SISTERSONG WOMEN OF COLOR REPRODUCTIVE HEALTH COLLECTIVE

COLLECTIVE VOICES

VOLUME 2 **ISSUE 7**

SUMMER 2007

LET'S TALK ABOUT Sex!

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SISTERSONG'S 10th YEAR ANNIVERSARY SPECIAL

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-Cherrie Moraga

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Women of Color Leadership Program
Reproductive Justice Leaders Project
Fall Session begins September 2007

The Reproductive Justice Leaders initiative is designed to train and develop leaders who will advocate for reproductive justice issues at the State Capitol, be involved in developing proactive policy initiatives, and create actions to mobilize other women of color around reproductive health and justice issues.

Target populations for the Reproductive Justice Leaders project will include people of color ages 18-44 in metropolitan Atlanta, Athens and other outlying cities.

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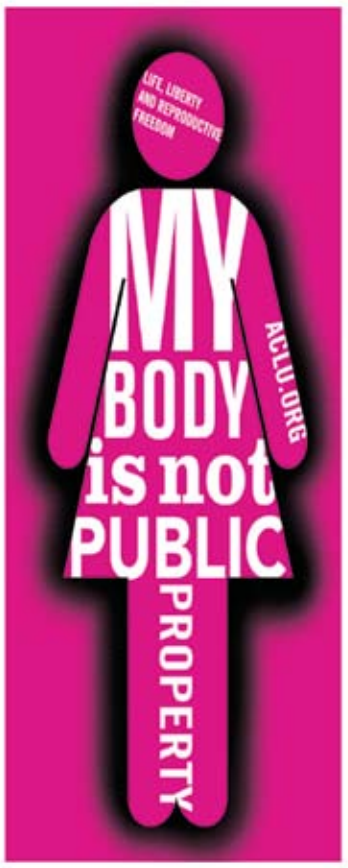

The ACLU Reproductive Freedom Project works daily in courts, legislatures, and communities to ensure that the decision whether or not to have a child is informed, meaningful, and protected from unwarranted government interference.

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To learn more, visit www.aclu.org/reproductiverights

ACLU AMERICAN CIVIL LIBERTIES UNION FOUNDATION

AirSpace

By Benita Miller Johnston
Brooklyn Young Mother's Collective

My mother would iron my school clothes for the week late Sunday night each week. While she ironed, the choreo-poem, *For Colored Girls who have Considered Suicide When the Rainbow is Enuf,* would vibrate from the record player throughout our house. From my second floor bedroom, my seven-year-old self absorbed the words and knew that there was something special happening between my mother and Shange. Today, in my work with low-income young mothers, I sometimes hear Shange's words floating in my memories. I particularly hear the words when a young mother gripping her baby close to her whispers some horror her everyday living brings – I think of a "night with beau Willie Brown," when the lady in red laments that "there was no air." These words resonate throughout the poem, which ends with a young mother watching her ex-paramour drop their children from a window.

Feeling unequipped to provide much needed air, and yearning for the safety of my seven-year-old life, I am tempted to retreat, but something about the way my mother and Shange shared those Sunday nights makes me know that I must stay present. I must share their stories and help them become and remain visible. I believe that the air Shange spoke of starts with supporting them to finish school. And because I want so much for them to have air to soar, I spend a great deal of my time talking up the value of education in helping to break the cycle of material and emotional poverty. I talk not just to them, but to teachers, funders (especially funders!) and their parents.

We hear it all the time, "she's having a baby," so she *has* to drop out of school. We hear it so much and say it so often it is hard to imagine that there is no causal link between childbirth and a young mother continuing her education while caring for an infant. In fact, many pregnant teens who have experienced school failure often become more engaged and determined to complete their education after giving birth. When this magic takes hold it is critical that we don't treat these very vulnerable young mothers and their children as rule breakers who deserve a sentence of social isolation, but instead, we commit ourselves to nurturing their possibilities and achieving their best selves.

