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Reproductive Freedoms and African American Women

Charlotte Rutherford, Esq.†

I. INTRODUCTION

As an African American, a civil rights lawyer, a mother, and a feminist, I view reproductive freedoms for African American women from both a personal and professional perspective. Reproductive freedoms are life and death issues for many African American women and, as such, deserve as much recognition as any other freedom. Despite the importance of reproductive freedom in the lives of African American women, traditional civil rights and women's organizations have ignored these interests.

This paper grows out of a speech I delivered at the Third Annual Conference of Women of Color and the Law. I was asked to speak about “Women of Color and Reproductive Rights.” I struggled with using that title for this paper because the term “reproductive rights” is a factually and conceptually misleading term. Too often, reproductive rights are defined solely as a woman’s right to an abortion. Poor women, however, do not have such a “right” in most states. Even though abortion is legal, poor women probably cannot afford one; in practice, therefore, no such “right” exists.

African American women seek “reproductive choice.” We want the power to make genuine choices about our reproductive health. Such choices must be informed and supported by access to quality health care. Unfortunately, the term “reproductive choice” is used synonymously with reproductive rights, and the meaning of choice again is narrowed to focus on the right to abortion. Instead of the terms “reproductive rights” or “reproductive choice,” I have selected “reproductive freedom” because of the term’s powerful symbolic and historic image. In addition, it accurately describes the desires and needs of

† Associate Counsel and Director, Black Women's Employment Program, NAACP Legal Defense and Educational Fund, Inc.; B.S. Portland State University, 1976; J.D. Howard University School of Law, 1983; LL.M. Georgetown University Law Center, 1985. The viewpoints expressed in this article are solely those of the author and do not necessarily reflect the views of the Legal Defense Fund. The author extends many thanks to Kim Barker, New York University Law School student, for her research and editing assistance as well as support in completing this paper.

1. The term “women of color” has been limited to African American women in the title of this paper because most collected and compiled data focuses only on African American and white women or white and non-white women. Data for all women of color groups in all of the subject areas discussed in this paper is not available. To the extent that it is available, however, data for other women of color groups is included.

2. Since the first days of slavery, the struggle for freedom has been the province of African Americans in the United States. That struggle is one of our most significant contributions to American history and
African American women.

This article challenges the reader to accept a definition of reproductive freedom which is broader than the right to abortion. African American women want and need reproductive freedoms that range from terminating unplanned and unwanted pregnancies to delivering healthy babies under healthy circumstances. This article also urges civil rights and women's groups to address in their respective agendas the reproductive health needs of African American women. Neither advocacy group has fought to recognize or secure reproductive freedoms for African American women as we define those freedoms. Without the active support of advocacy organizations, African American women find ourselves without a voice and often overlooked in discussions on reproductive issues.

When amicus curiae briefs for Webster v. Reproductive Health Services were organized, African American women's groups asked the NAACP Legal Defense and Educational Fund, Inc. (LDF) to write a factual argument on behalf of African American women who would be adversely affected by abortion restrictions. After much internal debate, leaders of the organization realized that the staff and supporters of LDF, like much of the African American community, were not unified on the issue. Furthermore, LDF had not concerned itself with or defined its position on the issue of abortion. Ultimately, LDF did not enter the case.

After LDF decided not to address the issues raised in Webster, a group of nationally recognized African American women active in public policy issues, including abortion rights, met with the LDF staff. They informed us that "[c]hoice is the essence of freedom" and that African American organizations historically have struggled to achieve freedom of choice in all areas of life. They contended that reproductive freedoms for African American women are as important as the freedom to choose a seat on a public bus, to attend a public

culture. African American women have participated fully in the fight for freedom. Harriet Tubman, Sojourner Truth, Ida B. Wells, Mary McLeod Bethune, Rosa Parks, Daisy Bates, Ella Baker, Fannie Lou Hamer, Pauli Murray, Shirley Chisholm, Angela Davis, and Mary Frances Berry, to name a few of our best known champions, form a long and continuous line of freedom fighters. My use of the term freedom in the context of reproductive issues and African American women adds the unique historical and cultural dimension of Africans in America to the discussion of reproductive health issues.


4. Women of color issues were represented among the briefs that were filed in Webster, but those issues were not presented by the organization that historically has championed the rights of people of color, particularly African Americans. The Center for Law & Social Justice, the National Conference of Black Lawyers, the National Lawyers Guild, and the Center for Constitutional Rights (counsel of record) represented the following amici curiae: National Council of Negro Women, Inc.; National Urban League, Inc.; The American Indian Health Care Association; The Asian American Legal Defense Fund; Committee for Hispanic Children and Families; The Mexican American Legal Defense and Education Fund; The National Black Women's Health Project; National Institute for Women of Color; National Women's Health Network; Organizacion Nacional de la Salud de la Mujer Latina; Organization of Asian Women; Puerto Rican Legal Defense and Education Fund; Women of Color Partnership Program of the Religious Coalition for Abortion Rights; Women of all Red Nations, North Dakota; YWCA of the U.S.A.; and other organizations.

school, or to live or work without restriction. They maintained that reproductive freedoms are civil rights issues for African American women and that LDF's voice needed to be heard.\footnote{African Americans have struggled to obtain full citizenship status and rights since the days of slavery. One of the most horrendous aspects of slavery, particularly for female slaves, was the master's complete control of the slave's body, including her sexual and reproductive life—an individual's most personal domain. Without the legal sanction of slavery, women who had been slaves were no longer required to bear children in order to enhance the slave master's property holdings, and they were allowed to keep and raise their own children. Bodily integrity and control over her reproductive capacity were as essential for the newly freed African American woman as the ability to leave the plantation and to work for pay. Many African American women today view reproductive choice issues as civil rights issues in much the same way as slave women viewed the continuum of freedoms they sought. As the oldest legal organization advocating on behalf of African Americans, LDF is an essential player in the struggle to secure reproductive choices for African American women.}

This group of African American women acknowledged that the African American community, especially male African American civil rights and religious leaders, did not visibly support choice. They reminded us that African American women, particularly teens, use abortion services at disproportionately high rates, which demonstrates that access to abortion services is vital to African American women. Furthermore, as one participant cogently noted, "we [women] are not making these babies alone . . . yet."\footnote{Author's recollection of statement by one of the participants.} Abortion is a family issue; many men support the choice to terminate unplanned and unwanted pregnancies.

Although not all African American and other women of color are poor, a disproportionate number of us are poor\footnote{In 1990, 29.3% of all African American families had incomes below the poverty level, compared to 8.1% of white families and 10.7% of families of all races. BLACK AMERICANS: A STATISTICAL SOURCEBOOK 285 (Alfred N. Garwood ed., 1992).} or near poor.\footnote{The "near poor" are defined as people with incomes below 150% of the poverty level. In 1987, one in four women between the ages of 15 and 44 was below 150% of poverty, and one in three had an income less than 200% of the poverty level.} Even many of us with upper incomes are closer to our poorer sisters than it might appear—missing two paychecks can make the difference between solvency and the brink of homelessness.\footnote{In 1988, 44.5% of all African American households were able to acquire interest-earning assets at financial institutions, while 76.6% of all white households held such assets. Another 1.9% of African American households held other interest-earning assets while 10.5% of white households held such assets. BLACK AMERICANS: A STATISTICAL SOURCEBOOK, supra note 8, at 293.} The amount of income and type of health

\begin{itemize}
\item 6. African Americans have struggled to obtain full citizenship status and rights since the days of slavery.
\item 7. Author's recollection of statement by one of the participants.
\item 8. In 1990, 29.3% of all African American families had incomes below the poverty level, compared to 8.1% of white families and 10.7% of families of all races. BLACK AMERICANS: A STATISTICAL SOURCEBOOK 285 (Alfred N. Garwood ed., 1992).
\item 9. The "near poor" are defined as people with incomes below 150% of the poverty level. In 1987, one in four women between the ages of 15 and 44 was below 150% of poverty, and one in three had an income less than 200% of the poverty level.
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\end{itemize}
insurance coverage one has determine one’s reproductive choices. Irrespective of what the law might state one’s reproductive rights to be, if money is needed to exercise those rights, most African American women and other poor women of color will not have many. The reproductive rights and choices of poor women of color are fairly limited and sometimes non-existent.

Moreover, the women also informed LDF that the question of race “colors” the definition of reproductive issues for African American women. The question of choice for African American women is not limited to the issue of abortion. African American women truly want choices—the choice of terminating an unplanned pregnancy as well as the choice of having a healthy baby. But as a result of our limited financial resources, many poor African American and other women of color find that reproductive health care that ensures healthy mothers and babies is unavailable. This leaves many African American women without meaningful choices.

Finally, the women informed us that white women’s organizations fail to address their broader definition of choice (discussed fully below). Discussions and policy decisions in the area of reproductive rights generally focus solely on abortion. Important reproductive freedoms for African American women and other poor women of color are not identified, fought for, or secured by either traditional civil rights or white women’s groups.

As a result of the dialogue with the persuasive sisters, LDF agreed to recognize reproductive health as an important civil right for African American families and to represent those interests. In order to determine the specific focus of LDF’s reproductive health docket, we met with direct service providers, public health policy experts, consultants, and African American women involved in reproductive health issues. This paper represents the opinion of those advocates and experts with whom we met and of the African American sisters who persuaded us to address the issue. They all stated emphatically that reproductive choice for African American women must encompass a broad definition of reproductive health issues, rather than focus only on the issue of access to abortion services.

At a minimum, reproductive freedoms for poor women should include:
1) access to reproductive health care;
2) access to early diagnosis and proper treatment for AIDS, sexually transmitted diseases, and various cancers;

affluent African American households have not acquired significant financial cushions with which they can remain solvent during hard economic times caused by illness and loss of work.

11. In 1985, 73% of all women aged 15 to 44 had some form of private insurance, 10% were covered by public sources, primarily Medicaid, and 17% were uninsured. Almost all private insurance covers surgery, hospital care, and diagnosis and treatment of illness, but over 80% of policies do not include office visits or services for preventive care, such as contraception. “Adding an estimated 59 percent of all women who are not covered for preventive care (80 percent of those covered by private insurance) to the 17 percent who have no health insurance at all indicates that at least 76 percent of all women of reproductive age must pay themselves for preventive, nonsurgical reproductive health care.” FORREST ET AL., supra note 8, at 18.
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3) access to prenatal care, including drug treatment programs for pregnant and parenting drug abusers;
4) access to appropriate contraceptives;
5) access to infertility services;
6) freedom from coerced or ill-informed consent to sterilization;
7) economic security, which could prevent possible exploitation of the poor with surrogacy contracts;
8) freedom from toxins in the workplace;
9) healthy nutrition and living space; and
10) the right to safe, legal, and affordable abortion services.

