

Abstract

The legalization of abortion in the United States has brought a dramatic improvement in women's health and reductions in maternal and infant mortality. For young women, low-income women, and women of color, however, access to abortion has been increasingly restricted. This article describes the obstacles to abortion access, including lack of federal funding; restrictive laws, encompassing those requiring parental consent or notification for a minor seeking an abortion, as well as those attempting to ban a certain procedure; stigmatization and marginalization of abortion; decreasing abortion services; and a shortage of providers. The article connects the erosions in rights relating to abortion to policies undermining poor women's rights in relation to having children.

La légalisation de l'avortement aux États-Unis a contribué à une amélioration importante de la santé de la femme et à la réduction de la mortalité maternelle et infantile. Toutefois, pour les femmes jeunes, les femmes à faibles revenus et les femmes de couleur, l'accès à l'avortement est de plus en plus restreint. Cet article décrit les obstacles à l'accès à l'avortement, notamment le manque de fonds du gouvernement fédéral, les lois restrictives, dont celles qui exigent le consentement parental ou la notification pour une personne mineure désirant avorter, de même que les lois visant à interdire une certaine procédure, la stigmatisation et la marginalisation de l'avortement, la diminution des services d'avortement et le manque de prestataires. L'article relie l'érosion des droits relatifs à l'avortement aux politiques minant le droit des femmes se rapportant à la procréation.

La legalización del aborto en los Estados Unidos ha resultado en mejoras espectaculares en la salud de la mujer y en la reducción de las tasas de mortalidad de madres y e infantil. Sin embargo para las mujeres jóvenes, mujeres de bajo ingresos, y las mujeres de color, el acceso al aborto se encuentra cada vez más limitado. Este artículo describe los obstáculos que existen para llegar a obtener un aborto, incluyendo la falta de financiamiento público; las leyes restrictivas, aquellas que requieren el consentimiento de los padres, o su notificación, para menores de edad que buscan el aborto, y las que intentan prohibir ciertos procedimientos; la estigmatización y la marginalización del aborto; la cantidad decreciente de servicios de aborto; y la escasez de proveedores. El artículo muestra el enlace entre el desgaste de los derechos al aborto y las políticas que debilitan paulatinamente los derechos de mujeres sin recursos con respecto a tener hijos.

ABORTION IN THE UNITED STATES: Barriers to Access

Marlene Gerber Fried

Assessing the current status of rights relating to abortion in the U.S. is a complex matter. From a public health perspective, if one looks at the statistics comparing maternal mortality in the U.S. to countries in which abortion remains illegal and unsafe, the situation in the U.S. looks extremely positive. Abortion has been legal since 1973, and it is widespread: there are between 1.2 and 1.4 million abortions annually.¹ There is virtually no mortality from abortion, and the complication rate for first-trimester abortion is about the same as for tonsillectomy. This is a dramatic improvement from maternal deaths in the era before legalization. While we cannot know the exact numbers because the cause of death was not always recorded (even today, studies find that 23–60% of maternal deaths are not recorded as such), we do know (from statistics based on death certificates) that there were 1407 deaths from induced abortion in 1940.² That number fell during the 1940s to 200–300 per year. It rose again in the 1950s and '60s and fell sharply after 1970, when the first state legalized abortion. From 1970 to 1980, legal abortion is estimated to have prevented 1500 pregnancy-related deaths and thousands of other complications. The availability of safe abortion also accounts for much of the decline in infant mortality.³

Focusing on abortion experiences, however, especially those of young and low-income women, presents a very different picture—one in which reproductive options are

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severely curtailed. The 28-year effort to restrict and ultimately to recriminalize abortion has had a devastating impact on many women's lives. The recent case of a 14-year-old girl in Arizona, 24 weeks pregnant, possibly as a result of rape, makes this all too clear.⁴ Her case became a political football. As a child in foster care in a state in which abortion after 20 weeks is prohibited by law, she had to receive a court order from her state's Supreme Court allowing her to go out of state to have an abortion. This young girl had to travel 1000 miles away, amid a flurry of anti-choice protests in both her home state and Kansas, where she went to obtain the abortion. Her case was leaked to the press even though it is against the law to release confidential information about children who are in the custody of the state. Anti-choice forces followed her to Kansas, where they lined the sidewalk outside the clinic in an effort to "persuade" her not to have an abortion. Sadly, a "normal" day for an abortion patient all too often requires running a gauntlet of protestors, having her confidential medical information made public, traveling long distances, and passing through metal detectors to see her doctor.

