

STUDENTS FOR CHOICE/VOX  
UNIVERSITY OF MICHIGAN, ANN ARBOR

# A MOVEMENT FOR SEXUAL AND REPRODUCTIVE EMPOWERMENT

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# HISTORICAL SUMMARY AND POLITICAL EVALUATIONS

UNDERSTANDING THE DYNAMIC SOCIAL AND POLITICAL NATURE OF  
THE ABORTION DEBATE

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## BRIEF HISTORICAL SUMMARY

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The history of the abortion debate as it exists in the United States begins with the professional organization of medicine as a male-dominated field in the mid-19<sup>th</sup> century. Prior to this point, termination of pregnancies prior to “quickening” (the moment in which the pregnant woman experiences fetal movement) was common accepted practice, usually performed in women’s homes or in the offices of physicians and midwives. The earliest laws were enacted against the unregulated distribution of poisonous abortifacents (drugs inducing miscarriage) and not the procedure itself, and were intended to protect women, not the unborn.

By the second half of the nineteenth century, mostly-male physicians sought to incorporate the fields of gynecology and obstetrics into the realm of medical science. These physicians became the first organized group of anti-abortionists as the AMA declared its opposition to abortion in 1859. In 1860, North Carolina became one of the first states outlawing abortion before and after quickening, and other states soon follow. A number of factors influenced physicians’ early attacks on abortion and demonstrate the underlying patriarchal agenda at hand. For one, midwifery was one area in which women held a great deal of social power independent from the control of men. Physicians blamed midwives for high mortality rates due to abortions in order to undermine the social standing of midwives and to elevate an emphasis on the scientific practice of medicine, which was argued to induce fewer septic deaths in pregnant women. Simultaneously, as women physicians were socially linked to “dangerous” and “unsanitary” midwives, the newly “immoral” practice of abortion undermined the morality, and thus professional standing, of female physicians who performed abortions. (See Morantz-Sanchez’s *Conduct Unbecoming a Woman* in which she details the hostilities between male and female physicians over the issue of abortion at the turn of the century.) Further, the moral status of (white) women during this time was unflappable under Victorian ideology in contrast to the questionable desires of men who sought to practice gynecology. (Remember that sexual modesty during this time meant that women preferred to seek the help of other women.) By claiming

moral superiority in terms of abortion, male (and some female) physicians could overcome the moral stigma of gynecological practice. These early debates demonstrate attempts by male physicians to place pregnancy under patriarchal institutional and scientific control.

Though illegal in many states, women and couples continued to seek abortions throughout the late 19<sup>th</sup> and 20<sup>th</sup> centuries. From the time of the first laws against abortion until the 1930s, abortion continued to be performed covertly, and providers remained esteemed members of the community, relatively free from police harassment. Increased demand for abortions in the 1930s because of financial deprivation resulted in further social, medical and legal tolerance. However, by the 1940s and early 50s, tolerance wanes as domesticity is politically reinvigorated. This era inaugurates new methods of controlling and restricting abortions and increased prosecution, especially of illegal female providers. Abortion services during this time were legally available only in hospitals and clinics where overwhelmingly male hospital abortion boards decided appeals for “therapeutic” abortions, with permission granted frequently on the condition of subsequent sterilization. Another favored method of social control that punished and humiliated women for their “aberrant” sexual behavior were probing investigations and highly publicized courtroom interrogations, where women were chastised for their sexual transgressions and male authorities—judges, lawyers, police, and physicians—asserted their authority over women’s bodies.

Still, sympathetic physicians continued to perform abortions underground, often with the protection of sympathetic communities. This persistent demand for abortion from the mid-1950s to 1973 also leads to a legalization movement that focuses not only on legal statutes, but on physician protection, networking, and safe procedures. In 1973, the U.S. Supreme Court rules in *Roe v. Wade*, based on a series of prior decisions in regard to marital privacy and self-determinacy, that the government should not interfere in decisions of such a private nature. Though many mark *Roe* as the culmination of the movement, the court’s emphasis on non-intervention rather than access results in a “rights gap” where the right to abortion is differentially accessible based on financial status. After *Roe*, the rise in anti-abortion activism has recognized this factor in a way that the pro-choice movement has not, effectively pushing for legislation that limits access to abortion services, including the *Hyde* amendment and *Casey* rulings that prevent federal funding for abortions. It has been predominantly in the last half century that an ideological emphasis on the unborn has replaced a politics of concern for the health of the pregnant woman.

