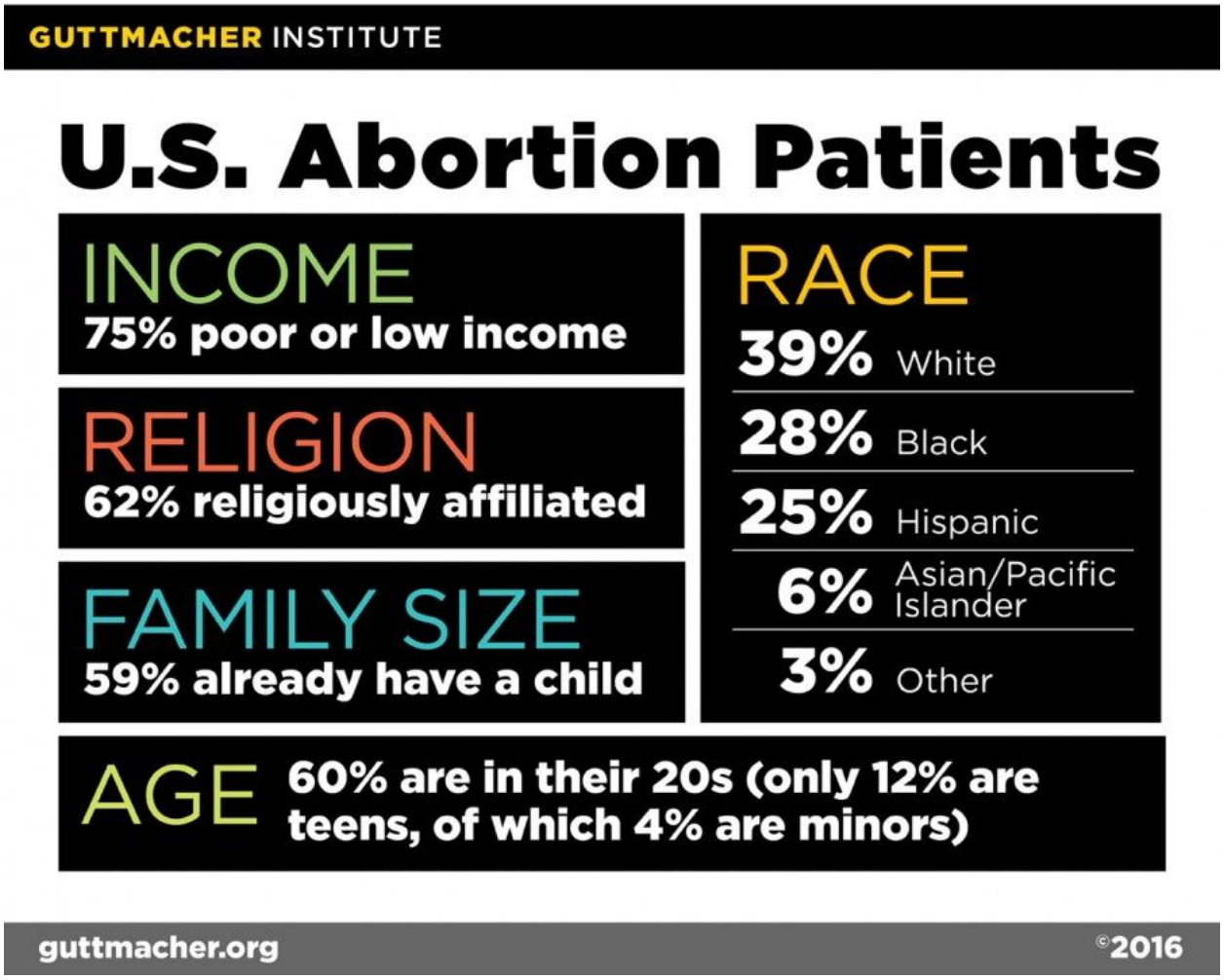
Dimensions of Reproductive Demographics and Oppression in the US

Key Demographics



Source: https://www.guttmacher.org/infographic/2016/us-abortion-patients -- This infographic details the proportion of abortion patients in the United States by demographic characteristic as of 2014, including race and ethnicity, income level and poverty status, religion and religious affiliation, age, and whether patients already have children. The data come from a nationally representative survey of nonhospital abortion patients in the United States.

