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**CHIPPING
AWAY AT
CHOICE:**

**FIVE GROWING THREATS TO
WOMEN'S HEALTHCARE
ACCESS AND AUTONOMY**

CHIPPING AWAY AT CHOICE:

Five Growing Threats to Women's Healthcare Access and Autonomy

The “War on Women” currently being waged by conservatives in the U.S. Congress and state legislatures is well documented. From attacking contraception to insulting rape survivors to threatening funding for reproductive healthcare, anti-choice legislators and activists are staging an assault on women's health, privacy and autonomy.

But while extreme attacks on reproductive rights – such as radical “personhood” bills that threaten to criminalize even some forms of birth control – rightly receive significant attention and opposition, more incremental anti-choice proposals frequently escape wide notice and face minimal resistance as they become law. Often presented as “common-sense” or “women's health” measures, these laws are in fact meant to gradually chip away at reproductive health access, undermining the foundation of long-standing rights.

By passing mandatory ultrasound and waiting period laws, or requiring doctors to provide inaccurate medical information, anti-choice politicians create a culture in which women's rights are up for grabs. As conservatives call for smaller government, they pass laws that intrude into our most private and significant decisions, put a script in our doctors' hands, and tell us we do not know our own minds. In addition, these laws are meant to chip away at women's constitutionally protected right to autonomy over our own bodies in a deliberate attempt to undermine *Roe v. Wade*.

The list of anti-choice tactics below is by no means comprehensive. State legislatures in recent years have had some success in restricting women's healthcare through defunding Planned Parenthood and other family planning services. At the national level, activists and legislators have staged a very public battle to restrict access to birth control and emergency contraception through the Affordable Care Act.

But this report outlines some of the quiet ways that anti-choice activists and legislators are working to restrict women's access to safe, affordable and

reliable reproductive care. These tactics are often overshadowed by louder, broader debates, but their ultimate goal is the same: to whittle down women's reproductive rights, and eliminate access to safe and legal abortion.

1 TRAP LAWS

TARGETED REGULATION OF ABORTION PROVIDERS

Five Quiet Threats to Women's Health

One of the most common ways state legislatures restrict women's access to healthcare is through Targeted Regulation of Abortion Providers (“TRAP”) laws, which subject clinics and doctors to burdensome and unnecessary restrictions in order to force them to close.

Designed to look like harmless regulations, TRAP laws often evade scrutiny and are frequently passed without significant opposition. But these laws are far from harmless: In fact, TRAP laws have a devastating impact on women's access to quality, affordable healthcare.

Currently, 45 states and the District of Columbia have TRAP laws in place. State legislators claim that these laws make clinics safer for women and ensure that abortions are performed in an appropriate medical setting.¹ In reality, however, TRAP laws burden clinics with overly stringent and unnecessary requirements that often necessitate major remodeling or other cost-prohibitive measures.

Some TRAP laws take the form of building regulations that require clinics to perform costly and unnecessary renovations. A Virginia clinic threatened by new TRAP regulations this year estimated that the cost of compliance could exceed \$500,000. It ultimately decided to shut its doors.²



Senate chambers in Austin, Texas

In Texas, a TRAP law passed by the state House in 2013 would require abortion clinics to adhere to the same standards as surgical clinics, even though many of the clinics only administer non-surgical abortions.³ After State Senator Wendy Davis staged an 11-hour filibuster of the bill, Gov. Rick Perry called a special session to pass it.⁴ The bill threatens to shutter most of the state's abortion clinics.⁵

Other TRAP laws require doctors providing abortions to obtain official affiliations with local hospitals. This can be a difficult or impossible task, especially for clinics that rely on doctors visiting from out of state. A 2012 Mississippi law targeting the state's lone abortion provider required all doctors performing abortions to have hospital admitting privileges; when the clinic's doctors sought those privileges, every local hospital denied their requests.⁶ (One concern was that anti-choice protesters would interfere with the hospitals' work if they supported abortion providers.⁷) Fortunately for Mississippi women, a federal court granted an injunction against enforcement of the admitting privileges requirement.⁸ The court found that, by forcing the state's only provider to close, the law would place an undue burden on women seeking abortions.⁹

Anti-choice legislators often tout TRAP laws as pro-women. But these laws in fact prevent women from obtaining care. By closing clinics, TRAP laws cut off access not only to abortion services, but to women's access to contraception, cancer screenings, STD testing and other vital healthcare services.

