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Reproductive Laws, Women of Color, and Low-Income Women

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Introduction

Reproductive rights, like other rights, are not just a matter of abstract theory. How these rights can be exercised and which segments of the population will be allowed to exercise them must be considered in light of existing social and economic conditions. Therefore, concerns about the effects of race, sex, and poverty, as well as law and technology, must be actively integrated into all work and discussions addressing reproductive health policy.

This chapter concerns the six areas identified by the Project on Reproductive Laws for the 1990s[1] as they affect low-income and women of color. Many, though not all, women of color are poor. Women of color are not all one group, just as women of color and poor women are not one group. They have different needs, behaviors, and cultural and social norms. One thing they do share is having been left out of the decision-making process concerning reproductive rights. Although my experience is as a black woman, I will attempt to identify issues that appear to be nearly universal to both women of color and poor women and point out instances where their perspectives might differ.

There is little information available about the reproductive needs of women of color. In general, the demographic data about non-Caucasian women are clustered together under the heading "nonwhite," as if there were only two racial groups, white and nonwhite. For example, published abortion statistics are broken down only into two ethnic categories—white and black. As a result of this dichotomization, understanding of the experience of specific groups such as Native American, Asian/Pacific Islander, and Latina women is inadequate. This dichotomization is itself evidence of the pressing need for more precise data gathering on issues concerning women of color. The information that is available generally fails to consider the obvious cultural and social differences related to differences in ethnicity and national heritage. In many cases, this has made it difficult to define and address particular problems and to make recommendations about their solutions.

For many women of color, taking control over their reproduction is a new step and involves issues never before considered. The reason for this is that women of color have not always had access to the prochoice movement. In the past, it has been difficult for many middle-class white feminists to understand and include the different perspectives

and experiences of poor and minority women. Thus, it is particularly important that adequate information on the needs and experiences of all women be made available now.

The broader economic and political structures of society impose objective limitations on reproductive choice, that is, decisions as to when, whether, and under what conditions to have a child. Very simply, women of color and poor women have fewer choices than other women. Basic health needs often go unmet in these communities. Poor women and women of color have a continuing history of negative experiences concerning reproduction, including their use of birth control pills, the IUD, and contraceptive injections of Depo-Provera;[2] sterilization abuse,[3] impeded access to abortion, coercive birthing procedures and hysterectomy,[4] and exposure to workplace hazards.[5]

Thus, the primary reproductive rights issues for poor women and women of color include access to health services and information, and the ability to give informed consent or informed refusal; access to financial resources; an end to discrimination relating to class and race, which creates the potential for abuse of the new technology; development of new policies and programs geared toward their needs; medical experimentation; and the need to explore and promote the extended family concept and alternative family structures. Given the history and circumstances of these groups, there are two overarching concerns. One is the desire to make reproductive services, including new technologies, broadly accessible. The other is the need to safeguard against abuse.

After considering each of the six topics, this chapter makes policy recommendations relating to the needs of poor women and women of color. These recommendations are designed to ensure

1. Access to quality prenatal care.
2. The birth of healthy, wanted children.
3. Protection against sterilization abuse.
4. Protection against occupational and environmental conditions harmful to fertility and health.
5. Protection from pharmaceutical experimentation and unnecessary medical procedures.
6. Access to accurate information about sex, conception, and contraception.
7. Access to safe, affordable abortion.

In light of the structural nature of the limitations on the exercise of reproductive choice by poor women and women of color, the recommendations often focus on affirmative policy initiatives rather than legal restraints.

Time Limits on Abortion

Poor women and women of color often live under circumstances that make it difficult for them to obtain early abortions. For instance, in 1971, nearly one in three nonwhite women of reproductive age lived below the poverty level. It is therefore important to develop affirmative programs that improve access to early procedures and, even more importantly, that reduce the risk of unwanted pregnancy. Unfortunately, however, such affirmative programs cannot totally obviate the need for late abortions. Thus, it is important to understand that laws restricting late abortions will continue to have a particular impact on poor women and women of color.

The Disproportionate Need for Post-First-Trimester Abortions

A significantly higher percentage of nonwhite women who get abortions do so after the first trimester, or first twelve weeks, of pregnancy. Of all abortions obtained by white women in 1983, 8.6 percent took place in the thirteenth week or later, but 12.0 percent of nonwhite women having abortions obtained them in that period. These figures represent the numbers of women who actually succeeded in obtaining post-first-trimester procedures, and they may seriously understate actual demand. Financial, geographical, and other barriers to access are likely to have a greater impact on nonwhite women, whose overall abortion rate is more than twice that of whites.