As the daughter of teen parents it was drilled into me by my fearful parents very early that "baby-having" was something that could potentially put me on the margins of my family and community life. No one ever talked in any great detail about the "baby-making" until one day my mother just smiled and presented me with a book about my body and sexuality. Later, when I turned 14, she gave me another gift, Alice Walker's *The Color Purple*, and through Celie's tragic letter, I learned that my living as a black girl was both sacred and dangerous. And I was a lucky black girl. I occupied a safe, comforting space in my family and community, and was shielded from many ugly things.

Nowadays, there doesn't seem to be many safe spaces for girls to just be and grow. No girl seems lucky or even particularly content. So, I can only imagine what it is like to be a pregnant teenage girl lugging her body through the world, doing her best to ignore the critical stares of strangers and friends. The girls know that their bellies often mean that they will struggle way beyond labor. They will struggle to overcome our placement of them at the very bottom of our list of concerns. We will worry about their children and parenting and lie about trying to break the cycle. We will isolate them and blame them for things like high crime, unemployment and poor education outcomes – we will link any hard-to-solve problem to their wombs.

Their hope declines and their families expand as we push them into a life of poverty. We don't honor their courage to give birth and we don't support their desire to strive. Instead we sentence them to a lifetime of poverty. Yes, young women should have access to contraception including abortion, but when they choose to mother; do they forfeit their right to human rights and community support?

Once, I spoke to a principal about admitting pregnant teens to his night school program so that girls could expedite completing their education. He whispered that they couldn't register for his school program because "they were pregnant." I whispered back, "I know." He smirked about the "numbers" of his current attendance roster, knowing his previous statement was illegal. The principal's sentiment speaks to society's consensus that "she should have kept her legs closed."

Three years ago, the New York City Comptroller reported that the city's public school system failed to serve more than 20,000 pregnant and mothering students

AirSpace continued on next page

Airspace continued from page 3

and that they had dropped out or been pushed out of school. There was no all-points-bulletin issued or state of emergency declared, instead, these missing 20,000 young women went largely unnoticed. Now, their children sit in classrooms all across New York City and we have no clue as to how they are faring. We didn't do right by them, but we have an opportunity to do better. We have to stop predicting negative outcomes for these families and construct positive opportunities for them to succeed. We must demand that youth development organizations, the childbirth community, and mainstream women's movement re-chart their courses and include the needs of these young women on their respective agendas. If we mean what we say about helping young women and girls, we have to dedicate ourselves to breathing life into a mass movement for education equity that reclaims and retains young mothers so that they have better opportunities. We must commit to providing them with the airspace to soar….

Benita Miller Johnston, Esq., is the Founder and Executive Director of the Brooklyn Young Mother's Collective (previously The Brooklyn Childcare Collective). The Collective is a youth-driven organization that believes in building leadership skills and providing opportunities for young mothers to self-actualize and fill the leadership void in our communities. We know that young mothers prosper when they build networks of support, have access to good information about their bodies and are an integral part of re-thinking community life for the benefit of themselves and their children.

Strategizing for the Next Phase of **Reproductive Justice**

By Brenda A. Joyner

In the first wave or phase of the reproductive justice movement, most of the attention that was given to reproductive health issues was framed in terms of abortion and choice, although there were reproductive justice proponents even before *Roe* (many of whom came out of the Black Civil Rights Movement, the feminist movement and the feminist self-help health movement). Some of the obsession with abortion and choice is rooted in a historical necessity stemming from women dying under a prohibitive abortion status, and after *Roe*, when clinics and healthcare providers were under violent siege and maneuvering in order to work in that context. So, the objective reproductive health status of women before *Roe* and the violence after *Roe* required continued focus on abortion and the "choice" framework was developed to support it. As one earlier feminist put it, "*Roe* did not give us freedom, but it brought relief." These historical aspects continue to frame the terms of a very defensive debate about abortion to this day.