I will not address all of the issues identified above in this paper. I have selected those issues that are either of concern to the greatest number of women or rarely ever discussed as they apply to African American women. I discuss why, at a minimum, a broad definition of reproductive freedoms must include access to adequate prenatal care; access to sex education and appropriate contraceptives; access to infertility services, including early diagnosis and proper treatment for preventable causes of infertility; concern about surrogacy and the potential exploitation of poor women of color; freedom from coerced or ill-informed consent to sterilization; freedom from reproductive hazards in the workplace; and, last but not least, the option of abortion. This paper will also provide some information on current legislative efforts to improve the delivery of services in some of the critical areas mentioned above.

II. PRENATAL CARE

As a result of inadequate prenatal care, African American mothers and babies unnecessarily die at disproportionate rates compared to white mothers and babies. Lack of prenatal care can result in low birth weight babies, infant mortality, and maternal mortality. “Babies born to mothers receiving no prenatal care are three times more likely to die in infancy than those whose mothers do receive such care.” This problem is particularly relevant to African Americans, whose infant mortality is twice that of whites. The fact

12. Low birth weight, defined as less than 5.5 pounds, is a leading cause of infant death. “Small babies who survive face an increased risk of being impaired for life by autism, retardation, cerebral palsy, epilepsy, learning disabilities, and vision or hearing loss.” CHILDREN’S DEFENSE FUND, A VISION FOR AMERICA’S FUTURE: AN AGENDA FOR THE 1990s 38 (1989).


14. Id. at 21.

In 1987, more than 38,000 infant deaths were recorded in the United States. Infant mortality is highest among Blacks—17.9 per 1,000 live births. For Whites, the 1987 infant mortality rate was 8.6; for all minority races as a group, it was 15.4. The overall infant mortality figure for American Indians and Alaska Natives in Reservation States is 9.7, based on 1984-86 data, but
that African American babies are twice as likely as white babies to be born to mothers who received late or no prenatal care contributes significantly to the disproportionately high infant mortality rate of African American babies.\textsuperscript{15}

In 1986, African American women were 3.8 times more likely than white women to die from pregnancy-related causes. All women of color were 3.3 times more likely than white women to die from pregnancy-related causes. The leading causes for these maternal deaths are considered "preventable or probably preventable through routine medical care before pregnancy, early and continuous prenatal care, risk appropriate delivery procedures, and routine care after birth."\textsuperscript{16}

As a result of inadequate prenatal care, African American mothers and babies are unnecessarily dying. Supporters of reproductive choice should support a woman's choice to bear a child and should advocate for better and more available prenatal care.

III. CONTRACEPTIVES AND SEX EDUCATION

Adequate education about the proper use of and access to contraceptives is essential to prevent unwanted pregnancies for sexually active heterosexual women. Each year, more than half of the over six million American women who become pregnant do so unintentionally.\textsuperscript{17} Of the approximately 3.4 million women with unintended pregnancies each year, forty-three percent, or approximately 1.5 million, practiced some form of contraception.\textsuperscript{18}

A society as divided as our own on the issue of pregnancy termination should encourage pregnancy prevention through education and easy access to contraceptives. Sex education and information about various forms of contraceptives ought to be widely available to younger as well as older women.

when measured separately, the rate for Alaska Natives is unusually high. Available records indicate that infant mortality among U.S. Hispanics, at 7.9, compares favorably with rates among non-Hispanic Whites. Some Asian-American groups, including Chinese, Japanese, and Filipino, have unusually low infant mortality rates, ranging from 4.0 to 4.7 (1986 data).


15. CHILDREN'S DEFENSE FUND, BLACK AND WHITE CHILDREN IN AMERICA: KEY FACTS 76 (1985). Nearly one African American baby out of ten is born to a mother who received late or no prenatal care. Among African American teenage mothers under age 15, the proportion increases to two in ten. Id. at 76. Blacks were more than twice as likely as Whites to have late (third trimester) or no prenatal care (11.1 percent vs. 5.0 percent), and the frequency of late or no care among American Indians was at least as high as that for Blacks—11.7 percent. Only 5.8 percent of Asian and Pacific Islander mothers delayed or did not obtain prenatal care. . . . Overall, 12.7 percent of Hispanic mothers had late or no care, while only 4.1 percent of non-Hispanic White mothers did. Non-Hispanic Black mothers had late or no care in 11.6 percent of cases. Within the Hispanic population, the percentages range widely, from 3.9 percent of Cuban mothers to 17.1 percent of Puerto Rican mothers.

U.S. DEP'T OF HEALTH AND HUMAN SERVICES, supra note 14, at 96.


17. RACHEL B. GOLD, ABORTION AND WOMEN'S HEALTH 11 (Alan Guttmacher Institute, 1990).

18. Id. at 12, 13.
School-based clinics (SBC’s) have proven effective in providing basic health care and contraceptive counseling to medically underserved teenagers, but unfortunately, the clinics are not widely available.\textsuperscript{19}

So little money has been invested in research about contraceptive methods that American women today have fewer contraceptive options than European women.\textsuperscript{20} Since the advent of the Pill in 1960, only one truly new contraceptive method—Norplant—has been approved by the Food and Drug Administration (FDA) for American markets. As discussed below, Norplant has not been welcomed unanimously and has the potential for misuse among poor African American women.

Approved by the FDA in December 1990, Norplant consists of six matchstick-sized rubber tubes filled with a steroid commonly used in contraceptive pills. The tubes are imbedded under a woman’s skin, usually inside her upper arm. The steroid is released slowly for up to five years, preventing pregnancy by suppressing ovulation. It has a 99.8 percent success rate\textsuperscript{21} and must be surgically removed.

Norplant operates like temporary sterilization and has been imposed as a criminal penalty for mothers who are convicted of child abuse\textsuperscript{22} and women

\textsuperscript{19} CENTER FOR POPULATION OPTIONS, SCHOOL-BASED CLINICS ENTER THE ‘90S: UPDATE, EVALUATION AND FUTURE CHALLENGES 1 (1989). There are only 150 school-based clinics that operate in middle, junior, and senior high schools. Most of these provide:

- primary health care, physical examinations, laboratory tests, diagnosis and treatment of illness and minor injuries, immunizations, gynecological exams, pregnancy testing and counseling, referral for prenatal care, birth control information and referral, nutrition education, weight reduction programs and counseling for substance abuse. Some offer prenatal care on site; a few dispense contraceptives and provide day care for children of students.

\textsuperscript{20} Nine new contraceptive methods were made available during the period 1980-1990. Most of them are only available abroad.

- Injectable steroids, for example, are now available in 90 countries. France and China offer RU-486, an abortion pill, with Sweden, the Netherlands and Britain perhaps soon to follow. In the United States, only a low-dose oral contraceptive, an IUD called the copper-T830A, the contraceptive sponge—and last week Norplant—reached consumers. Some former options, including five types of IUD’s, simply vanished in the litigious 1980s, although most were never shown to be unsafe, leaving women with fewer birth-control choices than they had five years ago. “The United States is the only country other than Iran in which the birth-control clock has been set back during the past 10 years,” says Carl Djerassi, who helped synthesize the Pill in 1951.


\textsuperscript{22} Darlene Johnson, a 27-year-old pregnant African American mother of four, was convicted of child abuse after beating two of her children with a belt and an electrical extension cord because she found them poking a wire in an electric socket. California Judge Howard Broadman gave Johnson the option of spending one year in prison and three years on probation, or four months in prison, three years on probation, and three years on Norplant. Johnson, unrepresented at sentencing, chose the Norplant sentence, but when she later changed her mind, the judge refused to change the order. The sentence has been appealed on the grounds that it violates her procreative rights, invades her privacy, and entails a judge practicing medicine without a license. Billy Allstetter, \textit{Compulsory Conception: Does the Punishment Fit
of childbearing age who have been convicted of drug possession.\textsuperscript{23} Furthermore, legislation that provides financial incentives to women receiving welfare in order to encourage their “voluntary” use of Norplant has been introduced in Louisiana and Kansas and is under consideration in several other states.\textsuperscript{24} While access to abortion services is denied public funding in most states, Norplant is funded by Medicaid in every state except California and Massachusetts.\textsuperscript{25}

While providing poor women with access to Norplant (which currently costs about $350 for the device, $90 for insertion, and $84 for removal) is laudable, offering cash incentives to poor women who are on welfare to encourage their use of Norplant should not be allowed. From the woman’s perspective, the primary issue is whether she has chosen voluntarily to restrict her procreative ability or has been unduly enticed to do so because of her limited economic situation. Another question is whether she had adequate information, including knowledge of other contraceptive options, with which to make an informed decision to use the device.

My primary concern, however, is that using cash incentives to encourage Norplant use among women receiving welfare is the wrong emphasis and sets the wrong tone. Limiting the procreative rights of poor African American women will not eliminate the root causes of poverty, which are racism, sexism, and classism. Fewer children will not ameliorate the lack of jobs and the poverty among African Americans, and we should not accept a policy position which implies that our disproportionate poverty rates can be solved if African Americans merely have fewer children. A policy targeting welfare women (mistakenly believed by most Americans to be primarily African Americans) is grounded in the same racism and classism that causes poverty and should not be permitted. At the same time, however, poor African American women should have the same procreative options which are available to affluent women, including Norplant if that is their choice.

Women must be able to control our reproductive lives; control must remain in our hands, not the hands of the doctor or the state. No coerced form of contraception should be approved or legislated. Even in rare cases where a woman has been convicted of child abuse or neglect, society should not permit courts to mandate her reproductive choices instead of ensuring through treatment that such behavior does not happen again. Women who want children

\textsuperscript{23} Legislation introduced in Kansas would require Norplant use for women of childbearing age convicted of felony possession or distribution of cocaine, crack, or heroin. Rees, supra note 21, at 16. \textsuperscript{24} Id. at 16. \textsuperscript{25} California Governor Pete Wilson allocated an extra $5 million to the Office of Family Planning to make Norplant available to poor women who are not eligible for Medicaid or Medi-Cal. Id. at 16. See also Editorial, Welcome Contrast on Birth Control, L.A. TIMES, May 20, 1991, at B4; Daniel Weintraub & George Skelton, Wilson Favors Use of Birth Control Implant, L.A. TIMES, May 17, 1991, at A1.
must be able to decide the number and timing of their children, and they must make those decisions fully informed of both their reproductive choices and the consequences of those choices.

