

REPRODUCTIVE JUSTICE BRIEFING BOOK

A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE

FORWARD
REPRODUCTIVE
FOR JUSTICE
ALL

**REPRODUCTIVE JUSTICE BRIEFING BOOK
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WHAT IS REPRODUCTIVE JUSTICE?

By Loretta Ross, SisterSong Women of Color Reproductive Health Collective

Reproductive Justice is the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights. This definition as outlined by Asian Communities for Reproductive Justice (ACRJ) offers a new perspective on reproductive issues advocacy, pointing out that for Indigenous women and women of color it is important to fight equally for (1) the right to have a child; (2) the right not to have a child; and (3) the right to parent the children we have, as well as to control our birthing options, such as midwifery. We also fight for the necessary enabling conditions to realize these rights. This is in contrast to the singular focus on abortion by the pro-choice movement that excludes other social justice movements.

The Reproductive Justice framework analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access. Reproductive Justice addresses the social reality of inequality, specifically, the inequality of opportunities that we have to control our reproductive destiny. Moving beyond a demand for privacy and respect for individual decision making to include the social supports necessary for our individual decisions to be optimally realized, this framework also includes obligations from our government for protecting women's human rights. Our options for making choices have to be safe, affordable and accessible, three minimal cornerstones of government support for all individual life decisions.

One of the key problems addressed by Reproductive Justice is the isolation of abortion from other social justice issues that concern communities of color: issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns. These issues directly affect an individual woman's decision-making process. By shifting the focus to reproductive oppression—the control and exploitation of women, girls, and individuals through our bodies, sexuality, labor, and reproduction—rather than a narrow focus on protecting the legal right to abortion, SisterSong Women of Color Reproductive Health Collective is developing a more inclusive vision of how to build a new movement.

Because reproductive oppression affects women's lives in multiple ways, a multi-pronged approach is needed to fight this exploitation and advance the well-being of women and girls. There are three main frameworks for fighting reproductive oppression defined by ACRJ:

- Reproductive Health, which deals with service delivery
- Reproductive Rights, which addresses legal issues, and
- Reproductive Justice, which focuses on movement building

Although these frameworks are distinct in their approaches, they work together to provide a comprehensive solution. Ultimately, as in any movement, all three components—service, advocacy and organizing—are crucial.

The Reproductive Justice analysis offers a framework for empowering women and girls relevant to every family. Instead of focusing on the means—a divisive debate on abortion and birth control that neglects the real-life experiences of women and girls—the Reproductive Justice analysis focuses on the ends: better lives for women, healthier families, and sustainable communities. This is a clear and consistent message for all social justice movements. Using this analysis, we can integrate multiple issues and bring together constituencies that are multi-racial, multi-generational, and multi-class in order to build a more powerful and relevant grassroots movement.

Reproductive Justice focuses on organizing women, girls and their communities to challenge structural power inequalities in a comprehensive and transformative process of empowerment that is based on SisterSong's self-help practices that link the personal to the political.

Reproductive Justice can be used as a theory for thinking about how to connect the dots in our lives. It is also a strategy for bringing together social justice movements. But also, it is a practice – a way of analyzing our lives through the art of telling our stories to realize our visions and bring fresh passion to our work.

The key strategies for achieving this vision include supporting the leadership and power of the most excluded groups of women, girls and individuals within a culturally relevant context. This will require holding ourselves and our allies accountable to the integrity of this vision. We have to address directly the inequitable distribution of power and resources within the movement, holding our allies and ourselves responsible for constructing principled, collaborative relationships that end the exploitation and competition within our movement. We also have to build the social, political and economic power of low-income women, Indigenous women, women of color, and their communities so that they are full participating partners in building this new movement. This requires integrating grassroots issues and constituencies that are multi-racial, multi-generational and multi-class into the national policy arena, as well as into the organizations that represent the movement.

SisterSong is building a network of allied social justice and human rights organizations that integrate the reproductive justice analysis into their work. We are using strategies of self-help and empowerment so that women who receive our services understand they are vital emerging leaders in determining the scope and direction of the Reproductive Justice and social justice movements.

RESOURCES

In order to find out more about Reproductive Justice, please visit the following websites:

www.sistersong.net

www.reproductivejustice.org

LISTEN UP!: HOW TO CONNECT WITH YOUNG WOMEN THROUGH REPRODUCTIVE JUSTICE

By Mary Mahoney, Pro-Choice Public Education Project

Now, I don't want to say this too loudly to a movement that already has so much on its plate, but the reproductive health and rights of young women must become a greater priority for a movement whose viability depends on the activism of youth to survive.

We have recently experienced some landmark developments in our field, such as the FDA approval of the human papilloma virus (HPV) vaccine Gardasil and prescription-free Emergency Contraception for people over 18. But until we can assure reproductive autonomy for all young people, we have little time to pat ourselves on the back.

Historically, adults, even progressive women in the reproductive rights movement, have acted as if they know best what young women need – and have typically only listened to young women with one ear. So what can we do as a movement to support young women in the fight against reproductive oppression and in the struggle for reproductive justice?

There are many ways to create and support spaces for young women's voices within this movement and to connect with them by focusing on *their* needs rather than our own agendas.

First, young people are growing up in a culture that exploits teen sexuality and at the same time denies it outright. No matter how resilient young people may be, they can't help being affected by images from *Girls Gone Wild* commercials and *Laguna Beach*. The media also harm youth by ignoring their public health needs: in the top 200 films of the past 20 years, condom use was only suggested once! Is unsafe sex *still* considered sexy? With so many innovative and entertaining advancements in technology and medicine, like musical condoms and chewable birth control, you would think Hollywood could do a better job of creating a safe, realistic space for youth to contemplate sexual activity.

Government policies directly harm young people. Between 1996 and 2005, Congress committed over \$1.1 billion through both federal and state matching funds to "abstinence-only" programs. Virtually no money went to comprehensive sex education. Today the only sex education for more than a third of all students is "abstinence only," even though this curriculum teaches falsehoods about condom effectiveness rates and other matters. LGBTQ youth are completely disregarded as sexual beings under this curriculum. Young women are being asked to take total responsibility for their bodies without access to education that would teach them how to make safe choices.

"Abstinence-only" programs respond to young people's reproductive and sexual health as a moral issue, not a public health issue. This, even while the number of new cases of STDs among 15-24 year olds is 9.1 million or roughly fifty percent of all new cases in the U.S, including 15,000 HIV/AIDS and 4.6 million HPV cases. Government and market-driven policies that block young people from healthy sexual choices also include parental notification laws for abortion access and regulations governing emergency contraception (EC) which mandate prescriptions for girls younger than 18, even though this makes it difficult for young women to obtain EC within the 72-hour window, and even though this restriction assumes that all young women have health insurance or money to visit their doctor and also assumes that they have doctors they trust.

Today young people want to address reproductive issues in their own, contemporary terms, focusing on prevention and families and healthy futures. We who advocate for and promote the activism of young women in the reproductive rights and health movement can support this activism with a reproductive justice framework. This framework looks at the whole woman and her entire set of life circumstances, from age to class to race to religion to sexual orientation, recognizing that these interconnected issues affect how she – and others – control her reproductive health and rights. In other words, it is important that we do not isolate abortion

from the totality of women's health and lives and do not alienate potential activists by focusing only on this one issue.

Young women completely understand this holistic approach to reproductive health and rights. They, along with women of color led groups, are transforming the movement to include access to health care, LGBTQ liberation, racial and economic justice, comprehensive sex education, maternal dignity and HIV/AIDS work. Young women are mobilizing their peers and constituencies by creating messages that connect with young people and working across movements to build the progressive and social justice movements from the ground up. Because what we choose to do today not only affects the lives of youths at present, but also their future health and ability to make smart choices for themselves throughout their lives, becoming involved in this area of the movement is an important step for any activist or organization. To support young women in this movement, we must follow their lead and meet them where they are on their road to reproductive autonomy.

RESOURCES

For more information on young women and reproductive justice issues:

- Pro-Choice Public Education Project – www.protectchoice.org
- Choice USA – www.choiceusa.org
- Advocates for Youth – www.advocatesforyouth.org
- Asian Communities for Reproductive Justice – www.reproductivejustice.org

ABSTINENCE-ONLY AND REPRODUCTIVE INJUSTICE

Based on the presentation "Abstinence and U.S. Abstinence-Only Education Policies: Ethical and Human Rights Concerns" by John S Santelli, MD, MPH, Rebecca Schleifer, JD, MPH and Lila J Lande, MPH

Abstinence promotion raises important ethical and human rights concerns when abstinence is presented to adolescents as the sole choice while health information on other choices is restricted or misrepresented. Access to complete and accurate HIV/AIDS and sexual health information has been recognized as a basic human right and essential to realizing the human right to the highest attainable standard of health. Abstinence-only restrictions put health educators and other health professionals in an ethical quandary, forcing them to choose to withhold potentially life-saving information or to breach federal government guidelines by disclosing such information.

The emphasis on "abstinence-only" educational programs in the U.S. causes systematic harm to domestic public health programs and may harm international HIV- prevention programs. Human rights groups criticized U.S. government policy as a source for misinformation and censorship in some countries receiving The President's Emergency Plan for AIDS Relief (Human Rights Watch, 2004). The Government Accountability Office, which is the investigative arm of U.S. Congress, issued a critique of U.S. foreign policy support for "abstinence-only" education in April 2006.

Governments have an obligation to provide accurate information to their citizens and avoid the provision of misinformation. Such obligations extend to government-funded health education and health care services. Access to accurate health information as a basic human right was explained in the 1994 International Conference on Population and Development Programme of Action. These principles include universal access to health care services and specifically highlight reproductive health stating that "All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so" (United Nations, 1994). The U.N. Committee on the Rights of the Child emphasized in 2003, "that effective HIV/AIDS prevention requires States to refrain from censoring, withholding, or intentionally misrepresenting health-related information, including sexual education and information ... State parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality" (Committee on the Rights of the Child, 2003).

As defined by the U.S. government's funding requirements, "abstinence-only" programs must withhold information on contraception and other aspects of human sexuality. These programs also promote scientifically questionable positions. It is unethical to provide misinformation or withhold information from adolescents about sexual health, including ways for sexually active teens to protect themselves from sexually transmitted infections and pregnancy. These current U.S. policies are ethically problematic, as they exclude accurate information about contraception, misinform by overemphasizing or misstating the risks of contraception, and fail to require the use of scientifically accurate information.

While health care ethics is founded on the notion of informed consent and free choice, U.S. federal "abstinence-only" programs are inherently coercive, withholding information needed to make informed choices and promoting questionable and inaccurate opinions. "Abstinence-only" programs are inconsistent with internationally accepted notions of human rights. "Abstinence-only" as a basis for health policy and programs should be abandoned.

RESOURCES

- Advocates for Youth - www.advocatesforyouth.org/sexeducation.htm
- American Civil Liberties Union:
 - Take Issue Take Charge Campaign - www.takeissuecharge.org

- Reproductive Freedom Project - www.aclu.org/reproductiverights/sexed/12670res20041201.html
- Human Rights Watch – www.hrw.org
- Legal Momentum – www.legalmomentum.org
- Sexuality Information and Education Council of the United States - www.siecus.org
- Society for Adolescent Medicine - www.adolescenthealth.org

ABSTINENCE-ONLY-UNTIL-MARRIAGE PROGRAMS CENSOR VITAL HEALTH CARE INFORMATION, JEOPARDIZING TEENS' HEALTH

by Lorraine Kenny, American Civil Liberties Union

Since 1996, Congress has allocated more than a billion dollars for programs that focus exclusively on abstinence-until-marriage and censor other information that can help young people make responsible, healthy, and safe decisions about sexual activity. There is no conclusive evidence that these programs reduce the rate of unintended pregnancy or sexually transmitted diseases (STDs). And to make matters worse, there *is* evidence that they deter sexually active teens from using condoms and other contraceptives.

To receive federal funds, abstinence-only-until-marriage programs must offer curricula that have as their "exclusive purpose" teaching the benefits of abstinence. In addition, recipients of federal abstinence-only dollars may not advocate contraceptive use or teach contraceptive methods except to emphasize their failure rates. Thus, grantees are forced either to omit any mention of topics such as contraception, abortion, homosexuality, and AIDS or to present these subjects in an incomplete and inaccurate manner.

Pushing misinformation about sex flies in the face of reality and fails to address young people's health needs. Engaging in sex before marriage is the cultural norm and has been for decades. Nearly two-thirds of all high school seniors have had sex, and considering the high rate of teen pregnancy and STD transmission in the United States, the need for accurate information couldn't be greater.

Abstinence-only-until-marriage programs don't stop at disseminating harmful misinformation about sex. They are also often rife with gender stereotypes and can have harmful effects on lesbian and gay teens. Many curricula dangerously stigmatize homosexuality. In a society that generally prohibits gays and lesbians from marrying, singling out marriage as the sole relationship in which sex is appropriate rejects the idea of same-sex sexual intimacy. Furthermore, many of the leading curricula address same-sex behavior only within the context of promiscuity and disease. All of this adds up to create a hostile environment for lesbian and gay students as well as for teens growing up with lesbian, gay, and/or single parents.

Ultimately, parents, teachers, and major medical groups, including the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetrics and Gynecology, support comprehensive sexuality education that stresses both abstinence and also provides students with complete and accurate information about how to protect themselves from unintended pregnancy and STDs. There is ample evidence that programs that include complete and accurate information about sex reduce sexual risk-taking and pregnancy among teens.

RESOURCES

- Take Issue, Take Charge campaign - <http://www.takeissuetakecharge.org>
- SIECUS State Profiles - <http://www.siecus.org/policy/states/index.html>
- Guttmacher Institute - Facts on Sex Education in the United States - http://www.guttmacher.org/pubs/fb_sexEd2006.html

YOUTH AND ADULTS CHANGING SEX EDUCATION

By Yessenia Cervantes, Illinois Caucus for Adolescent Health Youth Leader

Three years ago, students from a Chicago high school joined forces with the Illinois Caucus for Adolescent Health (ICAH) in order to press the Chicago Public Schools (CPS) to provide comprehensive sex education. Unfortunately, Chicago Public Schools had inconsistent standards regarding sex education, including a very ambiguous definition of what information teachers could provide.

A group of students at Curie High School, along with their history teacher, Michael Smith, created an activist leadership class called Forefront—which in life's mysterious ways, ended up partnering with ICAH. Later these students and ICAH reached out to other schools and organizations to join in the struggle to implement a realistic, reliable and responsible sexual education curriculum. Students themselves were clear about the need for such a curriculum. They reported that a majority of their health instructors presented either abstinence-only programs or no sexual education at all! Plus, there was inadequate funding for comprehensive curricula and no real training available for teachers who would be responsible of these classes.

The first step at Curie High School was to meet directly with the principal and physical education teachers, the ones responsible for teaching sexual education to the freshman class, the only grade where these topics were discussed at all. Unfortunately, the teachers did not welcome the concerns that the students voiced. Nevertheless, Forefront, with advice, training and guidance from ICAH, continued with a series of meetings with the local school council and principal. After a year, Curie's local school council provided a bit of money that the students used to purchase materials so that they could take on the role of sexual educators themselves, and so that they could continue to pursue this issue outside of their school. The principal also implemented a comprehensive sex education curriculum in a particular class.

In the second year of "the struggle," ICAH convened other youth working across the city to advocate for similar changes in their schools. The coalition took its concerns to the streets, organizing two rallies downtown at the CPS headquarters. One was held in a summer downpour and the other during a winter freeze.

Finally, the students got a seat at the table with top officials within CPS to shape a new policy. The coalition mobilized other organizations, parents, teachers, doctors, legislators, and even clergy to show up at the school board meeting in support of a comprehensive curriculum. On a beautiful spring day in April of 2006, the Chicago Board of Education unanimously passed the Family Life and Comprehensive Sexual Health Education policy mandating the teaching of comprehensive sex education in grades 6-12 and training for all teachers providing this education, and seating a student representative on the panel that approves all curricula used in CPS.

There is still much work to be done to implement this policy, to pass policies in other communities throughout the state, and to redirect our federal and state tax dollars to programs that really serve the needs of Illinois youth. However, we know that with a collaborative effort between youth and adults and with commitment to see our efforts through to real change, we can make sexual education a reality in this state and in our country.

RESOURCES

- Illinois Caucus for Adolescent Health - www.icaah.org
- Illinois Campaign for Responsible Sex Education - www.responsiblesexed.org
- Advocates for Youth - www.advocatesforyouth.org
- Sex, etc. www.sexetc.org
- My Sistahs - www.mysistahs.org

YOUNG WOMEN, EGG "DONATION," AND REPRODUCTIVE JUSTICE

By Emily Galpern, Center for Genetics and Society, and Edith Sargon, Choice USA

The use of new reproductive technologies can pose both benefits and risks to women. While the technologies have enabled millions of people around the world to have genetically-related children, they have the potential to decrease women's decision-making power, and certain methods have not been sufficiently tested. One practice that has largely gone unquestioned is paying young women to provide "donor eggs" to a woman undergoing in vitro fertilization who cannot conceive using her own eggs. While most women who have provided eggs for this procedure have said they don't do it only for the money, the majority say they would not have gone through the procedure if they hadn't been paid. The procedure is invasive, carries some known short-term risk, and the long term health risks are unknown.

Young women are specifically recruited for their eggs because they generally have more and better quality eggs. College campuses are inundated with advertising because they provide easy access to a large pool of highly educated young women with specific "desired characteristics," such as high SAT scores; athletic, mathematic, or musical ability; and specific ethnicities. Many women in college are also faced with high tuition and/or debt, making them prime targets for paid egg "donation."

Egg donors are recruited through fertility clinics, egg brokers, or by private solicitation. Desired qualities are often listed in ads, along with rates of compensation, ranging from \$5,000 to \$100,000 (the more specific the desired qualities, the higher the payment). Egg "donation" (in quotes because since the women are paid, these are not donations) raises reproductive justice concerns about health risks, exploitation, and commodification of young women's reproductive tissue.

PROCEDURE

Women inject three different hormones over the course of 4-6 weeks to "shut down" their ovaries, then "hyperstimulate" them in order to control the timing of the release of the mature eggs. This is followed by a surgical procedure under light anesthesia, during which an ultrasound-guided needle is inserted through the vaginal wall into the ovary and the eggs are suctioned out. Eggs are then fertilized in a laboratory with sperm, and the resulting viable embryo(s) are implanted into the uterus of the woman intending to become pregnant.

CONCERNS

Health risks

- The long term effects of the hormonal drugs are not well studied and researchers have not ruled out a link to reproductive cancers. 20-33% of women taking the hormonal drugs experience mild forms of ovarian hyperstimulation syndrome (OHSS). Severe cases (1%) can lead to hospitalization, renal failure and, though rare, death.
- The information women are given on the health risks varies. There is no standard ensuring medically accurate information, including information about long term risks.

Financial incentives

- While fertility clinics generally offer \$5,000-8,000 for third party egg donation, private solicitation offering \$10,000 or more is not uncommon. Some ads offer as much as \$80,000 or \$100,000. Offering large sums has created a disturbing commercial market in young women's reproductive tissue.

Lack of regulation

- There is no limit on the amount women can be paid for their eggs. The American Society for Reproductive Medicine (ASRM) recommends women not be paid more than \$5,000, or \$10,000 in rare cases, but it is a voluntary guideline and women are routinely paid more in private agreements.
- The ASRM recommends that women not undergo more than 6 egg retrieval cycles, but there is no system tracking donors who might sell eggs to different clinics, brokers, or

individuals. Multiple cycles also put women at greater risk for ovarian hyperstimulation syndrome and potentially for longer term effects.

Policy is needed in the following areas:

- Investigating alternatives to hormonally-stimulated egg retrieval.
- Developing standards of care for procuring eggs for fertility treatments.
- Collecting data on the health effects of egg retrieval, particularly long-term effects.
- Determining appropriate amounts of compensation.

If you are a young woman considering egg donation, or you've already donated your eggs:

- Ask questions: make sure you are fully informed about the process, health risks, and what is still unknown about long-term effects. Do independent research, and bring your concerns to the doctor who will be performing the procedure. If s/he won't address your questions, go to another clinic.
- Call Choice USA or the Center for Genetics and Society to join our campus-based campaign:
 - Contribute your questions: join other young women nationally in creating a questionnaire for women to use with physicians and fertility clinics.
 - Share your story: your experiences can shed some light for women who might be considering egg donation.
 - Work with college or university Student Health Centers: help make medically accurate information available to all women about egg retrieval.

RESOURCES

- Center for Genetics and Society <http://geneticsandsociety.org>
- Choice USA <http://www.choiceusa.org>
- Committee on Women, Population and the Environment <http://www.cwpe.org>
- Council for Responsible Genetics www.gene-watch.org
- Our Bodies Ourselves <http://www.ourbodiesourselves.org/default.asp>

GIRLMOM: WE ARE YOUNG/TEEN MOMS AND PRO-CHOICE

By Girlmom

[Below is an excerpt from Girlmom's mission statement, written by the website's first editor, Allison Crews. Allison became a fierce mother to Cade at age 15 and passed away in 2005 when she was just 22. Her life inspired all of us.]

Girlmom.com is a website designed and moderated BY and FOR young mothers. Girlmom is politically progressive, left-aligned, pro-choice, and feminist. Girlmom intends to support young mothers, of all backgrounds, in their struggles for reproductive freedom and social support.

