IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS

PLANNED PARENTHOOD ARKANSAS & EASTERN OKLAHOMA, d/b/a PLANNED PARENTHOOD OF THE HEARTLAND and STEPHANIE HO, M.D., on behalf of themselves and their patients, Plaintiffs, v. LARRY JEGLEY, Prosecuting Attorney for Pulaski County, in his official capacity, his agents and successors and MATT DURRETT, Prosecuting Attorney for Washington County, in his official capacity, his agents and successors, Defendants.	No. 4:15-cv-00784-KGB

DECLARATION OF STANLEY K. HENSHAW, PH.D. IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Stanley K. Henshaw, Ph.D., declares the following:

1. I am an independent consultant working on matters related to reproductive epidemiology, which is the study of the patterns, causes, and effects of behavior related to fertility in defined populations. Until 2013, I was for many years a Senior Fellow with the Guttmacher Institute, an independent nonprofit corporation involved in research, policy analysis, and public education in the field of reproductive health care. I joined the Guttmacher Institute in 1979 and served as its Deputy Director of Research from 1985 to 1999. Over the course of more than thirty years, I have researched and published extensively in the field of reproductive health care. I am the author of numerous studies on the effects of abortion restrictions, and am also familiar with the literature published by others in this area, including literature addressing the effect that an increase in the distance women must travel to obtain abortions has on their ability to obtain abortions. A

copy of my *curriculum vitae* is attached hereto as Exhibit A. I submit this declaration as an expert in reproductive epidemiology.

2. I understand that this lawsuit involves a challenge to two requirements of the Arkansas Abortion-Inducing Drugs Safety Act (the "Act"), specifically the requirements that:

- "Abortion-inducing drugs" may only be provided in a way that "satisfies the protocol authorized by the United States Food and Drug Administration, as outlined in the final printed labeling for the drug or drug regimen" ("FPL mandate"); and,
- A physician who provides medication abortion must contract with a physician who has "active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug" ("contracted physician requirement").

3. I understand that, because Plaintiff Planned Parenthood Arkansas & Eastern Oklahoma d/b/a Planned Parenthood of the Heartland ("PPH") cannot comply with the contracted physician requirement and because of the burdens of the FPL mandate, if the Act goes into effect, PPH will be forced to stop providing abortions entirely at both its Fayetteville and Little Rock health centers. I further understand that in fiscal 2015 alone, PPH's physicians provided over 500 medication abortions, over 300 of which were performed at the Fayetteville health center. Should PPH stop providing abortions, I understand there will be only one abortion provider remaining in the state, in Little Rock, which will offer only surgical abortion. Finally, I understand that Fayetteville is approximately 190 miles from Little Rock, and approximately 113 miles from the closest out-of-state abortion provider in Tulsa, Oklahoma.

4. The relevant demographic and epidemiological literature demonstrates that increasing the distance women must travel to obtain an abortion decreases the abortion rate, and that increased travel distance is associated with delays in abortion access. Based upon my review of the relevant research, it is my professional opinion that the elimination of abortion services at PPH will prevent a substantial number of women who would otherwise have had abortions in Arkansas from obtaining them, and will lead to delayed access to abortion for other women. These burdens are likely to be felt most acutely by low-income women, who are least able to overcome the costs and barriers that the increased travel would impose.

The Effect of Travel Distance on Abortion Rates

5. The best available research shows that increases in the distance women must travel in order to obtain abortions prevent women from having abortions they would have otherwise had. For example, in *Regulating Abortion: Impact on Patients and Providers in Texas*, Silvie Colman and Ted Joyce studied the impact of a Texas law that required that all abortions after 15 weeks' gestation be performed in an ambulatory surgical center ("ASC"). Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Tex.*, 30 J. Pol'y Analysis & Mgmt. 775 (2011). In 2004, when the law went into effect, none of the abortion clinics in Texas qualified as an ASC, which meant that there was an immediate decrease in the availability of abortion after fifteen weeks' gestation in the state. The result of this decreased availability of abortion providers was a significant increase in the average distance that a Texas woman had to travel to obtain an abortion after fifteen weeks' gestation: As the authors reported, the average distance from a woman's county of residence to the nearest county with a non-hospital provider of abortions after fifteen weeks' gestation increased from 33 miles in 2003 to 252 miles in 2004, an increased travel burden of 219 miles.

