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Contraceptive Comstockery: Reasoning from Immorality to Illness in the Twenty-First Century

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Contraceptive Comstockery: Reasoning from Immorality to Illness in the Twenty-First Century

PRISCILLA J. SMITH

*This Article examines the use by anti-contraception advocates of the claims that “contraception harms women” and “contraception is abortion,” claims made most prominently in litigation challenging Obamacare’s contraceptive coverage requirement. See *Burwell v. Hobby Lobby*, 134 S. Ct. 2751 (2014). The Article uncovers the nineteenth-century roots of these arguments and the strategic reasoning behind their current revival, to reveal that these claims are part of a broad attack on contraception grounded in opposition to non-procreative sex. In Part II, the Article reviews nineteenth-century reasoning about contraceptives, and then in Part III, discusses the modern revival of this Comstock era mode of reasoning about contraception which connected immorality and illness. Today, however, considerable social acceptance of sex for pleasure (at least for some people in some circumstances) means that straightforward arguments against contraception based on its immorality do not resonate as successfully as they once did. Social conservatives have publicly acknowledged as much, expressing an anxiety about the position of religion as “belief” rather than “truth,” and about a rise in what they call “sexualityism.” As a result, modern opponents of contraception have intentionally attempted to mask outmoded and unpopular moral opposition to non-procreative sex by using scientific discourse, citing the best science “we can currently lay our hands on,” for support.*

The problem for anti-contraception advocates, as revealed in Parts IV and V, is that the appeal to science is a purely rhetorical move, and their claims are contradicted by the latest scientific evidence. The Article establishes the safety and benefits of hormonal contraceptives to women’s and children’s health. The Article also shows that the claim that five hormonal contraceptives are abortifacients is false. Four out of five do not interfere with implantation of a fertilized egg and so cannot be said to terminate a “pregnancy,” even as redefined by opponents as occurring upon fertilization. Opposition to these hormonal contraceptives is thus not truly based on the view that destruction of a fertilized egg is immoral and should be considered an abortion. Rather, the opposition goes much deeper, stemming from a general objection to all forms of contraception and the ability of women to have sex without accepting the possibility of pregnancy and motherhood. The Article concludes in Part VI with evidence of the benefits of increased access to the most effective forms of contraception.

Anti-contraception advocates are deploying woman-protective health arguments to limit access to contraception using a strategy similar to that adopted to oppose abortion. Anti-contraception advocates have melded these arguments to contemporary anxieties about heterosexual women’s ability to survive on equal footing with men in today’s sexual and marital “marketplace” in order to stymie efforts to expand contraceptive access and to further restrict access where possible.

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Contraceptive Comstockery: Reasoning from Immorality to Illness in the Twenty-First Century

PRISCILLA J. SMITH*

I. INTRODUCTION

This Article interrogates two critiques of hormonal contraceptives to reveal that both critiques are animated by moral arguments against all non-procreative sex dressed up in faulty scientific reasoning. The two arguments are: (1) that contraceptives are bad for women’s health, and (2) that many hormonal contraceptives are actually abortifacients that terminate pregnancy because, it is argued, they could prevent a fertilized egg from implanting into a woman’s uterine lining. These claims circulated in anticipation of challenges to the contraceptive coverage requirement in the Affordable Care Act¹ and were submitted before the Supreme Court in the *Hobby Lobby*² litigation in the form of an amicus brief filed on behalf of a group called “Women Speak for Themselves.”³ Although these claims garnered significant attention recently during the *Hobby Lobby* litigation, in fact, the claims that contraceptives are bad for health and are morally equivalent to abortion have a long pedigree.

In fact, the modern claims that “contraception harms women” and “contraception is abortion” are modes of reasoning consciously modeled

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¹ See Helen M. Alvaré, *No Compelling Interest: The “Birth Control” Mandate and Religious Freedom*, 58 VILL. L. REV. 379, 379 (2013) (arguing that the Affordable Care Act has challenged the understanding of free exercise of religion as a human right).

² *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

³ Brief for Women Speak for Themselves as Amicus Curiae Supporting Respondents at 12–13, *Sebelius v. Hobby Lobby Stores*, 134 S. Ct. 1536 (2014) (Nos. 13-354, 13-356) (claiming that “[t]hese covered prescription drugs are specifically those that are designed to prevent implantation [W]hen an embryo cannot implant in the mother’s womb, it perishes.” (internal quotations omitted) (emphasis in original)). The argument was presented in that brief in support of the doctrinal claim that the government did not have a compelling interest in requiring contraceptive coverage and so could not defeat the plaintiffs’ claim that the contraceptive coverage requirement violated the plaintiffs’ right to free exercise of religion under the Religious Freedom Restoration Act (RFRA). *Id.* at 1–2.

on the claims of nineteenth century anti-contraception crusaders. These Comstock crusaders believed that illicit sexual acts, including non-procreative sex facilitated by contraception, were immoral and this immorality was the cause of illness and harm to women. These beliefs undergirded the federal Comstock Act, which banned the distribution of contraception and information regarding contraception, as well as state-level mini-Comstock laws in the late nineteenth and early twentieth centuries.

Today, however, considerable social acceptance of sex for pleasure (at least for some people in some circumstances) means that straightforward arguments against contraception based on its immorality do not resonate as successfully as they once did. Anti-contraceptive advocates can no longer rely on the tacit agreement that contraception leads to illicit sex, loose women, and over-stimulated young men. Social conservatives have publicly acknowledged as much, expressing an anxiety about the position of religion as “belief” rather than “truth,” and about a rise in what they call “sexualityism.”⁴ As a result, in reviving the message of their nineteenth century counterparts, modern opponents of contraception consciously chose to deemphasize moral arguments in favor of claims that contraception is bad for women’s health, relying on scientific claims that fall apart upon examination.⁵

Anti-contraception advocates are deploying woman-protective health arguments similar to the woman-protective reasoning adopted to oppose abortion⁶ when fetal-protective arguments failed to result in rejection of *Roe v. Wade*.⁷ Anti-contraception advocates have melded these arguments

⁴ See *infra* Part III.

⁵ Importantly, these claims are styled as defensive claims against government overreach designed to appeal to libertarians, anti-vaxxers, and other government skeptics along with social conservatives. See, e.g., *Burwell*, 134 S. Ct. at 2759 (discussing the plaintiffs’ claim that the federal government’s contraception coverage requirement infringes religious liberty).

⁶ See Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, AM. PSYCHOLOGICAL ASS’N 6 (2009), <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> (noting that evidence indicates that the relative risk of mental health problems due to an abortion is similar to the risk associated with an unplanned pregnancy, but that risk increases in certain circumstances). Despite extensive evidence that abortion does not increase suicide attempts or ideation overall, see *id.*, anti-abortion advocates have had some success in using claims of such harm to regulate abortion. See *Planned Parenthood Minnesota v. Rounds*, 686 F.3d 889, 904 (8th Cir. 2012) (“[A]lthough the record reflects ‘medical and scientific uncertainty,’ as to whether abortion itself is a causal factor in the observed correlation between abortion and suicide, there is nothing in the record to suggest that abortion as a cause *per se* has been ruled out with certainty. As a result, the disclosure of the observed correlation as an ‘increased risk’ is not unconstitutionally misleading or irrelevant under *Casey* and *Gonzales*.” (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)) (citation omitted)).

⁷ 410 U.S. 113 (1973); see *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (reaffirming central principles of *Roe*); Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 DUKE L.J. 1641, 1643 (2008) [hereinafter *The Right’s Reasons*] (“Instead, . . . [t]he supporters of [one state’s abortion] ban . . . speak in gentle tones

to contemporary anxieties about heterosexual women's ability to survive on equal footing with men in today's sexual and marital "marketplace"⁸ in order to stymie efforts to expand contraceptive access and to further restrict access where possible.⁹

The modes of reasoning that have undergirded efforts to regulate women's reproductive rights have not escaped attention. In 1992, Reva Siegel observed that the Supreme Court reasoned "about reproductive regulation in physiological paradigms . . . obscur[ing] the possibility that such regulation may be animated by constitutionally illicit judgments about women."¹⁰ By relying on "natural," physiological differences between the sexes to regulate reproduction, the Court "deflect[ed] attention from the social context in which judgments about protecting unborn life are formed and enforced."¹¹

More recently, Siegel traced the emergence of woman-protective anti-abortion discourse, documenting the spread of a new form of reasoning about abortion. As she wrote in 2008, the "claim that women need

about how abortion hurts women." (quoting Monica Davey, *National Battle over Abortion Focuses on South Dakota Vote*, N.Y. TIMES, Nov. 1, 2006, at A5).

⁸ Alvaré, *supra* note 1, at 380 (claiming that "contraception affects the 'marketplaces' for sex and marriage" by "lowering the 'price' of sex, by separating sexual intercourse from the understanding that sex makes children," and thereby increasing pressure on women to have sex outside of marriage); *id.* at 399 (arguing that contraception affects "sex and mating markets"). Alvaré argues that "[s]ingle women thus feel pressured, because if they do not participate in sex, they are at a classic competitive disadvantage because [s]exual activity without commitment is increasingly expected in premarital relationships," and that "the current sex and mating market enabled by contraception and abortion operates to the disadvantage of women, and the relative advantage of men, due to a series of incentives structured by their availability." *Id.* at 409 (internal quotation marks omitted). In making this argument, Alvaré reflects a view similar to that expressed by Pope Pius XI in 1930 concerning the ramifications of granting women equal status in marriage—that equality in marriage was a "false liberty and unnatural equality" that would be to "the detriment of the woman herself." Pope Pius XI, Encyclical Letter, *Casti Connubii* (On Christian Marriage) (Dec. 31, 1930). A woman who "descends from her truly regal throne to which she has been raised within the walls of the home" would "soon be reduced to the old state of slavery . . . and become as amongst the pagans the mere instrument of man." *Id.*

⁹ To be clear, it is my belief that difficulties women have in achieving and maintaining equality in the world of sex, love, and family formation, stem not from women's sexual equality and liberation, but rather from continued enforcement of sexual norms that, among other things, prioritize the fulfillment of male sexual desire over the fulfillment of female sexual desire. This enforcement of old sexual status norms despite new legal regimes providing increased sexual freedom for women conforms to what Reva Siegel has called "preservation through transformation," the idea that even after legal structures that reinforced certain status regimes are upset, those who contested the change in the legal structures will continue to attempt to enforce the old status regime with modern arguments. See Reva Siegel, "The Rule of Love": *Wife Beating as Prerogative and Privacy*, 105 YALE L.J. 2117, 2119 (1996) (arguing that "civil rights reform can breathe new life into a body of status law, by pressuring legal elites to translate it into a more contemporary, and less controversial, social idiom"). This point deserves its own treatment and is beyond the scope of this Article.

¹⁰ Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions on Equal Protection*, 44 STAN. L. REV. 261, 264 (1992) [hereinafter *Reasoning from the Body*].

¹¹ *Id.* at 334.

protection from abortion has been spreading within the anti-abortion movement for decades and played a central role in arguments for the abortion ban” enacted and later defeated in South Dakota.¹² Like the earlier appeals to nature and physiology, these woman-protective claims emphasize women’s physiology and emotional makeup in advancing the claim that abortion is physically and psychologically harmful.

As this Article documents, these woman-protective arguments have not been confined to objections to abortion, but have migrated to undergird opposition to contraception. The purpose of inserting this claim in the movement against contraceptive access is to extend the reach of “woman protective” arguments used to support restrictions on abortion¹³ and ultimately to embed these arguments in the law.¹⁴ If successful, this “abortionification,” as I’ve begun to call it, of contraceptives—which includes redefining some contraceptives *as* abortifacients—could undermine, or at the least prevent the expansion of, government programs that provide contraceptives or coverage of contraceptives,¹⁵ such as the Medicaid, Medicare, Title X programs,¹⁶ and the insurance programs

¹² Siegel, *The Right’s Reasons*, *supra* note 7, at 1643.

¹³ See Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1732–33 (2008) [hereinafter *Dignity and the Politics of Protection*] (discussing the impact of the insertion of “woman-protective” language in the Supreme Court’s decision upholding a restriction on abortion in *Gonzales v. Carhart*, 127 S. Ct. 1610, 1634 (2007)); *id.* at 1734, n.116 (citing Memorandum from James Bopp, Jr. & Richard E. Coleson on Pro-Life Strategy Issues 6 (Aug. 7, 2007), available at <http://operationrescue.org/pdfs/Bopp%20Memo%20re%20State%20HLA.pdf> (promoting an incrementalist approach to restricting abortion and expressing concern about the potential that the Court could adopt a broader equality protective framework in a case that does not involve incremental restrictions)); Siegel, *The Right’s Reasons*, *supra* note 7, at 1642–43, n.8 (“The woman-protective argument that appears in *Carhart* seems to have entered the case not through findings of Congress or the lower courts, but rather through amicus briefs filed in the Supreme Court . . .”).

¹⁴ In the abortion context, “woman-protective” reasoning is at the core of arguments about the proper standard to be applied in cases where the state claims that restrictions on abortion—such as hospital admitting privilege requirements, restrictions on medical abortions, and abortion clinic physical plant requirements—serve a state interest in women’s health. See, e.g., *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 913 (9th Cir. 2014) (“[U]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.” (internal quotations omitted) (emphasis omitted)); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 593 (5th Cir. 2014) (“The opinion next concluded that the statute places an undue burden *on women* seeking an abortion.” (emphasis added)); *Planned Parenthood of Wis. v. Van Hollen*, 738 F.3d 786, 789 (7th Cir. 2013) (“The plaintiffs . . . argue that the statute would do nothing to improve women’s health . . .”); *Planned Parenthood Southeast, Inc. v. Strange*, 33 F. Supp. 3d 1330, 1340–41 (M.D. Ala. 2014) (“The plaintiffs further argue that the clinic closures would impose significant harms on women seeking abortions and that the justifications are weak.”).

¹⁵ See, e.g., Rachel Benson Gold, *The Implications of Defining When a Woman Is Pregnant*, 8 GUTTMACHER REPORT ON PUB. POL’Y, No. 2, 2005, at 7, 10 (reporting that some states have enacted measures that exclude emergency contraceptives from Medicaid coverage on the ground that users of contraceptives intend to terminate pregnancies).

¹⁶ Titles XVIII and XIX of the Social Security Amendments Act of 1965, P.L. 89-97, created the

provided pursuant to the Affordable Care Act.¹⁷ As importantly, the attempt to clothe opposition to contraceptives in a benevolent concern for women's welfare is revealed here as a pretext for promoting a familiar, if outmoded, moral view that sexual intercourse is immoral if undertaken for pleasure alone, without the risk of pregnancy.¹⁸ Sex for pleasure, at least for women, is rejected.¹⁹

The Article proceeds in five parts. Part II first reviews nineteenth-century and early twentieth-century reasoning about contraceptives. It demonstrates that the original opponents of contraception believed that the immorality occasioned by contraceptives, that is non-procreative sex, caused illness.²⁰ Part II then traces the changing modes of reasoning used by advocates,²¹ modern medicine,²² and courts²³ that led to the landmark

Medicare and Medicaid programs that provide health insurance to the elderly and disabled, and to low-income individuals, respectively. Title X of the 1970 Public Health Service Act, P.L. 91-572, created a federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services.

¹⁷ Patient Protection and Affordable Care Act, P.L. 111-148 (2010).

¹⁸ See, e.g., LINDA GORDON, *THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA* 1 (3d ed. 2002) ("The acceptability of birth control has always depended on a morality that separates sex from reproduction. In the nineteenth century, when the birth control movement began, such a separation was widely considered immoral."); *id.* at 9 ("[C]onservatives . . . typically acceded to the notion that women were purer than men and that the only worthy purpose of sexual activity was reproduction."); *id.* at 161 ("They were . . . suspicious of contraception. They clung to notions . . . that sexual intercourse ought to be for reproduction. . . . The characteristic nineteenth-century suspicion of sexual pleasure itself shone through.")

¹⁹ See *id.* at 9, 11 ("[T]he essence of Victorian sexual respectability was hypocrisy. Victorian social norms preached the debilitating effects of sexual activity and the bracing effects of self-denial and chastity, but the Victorians simultaneously created a gigantic prostitution industry, and it was not unusual for 'respectable' men to patronize it. . . . This hypocrisy operated a double standard: the 'fair sex' was to be protected from dirty matters such as . . . sex. . . . Sex drive became, supposedly, a uniquely masculine trait. . . . Female chastity was no longer just a man's right but now also a woman's destiny. . . . The motherhood ideology also defined the context in which sexuality was allowable for women: the only justifiable purpose of sexual intercourse for 'respectable' women was reproduction." (internal footnote omitted)).

²⁰ See, e.g., *id.* at 106-07 (surveying late nineteenth-century medical works that concluded that contraception was "physically harmful," and "as a mortal threat" posed complications such as "hardening of the uterus" and "permanent sterility" (internal footnotes and citations omitted)).

²¹ See, e.g., *id.* at 138-39, 171-72 (comparing the efforts of pre-WWI radical sexual revolution leaders to transform the birth control issue into a broader agenda that united women's rights with civil liberties, labor movements, and socialist ideology, with the later efforts of the "professional" reformers who broke ties with socialists and radicals and relied on "centralized and professional campaign[s]" that opened clinics and lobbied for legislation).

²² See, e.g., Note, *Judicial Regulation of Birth Control under Obscenity Laws*, 50 *YALE L.J.* 682, 685 (1941) ("By permitting medical use of contraceptives, the federal courts have removed the impediment to vast improvements in public health standards threatened by archaic national legislation. Both maternal and infant welfare may demand intelligent child spacing and postponement of pregnancies until women are physically fit to undertake them." (internal footnote omitted)).

²³ See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 505 (1965) (White, J., concurring) (reasoning that Connecticut could not have grounded its ban on contraception on the notion that use of contraception is immoral or unwise in itself).

holdings in *Griswold v. Connecticut*²⁴ and *Eisenstadt v. Baird*,²⁵ providing constitutional protection for the right to contraceptives. Part III then turns to discuss the modern revival of the Comstock era modes of reasoning about contraception. As it explains, modern opponents of contraceptive access express anxiety about the ability of these moral arguments to persuade. In response, they consciously decided to argue that contraception harms women's health, vowing to cite the best science "we can currently lay our hands on"²⁶ to support those claims. In making this discursive move, contraception opponents have connected contraception to abortion to disrupt the gains made by *Griswold* and *Eisenstadt*, which normalized contraceptive use in many ways. By linking contraception to abortion, and emphasizing a claim that it harms women, opponents cultivate a sense that contraception, like abortion, is immoral²⁷ and detrimental to women's health.²⁸

Part IV responds directly to these emergent health claims. The problem for advocates is that they get the science wrong. This Article establishes the safety of hormonal contraceptives and the benefits they provide to women's and children's health.²⁹ As it shows, contraceptives pose few serious health risks to most women,³⁰ actually reduce the risks of some serious conditions to *all* women,³¹ and are far safer than the alternative for sexually active women—that alternative being pregnancy.³²

²⁴ *Id.* at 485–86 (holding that Connecticut's ban on contraceptives violated married couples' constitutional right to marital privacy).

