

Reframing Reproductive Rights: Introducing the Intersectionality of Socioeconomic Class into Questions of Reproductive Autonomy

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Introduction

In the United States, the reproductive rights movement has by and large been an effort to secure and maintain reproductive autonomy for middle- and high-class Americans. Most leaders in reproductive rights have been wealthy white women¹ who, although working towards the rights of women, have largely ignored questions of access for any woman who does not fit their privileged view of what a woman is. For example, Margaret Sanger founded Planned Parenthood in 1921 and then went on to support the compulsory sterilization of thousands of low-income women, primarily women of color. While what Sanger did for the reproductive rights movement in her creation of Planned Parenthood has been invaluable for millions of women, her actions later in her career were deeply damaging to low-income populations. In fact, because most reproductive rights campaigns have focused on the sheer legality of mechanisms of reproductive autonomy (i.e. abortions and contraceptives), the question of access has not been one these campaigns have examined, and more marginalized populations have been excluded from the fight for reproductive autonomy. While many of the resources that could help increase autonomy are technically available, they are not always accessible to all populations. This issue is particularly prevalent for low-income women.

When the Social Security Act passed in 1935, Aid to Families with Dependent Children (commonly known as “welfare”) created an entitlement program to support low-income families with children.² Theoretically, this legislation provides low-income families with the resources necessary to obtain food and other critical provisions, but simply providing financial aid has not done enough to lift poor families out of poverty. The

1 For the purposes of this analysis, the use of the word “women” will indicate cisgender women. This is not intended to be exclusionary of any non-cis identities. It simply narrows the scope of this analysis to discuss issues in reproductive rights specifically pertaining to cisgender women.

2 Office of the Assistant Secretary for Planning and Evaluation, “Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF) – Overview,” *U.S. Department of Health and Human Services*, 2009.

issue of financial stability is thoroughly exacerbated by the disability of many low-income women to be autonomous in controlling their reproductive systems. This is not an issue of simple capability or willpower; many low-income women struggle to raise families, even in two-parent households, because they are legally unable to make decisions that affect their survival. Because low-income women have little control over if and when they have children and the resources they are able to provide, they often become ensnared in a cycle of poverty from which they cannot free themselves.

Generally speaking, there has been significant progress made on behalf of women's reproductive autonomy, ever since the hallmark 1973 Supreme Court decision *Roe v. Wade*. In *Roe v. Wade*, a woman's right to obtain a safe and legal abortion was verified through the inclusion of reproductive autonomy as an aspect of the right to privacy implicit in the United States Constitution.³ Since this case, however, pressure from conservative politicians has mounted to cut down a woman's ability to obtain an abortion. For example, in 1992, *Planned Parenthood of Southeastern Pennsylvania v. Casey* was decided by the Supreme Court in favor of restrictions to obtaining abortions with the exception of what the court determined to be "undue burden" on the woman looking to obtain an abortion⁴. In this case, the requirement of written approval from the fetus's father was deemed an undue burden, but the requirement of parental consent for minors obtaining an abortion was upheld, as were other aspects of the Pennsylvania law *Planned Parenthood* challenged in this lawsuit. Similar challenges to reproductive freedom have continued to restrict women's abilities to control their reproductive systems. For example, from 2011 to 2014, state legislatures enacted two-hundred thirty-one new abortion restrictions, and, in 2015, 57% of women lived in states considered to be "hostile" or "extremely hostile" to reproductive rights.⁵

These affronts to reproductive freedom have not affected all women equally. Wealthy women are able to travel to obtain abortions if their state does not legally allow abortions to be performed, purchase birth control without coverage from insurance, and afford preventive reproductive health care on a regular basis. Even middle-class women can typically afford to have children and care for them as needed. But women who do not qualify as high- or middle-class are not so privileged; their lack of reproductive autonomy creates a serious hazard. Because of their socioeconomic position in society, low-income women are disadvantaged in their ability to exercise their reproductive rights.

Current literature discussing reproductive rights, however, typically frames the issue as being of equal consequence to all women. That is, most articles, books, and other sources concerning the rights of women's reproductive autonomy address the issue as one of gender inequality. According to these works, because women are restricted in their ability to exercise agency in their reproductive choices, the issue is, at its heart, a women's issue, and not one based on class. The intersectionality of reproductive rights rarely comes into play in the current literature and, when it does, it tends to concentrate more on the racial divide in reproductive autonomy than it does on class as indicative of agency.

One notable work addressing the racial divide in reproductive autonomy is Angela Davis's piece on Racism, Birth Control, and Reproductive Rights. In this piece, Davis reminds the reader that the freedoms women have gained in the fight for reproductive autonomy have not been equally distributed among racial or ethnic groups. Additionally, Davis notes

3 Cornell Law, "*Roe v. Wade*," *Legal Information Institute*, 2016.

4 Cornell Law, "*Planned Parenthood of Southeastern Pennsylvania et al v. Casey, Governor of Pennsylvania, et al*," *Legal Information Institute*, 2016.

5 Christina Cherel, "Holding the Line: Challenges to Reproductive Rights in 2016," *National Women's Health Network*, 2016.

that the movements themselves that worked for reproductive justice did so at a direct cost to racial equality, resulting in reproductive rights groups turning a blind eye to the coerced sterilization occurring in racial minority communities at that time, among other egregious acts of ignorance and racism towards women of color. Some leaders like Margaret Sanger did not just turn a blind eye, but instead actively participated in the sterilization of women of color as an attempt to forward their own movement for population control through contraception. Sanger, the founder of Planned Parenthood, actively reinforced the ideology of coerced sterilization, noting, “morons, mental defectives, epileptics, illiterates, paupers, unemployables, criminals, prostitutes and dope fiends’ ought to be surgically sterilized.”⁶ While this group Sanger describes does not specifically identify race as a qualification for coercive sterilization, people of color were disproportionately affected, particularly after World War II when “African Americans on welfare became the targets of coerced sterilization.”⁷ This exclusionary politics, Davis notes, breeds distrust between white women and women of color that cannot simply be mended through discontinuing the overtly racist activities of the movement’s past. Davis calls for reproductive rights activists to work to better understand the specific situation of women of color and the additional challenges they face in achieving reproductive autonomy.

Angela Davis’s assessment of the exclusion of women of color from women’s work regarding reproductive autonomy exemplifies the presence of work on race and the United States’ reproductive rights movement. Most of the present literature focuses on this dichotomy instead of concentrating on the intersectionality of class and gender in regards to reproductive autonomy. While there is a significant amount of intersection between populations of racial minorities and low-income communities due to a long history of legislation both explicitly and implicitly targeted at disempowering people of color, these two populations are not identical. The intersectionality between gender and race as it relates to reproductive rights is clearly of great importance; it is, however, not the entire story. Viewing reproductive rights through the lens of socioeconomic class allows for the examination of financial issues as an exacerbating factor in marginalized women’s struggle to obtain reproductive autonomy.

The literature on reproductive rights typically reduces the intersectionality between socioeconomic class and gender into one sentence or footnote, if it mentions it at all. Even organizations with a specific focus on reproductive rights, like the American Civil Liberties Union (ACLU)⁸ and the International Planned Parenthood Federation (IPPF)⁹, barely make mention of the issue at all. In both organizations’ stated policy goals, the accessibility of reproductive autonomy for low-income women is relegated to a single mention of the necessity of affordable access to abortion and birth control. The lack of awareness of class is even apparent in the United Nations’ Fourth Conference on Women in 1995, where then-First Lady Hillary Clinton delivered her famous “women’s rights are human rights” speech. Clinton produced a plan that addressed many global issues affecting women, but failed to

6 Angela Davis, “Racism, Birth Control and Reproductive Rights,” in *Women, Race, & Class* (New York: Random House, 1981), 361.

7 Randall Hansen and Desmond King, *Sterilized by the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America* (Cambridge: Cambridge University Press, 2013), 11.

8 American Civil Liberties Union, “Reproductive Freedom,” *American Civil Liberties Union*, 2016.

9 International Planned Parenthood Federation, *IPPF Charter Guidelines on Sexual and Reproductive Rights* (London: Regents College, 1997).

draw a direct correlation between a lack of reproductive autonomy and low socioeconomic status.¹⁰ Additionally, there was no mention to be found of improving low-income women's ability to raise children once they were born; the focus was almost exclusively on allowing women autonomy in their choice of whether and when to have children.

