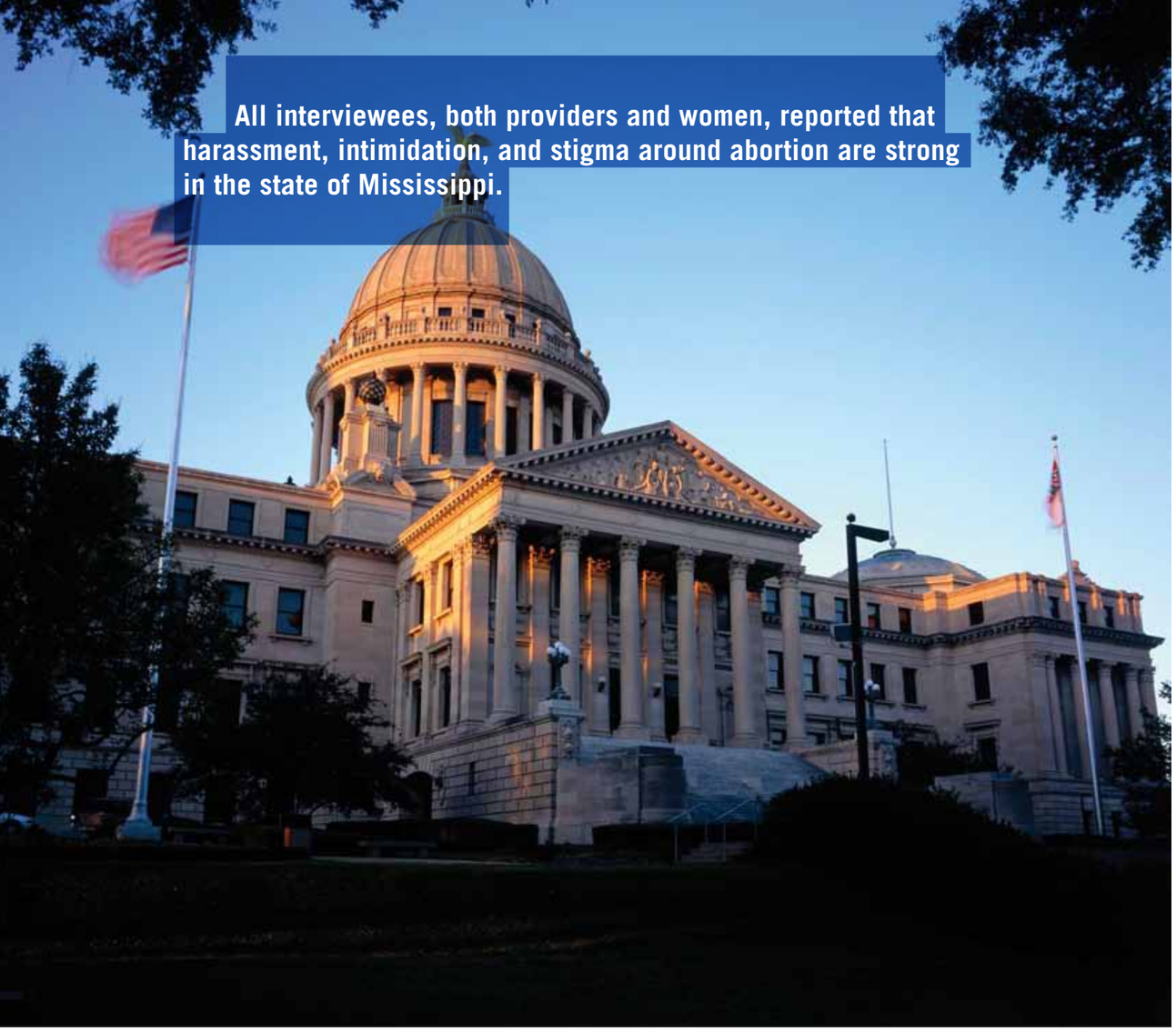
INVESTIGATIVE SPOTLIGHT

Challenges of FACE Enforcement: The Case Against Roy McMillan

In 1995, a federal district court in Mississippi issued a preliminary injunction against anti-abortion activist Roy McMillan that required him to stay in a "buffer zone" 25 feet away from Women's Health after concluding that McMillan endorses violence as a means to oppose abortion.[278] In June 1996, while the case was still pending, McMillan and the U.S. entered into a consent decree that enjoined McMillan from violating FACE while permitting him to admit no liability. In 1999, the U.S. brought another action against McMillan alleging violations of the 1996 consent decree and seeking an expanded buffer zone.[279] A federal district court found McMillan in civil contempt for violating the consent decree after hearing testimony that he frequently shouted "[W]here is a pipe bomber when you need one" when the physician walked into the clinic.[280] The court rejected the government's request for a larger buffer zone, however, finding that a 30-foot buffer would not affect McMillan's behavior because his threats are usually "hurled from a distance of approximately 80 feet."[281]

In 2008, the U.S. again brought a claim against McMillan for violations of the 1996 consent decree and sought a finding of civil contempt. The U.S. alleged that beginning on or about October 31, 2006, McMillan repeatedly violated the buffer zone.[282] It further alleged that McMillan made numerous threats of use of force against Dr. Booker, including "Your days are numbered, Booker."[283] The court mandated that McMillan stay at least 50 feet away from Women's Health, doubling the buffer zone.[284]

McMillan has violated the most recent order four to five times since, as documented on the clinic's surveillance cameras, but the Justice Department has been unresponsive to Dr. Booker and clinic management's complaints.[285] The doctor feels that the FBI is unresponsive and enforcement is not effective: "The courts are not good, it's a bad state to take something to court. It wastes my time and takes me away from the clinic, which is what [abortion opponents] want."[286]



All interviewees, both providers and women, reported that harassment, intimidation, and stigma around abortion are strong in the state of Mississippi.

General community stigmatization of abortion carries over to the willingness of trained physicians to provide this service. One local doctor who worked at the clinic felt pressured to quit when a nurse from her other workplace, who regularly protests at the clinic, recognized her.[287] Dr. Booker knew of four physicians who did abortions for their own patients privately and kept this secret in order to avoid picketing.[288] Likewise, the clinic's former administrator attributed difficulty in recruiting medical staff for Women's Health to the need to "put themselves out there" and the "backlash" in the community that goes along with working at an abortion clinic.[289] If the clinic were to lose Dr. Booker, clinic management does not know what they would do.[290] While there are several out-of-state physicians from Georgia and North Carolina who could fly in, one of those stopped doing so regularly in May 2008 because of the flagging economy and costs of the flights.[291]

Legal Restrictions on Abortion

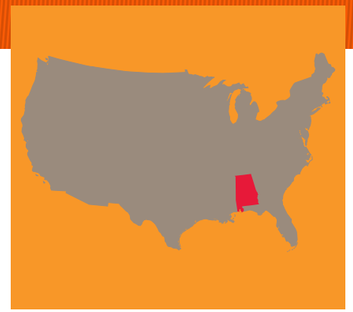
Women's Health staff cited state restrictions on abortion as the greatest obstacle that the clinic faces in providing abortions. "[T]rying to compete with the never-ending legislation, the battles with new things, the requirements for patients, the new bills"[292] burdens the clinic with new processes and expenses of compliance. For example, 18 restrictive bills on abortion were introduced in the 2009 state legislative session. The most pernicious of the current restrictions is the 24-hour mandatory delay and biased counseling law, which requires women seeking abortions to make trips on two separate days to the clinic in Jackson. No one interviewed thought there was a medical reason for this restriction. Rather, its purpose is to place another obstacle in the path of women seeking abortions by making the procedure more difficult to get and frightening them with false information about the risks of the procedure: "It was put into effect to outlaw abortion and make Mississippi abortion-free."[293]

The clinic provides counseling and abortion appointments six days per week in order to minimize the delay women may experience due to the restriction, which greatly increases staffing costs. It costs the clinic $100 per session to have a physician provide the brief, mandated group counseling which must take place 24 hours before the procedure.[294] As part of the counseling, Mississippi requires the physician to inform patients that there is competing evidence as to whether abortion may elevate breast cancer risk, although the scientific establishment has rejected this association.[295] Beyond the physician's hours, additional staff time is required to arrange and facilitate appointments. The clinic must also pay for the cost of printing the materials they are required to offer,[296] which include a color booklet with photographs and illustrations detailing fetal characteristics at two-week intervals, a pamphlet on birth control methods, and a booklet on the medical risks of pregnancy and abortion listing "services and options" related to carrying a pregnancy to term.

Mandatory delay is also expensive and burdensome for women who must twice arrange child care, time off work, transport, manage privacy issues,[297] and go through the "gauntlet" of protestors.[298] Patients are harmed financially, but do not change their decision to have an abortion.[299] Some women, however, are delayed beyond the gestational limits of the clinic. A staff member told the story of a woman who came for the first visit in her first trimester; by the time she returned, she was past the 16 week limit. "I asked her, 'What happened?' It was money, then transportation. That's how it goes, we get that a lot. They don't realize that [the cost] goes up - while they are working on getting the first trimester [fee], it goes up for the second trimester."[300] She noted that, when the clinic did abortions only twice a week, even more women "fell away" between the first and second appointments.

ALABAMA

Key Findings



Alabama exemplifies all of the major findings of this investigation. The Center for Reproductive Rights interviewed 15 providers and one woman at six clinics.[310] There is a scarcity of providers in the state, with many of the seven abortion clinics offering procedures only two or three days per week and clinics sharing and importing doctors. Intimidation and harassment are pervasive, varying by clinic site and depending on several factors, such as the lack of police response. Restrictions on abortion are burdensome and consume significant provider resources, particularly the mandatory delay and biased counseling requirements.[311] Burdens on patients are worsened by the intimidation and harassment they endure going into the clinics. Persistent stigma perpetuates the isolation and marginalization of abortion providers, as well as exacerbating the effects of anti-abortion activity and legal restrictions.

> "The right to decide when and how you reproduce should be one of the most basic rights we're guaranteed as citizens, morally, as humans … .[309]"
>
> - Birmingham clinic administrator

Alabama Information

Demographics: The state population is 4,661,900.[301] Alabama is the sixth poorest state in the nation, with 16.9 percent of its population living below the poverty level.[302]

Pregnancy and abortion: 11.9 per 1,000 women aged 15–44 obtained abortions in Alabama in 2005, representing 13 percent of all pregnancies in the state that year.[303]

Selected state law restrictions on abortion:

- 24-hour delay and biased counseling law requires mandated information be provided, in person or by return-receipt certified mail, by a "qualified person"[304] defined as a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician.[305]
- State materials on fetal development; abortion alternatives, methods, and risks; and fathers' obligations must be provided in person or by return-receipt certified mail 24 hours in advance.[306]
- An ultrasound is required to be performed by a physician prior to an abortion.[307]
- Abortion facilities that perform a certain number of abortions or "advertise" must be licensed and are subject to inspections by the state department of health.[308]

Availability of Abortion in Alabama

The seven clinics in Alabama serve women from a large geographic area encompassing Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, and Tennessee. For example, women routinely come to Reproductive Health Services (Repro Health) in Montgomery from 100-160 miles away;[312] in 2007, 720 out of 810 abortion patients at the Planned Parenthood in Birmingham drove over 150 miles to obtain services.[313] New Woman All Women's Health Care (New Woman) in Birmingham sees many patients from Mississippi: "These are poor women …who never left the state, or have never gone [farther than] a 50 mile radius of their homes. They ride the bus all night and we pick them up at the station, it's horrifying."[314]

Clinics in the state are clustered in Birmingham, Montgomery, Tuscaloosa, Huntsville, and Mobile. West Alabama Women's Center in Tuscaloosa—which, of all the clinics in the state, routinely performs the latest abortions, up to 20 weeks—receives referrals from the others.[315] The majority of clinics provide abortions at most three days per week.

Historically and today, many clinics face difficulties in finding doctors, particularly from the local community. About half of the physicians working at the clinics are from out of state, or from another part of the state. Several of the clinics share physicians, nearly all of whom work part-time at the clinics and hold other positions. For example, Alabama Women's Center for Reproductive Alternatives in Huntsville has a doctor who drives 170 miles from another part of the state,[316] another who flies in two to three times per month from California, and a third who is local.[317] These physicians cover two to three abortion sessions per week in total.

The scarcity of doctors is attributed to stigma and negative attitudes toward abortion;[318] some physicians' personal objections based on moral or religious grounds;[319] fear of harassment by protestors at one's home or practice and the personal and economic consequences;[320] and a lack of training for new physicians.[321] In Montgomery, where finding local physicians is "next to impossible," local physicians require new partners to sign contracts that include a provision that they will not support or perform abortions in their or other practices.[322] Stigma deters qualified staff from working in the clinics in Huntsville and Tuscaloosa.[323] In Montgomery and Huntsville, obtaining back-up physicians is particularly difficult.[324] Repro Health's back-up physician was threatened with recrimination from the local OB/GYN community if he did not relinquish the position.[325] A previous back-up denied that he was playing that role when questioned by the state health department.[326] The owner/administrator of the Alabama Women's Center was turned down by every OB/GYN in Huntsville, except one, when he sought a back-up.[327] In Tuscaloosa the clinic's owner and administrator has found doctors willing to perform the role, as long as their association with the clinic is kept secret.[328]

Harassment and Intimidation

Alabama has a history of intimidation and violence by abortion opponents. In 1998, Eric Rudolph, the "Olympic Park Bomber," bombed New Woman, killing an off-duty police officer and severely injuring a nurse. In 1997, the Tuscaloosa clinic was destroyed by arson.[329] Currently, all six clinics taking part in the investigation have anti-abortion activity. State regulations require that clinics report their schedule of abortion days and this information is available to the public, letting abortion opponents know on which days the clinics perform abortions.[330] The extreme acts of harm that have taken place particularly concern staff and physicians[331] (see box: *A Day in the Life of a Physician Who Provides Abortions in Alabama*).

> **"The protestors move quickly; it's like guerilla warfare.[333]"**
>
> **- Montgomery clinic administrator**

SAFETY PRECAUTIONS. All of the clinics take extensive and costly measures to shield patients and staff from intimidation and against potential clinic invasions and other extreme forms of harassment and violence. These include security cameras, volunteer patient escorts, personal precautions in arriving and departing, and substantial staff time diverted from patient care.

The two Birmingham clinics and Repro Health obtained video cameras so they can document evidence of malfeasance to use against the protestors,[332] whose unlawful activity often goes unobserved by even attentive police officers—"otherwise, it's just word against word. …The protestors move quickly; it's like guerilla warfare [.]"[333] Planned Parenthood has been considering legal actions in Birmingham, such as seeking an injunction to create a buffer zone, but this remedy appears to be prohibitively costly.[334] Since anti-abortion activity began in the fall of 2008, three Birmingham Planned Parenthood staff members have devoted at least 30 hours per week to dealing with it.[335]

The potential for property damage and physical harm is costly to clinics and staff in additional ways. In Tuscaloosa, when the 1997 arson caused over $400,000 worth of destruction to the facility, their insurance paid the claim but also terminated the policy.[336] The clinic had a long struggle getting new insurance; the clinic's owner/administrator said, "I hold my breath each year every time it comes time to renew. I don't know what would happen if we had a claim."[337] The protests also take a psychological toll on staff at all the clinics: "It's stressful, you feel like you're under siege. …It changes your feelings about wanting to come to work … but I feel so strongly about what I do."[338] Even at clinics with less aggressive activity, staff members take precautions such as circling the parking lot before pulling in to check if anyone is there—"How many people do that? But we do …"[339]

INVESTIGATIVE SPOTLIGHT

A Day in the Life of a Physician Who Provides Abortions in Alabama

Two physicians described the extensive safety precautions that they take. One[340] comes to the clinic two hours before the protestors, and sits and waits for the clinic to open; at the end of the day she watches for them to leave from the window or she "sneaks" out—"I try my best to look like a patient … . No scrubs." She gave up practicing on Saturdays a few years ago when one protestor figured out who she was, and waited four hours for her to come out. The following weekend she tried driving in without license plates and the protestors called the police. At a different clinic, she uses the back door and drives without license plates; if the protestors are in the back, the escorts will shield her. She takes circuitous routes, checks to see if she is being followed whether on foot or in her car, tries not to have a pattern in her approach to the clinic, never stops to take off the license plates in the same place, and has waited hours for protestors to leave. She has an unlisted phone number and if she has to call someone back on behalf of a patient, she does not leave a callback number, even to another physician.

A second physician[341] has developed an elaborate routine to avoid being seen by protestors at a particular clinic he travels to, which involves surveying the clinic from a site above the clinic property, having a key to the side door, having an "escape route" ready, parking where he can leave shielded by the door from the protestors, driving a loop when he leaves to avoid having his picture taken, and returning to the original surveillance spot to watch the protestors until they leave. He drives a rental car, constantly monitors the rearview window to make sure he is not being followed, and stays at a motel five to six miles away from the clinic, although there are closer places. "All this thinking about something I shouldn't have to think about," he said. Referring to the precautions he takes, and the activities of the protestors, the doctor stated, "It makes me not want to go to [that clinic]."

ANTI-ABORTION ACTIVITY. The two Birmingham clinics experience steady and aggressive anti-abortion activity. This is new for Birmingham Planned Parenthood, dating to the "40 Days for Life" campaign of September and November 2008.[342] Protestors taunt and threaten the escorts, attempting to stop cars as they enter and throw in printed materials.[343] New Woman has endured protests dating from the opening of the clinic in the 1980s. Since early 2008, the level and aggressive nature of the picketing has escalated (see box: *Problems with Law Enforcement at New Woman*).[344] Abortion opponents at both clinics yell, trespass on the clinic's property, and put footage of patients on YouTube.[345] Also, license plate numbers have been used to identify at least one of the physicians.[346] Protestors target patients they recognize and threaten to publicize their visit to the clinic to neighbors and employers.[347] At both clinics, protestors tell falsehoods that affect patients' trust and require reassurance from providers: "There was a lady last week, [one of the regular protestors] got to her, saying that the doctor's not licensed, we don't use licensed staff, there are six lawsuits against the clinic, we sent someone to the hospital last week, we're not licensed by the state. The poor woman was flipping out."[348] One of the physicians at New Woman noted similar activity there: "It scares some of them to death: 'The doctor's a butcher, you're going to die.'"[349]

INVESTIGATIVE SPOTLIGHT

Problems with Law Enforcement at New Woman Clinic

While police response is reported as usually fair in Huntsville and sympathetic in Montgomery, it has been hostile and ineffective at New Woman in Birmingham. Some of the protestors have been arrested hundreds of times: "Before I get down there to swear [out] the warrant, they're out, no bond. …That's why I stopped doing that and stopped sending staff down to testify."[350] In the summer of 2007, Operation Save America brought 400 people to the clinic for two weeks. The police blockaded the street that faces the front entrance of the clinic and leads to its parking lot. They wanted to escort patients: "Everything they do hurts the clinics. People couldn't get in; who wants a cop walking you in front of 400 people?"[351]

In addition to routine security measures, New Woman puts a radio outside to play loud music to counter the protestors' screaming and, on Saturdays, raises a temporary canvas wall constructed by one of the escorts to block the view of patients from the sidewalk.[352] Despite the fact that she is responding to the extreme volume of the protestors, police have threatened the co-owner with arrest for violating a noise ordinance. Police say that the clinic wants special treatment and have asked the clinic's co-owner and administrator "why she doesn't just try and get along" with the protestors.[353] "The police and the community hate us. They think that if we weren't here, there wouldn't be a problem. Nothing has changed in 35 years."[354] The clinic is collecting documentation in order to sue the police for failing to enforce local laws. The clinic has also been unsuccessful in getting enforcement at the federal level. "The FBI's position is that they don't get involved until after—I asked [an agent], 'You'll help after they kill us?' and he said 'Yes, Ma'am.'"[355]

The Huntsville and Mobile clinics, and Repro Health in Montgomery, have fewer protestors, but they are no less dedicated and menacing.

