

WHAT TO EXPECT: LEGAL DEVELOPMENTS AND CHALLENGES IN REPRODUCTIVE JUSTICE.

FEBRUARY 25, 2009

MS. SARA PERLE: Good morning everyone. My name is Sara Perle and I'm the Symposium Editor for the Cardozo Journal of Law and Gender. I want to welcome you to our 2009 symposium, "What to Expect: Legal Developments and Challenges in Reproductive Justice." The Cardozo Journal of Law and Gender, which is formerly the Cardozo Women's Law Journal, has been a pioneering publisher of gender related legal scholarship for over twenty years now and publishes the only annotated legal bibliography of gender related issues in different areas of law.

We publish three to four issues a year on a broad range of gender based topics that reflect interdisciplinary views on legal concerns affecting the lives of men and women. The subjects of our articles and notes include employment law, healthcare, human rights, family law and civil rights. Before I introduce our wonderful keynote speaker, I want to take a moment to thank everyone who has helped us bring this amazing event to life, especially Assistant Symposium Editors Kelly Schwab and Nikki Carpenter, our Editor-in-Chief Ashley Antler, our Submissions Editor Anusree Nair, who has helped put together our symposium issue of the journal, and the rest of the journal staff. If anyone has any questions about Cardozo, the journal or anything, all the staff have tags, find us anywhere and ask us.

To let you know, there are men's and women's bathroom around the corner, also non-gendered bathrooms on the second and third floors of the building.

Now it is my pleasure to introduce our keynote speaker Lynn Paltrow. Ms. Paltrow is the founder and executive director of National Advocates for Pregnant Women, an organization that works to secure the human civil rights, health and welfare of all women focusing on pregnant and parenting women, particularly those who are most vulnerable. Ms. Paltrow has also served as a senior staff attorney at the ACLU's Reproductive Freedom Project, as the director of special litigation at the Center of Reproductive Law and Policy and as the Vice President for Public Affairs for Planned Parenthood of New York City.

When this event was at its earliest stages, everyone we talked to said, “you have to get Lynn Paltrow to speak.” Considering her amazing reproductive justice work, I could think of no one better to introduce us to reproductive justice in the law and to frame our panels today. Thank you.

KEYNOTE ADDRESS

MS. LYNN PALTROW: Thank you so much for having me. I particularly want to thank, in addition to the Cardozo Journal of Law and Gender, Ashley and Sara because they learned a very important lesson in organizing this, which is persistence. Sometimes things get so overwhelming that I don’t always respond to the first request, so I honor you for your persistence and I very much appreciate being here. I also said, if I have to write a law review I can’t do it, so they were very kind and said I could just talk. I hope I’m not doing an injustice to all of the speakers who will be following me. I want to setup a framework that includes their work, but doesn’t address their work. They’ll be talking about many things that are within the reproductive justice framework. I’m here to try and push the envelope even further.

What to expect? I think we’re all relieved, the new President in terms of what can happen regarding reproductive rights and health. We saw some changes already leading up to the election. In other words, the democratic party platform for the first time, not only very explicitly, without limitation, defended a right to choose abortion, but also talked about the right to motherhood and didn’t use the language of safe motherhood, but put those two things together, which is, as far as I know, the first time any party platform has done that.

I believe the third debate, when President Obama was asked the question about abortion, he answered it, but then he moved on to questions of, for example, Lilly Ledbetter and equal pay for women, understanding, that if we just talk about abortion, it might not work. Now that he’s been in office, he’s already done things like lift the global gag rule and sign the Lilly Ledbetter Law into effect.

But we can’t expect more change unless we keep changing. I say that because we’ve been the mainstream pro-choice movement. Many of us have been working in more or less the same way for thirty years. While there’s been tremendous, brilliant, amazing work done, there’s an AA kind of saying “if you keep doing the same thing”—the definition of insanity is “if you keep

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doing the same thing and expect different results, then you're crazy." I think we've seen with this election that focusing more on the grass roots, making connections, that these are things that actually help as opposed to sticking just to certain talking points.

While we're making headway I think we have lots of reasons to know that your work in terms of reproductive justice, a notion that goes beyond defending abortion, goes beyond defending contraception, a notion of human rights, of fairness, that you have full employment guarantee even with this President, even with the changes.

What do I expect then? We have seen, up until now, between 1995 and 2004, states have enacted 409 anti-choice pieces of legislation. Just one sample year, 2005, over 650 bills were introduced that would directly or indirectly restrict access to abortion or contraception or advance the legal status of fetuses. One of the things that President Obama, as far as I can tell, and maybe some of you will think of ways he can do this and his administration, I don't think he can do very much about the fact that thirty states have fetus homicide statutes. Those statutes, all of which were passed under the guise of protecting pregnant women and unborn children from violence, almost all of these laws are passed after a particular hideous example of a woman being killed or beaten during her pregnancy and that she loses the pregnancy. Part of the research my organization, National Advocates for Pregnant Women is doing, is that we've discovered that the arrests of women that are going on around the country, all of them are justified by fetus homicide laws. In other words, if you can arrest a man who beats a pregnant woman on a fetus homicide theory, on the rights of a fetus theory, then that should also be applied to a pregnant woman who can't herself guarantee a healthy outcome to her pregnancy. In other words, a pregnant woman in relationship to her own body is no different from a man who beats a pregnant woman to death.

Those are at least thirty states with those laws, more that have achieved those by judicial fiat. We are already seeing bills, North Dakota, the House just passed a bill declaring constitutional rights for the unborn from the moment of fertilization by statute doing what we defeated in Colorado and South Dakota recently.

We also should be aware, as we take perhaps some pride or relief from the fact that the country is less red and blue and more purple, there are some states that did go even redder. Kansas, in reaction to this election, became a state that's even more hostile to women and reproductive rights. Again, the idea that we can all just go, we're safe, unfortunately isn't true. There is much more reason

to hope because we now have an administration and a context that gives us the opportunity to use certain tools like science and truth and effective organizing in addition to legal arguments. The other thing that's not going to change any time soon are the federal courts. The people most likely to resign from the Supreme Court are the liberal justices. The idea that we can all take a sigh of relief, *Roe*¹ is not going to be overturned, unfortunately, I don't think is true.

I want to talk about some of the connections and again, some of the issues that make get clearer our challenges and what we should be ongoing challenges. One of the things is the rhetoric. The rhetoric on the far, far end of the anti-abortion movement is not likely to change. What that looks like is this: abortion kills children. Who has abortions? Pregnant women have abortions. Pregnant women are killers. The message isn't lost on people. For decades, the Genocide Awareness Project, and I assure you that's not about Rwanda, an organization that's very popular west of the Hudson teaches that the worst Holocaust that occurs is the abortion Holocaust. If you compare the number of dead in any other Holocaust it's nothing compared to the number of dead unborn children. You have the changing faces of choice, religious choice and their pictures of bodies from concentration camps, racial choice showing an African American being lynched and then so-called reproductive choice. Then lots of literature like this, lynching is for amateurs when you compare it to abortion. Maybe the KKK didn't invent abortion, but they certainly can't be unhappy with the results. Then a little Klan parenthood pun or whatever you would call that.

Now, this is where have we failed, whatever aspect of this? There has been very little response to this massive propaganda campaign that goes on relentlessly in this country. More recently, the Religious Coalition for Reproductive Rights has finally developed a packet responding to this, but it's pretty tempest. It's pretty straightforward. I want to note that not a single progressive, liberal, Jewish women's group, for example, has responded to this barrage by saying, whatever your feelings are about abortion, you can be for it or against it, this in effect is a form of Holocaust denying because to say that a government's commitment to state approved genocide is not as bad as the individual decisions that women make in the course of their pregnancy is to deny the meaning of state sponsored genocide, particularly the one that was used to kill six million Jews and many million others. The failure to see how these things connect—it is part, every abortion argument, every anti-abortion argument, and I don't mean people who genuinely oppose it, but the politicized version of it that we all see, is connected to other larger, political issues. It's

¹ *Roe v. Wade*, 410 U.S. 959 (1973).

very deliberate. If we keep people defining genocide as something that individual women do over the course of their lives, dealing with their pregnancies, as the worst form of genocide, then as a country, as a community, we don't have to deal with real genocide. I was out in South Dakota working to challenge one of the anti-abortion measures there and I met three student representatives from the Genocide Awareness Project. I said, what do you think about Rwanda? They had no idea what I was talking about.

What has all this done? The abortion debate has created the illusion that there are two kinds of women. The kind that have abortions and kill their babies and the kind that give birth and have babies. That's a myth that we haven't really engaged very well over the last thirty or more years. The reality is that 61 percent of women who have abortions are already mothers. In other words, the woman who shows up at the abortion clinic, 61 percent of the women you can guess in the waiting are mothers. They've already given life. 84 percent of all women eventually become mothers by the time they're in their forties. We know that still in our culture today, women, whether they've ever been pregnant, do the overwhelming lion's share of free labor, taking care of children and the elderly. One thing just to mention as we are in these economic times, when they count the gross domestic product, they never count the value of women's unpaid work. Economists point out, feminist economists who bother to think about that, point out that if we actually had to pay for it we'd really go bankrupt. That's a way, when you hear these kinds of messages around abortion, again, it's not just about abortion, it's about how we value women and families.

There is this idea, do we take seriously also these images of abortion kills? It's a Holocaust? Who has abortions? Mothers have abortions, pregnant women are the ones who are having abortions. Do we really think a pregnant woman is no different from Hitler? Do we really think a pregnant woman is no different than the SS? Alveda King, a niece of Martin Luther King was in South Dakota lobbying, speaking for the ban, the first effort of the ballot measure that would have banned all abortions in the state in 2006. She said she opposed abortion because it was about supporting a person's right to live and a baby who could be aborted is like a slave. There are these, it's just like slavery. Is a pregnant woman really no different from a slave holder? Is a pregnant woman really no different from an executioner and a murderer? This language isn't just the Genocide Awareness Project. Shortly after the election, if you read in *The New York Times*, there was a story about Catholic Bishops, starting in again on their campaign against abortion, which they describe as the worst form of killing. Who are the worst murderers in the world? Not people who commit genocide, not people who do all sorts of other things, it's you and

me and the women we know. It's pregnant women are the worst murderers. They're the only people for whom there's no justifiable self-defense or anything else.

In South Dakota again, one columnist talked about the overwhelming number of abortions done in the state are done for expediency and convenience. Again, do we think of pregnancy as like having your nails done? Is it something for convenience that you just sit around and are pampered?

Now, what's been true for many years that is starting to change, is that mainstream pro-choice arguments against bans on abortion and restrictions of all kinds on abortion tend to be, you have the right to choose or you have the right to abortion and the right to contraception and when we get really wild and crazy we talk about stem cell research and maybe pregnant women who have cancer might be prevented from getting cancer treatments. I want to challenge that rhetoric that continues to predominate. If all we're defending is *Roe*, a Supreme Court decision, or defending abortion, then we've lost sight of what the real issue is. What we really ought to be defending is the rights of pregnant women, the humanity of pregnant women. It's not just a particular decision, not just choice. Of course, the reason that we are moving to a language of reproductive justice is that choice has been language that has spoken to some women, that there's a whole generation, particularly of white and upper-class, middle- and upper-class women, for whom abortion was the symbol of liberation, that abortion did mean the difference between equal and full participation in society and not. If you could have an abortion you had a shot of stepping out of traditional roles and staying there. If you are low-income, if you are disabled, if you are discriminated against in any other variety of way, you could have your abortion and you still don't get to participate fully and equally in society. Choice and the abortion issue isn't the symbol for you, of what's going to make the difference in your freedom, in your ability as a woman, as a result of your gender to be full and equal participants.

What are we defending? I think part of what's happened, too, is that second wave feminism is very frightened and justifiable so given our history. That if we expand our arguments to include the women who give birth, the 84 percent of all women, we are going to be pulled back into an ideology that says, that's our primary role, motherhood is what we're all about and we're just going to be going back to a time where women's equality and freedom couldn't be defined by anything except capacity for pregnancy and motherhood. The problem with that is if 84 percent of your constituency, the people you're trying to mobilize actually give birth and are raising children, it's really not even practically a good idea to ignore them, to not try to mobilize them in the

work that you're doing. In fact, what we've been successful with in places like Colorado and South Dakota and hopefully Texas and other places, is that we are bringing new constituents to these issues by talking to midwives and people who are advocating that women be treated well during birth. If 61 percent of women who have abortions are already mothers and 84 percent are going to become mothers, whether you're an abortion provider or a defender of abortion rights or you're defending home birth midwifery or just decent treatment when you give birth in a hospital, you're all representing the same women and perhaps we could be talking to each other and working together.

The other problem is that anti-abortion arguments don't just affect women who want to have abortions. This is Laura Pemberton, she's a fundamentalist, Christian woman who is profoundly opposed to abortion. She already had I think six children, maybe four, she had had one Cesarean section, it was surgery that was debilitating, prevented her from taking care of the kids she already had. She was pregnant again; she did not want to have unnecessary surgery. She wanted to have a vaginal birth if she could and resort to a C-section only if she needed it. In Florida, as is true in many parts of the country, there was not a single hospital in the state that would allow her to have a trial of labor. In other words, if you want to give birth with doctors around and equipment around, you must schedule a C-section now, otherwise, don't bother coming in. She decided to have a home birth. She became dehydrated, she went to the hospital simply to ask for fluids, when they saw that she had had a previous C-section they came to her and said, "no fluids, no treatment unless you agree to a C-section." The nurses came to her and said, "watch out, they're getting a court order, you better get out of here." She's barefoot, she's pregnant and barefoot, with her husband, flees down the back steps of the hospital and goes home to continue labor. She's in labor at home, she's six centimeters dilated, you have to get to ten to get the baby out, and she hears a knock on the door. It's an armed sheriff that's been sent by the hospital with a court order to take her into custody so that they can bring her back to the hospital for a hearing about whether she needs a C-section. Now, I'll point out that there were already state attorneys, people representing the state on behalf of the fetus, no lawyer for her.

She begs them, she's six centimeters dilated, she knows that labor slows down when you're in stress. She asks them to wait; she tries to deliver; she can't. She is in active labor. They take her into custody, put her in the back of an ambulance and strap her legs together. They take her to the hospital where she, in the end, is forced to have the Cesarean section. When she sues afterwards, and she didn't come to us, I just want to say, she sues afterwards, she says you violated enumerated rights, my right to due process, my right to

liberty, my right to all of these things. The decision from the District Court in Florida said, “no rights violated at all. Whatever the scope of Ms. Pemberton’s personal constitutional rights in this situation, they clearly did not outweigh the interest of the state of Florida and preserving the life of the unborn child.”² They used the anti-choice misinterpretation of *Roe* saying, *Roe* says since the state can outlaw abortions after viability, outlawing abortion is a worse violation of your rights than simply deciding how you should deliver your baby, so really no rights were violated at all. They described her as somebody who was brava. They cited data from doctors at the hospital that said, if she hadn’t had the C-section, she had a 26 percent chance of a uterine rupture and she could have died and the baby could have died. I just want to point that every first pregnancy and labor has approximately the same degree of risk of a uterine rupture.

She went on to prove these folks wrong. She subsequently—now she’s had C-sections, she subsequently gave birth to the twin boys without a Cesarean and a little girl in the front. Now, one thing I did learn from Laura, part of the reason she lost her case is I think she instructed her private counsel not to argue against fetal rights because she believes in them. As we developed a relationship and I don’t think I persuaded her. I persuaded her to come to our conference, which was hard because she thought being in the same room as the Planned Parenthood people might be a reason she would go to hell, essentially, but she came. I said, you lost because we can value fetuses from a moral perspective and an ethical and religious perspective, but if you win, if the anti-choice movement wins and they are recognized as separate legal persons you lose your right to control how you give birth. That’s exactly what happened to her.

It’s not just about abortion. This is another couple, John and Amber Marlowe, she went to give birth to her seventh wanted child. She’s going to take every child God sent her way. A doctor, who did not know her, decided her baby was too big, got a court order in Pennsylvania giving the hospital custody of her child before, during and after delivery and the right to force her to have a C-section. She and her husband did not think this was such a good idea. She fled the hospital, went to one where there are patient rights and they actually thought that applied to pregnant women too, gave birth vaginally to a perfectly healthy baby. Again, I want to point out they’re sitting on a lawn with these shirts on and stuff because even though they, too are—they call themselves true believers in the Bible, even though they are profoundly against abortion,

² *Pemberton v. Tallahassee Mem. Regional Med. Ctr., Inc.*, 66 F.Supp.2d 1247, 1251 (N.D. Fla. 1999).

they understood that anti-abortion ideology was what ended up being used as a justification to deny them the right to make medical health decisions on their own behalf.

I - - to Melissa Rowland. Melissa Rowland in Utah gave birth to twins, one was stillborn. She was arrested for murder. Why? They said because her refusal to have a C-section two weeks earlier than she did was the cause of the stillbirth and therefore they could charge her with murder based on the state's fetus homicide law.

This is all to point out that it is not just about abortion. The more we repeat that, the greater the chances are that we lose new allies.

The advance of fetal rights in this country, the assault on women, we've held back, we've protected the edges of *Roe* for a long, long time. Where we're losing it in the fetal rights place, which the minute *Roe* is up for turn, what that means is it's not going to be, if it is ever overturned, it's not going to be your mother's 1973 Chevy where if you had an illegal abortion, not before 1973, mostly you weren't going to get caught, mostly you weren't going to get prosecuted. The claim that no women were arrested is not true. Today, you now have laws that say feticide is murder. It's not like you're going to be charged with an illegal abortion and get one to ten years; you're going to go to jail for first degree murder if *Roe* is overturned. That's not hypothetical, we know that both from several illegal abortion cases since 1973 and many, many more against women like Melissa Rowland. By the way, when these are aggressively challenged, these arrests, we win. Many of these women have public defenders who are overwhelmed, who themselves don't know what the reproductive rights law is, and many of them plead guilty and end up serving many, many years in jail for having given birth, for having suffered a stillbirth, which by the way, 15-25 percent of all pregnancies end in miscarriage and stillbirth.

This is Regina McKnight.³ Regina McKnight had a stillbirth and a concurrent positive cocaine test. They said it was homicide by child abuse. An African American woman, cocaine—there are no studies actually that link cocaine use to stillbirth. If you think about it, given how the 85 percent of all counties no longer have abortion providers, if illegal drugs were really going to cause miscarriage, don't you think more women would be using them? Think about it, just as a matter of fact, it doesn't work even logically. She was convicted

³ McKnight v. State, 661 S.E.2d 354 (S.C. 2008).

and the way they did it is they said that the state's homicide by child abuse laws apply to women who unintentionally heighten the risk of a stillbirth. Now, that's not limited to illegal drugs. The principle established by the case had nothing to do with illegal drugs. It was a principle of heightening the risk of a stillbirth. Fortunately, with absolute persistence, in 2008 we did get the conviction overturned because we relentlessly attacked on all sides including the - - science that is used to convict lots of people in this country, but particularly as well pregnant women, the court finally read the science and said, the conviction was overturned, although the principle wasn't because she had failed to call experts who would have testified about recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition and lack of prenatal care or other conditions commonly associated with the urban poor. That's from the Supreme Court of South Carolina, unanimous decision. Now, my only question about that since is, what they mean by urban poor in South Carolina, but I'm going with it.

The use of the war on drugs and misinformation about the willingness to believe the misinformation and the hype in the media about illegal drugs had been used over and over again to justify efforts by prosecutors to get judges to rewrite the law, so that women who risk harm to their unborn children can be prosecuted. They generally start with low-income African-American women who are using illegal drugs.

These are just some of the mothers around the country who have been prosecuted, held in jail while they were pregnant to the point of dehydration and almost losing their pregnancies. Women who love their children, but who can't necessarily overcome an addiction faster than Rush Limbaugh in the short-term of a pregnancy.

Now, let me pull it back together. In terms of how do we use the knowledge that abortion can't be separated from all of the issues pregnant women face, that they can't be separated from issues of criminal justice, from drug policy reform, from the environment, from issues around access to healthcare. Here are a couple of ways. Twenty-eight states at least mandate specific informed consent for abortion services. Now, I think abortion is about the most informed decision anybody makes, not to say that it isn't complicated, but given the hoops that we now make most women jump through, you really have to want it to get to the one clinic in South Dakota, to get to the one clinic that are left in many states to do the waiting period, to raise the money, all of those things. Again, North Dakota right now has an informed consent for abortion that's going to require the doctors to tell the woman she is killing a full human being or something like that. Yet, the answer to that is, okay you want to keep

doing this, fine, but your legislation seems to say that you only care about pregnant women who want to end their pregnancies. What about the vast majority of women who don't want to end their pregnancies? Do you care about whether or not they are informed? Because only two states mandate specific information be provided to women about hospital C-section rates and induced labor rates. These are things that are out of control, that are dangerous to women, that are dangerous to babies when they're unnecessary and yet only two states even on paper require that information. Instead of just saying, right to abortion, right to abortion, what if we really took seriously the rights of pregnant women to information, wouldn't we have to support maternal information acts?

I urge all of you to get the movie if you haven't seen it, "The Business of Being Born" that describes the conditions under which American women are now giving birth. This doesn't go into the fact that we allow women to give birth shackled in prisons all across the country. It didn't come up in the book—"Pushed" by Jennifer Block—does a brilliant job of describing what the majority of birthing women in this country are being denied. While we have books on laws banning women from having abortions, more than 300 hospitals deny women, ban women with previous C-sections the right to go into labor and require them to have surgical deliveries or none at all at the hospitals. State laws like the law, the Oklahoma Mandatory Ultrasound Law for abortion patients. We tend to see those as abortion cases, but what they've done is set a precedent that says, a pregnant woman doesn't have the right to refuse the medical test. Every other human being in our country has a right to make decisions about what tests they undergo; this sets a principle beyond abortion. It says if you're pregnant you don't get to decide, *Carhart*⁴ said you can pass legislation that doesn't have to take women's health into account. What does that say about how we value or don't value pregnant women?

I want to end with this and talk about U.S. lawyers and whether you can move beyond traditional lawyering to a little more courageous and activist lawyering. In 2003, Norma McCorvey, known by the legal pseudonym "Jane Roe" whose life has been used by everybody, got taken by the anti-choice movement. She filed a motion in Texas saying, "Oh my God, I was wrong, things have changed, the law outlawing abortion should still hold in Texas." The reason is they said, you can only lift an injunction if things have changed. The three things that changed were we now know more about fetal development than we did, which was the same argument they used in 1973, women we now know

⁴ *Gonzales v. Carhart*, 550 U.S. 124 (2007).

are actually hurt by abortion and, my favorite, there is no longer a burden of unwanted motherhood. They wrote in their brief, today abandoned children laws and other post-*Roe* enacted legislation allow women to continue to do, to organize their intimate lives as they see fit with consequences of failed contraception now born mostly by the state not women. Women can no longer be fired or discriminated against at work if they are pregnant and they cannot be denied the right to an education because of pregnancy. In addition, impoverished women are given greater medical and social assistance by the state than at any time when *Roe* was decided.

Now, the lawyering part is, I have to say I have chosen at that time, with my organization not to do abortion cases because there are so many groups that do. Not one of them filed an amicus brief responding to any of this. Their view, sort of an appropriate, but narrow legal view was, this is a crazy case, the courts will never take it seriously, we don't need to respond. The problem is that the anti-choice movement uses tons of briefs like this as an organizing tool and as a way of distracting us from real issues and creating an illusion of government care. Very briefly, women can no longer be fired from their jobs because they're pregnant. Millions of women are not covered by the Pregnancy Discrimination Act, that's just a lie. Women can't be denied their right to education because of pregnancy. I got an e-mail yesterday from a woman in upstate New York, she's pregnant, she's going to be kicked out of Syracuse University student's housing if she has the baby, she just can't afford to give birth because she doesn't have enough health insurance. The idea that we allow, in the guise of abortion arguments, for the lies and for the misinformation about our government, around healthcare, about discrimination to continue, is something that we have to work on.

Let me just end by saying that, I look forward to hearing the other panelists and really want to say that we have seen that by being willing to include more than choice, also the issues of prenatal care, of birth and the dignity of women in general, has brought us many new allies and taken away people from the battle against abortion to shared values around healthcare, around dignity and around human rights. I hope you will join me in that struggle and be encouraged to think outside the traditional bounds your law school teachers might be teaching you today. Thank you very much. We have a few minutes for questions.

[*question omitted*]

Melissa Rowland, they made her a plea offer to child abuse and she was such an incredible self-advocate. I've never seen anything like this. Then there

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were other things they accused her of afterwards. She was so difficult to deal with in prison, that not only did they offer a plea bargain, but they said, “You get the plea bargain if you agree to leave Utah and never come back.”

FEMALE VOICE: Can you speak a little bit more about [the pregnant woman you mentioned at Syracuse University, who was at risk of being kicked out of student housing]?

MS. PALTROW: Well, I don’t know more than what the e-mail said, but I do know that we talk about being a country that values children and that is opposed—the culture of life. It’s a culture of life that doesn’t value the women who give that life. What it turns out is that in most universities you cannot have student housing if you have children, so you’re just out of luck. Some people are challenging that as a form of discrimination, which I think it is. If you’re a country that genuinely does value child bearing and children then you wouldn’t do that. Plus, she has all sorts of financial issues around healthcare because she’s a student, she’s trying to better herself. We will be against abortion, but not actually provide support to women who give birth to people who pay our taxes.

In this particular case, from what the e-mail says, but on the other, I’ve already spoken for too long. We get calls from Texas. I got a call over the last couple of years, a young woman kicked out of high school, missed too many classes, this particular woman both gave birth during her high school career, then I think her father died. Fortunately, there’s a group in Texas called Jane’s Due Process, which I suspect was setup to help kids through the parental consent provision, but also has information about discrimination against kids in school. New York City, part of the reason child welfare system, - - the few programs that they have for keeping pregnant teenagers in high school, they’re about to cut. They were never enough to begin with. The level of discrimination against pregnant women in this country is huge.

