REPRODUCTIVE RIGHTS:

A POLITICAL, PROFESSIONAL AND PERSONAL ISSUE

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THE BUSINESS AND PROFESSIONAL WOMEN'S FOUNDATION
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July 1992

Twenty years ago, it was a common practice for women to quit their jobs when they became pregnant -- either by choice or because their employer left them no choice. It was also rare for women to return to the workplace after the birth of the child -- they were expected to stay home and tend to their families' needs.

Women's roles as mothers and wives were intertwined with their roles in the work force -- and any change in the woman's reproductive status always had repercussions on her career choices. Even though women's work lives have changed considerably over the past two decades, their reproductive decisions still affect their employment decisions.

On first blush, reproductive rights might appear to be incidental to a woman's struggle for workplace equity. A thoughtful analysis of the issue, however, suggests that reproductive rights are essential to women's full participation in the workplace. Reproductive rights, boiled down to its essence, is about individuals being able to make choices without government involvement in this most personal of arenas. It is about workplaces where all employees are protected from reproductive health hazards. It is about the choice to be informed about and to use contraceptives. It is about infertility research. It is about the right to have children. It is also about the right to have an abortion.

Reproductive rights is not about being *pro-abortion*, though. No one is pro-abortion; rather, one is supportive of a woman's right to determine the choices that are best for her, under her own unique circumstances.

Today, women's reproductive rights are increasingly under siege. More and more, the issue of reproductive rights is posed as an ideological controversy encompassing much more than a woman's right to choose whether or not to have a child. The meaning of the family, motherhood and women's place in society are also included in this debate. A desire to return American society to more traditional times -- times in which, not coincidentally, women's options were much more restricted -- pervades the movement opposing reproductive rights. On one level, the opposition to reproductive rights is a response to the increasing empowerment of women. The underlying issue of reproductive rights is really quite simple, though. At question is "who decides?" -- the woman involved or the government.

Procreative decisions are by their very definition private ones, and once the door is opened to government restrictions it will be hard to close. If the government can deny women the right to terminate a pregnancy, then that same government can also force a woman to terminate a pregnancy. If a government can deny a woman access to contraceptive information and methods, it can also force these methods upon her. Restricting a woman's reproductive rights will not simply restrict her right to a safe, legal abortion or her right to use contraception. Rather, such restrictions will cede to the state the right to control her decisions about becoming a parent. Former Supreme Court Justice William Brennan wrote, "If the right to privacy

means anything, it is the right of the individual, married or single, to be free from unwanted governmental intrusions into matters so fundamentally affecting a person as to whether to bear or beget a child."

WHO HAS ABORTIONS?

For over a third of her life, the average American woman is trying to avoid pregnancy. Two-thirds of all women have at least one unintended pregnancy by the time they reach menopause. More than half of the 6 million pregnancies that occur in the United States each year are unintended, and half of those pregnancies, or 1.6 million, end in abortion.[1]

In 1960, 1.2 million illegal abortions were performed. In 1972, there were 650,000 legal abortions, by 1975, 1 million and by 1980, 1.6 million. The number of abortions has remained fairly constant since then.[2] Contrary to common opinion, women do not use abortion as a form of birth control. The majority of women obtaining abortions were using some variety of contraceptive method during the month in which they became pregnant, and 92 percent of women who are at risk of becoming pregnant practice some form of contraception.[3] Abortions are also not commonly performed after the first trimester. 91 percent of all abortions are performed in the first trimester. Only one-half of 1 percent of all abortions occur after the 20th week of pregnancy.[4]

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Young, unmarried women, the majority of them teenagers or in their early 20s, are those women most likely to choose to terminate their pregnancies. 82 percent of all women who had abortions in 1987 were unmarried and two-thirds had family incomes of $25,000 and under per year.[5]

A woman's decision to terminate a pregnancy is never made lightly. Women usually give a number of reasons for choosing to have an abortion but their economic situation always figures in the decision. The majority of women seeking an abortion are either enrolled in school or are employed. An unplanned pregnancy can wreak havoc on a woman's educational and employment plans -- not only during the pregnancy but for the rest of her life.

Compared with all American women of reproductive age, women seeking abortions are younger and poorer -- and usually not as able to handle the emotional and financial burdens posed by a child. For young women, an unplanned pregnancy can have particularly devastating results. Teenagers who become mothers are much more likely than other young women to develop health problems, to drop out of school, to have their marriages end in divorce and to struggle with poverty.[6] Furthermore, a four-year study conducted by the Johns Hopkins School of Hygiene and Public Health of 334 pregnant young women aged 17 and younger found that those who had

abortions did better economically, educationally and emotionally.

WHERE ARE ABORTIONS DONE?

Abortions are usually performed in clinics or private medical offices, not hospitals. 87 percent of abortions take place in physicians' offices or freestanding clinics that may or may not specialize in abortion services. Only 21 percent of all general, short-stay hospitals nationwide offer abortion services to their female patients.[7]

The number of obstetrician and gynecology programs that offer abortion training declined 22 percent between 1976 and 1985. Most of the programs that continue to offer training in abortion procedures offer the classes as electives, and anything voluntary in a medical curriculum is usually passed over by overloaded medical students. According to a report by the American College of Obstetricians and Gynecologists and the National Abortion Federation, the lack of training, as well as increased harassment and stigmatization of doctors who perform abortions, are significant factors in the decrease in physicians who offer abortion services.

