

Unit 2

Reproductive Choices: The Struggle for Change

The movement to achieve reproductive choice has been, and is, hard fought. People working for choice have had to challenge restrictive legislation, a well-financed right-wing religious and political movement, and cultural taboos to obtain the right to safe and effective contraception and the right to choose an abortion. Women have had to fight male-dominated structures, economic hardships, misinformation, and the suppression of credible information. The struggle began with **Margaret Sanger** and her historic work toward the development of accessible and safe birth control. **Oral contraception** was legalized for single people in 1972, but restrictions on contraception, such as excessive cost and the lack of federal funding, continue to limit reproductive choice for women. The movement to achieve **abortion rights**, including safe procedures and availability, faces ever increasing challenges. Many states impose restrictions, such as parental consent and notification laws, despite landmark Supreme Court cases legalizing a woman's fundamental right to an abortion. The right to reproductive choice remains a struggle, but the progress outlined in this unit provides both education and insight for taking action today.

Birth Control

THE BIRTH CONTROL MOVEMENT (1900s–1940s)

The Comstock Laws

At the turn of the century, the use and prescription of contraceptives was illegal under the restrictive anti-obscenity laws spearheaded by crusader Andrew Comstock in 1872. The Comstock laws classified contraceptives and abortifacents as obscene and prohibited the sharing of contraceptive information (Blanchard 13). However, these restrictions were considered absurd in many circles since many American women were already using “home remedies” to “bring on a period” (McLaren 228).

Unplanned pregnancies and the dire health consequences of illegal, unsafe abortions and “home remedies” caused physical, economic, and emotional stress, especially for low-income women. These grave consequences made apparent the

need for safe, legal and reliable tools with which women could control their own reproduction.

Margaret Sanger

During the early years of the 20th century, feminists, suffragists, and other civil libertarians argued that women's freedom to control their own bodies was fundamental to women's fight for social, economic, and political equality.

Margaret Sanger, the “mother” of the birth control movement, was born in 1879 to a Catholic family of 11 children (Reynolds 48). Her mother had eighteen pregnancies, seven of which resulted in miscarriage (Reynolds 48). Sanger herself married early and, in addition to being a busy activist, was the mother of three. Working as a nurse in New York City, Sanger saw firsthand the effect that unplanned pregnancies had on all women, especially low-income women and their families, and the desperate and dangerous

Sanger gained organizing experience in the Industrial Workers of the World (IWW) strikes of 1912. Her close circle of socially active and progressive friends included anarchist and reproductive rights activist Emma Goldman. In 1913, Sanger traveled to France where she learned about contraceptive methods and “recipes” that French mothers had been teaching their daughters for centuries (Reynolds 53).

Upon her return to the U.S. in 1914, she began to publish the magazine, *The Woman Rebel*, in which she gave detailed information about contraceptives and coined the phrase “**birth control**.” Sanger was subsequently arrested for violating the Comstock Laws (Planned Parenthood, “Margaret Sanger”). Instead of pursuing her own defense, however, Sanger worked on her next publication, a pamphlet entitled *Family Limitation* (Reynolds 54). In 1915, when Sanger’s case came to trial, all her appeals for postponement were denied. Sanger fled to Canada and then Europe, where she visited a French birth control clinic (Reynolds 55).

Upon her return in 1916, and with financial support from feminist philanthropist **Mabel Dodge** (Reynolds 58), Sanger opened America’s first birth control clinic in Brooklyn, New York. Advertisements were printed in English, Italian, and Yiddish.

Ten days after opening, and after serving 488 women and men, police shut down the birth control clinic (Planned Parenthood, “Margaret Sanger”). Sanger served prison time for violating the “little Comstock law” that “prohibited giving contraceptive advice for any reason” (Reynolds 60). Sanger’s sister, **Ethel Byrne**, went on a highly publicized hunger strike after being sentenced for her role in the operation of the clinic. Byrne grew weaker, was force-fed through a stomach tube, and was only released when Sanger accepted

the governor’s pardon on her sister’s behalf (Reynolds 60). Sanger’s illegal clinic serves as the effective beginning of the **Birth Control League of America** (Blanchard 23), the precursor to **Planned Parenthood**.

Sanger and Eugenics

Margaret Sanger believed in a woman’s right to control her own body – a very radical idea for her day. Sanger worried about poor women. She believed that they had the right to control their births and to improve their families’ ability to survive. As Ellen Chesler stated in her biography of Margaret Sanger, Sanger condemned the class bias of many eugenic writings, which called for “the regulation of human reproduction to improve the biological characteristics of humanity” (Chesler 122). She firmly believed that birth control would give poor women economic and educational opportunities.

Sanger was extremely concerned with racial questions. She believed that any clinic in Harlem must be led and run by African Americans. In 1930, Sanger opened a family planning clinic in Harlem, staffed by an African American doctor and social worker. The clinic was also endorsed by *The Amsterdam News* (the powerful local newspaper), the Abyssinian Baptist Church, the Urban League, and the black community’s elder statesman, **W.E.B. DuBois**. Also involved in the project were **Mary McLeod Bethune**, founder of the National Council of Negro Women, **Adam Clayton Powell Jr.**, pastor of the Abyssinian Baptist Church, and **Eleanor Roosevelt**.

Sanger was a committed opponent of racism and anti-Semitism. **Martin Luther King, Jr.** said of her:

There is a striking kinship between our movement and Margaret Sanger’s early efforts... Our sure beginning in the struggle for equality by nonviolent direct action may not

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have been so resolute without the tradition established by Margaret Sanger and people like her (King 1966).

However, Sanger held views now opposed by modern-day feminists and the Planned Parenthood Federation of America (PPFA). Sanger was so eager to attract support from the scientific community that “she deliberately courted the power of eugenically inclined academics and scientists to blunt the attacks of religious conservatives against her” (Chesler 216).

Within her movement for birth control, Sanger, like many great thinkers and agents of change, was influenced by her peers. Many “progressives” of the day favored the forced sterilization of the mentally and physically disabled, which they argued could not make birth control decisions for themselves. Such progressives lauded the opinion of Oliver Wendell Holmes, Jr. and Louis Brandeis along with the majority of the Supreme Court who voted in *Buck v. Bell*. In that case, the Court upheld a Virginia statute authorizing the involuntary sterilization of institutionalized inmates, saying: “Three generations of imbeciles are enough.” As Sanger biographer Ellen Chesler wrote, “Without any apparent concern for the potential of abuse, Margaret supported these initiatives and argued for the compatibility of this kind of eugenics and birth control” (Chesler 216).

Meanwhile the “most prominent leaders” of the eugenics movement remained opposed to birth control because they feared this radical idea would undermine their credibility. These men viewed Margaret Sanger as an advocate for women and the poor. In the end, Sanger paid a high price for the support of a few eugenicists and scientists. Eugenics declined in popularity by the end of the 1920s, and with the

rise of the Nazis in Europe in the 1930s was essentially placed in the dustbin of history. Nevertheless, Sanger’s small foray into eugenics gave her opponents on the right, and even on the left, an opportunity to discredit her work (Chesler 215-217).

While there is no denying that Sanger allowed herself to become caught up in the eugenic zeal of her time, her principal intent remained as it had been earlier, to redress economic and gender inequality and to promote healthier, happier families. Sanger remained steadfast that reproductive decisions be made on an individual not a social or cultural basis, and repudiated the racial stereotyping of the Immigration Act of 1924, arguing that “inherited traits varied by individual and not by group” (Chesler 215).

Post WWI

After the First World War, the movement to legalize birth control gained a wider acceptance. Doctors, in an effort to legitimize the study of contraception, sought more control over a political movement that until this time had been championed largely by feminists, suffragists, and eugenicists. In 1923, gynecologist Robert Latou Dickenson founded the Committee on Maternal Health (Critchlow 26) and in 1937, the **American Medical Association** endorsed contraception.

Margaret Sanger came to support physician control of contraception “because she realized that the birth control movement would not progress without it” (Reynolds 62). In 1917, Sanger started the scientific journal *Birth Control Review* (Reynolds 61) and in 1923, she founded the Birth Control Clinical Research Bureau to treat patients and keep accurate records in order to expand interpretation of the Comstock law. Sanger eventually withdrew from her Birth Control League of America in order to work at the Clinical

Research Bureau and at her Committee on Federal Legislation (Critchlow 3). As she was advised throughout the late 1920s, Sanger attempted to cultivate a more conservative image “as a married mother lobbying among legislators and professional elite” (Critchlow 34). In 1942, Sanger’s Birth Control League of America dropped its “controversial” title to become the **Planned Parenthood Federation of America** (Blanchard 23).