There is little information directly concerning very late abortions. Available data on women who obtain abortions after the first trimester, however, demonstrate that financial factors are very important. The enactment and implementation of the Hyde amendment terminating federal Medicaid funding for abortions has caused many poor women to delay having abortions while they raise the necessary funds. A study of a St. Louis clinic, for example, showed that in 1982, 38 percent of the Medicaid-eligible women interviewed who sought abortions after the tenth week attributed the delay between receiving the results of their pregnancy tests and obtaining their abortions to financial problems. Yet Medicaid-eligible women were not significantly later in obtaining abortions than other women before the Hyde amendment went into effect. Even where state Medicaid funding is in theory still available for abortions, it is often not available in practice. Welfare workers and other state officials do not always inform Medicaid recipients of their right to obtain Medicaid-funded abortions. Not all abortion providers are aware that reimbursement is available from Medicaid. Some providers who are aware are unwilling to except Medicaid, inpart because doctors are reluctant to assert that the abortions they perform fall within the particular categories being funded in their states and in part because Medicaid reimbursement rates are so low.[6]

Difficulty in locating abortion services also causes delay. In 1984, there were no abortion providers identified in 82 percent of the counties in the United States—that is, where 30 percent of all women of reproductive age lived. The availability of abortion services also varies considerably by state. Because abortion facilities are concentrated in metropolitan areas, access to abortion services is particularly difficult for rural women. In 1984, 79 percent of all nonmetropolitan women lived in counties that had no abortion facilities.[7] Although geographic access may not pose a significant problem for women of color from northern states who are concentrated in inner cities, it is a concern for women of color in southern states.

Not only are Native American women who live on reservations denied federal funding for abortions, but no Indian Health Service clinics or hospitals may perform abortions even when payment for those procedures is made privately. The Indian Health Service may be the only health care provider within hundreds of miles of the reservation, and as a result the impact of the regulations can be quite severe.

Women in prison, who are disproportionately poor and of color, may also have great difficulty in gaining access to abortion facilities. Abortion services are rarely available at the prison, and prison authorities are unwilling to release inmates for treatment. Recently adopted federal regulations specifically deny abortion services to federal prisoners.[8]

Even where abortion services exist, lack of information about them deters early abortion. Language barriers and the absence of culturally sensitive bilingual counselors and educational materials make gaining information about abortion services a special prob-

lem for Asian/Pacific and Hispanic women. This information gap would be severely exacerbated by the Reagan administration's proposed new Title I regulations, which would prohibit family planning services receiving federal monies under the Title X program from giving any information about the abortion option.[9]

Three factors have been identified as especially important in accounting for very late abortions: youth, medical conditions, and fetal anomalies. At least two of these, youth and medical problems, are likely to have disproportionate significance in the case of women of color. The significance of the problem of fetal anomalies for poor women and women of color is discussed below in the section on prenatal screening.

In 1981 (the latest year for which data are available), 43 percent of all abortions performed after the twentieth week of pregnancy were performed on teenagers. Women under fifteen years of age are most likely to obtain the latest abortions (those at twenty-one weeks or more gestation). Their delay is understandable in terms of the difficulties very young women experience in obtaining abortions. These difficulties include the parental notice and consent requirements in effect in some states, as well as the financial and information problems already discussed. Teenagers of color often have particular difficulty in obtaining an abortion. One study found that four out of ten black teenagers were unable to obtain a desired abortion, as compared to two out of ten white teenagers.[10]

Medical problems are also a factor in late abortions, including very late abortions. A major reason for very late abortions is the onset or worsening of certain diseases. Given the nature of their health problems, poor women and women of color are particularly vulnerable to such developments. For example, black women have higher rates of diabetes, cardiovascular disease, cervical cancer, and high blood pressure[11] than other women and may therefore be in greater need of late abortions. Similarly, the lack of prenatal and general health care that results from poverty may mean that serious health problems arise during pregnancy for many poor women.