Because TRAP laws are often embedded within complicated legislation and involve seemingly reasonable or innocuous regulation, they can fail to attract attention from the public. This allows legislators to pass these harmful laws without meaningful opposition or debate. In addition to casting TRAP laws as beneficial for

women's health, anti-choice lawmakers have employed a deceptive strategy of loading TRAP legislation with more controversial provisions. The contested portions of the bill are later dropped, so that conservative lawmakers can make a show of compromising, even while they achieve their ultimate goal of passing TRAP laws. For example, in January 2013, Indiana legislators introduced a bill¹⁰ that would have required two transvaginal ultrasounds before a woman could be given RU-486 for a medical abortion, and included various



TRAP provisions.¹¹ In response to considerable public protest, the ultrasound provisions were later dropped.¹² However, the TRAP provisions passed.¹³ In this way, legislators use extreme and controversial anti-choice measures as a Trojan horse for insidious laws that chip away at a woman's right to choose.

CPCs

CRISIS PREGNANCY CENTERS

2



CPC advertisement

Crisis pregnancy centers (CPCs) are so-called “abortion alternative” sites run by private organizations¹⁴ that claim to provide support, information and medical care to pregnant women.¹⁵ CPCs use misleading tactics to draw women in: The centers advertise themselves as legitimate health centers, purposely distorting the truth to take advantage of vulnerable women.¹⁶ In reality, CPCs do not present women with a full range of reproductive health options; instead, they use false information about abortion to pressure women into continuing unwanted pregnancies.

CPCs receive significant government funding but are subject to minimal oversight.¹⁷

In 2011, Texas cut its annual funding for family planning services by two-thirds (from \$111 million to \$37.9 million) over a two-year period, while increasing state funding for CPCs.¹⁸ All but one of Texas’ 33 CPCs have overt religious affiliations,¹⁹ and a government contractor’s inspection found that many clinics failed to properly label religious material as separate from educational material.²⁰

A NARAL investigation in North Carolina found that most CPCs in the state had no medical professionals on staff, yet 75 percent of the centers failed to

disclose that they were not medical facilities.²¹ What’s more, over two-thirds of the clinics that NARAL investigated provided false or misleading information about abortion to those seeking care.²² An investigator posing as a Jewish woman was told she would not go to heaven unless she converted to Christianity – at five different centers.²³

CPCs also receive federal funding. Between 2001 and 2006, CPCs received approximately \$30 million in federal funds.²⁴ A 2006 congressional report found that 20 out of 23 federally funded centers had given false or misleading information about the risks of abortion.²⁵

CPCs employ a variety of misleading tactics, including enticing low-income and uninsured women with promises of free medical care, usually pregnancy tests and ultrasounds.²⁶ Although many centers actually do provide these services, this is the extent of the medical assistance they offer. The results are then used as a tactic to pressure women into forgoing abortion.²⁷ CPCs have also been known

to rent spaces next door to legitimate women’s health clinics in an effort to confuse women seeking medical advice or abortions.²⁸

CPCs have become such an effective tool for the anti-choice movement that conservative legislators are increasingly including the centers in their efforts to block women from obtaining abortion care. In March 2013, South Dakota became the first (and, to date, only) state to require a woman to visit a CPC before obtaining an abortion.²⁹ The state also extended an existing 72-hour required waiting period to exclude weekends and holidays, with the alleged purpose of ensuring that a woman has ample time to schedule an appointment at a CPC before the procedure.³⁰ The CPC visit law is currently blocked while a legal challenge from Planned Parenthood proceeds in federal court.³¹

MANDATORY WAITING PERIODS

3

it more difficult for women to obtain the care they need and want, and to which they are legally entitled.