This is a question of, there is a precursor decision in South Carolina, you want to talk about judicial activism, it’s not the liberals. That court rewrote state law to redefine the word child in every state statute to include a viable unborn child. *Cornelia Whitner*,⁵ who gave birth to a perfectly healthy baby, but tested positive for cocaine created a risk of harm to a child, so is guilty of child endangering, so served eight years in jail at \$30,000 a year. I just might point out that if you’re a drunk driver, so I don’t think driving drunk is like being pregnant and being unable to overcome your addiction, but let’s use that for a

⁵ *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997).

second. If you were a drunk driver, where you are putting at risk the lives of foreign persons, do you know what the typical penalty for that is? A year probation, no jail time at all. Anyway, so one of the concerns was, this is not really about illegal drugs, this is setting a much broader precedent. What we know, and I sadly have—I have a very sad answer to your question, most of the women who have been arrested in the intervening years, have had positive drug tests, some for marijuana. There have been women who've been arrested for drinking alcohol while pregnant, but there is a case this week in South Carolina which proves the point. That is, a woman when she was eight months pregnant became very depressed, she had a history of psychiatric disorder and epilepsy, jumped out of a window to kill herself. She survived, she lost the baby, she's been charged with murder in South Carolina. The idea of these things can happen separate for all the things that pregnant women do, not true. Adrienne?

Ferguson, a number of us in this room were involved in challenging these policies around the country and practices.⁶ In *Ferguson*, most of the cases are coming in and helping a criminal defense lawyer get the charges dropped, dismissed or overturned. There's a hospital in South Carolina where they were secretly searching, particularly African-American patients for evidence of drug use. Then if they were positive, a white nurse would take that information and hand it to the police and then coordinate their in-house arrest. We had gotten the criminal charges dropped, then these women were willing to become affirmative plaintiffs saying that policy should be stopped because it violated, I think we have nine different theories, all of them true. Really it was all just about horrible racism and horrible medical practice. The problem, Adrienne, is that we won ultimately in the U.S. Supreme Court six to three, but we won on the principle that these were illegal searches and seizures, that consenting to a medical test is not the same as consenting to a search for criminal justice purposes. Part of the reality of being lawyers is, so they get around this by shoving a piece of paper in a woman's face in South Carolina that says, I consent to legal forensic testing, you don't know what that means. We don't have the resources to challenge it. That's a perfectly challengeable thing, a follow-up on the *Ferguson* case. That's a million dollar piece of litigation. Nobody has yet done that. You can win a big important Supreme Court case six to three and establish the principle of pregnant and women and public hospital patient's rights to be free from illegal searches and seizures and not have a whole lot of things change. I will say that with McKnight overturning the conviction, it hasn't changed the underlying law. We have reasons to

⁶ *Charleston v. Ferguson*, 532 U.S. 67 (2001).

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believe that bringing a new challenge, saying you really need to reverse the underlying decisions might be better received now.

Thank you very much. If any of you has the millions of dollars to do the litigation, please see me afterwards.

[BACKGROUND NOISE]

MS. PERLE: Thank you so much Ms. Paltrow. Before we start our next panel on sexuality and education, I want to take a moment to introduce our fabulous moderator for today, Professor Leslie Gerwin. Professor Gerwin is currently the Associate Director of the Program in Law and Public Affairs at Princeton University. She has served as legal advisor to the Louisiana Coalition for Reproductive Freedom, Director of Community Relations for Planned Parenthood of Louisiana and Executive Director of a Public Education Advocacy organization and is the policy architect of Louisiana's nationally recognized Adolescent School-Based Health Initiative. Professor Gerwin has taught in five graduate programs including three law schools and two public health programs and she currently teaches a course in public health law and policy here at Cardozo. As her student I want to recommend it to anyone 1Ls and 2Ls thinking about courses for next year, thank you for joining us.

MS. LESLIE GERWIN: Thank you. Welcome everyone. I want to just say that I'm honored and thrilled to be here and see all of you here. I also want to thank Lynn Paltrow for a really inspiring beginning, setting a tone for this morning's and afternoon's discussion. I cut my teeth in the reproductive rights battles in Louisiana. I thought that coming here I might have to explain what a thrill it is to be in an academic setting with such distinguished people and such serious students and members of the public who really want to look at these issues and think about them differently, but if you saw Governor Bobby Jindal's response to President Barack Obama last night, then I really don't have to explain what a wasteland of intellectual discourse and the absence of subtlety that characterizes that state. The rhetorical battles as well as the political battles that we fought down there.

Louisiana was a state in which the law equated children, slaves and women as being incompetent to have certain legal standing and certain legal rights. When the Emancipation Proclamation was passed and eventually they were forced to accept it, they got around to changing the Constitution and eliminating slaves, but it took a lot longer to eliminate or to abolish the prohibitions on women.

That's in 1990 when I entered the public policy and political arena, Louisiana was seeking to criminalize abortion, to have the strongest anti-abortion law in the country at that time. The idea was that they would send doctors to jail for 10 years, fine them \$10,000, but women would not be held liable because they were the victim. At least as Lynn Paltrow said in the beginning, we're moving toward some kind of equality, although it's not necessarily a very good thing in that regard. That was the same year that the Louisiana legislators laughed a spousal rape bill off of the House floor much to the chorus of national criticism that caused them to back-track.

I will say and I will like to echo the point about rhetoric. Since this is a law school and many of you are lawyers or becoming lawyers. That is really a key piece and even in the midst of massive defeats, rhetoric and thinking outside the box, and I hope I'm not one of those law professors to which she referred "thinking inside the box." We won a little battle down there when the legislators starting using the holocaust language, and that was that we took those legislators, several of them agreed to have lunch with Holocaust survivors. They came to understand the difference between the Holocaust with a capital "H" and their cavalier use of language that was seeking to inflame the situation. We didn't make, and we haven't made, as Lynn Paltrow said, a lot of progress in the larger sphere and that's still out there for you. The idea of changing one person's rhetoric of time, particularly when it's leadership is part of that thinking. I believe is part of that thinking outside the box.

Louisiana actually took its fight to the United States Supreme Court arguing that *Roe v. Wade* did not apply to the state. I think in part because much of it was below sea level or some such ideas. It is periodically entertained legislation that would curtail stem cell research, surrogacy, IVF, the debates turned not on the merits or the implications of the proposals, but actually on the economic consequences to the state of banning stem cell research for example, what that would do to their building of medical schools and environments and attracting conventions to the state. Again, there's all different ways to look at this and to be challenged and today, we have a line up of people who I'm thrilled to be able to hear and to introduce. They are people with vast experience, scholars and veterans of the issue and are thinking about it in all kinds of really wonderful and productive and educational ways. I would be remiss if I did not take the opportunity also to acknowledge the Cardozo Journal of Law and Gender and especially if I've mentioned names, I know I don't know everyone who worked on it, but I do have to single out Ashley Antler and Sara Perle, both of whom I've had the real pleasure of getting to know and know how really hard they worked on this. Most of you

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also know what an enormous amount of work it is to pull this together. Thank you and thank you for this honor.

My job is in part is to introduce the speakers. I know that you have their biographies in front of you, but then I wouldn't have a job, so please allow me to emphasize what a range of talent we have here today. On our first panel we have—I'm going to introduce both of them together and then let them go - - without interruption. Our first speaker will be Micah Globerson who currently works at the Office of Infrastructure and Engineering under the Bureau of Economic Growth, Agriculture and Trade at the United States Agency for International Development where he specializes in issues of infrastructure regulation, in the information and communication technology, energy and transport centers. Now you may notice that this very impressive accomplishment does not seem really to touch on today's panel, but he also has been involved in writing and publishing about the legal and analytical issues associated with the relatively new HPV vaccine, Gardasil, and his presentation today about which he has written several thoughtful articles, is not related to Mr. Globerson's day job. I think the required disclaimer follows, but his views do not come from the information that he acquired at his job or as a product of his position and not necessarily reflect the views of USAID or the United States government. Mr. Globerson holds a J.D. from the University of California Davis King Hall School of Law, a Masters of Public and International Affairs from the University of California San Diego where he studied China and International Economics and he has a BA in Philosophy from UCLA.

Our second speaker will be Bonnie Scott Jones who is Deputy Director of the United States Legal Program at the Center for Reproductive Rights. During her decade with the Center, she has served as lead counsel in complex constitutional litigation challenging restrictions on reproductive healthcare including Medicaid funding bans, abortion, facility regulations and reporting requirements for adolescent patients. Ms. Jones has also lead various non-litigation projects including the filing of a citizen's petition with the FDA on behalf of dozens of medical and health organizations seeking to make emergency contraception available over the counter. Prior to joining the Center she served two judicial clerkships, first for the Massachusetts Superior Court and then for the Honorable Mary Johnson Lowe of the United States District Court for the Southern District of New York. She is a graduate of Yale Law School and Sara Lawrence College. We welcome you both.

SEXUALITY AND EDUCATION

MR. MICAH GLOBERSON: I have copies of my presentation over there on the table if anyone wants it. First of all, I would like to thank the Cardozo Journal of Law and Gender and the five men who came to this presentation, thank you. It's good that people recognize that this is not just a women's issue. Thank you for introducing me. I think one of the reasons why I work on this and again, it's not my day job, is because I think the civil rights issues of my generation include issues pertaining to women, gays and the poor among other groups. This presentation will address issues in all those areas.

From listening to the prior two people who were speaking, I think that it's important to consider what we said before by Lynn about—what she said I think I actually wrote it down and she said that there was a time when women's role could not be defined by anything except for pregnancy and motherhood. I know that that doesn't seem like it has anything to do with the Gardasil issue, but actually, it is very relevant and you'll see why.

I'd like you to step back and think of a world in which there are two groups of people and they look at the same issue differently. Maybe you could see that there's an actual war for women's place in society and in that war, one of those battles in the abortion issue as was already discussed, and another one of those battles is the Gardasil issue. There are other battles going on, but you have one group of people who want to move forward and try to have a more progressive society that addresses the role of women in this society. You have another group of people who would prefer to go back to the way that things were before we had birth control and the ability to control their reproduction. Just consider that potential viewpoint in listening to my presentation today.

The human papillomavirus is suspected to be the most commonly sexually transmitted disease. The HPV virus is suspected to be the most common of all sexually transmitted infections. Actually, the term sexually transmitted disease has been, in many cases, now - - sexually transmitted infection because of diseases like HPV, which generally do not have any symptoms, though they can lead to other conditions such as, in this case, cancer. HPV infects three-fourths of all women in the United States. It is highly contagious and can overcome condoms and other forms of contraception, it's also passed from women during childbirth to their children. Most people don't think about this because there are hundreds of strains of HPV and many cause no symptoms. It infects—there have been different studies that have shown that it infects more than 40 percent of college women.

An American woman has a three-fourths chance of contracting this disease in her lifetime, so it's a very serious virus. Cervical cancer is triggered by the HPV virus and particularly certain forms of it. There are ten billion cases of cancer each year and 5 percent of those cases are cervical cancer, so that would be about 500,000 cases per year of cervical cancer. HPV causes about 30 percent of all the cancers that are caused by infectious agents.

Cervical cancer kills one-quarter of a million women each year and that translates to ten women each day in the United States approximately, which is 450,000 American women each year. Relative to other cancers in women, it accounts for 10 percent of all cancers in women and it is the second deadliest cancer after breast cancer over women. In some low-income countries it's the leading cause of cancer still.

Cervical cancer screening—mostly PAP smears—is highly effective at preventing cervical cancer. It can be 100 percent effective if the screening method used is effective and if the testing is done every three years. In the 1960s and 1970s will be - - was changed. Before that period, rates of infection and mortality have been uniform internationally, but that changed. Today, 83 percent of cases of cervical cancer and 85 percent of deaths are in developing countries.

Cervical cancer can be prevented again, and one of the ways of doing it is the PAP smear, the other way is the Gardasil vaccine, which prevents strains sixteen, eighteen, six and eleven. Strains sixteen and eighteen cause 70 percent of all cervical cancer, at least in the United States, and strains six and eleven cause 90 percent of genital warts. The vaccine also probably provides some cross-protection against other strains, but the extent to which that happens is not clear. The vaccine is ineffective against strains that a person's already contracted. Studies shows that a woman who has contracted any strain of HPV during her lifetime, then the vaccine is only going to be 17 percent effective, at least according to one study. Another study said 35 percent effective. Getting the vaccine to girls before they become sexually active can be extremely important.

Cervical cancer incidence and mortality in the United States is very interesting because it's not uniformly reached. In fact, it's highly un-uniform. Among Vietnamese women for example, the rate is five times higher than among white women. Cervical cancer incidence in the United States even when looked just between white, Hispanic and black women was also very different. Hispanic women are at the highest risk of getting infected with—having an incidence of cervical cancer and black women are the most likely to die from cervical

cancer between the three groups. The reasons for these differences have to do with both access and with cultural differences. Where you live in the country also can have a big impact on your susceptibility to contracting cervical cancer. People in rural areas are much more likely to get cervical cancer. Yet regardless of the GDP of the country, screening rates differ among wealth groups and that's true for Germany where wealthier women have 10 percent more access to effective screening. Even if you look at China, 90 percent of wealthy women have access to screening, one half of them get effective screening. Among poor women, only one half have access to any screening and 5 percent have access to effective screening.

To move onto the main issue, there is a CDC advisory panel that met before the Gardasil vaccine was commonly used in the U.S. They recommended the vaccine to girls and women between ages eleven and twenty-six. They also gave \$2 million to vaccinate the poorest girls in the country. The initial group targeted girls eleven to eighteen and the reason why these girls were particularly important was that they were just entering adolescence, they were least likely to be sexually active, they would be least likely to have contracted HPV, so they would get the greatest benefit from the program to encourage their vaccination. Additionally, there are already many programs for school vaccination. The vaccine schedule includes measles, mumps, rubella and many other diseases and I'm sure you're all familiar with that, including Gardasil is one more shot in that regimen was something that was relatively common to do.

There were a number of Gardasil policies that required school vaccination. The one that I studied in my initial paper was the policy in Texas. It was an executive order by Governor Rick Perry to mandate Gardasil usage in school. Girls had to get the shot in order to complete school, but their parents had a very open-ended, they could opt out. They could say that they did not want their daughter to get the shot and then she would not get the shot. The advantages of a policy like this were that it forced insurance companies to pay for the cost of the vaccine, which is huge because it's very expensive, 360 dollar three shot regimen. It also addressed the lack of information that many people may have about this, especially considering that many doctors and pharmacists are known to not provide information on drugs and vaccines that they do not feel that they would like people to know about. It would also reach the poorest girls who would need the vaccine the most. When I say that it reaches the poorest girls who need it the most, what I mean by that is that, those who are the poorest are the least likely to get cervical cancer screening. They're the least likely to be able to get that PAP smear later in life, so it's very important that they, of all the girls, get it or have access to the Gardasil

vaccine that can prevent them from getting cervical cancer as an additional protection. Again, those who can get and do get the screening are almost 100 percent protected against cervical cancer, so those who need it the most are the least likely to get that kind of screening.

I looked at the different arguments and opposition to the policy against Gardasil and most specifically that Texas policy that I mentioned. I would say there are four main lines of argument, but I only address one of those lines of argument in my paper. The first was an argument per se against Merck as a corporation. They were trying to seek profits and that was thought to be bad. There's some irony there that the same conservatives, who are generally pro-industry, are suddenly going against industry. Really, there was an overall criticism of capitalism. The model that we have for producing drugs is that companies are seeking profits, they try to make a drug and it's not an effective drug, then the FDA gets into trouble because you have the biotech situation or whatever kind of horrible vaccine situations we've had historically. Just to pick one random drug and one company and pursue as a line of attack seems baseless. That's the same argument that is true for the argument against vaccines in general. This is a vaccine that can cause autism; it can't. It is for an eleven-year-old, maybe girls as young as nine were recommended in the original policy. People don't get it that late—onset of autism as far as I know. The vaccine was not based on - - . There were no particular reasons to think that this vaccine was going to create any more problems than any other vaccine. Again, it was not a line of argument that I would pursue and I'm also not a scientist, so I did not discuss that further in my original paper.

There was also a concern about the policy in Texas being mandatory. That was really a nominal designation. The policy was called mandatory, but parents could opt out as well, so I did not find that to be in any way a compelling line of argument. However, the argument that the vaccine would engender promiscuity I thought to be very, actually a very strong line of argument after thinking it over more. I know it sounds kind of crazy, but there are many people who think that a vaccine like this could cause girls to become promiscuous and I tried to understand why people would think that, what the basis was in American thought and society to come to that conclusion of what it means.

Before I went into it in my paper I investigated the constitutional issues of the policy that would be specifically targeted at girls and require them to get the vaccination. Looking at it from a number of angles, well mostly I looked at it from the privacy of choice law angle and the Fourteenth Amendment, Equal Protection Law perspective.

One of the interesting arguments that I thought could arise would be if parents opt out, but a daughter sues because she still wants to get the shot. That probably would not be an issue because the constitution does not give affirmative rights. It gives you the right to do or not do something, but it's not going to require that the state has to give you something if your parents don't want it to happen. In this case, maybe the girl can sue for her right to go get the shot on her own, but her right to have the State give her a shot is probably not going to be enforced. In the case that the parents don't opt out and the daughter tries to serve her rights and not get the shot, that also really would not be an interesting issue I thought because I don't know why the state would insist on spending money to give someone a shot. It's not the kind of disease that's passed from coughing or something like this. As we'll discuss later, this vaccine, the way that it was used only for women or only for girls, it was not going to create her benefit, so it was not going to benefit Americans as a whole. It was going to benefit only the individuals who were vaccinated. If someone is insisting on not getting the vaccination, probably it would be easy to just rewrite the law, marginally differently to say that girls also can opt out in addition to their parents. I didn't think that that would create - - .

From the Fourteenth Amendment, Equal Protection side, there are cases such as *Frontiero v. Richardson*⁷ in which women are materially advantaged by law and the Court says that if that causes women to be stigmatized, then that's a problem, but in this case, I think that this does not stigmatize women it confronts a serious health issue that women have, but that's specific to their gender. Requiring girls to get a vaccination for that I don't think would be looked at as possibly stigmatizing.

An interesting issue would have been if women and gay men had special HPV risks. The first men to ask for the Gardasil shot were gay men in the United Kingdom. They thought that they suffered special risks from the anal cancers due to the HPV virus, so they wanted a vaccine for that. I thought that could create an interesting constitutional issue for gay people who might then have to be either recognized as a group constitutionally protected by the law in order to include them in a vaccine policy like this, or the whole group may fail and may be able to say, well it's not just women who need this shot, so we can't give it to just women. As it turns out, more recently, it's been shown that HPV it's a threat to both men and women, so this is a moot issue now, it was what I discussed in my first paper.

⁷ *Frontiero v. Richardson*, 411 U.S. 677 (1973).

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Discussing HPV then went further. Only in 2007 did official Centers for Disease Control U.S. literature recognize males' HPV risk. I think that's interesting. Not only did it then recognize the risk, but it said specifically that men didn't need to worry about the HPV virus. It was not a problem for them. Looking at this issue, I would urge people to think that HPV has always been a problem for men. Even if it were to only affect the women in men's lives it would still be a problem for men. The primary - - carrier has got to be men, so if we're only going to address women with the vaccine, then we're only going to address part of the problem.

There's a 2008 study that showed that of over 4,000 men studied, there was a 45 percent reduction in HPV infection rate from use of Gardasil. Merck is now applying for FDA approval to market their product, the Gardasil to men.

I - -said in my original paper if the public reaction would be the same, if the vaccine was recommended for boys as well as girls or instead of girls. Now, we'll probably get to see what's going to happen and it'll be interesting to see the public discourse that arises in this new context.

One of the unintentional effects of the decision by the CDC panel to recommend this vaccine for girls was to unintentionally create, based on a 1996 law, amended that all women between—or girls between ages eleven and twenty-six now have to receive or have to show evidence that they've received vaccinations of Gardasil, Gardasil being the only HPV vaccine that currently exists because tests haven't yet completed in the UK.

There were three important differences to note between this policy and the original school girl vaccination policy. First of all, you could only opt out of this by a full moral or religious objection to vaccines in general. That's to say that you would say, "I don't get any vaccines and so I'm not getting this one." You could opt out that way, but that is much stronger than that original policy of being able to opt out freely or at least fire your parents. It also includes not only girls eleven to eighteen, but women from nineteen to twenty-six, which is a substantial difference.

Additionally, immigrants are unlikely to be able to pay for this. Again, there was a 2 billion dollar subsidy that went with the original policy to address school girls, but there was no money to go with this and these girls are not yet U.S. citizens, they're not even U.S. current residents yet, so they're not probably going to have access to this subsidization. Obama has been trying to make some changes to the SCHIP program that may improve this, but right

now that has not been changed. Other girls coming to the country have to buy their own Gardasil shots right now and that can cost, again, at least 360 dollars.

Having a policy like this may have made sense if there was any sort of public immunity benefit. You want people coming into the country also getting the same shots that people in the country have, that would create an overall immunity for the population and the idea of a - - community is that if you immunize enough people, then you can protect even people who aren't immunized because it's going to reduce the number of disease vectors, but unless you immunize boys and men, that is definitely not going to be case, especially in the context of this particular condition because again, men are probably the primary vector for women's infection with HPV. This policy also has an important cost benefit analysis that was later addressed in *The New England Journal of Medicine* that vaccinating women in their adulthood may not be very useful if they're already sexually active. Again, the benefits of vaccinating somebody who has already contracted any form of HPV are much less than vaccinating someone who has not gotten the virus yet. There's also going to be a substantial cost burden for immigrants. In New York, in particular, immigrants make very little money and it's something that I've discussed in detail in my paper.

Most of my original paper, and I know I only have about three minutes left, focused on a feminist analysis of Gardasil. To run through components of the first, I discuss abstinence, education and pledges. In the U.S. it's important to recognize that 90 percent of Americans have premarital sex and that includes 88 percent of the girls that take abstinence pledges. Abstinence pledges are very interesting thing in this respect before, girls go with fathers to balls called purity balls, they have a whole box of - - . They have a whole kit and they promise that they're not going to have sex before marriage. That doesn't work. Abstinence and education itself does not lower the average age of first intercourse, which is about 17.4 years. Ironically, having a full sex education does lower the age of first intercourse. The irony is that the people who would like to increase the age of intercourse are not doing it through their own program and opposing the program that would actually - - that they would seem to have.

The general economy - - , which reviews government programs was very concerned about the misinformation that was coming through the programs are powering - - , requiring abstinence-only education. Throughout almost all of the Bush administration, the only thing that could be taught with Federal funds in school in terms of sex ed was abstinence-only. Even though this program was found to be probably not very effective for preliminary study, the funding

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for this program was doubled. There's - - that we best protect children by hiding information and teaching them very - - . That creates a significant danger because I think you can see this assumption and this conclusion apply again in Gardasil. There's an idea that if we don't protect them they'll be more protected. Again, it just does not make sense.

To skip to the end of my paper since I don't have as much time as I thought I did. The biggest thing I would like to say is that there have been a lot of debates so far. We can see that there was a statement that it would make women more promiscuous, that was made with respect to contraception, that was made with respect to emergency contraception and all those cases that were shown to not be the case. That's also not the case of the Gardasil debate. Why do we see this argument coming back again and again is because of an overall battle to determine — an overall war really to determine women's role - - change - - in society in which women have—there's no - - that can continue this - - .

I'm going to end this right here, but you guys have my presentation. Thank you very much.

MS. BONNIE SCOTT JONES: Happily, I was not going to use a PowerPoint. I'm going to talk a little bit about abstinence-only education programs. I and Michelle Movahed have written a paper on this topic. Copies are there. You won't need it. It doesn't contain any slides, but if you want to get a copy as you leave, it's over there.

Abstinence-only education programs are currently the primary government strategy in this country for addressing adolescent sexuality. The federal government has poured enormous amounts of money into these programs, particularly in the last decade, spending at least 1.5 billion dollars so far on the project. At the moment, there are three primary funding schemes, which filter this money into programs. They are the Adolescent and Family Life Act, also referred to as AFLA, the Title IV of the Social Security Act, which are the block grants that go to states, and then the community-based Abstinence Education Program, that's referred to sometimes as CBAE, that's it the biggest stream by far. What's interesting to know about that stream is that it is money that goes directly from the federal government to organizations and programs that offer abstinence-only education. It is not channeled through the states directly.

Despite the fact that we have a new administration in the White House, substantial amounts of money are still being spent on abstinence in the House

appropriations bill for fiscal year '09, somewhere in the range of a little under 100 million dollars is appropriated for abstinence-only education. Pursuant to federal law, any programs that use these federal monies must have the exclusive purpose of promoting abstinence until marriage. Part of what that means is that they may not advocate contraceptive use and they may in fact only discuss contraception in terms of describing the failure rate of various contraceptive methods.

Abstinence-only programs have been subject to a wide variety of criticism, not all of which I'm going to talk about today, but I'll just quickly go over them. The first is that the programs are ineffective, which has been spoken about already. - - The first criticism is that abstinence-only programs are ineffective. They don't, in fact, cause people to remain abstinent until marriage. They give students misinformation, they do not provide students with the information that they need to avoid either pregnancy or sexually transmitted disease contraction, they ignore the needs and circumstances of lesbian, gay, bisexual and transgender youth, they propagate religious values, they impose a disparate negative impact on girls as well as a disparate negative impact on youth of color. Those are just some of the criticisms, all of which I happen to agree with, but I'm only going to talk about one problem with abstinence-only programs today, which is the ways that they discriminate on the basis of sex.

I'm actually going to only focus on one particular way in which the programs discriminate, which is that they teach sex stereotypes as facts. I want to set the stage with giving just a few examples of the kinds of sex stereotypes that are taught in widely used abstinence-only curricula. As one common type of characterization describe certain emotional characteristics as particularly male or female. These are all going to be quotes, but I won't tell you all the quote marks, but they're all in the paper. For example, boys feel loved when their competency is acknowledged. They feel unloved when they are criticized or rarely affirmed. On the other hand, girls feel loved when their feelings are acknowledged and they feel unloved when they are not listened to or their feelings are not validated. Five major needs of boys in life are sexual fulfillment, recreational companionship, physical attractiveness, admiration and domestic support. The complimentary five major needs of girls are affection, conversation, honesty and openness, financial support and family commitment. There's also a whole set of generalizations about boys and girls abilities and ways of relating. Boys are usually better at spatial reasoning and they're superior skills in this area give them an advantage in math, engineering and architecture. Girls are much freer than boys in discussing their feelings, love, hate, anxiety and sadness. There are also a number of stereotypes about boys and girls attitudes toward sex. Under men's perception sex does not

equal a personal relationship, whereas under women's perception sex does equal a personal relationship. Men use love to get sex, women use sex to get love, etc. These are some of the things that are being taught in abstinence-only programs that, as I said, are very widely used programs in the country.