Different Forms of Time Limits

The limits on abortion may be imposed by various laws. Currently, there is concern about statutes that impose prohibitions on postviability abortions or seek to compel the use of the method most likely to preserve fetal life unless the woman's health would be jeopardized. Poor women and women of color bear the brunt of such laws because women with money and power can find ways to circumvent the law, just as they did prior to the legalization of abortion. Affluent women can either travel to a place where a procedure is legal or find a doctor who will certify that their health is at stake. Poor women who do not have such options are denied autonomy because, as the experience with Medicaid provisions allowing reimbursement only for health-threatening situations suggests, few doctors are willing to risk prosecution under these statutes.

Time limits on abortion may result from a provider's decision not to perform procedures past a certain point in pregnancy. Poor women and women of color today have limited access to facilities that provide abortions after the first trimester. Public hospitals are a major source of health care for poor women, yet only 17 percent of all public hospitals report performing abortions in 1985. Even where the lack of access does not result in an outright denial of abortion, it may cause women further delay that subjects them to increased health risks.[12]

Because most poor women must get abortions where they can find them, they may be severely limited in their choice of method. Although abortions done by the dilatation

and evacuation (D & E) technique, are safer and less upsetting for women, D & Es are not universally available. To obtain a D & E, a woman may be required to pay for a private gynecologist or travel to a facility where the procedure is done. The problem of obtaining an abortion after the twentieth week is even more acute. Because such a limited number of providers perform this procedure, locating a facility, scheduling the procedure, and traveling can all impose serious burdens on poor women.[13]

The question of abortions very late in pregnancy pits the well-being of the pregnant woman and other people against that of the unborn fetus. Although there is no consensus among poor women and women of color that the woman's interests are paramount, there is widespread appreciation of the circumstances that bring women to late abortions and a general sense that the state must not make the decision for the woman. Compelling the use of abortion methods that lead to fetal survival raises serious questions. How would the fate of a surviving fetus be determined? If a fetus were born alive, who would be responsible for its care? What if the mother did not want it? Who would be responsible for financial support? Where would the unwanted fetus be sent? Could it be experimented on? Given their economic circumstances and their history of being subjected to experimentation, poor women and women of color have valid fears about the intentions of the state toward an unwanted fetus.

Family Planning and Life Choices

The number of abortions needed can be drastically reduced by teaching men and women how to prevent unintended pregnancy, but the process may not be simple. When members of a community are denied their rights, how can they know what those rights are, much less learn to assert them? To be effective, family planning services must present information and services in culturally appropriate ways, involving bilingual materials and personnel. Family-planning programs must also take account of cultural attitudes and biases about birth control. Some women of color have been unwilling to limit their reproduction in order to redress past population decreases that resulted from war, famine, infant mortality, or genocide. Thus, such programs must make women of color aware of how the ability to take control of reproductive decisions will benefit their lives.

Another important aspect of providing family-planning services is helping teenagers make life-enhancing decisions despite the many barriers for young people in our society today. Many teenagers, faced with an empty future, believe that becoming a parent will stabilize their lives. Teenagers need information services, decision-making skills, opportunities for success, and help in building their skills and interests regarding both school and work. They also need family life and life-planning education, and adolescent health services staffed by concerned adults.

Recommendations

Family Planning

1. Information must be made available to young people and adults, on sex, pregnancy, contraception, and abortion and on how to make choices about them in ways that are culturally appropriate and targeted to the needs of specific communities. Interpreters should be available where necessary. Television, magazines, newspapers, and radio should help provide this information in a variety of languages.

2. Comprehensive job-skill development programs for young people and adults should be available in schools and community programs. In addition to providing needed job training and workplace skills, this type of training can build self-confidence and encourage men and women to make appropriate childbearing choices.
3. Expanded funding should be available to enable sexually active youngsters and teenagers to obtain family-planning services. If more young people and adults learned how to prevent unwanted pregnancies, there would be savings in the Aid to Families with Dependent Children and Medicaid programs. Knowledge about spacing pregnancies and education about prenatal care could also reduce the incidence of low-birth weight babies and associated medical costs.
4. Prochoice groups should develop stronger alliances with those concerned about teenage pregnancy.
5. Statistical data should be gathered regarding Latina, Asian, and Native American, as well as black and white, populations.
6. The Hyde amendment should be repealed.
7. In states funding abortions, Medicaid should offer more realistic and prompter reimbursement to encourage more providers to accept Medicaid patients without insisting on cash payments.
8. Where abortion funding is available, information clarifying abortion payment policies should be disseminated to health care providers. Welfare workers and hospital and clinic staff should be trained to know what Medicaid pays for. Community-based nongovernmental organizations should assist in disseminating information and in monitoring the information provided by public agencies.
9. Family-planning services must be able to provide abortion information and referrals.
10. Adequate services must be available at all stages of gestation.