Access to reproductive services and information, including information about the option of abortion, is being restricted for poor women, particularly women of color, who disproportionately rely on federally funded family planning clinics for contraceptives and general reproductive health services. The Supreme Court’s 1991 decision in Rust v. Sullivan forces family planning clinics to choose between receiving federal funding or providing unrestricted medical information to their pregnant patients; many clinics will reduce services rather than cease abortion counseling.

Rust v. Sullivan upheld regulations issued by the Department of Health and Human Services under Title X of the Public Health Service Act. The regulations restricted the speech of doctors and health professionals by prohibiting them from advising their pregnant patients about the abortion option, even if their patients expressly ask for such information. Nevertheless, the Supreme Court found them constitutional. Moreover, the Court upheld the “Gag Rule” requirement that a federally funded Title X program must be separated from a clinic’s range of other services, including

27. An informal telephone survey conducted by an LDF intern in October 1991 revealed that the “Gag Rule” provisions upheld in Rust had not yet been implemented and therefore clinics had not yet been affected. Most Planned Parenthood affiliates (representing 17% of all Title X clinics) reported that they would forego federal funds rather than compromise staff’s ability to provide abortion counseling and referrals. Other clinics were concerned that the Gag Rule would create conflicts with state informed consent laws governing doctors. These providers also indicated that they would forego federal funds.

The Alan Guttmacher Institute released a memorandum on the “Effects of Implementing the Gag Rule” on July 15, 1991, which stated:

Nationally, Title X contributed one-third of all public dollars spent for family planning in 1987 and well over half of all funds in some states. It is a major source of stable support for most clinics. (Medicaid, the Maternal and Child Health and Social Services block grants as well as state and local revenues contribute the balance.) Loss of Title X funding would so undermine the financial viability of many facilities that it would precipitate their closure.

Memorandum from the Alan Guttmacher Institute to Interested Parties 2 (July 15, 1991) (on file with author) (footnote omitted).
29. 42 C.F.R. §§ 59.7-.10 (1991). Section 59.8(a)(1) states that “a title X project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning.” Section 59.8(a)(2) states that Title X projects must refer every pregnant client “for appropriate prenatal and/or social services by furnishing a list of available providers that promote the welfare of mother and unborn child.” A Title X project is expressly prohibited from referring a pregnant woman to an abortion provider, even upon specific request. When asked for a referral to an abortion provider, the Title X doctor or health professional must tell the pregnant woman that “the project does not consider abortion an appropriate method for family planning and therefore does not counsel or refer for abortion.” 42 C.F.R. § 59.8(b)(5). The regulations broadly prohibit a Title X project from engaging in activities that “encourage, promote or advocate abortion as a method of family planning.” 42 C.F.R. § 59.10(a). Section 59.9 requires that Title X projects be organized so that they are “physically and financially separate” from prohibited abortion activities and that “[m]ere bookkeeping separation of title X funds from other monies is not sufficient.”

Challenges to the regulations contended that they were contrary to the underlying statute and that they violated First Amendment rights of doctors, staff, and patients and Fifth Amendment rights of pregnant women to make informed decisions about whether or not to exercise their constitutional right to abortion. Rust v. Sullivan, 111 S.Ct. at 1771-72, 1777.
publicly sponsored prenatal care programs and privately funded abortion services.30

For most clinics, the expense of establishing a separate facility with separate staff will be financially impossible. As a result of these regulations, most clinics that receive Title X funds will either eliminate abortion counseling or maintain their abortion counseling and services and lose federal funding altogether, jeopardizing overall financial stability and continued operation. Some programs will cease to operate entirely. Each alternative will have devastating consequences for poor women who rely on family planning clinics for contraceptives and general reproductive health services.

In an amici curiae brief on behalf of interested organizations, including women of color groups,31 LDF argued that the regulations violated Congress' intent to provide comprehensive reproductive health care services for poor women, particularly women of color,32 and that, as such, the regulations were invalid.33 Not only did the brief cite the legislative history, which was replete with references to the "poor women" and "minority women" who were to be served by the bill,34 but it also presented evidence that women of color are more likely to be served by these clinics.35

African American teenagers, in particular, rely heavily on clinic

30. 111 S.Ct. at 1769-1771.
32. Congress indicated that Title X was specifically aimed at eradicating a dual system of health care for poor and wealthy women. See PPFA v. Bowen, 680 F. Supp. 1465, 1469 (D. Colo. 1988) (Title X designed to eliminate two-tiered system of family planning services).
33. Amicus Brief for the Legal Defense Fund, supra note 31, at 1, 5. Under the Administrative Procedures Act, 5 U.S.C. § 706 (1977), a reviewing Court may invalidate agency regulations that conflict with the underlying law or are beyond the scope of statutory jurisdiction.
34. Amicus Brief for the Legal Defense Fund, supra note 31, at 5-14. In targeting the poor with this legislation, Congress recognized that Title X necessarily and specifically targeted minority women. See, e.g., 116 CONG. REC. 37,374 (1970) (statement of Rep. Schmitz) (“The people at whom this bill is specifically aimed are the poor . . . and . . . minorities”).
35. Amicus Brief for the Legal Defense Fund, supra note 31, at 29-34. In 1988, African American women represented 13% of 58 million U.S. women of reproductive age (15-44 years). THE ALAN GUTTMACHER INSTITUTE, FACTS IN BRIEF: CONTRACEPTIVE SERVICES (Sept. 25, 1991). In 1988, an estimated 3.74 million women used a Title X clinic in their last family planning visit during the previous 12 months; of these, 28.1% were African American and 3.2% were other women of color. WILLIAM D. MOSHER, NATIONAL CENTER FOR HEALTH STATISTICS, USE OF FAMILY PLANNING SERVICES IN THE UNITED STATES: 1982 AND 1988 at 4 (1990).
services. In an essential prevention strategy for those teens who are sexually active includes access to contraceptive services and counseling. Inadequate access to contraception services and counseling leads to large numbers of unintended pregnancies, disproportionately among young women of color. In 1988, there was an increase in both the number of births to young women under age twenty and the percentage of that population to give birth. African American and Latina teens accounted for virtually all of the recent increase in birth rates among teens.

Recognizing that poor women were most likely to be affected by the restrictions on the information a federally funded clinic may provide to its patients, the Court in Rust shifted the blame for having to receive restricted medical information onto the shoulders of the poor woman. It stated that "[t]he financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortion, but rather of her indigency." The Court not only blamed poor women for being poor, but also told them that they have no right to expect the same information that a woman who pays for private medical care receives. To justify this conclusion, the Court "engage[d] in uninformed fantasy," holding that "the Title X program regulations do not significantly impinge upon the doctor-patient relationship . . . Nor is the doctor-patient relationship established by the Title X program sufficiently all-encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice." While acknowledging that "[i]t would undoubtedly be easier for a woman seeking an abortion if she could receive information about abortion from a Title X project . . .", the Court nevertheless holds that "the Constitution does not require that the Government . . . provide that information." Finally, the Court rationalizes:

36. In 1988, 41% of all African American teenagers aged 15 to 19 had visited a family planning clinic within the last 12 months. MOSHER, supra note 35, at 2.
37. Relatively few pregnant teens practice regular contraception: Older abortion patients are more likely to have practiced some form of contraception than are younger patients who have been sexually active for a shorter time. Thirty-nine percent of abortion patients 17 years or younger said they had used some form of contraception in the month they had become pregnant, compared with 52 percent of patients 20-29 years old. Twenty-seven percent of patients 17 or younger said they had never practiced contraception, compared with only six percent of women in their twenties.
GOLD, supra note 17, at 12-14.
38. The birth rate among teens aged 15-17 rose 10% between 1986 and 1988, after having remained fairly stable for a decade. KRISTEN A. MOORE, FACTS AT A GLANCE 1 (Child Trends Inc., 1990). "Calculations by the Alan Guttmacher Institute indicate that in 1987, only 18% of the pregnancies to women under age 20 resulted in births that were intended, while 40% resulted in births that were not intended births, and 42% ended in abortions." Id.
39. Id.
41. Id. at 1782 n.3 (Blackmun, J., dissenting).
42. Id. at 1776.
43. Id. at 1777.
Congress' refusal to fund abortion counseling and advocacy leaves a pregnant woman with the same choices as if the government had chosen not to fund family-planning services at all. The difficulty that a woman encounters when a Title X project does not provide abortion counseling or referral leaves her in no different position than she would have been if the government had not enacted Title X.4

In other words, poor women who use federally-funded family planning clinics for health services have no right to expect to be fully informed about all medical options which might apply, including the option of abortion. Amazingly, it is the poor woman's "indigency" which has restricted her right to be fully informed, not the federal government's Gag Rule. Even though her health may be affected by her lack of information, her "indigency" is to blame, not the government's restrictions on what her doctor can tell her.

