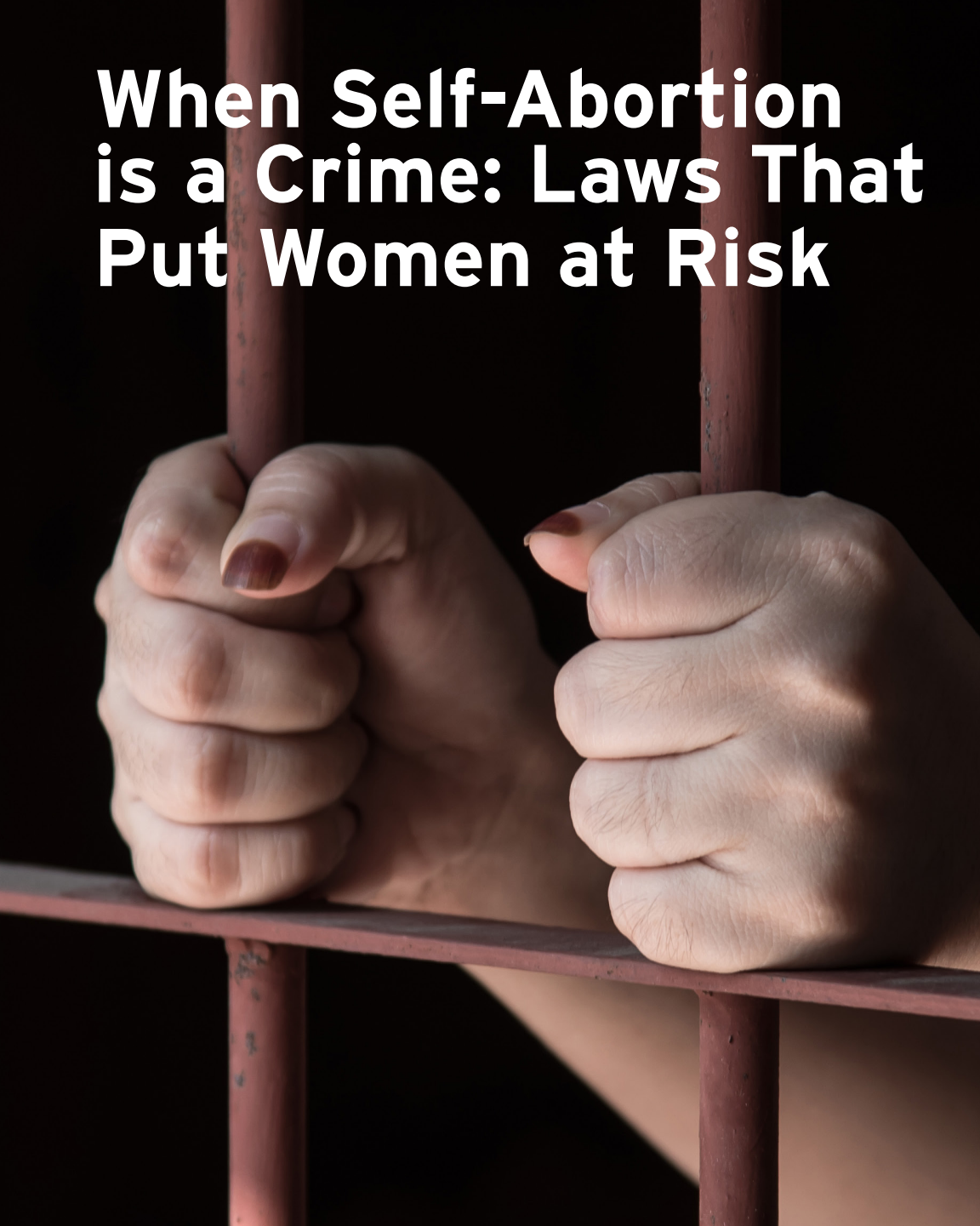


When Self-Abortion is a Crime: Laws That Put Women at Risk



A Report By:
The National Institute for Reproductive Health

June 2017

NIRH
National Institute for
Reproductive Health

The **National Institute for Reproductive Health** (National Institute) develops and implements innovative and proactive strategies on the state and local levels to galvanize public support, change policy, and remove barriers to reproductive health care, including abortion. Believing that a ground-up strategy is necessary to create lasting change, we work through a partnership model with organizations at the local, state, and national levels. We also engage in groundbreaking public opinion research and policy analysis to shape a new national conversation about reproductive freedom.

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National Institute for Reproductive Health

14 Wall Street Suite 3B

New York, NY 10005

Tel. 212-343-0114

info@nirhealth.org

www.nirhealth.org

Acknowledgements:

This report was written by Jordan Goldberg, Senior Policy Advisor, Rose MacKenzie, Policy Counsel, Winnie Ye, Policy and Program Associate, and Emily Kadar, Government Affairs and Advocacy Manager; with research assistance from Laura Narefsky, Legal Intern, and Shirin Dhanani, Legal Intern. Staff of the National Institute, including Andrea Miller, President; Maria Elena Perez, Chief Program Officer; Tara Sweeney, Vice President for Communications; Meredith Kormes, Associate Director of State Initiatives; and Danielle Castaldi-Micca, Director of Government Relations, contributed to and edited this report. Annie Zegers, Communications Assistant, and Zahra Bukhari, Communications Intern, designed this report.

Special thanks to Jill Adams, Melissa Mikesell, and Farah Diaz-Tello from the SIA Legal Team, and Diane Horvath-Cosper from Physician for Reproductive Health, who provided valuable feedback and guidance on this report. The National Institute also gratefully acknowledges the foundations and individual donors who make our work possible.

Contents

I.	Introduction	1
II.	Self-Abortion in the United States	3
III.	The Law Governing Abortion	8
IV.	How Criminalizing Self-abortion Hurts Women and Families	23
V.	Why is Self-abortion (Still) A Crime?	27
VI.	Focusing on Women’s Health and Safety	32

I. Introduction: Reflecting on the Criminalization of Self-abortion at a Pivotal Moment in American History

“Abortion is a fact of life. Women have always had them and they always will.”¹

Throughout history, women in the United States and around the globe have sought out abortions or induced their own when faced with an unintended pregnancy. The law governing their actions, however – as well as the legal consequences for those actions – has changed over time. Abortion was legal and generally available across the United States until the mid-1800s, when every state criminalized the practice.

From the mid-1800s until 1973, abortion was generally illegal across the country, but widely practiced at times by medical professionals and lay practitioners alike, as well as women themselves. Despite its illegality, throughout this period the general consensus was that the woman² herself was not a criminal.³ Indeed, only a few states ever enacted statutes specifically prohibiting women from inducing abortions upon themselves, and those statutes were virtually never enforced.⁴ “Self-induced abortion [was] never . . . treated as a criminal act.”⁵

In the 20th century, this phenomenon was generally viewed as an unfortunate – and potentially risky – result of lack of access to safe, legal, affordable abortion care from a medical provider.⁶ Although some women have safely and effectively used herbs or

drugs to end their pregnancies, self-abortion has also been associated with serious injury and death.⁷ After *Roe v. Wade* effectively made abortion legal across the United States in 1973, it was widely believed that the resulting arrival of safe and accessible abortion from medical providers would put an end to the conditions that had historically led women to take matters into their own hands.

But as we approach the 45th anniversary of *Roe*, our country sits at a new crossroads on abortion. Over the past four decades, and with a marked acceleration since 2010, state legislators in many parts of the country have created a patchwork of multiple, often-onerous restrictions on the provision of abortion care, such that while abortion remains technically legal, it not always accessible or affordable for women who need it. At the same time, there are now methods of self-induction that may be safe and effective.⁸

Now, even as women may be able to self-induce an abortion without attendant hazards to their health, they may face another serious complication: prosecution and incarceration. In a few states, including New York, inducing an abortion on oneself remains a crime. And, unfortunately, in

states where self-abortion is not an explicit crime, overzealous prosecutors have been over-reaching with other criminal statutes to punish women who act to end their own pregnancies.

Arguably, more than at any other time in the complicated legal history of abortion in the United States – from legal to illegal and back to legal again – the prosecution and imprisonment of women for inducing their own abortions and for other behavior during pregnancy has become a full-fledged

phenomenon, posing a great risk to their health and rights.⁹

This paper provides a historical perspective on the criminalization of abortion and self-abortion in New York and the United States and documents the harm such laws have on the health and lives of women and their families. It also suggests some policy approaches that would lead to better health outcomes for women and expand women’s ability to fully exercise their own constitutional rights.

II. Self-Abortion in the United States

During the 18th and early 19th centuries, self-abortion was the most common form of abortion.¹⁰ Women took drugs to “restore” or “bring on” their menses, often using herbs and plants that could be found in the woods or grown in home gardens, sometimes based on recipes written for this purpose in home medical guides.¹¹ Growing, taking, and selling these herbs and drugs was entirely legal, and by the mid-19th century was a booming business.¹² Local apothecaries had a large trade in herbal and other abortifacient preparations and “female remedies,” and the mid-1800s saw a “great upsurge of abortion.”¹³ In fact, the first statutes that criminalized abortifacients were poison control laws designed to protect women from harmful drugs and did nothing to regulate the act of self-inducing an abortion.¹⁴

Once states began to criminalize abortion in the mid-1800s, many women turned to illegal abortions provided by practitioners, while others ended their pregnancies with herbs, drugs, or physical trauma. Women sought out illegal abortions or performed their own abortions for the same reasons as they had when it was legal – to end unintended pregnancies. A study of the history of illegal abortions among low-income women in New York City found that most who attempted an abortion did so in the middle of their child bearing years and the procedure was “predominately used to stop pregnancies that came at an inappropriate time or from a union that was unsatisfactory[.]”¹⁵

The actual rate of abortions during the period in which abortion was mostly illegal is difficult to estimate, although a few studies and analyses have attempted to do so. One expert writing in 1860 believed that one in every five pregnancies ended in abortion across the United States.¹⁶ Another assessment, during the 1950s,

estimated the frequency of illegal induced abortions to be somewhere between 200,000 and 1.2 million annually.¹⁷ An analysis that extrapolated from North Carolina data estimated that there were 829,000 illegal abortions in 1967,¹⁸ while another extrapolating from the CDC’s death rate from illegal abortion estimated that 130,000 illegal abortions took place in 1972.¹⁹ Further, studies have concluded that in the early years of legalization, about two-thirds of legal abortions in effect replaced illegal procedures, and one study estimated that meant there were perhaps somewhere between 2.5 and 6.4 million illegal procedures performed in the 4-7 years prior to legalization.²⁰

Although abortion was illegal in almost all circumstances between the mid-1800s and 1973, there were ways to legally end a pregnancy for women with means, particularly those who had a longstanding relationship with a physician.²¹ Many states required a standing committee in a hospital to review abortion requests, meaning that a

woman would need to pay for both the review process and the procedure itself.²² In the mid-20th century, travel to the United Kingdom, Japan, or the handful of states that liberalized their abortion laws before *Roe v. Wade* was another option for women, but of course only for those who could afford the travel on top of the price of the procedure.²³ This meant that low-income women were much more likely to turn to illegal abortion, and many would likely turn to self-induction.²⁴ According to one study, women from the poorest neighborhoods in New York City who faced an unintended pregnancy had little access to medically supervised abortion and mostly tried to terminate their own pregnancies.²⁵

A survey of women in 1965 asking about their reproductive health history found that 80% of those who had reported abortion attempts had tried a self-abortion, and only 2% had had a physician involved in any way.²⁶ Another study by Dr. Judith Belsky at Bellevue Hospital in the 1960s showed that many of her patients attempted self-abortion both before and alongside attempting legal abortions, including by taking drugs, mechanical interference with the pregnancy, or physical trauma.²⁷ Among 199 patients seeking therapeutic, legal abortions, a third had already tried to self-induce or obtain an illegal abortion, and more than 80% of those who were denied a legal abortion ended up self-inducing or having an illegal abortion.²⁸

Studies documented that “the number of deaths following illegal abortions was significant. In the late 1920s, a Children’s Bureau study documented that at least 11 percent of deaths related to pregnancy and childbearing followed illegal abortions.”²⁹ Moreover, to the extent it is possible to document, the mortality and morbidity rates due to illegal abortion demonstrated a clear class and racial disparity in access to safe versus unsafe abortion, as well as a likelihood of a higher rate of self-abortion among women of color who were also often low-income, especially black and Puerto Rican women.

In the post-World War II years, Puerto Rican immigration to the mainland United States increased exponentially,³⁰ but when they arrived, Puerto Rican women frequently lacked access to health care and were historically the targets of a number of forms of reproductive oppression and coercion.³¹ In the United States, they and other “poor women, lacking funds, often used inexpensive, and often dangerous, self-induced measures” and might not have been able to afford follow-up medical care when there were complications.³² Between 1960-62, one out of two maternal deaths among all women of color was caused by abortion and specifically among Puerto Rican women, as compared with one out of four for white women.³³

The mortality and morbidity rate in the 1960s among her patients, particularly her low-income patients of color, led Dr. Belsky

to conclude that “broad restrictions on abortions . . . may result in severe distress among these patients, possibly leading to dangerous attempts at self-abortion and to emotional breakdown” and that access to abortion should therefore be available “on request in meeting the physical and psychological health needs of disadvantaged women.”³⁴ The mortality rate due to illegal abortions for non-white women from 1972-1974, the time period straddling legalization, was 12 times that for white women.³⁵

After *Roe v. Wade* in 1973, self-abortions continued for a variety of reasons, including lack of access to providers; language barriers; restrictions on public insurance coverage, such as the Hyde Amendment; or a lack of trust of the medical system.³⁶ Then, in the late 1980s and the 90s, there were public discussions within the feminist movement of a need for the widespread return of “self-help” abortions, “menstrual extractions”, and/or groups like the Jane Collective, an underground network that safely performed illegal abortions from 1969 until the procedure was legalized.³⁷

These discussions were prompted by new threats to access to abortion from state legislatures, a closely divided U.S. Supreme Court, and a significant and frightening increase in violence and harassment aimed at clinics and health care personnel involved in abortion care, along with the ongoing financial burdens posed by the lack of insurance coverage for abortion.³⁸

Around the same time, in 1994, Loretta Ross and a group of other prominent women of color created a new framework to view and advocate for reproductive freedom as an aspect of social justice, calling it reproductive justice. Recognizing that there were ongoing threats not just to abortion access but to the full range of reproductive decision making for women of color, this framework was developed to ensure that the constitutional rights to privacy, liberty, autonomy, and dignity meaningfully protected the most marginalized women – poor women of color – whose decisions about reproduction are limited not only the legality of abortion, but by the availability and accessibility of abortions, state-sponsored eugenic sterilization, punitive limits on funding for women who have children while receiving public benefits, and a host of other related reproductive oppressions.³⁹

The reproductive justice movement grew from these and other convenings and began to advocate for the repeal of the Hyde Amendment and broader access to abortion for women of color, and for policies that ensure that all people have “the right *not* to have a child[;] the right to *have* a child; and [t]he right to *parent* children in safe and healthy environments.”⁴⁰

In the last decade, there has been a marked increase in interest by both researchers and the media in the incidence and circumstances of self-abortion worldwide. Since the discovery that misoprostol, commonly used to treat ulcers, can be used

alone as an abortifacient and the subsequent development and approval of the mifepristone/misoprostol combination for medication abortion, self-abortion has become both potentially safer and less obvious.⁴¹ Although the combination of mifepristone and misoprostol is the standard of care for medication abortions up to ten weeks in the United States, with a 95% or more effectiveness rate,⁴² misoprostol used appropriately alone is 85% effective and will safely end most pregnancies under 16 weeks gestation.⁴³

After *Roe v. Wade* in 1973, self-abortions continued for a variety of reasons, including lack of access to providers; language barriers; restrictions on public insurance coverage, such as the Hyde Amendment; or a lack of trust of the medical system.

Two studies that tried to measure the incidence of self-induction in the United States from 2008 to 2010 suggested that it was still quite uncommon: slightly under 3% of abortion patients surveyed at clinics reported taking something to try and cause an abortion prior to coming to the clinic (1.2% had self-administered misoprostol and 1.4% had used some other substance such as vitamin C or herbs), and 4.6 % of respondents who had ever been pregnant reported attempting self-induction at some point in their lives.⁴⁴ It should be noted that these are patients who were seen in abortion clinics, and might not represent

the full number of women attempting self-abortion, as women who successful self-abort would not likely visit a clinic.

