CHAPTER 7

Health and Reproductive Justice

HEALTH AND WELLNESS

Health is a central issue in women's lives. Ask parents what they wish for their newborns and they speak first about hoping the baby is healthy; quiz people about their hopes for the new year and they speak about staying healthy; listen to politicians debate their positions before an election and health care is almost always a key issue. In contemporary U.S. society, good health is generally understood as a requirement for happy and productive living. Because women are prominent as both providers and consumers of health care, health issues and the health care system affect us on many levels. To make sense of the complexities of women's relationships to health care systems, we discuss five themes: equity, androcentrism, medicalization, stereotyping, and corporate responsibility. After this discussion we address reproductive justice and focus specifically on contraceptive technologies and abortion debates in the United States.

First, despite the passage of President Barack Obama's health care reform in 2010, described below, medical institutions in the United States provide different levels of service based on health insurance status and the general ability to pay. This issue of equity affects all aspects of health care, including access to fertility, contraceptive, and abortion facilities. Poor women are less healthy than those who are better off, whether the benchmark is mortality, the prevalence of acute or chronic diseases, or mental health. This is the issue of *equity*. Some people have better health care than others because of a two-tiered system that has different outcomes for those who can pay or who have health insurance and those who cannot afford to pay and do not have health insurance through their jobs or are not covered by welfare programs. This is a special problem as health care costs continue to rise. Some states are providing less coverage for low-income people, a problem because the United States, unlike most industrialized societies in the global north, does not yet have a nationalized health care system.

The health care reform that we do have in the United States at the time of this writing is the Patient Protection and Affordable Care Act (PPACA), commonly called the "Affordable Care Act," or simply "Obamacare." Together with the Health Care Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the health care system in the United States since the passage of Medicare and Medicaid in 1965. PPACA is aimed at increasing health insurance coverage and reducing the overall

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costs of health care. It provides a number of mechanisms, including individual mandates, subsidies, and tax credits, to employers and individuals in order to increase the coverage rate. Additional reforms aim to improve health care outcomes and streamline the delivery of health care. The U.S. Supreme Court upheld the constitutionality of this law in 2012.

In particular, the PPACA stated that, with a few exceptions, an individual cannot "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving federal financial assistance." This means that public or private entities receiving federal funds (private insurance companies often receive federal funds) can not discriminate against women on the basis of national origin, ethnicity, age, or disability. "Gender rating," charging women more than men for health insurance, is disallowed for individual and employer plans with more than 100 employees. It is estimated that women with individual health insurance plans have been paying up to 48 percent higher premiums. The legislation also requires insurers to provide maternity coverage (about three-quarters of plans have not included this) and that companies with more than 50 employees provide breast-feeding mothers with breaks and room to express milk. In addition, midwives and birth centers are covered. Other key aspects of the health care reform important for women's health include promises for preventive care provisions, mental health coverage, increased coverage for Medicaid and SCHIP (State Children's Health Insurance Program), and increased access for individuals to group rates. In addition, young people can stay on parents' health insurance policies until age 26, Medicare patients get better coverage, preexisting conditions and lifetime caps on coverage are eliminated, and employers are not able to give lesser plans to lower-paid workers.

Despite these gains, extreme opposition to President Obama's health care reform efforts resulted in the absence of a public option and limits on abortion coverage. Still, these changes in health care make sure that everyone in the United States has some kind of health insurance coverage. This legislation is especially important for women because growth in health costs over the last decade have had a disproportionate effect due to women's lower incomes, higher rates of chronic health problems, and greater need for reproductive health services. As discussed above, discriminatory practices charging women higher rates than men and refusing to cover essential service associated with reproductive health have had important consequences for women's health and well-being. Not surprisingly given the divisiveness of health care dialogue in the United States, enactment of health care reform has been slow, and more than half of respondents in a recent survey reported neglecting health care needs because of cost.

Back in 2013 approximately 19 million women were uninsured. Such women were more likely to have inadequate access to care, get a lower standard of care in the health system, and have poorer health outcomes. They were more likely to postpone care and to forgo filling prescriptions than their insured counterparts and often delayed or skipped important preventive care such as mammograms and Pap tests. One study attributed nearly 45,000 excess annual deaths to lack of health care coverage. For example, a 2013 study found that insurance, or the lack of it, proved to be the most powerful predictor of women's late-stage cancer. The study showed that being uninsured raises a woman's risk of late diagnosis by 80 percent. In addition, uninsured children are at greater risk of experiencing health problems such as obesity, heart disease, and asthma that continue to affect them as (potentially uninsured) adults, resulting in increased costs for public health care services. Such adverse effects of health care inequity carry long-term implications for families and society.

LEARNING ACTIVITY **Women, Heart Disease, and Cancer in Your State**

- To learn more about the prevalence of heart disease among women in your state, visit the CDC's website at *http://apps.nccd.cdc.gov/giscvh2/* and click on your state.
- To learn about the prevalence of cancer in your state, go to *http://apps.nccd.cdc.gov/DCPC_INCA/DCPC_INCA.aspx* and select your state.

Women are more likely to be employed in part-time work or full-time work without health insurance benefits and, compared to men, are more likely to be covered as a "dependent" by another adult's employer-based insurance. As a result, women are more vulnerable to losing their insurance coverage if they divorce or become widowed, or if a spouse or partner loses a job, or the spouse or partner's employer drops family coverage or increases premium and out-of-pocket costs. In addition, of course, employment has not necessarily ensured access to health insurance as more than two-thirds of uninsured women live in families in which they or a partner are working full time. As discussed, these obstacles cause low-income women (who are disproportionately women of color) to postpone care and delay preventive procedures.

Health club memberships and healthy foods are outside the reach of many low-income people, who also are more likely to live in neighborhoods that provide unhealthy environments with unsafe water because of the presence of hazardous waste associated with industrial production and the dumping of toxic chemicals in neighborhoods with little economic and political power. As discussed in Chapter 2, *environmental racism* has fostered an *environmental justice* movement. Low-income women are more susceptible to chronic conditions as well as acute problems that might have been avoided had preventive care been available. This costs the state millions of dollars annually and is not a fiscally-responsible way to provide health care services. Women of color are especially at risk for not having health care coverage and for receiving substandard care when they enter the system. They have higher maternal and infant mortality rates, higher rates of HIV infection, and their reproductive health is threatened by limited access to basic reproductive health care, including family planning services and abortion care. Services such as these can be understood as human rights, emphasizing the importance of such rights for social justice. In the reading "From Rights to Justice," Zakiya Luna expands understandings of uses of human rights in the United States and illustrates how race and gender identities contribute to social movement organizing around reproductive issues. In particular, she discusses the ways collective action by women of color has changed the face of reproductive rights organizing in the United States.

Professional health-related organizations (such as the American Medical Association [AMA]), health maintenance organizations (HMOs), insurance companies, pharmaceutical companies, and corporations representing other medical products and practices have enormous influence over health politics. In addition, health is not just about medical services. Health conditions, including incidence and mortality rates, are

related to such socioeconomic factors as poverty, poor nutrition, interpersonal violence, substandard housing, and lack of education. Many of the social issues that affect women on a daily basis and that contribute to increased tobacco use, chemical addictions, stress, and poor nutrition among women have their consequences in increased rates of heart disease, cancer, chronic obstructive pulmonary disease, diabetes, and obesity, to name just a few. Health problems are compounded by the aging of the population, such that by the year 2030, women (who are likely to have fewer economic resources than men) will represent approximately 81 percent of people who are older than 85.

Globally, women's health access is one of the most important issues determining justice and equity for women. The reading by Nancy Fugate Woods titled "A Global Health Imperative" makes this claim through a focus on the effects of globalization

HIV Among Women: Fact Sheet

FAST FACTS

- At the end of 2010, an estimated 25% of adults and adolescents aged 13 years or older living with a diagnosis of HIV in the United States were women.[a] But not all women are equally at risk for HIV infection. Women of color, especially black/African American women, are disproportionately affected by HIV infection compared with women of other races/ethnicities.
- New HIV infections among black/African American women decreased in 2010.

THE NUMBERS

While black/African American women continue to be far more affected by HIV than women of other races/ethnicities, recent data show early signs of an encouraging decrease in new HIV infections. CDC is cautiously optimistic that this is the beginning of a longer-term trend. CDC recommends that all people aged 13 to 64 get tested for HIV. Yet, 15% of women who are HIV-positive are unaware of their status.

NEW HIV INFECTIONS[b]

- In 2010, women accounted for an estimated 9,500, or 20%, of the estimated 47,500 new HIV infections in the United States. Most of these (8,000, or 84%) were from heterosexual contact with a person known to have, or to be a high risk for, HIV infection.
- In 2010, the fourth largest number of all new HIV infections among all people in the United States occurred among black/African American women with heterosexual contact (5,300 infections)[c] (see bar graph). Of the total number of new HIV infections among women in the United States in 2010, 64% occurred in blacks/African Americans, 18% were in whites, and 15% were in Hispanics/Latinas.[d]
- At some point in their lifetimes, an estimated 1 in 32 black/African American women will be diagnosed with HIV infection, compared with 1 in 106 Hispanic/Latino women and 1 in 526 white women.

(*continued*)

- In 2010, the rate of new HIV infections (per 100,000 population) among black/African American women was 20 times that of white women, and the rate among Hispanic/Latino women was 4 times the rate of white women. However, the number of new infections among black/African American women in 2010 (6,100) represented a decrease of 21% since 2008.
- Young women aged 25 to 44 accounted for the majority of new HIV infections among women in 2010.

HIV AND AIDS DIAGNOSES[e] AND DEATHS

- In 2011, an estimated 10,257 women aged 13 years or older received a diagnosis of HIV infection in the United States, down from 12,146 in 2008.
- Women accounted for 25% (7,949) of the estimated 32,052 AIDS diagnoses in 2011 and represent 20% (232,902) of the 1,155,792 cumulative AIDS diagnoses (including children) in the United States from the beginning of the epidemic through the end of 2011.
- In 2010, HIV was among the top 10 leading causes of death for black/African American women aged 15 to 64 and Hispanic/Latino women aged 25 to 44.