To achieve popular support for birth control, Sanger built “a national political campaign for birth control by organizing the country from the bottom up, mobilizing volunteers and constituents by congressional district and in turn by state and region” (Chesler 324). Moreover, Sanger mounted a lobbying campaign between 1931 and 1936. She hired Hazel Moore, a tough professional lobbyist from the American Red Cross, who worked alongside Sanger lobbying Congress for a birth control bill for six straight legislative sessions.

Financial backing for the birth control movement came from the organizing efforts of Sanger and her colleagues. The main source of financial support came from women, “predominantly in New York and its environs, where Margaret’s loyal lieutenant, **Ida Timme**, solicited contributions in increments of \$1,000 and up” (Chesler 324). Sanger and Timme also ran a direct mail program, which brought in hundreds of gifts of \$25 or under. Margaret Sanger’s name and her organizing capabilities provided legitimacy and donors to the birth control movement.

Birth control and family planning also began to gain the support of political moderates. The Comstock Laws were significantly liberalized in 1939 with the *U.S. v. One Package of Japanese Pessaries* case. The Supreme Court announced that contraceptives were not obscene, stating that “Congress, in enacting the Comstock

Act, had not been fully informed about the dangers of pregnancy and the usefulness of contraception” (Critchlow 4).

DEVELOPMENT OF THE PILL

Katherine McCormick, a friend of Margaret Sanger and a philanthropist, subsidized the scientific research into oral contraceptives. In 1950, McCormick inherited more than \$15 million dollars from her husband and consulted Sanger on how to “put it to good use” (Chesler 431). As one of the first female graduates of the Massachusetts Institute of Technology, McCormick was able to make knowledgeable decisions about funding research. She gave several thousand dollars to a research fund established by Planned Parenthood, which was then contributed to the Worcester Foundation for Experimental Biology “for preliminary investigations in the hormonal contraception being conducted by **Dr. Pincus** and his collaborator, **M. C. Chang**” (Chesler 432).

In 1951, **Carl Djerassi** and a team of chemists at the University of Mexico synthesized the first orally active progestin from yams. Building upon his research, Pincus and Chang determined that “oral administration of [progesterone] had a 90 percent rate of effectiveness” (Chesler 432). Following these preliminary discoveries, Katherine McCormick met with Dr. Pincus in 1953 and promised a contribution of \$10,000 – a commitment that would grow exponentially by the end of the year (Chesler 432). Katherine McCormick contributed more than \$2 million dollars to Dr. Pincus and his colleagues and left them more than \$1 million in her will. With her dedication and her vision, she was a financial key to the development of oral contraception.

Subsidized by McCormick, Drs. Pincus and Chang worked in Massachusetts under the auspices of **John Rock**, a Catholic but

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pro-birth control gynecologist from Harvard, who was chosen by Planned Parenthood to experiment with the new drug on patients in Boston. In 1956, large-scale clinical trials were undertaken in Puerto Rico and Mexico (McLaren 240). Finally, in 1960, “**Enovid-10**,” an estrogen/progesterone ovulation inhibitor, and the first birth control pill (Reynolds 114), was approved by the Food and Drug Administration (McLaren 240) and began to be manufactured by Syntex (Critchlow 42).

LEGALIZATION OF BIRTH CONTROL

Although widening public acceptance of birth control led some states to liberalize their Comstock laws, it took a U.S. Supreme Court decision to fully legalize contraceptive devices.

In 1964, the Supreme Court, in ***Griswold v. Connecticut***, legalized the prescription of birth control pills to married couples, announcing “The Connecticut statute forbidding use of contraceptives violates the right of marital privacy which is within the penumbra of specific guarantees of the Bill of Rights.” The decision was based on the Right to Privacy implied by the Bill of Rights and the Equal Protection Clause of the Fourteenth Amendment, elaborated by constitutional law scholar Thomas Emerson.

In 1972, ***Eisenstadt v. Baird*** extended the contraceptive access rights won for married people in *Griswold* to single people. This decision was based on the Right to Privacy and the Equal Protection Clause.

OPPOSITION TO BIRTH CONTROL

With the advent of the contraceptive pill, conservative and religious forces were forced to re-address the issue of contraception. Pope John XXIII formed a birth control commission in 1962 to examine the **Catholic Church’s** position. This diverse group of theologians, doctors, and

sociologists favored a change in the Church’s stance on contraception. In 1966, Pope Paul VI added fourteen cardinals and bishops “naming them the official commission and redefining all other members solely as ‘experts’” (McClory 3). After thorough debate, eight of the fifteen members of the commission agreed to submit to the Pope a Majority Report recommending that the Church change its condemnatory position on the contraceptive pill. Despite the majority opinion from his appointed commission, Pope Paul VI issued the *Humanae Vitae* in 1968. This encyclical “categorically reaffirmed the prohibition of contraception,” (McClory 6) and subsequently fostered growing public division over family planning in religious circles as well as the general public.

The **National Right to Life Committee** (NRLC) was constituted in the 1960s from the U.S. Catholic Conference Family Life Division, administered by the National Conference of Catholic Bishops. Formed in response to the development of the Pill, NRLC’s express purpose was to fight the advent of effective birth control, and later, legalized abortion.

Although not opposed to contraception, the **Food and Drug Administration** also impeded research and development of oral contraceptives by imposing “a multi-tier requirement for animal testing of female contraceptive agents (requirements that had never before been considered for any other drug)” (Djerassi, *The Pill*, 133). These requirements included two-year, multi-dose toxicity studies in rats, dogs, and monkeys before substantial human clinical experiments could be performed, followed by seven-year toxicity studies in beagle dogs and ten-year studies in monkeys. The FDA used extreme caution in approving a new drug that millions of women would be taking, but scientifically the menstrual cycles of rats and dogs are

too different to be extrapolated to women (Djerassi, *The Pill* 134). The primate requirement was dropped in 1987, but the dog testing was not abolished until 1991.

In 1970, Senator Gaylord Nelson held a series of Senate Subcommittee hearings, known as the Nelson Hearings, to investigate whether the public was properly informed of the Pill's alleged health hazards. The result was the FDA requirement that package inserts explaining the Pill's side effects must be included in every container of oral contraceptives. The Hearings curtailed much of the family planners' victory by prompting restrictions on the distribution of contraceptives. The sensational press coverage of the Hearings alarmed the American public by focusing on health risks associated with the Pill without clarifying the benefits. **If the same standards were applied to aspirin as are applied to the birth control pill, the insert for aspirin would need to be longer and more cautionary than for the birth control pill.** Public concern prompted by the hearings was one of the reasons the pharmaceutical industry decreased spending in the contraceptive field. "These hearings, more than any other single factor, have slowed down the development clock of new contraceptive methods" (Djerassi, *The Politics* 100).

RESTRICTIONS ON CONTRACEPTION

Excessive Cost of Birth Control

According to Planned Parenthood Federation of America, women must have one yearly gynecological visit, complete with a pelvic exam, Pap Smear, breast exam and blood pressure check in order to obtain a prescription for birth control pills. This yearly exam at Planned Parenthood costs between \$100-\$150 plus an additional \$60 test for sexually transmitted infections (STIs). (Some Planned Parenthood locations offer discounts for younger women of up to 50%.)

A yearly gynecological exam at a doctor's office costs between \$80-\$220, depending on the doctor or clinic. As in Planned Parenthood clinics, this includes a pelvic exam, Pap Smear, breast exam and blood pressure test. Many doctors also require a pregnancy test before prescribing birth control pills, which costs between \$10-\$20.

The cost to produce a monthly cycle of oral contraceptives is only \$.15 through bulk purchase by the U.S. Agency for International Development (USAID), but the typical consumer price is \$20- \$35 per month (Brown). Generic brands cost \$10 less, at around \$15-\$20. This \$15-\$30 per month fee is only in addition to the cost of a gynecological exam required before a prescription for birth control pills can be issued. **The minimum cost of oral contraceptives for one year, including the cost of the Pill and the examinations, is around \$250 and the maximum can range as high as \$640.** Additionally, very few insurance companies will provide for birth control pills that are used for birth control purposes.