Not only is the intersectionality between gender and socioeconomic status in the reproductive rights movement largely untouched by academic literature, but also many academic pieces view obtaining reproductive autonomy as a goal in and of itself, ignoring the larger utility of exercising this agency. For example, Onora O'Neill's piece on "Reproductive Autonomy and New Technologies" examines the implications of increasing reproductive freedoms with regard to abortion and birth control legality and access. However, her only mention of the effect of increasing such legislation in favor of providing reproductive autonomy to women describes how advantageous it was that "many women acquired greater control over their reproduction."¹¹ Even though women technically had the rights to exercise reproductive autonomy, many were still largely unable to access contraception, abortions, or other expressions of reproductive autonomy. O'Neill ends her analysis at the point of obtaining the legal right to autonomy. This is not the realistic situation for low-income women; being able to dictate when and how to have children, as well to live well with those children, provides women with an ability to live, not just to be autonomous. Having agency over their reproductive systems is often merely a positive side effect of achieving the autonomy necessary for survival.

The issue of reproductive rights extends beyond its gendered aspects. While any person with a uterus obviously has a stake in the issue of reproductive rights in that their ability to make personal and medical decisions for themselves is compromised with the reduction in reproductive autonomy and increased with its expansion, not all women are affected equally. Low-income women face significantly more disastrous consequences of being denied options regarding the right to choose safe control over their reproductive system than their higher-income counterparts do.

For low-income women, the stakes of legislation denying or increasing reproductive autonomy are extremely high. And, while there is significant literature concerning low-income women's access to certain aspects of reproductive rights (i.e. birth control, abortions, etc.) there are very few works fully addressing the intersectionality of socioeconomic status and gender in the context of reproductive autonomy. This thesis will delve directly into this topic by exploring low-income¹² women's reproductive autonomy through an analysis of their diminished access to contraception, abortion, and child rearing resources. Chapter One: Access to Contraception.

Section 1: Birth Control

Gaining access to birth control is, for many low-income women, a strenuous and virtually impossible process. The myriad forms of birth control (i.e. oral contraceptives,

10 Clinton, Hillary, "Women's Rights Are Human Rights," Nations Fourth World Conference on Women, Beijing, 5 Sept. 1995.

11 Onora O'Neill, "Reproductive Autonomy' and New Technologies," in *Autonomy and Trust in Bioethics*, (Cambridge: Cambridge University Press, 2002), 52.

12 For the purposes of this analysis, "low-income" will not designate a specific income threshold, but will instead indicate a standard of living below the relative distinction of "middle class." Essentially, "low-income" signifies any family or individual who cannot always afford basic necessities, including but not limited to reproductive health care.

intrauterine devices (IUDs), condoms, spermicides, etc.) are technically available to all women in that no population is specifically legally banned from purchasing any of these options, with the exception of minors in some cases. That said, many of these birth control methods are largely inaccessible to low-income women.

Oral Contraceptives

The birth control pill, for example, is the most popular method of birth control with 25% of women who use contraceptives at all using the pill.¹³ It is also popular among low-income women specifically, with one in five women aged 15-44 years up to 149% of the federal poverty level using it as their primary or secondary method of birth control.¹⁴ On average, oral contraceptives cost between \$160 and \$600 annually without insurance coverage.¹⁵ For women with insurance that covers contraceptives, as not all insurance plans do, the costs can vary widely throughout that range.

Additionally, the birth control pill can only be purchased with a prescription from a licensed physician.¹⁶ This means that acquiring birth control pills necessitates the completion of two steps: (1) a prescription must be obtained from a physician and (2) one must be prepared to pay up to \$50 per month for the prescription.¹⁷

Low-income women often experience difficulty in accessing reproductive health care clinics because of both monetary and non-monetary barriers to care. This includes, but is not limited to, lack of transportation, social disincentives, and an absence of clinics in many geographic areas. Because of low-income women's severely limited access to reproductive health care clinics where they could theoretically go to get a prescription for oral contraceptives, their chances of successfully obtaining a prescription is slim simply because of their lack of access to physicians. Second, even if a low-income woman is able to access a reproductive health care clinic and finds the time and money to meet with a doctor, most physicians require a pelvic exam before writing prescriptions for oral contraceptives. These exam scans cost up to \$250, even for women with insurance.¹⁸ At this point, the first pack of birth control pills already costs \$300, which is one-third of a month's income for an unmarried woman living at the federal poverty level.¹⁹

Additionally, even low-income women who are able to financially access oral contraceptives often have trouble using them to prevent pregnancy. There are a variety of indicators to assess whether someone is likely to correctly and effectively use a contraceptive correctly. Factors like "specific personal, social, and demographic characteristics such as race and ethnicity, mother's marital status, education, and religious affiliation"²⁰ are all

13 Guttmacher Institute, *Contraceptive Use in the United States* (New York: Guttmacher Institute, 2015).

14 Kimberly Daniels, Jill Daugherty, Jo Jones, and William Mosher, *Current Contraceptive Use and Variation by Selected Characteristics Among Women Aged 15-44: United States, 2011-2013*, National Health Statistics Reports, Washington DC: Center for Disease Control, 2015.

15 Kimberly Palmer, "The Real Cost of Birth Control," *US News & World Report*, 2012

16 Dawn Stacey, "Can You Buy Birth Control Pills Over-The-Counter?" *Verywell*, 2016.

17 Planned Parenthood Federation of America, "Birth Control Pills," *Planned Parenthood*, 2016.

18 Ibid.

19 Office of the Assistant Secretary for Planning and Evaluation. "2015 Poverty Guidelines." *U.S. Department of Health and Human Services*, 2015.

20 Marjorie R. Sable and M. Kay Libbus, "Beliefs Concerning Contraceptive Acquisition

indicative of a person's likelihood to successfully use birth control to prevent pregnancy. Outside of these relatively static determinants of success, low-income women also often face trouble in taking oral contraceptives consistently at the same time each day. In one study, one-third of low-income women expressed trouble with consistent habits, which "may be a reflection of the chaotic lives led by many women," especially those with low-incomes, who often "have multiple life stresses with few attendant coping skills and/or limited social support."²¹

While there have been recent efforts to increase accessibility to oral contraceptives for low-income women, these have largely been failed attempts. The requirement of a prescription to obtain oral contraceptives has existed since the Food and Drug Administration approved the first birth control pill, Enovid, in 1960.²² Current efforts in some states have focused on making oral contraceptives more accessible to low-income women by eliminating the expensive requirement of this in-person clinical visit by removing the prescription requirement.²³ For example, the state of California recently enacted a law making oral contraceptives available as over-the-counter medications, which has significantly increased low-income women in California's ability to obtain and continuously use birth control pills.²⁴ That said, even this progressive legislation does not require pharmacies to sell birth control over-the-counter; it merely permits it. Additionally, implementation of similar laws in states where it has been passed has been slow and not entirely successful.²⁵ Even with this progress in theoretical accessibility, there is no guarantee that access to oral contraceptives will improve in practice.

After the passage of the Affordable Care Act in 2010, the cost of birth control should have theoretically been covered through the act's expansion of Medicaid. However, because Medicaid expansion was made optional after the National Federation of Independent Business v. Sebelius Supreme Court case, nineteen states have chosen not to expand Medicaid and therefore do not provide comprehensive contraception coverage to their citizens.²⁶ Seven of these states that did not expand Medicaid have no birth control coverage whatsoever because they do not have any family planning program. Family planning programs are typically available to women who are ineligible for Medicaid but still need financial assistance in obtaining contraceptives.²⁷ In the thirty-two states that chose to expand Medicaid, the Affordable Care Act requires that "all [eighteen] FDA-approved methods of birth control must be covered without cost-sharing."²⁸ That is, women with

and Use Among Low-Income Women," *Journal of Health Care for the Poor and Underserved* 9, no. 3 (1998): 263.

21 Ibid, 272

22 Henry J. Kaiser Family Foundation, *Oral Contraceptive Pills*, The Kaiser Commission on Medicaid and the Uninsured, Menlo Park, CA: Henry J. Kaiser Family Foundation, 2016.