Since 1973, as a movement, we have experienced great difficulty moving outside of the "choice" framework. The overwhelming majority of our movement resources have been spent protecting what *Roe* gave women. It keeps mainstream women's organizations that focus on reproductive choice and rights alive, makes those organizations stronger to fight the next assault on the legal status of abortion; and to elect candidates to that end. For more than thirty years, the leadership, scholarship and visions of reproductive freedom that women of color and other feminists have brought to our movement have failed to get the airtime and support they deserve to influence the nature and scope of our political and educational strategies as we seek to keep ALL women safe and to buttress women's capacity for self-determination.

The irony is that women of color have, for decades, urged, cajoled, and at times, begged for a place at the table, instead of in the kitchen, where much of the real work was being done but went unrecognized and not given full public inclusion. But, there are indications that feminist/womanist reproductive justice activists are done with the phase of our movement that concentrates our energies on the sins of the past.

In response to the relative isolation of women of color leadership in the reproductive rights and social justice movement, and out of a real lived need to address growing disparities among women in mortality, morbidity, access to information and education, and economic and political power in the U.S. and the global context in general, independent and interdependent women of color led reproductive health and justice organizations have emerged. They sprung up in literally every indigenous community where women see and feel the huge stakes in communities in how reproductive health issues and concerns are formulated and framed. While this

Next Phase of RJ continued on next page

Next Phase of RJ continued from page 5

new phenomenon has its roots (at least in part) in several decades of exclusion and racism in the broader movement, today it is about more than dismay about the past. It is more about unearthing, clarifying and advocating through the usual and unusual avenues that offer possibilities for reform and social change. Books are being written and movies are being made chronicling the history of Black, Latina, Asian and Native American women's uncontestable contributions to women's reproductive freedom, rights and choice. New openings are being conceived and developed to enable women of color voices of the future to enter!

Our very hopes and dreams as women are at stake in the ability of the reproductive justice movement to further develop a worldview of its own; informed by the past but inspired by a new language, new visions and strategies for the way forward. The lives of women and girls are at stake, which without real choice, real capacity and real freedom, cannot do it alone within the same hegemonic paradigm received from centuries of colonialism, sexism, and slavery. Nor is a recalcitrant historical women's movement that has come full circle the answer for the future!

We are now in the second wave of the reproductive justice movement when the strategic framework must clarify its symbols and the terms of its vision. This is at a time when the court of public opinion (if *Casey v. Planned Parenthood* can be a measure or judge of that) is more, not less, receptive to greater restrictions on poor women's access to the reproductive healthcare. There is a public perception, even among some who support *Roe*, that women have abused the abortion right in the U.S., and that limits should be set which exceed those in *Roe*. These are perilous times for women. Yet, there is the perception that, with the first woman Speaker of the House and a viable woman presidential hopeful, things have never been better. But women of color know better! Poor and working women who occupy that category we refer to as the "feminization of poverty" understand the challenges they and their children face. The income gap between the rich and poor has never been greater. The reproductive justice movement is in a unique position to do something great, and that is, as Loretta Ross has said, "to connect the dots." This is a necessary part of successful movement work!

We must have and support a reproductive justice movement that, at once,

1. Provides massive education to women and to end public misperceptions about abortion abuse and the sexual behavior and responsibility of women and men;
2. Continues to be a force for authentic coalition-building among women of color reproductive health and justice organizations. (It is not enough to have a list of organizations that sometimes collaborate only to the limits of their self-interest.);
3. Devises strategies to limit the damaging effects of competition for money among reproductive justice organizations and leaders; and
4. Recognizes that large well financed family planning and population control-type organizations, whose programs are linked to monied interest with dubious objectives and intentions, will be of limited support to the struggle for justice and freedom.