Postviability Abortions

11. There should be no laws compelling completion of a pregnancy under any circumstances.
12. Responsibility for determining the fate of a live-born fetus must lay with the woman who bore it.
13. Fetal health should be secondary to that of the mother.

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Fetus as Patient

The topic of fetus as patient involves attempts by medical and legal authorities to compel women to follow doctors' orders and accept particular medical procedures while pregnant and when they give birth. For example, doctors and hospitals may seek court orders forcing women to undergo surgery on the fetus or to submit to cesarean sections rather than to give birth vaginally. Women may also be subject to criminal prosecution for "fetal abuse" or to civil suit by their children for their behavior while pregnant.

Medical and legal actions in the name of fetal rights raise many issues for poor women and women of color. A basic question is whether it is right to hold individual women responsible for poor outcomes at birth when many women are not able to live under healthful conditions. This topic thus implicates the general socioeconomic conditions

poor women and women of color experience that result in their lack of access to basic prenatal care and advanced prenatal, perinatal, and neonatal technologies. Holding individual women responsible under present circumstances is morally unjust, and it diverts attention from the need to correct the serious inequities that permeate today's society.

Liability for Poor Reproductive Outcomes

There is good reason to believe that poor women and women of color will be especially vulnerable to prosecutors' attempts to hold mothers responsible for bad reproductive outcomes. As a general matter, their children experience greater rates of infant mortality and low birth weight, which can result in physical and neurological illness. Infant mortality and morbidity among mothers who live below the poverty line are greatly increased, sometimes to as much as twice the rate experienced by other women.[14]

Although the data differentiated by racial and ethnic group are sparse and not standardized, they generally show that infant mortality rates for minority groups are disproportionately high. In 1982, for example, infant mortality rates for black infants were almost twice those of white infants. The infant mortality rates for Native Americans are also extremely high. Hispanics present a complex picture. Puerto Ricans generally have the highest infant mortality rates of any Hispanic group. Although the neonatal mortality rate for Mexican-Americans is considered low by some analysts, most studies suggest that the low death rate is the result of underreporting. Recent studies have shown that Mexican-Americans have a higher neonatal mortality rate in all birth weight categories than do blacks. Cuban-Americans have low infant mortality and high birth weights compared to other Hispanics. This is not surprising, given the higher socioeconomic status of Cuban-Americans compared to the other groups. The Asian population in the United States is quite diverse, and available data are inadequate. In general, perinatal outcomes for Asians in the United States are good, with relatively low incidence of low birth weight. Southeast Asian refugees, however, present a different picture with respect to perinatal outcomes, as a result of lower economic status and early childbearing.[15]

Socioeconomic conditions are an important element in these poor reproductive outcomes. Low-income women and women of color lack access to prenatal and neonatal care. In addition, many suffer from general ill health, broken families, and lack of social supports. They are more likely to be exposed to environmental hazards where they live or work. When poor women and women of color lack the resources necessary to help them bring healthy babies into the world, it does not make sense to hold them responsible for poor reproductive outcomes. Is it fair, for example, to say that an indigent woman is responsible for the consequences of deficiencies in her diet when Medicaid does not pay for vitamins? Similarly, is it fair to say an indigent woman is responsible for bearing a disabled fetus if Medicaid does not pay for abortion? It may be more just morally, if less feasible legally and politically to hold the state responsible for the high incidence of infant mortality and disability among the babies born to low-income women and women of color.

Compulsory High-Tech Procedures

Recent evidence suggests that hospital authorities' efforts to force pregnant women to accept high-tech procedures will be aimed disproportionately at low-income women and

women of color. In 1987, the *New England Journal of Medicine* published a report on the incidence of court-ordered obstetrical interventions, including forced cesarean sections and intrauterine transfusions. The report revealed that 81 percent of the women subjected to such court orders were black, Hispanic, or Asian; 44 percent were not married; 24 percent were not native English speakers; and none were private patients. Attempts to compel submission to procedures such as cesarean section, fetal monitoring, and other technologies presuppose that they have been adequately explained and that the pregnant woman has no good reason for refusing the procedure. Neither assumption may be warranted.