Moreover, a survey of 4,000 members of the American College of Obstetrics and Gynecology reported that while 84 percent of the members said they thought abortion should be legal and available, only one-third of the doctors actually performed abortions -- and two-thirds of that number performed very few abortions. The result of this is that 82 percent of the counties in the United States have no abortion providers and 79 percent of all rural women live in counties with no abortion providers.

ABORTION RIGHTS IN THE U.S.

Before 1850, the law with respect to abortion followed the pre-existing common law of England in all but a few states. Abortion was legal prior to "quickening," i.e. when the woman first felt the fetus move, usually in the 16th or 17th week of pregnancy. Abortion was commonly used by women as a method of contraception and was generally accepted. Abortionists and abortifacient agents were widely advertised, and most newspapers and periodicals of the day contained advertisements of the procedure.[8]

By 1890, however, every state had banned abortion, except in cases in which an abortion was necessary to save the life of the mother. The movement to ban abortion resulted primarily from the drive by physicians to "professionalize" the medical profession and the perceived threat to family values from women's increasing emancipation.

During the 19th century, a new relationship developed between women and their physicians, as physicians replaced women's traditional sources of medical care and knowledge. Physicians, led by a growing recognition of the need for professionalization of the their field, sought greater control of the standardization of medical training and certification and licensing procedures. Physicians also sought to control the growing number of "irregular" medical practitioners, including botanical doctors, homeopaths, midwives and abortionists.

Moreover, within a quarter of a century, what had begun as a movement by physicians to regulate abortion now included moral proscriptions against abortion and abortionists. "By the second half of the 19th Century, the medical establishment, the church and the state had joined forces and mounted an aggressive campaign against abortion, calling it the 'evil of the ages.' Underlying the high-minded talk of morality and medical safety was a more urgent fear that was taking hold of the country at that time: the consequences of the emancipation of women."[9]

"Voluntary motherhood" was thought to pose a serious threat to the stability of the family and of the community. The crusade to ban abortions focused on persuading women to accept their "proper" roles as wives and mothers. Anything that prevented women from accepting their biological imperative was deemed unnatural and immoral.

The ban on abortions did not prevent women from obtaining them, though. Illegal abortions were commonplace[10] and, by the 1950s, "therapeutic" abortions were being performed by most hospitals. However, women had to request permission for an abortion from a hospital board and guidelines were vague and varied from hospital to hospital. 42 states permitted abortions only if necessary to save the life of the mother. Other states allowed abortion to save a woman from "serious and permanent bodily injury" or if her "life and health" were threatened.[11]

By the 1960s, the climate surrounding a woman's right to an abortion had changed considerably. The American Medical Association endorsed a model law approving abortion to protect the mother's life and health -- including mental health -- and in cases of rape, incest and fetal abnormality. State legislatures also began to reconsider the issue in the late 1960s. Between 1967 and 1973, 17 states reformed their abortion laws or repealed them outright, and similar legislation was introduced in almost every state in the nation.[12] In the years immediately preceding the 1973 *Roe v. Wade* Supreme Court decision, abortion policy in the United States became a patchwork of differing regulations and restrictions.

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This patchwork had the side effect of creating a two-tiered system in which a woman's ability to obtain an abortion depended largely on her place of residence and her financial resources. In the two and half years prior to *Roe v. Wade*, nearly 350,000 women left their own state to obtain a legal abortion in New York.[13] If a woman did not live in a state in which abortion was legal and if she couldn't afford to travel to a state

in which it was legal, however, the alternative was often an illegal abortion.

ABORTION AND THE JUDICIARY

In 1973, the U.S. Supreme Court issued two decisions on abortion rights which established one law for the entire country. In *Roe v. Wade* and *Doe v. Bolton*, the Court held that the Constitution protects a woman's decision whether or not to terminate her pregnancy (*Roe v. Wade*), and that a State may not unduly burden the exercise of that fundamental right by regulations that prohibit or substantially limit access to the means of effectuating that decision (*Doe v. Bolton*).

The constitutional basis for the decisions rested upon the conclusion that the Fourteenth Amendment right of personal privacy includes a woman's decision whether to carry a pregnancy to term. With respect to the protection of the right of personal privacy against State interference, the Court held that since the right of personal privacy is a fundamental right, only a "compelling State interest" could justify its limitation by a State. The Court emphasized the durational nature of pregnancy and determined a State's interests to be sufficiently compelling to permit limitations on or prohibition of abortion only during certain stages of a pregnancy. The Court summarized its decision as follows:

> *For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgement of the pregnant woman's attending physician and the woman herself.
>
> *For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> *For the stage subsequent to viability, the State, in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgement, for the preservation of the life or health of the mother.[14]

In 1983, the Supreme Court issued related decisions in three cases: *City of Akron v. Akron Center for Reproductive Health, Inc.; Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*; and *Simopoulos v. Virginia*. These cases resolved questions relating to hospital requirements for second trimester abortions, informed consent requirements, waiting periods, parental notification and consent and disposal of fetal remains. The holdings in these cases reaffirmed *Roe v. Wade*, as well as the Court's intention to continue to follow the trimester framework balancing a woman's constitutional right to decide whether to terminate a pregnancy with the State's interest in protecting potential life.