We know from social science research that teaching these kinds of stereotypes impose real harms on student's well-being. Those harms may well support a claim of sex discrimination. However, what I have written about and what I'm going to talk more about today is the question of whether the teaching of gender stereotypes in and of itself constitutes sex discrimination regardless of whether you can show these social science based harms. I have argued that it does.

I think in some ways the answer to that question looks really obvious when you first start asking it, because it would seem like the explicit perpetuation of a sex stereotype by government entities should be sort of per se, the definition of discriminatory in our constitutional behavior. It's actually a somewhat more subtle question than it looks like. The reason for that is that this conduct looks really different from the kinds of discriminatory conduct dealt with in prior Supreme Court cases. The Court has not yet addressed Equal Protection claims in the sex context or anywhere else, it is just about stereotyping. The stereotyping is always matched up with some action that either denies or confirms a benefit on one gender over the other. They have never had to separate out the stereotyping and deal with it on its own.

In addition, the sex stereotyping in abstinence-only programs applies fairly equally to boys and girls. This isn't just one sex that's being stereotyped and told this is what you're like and this is what you can do. Both sexes are being told that, so it's a little different than a lot of other sex discrimination cases. My argument that this does constitute a constitutional violation is based on three fundamental principles of sex discrimination doctrine. I apologize in advance, I'm going to talk an awful of this presentation.

Three fundamental principles form this argument. The first is that over the past three decades of case law, the Supreme Court has established a strong rule against relying on stereotypes to justify differential treatment of the sexes. You can see this again and again in a long line of cases. The most recent demonstration of it is in the *Virginia Military Institute* ("VMI")⁸ decision where the Court rejected reliance on evidence about typical male and female tendencies and gender-based developmental differences. The Court found that

⁸ *United States v. Virginia*, 518 U.S. 515 (1996).

State actors controlling gates to opportunity may not exclude qualified individuals based on fixed notions concerning the roles and abilities of males and females. That's the culmination of this thirty years of doctrine.

The second principle is that in establishing that first rule, the Court has recognized that sex stereotypes are inherently harmful: both because they denigrate the individual dignity of the person being stereotyped and because they perpetuate or they create a self-perpetuating cycle of discrimination. The more you treat people on the basis of stereotypes the more you make those stereotypes true. Interestingly, the most recent demonstration of that principle can be found in the decision offered by Justice Rehnquist and the decision is *Nevada Department of Human Resources v. Hibbs*.⁹ This where he talked a great deal about the government's use of stereotypes perpetuates stereotypes. Of course, he was talking about the stereotypes of men mostly, but that's true of a lot of sex discrimination doctrines.

The third principle is that the reported accuracy of a generalization about the sexes is irrelevant to the constitutional inquiry. In other words, the fact that a generalization might reflect some truth about the current circumstances about some men and some women, does not alter the rule against relying on stereotypes. This is really important. What this means is that even if conventional wisdom or some data says that boys may seem to have an advantage over girls in for example, learning mathematics, the government cannot treat the sexes differently on the basis of a presumed mathematical superiority of boys. Again, this is partly because we don't know if the differences really exist. We also don't know if those differences exist, what caused them, and in particular, we don't know how much discrimination or the lingering effects has discrimination caused the differences. Those factors are what that's underlined in the Court's rejection of relying on stereotypes.

Again, that principle, the rejection of stereotypes even when they may be based on some evidence or some general perceptions about males and females are like, was most recently articulated by the Court, again in the *VMI* decision where the Court said that generalizations about the way women are, estimates of what is appropriate for most women, no longer justifies denying opportunity to women whose talent and capacity placed them outside the average description. Again, the Court is acknowledging there may be things that are true as generalization about many people of one sex and not the other sex. The government can't make decisions on that basis. It can't allocate benefits on that basis. It can't underlie how the government treats its citizens.

⁹ Nev. Dep't of Human Res. v. Hibbs, 538 U.S. 721 (2003).

Applying these three principles and using the Court's usual two-step Equal Protection analysis, I think demonstrates the unconstitutionality of teaching sex stereotypes. The first step of that analysis of course involves establishing that the government has classified on the basis of sex. This step has some conceptual subtlety in this context, because as I said, the government is teaching stereotypes about boys and girls. The teachings may well be harmful to both boys and girls, even equally harmful to both boys and girls. Nonetheless, given the precedent that I've talked about, I think that the Court has to recognize that the government classifies on the basis of sex when it teaches that the abilities, capacities, and emotional qualities of the sexes are inherently different, that they're inherent and inherently different. When they indoctrinate boys and girls with very different messages about who they are, what their potential is and what they are like.

The second step, let me just back up for one second. I just want to put a little footnote here, which is, although in talking about these stereotypes I am acknowledging and recognizing that the harmful effects may be equally felt by boys and girls this is a very separate argument than looking at whether abstinence-only programs have a disproportionate effect on girls for other reasons, which they may well have. To the extent that they are increasing unplanned pregnancies, that is obviously felt more by girls than boys. I don't want anyone to mistake my argument for saying that abstinence-only programs equally affect boys and girls, there are certainly ways in which they impact girls more. It's just that in the stereotype area, it may well be that it is just as harmful to a boy to tell him, you are like this, this is what you can do in life, as it is to tell the girl, this is what you are like and this is what you should do in life.

The second step of the equal protection analysis, I think is an easier one in this case because I think it would be extremely difficult for the government to justify its teaching of stereotypes under any level of constitutional scrutiny without having to resort to sex stereotypes in its justification. It's just hard to come up with reasons why you need to teach this way using stereotypes without calling upon stereotypes to do that, which as we know is not permissible. In addition, the facts that the evidence has consistently come out in our favor showing the programs are ineffective, obviously helps the argument that there isn't sufficient relationship between whatever the phase reported goals are and the methods that it's using, i.e., teaching stereotypes.

I think this should be basically a relatively easy and solid Equal Protection case. There's lots of reasons why it's difficult to bring a case and we can talk about that if anyone wants to for discussion part, but I think that there is a clear

constitutional violation here. As the Supreme Court said in *VMI*, Equal Protection principles are violated whenever public actors deny to women simply because they are women. I would presume to men simply because they are men. Equal opportunity to aspire, achieve, participate in and contribute to our society based on their individual talents and capacities. I think that's exactly what the government is doing when it teaches young people that their potential is governed not by their individual characteristics, but by their gender. Thank you.

[questions and answers omitted]

ASSISTED REPRODUCTION

MS. GERWIN: Assisted Reproduction has some very distinguished speakers that I've had the pleasure to meet this morning and I'm really looking forward to hearing from. I will introduce them all again in the order that they will speak and begin with Elizabeth Scott who is the Vice Dean and the Harold R. Medina Professor of Law at Columbia University School of Law. Her areas of scholarly interest are family and juvenile law and she has written extensively on marriage, divorce, child custody, adolescent decision making and the legal regulation of juvenile crime. Much of her research is interdisciplinary, applying social science research, developmental theory and behavioral economics to legal policy issues involving children and families. She's the author with Laurence Steinberg, a development psychologist, of "Rethinking Juvenile Justice," which came out last year with Harvard University Press and she's also the co-author of a widely used case book on family law and the co-author of a case book on children in the legal system. Ms. Scott was also a member of the John D. and Catherine T. MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice, which was an interdisciplinary research group that conducted longitudinal studies on adolescent's competence to stand trial. She was the founder and co-director for the Center for Children, Family and Law at the University of Virginia, which was also an interdisciplinary center promoting research that informs policy makers and practitioners on issues relating to children and family. In short, she is not one of those law professors who is helping you think within the box, but will push you to get out of it.

Noa Ben-Asher is currently an Associate in Law at Columbia Law School. In 2006 and 2007, she was the Williams Fellow at UCLA School of Law, where she taught an undergraduate course on gender theory. Before that, she was a litigation associate at the law firm of Proskauer Rose, LLP. Having been admitted to the bars both in New York State and in Israel, Ms. Ben-Asher has

published widely in law journals devoted to the study of gender and feminism, including those of Harvard and Yale. I believe we will be hearing a version of her forthcoming article in the Cardozo Law Review.

Bebe Anderson is the HIV Project Director at Lambda Legal, the largest and oldest national legal organization committed to achieving full recognition of the civil rights of lesbian, gay men, bisexuals, transgender people and those with HIV. Ms. Anderson joined Lambda Legal in 2006 after working for eight and a half years as a staff attorney in the Domestic Legal Program of the Center for Reproductive Rights. She previously served as co-executive director of the HIV Law Project, a not for profit legal services and advocacy organization here in New York City. Her legal practice experience includes serving as a partner in the California law firm of Erickson, Beasley, Hewitt and Wilson, a staff attorney with the Civil Division of the Legal Aid Society of New York City, and an associate at the law firm, which is now Pillsbury Winthrop. She is a graduate of Columbia University School of Law where she was a Harlan Fiske Stone Scholar and the recipient of the Rosenman Prize. She received her bachelor's degree in biology from the University of California at Santa Barbara.

Adrienne Asch is the Edward and Robin Milstein Professor of Bioethics at Yeshiva University and Professor of Epidemiology and Population Health and Family and Social Medicine at the Albert Einstein College of Medicine. Her work focuses on the ethical, political, psychological and social implications of human reproduction and the family. She is a prolific author of numerous articles and book chapters and is co-editor of *Prenatal Testing and Disability Rights* and *The Double-Edged Helix: Social Implications of Genetics in a Diverse Society*. She is a board member of the Society of Jewish Ethics and the American Civil Liberties Union, a fellow at the Hastings Center and a member of the New York State Task Force on Life and Law. She has also served as a member of the board of the American Society for Bioethics and Humanities, the Clinton Task Force on Healthcare Reform and the Ethical, Legal and Social Implications Policy Planning Group of the National Human Genome Research Institute. Her doctorate is in social psychology from Columbia University. Welcome to you all.

MS. ELIZABETH SCOTT: Thank you for that very nice introduction and thanks to the journal editors for putting together this conference. I've already learned a lot and I'm very, very happy to be here. What I'm going to talk to you about this morning is based on a paper that explores the social and political history of surrogacy over the past twenty years. There were two things that sparked my interest in this project. One was, popular media accounts of surrogacy. Two

things, last spring one was a cover, a very upbeat cover story in *Newsweek* magazine about surrogacy and the second, and this is a little embarrassing, was the film “Baby Mama” with Tina Fey and Amy Poehler. The other thing that was important and started me thinking about this issue was the recent enactment of laws that provide the relatively routine enforcement of surrogacy agreements.

What occurred to me in thinking about these things was how much the political and social meaning of surrogacy has changed over the past twenty years since the issue first captured public attention in the *Baby M* case in the late 1980s.¹⁰ Through *Baby M*, the legal battle between a New Jersey surrogate mother, Mary Beth Whitehead, and the child’s father, Bill Stern, surrogacy came to be framed as illegitimate commodification, a baby selling arrangement that exploited women and her children. This framing, which came about largely through a sustained effort of women’s groups and religious organizations was adopted by the New Jersey Supreme Court in *Baby M* and it prevailed for several years. Several states passed laws prohibiting or severely restricting surrogacy agreements, often with criminal penalties. Then, in the mid-nineties surrogacy almost disappeared as a political issue, although courts continued to deal with the disputes. In the past decade, surrogacy has reemerged as a legal issue, but the political dynamic has changed and it has come to be framed in public discourse in a more neutral role.

The paper looks at how surrogacy came to be framed as commodification during the *Baby M* litigation. I’m not going to look at that right now in my comments since time is brief. I’d be happy to take questions about it. Instead, I’m going to focus on two questions. One, the role of women’s advocates. Why did women’s groups mobilize against surrogacy in response to *Baby M* and then over time seemingly lose their enthusiasm for this issue? Second, why did the politics and social meaning of surrogacy change?

The framing of surrogacy as commodification resulted through the efforts of a number of different groups including child welfare and adoption advocates, civil liberties groups. The most powerful supporters were the Catholic Church and other religious organizations and women’s groups and feminists. Early in the trial, in the *Baby M* trial, there was some conflict and ambivalence among feminists and an acknowledgement that surrogacy was a hard issue. Surrogacy arrangements were distasteful, for reasons that I’ll return to, but some feminist thought where feminists endorse paternalistic, government restrictions on

¹⁰ In re *Baby M.*, 537 A.2d 1227(N.J. 1988).

women's reproductive choices in this context was intentioned with a broader feminist political agenda.

Now a debate about surrogacy continued in the academic literature, but in the political arena, feminists gradually united during the *Baby M* trial in support of Mary Beth Whitehead and of laws banning surrogacy and punishing birthers. For a few years after *Baby M*, feminists formed a powerful and quite successful coalition with conservative religious organizations lobbying for laws banning surrogacy and with not very much organized opposition. The high water mark of these efforts was the enactment of the New York statute in 1992, which is one of the strongest anti-surrogacy laws.

A political alliance of feminists and religious conservatives on an issue of reproductive choice is somewhat puzzling, so I wanted to try to figure out what explained it. In many ways, the feminist opposition to surrogacy was quite compatible with the feminist agenda. Some feminists saw surrogacy as yet another context in which women were valued primarily for their reproductive capacity. One commenter called "surrogacy the potting soil for men's seed." Beyond this, feminists argued that women needed protection because the decisions to enter surrogacy agreements were not voluntary or informed choices.

The feminists saw two problems with surrogacy decisions. First, that the decisions were coerced, at least indirectly. There was an intuition that women would agree to become pregnant and to sell their babies in the absence of dire financial circumstances or direct coercion. The second concern was that women couldn't anticipate at the time that they executed the surrogacy contract, the substantial risks that they would come to regret the decision to give away their baby due to the bond they were likely to develop with the infant, with the child during pregnancy.

This prediction gained force I think in part because the issue was first considered in the context of *Baby M*, which involved a surrogate who did experience great regret about her decision. The argument that women should have the freedom to make these decisions might have had more traction with feminists if the issue had come up in a different context.

Another reason that feminists rallied in support of Whitehead and against surrogacy was that the case, although it was technically about contract enforcement, it played out as a typical contested custody proceeding. Feminists and women's groups perceived, quite accurately I think, that Whitehead's parenting abilities were being unfairly scrutinized and criticized,

while Stern was presumed to be competent to assume the parental role despite his lack of experience. Child custody was an important issue in feminist legal agenda in the 1980s with the abandonment of the Tender Years presumption, all too often loving mothers like Mary Beth Whitehead lost their children to more powerful fathers. For many feminists, surrogacy and custody became conflated in the emotional context of *Baby M*.

The second part of the story has to do with the change in social meaning and the politics of surrogacy over the past decade. I think there's quite a bit of evidence that the commodification framing of surrogacy if it hasn't disappeared, at least is less powerful than it once was. Again, I turn to stories in the media, which very often depict surrogates not as victims, but as providing a valuable service to infertile couples.

The new surrogacy laws in several states don't aim to deter and punish these arrangements, but instead, to provide certainty about parental status and to protect all of the participants. For example, the 2004 Illinois Gestational Surrogacy Agreement provides that a child born through a gestational surrogacy contract is automatically the child of the intended parents at birth if certain requirements are met. This statute was enacted with very little opposition, almost a unanimous vote in the New York legislature.

What explains this recent reframing of surrogacy as a social and political issue? Well, I think the answer is complex, but there are two things that stand out. First, with the improvements in in vitro fertilization, gestational surrogacy has largely replaced the traditional arrangements in which the surrogate is the genetic as well as the gestational mother of the child. Second, the constellation of interest groups shaping legislation has changed. Parents' groups, adoption attorneys and brokers have been the driving force in lobbying for the supportive legislation, while women's advocates and civil liberties groups have pretty much withdrawn from the arena. Only religious and social conservatives lobby against the recent legislation.

The prevalence of gestational surrogacy today has been a big factor in diminishing the commodification frame. Courts have made it clear that intended parents have a stronger parental claim when the surrogate is not the genetic mother of the child and many modern statutes including the Illinois statute limit enforcement of surrogacy arrangements to gestational surrogacy. It's also clear that intended parents, surrogates and the public view these arrangements as very different from traditional surrogacy. Gestational surrogates, you see comments in the media a lot, gestations surrogate is not selling her own child, but performing a valuable service.

Well, some people who have read my article have suggested that this is a complete explanation for the change of heart toward surrogacy and that there really is no puzzle about why the social meaning has changed. I'm not sure I agree with that. I don't think that that is a complete answer and certainly not an answer for why feminists have withdrawn. For one thing, the importance of gestational surrogacy elevates the importance of genetic and biological parenthood. Suggesting that the traditional surrogate had a property-like claim to her own child that the gestational surrogate doesn't have. The gestational surrogate is described as a - - . The importance of the mother-child bond that's formed during pregnancy would seem to be just as strong arguably in a gestational arrangement as in a traditional surrogacy arrangement, unless we're saying that that bond is contingent on the genetic link between mother and child, but what about the nine months of nurturing the fetus?

The literature on pregnancy and motherhood seldom focuses on the relative importance of gestation and genetics. The reaction to gestational surrogacy seems to suggest that gestational motherhood is devalued when it's separated from genetic parenthood, which seems to be I would think is a somewhat uncomfortable notion.

The other factor that's been important in the reframing of surrogacy that feminists and liberals have withdrawn from the political arena, seems to me to be also very important. Although there isn't direct evidence of this, I think that some changes in the politics of abortion may have played an important role. The argument against surrogacy based on coercion and regret, have come somewhat untenable for many feminists because anti-choice advocates have invoked similar arguments against abortion, adopting what Reva Siegel calls the women protected rationale for banning abortion. This argument has two related, but distinct claims. One, that women are coerced by the boyfriends or family or clinic staff to obtain abortions that they would never otherwise obtain because it's unnatural conduct for a mother to kill her own child. Second, that many women come to regret their abortions and suffer from severe depression and what is called post-abortion syndrome. This rationale for abolishing abortion has gained traction in the political arena and in litigation. It was endorsed by the Supreme Court in *Gonzales v. Carhart* in 2007 as a justification for restricting abortion.

The claims against surrogacy that were made in the context of *Baby M* seem to me to be quite similar to this women protective argument that's made against abortion. Interestingly, Mary Beth Whitehead's attorney Harold Cassidy has been one of the leading advocates or one of the leading proponents of the

women protective argument in the context of abortion in South Dakota and elsewhere.

Surrogacy does pose real issues for women's advocates. Not so different in some ways from prostitution, which has long been a subject of debate. It also raises very uncomfortable issues about class, which I think Noa is going to talk about, which as only relatively wealthy individuals or couples can acquire a child through gestational surrogacy. Much of the distaste with *The New York Times Magazine* article by Alex Kuczynski, last fall, focused on the picture of Alex on the cover with her baby on the porch of her Hampton's home with her baby and her servant standing watch next to her. I think that that symbolized the issue of class is very relevant in thinking about surrogacy. Unlike abortion, surrogacy was never a core political issue for feminists. I think ultimately it became clear that support for restrictions on surrogacy undermined pro-choice advocacy.

MS. NOA BEN-ASHER: First, I would like to congratulate the Cardozo Journal of Law and Gender for organizing this symposium and for constantly remaining at the cutting edge of law and gender theory. Good job. Thank you for inviting me.

My talk today is entitled: The Curing Law on the Legal Evolution of Babymaking Markets. My topic is very much related to Professor Scott's main questions. I am also interested in how, what I call, baby making markets developed. My main argument is that a paradigm - - for infertility has shaped these baby making markets. I'm looking at a time frame between the 1950s and today. The three main markets that I talk about are market for sperm, market for eggs and markets for gestational surrogacy. Now, Professor Scott has said gestational surrogacy is distinct from what I call full surrogacy in that in gestational surrogacy the carrier is not genetically related to the child. What I call full surrogacy is the surrogacy arrangement for the genetic where the surrogate is also genetically related to the child and she provides the ova as well as the uterus.

I focus on three markets. The first part of my talk will show how a cure paradigm has in fact shaped these baby making markets. The second will briefly point to show failures that this paradigm for cure for infertility has caused. Then I will end with some more implications, specifically I will argue that since we're at a point where gestational surrogacy is being legalized as Professor Scott has said, there is no justification for keeping the ban on full surrogacy. That is going to be my - - ending.

I'll start with what I call the first phase of the cure paradigm, which takes place in the 1950s in the United States where sperm, the donation of sperm, what we call artificial insemination or donor insemination is prohibited because it is seen under the framework of adultery. Basically, you have a couple who cannot have a child due to male infertility, the donation of the sperm is prohibitive, it's seen as adultery and the sperm donor is viewed under law as the legal father of the child. That led to a situation where people just could not turn to sperm donations even though the technology itself was available since the nineteenth century.

In the 1950s I traced a movement towards legalizing those sperm donations. The movement comes from the medical community of medical experts saying, well in fact it's a cure for infertility, it's not adultery. Adultery is an old framework, it doesn't belong in the modern liberal scientific times. It is traditional and it's religious and now we can move forward to a new paradigm, which is a medical cure for infertility. In the 1950s the medical community was mobilizing behind this idea. By the 1960s the first important case is the 1968 decision of *People v. Sorenson* in the California Supreme Court.¹¹ That court said, well, it makes no sense anymore that sperm donations are adultery and it's actually a cure for infertility and you, the intended father, the husband of the woman who went through sperm donation is the real father, you're responsible for this child. You can't claim that you're not the father anymore. This was the 1968 Supreme Court of California. It was adopted by the Uniform Parentage Act of 1973 and this is basically state law today in all states.

There is a market today for sperm. You can buy sperm today anywhere on the internet. It is about 300 dollars and it's open and free. It's regulated on very minor issues. We see that a paradigm of cure has led to a free market for sperm, so we see a connection here between the scientific community, the law and eventually market. This is the first phase of the cure paradigm.

The second phase has to do with what Professor Scott just mentioned, which is the increase for fertilization development. Before I go there, there is the issue of the traditional surrogacy/full surrogacy. One of the main arguments in my article is that the cure paradigm did not catch on to the full surrogacy context. The full surrogacy arrangement was never seen as cure for infertility. Instead, it was seen as replacement of the mother and it was seen as commodification. In that sense, Professor Scott's arguments work together with my argument which is that, as long as we don't see a cure paradigm, as long as we don't see

¹¹ *People v. Sorensen*, 437 P.2d 495 (Cal. 1968).

a cure for infertility, we are under the paradigm of replacement commodification and baby selling. A surrogate as selling her own child and we have the *Baby M* court and other courts and then legislatures following that paradigm. It's a property interest in selling that child, it is not seen as a cure for infertility and no market develops for full surrogacy until the 1990s. It is practically abandoned as a practice.

In vitro fertilization allowed for the separation of genetics and gestation. One person could supply the genetic aspect, another woman, the carrying, so we have—and we have a new technology. My argument is that when we look at the cases of gestational surrogacy starting with *Johnson v. Calvert*, which is the Supreme Court of California in 1993 and on, we see a new paradigm, which is it's a service, it is not a mother.¹² It is not the mother because what I traced in the cases is that there is a cure for infertility going on. The surrogate is curing the woman with giving the eggs, so the act of surrogacy she is providing the service of cure. I traced this logic both in the cases and also in the medical literature that comes with it, that treats it also as cure. Just for example, the ASRM guidelines, which is the American Society for Reproductive Medicine defines gestational surrogacy as a treatment option available to women with certain clearly defined medical problems, usually an absent uterus to help them have their own genetic children. It's a cure and on the other hand it's your own genetic child, you're being cured by another woman who helps you have your own child. You have a property interest in the embryo.

I argue that this is a manifestation of the cure paradigm and when we go back to markets, we see that we have fully fledged markets for eggs today and for gestational surrogacy. Just for example, by 2004, most large fertility centers offered egg programs ranging between three-thousand and eight-thousand dollars and gestational surrogacy that is available in some, not all states yet, but there is a trend going in that direction for between thirty-thousand and eighty-thousand dollars. To sum up my main argument here, we see markets today for sperm, egg and gestational surrogacy. They're all led by a paradigm of cure for infertility. We do not have a market for full surrogacy because it is still today seen as replacement.

If we look at it from two perspectives, I think we have a failure here. One is from a market perspective in terms of the financial market that develops in baby making and another is from the logical exploitation. For these two reasons, I think we have failures. In terms of cost, IVF is very costly. It

¹² *Johnson v. Calvert*, 851 P.2d 776 (Cal. 1993).

costs—just to give you some numbers, a cycle of IVF costs 12,400 dollars in 2003 today it's a lot more. Eggs are 4,500 dollars whereas sperm is 300 dollars. Two main groups are affected by this. One is traditional families who simply cannot afford to enter the gestational surrogacy agreements because they just cannot enter those markets. The impact is that these people will turn to adoption and will not have the option of turning to surrogacy. Another group that's impacted is gay males today who cannot turn to full surrogacy and are forced into IVF clinics. The impact for both of these groups is that the cure paradigm, which led to cure markets, to baby markets, has left groups of people both on financial and sexual orientation basis out on the baby making business.

What do we do with this? I view that there are two main implications. That first we should—first, I argue that we should legalize full surrogacy and secondly, we should rethink of the paradigm in which we think about the baby making markets. I argue that we should move to a choice, to families of choice framework and move away from the cure for infertility paradigm.

In terms of exploitation, I just want to point out that if we're interested in exploiting, which was the main rationale in *Baby M*, that was exploiting for the surrogate, in fact, the gestational surrogacy context created more options for exploitation because we can single out black women who will carry a child as well as be singled out because they're the non-mother of the white child that they carry. We're actually opening up the possibility of more exploitation when we're opening just the market for gestational surrogacy. I argue that both from a feminist perspective and from a market perspective, if we legalize full surrogacy we're going to gain from both.

Now, if we legalize full surrogacy, the agreement is going to be much cheaper and we're going to take out the middle-man, which is the fertility clinics. We don't have the costs of IVF anymore, we have the regular cost of sperm donation because we're going for the full surrogacy arrangements. We will open the markets up for people who cannot otherwise afford to enter it.

That's my main argument. There's a normative aspect, there's a descriptive aspect and just two takeaway points. The first is, when we think about these markets, these are the markets that already exist, but there is a near market in the future, which is the one for frozen embryos. When we think about how this market is going to be regulated, we can think about it in terms of cure where it will be allowed only for people who cannot afford to otherwise have children and we would have a whole set of problems with that. Or we can start thinking about families of choice. My framework also helps to start thinking about the

next market for frozen embryos in which we could cure fully regulate I think, but with those frameworks in mind.

