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Amy Granger  
*University of New Orleans*

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Reproductive Freedom in the United States and Louisiana:  
An Assessment of the Last Decade, a Review of the Current Climate,  
And a Scenario for the Future

A Thesis

Submitted to the Graduate Faculty of the  
University of New Orleans  
in partial fulfillment of the  
requirements for the degree of

Master of Arts  
in  
Sociology

Amy Granger  
B.A. Tulane University, 1997  
December, 2009

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## **Abstract**

Government began legislating abortion in the mid nineteenth century and has controlled access to this service for women ever since. With the creation of hospital boards after WWII, state control over access became further entrenched. Regulations and restrictions since *Roe v. Wade* limit the availability of abortion services for women served by Medicaid and other social assistance programs. The existence of a class bias around access can be seen throughout the topic's history and legislation has unfairly targeted and therefore disproportionately affects poor women. The data show that these restrictions have no impact on the number of unintended pregnancies over the last 20 plus years. Without the ability to personally fund the procedure, poor women do not enjoy the same choices as women in other social classes. In the next decade, we are likely to experience more of the same without having a realistic conversation about Medicaid funding of abortion.

## **Keywords**

Abortion, Abortion and early legislation, Abortion and public funding of, hospital abortion boards, Intersectionality Theory, Liberal Feminism, *Roe v. Wade*, therapeutic abortions, Title X

## Introduction

In 2008, the landmark Supreme Court decision *Roe v. Wade* 410 U.S. 113 (1973) turned thirty five years old. According to the *Roe* decision, most laws against abortion in the United States violated a constitutional right to privacy under the Due Process Clause of the Fourteenth Amendment (findlaw.com1, 1973). The decision overturned all state and federal laws outlawing or restricting abortion that were inconsistent with its holdings. The end result of this decision was that abortions would become legally permissible for any reason a woman chooses up until the first trimester and that state governments could only regulate, but not prohibit abortion up until the second trimester. While framed in “trimester” terms, this meant that abortion was legal up until the "point at which the fetus becomes ‘viable,’ (viability is usually placed after the first trimester, somewhere between twenty four and twenty eight weeks). The Court also held that abortion after viability must be made available when needed to protect a woman's health, which the Court defined broadly in the companion case of *Doe v. Bolton*. These now historic court rulings affected an entire country and gave rise to new laws in all fifty states.

Ten years ago, when the case was observing its silver anniversary, women across the country were witnessing efforts at the local and state levels to undermine the rights guaranteed to them by *Roe*. In some states, lawmakers were doing everything in their power to chip away at the Court’s ruling including, but not limited to, state level mandates such as waiting periods, parental notification or consent requirements, and requiring controversial counseling sessions. Importantly, the populations most affected by these legislative efforts were low income and minority women. The collective end result of these regulations is that inequality exists between low income women and women of means in terms of access to both family planning services and abortion. As access to these services became more restricted by the states, the end result was the ability of the states to exert their power over individual choice in the face of federal laws that legitimized this choice.

This study begins with an historical overview of the rise of abortion legislation in the United States from the 19<sup>th</sup> century to the Supreme Court’s *Roe v Wade* decision and highlights

how class and gender issues were integrally interwoven in this history. Then, major attention is focused on groundbreaking legal decisions affecting abortion access after *Roe v Wade* became the law. Using data on abortion access for both the United States as a whole and for the state of Louisiana, this study will document how access to the abortion rights granted under *Roe v Wade* have gradually been eroded. Here again the focus will be on unequal class access to abortion. While pro-choice activists and lobbyists in every state commit themselves to ensuring that the guarantees made available by *Roe* do not become a thing of the past, I shall argue that the last twenty years have brought about restrictions to access, a reduction in services for low income women, and an overall political climate that threatens to continue to erode the gains won in 1973. The purpose of this paper is not to take a moral stand for or against abortion; nor is it the intent to argue whether abortion should be legal or illegal. As long as abortion remains legal in this country, all women should have the same right to access a safe procedure. This thesis argues that current laws that are aimed at restricting abortion access and undermining the Supreme Court's decision in *Roe v. Wade* have an unfair impact on low income women.

Any elimination of gains already made creates the question: where will the next ten years take us? Does the possibility exist that rights and freedoms fought for and won by a previous generation will become simply a memory? After documenting unequal access using data from the U.S and Louisiana, the conclusion of this paper will demonstrate that as the number of laws that restrict access continue to grow, a potential tipping point emerges that would enable lawmakers to overturn *Roe v. Wade* without enduring a prolonged series of debates and discussions. As such, we face the very real possibility that the freedoms enjoyed under *Roe v Wade* will be eliminated in the not so distant future.

### **Liberal Feminism and Intersectionality Theory**

In terms of feminist theoretical perspectives, the landmark decision of *Roe v. Wade* reflects a Liberal Feminist perspective in terms of its focus on individual rights and freedoms. Liberal Feminism has its roots in Enlightenment thought and, like their Enlightenment

predecessors, Liberal Feminists tend to focus on the individual rather than the group and view individuals as the masters or mistresses of their own fate. Another hallmark of Liberal Feminism is its assumption that one can achieve equality by working for reform within the system. Indeed, their primary goal is to obtain formal equality or equal civil rights in front of the law. In the case of *Roe* this meant the right to privacy in terms of individual choice and control over one's body. This reform-oriented perspective has been the dominant U.S. feminist perspective from the 19<sup>th</sup> century up until the present day.

However, there are some significant differences between the Liberal Feminism of the 19<sup>th</sup> and early 20<sup>th</sup> centuries and Liberal Feminism today. Most U.S. liberal politics began to change with the Great Depression and the New Deal of President Franklin Roosevelt and were further transformed during the "Great Society's War on Poverty" under President Lyndon B. Johnson. The new 20<sup>th</sup> century Liberalism, often referred to as Welfare Liberalism, holds that the forces of government should be marshaled to improve the living conditions for the greatest possible number of Americans, with particular emphasis on the excluded, marginalized and/or disadvantaged. Unlike 19<sup>th</sup> century Liberals who feared too much government involvement in individuals' lives, Welfare Liberals were willing to expand government involvement and government regulation of the economy and social life. The new social movements of the post-World War II era, such as the Civil Rights Movement and the Women's Movement, furthered recognition of the need for legislation to protect racial/ethnic minorities and women. Consequently, during the second wave Liberal feminists began embracing protective legislation that was designed to make up for past injustices, such as support for affirmative action. They also developed more serious challenges to the organization of personal life and addressed reproductive rights issues, gender inequalities within marriage and interpersonal relationships, as well as women's roles as mothers and wives. For example, most Liberal Feminists of the 19<sup>th</sup> century did not support birth control or abortion rights; rather they embraced what they called "voluntary motherhood" or the right to abstain from having sex with their husbands. By the second wave of the modern women's movement, most Liberal Feminists supported both birth control and a pro-choice position on abortion (Mann, forthcoming).

As noted above, the privacy rights and rights to individual choice under *Roe* were stated as formally equal rights. There is nothing in *Roe* that acknowledges the possibilities of substantive inequalities in access to abortion. This focus on formal equality ignores the impact of ascribed statuses on individuals' life chances. Ascribed statuses are positions acquired at birth such as one's race, gender and/or the social class into which one is born. While ascribed statuses are accidents of birth, they affect groups rather than simply individuals because they result in groups beginning at different locations on the playing field of life. For example, ascribed statuses affect such basic resources as whether one's parents are literate or whether they have sufficient income to provide for a child's health, education and welfare. They also have been used to exclude people from certain occupations or positions in society - as in the cases where race and gender historically precluded people from attending universities or holding high government offices. Ascribed statuses entail even more subtle differences, such as the presence or absence of social networks that can enhance upward mobility. Thus not all children start at the same place, when bodily inscriptions such as race and sex or social privileges such as inheritance can play a major role in life chances. This is why children born into wealthy families are often said to be born on third base and require fewer individual achievements to hit a home run in life. In short, ascribed statuses reflect persistent and systemic *social structural inequalities*.

As contrasted to Liberal Feminism, Intersectionality theory highlights the role of ascribed statuses by centering its theoretical assumptions on unequal social locations. Central to Intersectional analyses is the idea that structural inequalities, such as those based on race, class and gender, cannot be torn apart from the interactive impact on people's lives. Rather, Intersectionality theorists stress the interlocking and simultaneous nature of such inequalities or oppressions. Indeed, they argued that understanding the interwoven nature of these multiple oppressions requires a "radical break" with conventional ways of theoretically and methodologically understanding oppression as Intersectionality theorist Rose Brewer put it (1999).

Intersectionality theorists introduced a number of new concepts to explain their analysis of simultaneous and multiple oppressions. One of the more powerful concepts that provides almost a visual imagery of intersectional analyses is the concept of a matrix of domination. This

concept was developed by Patricia Hill Collins in her award winning book, *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (1990). Collins discusses how, within this matrix, people have a social location and an identity in terms of such important structural forms of oppression as race, ethnicity, social class, gender, and/or sexual orientation. Moreover, people could have social locations of both penalty and privilege, such as wealthy, Black males who have privilege by their class and gender positions, but who are penalized by their racial location. It is in this sense that Collins describes how people can occupy positions of simultaneously being both oppressed and oppressors.

Collins uses her concept of a matrix of domination to help explain the social constructionist view of knowledge that underlies Intersectionality theory. She argues that people not only create or construct knowledge, but also they do so from situated positions within different social locations, such as different race, gender and class locations. These diverse social locations shape and influence how people view the world. On the one hand, a specific location potentially enables people to see realities that are less visible to those in other locations. On the other hand, because no one can view the world from all of the various and diverse social locations each vantage point or perspective is partial or limited. Because all vantage points are partial, Collins suggests that a more developed understanding of the world can be generated by pivoting from the interpretations and knowledge of one group to those of another group (1990: 234). Thus, social knowledge is constructed in a quilt-like fashion where the social realities of diverse vantage points are interwoven to form a more complete fabric of the whole.

Angela Davis' work on reproductive issues illustrates well how women in diverse social locations may view reproductive rights issues differently. For example, in the 1970s when reproductive freedom had become one of the defining and rallying points of U.S. feminism, Davis argued that any campaign that spoke on behalf of *all* women was likely to be premised on a disregard for differences between women by race and social class. In her book *Women, Race, and Class* (1981), Davis analyzes what white U.S. feminists saw as an apparent lack of enthusiasm among women of color for abortion and reproductive rights legislation. She not only linked this to the history of U.S. slavery that negated Black slaves' rights to keep their own children, but also to 20<sup>th</sup> century U.S. practices of forced sterilization that disproportionately

impacted U.S. women of color (Davis, 1981/2003: 363-364). Rather than the freedom to have reproductive rights, the issue for these women was the freedom not to have contraception forced upon them. Later in this thesis, I will highlight how this problem of sterilization abuse was integrally connected to certain abortion issues.