The Title X regulations exacerbate poor women's already serious problem of inadequate access to contraceptives and health services, including abortion counseling. Furthermore, pregnancy at an early age for young women of color will most likely increase the probability of living in poverty.45 Teenage mothers and their children are significantly more likely to live in poverty than older mothers and their offspring.46

The prevention of unwanted and unintended births to both teenagers and other poor women will increase their families' chances of escaping the effects of poverty.47 At the same time, any restriction on health services and access to contraceptive and abortion information will have serious consequences for poor women who are already experiencing difficulty in locating affordable reproductive health care.48

44. Id.
45. Among households headed by individuals between 15 and 24 years of age, the poverty rate is staggering: 65.3% for young African American families and 28.5% for young white families. BLACK AMERICANS: A STATISTICAL SOURCEBOOK, supra note 8, at 285.
46. Of all women who received AFDC payments in 1988, 59% were 19 or younger when their first child was born. Nearly half of all children aged five or younger who lived in poverty in 1988 had mothers who began having children as teenagers. MOORE, supra note 38, at 2.
47. Poverty rates increase as the size of a family increases. In 1989, the poverty rate among all two-person African American families was 22.7% (compared to a poverty rate of 6.6% for a white two-person family). The poverty rate among six-person African American families was 44.3% (15.6% for comparable white families), and 51.2% among African American families with seven persons or more (compared to 25.5% for white families with seven persons or more). BLACK AMERICANS: A STATISTICAL SOURCEBOOK, supra note 8, at 285.
48. The tragic effects of what is truly a health care crisis for poor women are well known and widely documented. See, e.g., U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH STATUS OF MINORITIES AND LOW INCOME GROUPS, supra note 14, at 99; Irma J. Bland, Racial and Ethnic Influences: The Black Woman and Abortion, in PSYCHIATRIC ASPECTS OF ABORTION 171 (Nada L. Stotland ed., 1991); American Medical Association, Council on Ethical and Judicial Affairs, Black-White Disparities in Health Care, 263 JAMA 2344 (1990) ("i]nderlying the racial disparities in the quality of health among Americans are differences in both need and access. Blacks are more likely to require health care but are less likely to receive health care services."); see also Harris v. McRae, 448 U.S. 297, 339 (1977) (Marshall, J., dissenting); Beal v. Doe, 432 U.S. 438, 455, 459 (1977) (Marshall, J., dissenting) (taking note of paucity
Advocacy groups must work to ensure that poor women have access to all medically necessary information with which to make informed decisions about their reproductive health. Moreover, access to affordable and available reproductive health care services and pregnancy prevention programs must also be a high priority. The availability of such services is essential if African American and other poor women are to have meaningful choice in their reproductive lives.

IV. INFERTILITY SERVICES

The risk of infertility is one and a half times greater for African Americans than for whites, yet discussions of reproductive issues concerning African American women seldom include the need for infertility services. Currently, the risk factors contributing to infertility among African American women include sickle cell anemia and other genetic disorders, alcohol and drug abuse, nutritional deficiencies, untreated infectious diseases such as gonorrhea and pelvic inflammatory disease, and infection after childbirth or after a poorly performed abortion. According to Laurie Nsiah-Jefferson, other reasons for high infertility rates among poor women and women of color include "sterilization abuse, hysterectomies, IUD and birth control usage, lack of access to medical treatment, deleterious environmental and working conditions, and unnecessary surgery and medical experimentation."

Basic information and adequate reproductive health care could eliminate many of these causes of infertility. For example, screening for sexually transmitted diseases, especially chlamydia, as part of routine gynecological
exams could reduce the number of new infertility cases dramatically.53 Women who have been infected with chlamydia are twice as likely to experience an ectopic pregnancy, which can result in infertility;54 untreated chlamydia may account for as many as twenty thousand ectopic pregnancies each year.55

In general, adequate reproductive health care for poor African American women could prevent many avoidable cases of infertility. No woman should be allowed to become infertile against her wishes when adequate information and medical care can prevent infertility. Furthermore, low-income women who have difficulty conceiving should not be precluded from infertility services because of their poverty. The ability to have a child is as important as the ability to prevent having children. Advocacy groups should recognize that infertility treatment is an important element of meaningful reproductive choices and should ensure that adequate funds for infertility services are provided.

Whites and those with higher incomes are more likely to pursue infertility treatment than are African Americans and the poor.56 Given that the average fee for each infertility treatment is between $2,055 and $10,000,57 it is no wonder that poorer couples, a disproportionate number of whom are African Americans, do not pursue infertility treatment. Little information is available regarding the percentage of private insurance plans that cover infertility.58 Medicaid and Title X regulations include infertility services among family planning services;59 therefore, public funding for such services should be available. Unfortunately, "no precise data exist on the amount of public funds spent on infertility services,"60 and relatively few private physicians accept Medicaid for infertility services.61 Advocacy groups should also be mindful that some of the new reproductive technologies used to aid infertile couples, particularly surrogacy, may foster the exploitation of poor women.

V. SURROGACY

In the typical surrogacy arrangement, a married couple with a wife unable to bear children uses the husband's sperm to inseminate a fertile woman, who

54. Id. at 17-18.
55. Id.
56. About 75% of low-income women in need of infertility services have not received any services. "Among all higher income women, 47% have received no infertility services. . . . Women under 150% of poverty account for 22% of women in need of infertility services who have not received services, compared to 15% of all those in need." FORREST ET AL., supra note 8, at 71.
57. Id.
58. Id.
60. FORREST ET AL., supra note 8, at 71; see also Nsiah-Jefferson, supra note 52, at 50.
61. "While 45 percent of the physicians in the specialties surveyed provide infertility services, only 21 percent (47 percent of providers) accept Medicaid patients for infertility care and six percent (13 percent of providers) will lower their fees for low-income patients." FORREST ET AL., supra note 8, at 70.
Reproductive Freedoms

becomes the “surrogate mother.” The surrogate mother carries to term the fetus conceived from her egg and the husband’s sperm. Although the legal and constitutional status of surrogacy agreements is unresolved, most arrangements are governed by a contract whereby the surrogate mother is paid a sum of money and agrees to relinquish all parental rights to the child. The “rate” is normally between $10,000 and $15,000, and the surrogate is paired with the infertile couple either through a fertility agency or privately. Because of the high cost of the procedure, affluent couples (who will most likely be white) are probably the only couples who will benefit from surrogacy arrangements. Further, poor women may be attracted to such arrangements because of the relatively substantial fees offered.

In this type of surrogacy, an African American surrogate mother will produce an African American child for a white couple because the egg is that of the surrogate mother. It is therefore likely that in most instances African American women will not be chosen as surrogates to be used with the egg donor type technology. Other women of color who genetically have less “color” may be exploited, however, particularly women from less industrialized countries where wages are low and the “labor supply more submissive.”

The Baby M case indicated to surrogacy brokers and couples seeking surrogates that healthy white women who are unrelated to the couple may not be the best choice because a court may find that a surrogacy contract does not terminate a woman’s parental rights and grant her full custody or visitation. Surrogacy brokers may be more likely to prey upon the economic vulnerabilities of women of color who will not have the resources to fight rich white American couples in court.

A second kind of technology is potentially more dangerous for poor African American women. In vitro fertilization (IVF) is the process whereby several

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63. State contract and family law, including a consideration of the best interests of the child, usually control disputes between putative parents over a child produced through surrogacy.
64. [S]urrogate brokers have frankly admitted that they will turn to Third World women for their stables of contract breeders . . . John Stehura, president of the Bionetics Foundation, talked about his plans for a surrogate business in Mexico that would “supply” U.S. clients: “You could devastate them [Mexican women] with money and things.”

In the developing world, reproductive clinics offer market and research possibilities unhampered by even the few restrictions that exist in Western contexts. The technique of sex predetermination developed out of the rationale of “female fertility out of control” in the Third World—which could be solved by reducing the number of girls born. A chain of clinics in India, Jordan, Pakistan, Egypt, Malaysia, Singapore, and Taiwan, as well as several in the U.S., has been set up by . . . a U.S. entrepreneur of sperm separation technology. Pivet, an Australian company, has established IVF clinics in Brazil, India, Malaysia, and Indonesia, particularly for sex predetermination. Such clinics have been deluged with requests from financially well-off women affected by the stigma of not having produced a son.

eggs are removed from a woman's ovaries and fertilized in a petri dish with the sperm of her husband. A doctor then transfers the fertilized egg into the uterus of a woman other than the egg donor. This woman is called the "gestational mother." The gestational mother, unlike a surrogate mother, has no genetic connection to the child. The gestational mother is a vessel that allows infertile couples to have a child who inherits both parents' genetic make-up. Similar to the surrogate mother, the gestational mother normally agrees to relinquish all parental rights to the child and receives a fee. Because the gestational mother merely carries or incubates the fully fertilized egg of another woman and is expected to hand over the child after it is born, she becomes literally a "womb for rent."

IVF raises a number of ethical and legal issues of particular concern to African American women. Because IVF allows a woman to bear the child of a couple without having a genetic connection to the child, it creates the opportunity for African American women to give birth to completely white babies. Symbolically and historically, such an arrangement is reminiscent of the numbers of African American slave women who were forced to breastfeed white children the breast milk they created for their own children, or to act as "breeders" for the master's property.

A woman who gives birth to a child to whom she has no genetic connection will have little or no protection from the courts if, like Mary Beth Whitehead, the plaintiff in the Baby M case, she changes her mind and wants to keep the baby she has carried to term and delivered. This situation is alarming.

The case of Anna Johnson, an African American woman who gave birth to the child of a white husband and an Asian wife, highlights the conflicts. The California Court of Appeals ruled that genetics was the determining factor in parenthood. In October 1989, Crispina Calvert learned of co-worker Anna Johnson's interest in serving as a surrogate mother. Eventually, Crispina involved her husband Mark Calvert in discussions with Anna Johnson. The Calverts were unable to have children because of Crispina's hysterectomy. In January 1990, Johnson signed a contract with the Calverts, which stipulated that Johnson would be impregnated with an embryo from the sperm of Mark and the egg of Crispina. Johnson agreed to give birth to the child and to

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66. Field, supra note 62, at 35. IVF has helped very few people. There were fewer than 2,000 IVF births in the U.S. by 1988, compared with more than 4,000,000 U.S. births annually. George J. Annas, Fairy Tales Surrogate Mothers Tell, LAW, MEDICINE & HEALTH CARE, Spring 1988, at 27 & n.2. Annas believes that IVF and surrogate motherhood are "both classist and sexist: a method to obtain children genetically related to white males by exploiting poor women." Id. at 27.