My second takeaway point is that my general scholarship looks at points where bad turns to good in legal theory and in culture. This paper has shown that what was in the two moments of the cure paradigm, there was a bad moment that turned into good. With the sperm it was bad, adultery was seen as a bad thing, in the literature, as an evil almost under adultery, then it became good. What turned it good was the medical understanding of it. The body was medicalized, and suddenly what was bad turned into good. We have the same thing with the surrogacy context. Full surrogacy was seen as bad, evil, exploited. As soon as the medical community came in with the cure paradigm, science came in and it became good. That just gives you a general framework of where my scholarship is heading to look for the transitions in morality and law and to ask why. Thank you.

MS. BEBE ANDERSON: Hello. I want to thank the Cardozo Journal of Law and Gender for setting up this symposium and inviting me to speak and thank you all for being here. Now the question is, how's the mic going?

My topic today is focusing on the discriminatory barriers for lesbians, gays and people living with HIV in connection with assisted reproduction technologies, - - that make it difficult for them to participate in those technologies. My focus for my limited time today is on a little bit of background on that issue and then I'm going to talk about the denials of access to fertility services due to sexual orientation, focused on two of the matters that Lambda Legal has been involved: one, on behalf of a man, a gay man who is a would-be sperm donor and another, on behalf of a lesbian needing infertility services in California and being denied them due to religious objections. If I then have time, I'm going to speak briefly about some insurance laws and regulations that have been attributed in a way that limits infertility coverage to persons who having AIDS, and unprotected heterosexual intercourse that has not resulted in pregnancy, and thus obviously such interpretations have a negative impact for lesbians seeking the coverage of those services. I have prepared a journal article, which I hope will be published and it addresses other issues as well, which I again, don't have time to get into today.

First, just a little background. The area of assisted reproduction is tremendously important for many gays and lesbians. That's because if in general, if a gay man or a lesbian wants to have a genetically related child they need to turn to some type of assisted reproduction and particular artificial insemination for lesbians and use of surrogates as we've heard about today

already, for gay men. For people living with HIV, assisted reproduction comes in has various significance because indeed there is medical documentation that there is a potential risk of transmission of HIV via the sperm of a man who is living with HIV. For example, a female partner of a man with HIV can use artificial insemination as a way to totally avoid risk of any HIV infection from her partner, her male partner's sperm. There are certainly significant limitations on the use of sperm from people living with HIV in both law and regulation as well as in provider bias.

Historically, people living with HIV have been denied access to infertility services due mainly, to health and safety concerns, and in particular, because of this concern about the risk of transmission to the partner, and even to the offspring. With advances in medical treatment of people living with HIV, and advances in methods to reduce the risk of HIV transmission via sperm, that's actually led to some changes in opinions of at least the regulatory or professional organizations out there. Unfortunately, that hasn't yet translated much on the state legal statute and regulatory front.

For example, the American Society for Reproductive Medicine actually revised its ethical guidelines dealing with patients living with HIV in 2002 to both discuss methods then available for safely providing infertility treatment - - either the male or the female involved in the treatments has HIV. Also, actually stating in their revised guidelines that "[u]nless health care workers can show that they lack the skills and facilities to treat HIV-positive patients safely or that the patient refused reasonable testing and treatment, they may be legally as well as ethically obligated to provide requested reproductive assistance."¹³ That's a big shift in 2002. Then, the American College of Obstetricians and Gynecologists revised their ethical guidelines in 2007 issuing an opinion that states "there is an emerging consensus that indications for assisted reproductive technology use should not vary with HIV serostatus; therefore, assisted reproductive technology should be provided for couples in which one or both partners are infected with HIV."¹⁴ Unfortunately, people with HIV are still being turned away from access to such services and also, there are still restrictive state laws and regulations that affect people living with HIV that are addressed in the paper I've prepared, but won't get to today.

¹³ American Society for Reproductive Medicine ("ASRM"), *Human Immunodeficiency Virus and Infertility Treatment*, 77 FERTILITY & STERILITY 218, 221 (2002).

¹⁴ American College of Obstetricians and Gynecologists Committee on Ethics, *ACOG Committee Opinion: Human Immunodeficiency Virus 4* (2007), available at http://www.acog.org/from_home/publications/ethics/co389.pdf.

What I want to focus on right now is the issue of the tremendous discretion that providers of assisted reproduction have, which can have significant repercussions for lesbians and gays in particular. For providing reproductive services, there are many factors that doctors are allowed to use in screening and that includes HIV because of the medical risks I just mentioned. It also includes child-rearing ability. That is a factor that the ASRM has actually said and has sanctioned as a back-door to use in screening who you are going to provide assisted reproductive technologies to, as a provider.

We have seen and heard, and studies have shown that there have been refusals to provide services to lesbians and/or gays for a variety of reasons. Those reasons have included objections to providing services to unmarried individuals, which doesn't just impact lesbians and gays, but obviously given our marriage laws in this country, have a tremendous impact on lesbians and gays seeking the services. Religious objections to providing services to lesbians and gays, just personal moral objections and also sex-based stereotypes about child-rearing ability, and prejudices against gay parenting that come into play when, as I say, the providers of the services are allowed tremendous discretion to choose who gets the services.

Again, the professional organization that is supposed to be providing guidance for all of this has issued an important statement. Again, another Ethics Committee statement in 2006 saying that, "As a matter of ethics we believe that the ethical duty to treat persons with equal respect requires that fertility programs treat single persons and gay and lesbian couples equally with married couples in determining which services to provide."¹⁵

Again, the reality on the ground hasn't caught up with those ethical standards unfortunately. As a result, we at Lambda Legal have been involved with a couple of challenges to denials of assisted reproductive services to people based on sexual orientation. We have a matter on behalf of Dennis Barros who is a veterinarian in Orlando, Florida. He and his partner wanted to use the services of a surrogate mother and had her agreement to do that, and were going to have a child using Mr. Barros's sperm and the surrogate mother. They contacted the doctor's office that provided those types of services and explained what they wanted to do, their basis for their wanting to have a surrogate arrangement, that they had the woman lined up and that she had

¹⁵ The Ethics Committee of the ASRM, *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 86 FERTILITY & STERILITY 1333, 1335 (2006), available at http://www.asrm.org/Media/Ethics/fertility_gaylesunmarried.pdf.

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agreed and everything was all set, but they needed the doctor's office obviously to provide the medical services. They were given the appointment, everything seemed to be going forward and then all of a sudden right before the appointment the appointment was cancelled. They were told that the reason for the cancellation was that the doctor would not provide fertility services to Mr. Barros and he said that he wouldn't because of recent changes in FDA regulations and risk-screening criteria.

Well in fact, those were bogus incorrect bases for denying services to Mr. Barros. Lambda Legal became involved and informed the doctor that in fact, the FDA regulations do not prohibit gay men from donating sperm generally, and they specifically do not prohibit such donation when you have what is called a directed reproductive donor, which is someone who you know and they know. It is not a - - sperm donation and the FDA has been clear about that fortunately, in recent years. The complaint was filed with the City of Orlando Office of Human Relations. Many states have laws prohibiting discrimination and public accommodations on various bases. Federal law also prohibits discrimination and public accommodations and typically public accommodations include medical services and medical care providers are considered places of public accommodation. The City of Orlando actually, in addition to other bases such as sex discrimination, race discrimination, disability discrimination, is one of the municipalities that outlaws discrimination on the basis of sexual orientation. That's why we filed with the Office of Human Relations in the City of Orlando. Actually just last Thursday, there was a hearing before the Orlando Review Board and they decided by a two to one vote that in fact, discrimination had occurred in Mr. Barros's situation. The doctor had tried to defend his refusal to provide fertility services on three bases: one, that he was not - -, that didn't go anywhere; two, that he provided services to lesbians, so he couldn't possibly be discriminating against a gay man—that also didn't go anywhere. Then this final one of the FDA guidelines, which he said required him to freeze the sperm to six months and he could not [because he] didn't have the facilities to freeze sperm so he could take the sperm of a gay man.

Actually, the total distortion was the FDA provides the FDA regulations to again, direct reproductive donors. Generally, the FDA when they regulate a facility, they require that unless the sperm is coming from a sexually intimate partner, that there must be testing of the sperm for HIV and some other communicable diseases as well. There must be screening and the FDA doesn't set forth the risk factors, but they say there must be screening for risk factors for possible transmission of communicable diseases. Those requirements though, if you have a directed reproductive donor, though you still do the

testing of the screening, even if the person is considered unqualified, such as if the person has HIV—they're considered unqualified under the FDA guidelines—that is not a basis for using the sperm if you have the situation where the sperm donor knows the woman and the woman knows the sperm donor, the woman consents with that knowledge to have the sperm. Also, there is no requirement for delay in use of the sperm if it is a directed reproductive donor, whereas if you have an anonymous donor—irrespective of whether it's a gay man or not—there is a requirement that there be a test for HIV, etcetera, and then, that the sperm be frozen and there be a new test in six months to make sure that the donor doesn't have HIV and some other conditions. That is not specific to gay men and that is not required in directed reproductive donor situations.

There are some FDA guidelines that were actually in draft form when Mr. Barros was refused treatment, but are now adopted. They set forth risk screening criteria and they include men who have had sex with men in the last five years—those are non-binding. Those are not well documented scientifically for that time period, but they do exist, but they're totally non-binding guidelines and they, again, do not apply in a directed reproductive donor situation.

The other case I wanted to mention was the one we have in California on behalf of Lupita Benitez.¹⁶ She and her partner decided they wanted to have a child and that Ms. Benitez would become pregnant. Fortunately, she had insurance coverage. It turned out she was infertile unfortunately, but fortunately she had insurance coverage that would allow for her to get infertility services, but coverage was limited to one place that was on her plan. She went there - - called North Coast Women's Medical Group—sought services, and was informed by the doctor to whom she told she and her partner had explained the situation,

Well, I actually don't approve of helping lesbians become pregnant. I have religious objections to that, but probably someone else here could. Here you need to have actually medically insemination, which I would not be willing to do because of my religious objections. Probably someone else here can do that and maybe you won't need that, maybe other services will be sufficient.

The doctor did provide her with some other services. They weren't sufficient. Ms. Benitez needed medical insemination. She found out that not only that doctor, but none of the doctors there were willing to provide her with those

¹⁶ Benitez v. North Coast Women's Care Medical Group, Inc., 106 Cal. App. 4th 978 (Cal. App. 4th Dist. 2003).

services that were covered by her insurance policy because of religious objections to providing those services to a lesbian. The medical director told her that. She ended up filing suit against the clinic and the doctors there and alleging, based on state law, that the California anti-discrimination law prohibits discrimination in public accommodations on the basis of sexual orientation. The doctors defended in large part on the basis that they were simply exercising their constitutionally-protected rights of religion and speech.

The case was filed in 2001 and worked its way up to the California Supreme Court on a summary judgment motion on this issue of whether or not the doctors could validly defend their refusal and their discrimination based on their religious objections. The California Supreme Court issued a decision in August 2008, rejecting the religious freedom defense and holding that physician's constitutional rights to free exercise of religion under both the U.S. and the state constitution do not exempt them from their requirement that they act in accord with the requirements of California Civil Rights law and they do not give physicians a right to deny infertility treatment because of the sexual orientation of their patients.¹⁷ This was a very important victory for LGBT people in California, which fortunately does include sexual orientation as a prohibited basis for discriminatory treatment.

I will just mention briefly, assisted reproduction is obviously tremendously expensive, which is why it's so important that for example, if Ms. Benitez had insurance coverage for that. One problem that we heard about is interpretations of some of the laws, where the definition of infertility for the laws requiring insurance coverage turns on unprotected sexual intercourse for a particular period of time, which has been interpreted to deny some lesbians who are medically incapable of reproducing. Lesbians who are medically infertile are prevented from being able to get coverage because they are not able to establish they have had unprotected sex with a male for the required period of time. Other laws use the term "spouse" in a way that then has negative consequences for all unmarried people, but again, obviously, it is particularly problematic for lesbians. Again, these are issues that I have addressed in the paper that I have submitted.

I just wanted to end with pointing out that this is a tremendously important area for lesbians and gays and people who have HIV for some of the reasons I mentioned, but that they are running into a variety of barriers. Some of them are based on medicine, but many of them based on laws and regulations that have not kept up with the medicine and many of them based on provider

¹⁷ North Coast Women's Care Medical Group, Inc. v. Superior Court, 44 Cal. 4th 1145 (2008).

prejudices, some of which fortunately there are some legal basis to challenge, but many of which there are not. Thank you very much, I look forward to questions.

MS. ADRIENNE ASCH: Hello everyone. It's a pleasure to be here. I want to thank editors, particularly Sara Perle, a student in a class I taught here last year on "Reproduction, Law and Policy." One thing that was not mentioned is that I am teaching currently a course with Professor Ed Stein in reproduction policy and law, this very semester. If any of you students are in my class right now, Ashley, Nikki, maybe some other people, just close your ears, pretend you are not here because I am doing something I typically don't do, which is give some of my own views in this talk. I try to keep my own views out of the classroom.

This is a fabulous set of talks to be listening to and thinking about. I was involved in the *Baby M* case in New Jersey and this particular piece that I am going to do is part of a much longer project on assisted reproduction, so I have a lot that I want to talk with all of my panelists about during our lunch.

Now, let me talk about something somewhat different, going across the reproductive technology groups, sperm donation, egg donation and surrogate motherhood, and also implicating adoption and - - genetic diagnosis and prenatal testing. What I am interested in is talking about the phenomenon of trait selection that prospective parents now get to do for future offspring in a variety of ways.

Once upon a time, heterosexual people engaged in sex and in some small portion of those sexual encounters nature took its course; this was especially when there was abstinence-only. Nine months later, more or less, a baby would be born. Sometimes the pregnancies were planned and desired and at other times, they were not planned and became desired, and at still other times, they were unintended and might have been tolerated or recognized as a part of life to which women and men had to be resigned. Prospective parents did not know whether the child would be a boy or girl, would look like the mother or father or neither or both or whether the child would have any apparent health problems or disabilities known as birth defects. This is a long time ago.

Rarely could prospective parents exercise any control over or selection of the characteristics of their future children. Supports of reproduction and parenting took place in heterosexual marriages or long-term relationships. The parents could hope that some of their favorite genetic characteristics—eye color, hair color, facial features, body build—might be transmitted from parent to child or some characteristic of theirs, a long or short nose or large ears might not be

expressed in their child and that the child would instead have nose and ears like the person they had had a relationship with.

No one knew or could know and people went about the business of creating and raising all the same. The only instance in which parents might have some choice about a child's characteristics was in those instances in which they became parents through adoption. When domestic adoption was relatively easy, at least for white, middle class, heterosexual couples, prospective parents would sometimes indicate to an adoption agency that they really preferred a boy or a girl or that they hoped to find a baby from the same racial/ethnic group as theirs and that they wanted to make sure the child was healthy.

Starting in the 1970s when abortion became legal, when tests of fetal characteristics started to develop and when a variety of other changes made taboo topics like infertility much less taboo, the reproductive family formation picture in the U.S. began to change. We've been hearing a lot about that. White parents found it harder to become parents by adopting a white, healthy infant. Science and medicine announced the existence of tests for such characteristics as sickle cell anemia or Down's syndrome. In vitro fertilization, egg donation, surrogate motherhood or contract pregnancy, use of sperm donation by single women and lesbian couples all gave rise to non-traditional families.

The adoption context also changed so that more and more people in the United States decide to create families by adopting children who didn't look like them. They were bi-racial or they were from a different race or they were from Latin American, Eastern Europe, or Asia.

Now, most of the time adoption and egg and sperm donors and prenatal testing for health problems or disabilities are discussed as very different and separate topics. There are lots of reasons to do that, but the reason I'm putting them together is that they are all about this phenomenon of trying to learn something about the characteristics and have some control over the characteristics of children people who want to raise. What I want to put together is not so much a legal framework for making decisions about this, but instead philosophical questions.

If you have a couple in their thirties, a heterosexual couple in their thirties who decide that they are ready to become parents and they find themselves unable to conceive, they will go to Latin America to adopt a child. They speak Spanish; they are Caucasian, but have both lived in Latin America; they have taught English to Guatemalan children. They are confident that they can raise

a boy or girl whose country of origin is something with which they feel familiar, but they are uncomfortable about raising a child born ten miles away to an African American woman who feels she cannot be a good parent and wants to find a home for the child she bore.

Here is another common scenario. A single woman looks through profiles and photographs of men who have provided sperm to the clinic in which she will be inseminated. She is thirty-seven, a high school teacher living in the Northwest. Most of the available donors are Caucasian as she is and she comes across a description of a South Asian donor who is a computer wiz and cooks. She admires those activities and imagines that he is probably really smart and she wants her future child to be smart. She picks him to be the genetic father of her child.

Of course, we all know about the ads in college papers often for egg donors, sometimes for sperm donors, the infertile couple in their forties who've tried for ten years to have a child, but now will accept someone else's eggs or sperm as long as the donor is an athlete or a poet or a chess player or a cellist and as long as they scored at least 1500 on their SATs.

Of course, for many people born in the last thirty years, parents have used prenatal diagnostic techniques, and more recently pre-implantation genetic diagnosis, to discover tests like Down's syndrome, conditions for Down's syndrome, cystic fibrosis, Tay Sach's disease, spina bifida, muscular dystrophy, hemophilia, or sickle cell disease.

Now, what I want to raise, is that many commentators worry about possible sex selection or a futuristic scenarios of selecting only the embryo or fetus who will have the "musicality gene"—we can't do that now so don't worry about it. They don't find anything problematic about selecting against the future child who will have Down's syndrome or cystic fibrosis and most people don't think there is anything wrong when the prospective parents go to the adoption agency and say, we want a girl, but not a boy or we want a child from Eastern Europe, but not Latin America, Asia or of African American or bi-racial origin.

What I want to suggest is that although prospective parents are trying to ensure that the child they raise will be like them in looks or ethnicity or sex, or better than they are, or not having some feature that they don't like about themselves and hoping that the child has a feature commonly found in some group to which they don't belong. There are two problems with that. The arguments for selection are procreative autonomy and reproductive choice, the fact that we select our mates for their characteristics, so why not try to get donors who will

be like the mates we have if the donors are substituting for mates. Why not get donors who are like the mates we fantasize about if we don't have them? Why not try to control the characteristics if we can because so much of life is uncontrollable? Why not give ourselves the best chance to have a child who will have advantages in society, good looks, high intelligence, attributes like athleticism or mathematical aptitude? After all, we do all kinds of things to try to mold our children after they are born or after we adopt them, so why not start as early as we can?

I have two basic arguments against this practice, or at least for us to think about. One of them is an empirical claim; selecting genes will not necessarily get you what you want. It suggests a kind of genetic determinism that even the most confident behavioral geneticist no longer are so happy about—even people who think that intelligence or sexual orientation—and many of these are very disputed and complicated—predictions for addictive personality. Even people who recognize that there might be a genetic component to some of these characteristics will say that there is so much gene-gene interaction, so much gene-environment interaction, including gene-intrauterine environment interaction, that the straight-forward notion that the chess-playing egg donor will get you a chess-playing brilliant child just may not work. It reinforces a kind of determinism that I think is problematic.

Another problem is it is kind of synecdochal quality. That is, one characteristic that we are trying to select, or sometimes a host of characteristics, becomes more important than the whole context of a new human being and the whole social context of raising and nurturing and loving a child. We have notions in public life that we should not use characteristics, race, sex, sexual orientation, disability, age, religion to sum up a person. You should not reject our employees, our students, based on these characteristics. We have always distinguished however, in the private sphere. I want to say, not necessarily that the law should change the difference between intimate association of partners, friends and children, but that we may want to think about the difference between selecting a mate or a partner on lots of characteristics and selecting genes. When you select genes you are not selecting a person, you are selecting traits. That is very different from selecting a mate.

When you are trying to select a child or characteristics of a child, I'd like to suggest that you are perhaps changing notions of parent-child relationships that we might not want to change, even in the most modern of families. Perhaps we want to change the notion that we can parent or will parent and will nurture and appreciate and foster the development of whatever child we get. A lot of what has differentiated families, and here I am not talking about 1950s nuclear

families, but notions that can be true in the most non-traditional family—that nurturing a child and discovering the characteristics of that child is part of what differentiates parenthood from other kinds of activities that we engage in. Discovering who a new human being is, and trying to give ourselves to that child and foster the talents and deal with the deficits of that child might be something that we value in the notion of parenthood and that some of these characteristics or selection of traits may not foster.

The last thing I would say is that, as we work towards the more pluralistic, inclusive, non-discriminating society in the public sphere, we might want to think about whether we can keep separating and whether it is wise to separate public non-discrimination and private if you will, discrimination based on characteristics. Thank you.

MS. GERWIN: Well, there should be lots of questions, so the floor is open. Yes?

MALE VOICE: - - .

MS. BEN-ASHER: How do I think it will be influenced?

MALE VOICE: Yeah - - .

FEMALE VOICE: That is a very interesting question. One of the tenets of my argument is that once something passes the threshold of a cure and it is legitimized and it becomes publicly recognized and legalized, it no longer matters that it is a cure. For example, with the example of sperm in the 1950s, anyone can get it today. We don't care anymore if it really is seen as curing someone's body. Single women can just go and get it. My sense is that gestational surrogacy is now going through the process of legalization and so it won't matter. The courts are also recognizing gestational surrogacy agreements with gay men. My article discusses those recognitions of the courts and they are saying, well, it's available, it is legal, you can use it.

MS. GERWIN: Well, I'll put one on the table for Elizabeth and Noa and actually everybody can jump in. In the end of your talk and it occurred to me Elizabeth that you mentioned prostitution. I am curious as to how the concept of gestational surrogacy and the continuing disfavor of prostitution meet one another? Especially with gestational surrogacy, we are talking about women selling their bodies and the state regulating, or the state allowing that to happen in one instance, and not in another instance. It might be an argument for Noa to say, "Well in fact, while we once looked at full surrogacy as something we

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should condemn, maybe we should look again at the gestational surrogacy issue.”

MS. SCOTT: As something to condemn.

MS. GERWIN: As something to condemn or in fact to eliminate the restrictions on both. Maybe this is the time where we say this kind of moral, legal/moral regulation and women’s choices or men’s choices because it need not no longer be a woman’s issue, it should be something that the state should get out of?

MS. SCOTT: There has been a debate about prostitution, a feminist debate about prostitution that lines up with the debate about surrogacy. On the one hand, prostitution, like surrogacy, is characterized as being exploitative of women’s reproductive capacity; on the other hand, why not? Why shouldn’t women be able to make those decisions in both spheres? I think that for, and I guess I am on the latter side of that debate, but I think that there are many people, at least in the political arena, and mostly what I am trying to do, is to understand and observe what went on in the political arena, not to probe philosophical arguments about surrogacy. I think in the political arena, the claim, and this touches on Noa’s article as well, but the claim that infertile couples have a legitimate interest is much more powerful than the claim that—or much more palatable, than the claim that men need sex. I think that there is a much more sympathetic audience for this service than for the service of prostitution.

MS. BEN-ASHER: Can I just add? I absolutely agree with that and I think it’s a fascinating question because it is really close, reproductive labor versus sexual labor. A woman gives her body for one of—it could also be a man if we think about it closely. We really have a good bed here, like Professor Scott is saying, reproduction is good, so we’re going to allow that. Sex is bad, so we’re not going to allow that. I really think it falls on those grounds and I’m also on the side of choice for tax work.

MS. ASCH: I think that is right. I think you could make an argument though, this would not fly politically, but might fly philosophically, that sex work is only about the decisions that adults make about themselves and that reproductive activities eventually result in a new human being who might turn out to have some feelings about the manner of creation. Now, I am not saying—while politically we think it is really much better for people to want to reproduce than for people to want to have sex, I think there are some claims you could make that what adults do between themselves affecting only themselves is easier to argue for than practices that implicate new human beings.

MS. GERWIN: Yes, Ashley?

ASHLEY ANTLER: I have a question that as many of you were talking, I was reminded of a *New York Times Magazine* article that I read in 2006. - - - the gist of what I remember from it, the article was discussing young, professional, successful professional women who had foregone childbearing in the earlier years and had gotten to the point in their careers where they were satisfied with their careers, they were unmarried and they wanted to have children. What I remember is, they were painting the sperm market as empowering, that these women were in control and they would go out and shop for sperm donors. They would give a - - that Adrienne was talking about and that this article would frame it as an empowering thing for women. I am just curious how some of you would respond to that. Is this empowering for women or is that not necessarily accurate portrayal of women?

FEMALE VOICE: I certainly think women feel that it is empowering for them. I remember that article and I know the arguments for doing exactly what people are doing. My arguments against it or cautionary notes on it don't dispute the sense of empowerment on making a different argument.

FEMALE VOICE 1: This is a little bit of a segue, but as you were describing that article, I was thinking about another *New York Times Magazine* article about how women are empowered by leaving the rat race, the Lisa Belkin article several years ago—leaving the rat race and staying home and raising their children—an article that I found deeply troubling on several levels. If the question is whether women who want to pursue their career should have these options and who don't want to settle down and have children in the conventional way, I say yes. I agree that it is empowering.

MALE VOICE: [question omitted]

MS. BEN-ASHER: I think that the motivation for recent laws like the Illinois Gestational Surrogacy Act is to create certainty about parental status, which will benefit children. A lot of the horror stories about surrogacy have to do with the uncertainty of parental status and who is responsible for the child. In fact, most of the cases that come up don't have to do with the surrogate changing her mind, but with one of the intended parents deciding they don't want to go forward, maybe because the couple is divorcing or for whatever reason. I think the strongest motivation that legislatures have in these facilitative statutes that establish clearly parental status is to serve the welfare of children who are produced through these arrangements.

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MS. SCOTT: Although I am not using “best interest” language, I think some of my concerns about normative values of parent-child relationships are about—I don’t like the commodity language necessarily—trying to view future human beings as people with many characteristics rather than being sought or created for some, but not others, which might be a welfare of the child kind of framework, not in the best interest language.

MS. ASCH: I’ll just mention that in terms of providers assumptions about “best interest of the child” created through the use of assisted reproductive services, we have seen it play out in a way that has been negative for gays and lesbians because of the providers’ individual assumptions. This is not the state though doing that, but certainly some of the laws and their talk about spouses and their focus on their assumption about what the nature of a relationship that they sanction would play out, against lesbians and gays, sometimes those are also fueled by biases that are in part based on incorrect assumptions about impact on the children in those relationships.

FEMALE VOICE 2: I was wondering - - what to do about that - - at all - - and - - ?