Birth Control and Abortion Use by Religion in the US

More than 99% of people in the United States who identify as religious have ever used contraceptive methods such as the birth control pill, IUDs and condoms. Only 1% have solely used natural family planning.

According to data from the 2015–2017 National Survey of Family Growth, administered by the National Center for Health Statistics, the percentages of US women who have ever used a contraceptive method other than natural family planning (i.e. periodic abstinence, temperature rhythm and cervical mucus tests) are:

- 99.6% of women with no religious affiliation;
- 99.0% of Catholics;
    - Among Catholic women who had sex in the last 3 months, were not infertile/pregnant/postpartum and were not trying to get pregnant at the time of the survey:
        - 25% used sterilization
        - 15% used long-acting reversible contraceptives (like IUDs)
        - 25% used hormonal methods (like birth control pills)
- 99.4% of mainline Protestants;
    - Among mainline Protestant women who had sex in the last 3 months, were not infertile/pregnant/postpartum and were not trying to get pregnant at the time of the survey:
        - 26% used sterilization
        - 14% used long-acting reversible contraceptives
        - 28% used hormonal methods
- 99.3% of evangelical Protestants;
    - Among evangelical Protestant women who had sex in the last 3 months, were not infertile/pregnant/postpartum and were not trying to get pregnant at the time of the survey:
        - 36% used sterilization
        - 15% used long-acting reversible contraceptives
        - 20% used hormonal methods
- 95.7% of people with other religious affiliations.

Among US abortion patients in 2014:

- 17% of abortion patients identified as mainline Protestant;
- 13% as evangelical Protestant;
- 24% as Catholic;
- 38% reported no religious affiliation; and
- 8% reported some other affiliation.

Source:
https://www.guttmacher.org/article/2020/10/people-all-religions-use-birth-control-and-have-abortions

Sterilization and Long-Acting Reversible Contraceptives: Access and Coercion

Long-Acting Reversible Contraceptives (LARCs) such as IUDs, subcutaneous implants, or injections are more effective at preventing pregnancy than oral contraceptive pills. A couple relying on the pill is more than 45 times as likely to experience an unintended pregnancy in 1 year vs a couple relying on a LARC method. Access to LARCs has often been difficult for low-income people due to the historically high cost of access to these methods, and expansion of access regardless of ability to pay is important. However, coercive use of LARCs and coercive sterilization are two reproductive oppressions that have gone hand in hand when used against communities of color for decades.

Mary Alice Relf, age 12, and her 14-year-old sister Minnie were two young African American girls sterilized in Montgomery, AL in 1973. A nurse administering injectable contraceptives under a program funded through the federal Office of Economic Opportunity brought the girls to a physician's office for their shots. Their mother, who was unable to read, accompanied them and put an "X" on a form, thinking that she was consenting to the contraceptive injections. The girls and their mother were transferred to a hospital and their mother was escorted home; the girls were sterilized the next morning. The girls' parents did not know the operations had taken place until after they were done.

In Aiken County Hospital in SC, more than a third of the welfare recipients who gave birth during the first six months of 1973 were sterilized under a policy enforced by the county's three obstetricians. The physicians, who told patients they would refuse to continue to treat them after their third delivery unless they were sterilized, made statements like: "I feel that if I'm paying for them as a taxpayer, I want to put an end to their reproduction." Another said: "It's not a matter of money at all. It's that the individual shouldn't have any more children." Neither the hospital nor the state medical association objected; the hospital administrator described the policy as "well within accepted standards."

Ten low-income Latina women filed a case against Los Angeles County-USC Medical Center, stating that they had been coerced into being sterilized before or during labor, or immediately after giving birth in the 1970s. Some of the women had not understood that the sterilization procedure was permanent. One indicated she had not been informed about the sterilization until a postpartum visit weeks later. Another obtained an IUD from a family planning clinic six weeks after the surgery, and did not find out that she had been sterilized until 1974, two years later.

Coercive Use of LARCs

Norplant, a contraceptive implant offering up to five year of protection against pregnancy, was approved by the FDA in 1990. Just two days after the method's approval, a Philadelphia Inquirer editorial argued that although no one should be compelled to use the method, "there could be incentives to do so. What if welfare mothers were offered an increased benefit for agreeing to use this new, safe, long-term contraceptive?" The piece garnered immediate backlash, which led the newspaper to publish a formal apology less than two weeks later: "Great pain, anger and controversy have resulted from that editorial, and we deeply regret our decision to print it….In the previous editorial we said that women on welfare should be encouraged, but not compelled, to use Norplant. We suggested incentives, such as an additional benefit of some kind. Our critics countered that to dangle cash or some other benefit in front of a desperately poor woman is tantamount to coercion. They're right."