However, at this point, suffice it to say that all of these critical insights will be taken into account in this thesis. On the one hand, a major goal of this thesis is to document how women in the U.S. today do not have equal access to abortion. That is, they do not have equal access to the rights ostensibly attained in the *Roe v. Wade* decision because of certain structural inequalities. On the other hand, I will discuss how women in different social locations respond to reproductive right issues differently. For example, I shall examine how poor women are more likely to choose to have babies outside of wedlock for a variety of reasons that have to do with their specific social location. Indeed, although race has played a major role historically in women of color having reproductive choices forced upon them, I shall argue that today, class issues play a more significant role in reproductive choices and access. By foregrounding social class, I am not arguing that it can ever stand alone or apart from racial and gender issues in people's lives. I am simply arguing that social class needs to be better highlighted and addressed in relation to abortion access today.

### **The Rise of Abortion Legislation**

In 1973, the U.S. Supreme Court ruled on the *Roe v. Wade* decision that ended over a century of illegal abortion in this country. Although this decision was truly a landmark piece of legislation, it did not mean that abortion was not practiced in this country earlier. Rather, there is overwhelming evidence to suggest that throughout much of the 1800s abortion was practiced in the United States. Indeed, prior to the 1820s, no abortion legislation existed in this country (Mohr, 1978). So when and how did abortion in the United States become criminalized? Below, a brief overview of abortion practices and the rise of anti-abortion laws in the 19<sup>th</sup> century will help to ground this thesis' analyses within a historical framework. This historical grounding will

demonstrate that class bias in abortion legislation is not a new phenomenon, but has been part and parcel of the history of abortion and control over female reproduction in the United States.

Before we discuss anti-abortion legislation, we must first consider the state of medical knowledge at the time. The first major factor is the concept of “quickening”. In the absence of tests to confirm either paternity or a pregnancy, women in the 1700s and 1800s relied on fetal movement; quite simply, a woman was considered pregnant as soon as she could feel the fetus kick, or “quicken”. Prior to quickening, there was no reliable or accepted way to determine that a woman was actually pregnant and not suffering from some other health issue. Therefore, state legislation that was passed after the 1820s focused heavily on the concept of quickening. Abortion after quickening would eventually be made a crime, but legislatures remained silent on all activities prior to quickening because without a confirmed pregnancy, there could not be a possible crime (Mohr, 1978: 16).

The second factor to consider is the general public’s perception of women who sought abortions. Indeed, it was commonly believed that the only women who would seek out abortions would be young, unmarried, and lower class. Furthermore, their pregnancy was often believed to be the result of seduction by an older, more powerful man (the man’s behavior would be publicly condemned if discovered). In these cases, the woman was seen as a victim of seduction and as someone whose predicament warranted assistance and sympathy. It was assumed that neither middle- or upper-class women nor married women would either want or need services to terminate an unwanted pregnancy. However, as James Mohr observes in his study, Abortion in America: the Origins and Evolution of National Policy (1978), this set of assumptions was incorrect. Women across class lines were using various means to prevent or to end pregnancies - from potions to various homegrown methods of extraction - so as to limit the size of their families. Under the guise of “removing a blockage”, literature was widely available detailing all types of methods and theories to bring about a “missed menstrual cycle” (at the time, the missed menstrual cycle was the popular euphemism for a suspected pregnancy). The sheer number of publications and providers advertising their services, as well as the declining birth rate of middle-class women, suggest that abortion must have been widespread during the middle of the nineteenth century.

The third and final factor to consider is the overall state of the medical profession precisely because it was medical physicians who initially led the campaigns to criminalize abortion (Mohr, 1978). Physicians in the 19<sup>th</sup> century tended to be middle- or upper-class men. On the one hand, they were from more well-to-do classes because only these classes could afford to attend colleges. On the other hand, they tended to be men, because women were excluded from most medical schools in the 19<sup>th</sup> century. While physicians enjoyed a somewhat privileged social status in the 1800s, the training they received was often flawed in theory and in practice. Indeed, in terms of outcomes for the well-being of patients, physician's practices fared no better than the practices used by lay practitioners (Mohr, 1978). Indeed, throughout much of the 19<sup>th</sup> century there were many lay people practicing medicine. For example, barbers (given their sharp instruments) often served as surgeons and the red and white stripes that today signify a barber's shop represented the blood and bandages which in that era symbolized medical care. Moreover, lay practitioners who were involved in childbirth and other gynecological/reproductive issues were often women - as the term "midwives" implies (Mohr, 1978: 31). In short, because of Victorian sexual mores, most women regardless of their class position preferred to be served by midwives (other women) for their reproductive concerns.

In his history of abortion in America, Mohr explains physicians' key role in leading the movement to make abortion illegal as part of a larger campaign to drive lay practitioners out of the field of medicine. By making abortion illegal, physicians could undermine the role of midwives in at least that aspect of reproductive care. Thus, for Mohr, the crusade to make abortion illegal was both a class and gendered crusade for power and influence in the field of medicine. To buttress his argument, Mohr notes that, after the Civil War, when the status of physicians was more secure, these men of medicine showed little interest in the campaign against abortion. In turn, the discovery of the "germ theory" of disease in the late 1800s also greatly enhanced the success of medical knowledge. However, by that time the movement to make abortion illegal was already underway. Moreover, it drew mass support by fueling the flames of racism, classism and xenophobia. In particular, this campaign was directed toward addressing the falling birth rate of middle-class women. At a time when immigration was rapidly increasing into the U.S. and the fertility rates of working-class and poor women were higher, there was great fear

among the middle- and upper-classes that they would be outnumbered over time by lower classes people and especially people of color and ethnicity (Mann, 1986). Thus, in many ways, the crusade to make abortion illegal was linked to important gender and class issues and to the goal of increasing middle-class women's birth rates.

Hence, although state law makers initially had little interest in making abortion a criminal offense, the topic was brought front and center by physicians and by 1850 nearly every state and territory had some form of a law on the books. However, these laws were often ambiguous and almost always included the concept of quickening in their wording. Women who suspected a pregnancy, but who had not yet confirmed quickening, continued to seek the services of an abortion provider in increasing numbers. In addition, it was rare that a man or woman suspected of providing abortion services would be prosecuted; and if a prosecution was pursued, it historically always concluded without a conviction (Mohr, 1978: 41).

Depending on the state, laws referencing abortion entered the criminal code between 1821 and 1841 (Mohr, 1978: 25). Connecticut was the first state to enact such a law, but the statute specifically indicated that the woman must be "quick with child" and therefore ignored any activity to end a suspected pregnancy before the fourth or fifth month. In 1840, a revision to a Maine statute removed any reference to quickening, thus creating a more general criminal code that made it an offense to terminate a pregnancy, period. However, because pregnancy could not be confirmed without quickening, the revision was more a reflection of the general population's awareness of the prevalence of abortion throughout the country as opposed to an effort to increase prosecution. People's suspicions about the widespread use of abortion as a means of ending an unwanted pregnancy increased as a result of awareness campaigns by physicians. The physicians' campaigns also changed the general public's perception about which women would seek an abortion. As noted above, earlier it had been believed that only unmarried, low income women would seek an abortion as well as women who were the victims of a seduction. Later in the 19<sup>th</sup> century, armed with the knowledge that married, middle-class women were also seeking abortions, the public began to put more pressure on their legislatures to curb the practice. Furthermore, as states increased the number of abortion laws on the books, they did so with the general understanding that the laws were there to protect women, as women continued to be seen

as victims and their health needed to be protected. It was not until much later when women began to be viewed as contributing to the illegal activity that patients were given the same consideration in criminal codes as those performing the abortion. But laws without the capacity to prosecute behind them were rendered essentially meaningless and abortion rates continued to climb throughout the middle part of the century until 1880, with most researchers agreeing that a full 20% of pregnancies ended in abortion (Mohr, 1978:82).

The first wave of U.S. feminism also had increased its mass support by this time. However, unlike today, most feminists of this era did not support abortion and birth control. Rather, the vast majority of feminists supported what they called “voluntary motherhood” or the right to say no or abstain from sex with their husbands (Mann, 1986). Only more radical Anarchist and Socialist feminists in the 19<sup>th</sup> and early 20<sup>th</sup> century, such as Emma Goldman and Margaret Sanger, openly supported both birth control and abortion, but they were in the minority. Indeed, Sanger, who later became known as the “mother of planned parenthood” was arrested for opening a birth control clinic and for distributing birth control information by mail. Thus, even first wave feminism did not provide significant ammunition against the movement to criminalize abortion. As early as 1880 most states had either created or edited existing statutes that made abortion a crime during any point in gestation (Mohr, 1978: 200). These laws would remain essentially unchanged for almost the next one hundred years.

In summary, this brief overview of the early history of abortion legislation in the United States has demonstrated two major points relevant to the remainder of this discussion. First, the desire to control one’s fertility or family size is not reserved for a certain class or race of women. Interest in managing personal health, the ability to care and provide for children, and an understanding of what an unwanted pregnancy would entail were issues that affected women of all classes. Second, the rise of anti-abortion legislation was clearly a class-based and gendered struggle. The push to outlaw abortion came from well-to-do, male physicians who were trying to protect their professional status, push women out of the medical field, and secure the need for their own services. By basically eliminating competition from lay practitioners, nineteenth century certified physicians ensured financial stability for themselves and eliminated certain reproductive rights and common practices for every woman.

## Laying the Groundwork

A writer could dedicate volumes to adequately covering abortion practices and politics in the first half of the twentieth century that culminated with the *Roe v. Wade* decision. And while the argument of this paper is primarily concerned with contemporary legal decisions, it is not the intent to imply that recent events are the only ones of importance. As we saw in the 1800s, there always have been many powers at play in the debate surrounding abortion: legislatures, religious leaders, physicians, educators, and activists. It is considered general knowledge among those familiar with the topic that abortions continued to be available and widely utilized to control family size even during the decades when the procedure was illegal. There are a number of theories as to why activists took up the cause to legalize abortion, but none demonstrate how critical the situation was for women facing an unwanted pregnancy as succinctly as the statistics. Prior to 1973 and the *Roe v. Wade* decision, statistics measuring the rate of illegally obtained abortions in the U.S. were staggering. Some experts estimated that by 1950, over one million abortions were performed annually, with nine out of ten pregnancies to unmarried women ending in abortion in the years leading up to the famous court case (Solinger, 1998: xi). The two decades leading up to the *Roe* decision were transformational to the cause of abortion rights and give insight into the roots of the struggle that continued after *Roe*.

In the nineteenth century, we saw that policies against abortion tended to focus on providers as the best way to stop the practice. In those instances where an actual prosecution took place (in the latter half of the century), practitioners would receive jail time; while the woman, often seen as a victim of the practitioner, was more likely to receive the mercy of the courts. Throughout the first half of the twentieth century, while abortion remained illegal, it is believed that the practice was widespread - a sort of “don’t ask, don’t tell” policy permeated the legal environment. However, there was a dramatic shift following the Second World War. One of the main differences is that in the post-World War II era we see a significant increase in the attempt to prosecute and jail individuals, both those providing as well as those receiving abortion services. The days of providers operating under the legal radar came to a swift close.