PREVENTION CHALLENGES

The following risk factors contribute to prevention challenges for women:

- Women may be **unaware of their partner's risk factors** for HIV (such as injection drug use or unprotected sex with men, with multiple partners, or with anyone who has, or is at a high risk for, HIV). Some women may not insist on condom use because they fear that their partner will leave them or even physically abuse them.
- **Unprotected vaginal sex** is a much higher risk for HIV for women than for men, and **unprotected anal sex** is riskier for women than unprotected vaginal sex. Abstaining from sex or having sex with only a mutually monogamous partner who does not have HIV, and using condoms correctly and consistently, reduce the risk for HIV transmission.
- Women who have experienced **sexual abuse** may be more likely than women with no abuse history to engage in high-risk sexual behaviors like exchanging sex for drugs, having multiple partners, or having sex with a partner who is physically abusive when asked to use a condom.
- A substantial number of HIV infections among women are attributable to **injection drug and other substance use**—either directly, through sharing drug injection equipment contaminated with HIV, or indirectly, through engaging in high-risk behaviors like unprotected sex, while under the influence of drugs or alcohol.
- Some **sexually transmitted diseases** greatly increase the likelihood of acquiring or transmitting HIV. Rates of gonorrhea and syphilis are higher among women of color than among white women.

[a] Unless otherwise noted, this fact sheet defines women as adult and adolescent females aged 13 and older.
[b] "New HIV infections" refers to HIV incidence, or the number of people who are newly infected with HIV within a given period of time, whether they are aware of their infection or not.
[c] Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.
[d] Can be any race.
[e] HIV and AIDS diagnoses indicate that a person is diagnosed, but not when the person was infected.

on the status of girl children. As already discussed in previous chapters, globalization refers to the processes by which regional economies, societies, and cultures have become integrated through an interconnected global network of communication, transportation, and trade. Woods addresses the health status of girls in Sub-Saharan Africa and explores interventions at the level of social and health policy and health care delivery. The HIV/AIDS global pandemic is also an important illustration of issues of gender and racial/ethnic equity in this region of Africa and other parts of the world as well as in the United States.

By the end of 2010, according to the most recent data published by the U.S. Centers for Disease Control and Prevention, an estimated 25 percent of adolescents and adults living with an HIV diagnosis in the United States were women. In addition, women accounted for 20 percent of the new HIV infections. See the box "HIV Among Women" for more information. However, not all women are equally at risk for HIV infection. Women of color, especially African American women, were disproportionately affected. Indeed, the rate of new HIV infection for African American women was nearly 20 times that of white women and nearly 5 times that of Latinas. Even though new HIV infections among African American women fell in 2010 for the first time in many years, compared with members of other races and ethnicities they continue to account for a higher proportion of cases at all stages of HIV from new infections to deaths. Both African American women and men are at higher risk because of higher rates of poverty and less access to HIV-prevention education and affordable health care. These socioeconomic issues directly and indirectly increase the risk for HIV infection and affect the health of people living with, and at risk for, HIV. Late diagnosis of HIV infection, in particular, results in lack of early medical care and facilitates transmission to others. High prevalence means increased transmission and more rapid acceleration of a problem than in communities with low prevalence. Also the fact that African Americans tend to have sexual relations with partners of the same race/ethnicity means the smaller population encourages an increased risk of HIV infection.

In addition, all communities share consequences of the stigma, fear, discrimination, homophobia, and negative perceptions associated with HIV testing. This is especially problematic if people fear stigma more than infection, and choose to hide high-risk behavior rather than seek counseling and testing. Stigma and discrimination are key points in "Southern Discomfort," the reading by Carl Gaines. He explains that poverty and lack of access to preventative care and services are not the only explanations for the HIV epidemic. Conservative attitudes toward sexuality and lack of sex education, along with language and immigration barriers, are also important obstacles to controlling HIV infection, especially in the southern states of the United States.

Risk factors for all women, both in the United States and globally, include lack of power in relationships (as reflected by sexual violence against women; their lack of input into decisions such as whether a male partner wears a condom, visits a prostitute, or has multiple sexual partners, etc.), inadequate health care and HIV-prevention education, lack of education about body and sexuality, and the biological vulnerability of women during sexual intercourse that provides more sources of entry for the virus. Scholars suggest that many students in the United States are at risk for HIV infection when they have multiple sex partners, use condoms inconsistently, and combine alcohol and/or other drugs with their sexual experiences. Although students tend to be knowledgeable about HIV, this does not always lead to condom use.

For Better or For Worse® **by Lynn Johnston**

Although there has been increased funding for HIV/AIDS prevention, treatment, and care in Africa and the Caribbean, a U.S. "global gag rule" on the U.S. Agency for International Development (USAID) population-control program under Presidents Reagan, George H. W. Bush, and George W. Bush restricted foreign nongovernmental organizations (NGOs) that received USAID family-planning funds from using their own, non-U.S. funds to provide legal abortion services, lobby their own governments for abortion law reform, or even provide accurate medical counseling or referrals regarding abortion. It coincided with another U.S. policy that blocked contributions to the United Nations Population Fund. This fund supports programs in some 150 countries to improve poor women's reproductive health, reduce infant mortality, address sex trafficking, and prevent the spread of HIV/AIDS. Such policies undermine funding for other related health issues (as well as health and infant screening, nutritional programs, and health education) and encourage narrow, often religious, and abstinence-based approaches to HIV/AIDS prevention that exclude condom use. Officially known as the "Mexico City Policy," the global gag rule is an indirect method of targeting reproductive justice worldwide. Under the rule, organizations that even so much as mention abortion services to their clients, even for purely educational purposes as part of comprehensive sexual health instruction, are totally ineligible for funding from the United States. Health clinics have been forced to choose between censoring the health programs they have developed to serve women's needs or being denied the funding they need to keep their doors open at all. This global gag rule was lifted by President Obama in 2009, although it can be reinstated by another President at a later date. It is important to consider the ways anti-choice policies in the United States are threatening the quality of women's lives around the world.

The second theme of this chapter is *androcentrism* or male centeredness (see Chapter 1). The male body is constructed as normative and medical research has tended to focus on men (mostly white men), overgeneralizing the results of this research to others. Baseline data for heart monitors, for example, were based on middle-aged white men, causing serious complications for patients who did not fit this description. Until recently, women often were not included in clinical trials to determine the safety and effectiveness of drugs and other medical devices because it was thought that women's hormonal cycling or other factors peculiar to being female might constitute variables that could skew trial results. It was

by Lynn Johnston

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declared that excluding women protected them, because a woman might be pregnant or the drug might prevent future fertility. Drug companies did not want to get sued. Recently it has become increasingly clear that research from male-only trials may not apply equally to women, or may not provide data on important effects of drugs on women. Originally, researchers believed most sex differences in terms of reactions to drugs were most likely a result of differences in hormones, height, and/or weight. Scientists now know that these differences are more complex. Differences in the livers of men and women may explain why most women seem to metabolize drugs differently than men, for example. There may also be sex differences in pain tolerance and the ways individuals respond to pain medications. Laurie Edward's reading "The Gender Gap in Pain" discusses the ways men and women respond differently to drugs as well as pain, both acute and chronic. Today the National Science Foundation (NSF) and National Institutes of Health (NIH) have implemented regulations to ensure researchers receiving funds are free of gender discrimination and other kinds of bias, although as Edwards emphasizes, the application of medical research to clinical practice moves slowly, and "changes in assumptions about gender evolve even more slowly."

More money is spent on diseases that are more likely to afflict men. Related to this is the notion of "anatomy is destiny" (an example of biological determinism, already discussed in other chapters) whereby female physiology, and especially reproductive anatomy, is seen as central in understanding women's behavior. These trends have a long history. Social norms about femininity, for instance, have guided medical and scientific ideas about women's health, and female reproductive organs have long been perceived as sources of some kind of special emotional as well as physical health. "Female hysteria," for example, was a once-common nineteenth-century medical diagnosis of women in the United States and Europe that was "treated" by various practices that included hysterectomy (surgical removal of the uterus). Women thought to be suffering from it exhibited a wide array of symptoms, including nervousness, sexual desire or lack of desire, anxiety, and irritability. Basically women who transgressed cultural notions of femininity and had a tendency to cause trouble were suspected of suffering from the condition.

Third, *medicalization* is the process whereby normal functions of the body come to be seen as indicative of disease. This affects women in two ways. One, because women have more episodic changes in their bodies as a result of childbearing (for example, menstruation, pregnancy, childbirth, lactation, and menopause), they are more at risk for medical personnel interpreting these natural processes as problematic. Note how this tends to reinforce the argument that biology is destiny. Two, medicalization supports business and medical technologies. It tends to work against preventive medicine and encourages sophisticated medical technologies to "fix" problems after they occur. Medical services are dominated by drug treatments and surgery, and controlled by pharmaceutical companies, HMOs, and such professional organizations as the American Medical Association.

Fourth, the practices of *gender and ethnic profiling* encompass how notions about gender, race/ethnicity, and other identities inform everyday understanding of health care occupations and influence how medical practitioners treat their patients. For example, patients still often assume that white-coated white male orderlies are doctors and call women doctors "nurse." Women patients tend to interact differently with the health care system and are treated differently, often to the detriment of health outcomes.

Such differential treatment may occur as a result of provider bias. Provider bias concerns the ways stereotypes about people influence how providers interpret identical behaviors and clinical findings. Research in provider bias suggests several key interrelated factors about ways stereotypes influence how providers interpret identical behaviors and clinical findings. First, providers' conscious beliefs may be inconsistent with their automatic, unconscious reactions to low-income and/or minority patients. Second, when providers make complex judgments quickly, with insufficient and imperfect information or little time to gather information, they may "fill in the gaps" with beliefs associated with patients' social categories. Third, providers tend to be more likely to rely on stereotypes for "outgroup members" or people that do not act or look like them; and finally, providers may unconsciously favor those they feel to be similar to themselves, regardless of their conscious beliefs and politics.

For example, research suggests that physicians generally are more likely to consider emotional factors when diagnosing women's problems, and they are more likely to assume that the cause of illness is psychosomatic when the patient involved is female, prescribing more anxiety-mediating and mood-altering medication for women than for men. Although overall about 1 in 10 people in the United States older than age 12 takes antidepressant medication, the rate varies with about 6 percent of men and more than 15 percent of women, with white women having the highest rate. It is also interesting to note that the rate of antidepressant use in the United States has increased nearly 400 percent in the last 25 years and, according to the Centers for Disease Control, it is the most frequently used medication by persons aged 18 to 44 years. In addition, a recent study found that blacks, Latinas/os, and women generally waited longer for care. Whites waited an average of 24 minutes, while blacks had to wait an average of 31 minutes and Latinas/os had to wait 33 minutes on average. Homophobia and transphobia prevent LGBQT individuals from receiving fully informed care that affects their options and access.