Sheldon Segal, who led the team that created Norplant, said that the method was developed to enhance reproductive freedom, not restrict it, and that anyone seeking to use it for purposes of coercion would find him "leading the opposition." Responding to a legislative proposal in Kansas, Segal added that "the line between incentive and coercion gets very fuzzy. The $500 bonus can be a heavy government hand on the scales of choice for the poor….When you single out a welfare mother, wave a $500 bill in front of her face and say the government is going to induce you not to have children, you've gotten into a risky area, ethically and morally."

Between 1991 and 1994, legislators in 13 states introduced measures to provide women receiving public assistance with financial incentives to obtain the implant. In 1991 in TX, legislators proposed an amendment to an appropriations measure that would have offered a woman $300 if she agreed to receive the method and an additional $200 if she retained it for five years.

During those same years, legislators in seven states introduced bills that actually would have mandated Norplant use for some women. Some measures would have required the implant for a woman who gave birth to a newborn showing signs of substance use during pregnancy. A bill introduced in WA would have required the woman to keep the method in place until she was drug-free for six months. Another in NC would have mandated the implant for women who had had a publicly funded abortion, unless medically contraindicated. A 1993 SC bill introduced would have required a woman with two or more children to have a Norplant inserted as a condition of being able to start receiving welfare benefits. Other bills in MS, OH and SC would have required the method as a condition of continuing to receive benefits for existing children.

In the context of the fight over welfare reform in the mid-1990s, this approach paved the way for a debate over so-called family caps, which are policies aimed at limiting welfare

payments to families with more than a designated number of children or who have additional children while receiving welfare payments. Family caps remain in effect in several states today. California's family cap policy takes a unique approach—exempting a woman who has an additional birth due to contraceptive failure; specifically, the woman must provide written verification that she was using a LARC method at the time, or that she or her partner had been sterilized.

Legislators in CO and OH introduced measures that would have offered women convicted of a crime reduced legal sentences if they obtained the implant or agreed to be sterilized. In mid-1990s, CA, FL, IL, NE and TX judges ruled that a woman must accept implant insertion as a sentencing requirement, usually as a condition of a reduced sentence.

In 2014, a VA man facing charges of child endangerment agreed to have a vasectomy as part of a plea deal. The prosecutor who offered the deal described the arrangement as "in the best interest of the Commonwealth."

Safeguards Against Coercion

Medicaid rules have stipulated since 1972 that family planning services are covered only for individuals "who desire such services and supplies," and subsequent regulations put additional specific requirements on Medicaid-funded sterilizations. These rules bar using Medicaid funds to sterilize anyone who is institutionalized or younger than age 21. They also require a 30-day waiting period between the time a patient consents and when the procedure is performed. The regulations lay out specific procedures designed to ensure that patients give their informed consent, including a requirement that they be told that receipt of any other benefits cannot be conditioned on agreeing to be sterilized.

From its inception in 1970, Title X funded projects have been bound by similar restrictions on sterilization services. Federal regulations require programs to offer services without "any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services." Additionally, Title X regulations require that programs provide clients a choice of a broad range of contraceptive methods.

When Safeguards Become Restrictive

Safeguards can also have the unintended effect of impeding people's access to desired care. Medicaid's flat ban on sterilizations for individuals younger than 21 blocks access to services for young people who truly desire to terminate their childbearing ability. The 30-day waiting period may also restrict restricting access for patients who want the procedure concurrent with either abortion or childbirth. Additionally, it is noteworthy that

these restrictions apply to publicly funded procedures, but not to procedures obtained through private health insurance.

Questions remain going forward:

- Given the historical examples of women not having received the information they needed to make free and informed choices, what is the best way for clinicians to convey that some methods are more effective than others, while still ensuring that patients are given the full information they need to make decisions about what is most appropriate for them?
- Because financial incentives have been inappropriately used to influence reproductive choices in the past, how can payment systems that financially reward providers when more patients opt for the most effective methods, such as LARCs, be structured to avoid undermining the quality of the information and range of choices women receive?

Source: https://www.guttmacher.org/gpr/2014/09/guarding-against-coercion-while-ensuring-access-delicate-balance# Retrieved 2/7/2021