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Senate Committee on Health, Education, Labor, and Pensions
"The Assault on Women's Freedoms:
How Abortion Bans Have Created a Health Care Nightmare Across America"
June 4, 2023

Chairman Bernie Sanders (I-VT), Ranking Member Bill Cassidy, M.D. (R-LA)

Chairman Sanders, Ranking Member Cassidy, and members of the committee, thank you for inviting me to today's hearing.

I am a survivor of a failed saline infusion abortion and the Founder and CEO of *The Abortion Survivors Network*, which has connected with over 700 survivors of abortion procedures. Babies survived abortions before Roe vs. Wade, we survived during Roe vs. Wade, and babies are still surviving abortions, no matter where or how the abortion is performed, as I'll be sharing today. These experiences highlight the fundamental and undeniable humanity of the preborn and the needs, fears, and experiences of their mothers.

I appreciate the opportunity to have a serious conversation about this issue and for stories that highlight the impact of abortion to be told. My hope is that today's discussion is the catalyst for intellectual honesty, deeper conversations and understanding, and collective support across the aisle for women, children, and families.

Earlier this year, the Washington Post wrote a story about a woman named Evelyn. Evelyn was young and pregnant, and the article chronicled her decision to obtain an abortion and end her pregnancy. This is a common and familiar story, but this story had a plot twist. Her first abortion failed, her second also failed, but she persevered and sought a late-term abortion but was denied it. This, too, may be part of the familiar narratives. However, the redemption in her

story is evident, as she decided to place her child for adoption and now has a relationship with her daughter and the woman who raises her.[1] Her story is one of a failed abortion, one that I am very familiar with but many try to deny or hide. When the term "abortion survivor" is dismissed as "fake news," women like Evelyn and my birthmother, Ruth, are also being dismissed, their experience erased and denied with the experiences of those who survived– like Evelyn's daughter and me.

If we are going to talk about women's experiences with abortion and the nightmare of abortion, then we need to include these stories in the discussion, as well.

While Evelyn's trips to abortion clinics ended differently than expected—two separate attempts with medication abortion failed, and she was found to be too far along to abort a third time—they stand as proof that a pregnancy can continue after an abortion. Some of the most powerful words in this article came from the journalist, who expanded on and called attention to women's healthcare in America. Let me be clear: Women in America and around the world deserve better than abortion.

I empathize with Evelyn's shock at discovering that her first medication abortion failed. When a family friend and nurse arranged for bloodwork and an ultrasound at a hospital after months passed without her menstrual cycle returning, as directly quoted, she "fainted when she saw that there was a heartbeat, and was in and out of consciousness for about five minutes" (1).

As the journalist Amber Ferguson wrote with an honesty I appreciate,"Evelyn says she didn't know the pills sometimes didn't work. It is a rare occurrence, but she later learned that 3 percent of medication abortions fail when gestation reaches 70 days, or ten weeks, according to the American College of Obstetricians and Gynecologists. The odds of failure increase if the patient waits longer than prescribed to take the second dose of the medication, several medical experts said" (1)

[1] Ferguson, Amber. "After abortion attempts, two women now bound by child." April 6 2024. The Washington Post.

Abortion bans have not ended abortion– we've merely seen a shift to abortion pills. These pills have a lower success rate and result in women becoming their own DIY abortionist. The results of this access to abortion are staggering, nearly 1-8% of abortion pills fail, which means that women are still facing the same challenges as before, and put themselves and their child at risk for repeat abortion attempts (2345).

How could Evelyn know this when women aren't told this information? *The Abortion Survivors Network* hears these stories from women time and time again - they are shocked to discover they are still pregnant with the baby they attempted to abort. They are unaware that abortion procedures, including medication abortion, can fail. They feel shame and guilt, uncertainty and fear about their baby's future. They try to keep this a secret and often navigate it alone –whether they continue the pregnancy or attempt another abortion – or multiple abortions - as Evelyn did.

Women nationwide could identify with Evelyn's experience because it weaves several threads of an abortion experience. "Desperate, Evelyn found a website, Aid Access, that shipped abortion medication across the country. After speaking with a doctor by phone and paying $150, she waited for pills that were being mailed from India. Evelyn had told the doctor she wasn't sure the date of her last period" (1).

Shocking as it was for Evelyn, this second course of abortion drugs also failed to end her pregnancy.

This was not what Evelyn was told would happen. It must have been agonizing when she realized that not one, but now two medication abortions failed to end her pregnancy. But her story, and her daughter's story – her daughter's life— wasn't over yet.

As the article continues, "She found a clinic in Albuquerque that offered second-trimester abortions. She was past the halfway point in her pregnancy and approaching the third trimester, but she still had time, Evelyn told herself. The clinic staff warned about the health risks of having a surgical abortion so late in her pregnancy but helped connect her to two abortion organizations that covered the cost of her plane ticket, hotel, food and the $12,000 procedure…." (1).

