SISTERSONG WOMEN OF COLOR REPRODUCTIVE HEALTH COLLECTIVE

COLLECTIVE VOICES

VOLUME 2 ISSUE 8

THE MOTHER HOUSE

Home to the global movement for Reproductive Justice for women of color

THE 2008 ELECTION AND WOMEN OF COLOR

INSIDE THE COLLECTIVE

- Doctors discourage childbearing among minorities
- Undocumented immigrants and healthcare
- Criminalizing home births in Georgia
- Girls in pain, fainting due to Gardisil

Sister Song
Women Of Color Reproductive Health Collective

COLLECTIVE**VOICES**

"The real power, as you and I well know, is collective. I can't afford to be afraid of you, nor you of me. If it takes head-on collisions, let's do it. This polite timidity is killing us."
-Cherrie Moraga

Publisher.....SisterSong
Editor in Chief.....Loretta Ross
Managing Editor.....Yaminah Ahmad
Creative Director.....M.D. Marshall
Web Master..... Kai Gurley

Contributing Writers

Cynthia L. Jackson
Laura Jimenez
Luretha Senyo-Mensah

Send Ad Inquiries to:
collectivevoices@sistersong.net

Send Story Ideas to:
collectivevoices@sistersong.net
Address:
P.O. Box 311020
Atlanta, GA 31131
404-344-9629

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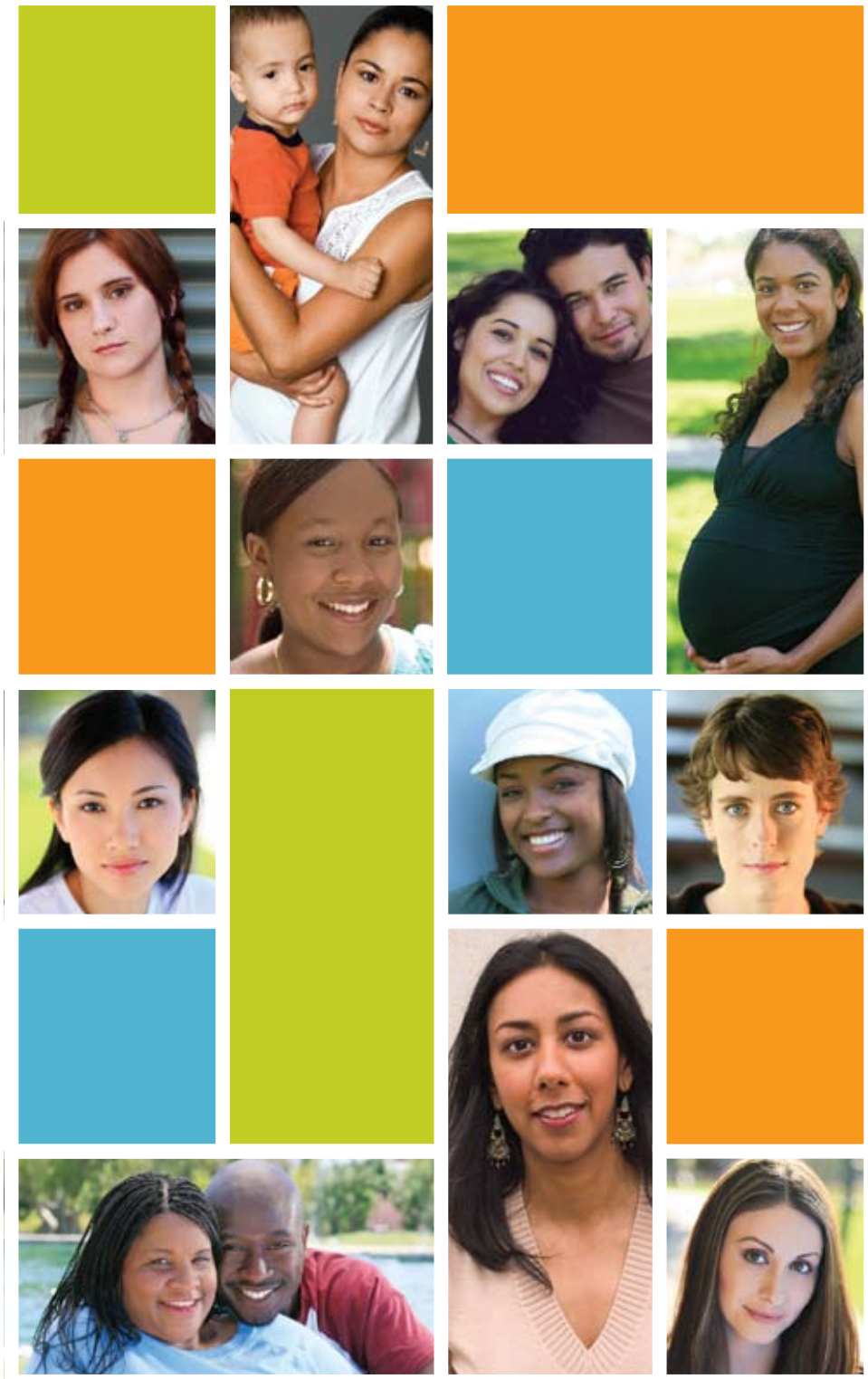

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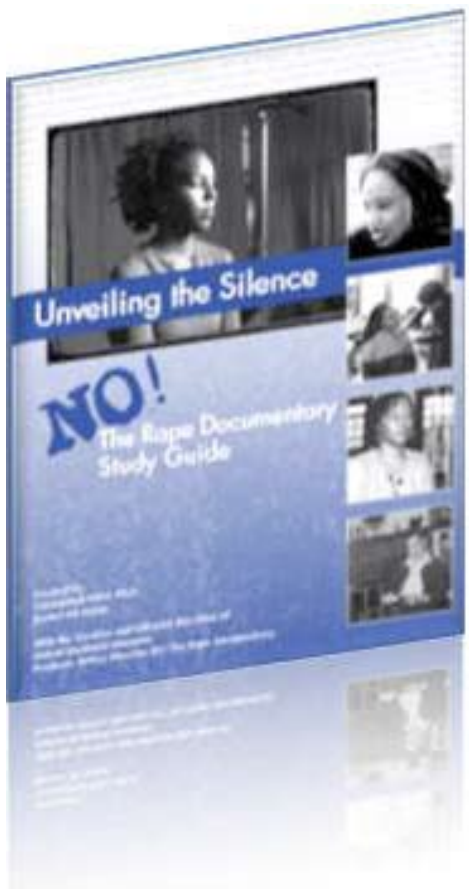
Unveiling The Silence:
NO! The Rape Documentary Study Guide Is Avaiable

By AfroLez Productions

A tool for educators and workshop facilitators, this study guide may be used within a workshop, class session, or semester-long course. You may decide to screen the documentary film in its entirety or use segments integrated into a broader course addressing race, gender, and sexuality. Viewing the film in segments allows for discussion related to themed sections. You may choose to work through the study guide chapter by chapter, or use it as a jumping off point for student-led exercises or longer activities

Our hope is that this study guide will be used as a companion to the film NO! by all individuals who are taking action in their communities to educate themselves and each other about rape and sexual assault. The film will get conversations going in your communities and on your campuses. You might host a screening of the film as a one-time event in your dorm, classroom, church, mosque, rape crisis center, shelter, correctional facility, living room, or in a community space, and facilitate a group discussion immediately following the screening or in the days following.



This 100-page guide includes:

• Producer/Director Statement

• Summaries of the different DVD chapters of NO! The Rape Documentary

• Excerpts from the transcribed testimonies of rape survivors and quotes from the documentary to spark discussion

• Myths and facts about rape and sexual assault so participants in discussions have relevant information regarding the truth about sexual violence and its impact

• A glossary of terms useful for talking about sexual assault in the African-American community

• Discussion questions about the subject of sexual assault to promote positive and informative conversations for participants

• Worksheets and handouts for participants to use to reflect on what they think they know about rape and sexual violence in their communities

• Additional essays on the role of religion in violence against women and the role of dance in healing sexual violence

• Production stills from the documentary.

• A bibliography of books, journals and articles on sexual violence

• A detailed listing of national organizations that address all forms of sexual violence

www.NOtheRapeDocumentary.org
www.myspace.com/afrolez

Thanks, SisterSong, for all that you do!

~Katie, Sara, and everyone else
at NARAL Pro-Choice Texas

NARAL Pro-Choice Texas is pleased to have SisterSong on the Advisory Committee of our new statewide coalition, Healthy Women, Healthy Families. *If you live in Texas, visit www.HealthyWomenHealthyFamilies.org to tell your lawmakers what YOU need to keep yourself and your family healthy!*

NARAL Pro-Choice Texas

NNAF
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National Network of **Abortion Funds** announces new resource booklet

NNAF is pleased to announce its member funds booklet, Immigrant Women's Abortion Access: Stories of Latina and Caribbean Women in Rhode Island and Southeastern Massachusetts. The Women's Health and Education Fund of Southeastern Massachusetts (www.whefsem.org located in Attleboro, MA) collaborated with Connections Co-op (www.connectionscoop.coop, a women's translation and interpretation cooperative in Providence, RI) to create the booklet.

The Immigrant Women's Abortion Access booklet enhances one's knowledge of immigrant women's struggles for reproductive justice by offering in-depth information on immigration, human rights and reproductive health, and most importantly, first-hand stories by women. The booklet also includes a list of resources on immigrant advocacy, reproductive justice, and domestic violence and sexual assault in the Rhode Island and Southeastern Massachusetts area.

If you would like to order printed copies, please email Yvette Koch at yvettekoch@hotmail.com. WHEFSEM is asking for $5 per booklet to cover the cost of printing and postage. Orders for over 20 booklets are $4.50/booklet.

SisterSong SuperStars!

Reproductive Justice goes Hollywood! Actress and comedienne Janeane Garofalo defended womenís rights when she used our phrase ìReproductive Justiceî on the HBO series, ìReal Time with Bill Maherî as she rebutted an anti-abortion right-winger John Fund who claimed that women donít support abortion rights. The show, aired on September 12, 2008, was a milestone for our movement. Janeane, who also spoke at the April 25, 2004 March for Womenís Lives, is now our favorite SisterSong SuperStar!

National Advocates for Pregnant Women gets heard in Court! On September 24, 2008, the 8th Circuit heard oral arguments in the Nelson v. Norris case. It was clear from the hearing that the justices had reviewed and taken notice of the amicus curiae brief that NAPW filed condemning the practice of shackling women during labor and delivery. Specifically, towards the end of the hearing, one of the judges asked the appellant's attorney: "Based on the amicus submission filed in support of the petition for rehearing, wasn't Arkansas an outlier in the world's community in terms of treatment of pregnant prisoners?" You can listen in on the oral argument by clicking on the link below: http://www.ca8.uscourts.gov/oralargs/oaFrame.html

Next Phase of RJ continued on next page

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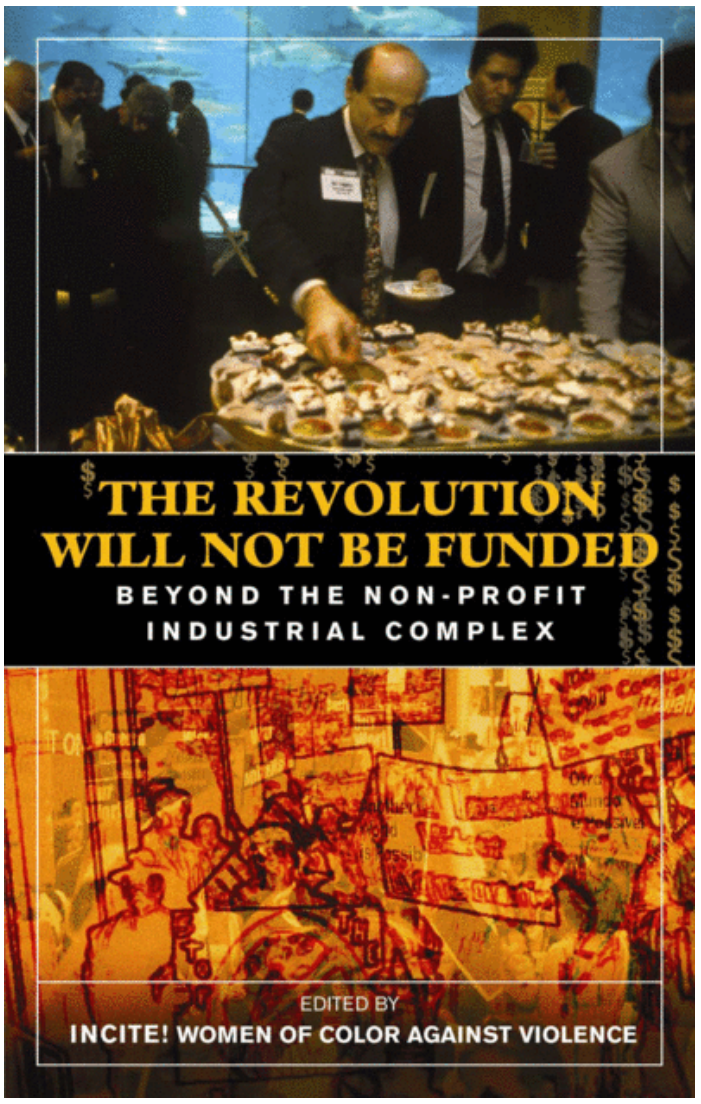
BOOK **REVIEW**

The Revolution Will Not Be Funded:
Beyond the Non-Profit Industrial Complex

Edited by Incite! Women of Color Against Violence
South End Press

The Revolution Will Not Be Funded is a riveting anthology of essays written by seasoned activists, thought leaders, scholars, and nonprofit professionals working in a range of social justice fields. Inspired by a 2004 conference of the same name that was co-organized by INCITE! Women of Color Against Violence and the Women of Color Collective of the University of California, Santa Barbara, the book continues the "conversation" that began at the conference. "This historic international gathering provided an opportunity for activists and organizers to share their struggles of organizing within the context of the non-profit system. While providing no simple answers, it did encourage a conversation on new ways to think about organizing and activism," writes Andrea Smith of INCITE! in her introduction to the book.

Smith's opening essay provides an overview of what she calls the "nonprofit industrial complex" and examines its impact on social justice movements in the United States, the role it has played in global organizing, and the prospect of re-conceptualizing the role of nonprofits in the twenty-first century. "Despite the legacy of grassroots, mass-movement building we have inherited from the '60s and '70s," she writes, "contemporary activists often experience difficulty developing or even imagining, structures for organizing outside this model. At the same time, however, social justice organizations across the country are critically re-thinking their investment in the 501(c)(3) system."



It is a theme, and concern, sounded throughout the collection. "We are so trapped into hierarchical, corporate, non-profit models that we are unable to structure ourselves differently, even when our missions advocate empowerment and self-determination of oppressed communities," argues Adjoa Florencia Jones de Almeida in her essay, "Radical Social Change: Searching for a New Foundation." And she echoes the thoughts of many when she muses, "Where are the mass movements of today in this country? The short answer — they got funded. While it may be overly simplistic to say so, it is important to recognize how limited social justice groups and organizations have become as they've been incorporated into the non-profit model."

Again and again the question is asked: Is the existing non-profit model truly the answer to strategizing and mobilizing real social change? Madonna Thunder Hawk offers the perspective of an activist in the Native American rights movement of the '60s and the '70s. "How we organized was different from how activists tend to respond now," Thunder Hawk explains. "We didn't wait for permission from anyone....Before, we focused on how to organize to make change, but now most people will only work within funding parameters... people are too busy building organizations."