Health professionals report that most women, irrespective of color or education, do not question a doctor's orders. Indeed they stress that the major problem is unquestioning acceptance rather than rejection of prescribed procedures, particularly among low-income women. Some women who do question high-tech procedures may do so because doctors have not been able to clearly explain the risks and benefits. Others may refuse because they have personally had related negative experiences in the past or heard of others' bad experiences. Despite their failure to question the authority of a physician, poor women and women of color might have good reason to do so. They have been the subjects of experimentation in public hospitals and public health care services. In teaching hospitals, unnecessary procedures are known to have been performed to give experience to doctors in training.[16] Individual legal actions directed at women who do resist doctor's orders may divert attention from these problems and encourage other women to submit to unnecessary and risky procedures. Genuine informed consent could be an important tool in addressing these problems. Women need relevant information in a form they can understand and a supportive environment in which to consider it. It is questionable whether our informed consent laws concerning these technologies and procedures work now. What can informed consent mean today when the informer and the person being informed are on the opposite sides of education, class, race, gender, language, and culture lines? We must develop mechanisms that will really allow women to decide what treatment they want and that will protect women against being pressured into accepting tests and procedures they either do not want or whose implications they do not understand.

Technology and Resource Allocation

The overuse of sophisticated technology has inflated the cost of providing routine obstetrical care for all women. Perinatal regionalization schemes, with other high-cost equipment and personnel, focus on end-stage care for mothers and babies with medical complications. Little or no attention is paid to organizing a system that ensures that every pregnant woman receive basic prenatal care in her community and an adequate diet—an investment in preventing complicated pregnancies. More children are likely to benefit from prenatal care than from high-tech therapies. Although greater emphasis on preventive care is important for all segments of the population, it is especially important for the traditionally disadvantaged. Those concerned with the fetus as patient should focus on these needs rather than question the behavior of individual women.

A change in focus from end-stage high-tech procedures aimed at individuals to broadly aimed basic prenatal care programs will make existing resources go further. When good prenatal care and other health and social interventions are not available, the

results are more difficult deliveries and more low–birth weight babies needing expensive technologies. With fewer pregnancy complications, it should be easier to arrange for all those who need high-tech services to get them.

Recommendations

1. State and local record keeping relating to prenatal care and reproductive outcomes for all women of color should be improved by maintaining separate statistics for black, Hispanic, Asian, and Native American women.
2. Private insurance coverage of maternity benefits should be mandated, and all payment caps should be removed. Where insurance is employment related, costs should be shared by employers and employees.
3. States should make every effort to enroll all eligible pregnant low-income women in prenatal programs funded by Medicaid. Eligibility standards should be modified to make more low-income women eligible for Medicaid. States should establish a payer of last resort system for situations where neither Medicaid nor private insurance provide maternity coverage.
4. Services available to low-income women should be increased by expanding existing programs for women, children, and families in underserved areas. Such services should be culturally appropriate and multilingual.
5. States should continue efforts to increase the numbers of obstetricians, gynecologists, family practitioners, and mid-level health professionals accepting Medicaid patients by use of incentive programs or legal mandate, if necessary.
6. Medicaid recipients should have the opportunity to use mid-level health professionals such as midwives, nurse practitioners, and physicians' assistants who offer cost-effective prenatal and infant care.
7. Legislation ensuring informed consent regarding the use of fetal monitoring, cesarean sections, ultrasound and similar procedures, and certain drugs should be enacted. Such legislation should be modeled on the present federal and state sterilization regulations, which are designed to ensure that the patient has adequate knowledge and is not making her decision under pressure.
8. Legal remedies should be available for overuse of technology, just as malpractice suits currently result in recoveries for underuse of technology.
9. Attempts should be made to identify and prohibit experimental procedures that are potentially harmful. All other experimentation should have rigorous standards of informed consent.
10. Legislation should be enacted to make more resources available for prenatal care by regulating the amount of resources spent on high-tech care.
11. Statistical information regarding the frequency of use of high-tech procedures, including the races and income levels of the recipients, should be published for each health care facility.

Reproductive Hazards in the Workplace

The reproductive health of minority and poor women may be impaired directly, through job-related hazards, or indirectly, as a consequence of having low-paying jobs without

benefits. Thus, their reproductive health, like their general health, is affected by their status as workers, as members of a minority group, and as women. Women of color and poor women often have the most hazardous jobs, risking physical, chemical, and psychological injury. Their low income may restrict their access to health care, and force them to live in neighborhoods contaminated by environmental pollutants and to exist on inadequate diets. Many work in positions with low pay and long hours, without benefits such as health insurance, maternity leave, vacation time, or sick pay.[17] Moreover, poverty and discrimination increase stress. Women who are heads of households are particularly likely to suffer hardships.