In her book, *Pregnancy and Power* (1998), Solinger argues that one reason a crackdown on providers increased was related to an overall change in how society defined the role of a women. During World War II, women entered the paid workforce in unprecedented numbers, but many were then displaced following the return of the soldiers. It was therefore prescribed that a woman's proper place was in the home with children *and* her husband; providing abortion went from a routine, albeit secret, occurrence to a crime worthy of front page news. And, according to Solinger, as this transformation occurred, men were once again provided an opportunity to assert their control over women and their reproduction in the form of the police and court system. As a side note, one particularly interesting detail here is that the literature does not present any sort of class bias in terms of prosecution. On the contrary, it appears women were equally prosecuted for their "crimes" regardless of social status, their lives published in daily papers so that they were also on display in the court of public opinion. The practice of creating legal roadblocks that disproportionately affect the poor may be more of a late modern invention (as we shall see in later sections), but class differences in access to abortion have always existed.

As in the 19th century, the medical community played a significant role in the debate that took place in the 1950s and 1960s via the recently created concepts of therapeutic abortions and the hospital abortion board. The therapeutic abortion was designed on the surface for situations where the mother's life was in danger and the service was provided by a licensed physician within a hospital. However, many women came to rely on the therapeutic abortion as the only legal way of securing the procedure (Solinger, 1998: 362). Because hospitals and their ethics boards were in control of who received the procedure, this type of abortion became, simply put, an inoffensive label for an often demeaning and difficult process. And because abortion was illegal at this time except in cases where the woman's life was at risk, it was the purpose of the experts on the board to determine whether a woman's life might be threatened and, if so, whether she could have an abortion. Thus, the boards were given final control over every woman seeking a hospital abortion. Moreover, because the process was stressful and often drawn out over weeks, women had to remain steadfast in their commitment. Additionally, many of these women would have occupied a higher social class because both financial stability (i.e. being a homemaker or in a position to take time away from their job) as well as appropriate connections

would have helped to ensure access to a therapeutic abortion. Several women in Solinger's sample reported studying psychiatric text books in order to make their case believable (Solinger, 1998: p. 363). In approximately half of those cases where the applicant was granted the abortion, the boards went a step further (often with lower income patients) and made sterilization an additional requirement of this procedure (Solinger, 1988). While today this act might raise every civil liberty flag imaginable, the fact of the matter is that this did happen and happened routinely. Not only had physicians given themselves the right to determine whether a woman with an unwanted pregnancy had a child at that moment, they also determined whether she was deemed worthy of ever having children again.

While physicians may have acted alongside women prior to WWII by providing services or at least referring a woman to someone who would, the post-War medical community appears to have taken the outward stance that abortions simply were no longer necessary (Solinger, 1998: 363). The underlying cause of abortion, unintended pregnancy, remained a major - if often unspoken - issue in the 1950s and 1960s. A Princeton University study estimated that in the 1960s, 62% of American women experienced at least one unintended pregnancy (Gold, 2003: 8). And while women across social classes experienced unintended pregnancies, it was during the rise of the therapeutic abortion that we can clearly see a class divide develop between women with means and those in need in terms of their options. According to Gold, middle- and upper-class women had limited access to legal abortion (a procedure which, we must remember was reserved for cases where the woman's life was in danger). In fact, women with means were granted therapeutic abortions much more frequently than their low income and working class counterparts. One study which reviewed 2,775 therapeutic abortions conducted between 1951 and 1962 found that 88% were to patients of private physicians meaning these women had the funds to not only pay for the procedure, but for the review process required to obtain the procedure as well (Gold, 2003:10). Then in 1967, England legalized abortion in cases where two physicians provided written consent. Before long, enterprising outlets were offering round trip packages including airfare, accommodations, vaccinations, etc. to well to do women<sup>1</sup> (Gold, 2003: 10). However, low income women were not in a financial position to take advantage of these new developments.

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<sup>1</sup> In the last three months of 1969, more than 600 American women made the cross Atlantic trip

Without access to hospital boards and the services they granted, low income women took the matter of an unintended pregnancy into their own hands, sometimes literally. A study in New York in the 1960s determined that one in ten women had received an illegal abortion and four in ten women had sought out the service. Additionally, a startling eight in ten respondents who had an abortion indicated that they had attempted a self-induced procedure while only two percent of the women surveyed reported that a physician was involved (Gold, 2003: 8). Hospital statistics during this time paint a similar picture. In 1962 at Harlem Hospital in New York, a facility for indigent patients, there was one hospital admission for abortion- related complications for every 42 deliveries. The situation in Los Angeles in 1968 was even more grave; there was one abortion-related admission for every 14 deliveries (Gold, 2003). These data demonstrate that low income women were in fact doing everything within their means to terminate unwanted pregnancies in the years leading up to the *Roe* decision. Although they did not have the same options available as their middle class counterparts, they were determined to control their reproduction.

In addition to effectively dismissing a woman's opinion on whether she felt confident in her ability to care for a child at that moment or at any time in the future, the medical community shifted its view of the overall role of the woman in pregnancy. Thanks to advances in imaging technology after 1950, fetuses were no longer an unknown; instead, a fetus could be pictured as the smallest of humans. The fetus then essentially began vying for dominance over the woman in terms of whose position was seen as more essential to consider. Solinger quotes physicians as referring to women as incubators for a fetus (1998: 21). Here, we begin to see where the underlying premise that a woman can be valued more for her ability to reproduce than what she may be able to contribute to her community outside of motherhood may have originated. Indeed, the notion that woman's "natural" place was in the home experienced a resurgence of popularity in the post World War II era as the state and other institutions of mass culture promoted this traditional idea of gender roles (PPFA4, 1997), even as illegal abortion rates surged.

This ideology continues to influence the abortion debate today by permeating the moral debate: what value do women bring to society as a whole? What do women offer beyond their

ability to add more people to that society? While in practice the landscape around the abortion debate changed dramatically between 1850 and 1950 in terms of the role of practitioners and the accessibility of abortion for women, in reality not much changed with regard to a woman's desire to control her reproductive health. Women continued to seek out abortion services no matter how difficult to obtain. Their determination to control their bodies was formidable.

### **Abortion Access in the Post-Roe Era**

While *Roe v. Wade* brought abortion back to the list of legal procedures, the bounty of restrictions that were soon to be placed on low income women provides reasonable evidence that the struggle to regain control of the female body continues to be relevant. Indeed, by the 1980s, the relationships at play within the political arena, which included a coalition of politically conservative, religiously conservative, and fiscally conservative Republicans, managed to skew the debate in such a way that popular opinion was all but ignored. While every Gallup poll since 1990 has indicated that no less than 53% of those polled believe in a woman's right to choose and all poll results since 2003 have returned support for abortion from the majority of respondents, crucial services continue to be denied in favor of those able to advance their political agendas (Teixeira, 2007). Since *Roe*, the courts' decisions in a number of relevant cases that influenced or directly impacted abortion rights in this country support the claim that a significant impediment to reproductive freedom exists for all women (though most notably for those in lower income levels). Specifically, legislation that limited choice during the last twenty years was primarily targeted at the poor and these restrictions on choice created major negative consequences for low income women around the country including the women of Louisiana.

Historically, it has been the federal Supreme Court that had the final say and, therefore, ultimately regulated abortion for the states. The Court's impact began with a critical component of the *Roe v. Wade* decision, which introduced the connection between trimesters and which services would be allowed under the law based on trimesters. While this decision signaled a departure from previous legislation prior to *Roe*, which was primarily concerned with the

concept of viability, the trimester format has essentially achieved the same result in that it determines when the government can step in and regulate a woman's choice. A woman's right to choose is only guaranteed through the first trimester after which state government regulations dictate a woman's remaining options (or lack thereof since abortion can be regulated in the second trimester and prohibited in the third). Since *Roe*, the Court has sifted through myriad state and local laws which were designed to use constitutionally sound measures (i.e. ones that could not be challenged as opposing rights set forth in the Constitution) to keep a woman from exercising her right to choose. The "liberal tendencies" of the Court in the 1970s were adjusted to the right of the political spectrum during the Reagan-Bush Sr. years with the addition of more conservative justices. The following is a brief chronological synopsis of cases of note in the 1970s and 1980s<sup>2</sup>:

- In 1977, just four years after *Roe*, the Hyde Amendment was established forbidding the use of federal funds for abortion except in cases of rape, incest, or life endangerment and set the precedent for government spending at both the federal and state levels. The amendment gave rise to numerous state laws dictating how public funds could be spent and continues to be in effect today. It is voted on annually as part of the budget for the Health and Human Resources division and has been re-enacted every year. As of 2008, only four states voluntarily cover abortions under Medicaid: Hawaii, Maryland, New York, and Washington (AGI5, 2008). The Hyde Amendment will be discussed in detail in a later section.

- Also in 1977, *Maher v. Roe* challenged a Connecticut law related to the Hyde Amendment which limited state Medicaid funding to "medically necessary" abortions as well as the state's refusal to fund "elective" procedures. The Court ruled that the Connecticut law was constitutional; the state need not fund a woman's exercise of her right to choose even though it pays the costs associated with childbirth. Numerous future decisions would rely on this interpretation of the role of the state, effectively strengthening the barriers to abortion confronting low income women.

- *Harris v. McRae*: in 1980, the Supreme Court upheld the Hyde Amendment, which restricts federal funding of abortion, ruling that there is no "constitutional right" for women to

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<sup>2</sup> All court cases and descriptions obtained from PPFA1, 2000

receive an abortion covered by a federal health plan like Medicaid (please see further discussion about the Amendment's impact later in this thesis).

- *Williams v. Zbaraz* in 1986. The practice of restricting state funds not only for abortions, but also for abortion counseling and referral, was found to be unconstitutional. This small victory for pro-choice advocates would soon be reversed.
- In *Webster v. Reproductive Health Services*, the Court reviewed a Missouri law that forbade the use of state funds, public employees, and public facilities for abortions that were not deemed necessary to save a woman's life. The law also requires the use of an ultrasound to determine viability and fetal development, which adds an expense (and a financial burden for low income women). And the Court concurred in 1989 that the state may implement a policy favoring childbirth over abortion (in this case, by the state refusing to use public resources). This decision was a major blow to the pro-choice movement as it allowed the states to legislate in an area that was previously thought to be protected under *Roe v. Wade*.

During the 1980s, the Republican Party managed to pass numerous state-level laws that were also subsequently upheld by the Supreme Court and effectively created a number of obstacles for women seeking an abortion. Women who were financially stable and who had been sufficiently educated by other women and midwives about the path of least resistance around these legal road blocks were not substantially affected. On the other hand, the Republican Party was successful in all but terminating the rights of the nation's poor women in relation to abortion. Tanya Melich, a Republican Party insider for more than twenty years, analyzed the relationship between the GOP and abortion issues in her book, *The Republican War Against Women* (1998). She contended that the root of the Republican's long-standing opposition to abortion stemmed from the belief that women, by occupation, should be mothers and legally, federally-supported abortion prevents women from taking their rightful place within the home. Undoubtedly, very few of the key GOP players during the Reagan and Bush years would admit to this openly misogynist stance. However, government policies enacted under these two Presidents created a class-based, double standard for access that is still evident. Many Republicans also opposed abortion for moral reasons, perhaps in part as an effort to appeal to the emotional and/or religious sides of their constituencies. One of the Reagan administration's most influential successes was to align within the party the members that opposed abortion because of

their view about the role of women within the larger society and those that opposed abortion on moral and religious grounds. As Republican power increased in the 1980s, they did not set their sights on necessarily overturning *Roe v. Wade* (a task that likely would have met with defeat). Rather, instead they focused on the destruction of funding for family planning programs along with any federal connection to abortion which could have possibly could have been viewed as “pro-choice”.