We need to pause here and truly consider Evelyn and her daughter.

The support she was offered after the failure of two medication abortions was to pay for her plane ticket, lodging, food, and the $12,000 abortion that posed risks to her health.

This is an abysmal response to Evelyn and her baby. Evelyn needed emotional support, medical and mental health care, financial assistance, and answers to the questions she had about the impact medication abortion attempts had on her developing baby. Evelyn's baby deserved more than to be subjected to yet another attempt to end her life. *Can you imagine a child in your own life subjected to so called "medical treatments" intended to weaken, starve, burn or dismember them limb by limb until they die?*

This is the reality of abortion. *And we should be ashamed of it.*

Yet this story did not end in an abortion clinic. 'I'm so sorry,' Evelyn remembers the nurse telling her, looking at the screen. 'You are too far along, 32 weeks pregnant,' she said, pausing before adding, 'We can't help you.' The clinic's doctors aren't trained to perform abortions after 24 weeks, according to Southwestern Women's Options.

"Suddenly out of options for ending the pregnancy, Evelyn began to consider a future that had once seemed impossible. She would be giving birth" (1).

In *Deaths and severe adverse events after the use of mifepristone as an abortifacient*[2]*,* the researchers found that in 452 patients with ongoing pregnancy after the use of mifepristone—102 (22.57%) chose to continue the pregnancy, 148 (32.74%) terminated again, one miscarried and

[2] Aultman, Kathi et al. "Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019." Issues in law & medicine vol. 36,1 (2021): 3-26.

201 (44.7%) had unknown outcomes. Although there are a number of ways to interpret these statistics, for today's hearing to I want to emphasize the researchers' concluding concern:

> "The significant number of women who chose to continue their pregnancy after initially choosing termination raises concerns regarding pre-abortion counseling and informed consent they received…Additionally, the high percentage of women with ongoing pregnancies for whom there is no follow up or known outcome is concerning. As health care providers, we are to continue to care for our patients and manage any complications yet in the AER's (Adverse Event Reports) we reviewed this was not the case for the abortion provider. **Furthermore a federal directory of known outcomes and birth defects is imperative" (2).**

This hearing purports that abortion bans have caused a nightmare for pregnant women who are facing an unplanned, unwanted, or a complicated pregnancy. I want to correct that false narrative and remind you all that the nightmare existed before any bans took effect. The nightmare is that women have been made to believe that pregnancy is a problem. The nightmare is that women are told abortion will solve that problem.

The nightmare is that this "solution" continues to be aggressively promoted so that it is seen as the *only* solution–like a plane ticket and $12,000 for a late-term abortion. I ask you to consider how different women's lives, children's lives, families, our society could be if just as much money was spent to provide financial assistance, housing, education and employment support, childcare, and medical and mental health care. This would lead to a new era of women's empowerment, that ends the generational trauma of abortion--if that too pricey, then perhaps, we are spending too much money helping women get abortions.

When women know there is support available to them outside of seeking an abortion, then they are empowered and will make choices that everyone can live with. Evelyn's story proves this can happen. My story, and countless others, are proof this is an attainable reality in America, it is not just a dream.

Research Related to Abortion Survivors

Compiled by
The Abortion Survivors Network

Chemical Abortion - References to Ongoing Pregnancy, Failure, and Efficacy

The efficacy of medical abortion: a meta-analysis

From the text: "*This meta-analysis estimates rates of primary clinical outcomes of medical abortion (successful abortion, incomplete abortion, and viable pregnancy) and compares them by regimen and gestational age…We found that efficacy decreases with increasing gestational age ($p < 0.001$), and differences by regimen are not statistically significant except at gestational age ≥57 days…We conclude that both mifepristone and methotrexate, when administered with misoprostol, have high levels of success at ≤49 days gestation but may have lower efficacy at longer gestation.*"

Medical Abortion in Early Pregnancy

From the text: "*Initially, clinical investigators administered Mifepristone alone for early abortion. For gestations up to 49 days…continuing pregnancies [occurred] in 7-40%…The single largest medical abortion trial included women through 49 days' gestation…Failures included continuing pregnancies (1.2%)…Aubeny and Peyron et al. performed a multicenter trial that included 1,108 women…continuing pregnancy rates increased with advancing gestational age…A randomized, blinded study in India evaluated a routine second dose of Misoprostol…Continuing pregnancy rates were significantly different. Drugs used for medical abortion may increase the risk of birth defects in continuing pregnancies.*"

The time gap between doses of mifepristone and misoprostol influences the percentage of continuing pregnancies. Three studies are listed with gap times from 15 minutes to 25 hours and continuing pregnancy rates from 0.1 to 0.7%. The greater the wait between medications the greater the likelihood of continuing pregnancy.

