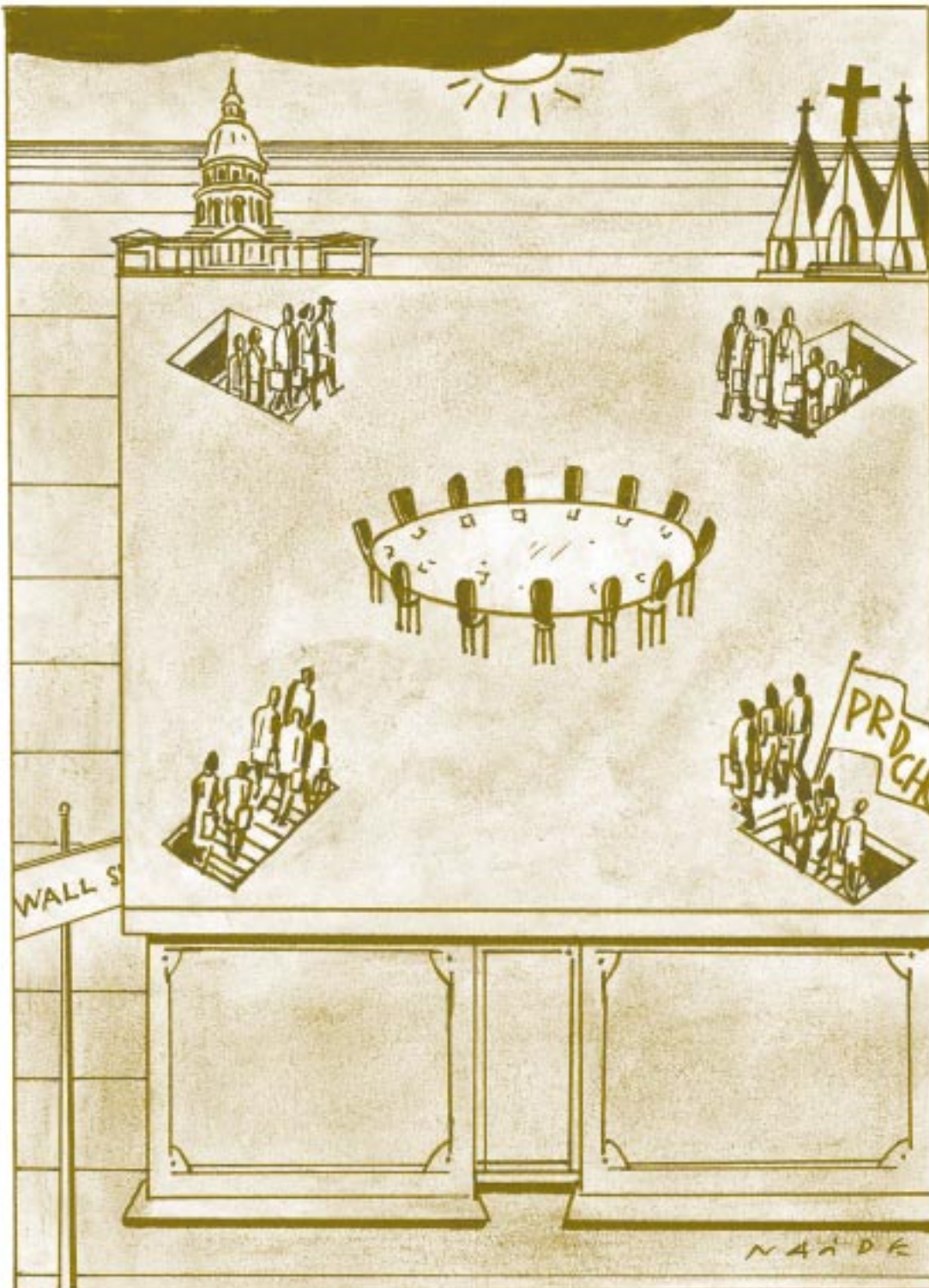


IDEAS

FOR AN OPEN SOCIETY



TOPIC #2: REPRODUCTIVE HEALTH AND RIGHTS

Everything about abortion in America has changed in the three decades since *Roe v. Wade* guaranteed a constitutional right of privacy to women, except the way we think and talk about it.”