²⁵ 405 U.S. 438, 454–55 (holding that Massachusetts's ban on contraceptives for use by non-married individuals, while allowing such use by married persons, violated the Equal Protection Clause).

²⁶ Helen Alvaré, *The White House and Sexualityism*, PUBLIC DISCOURSE (July 16, 2012), www.thepublicdiscourse.com/2012/07/5757/ ("I propose to examine th[e] ideology [of equal sexual liberty], not only from a woman's perspective, but also from the best scientific evidence we can currently lay our hands on.").

²⁷ *See, e.g.*, Allan C. Carlson, *Comstockery, Contraception, and the Family: The Remarkable Achievements of an Anti-Vice Crusader*, 23 FAM. AM.: ONLINE EDITION 3 (2009), available at <http://profam.org/pub/fia/fia.2301.htm> ("Comstock's greatest intellectual and political achievement was to link abortion and contraception to the availability of obscene literature in city streets. Countless observers have pointed to both aspects of linkage—abortion equals contraception and both acts equal obscenity—as naïve, foolish, and the product of raw ignorance. In truth, Comstock's views on contraception were framed by his sense of the dangers facing children and by his own psychology of the human mind; and they enjoyed the full support of a new and progressive American medical leadership." (internal footnotes, citations, quotations, and quotation marks omitted)).

²⁸ *See infra* Part III. *See, e.g.*, Carlson, *supra* note 27, at 4 ("Comstock linked abortion and contraception together for the common danger they posed to women's health. In this view, Comstock actually stood in solidarity with the cutting-edge medical authorities of his day.").

²⁹ *See infra* Part IV.C (arguing that contraceptives improve the health of children by, *inter alia*, allowing women to increase the space between births).

³⁰ *See infra* Part IV.B.1–3 (citing data discussing risks and benefits of hormonal contraceptives).

³¹ *See infra* Part IV.B–D (discussing medical evidence that use of contraceptives is far safer than pregnancy, does not increase risks of cancer and actually reduces the risks of some cancers).

³² *See, e.g.*, INST. OF MED. OF THE NAT'L ACADS., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 105–07 (2011), available at http://www.nap.edu/catalog.php?record_id=13181

This Part also makes clear that the claim that contraception is bad for women's health has normative content—that it is based on the view that women should refrain from sexual activity unless they are willing to carry any pregnancy that results to term.

Part V focuses on the attempt to equate contraception and abortion. As this Article shows, opposition to hormonal contraceptives is not truly based on the view that these methods of contraception are actually abortifacients, or even on the claim that the destruction of a fertilized egg is immoral and should be considered an abortion. Rather, the argument goes much deeper to undergird a more general objection to all forms of contraception *and* to the ability of women to have sex without accepting the possibility of pregnancy and motherhood.³³ On this account, the real objection to contraception is not its detrimental effects on women's health, but that it allows women to be sexual beings who can avoid their “natural” roles as mothers.³⁴

Finally, the Article ends with the good news in Part VI that programs providing increased access to the most effective contraception are already having a significant positive impact on the health of women and children, reducing rates of teen pregnancy, unintended pregnancy, poor pregnancy outcomes, and abortions.³⁵

II: NINETEENTH CENTURY OPPOSITION TO CONTRACEPTION

Women have been using various methods to control reproduction for millennia.³⁶ In the ancient world, long before humans understood the most basic facts about the human reproductive process, people used homemade folk remedies to attempt to prevent conception, with some success.³⁷ These

(reporting, *inter alia*, that the mortality rate in non-smoking users of contraception is significantly lower than the maternal death rate in live births).

³³ See *infra* Part V (showing that opposition to four of these contraceptives has not been withdrawn despite definitive scientific evidence that they do not work by preventing implantation of a fertilized egg and so cannot be said to terminate a “pregnancy” under any definition of that term).

³⁴ See, e.g., Siegel, *Reasoning from the Body*, *supra* note 10, at 299 (discussing the antiquated notion that women should have little control over their reproductive destiny because their role as life-givers is to ensure “reproduction of the social order”).

³⁵ See *infra* Part VI (citing data from recent studies examining impact of providing full options counseling and access to most effective contraceptives).

³⁶ See GORDON, *supra* note 18, at 7–9, 13 (“People have tried to control reproduction in virtually all known societies [B]irth control was widely practiced in pre-agricultural and nomadic societies There is a prevalent myth . . . that birth control technology came to use with modern medicine. This is far from the truth, as modern medicine did almost nothing prior to the 1950s to improve on birth control devices that were literally more than a millennium old.” (relying on NORMAN E. HIMES, *MEDICAL HISTORY OF CONTRACEPTION* 3–4 (1936)).

³⁷ See *id.* at 13 (“Birth control was not invented by scientists or doctors. It is part of folk culture, and women’s folklore in particular, in nearly all societies. . . . An extensive folklore of birth control was handed down from generation to generation in most traditional societies. . . . [There were a] variety of attempts to prevent conception, and creativity . . . behind them They [were] developed by

remedies included: homemade suppositories designed to coat the cervix and prevent sperm from passing into the uterus, various spermicidal agents made with acidic liquids like citrus juices or vinegar, rudimentary diaphragms or other devices that were placed over the cervical opening, various medicines or “potions,” douching or other attempts to “wash” sperm out of the vagina after intercourse, rudimentary condoms using animal skins or plants, withdrawal prior to ejaculation, and the “rhythm” method.³⁸ While these methods were improved upon over millennia, the effectiveness of contraceptives was not significantly improved until the development of rubber condoms and diaphragms in the nineteenth century, and the introduction of hormonal contraceptives in the twentieth century.³⁹

While birth control was “morally and religiously stigmatized in many parts of [the] world,” it was also widely practiced.⁴⁰ Use of contraception was opposed by many, though not all, religious authorities on the theory that interference with the procreative function of sex was immoral.⁴¹ The basis for this opposition is reflected in the words of Pope Pius XI who pronounced the view of the Roman Catholic Church in an Encyclical Letter issued in 1930:

[T]he conjugal act is destined primarily by nature for the

practice—through trial and error—in response to people’s needs. A cataloging of the extent, variety, and ingenuity of these practices is eloquent testimony to the intensity of women’s concern.”); *see also id.* at 16 (“[T]here is striking continuity between abortion techniques used in ancient societies and those used in modern ‘home-remedy’ abortions.”).

³⁸ *See id.* at 14, 16, 18–21 (outlining and describing all of the aforementioned pre-modern contraception and abortion practices).

³⁹ *See id.* at 14 (“All [pre-modern] techniques were practiced in the ancient world and in modern preindustrial societies. Indeed, until modern hormonal chemicals there were no essentially new birth control devices, only improvements of the old.”); *id.* at 32 (“[A] thriving nineteenth-century market provided contraceptive devices that did work. . . . Condoms were second in popularity to male withdrawal, according to the clinic studies of the 1920s and 1930s.”); *see also* LARA MARKS, *SEXUAL CHEMISTRY: A HISTORY OF THE CONTRACEPTIVE PILL* 3–4 (2001) (noting that increased effectiveness of the pill as well as other factors made the pill, first marketed in 1960, “a whole new bag of beans” (internal citations, quotation marks, and footnotes omitted)). By 1960, as demonstrated by the plaintiffs in the *Poe v. Ullman* litigation, one study showed “a failure of contraception in 14% of the cases studied with couples relying on the condom, 17.2% by those employing the diaphragm, and 48.2% by persons employing all other methods.” Brief for Appellants at 12, *Poe v. Ullman*, 367 U.S. 497 (1961) (No. 60) (citing Alan Guttmacher, et. al., *Contraception Among Two Thousand Private Obstetric Patients*, 140 JAMA 1265, 1267 (1949)). The effectiveness of modern contraceptives has taken a huge leap forward in the last fifty years, with some methods now approaching 100% effectiveness, even with typical use. *See* Div. of Reprod. Health, Nat’l Ctr. For Chronic Disease Prevention and Health Promotion, *U.S. Medical Eligibility Criteria for Contraceptive Use, 2010*, 59 MORBIDITY AND MORTALITY WEEKLY REPORT, June 18, 2010, at 1, 5 (reporting rates of effectiveness with typical use of certain contraceptives, including 99.2% and 99.8% for the two forms of intra-uterine devices, 99.95% for the implant, 92% for the combined oral contraceptive pills and 92% for the pill (99.78% if use is perfect)).

⁴⁰ GORDON, *supra* note 18, at 7.

⁴¹ *See id.* at 7, 9, 14 (discussing the condemnation of birth control by Judaism, Christianity, and Islam).

begetting of children . . . [T]hose who in exercising it deliberately frustrate its natural power and purpose sin against nature and commit a deed which is shameful and intrinsically vicious.⁴²

Despite the condemnation of contraceptive use by many religious authorities, in post-Revolutionary America birth control techniques were used by many, and their use appears to have increased significantly from the late eighteenth century—when women usually gave birth to eight children—until the start of the twentieth century when in 1900 the average married woman gave birth to three children.⁴³ While social disapproval drove the practice underground, a legal framework restricting contraceptives was not established in the United States until 1873 with the enactment of the Comstock Act,⁴⁴ a federal law banning, among other things, the manufacture, sale, advertisement, distribution through the mails, and importation of contraceptives.⁴⁵ As originally introduced, the bill included a kind of health exception, allowing for prescriptions issued by “a physician in good standing, given in good faith.”⁴⁶ The bill was then amended and the exception deleted,⁴⁷ though it was unclear whether Congress understood how the contraceptive ban would work, much less that the amendment deleted the physician’s exception.⁴⁸

⁴² *Casti Connubii*, *supra* note 8, at ¶54. In the same document, the Church condemned divorce, *see id.* at 12, sex outside of marriage, *see id.* at ¶34, ¶79, and the emancipation of women, *see id.* at ¶26 (noting the “primacy of the husband with regard to the wife and children, the ready subjection of the wife and her willing obedience”); *see id.* at ¶75 (noting in response to those who argued that women should be considered equal in marriage to men, “this false liberty and unnatural equality with the husband is to the detriment of the woman herself, for if the woman descends from her truly regal throne to which she has been raised within the walls of the home by means of the Gospel, she will soon be reduced to the old state of slavery (if not in appearance, certainly in reality) and become as amongst the pagans the mere instrument of man”).

⁴³ *See* GORDON, *supra* note 18, at 22–23 (noting that family size did not change as dramatically as the number of births; that the decrease in infant mortality rates over the nineteenth century meant women did not have to bear as many children to end up with a family of five; and that her account does not take into consideration pregnancies that resulted in abortion).

⁴⁴ Comstock Act, ch. 258, 17 Stat. 598 (1873) (naming the law “An Act for the Suppression of Trade in, and Circulation of, obscene Literature and Articles of immoral Use”).

⁴⁵ *Id.* at 598–99.

⁴⁶ CONG. GLOBE, 42d Cong., 3d Sess. 1436 (1873) (discussing Bill S. No. 1572 prohibiting sale of “any obscene . . . [literature or images] or other article of indecent or immoral nature, or any article or medicine for the prevention of conception, or for causing abortion, except on a prescription of a physician in good standing, given in good faith, or shall advertise the same for sale . . . or shall manufacture [the same], . . . or shall print any such article”).

⁴⁷ *See id.* at 1571 (approving the bill without the exemption); Comstock Act, ch. 258, 17 Stat. 598 (1873) (failing to provide a good faith medical exception in the final act).

⁴⁸ As others have reported, the substance of the Congressional Debate over the Comstock Act was extremely limited, and some members of Congress complained that they did not have time to fully understand the bill in general or the amendment in particular. *Judicial Regulation of Birth Control Under Obscenity Laws*, *supra* note 22, at 682 (citing CONG. GLOBE, 42d Cong., 3d Sess. 1436–37,

A. *Obscenity and the Connection Between Immorality and Health*

As evidenced by the Congressional debates over the Comstock Act, these nineteenth century opponents of contraception were fueled by the belief that illness was punishment for immoral sexual behavior. The ban on the manufacture and sale of contraceptives was enacted as part of a broader “purity campaign”⁴⁹ taking aim at the use of the mails to distribute “obscene literature,” images considered obscene because of their ability to cause sexual excitement.⁵⁰ Congress was scandalized when it discovered that trade in “obscene” or “immoral” literature was widespread.⁵¹ Representative Merriam of New York denounced the trade as a “nefarious and diabolical traffic” that was a threat to the Republic and the “vigor and purity of our youth.”⁵² He called “the attention of the country to this monstrous crime,” and urged Congress to do all that they could legislatively to achieve its “annihilation.”⁵³ Merriam made an appeal to masculinity, calling on his fellow Congressmen to bring “the outraged manhood of our age” to condemn what “womanhood” had failed to stop, that is:

the low brutality which threatened to destroy the future of this Republic by making merchandise of the morals of our youth. Recent revelations have convinced us that no home, however carefully guarded, no school however select, has

1524–25, 1571 (1873)) (providing discussion of the bill in the United States Senate); CONG. GLOBE, 42d Cong., 3d Sess. 2004 app. at 168–69 (1873) (providing a discussion of the bill in the House of Representatives)); see also Peter Smith, *The History and Future of the Legal Battle over Birth Control*, 49 CORNELL L.Q. 275, 276 (1964) (highlighting that very little debate or discussion accompanied the amendment removing the physician exemption from the act). On the other hand, the debate on the whole reveals a Congress that was intent on enacting a more rather than less restrictive bill. See CONG. GLOBE, 42d Cong., 3d Sess. 1524–25 (1873) (reassuring other Senators that the amendment to the bill removing the physician exemption made “no material alteration in the section” and that “[i]t is rather to strengthen it than otherwise”).

⁴⁹ For a discussion on the emergence of “purity campaign” as a phrase that encapsulated the effort to curtail the distribution of “offensive materials,” see Margaret A. Blanchard, *The American Urge to Censor: Freedom of Expression Versus the Desire to Sanitize Society—From Anthony Comstock to 2 Live Crew*, 33 WM. & MARY L. REV. 741, 747 (1992).

⁵⁰ See *Judicial Regulation of Birth Control Under Obscenity Laws*, *supra* note 22, at 682 (“By forbidding the mailing, importation, and interstate transportation of indecent articles and obscene publications and ‘contraceptives,’ Congress hoped to check the moral degeneration that followed the Civil War.”) (internal citations omitted); see also Smith, *supra* note 48, at 275–76 (noting that section two of the Comstock Act “prohibited the use of the mails for the sending of any of the materials or articles outlawed in section one” (internal citations omitted)).

⁵¹ See CONG. GLOBE, 42d Cong., 3d Sess. app. 168 (1873) (statement of Rep. C.L. Merriam) (reporting on the seizure of 15,000 “letters written by students of both sexes throughout our land ordering obscene literature”); *id.* at 1524 (statement of Sen. George Edmunds) (citing a Senate debate where Senator Edmunds referred to the Comstock Act as the “immoral literature” bill).

⁵² *Id.* app. at 168.

⁵³ *Id.* app. at 169.

been safe from these corrupting influences. The purity and beauty of womanhood has been no protection from the insults of this trade.⁵⁴

Merriam lamented the revelations that even “in some of our best schools,” children “were students of a debasing literature, thrust upon them by insidious and cowardly hands . . . a literature which kindles and inflames the brute forces born in man, and over which religion and education strive to obtain the mastery.”⁵⁵ He decried the “destruction [of] some promising boys, who, but for the deadly poison instilled into their young minds might have developed into wise and good men.”⁵⁶ Sexual desire aroused by obscene literature was considered so destructive that Merriam claimed that “victims of this traffic [of obscene literature] have filled the prisons and mad-houses,” and the literature “corrupt[ed] the principles, . . . inflame[d] the passions, . . . excite[d] impure desire, and . . . spread a blight over all the powers of the soul.”⁵⁷

The inclusion of a ban on contraceptive devices and abortifacients in the obscene literature bill was urged by Anthony Comstock,⁵⁸ a well-known crusader and member of the New York Committee on the Suppression of Vice.⁵⁹ To support the connection between contraceptives and the corrupting influence of obscene literature, Comstock reported that his investigations found that the businesses were often combined.⁶⁰ Moreover, contraception and abortion, like obscene literature, were considered to promote sex for pleasure rather than purely for procreation. Enacted at a time when pastors and parents warned that masturbation would make you go blind, obscene literature and contraceptives were considered part of the same evil to be stopped, the same threat to the “vigor and purity” of the Nation.⁶¹ Where obscene literature “inflame[d]” desires,⁶² contraceptives and abortion enabled people to act on their sexual desires and engage in sex while escaping the fear of procreation and

⁵⁴ *Id.* app. at 168.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.* app. at 169.

⁵⁸ *See id.* app. at 168–69 (quoting Comstock letter, included in Representative’s speech, stating, “I could easily detect and convict [men engaging in the traffic of obscene literature] if the law was only sufficient. . . . [A]ll we want to break up this nefarious business is a broader law”).

⁵⁹ Margaret A. Blanchard & John E. Semonche, *Anthony Comstock and His Adversaries: The Mixed Legacy of This Battle for Free Speech*, 11 COMM. L. & POL’Y 317, 320, 323 (2006).

⁶⁰ *See* CONG. GLOBE, 42d Cong., 3d Sess. app. at 168 (noting that those who sold the offending pictures and pornographic stories also sold “rubber articles for masturbation or for the professed prevention of conception” through the mails).

⁶¹ *See id.* (discussing the need to preserve the country’s youth by suppressing “trade in and circulation of obscene literature and articles of immoral use”).

⁶² *Id.*

sexually transmitted diseases.⁶³

Although the Congressional debates over the Comstock Act were abbreviated,⁶⁴ the debates show that drawing the connection between expression of sexual desire for its own sake and ill health was essential to the opposition. Opponents of contraceptives, nineteenth century physicians prominent among them,⁶⁵ stressed that sexual “impurity”—meaning sex for pleasure rather than procreation—bred weakness, a lack of vigor, and ultimately could make you physically ill.⁶⁶ While the health of the entire nation’s youth was at stake, crusaders against contraception expressed the greatest concern for women’s health, exhibiting a woman-protective reasoning that served crusaders well at the time given the significant dangers of illegal abortions. Specifically, physicians claimed that contraceptives would cause “hardening” of the uterus, sterility,⁶⁷ “[l]ocal congestions, nervous affections and debilities,” and other “diseases of the genital organ, from simple inflammation to the most serious degenerations.”⁶⁸

Both historian Linda Gordon, and Reva Siegel in her seminal article, *Reasoning from the Body*, trace the history of arguments made by leaders of the campaigns to criminalize abortion and contraception.⁶⁹ Physicians argued that abortion and contraception were both evils, united in posing a

⁶³ *Id.*

⁶⁴ *Id.* at 1436–37, 1524–25, 1571 (providing the transcript for debates over obscene literature within the Senate). Consideration in the House of Representatives was even more abbreviated. *See id.* at 2004, app. at 168–69 (providing the transcript for debates over obscene literature within the House).

