

Reproductive Justice Is... An NCJW Discussion Guide

“**Reproductive Justice Is...**” is an NCJW discussion guide designed for NCJW members and supporters to delve deeper into reproductive justice as an **intersectional framework**. This framework explores how different systems of oppression interact to affect a person’s ability to make personal decisions about their body, sexuality, health, and future. This guide includes articles about diverse identities and social justice struggles, followed by discussion questions to spark conversation.



How to Use This Discussion Guide

Here are a few ways you can use this resource to dig in to the reproductive justice framework. With the exception of the first set of articles on intersectionality, the pieces are not listed in any particular order. Adapt the questions to the needs of your NCJW section or community.

- ▶ **Put together a “reading club”** — Schedule a series of discussions for interested advocates and discuss each set of articles.
- ▶ **Discuss at a meeting** — Ask members of your board or advocacy committee to read one set of articles and then schedule time at the next meeting to discuss it.
- ▶ **Create handouts for an event** — Are you putting together a panel discussion on paid leave? Make copies of the “Reproductive Justice is Economic Justice” set of articles and hand them out.
- ▶ **Read aloud during Shabbat dinner** — Looking for a way to work some learning into your Shabbat meal? Select a set of articles to read aloud during dinner and then discuss.

The NCJW Washington office is available to provide additional resources and technical assistance. Contact Leanne Gale (Leanne@ncjwdc.org) with any questions.

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Please note that NCJW does not necessarily endorse the specific viewpoints presented in individual articles, and some articles may contain profanity.

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I. Intersectionality and Reproductive Justice: An Overview

A Tale of Two Movements

January 22, 2015

By Miriam Zoila Pérez in Colorlines

Today is the 42nd anniversary of the historic Roe v. Wade Supreme Court decision that opened the door for legal access to abortion in the United States. In the decades since, particularly in the last five years since the 2010 midterm elections, we've seen a steady rise in laws designed to limit or even eliminate that access. On the first day of the new Congress early this month, five bills alone were introduced that focused on restricting abortion access. Today the House of Representatives are set to vote on a proposed 20-week abortion ban.

While Roe v. Wade was a historic turning point for the reproductive rights movement, a new movement has blossomed in the decades since: reproductive justice (RJ). This 21-year-old movement seeks to change how we fight for abortion access by pairing it with the broader struggle to create, support and nurture the kinds of families we want. For RJ leaders and activists this idea is second nature, but the movement hasn't yet reached critical mass. For the uninitiated, here are six key differences between the reproductive justice and reproductive rights movements.

I. Race Matters

Race is a major dividing line between the two movements, both in terms of leadership as well as approach. RJ architects such as Loretta Ross developed a frame that focuses on the experiences of those marginalized by racism and discrimination because they felt that communities of color and the issues most important to them were not being represented in the traditional reproductive rights movement. Monica Raye Simpson, executive director of the Sistersong Women of Color Reproductive Justice Collective lays this out: "Women of color are concerned about feeding their children, they are concerned about making sure their child gets the medication they need, they are worried about their job security, they are worried about whether or not their child or partner will become the next Mike Brown or Eric Garner. All of these issues are RJ issues."

2. Poverty Does Too

Race is implicitly tied up with class in the U.S., so RJ analyzes how class--particularly poverty--shapes people's ability to choose when they parent. On the policy level, the movement has tackled the Hyde Amendment, a law passed in 1976 that severely restricts the use of federal funds for abortion services by people on Medicaid and Medicare and federal employees.

Some states have stepped in and funded these services, but most don't. That means that unless you have private insurance you must pay for abortion procedures out of pocket. This is just one example of how legal access to abortion means little to those who can't jump other hurdles such as cost. Procedures can cost anywhere from \$300-\$3000. Maria Elena Perez, director of policy and strategic partnerships at the National Institute for Reproductive Health, explains this further: "The right to reproductive health care is insufficient if low-income women can't afford those services or don't have transportation to the clinic or lack workplace policies that allow them to take time off for appointments." In response to financial hardship, grassroots groups have raised money to help people pay for their procedures through local abortion funds. Many of these groups utilize a reproductive justice analysis in their work.

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3. The Most Marginalized Are at the Center

“Reproductive justice recognizes that legal rights do not always translate to meaningful access. It centers the experiences of the marginalized--immigrants, people of color, queer and trans folks, youth, and low-income communities,” explains Jessica González-Rojas, executive director of the National Latina Institute for Reproductive Health. This ideology is a marked departure from reproductive rights--where focusing solely on legal access effectively puts those whose other needs are already being met at its center.

4. RJ Takes a Holistic Approach

Verónica Bayetti Flores, a queer immigrant writer and activist, explains: “A reproductive justice framework takes into account whether a person can afford an abortion; whether a gender non-conforming person can feel safe from the threat of discrimination or violence while accessing such gendered care; whether a person has a clinic nearby or whether they have to travel a significant distance; whether there’s an immigration checkpoint along the way; what access to transportation looks like; the economic impact for a person who does not have paid sick leave of taking several days off due to long-distance travel and waiting periods; whether the clinic is wheelchair accessible, and on and on.” Tannia Esparza, executive director of Young Women United, says that this frame includes people other than the woman seeking an abortion: “While the reproductive rights movement has advocated for much-needed abortion and contraception rights, the reproductive justice movement acknowledges the realities of whole people, whole families, and whole communities and asks us to challenge the systems that impact us the most.”

5. A Focus on the Right to Parent

In addition to securing women’s abortion rights, RJ emphasizes the right to parent. This is another place where race--and the experience of racism--shapes women’s experience. Women of color have faced major barriers to parenting through policies like coercive sterilization in public hospitals and prisons and racist stigma about who is fit to parent. “Reproductive justice works to ensure that we can express our sexuality without judgment, plan and prevent pregnancy and also have healthy pregnancies,” says Cristina Aguilar, executive director of Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR). This emphasis on parenting, and the challenges facing women of color who want to parent, has been a cornerstone of the RJ movement.

6. Building Connections Across Movements

Policy change using the RJ approach means combining efforts with other movements. “We think about our policy change work from a perspective that is multi-issue,” says Miriam Yeung, executive director of the National Asian Pacific American Women’s Forum. “We actively try to link organizations and leaders across silos.” This type of cross-sector alliance-building has been a strategy of reproductive justice groups. “If we want to see these anti-choice policies disappear,” says Sistersong’s Simpson, “We have to be willing to show up for our other movements so that we can build our collective power.”

Yeung points to the San Francisco-based opposition to sex-selective abortion bans as an example of the potential of cross-issue organizing. “We’ve been highlighting the racial injustice aspects of sex-selective abortion bans that target our community, and it gives us potentially a whole new set of allies to engage with us.” COLOR, the Latina RJ group in Colorado, has also successfully rejected a “personhood” ballot measure three times now, in part thanks to their successful organizing in Latino communities which resulted in “record-high turnout,” according to Aguilar.

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Tamika Middleton, interim executive director of SPARK Reproductive Justice NOW based in Atlanta, says that RJ activists must be on the offensive: “Offering a policy agenda that is rooted in reproductive justice principles gives us the power to force conservatives to engage in a debate that is framed by us rather than them,” she says. “By offering a policy agenda that seeks to address issues like poor sexual health outcomes, a living wage and police accountability--while being steadfast in our opposition to anti-choice policy--we can ensure that we are having a conversation about what we are for rather than what we are against.”

Discussion Questions

1. Based on this article, what is the difference between the reproductive justice and reproductive choice framework?
2. The article explains that under the reproductive justice framework, “the most marginalized are at the center.” What does that mean? What could that look like in your advocacy?
3. What are some examples of building connections across movements in the fight for reproductive justice? What could this look like in your community?
4. How does the reproductive justice framework connect to Jewish values?

[Why Intersectionality Can't Wait](#)

September 24, 2015

By Kimberlé Crenshaw in The Washington Post

Intersectionality was a lived reality before it became a term.

Today, nearly three decades after I first put a name to the concept, the term seems to be everywhere. But if women and girls of color continue to be left in the shadows, something vital to the understanding of intersectionality has been lost.

In 1976, Emma DeGraffenreid and several other black women sued General Motors for discrimination, arguing that the company segregated its workforce by race and gender: Blacks did one set of jobs and whites did another. According to the plaintiffs' experiences, women were welcome to apply for some jobs, while only men were suitable for others. This was of course a problem in and of itself, but for black women the consequences were compounded. You see, the black jobs were men's jobs, and the women's jobs were only for whites. Thus, while a black applicant might get hired to work on the floor of the factory if he were male; if she were a black female she would not be considered. Similarly, a woman might be hired as a secretary if she were white, but wouldn't have a chance at that job if she were black. Neither the black jobs nor the women's jobs were appropriate for black women, since they were neither male nor white. Wasn't this clearly discrimination, even if some blacks and some women were hired?

Unfortunately for DeGraffenreid and millions of other black women, the court dismissed their claims. Why? Because the court believed that black women should not be permitted to combine their race and gender claims into one. Because they could not prove that what happened to them was just like what happened to white women or black men, the discrimination that happened to these black women fell through the cracks.

It was in thinking about why such a "big miss" could have happened within the complex structure of anti-discrimination law that the term "intersectionality" was born. As a young law professor, I wanted to define this profound invisibility in relation to the law. Racial and gender discrimination overlapped not only in the workplace but in other arenas of life; equally significant, these burdens were almost completely absent from feminist and anti-racist advocacy. Intersectionality, then, was my attempt to make feminism, anti-racist activism, and anti-discrimination law do what I thought they should — highlight the multiple avenues through which racial and gender oppression were experienced so that the problems would be easier to discuss and understand.

Intersectionality is an analytic sensibility, a way of thinking about identity and its relationship to power. Originally articulated on behalf of black women, the term brought to light the invisibility of many constituents within groups that claim them as members, but often fail to represent them. Intersectional erasures are not exclusive to black women. People of color within LGBTQ movements; girls of color in the fight against the school-to-prison pipeline; women within immigration movements; trans women within feminist movements; and people with disabilities fighting police abuse — all face vulnerabilities that reflect the intersections of racism, sexism, class oppression, transphobia, able-ism and more. Intersectionality has given many advocates a way to frame their circumstances and to fight for their visibility and inclusion.

Intersectionality has been the banner under which many demands for inclusion have been made, but a term can do no more than those who use it have the power to demand. And not surprisingly, intersectionality has generated its share of debate and controversy.

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Conservatives have painted those who practice intersectionality as obsessed with “identity politics.” Of course, as the DeGraffenreid case shows, intersectionality is not just about identities but about the institutions that use identity to exclude and privilege. The better we understand how identities and power work together from one context to another, the less likely our movements for change are to fracture.

Others accuse intersectionality of being too theoretical, of being “all talk and no action.” To that I say we’ve been “talking” about racial equality since the era of slavery and we’re still not even close to realizing it. Instead of blaming the voices that highlight problems, we need to examine the structures of power that so successfully resist change.

Some have argued that intersectional understanding creates an atmosphere of bullying and “privilege checking.” Acknowledging privilege is hard — particularly for those who also experience discrimination and exclusion. While white women and men of color also experience discrimination, all too often their experiences are taken as the only point of departure for all conversations about discrimination. Being front and center in conversations about racism or sexism is a complicated privilege that is often hard to see.

Although the president’s recent call to support black women was commendable, undertaking intersectional work requires concrete action to address the barriers to equality facing women and girls of color in U.S. society.

Intersectionality alone cannot bring invisible bodies into view. Mere words won’t change the way that some people — the less-visible members of political constituencies — must continue to wait for leaders, decision-makers and others to see their struggles. In the context of addressing the racial disparities that still plague our nation, activists and stakeholders must raise awareness about the intersectional dimensions of racial injustice that must be addressed to enhance the lives of all youths of color.

This is why we continue the work of the #WhyWeCantWait Campaign, calling for holistic and inclusive approaches to racial justice. It is why “Say Her Name” continues to draw attention to the fact that women too are vulnerable to losing their lives at the hands of police. And it is why thousands have agreed that the tragedy in Charleston, S.C., demonstrates our need to sustain a vision of social justice that recognizes the ways racism, sexism and other inequalities work together to undermine us all. We simply do not have the luxury of building social movements that are not intersectional, nor can we believe we are doing intersectional work just by saying words.

Discussion Questions

1. How would you define intersectionality? Can you give an example?
2. What identities do you hold, and how do they intersect? How does intersectionality play a role in your life?
3. How does intersectionality play a role in your advocacy work? How could it play a greater role?
4. Who are the people most impacted by reproductive oppression? Who are the groups with power and privilege? What issues have historically been left out of the discussion on reproductive rights?

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2. Reproductive Justice is Economic Justice

Recent SNAP Restrictions Are Another Reminder That Poverty Is a Reproductive Issue

Jun 29, 2015

By Katie Klabusich in Rewire

I know firsthand that for many people, poverty is often related to a lack of access to basic health care, including abortion. This growing burden, carried primarily by poor people, is a blind spot for many.

My decision to have an abortion in 2010 wasn't influenced by a lack of financial stability; I knew at 30 years old that I didn't want children of my own. The circumstances that led to my unplanned pregnancy, however, were entirely due to almost a decade of living with food insecurity.