In summary, much of what this particular summary has illustrated is the extent to which the abortion debate is a political rather than moral one. Much of this history shows a persistent attempt to use abortion as a means for wresting medical, legal, and personal authority from women (which is not to characterize women as helpless victims, their courageous resistance brought us to where we are today). It is also crucial to note that the historical acceptance of abortion seems to vary to the extent in which feminist politics are prevalent. Abortion begins to come under attack in the 19<sup>th</sup> century at the same time in which a suffrage movement and the demand for female political power gains ascendance. (Also, certain states were granting women the vote as well as greater legal rights in terms of divorce and property. Women were also achieving power in professions and political movements such as abolition.) Similarly, backlash politics of this century coincide with the emergence of 2<sup>nd</sup> wave feminism and the unprecedented political, social, financial, and sexual independence of women. This movement is followed by the rise of the Religious Right and extreme anti-abortion activity. If these seem coincidence, consider the greater acceptance of abortion during the Depression, when it was understood that abortion was sought for familial rather than personal reasons. In other words, when it seems that women are seeking abortions for themselves and not for other social reasons do anti-abortion sentiments escalate.

Though this brief history has not explored sexual empowerment and contraception, the focus on the history of the abortion debate helps foreground the political nature of the debate. Knowledge of the history of abortion legislation can help us understand the nature of the debate and be better prepared to combat restrictions of reproductive self-determination. A few lessons we can learn from this history is that women do not make their reproductive decisions in a cultural void—there are always, personal, familial, and social concerns involved. Further, we should never value a sacrificial (familial, financial) or health decision over a “personal” one (career, unprepared), since it legitimates cultural and social authority over women’s reproductive lives at the expense of personal authority. Third, we can recognize that different historical moments call for different strategies, and that in the current conservative trend, we should balance legislative and social activism—that is, a focus not only on laws, but on sexual practices, health care policies, and education. And finally, abortion history reminds us that progressive change is always possible, even under what seem to be the most repressive of times. We should never allow ourselves to be convinced that our work is wasteful or ineffectual. Our work is fundamentally necessary to preserve the dignity of human life and self-determination.

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## POLITICAL EVALUATIONS

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The historical summary just presented aids our understanding of the fluid, rather than fixed, nature of the abortion debate and aids our understanding of a number of issues: Legal Rights vs. Access, Hyperbolic Language, Institutional Authority vs. Local Authority, and Sexual Freedom. What follows is a political analysis of these issues in relation to potential strategies for the movement. Also included will be an analysis of Providers, Medical Technology, and Health Care.

### LEGAL RIGHTS VS. ACCESS

As the past three decades have taught us, the landmark *Roe v. Wade* decision is only a conditional factor in determining the “right” to an abortion, but does not guarantee access to the same. Indeed legislation since the ruling has restricted access (for military women, minors) beyond the class inequities that already result in an access differential in this country. It is imperative that while the movement continues to work to prevent a reversal of that ruling, the majority of our effort goes towards considerations of access.

### HEALTH CARE

The issue of access evokes a need to focus a great deal of effort on reproductive health care, if not health care in general. Here, Planned Parenthood provides a strong working model with their low-cost emphasis on contraception, std prevention and treatment, abortion, and pre-natal care. Yet an emphasis on reproductive care needs also to concern itself with issues of nutrition, drug treatment, post-natal care, and infant mortality rates. In short, the social inequities that prevent access to abortion also prevent a large portion of this nation from access to a variety of reproductive health resources. Our commitment to unbiased health care available to all (not just reproductive health care), including preventative health care, is fundamental.

### INSTITUTIONAL VS. LOCAL AUTHORITY

A major factor that would aid our commitment to unbiased health care is a commitment to local or communal participation. Activists must make a greater effort to recruit and incorporate the concerns of minority groups, for the issue of abortion is, as previously mentioned, never fixed, and we must be sensitive to the conditions which affect different groups, communities, and nations

differently. Local groups and clinics, especially when nationally sponsored, must make a greater effort to recruit within the community in order to address the complexities of this issue on a local scale.