23 Ibid

24 California State Senate, Senate Bill no. 493, Sacramento, CA: California State Senate, 2013.

25 Kelly O'Mara, "It's Still Hard to Get Birth Control Pills in California Without a Prescription," *NPR*, 2016.

26 National Women's Law Center, *Reproductive Rights*, Washington DC: National Women's Law Center, 2016.

27 Henry J. Kaiser Family Foundation, *Private and Public Coverage of Contraceptive Services and Supplies in the United States*, The Kaiser Commission on Medicaid and the Uninsured, Menlo Park, CA: Henry J Kaiser Family Foundation, 2015.

28 Laurie Sobel, Adara Beamesderfer, and Alina Salganicoff, "Private Insurance Coverage of Contraception," *Henry J. Kaiser Family Foundation*, 2016.

Medicaid should be able to purchase oral contraceptives without co-pays. While this is certainly a positive for women with Medicaid, 26% of eligible women are not currently enrolled in any form of health insurance, making this coverage inaccessible for them. For these uninsured, low-income women, oral contraceptives are hard to obtain at a reasonable cost.

In the states that have not expanded Medicaid, there is a gap between those currently eligible for Medicaid (at or below 42% of the federal poverty level) and those eligible for marketplace subsidies (between 100 and 400% of the federal poverty level.)²⁹ The Kaiser Family Foundation points to nearly three million poor, uninsured adults falling into what they call the “coverage gap,” who are in this position because their states refuse to expand Medicaid. Historically, Medicaid covers the extremely poor (at or below 42% FPL), the disabled, pregnant women, elderly adults, and children. With the expansion of Medicaid through the Affordable Care Act, the program theoretically covers all low-income individuals under 138% the federal poverty level, regardless of whether or not they fit into the historically covered categories. If the nineteen states that have thus far not expanded Medicaid chose to do so, more than one and a half million low-income women would become eligible for Medicaid coverage of their birth control. Low-income women are paying a steep tax for states’ refusals to expand Medicaid.

The Male Condom

Another common form of birth control is the male condom, used as a primary source of birth control by 24% of low-income women and as a complementary form of birth control by 27% of low-income women in one study.³⁰ Only 15% of all women using contraception report male condom use,³¹ indicating that low-income women are generally more likely to use condoms than the average woman is. This high level of condom usage among low-income women is likely due to its low cost and high availability, particularly relative to that of oral contraceptives. The male condom costs between \$0.20 and \$2.50 per unit on average when purchased,³² and can often be found for free at health clinics, on college campuses, and in other community areas. While condoms are a relatively effective option, there are still several problems with reliance upon them as a primary method of birth control for low-income women.

First, while condoms can be found for free or at a low cost at many community areas, their technical accessibility does not necessarily indicate any practical accessibility. For example, women living in rural areas or without reliable transportation may face challenges obtaining male condoms similar to those they face accessing reproductive health care clinics. It may be difficult to get to the nearest Planned Parenthood or other health center to pick up free condoms.

Second, in the National Survey of Family Growth conducted in 2015, only 19.3% of women using condoms during sexual intercourse used them effectively and consistently. While perfect condom use prevents pregnancy 98% of the time, imperfect or inconsistent

29 Rachel Garfield and Anthony Damico, “The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid - An Update,” *The Kaiser Family Foundation*, 2016.

30 Forrest and Frost, 249

31 Jo Jones, William Mosher, and Kimberly Daniels, *Current Contraceptive Use in the United States, 2006-2010, and Changes in Patterns of Use Since 1995*, National Health Statistics Reports (Atlanta: Center for Disease Control, 2012).

32 Palmer

use decreases this success rate down to 82%.³³ If 80.7% of women using condoms are not doing so effectively, then their purpose of preventing unwanted pregnancy is negated and their use is virtually unnecessary.

Finally, many low-income women report a lack of social support for condom use. A study of homeless women found that many women have met “strong partners’ resistance when they wanted the men to use condoms,”³⁴ which disincentivized them from continuing to encourage condom use in their sexual encounters. Across the board, these women described their birth control decisions as being largely dominated by the preferences of their partner. Although this is not the case in every low-income woman’s situation, the reality of the matter is that homeless women are not the only ones moving in a patriarchal space. Similarly, 40% of low-income women in another study cited personal embarrassment in condom use as a deterrent from continued usage, and 17% cited male disinterest in condom use as yet another deterrent. So, while condoms are often an effective option for many women in preventing pregnancy, they can be inaccessible, often used inconsistently or ineffectively, and met with resistance from male partners.

Long-Term Birth Control

Long-term birth control is yet another option available to low-income women looking to exercise agency in their reproductive capabilities. However, without insurance, the insertion of an IUD (intrauterine device) can cost up to \$1000 and, even for those with insurance, the insertion and upkeep of this form of birth control can garner substantial out-of-pocket costs not covered by insurance.³⁵ One-eighth of the women in one 1996 study cited long-acting methods such as IUDs as the most effective form of birth control they currently used. In a more recent nationally representative survey, 8.1% of women at or below the federal poverty level used long-acting reversible contraceptive methods (i.e. IUDs) in 2009; this number increased to 13% in 2012.³⁶ While long-term contraceptive use has increased in the past several years, there are still a relatively small number of women who use them as their preferred method of birth control.

One consistent issue in studies determining the efficacy of long-term birth control is its negative connotation with women of color as a reinvention of the sterilization practices of the past. One study found that most demographic subgroups were equally likely to utilize long-term birth control, but black females were an outlier in their reduced usage of such forms of birth control. This study theorizes that this outcome is a result of “continued higher levels of medical mistrust among females in the black community, among other factors.”³⁷ This same study notes that, although their data predates the implementation of the Affordable Care Act’s contraceptive mandate, they saw significant increases in long-term birth control usage in women with full time jobs and private insurance coverage.³⁸ That is, long-term birth control is most effective for women with private health insurance,

33 Katherine Dexter McCormick Library, *The Truth About Condoms* (New York: Planned Parenthood Federation of America, 2011).

34 Gelberg et al, 93.

35 Michelle Andrews, “Can I Get my Insurance to Pay for an IUD Removal?” Kaiser Health News, 2014.

36 Megan L. Kavanaugh, Jenna Jerman, and Lawrence B. Finer, “Changes in Use of Long-Acting Reversible Contraceptive Methods Among U.S. Women, 2009-2012.”

37 Ibid, 924

38 Ibid, 926

as they are better able to cover the costs of the expensive insertion procedure.

Conclusion

The variety of birth control options available to the general public can be deceiving in permitting the conflation of availability with accessibility. The problem of insurance coverage being perceived as being indicative of accessibility also becomes an issue when discussing availability of birth control. However, if contraceptives are free or low-cost at face value, there are still many roadblocks that can present themselves, whether through non-monetary barriers or additional fine print costs that are not apparent in an initial overview of free and low-cost reproductive health options for low-income women. There is still a significant number of low-income women who experience diminished reproductive autonomy because of the political decisions made at the federal, state, and local levels which make it virtually impossible for them to control if and when they have a child. Because of this, women are often forced into motherhood before they are ready or capable of raising a child, further exacerbating their impoverished state.

Section Two: Abortion Access

Low-income women face many barriers to exercising their reproductive autonomy and preventing unwanted pregnancies, such as reduced access to contraception. If a poor woman does become pregnant, she has very limited options compared to women with higher incomes. Theoretically, low-income women have the option of either terminating or continuing pregnancy. This is a decision a woman typically makes through a personal and often spiritual exploration of her moral code to determine whether she should terminate the pregnancy, raise the child herself, or give her child up for adoption. However, because of her socioeconomic status, a low-income woman faces an extraordinary challenge in exercising any desire she may have to terminate a pregnancy. There are federal policies blocking women's access to abortion services, exacerbated by a hostile political climate towards pregnancy termination that makes it almost impossible for low-income women to obtain these services legally, safely, and at an affordable price.