After 2010, however, the landscape of abortion access again changed dramatically, with hundreds of new abortion restrictions enacted, particularly at the state level. Seven years later, more than half of all states are classified as “hostile” or “extremely hostile” to abortion.⁴⁵ These restrictions have significantly decreased access to abortion services – 57% of American women of reproductive age live in these hostile states, and 39% live in a county with no abortion clinic.⁴⁶

There have been several attempts to determine if self-abortion has become more common as a result of these restrictions. A 2014 survey of abortion patients found comparable numbers to the 2008 survey – 1.3% of abortion patients reported that they had ever taken misoprostol – although the practice was becoming more dispersed throughout the United States.⁴⁷ A 2015 survey in Texas estimated, based on survey data that somewhere between 100,000 and 240,000 women had attempted self-abortion at some point in their lives.⁴⁸

The New York Times performed an analysis of Google searches across the United States for information about self-abortion and found that there were more than 700,000 searches looking for information on self-abortion in 2015 alone.⁴⁹ Eight out of ten of the states with the highest search rates

were those classified by the Guttmacher Institute as hostile or extremely hostile to abortion.⁵⁰ Moreover, searches for information on self-abortion experienced a 40% leap in 2011, just as the increase in abortion restrictions got underway.⁵¹

In 2015, after a number of abortion restrictions had passed in Texas, researchers concluded that:

Poverty, limited resources, and local facility closures limited women's ability to obtain abortion care in a clinic setting and were key factors in deciding to attempt abortion self-induction. This is consistent with other research indicating that barriers to accessing clinic-based care are an important reason why women decide to attempt to self-induce their abortion.⁵²

When asked why they sought to induce an abortion on themselves, study respondents identified the closure of their local clinic and not having the money to travel or to pay for a procedure as two of the four primary reasons for attempting self-abortion, even though they would have rather have had their procedure at a clinic.⁵³ Self-induction was also more common in women who "reported that they had ever found it difficult to obtain reproductive health services," showing that accessibility of health services overall has an impact on women's decisions.⁵⁴ Some women in Texas also identified the shame and stigma associated with abortion as one of the primary reasons for self-inducing,⁵⁵

while others discussed self-induction as being more in line with their religious and ethical views.⁵⁶ In addition, some women self-induce abortions out of concerns about interacting with the medical system, preferring to have control over their own abortions.⁵⁷

In a 2016 article, Glamour surveyed 15 abortion providers in more than 10 states about this issue and "most . . . said they knew of women trying to self-induce abortions; five had seen patients who had attempted it."⁵⁸ The founder of Women on Web, an organization that mails misoprostol to women in countries where abortion is banned, said she received "nearly 600 emails last year from Americans frantic to end pregnancies under hard circumstances."⁵⁹ A group of anonymous activists said that "together they've helped at least 275 women perform abortions at home."⁶⁰

Women have turned to self-abortion for centuries, during periods of legality and illegality, for many of the same reasons – lack of access to a medical professional, logistical accessibility, financial barriers, cultural barriers, or because they do not want to engage with the formal medical system.⁶¹ As the numbers of state-level abortion restrictions have sky-rocketed, clinics have closed, and many women struggle to afford abortion, more women may be turning to self-abortion.

III. The Law Governing Abortion

In New York, the law regulating abortion has a long and complicated history, tied in with English common law and multiple revisions of the statutory criminal law, and buffeted by changes in policy positions on the part of the medical community, legal community, political parties, social movements, and religious organizations. In order to fully understand New York’s current law, particularly its unusual criminal prohibitions on self-abortion, it is necessary to understand how the law developed and was implemented and viewed over time.⁶²

a. Legal abortion in early American history

Throughout documented human history, the law was often neutral regarding the actions women and sometimes their healthcare providers or helpers took to prevent and terminate unintended pregnancies.⁶³ “Greek and Roman secular law and Jewish and Christian theology all recognized that there were times and circumstances where birth control and abortion were acceptable. At the time when the United States was founded, under English law, birth control and abortion were mostly legal, acceptable and used.”⁶⁴

Before modern medicine, women often obtained information from other women in their communities and used exercise, herbs, teas, drugs, or tools to induce a miscarriage.⁶⁵ Sometimes women acted with good information and safely ended their pregnancies – in other situations, women acted alone but unsafely or sought out care from unscrupulous providers who left them injured, or worse.⁶⁶ Nonetheless, as medical treatment developed, women

were often able to seek out relatively safe care from providers based in their communities, called “irregulars” to distinguish them from “regular” licensed physicians.⁶⁷

In this early period in United States history, abortion was not a criminal act until “quickening” (the point at which movement can be felt by the pregnant woman) and was not a crime at any point in pregnancy in some places.⁶⁸ “Quickening” is “a phenomenon which occurs in different times in different women, and in the same woman at different times in different pregnancies, but ordinarily takes place between the sixteenth and eighteenth week.”⁶⁹ “It is undisputed that the woman herself was not indictable for submitting to abortion or aborting herself, before quickening. . . . It was not a crime at all.”⁷⁰

After quickening, an abortion was sometimes considered a misdemeanor “on the part of the abortionist, and perhaps of the woman as well,”⁷¹ but the U.S. Supreme Court found that “it [is] doubtful that abortion was ever firmly established as a

common-law crime even with respect to the destruction of a quick fetus.”⁷²

Rather than being criminalized, under the common law, all women were viewed as having the liberty to terminate a pregnancy.⁷³ Indeed, common law held a “treasured value” for personal liberty, even when it could only be pursued at great cost; “though abortion was ‘dangerous to life’ [our forbearers] allowed women to risk it before quickening, without paternalistic interference from the State.”⁷⁴

b. Criminalization

In the 1800s, the modern medical landscape was just beginning to develop. The medical field was still mostly unregulated, and medicine was practiced by a mix of university-trained “regular” doctors, “irregular” health care providers (including “midwives . . . other, non-university-trained doctors”), and some “outright quacks.”⁷⁵ Medical discoveries about sanitation, hygiene and bacteria were leading to safer medical procedures in general, although surgery was still very dangerous.⁷⁶

"Fearing prosecution, many physicians treated their female patients badly – . . . questioning them in attempts to gain" information that could be used in prosecuting someone else "or delaying or refusing to provide needed medical care."

The first wave of criminal abortion laws were apparently motivated solely by concerns about patient health, and were not necessarily even particularly related to

concerns about abortion. “[T]here is some evidence that America’s first law that banned the giving of a ‘potion’ to cause an abortion in a woman ‘quick’ with child, in Connecticut in 1821, came out of an effort by physicians to ban all homemade remedies, whether for abortion or not, as simply being too dangerous.”⁷⁷ The Connecticut law did not criminalize the woman’s actions; indeed, one scholar characterized this law as “cho[osing] to preserve for Connecticut women their long-standing common law right to attempt to rid themselves of a suspected pregnancy they did not want . . . even though they risked poisoning themselves in the process.”⁷⁸

Similarly, the first criminal abortion law in New York in 1828 appears to have grown out of concern about surgery in general:

[B]efore the era of antiseptic surgery, about 30 percent of all serious operations, including abortion, resulted in death. During the same period, the death rate from childbirth was about 2 percent [so] the revised abortion law was drawn up not out of any legislative concern for the unborn child – in whom the Legislature had never expressed an interest – but out of concern for the life of the mother who had 15 times as great a chance of surviving childbirth as of surviving an abortion.⁷⁹

The 1828 New York criminal abortion statute also contained a “therapeutic exception” permitting abortion if the woman’s life was at risk – supporting the theory that the law was intended to protect

the woman's health: "If one's life would be endangered if the operation were not performed, it was only reasonable to allow the patient to gamble on surviving the operation."⁸⁰

At the same time, the medical profession had begun to organize around its own interests and sought to protect its profession from competition from non-physicians, such as midwives, traditional healers, herbalists, and others.⁸¹ The American Medical Association was formed in 1841 and soon focused on putting non-physicians out of business, including those who provided abortions.⁸²

No consensus about abortion existed in the medical community, with many physicians supporting and performing abortions while others focused on the developing fetus and opposed abortion.⁸³ However, beginning with the AMA in 1859, organized medical societies strongly opposed legal abortion and campaigned for restrictive laws that would leave the decision about whether to provide any women with an abortion strictly in physicians' hands.⁸⁴

Other political forces were at work as well, ranging from anti-immigrant groups that wanted to ensure a higher birth rate among native-born Protestant white women⁸⁵ to some religious groups that believed that a pregnancy was a life that should not be able to be terminated to some groups of female advocates working to advance "social purity" after the Civil War.⁸⁶

By the mid-1800s, the confluence of these efforts led to a wave of criminal abortion laws that permitted abortions only in a small set of circumstances and only when performed by a physician, frequently in a hospital setting.⁸⁷ Many of these laws required a panel of physicians to sign off on the abortion before the woman could obtain it.⁸⁸ However, very few of states enacted laws criminalizing a woman's conduct in inducing her own miscarriage.⁸⁹

Further, in regulating abortion, the legislatures seemed to remain focused on the patient safety and health. One of the few courts to interpret an early abortion statute, the New Jersey Supreme Court concluded that the 1849 New Jersey abortion law "was not [designed] to prevent the procuring of abortions, so much as to guard the health and life of the mother against the consequences of such attempts."⁹⁰

Others have noted that the "laws were aimed at regulating the activities of apothecaries and physicians, not at dissuading women from seeking abortions."⁹¹ Even states that prohibited self-abortion seemed concerned with protecting women's health rather than intending women to be prosecuted – "legislators had to find some way to deter women from what seemed to be causing their own destruction."⁹²

c. Early impact of criminalization on women

Despite the newly criminalized status of abortion, the numbers of abortions did not go down, with hundreds of thousands of women around the country continuing to seek out and have them.⁹³ Indeed, by the mid-1800s, as these laws were being enacted, abortion rates appeared to be rising.⁹⁴ “Abortion in the nineteenth century appears to have been concentrated in the middle and upper classes . . . and many writers felt that abortion was more common among the married than the unmarried”:⁹⁵

Beyond retrospective studies, there were more current, public indicators as well, including “the number of newspaper advertisements for abortifacients [which] serves as an indication of the size of the professional abortion trade in large cities towards the end of the century; one edition of the 1891 Boston Globe contained thirteen advertisements which offered ‘effective and painless’ remedies to ‘women in trouble.’”⁹⁶

Some of the methods used by women to end their own pregnancies were successful and relatively uncomplicated; according to one researcher, during this period “both midwives and physicians performed abortions, and many women induced their own abortions at home. At drugstores, women could buy abortifacients and instruments such as rubber catheters, to induce abortions. Most women survived their abortions, and most abortions

remained hidden from state authorities.”⁹⁷ Nonetheless, “[b]ecause the illegality of abortion compelled doctors to regard all miscarriages as suspect and to protect themselves against prosecution, women’s health care suffered. Fearing prosecution, many physicians treated their female patients badly – . . . questioning them in attempts to gain” information that could be used in prosecuting someone else “or delaying or refusing to provide needed medical care.”⁹⁸

d. Prosecutions

Enforcement of criminal abortion laws appears to have had two distinct periods, before the 1930s and after, as a result of the political climate and concerns about fertility rates during the different periods in United States history.⁹⁹

From the mid-1800s until about 1930, there were few criminal abortion prosecutions, and those only in cases where the woman died.¹⁰⁰ There are a variety of potential explanations for this, including that “a large segment of the public did not regard abortion as such a heinous practice.”¹⁰¹ Indeed, “[i]n most communities an unwritten agreement prevailed between law enforcement and practitioners: no death, no prosecution” and abortion providers both legitimate and otherwise publicly advertised their illegal services.¹⁰²

Where there were deaths, however, press coverage sensationalized them; indeed, some of the support for broad criminalization of abortion after the Civil

War seems to have been prompted by a wave of press coverage of abortion deaths in New York in the 1860s and 70s.¹⁰³ Nonetheless, it appears that no women were prosecuted for self-inducing during this period, although some states did criminalize it.¹⁰⁴

Prosecutions of practitioners of illegal abortions ramped up quickly in the 1940s.¹⁰⁵ Although public support for abortion access was actually building,¹⁰⁶ for a variety of reasons “prosecutors no longer focused their energies on the abortionists responsible for women’s deaths, but worked to shut down trusted and skilled abortionists, many of them physicians, who had operated clinics for years with little or no political interference.”¹⁰⁷ “[P]olice and prosecutors stepped up raids to abortionist’s offices,” collecting patient files and information that were then used to find former patients who would testify against the person who performed their abortions.¹⁰⁸

This shift in prosecutions resulted from a few broader societal changes: First, medical advancements made it possible to save more women’s lives after a botched abortion so there were fewer deaths overall; second, individual physicians were concerned about prosecution and, as a result, seemed more likely to turn women who came to them for help over to law enforcement;¹⁰⁹ and finally, because a broader and newly harsh focus on women’s morality made these prosecutions a useful tool to shame women.¹¹⁰

This new effort to prosecute practitioners who violated criminal abortion laws and expose the women who sought abortions appears to have been motivated by some of the latent racist, sexist rationales that animated the original enactment of the laws, including assumptions about women’s roles as mothers and the need to prevent women from having sex outside of marriage.¹¹¹ There became, in the words of one scholar, “a cultural mandate in postwar America,” enforceable by the medical establishment and the state, “to protect and preserve the links between sexuality, femininity, marriage and maternity,” at least for white, middle class women.¹¹²

Sexist ideas about women’s role in carrying pregnancies and raising children ultimately crossed race lines, as both white and black male leadership urged restrictions on women’s reproductive autonomy, even during the Civil Rights movement. Loretta Ross has written that between the 1920s through the 1970s, radical black male activists frequently opposed both contraception and abortion in order to build the black population and as a result political power: “Dick Gregory, a popular political activist, expressed his opposition to abortion rights in this way: ‘My answer to genocide, quite simply, is eight Black kids and another on the way.’”¹¹³

The abortion criminal trials became the focus of sensational press coverage and “transformed abortion from an everyday, if semi-secret, occurrence into a crime.”¹¹⁴ There were racial undertones to this wave of prosecutions as well, as “[b]lack women

who provided underground abortions were harassed and prosecuted more frequently than their white counterparts, especially white men.”¹¹⁵ Indeed, “police were especially eager to arrest women who performed abortions, regardless of their safety records.”¹¹⁶ Prosecutors actively tried to “catch women patients” in order to haul them into the court room as witnesses, routinely “put[t]ing their abortions on display for judge, jury and journalist.”¹¹⁷ Yet, prosecutions were still not aimed at the women themselves.

Legal abortion all but disappeared as well, for the same reasons. For those women who were able to obtain legal abortions through the newly created, difficult and complicated “therapeutic hospital board” process, they were frequently required to become sterilized at the same time, giving up their ability to choose to have children at all because they were unwilling to have a child at that particular point in time.¹¹⁸ By the 1960s, these boards no longer regularly approved many abortions.¹¹⁹ In 1965, only 300 requests for therapeutic abortions were approved in New York City annually, one-third of the number of legal abortions twenty years earlier.¹²⁰

The overall numbers of abortions did not seem to decline,¹²¹ even though “the number and rate of therapeutic abortions performed in U.S. hospitals plummeted,” and the increase in prosecutions in the 1940s and 50s directly reduced the availability of safe, albeit illegal, abortion.¹²² With more prosecutions and fewer physicians comfortable providing the care,

mortality and morbidity associated with abortion began to grow.

The lack of access to safe abortion, whether legal or not, also disproportionately affected women of color, and black women in particular, as white women appeared to have access to safer illegal abortions or to those hospital review boards, while black women were forced to find less-safe providers.¹²³ “One study estimated that 80 percent of deaths caused by illegal abortions in New York in the 1960s involved Black and Puerto Rican women. In Georgia between 1965 and 1967, the Black maternal death rate due to illegal abortion was fourteen times that of white women.”¹²⁴ Many of these deaths followed self-abortions.¹²⁵ Indeed, the proverbial clothes hanger became a symbol of self-abortion because women often resorted to violent and sometimes life-threatening methods.¹²⁶

As a brief from medical leaders to the California Supreme Court stated: “The hard, shocking – almost brutal – reality [is] that [criminal abortion laws] designed in 1850 to protect women from serious risks to life and health has in modern times become a scourge.”¹²⁷

e. The movement to reform abortion law

By the early 1960s, it was clear to many in the medical and legal fields that the law on abortion was no longer functioning. At the same time, the women’s movement began to focus on a woman’s ability to control her reproduction. A confluence of these and other social change factors created the

abortion rights movement and drove many states, including New York, to significantly change their abortion laws.