Two recent cases on which the Supreme Court has issued decisions have signaled

a change in the court's reasoning regarding a woman's constitutional right to abortion, though. In 1989, the Supreme Court upheld the constitutionality of Missouri's abortion-regulation statute in *Webster v. Reproductive Health Services.* While this decision was not an outright reversal of *Roe v. Wade,* it did indicate that the Court was willing to apply a less stringent standard of review to state restrictions with respect to a woman's right to abortion. Provisions which were held to be constitutional include the following: barring public employees from performing or assisting in abortions not necessary to save the life of the mother; barring the use of public buildings for performing abortions, despite the fact that there were no public monies involved; and requiring physicians who believe a woman requesting an abortion to be at least 20 weeks pregnant to perform tests to determine whether the fetus is viable. The Court's majority chose not to rule on the Missouri law's Preamble language which described life as beginning at conception with constitutional protections attaching at that point.[15]

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In 1992, The Supreme Court, in *Planned Parenthood of Southeastern Pennsylvania v. Casey,* ruled that restrictions on abortion contained in the Pennsylvania Abortion Control Act were constitutional. Upheld provisions include: women seeking abortions must receive counseling on risks and alternatives and wait at least 24 hours after the counseling to have the abortion; minors under 18 must get one parent's informed consent or a judge's approval for an abortion; no abortions may be performed after 24 weeks of pregnancy unless one is necessary to protect the woman's life or prevent permanent physical harm; and doctors must keep detailed records of abortions and their reasons for performing late-term abortions. A provision requiring married women to notify their husbands of their plan to have an abortion was struck down.

Like the *Webster* decision, *Casey* did not overrule *Roe* outright. In its five to four decision, the Court did give states sweeping power to restrict abortions; however, the decision also flatly declared that states may not outlaw all abortions. However, the Court did retreat from their ruling in *Roe* that the right to choose abortion is a fundamental right entitled to the highest degree of constitutional protection. Instead, they have adopted the "undue burden" standard promulgated by Justice Sandra Day O'Connor in the *Webster* decision. The "undue burden" standard means that unless a law is "an absolute obstacle" or "severe limitation" it will be upheld as constitutional so long as it is rational. Most of the restrictions held to be constitutional in *Casey* had previously been held to be unconstitutional.

The Court's decision in *Casey* leaves unresolved the question of what exactly constitutes an "undue burden." If a 24-hour waiting period is not an "undue burden," does this also mean that a 48-hour or one-week waiting period is not "undue?" May states now require that all abortions be performed in hospitals? May states require that clinics acquire licensing requirements that have the side effect of driving them out of business? Can states enact one of these restrictions but not all of them at the same time?

The Court announced in June 1992, that it was postponing a decision in *Bray v. Alexandria Women's Clinic* -- another case related to a woman's right to choose -- until after the case is reargued during its next term, which begins in October 1992. At issue in the *Bray* case is whether the federal Ku Klux Klan Act can be used to prevent antiabortion protesters from blockading access to abortion clinics. The *Bray* case results from Operation Rescue's (Operation Rescue is an anti-choice organization) appeal of the decision by the U.S. District Court for the Eastern District of Virginia to enjoin blockades at any women's health care clinics in northern Virginia. The U.S. Court of Appeals for the Fourth Circuit upheld the lower court's decision, and Operation Rescue then appealed to Supreme Court.

The argument in question revolves around a Reconstruction era statute, known as section 1985 (3) or the Ku Klux Klan Act, which empowers federal courts to prevent private individuals from conspiring to thwart the rights of a particular "class," when, in the process, the conspiracy infringes on the right of members of the class to travel interstate. The pro-choice movement is arguing that, by blockading clinics which perform abortions, Operation Rescue is hindering the rights of a particular class of women, i.e. pregnant women, to a legal abortion. The litigation is modeled on the 1971 Supreme Court decision, *Griffin v. Beckinridge*, which upheld the right of federal courts under the Ku Klux Klan statute to prohibit private individuals from trying to stop African-Americans from voting.

The Court's one-sentence order gave no reason why they were postponing the decision. It may be that they are deadlocked, since Justice Clarence Thomas had not taken his seat when the case was argued. Alternatively, the justices may have a majority on the result, but may differ on the reasoning and hope to be able to reach a consensus with Thomas' support.

ABORTION AND THE LEGISLATURE

Since the *Roe* decision, almost 500 bills relating to abortion have been introduced in Congress. Prior to 1989, most of the legislation sought to prohibit abortion. Since the *Webster* decision, however, legislation has been introduced in Congress seeking to make abortions more widely available and to codify the holdings in *Roe v. Wade*.[16]

Congress has also acted to restrict federal funding of abortion. Since 1973, funding restrictions have been attached to numerous appropriations bills. The greatest focus has been on restricting Medicaid abortions under the annual appropriations for the Department of

Health and Human Services (HHS). The series of restrictions, commonly known as the "Hyde amendments," prohibit federal funding of abortions, allowing exceptions only if continuing the pregnancy would endanger the life of the mother. Hyde-type restrictions have also been attached to the Department of Defense Authorization Act of 1984, the District of Columbia Appropriations Acts, and the Department of the Treasury and Postal Service Appropriations Act.