The Huntsville and Montgomery clinics face a core group of dedicated abortion opponents on a daily basis. The Huntsville clinic has a very narrow drive on one side of the facility bordered by a wall, making it easy for protestors to block the entrance, nearly causing accidents as patients drive into the clinic.[356] In Mobile, one of the regulars is Ed Markley, a priest who protested with Paul Hill in Pensacola.[357] He has been convicted of criminal trespass and served prison time for destruction of a suction machine with a sledgehammer at a Birmingham clinic in the 1980s.[358] Around Christmas 2007, Markley obtained the doctor's cell phone number and left him two voicemail messages.[359] Protestors remain at the Mobile clinic from 8:00 a.m. until the last car leaves.[360]

In Tuscaloosa, because the clinic is located in a large medical complex, protestors are restricted by local law to activities on Saturdays. Due to the physical layout of the property, the protestors must stay several hundred feet away and obtain a permit as required under a city ordinance. Despite these measures, in 2006, Operation Rescue came a day earlier than their permit allowed to protest at the clinic. There were several hundred protestors, praying, singing, marching, playing instruments, and leaving literature at the offices of the other tenants.[361] Despite disruption to the clinic and other tenants in the complex, the police failed to make any arrests, even when the protestors came inside the clinic.[362] The police did, however, handcuff and arrest the clinic owner when she went to speak to the organizer of the protest. The charges were later quietly dropped, but not until after damaging publicity and embarrassment.[363]

Legal Restrictions on Abortion

Alabama law requires mandated information to be delivered by "qualified staff," and an ultrasound must be performed by a physician prior to the abortion. None of the interviewees identified a medical purpose to the mandatory delay and biased counseling law. The owner and administrator of Repro Health said flatly, "The reason [for the law] was only to punish us monetarily, absolutely not to benefit the patient."[364] The law imposes a burden on patients as well as clinics, requiring two in-person visits. While clinics have the option to mail the required information in lieu of an in-person visit, this option is very expensive for the clinics—approximately $20 per mailing.[365] Mailing can also cause delay for patients, since a return receipt must be received in the mail 24 hours in advance of the abortion.[366]

The law limits the staff members who can deliver the mandated information to a list of licensed professionals. For some clinics, this means having to have a nurse in the clinic on non-surgical days when it would otherwise not be necessary.[367] Moreover, several of the administrators remarked that the law takes time away from care and replaces it with mandatory information delivery: "[It] does not in any way enhance medical services … ."[368]

THESE ARE POOR WOMEN WHO NEVER LEFT [MISSISSIPPI], OR WHO HAVE NEVER GONE [FARTHER THAN] A 50 MILE RADIUS FROM THEIR HOMES - Birmingham clinic administrator

Similarly, the law's requirement that an ultrasound be performed by a physician reduces the time for providing services. Both administrators and physicians stated that a trained technician was as good as or better than a physician when it came to performing ultrasounds.[369]

The clinics expend considerable resources to ameliorate the effects of the mandated delay on women. Except for Planned Parenthood, the clinics provide abortions at least two to three days per week, allowing women to receive counseling one day and make an appointment for an abortion for the following day or two, if their own obligations and schedules permit. The clinics also accept counseling provided at another clinic or provide counseling for patients who have to be referred to another clinic with a later gestational limit.[370] The Mobile provider refers many women to Pensacola, Florida; though it is an hour farther away, there is no waiting period in that state.[371] The Tuscaloosa clinic does not pass on the costs of the mandated visit to patients.[372] Clinics also assist women with transport or funding to ease the financial burden of having to pay travel and other costs for two visits. Repro Health is considering offering to pay for overnight accommodations for two to three patients per month traveling from Mississippi, Georgia, and Florida who have the greatest need.[373] The Huntsville clinic gives anyone coming from more than an hour away a travel discount of $100;[374] Planned Parenthood is planning a similar program.[375]

For some women, the effects of the mandatory delay cannot be avoided. One doctor told the story of a woman whose husband was being shipped out to Iraq the next day. The couple drove 250 miles to the clinic, but because the clinic did not have the return receipt confirming that she had received the mandatory information in the mail, the abortion could not be performed.[376] Another woman was turned away because the receipt said that the information had been received at 3 p.m. the day before, less than the required 24 hours since abortions are performed in the mornings.[377] Many women are turned away completely by the added expense of a second, in-person visit and carry to term for financial reasons.[378]

Mutually Reinforcing Medical and General Community Stigma

Stigma in local Alabama medical communities creates financial pressures on physicians and has deleterious effects on access.

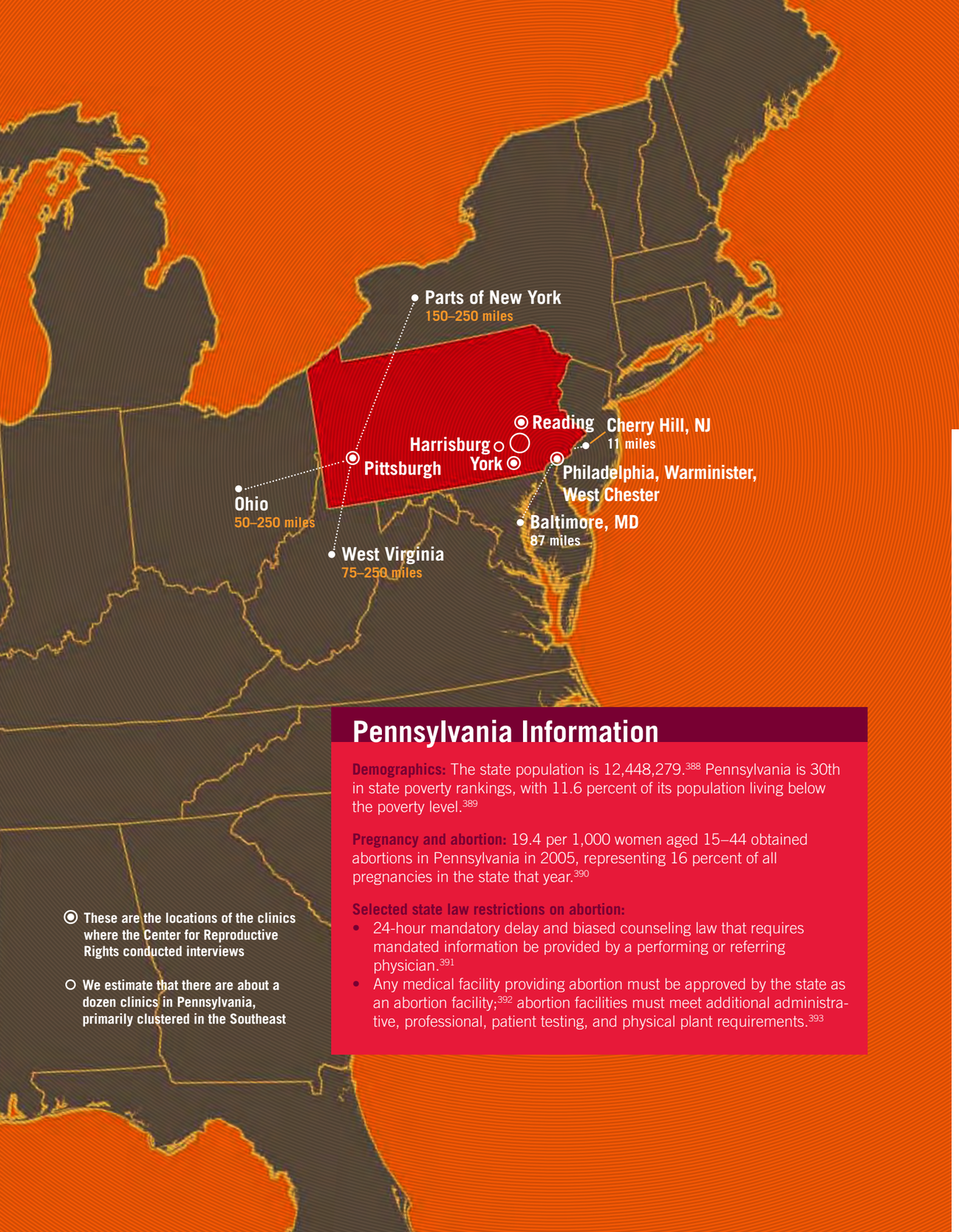
One clinic owner said that "[h]ealthcare providers look down on you the most." Another remarked, "I'm always circumspect about who I tell who I work for. I'm always thinking that I don't want to be labeled … because I may want to work with them."[379] A physician explained that in Mobile, the residency program at the University of South Alabama pressured residents into signing a statement on the first day stating that they did not want training in abortion. Commenting on the state's medical community, he said, "The official stance was 'we don't believe abortion should be done.' I know a bunch of doctors that personally the reason they take that stance is so they won't have a backlash with patients. They don't actually believe it."[380]

It is not only economic pressure and fear of damage to their reputations that deter practitioners in the "Bible Belt": "People are very torn. … I think that in their heart of hearts they would be just as happy to see *Roe* overturned because it goes against their deep-seated religious beliefs."[381] New Woman's co-owner stressed that doctors need to be willing to defend abortion as an important part of medical practice: "It's made it easier for people to say that they're not well-trained, that only slime and scumbags do abortion, because that's what they hear about."[382]

Stigma outside of the medical community is also common in the South.[383] The presence of protestors serves to reinforce the secrecy around obtaining or providing an abortion.[384] The Huntsville clinic owner is certain that stigma has had a damaging effect on him: "People don't want to do business with you, associate with you – they're scared of protestors, of how people in their church will think." One administrator pointed out that the effect that abortion-related stigma has on women is influenced by the anti-abortion activity: "There is still that shame attached to abortion and [protestors] exacerbate that. We can only do so much in here … ."[385] In the face of stigma, she felt that it was important for her to be visible as an abortion provider: "I don't know how we ask women to feel good about the choices they make if we're not comfortable talking about abortion."[386] One of the physicians pointed out that every year there is a rally of a couple of hundred abortion protestors on the anniversary of *Roe v. Wade* who parade to New Woman. Only a dozen or so supporters come out, even in liberal Birmingham: "I think there are more who are not anti-abortion, who think it should be legal, but they will not come out and stand on the corner."[387]

"Stigma outside of the medical community is also common in the South.[383] The presence of protestors serves to reinforce the secrecy around obtaining or providing an abortion.[384]" - Tuscaloosa clinic administrator

Bienville Square, Mobile



Pennsylvania Information

Demographics: The state population is 12,448,279.[388] Pennsylvania is 30th in state poverty rankings, with 11.6 percent of its population living below the poverty level.[389]

Pregnancy and abortion: 19.4 per 1,000 women aged 15–44 obtained abortions in Pennsylvania in 2005, representing 16 percent of all pregnancies in the state that year.[390]

Selected state law restrictions on abortion:

- 24-hour mandatory delay and biased counseling law that requires mandated information be provided by a performing or referring physician.[391]
- Any medical facility providing abortion must be approved by the state as an abortion facility;[392] abortion facilities must meet additional administrative, professional, patient testing, and physical plant requirements.[393]

PENNSYLVANIA

Key Findings

Pennsylvania abortion providers struggle with the scarcity of physicians, severe anti-abortion activity, and the heavy burdens of the Abortion Control Act. The Center for Reproductive Rights interviewed twenty-one providers at seven clinics in six locations and thirteen women in four locations. Despite the size of the state and the relatively large number of providers, Pennsylvania is reliant on a dozen clinics concentrated primarily in two areas of the state. Services are limited, as several clinics only provide abortions one day per week and others rely on only two or three physicians. Most clinics in the investigation experience intense harassment and intimidation and have a history of severe activity.

Fear and stigma resulting from routine protests deter physicians from providing abortion services. A 24-hour mandatory delay and biased counseling law frequently requires two visits for women seeking abortions, despite the resources expended by providers to reduce its effects. This obstacle for women is enhanced by the scarcity of providers in the state and the long distances women travel, particularly in the western region.

Availability of Abortion Services and Medical Community Stigma

About a dozen freestanding clinics in Pennsylvania provide the majority of abortions in the state. These are unevenly distributed; the clinics are largely concentrated in the Philadelphia area and southeast, and in Pittsburgh in the western part of the state. As a result, women travel great distances to obtain an abortion. For example, women go to Allegheny Reproductive Health Center (Allegheny Repro) in Pittsburgh from Harrisburg, eastern Ohio, New York (there are no providers between Pittsburgh and Buffalo), and West Virginia.[394] One woman interviewed at Allegheny Repro, a college student, traveled three hours from State College, Pennsylvania, where

WE'RE WHORES. UNTIL THEIR DAUGHTER GETS PREGNANT, THEN WE'RE HEROES; AFTER SHE'S NOT PREGNANT, WE'RE WHORES AGAIN - Pennsylvania doctor

there is a clinic that is not providing because it does not have a doctor.[395] Allegheny Repro is also the only practice in the area, outside of the hospital, that provides second-trimester abortions.[396]

In Philadelphia, Philadelphia Women's Center (the Women's Center) takes patients that other clinics in the area do not serve, including women 16- to 22-weeks pregnant, those with no financial resources, and patients with complex mental or physical health problems.[397] Women in later stages of pregnancy travel farther to get to the Women's Center than other patients.[398] Moreover, many of the smaller clinics, such as several of the Planned Parenthood clinics in Reading, York, West Chester, and Warminster provide abortions only one day per week.

All the providers interviewed for the investigation, representing seven clinics, were concerned with the scarcity of physicians. Some clinics, like York Planned Parenthood, have no local physicians.[399] Reading Planned Parenthood has one physician who provides surgical abortions and is shared with the Allentown and Trenton, New Jersey affiliates.[400] He drives three hours each way to work in Reading.[401] The lack of available doctors also affects the ability of some clinics to obtain a transfer agreement with a hospital no more than 30 minutes away, which is required by law.[402] The York and Warminster Planned Parenthood clinics are both in the precarious position of relying on a single person to sustain this relationship.[403] As the CEO of the affiliate that includes Warminster commented, "[the doctor] is not a youngster. When he gets too old, we won't have anyone. It's not inconceivable that we'd have to shut down for some time."[404]

The scarcity of doctors is attributed to the lack of trained physicians, fear of the negative impact of protestors on personal safety and private practices, and stigma derived from anti-abortion activity. Allegheny Repro has three physicians, each performing abortions one day per week. When one physician died unexpectedly in the past year, it was very difficult to find a replacement: "Young physicians don't even know how to perform abortions … maybe they performed five during their residency …"[405] A doctor concurred: "There are fewer and fewer physicians doing abortions in the city of Philadelphia, there's a handful, seven at most, who do abortions on a regular basis. I don't think it will change. … I think there would be a big void to fill if I stopped now. I'm sure there are people willing to step in, but they are not as experienced as I am."[406] He cited protests and personal safety as key factors: "Let's face it, there are physicians who have been killed. It's not just the inconvenience of protestors."[407] The Women's Center has two physicians; the clinic faces difficulties in staffing because they provide second-trimester procedures and it is difficult to find someone with the necessary surgical skills.[408]

Such stigma against abortion in the medical community is widely perceived by clinicians. It deters potential providers and further marginalizes those who do provide abortion services. One physician said, "It's like 'don't ask, don't tell' … It's not considered mainstream medicine."[409] Another doctor agreed: "I think, physicians in general, it's something they prefer not to talk about: they're uncomfortable or they don't want their [practice] group to know they're pro-choice because they'd be upset."[410] On paper, medical associations are supportive, but in practice they shy away from the issue of abortion; the county medical association in Pittsburgh has donated to anti-choice groups.[411] A physician who has performed abortions since 1966 put it bluntly: "We're whores. I worked in a hospital for 30 years, I was the busiest gynecologist there … No family practice doctor ever referred a patient to me for a hysterectomy or a cyst on the ovary. … Until their daughter gets pregnant, then we're heroes; after she's not pregnant, we're whores again. They sent me their daughters, sisters, wives [but not their patients]."[412]

Harassment and Intimidation

Although there are more providers in Pennsylvania than in some other states, all seven clinics in the investigation have a long history of anti-abortion activity by abortion opponents and are currently protested at least on the days that they provide abortions.

