

Regulation of Pregnancy and Childbirth

Establishment of Pregnant Women's Rights

In 1974, the Supreme Court ruled that a state insurance program that denied benefits to pregnant women by excluding pregnancy from a list of “compensable disabilities” did not violate the Equal Protection Clause of the Fourteenth Amendment.¹ Applying a “rational basis” level of review, instead of the “intermediate scrutiny” standard normally applied to gender discrimination, the court found that the exclusion of pregnancy was not a “mere pretext designed to effect an invidious discrimination” against women.²

- The ruling was effectively overturned by the Pregnancy Discrimination Act (PDA) amendment to Title VII of the 1964 Civil Rights Act, which required insurance providers to cover expenses for pregnancy-related conditions on the same basis as costs for all other medical conditions.³
- The PDA also prohibits discrimination against pregnant women in hiring, the availability of pregnancy-related work absences, and offering of fringe benefits.⁴
- An employer’s policy prohibiting women from working with lead-based chemicals was held unconstitutional in *International Union, UAW v. Johnson Controls*.⁵ The Court held that the PDA forbids “sex-specific fetal-protection policies”⁶ and established that employers cannot discriminate against women based on the “potential for pregnancy”⁷ in order to protect possible fetuses.
- The Family Medical Leave Act (FMLA), enacted in 1993, requires covered employers to grant women who have just given birth up to 12 weeks of unpaid, job-protected leave in a 12-month period; the FMLA also requires that health benefits be maintained during this time.⁸

Coercive Medical Treatment: Cesareans & VBAC

During the 1980s and early 1990s, the U.S. saw a trend of court decisions and government action attempting to “protect” women by regulating the manner of their pregnancies.⁹ Recently, this disturbing trend has seen a resurgence. The World Health Organization recommends that the rate of cesarean births should be between 10-15%.¹⁰ In the United States, the rate of cesarean surgeries is approximately 32%.¹¹

- Pregnant women are encountering more pressures, legal and psychological, to have cesareans. Hospitals in at least a dozen states have obtained court orders compelling unwilling women to undergo this major abdominal surgery, in some cases despite the pregnant woman’s physical resistance.¹² This is especially egregious given that the vast majority of women forced to undergo court-ordered cesarean surgeries are low-income Women of Color, who are some of society’s most vulnerable members.¹³
- A recent study suggesting that premature births are on the rise partly due to a record high cesarean rate supports the idea that there may be pressure from physicians to perform cesareans when there is not a genuine medical need.¹⁴ Premature babies are at increased risk for delayed brain development, breathing and feeding disorders, and various other health disorders and even death.¹⁵
- VBAC, or vaginal birth after cesarean, is an important option for women preparing for childbirth after a prior cesarean. According to the American Pregnancy Association, over 90% of women who have previously had a cesarean surgery are eligible candidates for VBAC.¹⁶ But although VBAC is a safe and reasonable choice for women with low-risk pregnancies, more than 40% of the hospitals in the U.S. *refuse* to allow a woman with a cesarean scar to attempt a vaginal delivery.¹⁷ Many hospitals claim to prohibit VBAC because they are unable to comply with unnecessarily strict guidelines from the American College of Obstetricians and Gynecologists (ACOG) and the American Society of Anesthesiologists.¹⁸ With the cesarean rate at an all-time high of 32%, this means a growing number of women

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must either consent to a subsequent cesarean against their wishes or decide to deliver outside a hospital setting.¹⁹

- In March 2010, the National Institutes of Health convened an independent panel of experts to address the safety and availability of VBAC.²⁰ Significantly, the panel's final statement affirmed that attempting vaginal delivery is a reasonable option for many women with prior cesareans and urged that current VBAC guidelines be revised to reflect this.²¹ Furthermore, the panel acknowledged that elective repeat cesarean is not a risk-free delivery;²² it also called for additional research to understand the various factors that influence decision-making for women who have had cesareans.²³
- Nevertheless, despite support for VBAC as a choice that should be available to pregnant women, the panel completely omitted any language about informed consent and patient autonomy from the final NIH consensus statement.²⁴ This outcome is particularly troubling because, according to one birthing rights advocate, "the panel refused to take a position on whether a pregnant woman has the same constitutional right to informed refusal as any other adult in the U.S."²⁵
- In July 2010, the American College of Obstetricians and Gynecologists (ACOG) did revise their guidelines on VBAC and stated that VBAC is a safe and appropriate choice for most women who have had a prior cesarean delivery.²⁶ However, these changes are not likely to lead to more VBAC access because ACOG retained their strict recommendations on VBAC emergency procedures, which many hospitals are unable able to meet.²⁷