We use the word “choice” constantly in the reproductive rights movement. Almost always, this is to indicate the legal right to choose what happens to us, as though life is so easily reduced to such technicalities. But the existence of a right does not ensure that those who need to exercise it will have access to it. I didn't choose my economic circumstances or the discrimination inherent in the pre-Affordable Care Act for-profit insurance industry, which together allowed the pregnancy to happen. So I have always bristled at the way an overuse of “choice” implies that options are a guarantee. In order for health and true equality to be in reach for all, we must understand what poverty is, who is affected by it, and deal with our discomfort as a culture acknowledging the millions who live and struggle under its weight.

When you are one of the 49 million United States residents who can't be sure they'll eat tomorrow or next week, every aspect of your life is about economics. The longer you live with uncertainty and instability, the more you realize that those who don't share your experience are unaware that all issues, movements, and public policy are rooted in economic justice—or injustice. I know firsthand that for many people, poverty is often related to a lack of access to basic health care, including abortion. This growing burden, carried primarily by poor people, is a blind spot for many legislatures and courts around the country, particularly where restrictions on abortion and other kinds of reproductive care are concerned.

I was reminded of the link between health-care access and poverty yet again in the face of the justifications from the current wave of governors and state representatives proposing rules undercutting vital food assistance programs. Maine's governor is worried about pickles; a Missouri lawmaker thinks Supplemental Nutrition Assistance Program (SNAP) recipients are living large on crab legs; and the Wisconsin legislature can't continue to abide poor people eating potatoes and jarred pasta sauce. Every week, it seems, another lawmaker is trying to find a guilt-free way to shave one percentage point off the budget by cutting programs that keep people alive and create economic growth.

Earlier this month, when the latest of these restrictions trickled down through the media, I found myself brimming with anger in response to the stigmatizing language and the pervasive focus on the middle class with no mention of the poor. Eventually, this spilled over into a hashtag on Twitter, #PovertyIs, which managed to trend briefly, despite the rarity of this topic in public conversations. People from around the world defied stigma and shaming to share their everyday experiences with poverty—the emotion, the strain, the stress, the hunger, the physical discomfort, and the decisions our friends and neighbors don't have to weigh constantly.

As I read the responses, I was reminded of my own abortion story—how for me, like many others, poverty meant deciding between food and other necessities. In my case, that was birth control.

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Five years ago, I was still living in Chicago when the generic birth control pill began to fail at countering my monthly migraines, debilitating cramps, and other symptoms that made working on my feet impossible. So I was prescribed the NuvaRing. It worked like a charm—at almost \$80 per month, because it was name-brand-only and the prescription plan I paid for out of pocket wouldn't cover it. At a healthy, pre-existing condition-free 28 years of age in the years before the Affordable Care Act, my health care was costing me an outrageous total of \$350 every month, assuming I didn't actually use it to see a doctor or fill additional prescriptions. Following my third job loss that year, I was forced to choose between food and birth control—certainly a health “care” system failure.

When I became pregnant as a result, I was relatively lucky in terms of getting to the procedure itself. My Chicago address had made it relatively easy to access care; even though many of the clinics in the city are picketed, there are, in fact many clinics. I was also lucky to have managers and co-workers at both jobs that either understood or didn't care that I needed a couple days off for a medical procedure. I even had my own OB-GYN with whom to discuss my circumstances. I only ended up at Planned Parenthood because my insurance didn't cover the elective procedure, so I went where I could find a way to afford the appointment.

Still, the most expensive part of my abortion wasn't the \$400 or so I charged to my credit card at the clinic; it was the unpaid time off from four shifts at two jobs. The ACA may have improved matters in some respects by eliminating the co-pays for contraception and annual exams—for which I am very grateful every day I enjoy the freedom of my IUD—but people still have to be able to physically access a clinic in order to appreciate this policy upgrade. When doctors' appointments require travel, time off, child care, follow-up prescriptions, follow-up appointments, and trips to the pharmacy, co-pays were never the only expense. And those of us living in poverty feel every payout. I wouldn't have been in a position where \$80 could break me if my economic circumstances had been at all stable before the prescription upgrade or losing that third job.

Recently, an unexpected medical bill led me to a new perspective on my unplanned pregnancy from five years ago. I'm one of many long-term underemployed United States residents with little-to-no room for error in my monthly budget. This latest health surprise put me over the edge completely. I wasn't able to play bill roulette or juggle basics or max out a credit card to bridge the gap this time around, so I applied for CalFresh, California's food assistance program.

After two years of covering the fight to keep Mississippi's only clinic open and spending time with activists in the Rio Grande Valley, my new situation, combined with the flood of proposed SNAP restrictions and the #PovertyIs responses, has re-centered economic justice in my advocacy and reporting. It's also refocused my abortion story, leading me to be bolder about the root causes of my unplanned pregnancy. I always cared about people's economic circumstances, but I now have a fundamentally different relationship to those affected by abortion restrictions and to the phrase used to measure the unnecessary ordeal they endure to attain access.

The undefined, unequally applied “undue burden” standard makes the disproportionate effect of abortion restrictions on the poor especially evident. The Fifth Circuit's most recent ruling again moves the goalposts on “undue burden” by deeming the ambulatory surgical center requirements of the Texas omnibus anti-abortion law HB 2 valid. Though the Supreme Court has stayed the ruling for now, according to advocates, if implemented, this provision of HB 2 could shutter all but nine clinics in the state.

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Simply looking at the second largest state in the union on a map is enough to grasp some level of how disastrous this would be for its 27 million residents. Living in the center of West Texas already meant at least a five-hour drive in one direction or another to access a clinic in either San Antonio or New Mexico. Add in waiting periods, ultrasounds, counseling, admitting privileges that limit the number of doctors available to perform procedures in any given region, and my two days off work and \$1,000 grand total in out-of-pocket cost and lost wages seems like a drop in the bucket. My ordeal five years ago was enough to go through, considering it shouldn't have been necessary. But my white, cis, documented, able-bodied privilege all stacks up to a comparatively easy road. Even my finances were less strained thanks to timing and hard work coming together; I didn't have \$1,000 lying around to throw away, but I was able to find it.

Texas is hardly an anomaly—it's simply a powerful visual depiction of how abortion restrictions affect a population over an enormous area. But the corridor stretching from the western border of Idaho to the eastern borders of North and South Dakota is a nearly 1,200-mile-wide clinic desert. Some states only have a single full-scale reproductive health clinic. Defunding Planned Parenthood through cuts to family planning services has caused five clinics to close in Indiana—none of which even provided abortion care. These “pro-life” policies have created a public health crisis in an area currently dealing with an HIV outbreak.

Meanwhile, on a federal level, House Republicans are attempting to eliminate Title X funding, a program that has provided millions of low-income people with STI testing, cancer screenings, contraception, and treatment since President Richard Nixon championed and signed it into law in 1970.

Nixon matter-of-factly explained why he was backing the law at the time: “It is my view that no American woman should be denied access to family planning assistance because of her economic condition.”

Almost everything seems to have changed in the past 45 years. The more I watched people on the #PovertyIs thread discuss putting off medical care despite having insurance because they couldn't get off work or couldn't afford the co-pays, the more absurd the debate about burden became to me. HB 2 alone has been in appeals for two years. How long does it take, exactly, for a handful of judges to decide whether 500 miles over three days or more, hundreds of dollars in lost pay and child care, and the emotional strain of navigating the ever-changing landscape is too much to put people through when they have the power to prevent all of it from happening in the first place? Why do those in power see the concept of “burden” as solely a political and/or legal issue, without direct connection to people's economic condition?

To those with modest or substantial means, the burden is automatically attached to the concept of our rights: how far is too far and how much is too much to exercise a constitutional right? But for those of us without a safety net, burden is a word that feels heavy. It sounds like the keys of a calculator clicking to determine whether this month's math means we eat, have heat, and can put enough gas in our cars to get to work. That heaviness is the intersection of reproductive justice and economic justice, and it should be given equal weight in policy discussions, in advocacy, and in our media.

Just as SNAP funding provides a lifeline to those who need it, access and funding to reproductive health care provide a basic level of bodily autonomy and the opportunity to determine one's own present and future. You can't be a functional, autonomous human without the ability to eat, just as you can't be fully human and free without the ability to control if, whether, and when you become a parent. These connections have long been clear and foundational to the reproductive justice movement built by women of color too-often sidelined and silenced by mainstream feminist and reproductive rights

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advocates. It's long past time that their voices and approach to culture change became the standard for advocacy work.

Bodily autonomy is about more than just controlling what is happening right now in your reproductive system. Having final say over what happens within and around your body determines whether or not you are the one who decides the direction of your life. Ensuring self-determination for all people is the foundation to achieving economic justice; acknowledging this reality strengthens our movement and ensures that we strive to help people in need today as we secure the rights of everyone for the future.

Discussion Questions

1. Identify the economic justice issues raised in this piece. How did they intersect to impact the author's abortion story?
2. When have you experienced or observed a time when access to reproductive health care was restricted or denied due to economic insecurity?
3. The author highlights how issues of reproductive health care access are directly tied to issues of economic security. In order to ensure reproductive justice for all, what are some ways to tackle these issues at the same time?
4. The author discusses how the idea of "choice" is often irrelevant when women do not have the economic means to truly be able to make their own decisions. How can pro-choice advocates reframe our messaging to be inclusive of all situations?

[California Minimum Wage Increase Is a Win for the Reproductive Justice Movement](#)

May 27, 2016

By Carley Towne in Huffington Post

Amid a barrage of depressingly frequent state-level attacks on abortion access, California Governor Jerry Brown and state labor unions struck a historic deal in April of 2016 that should be celebrated as a win for reproductive justice activists everywhere. Brown agreed to raise the minimum wage to \$15 by 2022 and ensure that after 2024, the state minimum wage will be indexed to the cost of living. While the deal has been widely celebrated as a win for the grassroots Fight for \$15 movement, many have failed to recognize how important increasing the minimum wage is for the reproductive justice movement.

This is unabashedly good news for the more than 5 million minimum wage workers across the state who will receive an average annual earnings increase of \$3700. Increasing the economic security of minimum wage workers, important for all women, is welcome news for anyone who is invested in balancing the scale of power in favor of marginalized communities. For those of us who have witnessed the swift degradation of abortion rights over the last five years, however, the \$15 minimum wage victory is particularly important.

Expanding workers' rights is a necessary tenet of the reproductive justice movement, as economic security is critical for all women - especially in light of the wage and other systemic disparities that women of color experience. Removing all barriers that stand in the way of a person's ability to access reproductive health care has always been and continues to be central to the reproductive justice movement. Since the Supreme Court's decision in *Roe v. Wade*, which recognized the constitutional right to terminate a pregnancy, reproductive justice activists have worked to make that right a reality. Reproductive justice activists recognize that ensuring everyone, regardless of income, has meaningful access to health care is integral to guaranteeing that right.

Increasing the minimum wage puts more money into workers' pockets, which is an important part of expanding economic security for workers and their families. While California does not require people to endure mandatory waiting periods or travel across state to access reproductive health care services, an abortion can cost upwards of \$1000. Particularly for under-insured and uninsured low-wage workers, this cost can be prohibitive. Working folks should not be forced to choose between accessing the reproductive health care services they need and fulfilling other basic needs.

Putting more money in workers' pockets will affect more than just someone's ability to pay for an abortion. Increasing the minimum wage has also been shown to reduce child poverty among female-headed households. Thirty-one percent of minimum wage workers in California are women who have children, so Jerry Brown's decision will substantially affect their ability to achieve economic security and provide the kind of life they want for their families.

Raising a person's purchasing power means that they have more control over the direction and quality of their lives and their children's lives. While raising the minimum wage is not a catchall solution to barriers Californians face when trying to exercise their right to choose, it's certainly a step in the right direction. The reproductive justice movement should celebrate and rally behind any law that not only expands meaningful access to abortion services, but places economic control back into the hands of all people.

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Discussion Questions:

1. How would increasing the minimum wage to a living wage of \$15 help advance reproductive justice?
2. How would increasing the minimum wage affect your life?
3. Through advocacy, organizing, community service, and *tzedakah* (philanthropy), NCJW works to realize its vision of a just society — a society in which each of us has full and equal access to the quality of life that we all deserve. How can we use our *tzedakah* effectively when it comes to the intersection of economic and reproductive justice?
4. What other economic justice victories might expand access to reproductive health care and advance reproductive justice?

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3. Reproductive Justice is Disability Justice

Disability and Reproductive Justice

December 21, 2013

By S.E. Smith in Disability Intersections

Reproductive justice includes the right to control the timing and spacing of children, if one wants to have them at all, but the issue of starting families and the right to have children is often overlooked, particularly among mainstream organisations. For some groups of marginalised people (such as the LGBTQ community and communities of colour), this right is critically threatened and in need of protection just as much as the right to access contraception and abortion services is; among disabled people, for example, there is a very real risk that the right to have and keep children without interference will be restricted thanks to attitudes about disability and parenting.