Poor women and women of color generally have limited recourse when their rights are violated. They have been excluded from trade unions that could have improved their circumstances in the past, and they are afraid to unionize now for fear of losing their jobs.

Large numbers of low-income women and women of color are employed in the health, textile, and apparel industries and in cleaning services. For example, 30 percent of all ancillary, auxillary, and service workers in the health service industry are female, and of this 30 percent, 84 percent are black. Women working in low-income jobs in the health field are exposed to heavy lifting and to chemical hazards such as sterilizing gases, anesthetic gases, X-rays, and drugs. As a result, black hospital workers suffer an even higher rate of primary and secondary infertility than black people generally. Similarly, although little research has been done specifically on reproductive hazards encountered by minority or other hospital workers, nonprofessional hospital workers may be at elevated risk for certain types of cancers (especially breast cancer) because of exposure to radiation and various chemical agents. Cancer-causing agents usually also cause spontaneous abortion.[18]

The textile industry is another source of danger to poor women and women of color. For example, in 1980, nationally over 20 percent of all operatives were black women. In New York City, where the bulk of the garment industry is located, approximately 25 percent are Puerto Rican. Sweatshops located in Chinatown and staffed overwhelmingly by Asian women are responsible for a significant share of production. Workers in this industry often work in high-dust areas, spaces in which picking and carding operations take place. They are exposed to chemicals, dyes, arsenic, heat, cold, inadequate ventilation, and excessive noise, all of which affect women's general reproductive health as well as the health of a fetus.[19] Most sweatshops are located in dilapidated storefronts or badly ventilated lofts, to the detriment of the women's reproductive and general health. There are approximately five hundred sweatshops in New York City, with unsafe and unhealthy conditions. There are no benefits, and the compensation is too low to allow women to pay for or take time off for prenatal care. Most women who work in such jobs are afraid to complain for fear of being fired or reported to immigration authorities as illegal aliens.[20]

Women of color are also found in laundry and cleaning establishments. In 1980, 40 percent of all clothing ironers and pressers, and 23 percent of all laundry and dry cleaning operatives were black. Jobs in this sector also pose serious health risks. The National Cancer Institute found a higher mortality rate among laundry and dry cleaning workers than among the general population as a whole and found that women in these jobs, particularly women of color, contracted cancer of the lung, cervix, uterus, and skin at excessive rates.[21]

Many minorities, especially blacks and Chicanos, work in agriculture. Of the estimated five million migrant and seasonal workers, 75 percent are Chicano, and 20 percent

are black. These workers are exposed to pesticides that cause liver, renal, and reproductive damage.[22]

For some poor women and women of color, the financial precariousness of their work poses the greatest hazard. Women in low-paying positions, whether in agriculture or as domestics in private homes, tend to have no health or other benefits, such as sick leave or vacation. As a result, many women are forced to work throughout their pregnancies and to return to work immediately after giving birth irrespective of the risks to their health. For example, some jobs require women to stand on their feet all day, although continuous standing can cause complications during pregnancy.[23] Moreover, many of these jobs pay just enough to prevent women from being eligible for Medicaid and the prenatal care services it covers.

Conclusion

Poor women and women of color have pressing needs for health services, including reproductive health services. They also have a history of maltreatment by the health care delivery system. For such women, making existing rights a reality and meeting the challenges posed by new modes of reproduction and reported advances in prenatal and perinatal technology are crucially related to these needs and history. Reproductive laws and policies for the 1990s must respond to the concerns of all women. The laws for the next decade must

1. Widen the dissemination of education and information concerning reproductive health.
2. Augment private and public funding to allow financial access to health services.
3. Bar unnecessary and forced medical and surgical treatments.
4. Prohibit discriminatory and eugenicist bias or practices in health care delivery.
5. Ensure confidentiality in health care records.
6. Protect the patient's right to informed consent and informed refusal.
7. Broaden education about reproductive health hazards in the workplace.
8. Facilitate the delivery of culturally appropriate health services to ensure effective health care.
9. Enhance the recruitment of people of color to train as health care providers.
10. Guarantee equity of access to all new reproductive technologies, accompanied by equal protection against abuses of these technologies.
11. Mandate the collection of data on local, state, and federal levels on the reproductive health status of women of color, including Hispanics, Asians, blacks, and Native Americans.
12. Increase preventive health care measures to counter the health problems caused by structural socioeconomic determinants, so that there will be less need to resort to high-tech therapies as solutions.