In states that recognize advance directives, or living wills, 25 states maintain explicit policies that any advance wishes of a woman are negated if she is pregnant.²⁸ In these states, if a woman has indicated that she wishes to have treatment withdrawn in advance, her wishes will be precluded, as life-sustaining treatment cannot be discontinued if there is the presence of a fetus.²⁹ Treatment will be administered in order to enable the fetus to be brought to term, even if such treatment is against the directives of the woman.³⁰

Coerced Sterilizations and Eugenics

While coerced sterilization may appear to be a shocking but archaic remnant of discredited eugenic theories, there are still many coercive sterilizations performed today in the U.S. and throughout the world. The victims of coerced sterilization tend to be from traditionally marginalized segments of the population particularly in regards to people of color and people with disabilities.³¹

- In the United States, many states passed compulsory sterilization laws in the early twentieth century for eugenic purposes.³² Twenty-nine states had enacted compulsory sterilization laws, and a majority of states still had such laws as of 1956.³³
- In 1927, *Buck v. Bell*, the Supreme Court legitimized Virginia's sterilization laws by finding that it was in the state's interest to sterilize an 18 year old woman who they deemed unfit because she was "feeble-minded" and "promiscuous".³⁴ From 1930 to the 1960s, sterilizations were performed on many more institutionalized women than men.³⁵ Men and women were compulsorily sterilized for different reasons.³⁶ Men were sterilized to treat their aggression and to eliminate their criminal behavior, while women were sterilized to control the results of their sexuality.³⁷ By 1961, 61% of the 62,162 total eugenic sterilizations in the United States were performed on women.³⁸
- Sterilization practices disproportionately affected women of color. During the 1960s and 1970s, thousands of poor Black women were coercively sterilized under federally funded

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programs.³⁹ It was common belief among Blacks in the South that Black women were routinely sterilized without their informed consent and for no medical reason.⁴⁰ Many women were coerced into sterilization under the threat that their welfare benefits would end unless they consented to the sterilization.⁴¹ This practice was so common that it became known as the “Mississippi appendectomy.”⁴²

- More than 25% of Native American women and 10% of Native American men were sterilized during the 1970s.⁴³ For many small Indian tribes, sometimes all of the pure blooded Native American women would be sterilized.⁴⁴ Many of these procedures were illegal and not in compliance with Indian Health Services’ policies.⁴⁵ These procedures were often conducted under false pretenses and misinformation.⁴⁶ Consent forms would not be in the woman’s language, welfare benefits would be threatened, or women would believe they were consenting to a different medical procedure.⁴⁷
- Despite a continuing consensus that freedom to procreate is a constitutional right,⁴⁸ court orders creating procreation penalties have gained some traction in state courts for offenses ranging from child abuse and neglect to drug abuse.⁴⁹
- Forcible sterilization continues to be a problem overseas. In *Maria Mamerita Mestanza Chavez v. Peru*,⁵⁰ the plaintiff’s family sued the Peruvian government for its policy of forced sterilization, which resulted in the plaintiff’s death. A settlement was reached under the Inter-American Commission on Human Rights which indemnified the Peruvian government from liability, despite the plaintiff’s assertions that they had engaged in a “massive, compulsory, and systematic government policy to stress sterilization as a means for rapidly altering the reproductive behavior of the population, especially poor, Indian, and rural women.”⁵¹ The Peruvian government provided one-time monetary compensation to the plaintiffs and assumed responsibility for investigating and seeking legal punishment for any perpetrators under Peruvian law.⁵²
- In March 2005, the Supreme Court of India ordered Indian state governments to comply with international human rights law in light of unsanitary and substandard conditions in “mass sterilization camps,” where many women are sterilized without being informed of the procedure.⁵³
- In *A.S. v. Hungary*,⁵⁴ a Hungarian Roma woman about to have a cesarean was asked to sign a statement of consent that contained the Latin word for “sterilization.” Only after the operation did she discover that she had agreed to a procedure that would make her permanently infertile. In August 2006, the U.N. Committee that monitors compliance with the Convention on the Elimination of Discrimination against Women (CEDAW) found Hungary in violation of CEDAW for failing to protect the woman’s rights.⁵⁵
- In Namibia, a trial is being litigated for women who were forcibly sterilized, without their informed consent, in public hospitals after testing positive for HIV.⁵⁶ The practice in many hospitals includes sterilizing women under duress during medical emergencies, or coercing women to sign consent forms without fully explaining the consequences of their medical treatment.⁵⁷ The practices have been criticized for violating Article 14 of Namibia’s Constitution, which provides that every citizen “shall have the right to marry and to found a family.”⁵⁸