Melich contended that the debate over the public funding of abortion illustrates the misogynistic strategy of the Republican philosophy. Aligning themselves with the beliefs of the New Right movement that abortion is morally wrong, the Republicans also appealed to fiscal conservatives by arguing that providing Medicaid funding for procedures is too expensive for the taxpayers (even though studies showed that the costs associated with prenatal care and childbirth far outweigh the costs of getting an abortion) (Melich, 1998: 151). In order to gain the support of moderate Party members, a compromise was offered that essentially said that while having an abortion was acceptable, it was not the responsibility of the taxpayers to cover the expense. One critical argument made by Melich is the belief that the response of the Republican Party over abortion rights further developed and entrenched the double standard of government policy, one that favors the rich over the poor and singles out women as targets. Leaving little room for alternative interpretations, the statistics presented thus far point to exactly this type of “double standard”. The Republican attack has not always been concentrated just on poor women; their attention also focused on the rights granted to minors, as part of their family values campaign. Supporters of mandatory consent laws argued that abortion infringes on the rights of parents by denying their obligation to guide their minor children (Melich, 1998: 275). Without due cause and seemingly in the absence of a clear, logical understanding of contemporary social behaviors, the Republicans moved ahead with their plan to undermine *Roe v. Wade*, without the formality of a court case. Quoting Sarah Weddington, who argued *Roe v. Wade* in 1970, she characterizes the Republican attack and the subsequent rulings of the Supreme Court (including, specifically, mandatory waiting periods) that favored their conservative rhetoric, slowly chipping away at the 1973 decision, as “patronizing” to women. She summarizes their effect by saying:

“It’s still her decision, but...the legislature can erect hurdles and roadblocks so that only women who are the most determined, who have the most money, who are the most sophisticated make it through...” (Wording quoted in Melich, 1998: 301).

It is important to ask how it became the acceptable norm to allow the state to manage private behavior and personal decisions amidst arguments by those same Republicans that it is not the obligation of the state to regulate society. Perhaps the question should be whether the government was convinced that effective regulation could occur in the absence of written laws concerning morality; are elected officials willing to allow individual choice if those choices would be in opposition to their own personally held beliefs or the beliefs of the most vocal members of their political party? Clearly, in the case presented thus far, the answer would be no. Following the *Roe* decision, public opinion polls consistently found that the majority of Americans favored legalized abortion, including a small majority of Republican delegates at the 1980 GOP Convention, as well as an overwhelming majority of voters polled in New York state in 1990 (Melich, 1998: 273). Yet, in spite of these statistics, both federal and particularly state legislatures enacted policies that essentially ignored the staggering number of unintended pregnancies that were occurring every year in this country. Furthermore, taking into consideration the welfare changes of the 1990s that restricted benefits and openly discouraged women from having a child while on public assistance but did nothing to advance pregnancy prevention, the policies were simply illogical when considered from a financial perspective. It would seem more logical that administrators of public assistance programs would support low income women who recognized that they were not in a position to provide for a child by advocating for programs (whether focused on prevention or abortion) that allowed these women to adequately address family planning needs and unwanted pregnancies.

One way in which societies and their members organize is around a set of norms and practices that are determined to be acceptable by the dominant group. The concept of “dominant” is critical to this discussion because, as we have seen, dominant does not necessarily equate to the majority opinion in a case where the acceptance of a practice is overridden by the heads of federal and state governments along with their ruling coalitions. In the case of abortion, while terminating a pregnancy for personal reasons may be a practice that was socially accepted

by the majority of members, its occurrence was not deemed acceptable by many lawmakers. Standing in opposition to “non-medical” abortions, these lawmakers used their power as a means of curtailing the number of procedures performed each year. The Supreme Court acted as a method of “checks and balance” to the states’ power. The Court further represented the interests of the states by repeatedly rendering decisions that ultimately reflected many conservative states’ biases against family planning and abortion. It becomes apparent why, after more than twenty five years, abortion continues to be one of the most divisive elements of American political and social life. A decade ago and still today, it is not a topic that is spoken about without political rancor. The question lingers without an answer: what recommendations could be made at the legislative level in order to merge public opinion and public policy?

This last question forces the discussion to move away from a middle-class vantage point and look at these issues from the vantage points of poor women. The proposition that the state can target low income women in its efforts to regulate reproduction can be illustrated by statistical data and a summary of conservative legislative actions that were upheld by court rulings. However, what has not been considered are the social norms and values that prevailed in poor communities at the time of this data, how these norms differed from those experienced in middle and upper-class populations and how powerful macro-level forces can effect the decisions made at the individual level. One school of thought is that, in the absence of middle and upper-class reasons for delaying motherhood such as completing educations and obtaining job skills, low income women often gain status within their communities, as well as acceptance among their peers, by having a child. In fact, instead of status defined by income or education, poor women found their place as contributing, valuable members of their community through child bearing.

In, Promises I Can Keep: Why Poor Women Put Motherhood Before Marriage (2005), researchers Kathryn Edin and Maria Kefalas compiled five years of interviews conducted with young mothers in an urban, Philadelphia neighborhood. In many cases, their findings suggest that unplanned pregnancy became, for the mother, an opportunity to turn their life around and begin making better life choices “for the sake of the baby” (Edin and Kefalas, 2005: 53). These women may have realized that they or their partners were on an unsuccessful path in terms of

financial and social stability and they believed that an unintended pregnancy offered a chance to correct that path. And while this arguably youthful and overly rosy outlook ignores the harsh realities of parenthood, including both the potential financial and emotional related stress, it would be unfair to simply dismiss it. This study also highlighted how class position rather than race or ethnicity was the major factor that influenced these decisions. Edin and Kefalas interviewed poor women of color and ethnicity, as well as poor white women and found their decisions to be mothers similar. Indeed, similar to the work on poverty done by William Julius Wilson in the late 1980s and early 1990s, Edin and Kefalas found the absence of financially stable, eligible mates as one of the more important factors in these decisions. From this perspective, one possible critique of expanding Medicaid coverage to include elective abortion would be that, even with this option open to poor women, a significant number may opt to continue their pregnancy to term, despite the financial burdens that will follow. Nevertheless, even if not all poor women would choose abortion, data suggests that more poor women would prefer choice. For example, one study out of the Alan Guttmacher Institute in 1998 estimated that between 20% to 35% of poor women would have had an abortion if the procedure was an option open to them under Medicaid.

To be clear, the intent here is not to gloss over the topic of poor women choosing motherhood over abortion as if it holds no importance. In reality, why low income women choose to have children is a separate discussion. The point emphasized in this thesis is that choice is the key goal and unless all women have this choice, there still exists a class bias in access to abortion whether or not individual women choose to use this option. In other words, what good is a discussion on why low income women choose to enter into motherhood if in reality there are no other options at their disposal? At the very least, the first step in reproductive freedom without class bias is access to family planning and abortion services for all women without restrictions based on the ability to pay. And, while the reasons why poor women may choose otherwise is important and deserving of its own research and findings, the major argument of this section of the thesis is that restricting a woman's ability to control her reproduction due to her income or ability to pay is inherently biased and prejudicial. The right to privacy, which includes the female body, is a right that should be extended to all women without exception and without consideration for politics. If abortion is an option that for various reasons

does not appeal to all women, it is still possible to argue that all women have a stake in ensuring that every woman is free to make her own decisions and, ultimately, to control the choices that will impact her future.

### **The Courts' Impact Continues**

In 1991 and 1992<sup>3</sup>, the Court handed down two definitive rulings concerning the use of public funds and the ability of the states to encourage childbirth over abortion, two ideas that would later find themselves in sharp contrast to the welfare reforms pushed through under the Clinton administration. In the late 1980s, the Title X<sup>4</sup> educational agenda included a strong directive to focus on abstinence only education at the expense of information about contraception and various methods of pregnancy prevention. This agenda also had a direct impact on the family planning and abortion information that could be provided in clinics funded by Title X. *Rust v. Sullivan* was a challenge to a 1988 regulation that prohibited the provision of information about abortion in family planning clinics with Title X funding. Instead, the law called for a compulsory referral for maternity care for a woman with an unintended pregnancy and the routine practice of “options counseling” (providing information pertaining to maternity services as well as abortion services) was eliminated. By upholding these regulations, the Court effectively reversed eighteen years of policies that allowed options counseling and abortion referral under the Title X program. This thesis will further discuss Title X and other public funding factors in a subsequent section.

The Court also upheld Pennsylvania’s Abortion Control Act in 1992 under *Planned Parenthood v. Casey*. While the decision reaffirmed the validity of a woman’s right to choose, it revoked the longstanding definition of that right as fundamental. The removal of the concept of fundamental is important as there continues to be the potential for this definition to enter into the federal debate. By removing the fundamental nature of the right to choose, one could argue that

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<sup>3</sup> All court cases and descriptions obtained from PPFA1, 2000

<sup>4</sup> The federal government’s Title X program provides public funding for family planning and preventive health screening services.

it is not guaranteed by the Constitution and is therefore not under the jurisdiction of the Federal government.

A Louisiana legislative decision in 2006 brought about the culmination of years of state policies whose main purpose was to eradicate a woman's legal right to choose. In the absence of a blanket restriction on all abortions in Louisiana, the legislature took the next closest step available to them. In June, 2006, SB 33 passed the Senate unopposed. The act, which criminalizes abortion except in cases where the woman's life is in danger, would automatically go into effect in the event that *Roe v. Wade* is ever overturned. Responding to news of the ban, Planned Parenthood Federation of America President, Cecile Richards, was quoted as saying, "This law puts extremist ideology above the health and safety of women. Medically accurate sex education and access to contraception are proven tools to prevent unintended pregnancies-abortion bans are not." (PPFA5, 2006). On this date, it was made abundantly clear that Louisiana lawmakers are not interested in education, prevention, or access to safe medical procedures. In contrast, these lawmakers are willing to risk the health, security, and well being of their constituents in order to further their platform. This ruling effectively made Louisiana one of the most hostile states in the nation with regard to a woman's right to choose.