Norplant costs about \$350 for the device and \$150-\$650 for counseling and insertion, although many clinics no longer offer this birth control device. An intrauterine device (IUD) costs about \$400 for an examination, the device, and its insertion.

Emergency Contraception ("The Morning After Pill" 1-888-NOT-2-LATE)

Emergency contraception (EC) is a method of preventing pregnancy after unprotected sexual intercourse - when a condom breaks, after a sexual assault, or any time unprotected sexual intercourse occurs. EC does not protect against sexually transmitted infections. There are two types of emergency contraceptive pills. One type, called PrevenTM, uses hormones that are the same type and dose as hormones used in some kinds of ordinary

birth control pills. These hormones are called estrogen and progestin. The other type of EC pill, called Plan B(r), contains only the hormone called progestin. It is more effective than the first type, and the risk of nausea and vomiting is also lower. EC pills are often called “morning after pills,” but can be taken immediately after unprotected intercourse. Each dose is 1 to 5 pills, depending on the brand. Most women can safely use EC, even if they cannot use birth control pills as their regular method of birth control.

While EC has often been referred to as the “morning-after pill,” this phrase is misleading because EC can be taken up to 72 hours after unprotected intercourse, not just the next morning. The hormones in EC can delay or prevent ovulation or interfere with fertilization. Neither a pelvic examination nor a pregnancy test is required before treatment. Overall, EC pills lower a woman’s risk of becoming pregnant by 75-88%. When taken within 24 hours of unprotected intercourse, EC is up to 95% effective. EC has minimal side effects, the most common being nausea. However, anti-nausea medication can be taken an hour before the first dose of EC pills to reduce such side effects.

Emergency contraception is an important backup method of birth control because it increases women’s control over their reproduction. According to the Alan Guttmacher Institute, there are 3 million unintended pregnancies in the US each year. EC has the potential to cut the number of unintended pregnancies in HALF and prevent as many as 800,000 abortions each year.

Many college health centers do not offer EC or are closed on the weekends, leaving women unable to find an off-campus EC provider within 72 hours. Despite the fact that EC pills are extremely safe and over 70 medical and women’s

health organizations, including the American Medical Association, have advocated making them available over the counter, Washington, California, and Alaska are currently the only states that allow women to obtain EC without a prescription. Some pharmacies have outright refused to fill prescriptions for EC pills (Wal-Mart, among others). EC can prevent thousands of unintended pregnancies in the US each year, but it must be taken within 72 hours. Young women must receive greater access to EC. The Feminist Majority Foundation is currently leading a nationwide campaign to allow women to access Emergency Contraception without a prescription, as “over-the-counter.”

Insurance Coverage

A recent study by the Women’s Research and Education Institute found that 67% of women in their reproductive years rely on private, employment-related coverage to provide for their health care needs. Unfortunately, a majority of these plans do not cover contraception, creating a 68% gender gap for out-of-pocket medical expenses, primarily due to reproductive health costs (Alan Guttmacher, “Uneven and Unequal”). Looking at large-group insurance plans, 97% cover prescription drugs, but only 33% of these plans provide for the birth control pill.

When analyzing the same large-group insurance plans, 97% provide for prenatal care because the Pregnancy Discrimination Act of 1978 requires coverage of maternity care for employment based groups with 15 or more employees. Due to this federal regulation, most women who are unable to receive contraception under their employment insurance are supported if or when they decide to have children. Women’s reproductive needs are otherwise not provided for by two-thirds of large-group plans (Alan Guttmacher, “Uneven and Unequal”).

The **Equality in Prescription Insurance and Contraceptive Coverage Act** (EPICC, S.766) introduced by Senator Olympia Snowe (R-ME) and Representative James Greenwood (R-PA) is a federal bill designed to promote family planning services that are neglected by many insurance plans. Insurance policies are required to cover prescription contraception drugs and services, including outpatient medical services (NFPRHA Report 5/21/97). This bill has been regularly introduced and is pending in Congress. It would ensure that insurance groups cover contraceptive related health services for women.

Medicaid

Medicaid, Title XIX of the Social Security Act of 1965, provides health care services to those individuals whose income is not sufficient to pay for medical expenses. Medicaid accounts for 58% of federal expenditures on contraceptive services and covers 7% of all family planning visits. Because Medicaid is a joint federal-state program, the federal government matches 90% of state expenditures for family planning (Brown). Health care professionals are reimbursed for medical services provided to eligible individuals. Requirements cover individuals who receive Aid to Families with Dependent Children (AFDC), single women who already have a child or are pregnant, and those who are 50% below the poverty line. Medicaid does not typically cover teenagers for family planning services because they do not meet these requirements (Planned Parenthood, “Medicaid Funding for Abortion”). For individuals who are eligible, finding an obstetrician-gynecologist is difficult since only 50% accept Medicaid reimbursement for contraceptive visits (Forrest and Samara).

Title X

Title X is part of the Public Health Service Act of 1970 signed by President Nixon to reduce unintended pregnancies by providing contraceptive and reproductive health services to low-income and young women. **Title X is designed to increase access to family planning services for low-income and young women not eligible for Medicaid.** Individuals using Title X clinics are charged fees based on their ability to pay. Women below the national poverty line receive free service. Teenagers are charged fees based on their income (rather than their parents’ income) for confidential and affordable care. This act establishes the only federally funded program exclusively dedicated to family planning services. Title X funds are distributed to reproductive health services that comply with their guidelines: about 58% of spending goes to state and local health departments, 17% to Planned Parenthood, and 25% to hospitals.

Title X requires that women faced with an unintended pregnancy be given “nondirective counseling on all legal and medical options including abortion” (Planned Parenthood, “Title X”). The American College of Obstetricians and Gynecologists (ACOG) developed the minimum standards of care that must be practiced by all health providers receiving Title X federal money. They require that:

- patients have various contraception options;
- no one is coerced into a particular method;
- all services are related to reproductive care;
- fees are based on ability to pay;
- no funds are used for abortion.

Title X clinics face decreasing funds combined with an increasing number of patients and clinic costs. They must comply with medical regulations and meet the growing need for contraception services, without the necessary increase in spending. In fact, while the number of women receiving care at Title X clinics increased 17% between 1981-91, the funding decreased 65% between 1980 and 1994 (NFPRHA 6/24/97). According to the Institute of Medicine, when spending decreased, unintended pregnancy began to increase. Ironically, Title X opponents in recent years often use the increase of unintended pregnancies to claim that these clinics are ineffective, not underfunded (Alan Guttmacher, "Issues in Brief").

Every public dollar spent on contraceptive service saves an average of \$4-\$20 on public costs according to several researchers, "depending on the horizon of health and social consequences included in the analysis" (Stewart). In 1994, federal and state funding for contraceptive services accounted for a total of \$715 million. Title X and the maternal and health social service block grants accounted for 31%, Medicaid contributed 46%, and individual states covered the remaining 23% of costs.

Parental Consent

There are no laws that directly prevent doctors from prescribing contraception to minors, but 35% of obstetrician-gynecologists refuse to provide contraceptives to minors without parental consent (Forrest and Samara). Additionally, most teenagers cannot visit a gynecologist without their parents' knowledge because they need help paying for the appointment. Title X clinics are designed without parental consent requirements for minors and are constantly under attack by anti-choice legislators. In 1981, the Reagan Administration attempted to pass a mandatory

parental notification guideline for clinics receiving Title X funds, but fortunately the Federal District Court declared this legislation unconstitutional. Fifteen years later, anti-choice legislators still try to prevent minors from receiving reproductive health care by introducing parental consent bills and refusing to authorize Title X.

Parental consent guidelines for Title X clinics contradict the very reason the clinics were created, which was to provide reproductive health care for low-income and young women. Requiring teenagers to obtain parental consent denies most minors access to necessary services. A Family Planning Perspectives study found that 86% of minors who use services funded by Title X are sexually active, and half had sex for the first time more than 11 months prior to visiting a clinic. A study in the *Journal of Pediatrics* found that 85% of teens would not seek care for sexually transmitted infections (STIs) if required to have parental notification or parental consent.

Catholic Hospitals

Catholic hospitals and their policies concerning emergency contraception and reproductive services also impede the availability of contraception information. Fifty-seven mergers and acquisitions between Catholic and non-Catholic hospitals have occurred since 1990. According to *The Catholics for a Free Choice*, ten Catholic hospitals have eliminated their reproductive services, six have legally separated their reproductive clinics, and "about one-third of the hospitals that have merged or affiliated with Catholic providers refuse to give information on their reproductive health care policies" (*Catholics for a Free Choice*).