There's a common belief that disabled people are not capable of parenting, particularly if they have cognitive, intellectual, or developmental impairments, or if they have physical impairments. An estimated 30% of disabled people, in contrast with 40% of nondisabled people, are parents struggling in a world where the right to parent is not protected if you don't have a normative body or brain. When your child can be taken from you because of who you are, you live in a constant state of tension; simply wheeling down the street with your child can become a balancing act.

Notably, some disabled people are barred from having children at all through forced and coerced contraception and sterilisation. It's commonly believed that these issues lie in the past, or occur primarily in the Global South, but this is in fact far from the truth. Involuntary sterilisation of disabled people happens worldwide, including in the US, with the United Nations noting that sterilisation is used as a form of torture in some regions of the world. Recent cases in both the United States and the United Kingdom illustrate that forcible sterilization is a clear and present danger.

For those allowed to retain some reproductive autonomy and control over their fertility, getting pregnant and deciding to keep the pregnancy does not necessarily equate to being permitted to raise the child. Disabled people are frequently hard-pressed to defend their parenting rights, a sharp contrast to the conventional approach to handling questions of parenting and autonomy, where the state is required to develop a compelling argument for separating a child from her home environment, and where reunion with the family is usually considered the primary goal.

For disabled people, having a child can be a constant battle. Not in the sense of fighting a willful teen, but in the sense of confronting an establishment that believes children would be safer in the homes of nondisabled parents—and, better yet, shouldn't be born to disabled people at all, on the grounds that they're unfit for the responsibility.

Arguments against allowing children to remain in the homes of disabled parents include claims that d/Deaf parents won't hear cries for help, quadriplegic parents won't be able to assist their children with tasks of daily living, and parents with intellectual impairments won't be able to understand and take on the responsibilities of parenting.

For disabled people, having a child can be a constant battle. Not in the sense of fighting a willful teen, but in the sense of confronting an establishment that believes children would be safer in the homes of nondisabled parents—and, better yet, shouldn't be born to disabled people at all, on the grounds that they're unfit for the responsibility. Beneath this runs a current of eugenic attitudes, sometimes even

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explicitly stated, a suggestion that disabled people shouldn't have children for reasons of social responsibility, because they might "pass it on."

Most states still have laws on the books permitting the seizure of a child on the grounds that disability makes someone an unfit parent. Such laws are clear violations of the Americans with Disabilities Act (ADA), and more than that, they're a profound human rights injustice, denying disabled people the basic right to build and have families, to have children and raise them in a safe and loving environment. When disability is used as grounds for taking a child into custody, it tears families apart and sends a dangerous social signal, a warning that disability is dangerous, and disabled people are not to be trusted with children.

This applies not just to parents who conceive naturally, but also to parents who are struggling to conceive and need assistance; treatments may be denied on the grounds of disability, a clear case of discrimination and one that shouldn't be tolerated. Few reproductive justice advocates have plunged into the tangled and complex ethical thicket of assisted reproduction, let alone laid out a clear case for the defense of parents who need assistance with conception or carrying a pregnancy; since some disabled people have impairments that necessitate assistance or require surrogate or donor material, this leaves them at a particular disadvantage.

Likewise, the adoption system in the US discriminates against disabled parents with a framework that puts barriers in the way of adoption for disabled people interested in fostering or adopting. Adoptive parents may be taken far into the process before being rejected on the grounds of impairments like cerebral palsy, despite ample evidence of their willingness and ability to care for children; this is a devastating turn of affairs for people who long for full social inclusion, which includes the opportunity to parent if they want to.

As we think about reproductive freedoms this week, we must consider all their permutations, and the importance of a world in which the right to parent is protected just as fiercely as the right not to parent, or to choose to wait to become a parent. Disabled people need the full force and support of the reproductive rights movement, and so do their children; freedom for some is justice for none, and no loving, competent parent should have to live in daily fear that her child will be taken from her simply because of who she is, how she lives her life, the fact that she lives interdependently rather than independently.

Discussion Questions

1. Have you experienced or witnessed the stigma against individuals with disabilities having and raising children described in this piece? How did it make you feel?
2. Did you confront or realize any biases you hold regarding people with disabilities becoming parents? How might these biases impact your advocacy work, and how might you overcome them?
3. As the author notes, reproductive justice reaches far beyond abortion and contraceptive access. What does reproductive justice look like for parents with disabilities, and how can we work to end the stigma they face and ensure they can have and raise children in the manner in which they choose?

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[Zika Virus Threat Puts Abortion Rights And Disability Rights On Collision Course](#)

February 4, 2016

By Chloe Angyal in Huffington Post

As more cases of Zika virus pop up in the U.S., abortion rights advocates are raising concerns about whether harsh abortion restrictions will affect pregnant women's ability to terminate pregnancies if they're infected with the virus.

Zika has been linked to microcephaly, in which babies are born with underdeveloped brains and abnormally small heads. Some cases seen in Brazil and elsewhere in the Americas have been severe. As The Huffington Post reported last week, people born with microcephaly "may suffer from additional ailments, including convulsions, impaired vision and hearing, deformed limbs and severe breathing problems."

In El Salvador, where abortion is completely outlawed, the government has advised women to simply not get pregnant until 2018. In Brazil and other Latin American countries, the outbreak has officials re-examining strict abortion laws. Here in the U.S., officials have stayed mum on the topic, but abortion rights advocates are rightly wondering what an increase in fetal abnormalities would mean at a time where abortion restrictions — from lengthy waiting periods to laws designed to shutter clinics — have left millions of American women without access to abortion care.

But if what the WHO calls an "explosion" of Zika does indeed lead to an uptick in fetal abnormalities in the U.S., the abortion rights movement faces another problem: a coming clash with the disability rights movement.

While abortion rights advocates might well point to Zika-linked microcephaly as evidence that the U.S. needs to liberalize abortion laws, disability rights advocates might argue otherwise. On the issue of abortion, the feminist and disability rights movement often come into uncomfortable conflict as they struggle to accommodate both the rights of a woman to control her own fertility and the rights of people with disabilities to exist.

Now, with the threat of Zika-linked fetal abnormalities looming, that fault line could well crack open, and at least one thought leader in disability rights is concerned by the hastiness with which calls for loosened abortion restrictions are being made.

There are clear parallels between the experiences of women and those of people with disabilities (not to mention overlaps between the two groups), noted Rosemarie Garland-Thomson, a professor of English at Emory University and a pioneer of the discipline of disability studies. Through much of history, she said, able-bodied women were not allowed to control their own reproduction.

"There's a long, deep and troubling history of women's reproduction being taken over by men and by a variety of other cultural institutions," she told HuffPost. Likewise, people with disabilities have long been subject to reproductive coercion, from the abandonment of newborns with disabilities to mandatory sterilization of women with disabilities. They have, said Garland-Thomson, "been eugenically eliminated from the world through selective abortion and other biomedical practices."

Both groups have similar histories of subjugation, particularly around medical decision-making. And on the issue of access to abortion, particularly in the age of prenatal fetal testing, those histories collide.

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It's important to note that the causal connection between Zika and microcephaly has not been clearly established. In Colombia, for example, many cases of Zika have been reported, with no corresponding increase in microcephaly. "I think everyone is concerned about that and with good reason, but we don't know that 100 percent for sure yet. It's not completely established," said Dr. Anne Davis, a practicing OB-GYN and an associate professor of Clinical Obstetrics at Columbia University.

And, though this week saw the first U.S. case of sexually transmitted Zika, most reproductive rights organizations are calling for a measured response, while the CDC is warning pregnant women to postpone travel to areas affected by Zika.

Complicating the abortion issue is the fact that microcephaly in a fetus cannot be detected until well into the second trimester of a pregnancy. "Late in the first trimester you can see the complete absence of the brain, anencephaly, but not microcephaly," says Davis, who is also an abortion provider who performs second-trimester abortions.

This presents a problem if microcephaly cases spike in the U.S. One percent of abortions performed in the U.S. happen in the second trimester and when they do, they usually happen because of a threat to the life of the mother or due to fetal abnormalities.

Abortion at this point in a pregnancy is rare and hard to come by. It's expensive — often well over \$1,000 — and that's before you factor in the cost of traveling and accommodation to see the few providers who perform the procedure, skipping days of work for travel and recovery (and waiting periods in between appointments, which some states require), securing childcare for any kids you might already have, and so on. "Once you detect [a fetal abnormality], it's not like you have an ultrasound and right that second they say 'OK, if it's the right choice for you, you can have your abortion,'" Davis says. The longer a woman waits — to make her choice, or to raise the money to exercise it — the more expensive the procedure becomes.

Pregnant women who choose to have an abortion when microcephaly shows up in fetal testing have an enormously difficult decision to make, Davis said. She does her best to explain to expecting families what they can expect their child's life to be like. "It depends on the severity of the microcephaly," she said. "There's a range, and you do have some information about that from ultrasounds. We can guide families about the severity of what we see. And that's where the real conversation occurs, doctor to family, doctor to woman. You can give people some guidance, it's not just a diagnosis and then you say 'well we'll see what happens.'"

Still, it's not an easy decision, as reproductive rights advocates acknowledge, and considering a potential child's quality of life is central to it. "What we argue for is empowered, informed decision-making," says Ilyse Hogue, president of NARAL Pro-Choice America. "Women make decisions for all sorts of reasons, and no one walks in their shoes but them. At the end of the day, we could litigate every individual case, but that undercuts the core value that's at stake, which is that we live in a country that prizes autonomy and information."

Embedded in the calls for re-examining abortion policies as Zika looms is the assumption that aborting a fetus with microcephaly is ethical and that women will want and should have the right to ability-selective abortions. There's little room, in the usual pro-choice argument, for the notion that that disabled child has the right to exist, or for questioning the notion that life with a disability is inherently worse than life without one. That having a child with a disability is undesirable is usually taken as a given, not just by pro-choice advocates, but by much of U.S. society.

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Somehow, what got written into the idea of reproductive choice and freedom is the assumption no woman is prepared or would want to parent a child with a disability.

Disability rights advocates argue otherwise. “Somehow, what got written into the idea of reproductive choice and freedom and self-determination for women is the assumption that no woman is prepared or would want to parent a child with a disability,” Garland-Thomson said.

She acknowledges that there are very real challenges involved in parenting a child with disabilities. Raising special needs children can be enormously resource-intensive, and is often done with limited government or other structural support. The same states that are narrowing abortion access “also offer almost no support for women who need quality care for special needs children,” Hogue observed.

Nicole Cliffe, editor of *The Toast* and the mother of a special needs child, expressed her frustration this week in a series of tweets. “We fail so terribly not just at providing disability resources, but for providing parents (esp[ecially] ESL parents) with the info to ACCESS them,” she wrote. “My child needs such minor support and I do not know how people without money and/or education navigate the paperwork and services and hoops.”

“It’s days off work, it’s out-of-pocket therapies until diagnoses kick in, it’s fighting your insurance, it’s becoming a full-time advocate,” she continued. “A kid with disabilities born into poverty should be able to receive adequate support and care, and we just do not provide that.”

How is it just, abortion rights advocates rightly ask, that the government force women to bring children with disabilities into the world under these circumstances? Garland-Thomson isn’t unsympathetic to this argument, but she notes that it wouldn’t hold water were we to substitute race of gender for disability.

She blames the lack of public knowledge about the lives of people with disabilities for the widespread belief that ability-selective abortions are normal, desirable and ethical.

“Reproductive self-determination is understood as a kind of *carte blanche* for women to exercise basically a kind of set of discriminatory attitudes and practices,” she said.

To allow reproductive justice and disability justice to coexist more harmoniously, Garland-Thomson doesn’t advocate restricting reproductive rights any further than they’ve been curtailed. “I think what we have to do is rescript the story: the story of disability is almost always a grim one, particularly in terms of prognosis,” she says. The solution, she argues, is to expand reproductive choices, “but we expand them in a deliberative way. I don’t think we should have a no-questions-asked abortion policy — we should have a lot of questions asked after viability.” The decision to terminate a pregnancy, she said, “should be a very deliberative process where there is full consideration of all the possible vectors of consideration for women, rather than just “holy shit, I don’t want to have a disabled kid.”

It’s hard to imagine, in the current political climate, how American states might enact policies to genuinely encourage that deliberative process. Disguising hurdles to abortion access as a way of ensuring that women carefully consider their choices — making them look at the ultrasound image, explaining to them what the fetus looks like — is a favored tactic of the anti-abortion movement. The result, as Davis says, is that “abortion access has been shrunken down to the size of a postage stamp.” Garland-Thomson is calling for a genuine, non-coercive version of that process, but in the U.S. in 2016, it’s hard to imagine how to protect it from anti-abortion hijacking. She also calls for new policies and systems that will allow all parents, regardless of means and the abilities of their children to flourish.

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While that sounds intensely desirable — as a long-term societal project — it doesn't suggest an answer to the fiercely urgent question: what do we do now? What do we do if a few months from now, when mosquito season arrives, hundreds or thousands of low-income women in Texas and Florida find themselves pregnant with fetuses that show severe brain damage? What does ethical behavior look like in the here and now, in this political reality?

As is often the case when it comes to abortion, the stakes are high — and there are no easy answers.