Ellen Chesler

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The abortion debate

Finding **common** **GROUND**

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either Al Gore nor George W. Bush made abortion a major campaign issue in last year's presidential race. Al Gore, though a strong supporter of choice, never offered to put women's reproductive rights in a "lockbox." George W. Bush, who talked frequently about valuing a "culture of life," ducked every opportunity to explain exactly what he meant. Even so, abortion registered a surprise third place among voters' concerns in at least two major exit polls—just behind social security and education and ahead of taxes. The gender gap in last year's presidential race turned into a chasm, with women favoring Gore by 11 points, and men going for Bush with an identical split, for a record 22-point divide. Each candidate's position on choice was a key factor.

How this happened is no mystery. Even as both candidates tried hard not to offend on either side, pro-choice supporters invested on an unprecedented scale in last year's national, state, and local elections. Planned Parenthood and NARAL together spent nearly \$20 million in targeted media and grassroots-organizing strategies. They layered these directly partisan dollars on top of already sizable independent public education budgets, developed in recent years in response to erosions of support attributed to huge advertising campaigns by the Christian right. Emily's List, which raises money for Democratic women candidates, also spent lavishly on pro-choice women running for the House and Senate, who won in several high-profile races, and moved the issue up on the political radar screen. Meanwhile, conservatives remained uncharacteristically quiet, counting on their man to take the White House by courting centrist voters—a bet that seems to have paid off in the appointment of high-profile abortion opponents to the Bush cabinet.

But political obligations aside, President Bush and his advisors can read the numbers as well as anyone else. And they no doubt understand the peril of remaining captive to the extreme right wing on this issue. Public opinion polls have long shown that the country overwhelmingly supports responsible sex education and family planning. And though the cohort that endorses abortions without restrictions has declined somewhat in recent years under pressure of persistent assaults from the right, still only between 17 and 19 percent of the population would ban them outright. The political debate over abortion may be "frozen in time," as Robin Toner of the *New York Times* wrote, but the clear majority of Americans who voted their pro-choice sentiments last year seem to want an end to the stalemate.

BY ELLEN CHESLER

It is time to try to find some common ground in the abortion debate.

For the truth is that everything about abortion in America has changed in the three decades since *Roe v. Wade* guaranteed a constitutional right of privacy to women, except the way we think and talk about it. As Robin Toner also observed: “Science has changed, the culture has changed, public attitudes have changed, but the politics of abortion unfolds like a Kabuki play, stylized and familiar.”

Abortion discourse still sounds like what the Constitutional scholar Laurence H. Tribe once called a “clash of absolutes.” But the plain facts of the matter have altered dramatically in 30 years. A woman’s decision to terminate an unwanted pregnancy today involves any number of medical, moral, and practical considerations that were not available to her back then. We need to account for these developments.

There is first the matter of emergency contraception, more commonly known as the “morning after” pill, which actually works up to 72 hours to interrupt the development of a fertilized ovum so it never implants in the uterine wall and never technically becomes a pregnancy. The regimen is well known and widely used in Western Europe, where a dedicated product is now available without prescription. The French distribute it in high schools.

For years, U.S. physicians have routinely broken up packages of standard, oral anovulent, birth control pills and administered consecutive double doses of them to women reporting unprotected intercourse and fear of unwanted pregnancy. The procedure, which produces moderate nausea but no other side effects, is especially prevalent on college campuses. Yet, pill manufacturers here, fearing protests by anti-abortion zealots, declined to market a dedicated product, and the Food and Drug Administration only recently approved one, after nearly a decade of effort by nonprofit reproductive rights groups.

The FDA is now considering a petition to bring emergency contraception over-the-counter, so it can be made widely available. Accomplishing this goal, while also edu-

cating clinicians and consumers about the method through widespread replication by public health departments of social marketing projects that have been successfully piloted by private institutions, should be a first priority of rational government policy. It is estimated that emergency contraception alone could prevent half of all unintended pregnancies — about 3 million a year in the U.S. — half of which now result in abortion.

The method is especially warranted as a backup to condoms, which as a result of successful educational campaigns are now widely used to protect against sexually transmitted disease.

Condoms work as contraception, of course, and recent research shows that they account for a significant percentage of the substantial decline in adolescent pregnancy that has been achieved in this country in the last decade. The only problem is that, even with good intentions, they have a high failure rate and need “a Plan B.”