⁶⁵ Much has been written about the prominent role of nineteenth century physicians in the campaign to make contraception and abortions illegal and to obtain a near monopoly over the treatment of upper and middle class women’s diseases, reproductive health care in particular, by limiting the role of mid-wives. *See, e.g.*, GORDON, *supra* note 18, at 105–24; *id.* at 106 (“Physicians had obtained a monopoly on the treatment of upper- and middle-class women’s diseases and pregnancies in part by forcing out midwives and popular healers . . . Birth control, part of the growing self-assertion of women generally, particularly annoyed many doctors.”). *See* Siegel, *Reasoning from the Body*, *supra* note 10, at 281–87 (citing *also* LINDA GORDON, *WOMAN’S BODY, WOMAN’S RIGHT: A SOCIAL HISTORY OF BIRTH CONTROL IN AMERICA* (1976); KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* (1984); JAMES C. MOHR, *ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900* (1978)).

⁶⁶ *See, e.g.*, CONG. GLOBE, 42d Cong., 3d Sess. app. at 168-69.

⁶⁷ GORDON, *supra* note 18, at 106–07.

⁶⁸ Carlson, *supra* note 27 (quoting H.R. Storer, *The Criminality and Physical Evils of Forced Abortions*, 16 and L.F.E. BERGERET, *THE PREVENTIVE OBSTACLE, OR CONJUGAL ONANISM: THE DANGERS AND INCONVENIENCES TO THE INDIVIDUAL, TO THE FAMILY, AND TO SOCIETY, OF FRAUDS IN THE ACCOMPLISHMENT OF THE GENERATIVE FUNCTIONS* 6 (P. DeMarmon trans., 1870)). *See also id.* (noting physician “catalogue[d] the female diseases’ caused by these practices”) (citing Horatio Robinson Storer, *The Criminality and Physical Evils of Forced Abortions*, 16 *TRANSACTIONS OF THE AM. MED. ASS’N* 741 (1866)); *id.* (citing D. Humphreys Storer, *Two Frequent Causes of Uterine Disease*, 6 *J. GYNAECOLOGICAL SOC’Y BOS.* 194, 195–203 (1855)).

⁶⁹ GORDON, *supra* note 18, at 106–07; Siegel, *Reasoning from the Body*, *supra* note 10, at 265.

danger to women's health.⁷⁰ For example, a tract entitled *Conjugal Sins* condemned as “linked and like evils, masturbation, contraception, and abortion,” while a lecture entitled *On Conjugal Onanism and Kindred Sins* delivered by a physician prominent in the anti-abortion campaign to students at the University of Pennsylvania “sought to demonstrate the diseases attributable to the interruption of intercourse.”⁷¹ The physician argued that:

[M]an must suffer the punishment of the onanist if he parts with the ‘seed of another life’ in any other way than in that which it tends to become fruitful . . . [but] [t]he wife suffers the most, because she both sins and is sinned against. She sins because she shirks those responsibilities for which she was created. She is sinned against, because she is defrauded of her [conjugal] rights⁷²

Yet another leader of the campaign to criminalize abortion argued that “the prevention of pregnancy, by whatever means it may be sought, by cold vaginal injections, or by incomplete or impeded sexual intercourse, is alike destructive to sensual enjoyment and to the woman's health.”⁷³

Linda Gordon documents the claims made by physicians of the time “that contraception was physically harmful, and the harm often described as a mortal threat.”⁷⁴ These physicians referred to the use of birth control during sex between a married couple as “onanism” and “marital masturbation.”⁷⁵ Sometimes the claim was that interfering in the sex act's possible procreative function caused the harm. Sometimes the claim went further. At least one physician opponent of birth control and abortion “charged that not having children was in itself unhealthy: a woman still childless at twenty-five would have a ‘continuous tendency to degeneracy and atrophy of the reproductive organs.’”⁷⁶ Having a few children was not enough; continuous childbearing every two to three years was said to be necessary for “permanent good health.”⁷⁷ Indeed, according to a contemporary anti-contraception advocate, when chiding a young female journalist for seeking the decriminalization of contraception, Comstock identified contraception as working “the greatest demoralization” and

⁷⁰ *Id.* at 293; *see also id.* at 293 n.119 (“[C]linical case histories of women suffering diseases attributed to conjugal onanism.”).

⁷¹ *Id.* at 293.

⁷² *Id.* (internal quotation omitted).

⁷³ *Id.* at 294 n.122 (quoting HORATIO ROBINSON STORER, *WHY NOT? A BOOK FOR EVERY WOMAN* 61 (Boston: Lee & Shepard 1868)).

⁷⁴ GORDON, *supra* note 18, at 106–07.

⁷⁵ *Id.* at 107.

⁷⁶ *Id.* (citation omitted).

⁷⁷ Siegel, *Reasoning from the Body*, *supra* note 10, at 294 n.123 (quoting HORATIO ROBINSON STORER, *IS IT I?, A BOOK FOR EVERY MAN* 115-16 (photo. reprint 1974) (Boston, Lee & Shepard 1868)).

specifically married immorality and disease declaring:

God has set certain natural barriers. If you turn loose the passions and break down the fear you bring . . . disaster. . . . It would debase sacred things, break down the health of women, and disseminate a greater curse than the plagues and diseases of Europe.⁷⁸

B. *Federal and State Court Litigation After Comstock and the Rise of a Social Movement*

Attempts to repeal or modify the Comstock Act in the late nineteenth and early twentieth centuries were unsuccessful.⁷⁹ Ultimately though, advocates for birth control,⁸⁰ and a small group of sex reformers who worked against sexual repression at the turn of the century,⁸¹ altered societal acceptance of contraceptives and sex for pleasure.⁸² As medical knowledge about contraceptives and reproductive functions modernized, the Comstock Act's connection between obscenity and immorality on the one hand and contraceptives on the other hand proved the undoing of the

⁷⁸ Carlson, *supra* note 27.

⁷⁹ See Smith, *supra* note 48, at 276–77 (indicating that there were “unsuccessful attempts to repeal or modify the Comstock Act” in 1878, 1919, 1923, and many times between 1930 and 1936).

⁸⁰ Much has been written about the motives of early birth control advocates, such as Margaret Sanger and the original founders of Planned Parenthood. There is significant evidence that one purpose of promoting birth control was to limit family size among immigrants, African-Americans freed from slavery, and the poor. GORDON, *supra* note 18, at 196–97. Though a small band of “free love” advocates pressed for reforms for the right of all to express sexual desire in consensual circumstances, see, e.g., *id.* at 126, the right to contraception as an issue of sexual freedom and women's equality did not become a prominent aspect of the movement until the mid-twentieth century. For different views on the legacy of Margaret Sanger, compare ANGELA FRANKS, MARGARET SANGER'S EUGENIC LEGACY: THE CONTROL OF FEMALE FERTILITY 66 (2005) (arguing that Sanger had a genuine commitment to the eugenic ideology), with ELLEN CHESLER, WOMAN OF VALOR: MARGARET SANGER AND THE BIRTH CONTROL MOVEMENT IN AMERICA 195–96 (1992) (arguing that Sanger did not believe in the more “offensive” assumptions underlying the eugenics movement, and saw eugenics as a method of “controlled fertility” which would help women gain educational and economic opportunities).

⁸¹ For a short discussion of the work of these reformers, see GORDON, *supra* note 18, at 138–52. See also EMMA GOLDMAN, ANARCHISM AND OTHER ESSAYS 233, 237 (2d ed. 1911) (arguing that love is free and should be separated from marriage and that “[i]t is safe to say that a large percentage of the unhappiness, misery, distress, and physical suffering of matrimony is due to the criminal ignorance in sex matters that is being extolled as a great virtue”).

⁸² Public opinion polls at the time confirmed the change in views. See *Judicial Regulation of Birth Control Under Obscenity Laws*, *supra* note 22, at 685–86 n.35 (describing poll results which indicated public opposition to birth control laws). In addition, studies confirmed a rise in sexual activity. See GORDON, *supra* note 18, at 130–31 (describing a study of college-educated women which found that women born between 1890–1899 had “twice as high a percentage of premarital intercourse as those born before 1890,” and the trend continued. Of those born before 1890, 13.5% experienced intercourse before marriage; of those born between 1890–99, the percentage increased to 26%; of those born between 1900–1909, 48.8% had premarital intercourse; and of those born after 1909, 68.3% had intercourse prior to marriage).

Act's contraceptive ban. In 1936, in a case challenging forfeiture of a package of contraceptives that had been ordered under the federal importation ban,⁸³ the Second Circuit reasoned that because contraceptive use to promote health was no longer considered immoral, a federal law intending to prevent immoral behavior could no longer be interpreted to preclude the use of contraceptives to promote health. As a result, the court held that the federal statute did not apply to physicians who sought to save the lives and promote the health of their patients.⁸⁴ These physicians were "excepted by implication from the literal terms of the statute."⁸⁵ Noting that state law allowed for the sale of contraception to physicians "who may in good faith prescribe their use for the cure or prevention of disease,"⁸⁶ the Court wrote:

All the statutes we have referred to were part of a continuous scheme to suppress immoral articles and obscene literature and should so far as possible be construed together and consistently. If this be done, the articles here in question ought not to be forfeited when not intended for an immoral purpose.⁸⁷

As a 1941 Note published in the *Yale Law Journal* commented, "[b]y permitting medical use of contraceptives, the federal courts have removed the impediment to vast improvements in public health standards threatened by archaic national legislation."⁸⁸

After the teeth were removed from the federal Comstock Act, though, state laws restricting access to contraceptives remained. In the early twentieth century, courts issued influential decisions holding tight to moral reasoning to uphold bans on contraceptive prescribing in states with some of the most restrictive laws in the country—New York, Massachusetts, and

⁸³ *United States v. One Package*, 86 F.2d 737 (2d Cir. 1936). The claimant was an obstetrician/gynecologist named Hannah Stone who testified that "the use of contraceptives was in many cases necessary for the health of women" and that she prescribed the use of pessaries in cases where "it would not be desirable for a patient to undertake a pregnancy." *Id.* at 738. This testimony was not disputed by the Government. *Id.*

⁸⁴ *Id.* at 738.

⁸⁵ *Id.*

⁸⁶ *Id.* (citing *People v. Sanger*, 118 N.E. 637, 637–38 (N.Y. 1918)).

⁸⁷ *Id.* at 739.

⁸⁸ *Judicial Regulation of Birth Control Under Obscenity Laws*, *supra* note 22, at 685; *see also id.* at 685 n.25 ("Maternal and infant deaths vary directly with the number of children per mother and vary inversely with the length of time since the last preceding birth." (citing, *inter alia*, U.S. DEPT. OF LABOR, CHILDREN'S BUREAU, CAUSAL FACTORS IN INFANT MORTALITY 48, 60 (1940)). The author also remarked on the alarming prevalence of unsafe abortions performed annually in the United States. *Id.* at 685 n.26 ("Abortions bring death to at least twenty-two American women every day and cause serious injury to countless others. Ninety per cent of such operations are performed on married women." (citing DOROTHY DUNBAR BROMLEY, BIRTH CONTROL: ITS USE AND MISUSE 138 (1934))).

Connecticut.⁸⁹ In these states, the newly formed Planned Parenthood League had opened clinics that distributed educational materials and birth control devices and advocates used civil disobedience to challenge the restrictive laws.⁹⁰

In 1917, a New York court rejected a constitutional challenge to the state law, embracing the idea that the fear of pregnancy and sexually transmitted infections was necessary to discourage immoral sex.⁹¹ Contraception removed this fear, thereby encouraging immoral behavior. The New York trial court's decision in *People v. Byrne*⁹² upheld the prosecution of Margaret Sanger's sister for distributing an educational pamphlet concerning contraceptives:

While there are other reasons that keep unmarried people from indulging their passions, the fear that pregnancy will result is one of the potent ones. To remove that fear would unquestionably result in an increase of immorality.⁹³

In that case, the court explicitly rejected the idea that women had an "absolute right to enjoyment of sexual relations" without the fear of pregnancy.⁹⁴ New York's legislature liberalized its 1881 law to allow an

⁸⁹ See *State v. Nelson*, 11 A.2d 856, 860 (Conn. 1940) (noting that between 1873, when Congress enacted the Comstock Act, and 1940, at least twenty-six states passed laws relating to birth control, and "[o]f th[o]se, eight, including Connecticut and Massachusetts, attempt[ed] complete suppression; . . . a few (including New York) contain exceptions which permit prescription under certain circumstances") (citing Note, *Some Legislative Aspects of the Birth-Control Problem*, 45 HARV. L. REV. 723, 723–24 (1932); Note, *Contraceptives and the Law*, 6 U. CHI. L. REV. 260, 260–61 (1939); MARIE CARMICHAEL STOPES, *CONTRACEPTION (BIRTH CONTROL): ITS THEORY, HISTORY AND PRACTICE; A MANUAL FOR THE MEDICAL AND LEGAL PROFESSIONS*, 354, 355 (1924)); Smith, *supra* note 48, at 279 (arguing that Connecticut statutes were the "strictest in the nation").

⁹⁰ See, e.g., Smith, *supra* note 48, at 285 (noting that the defendant violated the Comstock Act by selling "an article designed to prevent conception and distributing . . . pamphlets").

⁹¹ See, e.g., *People v. Byrne*, 163 N.Y.S. 682, 686 (N.Y. Sup. Ct. 1917) (ruling that fear of pregnancy and venereal diseases was necessary to discourage immorality and was within the police powers of the state).

⁹² *Id.* at 682.

⁹³ *Id.* at 686 ("[T]he court is of the opinion that the public good justified the passage of this statute and requires its enforcement."); see also *id.* ("A statute making it a crime to advertise the treatment or cure of venereal diseases has been held to be a valid exercise of the police power of the state, as it is against public policy to advertise that such diseases can be easily and cheaply cured. 'It has a decided tendency to minimize unduly the disastrous consequences of indulging in dissolute action.'" (quoting *State v. Hollinshead*, 151 P. 710, 711 (Or. 1915))); see also *People v. Kennedy*, 142 N.W. 771, 772, 775 (Mich. 1913) (holding that an act prohibiting the "advertisement of the treating or curing of venereal diseases" was constitutional). The court wrote that one pamphlet entitled "What Every Girl Should Know," "contains matters which not only should not be known by every girl, but which perhaps should not be known by any" and "contains pictures of certain organs of a woman." *Byrne*, 163 N.Y.S. at 684, 686.

⁹⁴ *Byrne*, 163 N.Y.S. at 687. The next year, the New York court interpreted the state's statutory exception to be broad enough to protect a physician who in good faith gives contraceptive "help or advice to a married person to cure or prevent disease," but not to permit "advertisements regarding such

exemption for physicians prescribing contraceptives for health purposes.⁹⁵

While many other states liberalized their laws to allow for medical use of contraception at the very least, Connecticut and Massachusetts held firmly to their Comstock era statutes and reasoning. In 1917, in *Commonwealth v. Allison*,⁹⁶ the Massachusetts high court upheld that state's 1879 statute banning contraceptives as within the police power of the state "to promote the public morals and in a broad sense the public health and safety."⁹⁷ The Court held that the Legislature's purpose in 1879 had been "to protect purity, to preserve chastity, to encourage continence and self restraint, to defend the sanctity of the home, and thus to engender in the state and nation a virile and virtuous race of men and women."⁹⁸ The same court confirmed this view in 1938. In *Commonwealth v. Gardner*,⁹⁹ two years *after* the decision allowing medical prescribing under the federal Comstock Act, the Massachusetts court again refused to liberalize its view of the Massachusetts law, upholding the prosecution of doctors and nurses of a birth control clinic. The court refusing to read the statute to include an exception permitting physicians to prescribe contraceptives even if intended for the "preservation of life or health," and even if applied only to married women.¹⁰⁰ The Massachusetts high court finally allowed a very narrow exception to sell contraceptives where "sold for the prevention of [venereal] disease,"¹⁰¹ but refused to allow prescribing to avoid pregnancy where the woman's health would be particularly at risk during pregnancy. Just four years later, the Court confirmed the narrowness of the exception, upholding a conviction finding enough evidence that the defendant advertised "instruments or articles" with the intent that they be used for contraception as well as for protection against disease.¹⁰²

matters, nor promiscuous advice to patients irrespective of their condition." *People v. Sanger*, 118 N.E. 637, 637-38 (N.Y. 1918).

⁹⁵ See Smith, *supra* note 48, at 278 (noting an exception to the New York statute that allowed physicians to prescribe contraceptive devices for the "cure and prevention of disease").

⁹⁶ 116 N.E. 265 (Mass. 1917).

⁹⁷ *Id.* at 266 (upholding a ban on the advertising of contraceptive drugs, medicines, or articles).

⁹⁸ *Id.*

⁹⁹ 15 N.E.2d 222 (Mass. 1938).

¹⁰⁰ See *id.* at 222-24 (holding that a complete prohibition on the sale of contraceptives was necessary to suppress immorality); see also *Commonwealth v. Corbett*, 29 N.E.2d 151, 152 (Mass. 1940) (affirming the decision in *Commonwealth v. Gardner*, 15 N.E.2d 222 (Mass. 1938), that the use of contraceptives by married women for whom pregnancy was "unusually dangerous to their health" was still prohibited).

¹⁰¹ See *Commonwealth v. Corbett*, 307 Mass. 7, 8-9, 29 N.E.2d 151, 152 (Mass. 1940) (arguing that the use of condoms for prevention of disease was valid because the victims of these sexually transmitted infections could be "innocent" victims, such as the wives or husbands and children of a guilty party who contracted the disease through illicit sex).

¹⁰² *Commonwealth v. Goldberg*, 55 N.E.2d 951, 953 (Mass. 1944); see also Smith, *supra* note 48, at 277-79 (arguing that Massachusetts's strict contraception statute rivals Connecticut's statutes, which are regarded as the "strictest in the nation").

Similarly, in Connecticut, the prosecution of medical personnel at a Planned Parenthood clinic for assisting and counseling a married woman in the use of contraceptives in order to preserve her “general health” was upheld against the defendants claim that the statute was unconstitutional.¹⁰³ Citing the Massachusetts case and the early New York case approvingly, the Court wrote in *State v. Nelson*¹⁰⁴:

[I]t is not for us to say that the Legislature might not reasonably hold that the artificial limitation of even legitimate child-bearing would be inimical to the public welfare and, as well, that use of contraceptives, and assistance therein or tending thereto, would be injurious to public morals, indeed, it is not precluded from considering that not all married people are immune from temptation or inclination to extra-marital indulgence, as to which risk of illegitimate pregnancy is a recognized deterrent deemed desirable in the interests of morality.¹⁰⁵

The Connecticut court reversed the lower court’s ruling that the statute was unconstitutional unless interpreted to include this exception,¹⁰⁶ but reserved the question of whether “an implied exception might be recognized when pregnancy would jeopardize life.”¹⁰⁷ Just two years later, the Connecticut court confirmed this strict interpretation of the statute, refusing to interpret the statute to include an implied exception to permit a physician to give contraceptive information and prescriptions even to a married woman whose life would be jeopardized by pregnancy.¹⁰⁸

This refusal of Massachusetts and Connecticut courts to liberalize their statutes to allow contraceptives to prevent pregnancy where pregnancy posed a risk to the life of the woman set up the resulting challenges in *Poe v. Ullman*,¹⁰⁹ *Griswold v. Connecticut*,¹¹⁰ and *Eisenstadt v. Baird*.¹¹¹ In these cases, the Court had before it evidence refuting the claim that the use of medical contraceptives was or could be harmful;¹¹² establishing the

¹⁰³ *State v. Nelson*, 11 A.2d 856, 856–57, 860, 862 (Conn. 1940).