There exists no other space where young mothers who have also chosen abortion can speak freely and honestly about all their reproductive choices. As young mothers, we all know what it is like for our reproductive choices to be questioned and judged as "deviant", or wrong, by the rest of society. Women who have abortions receive this same judgment, but to a larger extent, and are called murderers, baby killers, whores, sluts, immoral...the list goes on. Because of this, most women who have abortions are shamed into silence, and don't openly speak of these choices that they have made. No woman should ever feel ashamed for choosing what is best for herself, her womb, her existing and her potential children, and her life.

We believe that all teenagers are sexual beings with the ability to love, procreate and nurture. We believe that teenagers have the innate ability to parent well, but are socially conditioned to believe that they are irresponsible and reckless. We believe that such social conditioning often creates a self-fulfilling prophecy, in which teenage parents believe that they cannot parent well and move on to not parent well. We believe that in order to solve the "problems" associated with the "epidemic" of teen pregnancy, we must reassess and change our collective social attitudes towards teenage childbearing. We believe that in order for teen parents to succeed, they must be encouraged to do so and assured that they are capable. Degrading, vilifying, marginalizing, and rejecting teen mothers (as is customary in our society) is counterproductive and illogical. Teen mothers will succeed if allowed the opportunity. When a teenage girl finds herself pregnant, it is one of the few times during her life course where she will not only be expected to fail, but socially encouraged to fail. We believe that encouragement and support beget success.

We encourage all young mothers to speak loudly and boldly of their experiences and choices, in the hope that young women of future generations will feel more secure in doing the same. We support the right of others to choose to not bear children and expect similar support and respect for our choice to become parents. We encourage debate when it is employed in an effort to open our minds and broaden our horizons. We discourage debate when it silences or tramples over the voices of mothers trying to garner support and advice.

We reject all ageism, racism, sexism, classism, and other prejudices and stereotypes. We are actively working towards creating an equal society, in which the right to bear or to delay bearing children is secured for all and all children are allowed the right to excel and thrive. We support women receiving public assistance, and feel that no woman should have to justify exercising her legal right to do so. We support lesbian, queer, bi, trans, and poly mamas and feel that no one should ever have to justify or explain their sexual identity and practices.

We believe in the idea of youth liberation, and feel that teen parents should be freed from social restraints that restrict their ability to parent effectively and independently. We encourage mothers to continue their educations and earn higher degrees. At the same time, we encourage mothers to make choices for themselves and reject the system that exploits them. We encourage mothers to seek independent employment when possible, to purchase independently produced items, and maintain a DIY philosophy, in order to reject the patriarchal system that oppresses us.

---Allison Crews

Many times we are told explicitly or tacitly, that young mothers are not pro-choice. "People always assume I'm anti-choice and it gets on my nerves. Just because I got pregnant at 15 doesn't mean I don't agree with abortion; it just means I made a very important choice and the right choice for me. That's what is just so great about being pro-choice," writes Elsy. Some feel that the traditional pro-choice movements have falsely assumed that because we continued an unplanned pregnancy out-of-wedlock, we must be against abortion. Deciding to continue a pregnancy does not mean that we would not, under different circumstances, choose to terminate a pregnancy. "I think its because I had a kid when I was young or something, they think I only continued the pregnancy because I was against abortion.... People have all these assumptions of what a feminist or a pro-choice person is supposed to be, and they usually do not picture a teen mom," reminds Skykid who became a mom at 17.

Society pushes a notion of what circumstances make an "ideal" pregnancy, or an "ideal" mother. When the National Campaign to Prevent Teen Pregnancy decided to make their campaign pictures of young girls with the words "cheap, dirty, reject, nobody" in their print ads it took stereotyping to a new level. Just because you had a child when you were young, does not mean you're bound to live out the role that others assume you will. Many forget that some young women have planned our pregnancies, just like their older counterparts. These ideas about young mothers perpetuate dominant power structures. Society teaches us that you are not a "good mother" if you aren't older, married (to a man), rich, and white. Unfortunately the feminist movement has not always deconstructed the intersectionality of race and class issues. Biogrrlwonder, young transgender dad writes, "A lot of 'pro-choice' people (all of them with well-paying jobs and Ph.D.s) told me it was unethical for me to continue my pregnancy until I was financially on my own feet, like I had to have X amount of money and X amount of support or otherwise it was wrong to choose to parent. And it's not that simple."

Jenni, who became a mother at 19, describes the importance of social supports for young mothers, "When I was unsure of leaving my son's dad because of my apprehension about what my life would hold afterwards, Girlmoms supported my decision. When I wanted to go back to school, they were there to tell me it would all work out, and I could do this. I believed them and two years later I graduated from college." Hillary, a 21-year-old college student in Texas and mom to a 2-year-old son echoes this sentiment, "Motherhood can be very isolating, and it's hard to navigate and find a peer. When I was a teenage stay-at-home-mom/nanny in a new city with few contacts and no real idea of how to get myself around and dealing with post-partum depression, Girlmom gave me - I want to say "a way out" but that's not really what I mean - maybe a way in?"

17-year-old mom Lexi, writes, "Girlmom has helped me be proud of being a teen mom. I have learned/unlearned a lot of things, and it has really opened my eyes to what I am capable of doing in the future. I love hearing about other teen moms and what they have accomplished in their lives. It has really shown me that just because I have a child, that does not mean that I can't have a future. I hope that some day people will learn that teen moms are not worthless or trying to use the government or whatever else they say about us, that we are capable of contributing to the community. I think that it is a woman's choice to do what she wants with her body. I hope that in the future women will not be looked down at for aborting, adopting, or deciding to have a baby. Too many people look down at others for doing things, but they don't understand what other people are going through or what their stories are."

On Girlmom, many young moms decide to speak forcefully about our reproductive options. Many believe that our community of young women doesn't know enough about abortion and that some cling to false beliefs. Jenni states, "I have seen many young girls who have opted to continue a pregnancy they did not want because they didn't know all the options. So many girls stumble upon Girlmom not knowing about abortion and being dead set against it." Hillary continues, "Reproductive justice, for me, is a human rights issue as well as a personal issue. My agency over my own body is my basic human right, whether that means choosing when and

whether to grow a fetus in my uterus, choosing when and whether to have sexual relations with another person, or choosing how I am physically treated, it all comes down to the same basic right: the right to physical autonomy."

Heather, is one of the current moderators at Girlmom. She is a 24-year-old single mama to an almost 6-year-old girl-child living "in the vast lands of North Dakota." She writes, "I have always been pro-choice, but there's always that weird stigma around abortion and it's a hush-hush subject. I don't think it's fair for girls, sexually active or not, to not know about such an important issue and option they CAN have at any age, any time, any situation and to NOT FEEL BAD ABOUT IT. I have a daughter. I want her to have all reproductive options available for her. Reproductive rights go beyond abortion. Girl-mom has helped me learn and unlearn so much about women's issues, racism, radicalism, phobias, sexuality, trans issues, just to name a few. Girl-mom has helped me get past my abusive baby-daddy to finally leave him. Girlmom has helped me get past issues of concern to me and give me the confidence to be who I am, do what I do, and make the decisions I do."

Charlie, the current editor of Girlmom, became a mom at age 16, planning her pregnancy. She is currently a single mom in Austin and an undergrad who receives a full scholarship. Charlie explains that society tries to shame women's sexual choices and creates a false hierarchy between teen parents such as, single vs. coupled parenting, or planned vs. unplanned pregnancies. She says, "Us Girlmoms got pregnant in all different ways, we planned it, we slipped up, we had violence used against us. But the thing about Girlmom, is that we empower every young mama to pin that invisible merit badge to their chests and be able to say, "No matter the circumstances of the conception, I am a mother by choice."

Take a look at the history for years and years and you will see that reproductive rights and issues have always been around. It's amazing. It's not a new issue, at all. Yet we are still standing up and fighting. And fighting - we will NOT stop.

RESOURCES

- <http://www.girl-mom.com>

SEX, LIES & BIRTH CONTROL: WHAT YOU NEED TO KNOW ABOUT YOUR BIRTH CONTROL CAMPAIGN

By the Committee on Women, Population and the Environment (CWPE)

As women of color, our rights to safe and voluntary sex, birth control and motherhood are increasingly restricted, controlled and criminalized. Punitive welfare policies dictate families' lives. Coercive programs target low income and women of color for high risk contraceptives. New laws and policies make abortion access more difficult and costly. These developments devalue our human rights and harm our ability to sustain our families, our communities, and our lives. Attacks on women's health constitute unethical attempts to control women's lives and dictate who among us can have, keep, and raise children. We strongly oppose demographically driven population policies that do not ensure safe and secure environments for all women.

In the 1990's many health care providers and reproductive rights activists in the US embraced Norplant and Depo-Provera as highly effective, long lasting birth control methods that expand women's contraceptive "choices." Supporters, however, have ignored the crucial fact that Norplant and Depo have been associated with serious risks, especially for poor and politically powerless women.

WHAT YOU NEED TO KNOW ABOUT YOUR BIRTH CONTROL CAMPAIGN

seeks to build knowledge and promote systemic change by highlighting the risks, side effects and history of birth control and by collecting the testimonials of women who have had their bodies and lives greatly impacted by contraceptives and coercive reproductive practices.

Depo Provera (also know as depo or the shot) is an injectable form of the hormone, progesterone. The hormone enters the blood stream and works systemically to prevent pregnancy by preventing the release of eggs from the ovaries and by thickening the cervical mucus to impede sperm movement.

- **Critical Concerns:** Most women who use depo gain weight. Many experience irregular menstrual bleeding, nausea, depression, loss of sex drive, delayed return of fertility and/or sterility, headaches, hair loss, acne, nervousness, increased risk of breast, cervical and uterine cancers. Depo is not a barrier method and can increase risk of getting STD's and HIV.

- **History:** Depo was involuntarily tested on 14,000 women from 1967 to 1978, by Upjohn, Inc. 50% of the subjects were African American, low income and rural women subjected to trials without their consent. Today poor women, women of color, and young women are targeted users. Depo is still considered a "foolproof method" despite its effects on women's health.

If you have a story about depo please contact depodiaries@cwpe.org.

Implanon & Norplant (also known as Jadelle)

These contraceptive implants release a hormone through a set of rods under the skin of the upper arm. Implanon, a silicone rod approximately 1.5 inches, approved by the FDA in August 2006, is the only implant currently marketed in the US. Implanon works systemically, preventing pregnancy for three years by gradually releasing etonogestrel into the body, preventing the monthly release of an egg and thickening the cervical mucous to impede sperm movement.

- **Critical Concerns:** The Implanon rod is marketed as a "set it and forget it" contraceptive even though this method requires six-month checkups. Removal can be difficult and must be performed by a provider. Once implanted, side effects, including prolonged, frequent, or infrequent bleeding or no periods at all, possible weight gain, headaches, nausea, breast pain, and acne, are often irreversible. Less frequently, women have experienced hair loss, mood changes, painful periods and loss of sexual

desire. This method does not provide protection against sexually infectious diseases and HIV.

- **History:** Many women have reported that removal is painful because of weight gain or scar tissue growth over the implant. In some cases implants have broken up within the arm, and doctors have had difficulty removing these floating pieces. The long term effect of the hormone release has yet to be researched.

Quinacrine is a pellet inserted into the uterus, causing scar tissue formation that blocks the fallopian tubes and makes the passage of eggs impossible.

- **Critical Concerns:** Quinacrine has not been adequately tested for long term side effects, although the pellet is associated with a number of serious short-term side effects, including burning and irritation of the vaginal walls, narrowing of the cervical opening, uterine adhesions, stimulation of the central nervous system, toxic psychosis, and perforation of the uterus. Quinacrine is also an agent that causes mutations in the living cells. It is, of course, not a barrier method for sexually infectious diseases and HIV.

- **History:** Quinacrine was originally administered as an anti-malarial drug but has never been approved by the FDA or any other regulatory body as a method of sterilization. However, it continues to be used in "experimental studies" associated with fertility control, and by private physicians in the US who may be using the drug unethically and involuntarily on women. Quinacrine may provide another example in which poor women, particularly women of color from developing and developed countries are being used as guinea pigs in the name of advancing reproductive technology.

In 2007 manufacturers, doctors and policy makers promote these methods to young and poor women of color. Judges still mandate that some convicted women take Depo-Provera as part of their punishment. For many women, these methods of birth control are not a "choice." Government and industry are devoting substantial resources to developing methods to limit the reproductive activity of women of color and poor women, for example by new immunological contraceptives and chemical methods of sterilization such as Quinacrine. By challenging profit driven birth control, by objecting to the practice of subjecting women's bodies to unethical testing, and by organizing against high risk and adverse side effects from "fool proof" contraceptives, we are seeking reproductive justice that secures the safety of women, and ensures our physical, spiritual and emotional well being.

RESOURCES

To learn more about the "What You Need to Know about Your Birth Control" Campaign, visit: www.cwpe.org

BIRTH CONTROL AND GENDER JUSTICE

By Cristina Page

When the Christian Right targets family planning, they take aim at something important. Birth control has led to a transformation of our society, one so sweeping and rapid that only recently have we had the occasion to take stock of its impact. The pro-choice movement, which grew out of the contraception movement, fights against pernicious, puritan views of sex; guided by the belief that a society in which sex for pleasure, made possible by birth control, was an accepted part of the human condition could change the world.

The Supreme Court didn't grant unmarried people legal access to birth control until 1972 (a year before abortion was legalized). For many in the religious right, this is the period in which everything started to go wrong: from the breakdown of the nuclear family to a generalized increase in permissiveness to a denigration of American morals. For many opponents of reproductive justice, the period before birth control was legalized serves as a kind of sentimental era, and also a model. For the opponents of birth control, the wife and mother of the 1950s seemed to have it together. Even today, June Cleaver is the benchmark Mom to which every other mother is compared. What was the reality for the pre-birth-control mom, though?

In her masterful book, *The Way We Never Were: American Families and the Nostalgia Trap*, historian Stephanie Coontz, explains that in the fifties birth rates soared, doubling the time devoted to child care.¹ Consequently, women's educational parity with men dropped sharply, while their housework time increased exponentially—despite having new “time-saving” household technologies.² And with women assigned to endless tasks in the home, men shouldered the full responsibility of supporting the family economically. One dire consequence was that one in four Americans in the mid-1950s lived in poverty.³

Not surprisingly, national polls conducted during the fifties found that slightly less than 1/3 of working-class couples reported being happily or very happily married.⁴ Part of the reason for unhappy marriages in the 1950s was that many couples didn't really want to be married in the first place. They were trapped into marriage by unintended pregnancy. With no sex ed, no birth control, no legal abortion – the exact legislative agenda of today's anti-choice movement! – teen birth rates soared, reaching highs that have not been equaled since.

After the right to birth control was won, we witnessed a massive transformation of society. Women rushed into college so quickly, so enthusiastically, that since 1970 the number of women graduating from college more than doubled.⁵ Researchers studying the effects of the Pill, found that the percentage of all lawyers and judges who are women was 5.1 percent in 1970 and surged to 29.7 percent in 2000. The share of female physicians increased from 9.1 percent in 1970 to 27.9 percent in 2000. Similar patterns hold for occupations such as dentists, architects, veterinarians, economists, and most of the engineering fields.

Once birth control became legal nationwide, and especially after the introduction of the instantly popular birth control pill, women's lives were transformed. June Cleaver became Hillary Clinton.

RESOURCES

For more information about the war on contraception or to get involved protecting the right to plan a family please visit www.birthcontrolwatch.org

¹ Stephanie Coontz, *The Way We Never Were: American Families and the Nostalgia Trap* (New York: Basic Books, 1992), 39.

² Coontz, 25-26.

³ Coontz, 29.

⁴ Coontz, 36.

⁵ National Center for Education Statistics, “Fast Facts: Title IX,” <http://nces.ed.gov/fastfacts/display.asp?id=93> (accessed April 7, 2005).

"PHARMACISTS' REFUSALS" AND REPRODUCTIVE JUSTICE

By Carole Joffe, University of California, Davis

"Pharmacists' refusals" are a fairly recent and disturbing development in the Right's ongoing war against reproductive justice. This phrase refers to the practice of some pharmacists, often affiliated with a group called "Pharmacists for Life," to refuse to fill prescriptions for contraception because of moral or religious objections.

Some pharmacists began to refuse to fill prescription in the late 1990s, around the time that the FDA approved Emergency Contraception (EC) as a dedicated product, to be made available by prescription. (Previously, a small number of health care providers gave patients a higher than normal dose of birth control pills as EC). Some individual pharmacists immediately announced their opposition to EC, claiming it was an "abortafacient" (that is, something that causes an abortion). The Wal-Mart chain, often the only pharmacy in rural areas, announced that it would not stock EC in its stores.

The pharmacist refusal movement is part of a larger phenomenon: the escalation of the campaign against abortion to include a campaign against contraception. Medically, pregnancy is defined as commencing with the implantation of a fertilized egg into the uterine wall. But many in the antiabortion movement and in Religious Right circles now define a pregnancy as beginning with the fertilization of the egg and oppose contraception on moral grounds. After hosting a conference in fall 2006 titled "Contraception is Not the Answer," the Pro-Life Action League posted a statement on its website that claimed, "The entire edifice of sexual license, perversion and abortion is erected upon the foundation of contraception."

There is no reliable data on how many pharmacists' refusals are taking place. Most seem to be in "red" states, but pharmacists' refusals have been reported all over the country, including such "blue" areas as Northern California. While refusals started with EC, they soon spread to regular oral contraception. There have been egregious instances reported in which rape victims were denied EC; in which married women were denied their regular monthly packet of birth control pills and the pharmacist lectured them on their immoral behavior; in which women in rural areas were forced to drive many miles to find a drug store that would fill such prescriptions; in which a pharmacist confiscated a women's EC prescription, making it impossible for her to present it at another facility. Even the recent FDA decision to make EC available without a prescription to women over eighteen has not stopped such occurrences. Because of the age limit, the medication is kept behind the counter, and women still have to request it from a pharmacist.

Pharmacists' refusals have generated various actions by both supporters and opponents of this policy. A handful of states have passed legislation or regulations specifically allowing pharmacists such refusals, while several states have passed legislation mandating that prescriptions must be filled, and many more states are considering bills, on both sides of the issue. The major professional organization within the field of pharmacy, the American Pharmacist Association, has put forward a compromise position which affirms the pharmacist's right "to exercise conscientious refusal" but which also stipulates that patients should be ensured access to her prescribed medication, for example by another pharmacist, or by a referral to another pharmacy. While perhaps not too onerous for women in urban areas, the need to find another drug store can be very difficult for women in rural areas. State pharmacy boards have also issued various statements, mostly similar to that of the APA.

Advocacy groups and grass roots activists in the reproductive justice movement are playing an important role in the campaign against such refusals. Activists in Massachusetts, for example, were instrumental in filing a lawsuit and getting Wal-Mart to change its policies. Activists are also encouraging media coverage of instances of pharmacy refusals, an effective strategy in this campaign because the American public is strongly supportive of contraception. Some 98% of heterosexually active women have used at least one form of contraception at some point. And about 80% of these women have used birth control pills. A recent American Civil Liberties

Union poll showed that 88% of respondents opposed pharmacists' refusals. In short, one unanticipated outcome of the pharmacy refusal movement may be to dramatically highlight the country's rejection of the reproductive agenda of the Religious Right.

RESOURCES

If a woman is refused EC at a local pharmacy, she can call 1-888-668-2528, an emergency hotline managed by the Association of Reproduction Health Professionals, to find out the nearest facility where she can be helped. She may also receive such information at www.go2planB.com. Other organizations, which have valuable information on this topic on their websites, including how to become politically involved, include:

- The MergerWatch Project, www.mergerwatch.org
- National Women's Law Center, www.wmlc.org
- American Civil Liberties Union, www.aclu.org
- Planned Parenthood Federation of America, www.ppfa.org
- National Health Law Program, www.healthlaw.org

MEDICAID AND WOMEN'S REPRODUCTIVE HEALTH

By the National Women's Law Center

Since the average cost of having a baby today is over \$8,800, access to affordable, quality, comprehensive health care is a critical component in a woman's decision whether to parent a child. Also many medical conditions are aggravated by pregnancy including sickle-cell disease, heart disease, diabetes, asthma and high blood pressure, so for a woman with these and other conditions, the costs can be far higher.

Women of reproductive age (15-44) are the most likely of any demographic group to lack health insurance. Medicaid, a federal and state program that provides health insurance for certain low-income individuals, helps fill that gap. Approximately **seven million** women of reproductive age rely on Medicaid; and women comprise **71%** of the program's adult insurees. Medicaid helps guarantee that low-income women have an equal right to health care and the ability to control their reproductive destiny.

Through Medicaid, women can access a wide range of services including pregnancy-related care, preventive screenings, and diagnosis and treatment of chronic illnesses including breast and cervical cancer and HIV/AIDS. Medicaid currently pays for over one third of all births in the United States.