The initial stages of the abortion reform movement focused on the legality of “therapeutic abortions” for situations where there were health concerns regarding the woman or fetus or cases of rape or incest – despite the fact that most women seek abortions for other reasons, such as the need to complete education, care for existing children, or because of financial hardship.¹²⁸

In 1962, the American Law Institute (ALI), an influential independent scholarly organization that aims to clarify and improve American law, finalized and published a new abortion law model focused on protecting abortion providers from prosecution when performing abortions for those facing substantial physical or mental health risk, fetal abnormality, or pregnancy due to rape or incest.¹²⁹

That same year, Sherri Chessen Finkbine, a mother of four and children’s television host living in Arizona, was thrust into the national spotlight during her quest for an abortion.¹³⁰ In the initial months of her fifth pregnancy, she took thalidomide, a sleeping pill linked to children born with severe birth defects. After Finkbine went public with her story in an effort to warn other pregnant women against taking thalidomide, she was unable to obtain a therapeutic abortion in Arizona and ended up being forced to travel to Sweden to terminate.¹³¹ *Life* followed

the Finkbine story with other human interest stories spotlighting those seeking abortions in cases of fetal abnormality.¹³² *Harper’s Magazine* published a similar story entitled “The Right Not to be Born”, which “described the experiences of a Black woman who was denied an abortion after being exposed to the German measles.”¹³³

The American Medical Association (AMA) changed its posture on abortion, revising its position in 1967 and again in 1970. The 1967 revision proposed allowing legal abortions by a licensed physician in an accredited hospital with the written approval of two other consulting physicians, in select cases: “to safeguard the health or life of the patient, or to prevent the birth of a severely crippled, deformed, or abnormal infant.”¹³⁴

By the late 1960s, those opposed to the current abortion law included a wide and diverse array of organizations, professions and people: medical providers advocating reform, feminist activists calling for repeal, along with some population-control focused environmentalists, and large groups of liberal religious leaders, who served to counterbalance the Catholic Church’s loud opposition to any attempt to reform the abortion law.

By 1970, the AMA approved a dramatically different proposal, concluding that abortion should be regulated like any other medical procedure and that the “Principle of Medical Ethics of the AMA does not prohibit

a physician from performing in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.”¹³⁵ Neither statement addressed self-abortion or the criminal prosecution of women.

Although advocates originally sought abortion law reform, the women’s liberation movement soon adopted abortion rights as a primary cause and reoriented the approach from *reform* to *repeal*.¹³⁶ At the same time, black women activists were advocating both for repeal of abortion laws and an end to significant and unique reproductive injustices suffered by black and Latina women, particularly forced sterilization.¹³⁷ The prevailing notion at the time – that struggles around reproductive health were exclusively white women’s terrain – was reinforced both by the male leaders of the black power movement, who opposed reproductive freedom, and white feminist leaders, who often ignored the issues facing black and brown communities.¹³⁸

Moreover, the modern abortion rights movement has suffered criticism over the years from being overly concerned about and led by white women, with the accompanying myth that “abortion is a white middle-class women’s issue.”¹³⁹ These ideas and history sometimes causes the false perception that women of color were not involved in the movement to legalize abortion.¹⁴⁰ Frances Beal, the leader of the black Women’s Liberation Committee of the Student Nonviolent Coordinating Committee (SNCC), sought to

refute that assumption, writing in 1969 that, “Black women have the right and responsibility to determine when it is in the interest of the struggle to have children or not to have them and this right must not be relinquished.”¹⁴¹ Indeed, women of color were leaders in the abortion rights movement from the beginning, including women like Tennessee State Senator Dr. Dorothy Brown, “one of the first Black female general surgeons in the South” who introduced a bill to legalize abortion in 1967.¹⁴²

By the late 1960s, those opposed to the current abortion law included a wide and diverse array of organizations, professions and people: medical providers advocating reform, feminist activists calling for repeal, along with some population-control focused environmentalists,¹⁴³ and large groups of liberal religious leaders, who served to counterbalance the Catholic Church’s loud opposition to any attempt to reform the abortion law.¹⁴⁴ These groups ultimately united as a powerful and persuasive coalition to successfully urge abortion law reform and repeal in New York and several other states.

f. New York’s 1970 abortion law

The call for reform in New York began as a limited attempt to expand the very narrow law that permitted abortion only to save the life of the mother – a law which resulted annually in roughly 300 legal abortions but up to an estimated 100,000 illegal abortions, with 2,000 women dying each year and hundreds more suffering

from complications after a botched procedure.¹⁴⁵ States all over the country were beginning to reform their own abortion laws, adopting the American Law Institute's model recommendation: Between 1962 and 1972, thirteen states amended their laws to allow abortions in cases of rape, health risks, and fetal anomalies.¹⁴⁶

In December 1964, the New York Academy of Medicine became the first organization to recommend a change to the state's abortion law, issuing a report that urged reform.¹⁴⁷ The Academy mentioned the lack of uniform decision-making around what was considered a medically necessary abortion, called the existing abortion law "discriminatory" and "unsupported by logic," and recommended that the law be amended to allow therapeutic abortions when "there is a substantial risk that the continuance of pregnancy would gravely impair the physical or mental health of the mother, or that the child would be born with grave physical or mental defects."¹⁴⁸

What followed was a dramatic, multi-year process to change the New York law. Bills were introduced in the New York State Legislature in both 1966 and 1967 that would have reformed the law to allow abortions under the types of exceptional circumstances recommended by the New York Academy of Medicine report.¹⁴⁹ Although both bills had support from Governor Nelson Rockefeller, the United States Senators representing New York¹⁵⁰ and a growing number of medical and religious groups,¹⁵¹ each failed.¹⁵² When the

bills failed, advocates publicly vowed to break the law and help women find safe abortions. Lawrence Lader, Chairman of the Members of the Citizen's Advisory Committee on the Association for the Study of Abortion, said he would help women access "necessary medical services."¹⁵³ Another group consisting of twenty-one Protestant Ministers and Rabbis announced the Clergymen's Consultation Service on Abortion, which would also provide assistance to those in need of legal abortion.¹⁵⁴

By January 1968, the mood in the legislature and public had shifted. The Assembly Speaker began the session promising a vote on abortion reform.¹⁵⁵ Governor Rockefeller created a citizen's Committee on Abortion Law to consider the issue and make recommendations about reform¹⁵⁶ and strongly urged action, saying that abortion reform would "permit [New York] to catch up with...states and nations in this field" and alleviate "human tragedy."¹⁵⁷

The general public was also in favor of reform: According to the poll ordered by the Association for the Study of Abortion, if a referendum were held on January 1968, seventy-five percent of New Yorkers were in favor of reform with seventeen percent opposed and eight percent undecided.¹⁵⁸ Moreover, polling showed that 72 percent of Roman Catholics were in favor of updating the eighty-five year old law.¹⁵⁹ The 1968 bill initially passed a committee,¹⁶⁰ but despite the changing political environment and building pressure,¹⁶¹ this bill also failed

after a heated floor debate in the Assembly.¹⁶²

During the 1969-1970 legislative session, abortion reforms were buoyed by a changed political climate and new leadership.¹⁶³ The Republicans had won control of the Assembly and both the newly-elected Assembly Speaker, a Republican from Montauk, and the minority leader, a Democrat from Brooklyn, supported abortion reform. In the Senate, Republican Senate leadership was willing to bring the issue to the floor.¹⁶⁴ There were several bill versions in 1969, all focused on various exceptional circumstances, with a more progressive bill being worked up in the Senate while two narrower bills progressed in the Assembly.¹⁶⁵

When the Senate finally passed a bill, on March 18, 1970, it was a departure from the moderate reform legislation that had been pending in various forms since 1967. The Senate bill allowed abortion whenever agreed to by the woman and her doctor, with no gestational limits. The Assembly then had to consider whether to embrace this broader approach. As a compromise, the chief sponsor of the Assembly bill, Republican Assemblywoman Constance Cook accepted an amendment to limit abortion after 24 weeks to cases when the mother's life was in danger.

After an intense eight-hour debate on March 30th, the bill came close to failure.¹⁶⁶ Assemblywoman Cook angrily spoke out:

I submit to you we are not considering here today abortion on demand – we have that already. The only question is how abortions are to be had. Right now, if you have \$25 you can get an abortion in the back alley under the most abominable conditions, but if you have \$2,500 then you can go elsewhere and get a proper abortion. I hope we, in our debate, never lose sight of that fact. We now have abortion on demand...and what we are here to do is put the illegal abortionist out of business.¹⁶⁷

On April 9th, Assembly members voted again, although the bill was expected to fail by one vote. However, at the last minute, Assemblyman George Michaels, a Democrat from Auburn, changed his position. Tearfully, he stood and said, "I realize, Mr. Speaker, that I am terminating my political career, but I cannot in good conscience sit here and allow my vote to be the one that defeats this bill. I ask that my vote be changed from 'no' to 'yes.'"¹⁶⁸

Governor Rockefeller signed the abortion bill into law on April 11, 1970.¹⁶⁹ In its final form, the new law made abortion far more available in New York than it ever had been, allowing physicians to provide abortions up to 24 weeks of pregnancy, or thereafter to save a woman's life but notably not in order to preserve her health.¹⁷⁰ Despite this significant advancement, the reform law did not address the fact that abortions outside of these situations were still a crime, and that any self-abortion by a woman without the involvement of a physician, at any point in pregnancy, could be prosecuted.

g. The constitutional right to end a pregnancy

While advocates and activists in New York sought change through the legislative process, medical providers, other advocates, and lawyers were pursuing a different strategy through the courts. In the 1960s and early 1970s, legal scholars and then the courts recognized that the United States Constitution, as well as some state Constitutions, offered strong protection for many of the types of activities and decisions typically considered part of an individual's sexual and reproductive private life, including whether to use contraception or have an abortion.¹⁷¹ Although few of these cases touched directly on self-abortion, reviewing the underlying rationale for these decisions compels the conclusion that whether a woman turns to a medical provider to terminate her pregnancy or terminates it using methods of her own, her decision is protected.

Despite this significant advancement, the reform law did not address the fact that abortions outside of these situations were still a crime, and that any self-abortion by a woman without the involvement of a physician, at any point in pregnancy, could be prosecuted.

In 1965, the U.S. Supreme Court held that the Constitution protected a right to privacy, which extended to the rights of married couples to use contraception without fear of criminal prosecution.¹⁷² A few years later, the Court recognized that

unmarried individuals also had the right to decide whether to use contraception, stating: "If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."¹⁷³

In 1971, in *Abele v. Markle*, a three-judge panel of the United States District Court of Connecticut became the first federal court to consider an abortion statute, when a group of women, doctors, nurses, and medical counselors challenged three 19th century statutes about abortion. One of the three statutes at issue directly criminalized self-induction as well as making the woman the primary criminal in any abortion; the other two statutes criminalized anyone else's involvement in helping a woman to obtain or induce an abortion, except in cases necessary to preserve the life of the woman or fetus.¹⁷⁴

The court held that each of the statutes violated the Ninth Amendment and the Due Process Clause of the Fourteenth Amendment.¹⁷⁵ In so holding, the two-judge majority recognized that society's view of women had changed radically since 1860 and that "[t]he decision to carry and bear a child has extraordinary ramifications for a woman [including that childbirth presents some danger to life and health]," and that "determining whether or not to bear a child is of fundamental importance to a woman."¹⁷⁶

This was the first case in which a federal court found a criminal self-abortion law unconstitutional.¹⁷⁷ Although the Connecticut statutes directly criminalized self-induction, the court did not separately analyze the woman's actions – the lack of discussion strongly implies that the court believed the constitutional right necessarily extended both to women seeking abortions from providers and to women who choose to induce an abortion upon themselves.¹⁷⁸ Decades later, the Ninth Circuit Court of Appeals similarly rejected the idea that “criminal liability may extend to a pregnant woman who obtain[s] an abortion in a manner inconsistent with state abortion statutes.”¹⁷⁹

By 1971, the U.S. Supreme Court had also taken its first abortion cases to be decided on the merits, *Roe v. Wade* and *Doe v. Bolton*.¹⁸⁰ These cases represented the abortion laws of Texas and Georgia, respectively, which were emblematic of the two distinct types of abortion statutes in the United States at the time, the more restrictive laws that were virtually unchanged since the 1800s and a more recent “reformed” group of laws that contained exceptions for situations such as rape and incest.¹⁸¹ Neither the Texas law nor the Georgia law criminalized or prohibited self-abortion.

In *Roe*, plaintiffs challenged a statute, enacted in 1854, that banned abortion except when necessary to save a woman's life.¹⁸² The majority noted that “at common law, at the time of the adoption of our Constitution, and through the major portion

of the 19th century . . . a woman enjoyed a substantially broader right to terminate a pregnancy than she does in most states today.”¹⁸³ After reviewing the relevant case law, the Court held that the right of privacy recognized in *Griswold* and earlier cases “is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.”¹⁸⁴

The Court also held that despite this important right, the “[s]tate may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision.”¹⁸⁵ However, the Court rejected one of Texas's core arguments, that “life begins at conception and is present throughout pregnancy,” holding that the Court “need not resolve the difficult question of when life begins” and that Texas could not “by adopting one theory of life . . . override the rights of the pregnant woman that are at stake.”¹⁸⁶

"For many women of color, the immediate concern in the area of reproductive rights is not abuse in the private sphere, but abuse of government power."

Two important concurrences were filed in *Roe*: In the first, Justice Stewart noted that in his view, this right was derived directly from the “liberty” protected by the Due Process Clause.¹⁸⁷ This analysis gained significance in later Supreme Court abortion

cases. The second concurrence was by Chief Justice Burger, who was intent on protecting women from arbitrary state action: At oral argument, counsel for the state of Texas had informed the court that despite the lack of such exceptions in the statute “early abortion procedures were routinely permitted [by hospitals or physicians without interference from law enforcement] in certain exceptional cases, such as nonconsensual pregnancies resulting from rape and incest.” Chief Justice Burger noted that “[i]n the face of a rigid and narrow statute . . . no one in these circumstances should be placed in a posture of dependence on a prosecutorial policy or prosecutorial discretion.”¹⁸⁸

Although neither the majority opinion nor the concurrences directly addressed criminalization of self-abortion, Burger’s concurrence indicates an unwillingness to uphold abortion laws that are enforced in a discriminatory, unpredictable way.