Finally, a focus on women's health must discuss the issue of *corporate responsibility* and the role of the state in guiding and establishing that responsibility. This relates to how national and transnational corporations with strong profit motives affect our lives in terms of environmental degradation and toxic exposure, food additives, and problematic medical practices, and the ways decisions at national and international levels affect these practices. Examples include concern with greenhouse gases and global climate change, use of pesticides and herbicides, genetically modified food and corporate control of bioresources, and growth hormones in beef and dairy food products. All these issues are related to the corporatization of life and the global economy, the stresses of life in postindustrial societies, and ultimately the quality of life on the planet.

There is increasing interest in exploring the role of stress in our lives, as well as the connections between mind and body in terms of illness. Scientists have long known about these connections and have emphasized that it is less stress per se (of work, relationships, trauma, etc.) that affects the immune system, but more how individuals interpret or make meaning of that stress. It seems that stresses we choose evoke different responses from those we cannot control, with feelings of helplessness being worse than the stressor itself. While stress affects everyone, there is differential impact based on where a person lives, the kind of work s/he performs, the food s/he can afford to eat, and so forth. These stresses and the discriminations associated with being a target group member are examples of what scholars call *structural violence*, discussed later in Chapter 10.

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LEARNING ACTIVITY

Breast Science

Go to the web page of the Breast Cancer Fund at *www.breastcancerfund.org*. Follow the "Clear Science" link. What does science tell us about the complex causes of breast cancer? Which chemicals are linked to breast cancer? Which populations are most vulnerable to breast cancer? Now go to the website of the National Cancer Institute at *www.cancer.gov/cancertopics/types/breast*. What are the incidences and death rates of breast cancer in the United States? Identify five facts about breast cancer that are new to you.

As mentioned above, differential exposure to environmental problems on the part of marginalized peoples has fostered an environmental justice movement to resist these inequities that occur as a result of lack of economic, social, and political power. In particular, environmental racism reflects the fact that people of color in the United States are disproportionately exposed to toxic environments due to the dumping of chemical and other waste on Native American lands and in urban areas where more people of color live. Environmental waste tends not to be dumped in areas populated by people of high socioeconomic status or where property values are high. The dumping of radioactive waste at Yucca Mountain, Nevada, despite the impact of this on the Western Shoshone tribe that considers the mountain sacred, is a case in point. People in developing countries who work in factories and sweatshops within the global economy (especially young women, who are often hired because they are cheap, dispensable, and easily controlled workers) are particularly at risk for occupational disease. See, for example, the reading in Chapter 9 by Momo Chang on the occupational hazards to health endured by workers in the nail salon industry.

Breast cancer is one important health issue closely tied to environmental problems and therefore to corporate responsibility. According to a 2013 National Cancer Institute fact sheet, 1 in 8 women will be diagnosed with breast cancer over a lifetime (compared to 1 in 20 in 1960). The relative increase in women living longer does not explain this increase in breast cancer incidence. It is the most common form of cancer in women and the number-two cause of cancer death (lung and bronchial cancer causes the most deaths), except in the case of Latinas, for whom breast cancer is the number-one cause of cancer death. Approximately 40,000 women die from breast cancer every year; men also can have the disease. Although African American women are not more susceptible to breast cancer, African American women aged 35 to 44 years are more than twice as likely to die from it. This is because they tend to have more advanced tumors as a result of poorer screening and reduced access to health care services.

Breast cancer research works to find a "cure," despite the fact that a focus on environmental contributors could work effectively to prevent breast cancer. The pink ribbon campaign for the cure, while a formidable support for breast cancer research and the empowerment of survivors, inadequately addresses environmental links to breast cancer. This is especially important because less than 10 percent of breast cancer cases have a genetic cause. About half of all breast cancer cases cannot be explained by known risk factors, encouraging scientists to suspect toxic chemicals in the environment playing a role in breast cancer risk. In particular, it has been hypothesized that environmental estrogens may

play a role in the increasing incidence of breast cancer, testicular cancer, and other problems of the human reproductive system.

Environmental estrogens (also known as xenoestrogens) mimic the effects of human estrogen or affect its level in the body indirectly by disrupting the ways human estrogen is produced or used. Although some are naturally occurring (for example, phytoestrogens in plants such as soybeans), the greatest concern is synthetic estrogens that are not easily broken down and can be stored in the body's fat cells. More than 30 years ago researchers showed that organochlorines, a family of compounds including the pesticide DDT and the industrial chemicals known as polychlorinated biphenyls (PCBs), could mimic human estrogen and induce mammary tumors in laboratory animals. Organochlorines are organic compounds containing chlorine bonded to carbon. Virtually unknown in nature, they are primarily products or by-products of the chemical industry. Their largest single use is in the manufacture of polyvinyl chloride (PVC) plastics, but they are also used in bleaching, disinfection, dry cleaning, fire prevention, refrigeration, and such pesticides as DDT and atrazine. Although PCBs and DDT were banned years ago, they are still with us because they persist in the environment. An EPA (Environmental Protection Agency) report on dioxin, another highly toxic organochlorine, reports that North Americans have far higher levels of dioxin in their systems than was previously thought, raising new questions about the chemical's relationship to breast cancer and other health problems. It is also known that the plastic chemical BPA (Bisphenol A) (present in cash register receipts, the lining of canned goods, and in sporting equipment and medical supplies) is carcinogenic (cancer-promoting) and can cause lowered male sperm count.

Focusing on environmental issues necessarily involves addressing the effects of U.S. corporations and businesses on environmental quality. Even if exposure to toxic chemicals in the environment was shown to be associated with only 10 to 20 percent of breast cancer cases (a very conservative estimate, because, as already mentioned, about half of all breast cancer cases cannot be explained by known risk factors), policy enforced by the U.S. government to control individual and corporate use of toxic chemicals could prevent between 9,000 and 36,000 women and men from contracting the disease every year. In this way the "cure" is much more within reach than is acknowledged. See the sidebar "Breast Science" for links to help you explore the complex causes of breast cancer in the United States.

These environmental toxins are also affecting men's health, of course, and not only because men are also diagnosed with breast cancer. In particular, as well as other cancer risks, environmental estrogens are linked to the decrease in testosterone levels among men today (other causes include increased weight and decreased smoking). In 2006, researchers reported that the average 50-year-old man has almost 20 percent less testosterone than his father did 20 years ago.

REPRODUCTIVE JUSTICE

Reproductive justice involves being able to have safe and affordable birthing and parenting options; reliable, safe, and affordable birth control technologies; freedom from forced sterilization; and the availability of abortion. In other words, a key aspect of reproductive justice is the extent to which people can control their reproduction and therefore shape the

"All I really want is control over my own body!"

quality and character of their lives. Worldwide, some 215 million women have an "unmet need" for family planning, meaning that they want to either space or limit births but do not have access or lack consistent access to reliable methods of birth control that fit their personal needs. Women with unmet need make up 82 percent of the estimated 75 million unintended pregnancies that occur each year. The remaining 18 percent are due to inconsistent method use or method failure. Providing all women with basic family planning services is first and foremost a matter of basic human rights and bodily integrity. However, despite the importance of reproductive freedom in the United States and worldwide, it is increasingly under attack. For women of color in the United States in particular, as the reading "From Rights to Justice" by Zakiya Luna emphasizes, resisting population control while simultaneously claiming the right to bodily self-determination, including the right to contraception and abortion or the right to have children, is at the heart of the struggle for reproductive justice. Finally, another key aspect of reproductive choice is the right to assisted reproductive technologies for infertile couples who want children. Jennifer Parks discusses these technologies in the reading "Rethinking Radical Politics in the Context of Assisted Reproductive Technology." In response to debates about whether these technologies are ultimately good or bad for women, she makes the case that they are neither inherently liberating nor entirely oppressive. Rather, the consequences of these technologies can be understood only by considering how they are actually taken up within specific communities. In the sections that follow, we discuss the politics of sterilization, contraceptive technologies, and issues surrounding abortion.

Sterilization Practices

Female sterilization includes tubal ligation, a surgical procedure in which the fallopian tubes are blocked ("having the tubes tied"), and hysterectomy, in which the uterus is removed. A less invasive alternative to tubal ligation is a springlike device called *Essure* that blocks the fallopian tubes. Although hysterectomy (the removal of the uterus) is usually performed for medical reasons not associated with a desire for sterilization, this procedure results in sterilization. Vasectomy is permanent birth control for men, or male sterilization. It is effective and safe and does not limit male sexual pleasure. Countless women freely choose sterilization as a form of permanent birth control, and it is a useful method of family planning for many. "Freely choose," however, assumes a range of options not available to some women. In other words, "freely choose" is difficult in a racist, class-based, and sexist society that does not provide all people with the same options from which to choose.

HISTORICAL MOMENT The Women's Health Movement

From the beginnings of the medical industry, women often suffered from the humiliation and degradation of medical practitioners who treated women as hysterical and as hypochondriacs, who medicalized normal female body functions, and who prevented women from controlling their own health. In 1969, as the women's movement heightened consciousness about other issues, women also began to examine the ways they had been treated and the ways women's

biology and health had been largely unexplored. In the spring of that year, several women participated in a workshop on "women and their bodies" at a Boston conference. As they vented their anger at the medical establishment, they also began to make plans to take action. Although most of them had no medical training, they spent the summer studying all facets of women's health and the health care system. Then they began giving courses on women's bodies wherever they could find an audience. These women became known as the Boston Women's Health Collective and published their notes and lectures in what would eventually be known as *Our Bodies, Ourselves.*

Their efforts resulted in a national women's health movement. In March 1971 800 women gathered for the first women's health conference in New York. Women patients began to question doctors' authority and to bring patient advocates to their medical appointments to take notes on their treatment by medical professionals. Feminists questioned established medical practices such as the gendered diagnosis and treatment of depression, the recommendation for radical mastectomies whenever breast cancer was found, and the high incidence of cesarean deliveries and hysterectomies.