MS. ASCH: Well, I did find all that controversy very interesting, having just been immersing myself in this issue of the provider discretion. It is one of many screening techniques providers typically can refuse to provide a service to someone as long as they are not doing it for an illegal purpose or illegal reason such as discrimination, but it was interesting to see the tremendous amount of discretion that providers of assisted reproduction have and to see this child rearing and being one of the sanctioned pieces. I have not read all of what ASRM has said about how they are supposed to use that factor and what they are supposed to consider, but certainly when you just leave it up to individual providers to have their biases come in, there’s tremendous risk of negative impact, which we’ve seen and read about. The controversy about the woman in California really starkly shows the amount of discretion, unregulated discretion, that providers of assisted reproduction have and how they are going to use that is going to come out in different ways, as you have seen. You have heard in the press some doctors saying, “Well that would never, that should never happen, that’s absolutely improper,” and others obviously felt it was proper and went ahead and did that. You are setting yourself up for a situation in which the outcomes will be different and they are going to be based on a whole lot of biases, for good or ill, in either providing services or turning them away. I worry that as a result of this there may be further clamping down at least from the professional organization, and that may go too far and be more restrictive in a way that would impact lesbians and gays. I don’t know how

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this is going to play out, but I think it is going to continue to bubble through and be in effect what the guidelines are, so I think something to very much watch for. A lot of the laws that are imposing restrictions, I don't think many of them were in this area, like the insurance for assisted reproductive services. I don't think they were intentionally designed to limit coverage in a way that would impact lesbians and gays, they just were not thought through. That typically happens. So frequently things just are not thought through and so they have these repercussions and I fear that could happen here too.

MS. PERLE: Well, we're getting sufficiently close so that we can continue this privately or over lunch. Next panel starts at 2:15.

MS. GERWIN: Well, thank you to our panelists.

YOUNG WOMEN'S ACCESS TO REPRODUCTIVE HEALTH

MS. GERWIN: Our third panel is on young women's access to abortion. The panelists got together and decided that they would concentrate on the issue of abortion, which really is sort of back to the future now, because this is sort of where we started from in terms of this movement, and now we'll explore those dimensions.

Our first speaker will be Rachel Rebouché, who is the Associate Director of Adolescent Health Programs at the National Partnership for Women and Families in Washington, D.C., and she teaches family law and comparative family law as an adjunct professor at American University's Washington College of Law. Her published writings include *Examinations of Comparative Abortion Law*, *the Protocol on Women's Rights to the African Charter*, *Gender and Post Conflict Power Sharing Arrangements*, and *The Strategies of Lawyers, Collectives, and Human Rights Reform*. Prior to her current position, Ms. Rebouché was a Women's Law and Public Policy Fellow at the National Women's Law Center and a law clerk to Justice Kate O'Regan on the Constitutional Court of South Africa. She is a graduate of Harvard Law School, where she served as Editor-in-Chief of the *Harvard Journal of Law and Gender*. You make all of us here feel very good. She also received an LLM at International Human Rights Law from Queens University in Belfast, and worked for the Northern Ireland Human Rights Commission and the Queens Human Rights Centre.

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Our next speaker will be Susan Frietsche, who is the Senior Staff Attorney for The Women's Law Project, a nonprofit women's legal advocacy organization with offices in Philadelphia and Pittsburgh. Since joining the Law Project staff in 1992, she has litigated, lobbied, and organized on behalf of reproductive health care providers and their patients, teenaged women needing confidential abortions, low income women, domestic violence survivors, custodial parents of child support, lesbian and gay parents, incarcerated women, and pregnant women excluded from substance abuse treatment. In addition to her work at The Women's Law Project, Ms. Frietsche is an Adjunct Professor at the University of Pittsburgh Law School. She is a graduate of Bryn Mawr College and Temple Law School.

And last, but certainly not least, Professor Linda J. Wharton is an Associate Professor of Political Science at the Richard Stockton College of New Jersey, where she teaches courses in constitutional law, civil liberties, gender, and the political action, and public education and the law. Professor Wharton's scholarly research and writing focuses on issues of state and federal constitutional law, with special concentration on the law of gender discrimination. Before joining the faculty at Stockton she served as the Managing Attorney of The Women's Law Project in Philadelphia, where she specialized in litigation and law reform relating to gender discrimination. In this capacity she also served as the co-lead counsel in *Planned Parenthood v. Casey*, which most of you probably know was the challenge to Pennsylvania's restrictive abortion law, and was heard by the Supreme Court in 1992.¹⁸ She has also taught courses in sex discrimination law at the University of Pennsylvania Law School, Rutgers Law School, and in Women's Studies Department at the University of Pennsylvania. She is currently the Chair of the Board of Directors of the National Women's History Project. Professor Wharton is a graduate of Bryn Mawr College and Rutgers Law School, and she was the Law Clerk to the Honorable Dolores K. Sloviter of the United States Court of Appeals for the Third Circuit.

So I give you Ms. Rebouché.

MS. REBOUCHÉ: I—I think I'm going to sit here —

MS. GERWIN: [Interposing] Okay.

MS. REBOUCHÉ: —if that's fine. Good afternoon. Thank you very much for that introduction. I'm going to spend my fifteen minutes this afternoon doing two

¹⁸ *Planned Parenthood v. Casey*, 510 U.S. 1309 (1994).

things. The first is describing the background that will inform our conversation today among the three of us—parental involvement laws—and then I’m going to discuss, in a more general way, some of the difficulties in implementing those parental involvement laws.

So just as background, as most people in this room know, there are normally two forms of parental involvement statutes. There are the consent laws and notice laws. Consent provisions require that a minor get either consent from one, or in a couple of states, from both parents.

And notice provisions require that clinics alert a parent to a minor’s abortion decision, usually forty-eight hours or so in advance, by means of notice set out in the statute—registered mail with special delivery—that kind of thing.

Parental involvement laws have a thirty year history. In *Planned Parenthood of Central Missouri v. Danforth*,¹⁹ in 1976, the Supreme Court first considered a parental involvement law and struck down a Missouri law that required parental consent unless an abortion was necessary to save the life of a minor.

The next time the Court considered the law was in *Bellotti v. Baird*.²⁰ The Supreme Court held that, in order to be constitutional, parental involvement laws must include an alternative process that allows a minor to show she is either mature enough to make the decision to have an abortion independently from her parents or that it is in her best interests to act without parental involvement.

This is really the standard we still work with today. The standard was reaffirmed, in *Casey*, which Linda will discuss at greater length. Almost all parental involvement laws define the alternative process in *Bellotti* as a hearing before a judge who will determine whether a minor is mature or if waiver would be in the minors’ best interests. This process—commonly called the “judicial bypass”—must be timely and confidential.

So what do parental involvement laws look like today? Thirty-five states have them, so it’s by no means a minority trend, and they fall along a spectrum of restrictiveness. Some states have a relatively broad waiver provision, so they allow nonparents to give consent for a minor’s abortion—so a grandparent, an aunt, a sibling of a certain age, as defined by the statute.

¹⁹ *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

²⁰ *Bellotti v. Baird*, 443 U.S. 622 (1979).

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And some states' statutes, like Maryland's, allow a physician to do what basically a judge does in a bypass hearing—determine that the minor is mature or it is in her best interests to not involve her parents.

Some states allow an exception to parental notice or consent if there has been a rape, or incest, or abuse, or neglect, and a couple of states, redefine the age of minority for an abortion decision. So if you're under sixteen in Delaware, you need parental notice; if you're under seventeen in South Carolina, you need parental consent.

So as I said, there is a spectrum of what laws require, and sadly those states with stricter provisions are more numerous and are more typical. At the end of the more restrictive part of the spectrum are states like Mississippi and North Dakota, that require both parents to consent, or Minnesota, which requires both parents to be notified. And then a couple of states require both notice and consent. So they really, really want parents involved.

In addition, courts in several states have enjoined the operation of their parental involvement laws—and that will also be spoken about in a minute—under state or federal constitutional challenges. The first state to repeal its parental notification law was New Hampshire in the summer of 2007. And then of the states remaining, you have no law that speaks to how parents are involved in a minor's abortion decision. Minors can pursue an abortion as any adult woman would.

So that is the law of the land. The National Partnership for Women & Families is involved in a project that will look at how the law in those thirty-five states actually operates. So not just what statutes say—what I described to you just now—but what's actually happening on the ground. To figure this out, we interviewed the lawyers, judges and court personnel, clinic operators and patient educators, advocates and hotline operator—the people working most directly with minors—to figure out best and worst practices around the bypass in each state where parental involvement laws are in force.

To give you a sense of some of the dilemmas that minors face when parental involvement laws are applied, I'd like to offer two hypothetical "Janes" at opposite ends of the spectrum.

So let's first consider Jane One, our first Jane. She lives in a state with a notice law, she is sixteen, she has a good relationship with her mother and her father. She does not think she's ready to become a mother. She calls a clinic, the

number of which she finds in her local phonebook, and she calls it because it's relatively close to her house.

The clinic tells her about the state's notice law, and they explain that, in essence, the clinic will have to send one of her parents a registered letter that will tell them that she wants to have an abortion. The clinic then tells her if she doesn't think that she wants to do that, or she cannot do that for whatever reason—her parents are not available, they are not physically present—she can go through this process called the judicial bypass. They explain that they have a very good relationship with a local lawyer who can represent her for free. The lawyer will file a petition for her in the juvenile court of the county in which the clinic is located. There is a judge that hears most all the bypass petitions in this city, and the judge has a reputation for putting minors at ease and acting with compassion.

The clinic describes, in some detail, what that process is like, that they can arrange an appointment for her after school. They give her the name of the lawyer, they explain that the lawyer can also meet her after school and petition for a hearing after school, and in most cases they can arrange her abortion appointment and the hearing the same day.

If she has trouble paying, they can give her a name of someone to contact—a statewide fund affiliated with a national group that helps women meet the costs of their abortions. That's Jane One. Still not ideal. You're sixteen, it's probably not your ideal Wednesday morning, to call a clinic and walk through your abortion options, one of which includes going before a judge you've never met, never heard of, et cetera.

But let's consider Jane Two, toward the other end of the spectrum. Jane Two lives in a state with a consent law. She's fifteen and she has a tense relationship with her mother with whom she lives, and she hasn't seen her father in years. She's afraid she'll get kicked out of the house if her mom knows she's pregnant. She and her mom live in a small town, fairly remote from the closest big city where the state's only three abortion providers are.

Jane finds the number of one of the three clinics and calls. The clinic tells her she'll have to come into the clinic with one parent, who will need to show a photo ID that matches the parent's signature, and who will return a signed and notarized consent form.

Jane explains to the clinic receptionist that she does not want to tell her mom and she's not sure where her dad is. The clinic tells her that she will have to go before a judge if she wants to get an abortion without involving her parents, although the reception notes that she is not sure how the process works in Jane's part of the state.

The clinic advised her to call a clerk in her town's court. Jane worries that if she calls the court, someone she knows is going to answer the phone because, after all, it is a fairly small town. She calls anyway. The clerk has no idea what Jane is talking about. In fact, the clerk is pretty sure that judges "just don't do that kind of thing" in this part of the state.

Jane calls back the clinic, explains the dilemma, and the clinic gives her the number of a courthouse in the city where other young women, seen by the clinic, have gone before a judge. Jane calls the clerk at the court. The Court explains that she has to file a petition. Jane doesn't realize that under her state's parent involvement law she is entitled to a lawyer. The court is a three-hour drive away and only schedules hearings during normal business hours, nine to five, and Jane is too young, at fifteen, to have a driver's license (or a car for that matter).

So are you exhausted yet? At this point, a fifteen-year old may not get in front of this judge, right? That is a lot to ask of most anyone, but particularly from a fifteen-year-old who has probably not navigated a legal system like this before.

But let's assume she gets to the court and somehow manages to file a petition with the help of a court clerk, or has a public defender assigned to her, or a pro bono lawyer assigned to her. Let's assume now that the judge she appears before just doesn't like women under sixteen having sex. She thinks it's terrible that women younger than sixteen are sexually active, and in her hearing she asks Jane things like: "why did you have sex at such a young age? Who is the father? Is he your boyfriend? Where did you have sex?" Moreover, this judge is not too keen on abortion. She asks Jane, "did you know that an abortion could kill you? Are you familiar with the risk of abortion?"

Jane finds the process humiliating. And by the way, if Jane was in Alabama a few years back, that judge would have not only asked those types of questions, but would have appointed a guardian ad litem, not for her, but for the fetus. So Jane would have been cross-examined by this guardian ad litem on behalf of the interests of the fetus.

So taking these two hypos, we can imagine that among our thirty-five states, minors grapple with combinations of these impediments in circumstances where the landscape of clinic support (that is, what a clinic can do to help a minor) and legal support (where there is a lawyer to represent a minor and a judge to apply the law fairly, compassionately) change not only from state to state, but from county to county, and from courthouse to courthouse.

So the Partnership has a fairly large task in front of us, to figure out how the bypass works on the ground. Because we not only have the logistical difficulties of figuring out how the bypass works in all these different locales, but a fair amount of discretion, and thus many different practices, among clinical and legal actors in each jurisdiction.

Today's time constraints only allow me to touch upon some of the most troubling issues associated with the bypass. You can probably already tell from these two fictional accounts that the bypass can further marginalize already marginalized minors. Who are they? They include minors who do not speak English as a first language; they are minors from immigrant communities that worry about their family's immigrant status; they are minors from low-income families; geographically isolated minors; minors in foster care, or who have the state as a guardian.

So the theme for the conference, "what to expect"—I think there's a misperception that parental involvement laws are this great compromise, that parents get to help their kids make difficult decisions, and mature girls get to make decisions when their parents are unreasonable or unavailable, and what's wrong with that? The judicial bypass serves as some sort of safety valve.

Well, what's wrong is that most people outside of our community, and maybe some within the reproductive rights community, do not understand the scope of how unfairly and arbitrarily these laws can be applied. This is not to say that there is no hope—Prop 4 failing in California, New Hampshire repealing its law, suggests some reason to be optimistic. But that said, it must emphasize enough how often these laws come up, and how the iterations of these laws become more restrictive and more restrictive, as seen in the federal fight over this very issue.

So one idea is what we need to expect is that this fight is far from over, and it still creates a very real problem for a lot of minors. Perhaps we need to change our discourse about minors' rights, what rights minors deserve, and also about adolescent sexuality, because a lot of this is rooted in a distaste for talking and

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thinking about minor sexuality. We could have a whole conference just on that one point.

But I'm going to leave it there, since I am out of time; Linda and Sue will talk about some strategies for reform in more detail. Thank you.

[Applause]

MS. FRIETSCHER: Thanks Rachel. I hope this mic is behaving. Can you hear me? Is that all right? Well, good afternoon, and thank you to the Cardozo Journal of Law and Gender for putting on this wonderful conference, and for that lovely lunch, and for inviting me to speak.

My name is Sue Frietsche. I'm a staff attorney at The Women's Law Project. The Women's Law Project is a nonprofit women's legal advocacy organization. It has been around since 1974. We have two offices; one in Philadelphia, one in Pittsburgh. I opened the Pittsburgh office in 2002 and that's my current base of operations there.

I want to talk to you about young women's access to the judicial bypass system in Pennsylvania, and in preparing for today's talk I realized something that had not clearly occurred to me before, which is somewhat depressing. I have been working on the Pennsylvania judicial bypass system for fifteen years and it still stinks. So I'll tell you in some detail why I have arrived at that conclusion.

The perspective I'm bringing to this is twofold. First, I worked on the post Supreme Court proceedings in *Planned Parenthood v. Casey*. After the Supreme Court upheld most of the provisions of the Pennsylvania Abortion Control Act in 1992, striking down only the husband notification provision and its related reporting requirement, upholding, as part of that law, Pennsylvania's one parent informed parental consent statute, the Supreme Court remanded the case and, with Linda, who was also at The Law Project at that time, and in fact, was lead co-counsel in *Casey*. We worked for the next two years to try to keep the statute that, after all the U.S. Supreme Court had just upheld, from taking effect, and we actually did it for about almost two years, actually, through a variety of creative legal strategies of Linda's primarily.

But in the course of doing that we had to face the fact that sooner or later this parental consent law was ultimately going to take effect. Our last strategy to hold off the day of reckoning was to file a state court challenge called

CHOICE v. Preate in which we allege that, whether it was constitutional on its face, the Pennsylvania Abortion Control Act could not be implemented because the state was not ready to implement it, that the required fetal photographs and so-called informed consent materials were not published yet, which providers were required by the Act to distribute, and also importantly that the judicial bypass system did not exist, that our county courts were not prepared to see minor patients and we were able to get a brief injunction from our commonwealth court preventing implementation of the law, pending the state's readiness.

We ended up settling out that state court challenge, and the terms of the settlement were that we would work with the Attorney General, our opposing counsel, to come up with rules and forms governing judicial bypass proceedings. I brought some of the forms with me today. They are over there. I don't offer them as models of perfection by any means. I mean, a lot of what is wrong with them was required by the Statute. However, you will notice that they are extremely bare bones. Very, very spare, and I think that's a strength.

The early implementation of the judicial bypass system in Pennsylvania was sort of just extremely pressured. This was because, as you can imagine, there was a lot of publicity about this abortion law taking effect. I mean, there was tons of publicity around *Casey*, and Pennsylvania was the—the genesis of all that.

We did sense some kind of—a lot of misinformation and panic on the part of some women in Pennsylvania. At The Law Project we got a call from a Philadelphia doctor who reported that around the time that the law was to take effect, in March of 1994, he had started seeing cervical lacerations that are consistent with self-abortion, that he had concluded that women were trying to self-abort because they thought that the law was going to be so restrictive that they couldn't get a legal abortion.

We also got calls, interestingly, from more than one young woman. I can't recall exactly how many, but we got several calls from young women who were pregnant and did not want to get abortions, who thought that the law had changed to permit their parents to force them to get abortions.

So the lesson that they were taking from the parental consent and judicial bypass law was that they had simply lost their freedom to make any reproductive choice at all. Very, very sobering.

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We did a public education campaign to try to counteract this kind of panic, which, you know, back then we really didn't have the kind of internet resources that you could certainly use very fruitfully today. We mostly used bright pink stickers that we made zillions.

MS. WHARTON: [Interposing] Yes.

MS. FRIETSCHE: Remember the stickers?

MS. WHARTON: Uh huh.

MS. FRIETSCHE: Everyone put them in, you know, you saw them everywhere. You saw them in public libraries, and in subway stations, and in women's rooms, and just, you know, turnpike toll plazas, you saw them everywhere. And the stickers basically directed people to call a statewide pro-choice telephone hotline run by the organization Choice, which then was going to be set up to try to deploy anyone needing help to the resources in each individual county.

We ended up first trying to replace all the little county forms and rules that had sort of sprung up overnight with what we thought were the more protective rules that we'd negotiated out with the Attorney General, and in some cases the forms that the local courts came up with were kind of horror shows. I remember one was twenty-seven pages long, I mean, I can't even imagine being, you know, you wouldn't even have to be a minor to be daunted by that. I could not complete a twenty-seven page-long application to get an abortion that asked me about my birth control method, and my relationship with my parents, my religious beliefs, I mean, this thing was an absolute nightmare.

So in at least two counties, we had forms that were at that level of intrusiveness and burden, so, you know, by working with the local bars in those counties, and women's advocates, and with the courts themselves, we were able to. I don't think there are any of those forms in use at this time. The state level forms are all in use.

We had to recruit and train attorneys in many counties. Fortunately our parental consent law has a choice of venue, so you can go to court either in the county where your provider is located, or in the county where you live. And as this system has developed, the few counties that have freestanding abortion providers, anywhere between ten and twelve at any time, have a workable judicial bypass system in place for the most part.

The ones that don't, the rest of the sixty-seven counties, have nothing, and most of those other counties have never seen a single bypass and maybe never will, and I think to this day, would not know what to do with a bypass petitioner if she walked in the door.

We met with judges, court administrators, administrative judges in seven counties in a really concerted training project, which took, oh, I don't know, the better part of a year, I think, before we were able to get into and meet with judges in these key counties.

At this time, the last time I checked, there's probably a little under two hundred judicial bypasses done a year in Philadelphia County. Somewhat under a hundred done a year in Allegheny County, which is where Pittsburgh is located, and then a handful done in the rest of the eight or ten other counties that have freestanding abortion clinics like, for example, Allentown, maybe twenty a year in Lehigh County.

Since March of 1994, all bypasses in Pennsylvania have all been granted, with three exceptions that I'm aware of. There may be others, but I know of three. The first was a denial that happened right after implementation. I don't know how this happened, but a young woman in Western Pennsylvania figured out how to do a bypass petition, I think before the forms were even really readily available. She figured out what court to go to, she got before a judge, and without an attorney, she represented herself. She was not actually able to meet the statutory standard of showing that she had been counseled. She went straight to court. She hadn't even gotten her pregnancy confirmed. So the Court at least, you know, consistent with the statute, denied her bypass petition. I'm just stunned that she was able to do this really. However, she got hooked up with a provider, the provider counseled her, she re-filed her petition in a different county, it was granted, and she was—she was fine except for the fact that this poor thing had to go through two bypasses.

The second denial was more serious and happened pretty recently. It was in 2003. A Philadelphia judge denied a minor's bypass petition solely because the judge thought that she was too far along in her pregnancy. This young woman already had one child, was the victim of abuse or neglect, and so, was in the care of the Department of Human Services of Philadelphia, and the Department of Human Services couldn't figure out who was supposed to pay for this young woman's abortion procedure, so she was delayed for many weeks, while the system was trying to figure out who was responsible for her care.

By the time she got before her bypass judge in Philadelphia, she was twenty weeks pregnant, and she got denied on that basis. I'm happy to say in the only appeal that has ever taken place in Pennsylvania, within a matter of, I think, three days from the date of her trial, her bypass hearing before the trial judge, the Superior Court had reversed her denial and actually entered judgment. There was no remand so she was able to get her procedure.

The third denial was very troubling, and this came, again, just a few years ago. A petitioner in Erie County was denied a hearing by a judge who simply said I can't see you until several weeks from now, if then. So there are various reasons why this young woman could not come down to Pittsburgh to get her bypass, and we ended up actually drafting a complaint, alleging that as it was being applied in Erie County, Pennsylvania's Parent Consent Law was unconstitutional because it in effect, lacked a bypass provision.

We of course could not directly sue the Court, though that would have been sort of more fun, the official we had to name was pro-choice Governor Ed Rendell, and when I made the courtesy call to his general counsel to tell that person about it, the problem was resolved and it was resolved within twenty-four hours over a Thanksgiving weekend, which was quite impressive, I thought. But it was not resolved fully because, although the Erie County Court pledged that they would make bypasses available, appropriately and in accordance with the law, sadly, our client had given up on us and had found a way to get to New York, and as far as I know there hasn't been another bypass even attempted in Erie County after that.

There is still great difficulty in availability, which has been documented by a researcher named Helena Silverstein, who has written extensively about the problems in getting into court in most of the counties in Pennsylvania. We also have terrible difficulties, which Rachel alluded to, in just simply the inherently intrusive and burdensome nature of bypasses.

While I was representing bypass clients, I had one client who was recognized in the hall of the courthouse, we had another client who had to, we both had to, wait for three-and-a-half hours to get in to see a judge because the judge had something just more important on the agenda that day. I had minors get lost trying to find their way through downtown Pittsburgh, I had minors coming in from rural counties who did not have appropriate clothing for a Pittsburgh winter and were stuck standing outside the locked courthouse doors for a half hour because the provider had, in an excess of caution, told them to show up a half hour before they actually had to show up, afraid that the kids would be late and miss their bypass.

You know, there have been some inappropriate questioning by judges, giving medical advice from the bench a couple of times, we've seen some anecdotal evidence that there are young women who we're just simply not reaching at all, and I'll just give you two examples of that.

One is a number of young women who I represented told me that they had considered waiting until their eighteenth birthday. This was not unusual to hear this from them. Most of my bypass clients were seventeen, and many of them had at least considered hanging in there until their eighteenth birthday, which would have meant some of them would be coming in at the fourth, fifth, sixth month of pregnancy. And they had made the decision not to, but for some of them it was a close call.

Another anecdote I just recently heard from a provider who was talking to a bypass petitioner, and complimented her on how calm she was during her bypass hearing. The young woman said "Well, I didn't like going to court, but I thought it was better than what my friend did, which was she tried to do it herself and she really hurt herself."

So, you know, with anecdotes like that, I just want to encourage us not to backburner judicial bypass problems simply because we have had to live with these systems for decades now, and we should be at the forefront of the pro choice agenda, and there have been some strategies developed for lessening some of the burden.

Just to list them briefly: telephonic hearings, so that the young woman does not have to actually show up at court. We have done that at least once, maybe more in Philadelphia. They are very humane, if a judge will do it, it might be worth a shot. Conducting the hearings in chambers with the judge in shirtsleeves instead of a big scary black robe; assigning bypass hearings to masters if judges are too busy to fit a timely bypass into their schedule; using non-lawyers to represent minors in bypass hearings—this is not my preference, but one of the Pennsylvania clinics is using this strategy, and it has been working for many years; and then, finally using law students and other volunteers to help the process go a little easier, and there's some wonderful work being done by the Penn Repro Rights Project, run out of the University of Pennsylvania Law School in Philadelphia, and during questions if you want to know more about that, please let me know.

All of these strategies though really are sort of stopgap, and they only minimize really, really, really terrible, terrible burdens on a minority of young

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women who actually can make it through the process. They are not the answer. So now I want to turn it over to Linda Wharton, who can talk about more satisfying and more permanent possible solutions.

[Applause]

MS. WHARTON: I'm going to stand, not because I am oppositional, but just because I always stand when I teach, so I am not sure I could do it the other way.

Thanks to the general staff for sponsoring this symposium. It's great. I know how hard it is to put these things together, and you have done a great job.

I'm really honored to be here today on this panel with Rachel and Sue, and Sue, over these past fifteen years, has done amazing work on behalf of young women in Pennsylvania. It is an awful system, but she has done everything humanly possible to make it, you know, accessible to young ladies in Pennsylvania.

As Sue mentioned, in the early 1990s in *Planned Parenthood v. Casey*, we worked very, very hard, although ultimately unsuccessfully, to convince the United States Supreme Court to invalidate Pennsylvania's parental consent provision.

Not only did we lose on the merits of that challenge to the parental consent provision, winning only in our challenge to the husband of the patient provision, but in *Casey* as you know, I am sure most of you know, the Supreme Court rejected *Roe's* strict scrutiny standard and its trimester framework, and replaced it with the so-called undue burden standard. Under that undue burden standard, restrictions on pre-viability abortions are okay, as long as they don't unduly burden women in accessing abortion.