The decisions in *Roe v. Wade* and *Doe v. Bolton* had the impact of suspending the existing abortion laws in 44 states.¹⁸⁹ In the years since *Roe* and *Doe*, federal and state courts have decided scores of cases relating to abortion. Over time, Justice Stewart’s analysis grounding the right in the concept of liberty became the most compelling, and in *Planned Parenthood v. Casey*, in 1992, the Court stated clearly that:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and

education. Our cases recognize “the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.” Our precedents “have respected the private realm of family life which the state cannot enter.” These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.¹⁹⁰

While the Court has since upheld some restrictions on abortion, the most recent case, *Whole Woman’s Health v. Hellerstedt*, made clear that abortion laws must actually benefit women’s health and rights, rather than impose arbitrary burdens, and that courts assessing those laws may not necessarily simply “infer that the legislature sought to further a constitutionally acceptable objective.”¹⁹¹ This finding is critical because, as discussed below, the state interest in criminalizing self-abortion is far from clear.

h. Post-Roe criminalization and prosecution

Although *Roe* recognized women’s constitutional right to terminate a pregnancy prior to viability, the statutes on the books in 1973 that were inconsistent

with that holding were not eliminated. Instead, in many states, parts of the pre-*Roe* statutes co-exist with the post-*Roe* legal system, so that the two must be read together to determine the law in any given state. In New York, several pre-*Roe* criminal abortion laws appear to still be enforceable despite being inconsistent with *Roe*, including the prohibitions on self-abortion and the criminal ban on abortions after 24 weeks, even if the fetus is not viable or the woman's health is in danger. Although physicians and hospitals have been reassured by advocates and lawyers that there are clear constitutional protections in the latter circumstances, most are unwilling to offer that care out of fear of prosecution.¹⁹²

Both within and outside of New York, however, an even more pernicious and harmful method of using the criminal law to control women's behavior has arisen – “an alarming trend towards greater state intervention into the lives of pregnant women under the rationale of protecting the fetus from harm.”¹⁹³ Although the self-abortion statutes have been on the books in New York since 1845, they were considered a “dead letter” as late as 1967, having sat unused for over a century.¹⁹⁴

Only now, in the 21st century, are women in New York and elsewhere being targeted directly and specifically by criminal prosecutors.¹⁹⁵ Indeed, the state's criminal laws prohibiting self-abortion throughout pregnancy have actually been used, with at least five women charged in the last thirty years; four of the cases were dismissed,

with a fifth ending in a conditional discharge.¹⁹⁶

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While some women have been specifically charged with inducing their own abortions,¹⁹⁷ in the majority of cases nationwide, these criminal prosecutions deal with the opposite side of the reproductive decision coin – the decision to carry a pregnancy to term.¹⁹⁸

There are law enforcement efforts to prosecute women for drug use or a variety of other acts or omissions believed, often erroneously, to have affected a pregnancy.¹⁹⁹ “When the government prosecutes, its intervention is not designed to protect babies from the irresponsible actions of their mothers (as is arguably the case when the state takes custody of a pregnant addict or her child). Rather, the government criminalizes the mother as a consequence of her decision to bear a child.”²⁰⁰ This, too, implicates women's right to choose whether and when to become a parent, and violates the core tenants of the constitutional freedoms recognized in the right to privacy, liberty, autonomy and bodily integrity cases.²⁰¹

Professor Dorothy Roberts, a preeminent legal scholar, has written that

the protection from government abuse . . . makes the right of privacy a useful legal tool for protecting the reproductive rights of women of color. Poor women of color are especially vulnerable to government control over their decisions For many women of color, the immediate concern in the area of reproductive rights is not abuse in the private sphere, but abuse of government power.²⁰²

Although most of these constitutional cases focus on women's reproductive rights in the context of contraception and abortion, the firmly established rights found in these

Whether they are choosing to end a pregnancy or continue one, low-income women and women of color are more likely to be the target of investigations and prosecutions, as they are less likely to be able to access private medical care and more likely to regularly encounter police and other government officials in their day-to-day lives.²⁰⁵

decisions, to liberty, autonomy, privacy and bodily integrity, should be interpreted to extend to the full range of reproductive decision-making.²⁰³ The decisions to avoid pregnancy or terminate an unintended pregnancy are part of a broader set of decisions and rights, as women and men determine when and whether to become parents or whether to become parents again. These decisions take place in the context of an individual's life, burdened by many different factors, including an individual's race and class; thus, ensuring full protection of these rights necessarily means understanding how the law impacts those who are impacted in multiple ways.²⁰⁴

In the post-*Roe* world, women themselves, and low-income women and women of color in particular, are at more risk of criminal prosecution for abortion and other pregnancy outcomes than at any other point in history. As we enter this new period of the criminalization of pregnancy, recognizing the full scope of reproductive rights will be critical to protecting the groups most likely to be unfairly targeted.²⁰⁶

IV. How Criminalizing Self-Abortion Hurts Women and Families

It is well documented that between the mid-1800s and 1973, the criminalization of abortion, including self-abortion in some instances, caused significant harm to women and to society. Women frequently turned to illegal and self-abortions, and many died: low-income women and women of color disproportionately suffered under this criminalization scheme, and were also the most likely to suffer serious health consequences or death.²⁰⁷ Even after legalization, some women turned to illegal or self-abortions – often because of financial or other barriers to legal abortion care – and those with the least access to care were most likely to face continued health risks.²⁰⁸

In recent years, the marked increase in laws restricting the provision of abortion has reduced the availability of this care,²⁰⁹ which, in turn, may lead to or already be causing more women to consider self-abortions. While the availability of medication abortion may have made this option safer and more effective than self-induction used to be, new risks are created by the recent push to use laws around abortion and other laws to punish women themselves²¹⁰ – with increased monitoring and prosecution opening the door to a range of negative outcomes for women, families, and communities.

Fear of prosecution makes it more difficult to share or acquire accurate, reliable information about the safer methods of self-abortion, including medications like mifepristone or misoprostol. Abortion clinics, health care providers, and other health care professionals may be reluctant to give out information, including even the basic facts about the appropriate dosage or potential complications after self-abortion.²¹¹ Community-based sources, such as friends and family, may fear sharing information, leaving women to cobble together information from a variety of potentially less trustworthy sources, such as internet searches.²¹²

Women may feel they have to turn to less secure sources for drugs, such as flea/swap markets or the internet.²¹³ Even when women find a place to buy misoprostol, the places where they make those purchases may be unable to provide adequate information. In Mexico, for example, pharmacists are technically only able to provide information about misoprostol as an ulcer treatment, since that is the indication for which it is approved,²¹⁴ although anecdotal information indicates that some pharmacists in Mexico may give instructions for the use of misoprostol to end a pregnancy. Online, women may be able to order misoprostol from reputable

sources, but they may also end up ordering pills that could be fake, contaminated, or an unknown dose.²¹⁵

This fear of prosecution also limits women's ability to seek the health care they may need after attempting to self-abort or even simply after a spontaneous miscarriage – in rare cases, women may experience serious health complications or even death due to their inability to seek out medical care.²¹⁶

Because self-abortion is generally accomplished in private, it is usually only medical professionals who discover its occurrence, when they see patients who are experiencing complications. This puts medical professionals in a position where some feel or believe they are obligated (or are unsure of their obligations) to report those activities to law enforcement, and, thus, states that criminalize women's behavior during pregnancy encourage medical professionals to view their patients with suspicion and to involve the police, thereby damaging the confidential doctor-patient relationship.²¹⁷

There is clear consensus among “the medical and public health [communities] . . . that punitive approaches undermine maternal, fetal, and child health by deterring women from care and from communicating openly with people who might be able to help them.”²¹⁸

Countries with legal restrictions on abortion that *do* prosecute women provide even

clearer examples of these risks: For example, in El Salvador, which has one of the most restrictive abortion laws in the world, it is a criminal offense for a woman to have an abortion and those who are found guilty of terminating their pregnancies face long jail sentences.²¹⁹ The laws criminalizing self-abortion are used to investigate any woman suspected of self-aborting, and women seeking care for miscarriages are often “interrogated by the police, sometimes resulting in homicide prosecutions.”²²⁰ Moreover, the law interjects directly between women and their health care providers: Among the cases of women prosecuted for abortion, 57% of complaints originated from health care professionals.²²¹ As in the United States, El Salvadorian women with fewest resources are affected most by this law.²²²

This destructive relationship between the medical community and the criminal justice system exists in the United States as well. In one survey of more than four hundred cases of arrests and forced interventions on pregnant women, 53% of the cases were reported to police by a health care provider or social worker, and another 17% were reported by a health care provider to child protective services who then reported to the police.²²³ In some cases, women who had recently gone through birth, a miscarriage, or were suspected of self-inducing an abortion were subjected to bedside interrogations, leading to “humiliating police questioning about intimate details of their lives while lying,

and sometimes dying, in their hospital beds.”²²⁴ As one plaintiff argued, prosecuting women for the death of their fetus makes women’s rights “contingent on producing a child who is healthy” and makes “pregnant women guarantors of a live birth on pain of criminal homicide prosecution.”²²⁵ Furthermore, any actions a woman takes that could potentially increase likelihood of miscarriage, including common daily activities like riding a bike, could be used as evidence of harmful intent or even criminalized.²²⁶

Low-income women and women of color in the United States are particularly vulnerable to this type of prosecution, as they have less access to affordable legal abortion as well as other health care services, are more vulnerable to government monitoring, and are also more likely to be targets of prosecution by law enforcement.²²⁷ Black women, in particular, are more likely to be reported to government authorities by health care professionals.²²⁸ The survey of more than four hundred cases showed patterns among prosecution, in particular that

low-income women, especially in some southern states, are particularly vulnerable to these state actions, and that pregnant African American women are significantly more likely to be arrested, reported by hospital staff, and subjected to felony charges. These findings are consistent with ... well-documented racially disproportionate application of criminal laws to African

American communities in general and to pregnant African American women in particular.²²⁹

Finally, when women are arrested, prosecuted, and then jailed for self-abortion, their health and that of their family will suffer further.²³⁰ Recent studies have documented that incarceration has a serious and long-lasting impact on women’s overall health and the health and lives of their children, especially women of color and their families: “incarcerated women are. . . placed in close proximity to a population . . . with high rates of infectious and chronic diseases” often without the ability to access necessary health services.

“[Research] findings challenge the notion that arrests and detentions promote maternal, fetal, and child health or provide a path to appropriate treatment. Significantly, detention in health and correctional facilities has not meant that the pregnant women (and their fetuses) received prompt or appropriate prenatal care.”²³¹ “Incarceration also affects families by separating women from their children, often forcing children into foster care and leaving them vulnerable to psychological, educational, and social problems.”²³² Moreover, many women may be at risk for deportation if they are arrested for any reason, particularly in the current political climate.²³³

Although states have an interest in promoting safe abortions, making self-

abortion a crime serves only to make women less safe, and particularly increases the risks for low-income women, women of color, and women living in rural areas. As access to abortion decreases and women turn to self-abortion, the state's interest in protecting health and safety is not

advanced by discouraging women from finding medically accurate information before attempting to self-induce, seeking out medical assistance afterwards if they need to, or making miscarriage a potential suspicious outcome in any situation.

V. Why is Self-Abortion (Still) a Crime in New York?

Given the constitutional rights at stake, the intimacy of the decisions involved, and the health considerations for women, it is surprising that laws criminalizing self-abortion remain on the books in New York and a handful of other states. For a state to make a particular course of conduct a crime punishable by imprisonment – the clearest denial of an individual’s fundamental right to liberty – the state must have a strong interest in preventing the particular behavior or outcome.²³⁴ When the relevant conduct is entitled to constitutional protection, such as making decisions about whether and when to bear a child, the state’s interest must be compelling or the “government intrusion as extreme as criminal prosecution would unduly infringe on protected autonomy.”²³⁵

The state interests that underlie the criminalization of self-abortion are not easily ascertained; few laws make such actions a crime and the legislative intent has rarely been documented. What documentation exists provides only criticism of such laws, not support. Professor Cyril Means wrote an authoritative history on New York abortion law until 1968 and dealt specifically and critically with the issue of criminalization of self-abortion, calling such laws a “dead letter.”²³⁶ Practice commentaries (editorial companions found in statute books, written by experts to explain changes made to the

law, clarify the meaning of terms, and offer practice suggestions) for both the Model Penal Code in 1962 and the 1970 New York abortion reform law disclaim a strong state interest in maintaining this criminal prohibition. Ultimately, there is very little clear rationale for or state interest in maintaining these criminal laws.

The first criminal abortion law in New York, in 1828, did not prohibit self-abortion.²³⁷ An amendment to that law in 1845 “for the first time brought the abortee herself under the criminal sanctions of the law.”²³⁸

Although the code has been revised many times, through the 1970 law that exists today,²³⁹ the prohibition on self-induction remained. Over the course of time, the penalties varied for abortions before and after quickening, and then starting in 1965, before and after 24 weeks of pregnancy.²⁴⁰

Professor Means offers only one state interest for criminalizing the woman’s behavior and abortion in general – the health of the woman and the danger of abortion, criminalized “under the surgical conditions of 140 years ago, when not only all abortions but all other surgical operations, even in hospitals, were often fatal.”²⁴¹ Indeed, “protection of the patient’s health and life” is the only state interest ever mentioned in the legislative materials for the entire 140 years of abortion law in New York State until 1968.²⁴²

Moreover, the state of New York did not view a pre-“quickened” fetus as an entity warranting of state protection: Prior to 1968, the law permitted the death penalty to be imposed on pregnant women before quickening.²⁴³ If the state had found a compelling interest in fetal protection in the early stages of pregnancy, it would not have approved executing pregnant women.²⁴⁴

Of course, many others outside of the legislature have advanced other interests to support the prohibition of abortion, usually with one or more of these three underlying rationales: an interest in protecting women’s morality (i.e. preventing non-procreative sex), an interest in expanding the population (sometimes called a “pronatalist” interest, and usually only in reference to the white population),²⁴⁵ and an interest in potential or fetal life.²⁴⁶

As noted above, the interest in potential or fetal life did not motivate the enactment or continuance of the law. These other two interests may have been motivating for lobbyists outside of the legislature, but could not be viewed as legitimate today. While much of the initial support for criminalization of abortion came from the medical community seeking to protect women’s health and protect its own professional interests,²⁴⁷ medical groups appeared to offer up more moralistic interests as rationales as well – a 1867 resolution adopted by the Medical Society of the State of New York asserts that women should be prohibited from having

abortions because “from the first moment of conception, there is a living creature in the process of development to full maturity” and “women . . . ought to be and unquestionably are the conservators of morality and of virtue.”²⁴⁸

As noted by the district court in *Abele v. Markle*, a desire to “protect[] the mother’s morals,” could have been behind the criminal abortion statutes, “apparently proceed[ing] from the premise that if abortion is prohibited, the threat of having to bear a child will deter a woman from sexual intercourse.”²⁴⁹ Such archaic stereotypes about women’s proper role as mothers have long since been rejected by courts as legitimate justifications for burdening women’s fundamental rights.²⁵⁰

As for the concerns about fertility among white Protestant women that initially motivated some, or even concerns about broader societal fertility, neither racist ideas nor governmental interest in population expansion were persuasive to courts in the 1970s, nor would they be today.²⁵¹

No matter what state interest underlay the prohibition of abortion generally, it seems even more likely that there was simply no state interest behind the criminalization of self-abortion at any time. Professor Means writes, regarding the 1845 statutes and subsequent revisions, that “the section bringing the woman within the ambit of the statute” was never intended to be and could never be enforced.²⁵²

New York is in the minority of American states whose statutes go through the solemn mockery of proclaiming the woman guilty of crime if she either aborts herself or submits to an abortion, although everyone knows that no such woman ever has been, or is ever likely to be, prosecuted. The reason these statutes are dead letters is simple. *Convictions require unanimous jury verdicts, and it would be difficult to empanel a jury today, at least one or two of whose members did not, if male, have a close female relative who had undergone an illegal abortion, or who, if female, had not undergone one herself.* Prosecutors know very well which laws merely serve the ends of social hypocrisy, but, under which juries simply will not convict, and they do not put their reputations for securing convictions in jeopardy by initiating prosecutions where their chances of success are virtually nil.²⁵³

Moreover, in 1942, a new section was added to the New York criminal law giving women who had obtained or induced abortions immunity if they testified against the person who performed the abortion (or presumably provided the mechanism for the abortion), thus “bring[ing] the matter around full circle to about where it would be if the woman were not considered a criminal in the first place.”²⁵⁴ Because the woman was unlikely to be prosecuted and could evade prosecution by testifying against someone else, the state interest in criminalizing her behavior appears to have been weak.

Similarly, when the American Law Institute released the Model Penal Code in 1962, its committees had carefully considered whether and to what extent either self-abortion or aiding a woman in self-abortion should be criminalized.²⁵⁵ The final recommendation proposes criminalizing self-abortion after twenty-six weeks as a third degree felony, with accompanying commentary recommending “exemption from criminal liability, except in the late-pregnancy situation,” because “criminal liability of the woman for abortion committed on herself has not been useful in suppressing self-abortion” and the “prospect of prosecution is unlikely to deter” women.²⁵⁶

Had the drafters of the MPC viewed protection of fetal life as an interest warranting state action earlier in pregnancy, they would have recommended criminalization for ending a pregnancy at any stage. Notably, these recommendations were made before the U.S. Supreme Court had recognized that women have a constitutional right to make their own reproductive decisions about conception and pregnancy.²⁵⁷

Despite this recommendation, New York maintained its prohibition on self-abortion throughout the entire course of pregnancy, even in the 1970 law that made abortion much more widely available in the state. The writer of the Practice Commentary accompanying the 1970 abortion law, a

former Manhattan District Attorney, was thoroughly confused by the presence of the self-abortion prohibition, writing that “the language of [this section] is so ambiguous and confusing as to preclude any positive assertion concerning either its meaning or legislative intent,” and that “the most sensible construction of the 1970 amendment – though not the literal one – is that an act [of self abortion] can never be criminal” under any circumstances.²⁵⁸ The last paragraph of his commentary called for a “thorough overhauling” of the self-abortion phrases of the legislation, the urgency of which was “tempered [only] by the fact that self-abortion is a rarely prosecuted crime.”²⁵⁹

In fact, the modern practice commentary, used by practitioners in 2017, quotes part of this interpretation of the 1970 self-abortion provision, that within the 24 week period, “such act is not criminal”²⁶⁰ but provides no further context or guidance. The 2017 version does not even acknowledge that the literal statutory language does in fact criminalize this behavior.