Although the federal Medicaid program does not cover abortions except in rare circumstances [see *The Hyde Amendment Violates Reproductive Justice and Discriminates Against Poor Women and Women of Color*], this insurance program is an important source of funding for **family planning services**. Voluntary, accessible family planning services allow women to decide whether to parent or not parent a child, how to control their reproductive and economic lives, and how to make informed decisions about maintaining and improving their health by

- (1) allowing for early detection of disease through regular health screenings;*
- (2) spacing the birth of children in order to improve health care outcomes for both mothers and children;*
- (3) avoiding economic oppression caused by unintended pregnancies, and/or high-risk pregnancies;*
- (4) facilitating women's choices about staying in the workforce or completing their education.*

Twenty-six states now offer family planning services to low-income women who are ineligible for Medicaid. Every other state can and should offer these services to allow all low-income women to freely determine their own reproductive destiny.

One growing challenge is finding providers who accept Medicaid. As one health policy expert said, at some point a Medicaid card becomes a hunting license. Provider reimbursement must be adequate to guarantee Medicaid patients equal access to a full range of providers and services, including reproductive health care.

A recent requirement for proof of citizenship when applying or reapplying for Medicaid has also created obstacles to care. Adopted under the guise of preventing undocumented immigrants from accessing Medicaid, the impact of this ill-advised rule has been borne overwhelmingly by Americans who lack the necessary documents, such as a birth certificate or passport, to prove their citizenship status.

Medicaid funding is under constant political attack. As Medicaid grows to be a larger portion of state and federal budgets, protecting and preserving program funding and benefits proves to be a bigger challenge. We must ensure that adequate funding of this critical program remains a top priority.

RESOURCES

- "Improving Latina Health through Medicaid Advocacy: A Toolkit" National Women's Law Center & National Council of La Raza, 2007 - www.nwlc.org
- "Medicaid Turns 40. What You Didn't Know About This Vital Source of Family Planning Funding," July 29, 2005, The Alan Guttmacher Institute - www.guttmacher.org/media/inthenews/2005/07/29/index.html
- National Women's Law Center - www.nwlc.org

REPRODUCTIVE JUSTICE AND HEALTH CARE REFORM

By the National Women's Law Center

The health care system in this country is in crisis: nearly 47 million people lack health insurance; millions more have inadequate coverage. For women of childbearing age, the statistics are bleak: one in five lacked health coverage in 2006.

Access to affordable, quality, comprehensive health care is a critical factor in whether a woman can freely decide to parent a child. The inadequacies of the current health care system can have a tremendous impact on this decision.

For women, health care affordability is a challenge. They are more likely to need and use health services, but on average have lower incomes than men and therefore less financial ability to pay for their greater health care needs. At the same time, for those lucky enough to have it, many women's health insurance coverage is precarious and incomplete.

Today, state and federal legislatures, as well as the general public are debating ways to reform the health care system. In this context, advocates must be vigilant to ensure that women achieve access to a full range of reproductive health services. In Massachusetts, during health care reform debates, critical questions arose regarding what reproductive health care services to include and whether to provide contraceptives in the prescription drug coverage. A public board had the power to decide these matters. Fortunately the board ultimately decided to offer both abortions and contraceptive coverage. Certainly, it is easy to picture different outcomes elsewhere.

One recent study looked at the cost of maternity care for women enrolled in "consumer-driven health plans," and found that such women are often subjected to very high out-of-pocket costs, including deductibles that can apply to prenatal care. The study found that under some plans, women might have to pay as much as half of the cost of their pregnancy out-of-pocket. These kinds of outcomes have disproportionate financial impacts on lower-income women, and surely influence the decisions of many women about whether to have a child.

Health care reform will have a significant impact on women and their decisions about whether and when to give birth. The following questions must be asked to determine which policies would have the greatest impact on women. Does the policy:

- Assure that all individuals have coverage?
- Extend coverage to the uninsured without eroding the coverage of the insured?
- Utilize large groups to spread risk and lower cost?
- If building on employer-sponsored coverage, ensure that all employees, including part-time employees and dependents have access to coverage?
- Enable individuals who are outside the labor force to obtain coverage?
- Provide subsidies to ensure that low-income individuals can afford health coverage?
- Ensure comprehensive benefits, including a full range of reproductive health services?
- Ensure that out-of-pocket costs (i.e.: co-payments and deductibles) are affordable relative to the individual's income?

Advocates must be active participants in this debate. We need to ensure that affordable access to a **full** range of reproductive health services is a key part of any health reform plan!

RESOURCES

- "Women and Health Coverage: A Framework for Moving Forward," www.nwlc.org
- "Women and Health Coverage: the Affordability Gap," www.nwlc.org
- "Census Data on Uninsured Women and Children," 2007, March of Dimes - www.marchofdimes.com
- "Maternity Care and Consumer-Driven Health Plans" 2007, Kaiser Family Foundation - <http://www.kff.org/womenshealth/whp061207pkg.cfm>

ABORTION RIGHTS AND REPRODUCTIVE JUSTICE

By Marlene Fried and Susan Yanow

"Access to safe abortion is both a fundamental human right and central to women's health. Where abortion is illegal or inaccessible, the search for abortion humiliates women and undermines their self-respect and dignity."

Advocating for Abortion Access, The Johannesburg Initiative, Preface, Zanele Hlatshwayo and Barbara Klugman, Women's Health Project, Johannesburg, South Africa, p.X

Because a woman's ability to control her reproduction is fundamental to her ability to control her life, reproductive autonomy is a core aspect of reproductive justice. Achieving this goal requires access to safe abortion, comprehensive sex education, freedom from coerced sex, and birth control appropriate to each woman's health and life. It also requires that women have all that they need to have and raise children.

The political Right in the U.S. has made opposition to abortion the centerpiece of a broad conservative agenda. As a result, the abortion issue dominates reproductive and sexual politics worldwide. Threats to abortion access - legal, illegal, and sometimes violent - have been persistent. There have been highly visible attacks: in the U.S., seven people involved in abortion care have been murdered since 1994, and over 80% of clinics which offer abortion services have experienced violence, threats and serious harassment. Innumerable legal and economic barriers have been established to limit women's ability to obtain an abortion.

For example:

- 28 states mandate that, before an abortion, women receive scripted counseling that includes misinformation/unwanted information.
- 24 states require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between counseling and the abortion.
- 34 states require some type of parental involvement in a minor's decision to have an abortion.
- The Hyde Amendment of 1977 cut off all Federal Medicaid funds for abortions. As a result, women without economic resources are forced to forgo other basic necessities in order to pay for their abortion, or they must carry their unplanned pregnancy to term.
- Women who are Federal employees, covered by Indian Health Service, in the military or on disability insurance do not have coverage for abortion care.
- Many private insurers exclude coverage of abortion in their policies.
- Many states have laws that regulate the medical practices or facilities of doctors who provide abortions by imposing burdensome requirements that are different and more stringent than regulations applied to comparable medical practices.

Although one out of every 3 women in the U. S. will have an abortion before the age of 45, 87% of all US counties and 97% of all rural US counties have no abortion provider. The burden of needing to travel, and costs associated with this travel, add to the obstacles many women face when needing an abortion.

The impact of these restrictions is experienced most heavily by young, rural, undocumented, and low-income women, who are disproportionately, women of color.

U.S. policies also have a devastating impact on women around the world. The global gag rule remains in place, undermining services and the health of millions of people worldwide.

While abortion rights are central to women's freedom, they are only part of the picture. Within the reproductive rights movement, there has been frustration over the mainstream pro-choice movement's singular focus on abortion, and its use of the framework of individual choice. The inadequacy of "choice," the failure to disassociate abortion politics from population control, and reducing reproductive rights to the issue of abortion, alone, have

divided feminists for decades. In contrast, the framework of reproductive justice is rejuvenating the meaning and practice of reproductive rights with an expansive multi-issue perspective and agenda for action. This provides an opportunity to create new alliances internationally and joins the abortion rights struggle to other health and social justice movements.

RESOURCES

- www.sistersong.net
- www.acrj.org
- <http://popdev.hampshire.edu>
- www.nationaladvocates.org
- www.hyde30years.nnaf.org
- <http://clpp.hampshire.edu>
- Jael Silliman et al, *Undivided Rights: Women of Color Organize for Reproductive Justice*
- Rickie Solinger, *Beggars and Choosers*
- Dorothy Roberts, *Killing the Black Body*

THE PERSONAL IS POLITICAL: ABORTION STIGMA AND REPRODUCTIVE JUSTICE

By Grayson Dempsey, Backline

From 1973 to 2002, more than 42 million legal abortions occurred in the United States⁶, and countless other women considered abortion as an option even if they ultimately decided to continue their pregnancies. This staggering number of Americans who have personally been affected by abortion should mean that the legality and accessibility of services should be solidly protected. And yet just 49% of Americans identify as “pro-choice”, and an even smaller number – 41% - believe abortion should be legal in all or most circumstances.⁷

This lack of support for abortion rights has not only led to increased policy restrictions but also to growing stigmatization of women who are thinking about, or who have had, abortions. Anti-abortion activists have strategically targeted these women and have mobilized them as the new face of the pro-life movement. Billboards and picket signs reading *I Regret My Abortion* and *Abortion Hurts Women* are becoming more common in cities across the nation, and pro-life counseling services offer women support before and after their abortion while encouraging them to take political action towards criminalizing the procedure.

This leaves many of us wondering how women and their loved ones who seek reproductive health services choose to be silent about what they've done, and sometimes even condemn others who terminate their pregnancies. When we ask women about these matters, we hear about their isolation, fear, and the belief that both sides of the political spectrum will criticize them if they tell the truth about their experiences. Many mainstream organizations have used problematic slogans such as “pro-choice not pro-abortion,” justifying the position that says it's ok to fight for the legal right to choose, but it's also ok to judge any woman harshly who actually had an abortion. Studies⁸ and experience have shown that when women have the opportunity to share their experiences, and when they possess the tools for healthy coping during pregnancy and after an abortion, shame and stigma are reduced. Possessing self-reliance and having positive personal experiences increase the likelihood that women promote Reproductive Justice issues at the grassroots and policy level.

How can we, as a movement, offer this type of support to women? National talk lines such as **Backline** offer a confidential place for women and their loved ones to talk about all aspects of pregnancy, parenting, abortion and adoption without fear of political manipulation. **Exhale** offers after-abortion support with an emphasis on a “pro-voice” framework, which does not take sides on the pro-choice/pro-life debate. Recent films such as *The Abortion Diaries* and *Speak Out: I Had An Abortion* feature women telling their personal stories, and the corresponding *I Had An Abortion* t-shirt has sparked intense dialogue within communities around the nation. Websites such as *I'm Not Sorry* and *Project Voice* offer forums for women to read and write about their abortion experience. This idea that the personal is political has been at the heart of the Reproductive Justice movement for decades, and now a new generation of activists is realizing that without the ability to speak the truth, the right to access all reproductive health services will remain disconnected from the millions of people whose unique stories are at the heart of this issue.

RESOURCES

- Backline: www.yourbackline.org
- Exhale: www.4exhale.org
- The Abortion Conversation Project: www.abortionconversation.com
- *The Abortion Diaries*: www.theabortiondiaries.com
- *Speak Out: I Had An Abortion*: www.speakoutfilms.com
- *I'm Not Sorry*: www.imnotsorry.net
- *Project Voice*: www.theabortionproject.org

⁶ Finer LB and Henshaw SK, Estimates of U.S. abortion incidence in 2001 and 2002, The Alan Guttmacher Institute (AGI), 2005, <http://www.guttmacher.org/pubs/2005/05/18/ab_incidence.pdf>, accessed May 17, 2005.

⁷ The Gallup Poll, <http://www.galluppoll.com/content/?ci=27628> (September 2, 2007).

⁸ Feminist Women's Health Center, *Listening to the Women We Serve: Young Women's Attitudes About Abortion and Choice*, 2004.

WHEN *ROE V. WADE* FALLS, WHO WILL CATCH US?

By Rebecca Trotzky Surr, Medical Student, University of Minnesota,

"I do this, not because I enjoy it, but because as a resident I saw wards of septic women dying in the backrooms of hospitals," explains one of my OBGYN mentors Dr. Baram. He's a wiry, grey-haired and balding man. A generation has passed between *Roe* and me; 57% percent of abortion providers are older than 50. Physicians like Doctor Baram hold us young medical students accountable to this history.

"Overnight, women stopped dying. When abortion became legal, women stopped dying in the back rooms of hospitals, ignored by their families and mistreated by all the hospital staff. That's when I knew that I wanted to provide this service. But, I am growing tired." Dr. Baram continues. I know the history, but hearing it firsthand sends shivers across my body. He is brutally honest; he wants us students to take a share of the reproductive health care responsibilities, but he also wants us to know what we're getting into.

"*Without providers, there is no choice,*" is the motto of Medical Students for Choice. As a medical student, I am on the frontlines of the messy legacy of *Roe v. Wade*. Yes, it legalized a woman's right to receive an abortion. But in the contested space of women's health care, too few medical students choose to follow in the footsteps of Dr. Baram by providing abortions as a part of comprehensive health care services. Moreover, many health professionals see reproductive health care very narrowly—as simply abortion services. The social and economic dignity of women includes the ability to choose our romantic partners, to feel good about our bodies, to have sex consensually away from manipulations and abuse, good sexual education, universal health care, free access to contraception, childcare, jobs, housing, and education. Doctors are notoriously bad at addressing these concerns with our patients.

Frankly, I'm not satisfied with many mainstream pro-choice organizations. I don't often see my patients well represented, nor do I see myself reflected, in leadership positions. Even though I am a medical student navigating halls of privilege in the ivory tower, I first and foremost identify as young single mom living below the poverty line. My politics are grounded in my life's experiences.

Presently, I'm in the middle of medical school in the middle of the country. Although legal, safe abortions are not accessible to every woman. There are only 11 abortion providers in my state. Zero in the next state over. One of the other neighboring states is seriously considering outlawing abortion. What was once seen as a straightforward legal victory has not translated into a smooth victory for women's reproductive health. Sure abortion is legal. But, does it matter if these services are so limited as to be unattainable?

My medical student classmates represent the hesitantly pro-choice political climate of today. Most medical students do not know about choice issues. They are middle-of-the-road, liberal or conservative, susceptible to the same myths and stereotypes as everyone else in the United States. In an independent research project, I surveyed my classmates after our sexual education course. More than simply not knowing basic facts about reproductive health, most of us were biased about what we thought we knew. We drastically overestimated abortion's risks, underestimated its prevalence—by factors of more than ten. If health care providers, the only people legally responsible for operationalizing *Roe v. Wade*, are anti-choice, does this mean that the women's health movement has failed?

I don't know if the movement predicted these regressive reactions to *Roe v. Wade*. In a way, I feel as if we became comfortable after winning the Supreme Court decision. There is a world to fight for, yet we are often limited to talking about *Roe v. Wade*. I wish we could take the legalization of abortion for granted, so that we could focus on more meaningful discussions and other kinds of activism. Instead, we keep circling around a legal decision that is almost 35-years-old.

Since entering medical school, I'm asked by many activists if I think *Roe v. Wade* will fall, or more pointedly, what our physician-response will be when abortion is illegal. For their part, many grey-haired elder doctors say poignantly, "Well, I was providing safe abortions before *Roe v. Wade*. If the law falls, I will continue to provide safe abortions." Younger docs are forceful too. One young resident at a national conference for Medical Students for Choice summarized a common viewpoint, "If *Roe* falls, you'll find me in jail the next day because I will continue to do what I am trained to do—providing women quality health care." Though noble and heroic, I'm not sure how we doctors will be best serving our communities from behind bars. I pray that day doesn't come. But, if *Roe v. Wade* is overturned, I will stand with a growing network including my well-heeled physician colleagues and my radical women friends, with newly purchased speculums, to catch us all.

RESOURCES

- Medical Students for Choice - www.ms4c.org
- A Medical Student's Guide to Improving Reproductive Health Curricula from the Association of Reproductive Health Professionals - www.arhp.org/studentguide

REGULATING “CHOICE”: STERILIZATION ABUSE IN THE UNITED STATES, THEN AND NOW
By Jaime Anno, MPH Candidate, Mailman School of Public Health, Columbia University

Sterilization, including forced termination of fertility, and other forms of birth control have historically been implemented in the name of “scientific” eugenics -- the practice of improving the quality of a population by restricting or aborting the child bearing capacity of some groups of individuals. Often the state has endorsed these practices, determining that the reproductive capacity of certain individuals cannot be exercised in the interest of society; that is, sometimes society has decided that certain children should not be born.

Throughout the first half of the twentieth century in the United States, various authorities targeted individuals in interracial relationships for sterilization. Other targeted groups included persons suffering from epilepsy and “feeblemindedness.” Individuals who medical and other authorities labeled sexually promiscuous or homosexual were also vulnerable, as were institutionalized people, especially people of color. Medical staff in asylums of various kinds, and in jails and welfare wards engaged in this practice, sometimes under the direction of judicial or psychiatric authority.

Angela Davis points out that aggressive sterilization abuse was often contemporaneous with and provoked by fears that “the white race” was undergoing dangerous degradation, a phenomenon that commentators called “race suicide.” Many white authorities and others identified the antidote to “race suicide” – sterilization of people of color. Davis explains that “although the operations were justified as measures to prevent the reproduction of ‘mentally deficient persons,’” the men and women sterilized were disproportionately black. Davis notes that between 1964 and 1981, “approximately 65 percent of the women sterilized in North Carolina were Black and approximately 35 percent were white”.⁹

By the middle of the twentieth century, state eugenics boards were much more likely to designate people of color than whites as “mentally unfit” to reproduce, even when these persons had never been hospitalized. These designations clearly reflected the race and class of the targets. Typically, a young woman was visited by a social worker because her family received welfare. Social workers’ notes indicated concern about “promiscuity,” and recorded warnings that the family would be thrown off the welfare rolls if the offending girl were not sterilized. Outside authorities conflated issues of control over sexuality and bodies with issues of gender, race, and class.

Today, eugenics boards and commissions have been disbanded across the country, and most Americans consider eugenics outdated and unjust. However, even today, forms of sterilization abuse occurs. Adele Clarke observes, “Subtle sterilization abuses include situations in which a woman or man legally consents to sterilization, but the social conditions in which they do so are abusive – the conditions of their lives constrain their capacity to exercise genuine reproductive choice and autonomy.”¹⁰

Other forms of subtle sterilization abuse can occur when women lack the abortion option; when people may become pregnant while economic constraints govern their reproductive choices; when people considering sterilization do not understand that the effects of the operation are permanent; and when people possess inadequate information about contraceptive alternatives to sterilization.

⁹Davis, Angela. 1981. “Racism, Birth Control and Reproductive Rights.” *Women, Race, and Class*. NY: Vintage Books. 11.

¹⁰ Clarke, Adele. 1984. “Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis.” *Test-tube Women: What Future For Motherhood?* Edited by Rita Arditti, et. al. London: Pandora Press. 188-212.

Thus, while scientific eugenics no longer occurs under that name, the determination and the practice of controlling the reproduction of some groups and supporting the reproduction of other groups persists in the United States.

RESOURCES

- Begos, Kevin, et al. April 15, 2003. "Against Their Will: North Carolina's Sterilization Program." <http://againsttheirwill.journalnow.com>
- Clarke, Adele. 1984. "Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis." *Test-tube Women: What Future For Motherhood?* Edited by Rita Arditti, et. al. London: Pandora Press. 188-212.
- Davis, Angela. 1981. "Racism, Birth Control and Reproductive Rights." *Women, Race, and Class*. NY: Vintage Books.
- Duster, Troy. 1990. *Backdoor to Eugenics*. NY: Routledge.
- Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. NY: Vintage Books.

RACE, CLASS, AND PERSPECTIVES ON REPRODUCTIVE MATTERS

By Amy Allina, National Women's Health Network

Safe and accessible abortion and contraception have been core priorities of the progressive women's health movement since this movement began. But there have been moments when the women's health and the reproductive rights communities have been divided over particular contraceptives or ways of delivering reproductive health services. The reproductive justice vision offers a way of understanding the intersection of reproductive and social justice concerns that sheds light on the underlying cause of those divisions and suggests a way forward that may help these allied communities to avoid or resolve similar conflicts in the future.

The debates over waiting periods for sterilization and the safety of long-acting hormonal contraceptives are two issues where there have been divisions. In both cases, the experiences that low-income women and women of color have had with the technologies and services in question were fundamentally different from the experiences of middle-class and wealthy white women. These different experiences naturally shaped very different attitudes.

When poor women and women of color organized against involuntary sterilization, they fought to establish mandatory waiting periods that would allow women time and space away from clinicians who might be pushing them during or after childbirth to agree to be sterilized. These women wanted to make decisions about their fertility in a context when they were not experiencing postpartum vulnerabilities of various kinds. They also advocated for a written informed consent procedure to ensure that women would get full information about sterilization before making the decision. These policies made a lot of sense as a way to protect the rights of women who had been subject to sterilization abuse. But they came into conflict with the interests of white women, many with financial resources, who were trying to eliminate barriers to sterilization and enhance access to that choice and to what they defined as reproductive autonomy.

A similar racial and economic divide emerged with the introduction of long-acting hormonal contraception delivered by shots and implants. Women who had historically been defined as good choice-makers and producers of valuable children often liked the contraceptive efficiency represented by these new forms of birth control. But women from groups that authorities had historically coerced to contracept, often viewed long-acting methods with a great deal of suspicion. When policymakers moved quickly to establish Medicaid coverage for the new contraceptives, some poor women and women of color were suspicious. The suspicions of some women were deepened as well when judges sentenced women facing drug charges and other criminal convictions to become Norplant (the first contraceptive implant) users. Women who saw the new contraceptives as welcome additions to the range of choices available to them could accept some health risks and adjust to side effects that they were warned to expect. Women whose range of options was constrained by economic or other restrictions saw the risks and side effects as unacceptable threats to their health. These different perspectives, depending on race and class, have created political divisions within communities of women in the women's health movement and the reproductive rights movement.