SEX EDUCATION

United States

Comprehensive sex education in our public schools is essential to provide young

women and men with the ability to make mature, informed decisions about their reproductive needs.

- Only 10% of American students receive comprehensive sex education.
- Thirty-two states require that schools provide sex education, yet most school systems with sex education fail to provide comprehensive information.
- Sex education programs can have limited effectiveness due to state policies prohibiting or not requiring the discussion of certain topics related to pregnancy and STI prevention.
- A majority of state guides have incomplete coverage of contraceptive options.
- Only 40% percent of teenagers were told in their sex education classes where to obtain contraception (Planned Parenthood, “Sexuality Education”).
- Twelve states mandate that sex education classes teach abstinence but do not require them to teach contraception.
- Eleven states require that sex education cover both contraception and abstinence, three states mandate contraception coverage at the junior and senior high schools, and only five states are required to educate about condoms (NARAL, “Who Decides?”).
- Eighty-nine percent of parents want sex education in the school and 73% support having contraceptives available at school (Planned Parenthood, “Sexuality Education”).

The Clinton Administration promised to increase federal support for effective sex education programs at the local level, but it also supported a restrictive and misleading abstinence-only program (Transitions 1997). A Health and Human Services

document from 1996 recommends five reportedly successful sex education programs, but not one of these programs meets the abstinence-only guidelines. Abstinence-only education programs promote gender-role stereotypes, use scare tactics with misinformation, and also omit information about contraception and the prevention of Sexually Transmitted Infections (Planned Parenthood, “Sexuality Education”).

Europe

Contraceptives are free, by and large, as part of most National Health Systems in **Western Europe**. The Netherlands, which has the lowest percentage of adolescent pregnancies, provides its citizens with comprehensive sex education in its school system and in the mass media. Additionally, three out of four Dutch children claim to receive information about sex at home. Family planning services are provided both by general practitioners and by specialized clinics, which increases accessibility.

Teenage Pregnancy Rates (age 15 to 19):

Netherlands	14 per 1,000
Sweden	35 per 1,000
France	43 per 1,000
Canada	44 per 1,000
England/Wales	45 per 1,000
United States	96 per 1,000

Abortion

ABORTION RIGHTS MOVEMENT (LATE 1960s – 1990s)

Making the Procedure Safe

Before the advent of sophisticated medical technology in the 1960s, the abortion mortality rate was very high. In fact, abortion techniques are much safer today than in the past. Thus, states previously felt justified in regulating abortion

due to the life-threatening nature of the abortion procedure (Blanchard 17-18).

By 1970, however, this argument had lost its legitimacy. Still, by 1972 therapeutic abortion was only legal in four states: New York, Colorado, California, and North Carolina, with various combinations of restrictions such as:

1. Approval by a panel of doctors
2. Approval of a psychiatrist
3. A state residency requirement for the woman (usually six months)
4. Parental or spousal consent
5. State-sanctioned “informed” consent (Blanchard 16).

Today, the risk of complication from an abortion in the first trimester is considerably less than a woman faces giving birth. In fact “[a]bortion is safer than taking an injection of penicillin,” according to Dr. David Grimes (*Abortion for Survival* 7). Abortion today is the most common invasive surgical procedure in the United States.

Sherri Finkbine

Sherri Finkbine of “Romper Room”, one of the leading children’s television shows, was a T.V. personality in the 1960s. During the second month of Finkbine’s pregnancy, she ingested thalidomide, a sedative known to cause fetal deformities. Finkbine decided to have an abortion and even obtained the mandatory doctor and hospital approvals. Unfortunately, both parties subsequently relinquished their support due to the mass of publicity surrounding the case. Furthermore, the law in her home state of Arizona stipulated that abortions could only be performed if the pregnancy threatened the life of the woman. Eventually, Finkbine obtained an abortion in Sweden. Her situation pro-

pelled the abortion debate to the national forefront (Blanchard 22-3).

Model Penal Code Law (German Measles)

In 1964, German measles, or rubella, swept the United States. This epidemic was a great concern for pregnant women because of the risk of birth defects associated with rubella. Subsequently, there was a surge in demand for abortions, and “the disparity between their actual practices and the state laws governing them led some doctors to begin pressuring state legislatures for change” (Blanchard 23). In 1959, the American Law Institute revised the abortion section of the Model Penal Code, “which became the model for most of the state revisions in the late 1960s” (Blanchard 23). Although still mandating the approval of two doctors, this model law permitted abortions in instances where the woman’s life or mental health was endangered, when pregnancy resulted from rape or incest, and when fetal deformities were present.

LEGALIZING ABORTION

In the early 1960s, the movement to legalize abortion caught fire due to the intense media coverage of the Sherri Finkbine case (1962) and the German measles or rubella epidemic (1964). The campaign to liberalize abortion laws, which included underground abortion networks, civil disobedience, and legislative campaigns, along with initiative and referendum efforts, expanded in response to a variety of economic and demographic factors. Organizations were also formed, such as the **National Association for the Repeal of Abortion Laws** (NARAL), which convened in 1969. NARAL brought together feminists, physicians, lawyers, population control advocates, and religious groups, with the goal of legalizing elective abortions (Jackman “Feminism, Direct Democracy, and Power” 79-80).

SUPREME COURT LEGALIZES ABORTION

Roe v. Wade (1973)

In *Roe v. Wade*, the U.S. Supreme Court legalized abortion by ruling 7-2 that the right to privacy extended to a woman's decision whether or not to terminate her pregnancy. Argued by Attorney Sarah Weddington, *Roe* was brought as a class action lawsuit challenging the constitutionality of a Texas law that prohibited abortion except to save the woman's life.

Delivering the opinion of the Court, **Justice Blackmun** stated:

"The right to privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court has determined in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice is altogether apparent. Specific and direct harm medically diagnosable in even early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider."

However, *Roe v. Wade* fell short of declaring a woman's absolute right to abortion. The opinion continued,

".... [But] the privacy right involved ... cannot be said to be absolute and must be

considered against important state interests in regulation ... It is reasonable and appropriate for a State to decide that at some point in time another interest, that of the health of the mother or that of potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly."

The Court established a **trimester framework** for defining the grounds on which the state could regulate the provision of abortion services to women. During the first trimester of pregnancy, the state could only require abortions be performed by a licensed physician. According to *Roe*, additional regulations could be placed on abortions in the second trimester only for the purpose of protecting a woman's health in which the state had a compelling interest. The Court ruled that at the point of viability the state also had an interest in protecting fetal life and could establish regulations accordingly, in the third trimester. However, this interest did not supercede an abortion to "preserve the life or health of the mother."

In *Roe v. Wade*, the Court also assigned much of the right in abortion decision-making to the physician. The Court ruled, "The decision vindicates the right of the physician to administer medical treatment according to his [sic] professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." Immediately following *Roe*, the Supreme Court invalidated a variety of other restrictive state laws.

Doe v. Bolton (1973)

In *Doe v. Bolton*, a companion case to *Roe*, the Court invalidated a Georgia law

The Medical Uses of Mifepristone

ABORTION & FERTILITY CONTROL

Mifepristone works by blocking the action of progesterone, which is necessary to sustain a pregnancy. A woman can take mifepristone as soon as she knows she is pregnant. Mifepristone is administered orally, is non-invasive, requires no anesthesia, and bears less risk of infection than surgical abortion. Many women prefer mifepristone because the procedure is more private and allows them greater psychological control in ending a pregnancy. Administered with a single dose of a misoprostol (a prostaglandin given orally), mifepristone has been proven to be highly successful in terminating pregnancy within the first nine weeks. Studies also show that mifepristone is a safe, effective emergency contraceptive. Preliminary studies also indicate that mifepristone can act as both a male and female contraceptive.

MENINGIOMAS

Meningiomas account for 15% of all primary brain tumors and 12% of all spinal cord tumors. Meningiomas occur two times more frequently in women than men. Meningiomas may enlarge or become symptomatic during the menstrual cycle or pregnancy, and are positively associated with breast cancer. These facts suggest that estrogen and progesterone, which are at elevated levels during these cycles, influence tumor growth. By binding with progesterone receptors, mifepristone may inhibit the growth of, or actually reduce meningiomas. The Feminist Majority Foundation currently operates a Compassionate Use Program in which about three dozen meningioma patients, with special FDA approval, are being treated with mifepristone under their physician's care. Many of these patients report that mifepristone has eased their pain and suffering. Some have said that the drug is saving their lives.