Although the MPC commentary and commentary on the New York law suggests a state interest exists in criminalizing abortion after 24 weeks of pregnancy, that interest is not explained and may also have been related to the woman’s health and safety. When the law was amended in 1965, dividing abortion into periods before and after 24 weeks, the Commission Staff Note

merely recognizes that “[g]reater liability is predicated [after 24 weeks] because an abortion at this stage is considerable more dangerous.”²⁶¹ “[O]bviously, it is no more dangerous to the foetus by reason of being performed after rather than before the end of the 24th week of pregnancy; it is, therefore, the greater danger to the patient, *and only to her*, that inspires this new distinction.”²⁶²

That being the case, the same questions remain regarding the rational relationship between the state’s concern for a woman’s health and safety and its ability to invade her privacy and liberty, and to incarcerate her. Moreover, by criminalizing abortion at any point in pregnancy, whether before or after 24 weeks, with the clear, century-old understanding that very few such situations will ever be prosecuted, the state is authorizing prosecutors to pursue the same type of selective enforcement that concerned Chief Justice Burger in the *Roe* case.²⁶³

Such prosecutions are likely to target low-income women and women of color the most, as those groups are most likely to encounter or to be reported to law enforcement in a number of circumstances.²⁶⁴ As other courts have since noted, investigations into the ways that pregnancies progress and end may veer so closely into state control over women’s every move during pregnancy that laws authorizing those investigations trespass on women’s constitutional

rights.²⁶⁵ In addition, laws that criminalize self-abortion at any point run the risk of criminalizing every miscarriage and interposing the state's criminal law into physician-patient interactions, as was documented during the years where abortion was widely illegal.²⁶⁶

Whatever state interest there was in criminalizing self-abortion in most cases – at best an interest in protecting the woman's life and health in the days when surgery was dangerous – has long since disappeared. Even though self-abortion may, depending on the method, carry some risks for the woman,²⁶⁷ the state does not

appear to have a sufficient enough interest in protecting the woman's health in those circumstances to justify both intruding upon her own constitutional rights in her pregnancy outcome and doing so in the most extreme manner, namely criminal prosecution and incarceration.²⁶⁸

Nonetheless, despite the lack of a significant or compelling state interest, these laws remain on the books, and self-abortion remains, for the moment, a crime that some prosecutors, and politicians, are willing to pursue.²⁶⁹

VI. Focusing on Women's Health and Safety

Law, policy, and medicine on abortion have all changed radically since the first criminal prohibition was enacted in New York in 1828, and New York's criminal prohibition on self-abortion was enacted in 1845. In 2017, abortion is both common and safe, one of the safest procedures available in the country today.²⁷⁰ Nonetheless, women still face barriers to care and in some cases still induce their own abortions. Maintaining a crime of self-abortion in New York State appears to serve no reasonable state purpose, but may cause great harm to women, particularly low-income women and women of color, who are most likely to encounter or to be reported to law enforcement.

If policymakers want to consider solutions to address both the lack of access to care and the harm to women that comes from criminal prohibitions, there are several policy options that could be pursued:

Decriminalize self-abortion: A first step would be to ensure that there are no criminal penalties associated with women ending their own pregnancies using medications or any other means. In New York State, this would require repealing Penal Laws §125.55 and §125.50, and could also include enacting new legislation to ensure that prosecutors do not use other, non-specific criminal laws to prosecute women who end their own pregnancies. The proposals should also ensure that no other people are prosecuted in these situations, including friends and other advocates who may help a woman access information, the means to end a pregnancy, or related medical assistance.

Increase access to abortion: Because most women who self-induce abortions appear to do so as a result of barriers to accessing abortion in a medical setting, proposals to increase access to abortion, including medication abortion, should be pursued. Specific proposals could include reviewing the state's abortion laws and ensuring that they fully enable broad access to care, including ensuring public and private insurance coverage for abortion care and repealing laws that prohibit that coverage, like the federal Hyde Amendment. In New York, that could include repealing the law that allows only a physician, rather than any qualified health care provider, to provide abortion care, and supporting policies that advance telemedicine for medication abortion, a technological advance that holds great promise in expanding access to abortion care for rural women.

Provide public education about abortion: Another barrier to abortion access that may lead women to self-induce is a lack of information about the legality and availability of abortion. Access to this information is further impeded by stigma associated with

abortion, which makes it harder for women to get this information from their friends and family. Policymakers could fund a public education campaign to promote information about abortion, including how to access it, including, for example, printed materials, billboards, and referrals. For example, policymakers could fund a pilot project to put up billboards and posters in English, Spanish, and other relevant language saying “Abortion is safe and accessible in your community, find out more at [state web address].gov,” which could then refer to local abortion providers. Further, policymakers could ensure that grants or funding under these new programs are given directly to community-based organizations in the communities most likely to benefit from the campaigns.

Expand access to contraception: Unintended pregnancy is a primary reason people seek abortions, and likewise self-abortion. Increasing women’s ability to control when they become pregnant by improving access to contraception is a key part of reducing unintended pregnancy and therefore the need for self-abortion. Various administrative and legislative proposals exist to advance access to contraception, including maintaining no co-pays for contraception, expanding the types of contraception covered by insurance, whether available by prescription or over the counter, as well as the amount of medication that can be provided at one time.

VII. Conclusion

The complicated history of self-abortion in the United States leaves one fact entirely clear: Women have always ended their own pregnancies when the situation requires it, and criminalizing their conduct does nothing but create risks for women and their families. Instead of maintaining these criminal laws, policymakers should consider creating policies that support all women's access to comprehensive reproductive health care and that enable all women to actually choose whether and when to become a parent.

Endnotes

¹ Shirley Chisholm, UNBOSSSED AND UNBOUGHT 117 (1972).

² Throughout this document, we use the term “women” but recognize that other people, like trans men, can become pregnant, and intend for them to be included in this analysis as well.

³ See, e.g., Cyril C. Means, Jr., *The Law of New York Concerning Abortion and the Status of the Foetus, 1664-1968: A Case of Cessation of Constitutionality*, 14 N.Y.L.F. 411, 488 (1968).

⁴ See JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY 145 (1978) (noting that in the first wave of criminal laws, between 1840 and 1860, only three states “struck the immunities traditionally enjoyed by American women in cases of abortion”). *But see id.* at 227 (noting that more states criminalized the women seeking abortion in the 1870s).

⁵ SARAH WEDDINGTON, A QUESTION OF CHOICE 97 (1993).

⁶ See Rickie Solinger, *Introduction* to ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000 4 (Rickie Solinger ed., 1998).

⁷ See Waldo L. Fielding, *Repairing the Damage, Before Roe*, N.Y. TIMES, June 3, 2008, <http://www.nytimes.com/2008/06/03/health/views/03essa.html> (last visited June 3, 2017) (“The familiar symbol of illegal abortion is the infamous ‘coat hanger’ – which may be the symbol, but is in no way a myth. In my years in New York, several women arrived with a hanger still in place. Whoever put it in – perhaps the patient herself – found it trapped in the cervix and could not remove it.”).

⁸ Some international studies have shown that self-abortion through medication can be safe and effective when taken according to evidence-based recommendations. See *Safe abortion: technical and policy guidance for health systems*, WORLD HEALTH ORG. (2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 at 23. The World Health Organization has recognized that women can manage use of the mifepristone and misoprostol combination without direct supervision of a health care provider when they have accurate information and access to a health care provider should they need or want it at any stage of the process. *Id.* at 23, 46. The World Health Organization has also stated that mifepristone is not available, misoprostol used alone can be a safe and effective method to end a pregnancy. *Id.*

⁹ See, e.g., Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

¹⁰ LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND THE LAW IN THE UNITED STATES, 1867-1973 8-9 (1998); see also MOHR, *supra* note 4, at 4.

¹¹ REAGAN, *supra* note 10, at 9.

¹² *Id.* at 8-9.

¹³ MOHR, *supra* note 4, at 53-55.

¹⁴ REAGAN, *supra* note 10, at 9-10.

¹⁵ Steven Polgar & Ellen S. Fried, *The Bad Old Days: Clandestine Abortions Among the Poor in New York City Before Liberalization of the Abortion Law*, 8 FAMILY PLANNING PERSPECTIVES 125, 125-26 (1976); see also Rachel B. Gold, *Lessons from Before Roe: Will Past be Prologue?*, 6 GUTTMACHER POL’Y REV. 8 (2003) (in the 1960s, 62% of Americans wanting children at some point were likely to experience at least one unintended pregnancy).

¹⁶ ROSALIND P. PETCHESKY, ABORTION AND WOMAN’S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM 78 (1985).

¹⁷ *Id.* at 113; Willard Cates, Jr. & Roger Rochat, *Illegal Abortions in the United States: 1972-1974*, 8 FAMILY PLANNING PERSPECTIVES 86, 92 (1976).

¹⁸ Gold, *supra* note 15, at 8.

¹⁹ Cates & Rochat, *supra* note 17, at 92.

²⁰ Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 41, 43 (2011); *see also* PETCHESKY, *supra* note 16, at 113.

²¹ *Id.* at 133 (“The consistently larger number and higher rate of abortions performed at University Hospital each year between 1964 and 1969 [compared with the numbers at a public hospital] suggests that women who could afford private care had easier access to legal abortion than medically indigent women, even though the criteria for therapeutic abortion were presumably the same at both institutions.”); Gold, *supra* note 15, at 10.

²² Gold, *supra* note 15, at 10.

²³ *Id.*

²⁴ Polgar & Fried, *supra* note 15, at 126 (only 16% of a sample of women living in poverty in New York City were aware of a specific person who might help them terminate a pregnancy).

²⁵ *Id.*

²⁶ *Id.*

²⁷ Judith E. Belsky, *Medically Indigent Women Seeking Abortion Prior to Legalization: New York City, 1969-1970*, 24 FAMILY PLANNING PERSPECTIVES 129, 130 (1992).

²⁸ *Id.* at 131-132.

²⁹ Leslie J. Reagan, “About to Meet Her Maker”: Women, Doctors, Dying Declarations, and the State’s Investigation of Abortion, *Chicago, 1867-1940*, 77 J. OF AM. HIST. 1240, 1245 (1991).

³⁰ Samantha Gibson, Puerto Rican Migration to the US, Primary Source Set, <https://dp.la/primary-source-sets/sets/puerto-rican-migration-to-the-us/> (last visited June 19, 2017); Antonia Darder, *Colonized Wombs? Reproduction Rights and Puerto Rican Women*, THE PUBLIC, December 2006, <http://publici.ucimc.org/colonized-wombs-reproduction-rights-and-puerto-rican-women/> (last visited June 19, 2017).

³¹ *See* Angela Hooton, *A Broader Vision Of The Reproductive Rights Movement: Fusing Mainstream And Latina Feminism*, 3 Am. U. J. Gender Soc. Pol’y & L. 59 (2005) (“Latinas have a long history of forced sterilization in the United States and Puerto Rico. . . . The history of sterilization provides an example of how Latinas have been unable to fulfill their reproductive choice to bear children. Latinas have also been constrained in their ability to prevent or terminate unwanted pregnancies because of financial barriers. Historically, Latinas have had a high rate of poverty and limited access to public health programs.”); *see also* LORETTA ROSS & RICKIE SOLINGER, *REPRODUCTIVE JUSTICE: AN INTRODUCTION* 46 (2017).

³² *Id.* at 1246.

³³ Belsky, *supra* note 27, at 133.

³⁴ Belsky, *supra* note 27, at 134.

³⁵ Gold, *supra* note 15, at 10.

³⁶ *See* Jill E. Adams & Melissa Mikesell, Primer on Self-Induced Abortion, THE SIA LEGAL TEAM (2017), <https://www.law.berkeley.edu/wp-content/uploads/2016/01/Primer-on-Self-Induced-Abortions.pdf>; the Hyde Amendment, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976) (prohibiting Medicaid from providing insurance coverage for abortion except in cases where the abortion is necessary to save a woman’s life or in cases of rape and incest, now extends to most federal programs).

³⁷ *See, e.g.*, Diane Curtis, *Doctored Rights: Menstrual Extraction, Self-Help Gynecological Care, and the Law*, 20 N.Y.U. REV. L. & SOC. CHANGE 427 (1994); Barbara Brotman, *Secret Abortion Group of ‘60s Prepares for Return*, CHI. TRIB., Aug. 28, 1989, at 1, 8; *Women Turn to Self-Help Groups for Abortions, Despite the Risks*, N.Y. TIMES, Sept. 8, 1992, <http://www.nytimes.com/1992/09/09/news/women-turn-to-self-help-groups-for-abortions-despite-the-risks.html>.

³⁸ See Curtis, *supra* note 37; Brotman, *supra* note 37.

³⁹ For a history of the reproductive justice movement, see LORETTA ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION (Rickie Solinger, Khiara M. Bridges, Zakiya Luna, & Ruby Tapia eds., 2017).

⁴⁰ *Id.* at 9.

⁴¹ Rachel K. Jones, *How Commonly Do U.S. Abortion Patients Report Attempts to Self-induce?*, 204 AM. J. OF OBSTETRICS & GYNECOLOGY 23e.1, 23e.1 (2011); see Regina M. Barbosa & Margareth Arilha, *The Brazilian Experience with Cytotec*, 24 STUD. IN FAM. PLAN. 236, 237 (1993).

⁴² *Issue Brief: Safety and effectiveness of first-trimester medication abortion in the United States*, ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (ANSIRH) (Aug. 2016), <https://www.ansirh.org/sites/default/files/publications/files/medication-abortion-safety.pdf>.

⁴³ Francine Coeytaux, Leila Hessini, & Amy Allina, *Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands*, 25 WOMEN'S HEALTH ISSUES 608, 609 (2015).

⁴⁴ Jones, *supra* note, at 41, at 23e.1; see Dan Grossman et al., *Self-induction of Abortion Among Women in the United States*, 18 REPROD. HEALTH MATTERS 136, 143 (2010).

⁴⁵ Elizabeth Nash et al., *Policy Trends in the States: 2016*, GUTTMACHER INST. (Jan. 3, 2017) <https://www.guttmacher.org/article/2017/01/policy-trends-states-2016> (last visited June 5, 2017).

⁴⁶ *Id.*

⁴⁷ Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST. (May 2016) <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014> (last visited June 19, 2017)

⁴⁸ Dan Grossman, et al., *Knowledge, Opinion and Experience Related to Abortion Self-induction in Texas*, IBIS REPROD. HEALTH, Nov. 17, 2015, at 2.

⁴⁹ Seth Stephens-Davidowitz, *The Return of the D.I.Y. Abortion*, N.Y. TIMES (Mar. 5, 2016), <https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html>.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Texas Women's Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options*, IBIS REPROD. HEALTH, Nov. 17 2015, at 5.

⁵³ *Id.* at 2 (“Procedure costs, travel distances, and clinic closures contributed to these women’s decisions to use more affordable abortion options closer to home despite their preference for obtaining a procedure at a clinic.”).

⁵⁴ Grossman et al., *Knowledge, Opinion and Experience*, *supra* note 48, at 2.

⁵⁵ *Texas Women's Experiences*, *supra* note 52, at 2.

⁵⁶ Grossman et al., *Self-Induction of Abortion*, *supra* note 44, at 142 (“Often women spoke about the idea that menstrual regulation with self-induction was something that could avoid an abortion. For some the idea of menstrual regulation was more compatible with their religious or ethical views. ‘When I was growing up I was against abortion... You know the whole Catholic.. you know it’s wrong. You get pregnant then you keep it and that’s it. But I never really thought of the whole malta and aspirin thing as inducing your own abortion...’ (New York 1, age 17)[.]”).

⁵⁷ *Id.* at 141 (“Although most [women] who had a prior clinic abortion did not emphasize negative aspects of the experience, a few did cite this as a reason for avoiding clinics. ... More women said they had heard negative things about abortion clinics and procedures from friends. Some mentioned being worried about the possibility of complications, such as uterine perforation, or believed that general anesthesia was required. ... A few expressed a generalized fear of doctors[.]”).

⁵⁸ Phoebe Zerwick, *The Rise of DIY Abortion*, GLAMOUR, (May 31, 2016, 9:00 AM), <http://www.glamour.com/story/the-rise-of-the-diy-abortion>.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ See Adams & Mikesell, *supra* note 36.