Looking at the experience of abortion providers, we may see the extent to which fear and danger permeate their work. In September 1999, clinics in the U.S. and doctors who perform abortions received an alert warning that extremists had proclaimed September 19 "Anti-Abortion Day."⁵ A web site with links to the most extreme and violent parts of the movement encouraged anti-choice activists to "celebrate" anti-abortion day "appropriately." Such threats must be taken seriously: to date, there have been seven murders, and over 80% of clinics have experienced threats and harassment.⁵ Abortion in the U.S. is literally under siege. Providers operate under constant threat, and many clinics have become secured fortresses. A "normal" workday for providers includes wearing a bullet-proof vest, checking for bombs, and being constantly aware of who is around them. There is no other medical service for which the dangers to the provider are much greater than those to the patient. There is no other medical service for which violence statistics must be collected.

This article will give a picture of abortion in the U.S. at the end of the 20th century from the vantage point of those women who bear the brunt of restricted access. This analysis is informed by the author's 20 years of activism, most recently in the National Network of Abortion Funds, a growing network of 67 grassroots groups throughout the U.S. who raise money for women who want abortions but cannot afford them. For tens of thousands of women in the U.S. annually, the lack of access to abortion remains a key obstacle to fully exercising their reproductive rights. Although one cannot deny the substantial gains made in women's health and mortality reduction since the legalization of abortion, access remains an issue, as it was in the U.S. before abortion was legalized, and as it still is for millions of women living in countries where abortion is illegal or severely restricted. The barriers to access that will be discussed here—from economic constraints to the relentless efforts by anti-choice forces to deny women access—are not unique to the U.S. They are pervasive throughout the world, regardless of the legal status of abortion. Nevertheless, one should not conclude from this that legality is unimportant. Activists worldwide have learned that the legalization of abortion is necessary but not sufficient to insure the availability of safe abortion to all women who seek it. Women's health advocates are continuing to work against legal restrictions and for funding, training of health professionals, and access to the full range of safe abortion methods.

While battles over abortion tend to dominate reproductive rights politics in the U.S., many U.S. advocacy groups, especially those organized by women of color, have a broader agenda. Like their counterparts in developing countries, they see abortion as part of a larger struggle for all the conditions that will make women's reproductive and sexual freedom a reality.

Legal but Inaccessible

There is an extreme dissonance between the wide availability of abortion and its inaccessibility to women on the social and economic margins. Legal abortion *is* one of the safest surgical procedures in the U.S. today, and it *is* rela-

tively inexpensive compared to other surgical procedures. At the same time, it remains out of reach for thousands of women each year who find that the expense, location, and shortage of services, burdensome legal restrictions, and anti-abortion threats and violence create daunting barriers. Abortion Funds get calls from women all over the U.S.—women in prison, young women, women who have been raped, “undocumented” women, and women with few economic resources. The organization repeatedly hears of the desperation of girls and women like the 17-year-old with one child who drank a bottle of rubbing alcohol to cause a miscarriage and the 14-year-old who asked her boyfriend to kick her in the stomach and push her down the stairs.⁷ For these women it is as if abortion had never been legalized.

While violence and harassment pose the most visible threat, access to abortion has been even more systematically eroded by other strategies. Since legalization in 1973, there has been a sustained effort by anti-choice forces to undermine these rights. As a result, abortion access, especially for low-income women, women of color, and young women, has become dangerously limited by restrictive legislation, judicial decisions, and relentless anti-abortion activity, both legal and illegal. Abortion providers are marginalized within the medical profession, and women who have abortions are stigmatized, stereotyped as selfish, or portrayed as hapless victims incapable of making their own decisions. The experience of abortion continues to be marked by silence and isolation despite the 35 million legal abortions in the U.S. since 1973 and millions of illegal abortions prior to that time.

In addition to the direct attacks on clinics and providers, abortion access has been undermined primarily through the denial of public funding for abortion, restrictive legislation such as mandatory waiting periods and parental consent laws that impose burdens on women and on clinics, a shortage of services, and a lack of training for new providers.

Funding

Within the system of privatized health care in the U.S., a large majority of abortions must be paid for by the patients

themselves. About one third of women lack employment-linked health insurance. One third of private plans do not cover abortion services or cover them only for certain medical indications. At least 37 million Americans have no health care coverage at all, including nine million women of childbearing age.⁸ And abortion coverage is prohibited by Medicaid, the publicly funded federal program that covers “necessary medical services” for low-income people.⁹ Abortion is the only reproductive health care service that is not covered by Medicaid. In effect, these policies deny low-income women equal access to abortion.