6. Colman and Joyce concluded that this increase in travel distance had a substantial negative impact on the ability of Texas women to obtain abortions after fifteen weeks' gestation. Examining vital records from Texas and from the health departments of neighboring and nearby states, the authors found that in 2004, the law was associated with a 69% decrease in the number of Texas women who obtained abortions after fifteen weeks, notwithstanding a fourfold increase in the number of Texas women who went out of state for such abortions. In other words, because of the law, many more Texas women traveled out of state to obtain abortions in 2004 than had previously been the case, but despite that fact, there still was a nearly 70% decline in the number of Texas women having abortions after fifteen weeks in the year the ASC law went into effect. As the study explains, although the Texas law may have encouraged some Texas women to have abortions earlier in pregnancy, this did not offset the reduction in the abortion rate that the increase in travel distance imposed: The study estimated that as a result of the law, over the course of three years, 6,631 abortions did not take place that would otherwise have occurred. In other words, even accounting for women who were able to obtain abortions out of state and women who were able to have earlier abortions, the travel burden imposed by the ASC law prevented thousands of women from obtaining abortions.

7. Similarly, in their study on Georgia abortion rates, Shelton et al. concluded that "the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one." James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persp. 260 (1976). The Shelton study examined abortion rates in Georgia counties at various distances from Atlanta (where all of the major abortion providers in Georgia were located in 1974), and found that for every ten miles of distance from Atlanta, there was a decline of 6.7 abortions per 1,000 live births.

8. In addition, the Shelton study evaluated the impact that reducing the distance women had to travel to obtain abortion care had on abortion rates, and found once again that distance had a substantial impact on abortion rates. Specifically, between 1974 and 1975, two new abortion clinics opened in Georgia—one in Muscogee County and one in Richmond County, each of which is more than 100 miles from Atlanta. From 1974 to 1975, Muscogee County saw a 35% increase in the number of abortions per 1,000 live births, and, significantly, the counties within fifty miles of Muscogee saw a nearly 43% increase. Similarly, from 1974 to 1975, Richmond County had a nearly 49% increase in the number of abortions per live 1,000 live births, and the counties within fifty miles of Richmond—all of which are more than fifty miles from Atlanta—saw a 40% increase. The findings from the Shelton study show that travel distance, including distances far less than those at issue in the Joyce study, has a substantial effect on abortion access.

9. Other studies of the impact of travel distance on abortion rates have reached comparable conclusions—longer travel distances to access an abortion provider correlate with lower abortion rates. *See* Robert W. Brown, R. Todd Jewell & Jeffrey J. Rous, *Provider Availability, Race, and Abortion Demand*, 67 S. Econ. J. 656 (2001); Sharon A. Dobie, et al., *Abortion Servs. in Rural Wash. St., 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Fam. Plan. Persp. 241 (1999). The Brown study of Texas counties found that a doubling of the distance to a county with an abortion provider was associated with a 23% decline in the abortion ratio for white women, 27% for African-American women, and 50% for Hispanic women. The Dobie study found that due to a decline in the number of providers, abortion services became less available in rural but not urban areas between 1983-1984 and 1993-1994. On average, the distance traveled by rural women for an abortion increased by 12 miles. The abortion rate

among rural women declined by 27% and among urban women 17%. Thus, the 12-mile increase in distance caused a 10% fall in abortions among rural women as compared with urban women.[1]