⁶² Much of this history from 1664 to 1968 was authoritatively documented in a renowned article written by Professor Cyril Means in 1968, after Professor Means had participated in Governor Rockefeller's Commission Appointed to Review New York's Abortion Law that same year. Means, *supra* note 3.

⁶³ PETCHESKY, *supra* note 16, at 30.

⁶⁴ ALEXANDER SANGER, BEYOND CHOICE: REPRODUCTIVE FREEDOM IN THE 21ST CENTURY 21 (2004).

⁶⁵ PETCHESKY, *supra* note 16, at 50-51 ("A survey of one hundred patients by a Berlin doctor in 1919 regarding their birth control and abortion methods contains references to many 'folk' methods reported to have been effective abortifacients, apparently without dire consequences: hot baths, jumping off chairs and stools, douching with soapy water or Lysol, using a commercial 'period remedy,' drinking various drugs and teas, and '[poking] around with a quill a little bit until blood came and then a doctor scraped me out.');" *see also id.* at 52 (citing a study of abortion in France in the late 19th and early 20th centuries).

⁶⁶ See *supra* notes 14-34 and accompanying text.

⁶⁷ SANGER, *supra* note 64, at 25.

⁶⁸ See *Roe v. Wade*, 410 U.S. 113, 132-36 (1973) (holding modified by *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833 (1992)); Means, *supra* note 3, at 420.

⁶⁹ Means, *supra* note 3, at 412.

⁷⁰ *Id.* at 420.

⁷¹ *Id.* at 420, 428.

⁷² *Roe*, 410 U.S. at 132-36.

⁷³ Means, *supra* note 3, at 430.

⁷⁴ *Id.* at 438-39; *see also id.* at 437 ("The common law exhibited an ambivalence in the matter of abortion that underlines its native respect for the two great values of liberty and life. So fond was it of liberty, that it allowed pregnant women to run the risk of death on the operating table, at a time when this risk was real and substantial, if she chose to rid herself of the foetus before quickening[.]").

⁷⁵ SANGER, *supra* note 64, at 25.

⁷⁶ "[A]ll abortions, even those performed by licensed physicians in hospitals, [were] considered medically dangerous in the nineteenth century" because "[u]ntil 1867 . . . all forms of surgery were inherently dangerous to the life of the patient, since surgeons did not know what caused infection or how to prevent it." Means, *supra* note 3, at 435-36. Between 1857 and 1867, Louis Pasteur and Lord Lister made discoveries having to do with bacteria and antiseptics, resulting in safer "aseptic surgery." *Id.* at 436.

⁷⁷ SANGER, *supra* note 64, at 25.

⁷⁸ MOHR, *supra* note 4, at 22.

⁷⁹ Linda J. Greenhouse, *Constitutional Question: Is There a Right to Abortion?*, N.Y. TIMES, Jan. 25, 1970, at 30. By the middle of the 20th century, the medical facts had been reversed – it was by then safer for a woman to have an abortion than to give birth. See Means, *supra* note 3, at 513; *Abele v. Markle*, 342 F. Supp. 800, 809 n.16 (D.Conn. 1972) (Newman, J., concurring); *Roe v. Wade*, 410 U.S. 113, 149 (1973).

⁸⁰ Means, *supra* note 3, at 452. The New York statute was used as a model for many other states and incorporated two main concepts: it prohibited termination of a pregnancy at any point, but had different penalties for abortion before and after "quickening," and included this therapeutic life exception, which was not part of common law. *Roe*, 410 U.S. at 138.

⁸¹ PETCHESKY, *supra* note 16, at 80-81; SANGER, *supra* note 64, at 25-26.

⁸² PETCHESKY, *supra* note 16, at 80-81; SANGER, *supra* note 64, at 26. Among other areas, the AMA's first focus was to prevent irregulars from delivering babies, as this was an otherwise lucrative area of

practice for trained physicians. SANGER, *supra* note 64, at 26.

⁸³ PETCHESKY, *supra* note 16, at 80.

⁸⁴ *Id.* at 79 (citing MOHR, *supra* note 4, at 157); SANGER, *supra* note 64, at 26 (citing MOHR, *supra* note 4, at 161).

⁸⁵ “The decline of native fertility was alarming some Protestants, particularly in light of the very high fertility of the vast number of immigrants who poured into America beginning with the 1840s. Fears of ‘race suicide’ and Catholic domination arose in the minds of some Protestants, and, since abortion was seen to be a major factor in the decline of Protestant fertility, the suppression of abortion was one logical remedy for Protestant fears.” R. Sauer, *Attitudes to Abortion in America, 1800-1973*, 28 POPULATION STUD. 53, 59 (1974); *see also* MOHR, *supra* note 4, at 207 (quoting Ohio legislators in 1868: “Do [our native women] realize that in avoiding the duties and responsibilities of married life, they are, in effect, living in a state of legalized prostitution? Shall we permit our broad and fertile prairies to be settled only by the children of aliens?”).

⁸⁶ PETCHESKY, *supra* note 16, at 80; SANGER, *supra* note 64, at 28-29.

⁸⁷ Means, *supra* note 3, at 451.

⁸⁸ *Id.*

⁸⁹ MOHR, *supra* note 4, at 22; *see* *Abele v. Markle*, 342 F. Supp. 800, 806 (D.Conn. 1972) (Newman, J., concurring) (“Prior to 1860, it was not a crime in Connecticut for a woman to cause her own miscarriage.”).

⁹⁰ Means, *supra* note 3, at 452 (quoting *State v. Murphy*, 27 N.J.L. 112, 114 (Sup. Ct. 1858)); *see also* *Evans v. People*, 49 N.Y. 86, 90 (N.Y. 1872) (rejecting the idea that an abortion before quickening could be murder, noting that “there is a period during gestation when, although there may be embryo life in the foetus, there is no living child”).

⁹¹ MOHR, *supra* note 4, at 43.

⁹² *Id.* at 125.

⁹³ *See supra* notes 17-28 and accompanying text; Cates & Rochat, *supra* note 17, at 92; Gold, *supra* note 15, at 9; Sauer, *supra* note 85, at 55; *see also* Reagan, *supra* note 29, at 1245 (from a physician in Chicago in 1904 estimating six to ten thousand abortions in that city annually).

⁹⁴ PETCHESKY, *supra* note 16, at 78; Reagan, *supra* 29, at 1245.

⁹⁵ Sauer, *supra* note 85, at 55.

⁹⁶ *Id.*

⁹⁷ Reagan, *supra* 29, at 1245.

⁹⁸ *Id.* at 1255.

⁹⁹ *See, e.g.*, Loretta J. Ross, *African-American Women and Abortion*, in *ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000* 161, 171 (Rickie Solinger ed., 1998); Reagan, *supra* note 29, at 1262; ROSS & SOLINGER, *supra* note 31, at 44-45.

¹⁰⁰ *See* Reagan, *supra* note 29, at 1247; Means, *supra* note 3. Moreover, there is some evidence that even these prosecutions were not generally successful at obtaining convictions: “Jurors were hard to mobilize to convict a physician who had done exactly what the patient had asked him to do, even where her death had ensued, even where no more than seven years’ imprisonment could be imposed.”

Means, *supra* note 3, at 476.

¹⁰¹ Sauer, *supra* note 85, at 56.

¹⁰² Rickie Solinger, *Pregnancy and Power Before Roe v. Wade, 1950-1970*, in *ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000* 15, 17 (Rickie Solinger ed., 1998); Sauer, *supra* note 85, at 55.

¹⁰³ Means, *supra* note 3, at 455, 463-482.

¹⁰⁴ *Id.* at 488

¹⁰⁵ Ross, *supra* note 99, at 173.

- ¹⁰⁶ Sauer, *supra* note 85, at 61.
- ¹⁰⁷ REAGAN, *supra* note 10, at 160-161; Reagan, *supra* note 29, at 1262.
- ¹⁰⁸ Reagan, *supra* note 29, at 1262.
- ¹⁰⁹ Ross, *supra* note 99, at 173.
- ¹¹⁰ Reagan, *supra* 29, at 1262; see also Solinger, *Pregnancy and Power*, *supra* note 102, at 18. In the 1940s, hospitals began instituting therapeutic abortion committees, enlisting the help of psychiatrists and minimizing individual culpability for doctors who feared prosecution. Solinger, *Pregnancy and Power*, *supra* note 102, at 22-23
- ¹¹¹ See Ross, *supra* note 99, at 173; Solinger, *Pregnancy and Power*, *supra* note 102, at 18.
- ¹¹² Solinger, *Pregnancy and Power*, *supra* note 102, at 26.
- ¹¹³ Ross, *supra* note 99, at 180. Notably, just as in the white civil rights community, there were some Black male-led organizations that did support abortion rights, including the Black Panther Party. *Id.* at 181.
- ¹¹⁴ Solinger, *Pregnancy and Power*, *supra* note 102, at 18.
- ¹¹⁵ *Id.*
- ¹¹⁶ *Id.*
- ¹¹⁷ REAGAN, *supra* note 10, at 161.
- ¹¹⁸ Solinger, *Pregnancy and Power*, *supra* note 102, at 24.
- ¹¹⁹ REAGAN, *supra* note 10, at 160-161; Solinger, *Pregnancy and Power*, *supra* note 102, at 23.
- ¹²⁰ Lawrence Lader, *The Scandal of Abortion Laws*, N.Y. TIMES, April 25, 1965, at SM32.
- ¹²¹ Sauer, *supra* note 85, at 62 (estimating anywhere from 200,000 to 1.2 million abortions a year throughout this period); see, e.g., *People v. Belous*, 458 P.2d 194, 201 (Cal. 1969) (estimating “35,000 to 100,000 ... abortions each year” in California).
- ¹²² Solinger, *Pregnancy and Power*, *supra* note 102, at 21.
- ¹²³ See Ross, *supra* note 99, at 161; Greenhouse, *supra* note 71 (“More than 90 percent of the legal abortions in New York City hospitals [before 1970 were] performed on white women, while nonwhite women account for a large proportion of the deaths from bungled, illegal abortions.”).
- ¹²⁴ Ross, *supra* note 99, at 161.
- ¹²⁵ *Id.* at 173, 174-75 (“Nurses reported that ‘sticks, rocks, chopsticks, rubber or plastic tubes, gauze or cotton packing, ballpoint pens, coat hangers, or knitting needles... douches believed effective in inducing abortions made from detergents, orange juice, vinegar, bleach, disinfectant, lye, potassium permanganate or colas.”).
- ¹²⁶ *People v. Belous*, 458 P.2d 194, 201 (Cal. 1969) (“The Los Angeles County Hospital, alone, for example, in 1961 admitted over 3,500 patients treated for [criminal] abortions.”); SANGER, *supra* note 64, at 29; WEDDINGTON, *supra* note 5, at 40; *id.* at 15 (“Before abortion became legal in California in 1967, the county hospital in Los Angeles had a ward called the IOB (infected obstetrics) ward. It had about sixty beds for women suffering the results of botched abortions, and sometimes abortions they had performed themselves. Doctors and nurses who worked at public hospitals in the days when abortion was illegal remember women who died in their arms.”); see also Reagan, *supra* note 29, at 1245-46.
- ¹²⁷ *Belous*, 458 P.2d at 201 (quoting brief compiled by “178 deans of medical schools, including the deans of all California medical schools, chairmen of medical school departments, and professors of medical schools”).
- ¹²⁸ Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 PERSP. ON SEXUAL AND REPROD. HEALTH 110, 110 (2005).
- ¹²⁹ American Law Institute, *American Law Institute Abortion Policy, 1962*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT’S RULING* 24, 25 (Linda Greenhouse & Reva Siegel eds. 2010). While the ALI policy ultimately led 12 states to reform their abortion laws, it would

not survive past 1973, when Georgia's ALI-style law was struck down in *Doe v. Bolton*, the companion case to *Roe v. Wade*. *Doe v. Bolton*, 410 U.S. 179 (1973).

¹³⁰ Sherri Chessen Finkbine, *The Lesser of Two Evils*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 11*, 11 (Linda Greenhouse & Reva Siegel eds. 2010).

¹³¹ J.R. Eyerman, *Packing a Suitcase*, GETTY IMAGES, <http://www.gettyimages.com/detail/news-photo/watched-by-her-daughter-lucy-pregnant-american-television-news-photo/53273924#watched-by-her-daughter-lucy-pregnant-american-television-show-host-picture-id53273924>.

¹³² Eliza Berman, *How a German Measles Epidemic Stoked the Abortion Debate in 1965*, TIME (Feb. 2, 2015), <http://time.com/3692652/measles-abortion-1960s/>.

¹³³ Ross, *supra* note 99, at 183.

¹³⁴ Committee on Human Reproduction, *AMA Policy on Therapeutic Abortion*, 201 JAMA 544, 544 (1967).

¹³⁵ American Medical Association, *American Medical Association Policy Statements, 1967 and 1970*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 25*, 28 (Linda Greenhouse & Reva Siegel eds. 2010).

¹³⁶ The 1967 "Bill of Rights" adopted by the National Organization for Women (NOW) included "The Right of Women to Control their Reproductive Lives." National Organization for Women, *National Organization for Women Bill of Rights*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 36*, 37 (Linda Greenhouse & Reva Siegel eds. 2010); *see also* National Association for Repeal of Abortion Laws, *NARAL Policy Statement*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 40*, 40 (Linda Greenhouse & Reva Siegel eds. 2010) ("NARAL, recognizing the basic human right of a woman to limit her own reproduction, is dedicated to the elimination of all laws and practices that would compel any woman to bear a child against her will.").

¹³⁷ Ross & Solinger, *supra* note 31, throughout.

¹³⁸ *See, e.g.*, Ross & Solinger, *supra* note 31, at 47-48.

¹³⁹ Solinger, *Introduction*, *supra* note 6, at 5; *see e.g.*, Ross, *supra* note 99, at 182; Shell Fischer, *The Hush on Abortion*, IN THESE TIMES (Apr. 9, 2010), http://inthesetimes.com/article/5742/the_hush_on_abortion.

¹⁴⁰ *See e.g.*, Fischer, *supra* note 139; P.R. Lockhart, *The Untold Story About Black Women and Abortions*, MOTHER JONES (Oct. 6, 2016), <http://www.motherjones.com/media/2016/10/true-stories-hard-choices-documentary-abortion-black-women/>.

¹⁴¹ Ross, *supra* note 99, at 183.

¹⁴² *Id.* at 183; *see id.* at 177, 179 (discussing Black women participants in Jane, and discussing "seventy women members of the National Welfare Rights Organization rebuff[ing] attempts by African American men to close family-planning clinics).

¹⁴³ Groups like Zero Population Growth and activists like Paul Ehrlich, author of the bestselling and alarmist *The Population Bomb*, maintained that the earth was doomed without widespread "population control," and thus abortion was not merely a matter of civil rights, women's liberation, or public health, but rather what Ehrlich termed a "highly effective weapon in the armory of population control." PAUL EHRLICH, *THE POPULATION BOMB* 88 (1968). This argument, like that of abortion reformers who championed eugenics, is extremely problematic but was nevertheless was somewhat persuasive in the 1960s. Linda Greenhouse & Reva Siegel, *Introduction to Population Connection, Zero Population Growth*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 55*, 55 (Linda Greenhouse & Reva Siegel eds. 2010).

¹⁴⁴ Religious organizations included the Clergy Consultation Service on Abortion, founded by a group of New York ministers and rabbis in 1967, which served as a trusted resource for hundreds of thousands of women seeking illegal abortion services. Howard Moody, *Clergy Statement on Abortion Law Reform and Consultation Service on Abortion (1967)*, in *BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE*

BEFORE THE SUPREME COURT'S RULING 29, 31 (Linda Greenhouse & Reva Siegel eds. 2010). Many other organizations representing liberal sects like Unitarian Universalism and Reform Judaism issued statements in support of abortion rights. See, e.g., Union for Reform Judaism, *Union for Reform Judaism, 49th General Assembly, Montreal, Quebec (November 1967)*, in BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 69, 69 (Linda Greenhouse & Reva Siegel eds. 2010); Unitarian Universalist Association, *1963 General Resolution*, <http://www.uua.org/action/statements/reform-abortion-statutes>.

¹⁴⁵ REAGAN, *supra* note 10, at 160-161; Solinger, *Pregnancy and Power*, *supra* note 102, at 21-22; see Lader, *supra* note 120, at SM32; Sydney H. Schanberg, *The Abortion Issue – Some Pros and Cons*, N.Y. TIMES, Feb. 11, 1967, at 175.