In 1980, the Supreme Court, in *Harris v. McRae,* upheld the constitutionality of the Hyde amendments.[17] Furthermore, the Court's decision upheld the right of a State participating in the Medicaid program to fund only those medically necessary abortions for which it received Federal reimbursement.

In addition to placing funding restrictions on appropriations bills, Congress has also attached restrictions on abortion to substantive legislation including the Family Planning Services and Population Research Act of 1970, the Health Programs Extension Act of 1973, the Legal Services Corporation Act of 1974, the Pregnancy Disability Amendment to Title VII of the Civil Rights Act of 1964, the Public Health Service Act Amendments of 1979 and Title IX of the Budget Reconciliation Act of 1981.[18]

TITLE X

Title X of the Public Health Service Act was enacted in 1970 and is the only federal program which provides funding for family planning programs. It authorizes project grants to public and private nonprofit organizations for the provision of family planning services to all who want and need them -- including adolescents -- with priority given to low-income persons.

The purpose of Title X is the provision of contraceptive information and services (along with related preventive health services) in order to help lower the incidence of unintended pregnancy, improve maternal and infant health and reduce the incidence of abortion. In FY 1991, $141 million was available for Title X services, a decline from $162 million in FY 1981.[19]

Almost 5 million women, including 1.5 million teenagers, annually receive services through federally supported family planning clinics. The typical client is young, has a low or marginal income and does not have children. Title X funded clinics are located in all 50 states and in two-thirds of all counties -- they are often the only health care providers in the community. 88 percent of all poor women of reproductive age live in a county with a Title X funded clinic.[20]

Publicly funded health care providers serve 25 percent of American women who use contraceptives. The services provided by the clinics are estimated to prevent a substantial number of unintended pregnancies and the attendant unwanted births and abortions. For every 1,000 women who obtain contraceptives from publicly funded providers, 260 unintended pregnancies are avoided, as are 122 unwanted babies and 114 abortions.[21]

Since its enactment in 1970, Title X has included a prohibition on the use of family planning funds for abortions. Investigations by the General Accounting Office and the Inspector General of the Department of Health and Human Services have shown that Title X providers are scrupulous in their adherence to the law and regulations regarding abortion.

STATE RESTRICTIONS ON ABORTION

State imposed restrictions on abortion take a variety of forms, but they invariably have the greatest impact on low-income women -- who suffer from the cutoff of federal and state funds, as well as the resulting shortage of public services -- and on teenage women -- who, in many states and localities, face parental consent or notification requirements.

MEDICAID RESTRICTIONS

The 1965 Amendment to the Social Security Act, known as Title XIX, established the Medicaid program, under which states could treat family planning as a reimbursable service. Today, 9 percent of women of reproductive age rely on Medicaid for their health care. As a result of the Hyde Amendments, however, federal Medicaid funds may be used for an abortion only if the life of the women is endangered. Only 13 states use their own revenues to provide medically necessary abortion services for their low-income residents.

The Supreme Court has issued decisions in two categories of public funding cases regarding abortion: those involving funding restrictions for nontherapeutic abortions; and those involving funding limitations for therapeutic, or medically necessary, abortions.[22]

In 1977, the Court ruled in three related decisions (*Beal v. Doe, Maher v. Doe* and *Poelker v. Doe*) that States have neither a statutory nor a constitutional obligation to provide funding to indigent women for abortions which are not deemed medically necessary. States are also not required to provide access to public facilities for the performance of nontherapeutic abortions.

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Beal v. Doe concerned whether Title XIX of the Social Security Act required the funding of nontherapeutic abortions as a condition of participation in the Medicaid program established by the Act. The Court held that nothing in the language or legislative history of Title XIX required a participating State to fund every medical procedure falling within the delineated categories of medical care. The Court further ruled that it was not inconsistent with the Act's goals to refuse to fund unnecessary

medical services. However, they did indicate that Title XIX did not *restrict* a State from covering nontherapeutic abortions, if it chose to do so.

Maher v. Roe concerned a constitutional challenge to Connecticut's refusal to reimburse Medicaid recipients for abortion expenses except in cases where the attending physician certified the abortion to have been necessary to protect the mother's physical or mental health. The Court held that the Equal Protection Clause in the Constitution does not require a State participating in the Medicaid program to pay expenses incurred due to nontherapeutic abortions simply because the State reimburses for expenses relating to childbirth. Specifically, the Court held that Connecticut's policy of favoring childbirth over abortion did not violate the fundamental right of privacy recognized in *Roe*.

Poelker v. Doe concerned whether the States must provide indigent women access to public facilities for abortions which are not necessary to protect the life or health of the mother. The Court's ruling upheld the regulation of the municipalities of St. Louis that denied indigent pregnant women access to nontherapeutic abortions performed at public hospitals.

75 to 80 percent of the women who would have obtained a publicly funded abortion are able to raise the money to pay for the abortion themselves, albeit often at a high cost to themselves and their family. These women are far more likely than other patients to say they had to let bills go unpaid or to buy less food to pay for their abortion. Abortions may also be delayed by two to three weeks in order for the woman to obtain the necessary funds.[23]

PARENTAL CONSENT AND NOTIFICATION REGULATIONS

Since 1973, when the U.S. Supreme Court legalized abortion, the question of whether states should mandate parental involvement in a minor's decision to terminate a pregnancy has been the subject of intense public debate. Hundreds of proposals to require parental consent or notification have been introduced in state legislatures throughout the country.[24] Forty percent of young women in the United States will become pregnant at least once while they are in their teens. 85 percent, or 1.1. million, of these teen-age pregnancies are unintended.[25]

States have traditionally required that parents give their consent before a minor receives medical treatment, although there have long been exceptions to this rule. Some states have adopted the so-called "mature minor rule" with regard to medical treatment. Under this rule, a minor who is judged sufficiently intelligent and mature enough to understand the nature and consequences of a proposed treatment can obtain or consent to medical treatment without consulting her or his parents and/or securing their permission.