By recognizing the ways that reproductive concerns are intertwined with the economic, political, social and cultural realities of women's lives, the reproductive justice framework creates the possibility of building understanding between the two communities and bringing them into greater accord – as well as enlarging the possibility for the emergence of a unified and strengthened movement speaking in one voice.

THINKING SOUTH: LOCATING A REPRODUCTIVE JUSTICE MOVEMENT

By Paris Hatcher, SPARK! Reproductive Justice NOW

The summer of 2007, Operation Save America, a violent anti-choice organization linked to terrorists like Eric Rudolph (Atlanta Olympic Games bombing and the bombing of a gay club and two abortion clinics) descended upon the New Woman All Women Clinic in Birmingham, Alabama, for its annual siege. As I stood across from an all-white mob that was using big photographs of Black children to justify their call to end abortion, I realized the importance of thinking about the South, specifically, and locating the South in our reproductive justice movement.

The idea of “thinking South” is more than pointing out this geographical area on a map. It means that we have to examine the essential role of the South in constructing race and gender in our society and giving context to our current reproductive justice movement. When Operation Save America presents itself as a group of “good” white folks protecting Black bodies, the anti-choice group is strategically drawing the connection between abortion and the racialized and violent history of the South.

The antis are clearly trying to attract people of color to their overwhelmingly white movement. But “thinking South” offers the reproductive justice movement an opportunity to challenge white supremacy and white control of our bodies and communities. The reproductive justice challenge springs directly from our memory of the Southern histories of genocide and slavery that shaped experiences of race, gender, class, and sexuality in this country.

Reproductive justice and multi issue social justice organizations based in the South know that our work is the continuation and re-articulation of the work of freedom fighters of our not so distant past. These fighters included the many nameless Black and Native women who knew herbs, used gynecological resistance, caught each others' babies, and built radical families and communities before, during, and after colonialism and slavery. These fighters persisted, continuing their work while they and their people were under attack, sold, bought, and killed. Thinking and locating our reproductive justice movement in the South honors the legacy of our foremothers and also provides a foundation to our current struggle.

As we move forward, the fight for reproductive justice, a movement that centers on the lives of women of color, must locate and think South. Beyond geography, the South offers an opportunity to channel movements and frameworks that have always been indivisibly linked to freedom, liberation, and reproductive justice. Although steeped in a rich and graphic past, the South as a political entity reminds us of our radical roots and of the on-going fight for our bodies, our communities, and our future.

RESOURCES

- SPARK! Reproductive Justice NOW (Formerly Georgians for Choice)
<http://www.georgiansforchoice.org>

THE HYDE AMENDMENT VIOLATES REPRODUCTIVE JUSTICE AND DISCRIMINATES AGAINST POOR WOMEN AND WOMEN OF COLOR

By Stephanie Poggi, National Network of Abortion Funds

Reproductive justice requires that all women and girls have the power and resources to make decisions about their bodies, lives, families, and communities.

Since 1976, the Hyde Amendment has violated these human rights by forbidding public funding of abortion – and thus, effectively denying the right to abortion to thousands and thousands of poor women. Because of the Hyde Amendment, women across the U.S. struggle to raise money to cover the cost of abortion. They often sacrifice food and other necessities and delay paying rent and utilities. Too often, they can't raise enough money and they are unable to obtain an abortion.

In 1973, after *Roe v. Wade*, low-income women who received health care through Medicaid were covered for abortions. Federal Medicaid paid for almost half of all abortions performed in the United States (270,000 abortions out of a total of 615,800 performed). But just three years later, Congress passed the Hyde Amendment, which banned Medicaid coverage of abortion. Since that time, federal Medicaid has covered virtually no abortions.

As Supreme Court Justice Thurgood Marshall noted in 1980, in his dissent to the Court's decision upholding the Hyde Amendment, "[F]or women eligible for Medicaid – poor women – denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether. By definition, these women do not have the money to pay for an abortion themselves."

Most states have also banned state Medicaid funding for abortion, and Congress has severely restricted abortion funding in virtually every federal program, including health programs for military personnel and their families, disabled women, federal prisoners, and women receiving care from Indian Health Services. For the more than 12 million women who depend on Medicaid and other federal programs, the impact of the Hyde Amendment and state funding bans is staggering. It is estimated that as many as one in three low-income women who would have an abortion if it were covered by Medicaid are instead compelled to continue the pregnancy.

Because of racialized poverty in the U.S., women of color disproportionately rely on public sources of health care; so the denial of Medicaid funding impacts these women most heavily. The fight to restore Medicaid coverage is an important matter of racial justice, as well as economic justice and women's rights.

The National Network of Abortion Funds, an association of 109 grassroots groups that help low-income women to pay for abortions, has joined with allies nationwide to launch the *Hyde – 30 Years is Enough!* Campaign. The campaign is fighting for expanded public funding of abortion on the state level, repeal of the Hyde Amendment, adequate support for low-income women to care for their children and families with dignity, and social justice for all. The *Hyde - 30 Years is Enough!* Coalition includes groups working on reproductive rights, health care access, prisoner rights, LGBTQ rights, labor rights, social justice and human rights. Participating organizations and campaign activities across the U.S. are at www.hyde30years.nnaf.org.

RESOURCES

- "*Abortion Funding: A Matter of Justice*," National Network of Abortion Funds, 2005 at www.nnaf.org

REPRODUCTIVE JUSTICE AND WOMEN OF COLOR

By Toni M. Bond, *African American Women Evolving*

When women of color look at reproductive health through a lens that considers race, class, and gender, they can begin to understand why embracing the reproductive justice framework is so important. We can recognize reproductive justice as the missing link in the larger movement's attempts to organize and partner with women of color. The reproductive justice framework highlights the intersectionality of race, class, and gender because it is rooted in the recognition of the histories of reproductive oppression and abuse in all communities, especially communities where women of color live. Reproductive justice highlights women's ability to exercise self-determination, including making decisions about their reproductive lives. Reproductive justice clarifies the ways that women's decisions are shaped by unequal access to power and resources, by the environment, by economics, and culture.

For women of color, embracing or using the reproductive justice framework in our work is second nature because the disparities in reproductive health are about more than the differences between the "haves" and the "have nots." Our struggle has been about reproductive autonomy; the right to have an abortion and also the right to conceive, bear, and raise children. Women of color understand how policies controlling welfare, access to contraceptives and other family planning services, abortion access, the war on drugs and the criminalization of women of color who use drugs, largely Black women, serve to further a white supremacist agenda that is still very much intent upon controlling the childbearing of Black women and other women of color. When we understand how these issues are all implicated in the concept of reproductive justice, we can see clearly that achieving human rights for all involves undoing all of these punitive and restrictive policies. Only then can women of color achieve social, political, and economic parity with whites, and full human rights.

Our lives are more than the value of our uteruses and when we experience reproductive oppression it impacts our total lives. Consequently, we cannot "overcome" one form of oppression without addressing other the forms of injustice we experience. As a woman of color working on reproductive justice at the grassroots level, it is imperative that I also fight against sexual and domestic violence, homophobia, HIV/AIDS, and substance abuse as a part of the fight for abortion access and the right to bear children. The reproductive justice framework recognizes the totality of my life as a woman of color and empowers me to do the work in ways that respect culture and embrace my leadership ability and potential.

We seek to build leadership from the margins to the center and organize grassroots constituencies to collectively affect institutional and policy changes so that we are able to obtain the best possible reproductive and sexual health.

RESOURCES

Women of color organizations grounded in the reproductive justice framework include:

- **SisterSong Women of Color Reproductive Health Collective** www.SisterSong.net
- **SisterLove** works to eradicate the impact of HIV/AIDS and other reproductive health challenges upon women and their families through education, prevention, support and human rights advocacy in the United States and around the world. www.SisterLove.org
- **Asian Communities for Reproductive Justice** places the reproductive health and rights of Asian women and girls within a social justice framework. ACRJ promotes and protects reproductive justice through organizing, building leadership capacity, developing alliances, and education to achieve change. www.reproductivejustice.org
- **National Latina Institute for Reproductive Health** works to ensure the fundamental human right to reproductive health care for Latinas, their families and their communities through education, policy advocacy, and community mobilization. www.latinainstitute.org
- **National Asian Pacific Women's Forum** is the only national, multi-issue APA women's organization in the country. Its mission is to build a movement to advance social justice and human rights for APA women and girls. www.napawf.org
- *Killing the Black Body* by Dorothy Roberts
- *Undivided Rights* by Loretta Ross, Marlene Gerber Fried, Jael Silliman, and Elena Gutierrez

REPRODUCTIVE JUSTICE ISSUES FOR ASIAN AND PACIFIC ISLANDER WOMEN

By Maria Nakae, Asian Communities for Reproductive Justice

Like all women of color, Asian and Pacific Islander (API) women in the United States are negatively impacted by policies and practices that aim to control their bodies, sexuality, and reproduction. Because this is a result of multiple systems of oppression based on race, class, gender, age, immigration status, and language ability, issues of reproductive justice for API women are inherently connected to their struggle for social justice. The following is a snapshot of the wide-ranging reproductive justice issues that impact API women.

Access to health care

API women face numerous barriers to health care, including lack of health insurance, weak enforcement of regulations that mandate interpretation and translation services, and health professionals who are untrained to serve diverse communities. Furthermore, cultural ignorance and discrimination by providers lead many women to distrust the medical system. A grave consequence is that API women do not use reproductive health services adequately. They have an extremely low rate of pap exams, resulting in a disproportionately high incidence of cervical cancer. Vietnamese have the highest rate of all ethnic groups, which is almost five times higher than white women.

Hazardous, low-wage employment

Barriers to health care are extremely problematic, considering API women are concentrated in low wage jobs with hazardous work environments and no employer-based health insurance or worker protections. For women who are undocumented or limited English proficient, there are few other opportunities for work besides the garment industry, nail salons, massage parlors, and electronics manufacturing. API women who perform domestic work are especially vulnerable to unregulated working conditions, and are often subjected to exploitation and abuse.

Human trafficking

To meet the demand for cheap and unpaid labor, women are trafficked illegally from countries across Asia and enslaved in domestic work, sweatshops, and the sex trade. Completely isolated from the outside world, trafficked women are extremely vulnerable to physical, sexual, and emotional violence. Without any access to health care, unwanted pregnancies, forced abortions, and sexually transmitted infections are common.

Exposure to environmental toxins

API women are frequently exposed to environmental toxins both in the workplace and at home. Nail salon workers are exposed to phthalates and other toxins, and workers in electronics manufacturing plants are exposed to chemicals and heavy metals that lead to miscarriage and birth defects. Many immigrant and refugee families from Southeast Asia have settled in low-income communities near polluting facilities that emit chemicals such as dioxin, a reproductive toxin that is linked to infertility, miscarriage, and birth defects.

Anti-immigrant policies

Immigration restrictions, backlogs, and deportation are major obstacles to family reunification, preventing API women from maintaining and caring for their families. Federal and state policies restrict non-citizens' access to public assistance and publicly funded health care and social services, including prenatal care. Citizenship documentation requirements for utilizing free and low-cost clinics cause many immigrant API women to delay or forgo care, even when care is necessary.

Every day, API women face challenges to their bodily self-determination. To achieve reproductive justice, API women must have the power and resources to decide and act on what is best for themselves, their families, and their communities in all areas of their lives.

RESOURCES

- Asian Communities for Reproductive Justice (ACRJ) www.reproductivejustice.org
- National Asian Pacific American Women's Forum (NAPAWF) www.napawf.org
- Khmer Girls in Action (KGA) www.kgalb.org
- *A New Vision for Advancing our Movement for Reproductive Health, Reproductive Rights, and Reproductive Justice*, by Asian Communities for Reproductive Justice
- *Undivided Rights: Women of Color Organize for Reproductive Justice*, by Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez
- *Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women*, by NAPAWF
- *Asian American Women: Issues, Concerns, and Responsive Human and Civil Rights Advocacy*, By Lora Jo Foo

REPRODUCTIVE JUSTICE AND LESBIAN, GAY, BISEXUAL & TRANSGENDER LIBERATION

By Alisa Wellek, *The Lesbian, Gay, Bisexual & Transgender Community Center* and Miriam Yeung, *National Asian Pacific American Women's Forum*

What is reproductive justice without the ability to fully express, control and affirm ones sexuality? Incomplete, at best.

The common ground for the LGBT liberation and the reproductive justice movements has a long and rich history even though we have often been strategically divided. Reproductive freedom was a lynchpin of the modern feminist movement of the 1960s and 1970s. New contraceptives and reproductive technologies liberated women from unwanted pregnancy as a consequence of heterosexual sex. When women could take control of their reproductive destinies, they also had more control over their own sexual pleasure. The freedom and legitimacy of sexual activity without reproduction as an outcome is as fundamental to the liberation of LGBT people as it is to heterosexual women and their male partners.

Legal advocates are perhaps the most aware of the intersections between our movements, for they can clearly see the connections in the work they do fighting for LGBT liberation and/or reproductive rights every day. The decisions in *Griswold v. Connecticut* (1965) and *Eisenstadt v. Baird* (1972) held first that criminal prohibition of contraceptive devices for married couples, and later for any individual, violated a fundamental right of privacy. These cases helped lay the groundwork for an argument that the individual has a right to decide how and when to engage in consensual sexual activity. Furthermore, the 2003 Supreme Court decision, *Lawrence v. Texas*, which decriminalized same-sex relations between consenting adults, relied upon two of the most influential reproductive rights cases—*Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992)—to emphasize that attacks on either of our struggles can no longer be separated.

Furthermore, an important aspect of the obstacles that face both of these movements concerns the right-wing political agenda that targets both reproductive freedom and LGBT rights. Proponents virulently pursue this agenda, seeking to control sexuality, gender conformity, reproductive choice and the legal definitions of family. They have been successful in influencing the make-up of the Supreme Court, supporting individuals committed to rolling back the hard-won gains of both our movements.

Policies sponsored by right-wing extremists attacking reproductive justice and LGBT liberation have detrimental effects on all of us. For example, the "Marriage Imperative" for low-income families not only works against women who are trying to escape abusive situations, but also actively discriminates against LGBT people who are not allowed to marry. Sex education programs that promote "abstinence until marriage" serve to deny young people information about safer sex and prevention of pregnancy and HIV/AIDS. They also further marginalize and alienate LGBT youth by defining their sexuality as pathological. Health insurance policies often refuse to cover contraception, emergency contraception, and abortion. Likewise, these policies often have restrictions on or lack of coverage for infertility services, especially services needed to create LGBT families. These are just a few of the many policy intersections that affect both our movements.

What can you do?

- Join our Causes in Common coalition www.causesincommon.org and be part of a growing national network of organizations committed to seeing connections in our movements and working toward shared goals.
- Make the connections between movements in your work. You can do this in your speech, in your literature, in joint forums, and in your outreach.

- Build campaigns around shared goals, such as comprehensive sex education. Be an ally even when your primary issue is not at the forefront.
- Educate others about the reproductive justice and human rights frameworks. Visit www.sistersong.net for information on trainings.
- Service providers can integrate reproductive health, LGBT competent services, transgender health care, and HIV/AIDS services.
- Learn more. Visit www.causesincommon.org to download *Causes in Common: Reproductive Justice and LGBT Liberation* and check out the resources page to find more recommended readings.

IMMIGRANT RIGHTS AND REPRODUCTIVE JUSTICE

By Jessica Gonzalez-Rojas and Aishia Glasford, National Latina Institute for Reproductive Health

It is hard to deny the invaluable economic, political and social contributions that immigrant communities have made in the lives of every U.S. citizen. However, many immigrants, especially, women and children who are of undocumented status, fall into the shadows of U.S. society as a result of the difficulties they have on the path to citizenship. According the Census data, there are approximately 17.5 million immigrant women in the United States today, 3 million of whom are undocumented, and 16 percent of whom live in poverty. These women encounter obstacles to employment and health access; they also face violence and discrimination. A fair and comprehensive approach to immigration reform addressing the needs of immigrant women including discriminatory and violent practices, would provide a solid foundation for immigrant women and their families to achieve social justice and integration into U.S. society. Immigrant rights and reproductive justice are intrinsically linked because the reproductive health of immigrant women is profoundly affected by immigration policy.

Advocates of fair immigration reform are demanding the right to: live in our society without fearing deportation and discrimination; have access to our educational, health, and safety-net programs and systems; and work with basic protections and benefits, including health care coverage. Reproductive justice activists are similarly fighting for women's equal opportunity to fully participate in society, the freedom to determine the course of their lives, and the right and ability to access basic reproductive health services free of discrimination, harassment and shame. Both our progressive social agendas have been called "radical" and out of the mainstream. We know, however, that our shared values of self-determination and the freedom to live our lives with dignity are anything but radical.

Immigration and abortion rights are two of the most volatile issues of our time. The anti-immigrant and anti-choice movements have been very successful over the last several years at eroding basic rights at the state and federal levels. It is important to recognize that many of the individuals who want to stop immigrants from accessing basic health services, including prenatal care, are the same ones who support restrictions on women's access to abortion and family planning services. In this very hostile political environment, advocates for reproductive rights and immigrant rights must support each other. We must work together to stop efforts to criminalize immigrants AND criminalize abortion. We must speak out together to demand legalization for undocumented immigrants AND to demand access to basic reproductive health care services. We must work together and support each other in our common quest for *salud, dignidad y justicia*.

With immigration reform looming, the time is now for reproductive health organizations dedicated to promoting the basic values of dignity, justice, and self-determination to raise their voices in support of fair and just immigration policies. We must advocate for the basic human right to health care, regardless of immigration status. We must continue to highlight how the right and ability to access health care information and services, including reproductive health care, is unjustly linked to racial, ethnic, socio-economic, sexuality and immigration status. The reproductive rights community must speak for immigration reform, including the rights and dignity of undocumented immigrants. This way, we can move one step closer to achieving reproductive justice and the American "dream."

RESOURCES

For more information and resources, or to get involved in the National Coalition for Immigrant Women's Rights, visit the National Latina Institute for Reproductive Health:

www.latinainstitute.org

MADE IN THE USA: ADVANCING REPRODUCTIVE JUSTICE IN THE IMMIGRATION DEBATE

By Priscilla Huang, National Asian Pacific American Women's Forum

Yuki Lin, born on the stroke of midnight this New Year's, became the winner of a random drawing for a national Toys "R" Us sweepstakes. The company had promised a \$25,000 U.S. savings bond to the "first American baby born in 2007." However, Yuki lost her prize after the company learned that her mother was an undocumented U.S. resident. Instead, the bond went to a baby in Gainesville, Georgia, described by her mother as "an American all the way."

The toy retailer soon found itself in the midst of the country's heated immigration debate. Under mounting pressure, Toys "R" Us reversed its decision and awarded savings bonds to all three babies, including Yuki. The issue of citizenship was at the heart of this controversy: Is a baby born to undocumented immigrants an American in the same way that a baby born to non-immigrant parents is? Since the 14th Amendment grants automatic citizenship to persons born on U.S. soil, both babies have equal standing as citizens. Not all people, however, view citizenship this way. As the grandmother of the Gainesville baby told reporters, "If [the mother is] an illegal alien, that makes the baby illegal."

Today's immigration debate extends beyond the goal of limiting the rights and humanity of immigrants: It's about controlling who may be considered an American. Anti-immigrant activists contend that American citizenship is not about where you were born, but who gave birth to you. By extension, they believe "the 14th amendment notwithstanding" that the government must limit the reproductive capacities of immigrant women. Thus, immigrant women of childbearing age are central targets of unjust immigration reform policies.

Anti-immigrant groups, such as the Federation of American Immigration Reform (FAIR), believe immigrant women of childbearing age are a significant source of the country's so-called "illegal immigration crisis" and want to limit the number of immigrant births on U.S. soil. They are calling for changes to *jus soli*, our birthright citizenship laws. Unfortunately, some Congressional members are listening. Recently lawmakers have introduced the Citizenship Reform Act which would amend the Immigration and Nationality Act to deny birthright citizenship to children of parents who are neither citizens nor permanent resident aliens.

Groups like FAIR assert that immigrant women enter the U.S. to give birth to "anchor babies," who can then sponsor the immigration of other relatives upon reaching the age of 21, all of whom create a drain on the country's social service programs. The irrational stance of anti-immigrant advocates echoes that of 1990's welfare reformers. Both assume that childbearing by immigrants or poor women of color creates a cycle of poverty and dependence on the government. Immigrant women and women on welfare are depicted as irresponsible mothers and fraudulent freeloaders.

They're wrong. Several studies have shown that immigrants "documented and undocumented" access social welfare services at much lower rates than U.S.-born citizens. Furthermore, under the 1996 Welfare Reform Act, new immigrants are barred from accessing Medicaid benefits for five years, and sponsor liability rules often render many of these immigrants ineligible for services even after that expiration date. And there is no evidence of intergenerational welfare dependency between immigrant parents and children.