The negative consequences of organization building and the "professionalization" of the social justice field is another recurrent theme in the book. In his essay, "Social Service or Social Change," Paul Kivel pulls no punches when he lists the questions we should be asking ourselves, questions like "What are the historical roots of the work that you do?" and "In what ways does funding influence how the work gets defined?" Kivel also cautions the reader that "As we become dependent on this work for our livelihood, 'professionalized', and caught up in the demands of doing the work, there is a strong tendency for us to become ever more disconnected from the everyday political struggles in our communities for economic, racial and gender-based justices...those social justice issues which our work originally grew out of." The essays in the book are full of lessons learned, unresolved issues, and perspectives on the future of social justice movements and the nonprofit sector. We discover, for example, that there is a difference between social service and social change, and that making this distinction can be helpful in assessing the viability and appropriate use of the 501(c)(3) model. We're also told that reliance on foundation and/or government funding adversely impacts the course of community mobilizing and organizing; that having a strong individual donor base and a portfolio of diverse funding streams, including earned income, is key to an organization's financial stability; and that there are alternatives to the 501(c)(3) model, including some that already exist outside the U.S., that may be better suited for social justice causes.

Through it all, the essays in The Revolution Will Not Be Funded challenge the reader to keep an open mind. Some are likely to annoy and maybe even anger readers with their unapologetic, often scathing criticisms of private foundations and the role they have played in the history of social movements in the United States and abroad. Others are likely to strike the questioning reader as thought-provoking and refreshing.

Despite the diversity of perspectives and writing styles, however, the authors all share a common interest in posing tough questions that demand to be addressed as the nonprofit sector moves into the 21st century. Often while dipping into the book, I was reminded of Martin Luther King, Jr.'s famous injunction: "We are confronted with the fierce urgency of now."

In the spirit of Dr. King, The Revolution Will Not Be Funded is a call to all social justice organizations and movements to examine their assumptions and models. And, if you're like me, it may even cause you to reflect on the "professionalizing" of your own passion and sense of injustice over the years and to ask, "Am I still an activist?"

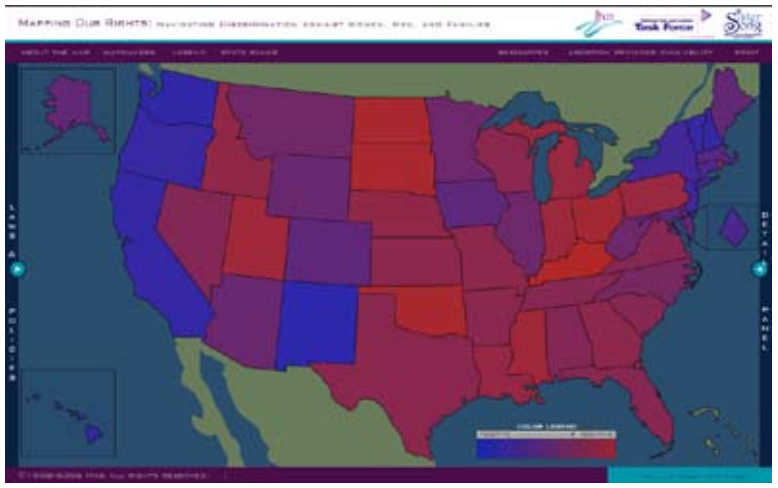
Luz Rodriguez
SisterSong Board Treasurer and Co-Founder

CENTER FOR REPRODUCTIVE RIGHTS

Using the law to promote and defend women's reproductive rights around the world

www.reproductiverights.org

Mapping Our Rights Website Updated



Have you ever wanted to find the scattered policy information on reproductive justice you need as an activist in your state? Do you need to know who else is working on similar issues in your community? Many SisterSong activists have urgently needed this information but had to search many different websites and read multiple publications to find the data they need. For example, information on poverty, teen pregnancy, midwifery, LGBTQ issues, sex education, and abortion laws are located in different places provided by a multitude of organizations.

Recognizing this dilemma, the Mapping Our Rights (MOR) website was created in 2006 by Ipas, SisterSong, and the National Gay and Lesbian Task Force to provide activists with an easily accessible source of policy information on different reproductive justice issues located in one place: (http://www.mappingourrights.org/). The site ranks the states and the District of Columbia based on which human rights are upheld or denied by the states.

Without the knowledge and understanding of state and local policies that may prohibit or impede their access to services, women of color are unable to access the services to which they are entitled. It is also difficult for advocates to assist them because of the complexity and range of laws that vary by each state. Women of color must have access to the information, resources and power for them to make independent, knowledgeable and informed choices. Reproductive Justice can only be realized when affordable and accessible services, along with medically accurate and linguistically appropriate information, are in place for everyone.

In 2008, management of the MOR website transferred from Ipas to SisterSong, and it has been updated with the latest data available. The Center for Reproductive Rights has also joined the management team for the website, along with Ipas and SisterSong. The website will be re-designed in 2009 to make it interactive, for the first time, so that instead of just receiving information, activists will be able to upload data as well and use it for social change networking. It will have the capacity to link activists with others who are working on the same issues by allowing the uploading of photos, videos, and success stories. It will also allow activists to provide the latest updated information on policy and regulatory developments in their state.

MOR is a vital tool for activists, but we have found that not only activists use the site. Many people inquire about the best state to live in or the best state to vacation in, if concern about social justice influences their decisions. One user even asked us to post information about gun laws by state to see if some states are safer than others. However it is used, we need this information because our human rights should not be decided by our geography.

SisterSong offers trainings on how to best use the MOR website, but it is easily accessed and very navigable on its own. If you have information you would like to see on the website or would like to request a training, please send an email to info@sistersong.net.

Reproductive Health Technologies Project

Thank You SisterSong for Another Year of Leadership in the Fight for Reproductive Justice!

The Reproductive Health Technologies Project seeks to advance the ability of every woman to achieve full reproductive freedom with access to the safest, most effective and preferred methods for controlling her fertility and protecting her health.

The Reproductive Health Technologies Project
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Colorado Organization for Latina Opportunity and Reproductive Rights

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Let's Talk About Sex! Conference Perspectives

"A Call to Respond"

Women's Health Advocate,
California Black Women's Health Project

By Cynthia L. Jackson

Images of a diverse assemblage of people of color, which cross the span of practically every ethnic group, a display representing a multi-generational population, stay pressed in the forecourt of my mind. I am not dreaming. I am not casting a spell on what I wish to see manifest in the movement of socio-political change. I am, however, in attendance at the 2007 "Let's Talk About Sex" SisterSong Conference: A Pro-sex Space for the Pro-choice Movement, which was held in May 2007 in Chicago, Illinois.

My introduction to SisterSong and the powerhouse of women leadership within the current women rights movement, and more particularly, the women's reproductive justice movement, left me reeling . . . reeling with excitement, reeling from an estrogen-induced political agenda, reeling from openly explored and identified sexual orientation, and reeling from the liberation of once again being able to verbalize and actualize the story of women from the past and the assignment of women present. How exhilarating it is to be in the company of such women!

From the eclectic array of speakers, from former US Surgeon General, Dr. M. Joycelyn Elders to Professor Dorothy Roberts, author of Killing the Black Body: Race, Reproduction, and the Meaning of Liberty, the program outlining SisterSong's Second National Conference and Tenth Anniversary Celebration was destined to challenge conventional thought processes and rouse attendees to look at the women's reproductive health movement with new eyes. The potent voice of the teen, preteen and beginning-women populations was represented both creatively and culturally through young socio-political activists like Claudia De la Cruz, Youth Director of the Dominican Women's Development Center in New York and the Illinois Caucus for Adolescent Health, represented by two powerhouses in the form of Adaku Utah and Yessenia Cervantes, who presented an A-Z, grassroots mobilizing workshop, which doubled as a radical boot camp in community organizing and a call-to-respond in their workshop entitled, "Youth Taking Action: Organizing to Improve Sex Education in our Schools & Communities."

In addition to the dynamic speakers represented, the plenary reviews were another winning piece to the SisterSong puzzle - integrating a collection of various leaders and experts on a variety of related subjects including LGBTQQI agendas, HIV/AIDS activism, community rebuilding and organizing, and women's sexual rights for every ethnic group. The esteemed SisterSong National Coordinator and co-author of Undivided Rights: Women of Color Organize for Reproductive Justice, Loretta Ross, set the tone by sharing her candid experience and views on where we are collectively in the women's reproductive health movement and kicked off the first plenary entitled: Nothing About US Without US is For Us.

Among many of the conference highlights, which included stand-up comedienne, Ali Wong, and author of The PocketBook Monologues Sharon K. McGhee, the Hip-Hop Feminist Nation stood out as the crème de la crème whose spoken word, song and poetry verbalized the pain and strength of what it's like to be young and female growing up in the contemporary U.S.

Needless to say, the SisterSong Women of Color Reproductive Health Collective is a movement to be mindful of. As a mental health professional, I consider myself fortunate to have been asked to attend such an event. I was personally challenged after attending a workshop for sexual assault survivors and found myself perplexed at the incongruence of an ideology admitted by some of my young sisters who misidentified self-care with self-harm by redefining body mutilation, or cutting, and calling it "body modification." As emotional caretakers of the community, it alerted me to re-examine exactly what we're up against, and provoked me into repacking my arsenal of mental health tools and to refocus on the emotional well being and care of our youth. Young people require unrelenting nurturing. A constant and careful examination of the behavior of our young sisters remains a necessity for the continued development of our youth. Because I had yet to come across this ideology during my field experience, I am grateful to SisterSong for the opportunity to enlighten me on yet another phenomenon in current adolescent life.

This is merely one of the reasons why working together is crucial to our survival. Aligning ourselves with compatible, grassroots organizations, as well as complementary and creative funding resources, has proven to be a viable tool in many of the human rights movements of the past. Our communal success, while incremental, has advanced because of such unification. We must at once recognize and affirm the leaders of our time, acknowledging the endless and exhausting work that they do for women, for the community, and for the continued civil liberties of humanity. We salute the SisterSong: Women of Color Reproductive Health Collective!

Find more information about SisterSong, visit www.SisterSong.net

For more information about the California Black Women's Health Project,

visit www.cabwhp.org

Cynthia L. Jackson, MA, MFTI

Women's Health Advocate and graduate of the California Black Women's Health Project

"A Letter to the Editor"

By Dr. Mehret Mandefro

I co-founded a collective called TruthAIDS that is focused on developing alternative HIV primary prevention strategies with my colleague Dr. Manel Silva. TruthAIDS was born out of our experience as physicians working to prevent and treat HIV in the South Bronx. We came to realize that conversations about HIV prevention had to start with love, trust, identity, abuse and support in order to make safe sex a reality. Our efforts to uncover this missing dialogue led us to create new strategies that address domestic issues in a public space. Approaching HIV prevention from this perspective presents an opportunity to expand preventative health in new ways that has the potential to transform our lives.

In the nascent stages of the collective, Dr. Silva and I became acutely aware that in order to make these alternative strategies a reality, we needed to partner up with grassroots organizations. As we started asking around to find out what unifying organizations existed, SisterSong was named by many doing reproductive justice work. As we learned more about SisterSong we realized the army it would take to do the work was already organized, mobilized and had an upcoming conference. We immediately submitted an abstract for the SisterSong National Conference, and eagerly waited to learn more. For TruthAIDS, attending the SisterSong National Conference was the beginning of many relationships between other women of color who were willing to teach us and connect us with others doing the same. We have since teamed up with Aishah Shahidah Simmons of AfroLez Productions to create a documentary that will explore the intersection of violence against women and HIV thus adding to the arsenal of alternative HIV prevention strategies.

In closing, prior to finding SisterSong, as physicians who were serving the poorest urban congressional district of America, the patient experiences we saw day in and day out had left our souls a bit on the weary side. Witnessing the shear scale of the socially oppressive forces determining health in communities like the South Bronx is not only humbling but can leave you lost. So for TruthAIDS, finding SisterSong, when we did, was like coming home to find the energy you need to keep on keeping on.

Let's Talk About Sex!

Young Women United of New Mexico

Last month, the Circle of Strength went to Chicago to participate in SisterSong's "Let's Talk About Sex Conference." There were a variety of workshops ranging from reproductive health, to the over sexualization of women of color, and even a workshop on erotic childbirth. Let's Talk About Sex was all about reproductive justice, sexual heath, and sisterhood. This was one of the best conferences we've ever been to and I think it was because we felt so comfortable. I feel like at other conferences we are often the only group working around reproductive health and sex education. Everyone at LTAS was on the same page. The only drawback was that there was only two, hour and a half sessions a day with about 10-15 workshops to choose from. We had so many choices; we just wish we had time to do more. All of the workshops were fun. There was a cool tent set up in the parking lot of the hotel where different organizations sold T-shirts, books, posters, sex toys, sex books, jewelry, and bags. The LTAS conference in Chicago was all around super dope. Much love to SisterSong for the scholarships!

FROM YOUNG WOMEN UNITED in Albuquerque

Breast Cancer Gene Mutation among **Latina and African American Women**

A genetic mutation already known to be more common in Ashkenazi Jewish breast cancer patients is also prevalent in Hispanic and young African-American women with breast cancer, according to one of the largest, multiracial studies of the mutation to date.

Researchers at the Stanford University School of Medicine and the Northern California Cancer Center reported the finding from a study of 3,181 breast cancer patients in Northern California. It revealed that although Ashkenazi Jewish women with breast cancer had the highest rate of the BRCA1 mutation at 8.3 percent, Hispanic women with breast cancer were next most likely, with a rate of 3.5 percent. Non-Hispanic whites with breast cancer showed a 2.2 percent rate, followed by 1.3 percent of African-American women of all ages and 0.5 percent in Asian-American women. Of the African-American breast cancer patients under age 35, 16.7 percent had the mutation.

The work, which was published in the Dec. 26, 2007 issue of the Journal of the American Medical Association, marks the largest study to date to look at the prevalence of BRCA1 mutations among patients in the four ethnic and racial groups, said lead author Esther John, PhD, research scientist at the Northern California Cancer Center and consulting associate professor of health research and policy at Stanford.

The information could help doctors decide which patients to refer to genetic counseling, the researchers said. They added that they hope the information prompts genetic counselors to develop materials for discussing breast cancer risk in a culturally sensitive way and in languages other than English.

"If a woman has breast cancer she may ask the question, 'Could I be a carrier for a BRCA1 mutation,' and 'If I am, my daughters and sons need to know it,'" said senior author Alice Whittemore, PhD, professor of health research and policy at Stanford. She said that until now, doctors knew only that Ashkenazi Jewish women were more likely to carry a mutation, and therefore frequently referred these women to genetic counseling. What they didn't know is how women of different ethnic groups needed to be treated in terms of their BRCA1 status.

"Traditionally studies have focused on white women," said John. "There is a great need to study racial minorities in the United States."

The risk of a woman developing breast cancer sometime during her life is about one in eight. Although death rates from the disease are dropping, the American Cancer Society estimates that 40,000 women will die from the disease this year.

All people have the BRCA1 gene, which makes a protein that helps the cell repair its DNA. Women who inherit a mutation in that gene from either parent are less able to fix DNA damage and tend to accumulate mutations that lead to cancer. They have a roughly 65 percent risk of developing breast cancer and 39 percent risk of ovarian cancer. If one family member tests positive for a mutation, it can alert other women in the family to also get tested and to take preventive measures.

Without the information from this study, doctors have treated all women other than Ashkenazi Jews as having the same risk level for the mutation. Now doctors who see Hispanic or young African-American breast cancer patients have more information to guide their decisions about referring those women to genetic counseling or testing.

"The message is that these minority breast cancer patients may need screening in ways that we hadn't appreciated before," Whittemore said. She noted that Hispanic women in Northern California, where this study was conducted, derive from different countries than Hispanic women from the East Coast. For that reason, the findings may not apply to Hispanic people in other parts of the country.

The research team found a few other surprises in the data. One is that although mutations can occur throughout the BRCA1 gene, the Hispanic women in the study were more likely to carry a particular mutation that's also common in Ashkenazi Jewish women. Other ethnic groups carried a wide range of different mutations.

John and Whittemore think the Hispanic women may have this mutation because of their Spanish ancestry. Spain was the home of Sephardic Jews who could have shared the mutation with Ashkenazi Jews of Eastern European origin.