As Americans are made to comprehend and access this so-called “morning-after” opportunity, so they also need a clearer understanding of the availability of new “month-after” options, for it is following the first missed period that many women suspect they are pregnant. Few ordinary Americans — and probably still fewer federal and state legislators — may realize that when *Roe* became the law of this land, a woman could not even confirm a pregnancy until seven weeks or more into gestation. To terminate



that pregnancy she had to wait at least several more weeks, until her cervix softened, so a physician could insert the metal surgical instrument then necessary to perform a standard dilation and curettage of the uterus.

Given the moral freight and potential medical risk attached to this procedure in the years when it was illegal and performed largely underground, a not unreasonable decision was made at the time to provide abortions in free-standing clinics patterned after pioneering birth con-

The intense politics of abortion, however, have already resulted in the dissemination of a good deal of misinformation among providers and patients, not to speak of politicians.

trol facilities. This, of course, had the unforeseen but unfortunate consequence of further stigmatizing the matter and of forcing women and the courageous doctors who looked after them to become easily identified targets of abortion protestors.

Today, by contrast, a simple urine sample registers the hormonal changes that confirm pregnancy in its earliest stages and is available inexpensively for home use. The recent approval of mifepristone (long known as RU-486) in the U.S. means that an unwanted pregnancy can be ended as soon as it is detected. Regulations here limit use of the pill to up to seven weeks, though in some parts of Europe and Asia hundreds of thousands of women are using it effectively and without incidence up to nine weeks of their pregnancies. The simple regimen requires a combination of two pills taken in sequence—mifepristone, a hormone disrupter that interrupts the body's natural chemistry, followed by misoprostal, which induces moderate uterine contractions and produces the appear-

ance of a normal to intense menstruation lasting up to five days.

The crucial distinction, of course, is that the process eliminates a fertilized ovum. In all other respects it does not differ much from what most women experience as a monthly matter from menarche to menopause, when they eliminate unfertilized eggs along with the contents of the uterine lining, without much fuss over the loss. Indeed, recent medical research confirms that about half of all conceptions spontaneously abort and pass away naturally.

Much has been made of the cramping and bleeding that accompany the new “early option” pill, as it is being called, but in only rare instances is it beyond what most women routinely experience. The intense politics of abortion, however, have already resulted in the dissemination of a good deal of misinformation among providers and patients, not to speak of politicians. The first challenge to advocates is to overcome these distortions with education and training, akin to what has worked in the past for new methods of contraception. The second challenge is to untangle the thicket of legal provisions and regulations that govern surgical abortion at the state and local levels, which, realistically, may not need to extend to earlier options.

To this end, it may be important to point out that on the rare occasions when the early option pill results in excessive bleeding—or fails to work—a simple mechanical procedure can be used to evacuate the uterine contents without trauma. Manual vacuum aspiration of the uterus—using an inexpensive plastic cannula that creates a suction strong enough to dislodge the tiny embryo—is a variation on primitive menstrual extraction techniques used long ago. But the new technology makes this a safer, cheaper and more accessible procedure than existed before, one that, as an alternative to or as a back-up for the early option pill, can be easily administered in comprehensive



women's health clinics or in doctors' offices. This can be accomplished either by physicians themselves, or perhaps preferably, by well-trained mid-level practitioners, such as nurses and mid-

wives, who now routinely dispense hormonal contraception under medical supervision. Projects to pilot such practices are beginning to get underway with support from the Open Society Institute and other foundations, but to achieve meaningful scale, they will require much broader investment.

These two new methods have the potential to significantly transform the landscape of abortion provision in the United States. More than half of all abortions in this country today already take place within eight weeks of gestation, and three-quarters within 12 weeks, considerably earlier than in the past. The rest follow in the second trimester, with a few highly publicized exceptions occurring later, almost always because the health and well-being of either fetus or mother are in question. These too have now been constitutionally protected and must remain so.

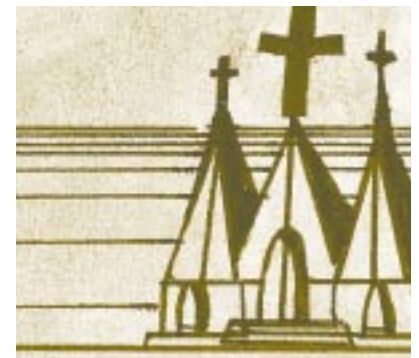
Still, recent surveys funded by OSI reveal that providers and patients are eager to push the process even earlier and to integrate it back into standard medical practice. The timing is right for this in view of a growing trend nationwide toward the provision of comprehensive health services to women in neighborhood clinics affiliated with hospitals.