Mandatory waiting periods require a woman to wait a certain amount of time (usually 24 hours) between consulting with a physician and undergoing an abortion.³² To date, more than 25 states have passed such laws³³; the longest current waiting period is in South Dakota, where women are forced to wait 72 hours, excluding weekends and holidays, before accessing abortion care.³⁴ Proponents of these laws claim they ensure that patients have time to receive counseling and consider all the options before having an abortion. In fact, studies have shown that mandatory waiting periods hurt patients, causing both emotional and financial harm.³⁵

Eighty-seven percent of U.S. counties do not contain a clinic that performs abortions.³⁶ This leaves millions of women without sufficient access to abortion care, forcing some patients to travel hundreds of miles to reach the nearest clinic.³⁷ Waiting periods disproportionately impact low-income and rural women because these laws require a woman to make two separate trips to an abortion clinic within a short period of time.³⁸ This may necessitate taking unpaid time off from work, making childcare arrangements, paying for lodging and traveling long distances. Many women seeking abortions are low-income single mothers,³⁹ and these laws place an enormous burden on such women; their limited means are stretched by anti-choice laws, and waiting periods mean that they must spend more time away from their children and jobs.

Waiting periods do the opposite of what legislators claim – rather than giving women time to consider their choice, they simply make it more difficult and costly to access desired care. These paternalistic laws assume that women do not carefully consider their options before choosing abortion. In fact, evidence shows just the opposite.⁴⁰ Studies show that waiting periods have an adverse emotional impact on women⁴¹ and do not change their minds about abortion.⁴² The primary impact – and intent – of waiting periods is to make

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RACE & SEX-SELECTIVE ABORTION BANS

Conservative lawmakers are increasingly turning to seemingly innocuous bans on race- and sex-selective abortion in the effort to restrict women's access to reproductive healthcare. Evidence suggests that the actual incidence of race- and sex-selective abortions in the U.S. is minimal.⁴³ In practice, these laws do nothing to combat actual discrimination, but instead serve as one more barrier to access, especially for minority women.⁴⁴

In 2011, Arizona became the first state to ban race- and sex-selective abortions.⁴⁵ The law made it a felony to knowingly perform or finance an abortion sought due to the race or sex of the fetus.⁴⁶ A federal ban – Prenatal Nondiscrimination Act (PRENDA) – has also been proposed, but it failed to pass in the House.⁴⁷

The ACLU is currently suing over the Arizona law, arguing that it creates an unconstitutional interference with a woman's right to choose, and that it requires doctors to engage in racial profiling and discrimination.⁴⁸ A major concern is that Asian-American women will be profiled and discriminated against in seeking abortion care, due to stereotypes that such women would be more likely to seek abortions of female fetuses.⁴⁹

24 TO 72+ HOURS MANDATORY WAITING PERIOD

MORE THAN 25 STATES HAVE PASSED SUCH LAWS. THE LONGEST CURRENT WAITING PERIOD IS IN **SOUTH DAKOTA**, WHERE WOMEN ARE FORCED TO WAIT 72 HOURS, EXCLUDING WEEKENDS AND HOLIDAYS

SOUTH
DAKOTA

Advocates are also concerned that African-American women will face discrimination and incorrect assumptions about their motivations for seeking abortions.⁵⁰ Higher rates of abortion among African-American women have led conservatives to claim that race-selective abortion is a widespread problem

and even to allege that abortion rights advocates are perpetrating a “genocide” against African Americans.⁵¹ These claims are not only false; they are insulting to women making private, personal choices about abortion.

These laws are dangerous to women of color and immigrants, as they place yet another barrier in the way of accessing safe reproductive healthcare. Women may be deterred from seeking care if they fear discrimination, refusal of service or criminal liability. These bans are virtually impossible to enforce; they only make it more difficult for vulnerable women to access care, while doing nothing to achieve the stated goal.

INTERFERENCE WITH MEDICAL PROVIDERS

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Some of the most insidious laws seeking to limit women’s access to reproductive care create barriers between women and their doctors by mandating that doctors provide medically inaccurate information or perform medically unnecessary procedures.

Restrictive laws do not protect women or lower rates of abortion; instead, they worsen the burden on women and may have a deleterious effect on the trend toward early abortion.⁵² Such laws also waste medical resources by mandating unnecessary treatment and interfere with physician judgment. Instead of a decision made by a doctor, in consultation with a patient and considering her health and circumstances, the government tells doctors what they must do, regardless of patient needs or medical necessity.