67. Nsiah-Jefferson, supra note 52, at 52.


70. The Calverts used an attorney to arrange the contract, which was signed at the Center for Reproductive Health, a surrogate broker. Johnson was to be paid $2,000 at the end of the first and second trimesters, $1,000 a month before and after the birth, and $4,000 six weeks after the birth. Philip Hager, State High Court to Rule in O.C. Surrogacy Case, L.A. TIMES, Jan. 24, 1992, at A1.
relinquish her parental rights. On September 19, 1990, Anna Johnson gave birth to a baby boy. Two days later, the court allowed the Calverts to take the baby home without prejudice to Anna’s rights. 71

Upholding the Superior Court decision, the Court of Appeals framed the conflict between the Calverts and Johnson as a question of who is the natural mother, “the woman who nurtures the child in her womb and gives birth or an otherwise infertile woman whose egg is implanted in the woman who gives birth?” 72 In reaching the decision that Anna Johnson is not the “legal” or “natural” mother of the child because she had no genetic connection to the child, the court relied on the legislature’s treatment of paternity questions. 73

Under the California Uniform Parentage Act, 74 if a woman’s husband is not the biological father of her child, he is not the legal father. 75 Using this same reasoning, the Court of Appeals found that Anna was not the genetic, biological, or natural mother of the baby that she carried to term. 76 The danger and fallacy in this type of analysis is that it fails to acknowledge that a different physiological or emotional relationship exists between a mother and child than between a father and child. A woman, unlike a man, has a physical connection to her child that goes beyond genetics. A fetus depends entirely on the mother’s biology for survival. The fetus is a part of the mother. According to California courts, however, Anna Johnson’s interest in the child is nonexistent because her womb and body merely nurtured the fetus, her body did not produce the egg.

This case is different from the Baby M case. 77 In Baby M, Mary Beth Whitehead had a biological connection to the child she carried. Hence, she was the genetic and biological mother. Because Whitehead was the biological mother of the child—her own egg was fertilized and she gave birth to the child—maternity was never a question. The issue was whether parental rights could be legally terminated by surrogate agreements. Ultimately, the New Jersey court declared surrogate contracts illegal and unenforceable. It then weighed Whitehead’s maternal rights and the father’s paternal rights against the best interest of the child to determine custody. 78

The court saw the core issue in Anna Johnson’s case as the definition of

73. Id.
74. The 1975 Parentage Act sought to eliminate distinctions between legitimate and illegitimate children, and based parent and child rights on the existence of a parent-child relationship, not the marital status of the parents. CAL. CIV. CODE §§ 7000-7021 (West 1983).
75. Experts use blood tests to determine that a husband is not the biological father of the child, even if the husband and wife are cohabitating. 234 Cal. App. 3d at 1567.
76. Anna stipulated that Crispina was genetically related to the child, and blood tests confirmed that the child was not genetically related to Anna. Id. at 1569.
78. The court declared that the child’s best interests called for awarding custody to her father, Daniel Stern. 537 A.2d at 1259.
Johnson's attorney argued that under a California statute which states that "[t]he parent and child relationship may be established . . . [b]etween a child and the natural mother . . . by proof of her having given birth to the child . . . .", the birth mother is the natural mother. The court rejected this argument, holding that the statute cannot be read to state that the birth mother is always the natural mother. Having firmly established that Anna was not the "natural mother," the court found that she was not the legal mother and thus had no parental rights.

Another issue strongly pervades the Anna Johnson case: Can a Black woman ever be the "natural" mother of a white child? Race issues have permeated virtually every policy issue in this country since its founding. In 1903, W.E.B. DuBois said that "the problem of the Twentieth Century is the problem of the color line." Given our continuing struggle with race issues, both domestically and internationally, race will also be the problem of the twenty-first century. The decision in Anna Johnson's case is painfully reminiscent of slavery and the days of the breeder woman whose feelings for her child, whether born out of love or out of rape, were disregarded when men with power over her made decisions about the child.

Anna Johnson's lawyer noted the historical connection between slavery and Anna's situation:

This case is what critics who oppose surrogacy have been warning legislators—what we are going to see is a wealthy couple like the Calverts preying on the poor, which generally translates into preying on blacks. I hope this is recognized as a civil rights issue and a classic case of exploitation and a slave contract . . .

Advocates must be vigilant in their efforts on behalf of poor women. Both civil rights and women's advocates must ensure that poor women are not economically exploited through surrogacy contracts, and that their attachment

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79. 234 Cal. App. 3d at 1562. The appellate court did not even address whether surrogacy contracts were legal.
80. CAL. CIV. CODE § 7003 (West 1983).
82. Id.
83. The child in the Johnson case was of Filipino and white parentage.
84. See generally LEON HIGGINBOTHAM, IN THE MATTER OF COLOR (1978).
86. See, e.g., DAVIS, supra note 68, at 7 ("Since slave women were classified as 'breeders' as opposed to 'mothers,' their infant children could be sold away from them like calves from cows. One year after the importation of Africans was halted, a South Carolina court ruled that female slaves had no legal claims whatever on their children. Consequently, according to this ruling, children could be sold away from their mothers at any age because 'the young of slaves . . . stand on the same footing as other animals.'" (omission in original) (footnote omitted)).
87. David Behrens, Test-Tube Baby in Tug-of-War, NEWSDAY, Sept. 21, 1990, at 1, 23 (omission in original).
to their children is considered in any dispute over custody or visitation. The
decision should not be based merely on the relative economic positions of the
contending parents or on the myth that a child produced by another woman's
egg has no relationship to the woman actually giving birth.

In some respects, surrogacy could be considered gainful employment. Yet
it could also be considered baby-selling. Public policy advocates, medical
experts, and former surrogates should discuss and debate a variety of ways to
prevent economic exploitation and the potentially harmful psychological effects
on a surrogate mother who is deprived of the child she bore. At the same time,
they should try to make surrogate services available to all women who need
them. Government regulations should be carefully developed for surrogacy.
Such regulations might treat surrogate mothers like organ donors and prohibit
payment for services. Surrogacy is too critical an area to allow surrogacy
brokers and lawyers to control.

VI. STERILIZATION

African American women have not had genuine access to voluntary
sterilization—the informed choice of a woman to forego future pregnancies by
removing her uterus or cutting or blocking her fallopian tubes. Instead, African
American women have often been victims of involuntary surgical procedures
that strip them of their ability to reproduce.

The early birth control movement included strong factions advocating
eugenics or compulsory sterilization of “unfit” persons—“[m]orons, mental
defectives, epileptics, illiterates, paupers, unemployables, criminals, prostitutes
and dope fiends.” At least twenty-six states had passed compulsory
sterilization laws by 1932.

During the 1970s, several instances of blatant sterilization abuse were
exposed. For example, public assistance officials tricked illiterate black welfare
recipients into consenting to the sterilization of their teenage daughters. Native
American women under twenty-one years of age were subjected to radical
hysterectomies and informed consent procedures were ignored. Doctors agreed
to deliver the babies of Black Medicaid patients on the condition that the
woman be sterilized. Doctors have also conditioned the performance of
abortions on “consent” to sterilization.

By 1982, only fifteen percent of white women were sterilized, compared
to twenty-four percent of African American women, thirty-five percent of

88. DAVIS, supra note 68, at 214 (quoting GENA COREA, THE HIDDEN MALPRACTICE 149 (1977)).
Birth control became population control, and “exterminate[ing] the Negro population” was included in the
plan. DAVIS, supra, at 215.
89. DAVIS, supra note 68, at 214.
90. Nsiah-Jefferson, supra note 52, at 44 n.112; BLACK WOMEN'S COMMUNITY DEV. FOUND., supra
note 52, at 80-90.
Puerto Rican women, and forty-two percent of Native American women. Among Hispanic women living in the Northeast, sterilization rates as high as sixty-five percent have been reported. African American women of all marital statuses were more likely than white women to use sterilization as a contraceptive method. African American areas in the South have the highest rates of hysterectomy and tubal ligation in the United States.

Current sterilization abuse takes many forms, and is usually not as blatantly coercive as in the past. An assessment of the voluntariness of a woman’s decision to be sterilized must take into account the information available to her at the time the decision is made. Many women agree to sterilization, believing that the procedure is reversible. Health professionals may contribute to this mistaken belief by describing the procedure as “tying the tubes”—an image which reinforces the belief that “what can be tied can be untied later.”

One study reported that forty-five percent of the sterilized African American women interviewed did not realize the procedure was irreversible. Forty percent of the sample expressed regret over their decisions to be sterilized.

Since the abuses of the 1970s, regulations have been adopted to ensure that informed consent is obtained for all federally-funded sterilizations. Researchers complain, however, of the inadequate monitoring of these regulations. Data that is collected is not published or made publicly available. As a result, the effectiveness of these regulations is unknown.

The federal government still subsidizes sterilizations for women eligible for Medicaid coverage, though it will not pay for abortions. Moreover, doctors may improperly steer women with “too many” children or women whom they consider incapable of properly using contraceptives toward sterilization. Doctors may also recommend sterilization to women with fibroid tumors, even though these tumors generally do not require hysterectomies for proper treatment.

91. Vicki Alexander, Black Women and Health, 6 CHOICES 6, 16 (Women’s Medical Ctr. 1986).
92. Nsiah-Jefferson, supra note 52, at 46 n.120.
93. Id. at 46 n.122.
94. Id. at 46 n.123.
95. Id. at 44.
96. Id. at 44 n.113.
97. Id.
100. 42 C.F.R. §§ 441.253-.254 (1991) provide funding for sterilizations and hysterectomies while 42 CFR §§ 441.202-.203 restrict funding for abortions to situations in which a doctor certifies that the life of the mother would be endangered if the fetus were carried to term.

A recent review of the impact of Michigan’s ban on state-funded abortions found that 400 more sterilizations were performed in the first year of the ban than in the previous year when state funds for Medicaid abortions were available. The study projected an increase of 1,500 sterilizations from 1988 to 1990. Medicaid sterilizations for 1990 were expected to total 6,100. Deborah Chargot, Abortion and the Poor—Medicaid Ban Develops Cycle of Angry Mothers, Unwanted Babies, DETROIT FREE PRESS, Aug. 5, 1990, at 1F.

101. BLACK WOMEN’S COMMUNITY DEV. FOUND., supra note 52, at 20.
simply to provide interns and residents with surgical experience.\footnote{102} Before a woman can “consent” to sterilization she must have available to her all relevant information about her condition, her options, and the permanent effect of sterilization.\footnote{103} Poor women and women of color do not receive this information. In this area, as in all other matters of reproductive health, advocates should ensure that women have access to all of the available information about their condition and the possible effects and outcomes of various medical procedures before they make irreversible reproductive health decisions. Furthermore, the regulations for ensuring that women give their informed consent to sterilizations that are subsidized with federal funds should be monitored closely to prevent sterilization abuse.\footnote{104} The federal government must make the monitoring data available for scrutiny. Poor women should not be victims of unnecessary sterilization procedures, and advocates of choice should work to ensure that they are not.