Three of the seven clinics—the Women's Center, Warminster Planned Parenthood, and West Chester Planned Parenthood—experienced complete obstructions of clinic entrances in 2007. In November, the Women's Center was blockaded by Operation Rescue to mark the 20th anniversary of a city-wide blockade.[413] One hundred abortion opponents blocked the street with vehicles, including an ultrasound mobile, and barricaded the front door and emergency exits by sitting in.[414] Police locked staff in and out of the clinic and patients could not be attended to for three hours.[415] Clinic staff even brought patients into their cars to keep warm.[416] Because the clinic had been assured by police that access would not be a problem, patients started two-day abortion procedures on the Friday before the Saturday of the blockade.[417] The director of clinic affairs described sitting in the back of a police car keeping warm a minor who was 21 weeks pregnant, bleeding, in the middle of the abortion process and unable to get into the clinic.[418] (See box: *The Failure of Police Response: The Experience of Philadelphia Women's Center.*)

The steady intimidation and harassment from protestors mushrooms on Saturdays and during staged events like the "40 Days for Life" campaign. Allegheny Repro has several hundred protestors on Saturdays, including busloads of college students.[419] They try to block women from entering the clinic, including by putting their arms around women and hanging on to them; they also stand on a nearby corner and misdirect cars away from the clinic.[420] In York, large groups of protestors directly harass clinic staff[421] and are aggressive towards the police. They have taken video; pushed, shoved, and elbowed patients; and conducted a "rolling blockade" by stepping one after the other in front of someone seeking to enter the clinic, creating "an obstacle course."[422] At West Chester Planned Parenthood and the Women's Center, protestors yell homophobic and racist slurs,[423] as well as threats, to people they believe to be staff: "'You're a pig;' 'You deserve to die.'"[424] In September 2008, at the Women's Center, a protestor took photos of patients and escorts and told them, "You won't be smiling on your deathbed."[425] If the police are absent, protestors always try to get upstairs into the clinic.[426] In November 2008, the Women's Center and the two Planned Parenthood clinics in Philadelphia that provide abortions had their doors disabled and stuck closed with spray foam insulation.[427]

Clinics that have buffer zones are able to physically separate protestors from patients and staff to some degree. Pittsburgh has a buffer zone ordinance requiring protestors to stay 15 feet away from the clinic entrance. Although it has made a difference, protestors test its limits.[428] About twice a month the police are called and read the buffer zone ordinance (as provided by the clinic) to the protestors.[429] In West Chester, the clinic has a parking lot in front of the building that is private property, so the protestors are confined to a strip of sidewalk along the street.[430] This has not prevented all contact, however; within the past few years, a protestor with a concealed weapon pushed an escort down, breaking his wrist. The aggressor was eventually taken into custody by the police.[431]

All clinics in the investigation take security measures. Nearly all the clinics have volunteer escorts and four Planned Parenthood clinics (York, Reading, West Chester, and Warminster) employ off-duty police officers as security guards.[442] Two clinics, York Planned Parenthood and the Women's Center, have a staff person or volunteer dedicated to coordinating security matters. In York, the security coordinator manages a team of 15 volunteer escorts.[443] A dozen cameras are mounted around the building.[444] Video taken by the clinic has been used as evidence against protestors in lawsuits that the protestors have brought against the city.[445] All the windows on the first floor are bricked closed to increase safety.[446]

Efforts to provide security to staff and patients at the Women's Center have been costly: at least 2,000 hours of management time over the last two years, plus opportunity costs and financial outlays.[447] Despite a huge investment of resources, the clinic has not been as effective as it would like: "[T]he anti-choice

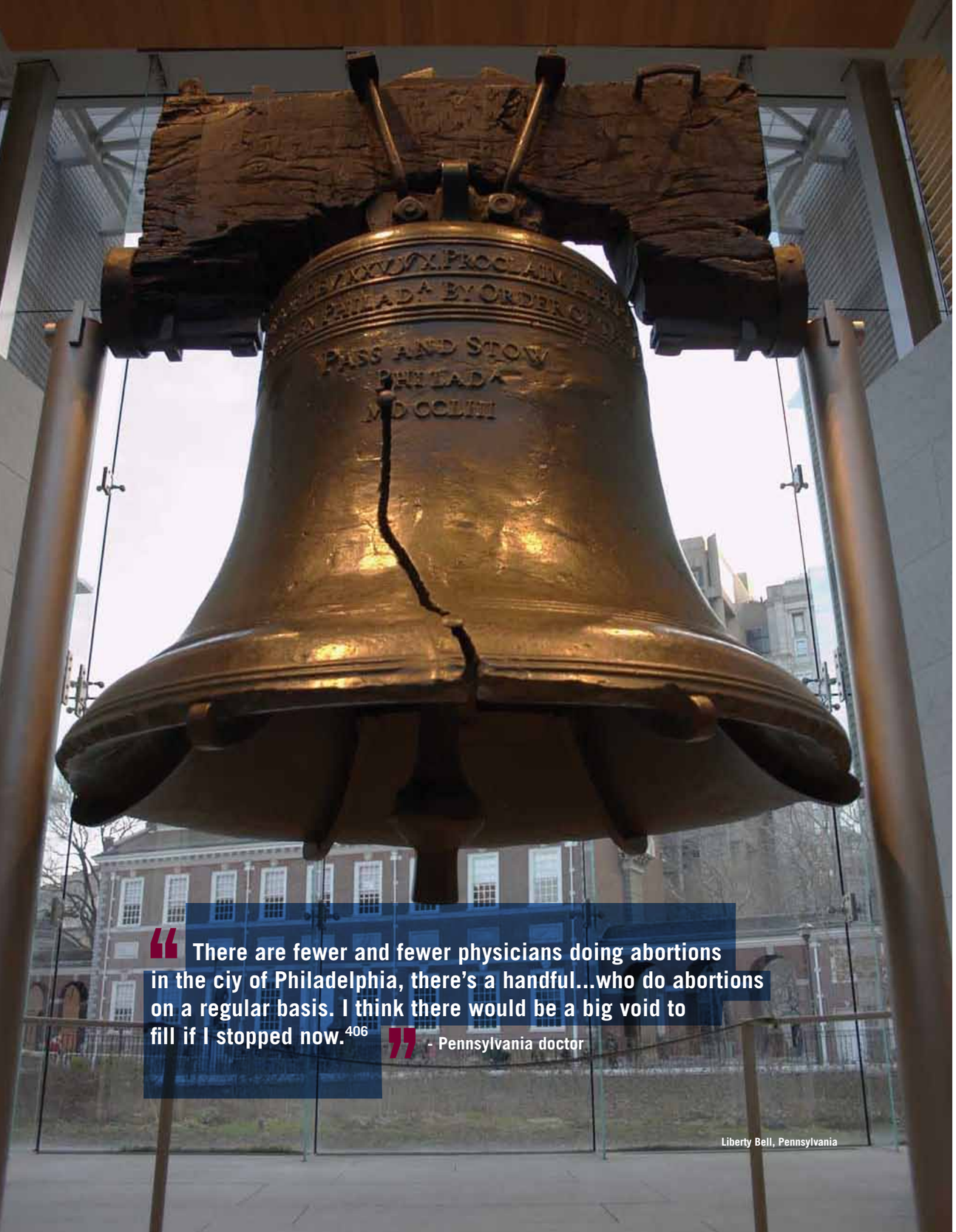
INVESTIGATIVE SPOTLIGHT

The Failure of Police Response: the Experience of the Philadelphia Women's Center

Staff members at the Women's Center are frustrated by the police response to the serious anti-abortion activity at the clinic. After the police failed to protect the clinic during the 2007 blockade, the clinic and the police established specific liaison relationships and held many informal and formal meetings, but nothing has changed. The police keep the peace on Saturdays, enforce the private property boundaries, and keep staff from having to engage directly with the protestors.[432] But the police's lack of response to threats against clinic workers frustrates staff members, who feel that they have no recourse.[433] One said, "I don't feel confident that, if [a blockade] happened again, they would respond better."[434]

The Women's Center director attributes heightened protestor activity since the blockade to the failure of the local police to curtail the protestors' lawbreaking.[435] "One of the problems is that it has become normal … They are frustrated when we call, they want us to just deal with it."[436] Police officers have told staff that harassment and other activities of abortion opponents are part of their work as abortion providers and they should feel lucky to be there at all.[437] "We're not the ideal victim—there are some victims you want to help and some you blame, and they blame us."[438]

The Women's Center has been working with the Women's Law Project, a legal organization specializing in women's rights, for three years to obtain a buffer zone modeled on the one in Pittsburgh. They believe that the new law would overcome the police's claims that it is not their responsibility to enforce FACE.[439] The Women's Center director believes that what is needed is a "changing of the guard" in the responsible division of the police department and a public conversation around women's and provider's stories, "so that [they] are not so easily dehumanized and vilified."[440] Community stigma around abortion permits the police to allow harassment and intimidation to take place at the clinic with impunity—"because in most people's work, if this occurred, stuff would happen."[441]



“There are fewer and fewer physicians doing abortions in the ciy of Philadelphia, there’s a handful…who do abortions on a regular basis. I think there would be a big void to fill if I stopped now.[406]”

- Pennsylvania doctor

Liberty Bell, Pennsylvania

movement has a lot of energy, people, time, money, and consistency, and our primary focus is seeing patients and not fighting off protestors. … and part of it is that the Philadelphia police have not done an even basic job of enforcing the law.”[448]

While staff primarily report concern for patients and frustration with protestors, several clinics have lost or been unable to hire workers because of the strain of having to cope with harassment and intimidation. One staff member in Reading would call from across the street to the clinic to arrange for someone to meet her at the door so that she would not have to confront the protestors alone.[449] Staff in York are affected by slurs, including “racial, weight, and homophobic epithets, they criticize anything they can think of.”[450] In addition to security measures, anti-abortion activity costs clinics in other ways. At the Women’s Center, it is a frustrating distraction and a drain from providing high quality patient care for staff to spend so much time and energy dealing with the protestors and counseling patients affected by them. [451] One staff member commented, “You never know what you are going to come to when you go to work and is that okay?”[452]

Many patients are upset by or fearful of encountering the protestors. A woman interviewed in York described her apprehension: “I thought they would be farther away. I didn’t realize they’d be in my face.”[453] Allegheny Repro staff reported that some women have left the clinic, deterred from getting abortions by the presence of protestors.[454] A staff member at York Planned Parenthood made a similar observation: “I’ve seen patients driving down the street; the protestors yell at them [in] the car. They don’t come in because they’re so freaked out.”[455] Some women may eventually return to the clinics, but by then, they are often either past the gestational limit or unable to afford the additional expense of the procedure.[456] A nurse expressed her frustration that patients are influenced by the “misinformation” given to them by abortion opponents; for example, protestors have claimed that a 35-week-old fetus in a photograph was much younger to frighten the patients.[457] One patient at Allegheny Repro, a 22-year-old mother of one whose cousin works at the clinic, said, “Protestors make you want to kill yourself when you leave.”[458]

“The doctors are the bravest, I think. I don’t think the protestors want me. I could be wrong, but I don’t think that I’m their target.[459]”

- Philadelphia clinic staff member

Several physicians interviewed experienced targeted harassment, threats, and vandalism by abortion opponents. One physician who has been extensively protested at his residences takes a number of precautions.[460] He parks away from the clinic to prevent the tracking of his address through the motor vehicle

registry. He has an unlisted phone number. He owns a bulletproof vest. He feels that he is being stalked, as he has moved from town to town followed by the protestors. When the vandalism started, it "made me feel like I don't know what they will do."[461] He has notified the local police about the activity, but the authorities have said there is nothing they can do as long as the protestors do not trespass or become violent. One police officer said, "That's what you get for what you do."[462] Another doctor curtails her practice, providing only medication abortion for fear of her young children and family being targeted by protestors.[463] A third physician does not feel like the police can protect him because "they can only respond, they can't initiate, or they would be in court."[464] A doctor who built security features into her new house stated, "It really pisses me off. I'm a physician. I should not have to live like this."[465]

Legal Restrictions on Abortion

Pennsylvania requires abortion providers to observe the 24-hour mandatory delay and biased counseling provisions of the Abortion Control Act. These restrictions have enormous implications for allocation of clinic staff and often damage the physician-patient relationship.

Although a woman's own physician could provide the counseling, most patients do not feel comfortable discussing abortion with their doctors, so they call the clinic.[466] The Women's Center staff report that they receive feedback from some patients indicating that patients blame them for the requirement.[467] One physician believes that private physicians are deterred from providing abortion by the burden of the process and the stigma engendered by the 24-hour requirement.[468] Another pointed out that the mandatory information is already a required part of obtaining informed consent, as legally mandated for any medical procedure: "it just binds our hands of how we have to say it."[469] She noted that it is not necessary for a doctor to provide this information and that physicians can delegate this duty for more complicated medical procedures than abortion.[470]

In order to ameliorate the effect on patients, clinics variously offer a telephone appointment with a doctor or an in-person group meeting or video viewing to comply with the restriction. At Allegheny Repro, while the clinic has an in-person video option, two physicians take calls from women for an hour and a half twice a week to satisfy the requirements,[471] allowing most women who live a significant distance away to avoid two visits to the clinic.[472] The volume of women calling, however, may result in busy signals; women may also be unable to make the call during the available times.[473] The clinic is often forced to reschedule abortion appointments so women can comply with the 24-hour delay,[474] or to turn women away, some of whom do not come back.[475]

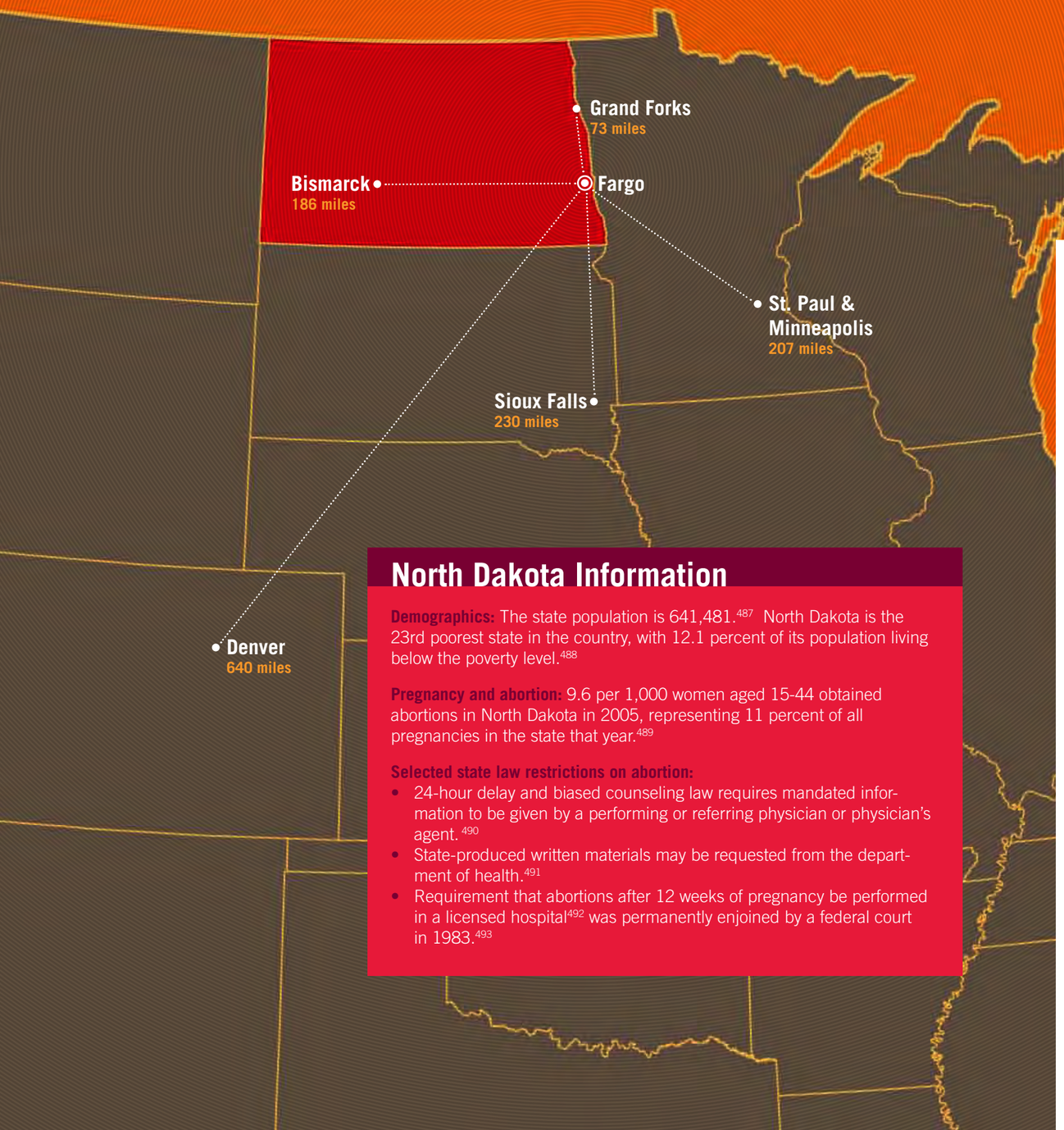
Even clinics that attempt to make the required visit meaningful and useful to women report that many patients face increased costs, stress, travel, and delay due to the restriction and may delay the abortion for a significant time, or forgo it altogether, as a result. "It always seems to be a time-sensitive issue, a ticking time bomb … it adds to a chaotic [atmosphere] that has no place in healthcare."[476] The lack of providers and the restricted provision schedules of some clinics, together with the mandated waiting period, can delay women for a significant period of time: "So, if a patient comes in on Monday, at 10 weeks, four days, and our Friday is full, now she'll be too far along [the clinic's limit is 12 weeks]. If she could have had it that day, it would've been fine."[477] The most vulnerable women are harmed the most (see box: *Mandatory Delay Harms Vulnerable Women*). The administrator of the Women's Center commented on the negative effect of interrelationship of the stigma surrounding abortion and the waiting period on women: "Patients A, B, and C are just inconvenienced, but in the big picture, somehow it contributes to the idea that you are doing something wrong. … I think that's very harmful."[478]

INVESTIGATIVE SPOTLIGHT

Mandatory Delay Harms Vulnerable Women

Young women's rights are particularly undermined by mandatory delays. They are often farther along in their pregnancies when they come to a clinic, and they have less access to transportation and financial resources.[479] Women who are seeking second-trimester abortions, or later abortions due to fetal anomalies or for genetic reasons, are also more severely harmed.[480] Some women will go to New Jersey or New York to avoid the restriction.[481] One physician characterizes the restriction as one of the "roadblocks for safe and early abortions."[482] The Women's Center director reports that it is very common for women to be delayed for two weeks, particularly single mothers who can only come to the clinic once in a given week.[483] Women with limited financial resources and rural women also struggle for a longer period,[484] since having to obtain childcare, time off work, and transport for two days is a particular hardship.[485] Some women "trade their physical safety for access to abortion," as in the case of two women living in a shelter who were pregnant by their abusers; leaving the safe house twice to go to the Women's Center was both dangerous and frightening for them.[486]

NORTH DAKOTA



North Dakota Information

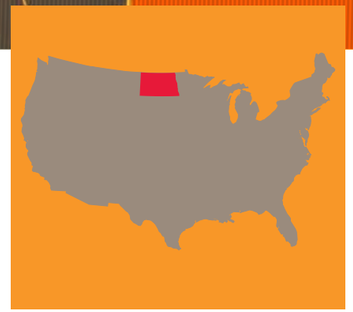
Demographics: The state population is 641,481.[487] North Dakota is the 23rd poorest state in the country, with 12.1 percent of its population living below the poverty level.[488]

Pregnancy and abortion: 9.6 per 1,000 women aged 15-44 obtained abortions in North Dakota in 2005, representing 11 percent of all pregnancies in the state that year.[489]

Selected state law restrictions on abortion:

- 24-hour delay and biased counseling law requires mandated information to be given by a performing or referring physician or physician's agent.[490]
- State-produced written materials may be requested from the department of health.[491]
- Requirement that abortions after 12 weeks of pregnancy be performed in a licensed hospital[492] was permanently enjoined by a federal court in 1983.[493]

Key Findings



There is only one abortion clinic in North Dakota, the Red River Women's Clinic (Red River). The Center for Reproductive Rights interviewed eight staff members, three doctors who work at the clinic, and six women seeking abortions. Stigma, harassment and intimidation of doctors in North Dakota are so great that the clinic lacks local physicians and all four part-time doctors travel from out of state. The history of violence in Fargo by abortion opponents also contributes to this scarcity.