#### **HYPERBOLIC LANGUAGE**

Though it is much the fault of the media for creating the hyperbolic language that divides the movement as oppositions between democratic “choice” and the ever infallible promotion of “life,” we must be careful to consider the uses and abuses of these terms and to avoid the types of oppositional language that perpetuates misinformation.

- First, the use of the term “choice” is hyperbolic in its associations with democratic process and is ironically apolitical. Choice implies personal decisions alienated from historical, social, and political contexts and negatively places the onus of reproduction on the one who “chooses,” the woman. If “choice” is to be used in our language, it should be in terms of expanding choices via reproductive health services, not in terms of severely constricted choices made.
- The movement’s emphasis on “rights” is also apolitical, since it does not address the deep inequities of our society that prevent a wide range of women and families from obtaining abortion services. And though much of our work has gone towards addressing these inequities, our language has yet to reflect this change in the movement’s political and social emphasis.
- It is necessary that we consider changes in our public image through the language that we use, including the way we define ourselves and our operative organizations. We are unfortunately still reigned in to the white, middle class image that haunts feminism as a whole, and a changed emphasis on language would promote a pro-choice movement more sensitive to the reproductive issues that plague minority and low-income communities. An emphasis, for example, on “reproductive empowerment” as a political process involving individuals, communities, and governments is much more reflective of the actual work and activism that we do. than terms such as pro-choice and reproductive rights.

#### **PROVIDERS**

Our providers have experienced unprecedented violence and intimidation against themselves, their coworkers, and their families in the past decades. In

the face of unimaginable hostility, our courageous providers return to work each day to service our reproductive needs. Though much work has been done on protecting clinics, their physicians, and their patients, more work needs to be done in terms of appreciation, protection, and violence awareness. We must never forget that abortion physicians take on the daily physical risks that many of us will never face. They deserve a central, not marginal, consideration as we develop strategies and goals for the movement.

It is our belief that we have unwittingly damaged many of the most courageous pre-*Roe* providers and continue to place a stigma on current providers in the fear campaigns that associate illegal abortion with back-alley clinics. For prior to *Roe*, scores of competent physicians provided safe abortions for women while risking potential prosecution and imprisonment, themselves the predominant, but now-invisible, victims of abortion's criminal status. Further, most of the deaths induced during prohibition were the result of self-induced abortions from women unable to locate competent physicians. The enduring myth of the back-alley abortionist has a way of bleeding across time to infect the professional standing of current providers which may, ironically, provide justification for violence against them. For the sake of our providers, we must find another way to illustrate the potential problems of abortion criminalization than by linking abortion to black market health care.

#### REPRODUCTIVE TECHNOLOGY

Reproductive technologies have provided important advancements in self-determination and reproductive health. Yet we must be careful not to allow our own desires for development aid profit-hungry pharmaceutical companies who exploit poor and minority communities as guinea pigs for these developments. This abuse is especially frequent among welfare recipients, who are often subjects of experimentation without their knowledge or are coerced to submit at the risk of losing aid. We must also oppose the judicial uses of reproductive technologies as “creative” punishments for women (sterilization, iud implants, etc.).

Further, we must never shy from our cultural “right” to reproductive technologies. Technology has been consistently deployed to free humanity from its own biological restrictions. In regard to reproduction, technologies have been used to aid women in regulating menstruation and treatment of infertility, among many uses, and for men, for vasectomies and impotence. Our culture's consistent deployment of technology in order to liberate the species from the limits of the body must be universally available to both men

and women, so that neither are enslaved to their fertility. Access to reproductive technology is truly an issue of social equality, not morality or biology.

#### **SEXUAL FREEDOM**

At the heart of the abortion debate, for both proponents and opponents, is the separation of female sexuality from maternity. The issue of female sexuality lingers in every discussion, and the sexual double standard lingers still, where the discursive absence of male sexual activity and contribution to the condition of pregnancy remain unquestioned and unchallenged. It is necessary, then, that the movement for reproductive empowerment fundamentally address issues of sexual responsibility and empowerment, not only as a component of abortion prevention, but as a major component of physical and psychological reproductive health. With these concerns in mind, we must continue to push for responsible sex education and healthy sexual relationships and affirm the much more accessible exercise of sexual freedom.