Discussion Questions

1. Each and every one of us is made in the image of God — *B'tselem Elohim* (Genesis 1:26). What does this Jewish teaching mean to you in the context of disabilities and reproductive justice?
2. The author highlights how some disability rights activists fear that the intersection of abortion access and the threat of Zika virus will lead to unethical or discriminatory decisions. How can reproductive justice advocates walk this fine line? How can we empower and ensure a woman is able to make a decision that is best for her?
3. Besides abortion access, what kinds of reproductive health care must be available to women who decide to carry a pregnancy with fetal abnormalities to term and raise a child with disabilities? How does economic justice come into play in this context?

4. Reproductive Justice is Racial Justice

Is Egg Freezing Only for White Women?

May 21, 2016

By Reniqua Allen in the New York Times

It all started with these little chocolate colored pink and blue ceramic babies. They were a strange Christmas gift from an older family friend who, I assumed, didn't realize that baby figurines were better suited for a person with a nursery and not someone who uses her spare bedroom for dirty laundry.

But the friend, Ms. Rosalie, made it clear that these brown babies on rocking horses were not a mistake. They were a reminder that my childbearing years were slowly ticking away, and that I should try to have a child soon whether or not I was married. I nervously laughed and hid the gift in the basement of my mother's house.

A few months later, after an unsurprising breakup, I looked at the fading surgery scar across my abdomen — the remnant of surgery I had eight years earlier to remove uterine fibroids and treat endometriosis — and realized it was time to heed Ms. Rosalie's advice. I started thinking about freezing my eggs.

A lot of people are talking about egg freezing: It's the latest perk for professional women at companies like Facebook and Apple; it's being marketed as a welcome solution for millennial women who want more control over their reproductive lives. It's moving more mainstream. But few of the women having these conversations are black, and few of the discussions are geared toward black women.

A survey conducted by researchers at the Fertility Center at New York University Langone Medical Center and New York University School of Medicine found that between 2005 and 2011, 80 percent of respondents who had frozen eggs at their center to preserve fertility were white. Four percent were black. In my own small anecdotal survey, none of my close-knit circle of black female friends in their 30s had considered the procedure.

Part of the problem is superficial — the photos of happy patients on fertility websites and brochures don't look much like me, so it didn't seem like egg freezing was targeted toward me, even though I am a professional woman in my 30s. It felt like my community had been left behind in this new path to maternal "empowerment" that centers on elite white women, who have long been thought of as the model of femininity and motherhood.

My concern went deeper than whitewashed brochures, and even beyond the price, though with costs starting around \$10,000 in many cases, that is a factor. While assisted reproductive technology can help women delay motherhood, it can also help them eventually decide to do it on their own.

Considering this procedure opens up the possibility that I could become a single mom as a black woman. I worried about becoming a stereotype, a stigma, despite coming from a loving, stable, middle-class single-parent home myself.

Still, I wanted to know more about my options. I thought I might get some of my questions answered during an information session at a downtown New York City fertility clinic, where the room was lily-white, both in terms of attendees and aesthetics.

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I was uncharacteristically quiet during the session, perhaps because I was only one of a handful of nonwhite women and one of only two black women in the crowded space. I wanted to ask the other black woman in the room, who happened to be sitting next to me, what she thought: Did she have concerns about stigma? Lingering worry about the history of black women and forced sterility treatments — was this a front for secret government tests? Fear that she would be seen, negatively, as a “baby mama” — a term that even the very much married Michelle Obama once had thrown in her face?

But racial solidarity today can be a tricky thing, valuable to some and a disdainful reminder of the past to others. So I stayed silent and imagined what it would feel like to tell someone I had a kid on my own.

Black women aren’t given the luxury of having their nontraditional choices appear to be new and radical. When we make “unconventional” decisions around reproduction, we’re stigmatized. Or labeled angry. Or lonely. Or difficult. We’re robbed of our agency to do and be anything that’s outside of the boundaries of whatever is perceived as normal.

Poor black women are criticized for having too many babies they “can’t afford” and professional middle-class black women are criticized for being too picky and not finding a man. But when professional white women follow these same patterns, it’s often labeled a trend or brave or empowering.

“There’s stigma on us if we decide to have an abortion,” said Monica Simpson, the executive director of SisterSong, a reproductive justice organization for minority women. “There’s stigma on us if we decide to have multiple children. There’s stigma on us if we decide to use in vitro or if we are in same-gender loving relationships or queer relationships and we are creating families outside the ‘normal’ context.”

Last year, the former model Tyra Banks admitted that she struggled with fertility treatments and recently announced that she and her partner had successfully had a baby via a surrogate. And BET’s “Being Mary Jane” had its lead character freeze her eggs on the fictional show. It is a step in the right direction, and I’m glad more black women are speaking up about these issues. But the more I continued to research egg freezing, the more I could not separate it from questions of race.

I called Dr. Desireé McCarthy-Keith, an obstetrician gynecologist and a fertility specialist in Atlanta, who is working to change the discussion around these technologies. She confirmed that it wasn’t just my imagination and said black women are left out of the conversation around egg freezing, though it’s “slowly changing.”

“Historically, fertility treatments have been mostly targeted to and used by white women, middle-class women, so the initial presentation of fertility treatments, they didn’t really include us in the conversation,” she said.

Ms. Simpson, of SisterSong, said there was a real divide between white and black women who consider this technology. “I have black women who decide to be single moms, but they know they can’t create a blog and say, ‘I’m getting ready to be a single mom.’ That’s nothing new for us, and it’s nothing we can wear as a badge of honor because we’ve been stigmatized for that, we’ve been demonized for that.”

Dr. McCarthy-Keith said within the black community there are still women who think “we” don’t do things like freeze our eggs, so support is sometimes lacking.

At her diverse practice in Atlanta, she said she’s encountered fewer black patients who undergo egg-freezing procedures for the sole purpose of delaying childbirth, but thinks that it could also be because black patients simply aren’t being advised about these procedures at the same rate as their white counterparts.

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I WANT motherhood to be on my own terms instead of society defining what it should look like and how I should make it happen. But this is hard in a world that often believes that women who look like me are hypersexual, unfeminine and undesirable — anything but motherly.

Of course, there are many other concerns that I have about egg freezing: the medical worries, the costs, will it make me bloat (!), but this small part of it, this anxiety about the stigma of single motherhood, exposes things about myself that I don't like to admit. Me trying to assimilate. Me trying to overcompensate for all the other stereotypical behavior I do embrace. (I'm loud. I'm always late. I love Moscato.) Me wanting to have that traditional life that looks like Mayberry. I want to get married and have a kid someday, and I'm not ready to give up on that idea, but I also wonder why I'm so afraid of the prospect of single parenthood.

It's my respectability politics gone amok.

Or maybe it's just me trying to work out issues over my absentee father — my own lonely tears and youthful feelings of abandonment that make me ambivalent about putting a child through something similar.

I'm still considering freezing my eggs. I appreciate that women who are overwhelmed and overburdened by reproductive issues have more options. But I also hope that the fertility industry will realize the narrowness of the lens that it's using to talk about this technology. I want black women to feel like egg freezing isn't just for their rich, white peers and to know that we, too, can make unconventional decisions the norm.

Discussion Questions

1. The author quotes reproductive justice leader Monica Simpson referring to racial bias that black women face when it comes to family and reproductive decisions, who said, "There's stigma on us if we decide to have an abortion... There's stigma on us if we decide to have multiple children. There's stigma on us if we decide to use in vitro or if we are in same-gender loving relationships or queer relationships and we are creating families outside the 'normal' context."
 - a. Have you experienced or witnessed the impact of such biases or stereotypes around black women, or realize biases you hold around black women and issues of pregnancy, parenting, and family building? How did it make you feel?
 - b. How might such biases impact your work as an advocate, and how might you overcome them?
2. NCJW believes that every human being, regardless of race, ethnicity, gender, or any other factor has the right and deserves the resources to have or not have children. How can we work to include women of color in fertility assistance? What other barriers to pregnancy related care do women of color face and how can we work to undo them?

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What the War on Reproductive Rights Has to do With Poverty and Race

May 25, 2016

By Renee Bracey Sherman in Yes! Magazine

When Justice Harry A. Blackmun authored the decision legalizing abortion in *Roe v. Wade*, he wrote that “[t]he right of personal privacy includes the abortion decision, but this right is not unqualified and must be considered against important state interests in regulation.” Although this was a win for those seeking to both legalize abortion and prevent harm inflicted on people seeking illegal and unsafe abortions, it also opened the door to restrictions on abortion.

The closures are particularly concentrated in the South where more than half of Black Americans reside. That door was pushed open further with the ruling in *Planned Parenthood v. Casey*, which allowed states to regulate abortion provided they didn’t create an “undue burden” to patients seeking care. State politicians across the country have marched right through that door. The Guttmacher Institute reports that one-quarter of the more than one thousand state abortion restrictions were passed between 2011 and 2015—mostly in conservative states.

And it’s working. In 2011, almost 90 percent of counties did not have an abortion provider, and since then that number has increased. Five states (Mississippi, Missouri, North Dakota, South Dakota, and Wyoming) have only one abortion clinic in the entire state, while others like Alabama, Georgia, Louisiana, Ohio, and Texas have only a handful of clinics left; a drastic shift from just a few years ago.

The closures are particularly concentrated in the South where more than half of Black Americans reside. Despite anti-choice activists repeating the myth that most abortion clinics are set up in predominantly Black communities, fewer than one in ten are actually in communities with a majority of people of color.

With this tidal wave of anti-choice laws quickly washing away the rights *Roe v. Wade* gave to all women, it’s clear that not all communities are impacted the same. In the United States, race and class are major factors in who can access abortion care, contraception, and maternal health care. However, mainstream discourse too often separates race and class from abortion. It ignores the complex issues around a person’s ability to decide whether, when, and how to become a parent. It ignores how crucial the abortion decision is to gender equity, economic stability, and a healthy life free from violence. Mainstream discourse about abortion decisions does not often include the ability of someone to parent their children with dignity.

One in three cisgender women in the United States will have an abortion before age 45. I am one of them.

At the age of 19, I realized I was pregnant. The frequent naps, sore breasts, and vomiting tipped me off, but I was in denial. Until my then-boyfriend’s best friend clearly pointed it out: “Dude, she’s pregnant.”

Once the CVS pregnancy test confirmed the result, we sat on the couch and discussed what to do. I knew my hourly retail job wouldn’t allow me to give my child the future I had always imagined. I was struggling in college and didn’t have the \$30 to pick up a birth control pill pack in the first place. As I weighed my options and briefly flirted with the idea of becoming a parent, I thought about the life that I would be able to provide my child.

My then-boyfriend, also 19, had dropped out of high school a few months into our freshman year. This pregnancy came after he had recently served time on a drug charge in a prison boot camp program for

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first time offenders. Our relationship was toxic, and getting increasingly violent. His boxer's fracture, given to him by the wall next to my head, had recently healed.

While many people do make a family work with a frequently incarcerated partner, I wasn't sure that was what I wanted. The lack of a safety net for families living in poverty and the structural racism impacting Black families were always in the back of my mind. Even in the best of circumstances, I questioned whether I could protect my child from all the harms of the world. Considering the additional harms this potential family configuration would create, why would I have a child when I felt least equipped?

My decision was clear: I was not ready to become a parent. I simply didn't want to be pregnant anymore.

I wasn't alone in my decision. Every year, more than a million women choose to have an abortion, a third of them Black women. My abortion was a decision I feel lucky to have been able to make.

I have been sharing my abortion story for several years. These days, more people than ever are sharing their own stories in an effort to destigmatize the experience. Last year, an explosive social media campaign #ShoutYourAbortion launched on September 19. Organizers of that campaign encouraged everyone to share stories of how their lives were transformed because they had access to safe and legal abortions. This campaign continues to change the narrative of abortion, from one of shame and stigma, to one of people who are grateful and liberated. However, like many visibility campaigns, voices of more affluent White women often rise to the top even though the majority of people seeking abortions are people of color.

ForHarriet writer Altheria Gaston offers one explanation: Black women's abortion stigma is compounded by misogynoir, "a term that captures the unique oppression Black women experience not just as a result of sexism, but as a result of sexism that is tinted by our Blackness," she wrote. "It can serve as a caveat that Black women and women who are poor may face different consequences for shouting their abortion than White and affluent women."

This is something I've experienced myself. The additional stigma borne by people of color makes increased visibility challenging. It can invite a racist, anti-abortion backlash in addition to the usual misogynistic hate. All of a sudden, rather than simply being a "slut" for having had an abortion and daring to speak in positive terms about it, you're also a "race-traitor" perpetrating genocide against your own people. These race-baiting tactics don't show up just online—they're being imported into our communities.

While claiming to care about Black lives, anti-abortion advocates have used racist billboard campaigns to shame Black women out of having abortions without addressing any of the reasons why we choose abortion: lack of access to contraception and comprehensive sexual health education, along with severe cuts to health care, safety net, and nutritional programs. In 2010, 65 billboards went up in Atlanta declaring, "Black children are an endangered species." Famously, in Chicago, a billboard featured an image of President Barack Obama and stated, "Every 21 minutes, our next possible leader is aborted."

