

***Griswold v. Connecticut* — The Impact of Legal Birth Control and the Challenges that Remain**

On June 7, 1965, the U.S. Supreme Court, in *Griswold v. Connecticut* (381 U.S. 479 (1965)), struck down a Connecticut law that had made the use of birth control by married couples illegal. The court's landmark decision — coming five years after oral contraceptives became available to American women and 49 years after Margaret Sanger opened the first birth control clinic in the U.S. — provided the first constitutional protection for birth control and paved the way for the nearly unanimous acceptance of contraception that now exists in this country.

The court's recognition of individuals' right to privacy in deciding when and whether to have a child in *Griswold* became the basis for later reproductive rights decisions. In *Eisenstadt v. Baird* (405 U.S. 438 (1972)), the court extended the constitutional protection to unmarried couples; in *Roe v. Wade* (410 U.S. 113 (1973)), the court recognized a woman's right to choose abortion; in *Carey v. Population Services International* (431 U.S. 678 (1977)), the court legalized not only the sale of nonprescription contraceptives by persons other than licensed pharmacists, but also the sale or distribution of contraceptives to minors under sixteen and the advertisement of contraception; and in *Planned Parenthood of Southeastern Pennsylvania v. Casey* (505 U.S. 833 (1992)), the court reaffirmed a woman's right to choose. *Griswold* was also cited in the argument for the right to privacy in the court's 2003 decision in *Lawrence v. Texas* (539 U.S. 558 (2003)), which overturned Texas sodomy laws.

While challenges remain in the struggle to provide universal access to birth control, the court's 1965

decision in *Griswold* granted constitutional protection to the life-enhancing work of Planned Parenthood staff and volunteers and other advocates of reproductive freedom in the U.S.

In the 47 years since birth control for married couples was first protected in the U.S., profound and beneficial social changes occurred, in large part because of women's relatively new freedom to control their fertility. Maternal and infant health have improved dramatically, the infant death rate has plummeted, and women have been able to fulfill increasingly diverse educational, social, political, and professional aspirations.

The ability to plan and space pregnancies has contributed to improved maternal, infant, and family health.

- In 1965, there were 31.6 maternal deaths per 100,000 live births (NCHS, 1967). In 2007, the rate had been reduced by 60 percent, to 12.7 maternal deaths per 100,000 live births (Xu et al, 2010).
- In 1965, 24.7 infants under one year of age died per 1,000 live births (NCHS, 1967). In 2009, this figure had declined to 6.42 infant deaths per 1,000 live births (Kochanek et al., 2011).

Since 1965, there has been a dramatic decline in unwanted births, the result of pregnancies that women wanted neither at the time they were conceived nor at any future time. This decline is particularly welcome because unwanted births are

associated with delayed access to prenatal care and increased child abuse and neglect (Committee on Unintended Pregnancy, 1995; Piccinino, 1994).

- In 1961–1965, 20 percent of births to married women in the U.S. were unwanted. (Mosher, 1988). By 2002, only nine percent of births to married women in the United States were unwanted (Chandra et al., 2005).

Mistimed births — those that happened sooner than the mother wanted them — have also declined markedly.

- In 1961–1965, 45 percent of births to married American women were mistimed (Mosher, 1988); in 2002, only 14.1 percent of births to married women in the U.S. were mistimed (Chandra et al., 2005).

By enabling women to control their fertility, access to contraception broadens their ability to make other choices about their lives, including those related to education and employment.

Since 1965, the number of women in the U.S. labor force more than doubled, and women's income now constitutes a growing proportion of family income.