ENDOMETRIOSIS & FIBROID TUMORS

Ten to twenty percent of American women of childbearing age have endometriosis. Mifepristone shows promise as a treatment for endometriosis, which is a chronic, painful, long-term disease that can affect women throughout their entire reproductive years. Mifepristone is a non-competitive anti-estrogen. As such, mifepristone blocks the capacity of the endome-

trial tissue to grow in response to estrogen, making mifepristone a possible hormonal treatment for endometriosis. In addition, researchers believe that mifepristone is a promising treatment option for uterine fibroid tumors. Fibroid tumors, which afflict about 30% of women, are a leading cause of hysterectomies.

BREAST, ENDOMETRIAL, & OVARIAN CANCERS

As an antiprogestosterone, mifepristone may be effective in treating progesterone-dependent forms of breast cancer. Experts estimate that mifepristone may be an effective treatment of 40% of breast cancer tumors. The majority of endometrial cancer tumors are both estrogen- and progesterone-dependent. In vitro studies have shown that mifepristone may inhibit endometrial cancer cells. In a recent study of 34 ovarian cancer patients whose tumors were resistant to other treatments, 26.5% responded to mifepristone treatment; three patients had a complete response and six had a partial response.

PSYCHOTIC DEPRESSION AND CUSHING'S SYNDROME

Researchers at Stanford University have found that patients with psychotic major depression who are treated with mifepristone show significant reductions in symptoms. In a multi-center, Phase II clinical trial, two-thirds of patients improved within 7 days as a result of mifepristone treatment. Mifepristone is proving to be an effective treatment for psychotic major depression because as an anti-glucocorticoid it blocks the action of cortisol. High levels of cortisol can cause extreme symptoms of depression such as hallucinations and paranoia. Cushing's Syndrome, a sometimes fatal adrenal disorder, also results from an overproduction of the cortisol. An important National Institute of Health (NIH) study has shown that when people with inoperable Cushing's Syndrome were treated with mifepristone, more than 50% experienced reversal and control of the disease as well as complete regression of the Syndrome's physical features. Mifepristone also may prove effective in treating several other conditions and diseases that are caused by elevated levels of cortisol. These health problems include depression, alcoholism, substance abuse, HIV virus, anorexia nervosa, ulcers, diabetes, Parkinson's, multiple sclerosis, and Alzheimer's.

that allowed abortions to be performed by a physician only in cases where continued pregnancy would endanger a woman's life or injure her health, if the fetus would be likely to be born with a serious defect, or if the pregnancy resulted from rape. Argued by Attorney **Marjorie Pitts Hames**, the case against the Georgia law was brought by an indigent woman who was denied an abortion in her eighth week of pregnancy. Several Georgia physicians and other health professionals joined the challenge to the state law.

The law, enacted in 1968 as a part of abortion law reform, further stipulated that two additional physicians must concur with the woman's physician before an abortion could be performed, that abortions could only be performed in accredited hospitals, and that the abortion receive approval from a hospital staff abortion committee. The Court found that these requirements were "unduly restrictive" of both the rights of the patient and her physician's rights to practice medicine. In his ruling for the Court, Blackmun wrote, "...the medical judgment may be exercised in the light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he [sic] needs to make his [sic] best medical judgment."

Both *Roe v. Wade* and *Doe v. Bolton* sanctioned a woman's fundamental right to have an abortion. The ultimate decision to have an abortion, however, rested upon a doctor's "professional medical judgment."

MIFEPRISTONE: A MEDICAL BREAKTHROUGH

After a twelve-year campaign led by the Feminist Majority Foundation, the FDA approved mifepristone – formerly known as RU 486 – for use in the United States on September 28th, 2000. Hailed as a land-

mark victory for the advancement of women's health, mifepristone is a medication that provides women with a safe and effective method of early medical (non-surgical) abortion. Beyond its use as a method of early abortion, preliminary studies indicate that mifepristone shows promise as a treatment for fibroid tumors, endometriosis, Cushing's Syndrome, meningiomas, some breast and ovarian cancers, and a myriad of other serious diseases and medical conditions that primarily affect women.

The Fight For Mifepristone

Over a twelve-year period, the Feminist Majority Foundation (FMF) waged a massive, multifaceted campaign to make mifepristone available in the United States. The Campaign for Mifepristone and Women's Health Research included meetings in Europe with the original RU 486 patent holders; countless meetings in the U.S. with the Population Council and Danco, Roussel Uclaf and Hoechst AG; innumerable briefings and strategy sessions with other abortion rights and women's rights organizations; participation in dozens of conferences in the U.S. and abroad to urge support for mifepristone; demonstrations on both East and West Coasts; and testimony before Congress, FDA, and state legislatures among other strategies. The following tells the story of this remarkable campaign:

1988

RU 486 becomes available in France in October 1988, after the French Minister of Health declares RU 486 "the moral property of women" and orders Roussel Uclaf to return RU 486 to the market following the company's decision to withdraw the drug in the wake of anti-abortion pressure. Anti-abortion forces threaten Roussel Uclaf's parent company, Hoechst AG, with

economic reprisal if RU 486 is marketed in the United States. FMF meets with leading scientists and reviews scientific literature to ascertain the safety, efficacy, and benefits of RU 486.

1989

In March, Hoechst informs abortion opponents that “it is not our intention to market or distribute RU 486 outside of France.” The Food and Drug Administration (FDA) bans importation of RU 486 for personal use in response to anti-abortion Congressional pressure.

FMF launches the Campaign for RU 486 and Women’s Health Research, a massive public education campaign to generate petitions to the European manufacturers of RU 486 urging licensing of RU 486 in the U.S. and begins the drive to win support from women’s, scientific, and medical organizations.

1990

The ten-member FMF delegation of feminist leaders, including FMF President Eleanor Smeal, Chair Peg Yorkin, and Research Director Jennifer Jackman, Ph.D., and prominent scientists travels to Europe to meet with officials of Roussel Uclaf and Hoechst AG. The delegation, which is the first-ever American group to meet with Roussel Uclaf CEO Dr. Edouard Sakiz, presents over 115,000 petitions from American citizens in support of RU 486. The meeting forges a long-lasting relationship with Dr. Sakiz and his colleagues that proves key over the course of the next decade to removing obstacles to RU 486 availability.

Congressman Ron Wyden (D-OR) holds a series of hearings on RU 486 before the House Small Business Committee. Scientists and FMF President Eleanor Smeal testify that the import alert has hindered research on non-abortion RU

486 indications, including its use as a possible treatment for cancer.

1991

The American Association for Advancement of Science (AAAS) endorses the testing and use of RU 486. Having secured AAAS support, the Feminist Majority Foundation successfully pursues RU 486 endorsements from almost every major scientific and medical organization in the country. FMF collects over 3,000 individual scientists’ petitions.

New Hampshire becomes the first state in the nation to pass a resolution urging the commencement of clinical trials of RU 486 in that state. FMF testifies before the New Hampshire legislature, and successfully urges other states to adopt resolutions based on the New Hampshire model.

FMF Board Chair Peg Yorkin announces an historic \$10 million dollar endowment and gift to the Feminist Majority Foundation and Fund. The donation is especially targeted for the Foundation’s Campaign for RU 486 and Women’s Health Research.

1992

A second FMF delegation, led by Smeal, Yorkin, and Jackman, meets with officials from Hoechst AG to urge U.S. marketing of RU 486, delivering an additional 110,000 petitions supporting RU 486.

FMF announces its Web of Influence Campaign to educate the public on U.S. companies and institutions that do business with Hoechst AG and Roussel Uclaf and to encourage those companies to ask that RU 486 be distributed here. FMF holds an RU 486 picket at the Treviera Twosome race in New York City, sponsored by Hoechst Celanese and Nike.

In the first direct challenge to the FDA import alert on RU 486, a pregnant American woman, Leona Benten, returns from

Europe with a prescription of RU 486. Customs officials seize the RU 486 upon the arrival of Benten and Larry Lader of Abortion Rights Mobilization at JFK Airport. Smeal joins Lader and Benten at JFK for a news conference condemning the ban.