Outdated Constraints on Early-term Abortions

In the early stages of pregnancy, a woman can choose medical abortion instead of a surgical abortion.⁵³ In a medical abortion, the pregnancy is terminated by taking an FDA-approved medication that consists of the drugs mifepristone and misoprostol (sold under the brand name Mifeprex).⁵⁴ Medical abortion is a safe and effective treatment for women in the first seven to nine weeks of pregnancy.⁵⁵ The pill is safe enough to be taken at home, and normally does not

require any follow-up care.⁵⁶

The World Health Organization has long recommended that nurse-midwives, nurse-practitioners and physician assistants be permitted to prescribe Mifeprex.⁵⁷ However, FDA guidelines state that only a licensed physician may prescribe Mifeprex, and the agency requires that women seeking to take the drug make three separate visits to a doctor.⁵⁸ On the first visit, the patient is counseled and given a dose of Mifeprex.⁵⁹ Two days later, she returns for a second dose.⁶⁰ Two weeks after that, she has a follow-up visit.⁶¹

These cumbersome requirements are severely outdated and place an unnecessary burden on women. One study found that by 2001, 83 percent of providers were not using the FDA guidelines for medical abortion.⁶² However, several states still require doctors to comply with some or all of these guidelines.⁶³ Two states have laws requiring complete compliance with the FDA guidelines, while 39 others require compliance with some of the guidelines.⁶⁴ Most of these states limit prescribing authority to licensed physicians, while 10 require an ultrasound before Mifeprex is prescribed and eight require a physician to be present when the patient takes the medication, ruling out telemedicine.⁶⁵

Nine out of 10 abortions occur in the first 12 weeks of pregnancy, partly due to the advent of Mifeprex.⁶⁶

87%

OF U.S. COUNTIES DO NOT HAVE A CLINIC THAT PERFORMS ABORTIONS



Laws that restrict access to medical abortion place a burden on women by requiring multiple unnecessary doctor visits, depriving them of the chance to take the medication in the privacy and comfort of their own homes, forcing them to undergo unnecessary ultrasounds and attend counseling sessions, and requiring them to see a physician for a simple prescription. Instead of respecting the judgment and autonomy of women and their need for healthcare access, these laws complicate what should be a simple medical treatment.



Transvaginal ultrasound wand photo by Universidad EAFIT

Mandatory Counseling Laws

Mandatory counseling laws are another tactic used by anti-choice legislators to interfere with the doctor-patient relationship. Such laws limit a doctor's ability to adequately address a patient's needs on an individual basis, and threaten patient health by requiring that they be misinformed by their medical provider.

Currently, 25 states require that a woman be informed about the abortion procedure and fetal development.⁶⁷ Thirty-three states require that a woman be told the gestational age of the fetus, and 27 states require counseling on the stages of fetal development.⁶⁸ Twelve states mandate that a patient be told of the ability of a fetus to feel pain, despite the lack of scientific evidence for such a claim.⁶⁹ (An article published in the *Journal of the American Medical Association* found that fetuses cannot experience pain before 35 to 37 weeks of pregnancy.)⁷⁰ Five states require that a woman be told that personhood begins at conception (a blatantly unscientific claim).⁷¹ Twenty-four states require counseling about the potential risks of abortion.⁷²

Several of these states mandate that a doctor provide inaccurate information on the connection between abortion and breast cancer, and abortion and infertility.⁷³ Several states mandate that doctors give women biased information about the emotional and psychological impact of abortion.⁷⁴

By requiring medical professionals to provide biased and incorrect information, mandatory counseling laws corrupt the doctor-patient relationship and sacrifice women's well-being. To the lawmakers behind these bills, it is more important to dissuade women from abortion than it is to provide comprehensive and accurate medical information. Doctors are often unwilling participants in this charade, in which they are given a politically motivated script that they must present to their patients. Instead of receiving competent medical care, patients are bombarded with anti-choice propaganda that disregards their wishes, needs and rights.

Mandatory Ultrasound Laws

Mandatory ultrasound laws are another way in which legislators interfere with the doctor-patient relationship. Such laws require abortion providers to perform an ultrasound on a woman seeking a first-trimester abortion, even though such a procedure is generally not medically necessary.⁷⁵ Anti-choice activists claim that these laws help women to understand their decisions by giving them the benefit of more information.⁷⁶ However, by mandating unnecessary medical procedures, these laws burden women, make abortion more costly and time-consuming, waste medical resources and interfere with a doctor's discretion.