Although abortion was legalized through the Supreme Court case *Roe v. Wade* in 1973, it still remains a controversial and deeply partisan issue. *Roe v. Wade* decreed the right to an abortion by determining that statutes that make abortions criminal, even statutes that denote medically necessary abortions as permissible, are unconstitutional invasions of privacy. Despite this precedent, the 2016 Republican Party Platform included a provision directly supporting legislation that would cut funding to health care subsidies that covered abortion.³⁹ That is, the Republican Party placed itself in direct opposition to any federal, state, or local funding of abortions. Conversely, the 2016 Democratic Party Platform asserted their belief that "every woman should have access to quality reproductive health care services, including safe and legal abortion -- regardless of where she lives, how much money she makes, or how she is insured."⁴⁰ Clearly there is a stark divide between the two major political parties in their opinions on abortion as a fundamental aspect of

39 Republican National Convention, "Republican Platform 2016," (Political Party Platform, Washington DC, 2016), 13.

40 Democratic National Convention, "Democratic Platform 2016," (Political Party Platform, Washington DC, 2016), 37.

health care worthy of government support and subsidization. While abortion is certainly a divisive issue and some view it as a morally reprehensible act, restricting women's access to the procedure is reducing women's control of their reproductive system, regardless of the morality of the procedure itself. In arguing that the issue of reproductive rights is, at its heart, an issue based in socioeconomic class, the morality of abortion is an unrelated aside and will not be further considered in this analysis.

The Hyde Amendment

One of the most restrictive pieces of legislation concerning abortion is the Hyde Amendment. Initially passed in 1973, the Hyde Amendment requires that no federal funds “shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.”⁴¹ That is, unless the fetus is directly harmful to the life of the mother, the only funding that can go towards an abortion is funding from states or private organizations; the federal government cannot be involved in financing abortions at any level. The amendment primarily affects Medicaid, the main venue through which the federal government contributes to the cost of individual medical procedures. Medicaid uses combined federal and state funds to pay for the cost of medical care for low-income populations (and exclusively for the very poor and disabled populations of the nineteen states that have chosen to not expand Medicaid). Because the Hyde Amendment mandates that abortions must not be federally funded if they are to be funded at all, the burden is typically on the states to choose whether to contribute fully to abortion procedures in their state or to refuse to contribute at all.

By placing this burden on states, the amendment invites states to express their political views on abortion through their funding, or lack thereof, of the procedure. More conservative states like Texas, Ohio, and Georgia have chosen to remove abortion coverage from Medicaid altogether.⁴² In these states, abortion is not an option unless it is fully privately funded. A variety of studies examining the effect of the Hyde Amendment indicate that “20 to 25% of the women who would have received publicly funded abortions [in states where it is now illegal to fund abortions] instead gave birth when that funding became unavailable.”⁴³ A study performed in 1993 indicated that states that chose to restrict Medicaid coverage of abortion had fewer abortions performed overall, though not for a lack of demand for the procedure.⁴⁴ Rather, this decrease in performed abortions caused by the Hyde Amendment in part exhibits a reduced availability for low-income women who would have otherwise had abortions.

Abortion Availability

Low-income women are generally more likely to need or desire abortions than women

- 41 Hyde Amendment, Public Law 94 - 439, US Statutes at Large 94 (1976): 209.
- 42 Willard Cates Jr., “The Hyde Amendment In Action: How Did the Restriction of Federal Funds for Abortion Affect Low-Income Women?” *Journal of the American Medical Association* 246, no. 10 (1981): 1111.
- 43 Rebecca Blank, Christine George, and Rebecca London, “State Abortion Rates the Impact of Policies, Providers, Politics, Demographics, and Economic Environment,” *Journal of Health Economics* 15, no. 5 (1996): 516.
- 44 Heather Boonstra and Adam Sonfield, “Rights Without Access: Revisiting Public Funding of Abortion for Poor Women,” *The Guttmacher Report on Public Policy* 3, no. 2 (2000): 8.

with higher incomes are. Poor women are over three times more likely to have unwanted pregnancies than their higher income counterparts.⁴⁵ However, this discrepancy does not arise from higher rates of sexual activity; there is no “sex gap” by income. ⁴⁶Although low-income women are not necessarily at a higher risk of engaging in sexual contact, their ability to obtain and use contraceptives is thoroughly diminished; the disparity in unintended pregnancies arises from a lack of access to preventive resources.

However, while low-income women are more likely to need or desire abortions, a plurality of abortions are performed on women living on more than four times the federal poverty level, while only 8.6% of women living under the federal poverty level have had abortions.⁴⁷ Somehow, the group of women more likely to experience an unintended pregnancy, and therefore likely to have a higher desire for abortions, has the lowest overall occurrence of abortions. A study done in 2015 examining the gap in unintended childbirth stemming from socioeconomic status found that low-income women have severely reduced access to abortion services, which causes the discrepancy in presumptive desire for abortions and actual incidence.⁴⁸

The federal government’s restrictions on abortion funding have serious financial implications for low-income women. Because the federal government is not permitted to provide funding for abortions, and because states choose whether or not to fund abortions through Medicaid based on their political leanings, most women with Medicaid coverage have to pay out-of-pocket for abortions. Even in the seventeen states where state-funded Medicaid does cover abortions, there are numerous other barriers to accessing care. Several states are under court order to cover only abortions that are medically necessary to prevent the death of the mother;⁴⁹ some states choose to deter abortions by providing an extremely low reimbursement rate and insisting on extensive delays before women can have the procedure.⁵⁰ This lack of coverage for abortions through public health care specifically targets low-income women and significantly decreases their access to pregnancy terminations; most women, with or without insurance, are forced to pay out of pocket for abortions.⁵¹ This further emphasizes the centrality of socioeconomic status in reproductive rights, since low-income women are significantly more affected by abortion bans and restrictions than their higher income counterparts.

45 Richard Reeves and Joanna Venator, “Sex, Contraception, or Abortion? Explaining Class Gaps in Unintended Childbearing,” *Center on Children and Families at Brookings*, 2015.

46 Ibid.

47 Ibid.

48 Diana Lara, Kelsey Holt, and Melanie Peña, “Knowledge of Abortion Laws and Services Among Low-Income Women in Three United States Cities,” *Journal of Immigrant and Minority Health* 17, no. 6 (2015): 1815.

49 Adam Sonfield, Casey Alrich, and Rachel Benson Gold, “Public Funding for Family Planning, Sterilization and Abortion Services, FY 1980–2006,” *Occasional Report no. 38*, New York: Guttmacher Institute, 2008.

50 Danielle Bessett, Katey Gorski, Deepani Jinadasa, Marcy Ostrow, and Megan Peterson, “Out of Time and Out of Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts,” *Women’s Health Issues* 21, no. 3 (2011): S23.

51 Adrienne Nickerson, Ruth Manski, and Amanda Dennis, “A Qualitative Investigation of Low-Income Abortion Clients’ Attitudes Towards Public Funding for Abortion,” *Women and Health* 54, no. 7 (2014): 673.

The Cost of Abortions

Theoretically, health insurance is intended to provide coverage to protect clients from the financial consequences of catastrophic health events that would otherwise bankrupt an individual or family. Based on this purpose, low-income women should be assured medical treatment for health events that could otherwise bankrupt them. Having an unplanned child certainly comes with the risk of catastrophic financial consequences, indicating that low-income women's health insurance should cover the procedures necessary to shield them from such dangerous outcomes.

On average, an abortion costs about \$470 in the first trimester.⁵² This figure amounts to approximately 50% of a monthly paycheck for a single woman living at the federal poverty line⁵³ and, without Medicaid coverage, these payments must come entirely out of pocket. Many women in conservative states where Medicaid does not cover abortions report having to draw from their own personal resources to pay for the procedure, often requiring them to borrow money from family and friends and placing them in severe financial distress.⁵⁴ These policies restricting abortion coverage "appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, therefore interfering with a woman's reproductive life plans."⁵⁵ One study showed that "women who [are] able to raise the money needed for an abortion [generally] do so at a great sacrifice to themselves and their families."⁵⁶ Forcing low-income women to pay for pregnancy termination procedures out of pocket puts them in risky and often dangerous financial positions.