The restrictions on funding came soon after legalization. Federal Medicaid covered abortion from the late 1960s, when state-level abortion laws began to be liberalized, until 1977, four years after *Roe v. Wade* made abortion legal nationwide. Each year since then, the U.S. Congress has passed different versions of the Hyde Amendment, which prohibits federal funding of abortion. Initially, the only exception was for cases of endangerment of the life of the pregnant woman. In 1993, exceptions for rape and incest were added, but only after a long battle. Most states have followed these federal precedents, but even this minimal “liberalization” had to be fought out in court when several states refused to comply.¹⁰

The impact of the Hyde Amendment has been devastating. Between 1973 and 1977, the federal government paid for about one third of all abortions. Now it pays for virtually none. Since the average cost of a first-trimester abortion is \$296 (nearly two thirds the amount of the average maximum monthly welfare payment for a family of three), some welfare recipients cannot afford abortions at all.¹¹ It is estimated that 20–35% of women eligible for Medicaid who have wanted abortions have instead carried their pregnancies to term because funding has been unavailable.¹² Others are forced to divert money from food, rent, and utilities in order to pay for their abortion. Even when women have been able to raise the money, the time needed to search for funding makes it more likely that they will need a more costly and difficult second-trimester procedure. It is estimated that one in five Medicaid-eligible women who have had second-trimester abortions would

have had first-trimester abortions if the lack of public funds had not resulted in delays.¹³

One recent example underscores the rigidity of the federal standard. A Medicaid recipient with a life-threatening heart condition sought an abortion in the first trimester of pregnancy.¹⁴ The hospital where she received treatment for her heart condition refused to perform the abortion on the grounds that the chance that she would die from the pregnancy was less than 50%. Ultimately, she had to be transported by ambulance to another state at a cost of thousands of dollars, raised by grassroots Abortion Funds.

These restrictions also deny abortion access to Native American women, who rely on the government-funded Indian Health Service for their medical care; federal employees and their dependents; federal prisoners; Peace Corps volunteers; and military personnel and their dependents.

Decreasing Services

Abortion services are severely limited despite the facts that (1) abortion is legal, (2) there are 40,000 obstetrician-gynecologists (ob-gyns) practicing in the U.S., (3) abortion is the most common obstetrical surgical procedure women undergo (at 1992 rates, about 43% of U.S. women will have an abortion during their lives) and the most commonly performed surgical procedure in the U.S., and (4) excellent surgical and medical methods of abortion exist.¹⁵ The number of abortion providers in hospitals, clinics, and physicians' offices, however, has declined since the 1980s, and services are very unevenly distributed. Nine in ten abortion providers are now located in metropolitan areas; across the United States, about one-third fewer counties have an abortion provider now than in the late 1970s.¹⁶ Ninety-four percent of non-metropolitan counties have no services, and 85% of rural women live in these underserved counties. One quarter of women who have abortions travel more than 50 miles from home to obtain them.¹⁷ Yet the provider shortage has only come to public attention in the last few years, although it represents a major threat to safe and legal access to abortion.

As older physicians retire, few medical students are being trained in abortion techniques to take their place.

Almost half of graduating residents in obstetrics-gynecology have never performed a first-trimester abortion. Many hospitals do so few abortions that they cannot even qualify as appropriate training sites.¹⁸

Anti-abortion violence and harassment aimed at clinics, doctors, and clinic workers contribute to this situation. Clinics and providers have been targets of violence since the early 1980s. Thus far, 1993 was the peak year for anti-choice violence, but levels remain unacceptably high. Acts of violence have included death threats, stalking, arson, bomb threats, invasions, blockades, and chemical attacks with materials such as butyric acid.¹⁹

Anti-abortion activists are also targeting medical students in an effort to cut off the supply of potential providers for the future. Life Dynamics Inc., an anti-abortion organization engaged in a range of activities to intimidate, harass, and ultimately dissuade doctors from providing abortions, produced two anti-abortion comic books and sent them to thousands of medical students and doctors in the U.S. and Canada. The first, *Bottom Feeder*, included "jokes" such as, "What do you do if you find yourself in a room with Hitler, Mussolini, and an abortionist, and you have only two bullets? Answer: Shoot the abortionist twice." The most recent publication, *Quack the Ripper*, "depicts doctors who perform abortions as zealots, amoral buffoons, and psychotics, and has sparked fears for their safety," in the words of the Pro-Choice Action Network.²⁰ The mailing's implicit message is also meant to intimidate. By sending it to students' home addresses, the anti-abortion movement sends a frightening message: "we know who you are and where to find you."

While the newer methods of early abortion have the potential to expand abortion services, the most important factors leading to later abortions are not related to the techniques involved but to the barriers to access. Nor are they the answer to the political battle. Abortion rights advocates will have to resist efforts to use early abortion as a way of justifying further restrictions on and marginalization of later abortion. Surgical abortion will continue to be necessary not just as a backup to other methods, but as the safest and best method for the vast majority of women who do not

make their decisions until after the seventh week of pregnancy.²¹ Yet the opposition will not be daunted. They have already organized Pharmacists for Life, a group committed to refusing to fill prescriptions for mifepristone, known more commonly as RU-486, and emergency contraception.

Restricting Young Women's Abortion Rights

Controlling young women's sexuality has been a particular concern of the anti-abortion movement, and they have had considerable legislative and ideological success in this area. About 40% of the one million teens who become pregnant annually choose abortion. Laws that require minors seeking abortions either to obtain parental consent or to notify their parents are enforced in 39 out of 52 states.²² Health care providers face loss of license and, in some cases, criminal penalties for failure to comply.