\section*{VII. Workplace Toxins}

The toxins and hazards to which African Americans and other people of color are exposed in the workplace damage our overall health status. Although there is a limited amount of race-specific data available, studies demonstrate that men and women of color are overrepresented in dirty and dangerous industries and jobs.\footnote{105} Clean and safe work environments are essential to the well-being of people of color.

In United Automobile Workers v. Johnson Controls, Inc.,\footnote{106} commonly called the “fetal protection” case, the Supreme Court decided that Title VII of the Civil Rights Act of 1964\footnote{107} prohibits an employer from excluding all women of child-bearing capacity from certain jobs even if the employer’s goal is to prevent possible damage to potential or developing fetuses.\footnote{108} Johnson Controls, a battery manufacturer, excluded all women under the age of seventy

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103. Informed consent is one of the most deeply rooted traditions in American medicine. Basic tenets of professional medical ethics and established medical care standards require health care providers to obtain a patient’s voluntary and fully informed consent. The Principles of Medical Ethics of the American Medical Association recognize that “the patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.” Gold, supra note 17, at 46 n.156, citing American Medical Ass’n, Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Ass’n 31, 32 (1986).
104. In 1974, shortly after the federal informed consent guidelines were issued, a paper on the subject of sterilization labelling the guidelines as “impotent directives without any ‘police powers,’” quoted the Director of the Office of Population Affairs for HEW (now HHS). The paper characterized the guidelines as “the United States government’s way of saying that the poor and all those people luckless enough to have been labeled ‘mentally defective’ still have no rights which any physician need respect.” Black Women’s Community Dev. Found., supra note 52, at 88 (citation omitted).
105. See infra notes 114-122 and accompanying text (discussing dirty and dangerous industries and jobs).
108. 111 S.Ct. at 1207.
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(except those who provided medical proof of sterility) from jobs with a certain lead exposure level as well as from all entry-level jobs that could lead to the higher-lead jobs. As a result of the policy, the company essentially stopped hiring women for production jobs. If the policy had been upheld, as many as twenty million jobs nation-wide could have been closed to women. This result would have effectively forced women to choose between their jobs and their ability to have children.

Gloyce Qualls, one of the plaintiffs in Johnson Controls, was demoted as a result of the fetal protection policy. Two weeks after being notified of the policy, Qualls had a tubal ligation. Her salary would have been cut from $450 per week to $200 per week had she not been sterilized. While the decision protects women like Gloyce Qualls from forced sterilization in order to maintain higher paying jobs, the decision does not address the work conditions which threaten the health and safety of women and their fetuses. The Johnson Controls decision must therefore be viewed cautiously. Gloyce Qualls could be rendered infertile simply by doing her job.

LDF filed an amicus brief with the Supreme Court in Johnson Controls, arguing that if the Court upheld the lower court's decision, the standards of proving an employment discrimination case would be relaxed and extended beyond fetal protection policies. The belief that some individuals within a class of workers may be particularly susceptible to the harmful effects of toxic substances cannot justify categorical exclusion of that class. Title VII should not allow employers to institute policies that sacrifice women's employment opportunities merely in order to avoid cleaning dirty workplaces.

110. Florence Estes, Battery Workers Pulled Together to Pursue the Right to Their Jobs, CHI. TRIB., Apr. 28, 1991, at 3
112. Title VII recognizes two forms of discrimination: disparate impact, 42 U.S.C. § 2000e-2(a)(2), and disparate treatment, 42 U.S.C. § 2000e-2(a)(1). Disparate impact claims "involve employment practices that are facially neutral in their treatment of different groups but that in fact fall more harshly on one group than another and cannot be justified by business necessity." International Brotherhood of Teamsters v. United States, 431 U.S. 324, 335 n.15 (1977). Disparate impact theories apply to employment devices such as high school requirements, pen and paper tests, and height and weight requirements. Employers may assert a business necessity defense to justify facially neutral practices that have an adverse impact on members of protected classes.

Disparate treatment theories, on the other hand, prohibit both overt or facial and covert or pretextual discrimination. Disparate treatment theories apply to contentions that an employer treats some employees less favorably than others because of their race, color, sex, religion, age, or national origin. "Disparate treatment... is the most easily understood type of discrimination." Teamsters, 431 U.S. at 335 n.15. Employers may defend against evidence of disparate treatment on the basis of sex by showing that the challenged policy or practice is a "bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise." 42 U.S.C. § 2000e-2(e). This is "an extremely narrow exception."

By definition, an explicit classification based on sex and the capacity to have children is not gender neutral and constitutes a per se violation of the Act, or disparate treatment. Johnson Controls' policy presented a case of intentional discrimination which could be justified only by the narrow BFOQ defense.
Although the decision means that women cannot be denied access to certain blue collar jobs, the decision might also be interpreted as granting women equal access to excessively hazardous workplaces.

The Johnson Controls decision marks a victory against invidious discrimination based on gender and women's child-bearing capabilities, but it does not address the work conditions that place women and their fetuses at risk. In its amicus brief, LDF argued that African Americans are overrepresented in predominantly male occupations in dirty traditional industries. Policies that allow employers to focus solely on potential fetal risks do not address the broader issue of unsafe conditions for all workers. In particular, such policies do not recognize that hazardous work conditions can adversely affect men's reproductive capacity.\(^{113}\) LDF argued that employers should be required to reduce hazardous exposures to safe levels for all workers or to find product substitutes.

Toxic work environments pose a particular danger to the overall health status of African American workers because of our overrepresentation in certain dirty industries and jobs. African Americans and other people of color are overrepresented in laundry and dry cleaning, tobacco manufacture, fabric mills, smelters, hospitals, and farmwork.\(^{114}\) Each of these industries exposes workers to chemicals and toxic substances that have been linked to cancer. Furthermore, migrant farm workers, estimated to be seventy-five percent Chicano and twenty percent African American, have among the most dangerous and least protected jobs of all workers.\(^{115}\) Their exposure to pesticides, heat, mechanical hazards, noise, and dust combine with poverty and poor medical care to lower the life expectancy of a farmworker to forty-nine years, more than twenty years less than the national average.\(^{116}\)

As Davis explains in an article focusing on the workplace health and safety of African American workers:

[II]Ilness, disease, and death has [sic] continued to take its toll among black workers, due to unchecked hazardous working conditions and exposure to toxic substances . . .

Fifteen percent of the black work force (one to one and one-half million) are unable to work due to permanent or partial job-related disabilities. Black workers have a 37 percent greater chance than whites of suffering an occupational injury or illness. Black workers are one and one-half times more likely than whites to be severely disabled from job injuries and illness


\(^{114}\) STEPHANIE POLLACK & JO ANN GROZUCZAK, REAGAN, TOXICS AND MINORITIES 2 (1984).

\(^{115}\) \textit{Id.} at 41.

\(^{116}\) \textit{Id.}
and face a 20 percent greater chance than whites of dying from job-related injuries and illnesses.\textsuperscript{117}

The health status of African American women workers is adversely affected by the hazardous work conditions found in predominantly female occupations. Although only seventeen percent of all service occupations were filled by African Americans in 1987, African Americans, especially women, occupied an overwhelming number of the jobs involving contact with toxic substances. African Americans comprised over thirty percent of all nursing aides, orderlies and attendants; thirty percent of maids and housemen; and twenty-three percent of all private household workers.\textsuperscript{118} African American women are over-represented among health service workers,\textsuperscript{119} who commonly suffer from occupational diseases.\textsuperscript{120}

Increasingly, young African American women are avoiding private household and service jobs—areas that have employed large numbers of older African American women—and moving into clerical jobs.\textsuperscript{121} Clerical work poses dangers to the health and welfare of African American women. According to Leith Mullings, "[t]he hazards of clerical work include muscular and circulatory disorders, fatigue, and exposure to dangerous chemicals such as benzene, toluene, and other organic solvents."\textsuperscript{122}

Any policies that permit employers to avoid their duty to provide safe and clean working environments for all workers will have doubly devastating effects on African American workers. Health indices of African Americans will continue to lag behind white Americans if employers are allowed to evade their responsibility for toxic work environments.

Advocates should not retreat from the position that a clean work


\textsuperscript{118}. \textsc{Bureau of the Census, U.S. Dep't of Commerce, Statistical Abstract of the United States} 389 (1989).

\textsuperscript{119}. While African American women comprised 5.4% of the total labor force in 1981, they constituted 24% of all nursing aides, 19% of all practical nurses, 16% of all health aides, and 16% of all other health service workers. Julienne Malveaux, \textit{Low Wage Black Women: Occupational Descriptions, Strategies for Change} 93 (1984) (unpublished paper prepared for NAACP Legal Defense and Educational Fund, Inc.).


\textsuperscript{122}. Mullings, supra note 120, at 128. "In offices, newsrooms and at switchboards, growing numbers of people who work hour after hour on computer keyboards are developing sometimes crippling symptoms in their hands." Jane Brody, \textit{Computer Users' Injuries Are Often Preventable}, N.Y. TIMES, Mar. 4, 1992, at C14. One of the most common of several hand-wrist problems that beset computer operators is carpal tunnel syndrome, in which the nerve passing through the wrist becomes pinched by swollen tissues, causing numbness and tingling in the fingers at first, then crippling pain, permanent nerve damage, and loss of muscle control that can render the hand almost useless. Repetitive wrist motion injuries can be prevented with appropriately adjusted chairs and tables, proper posture, regular exercises and rest periods, and early detection. \textit{Id. See also} Bob Baker, \textit{Repetitive-Motion Illness on Rise, Experts Say}, L.A. TIMES, Mar. 29, 1991, at A3 (repetitive-motion illness, called "the occupational disease of the '90s," affects "wide variety of workers, from supermarket clerks to meat cutters to operators of computer terminals").
environment is necessary for all workers. Although women (as well as men) should be permitted to make their own educated and informed choices about work and reproductive risks, merely supplying women with the available information with which to make those choices is insufficient. Such information is unreliable because too few studies have been performed. Research is especially scarce regarding the effects of toxins on male reproductive systems.