To bring about the enactment of such laws, more information regarding the views, the life experiences, and the circumstances of poor women and women of color must be made available. Most importantly, poor women and women of color must be included in the decision-making process, so that more attention will be paid to their needs.

Notes

1. The areas are time limits on abortion, prenatal screening, fetus as patient, reproductive hazards in the workplace, interference with reproductive choice, and alternative modes of reproduction.

2. Adele Clarke, "Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis," in Test-Tube Women; R. Arditti, R. D. Klein, and S. Minden, eds. (1984), p. 199; "Birth Control Blamed for Health Problems," Intern Extra (April 7, 1983), p. 60. The United States Indian Health Service continues to give Depo-Provera to mentally retarded native American women in this country although it has been banned for contraceptive use in the United States since 1984. "Native Americans Given Depo-Provera," Listen Real Loud 8:1 (Spring 1987), p. A-7.

3. Judith Levin, and Nadine Taub, "Reproductive Rights," in Women and the Law; Carol Lefcourt, ed. (1987), pp. 10A-27-28.

4. Charles B. Arnold, "Public Health Aspects of Contraceptive Sterilization," in Behavioral–Social Aspects of Contraceptive Sterilization; S. H. Newman and Z. E. Klein, eds. (1978).

5. Leith Mullings, "Women of Color and Occupational Health," in Double Exposure; Wendy Chavkin, ed. (1984).

6. Stanley K. Henshaw, J. D. Forrest, and Elaine Blaine, "Abortion Services in the United States, 1981 and 1982," Family Planning Perspectives 16:3 (May/June 1984), p. 127. Of the providers in five states surveyed (Connecticut, Maryland, Massachusetts, New Jersey, and Pennsylvania), 10 percent were unaware that reimbursement was available.

7. Henshaw et al., "Abortion Services in the United States, 1984 and 1985," p. 65.

8. See 28 C.F.R. § 551.23 (December 30, 1986) providing that during fiscal year 1987 the Bureau of Prisons may pay for an abortion only where the life of the mother would be endangered if the fetus were carried to term or if the pregnancy is the result of rape.

9. "Rule on Abortion Counseling Is Blocked," *New York Times*, February 17, 1988, p. A10. Centers for Disease Control, Abortion Surveillance 1981 (November 1985), Table 14, p. 37.

10. Alan Guttmacher Institute, Teenage Pregnancy: The Problem That Hasn't Gone Away (1981) (an analysis of data from 1970).

11. U.S. Department of Health and Human Services, Report of Secretary's Task Force on Black and Minority Health, Executive Summary, vol. I (August 1985), p. 71.

12. W. Cates, Jr., and D. A. Grimes, "Morbidity and Mortality in the United States," in Abortion and Sterilization; Jane Hodgson, M.D., ed. (1983), pp. 158–59.

13. Boston Women's Health Book Collective, The New Our Bodies, Ourselves (1986), p. 303.

14. George C. Cunningham, former chief of Child and Maternal Health, California Department of Health Services, telephone conversation, January 25, 1987.

15. Report of Secretary's Task Force on Black and Minority Health, vol. I, pp. 180–81.

16. Gena Corea, The Hidden Malpractice: How American Medicine Mistreats Women (1985), pp. 200–3; Diana Scully, Men Who Control Women's Health; The Miseducation of Obstetrician–Gynecologists (1980), pp. 120–40 (see discussion of women as "teaching material").

17. U.S. Commission on Civil Rights, Health Insurance Coverage and Employment Opportunities for Minorities and Women, Clearinghouse Publication 72 (September 1982).

18. Joanna Brown, and Ronnie Scheir, "Workplace May Be Hazardous to Health of Blue Collar Minorities," The Chicago Reporter 10:3 (March 1981), p. 1.

19. Mullings, p. 129.

20. Ibid.

21. A. Blair, P. DeConfle, and D. Grassman, "Causes of Death Among Laundry and Dry Cleaning Workers," American Journal of Public Health 69:5 (May 1979), pp. 508–11.

22. F. W. Kutz, A. R. Yobs, and S. C. Strassman, "Stratification of Organochlorine Insect Residues in Human Adipose Tissue," Journal of Occupational Medicine 19:9 (1977), pp. 619–22; Mor-