Bill Clinton is elected President of the United States. After his election, FMF documents Clinton's campaign statements supporting RU 486 and prepares a memo urging steps that the new Administration could take to help make RU 486 available. FMF sends letters to Roussel Uclaf and Hoechst AG informing them that with Clinton's election and the election of more women and pro-choice members of Congress, the political obstacles to RU 486 in this country had effectively been removed.

1993

President Clinton issues an Executive Order instructing the FDA to re-evaluate the RU 486 import alert and directing the Secretary of Health and Human Services to "assess initiatives... [that can] promote the testing, licensing, and manufacturing of RU 486 or other antiprogestins."

Lader, along with Smeal, announces a strategy to remove Roussel Uclaf's patent on RU 486, using an existing law that allows Congress to remove patents on products not being marketed in the U.S. Lader also announces that the RU 486 compound has been replicated by scientists in New York State. Rep. Ron Wyden promises to hold a Congressional hearing on removal of patent rights if there is no agreement to commence U.S. trials in three months.

Shortly after, Hoechst AG and Roussel Uclaf say they will allow the Population Council to test and manufacture RU 486. However, Hoechst AG continues to prohibit Roussel Uclaf from selling RU 486 to a U.S. distributor in the interim, while an American manufacturer is established and gains FDA approval. FMF sends a letter,

with 100,000 more petitions, to Hoechst AG CEO Wolfgang Hilger urging the company to permit the sale of RU 486 to the U.S. during the interim period.

FMF outnumbers RU 486 opponents by 5-1 at a demonstration in front of the French Embassy called by Operation Rescue. Negotiations to allow the Population Council to seek FDA approval for RU 486 stall. The Feminist Majority continues its "No More Delays" petition campaign.

1994

Marking the tenth month of negotiations between the Population Council and Roussel Uclaf, the FMF sends another 50,000 petitions to Hoechst AG on the 20th anniversary of the *Roe v. Wade* Supreme Court decision legalizing abortion.

U.S. Health and Human Services Secretary Donna Shalala sets May 15 as the deadline for the conclusion of Population Council and Roussel Uclaf negotiations. Congressman Wyden schedules a May 16 RU 486 hearing.

On May 16, Roussel Uclaf assigns its U.S. patent rights for RU 486 without remuneration to the Population Council. The transfer of patent rights is attributed not only to the Clinton Administration, but also to the FMF's ongoing campaign. Roussel Uclaf's Dr. Sakiz wrote to Smeal, "it is mainly your own determination and that of all of the Feminist Majority Foundation's members and other pro-choice supporters that largely contributed to this successful issue."

FMF, in cooperation with the Population Council, announces the establishment of a revolving fund to raise money for mifepristone clinical trials and future anti-progestin research.

1995

With the award of U.S. patent rights to the Population Council, the Feminist

Majority Foundation spends the next five years working to end delays in arrangements for the manufacture and distribution of mifepristone, to prevent Congressional interference, and to keep women's groups and women's interests at the table throughout the long process of making mifepristone available to U.S. women.

1996

The Population Council submits to the FDA a New Drug Application (NDA) for mifepristone as an early abortion method. FMF President Eleanor Smeal serves on board of Advances in Health Technology, the initial non-profit organization created to represent women's groups in mifepristone distribution.

The FDA Advisory Committee on Reproductive Health Drugs holds a mifepristone safety and efficacy public hearing. FMF organizes testimony from women's and scientific organizations in favor of mifepristone. After hearing testimony, the Advisory Committee recommends approval of mifepristone.

The FDA takes the next step in the approval process by issuing an "approvable" letter in September to the Population Council in response to mifepristone NDA application.

1997

Hoechst AG turns over worldwide (non-U.S.) patent rights for mifepristone to Dr. Edouard Sakiz, whose new company, Exelgyn, will distribute the compound as a method of early abortion and will begin testing on the drug's other indications.

1999

Under agreement with Exelgyn, Population Council, and the Danco Group, the FMF is awarded sole responsibility for distributing mifepristone for compassionate use patients who suffer from serious or

life-threatening diseases and conditions for which no other treatment is available, such as meningioma (brain tumors).

2000

The FDA issues a second "approvable" letter in February. Final approval is anticipated later in 2000.

FMF leads the campaign with other major women's rights and medical organizations to oppose restrictions on mifepristone under FDA consideration that would have severely restricted the drug's availability. Final approval of mifepristone set the less onerous requirements that physicians be able to diagnose gestational age and ectopic pregnancy and that they be trained to provide surgical abortion or to refer patients to other physicians capable of performing this procedure.

Mifepristone is approved by the FDA on September 28 and is marketed by Danco Laboratories under the trade name Mifeprex. FMF declares a "total victory for U.S. women. At long last, science trumps anti-abortion politics and medical McCarthyism."

2001

In his confirmation hearing, Secretary of Health and Human Services Tommy Thompson said he might conduct a review of mifepristone. Later, Thompson backed away from his threat. During the 2000 campaign, President Bush pledged to sign any legislation restricting mifepristone.

The Feminist Majority Foundation launches the *Prescribe Choice* campaign to expand the availability of emergency contraception and mifepristone through campus health centers at colleges and universities nationwide.

2002

A study conducted in the United Kingdom and China found that

mifepristone has the potential to be used as a low-dose daily oral contraceptive.

The Journal of Biological Psychiatry published a study by Stanford University researchers finding that mifepristone is effective in treating psychotic depression. In a multi-center, Phase II study, two-thirds of patients showed dramatic improvement within 7 days of treatment. As an anti-glucocorticoid, mifepristone blocks the action of cortisol. High cortisol levels can cause extreme symptoms of depression such as hallucinations and paranoia. The FDA has placed mifepristone on the fast track for approval as a treatment for psychotic major depression.

Anti-abortion groups including Concerned Women for America, the American Association of Pro-Life Obstetricians and Gynecologists, and the Christian Medical Association submitted a 90-page petition to the Food and Drug Administration (FDA) asking for an immediate ban on mifepristone.

Danco announces that in the two years since FDA approval, 100,000 women have used mifepristone to terminate a pregnancy. Over 1 million have used mifepristone in Europe since its approval in France in 1988.

President Bush reconstitutes the FDA Reproductive Health Drugs Advisory Committee, which recommended approval of mifepristone in 1996. The panel now includes Dr. W. David Hager, who authored the Christian Medical Association petition to remove mifepristone from the market. The Feminist Majority Foundation and other women's organizations protested the appointment of Hager, who was initially slated to chair the committee but then was only appointed as a member.

Looking Towards the Future

Eighty-six per cent of U.S. counties and 95% of rural counties do not have an

abortion provider. The approval of mifepristone has the potential to increase the number of abortion providers by enabling doctors who do not currently perform surgical abortions to administer the medication from their private offices. Many doctors who do not perform surgical abortions have said that they would prescribe mifepristone for medical abortion. An increase in the number of doctors providing medical abortion will make it harder for anti-abortion extremists to target specific abortion providers and also improve women's access to safe abortion procedures.

The next step in the Feminist Majority Foundation's Campaign for Mifepristone & Women's Health Research is to mobilize the public and the scientific community to demand that clinical trials on mifepristone move forward. In the 1990s, anti-abortion politics brought mifepristone research to a virtual standstill. With FDA approval, supplies of the medicine are now available in the United States. The FMF will be leading the fight to urge the National Institutes of Health (NIH) – the largest funder of medical research in the world – and other research institutions to sponsor clinical trials on mifepristone's many promising indications.

RESTRICTIONS ON ABORTION

Parental Consent/Notification

Parental consent laws exist in 30 states, but the degree of parental involvement differs in definition from state to state. Fifteen states require the consent of one or both parents and 15 require notification of one or both parents. Eight states currently have parental consent or notification laws that have been enjoined and therefore are not in effect (Alan Guttmacher, *Issues in Brief*). Some states, such as Wisconsin, North and South Carolina, Iowa, and Delaware, allow for a close relative, counse-

lor, or physician (besides the one performing the abortion) to consent or be notified in place of a minor's parent.