No discussion of recent events related to the fight to protect a woman's right to choose would be complete without mentioning *Gonzales v. Planned Parenthood*. In April of 2007, the U.S. Supreme Court handed down a ruling that was not only in contradiction to previous rulings regarding abortion rights, but effectively created a significant negative impact on the work of abortion advocates. The 5-4 decision upheld the controversial (and misleadingly named) "Partial Birth Abortion" ban of 2003 (findlaw.com2, 2007). Previously, the Court has always maintained a focus on upholding a woman's health as the most important concern. In contrast, this ruling did not specify the types of procedures that were banned or the circumstances that were protected. Instead, the Court gave broad recognition of the states' interests. One dissenting opinion sums up the Court's decision succinctly and accurately: "In candor, the Act, and the Court's defense of it, cannot be understood as anything other than an effort to chip away at a right declared again and again by this Court" (Lambert, 2007). Ultimately, the Court chose not to limit the scope of what procedures the Act bans and argued that the safety of the procedures

covered under the ban remained in question (even though the so called Partial Birth Abortion procedure is commonly considered by medical professionals as one of the safest available in the second trimester). A dissenting opinion summed up this reversal in philosophy as follows: “the Court retreated from a rule of law that, in the face of medical disagreement, there must be a health exception, and adopted a different rule: in the face of medical disagreement, legislatures can decide whether or not to include a health exception” (Lambert, 2007). The implications of this radical shift in philosophy are immediately clear. When did it become more appropriate for lawmakers, rather than physicians, to make medical decisions?

The most crucial consequence of the 2007 Court decision is the ruling’s further solidification of the states’ interest in restricting access to abortion. This follows the 1992 decision of *Planned Parenthood vs. Casey* which also recognized the states’ interest, power, and control over the availability of abortion services. The Court concluded in its majority opinion that striking down the Act would be in opposition to the central conclusion of Casey and confirmed the government’s interest in “preserving and promoting fetal life” as follows:

Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn (findlaw.com3, 2007).

Perhaps most alarming is the section of the opinion that followed, which discussed issues not part of the original proceedings, including the guilt a woman may feel upon learning the specific steps of the procedure addressed in the act and how these feelings may cause her to carry the fetus to term. An excerpt is provided below:

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision...While we find no reliable data to measure this phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained...Severe depression and loss of esteem can follow (findlaw.com3).

What is most obvious here is the Court's blatant anti-choice stance and willingness to contradict 30 years of prior Court rulings when given the opportunity. It should be immediately clear from the above excerpt that those rights provided under *Roe vs. Wade* are in no way guaranteed. Reading the excerpt above, one is inclined to ask if the authors are writing using the rule of law to guide their decision as is expected of officers of the Court, or if they are relying instead on a personal belief that is morally opposed to abortion. Continuing in this vein of reasoning will have a profound affect on all women, regardless of age, class, race, or ethnicity.

As we have seen, although abortion has remained legal in this country since *Roe*, obtaining the procedure can be a difficult and time consuming process due to the number of restrictions and regulations in place. In her essay, "*Abortion in the United States- Legal but Inaccessible*" (1998), Marlene Gerber Fried (who manages a private network that assists low-income women in funding abortions) recounts the numerous stories she has personally heard from women desperate to end an unwanted pregnancy. She argues that while abortion is one of the safest surgical procedures available, that safety is itself a privilege (Fried, 1998). If a woman is in a position where she cannot afford to have the procedure in a licensed medical facility, but is still determined to end the pregnancy, she may be doomed to suffer the unknowns and potential repercussions involved with a self-performed abortion or with a just as risky "back alley" abortion provided by an untrained individual. Because abortions are often inaccessible to poor women due to the cost involved (both the cost of the procedure and the associated costs of traveling to a clinic), they have in the past and continue in the present to resort to these drastic, unsafe measures. As the statistics from the 1950s suggest, abortions were available prior to legalization, but access was dependent on one's economic resources. This situation continues today in the age of legal abortion. Activists involved in reproductive issues since *Roe* who have focused on the plight of low income women have witnessed the reality that access continues to be directly related to a woman's financial situation. Fried put it best when she proclaimed that, "the ability of a woman today to obtain an abortion is as dependent as ever on her economic status, age, race, and where she lives" (1998).

## **The Data: Comparing Two Decades**

The years since 1973 have brought a crushing number of restrictions and legislation around abortion access, particularly for low income women. But what has a focus on reducing abortion through regulation done to the number of actual abortions performed each year? And what has been the real, measurable impact to poor women? Comparing national data from the last two decades will show that even with restrictions and regulations in place to curb abortion, there has not been a decrease in the number of abortions performed annually. In addition, while the situation for middle and upper class women has recently improved (both in terms of a reduction in the number of unwanted pregnancies and a corresponding reduction in the number of abortions), the situation for poor women has actually deteriorated. Focusing on the statistics in Louisiana, a state where poor women are disproportionately represented in the population, will highlight the reality facing many low income women.

The table below briefly highlights a handful of statistics relevant to the accessibility of abortion for all women in the 1990s compared to the 2000s. In 1992, there was no abortion provider in 84% of counties in the United States, a group made up of mostly rural and suburban areas. In 2000, the percentage of counties without a provider was up to 87%. Thirty percent of all women ages fifteen to forty four in 1990 resided in these counties, a number which increased to 35% ten years later. One in every four women had to travel more than fifty miles to obtain abortion services. These conditions are especially detrimental to low income women who may not have access to reliable transportation nor the funds required for a long distance trip. Furthermore, the majority of residency programs in both gynecology and family practice in the U.S. do not require instruction in abortion procedures (PPFA4, 1997). As Table 1 below shows the number of providers continued to steadily decrease during the last twenty years.

Table 1

Comparing National Abortion Statistics: 1990s to 2000s<sup>5</sup>

	<b>1990s</b>	<b>2000s</b>
Percentage of US counties without abortion services	84%	87%
Percentage of women residing in a county without abortion services	30%	35%
Percentage of women who must travel > 50 miles for abortion services	25%	25%
Decline in abortion providers from 1988 to 1992	8%	8%
Percentage of pregnancies in 1996 that were unintended	49%	49%
Percentage of unintended pregnancies terminated by abortion	50%	50%

The data above shows that with the exception of a decline in the number of providers, the remaining statistics have remained constant over the course of ten years. But how does the Louisiana landscape compare with the rest of the country? The following table compares the 2000 data from Table 1 with the corresponding data for Louisiana.

Table Two

Comparing Louisiana to the National Picture Circa 2005<sup>6</sup>

	<b>National</b>	<b>Louisiana</b>
Percentage of US counties and LA parishes without abortion services	87%	92%
Percentage of women residing in a county without abortion services	35%	62%
Percentage of women who traveled > 50 miles for abortion services	25%	31%
Decline in abortion providers from 1992 to 2005	8%	47%
Percentage of pregnancies in 2005 that were unintended	49%	52%
Percentage of unintended pregnancies terminated by abortion	48%	50%

<sup>5</sup> 1990 data adapted from Alan Guttmacher Institute, February 2000; 2000 data courtesy of Wharton, 2006. See References for detail.

<sup>6</sup> Overview courtesy of Wharton, 2006

Additionally, Louisiana continues to have a number of restrictions in place:

- Unless removed by the Court, the use of a state-mandated waiting period (24 hours) which includes receipt of literature designed to change her decision
- Counseling ban- state employees or employees of a social service agency supported in any part by government funds cannot recommend that a woman have an abortion, unless a physician is acting to preserve her life
- Parental consent- parental consent is required even in cases of rape or incest
- Refusal clause- certain individuals and entities can simply refuse to perform an abortion with no further explanation, services, or referral required
- **Restrictions for low income women-** the use of public funds for an abortion is prohibited except in cases of rape, incest, or the endangerment of the mother
- TRAP laws<sup>7</sup> - a variety of administrative and regulatory requirements imposed on abortion providers alone and no other health care providers the purpose of which is to make providing abortion services more difficult

The only state-level restriction that has been removed in recent years was related to a previous requirement to provide additional, state authored literature as part of the 24 hour waiting period. The required literature laid out a link between abortion and breast cancer. In 2004, this literature was no longer deemed required reading, if only because the contents were not based on any sound medical evidence, nor were the assumptions contained within free of multiple errors (AGI4, 2008).

Abortion restrictions varied widely from state to state; in addition to the requirements outlined above, Louisiana offered no protection from protesters for clinics or their patients and restricted services after a specified point in the pregnancy. Most important to this argument, the state stringently restricted state funding for Medicaid recipients to cases of life-endangerment,

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<sup>7</sup> TRAP stands for Targeted Regulation of Abortion Provider laws. A sampling of TRAP laws in Louisiana include: clinic must be specially licensed as an outpatient abortion facility if more than 5 abortions are performed per month; room where the procedure is performed must be a minimum of 120 square feet; facility must have a governing body; special malpractice liability for providers (the physician is “liable to the mother of the unborn child for any damages occasioned by the abortion” and suits can be brought for up to 10 years following the procedure) (NARAL, 2009)

rape, and incest (AGI3, 2000)<sup>8</sup>. As a side note, the law included exceptions for Medicaid patients in cases of rape and incest over the objection of conservative policy makers who claimed that, if these exceptions were included, all low income women would cry rape in order to receive a free abortion (AGI3, 2000)! Overall, states (like Louisiana) with the strongest anti-abortion laws were also the states where women had lower levels of education, higher levels of poverty, and lower ratios of male to female earnings (PPFA3, 2000). In other words, these anti-abortion states have the largest number of low income women who are affected by laws that target the poor. Compared to pro-choice states, anti-abortion states spent far less money per child on a range of services from education to welfare. In 2000, Louisiana was classified as one of the top anti-abortion states in the country.

Alone, the statistical picture of abortion provided above would be insufficient to explain the absence of universal access regardless of class to reproductive choices or restrictions created by the states. With little doubt, government policies concerning abortions have a detrimental effect on low income women. The resulting double standard means control over the rights of low income women, while middle- and upper-class women continue to have access to a range of services. This dichotomy has potentially severe consequences for both mother and child. The added burden created by an unplanned pregnancy particularly for a woman living in poverty needs to be addressed, along with the insufficiencies that are created when the state only offers abstinence-focused family planning services, and the role that political decisions play in fostering a dependence on social welfare programs. In a study conducted by Kathryn Kost and Jacqueline Forrest the Alan Guttmacher Institute reported that the majority of births to women under twenty five years of age were unintended: 78% in the case of women ages 15-17; 68% for women 18-19; and, 50% for women 20-24. In addition, 66% of all births to African Americans across age groups were unintended, with 64% of those unintended births attributed to women living below the poverty line (approximately \$12,000 for one parent and two children at the time of the study); 52% of the remaining unintended pregnancies were to women whose income brings them within 149% of the poverty line. In contrast, of all intended births captured in the

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<sup>8</sup> The 1964 Hobbs Act and the 1970 Racketeer Influenced and Corrupt Organizations Act (RICO) were used as legal tools against aggressive clinic protesters. However, the 2003 Supreme Court ruling in *Scheidler v. National Organization for Women* made it all but impossible to apply RICO by stating that protester activities do not fit the definition of extortion under these statutes (Mauro, 2003).

study's total sample, only 9% were to African American women, while African American women in the sample contributed 25% of all unintended births (Kost et al, 1995). In general, research conducted in the 1990s indicated that births to unmarried women are more likely to be unintended (when compared with married women) and a woman with an unintended pregnancy is twice as likely to live in poverty as a woman with a planned pregnancy.