Not surprisingly, pregnant immigrant women have become targets for deportation by immigration officials. On February 7, 2006, Immigration and Customs Enforcement (ICE) officials tried to forcibly deport Jiang Zhen Xing, a Chinese woman pregnant with twins. While her husband and two sons waited for her to complete what should have been a routine interview in a Philadelphia immigration office, ICE officials hustled Mrs. Jiang into a minivan and drove her to New York's JFK airport for immediate deportation back to China. After complaining for hours of severe stomach pains, she was eventually taken to a hospital where doctors found that she had suffered a miscarriage.

Mrs. Jiang had lived in the U.S. since 1995. Although she entered the country as an undocumented immigrant, she made an agreement with the ICE in 2004 that allowed her to remain in the U.S. as long as she attended routine check-in interviews at a local immigration office. Jiang's case raises an important question: Why would immigration officials be in such a rush to send a pregnant woman back to her country of origin after she had been allowed to stay in the U.S. for over 10 years? Supporters of Mrs. Jiang and other immigrant women targeted while pregnant believe the harassment stems from nativist fears of immigrant mothers giving birth to U.S.-citizen children.

Anti-immigrant policy makers and advocates are also trying to exploit anti-immigrant hysteria as a vehicle for denying all women the right to reproductive autonomy, and are manipulating the issue of immigration reform to advance an anti-choice agenda. In November 2006, a report from the Missouri House Special Committee on Immigration Reform concluded that abortion was partly to blame for the "problem of illegal immigration" because it caused a shortage of American workers. As the author, Rep. Edgar Emery (R), explained: "If you kill 44 million of your potential workers, it's not too surprising we would be desperate for workers."

Contemporary immigration reform policies recall the early 1900s eugenics movement, which was rooted in the fear that immigrants (and other undesirable groups) were out-breeding "old stock" Americans. Like the anti-immigrant advocates of today, eugenicists believed that curbing the fertility of such socially unfit groups would help reduce social welfare costs.

Clearly, then, immigrant rights has become a reproductive justice issue. We must challenge the assumption that immigrant mothers are the country's new welfare queens, and reexamine what makes a newborn "an American all the way."

What You Can Do

- National Asian Pacific American Women's Forum (www.napawf.org) for fact sheets and issue briefs on a range of reproductive justice issues impacting API women.
- Justice for Jiang Zhen Xing Campaign (www.aounited.org) contact: Helen Gym
- Encourage your organization to join the National Coalition of Immigrant Women's Rights (contact NAPAWF for more information).
- Oppose any efforts to pass the Citizenship Reform Act (H.R. 133) or similar bills that seek to deny birthright citizenship to the children of immigrants.
- Ask your local health provider to provide culturally competent and linguistically appropriate services to all members in your community.

INCARCERATED WOMEN AND REPRODUCTIVE JUSTICE

By Rachel Roth

Imprisonment is a critical issue for people who care about reproductive justice, because it endangers women's health, jeopardizes women's right to motherhood, and takes a disproportionate toll on poor women and women of color. The United States has the largest imprisoned population in the world, with the number of women rising from about 14,000 in the early 1970's to more than 200,000 today. These numbers reflect policy choices, including mandatory sentencing policies that harshly punish even minor, non-violent, drug-related offenses, as well as racial biases in policing and prosecution. Historically, there has been little accountability for what goes on behind prison walls, but a growing number of activists are working to change that.

Women tell deeply troubling stories about the way that imprisonment undermines their right to determine their reproductive lives. Many jails and prisons restrict women's access to abortion, even though women do not lose their right to have an abortion simply because they are imprisoned. On the flip side, women report that prenatal care is often sub-standard, miscarriage not treated as a medical emergency, and shackling common during labor and childbirth. Women also report a dangerous lack of routine preventive care. Without timely Pap tests or treatment for ovarian cysts, for instance, women may wind up with life-threatening conditions and major surgery, including hysterectomies. This medical neglect not only threatens women's future ability to have children, but women's very lives.

Most imprisoned women are mothers. Maintaining relationships with their children is incredibly challenging, thanks to limited visiting hours, the exorbitant cost of collect phone calls, and distance from home. In many states, women's prisons are in remote rural areas, even though most of the women come from cities; some women are sent to serve their time in other states. Worse yet, women who must place their children in foster care risk losing them forever.

Having a criminal record, especially a felony drug conviction, which so many women have, severely compromises another core component of reproductive justice – the ability to be a parent to one's children. This is because federal and state policies make it difficult or impossible for people with felony convictions to get public housing, food stamps or public assistance (TANF), student loans, or jobs – exactly the things that low-income women need to take care of their children. Without a place to live, women cannot regain custody of their children and begin the process of renewing family life together. Because many people with felony convictions are denied the right to vote, they cannot participate in the traditional political process to influence the policy decisions that directly affect their lives.

In addition to the impact on individuals and families, imprisonment exacts a price from all of us. At \$60 billion per year, the budget for locking people up drains resources from initiatives that would foster reproductive justice, such as universal health care, substance abuse treatment, education, child care, and public works. And, finally, relegating an ever-bigger group of people to permanent second-class citizenship is at odds with an open and democratic society.

RESOURCES

There are few national resources for women in prison, let alone organizations working at the intersection of reproductive justice and imprisonment. All of the organizations below have something to offer, whether resources for women coming home or for families with a parent in prison, or resources specifically for the struggle for reproductive justice. All of these organizations have web sites, often with links to other groups and with articles and reports that can be downloaded for free.

- American Civil Liberties Union (national office and local chapters) ; see especially "Your Right to Pregnancy-Related Health Care in Prison or Jail," a fact sheet with contact information for women needing assistance to obtain an abortion or prenatal care

- American Friends Service Committee (national office and local chapters)
- Amnesty International (national office and local chapters)
- Critical Resistance (national office and local chapters)
- Family & Corrections Network, with link to the Children's Bill of Rights for children with parents in prison
- Human Rights Watch www.hrw.org
- Legal Action Center, *After Prison: Roadblocks to Reentry* (information on all 50 states)
- National Advocates for Pregnant Women www.advocatesforpregnantwomen.org
- California: Center for Young Women's Development, Justice Now, Legal Services for Prisoners with Children
- Washington: The Birth Attendants
- Illinois: Chicago Legal Advocacy for Incarcerated Mothers
- Georgia: Aid to Children of Imprisoned Mothers, Inc.
- District of Columbia: Our Place, DC, and DC Prisoners' Project of the Washington Lawyers' Committee for Civil Rights and Urban Affairs
- Maryland: Power Inside
- New York: Correctional Association of New York, Women in Prison Project
- Women and Prison: A Site for Resistance www.womenandprison.org
- *Defending Justice: An Activist Resource Kit* www.defendingjustice.org
- *Feminist Studies* vol. 30, no. 2 (2004) and *Social Politics* vol. 11, no. 3 (2004), special issues on women and prison

REPRODUCTIVE JUSTICE: A MOVEMENT OF RESISTANCE LED BY GIRLS AND TRANSGIRLS INVOLVED IN THE SEX TRADE AND STREET ECONOMY

By Young Women's Empowerment Project

Young Women's Empowerment Project is a project by and for girls and transgender girls in the sex trade and street economies. We are a project that is about building sisterhood in our communities and our hoods. For us the sex trade is a social justice issue because it is a massive system that impacts people from all walks of life especially girls, transgender girls, and young women of color. We believe in taking care of ourselves and empowering each other to take control of our own lives. We believe in building bridges between girls and transgender girls, between those of us who are survivors of forced involvement and those of us who do what we have to do to survive and make the best choices we can.

YWEP believes that we are especially affected by the sex trade because racism, sexism, male dominance, ageism, the prison industrial complex and the drug war target us and our communities. The sex trade and streets economies exist and thrive because of the lack of resources, choices, support, education and respect.

We fight back by making sure our voice is heard at the national level in Third Wave's Reproductive Health and Justice Initiative Network. We do youth-to-youth outreach, supporting hundreds of girls with health-based harm reduction information on our bodymindspirit. Our popular education workshops teach us underground methods to take care of our bodies, since we can't always get healthcare.

Our vision of reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of girls and queer peoples. We want the power and resources to make healthy decisions about our bodies, sexuality for ourselves, our families, and our communities.

Reproductive Justice means harm reduction. It looks like non-condemning, just and accessible treatment. It looks like an end to the police state, an end to sexual violence, harassment, gender profiling, and brutality. It looks like an end to the prison industrial complex and the militarization and gentrification in our communities.

Our reproductive justice movement work denounces violence against our constituents. We demand an end to the criminalization of young mothers who use drugs, or have forced abortions/sterilization and experience poverty. We stand in solidarity with sisters killed due to misogyny, sex or gender, age or race/ethnicity and victims of femicide.

Although society blames us, we call out the systems that are responsible. We are here to fight against misogyny and hold our oppressors accountable. We support acts of rebellion and resistance; all girls building and keeping sisterhood, and we fight for reproductive justice that acknowledges the realities and complexities of our lives. We know females may have tendencies to hate other females, but to females everywhere we say: It's easier for our oppressors to try and take us down one by one, but if we stand together as a group, nothing can stop us.

RESOURCES

- Young Women's Empowerment Project - <http://www.youarepriceless.org>

DISABLED WOMEN AND REPRODUCTIVE JUSTICE

By Mia Mingus, SPARK Reproductive Justice NOW

In the United States, a culture of ableism, which maintains that able-bodied people are superior and most valuable, prevails. In this culture, disability is feared, hated, and typically regarded as a condition that reduces the value of disabled people. The reproductive justice framework helps us understand how eugenic "science" is still a vibrant part of U.S. culture that interacts with and shapes the reproductive lives of disabled women in many ways.

Right to Parent

Women with disabilities (WWD) have a long history of forced sterilization, are often seen as "unfit" mothers and are discouraged from having children, or not allowed to adopt children. Authorities press disabled women to feel guilty for their decisions to be parents, pointing out that their decision will take a "toll" on their children, families, communities and on themselves.

Sexuality

Society typically defines disabled women as asexual and as dependent on able-bodied people, undermining these women's access to reproductive health. Disabled women and girls often do not receive sex and reproductive health education. Health care providers may fail to ask WWD about their sexual lives, conduct full pelvic exams or screen WWD for STD/HIV, because it is assumed that these women do not have sex, or that they should not have sex. Because disabled women are seen as possessing less than "valuable" or "functional" wombs to carry children, their reproductive health may go unchecked and uncared for. WWD, a group with pathologized bodies, have the right to receive care and also the right to refuse it.

Access to Services

Women with disabilities have limited access to health care services and information. WWD may not have access to suitable transportation (mass transit, use of a wheelchair-accessible automobile). Clinic facilities may be inaccessible (lacking ramps, Braille, sign language interpreters, equipment). Reproductive health information may not be accessible to WWD due to issues surrounding language and interpretation, isolation due to the level of stigma still associated with most forms of disabilities, dependency on care givers, and limited access to other WWD. Disability and class also may limit WWD's access to computers, communication devices, or mobility equipment. Women with mental disabilities also encounter barriers when it comes to accessing reproductive health services: they may be institutionalized, vilified as drug users and addicts. These women may not be allowed to have a role in decisions regarding their reproductive health and their bodies.

Sexual Violence

Violence against disabled women and girls is very common. Power imbalance and isolation can create special vulnerability (domestic violence, sexual assault, abuse) for disabled women dependent on caregivers. Caregivers (partners, nurses, family members, doctors) may withhold medication, medical care and information, or transportation as an expression of power and control.

Eugenics/Population Control

The continuing power of eugenic thought in the U.S. justifies population control measures for WWD and disabled children. The medical establishment pathologizes "disabling traits," associates these traits with "social problems," and defines them as targets to "cure" and "conquer." Disabled women have been routinely sterilized or maintained on birth control, such as Depo-Provera which stops periods and prevents conception. These practices have been convenient for care givers and institutions. While traditionally the project of wiping out disability has centered on eliminating disabled bodies, today, Inheritable Genetic Modification (IGM), aims to modify the human gene pool to exclude genes that cause (or might cause) various disabilities.

The use of Prenatal Diagnostics (ultrasounds and amniocentesis) to deselect and abort fetuses with disabilities (down syndrome, spina bifida, muscular dystrophy, sickle cell anemia and many more), illustrates the deeply entrenched ableism among women and the culture-at-large. While many pro-choice TAB feminists argue for the right to abortion, many disabled feminists question the inherent ableism that surrounds the decisions to abort.

The framework of reproductive justice provides an analysis grounded in human rights and collective social justice. "Justice," rather than "right to privacy," allows for a broader analysis and more complicated approach to the politics and challenges surrounding WWD and reproductive justice. For many WWD, the right to privacy is not a privileged experience in relation to one's body. Disabled women and girl's bodies have long been invaded and seen as the property of the medical industry, doctors, the state, family members, and care givers. The goal should not be to "cure the world of disabilities" or to do away with disabled people. The goal should be to work for communities that provide accessible opportunities and resources, human rights, and reproductive justice for WWD.

RESOURCES

- www.genetics-and-society.org
- www.worldenable.net/women/default.htm
- <http://disabilitystudies.syr.edu/resources/motherhood.aspx>
- www.crlp.org/pdf/pub_bp_disabilities.pdf
- www.disabilityhistory.org/dwa/edge/curriculum
- <http://hrw.org/women/disabled.html>
- www.disabilityhistory.org/dwa/index.html
- Shelly Tremain, *Bio-Politics, and the Government of Impairment in Pregnancy*, Hypatia, 2006
- Rickie Solinger, ed., *Abortion Wars: A Half Century of Struggle, 1950-2000*, Berkeley: University of California, 1998
- Eric Parens and Adrienne Asch, *Prenatal Testing and Disability Rights*, Georgetown University Press. 2000.
- U.S. Disability Authors: Adrienne Asch, Marsha Saxton, Anne Finger, Laura Hershey, Mary Johnson, Deborah Kaplan, Peg Nosek, Carol Gil, Lisa Blumberg, Anita Silvers, Debra Kent, Simi Linton.

THE MYTH OF NORM: GENETIC TECHNOLOGIES AND THE DE-SELECTION OF DISABLED BODIES A REPRODUCTIVE JUSTICE PERSPECTIVE

By Mia Mingus, SPARK! Reproductive Justice NOW, and Patty Berne, Center for Genetics and Society

The myth of the "normative body" is everywhere – cultural messaging includes how our bodies should look, move, function, smell, feel, and so on. The "normative body" rests upon the idea that certain bodies are valuable or useful, while other bodies are disposable or "burdensome". We are taught that bodies which exist outside of this "norm" are inherently wrong and must be treated differently from "valuable" bodies. Too many people imagine bodies of color, disabled bodies, poor bodies, female bodies, queer bodies, genderqueer bodies, fat bodies, drug addicted bodies, old bodies, sick bodies as bodies which need to be policed and controlled.

A thorough understanding of the myth of the "normative body" and its impacts on different communities (as well as its impacts on bodies which occupy one or more of these groups,) requires an intersectional analysis. In using a framework that holds multiple experiences and connects multiple systems of oppression, we can resist the idea of the "good body" or, in contemporary lingo, the body that results from the "good gene".

Designing the Body

Within this construct of "desirable" and "undesirable" bodies, emerging assisted reproductive and genetic technologies (ARGTs) are developing at breakneck speed. The new technologies are emerging, in fact, far more quickly than the vocabulary and public dialogues we need to discuss these developments. ARGTs include technologies which "test" sperm and/or embryos for a particular genetic characteristic. In conjunction with in-vitro fertilization, a woman, couple or prospective parent can use sperm sorting or PGD (pre-implantation genetic diagnosis), then select for or against a given characteristic. Prospective parents make choices, for example, to implant an XX or an XY embryo, or to implant an embryo without the genetic markers associated with Down's syndrome, spinal muscular atrophy, or early Alzheimer's, to name a few.

The current public dialogue often refers to individual choices, for example, a couple selecting an XX embryo because of their gender-based hopes and expectations for their new family member. Yet individual choices are made within a social context which privileges some bodies and lives and devalues others. The social implications of these individual choices must be included as part of the discussion and analysis as well.

Eugenics: improving the human species through genetics

Many strategies are currently used and have been used historically to ensure that "valuable" bodies reproduce and parent and that the reproduction of "unacceptable" persons is restricted. Politicians and other authorities have institutionalized the forced sterilization of people with disabilities. They have enacted laws criminalizing mixed-race marriage. They have legislated "family caps" on welfare benefits, restricting reproduction options for poor women. Generally, society has provided incentives for white "educated" young women to become egg "donors" and has celebrated a middle class white couple's hyper-fertility, for example, when sextuplets are born into such a family. We believe that without broad dialogue about emerging assisted reproductive and genetic technologies, the eugenic potential for these new modalities is all too likely.

Reproductive oppression includes both limiting choices that individuals can make and also limiting the contexts in which we can make them. White supremacy, heterosexism, male supremacy, ableism, the power of the medical industrial complex, and economic exploitation are all mechanisms of oppression that become enacted through reproductive means, targeting both individuals and communities.

As reproductive justice activists, we must find ways to organize against and resist the oppressive uses and impacts of ARGTs. Building alliances and coalition among different movements and

communities can help to ensure that we are not advancing the rights of some over the rights of others. Building alliances also allows us to create a space where we can begin to strategize and organize collectively. Reproductive rights advocates are committed to keeping abortion legal. Disability activists have voiced critical concerns about the use of prenatal diagnostic tests and ARGTs to select against the birth of a child with differing abilities. LGBTI people and queer communities offer models of family which centralize intentional relationships and longstanding kinship, challenging the value placed exclusively on biological children while simultaneously affirming our rights to use ARGTs to create families. All of these movements offer lessons. It is in these intersections that we find the essential work of reproductive justice. ARGTs provide us a critical opportunity to unflinchingly place "justice" at the center of our organizing, resistance and movements.

RESOURCES

- Center for Genetics and Society - www.geneticsandsociety.org
- The British Council of Disabled People - www.bcodp.org.uk/library/genetics
- Gender Justice in the Gene Age - www.gjga.org/conference.asp?action=item&source=documents&id=79
- "Disability Equality and Prenatal Testing: Contradictory or Compatible?" Adrienne Asch, Florida State University Law Review, 2003
- Prenatal Testing and Disability Rights, Hastings Center Studies in Ethics Series, Erik Parens and Adrienne Asch (eds.), Georgetown University Press, October 2000

REPRODUCTIVE JUSTICE FOR ALL PREGNANT WOMEN

By Lynn Paltrow, National Advocates for Pregnant Women

By focusing on the rights of all pregnant women, including those who are continuing their pregnancies to term, those who are young, low income, of color, and those who use drugs, National Advocates for Pregnant Women (NAPW) believes that we can broaden and strengthens the reproductive and women's rights and other progressive movements in America today. By shifting the reproductive rights paradigm – from one focused on abortion to one that focuses on the shared values at the heart of a range of interrelated reproductive, social and family justice issues – we can speak to and engage millions of potential new advocates and activists.

NAPW sees the common threads and threats connecting women who have abortions and those seeking to continue their pregnancies to term.

Sixty-one percent of women who have abortions are already mothers, and most of the remaining 39% will go on to become mothers. Over the course of their lives, 85% of all women bring life into this world and provide the vast majority of care for the lives of those around them — without compensation. Yet women's needs are rarely the focus of legislation. Nor do our lawmakers seem particularly interested in the needs of children.

While the U.S. was reinterpreting the Children's Health Insurance Program to allow states to cover the "unborn," more than 46 million people, including 9 million children and millions of women in the US of childbearing age, were uninsured.

At the same time as Congress voted the Unborn Victims of Violence Act into law, the US was simultaneously deregulating coal burning power plants that release significant amounts of mercury — which is especially poisonous to fetuses and children — into the environment.

Our lawmakers' consideration of more than 600 abortion related bills a year creates the illusion that the only aspect of pregnancy that needs attention is abortion. In reality far too many pregnant and birthing women lack access to the kind of care, support, and critical information they need.

The rate of caesarean section has soared in the US, where more than one million women each year — that's one in three — now have this surgical intervention, despite the fact that it is often unnecessary and can increase risks for mothers and babies alike. Yet only two states mandate hospitals to disclose their c-section rates.

The US routinely pumps money into pregnancy "crisis centers" whose primary purpose is to deter women from having abortions — despite the fact that staff have been documented providing false and misleading information. Yet birthing centers and drug treatment programs for pregnant and parenting women in many parts of the US lack the funding they need to stay open or to meet the pressing demands for these services.

The abortion issue has been used with stunning effectiveness to divide the electorate. But there are a surprising number of issues on which all pregnant women and mothers have shared interests. All women need resources that will enable them to have healthy children and strong families; many women, regardless of their views on abortion, do not possess these resources.

America is the only industrialized nation that does not have a system of national health insurance and is one of only two that does not require any paid maternity leave. Moreover, millions of pregnant women, especially those who work part-time or for small companies — and regardless of their views on abortion — lack legal protection from workplace discrimination based on pregnancy.

By listening to and working with those who advocate for women seeking to go to term and by redirecting attention and energy to affirmative legislation that ensures policies made to advance a culture of life that actually values the women who give that life, we can stop the focus on abortion and advance reproductive justice for all women.