Drugs and Pregnancy

One trend in the United States involves criminal sanctions against women who use drugs before and during their pregnancies, despite evidence that treatment, rather than penalties, is a more effective policy.⁵⁹ Women in at least nine states have been prosecuted for “endangering the fetus” by engaging in drug use during pregnancy.⁶⁰

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- Fifteen states regard substance abuse during pregnancy as child abuse under civil child-welfare statutes,⁶¹ with at least four states (MN, OK, SD and WI) recognizing substance abuse as grounds for civil commitment.⁶² South Carolina became the first (and currently only) state to uphold a conviction of a pregnant woman for child neglect of a viable fetus. In *Whitner v. South Carolina*,⁶³ the South Carolina Supreme Court ruled that a pregnant woman could be charged with unlawful child neglect for actions taken during pregnancy, a decision that encouraged law enforcement leeway to arrest and prosecute pregnant women suffering from substance addictions.⁶⁴
- The State of Alabama has prosecuted at least 40 pregnant women for the crime of “exposing her child to a meth lab” by ingesting drugs.⁶⁵ The State’s chemical endangerment law, which was originally intended to prosecute people who bring children to dangerous locations such as methamphetamine labs, is being used to prosecute pregnant women who use controlled substances.⁶⁶ According to prosecutors, the womb of a pregnant woman who uses meth is considered an illegal “drug lab” and their unborn fetus is considered a child.⁶⁷ Alabama legislators have attempted to pass a bill that expands the law to incorporate these provisions.⁶⁸
- A study by the *Journal of the American Medical Association* (JAMA) found that the criminal prosecution of pregnant women generally falls into three categories: 1) child endangerment/abuse, 2) illegal drug delivery to a minor, or 3) fetal murder/manslaughter.⁶⁹ Although no state has yet adopted laws that create unique criminal penalties for pregnant women who are drug users, each individual prosecution presents an opportunity for courts to determine if existing statutes can be expanded to cover these behaviors.⁷⁰ The Supreme Court in *Ferguson v. City of Charleston* declared that a state hospital regulation requiring pregnant women to be tested for drugs and be reported to the police if the test results were positive violated the Fourth Amendment prohibition against searches without probable cause.⁷¹ However, the case only addressed the issue of evidence collection for criminal prosecution of pregnant women, remaining silent on the more general question of whether such prosecutions are permissible.⁷²
- Many states now have laws that consider fetuses, embryos, or zygotes “persons” for the purpose of criminal statutes. See the LSRJ Fetal Rights fact sheet for more information on the ongoing attempts to assert “fetal personhood.”⁷³
- In addition, there are also controversial private programs such as Project Prevention, formerly known as CRACK (Children Requiring a Caring Kommunity), that compensate substance-using women in exchange for agreeing to be sterilized or use long-term birth control.⁷⁴
 - Though programs such as Project Prevention are privately-run, more and more of their referrals are coming from publicly funded jails, hospitals, drug treatment centers, and probation centers.⁷⁵
 - Opponents of these programs argue that they target predominantly poor Women of Color, and that the money funneled into these organizations should instead be used to provide affordable drug treatment programs for pregnant women and mothers.⁷⁶

Social Safety Net Policies

In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA),⁷⁷ which eliminated the federal guarantee of Aid to Families with Dependent Children and created Temporary Assistance for Needy Families (TANF). One of the PRWORA’s major goals is to reduce the number of children born “out-of-wedlock.”⁷⁸

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- One of the provisions of the PRWORA, the “Bonus to Reward Decrease in Illegitimacy,” gave a special cash reward to the five states that demonstrated the highest net decrease in out-of-wedlock births while keeping the ratio of abortions to live births below the 1995 level.⁷⁹
- Under “child exclusion” or “family cap” policies, states may refuse to provide additional benefits to a child born to a mother currently receiving TANF benefits.⁸⁰ Following welfare reform, welfare-eligible women had an increased likelihood of being uninsured pre-pregnancy and a higher probability of delaying enrollment into Medicaid until the prenatal period.⁸¹