10. A recent study of the effects of abortion restrictions in Texas similar to those at issue in this case also confirms the impact of distance as a barrier to women with unwanted pregnancies. *See* Daniel Grossman, et al., *Change in Abortion Servs. After Implementation of a Restrictive L. in Tex.*, 90 Contraception 496 (2014). In November 2013, a law in Texas containing a medication abortion FPL mandate and requiring abortion providers to have hospital admitting privileges resulted in the reduction of the number of abortion providers in Texas from 41 to 22. Prior to this law going into effect, approximately 10,000 women lived more than 200 miles from an abortion provider; after the law went into effect, approximately 290,000 women lived more than 200 miles from an abortion provider. Correspondingly, during the six months after the law took effect, the abortion rate declined by 13% compared with the same six months in the previous year. Since three-fourths of the state's population of women of reproductive age reside in the four largest metropolitan areas, each of which continued to have three or more abortion facilities, the decline must have been much greater than 13% in the other areas of the state. In these areas of the state, the number of providers declined from 11 to 2. In the Lower Rio Grande Valley, where the only two clinics closed, the number of abortions declined 21%. In

[1] The Shelton study addresses whether these results can be explained by the possibility that "rural women (who generally live farther away [from abortion providers]) may, in fact, simply desire or need fewer abortions." James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persps. 260, 262 (1976). As the authors explain, the data do not support this alternative explanation for the effect of distance on abortion incidence: "However, when only rural counties are included, the negative correlation is still strongly apparent. In addition, the opening of two new freestanding clinics in two small *urban* counties resulted in approximately the same percent increase in use of abortion in the surrounding *rural* counties as in the urban counties where the clinics operated." *Id.* (emphasis in original). In other words, the data support the conclusion that it is travel distance, not urban versus rural preferences, that accounts for the impact on abortion incidence.

addition, statewide there was a statistically significant increase in the proportion of abortions that occurred in the second trimester.

11. Considering the results of these studies, I estimate that, in general, an additional travel burden of 100 miles will cause 20 to 25% of women who would have otherwise obtained abortions not to obtain them. Greater distances will be a barrier to an even higher percentage of women.

Impact on Low-Income Women

12. Increasing the travel distance increases the financial cost and logistical hurdles of obtaining an abortion. *See* James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persps. 260 (1976); R. Todd Jewell & Robert W. Brown, *An Econ. Analysis of Abortion: The Effect of Travel Cost on Teenagers*, 37 Soc. Sci. J. 113 (2000). The impact of increasing the distance women must travel to obtain an abortion (and, by extension, the financial and logistical barriers to abortion access) will be particularly acute for low-income women. Indeed, many low-income women already strain to access and afford abortion services, and low-income women have fewer resources to overcome the burdens that diminished access to abortion providers would impose.

13. Due to a combination of factors, including relative lack of access to medical services and difficulty accessing and affording contraceptives, low-income women have more unintended pregnancies, and higher abortion rates, than women with higher incomes. *See* Lawrence B. Finer & Mia R. Zolna, *Shifts in Intended and Unintended Pregnancies in the United States, 2001-2008*, 104 (no. S1) Am. J. of Pub. Health S43 (2014). Consequently, a disproportionately high percentage of the women who seek abortions have poverty-level incomes. In 2008, 42% of women having abortions in the United States had incomes below the

federal poverty level (in 2015, $11,770 for a single person, or $24,250 for a family of four, *see* 2015 Poverty Guidelines, U.S. Dep't of Health and Hum. Servs. (Sept. 3, 2015), http://aspe.hhs.gov/poverty/15poverty.cfm#thresholds), and another 27% had incomes between 100 and 199% of poverty. *See* Rachel K. Jones, Lawrence B. Finer & Susheela Singh, *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Institute (2010), https://www.guttmacher.org/pubs/US-Abortion-Patients.pdf.

14. Research shows that increases in the cost associated with obtaining an abortion have a major impact on the ability of low-income women to access abortion services. For example, a study on data from North Carolina examined the impact of short-term cutoffs in public funding for abortion for indigent women. The state of North Carolina provided a fixed amount of funds that could be used to pay for abortions for women who were indigent. During five of the years between 1980 and 1994, the fund was depleted, on average four months before the end of the fiscal year. The authors of the study found that the annual cutoff when these funds were depleted—that is, the period when indigent women had to pay the cost of the procedure without state assistance—was associated with a statistically significant decline in abortions and a statistically significant rise in births: "the implication is that a shortfall in funding would have resulted in over 1 in 3 women (37%) who would have obtained an abortion if the state had paid for it, instead decided to carry the baby to term." Phillip J. Cook, et al., *The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes*, 18 J. of Health Econ. 241 (1999). As the authors note, it "is rather remarkable that the necessity of paying a couple-of-hundred-dollar fee for an abortion is sufficient to persuade (or compel) some women to incur the much larger financial and personal costs of bearing an unwanted child." The study indicates that for indigent

women, increases in the cost of obtaining an abortion can have a substantial negative impact on their ability to obtain abortions.