The prevalence of the mutation in young African-American women with breast cancer also came as a surprise, given that the rate is low in the overall African-American population. The researchers say the finding is consistent with a long-known pattern that when young African-American women get breast cancer it tends to be a particularly aggressive form of the disease, which is a hallmark of tumors that arise from BRCA1 mutations. Whittemore said this information doesn't change how doctors treat those tumors, but it could help prompt more doctors to recommend genetic counseling for those young African-American breast cancer patients.

Other Stanford researchers who participated in this study include Gail Gong, PhD, a research associate; Anna Felberg, a programmer in health research and policy; Dee West, PhD, professor of health research and policy at Stanford and chief scientific officer at the Northern California Cancer Center, and Amanda Phipps, epidemiologist at the NCCC. The work was funded by the National Cancer Institute.

The Midwest Access Project envisions a society in which integrated, comprehensive reproductive health care is fully accessible to all. We exist to increase the provision of full-spectrum reproductive health care in the region, without barriers to access, through education and training of health care providers and the public.

Midwest Access Project

The 2008 Elections and Women of Color

By Loretta Ross, SisterSong National Coordinator

By the time many of you read this article, the elections will be over. As I write this, I have no idea who will win. But the issues that compel us to lift our voices as women of color and Indigenous women in an urgent call for action do not disappear because of one election. We have hundreds of years of experience telling us that we do not directly control the levers of power in this country. Chances are that we will either receive less than we expected or more than we feared from this election.

Nonetheless, this presidential race may be the most important one in recent memory, pitting a neo-liberal against a neo-conservative. It is already the most symbolic, with race and gender taking center stage in a presidential contest like never before. If nothing else, this election is a measure of the impact of race, class and gender politics on the voting public. While all elections in fact are barometers of those issues, this election more clearly brings these issues out of the closet. With the candidacies of Hillary Clinton and Sarah Palin, the women's vote was carefully energized and calculated. The election will provide clear information about the voting patterns of white women, which may be truly informative for women of color as we evaluate our alliances to see if race trumps gender in the privacy of the voting booth. A recent Stanford University poll revealed that at least 1/3 of the white voting public harbors deep negative views against African Americans. Other polls suggest that approximately 20% of Clinton's supporters will back McCain/Palin. This may be the clearest referendum on white supremacy, gender and American politics since the 1968 George Wallace campaign.

I don't believe women would be so divided if we had honest answers from candidates, but perhaps that's too much to expect. What frustrates me most about political candidates of all persuasions is that they fear saying exactly what they mean when asked an unscripted question. We can hear the political wheels churning as they calculate the safest and least-informative answers to real questions for which we need direct answers. We rarely hear them actually thinking out loud: saying what is really in their hearts or on their minds. Instead, we hear them carefully parsing words to avoid verbal landmines that someone may lob back at them in the future to explode their candidacies.

This collective failure to be honest with the public is what makes many women of color distrust our political and economic systems and the mainstream media that reports on it. Not only do mainstream reporters rarely ask the hard questions of candidates, they almost never ask the questions that mean the most to women of color. In a campaign clearly featuring the race and gender of the candidates as sub-plots, reporters don't ask hard questions about racism and sexism in America, in the media, or among the voting public. They certainly cannot even define intersectionality as it affects our issues, or understand that all issues are interconnected in our worldview in which race and gender and class and gender identity are inseparable. This is particularly vexing for women of color who desperately need to feel that we matter to these candidates, not just as their mules of labor and reproduction, but as people whose opinions carry weight and whose needs are respected.

You may be forgiven for thinking we are violating the same standards we apply to candidates because we cannot fully speak our hearts and minds about the elections. As a 501(c)(3) non-profit organization, SisterSong is prohibited by the IRS from saying exactly what we think about the elections. We can neither endorse any candidate nor spend much of our resources influencing legislation. But there are things we can do that are both legal and necessary to represent the interests of women of color: 1) We can educate folks about the significance of this election; 2) We can talk about the issues and how important they are to women of color; and 3) We can urge people to vote, in case the votes are counted.

Some key concerns important to women of color will be revealed by this election. Primary among these is the integrity of the voting process itself. If massive voter disenfranchisement occurs through voting irregularities, prohibitions or denials, this will definitely confirm that the entire voting process is manipulated to produce results that do not represent the will of the people. We can work to ensure that our outrage is felt in the corridors of power by joining efforts such as the "Protect the Vote" project organized by the Election Protection Coalition (http://www.866ourvote.org/). This will be a long-term effort because many of us are convinced that the 2000 and 2004 elections were stolen by manipulation of the voting technology and the voting rolls, but we have no choice but to fight for the integrity of the voting process if we are to continue to participate in electoral politics.

Regardless of who gets elected president, as women of color we have to present our demands so that our needs are not overlooked. There is no guarantee that these demands will be heard, but we must make sure that we use the process of formulating and presenting these demands to build, energize and consolidate our base of power in our communities on behalf of women of color. This process will not only help to build our power and lift our voices; it will also help us clarify what we are fighting for, not just what we are fighting against. This is an important step because lack of clarity about our goals as communities of color will inevitably lead to a lack of clarity about how to get there. As one activist put it, "now that we have legs, where are we going?"

We cannot take anything for granted whoever wins. There is no guarantee that either presidential candidate knows the concerns and needs of our communities or that he will prioritize our needs over the thousands of lobbyists clamoring for his attention. Some have suggested that we organize our own "100 Days" Campaign to itemize the top three or four priorities we would like to see addressed at the beginning of the new administration.

This idea has considerable merit, but we are an embryonic reproductive justice movement. We are just getting used to the idea that we have our own spaces for convening our voices and making our own autonomous decisions, such as SisterSong conferences and meetings. We have a transformative reproductive justice analysis that has changed the direction of the pro-choice movement, but it is largely unknown outside of activist circles. Whether we can put together such a process within the first 100 days of the new administration is uncertain, but that doesn't mean we should not have discussions about generating some priority issues that affect all communities of color. Even if we're part of a larger coalition presenting priorities to the new administration, we can ensure that our needs are represented within those settings.

The recent taxpayer-financed bailout of Wall Street is of major concern. It is deeply ironic that the same government that pushes an ideology of "personal responsibility" on the taxpaying public (especially people in poverty!) would loot our treasury to rescue companies that were anything but personally responsible for the mess of their own creation. Have we moved from "welfare Cadillacs" to "welfare limousines?"

There is little money left to fix the things we really need in this country, such as our collapsing infrastructure of bridges, water systems, levees, electrical systems, and roads. Not to mention the mortgage crisis and the millions of people losing their homes through foreclosures and losing their jobs through outsourcing. Yet a trillion dollars will be squandered to bailout exceedingly reckless corporations that have failed to invest their profits into our country. Instead, they line their own greedy pockets. What isn't spent on Wall Street is spent fighting ill-advised wars to increase the profits of oil companies with their own runaway revenues. I wouldn't be surprised if the taxpayers aren't asked in the near future to rescue them as well. We didn't have a say in the past bailouts and we probably won't have much control over future decisions that redirect taxpayer money to the wealthy.

It will be difficult, if not impossible, to bring into this panicked conversation the need to meet the human needs of people in our communities, what the politicians condescendingly call "Main Street." Whatever our needs, we will be told the country cannot afford to meet them because we are carrying the largest deficit in the history of the world. After 30 years of privatization, union-busting, disinvestment in infrastructure, healthcare, welfare and education, our country has no strategy that will put people over profits and ensure that the next generation will be at least as secure as the present one.

While it's true that both men and women are suffering in this undeclared Depression, women will suffer more. Women in the U.S. are still paid only 77 cents for every dollar earned by men -- mothers only 73 cents, and single mothers about 60 cents. For women of color, the numbers are even worse -- African-American women earn 63 cents and Latina women earn 52 cents for every dollar paid to white men. With numbers like these, it's easy to see why protection from wage and other job discrimination is a critical component of economic security for women and families, especially in this economic crisis caused by Wall Street greed.

These 20 demands are just some of the issues we as women of color need to demand be addressed by the new administration. While this is not a comprehensive list of everything we seek, these issues can form the basis of future discussions about what women of color should expect as affirmations of our human rights by our government.

However, there are over-arching issues that require our attention as well. For the past several decades, an ideologically-driven attack on science has distorted many policies and regulations in our society. From the teaching of Creationism instead of evolution to the manufacturing of false claims to ban contraceptives and abortion, science has been held hostage to ideology. People need to understand the vital difference between facts and opinions. We demand that evidence-based data again be respected and form the basis of policy decisions, not the narrow views of human rights opponents who believe we should all live under their particular religious views.

More money needs to be spent on research on the health care concerns of all women, but particularly women of color. There is much missing data because we are not a priority in this country. In some cases, the research offered is incomplete or distorted because an intersectional analysis was not used to compile or interpret the data. For example, earlier this year the CDC reported that 50% of African American teens would contract a STD. Left unexamined, it furthered the myths of recklessness and hyper-sexuality of black children. By releasing this data without an intersectional analysis, it was left to activists to point out the missed correlation between sexual abuse of African American teenagers and the STD rate. If sexual abuse affects 25% of black girls each year, there is probably a relationship between violence against women and the health statistics. These types of uninvestigated intersections must be lifted by reproductive justice activists so that we have the facts we

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need to work for healthy communities and families.

Another foundational issue is the failure of our health care system. Women of color should join the demand for universal health care, such as by working with the Raising Women's Voices Campaign organized by the Avery Institute, the National Women's Health Network and MergerWatch. (see the Raising Women's Voices Website http://www.raisingwomensvoices.net for more information). Skyrocketing health care costs devastate our families and communities. Nearly a half-million people file for bankruptcy each year because of high medical costs. Another 46 million lack health insurance. We should demand an expansion of Medicaid and Medicare to include the entire population, but also to ensure that fair rates are paid to providers so that they are not forced to accept below-market rates set by the government. Instead, our present system rewards insurance companies that pocket billions in profits while restricting coverage for policyholders. This money could be used instead to offset our basic health care costs. Universal coverage would also significantly reduce the administrative costs of the Medicare and Medicaid systems since millions are spent on eligibility investigations rather than providing medical care.

We must work to end health care disparities suffered by people of color when our health care services and outcomes are compared to those of white people. Of course, racism, sexism, classism, and homophobia in the health care system should be eliminated. But we cannot stop there. The entire debate about health care disparities assumes that the health care white people receive is adequate. Do we really want to settle for the poor treatment that is standard in our society or do we question why the bar is set so low for all people? Health care is a human right. Reproductive justice activists must demand that the new administration pay urgent attention to the needs of people in our society, particularly the most vulnerable amongst us. We have to change the nature of policy debates in our society so that vulnerable populations, such as immigrants, are not seen as disposable people without human rights. Specifically, we have to understand the role of policy work in movement building that harnesses our collective power as Indigenous women and women of color.

SisterSong will continue our work of building a movement of women of color and Indigenous women to build our power to demand the attention of elected officials and policymakers. This is long-term work that will require investing in the leadership of women of color, particularly young women. It will also require that we envision beyond the 2008 elections and build a human rights culture in the United States that radically transforms our country's spending priorities. Until human rights standards are infused into our political system, we will not have candidates or elections that meet our needs. If politicians say they care about family values, they must prove that they care about our families.

Otherwise, it will be business as usual regardless of who is sitting in the White House.

Countering the Black Anti-Abortion Movement

By Loretta Ross, SisterSong National Coordinator

Leaders of the Black anti-abortion movement visited Atlanta in July 2008 to stake a claim for the mantle of the Civil Rights movement. Since Atlanta is the birthplace of Dr. King's dream of human rights for all people, they decided to lay siege to several abortion clinics in our city to try to persuade folks that abortion is a form of genocide against African Americans and should be restricted based on race.

Fortunately, they threw a party and no one came. Not even the media. Black people in Atlanta yawned and focused on more relevant issues like the economy. Their events fizzled out and they were left sputtering about the "Black holocaust" to themselves in empty rooms. They even had trouble finding an African American church sufficiently befuddled to host them. This may have been because they foolishly organized protests at three churches that would not condemn Black women who chose to have abortions. If they had asked me, I might have reminded them that the last folks who protested against Black churches wore white sheets and hoods, and the comparison was not flattering.

Organized under the auspices of Operation Save America (formerly Operation Rescue), they sought to commemorate the 20th anniversary of Operation Rescue's 1988 protests at the Democratic National Convention in Atlanta that launched OR into national prominence. OSA, in its new garb and rhetoric, held its annual convention in Atlanta, after which they organized a sparsely-attended demonstration against Atlanta's Gay Pride parade.

Frankly, I find it convenient that OSA would rail against the queer community one week and then next support a few African Americans to stand on street corners with signs of aborted fetuses to call abortion "Black genocide." Rarely do our opponents offer such a perfect opportunity to bring the Queer Rights and the Reproductive Justice movements together in the same city at the same time in a united front against their racism, sexism, homophobia and bigotry.

Despite the clumsiness of their tactics, the Black anti-abortion movement must be taken very seriously by African American women in the reproductive justice movement. We know they don't represent our views and we are not fooled into thinking that they care about gender justice for women. In fact, if they had their way, we would be re-enslaved once again, based on our fertility. Where have we heard that one before?

The reason the Black anti-abortion movement must be carefully studied through opposition research is that they carefully exploit religious values to make inroads into our communities. Through clever positioning and photo-ops by the right wing, they appear stronger and more numerous than they actually are. They poison the soil in which we must toil.

For example, the NAACP endorsed the 2004 March for Women's Lives and its president, Julian Bond, spoke movingly at the march, aligning this historic civil rights organization with a major women's rights demonstration for the first time in its 95-year old history. For those of us who worked for years to bring the Civil Rights and Women's Movement closer together, this was a victory we celebrated with pride and joy because many Civil Rights organizations see feminism in general and abortion in particular as too controversial. They sometimes fail to speak out to support African American women in our struggle to exercise self-determination in controlling our bodies and the future of our families. This was a bold, brave and timely move. Many of us joined the NAACP because of this courageous stance for reproductive justice.

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SisterSong believes that we should have a society that prioritizes taking care of its people not its transnational corporations. If we were to launch a "100 Days" campaign, there are many reproductive justice issues we should bring to the attention of the new administration beginning with our first 20 priorities (see box on opposite page)

1. Basic reproductive options should be safe, affordable and accessible.

2. Birth control should be affordable for all women.

3. The Hyde Amendment restricting abortion funding for poor women should be eliminated. In fact, all abortion restrictions should be removed, including the Global Gag Rule, and federal prohibitions that affect Native American women, women in the military, women in the Peace Corps, incarcerated women, and women in the District of Columbia.

4. There should be improved access to Emergency Contraception (the "morning after" pill), removing restrictions for young women under 18, and requiring pharmacies to make EC available without discrimination.

5. Medical providers such as pharmacists and doctors should not be allowed to use "conscience clauses" to refuse legal reproductive health care for women, including reversing the 2008 HHS Federal Refusal Rule that would allow even more widespread medical refusals for legal healthcare.

6. Funding for reproductive health care through Title X should be at least equalized to the wasteful spending on abstinence education.

7. Comprehensive sex education should be totally funded through Title V that includes evidence-based information about sexual health.

8. The sexual rights of young people should be respected and protected, including the rights of young mothers.

9. Women should have the right to accept or refuse medical care, ending forced Caesarians

10. Women should have the right to use midwives to deliver their babies and midwives should not be criminalized for providing these services.

11. New reproductive technologies should be regulated to ensure they are not socially abused by greedy profiteers.

12. Living wages should be the standard for all workers, not minimum wages.

13. Disabled, immigrant, gender non-conforming, transgender and queer people should have the same reproductive rights as everyone else.

14. Anti-prostitution legislation that harms women should be revoked.

15. Eliminating STIs and HIV/AIDS should be reprioritized with adequate funding for ending these diseases in communities of color, including supporting female condoms as well as male condoms, and expanding research on microbicides.