- In 1965, 26.2 million women participated in the U.S. labor force; by 2008, the number had risen to 71.6 million (U.S. Bureau of Labor Statistics, 2012).
- The labor force participation rate of married women nearly doubled between 1960 and 2008 — from 31.9 to 61 percent (U.S. Census Bureau, 2000; U.S. Census Bureau, 2011a).
- By 2010, 29.2 percent of women in dual-income families earned more than their husbands (U.S. Census Bureau, 2011b).
- Between 1960 and 2010 the percentage of women who had completed four or more years of college increased fivefold — from 5.8 percent to 29.6 percent (Snyder and Dillow, 2011).
- In 1960, only 10 percent of all doctorate degrees were awarded to women. By 2009, 52 percent were won by women (Snyder and Dillow, 2011).

Publicly funded contraception programs have increased the ability of lower-income women to exercise the right to control their fertility.

Family planning services available through Medicaid and Title X of the U.S. Public Health Service Act help women prevent 1.94 million unintended pregnancies each year. Without these family planning services, the numbers of unintended pregnancies and abortions would be nearly two-thirds higher than they are now (Gold, et al., 2009).

The reduction in unwanted births since 1965 is largely a result of Americans' shift to the more effective contraceptive methods that have become available.

- Among married women using contraception, the percentage relying on the most effective methods — the pill, the IUD, tubal sterilization, and vasectomy — grew from 38 percent in 1965 to an estimated 58 percent in 2009 (Mosher, 1988; Mosher et al., 2010).
- More than one-third of all women at risk of unintended pregnancy rely on voluntary sterilization — 27.1 percent have had a tubal sterilization and 9.8 percent are protected by their partner's vasectomy (Guttmacher Institute, 2010a).
- Oral contraception is the most commonly used reversible method — the choice of 28 percent of women at risk of unintended pregnancy — followed by the condom, used by 16.1 percent of women at risk of unintended pregnancy (Guttmacher Institute, 2010a).

Investing in family planning is cost-effective. A study that measured the cost of contraceptive methods compared to the cost of unintended pregnancies when no contraception was used found that the total savings to the health care system falls between \$9,000 and \$14,000 per woman over five years of contraceptive use (Trussell et al., 1995).

The Challenges

In the last 47 years it has become clear that making good reproductive decisions does not rest on the legalization of birth control alone — in order to make responsible choices for themselves, women and men need access to sexual and reproductive health information and services.

Despite the overall reduction in unwanted pregnancy during the last decades, American women still experience some three million unintended pregnancies each year — 49 percent of all pregnancies (Finer & Zolna, 2011).

Forty-three percent of unintended pregnancies that do not end in miscarriage or stillbirth are terminated by induced abortion (Finer & Zolna, 2011).

Unintended pregnancy is associated with a number of serious public health consequences, including delayed access to prenatal care, increased likelihood of alcohol and tobacco use during pregnancy, low birth weight, and child abuse and neglect (Committee on Unintended Pregnancy, 1995).

Cost is a major barrier against access to contraception. Even though birth control is basic to women's health care, not all insurance plans cover the full range of contraceptive choices, and while funding for contraception for poor women is provided through Title X and Medicaid, funding has not kept up with demand.

- Public funding for family planning has been inconsistent over the years and has decreased in many states. Although federal funding for family planning rose 18 percent between 1980 and 2006, when inflation is taken into account, funding decreased or stagnated in 18 states and the District of Columbia between 1994 and 2006 (Sonfield, et al., 2008).
- Steps to remove economic barriers impeding access to contraception are succeeding, however, at both the state and federal levels. As of January 2012, 28 states now have contraceptive equity laws requiring health plans to provide coverage for all FDA-approved contraceptives (Guttmacher Institute, 2012a). In 1998, a contraceptive coverage requirement was added to the Federal Employees Health Benefits Plan (PL 106-58). This coverage remains in effect today (NCSL, 2010). On August 1, 2011, the U.S. Department of Health and Human Services (HHS) announced that the full range of FDA-approved contraceptive methods will be included as one of eight women's preventive health service that will be available without co-pays or cost sharing as part of the Affordable Care Act. The HHS announcement followed a strong recommendation from the Institute of Medicine (IOM), an independent, nonpartisan medical body (HHS, 2011).