Although the supporters of such laws claim that they are meant to protect the health and promote the best interests of young women, in fact they are a threat to both health and well-being. Parental involvement laws, even though they include provisions for judicial bypass for young women who are unwilling to or cannot tell their parents, often require travel, extra time, and money. Although most teens who go through the judicial process are ultimately given permission by the court to have an abortion, the experience may be humiliating and traumatizing. The laws require a young woman to discuss her pregnancy and personal details about her life in front of strangers in a courtroom. Although these procedures are supposed to be confidential, in rural areas and small towns a young woman may find that confidentiality is impossible to maintain.²³

To avoid such laws, many young women go to a neighboring state for their abortions, often accompanied by another relative. Proposed legislation known as the Child Custody Protection Act, passed by the House of Representatives on July 1, 1999 but still in committee in the Senate, aims to eliminate this alternative. If passed, the bill would make it a crime for anyone other than a parent to transport a minor across state lines for an abortion unless the young woman had already met the obligations of her

state's parental involvement law. A grandparent, a close family friend, or a member of the clergy could be prosecuted and jailed for accompanying a minor to get an abortion if the home state requires parental notification or consent. This legislation would deny the support of caring adults to vulnerable young women who are trying to deal with an unwanted pregnancy. As with campaigns mandating the exclusive teaching of abstinence in sexual education, the intent here is clear: control of young women's sexuality, rather than respect for their rights and health.

Restricting Abortion Methods

While efforts to ban abortion entirely have failed thus far, opponents of abortion have been trying to enact laws banning certain methods or defining them so vaguely that these laws could potentially be used to prohibit *all* abortions. Since 1995, there have been efforts at the federal and state level to ban a specific abortion procedure known as intact dilation and extraction (D&E).²⁴ Congress has passed such legislation twice, as have 28 states. While the courts have been ruling the bans unconstitutional, opponents of abortion are winning the ideological battle. Strategically these initiatives have enabled them to portray second- and third-trimester abortions negatively. While battles over the bans and other legal restrictions have weakened and fragmented the pro-choice movement, the anti-abortion movement has been able to use such fights as opportunities to consolidate itself, to draw in new supporters, and to build support for other restrictions on abortion. They have not achieved their ultimate objective, but, as we have seen, they have won significant victories.

Generating moral disapproval has been a key strategy in efforts to restrict and recriminalize abortion and in shaping public opinion. For example, in the area of public funding for abortion, anti-choice forces argue, "Abortion may be legal, but why should we be forced to pay for something that is morally repugnant?" Moral repugnance has been the hallmark of the campaign against "partial-birth" abortion. The opponents of abortion have been increasingly successful in projecting the idea that there is a universal consensus about

the immorality of abortion. Widening the chasm between the moral and the legal status of abortion undermines support for abortion rights. It is difficult to stand up for abortion rights if doing so means that you are standing for immorality at worst and a necessary evil at best.

Population Control: Undermining Poor Women's Right to Have Children

The mainstream pro-choice movement in the United States has largely failed to address the fact that governmental policies to control which women will have children are fundamentally antithetical to reproductive choice. Instead, it has focused primarily on restrictions on abortion itself. As this article has argued, the brunt of these restrictions has been borne by young women, low-income women, and women of color.²⁵ Yet it is also important to emphasize that historically, from the oppression of Native American women through slavery to the present, the right to *have* children, not the right *not* to, has been the front-line reproductive rights concern for these women.²⁶ Today, legislation curtailing public assistance to low-income women and their families and criminalizing women's behavior during pregnancy, the promotion of long-acting contraceptives and sterilization, and the resurrection of the stigma of illegitimacy all aim to control the fertility of those considered unfit for motherhood and to punish them if they become pregnant.

Young, low-income women of color are the scapegoats blamed for poverty, child abuse, drug addiction, violence, and general societal deterioration. Proposed solutions to these social problems have included a series of callous, punitive, and coercive measures designed to control the lives and reproductive capacity of low-income women. Several provisions of the 1996 welfare law known as the Personal Responsibility and Work Opportunity Reconciliation Act, for example, made it easier for states to reduce poor women's reproductive choices via cuts to nutrition programs for children in family day care and in summer food programs, as well as to child care, family planning, legal services, foster care, and programs for at-risk youth—all services for low-income families. Other provisions of the law imposed strict

time limits on receiving benefits, required single parents with children to work 30 hours per week, and simultaneously cut child-care subsidies. Thus low-income mothers are often forced to choose between inadequate child care (since they cannot afford high-quality services) and a loss of benefits if they stay home to care for their children.