This standard has proven, in litigation, to be a very, very difficult one to meet. A couple of years ago, along with our *Casey* colleague, Kathryn Kolbert, Sue and I looked carefully at the post-*Casey* litigation in both the Supreme Court and the lower federal courts, and we were looking to assess how the standard has been applied since 1992.

And what we found was quite disheartening. Although some courts have applied that standard with some rigor, many, many others have narrowly

applied the undue burden standard so as to make it very, very difficult to mount a successful legal challenge to parental involvement laws and other restrictions, such as forced waiting periods.

Our findings have been published in the Yale Journal of Law and Feminism, but I just want to just briefly review what we found when we looked at this carefully.

First of all, too many courts are imposing unattainable evidentiary burdens on plaintiffs. Indeed, many are just reflexively sustaining the constitutionality of restrictions similar to those upheld in *Casey*, despite a very different and stronger factual record of burdensome effect.

Many others are incorrectly scrutinizing the effect of an abortion restriction in isolation from other restrictions that basically compound its burdensome impact.

In most states, for example, young women are not having to navigate just parental notification or parental consent statutes. They are also having to navigate waiting periods, cut offs of public funding, bans on certain abortion procedures, and a whole raft of other abortion restrictions.

So when courts ignore this reality, they are basically allowing states to pile on, you know, restriction after restriction so that ultimately young women, and other women, have to conquer a kind of daunting, insurmountable in many cases, obstacle course in order to obtain an abortion, and the courts are just ignoring that.

Our analysis also revealed a disturbing tendency of courts to evaluate the impact of restrictions from the point of view of the privileged, or at least women with whom upper-middle class, older, white, largely male judges could easily identify with, rather than looking at these restrictions from the perspective of the women and girls often affected by the restrictions.

Again, this failure to take into account the context of poverty and other kind of real-life circumstances in which abortion restrictions operate, leads many federal courts to just minimize the negative impact of these abortion restrictions—very, very problematic.

There is a lot more detail in our article, and if you're interested I can give you a citation to it.

So our findings about the difficulties of proceeding with litigation under the federal constitution led me, most recently, to focus my research on considering the status of alternative litigation strategies, and I ended up focusing on one particular strategy, which I want to highlight, and that is challenging abortion restrictions under state constitutions.

The background here is that although state courts are of course bound by Supreme Court decisions limiting federal constitutional guarantees, they can exercise independent judgment in construing their state constitutions, and in this way, as I'm sure you know, over the past thirty years, as the Warren Court revolution has subsided and protection for individual rights under the federal constitution has waned, state courts have expansively protected individual rights in a whole bunch of areas: public school financing, the hot one now is same sex marriage equality, sexual intimacy between consenting adults. There are a whole bunch of areas where we have got lots of good protection from the state courts.

Abortion has been one area in which challenges have been brought now for several decades under state constitutions. How many of you who are law students here have taken a state constitutional law course? I highly encourage you to do that. State constitutions are really important, and they are just increasing source of protection for individual rights.

State constitutions offer a variety of constitutional guarantees that protect reproductive rights. Although there is no state constitution that affirmatively protects the right to abortion, most of them contain provisions that can be very useful ground for protecting reproductive rights.

For example, ten states have, in their state constitutions, provisions that explicitly protect privacy rights, so they are unlike the federal constitution where we get that protection implicitly—we are drawing on that, not explicitly.

In other states, courts have found protection for individual privacy in a variety of other state constitutional law guarantees, like due process provisions.

State constitutions also offer rich protection for equality rights. Fifteen states have equal protection provisions like the—the Fourteenth Amendment's Equal Protection Clause. Other state constitutions protect equality interests through a variety of other provisions. For example, a number of states contain explicit protection in their state constitutions against sex-based discrimination. They

have so-called equal rights amendments. You know, we don't have an equal rights amendment, sadly, we came very close to getting one in the—in the seventies and the eighties, but we don't have an equal rights amendment in our Federal Constitution. We have got a whole bunch of states that do have them.

So over the past twenty-five years, litigators from the Women's Law Project, the ACLU Reproductive Freedom Project, the Center for Reproductive Rights and other organizations, have used state constitutions on a number of occasions.

I am going to focus on challenges to parental involvement laws, but in fact, these state con law challenges have been brought to a variety of kinds of abortion restrictions, from cut-offs of public funding, to forced waiting periods, to regulations that target abortion providers with burdensome licensing requirements.

So as Rachel discussed, under *Belotti v. Baird* and subsequent Supreme Court decisions, parental involvement laws basically pass muster under the Federal Constitution, so long as they have an adequate alternative judicial bypass mechanism.

Although these laws have not been challenged that often on state constitutional grounds, the success rate when these challenges have been brought is very high, and it is impressive. Indeed, most of the state courts that have evaluated parental involvement mandates under their state constitutions have invalidated them, and importantly, in doing so, they have explicitly rejected the judicial bypass as an adequate safeguard for young women's rights—very, very important. A total of five state supreme courts have struck down these laws.

Three state supreme courts, Florida, California, and Alaska, have relied on their explicit privacy guarantees in their state constitutions. I am from New Jersey, so I am proud of this; New Jersey's State Supreme Court struck down a parental consent provision on both equal protection and implied privacy provisions in the New Jersey constitution. The Massachusetts Supreme Court struck down a very onerous two-parent consent law a few years ago, and in addition, some lower courts, including a court in Montana, have ruled favorably in these challenges. So, impressive.

What is interesting in reading these state court decisions is that they typically apply a highly protective strict scrutiny standard of review and find that the state has not met their burden of justification for invading minor's rights.

Let me talk about one particular decision. The California court, in a case called *American Academy of Pediatrics v. Lungren*,²¹ for example, acknowledged that the state's interest in protecting the physical, emotional, and psychological health of minors and preserving parent, child relationships were compelling interests, but it rejected the state's contention that the statute was necessary to protect young women's health.

And the court found that the state's asserted justifications for the statute were undermined by the existence in California of other statutes that authorized a young woman, without parental consent, to obtain medical care and make other important decisions in analogous context that posed equal or greater risk to young women's health.

For example, in California, as in many states, young women can go forward with the pregnancy and actually give birth without parental consent. So the California Supreme Court said basically there is an obligation here on the part of the state to act neutrally, to act even-handedly, to not treat abortion differently than these other situations.

The Court mostly cited a whole bunch of evidence amassed at trial that overwhelmingly indicated that the parental consent law would not serve, but rather would impede the state's interest in protecting the health of minors and enhancing the parent, child relationship.

What is interesting also about these decisions is that they employ a highly contextualized analysis that focuses on the realities of young women's lives. So that they are actually really, going through this exercise of reading all the federal decisions and then reading all these state decisions, was really pretty stunning. In stark contrast, for example, to the federal decisions, the New Jersey Supreme Court, in *Planned Parenthood of Central New Jersey v. Farmer*,²² which was decided in 2000, is especially noteworthy for its willingness to assess the impact of the law in the context of the real-life challenges that make abortion access difficult for young women.

The Court carefully, very, very carefully, considered the ways in which abortion laws exploit and exacerbate these—these difficulties, so they are just wonderful, wonderful opinions and, you know, I was delighted to find them.

²¹ *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797 (Cal. 1997).

²² *Planned Parenthood of Cent. New Jersey v. Farmer*, 762 A.2d 620 (N.J. 2000).

So clearly these state court decisions are playing an important role in strengthening protection for abortion rights. Is this strategy an abortion rights panacea? Absolutely not. I don't want to leave a misimpression. Obviously securing full protection for reproductive rights, under the Federal Constitution, and thereby guaranteeing protection for all women, is far, far preferable, so clearly we have to continue our work, you know, at the federal level and do the federal litigation.

Also from a practical standpoint, the strategy of safeguarding abortion rights through state constitutions involves, you know, challenges and potential pitfalls. Many state court judges are resistant, and they don't undertake an analysis that is truly independent of federal law. Many of them place heavy reliance, you know, kind of heavy, unexamined kind of major reliance on federal abortion precedent.

And in fact, the reluctance of state court judges may be greater in abortion cases where ideology and fear of reprisal may inhibit truly independent constitutional analysis. You may know that many, state court judges are elected, and decisions favoring abortion rights may rally anti-choice opposition against them in the next election, so they're very mindful of that.

Also there is always a real possibility of backlash against favorable state court abortion decisions in the form of constitutional amendments. I'm sure you're all aware of what's gone on with, you know, in California with the passage of Prop 8 and the effort to undue the favorable same sex marriage decision from the California Supreme Court.

State court decisions favoring abortion rights have met with that kind of opposition. I think it has been more limited, however, which is interesting. In the parental involvement area, there is a Florida Supreme Court decision that was overturned by a successful constitutional amendment that now allows parental notification in Florida. It's the only one I'm aware of though that is successful. It has been tried three times now in California and it has failed, including last November, when Prop 8 passed. The voters rejected a parental notification amendment on the California ballot.

So clearly this possibility of backlash has to be anticipated and countered with public education initiatives, you know, about the dangers posed by the—by these, you know, seemingly harmless abortion provisions like parental involvement laws.

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So there is considerable downside here, and danger. But on the other hand, you know, I think these challenges have a lot of advantages. You know, they get litigators out of the need to meet this tough, undue burden standard and obviously the victories in these state court challenges make an enormous difference in the lives of women and girls in individual states where there are victories.

But the positive impact can also kind of spread beyond that state's borders, because when I found is that there's kind of this ripple effect, and state court judges look to other state court decisions and cite them favorably, so they influence other state courts, and I think perhaps there's a chance that ultimately they can influence the Supreme Court of the United States itself. And the best example of this, I think, is in after *Bowers v. Hardwick*²³ was decided. Litigators went into state courts and they challenged criminal sodomy laws, and a handful of brave state supreme courts struck down criminal bans on sodomy.

In 2003, when the Supreme Court decided *Lawrence v. Texas*,²⁴ one of the things that the Court cited in its opinion was the fact that there were these five state supreme courts that had refused to follow *Bowers v. Hardwick*. So it does have this in—potential positive influence at the federal level as well.

And the other thing, you know, I want to emphasize is that these state court venues also free reproductive rights litigators to advance legal claims that are not typically made in federal court, where abortion rights have primarily been rounded in privacy theory.

Professor Reva Siegel, who has been mentioned earlier in the day and other feminist legal scholars, have correctly championed the use, for example, of equality theory in challenging abortion restrictions, so that's something important to think about using equality theory. In some state courts—there's a great case out of New Mexico which struck down a ban on public funding for abortion, and relied on equality theory, relied on New Mexico's state equal rights amendment, they do offer this opportunity to think outside of the box, which I also love.

So my conclusion is that they are a fruitful alternative venue for challenging restrictions, not only on young women's rights but, you know, on all women's abortion rights.

²³ *Bowers v. Hardwick*, 478 U.S. 186 (1986)

²⁴ *Lawrence v. Texas*, 539 U.S. 558 (2003).

Thank you.

[Applause]

MS. GERWIN: Well, you have before you three extraordinary women lawyers who have blazed the trail, and demonstrated from the most bleak to at least some hope, the value in creative lawyering and I'm sure you must have some questions for them, or ask them to follow up on some of the stories. Yes, ma'am, go ahead.

FEMALE VOICE: - - of all I'm curious - - about their - - kind of - - for them or - - .

MS. REBOUCHÉ: Well, thank you for addressing that. It's a methodology point for our work at the Partnership that we have not talked directly to minors. Our hypotheticals were in some ways to skirt talking about the conclusions and the specific examples that we've come across in doing the work, because it's not public yet. And we have also operated in confidentiality, so everyone who's participated in this research is anonymous, from the judges, to lawyers, to clinic directors, and it's really from the clinic directors and lawyers that we hear most about minors' experiences. So the hypothetical rather than suggesting that there was one person who had that experience, it is a compilation of many different experiences we have heard about from across the country.

So whether to interview minors is an interesting question we're wrestling with. We are funded by an anonymous donor, and there are certain restrictions on what our research can do. But it's certainly one that we are considering in the scope of this.

One of the things that I wanted to add was for the younger women in particular, of which, from our research so far, there are a greater percentage of women seeking abortions than you would suspect. I agree that many of the women are seventeen, about to be eighteen, but there are a significant number that are fourteen, fifteen, and a percentage as well that are as young as twelve, thirteen, and for those women that the system is dire, I mean, and to be honest, a lot of those women are victims of violence, rape, incest, abuse, so their stories are even more bleak.

But it's an interesting question about how to capture their stories, and know how to think about solutions for this particularly vulnerable group of minors

interfacing with the legal system in a way that is sensitive to their needs. I'll just conclude by saying one issue that comes to my mind, for example, is that we've heard from a number of people that judges are repulsed by younger women coming before them, having been sexually active, and punish them through questioning, or denying their petition, or making the process more humiliating than it already is, so that is a difficulty we are facing. For those minors in particular, the waiting periods, having to get back and forth to clinics, I skipped over in the paragraph of my presentation that idea that Jane Two in that example probably has gone to the clinic three times, you know, maybe to make the appointment, maybe to go back for counseling, then to go back for the abortion. She has probably gone to court twice to file, then to go to the hearing, and then she has probably even met with the lawyer once before that, so that's a number of trips that a fifteen-year-old would have to figure out how get to these places without telling her parents. Sorry to go on.

FEMALE VOICE: - - and remember that - - moment - - after that incident - - that is partial - - I'm sorry, that is no—that is - - that, and difficulty for them - - think that at this - - that while - - .

MS. REBOUCHÉ: So something interesting is that a good example that is in line with your example is in the Prop 4 fight they—they spent a lot of time thinking about how to frame the media message in that fight, and they found two things that I think are very interesting. One, is that people didn't remember voting twice before on the same exact issue. So everyone they interviewed said what, parental involvement, that's been on the ballot before? I mean, it was amnesia about the prior two fights.

And then the second thing I thought was interesting was what really resonated with people, was something called “the bubble ad,” and it showed this bubble floating from one lawn to another, and this one house had this beautifully manicured lawn and this beautiful family. You could hear laughter and so on and so forth, idyllic home. And then the bubble floated across the fence to a darker, you know, gray sky with ominous noise, and yelling, and, you know, disarray, and the voiceover says basically, “if all our families were like your families then this wouldn't be a problem. But not all families have the same great relationship you have with your kids.” And so the reason I bring it up is that no one wants to be told they are a bad parent. No one wants to be told their minor wants to make decisions without consulting them, and the message that seemed successful in California was saying we know you are not bad parents, and your daughter would tell you if she was pregnant, but there are those other, bad families where it's a real problem.

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And so I hear what you're saying about using that exception to put forward a message and is it very effective, but in a sense, it's a weird compromise of meeting people where they are prepared to go in terms of minors rights. That's my point, we have to change our perception about what rights minors deserve in minors' sexuality, because until then, we are not going to necessarily change that dialog about the good parents, the bad parents, the good minor, the bad minor. But I think it's an interesting question.

MS. WHARTON: Yes, it is. I would just like to add that, you know, from the point of view of the minor going through the judicial bypass, I did dozens and dozens of these, and it was never alright for even one of them. No matter how mature she was, no matter how poised, no matter how prepared, no matter how kind the judge was, no matter how little logistical trouble she had had getting hooked into the system and finding me, and getting to court, it didn't matter. It is inherently cruel. For every one of them it was cruel. Every one of them, when I shook their hands in the beginning to introduce myself, their hands were ice. It's cruel.

MS. GERWIN: Yes.

FEMALE VOICE: Going off of that - - think women have - - a way to find - - .

MS. REBOUCHÉ: So let me see if I know what you mean. Do you mean in terms of a framing?

MS. WHARTON: Yeah.

MS. REBOUCHÉ: The framing should be about being a better parent, or...

FEMALE VOICE: Again, going off of that - - strategies - - .

MS. REBOUCHÉ: Well, I think that that was a strategy. I didn't mean to suggest I think that's a strategy to pursue in the long term because I think that what happened is they did a lot of focus groups, dial groups, and tested different messages on different populations of people, and figured out what would resonate. And I think that it potentially could be different in another context.

Personally I think there's something inherently arbitrary in every bypass petition, and that I think that it is one of the things that keeps these laws on the book and keeps them coming back is that we have this kind of fictional idea of the perfect family home that you see very clearly in cases like *Belotti*, where

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the court believes there is this nuclear family with a counseling role that is unique and special to the parent, minor relationship, which we know there is in good parent, child relationships of course that exist, but it's the idea itself is the crux of what makes minors abortion decisions different than other women's decisions. I think that there's no good way to implement that standard without creating processes like the bypass that are anything but those nurturing, counseling, affirmative relationships, and so if that's what the bypass is meant to mirror, then it fails miserably, and I wouldn't want to give the impression that if we could only replicate the good family, then the process would be okay.

MS. GERWIN: Yes.

FEMALE VOICE: What - - minors - - .

MS. WHARTON: I haven't looked at it. It strikes me as crazy, but, you know, I can't give a really considered answer to it myself.

MS. FRIERSCHÉ: No, I can't either. I haven't heard about any planned challenges but I can't imagine they're not being considered.

MS. GERWIN: Yeah. We tried, at one point this goes back years, and they didn't succeed in getting a law like that through when I was working down in Louisiana, but our position was that if you were going to do that, that you had to then give pregnant women the right to claim their pregnancy as a tax deduction. In which case, it was then a dependent, and in which case such a bill, if you could attach such a provision to the same bill that was going through, the legislature, then needed a fiscal note, and you would then have to again cost it out, and it would change the conversation. It is not the ideal, it's not just as a matter of discrimination against women or young girls, but it actually has, if we're going to go all the way, let's go all the way and see what kind of - - .

MS. FRIETSCHÉ: [Interposing] Yeah.

MS. WHARTON: —absurd - - certainly get. - -

MS. FRIETSCHÉ: Right. Yeah. The downside of course is we are further embedding in law the notion of fetal rights, which is really problematic.

MS. REBOUCHÉ: Or making fun of the whole thing, if you could carry - - .

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MS. FRIETSCHE: Yeah.

MS. REBOUCHÉ: —it off with aplomb. Yes.

FEMALE VOICE: - - and also - - you know, - - laws or tax law - - .

MS. WHARTON: Uh huh.

FEMALE VOICE: - - .

MS. REBOUCHÉ: So, one last question - - .

FEMALE VOICE: - - .

MS. FRIETSCHE: Boy, that's, you know, I think it would have a similar impact on the petitioner as having to go to court. You know, maybe it would be a little bit better if it was an administrative hearing officer, rather than an actual judge, but I don't know if it would be that much more meaning. But, you know, meaningfully less stressful on the young woman. And on the other hand, you do have someone who possibly, you know, is less trained, maybe a little less willing to conform to their very limited judicial role in these cases. You know, but which actually should be nothing more than making a determination that the young woman is mature, and if not, that the abortion is in her best interest. You know, it's a very, very limited role. I worry about what kind of liberties might be taken.

MS. WHARTON: Yeah. It's also dangerous to sort of buy into sort of trying to make these things look more reasonable.

MS. FRIERSCHE: Uh huh.

MS. WHARTON: You know, that—that's sometimes the strategy in—in legislatures and it can be very dangerous.

MS. REBOUCHÉ: I—I think that—I mean, I think my—my first point would be that giving it to admin judges would be potentially a—would be one way to address a perceived problem of delay in getting before a judge, and I think that a lot of the research we're seeing shows that whereas that's a problem in some areas, it's not the biggest problem. Actually you can—if you can figure out how the system works, you can get a hearing, usually within a couple of

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weeks, which is still delay and not preferable, but that is the—that is—that’s more on the extreme, and—and there’ll be more about that in—in some of our work later. But—so if you were to try to change the law to make it seem more reasonable, which I agree is a tricky strategy, because on one hand you’re trying to make a law that you think is unworkable, more workable, and thus reducing your argument that it’s unworkable and shouldn’t exist. There’s an inherent tension there for any reform because ultimately I think all of us think there should be no bypass, but how do you make it fair? Do you detract from the—your own argument that it’s not fair? But that said, if I had to—if I had to pick one thing to do to make a law, quote, end quote, more fair, is instead of broadening who could hear a bypass, I would broaden who could give consent. So if you were going to go through the process of trying to open a law and change something, or a new law coming forward, I would try to stick a grandmother or grandfather provision in there, or a—a sibling or an adult over twenty-five, or something that if you had to make legislative compromises, that’s the one I would take, so that you didn’t have to get to the court in the first place.

MS. WHARTON: Yeah.

MS. REBOUCHÉ: You had a physician being able to—to make those decisions, you had a—who—or whoever—or a—whoever was custodian of the minor, whether that be, not necessarily a guardian, but whoever the minor was living with, you know, something like that, that broaden those grounds, so you didn’t have to get—jump through all the other hurdles, like getting to court, like getting a lawyer, that kind of thing. But the—sadly the—the problem is for laws that are already in existence, once you open them up, you get all kinds of crazy, right? You get all kinds of other changes that people want to load into it, because once you open up the amendment process then you don’t necessarily—you have to make sure you’ve got the political will to fight back changes you don’t want, and that’s tricky, I think.

MS. GERWIN: Well, will you join me in thanking our panel?

[Applause]

MS. GERWIN: And we have one more great panel, so- - .

REPRODUCTIVE HUMAN RIGHTS

MS. GERWIN: So it's my pleasure to introduce the four panelists to talk about reproductive human rights. Our first speaker will be Melissa Upreti. She is the Legal Advisor for Asia with the International Legal Program of the Center for Reproductive Rights. She is spearheading two regional research projects that constitute part of the acclaimed Women of the World Series of Reports in South Asia, and East and Southeast Asia. She led a fact-finding mission to investigate women in prison for abortion in Nepal, and also designed and led several advocacy initiatives for the center in Nepal which contributed to the decriminalization of abortion in 2002. Prior to joining the center in 2000, Ms. Upreti was a programme officer at the Asia Foundation in Nepal, an assistant to the Senior Advocate at the Supreme Court of Nepal, and a researcher and counselor at the Legal Aid and Consultancy Center in Nepal. Ms. Upreti is a graduate of North Bengal University in India, and received a Master of Laws from Columbia University School of Law, where she was a Harlan Fiske Stone Scholar.

She will be followed by Suzanne Stolz, a staff attorney in the U.S. Legal Program at the Center for Reproductive Rights. Her work focuses on using litigation to advance reproductive rights and to ensure women's access to reproductive health care services. Prior to joining the Center she served as an associate with two of New York's leading matrimonial and family law practices, as well as at the firm of Kirkland and Ellis. After graduating from law school she clerked for the honorable Diane E. Murphy of the United States Court of Appeals for the Eighth Circuit. She earned her juris doctor from Harvard Law School and received her B.A. from Wellesley College.

Our third speaker will be Dana Sussman. Dana's work focuses on increasing access to reproductive health care services for women in the United States by challenging restrictive abortion laws, ensuring contraceptive equity in employment benefit plans, and increasing awareness of the challenges abortion providers face. Ms. Sussman's work also addresses the reproductive health care needs of incarcerated women. She recently coauthored an amicus brief in the case of *Norris v. Nelson*, which is currently before the Eighth Circuit, challenging the use of shackles on incarcerated pregnant women. Ms. Sussman received a joint JD and Masters in Public Health degree from Northeastern University School of Law and Tufts University School of Medicine in 2007.

And finally Janette Amer is a Senior Social Affairs Officer in Women's Rights Section of the Division of Advancement of Women in the Department of Economic and Social Affairs at the United Nations. A lawyer by training, she first joined the United Nations in 1992, working for nine years at the United Nations' Office of Legal Affairs. During this time she spent a year in Bosnia Herzegovina as the legal advisor for the United Nations Peacekeeping Mission.

She joined the U.N. Division for the Advancement of Women in 2001, where she spent a number of years working with the Committee on the elimination of discrimination against women. In the past couple of years her work has focused on violence against women, including trafficking in women and girls, and strengthening comprehensive legal frameworks to prevent all kinds of violence against women. So will you join me in welcome first Ms. Upreti?

MS. UPRETI: Thank you. Good afternoon, everybody. Thank you for that wonderful introduction, and thank you everybody for being here today. Thank you to Cardozo Journal of Law and Gender. But a special thank you to Sara, of course, who invited me to this event. I'm very, very happy to be here.

So I'm going to kick off this panel by talking a little bit about reproductive rights as human rights. I just discovered that our presentations actually complement each other very well, so I'm going to talk a little bit about the international framework and some of the mechanisms, but focus more on human rights strategies that I've been using in my work as a legal advisor at the Center for Reproductive Rights.

So to begin with, I'd like to start with just stating very explicitly by reinforcing that—the idea that reproductive rights are human rights, and this is very clearly stated in international human rights law. The definition itself is found in the policy document which was adopted in Cairo, in 1994, at the International Conference in Population and Development. But it defines it in a way that clearly grounds reproductive rights in the norms that are found in international treaties and legal guarantees of human rights.

Just very quickly it says reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, and to have the information means to do so, and the right to attain the highest standard of sexual and reproductive health.

International treaties that constitute the basis for women's reproductive rights which, when we talk about reproductive rights, there are actually around ten to twelve rights that are implicated, but in short, in terms of principles, it implicates the right to access reproductive health services, and the right to reproductive self-determination.

From the point of view of issues and violations, and when we define issues, we usually look at—the four main rights we look at are the right to life, the right to health, the right to nondiscrimination, and the right to privacy, which is the basis for the right to reproductive self-determination.

So, these different rights can be found in various international treaties. The Covenant on Civil and Political Rights, the Covenant on Economic Social Cultural Rights, the Convention and the Elimination of All Forms of Discrimination Against Women, also known as CEDAW, and the Convention and the Elimination of Racial Discrimination, Convention Against Torture, Convention on the Rights of the Child, and Convention on the Rights of Persons With Disabilities.

Fortunately Janette, who will present next, is going to go more into the details of the norms and the content, so I'm just going to briefly touch upon them so that I can get to the strategies.

International treaties, once signed and ratified by governments, are implemented through a process of reporting and compliance. Basically when a country signs and ratifies a treaty, they're obligated to report to something called a treaty monitoring body, and each treaty has a monitoring body.

So a government reports every four years or so, and they basically report on what they've been doing in their country to implement the provisions of the treaty and that is analyzed in the—again a shadow report that is submitted by not governmental organizations, that talks about, well, firstly it presents their version of what the government has been doing. So the Committees usually have two different perspectives on treaty implementation. And it's on the basis of that, that they identify issues of concern, and they make recommendations to governments for action.