Although the original members of the women's health movement tended to be well-educated, middle-class white women, the movement quickly expanded to work with poor women and women of color to address the inequities caused by the intersections of gender with race and social class. Together, these women worked on reproductive rights, recognizing that for many poor women and women of color, the right to abortion was not as paramount as the right to be free from forced sterilization. Their work shaped the agenda of the National Women's Health Network, founded in 1975 and dedicated to advancing the health of women of all races and social classes.

Source: Ruth Rosen, *The World Split Open: How the Modern Women's Movement Changed America* (New York: Viking, 2000).

As a result, women on welfare are more likely to be sterilized than women who are not on welfare, and women of color and women in nonindustrialized countries are disproportionately more likely to receive this procedure rather than being offered more expensive contraceptive options. Lingering here is the racist and classist idea that certain groups have more right to reproduce than others: a belief and social practice called *eugenics.* Policies providing support for sterilization that make it free or very accessible obviously no longer force women to be sterilized. Rather, policies like these make the option attractive at a time when other options are limited.

One of the unfortunate legacies of reproductive history is that some women have been sterilized against their will, usually articulated as "against their full, informed consent." In the 1970s it was learned that many poor women—especially women of color, and Native American women in particular, as well as women who were mentally disabled or incarcerated—had undergone forced sterilization. Situations varied, but often they included women not giving consent at all, not knowing what was happening, believing they were having a different procedure, being strongly pressured to consent, or being unable to

read or to understand the options told to them. The latter was especially true for women who did not speak or read English. Forced sterilization is now against the law, although problems remain. One consequence of forced sterilization for women of color in the United States was suspicion of birth control technologies as another potential tool of genocide. For example, when the contraceptive pill was available in the 1960s, some women of color remembered this history of forced sterilization and resisted its marketing, fearing the pill was another way to limit the non-white population. This was especially significant since the pill was originally tested on women in Puerto Rico.

Parenting Options and Contraceptive Technologies

In considering reproductive choice, it is important to think about the motivations for having children as well as the motivations for limiting fertility. Most people, women and men, assume they will have children at some point in their lives, and, for some, reproduction and parenting are less of a choice than something that people just do. Although in many non-industrial societies children can be economic assets, in contemporary U.S. society, for the most part, children consume much more than they produce. Some women do see children as insurance in their old age, but generally today we have children for emotional reasons such as personal and marital fulfillment, and for social reasons such as carrying on the family name and fulfilling religious mandates.

Childbirth is an experience that has been shared by millions of women the world over. Women have historically helped other women at this time, strengthening family and kinship bonds and the ties of friendship. As the medical profession gained power and status and developed various technologies (forceps, for example), women's traditional authority associated with birthing was eclipsed by an increasing medicalization of birthing. Again, the medicalization of childbirth regards birthing as an irregular episode that requires medical procedures, often including invasive forms of "treatment." As these trends gained social power, women who could afford it started going to hospitals to birth their children instead of being attended at home by relatives, friends, or midwives. Unfortunately, in these early days, hospitals were relatively dangerous places where sanitation was questionable and women in childbirth were attended by doctors who knew far less about birthing than did midwives. As the twentieth century progressed and birthing in hospitals became routine, women gave birth lying down in the pelvic exam position with their feet in stirrups, sometimes with their arms strapped down; they were given drugs and episiotomies (an incision from the vagina toward the anus to prevent tearing) and were routinely shaved in the pubic area. By the late twentieth century, thanks to a strong consumer movement, women were giving birth under more humane conditions. Birthing centers now predominate in most hospitals, and doctors no longer perform and administer the routine procedures and drugs they used to. Nonetheless, a large number of pregnant women (especially women of color) do not receive any health care at all, and a larger number still receive inadequate health care, some resorting to emergency rooms to deliver babies and having their first contact with the medical establishment at this time. As you can imagine, this scenario results in increased complications and potential unhealthy babies, and costs society much more financially than if routine health screening and preventive health care had been available.

Why might women want to control their fertility? The first and obvious answer concerns health. Over a woman's reproductive life, she could potentially birth many children

and be in a constant state of pregnancy and lactation. Such a regimen compromises maximum health. Second, birthing large numbers of children might be seen as irresponsible in the context of world population and a planet with finite resources. Third, birthing is expensive and the raising of children even more expensive. Fourth, given that women have primary responsibility for childcare and that in the global north and many other regions the organization of mothering tends to isolate women in their homes, it is important to consider the emotional effects of constant child rearing. And, finally, if women had unlimited children, the constant caretaking of these children would preempt women's ability to be involved in other productive work outside the home. This "indirect cost" concept involves the loss or limitation of financial autonomy, work-related or professional identity, and creative and ego development.

Although today women are as likely to have children as they ever were, three facts stand out. First, the average family size decreased as the twentieth century progressed. Second, women are having children later in life than they did in earlier times in our society. Both of these trends are related to changes in health care technologies that have raised health care standards and encouraged parenting at later ages, the availability of birth control and abortion, and the increase in women's education and participation in paid labor with subsequent postponement of marriage and child rearing. Third, there has been a significant increase in the number of children born to single women, especially among non-white populations since the 1970s. Specifically, according to the most recent U.S. Census data, about a third of all children live in a single-parent home and approximately 85 percent of single-parent households are headed by women. The percentage of U.S. households headed by a single parent has nearly doubled since 1970. Approximately 40 percent of all babies are born to unmarried women who may or may not be partnered. One in 10 babies is born to a teenage mother, although these rates have been falling since 1991 with the exception of a two-year increase between 2005 and 2007 (which coincided with increased funding for abstinence-only sex education programs). Half of young women who have babies in their teens do not earn a high school diploma by age 22. A third of their children will go on to become teen parents and are also more likely to do poorly in school and drop out. Teens of color are especially susceptible to early pregnancy.

Unwanted unwed births, especially among teenagers, may result from lack of knowledge and support about reproduction and contraception in the context of an increasing sexually active population, poverty and lack of opportunities for education and employment, failure of family and school systems to keep young people in school, the increased use of alcohol and other drugs, and increasing restrictions on access to abortion services. Some girls see motherhood as a rite of passage into adulthood, as a way to escape families of origin, or as a way to connect with another human being whom they may believe will love them unconditionally. Because the largest increase in unmarried births has been among women aged 25 years and older, these changes also reflect changing norms about raising a child out of wedlock, either alone or in a heterosexual or lesbian cohabiting, or living together, arrangement, and the fact that some women are wary of marriage and/or choose and have the resources to maintain families outside of legal marriage.

Birth control technologies have been around for a long time. Many preindustrial societies used suppositories coated in various substances that blocked the cervix or functioned as spermicides; the condom was used originally to prevent the spread of syphilis,

although it was discovered that it functioned as a contraceptive; and the concept of the intrauterine device was first used by Bedouins who hoped to prevent camels from conceiving during long treks across the desert by inserting small pebbles into the uterus. Nineteenth-century couples in the United States used "coitus interruptus" (withdrawal before ejaculation), the rhythm method (sexual intercourse only during nonfertile times), condoms, and abstinence. Although technologies of one kind or another have been around for generations, the issue for women has been the control of, and access to, these technologies. Patriarchal societies have long understood that to control women's lives it is necessary to control women's reproductive options. In this way, information about, access to, and denial of birth control technologies are central aspects of women's role and status in society.

In 1873 the Comstock Act made it illegal to send any "obscene, lewd, and/or lascivious" materials through the mail, including contraceptive devices and information. In addition to banning contraceptives and "quack" medicines, this act also banned the distribution of information on abortion. The state and federal restrictions became known as the Comstock Laws. Women understood that the denial of contraception kept them in the domestic sphere and, more importantly, exposed them to repetitive and often dangerous pregnancies. In response, a social movement emerged that was organized around reproductive choice. Called "voluntary motherhood," this movement not only involved giving women access to birth control, but also worked to facilitate reproduction and parenting under the most safe, humane, and dignified conditions. Many of its followers sought to control male sexual behaviors and advocated a social purity politics that saw male "vice" (prostitution, sexually transmitted infections, and sexual abuse) as the problem. Margaret Sanger was a leader of this movement and in 1931 wrote *My Fight for Birth Control* about her decision to become involved in the struggle for reproductive choice.

One unfortunate aspect, however, was the early birth control movement's affiliation with an emerging eugenics movement that argued only the "fit" should be encouraged to reproduce. Birth control was therefore necessary to prevent the "unfit" from unlimited reproduction. The "unfit" included poor and immigrant populations, the "feebleminded," and criminals. Using a rationale grounded in eugenics, birth control proponents were able to argue their case while receiving the support of those in power in society. Nonetheless, although contraceptive availability varied from state to state, it was not until a Supreme Court decision (*Griswold v. Connecticut*) in 1965 that married couples were allowed legal rights to birth control. The Court's ruling said that the prohibition of contraceptive use by married people was unconstitutional in that it violated the constitutional right to privacy. This legal right was extended to single people in 1972 and to minors in 1977.

Today there are a variety of contraceptive methods available. Their accessibility is limited by the availability of information about them, by cost, and by health care providers' sponsorship. As you read about these technologies, consider the following questions: Whose body is being affected? Who gets to deal with the side effects? Who is paying for these methods? Who will pay if these methods fail? Who will be hurt if these side effects become more serious? These questions are framed by racialized gender relations and the context of the U.S. economy and its health organizations.

Other than tubal ligation where women are surgically sterilized and vasectomy where men are surgically sterilized, birth control methods include, first, the intrauterine device (IUD), a small, t-shaped device made of flexible plastic that is inserted into the uterus

ACTIVIST PROFILE

SisterLove

The beginnings of SisterLove can be traced to a small group of women in Atlanta who organized to educate women about HIV/AIDS, self-help, and safer sex. Founded in 1989, SisterLove "is on a mission to eradicate the adverse impact of HIV/AIDS and other reproductive health challenges upon women and their families through education, prevention, support and human rights advocacy in the United States and around the world."[1] A part of the reproductive justice movement, which centers the reproductive health needs of women of color, SisterLove focuses on HIV prevention and outreach to women of color in Atlanta.