Abortion availability is a significant obstacle to women's access to services in North Dakota. Red River, located in Fargo, provides abortions only one to two days per week, and covers an extensive geographic area comprising all of North Dakota and parts of surrounding states. Despite an active anti-abortion legislature, Red River is able to operate in this environment because of the commitment, ingenuity, and resourcefulness of its leadership and staff. Key factors to the clinic's continued viability are a roster of security measures, the shielding of doctors from harassing encounters, the adaptation of operations and expenditure of resources to reduce the effects of the mandatory delay/biased counseling law on patients, and vigorous efforts to maintain a sound relationship with local police and businesses.

> "The harm to doctors and providers is a human rights issue. Controlling the number, the timing of children is a basic human right.[494]" - Fargo clinic administrator

Availability of Abortion in North Dakota

Red River has been the only provider in the state since February 2001, when the Fargo Women's Health Organization (Fargo Women's) closed.[495] Finding physicians to work in the clinic has been a major obstacle.[496] The clinic has four physicians who fly in from the Twin Cities or Denver; one retired in May 2009, another is shared with Planned Parenthood in Sioux Falls, and a third only fills in for absences of the others. They have never had any local physicians. "There are a handful of doctors in this area who have served this area—North Dakota, South Dakota, Minnesota."[497] Jane Bovard, co-founder and co-owner of the clinic, who has worked in abortion services in Fargo since 1981, identified two reasons for this: 1) a medical community model where most doctors work in large clinics attached to hospitals and need board approval to take on other work; and 2) physicians' fears, in this small community, that they would be harassed at their homes and offices by protestors.

Protestors have been very visible at the clinic, at Jane Bovard's house, and in the local media for many years. Picketing may have both direct personal and family consequences on physicians and potentially devastating financial impact on a practice if it is boycotted.[498]

Women typically come to Red River from a five- to six-hour radius, including parts of Minnesota and South Dakota.[499] Many have limited financial resources. Because the clinic is the sole provider in North Dakota and offers abortions only one or two days each week, women typically have to wait one to two weeks for an appointment.[500] Were the clinic to cease performing abortions, all interviewees stated that the harm would be dire, even unimaginable. Women would travel up to eleven hours to Minnesota,[501] attempt to self-induce,[502] or carry to term.[503] "It would be a step backward for women."[504] This would compound a situation where distance and travel, lack of financial resources, and the need to evade stigma through secrecy are already a source of delay for women, who may not know how advanced their pregnancy is as they are making arrangements to obtain an abortion.[505] As it is, some women have come to the clinic past the gestational limit and have had to organize yet again to go somewhere else.[506]

Harassment and Intimidation

There are abortion opponents at the clinic every day on which abortions are performed. While blockades and violence have dramatically decreased in Fargo, the history of clinic violence influences staff vigilance and the measures taken to protect physicians, staff, and patients (see box: *The Legacy of Clinic Violence in North Dakota*). The clinic is in a commercial neighborhood of Fargo; a green carpet slightly larger than a doormat demarcates clinic property from the public sidewalk. A sign on the door states that trespassing onto the mat is a federal crime.

There is only one abortion clinic in North Dakota, the Red River Women's Clinic in Fargo.

Since mid-2007, protestors at the clinic have become louder and more aggressive, getting in the way of patients and calling the police and making up complaints, such as claiming there is an unaccompanied minor in the clinic.[507] For the most part, protestors are a core group of regulars with changing leadership, augmented at least once per year in the fall by a larger group at events such as the "40 Days for Life" campaign in 2007 and 2008, and by massive prayer demonstrations put on every year by the Catholic Church.[508] The clinic's administrator reports, "They all know my name and who we are. …It's the unfamiliar faces that are concerning."[509] Usually protestors sing, pray, try to engage patients with pamphlets and conversation, berate staff for working at the clinic, insult women, and try to dissuade them from having abortions. One has taken pictures from a corner near the clinic and put police crime scene tape around the building to keep patients from coming in;[510] protestors have also stood on the green mat and held the front door open, which prevented the clinic from buzzing patients inside.[511]

INVESTIGATIVE SPOTLIGHT

The Legacy of Clinic Violence in North Dakota

In the early 1990s, Fargo Women's was subject to a series of clinic invasions and extreme actions by the Lambs of Christ to block clinic access, including bicycle chaining and using 100-pound cement blocks to secure protestors at the entrances to the clinic, and welding protestors inside a station wagon containing heavy appliances as a blockade.[512]

Lysa Ringquist is an operating room assistant at Red River who worked with Fargo Women's for 10 years before Red River opened. Discussing an incident of harassment of Jane Bovard some years ago she said, "It scared me because the clinic was being firebombed—it makes me sad, it was really scary…" She then broke into tears. "The ATF [federal law enforcement agency] had to come in and teach us not to put scrubs on before going in, to keep an eye on the mirrors [while driving]—we still use those tips and tricks."[513]

Red River has largely been free of the violence and extreme events to which Fargo Women's was subjected. Long-term staff who worked at both clinics attribute this to the differences made by the passage of FACE before the clinic opened, which reduced the number and gravity of incidents by the protestors;[514] the location of the clinic on a downtown street, which "makes the protestors more visible, and they're seen as outlandish if they try to do the same tactics;" a change in police attitudes dating to the blockades at Fargo Women's; and the local business association, which is vigorous in encouraging the enforcement of sign and noise ordinances.[515]

Nevertheless, the legacy of the violence colors the effect of protest on both staff and patients; some of the latter "think of the '90s, when the Lambs of Christ were here … I try to reassure them that it's usually not a mob."[516]

The clinic's security is a product of the lessons learned from the experiences of Fargo Women's.[517] The clinic has an interior locked door at the bottom of a stairwell and patients and visitors must have an appointment, identify themselves, and be buzzed in. This is to prevent clinic invasions; the last one was four or five years ago.[518] The clinic has an alarm system and security cameras and a stun gun is kept at the front desk.[519] The building is sound-proof and there are no windows.[520] During the "40 Days for Life" in 2008, the clinic solicited volunteer escorts from the community and hired a head escort.[521] The escorts have been so successful in terms of protecting and reassuring patients (and staff) that they have continued after the end of the anti-abortion campaign.[522]

In order to feel safe from protestors, physicians take steps to safeguard their identities and contact information, such as having post office boxes and unlisted phone numbers. A clinic staffer picks up each doctor at the airport and brings her into the clinic: "I always look up, I always look around to see who could be a sniper on the building. It made me realize that I would jump right in front of the doctor. It scares me to this day … [i]t's the lives of the doctor[s]."[523] One doctor reported that, although the aggressiveness of anti-abortion activity—and the consequent real and perceived threat of violence—has decreased over the years, she did still feel it. "I have a new bulletproof vest … just the fact that I have it."[524]

Legal Restrictions on Abortion

Red River has survived the constant onslaught of barriers by fighting or finding solutions to obstacles to provision, and in being willing to take on additional burdens to ameliorate the effects on women's access to services. Along with Fargo Women's, the clinic has challenged laws restricting abortion, resulting in changes that have made the laws a little easier to implement and less onerous for patients. Jane Bovard commented, "In a way North Dakota being a testing ground [for restrictions] is bad, but it's also good because they pass laws before they get savvy about it." The clinic's reputation for compliance is protective—"We've turned women away if we think we can't comply."[525] On the other hand, an anti-abortion legislature means that "[w]omen's voices are squelched. We need to hear more on women's healthcare and access to healthcare without interruption. We have legislative work to do."[526]

When it first passed, the mandatory delay and biased counseling law was challenged by Fargo Women's as unconstitutional; though this challenge failed, the federal appeals court agreed with the state Attorney General that the mandated information could be given over the phone.[527] The restriction nevertheless requires the hiring of an additional full-time staff person[528] and causes a week's delay for patients who call within 24 hours of the once-weekly abortion session.[529] Everyone agrees that there is no medical reason for the restriction. The purpose of the law is to interfere with women's decision to have an abortion, harass them,[530] and force them to defer obtaining the procedure: "You have to have all your ducks in a row to get here … There's only a

certain amount of time in pregnancy to do this."[531] One physician noted some women end up passing the gestational limit for the procedure.[532] She said, "It boils down to the same thing—the determination of women and the dedication of doctors. Those who propose [restrictive] laws are against abortion in any way, shape, or form."[533]

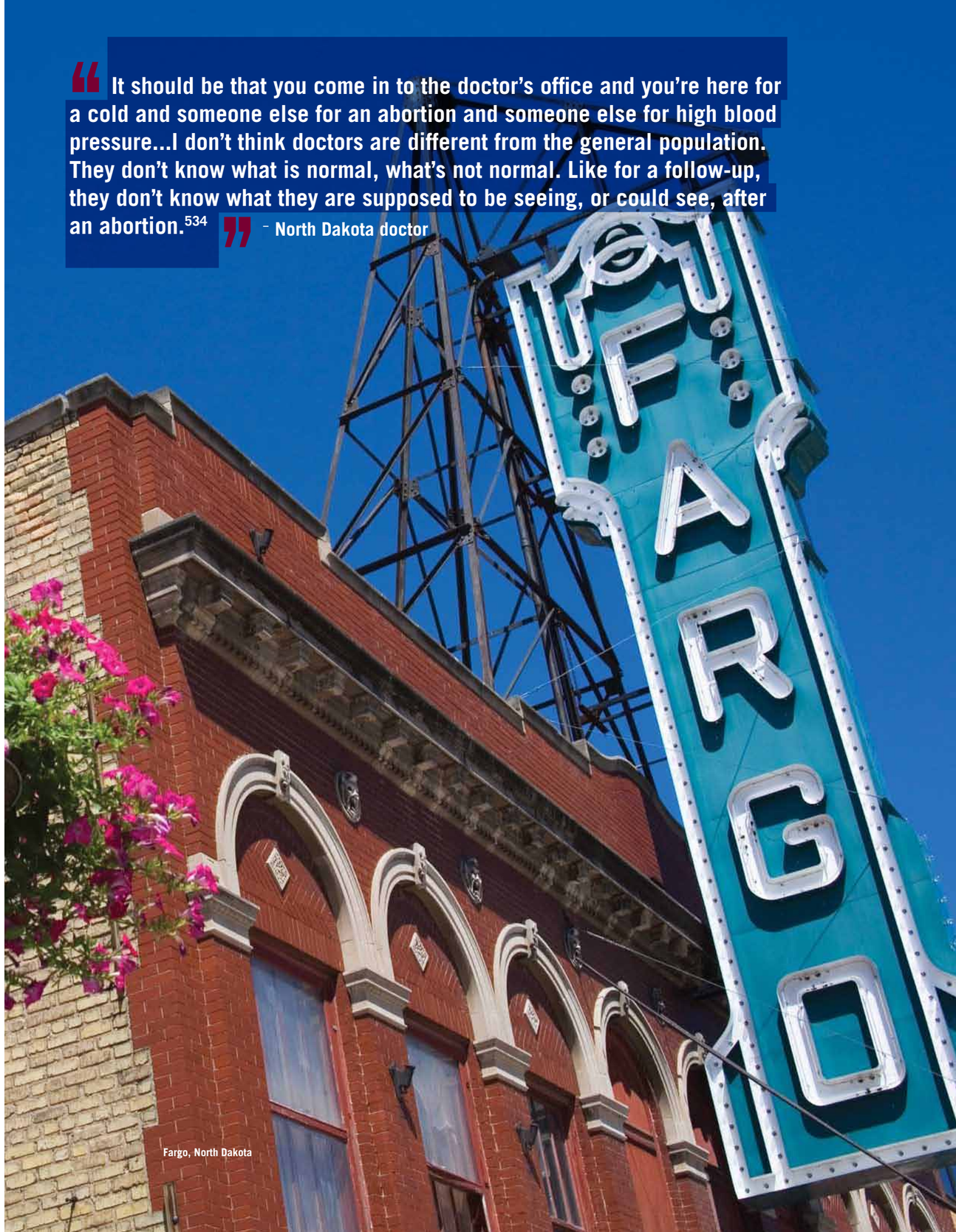
Stigma Surrounding Abortion in the Medical and General Communities

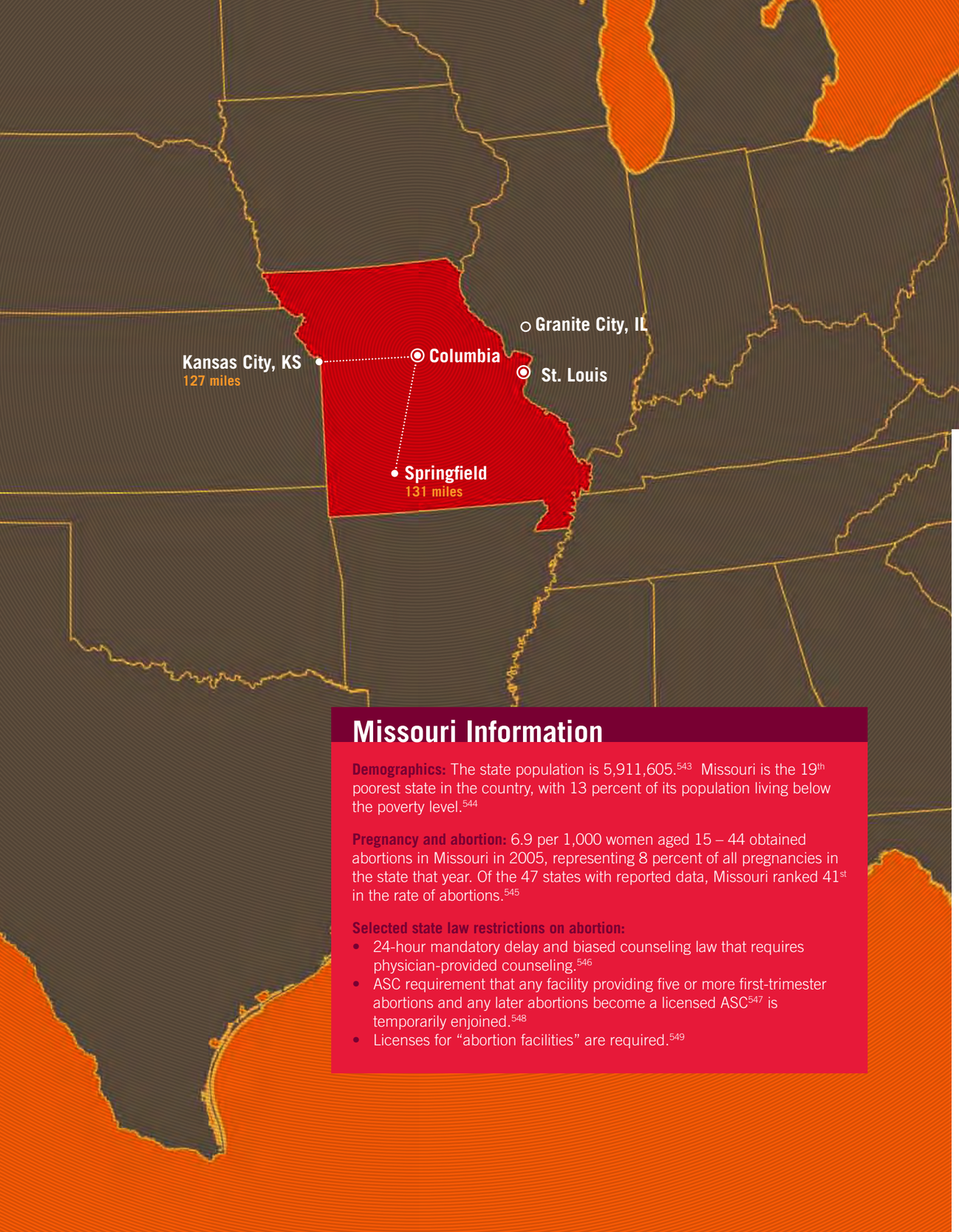
Pervasive and persistent stigma around abortion exist in both the medical and general communities in North Dakota, producing a scarcity of providers, creating reluctance in some staff to disclose where they work, and largely silencing those who support abortion rights. One physician attributes stigma in the two communities to the same source:

"I think it's the unknown. … Abortion is not part of healthcare, it's not done by your own doctor, women have to travel and go to special clinics. It's something different, it's not mainstream, it's isolated. It should be that you come in to the doctor's office and you're here for a cold and someone else for an abortion and someone else for high blood pressure. The idea of it not being healthcare, not being common--which it is. The idea that it's unsafe--which it isn't. When it's in the news, it's something bad has happened, which is actually rare. I don't think doctors are different from the general population. They don't know what is normal, what's not normal. Like for a follow-up, they don't know what they are supposed to be seeing, or could see, after an abortion."[534]

In addition to fear of community reprisal, practice partners' refusal to allow the provision of abortion is another obstacle that deters physicians from providing services.[535] One of the women interviewed pointed out that her physician is pro-choice but is unable to prescribe a medication abortion for her because "his hospital directors look down on this."[536]

Interviewees see a mix of views on abortion in Fargo, and to a lesser extent, in the rest of more conservative North Dakota. Everyone interviewed thought there is some community support in and around Fargo for the clinic itself—expressed by cards, letters, the range of people volunteering as escorts, donations, state and local women's networks, a student pro-choice group on one university campus, and "the fact that we're still here."[537] Several felt that there is significant support, but that it was silent because of widespread social stigma:[538] "A woman, in her 50s, drove up during the '40 Days' and gave a $50 check; she said, 'I'm part of the silent majority.'"[539] Because abortion opponents are so loud, those who support abortion feel isolated and alone in their support;[540] "[f]rom this region, you feel you have to be in the closet."[541] The lack of visible support fails, therefore, to counter the very visible anti-abortion protestors.[542]





MISSOURI

Missouri Information

Demographics: The state population is 5,911,605.[543] Missouri is the 19th poorest state in the country, with 13 percent of its population living below the poverty level.[544]

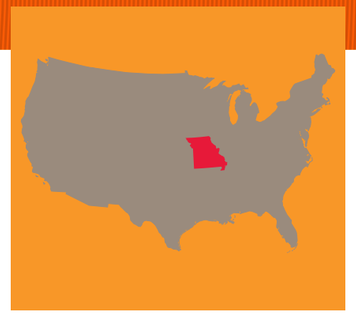
Pregnancy and abortion: 6.9 per 1,000 women aged 15 – 44 obtained abortions in Missouri in 2005, representing 8 percent of all pregnancies in the state that year. Of the 47 states with reported data, Missouri ranked 41st in the rate of abortions.[545]

Selected state law restrictions on abortion:

- 24-hour mandatory delay and biased counseling law that requires physician-provided counseling.[546]
- ASC requirement that any facility providing five or more first-trimester abortions and any later abortions become a licensed ASC[547] is temporarily enjoined.[548]
- Licenses for "abortion facilities" are required.[549]

Key Findings

As a result of legal restrictions imposed on Missouri by an active legislature, and the deterrent effects of intimidation and persistent stigma, women in Missouri depend on only two clinics and one private practice for abortion services. The Center for Reproductive Rights interviewed twelve staff and physicians and three women at the three providers. Two providers are on precarious footing, in large part due to the state's ASC law, which is temporarily enjoined with respect to all three. Should it take effect, Missouri could have one remaining abortion clinic.