One physician at a Texas clinic, forced to describe a fetus with a severe molecular flaw, told his patient, "I'm so sorry that I have to do this – but if I don't, I can lose my license."⁷⁷ After reading state-mandated literature on the risks of abortion, the physician informed the woman that "the legal side" of her abortion care would be over only when she returned to the clinic after a mandatory 24-hour waiting period: "Then [after the waiting period] we'll care for you and give you the information you need in the way we think is right."⁷⁸

Currently, 21 states have laws requiring pre-abortion ultrasounds.⁷⁹ Louisiana and Texas require a doctor to perform an ultrasound, and then show and describe

the image to the woman.⁸⁰ The other 19 states have varying requirements that a woman be given the opportunity to view an ultrasound image.⁸¹ In 2012, Virginia was at the center of a debate over a proposed law that would have required women to undergo an invasive and medically unnecessary transvaginal ultrasound before accessing abortion care.⁸² Facing a major public outcry, legislators amended the law to require an abdominal ultrasound instead, and this version of the bill was signed into law by Virginia Gov. Bob McDonnell.⁸³ A 2013 attempt to repeal the bill was voted down by Republicans in the state legislature.⁸⁴

Like many other laws that restrict abortion access, mandatory ultrasounds burden women and make it more difficult to obtain care. An

American Independent found that viewing an ultrasound image or hearing a fetal heartbeat did not change women's minds about abortion.⁹¹ In passing these laws, legislators betray a fundamental misunderstanding about the reasons women choose to terminate their pregnancies. In reality, women primarily have abortions due to external circumstances⁹² (75 percent of patients cited existing family obligations and financial constraints, and 60 percent already had children.⁹³) Mandatory ultrasound policies are a coercive effort at emotional manipulation that has no place in the law and whose only result is to harm women.

Broadsides on *Roe v. Wade*: The Growing Danger of Personhood and Heartbeat Bills

21 STATES
HAVE LAWS REQUIRING PRE-ABORTION ULTRASOUNDS
LOUISIANA & TEXAS REQUIRE A DOCTOR TO SHOW & DESCRIBE THE IMAGE

\$200-\$1200 THE COST OF AN ULTRASOUND
MANY INSURANCE COMPANIES WILL NOT COVER
THE PROCEDURE BECAUSE IT'S NOT MEDICALLY NECESSARY

LA TEXAS

abdominal ultrasound performed before 12 weeks of pregnancy (when the vast majority of abortions take place)⁸⁵ is generally not medically necessary,⁸⁶ making such laws a waste of time for women and medical providers. Mandatory ultrasound laws also cost women money. An ultrasound costs between \$200 and \$1,200, and many insurance companies will not cover the procedure, as it is medically unnecessary.⁸⁷ Virginia's law requires that a woman be given information on obtaining a free ultrasound.⁸⁸ However, a list of free ultrasound providers compiled by the Virginia Department of Health was dominated by crisis pregnancy centers, which provide biased or false information and often do not have medical personnel on staff.⁸⁹

Mandatory ultrasound laws are also used in conjunction with waiting period laws to delay a woman's access to abortion care. In states with both laws, a woman often has to wait 24 hours or more between ultrasound and abortion.⁹⁰ These delays fall especially hard on low-income women and those living in rural areas.

Finally, mandatory ultrasound laws do not change women's minds about abortion. A study by The

Since the Supreme Court affirmed a woman's right to choose an abortion in 1973's *Roe v. Wade*, anti-choice activists have been split on how to go about restricting abortion rights.

Several major anti-choice groups, including Americans United for Life, argue for taking incremental measures in legislatures and in the courts to chip away at *Roe*'s protections. AUL's general counsel once compared his group's approach to carving a Christmas ham: "Each slice makes it smaller and smaller until it is no more."

While this "slice-by-slice" approach still dominates the anti-choice movement, more extreme attacks on choice have begun to enjoy some success in states and in the U.S. Congress. These blatantly unconstitutional head-on attacks on *Roe* – including "personhood," "heartbeat" and "fetal pain" measures – are frequently blocked by voters, legislatures and the courts. But even if these measures never become law, they present a real threat to women's health: By spreading these extreme views, anti-choice activists create a culture in which established rights are questioned, abortion providers live in fear and women's health access continues to be up for debate.