Under the rubric of "welfare reform," the government uses subsistence benefits to manipulate and coerce poor women's reproductive decisions. For example, a "family cap" denies increased payments to women who conceive and bear another child while receiving public assistance. The illegitimacy bonus is another such policy. It offers a federal bounty of \$20–\$25 million for three years to the five states with the largest decrease in out-of-wedlock birth rates with a simultaneous reduction in abortion rates below 1995 levels. This legislation revives the stigma of illegitimacy.²⁷

The 1996 welfare law has also tried to change the way sex education is taught by earmarking \$88 million for programs that teach that abstinence is the expected standard, the *only* way to avoid out-of-wedlock pregnancy, and that extramarital sexual activity is likely to have harmful psychological and physical effects.²⁸

Little attention and less money are directed toward supporting young mothers or enhancing educational and job opportunities for young, low-income women. Instead, the punitive ideological and legislative policies championed by conservatives argue that there is a connection between illegitimacy, poverty, and social decay.²⁹

In fact, welfare reform legislation is just another form of population control, veiled to make it more acceptable. Compulsory sterilization was government policy in 30 states from the 1920s to the 1960s.³⁰ Even after such laws were repealed, coercive sterilization was implemented by doctors paid by the government to provide health care for low-income women. In the 1970s, between 100,000 and 150,000 poor women, half of whom were African-American, were sterilized annually under federally funded programs.³¹ Sterilization by hysterectomy was so routinely performed on African-American women in the South that it was referred to as a "Mississippi appendectomy."³² A program in

Puerto Rico during the 1950s and '60s resulted in the sterilization of more than one-third of women of childbearing age. Likewise, the U.S. government sterilized more than 25% of Native American women living on reservations during the 1970s.³³ Reflecting on the similarities between contemporary and historical policies, Dorothy Roberts writes, "Although less blatant than the involuntary sterilization laws of the eugenics movement and government-sponsored sterilization abuse, these policies continue to devalue procreation on the basis of race and class."³⁴

Contemporary eugenicist social policy is reinforced by new academic work such as "Legalized Abortion and Crime," the recent study by economists Steven Levitt and John Donohue, which purports to show a relationship between legalized abortion and a decline in the crime rate.³⁵ They argue that women who choose abortion—most commonly teenagers, minorities, and the poor—are also at greatest risk for bearing children who would have been likely to commit crimes as young adults.³⁶ The assumption here is that the children of poor and minority women are more likely to be criminals. Using this theory to provide legitimacy for restricting the reproduction of undesirables is a distortion of reproductive freedom.

Overtly coercive policies are still with us, although now they may be privatized. One organization based in California known as Children Requiring A Caring Kommunity (C.R.A.C.K.) offers drug-addicted women \$200 to be sterilized. Their cynical message to women is: "Why let a pregnancy ruin your drug habit?"³⁷ Thus far, 64 women have received cash under this program; another 45 have been permanently sterilized by tubal ligation. The organization is now expanding to other states including Illinois, Florida, Minnesota, Washington, and New Hampshire. While the coercion here is economic rather than legislative, it is no less problematic in that it pushes indigent women in need of treatment to choose between their reproductive capacity and cash.

On the legal side, criminalization of women with drug and alcohol addictions began in the 1980s with the prosecution of women, mostly African-American and poor, for giving birth to babies who tested positive for drugs, most com-

monly cocaine.³⁸ Most recently, two new South Dakota laws permit involuntary and/or emergency commitment of pregnant women to hospitals for alcohol or drug treatment.³⁹ Such legislation drives women away from the health care system, especially from seeking voluntary treatment, for fear that they will be committed or prosecuted. A blatant disregard for the life and health of these women pervades all of these policies, in which women are portrayed as enemies of children. At the same time, the state provides insufficient treatment options for drug and alcohol addictions. There are almost no treatment programs serving pregnant women and women with children or programs to educate women about healthy pregnancy. It is difficult to hear sincerity in the alleged concern for poor babies when it is coming from the same lawmakers who show so little concern for poor children when they slash social welfare and education programs. Given the lack of available treatment programs, especially for pregnant women and women with children, the promotion of sterilization seems especially problematic.

Low-income women of color are also the targets for long-acting contraceptives. Soon after Norplant was introduced in the United States, proposals were advanced to make welfare benefits conditional on Norplant use.⁴⁰ Now, proponents of population control who have aggressively promoted quinacrine sterilization in developing countries are bringing it to the U.S. Over 100,000 women were sterilized with this method in Vietnam, Chile, and India in trials lacking adequate informed consent, screening, or follow-up. In India, illegal trials were carried out, and the drug was imported without any license from the government. In 1997, a coalition of groups succeeded in having the method banned in India after serious abuses in trials conducted there came to light. Opponents point to the extremely high failure rate and unacceptably high rates of complications including extreme body ache, dizziness, painful periods, irregular bleedings, and ectopic pregnancy.⁴¹ There is hardly any information about the long-term effects, although laboratory tests indicate that the drug is mutagenic and may possibly be carcinogenic.⁴²