In response, billboards have gone up that speak to the needs of Black women. In Memphis, Tennessee, SisterReach used several billboards to address the need for access to health care that includes reproductive care, neighborhoods free from toxins and violence, and quality schools. The message of New Voices Cleveland's billboard, in the wake of the 2014 police shooting of 12-year-old Tamir Rice, was that reproductive justice must include assurance that families are able to raise children free from racist violence, including police brutality.

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Seeing reproductive health, rights, and justice in this larger, intersectional context clearly underscores what women in communities of color need. More to the point, it shows the needs anti-abortion advocates and politicians are not addressing.

Sexual exploitation, violence, and forced reproduction were a central part of the slave trade after Congress passed the Act Prohibiting Importation of Slaves in 1807. Without the ability to import slaves from Africa and the Caribbean, slaveholders focused additional resources on ensuring their female slaves became pregnant and gave birth to healthy children—to create future slaves and expand property. Slaveholders used rape as a tool for procreation as well as a weapon to punish female slaves or for sexual gratification. “Slavery is terrible for men, but it is far more terrible for women,” said Harriet Jacobs, an escaped slave and writer quoted in Dr. Dorothy Roberts’ book *Killing the Black Body*.

Enslaved women used herbs such as black haw root, red shank root, red pepper, and gunpowder as forms of contraception as well as to increase the spacing between their pregnancies and to terminate pregnancies. The ability to prevent unintended pregnancies and to abort unwanted pregnancies traditionally allowed women to protect their health (abortion is safer than carrying a pregnancy to term) and to control the size of their family. To control one’s reproductive health and fertility during slavery was seen as an act of rebellion challenging slaveholder authority. Abortion’s stigma may have its beginnings here as it denied slave owners the ability to profit from enslaved women’s bodies.

Once slavery was abolished and Black women needed support in raising their families, their fertility was deemed irresponsible and a burden to society. Yet access to birth control and abortion care was segregated. Historian Leslie J. Reagan writes, in *When Abortion Was a Crime*, that White hospitals and providers refused to offer health care to Black patients forcing Black doctors to set up separate illegal abortion and birth control clinics.

Race and racism have been intertwined with reproductive health care—and its lack. Hundreds of years later, not much has changed.

Although media depictions tend to portray a woman getting an abortion as a young, single, White, middle-class woman without children, the majority of people having abortions are in fact people of color, the majority of whom are already parenting in poverty. According to the Guttmacher Institute, Black women account for 30 percent of abortions, Latinas account for 25 percent, and other non-White races account for 9 percent.

And there are other complexities buried in the statistics. While it’s true that Black women obtain abortions at five times the rate of White women, researchers attribute this to lack of health insurance and contraception access. And here’s the unfunny punchline: Low-income women tend to get their contraception dispensed from the same reproductive health care clinics that are being shut down.

Because these low-income women don’t have access to contraception, they need access to abortion care. Of all women obtaining abortions, 42 percent are living below the federal poverty level of \$10,830 for a single woman without children. Another 37 percent live between 100 percent and 199 percent of the federal poverty level. And another unfunny punchline: Women denied the abortions they seek are three times more likely to be living in poverty two years later.

Among the abortion restriction policies that drive numbers like these, the Hyde Amendment is singular in its effect of turning abortion access into a war on the poor. Hyde denied Medicaid recipients, disproportionately women of color, access to abortion care by banning insurance coverage. This policy leads one in four women to carry a pregnancy to term that she otherwise might not have.

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It's been 40 years since *Roe v. Wade*. Many Americans can recall the days before the landmark decision, when women sought abortions from illegal providers and died as a result. We haven't come so far. According to a 2015 study by the Texas Policy Evaluation Project at the University of Texas at Austin, an estimated 100,000 to 240,000 women have attempted self-induced abortions because of an inability to access a medical abortion.

In June 2015, Kenlissia Jones, a 23-year-old Black woman, was arrested in Georgia on charges of malice murder and possession of a dangerous drug after she attempted to self-induce her abortion with medication, reportedly because of a breakup with her partner and the lack of abortion-care providers in her community. Jones, who was allegedly 22 weeks pregnant, purchased abortion medication online but rushed to the hospital when she began to bleed. A hospital social worker called police, and Jones was arrested. The murder charge was later dropped.

Jones is one more in a long line of women of color who have faced criminal charges and jail time for, or for being suspected of, self-inducing an abortion. Earlier in 2015, in Indiana, Purvi Patel, a 33-year-old Indian American woman was accused of feticide after seeking treatment at an emergency room for a miscarriage. Authorities found text messages where Patel told a friend she purchased abortion medication from a Hong Kong pharmacy. Patel is serving a 20-year sentence, and in May 2016 filed an appeal. There are many others. Women of color tend to live in poverty and tend to lack access to reproductive health care. They also tend to be criminalized for self-inducing abortions. As states increasingly criminalize abortion, low-income women of color are the targets.

It is paramount that we fight for reproductive justice and bodily autonomy at the same time we fight for Black liberation. As activists attempt to reverse the tide of abortion restrictions, it would be a mistake not to make racial and economic injustice central themes in the reproductive rights movement going forward. Lives depend on it.

Discussion Questions

1. What factors does the author describe as intersecting with race to make black women's access to abortion disproportionately difficult and stigmatized? How can you help eliminate such concrete barriers, as well as stigma?
2. Altheria Gaston explains *misogynoir*, "a term that captures the unique oppression Black women experience not just as a result of sexism, but as a result of sexism that is tinted by our Blackness." Have you witnessed or experienced this form of oppression? How did it make you feel? What are some ways that advocates seeking to advance reproductive justice can help dismantle it?
3. How can we unite multiple social justice movements under the umbrella of reproductive justice in order to help women of many identities? What are some steps you can take in your own community?

5. Reproductive Justice is Immigrant Justice

[Want to Expand Abortion Rights in Texas? Better Talk About Immigration, Too](#)

April 16, 2014

By Dani McClain in The Nation

If you follow the wave of anti-choice laws restricting abortion at the state level, you know things look bleak in Texas. Last month, the last two clinics in the Rio Grande Valley closed, leaving women in rural South Texas without access to services. Because of the hurdles providers now have to clear as a result of House Bill 2, which passed in July, the number of clinics in the state has dropped by nearly half—from 44 in 2011 to 24 today. By the fall, just six facilities providing abortion are expected to remain.

Legal challenges are in the works, but for now anti-choice advocates there are winning. So my ears perked up last week at a talk at UC Berkeley on the past, present and future of reproductive justice when I heard these words from someone considered one of the movement's top tacticians: "If you lead with immigration reform, you might actually get abortion access in Texas."

Heads nodded and tweets were fired off as Sujatha Jesudason, who directs CoreAlign, an organization supporting new leaders in the fight for sexual and reproductive health, offered this take on how to best achieve policy change. But the room was mostly filled with activists and academics who are already acquainted with reproductive justice, a 20-year-old framework for advocacy and organizing that links abortion to other social and economic issues. Reproductive justice gives a more inclusive set of rights — the right to have children, not have children, and to parent with dignity — equal weight with the right to safely and legally terminate a pregnancy. For anyone not already familiar with the concept, the idea that you vote for one issue and somehow end up with a victory elsewhere may feel like a leap of logic, if not a bait and switch.

Not if you understand the barriers a woman in the Rio Grande Valley or California's Central Valley faces when she has an unplanned pregnancy, said Samara Azam-Yu, when I asked her perspective. Azam-Yu directs ACCESS, an Oakland, CA-based hotline that offers reproductive health information to callers statewide. "Abortion is a priority issue for a lot of our callers but it's not the most pressing issue that they're facing in their lives," she said. "When we make strides on the other broader issues, it improves abortion access."

Here's how, she said: An undocumented woman in the Central Valley has a good chance of having a high-risk pregnancy, given high rates of asthma and obesity and other health disparities associated with poverty and inability to access health care. She may need to travel to see an abortion provider, but that means taking a bus or a train and chancing a run-in with ICE. A victory on immigration reform would mean removing the fear of deportation that keeps women immobilized, isolated and away from the services they need. Talking about health access as it relates to reform could be a way to motivate voters who care about immigrant rights but don't feel connected to the abortion rights movement.

A bill introduced in the US House last month — the Health Equity and Access Under the Law for Immigrant Women & Families Act — is trying to do just that by making insurance available to more than 600,000 people who are in the US lawfully but face a five-year wait in some states before they can access benefits such as Medicaid and the Children's Health Insurance Program. Connecting the dots in new ways was also an important component of last year's victory over an Albuquerque ballot initiative that would have banned abortion in the city — and effectively the region — after 20 weeks.

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In Albuquerque, the goal wasn't to advance immigrant rights while defeating the bill, but to use language that would resonate with Latino voters — typically considered too conservative to be reliable on abortion rights issues — and get them to come to the polls during the November special election.

“We brought the issue out of the ivory towers of reproductive rights conversations and made it about real people experiencing barriers to access health,” Tannia Esparza, who directs Young Women United (YWU), told me. “There’s a whole generation of young people, people of color who haven’t been included in those conversations in the same way.”

YWU, a local organization led by women of color, was part of the coalition that opposed the initiative and pushed for a new approach to talking about abortion that would reach beyond the middle class white voters who could be counted on to reject the proposal. The group used language that they knew from anecdotal evidence and from research would mobilize a broader base, language that focused on the importance of women and families making decisions for themselves. One piece of campaign literature read, “We are parents, tías, niños, brothers and sisters. We are neighbors, friends, people of faith — We are New Mexican families... Our New Mexican families do not need government interference in our private decisions.” It turned out to be key to avoid labels like “pro-choice” and “pro-life,” which Esparza calls polarizing. It worked: More than 80,000 Albuquerque voters went to the polls, more than had turned out for the mayoral race six weeks prior. Ten percent more Democrats weighed in on the ban than had chosen the city's mayor, compared to 4 percent more Republicans and 7 percent more Independents. YWU's research and polling showed that their work in Latino communities paid off at the polls. According to Micaela Cadena, the group's policy director: “We won over Latino Democrats. Those who were Independent or Republican, we held their vote to where it was in the beginning [of the campaign].”

It's a strategy that could be useful to abortion rights proponents in nearby Arizona, where legislators passed a law last week allowing health inspectors to make surprise visits to abortion clinics without first getting a warrant, and where a temporary court order is the only thing keeping a new restriction on medication abortion from going into effect.

Moving away from a singular focus on abortion isn't about aligning with one particular movement, it's about creating a big tent that's appealing to progressive Millennials, according to Jesudason.

“How can we bring a gender perspective to discussions around minimum wage or immigration reform, knowing that they're all the same voters?” she said when we spoke after last week's talk. “If people are going to vote progressively on minimum wage or marriage equality, they're just as likely to vote progressively on choice issues.”

Discussion Questions

1. The author discusses ways that abortion access can be reframed in terms of other social justice issues. Besides immigration reform, how might abortion or other health care access issues be reframed to gain support in your community?
2. Under current law, many lawfully present immigrants must endure a five year waiting period to access health insurance. In what ways could this be a violation of reproductive justice?
3. How can women of different identities, such as women of color and immigrant women, be included in the “ivory tower” of reproductive justice conversations that Tannia Esparza mentions?

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'Women Are Dying': The Severe Effects of Clinic Closures on Undocumented Women

May 24, 2016

By Nandita Raghuram in Broadly

In the US, undocumented women struggle to obtain necessary and sometimes lifesaving reproductive health care—and things are only getting worse.

The Rio Grande Valley sits at the southernmost tip of Texas, nestled right above Mexico. One of the poorest places in America, it is also home to nine percent of the state's undocumented immigrants. Almost half of its population has less than a ninth-grade education. There are a high number of colonias here—unincorporated communities that don't have basic services like plumbing, clean water, sewage, electricity, and paved roads.

For many women living in the region, accessing affordable reproductive health care is yet another problem to add to the list. Nine out of 32 family planning clinics in the area shuttered between 2011 and 2012, while 82 clinics have closed in the state as a whole. That means that women seeking contraception, a routine pap smear, or a mammogram are left without options.

The Rio Grande Valley is far from an anomaly: Finding adequate health and abortion care proves difficult in other parts of the country as well. Prohibitive federal and state laws surrounding health insurance, combined with decreased funding to clinics, unsteady income, and a lack of transportation, leave very few options for undocumented immigrants. These factors come together in a pernicious way, leading to dire health consequences and perpetuating cycles of poverty.

One woman I spoke to, Gabriela Hernandez, says that as a child, she only went to the doctor for emergencies. Originally from Ciudad Juarez in Mexico, Hernandez has lived in the United States for 16 years. She was approved for a work permit in October of 2013, but some of her family remains undocumented. When she was younger, health care was hard to find. “Growing up, my mom was also afraid that we could be deported or not be able to afford to go to the doctor, so we hardly went,” she told me over email. Most “undocumented people don't have health care, so going to the doctor is expensive and finding a clinic that could help low income [people] was hard because of the language, location, or time.”