Even women with insurance coverage for abortions are not always able to put that coverage to use in obtaining abortions. In a 2014 study examining low-income abortion patients' attitudes towards public funding for abortions, only 27% of the studied women had used public insurance to fund their abortion care even though 58% of the women had insurance at the time of their abortion.⁵⁷ Some of the women who did not use public insurance to fund their abortion did so out of necessity, not by choice. However, some reported that they were unaware of their coverage at the time of their abortion, only to find out later that this was a misconception and they could have been covered all along. Others were concerned that, if they used their insurance to cover an abortion, their families or employers would find out about the procedure and they would suffer negative consequences.⁵⁸ According to another study, "lack of knowledge of abortion laws and services"⁵⁹ is one of the major factors diminishing access to services." Health care literacy

52 Kelly Blanchard, Amanda Dennis, and Ruth Manski, "Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-Income Women," *Journal of Health Care for the Poor and Underserved* 25, no. 4 (2014): 1572.

53 Office of the Assistant Secretary for Planning and Evaluation.

54 Blanchard et al, 1572.

55 Ibid., 1581

56 Boonstra and Sonfield, 10.

57 Nickerson et al, 678.

58 Ibid

59 Lara et al, 1811

is generally low in low-income populations;⁶⁰ convoluted legislation and lack of efforts to educate communities can severely impact low-income women's access to abortion services.

The consequences of attempting to obtain an abortion can be disastrous for low-income women. Some of these consequences are financial, while others are non-monetary, such as increased delays in abortion obtainment, which can pose serious health risks. One study found that Medicaid-eligible women wait on average two to three weeks longer than higher income women to have abortions, primarily due to difficulties in accessing funds for the procedure.⁶¹ It is estimated that one-fifth of low-income women who have had second-trimester abortions would have had first-trimester abortions if their lack of funding had not resulted in significant delays in care.⁶² Second-trimester abortions are both significantly more expensive and dangerous than first-trimester abortions. They require women to take extended time off work and can necessitate expensive and time-consuming travel because not all clinics are equipped to perform second-trimester abortions. Additionally, the earlier an abortion is performed, the safer the procedure generally is.⁶³ Because low-income women often have to wait longer to receive abortions, they are at a higher risk for medical complications from the procedure.

Having an abortion is an expensive procedure for women both with and without Medicaid. Because slightly more than one-quarter of women living under the federal poverty line are uninsured even after thirty-two states have expanded Medicaid,⁶⁴ the number of low-income women without any sort of subsidy on their abortions is staggering. Without insurance or state subsidization, the procedure can cost between \$415 and \$1110, depending on the level of sedation the patient wants or requires and how far along she is in her pregnancy at the time of the abortion.⁶⁵ For a single, uninsured woman living at the federal poverty line, an abortion can cost between 42 and 131% of her monthly untaxed income.⁶⁶ These numbers indicate that, even if a woman is able to have an abortion at four weeks gestation (the earliest at which one can have abortion), she would likely still have to sacrifice paying bills, childcare, or other expenses, in addition to a loss of income for time taken off work. Additionally, most low-income women are unable to have abortions promptly upon discovering their pregnancies due to lack of immediately disposable income, transportation needs, demanding work schedules, and other complications that restrict their ability to leave town for several days to have the procedure.

Political Retributions and Abortion Clinics

Since the passage of *Roe v. Wade* in 1973, the political outcry from pro-life conservative

60 Ibid, 1812

61 Stanley Henshaw, Theodore Joyce, Amanda Dennis, Lawrence Finer and Kelly Blanchard, *Restrictions on Medicaid Funding for Abortions: A Literature Review*, New York: Guttmacher Institute, 2009.

62 Marlene Gerber Fried, "Abortion in the United States: Barriers to Access," *Health and Human Rights* 4, no. 2 (2000): 180

63 Christine Dehlendorf and Tracy Weitz, "Access to Abortion Services: A Neglected Health Disparity," *Journal of Health Care for the Poor and Underserved* 22, no. 2 (2011): 417.

64 Henry J Kaiser Family Foundation, "Women's Health Insurance Coverage," *Henry J Kaiser Family Foundation*, 2 February 2016.

65 Planned Parenthood of Western Pennsylvania, "Fees for Services," Planned Parenthood of Western Pennsylvania, 2016.

66 Office of the Assistant Secretary for Planning and Evaluation.

politicians against the legality of abortion has sharply increased. The National Right to Life Committee (NLRC), a major leader in the pro-life, anti-abortion movement, was founded in 1968 and, since then, has dedicated its purpose to decreasing access to abortions nationwide.⁶⁷ The organization has explicitly stated on their website that they exclusively sponsor legislation which advances the “protection of human life and [supports] the election of public officials who defend life.”⁶⁸ To achieve this goal, the NLRC supports legislation that renders abortions illegal or more difficult to obtain, or places regulations on abortion providers that would increase barriers to providing care. One study noted that, when the problem of unsafe abortion facilities or other abortion-related issues arises, “by focusing only on prevention of the need for abortion... [legislators] ignore the question of whether... communities with known need for abortion services have adequate access to these services.”⁶⁹ The same study also noted that organizations like the National Right to Life Committee focus more on restricting abortions than on addressing the underlying causes of the need for abortions. Instead of sponsoring bills that would provide low-income women with the resources to prevent unwanted pregnancy, such as increased and improved sex education, better access to contraception, and preventive reproductive health care, the NLRC focuses its resources on legislation that addresses the symptoms of the problem— the need for abortions— rather than the problem itself— the systemic lack of access to pregnancy prevention for low-income women.

Because of this increased attention on restricting access to abortions, clinics are closing at a record pace. In February 2016, Bloomberg BusinessWeek noted that one-hundred sixty-two abortion providers have closed their doors since 2011.⁷⁰ For example, Texas has some of the most restrictive abortion legislation in the United States and, subsequently, Texas abortion clinics have become increasingly inaccessible. Additionally, there has been a 54% decrease in women served at abortion clinics in Texas, and one-hundred thirty-one Texas clinics have closed or significantly reduced their operating hours.⁷¹ By having clinics around them close, many have been forced to increase prices, switching from a sliding fee scale to a fixed fee for service system,⁷² which disproportionately affects low-income women. Low-income women’s access to abortion clinics also depends heavily on their ability to find transportation and time outside of working hours to visit the clinic. For example, anyone living in the Texas panhandle or in the southernmost tip of the state does not have an abortion clinic within one-hundred miles of them.⁷³ 87% of counties

67 National Right to Life, “History of National Right to Life,” *National Right to Life*, 2016.

68 Ibid

69 Dehlendorf and Weitz, 415

70 Esmé Deprez, “Abortion Clinics are Closing at a Record Pace.”

71 Kari White, PhD, MPH, Kristine Hopkins, PhD, Abigail Aiken, MD, PhD, Amanda Stevenson, MA, Celia Hubert, MA, Daniel Grossman, MD, and Joseph Potter, PhD, “The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas,” *American Journal of Public Health*, 105, no. 5 (2015): 855.

72 White et al, 854.

73 Caitlin Gerds, PhD, MHS, Liza Guentes, MPH, Daniel Grossman, MD, Kari White, PhD, MPH, Brianna Keefe-Oates, MPH, Sara Baum, MPH, Kristine Hopkins, PhD, Chandler Stolp, PhD, and Joseph Potter, PhD, “Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas,” *American Journal*

nationwide have no known health care facility that provides abortions, and the number of such facilities is declining over time.⁷⁴ Because of this, any woman who requires an abortion and lives in these areas is forced to take time off work to travel to the nearest clinic, pay for transportation and lodging, and incur other expenses outside of the cost of the actual procedure itself. In a study published in May 2016, 23% of women obtaining abortions in Texas had out-of-pocket expenses of more than \$100.⁷⁵

Abortions incur not only financial risks, but also threats to personal safety. To date, over 80% of clinics have experienced threats and harassment toward patients and staff because they perform abortions.⁷⁶ Women often become entangled in anti-choice / pro-life protests of abortion clinics; a “normal” day for an abortion patient can require “running a gauntlet of protesters, [or] having her confidential medical information made public.”⁷⁷ While, theoretically, abortions are performed confidentially, “in rural areas and small towns a young woman may find that confidentiality is impossible to maintain.”⁷⁸ This can severely jeopardize the safety of the woman. Medical procedures are usually only dangerous if there is a risk of health repercussions from the procedure itself. Abortions, however, are dangerous in that patients are villainized and often directly threatened. This danger applies to women of all levels of wealth, not just low-income women.