¹⁰⁴ 11 A.2d 856 (Conn. 1940).

¹⁰⁵ *See id.* at 860–61 (discussing legislative power to regulate “health and morals”).

¹⁰⁶ *Id.* at 858, 862.

¹⁰⁷ *Id.* at 859 (internal quotation marks omitted).

¹⁰⁸ *See Tileston v. Ullman*, 26 A.2d 582, 584, 587–88 (Conn. 1942) (refusing to rewrite the statute to include an exception where an alternative to avoid harm to the woman existed, complete abstinence, which “the legislature was entitled to believe was reasonable and practicable”), *appeal dismissed*, 318 U.S. 44, 46 (1943).

¹⁰⁹ 367 U.S. 497 (1961).

¹¹⁰ 381 U.S. 479 (1965).

¹¹¹ 405 U.S. 438 (1972).

¹¹² *See* Brief of Planned Parenthood Fed’n of Am., Inc. as Amicus Curiae Supporting Appellants at 28, *Poe v. Ullman*, 367 U.S. 497 (1961) (No. 60) (“Medical writers generally affirm the efficacy and

widespread acceptance by organized religions of “the need for control of conception by married couples in at least some cases;”¹¹³ and in *Poe* and *Griswold*, establishing the extreme nature of Connecticut’s ban on the use of contraceptives.¹¹⁴ The Court issued limited opinions striking down the Connecticut¹¹⁵ and Massachusetts¹¹⁶ statutes, stopping well short of celebrating a right to consensual sex. First, in a case challenging Connecticut’s statute, the Court held that the law violated a married couples’ constitutional right to privacy.¹¹⁷ *Griswold* represented a sea change in that the Court did not entertain the idea that contraceptive use in and of itself was immoral, though the Court left open the possibility that it might be appropriate to use the fear of conception to deter illicit sexual relations.¹¹⁸ Finally, in a 1972 case challenging the Massachusetts statute, the Court stopped short of an explicit holding that single individuals had a constitutional privacy right to contraceptives, but implied as much. The Court held that if married couples had access to contraceptives, denying

freedom from deleterious consequences of drugs and devices for contraception.”); Brief of Planned Parenthood Fed’n of Am., Inc. as *Amicus Curiae* Supporting Appellants at 15, *Griswold v. Connecticut*, 381 U.S. 479 (1965) (No. 496) [hereinafter Brief of Planned Parenthood, *Griswold*] (“As is clear from Appendix B and the physicians’ brief, modern contraceptives are effective; they are safe; they are freely manufactured and are distributed by doctors, hospitals and public health agencies throughout the country; they are regulated (and validated) as to quality, safety and effectiveness by governmental agencies.”); Brief of Appellee at 20, *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (No. 70-17) (“What is involved, is this appellee’s right to disseminate information and to distribute a safe and medically approved article . . .”).

¹¹³ See Brief of Planned Parenthood, *Poe*, *supra* note 112, at 30–37 (discussing statements from and positions issued by Protestant churches; Jewish opinion leaders; and the Roman Catholic Church, which expressed a limited approval of the rhythm method). For more information on the Roman Catholic position, see sources cited in Brief of Planned Parenthood, *Poe*, *supra* note 112, at 35 nn.26–27.

¹¹⁴ See Brief of Planned Parenthood, *Griswold*, *supra* note 112, at 27 (“Connecticut’s prohibition of the use of contraceptives is unique. In no other American jurisdiction (or so far as we know, any foreign jurisdiction), has the state imposed such a bar to marital freedom and privacy.”); Brief of Planned Parenthood, *Poe*, *supra* note 112, at 37–38 (discussing the legal and widespread use of medical prescription of contraceptives through the United States, and stating that “Connecticut alone has legislated with reference to the ‘use’ of contraceptives and has construed its statute to prohibit use by all persons under all circumstances”).

¹¹⁵ See *Griswold*, 381 U.S. at 480, 485 (holding that Connecticut’s law banning the use of contraceptives cannot stand).

¹¹⁶ See *Eisenstadt*, 405 U.S. at 454–55 (“[Massachusetts] could not, consistently with the Equal Protection Clause, outlaw distribution to unmarried but not to married persons.”).

¹¹⁷ See *Griswold*, 381 U.S. at 480, 485–86 (striking down a Connecticut statute, “which[] in forbidding the use of contraceptives,” had a “maximum destructive impact upon” a relationship lying with the zone of privacy created by several fundamental constitutional rights).

¹¹⁸ See, e.g., *id.* at 505 (White, J., concurring) (“There is no serious contention that Connecticut thinks the use of artificial or external methods of contraception immoral or unwise in itself, or that the anti-use statute is founded upon any policy of promoting population expansion. Rather, the statute is said to serve the State’s policy against all forms of promiscuous or illicit sexual relationships, be they premarital or extramarital, concededly a permissible and legitimate legislative goal.”).

access to single people violated constitutional equality guarantees.¹¹⁹ The Court also found it “unreasonable to assume that Massachusetts has prescribed pregnancy and the birth of an unwanted child as punishment for fornication,”¹²⁰ and questioned “the assumption that the fear of pregnancy operates as a deterrent to fornication.”¹²¹

III. THE MODERN REVIVAL OF COMSTOCKERY—CONTEMPORARY MODES OF REASONING AGAINST CONTRACEPTION

The nineteenth and early twentieth century view that contraceptive use leads to immoral behavior, i.e., non-procreative sex, receded from the public sphere after *Griswold* and *Eisenstadt* but reemerged publicly with full force in the beginning of the twenty-first century. Perhaps most brazenly, advocates for contraceptive access were accused of being sluts on air by a prominent right-wing talk radio host during the 2012 Presidential campaign,¹²² and were described as women whose libidos were “out of control” by a former Governor and Presidential candidate during debates over expanded access to contraception included in the Affordable Care Act, setting off a media frenzy both times.¹²³ In response to news that a program through the Colorado Family Planning Initiative offering 30,000 contraceptive implants or intrauterine devices (IUDs) at low or no cost to low-income women at sixty-eight family-planning clinics across Colorado had lowered teen birth rates 40%, the Colorado Right to Life spokesman objected that offering contraception to teens sends the message that you can “have all the sex you want. . . . When you teach children that they’re animals—that they have evolved from pigs and dogs and apes—then they act like animals.”¹²⁴

In reviving the claim that access to contraceptives increases immoral

¹¹⁹ See *Eisenstadt*, 405 U.S. 454–55 (“[Massachusetts] could not, consistently with the Equal Protection Clause, outlaw distribution to unmarried but not to married persons If the right of 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.”).

¹²⁰ *Id.* at 448.

¹²¹ *Id.* at 449.

¹²² Jack Mirkinson, *Rush Limbaugh: Sandra Fluke, Woman Denied Right to Speak at Contraception Hearing a ‘Slut’*, HUFFINGTON POST (Apr. 30, 2012, 5:12 AM), http://www.huffingtonpost.com/2012/02/29/rush-limbaugh-sandra-fluke-slut_n_1311640.html.

¹²³ Aaron Blake, *Huckabee: Dems Think Women Can’t Control Their Libido*, WASH. POST (Jan. 23, 2014), <http://www.washingtonpost.com/blogs/post-politics/wp/2014/01/23/huckabee-dems-think-women-cant-control-their-libido/>; Abby D. Phillip, *Mike Huckabee: Dems Think Women Can’t Control their Libido’ Without Government*, ABC NEWS (Jan. 23, 2014, 4:58 PM), <http://abcnews.go.com/blogs/politics/2014/01/mike-huckabee-dems-think-women-cant-control-their-libido-without-government/>.

¹²⁴ Gail Sullivan, *How Colorado’s Teen Birthrate Dropped 40% in Four Years*, WASH. POST (Aug. 12, 2014), <http://www.washingtonpost.com/news/morning-mix/wp/2014/08/12/how-colorados-teen-birthrate-dropped-40-in-four-years/> (quoting Colorado Right to Life spokesperson Bob Enyart).

behavior, opponents appear to be intentionally modeling their efforts on those of nineteenth century opponents of contraception and abortion, especially Anthony Comstock. Allan Carlson, President of The Howard Center for Family, Religion, and Society, draws on this nineteenth century history in an article¹²⁵ that appears as a sort of strategic blueprint for contemporary opponents of contraceptives. The article celebrates the role of Evangelical Protestants in general, and Anthony Comstock in particular, in enacting the “only effective laws suppressing birth control information and devices.”¹²⁶ According to Carlson, opposition to contraception for Anthony Comstock was grounded in “a natural law that encompassed human sexuality.”¹²⁷ Carlson grounds Comstock’s success in two strategies. The first was connecting contraceptives and abortion to obscenity and immorality. As reported by Carlson, Comstock argued to his backers that the “availability of contraceptives encouraged immoral behavior,” i.e., non-procreative sex, and that obscene literature was:

“[C]unningly calculated to inflame the passions and lead the victims from one step of vice to another, ending in utmost lust. [With] victims . . . polluted in thought and imagination . . . the authors of their debasement [then] present a variety of implements by the aid of which they promise them the practice of licentiousness without its direful consequences. [Birth control allowed the despoilers of the innocents] to minister to the most degrading appetites . . . [and] conceal the crime which may be

¹²⁵ The article, Carlson, *supra* note 27, is published by The Howard Center for Family, Religion, and Society. The Howard Center “believes the natural family is the fundamental unit of society; that it is the basis of all healthy and progressive civilizations.” *The Natural Family*, HOWARD CENTER FOR FAM., RELIGION & SOC’Y (Feb. 10, 2007), http://profam.org/THC/xthc_tnf.htm. The natural family, the Center declares, “is the fundamental social unit, inscribed in human nature, and centered around the voluntary union of a man and a woman in a lifelong covenant of marriage, for the purposes of:

satisfying the longings of the human heart to give and receive love;
 welcoming and ensuring the full physical and emotional development of children;
 sharing a home that serves as the center for social, educational, economic, and spiritual life;
 building strong bonds among the generations to pass on a way of life that has transcendent meaning;
 extending a hand of compassion to individuals and households whose circumstances fall short of these ideals.”

Id.

¹²⁶ Carlson, *supra* note 27. Anthony Comstock is described as “the apotheosis, the fine flower of Puritanism,” “a symbol, a caricature, a physical embodiment of the entire cause of purity and puritanism.” *Id.*

¹²⁷ *Id.*

contemplated or per chance already committed.”¹²⁸

In addition to embracing the notion that non-procreative sex is immoral, Carlson also celebrates Comstock’s second successful strategy—linking abortion and contraception together because of “the common danger they posed to women’s health.”¹²⁹ Carlson points out that Comstock had the benefit of being supported by the nineteenth century physicians, discussed previously in Part II.A, who believed that contraception caused “uterine disease.”¹³⁰ Carlson quotes physicians involved in the campaign to criminalize abortion and contraception who believed that any attempt to prevent pregnancy, even by a married couple, other than by complete abstinence from intercourse “are alike disastrous to a woman’s mental, moral, and physical well-being,”¹³¹ and that “[l]ocal congestions, nervous affections and debilities are the direct and indisputable results of *coitus imperfecti*.”¹³² In their view, intercourse using contraception was “rendered but a species of self-abuse,” that is, masturbation.¹³³

Carlson’s point is not that these pre-modern “medical” claims are valid, though he is unconcerned that the views were incorrect. The claim that contraception harms health for Comstock in the nineteenth century, as well as for Carlson today in the twentieth-first century, is based in the view that a sex act for pleasure—whether masturbation, sex with a prostitute, or sex in marriage for non-procreative purposes—is an immoral act, a seed spilled without purpose, a “conjugal onanism.”¹³⁴ Its harm to health comes from its immorality; linking these claims to a scientific discourse was a

¹²⁸ *Id.* (quoting The New York Society for the Suppression of Vice, *Second Report* (1876) in NICOLA BEISEL, *IMPERILED INNOCENTS: ANTHONY COMSTOCK AND FAMILY REPRODUCTION IN VICTORIAN AMERICA* 40–41 (1997) (quoting Comstock) (internal quotation marks omitted)).

¹²⁹ *Id.*

¹³⁰ *Id.* (citing D. Humphreys Storer, *Two Frequent Causes of Uterine Disease*, 6 J. GYNAECOLOGICAL SOC’Y BOS. 194, 195–203 (1855)); see *supra* Part II.A (discussing Comstock and the alleged connection between obscene materials, contraception, and illness).

¹³¹ Carlson, *supra* note 27 (quoting Horatio Robinson Storer, *The Criminality and Physical Evils of Forced Abortions*, 16 TRANSACTIONS OF THE AM. MED. ASS’N 741 (1866)); see also *id.* (quoting a physician stating that “[t]he evil results of the whole system of avoiding offspring in the married state are so palpable and so gross, that one can scarcely find language strong enough to denounce it in suitable manner” and citing the “catalogue of the female diseases’ caused by these practices”); see *supra* Part II.A (“As evidenced by the Congressional debates over the Comstock Act, these nineteenth century opponents of contraception were fueled by the belief that illness was punishment for immoral sexual behavior.”).

¹³² Carlson, *supra* note 27.

¹³³ *Id.* (quoting AUGUSTUS K. GARDNER, *CONJUGAL SINS AGAINST THE LAWS OF LIFE AND HEALTH* 230–31 (1870)).

¹³⁴ *Id.* (citing L.F.E. BERGERET, *THE PREVENTIVE OBSTACLE, OR CONJUGAL ONANISM: THE DANGERS AND INCONVENIENCES TO THE INDIVIDUAL, TO THE FAMILY, AND TO SOCIETY, OF FRAUDS IN THE ACCOMPLISHMENT OF THE GENERATIVE FUNCTIONS* 6 (P. DeMarmon trans., 1870)). (concluding that “Genesiac frauds [contraception] may provoke in [the woman] diseases of the genital organ, from simple inflammation to the most serious degenerations.”) (emphasis added)).

way to validate the claims to the mainstream. His point is that this linkage of contraception and abortion to immorality and illness—supported by the pre-modern views of some anti-contraceptive crusaders at the time—was successful.

A debate in the on-line magazine *Public Discourse* provides further insight into contemporary opposition to contraception.¹³⁵ In those pages, social conservatives have been remarkably transparent about their hostility to contraceptive use and about their view that non-procreative sex is “immoral,” even when between married couples.¹³⁶ Scholars advocating a “natural law” approach,¹³⁷ such as John Finnis and Robert George, believe that all forms of non-procreative sex, from sex between persons of the same sex, to masturbation, fornication, adultery and bestiality, are equally immoral, because they share the same “one morally disqualifying feature.”¹³⁸ The “truly *morally significant* thing” about all these non-procreative forms of sex, according to Finnis and George, is that, “in diverse forms, they involve disrespect for the basic good of marriage.”¹³⁹

As socially conservative scholars debate the ethics of sex,¹⁴⁰ often in the on-line pages of *Public Discourse*, they express an anxiety about the position of religion as “belief” rather than “truth,” about the ability of their moral beliefs to convince, and about the salience of their ethics to the younger generation and the rise in what one scholar calls “sexualityism.”¹⁴¹ For example, Gerry Bradley decries the statement of an English Lord (aptly named Lord Justice Laws) who declared, in denying a religious

¹³⁵ This opposition is part of what have been called the “conscience wars.” See generally Doug NeJaime & Reva Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 *YALE L.J.* 2516 (2015).

¹³⁶ See, e.g., John Finnis, Robert P. George, *Natural Law and the Unity and Truth of Sexual Ethics: A Reply to Gary Gutting*, at 3 *PUBLIC DISCOURSE*, http://www.thepublicdiscourse.com/2015/03/14635/?utm_source=The+Witherspoon+Institute&utm_campaign=7523d98a78-RSS_EMAIL_CAMPAIGN&utm_medium=email&utm_term=0_15ce6af37b-7523d98a78-84111329

¹³⁷ *Id.* (arguing that “Catholic sexual ethics are as fully reasonable today as they were in the time of St Paul. In fact, the natural law understanding of human fulfillment is inherently intelligible even without a theistic framework.”).

¹³⁸ *Id.* (“[I]f people *are willing* to perform a sex act that fails to embody *permanent* commitment, or a bond that is *procreative* in type (whether or not it is, or can in the circumstances be, procreative in effect), they disable themselves from willing in such a way that their sexual congress can actualize and express the good of marriage, which is inherently permanent and procreative in type.”). Finnis and George are careful to point out that although all these forms of non-procreative sex share the same “morally disqualifying feature,” “[bestiality] is more degrading than the others, of course, in expressing an equality between persons and beasts; these kinds of act aren’t alike in every morally significant respect and degree—the point is just that there is one morally disqualifying feature they all share.” *Id.*

¹³⁹ *Id.* (“only acts of spouses that fulfill the behavioral conditions of procreation have validly consummated marriage—and they do that whether or not the non-behavioral conditions of procreation happen to obtain. In short, only such sex acts are *marital*.”).

¹⁴⁰ For now, I leave to others the efforts to puzzle about how masturbation or non-procreative sex between a married heterosexual couple, or any sex other than adultery in relation to the adulterer’s own marriage is showing disrespect for the basic good of marriage.

¹⁴¹ *Id.* (defining sexualityism as “a commitment to uncommitted, unencumbered, inconsequential sex”).

exemption to a relationship counselor who would not endorse the sexual activities of same-sex couples, that any exemption would be “unprincipled” because it would not “advance the general good on objective grounds, but . . . give effect to the force of subjective opinion.”¹⁴² As Bradley complains:

How so? [Justice] Laws asserted that it “must be so, since in the eyes of everyone save the believer religious faith is necessarily subjective, being incommunicable by any kind of proof or evidence. It may of course be *true*; but the ascertainment of such a truth lies beyond the means by which laws are made in a reasonable society.” Against the demands of “equal sexual liberty” . . . solicitude for the opaque commitments of the religious subject count for nothing.¹⁴³

If their moral beliefs no longer hold the power of “truth,” a new source of truth must be marshaled, and that, it is suggested, is scientific truth. As scholar Helen Alvaré proclaims, “I propose to examine th[e] ideology [of equal sexual liberty], not only from a woman’s perspective, but also from the best scientific evidence we can currently lay our hands on.”¹⁴⁴ Thus, the decision to reason through science, to muster the best science “we can lay our hands on” in support of a moral claim against contraception emerges as a strategic and practical decision made because of a concern that moral arguments will no longer persuade on their own.