Early in the twentieth century, birth control pioneer Margaret Sanger first established the essential relationship between a woman's reproductive autonomy and the full achievement of her civil and human rights. Sanger also advanced still resonant arguments for investing in the power and potential of women as a means to advance

America's larger commitments to social and economic progress. She envisioned communities in which small families might comfortably incubate the habits of good citizenship on which democratic government invariably rests. She dedicated herself to political accommodation and built the modern family planning movement around those principles. Margaret Sanger and George W. Bush span a turbulent century, but the gulf between them may not be as wide as it seems. His paternal grandmother, after all, was once a devoted official of Planned Parenthood in Connecticut, and his father, as a Republican member of Congress from Texas in the 1960's, actually sponsored the first federal family planning laws.

During last year's campaign, the younger Bush said abortion shouldn't be a litmus test for judges. He said he wasn't sure he could do anything about the Food and Drug Administration's recent approval of mifepristone, therein acknowledging the agency's stringent grounds for revocation, which require new evidence of a potential hazard that is highly unlikely to materialize. He even talked about seeking "common ground" on these divisive matters.

Rather than now bend to those who would distort his family's proud legacy of support for family planning, President Bush may be wise to embrace it. Realistically, he may not be willing, or politically able, to offer any affirmative endorsement of the provision of early options to end unwanted pregnancies into the continuum of safe, affordable and accessible reproductive health services. But he could choose not to stand in the way.



Ellen Chesler is a Senior Fellow at the Open Society Institute, where she directs the foundation's Program on Reproductive Health and Rights. She is author of [Woman of Valor: Margaret Sanger and the Birth Control Movement in America](#).

Manhattanville MIC Center

Model neighborhood reproductive health care

If Margaret Sanger were alive today, the Manhattanville MIC health center on 135th Street in Harlem is the sort of center she might plan. Its bright orange walls, sunny skylights, and ceilings painted with butterflies bring to mind the cheerful curtains Sanger hung on the windows of her pioneering storefront birth control clinic in Brooklyn in 1916. These decorative touches make the Manhattanville center seem less like a standard government-sponsored health facility, and more like the cozy office of a private doctor.

Founded more than 30 years ago, Manhattanville is one of the eight Maternity, Infant Care-Women's Health Services (MIC) centers run by the Medical Health and Research Association of New York City (MHRA) that offers family planning services and prenatal care to women in low-income neighborhoods. Most MIC patients are either Medicaid recipients or pay for services on a sliding scale geared to income and family size. MIC's mission is to offer their patients health care that meets private practice standards, such as preventive treatment and an established relationship with one doctor—services that MHRA President and CEO Ellen Rautenberg says middle class women take for granted. "The worst problem poor women have," explains Rautenberg, "is falling through the cracks."

One way MIC accomplishes its goal of continuous care is by allowing each patient to have her own doctor or certified midwife. "When patients step in our door," explains Manhattanville administrator Joyce Marshall, "the first question they hear is: 'Who's your provider?'" If a woman first comes to the center for a pregnancy test, she's assigned one of a team of physicians or midwives.

This professional administers the test, delivers the results, and counsels the woman about her various options. If the patient is pregnant and wants to have her baby, she can continue to see the same person throughout her pregnancy and delivery, just like she would at a private practice. Manhattanville's partnership with Columbia Presbyterian Hospital allows a doctor familiar with the patient and her medical history to deliver the baby at the hospital; that same provider then follows up at the center with the woman's postpartum check-ups.

Right now, the one obstacle preventing MHRA from providing complete reproductive care is its inability to offer abortions. If an MIC patient chooses to end her pregnancy, her provider can counsel her on the range of birth control methods available to prevent future pregnancies, but he or she cannot terminate the unwanted pregnancy. This is not unusual. In the U.S., most comprehensive women's health facilities don't perform abortions, and New York's MIC centers are no exception. Should an MIC patient request an abortion, her doctor's only option is to refer her to a free-standing facility or public hospital (if the patient has Medicaid coverage), where she will be treated by an unfamiliar doctor in an unfamiliar setting.