These challenges can prove deadly. Cervical cancer, for example, is highly preventable disease, but the rate is almost twice as high for Hispanic women along the border than non-Hispanic women. “It's not because they're less healthy or there's something inherently wrong with their bodies,” Jessica González-Rojas, the executive director at the National Latina Institute for Reproductive Health, says. “It's literally because they do not have access to regular, affordable, quality health care.” Eveline Shen, the executive director at Forward Together, similarly says that that “undocumented women are less likely to use prenatal services and have higher rates of low birth weight than documented immigrants.”

As Katrina Anderson, the interim director for US Human Rights and Foreign Policy at the Center for Reproductive Rights, explains, there are some women in the Rio Grande Valley who know that they have symptoms of cancer but can't get treatment. “They have large cysts in their ovaries or in their uterus and they're unable to access any kind of screening.” That means they're living in a state of anxiety and pain. She says that some women hadn't received any kind of test even after two years of living with symptoms. “There are people who get totally preventable forms of cancer, like cervical cancer, and die from it prematurely.”

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According to Anderson, this dangerously restricted access comes from two sources: policy-based barriers and structural barriers. Coverage (and lack thereof) “depends on your status, and it depends on where you live,” she says.

In most cases, under federal law, undocumented immigrants can't sign up for health insurance under Medicaid and the Children's Health Insurance Program despite being low income. They're also not able to purchase health care. That means women are often denied easy access to preventive reproductive health care, such as wellness exams or contraception. González-Rojas told me that undocumented immigrants can meet many of their needs through federally-qualified community health centers or Title X clinics, which provide contraception, sexuality education, and other forms of family planning health care. But understanding which clinics to go to is yet another challenge.

Max Hadler, a health advocacy specialist at the New York Immigration Coalition, explains that accessing quality reproductive health care is difficult precisely because “it's very complex—even for people who study this all the time—to understand what the options are.” Laws differ by state, so deciphering their nuances is even more complicated. While some states, like New York, provide insurance for undocumented immigrants and also offer services for children and pregnant women, not all do.

Texas is the poster child for reduced health care access and its effects. A report from the Center for Reproductive Health and the National Latina Institute for Reproductive Health entitled *Nuestro Voz, Nuestro Salud, Nuestro Texas* surveyed the severity of the problem in the Rio Grande Valley. Seventy-eight percent of the women interviewed (including lawfully present immigrants) didn't have health insurance at all. The report states that “most US lawful permanent residents and citizens interviewed are low-income but do not meet the extremely low threshold for Medicaid in Texas. Others do not qualify for Medicaid because they lack US residency or citizenship.” Out of the 19 undocumented women interviewed for the report, 11 said that their immigration status posed as an impediment to accessing reproductive health care.

Barriers here also tend to be more restrictive than other parts of the country. For example, while, nationally, lawfully presenting immigrants must wait five years to become eligible for Medicaid, Anderson explains how there you can be a lawfully present immigrant, living in Texas for years, and still not be eligible for Medicaid.

But even if one were to qualify for insurance, structural barriers—such as a lack of transportation, poverty, and border checkpoints that make travel to distant clinics anxiety-ridden and difficult—cause even more difficulties when accessing the basic care every woman needs. Shen explained that many undocumented immigrants depend on federally-funded Title X clinics, but “border cities often exist in remote areas, far from abortion and family planning clinics, making it difficult to get to where services are offered.”

Making matters worse, the cost for these services is prohibitive. In the Rio Grande Valley “nearly every woman interviewed identified cost as the primary barrier to accessing reproductive health services and supplies,” according to the *Nuestro Voz, Nuestro Salud, Nuestro Texas* report. If a woman could pay for a preventive care visit, subsequent tests, follow-up care, medication, and contraception were often unaffordable.

The first [clinics] to go are the ones in rural areas where undocumented people tend to reside. Anderson says that the only option for undocumented women is often those clinics that provide free or sliding scale services regardless of insurance or immigration status. But as funding decreases and these clinics close, an undocumented woman is likely to encounter even more roadblocks on the road to decent health care.

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As Daniela Ramirez, a spokesperson for Planned Parenthood, notes, “Blocking patients from receiving care at Planned Parenthood—and thus reducing the availability of quality, trusted health care providers—also strikes a huge blow to undocumented immigrants' already limited access to reproductive health care.” The *Nuestro Voz*, *Nuestro Salud*, *Nuestro Texas* report similarly concluded that “the clinic closures and the severe reduction of services in the Valley have greatly exacerbated these systemic barriers by requiring women to wait longer for appointments, travel further away from their communities, and pay more for reproductive health goods and services.”

As Anderson says “the first [clinics] to go are the ones in rural areas where undocumented people tend to reside.” To make matters worse, public transportation in places like the Rio Grande Valley is limited. The *Nuestro Voz*, *Nuestro Salud*, *Nuestro Texas* report explains that women will often ask friends or family for help, but “arranging rides around others' availability—most commonly in the evenings after work—is often challenging due to limited appointments at clinics.” On top of that, women must find babysitters or bring their children with them.

Almost every person I spoke to cited fear as another hurdle. According to Ramirez, “many immigrants stay home instead of visiting a health care provider for fear of encountering law enforcement.” Hadler similarly said that there's “a huge amount of stigma and fear around approaching any sort of authority such as a health care provider.” Shen explained that a huge reason that pregnant immigrants don't get prenatal care is because of “fear of ICE, police, and health care providers — of being reported for one's documentation status while accessing health care.” These fears are not unfounded. One undocumented woman recently faced deportation after visiting an OB-GYN.

These roadblocks increase exponentially when a woman tries to access an abortion. When Grace Klein worked as a Patient Advocate at Cleveland's Preterm clinic, a woman came in asking for an abortion. Throughout their introductory session, as Klein was explaining the procedure and asking how she was doing, the woman acted uneasy and nervous. Towards the end, the woman became tense and asked, “So do you need to see my papers?” When Klein assured the woman that she was safe there, she says, she “saw her whole body just relax.”

Since abortion is not covered by Medicaid in most cases, an undocumented woman who wishes to terminate an unwanted pregnancy has few options. Republican-backed restrictions on abortion clinics put even more strain on undocumented immigrants by closing providers and forcing women to travel across long distances in order to receive an abortion. Ramirez says that, “for undocumented women, this could put safe abortion completely out of reach, since these drives may require crossing border checkpoints.” Zoey Lichtenheld, Communications Coordinator at NARAL Pro-Choice Texas, agreed, noting, “It's impossible for them to travel to the nearest clinic without going through border checkpoints.”

As a result, some undocumented women will choose to self-induce abortions. Ramirez says, “Research and experience have shown that where abortion is illegal or highly restricted, women may resort to self-inflicted trauma, consumption of chemicals, self-medication, and even unqualified, untrained and likely unsafe providers.”

Moreover, a woman who wants an abortion but can't get one is three times as likely to drop below the poverty line in the years following. “A woman struggling to make ends meet should not have to make the decision about whether or not to end her pregnancy based on how she gets her health coverage or how much money she has—her decision should be based on what is best for her and her family's circumstances,” says Ramirez.

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Undocumented women are experiencing the struggles that all women in America are experiencing right now: an increasing lack of control over their health and their bodies. The difference is that undocumented immigrants are further caught in “the intersection of anti-immigration policies and restrictive reproductive health care legislation,” according to Ramirez.

And the results are harrowing. As Gonzalez-Rojas puts it, “Women are dying.””

Discussion Questions

1. Share your family’s immigration story. How has it shaped your understanding of reproductive justice?
2. Given the stories shared in the article, what are the different systems of oppression facing immigrant women living in the Rio Grande Valley? In order to advance reproductive justice, which issue is the most important one to tackle? Can more than one challenge be addressed simultaneously?
3. In addition to restrictive laws about health care coverage, how are immigrant women in a particularly harrowing position when it comes to reproductive justice?
4. Our Jewish values teach us to pursue justice for all (Deuteronomy 16:20), to take action when we witness injustice (Leviticus 19:16), and that we must “do what is right and what is good.” (Deuteronomy 6:18). What does it mean to take action against injustice? What would justice look like for immigrant women and children?

6. Reproductive Justice is LGBTQ Justice

Abortion Access Is an LGBT Issue

October 1, 2013

By Lauren Paulk in National Center for Lesbian Rights

September 30th marked the 37th anniversary of the enactment of the Hyde Amendment, the federal provision that bans Medicaid coverage for abortion-related health care. The Hyde Amendment has been one of the most devastating attacks on the ability for low-income families to access health care. Since the Amendment passed, people relying on Medicaid for health coverage have effectively been prevented from accessing crucially important abortion-related care. This tragic anniversary comes at the end of September, which is Abortion Access Month. This month, activists have been having difficult and affirming conversations about who exactly has access to abortion, and what access truly means.

Disturbingly, we have seen a narrative emerge that imagines the movement for access to abortion, contraception, and other reproductive justice issues is separate from (and sometimes, alarmingly, in opposition to) the movement for LGBT equality.

This could not be further from the truth. Not only is there a high level of representation of LGBT people in organizations that fight for reproductive justice, but LGBT people themselves are deeply and personally affected by reproductive issues like abortion restrictions, access to contraception, and comprehensive sex education. All LGBT-identified people who could become pregnant are at risk for an unintended pregnancy, and in fact studies have shown that lesbian young women in particular are two to ten times more likely to become pregnant than heterosexual youth. Moreover, lesbian and bisexual women are often at higher risk of sexual assault due in part to their sexual orientation, which may also result in an unplanned pregnancy. Attempting to fabricate a reality where the only people who care about access to abortion and contraception are non-transgender heterosexual women does not comport with what those of us working in the reproductive justice community already know: abortion access is an LGBT issue, and LGBT issues are reproductive justice issues.

We must understand this issue in terms of a broader social justice movement and the overlapping forms of marginalization that further victimize LGBT people attempting to access their full reproductive rights. A number of issues work together to increase the vulnerability of the LGBT community in this area. The Hyde Amendment's bar on federal funding for abortion mainly affects—and was designed to affect—low-income people, including the high percentage of the LGBT community that is low-income and living below the poverty line. The failure of our educational system to provide comprehensive and inclusive sex education is part of what makes LGBT youth more susceptible to unintended pregnancies, potentially resulting from engaging in “camouflage” sex in order to avoid facing torment for their sexual orientation or gender identity. Due to a number of tragic factors, LGBT young people, particularly queer and transgender youth, are disproportionately homeless and housing insecure, and may engage in survival sex that may result in unplanned pregnancy and/or sexual assault. We cannot continue to talk about access to abortion as just a “woman’s issue” because this erases transgender, genderqueer, two-spirit, and agender individuals that may need access to abortion.

Abortion access is not just a woman’s issue. It’s a health care issue. It’s an economic justice issue. It’s an education issue. It’s a youth issue. It’s an LGBT issue.

It is our issue.

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NCLR is proud to work on reproductive justice for LGBT people and families and to recognize the importance of the intersecting identities and needs of the LGBT community. We stand with reproductive justice organizations across the country fighting for access to abortion—which includes working to repeal the Hyde Amendment—and we are committed to ensuring an LGBT perspective on all reproductive justice issues is heard and incorporated into advocacy efforts.

Discussion Questions:

1. Lauren Paulk highlights the myth that “imagines the movement for access to abortion, contraception, and other reproductive justice issues is separate from (and sometimes, alarmingly, in opposition to) the movement for LGBT equality.” Why might LGBTQ equality be perceived as disconnected or counter to the reproductive justice movement? How could this myth be dispelled?
2. The reproductive justice movement affirms the rights to have full autonomy over our bodies; to have or not have children; to birth and/or parent our children with dignity; and to live and/or raise a family in a safe healthy environment. How do the reproductive health care access issues described by the author and other LGBTQ equality issues relate to each other in the context of these rights?
3. When have you experienced or observed a time when reproductive justice was restricted or denied due to the gender or sexual orientation of a person or group?
4. How can we encourage different groups of activists, fighting for different specific issues, to come together around reproductive justice, as it affects all populations?

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4 Ways to Center Trans Women in Reproductive Justice

November 15, 2015

By Luna Merbruja in Everyday Feminism

I was seventeen years old the first time I was told I was going to be sterilized.

I couldn't believe it. I knew rumors from other trans people that you might be sterile after starting Hormone Replacement Therapy (HRT), but I wasn't informed it was going to happen.

The therapist I met had a huge list of Things to Consider before beginning HRT, but by far, sterilization was the one facet I could not grapple with at the time.

My whole life, I had dreamed intimately about being a mother.

My child would be a chubby Brown baby with dark brown eyes and a thick head of hair, with my DNA being part of the magic of this angel's existence.

But that dream was cut suddenly short. This doctor told my seventeen-year-old self that I was going to be infertile a year into treatment.

The other option I was offered was to sperm bank my potential future babies. The price range I was given by the doctor was \$500 for the initial freezing, and approximately \$50/month to keep my sperm frozen.

I immediately knew that wasn't an option, and that once again a financial barrier had come between me and my dreams. I left feeling defeated, like I had no choice but to start HRT quickly and figure out child creation later.

Before I could debate the dilemma further, I was informed I needed my mother's consent to start HRT. When I asked her, she refused treatment and cut me off the family health plan.