16. Links between environmental contaminants and reproductive health must be investigated. Our families deserve safe communities free from violence and toxins.

17. Traditional ways of providing health care to our communities should be respected.

18. Fund Birth Centers through Medicaid, protecting access for low-income women.

19. Stop shackling pregnant, incarcerated women during labor and delivery and, in fact, investigate all reproductive abuses against incarcerated women to ensure they have the optimal opportunity to have healthy babies and to use contraceptives.

20. End citizenship documentation requirements for healthcare. Healthcare should be affordable, accessible and safe for all people. The human right to health is not negotiable based on immigration status.

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It's a good thing we did, because immediately after the March, Black anti-abortionists began to demand that the NAACP rescind its endorsement of the March. The organization held the line and did not cave in, but the abortion opponents within its ranks have not given up and this will be a continuing struggle for years to come.

This conflict represents the increasing inroads potentially achieved by carefully orchestrated campaigns by Black surrogates for the religious and political right. They not only oppose abortion, but they also organize on behalf of many other right wing causes, such as opposing stem cell research, supporting charter schools, opposing affirmative action, etc. Similar efforts are underway in other communities of color.

Generously funded by a predominantly white anti-abortion movement desperate for Black representatives, the Black anti-abortion movement seeks to drive a wedge into the African American community. Another example is how spokespeople inaccurately accuse Barack Obama of supporting Black infanticide. Day Gardner, president of the National Black Pro-Life Union, repeated lies circulated by anti-abortionists and said that Obama "oppose(d) legislation to protect children born alive."

The primary target for the ire of the Black anti-abortion movement is Planned Parenthood Federation of America. They accuse Planned Parenthood of deliberately seeking the elimination of Black babies because PPFA provides a majority of the affordable reproductive health services for African American communities.

They distort the record of Margaret Sanger, the PPFA founder, often by attributing to her statements made by others. As I researched in my earlier work on African American women and abortion, Margaret Sanger believed that fertility control was linked to upward social mobility for all women, regardless of race or immigrant status. Her arguments persuaded middle-class women, both Black and white, to use birth control when available.

She launched the Negro Project in 1939 that hired several African-American ministers to travel through the South to recruit African-American doctors. The project proposal included a quote by W. E. B. DuBois, saying that "the mass of ignorant Negroes still breed carelessly and disastrously, so that the increase among Negroes, even more than the increase among Whites, is from that part of the population least intelligent and fit, and least able to rear their children properly." This quote, often mistakenly attributed to Sanger, reflected the shared race and class biases of the project's founders.

The Negro Project relied on Black ministers because of its white sponsors' belief that "the most successful educational approach to the Negro is through a religious appeal." Sanger wrote, "We do not want word to go out that we want to exterminate the Negro population and the minister is the man who can straighten out that idea if it ever occurs to any of their more rebellious members."

While we should not ever try to disguise or deny the tendencies towards eugenics represented in the writings and speeches of that period, we should also not overstate them either. African American women during Margaret Sanger's time were as equally committed to resisting population control and selective breeding through eugenics as we are today. They took Sanger and DuBois to task for their remarks, yet they also recognized the importance of family planning for the Black community and demanded the placement of clinics in our communities so that we would have access to urgently needed reproductive health services.

What is perhaps most intriguing about the attacks on PPFA is the organization's official policy not to defend itself more strongly against these charges of racism and genocide. I don't believe it's because they don't want to give credence to these allegations, but maybe because they don't want to bring further attention to the specious claims made by the Black anti-abortionists. That is a question for PPFA to answer.

Irrespective of PPFA's lack of response, African American women must organize and speak out against those who tell us that we are now responsible for the genocide of our own people. Talk about a "blame the victim" strategy! In the immortal words of Clarence Thomas, we are now accused of "lynching" our children in our wombs and practicing white supremacy on ourselves. Black women are again blamed for the social conditions in our communities and demonized by those who claim they only want to save our souls (and the souls of our unborn children). This is what lies on steroids look like.

Who are these people? Information on them is suspiciously scant. Few reveal their connections to white anti-abortion organizations, their origins, or the sources of their funding. They are most frequently seen at anti-abortion press conferences and conventions. One wonders if they are the result of affirmative action by the antis.

Of course, the most famous of the Black anti-abortionists is Alveda King, niece of Dr. Martin Luther King, Jr. She is a Pastoral Associate, a member of Priests for Life, and Director of African American Outreach for the Gospel of Life Ministries. Because her father was Dr. King's brother, Alveda is the leading voice for linking the anti-abortionists to the Civil Rights movement. This is despite the fact that both Martin Luther King and Coretta Scott King were strong supporters of family planning in general, and Planned Parenthood in particular. Alveda King has spoken out strongly against gay rights, in support of charter schools, and lives in Atlanta.

Probably the most widely-known Black anti-abortion minister is Rev. Clenard H. Childress of New Jersey, founder of the BlackGenocide.org project and website. He is the president of the Northeast Chapter of Life Education and Resource Network (L.E.A.R.N.), established in 1993. He claims that the "high rate of abortion has decimated the Black family and destroyed Black neighborhoods to the detriment of society at large." He led protests at the 2008 NAACP convention in Cincinnati and has accused the organization of practicing racism against Black children. He is also on the board of the Center for Bio-Ethical Reform that circulates the Genocide Awareness Project (GAP) poster displays on college campuses across the nation to create controversy among young people about Black abortion.

I have spoken on many campuses in the wake of the GAP project to provide accurate historical and contemporary information about Black women's views on abortion. Students are understandably confused when presented with seemingly fact-based information that claims that Black women are the scourge of the African American community.

Rev. Johnny Hunter is the national president of L.E.A.R.N., headquartered in North Carolina, which he describes as the largest, African-American, evangelical, pro-life ministry in the United States. Hunter spoke at the press conference organized by Trent Franks in September in support of the Prenatal Non-Discrimination Act that wants to restrict abortions based on "sex and race selection." (see related article in this issue)

Another featured leader is Day Gardner, president of the National Black Pro-Life Union in Washington, D.C., who also spoke at the press conference in September. The National Black Pro-Life Union was founded to serve as a clearinghouse to coordinate the flow of communications among all African American pro-life organizations and individuals in order to better network and combine resources. A former beauty queen in a Miss America pageant and radio broadcaster (again, where have we heard that one before?), she unsuccessfully ran for a seat in the Maryland State Legislature. She is the former national director of Black Americans for Life, a branch of the National Right to Life Committee.

Walter Hoye, a Berkeley preacher and founder of Issues4Life, claims that abortion "is a moral issue as far as the church is concerned, and we want to strengthen the African-American leadership." Hoye said that abstinence "is Christianity 101. But when people decide to have sex outside of marriage, we want to do other things like post-abortion counseling, anger management, day care and recovery programs." He adds that people should be equally concerned with abortion clinics located in predominately Black neighborhoods as they are with homicides, liquor stores and genocide in Africa. Interestingly, Hoye also warns African Americans about the threats biotechnologies pose for the elimination of Black people.

Alan Keyes, perennial presidential candidate, is also well-known in anti-abortion circles. Keyes first came to national attention when President Reagan appointed him as adviser to

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Maureen Reagan (daughter of the president), as she led the official U.S. delegation to the UN World Conference for Women in Kenya in 1985. At this meeting, the U.S. affirmed its support for the infamous 1984 "Mexico City" policy that banned U.S. funds from supporting abortion worldwide. Keyes helped lead the anti-abortion protests at the 2008 Democratic National Convention in Denver, and is a favorite of the right for his fierce extreme views on a number of issues.

There are a handful of other Black spokespeople for the anti-abortion movement. The point is not how many there are but the disproportionate impact they have. They have created the false impression that if only Black people were warned that abortion is genocide, women would stop having them in order to preserve the Black race, either voluntarily or pressured by the men in their lives.

The sexism in their viewpoints is mind-boggling. To them, Black women are the poor dupes of the abortion rights movement, lacking agency and decision-making of our own. In fact, this is a reassertion of Black male supremacy over the self-determination of women. It doesn't matter whether it is from the lips of a man or a woman. It is about re-enslaving Black women by making us breeders for someone else's cause.

I am reminded when Shirley Chisholm, the first Black woman in Congress, dismissed the genocide argument when asked to discuss her views on abortion and birth control:

To label family planning and legal abortion programs "genocide" is male rhetoric, for male ears. It falls flat to female listeners and to thoughtful male ones. Women know, and so do many men, that two or three children who are wanted, prepared for, reared amid love and stability, and educated to the limit of their ability will mean more for the future of the Black and brown races from which they come than any number of neglected, hungry, ill-housed and ill-clothed youngsters.

Black anti-abortionists are surprisingly unoriginal in these sentiments that were first offered by Marcus Garvey in the 1920s who suggested that the Black population should have as many children as possible to counter the impact of white supremacy during the Jim Crow era. He wanted people of African descent to overwhelm white people through numbers.

It is up to those of us who are women of color in the reproductive justice movement to counter these anti-abortionists. An excellent example was offered by SPARK for Reproductive Justice when the protestors arrived in Atlanta. SPARK organized a week-long series of activities involving SisterSong, Planned Parenthood, the Feminist Women's Health Center, the NAACP, youth groups, and others to protest at OSA events. "I'm out here because OSA is a racist, homophobic, misogynist organization," said Paris Hatcher, co-director of SPARK. Other activists pointed out the obvious anti-Semitism in comparing abortion to the Jewish Holocaust, or in comparing African American women to the Nazis. In response to an inquiry from a reporter, Paris replied, "I think to simplify reproductive justice down to just the abortion debate is really simplistic. I think why queer people, why LGBT people, should be involved is because we're talking about our bodies, our sexuality and being able to express that freely."

Another group that fiercely fights Black abortion opponents is the Religious Coalition for Reproductive Choice in Washington, D.C., under the leadership of Rev. Carlton Veazey and Rev. Penny Willis. They offer strong religious voices to challenge the perception that Black people of faith oppose women's rights and are weak in their support for reproductive justice. They organize the annual National Black Religious Summit on Sexuality with hundreds of participants to address a number of difficult issues like HIV/AIDS, violence against women, and reproductive justice.

We need more opposition research on these opponents of women's human rights. We need our leading African American women's and Civil Rights organizations to speak out more strongly in support of reproductive justice. We need to especially organize young people to resist the misinformation directed at them by these groups. Many of our campuses are unaware of the activities of the Black anti-abortionists until they show up, usually invited by a white anti-abortion group. But mostly, we need to let the world know that they do not speak for Black women. As my mother would say, "they might be our color, but they are not our kind."

We are the vision and the voice of the movement: Cultural Work and Reproductive Justice

By Laura Jiménez
SisterSong Deputy Coordinator

I cannot count the number of times that I have attended events of social justice organizations that have been enhanced, in fact driven, by the performance of a musical group, a poet, a performance artist, the screening of a documentary or film, or where the space used has been enlivened with the works of visual artists, paintings, sculpture, and photography. It is amazing to encounter the different cultural expressions of artists who identify themselves in various ways and devote their work to the growth and survival of their communities.

Here at SisterSong, we have just finished with the convening of "Let's Talk About Sex!", our 2nd National Conference. Since that event early this summer, I have had the opportunity to think about how it is that our cultural workers support, enhance and promote our mission for reproductive justice. For example, the conference would not have been the same without our sistas' support: the comedy of Ali Wong, who humorously provoked us to think about the overwhelming marketing campaign for Gardasil (the new HPV vaccine for girls), vibrators, and who raucously dubbed our conference – "Non-profit girls gone wild"; or Irene Carranza's art piece "Raven Blue" which created a sensual tone for the conference program's back cover, and; the performance of "The Pocketbook Monologues" by Sharon McGhee and friends, a piece which expressed the pain and pleasure of women's sexual experiences through an African American cultural perspective. Additionally, we were honored to have the many poets, filmmakers, poetry collectives, body workers and healers that attended the conference and shared their work with us during the conference and during informal, after hours gatherings. All of these expressions are important because in one way or another, they are reflections of who we are and what our experiences as women of color have been.

In the piece, "Arte es vida", a statement by the Esperanza Peace and Justice Center in San Antonio, Texas, the crucial role of art and culture are described in terms of the survival of the community:

"As people moved by a vision of social justice, as people of color, as working class and poor people, as native people and immigrant, as women, men, old and young, queer and straight, we have learned the power of culture and art in our lives. We have come to understand that to participate fully in this world, we must be culturally grounded, confident of our voices, and certain of the value of our contributions in life. Cultura y arte give us this grounding. They connect us to our histories and nurture the seeds of our self-worth. From our abuelitas, parents and children, from our comadres and compadres, from our sisters and brothers throughout the world, we have learned that social and political divisions cannot be bridged without accurate and respectful cultural understanding. Through artistic creation and cultural expression, we as historically silenced and isolated individuals have come to new understandings of ourselves, each other, and the world."

It is necessary to remember that when we talk about reproductive justice, we are not just talking about physical reproduction, we are also talking about the survival of our communities. As referenced in the statement above, our cultural workers have over time found beautiful and intriguing ways of rooting us to our cultures, reminding us of our history and expressing our joys and sorrows. They have shared with us their gift of combining storytelling and memory with beauty, humor, rhythm and passion. This gift has enabled many of our communities to maintain their existences over thousands of years through a shared knowledge and understanding of a dance, a song, a ritual, an artistic tradition – they are the keepers and reproducers of our culture, which is what we cling to through the hard times. They remind of us of who we are, where we came from, and what is important to us. They are the vision and the voice of the movement.

This means that as individuals and organizations in the movement, it is important not only that we include our cultural workers in our events as a recognition of the important role that they play in organizing our communities and promoting our messages, but that we also mobilize our own resources to support their work so that they can continue to be the vision and the voice of our movement.

Effective Teen Sex Education

A growing number of sex education programs that support both abstinence and the use of contraception for sexually active teens have now shown positive effects in delaying first intercourse, improving contraceptive use, and preventing pregnancy or sexually transmitted among teens, according to a new report released in November 2007 by the National Campaign to Prevent Teen and Unplanned Pregnancy. Other interventions--several that mention sex little or not at all--have also shown effective results.

"Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases", by researcher Douglas Kirby, Ph.D., is a comprehensive review of evaluation research that answers the question, what programs work to prevent teen pregnancy and STDs. The report's findings are based on a total of 115 program evaluations.

Two-thirds of sex education programs examined in the report that focus on both abstinence and contraception had a positive effect on teen sexual behavior--for example, they delayed the initiation of sex, improved contraceptive use, or did both. Despite the concerns of some adults, none of the programs that discussed abstinence and contraception hastened the initiation of sex or increased the frequency of sex among teens.

The report also notes that, at present, there is no strong evidence that programs that stress abstinence as the only acceptable behavior for unmarried teens delay the initiation of sex, hasten the return to abstinence, or reduce the number of sexual partners.

"Emerging Answers 2007" identifies 15 programs with strong evidence of success. Seven are classified as sex education programs, two are community service learning programs, two are programs with several components, two involve ways clinicians interact with patients, and one is a parent-teen program.

Other results from the report include:

- Teen girls and young women who receive emergency contraception from clinics in advance of having sex are not more likely to have sex and are more likely to use emergency contraception if they do have sex than those who do not receive emergency contraception in advance.
- Some longer sex education videos that are interactive and viewed many times can have a positive effect on teen sexual behavior.
- School-based and school-linked clinics and school condom-availability programs do not increase sexual activity, but it is not clear whether they increase the use of contraception.
- Programs for parents and their teens sometimes reduce risky sexual behavior among teens by delaying sex or increasing contraceptive use.
- Most programs that are effective at changing behavior give a clear message about avoiding risky sexual behavior, either by abstaining from sex or by using contraception.
- There are now several sex education programs that have been evaluated multiple times. Results from these evaluations suggest that when the original programs are carefully replicated in similar settings with similar populations of young people, the program's positive effects on teen sexual behavior can also be replicated.