With just vaginal misoprostol continuing pregnancy occurs in 4-10% of women.

Buccal Versus Vaginal Misoprostol Administration for the Induction of First and Second Trimester Abortions

From the text: "*Patients seeking abortion in second trimester were given 200 mg mifepristone followed by misoprostol 6 hourly for maximum of 6 doses by buccal or vaginal route…Three patients had continued pregnancy after maximum of 6 doses of misoprostol (36 h after first dose).*"

First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review

From the text: "*We identified 87 trials that collectively included 120 groups of women treated with a regimen of interest. Of the 47,283 treated subjects in these groups, abortion outcome data were reported for 45,528 (96%). Treatment failure occurred in 2,192 (4.8%) of these evaluable subjects. Ongoing pregnancy was reported in 1.1% (499/45,150) of the evaluable subjects in the 117 trial groups reporting this outcome. The risk of medical abortion failure was higher among trial groups in which at least 25% of subjects had gestational age >8 weeks, the specified interval between mifepristone and misoprostol was less than 24 h, the total misoprostol dose was 400 mcg (rather than higher), or the misoprostol was administered by the oral route (rather than by vaginal, buccal, or sublingual routes).*"

The efficacy of medical abortion: a meta-analysis

From the text: "*For gestations ≤49 days, mean rates of…ongoing (viable) pregnancy [were] 1–3%. For gestations of 50–56 days, the mean rate of…ongoing pregnancy [was] 3–5%. For ≥57 days, success was lower for mifepristone/misoprostol (85%, 95% confidence interval 78–91%) than for mifepristone/other prostaglandin analogues 95% (CI 91–98%, p = 0.006).*"

Two Distinct Oral Routes of Misoprostol in Mifepristone Medical Abortion

From the text: "*Ongoing pregnancy [through 49 days' gestation] occurred in 3.5% (15 of 426) of women who took oral misoprostol compared with 1.0% (4 of 421) of women in the buccal group (P.012; RR 3.71, 95% CI 1.24 –11.07)…Furthermore, in this gestational age group [57-63 days], there were significantly more ongoing pregnancies among women who took misoprostol orally (7.9% [9 of 114]) compared with buccally (1.7% [2 of 115]; P.029, RR 4.54, 95% CI 1.0 –20.55).*"

Deaths and Severe Adverse Events After the Use of Mifepristone

From the text: "[from FDA documents there were] 2660 (83.20%) Codable US AERs. Of these, 20 were Deaths, 529 were Life-threatening, 1957 were Severe, 151 were Moderate, and 3 were Mild…*Of 452 patients with ongoing pregnancies, 102 (22.57%) chose to keep their baby, 148 (32.74%) had terminations, 1 (0.22%) miscarried, and 201 (44.47%) had unknown outcomes. Of those with an unknown outcome, there were 44 patients referred or scheduled for termination, who did not follow through (39 no-showed, 3 canceled, 2 did not schedule)…A mandatory registry of ongoing pregnancies is essential considering the number of ongoing pregnancies especially considering the known teratogenicity of misoprostol.*"

"The 2016 changes in the Regimen and Prescriber Agreement extended the original gestational age limit from 49 days to 70 days, changed the mifepristone dose from 600 mg to 200 mg orally, changed the misoprostol dose from 400 mcg orally on Day 3 to 800 mcg buccally on Day 2 or 3, allowed non- physicians to become prescribers, reduced the number of required office visits from 3 to just one initial office visit…The requirement to report ongoing pregnancies that are not terminated was also eliminated."

Mifepristone With Buccal Misoprostol for Medical Abortion

From the text: "The overall efficacy of mifepristone followed by buccal misoprostol is 96.7% (95% confidence interval [CI] 96.5–96.8%) and the continuing pregnancy rate

is 0.8% (95% CI 0.7–0.9%) in approximately 33,000 pregnancies through 63 days of gestation…Currently available data suggest that regimens with a 24-hour time interval between mifepristone and buccal misoprostol administration are slightly less effective than those with a 24- to 48-hour interval."

Medical abortion in the late first trimester: a systematic review

From the text: "Medical abortion, as compared with surgical abortion, was effective in the late first trimester (94.6% versus 97.9% complete abortion). A combined regimen of mifepristone and misoprostol was significantly more effective than misoprostol alone (90.4 versus 81.6% complete abortion). Complete abortion rates for all regimens investigated ranged from 78.6% to 94.6%. Success rates were higher with repeat dosing of misoprostol both in combination regimens and alone, and with vaginal compared with oral administration for repeat dosing."