So two examples that I have here on my slide are a concluding comment made to the government of the Philippines with regard to their abortion law, their provisions of the penal code that criminalize abortion, and essentially it's, it operates as a - - it's not permitted on any ground.

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So the Committee, the Social and Cultural Rights Committee, did note with concern that under the State party's legal system, that's how they refer to—to governments that have signed and ratified—abortion is illegal in all circumstances, even when the woman's life or health is in danger, or pregnancy is the result of rape or incest, and that complications from unsafe abortions are among the principle causes of maternal deaths. And the Committee went on to urge the government of the Philippines to consider decriminalizing abortion on certain grounds.

Similarly in the case of India, the CEDAW Committee, the body that monitors the women's convention, expressed concern about the very high incidence of maternal mortality, India accounts for the highest number of maternal deaths for any country in the world, and the Committee made an observation when the government reported to them a couple of years ago, and urged the State party, the government of India, to prioritize decreasing maternal mortality rates by establishing adequate obstetric delivery services and ensuring women access to health services, including safe abortion and gender sensitive, comprehensive contraceptive services.

So these are examples of how treaty monitoring bodies explain what states are obligated to do under the terms of the treaties that they have signed and ratified.

There are documents called Optional Protocols, which are essentially like treaties, but under international law they create specific mechanisms. So this is an example of how the process of accountability has been set up. The procedure that I mentioned earlier, where governments periodically report to treaty monitoring bodies, is also part of an international accountability process. But the Optional Protocol is established, its very specific processes, whereby these treaty monitoring bodies may entertain individual complaints, which would be similar to a case filed in a court, and also they have the authority to conduct inquiries if they are informed about human rights violations of a large scale in a particular country.

Now, I'm not going to get into the details of the processes, but I'm telling you this, just to give you a sense of how governments can be held accountable, and how individuals could use the international system to ensure that the rights guaranteed under these treaties are actually fulfilled. Janette will talk about some specific examples of these mechanisms being used by certain countries.

In terms of notable developments in international law that are relevant to reproductive rights, there are a couple of cases that have been handled by these international bodies in recent years that are very interesting and worth noting. Janette will talk in more detail about some of these cases, but I'd just like to highlight a few of them.

In *Paulina v. Mexico*,²⁵ this was a case involving denial of access to legal abortion to a young girl who had been raped, and under Mexico's law, I mean, she was eligible to have a legal abortion, but the administrative authorities denied, they refused to authorize the procedure, as a result of which was that she ended up giving birth.

But—and this case is filed in Inter-American Commission of Human Rights, and I think that a notable development from this case is the fact that she was awarded compensation but, the government of Mexico was held responsible for violating her rights and the government entered into a settlement with the Commission and awarded her compensation.

So this is an interesting development, because it serves as a precedent for seeking compensation for violations of reproductive rights.

*K.L. v. Peru*²⁶ is a case involving an adolescent who was diagnosed with an encephalic fetus, and usually in such cases even if the pregnancy reaches full term and a child is born from the pregnancy, the chances of survival are pretty much nonexistent, and that's what happened in this case. The woman did give birth, but the child died a few days after birth. And this case was filed as an individual complaint for the Human Rights Committee, and once the notable—most notable—development here is that the Committee recognized that K.L.'s right to freedom from cruel, inhuman, and degrading treatment had been violated by the State's failure to provide an abortion.

Then the incident in Hungary is another case involving - - of informed consent. Janette's going to talk about this, I'll skip this in the interest of time.

And then another interesting development which is more recent is, I mentioned earlier that these international treaty monitoring bodies issue concluding comments and observations to countries, guiding—telling them what to do

²⁵ *Paulina Ramírez v. Mexico*, Petition 161-02, Inter-Am. C.H.R., Report No. Report No 21/07 (2006).

²⁶ *K.L. v. Peru*, Communication No. 1153/2003, UN Doc CCPR/C/85/D/1153/2003. Human Rights Committee (Nov. 22, 2005).

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to—what they need to do to implement the rights in the domestic context, and this was an observation made with—by the Committee Against Torture on the issue of post abortion care, where they essentially said that denial of post abortion care may constitute torture.

So these are some new characterizations that are coming out of international cases that are notable developments that I think are very interesting and can be useful for application in the domestic context with framing issues.

When we've developed strategies to address reproductive rights issues, in order to make international human rights law applicable and relevant, we often look for hooks in the domestic legal context, and most often we find those hooks in, first of all, the fact that a government has signed and ratified a treaty makes them legally obligated to implement the treaty provisions.

Even if a government has just signed a treaty and not ratified it, they still have an obligation not to act in a manner that is—that contradicts the spirit and provisions of the treaty.

In addition to that, we find sometimes that national constitutions have provisions that explicitly state that international law shall be applicable at the domestic context.

National legislation is another place to look for a hook, because sometimes national—certain laws, for example the Philippines right now: they have drafted a reproductive health bill, and that draft has language that bases their bill on international human rights standards.

Similarly national—there are a lot of national reproductive health policies that refer to the program of action adopted in Cairo in 1994. Jurisprudence is another place to look, because there are sometimes court decisions that incorporate international human rights norms.

And human rights institutions usually have statutes that state that, the institution shall be responsible for implementing international human rights standards in the domestic context.

As far as this is concerned, our core strategies comprise of higher - - litigation, fact-finding and documentation, international reporting to treaty monitoring bodies, and bringing individual complaints, filing cases with international bodies, as well as human rights advocacy.

Some examples of our work, I'm just going to quickly go through some of them. We're doing some work in the Philippines and some of the issues that we're working on there are contraceptive access and unsafe abortion. And in terms of human rights strategies, what we're doing to address some of the violations associated with denial of access to modern contraceptives and the criminalization of abortion are litigation.

There's a case that we filed last year which challenges an executive order introduced by a mayor, the former mayor of Manila City, which effectively bans modern contraceptives in Manila City. We did a fact-finding report in 2007 called "Imposing Misery" that documents the impact of this order, and our case is based on this—the findings of this study.

And we've been doing a lot of human rights advocacy and more recently we started making the connection between the executive order as a problematic policy and the reproductive health bill which is being proposed in the national parliament. So these are some strategies that we're using in the Philippines.

In Nepal—we've done a lot of work in Nepal on the issues of unsafe abortion and the imprisonment of women for abortion. Up until 2002 it was pretty much banned on all grounds. So the strategy—human rights strategies that we implemented there were fact-finding, we did a report too, released in 2001 that documented—that first of all contained a critique on the ban on abortion from a human rights perspective, and then also documented the impact of the abortion—of the provisions on women who were in prison.

We also got involved in abortion law reform and more recently constitutional law reform, and now abortion is legal on very broad grounds in Nepal, and the interim Constitution recognized reproduction—recognizes reproductive rights as fundamental rights.

And we've also been doing litigation in there. We did this after abortion became legal to ensure that access was actually provided by the government, because what often happens is, you know, abortion becomes legal or something becomes legal, but the government doesn't really follow up on that, and invest resources that ensure that the service is available. So we brought a case against—all our arguments are based on international laws and state obligations that arise from guarantees of rights.

And then one last example is that of India. We're working on the issue of maternal mortality in India, and the Center has been working on this issue for several years now, and we've really contributed to the development of the idea that the right to survive pregnancy and childbirth is a human right, and when women die due to preventable causes related to pregnancy, their human rights are violated, and that the state can be held accountable for that. So we're implementing this idea through human rights strategies such as litigation, and in India what you would call a class action lawsuit here is referred to as public interest lawsuit there, so it's constitutional litigation with—that has implications for the interest of the broader public, and in human rights advocacy.

An example of our advocacy work, well, I just included some photographs here to give you a sense of the context of some of the issues arising from poor access to quality of care that we're trying to address through our strategies, and this is our latest report which is essentially a tool for lawyers, judges, and academics to promote the use of international and constitutional law for ensuring accountability and change.

So, some of our ideas are, I think, pretty cutting edge and ground breaking. Some of the ideas—issues that we work on tend to be—some of them are traditional, but I think for the most part they tend to be very controversial. Some of the lessons that I have learned through my work on the usefulness of using human rights based strategies is, the norms are essentially human rights, are universal standards, and they establish criteria, and so they can be very powerful tools for holding governments accountable for violations.

The language is crafted in terms of entitlements and state obligations, and that is also very powerful.

I think using a human rights framework also can allow you to look beyond the domestic framework and enable you to frame, identify violations and frame issues in a new way.

An example of redefining an issue would be, for example, our work in the Philippines. Right now abortion is considered to be either a crime or a sin. These are the only two ways in which people look at abortion. What we are trying to—going to do through our report and our work is try to help people understand abortion in a different light, and understand that there are implications for a woman's right to life, both for a woman's right to nondiscrimination and for a woman's right to health and self determination.

The human rights framework can be very useful for accountability. Sometimes national mechanisms are not enough, and so the international framework creates international bodies which can offer solutions to problems.

Human rights strategies require a multi-pronged approach. I think from the examples that I gave you it's quite clear that we're not just doing one thing in a country, but we are doing a number of things in each, and they're usually—and they're usually interconnected.

The fact-finding missions usually provide a basis for litigation which must be accompanied by human rights advocacy to really be successful.

And then I think another advantage of using human rights based strategies is that it allows for the creation of broad alliances because to be a human rights advocate, you don't need to be a lawyer, and it really creates an opportunity for a wide arrange of stakeholders and actors, health service providers, feminists, lawyers, to collaborate around an issue and to try to address it together.

Some of the challenges in using human rights strategies is, and I think this is pretty universal, is that there is still insufficient awareness of human rights standards, whether among government officials, or even the public, or even lawyers.

There's inadequate training in human rights. I think in order to use international human rights law you need to have certain skills, analytical skills. You need to understand how to apply the norms and then you know how to develop these strategies, and that comes through, having the opportunity to learn the theoretical perspectives in law school, and then getting an opportunity to actually work in the area of human rights.

In terms of enforceability, there are all these questions about whether international law is binding or not and, as lawyers I think one of the traps we tend to fall into is to sort of try to make a direct comparison between international human rights norms and, the laws that we're used to in our national context. And I think that that can be like comparing apples to oranges, because national legislation offers one thing, it's based on certain, our constitutional framework, our—usually the constitution and, our national frameworks, but international human rights norms are enforceable in the sense that, any - - enforceability is that governments try to get away with not enforcing international law and not abiding by it. But technically it is legally binding because the governments have signed and ratified these treaties.

And then, one of the other challenges is that we usually end up addressing some of the most controversial issues, and so, whenever you're addressing controversy, obviously it's—there are very inherent challenges to that.

In terms of opportunities for promoting human rights, whether it's back in India, Nepal, the Philippines, or even in this country, I think certain common - - points. Our number one: academia. I think that is really where the greatest need and opportunity lies. I think the lawyers need to learn about these things early on, they need to understand the framework, they need to understand how it's different, and they need to understand how it can be used effectively.

I think legislation is very important. If legislation is crafted in a way that there's some acknowledgment of human rights or human rights norms, if there's a commitment to human rights, then that can be a basis for ensuring the practical fulfillment of rights in the domestic arena.

Policy implementation also. If you look at reproductive health policies across the world, most of them refer to the program of action adopted in Cairo, so that's another place where you find human rights standards, and I think when governments and others try to measure policy implementation, human rights standards can be used to measure implementation as well.

Judicial decision making is another opportunity for promoting human rights, and we try to promote that through our litigation. And one very, common and simple way in which we do that is we fix our arguments on international human rights norms and we always include what treaty monitoring bodies have recommended to governments as part of the basis of our arguments.

And then finally strategic advocacy is very, very important for promoting human rights, especially through the media, because there isn't enough public awareness and understanding of human rights norms, and I think we can only go so far with, our cases and, our work. If there isn't a public that's receptive to what we say is happening, or what we say is wrong, or what we say in terms—about the violations, then the impact of human rights becomes very limited.

So I'm going to end up at that, we have a lot of publications that—we work at several regions across the world, so for further information please feel free to visit our website and it was a pleasure giving this presentation. Thank you very much.

[Applause]

MS. AMER: Thank you very much. It's really a pleasure to be here, and we really appreciate the invitation. It's always nice to leave U.N. Headquarters and come into the real world. As Melissa mentioned, she and I are going over some of the same principles and norms, so you all should be experts by the end—hearing it again, and I think what mine—I'm going to go more on a chronological basis in terms of the development of the international framework, both in the legal and with the treaties and the policy documents coming from some of the conferences and general assembly resolutions.

As Melissa mentioned from the very beginning, we all know reproductive and sexual health is a basic right for all of us and has to be looked at within the framework of human rights.

The foundations for the international protection of reproductive rights were established in the Charter of the U.N., which as you may all know, but this dates from 1945, and also then the 1948 Universal Declaration on Human Rights. Article 1 of the Charter, the U.N. Charter sets out as one of the purposes of the U.N., the promotion and encouragement or respect for human rights and fundamental freedoms for all, without distinction on the grounds of race, sex, language, or religion, and in the Universal Declaration three years later, mentioned health as part of the right to an adequate standard of living, and established the fundamental right of equality and nondiscrimination as the cornerstone of the international human rights framework.

The international human rights treaties were—that were adopted following the Universal Declaration, which was adopted by the General Assembly and be considered the policy—a policy document, although it's now pretty much customary law. But initially it was a General Assembly resolution.

Following that, then there were a series of treaties which states then become parties to, and then those are legally binding once they become a party.

So these human rights treaties have expert bodies which Melissa also mentioned, to monitor them, and the treaties, together with the expert bodies, have elaborated the right to health and specifically the right to reproductive health. And one of the first examples of this was the 1966 International Covenant on Economic Social and Cultural Rights, which sets out the right of

everyone to the enjoyment of the highest attainment standard of physical and mental health, and addresses reproductive health issues in several of its provisions, including calling on states to take steps to reduce the stillbirth rate, and calling for protection to be accorded to mothers during a reasonable period before and after childbirth.

The Covenant's monitoring body, which is the Committee on Economic, Social, and Cultural Rights, in its General Comment 14, which gives an interpretation of what the meaning is of the different provisions of the Covenant, makes clear that the right to health, including reproductive health, extends to health care and services, as well as the underlying determinants of health, such as access to safe water, sanitation, food, nutrition, housing, and healthy environmental conditions, as well as access to health related education and information.

Then we have the 1979 Convention on the Elimination of all forms of Discrimination Against Women, which Melissa mentioned also. This is a landmark treaty which sets out a comprehensive legal framework for women's equality and establish a focused women—women specific human rights regime.

This treaty obligates states' parties to eliminate discrimination against women in the field of health care in order to ensure access to health care services, including those relating to family planning services, pregnancy, confinement, and post natal period.

States are also obligated, under the Convention, to ensure that women enjoy the right to freely determine the number and spacing of their children, and of access to the information, education, and means to enable them to exercise this right.

The Convention specifically calls upon states to ensure to women in rural areas the right to have access to adequate health care facilities, including counseling and services in family planning.

The Committee on the Elimination of Discrimination against Women, which is the body which monitors the Convention, in its General Recommendation 24 on Women and Health, affirms that access to health care, including reproductive health, is a basic right under the convention. In this recommendation it addresses violence against women, sexually transmitted diseases and HIV/AIDS, female genital mutilation, child marriage, unwanted

pregnancies, unsafe medical procedures such as illegal abortion, provision and access to services, safe motherhood, and quality of services provided. All of these issues are to be addressed by states in accordance with their obligations under the convention.

The Committee has adopted a number of other general recommendations that are relevant to the reproductive health of women, and these include recommendations on violence against women, female circumcision, prevention and control of AIDS, and equality in marriage and family relations.

International policy instruments, including the declarations and resolutions adopted by human bodies, and documents disseminated from U.N. conferences and summit meetings have also been instrumental in enhancing the visibility of reproductive rights, and added important political commitments and recommendations for action.

The 1994 International Conference on Population Development in Cairo, which Melissa mentioned, was a milestone conference, informs the blueprint for reproductive health policy around the world. The program of action adopted by the Conference highlighted the right of women and men to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right of access to appropriate health care services that enable women to go safely through pregnancy and childbirth, and provide the best chance of having a healthy infant.

The Conference made clear that reproductive rights are inextricable from other human rights, and that empowering women and improving their status are important ends in themselves, and essential for achieving sustainable development.

The 1995 U.N. World Conference on Women in Beijing reaffirmed and strengthened the consensus that had emerged in Cairo. The Beijing platform for action adopted by the Conference made clear that the human rights of women include the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health free of coercion, discrimination, and violence.

The platform for action highlighted the need for reproductive health services for young people and - - perspective in addressing HIV/AIDS and other sexually transmitted diseases.

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The platform also raised the possibility of decriminalizing abortion, inviting governments to consider reviewing laws containing punitive measures against women who have undergone illegal abortions.

Now, these international obligations and commitments must, of course, be implemented, and one demonstration of the international framework in practice is the jurisprudence of the human rights treaty bodies.

I'd like to mention two of these cases which Melissa also mentioned briefly.

One of them was *A.S. v. Hungary*,²⁷ which was decided by the Committee on the Elimination of Discrimination against Women in 2006, and in that case, while undergoing surgery in connection with a miscarriage in a public hospital in Hungary, A.S. was asked to sign a statement of consent to a caesarean section. The statement contained a barely legible note using the Latin word for sterilization. Only after the operation did AS realize the meaning of the word sterilization in the note that she had signed, and that she would be permanently infertile.

The Committee on the Elimination of Discrimination against Women found Hungary in violation of the Convention for its failure to protect A.S.'s reproductive rights. Specifically, the Committee found that the State failed to provide appropriate information and advice on family planning to the complainant, and that the state had not ensured that she gave her fully informed consent to be sterilized.

The Committee recommended that the state party provide appropriate compensation to A.S., and take a number of general measures to ensure the provisions of the Convention and international standards are adhered to.

And I can say that the Committee on the Elimination of Discrimination has followed up with Hungary on numerous occasions to make sure that these—this decision has been implemented, and that's still ongoing, but they do—whether it was a specific follow up procedure that was carried out, and then each time the Committee reports—each time Hungary reports to the Committee, it's also always asked the steps it's taken to implement this decision.

²⁷ *A.S. v. Hungary*, United Nations Committee on the Elimination of Discrimination against Women, Communication No: 2/2004 (Aug. 14, 2006).

So the second case is *K.L. v. Peru*. That was in 2005, and that was decided by the Human Rights Committee under the International Covenant on Civil and Political Rights.

In this case medical authorities denied a seventeen-year-old girl the authorization for a therapeutic abortion which was legal under Peruvian law, and this was also mentioned by Melissa. So she was forced to carry a nonviable pregnancy to full term, and as Melissa mentioned, the child lived for four days, but the mother had to breastfeed the baby, looking at her deformities, and then the baby died, and she was essentially after that went into severe depression, and had major psychological and physical effects from that.

So the Human Rights Committee found that the Peruvian government had violated a series of K.L.'s rights under the Covenant, including the right to be free from torture, cruel inhumane, and degrading treatment, which is Article 7, the right to privacy, Article 17, and the right to protection as a minor, Article 24.

The Committee required the State party to provide K.L. an effective remedy, including compensation, and take steps to ensure that similar violations do not occur in the future.

This decision marked the first time that an international human rights treaty body held a government accountable for failing to ensure access to legal abortion services.

It's clear from the international framework that we have, that everyone has the right to enjoy reproductive and sexual health, and the obligation of states include ensuring family planning services, sex and reproductive health education, availability of contraceptives, prenatal care and safe motherhood, and protection against sexually transmitted diseases, including HIV/AIDS.

Health care systems must also be adequately funded and regulated, and they must be accountable, including ensuring adequate remedies when reproductive health rights are violated.

Now, however, despite progress in developing this framework, reproductive and sexual health problems remain the leading cause of ill health and death for women worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies,

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maternal death, and disability, including fistulas, sexually transmitted infections including HIV/AIDS, gender based violence, and other problems.

Much more needs to be done to ensure implementation of this framework at the national level, especially failure to meet the Millennium Development Goal 5 on the improvement of maternal health, which has as one of its main targets to achieve by 2015, universal access to reproductive health.

Meeting this goal will require a holistic view. This must address the interdependence and linkages of reproductive rights with other human rights and issues, as well as underlying discrimination against women and their inequality with men.

Poverty and discrimination prevent women worldwide from exercising their reproductive rights. A U.N. study has recently noted that differences in reproductive health between rich and poor, both between and within countries, are larger than in any other area of health care.

Moreover, many of the risks to women's reproductive and sexual health are caused by the failure to respect the full equality of women, and by attitudes and practices which reinforce gender role stereotypes and women's subordination.

Let me take the example of violence against women, which is a form of discrimination against women and a violation of a number of their rights. There are direct links between violence against women and poor sexual and reproductive health.

Forms of violence, such as forced marriage, forced pregnancy, sexual violence, trafficking, female genital mutilation, and others, have serious negative consequences for sexual and reproductive health. Sex violence fuels unwanted pregnancies, unsafe abortions, fistulas, sexually transmitted infections, and HIV. Women in abusive relationships are prevented from negotiating condom use or using other contraceptives, and violence during a pregnancy has serious repercussions for both infant and maternal health outcomes.

Interventions for preventing and responding to violence against women enhance women's reproductive health, including lessening the vulnerability to HIV and other sexually transmitted diseases, and at the same time, ensuring women's sexual and reproductive rights, are key to HIV prevention and enhance the right to be free from violence.

So it's therefore evident that work to achieve reproductive rights must be undertaken in the context of the overall realization of women's human rights and gender equality in order to be truly effective.

In closing, let me just stress, as Melissa also mentioned, that the international standards that have been developed are out there, they should be used in your writings and disseminated widely, including by bringing cases to the human rights treaty bodies.

We're all waiting anxiously for the U.S. to become a party to CEDAW, and we understand that might be on the way, finally, so we should all keep our eyes open for that, and hopefully then the U.S. will also become a party to the optional protocol, and then can join in some of the individual cases. Thank you very much.

[Applause]

MS. STOLZ: I first want to thank the Cardozo Journal of Law and Gender putting together this wonderful conference—symposium, and for inviting me to be here today.

As you've just heard from Melissa and Janette, over the past thirty years the international human rights community has recognized reproductive rights as human rights, and has been expanding protections of reproductive rights under human rights treaties.

During the same time period, the trend in the U.S. has been quite the opposite. Over the past thirty years the trend has been restricting access to reproductive rights and chipping away at those rights as guaranteed by *Roe v. Wade*.

Since the U.S. is becoming more hostile to reproductive rights while the international community has been growing more protective of human rights, advocates have started to wonder how we can use the gains being made internationally in our domestic reproductive rights advocacy. So that's what I'm going to talk a little bit about today; how and why we should use a human rights framework in our U.S. based advocacy work for reproductive rights.

I first want to start out just briefly by discussing what we actually have available to us in the U.S., because I'm sure as Janette just mentioned, we're

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not a party to CEDAW, and some of you are probably aware that the U.S. kind of has a trend of not ratifying the most important human rights treaties.

And I have to admit that we are limited in the U.S., and that the U.S. has not ratified the most important treaties that protect reproductive rights. Specifically, the U.S. has not ratified CEDAW, it has not ratified the Economic, Social, and Cultural Rights Convention, or the Convention on the Rights of the Child.

It has signed all of these treaties, which I believe Melissa mentioned means that the U.S. has an obligation to refrain from actions that defeat these treaties' object and purpose, but it's really not that strong of a protection, and it means that we don't have access to the treaty monitoring bodies or really any way to hold the U.S.'s feet to the fire in order to make sure that they comply with these treaties.

However, the U.S. has ratified the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, or CERD, and the Convention Against Torture and Cruel, Inhumane, and Degrading Treatment.

Plus, regionally the U.S. is subject to the American Declaration of the Rights and Duties Man, and the Inter-American Commission on Human Rights, because it is a part of the organization of American States.

So now, how and why should we use human rights strategies in a domestic reproductive rights advocacy? I believe there are two main categories of strategic benefits for using a human rights framework in our advocacy work.

First, the human rights framework can help change a perception about an issue, and as perceptions change we can even bring about different norm internationalization, that can eventually hopefully change—even change our law, and second, human rights framework and treaties provide advocates with new tools, forums, and alliances that can only strengthen their work.

To start by discussing how human rights framework contains perceptions about an issue, especially about an issue as contentious as reproductive rights, it does this first by helping expand our definition of rights, and how we conceptualize our rights.

International human rights go beyond the rights available under the U.S. Constitution and laws, and include, for example, a right to education and a right to health care, and a right against policies that have discriminatory effects.

It also—the human rights framework also helps expand what we think about our government’s obligation to protect our rights. State obligations to uphold human rights go beyond what we in the U.S. traditionally think about our government’s requirements to protect our rights, and do so in ways that I believe are very important in the reproductive rights context.

States have a tripartite obligation to respect, protect, and fulfill human rights, and what that means is that first states have to respect human rights, and therefore they cannot interfere with an individual’s exercise of a right. They then have to protect human rights, meaning that they have to ensure that third parties can’t interfere with an individual’s exercise of a right. And they also have to fulfill human rights, which means that the state must put in place the conditions necessary to make possible the enjoyment of the right.

I think the U.S. we’re very used to thinking of the government’s obligation not to interfere with our rights, but we’re not really used to thinking at all about the government’s obligation to help us be able to enjoy our rights, or their requirement to help us fulfill our rights, and that is a big difference between the U.S.’s focus mainly on negative rights, and the human rights focus on both negative and positive rights.

Negative rights are characterized as the right to be left alone and depend only on the duty of the government to restrain from intervening in the exercise of an individual’s rights.

On the other hand, positive rights require affirmative acts by the governments to enable the enjoyment of the right.

Human rights treaties commonly discuss positive rights as rights to be progressively realized by a state, to the extent of its available resources.

In contrast, the U.S. legal system does not recognize a government obligation under the Constitution to provide positive rights, and that makes such rights out of reach for those disadvantaged by poverty, race, education, or any number of other factors.

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So how can we work on expanding the definition of reproductive rights, and also our idea of how the government should help us fulfill our reproductive rights in our U.S. advocacy work?

I think as we've heard all day today, the conversation around work—or around reproductive rights in the U.S. has become stale. It's become stale because it keeps running around the issue of whether or not the right to privacy in *Roe* is legitimate, and gets caught up in that legal jurisprudence.

And it has also been greatly limited by our opponents just to the conversation about abortion and has limited us from being able to talk about the full range of reproductive rights.