While incremental measures such as those outlined above provide the greatest immediate threat to women's healthcare access, it is important to also understand the risks posed by extreme broadsides on *Roe v. Wade*. In fact, anti-choice advocates see

even these extremist laws as incremental steps in chipping away at abortion rights: Even if personhood and heartbeat bills are overturned upon challenge, they have succeeded in calling abortion rights into question, and forcing pro-choice groups to spend time and money fighting these unconstitutional bans.⁹⁴

The “personhood” movement defines life as beginning at conception; a fetal personhood law would grant full legal rights to human embryos from the moment of fertilization.⁹⁵ Personhood laws present an extreme threat to women’s rights and health, preventing doctors from providing appropriate care to women, even when their lives are in danger. For example, under personhood laws, doctors could face restrictions on the treatment of ectopic⁹⁶ and molar⁹⁷ pregnancies, life-threatening conditions that necessitate early termination.⁹⁸ Personhood also leaves no room for considering the health or well-being of the pregnant woman. Under such a law, a woman would be forced to continue a pregnancy even if it was conceived against her will, through rape or incest.⁹⁹

North Dakota is the only state to have passed a personhood amendment to date, although several other states are considering such laws.¹⁰⁰ Passed by the state legislature in March 2013, the measure will come before voters in November 2014.¹⁰¹ If successful, it would change the state’s constitution to include a complete ban on abortion with no exceptions.¹⁰² Personhood laws are in blatant violation of *Roe v. Wade* and *Planned Parenthood v. Casey*, which held that the state does not have a strong enough interest to justify banning abortion before viability (about 24 weeks), and would therefore almost certainly be struck down if challenged in court.¹⁰³ But any decision could be appealed to the Supreme Court, which could overrule (or just find a way around) its precedents. The ultimate goal of the extreme personhood agenda is to overturn *Roe v. Wade* and

PERSONHOOD LAWS ARE IN BLATANT VIOLATION OF *ROE V. WADE* AND *PLANNED PARENTHOOD V. CASEY*



Personhood laws present an extreme threat to women’s rights and health, preventing doctors from providing appropriate care to women, even when their lives are in danger.

ban all abortions in the United States.¹⁰⁴

Heartbeat bills are less extreme than personhood bills, but, if passed and allowed to stand, would still severely limit abortion rights. Under a heartbeat law, abortions are banned after the point at which a fetal heartbeat can be detected on an ultrasound.¹⁰⁵ A heartbeat can be detected as early as six weeks into pregnancy – before some women may even be aware that they are pregnant¹⁰⁶ – but can only be detected using a transvaginal ultrasound.¹⁰⁷ Under a heartbeat law, a woman seeking an early-term abortion may have to submit to an unnecessary and invasive procedure to find out if she can legally terminate an unwanted pregnancy.

Heartbeat bills place an arbitrary limitation on a woman’s right to choose. The ability to hear a fetal heartbeat is completely irrelevant to the safety, necessity or legality of an abortion. Such laws are merely another attempt by anti-choice legislators to make it impossible for women to access safe and legal healthcare.

To date, North Dakota and Arkansas are the only states to have passed heartbeat bills, although similar laws are being considered by several others.¹⁰⁸ North Dakota's heartbeat bill will go into effect on August 1, 2013, but the Center for Reproductive Rights (among other advocacy organizations) has stated that it will file a lawsuit challenging the law before that date.¹⁰⁹ ACLU and CRR are currently challenging the Arkansas law; in May 2013, a federal judge granted a preliminary injunction blocking the law from going into effect.¹¹⁰

"Fetal pain" bills restrict abortion based on dubious scientific evidence that fetuses can feel pain after 20 weeks of pregnancy.¹¹¹ Since 2010, 10 states have passed fetal pain bills.¹¹² In June 2013, the U.S. House approved H.R. 1797, a national version of a fetal pain bill, which would ban abortion beginning at 20 weeks.¹¹³ However, such a law is unlikely to withstand constitutional scrutiny. Idaho's law was the first to be rejected by the courts. A federal district court struck down the law, citing *Roe v. Wade's* determination that pre-viability bans on abortion are impermissible.¹¹⁴ Similar laws in other states have been temporarily or permanently enjoined.¹¹⁵

Conclusion

The proliferation of extreme, blatantly unconstitutional "personhood" and "heartbeat" bills rightly continues to dominate headlines. But behind this troubling trend, quieter attacks on choice continue to chip away at women's constitutional right to legal abortion and reproductive healthcare. Reproductive choice loses its meaning if women lose the ability to access quality, affordable care. Anti-choice activists and lawmakers know that short of a reversal of *Roe v. Wade*, these incremental measures are the best hope they have for eliminating reproductive choice.