Targeting the information to women alone is too narrow a focus and will perpetuate the belief that only women are responsible for poor pregnancy outcomes. Most importantly, economic concerns may deprive many women, particularly women of color, of any real choice. They may be forced to accept the best paying jobs they can find, irrespective of health concerns. Women heading families alone may not be able to survive without the health and pension benefits that accompany better paying jobs. These women may be persuaded to accept sterilization in order to work in higher paying jobs that are potentially hazardous. Gloyce Qualls' decision to undergo a tubal ligation was motivated by economic considerations. No woman should be placed in such a dilemma.

VIII. Abortion

Women have used abortion as a method of limiting unwanted or unplanned pregnancies throughout history, regardless of the legal status of abortions. Abortions early in pregnancy were permitted under traditional common law until the middle of the 1800s. By 1900, abortion was illegal throughout the United States. Historians have noted that African women enslaved in the United States aborted pregnancies rather than bearing children into slavery or giving birth to the products of slave masters' rapes.

Clearly, abortions will continue, whether legal or illegal. The question is whether abortions will be performed safely. Will the abortion be performed by a doctor or will it be self-induced? Will it be performed in the first

124. See Paula Giddings, supra note 68, at 46 (1984); Davis, supra note 68, at 204-05.
125. Abortion-related deaths are common in countries where abortion is still illegal, particularly in Central and South America. The Pan American Health Organization states that abortion is now Latin America's leading cause of pregnancy-related mortality. The World Health Organization reports that as many as 200,000 women die every year because of unsafe abortions in developing countries—nearly 25% of them in Latin America. They report that between 10 and 20 million women have abortions each year in Latin America and 45% of all the maternity beds in that region of the world are taken up by women who have complications of illegal abortions. Dr. Kenneth Edelin (unpublished comments, on file with author).
twelve to fourteen weeks of pregnancy, or later, when complications are more likely to arise?^{127}

For poor women, the answers to these crucial questions depend on how soon they can raise sufficient funds for the abortion.^{128} Scarcity of abortion providers exacerbates this problem, especially in rural areas.^{129} In 1985, eighty-two percent of all counties in the United States—home to almost one-third of all women of reproductive age—had no abortion provider.^{130}

In 1973, the Supreme Court ruled in Roe v. Wade^{131} that a woman’s constitutional right to privacy includes her right to decide whether or not to terminate her pregnancy. The Court stressed, however, that a woman’s right to choose abortion is not absolute. Instead, her interest must compete with the state’s legitimate interest in protecting both the health of the pregnant woman and the developing life. The Court set out a framework within which states could regulate abortion. State interference with the woman’s right to abort during the first trimester of pregnancy—roughly the first twelve to fourteen weeks—essentially is prohibited. States can, however, pass laws to protect the potential life of the fetus at the point of viability (the ability to survive outside the woman’s body). A state’s interest in protecting the fetus can be limited in cases where it is necessary to protect the life or health of the woman.

In 1980, the Supreme Court upheld the Hyde Amendment^{132}—the federal government’s ban on the use of federal Medicaid funds to pay for abortions for poor women (except when necessary to save the life of the mother or when the pregnancies were the result of rape or incest).^{133} 

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127. The timing of the abortion significantly affects women’s health. More than half of all abortions are performed at or before eight weeks of pregnancy, when the procedure is the safest. The death rate from an abortion performed at or before eight weeks of pregnancy is 0.2 deaths per 100,000 procedures. The risk increases as gestation continues. Abortions performed at 11 or 12 weeks of pregnancy are three times more dangerous for the woman than abortions performed at or before eight weeks, although the rate of death from abortion at 11 or 12 weeks was only 0.6 per 100,000 procedures during 1981-1985. The nine percent of abortions performed in the second trimester accounted for 53% of all abortion deaths from 1981 to 1985. GOLD, supra note 17, at 29-30.

128. Nearly 60 percent of Medicaid patients, compared with 25 percent of more affluent patients, say that paying for an abortion entailed serious hardship, such as letting bills go unpaid or buying less food or clothing in order to pay for their abortion. GOLD, supra note 17, at 52 n.186, citing Stanley K. Henshaw & Lynn S. Wallisch, The Medicaid Cutoff and Abortion Services for the Poor, 16 FAMILY PLANNING PERSPECTIVES 170 (1984).

129. Moreover, it often takes considerable time to obtain the money needed to pay for an abortion. While not all Medicaid-eligible women are forced to delay their abortions, many abortions are delayed by as much as two to three weeks. In 1982, after the ban on federal funding was implemented, 50% of Medicaid-eligible patients at one clinic had their abortions after nine weeks of pregnancy, compared with only 37% of non-Medicaid-eligible women. Id.

130. Abortion services are less available in rural than in urban areas; nine out of ten nonmetropolitan counties have no facility that performs abortions. Only two percent of the nation’s total abortions were performed in nonmetropolitan areas in 1985. Stanley K. Henshaw et al., Abortion Services in the United States, 1984 and 1985, 19 FAMILY PLANNING PERSPECTIVES, Mar.-Apr. 1987, at 63-5.


that the Amendment did not place any governmental obstacle in the path of a woman choosing to terminate her pregnancy. Instead, the Hyde Amendment encouraged “alternative activity” deemed in the public interest, and left an indigent woman with “the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all.”

Since *Harris v. McRae*, poor women have had a difficult time financing abortion. Only thirteen states continue to use their own revenues to provide medically necessary abortion services for their low-income residents. Poor women tend to have abortions later in their pregnancies, thus increasing the health risks and the cost of the service. In essence, the Court ruled that the existence of a constitutionally protected right to an abortion did not require the government to provide an access to that right. Without equal access, a right amounts to a privilege—for many African American women such a “privilege” does not exist.

In 1989, the Court’s decision in *Webster v. Reproductive Health Services* signaled to states that further restrictions on access to abortion are acceptable. In *Webster*, the court upheld a Missouri statute which (1) declared in its preamble that life begins at conception; (2) prohibited public employees and facilities from performing or assisting with an abortion when not necessary to save the life of the mother; (3) prohibited the use of public funds for “encouraging or counseling” about abortion; and (4) required doctors who believe a fetus may be twenty weeks to determine viability by performing certain medical tests. Again, the court upheld the notion that states do not have an affirmative duty to assist women who seek to exercise the constitutional right to an abortion. Since *Webster*, a number of states have considered laws requiring parental or spousal consent or notification, expanding the information doctors are required to provide in order to have informed consent, or imposing a waiting period before the procedure can take place.

In 1990, the Court upheld parental notification laws in *Hodgson v. Minnesota* and *Ohio v. Akron Center for Reproductive Health*.

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134. 448 U.S. at 317.
136. See supra note 127 (health risks increase with additional gestation time). Abortion services provided by hospitals are typically two to three times more costly than services performed in clinics and physicians’ offices. *GOLD*, supra note 17, at 49.
138. *Id.* at 501.
139. Planned Parenthood of Southeastern Pennsylvania v. Casey, 947 F.2d 682 (3d Cir. 1991), *cert. granted*, 112 S.Ct. 931 (1992), which is currently pending before the Supreme Court, may determine the continued validity of *Roe v. Wade*. The case challenges Pennsylvania’s restrictive abortion laws, which require: (1) doctors to deliver a specific statement regarding the fetus before performing an abortion; (2) a 24-hour waiting period before an abortion can be performed; (3) parental consent for minors; and (4) spousal notification. *Id.*
reasoning that as long as a judicial bypass procedure was available as an alternative to parental notification, the law was constitutional.\textsuperscript{142} For teenagers, especially poor African American ones, judicial bypass is usually no alternative at all.

Theoretically, a young woman who can't notify both parents has the option of taking her case to a judge, regardless of her race or socioeconomic status. But to suggest that negotiating the complexities of an already overburdened legal system is a real option for a poor black teenage girl is to engage in the cruelest type of legal hair-splitting. What is the chance that the type of person least likely to be able to locate, contact, or afford an attorney can get a fair hearing when they are also those most likely to be discriminated against because of their age, sex, and race?

Parental notification, which can be casually dismissed by middle-class women, literally becomes a life and death issue to less fortunate women. . . . [W]omen under 15 years of age are those who are most likely to obtain abortions later than 21 weeks. When a young woman has already had her life options limited by being poor or restricted by still-existing racial barriers, reducing her options even further increases the risk of complications of a late abortion.\textsuperscript{143}

Women who abort after fifteen weeks of pregnancy are disproportionately under eighteen, African American, unemployed, poor enough to be Medicaid-eligible, pregnant as a result of rape or incest, or carrying a fetus diagnosed with severe defects.\textsuperscript{144} In addition, women under fifteen years of age are those who are most likely to obtain abortions after twenty-one weeks.\textsuperscript{145}

Time-consuming court procedures increase the risk of complications from a late abortion. More restrictive state laws are expected to be proposed. Women of color need to participate actively at the local level to prevent barriers to abortion services.

African American teens are not only more likely to have late abortions than white teens, but are also twice as likely as white teens to become pregnant in the first place.\textsuperscript{146} Of 10,200 births to mothers under age fifteen in 1986, fifty-eight percent of the mothers were African American, thirty-nine percent

\textsuperscript{141} 110 S.Ct. 2972 (1990).
\textsuperscript{142} A teen who is astute enough to maneuver the judicial process can avoid parental notification requirements by showing a judge that her decision to have an abortion is a mature one made in her best interests.
\textsuperscript{143} Billye Y. Avery, Being Pro-Choice Isn't An Abstract Issue for Black Teenagers (unpublished memorandum, on file with author).
\textsuperscript{144} GOLD, supra note 17, at 58.
\textsuperscript{145} Avery, supra note 143.
\textsuperscript{146} CHILDREN'S DEFENSE FUND, supra note 15, at 39.
were white, and thirteen percent were Hispanic. While thirty-nine out of one hundred African American teens with unintended pregnancy actually have a baby, only twenty-five out of one hundred white teens have babies.

As a result, any restrictions on abortion access and low-cost abortion services provided by clinics will disproportionately affect women of color. Reproductive rights advocates should oppose such restrictions at the state as well as the federal level. For women, especially women of color, abortion is a life and death issue.

IX. Women's Health Equity Act

In late July 1990, United States Representatives Patricia Schroeder (D-CO) and Olympia Snowe (R-ME), Co-Chairs of the Congressional Caucus for Women's Issues, introduced the Women's Health Equity Act of 1990 (WHEA). This omnibus package of legislation focuses on women's health and seeks to guarantee women greater equity in medical research and the delivery of health care services. It includes twenty individual bills divided into three separate titles—research, services, and prevention.