15. Other studies have reached similar results, concluding that when indigent women were faced with paying for the cost of abortions that had previously been covered by Medicaid, many were prevented from obtaining abortions altogether. *See* James Trussell, et al., *The Impact of Restricting Medicaid Financing for Abortion*, 12 Fam. Plan. Persp. 120 (1980); *Effects of Restricting Federal Funds for Abortion – Tex.*, 29 Morbidity & Mortality Wkly. Rep. 253 (1980).

16. The impact of cost on abortion access for low-income women is not, of course, confined to the Medicaid context. Multiple studies have shown that women who experience delays in obtaining abortions frequently cite among the factors that caused the delay (1) acquiring the funds to pay for the procedure, and (2) overcoming transportation-related hurdles. For example, in a 2006 sample of 1,209 abortion patients in 11 clinics, among those who said that they would have preferred to have had their abortions earlier, 26% said they were delayed by the time needed to acquire the money needed to have the abortion, and 7% were delayed because there was no nearby clinic and they had to arrange transportation. Lawrence B. Finer, et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334 (2006).

17. Similarly, a survey of women who had abortions at 30 clinics selected to represent all clinics nationally showed that, of women who had abortions at or after 16 weeks and experienced delay, 28% reported that a reason for the delay was the time they needed to obtain money to pay for the abortion, and 12% reported that a reason was that they had to arrange

transportation because there was no nearby provider. Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20 Fam. Plan. Persps. 169 (1988).

18. Moreover, the Finer and Torres studies make clear that "[l]ower-income women are . . . more likely to have later abortions," Finer, *supra*, at 335, and that for women who seek abortions in the second trimester but who would have preferred to have had earlier abortions, the burdens of raising money for the procedure and making travel arrangements to access the clinic played an especially significant role in causing delay. In the Finer study, of second-trimester patients who experienced unwanted delay, 36% attributed the delay to the need to raise money; 16% were delayed because they had difficulty finding out where to get an abortion; and 9% were delayed by the need to obtain transportation to a non-local provider. The Torres study found that of women seeking abortions at sixteen weeks or later who experienced delay, nearly half attributed the delay to difficulties in making arrangements for the abortion—difficulties that included the time necessary to raise money, challenges in arranging for transportation, trouble finding out where to obtain an abortion, and difficulty in arranging for child care.

19. It is also important to recognize that the Finer and Torres studies reviewed above necessarily capture only those women who *were* ultimately able to obtain abortions. For many women, however, increasing the travel and financial burdens associated with obtaining an abortion can impose an insurmountable barrier, as the other studies discussed above indicate.

Application of this Research to the Present Case

20. As the preceding discussion explains, research shows that an increase in the distance women must travel to access an abortion leads to a decrease in the abortion rate. When women are forced to travel longer distances to obtain an abortion, some women are unable to do so—that is, some women who would otherwise have terminated their pregnancies are prevented

from doing so. And of the women who are able to travel to a non-local provider, longer travel distances (and the increased cost associated with them) lead to delayed access to abortions, especially for low-income women.

21. As set forth above, I understand that PPH's Fayetteville health center is the only abortion provider in the Fayetteville metropolitan area, and that the only remaining provider in the state should the Act go into effect will be located in Little Rock, approximately 190 miles away. Women living in Fayetteville who currently do not need to travel to obtain an abortion would need to travel an additional 190 miles each way to obtain an abortion in Little Rock should the Act go into effect. In addition, even if only the FPL mandate goes into effect, such that PPH is able to provide medication abortions in Fayetteville according to the FPL regimen, women whose pregnancies are between 49 and 63 days gestation will still have to travel to Little Rock for a surgical abortion. I understand that the majority of PPH's medication abortion patients in Fayetteville fall into this category, so a substantial number of women would still be affected by the travel burden if only the FPL mandate went into effect.