Initially, I was incredibly angry that she became a barrier to HRT as well. Given more time to think about sterilization, I came to conclusion that it was too great a compromise to make. I dropped the idea of starting HRT.

Four years later, I found myself in a doctor's office two days before Christmas asking for HRT. Still financially broke and unable to afford a sperm bank, I began HRT with a year promise to myself that if I didn't like the effects, I would stop.

Since then, I have crossed the threshold of sterilization. I mourned the inability to have my own genetic children from my thousands of bloodlines, each radically entwined with Brown resistance.

I can't have babies. And no one in the reproductive justice movement is talking about this.

It wasn't until I watched Micha Cardenas perform about her pregnancy as a trans woman that I had a major breakthrough moment. It was – and still is – possible to become pregnant again.

What this means is that trans women who stop taking HRT for a few months can reverse sterilization and become pregnant with viable sperm.

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In the audience, as Micha stood before her artwork and moving telescope images of her viable sperm, I cried whole-heartedly. She had been on HRT for many years and still was able to become pregnant.

This opened up a whole new realm of possibilities and hope. And joy! And happiness!

It also opened up volcanic anger. I spent many hours heatedly dissecting all the systems and structures in place that limited my knowledge and ability to create a family.

From this experience, I have compiled a short list to make changes in the reproductive justice movement to center trans women. Hopefully, with more education and a focus on trans women, many more women will not have to view HRT treatment as an ending to their family-making goals.

Hopefully, by educating and applying these tips to reproductive justice, we can open up many more possibilities to trans women looking to create families.

1. Affordable and Free Sperm Banking Options

From my experience, you can see how sperm banking was not an option within my financial means.

Unfortunately, many doctors, including the ones trained in transgender competency care, urge young trans girls to start HRT as soon as possible.

As a 21-year-old, I'm still being told by a doctor who's seen dozens, if not hundreds, of trans patients to take the maximum dosage to get the "best results" – which essentially means "to look as cis as possible." She recommended this after I shared my reservations around sterilization.

So, what can we do?

According to Planned Parenthood, birth control pills cost between \$0-\$50/month depending on an individual's health plan. Fairfax Cryobank charges \$40/month for sperm storage, after an initial consultation and standard processing and freezing cost of \$500.

Though the costs are relatively expensive, the reproductive justice movement has fought tirelessly to make birth control affordable.

I'd like to see that same passion and dedication to providing trans women with reproductive options.

This looks like fundraising and organizing to change public policy to include affordable and free sperm banking options for trans women under health care plans, both public and private.

2. Protecting Trans Women from Violence

Morgan Robyn Collado inspired me to reframe reproductive justice to center trans women with her speech at the Civil Liberties and Public Policy conference.

Morgan states in this speech,

"If trans women of color cannot reproduce because of the violence that we face, than it is a reproductive issue. If we cannot build the network of people and community that constitutes a family because of the transmisogyny we face, than it is a reproductive issue."

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Put simply, if we aren't alive, how are we to create families?

The issue of violence against trans women is a state of emergency. In 2015 alone, over twenty trans women have been murdered, and at least fifteen of them were Black.

As clear as these murders are due to transmisogyny, they're also greatly informed by misogynoir – the misogyny that specifically targets Black women.

This type of violence is rarely accidental. Many trans women are abused and murdered by their intimate partners, which makes protection from violence a more difficult task.

In order to protect trans women from violence, there must be an investment to combat anti-Blackness and transmisogyny within our own selves and our larger communities.

This means educating yourself on multiple feminist issues, supporting living trans women by employing us in sustainable careers, and calling out transmisogyny whenever it presents itself to change the current culture to one that humanizes us.

Until we're seen as lovable humans with worth, we will continue to suffer extreme violence. And no one can create healthy, happy families under that circumstance.

3. Gainful Employment with Health Benefits

Ah, employment. Aren't we all looking for that one job that fulfills all our needs that isn't also soul-sucking?

Yes, we all are. And the ones least likely to get it is – did you guess it? – trans women.

Sure, this is kind of idealistic. But unless I set my aims high and my hopes even higher, I'm not sure half the amazing work I do would ever get done.

So please, help make this dream come true.

Give trans women the opportunity to fuck up, to grow professionally, to be taken seriously in a workplace.

Very few work environments support us learning to become better workers. Most places have incredibly high and sometimes unattainable qualifications for trans women.

For example, if I were to apply for a minimum wage retail job today, I may not be able to use my references because I was using my birth name and wrong pronouns.

Most places that I have looked into ask for at least a year's experience, and though I have that from working at a few different stores, I cannot validate that work history without outing myself as trans (either to my new or previous employer).

What can be useful – and so incredibly relieving – would be to partner up with LGBTQIA+ organizations and advertise specifically towards trans women.

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I don't mean just minimum wage jobs. I mean careers where I can have a health plan and benefits that extend to my family, including an income lovely and large enough to support children.

Most professional positions for trans women that currently exist are within the non-profit sector. While the work can be passionate, it rarely offers all the necessary benefits to accommodate family creation and sustainability.

4. Trans-Specific Adoption and Fostering Policies

I will admit, I am not a policy-writer. However, I believe many exist out there in the ether of this vast reproductive justice movement, and you are needed to make structural change to support trans women in making families!

What these policies need to include is bias and sensitivity training to identify the ways people project transmisogyny onto trans women seeking to start families.

For example, the idea that trans women are child molesters is highly prevalent and definitely acts as a barrier for us to start families.

Having policies in place that specifically state non-discriminatory practices, along with adequate trainings to identify biases and educate about basic respect towards trans people, will greatly improve the chances of trans women being able to adopt and/or foster children.

Even better, having trans women on staff in these adoption and fostering agencies to work with soon-to-be trans mothers would be dreamy!

It's absolutely crucial that we have someone to talk mother anxieties with. It's already difficult enough navigating all the feelings around not being able to carry children, and the constant (fucked up) reminder that "real women" have menstrual cycles.

Having one person who can really hear and validate our mothering anxieties without denying us our womanhood is imperative to creating a culture of support for trans women's families.

Historically, trans women have been at the forefront of liberatory actions and enacted incredible amounts of emotional and physical labor towards creating homes for youth.

Countless trans women have housed and fed homeless queer and trans youth, much like Marsha P. Johnson and Sylvia Rivera did with the STAR House.

The creation of Ball Culture "Houses" was another way that trans women created homes for Black and Brown queer and trans people of all ages to have a chosen family that loved and accepted them.

These alternative family structures are historically significant in liberation work. They are also ongoing in present-day organizations and shelters like Casa Ruby and Jazzie's Place.

Supporting trans women in creating families is necessary for the reproductive justice movement. It is not sustainable, as we have seen with the closing of the STAR House and Transie House, to operate solely on a few individuals to provide for a large community.

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If we have systems and structures in place to support us starting families, we can have fewer queer and trans youth shuffling through the foster care system or ending up on the streets.

I have a few more years before I'm ready to start having my own children, and I hope to see enough progress so I can have multiple options on how to go about starting my family.

This is a good starting point for you to take back to your reproductive justice work and start strategizing how to change your own communities to better support trans women.

Discussion Questions:

1. The author, Luna Merbruja, describes many areas of life and systems of oppression that impact the health, economic security, safety and well-being of trans people. How did this make you feel? Was anything surprising or new to you? Have you witnessed or experienced any of the issues that Luna described?
2. What does reproductive justice look like for trans individuals and families beyond health care? How can we advocate for the reproductive rights of trans individuals outside of the health care system?
3. How would guaranteeing free or affordable sperm banking options support reproductive justice for all individuals, not just cisgender women? (*Cisgender denotes a person who is comfortable in the gender they were assigned at birth.*)
4. In Judaism's teachings of the Sages (*Pirke Avot*), Rabbi Eliezer says, "Let your neighbor's dignity be precious to you as your own" (*Pirke Avot 2:10*). What can the reproductive justice movement do to further the dignity of LGBTQ individuals, and specifically trans women?

7. Reproductive Justice is Justice for Youth and Young Parents

Honest Sex Education: Charting the Course to a Sexually Healthy Nation

By Debra Hauser in *American Sexual Health Association*

Every hour of every day in the United States 85 youth become pregnant, 425 contract an STI, and two contract HIV. Every hour of every day. Yet, 30 years of public health research demonstrates that comprehensive sex education can provide young people with the essential information and skills they need to reduce their risk for unplanned pregnancy and STIs, including HIV. When done well, comprehensive sex education can also help young people traverse puberty, understand the difference between healthy and unhealthy relationships, develop a positive body image, communicate effectively, make informed decisions, and navigate the health care system. In short, quality sex education can go beyond the promotion of abstinence or even the prevention of unplanned pregnancy and disease to provide a lifelong foundation for sexual health.

Comprehensive sexuality education, when done well, can also help shift the culture of fear, shame, and denial which permeates our society and create instead a culture in which sexuality is accepted as normal, natural, and healthy; one in which young people are valued and celebrated for who they are no matter their sexual orientation, gender identity, or gender expression; where sexual development is recognized as an important task of adolescence and education about sexuality is valued over the promotion of ignorance.

One would imagine then, that in the wake of the evidence, policy and practice in support of comprehensive sex education would follow suit. Unfortunately, the United States is home to a conspiracy of silence, shame, and fear that surrounds adolescent sexual health. All too often, politics and ideology trump science, not to mention basic common sense. Since the 1990s, social conservatives have promoted an abstinence-only or “just-say-no” approach to sex education. Deeply rooted in social conservatism, abstinence-only-until-marriage programs are a strategic initiative designed to undermine gains in both the women’s rights and gay rights movements. These programs are anti-gay, anti-woman, anti-sex, anti-contraception, and pro-heterosexual marriage. In other words, social conservatives were able to convince the U.S. government to spend more than 1.5 billion dollars since 1998 to undermine public confidence in condoms and contraception, promote homophobia, stigmatize sexuality and sexual development, and inculcate youth with notions of traditional gender stereotypes.

Though we are by no means where we want to be, there has been a great deal of progress in recent years, especially in dismantling abstinence-only programs. By 2010, sex education advocates had helped to eliminate two-thirds of federal abstinence-only funding and to shape two new federal funding streams for evidence based sex education—the Presidents’ Teen Pregnancy Prevention Initiative at \$75 million and the Personal Responsibility Education Program at \$110 million. By 2012, 14 states and Washington, D.C. had rejected what was left of federal abstinence-only funding, while most states happily accepted the new funding sources. In addition, over the past few years Colorado, Illinois, Mississippi, North Carolina, Washington, and Wisconsin were among the states that passed new sex education laws. In 2013 alone, Alabama, Nevada, and South Carolina also introduced sex education bills (that did not pass but will most likely be reintroduced); the Broward County School District in Florida introduced a new sex education policy that will be voted on in 2014; Chicago Public Schools passed a comprehensive sex education policy which mandates sex education at every grade level; the Tulsa School Board (Oklahoma) voted to implement comprehensive sex education to select schools, with plans to expand across the district; and the National Sexuality Education Standards were widely used to fuel sex education advocacy and implementation efforts across the country.

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In addition, sex education implementation took a huge leap forward with the launch of the WISE initiative (Working to Institutionalize Sex Education). WISE's goal is to pilot, field test, map, and scale up a strategy for sex education implementation and institutionalization in school districts with positive or neutral policy climates. Currently operating in ten states, WISE is reaching hundreds of thousands of young people each year with new or improved sex education.

Fueled by the success of WISE and the National Sexuality Education Standards, in 2013 the CDC's Division of Adolescent and School Health began funding 19 state education agencies and 17 large municipal school districts to implement what it calls exemplary sexual health education or ESHE.

All of this is contributing to some success: the teen pregnancy rates have dropped 52 percent since 1991—driven down primarily by young people using condoms and contraception more consistently than ever before. But change has not come easily, nor has it been consistent. We still face rising rates of STIs, including HIV infections, among young people. Improvements in sex education are unevenly spread, and there are pockets in most states, and particularly in the South, where abstinence-only education continues to prevail.

To truly become a sexually healthy nation, we will need to continue to confront the cultural myths that undermine rights, pragmatism, and basic common sense when it comes to sex education in America.

We should start with the myth that education is a threat rather than a solution—the belief that educating young people about sex causes them to have sex continues to prevail. Research has debunked this falsehood for decades but opponents of comprehensive sex education cannot seem to let go of their “umbrellas cause rain” argument.

The second myth is that just say no until marriage constitutes a viable national sex education policy in a country where 95 percent of people have sex prior to marriage and 70 percent of young people have sex by the age of 19. Throughout the industrialized world, the average age of sexual initiation is 17. Trying to stop this behavior in its tracks by censoring information about condoms and birth control is not just naïve and ineffective, it's dangerous and irresponsible. Denial will never be a successful strategy when it comes to sex education in America.

We must also refute the idea that young people are incapable of regulating their sexual behavior in a responsible fashion. This “teens run amok” stereotype fuels the perception that young people are problems in the making rather than partners in prevention. Yet despite the characterization, U.S. teens are often more responsible than their adult counterparts (condom use being one example). The bottom line: respect youth and give them the information, education, support, and guidance that they need, and they will act responsibly.