Even once a woman has reached a clinic that provides abortion services, thirty-five states require that women first receive counseling⁷⁹ before an abortion is performed. Twenty-seven of these states also have mandatory waiting periods after counseling, typically twenty-four hours, before an abortion can be performed.⁸⁰ If a woman resides in any of these twenty-seven states, she is required to wait at least a full day between arriving at the abortion clinic and receiving her abortion. As previously mentioned, however, many states do not have easily accessible abortion clinics, and, if a woman has had to travel to get her abortion, she would have to accommodate this mandatory waiting period into her travel plans.

If a woman with Medicaid living at the federal poverty level in Lubbock, Texas finds out that she is pregnant and desires an abortion, she has myriad barriers before she can access the procedure. From Lubbock, the nearest clinic providing abortion services is in Dallas, Texas. She would need to travel to Dallas from Lubbock, a three-hundred forty-six mile trip. Assuming that she even has a reliable source of transportation to get her to Dallas (a five hour trip), she would then need to make an appointment with the clinic, travel there, receive counseling attempting to discourage her from terminating her pregnancy, wait the mandatory twenty-four hour waiting period between counseling and procedure, and only

of Public Health 106, no. 5 (2016): 861.

74 Dehlendorf and Weitz, 416.

75 Gerds et al, 859.

76 Fried, 176.

77 Ibid.

78 Fried, 182.

79 Counseling can include information on the medical risks of having an abortion, details about the procedure and gestational age of the fetus, and reasons why some women choose not to have an abortion. Some states even necessitate providing false information about abortion increasing risk factors for breast cancer and other correlations that have been scientifically disproven.

80 Guttmacher Institute, “Counseling and Waiting Periods for Abortion,” *Guttmacher Institute*, 2016.

then could she undergo the actual abortion. In order to obtain an abortion, this woman has had to pay the full cost of the procedure, since Texas does not provide abortion coverage under Medicaid, pay for lodgings and transportation, and potentially miss two paid days of work. Additionally, she may have needed to pay for childcare depending on whether or not she has children. If she lived in North Carolina, Missouri, Utah, or Oklahoma, she would have had to wait seventy-two hours before obtaining her abortion,⁸¹ stretching the time necessary for obtaining the procedure to more than three days. This is virtually impossible for any low-income woman who needs to hold a steady job to make a living. Many low wage jobs do not offer vacation time or sick days, and a woman living in one of these states trying to have an abortion could lose employment because of this.

The Option of Adoption

Many would propose that, in the absence of abortion availability or the resources necessary to raise a child, a low-income mother should put her child up for adoption after its birth. Much of the time, this is a great option that often benefits both the child and the mother after that child is born. Putting a child up for adoption can provide a higher quality life for a child whose parent(s) are not ready to raise them, emotionally or financially. That said, pregnancy is not inexpensive and many low-income women cannot afford to carry a pregnancy to term in the first place. Doing so requires paying for numerous doctors visits and prenatal care and medications, taking time off work to give birth to the child and recover in the postpartum period, enduring the stress and emotional consequences of carrying a baby for forty weeks and then giving it up to be raised by another family. While adoption is a great option for many women, it is not always viable for low-income women, and it is certainly not a solution to the issue of low-income women's entrapment in a cycle of poverty because of their reproductive system.

Conclusion

The costs of obtaining an abortion, both financial and otherwise, make abortions virtually inaccessible for low-income women. The Hyde Amendment makes it particularly difficult for low-income women to access pregnancy termination, as do mandatory waiting periods and clinic closures. Many women are forced to travel extensively and expensively, face severe financial risk, and battle myriad other obstacles in obtaining their abortions. Many others find these obstacles insurmountable and must carry out the For many low-income women, the barriers to obtaining abortions are so high that "it is as if abortion had never been legalized."⁸²

Section Three: The Effects of Diminished Reproductive Autonomy

Because low-income women face massive barriers in accessing contraception and abortion services, they have very little control over whether or not they become pregnant and, subsequently, are typically forced to carry the child to term. However, after bringing a child into the world, whether by choice or by lack of reproductive autonomy, low-income

81 Ibid.

82 Fried, 178.

women continue to face incredible difficulty due to unfavorable welfare policies. While welfare policies theoretically intend to provide aid to poor mothers, they are typically unable to provide the necessary funds for adequate child rearing, making it extremely difficult to be a low-income mother.

Federal Welfare Programs

In 1935, Franklin D. Roosevelt signed the Social Security Act into law, one facet of which created a cash assistance program to aid low-income families with providing for their children. Aid to Families with Dependent Children (AFDC) was a federal assistance program that provided cash for children who had at least one absentee parent, which was defined as a father or mother absent from the home because they were “incapacitated, deceased, or unemployed.”⁸³ AFDC was an active part of the federal government for over sixty years until, amid concerns that federal programs for poor mothers incentivized living on welfare rather than attempting to gain employment, Bill Clinton signed the 1996 Personal Responsibility and Work Opportunity Act (PRWOA).⁸⁴ This act instated Temporary Assistance to Needy Families (TANF), which came to be referred to colloquially simply as “welfare.” TANF provides “poor people, mostly female-headed households and their children” with “a monthly cash payment for food, rent, and other basic necessities.”⁸⁵

Temporary Assistance to Needy Families had a similar goal as Aid to Families with Dependent Children in that both acts aimed to provide financial assistance to low-income families with children. However, TANF provided much more restrictive limitations and much smaller funding for families. For example, while TANF is technically available for families that are able to “demonstrate need,” this benchmark is highly subjective; there is no federal standard for TANF eligibility and states determine their cutoffs independently and, it seems, somewhat arbitrarily. The maximum monthly income for families receiving TANF varies from \$1829 in Wisconsin to \$268 in Alabama for single mothers with two children.⁸⁶ Wisconsin’s cutoff allows for families slightly above the poverty line (\$1680 per month for a family of three) to receive welfare benefits, but Alabama only provides benefits at 16% of the federal poverty level. This leaves women in a strenuous situation wherein they may live under the federal poverty level and could qualify for welfare benefits in a state like Wisconsin, but not in Alabama. If they happen to reside in Alabama, they are likely to struggle to pay for their children because the very government program designed to help them provide resources for their families denies them assistance because they are not “poor enough.”

One of the most restrictive aspects of the 1996 welfare reform was the instatement

- 83 Office of the Assistant Secretary for Planning and Evaluation, “Aid to Families with Dependent Children (AFDC) and Temporary Assistance for Needy Families (TANF) – Overview,” *U.S. Department of Health and Human Services*, November 30, 2009.
- 84 Office of Child Support Enforcement, “The Personal Responsibility and Work Opportunity Reconciliation Act of 1996,” *U.S. Department of Health and Human Services*, November 1, 1995.
- 85 Joel Blau, *The Dynamics of Social Welfare Policy* (Oxford: Oxford University Press, 2004), 287.
- 86 Gene Falk, *Temporary Assistance for Needy Families (TANF): Eligibility and Benefit Amounts in State TANF Cash Assistance Programs*, Washington DC: Congressional Research Service, July 22, 2014.

of time limits, which permitted welfare recipients to receive welfare for a limited amount of time. After this period, it is presumed that the welfare recipient should have become employed by that time and welfare subsidies are cut off for the family. These time limits are designated directly by the states. While there is some evidence that time limits may be an effective incentive to encourage people on welfare to seek employment, upon studying the data from TANF's implementation, "the cancellation of welfare benefits at a time limit [do not] induce many recipients to go to work."⁸⁷ That is, the limitations imposed on welfare recipients are largely unfruitful and are more restrictive than they are beneficial.

The Costs of Child Rearing

The average total cost to a low-income mother raising a child from birth to age eighteen is around \$176,550.⁸⁸ For a low-income woman to raise a child, she needs to earn an average of \$9,808 in yearly expendable income for food, education, and other supplies. This amounts to \$817 per month spent only on the child. If a single, low-income woman living at the federal poverty level has a child, she has approximately \$1335 in average total monthly income,⁸⁹ leaving only \$518 for her to spend on housing, food, and other necessities for herself each month.