The organization's "Healthy Love" workshop provides prevention strategies. The facilitators take their programs into communities and offer them in spaces where participants feel safe and comfortable. SisterLove's website explains, "The workshop encourages participants to be confident in approaching their own sexuality and to demand safe behaviors from themselves and their partners. It also provides the opportunity for women to explore, discuss and dispel the barriers to practicing safer sex. The HLW respects the cultural traditions of African-American women who, throughout time, have gathered to support one another in times of crisis and growth."[2] Another outreach program focuses on HIV prevention education with women attending historically black colleges and universities.

SisterLove also offers a "Bridge Leadership" program that connects the group to a variety of other reproductive justice organizations, including SisterSong, and supports collaborative projects. The organization also has a capacity-building project in South Africa to enhance the capacity and leadership capabilities of NGOs and community-based organizations working with women and youth to prevent HIV.

As staff member Omisegun Pennick reminds us, "Indeed, 30 years into the epidemic we still have to drive the conversation around the absolute inclusion of women, especially women of color, in the movement to eradicate HIV/AIDS throughout the globe. We have to actively engage researchers in remembering to include women of color when talking about Pre-Exposure Prophylaxis (PreP) and other clinical treatments. We must support the critical work of campaigns such as the 30 for 30 to ensure that a minimum of 30% of the national resources for HIV/AIDS are given to organizations that directly serve women. We have to rally at the local, regional, and national level to ensure that policies and plans such as the National AIDS Strategy directly include women."[3]

[1] *http://sisterlove.org/about-us/.*
[2] *http://sisterlove.org/our-work/health-education-prevention/.*
[3] *http://sisterloveinc.blogspot.com/.*

and prevents the implantation of a fertilized egg. IUDs are available only by prescription, must be inserted by a clinician, and are a popular form of reversible birth control. Trade names include *ParaGard* and *Mirena* (the latter is an IUD that contains hormones). IUDs generally last up to 10 years, can result in heavier periods (although IUDs with hormones claim to reduce menstrual cramping and flow), and may increase the risk of pelvic inflammatory disease among women with multiple sexual partners. It is important to remember that IUDs do not protect against HIV/AIDS and other sexually transmitted infections.

Second are hormone regulation contraceptive methods. The combined oral contraceptive pill (COCP), often referred to as the birth control pill or colloquially as "the pill," is an oral contraceptive that contains a combination of two hormones: progestin and estrogen. It became widely available in the United States in the 1960s and quickly became the most popular means of contraception despite such side effects as nausea, weight gain, breast tenderness, and headaches. Combination pills usually work by preventing a woman's ovaries from releasing eggs (ovulation). They also thicken the cervical mucus, which keeps sperm from joining with an egg. Extended cycle pills are COCPs designed to reduce or eliminate menstrual bleeding. They usually produce a period every three months. The progestin-only or "mini pill" contains no estrogen and has fewer side effects than the regular pill, and it works by thickening cervical mucus and/or preventing ovulation. Taking the pill daily maintains the level of hormone that is needed to prevent pregnancy and it is important that this pill is taken at exactly the same time every day. The birth control pill trademarked as *YAZ* was marketed to appeal to young women through its claims to treat emotional and physical premenstrual symptoms and control moderate acne. *YAZ* is currently involved in lawsuits worldwide with alleged health problems including blood clots, pulmonary embolism, stroke, gallbladder complications, and heart attacks caused by the medication.

Contraception options also include implants such as *Norplant,* a contraceptive device implanted under the skin of the upper arm that releases a small amount of the hormone progestin through the inserted capsules for up to 5 years. As a result of lawsuits associated with unanticipated side effects, the maker of *Norplant* no longer markets this device in the United States, although it is available worldwide. *Depo-Provera* also uses progestin that is injected into the muscle every 11 weeks. It inhibits the secretion of hormones that stimulate the ovaries and prevents ovulation. It also thickens cervical mucus to prevent the entrance of sperm into the uterus. Risks include loss of bone density and side effects generally associated with the pill, such as weight gain, irregular, heavy, or no bleeding, headaches, depression, and mood changes. In addition, it may take up to a year after discontinuing use of *Depo-Provera* before a woman is fertile again. Alongside implants and injections are contraceptive patches, such as *Ortho Evra*, placed on the arm, buttocks, or abdomen, that releases hormones. Since its introduction in 2002, there have been a substantial number of lawsuits by plaintiffs citing serious blood clot–related injuries associated with *Ortho Evra.* This resulted in a warning from the Food and Drug Administration (FDA) for *Ortho Evra* in 2005.

Vaginal rings are also relatively popular contraceptives in the United States. One device marketed under the name *NuvaRing* was approved in 2001. It is a flexible, transparent ring about 2 inches in diameter that women insert vaginally once a month. The ring releases a continuous dose of estrogen and progestin. The ring remains in the vagina for 21 days and is then removed, discarded, and a new ring inserted. None of these hormone methods protect against HIV/AIDS and other sexually transmitted infections.

Next are the barrier methods. The diaphragm, cervical cap, and shield are barrier devices that are inserted into the vagina before sexual intercourse, fit over the cervix, and prevent sperm from entering the uterus. These methods work in conjunction with spermicidal jelly that is placed along the rim of the device. Some women use them in conjunction with spermicidal foam that is inserted into the vagina with a small plunger. Unlike the other methods, spermicides are available at any drugstore, but the diaphragm or cervical cap must be obtained from a physician or clinic. Also available at drugstores are vaginal

Sexually Transmitted Infections

Every year more than 12 million cases of sexually transmitted infections (STIs) are reported in the United States. The health impact of STIs is particularly severe for women. Because the infections often cause few or no symptoms and may go untreated, women are at risk for complications from STIs, including ectopic (tubal) pregnancy, infertility, chronic pelvic pain, and poor pregnancy outcomes.

CHLAMYDIA

Chlamydia is the most common bacterial sexually transmitted disease in the United States. It causes an estimated 4 million infections annually, primarily among adolescents and young adults. In women, untreated infections can progress to involve the upper reproductive tract and may result in serious complications. About 75 percent of women infected with chlamydia have few or no symptoms, and without testing and treatment the infection may persist for as long as 15 months. Without treatment, 20–40 percent of women with chlamydia may develop pelvic inflammatory disease (PID).

PELVIC INFLAMMATORY DISEASE

PID refers to upper reproductive tract infection in women, which often develops when STIs go untreated or are inadequately treated. Each year, PID and its complications affect more than 750,000 women. PID can cause chronic pelvic pain or harm to the reproductive organs. Permanent damage to the fallopian tubes can result from a single episode of PID and is even more common after a second or third episode.

One potentially fatal complication of PID is ectopic pregnancy, an abnormal condition that occurs when a fertilized egg implants in a location other than the uterus, often in a fallopian tube. It is estimated that ectopic pregnancy has increased about fivefold over a 20-year period. Among African American women, ectopic pregnancy is the leading cause of pregnancy-related deaths.

GONORRHEA

Gonorrhea is a common bacterial STI that can be treated with antibiotics. Although gonorrhea rates among adults have declined, rates among adolescents have risen or remained unchanged. Adolescent females aged 15–19 have the highest rates of gonorrhea.

HUMAN IMMUNODEFICIENCY VIRUS

Human immunodeficiency virus (HIV) is the virus that causes AIDS. The risk of a woman acquiring or transmitting HIV is increased by the presence of other STIs. In particular, the presence of genital ulcers, such as those produced by syphilis

(*continued*)

and herpes, or the presence of an inflammatory STI, such as chlamydia or gonorrhea, may make HIV transmission easier.

HERPES SIMPLEX VIRUS (HSV)

Genital herpes is a disease caused by herpes simplex virus (HSV). The disease may recur periodically and has no cure. Scientists have estimated that about 30 million persons in the United States may have genital HSV infection. Most infected persons never recognize the symptoms of genital herpes; some will have symptoms shortly after infection and never again. A minority of those infected will have recurrent episodes of genital sores. Many cases of genital herpes are acquired from people who do not know they are infected or who had no symptoms at the time of the sexual contact.

HUMAN PAPILLOMA VIRUS (HPV)

HPV is a virus that sometimes causes genital warts but in many cases infects people without causing noticeable symptoms. Concern about HPV has increased in recent years after several studies showed that HPV infection is associated with the development of cervical cancer. Infection with a high-risk type of HPV is one risk factor for cervical cancer, which causes 4,500 deaths among women each year.

SYPHILIS

Syphilis is a bacterial infection that can be cured with antibiotics. Female adolescents are twice as likely to have syphilis as male adolescents. African American women have syphilis rates that are seven times greater than the female population as a whole.

Such infections among infants are largely preventable if women receive appropriate diagnosis and treatment during prenatal care. Death of the fetus or newborn infant occurs in up to 40 percent of pregnant women who have untreated syphilis.

CONDOM EFFECTIVENESS AND RELIABILITY

When used consistently and correctly, latex condoms are very effective in preventing a variety of STDs, including HIV infection. Multiple studies have demonstrated a strong protective effect of condom use. Condom breakage rates are low in the United States—no higher than 2 per 100 condoms used. Most cases of condom failure result from incorrect or inconsistent use.

For further information, contact the Office of Women's Health, Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA 30033; phone: 800-232-4636.

Source: www.cdc.gov/od/owh/whstd.htm.

sponges that are coated with spermicide, inserted into the vagina, and work to block the cervix and absorb sperm. All these barrier methods work best when used in conjunction with a condom and are much less effective when used alone. The male condom is a latex rubber tube that comes rolled up and is unrolled on the penis. The female condom is a floppy polyurethane tube with an inner ring at the closed end that fits over the cervix and an outer ring at the open end that hangs outside the vagina. Condoms block sperm from entering the vagina and, when used properly in conjunction with other barrier methods, are highly effective in preventing pregnancy. Another very important aspect of condoms is that they are the only form of contraception that offers prevention against sexually transmitted diseases (STDs) generally and HIV/AIDS in particular. All health care providers emphasize that individuals not in a mutually monogamous sexual relationship should always use condoms in conjunction with other methods.