All states with a mandatory parental consent law are required by the U.S. Supreme Court to have a **judicial bypass**. This provision allows minors to bypass the parental consent requirement only if a judge finds the teenager to be mature enough to make this decision (NARAL, "Executive Orders"). The judicial bypass does not take into consideration the position judges have on abortion or a minor's ability to attend a court hearing. The American Medical Association Council on Ethical and Judicial Affairs, the American Academy of Pediatrics, and other medical groups do not support parental consent laws because of the **increased risks to a minor's health from both delay and illegal alternatives** (NARAL, "In the Courts").

Becky Bell was a victim of the Indiana parental consent law requirement. In 1988, she chose to have an illegal abortion and died from massive infections at age 17. Parental laws do not reduce the need for teenage abortion. Minors often travel to surrounding states that do not have parental consent laws. This sometimes delays the procedure until the second trimester and increases the health risks for minors. Eleven percent of all abortions are performed after twelve weeks of pregnancy, 22% of the 11% are women under age 15, and 9% are women over the age of 20 (Brown).

Anti-choice legislators often argue that a minor is unable to make mature decisions about medical procedures, but most states consider a teenager "emancipated" for maternity care and surgery decisions made during delivery. Thirty-three states and the District of Columbia do not require parental permission if a minor decides to give up her child for adoption. Also, according to a 1995 survey, a teenage

mother has the authority to make health care decisions for herself and her child in 28 states and the District of Columbia (Alan Guttmacher, "Uneven and Equal").

Informed Consent/Waiting Periods

The 1992 *Planned Parenthood v. Casey* upheld mandatory 24-hour waiting periods. This case defines "informed consent" as information a woman should have about fetal development prior to having an abortion. The *Casey* decision provided states with legal backing to pass legislative restrictions on abortion. The number of states enforcing a mandatory waiting period has increased by 450%, from 2 to 11. Thirty-six states have abortion specific "informed consent" laws that require a woman to receive lectures on fetal development, prenatal care, and adoption. Eleven of these 36 states enforce a waiting period after a woman's consultation. The waiting periods differ in length, from 1 to 24 hours (NARAL, "Who Decides?").

As of 1992, 94% of non-metropolitan counties did not have an abortion provider, while 85% of women lived in non-metropolitan areas. Sixteen percent of women traveled 50 to 100 miles, while 8% traveled more than 100 miles for a non-hospital abortion. Women in North and South Dakota have only one abortion provider in each state (*Abortion Denied*). Mandatory waiting periods present serious financial barriers to low-income women that live in areas without abortion providers. Many women are unable to afford the travel expenses incurred by hotel, transportation, child-care (for mothers), and time off from work. The effects of mandatory delays increase women's health risks by delaying the procedure usually much longer than 24 hours.

Cutting of Medicaid – Hyde Amendment

The Hyde Amendment, first introduced in 1977 by U.S. Representative

Henry Hyde (R - IL), prohibited Medicaid funding of abortions. The amendment was passed as a rider to an annual funding measure for the Department of Health and Human Services and signed into law by President Carter. **By 1979, the U.S. Government had forbidden the use of federal dollars for abortions.**

The Hyde Amendment banned the use of Medicaid federal spending on abortions. The only exception, an abortion to save a woman's life, was added in 1981. Sixteen states and the District of Columbia continue to use state Medicaid funds to cover abortion, but only for women who are citizens of those states who meet eligibility requirements. Congress expanded Medicaid abortion coverage in 1993 to cover cases of rape and incest. In December of 1993, the Clinton Administration ordered six states to comply with the new law. Twelve lawsuits are currently pending concerning states' refusal to follow federal regulation (Planned Parenthood, "Medicaid Funding for Abortion"). **Rosie Jimenez**, a single mother in Texas on welfare with a five-year old daughter, was the first victim of the Hyde Amendment. Jimenez was saving money to attend college, and rather than spending the money on a legal abortion, she decided to have a back-alley abortion. She feared that if she gave up her tuition money, she would never make it off of welfare. Rosie Jimenez died in 1977 from this illegal abortion.

ADDITIONAL SUPREME COURT CASES

Bellotti v. Baird (1976) and Bellotti v. Baird II (1979)

In a series of decisions based on a Massachusetts parental consent law, the Supreme Court ruled that **young women do not have the same constitutional protection of access to abortion as adult women.** In *Bellotti v. Baird*, the Court held that a Massachusetts law requiring consent from both parents before a minor could obtain

an abortion would be constitutional as long as the state instituted a judicial bypass procedure. In 1979, the Court ruled in the subsequent *Bellotti v. Baird* (Bellotti II) decision by 8-1 that state parental consent laws must permit a minor to seek a judicial waiver of parental consent. The Court further stated that **judicial permission for an abortion must be granted if the judge finds that the minor is mature or that the abortion is in the best interests of the minor.** Later decisions reaffirmed the judicial bypass requirement on parental consent and notification measures.

Harris v. McCrae (1981)

Several Supreme Court decisions allowing states and municipalities to restrict the use of public dollars and public facilities for "elective" abortions culminated in the Court's 1981 *Harris v. McCrae* ruling upholding a ban on federally funded abortions, except to save the life of the woman. In the Harris decision, which upheld the 1977 Hyde Amendment, the Court ruled that "although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation" such as economic deprivation. In other words, **the Court said the government has no affirmative obligation to provide public funds to provide the legal right of abortion to poor women.** The Court upheld additional abortion restrictions following *Harris*.

Thornburg v. American College of Obstetricians and Gynecologists (1986)

The U.S. Supreme Court ruled against a restrictive Pennsylvania law in a 5-4 decision. The Court struck down sections of the law requiring the provision of anti-abortion information to patients. The provisions specified the use of procedures to preserve the life of the fetus in post-

viability abortions even if the procedures jeopardized the woman, and mandated the presence of a second physician in post-viability abortions.

Writing for the Court, Blackmun more explicitly framed the right to choose an abortion in women's terms:

"Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government... That promise extends to women as well as to men. Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision - with the guidance of her physician and within the limits specified in Roe - whether to end her pregnancy. A woman's right to make that choice freely is fundamental. Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all."

Webster v. Reproductive Health Services (1989)

In a major setback for abortion rights advocates, the U.S. Supreme Court, in *Webster v. Reproductive Health Services*, upheld in a 5-4 ruling a Missouri law restricting abortion. The case was brought by five health professionals employed by the state, the Reproductive Health Services clinic, and Planned Parenthood of Kansas City. The law declared that life begins at conception, prohibited public employees from performing or assisting abortions not necessary to save the woman's life, outlawed the use of public facilities for abortions not necessary to save the life of the woman, and required physicians to perform fetal viability tests.

Anticipating that the Court's decision would invite more state restrictions on abortion, Blackmun concluded in his dissent: "For today, at least, the law of abortion stands undisturbed. For today, the women of

this Nation still retain the liberty to control their destinies. But the signs are evident and very ominous, and a chill wind blows."

Planned Parenthood of Southeastern Pennsylvania v. Casey (1992)

Without overturning *Roe*, the U.S. Supreme Court in *Planned Parenthood v. Casey* upheld almost all of the abortion restrictions contained in the Pennsylvania Abortion Control Act (1989). The only part of Pennsylvania's abortion law that the Court struck down was the mandatory spousal consent provision for married women seeking abortions. The Court failed to repeal restrictions including informed consent, 24-hour waiting period, and publicly accessible statistical data on provision of abortion services.

Stenberg v. Carhart (2000)

In a narrow 5-4 decision, the U.S. Supreme Court ruled that abortion procedure bans that anti-choice abortion forces call "partial-birth" abortion bans are unconstitutional, as they create an "undue burden" on women seeking abortions. The court's ruling struck down the Nebraska law along with similar laws which had been enacted in 30 other states. The majority of these bans did not include exceptions for the life or health of women, nor did they provide clear guidelines to physicians about which specific abortion procedures the bans prohibited.

In fact, "partial birth" abortion is not a medical term and does not identify any particular abortion procedure. It is a deliberately vivid and inaccurate term invented by anti-choice extremists that has been refuted by doctors all over the country. These bans that are more correctly called abortion procedure bans could actually prohibit safe and common abortion procedures used in the 2nd and even 1st trimester of pregnancy.



Unit 2 ■ Reproductive Choices: The Struggle for Change

These abortion procedure bans represent yet another anti-choice attempt to chip away at *Roe v. Wade*. Though unsuccessful, with anticipated retirements of U.S. Supreme Court Justices in the next few years and the very real possibility that

George W. Bush will nominate anti-choice justices to replace pro-choice justices, the very narrow 5-4 pro-choice majority that affirmed *Roe* in *Planned Parenthood v. Casey* and *Stenberg v. Carhart*, could tip to a 5-4 anti-choice majority.