The benefits from AFDC did not adequately compensate for the cost of raising a child. Benefits ranged from between \$703 per month in New York to \$120 in Mississippi for a family of three.⁹⁰ Considering that the cost of raising a child equates to around \$817 per month, even an AFDC grant in New York only covers 86% of the necessary amount. This reveals a deficit in the program that, because of the financial benefits it provides low-income individuals, was cut for being seen as too generous. After transitioning to welfare from AFDC, the benefits provided by states for low-income mothers range from \$1005 per month in Minnesota to \$170 in Mississippi.⁹¹ While the funds provided from a state like Minnesota do exceed the \$817 benchmark, Minnesota and Alaska (at \$923)⁹² are the only states that provide benefits above \$817 per month. That is, most states do not provide adequate funding for low-income women, even though the legislation of TANF directly attempts to meet the goal of providing living wages for low-income mothers.

The financial strains placed on working mothers clearly necessitate the need for further government benefits, but it is also important that mothers are able to keep a steady job in order to contribute to the cost of raising a child. Jobs in the service industry typically require the least experience and education of any job type, making them accessible to low-income individuals who have not earned college degrees or cultivated a resume. Generally, however, service industry jobs provide relatively low wages.⁹³ When utilized as a sole source

87 Dan Bloom, Mary Farrell, Barbara Fink, and Diana Adams-Ciardullo, *Welfare Time Limits: State Policies, Implementation, and Effects on Families*, Washington, DC: Department of Health and Human Services Administration for Children and Families, 2016.

88 CNN, "How Much Will it Cost to Raise Your Child," *CNN Money*, 2016.

89 Office of the Assistant Secretary for Planning and Evaluation

90 Pub. L. 74 - 271, 74th Cong. (1935).

91 Congressional Research Service, *Maximum Monthly TANF Cash Benefit Amounts for Households Headed by Single Parent, By Family Size and State, July 2010*, Washington, DC: House Ways and Means Committee, 2012.

92 Ibid.

93 Eve Tahmincioglu, "The 8 Lowest-Paying Jobs in America," NBC News, 2016.

significantly worse for women than it is for men, with women earning an average of 78.58% of what men earn for the same service jobs.⁹⁴ This indicates that it is more challenging for a single mother to earn enough to support a child than it would be for a single father because, from the beginning, she has a much more difficult time earning the necessary income.

Paid and Unpaid Maternity Leave

In addition to providing female employees with smaller wages than men, these service industry jobs do not account for the unique risks faced by working women in low-income positions. This often leads to women losing their jobs because of events like a pregnancy or child rearing and caretaking responsibilities that force them to take time off of work. Only 60% of all workers are covered by paid family leave policies; this number drops to 50% when considering low-income workers with access to paid leave.⁹⁵ While some low-income employees do have access to unpaid leave, they are often unable to take advantage of this because they already barely earn enough to cover basic payments. Taking unpaid time off of work, even for an unavoidable reason, is deeply disincentivized.

Currently, the United States is the only “developed” country to not offer federally subsidized paid maternal leave,⁹⁶ meaning working mothers have extremely limited options in their ability to take time off work after the birth of their child. The Family and Medical Leave Act covers up to twelve weeks of unpaid leave for employees in qualified industries. However, because this only applies to private-sector employers with more than fifty employees, public agency employers, or schoolteachers,⁹⁷ not all Americans are covered and low-income individuals are specifically left out.

Four states currently have laws requiring companies to provide paid maternal leave (California, New Jersey, Massachusetts, and Rhode Island),⁹⁸ but not even all of these states fully compensate for time taken off; the definition of “paid maternal leave” is flexible. For example, Rhode Island only pays 60% of a woman’s salary during her time off from work.⁹⁹ The Federal Employees Paid Parental Leave Act of 2015 covers maternity and paternity leave for federal employees,¹⁰⁰ which only make up about 7% of Americans.¹⁰¹ Overall, only 12% of Americans have access to paid parental leave (including maternity leave) and this number drops to 5% for low-wage earners.¹⁰²

By not providing low-income women with paid maternity leave, the United States forces women to choose between three options: (1) take unpaid leave from work, if their company happens to offer it, (2) not take the time off from work they need to fully recover

94 David McCandless, “Gender Pay Gap US,” *Information is Beautiful*, 2014.

95 The Council of Economic Advisers, *The Economics of Paid and Unpaid Leave*, Washington, DC: Executive Office of the President of the United States, 2014.

96 Ibid.

97 United States Department of Labor, “Paid Leave,” *United States Department of Labor*, 2016.

98 Ibid.

99 Ibid.

100 H.R. 532, 114th Cong. (2015).

101 Henry Blodget, “Guess What Percentage of Americans Work For the Government Now Versus the Late 1970s?” *Business Insider*, July 24, 2012.

102 Lyndsey Gilpin, “10 Things You Need to Know About Maternity Leave in the US,” *TechRepublic*, May 8, 2015.

from giving birth, forcing them to send their child to a daycare very early or leave them at home with a friend or relative, and (3) lose their jobs by taking off time they were not afforded by their employer. All three of these options have drastic consequences for low-income women. About 50% of women who took paid or unpaid maternity leave returned from work within three months of childbirth between 2005 and 2007.¹⁰³ However, not taking adequate time off from work after giving birth can have physical and mental health implications for both the mother and the baby; forcing women to return from work before they are ready puts them at risk for serious medical complications. Additionally, a week's pay for a woman living at the federal poverty line is \$308,¹⁰⁴ meaning that even if a woman was to return to work after two weeks (which about 10% of all women do),¹⁰⁵ her income for that month would be reduced to \$616, which can result in her not being able to afford rent, food, and other necessities. And this is all assuming she even has a job to return to—many women are forced to quit their jobs in order to take time off to give birth to a baby.

The Expenses of Childbirth and Child Care

The actual birth of the child can also be vastly expensive. Birthing children is expensive and, for the 25% of low-income women without insurance, it is unsubsidized.¹⁰⁶ Without insurance, a vaginal birth costs around \$30,000 and a Cesarean section costs about \$50,000.¹⁰⁷ Medicaid covers about 98% of the cost of a vaginal birth and around 97% of the cost of a Cesarean section, making the out-of-pocket cost for the woman around \$600 and \$1,500 for vaginal and Cesarean births, respectively. While this coverage provides for a large percentage of the cost of a birth, Medicaid coverage still does not make birthing a child an affordable process. This disproportionately impacts the women who, as previously discussed, have very little opportunity to prevent pregnancy and birth.

Even after a low-income woman has given birth to a child, she is financially disadvantaged in her ability both to continue earning money and to obtain reliable childcare. Welfare “rarely cover[s] the unique risks faced by working women, such as the loss of income due to pregnancy and childrearing and caretaking responsibilities.”¹⁰⁸ For example, if a low-income mother is single, she is forced to bear the responsibility of caring for her child when he or she falls ill, potentially causing her to miss time at work, resulting in income loss. Three-quarters of women living below the federal poverty line are unable to use paid sick days to take care of a sick child, and one in five low-wage mothers reported losing a job within the last four years because they needed to take time off to care for a sick child.¹⁰⁹ Additionally, even if the mother does not lose her job, assuming she earns the average wage for workers without paid sick time, a “single working parent of two children cannot miss more than three days of work in a month without falling below the federal

103 Lynda Laughlin, *Maternity Leave and Employment Patterns of First-Time Mothers, 1961-2008*, Washington, DC: United States Census Bureau, 2011.

104 Office of the Assistant Secretary for Planning and Evaluation.

105 Laughlin, Lynda, *Maternity Leave and Employment Patterns of First-Time Mothers, 1961-2008*.

106 Truven Health Analytics, “The Cost of Having a Baby in the United States,” *Truven Health Analytics*, Ann Arbor: Truven Health Analytics, 2013.

107 Ibid.

108 Blau 142.

109 Liz Ben-Ishai, “Wages Lost, Jobs at Risk,” CLASP, February 13, 2015.

poverty line.”¹¹⁰ If anything goes wrong with the child’s health, it is the responsibility of the parents not only to financially support their child’s medical care, but also to forego the money they would have otherwise earned at work had their child not needed to stay home.