Finally, we must address our conflicted cultural norms around sexuality itself. In America, we use sex to sell everything from laptops to lipstick; we parade advertisements for Viagra and Cialis across TV screens in prime time; and we promote sex-drenched sitcoms during what was once the “family hour.” Yet, advertising for condoms during the same time slots is deemed “too controversial” despite the fact that condoms are the most effective disease prevention tool available for those who are sexually active.

On the one hand, young people are being told that sex is dirty, filthy, and disgusting while on the other they are being asked to save it for someone they love. Sex is used for entertainment and commerce but rarely spoken of openly and honestly in our homes, schools, and faith communities. We obsess about what makes us sexually attractive but spend little time educating one another about what makes us successful as partners in a relationship.

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Culture will continue to dictate the ceiling for progress on sexual health in America. The sex education our youth get will be decided by how tightly our culture holds on to the fear, shame, and denial promoted by social conservatives and their “just say no” approach. We need to break through this ceiling and provide young people with comprehensive sex education. Only then will we become a society where sexuality is viewed as a normal, natural, positive part of life; where young people are valued as assets rather than liabilities; where public policy is shaped by science and evidence; and responsibilities are properly balanced with rights in a way that empowers young people to become sexually healthy adults.

I don't think it is overstated to say that we have begun to reframe the debate; but how far we go will be determined by our willingness to educate our children—honestly and openly. Only then will we become a sexually healthy nation.

Discussion Questions

1. As the author describes, the “umbrellas cause rain” argument — i.e. that if you teach young people about safe sex, they will have more sex — has been continually disproven, yet the myth is still promulgated in the media and repeated by politicians and educators. Why do you think this is and what can we do to stop this inaccuracy?
2. How does comprehensive sex education relate to young people's right to have autonomy over their bodies?
3. What was your experience with sex education in school? How did your sex education (or lack thereof) impact your feelings of shame or your ability to embrace issues surrounding sex and sexuality?
4. Besides advancing comprehensive sex education in schools, what can we do in our communities, to eliminate the stigma, fear, and denial that surround sex and sexuality?

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[Teen Moms Need Support, Not Shame](#)

May 8, 2016

By Alex Ronan in the *New York Magazine*

When Gloria Malone and Natasha Vianna got pregnant as teens, they thought their lives were over. This is, after all, what many teen pregnancy campaigns suggest. “You think being in school sucks? You know what sucks a lot more? A baby — every 2 hours for feeding time,” reads one ad from the Candie’s Foundation. Another says, “You’re supposed to be changing the world, not changing diapers.”

Over the past 20 years, [the teen birth rate has declined almost continuously](#), but the U.S. has the highest teen pregnancy rates in the developed world. [Statistically](#), teen parents in the U.S. are less likely to finish high school, more likely to experience poverty as adults, and more likely to have kids with poorer behavioral, educational, and health outcomes. But many teens that become pregnant were already disadvantaged, and the stigma only makes things worse.

Giving birth at 15 and 17 respectively inspired Malone and Vianna to improve the experiences of other teen moms. They founded [#noteenshame](#) with five other teen moms from across the country; and what started as a hashtag has become a larger effort to support teen moms, call out campaigns that traffic in stigma, and provide basic information and support to young parents. In addition to challenging shaming teen-pregnancy-prevention campaigns, founding members also consult with politicians around the country on improving outcomes for teen moms and how to create comprehensive sex ed. Vianna, now 27, [gave a TedTalk in 2013](#), worked with Boston politicians to [revise and implement a new policy for parenting students](#), and is the Digital Communications Manager at the Massachusetts Alliance on Teen Pregnancy. Malone, now 23, has written for the [New York Times](#), taken on Bill O’Reilly, and created a [website for teen moms in New York](#).

Over a three-way call one evening — “one of the perks of interviewing young parents is they’re home on a Friday night,” Malone quipped — they shared their experiences as pregnant and parenting teens, talked about the shame and stigma they’ve worked to overcome, and articulated what needs to change when it comes to teen pregnancy prevention. *This interview has been edited and condensed:*

I’ve noticed a lot of organizations that pose as supportive of teen pregnancy do so only because they’re pro-life. How do you guys identify?

Natasha Vianna: I’m pro-choice and fully support abortion rights access.

Gloria Malone: Yeah, me too.

Vianna: With [#noteenshame](#) we try to recognize that all young people deserve access to comprehensive and accurate information about their sexual and reproductive health as well as complete agency and autonomy over their own bodies.

What was it like becoming pregnant as a teen?

Vianna: Prior to pregnancy, I often heard that when you become a teen parent you lose all your friends. But actually, my friends became even more supportive than ever; it was the adults in my life that made things really hard.

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Malone: Same for me. My academic adviser stopped talking to me completely. I had teachers not give me assignments; I had teachers who would change the seating arrangements and purposely put me in a tiny desk when I was super pregnant. When I decided to move to a table that was right behind me, they were like, “What do you think you’re doing? You think you’re an adult cause you’re pregnant?” And I was like, “No, I just think I can’t fit in my fucking desk.”

Vianna: I remember going to my guidance counselor’s office and asking, “Why am I removed from my honor’s classes?” and my guidance counselor said, “Well, now that you’re pregnant, you’re not going to be able to do that kind of work anymore,” as if getting pregnant meant losing my brain. Later, I came back to her office to ask if someone could help me apply for college and was told, “It’s unlikely you’ll even graduate, so let’s just focus on finishing high school.” When adults continue you tell you you’re not capable, you start to believe it.

Statistically, teen moms are more likely to be black or Latina, face socioeconomic barriers, and lack access to comprehensive sex ed. Many are kicked out of their homes when they become pregnant. Do you feel like your experience mirrors that of most teen moms?

Vianna: Yeah. When I told my parents I was pregnant, they kicked me out of my house. I was just 8 or 9 weeks pregnant and I was forced to take whatever I could and move in with my boyfriend that same day. When I secretly shared my pregnancy with my school nurse and clarified that I wasn’t sure if I would choose an abortion or carry to term, she violated privacy and told my teachers about my pregnancy and within a week, my whole school knew. I felt trapped and knew that if I chose an abortion, I couldn’t hide it like I thought I had to, but if I carried to term, I also knew that the same people who would judge me for an abortion wouldn’t have stuck around to support me.

After moving in with my boyfriend, my parents also stopped paying tuition for my high school (I was in a Catholic high school at the time) so I had to enroll myself in the local public high school where I would start my senior year as the new pregnant girl.

Malone: I’m a black Latina who grew up in deep poverty with my single mother and sibling. Thankfully, I didn’t get kicked out. That said, my family struggled for a very long time with how to support me.

I returned to school maybe two weeks after having my daughter because I didn’t want to be failed out of school on account of my pregnancy. My daily schedule was wake up, tend to my child, pack her and my bags for the day, drop her off at the sitter, illegally park my car to be able to go to school, go to school, pick up my daughter, go home, and get ready for work at the local Taco Bell until about 9 p.m. I didn’t have much financial support from my family and my daughter’s father worked out of town often so all of the child rearing was left up to me, alone.

Vianna: Yeah, I spent a lot of time alone with my daughter too. Not having love from my family made me feel like I was a burden. I wasn’t asking anyone to support the reality that I got pregnant, but I wished there were people who cared that the isolation and stress I felt during my pregnancy wasn’t healthy for me or for my baby. It took years (and I’m still trying) to unpack the ways in which I internalized a feeling of worthlessness.

How did that stigma and shaming impact your experience of giving birth and raising a newborn?

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Malone: It was very, very isolating. I was in an abusive relationship, but that was the person that was “there for me” when everyone else was turning away.

Vianna: For my entire pregnancy people had been telling me, “this child is going to ruin your life,” “you’re never going to be able to accomplish your dreams.” As I was giving birth I was thinking, *Holy crap, I’m giving birth to this person whose life is going to end mine.* I had a really hard time bonding with my daughter. I became really depressed, I didn’t want to ask for help or ask those normal questions first-time parents have because I felt like asking would be a reflection of me as a teen parent and not just a first time parent.

Malone: I had no idea that your breast milk had to come in. I was too scared to ask anyone!

Vianna: Exactly. If I was struggling, I’d tell myself *I asked for this or it’s my fault for getting pregnant.* When my daughter was younger, I would sometimes lay beside her while she slept and I would cry and apologize for not being the person she deserved. It was a horrible feeling to believe that I could never be what she needed, but I’m glad I overcame that. I have a strong relationship with her today.

It seems like part of the stigma surrounding teen parents is never allowing teen moms to express the positive aspects of their experiences. What were some of the best things about being a young parent?

Vianna: Oh, I love this question. In terms of parenting, it’s great that I can look back at my relationship with my mom and I can remember so clearly what it feels like to be a kid and I can apply that to how I parent my child. Plus, I like the fact that she’s going to be in college when I’m 35. That’s exciting.

Malone: When my daughter is in college, I’m going to be a hot 30-year-old, [*laughs*], I’m going to have money in my account, I’m going to be traveling, and my friends are going to be calling me saying, “How do I breastfeed?” That’s when I’ll go, “Sorry, should’ve been a teen mom.” [*Laughs*] But seriously, I love that we’re learning together, that I feel comfortable saying, “I don’t know, let me get back to you.” I love that my daughter has seen me accomplish things. She’s seen me graduate high school, she’s seen me graduate college.

Vianna: Gloria and I were just talking about how our experiences being stigmatized have influenced how we’re raising our daughters.

What do you mean?

Vianna: Maybe I can just give an example. When my daughter was in kindergarten, I picked her up one day and she was immediately like, “I have to tell you something. I got in trouble today.” I asked what happened and she said, “There’s a boy in my class who said girls can’t burp. He kept saying it. So I burped. I got in trouble, but I had to show that girls can burp.” On one hand I was like, *hmm*, she shouldn’t be burping in class, but, also, high five. It was great to see my little feminist daughter challenging things.

But even on bigger issues she’s really internalized our conversations. This one time, we were eating dinner and she was like, “I heard something at school today, one of the girls in my class told me that it’s impossible for me to be here because you and my dad aren’t married.” I got really nervous, because I wasn’t prepared to have that conversation. I was like, “Well, how does that make you feel?” She was

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like, “I’m not sure,” got really quiet, and then was like, “Actually, y’know what? I’m fine because I’m the expert on my life and no one can tell me about my life but me.”

Do you ever worry that in trying to counteract the narratives about teen moms you feel like you can’t acknowledge the difficult aspects or that you feel like you’re painting an overly rosy picture?

Malone: No, not really. Recently, I had a woman, 65 years old, email me and tell me that she’s still terrified to say her age in relation to her daughters for fear that people will figure out she was a teen mom. That’s a heavy-ass burden to carry around. Sometimes people think I’m glorifying my experience, but I think they’re just uncomfortable hearing about a teen mom who’s successful.

Motherhood was a very politicizing moment for both of you. How has your awareness and experience influenced what you want to see changed?

Malone: There’s a whole system in place to prevent people from getting the help they need because there’s this stereotype that they don’t deserve it. For example, teen moms often get kicked out of their homes, but they’re not allowed to stay in homeless shelters because it’s “a child with a child.”

Vianna: Instead of focusing on teen pregnancy prevention, we need to focus on positive youth development. My pregnancy was this lightning rod for people to blame all of my issues and all of my problems, but the reality is that preventing a pregnancy does not increase opportunities for young people. It does not improve their equitable access to quality education. It does not make their communities safer. As a society, we’re so focused on making sure teens don’t get pregnant before their 20th birthday that we miss out on conversations about consent, healthy relationships, and agency.

If we look at the communities, if we empower young people to make decisions for themselves and give them the tools to make those decisions, we will see a decrease in teen pregnancy because we know that 80 percent of teen pregnancies are unplanned.

You both embrace your position as teen moms. As you’ve grown older, does it still impact the way you’re able to talk about motherhood?

Vianna: Yes. If society is going to stigmatize me and spend millions of dollars to label me and my child as a public health issue, I deserve at the very least, the basic right to share my truth. If we removed the teen aspect and I said, “I’m happy to be a mom,” no one would say, “How dare you be happy to be a mom! You must be lying, and you’re also setting a bad example.”

Malone: Honestly, I would like to see the phrase *teen mom* disappear off the face of the earth. Why are we the only demographic of moms that are singled out by our age? Why are we teen moms? Why can’t we just be moms?

Discussion Questions

1. Have you witnessed or experienced the stories of stigma that Natasha Vianna and Gloria Malone describe around being a young person who is pregnant and being a younger parent?
2. When reading this article, did you notice biases or stereotypes that you hold around young people who are pregnant and who are parents?

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3. How do the girls' different identities influence their pregnancy and motherhood?
4. Reproductive justice encompasses all aspects of family planning and raising a child, not only contraception and abortion. How can the reproductive justice movement work to support younger parents and other women who have their pregnancies stigmatized?
5. Comprehensive sex education is vital to prevent unintended pregnancies and empower women and girls to make their own decisions about their health, family and future. How can sex education balance preventing unintended teen pregnancy with eliminating the stigma surrounding young parents?