"Teen pregnancy and birth rates have declined by about one-third since the early 1990s--a remarkable success story," said Sarah Brown, CEO of the National Campaign. "Even so, it is still the case that one in three girls in the United States get pregnant by age 20. Given the nation's stubbornly high rate of teen pregnancy, it is most welcome news that the menu of proven, research-based interventions that help young people make better decisions about sex, pregnancy and parenthood is expanding."

For more information about the National Campaign and this report, please visit:
www.TheNationalCampaign.org/EA 2007.

Challenges and Opportunities for U.S. Family Planning Clinics in Providing the HPV Vaccine

By Rachel Benson Gold, Alan Guttmacher Institute

Like a modern-day Icarus, the newly introduced HPV vaccine in the United States soared high with the promise of preventing cervical cancer, but crashed back to earth as efforts to require it as a condition for girls' attendance of middle-school ignited a firestorm of controversy. With that fall, the focus of public health and vaccine advocates is necessarily shifting from advocacy around school mandates to finding more targeted ways of getting the vaccine to girls and young women, as well as information about the vaccine's importance and benefits to parents and the public.

This shift has moved the nation's clinic-based family planning service providers much closer to center stage in the vaccine introduction effort. Family planning clinics constitute a major source of health care information and services to low-income and minority women, precisely those women who are at highest risk for cervical cancer. Recasting family planning providers as sources of vaccine-related information and services poses myriad challenges, but if these challenges can be met, family planning clinics are uniquely positioned to play a central role in reducing long-standing disparities in cervical cancer incidence and deaths in the United States.

Off and Running...

For much of 2006, it appeared that the introduction of the HPV vaccine was on a fast track to being one of the great public health success stories of our time. Gardasil, developed by Merck, had been shown to be virtually 100% effective in preventing the strains of HPV responsible for 70% of cervical cancer cases. Review of the vaccine (but not the research itself) was expedited by the federal Food and Drug Administration (FDA) under a priority process designed for products with potential to provide significant health benefits, and approval was granted in early June. (A second vaccine, Cervarix, was submitted to FDA in March 2007 by GlaxoSmithKline.) In addition, Gardasil has been approved in 75 other countries around the world.

Within weeks, Gardasil was endorsed by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP), which is responsible for maintaining the nation's schedule of recommended vaccines. Because Gardasil is most

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effective before HPV exposure (which, given current levels within the U.S. population, is essentially a marker for sexual activity), the ACIP recommended that the vaccine be routinely administered to all girls ages 11–12, and as early as age nine at a doctor's discretion. At the same time, the panel recommended vaccination of all adolescents and young women ages 13–26, as part of a national "catch-up" campaign for those who have not already been vaccinated.

The recommendations of the ACIP are typically used as a guide to states in establishing the package of vaccines that will be required for school attendance. These school-based immunization requirements, which exist in some form in all 50 states, are widely credited for the success of immunization programs in the United States. They have also played a key role in helping to close racial, ethnic and socioeconomic gaps in immunization rates, and have proven to be far more effective than guidelines recommending the vaccine for certain age-groups or high-risk populations.

State legislators rushed to introduce school-mandate proposals as soon as the chambers opened for business in 2007. Although widely accepted initially as a critical step to ensuring near-universal coverage of the vaccine, these proposals instead became the focal point for multiple strains of concern, and opposition.

...But Opposition Mounts

Virtually as soon as Merck publicly announced the results of its long-term clinical trials in October 2005, conservative activists began suggesting that inoculating young adolescents against HPV would encourage teenage sexual promiscuity. The heads of various "family values" groups publicly declared that they would not vaccinate their own children. Vaccination "sends the wrong message," asserted Tony Perkins of the Family Research Council (FRC). "Our concern is that this vaccine will be marketed to a segment of the population that should be getting a message about abstinence."

In response to public opinion, however, that hard-line argument was soon dropped. Within a few months, opposition to the vaccine itself morphed into opposition to school mandates, which according to Wendy Wright, president of Concerned Women for America, would be "an end-run around parental rights." Although, according to the National Conference of State Legislatures, most states allow exemptions from mandates in the case of a medical condition or a religious objection, and nearly half allow exemptions for "philosophical" reasons, that was not enough to quell the opposition. "Parents know what's best for their daughters. "Provisions allowing parents to opt out, says Wright, "puts the parents in a position where they have to justify themselves to government officials."

In addition, the school-mandate effort was drawing fire from some consumer groups concerned about vaccine safety in general and publicly leery of the underlying motivations of the for-profit pharmaceutical industry. (Merck's own Vioxx had been removed from the market in 2004 because of previously unknown or undisclosed safety risks.) Indeed, the speed with which Gardasil arrived on the scene exacerbated underlying public concerns and raised fundamental questions about whether the government's review and approval process had been adequate to ensure the drug's safety.

Coming hard on the heels of the expedited FDA approval, the full-force drive for school mandates increasingly began to appear premature. Indeed, by the end of the first quarter of 2007, legislation to mandate HPV vaccination for middle school girls was pending in 25 states and Washington, DC. In contrast, it took three years for even a single state to mandate the chickenpox vaccine, and a full eight years for one state to do so in the case of the Hepatitis B vaccine, according to Stateline.org. A suspicion in the minds of some—that with a second vaccine moving through the FDA approval process, Merck might have been more interested in locking in market share than in ensuring the safety of its product—only deepened the distrust.

Communities of Color Weigh In

These concerns merged in some minority communities, notwithstanding the fact that these are the same communities that disproportionately bear the burden of cervical cancer in the United States. When, for example, a school mandate was proposed for the predominately black District of Columbia by two white members of the city council—albeit members with a long history of activism on public health issues—deep-seated concern was given a powerful voice by Washington Post columnist Courtland Milloy. In a widely read column appearing in mid-January 2007, Milloy opposed the mandate, saying "After all, your daughter is 11 and probably black, so the assumption is she'll be having unprotected sex in no time—but don't take offense." Milloy went on to echo concerns about whether the process had gone too far too fast, raising the question of whether enough care had been taken to explore potential adverse side effects before moving to mandate it for young black girls.

Finally, he reprised the well-documented history of medical and sexual abuse of communities of color, including research on poor black men conducted in the absence of adequate—or sometimes any—ethical safeguards, involuntary sterilization of young girls and efforts to entice women to accept long-acting birth control in lieu of serving jail time. Jill Morrison, senior counsel for the National Women's Law Center who herself is black, commented on the concerns expressed at a community meeting in the District, saying "Because of history, anything new is going to be looked at skeptically." And, in a reference to the widely discredited, federally funded study of the impact of untreated syphilis on poor black men in Alabama, she added "Then you add in the sex part and the presumption of promiscuity, and it's Tuskegee all over again."

Death of a Campaign

Within weeks of Milloy's column, a serious misstep by Merck gave vaccine opponents even more ammunition: News broke that the company had been financially supporting efforts to lobby state legislators to support the school-mandate legislation. (As if this were not enough, it also turned out that the former chief of staff for Texas Gov. Rick Perry (R)—one of the most vocal supporters of the vaccine, who mandated it by executive order only to be overturned by the legislature—was now a lobbyist for Merck.) Merck quickly suspended its lobbying activities, but the damage was done.

Ultimately, the mainstream public health community joined the fray, and delivered the final blow. "For many of us in public health who have been involved in immunization and state laws, it's been too quick," said Neal Halsey, director of the Institute for Vaccine Safety at the Johns Hopkins Bloomberg School of Public Health.

"You want the demand to come from the public who realize the potential benefits from the vaccine, not to be imposed upon them," he continued. For its part, while continuing to firmly support voluntary use of the vaccine, and including it in its schedule of vaccines to be routinely administered to adolescents, the American Academy of Pediatrics declined to support school mandates, promoting instead a "go-slow" approach focusing on public education and careful monitoring of the vaccine's safety.

Opponents now comprised an unlikely combination of supporters of parental rights,

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COVER

THE MOTHER HOUSE

In June 2007, SisterSong made history by becoming the first national women of color reproductive justice organization to purchase our own office building! We bought the Mother House, the original home in Atlanta of the National Black Women's Health Project (NBWHP), founded in 1983. By partnering with Sisterlove (an Atlanta-based women's HIV/AIDS project and SisterSong co-founding organization), that later purchased a half-interest in the property, SisterSong has established a permanent, stable home for our growth and prosperity.

This was a fitting triumph in celebration of our 10th anniversary. The Mother House is a large mansion, built in 1900, that has been designated a Historic Landmark in the West End of Atlanta. It has eight large offices, three bathrooms, three conference rooms, and is fully ADA compliant with parking spaces for 25 cars and a wheelchair access ramp.

After searching for several long months for financing among several banks with which SisterSong does business, we finally located a favorable fixed-rate 15-year loan from Colonial Bank that keeps our monthly mortgage below $4,000/month. Split between the two organizations sharing the space, this means that SisterSong and Sisterlove are purchasing property for much less than either organization would pay for rent on similar space. We made it under the wire before the mortgage meltdown that now probably would not allow non-profits like ours to purchase commercial property. We also learned a

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We could not have afforded this property without the generosity of the Bert and Mary Meyer Foundation that bought the building in 1996 from NBWHP. Appraised at nearly $800,000, we could not have purchased the property if Barbara Meyer, head of the foundation, was not determined that the property would remain in control of the women's community of Atlanta. The Foundation invested more than $300,000 in improvements in the building (updated electricity, plumbing, air conditioning and restoration), yet sold it to us for $468,000, slightly half over its market value. This made the property not only affordable, but we acquired more than $300,000 in equity in an exquisite piece of real estate simply by making the deal. As the Management Circle of SisterSong realized, some deals are too good to walk away from.

When we first learned about the property, we were scared – concerned that our capacity as an emerging reproductive justice organization would keep us from taking advantage of this generous offer. In fact, some folks advised us not to do it, genuinely concerned about SisterSong's acquisition of this debt. On the other hand, many advised us to take the leap, including Byllye Avery, NBWHP founder, who correctly predicted that the benefits to SisterSong would outweigh the risks. Byllye came back to Atlanta from Boston to speak at our Open House and has encouraged many donors to help us out.

Our first investment was to convert one of the largest bathrooms to make it wheelchair accessible. With furniture donated from the Atlanta Feminist Women's Health Center and Sisterlove, among others, we were able to move in and have a fully functional office building in July and things have been rocking ever since.

We also make the space available for other community groups to use, and they have seized the opportunity to have affordable and accessible space. For example, in August, we rented the space to a local gay and lesbian ministry for morning church services. That same afternoon, a Rwandan investment group used the main conference room to discuss how to invest in their country following the devastating genocide. That evening, we prepared the space to host refugees from New Orleans fleeing hurricanes Ike and Gustav. In September, we erected a Red Tent and shared birthing stories with each other, followed by two events for young people titled "Conversations with Our Daughters" and "Conversations with Our Sons." In addition, Morehouse School of Medicine uses the space for off-campus public health classes, and Sisterlove has created a Cyber Café on the top floor to teach computer skills to women living with HIV/AIDS.

We had to step out there on faith to believe and it has paid off. We quietly began a Capital Campaign for the property to make some improvements, retire the debt, and begin an endowment fund. When Gloria Steinem was in town in September, we persuaded her to visit the Mother House and support our efforts and she committed to getting in touch with some donors in the Atlanta area to help us out. Other donors like Irene Crowe and Isa Williams, have made large contributions to seed the campaign. To date, we have raised more than $30,000 from our Management Circle and individual donors.

We still need support from our national SisterSong community. Donations can be made at our website, www.sistersong.net. We would like to secure our parking lot with a fence because we work late in the evenings and have evening events at which we'd like better security. We want to insulate the building better because it leaks like a sieve in the winter and drives our heating costs sky high. We want to landscape the property so that we can have some of our meetings outdoors among the lush vegetation on the property. These are minor improvement we are sure we will achieve with help from our community of sisters in SisterSong.

We'd like all of our members and supporters to consider the Mother House your home in Atlanta. When you are planning a meeting here or just visiting, this is your space of which you can be very proud. SisterSong continues to break ground in many ways, and we believe that women of color deserve not only to have our own spaces, but to own the spaces we have.

Health Officials Report Pain, Fainting Among Girls Receiving Merck's **HPV Vaccine Gardasil**

U.S. health officials in recent months have received reports of pain and fainting among teenage girls who receive Merck's human papillomavirus vaccine Gardasil, the AP/International Herald Tribune reports. Gardasil in clinical trials has been shown to be 100% effective in preventing infection with HPV strains 16 and 18, which together cause about 70% of cervical cancer cases, and about 99% effective in preventing HPV strains 6 and 11, which cause about 90% of genital warts cases. According to health officials, about 230 cases of vaccine-related fainting among girls were reported between 2005 and July 2007. Between 2002 and 2004, there were about 50 reports of fainting. About 180 of the cases reported between 2005 and July 2007 followed a dose of Gardasil, which reached the market in 2006. In addition, some girls say the pain associated with the vaccine is short-lived, but others say it is uncomfortable driving with or sleeping on the injection arm for up to a day after receiving the shot. Merck officials attribute the pain partly to the virus-like particles in the shot. Pre-marketing studies showed more reports of pain from Gardasil than from a placebo, and patients reported more pain when given shots with more of the particles. However, it is unclear whether the pain associated with Gardasil is connected with the increase in reported fainting cases, Barbara Slade, an immunization safety specialist at CDC, said. Teens tend to faint from needles, so Gardasil's three-dose regimen for adolescents would be expected to cause more cases of fainting, she added. Preliminary studies indicate 10% to 20% of adolescents have received at least one dose of Gardasil. Researchers said those rates are because of reasons other than worries about pain, including:

- The vaccine's $120 per dose cost;
- Limited initial supplies; and
- Mixed feelings among some parents and doctors about a vaccine that targets a virus that can be sexually transmitted (AP/International Herald Tribune, 1/3).

News that the FDA knew as early as 2003 that Human Papilloma Virus (HPV) was not linked to cervical cancer is shocking. Mike Adams from News Target Cites numerous FDA documents and clinical studies to show that HPV vaccines are not only ineffective, they may actually be dangerous! Is this scandalous revelation on the front page of all the newspapers and the first item on all news reports? How can the FDA, the US government agency that approves all drugs, have given the go-ahead to the development and marketing of the vaccine Gardasil when it knew that HPV did not cause cervical cancer? On International Women's Day, March 8th 2007, the then federal Health Minister Tony Abbott announced to the Australian people that the much heralded Cervical Cancer Vaccination program was set to begin. Now many months later it is known that Gardasil, which is recommended for girls as young as 12 years old, is causing side effects ranging from seizures and numbness to dizzy spells, fainting and paralysis. More than 17 girls a week in Australia have experienced such reactions after receiving the vaccination, the Department of Health and Aging refuses to release their details. By November 30, 2007, 496 adverse reaction reports were filed with the Therapeutic Goods Association of Australia. Of them, 468 had the cervical cancer vaccine as the sole suspected cause. In the United States up to 1,700 women have reported adverse reactions from Gardasil, including at least seven deaths. Tragically more than 10 million doses of Gardasil have been distributed worldwide. The adverse effects are shocking in themselves but especially when you consider that there is no need for this vaccine in the first place. HPV, the Human Papilloma Virus, is blamed for cervical cancer but this is a very common virus and can be found in about 80% of both men and women. Most of us have had, at one time or another, the HPV virus but most of us do not suffer or die from cervical cancer. In fact, only one percent of women do develop cervical cancer with the year 2000 figures on the mortality rates for cervical cancer being 3.3 women per 100,000 population in the US and 4 women per 100,000 population in Australia.