In March 2010, the Patient Protection Affordable Care Act (PPACA) passed, which will increase access and affordability of health care insurance and coverage for uninsured pregnant women.⁸² The PPACA includes protection for childbearing women and newborns through the inclusion of maternal and newborn care in a defined package of “essential health benefits”.⁸³ Beginning in 2014, essential services must be covered in policies available through state insurance exchanges.⁸⁴ The PPACA also created two new programs for child bearing families, the Maternal, Infant and Early Childhood Home Visiting Program and the Pregnancy Assistance Fund.⁸⁵

- **Maternal, Infant and Early Childhood Home Visiting Program** awards grants for services in at risk communities, with a focus on strengthening families and community resources and improving maternal and newborn health, child health, and school readiness.⁸⁶
- **Pregnancy Assistance Fund** provides grants to States and tribes to help support pregnant and parenting teens and women who are enrolled in higher education programs with child care, housing, baby supplies and food, and other support and protective services.⁸⁷ The act also provides grants to organizations to provide personal responsibility education to young people to reduce pregnancy and sexually transmitted infection rates by delaying sexual activity and increasing contraceptive use when sexually active.⁸⁸

Birthing Rights, Midwives, and Doulas

In light of the coercive medical treatment discussed above and hospitals’ increasing tendency to ignore pregnant women’s wishes regarding prenatal and birthing care, many women are turning to doulas and midwives, either instead of hospitalization or in conjunction with it.

- Midwives are health care professionals who specialize in pregnancy and childbirth.⁸⁹ However, depending on the amount of training the midwife has, he or she can also provide gynecologic exams, birth control, and primary health care.⁹⁰ Currently, 27 states legally authorize Certified Professional Midwives (CPM) to perform medical services, while 23 states, the District of Columbia, and Puerto Rico subject CPMs to criminal prosecution for practicing medicine without a license.⁹¹ Advocates are currently working to change legislation to provide licensure and incorporate the practice within the state and federal healthcare structure.⁹²
- Previously, Medicare reimbursed certified nurse-midwives at the rate of 65% of the physician rate. Due to the Affordable Care Act, beginning in 2011, Medicare will be required to reimburse certified nurse-midwives at the rate of 100 percent.⁹³ This 100 percent reimbursement may be expected to increase access to nurse-midwifery care, enable the growth of independent nurse-midwifery practice, and make nurse-midwives more visible in group practices and health plans.⁹⁴
- Doulas are trained, experienced professionals who provide continuous support to the pregnant woman before, during, and immediately after birth.⁹⁵ The most important difference between midwives and doulas are that doulas do not perform medical care.⁹⁶

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Some doulas also provide support and care for women receiving a medication or surgical abortion, as well as women who have experienced a miscarriage or other fetal loss.⁹⁷

- As pregnancy and childbirth have become increasingly regulated, more and more women are turning to midwives and doulas, who allow women to have much more control over their own pregnancy and childbirth than most hospitals do.⁹⁸ Further, many pregnant women are opting to use midwives and doulas in conjunction with hospitals to retain control over the birth process while still being assured of prompt hospital attention should any serious complications arise.⁹⁹ Women wishing to choose homebirths face increasing pressure from medical professionals to plan for childbirth in a hospital setting. In 2008, the American Medical Association issued a statement discouraging homebirths.¹⁰⁰
- Many clinical studies have found that the presence of a midwife or doula during childbirth tends to lead to: shorter labor, fewer complications during labor, fewer requests for pain medication, and a reduced need for cesareans, labor-inducing drugs, forceps, or vacuum extraction.¹⁰¹

¹ *Geduldig v. Aiello*, 417 U.S. 484, 497 (1974).

² *Id.*

³ Pregnancy Discrimination Act, 42 U.S.C. ch. 121, § 2000(e) § 701(k) (2010).

⁴ *Id.*

⁵ 499 U.S. 187, 187-89 (1991).

⁶ *Id.* at 208.

⁷ *Id.* at 199.

⁸ The Family Medical Leave Act, 29 U.S.C. ch. 28 §§ 2611-2619 (2010)..