Adopting this blueprint, the *Hobby Lobby* amicus brief filed on behalf of “Women Speak for Themselves,”¹⁴⁵ and the article on which the brief appears to have been based,¹⁴⁶ also bear a remarkable resemblance to Carlson’s Comstock strategy. Contraception is linked directly with abortion, and opposition to increased access to contraceptives is based in part, as it was in the nineteenth century, on the claim that contraceptive use will make women sick. Styled as a defensive claim—specifically a claim that government tyranny forces conscientious objectors to be complicit in sin—this form of opposition to contraception is designed to appeal both to libertarians, anarchists and other government skeptics who oppose government overreach no matter their views on contraception itself, as well

¹⁴² Gerard V. Bradley, *What’s Behind the HHS Mandate*, PUBLIC DISCOURSE (June 5, 2012), <http://www.thepublicdiscourse.com/2012/06/5562/>.

¹⁴³ *Id.*

¹⁴⁴ Helen Alvaré, *The White House and Sexualityism*, *supra* note 26 (“I propose to examine th[e] ideology [of equal sexual liberty], not only from a woman’s perspective, but also from the best scientific evidence we can currently lay our hands on.”).

¹⁴⁵ Brief of Curiae Women Speak for Themselves, *supra* note 3.

¹⁴⁶ Alvaré, *supra* note 1.

as to social conservatives who champion a normative view in which sexual intercourse takes place only between heterosexual married couples intent on procreation.

While these opponents of contraception believe in the immorality of contraceptive use, they attempt to efface the morality claims by arguing in the language of science and medicine (1) that contraceptives are harmful to women's physical health, and (2) that some hormonal contraceptives are abortifacients—both of which are contradicted by scientific and medical knowledge. The difference between these health claims based on science and the former health claims based on morals is that we can test them.¹⁴⁷ By every measure of objective scrutiny, these claims lack scientific basis, and are just the latest version of the idea that sex for pleasure—not for procreative purposes—is immoral, and that this immoral act will make you sick.¹⁴⁸

¹⁴⁷ Richard A. Posner, *The Problematics of Moral and Legal Theory*, 111 HARV. L. REV. 1637, 1652 (1998) (“When moral claims are . . . defended as functional—a space is created for moral criticism based on empirical investigation. In that situation we can employ the moral premises of the culture whose morality is at issue, and reasoning from common premises reach a conclusion that our local interlocutor may be forced as a matter of logic to accept (if he is logical.)”); see also RICHARD A. POSNER, SEX AND REASON 220–40 (1992) (“this kind of instrumental criticism of moral codes, specifically codes of sexual morality”).

¹⁴⁸ Another version of the claim is seen in the abortion context, where opponents of abortion have argued, despite overwhelming scientific evidence to the contrary, that abortion causes breast cancer and mental health harms. A woman who decides not to carry a pregnancy to term *must* be making herself sick, these advocates believe, because it is so against her very nature. See, e.g., *Report of the South Dakota Task Force to Study Abortion*, LIBERTY COUNS. 41, 52 (2005), http://www.lc.org/attachments/SD_abortion_rpt.pdf (listing “negative effects of abortion” including anxiety, psychological numbing, depression, and suicidal ideation, and explaining that “attachment between mother and child begins most immediately after conception and the basis of maternal attachment is both psychological and physical, and this process, and the natural protective urges of maternal attachment, often form irrespective of whether the pregnancy was intended or wanted”); but cf. *Gonzales v. Carhart*, 550 U.S. 124, 183 n.7 (2007) (Ginsburg, J., dissenting) (listing studies in support of the proposition that the weight of scientific evidence does not comport “with the idea that having an abortion is any more dangerous to a woman’s long-term mental health than delivering and parenting a child that she did not intend to have”); *Fact Sheet: Abortion, Miscarriage, and Breast Cancer Risk*, NAT’L CANCER INST. (Jan. 12, 2010), <http://www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage> (“In February 2003, the National Cancer Institute (NCI) convened a workshop of over 100 of the world’s leading experts who study pregnancy and breast cancer risk. . . . They concluded that having an abortion or miscarriage does not increase a woman’s subsequent risk of developing breast cancer.”); *Report of the APA Task Force on Mental Health and Abortion*, AM. PSYCHOLOGICAL ASS’N 4 (2008), <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> (noting that evidence indicates that the relative risk of mental health problems due to an abortion is similar to the risk associated with an unplanned pregnancy but that risk increases in certain circumstances). See also *MKB Mgm’t Corp. v. Burdick*, 16 F. Supp. 3d 1059, 1062 (D.N.D. 2014) (explaining that the government has an interest in preventing pre-viability abortions to “protect[] the physical and mental health of women who may seek to procure an abortion”); Siegel, *The Right’s Reasons*, *supra* note 7, at 1688 (discussing reliance on claims that abortion harms women to support abortion restrictions).

IV. CONTRACEPTIVES SAVE WOMEN'S LIVES, AND BENEFIT THE HEALTH OF WOMEN AND CHILDREN.

The overwhelming global medical consensus is that contraceptives improve women's health and lives. Government bodies under both Republican¹⁴⁹ and Democratic Administrations and a wide range of private-sector experts, such as the American Medical Association and the American College of Obstetricians and Gynecologists, have long recognized that contraceptive services are a safe, vital, and effective component of preventive and public health care.¹⁵⁰ As the most authoritative text on contraceptives states: "In general contraceptives pose few serious health risks to users . . . [and] the use of contraceptive methods is generally far safer than pregnancy."¹⁵¹ It is indisputable that contraception allows individual women who are sexually active to control their reproductive lives safely by choosing whether to vastly reduce their risk of pregnancy to near zero.¹⁵²

Despite the overwhelming support for contraceptive use among medical authorities worldwide, opponents of contraception today have begun to follow the lead of their nineteenth century counterparts,¹⁵³ claiming that contraceptives are bad for women's health.¹⁵⁴ These bad for health claims have been made most prominently in an amicus brief¹⁵⁵ filed in the *Hobby Lobby*¹⁵⁶ litigation. The brief criticizes the federal government's brief in the case as well as the Institute of Medicine Report¹⁵⁷ (IOM Report) that recommended that contraceptives be included

¹⁴⁹ See Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions About Backlash*, 120 YALE L.J. 2028, 2052–71 (2011) (discussing the realignment of the Republican party on abortion).

¹⁵⁰ Adam Sonfield, *The Case for Insurance Coverage of Contraceptive Services And Supplies Without Cost-Sharing*, 14 GUTTMACHER POL'Y REV., Winter 2011, at 7, 7–9 (2011).

¹⁵¹ ROBERT A. HATCHER ET AL., *CONTRACEPTIVE TECHNOLOGY* 61 (20th rev. ed. 2011).

¹⁵² For efficacy rates of various contraceptives, see *U.S. Medical Eligibility Criteria*, *supra* note 39, at 5.

¹⁵³ Notably, although their claims are focused on hormonal contraceptives, the opponents do not recommend the use of the presumably safe "barrier" methods (condoms and diaphragms) but instead advocate sexual abstinence or the rhythm method—even within marriage—as the alternative for women who do not desire pregnancy and childbirth. See Alvaré, *supra* note 1, at 382 (discussing the Catholic religion's "refusal to facilitate access to contraception"). In this way, the opponents reveal that underlying their critique of contraceptives is the fundamental moral belief—one shared with Anthony Comstock—that *any* interference with the possibility of procreation during intercourse is itself immoral.

¹⁵⁴ See, e.g., *id.* at 412 ("[T]here is additional evidence that greater use of contraception . . . can harm women's health.").

¹⁵⁵ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 33–36.

¹⁵⁶ 134 S. Ct. 2751 (2014).

¹⁵⁷ See INSTITUTE OF MEDICINE, *CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAP*, *supra* note 32 (recommending that contraceptive services be provided at no cost as part of the Affordable Care Act, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 424 (2010) (codified in scattered sections of the U.S. Code)).

at no cost as part of the preventive health care package required under the Affordable Care Act.¹⁵⁸ The brief claims that the U.S. Department of Health and Human Services and its IOM Report “does not devote sufficient attention to the possibility that increasing access to contraception might directly harm women’s health.”¹⁵⁹ The brief goes on to claim that hormonal contraceptives have cardiovascular risks, cause cancer, and increase the risk of contracting HIV.¹⁶⁰ It also attempts to *undermine* the IOM Report’s findings that contraceptives (1) are good for women because they reduce unintended pregnancies, and therefore abortions,¹⁶¹ and (2) are good for children both because they increase the spacing between births which results in healthier birth outcomes,¹⁶² and increase the proportion of children born who are wanted.¹⁶³ Some of the claims made in the amicus brief are simply incorrect; others nonsensical. In what follows, I refute these health claims.

A. *Contraindications and the Medical Eligibility Criteria*

The claim made by the amicus brief that contraceptives harm women’s health appears to be based primarily on concerns about women for whom the use of hormonal contraceptives carries higher-risks than for most women.¹⁶⁴ For example, opponents harp on the idea that hormonal contraceptives may be contraindicated for some women who smoke,¹⁶⁵ as if women will be prescribed contraceptives without regard to their risk factors, and as if the fact that hormonal contraceptives are not appropriate for some women makes them inappropriate for all women. They also ignore the fact that pregnancy is usually far more dangerous than hormonal contraceptives for women whose medical conditions or health histories

¹⁵⁸ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 4–5.

¹⁵⁹ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 33. The brief argues that the regulations do not serve a sufficiently compelling state interest to defeat the plaintiffs’ claims that the regulations violated the Religious Freedom Restoration Act (RFRA). *Id.* at 4–10. After assuming without deciding that the regulations served a compelling state interest, *Hobby Lobby*, 134 S. Ct. at 2759, the Court then held that the government did not meet its burden under RFRA of establishing that the regulations were narrowly tailored to serve that interest. *Id.* at 2781–82. Justice Kennedy wrote separately to stress that “[i]t is important to confirm that a premise of the Court’s opinion is its assumption that the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees,” which could indicate that he believes the interest is compelling. *Id.* at 2786 (Kennedy, J., concurring). However, this remains unclear.

¹⁶⁰ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 35–36.

¹⁶¹ *Id.* at 22–31.

¹⁶² *Id.* at 11–14.

¹⁶³ *See id.* at 22–29 (arguing that HHS’s claim that increased contraceptive use reduces rates of unintended pregnancy is not borne out by the evidence).

¹⁶⁴ *Id.* at 33–37.

¹⁶⁵ *See* Alvaré, *supra* note 1, at 417 (“[A]s of 2008, over 18% of American women smoke This is a large cohort of women who might both receive free hormonal contraception as a consequence of the . . . Mandate, while being admittedly quite susceptible to harms from hormonal contraceptives.”).

counsel against the use of hormonal contraceptives.¹⁶⁶ If hormonal contraceptives carry unacceptable risks for individual woman,¹⁶⁷ other methods such as barrier methods are an option. Rather than recommending that these women use non-hormonal contraceptives, however, opponents of contraception counsel only sexual abstinence.¹⁶⁸

Like other medical providers, family planning providers take into consideration the risks of treatment for an individual patient, as compared to alternative treatments or the option of no treatment. To optimize and improve uniformity in contraceptive prescribing, the World Health Organization created “medical eligibility criteria,” evidence-based guidance on the safety of contraceptive method use for women and men worldwide who have specific characteristics and medical conditions.¹⁶⁹ The World Health Organization used a “consensus process” involving a group of “international family planning experts” who reviewed the best medical evidence available globally.¹⁷⁰ Experts report that in the absence of these guidelines, “[p]ast experience suggests that . . . unnecessary restrictions to contraceptive access may be imposed.”¹⁷¹

First published in 1996, the World Health Organization Medical Eligibility Criteria for Contraceptive Use is now in its fourth edition,¹⁷² and was recently adapted for U.S. providers by the Centers for Disease Control and Prevention.¹⁷³ The U.S. Medical Eligibility Criteria for Contraceptive Use, 2010¹⁷⁴ classifies medical conditions that affect eligibility for different types of contraception into four numeric categories as follows:

Category 1. A condition for which there is no restriction for the use of the contraceptive method.

Category 2. A condition for which the advantages of using

¹⁶⁶ See *supra* Part IV.B.1; see also HATCHER ET AL., *supra* note 151, at 61 (“[T]he use of contraceptive methods is generally far safer than pregnancy.”).

¹⁶⁷ See HATCHER ET AL., *supra* note 151, at 61–63 (noting that while “[i]n general, contraceptives pose few serious health risks,” some have been linked to higher risks of cardiovascular disease and some types of cancer).

¹⁶⁸ See Alvaré, *supra* note 1, at 435 (“It should only be remarked here that the churches opposing the Mandate hold, and teach women and men to maintain, an understanding of the sacredness of sexual intercourse, and its intrinsic connection with the procreating of new, vulnerable, human life.”).

¹⁶⁹ See *U.S. Medical Eligibility Criteria*, *supra* note 39, at 1.

¹⁷⁰ See HATCHER ET AL., *supra* note 151, at 75–76.

¹⁷¹ *Id.* at 75 (discussing need for continual updating of medical eligibility criteria to keep up with new scientific evidence).

¹⁷² *Id.*; see also *U.S. Medical Eligibility Criteria*, *supra* note 39, at 1–2 (discussing process for development of criteria).

¹⁷³ *Id.* at 1–2. The CDC MEC included changes taking new scientific evidence into account. *Id.* at 2.

¹⁷⁴ See *U.S. Medical Eligibility Criteria*, *supra* note 39, at 1–2 (containing recommendations for health-care providers for the safe use of contraceptive methods by women and men with various characteristics and medical conditions).

the method generally outweigh the theoretical or proven risks. (The method can generally be used, but careful follow-up may be required.)

Category 3. A condition for which the theoretical or proven risks usually outweigh the advantages of using the method. . . . Provision of a . . . method to a woman with a . . . Category 3 [condition] requires careful clinical judgment and access to clinical services. The severity of the condition and the availability, practicality, and acceptability of alternative methods should be taken into account.

Category 4. A condition that represents an unacceptable health risk if the contraceptive method is used.¹⁷⁵

Following the eligibility criteria, family planning providers in the U.S. take into account an individual patient's particular circumstances,¹⁷⁶ and (1) determine whether this individual patient has a condition for which certain contraceptives are contraindicated; and (2) compare the risk of treatment compared to alternative treatments or no treatment. Physicians take answers to these questions and additional elements such as effectiveness, availability (including accessibility and affordability), and acceptability into account when making recommendations to patients.¹⁷⁷ As the textbook *Contraceptive Technology* notes, these “[e]vidence-based guidelines regarding which women are medically eligible for contraceptive methods will help to assure that women are not exposed to inappropriate risks, while at the same time not denied access to methods that are medically appropriate.”¹⁷⁸ Throughout all counseling, “[v]oluntary informed choice of contraception methods is an essential guiding principle.”¹⁷⁹ A review of specific risks follows.

B. *Benefits and Risks of Contraceptives to Women's Health*

Anti-contraception opponents ignore that hormonal contraceptives benefit women's health by reducing the risks to *all* women of some serious conditions, including protection against some cancers, and that they are far

¹⁷⁵ HATCHER ET AL., *supra* note 151, at 77–78.

¹⁷⁶ See *id.* at 76 (“[U.S. Medical Eligibility Criteria] recommendations are meant to serve as a source of general clinical guidance. Health care providers should always consider the individual clinical circumstances of each person seeking family planning services.”).

¹⁷⁷ *Id.* at 80; see *id.* at 46 (“Because most people will use a variety of contraceptive methods throughout their lives, they should be knowledgeable about various contraceptive methods. The patient's choice of a contraceptive method depends on several major factors: efficacy, safety, cost, noncontraceptive benefits, and personal considerations.”).

¹⁷⁸ *Id.* at 75.

¹⁷⁹ *Id.* at 80.

safer than the alternative for sexually active women—the alternative being pregnancy.¹⁸⁰ There are risks, however, that must always be taken into account. Here I consider the risks of death, cancer, and cardiovascular disease.

1. *Risk of Death from Pregnancy Versus Hormonal Contraception*

The risk of death from pregnancy in the United States is 1 in 6,900,¹⁸¹ while the risk of death from using combined oral contraceptives is as follows:

nonsmokers aged 15-34	1 in 1,667,000
nonsmokers aged 35-54	1 in 33,300
smokers aged 15-34	1 in 57,800
smokers aged 35-54	1 in 5,200 ¹⁸²

Patients who are properly informed of these risks can choose whether to use contraceptives, and if they desire to use contraceptives, which contraceptives to use.

2. *Impact on Cancer Risks*

Opponents falsely claim that contraceptive pills cause cancer,¹⁸³ citing primarily¹⁸⁴ to the inclusion of estrogen-progestogen oral contraceptives, also known as combined oral contraceptives or COCs, on a list of “known

¹⁸⁰ *Id.* at 61–68; Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,872 (July 2, 2013) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pts. 2510, 2590, 45 C.F.R. pts. 147, 156) (citing INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS 107 (2011)).

¹⁸¹ *Id.* at 62 (citing Cynthia Berg et al., *Pregnancy-Related Mortality in the United States, 1998 to 2005*, 116 AM. J. OBSTETRICS & GYNECOLOGY 1302, 1302 (2010)).

¹⁸² *Id.* (citing Pamela Schwingl et al., *Estimates of the Risk of Cardiovascular Death Attributable to Low-Dose Oral Contraceptives in the United States*, 180 AM. J. OBSTETRICS & GYNECOLOGY 241, 241–49 (1999)).

¹⁸³ Brief of Curiae Women Speak for Themselves, *supra* note 3, at 33–36.