# POLICY COMMITMENTS

## STRATEGIES FOR A VIABLE AND DIVERSE MOVEMENT

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### POINTS OF COMMITMENT

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1. A movement for sexual and reproductive empowerment should be possessed of diverse social and political strategies and organizations.
  - Legislative efforts should involve both lobbying and grass-roots approaches, fostering communication between citizens and lawmakers. In terms of elections, we should focus not only on voting for pro-choice candidates, but on providing a venue in which potential pro-choice candidates can develop and thrive, thus increasing the number of pro-choice candidates for whom we can vote.
  - Organizational efforts should be local, regional, national, and global. The larger organizational groups support, but do not control or dictate the activities of the smaller groups. This type of structure ensures communal specificity, but does not divest the movement of national structure, operations, support, and community.
  - A diverse movement needs diverse members. Coalitions and diversity may complicate issues and bring tensions to the fore, but their influence enhances the political viability of any social movement as well as aid its overall effectiveness. Diversity not only refers to race, class, and age diversity, but also to the potential contributions of members from a wide variety of fields and areas. We must seek out and support pro-choice professionals and potential pro-choice professionals in a variety of areas: medicine, law, education, social work, politics/ policy, psychiatry/ psychology, religion, technology, philosophy, labor, environmentalism, etc.
  
2. A movement for sexual and reproductive empowerment is one focused not only on abortion and contraception, but also on a multitude of other related reproductive health concerns. What follows is a list of some of such concerns and potential corresponding issues.
  - Abortion access—issues of finance, location, restrictive laws, violence
  - Contraception—equitable, affordable, and available contraception that is safe and not tested or administered in racially or class-biased ways. In

many cases, education and awareness activity is also necessary to discuss cultural biases.

- Sex Education—providing our youth with resources and information to empower their sexual decisions. Pregnant teens have a lesser likelihood of graduating high school than their counterparts, and their children are more likely to suffer malnutrition, disease, and abuse.
- STD Prevention and Treatment—while important focus is on stds that can lead to death, certain infections can also lead to sterility and infertility.
- Cancer Screenings and Treatment—screenings can prevent cancer-related deaths; they must be available to all.
- Drug Abuse—drug use is an unexplored area in which federal regulations infuse a woman’s maternal condition and the choices she makes as well as the treatments available.
- Pre and Post-Natal Care—resources for healthy pregnancy, childbirth, and infant care must be made universally available.
- Physician Training and Conscience Clauses—conscience clauses must be fought and physicians trained in bias-free (insomuch as is possible) environments.
- Countering Propaganda—where dangers exist, they should be reported, where they are invented, they must be refuted.
- Product Safety—certain birth control products as well as tampons have been shown to have certain health risks that must be countered and communicated.
- Fertility and Infertility. Certain procedures have been over-estimated in their value and have extracted untold sums from women and families.
- Child Care and Leave Policies—women disproportionately carry the burden of child care, while men are discriminated against in terms of leave policies, both situations must be amended.
- Welfare—policies often dictate prejudices and stereotypes against minorities and poor that severely restrict or direct sexual and reproductive health decisions.
- Sexual and Domestic Abuse—sexual abuse fosters a significant number of unplanned pregnancies, especially among young women, and domestic abuse ends a number of desired pregnancies, often endangering the health and life of the mother.
- State Health Care—if access is to be a concern, universal health care must be central, no matter political affiliation. Political debates about the government’s role leave families in the cold, while coalitions could

build a strong system that satisfied proponents of universal health care and limited government.

- Reproductive Technologies—serious philosophical debates about genetic interference, disability and selective abortion, among others, have been enacted by reproductive technologies, which have also, incidentally, contributed to fetal imagery that has aided anti-abortion groups.
- Sterilization—unnecessary hysterectomies, forced sterilization, etc.
- Environmental Factors—role of pollution in creating birth abnormalities, breast and other reproductive cancers, sterility, and infertility.
- Smoking Cessation—smoking causes birth defects, health risks in women on birth control pills, second hand smoke in infants, etc.
- Men—we must not forget that men have sexual and reproductive systems, too. All of said policies, reproductive concerns, as well as language, should work to locate and support men in terms of health and responsibility, as well as personal and social power.