In Australia there are about 740 cases of cervical cancer each year and around 270 deaths from the disease. Mortality rates generally increase with age, with the highest number of deaths occurring between 75-79. Less than 6 percent of cervical cancer deaths occur in women under 35 years of age. The US National Cancer Institute says, however, that direct causation has not been proven. In a controlled study of age-matched women, 67% of those with cervical cancer and 43% of those without were found to be HPV-positive. These cancers are observed on average only 20-50 years after infection. Other more credible risk factors for cervical cancer are smoking, malnutrition, a weak immune system, and the contraceptive pill. However lifestyle changes are not so easy to change and it is far more palatable and extremely more lucrative for vaccine manufacturers to sell the people another vaccine. But where are the mainstream reporters and doctors and public health officials who should be bringing the FDA and the politicians to answer this miscarriage of science and medicine?

And speaking of injustice, immigrants seeking citizenship are now required to get five new vaccinations, Gardasil being one of them. It is the most expensive vaccine, increasing more barriers for women. Jessica Gonzalez-Rojas, director of Policy and Advocacy at NLIRH, said in article for RH Reality Check, "Instead of mandating vaccines for immigrant women's bodies, the U.S. government should increase access to health information and services that are unbiased, age-appropriate, culturally-competent and non-coercive." She continued, "Mandating a vaccine that specifically targets young non-citizen women is both sexist and xenophobic. It will only add to the current anxieties among many communities of color about the vaccine and the government's interest in vaccinating a particular community, in this case, immigrant women."

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opponents of vaccines in general, drug company critics, communities of color and public health advocates. The effort to require the vaccine for school entry was effectively over. By July, with all but nine state legislatures having adjourned for the year, Virginia was the only state to have adopted a mandate. Significantly, the Washington, DC, mandate was ultimately approved, but only after a provision was added to delay its implementation for a year to permit an aggressive public education effort designed to ensure that parents had adequate information on which to base a decision about whether to exercise their prerogative under the measure to opt out.

Family Planning Clinics to the Fore

The effective demise of the school-mandate campaign is reshaping the roll-out of the HPV vaccine in the United States. At a minimum, it puts increased focus on the importance of reaching out to information about the HPV vaccine.

"The nationwide network of 7,500 family planning clinics," says Dorothy Mann of the Family Planning Council in Philadelphia, "constitutes the front line when it comes to caring for this age-group." Indeed, in 2002, one-third of all women 15–24 who obtained any reproductive health service at all did so at a family planning clinic. Among low-income women, nearly four in 10 who obtained a service did so at a clinic. And family planning clinics are a major source of services related to sexually transmitted infections (STIs); nearly four in 10 women 15–24 receiving STI tests or treatment did so at a clinic. For many of these young women, a periodic family planning visit may be their only interaction with the health care system.

Moreover, family planning clinics are uniquely positioned to reach women at high risk of developing cervical cancer. Over one in four black women (28%) who received any reproductive health service and 40% of Hispanic women doing so looked to a family planning clinic for that care. Cervical cancer incidence among black women is nearly 1.5 times that among white women, and mortality is more than twice as high. Hispanic women have the highest levels of cervical cancer in the country.

Finally, as a trusted source of reliable health care information, and as a major provider of services to adult women and parents as well as young, unmarried women, family planning clinics can make a significant down payment toward the broad-based public education effort about cervical cancer and the importance of the HPV vaccine called for by the American Academy of Pediatrics and others. Just over half of clinic clients are 25 or older, and nearly three in 10 are married; almost six in 10 (57%) are parents. By providing solid information to these women about cervical cancer, the importance of preventing HPV and the benefits of the HPV vaccine, family planning clinics have an important role to play in educating adults and, specifically, equipping parents to make well-informed decisions about vaccination of their children.

Covering the Cost

Perhaps the greatest challenge confronting family planning providers seeking to become actual providers of the HPV vaccine is finding a way to cover the cost. Doing so will be no small feat: Gardasil has the highest public sector cost of any vaccine listed on the CDC Vaccine Price List. Although approval by the ACIP admitted Gardasil into the funding streams usually used for vaccines, these programs have their own complicated requirements and restrictions, and in some cases are largely unfamiliar to the family planning provider community.

With 57% of the nation's family planning clinics recipients of funds under the Title X family planning program, it would be natural for clinics to look first to Title X. But Gardasil's steep cost—approximately $300 for the three-shot regimen per client, even with the discount given to clinics—makes it highly unlikely that Title X could ever underwrite the expense on a large scale. (State laws requiring providers generally to obtain parental consent when administering vaccines to minors further complicate the situation, likely barring the use of Title X funds for the vaccine in many of those states.) Another attractive but unlikely source of significant support over the long run is private philanthropy, although individual donor support has been received in a few cases.

An important potential funding source, however, is the Vaccines for Children (VFC) program, a massive federal program that covers more than four in 10 childhood vaccine doses given each year. The program provides free vaccines, including the HPV vaccine, to children through age 18 who are uninsured, underinsured (that is, covered by insurance that does not cover vaccines), eligible for Medicaid, native American or Alaskan natives. Family planning clinics must apply for enrollment with their state VFC program and meet a range of program requirements that vary from state to state.

In all states, Medicaid covers the vaccine for program recipients aged 19–20. But for women 21–26, each state program makes its own decision. According to Alexandra Stewart, who studies vaccine policy at George Washington University, 22 state Medicaid programs are covering the vaccine for individuals in this age range, and 22 are not. (The status of coverage in the remaining states was unknown as of April.)

Nine states, according to Stewart, have allocated state funds for the vaccine. New Hampshire, for example, plans to spend nearly $5 million on Gardasil this year, more than a quarter of the state's entire budget for immunizations. Under the program, the vaccine will be given at no charge to 11–18-year-old girls. Similarly, the Washington legislature allocated $12 million to provide the vaccine at no cost to girls 11–18; the state believes that this will cover the cost of vaccines for 94,000 girls over the next two years. And in South Dakota, the state program provided almost 20,000 doses between January and mid-May.

Private insurance generally will cover the cost for insured women up to age 26, the upper age limit approved by the ACIP. Merck estimates that 94% of individuals with private insurance coverage are in plans that cover the vaccine; three states—Colorado, Nevada and New Mexico—enacted laws this year mandating coverage in private plans. According to media reports, however, both public and private-sector providers are becoming increasingly frustrated with the low levels of payment through insurance plans, especially given the high up-front cost of the vaccine to providers.

Finally, in mid-2006, Merck established a patient assistance program that will reimburse clinics and other providers for the cost of vaccines, including HPV, for uninsured, low-income adults. According to Merck, applications are processed quickly so that patients can apply and receive the vaccine during the same visit. On the other hand, because insurance status may change, a client must reapply for coverage for each of the three vaccine doses. While an increasingly important source of funding, program requirements make participation difficult, if not impossible, for some family planning clinics. Government entities, such as health department clinics, are not eligible to participate. Moreover, participating providers must pay for the vaccine up-front and then be reimbursed on a quarterly basis. As a result, some providers are able to participate only if they have another source of funding that can tide them over until their quarterly reimbursement arrives.

Forging Ahead

As daunting as the financial challenges are, they are by no means the only ones facing family planning providers seeking to make a direct contribution to the HPV vaccination effort. For a family planning clinic to recast itself as a vaccine provider, it must do everything from making fundamental decisions about the population to which the vaccine will be offered to arranging for staff training to designing specific protocols for counseling and service delivery. Although no systematic data are available on the number of family planning clinics engaged in these activities, some programs around the country are clearly stepping into the fray.

In designing their programs, these family planning clinics are grappling with the basic question of to whom to offer the vaccine. Some providers, such as the Family Planning Council in Philadelphia, are focusing their HPV vaccination efforts on their existing family planning clients, trying to make the vaccine one of the menu of services offered to these clients. Others, such as those funded through the Missouri Family Health Council, are serving vaccine-only clients who make an appointment specifically for the vaccine. In yet another approach, Tapestry Health in Western Massachusetts is also offering special, freestanding vaccine-only clinics. Starting with one clinic site in Amherst in January, Tapestry has held special clinics at seven sites across western Massachusetts. The 2–3-hour sessions are generally held on weekdays in the late afternoon and early evening, although they are looking to expand to Saturdays.

Program decisions may intersect with decisions about funding sources, notably the VFC program. One issue that has arisen with family planning providers seeking to enroll with VFC is the package of vaccines that must be offered. In Utah, for example, family planning providers are required to offer the full range of vaccines required for adolescents and young adults as a condition of program participation. However, in Missouri, the program ultimately agreed to permit family planning clinics to offer only the HPV vaccine, as is the case in Massachusetts.

Having secured funding and decided to whom to offer the vaccine, a host of other service delivery challenges ensue. Working through them requires significant thought and effort since, as Karrie Galloway of Planned Parenthood of Utah frankly admits, delivering vaccines "isn't in our traditional bag of skills." To make programs work, clinics will often have to train a staff that is largely unfamiliar with procuring, administering or even storing vaccines. (The VFC program, for example, has special and costly requirements related to vaccine refrigeration.) Accordingly, Galloway brought representatives of Merck in to brief both the clinical and administrative staff, and then run a training program for the entire staff.

There are other service delivery challenges as well. For example, because of the unique three-shot regimen involved in the vaccine, clinics will need to develop service delivery protocols that include a system to ensure that women return for subsequent shots—a challenge as shots are not timed to coincide with regular clinic visits. Finally, there is the critical issue of counseling and education. Agencies such as the Family Planning Council in Philadelphia and Tapestry Health in Massachusetts have developed detailed policies and protocols designed to ensure that clients are given the full information they need to make an informed choice—a necessity in any context, but one particularly relevant here as the controversy over the HPV vaccine has gained steam.

In theory, then, the national network of family planning clinics may constitute a near-perfect system to deliver the HPV vaccine—and information and education about the vaccine—to a population at high risk of cervical cancer for whom it has the promise of being highly effective. Making that theory a reality is no easy task, however, involving as it does a significant effort from a system already beset with serious challenges, including, but not limited to, a dearth of financing. But if those obstacles can be overcome, family planning clinics are poised to provide an additional, critical public health service to individuals in need and, by meeting that need, make major inroads in reducing disparities in cervical cancer that have long been a critical social and public heath imperative.

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Criminalizing **Home Births** in Georgia

By Luretha Senyo-Mensah
Education and Advocacy Coordinator, SisterSong

During my childhood, I was often in the presence of a loving grandmother who was the "mother" of her church and had a beautiful vegetable and herb garden in the backyard of a meticulously clean house. The smells of pine soapand bleach on white, sun freshened sheets evokes childhood memories of my grandmother's house. I was later to learn that before migrating to California, she had been a midwife in a rural sharecropping community in Alabama and had delivered more than 300 babies.

There has been a revival in many of the "traditional" ways that lead to healthy pregnancies and childbirth. Increasingly, women and their families are making positive, consciously informed choices about where they want to have their babies and who they want to deliver them. Alternative birthing sites, including birthing centers and home, are viable options for many families. The demand for midwives and doulas has increased as women are now choosing more holistic paths to childbirth.

But imagine having a glorious birthing experience at home, delivering a healthy baby, only to be threatened with charges of child abuse and neglect? Or, what if you chose a midwife to deliver your baby and she was arrested when she accompanied you to the hospital? Unfortunately, in states where the laws regarding midwifery are ambiguous, these types of events are not uncommon.

In November 2007, "Martha" (name withheld for confidentiality purposes), a staff person in the military, gave birth to a healthy daughter in her home in Georgia. Throughout her entire pregnancy, she received routine prenatal care from an obstetrician; her prenatal visits were always less than 30 minutes, as her pregnancy was considered low risk. Martha ate nutritiously, exercised daily and was in excellent health. She visited the local hospital, met the staff and worked with them on a birth plan. Martha and her husband enrolled in and attended childbirth education and coaching classes and hired a doula to assist her husband with the coaching. During the last trimester of her pregnancy, she hired a midwife who saw her bi-weekly. That midwife assisted Martha and her husband with the delivery of their baby at home.

After the birth of her child, Martha was contacted by a military version of the social services/family advocacy agency. Why? She was under investigation for child negligence and endangerment; she was informed that she and her husband were subject to legal action and consequences because she had given birth in the home with the assistance of a midwife. Although it is legal to give birth in the home in Georgia, it is illegal for a midwife to assist with that delivery. Martha's mistake was that she had hired a Direct Entry Midwife (DEM) to assist with her delivery.

Midwifery Certification in Georgia

There are varying types of recognized midwifery certifications. (See a description of these certifications on the SisterSong website at www.sistersong.net). In Georgia, DEM are the source of controversy. The DEM enters the profession of midwifery through a variety of routes, which may include self-directed study, apprenticeship with a senior midwife, doctor or attendance at a direct entry midwifery program. They can practice in the home, or in hospital birth center settings. However, they are subject to the rules, regulations and protocols that exist in the state in which they want to practice.

Currently, in the state of Georgia, there are certification regulations and laws that actually support midwifery. In order to practice, an individual must be a certified DEM. Right now, however, certification is unavailable; the Department of Human Resources (DHR) eliminated certification 1979 and it has not since been reinstated. There are midwives who have been certified through other nationally recognized sources or accredited programs, who continue to practice in Georgia. However, they cannot obtain DEM certification because of the current state prohibition. Consequently, while it is legal for women to give birth at home, it is illegal for midwives to assist with the birth. Doing so can result in the arrest and prosecution of both the family and the midwife.

Advocates for midwifery maintain that a major reason that these prohibitions are in place is because maternity care is big business in the United States, especially hospitals. For example, of the total hospital stays for women, approximately 25% are for pregnancy and childbirth. Advocates suggest that the practice of midwifery and the availability of holistic, safe, alternative birthing options may be viewed as "competition" by special interest groups and this is one of the major reasons that midwifery certification is regulated so vigorously. (1)

The ban on DEM certification in Georgia and other poses a legal risk for midwives; they can be arbitrarily arrested, or placed under investigation. Many midwives do not want to accompany mothers and newborns to the hospital, or complete birth certificates for fear of prosecution and arrest. There have been instances of hospital personnel who have "reported" midwives even though the birth outcomes were favorable for both the mother and the newborn.

Midwifery History in Georgia

The practice of midwifery was a common practice in Indigenous communities and other communities of color. This was certainly true in the African-American community in Georgia and other parts of the southern United States. Historically, because of racism and segregation, African-American women gave birth in the home or another birth setting rather than depend on services from racist or indifferent providers. This was the case for both urban and rural areas of Georgia. Midwives assisted women with their births, but they also provided the mothers with individual support during the pregnancy and after the birth. This included emotional, social, educational and spiritual support as well as nutritional and health counseling. Grand ("granny") Midwives were not only health advisors, but were also considered pillars of the community and provided health literacy, knowledge and health care for pregnant women, but for all members of the community. The Grand Midwives were credible, respected, their counsel was sought and their directives were followed. They were often the thread that held together the fabric of the community.

Midwifery and Improved Birth Outcomes

African-American infant mortality and morbidity rates are twice that of white babies; Latino infant mortality is also on the rise. There is evidence that the care provided by midwives during pregnancy, birth and after birth can significantly affect infant mortality and morbidity rates in certain communities. Midwives can provide more one-on-one attention for expectant mothers before, during and after the birth. Many believe that replicating models of care like the ones provided by the "Grand Midwives" and adapting it to contemporary standards would improve the birth outcomes in communities of color. This model would be especially effective for young women of color who require extra attention and are in isolated settings in both the urban and rural areas.

The International Center for Traditional Childbearing (ICTC) is a national non-profit organization that addresses infant mortality factors by increasing education and awareness, thus creating better birth outcomes. Organizations like ICTC, as well as other advocates and providers, maintain that community-based midwives can help to reduce these high mortality and morbidity rates in communities of color.

The Georgia House Committee Study on Direct Entry Midwives

In 2006, the Georgia state legislature passed a resolution for a study committee on midwifery practices in the state. The House Study Committee on Direct Entry Midwives (HR 1341) held a series of meetings, hearings and testimonies involving midwives licensed in other states, obstetricians and other interested parties.