RESOURCES

- To learn more about NAPW go to: www.advocatesforpregnantwomen.org
- If you agree that it is time to stop allowing the abortion issue to dominate our legislatures and that it is time start focusing instead on promoting policies that will further the health and human rights of all pregnant, birthing, and parenting women look at NAPW's fact sheet offering positive policies that can you support as an alternatives to anti-abortion, fetal rights, and punitive pregnancy bills being introduced across the country: <http://advocatesforpregnantwomen.org/YourState%3F.pdf>
- The Coalition for Improving Maternity Services: <http://www.motherfriendly.org>
- Citizens for Midwifery: <http://cfmidwifery.org>
- The International Cesarean Awareness Network: <http://www.ican-online.org>
- Choices in Childbirth: <http://choicesinchildbirth.org>
- International Center on Traditional Childbearing: <http://www.blackmidwives.org>
- *Unbending Gender: Why Work and Family Conflict and What to do About It* by Joan Williams
- African American Women Evolving: <http://www.aaweonline.org>
- Momsrising.org: <http://momsrising.org>

And don't just sit there. When you read, see, or hear remarks that undermine the value of women and the work they do speak out. Complain to your local newspapers and media stations when they use disparaging and false terms like "crack moms" and "crack babies," used to justify arrest and punishment (not treatment) of pregnant women. Speak out when abortion is compared to the Holocaust or Slavery and pregnant women who have abortions are analogized to Nazis and slaveholders. Speak out when legislators who claim to support a culture of life, fail to value the women who give that life! Meet for tea or coffee with the midwives and birthing activists in your community, find the common ground and work together on at least one project you can agree on.

MEN AND REPRODUCTIVE JUSTICE

By Rus Ervin Funk, MensWork: Eliminating Violence Against Women, Inc.

The reproductive justice movement focuses primarily on women. There is little in the discourse of the movement that either mentions men or is relevant to men. For the most part, this is both necessary and as it should be. Reproductive justice does, largely, need to be focused on the voices and experience of women – with women in the leadership. Women clearly face graver limitations and attacks on their reproductive options and behavior than men, and reproductive issues impact women much more directly and profoundly than they do men.

Men do have a role and should have a voice, but it is important to recognize that some “men’s rights” activism constitutes threats to women (and ultimately, to men’s own) access to reproductive justice. For example, men have made efforts to expand father’s rights and to increase men’s ability (as fathers or husbands) to limit women’s access to abortion.

Still, men can play many roles in expanding reproductive justice. For example, men can work to ensure their own reproductive health and can work for adequate community resources and services to meet men’s reproductive health needs – resources that are currently unavailable to many men. Men have a role to play in supporting their partners as they seek a full range of reproductive health services. Men also have a role in working to stop sexist violence, a widespread barrier to women’s (and men’s) reproductive justice. Studies have linked childhood sexual abuse and teenage sexual risk-taking and sexual abuse to a wide variety of health-related problems.

All forms of male sexual violence, including domestic and dating violence, rape and sexual assault, sexual harassment, pornography and prostitution, are sexist because they are overwhelmingly perpetrated by men against women and because they work in concert to maintain men’s unearned dominance over women. Each of these forms of violence and abuse occurs in a broader sexist context in which women’s lives are systematically devalued, while men’s lives are systematically overvalued.

Men’s violence against women is perpetrated in ways that directly limit women’s reproductive options and health (such as targeted violence during pregnancy, or sabotage of contraception) and in ways that indirectly limit women’s reproductive options and health (such as looking at women primarily as sexual or reproductive objects, or coercing women to have sex when they don’t freely choose to).

The sexist context in which men’s violence against women occurs is also the context in which women’s reproductive justice is limited and in which women’s voices are silenced. When men support women’s efforts to expand reproductive justice, men are engaging in work to eliminate sexism (and all other forms of oppressive systems including, but not limited to, racism, homophobia, classism, able-ism, and age-ism). Only by creating an environment of gender justice will we succeed in creating and maintaining reproductive justice and a world in which women (and men) are free from all forms of men’s violence.

Men’s work to end sexist violence occurs on two levels: the personal and the social or collective. It is essential, though not enough, for men make a personal commitment to be respectful to women in their lives and to give up abusive behavior. It is critical, but not enough, for men to work collectively to address institutional sexism, racism and homophobia (in attitudes, beliefs social norms and institutional practices) that allows, excuses, and encourages men’s violence – and which continues to limit women and men’s access to reproductive justice. Men’s work is “both-and.”

On the personal level, men must work to ban gender, racial and homophobic slurs from our personal vocabularies and stop tolerating this language in those around us. We need to stop undermining women’s authority, voice, and inherent power. We need to pay attention to how

our own sexual and reproductive behaviors interfere with women's (and other men's) sexual and reproductive rights. We need to support women (and ultimately on ourselves) by donating to and fundraising for organizations supporting reproductive justice. We need to ask women if it's okay to touch them and how. We need to stop using pornography, and never visit strip club or use a woman or man who has been prostituted. (As a men's group in Philippines says, "Real men don't buy women.") We need to wear condoms. We need to shut up and listen to what women have to say.

On the collective and social level, we need to organize locally to support women's rights. Organizations such as MensWork: Eliminating Violence Against Women (Louisville, KY), Men Stopping Violence (Atlanta, GA), A Call to Men (New York, NY), Men Ending Violence (Seattle, WA), are examples of local and effective organizing by men. Men need to organize marches, demonstrations, fundraisers and other public events (and provide child care) supporting reproductive justice. We need to join women as they work for reproductive justice.

As Frederick Douglass said, "It is not up to men to give women what is rightfully theirs." It is decidedly *not* men's role (or place) to "give" women reproductive justice (including the freedom from men's violence). Reproductive justice is what women inherently own. Men's role is either to actively support women's efforts to expand reproductive justice, or get out of the way. The work that men can do, both individually and collectively, is limitless. We (men) simply need to begin.

RESOURCES

- MensWork: Eliminating Violence Against Women - <http://mensworknb.com/english.htm>
- Men Stopping Violence - <http://www.menstoppingviolence.org>
- A Call to Men - <http://www.acalltomen.com>
- Men Ending Violence - <http://www.vahealth.org/civp/sexualviolence/menendingviolence>

ADOPTION AND REPRODUCTIVE JUSTICE

By Laura Briggs, University of Arizona

Human rights in relation to adoption are often framed as the right *to* adopt. Law and practice discriminates between "proper" families and those that may be banned from adopting: lesbian and gay people, single people, impoverished people, people with disabilities, and so forth. Normalizing and judgmental limitations on who can adopt are reproductive justice issues. The broader question though is whether the "need" to put a child up for adoption is a signal that the conditions of reproductive freedom are not being met. In the United States and Western Europe since the 1970s, fewer children have been "available" for adoption as women have had more access to family limitation methods and the resources to raise their children as single mothers. For the most part, the only children available for adoption are those forcibly separated from their mothers and families by the state under charges of abuse and neglect—disproportionately children of color, suggesting that this kind of policing of families is racist. As movements for reproductive freedom have had increased success, adoption has become rarer.

As a result, people from wealthy countries have sought adoption from poorer ones. Concerns about adoption have led human rights activists to seek and win the 1993 Hague Convention on Intercountry Adoption. It says that keeping families together is preferable to adoption, and intra-country adoption, to inter-country adoption. In most countries, the trend is toward national adoption. A handful of countries—Guatemala, China, Russia, and South Korea, alongside some Eastern European countries and a small but growing number of African nations (Ethiopia, Liberia)—continue sending large numbers of children into intercountry adoptions. Legal obstacles or high costs in these nations limit intra-country adoptions. In China, growing restrictions on transnational adoption and reports of declining orphanage populations seem to signal the expansion of national adoption. The Hague framework tries to ensure that birth parents relinquish their children by choice. However, a reproductive justice framework would ask whether "choice" is a meaningful concept under the conditions of growing material scarcity in, say, the lives of rural indigenous people in Guatemala—the group with the highest per capita rate of adoption. Scholars have argued that what characterizes South Korea and China are work rules in manufacturing plants that prevent women from keeping their jobs and having a child, and neoliberal governments that fail to build a welfare system to support women and children. Although rarely noted, the U.S. is also a "sending" country for children into transnational adoptions.

In the U.S., there has been significant activism for "open records" in adoption. Groups like Bastard Nation have insisted that adoptees have a right to know their origins, arguing that the desire to protect the identity of birth parents is conservative and sexist, about hiding the "shame" of single motherhood. In a different vein, in the 1970s, racial justice groups argued that widespread adoption of Black and indigenous children by white families represented a denigration of African-American and Indian families, and fought to persuade social workers and lawmakers to at least favor in-group child placement.

Some of the most significant adoption activism has been in Latin America, where human rights groups have fought to reunite the children "disappeared" during the civil wars and dirty wars of the 1970s-90s with surviving family members. From Argentina to Guatemala post facto amnesties pardoned those who tortured, murdered, and disappeared civilians during these wars. The disappearances of children and their adoption has proven to be the one "dirty war" crime that could be prosecuted, as it continued beyond the period of amnesty. In 2005 in El Salvador, Pro Busqueda won damages and a judgment from the International Court of Human Rights that the Salvadoran military had indeed disappeared children. In Argentina, The *Abuelas de la Plaza de Mayo*, HIJOS, and other relatives mounted a 15-year campaign to establish their relationship to the adopted children of prominent families through DNA testing, and in June 1998, former president Jorge Rafael Videla was arrested and convicted for running a government-sponsored illegal adoption operation during the Dirty War. He remains under house arrest.

RESOURCES

- Kay Johnson, *Wanting a Daughter, Needing a Son: Abandonment, Adoption, and Orphanage Care in China* (Yeong and Yeong Book Company, 2004).
- Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (New York: Basic, 2002).
- Bastard Nation <http://www.bastards.org>
- Fedefam La Federación Latinoamericana de Asociaciones de Familiares de Detenidos-Desaparecidos (Latin American Federation of Associations of Family Members of the Detained-Disappeared) <http://www.desaparecidos.org/fedefam>

TRANSNATIONAL AND TRANSRACIAL ADOPTION: THE RIGHT OF POOR WOMEN OF COLOR TO KEEP AND RAISE THEIR CHILDREN

By Jane Jeong Trenka, Sun Yung Shin, Julia Chinyere Oparah, Jae Ran Kim, and Shannon Gibney

Since the 1980s, the dramatic increase in *transnational* adoption has generated a *transracial* adoption boom. According to the U.S. Department of State, a growing number of US citizens are choosing to adopt children from overseas due to a perceived reduction in the number of healthy infants available within the country. In 1992, the United States issued 6,472 “orphan” visas for internationally adopted children. Ten years later, the figure had risen to 20,099. Most of these children came from East Asia, Eastern Europe, and Latin America. This shift in adoption patterns is also due to the valuing of European, Latin American and Asian children over Black children, and prospective adopters’ desire to adopt children who do not come with the “baggage” of home communities and potentially interfering family members nearby. While the United States is the largest adoption industry “consumer,” thousands of children are also brought to Western Europe, Canada, and Australia for adoption each year.

Discussions about adoption have typically separated adoptees who were adopted across racial lines within their country of origin (often referred to as “transracial adoptees”) from those who were adopted transnationally (referred to as “international” or “intercountry” adoptees). This separation prevents us from recognizing our commonalities as a source of solidarity. It also suggests that the problems facing transnational adoptees are primarily related to finding a family and adapting to a new country, rather than to the traumatic experiences of racism, marginalization, and discrimination, both systematically and on the personal level, within our adoptive communities. Increasingly, many of us who have been described in the adoption literature as intercountry or international adoptees have decided to redefine ourselves as *transracial* adoptees. This redefinition emphasizes how relentless our racialization has been throughout our lives.

As adult, politicized *transracial* adoptees, we are united across national, ethnic, and cultural borders by our experience. We are determined to make connections between personal struggles and broader movements for peace and justice. We are committed to challenging the use of transracial and transnational adoption as a panacea to social ills rooted in colonial histories and contemporary global inequalities. Moreover, we reject the idea that the increasing popularity of transracial adoption heralds the dawning of a new era beyond race and racism.

At the heart of our adoptions are the reproductive choices of our mothers – choices that were most often made in the context of limited options. For us, reproductive rights can never be reduced to the right to a safe and legalized abortion or freedom from dangerous contraceptives or forced sterilization. Instead, we must work to create and sustain a world in which low-income women of color do not have to send away their children so that the family that remains can survive. How can this emerging movement of politicized, adult transracial adoptees, connect with other movements for social justice – such the labor movement, environmental movements, anti-globalization efforts, and women’s movements – to create a more just world for our mothers, and for the millions of women like them across the world?

RESOURCES

- www.outsiderswithin.com
- harlowmonkey.typepad.com

FOSTER CARE AND REPRODUCTIVE JUSTICE

By Dorothy Roberts, Northwestern University

We should extend our struggle for reproductive justice to challenge the foster care system because it violates thousands of women's right to parent their children. Most of the billions of dollars spent by the U.S. child welfare system go to removing children from their homes and maintaining them in foster care. Foster care is a political institution reflecting social inequities, including race, class, and gender hierarchies, and serving powerful ideologies and interests. The U.S. child welfare system is and always has been designed to regulate poor families. Most cases of child maltreatment involve parental neglect, which is usually difficult to disentangle from the conditions of poverty. Nationwide, there are twice as many neglected children in foster care as children who are physically abused. The child welfare system hides the systemic reasons for poor families' hardships by attributing them to parental deficits and pathologies that require therapeutic remedies rather than social change.

Foster care is also marked by shocking racial disparities. In 2000, Black children made up two-fifths of the nation's foster care population, although they represented less than one-fifth of the nation's children. Black children were four times as likely as white children to be in foster care. Taken together, children of color comprised only about 30 percent of the general population, but about 60 per cent of children in foster care. Most children awaiting adoption in the nation's foster care system are African American or Latino. Researchers have detected differential treatment at every point in the child welfare decision making process – reporting, investigation and substantiation, child placement, service provision, and permanency decision making. For example, Black women are much more likely than white women to be reported by hospital staff for substance abuse during pregnancy and to have their babies removed by child protective services. Child protection decisions are influenced by deeply-embedded racial stereotypes about female immorality and family dysfunction. The racial disparity in the child welfare system also reflects a political choice to address the startling rates of child poverty in communities of color by punishing parents instead of tackling poverty's societal roots.

In the last decade, government policy has intensified its focus on "freeing" children in foster care for adoption by terminating parental rights rather than preserving families. The Adoption and Safe Families Act, passed by Congress in 1997, implements a preference for adoption by establishing swifter timetables for states to petition for termination of parental rights and offering financial incentives to states to move more children from foster care into adoptive homes. It also weakens the chances of family preservation by encouraging agencies to make concurrent efforts to place foster children with adoptive parents while trying to reunite them with their families. Federal child welfare policy places foster children on a "fast track" to adoption as a strategy for curing the ills of the child welfare system, especially reducing the enormous foster care population. Reproductive justice advocates should work to radically transform the child welfare system into one that generously and non-coercively supports families instead of tearing them apart.

RESOURCES

More information about foster care and the struggle for reproductive justice can be found in the following sources:

- Renny Golden, *War on the Family: Mothers in Prison and the Families They Leave Behind* (Routledge 2005)
- Dorothy Roberts, *Shattered Bonds: The Color of Child Welfare* (Basic Books 2002).
- Rickie Solinger, *Beggars and Choosers: How the Politics of Choice Shapes Adoption, Abortion, and Welfare in the United States* (Hill and Wang 2001).
- Bronx Defenders Family Defense Project, www.bronxdefenders.org
- Child Welfare Organizing Project, www.cwop.org
- National Advocates for Pregnant Women, www.advocatesforpregnantwomen.org
- National Coalition for Child Protection Reform, www.nccpr.org

ASSISTED REPRODUCTIVE TECHNOLOGIES AND REPRODUCTIVE JUSTICE

By the National Gender, Eugenics & Biotechnology Task Force and Staff Members of the Committee on Women, Population and the Environment

Today Americans face an unregulated system of reproductive screening selection, human reproductive cloning, egg marketing, and genetic technologies, all of which can potentially be used to drive a dominant perspective of who is 'fit' or 'unfit' to reproduce. The Committee on Women, Population and the Environment (CWPE) wants women and all types of families to have more reproductive opportunities, CWPE also wants to challenge the potential exploitation of women, the increased risk of inequities and health disparities, and the socio-cultural implications of genetic technologies. We believe that many activists, healthcare providers, scientific researchers, social justice advocates, and all those concerned with community health have to grapple with the profound political and social implications of the new human genetic and reproductive technologies and its impact on our human rights.

THE SCIENCE AND SOCIAL JUSTICE CONCERNS

Screening & De-Selection:

- **Sex Selection** (prenatal screening using ultrasound tests or amniocentesis to determine the sex of the baby) has promoted the selective aborting of female fetuses. This practice deepens social/gender inequities and discriminatory practices against girls and women.
- **Pre-Implantation Genetic Diagnosis (PGD)** is a process for retrieving a woman's eggs through in vitro fertilization, fertilizing the eggs, and extracting a cell testing. Based on the cell's genetic traits, it is implanted in the woman's uterus. This highly medicalized procedure increases pressure on parents to de-select based on genetic and physical traits targeting disability, sexual orientation and gender variance as 'genetically inferior'.

Research

- **Stem Cell Research:** depends on women providing eggs, an invasive procedure that may have long term consequences.
- **Egg Trafficking:** the increased need for eggs for scientific research can potentially be used to further exploit women's bodies, as well as put women at risk for long term side effects from use of stimulants to produce multiple eggs

We are seeking to:

- Build an intersectional analysis approach to ensure that traits are not de-selected based on gender, race, ethnicity, sexuality and physical ability.
- Challenge eugenic agendas prescribing who is 'fit' and 'unfit' to reproduce or be reproduced.
- Define ethics for biotechnologies, and human experimentation to avoid potential exploitation of human subjects with use of these technologies.
- Critique increased commercial and privatized control of genetic traits and DNA.
- Oppose discriminatory practices of fertility clinics that will not permit LGBTIQ parents and women with disabilities to have the choice to use assisted reproductive technologies.

Take a Stand on Genetic Technologies & Eugenics by:

Providing access to information and critical progressive perspectives on the scientific and policy basics of new human genetic and reproductive technologies and increasing the visibility of these issues inside a reproductive justice and human rights framework

Cultivating cross-movement organizing to connect these issues to other health, gender, and environment and racial justice agendas

Building collective reproductive and human rights actions and networks to challenge current and potential eugenic applications of these technologies

Inciting critical dialogue on the increased practice of sex selection in the U.S., as a method of population control and working to end this practice globally

RESOURCES

- Center for Genetics & Society <http://www.genetics-and-society.org>
- Council for Responsible Genetics <http://www.gene-watch.org>
- Our Bodies Ourselves <http://www.ourbodiesourselves.org>

10 REASONS TO RETHINK OVERPOPULATION

By the Population and Development Program at Hampshire College

A central requirement for reproductive justice is not only for women to have the right *not to* have children, but to also exercise the right *to* have children. Women have been denied this right through population control programs that care more about reducing birth rates than empowering women to have control over their reproductive health and rights. The ideology that informed the programs has not gone away, and below are ten reasons why rethinking overpopulation is vital to creating the global understanding and solidarity needed to advance women's reproductive and sexual rights.

1. The population 'explosion' is over. Although world population is still growing and is expected to reach 9 billion by the year 2050, the era of rapid growth is over. With increasing education, urbanization, and women's work outside the home, birth rates have fallen in almost every part of the world and now average 2.7 births per woman.

2. The focus on population masks the complex causes of poverty and inequality. A narrow focus on human numbers obscures the way different economic and political systems operate to perpetuate poverty and inequality. It places the blame on the people with the least amount of resources and power rather than on corrupt governments and rich elites.

3. Hunger is not the result of 'too many mouths' to feed. Global food production has consistently outpaced population growth. People go hungry because they do not have the land on which to grow food or the money with which to buy it.

4. Population growth is not the driving force behind environmental degradation. Blaming environmental degradation on overpopulation lets the real culprits off the hook. The richest fifth of the world's people consume 66 times as many resources as the poorest fifth. The U.S., with a low fertility rate, is the largest emitter of greenhouse gases responsible for global warming.

5. Population pressure is not a root cause of political insecurity and conflict. Especially since 9/11, conflict in the Middle East has been linked to a 'youth bulge' of too many young men whose numbers supposedly make them prone to violence. Blaming population pressure for instability takes the onus off powerful actors and political choices.

6. Population control targets women's fertility and restricts reproductive rights. All women should have access to high quality, voluntary reproductive health services, including safe birth control and abortion. In contrast, population control programs try to drive down birth rates through coercive social policies and the aggressive promotion of sterilization or long-acting contraceptives that can threaten women's health.

7. Population control programs have a negative effect on basic health care. Under pressure from international population agencies, many poor countries made population control a higher priority than primary health care from the 1970s on. Reducing fertility was considered more important than preventing and treating debilitating diseases like malaria, improving maternal and child health, and addressing malnutrition.

8. Population alarmism encourages apocalyptic thinking that legitimizes human rights abuses. Dire predictions of population-induced mass famine and environmental collapse have long been popular in the U.S. Population funding appeals still play on such fears even though they have not been borne out in reality. This sense of emergency leads to an elitist moral relativism, in which 'we' know best and 'our' rights are more worthy than 'theirs.'