Because of the stigmatization of physicians who provide abortions in the medical community and the ongoing threat of intimidation, administrators at two of the clinics (including the largest and the only second-trimester provider) rely on medical residents and volunteer doctors to provide services. Economic pressures, linked to stigma, also deter physicians from performing abortions. Harassment and intimidation are particularly acute at Planned Parenthood in St. Louis, requiring a consistent outlay of scarce resources to decrease the harms to patient access and staff morale.

Availability of Abortion in Missouri

Three abortion providers serve Missouri and the surrounding states: Planned Parenthood in St. Louis, Planned Parenthood in Columbia, and a private pratice outside of St. Louis. All three provide healthcare services in addition to abortion.

St. Louis Planned Parenthood serves women from hundreds of miles away in at least half a dozen states, in part because it provides second-trimester procedures.[550] Columbia Planned Parenthood serves women "from every direction," including many from three to four hours away in Springfield, Missouri, and Arkansas.[551] This is primarily because it is the closest provider, and despite the fact that women have to wait a minimum of nearly a week for an appointment because the clinic provides only one evening per week and the schedule is almost always full.[552] The third Missouri provider is a solo gynecologic practice with one physician; women come from all over the state and Illinois for abortion services.[553]

PEOPLE THINK THERE ARE CERTAIN CASES WHERE [ABORTION] SHOULD BE LEGAL BUT WOULD RATHER NOT KNOW ABOUT IT OR HAVE ANYTHING TO DO WITH IT – Missouri doctor

There is a shortage of physicians willing to provide abortions in Missouri. The sole physician at the only private practice actively providing abortions in the state is 69 years old.[554] Columbia Planned Parenthood relies on a resident at the medical center at the University of Missouri.[555] The clinic has only been able to provide abortion services because medical residents organize themselves to find a provider for the clinic, usually for a one-year stint.[556] St. Louis Planned Parenthood is reliant in part on the residency training program established in the past two years at nearby Barnes-Jewish Hospital at Washington University Medical Center.[557] Their primary providers are part-time at the clinic and at least one travels from out of state. In order to meet the biased counseling requirement for over 6,000 patients a year, the clinic recruits and must accommodate the schedules of volunteer doctors.[558]

If any of the three clinics were to stop providing abortions, the harm would be devastating for women. Hope Clinic in Granite City, Illinois, across the river from St. Louis, would not be able to accommodate the large caseload of St. Louis Planned Parenthood. Poor women, in particular, would be harmed:

"Whenever there are more restrictions, women who have means go and get abortions and the women who are penalized are the women who have very little in terms of financial resources and family support. I take care of a lot of women who come from four hours away and have no car. A friend has to drive them. Or they have a two-day procedure and have to stay overnight and pay for lodging. Later … abortions would be particularly affected—usually women are presenting in the second trimester because they didn't know where to go or they didn't have transportation."[559]

Stigma in the Medical and General Communities

Stigma from local medical and general communities place immense economic, professional, and personal pressures on physicians that deter them from performing abortions.

Physicians fear that being identified as an abortion provider will solicit verbal or physical attacks and picketers, in turn affecting their incomes, careers, and families.[560] One physician at St. Louis Planned Parenthood knows local doctors who are trained in abortion, but choose not to perform them because any association with abortion potentially brings picketing and criticism, which may cause them to lose patients.[561] The solo praticioner, who provides a range of gynecologic services, said that performing abortions has been costly for him because of the damage to his reputation.[562] Only a half-dozen or so colleagues refer patients to him for any procedure. Some doctors in his community will not speak to him: "I'm sure they would interfere with me any way they could, if they could."[563]

One nurse thinks that the lack of providers in Missouri potentially has had a lot do with the stigma of being labeled an "'abortion doctor'" or an "'abortionist.'"[564] Moreover, legal restrictions on abortion create exceptionalism and result in abortion being perceived as sub-standard care and illegitimate. A physician who also works at a local hospital remarked that, "If it was normative, they wouldn't think about it."[565] Over half of the labor and delivery nurses at the hospital opt out of abortion care; "[i]t's not seen as a valid healthcare service the way other things that we do are."[566] A nurse practitioner says flatly, "They perceive it as shoddy care."[567]

Abortion is also stigmatized in the broader population. More than half of those interviewed thought that there was local community support for abortion services where providers were located, in the St. Louis area and Columbia. Several interviewees asserted that the state as a whole, however, is politically and religiously conservative.[568] Most characterized the existing support for abortion services as quiet and less public than the opposition, noting in particular that local Catholic churches in St. Louis are outspoken in opposing abortions. [569] Others were even less positive, remarking that "it's one of those things where people think there are certain cases where it should be legal, but would rather not know about it or have anything to do with it. I think people have a lot of misperceptions about who gets an abortion and why they do. My guess is that in the Midwest, the South, it's worse [than in other parts of the country]."[570]

Harassment and Intimidation

St. Louis Planned Parenthood, the facility that provides the most abortions in Missouri, is the clinic most affected by anti-abortion activity. The clinic has protestors on four to five out of the six days per week that it performs abortions. The clinic has a group of up to a dozen regular protestors, which grows to 50 to70 on Saturdays.[571] One protestor wraps 20–30 large signs around trees, hydrants, and lampposts along the building,[547] in violation of local law. Protestors use bullhorns[573] and walk slowly across the driveway entrance to block access and tell drivers to open the windows so they can hand in literature.[574] On the Saturday closest to the anniversary of the *Roe v. Wade* decision each January, there are typically 400 to 500 protestors led by the local Archbishop.[575]

Protestors know many of the staff by name and title, and know where they live.[576] Several staff described a man who regularly walks beside them quoting scripture and a woman who yells slurs and epithets and takes photos of staff

and of patients' cars.[577] Because of the layout of the facility, which has a separate, gated parking lot for staff across the street, clinic workers can be readily identified by protestors who target them as they walk in, saying that they have "blood on their hands" and remarking "you've got to keep your strength up for killing babies."[578]

Anti-abortion activities at abortion providers have shaken some women's trust in the medical care that they come to receive. At the private practice, patients are scared by the lies that protestors tell regarding the safety, risks, and nature of abortion. Patients have asked if the clinic's surgical instruments are sterilized. One woman wanted to know "'if they were going to stick a knife up inside her.'"[579] Others are intimidated by protest activity[580] and worry about protecting their identities.[581] The surgical center coordinator at St. Louis Planned Parenthood has observed that on some days when there are more protestors, the no-show rate for procedures and counseling goes up.[582] She noted that this can seriously harm women who are on the verge of a fee increase due to increased gestational age, or close to the gestational limit.

Patients may be temporarily deterred or delayed, drive around the block when they see the protestors, call for advice, or reschedule to another day.[583] Routine intimidation and harassment—"a kind of behavior I'm not sure we would find acceptable in other settings, as a citizenry"[584]—also has significant effects on staff (see box: *Intimidation and Harassment: One Staff Member's Experiences*).

Legal Restrictions on Abortion

Missouri's legislature regularly produces new anti-abortion restrictions every year. In the 2009 legislative session, 19 such bills were introduced. One physician remarked that the laws are not only intended to limit women's access to abortion services, but also designed to "intimidate doctors away from providing abortions."[586] These laws achieve this result by creating hoops that are too onerous for providers to jump through, effectively discouraging private practitioners from providing.[587] Additionally, they target and marginalize physicians who provide abortions.[588]

Mandatory Delay and Biased Counseling

One particularly burdensome legal requirement is that mandated counseling must be provided by physicians. An administrator said, "I feel like we are still operationally struggling with it. It takes a lot of extra scheduling of people, extra energy, to figure out how to make it work for patients and for us, and to be in compliance. The building was built for a certain occupancy and now it's doubled with the two visits and we have limited hours of operation."[589] A doctor characterized the restriction as having "enormous impact" and said that the St. Louis clinic serves fewer patients than it would but for this mandate.[590]

Most providers interviewed were vehement in their condemnation of the mandatory delay and biased counseling restriction as a hurdle intended to dissuade women from obtaining abortions. The information a woman should

INVESTIGATIVE SPOTLIGHT

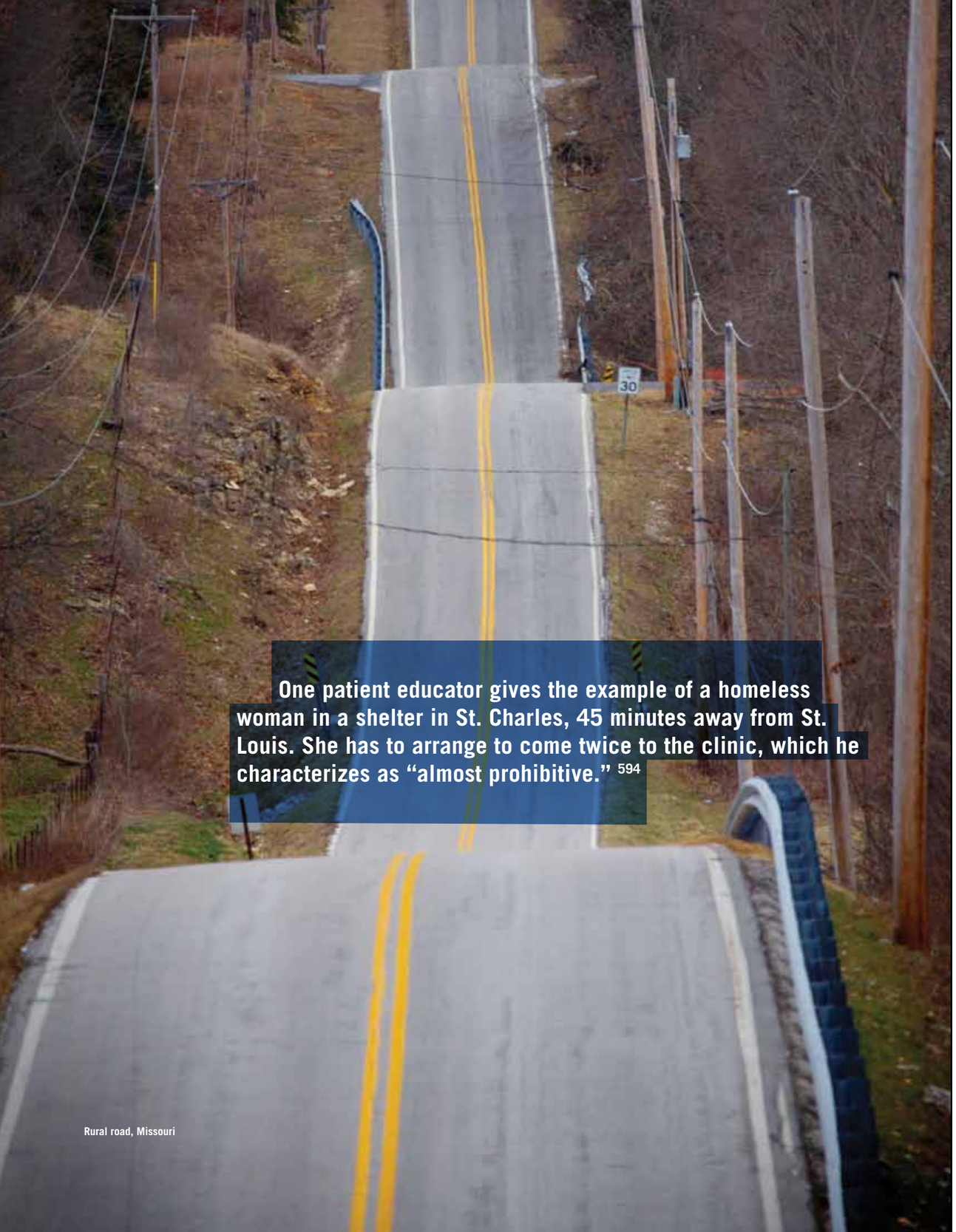
Intimidation and Harassment: One Staff Member's Experiences

"[P]roviding the service and getting up every day and coming here is our way of defending the right [to abortion], even in a small way.[585]" **– Misssouri clinic staff member**

A patient educator and nursing assistant at St. Louis Planned Parenthood has worked there since mid-2007. Previously, he volunteered and then worked at Hope Clinic for four years. He characterizes the protestors at St. Louis Planned Parenthood as hateful, singling him out for being gay and saying "a lot of pretty serious, weird stuff, like 'How many little boys are you going to molest today?'" He prefers that he be accosted rather than the patients, but "the patients still hear that remark and maybe it changes how they look at me or my co-workers." The protestors do affect him: "I value this work so much it's hard to hear them belittle it. It affects you, it definitely sticks with you. [But] knowing they're there never makes me not want to come to work."

The staff member took a six-month break from Hope Clinic after protestors camped outside his parents' house (where he lived), left dead animals there, and threatened his parents' dogs. He pressed charges against a protestor for assault when he was grabbed by the neck at Hope and forced to the ground. Another time, the protestors had him arrested for attempted murder, claiming that he had tried to hit them with his car in an alley leading to the employee parking lot. He was arrested at the clinic but the judge threw out the charge for reckless driving and chastised the prosecution after viewing the security tape. He has been picketed at an ice cream store when he was working alone ("John Doe* kills babies") and followed by the same woman who came to his parents' house. His response to the protestors at Planned Parenthood is usually anger, but sometimes fear: "Are they going to hurt me?"

** The name of the staff member has been changed for his protection.*



One patient educator gives the example of a homeless woman in a shelter in St. Charles, 45 minutes away from St. Louis. She has to arrange to come twice to the clinic, which he characterizes as "almost prohibitive." [594]

Rural road, Missouri

receive to be medically informed is available without the mandatory counseling.[591] According to the St. Louis doctor, who has been performing abortions since 1969, the idea that a woman might change her mind in 24 hours is absurd: "I've never believed women seek abortions on a willy-nilly basis. It's a deeply thought-through and troubling decision."[592]

St. Louis Planned Parenthood attributes an upward trend in the number of mid-first trimester and second trimester abortions at the clinic to the informed consent requirement.[593] The vast majority of women seeking abortions must make two in-person visits. One patient educator gives the example of a homeless woman in a shelter in St. Charles, 45 minutes away from St. Louis. She has to arrange to come twice to the clinic, which he characterizes as "almost prohibitive."[594] A physician pointed out that there are very few providers in Missouri and the Midwest, and there are women who can only travel on the weekends; they must wait a week between the two visits. Delay is routine at Columbia Planned Parenthood because "basically there is a two-hour window on Sunday before the [Thursday] appointment they have to speak with [the doctor, by phone]." As a result of the limited time for counseling appointments, women are delayed almost every week; most reschedule, others travel to St. Louis or Kansas City, Kansas.[595]

Ambulatory Surgical Center Requirement

Missouri is the first state in the country to require that first-trimester abortion providers be licensed as ASCs. There is no medical reason for the restriction, which even applies to medical abortion. Columbia Planned Parenthood's administrator points out that the clinic does not offer sedation or go past the first trimester, when abortion is at its safest.[596] The doctor in solo practice stated, "It doesn't make sense. Anything requiring an ambulatory surgical center will go there. … If you can perform five [abortions] in the office and the sixth one is illegal—it doesn't make sense. We do a lot of surgical procedures in this office, hysterectomies … and they are just restricting one. It seems political."[597]

While the ASC requirement is unnecessary, the cost of meeting it is prohibitively expensive. The private provider would be unable to provide abortions if it undertook the necessary extensive and costly renovations.[598] The law makes the practice's integrated model of reproductive healthcare nearly impossible in Missouri, leaving women with little opportunity to obtain this type of service. Columbia Planned Parenthood is currently taking contractor bids to determine whether it will be able to renovate the facility where it has been located for twenty years in order to meet the ASC standards.[599]

Should the law take effect, given the costs and difficulties of renovating to meet the requirements, Missouri could be left with only one provider of abortion in the entire state, St. Louis Planned Parenthood. It is licensed as an ASC, having had the foresight as a second-trimester provider to meet those requirements when it bought and renovated its current facility.[600] •

CONCLUSION

The Center for Reproductive Rights' investigation demonstrates that abortion providers, such as those interviewed for this report, are human rights defenders—and that they are routinely targeted, by both government and non-government actors, for the work that they do in supporting women to exercise their fundamental right to make decisions about their reproductive lives. The U.S. has an affirmative obligation to protect abortion providers—both because of their status as human rights defenders, and because of the key role they play in ensuring that women are able to realize their rights to reproductive autonomy and health.

The Center for Reproductive Rights encourages the government at all levels to adopt and enforce measures to improve the safety of providers and to eliminate laws that impede their work. The medical community has a significant role to play in strongly condemning attacks on abortion providers, reversing the marginalization of abortion from other medical care, and creating opportunities for new providers to train and practice. Also, without efforts at the community level to educate policymakers and the public that abortion is a significant component of reproductive healthcare, health workers who provide abortion will continue to experience the cumulative effects of intimidation, harassment, legal restrictions, and stigma.

Women seeking abortions—and particularly those who are most vulnerable—will continue to confront a scarcity of abortion services and bear the brunt of legal restrictions on abortion, including funding restrictions. As the report shows, proactive efforts by clinics and physicians can minimize the harms to physician availability and patient access, but they cannot eliminate them.