Improved contraceptive use has contributed to lowered U.S. teenage pregnancy rate, though it remains the highest in the developed world.

Although the rate of teenage pregnancy in the United States has been declining, in 2006 it increased for the first time in a decade, and it remains the highest in the developed world. Each year, nearly 750,000 American teenagers become pregnant (Guttmacher Institute, 2010b). The majority of these pregnancies — 82 percent — are unintended (Finer & Zolna, 2011).

- Between 1990 and 2005, the national teen pregnancy rate fell 41 percent, from 116.9 to a record low of 69.5 pregnancies per 1,000 women aged 15–19. In 2006, it rose for the first time in more than a decade to 71.5 pregnancies per 1,000 women aged 15–19 — an increase of three percent (Guttmacher Institute, 2010b). Eighty-six percent of the decline through 2005 resulted from improved contraceptive use among sexually active teenagers, and another 14 percent was attributable to increased abstinence (Santelli et al., 2007). An earlier study pointed out that another cause for the reduction of teen pregnancy is that adolescents are increasingly substituting other kinds of sex play for vaginal intercourse (Weiss & Bullough, 2004).

Studies have confirmed that the results of teenage parenting are often discouraging for both mother and child.

- Pregnant teenagers are more likely than women who delay childbearing to experience maternal illness, miscarriage, stillbirth, and neonatal death (Luker, 1996).
- Teen mothers are less likely to graduate from high school and more likely than their peers who delay childbearing to live in poverty and to rely on welfare (Hoffman, 2006).
- The children of teenage mothers are often born at low birth weight, experience health and developmental problems, and are frequently poor, abused, and/or neglected (Hoffman & Maynard, 2008; Martin et al., 2009; National Campaign to Prevent Teen and Unplanned Pregnancy, n.d.).

Teenage pregnancy poses a substantial financial burden to society, estimated at \$10.9 billion annually in lost tax revenues, public assistance, child health care, foster care, and involvement with the criminal justice system (NCPTUP, 2011).

Access to birth control is still problematic.

Increasingly, women and men no longer need to abstain from sex for fear of having more children than they can afford or in terror of endangering a woman's health with a high-risk pregnancy. In 1965, 35 percent of married women in the U.S. used a safe and effective method of family planning. Only one out of 10 women in the developing world did so. Today 55 percent of couples worldwide rely on modern methods of birth control to maintain the health and well-being of their families (PRB, 2011; Ryder & Westoff, 1971).

But access is not universal. Worldwide, 215 million women who want to use modern contraceptive methods cannot access them (Singh et al., 2009). And although nine out of 10 employer-based insurance plans in the U.S. covered the cost of contraception by 2004 (Sonfield et al., 2004), there were 17.4 million U.S. women in 2008 who were still in need of publicly funded family planning services. That number included an increase of six percent or one million women since 2000 (Gutmacher, 2010c).

Inability to pay is not the only block to access for women seeking modern methods of contraception. Forty-six states now have refusal statutes written into their state legislation. The majority refer only to abortion. However, 13 of these states have statutes that pertain to both abortion and contraception. Ten of the 13 explicitly allow health care providers to refuse to provide birth control, contraception, and/or family planning services. There are six states with existing laws or regulations which explicitly permit pharmacists to refuse to dispense contraception — five additional states have broadly written refusal clauses that may also pertain to pharmacists (Guttmacher Institute, 2012b).

Planned Parenthood believes that all well-woman exam visits and all FDA-approved prescription contraception methods, including emergency contraception when prescribed, should be covered under private health insurance plans as preventive care with no cost sharing. The HHS decision to include contraception as a women's preventive health service available without co-pays or cost sharing as part of the Affordable Care Act is a historic victory for women's health. The bottom line is that no woman should go without preventive care, including contraception, because she does not have the means to pay

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