9. Threatening images of overpopulation reinforce racial and ethnic stereotypes and scapegoat immigrants and other vulnerable communities. Negative media images of starving African babies, poor, pregnant women of color, and hordes of dangerous Third World men drive home the message that 'those people' outnumber 'us.' Fear of overpopulation in the Third World often translates into fear of increasing immigration to the West, and thereby people of color becoming the majority.

10. Conventional views of overpopulation stand in the way of greater global understanding and solidarity. Fears of overpopulation are deeply divisive and harmful. In order to protect and advance reproductive rights in a hostile climate, we urgently need to work together across borders of gender, race, class and nationality. Rethinking population helps open the way.

RESOURCES

- The Committee on Women, Population and the Environment – www.cwpe.org
- Population in Perspective: A Curriculum Resource – www.populationinperspective.org
- Babies, Burdens and Threats: Current Faces of Population Control - <http://popdev.hampshire.edu/projects/ppi>
- The Corner House – www.thecornerhouse.org.uk

ENVIRONMENTAL JUSTICE: WOMAN IS THE FIRST ENVIRONMENT

By Katsi Cook, Mohawk Nation at Akwesasne

"The environmental justice movement is the confluence of three of America's greatest challenges: the struggle against racism and poverty; the effort to preserve and improve the environment; and the compelling need to shift social institutions from class division and environmental depletion to social unity and global sustainability"

First National People of Color Environmental Leadership Summit 1991, Report to the U.S. EPA and the Office of the President

Environmental justice shares with reproductive justice the essential and broad ideological frame of social justice with a focus on the *whole* instead of the *sole*, including the multi-dimensional indicators stated in the World Health Organization definition of health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity", as well as the ability to lead a "socially and economically productive life." I would add cultural well-being to this definition since ecologists have pointed out that biological diversity and cultural diversity go hand in hand. One is connected directly to the other.

In my experience as a Mohawk midwife, women's health advocate and activist for environmental restoration in my Tribal community, the Mohawk Nation at Akwesasne, I see that reproductive justice and environmental justice intersect at the nexus of woman's blood and voice. Environmental justice and reproductive justice intersect at the very center of woman's role in the processes and patterns of continuous creation. Of the sacred things that there are to be said about this, *woman is the first environment* is an original instruction. In pregnancy, our bodies sustain life. Our unborn see through our eyes and hear through our ears. Everything the mother feels, the baby feels, too. At the breast of women, the generations are nourished. From the bodies of women flows the relationship of those generations both to society and to the natural world. In this way is the Earth our mother, our ancestors said. In this way, we as women are earth.

Because our nursing infants are at the top of the food chain, they inherit a body burden of industrial contaminants from our blood by way of our milk; thus are we part of the landfill, colonized. This stark sacrilege came to my attention when a mother in my care who lived not far from the General Motors Corporation landfill asked if it was safe to breastfeed. This National Priority List (1983) toxic waste site, situated on the banks of the St. Lawrence River, featured two PCB-filled open lagoons which leaked into our St. Lawrence River – life-blood of our community – and contaminated the local food chain. Each generation of our vulnerable young inherited a body burden of local industrial contaminants from their mothers who consumed locally caught fish.

Many Mohawk traditional cultural practices are protective of the health of women, children and the community. I can think of no more powerful example of this than breastfeeding, the health benefits of which for the mother-infant pair are well documented. In order to protect this valuable, sustainable cultural resource, I approached the St. Regis Mohawk Tribal Council and Mohawk Council of Akwesasne. I wanted to engage with them in the democratizing constructs of participatory action research, in collaboration with agencies inside and outside our community. Our story and unique context as a designated environmental justice community co-evolved our struggle for reproductive justice. The restoration of culture-sustaining practitioners such as midwives and doulas (who provide woman-centered, continuous childbearing and childbirthing support) were always included with strategies for the restoration of the holism of our environment in the protection of women's health over the life span. We understood that many other aspects of women's health were at risk from exposure to industrial chemicals in our environment. Environmental estrogens, reproductive cancers, reproductive failure, autoimmune diseases, thyroid disease and a host of other concerns fill our clinic charts and community meetings. The integration of multiple bases of knowledge, and their translation across

collaborative bridges, engaged our community in the learning curve that always ensues when community members, organizations and agencies attempt to understand each others' languages, cultures and issues. It requires a willingness to see through another's eyes to overcome limited perspectives of what is possible; to hear through another's ears to develop joint strategies for action.

RESOURCES

- www.ejnet.org/ej
- www.niehs.nih.gov/translat/envjust/envjust.htm
- www.epa.gov/compliance/environmentaljustice/index.html
- www.cdc.gov/nceh/dls/report
- *Building Healthy Communities from the Ground Up*, available on pdf at www.environmentalhealth.org/EJReport.pdf
- *Environmental Justice: Building a Unified Vision of Health and the Environment*, Charles Lee, *Environmental Health Perspectives*, Vol. 110, #S2, April 2002
- *Our Stolen Future: Are We Threatening our Fertility, Intelligence and Survival? A Scientific Detective Story* by Theo Colborn et.al (Plume Paperback, 1997)
- *Having Faith: An Ecologist's Journey to Motherhood* by Sandra Sterngraber (Perseus Publishing, 2001)
- *All Our Relations: Native Struggles for Land and Life*, by Winona LaDuke (South End Press, 1999)
- *Tainted Milk: Breastmilk, Feminism, and the Politics of Environmental Degradation* by Maia Boswell-Penc (State University of New York at Albany Press, 2006)

SPIRITUALITY: A TOOL TO ACHIEVE REPRODUCTIVE JUSTICE

By Emily P. Goodstein, Spiritual Youth for Reproductive Freedom

Before the Supreme Court legalized abortion in *Roe v. Wade*, clergy and lay leaders from many faith traditions provided women with referrals to safe abortion services. The work of these clergy people remained largely off the radar of their congregants, nor was it connected to broader issues contributing to women's need for pregnancy termination through abortion.

In 1973, several clergy people came together to take their discreet abortion referral service out from behind closed doors and into pews and voting booths. The Religious Coalition for Abortion Rights (RCAR) was formed and clergy voices were added to the growing national discourse about family planning and abortion. As it grew, the Coalition exhibited its commitment to a broader framework of issues. In 1993, RCAR changed its name to become the Religious Coalition for Reproductive Choice (RCRC), encompassing a commitment to a broad spectrum of reproductive freedom, choice, equality, and justice. The organization serves as a unique interfaith voice in the larger conversation about reproductive justice. RCRC's member organizations are religiously and theologically diverse, yet are unified in the commitment to preserve reproductive choice as a basic part of religious liberty.

A brief visit to the RCRC website (www.rcrc.org) makes the connections between spirituality and reproductive justice very clear. RCRC's rational, healing perspective looks beyond the bitter abortion debate to seek solutions to pressing problems through clergy and congregational support and faith-based messages. The Coalition focuses on unintended pregnancy, the spread of HIV/AIDS, inadequate health care and health insurance, and the severe reduction in reproductive health care services. The Coalition supports access to sex education, family planning and contraception, affordable child care and health care, and adoption services as well as safe, legal, abortion services, regardless of income. The Coalition's work centers on public policies that ensure the medical, economic, and educational resources necessary for healthy families and communities that are equipped to nurture children in peace and love.

The Coalition is currently comprised of over 40 organizations representing 15 different faith traditions and religious groups! The organization disseminates religious messages and resources while coordinating programming suitable for congregations and religious communities affirming reproductive justice. Signature programs include:

Clergy for Choice Network: RCRC's Clergy for Choice community trains clergy to counsel women facing problem pregnancies and reproductive loss, connects clergy to public speaking events and worship services, facilitates advocacy efforts through lobby visits with elected officials and opportunities to testify before state legislatures, and produces materials to assist with educational programs for congregants about local and national issues.

Spiritual Youth for Reproductive Freedom (SYRF): SYRF educates, organizes and empowers youth and young adults (ages 16-30) to put their faith into action and advocate for pro-choice social justice. SYRF creates venues for youth education and activism, designs youth-specific materials, and builds lasting relationships with youth oriented organizations, campus clergy, and youth programs of our denominations. Since young people lead this program, SYRF lifts up pro-faith youth and young adult perspectives on reproductive choice issues and provides young people with tools and opportunities to advocate for choice on their campuses, high schools, congregations and communities.

Black Church Initiative: The Black Church Initiative addresses teen childbearing, sexuality education, unintended pregnancies, and other reproductive health issues within the context of African American culture and religion. Within the Black Church Initiative, several specific programs include:

Keeping It Real!: A Faith-Based Teen Dialogue Model on Sex and Sexuality provides African American Christian educators, ministry leaders and youth ministers with a sexuality education model to address teen pregnancy prevention and better provide young men and women with the resources needed to make healthy, responsible decisions as spiritual and sexual beings.

Breaking the Silence: A Faith-Based Sexuality Curriculum for local congregations is a sexuality education model developed to assist local congregations, parents, guardians, and clergy address sex and sexuality to assist teens in making healthy life choices.

Generation to Generation: From Silence to Shouting: A special mothers and daughters (13-18) project developed to reduce teen pregnancy in Ward 8 in the District of Columbia. The year-long effort is designed to collaborate with faith and community-based agencies to strengthen relationships, engage participants in cultural and skills building activities, increase self-esteem and self

La Iniciativa Latina: The goal of La Iniciativa Latina is to assist Latino communities in addressing human sexuality from a faith informed perspective. This assistance will be made possible through education, training, and open forums on subjects including but not limited to, comprehensive sexuality education, reproductive health and justice education, teen pregnancy prevention, HIV/AIDS from a religious perspective that reflects an understanding of Latino culture.

RESOURCES

For more information, please visit the RCRC website www.rcrc.org

REPRODUCTIVE JUSTICE WORLDWIDE: OPPOSITION TO WOMEN'S RIGHTS AT THE UNITED NATIONS

By Pam Chamberlain, Political Research Associates

The U.S. Christian Right not only seeks to restrict women's reproductive rights in this country, but for the past several years it has set its sights on other countries as well. A growing number of U.S.-based nongovernmental organizations (NGOs), like Concerned Women for America, Focus on the Family and the National Right to Life Committee, have been granted consultative status at the United Nations. In a world where nearly 80,000 women die annually from unsafe abortions, these U.S. groups are trying to apply a home-grown conservative Christian analysis to limit the political and sexual empowerment of women worldwide.

UN population and women's conferences in the 1980s and 1990s allowed for great strides in the international feminist and women's health movements. A small but vigorous backlash to such gains has emerged in the form of these conservative NGOs. They oppose UN programs and platforms promoting access to abortion, contraception, and young women's sexuality education, and they attack such important human rights documents as CEDAW, the Convention on the Elimination of All Forms of Discrimination Against Women and venerable UN programs like UNICEF.

These Christian Right groups reinforce the anti-woman thinking behind the Bush administration's actions such as the reinstatement of the Global Gag Rule (which has disrupted abortion access, family planning services, prenatal care and HIV/AIDS prevention worldwide) and Congressional criticism of the United Nations Population Fund (falsely claiming it encourages coerced abortions in China). Among the U.S. Christian Right, such attacks have fueled a growing distrust of the UN and its human rights and women's justice framework. Through deliberate bureaucratic interventions that slow the decision-making process at the UN and the development of coalitions with conservative religious groups worldwide, these groups are trying to restrict women's access to reproductive services and the guarantee of their human rights based on conservative values. Their work threatens to increase the challenge of reproductive justice advocates in this country.

RESOURCES AND ACTIVIST OPPORTUNITIES

Many more liberal and progressive groups than conservative ones are active at the UN or are concerned about international women's issues, and several depend on grassroots support. Starred organizations (*) offer activist involvement.

Advocates for Youth *

Supports and provides space for youth leadership, especially around reproductive rights.

<http://www.advocatesforyouth.org/>

Born Again: The Christian Right Globalized, by Jennifer S. Butler (Ann Arbor, Mich.: Pluto Press) 2006. This is an easy-to-read and comprehensive look at the Christian Right at the United Nations.

Catholics for Free Choice *

Tracks the work of the Catholic Church to restrict access to abortion. Home of the campaign to change the status of the Vatican at the UN. <http://www.catholicsforchoice.org>

<http://www.seechange.org>

Center for Reproductive Rights *

A legal advocacy organization for women's rights worldwide. Home of the Vote for Choice campaign. <http://www.crlp.org/>

Center for Women's Global Leadership *

An international leadership development and advocacy organization for women

<http://www.cwgl.rutgers.edu/>

Feminist Majority *

National lobbying and organizing organization for women's equality.

<http://feministmajority.org>

Guttmacher Institute

The premier research institution for women's reproductive health.

<http://www.guttmacher.org>

Human Rights Watch *

Advocates for global women's rights in the context of human rights; watchdogs country by country. <http://www.hrw.org>

International Planned Parenthood Federation

Member organization for 40 countries committed to reproductive freedom in the Americas; publishes useful reports. <http://www.ippf.org>

The International Women's Health Coalition *

Vibrant advocacy and financial supporter for global reproductive health; home to the International Sexual and Reproductive Rights Coalition.

<http://www.iwhc.org/resources/bushsotherwar/index.cfm>

Ipas

An effective international women's reproductive health access and advocacy organization based in North Carolina. <http://www.ipas.org/english/default.asp>

Political Research Associates

Offers comprehensive resources and analysis about the full range of the U.S. political Right and has published on conservative NGOs at the UN.

http://www.publiceye.org/reproductive_rights/UNdoingReproFreedomSimple.html **The**

Population and Development Program at Hampshire College *

Publishes a series of papers and a curriculum that offer a critical analysis of the intersection of reproductive rights and population concerns, both nationally and internationally.

<http://popdev.hampshire.edu>

SIECUS International Right-Wing Watch * *The Sexuality Information and Education Council of the United States publishes a free online periodical focusing on conservative campaigns that oppose women's reproductive freedom.*

<http://www.siecus.org/inter>

THE CHALLENGES OF REPRODUCTIVE JUSTICE IN EASTERN EUROPE

By Joanna Mistal, Ph.D., Mailman School of Public Health, Columbia University

In recent years, the Vatican has intensified its efforts to restrict reproductive rights in Eastern Europe. The secular nature of the state socialist regimes that held power in this part of the world until 1989 had a protective effect against the intrusion of the Church into matters of reproductive rights, but once communism collapsed the Church began to force restrictions on abortion and encourage a widespread use of the so-called conscience clause.¹¹ Poland serves as the most severe example of this trend and a potential warning of things to come.

After the fall of communism in Poland, the new Catholic-nationalist government criminalized abortion in 1993 making the Polish law the most restrictive in Europe, outside of Ireland. The newfound political power of the Church was not only decisive in restricting abortion but also in eliminating contraceptive health insurance coverage and sex education from schools.

The current law makes abortion legal only if the woman's life or health is in danger, a fetal deformity exists, or the pregnancy resulted from rape or incest. But even the right to abortion under these limited conditions is being eroded—abortions that qualify as legal are systematically denied forcing women to pursue them illegally. Such refusals make this already narrow right to abortion de facto much narrower than the formal policy would indicate.

The case of Alicja Tysic illustrates the severity of this problem. Tysic, a single mother of two on a welfare allowance of \$179/month, qualified for a legal abortion on the grounds that a third pregnancy posed a danger to her already impaired eyesight—she suffered severe myopia of -20 diopters in each eye. Although three ophthalmologists stated the health danger if she carried the pregnancy to term, none of the doctors was willing to authorize an abortion. By the second month of her pregnancy her vision had worsened to -24 diopters and, as predicted, she suffered a retinal hemorrhage during the delivery which impaired her eyesight to 5 feet. She has been classified as disabled. In 2005, after her criminal charges against the head of gynecology and obstetrics of the Warsaw hospital that refused the abortion were dismissed by the district prosecutor, Tysic went to the European Court of Human Rights where she argued that Poland violated the European Convention for the Protection of Human Rights and Fundamental Freedoms by neglecting to provide a legal mechanism through which a woman could exercise her right to abortion within the current law. In March 2007 Tysic won the case—the Court declared that her human rights were violated when she was denied an abortion on therapeutic grounds. Sadly, the ruling will not affect the Polish abortion law but it is expected to force Poland to create a legal mechanism of appeal for women who have experienced a refusal.

Poland's reproductive injustices are the most apparent among the Eastern European nations but the trend is equally ominous elsewhere. In Hungary, the Czech Republic, and Bulgaria, public abortion funding was eliminated in 1992, while Slovakia is currently considering a treaty with Vatican that would allow hospitals to deny abortions on religious grounds, thereby circumventing Slovakia's liberal abortion law currently in place. Such restrictions have resulted in an alarming rise in illegal abortions, as is the case in Poland, and given the widespread feminization of poverty across Eastern Europe after the fall of communism, this problem will adversely affect the rights and health of an increasing number of women.

RESOURCES

- The European Court of Human Rights - www.echr.coe.int/ECHR
- The Federation for Women and Family Planning - www.federa.org.pl/?lang=2
- The Network of East-West Women - www.neww.org.pl/en.php/links/view/1.html?id=7
- International Planned Parenthood Federation European Network: - www.ippfen.org/en

¹¹ The only exception was Romania where the dictatorship of Nicolae Ceausescu instituted a ban on abortion in 1966 as part of a state pronatalist policy.

LAW, MEDICINE AND MORALITY: THE THREAT TO REPRODUCTIVE JUSTICE

By Lois Uttley, MergerWatch Project

Across the United States, women are being denied needed reproductive health care because their hospitals, HMOs, pharmacies, employers and health care providers are using religious doctrine or moral beliefs to restrict access to medical information and services:

A woman who has just been raped arrives at a hospital emergency room. "What if I become pregnant from the rape? Is there something I can do to prevent it?" she asks. "I'm sorry," the ER doctor says, "but we aren't allowed to give you emergency contraception. It's against the religious doctrine of our hospital."

A mother of two is about to deliver her third child. "My doctor says my high blood pressure is so dangerous that I shouldn't have any more children. I'm planning to have my tubes tied right after I give birth," she tells the nurse who is helping her fill out paperwork for admission to the hospital. "I'm sorry," the nurse says, "but our hospital has joined a religious health system and it has banned tubal ligations."

A young woman goes to the pharmacy to refill her birth control prescription. The pharmacist on duty refuses, saying "I believe birth control is the same as abortion and you will go to hell if you use it, so I will not dispense it to you."

A 40-year-old woman comes to a hospital emergency department and is diagnosed with a dangerous ectopic pregnancy. But the ER staff refuses to end the pregnancy, out of fear they would violate the religiously-sponsored hospitals ban on abortions. Instead, they put her in an ambulance and send her to another hospital.

These scenarios, all based on real-life stories, illustrate the daily obstacles women are facing in trying to obtain reproductive health care. All of the services in question are legal in the United States. But none of these women was able to actually obtain the needed reproductive health care in a timely manner because their health care providers were able to cite personal moral beliefs or institutional religious rules and refuse to provide the care.

The intersection of law, medicine and morality in the American health system poses a serious threat to reproductive justice. When religious doctrine or a health provider's moral beliefs can override a woman's need for reproductive health care, she suffers a violation of her basic right to manage her reproductive capacity. She is denied the right and access to safe, respectful and affordable contraceptive and abortion services.

Unfortunately, public policymakers have all too often protected the religious freedom of health care providers, at the expense of the patient's religious freedom and right to reproductive justice. Hospitals affiliated with conservative religious entities (such as the Roman Catholic Church, Baptist Church and the Seventh Day Adventists) operate one in every five hospital beds in the United States. By lobbying Congress and state Legislatures, these hospitals have won the right to refuse to provide abortions or sterilizations, while still holding licenses to serve the general public and remaining eligible to receive more than \$40 billion in public funding each year. In several states, Catholic hospitals are campaigning against proposed state laws that would require them to offer emergency contraception to rape victims.

More recently, individual health providers – including pharmacists, physicians and nurses – have campaigned for, and in some cases, won the right to use religious or moral beliefs to refuse care. Instances of pharmacist refusals to fill contraceptive prescriptions have been reported in 19 states. A case being litigated in California has highlighted another aspect of this intersection of law, medicine and morality in the United States. A lesbian couple was denied access to assisted

reproductive technology by a group of physicians who were all Christians and did not approve of lesbian parenting.

Congress and the Bush administration have also introduced conservative religious beliefs into government health care programs and funding streams, by promoting abstinence-only sexuality education and censoring government web sites so that they provide incomplete or inaccurate information about condom use to prevent sexually-transmitted diseases.

Groups committed to reproductive justice are working to fight the intrusion of religious doctrine and moral beliefs into medical care in the United States. The MergerWatch Project is assisting community-based activists who are trying to stop the spread of religious health care restrictions when nonsectarian community hospitals merge with hospitals that have religiously-based service prohibitions. The project also works on the national and state levels to protect consumer access to vital reproductive health services and prevent the use of religious concepts in government health policy. To learn more about the project, and what you can do to stop this threat to reproductive justice, visit our website at www.mergerwatch.org.

RESOURCES

You can learn more about religiously-based health restrictions by visiting the websites of the organizations with which MergerWatch collaborates regularly. They include:

- Catholics for a Free Choice, www.catholicsforchoice.org
- the Religious Coalition for Reproductive Choice, www.rcrc.org
- Physicians for Reproductive Choice and Health, www.prch.org
- National Women's Law Center, www.nwlc.org

USING INTERNATIONAL HUMAN RIGHTS LAW TO ADVANCE REPRODUCTIVE JUSTICE

By Katrina Anderson, Center for Reproductive Rights

What are human rights?