22. The research reviewed above shows that such an increase in the travel distance needed to access an abortion will prevent at least 20 to 25% of affected women in and around Fayetteville from obtaining an abortion. In particular, the Matthews, Shelton, and Brown studies specifically demonstrate that changes in travel distances of even lesser magnitude than the 190 mile increase here significantly impact abortion rates. In addition, given that women in Arkansas must generally make two trips to an abortion provider (separated by forty-eight hours) before obtaining an abortion, the effect of eliminating the closest abortion provider would likely be even more burdensome for women in and around Fayetteville than the effect shown in these studies. The additional 190 miles translates into 760 miles for two round trips.

23. Traveling out of state would not alleviate these burdens either. Fayetteville is approximately 113 miles from the closest out of state abortion provider in Tulsa, Oklahoma, and it is my understanding that Oklahoma also requires that patients make two trips to an abortion provider (separated by 72 hours) before obtaining an abortion.

24. The travel burdens reviewed above are likely to be especially great for low-income women, who are least likely to be able to overcome the financial and logistical hurdles such additional travel would entail. As noted above, 42% of women who have abortions have incomes below the federal poverty level—that is, less than $11,770 in annual income for a single individual.[2]

25. To put these figures into perspective, an income below the federal poverty level amounts to less than $980.83 per month. The fair market rent for a one-bedroom apartment in Fayetteville, Arkansas, as determined by the United States Department of Housing and Urban Development, is $548 per month.[3] If an individual in Fayetteville with an income below the federal poverty level were to pay the fair-market rate in rent, she would have less than $432.83 per month remaining to cover the cost of food, child care, clothing, transportation, utility bills, and other necessities. Without even accounting for costs such as travel and time off of work, the average cost of a first-trimester abortion is nearly $500, and the average cost of a later procedure is much greater.[4] And unlike the costs of other forms of medical care, federal and state Medicaid do not cover the cost of an abortion. With such limited financial resources, low-income women

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[2] *See* Rachel K. Jones, Lawrence B. Finer & Susheela Singh, *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Institute (2010), https://www.guttmacher.org/pubs/US-Abortion-Patients.pdf.

[3] *See* Fair Market Rent, U.S.Dep't of Housing and Urb. Dev., http://www.huduser.org/portal/datasets/fmr/fmrs/FY2015_code/select_Geography.odn.

[4] *See* Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Servs. in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24 Women's Health Issues 419 (2014).

affected by the closure of PPH's Fayetteville health center will be severely burdened by the resultant increase in travel distance. Such travel is not free. A woman would at the very least have to pay for transportation costs (e.g., gas, tolls, cost of public transportation) and possibly for lodging—and the likelihood of having to pay for lodging is heightened by Arkansas's 48-hour waiting period law requiring two separate visits to the clinic. And on top of the direct travel costs themselves, forcing women to travel longer distances to access abortion services would mean increasing other costs women must shoulder in order to access care, including costs of childcare and of taking time off of work. Given this array of costs, it is little wonder that the research shows that imposing the sort of travel burdens that women would face if the Fayetteville health center ceased providing abortions amounts to an insurmountable barrier to their ability to obtain an abortion.

26. Finally, it is my opinion that even when women are able to overcome the above-described obstacles and travel to an abortion clinic, many are likely to experience unwanted delay. Unwanted delay increases the cost of the procedure (potentially putting access to an abortion even further out of reach for indigent women).

27. In summary, it is my opinion that the elimination of abortion services in Fayetteville will prevent a substantial proportion of women who would have obtained an abortion at the Fayetteville health center from being able to obtain abortions, and will cause many of the women who are ultimately able to access an abortion provider to experience unwanted delay.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: January 17, 2016

Stanley K. Henshaw, Ph. D.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on January 19, 2016, I electronically filed the forgoing with the Clerk of the Court using the CM/ECF system, which shall send notification of such filing to the following:

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/s/ Bettina E. Brownstein
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EXHIBIT A

Curriculum Vitae

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STANLEY K. HENSHAW
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Education

Ph.D. Columbia University, Department of Sociology, 1971.