¹⁴⁶ Judith Bourne, James Kahn, S. Beach Conger, & Carl Tyler Jr., *Surveillance of Legal Abortions in the United States, 1970*, 1 J. OBSTETRIC, GYNECOLOGICAL, & NEONATAL NURSING 17 (1972).

¹⁴⁷ Emanuel Perlmutter, *Change Advised in Abortion Law*, N.Y. TIMES, Dec. 13, 1964, at 48.

¹⁴⁸ *Id.* Many other individual physicians and medical organizations quickly followed suit. Theodore Jones, *Change is Sought in Abortion Law: 1,200 State Obstetricians Favor Easing of Rules*, N.Y. TIMES, Jan. 30, 1965, at 73; *Leading Physician Calls for Changes in Abortion Law*, N.Y. TIMES, Oct. 26, 1965, at 37.

¹⁴⁹ John Sibley, *Abortion Reform Urged in Albany*, N.Y. TIMES, Mar. 7, 1966, at 28.

¹⁵⁰ Sydney Schanberg, *Javitz Calls on Legislature to Pass Abortion Reform*, N.Y. TIMES, Feb. 29, 1967, at 1; James R. Sikes, *Kennedy Predicts Abortion Reform*, N.Y. TIMES, Feb. 17, 1967, at 1.

¹⁵¹ *New Abortion Law Urged by Doctors at Meeting Here*, N.Y. TIMES, Dec. 6, 1966, at 27; *Obstetricians Back New Abortion Law*, N.Y. TIMES, July 20, 1966, at 61; *Rockefeller Urges Abortion Review*, N.Y. TIMES, Dec. 21, 1966, at 34; Sydney Schanberg, *Abortion Change Killed in Albany by Vote of 15 to 3*, N.Y. TIMES, Mar. 7, 1967, at 1; Sydney H. Schanberg, *Abortion Reform is Held Unlikely*, N.Y. TIMES, Jan. 10, 1967, at 1; Sydney H. Schanberg, *Liberal Catholics Decline to Support Abortion Reforms*, N.Y. TIMES, Jan. 29, 1967, at 1. Notably, perspectives on the grounds upon which abortions should be available varied, from narrow exceptions to “humanitarian” reasons. See also Sydney Schanberg, *40 Catholic Laymen Back Abortion Bill*, N.Y. TIMES, Mar. 5, 1967, at 28.

¹⁵² Sydney Schanberg, *Abortion Change Killed in Albany by Vote of 15 to 3*, N.Y. TIMES, Mar. 7, 1967, at 1; Sydney H. Schanberg, *Abortion Reform is Held Unlikely*, N.Y. TIMES, Jan. 10, 1967, at 1; Sydney H. Schanberg, *Liberal Catholics Decline to Support Abortion Reforms*, N.Y. TIMES, Jan. 29, 1967, at 1.

¹⁵³ Martin Gansberg, *Marchers Favor Abortion Reform*, N.Y. TIMES, Mar. 12, 1967, at 40; Martin Tolchin, *Defiance Pledged on Abortion Law*, N.Y. TIMES, Mar. 12, 1967, at 81.

¹⁵⁴ Edward Fiske, *Clergymen Offer Abortion Advice*, N.Y. TIMES, Mar. 22, 1967, at 1; see also Sarah McCammon, *50 Years Ago, A Network Of Clergy Helped Women Seeking Abortion*, NPR, May 19, 2017, <http://www.npr.org/2017/05/19/529175737/50-years-ago-a-network-of-clergy-helped-women-seeking-abortion> (last visited June 19, 2017).

¹⁵⁵ Sydney Schanberg, *Legislature Meets Today*, N.Y. TIMES, Jan. 2, 1968, at 1.

¹⁵⁶ *Abortion Panel Chief*, N.Y. TIMES, Jan. 23, 1968, at 26. One of the key participants in this committee was Professor Cyril Means, who later wrote an authoritative work on the history and purpose of New York abortion law, arguing that it could no longer be considered constitutional. Means, *supra* note 3.

¹⁵⁷ Sydney Schanberg, *Rockefeller Asks Abortion Reform*, N.Y. TIMES, Jan. 9, 1968, at 1. In 1967, Great Britain had reformed its own abortion laws to allow abortion within the first 24 weeks of pregnancy for a variety of reasons, including social and economic reasons, and further in cases in which the mother's life or health is “gravely threatened” or there is significant risk for fetal abnormality, at any point in pregnancy. M. Ralson & E. Podrebarac, *Abortion Laws Around the World*, PEW RESEARCH CTR., (Sept. 30, 2008) <http://www.pewforum.org/2008/09/30/abortion-laws-around-the-world/> (last visited June 17, 2017). In addition to the thirteen states that adopted the ALI recommendation, in 1970, Alaska, Hawaii

and Washington all adopted abortion laws that allowed abortions to be provided until the point of viability, based on the woman's decision and consultation with her physician. The Alan Guttmacher Institute, *Abortion in the United States: Two Centuries of Experience*, 2 ISSUES IN BRIEF 1, 3 (1982).

¹⁵⁸ Schanberg, *Rockefeller Asks Abortion Reform*, *supra* note 157, at 1.

¹⁵⁹ *Id.*

¹⁶⁰ James F. Clarity, *Abortion Reforms Gain in Assembly*, N.Y. TIMES, Feb. 6, 1968, at 1; Martin Tolchin, *Demonstrators Brave Weather to Picket Hearing on Abortion Reform*, N.Y. TIMES, Mar. 1, 1968, at 26.

¹⁶¹ Among other supporters of reform, the Citizen's Committee urged specific reform recommendations. James F. Clarity, *Governor Backs Report Urging Major Abortion Law Reforms*, N.Y. TIMES, Mar. 30, 1968.

¹⁶² John Kifner, *Abortion Reform Dies in Assembly*, N.Y. TIMES, April 3, 1968, at 1.

¹⁶³ James F. Clarity, *Abortion Reformers Confident Albany Session Will Pass a Bill*, N.Y. TIMES, Jan. 14, 1969, at 35.

¹⁶⁴ *Abortion Reformers Confident Albany Session Will Pass a Bill*, *supra* note 163, at 35; Bill Kovach, *Brydges Sees Governor Backed on Budget Cuts*, N.Y. TIMES, Jan. 27, 1969.

¹⁶⁵ Bill Kovach, *Governor Asks Legislature for Abortion Reform*, N.Y. TIMES, Feb. 2, 1969, at 27; Sydney Schanberg, *Albany Action on Abortion Reform Seen as Likely*, N.Y. TIMES, Jan. 29, 1969, at 22; Sydney Schanberg, *State Senate Unit to Offer Wide Abortion Reform*, N.Y. TIMES, Mar. 3, 1969, at 33.

¹⁶⁶ The bill failed by a vote of 73 to 71, short three votes needed to reach the 76 threshold for passage. Prior to the roll call, Speaker Duryea announced he would not count the votes cast by assembly members who left the chamber before the vote, observing an old Assembly rule that traditionally was not enforced. As a result, two affirmative votes from Democratic Assemblyman Hulan E. Jack of Manhattan and Herbert J. Miller from Queens were not counted. If those two votes were counted, the bill would have only needed one more vote to pass. In cases like this, the Speaker typically votes to break the tie – and Duryea, according to supporters of the bill, previously said that if the bill received 75 votes, he would provide the 76th and final vote needed. However, in an effort to save the bill, chief-sponsor Constance Cook used a parliamentary maneuver to table the bill rather than allowing the final vote to be recorded, thus preserving the bill to be brought up again for another vote. Bill Kovach, *Abortion Reform Beaten in the Assembly by 3 Votes*, N.Y. TIMES, Mar. 30, 1970, at 1.

¹⁶⁷ *Id.*

¹⁶⁸ Michaels felt compelled to switch his vote because of his sons, who begged him not to let his vote be the one that defeated the bill, even though he knew the majority of his constituents opposed abortion reform and would likely oust him. Francis X. Cline, *Lobbies Included Wives and Clergy*, N.Y. TIMES, Apr. 11, 1970, at 17.

¹⁶⁹ Bill Kovach, *Rockefeller, Signing Abortion Bill, Credits Women's Group*, N.Y. TIMES, Apr. 11, 1970, at 47.

¹⁷⁰ Three years later, the Supreme Court would hold that all states must allow abortions after viability when necessary to protect a woman's health. *Roe v. Wade*, 410 U.S. 113 (1973).

¹⁷¹ These cases built off of a line of cases that included *Skinner v. Oklahoma*, 316 U.S. 535 (1942), which recognized that procreation is "one of the basic civil rights of man" and "fundamental to the very existence and survival of the race." See, e.g., *Roe*, 410 U.S. 113; *Eisenstadt v. Baird*, 405 U.S. 468 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *People v. Belous*, 458 P. 2d 194, 199 (Cal. 1969) (holding "[t]he fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgement of a 'right of privacy' or 'liberty' in matters related to marriage, family and sex" and that although the "when the first abortion law was adopted in 1850 . . . the great and direct interference with a woman's constitutional rights was warranted by considerations of the woman's health" based on the limitations of medical care at the time, abortion in the first trimester was now safer than childbirth and the California law was now unconstitutional); Means, *supra* note 3; Greenhouse, *supra* note 79.

¹⁷² *Griswold*, 381 U.S. 479. Notably, the Court was particularly troubled by the implications of how this particular criminal law could be enforced: “Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship.” *Id.* at 483.

¹⁷³ *Eisenstadt*, 405 U.S. at 453 (“Whatever the rights of the individual to access contraceptives may be, the rights must be the same for the unmarried and married alike.”).

¹⁷⁴ *Abele v. Markle*, 342 F. Supp. 800, 806-07 (D. Conn. 1972).

¹⁷⁵ *Id.* at 801.

¹⁷⁶ *Id.* at 801-02. The majority opinion did not provide an extensive analysis of the relevant state interests at issue, but a concurring opinion filed by Judge Newman did. He concluded that although it was not easy to determine the state interest in the 1860 abortion statutes due to “the paucity of relevant [legislative] materials,” the state interests were likely based on health concerns about the safety of abortion and, based on the then-prevailing morality, to deter women from having sexual intercourse. These interests, he found, no longer were sufficient (if they ever had been) to override the woman’s own constitutional right to determine whether to remain pregnant or have an abortion. *Id.* at 810 (Newman, J., concurring). He noted that only one Connecticut Supreme Court case dealt with the purpose of these statutes, and that the language in the decision indicated that they were intended to protect women’s “health and perhaps life against the risk of a dangerous operation to which she might be tempted to submit,” as well as to “deter[] fornication” or otherwise “inhibit[] non-procreative sexual relations.” *Id.* at 809 (Newman, J., concurring). Notably, he was “persuaded that protecting the life of the unborn child was most likely not a purpose of the 1860 legislature.” *Id.* at 810 (Newman, J., concurring).

¹⁷⁷ *Id.* at 804; see *McCormack v. Hiedeman*, 694 F.3d 1004 (9th Cir. 2012).

¹⁷⁸ *Abele*, 342 F. Supp. at 804-05 (“[T]he state’s interests are insufficient to take from the woman the decision after conception whether she will bear a child and . . . she, as the appropriate decision maker, must be free to choose. . . we grant only declaratory relief to this effect as there is no reason to believe that the state will not obey our mandate.”). The only discussion in any of the opinions that differentiates between self-induction and abortion provided by a physician relates to the appropriate remedy – Judge Newman in concurrence notes that he would have enjoined the statute rather than simply issued a declaratory judgement, because with a declaratory judgement, there was still a risk of prosecution, although the defendant could use the court’s declaratory judgement about the statute as a defense in criminal court. Judge Newman believed this was an inadequate remedy because the plaintiff wanted to have an abortion with a physician and she might not be able to find one willing to take the risk of prosecution, even with the defense provided by a holding that the statute was unconstitutional. *Id.* at 812 (Newman, J., concurring). Although this analysis is procedural, it clearly indicates that the Court fully intended to address both situations where a woman wanted to self-induce and situations where she sought a provider-based abortion.

¹⁷⁹ *McCormack*, 694 F.3d at 1011.

¹⁸⁰ WEDDINGTON, *supra* note 5, at 105, 131.

¹⁸¹ *Id.* at 81.

¹⁸² *Roe v. Wade*, 410 U.S. 113, 117-18 (1973).

¹⁸³ *Id.* at 140. The Court examined the state’s interests in prohibiting abortion, including the potential (although likely improper) interest in discouraging sex, the concerns about the safety of abortion as they existed, and the state’s interest “in protecting prenatal life.” *Id.* at 149-50 (noting also that there was some disagreement among scholars and jurists about whether this last interest was truly involved, pointing out that “in many states, including Texas . . . the woman herself could not be prosecuted for self-abortion or for cooperating in an abortion performed upon her by another,” thus imply that fetal

life could not have been the state's primary interest).

¹⁸⁴ *Id.* at 153.

¹⁸⁵ *Id.* at 154.

¹⁸⁶ *Id.* at 159, 162. In so holding, the Court's opinion canvassed a variety of different perspectives on when life begins, from the Stoics to Judaism, Protestant beliefs, modern medical conclusions and the Catholic Church's position.

¹⁸⁷ *Id.* at 169 (Stewart, J., concurring) (quoting Justice Harlan that "[T]he full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution. . . . It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints[.]").

¹⁸⁸ *Id.* at 208 (Burger, C.J., concurring).

¹⁸⁹ WEDDINGTON, *supra* note 5, at 169; see Katherine Grainger et al., *What if Roe Fell?* CTR. FOR REPRODUCTIVE RIGHTS (Nov. 2007), available at

https://www.reproductiverights.org/sites/default/files/documents/Roe_PublicationPF4a.pdf (describing the impact on various state laws if *Roe* were overturned, given that some were repealed, others left on the books, and others partly or entirely enjoined by other courts).

¹⁹⁰ *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992) (internal citations omitted) (noting the connection and overlapping considerations of the rights of "personal autonomy and bodily integrity, akin to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection").

¹⁹¹ *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016); see also Means, *supra* note 3, at 453 (writing in 1968, "it is a matter for serious consideration whether the invocation of this recognized chief purpose of the police power of the State (citizens' health and life) and no other (e.g., morals, population promotion, etc.) renders abortion statutes today . . . vulnerable to constitutional attack. Women have been deprived of an ancient common-law liberty in the name of health.").

¹⁹² Christina Cauterucci, *New York Still Bans Abortion After 24 Weeks*, May 25, 2017,

http://www.slate.com/blogs/xx_factor/2017/05/25/new_york_state_still_bans_abortions_after_24_weeks_a_proposed_law_could.html (last visited June 17, 2017); Katharine Bodde & Sebastian Krueger, *Critical Conditions: How New York's Unconstitutional Abortion Law Jeopardizes Women's Health*, *New York Civil Liberties Union* (2017), available at

https://www.nyclu.org/sites/default/files/field_documents/nyclu_criticalconditions_20170126.pdf. A 2016 formal opinion from Attorney General Eric Scheniderman clarified that "New York law cannot criminalize what the federal Constitution protects. . . . Accordingly, . . . an abortion performed after 24 weeks from the commencement of pregnancy is lawful in New York when the fetus is not viable or when the abortion is necessary to protect the health of the pregnant woman." N.Y. Attorney General Opinion No. 2016-F1, Sept. 7, 2016. There is anecdotal evidence that hospitals and physicians are more comfortable providing that necessary care. Moreover, a bill pending in the New York legislature, passed by the Assembly and considered by the Senate, would eliminate the confusion by repealing the conflicting provisions. See Reproductive Health Act, N.Y. S. 2796 (as passed by N.Y. Assembly, Jan. 17, 2017).

¹⁹³ Roberts, *supra* note 9, at 1421.

¹⁹⁴ Means, *supra* note 3, at 488.

¹⁹⁵ See generally Roberts, *supra* note 9.

¹⁹⁶ See Anemona Hartocollis, *After Fetus is Found in Trash, a Rare Charge of Self-Abortion*, N.Y. TIMES (Dec. 2, 2011), <http://www.nytimes.com/2011/12/02/nyregion/self-abortion-charge-after-fetus-found-in-trash-in-washington-heights.html>; NBC4, *Self-Abortion Charges Dropped in Case of Fetus Left in Trash* (Jan. 3, 2012), <http://www.nbcnewyork.com/news/local/Self-Abortion-Fetus-Trash-Charges-Dropped->

[136608803.html](#).