Finally, emergency contraception (EC), commonly known as the "morning-after pill" or by the trade-name Plan B, used after unprotected heterosexual intercourse is now available. Plan B and its generic, *Next Choice*, were approved by the FDA in 1997. Plan B is most effective if taken within 12 hours, although it offers protection for 3 days with some protection for up to 5 days. EC provides a high dose of the same hormones as are in birth control pills to prevent ovulation and fertilization. A *New England Journal of Medicine* study reported that almost 2 million of the approximately 3 million unintended pregnancies a year might be prevented if EC was more readily available. In addition, a study in the *Journal of the American Medical Association* reported that women with easy access to EC were not more likely to engage in unprotected heterosexual contact or abandon the use of other forms of birth control. The FDA has approved Plan B for over-the-counter sales for individuals aged 17 years and older, but women still face barriers when trying to obtain the medication in some communities. Plan B is expensive and current prices make it too expensive for some women. A new EC, *EllaOne* (ulipristal acetate), is more effective than Plan B in being able to work effectively for 5 days after unprotected sex rather than 3, and to provide less than 2 percent chance of pregnancy, a fail rate nearly half that of Plan B. Note that EC is different from the drug mifeprex (the U.S. trade name for mifepristone), also known as RU-486 and discussed in the following section, that works by terminating an early pregnancy and is known as a "medical abortion." Emergency contraception does not terminate a pregnancy but prevents one from occurring. It is important to understand the ways these two medications serve two different purposes and work completely differently from one another. As mentioned, RU-486 results in a termination of a pregnancy and is used only after pregnancy is established (and no more than 49 days since a woman's last menstrual period). On the other hand, EC or Plan B is used to prevent pregnancy. It will not harm an existing pregnancy and does not cause an abortion.

Current debate on EC concerns "refusal clauses" or the rights of medical personnel to deny medication such as Plan B based on their personal ideology. Currently 47 states and the District of Columbia allow certain individuals or entities to refuse to provide women specific reproductive-health services, information, or referrals. Nine states have adopted restrictions on EC specifically. In addition, the 2013 position statement of the American College of Clinical Pharmacy "supports the prerogative of a pharmacist to decline to personally participate in situations involving the legally sanctioned provision and/or use of medical and related devices or services that conflict with that pharmacist's moral, ethical, or religious beliefs." As of this writing, six states (Arkansas, California, Georgia, Idaho, Mississippi, South Dakota) have passed laws allowing a pharmacist the right to

refuse to dispense EC and other contraception drugs and contraceptives and five (Illinois, Massachusetts, North Carolina, Pennsylvania, Washington) have passed legislation requiring pharmacists to fill or transfer certain prescriptions.

Many (including pharmacists) are opposed to such a stance, especially when it denies rape victims access to medication that is legally their right. The National Abortion Federation reports that approximately 13,000 women in the United States become pregnant as a result of rape every year. Timely access to EC ensures rape survivors the right to avoid additional trauma associated with pregnancy. Polls also show that nearly 80 percent of U.S. women want hospitals, whether religiously affiliated or not, to offer EC to rape survivors. Critics of pharmacists' ability to refuse dispensing EC and other medication emphasize that although these health workers have the right to consider their own religious or political beliefs in determining what medical decisions they make for their own care, these beliefs should not determine the care they provide customers and patients. In addition, the State Pharmacy Boards of some states have professional guidelines requiring pharmacists to fill prescriptions without recourse to their personal beliefs. Currently, 16 states and the District of Columbia require emergency rooms to provide information about EC and most of these also require EC-related services to sexual assault victims.

Abortion

Although induced abortion, the removal of the fertilized ovum or fetus from the uterus, is only one aspect of reproductive justice, it has dominated discussion of this topic. This is unfortunate because reproductive rights are about much more than abortion. Nonetheless, this is one topic that generates unease and often heated discussion. *Pro-choice* advocates believe that abortion is women's choice, women should not be forced to have children against their will, a fertilized ovum should not have all the legal and moral rights of personhood, and all children should be wanted children. Pro-choice advocates tend to believe in a woman's right to have an abortion even though they might not make that decision for themselves. *Pro-life* advocates believe that human personhood begins at conception and a fertilized ovum or fetus has the right to full moral and legal rights of personhood. They believe that rights about the sanctity of human life outweigh the rights of mothers. Some pro-life advocates see abortion as murder and doctors and other health care workers who assist in providing abortion services as accomplices to a crime.

According to the most recent Gallup poll published in 2013, and 40 years after the Supreme Court issued its opinion in *Roe v. Wade* that legalized abortion, significantly more people want the landmark abortion decision kept in place rather than overturned (53 percent to 29 percent with 18 percent having no opinion). The poll also showed that 48 percent of Americans consider themselves "pro-choice" (defined as in favor of women's choice to access abortion facilities), 44 percent "pro-life" (against abortion under varying circumstances), and the rest uncertain. The Rasmussen poll conducted at a similar time showed 54 percent pro-choice and 38 percent pro-life. Rasmussen polls tend to show higher pro-choice sentiment than Gallup polls, most likely because they survey likely voters, whereas Gallup surveys the population as a whole. However, these are two of several consecutive polls since May 2009 showing more people in the United States are pro-life than pro-choice, with more women than men advocating pro-choice views. Gallup shows 50 percent of women and 47 percent of men identify as pro-choice. People's support

for pro-choice policies varies by political party, but also by demographic characteristics. People in the United States with no religious affiliation and self-described liberals are the most likely to call themselves pro-choice, with roughly 8 in 10 choosing this label. Those with a college education and high-income earners are also nearly as oriented to the pro-choice position as are Democrats, followed by those who live in the eastern part of the United States, those who live in cities, and young adults generally. On the other end of the spectrum, religiously-affiliated individuals, low-income individuals, adults with no college education, and those who live in the southern part of the United States are more likely to join Republicans and conservatives as the least pro-choice. Overall, a solid majority of Americans (61 percent) believe abortion should generally be legal in the first three months of pregnancy, while 31 percent disagree. However, support for abortions after the first trimester drops off sharply. Gallup has found this pattern each time it has asked this question since 1996, indicating that people in the United States attach much greater value to the fetus as it approaches viability, starting in the second trimester. These data show that relatively few Americans are positioned at either extreme of the spectrum of beliefs—that abortion should be legal in all circumstances or illegal in all circumstances. Despite this "middle ground" position among most people, the public debate on abortion tends to be highly polarized.

Issues associated with feminist pro-choice politics include moral responsibilities associated with requiring the birth of unwanted children, because the forces attempting to deny women safe and legal abortions are the very same ones that call for reductions in

LEARNING ACTIVITY Framing the Debate

The words we choose to talk about issues matter, and the frames we create for understanding reproductive rights shape the conversation. Below are some of the ways anti-choice activists frame the debate. Search on the Web, newspapers, TV, or social media to find examples of these frames. How do you think these frames shape the debate? How do advocates of reproductive justice frame the debate? What differences do these frames make?

- "Abortion as murder"
- "Fetal personhood"
- "Partial-birth abortion"
- "Abortion as holocaust/genocide"
- "Rape exemptions"
- "Abortion as harm to women"
- "Sexual morality"
- "Abstinence-only until marriage"
- "The right to conscience"[1]

[1] These frames are identified in *http://www.politicalresearch.org/wp-content/uploads/downloads/2013/04/Defending-Reproductive-Justice-ARK-Final.pdf*.

the social, medical, educational, and economic support of poor children. Does "pro-life" include being "for life" of these children once they are born? "Pro-life" politicians often tend to vote against increased spending for services for women and families. The second issue raised includes the moral responsibilities involved in requiring women to be mothers against their will. If you do grant full personhood rights to a fertilized ovum or fetus, then at what point do these rights take priority over the rights of another fully established person, the mother? What of fathers' rights? Third, several studies have shown that between two-thirds and three-quarters of all women accessing abortions would have an illegal abortion if abortion were illegal. Illegal abortions have high mortality rates; issues do not go away just by making them illegal. Although most feminists consider themselves pro-choice, there are exceptions, most notably the Feminists for Life of America organization. Their motto is "Pro Woman Pro Life" and they advocate opposition to all forms of violence, characterizing abortion as violence against women as well as against the fetus.

In the years since *Roe v. Wade,* the Supreme Court ruling legalizing abortion in the United States, thousands of women's lives have been saved by access to legal abortion. It is estimated that before 1973, 1.2 million U.S. women resorted to illegal abortions each year and that botched illegal abortions caused as many as 5,000 annual deaths. Barriers to abortion endanger women's health by forcing women to delay the procedure, compelling them to carry unwanted pregnancies to term, and leading them to seek unsafe and illegal abortions.

About half of U.S. pregnancies—more than 3 million each year—are unintended and about 4 in 10 of these are terminated by abortion. By age 45, at least half of all American women will have experienced an unintended pregnancy and about one-third will have had an abortion. Almost 9 in 10 abortions occur in the first 12 weeks of pregnancy (the first trimester) and 62 percent of all abortions take place in the first 9 weeks. About 1.5 percent occur at 21 weeks or later. Women who have abortions come from all racial, ethnic, socioeconomic, and religious backgrounds and their motivations vary. Among women obtaining abortions, approximately half of these are younger than 25 years and 18 percent are teenagers. About 61 percent of abortions are obtained by women who have one or more children. The abortion rate is highest among women who are 20 to 24 years old (33 percent of all abortions). African American women are three times more likely to have an abortion than white women, and Latinas are two and a half times as likely, reflecting in part socioeconomic issues associated with raising children and, possibly, reduced adoption opportunities for children of color compared with white children. Approximately two-thirds of all abortions are obtained by never-married women (although many may be cohabiting), and the same number (although not necessarily the same women) intend to have children in the future. See box "Facts About Abortion, Choice, and Women's Health" for more details.

In the United States, abortion was not limited by law or even opposed by the church until the nineteenth century. In 1800 there were no states with anti-abortion laws and abortion was a relatively common occurrence through the use of pills, powders, and mechanical devices. Generally, abortion was allowed before "quickening," understood as that time when the fetus's movements could be felt by the mother (usually between 3 and 4 months). Between 1821 and 1840, 10 states enacted laws that included provisions on abortion, although in five these applied only to abortions after quickening. Between 1840 and 1860 the numbers of abortions increased such that some scholars estimate one abortion for every five or six live births. According to James Mohr's *Abortion in America,* abortion became more popular with married women and those of the middle and upper classes. This alarmed

physicians in the rapidly growing medical profession. Mohr explains that physicians' concerns centered on ethical issues, scientific reasons to question the importance of quickening, the dangers of abortion for women, and the desire of physicians to rid themselves of some competitors such as midwives and others who helped provide abortions. He suggests that physicians were the major force in the enactment of laws against abortion in the nineteenth century, working through the American Medical Association to campaign to get state legislatures to further restrict abortion. Between 1860 and 1880 more than 40 laws restricted abortion and remained largely intact for a century. Abortion became less visible and the Comstock Laws prevented information about them. Abortions continued by performing the procedure but calling it something else, and in some states they were performed to save a mother's health and life. Not surprisingly, illegal abortions were rampant and often unsafe. By 1860 the Catholic Church officially had ruled against abortion despite the fact that, as explained, religious objections were not at the root of anti-abortion legislation. By the mid-twentieth century resistance to abortion laws had increased such that in 1959 the American Law Institute proposed revisions used by a number of states. It is important to understand that the Supreme Court decisions of the 1970s were not a modern "weakening" of moral standards, but a return to what many Americans believed and practiced in the past.