In addition to suggesting that DEM certification be reinstated, the study committee developed a number of recommendations that included: a) funding a demonstration project to lower the infant mortality rate in the African-American community by providing mobile midwifery services and prenatal care to expectant mothers, and b) funding the development of alternative birthing centers in both urban and rural areas using midwives as the primary providers of care. (2)

CONTINUED ON NEXT PAGE>>>

An examination of undocumented **immigrants** and U.S. health care

According to a report by USA Today released January 2008, approximately 12 million illegal immigrants live in the United States with most relying on federally funded community health centers for basic services and even free prescription samples and over-the-counter drugs.

The report stated that estimates of 59 percent of the nationís illegal immigrants have no health insurance, compared to 25 percent of legal immigrants and 14 percent of U.S. citizens, according to the Pew Hispanic Center. The immigrant population has driven the number of uninsured people to increase about 30 percent since 1980.

A study by the Federation for American Immigration Reform stated in a 2004 study that California spends $1.4 billion annually on health care for illegal immigrants, according to USA Today. The Journal of the American Medical Association stated in a March 2007 article that emergency Medicaid costs for illegal immigrants rose from 2001 to 2004 by 28 percent, with researchers indicating injuries, difficulties with chronic diseases and increases in childbirth as the reason.

According to USA Today, ìFor many illegal immigrants, the fear of deportation outweighs the pain of illness or injury, so they live with their afflictions rather than seeking help until their health problems become critical.î It continued, ìThat makes things worse ó for them, for hospitals that eventually treat them, and for taxpayers who ultimately foot the bill.î

But it stated that some are visiting one of the 4,000 federally funded health centers, which have been established in the last 40 years. Over 6 million uninsured people were serviced through the centers in 2006, a 50 percent increase since 2001, according to USA Today.

Former Surgeon General says Federal Efforts to **Eliminate Disparities** are Underfunded

In a webcast panel discussion with Kaiser Family Foundation in December 2007, former Surgeon General Dr. David Satcher said that federal efforts to eliminate racial, ethnic disparities need more funding.

During his tenure Dr. Satcher established the platform “Healthy People 2010,” which had a goal to eliminate health disparities by 2010. When looking back during his conversation with co-moderator Marsha Lillie-Blanton, senior advisor on Race, Ethnicity and Health Care for Kaiser Family Foundation, Dr. Satcher said there’s a lot of progress, including the implementation of the CDC’s Racial and Ethnic Approaches to Community Health (REACH) program, but so much more can be accomplished with proper funding.

“If we had eliminated disparities in health in the last century, there would have been 83,500 fewer deaths among African Americans,” he said. “And that includes almost 25,000 from heart disease, 22,000 from diabetes, and on and on. Even almost 5,000 African American babies died that would not have died if we had eliminated disparities in health in the last century.”

With 195 objectives and sub-objectives included in “Healthy People 2010,” only 24 objectives have seen a decrease in disparities. “I don’t think we’ve adequately supported the goal of eliminating disparities in health.” He stated that the little progress is about numbers. “NIH’s (National Institute on Health) budget is $28 billion, and if the National Center for Minority Health and Health Disparities received less than $250 million for its budget that tells you that we have not made a serious effort.”

He also pointed out that the system is reactive rather than proactive. Legislation could have been in place back in 2000 when “Healthy People” started to eliminate current health issues like access and disparities. “Going back to the 2000 study, if we did eliminate disparities, if African Americans just had the same insurance coverage rates as Whites – just comparing those two groups – there would be almost three million fewer African Americans uninsured,” he said. “There are people who live in communities where they don’t have access to healthcare, so we have not dealt with the issue of access to healthcare. I think we could have solved that problem if we had really been serious about this.”

CONTINUED FROM PAGE 21

Concerns About Direct Entry Midwife (DEM) Certification

Currently, of the states where midwifery is legal, the midwives have to be trained and certified through the North American Registry of Midwives (NARM), a nationally and internationally recognized accreditation agency. There is a belief that this certification will ensure that midwives are appropriately trained and “qualified”. Certification of this type will enable midwives to receive reimbursement through Medicaid and other health insurance coverage.

While they are willing to pursue this certification process, some midwives, particularly those in communities of color, have a different perception; they believe that they are already qualified because of their prior experiences and successful deliveries. There is some concern that requiring a NARM certification may create an obstacle to qualified midwives in most communities of color, including immigrant communities. The proposed certification process could lead to possible racial and class elitism, which would reduce the availability of midwifery services for those communities that need it. For example, the fee for the certification process is $1,500, which may be a financial hardship for many; the written test may pose some cultural and linguistic challenges.

In addition, candidates are required to attend a set number of births within a given timeframe. This may be a challenge for midwives of color because members of their communities often give birth in a hospital setting instead of in the home, or other alternative setting. Low-income families cannot afford the cost of hiring a midwife and will most likely give birth in the hospital, which can be financed by Medicaid.

In the meantime, the recommendations from the House Study Committee on Direct Entry Midwife will be submitted to the Georgia State Legislature this year. It hoped that ultimately, the ban will be lifted and that legislation will be passed to reinstate DEM certification in Georgia.

State Laws Governing Direct Entry Midwifery In Your State

The legal status of direct entry midwifery varies by state and is subject to interpretation by the courts, state regulatory boards and legal experts. In some states the laws are unclear and legal experts have differed over the interpretation. For general information on the status of midwifery regulations in your state, go to the SisterSong website www.mappingourrights.org.

In the case of Martha, she has not yet been prosecuted, but she fears that it may still happen. Women should have the right to have their children under the conditions they choose that are safe for the mother and the child. SisterSong will monitor this case and others that wrongly criminalize midwives for providing such exquisite care to women.

Notes:

(1) “Effects of Hospital Economics on Maternity Care”; Susan Hodges and Henri Goer. Reprinted from Citizens for Midwifery News, Spring/Summer 2004.

(2) “House Study Committee On Direct Entry Midwifery” (HR 1341); Georgia House of Representatives; Representatives Stephanie Benefield, Mable Thomas, Donna Sheldon and Buddy Carter; Debbie Pulley, CPM, Dr. John Schiller, OB/GYN, Linda “Nasrah” Annor, Lay Midwife. 2006

Banning Abortions for **Sex-** and **Race**-Selection

by Loretta Ross, SisterSong National Coordinator

Apparently there is no limit to the creativity of those who want to limit women's freedom by restricting abortion. A federal bill to ban abortions in case of sex or race selection was introduced on September 23, 2008 by Congressman Trent Franks (R-Arizona) to keep women from choosing to have an abortion, purportedly based on the sex or race of the fetus. This bill, the "Prenatal Nondiscrimination Act" or PreNDA, while it will probably not pass either now or in the new Congress in 2009, warns reproductive justice activists about the new tactics anti-abortionists will use to try to drive wedges into our movements. We must analyze this strategy by the right and inform our communities about this cynical manipulation of our values.

The National Asian Pacific American Women's Forum (NAPAWF), Generations Ahead and Manavi were alerted to this bill by Rep. Frank's office who assumed that all three organizations would support this bill based on their concerns about son preference and sex-selection. The three organizations with SisterSong reached out to their networks to coordinate a cross-movement and broad-based response. NAPAWF is a national, multi-issue Asian Pacific Islander women's organization in the country that works to build a movement to advance social justice and human rights for API women and girls. Manavi is a New Jersey-based women's rights organization that works to end all forms of violence against South Asian women living in the U.S. Generations Ahead is a new organization working to expand public debate on genetic technologies from a social justice perspective.

Although Franks reached out to South Asian women's organizations in the U.S. to enlist their support, the organizations clearly saw through this clumsy attempt to get them to oppose abortion by preying on their concerns about son preference. In countries like India and China, activism on these issues are located within a context where there is clear support for safe and legal abortion and abortion rights are not contested. Therefore Asian communities are able to address son preference, as result of sexism, without undermining abortion rights.

In fact, his efforts alerted all of us to his plans to use a familiar tactic of creating an alleged problem to attack abortion rights. This man who calls abortion "the greatest human holocaust in human history" echoes other attempts by abortion opponents to limit women's human rights. Abortion opponents fabricated the myth of "partial birth abortions" and passed the first legislation restricting a particular abortion procedure in 2003. They also fabricated the false link between breast cancer and abortion, and they are at it again. In Wisconsin, they fabricated the specter of "coerced" abortions to launch another anti-abortion bill last year (see related article on page 26)

The bill does not target women but focuses instead on the doctors who perform abortions with threats of civil lawsuits from women and their families. In other words, if doctors are convinced that they may be sued by women who later claim they were coerced into having an abortion based on sex or race selection, doctors may logically become more reluctant to provide abortion services, even if the claims cannot be proven or justified with any real evidence. It may be enough to simply say that every female fetus aborted is a possible case of coercive sex selection.

The strategy to leave doctors exposed to financial liabilities is not new. If the bill permits lawsuits against clinic staff for an individual's decisions, this creates a chill factor for people who later question their own decisions and want someone to blame.

What this bill ultimately achieves is to reinforce the false "coerced abortion" frame that opponents have used before. While women may have legitimate feelings about their abortion experiences that span a wide range of emotions, abortion opponents have tried to create the illusion that abortions are widely forced upon women in the U.S. In this false frame, women need to be protected from abortion providers and advocates who allegedly urge them to have abortions for profit.

Another aspect of the proposed legislation is to create the false perception that women are forced to engage in "race selection" abortion that would, for example, prohibit a white woman from being coerced into having an abortion if she was pregnant with a black child. Black women could then be accused of race selection for all their abortions, regardless of the race of the father. It is believed that this specious race selection argument was added to the bill at the urging of black anti-abortion activists who claim that abortion in the African American community is a form of black genocide (see related article on page 11).

While we pick ourselves off of the floor laughing, we have to be careful not to leave this obviously silly argument uncontested. There is absolutely no data supporting the contention that race selection abortions occur. Even if some woman can be found who will claim that she aborted a child because of its race, it still does not trump the fact that a woman has the right to have an abortion even if one disagrees with her reasons for doing so. It's her body, her choice, and her right.

It is unlikely that the race selection provisions will endure or be credible. The race issue muddies and weakens the bill because it will be difficult to persuade the public that race selection abortions occur, or that they are a problem since most abortions of black fetuses are obtained by black women. It is more likely that a small portion of the white voting public may sympathize with a white woman forced to abort a non-white fetus. This blatant prejudice would drive a wedge into the anti-abortion base Franks is trying to consolidate.

While this is a patently transparent strategy to attack abortion rights, it does present challenges for reproductive justice advocates. First of all, the key spokespeople who need to speak out against this bill must be women of color and immigrants. This will mean that the mainstream pro-choice community must support these leaders and their organizations because the most credible voices are those from the affected community.

Second, this legislation provides an opportunity for the reproductive justice (RJ) and violence against women (VAW) movements to come together to strengthen our bonds and determination not to fall victim to divide-and-conquer tactics. This also may be challenging because the movement to end violence against women has its progressive and conservative wings, like any other social justice movements. Some more conservative VAW advocates believe abortion is too controversial and do not want to be associated with the RJ movement, for fear of losing funding or supporters for the supposedly "safe" work of ending violence against women. Moreover, some within that movement may be susceptible to the argument that abortion itself is violence against women. They may be vulnerable to appeals by opponents such as Franks.

Third, the bill's supporters claim they are fighting for the "human rights of the unborn," a stance that distorts the entire human rights framework but may confuse those unfamiliar with the actual language of the Universal Declaration of Human Rights. In the first article of the UDHR, the exact language is "All human beings are born free and equal in dignity and rights." When the UDHR was written in 1948, there was no anti-abortion movement as we know it, but instead there was a common sense recognition that one has to be born to claim human rights. In fact, one cannot violate the human rights of people already here to claim rights for those not yet born without undermining the very concept. It violates women's human rights to reduce us to mere vessels for the unborn without our consent. Such an interpretation would enslave all women, holding our bodies hostage. There is another name for one human being involuntarily serving another; it's called slavery.

Fourth, since the bill is framed around coercion and immigrant communities, it may undermine support for abortion in a way that is nuanced and complicated. For years, women have denounced sex selection as a product of a sexist society that devalues girl children and women's moral decision-making. No policy documents at the United Nations specifically condemn sex selection for abortion. However, even in those countries in which legislation exists, the laws are carefully crafted so as to not undermine support for abortion rights but rather to enforce the rights of women to make their own decisions about their bodies.

In any case, the question about how to determine if an abortion occurred for sex selection or race selection is not clear. Gossip among clinic workers or reports from family members or male partners opposed to abortion might be the only evidence available to claim that a provider performed a sex selection or race selection abortion.

Are immigrant women coerced into having sex selection abortions in the U.S? We don't know, and neither does Trent Franks. Until we do have data to prove the practice occurs, it is dangerous to offer legislation that restricts the choices of women to fight a problem that may not exist. Sex selection is a problem resulting from sexism and the devaluing of women. As feminists, we are firmly against son preference in all its manifestations. We also support the rights of immigrant women, women of color and low income women to make the best reproductive decisions for themselves and their families. Congressman Franks, who has voted consistently against legislation supporting the rights of immigrants and women, cannot be trusted that he has our interests at heart in this cynically manipulative legislation.

NAPAWF, SisterSong and Generations Ahead are leading the national discussions and convening meetings to share information about reproductive technologies and their impacts on communities of color. More information may be found at www.napawf.org and www.generations-ahead.org.

Post-Katrina **Health of Vietnamese** New Orleanians

The New Orleans Times-Picayune recently reported on a study by researchers at Tulane University examining the Vietnamese community's access to health care during and after Hurricane Katrina.

The study, written by lead author Mark VanLandingham, a professor at the School of Public Health and Tropical Medicine, collected data just before Hurricane Katrina struck in late August 2005 and conducted an initial follow-up during the fall of 2006. The study discovered a significant decline physical and emotional health, especially in the age group 40-49 "who likely bear most of the burden of worry and care for [their] families" than young adults 20-39 years old.

The study also stated that Vietnamese traditions concerning mental health conflict with western belief systems and may be a barrier to accessing care. In addition, "Very high pressures to succeed from the family and community, trauma related to the war and their subsequent exodus, and a vast cultural gulf between the sending and receiving countries may lead to higher baseline levels of stress among this working-age adult immigrant population with respect to more long term U.S. natives."

The Vietnamese community was primarily located in a marginalized part of the city "which is on the far edge of land recently reclaimed from the swamp surrounding New Orleans," increasing their risk of loss, access to information and health care, the study reported. In addition, it cited that 93 percent of Vietnamese speak their native language at home and 65 percent do not speak English, creating a language barrier. It also stated that most Vietnamese living in the enclave area "occupy fairly vulnerable and low-wage positions of social status" but are more likely attached to their neighborhood and a "sudden displacement from that neighborhood, with its cultural symbols and settled interpersonal networks, may for that very reason suddenly remove sources of comfort and adjustment." It continued, "Even Vietnamese who had moved out of the ethnic neighborhood to other parts of the New Orleans area generally retain strong ties to the neighborhood and saw it as a symbolic center of ethnic identity."

But the study said that in addition to the systematic differences between this group and blacks and whites, it found that "while many remained in their original community in the heavily flooded lower ninth ward, other families had migrated to the more affluent west bank."

Racial, Ethnic Disparities among Children's Health

In the study, "Racial and Ethnic Disparities in Medical and Dental Health, Access to Care and use of Services in U.S. Children's Health," headed up by Glenn Flores of the University of Texas Southwestern Medical Center and Sandra Tomany-Korman of Signature Science, examined racial and ethnic disparities in medical and oral health as well as access to care and use of services for whites, African Americans, Latino, Asian/Pacific Islander, Native American and multiracial children.

The study, which was published in Pediatrics January 2008, stated that minority children in America are confronted with the "triple threat" of greater health risks which consisted of substandard oral health, hardships with access to medical and dental care and less receipt of medical prescriptions.