¹⁸⁴ The brief also cites a World Health Organization document without mentioning that the document states (1) that “the use of COCs *modifies* slightly the risk of cancer, increasing it in some sites (cervix, breast, liver), decreasing it in others (endometrium, ovary),” (2) that some of the data showing increased risk “refer to older higher-dose COC preparations,” and (3) that WHO committees that create evidence-based family planning guidelines based on regular reviews of the safety of COCs “have determined that for most healthy women, the health benefits [of COCs] clearly exceed the health risks.” See *id.* at 36 n.157 (emphasis added) (citing WORLD HEALTH ORG., STATEMENT: CARCINOGENICITY OF COMBINED HORMONAL CONTRACEPTIVES AND COMBINED MENOPAUSAL TREATMENT 1 (2005), available at http://www.who.int/reproductivehealth/topics/ageing/cocs_hrt_statement.pdf). Finally, the brief cites to a paper examining breast cancer risk in women with one of the breast cancer genes, known as BRCA-1 or BRCA-2. See *id.* (citing Steven A. Narod et al., *Oral Contraceptives and the Risk of Breast Cancer in BRCA1 and BRCA2 Mutation Carriers*, 94 J. NAT’L CANCER INST. 1773, 1773 (2002) (stating that for women with one of these genes or with a family history of breast cancer, hormonal contraceptives may indeed be contraindicated)).

carcinogens” published by the American Cancer Society.¹⁸⁵ The brief fails to disclose that this list, which also includes “alcoholic beverages,” includes substances that are known to cause cancer *under certain circumstances*.¹⁸⁶ As the American Cancer Society emphasizes in a section entitled “*Some important points about the IARC and NTP lists here*,” “[t]he lists themselves say nothing about how likely it is that an agent will cause cancer,” and the likelihood of an agent causing cancer may be based on the amount and type of exposure.¹⁸⁷ Indeed, the society states that “[e]ven if a substance or exposure is known or suspected to cause cancer, this does not necessarily mean that it can or should be avoided at all costs,” and refers specifically to “estrogen,” a “known carcinogen that occurs naturally in the body.”¹⁸⁸

In fact, the best research shows that overall, the net effect of COC use on cancer is “negligible.”¹⁸⁹ COCs actually protect users against cancers of the endometrium and ovary,¹⁹⁰ and may also protect against colorectal and uterine cancers.¹⁹¹ The opposition completely ignores the most recent studies—large, prospective cohort trials in the United States and United Kingdom—both of which found *no* association between current or former use of combined oral contraceptives, and an increased risk of diagnosis of breast cancer.¹⁹² As the authors of one of the newer studies noted, an older study finding an association between the use of COCs and an increased risk of breast cancer in young women was outdated.¹⁹³ The old study had pooled data from fifty-four epidemiologic studies conducted over the past

¹⁸⁵ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 36 (citing *Known and Probable Human Carcinogens*, AM. CANCER SOC’Y, <http://www.cancer.org/cancer/cancercauses/othercarcinogens/generalinformationaboutcarcinogens/known-and-probable-human-carcinogens> (last visited Feb. 13, 2015)).

¹⁸⁶ *Known and Probable Human Carcinogens*, AM. CANCER SOC’Y, <http://www.cancer.org/cancer/cancercauses/othercarcinogens/generalinformationaboutcarcinogens/known-and-probable-human-carcinogens> (last visited Feb. 13, 2015).

¹⁸⁷ *Id.* (“As noted above, the type and extent of exposure to a substance may also play a role. You should consider the actual amount of increased risk when deciding if you should limit or avoid an exposure.”).

¹⁸⁸ *Id.*

¹⁸⁹ HATCHER ET AL., *supra* note 151, at 63.

¹⁹⁰ *Id.* at 62–63 (citing Ronald Burkman et al., *Safety Concerns and Health Benefits Associated with Oral Contraception*, 190 AM. J. OBSTETRICS & GYNECOLOGY S5, S8 (2004)).

¹⁹¹ *Id.* (citing Philip C. Hannaford et al., *Mortality Among Contraceptive Pill Users: Cohort Evidence from Royal College of General Practitioners’ Oral Contraception Study*, 340 BRIT. MED. J. c927, c927 (2010) (reporting that a recent study found that the risk of death for colorectal, uterine, and ovarian cancer is lower among women who had used COCs than those who had never used COCs)).

¹⁹² *Id.* at 63 (citing Philip C. Hannaford et al., *Cancer Risk Among Users of Oral Contraceptives: Cohort Data from the Royal College of General Practitioners’ Oral Contraception Study*, 335 BRIT. MED. J. 651, 651 (2007); Polly A. Marchbanks et al., *Oral Contraceptives and the Risk of Breast Cancer*, 346 NEW ENG. J. MED. 2025, 2025 (2002)).

¹⁹³ *Id.* (citing Ronald Burkman et al., *Safety Concerns and Health Benefits Associated with Oral Contraception*, 190 AM. J. OBSTETRICS & GYNECOLOGY S5 (2004)).

twenty-five years, and new data was needed “now that larger numbers of women who took oral contraceptives early in their reproductive years are reaching the age at which the risk of breast cancer is highest.”¹⁹⁴ In response, scientists designed a population based case-control study, the National Institute of Child Health and Human Development Women’s Contraceptive and Reproductive Experiences (Women’s CARE) Study, to examine the use of oral contraceptives as a risk factor for breast cancer in women who were thirty-five to sixty-four years old and in subgroups of women defined according to race, age, presence or absence of a family history of breast cancer, and other factors.¹⁹⁵ The study interviewed approximately 9,000 women, approximately half with breast cancer and half without, who were interviewed as controls, and determined their relative risks of breast cancer.¹⁹⁶ The researchers found that “[a]mong women from 35 to 64 years of age, current or former oral contraceptive use was not associated with a significantly increased risk of breast cancer.”¹⁹⁷

Similarly, a study in the United Kingdom reported in the *British Medical Journal* that included more than a million “woman years” of observation accumulated over thirty-six years, found that oral contraception was not associated with a significantly increased risk of any cancer and that “the estimated overall absolute reduction in risk of any cancer among ever users of combined oral contraceptives was 45 per 100,000 woman years”¹⁹⁸

Depending on which dataset was examined, our analyses suggest either a statistically significant 12% reduced risk of any cancer (main dataset) or a more modest, non-significant, 3% reduction (general practitioner observation dataset). In either case we found no evidence of a substantial increased risk of cancer overall. A major strength of the study was the ability to include more than a million woman years of observation, accumulated over 36 years. Virtually all of the women in the study are now post-menopausal, of an age when many cancers become common.¹⁹⁹

Finally, another three studies have found that COC use has neither a

¹⁹⁴ Marchbanks et al., *supra* note 192, at 2025.

¹⁹⁵ *Id.* at 2025–26.

¹⁹⁶ *Id.* at 2025.

¹⁹⁷ *Id.*

¹⁹⁸ Hannaford et al., *supra* note 192, at 653–54.

¹⁹⁹ *Id.* at 653.

harmful nor a beneficial effect on breast cancer mortality.²⁰⁰

3. *Impact on Cardiovascular Disease*

The opponents' claim that hormonal contraceptives increase the risks of cardiovascular disease, i.e., myocardial infarction (heart attack) and stroke, is false as applied to most women.²⁰¹ Although the use of COCs is generally associated with an increased risk of cardiovascular disease because it can increase the risk of developing a clot that can cause a heart attack or a stroke, there is no increased risk of stroke in nonsmoking women under age thirty-five, who use COCs with less than fifty mcg estrogen.²⁰² Similarly, women who do not smoke, are not diabetic, and have normal blood pressure levels have *no* increased risk of myocardial infarction.²⁰³ Finally, the evidence shows that women are at the biggest risk of forming a clot that could cause a heart attack or stroke when they are pregnant.²⁰⁴ Therefore, any contraceptive that prevents pregnancy ultimately *decreases* the risk of forming a clot.²⁰⁵

C. *Contraceptives Improve the Health of Children By Allowing Women to Increase the Space Between Births.*

There is confusion in both the IOM Report and in the opposition Amicus Brief and article between the impact of the *intentionality* of pregnancy on maternal and child health with the impact of *birth spacing* on birth outcomes. I will assume for the sake of argument that *neither* the IOM Report *nor* the opponents of contraception intended to confuse the two. It may be that confusion on the issue is more useful to the opponents than it is to the IOM Report, but either way, I aim to end the confusion here. In this Article, I separate these two factors that potentially impact maternal and child health and discuss what the most recent data shows and does not show about each.

As the IOM Report found, increasing the space between births²⁰⁶—

²⁰⁰ HATCHER ET AL., *supra* note 151, at 63 (citing Hannaford et al., *supra* note 192; M. Vessey, et al., *Factors Affecting Mortality in a Large Cohort Study with Special Reference to Oral Contraceptive Use*, 82 *CONTRACEPTION* 221 (2010); P.A. Wingo et al., *Oral Contraceptives and the Risk of Death from Breast Cancer*, 110 *OBSTETRICS & GYNECOLOGY* 793 (2007)).

²⁰¹ Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 35.

²⁰² *Id.*

²⁰³ HATCHER ET AL., *supra* note 151, at 63.

²⁰⁴ *Id.*

²⁰⁵ *See id.* (discussing how women are at the highest risk of forming a blood clot that could cause a heart attack or stroke when they are pregnant).

²⁰⁶ This should not be confused with the evidence concerning the impact on the health of children born of “unintended” pregnancies. Opponents of contraception have tried to undermine the very strong evidence that longer pregnancy intervals improve birth outcomes by confusing it with the evidence concerning the impact on the health of children born of “unintended” pregnancies. Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 36. The benefits of reducing unintended pregnancies—which I discuss *infra* at Part IV.D—are significant but differ from the benefits of

which contraception allows—reduces adverse pregnancy outcomes, like preterm births, prematurity, and low-birth weight.²⁰⁷ One critic of contraceptive use disputes this finding but reveals that her main concern is not the health of children who are born, but rather a normative concern that the procreative potential of intercourse is being impeded. She writes, “children’s health is not boosted by their being prevented from coming into being.”²⁰⁸ Actually, the research establishes that children *are* healthier when there is more space between pregnancies. This same anti-contraception advocate disputes this fact, arguing that the papers relied on by the IOM Report “claim only to show an ‘associat[ion],’ not causation, between shorter pregnancy intervals and low birth weight.”²⁰⁹ This is not only incorrect because one of the papers specifically finds causation,²¹⁰ but it is also based on a fundamental and quite shocking misunderstanding of the purposes and benefits of quantitative statistical analysis.²¹¹

The purpose of statistical analysis is to determine whether certain studied factors are “associated” with certain outcomes and, if so, how strong the associations are. To determine the strength of the associations, study authors attempt to control for other potential causes, which constitute potential confounding factors. The more confounding factors are eliminated as potential causes of a given outcome, the likelier it is that the studied factor is the cause. As a basic quantitative research text notes, “a well-designed quantitative study will allow us not just to look at what happens, but to provide an explanation of why it happens as well. The key lies in your research design and what variables you collect.”²¹²

The studies relied on by the IOM Report recommending increased access to contraceptives show “associations” of varying strengths that are carefully explained.²¹³ Based on the strength of these associations, and by

increasing pregnancy intervals.

²⁰⁷ Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39870, 39872 (July 2, 2013).

²⁰⁸ Alvaré, *supra* note 1, at 392.

²⁰⁹ Alvaré, *supra* note 1, at 393.

²¹⁰ B.P. Zhu, *Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent US Studies*, 89 INT’L J. OF GYNECOLOGY & OBSTETRICS S25, S31 (2005).

²¹¹ I note that while the Amicus Brief’s critique of the IOM Report supporting increased access to contraceptives uses these general criticisms of social science methods to attack studies that undermine their point of view, the Brief relies on other studies using these same criticized methods, when they find data that they believe supports their point of view. *E.g.*, *supra* Part IV.B.2. While there is a deep and extensive literature about debates concerning the use of statistical analyses in social science, the opponents’ willingness to rely on the same methods they criticize undermines any presumption that they are engaging seriously with these critiques of social science and further undermines the claim that contraception harms women.

²¹² As *Introduction to Quantitative Research* explains, the idea that “[w]e can never explain things by using quantitative research,” is one of the “common misconceptions” concerning quantitative research. DANIEL MUIJS, *DOING QUANTITATIVE RESEARCH IN EDUCATION WITH SPSS 9* (2d ed. 2011).

²¹³ *E.g.*, Agustin Conde-Agudelo et al., *Birth Spacing and Risk of Adverse Perinatal Outcomes*, *A*

controlling for other possible confounding factors, study authors are able to make causal inferences about the hypotheses studied or to provide an assessment of the likelihood of causation based on the strength of the associations. As a major text in the field states:

Avoiding causal language when causality is the real subject of investigation either renders the research irrelevant or permits it to remain undisciplined by the rules of scientific inference. Our uncertainty about causal inferences will never be eliminated. But this uncertainty should not suggest that we avoid attempts at causal inference. Rather we should draw causal inferences where they seem appropriate but also provide the reader with the best and most honest estimate of the uncertainty of that inference.²¹⁴

Turning back to the scientific literature relied upon by the IOM Report concerning the relationship between birth outcomes and longer intervals between pregnancies, one of the three papers cited reports that “there is a *causal* relationship between interpregnancy interval and adverse birth outcomes,” and “[t]he optimal interpregnancy interval for preventing adverse birth outcomes appeared to be approximately 18–23 months, departing from which the risk for adverse birth outcomes increased, although the increase was not appreciable unless the interpregnancy interval was shorter than 6 months or longer than 5 years.”²¹⁵ That paper reported on three studies that were “conducted in various populations, using different study designs, stratified by, and controlling for various maternal reproductive risk factors [that] addressed a number of methodological limitations regarding previously published studies.”²¹⁶

The second and third papers did not claim causation, but did report a “significant association” and an “independent association” respectively between pregnancy intervals and an increased risk of adverse pregnancy outcomes.²¹⁷ The second paper is a systematic review published in the *Journal of the American Medical Association* using three different meta-

Meta Analysis, 295 *JAMA* 1809, 1809–23 (2006); Elena Fuentes-Afflick & Nancy A. Hessel, *Interpregnancy Interval and the Risk of Premature Infants*, 95 *OBSTETRICS & GYNECOLOGY* 383, 383–390 (2000); Zhu, *supra* note 210, at S25–S33.

²¹⁴ GARY KING ET AL., *DESIGNING SOCIAL INQUIRY: SCIENTIFIC INFERENCE IN QUALITATIVE RESEARCH* 76 (1994); *see also* *RETHINKING SOCIAL INQUIRY: DIVERSE TOOLS, SHARED STANDARDS* 184–85 (Henry E. Brady & David Collier eds., 2d ed. 2010) (discussing “causal-process observations”).

²¹⁵ Zhu, *supra* note 210, at S31 (emphasis added).

²¹⁶ *Id.* at S31.

²¹⁷ *See* Conde-Agudelo et al., *supra* note 213, at 1821 (“birth to conception intervals shorter than 18 months and longer than 59 months are significantly associated with increased risk of several adverse perinatal outcomes, such as preterm birth, LBW, and SGA.”); Fuentes-Afflick & Hessel, *supra* note 213, at 388 (“we found that interpregnancy intervals less than 18 months and more than 59 months were independently associated with the risk of premature infants”).

analytical techniques to pool data from numerous individual studies of the relationship between pregnancy intervals and adverse perinatal outcomes.²¹⁸ That paper reports that birth to conception intervals shorter than eighteen months and longer than fifty-nine months are “significantly associated” with increased risk of several adverse perinatal outcomes, such as preterm birth, low birth weight, and fetuses that are small for gestational age.²¹⁹ The study controlled for a number of potential confounding factors that had been suggested such as socioeconomic status, unstable lifestyles, failure to use health care services, or inadequate use of such services, unplanned pregnancies, and other behavioral or psychological determinants.²²⁰ However, the study reports that “the birth spacing effects are not strongly attenuated when socioeconomic and maternal characteristics are controlled for suggest[ing] that the effects *are not caused by these confounding factors*,” which importantly include the *unplanned* nature of the pregnancy.²²¹

The third paper similarly found that “interpregnancy intervals were independently associated with the risk of prematurity in [the] study.”²²² It also reported that two other factors were associated more strongly with the risk of premature infants, namely previous premature or small for gestational age infant and utilization of prenatal care, both of which were consistent with previous studies.²²³ Thus, the paper identified interpregnancy interval as a third strong indicator of adverse pregnancy outcomes which, unlike previous indicators of adverse pregnancy outcomes, is a potentially modifiable factor. As two papers reporting strong associations and eliminating potential confounding factors, they, like the first paper,²²⁴ provide strong evidence of a causal link. Because interpregnancy intervals are a potentially modifiable risk factor for low birth weight,²²⁵ recommendations that come from these studies support the use of family planning to support optimal pregnancy spacing.²²⁶

D. *Impact of Pregnancy Intention on Child and Maternal Health*

The opponents argue that when studying the impact of pregnancy intention on health, the failure to account for differing categories of intention invalidates study findings as a whole.²²⁷ If a pregnancy is

²¹⁸ Conde-Agudelo et al., *supra* note 213, at 1821.

²¹⁹ *Id.*

²²⁰ *Id.* at 1809, 1821.

²²¹ *Id.* at 1821.

²²² Fuentes-Afflick & Hessol, *supra* note 213, at 388–89.

²²³ *Id.*

²²⁴ *See* Zhu, *supra* note 210.

²²⁵ *Id.*

²²⁶ Fuentes-Afflick & Hessol, *supra* note 213, at 389; Zhu, *supra* note 210, at S32.

²²⁷ *See, e.g.*, Brief of Amicus Curiae Women Speak for Themselves, *supra* note 3, at 22–23.

“unintended,” this can mean either (1) that the woman wants to have a child, or another child, in the future but not at the time she gets pregnant, or (2) the woman has finished childbearing or does not ever intend to have a child.²²⁸ As a 2008 literature review explained, most survey instruments will refer to the first group as pregnancies that are “mistimed” or “wanted later,” and the second group as pregnancies that are “not wanted at all.”²²⁹ Studies often consider these two categories together, underestimating the true effect of pregnancies that are “not wanted at all,” and overestimating the effect of a pregnancy that is “mistimed” or “wanted later.”²³⁰ While it would be helpful if future studies separated outcomes based on these different categories to assist public health officials in formulating strategies to help those impacted most negatively by unintended pregnancy, it does not undermine what we do know about unintended pregnancies as a group.²³¹ A recent survey of the literature concerning the impact of intention on birth outcomes clarifies what current studies do and do not tell us about this factor.²³²

In a literature review examining the evidence of the impact of intention on child and parental health, the authors report that the field is incomplete. On the one hand, the authors report a considerable number of studies (often conducted in the United States), showing consistently disturbing results on prenatal care, breastfeeding, child abuse, maternal health, and abortions. These are outcomes that cannot be ignored and that are described in what follows.²³³ On the other hand, the evidence of the impact of intention on some child and parental health outcomes is “mixed and . . . limited by an insufficient number of studies for some outcomes” and by some measurement and analytical concerns.²³⁴ For example, for outcomes “such as maternal risk behaviors, pregnancy outcomes, and curative care, developed country studies failed to find a significant association with pregnancy intention[, with] the paucity of studies . . . preclud[ing] an overall assessment of such an impact.”²³⁵ The authors call for more studies to address these concerns and to increase understanding of the impacts of

²²⁸ Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 *STUD. FAM. PLAN.* 18, 19 (2008).

²²⁹ *Id.* at 19–20.

²³⁰ *Id.* at 19.

²³¹ See Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 *PERSP. ON SEXUAL & REPROD. HEALTH* 90, 91 (2006) (“[C]lassifying all pregnancies ending in abortion as unintended should have minimal impact on our calculated rates.”).

²³² Gipson, *supra* note 228, at 18–19.

²³³ *Id.* at 29–30.

²³⁴ *Id.* at 29.