In 1969 Planned Parenthood supported the repeal of anti-abortion laws. Then in 1970 Hawaii and New York repealed their abortion legislation, but a 1972 referendum in Michigan to do so was defeated. Change came in 1973 when the United States Supreme Court ruled in *Roe v. Wade* that a Texas anti-abortion statute was unconstitutional and overturned all states' bans on abortion. The ruling used the *Griswold v. Connecticut* decision in arguing that abortion must be considered part of privacy rights in deciding whether to have children. It did not, however, attempt to decide the religious or philosophical issue about when life begins. The Court did agree that, under the law, a fetus is not treated as a legal person with civil rights. The ruling went on to divide pregnancy into three equal stages, or trimesters, and explained the differential interventions that the state could make during these different periods. The *Roe v. Wade* ruling held that the U.S. Constitution protects a woman's decision to terminate her pregnancy and allowed first-trimester abortions on demand. It declared that only after the fetus is viable, capable of sustained survival outside the woman's body with or without artificial aid, may the states control abortion. Abortions necessary to preserve the life or health of the mother must be allowed, however, even after fetal viability. Prior to viability, states can regulate abortion, but only if the regulation does not impose a "substantial obstacle" in the path of women.

There has been a general chipping away of women's rights to abortion since *Roe v. Wade*. Subsequent legislative and legal challenges have made abortion access more difficult and dangerous, but there has been no ruling yet that says life begins at conception and therefore no overturning of *Roe v. Wade*. Activities limiting legal rights to abortion currently include laws restricting poor and young women's access, refusal clauses (like those discussed previously that allow pharmacists to choose not to dispense medication if such practices offend their religious or political beliefs), bans on rarely-occurring late term abortion methods that protect women's health, violent tactics that intimidate doctors and patients, and pregnancy crisis centers that mislead women by purporting to offer full services but work to mislead and dissuade women from accessing an abortion. These restrictions on safe, legal abortions are discussed below. If the Supreme Court were to overturn

Roe v. Wade, abortion policy would revert to the states. Currently four states (Louisiana, Mississippi, North Dakota, South Dakota) have laws imposing near-total criminal bans on abortion (sometimes known as "trigger" bans) if *Roe v. Wade* were to be overturned.

One of the first restrictions on abortion rights was the Hyde Amendment, sponsored by Henry Hyde, a Republican senator from Illinois. It was an amendment to the 1977 Health, Education, and Welfare Appropriations Act and gave states the right to prohibit the use of Medicaid funds for abortion, thus limiting abortion to those women who could afford to pay and restricting abortion for poor women. Note that this was accompanied by Supreme Court rulings (*Beal v. Doe,* 1977) that said that states could refuse to use Medicaid funds to pay for abortions and that Congress could forbid states to use federal funds (including Medicaid) to pay for abortion services (*Harris v. McRae,* 1980). The latter ruling also allowed states to deny funds even for medically necessary abortions.

Second, the 1989 *Webster v. Reproductive Health Services,* sponsored by Missouri State Attorney William Webster, upheld a state's right to prevent public facilities or public employees from assisting with abortions, to prevent counseling concerning abortion if public funds were involved, and to allow parental notification rights. The latter restricts abortion for young women as parental involvement laws require young women who seek abortion care to tell their parents or get their permission, regardless of their family circumstances.

Third, Planned Parenthood v. Casey, although upholding *Roe v. Wade* in 1992, also upheld the state's right to restrict abortion in various ways: parental notification, mandatory counseling and waiting periods, and limitations on public spending for abortion services. Refusal clauses and counseling bans limit women's access to honest information and medical care, making it virtually impossible for some women to access abortion services altogether. Refusal clauses permit a broad range of individuals and/or

LEARNING ACTIVITY Debating Reproductive Rights

Select one of the following topics to research from various perspectives. Be sure to represent perspectives that both support and oppose the topic, and be sure to examine various feminist analyses of the topic. Present your findings to your classmates. You may want to present your findings in the form of a debate, a Q & A session, or a pros and cons list.

TOPICS

1. The morning-after pill
2. The right to have children (particularly for lesbians, women with disabilities, single women, and older women)
3. Assisted reproductive technologies
4. Abstinence-only education
5. Distributing condoms in public schools
6. Selective reduction (abortion of one or more fetuses when pregnancy results in multiple fetuses)

Facts About Abortion, Choice, and Women's Health

- Between 1973, when abortion was made legal in the United States, and 1990, the number of deaths per 100,000 legal abortion procedures declined tenfold. By 1990, the risk of death from legal abortion had declined to 0.3 death per 100,000. (This rate is half the risk of a tonsillectomy and one-hundredth the risk of an appendectomy.)
- The mortality rate associated with childbirth is 10 times higher than for legal abortion.
- Worldwide, 125,000 to 200,000 women die each year from complications related to unsafe and illegal abortions.
- In 87 percent of the counties in the United States, no physicians are willing or able to provide abortions.
- Only 12 percent of ob-gyn residency programs in the United States offer routine training in abortion procedures.
- Eighty-eight percent of abortions are performed before the end of the first trimester of pregnancy.
- Sixty-four percent of states prohibit most government funding for abortion, making access to the procedure impossible for many poor women.
- Thirty-eight states have enacted parental consent or notice requirements for minors seeking abortions.
- Abortion has no overall effect on the risk of breast cancer.
- Abortion does not increase the risk of complications during future pregnancies or deliveries.
- Emergency contraceptives reduce a woman's chance of becoming pregnant by 75 percent when taken within 72 hours of unprotected sex with a second dose 12 hours after the first.
- Emergency contraceptives do not cause abortions; they inhibit ovulation, fertilization, or implantation before a pregnancy occurs.
- Use of emergency contraceptives could reduce the number of unintended pregnancies and abortions by half annually.
- Eighty-nine percent of women aged 18 to 44 have not heard of or do not know the key facts critical to the use of emergency contraceptives.

Sources: NARAL Publications: *www.naral.org;* Reproductive Health and Rights Center: *www.choice.org.*

institutions—hospitals, hospital employees, health care providers, pharmacists, employers, and insurers—to refuse to provide, pay for, counsel, or even give referrals for medical treatment that they personally oppose. Counseling bans, also known as "gag rules," prohibit health care providers, including individuals, under certain circumstances, from counseling or referring women for abortion care, preventing doctors from treating their patients responsibly, and severely limiting women's ability to make informed decisions. In 2013 there were 21 states with laws prohibiting some or all state organizations that receive state funds from providing counseling or referring women for abortion services. There have also been state rulings that require pregnant women to be offered ultrasound images of her fetus before she can have an abortion (even in the case of pregnancy due to rape or incest) and shield physicians from lawsuits if they choose not to tell a pregnant

patient that her fetus has a birth defect for fear she might opt for abortion. Other bills in Mississippi and Virginia have been debated that require women to have ultrasounds before abortions can be performed.

Congress has also imposed restrictions on abortion care for women who depend on the government for their health care needs, including women serving in the military. With very rare exceptions, almost all women who obtain health care through federal programs are subject to additional restrictions on their right to choose. Unlike women who can use their own funds or private health insurance to pay for abortion care, women insured by federal health plans often lack the means to pay for an abortion. These include low-income women who receive health care through Medicare or Medicaid, federal employees and military personnel and their dependents, and women in federal prisons.

Webster v. Reproductive Health Services and *Planned Parenthood v. Casey* both gave states the right to impose parental involvement laws. Attempts to mandate parental involvement often seem reasonable, but unfortunately may endanger vulnerable teenagers. Some young women cannot involve their parents because they come from homes where physical violence or emotional abuse is prevalent, because their pregnancies are the result of incest, or because they fear parental anger and disappointment. In these circumstances, some young women feel they cannot involve their parents in the decision to terminate a crisis pregnancy. Mandatory parental involvement laws (both notice and consent: "notice" requires notification of intent to terminate a pregnancy; "consent" requires the permission of one or both biological parents) do not solve the problem of troubled family communication; they only exacerbate a potentially dangerous situation. In other words, although in a perfect world it would be positive for parents to provide guidance at this time, we do not live in a perfect world and instead of protecting young women, these laws have been shown to have serious consequences such as illegal and self-induced abortion, family violence, and suicide. Most states have laws that make it harder for teens to make a responsible and safe decision in a difficult situation. For example, 23 states currently require parental consent, 15 require parental notice, and 11 have parental notice and/or consent laws but permit other adults to stand in for a parent.

The *fourth* "chipping away" of *Roe v. Wade* occurred in September 2000 when the FDA approved mifepristone (mifeprex), formerly known as RU-486, an antiprogesterone drug that blocks receptors of progesterone, a key hormone in the establishment and maintenance of human pregnancy. Used in conjunction with a prostaglandin such as misoprostol, mifepristone induces abortion when administered early in a pregnancy, providing women with a medical alternative to traditional aspiration (suction) abortion. This drug has proven to be a safe and effective option for women seeking an abortion during the first few weeks of pregnancy since its approval in France in 1988. FDA approval of RU-486 in the United States requires a doctor administer and supervise the use of the drug as an abortifacient. Research in Europe suggests that the availability of this drug has not increased abortion rates generally. In the United States, however, RU-486 has been the target for anti-choice lobbying and activism to block access to the drug. Such efforts resulted in the "RU-486 Suspension and Review Act" of 2003, 2005, and 2007, which failed to advance in each session. Again, refusal clauses concerning pharmacists' rights to deny medication based on their personal ideology are a central aspect of this debate.