Low income, minority women find themselves in a particularly vulnerable and critical population when they are less than twenty five years of age. Out of wedlock births account for almost 70% of births to women ages 15-19, which reflect broader trends in sexual and reproductive behavior for women in all age groups during that time (AGI2, 1998). Specifically, AGI reported that an overwhelming proportion of all births are both unplanned and to unmarried women. However, it is important to disprove a popular misconception that many welfare recipients are teenage mothers looking for a free ride: in 1998, only 5% of mothers receiving welfare were teenagers and just 1% were under age 18. Changes to welfare regulations enacted under the Clinton administration require teen mothers to live with an adult and either stay in school or enroll in some type of job training program in order to receive benefits. While it cannot be argued that there are different responses to pregnancies by social class, in an article entitled, "Teenage Pregnancy and the Welfare Reform Debate" (1998), AGI researchers maintained that ensuring teens' access to family planning services would enable them to avoid unplanned pregnancies (and therefore unwanted births) and would be essential to avoiding or escaping poverty (AGI2). This then becomes another argument for abortion coverage under Medicaid. If an unwanted pregnancy is not avoided, but could be terminated, it is one way to help a woman avoid a future constrained by poverty.

The 1998 AGI article further claimed that reform rested on two false assumptions: (1) that poor, unmarried teens deliberately get pregnant and have babies to collect welfare, and (2) that withholding benefits will, in and of itself, discourage out of wedlock births. These misguided generalizations served to fuel the argument to restrict as many types of benefits as possible from low income women, including state funded elective abortions. Contrary to stereotypes, the *opposite* of both assumptions above are found to be the case in the AGI supported study. Indications at the time were that the overwhelming majority of low income

young women were using some type of contraceptive to prevent pregnancy. When asked if they used a form of birth control on an ongoing basis, 71% of low income teens reported that they did. But low income teens were twice as likely as higher income teens to have an unplanned pregnancy while using the pill or condom, and accounted for 73% of all unplanned pregnancies among women ages 15-19 even though they accounted for only 38% of women in that age group (AGI2, 1998). Therefore, withholding abortion services would likely do little to reduce the number of unplanned pregnancies and unintended births. Considering these statistics, it seems apparent that in addition to family planning services, there needs to be the provision of an accessible alternative to carrying an unintended pregnancy to term.

The AGI survey also found that there are widely differing patterns of individual control over childbearing across racial groups with African American women most likely to have an unwanted, mistimed birth. One reason that black women experience higher rates of unwanted births could be related to their limited access to family planning services that control reproduction. Additionally, black women may also decide to continue an unwanted pregnancy to term more often than their white counterparts. Regardless of the reason behind the statistics (and to be sure, there is not one explanation) restrictions on abortion that severely affect the underclass have a greater impact on African American women as a disproportionate number of poor women are African American. Of the 932,290 births attributed to women living below the poverty line, 64% were unintended. After reviewing the data, one could argue that a portion of these unintended births could have been prevented with adequate access to family planning and abortion services. With proper information and the availability of applicable medical services, low income women could have the option of preventing or eliminating an unintended pregnancy.

The data do not support the theory that single mothers are an acceptable norm among women, including low income women. Most women, including teens, would prefer to give birth within marriage (AGI2, 1998). However, the reality is that marriage is often not a realistic or even desirable option for low income women. While one third of unintended pregnancies to teens ended in abortion in the late nineties, the proportion of pregnancies resulting in birth (rather than ending the pregnancy) rose steadily in the previous decade (AGI2, 1998). It seems fair to assume that this could be partially the result of the numerous state-level regulations that severely

limit a teen's access to abortion services. These obstacles are further compounded by the federal government policy that extends Medicaid coverage for prenatal care and delivery, but not for abortion. As will be discussed later, a significant number of women on Medicaid would consider abortion if the service was covered (see pages 35 and 43). And while the Guttmacher Institute research found that the majority of women prefer a circumstance that includes marriage, there may also have been a shift in the choice for some women to give birth outside of marriage. While abortion utilization is based on numerous factors, access is a basic requirement. Childbearing among teens was heavily concentrated among the poor, most of whom were unmarried. AGI research indicates that 70% of higher income teens that became pregnant had abortions. State waiting periods and parental notification have had little effect on abortion utilization within the middle-class family unit. The middle-class rationale argues that motherhood should be delayed in favor of education, establishing financial security, and marriage. In contrast, poor teenagers may have few to no prospects for a good education and subsequent career and therefore would have little incentive to delay childbearing; only 39% terminated an unplanned pregnancy (AGI2, 1998).

Current abortion statistics give the U.S. the dubious distinction of having the highest rate of teen pregnancy among all industrialized nations (Kearney, 2008). And, as mentioned previously, because teen motherhood is one predictor of poverty, these statistics are particularly troubling. Low income women continue to account for a disproportionate number of the unintended pregnancies in this country. While poor women make up only 16% of the total population of women at risk for an unplanned pregnancy, they accounted for 30% of all actual unintended pregnancies (PRCH, 2008). Furthermore, low income women are also overrepresented among abortion patients: 57% of women having an abortion lived at less than twice the poverty level of \$28,300 for a family of three (2008). Louisiana outnumbered the national averages in terms of the percentage of the population in poverty, as well as in births to both teenage and unmarried mothers (US Census1, 2000). There were 793,472 people in Louisiana living below the poverty line, a group that comprised 18.4% of the state population, as compared with 13.3% of the U.S. population. In Orleans Parish, the numbers are even more striking: 27.9% of the city lived below the federal poverty line (US Census2, 2000).

The statistics that highlight how the proportion of unintended pregnancies that end in birth are concentrated among the poor have a strong connection to the size of the government welfare roles. Between 1970 and 1993, the number of families on AFDC increased 163%, from two million to five million (AGI2, 1998). Why should educators and advocates have concentrated on women below age twenty five, and specifically teenagers, when targeting family planning and reproductive choice efforts? In 1993, of the 3.8 million mothers who were recipients of the now defunct AFDC plan, 55% became mothers when they were teenagers. Of all unmarried teen mothers, 75% began receiving benefits within five years of the birth of their first child, and women who gave birth as teens were among the poorest AFDC recipients: in 1993, 53% had incomes below 50% of the federal poverty line (AGI2, 1998). Missing from the debate that surrounded the welfare reforms of the late nineties was the possibility of allowing women to make decisions for themselves about whether and when to have a child. In contrast, instead of engaging in this conversation, the federal government chose to ensure that Medicaid recipients could not receive an elective abortion under the program. The lack of this essential prerequisite to taking charge of one's life meant that there was no assurance that poor teens and women on or at risk of welfare had easy access to family planning and abortion services. Studies indicate that anywhere from 20% to 35% of Medicaid eligible women who continued their pregnancy to term would have had an abortion if coverage were available (AGI2, 1998). This amounts to, at a minimum, 100,000 women who were denied access to personal empowerment (20% of the more than 500,000 unintended births that occurred to women living below the poverty line in 1988). Providing access to abortion services for poor women could be one way to empower these women and give them the ultimate control over their bodies and their futures, thus freeing them from not only government regulations on their health, but also from the constraints of poverty. That is not to say that all poor, pregnant teenagers would choose an abortion if one was provided under Medicaid coverage. Rather, this highlights the double standard that existed and continues to exist today: pregnancies and the cost of child birth are covered; other options- options that arguably could keep a mother off the welfare rolls- are not.

Overall, the Physicians for Reproductive Choice and Health (PRCH) survey found that both unintended pregnancies and abortions are increasingly concentrated among poor women. While abortion rates fell among high economic groups prior to 2000, these rates increased

among poor women during the same time period. Bottom line: women living below the federal poverty line are experiencing unintended pregnancies at an alarming rate today when compared to higher income women. It seems more critical now to ensure that low income women have access to reliable and affordable family planning services. Further confounding the increasing rate of unintended pregnancies is the steady decline in the number of abortion providers. Not only are low income women experiencing a higher rate of unplanned pregnancies, but they must also travel farther to obtain abortion services. In 2005, 97% of U.S. counties had no abortion provider, up from 87% a few years earlier (PRCH, 2008).

Alongside the distance a woman is required to travel to obtain the procedure, the reality for poor women comes down to the cost involved. In 2005, the average cost for a nonhospital abortion with local anesthesia was \$523. Since Medicaid does not cover elective abortion and most poor women do not have private health insurance, obviously this cost is their financial responsibility. And while \$532 may not seem like a huge expense for a middle income family or professional woman, it can be a massive financial burden for a woman living below the poverty line especially if she is concerned about providing for her existing children. While conservative opponents would have you believe that women across all social classes use abortion as a low consequence form of birth control with little regard for the process or aftermath, patient surveys show a markedly different reality. The overwhelming majority of women understand the massive responsibilities of parenthood as they already have children. For them, abortion is not a type of “after the fact” birth control method; rather, it is the result of understanding their current situation as well as concern over their ability to effectively care for another child (PRCH, 2008).

Between 1994 and 2001, the rate of unintended pregnancies remained relatively flat. However, these data are misleading. In fact, during this time period the rate of unintended pregnancies among high income women declined 20% while the rate among lower income women actually *increased* 29% (Frost, 2008). This shows not only that there may be a difference in access to family planning services by class, but also that abortion continues to be a very real need for low income women. As the rate of unintended pregnancies rises, so too would the need for abortion funding. Anti-abortion politics have succeeded in controlling the reproduction options of low income women by controlling how family planning funds are spent

(since the majority of program funds distributed under Title X go to abstinence only programs via Community-Based Abstinence Education grants<sup>9</sup>) and also by ensuring that poor women cannot choose abortion if they don't have the several hundred dollars required to pay for the procedure. Policy makers continue to press forward with more and more bills aimed at reducing access to reproductive services in spite of the women who are affected and the impact that an unplanned pregnancy has on the individual and the larger community.

We should continue to ask ourselves how many unintended pregnancies could have been avoided with better access to family planning services and health education. Approximately one in five pregnancies ended in abortion in 2005. While state legislatures across the country are funneling family planning funds into abstinence programs and enacting restrictions to abortion services beginning in the second trimester, thanks to medical advances women actually have more options available to them if they terminate a pregnancy in the early part of the first trimester (prior to nine weeks gestation). One such option: a medication abortion is a procedure that uses a drug or combination of drugs to terminate a pregnancy during the first nine weeks of pregnancy. This type of abortion accounted for 13% of all abortions provided in 2005. As the abortion rate declined during the early part of the 21<sup>st</sup> century, the number of providers offering medication abortion services across the country increased by more than 20%. In 2005, 57% of abortion providers offered medication abortion services compared to 33% in 2001. Statistics show that more than 60% of abortions take place in the first eight weeks of pregnancy or earlier (Jones, 2008). Therefore it appears that, based on their behavior, women not only understand the options available to them (and perhaps how these options dwindle over the course of their pregnancy), but more importantly that women are making a concrete decision regarding their pregnancy without delay. However, low income women still face a financial burden with this advancement as nationwide the cost of a medication abortion ranges from \$350 to \$650 (PPFA6, 2009).