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¹² Lisa Collier Cool, *Could You Be Forced To Have A C-Section?*, NAT'L ADVOC. FOR PREGNANT WOMEN, (May 20, 2005), *available at*

http://www.advocatesforpregnantwomen.org/main/publications/articles_and_reports/could_you_be_forced_to_have_a_csection_1.php.

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¹⁶ *Promoting Pregnancy Wellness, VBAC: Vaginal Birth after Cesarean*, AMER. PREGNANCY ASS'N, <http://www.americanpregnancy.org/labornbirth/vbac.html> (last updated Dec. 2006).

¹⁷ *Who is ICAN?*, INT'L CESAREAN AWARENESS NETWORK, <http://www.ican-online.org> (last visited June 28, 2011).

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¹⁹ Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L.REV. 955, 961 (2010).

²⁰ Amie Newman, *NIH Vaginal Birth After Cesarean Panel: Do Pregnant Women Have Full Decision Making Power?*, RH REALITY CHECK (Mar. 10, 2010), <http://www.rhrealitycheck.org/blog/2010/03/10/vaginal-birth-after-cesarean-panel-pregnant-women-have-full-decision-making-power>.

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²² Gina Crosley-Corcoran, *Once a Cesarean, Rarely a Choice*, RH REALITY CHECK (March 11, 2010), <http://www.rhrealitycheck.org/blog/2010/03/09/oncescesarean-rarelychoice>.

²³ Newman, *supra* note 20.

²⁴ Crosley-Corcoran, *supra* note 22

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- ³⁴ 274 U.S. 200 (1927).
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- ⁴⁵ *Id.*
- ⁴⁶ *Id.*
- ⁴⁷ *Id.*
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⁶⁸ H.B.8, 2011 Leg., Reg. Session (Ala. 2011).

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⁷¹ 532 U.S. 67, 68 (2001).

⁷² *Id.*

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⁸⁵ *Id.*

⁸⁶ Press Release, Health Resources and Services Administration, HHS announces Maternal, Infant, and Early Childhood Home Visiting program funding opportunity, (June 1, 2011), available at <http://www.hrsa.gov/about/news/pressreleases/110601homevisiting.html>.

⁸⁷ Press Release, U.S. Dept. of Health and Human Services, HHS awards \$27 million for the support of pregnant and parenting teens and women, (Sept. 28, 2010) available at <http://www.hhs.gov/news/press/2010pres/09/20100928d.html>.

⁸⁸ *Id.*

⁸⁹ *What is MANA?*, MIDWIVES ALLIANCE OF NORTH AM. (MANA), <http://mana.org/about.html> (last visited June 26, 2011).

⁹⁰ *Midwifery 101*, MYMIDWIFE.ORG, <http://www.mymidwife.org/Midwifery-101> (last visited June 26, 2011).

⁹¹ *The Push States*, THE BIG PUSH FOR MIDWIVES, <http://www.thebigpushformidwives.org/index.cfm/fuseaction/home.stateStatus/index.htm> (last visited June 26, 2011).

⁹² *Id.*

⁹³ *Equitable Reimbursement for Midwifery Services Health Care Reform Law*, AM. COLL. OF NURSE-MIDWIVES, <http://www.midwife.org/index.asp?bid=59&cat=7&button=Search&rec=237> (last visited June 27, 2011).

⁹⁴ Sakala, *supra* note 82.

⁹⁵ *What is a Doula?*, DOULAS OF NORTH AM., <http://www.dona.org/mothers/index.php> (last visited June 26, 2011).



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⁹⁶ *Doula vs. Midwife*, ALLNURSES.COM, <http://allnurses.com/ob-gyn-nursing/doula-vs-midwife-203295.html> (last visited June 29, 2011).

⁹⁷ *What is a Doula?*, THE DOULA PROJECT: SUPPORTING PEOPLE ACROSS THE SPECTRUM OF PREGNANCY, <http://www.doulaproject.org/what-is-a-doula.html> (last visited June 29, 2011).

⁹⁸ MANA *supra* note 89.

⁹⁹ *See id.*

¹⁰⁰ AM. MED. ASS'N HOUSE OF DELEGATES, Resolution 205 (A-08) (Received 4/28/08), *available at* www.ama-assn.org/ama1/pub/upload/mm/471/205.doc (last visited June 27, 2011).

¹⁰¹ *Why Use a Doula?*, DOULAS OF NORTH AM. INT'L, http://www.dona.org/mothers/why_use_a_doula.php (last visited June 27, 2011); *see also* MANA, *supra* note 90.