A human rights framework can broaden the discussion by bringing in a discussion of new rights beyond just the right to privacy, which is still an extremely important right, but then we get to talk about things like Melissa was discussing; the right to have - - and the right to life, and we also get to start talking about positive rights and what the U.S. government should have to do in order to ensure that all women actually enjoy their reproductive rights.

A human rights framework can also provide new framing in our thinking than that we're used to on our traditional constitutional law. For example, we haven't had great success in protecting reproductive rights under the U.S. equal protection law. I think this is in part because equal protection law with its similarly situated analysis provides us with a theory of equality that makes sure that those who are the same are treated the same, but it fails to accommodate real biological differences between men and women, and it fails to really look at how those differences can be played out when someone is regulating sexual activity and regulating reproductive rights.

However, if we look to human rights law, we can use principles from CEDAW to provide us with a theory of substantive equality that incorporates both equal treatment under the law, like we have under equal protection, but also recognizes women's differences and takes those into account in ways that can be useful in our advocacy work, and hopefully as a long term strategy, possibly even useful in our litigation strategies.

When we all start thinking more broadly about rights and start incorporating broader ideas of our rights and government obligation to protect those rights into our social dialog, our social movements, our policy and advocacy work, and even litigation, we start the process of human rights norm internalization

into U.S. law, and traditionally it was thought that the way human rights law and the way human rights norms got internalized into a country's law was just from the top down.

Meaning that, the national government would ratify a treaty, and then the national government would make sure that all the—the laws in the country fulfilled the—the treaty's purpose and object, and so everything came from the top down.

Recently scholars have been looking a lot more at the ways in which state and local governments, as well as social activists, play a role in incorporating human rights norms from the bottom up, and they do so by incorporating human rights norms into local legislation and policy, but also into the dialog around rights that's going around—going on in local communities.

A good example of how norm internationalization can occur from the bottom up is the local movements over the ratification of CEDAW. The most famous and successful of which was by two women's rights activists in San Francisco who started a movement to have San Francisco enact—to have CEDAW enacted as part of San Francisco's law.

The movement not only drew attention to the U.S.'s failure to ratify CEDAW, but it also started a local organizing and education strategy that supported the process of norm internalization into discussions about laws, policy, and just a conversation about how we should think about women's rights in the San Francisco area.

It then spread up from there as more cities looked into local ratifications of CEDAW.

In addition to helping change the conversation, which I hope actually helped change the laws and a long term strategy, the human rights framework provides domestic advocates with new tools, forums, and alliances for doing their advocacy work.

And this means that advocates have access to the human rights treaty monitoring bodies, that—that Melissa and Janette were talking about, but it also means building alliances with other countries who have been doing human rights for a lot longer than some—than most domestic advocates.

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But also its other domestic advocates who may not have come together before because we're working on more specific rights under U.S. law, but we work together under broad—the broader rights as defined by human rights law.

A good example of this recently was in 2007, the U.S. was required to report to the CERD Committee about how it was fulfilling its obligations under the CERD treaty. And a coalition of 250 U.S. organizations, including the Center for Reproductive Rights, submitted a shadow report to the Committee, outlining numerous ways that the U.S. government has failed to eliminate racial discrimination in the United States, including in the area of reproductive rights.

In March 2008 the Committee issued concluding observations, saying that the U.S. was falling short in its duty to eliminate persistent racial inequalities and reproductive and sexual health care. It called on the U.S. to take steps necessary to address wide range—racial disparaging in the field of sexual and reproductive health care, including having to reduce the high rates of maternal and infant mortality, unintended pregnancies leading to higher abortion rates, and the growing epidemic of HIV/AIDS around—among women of color.

This reporting process not only allowed for new alliances to be formed by groups who were working together on the shadow report who may have never even considered working together before, but it also provided a new forum for domestic advocate to advance reproductive rights.

[Applause]

MS. SUSSMAN: I just wanted to thank Sara and the members of the Cardozo Journal of Law and Gender for creating this wonderful symposium, and for inviting us to speak.

I'm going to present what I've written in my article, which is a good example of how international human rights law can be used in the U.S. context in reproductive—in the reproductive justice framework.

And the issue that I'm speaking on specifically is challenging the practice—the ongoing practice of shackling incarcerated women during labor and delivery.

It has gotten a lot of press in the past ten years or so, thanks to great work by human rights advocates at the international level, and my article discusses why

it's time for reproductive justice litigators to use that—those accomplishments on the international level in domestic litigation to challenge the practice.

So it goes without saying that the practice is brutal, humiliating, unsafe, and medically unsound. The American College for Obstetricians and Gynecologists has come out against it, as has the American Public Health Association. It has drawn criticism by the U.N. Special Rappateur on Violence against Women when she visited the U.S. about ten years ago and visited women's prisons and jails. And also a strong criticism from U.N. treaty monitoring bodies in two treaties that the U.S. has signed onto.

I sort of chronicle where the advocacy began, and I think it really began about ten years ago in an Amnesty International Report called "Not Part of My Sentence" that chronicles the regular practice of using restraints and shackles on incarcerated pregnant women during transport to the hospital, during labor, and even during delivery.

And when I'm talking about shackles, most people assume it's the ankle shackles together. In some cases it actually is—more often than not it's a wrist and an ankle—one ankle shackled to the hospital bed so she can't turn over, she can't walk, she can't go to the bathroom, and this can be for, two hours to over a day.

And this report, the Amnesty report garnered a lot of attention in the mainstream press, and it's been used successfully as an advocacy tool in the international human rights treaty monitoring body.

In 1999, as I said before, the U.N. Special Rappateur on Violence against Women visited the U.S. and several prisons and jails. She focused mostly on the sexual abuse of female prisoners, which is another horrific and ongoing problem, but she did note that the practice of restraining pregnant women during labor and delivery violated international standards against cruel, inhuman, and degrading treatment.

In 2000, Amnesty took its report to the—to the U.N. Committee against Torture and in the Committee's concluding observations, it expressed concern for the humiliating and degrading circumstances in which female prisoners are detained in the U.S.

Again, I assume you might already know this, but this is an incredibly unusual practice. The U.S. is maybe the only country in the world that does this. It

certainly is one of only a handful, if that. Although it is unclear, it's just that most countries' restraint policies with their prisoners are so—they're nonexistent, so it's hard to even—most countries would never even consider doing such a thing. And—and many countries don't incarcerate pregnant women at all. They wait until they—they've completed their pregnancy.

So again in 2003 and then in 2006 the practice was brought before other treaty monitoring bodies. The Human Rights Committee which monitors compliance with the ICCPR, and the Committee against Torture again, by human rights advocates and prisoner's rights advocates, and both committees issued concluding observations, leveling harsh criticism on the U.S. for continuing this practice.

Since these efforts, the international human rights efforts began on this issue about ten years ago, three states have passed anti-shackling legislation. That's Illinois, California, and Vermont, and at least ten states have changed their Department of Corrections regulations on this practice, and it shifted the default to no shackling, whereas before it was shackling unless there is, extenuating circumstances. And usually the exceptions are for a substantial flight risk, which I don't know if you've been pregnant, but I don't imagine a woman in labor would constitute a substantial flight risk in any circumstance, but if there is a substantial flight risk she may be shackled in some states. And then the other concern is a security risk or a safety risk for the woman herself, if she might, harm herself, hospital staff, that kind of thing.

So ten states have changed their policies, three states have laws, and then in 2008 both the Federal Bureau of Prisons changed its policy to eliminate the use of shackles in—in nearly all circumstances, and U.S. Marshals changed their policy. And also in 2008 the Second Chance Act was signed into law, which includes a provision that requires that the Federal Bureau of Prisons record every instance of shackles it uses on pregnant women during labor and delivery, and must justify it by documented security risks, so we may actually have, at least federally, some sort of record on how often this is happening, because we don't really know exactly how often it is happening.

On the litigation side, to my knowledge there's only been three cases that have been brought, addressing this issue. The first one was in 1996, which was a large class action lawsuit that was brought against the Department of Corrections in the District of Columbia.²⁸ That included only a paragraph on

²⁸ *Women Prisoners of Dist. of Columbia Dep't. of Corr. v. Dist. of Columbia*, 93 F.3d 910 (D.C. Cir. 1996).

shackling as a reform of many, many policies related to female prisoners, including cross gender pat downs, and educational opportunities, and sexual mistreatment and other things. But in the settlement agreement that came out of that, the policy was changed.

Another case is *Norris v. Nelson*,²⁹ which is still pending before the Eighth Circuit. It came out of Arkansas. The Center wrote an amicus brief, highlighting a lot of the human rights law in that case, and we're still waiting to hear about that. I'll talk a little bit more about that later.

And then finally a case that was filed this December—past December in Chicago.³⁰ If, you may remember that I said that Illinois has an anti-shackling law, and this is in Chicago.

Two women were shackled—they were actually not even in prison, they were in a residential treatment facility for pregnant—incarcerated pregnant women. Both were taken to the hospital. One woman was shackled by her ankle and her wrist to the hospital bed for eleven hours, including during labor, which is a pretty, pretty extreme case. So there is still litigation going on, and it just sort of proves that, these shackling laws are important and policy changes are important, but, litigation to vindicate these women's rights is essential.

So you may be wondering why I consider this a reproductive justice issue, as opposed to a prisoner's rights issue or a human rights issue.

As many of you know, the reproductive justice movement grew out of a major critique of the pro-choice paradigm, and that that paradigm didn't resonate with certain communities of women, particularly communities of color, because it assumes that all women have access to the full spectrum of choices.

It fails to acknowledge that, due to economic restrictions like the Hyde Amendment, which restricts Medicaid funding on abortion services, or family caps on—under state welfare laws, and, structural racism and sexism that devalues women of color and—and portrays them as unfit and undeserving mothers.

The reproductive justice movement seeks to embed issues of reproductive health and gender inequality within broader structure—within broader

²⁹ *Norris v. Nelson*, No. 07-2481(8th Cir. Oct. 2, 2007).

³⁰ Amended Complaint, *Zaborowski v. Sheriff of Cook County*, No. 08-cv-06946 (N.D.Ill. Jan. 28, 2009).

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struggles against oppression and injustice, and establishes that reproductive repression is inherently connected to other struggles for social justice and for human rights.

So the limited issue of abortion and access to abortion and access to contraception simply doesn't resonate with some communities, and—and the right to give birth with dignity and to have cohesive family units, even if you are incarcerated, to maintain, to prevent your child from entering the foster care system before you're able to get out of prison, and these are issues that are very important and are often not considered within the normal, reproductive rights framework.

So the shackling of pregnant women during labor, and I'm quoting from Ricky Salinger, functions as a punishment appropriate for reproductively insubordinate women. That is women who should not be having babies, who do not deserve to be mothers, and yet they are.

So it's sending a message that these women shouldn't—it's that their own fault if they got pregnant—they shouldn't be pregnant in the first place, they shouldn't be in jail. This is another kind of punishment.

And this population of women come from the most—many come from the most marginalized segments of society. They are disproportionately poor, many—the majority are of color, they are young, the average age—the largest segment is between the ages of twenty-five and thirty-nine—so they're incarcerated during their reproductive lifespan. Most are already mothers to minor children and they're trying to hold on to custody of those minor children.

The female prison population has its rate of increase has surpassed the rate of increase for American men who are incarcerated. It has—the population since 1980—has increased sevenfold, and that's mostly attributed to the war on drugs, which has really become a war on women, and most women are in prison for nonviolent offenses. It's mostly property related crimes, like fraudulent checks, or larceny, or drug crimes.

And so now I'm just going to talk briefly about how litigation can build on the successes that human rights advocates have had in bringing challenges to the—these shackling practices.

Although international human rights treaties and the law for nations are not viewed by American courts as controlling authority, the Supreme Court has long recognized the relevance of international law in ascertaining the—contemporary standards of decency standard, which is the—in the amendment in, informing the cruel and unusual punishment analysis.

So we can use the successes on the international level strategically and legally, to determine what those contemporary standards of decency are. And if you compare the U.S. practices to international practices, it seems as though the U.S. is not adhering to the contemporary standards of decency in this area.

Cases that have been brought on behalf of pregnant women in prison for inadequate prenatal care or other issues of—relating to health care have been brought under a deliberate indifference to a serious medical need standard, and that standard I think works in the context of prenatal care, because pregnancy and being in labor has been, universally agreed as a serious medical need.

But *Norris v. Nelson*, which is that case in Arkansas that's still pending, was also brought under the serious medical needs standard, and I believe that that's the improper standard, and it didn't work with the Eighth—with the Eighth Circuit Panel. Basically the Eighth Circuit Panel said that yes, pregnancy and going into labor is a serious medical need, but the fact that the pregnant woman was transported and admitted to the hospital on time, in time for her to give birth, even though she was shackled the whole time, concretely demonstrated a deliberate concern for her well being, and not indifference.

So clearly the deliberate indifference to a serious medical need is not going to get us where we want to go.

I argue that the proper standard is the inmate treatment standard, or the conditions of confinement standard, which has both an objective and a subjective component.

The objective component focuses on the seriousness of the risk or the deprivation, as measured by contemporary standards of decency, which I would argue is informed by international standards.

And then the subjective component focuses on the state of mind of the prison official whose acts or omissions caused the alleged risk.

And I just very briefly want to parallel a recent Supreme Court case with what happened in the Arkansas case and you'll see where this standard can get us.

So, in 2002 the Supreme Court decided a case called *Hope v. Pelzer*,³¹ which applied that treatment—inmate treatment standard.

Larry Hope was an inmate who was handcuffed to a hitching post outside in the south—I forget which state—as a punishment for disruptive conduct. On the first occasion he was handcuffed for two hours. He was—his arms were held above shoulder height and his hands, shoulders and his arms grew tired from being handcuffed. Whenever he tried to move his arms to improve the circulation, the handcuffs cut—the handcuffs cut into his wrists.

On the second occasion he was handcuffed for seven hours outside. The guards made him take off his shirt. He remained shirtless all day, while the sun beat down on him, he was given water only once, and he was given no bathroom breaks.

The Supreme Court said, based on those facts, the Eighth Amendment violation was obvious, and I quote,

Despite the clear lack of an emergency situation, the respondents knowingly subjected him to a substantial risk of physical harm, to unnecessary pain caused by the handcuffs, and the restricted position of confinement for a seven hour period, to unnecessary exposure to the heat of the sun, to prolonged thirst and taunting, and to a deprivation of bathroom breaks that created a risk of particular discomfort and humiliation. The use of the hitching post, under these circumstances, violated a basic concept underlying the Eighth Amendment, which is nothing less than the dignity of man.³²

Okay. So applying that—that analysis to the *Norris v. Nelson* case, this woman is—I haven't met her, but I've worked with advocates who have and she's, I think, no more than, like, ninety-five pounds, so not a huge, physical risk for the—the big prison officials. She went into labor in the correctional facility at five o'clock in the morning. She wasn't transferred to the hospital until about twelve hours later. She was shackled during transport and she remained shackled when she was admitted to the hospital. The prison officials refused to remove her leg restraints and her wrist restraints, despite the requests of the obstetrician and the—or the obstetrical nurse and the attending physician.

³¹ *Hope v. Pelzer*, 536 U.S. 730, 738 (2002).

³² *Hope*, 536 U.S. at 738-39 (2002).

The restraints were eventually removed when she was placed on the delivery table, where she delivered a 9 pound, 7-3/4 ounce baby via natural childbirth, which we made sure we included in our brief, those details.

Her restraints were reapplied five minutes after giving birth, and she experienced a herniated disc and severe mental anguish as a result of this treatment, and if you compare the two cases, I think the parallels are clear. Neither Larry Hope, in the *Hope v. Pelzer* case, nor Ms. Nelson, posed a security threat.

Mr. Hope suffered unnecessary pain caused by the hitching post and the handcuffs. Ms. Nelson suffered unnecessary pain caused by the shackles and the restrictions they placed on her movements while in labor. Both were denied bathroom breaks, both were subjected to humiliation and unsanitary conditions based on the fact that they could not move to go to the bathroom, and both were subjected to the risk of serious physical injury.

So I encourage you to think broadly about reproductive justice and how it might apply to different populations of women and—and think broadly about beyond, beyond abortion and contraception and as you are here, and to follow these cases and to look to marginalized populations that are not always served by the traditional, I guess, pro-choice paradigm, and think expansively about reproductive justice. Thank you.

[Applause]

MS. GERWIN: Well, you've just had a mind boggling tour through the international conventions of the conventions of international law in a really quite extensive way from the experts in it, and we have time for some questions. Yes.

FEMALE VOICE: - - .

MS. SUSSMAN: Right. Unfortunately we've run up with that—with that problem consistently, because most of the—the anti-shackling laws and regulations have—don't include transport and specifically I think so. I think that was a compromise that advocates had to sort of give up on. There are some, the—the issue of discretion is also problematic, and the laws do give prison officials a

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good amount of discretion as well. Some of them include language like “the least restrictive means necessary,” which may be helpful.

You know, I’ve heard stories of women that are sort of jostled around in those vans, in those Department of Correction vans, and they have no way to sort of brace themselves, so perhaps trying to—trying to figure out, or, talking with the local chapter—chapter of the American College of Obstetricians, Gynecologists, and see what they might recommend as the least restrictive means necessary.

Having public health and organizations come out against this has been really, really powerful, so working with physicians on what is the safest way to address security concerns and—so-called security concerns and the health of the pregnant woman and the fetus, is helpful.

MS. GERWIN: Yes.

FEMALE VOICE: - - how—I—I did—I possibly did the - - that gets the - - secured - - that would be - - .

MS. AMER: Yeah, I mean, maybe all of us can answer that. I mean, I—from the very beginning I think when you look at these norms they represent a consensus. So really, they’re not just Europe and the U.S. and the western countries getting together and deciding, this is what these standards should be. And they haven’t, which is why it’s taken, I mean, since the U.N. was established in 1945, to develop this full framework, it’s taking decades, and I think the reason is, is because they are consensus documents. We have 195 members and they have agreed to them. So whenever I heard that document I may think we have to take a step back and say, this is not a bilateral—this is not, an EU initiative, this is not—this is the international community that has spoken. It’s been very difficult negotiations. If any of you have been to any of the world conferences, I mean, it’s very sensitive. Each country has its own, interests and sensitivities, but it’s always been amazing that they have managed to come as far as they have.

So I always, I think it’s—it’s an easy scapegoat argument, just to sort of write them off and say this is an imposition from the West. But really when you look at where they came from and how they’ve been developed, they—they’re not, they’re universal, they’ve been agreed through very, very difficult consensus building forum, so, I mean, that’s from the very beginning of it.

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But in terms of strategies, also, I mean, just before that, I mean, the treaty bodies is again, like the CRC has the most parties, and I don't know what they're up to. Do you know what they're up to now?

MS. UPRETI: I don't know.

MS. AMER: Yeah, I mean, it—they're close to universal. I mean, it—CEDAW itself is up to 185, and so, you are looking at really not just one region that is imposing and with the human rights treaty bodies it's also, geographical balance when they're elected each, through their election it's a regional process and it's, it's not heavy in one region or another. So they are looking from their own perspectives, which is the same type of situation when you're in the treaty body sessions, that you're dealing with different views, and different cultures, and different experiences on—on issues, but they do again come to these amazing principles that, as was mentioned, that the universal in some ways are ahead of here in the U.S. So it is a really interesting process to see, and I don't think that it's, one group imposing on others at all. But in terms of strategies, apparently you are. Bad, huh?

FEMALE VOICE: - - Congress and - - it would start to focus in on - - so I—went up to - - are you worried about what the focus - - to - - and particularly to have - - in the - - certain questions. What—what has the - - in the quality of - - or who were formal - - that are - - .

MS. STOLZ: I guess yes, but, well, I mean, I would hope that since treaties are - - that - - that it wouldn't be that way, but the problem I think—the biggest problem is if we ratified CEDAW tomorrow, we'd probably, well, it would be non-self executing, because we—and we're if it—or we'd make sure that it wasn't, and I think the worry that I'd have is that a lot of times we either put in our official reservations understanding and is it declarations. RUD, because I just - - too much.

That which we've done in other things, and we've especially done in relating to things relating to reproductive rights, that we basically have said we're sort of interpreting this as the U.S. doesn't go beyond the Constitution, and my worry would be that when we both put that in and then a court looking at it would therefore say okay, that's great, but we have this great protection under the Fourteenth Amendment, the equal protection, and that they were limited.

I think that is—I think of it as a real concern. I think one of the things we—that would be the most beneficial from ratifying CEDAW was to be able to use

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the CEDAW Committee and get to the U.N., because I don't know that we wouldn't have to do a lot of work on what I was talking about in building a dialog and building this into our dialog and policy work before we'd really want to use it in our litigation, because I'd be worried about it being too limited before ideas were really changed, which is such a long term strategy, I know, but I'm still hopeful about it.

FEMALE VOICE: - - it's not—it's not a - - that would - - process, in fact the processes - - so that's—I guess that's the - - the court would - - eliminate, not - - that we—we should narrow the concept, we're—we'll say this contradicts it, - - .

MS. STOLZ: Yeah, I think they would be allowed to do that. I just think in that case to what extent we—we could argue that the U.S. was not—by limiting CEDAW in that way, by its constitution, we could then argue that you're not—it's not really fulfilling its obligations under the treaty, and there—and, I mean, to what extent, and when looking at it, depending on who is really looking at it, they'd have to be saying, well, once we ratify the treaty and made it and did whatever, the laws of the land are supposed to follow it.

And whether or not—then we could get into using, okay, now that we've done this we have to think about CEDAW when we're thinking about the constitution. I just don't know if that's possible, and given the current makeup of the judiciary, I would say it's probably not. But I—it could be. I mean, I think an argument could be made that if you're going to really restrict CEDAW to just what you think, you're not fulfilling your obligations and you haven't really ratified it, like, done what you need to do.

But then again that would probably mean having to go back to the treaty monitoring body and using them, rather than anything we can directly do in courts here.

MS. GERWIN: Yes - - .

FEMALE VOICE: - - .

MS. STOLZ: Well, it depends. I think it—cities and states have actually been much more accepting than necessarily—the federal government and also federal courts to hearing international law arguments. It was a huge movement in San Francisco, with a lot of people involved in an education campaign, and

a grass roots campaign about it, which really got - - and it was also San Francisco, which I think probably helped everything.

But New York has been trying to get its own CEDAW for a really long time, so I think and has been met with a lot of resistance, and I think the movement keeps growing and—and then going away, and—but I do think, in terms of the—sort of the—the feel in the federal government and federal courts that local areas are—are more open. There are even, smaller counties that are looking into it, and I just think in terms of what we can really do, that those are usually more open or even, as we are hearing earlier, state constitutions—when you're using state constitutions, some courts and states are willing to think about international law much more when they're thinking about their own constitution and what's rights mean, than not all of them, but some of them are much more willing to take it in, and I just think that that's an opportunity that we need to be looking for is, like, a lower level of where work can—where it can be percept—people are willing to listen and—and take it into account.

But you, in certain areas you're going to find just as much a resistance as you've been finding federally.

MS. GERWIN: I'm going to exercise the prerogative of the Chair, for one moment, and speak to the students that are here and to the other young people that—that are here, and since you're all younger than I am, you can all listen.

The individuals that you've heard from today are those in whose footsteps you'll follow. They have detailed for you the progress, the setbacks, the promise of success, and the fears of continuing discrimination and injury to women. And they have laid out the new challenges that are ahead of you.

They've illustrated the importance of language. You—we've almost come full circle today with the—the final presentation. The idea that rhetoric and conversation and issue framing really do matter, and that is, as lawyers, that's what you've been trained to do. From the language of reproductive justice that's replaced or may have replaced freedom of choice, to that of human rights. They've demonstrated that the search for legal remedies requires creativity, multifaceted strategies, approaches that are outside the box, that push the margins and the need for collaboration.

And they've detailed the need for law to insist upon and to rely upon good science, as well as the need for law to keep pace with the new and challenging

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discoveries and technology. And always with due regard for the doctrine of unintended consequences.

And they've cautioned you to understand the difference between changing the law or what the legal text says, and what happens in operation.

And we've all learned that effective change requires us, as lawyers, or people who know something about the law, to have an understanding not just of law, but of policy and politics, and the moral dimensions of the problems that we seek to address.

I suspect that I speak for many of you when I thank the panelists, and that I speak personally when I thank the panelists and the organizers, and to all of you who have come to listen, and to ask questions, and to learn, and I'm really honored to have served as your moderator today.

And so with that, I want to especially thank the organizers, to Sara, and I want to recognize Ashley, who would like the last word. So thank you.

[Applause]

MS. ASHLEY ANTLER: I'm going to echo Leslie's thanks, because we can't end the symposium today without thanking a lot of people. So first I want to echo Leslie's last comments and thank all of the speakers today.

Personally it's been incredibly eye-opening and engaging to sit here today and listen to all of the diverse viewpoints, and I speak—I think, on behalf of everyone—that we're really grateful to the panelists here, and all of the speakers today, for coming to Cardozo and sharing your thoughts with us. So thank you to all the speakers.

And I also want to thank to everyone that's come to attend today. The turnout today has been great, and we're really grateful for all of your support, and hope that all of you are leaving inspired and that your minds have been stretched, as mine has been.

I want to thank Leslie Gerwin, who has been up in the front of the room since nine o'clock this morning, and has been moderating. Your insights have really facilitated all of these conversations, and we're really grateful that you were here today to help us.

And lastly, but certainly not least, a huge, huge thanks and round of applause should be given to Sara Perle, who has been working tirelessly to plan this symposium. The planning began actually last spring, and since then it's due in large part, but not solely to her persistence, her vision for today, and her dedication to this event that it was the success that it was. So, Sara, thank you so much..

[Applause]

And I also want to thank Nikki Carpenter and Kelly Schwab who were Sarah's right hand women in planning this event. I know that all of you collaborated really impressively. Your teamwork this year has been really, really great, and I know that today ran so smoothly, in part, due to all of your really hard work. So with that, if the three of you could all come up, we want to acknowledge you with just a small token of appreciation for your work.

[Applause]

MS. SARA PERLE: Thank you so much to everyone. Thank you to Ashley, who also has put up with all of our questions and crises. She's been wonderful, and incredibly helpful in this entire process, and thank you to Kelly and Nikki for being such great help.

Thank you everyone for coming. This has been a great event. I'm so proud to have been a part of it. Please join us just outside this room, right where breakfast was, for drinks, desserts, and appetizers in our reception. I hope you enjoyed it and learned a lot. Thank you.

[Applause]