This isolation of abortion is based on the model for reproductive care first established by Sanger at the start of the twentieth century, when almost all birth control was illegal, and it was crucial to gather the few doctors willing to circumvent the law in one clinic. Today, abortion is isolated in this manner in only a handful of countries outside the U.S., and most reproductive rights advocates agree that such isolation stigmatizes abortion and exacts a high emotional cost from the women who choose it. The relatively small number of abortion clinics (86 per-

BY JANE MANNERS

cent of U.S. counties have no provider at all) means that many women seeking abortions have to travel long distances to reach a clinic, often at considerable expense. And of course, the scarcity of clinics makes them easy targets for the protestors who routinely picket abortion facilities.

WHEN THE FDA FINALLY approved mifepristone—commonly referred to as RU-486, or medical abortion—last September, MHRA administrators recognized an opportunity to free their patients from these unnecessary hardships. If MIC centers could offer their patients this early option, they reasoned, it would relieve much of the emotional toll and public shame

of a visit to an abortion clinic. Moreover, it would fill a hole in the continuum of patient care the centers sought to offer, from family planning services right through post-partum check-ups.

Rautenberg and her colleagues know that introducing medical abortion will not be a simple matter. The populations served by MIC's eight centers are largely (68 percent) foreign-born, and come from cultural backgrounds shaped by conservative religious beliefs. Some of the centers' teenage patients, for example, are more comfortable chancing pregnancy than using contraception, because using contraception indicates the sex is premeditated; Muslim patients are rarely permitted to use contraception at all, and can speak about medical matters only through their husbands. Abortion is often, religiously and culturally speaking, out of the question.

Right now, with the help of a two-year grant from OSI's Reproductive Health and Rights Program, MHRA administrators are figuring out how to get past these obstacles. Rautenberg expects that both patients and clinic staffers—many of whom come from the communities they serve, and share their patients' misgivings about abortion—will need training in medical abortion, both to familiarize them with the procedure and to overcome any ethical reservations they might have. MHRA will also have to find a source of permanent funding for the project, since 75 percent of its patients are uninsured, and most of MIC's budget comes from federal and state programs that don't cover

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abortion. And MIC centers must clear several legal hurdles as well, such as limits on who can provide abortions, where they can be performed and what regulatory and licensing protocols they must follow.

Once these steps have been taken, MHRA will introduce medical abortion at a pilot center. It hopes to accomplish this in early 2002, and to extend the service to four other MIC centers soon after that. By offering medical abortion across its network, MHRA will finally be able to provide poor women throughout New York City with the continuous reproductive health care they deserve.

Jane Manners is a program associate for OSI's Governance and Public Policy program. Previously, she was a staff writer at Brill's Content magazine.

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IDEAS

FOR AN OPEN SOCIETY

OSI and reproductive health and rights

The Open Society Institute initiated the Program on Reproductive Health and Rights in support of the overriding individual and social value of reproductive autonomy for women. The program's mission is to promote the development of policies and practices to protect women's comprehensive sexual and reproductive health care, including abortion, both in the United States and in the countries and regions where OSI operates abroad. The pro-

gram funds projects that involve grassroots advocacy and litigation; new contraceptive and pregnancy termination technologies; improved communications strategies and message development in support of a values-based, progressive agenda for sexual and reproductive health and rights; and advocacy and model service delivery efforts to implement the women centered development agenda agreed upon at U.N. conferences in Cairo and Beijing in 1994-95.

The Open Society Institute is a private operating and grantmaking foundation that promotes the development of open society around the world. OSI's U.S. Programs seek to strengthen democracy in the United States by addressing barriers to opportunity and justice, broadening public discussion about such barriers, and assisting marginalized groups to participate equally in civil society and to make their voices heard. U.S. Programs

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challenge over-reliance on the market by advocating appropriate government responsibility for human needs and promoting public interest and service values in law, medicine, and the media. OSI's U.S. Programs support initiatives in a range of areas, including access to justice for low and moderate income people; independence of the judiciary; ending the death penalty; reducing gun violence and over-reliance on incarceration; drug policy reform; inner-city education and youth programs; fair treatment of immigrants; reproductive health and choice; campaign finance reform; and improved care of the dying. OSI is part of the network of foundations, created and funded by George Soros, active in more than 50 countries around the world.



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