A.B. Harvard College, 1960. Field of concentration, physics.

Professional Experience

2000 - present: Consultant for various nonprofit organizations on research concerning fertility control services and behavior.

2000 - 2013: Senior Fellow, Guttmacher Institute, New York, New York (part-time consultant). Report writing and advising on research regarding abortion and family planning services.

1979 - 1985: Senior Research Associate, and 1985 - 1999: Deputy Director of Research, The Alan Guttmacher Institute. General duties include proposal writing, design, supervision of data collection, analysis and report writing for research projects on fertility-related issues. Responsible for overseeing a periodic survey of all abortion providers in the United States.

1978 - 1979: Senior Analyst, Zanes & Assoc. Inc., a marketing research firm in Fort Lee, New Jersey. Responsibilities included supervising two project directors, overseeing all phases of survey research projects (sampling, questionnaire construction, data collection and validation, data processing, analysis, and report writing), and report writing for focus group interviews.

1977 - 1978: Senior Analyst, Roger Seasonwein Associates, New Rochelle, New York. Responsibilities were concentrated in the following areas of public opinion research: questionnaire construction, survey data analysis using multivariate and other statistical methods, report writing, and statistical programming.

1976 - 1978: Coadjutant, Rutgers University, teaching statistics in the nursing master's degree program, and consulting on various survey research projects.

1971 - 1976: Research Associate, Cornell University Medical College, Department of Public Health. Evaluated the PRIMEX Family Nurse Practitioner Project using survey research and experimental techniques. Also conducted an evaluation of a continuing education program for physicians and nurses.

1971 - 1975: Survey research consultant on various projects, including a study of alcoholism programs conducted by the National Study Service, a study of hospital administrators by the Alumni Association of the Columbia University School of Public Health, and others.

1969 - 1971: Research Associate, Columbia University School of Public Health. Conducted a study of consumer reactions to automated multiphasic health screening. The research involved personal interviews with 1,300 users and potential users of a free health testing program to identify factors related to acceptance and utilization of the program.

1967 - 1968: Consultant on the evaluation of an experimental rehabilitation program for skid-row alcoholics administered by the Community Council of Greater New York.

1965 - 1967: Senior Research Assistant, Bureau of Applied Social Research, Columbia University, on the "Homelessness Project," a study of skid-row alcoholics.

Professional Activities

Reviewer for the *American Journal of Epidemiology, American Journal of Obstetrics and Gynecology, American Journal of Preventive Medicine, American Journal of Public Health*, *American Psychologist, BMC Public Health, Contraception, Demography*, *Health Reports* (published by Statistics Canada), *The Journal of Rural Health, Journal of Policy Analysis and Management, Journal of the American Medical Association*, *Journal of the American Medical Women's Association, Obstetrics & Gynecology, Paediatric and Perinatal Epidemiology, Perspectives on Sexual and Reproductive Health, Psychological Medicine, Public Health Reports*, *Social Science & Medicine, Social Science Quarterly, Studies in Family Planning*, and *Women's Reproductive Health.*

Member, Board of Directors, Abortion Access Project (Cambridge, MA), 2005 to 2011.

Member, Board of Directors, National Abortion Federation, 1989 to 1995.

Associate Editor, *Health and Society: The Milbank Memorial Fund Quarterly*, December, 1973 to June, 1976.