Moreover, the tactics of intimidation, harassment, and legal activism that anti-abortion activists use are dynamic, constantly reinventing themselves in new forms that burden abortion providers. The stigma surrounding abortion is well-rooted in society and requires consistent effort and vigilance to change the beliefs and norms that anchor it. Urgent action is required to recognize abortion providers as human rights defenders. Advocates and policymakers at all levels must pursue remedies to promote and protect the rights of providers and hold perpetrators of violations accountable.•

RECOMMENDATIONS

To State and Local Governments

Lawmakers

- Adopt resolutions recognizing reproductive healthcare workers, including abortion providers, as human rights defenders
- Adopt resolutions recognizing that access to a full range of reproductive health services, including abortion, is a human right
- Pass laws and ordinances protecting clinic access and ensuring the safety of abortion providers and patients, such as buffer zones, noise and signage restrictions and residential picketing prohibitions
- Repeal mandatory delay and biased counseling laws
- Repeal TRAP laws and regulate abortion providers in the same manner as other medical care providers

Police

- Enforce court orders granting injunctive relief or other protections to abortion providers
- Cooperate with federal agents on alleged FACE violations
- Enforce local laws and ordinances to protect abortion providers from intimidation and harassment, including harassment, stalking, trespass, signage, noise, and permit laws
- Ensure that officers are trained and have supervisory support to enforce ordinances and laws protecting abortion providers

To the U.S. Government

- Recognize the special role of human rights defenders, including reproductive health workers who provide abortions, in ensuring reproductive rights as human rights
  - Implement national laws and guidelines reflecting international obligations to protect human rights defenders
- Repeal federal funding restrictions on abortion, including the Hyde Amendment

Department of Justice

- Devote additional resources to provide training for and improve cooperation between federal, state, and local law enforcement agencies in responding to violence and threats of violence directed at abortion providers
- Devote additional resources to enforcing the Freedom of Access to Clinic Entrances Act and related federal statutes

To United Nations Special Rapporteurs

- Speak out against violations of reproductive rights as fundamental human rights violations
- Promote respect for reproductive rights defenders by highlighting the importance of their work globally, including in the U.S.
- Issue communications to the U.S. government concerning individual defenders of reproductive rights, particularly U.S. abortion providers who face persecution or heightened risk because of their work as defenders
  - Follow up with the U.S. government to ensure that mechanisms are designed and implemented to address root problems of gender discrimination and the stigma surrounding abortion and to ensure that defenders who are harmed receive appropriate remedies

To the Medical Community

- Support and create measures to increase the number of physicians performing abortions, including by teaching abortion in medical school curricula, clinic rotations, and residency programs
- Advocate the repeal of laws restricting abortion, such as mandatory delay and biased counseling laws and TRAP laws
- Adopt resolutions supporting abortion providers and condemning the stigmatization of abortion and violence and harassment of health workers providing abortion

To Non-Governmental Organizations

- Educate the public and policymakers on access to reproductive health-care as a human right and abortion services as an integral part of women's healthcare
- Support abortion providers in order to reduce stigma and secure the safety of clinic staff and women seeking abortion services, including by assisting with the recruitment of clinic escorts and other volunteers and the documentation of evidence of potential legal and human rights violations •

Urgent action is required to recognize abortion providers as human rights defenders, to protect their rights and to hold those who perpetrate violations accountable.

ENDNOTES

1 The majority of provider interviews were conducted in person; other interviews took place over the phone. All interviews with women seeking abortions were in-person. Only adults age 18 or over were eligible to participate in the investigation. Fourteen providers and one woman were videotaped telling their stories. Additional documentation is available on the CRR website, www.reproductiverights.org.

2 Katharine O'Connell, Heidi E. Jones, Melissa Simon, Vicki Saporta, Maureen Paul, E. Steve Lichtenberg, *First trimester surgical abortion practices: a survey of National Abortion Federation members*. 79 Contraception 385, 385 (2009).

3 Laurie D. Elam-Evans, Lilo T. Strauss, Joy Herndon, Wilda Y. Parker, Sara Whitehead & Cynthia J. Berg, Morbidity and Mortality Weekly Report, Abortion Surveillance—United States, 1999 (2002), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5109a1.htm (last visited May 21, 2009).

4 Unintended pregnancies account for nearly half of all pregnancies in the U.S. Guttmacher Institute, An Overview of Abortion in the United States (January 2008), http://www.guttmacher.org/media/presskits/2005/06/28/abortionoverview.html (last visited April 7, 2009).

5 Stanley K. Henshaw & Kathryn Kost, Guttmacher Institute, Trends in the Characteristics of Women Obtaining Abortions, 1974-2004 (August 2008), http://www.guttmacher.org/pubs/2008/09/18/Report_Trends_Women_Obtaining_Abortions.pdf (last visited May 21, 2009).

6 *Id*. at 13.

7 Lawrence B. Finer & Stanley Henshaw, *Abortion Incidence and Services in the United States in 2000*. 35 Perspectives on Sexual and Reproductive Health 6, 10 (2003), *available at* http://www.guttmacher.org/pubs/psrh/full/3500603.pdf (last visited May 21, 2009).

8 *Id*. at 10-11.

9 Lawrence B. Finer & Stanley Henshaw, *The Accessibility of Abortion Services in the United States, 2001*. 35 Perspectives on Sexual and Reproductive Health 16, 18 (2003), *available at* http://www.guttmacher.org/pubs/psrh/full/3501603.pdf (last visited May 25, 2009).

10 E. Steve Lichtenberg, Maureen Paul, Heidi Jones, *First trimester surgical abortion practices: a survey of National Abortion Federation members*. 64 Contraception 345, 351 (2001)

11 Eve Espey, Tony Ogburn, Alice Chavez, Clifford Qualls & Mario Leyba, *Abortion education in medical schools: A national survey.* 192 Obstet Gynecol 640, 642-643 (2005); Katherine L. Eastwood, Jennifer E. Kacmar, Jody Steinauer, Sherry Weitzen & Lori A. Boardman *Abortion training in United States Obstetrics and Gynecology Residency Programs,* 108 Obstet. Gynecol. 303, 307 (2006).

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51 ICPD Programme of Action, ¶ 7.3.

52 Committee on Economic, Social, and Cultural Rights (CESCR), *General Comment No. 14: the Right to the Highest Attainable Standard of Health (Art. 12)*, ¶ 12, U.N. Doc. E/C.12/2000/4 (July 4, 2000) (describing the three types or levels of obligations imposed upon States parties to a treaty); Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, art. 12, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; CESCR, General Comment No. 14, ¶ 8; *ICPD Programme of Action*, Principle 8.

53 Concluding observations of the HRC regarding: Chile, 30 March 1999, CCPR/C/79/Add.104 at ¶ 15; Colombia, 1 Apr. 1997, CCPR/C/79/Add.76 at ¶ 24; Ecuador, 18 Aug. 1998, CCPR/C/79/Add.92 at ¶ 11; Guatemala, 27 Aug. 2001, CCPR/CO/72/GTM at ¶ 19; Mali, 16 Apr. 2003, CCPR/CO/77/MLI at ¶ 14; Mongolia, 25 May 2000, CCPR/C/79/Add.120 at ¶ 8(b); Peru, 15 Nov. 2000, CCPR/CO/70/PER at ¶ 20; Poland, 29 July 1999, CCPR/C/79/Add.110 at ¶ 11, and United Republic of Tanzania, 18 Aug. 1998, CCPR/C/79/Add.97 at ¶ 15. Concluding observations of CEDAW regarding: Belize, 1 July 1999, A/54/38 at ¶ 56; Colombia, 5 February 1999, A/54/38 at ¶ 393; and Dominican Republic, 14 May 1998, A/53/38, at ¶ 337.

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55 *See* CERD, art. 5(e)(iv) (ensuring equal access to healthcare); *see also* Committee on the Elimination of Racial Discrimination, *General Recommendation XXV: Gender Related Dimensions of Racial Discrimination,* U.N. Doc. A/55/18, annex V at 152 (2000) (noting the Convention requires States parties to consider how racial discrimination affects women differently than men and to take a gender approach in its implementation).

56 CEDAW, art. 12.

57 CEDAW, arts. 10(h), 16.1(e); *Beijing Declaration and Platform for Action*, ¶¶ 106(f), 107(e), 223; *ICPD Programme of Action*, Principle 8, ¶¶ 7.2, 7.3, 7.45.

58 KL v. Peru (1153/2003), ¶ 6.4, U.N. Doc. CCPR/C/85/D/1153/2003 (2005); 13 IHRR 355 (2006).

59 Roe v. Wade, *supra* note 26.

60 International Coalition on Women Human Rights Defenders, Claiming Rights, Claiming Justice: A Guidebook on Women Human Rights Defenders 15 (Chiang Mai, Thailand, 2007) (defining women's rights defenders as "women's human rights defenders include women active in human rights defence who are targeted for *who they are* as well as all those active in the defence of women's rights who are targeted for *what they do*.")

61 Hina Jilani served from 2000–2008 as the Special Representative of the Secretary-General on the situation of human rights defenders. Her mandate was renewed once by the Commission on Human Rights in 2003, and again by the Human Rights Council in 2007. In March 2008, the Human Rights Council continued the mandate for another three years and appointed Margaret Sekaggya the new Special Rapporteur on the Situation of Human Rights Defenders.

62 *See, e.g.,* Human Rights Council, *Report Submitted by Ms. Hina Jilani, the Special Representative of the Secretary-General on Human Rights Defenders: Promotion and Protection of Human Rights Defenders*, 58th Sess., para. 90-92, U.N. Doc. E/CN.4/2002/106 (2002); Human Rights Council, *Report submitted by the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya: Addendum: Summary of cases transmitted to Governments and replies received*, 10th Sess., para. 559, U.N. Doc. A/HRC/10/12/Add.1 (2009).

63 Report of the Special Representative to the Human Rights Council, 4th Sess., Provisional Agenda Item 2, ¶ 55, U.N. Doc. A/HRC/4/37 (2007); Report submitted by the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya, Addendum, 10th session, Agenda Item 3, ¶ 559, U.N. Doc. A/HRC/10/12/Add.1 (2009).

64 Report submitted by the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya, Addendum, Tenth session, Agenda Item 3, ¶ 592, U.N. Doc. A/HRC/10/12/Add.1 (2009).

65 *Report of the Special Representative of the Secretary-General on Human Rights Defenders, Hina Jilani: Mission to Nigeria*, 62nd Sess., Provisional Agenda Item 17(b), ¶ 86, U.N. Doc. E/CN.4/2006/95/Add.2 (2006) (expressing concern that in Nigeria "[o]rganizations working on reproductive rights and health issues have been subjects of slander campaigns and attacks against them") [hereinafter Report of the Special Representative on her Mission to Nigeria]

66 Committee Against Torture, Nicaragua: Observaciones finales del Comité contra la Tortura [*Concluding Observations: Nicaragua*], 42nd Sess., ¶ 18, U.N. Doc. CAT/C/NIC/CO/1 (2009), *available at* http://www2.ohchr.org/english/bodies/cat/docs/cobs/CAT.C.NIC.CO.1_sp.pdf.

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69 Committee Against Torture, *supra* note 66, at ¶¶ 16, 18.

70 Center for Reproductive Rights, Likhaan, & ReproCen, Imposing Misery: the Impact of Manila's Ban on Contraception 27-30 (2007) *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/Philippines%20report.pdf.

71 *See Report submitted by the Special Representative of the Secretary-General on human rights defenders, Hina Jilani*, 4th Sess. paras. 70-72, U.N. Doc. A/HRC/4/37 (2007) (reporting that since the establishment of her mandate, the Special Representative has sent 36 communications to countries in all regions concerning the right to health and has raised issues ranging from threats to health providers treating civilians in the Occupied Territories to those assisting people living with HIV/AIDS in China); *Report Submitted by Ms. Hina Jilani, the Special Representative of the Secretary-General on the Situation of Human Rights Defenders, pursuant to the Commission on Human Rights resolution 2000/61*, 59th Sess., Provisional agenda item no. 17(b); ¶ 50, U.N. Doc. E/CN.4/2003/104 (Jan. 3, 2003) (explaining that "human rights defenders in such capacities as medical personnel … make essential contributions to the achievement of [the Millenium Development] goals.")

72 *See Report Submitted by the Special Representative on Human Rights Defenders, Hina Jilani*, 4th Sess., Provisional Agenda Item 2, 2007, ¶¶ 70-72, U.N. Doc. A/HRC/4/37 (2007).

73 *Report submitted by the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya, Addendum*, 10th Sess., Agenda Item 3, ¶ 1200-03, U.N. Doc. A/HRC/10/12/Add.1 (2009); *Report Submitted by the Special Representative of the Secretary-General on the Situation of Human Rights Defenders, Hina Jilani*, 7th Sess., Agenda Item 3, ¶¶ 1080-83, U.N. Doc. A/HRC/7/28/Add.1 (2008).

74 *Report submitted by the Special Rapporteur on the situation of human rights defenders, Margaret Sekaggya, Addendum*, 10th Sess., Agenda Item 3, ¶ 941, U.N. Doc. A/HRC/10/12/Add.1 (2009).

75 *Report Submitted by the Special Representative of the Secretary-General on the Situation of Human Rights Defenders, Hina Jilani*, 7th Sess., Agenda Item 3, ¶¶ 283-88, U.N. Doc. A/HRC/7/28/Add.1 (2008).

76 In calling on Nicaragua to repeal a law criminalizing the provision of abortion where necessary to preserve a woman's health, the Commission explained that the law "hinders the work of health care professionals, whose mission is to protect the lives of their patients and provide them with adequate treatment," therefore "endanger[ing] women's lives as well as their physical and psychological integrity." Letter from Santiago Canton and Victor Abramovich to HE Norman Calderas Cardenal, Nicaraguan Minister of Foreign Affairs (Nov. 10, 2006), *available at* http://www.reproderechos.org/pdf/index_nicaragua_english.pdf.

77 Declaration on Human Rights Defenders, art. 7 (stating "[e]veryone has the right, individually and in association with others, to develop and discuss new human rights ideas and principles and to advocate their acceptance.").

78 *U.N. High Commission for Human Rights,* Commission on Human Rights Resolution 2003/64 (Apr. 24, 2003), *available at http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/a8d8d5bafc6c01eac1256d24003273e4?Opendocument* (last visited June 3, 2009).

79 Interview with Anonymous Pennsylvania Staff Member #5, by telephone, Nov. 24, 2008.

80 Interview with Elizabeth Barnes, by telephone, Dec. 19, 2008.

81 Interview with Gerri Laster, El Paso, Texas, Dec. 10, 2008.

82 Interview with Anonymous Pennsylvania Doctor #3, York, Pennsylvania, Dec. 5, 2008

83 Interview with Abby Johnson, Bryan, Texas, Dec. 8, 2008.

84 Interview with Marisa, Philadelphia, Pennsylvania, Dec. 4, 2008.

85 Interview with Anonymous Pennsylvania Woman #1, Philadelphia, Pennsylvania, Dec. 4, 2008.

86 Interview with Anonymous Pennsylvania Woman #6, Pittsburgh, Pennsylvania, Dec. 3, 2008

87 Kaiser Family Foundation, Kaiser Commission n Medicaid Facts: Medicaid and the Uninsured (2008), http://www.kff.org/medicaid/upload/7235_03-2.pdf (last visited May 28, 2009).

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89 Kaiser Family Foundation, Individual State Profiles, http://www.statehealthfacts.org/profile.jsp (last visited Mar. 30, 2009).

90 Eighteen to 35 percent of women end up carrying to term, according to studies. Heather Boonstra, *The Heart of the Matter: Public Funding for Poor Women in the United States*, 10 Guttmacher Policy Review 12, 16 (2007).

91 Interview with Texas Anonymous Woman #4, McAllen, Texas, Dec. 10, 2008.

92 Interview with Anonymous North Dakota Woman #2, Fargo, North Dakota, Nov. 12, 2008.

93 Interview with Anonymous North Dakota Woman #4, Fargo, North Dakota, Nov. 12, 2008.

94 Interview with Anonymous Pennsylvania Doctor #6, Reading, Pennsylvania, Dec. 16, 2008

95 Arietta v. City of Allentown, No. 04-CV-05306, 2007 WL 2071671, at *3 (E.D. Pa. July 12, 2007); Arietta v. City of Allentown, No. Civ.A.04-226, 2004 WL 1774623 (E.D. Pa. Aug. 9, 2004).

96 CRR invited AWC to participate in the investigation, but the clinic was unable to do so due to the ongoing litigation.

97 Jennifer Boulanger, Op-Ed., *...But Allentown Protesters are Impeding Access Now*, The Morning Call (Allentown, Pennsylvania), Jan. 22, 2008, at A9.

98 Allentown Women's Center, Information About Protesting Activity at the Allentown Women's Center, Center for Reproductive Rights personal communication with Jennifer Boulanger, Oct. 7, 2008.

99 *Id.*

100 *See* Kuhns v. City of Allentown, NO. 08-CV-2606 (Docket) (E.D.Pa. Jun. 4, 2008). *See also* Kuhns v. City of Allentown, No. 08-cv-2606, 2009 WL 902334 (E.D.Pa. Mar. 31, 2009) (granting in part and denying in part defendants Allentown Women's Center and Jennifer Boulanger's Motion to Dismiss).

101 Jennifer Boulanger, Administrator, Allentown Women's Center, Supplemental Testimony for the Thematic Hearing on Women's Human Rights Defenders Before the Inter-American Commission on Human Rights, (October 28, 2008).

102 Interview with Holly Peterson, Birmingham, Alabama, Nov. 20, 2008.

103 Interview with Amy Hagstrom Miller, Austin, Texas, Dec. 12, 2008

104 Interview with Larissa Lindsay, Houston, Texas, Dec. 8, 2008.

105 *See* "The Evolving Nature of Intimidation and Harassment: Lawsuits by Protestors," Findings Across States, Section 2. A blog run by this protestor, John Dunkle, was responsible for driving at least one doctor in the state out of practice by giving instructions on how to kill her. Background interview with Sue Frietsche, Women's Law Project, by telephone, Aug. 29, 2008.

106 *See* "Challenges of FACE Enforcement: The Case Against Roy McMillan," Mississippi, Findings Across States.

107 Background interview with Austin Planned Parenthood staff member, Austin, Texas, Dec. 12, 2008.

108 Interview with Gloria Gray, by telephone, Nov. 21, 2008.

109 At Whole Woman's Health in Austin, Texas, the clinic's business liability policy does not cover abortion-related emergencies, such as fire bombing. Interview with Amy Hagstrom Miller, *supra* note 103.

110 Interview with Rebecca Sorgert, Fargo, North Dakota, Nov. 11, 2008.

111 Interview with Anonymous Pennsylvania Doctor #1, Philadelphia, Pennsylvania, Dec. 4, 2008.

112 *Id.*

113 Interview with Anonymous Pennsylvania Doctor #6, *supra* note 94.

114 Interview with Amanda Kifferly, Philadelphia, Pennsylvania, Dec. 4, 2008.

115 Interview with Anonymous Pennsylvania Staff Member #6, West Chester, Pennsylvania, Dec. 3, 2008.

116 Interview with Amanda Kifferly, *supra* note 114.

117 Interview with Abby Johnson, *supra* note 83.

118 *Id.*

119 Interview with Amy Hagstrom Miller, *supra* note 103.

120 Interview with Holly Peterson, *supra* note 102.

121 Interview with Diane Derzis, Birmingham, Alabama, Nov. 19. 2008.

122 Interview with Elizabeth Barnes, *supra* note 80.

123 Interview with Anonymous North Dakota Doctor #2, St. Paul, Minnesota, Nov. 14, 2008.

124 Interview with Anonymous Texas Doctor #4, Austin, Texas, Dec. 12, 2008.

125 Interview with Anonymous Missouri Staff Member #2, St. Louis, Missouri, Dec. 16, 2008.

126 Or, in the case of Missouri, in a law that is the first of its kind, provide a quantity of first-term abortions above a certain number.