Furthermore, in a landmark 1967 decision, *In re Gault*, relating to juvenile delinquency proceedings, the Supreme Court concluded that "constitutional rights do not mature and come into

being magically only when one attains the state-defined age of majority," and held that the Bill of Rights and the Fourteenth Amendment's guarantee against the deprivation of liberty without due process protects minors, as well as adults. The Court subsequently ruled in *Carey V. Population Services International* (1977) that minors have a constitutional right to privacy that includes the right to obtain contraceptives. The Court's ruling in *Planned Parenthood of Central Missouri v. Danforth* (1979) established the right of minors to decide to terminate an unwanted pregnancy and further established that a state may not give parents an absolute veto over their minor daughter's decision to have an abortion. However, in decisions in *Bellotti v. Baird, City of Akron v. Akron Center for Reproductive Health* and *Planned Parenthood Associations of Kansas City, Mo., Inc., v. Ashcroft*, the Court held that a state may require a young woman to obtain the consent of one or both parents if the regulations include a judicial bypass provision. Judicial bypass is the process by which a young woman may obtain authorization for an abortion from a judge or administrative agency, and thus not have to inform or seek consent from her parents.

In their decisions in these cases, the Court also ruled that when a minor chooses to exercise the judicial bypass option, the judge must authorize the abortion if he or she determines that the teenager is mature enough to make the decision by herself or, if the young woman is deemed immature, that an abortion is in her best interests. Bypass proceedings must be confidential and expeditious, and the young woman must have an opportunity to appeal if her petition is denied.[26]

Recently, in *Ohio v. Akron Center for Reproductive Health* and *Hodgson v. Minnesota*, the Court ruled that a state may require a doctor to notify one or both parents of their daughter's plans to terminate a pregnancy. This requirement may be imposed even if the parents are divorced or were never married, if one of the parents has never provided support, and even if one of the parents is abusive. The Court found in *Hodgson* that a judicial bypass provision must be provided in instances where both parents must be notified. In *Ohio v. Akron Center for Reproductive Health*, however, the Court specifically did not issue a ruling on whether a state must provide a judicial bypass procedure if the regulation requires the notification of only one parent. The Court's recent decision in *Planned Parenthood v. Casey* also upheld a parental notification provision. 18 states have laws mandating the involvement of at least one parent in the abortion decision: In 10 of these, a minor must have the *consent* of one or both parents;

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in the other eight, one or both parents must be *notified* prior to the abortion.

Almost all states, however, have passed laws that specifically authorize teenagers to consent to or obtain medical treatment for health problems relating to sexual activity, substance abuse or mental health. Furthermore, no state mandates parental involvement in a teenager's consent to medical treatment for sexually transmitted diseases (STDs), substance abuse, contraceptive services or prenatal care and delivery services. Only four states mandate that parents must play a role in their teenage daughter's decision to place her child up for adoption -- two-thirds of the other states explicitly recognize a young woman's authority to make that decision by herself.[27]

BIRTH CONTROL IN THE U.S.

Colonial women had an average of eight children over their lifetimes, according to demographic estimates. By 1873, however, fertility rates in the United States had declined to about four births per woman. Lower mortality rates and improved living standards resulted in many people attempting to reduce the size of their families. Their ability to limit the number of children they had was quite limited, however.