IDEAS FOR ACTIVISM

Ten Things You Can Do to Protect Choice

1. *Volunteer for a pro-choice organization.* Pro-choice organizations need volunteers. There are dozens of organizations working in various ways to help women get the services they need. For pro-choice organizations nationwide, check *www.choice.org.*
2. *Write a letter to a local clinic or abortion provider thanking them for putting themselves on the line for women.* Doctors and clinic workers hear vociferously from those opposed to abortion. Hearing a few words of thanks goes a long way.
3. *Monitor your local paper for articles about abortion.* Write a letter to the editor thanking them for accurate coverage or correcting them if coverage is biased.
4. *Find out how your elected representatives have voted on abortion.* Call and ask for their voting records, not just on bills relating to legality of abortion, but also on related issues such as funding for poor women, restrictions meant to impede a woman's access to services (such as waiting periods and informed consent), and contraceptives funding and/or insurance coverage. Whether or not you agree with the votes of your elected officials, write and let them know that this is an issue on which you make voting decisions. Anti-choice activists don't hesitate to do this; you should do it too.
5. *Talk to your children now about abortion. Explain why you believe it's a decision only a woman can make for herself.*
6. *If you have had an abortion, legal or illegal, consider discussing it with people in your life.* More than 40 percent of American women will have at least one abortion sometime during their lives. More openness about the subject might lead to less judgment, more understanding, and fewer attempts to make it illegal.
7. *Volunteer for a candidate whom you know to be pro-choice.*
8. *Be an escort at a clinic that provides abortions.*
9. *Vote!*
10. *Hold a house meeting to discuss choice with your friends.* You could show one or all of Dorothy Fadiman's excellent documentaries from the trilogy *From the Back Alleys to the Supreme Court and Beyond. When Abortion Was Illegal* is a good conversation starter. For information on obtaining these videos, contact the CARAL ProChoice Education Fund or *Concentric Media.*

Source: www.choice.org.

Fifth, in 2003, the U.S. Congress passed the Federal Abortion Ban, and President George W. Bush signed it into law. The ban outlaws certain second trimester abortions that leading medical and health organizations, doctors, medical school professors, and other experts have repeatedly declared under oath as necessary to protect women's health. These are performed when the life or health of the mother is at risk or when the baby is too malformed (for example, in severe cases of hydrocephalus where the baby cannot live and a normal delivery would kill the mother). In 2007 the U.S. Supreme Court upheld this first ever federal ban on an abortion procedure. Surprisingly, and reversing three decades of

legal rulings, the federal ban does not allow an exception when women's health is in danger. The court's decision gives the go-ahead to the states to restrict abortion services (discussed below) and paves the way for new legislation to enact additional bans on abortion, including those that doctors say are safe and medically necessary.

Following this federal ban on abortion is the restriction of rare, late-term abortions at the state level. In 2010, for example, Nebraska passed the country's most restrictive abortion law that barred abortions after 20 weeks. In 2011, Alabama, Idaho, Indiana, Kansas, and Oklahoma followed suit; and in 2012, Arizona, Georgia, and Louisiana passed curbs of their own. If laws provide exceptions for the life or health of the woman, they may be considered constitutional under *Roe v. Wade*. Many scholars, however, have emphasized that the movement to limit rare, late-term abortions is a "straw-man" argument in which a perceived opponent is misrepresented in order to create the illusion of having refuted the argument by replacing it with a superficially similar, yet unequivalent, position (the "straw man"). The misrepresentation is the notion that late-term abortions occur frequently and willingly by women rather than rarely and usually as a result of a medical emergency. Such tactics have been used throughout history in polemical debates, particularly in cases of highly charged, emotional issues. With the exception of laws in Arizona, Idaho, and Georgia, many of these cases have not been challenged as unconstitutional (Idaho's law was found to be unconstitutional as of this writing). This is due in part because they do not really have a serious effect: As already discussed, less than 2 percent of abortions occur after 20 weeks. Still, their real effect is two-fold: misrepresentation and the energizing of a movement to limit women's reproductive freedom, and the hope among anti-choice activists to force these laws for consideration by the U.S. Supreme Court with the goal of overturning *Roe v. Wade*. As of this writing, the latter may occur as states moved to pass earlier bans. For example, in 2013 Arkansas passed a ban on all abortions after 12 weeks (despite the veto of its governor), and North Dakota proceeded to pass the most restrictive law on all abortions after 6 weeks. While the Arkansas law still does not affect many procedures, the North Dakota law, although seemingly unconstitutional, basically bans all abortions in the state. Again the goal is to put abortion back in front of the Supreme Court, get *Roe v. Wade* overturned, and return abortion policymaking power to the states.

The *sixth* "chipping away" of abortion rights occurred in April 2004 when President George W. Bush signed the Unborn Victims of Violence Act into law, giving the zygote, embryo, or fetus the same legal rights as a person and preparing the groundwork for further restrictions on abortion access. Also known as the Laci Peterson Law, in reference to the murder of a woman and her unborn child, this law creates the notion of double homicide in the case of the murder of a pregnant woman, although the law has jurisdiction only for homicides committed on federal property. This law is somewhat controversial for women's rights supporters. Though written to support survivors of violence by establishing that a fetus of any gestational age has equal personhood with a woman, it jeopardizes women's rights to safe and legal abortions.

Seventh, versions of the Child Interstate Abortion Notification Act passed the House of Representatives between 1998 and 2007, but none yet (as of this writing) has been sent to the President for signing. It seeks to make it a crime to take a minor woman (under 18 years of age) residing in a state with parental notification and/or consent laws across state lines to access an abortion. It also seeks to create a national requirement for parental notification for underage women wanting to terminate a pregnancy and requires a 24-hour waiting period for a minor's abortion. Doctors and others could be prosecuted

under the legislation. Supporters of the bill declare it necessary to protect young women because an adult predator could impregnate a girl and then force her to have an abortion to hide the crime. Opponents say the bill is too far-reaching, explaining that it sets up more roadblocks for women who have the right to safe and legal abortion, and could further isolate young women by making it a crime for a family member or other caring adult to provide assistance. Major medical and public health organizations, including the American Medical Association and the American Academy of Pediatrics, oppose such efforts to prevent young women from receiving confidential health services.

Finally, restrictions on abortion occur as a result of requirements such as those passed in Michigan in 2012 where clinics providing a certain number of surgical abortions per year and publicly advertising outpatient abortion services be licensed as free-standing outpatient surgical facilities. Restrictions also include violence and harassment of medical personnel who provide legal abortion services. These violent tactics intimidate medical personnel and patients seeking reproductive health care. In May 2009, for example, Dr. George Tiller was murdered inside his church in Wichita, Kansas. He was killed because he was a doctor who provided abortion services. Such medical personnel providing legal services face ongoing threats of murder, violence, and intimidation. They continue to face harassment, bombings and arson, death threats, kidnapping, assault, and stalking. Patients visiting clinics may also be targeted, as anti-abortion extremists often use such tactics to block patients' access to medical care.

Abortion in the United States remains legal, but its availability and accessibility is limited. As "The Only Good Abortion Is My Abortion," the first essay by Maggie Koerth-Baker in the reading "Freedom to Choose: Four Essays on Abortion Rights," emphasizes, there is less resistance to "good" abortions (meaning acceptable, as in her case because of fetal damage and the inevitability of miscarriage). She makes the case that there is no reason to treat the decision she has to make any differently than the decisions made by other women. Such resistance to women's right to choose, however, varies by state. At the moment there are three states in the United States that have only one abortion clinic and almost 90 percent of counties have no abortion provider at all. In addition, approximately one in six hospital patients are treated at Catholic hospitals that adhere to religious directives restricting certain procedures. The second essay in "Freedom to Choose?," this time an article titled "Treatment Denied" by Molly M. Ginty, addresses this issue. Despite its legality, abortion is heavily restricted in many states.

One piece of legislation, however, was passed in 1994 to safeguard women's right to access their legal rights. After the public outcry associated with the public harassment, wounding, and death of abortion services providers, and the vandalism and bombing of various clinics, the Supreme Court ruled in *Madsen et al. v. Women's Health Center, Inc.* to allow a buffer zone around clinics to allow patients and employees access and to control noise around the premises. The same year, the Freedom of Access to Clinic Entrances (FACE) Act made it a federal crime to block access, harass, or incite violence in the context of abortion services. FACE provides federal protection against unlawful tactics used by abortion opponents. It provides civil remedies and criminal penalties for a range of violent, obstructive, or threatening conduct directed at reproductive-health providers or patients. Courts repeatedly have upheld the law as constitutional, and scholars describe FACE as a significant factor in reducing clinic violence. In addition, 16 states and the District of Columbia have laws that protect health care facilities, providers, and/or patients from blockades, harassment, and/or other violence. Finally, seven states have

passed *Freedom of Choice Acts* that codify a woman's right to choose, making the protections of *Roe v. Wade* part of state law. These states include California, Connecticut, Hawaii, Maine, Maryland, Nevada, and Washington. The latter three states passed this through ballot initiatives.

In closing this chapter it is important to emphasize that only 12 percent of ob-gyn medical residency programs offer routine training in abortion procedures. There has also been a significant increase in Crisis Pregnancy Centers (CPCs) that claim to offer comprehensive services but are actually focused on reducing abortions. Currently it is estimated there are between 2,300 and 4,000 CPCs in the United States. Many of these are unregulated and unlicensed and may not be required to follow privacy-protection laws required of physicians and comprehensive health clinics. They have been well documented as operating in close proximity to health clinics, mimicking the style or names of clinics that offer abortion services, and functioning to actively dissuade women from seeking an abortion. They use deceptive tactics to mislead women about pregnancy-related issues, making false claims such as abortion causes breast cancer or mental illness or can lead to sterility. Many CPCs receive state and federal funding and a recent study found that 87 percent of CPCs that receive federal funding provide false and unscientific information about abortion. The last essay in "Freedom to Choose?," titled "The Anti-Abortion Clinic Across the Street," discusses the current proliferation of CPCs. In this article the author, Kathryn Joyce, also addresses the relationship between CPCs and the violent anti-choice movement that advocates clinic violence. Such problems have prompted several cities including Baltimore and Austin to propose legislation to prevent such activities and a federal bill (Stop Deceptive Advertising Women's Services Act) was reintroduced to Congress in 2010. Under this act it would be illegal for CPCs to falsely advertise their services. Such legislation is important in addressing the obstacles to and limitations of access that disproportionately affect poor women, women of color, and young women.