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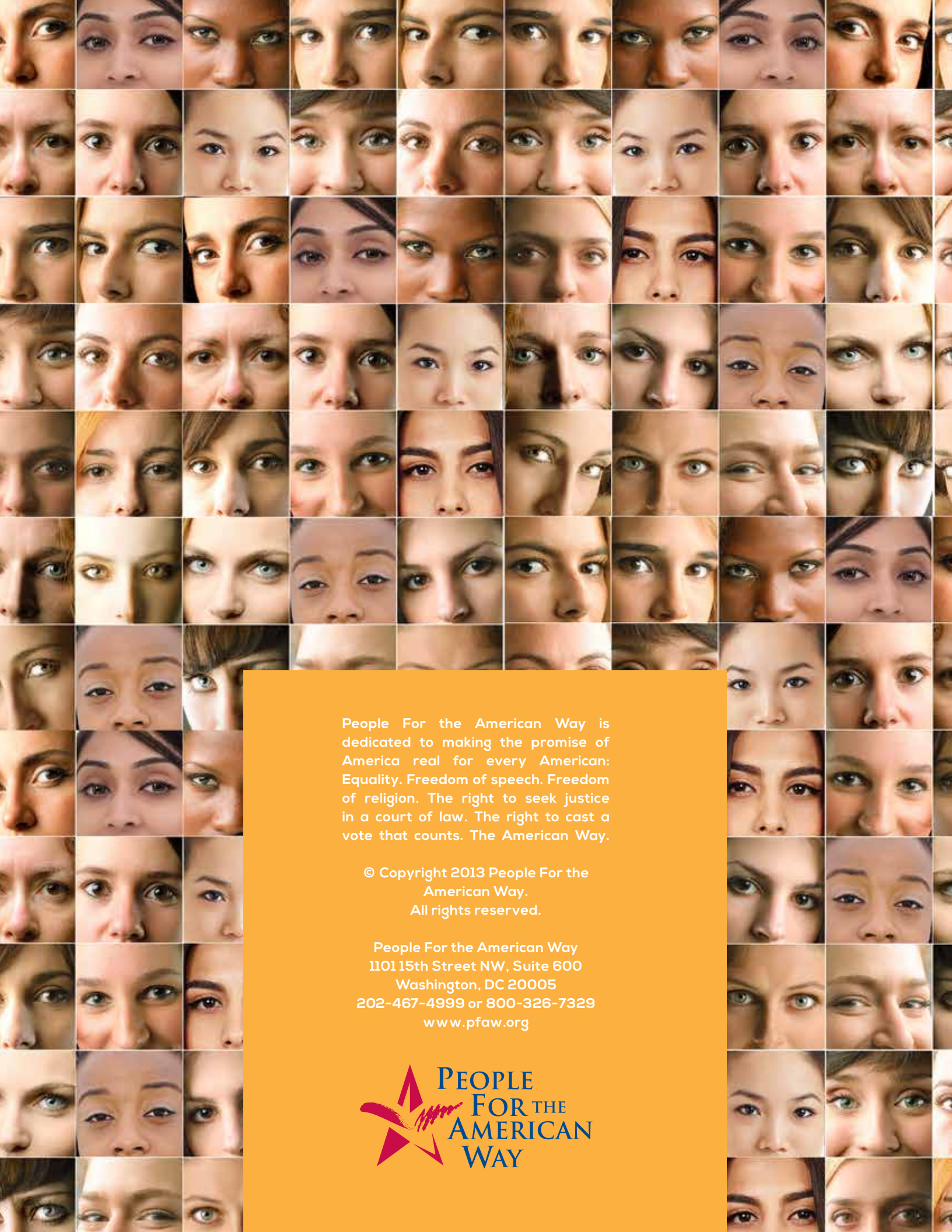
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People For the American Way
1101 15th Street NW, Suite 600
Washington, DC 20005
202-467-4999 or 800-326-7329
www.pfaw.org