Memberships:

American Public Health Association
European Society of Contraception and Reproductive Health
International Union for the Scientific Study of Population
Population Association of America
Society of Family Planning

Honors:

2015 Lifetime Achievement Award, Society of Family Planning, 2015

Felicia Stewart Advocacy Award, American Public Health Association, Population, Reproduction, and Sexual Health Section, 2015
Alan Guttmacher Lectureship, Association of Reproductive Health Professionals, 2008
Carl S. Shultz Award in Recognition of Outstanding Contributions to the Field of Family Planning and Reproductive Health, American Public Health Association, Population, Family Planning and Reproductive Health Section, 2006
Champion of Reproductive Health, Ipas (Chapel Hill, NC), 2004
Christopher Tietze Humanitarian Award, National Abortion Federation (Washington, DC), 2000
Outstanding Scientific Contribution, National Family Planning and Reproductive Health Association (Washington, DC), 2000
Best Clinical Paper, National Abortion Federation (Washington, DC), 1986

Expert witness in numerous federal and state legal proceedings concerning abortion and adolescent sexual behavior.

Publications

Kathryn Kost and Stanley Henshaw: *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*. New York: Guttmacher Institute, May, 2014 (http://www.guttmacher.org/pubs/USTPtrends10.pdf).

Stanley K. Henshaw: "Epidemiological Aspects of Induced Abortion." The Global Library of Women's Medicine. (ISSN: 1756-2228) 2014; DOI 10.3843/GLOWM.10437 (http://www.glowm.com/section_view/item/436).

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Gilda Sedgh, Susheela Singh, Iqbal Shah, Elisabeth Aahman, Stanley K. Henshaw and Akinrinola Bankole: "Induced abortion: incidence and trends worldwide from 1995 to 2008." *The Lancet* 379:625-632, 2012.

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Gilda Sedgh, Susheela Singh, Stanley K. Henshaw, and Akinrinola Bankole: "Legal Abortion Worldwide in 2008: Levels and Recent Trends." *International Perspectives on Sexual and Reproductive Health* 37:84-94, 2011.

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Stanley K. Henshaw: "Issues in Contraception and Abortion: The Debate Rages." In Madelon L Finkle, ed., *Public Health in the 21st Century, Volume 1: Global Issues in Public Health*. Santa Barbara: Praeger, 2010, 347-370.

Jennifer J. Frost, Stanley K. Henshaw, and Adam Sonfield: *Contraceptive Needs and Services: National and State Data, 2008 Update*. New York: Guttmacher Institute, May 2010.

Stephanie J. Ventura, Joyce C. Abma, William D. Mosher and Stanley K. Henshaw: "Estimated Pregnancy Rates for the United States, 1990-2005: An Update." *National Vital Statistics Reports,* Vol. 58, No. 4, 2009.

Stanley K. Henshaw, Theodore J. Joyce, Amanda Dennis, Lawrence B. Finer and Kelly Blanchard: *Restrictions on Medicaid Funding for Abortions: A Literature Review.* New York: Guttmacher Institute, June 2009.

Theodore J. Joyce, Stanley K. Henshaw, Amanda Dennis, Lawrence B. Finer and Kelly Blanchard: *The Impact of State Mandatory Counseling and Waiting Period Laws on Abortion: A Literature Review.* New York: Guttmacher Institute, April 2009.

Amanda Dennis, Stanley K. Henshaw, Theodore J. Joyce, Lawrence B. Finer and Kelly Blanchard: *The Impact of Laws Requiring Parental Involvement for Abortion: A Literature Review.* New York: Guttmacher Institute, March 2009.

Rachel K. Jones, Kathryn Kost, Susheela Singh, Stanley K. Henshaw and Lawrence B. Finer: "Trends in Abortion in the United States." *Clinical Obstetrics and Gynecology* 52:119-129, 2009.

Stanley K. Henshaw: "Induced Abortion: Epidemiologic Aspects." In John J. Sciarra, ed., *The Global Library of Women's Medicine (ISSN: 1756-2228)* 2008; DOI 10.3843/GLOWM.10437, 2008.

Stanley K. Henshaw and Kathryn Kost: *Trends in the Characteristics of Women Obtaining Abortions, 1974-2004.* New York: Guttmacher Institute, 2008.

Stephanie J. Ventura, Joyce C. Abma, William D. Mosher and Stanley K. Henshaw: "Estimated Pregnancy Rates by Outcome for the United States, 1990-2004." *National Vital Statistics Reports,* Vol. 56, No. 15, 2008.

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