If a mother is expected to work, as most low-income mothers are forced to in order to make ends meet, she must find a way to afford childcare until her child is old enough to attend public school. Currently the Child Care and Development Fund (CCDF) provides childcare subsidies for low-income working families.¹¹¹ Generally, a family’s gross monthly income must be under 127% of the federal poverty level for them to be eligible for childcare subsidies.¹¹² For a single mother with one child, this requires that she earn a yearly income of \$20,345. The nationwide average cost of a month of day care is \$972.¹¹³ So, if a woman in a family of three is living just above the 127% benchmark for CCDF subsidies, her monthly income is reduced to \$1,695, or \$723 after subtracting average childcare expenses. This does not leave enough income to provide food and other necessities for the child (\$817 required monthly for such expenses), let alone rent or any other payments the mother might need to make. Even with a federal program like CCDF, childcare is rendered almost entirely unaffordable for low-income women.

Many single, low-income mothers “avoid or reduce the costs of child care by using informal care, and as a result single mothers who work are twice as likely to rely on relatives for care than are married mothers.”¹¹⁴ However, those who lack this option are left without a chance to work while they have a young child. A study done in 1974 found that the estimated cost of childcare had a significant negative effect on a woman’s ability to find and maintain a job.¹¹⁵

The Cycle of Government Dependency

One of the primary motivations in reforming welfare in the 1990s was the theory that providing benefits to low-income mothers and subsidizing the cost of childrearing incentivized remaining at a low-income level and continuing to absorb government funds. However, even women who work while on welfare in an attempt to extract themselves from the cycle of government dependency find it difficult to maintain jobs, largely because of the demands of childrearing. Most working-class women “work one shift at the office or factory and a ‘second shift’ at home,”¹¹⁶ where they take care of the household responsibilities. Hochschild estimates that women, on average, spend an equivalent of a full month executing their “second shift” responsibilities. For low-income mothers, this time spent maintaining a home often detracts from their ability to find and maintain their primary employment.

Although work is common among women on welfare, “much of it is short-term

110 Ibid.

111 Offices of Child Care, *Child Care and Development Fund*, Washington, DC. Administration of Children and Families, 2016.

112 Children’s Bureau, Inc., “CCDF Eligibility Guidelines,” *Children’s Bureau, Inc.*, 2016.

113 Center for Nutrition Policy and Promotion, “USDA Cost of Raising a Child Calculator,” *United States Department of Agriculture*, 2016.

114 Wenjui Han and Jane Waldfogel, “Child Care Costs and Women’s Employment: A Comparison of Single and Married Mothers with Pre-School-Aged Children,” *Social Science Quarterly* 82, no. 3 (2001): 553.

115 Ibid., 554

116 Arlie Hochschild, *The Second Shift* (Avon Books: New York, 1989), 4.

and relatively unreliable.”¹¹⁷ This results from a variety of factors, including a lack of education denying low-income women the ability to advance to better paying positions. If women on welfare were to follow the same employment paths as those who do not qualify for welfare with similar family responsibilities, they could theoretically be expected to work 30% more of the time.¹¹⁸ However, the very thing that makes them unable to work is their low-income status. For example, because they are not able to obtain jobs that provide them with sick days, they must risk losing their current jobs to take off time to care for their children.

There is a relatively common perception within American politics that low-income mothers remain in a cycle of poverty because of their decision to have children, not because of any exogenous factors maintaining their impoverishment. For example, the myth that if “single mothers got married, they need welfare,”¹¹⁹ places the blame for poverty on low-income women’s marital status. This is a myth because, while women who have children out of wedlock are at least three times as likely to need welfare than those who have children while married, this is simply a correlation and not a direct causation; these two-thirds of welfare recipients could not “have made themselves self-sufficient by marrying the man who fathered their children.”¹²⁰ Their poverty plays more of a part in the challenges they face raising their child than their unmarried status.

Similarly, the burden low-income women bear in their attempts to raise children does not arise from being teen mothers or from a lack of education, as many suggest.¹²¹ Instead, negative rhetoric creates a cycle of powerlessness, wherein the “social construction of target population framework... posits that society, the target population, and associated actors... [influence] whether they are viewed as politically powerful.”¹²² Additionally, “although the majority of public assistance recipients are white, welfare’s association with [people of color] in the public imagination continues to drive policy around poverty issues as a whole.”¹²³ In the case of low-income mothers, many are stigmatized as teen moms and “welfare queens,” effectively demonizing them and negating any public support by branding them as the undeserving poor.

In Conclusion, low-income women consistently face extreme challenges in exercising control over their reproductive system. This affects not only their capacity to be autonomous in their decisions of if or when to have children, but also their ability to raise the child they were effectively forced into having. Discussions of reproductive rights tend to focus on the effects policies have on women’s ability to exist and succeed without taking into account the policies that forced them into these situations in the first place. However, when low-income women are examined more closely, it is apparent that they are specifically victimized by the lack of reproductive autonomy they are afforded, which causes them to

117 LaDonna Pavetti, *How Much More Can They Work? Setting Realistic Expectations for Welfare Mothers*, Washington, DC: Urban Institute, 2012.

118 Ibid.

119 Kathryn Edin and Christopher Jencks, “Do Poor Women Have a Right to Bear Children?” *The American Prospect* 6, no. 20 (1995): 44.

120 Ibid.

121 Ibid.

122 Angel James and Moira Rashid, “‘Welfare Queens’ and ‘Teen Moms’: How the Social Construction of Fertile Women Impacts Unintended Pregnancy Prevention Policy in the United States,” *Policy, Politics, and Nursing Practice* 14, no. 3 (2013): 128.

123 Ann Cammett, “Deadbeat Dads and Welfare Queens: How Metaphor Shapes Poverty Law,” *Boston College Journal of Law and Social Justice* 34, no. 2 (2014): 236.

experience diminished agency in their decision if and when to have a child. Not allowing a woman any chance for reproductive autonomy virtually forces her into motherhood and can put her in the situation of not being able to afford her child or children. This has damaging effects for both the mother and child and, in the end, further perpetuates the cycle of poverty by denying low-income families adequate financial resources.

Conclusion

The barriers to reproductive autonomy faced by low-income women are, at least partially, an effect of the lack of intersectionality in the reproductive rights movement. While some reproductive rights organizations have moved to make costs less of a factor in obtaining reproductive autonomy, it is still virtually impossible in many regards for low-income women to control their reproductive systems. There are astronomical costs, both monetary and non-monetary, to control reproduction in such a way that allows a woman to determine when and if she has children. For example, a woman living at the federal poverty level faces significant barriers in trying not to conceive a child when she is not prepared to start a family, in trying to terminate a pregnancy once she does become pregnant, and in raising that child once she has given birth. That is, because low-income women are largely unable to exercise their reproductive autonomy, they become trapped in a cycle of poverty from which they cannot escape. If we are to do anything but require low-income women to cease any and all sexual activity, there needs to be a solution to both the monetary and non-monetary barriers to reproductive autonomy.

By reframing reproductive rights as a class-based issue rather than exclusively a gender issue, one is able to more easily see that, when reproductive autonomy comes into question, it is low-income women who are harmed the most, not just women at large. Because of this, it is thoroughly necessary for the reproductive rights movements to refocus their efforts away from providing aid primarily to middle- and high-class women who are already able to afford these services and move towards addressing the issues low-income women face. When reproductive rights organizations move to increase accessibility to contraception, abortion, or other facets of reproductive autonomy, they still leave these products out of reach for low-income women. By making their efforts effective for women at all income levels, the movement can increase all women's ability to maintain reproductive autonomy instead of just concentrating on those who can afford to do so.

While, reproductive rights certainly affects and is defined by gender, this should not be the sole area of concentration. Because women possess a reproductive system whereas men do not, any organization aiming to provide increased reproductive autonomy to individuals will virtually always concentrate their efforts on women. But, low-income women are disproportionately affected by assaults on reproductive autonomy. Some of these barriers to agency are legislative, indicating their intentionality, while some are mere products of a system crafted by and for individuals with middle to high incomes.

While there has been substantial work relating race to the reproductive rights movement, asserting that women of color have all too often been left out of the progress white women have enjoyed, the issue of socioeconomic class in reproductive rights has been relatively untouched as a subject of research. By analyzing the effects socioeconomic status has on a woman's ability to exercise her reproductive autonomy, we see that, while women are affected by assaults on autonomy, low-income women are the more specific victims. This reframing of the issue of reproductive rights as one based in class rather than exclusively in gender provides perspective where there was little before.

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