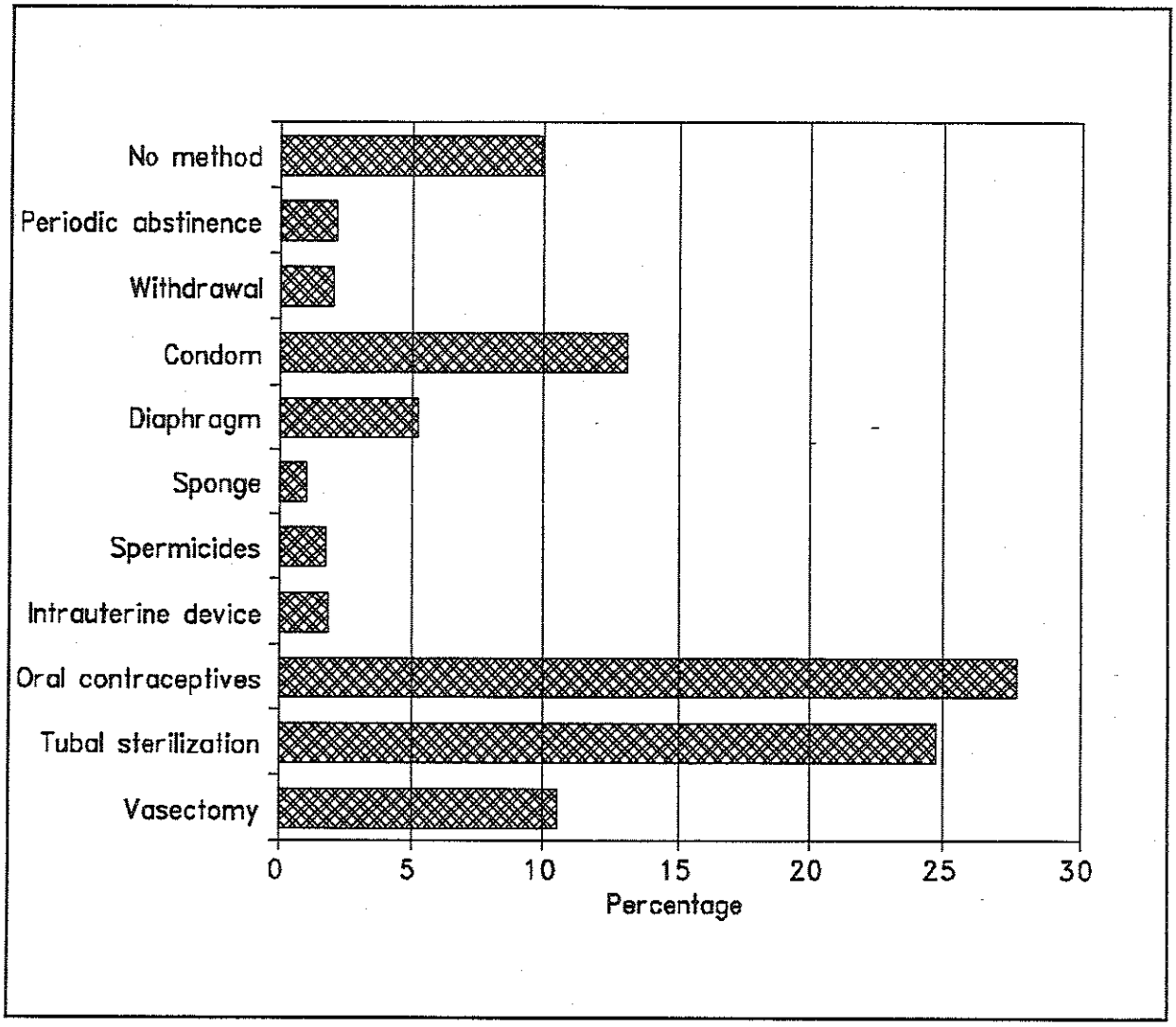
The only contraceptive methods widely available to Americans during the 19th century were douches, "natural" family planning methods and abstinence. Well-connected women with access to European markets were sometimes able to obtain diaphragms and condoms, but these were not available to the general population. It is believed that abortion was the most widely used method of limiting family size.[28]

Contraception was not only generally unavailable -- it was also illegal. Under the Comstock Law, passed by Congress in 1873, the distribution of "obscenities" such as contraceptives and contraceptive information through the mails was prohibited. The Comstock law served as a model for growing numbers of anti-contraceptive laws across the country, further restricting information and access to contraceptive methods.

The first birth control clinic to operate in the United States was opened on October 16, 1916 by Margaret Sanger. The clinic remained open less than a month before she was arrested, indicted and sent to prison for violating New York's anti-obscenity statues by discussing and disseminating information about and methods of contraception. Sanger appealed her conviction and the New York Court of Appeals, while refusing to overturn the conviction, did broaden the interpretation of New York's Comstock statute to allow physicians to prescribe contraceptives for married couples in order to prevent disease.[29]

Birth control remained generally unavailable and illegal in the United States until a 1936 decision by the U.S. Circuit Court of Appeals. *U.S. v. One Package of Japanese Pessaries* ordered a sweeping liberalization of federal Comstock statues as applied to the importing of contraceptive devices. This decision established the right of physicians to use their own best judgment in prescribing birth control.

Figure 1 - Primary Contraceptive Methods, 1991



This right was broadened by a 1965 Supreme Court decision, *Griswold v. Connecticut*, that struck down state laws prohibiting the use of contraceptives by married couples. The decision resulted in the immediate liberalization of family planning legislation in 10 states. Moreover, in a 1972 decision, *Eisenstadt v. Baird*, the Supreme Court struck down a Massachusetts statute that barred the distribution of contraceptives to unmarried people.[30]

STATUS OF CONTRACEPTIVE RESEARCH

Rapid progress in the research, development and dissemination of modern contraceptives was made during the 1950s, 1960s and 1970s. The introduction in 1960 of the oral contraceptive or "the pill" was widely hailed as a medical marvel which would allow women, as never before, to control their reproductive lives. As with other

contraceptive methods, however, the pill, because of side effects, cannot be used by all women, leaving these women reliant on other methods.

After the introduction of the pill, contraceptive research and development in the United States ground to a standstill. This was due to a variety of reasons, including insufficient public funding for research and evaluation, a shortage of scientists entering the field of contraceptive research, a "spillover" effect from the politics of abortion rights, product liability crisis and cumbersome Food and Drug Administration regulations and approval procedures.[31] Since the late 1970s, only one new contraceptive method has been made available in the United States.