127 Background interview with Susan Hill, National Women's Health Organization, by telephone, Aug. 28, 2008.

128 Interview with June Ayers, by telephone, Nov. 18, 2008.

129 Interview with Gloria Gray, *supra* note 108.

130 Interview with Dalton Johnson, Huntsville, Alabama, Nov. 21, 2008.

131 Interview with June Ayers, *supra* note 128.

132 Interview with Dyann Santos, Houston, Texas, Dec. 9, 2008.

133 *Id.*

134 *Id.*

135 Interview with Abby Johnson, *supra* note 83; interview with Dyann Santos, *supra* note 132.

136 Interview with Dyann Santos, *supra* note 132.

137 Interview with Amy Hagstrom Miller, *supra* note 103.

138 *Id.*

139 *Id.*

140 Interview with Dyann Santos, *supra* note 132; interview with Amy Hagstrom Miller, *supra* note 103.

141 Interview with Anonymous Pennsylvania Staff Member #5, *supra* note 79.

142 Interview with Dalton Johnson, *supra* note 130.

143 Interview with Betty Thompson, Jackson, Mississippi, Nov. 5, 2008; interview with Anonymous Mississippi Staff Member #2, Jackson, Mississippi, Nov. 6, 2008.

144 Interview with Anonymous Missouri Staff Member #8, by telephone, Jan. 2, 2009.

145 Interview with Karen Pieper Hildebrand, Midland, Texas, Dec. 8, 2008.

146 Interview with Andrea Ferrigno, McAllen, Texas, Dec. 10, 2008.

147 She is referring both to the Fargo Women's Health Organization (now closed) and the Red River Women's Clinic. Interview with Jane Bovard, by telephone, Nov. 13, 2008.

148 Interview with Gerri Laster, *supra* note 81.

149 U.S. CENSUS BUREAU, ANNUAL ESTIMATES OF THE RESIDENT POPULATION FOR THE UNITED STATES, REGIONS, STATES, AND PUERTO RICO: APRIL 1, 2000 TO JULY 1, 2008 (2008), http://www.census.gov/popest/states/NST-annest.html (last visited May 22, 2009)

150 U.S. CENSUS BUREAU, INCOME, EARNINGS AND POVERTY DATA FROM THE 2007 AMERICAN COMMUNITY SURVEY 21 (2008), http://www.census.gov/prod/2008pubs/acs-09.pdf (last visited May 22, 2009).

151 GUTTMACHER INSTITUTE, STATE FACTS ABOUT ABORTION: TEXAS (2008), http://www.guttmacher.org/pubs/sfaa/pdf/texas.pdf (last visited Mar. 31, 2009).

152 TEX. HEALTH & SAFETY CODE ANN. §§ 171.012(a)(1)-(4) (2003).

153 TEX. HEALTH & SAFETY CODE ANN. § 171.014 (2003); Texas Department of State Health Services, Woman's Right to Know Act (2003), *available* at http://www.dshs.state.tx.us/wrtk/default.shtm (last visited May 22, 2009).

154 TEX. HEALTH & SAFETY CODE ANN. § 171.004 (2003).

155 TEX. HEALTH & SAFETY CODE ANN. §§ 245.003(b) (1989), 245.004(b)(1) (2003).

156 TEX. HEALTH & SAFETY CODE ANN. §§ 245.006-.023.

157 One physician has provided abortions in Alabama and Texas and was interviewed for both states.

158 Interview with Gerri Laster, *supra* note 81.

159 Interview with Anonymous Texas Doctor #3, El Paso, Texas, Dec. 10, 2008.

160 Interview with Gerri Laster, *supra* note 81.

161 Interview with Samantha Mendoza, El Paso, Texas, Dec. 10, 2008.

162 Interview with Gerri Laster, *supra* note 81. The United States government bans almost all abortion services at U.S. military hospitals and other medical facilities of the Department of Defense, including those paid for by the woman using her own funds. 10 U.S.C. § 1093 (b)

(1984).
163 Interview with Anonymous Texas Doctor #1, Midland, Texas, Dec. 8, 2008.
164 Interview with Abby Johnson, *supra* note 83.
165 Interview with Andrea Ferrigno, *supra* note 146.
166 Interview with Marjorie Eisen, Houston, Texas, Dec. 9, 2008.
167 Interview with Dr. Lester Minto, by telephone, Dec. 17, 2008.
168 Interview with Brandi Bedford, Austin, Texas, Dec. 11, 2008.
169 Interview with Andrea Ferrigno, *supra* note 146.
170 Interview with Gerri Laster, *supra* note 81.
171 Interview with Karen Pieper Hildebrand, *supra* note 145.
172 *Id.*
173 Interview with Anonymous Texas Doctor #1, *supra* note 163.
174 Interview with Dyann Santos, *supra* note 132.
175 *Id.*
176 Interview with Abby Johnson, *supra* note 83; interview with Dyann Santos, *supra* note 132.
177 Interview with Brandi Bedford, *supra* note 168.
178 Interview with Anonymous Doctor #1, by telephone, Jan. 5, 2009.
179 Interview with Amy Hagstrom Miller, *supra* note 103.
180 Interview with Dr. Alan Braid, by telephone, Feb. 2, 2009.
181 *Id.*
182 Interview with Anonymous Texas Doctor #4, *supra* note 124.
183 Interview with Gerri Laster, *supra* note 81; interview with Samantha Mendoza, *supra* note 161.
184 Interview with Anonymous Doctor #1, *supra* note 178.
185 Interview with Abby Johnson, *supra* note 83; interview with Karen Pieper Hildebrand, *supra* note 145.
186 Interview with Anonymous Texas Doctor #1, *supra* note 163.
187 Interview with Abby Johnson, *supra* note 83.
188 Interview with Anonymous Texas Doctor #3, *supra* note 159.
189 Interview with Karen Pieper Hildebrand, *supra* note 145.
190 Interview with Andrea Ferrigno, *supra* note 146.
191 Interview with Amy Hagstrom Miller, *supra* note 103.
192 *Id.*
193 Interview with Laura Kaminczak, Bryan, Texas, Dec. 8, 2008.
194 Interview with Abby Johnson, *supra* note 83.
195 *Id.*
196 Interview with Dyann Santos, *supra* note 132.
197 *Id.*
198 Interview with Abby Johnson, *supra* note 83.
199 *Id.*
200 *Id.*
201 *Id.*
202 *Id.*
203 Interview with Dyann Santos, *supra* note 132.
204 *Id.*
205 *Id.*
206 Interview with Karen Pieper Hildebrand, *supra* note 145.
207 *Id.*
208 Interview with Andrea Ferrigno, *supra* note 146.
209 *Id.*
210 Interview with Amy Hagstrom Miller, *supra* note 103.
211 Interview with Andrea Ferrigno, *supra* note 146.
212 Interview with Dyann Santos, *supra* note 132.
213 Interview with Larissa Lindsay, *supra* note 104.
214 Interview with Bill Crowden, by telephone, Dec. 17, 2008.
215 Interview with Dyann Santos, *supra* note 132.
216 Interview with Abby Johnson, *supra* note 83.
217 Interview with Dyann Santos, *supra* note 132.
218 Interview with Dyann Santos, *supra* note 132; interview with Brandi Bedford, *supra* note 168.
219 Interview with Anonymous Texas Doctor #3, *supra* note 159; interview with Dr. Alan Braid, *supra* note 180.
220 Interview with Anonymous Texas Doctor #3, *supra* note 159.
221 Interview with Gerri Laster, *supra* note 81.
222 Interview with Amy Hagstrom Miller, *supra* note 103.
223 The Bryan Planned Parenthood stops at 13 weeks, 6 days; the Austin Planned Parenthood is an ASC.
224 Interview with Gerri Laster, *supra* note 81.
225 *Id.*
226 Interview with Dr. Alan Braid, *supra* note 180.
227 Interview with Amy Hagstrom Miller, *supra* note 103.
228 Interview with Dr. Alan Braid, *supra* note 180.
229 Interview with Amy Hagstrom Miller, *supra* note 103.
230 Interview with Bill Crowden, *supra* note 214.
231 Interview with Anonymous Texas Staff Member #1, Midland, Texas, Dec. 8, 2008.
232 Interview with Dyann Santos, *supra* note 132.
233 Interview with Amy Hagstrom Miller, *supra* note 103. The woman must also attest to the choice that she made: to receive a printed copy of the materials, review them on the state's website or decline them. 25 Tex. Admin. Code § 139.52(a)(1) (2004).
234 Interview with Abby Johnson, *supra* note 83; *see also*, Texas Department of State Health Services, *supra* note 280.
235 Interview with Laura Kaminczak, *supra* note 193; interviews with Dyann Santos, *supra* note 132, and Marjorie Eisen, *supra* note 166; interview with Samantha Mendoza, *supra* note 161; interview with Bill Crowden, *supra* note 214.
236 Interview with Bill Crowden, *supra* note 214.
237 Interview with Gerri Laster, *supra* note 81; interview with Samantha Mendoza, *supra* note 161.
238 Interview with Karen Pieper Hildebrand, *supra* note 145.
239 Interview with Abby Johnson, *supra* note 83.
240 *Id.*
241 Interview with Samantha Mendoza, *supra* note 161.
242 Interview with Andrea Ferrigno,*supra* note 146.
243 Interview with Samantha Mendoza, *supra* note 161.
244 Interview with Gerri Laster, *supra* note 81.
245 *Id.*
246 Interview with Gerri Laster, *supra* note 81.
247 Interview with Samantha Mendoza, *supra* note 161.
248 Interview with Gerri Laster, *supra* note 81.
249 Interview with Samantha Mendoza, *supra* note 161.
250 Interview with Andrea Ferrigno, *supra* note 146.
251 Interview with Samantha Mendoza, *supra*note 161.
252 Interview with Andrea Ferrigno, *supra* note 146.
253 Interview with Anonymous Texas Woman #4, *supra* note 91.
254 U.S. Census Bureau, *supra* note 149
255 U.S. Census Bureau, *supra* note 150
256 Guttmacher Institute, State Facts About Abortion: Mississippi (2008), http://www.guttmacher.org/pubs/sfaa/pdf/Mississippi.pdf (last visited Mar. 31, 2009).
257 Miss. Code. Ann. §§ 41-41-33(1)(a)(i)-(iv) (1991).
258 Miss. Code Ann. § 41-41-34(1)(b) (2007).
259 Miss. Code Ann. §§ 41-75-1(e), (f) (2006); Miss. Code R. §§ 12 000 034 (102.1), (102.3) (2005).
260 Miss. Code Ann. § 41-75-13 (1996); Miss. Code R. §15 301 044 (2008).
261 Miss. Code Ann. § 41-75-1(e) (2007).
262 Interview with Betty Thompson, *supra* note 143.
263 *Id.*
264 *Id.*
265 Interview with Dr. Joseph Booker, Jackson, Mississippi, Nov. 5, 2008.
266 *Id.*; interviews with Anonymous Mississippi Staff Members #1 and #2, Jackson, Mississippi, Nov. 6, 2008.
267 Interview with Dr. Joseph Booker, *supra* note 265.
268 Interview with Anonymous Mississippi Staff Member #2, *supra* note 143.
269 *Id.*
270 Interview with Betty Thompson, *supra* note 143.
271 Interview with Dr. Joseph Booker, *supra* note 265.
272 Interview with Anonymous Mississippi Staff Member #2, *supra* note 143.
273 *Id.*
274 Interview with Anonymous Mississippi Staff Member #1, *supra* note 266.
275 Interview with Dr. Joseph Booker, *supra* note 265.
276 *Id.*
277 *Id.*
278 United States v. McMillan, 946 F. Supp. 1254, 1268 (S.D. Miss. 1995).
279 United States v. McMillan, 53 F. Supp.2d 895 (S.D. Miss. 1999).
280 *Id.* at 898, 907.
281 *Id.* at 908.
282 Motion for Order to Show Cause Why Defendant Should Not Be Held In Civil Contempt, United States v. McMillan, (S.D.Miss.2008) (No. 2:95-cv-633 HTW JCS).
283 *Id.*
284 Feminist Wire, *Anti-Abortion Extremist Must Stay 50 Feet from Mississippi Clinic,* Ms. Magazine, April 9, 2008, *available at* http://www.msmagazine.com/news/uswirestory.asp?id=10932 (last visited Mar. 30, 2009).
285 Interview with Dr. Joseph Booker, *supra* note 265.
286 *Id.*
287 Interview with Anonymous Mississippi Staff Member #2, *supra* note 143.
288 Interview with Dr. Joseph Booker, *supra* note 265.
289 Interview with Betty Thompson, *supra* note 143.
290 Interview with Anonymous Mississippi Staff Member #2, *supra* note 143.
291 *Id.*
292 *Id.*
293 Interview with Dr. Joseph Booker, *supra* note 265.
294 Interview with Betty Thompson, *supra* note 143.
295 *See* National Cancer Institute, Fact Sheet: Abortion, Miscarriage and Breast Cancer Risk (2003), http://www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage. *See also,* Henry J. Kaiser Family Foundation, Abortion in the US: Utilization, Financing, and Access (2008), http://www.kff.org/womenshealth/upload/3269-02.pdf (citing studies from 1997, 2004 and 2007 finding no association between abortion and increased breast cancer risk.). Mississippi's written materials state: "Medical professionals disagree about a possible connection between abortion and breast cancer risk. Some studies show [a link]… Other studies have found no link … ." Dr. Booker explicitly tells patients that the state mandates certain information be given to them and that there is no scientific evidence of association between breast cancer and abortion. Interview with Dr. Joseph Booker, *supra* note 265.
296 Interview with Betty Thompson, *supra* note 143.
297 *Id.*
298 Interview with Dr. Joseph Booker, *supra* note 265.
299 Interview with Betty Thompson, *supra* note 143.
300 Interview with Anonymous Mississippi Staff Member #1, *supra* note 266.
301 U.S. Census Bureau, *supra* note 149.
302 Alabamba is tied with West Virginia. U.S. Census Bureau *supra* note 150.
303 Arbitrary and inconsistent health department enforcement of TRAP regulations also significantly burdens providers. See "Arbitrary Department of Health Inspections," Section V(C).
304 ALA. CODE § 26-23A-4(a) (2002).
305 ALA. CODE § 26-23A-3(9) (2002).
306 ALA. CODE § 26, *supra* note 304.
307 ALA. CODE § 26-23A-4(b)(4) (2002).
308 ALA. ADMIN. CODE r. 420-5-1-.01(2)(b), (4) (2004).
309 Interview with Holly Peterson, *supra* note 102.
310 One physician has provided abortions in Alabama and Texas and was interviewed for both states.
311 Arbitrary and inconsistent health department enforcement of TRAP regulations also significantly burdens providers. See "Arbitrary Department of Health Inspections," Findings Across States, Section 3.
312 Interview with June Ayers, *supra* note 128.
313 Document given to the Center for Reproductive Rights by Holly Peterson, Birmingham, Alabama, Nov. 20, 2008.
314 Interview with Diane Derzis, *supra* note 121.
315 *Id.*; interview with Gloria Gray, *supra* note 108.
316 Interview with Anonymous Alabama Doctor #5, Huntsville, Alabama, Nov. 21, 2008.
317 Interview with Dalton Johnson, *supra* note 130.
318 Interview with June Ayers, *supra* note 128; interview with Diane Derzis, *supra* note 121.
319 Interview with Anonymous Alabama Doctor #2, Birmingham, Alabama, Nov. 19, 2008.
320 Interview with Diane Derzis, *supra* note 121; interview with Gloria Gray, *supra* note 108..
321 Interview with Anonymous Alabama Doctor #2, *supra* note 319; interview with Dalton Johnson, *supra* note 130.
322 Interview with June Ayers, *supra* note 128.
323 Interview with Dalton Johnson, *supra* note 130; interview with Gloria Gray, *supra* note 108.
324 Interview with June Ayers, *supra* note 128; interview with Dalton Johnson, *supra* note 130. A written contract with a back-up, or "outside covering" physician, is mandated if there is no physician at the facility who can meet the hospital admitting privileges requirement. Ala. Admin. Code r.420-5-1-.03(6)(b) (2004).
325 Interview with June Ayers, *supra* note 128.
326 *Id.*
327 Interview with Dalton Johnson, *supra* note 130.
328 Interview with Gloria Gray, *supra* note 108.
329 The perpetrator of the arson was never identified. Interview with Gloria Gray, *supra* note 108.
330 Interview with Anonymous Alabama Doctor #3, Birmingham, Alabama, Nov. 19, 2008.
331 Every physician interviewed mentioned the bombing, even if they were not in Alabama at the time it occurred; six out of seven did not want to be identified by name in the report to protect their identities.
332 Interview with Laurasenia Coleman, Montgomery, Alabama, Nov. 18, 2008; interview with Diane Derzis, *supra* note 121; interview with Holly Peterson, *supra* note 102.
333 Interview with June Ayers, *supra* note 128.
334 Interview with Barbara Buchanan, Birmingham, Alabama, Nov. 20, 2008.
335 *Id.*
336 Interview with Gloria Gray, *supra* note 108.
337 *Id.*
338 Interview with Holly Peterson, *supra* note 102.
339 Interview with June Ayers, *supra* note 128.
340 Interview with Anonymous Alabama Doctor #1, Birmingham, Alabama, Nov. 17, 2008.
341 Interview with Anonymous Alabama Doctor #3, *supra* note 330.
342 Interview with Barbara Buchanan, *supra* note 334; interview with Holly Peterson, *supra* note 102.
343 Interview with Holly Peterson, *supra* note 102.
344 Interview with Diane Derzis, *supra* note 121; interview with Holly Peterson, *supra* note 102.
345 Interview with Diane Derzis, *supra* note 121.
346 *Id.*
347 Interview with Holly Peterson, *supra* note 102.
348 *Id.*
349 Interview with Anonymous Alabama Doctor #1, *supra* note 340.
350 Interview with Diane Derzis, *supra* note 121.
351 *Id.*
352 *Id.*
353 *Id.*
354 *Id.*
355 *Id.*
356 Interview with Dalton Johnson, *supra* note 130.
357 Interview with Holly Peterson, *supra* note 102. Paul Hill was executed for the murder of Dr. John Britton and clinic escort James Barrett.
358 Interview with Anonymous Alabama Doctor #3, *supra* note 330.
359 The messages said that Markley heard that the doctor was "'in the AB business,'" that Markley thought he might be Catholic from his name, and that the doctor should call him if he ever "'wanted to talk.'" Interview with Anonymous Alabama Doctor #3, *supra* note 330.
360 *Id.*
341 Interview with Gloria Gray, *supra* note 108.
362 *Id.*
363 *Id.*
364 Interview with June Ayers, *supra* note 128.
365 *Id.*
366 *Id.*; interview with Diane Derzis, *supra* note 121; interview with Barbara Buchanan, *supra* note 334. In fact, without having brought a successful lawsuit, the clinics would have to bear the costs of copyright, printing and shipping for the materials themselves, which include a thick and heavy resource directory. Summit Med. Ctr. of Ala., Inc. v. Riley, 318 F.Supp.2d 1109 (M.D.Ala. 2003). Interview with Gloria Gray, *supra* note 108.
367 Interview with June Ayers, *supra* note 128; interview with Dalton Johnson, *supra* note 130.
368 Interview with Diane Derzis, *supra* note 121.
369 Interview with Anonymous Alabama Doctor #4, by telephone, Nov. 21, 2008; interview with Gloria Gray, *supra* note 108; interview with Anonymous Alabama Doctor #5, *supra* note 316.
370 Interview with Holly Peterson, *supra* note 102; interview with Gloria Gray, *supra* note 108.
371 Interview with Holly Peterson, *supra* note 102.
372 Interview with Gloria Gray, *supra* note 108.
373 Interview with Laurasenia Coleman, *supra* note 332.
374 Interview with Dalton Johnson, *supra* note 130.
375 Interview with Holly Peterson, *supra* note 102.
376 Interview with Anonymous Alabama Doctor #1, *supra* note 340.
377 *Id.*
378 Interview with Diane Derzis, *supra* note 121; interview with Gloria Gray, *supra* note 108; interview with Dalton Johnson, *supra* note 130.
379 Interview with Anonymous Alabama Doctor #3, *supra* note 330.
380 Interview with Anonymous