The Act responds to the limited funding and research devoted to women's health issues. For instance, the National Institute of Health (NIH), the nation's major source of funding for medical research, spends only about thirteen percent of its budget on women's health research. Additionally, a study by the General Accounting Office (GAO) found that NIH had made little progress in implementing its policy designed to include women in clinical research studies and that NIH lacked appropriate mechanisms for monitoring compliance with the policy. Research on diseases specific to women is inadequate. For example, breast cancer death rates increased twenty-four percent between 1979 and 1986, yet very little research has been conducted. For diseases common to both sexes, virtually all research is conducted on men. Although women are the fastest growing group of those infected with AIDS and heart disease is the number one killer of women,
research on the particular problems of women affected by these diseases remains scarce. Only Congressional action can address this startling state of affairs.

Advocates of civil rights, health issues, and women's issues should follow this omnibus package of legislation and ensure that the general public knows such legislation is pending. The media has paid very little attention to the bills which have been introduced, though grass-roots support for these bills will be needed. Again, it is a matter of life and death for American women.

X. CONCLUSION

This paper has developed several specific reproductive health issues that affect African American women's definition of reproductive choice. Though all women share these health concerns, the reproductive choices of African American women in particular are too often limited by poverty. African American women genuinely support a woman's right to choose whether or not to have a baby. The larger women's movement unfortunately has focused too narrowly on the choice of not having a baby while ignoring the fact that many women choose to carry pregnancies to term. These women should not be penalized, nor should their children be endangered because of their economic status.

The problems and issues of African American women should not be the concern solely of African American women. Civil rights and women's groups should be responsive to the needs of the group whose interests converge with both. Yet neither group embraces African American women and our concerns. All advocates of women's rights and racial justice should join forces to ensure that the health and welfare of children born to the least economically and politically powerful group—African American women—are guaranteed. Too often, African American women have slipped through the cracks.
Appendix

Congressional Caucus for Women's Issues†

The Women's Health Equity Act of 1991

H.R. 1161, Introduced by Reps. Patricia Schroeder and Olympia Snowe
S. 514, Introduced by Sen. Barbara Mikulski
February 1991

TITLE I—RESEARCH


H.R. 1263 would permanently authorize the Office of Research on Women's Health, established by NIH [National Institute of Health] in September 1990. The office would serve as overseer and coordinator of efforts to improve women's health research at NIH, and would evaluate the representation of women among senior physicians and scientists and develop programs to increase their representation. The office would also be required to develop a plan for an intramural program in obstetrics and gynecology at NIH. That program would be instituted in the second year after the legislation's enactment. The Women's Health Research Act also authorizes the establishment of three multidisciplinary centers of excellence around the country to conduct research on women's health. H.R. 1263 would authorize $20 million in fiscal year 1992 for the Office for Women's Health Research, and $7.5 million for the centers of excellence.

2. Clinical Trials Fairness Act (H.R. 1160, Rep. Patricia Schroeder)

This legislation would codify NIH's policy regarding the inclusion of women and minorities in research, and extend that policy to the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), which has been in voluntary compliance with the policy since 1987. H.R. 1160 would require the inclusion of women and minorities, where feasible and appropriate, in all clinical trials—both intramural and extramural—funded by NIH and ADAMHA. Exceptions would be permitted where inclusion of these groups

† For more information and the full text of each bill, contact the Congressional Caucus for Women's Issues, 2471 Rayburn Building, Washington, D.C. 20515, tel. (202) 225-6740.
would endanger their health or would be inappropriate to the purpose of the research.


H.R. 1264 would create a new Office of Research on Women’s Mental Health and Substance Abuse at the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) charged with many of the same tasks as the Office for Women’s Health Research at NIH, including coordinating efforts to improve research on women’s mental health and substance abuse, supplementing existing research funds, ensuring that women are included in clinical study populations, and developing programs to increase the number of senior women scientists at ADAMHA. The Office would also make grants for the establishment of centers of excellence on women’s mental health. H.R. 1264 would authorize $20 million for the new Office and $7.5 million for the centers for excellence in fiscal year 1992.

4. Women and Alcohol Abuse (H.R. 1000, Rep. Mary Rose Oakar)

This legislation would increase funding for the National Institute of Alcohol Abuse and Alcoholism at ADAMHA by $23 million for research on alcoholism, giving priority to problems unique to women.


H.R. 381 would authorize an additional $25 million earmarked specifically for basic breast cancer research at the National Cancer Institute (NCI).

6. Contraceptive and Infertility Research Centers Act (H.R. 2651, Reps. Patricia Schroeder and Olympia Snowe)

H.R. 2651 would provide $15 million for the development and operation of three contraceptive and two fertility research centers which would conduct clinical and other applied research; develop protocols for training physicians, scientists, nurses and other health professionals; and develop continuing education programs for such professionals. In addition, the bill creates a grant and loan repayment program to attract top-notch scientists to work at the centers.

7. Sense of Congress Resolution on Contraceptive and Infertility Research (H. Con. Res. 166, Reps. Patricia Schroeder and Olympia Snowe)

H. Con. Res. 166 expresses the sense of Congress that contraception and
fertility research, development, and education should be a national priority, and sets specific research goals for the next 20 years. The resolution also urges Congress to require the Secretary of Health and Human Services to reestablish the Ethics Advisory Board, which was terminated in 1980. NIH currently cannot conduct research on in vitro fertilization without the express approval of the Ethics Advisory Board.


This legislation would authorize a $10 million Women and AIDS research initiative within NIH and ADAMHA that would support both intramural and extramural research concerning HIV transmission, development, treatment and prevention in women. The bill also authorizes $6 million to create a new program under the Community Based Clinical Research Initiative (P.L. 100-607), which provides funds for the establishment of research organizations located in community settings to provide access to clinical research for populations at high risk for HIV infection. Under the legislation, funds would be used to expand clinical trials involving AIDS treatment for women. The bill makes clear that money under this program could be used for support services, such as child care and transportation.


H.R. 148 would authorize $30 million a year for the National Cancer Institute on basic research to develop an early-detection test and to determine whether there is a genetic basis for ovarian cancer.


H.R. 1212 authorizes an additional $62 million for federal research on osteoporosis, including basic research into the causes of the disease as well as treatments to restore bone loss or prevent further bone loss. The legislation would also provide for the establishment of an Interagency Council to promote and coordinate research and education and health promotion programs; an Advisory Panel to make recommendations about the disease; and a Resource Center to compile and disseminate information.

**Title II—Services**


H.R. 382 would withhold federal Medicaid funds from states that do not
enact laws requiring physicians and surgeons to inform breast cancer patients of alternative effective methods of treatment for breast cancer before treatment begins.


   This legislation authorizes direct reimbursement for nurse practitioners specializing in women's health under the Medicare and Medicaid programs, in order to improve access to prenatal care and preventive gynecological care for low-income and older women.


   H.R. 1398 would revise the Adolescent Family Life Act (AFLA) to provide $60 million for comprehensive prenatal and postpartum care, well-baby and well-child care, family planning, and family life and parenting education. The new program would also provide for preventive education and screening for sexually transmitted diseases and referral for treatment. Under H.R. 1398, both teen mothers and fathers would be eligible for counseling and referral services for employment, employment training, nutrition, substance abuse, and adoption services. Unlike the current program, H.R. 1398 would encourage parental and family involvement, but would not deny services to teenagers who choose not to consult their parents. In addition, pregnant teenagers would be informed of the availability of counseling for all legal options regarding pregnancy. No funds under the legislation could be used to pay for an abortion.


   H.R. 1128 would provide grants for the establishment or support of adolescent health demonstration projects in secondary schools. These projects would provide health care information and services. The projects would be required to encourage family participation, to obtain the approval of the local school board before the project is implemented, and establish a community advisory committee. No funds under the legislation could be [used] to perform or to pay for an abortion.

This bill expands current health insurance continuation provisions under COBRA to require employers to provide health insurance coverage for widowed, divorced and legally separated spouses age 50 and above until they obtain alternate coverage or become eligible for Medicare. The bill also requires continued coverage for their dependent children until they reach age 23.


H.R. 927 requires that all federal employee health insurance plans that provide obstetrical benefits also cover medical procedures for overcoming infertility and any necessary expenses related to the adoption of a child. The legislation also allows federal employees to use sick leave for family building activities.

TITLE III—PREVENTION


H.R. 290 requires states to provide Medicaid coverage for all pregnant women and children under age six with incomes up to 185 percent of poverty. The House of Representatives had passed similar legislation in 1989 as part of budget reconciliation; however, Congress eventually reduced coverage to pregnant women and young children with incomes up to 133 percent of poverty.


This legislation would require states to provide Medicaid coverage for routine mammography and pap smear screening. Such coverage is currently optional.


H.R. 3462 would address concerns regarding the quality of mammography screening by requiring that all mammography screening facilities receive certification by a national accreditation body. Each facility issued a certificate must use equipment designed specifically for mammography, use only qualified individuals who meet state licensing requirements or who have been trained
and certified to perform mammograms, and use only qualified radiologists who are certified to interpret the results of the mammogram. Annual inspections of certified facilities would be authorized under the legislation.


H.R. 1213 would expand Medicare reimbursement for updated technologies for diagnostic testing for osteoporosis. Only individuals at high risk of developing osteoporosis, including women with an estrogen deficiency and individuals with vertebral abnormalities, would be covered under the legislation.


This legislation would authorize $10 million under the AIDS prevention program for select family planning clinics and other public health clinics that provide preventive health services for women in high risk areas to design and carry out innovative programs of outreach, referral, services, and training, including family planning, screening and treatment for sexually-transmitted diseases, and counseling and testing for the HIV virus. Clinics would also develop improved referral arrangements with agencies that serve women and their partners, including drug abuse clinics, STD clinics, and homeless shelters, and would provide appropriate follow-up services. In addition, funds would be available to train clinic personnel in dealing with persons at high risk of AIDS, sexually-transmitted diseases, and unintended pregnancy.


H.R. 3461 would authorize the Centers for Disease Control to provide $80 million to family planning clinics and STD clinics to provide outreach and counseling to women on the prevention and control of chlamydia and gonorrhea, to screen women for the diseases, and to provide treatment to women and their partners. Funds would also be used to develop and disseminate public information and education programs, and to collect data on the incidence of chlamydia and gonorrhea.