The human rights framework rests on the simple but powerful moral proposition that people's rights derive from our inherent dignity—not from the benevolence of governments or the will of legislative majorities. This notion has, in turn, given birth to an umbrella of rights and to an international legal system charged with ensuring governments' compliance with their obligations. Women's reproductive rights under human rights law are a composite of a number of separate rights, including:

the right to health, reproductive health and family planning

the right to equal access to and non-discriminatory treatment in health care

the right to decide the number and spacing of one's children

the right to marry and to found a family

the right to be free from gender discrimination of all kinds

the right to privacy

These universally applicable rights are enshrined in human rights treaties, which are legally binding among nation states, and international consensus documents, which are not binding but reflect international agreement on human rights norms.

Why is the human rights framework useful for reproductive justice advocates?

The reproductive justice movement urges policy makers to take into account how forces such as racism, sexism, and classism intersect to deprive certain groups of people of their rights. Human rights law also integrates this approach by obligating governments not just to respect rights, but also to fulfill the economic and social conditions that enable people to exercise their rights. Using the human rights framework, reproductive justice advocates can expand the U.S. legal system's limited constitutional interpretation of reproductive rights as *negative* rights (proscribing government interference at certain points), arguing instead that the government has a *positive* obligation to provide the resources necessary for women and men to make meaningful reproductive decisions.

How can reproductive justice advocates use the international human rights framework?

The United States has ratified two important international human rights instruments: the International Convention on the Elimination of Racial Discrimination (ICERD) and the International Convention on Civil and Political Rights (ICCPR). As a State Party, the U.S. is obligated to periodically report on its progress in implementing each treaty to the U.N. committee responsible for monitoring state compliance. Non-governmental organizations can submit "shadow reports" to provide the committee with crucial information to establish a more complete record for state accountability and help it formulate recommendations to the government. They can also serve as public education tools and be used in lobbying work for legislative reform at the national, state, and local levels. In 2006, the Center for Reproductive Rights (CRR) submitted a shadow report to the Human Rights Committee, which monitors compliance with the ICCPR, detailing the U.S. government's failure to promote reproductive

rights. In 2007, CRR will submit a report to the CERD Committee analyzing the unequal access to reproductive rights for women of color in the U.S.

In addition, advocates may choose to bring their concerns to the U.N. Special Rapporteurs on Health and/or Violence Against Women. Rapporteurs gather information from multiple sources, write reports that highlight best practices as well as obstacles to securing particular rights, discuss solutions directly with governments, and make recommendations.

Finally, advocates can file a petition with the Inter-American Commission for Human Rights asserting a violation of the American Declaration of the Rights and Duties of Man, to which the U.S. is a party. Petitioners can also request a public hearing with the commissioners, which gives victims their day in court, educates the commissioners about an issue, and attracts media attention useful for ongoing advocacy campaigns.

RESOURCES

- *Something Inside So Strong: A Resource Guide on Human Rights in the United States*, available at <http://www.ushrnetwork.org/page2.cfm>
- Center for Reproductive Rights, *Bringing Rights to Bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*, and *Women's Reproductive Rights in the United States: A Shadow Report to the Human Rights Committee*, both available at http://www.reproductiverights.org/pub_shadow.html

REPRODUCTIVE JUSTICE REQUIRES EQUAL TREATMENT AND CONSTITUTIONAL PROTECTION FOR PREGNANT WOMEN

By Jill C. Morrison, National Women's Law Center

Nationwide, pregnant women are being deprived of the most basic constitutional rights. While the most well-known of these violations involve prosecution for drug use, women have also been targeted for non-drug related behaviors. This treatment is unfounded: pregnancy does not require women to surrender their constitutional rights.

Pregnant women have refused to have medical procedures only to have the procedures performed against their will. Laura Pemberton sought fluids at a hospital emergency room, but was taken into police custody and forced to have a cesarean section instead of the natural home birth she desired.¹² In another case, a court ordered a woman to have her cervix sewn to prevent pregnancy complications, in accordance with her husband's wishes but against her own religiously-based objection.¹³ Cancer patient Angela Carder's death was hastened because a court granted a hospital's request to perform a cesarean section (against Ms. Carder's wishes).¹⁴

Legal precedents clearly establish that one individual cannot be forced to relinquish his or her life or liberty for another's benefit, but this principle is sometimes ignored when it comes to pregnant women. A court would never dream of ordering one person to donate an organ to another person, even if it was a matter of life or death or the individuals were a parent and his or her child. Yet pregnant women have been denied these same fundamental rights of privacy, bodily integrity and autonomy.

Pregnant women have been prosecuted based only on evidence of positive drug tests, but the same evidence would not support a case against non-pregnant women or men. The Supreme Court has held that punishing a person for being an addict is the equivalent of punishing an illness, concluding that it is unconstitutional to make a crime of a person's status.¹⁵ While it is a crime to possess or distribute drugs, testing positive for drugs is not in and of itself a crime (though testing positive may violate a person's condition of probation).

In order to punish women but avoid constitutional limitations on prosecuting drug use, prosecutors have used other laws such as drug distribution, child endangerment and homicide. However, invoking these laws also violates the constitutional rights of pregnant women. Denying pregnant women the legal protections afforded to others is a serious reproductive injustice. Under the constitution, individuals are entitled to:

- The right not to be prosecuted under a law that is not intended to include the acts alleged. The language of state child endangerment and homicide laws makes it clear that these laws were not intended to include the acts of pregnant women alleged to cause fetal harm.
- The right to receive legal notice that the act is a crime. Pregnant women who take drugs have no reason to believe that they could be charged under the drug distribution, child endangerment or homicide laws.
- The right to be free of prosecution under laws that require criminal intent when there is no evidence of such intent. Women do not use drugs for the purpose of delivering those drugs to their fetuses, nor do they intend to cause their fetuses harm.

¹² *Pemberton v. Tallahassee Memorial Regional Medical Center*, 66 F. Supp.2d 1247 (N.D. Fla. 1999).

¹³ She was later spared that fate by a higher court. *Taft v. Taft*, 446 N.E.2d 395, 396 (Mass. 1983).

¹⁴ *In re A.C.*, 573 A.2d 1235 (D.C. 1990), *rev'g en banc*, *In re A.C.*, 533 A.2d 611 (D.C. 1987).

¹⁵ *Robinson v. California*, 370 U.S. 660 (1962).

- The right to reproductive freedom. A pregnant woman threatened with prosecution could avoid criminal charges only by terminating her pregnancy. This is clearly an imposition on her right to carry a child to term if she so chooses.

Prosecutors argue that their actions protect fetal and infant health, but these punitive measures only discourage women from seeking medical care during pregnancy. Compassionate alternatives that respect women's constitutional rights and provide equal protection under the law are more effective in improving health outcomes for women and their children.

In your state, oppose legislative efforts to criminalize the behaviors of pregnant women. Locally, be aware of efforts to test and prosecute pregnant women based on their drug use. Ensure that your state and local officials support recovery from substance abuse, rather than punitive measures against pregnant women. And if you hear about a pregnant woman who is being forced to have medical treatment against her will, contact the National Women's Law Center or the organizations below.

RESOURCES

- National Advocates for Pregnant Women - www.advocatesforpregnantwomen.org
- American Civil Liberties Union - www.aclu.org
- Drug Policy Alliance - www.drugpolicy.org
- National Women's Law Center - www.nwlc.org

SOME HOW-TOS ON USING MEDIA AS A REPRODUCTIVE JUSTICE ORGANIZING TOOL

By Ariel Dougherty

Showing films (video, DVD) can be both entertaining and educational. While many women have been organizing around a broad array of reproductive justice issues, others of us have been organizing around media justice issues.

EMPOWERMENT

We define film --- its screening before audiences, as well as its creation --- as an empowerment tool. Just as everyone has the right to full and comprehensive health services for herself and family, each of us also possesses the right "to seek, receive and impart information and ideas through any media" (Article 19, Universal Declaration of Human Rights). Many of us teach media skills so that more and more people have the ability to tell their own stories, using their own voices and images. Especially now with the costs of production drastically reduced, new digital technology, and self-distribution a real possibility, film can become a vehicle for people-to-people communication and for strengthening culture within and among communities.

SOME TYPES OF SCREENINGS

Is your screening a one-time occasion? Or might it be more on-going? You want a friendly and comfortable place --- large enough to hold the crowd you anticipate, but not so large that it will overwhelm the crowd that comes. Building an audience -- like everything -- takes time and work. Community centers and churches are good sites. But think outside the box, too. In fair weather outside screenings are fun! Neighborhood parks are excellent sites, and so are rooftops. There are times, too, when you need to be more aggressive and take the screening to your audience. This is best with short films like *Becky's Story*. At 15 this girl took an abstinence pledge. Ill-informed, she became pregnant and a mom at 20. This experience turned Becky into an advocate for comprehensive sex education. You know your community, and what is the best strategy for doing outreach. The point is to be imaginative and strategic.

EQUIPMENT

Today, all new material is coming out in DVD format. Some distributors have not converted all older, VHS media to digital. Most new computers can play a DVD, but you need a "projector" to blow up the image, and you WILL NEED speakers to amplify the sound. Someone in your group may have (some of) this equipment. Or, check around with other community organizations. Some youth techie may be able to assist here. Encourage your techie to teach others ---both boys and girls (men and women)--- to set up and strike all the equipment. Just as boys and girls both need to be condom friendly, they all need to know media tech skills, too. One other wise thing to do prior to the screening is to test that the DVD operates well on the equipment you will be using. There can be glitches between making DVDs on Macs and PCs, and you want to solve all these matters prior to the screening. With a very small crowd, it is okay to show a VHS tape on a TV monitor, but for large groups it is best to project this too. Dual playback machines set up for both VHS and DVD can be purchased fairly cheaply. Last year after running a youth film program the local arts council in my town (population 10,000) bought a whole presentation system so we could have more community screenings. Groups can borrow the set-up. Maybe there is such a resource in your community. Occasionally 16mm film is the format. Maybe schools still have an old projector in the closet. Or try the Salvation Army? And there may even be a time when a 35MM film is useful in your work, maybe as a fund raiser. In this case, make arrangements with your local movie house.

RESOURCES

Especially check out MediaRights.org. They have lots of tools for activist use of social change media. They provide a vehicle for potential collaborations between your organization's activities and filmmakers. The resources section is extensive. PLUS---they have close to 7,000 social change films listed that can be searched by issues. The descriptions are directed to activist use. And in most cases there is a direct link to the distributors.

Distributors, too, can be very helpful. Almost all have long experience presenting media in community settings. So ask away. In particular check out their community screening rates.

ListenUp.org has a wealth of information about the burgeoning youth media movement. Most women's films enter the market through hundreds of women's film festivals. It's work, but do a net search "[women's film festivals](#)". Festival by festival you will find a wealth of new works. sistersincinema.com has a guide of African American women's feature films.

SPEAKERS

A discussion leader is always a good idea, especially if you want to encourage further involvement or action from such a screening. There are many kinds of people to have speak -- community leaders, academics, activists. And don't forget the filmmakers. After a few years of working on the film they are well versed in the subject, and are passionate about the issue. Further, they will also have an interesting story or two they learned making the work.

SOME OTHER MEDIA CONSIDERATIONS

Rampart media consolidation has adverse effect on all our organizing work, our access to information and coverage of our issues. In short, democracy is threatened. Media activists have been urging groups, 'if media is not your first issue, make it your second'. Here are some groups that work on media reform: freepress.net (they organize a national conference, next one June 2008 in Minneapolis); reclaimthemedial.org; mediatank.org; media-alliance.org; Manhattan Neighborhood Network at mnn.org; and youthmediacouncil.org.

Is there Public Access television in your community? Make a show about your issues. It is fantastic community outreach. Collaborate with other organizations to pool time, talent and resources. Access staff can assist, but you have to take the initiative. Utilize this great public resource to expand services of your organization. Be inventive; evolve a format that works for your group's needs. Give voice to your issues in your community.

Community radio is the most accessible media. Listen around. Maybe you can find a place for reproductive justice issues on the dial.

THE INCOMPATIBILITY OF NEO-LIBERAL "CHOICE" AND REPRODUCTIVE JUSTICE

By Rickie Solinger

What happens when women's special guarantee – the promise that all women can decide for themselves whether and when to have children – is expressed by the individualistic, marketplace term "choice"? For one thing, the term "reproductive choice" invites many people to distinguish, in consumer-culture fashion, between a woman who can – and a woman who can't -- *afford* to make a choice – even when we're talking about issues that seem to refer to fundamental human dignity and human rights. The *language of choice* masks issues of safety and potential danger at the heart of women's special guarantee.

The underlying assumptions of "reproductive choice" refer to the individual woman's economic suitability and even to her eugenic suitability as a mother of future citizens. According to politicians and public policy, choice-making should be associated with – and typically reserved for – women with resources: only a woman with a sufficient bank account (and other personal resources such as a "normal" genetic profile or a "normal" IQ) has the makings of a legitimate mother. According to the Hyde Amendment, only a woman with enough money to pay can "choose" abortion. By extension, then, engaging in heterosexual sex is a class privilege as well, reserved only for women in a position to make – and pay for – appropriate reproductive choices. Pursuing fertility treatments is a class privilege. The Supreme Court – and public opinion – asserts that women do not have a *right to decide* whether and when to become mothers; they merely have a consumer's choice.

Historical distinctions between women of color and white women, between poor and middle-class women, between "able-bodied" and "disabled" women have been reproduced and institutionalized in the "era of choice," in part by defining some groups of women as good choice-makers, some as bad. Welfare laws and policies have been based on these distinctions. So have adoption practices which allow some American women to make choices that depend on the reproductive choicelessness of other women, often those living in the poorest countries on earth. "Choice" has turned out to be a term and an idea that reflects and justifies the commodification of reproduction and a hard set of financial and other degrading qualifications for reproductive dignity and "legitimate" motherhood.

Too frequently, policymakers and others define women as too young, too poor, too not-white, too foreign, too disabled, too gay, too homeless, for example, to be "legitimate mothers." When women in these categories become pregnant and have babies, they are regularly defined as bad choice makers and as appropriate targets for various kinds of punishment. Politicians and policymakers support cutting inappropriately reproducing girls and women off welfare. Public opinion and public policy support expedited separation of these women from their children in various ways. Representations of "bad-choice-making women" in the mass media justify these females as targets for sterilization and incarceration, as potential "surrogate mothers" and "birth mothers," but not as "real mothers."

The concept of "reproductive choice," which in policy and in practice (if not always intentionally) divides women against each other, and judges women's individual suitability for sex and reproduction, is the opposite of reproductive justice. "Reproductive choice" supports a range of responses to women's reproductive activity, from approval and material benefits to condemnations and punishments, depending on any given woman's race, class, age, sexual orientation, health, and other personal characteristics. "Reproductive choice" makes individual, bad-choicemaking women into culprits and effaces the impacts of low wages, the housing crisis, the lack of medical care, racism, under-funded educational systems, racialized incarceration, war, and other factors that shape the context of reproduction differently for different groups of women.

"Choice" too often suggests that the most vulnerable people in the country are the most powerful and dangerous, by claiming that when poor women, especially poor women of color

make the wrong choices, especially if they make the choice to reproduce themselves, the country will go to hell.

Reproductive justice, on the other hand, defines the right to reproduce safely and with dignity as a fundamental human right, in the same way as reproductive justice defines the right not to reproduce. Reproductive justice is based on the understanding that real reproductive dignity and safety depends on access to a full range of community-based resources, and that poor women and others who lack these resources should not be constrained from managing their reproductive capacity, should not be prevented from being mothers, or punished if they become mothers. Instead, a just society would recognize that the right to reproduce or not is a foundational human right. This society would make sure that all women and girls possess adequate resources to manage their fertility with dignity and safety.

ABORTION MATTERS TO REPRODUCTIVE JUSTICE

By Leila Hessini, Lonna Hays, Emily Turner, and Sarah Packer, IPAS

Reproductive justice includes the right of all women to safe and voluntary contraception; to become pregnant, carry, and bear children in a context free of violence and environmental toxins; and to affordable and non-judgmental abortion services. Many women, however, do not have the option to protect themselves against an unwanted pregnancy, to continue an unintended but wanted pregnancy, or to have a safe abortion. Despite *Roe v. Wade's* significance, the "right" to abortion means little to those whose options are already restricted by race, gender, sexuality, age, ability, or income. Traditionally, the issue of abortion has been isolated by the stigma attached to it. Nevertheless, abortion is a common part of the sexual and reproductive lives of most women, and its inclusion in the reproductive justice movement is essential in the pursuit of equality and justice.

Concrete examples illustrate why abortion is essential to achieving reproductive justice: Looking at abortion in the context of women's lives and articulating how it is inextricably linked to all facets of the reproductive justice movement can help de-stigmatize this very common, yet controversial, issue and foster its inclusion in other areas of social justice work.

These examples are not exclusive of each other and often combinations of factors play a role in a woman's reproductive oppression:

Abortion is a matter of...

- **Racial inequity:** When a Native American woman is denied coverage for an abortion because her health care is federally funded and is therefore subject to federal restrictions.
- **Economic justice:** When a woman discovers that abortion is not covered by her insurance policy. Most women seeking services (74%) pay an average of \$468 out of pocket for a first-trimester abortion.
- **Youth issues:** When a pregnant teenager asks her boyfriend to beat her until she miscarries because she is subject to parental notification laws and feels she cannot involve her parents.
- **Violence:** When a woman is coerced into an abortion by her abusive husband or partner. Pregnant women in general are most likely to experience domestic violence. The leading cause of death for pregnant women is homicide.
- **Religious intolerance:** When a woman with a dangerous ectopic pregnancy is refused treatment in a Catholic hospital because her life-saving surgery would be considered an abortion.
- **Immigrants' rights:** When an immigrant woman's language barriers and lack of access to health services cause her to resort to an illegal, unsafe abortion.
- **Rights for people with disabilities:** When women in the U.S. with schizophrenia have less access to abortion through federal programs, such as Medicaid, and have higher rates of unintended pregnancy than women without mental illness.
- **Imperialism:** When U.S. foreign aid policies deny abortion care and referrals to women in developing countries who face the highest risks of dying during childbirth, and lead to the closure of clinics that once provided well-baby care, immunizations, and other comprehensive health services that actually reduce the need for abortions

...And all of these issues are matters of reproductive justice.

As the reproductive justice framework teaches us, these injustices cannot be divided. We may not be able to work on every issue, but we can ask ourselves: How does my work support or undermine the work of others in this movement? Although abortion can be a difficult and controversial topic, its inclusion in activism and advocacy is critical to the holistic vision of reproductive freedom and justice.

Suggested Actions

- **Volunteer** as an advocate for women seeking abortion, or start an abortion fund to help low-income women afford services.
- **Ask your healthcare provider and health center about the services they provide.** Find out if your provider considers him or herself LGBT-friendly or provides contraceptives and abortion services.
- **Educate** your friends, family and peers about the importance of access to safe, affordable abortion.

RESOURCES

- Center for Reproductive Rights, <http://www.crlp.org>
- MergerWatch, <http://www.mergerwatch.org>
- National Network of Abortion Funds, www.nnaf.org
- SisterSong, www.sistersong.net

CONDITIONS OF REPRODUCTIVE JUSTICE

By Rickie Solinger

Reproductive Justice recognizes women's right to reproduce as a foundational human right.

The right to be recognized as a legitimate reproducer regardless of race, religion, sexual orientation, economic status, age, immigrant status, citizenship status, ability/disability status, and status as an incarcerated woman encompasses the following:

Women's right to manage their reproductive capacity

1. The right to decide whether or not to become a mother and when;
2. The right to primary culturally competent preventive health care;
3. The right to accurate information about sexuality and reproduction;
4. The right to accurate contraceptive information;
5. The right and access to safe, respectful, and affordable contraceptive materials and services; and
6. The right to abortion and access to full information about safe, respectful, affordable abortion services;
7. The right to and equal access to the benefits of and information about the potential risks of reproductive technology.

Women's right to adequate information, resources, services and personal safety while pregnant

1. The right and access to safe, respectful, and affordable medical care during and after pregnancy including treatment for HIV/AIDS, drug and alcohol addiction, and other chronic conditions, including the right to seek medical care during pregnancy without fear of criminal prosecution or medical interventions against the pregnant woman's will;
2. The right of incarcerated women to safe and respectful care during and after pregnancy, including the right to give birth in a safe, respectful, medically-appropriate environment;
3. The right and access to economic security, including the right to earn a living wage;
4. The right to physical safety, including the right to adequate housing and structural protections against rape and sexual violence;
5. The right to practice religion or not, freely and safely, so that authorities cannot coerce women to undergo medical interventions that conflict with their religious convictions;
6. The right to be pregnant in an environmentally safe context;
7. The right to decide among birthing options and access to those services.

A woman's right to be the parent of her child

1. The right to economic resources sufficient to be a parent, including the right to earn a living wage;
2. The right to education and training in preparation for earning a living wage;
3. The right to decide whether or not to be the parent of the child one gives birth to;
4. The right to parent in a physically and environmentally safe context;
5. The right to leave from work to care for newborns or others in need of care;
6. The right to affordable, high-quality child care.