Currently only one pharmaceutical company in the United States -- Ortho Pharmaceutical Corporation -- is still involved in contraceptive research. In contrast, in the 1970s over half a dozen companies were actively involved in contraceptive research and development. Today, nonprofit organizations and small entrepreneurial groups have taken the place of the large pharmaceutical firms. The Federal government and private foundations are the primary sources of financial support for basic reproductive research and contraceptive development. The level of funding provided by these sources is inadequate, however. Dr. Bernadine Healy, Director of the National Institute of Health has said, "Contraception is one of the scientific areas...that has been under-explored and must be pursued as part of our responsibility to the public health of this country."

Furthermore, relatively few advanced degrees in reproductive biology are currently being pursued in the United States. The static level of funding for contraceptive research and development by the government, foundations and the pharmaceutical industry has discouraged scientists from pursuing research in this area.[32] Moreover, there are fewer and fewer opportunities for employment available to people in this field.

The National Research Council published a report in 1990 which raised these questions: Is the decrease in demand for contraceptive research causing the shortage of students? Or is the lack of trained scientists causing the decline in contraceptive research? Determining precisely what is the cause and what is the effect is difficult; however, it is clear that the dearth of private industry positions, combined with the public controversy surrounding the field, make reproductive research and development less appealing to younger scientists than other medical research and development fields.

The need for a broader variety of effective contraceptive options is well-established. Fewer methods are available to women and their partners in the United States than in other industrialized countries, and there is also greater reliance on less-effective methods. More than 57 million American women of childbearing age struggle each year with the failings and side effects of available methods of birth control. In 1988, 39 million American women were at risk for an unintended pregnancy. Of these women, 90 percent used some contraceptive method, yet 3.5 million

unintended pregnancies happened that year.[33] Of the women who use no contraceptive method, the majority do not practice contraception because of concerns about the health risks and side effects, and/or the lack of affordable and available reproductive health care and contraceptive methods.[34]

NORPLANT

Norplant is the first new birth control device offered to U.S. women in 25 years. Norplant works by releasing a synthetic hormone -- progestin -- that suppresses ovulation. Six tubes filled with crystallized synthetic progestin, each the length of a matchstick, are surgically inserted just beneath the skin of the upper arm, where they slowly release the hormone for five years, or until the implants are removed. Norplant's effectiveness rating is 98 percent, and the effectiveness does not depend on the user.

Norplant, like other birth control methods, is not the ideal contraceptive for everyone. There are side effects, and Norplant is less effective with women who weigh over 150 pounds. Cost may also be a prohibitive factor for women wishing to use this method. According to Wyeth-Ayerst, the manufacturer of Norplant, the median fee for the implant and its insertion is $580.

Norplant is already being used by approximately 100,000 American women. Worldwide, an estimated 1.5 million women are using the method. 48 states and the District of Columbia have approved Norplant for women who are eligible under their state Medicaid programs. The two remaining states -- California and Massachusetts -- are reportedly in the process of deciding whether to approve Norplant.

VAGINAL POUCH

Another contraceptive method that may soon be available for the public is the Reality Vaginal Pouch. An 11-member FDA panel has given preliminary approval to the new female contraceptive that is designed to prevent pregnancy and protect vaginal exposure to sexually transmitted diseases. The device consists of a 7-inch lubricated polyurethane sheath that lines the vagina and is held in place on either end by a flexible ring. The device is inserted in much the same manner as a diaphragm, but is not reusable. According to preliminary studies, the pouch breaks or slips about 3 percent of the time, compared with a 1 to 12 percent failure rate for male condoms. Similar devices have already been approved in Britain, France, and Switzerland.

RU 486

RU 486, developed by Roussel Uclaf, a French pharmaceutical company, is a contraceptive method used in other countries but is not available in the United States. Since 1982, RU 486 has been available in Europe; however, Roussel Uclaf has not even begun the process of pursuing FDA approval due to threats of a company boycott by anti-choice crusaders and the company's fear of product liability costs.

RU 486 works by blocking the hormone progesterone from reaching the uterine

cell receptors; without progesterone, the uterine lining breaks down, the fertilized egg is dispelled and menstruation occurs. RU 486 has a 96 percent effectiveness rating.

RU 486 has been used in clinical trials by over 4,000 women in 20 countries, a larger sampling than the FDA would require in the United States. All the research has shown the drug to be effective only in terminating pregnancy in its earliest stages -- up to six or seven weeks after the onset of the last menstrual period. After eight weeks, the drug is virtually ineffective.

RU 486 does not appear to have serious side effects and also does not appear to pose any risk of long term health effects. Few women experience side effects more severe than those of a normal to heavy menstrual period.

Moreover, RU 486 has many potential uses beyond abortion. It shows promise in treating Cushing's Syndrome, a hormonal disorder usually treated by removing the adrenal glands, as well as certain types of breast cancer and endometriosis, glaucoma, hypertension, diabetes, osteoporosis and AIDS. Research has also indicated that RU 486 can be used as a cervical softener, potentially eliminating the need for many cesarean births.

Medical research on additional uses of RU 486 is being hindered in the United States, however. In December 1991, the House Small Business Subcommittee on Regulation, Business Opportunities and Energy heard testimony from a number of witnesses who described the critical medical research that is being impeded by Roussel Uclaf's refusal to pursue making RU 486 available in the United States. Dr. Etienne Emile-Baulieu, the developer of RU 486, also testified and explained that he had decided to conduct testing of the drug in Canada rather than the United States.