Doctor #1, *supra* note 178.
381 Interview with Anonymous Alabama Doctor #4, *supra* note 369.
382 Interview with Diane Derzis, *supra* note 121.
383 Interview with Gloria Gray, *supra* note 108.
384 *Id.*
385 Interview with Diane Derzis, *supra* note 121.
386 *Id.*
387 Interview with Anonymous Alabama Doctor #1, *supra* note 340.
388 U.S. Census Bureau, *supra* note 149.
389 U.S. Census Bureau, *supra* note 150.
390 Guttmacher Institute, State Facts About Abortion: Pennsylvania (2008), http://www.guttmacher.org/pubs/sfaa/pdf/pennsylvania.pdf (last visited Mar. 31, 2009).
391 18 Pa. Cons. Stat. Ann. § 3205 (1989).
392 28 Pa. Code § 29.43(a) (2009).
393 28 Pa. Code §§ 29.33, .38 (2009).
394 Interview with Claire Keyes, Pittsburgh, Pennsylvania, Dec. 3, 2008.
395 Interview with Anonymous Pennsylvania Woman #9, Pittsburgh, Pennsylvania, Dec. 4, 2008.
396 Interview with Eli Kuti, Pittsburgh, Pennsylvania, Dec. 3, 2008.
397 Interviews with Ariel Kobylak and Leah Chamberlain, Philadelphia, Pennsylvania, Dec. 4, 2008; interview with Elizabeth Barnes, *supra* note 80. According to Elizabeth Barnes, while the University of Pennsylvania hospital started providing abortions for some of these vulnerable women in late 2008, their schedule is very limited and the costs of the procedure are many times that of the clinic.
398 Interview with Elizabeth Barnes, *supra* note 80.
399 Interview with Suellen Craig, York, Pennsylvania, Dec. 5, 2008.
400 Interview with Anonymous Pennsylvania Doctor #6, *supra* note 94.
401 *Id.*
402 28 Pa. Code § 29.33(10) (2009).
403 Interview with Anonymous Pennsylvania Staff Member #5, *supra* note 79; interview with Suellen Craig, *supra* note 399.
404 Interview with Anonymous Pennsylvania Staff Member #5, *supra* note 79.
405 Interview with Claire Keyes, *supra* note 394.
406 Interview with Anonymous Pennsylvania Doctor #1, *supra* note 111.
407 *Id.*
407 Interview with Elizabeth Barnes, *supra* note 79.
409 Interview with Anonymous Pennsylvania Doctor #4, Dec. 16, 2008.
410 Interview with Anonymous Pennsylvania Doctor #2, York, Pennsylvania, Dec. 5, 2008.
411 Interview with Anonymous Pennsylvania Doctor #5, Pittsburgh, Pennsylvania, Dec. 4, 2008.
412 Interview with Anonymous Pennsylvania Doctor #3, *supra* note 82.
413 Interview with Amanda Kifferly, *supra* note 114.
414 *Id.*
415 Interview with Ariel Kobylak, Philadelphia, *supra* note 397.
416 Interview with Amanda Kifferly, *supra* note 114.
417 *Id.*
418 *Id.*
419 Interview with Eli Kuti, *supra* note 396.
420 *Id.*
421 Interview with Anonymous Pennsylvania Doctor #2, *supra* note 410.
422 *Id.*
423 Interview with Anonymous Pennsylvania Staff Member #6, *supra* note 115; interview with Leah Chamberlain, *supra* note 397.
424 Interview with Elizabeth Barnes, *supra* note 80.
425 Email communication from Marisa, Dec. 22, 2008.
426 Interview with Elizabeth Barnes, *supra* note 80.
427 Interview with Amanda Kifferly, *supra* note 114.
428 Interview with Claire Keyes, *supra* note 394.
429 Interview with Eli Kuti, *supra* note 396.
430 Interview with Anonymous Pennsylvania Staff Member #6, *supra* note 115.
431 *Id.*
432 Interview with Marisa, *supra* note 84.
433 *Id.*
434 Interview with Ariel Kobylak, *supra* note 397.
435 Interview with Elizabeth Barnes, *supra* note 80.
436 *Id.*
437 Interview with Marisa, *supra* note 84; interview with Elizabeth Barnes, *supra* note 80.
438 Interview with Ariel Kobylak, *supra* note 397.
439 Interview with Marisa, *supra* note 84.
440 Interview with Elizabeth Barnes, *supra* note 80.
441 Interview with Marisa, *supra* note 84.
442 Interview with Anonymous Pennsylvania Staff Member #5, *supra* note 79; interview with Anonymous Pennsylvania Staff Member #6, *supra* note 115; interview with Suellen Craig, *supra* note 399; interview with Anonymous Pennsylvania Staff Member #3, Reading, Pennsylvania, Dec. 16, 2008.
443 Interview with Steve Neubauer, York, Pennsylvania, Dec. 5, 2008.
444 *Id.*
445 *Id.*
446 Interview with Suellen Craig, *supra* note 399.
447 Interview with Elizabeth Barnes, *supra* note 80.
448 *Id.*
449 Interview with Anonymous Pennsylvania Staff Member #2, Reading, Pennsylvania, Dec. 16, 2008.
450 Interview with Suellen Craig, *supra* note 399.
451 Interview with Elizabeth Barnes, *supra* note 80.
452 Interview with Marisa, *supra* note 84.
453 Interview with Anonymous Pennsylvania Woman #3, York, Pennsylvania, Dec. 5, 2008.
454 Interview with Claire Keyes, *supra* note 394.
455 Interview with Anonymous Pennsylvania Staff Member #3, York, Pennsylvania, Dec. 5, 2008.
456 Interview with Anonymous Pennsylvania Doctor #5, *supra* note 411.
457 Interview with Anonymous Pennsylvania Staff Member #1, Reading, Pennsylvania, Dec. 16, 2008.
458 Interview with Anonymous Pennsylvania Woman #6, *supra* note 86.
459 Interview with Marisa, *supra* note 84.
460 Interview with Anonymous Pennsylvania Doctor #1, *supra* note 111.
461 *Id.*
462 *Id.*
463 Interview with Anonymous Pennsylvania Doctor #4, *supra* note 409.
464 Interview with Anonymous Pennsylvania Doctor #3, *supra* note 82.
465 Interview with Anonymous Pennsylvania Doctor #2, *supra* note 410.
466 Interview with Anonymous Pennsylvania Doctor #5, *supra* note 411.
467 Interviews with Amanda Kifferly, *supra* note 114, Ariel Kobyak, *supra* note 397, and Marisa, *supra* note 84.
468 Interview with Anonymous Pennsylvania Doctor #4, *supra* note 409.
469 Interview with Anonymous Pennsylvania Doctor #2, *supra* note 410.
470 *Id.*
471 Interview with Eli Kuti, *supra* note 396.
472 Interview with Eli Kuti, *supra* note 396; interview with Anonymous Pennsylvania Doctor #5, *supra* note 411.
473 Interview with Eli Kuti, *supra* note 396.
474 Interview with Claire Keyes, *supra* note 394.
475 Interview with Eli Kuti, *supra* note 396.
476 Interview with Amanda Kifferly, *supra* note 114.
477 Interview with Anonymous Pennsylvania Doctor #2, *supra* note 410.
478 Interview with Ariel Kobylak, *supra* note 114.
479 Interview with Anonymous Pennsylvania Staff Member #6, *supra* note 115.
480 Interview with Anonymous Pennsylvania Doctor #5, *supra* note 411.
481 Interview with Anonymous Pennsylvania Doctor #6, *supra* note 94.
482 Interview with Anonymous Pennsylvania Doctor #4, *supra* note 409.
483 Interview with Elizabeth Barnes, *supra* note 80.
484 Interview with Anonymous Pennsylvania Doctor #4, *supra* note 409.
485 Interview with Suellen Craig, *supra* note 399.
486 Interview with Elizabeth Barnes, *supra* note 80.
487 U.S. Census Bureau, *supra* note 149.
488 North Dakota is tied with Florida and Idaho. U.S. Census Bureau, *supra* note 150.
489 Guttmacher Institute, State Facts About Abortion: North Dakota (2008), http://www.guttmacher.org/pubs/sfaa/pdf/north_dakota.pdf (last visited Mar. 31, 2009).
490 N.D. Cent. Code § 14-02.1-02(5) (1995).
491 *See* North Dakota Department of Health, Fetal Growth and Development Booklet, http://www.ndhealth.gov/familyhealth/publications/fetalgrowthbooklet/htm (last visited May 26, 2009).
492 N.D. Cent. Code § 14-02.1-04(2) (1979).
493 Miks v. Olson, No. A3-82-78 (D.N.D. Aug. 25, 1983) (stipulation for judgment).
494 Interview with Tammi Kromenaker, Fargo, North Dakota, Nov. 11, 2008.
495 *Id.*
496 *Id.*; interview with Jane Bovard, *supra* note 147.
497 Interview with Jane Bovard, *supra* note 147.
498 Interview with Anonymous North Dakota Doctor #2, *supra* note 123.
499 Interview with Tammi Kromenaker, *supra* note 494.
500 *Id.*
501 *Id.*, interview with Sarah Haeder, Fargo, North Dakota, Nov. 11, 2008.
502 Interview with Anonymous North Dakota Staff Member #1, Fargo, North Dakota, Nov. 11, 2008; Interview with Anonymous North Dakota Staff Member #2, Fargo, North Dakota, Nov. 11, 2008.
503 Interview with Tammi Kromenaker, *supra* note 494; interview with Lysa Ringquist, Fargo, North Dakota, Nov. 11, 2008; interview with Jane Bovard, *supra* note 147.
504 Interview with Anonymous North Dakota Staff Member #2, *supra* note 502.
505 Interview with Anonymous North Dakota Doctor #2, *supra* note 123.
506 Interview with Anonymous North Dakota Staff Member #2, *supra* note 502; interview with Rebecca Sorgert, *supra* note 110.
507 Interview with Tammi Kromenaker, *supra* note 494.
508 Interview with Jane Bovard, *supra* note 147.
509 Interview with Tammi Kromenaker, *supra* note 494.
510 Interview with Jane Bovard, *supra* note 147; interview with Tammi Kromenaker, *supra* note 494.
511 Interview with Jane Bovard, *supra* note 147.
512 Interview with Jane Bovard, *supra* note 147; interview with Lysa Ringquist, *supra* note 503.
513 Interview with Lysa Ringquist, *supra* note 503.
514 Interview with Jane Bovard, *supra* note 147; interview with Lysa Ringquist, *supra* note 503.
515 Interview with Lysa Ringquist, *supra* note 503.
516 Interview with Anonymous North Dakota Staff Member #2, *supra* note 502; The Lambs of Christ is an extremist anti-abortion group linked to James Kopp, who was convicted of murdering New York abortion provider Dr. Barnett Slepian by sniper-fire in 1998.
517 Interview with Jane Bovard, *supra* note 147.
518 *Id.*
519 Interview with Tammi Kromenaker, *supra* note 494; interview with Jane Bovard, *supra* note 147.
520 Interview with Lysa Ringquist, *supra* note 503.
521 Interview with Tammi Kromenaker, *supra* note 494.
522 *Id.*
523 Interview with Lysa Ringquist, *supra* note 503.
524 Interview with Anonymous North Dakota Doctor #2, *supra* note 123.
525 Interview with Tammi Kromenaker, *supra* note 494.
526 Interview with Lysa Ringquist, *supra* note 503.
527 Interview with Jane Bovard, *supra* note 147. The case was Fargo Women's Health Org. v. Schafer, 18 F.3d 526 (8th Cir. 1994). The Center for Reproductive Rights (at that time, the Center for Reproductive Law and Policy) represented Fargo Women's in the lawsuit.
528 *Id.*
529 *Id.*
530 Interview with Lysa Ringquist, *supra* note 503.
532 Interview with Rebecca Sorgert, *supra* note 110.
532 Interview with Anonymous North Dakota Doctor #1, by telephone, Nov. 13, 2008.
533 *Id.*
534 Interview with Dr. K. Eggleston, Fargo, North Dakota, Nov. 12, 2008.
535 Interview with Anonymous North Dakota Doctor #1, *supra* note 532.
536 Interview with Anonymous North Dakota Woman #2, *supra* note 92.
537 Interview with Dr. K. Eggleston, *supra* note 534.
538 Interviews with Rebecca Sorgert, *supra* note 110, Sarah Haeder, *supra* note 501, Tammi Kromenaker, *supra* note 494, and Lysa Ringquist, *supra* note 503.
539 Interview with Tammi Kromenaker, *supra* note 494.
540 *Id.*
541 Interview with Sarah Haeder, *supra* note 501.
542 Interview with Dr. K. Eggleston, *supra* note 534.
543 U.S. Census Bureau, *supra* note 149.
544 U.S. Census Bureau, *supra* note 150.
545 Guttmacher Institute, State Facts About Abortion: Missouri (2008), http://www.guttmacher.org/pubs/sfaa/pdf/missouri.pdf (last visited Mar. 31, 2009).
546 Mo. Rev. Stat. § 188.039 (2003).
547 Mo. Ann. Stat. § 197.200(1) (2007).
548 Planned Parenthood of Kansas and Mid-Missouri Inc. v. Drummond, No. 07-4164-CV-C-ODS (W.D. Mo. filed Sept. 24, 2007).
549 Mo. Code Regs. Ann. tit. 19, §§ 30-30.050(1)(A), (B), 30.050(2)(A) (1987).
550 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
551 Interview with Anonymous Missouri Staff Member #8, *supra* note 144.
552 *Id.*
553 Interview with Anonymous Missouri Staff Member #1, Missouri, Dec. 15, 2008.
554 Interview with Anonymous Missouri Doctor #2, by telephone, Dec. 15, 2008.
555 Interview with Anonymous Missouri Staff Member #8, *supra* note 144.
556 Background interview with Peter Brownlie, Planned Parenthood of Kansas and Mid-Missouri, by telephone, Oct. 16, 2008.
557 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
558 Id.
559 Interview with Anonymous Missouri Doctor #1, by telephone, Jan. 2, 2009.
560 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
561 Interview with Anonymous Missouri Doctor #3, by telephone, Dec. 16, 2008.
562 Interview with Anonymous Missouri Doctor #2, *supra* note 554.
562 Id.
564 Interview with Anonymous Missouri Staff Member #1, *supra* note 553.
565 Interview with Anonymous Missouri Doctor #1, *supra* note 559.
566 *Id.*
567 Interview with Anonymous Missouri Staff Member #7, St. Louis, Missouri, Dec. 16, 2008.
568 Interview with Anonymous Missouri Doctor #2, *supra* note 554; interview with Anonymous Missouri Staff Member #4, St. Louis, Missouri, Dec. 16, 2008.
569 Interview with Anonymous Missouri Staff Member #3, St. Louis, Missouri, Dec. 16, 2008; interview with Anonymous Missouri Staff Member #4, *supra* note 568; interview with Anonymous Missouri Doctor #3, supra note 561.
570 Interview with Anonymous Missouri Doctor #1, *supra*note 559.
571 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
572 Interview with Anonymous Staff Member #1, by telephone, Dec. 11, 2008.
573 Interview with Anonymous Missouri Staff Member #7, supra note 567.
574 Interview with Anonymous Staff Member #1, *supra* note 572.
575 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
576 Interview with Anonymous Missouri Staff Member #7, supra note 567.
577 Interviews with Anonymous Missouri Staff Member #3, supra note 569, and Anonymous Missouri Staff Member #4, *supra* note 568.
578 Interview with Anonymous Missouri Staff Member #3, *supra* note 569.
579 Interview with Anonymous Missouri Staff Member #1, *supra* note 553.
580 Interview with Anonymous Missouri Doctor #1, *supra* note 559.
581 Interview with Anonymous Missouri Staff Member #1, *supra* note 553; interview with Anonymous Missouri Staff Member #2, supra note 125.
582 Interview with Anonymous Missouri Staff Member #3, supra note 569.
583 Interview with Anonymous Missouri Staff Member #1, *supra* note 553; interview with Anonymous Missouri Staff Member #2, supra note 125.
584 Interview with Anonymous Staff Member #1, *supra* note 572.
585 Interview with Anonymous Missouri Staff Member #5, St. Louis, Missouri, Dec. 16, 2008.
586 Interview with Anonymous Missouri Doctor #1, supra note 559. For example, physicians who perform abortions are required to have clinical privileges at a hospital providing OB/GYN care within 30 miles of where the abortion is performed. Mo. Ann. Stat. § 188.080 (2005).
587 Interview with Anonymous Missouri Doctor #1, *supra* note 559.
588 *Id.*

589 Interview with Anonymous Missouri Staff Member #2, *supra* note 125.
590 Interview with Anonymous Missouri Doctor #3, *supra* note 561.
591 Interview with Anonymous Missouri Staff Member #7, supra note 567.
592 Interview with Anonymous Missouri Doctor #3, *supra* note 561.
593 Interview with Anonymous Missouri Staff Member #2, *supra* note 125. Providers attempted to warn the Missouri Legislature that this would occur even before the law passed, given that similar restrictions in other states resulted in delays in women's access to abortion.
594 Interview with Anonymous Missouri Staff Member #5, *supra* note 585.
595 Interview with Anonymous Missouri Staff Member #8, *supra* note 144.
596 *Id.*
597 Interview with Anonymous Missouri Doctor #2, *supra* note 554.
598 *Id.*
599 Interview with Anonymous Missouri Staff Member #8, *supra* note 144.
600 Interview with Anonymous Missouri Staff Member #2, *supra* note 125. •

The Center for Reproductive Rights is
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