One of the largest misconceptions might be that pro-choice advocates are “pro abortion”. To the contrary, pro-choice supporters are just as anxious as anti-choice supporters to realize a

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<sup>9</sup> The 2009 Fiscal Year Budget included \$113 million in funding for abstinence-only education versus a \$299 million budget for the entire Title X program (SIECUS, 2008)

reduction in the number of abortions. However, the means to the same end are markedly different. Many advocates of choice (such as the largest and most powerful, Planned Parenthood) are ultimately interested in providing women with the knowledge and tools necessary to take control of their bodies, which would prevent an unintended pregnancy in the first place, and thereby eliminating the need for abortion. New contraceptive methods that require less maintenance (i.e. attending to one's chosen method quarterly rather than daily or sporadically) have been successful in reducing the number of assumed to be unintended pregnancies. Unfortunately, any cause to celebrate this development should be tempered as the numbers behind this compelling statistic demonstrate that this reduction has not been experienced equally across class lines. The following section will examine the lack of public funding for abortion and its impact on poor women.

### **The Public Funding Factor**

Clinics and programs funded by Title X are the government's attempt to give low income women the means necessary to prevent unintended pregnancies. This service is indispensable absent the required personal funds to accomplish the same without state involvement. When faced with an unintended pregnancy and eventually the birth of an unplanned child, what are the consequences for both the woman and her family? Public policy should be about creating change; identifying an issue that needs to be rethought and retooled and then implementing a policy to work towards affecting that issue. Policies that restrict access to abortion services can clearly have the basic effect of reducing the number of abortions. But does a decrease in the abortion rate necessarily correspond with a reduction in the rate of unintended pregnancies or is it simply the result of policies that make obtaining a safe, legal abortion more difficult? Do decreases in the abortion rate instead indicate a rise in the number of unintended births to women who may have chosen abortion if the procedure was covered? The obvious question that needs to be answered is where has more than a decade of refusing to cover elective abortions under Medicaid led us? The head of Louisiana's Planned Parenthood chapter recognized the urgency around this issue in an interview in 2006 immediately preceding the passage of SB 33 06. She

claimed that low income women will likely be the hardest hit if the state's policy makers ever realized their vision of entirely outlawing abortion, (PPFA5, 2006).

As a response to the rising rates of unintended pregnancies during the 1960s, the federal government introduced the Title X program in 1970. The intent of the program was to provide those services necessary for millions of women to prevent unintended pregnancies and obtain reproductive health care. Signing the bill into law in 1970, former President Nixon was quoted as saying,

No American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of family planning services... (PPFA1, 2000).

It is important to note that the Title X program began before abortion was legalized. By law, no Title X funds have ever been spent on abortion. Originally, planning guidelines required that women who faced unintended pregnancies be given nondirective counseling on all of their legal and medical options. Later, the Supreme Court allowed individual states to determine whether or not women on Medicaid qualified for this apparent luxury or instead were to be presented with information that offered carrying the pregnancy to term as the only option available. On a positive note, and despite their requirement to be overtly one-sided in their counseling approach (abortion is not often mentioned), family planning clinics funded by Title X have assisted millions of low income women in preventing unwanted pregnancies. Of the women using these clinics, 60% had incomes below the federal poverty line and they served as the only source of family planning services for more than 80% of the clients (PPFA1, 2000). Each dollar spent on family planning saved an estimated \$3 that would have otherwise been spent on Medicaid costs for pregnancy related care and medical care for newborns (PPFA1, 2000).

At almost three and a half million dollars, the state's 2006 Title X expenditure sounds like a fairly sizable budget. Annually, more than 20,000 Louisiana women under the age of 20 received services at a clinic funded by Title X. However, the overall number of annual patients irrespective of age is 77,000 women, which would mean \$44 per patient. A few years prior to this statistical data in 2000, the Alan Guttmacher Institute began calculating the assumed number

of unintended pregnancies that were averted due to public funding. AGI concluded that in 2001, 19,300 unintended pregnancies were averted in Louisiana due to publicly supported family planning clinics and *13,000 unintended pregnancies were averted due to Title X supported family planning clinics*, for a total of 32,300 unplanned pregnancies, or roughly one third of the 94,000 actual pregnancies in Louisiana in 2000 (Gold, 2001). In July, 2008, AGI published updated statistics for the country, estimating that publicly funded family planning clinics prevent 1.4 million unintended pregnancies each year. The researchers based their conclusion on taking the seven million women who receive contraceptive services annually from a publicly supported clinic and assuming that without these services, the annual number of both unintended pregnancies and abortions would be approximately 50% higher (as half of all unintended births end in abortion). These estimates serve to highlight the critical role public funding plays in reducing the number of unintended pregnancies as the number of women who need assistance continues to rise (by more than one million women since the 2000 statistics were published) (Frost, 2008).

In 2006, Louisiana spent in total more than \$20 million in public funds for family planning services, including more than \$11 million in Medicaid and \$3.4 million in Title X. This represents a significant increase from spending in the eighties and early nineties (AGI7, 2008). The national teenage pregnancy rate reached its lowest level in thirty years in 2006, down 36% from its peak in 1990. Among African American teenagers, the pregnancy rate declined even more sharply, dropping 40% (Jones, 2008). Depending on where the statistics originated, research suggests that this decline is the result of a combination of changes in contraceptive practices (including long term injectables and implant methods) and secondarily, to a decrease in sexual activity among teens. Of course, the obvious implication for the abortion rate is that with fewer pregnancies and therefore fewer unintended pregnancies, we will also see a similar decline in the abortion rate among teenagers.

None of the research reviewed indicates that the decline in the teenage pregnancy rate is an intended result of restrictions on health and sex education. It is important to recall that the Title X program teaches almost exclusively an abstinence only agenda at a cost of over \$100 million annually. Also, it has never been directly shown that the availability of health education

beyond an abstinence program leads to promiscuity and increased sexual activity among teenagers. Based on this information, it is possible that the decline is in fact attributable to a movement towards use of long term contraceptive devices and a change in the types of sexual activities that teenagers engage in. It has been suggested by various media outlets that due to social pressures, teenagers desires for a certain reputation, and a fear of AIDS, are forgoing sex not in the name of abstinence but instead in favor of alternate forms of sexual stimulation such as oral and/or anal sex. Some data suggest that this conclusion are that, while the teenage birth rate may be in decline, indicating a potential decline in intercourse among teens, the rate of sexually transmitted infections among teens is on the rise, indicating that teens remain very much sexually active. A recent study conducted by the Centers for Disease Control found that approximately 25% of teens are infected with a STD, and the infection rates for gonorrhea, syphilis, and Chlamydia all increased from 2002 to 2007 (CDC2, 2009). As a side note, the increase in sexually transmitted diseases points to the very real possibility that abstinence education is not working to reduce sexual activity in teenagers.

It is widely known that African Americans make up a disproportionate number of the poor in this country, so one could reasonably conclude that Black women experience an even greater burden under cutbacks in spending to federal and state family planning programs. In her essay, "Sick and Tired of Being Sick and Tired: The Politics of Black Women's Health" (1990), Angela Davis illustrates the dire circumstances in which many African American women find themselves at the intersection of race and poverty. Davis argues that African American women often find that their enemies in the battle for quality health care are social and political (Davis, 1990: 55). Furthermore, when health care and access to care are turned into commodities the ones that obviously suffer the most are those without the means to afford such care. Davis continues by arguing that with cutbacks in spending on programs designed to assist poor women, accessibility has become an enormous issue. In few cases is this more apparent than access to quality, affordable family planning services; here, the dichotomy is unmistakable. While federal funding for abortion services is essentially non-existent, surgical sterilization continues to be offered as a service financially backed by the government (Davis, 1990: 58). The anti-choice undercurrents of today's political environment are so strong and have had such a dramatic, direct effect on legislation around the country as well as in Louisiana, a person approaching the subject

of abortion choice today from a pro-choice framework may very well be justified if they find themselves feeling apprehensive, disillusioned, or disheartened. A woman's right to control her reproduction has been under constant attack for the last twenty five years, making the outlook for the next decade unpromising at best. Will it be possible to simply keep from losing more ground around reproductive freedom without experiencing a further erosion of rights? Or will the pro-choice movement actually gain some legislative ground in the future?

The best place for the abortion movement to gain legislative ground is by focusing on the Hyde Amendment. First passed in 1976, the Hyde Amendment and other similar funding bans prohibit the use of federal funds for abortion. So it is this Amendment that effectively limits access to abortion for low income women (in addition to women in the military, federal employees, and Native American women, just to name a few of the other affected groups). On its initial passing, the Amendment swept through the House with a 207-167 vote, helped in part by the anti-big government and anti-welfare sentiment of the time. While abortion activists initially won an injunction against the funding ban arguing that it was unconstitutional, that injunction was lifted in 1977 (Arons, 2006). It is important to note that the Amendment is voted on annually as part of the Health and Human Services budget, so every year for more than 30 years the federal government has restricted access for low income women in a move that further cements the class bias in abortion availability. Coupled with a lack of service providers throughout most of the country, funding restrictions are one of the most significant barriers to abortion for low income women. Additionally, the government further complicates the situation for the poor by refusing to increase funding for contraception and continuing to support an abstinence only education agenda that has not shown to have had any significant impact on the number of abortions annually (Arons et al, 2006). While the Supreme Court upheld the constitutionality of the Amendment in 1980 in *Harris v. McRae*, it has actually undergone several revisions, most notably the exceptions for rape, incest, and health of the mother have been included or removed at various points in time (Arons, 2006). Today, the exceptions include rape and incest but not the health of the mother; so a low income woman who, without assistance, cannot afford an abortion but is facing circumstances where her health or fertility may be jeopardized must continue with her pregnancy.

The impact of the Hyde Amendment on low income women cannot be denied. Before the funding ban was enacted, Medicaid covered approximately one third of all abortions annually (Arons, 2006). This figure is in sharp contrast to post-Hyde Amendment data which indicate that Medicaid covers virtually no abortions even in cases of rape or incest where a tremendous burden of proof exists for the woman seeking an abortion<sup>10</sup>. Various studies have shown that up to 35% of Medicaid eligible women would have had an abortion if funds were available to cover the procedure. Obviously, as there are 12 million women of reproductive age on Medicaid, this represents a significant number of women who are carrying an unwanted pregnancy to term because no other option exists. The Amendment, along with subsequent court decisions, denies all women on a federal health insurance program the right to a safe abortion.

In 2004, Congress passed an amendment to the budget bill allowing publicly funded institutions to refuse to provide abortion services or referrals to women (Arons, 2006). The critical point here is that publicly funded institutions are more likely to provide services to the poor than privately funded ones, so again the federal government has taken aim at low income women and created another hurdle in their access to abortion services. Congress has an opportunity every year to lift the funding ban and the abortion movement therefore has an annual opportunity to provide Congress with the motivation to do so, whether this is accomplished by hearing from medical professionals and affected women or by reviewing evidence that demonstrates the hardship an unwanted pregnancy creates. The fact that more focus has not been paid to the Hyde Amendment represents a potential failure as well as an important task for the future of the movement. Activists need to actively work towards repealing the various funding bans in order to create equal access to abortion for all women regardless of class.