Complications after Second Trimester Surgical and Medical Abortion (Failure - Born-Alive Infant)

From the text: One randomised controlled trial was identified that compared outcomes between D&E and mifepristone–misoprostol medical abortion in the second trimester…The study was stopped after one year with only 18 enrolled subjects…Women assigned to receive mifepristone–misoprostol reported significantly more pain than those undergoing D&E (p=0.03). Although there were no statistically significant differences in complications between the two groups, six of nine women randomised to mifepristone–misoprostol had one or more adverse events associated with the procedure…one woman delivered a fetus that showed signs of life.

Chemical Abortion Reversal

A case series detailing the successful reversal of the effects of mifepristone using progesterone

From the text: "Intramuscular progesterone and high dose oral progesterone were

the most effective with reversal rates of 64% (P < 0.001) and 68% (P < 0.001), respectively. There was no apparent increased risk of birth defects. Conclusions: The reversal of the effects of mifepristone using progesterone is safe and effective."

Reversal of medication abortion with progesterone: a systematic review

From the text: "Data were available for 561 individuals who received progesterone after mifepristone, of whom 271 (48%) had ongoing pregnancies. The quality of the evidence in the case series was low due to methodological and ethical issues. Enrollment in the randomised trial stopped early due to bleeding events in both arms. The ongoing pregnancy rate for individuals ≤7 weeks who received progesterone was 42% (95% CI 37-48) compared with 22% (95% CI 11-39) for mifepristone alone. At 7–8 weeks, the ongoing pregnancy rate was 62% (95% CI 52-71) in the progesterone group and 50% (95% CI 15- 85) in the mifepristone alone group. Conclusion: Based mostly on poor-quality data, it appears the ongoing pregnancy rate in individuals treated with progesterone after mifepristone is not significantly higher compared to that of individuals receiving mifepristone alone."

Surgical Abortion Failure - Continuing Pregnancy

Early surgical abortion: Efficacy and safety

From the text: "*A total of 1132 eligible women had an early surgical abortion at Planned Parenthood between January 1, 1998, and August 31, 2000…2% of women had failed attempted abortions.*"

Surgical Abortion Failure - Born-Alive Infant

Born-Alive Abortion Survivors: Just the Facts

Babies have been known to survive abortion. At the start of 2023, 10 states required reporting on abortion survivors. There is no federal criminal penalty for neglecting to provide care to an infant who survives an abortion. 38 states have laws protecting born-alive infants, however, only 18 have sufficient protections. Born-Alive Abortion Survivor Legislation would require reasonable medical care be provided to surviving

infants. This is important since abortionists are generally not accountable to anyone for the care of a surviving infant.

Estimated Number of Born-Alive Abortion Survivors from Extrapolated Canadian Data

The United States lacks sufficient born-alive abortion recording requirements. The Canadian government funds institutions that collect data on abortion survivors within Canada. Mostly the same types of abortion procedures are performed in Canada as in the United States with similarly ranked healthcare performance. In Canada, an average of 0.21% of surgical abortions result in a live birth. If this rate holds true for the United States, then based on the CDC and Johnson's Archive abortion numbers, there are an average of 1,734 survivors each year.

Questions and Answers on Born-Alive Abortion Survivors

Late-term abortions still happen in the U.S. and frequently for the same reasons as earlier abortions - not because of fatal defects. There are many witnesses of abortion survival, both from personal stories and from state, CDC, and Canadian data. While life should be a basic right, only 18 states have adequate protections for born-alive abortion survivors.

Efficacy of Medical Versus Surgical Abortion

Randomized comparison of efficacy, acceptability and cost of medical versus surgical abortion

From the text: *Comparing abortion failure rates between medical and surgical abortion is difficult because the definition of a "failure" is inherently biased by the procedure itself. Since the goal of a medical abortion is to achieve complete expulsion without requiring a surgical procedure, a suction aspiration performed for any reason (including incomplete abortion, hemorrhage, continuing [viable] pregnancy, or patient request) is considered a failure of the method [4]. However, with surgical abortion, a repeat aspiration for an incomplete abortion, hemorrhage, or hematometra is considered a "complication," but not a "failure." After a surgical*

abortion, the procedure is considered to be a failure only if there is a continuing pregnancy.

Medical versus surgical abortion efficacy, complications and leave of absence compared in a partly randomized study

From the text: "*The number of complications was identical after the two methods, but surgical abortion was associated with a higher success rate [97.7% (708/725) vs. 94.1% (386/410)…We conclude that the chance of a primary successful termination at GA ≤63 days is higher after a surgical abortion in general anesthesia compared to a medical abortion induced with 600 mg mifepristone and 1 mg gemeprost.*"

Medical versus surgical abortion

From the text: "*Medical regimen had more side effects than surgical abortion, including bleeding, cramping, nausea and vomiting. Only fever was more frequent in the surgical method. The failure rates for medical abortion exceeded those for surgical abortion, 16.0% vs. 4.0%.*"