Waning Support for Reproductive Rights

Although these erosions in rights shape women's reproductive experiences, many people in the U.S., even those who support safe and legal access to abortion, are unaware of the extent to which abortion access has been diminished, and they fail to see the link between controlling the fertility of "undesirable" women and maintaining their own rights. For example, there is growing support among young people for restrictions on abortion. A 1998 study by the University of California showed that support for legal abortion among young women had dropped every year for the previous nine years, from 65.5% in 1989 to 49.5%.⁴³

Research on the same age group done by the Pro-Choice Public Education Project uncovered similar opinions.⁴⁴ Young people think that abortion is overused. Although young women are frequent targets of restrictive policies, they are convinced that government restrictions are needed to keep abortion safe. They are not dismayed by the narrowing access to abortion services; they think that "choice" will always be there for those who need it.

Polls conducted by Choice USA in June 1997 and March 1999 reveal quite a bit of confusion and misinformation among 15–22-year-olds about when most abortions occur and the rates of complications and psychological problems following abortion.⁴⁵ If lack of information accounts for young people's attitudes about abortion, this should be cause for concern among advocates of abortion rights.

Broadening Our Vision

As part of a strategy to expand reproductive rights in the U.S., the notion of "choice" itself must be expanded to take into account the experiences of low-income women. Women who face obstacles to having children or to having an abortion do not see themselves as having choices. Having an abortion because one cannot afford a child in a society that privatizes childrearing is not an expression of reproductive freedom. Historically, movements for reproductive choice in the United States have not advocated for the right to have children. By focusing on women's efforts not to have children, the pro-choice movement has neglected the right

to have them. Traditionally, organizations of women of color have taken the lead in placing abortion rights within a broader agenda that includes advocacy not only for women's health, but for all of the other economic and social rights needed to have real control over one's life. Younger activists, too, who have been negotiating their sexual and reproductive lives through the terrain of HIV/AIDS and other sexually transmitted diseases, sexual abuse and violence against women, and the demonization of lesbians and gay men, also tend to have a broader vision of reproductive rights.

Underlying these important corrections and critiques is a challenge to the market model of choice. The availability of a product for sale does not in itself constitute the sort of choice that reproductive rights advocates seek. At a recent meeting of abortion providers, this point was made clear when a dedicated female physician responded sharply to criticism of quinacrine sterilization. She argued that this new method was an expansion of women's reproductive "choices." The race and class dimensions of its use were invisible to her.⁴⁶ In this view, quinacrine sterilization without appropriate testing is welcomed because it is cheap and thus affordable to women who lack reasonable reproductive options. As one of the doctors who plans to use it said, "Bear in mind that we are not talking about 25-year-old childless Susie Smith in suburbia under the care of Jack Jones, MD. . . . [W]e are talking about women with burgeoning families, little food, little money, little health care, possible AIDS and no reliable contraception."⁴⁷

As we have seen, reproductive rights advocates in the U.S. face formidable challenges, not just from the anti-choice forces, but also from those who are seen as allies. In trying to control their sexual and reproductive lives, women face opposition from fundamentalism on the one hand and, on the other, population-control programs that aggressively seek to limit their fertility. Because of the tendency to separate the abortion issue from other aspects of reproductive rights, the threat to reproductive choice posed by population-control policies has been obscured. In fact, all the major population organizations are seen as part of the pro-choice movement because of their staunch support for legal abor-

tion and opposition to restrictions. Some population groups have even solicited the support of pro-choice organizations in attempts to create a consensus around the threat of over-population.

Yet rationalizations for population policies that control the fertility of low-income women may ultimately legitimize controlling all women. Policies that deny women the right to have children are really just the other side of the coin of abortion restriction. Both deny a woman the right to control her own childbearing.

It is especially important to bring these issues to the forefront of the pro-choice movement at this moment, when, as we have seen, the ideology that blames low-income women's fertility for their poverty is being used to justify punitive policies aimed at deterring them from having children. There is an important political opportunity here to expose the links between coercive policies in the developing world and in the U.S. Navigating the double challenge, however, is difficult. We must distinguish our feminist critique of population control and dangerous contraception from the anti-abortion movement's opposition to abortion and all forms of birth control. One way to do this is to continue strong advocacy for safe and accessible abortion.

To halt the erosion of abortion access, to counteract other threats to reproductive rights, and to expand women's rights and access to meaningful reproductive choice, the fragility of existing rights must be grasped, and the vision of what we want must be broadened. Members of the movement in the U.S. can learn from our sisters in other countries. While the abortion rights battle has been politically isolated in the U.S., the women's agenda internationally, especially in the developing world, integrates a wide range of issues, as can be seen in the Programme of Action of the 1994 International Conference on Population and Development and the Platform for Action of the 1995 Fourth World Conference on Women.⁴⁸ Advocates for women's rights and health have placed abortion in a broad human rights framework, incorporating concerns about maternal and infant mortality, population control, economic rights, violence against women, and environmental destruction.