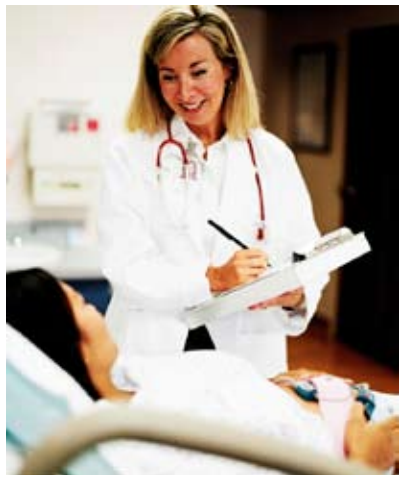
It also discovered many specific disparities persisted among the particular groups, including "increased odds of suboptimal health status, overweight, asthma, activity limitations, behavioral and speech problems, emotional difficulties, un-insurance, suboptimal dental health, no usual source of care, unmet medical and dental needs, transportation barriers to care, problems getting specialty care, no medical or dental visit in the past year, emergency department visits not receiving mental health, and not receiving prescription medications."

For example, Latino children suffer from bad teeth conditions while African American children have behavioral problems, and skin allergies. In addition, it found that Native American children have hearing and vision problems while Asian or Pacific Islander children have delays in development and problems in the bones, joints or muscles.

The study used data from a 2003-2004 survey from the "National Survey of Children's Health," consisting of parents and guardians of 102,353 children up to 17 years old.

Effects of Language Barriers on **Quality Care**

Hablamos Juntos is pleased to announce the Journal of General Internal Medicine (JGIM) published a special supplement on language barriers. The supplement is sponsored by Hablamos Juntos, an initiative of the Robert Wood Johnson Foundation to: 1) highlight state-of-the-art research about the effects of language barriers on access, quality and cost of health care; 2) provide insight for clinicians, educators, researchers, administrators, and policy makers on addressing language barriers in healthcare settings; and 3) draw attention to unexplored areas of research and education.



The issue includes several peer-reviewed studies on the consequences of language barriers for patients who speak little, if any, English and the impact of the absence of language services in health care settings. Two articles in the supplement attest to the role of language barriers in explaining racial/ethnic disparities in health care (Cheng et al and Sentell et al) and another (Chen et al) reviews the legal basis for attending to language barriers. Several studies report measurable disparities in quality of care result when patients and providers do not speak the same language and another (Partida) points out coordinated, systemic efforts are needed to conduct research and develop solutions to transform our English language health care system into one that is fully accessible to Americans with limited English proficiency (LEP).

In a foreword to the supplement, Richard H. Carmona, M.D., 17th Surgeon General of the United States, attests we push LEP immigrants to the fringes of our society and shares his family's experiences and the vital importance of culturally and linguistically appropriate health information. "Until my family found a local doctor who spoke Spanish and understood our culture, we often struggled to understand what we needed to do to prevent diseases or to recover from illness or injuries," said Carmona. "Language difficulties can create a wall of confusion and misunderstanding between health professionals and the people we are trying to serve, essentially becoming barriers to quality care. Our nation must increase its determination to serve diverse populations by providing culturally and linguistically appropriate care to our patients."

In supporting the supplement, the Robert Wood Johnson Foundation demonstrates its national commitment to programs that bring more equality to the health care system. "The quality of health care for all Americans will not be improved without a concentrated effort to ensure that patients who are limited English proficient have access to language services and assistance in clinical encounters within America's hospitals and health systems," said Risa Lavizzo-Mourey, M.D., MBA, president and CEO of the Robert Wood Johnson Foundation. "I am hopeful that, with continued vigilance, we will identify solutions to address language barriers that affect the quality of patient care."

For more information, visit www.hablamosjuntos.org.

(Source: www.hablamosjuntos.org)

Racial/Ethnic disparities reported in New Mexico

In November 2007, the New Mexico Department of Health released the second edition of the Health Disparities Report Card, which stated that the rate of women in New Mexico receiving late or no prenatal care is higher than the national rate.

American Indian women have the highest rate of beginning care in their third trimester or seeking no prenatal care at all, with a rate of 40.3 per 100, compared to African Americans at 28.6, Hispanics 30.1, Asian/Pacific Islander 19.4 and whites at 21.2 per 100. The state's rate per 100 is 28.6, compared to the U.S., which is 16.1.

According to the report, New Mexico's infant mortality is lower than the United States, but the rate for African Americans is more than double than whites and Hispanics, with male infant mortality at a higher rate than female infant mortality. The infant mortality rate for African Americans is 13.0 per 1,000, compared to American Indians at 7.8, whites at 5.6, Hispanics at 5.3, and Asian/Pacific Islanders at 2.2.

In addition, the rate among New Mexican teen births is more than 60 percent than the national rate. Hispanics teens hold a steady lead in having the highest rate, with no dramatic decrease over a period of time. Hispanic teens between the ages 15-17 have a ratio of 55.3 per 1,000, compared to African Americans at 21.4, American Indians at 13.6, whites at 13.3 and Asian/Pacific Islander at 6.0. New Mexico leads the U.S. in teen births with a ratio of 35.6, compared to the national rate at 21.4.

reproductive
health
access
project

The Reproductive Health Access Project (RHAP) seeks to ensure that women and teens at every socioeconomic level can readily obtain birth control and abortion from their own primary care clinician. Clinicians who treat entire families recognize the importance of preparing for parenthood; by allowing women to decide whether and when to have children, reproductive services enable all family members to reach their full potential. Through training, advocacy and mentoring programs, RHAP helps family physicians and other clinicians make birth control and early abortion services a part of routine medical care.

PO Box 21191, New York, NY 10025
info@reproductiveaccess.org
www.reproductiveaccess.com

RH Reality Check
Information and Analysis for Reproductive Health

Contraception STI Prevention

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Maternal Health Women's Rights

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RH Reality Check is honored to support SisterSong's National Membership Meeting

Partnering for a Pro-Choice Future

NARAL Pro-Choice America Foundation salutes SisterSong at their 11th annual conference, *Collective Voices.*

NARAL Pro-Choice America Foundation joins members of SisterSong in nurturing a progressive community that safeguards our rights to reproductive freedom and justice.

NARAL
Pro-Choice America Foundation

Cervical Cancer Risk for Women on US-Mexican Border

Drs. John Moraros and Yelena Bird of New Mexico State University's Department of Health Science received $75,000 in grants from the Center for Border Health Research to study the increased risks of Hispanic women living on the US-Mexican border contracting breast and cervical cancer.

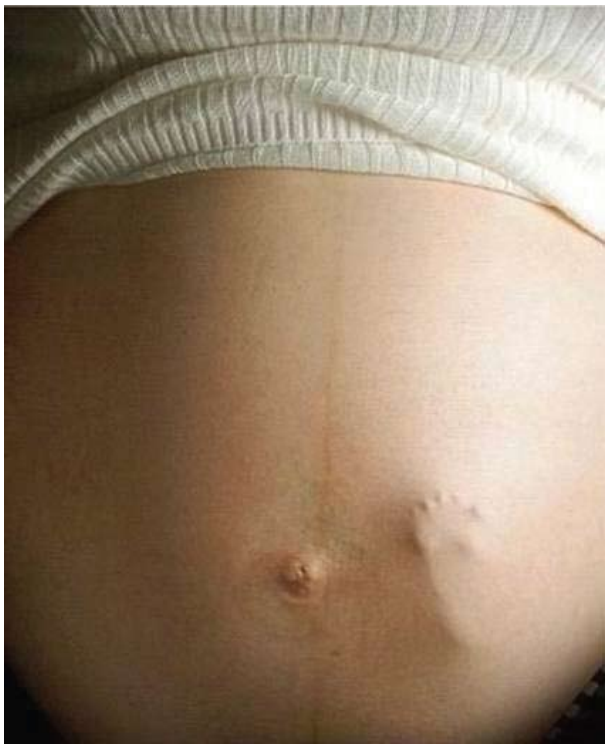
Dr. Moraros, who is leading the study on cervical cancer said, "Hispanic women on the U.S.-Mexico border are more likely to die of cervical cancer and breast cancer than women who live elsewhere in the U.S. or Mexico," reported the Las Cruces Sun-News. He continued, "Low participation by Latinas in early detection screening programs is a serious problem. That puts women at risk because often the diseases aren't diagnosed until they are very advanced and treatment options are less effective."

Dr. Moraros said in a report that the likely cause of cervical cancer is a sexually transmitted infection with the human papilloma virus (HPV). He found that 10 percent of the women living on the border had abnormal Pap smears, and of that group, 10 percent had HPV that, if left untreated, could lead to cancer. Currently, it is estimated that a patient in Mexico dies from the disease every two hours.

While Dr. Moraros continues to study cervical cancer, his wife, Dr. Bird, tracks hereditary breast cancer among the same target group. It is estimated that one in every five Latina women living on the border will get the disease. Dr. Bird studies samples from breast tissues of women who have hereditary breast cancer and use the molecular biological markers of gene expression to determine the risk of developing the disease. Dr. Bird told the university paper that lack of education and access to care as well as the discomfort of the exam deters women from seeking help. In addition to reducing death rates, Dr. Bird also hopes her findings will identify a new screening, along with mammography, that will detect the disease at an earlier stage, presenting a higher survival rate.

REPRODUCTIVE **JUSTICE**

Doctors' Advice Discourages Childbearing Among **Women of Color**

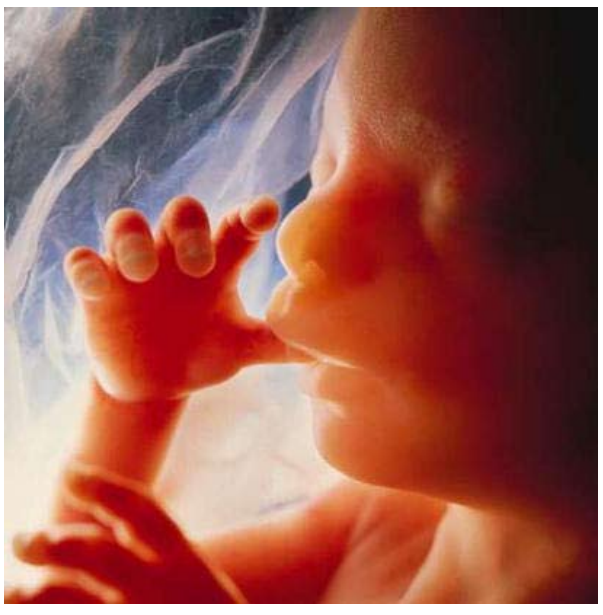


In October 2007, the American Journal of Public Health published "Intersections of Ethnicity and Social Class in Provider Advice Regarding Reproductive Health," which detailed a study about how women look at reproductive health care they receive based on their ethnicity and social class.

Roberta Downing and Thomas LaVeist of Johns Hopkins University and health Bullock of the University of California-Santa Cruz assessed whether "health care providers are perceived as advising low-income women, particularly women of color, to limit their childbearing and to what extent they fell they are discouraged by providers from having future children," stated the report.

Researchers conducted a survey about pregnancy-related health care experiences with 339 low-income and middle-income women of ethnically diverse backgrounds in the Los Angeles area. They found that low-income women of color were more likely advised to limit their childbearing than middle-income white women. Low-income Latinas also had greater odds of being discouraged from having children than did middle-class white women.

The study stated, "More research is needed regarding how ethnicity and social class impact women's experiences with reproductive health care."



"Coerced" **Abortion** Bill in Wisconsin

In October 2007, the Wisconsin Assembly voted 65-32 to pass Assembly Bill 427, authored by state Rep. Mark Gundrum (R), and state Rep. Pat Strachota (R), which "requires that the physician who is to perform or induce the abortion determine whether or not the woman's consent is, in fact, voluntary," states the bill. "If the physician has reason to suspect that the woman is in danger of being physically harmed by anyone who is coercing the woman to consent to an abortion against her will, the physician must inform the woman of services for victims or individuals at risk of domestic abuse and provide her with private access to a telephone if she states that she wishes to call for assistance."

Planned Parenthood Advocates of Wisconsin opposed the legislation, stating, "It is a shame the Assembly wastes time debating a bill that accomplishes nothing, while rape survivors and health care advocates have had to work for seven years to pass a bill in the Assembly to improve informed consent for rape victims to no avail," said PPAWI Vice President of Public Affairs Lisa Boyce. "Giving rape victims information about all of their treatment options, including information about and access to birth control to prevent pregnancy following assault, should be a priority."

Kelda Helen Roys, executive director for NARAL pro-Choice Wisconsin, said the bill is unnecessary because consent is already legally required to perform an abortion. "The bill is a cynical attempt to score political points with those who want to criminalize abortion," Roys said.

Duke Studies **Premature Babies** in South

According to the Associated Press (AP), Duke University's new center is the first to study premature and underweight babies in the South. With a $7.7 million grant from the U.S. environmental Protection Agency, the largest grant awarded for a children's research center, Duke will conduct a five-year study on conditions that contribute to infant mortality.

Marie Lynn Miranda, an associate research professor and director of the new Southern Center on Environmentally Driven Disparities in Birth Outcomes, said the study focuses how its environment, genes and socioeconomic status affect a child's birth. In particular, she added they are monitoring exposure to mercury, lead and pesticides as well as stress and the health of the mother.

"These inequalities are especially pronounced in the American South," Miranda said. "It's not just a difference in income and socioeconomic status. There's more going on."

The AP reported that 18 percent of black women give birth to premature babies, compared to 12 percent among Hispanic babies and 11 percent among white babies, but in North Carolina, "15 percent of black babies are born prematurely, compared to 11 percent for whites and 8.5 percent for Hispanics."

Researchers are reviewing data accumulated over a 15-year period on live births in North Carolina. In addition, "researchers also will collect data on 1,200 to 1,500 women who go to the Lincoln Community Health Center or Duke Hospital's obstetrics clinic for care. The women who volunteer to participate will be asked to fill out psychological questionnaires and give blood samples to be used for chemical and genetic tests," stated AP.

North Carolina's infant mortality rate for minorities is more than double the rate for whites, with 14.9 percent deaths per 1,000 births in 2005.

Native American Women in Oklahoma Increase **Prenatal Care** Use

A study released by the Health Department's Pregnancy Risk Assessment Monitoring System in December 2007, reported that 77 percent of American Indian in Oklahoma received first trimester prenatal care, compared with nearly 79 percent of white mothers, according to Tulsa World.

Data from 2000 to 2005 was compared with a report made in 1994 and it showed "a narrowing gap between American Indian and white women in Oklahoma in access to and usage of prenatal care."

The report also found that:

- 95.7% of American Indian pregnant women and 97% of white pregnant women confirmed their pregnancies in the first trimester, an improvement over the figures from the 1994 report (AP/Oklahoman, 12/12);
- More American Indian pregnant women than white pregnant women smoked before pregnancy, though American Indian women were more likely than white women to stop smoking during pregnancy;
- One-quarter of Oklahoma's American Indian women who had given birth had become pregnant before age 18, compared with 14.3% of white women who had given birth before 18 (Tulsa World, 12/13); and
- American Indian women were more likely than white women to have unintended pregnancies and not be married at the time they gave birth (AP/Oklahoman, 12/12).

According to Tulsa World, the study recommended developing culturally appropriate educational programs on the early signs of pregnancy and prenatal care throughout the pregnancy, creating ways for women seeking prenatal care to get it immediately and identifying ways educate Native American women on family planning, with health facilities offering easier ways to access birth control prescriptions.

Sister Song


05/31/2007

Loretta Ross with high school students participating in a summer project with the feminist archive at the Roxcy O'Neal Bolton Women's History Gallery at the Women's Park in Miami. (caption for first picture)

"Condom Coutour"

Brazilian artist Adrianna Bertin (on the right) is standing next to one of her creations, a prom dress made out of condoms. Prudence Mabele, the Founder/Executive Director of Positive Women's Network in South Africa, looks on as Adrianna describes her body of work which includes clothing, sculptures, visual art and other stuff - all out of condoms.

Check out her website at www.adrianabertini.com.br or email her email at info@adrianabertini.com.br.

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