REPRODUCTIVE RIGHTS IN THE WORKPLACE

Workplace hazards to reproduction have typically been considered to be of concern only for women employees. Historically, "protective" labor laws have been based on assumptions that reproduction weakened women, whether or not they were actually pregnant, that women were more susceptible to various workplace diseases and that women needed "special consideration" in the workplace. These laws regulated women's work lives, generally by prohibiting their access to certain occupations and mandating shortened workweeks. Protective labor laws also had the -- perhaps not unintended -- side effect of confining women to low-paying, dead-end jobs. Protective legislation was held to be constitutional by the Supreme Court in *Muller v. Oregon*, in which they ruled that the well-being of future generations depended on the well-being of women. This made childbearing a public as well as a private interest, and empowered the State to regulate women's reproductive lives.

The Court, however, recently reversed this decision. In *United Auto Workers (UAW) v. Johnson Controls*, the Supreme Court ruled that policies which deny

women access to jobs, simply because of their potential reproduction, are discriminatory and, thus, unconstitutional. *Johnson* challenged an employment policy at the nation's largest automobile battery manufacturer which barred all "fertile women" -- defined as any woman under 70 years of age who could not provide medical proof of sterility -- from jobs that might put their reproductive health at risk because of lead exposure. Although studies have shown that men's reproductive health is also at risk from lead exposure, their access to the jobs in question was not limited. This policy effectively denied many high-paying jobs with promotional possibilities to female employees of Johnson Controls.

The case was decided in March 1991, and the ruling was widely interpreted as a victory for working women. In its decision, the Court confirmed both the Civil Rights Act, which prohibits discrimination on the basis of religion, sex or national origin, and the Pregnancy Discrimination Act (PDA), which held that employers cannot treat pregnant workers differently unless their ability to work is affected by the pregnancy. In the majority decision for the Court, Justice Harry Blackmun wrote, "With the PDA, Congress made clear that the decision to become pregnant or to work while being either pregnant or capable of becoming pregnant was reserved for each individual woman to make for herself. Furthermore, decisions about the welfare of future children must be left to the parents who conceive, bear, support and raise them rather than to the employers who hire those parents."

It has been estimated that 20 million industrial jobs could be closed to women because of "fetal protection" policies, like those at the Johnson Controls plant. Many of these jobs are high-paying, traditionally male jobs that women already have difficulty breaking into. It is not coincidental that the majority of these "fetal protection" policies were instituted just after women's access to jobs previously denied to them was assured by Court rulings.

In industries in which large numbers of women are employed, "fetal protection" policies are unheard of. When studies found that anesthetic gases caused spontaneous abortions, hospitals didn't ban their female employees from jobs requiring them to be exposed to the gases. Instead they installed devices that eliminated the problem.[35] Moreover, companies have not sought to institute policies "protecting" their female employees from workplace hazards stemming from traditionally female jobs, such as clerical jobs which often have high levels of use of Video Display Terminals (VDTs), even though use of VDTS has been linked to higher miscarriage rates, birth defects and other fertility ills.

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REPRODUCTIVE HAZARDS IN THE WORKPLACE

In general, toxic substances affect women and men in the same ways. Toxins found in the workplace which are hazardous to reproductive health are no different -- even though they are often thought to affect only women.

A reproductive hazard is any agent that has harmful effects on the development of a fetus. These hazards can be chemicals (like pesticides), physical agents (like X-rays) or work practices (like heavy lifting).[36]

Reproductive hazards found in the workplace affect women by disrupting their reproductive hormones, causing menstrual disorders, sterility or loss of sexual drive. Toxic substances may also damage the ovaries, eventually resulting in early menopause or ovarian disease. Environmental mutagens can also damage the genetic materials in a woman's eggs, causing spontaneous abortions or birth defects.

Substantial evidence exists that men's reproductive health is also harmed by workplace toxins.[37] A toxic agent can disturb sperm cells at any one of several stages of rapid growth, causing problems with fertility through a total lack of sperm, low sperm production or malformed sperm. Toxics may also be causing an overall decline in sperm counts in American men. Furthermore, some reproductive hazards are mutagens. When a mutation occurs in sperm cells, men can pass damaged genes on to future generations, which can result in spontaneous abortions or inherited birth defects.

The management of workplace risk to reproductive health presents increasingly complex choices to employers, workers and legislators. Protection of reproductive health -- for both female and male employees -- depends primarily on adequate engineering and exposure controls, educational programs and personal protective equipment.[38] Simply keeping women out of jobs with potential hazards for reproductive health obscures the issue that these hazards put both female and male workers at risk.

CONCLUSION

Reproductive rights has an effect on all areas of women's lives. The degree of control women are able to exercise over their reproductive lives directly affects their educational and employment opportunities, income level and physical and emotional well being. It also affects the economic and social conditions the children they do bear will experience throughout their lives.

Women can never hope to be free to exercise all their choices and to achieve equal opportunity -- in the workplace and in their personal lives -- without the right to control their own bodies. Supreme Court Justice Harry Blackmun expressed this sentiment best when he wrote, "Millions of women have ordered their lives around the right to reproductive choice, and this right has become vital to the full participation of women in the economic and political walks of American life."

Notes

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4. Ibid.

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9. *Whose Life*, Catherine Whitney, William Morrow and Company, Inc., 1991.

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