¹⁹⁷ See McCormack v. Hiedeman, 694 F.3d 1004 (9th Cir. 2012); Bei Bei Shuai v. State, 966 N.E.2d 619 (Ind. Ct. App. 2012); The Self-Induced Abortion Legal Team, *How Do State Laws Criminalize Abortion*, <https://www.sialegalteam.org/laws>.

¹⁹⁸ Roberts, *supra* note 9, at 1432.

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ See generally Roberts, *supra* note 9. A similar situation has arisen in England, which revised its own abortion laws in the mid-1800s and again in the 1960s to be very similar to New York's laws. English law currently prohibits self-abortion, with a serious penalty for violations, and although women themselves are rarely prosecuted, English law enforcement uses those laws to seize drugs, search homes, and generally intrude on the private reproductive decision-making of women all over the United Kingdom. Radhika Sanghani, *Women's Charities Call To End Cruel Abortion Laws in the UK*, THE TELEGRAPH (Feb. 2, 2016), <http://www.telegraph.co.uk/women/life/womens-charities-call-to-end-cruel-abortion-laws-in-the-uk/>. In the UK, support is building for repeal of this harmful law. On June 27, 2017, the British Medical Association voted to support a change in the law, to decriminalize abortion and self-abortion in the United Kingdom: "The organisation wants abortion to be treated like any other medical procedure and therefore to be regulated and subject to certain standards and will now look to lobby government to change the law." Nick Triggle, , BBC News, June 27, 2017, <http://www.bbc.com/news/health-40418986> (last visited June 28, 2017). British advocates applauded the move and urged Parliament to take the necessary steps to repeal the outdated law. Ann Furedi, *Why UK abortion laws should be scrapped - they are 50 years out of date*, The Telegraph, June 28, 2017, <http://www.telegraph.co.uk/women/life/uk-abortion-laws-should-scrapped-50-years-date/> (last visited June 28, 2017).

²⁰² Roberts, *supra* note 9, at 1468-70.

²⁰³ See e.g., Jill E. Adams & Melissa Mikesell, *And Damned If They Don't: Prototype Theories to End Punitive Policies Against Pregnant People Living In Poverty*, 18 Geo. J. Gender & L. 283, 323-24 (2017); Roberts, *supra* note 9, at 1479.

²⁰⁴ Zakiya Luna & Kristen Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 328 (2013) ("The idea of a coconstitutive relationship between (marginalized) social identities is often referred to as intersectionality, a term coined by legal scholar Kimberlé Crenshaw").

²⁰⁵ Adams & Mikesell, *supra* note 203, at 323-24.

²⁰⁶ See generally *id.*

²⁰⁷ Angela Bonavoglia, *Introduction to THE CHOICES WE MADE: TWENTY-FIVE WOMEN AND MEN SPEAK ABOUT ABORTION* xix, xxiii (Angela Bonavoglia ed., 1991); Gold, *supra* note 15, at 8.

²⁰⁸ Cates & Rochat, *supra* note 17, at 87-91. Specific evidence of this continued phenomenon was found in a study in 1974, which noted that the availability of legal abortion services was limited especially for low-income women and women who lived in rural or other non-metropolitan areas; those characteristics tracked closely with those who died from illegal abortions. *Id.*

²⁰⁹ Nash, *supra* note 45 (more than half of all states are now classified as "hostile" or "extremely hostile" to abortion access and 39% of American women live in a county with no abortion provider).

²¹⁰ Adams & Mikesell, *supra* note 203, at 321-332.

²¹¹ Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, THE ATLANTIC, Jun. 27, 2014; Zerwick, *supra* note 58 (the staff at the Whole Women's Health clinic in Texas often receives calls asking for information about misoprostol and self-induction but is unable to answer those questions, and the hotline staff at the National Abortion Federation regularly hears from women who tried and failed to end their own pregnancy).

²¹² Seth Stephens-Davidowitz, *The Return of the D.I.Y. Abortion*, N.Y. TIMES, Mar. 5, 2016.

²¹³ Zerwick, *supra* note 58 (“Pills bought online or through a nonmedical source can be fake or contaminated, and it’s impossible to confirm the dose. ‘One patient ordered pills online – she thought they had worked, but they had not,’ a provider in the South told *Glamour*. ‘I saw her when she was in her second trimester. Instead of a simple early abortion, she needed a more complex procedure.’”).

²¹⁴ Hellerstein, *supra* note 211; Zerwick, *supra* note 58. In other situations, the sellers may not know themselves: “Lopez [a vendor at the Alamo Flea Market] is the first to admit he knew nothing about the pills when he was selling them. ‘I’m not a doctor, I sell things,’ he acknowledges, picking up a medicine bottle. ‘I don’t know anything else.’” Hellerstein, *supra* note 211.

²¹⁵ See Patrick Adams, Spreading Plan C to End Pregnancy, N.Y. TIMES, April 27, 2017, <https://www.nytimes.com/2017/04/27/opinion/spreading-plan-c-to-end-pregnancy.html> (last visited June 19, 2017); Zerwick, *supra* note 58.

²¹⁶ April L. Cherry, *Shifting Our Focus from Retribution to Social Justice: An Alternative Vision for the Treatment of Pregnant Women Who Harm Their Fetuses*, 28 J.L. & HEALTH 6, 24 (2015).

²¹⁷ *Id.*; see also Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POLICY REVIEW 70, 74 (2015); The Self-Induced Abortion Legal Team, *Making Abortion a Crime (Again): How Extreme Prosecutors Attempt to Punish People for Abortions in the U.S.*, https://docs.wixstatic.com/ugd/aa251a_09c00144ac5b4bb997637bc3ac2c7259.pdf.

²¹⁸ Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women’s Legal Status and Public Health*, 38 J. HEALTH POL. POL’Y & L. 299, 332 (2013).

²¹⁹ AMNESTY INTERNATIONAL, ON THE BRINK OF DEATH: VIOLENCE AGAINST WOMEN AND THE ABORTION BAN IN EL SALVADOR 7 (2014).

²²⁰ “[T]he mere existence of medication abortion is providing some legal authorities reason to conduct fishing expeditions to go after not only women who have clearly terminated a pregnancy, but also women whom they suspect having done so.” Rowan, *supra* note 217, at 74.

²²¹ *Id.* at 33.

²²² *Id.*

²²³ *Id.*

²²⁴ Paltrow & Flavin, *supra* note 218, at 328.

²²⁵ Lawrence J. Nelson, *A Crisis for Women’s Rights? Surveying Feticide Statutes for Content, Coverage, and Constitutionality*, 6 U. DENV. CRIM. L. REV. 63, 79-80 (2016).

²²⁶ *Id.* at 91. (“Common activities could possibly cause a miscarriage: working (e.g., as a law enforcement officer or fire fighter), playing sports, strenuous hiking or climbing, skiing, undergoing medical treatment dangerous to the unborn (e.g., chemotherapy), and driving. Pregnant women should be able to engage in activities like these without fear that doing so could turn them into criminals if the unborn they carry happens to die.”).

²²⁷ Roberts, *supra* note 9, at 1422; Rowan, *supra* note 217, at 74; see also KHIARA M. BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RADICALIZATION, 41 (2011) as reprinted in MELISSA MURRAY & KRISTIN LUKER, CASES ON REPRODUCTIVE RIGHTS AND JUSTICE 155-59 (2015) (“[T]he pregnant women who decide to attempt prenatal care with state assistance find themselves . . . most decidedly within the reach of the disciplinary, regulatory and biopolitical state.”).

²²⁸ Roberts, *supra* note 9, 1432.

²²⁹ Paltrow & Flavin, *supra* note 218, at 333.

²³⁰ In El Salvador, at least 26 women had served jail time by 2011, many with a sentence of 30-50 years.

²³¹ Paltrow & Flavin, *supra* note 218, at 332.

²³² Nicholas Freudenberg, *Adverse Effects of US Jail and Prison Policies on the Health and Well-Being of*

Women of Color, 92 AM. J. PUB. HEALTH 1895 (2002); see also Tamar Kraft-Stolar, *Reproductive Injustice: The State of Reproductive Healthcare for Women in New York's Prisons*, N.Y. CORR. ASSOC. WOMEN IN PRISON PROJECT (2015), <http://www.correctionalassociation.org/wp-content/uploads/2015/03/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf>.

²³³ See, e.g., Tara Culp-Ressler, *Immigrant Woman Could Face Deportation After She Tried to Go To the Doctor*, SLATE, Sept. 14, 2015, available at <https://thinkprogress.org/immigrant-woman-could-face-deportation-after-she-tried-to-go-to-the-doctor-50cc535f3ba6>; Press Release, The National Latina Institute for Reproductive Health, *The National Latina Institute for Reproductive Health Condemns Nationwide ICE Retaliation and Intimidation* (February 10, 2017), available at <http://www.latinainstitute.org/en/national-latina-institute-reproductive-health-condemns-nationwide-ice-retaliation-and-intimidation>.

²³⁴ “The Supreme Court has long recognized that liberty from confinement is a fundamental right.” Sherry F. Colb, *Freedom From Incarceration: Why Is This Right Different From All Other Rights?*, 69 N.Y.U. L. Rev. 781, 787 (1994); but see *id.* at 791-92 (“Though liberty from confinement is an essential, core right of citizenship, a criminal conviction nonetheless extinguishes that right. While a criminal conviction must be ‘valid,’ this requirement places minimal substantive limits upon the government. A valid conviction entails many procedural protections; however, the only substantive component of a ‘valid’ conviction is that the criminal conduct not be constitutionally protected as a fundamental right.”).

²³⁵ See Roberts, *supra* note 9, at 1467-68 (“The Court has expressly distinguished, for example, the government’s refusal to subsidize the exercise of the abortion right from the infliction of criminal penalties on the exercise of that right. Criminal prosecutions of drug-addicted mothers do more than discourage a choice; they exact a severe penalty on the drug user for choosing to complete her pregnancy.”).

²³⁶ Means, *supra* note 3, at 459. One of the few contemporaneous statements about such a law, written by a physician who advocated abortion prohibitions in Wisconsin in 1870, supports that conclusion: “It is an undoubted fact that, especially in high life, and in the middle ranks of society, many wives (and often with the connivance of their husbands) take measures of this kind. It is not probable that any law could be enforced in such cases; but the fact of the existence of a law making it criminal, would probably have a moral influence to prevent it to some extent.”). MOHR, *supra* note 4, at 140.

²³⁷ Means, *supra* note 3, at 445, 447.

²³⁸ *Id.* at 454.

²³⁹ *Id.* at 462. At one point, due to bad statutory drafting “a woman who submitted to a surgical abortion before quickening was made guilty of a new statutory misdemeanor, whereas the surgeon who performed it was guiltless of any crime”; ironically, although that drafting error was fixed in the next amendment, it is the state of the law once again today. *Id.*; N.Y. PENAL LAW §125.50 & §125.55 (McKinney 2017).

²⁴⁰ Professor Means posits that “[t]he 24-week period can be considered as parallel to the common law concept of quickening,” noting that “[o]ften the only witness who can testify as to whether quickening has yet taken place is the woman herself,” lending more reliability to “a fixed period of weeks.” Means, *supra* note 3, at 498, 502.

²⁴¹ *Id.* at 418.

²⁴² *Id.* at 453.

²⁴³ *Id.* at 508.

²⁴⁴ New York’s death penalty was eliminated at one point and later reinstated: when the death penalty was revised in 1995, the legislature exempted all pregnant women from it. See Assembly Bill 4843, 191st Leg. (N.Y. 1995).

²⁴⁵ See *supra* note 85 and accompanying text; *Abele v. Markle*, 342 F. Supp. 800, 803-04 (D.Conn. 1972).

²⁴⁶ MOHR, *supra* note 4, at 36.

²⁴⁷ See *supra* notes 75-86 and accompanying text.

²⁴⁸ Means, *supra* note 3, at 459.

²⁴⁹ Abele, 342 at 810 (Newman, J., concurring); see *supra* note 176.

²⁵⁰ Sessions v. Morales-Santana, No. 15-1191, 2017 WL 2507339, at *1 (U.S. June 12, 2017); Nevada Dep't of Human Res. v. Hibbs, 538 U.S. 721 (2003); Reed v. Reed, 404 U.S. 71 (1971).

²⁵¹ See, e.g., Abele v. Markle, 342 F. Supp. 800, 803-04 (D.Conn. 1972).

²⁵² Means, *supra* note 3, at 488.

²⁵³ *Id.* at 492-93 (emphasis added).

²⁵⁴ Means, *supra* note 3, at 493 (quoting Professor George). This change in the law may have been motivated by the fact that in the 1940s, prosecutors were becoming interested in pursuing abortion practitioners whose patients were living, and were insistent on bringing the women themselves into court. See *supra* section III.d.

²⁵⁵ MODEL PENAL CODE § 201.11(3) (AM. LAW INST. 1962).

²⁵⁶ *Id.*

²⁵⁷ See Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); Planned Parenthood of Se. Pennsylvania v. Casey, 505 U.S. 833 (1992); Roe v. Wade, 410 U.S. 113 (1973); Eisenstadt v. Baird, 405 U.S. 438 (1972); see also Lawrence v. Texas, 539 U.S. 558, 562 (2003) ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.").

²⁵⁸ N.Y. PENAL LAW § 125.40, practice cmt. (McKinney). The commentary on the abortion amendments to New York penal code was drafted by Richard G. Denzer, executive director of the Commission on Revision of the Penal Law and Criminal Code and former ADA for New York County.

²⁵⁹ *Id.*

²⁶⁰ *Id.*

²⁶¹ Means, *supra* note 3, at 502.

²⁶² *Id.*

²⁶³ See Roe v. Wade, 410 U.S. 113, 208 (1973) (Burger, C.J. concurring).

²⁶⁴ Roberts, *supra* note 9, at 1422; Rowan, *supra* note 217, at 74.

²⁶⁵ Commonwealth v. Pugh, 462 Mass. 482 (Mass. 2012). In the context of a woman being prosecuted for the death of her newborn after giving birth without medical assistance in her own bathroom, the Massachusetts Court held: "Although the vast majority of women elect hospital births, medically unassisted births continue to take place by choice and by necessity. 'Children are born of unattended mothers on trains, in taxis, and in other out of the way places, and we fear to open up a field for unjust prosecutions of actually innocent women.' Unassisted childbirth has always been a legally recognized alternative to medically assisted childbirth. All births, regardless of venue, carry inherent risks; in the ordinary course, competent women who are pregnant may weigh these risks themselves and make decisions about the course of their own pregnancies and childbirths." *Id.* at 505-06. Pregnancy presents a unique circumstance because "anything which a pregnant woman does or does not do may have an impact, either positive or negative, on her development fetus." *Id.* (quoting Stallman v. Youngquist, 531 N.E.2d 355, 359 (Ill. 1988)).

²⁶⁶ See Reagan, *supra* 29, at, 1255.

²⁶⁷ See *Information Sheet: Safe and unsafe induced abortion: Global and regional levels in 2008, and trends during 1995–2008*, WORLD HEALTH ORG. (2012), available at http://apps.who.int/iris/bitstream/10665/75174/1/WHO_RHR_12.02_eng.pdf (describing the characteristics and occurrence of unsafe abortion, including many methods and types of self-abortion); Teresa A Saultes, Diane Devita & Jason D. Heiner, *The Back Alley Revisited: Sepsis after Attempted Self-Induced Abortion*, 10 West J. Emerg. Med. (2009). But see Daniel Grossman, *The New Face of Self-*

Induced Abortion, HOUSTON CHRONICLE, Jan. 21, 2016, <http://www.houstonchronicle.com/opinion/outlook/article/Grossman-The-new-face-of-self-induced-abortion-6775378.php> (last visited June 19, 2017) (“This is the new face of self-induced abortion - in the U.S. and the world over. It's rare that women use coat hangers. Now women are more likely to use misoprostol, a very safe and effective medication, to end an early pregnancy without additional intervention.”).

²⁶⁸ See generally Roberts, *supra* note 9.

²⁶⁹ The Self-Induced Abortion Legal Team, *supra* note 217; Matt Flegenheimer & Maggie Haberman, *Donald Trump, Abortion Foe, Eyes Punishment for Women, Then Recants*, N.Y. TIMES (Mar. 30, 2016), <https://www.nytimes.com/2016/03/31/us/politics/donald-trump-abortion.html> (last visited June 5, 2017).

²⁷⁰ *Fact Sheet: Induced Abortion in the United States*, GUTTMACHER INST. (Jan. 2017), <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states> (last visited June 19, 2017).