Battles over restricting abortion are fundamentally about women's power and who will control women's fertility. It is to be hoped that the abortion rights movement in the U.S. will strengthen its ties to those fighting for the range of rights necessary to have genuine reproductive freedom. The need is urgent to reshape the opinions of pro-choice supporters, the general public, and especially young people to affirm the links between rights relating to abortion, human rights, and social justice.

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4. Kaiser Daily Reproductive Health Report, 2 September 1999, 3 September 1999, 9 September 1999, available from the Kaiser Family Foundation at <http://report.kff.org/repro/>.
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6. Dr. David Gunn, March 10, 1993, Pensacola, Florida; Dr. John Britton, July 29, 1994, Pensacola, Florida; James Barrett, clinic escort, July 29, 1994, Pensacola, Florida; Shannon Lowney, clinic worker, December 30, 1994, Boston, Massachusetts; LeeAnn Nichols, clinic worker, December 30, 1994, Boston, Massachusetts; Officer Robert Sanderson, clinic security officer, January 29, 1998, Atlanta, Georgia; Dr. Barnett Slepian, October 23, 1998. Dr. Slepian was murdered at his home; the others were all murdered at their clinics.
7. Legal But Out of Reach: Experiences from the National Network of Abortion Funds (National Network of Abortion Funds, 1998). Available from <http://hamp.hampshire.edu/~clpp/nnaf>.
8. S. Lerner and J. Freedman, "Abortion and Health Care Reform," *Journal of the American Medical Women's Association* 1994, 49(5): 144.
9. P. Donovan, *The Politics of Blame: Family Planning, Abortion and the Poor* (New York: Alan Guttmacher Institute, 1995), p. 6. Donovan points out that even before the Hyde Amendment, some women in need of subsidized abortion services were unable to obtain them either because the states had policies prohibiting coverage or because the services were not available or accessible to them. The eligibility ceilings are set so low that Medicaid itself covers fewer than half of those who live in poverty.
10. As of April 1999, Medicaid in 17 states covered abortions for health reasons. Of the remaining 35 states, only one provided coverage in cases of reported rape, incest, or life endangerment or when a woman would suffer grave, long-lasting physical health damage due to a condition existing prior to the abortion. Two states limit coverage to cases of life endangerment, reported rape and incest or fetal anomaly; the rest cover only

cases of rape and incest and life endangerment.

11. Donovan (see note 9), p. 27. The cost of an abortion goes up approximately \$100 per week of pregnancy and varies according to the type of procedure and the type of facility. Abortions in hospitals are more costly. On the other hand, hospitals have federal money for free care that can sometimes be accessed for abortions. Medical abortion with mifepristone is expected to cost the same as surgical abortion (National Abortion Federation Fact Sheet).

12. S. Henshaw, "Factors Hindering Access to Abortion Services," *Family Planning Perspectives* 1995, 27(2): 54–59, 87.

13. *Abortion Delivery in the United States: What Do Current Trends and Non-Surgical Alternatives Mean for the Future?* (New York: Alan Guttmacher Institute, 1995).

14. A. Goldstein, "A Life at Risk, an Abortion Denied: Ailing Louisiana Woman at Center of a Debate over Access," *Washington Post*, 20 October 1998, sec. A.

15. The statistic on the number of ob-gyns in the U.S. comes from Rosenfield (see note 1), p. xv. The statistics on the frequency of abortion come from J. Edwards, P. Daney, and M. Paul, "Surgical Abortion in the First Trimester," in Paul et al. (see note 1), p. 107. A discussion of abortion methods is found in M. Potts, Foreword, in Paul et al. (see note 1), p. xi.

16. "Abortion Providers Decreased 14% Between 1992 and 1996," 11 December 1998, press release available from the Alan Guttmacher Institute at www.agi-usa.org.

17. Alan Guttmacher Institute (see note 16).

18. Only 12% of ob-gyn residency programs require training for first-trimester abortions, and only 7% require training for second-trimester abortions. Thirty percent of programs offer no training at all. See C. Westhoff, "Abortion Training in Residency Programs," *Journal of the American Medical Women's Association* 1994, 49(5): 159–62, 164.

19. Up-to-date statistics on clinic violence and harassment can be obtained from the National Abortion Federation (<http://www.prochoice.org>) and the Feminist Majority Foundation (<http://www.feminist.org>), which issues an annual Clinic Violence Survey Report.

20. "Abusive Comic Book Mailed to Canadian Doctors," *Pro-Choice Press*, Spring 1999 (available from the Pro-Choice Action Network at <http://www.prochoiceconnection.com/pro-can/99spring.html#comic>).

21. This section is taken from M. Fried with M. Paul, "Abortion," *Our Bodies, Ourselves for the New Century* (Boston: Boston Women's Health Collective, 1998), p. 402.