**A MOVEMENT FOR REPRODUCTIVE AND SEXUAL EMPOWERMENT  
IS COMMITTED TO:**

1. Community controlled reproductive health, federally supported, involving the significant, but not exclusive involvement of women.
2. Safe, affordable, and accessible contraception. Continued research free from exploitative testing practices.
3. Culturally, racially, and economically sensitive family planning services staffed by fully trained medical and counseling personnel.
4. Safe, legal, and accessible abortion services.
5. Affordable health care, including reproductive health care, free from religious, racist, homophobic, and nationalist bias.
6. Required abortion training for all licensed ob/gyn practitioners, and the abolition of medical conscience clauses.
7. The promotion of fair Medicare funding for abortion.
8. Prescriptive contraceptive coverage for all insurance plans that cover prescription drugs.
9. Comprehensive safe sex education with significant, but not exclusive focus on abstinence. Such education should not place exclusive emphasis on marital sexuality, but on responsible, mature, and monogamous relationships in or out of marriage.

10. Extensive funding for reproductive cancer research—advocacy against environmental carcinogens.
11. Fullest prosecution under the law to those who would harm abortion supporters and providers. Continued commitment to a peaceful movement.
12. National commitment to pre- and post-natal care and reduction of infant mortality rates in all communities.
13. Commitment to promote and elect pro-choice politicians.
14. Utilizing legislative lobbying and advocacy to promote goals.
15. Education, information, and awareness of reproductive and sexual health issues in order to promote a more healthy community and to counter propaganda. Commitment to fight restrictions on our exercise of free speech.
16. Building a movement of diversity in members and goals across professional fields, cultures, geographies, nations, races, and economically divided classes.
17. Continued recognition of the myriad issues related to sexual and reproductive health and commitment to consistently expand the reproductive and sexual health options available to women, couples, families and communities.

# SFC MISSION STATEMENT

DEFINING THE NATURE OF OUR LOCAL COMMITMENT AND  
OPERATIVE STRATEGIES

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## MISSION STATEMENT

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Students for Choice was founded with the intent to be a resource for students, staff, and faculty at the University of Michigan. SFC was founded to provide the community with accurate information on all aspects of women's reproductive rights, and to protect reproductive choice and access to family planning.

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## GOALS AND STRATEGIES

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### **Defining our community.**

Students for Choice acts on behalf of a specific constituency at the University of Michigan who tend predominantly to be young, middle-upper class, well-educated, and sexually and politically liberal. We also define our larger community, both Ann Arbor and Ypsilanti, as well as the state of Michigan, as the focus of our efforts.

### **Our history.**

In the past, Students for Choice activity has been organized around contraception awareness and availability, political commitment to legal abortion with activities directed towards awareness and legislation. We have worked in cooperation with pro-choice groups such as MARAL and Mid-Michigan Planned Parenthood and have formed campus coalitions with abortion-friendly groups such as Campus Democrats and the ACLU. These are important components of our activism and will continue to be central.

### **Future Directions.**

1. Initiatives towards fostering solidarity and relationships in the Students for Choice community. Commitment towards more social activities, education, and discussions within the group.
2. Commitment to fostering development of future activists through sharing resources, encouraging recruitment from pro-choice and other feminist organizations, and through engaging in activities that expand our experiential horizons.

3. Our mission statement notes that our work is geared towards “protecting” access, as though access is currently faring well. Students for Choice must make a greater commitment to programs and actions that address legislative, social, and economic restrictions to access.
4. Important work remains to be done building coalitions, perhaps structural (permanent), with other pro-choice groups in order to strengthen the solidarity of the campus activities and to diversify our approaches. This also involves a concerted effort to recruit graduate students.
5. New directions for coalitions include the Green Party, which advocates public health care, including abortion services. Libertarians agree primarily with the *Roe* decision in regards to government non-intervention and are generally opposed to both government restrictions as well as government protections, making a coalition most useful in areas of social activism. Many minority groups believe in community-controlled health care, and it would be beneficial to form relationships with those groups who support strong reproductive communities. Finally, we must seek out relationships with the many pro-choice religious groups who support reproductive health care for women and families.
6. An emphasis on sexual empowerment and sexual health must be re-invigorated into our platform, including coalitions to anti-violence groups, anti-cancer groups, std prevention groups, and lgbt organizations.