²³⁵ *Id.* at 30.

intention on pregnancy outcomes.²³⁶

1. *Impact of Pregnancy Intention on Prenatal Care, Breastfeeding, Child Abuse, and Maternal Health*

The evidence concerning the impact of whether a pregnancy is intended on prenatal care and breastfeeding behavior “is relatively consistent, showing a negative effect of unintended pregnancy.”²³⁷ Studies in developed countries “found more pronounced effects on the timing, rather than the frequency, of antenatal care and found persistent negative effects on the breastfeeding of children who resulted from unintended pregnancies.”²³⁸ For example, “[n]early all United States and European studies assessing the effect of pregnancy intention on breastfeeding have concluded that children who are born from unintended pregnancies are less likely to be breastfed or are more likely to be breastfed for a shorter duration, compared with children whose birth was intended.”²³⁹ Even within the same family, children born from unintended pregnancies “were significantly less likely to be breastfed, after controlling for other sociodemographic characteristics.”²⁴⁰

Moreover, studies from developed countries suggest a positive association between unintended pregnancy and child abuse. In a population-based study that analyzed data for 14,256 children from the United Kingdom:

Children . . . who were registered with the child protection agency by the age of six . . . were nearly three times more likely than others to have resulted from a pregnancy that the mother considered to be unintended . . . , after controlling for birth weight, child health, developmental problems, and reported positive attributes of the child.²⁴¹

With regard to a link between unintended childbearing and *maternal* health outcomes, studies have not shown any impact on maternal physical health, but a number of studies from developed countries suggest a link between unintended childbearing and a significantly increased risk of maternal depression, anxiety, and a decline in psychological well-being or

²³⁶ See *id.* (discussing the need for future studies on the topic to try to pinpoint the causal relationship between presence of intent in pregnancy and children’s health outcomes more accurately).

²³⁷ *Id.* at 30. On the other hand, “[n]o effects were found in the few studies assessing the association between pregnancy intention and well-baby care, child immunization, or curative care in the United States and Europe.” *Id.* at 25.

²³⁸ *Id.* at 30.

²³⁹ *Id.* at 24.

²⁴⁰ *Id.*

²⁴¹ *Id.* at 27.

psychosocial conditions.²⁴² As one 1999 study of longitudinal data from the National Survey of Families and Households found, “[a]fter controlling for maternal characteristics, total number of children in the family, and presence in the household of a child aged five to eighteen, mothers who had experienced any unwanted births reported higher levels of depression and lower levels of happiness.”²⁴³ This 1999 study also found that “mothers who had experienced unwanted births were more likely to spank or slap their children and to have spent less leisure time with them, compared with other mothers.”²⁴⁴ While the studies showed that negative outcomes were “significantly exacerbated by the mother’s mental health status,” more research is needed to control for preexisting mental illness and other markers of prior psychosocial well-being before firm assessments can be made.²⁴⁵

As a result of these established negative outcomes, the study authors conclude that

[t]he evidence of the impact of unintended pregnancy on abortion-related morbidity and mortality points to the need for primary and secondary prevention efforts. Primary prevention, through the increased provision and use of effective contraceptive methods, can reduce levels of unintended pregnancy. In the event of an unintended pregnancy, secondary prevention efforts can help to ensure safe abortion and postabortion services to prevent ongoing illness and death for the estimated 46 million women around the world who have abortions each year.²⁴⁶

2. *Impact of Pregnancy Intention on Abortion*

One of the greatest benefits of contraception is that it reduces the number of unintended pregnancies, thereby reducing the number of abortions. In 2001, unintended pregnancies accounted for 49% of all pregnancies, 3.1 million of a total of 6.4 million pregnancies, or 51 pregnancies per 1,000 women aged fifteen to forty-four in the United States.²⁴⁷ Of these 3.1 million unintended pregnancies, 42%—or approximately 20% of all pregnancies—ended in abortions.²⁴⁸ One *could* reduce the proportion of pregnancies that are called “unintended” if that

²⁴² *Id.* at 28.

²⁴³ *Id.*

²⁴⁴ *Id.*

²⁴⁵ *Id.* at 28, 30.

²⁴⁶ *Id.* at 29–30.

²⁴⁷ Finer & Henshaw, *supra* note 231, at 90–92, 92 fig.1, 93, 93 tbl.1. In 2001, unintended pregnancies accounted for 49% of all pregnancies, a rate virtually unchanged from 1994. *Id.* at 92.

²⁴⁸ *Id.*

group were limited to those pregnancies that are “never wanted,” and creating a third group of “mistimed/wanted later” pregnancies. Presumably the proportion of pregnancies that are “never wanted” that then result in abortion is going to be higher than the proportion of pregnancies that are “mistimed,” or “wanted later.” The reclassification will not reduce the overall proportion of pregnancies that result in abortions, though. Contraception that reduces the incidence of pregnancies that are “never wanted,” as well as those that are “mistimed” or “wanted later” will.²⁴⁹

Reduction of the incidence of abortions occurring in this fashion is a good thing if you believe in reproductive rights and justice, because the reduction of abortions is coming from reduction in the *demand* for abortion, as opposed to coming from cutting off the supply of or restricting the ability of women to access abortions.²⁵⁰ This should also be a good thing if you are against abortion itself. If your opposition to abortion is, however, in part based on the idea that the risk of pregnancy serves as a check on, or punishment for, immoral sex—sex outside of marriage, or sex between husband and wife undertaken for pleasure alone with as close to zero risk of pregnancy as possible—then this is not necessarily so. Instead of being viewed as a good that reduces the number of abortions, contraceptives are seen as promoting immoral sex and allowing it to go unpunished.²⁵¹

V. CONTRACEPTIVES ARE NOT ABORTIFACIENTS

The opponents of contraception also follow in the footsteps of Anthony Comstock by linking contraception to abortion.²⁵² In the twenty-first century, this linkage is attempted by arguing that some contraceptive drugs and devices actually operate as abortifacients and end a

²⁴⁹ *Finer & Henshaw, supra note 231*, at 90–92; *see also* INST. OF MED., CLINICAL PREVENTIVE SERVICES FOR WOMEN: CLOSING THE GAPS, *supra note 32*, at 105 (2011); John Bongaarts & Charles F. Westoff, *The Potential Role of Contraception in Reducing Abortion*, 31 *STUD. IN FAM. PLAN.* 193, 200 (2000) (“The incidence of abortion can be reduced by raising contraceptive prevalence and effectiveness.”); Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 *OBSTETRICS & GYNECOLOGY* 1291, 1291–93, 1295–96 (2012) discussing the results of a study conducted on women at risk of unintended pregnancy that showed a decrease in abortion rates with women enrolled in the Contraceptive CHOICE Project).

²⁵⁰ *See Bongaarts & Westoff, supra note 249*, at 200 (arguing that if contraceptives were more accessible to women, the need for abortions due to unintended pregnancies would decrease).

²⁵¹ *See, e.g., Paul D. O’Callaghan, Pseudosex in Pseudotheology*, 4 *CHRISTIAN BIOETHICS* 83, 83–84, 86–87 (1998) (presenting the argument of John Beaumont that social acceptance of contraceptive sex leads to further social acceptance of other forms of immoral sex, such as homosexual intercourse).

²⁵² *See Maryam T. Afif, Comment, Prescription Ethics: Can States Protect Pharmacists Who Refuse to Dispense Contraceptive Prescriptions?*, 26 *PACE L. REV.* 243, 244–46 (2005) (explaining the history of Anthony Comstock’s crusade against immoral behavior and describing publications that promoted the use of birth control and abortions, which led several states to criminalize the use of contraceptives and abortions).

“pregnancy.”²⁵³ The argument relies on two claims, both of which are false.

First, the opponents argue that “pregnancy” occurs as soon as the egg is fertilized by the sperm, prior to implantation of the fertilized egg into the uterine lining. As shown below, this is contrary to the medical definition of pregnancy, not to mention common sense given the significant number of fertilized eggs that fail to implant on their own, exiting the body with no fanfare, without the use of any contraceptive device. Second, the opponents also argue that contraceptive devices have the power to *prevent* implantation of a fertilized egg. They lodge this accusation against five contraceptive methods in the *Hobby Lobby* litigation. As I discuss in detail below, it has been established conclusively that four of the five contraceptive methods cannot prevent implantation of a fertilized egg and so cannot terminate a “pregnancy,” *even defined in the way the opponents define it*. The fifth, the copper IUD, could prevent implantation, but only if inserted after ovulation, i.e., after the egg has been released from the ovary but before it has traveled out of the body. Notably, despite this proof that these four contraceptives can *never* act to prevent implantation of the fertilized egg and so do not “abort” a “pregnancy,” even under the incorrect definition of that term used by the opposition, anti-contraception advocates have not withdrawn their opposition to these four forms of contraception.

A. Definition of Pregnancy

The opposition’s claim that an “abortion” can occur if a fertilized egg is prevented from implanting into the uterine lining relies on the contention that “pregnancy” begins when the ovum is fertilized by sperm—even before the egg has implanted in the uterine lining. This is an argument anti-abortion and anti-contraceptive advocates have used inconsistently in the past.²⁵⁴

One problem with the opposition’s claim is that according to the descriptions of pregnancy in obstetrical textbooks written by professional organizations of obstetricians and gynecologists in the United States and abroad, and by the United States Federal Government, “pregnancy” starts

²⁵³ “Other religious institutions opposed only to abortion were affected by the Mandate’s inclusion of ECs and other contraceptives, which, according to the federal government and their manufacturers, can act at some times as an abortifacient, i.e., to destroy a human embryo.” Alvaré, *supra* note 1, at 384. In *Burwell v. Hobby Lobby*, the claimants opposed coverage of four types of contraceptives because they believed they were abortifacients. 134 S. Ct. 2751, 2759 (2014).

²⁵⁴ Joerg Dreweke, *Contraception Is Not Abortion: The Strategic Campaign of Antiabortion Groups to Persuade the Public Otherwise*, 17 GUTTMACHER POL’Y REV., Fall 2014, at 14, 14 (noting that anti-abortion groups have “selectively embraced the core ‘personhood’ argument—that U.S. policy should in some circumstances recognize pregnancy as beginning at fertilization—as a way to undermine access to birth control”).

only after implantation of an already fertilized egg. For example, the American College of Obstetricians and Gynecologists notes that a “pregnancy is considered to be established only after implantation is complete,”²⁵⁵ a process that “can be completed as early as eight days or as late as 18 days after fertilization, but [that] usually takes about 14 days.”²⁵⁶ Indeed, it is only after implantation that a pregnancy test will register as positive because of the hormonal changes that occur after implantation.²⁵⁷

The National Institutes of Health take a similar position. Federal regulations governing human subjects research define pregnancy as “encompass[ing] the period of time from implantation until delivery.”²⁵⁸ Part of the reason for this definition is the high number of fertilized eggs that fail to implant even without the use of any contraceptives.²⁵⁹ According to the American College of Obstetricians and Gynecologists, “between one-third and one-half of all fertilized eggs never fully implant.”²⁶⁰

Opponents dismiss these definitions of pregnancy, attributing the definitions to the supposed pro-choice leanings of both the American College of Obstetricians and Gynecologists and the federal government.²⁶¹ But this ignores that even the *Bush Administration*, self-defined as promoting a “culture of life,”²⁶² adopted rules to implement the Hyde Amendment—the federal statute banning federal funding for abortions in the Medicaid program²⁶³—that defined pregnancy in accordance with the medical consensus represented by the American College of Obstetricians

²⁵⁵ Rachel Benson Gold, *supra* note 15, at 7, 8 (quoting the American College of Obstetricians and Gynecologists’ position).

²⁵⁶ *Id.*

²⁵⁷ It takes two weeks for a urine pregnancy test to become positive. See Allen J. Wilcox, Donna Day Baird, & Clarice R. Weinberg, *Time of Implantation of the Conceptus and Loss of Pregnancy*, 340 NEW ENG. J. MED. 1796, 1797 (1999) (noting that it normally takes eight, nine, or ten days for implantation to occur after ovulation).

²⁵⁸ 45 C.F.R. § 46.202(f) (2013).

²⁵⁹ Gold, *supra* note 15, at 8 (citing ACOG).

²⁶⁰ *Id.*

²⁶¹ See CATHY CLEAVER RUSE & ROB SCHWARZWALDER, FAMILY RESEARCH COUNCIL, THE BEST PRO-LIFE ARGUMENTS FOR SECULAR AUDIENCES 2 (2011), available at <http://downloads.frc.org/EF/EF11J30.pdf> (citing ROBERT G. MARSHALL & CHARLES A. DONOVAN, BLESSED ARE THE BARREN: THE SOCIAL POLICY OF PLANNED PARENTHOOD 293 (1991) (reporting that in 1965, “ACOG stated in its first *Terminology Bulletin* that ‘Conception is the implantation of a fertilized ovum’”)); see also MARSHALL & DONOVAN, BLESSED ARE THE BARREN: THE SOCIAL POLICY OF PLANNED PARENTHOOD at 293 (1991) (“[G]iven the political leaning of governmental agencies, academic institutions, and the scientific publishing industry it would not be surprising if it were correct that ‘the medical community has long been clear: Pregnancy is established when a fertilized egg has been implanted in the wall of a woman’s uterus.’” (quoting Gold, *supra* note 15, at 7)).

²⁶² Michael A. Fletcher, *Bush Hails Progress Toward ‘Culture of Life’; Limits on Abortion, Stem Cell Use Cited*, WASH. POST, Jan. 25, 2005, at A3 (internal quotation marks omitted).

²⁶³ Gold, *supra* note 15, at 7.

and Gynecologists.²⁶⁴ Those rules block the use of public funds to pay for abortion services for low-income women but make clear that funding *is* available for “drugs or devices to prevent implantation of the fertilized ovum,” thus excluding these drugs and devices from the definition of abortion.²⁶⁵ These rules, which remain in effect today, say that pregnancy “encompasses the period of time from implantation until delivery.”²⁶⁶

Thus, even if the contraceptives could prevent a fertilized egg from implanting, they would not be terminating a “pregnancy”; they would be preventing one.²⁶⁷ Opposition to any drug or device that prevents a fertilized egg from implanting in a woman’s uterine lining, opposition stemming from their belief that a fertilized egg is a “human life” deserving of protection, is therefore not opposition to “abortion,” it is by definition opposition to a form of contraception.²⁶⁸

B. *Mechanisms of Action of Emergency Contraception and IUDs*

In response to this claim, one could argue that the important point is not whether prevention of implantation by a fertilized egg is termination of a “pregnancy,” and thus is considered an “abortion.” Instead, one could argue that one is opposed to medicines or devices that prevent a fertilized egg from implanting because one believes that the fertilized egg is a “human life,” and preventing implantation is immoral in its own right, even if one were to call it contraception or prevention of implantation by a fertilized egg. Indeed, one could simply argue that one is opposed to certain forms of contraception that had this effect. This is a perfectly valid moral position for someone to hold and has the benefit of honesty, of not trying to muddy the waters by playing fast and loose with medical terminology.

The problem with this second argument is that once again the science does not support the opposition. The question is whether Emergency Contraception and IUDs, which were singled out for attack in the *Hobby Lobby* litigation,²⁶⁹ are effective only because they prevent fertilization in

²⁶⁴ See *id.* (noting that the same federal regulations meant to effect the Hyde Amendment eventually aligned with the medical community’s consensus that pregnancy begins once implantation has commenced).

²⁶⁵ *Id.* (internal quotation marks omitted).

²⁶⁶ *Id.* (internal quotation marks omitted).

²⁶⁷ See 45 C.F.R. § 46.202(f) (2013) (providing the legal definition of pregnancy as beginning at implantation); *infra* note 269 (explaining that contraceptives cannot act after the embryo is implanted).

²⁶⁸ *Id.*

²⁶⁹ It is undisputed that none of the products clinicians and scientists call contraceptives can act after the embryo is implanted in the uterine lining, which is when a pregnancy begins. See Gillian Dean & Eleanor Bimla Schwarz, *Intrauterine Contraceptives (IUCs)*, in *CONTRACEPTIVE TECHNOLOGY* 147, 150 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing mechanism of action); see also Deborah Bartz & Alisa B. Goldberg, *Injectable Contraceptives in Contraceptive Technology*, in *CONTRACEPTIVE TECHNOLOGY* 209, 210 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing

the first instance or whether they sometimes are also effective in preventing implantation of a fertilized egg. Although the evidence was not always clear, as discussed in what follows, the medical evidence has now conclusively established that four of the five contraceptives never act to prevent implantation and so *never* act as abortifacients, *even under the opponents' expanded definition of pregnancy and abortion*; only one, the copper IUD, could sometimes prevent implantation of a fertilized egg if inserted *after* ovulation.²⁷⁰

The opponents of contraception ignore research finalized in the last fifteen years concerning the mechanism of action of EC pills and IUDs.²⁷¹ There are two types of dedicated emergency contraceptive pills²⁷² that are available for use in the United States: “Plan B One-Step”²⁷³ (and its generic alternative, Next Choice)²⁷⁴ and “ella.”²⁷⁵ Copper-releasing IUDs can also be used as an emergency contraceptive device, though they are primarily used as a regular form of birth control.²⁷⁶ A document written in 2006 and made public by the Federal Drug Administration stated that Plan B “*may* prevent a fertilized egg from attaching to the womb (implantation).”²⁷⁷

mechanism of action); Kavita Nanda, *Contraceptive Patch and Vaginal Contraceptive Ring*, in *CONTRACEPTIVE TECHNOLOGY* 343, 344, 355–56 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing mechanism of action); Anita L. Nelson & Carrie Cwiak, *Combined Oral Contraceptives (COCs)*, in *CONTRACEPTIVE TECHNOLOGY* 249, 257–58 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing mechanism of action); Elizabeth G. Raymond, *Contraceptive Implants in Contraceptive Technology*, in *CONTRACEPTIVE TECHNOLOGY* 193, 194–95 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing mechanism of action); Elizabeth G. Raymond, *Progestin-Only Pills*, in *CONTRACEPTIVE TECHNOLOGY*, 237, 237–38 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011) (discussing mechanism of action).

²⁷⁰ This arguably should have an impact on the position of Hobby Lobby Stores and other claimants opposing coverage of contraceptives on the basis that they prevent implantation of a fertilized egg. If that was truly the basis—and not an objection to all contraceptives or to hormonal contraceptives based on the use of a hormone, now that the Emergency Contraceptives Plan B, Ella, and the hormonal IUD have been shown to act only by preventing ovulation and *not* by impacting fertilization—then these claimants should agree to cover them.

²⁷¹ First, it bears emphasis that none of the various Emergency Contraception options, nor any other form of contraception, acts to terminate a pregnancy when pregnancy is defined—as ACOG and all other major ob/gyn organizations define it—as occurring after the process of implantation is complete. In other words, they cannot abort a pregnancy so defined and, as such, are completely different medically from “medical abortion” or “the abortion pill.” See *CONTRACEPTIVE TECHNOLOGY*, *supra* note 151 (describing mechanisms of action of all contraceptive medications and devices).

²⁷² James Trussell & Eleanor Bimla Schwarz, *Emergency Contraception*, in *CONTRACEPTIVE TECHNOLOGY* 113–45 (Robert A. Hatcher et al. eds., 20th rev. ed. 2011).

²⁷³ Plan B One-Step (a single 1,500 mcg levonorgestrel pill) replaced the previously available Plan B (two 750 mcg tablets of levonorgestrel) in 2009. *Id.* at 113.