22. K. Kolbert, B. S. Jones, A. Miller, and R. L. Pangi, "Legal Issues Related to Abortion in the United States," in Paul et al. (see note 1), p. 237.

23. "Tell It to The Judge," *Reproductive Freedom News* 1999, 8(8).

24. D&E is a method in which the fetus is given an injection so that it dies in the womb. Fluid is then removed from the cranium of the fetus, as this is the only way to bring the head out without causing tears or bleeding in the woman's cervix, and the fetus is removed intact. This method is generally used only in the third trimester when the life of the

pregnant woman is at risk or in cases of serious fetal anomaly. It may also be used from 20 to 24 weeks of pregnancy if the doctor determines that it is the best procedure to use in the circumstances. As such, it is rare; the overwhelming majority of abortions are performed in the first trimester.

This procedure is also known as D&X. The anti-abortion movement calls the procedure "Partial Birth Abortion." This term, however, is political, not medical, coined in an attempt to portray the procedure as infanticide. Most courts in the U.S. have continued to rule that determinations of appropriate medical procedures may not be made by legislatures, but must be left to the physician attending a woman. See Kolbert (note 22), p. 234.

25. For example, Dorothy Roberts points out that African-American women are five times more likely to live in poverty, five times more likely to be on welfare, and three times more likely to be unemployed than are white women. See D. Roberts, "Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy," in R. Solinger (ed), *Abortion Wars: A Half Century of Struggle, 1950-2000* (Berkeley: University of California Press, 1998), p. 152.

26. Roberts (see note 25), p. 152; see also A. Davis, *Women, Race and Class* (New York: Random House, 1981), ch. 12.

27. K. Judd with S. Bittenweiser, "Welfare Reform Update" (ProChoice Resource Center, Inc., 1999).

28. Draft Block Grant Application Guidance, Abstinence Education Provision of the 1996 Welfare Law, found in Judd (see note 27), pp. 6-28.

29. Charles Murray described illegitimacy as "the single most important social problem of our time—more important than crime, drugs, poverty, illiteracy, welfare or homelessness because it drives everything else." See C. Murray, "The Coming White Underclass," *Wall Street Journal*, 29 October 1993. Although young African American women usually bear the brunt of the demonization in the furor surrounding illegitimacy, Murray's focus is on white teenagers. Some critics have argued that his real concern is the breakdown of white families and white male authority.

30. For a comprehensive discussion of compulsory and coercive sterilization in the U.S., see D. Roberts, *Killing the Black Body: Race, Reproduction and the Meaning of Liberty* (New York: Pantheon, 1997), ch. 2 and 3.

31. Roberts (see note 30), p. 93. Roberts points out that this rate equals that reached by the Nazis in the 1930s.

32. Roberts (see note 30), p. 90.

33. Roberts (see note 30), pp. 94-95.

34. Roberts (see note 25), p. 125.

35. S. Levitt and J. Donohue, "Legalized Abortion and Crime," JCPR Working Paper 104.0/1999-10-01. Although the results of this study were reported in the press, the study itself is only available from the Northwestern University/University of Chicago Joint Center for Poverty Research at <http://www.jcpr.org/wp/WPprofile.cfm?ID=104>.

36. K. Brandon, "The Abortion-Crime Rate Puzzle," *Chicago Tribune*, 8 August 1999.

37. C.R.A.C.K. outreach flyer.
38. For a full discussion and documentation of cases, see Roberts (note 30), ch. 4. Roberts cites attorney Lynn Paltrow, who has championed many of these cases in court and is a leading expert in this area.
39. T. Underberg, "Legislation Seeks to Control Pregnant Women," *ProChoice IDEA*, Winter 1998–1999, p. 17.
40. Roberts (see note 30), pp. 209–10, 228–29.
41. S. Mulay, "Quinacrine Sterilisation: Unethical Trials," *Economic and Political Weekly*, 26 April 1997.
42. M. Rao, "Quinacrine Sterilizations Banned," *Political Environments* 1998, 6: 7.
43. L. J. Sax, A. W. Astin, W. S. Korn, and K. M. Mahoney, *The American College Freshman: National Norms for Fall 1998* (Los Angeles: Higher Education Research Institute, University of California, Los Angeles, 1998).
44. In March 1997, the Pro-Choice Public Education project conducted a qualitative research project entitled "An Exploration of Young Women's Attitudes Toward Pro-Choice" to explore the attitudes of young women born after *Roe v. Wade*.
45. These polls were never published. The information cited here was released to the press by Choice USA.
46. Author's notes from National Abortion Federation Meeting, April 1999.
47. R. Bhatia and A. Hendrixson, "Update on the Quinacrine Controversy," *The Fight for Reproductive Freedom* 1999, 13(2): 7–8.
48. Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, 5–13 September 1994, UN Doc. A/CONF.171/13 (18 October 1994); Platform for Action of the Fourth World Conference on Women, September 1995, UN Doc. A/CONF.177/20 (October 17, 1995).