Feminist Majority Foundation Campaigns

The Feminist Majority Foundation Choices Campus Leadership Program is currently working on two national campaigns: Prescribe Choice (including our Emergency Contraception Over-the-Counter Initiative) and Never Go Back.

PRESCRIBE CHOICE AND EMERGENCY CONTRACEPTION OVER-THE-COUNTER

Campaign to improve women's health services on campus, increase campus availability of emergency contraception and mifepristone, improve health center services for sexual assault survivors, and make emergency contraception available over-the-counter in the U.S.

NEVER GO BACK

Public education campaign about the impending threat to legal abortion, the role of the Supreme Court in affirming or overturning *Roe v. Wade*, and the importance of the filibuster as a winnable strategy for stopping anti-choice judicial nominees.

Pro-Choice Speakers Bureau

A speakers bureau is a team of Leadership Alliance members who are trained in conducting pro-choice educational presentations for the campus community. This team will advertise its services to dorms, student organizations, classes, and other campus groups. These groups will then invite the speaker's bureau to conduct its pro-choice programming for their group. Essentially, your Leadership Alliance speakers bureau is a travelling band of teachers, disseminating pro-choice education throughout your campus.

Organizing a pro-choice speakers bureau is an excellent way to expose a wide range of students on your campus to pro-choice reproductive rights education. The speakers bureau also offers Leadership Alliance organizers an excellent opportunity to practice public speaking, professional presentation, and innovative peer teaching strategies. The action is a means by which leaders can creatively apply the information they have learned in this unit of the Study and Action Manual. Your Leadership Alliance can design the educational campaign in a variety of ways, using a broad range of teaching methods, exercises, and materials for your presentations.

PEOPLE POWER AND COMMITTEES

There are two main components involved in organizing a pro-choice speakers bureau. First, you need to train your speakers. Next, you need to organize the actual presentations.

- You will need between 6 and 12 Leadership Alliance members participating in the speakers bureau, as well as FMLA Alumnae, community activists, local experts (perhaps clinic workers), and professors to help you organize and conduct the training sessions. These people will also work on developing the presentation materials and the training.
- We recommend dividing the work among different students in the Leadership Alliance by organizing committees. Some suggested committees include:

Presentation Committee Utilizing Unit 2 of the SAM, this group will develop the content

of the presentation, in addition to developing creative ways of presenting the materials. One suggestion is to view *Abortion for Survival* and/or *Abortion Denied* as a part of the presentation. Additional sources of information include our website at (www.FeministCampus.org), Campus Organizers, community leaders, and FMLA alumnae.

Training Committee – This group will organize the speakers’ training sessions. In addition to using the materials that will be a part of the presentations as basis for training, this committee should also invite local clinic workers, and knowledgeable professors to participate in the training sessions.

Speakers Committee – This group should commit to participating in all of the trainings, as well as be willing to regularly set aside time to conduct educational presentations.

Advertising/ Publicity Committee – This committee is responsible for advertising the services of the speakers bureau throughout campus and the surrounding community, in addition to setting up presentation engagements with campus groups.

MATERIALS AND EQUIPMENT

- Space reserved for training and/or presentations
- Hand-outs and evaluations for distribution to audiences
- Any overheads, projectors, videos and VCRs you will need
- Large poster pad (with tape or a stand) and markers, or chalkboard and chalk for the presentation
- All presentation notes and reference notes
- Leadership Alliance information and sign-in sheet

TIMELINE

The major time investment for this project is its set up – the development of the presentation and the training. This process could take up to two months. Contacting faculty and community pro-choice activists, and pulling together the training session will take the bulk of that time. Of course, the project, once set up, will be ongoing.

BUDGET

This project can be organized with very little money, although some financial investment is necessary. Costs will vary widely depending on your choice of materials and publicity, as these are the major costs for the action. You will need to pay for ads in newspapers, paper and photocopies for flyers and training materials, materials for distribution during the presentation, any overheads or visuals you will use during your presentation, writing materials for your training and presentations, and any food you will have at your training and/or presentations.

PUBLICITY

Refer to www.FeministCampus.org for strategies and suggestions on successful advertising for your project. However, the groups you should most heavily target with your publicity are dorms, sororities, the executive councils of student organizations, Women’s Studies professors, the first year orientation coordinator, and other campus group leaders.

SOME HELPFUL HINTS

Presentation Tips

The most important and difficult part of this action is developing your pro-choice educational presentation – essentially the “product” you will be delivering to your campus community. The bulk of your information will come from Unit 2 of the SAM. Because you are advertising your service throughout campus, groups will be turning to you as reproductive rights “experts,” and “experts” you must be! To ensure that your presentation is as professional and successful as possible, you should:

- Know your sources. Don’t just ramble off figures, but make sure you know where those figures came from and that they are current and accurate.
- Provide visual aids and handouts. The more ways in which you present the material, the better the chance your audience will absorb it. Moreover, handouts and visual aids, overheads, or video clips keep things interesting.
- Keep your presentation brief (about one hour or less) and well organized. When presenting, a great outline is always: “This is what I am going to talk about,” then talk about it, and finally end with “this is what I just said.”
- Leave time for questions and answers. All members of the speakers bureau **MUST KNOW THE FACTS** as well as where to turn for more information!
- Consult Leadership Council members, faculty, and local experts for advice on, and participation in, your presentations. Also, run your ideas by your Leadership Alliance Campus Organizer.
- Always work in pairs while conducting a speakers bureau presentation— if two people can’t be there to conduct the session, then you should reschedule.

Training Tips

The next vital component of a successful speakers bureau program is providing thorough training for all speakers. All presenters must be well trained in the content and delivery of the presentation, as well as have a thorough understanding of the issues in order to answer questions and refer peers to additional resources. To ensure that your training helps speakers achieve this level of competency and professionalism:

- Include a great deal of rehearsal and role playing exercises in which speakers trade off presenting different aspects of the program with asking questions of the presenter.
- Have speakers watch others present the program before conducting it themselves.

Tips for the Long Term

- Periodically gather the speakers together to re-assess the presentation. Is it going well? What are some common questions? What is the response? How can the presentation be improved or updated?
- As with all successful educational presentations, your speakers bureau should include an opportunity for feedback. Handing out anonymous evaluation forms after the presentation is one good method of getting constructive criticism.

- Be creative. There are a variety of ways to vary your presentation in order to keep it interesting and innovative. For groups that have already seen your presentation, offer additional reproductive rights educational programming. For example, you might suggest that they view *Abortion Denied*, *Abortion for Survival*, or another pro-choice film. Also, try organizing informal “teach-in” discussions including peer educators from your speakers bureau, professors specializing in reproductive rights history and research, and local clinic workers. In a “teach-in,” the “experts” and audience sit in a circle and each “expert” is given the opportunity to speak briefly. Panel and audience members then engage in an informal discussion.

Additional Actions

“DID YOU KNOW” CAMPAIGN

This is a high visibility action. It involves choosing particularly important, little known, and/or shocking statistics from SAM and videos and putting those facts on brightly colored flyers or posters. To grab attention, the facts should all be under the heading, “Did You Know?” or another catchy phrase.

PRO-CHOICE FILM FESTIVAL

This involves showing pro-choice films such as *Abortion Denied*, *Abortion for Survival*, *If these Walls Could Talk*, *Jane: An Abortion Service*, *When Abortion was Illegal: Untold Stories*, *From Danger to Dignity: The Fight for Safe Abortion*, and *The Fragile Promise of Choice*. For more information on these videos and how to obtain copies of them, consult the list of films suggested for the anniversary of *Roe v. Wade*.

WHAT’S THE STATE OF YOUR STATE?

Find out the current laws, incidence, and accessibility of abortion in your state. Then, let your campus know! This information is available through the NARAL: Pro-Choice America’s annual publication, *Who Decides? A State by State Review of Abortion and Reproductive Rights*. To obtain a copy of the book, call NARAL at (202) 973-3000, or call your Campus Organizer to send you the information on your state. *Who Decides?* is also available online via NARAL at <http://www.naral.org>. Alternatively, you can call your state legislator to obtain a copy of the laws for your state, although the NARAL book and website are helpful in understanding the laws and their repercussions.

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