²⁷⁴ A generic version of Plan B was approved in 2009. *Id.*

²⁷⁵ A single 30 mg ulipristal pill was approved in 2010 by the Federal Drug Administration. *Id.*

²⁷⁶ *Id.* at 121.

²⁷⁷ *FDA's Decision Regarding Plan B: Questions and Answers*, FDA, <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm109795.htm> (last updated Mar. 4, 2009) (emphasis added). The entire statement in response to the question “How does Plan B work?” reads: “Plan B works like other birth control pills to prevent pregnancy. Plan

This document, originally made available during the Bush Administration, refers to Plan B as a contraceptive that “prevent[s] pregnancy,” “acts primarily by stopping the release of an egg from the ovary (ovulation),” and “*may* prevent the union of sperm and egg (fertilization).”²⁷⁸

However, the results of a 2012 study of the mechanisms of action of the three forms of emergency contraception—Plan B (using the hormone levonorgestrel (LNG)), ella (using the hormonal Ulipristal acetate (UPA)), and the copper intrauterine device (CU-IUD)—confirm that: (1) Plan B and ella both work by delaying or inhibiting ovulation and not by inhibiting implantation of a fertilized egg;²⁷⁹ (2) ella’s increased effectiveness results from its additional direct inhibitory effect on follicular rupture, which allows it to be effective even when administered shortly before ovulation,²⁸⁰ a time period when use of Plan B is no longer effective; and (3) any effect of ella on the endometrium, the uterine lining, was dose dependent. The effect of the proper dose of ella used for Emergency Contraceptive purposes was “similar to that of placebo.”²⁸¹ The study did find that the additional increased effectiveness of the copper IUD stems from the additional effect it has on the endometrium.²⁸² Thus, the only one of these emergency contraceptive devices that could potentially prevent the implantation of a fertilized egg is a copper IUD.

Because opponents of contraceptives continue to oppose their use even when it is clear that they work by *preventing* conception, rather than by preventing a fertilized egg from implanting, the campaign against contraceptives is revealed to reflect conflicts reaching far beyond the “abortion question,” and the ethics of protection of “human life.” Rather, the campaign reflects conflicts concerning the propriety of non-procreative sex and particularly the ability of women to express their sexual desire without consequences, without fear of pregnancy.²⁸³

B acts primarily by stopping the release of an egg from the ovary (ovulation). It may prevent the union of sperm and egg (fertilization). If fertilization does occur, Plan B may prevent a fertilized egg from attaching to the womb (implantation). If a fertilized egg is implanted prior to taking Plan B, Plan B will not work.” *Id.*

²⁷⁸ *Id.* (emphasis added).

²⁷⁹ Kristina Gemzell-Danielsson et al., *Emergency Contraception—Mechanisms of Action*, 87 *CONTRACEPTION* 300, 305 (2013).

²⁸⁰ *Id.*

²⁸¹ *Id.* at 304.

²⁸² *Id.*

²⁸³ *Cf.* Siegel, *Reasoning from the Body*, *supra* note 10, at 301–02 (noting that a similar conflict concerning gender roles, motherhood, and women’s sexuality lurks behind opposition to abortion based on a claimed desire to protect potential life).

VI. INCREASED ACCESS TO THE MOST EFFECTIVE CONTRACEPTIVES
LOWERS THE RATE OF TEEN PREGNANCY,
UNINTENDED PREGNANCIES, AND ABORTIONS

Finally, I close with a report from the field, which provides the good news that removing financial barriers and providing full-options counseling about *all* forms of contraception to a group of sexually active women who sought to avoid pregnancy for at least twelve months works to reduce the numbers of abortions, teen pregnancy rates, and high risk births.²⁸⁴ Public health practitioners report²⁸⁵ that the increasing acceptance of IUDs and contraceptive implants, also known as “long acting reversible contraceptives,” or “LARCs,” is “fundamentally changing the landscape of reproductive health.”²⁸⁶ LARC use is endorsed by the premier organizations in the medical field, such as the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, as well as government and international agencies like the Centers for Disease Control and Prevention and the World Health Organization, because of their safety records and extremely low failure rates.²⁸⁷ LARC use is considered appropriate both for young women and teenagers who have not yet given birth and for older women who have already had children.²⁸⁸

²⁸⁴ Gina M. Secura et al., *Provision of No-Cost, Long-Acting Contraception and Teenage Pregnancy*, 371 NEW ENG. J. MED. 1316, 1320 (2014). Contraceptive opponents make another claim that increasing access to the most effective forms of contraception leads to an increase in unintended pregnancy, rather than a decrease, on a population basis because it will increase rates of sexual activity. See, e.g., Keith Riler, Editorial, *Studies: Birth Control, Contraception Don't Cut Abortions*, LIFE NEWS (Feb. 17, 2012), <http://www.lifenews.com/2012/02/17/studies-birth-control-contraception-dont-cut-abortions/> (“Studies have shown that contraception increases sexual activity . . . [a]nd more sex means more pregnancies.”). A full response to this claim is outside the scope of this Article. Here, I simply point out that the opponents have no evidence to support their claims. Indeed, all the evidence is to the contrary; increased access to the most effective contraceptives is having the opposite effect with no evidence of a change in the rates of sexual activity. Secura et al., *supra*, 371 NEW ENG. J. MED. at 1320.

²⁸⁵ The opposition criticizes case studies establishing the success of programs offering the most effective contraceptives at no cost. The opposition repeatedly discounts case studies because they study only one population in one geographic area, and are not generalizable. Here, the opposition is demonstrating one of the “five misunderstandings about case-study research.” See Bent Flyvbjerg, *Five Misunderstandings About Case-Study Research*, 12 QUALITATIVE INQUIRY 219, 221, 224–25 (2006) (refuting the claim that “[o]ne cannot generalize on the basis of an individual case; therefore, the case study cannot contribute to scientific development”). As Flyvbjerg explains, “it is incorrect to conclude that one cannot generalize from a single case. It depends on the case one is speaking of and how it is chosen.” *Id.* at 225. “This applies to the natural sciences as well as to the study of human affairs.” *Id.* Indeed, “[o]ne *can* often generalize on the basis of a single case, and the case study may be central to scientific development via generalization as supplement or alternative to other methods.” *Id.* at 228 (emphasis added).

²⁸⁶ Sue Ricketts et al., *Game Change in Colorado: Widespread Use of Long-Acting Reversible Contraceptives and Rapid Decline in Births Among Young, Low-Income Women*, 46 PERSP. ON SEXUAL & REPROD. HEALTH 125, 125 (2014).

²⁸⁷ *Id.*

²⁸⁸ *Id.*

LARCs have lower failure rates than condoms, diaphragms, and other hormonal contraceptives like the pill, patch, and ring.²⁸⁹ Their low failure rates are influenced by the reduced likelihood, as compared with the pill and condoms, that users will use them incorrectly or fail to use them.²⁹⁰

Despite these advantages, there are substantial barriers to LARC use, such as a lack of awareness among consumers and providers about the availability, safety, and appropriateness of LARC methods, the time required for counseling, and the high initial costs associated with their implantation.²⁹¹ Even Title X clinics—which receive funding to provide a broad range of contraceptives to low-income patients, including LARC methods, the pill, the patch, and barrier methods such as the diaphragm and condoms²⁹²—have “historically struggled to meet the demand” for IUDs and implants due to “their limited budgets and sliding-fee requirements,” and the high upfront costs associated with the implantation of these methods.²⁹³ Because of their advantages and the need to reduce these recognized barriers, a number of pilot projects have been initiated across the country to provide increased funding for and education about LARCs.²⁹⁴ Studies of these projects show that when women receive appropriate counseling regarding both the risks and benefits of contraceptives and the appropriateness of different methods of contraceptives to each individual, the rates of teenage births, unintended pregnancies, and abortions drop dramatically.²⁹⁵

²⁸⁹ *Id.*

²⁹⁰ *Id.*

²⁹¹ See *id.* (citing Stephanie B. Teal & S. Elizabeth Romer, *Awareness of Long-Acting Reversible Contraception Among Teens and Young Adults*, 52 J. ADOLESCENT HEALTH S35, S36–S37 (2013) (describing the lack of awareness among teens and young adults of the benefits and safety of long-acting reversible contraception)); see also Nancy A. Dodson et al., *Teen Pregnancy Prevention on a LARC: An Update on Long-Acting Reversible Contraception for the Primary Care Provider*, 24 CURRENT OPINION IN PEDIATRICS, 439, 442 (2012) (“A study involving telephone surveys and focus groups of women aged 18–30 years found low levels of awareness of LARC methods.”); M.L. Kavanaugh et al., *Long-Acting Reversible Contraception for Adolescents and Young Adults: Patient and Provider Perspectives*, 26 J. PEDIATRIC & ADOLESCENT GYNECOLOGY 86, 91–92 (2013) (describing cost barriers to initial implantation of LARCs); Secura et al., *supra* note 284, at 1316, 1317 (2014) (“Lack of information about effective contraception, limited access, and cost remain barriers to use of LARC methods by teens.”).

²⁹² Ricketts et al., *supra* note 286, at 126.

²⁹³ *Id.*

²⁹⁴ *Id.*; see Secura et al., *supra* note 284, at 1317–18 (describing the Contraceptive CHOICE Project’s program whereby it provided LARCs to adolescents).

²⁹⁵ *E.g.*, Ricketts et al., *supra* note 286, at 129 (“The two-year decline in the proportion of births that were high-risk was 24% (a statistically significant decrease), and the decline in the number of such births was 27%.”); Secura et al., *supra* note 284, at 1320 (“We found that pregnancy, birth, and abortion rates were low among teenage girls and women enrolled in a project that removed financial and access barriers to contraception and informed them about the particular efficacy of LARC methods. The observed rates of pregnancy, birth, and abortion were substantially lower than national rates among all U.S. teens, particularly when compared with sexually experienced U.S. teens.”).

For example, the Contraceptive CHOICE Project, a prospective cohort study focused on 9,256 girls and women who ranged from fourteen to forty-five years old and who lived in the Saint Louis area concluded that the rates of pregnancy, birth, and abortion were “substantially lower than the national rates” among all U.S. teens, “particularly when compared with sexually experienced U.S. teens.”²⁹⁶ Abortion rates from the CHOICE cohort were less than half the regional and national rates; the rate of teenage birth within the CHOICE cohort was 6.3 per 1,000,²⁹⁷ compared to the U.S. rate of 34.4 per 1,000.²⁹⁸ The rates were lower than the national rates among different age groups and among both white and black teens.²⁹⁹ Women and adolescents were eligible for enrollment in the study if they had no desire to become pregnant for at least twelve months, were sexually active or planning to be sexually active with a male partner, and were either not using a contraceptive method or were willing to switch to a new, reversible method.³⁰⁰ All women provided written informed consent.³⁰¹ Enrollees received standardized counseling regarding commonly used reversible methods, which were presented “in order from most to least effective, and the potential side effects, risks, and benefits of each method were reviewed.”³⁰²

A similar program in Colorado, the Colorado Family Planning Initiative, was so successful that it has been described as “game-chang[ing].”³⁰³ In 2009, the Initiative received private funding to initiate a program at twenty-eight family planning clinics in counties that contained 95% of the state’s total population.³⁰⁴ The Initiative was designed to address barriers to LARC use by training providers and providing funding for LARC methods.³⁰⁵ Although all clients at or below 100% of the federal poverty level paid nothing³⁰⁶ regardless of their chosen method, the LARC methods and the contraceptive ring were offered to *all* clients at no cost, while all other methods were offered on a sliding-fee scale.³⁰⁷ The study reported that between 2009 and 2011, LARC method use among women between fifteen and twenty-four years old had grown from below 5% to

²⁹⁶ Secura et al., *supra* note 284, at 1317, 1320.

²⁹⁷ Ricketts et al., *supra* note 286, at 129 tbl.4.

²⁹⁸ Secura et al., *supra* note 284, at 1320 tbl.2.

²⁹⁹ *Id.* at 1320.

³⁰⁰ *Id.* at 1317.

³⁰¹ *Id.*

³⁰² *Id.* The use of standardized counseling and obtaining proper informed consent is of vital importance to insure that no women are pressured into using contraception or a specific method of contraception.

³⁰³ Ricketts et al., *supra* note 286, at 131.

³⁰⁴ *Id.* at 126.

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ *Id.*

19%.³⁰⁸

The study showed a significant positive impact on birth rates, abortion rates, and high-risk births among teens and young women in the Initiative counties as compared to women in the same age cohorts in the non-Initiative counties.³⁰⁹ First, the birth rate among all fifteen to nineteen-year-olds in Colorado declined 26% in just two years, between 2009 and 2011 (from thirty-seven to twenty-eight births per one thousand).³¹⁰ During the same period, the birth rate declined 12% among Colorado women aged twenty to twenty-four (from eighty-nine to seventy-eight per one thousand).³¹¹ Though not all of this decrease was due to LARC use, study authors estimated that approximately 75% of the decline of the birth rates among these age groups could be attributed to the decline in births among low-income women in the CFPI counties.³¹² Study authors were also able to rule out alternative explanations for the drop in fertility rates, such as the potential that the rate of sexual activity decreased.³¹³ The Colorado Youth Risk Behavior Survey and the state Behavioral Risk Factor Surveillance System data showed “no significant change . . . in sexual activity among high school students,” or among women aged eighteen to twenty-four during the study time period.³¹⁴

While the rate of abortions for twenty to twenty-four-year-old women in the non-CFPI counties remained “essentially stable,”³¹⁵ with a slight *increase* between 2008 and 2011 (from twenty-six to twenty-eight per one thousand),³¹⁶ the decline in the rate of abortions for twenty to twenty-four-year-olds in the CFPI group was a stunning 18%.³¹⁷ There was also an extraordinary decline in the rate of abortions for fifteen to nineteen-year-olds, which occurred both amongst those in the CFPI group and amongst those in the non-CFPI group.³¹⁸ The success of the family planning initiative in this instance is reflected in the higher rate of decline for those in the CFPI group (34%) than for those in the non-CFPI group (still a

³⁰⁸ *Id.* at 128.

³⁰⁹ *See id.* at 128–29 (discussing the statistically significant changes which occurred in birth rates, high-risk birth rates, and abortion rates).

³¹⁰ *Id.* at 129.

³¹¹ *Id.*

³¹² *See id.* (“An estimated 77% and 74% of the decline among these age-groups, respectively, can be attributed to the decline in births among low-income women in the CFPI counties.”).

³¹³ *Id.* at 131.

³¹⁴ *Id.*; *see id.* at 130 (“Nationally, widespread use of the pill and other hormonal methods has contributed to steady declines in fertility rates among young women in recent decades, but our finding of a rapid increase in LARC use—followed by a marked drop in fertility that was especially large among teenagers—constitutes a new phenomenon.” (footnote omitted)).

³¹⁵ *Id.* at 129.

³¹⁶ *Id.*

³¹⁷ *Id.*

³¹⁸ *Id.*

significant 29%).³¹⁹ Finally, the number of high-risk births in CFPI counties decreased in two years from a total of 4,052 in 2009 to 2,940 in 2011, representing a drop of 27%.³²⁰ In the non-CFPI counties, the number of high-risk births declined from 272 to 233 between 2009 and 2011, a decrease of only 14.3%.³²¹

Another study evaluated the impact of California's Family Planning, Access, Care and Treatment (Family PACT) Program.³²² Family PACT was initially implemented by the California Legislature in 1997 and "received federal financial participation through a Medicaid Family Planning expansion waiver program in 2000."³²³ "In March 2011, California received approval from the Federal Centers for Medicare and Medicaid Service to make Family PACT a State Plan" as allowed by the Affordable Care Act, enacted in March 2010.³²⁴

Family PACT, the nation's largest Medicaid family planning expansion program, served more than 1.7 million clients in fiscal year 2008–09, and reached more women and men than all the other Medicaid "waiver programs" combined.³²⁵ "Family PACT provides reproductive health and family planning services, including all U.S. Food and Drug Administration-approved contraceptive methods, to eligible uninsured clients who are at or below 200% of the federal poverty level."³²⁶ Study authors estimated that 286,700 unintended pregnancies were averted by Family PACT services; 207,500 were avoided by adults (aged twenty to forty-four years old) and almost 79,200 were avoided by adolescents (aged fifteen to nineteen years old).³²⁷ "[T]he unintended pregnancies that were prevented would have resulted in almost 120,000 abortions."³²⁸ These estimates were arrived at by adopting "conservative assumptions about contraceptive use within the program and failure rates to avoid overestimating the fertility effect of the program."³²⁹

Finally, a recent related study found declines in abortion following

³¹⁹ *Id.*

³²⁰ *Id.*

³²¹ *Id.*

³²² See generally Diana G. Foster et al., *Estimating the Fertility Effect of Expansions of Publicly Funded Family Planning Services in California*, 21 *WOMEN'S HEALTH ISSUES* 418, 418–24 (2011) (reporting the methodology and results of a study that observed the number of prevented unintended pregnancies accomplished by California's Family PACT program and, therefore, the program's impact).

³²³ *Id.* at 418.

³²⁴ *Id.*

³²⁵ *Id.*

³²⁶ *Id.*

³²⁷ *Id.* at 422 tbl.5.

³²⁸ *Id.* at 423.

³²⁹ *Id.*

increases in LARC use in Iowa.³³⁰ By assessing changes in LARC use and subsequent abortion while controlling for initial LARC use, the study was “able to remove region-level confounding, isolate the effect of LARC use on abortion and establish a clear temporal relationship between LARC and abortion.”³³¹ Despite an increase in access to abortions in Iowa, the number of resident abortions decreased from 5,198 to 3,887 (8.7 per 1000 women aged 15 to 44 years old to 6.7 per 1,000 women in the same age group).³³² Controlling for percentages of women living below the poverty line, population density, and the increased availability of abortions, the authors found a “significant longitudinal association between increases in LARC use and the subsequent declines in abortion across Iowa regions.”³³³ The study’s authors state that their estimates suggest that a small increase of “1 LARC user per 100 women in a given region was associated with a 4% reduction in the odds of abortion for women living in that region.”³³⁴

VII. CONCLUSION

Underlying the opposition to contraception today, opposition framed in woman-protective terms, lies an aversion to sex for pleasure, sex undertaken for reasons other than procreation. This opposition to non-procreative sex is remarkably regressive, extends to sex for pleasure within marriage, and unites the opposition against reproductive rights and same-sex marriage. To counteract the forces opposing broad contraceptive access, we must examine the reasoning behind the opposition, look with skepticism at reasons that appeal to science and abortion bias, and demand that our decision-making bodies do the same.

³³⁰ M.A. Biggs et al., *Did Increasing Use of Highly Effective Contraception Contribute to Declining Abortions in Iowa?*, 91 *CONTRACEPTION* 167, 170 (2015).

³³¹ *Id.* at 172.

³³² *Id.* at 170 tbl.1.

³³³ *Id.*

³³⁴ *Id.* at 169–70.