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<sup>10</sup> The victim must use the Courts and Police Department records to “prove” that a rape or incest occurred and then apply for a Medicaid funded procedure (Arons, 2006).

## **Limitations and Future Research Opportunities**

It is important to note that while there are several angles from which this discussion could be framed, it is the goal of this analysis to use primarily a gender/class perspective. In much of the South and in Louisiana specifically, social researchers find that race and class are intertwined in such a way that after a preliminary review, it would seem as if the two factors are integrally connected. Therefore, it may appear as if the discussion partially ignores the impact of race or does not fully explore the plight of African American women in relation to abortion access and utilization. However, when the discussion is limited to access to medical services, once the geographical factor is controlled for (i.e. the distance a woman must travel to obtain abortion and/or family planning services) the argument is that women who occupy the same class have many of the same frustrations and experience many of the same restrictions regardless of race. Therefore, a class based focus was chosen for the discussion which could mean that important racial factors were not given enough attention.

The material presented is limited by a number of factors: both the historical sections, as well as the content around the Republican Party, rely on only a handful of sources, which in theory may focus the discussion too narrowly or provide inaccurate information. Due to space limitations, changes in social behaviors, attitudes, and medical advances in the 20<sup>th</sup> century are only briefly discussed, which means the paper jumps from the 19<sup>th</sup> century to 1973 without a thorough discussion of the events in between (for example, a more detailed section on the creation of hospital boards, forced sterilization, and the lengths to which women would go to obtain therapeutic abortions).

There is obviously the opportunity to engage in a great deal of additional research on this critical topic. One such opportunity would be an in-depth examination of rates and trends of abortion utilization in the four states that voluntarily cover abortion under Medicaid. Using these states as a test population of sorts, an examination of the data may show whether there is higher abortion utilization rates among low income women and a correlation between the availability of publicly funded services and a woman's decision to delay motherhood. In conjunction with an

examination of the data, it would be beneficial to interview a selection of the affected population to better understand why they chose abortion over birth and what factors influenced their choice. More work needs to be done around understanding why low income women choose to continue a pregnancy to term even when the circumstances appear less than ideal to an outsider. In Promises I Can Keep (2006), Edin and Kefalas laid the groundwork with their findings (discussed earlier), but their research was limited to a sample population in a certain neighborhood in Philadelphia and may not be generalizable to the broader population. Additionally, the findings indicated that perhaps the researchers were not able to remain completely impartial when interviewing their subjects and, instead, began to rationalize the choices and sympathize with the subjects' situations and decisions. Therefore, a study that mirrors their basic approach but with a sample that crosses racial, as well as class boundaries, would serve to enhance our knowledge.

### **Conclusion**

In June of 2008, *Time* magazine ran an article stating that the most recent national data show a 3% rise in teen pregnancies in 2006 — the first increase in 15 years. The article covered a new story out of the blue-collar, port town of Gloucester, Massachusetts, where reportedly a group of sixteen year old students were involved in a pregnancy pact. Citing a marked increase in pregnancy tests administered by the school nurse, clinic personnel began to advocate the prescription of contraceptives regardless of parental consent, a course of action practiced at about 15 public high schools in Massachusetts. Gloucester teens had to travel about 20 miles to reach the nearest women's health clinic. Younger girls had to get a ride or take the train and walk. But the notion of a school handing out birth control pills was met with hostility and the clinic personnel resigned in protest on May 30<sup>th</sup> (Kingsbury, 2008).

None of the efforts of the last decade to restrict women's access to abortion have led to a significant reduction in the number of unplanned pregnancies. Today, the statistics are beginning to move in the opposite direction and demonstrate an increase in the number of unplanned pregnancies. And while the majority of pro-choice activists have remained on a liberal

feminist track, attempting to change the course of unplanned pregnancies in this country by changing the laws and stressing the rights and power of the individual, the fact remains that this approach also has not led to a decrease in unplanned pregnancies. As we have seen in the preceding pages, unintended pregnancies and the effects of these pregnancies have been major issues affecting women for centuries. Let's consider two scenarios. Scenario one: if abortion was outlawed tomorrow, women with means would continue to be able to make the right choice for them (and have elective abortions if that were their choice) as money buys options. Because an abortion does not require a hospital stay or extensive follow-up, it seems possible that family practitioners or other providers could offer "off the record" services to those with the funds to pay for them. This scenario played out in the mid-nineteenth century when abortions after quickening were not unheard of when women had the knowledge and the means necessary to secure the procedure. It was also evident during the time that abortion was illegal in the 20<sup>th</sup> century as one million abortions were performed annually. No woman should be forced to continue an unwanted pregnancy as the repercussions are life changing. The bottom line is that the mantra, "every child a wanted child" benefits not only the woman and her family, but also society at large. This position simply cannot be stressed enough in today's hostile, restrictive environment.

Scenario two: if, hypothetically, elective abortions were covered by Medicaid starting tomorrow and even if no Medicaid recipient elected to have an abortion, the point of this paper remains: all women should still have choices. Choice should not be about what one can afford nor should it be about what decision one ultimately ends up making. Choice is about actually having more than one distinct path to take as well as the freedom to decide what path is best for each individual situation. There is no option if only one choice is feasible.

The preceding pages used a liberal feminist argument grounded in creating change through policy and the Courts informed by Intersectionality Theory to discuss abortion politics. Low income women today do not have equal access to the rights ostensibly attained in the *Roe v. Wade* decision because of the structural inequalities they experience because of their social class. This paper has also highlighted the rise of abortion laws during the nineteenth century and their roots in a medical profession trying to establish its dominance. I have discussed the strong class

bias that existed during the 1950s and 1960s within the abortion debate. Legislative attempts since *Roe* to chip away at a woman's ability to control her reproduction were outlined including those laws and statutes that have specifically targeted low income women. This paper demonstrated the lengths to which low income women must go to in today's society in order to exercise their federally granted rights. The current situation where abortion access is determined by class should come as no surprise. It is entirely realistic to presume that state mandates and restrictions in the next ten years will continue to limit a woman's right to choose, restrict her options, and hinder access to family planning services. However, a full fifty nine percent of Americans surveyed by Gallup in 2007 support a woman's right to choose on some level (Teixeira, 2007). In this case, policy makers are not making decisions that reflect the majority of their constituents.

To demonstrate the real risk to reproductive freedom that is present in today's climate, we need to look no further than the "partial birth" abortion debate discussed earlier in this paper. Anti-choice groups used this as an opportunity to further their agenda by creating a cloud of rhetoric and half truths around the issue. The opposition painted the picture that this procedure was common, as if women in their eighth month of pregnancy suddenly came to the realization that they did not want to continue with their pregnancy and decided to do something about it. As of 2009, 31 states have banned partial birth abortions, while only four of those states include a health exception (KKF, 2009). In reality, the procedure is extremely rare and is reserved for instances involving serious complications with the mother or fetus. According to research from the Guttmacher Institute, in 2000 there were 2,200 partial birth abortions performed, or approximately .2% of the 1.3 million abortions believed to have been performed in that year (Rovner, 2006). Moreover, from a medical perspective, it is considered a reasonably safe method considering the circumstances. However, that reality does not do much to support the case for making abortion illegal, so the reality was twisted until anti-choice groups were left with something they could work with. By manipulating the real issues facing women today, decisions are made at the federal and state levels that have a profound impact on women without a full consideration of the implications.

The argument in this thesis has placed much of the responsibility on lawmakers for the current disparity between low income women and their higher wage earning counterparts. Do lawmakers intentionally target the poor when making decisions that affect reproductive freedom or is the one sided impact of these regulations unintentional? We may never be able to accurately and completely answer that question. However, what is known is that lawmakers have found a readily accessible way to control abortion in this country through funding. The act of repealing the *Roe v. Wade* decision could seem insurmountable in the near term, but as demonstrated above, it is fairly easy to dictate which services will be offered to which classes as well as determine how funds will be applied. So perhaps the answer lies somewhere in the middle. At the very least, lawmakers have shown that they have a blatant disregard for how their decisions affect the poor. And, to take a more cynical perspective, perhaps lawmakers realize that low income women are easier to control through legislation as they do not have an organized voice or strong advocate operating on their behalf. Whatever the case, the end result is the same. After a review of the legislation it is difficult to deny that many of the policies and laws coming out of state legislatures across the country focus on public funding (and decreases in and/or restrictions on funding), and because public funding decisions have the greatest impact on the poor that on these funds, the laws will disproportionately impact low income women.

Recently, President Obama reversed the Bush policy on stem cell research making way for additional studies using stem cells. The two topics- stem cell research and abortion- are directly related to each other as both deal with what is legally accepted with regard to the fetus. Furthermore, while Obama recently nominated a Supreme Court justice who was unwilling to provide details on her abortion stance, he is almost certain to have another opportunity, as well as opportunities to appoint justices at the federal district level. It is reasonably safe to assume, based on the President's pro-choice stance that his nominations will back a woman's right to choose. Concurrently, there has been a dramatic change in the Republican Party. In the 1980s and 1990s, the GOP successfully created a number of abortion restrictions relying on support from a coalition of anti-big government and anti-welfare party members and outspoken conservative Christians. However, this coalition within the Republican Party has eroded today as the conservative Christian right-wing appears to be alienating more moderate Republicans.

Without the cohesion of this coalition, the GOP lost not only the most recent Presidential election, but also considerable power within Congress.

Pro-choice advocates could see these developments as a victory for their larger cause as many restrictions currently facing low income women are at the state level and these could be reversed with a different judicial system. Even the Hyde Amendment could be changed with a new Congress. However, because of the crushing number of laws and policies enacted in the last decade, the outlook for the next decade is far from rosy. Indeed, the recent debates over excluding coverage for abortions from Obama's national health care plan, does not bode well for the pro-choice agenda. In fact, it is the conclusion of this analysis that the next decade could be titled, *A Time of Status Quo*. Overall, women may not continue to lose ground when it comes to their reproductive rights and choices, but it is unlikely that attitudes will shift in such a way where low income women would experience a reality that includes more choices available to them, including Medicaid funding of elective abortion. Furthermore, with today's economic downfall that includes state budget deficits and cash strapped charitable organizations, it is even more unlikely that the necessary funding will be available to increase outreach and education efforts around family planning, never mind further expanding options available to low income women dealing with an unintended pregnancy. Therefore, one could easily conclude that in the absence of efforts to do otherwise, the unintended pregnancy rate among low income women will remain disproportionately high when compared to women in other economic classes and difficulties in obtaining family planning and/or abortion services will continue for this segment of the population.

We should strive to be a society where *all* women have the knowledge and tools necessary to control their reproduction regardless of their ability to pay as this would have a profoundly positive effect on society as a whole. Until we can meet this challenge head on, low income women will continue to be affected by their social class location and the disproportionate lack of access to abortion that this entails.

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## **Vita**

Amy Granger was born in Enid, Oklahoma and received her B.A. in Sociology from Tulane University in New Orleans, Louisiana. Her interest in reproductive freedom and women's rights began at an early age and she focused on these topics, exploring as many different aspects as possible, throughout her undergraduate and graduate careers. She has worked in finance for the past seven years and currently resides in Birmingham, Alabama with her husband.