The reproductive justice movement must go grassroots! A tool that worked effectively in the early stages of the contemporary women's movement was consciousness-raising (CR), where relatively small groups of women all over the country worked through problems obstructing women's liberation in their homes. These CR groups tied their internal processes to external political action. Such a tool needs to be developed by the broad spectrum of women of color-led reproductive justice organizations, with respect for issues and priorities of cultural diversity, and with the purpose of bringing young and new women into the movement for women's health and freedom.

Disparity in **Pregnancy**-Related Mortality

In the study, "The Black-White Disparity in Pregnancy-Related Mortality from Five Conditions Differences in Prevalence and Case-Fatality Rates," published by the *American Journal of Public Health*, researchers reported that there is a high disparity among Black women concerning pregnancy-related mortality. Between 1988 and 1999, data was collected from the National Hospital discharge Survey and from the Pregnancy Mortality Surveillance System, stated Myra Tucker, physician at CDC, who was a part of the research team. Researchers calculated case-related fatality rates for preeclampsia, eclampsia, abruption placentae, placenta previa and postpartum hemorrhage, which account for 26 percent of all pregnancy-related deaths. According to the *United Press International*, the study reported that fatality rates among Black women with the conditions were two to three times higher than their white counterparts. For every 100,000 women who had preeclampsia, 27 white women died while approximately 73 Black women died. The study also showed that for every 100,000 women who developed postpartum hemorrhage, one white woman died, compared with 68 Black women. In order to determine the reasons behind the disparity, researchers stated that a "complex interaction of biological and health services factors must be untangled," reported *Reuters Health*.

Morehouse School of Medicine Examines **Prison Health**

In a brief titled, "Prison Health and the Health of the Public: Ties that Bind" by Community Voices, a national initiative located at the National Center for Primary Care at Morehouse School of Medicine, researchers reported that untreated illnesses and contagious diseases in a prison population can be exposed to entire communities.

Many prisoners, of the estimated 2.2 million in prisons and jails, are plagued with HIV/AIDS, hepatitis, tuberculosis, diabetes, hypertension and asthma, as well as undiagnosed or untreated mental illnesses. The report cited that the rise of HIV cases among African American women is in correlation with the release of HIV-positive male prisoners. When they are released, former inmates struggle to re-integrate into society and are coping with meeting their basic needs like jobs and housing. More than likely they return to their low-income communities with no access to necessary health services: health care, mental health care and substance abuse treatment. Community Voices is working to seek innovative models, strategies, and solutions to address these issues. *For more information, visit communityvoices.org*

U.S. Healthcare System Performs Poorly in Many Areas

In the report, "Why Not the Best? Results From a National Scorecard on U.S. Health System," by the Commonwealth Fund, the U.S. healthcare system is operating below average considering the level of investment in healthcare. The study finds that the United States scored an average of 66 out of a total of 100 on thirty-seven national indicators related to healthcare access, efficiency, quality, and equity. It also reported that the U.S. ranked at the bottom on healthy life expectancy at birth and age 60 among industrialized countries.

There are also significant disparities between national averages and levels of higher performance including the percentage of adults obtaining screening and preventive care, hospital deaths and national spending on insurance administrative costs. The study found that there was a change regarding the quality of healthcare from state to state and across hospitals and health plans. Furthermore, it stated that the country could save approximately 100,000 to 150,000 lives and an estimated $50 billion to $100 billion annually.

To read or download the complete report (36 pages, PDF), visit: http://=conline.foundationcenter.org/pnd/10004498/story/

Minority Women Less Aware of Risk for **Heart Disease** than Whites

In a study published by the *Journal of Women's Health*, minority women in the United States are less aware of their risk for heart conditions and stroke even though they are at a higher risk of developing cardiovascular disease, *Reuters* reported. In telephone interviews among more than 1,000 women nationwide, researchers asked participants if they knew about the risk factors for heart disease. The study found that 31 percent of Black women and 29 percent of Hispanic women knew about heart disease, compared with 68 percent of white women. The study also reported that all women were uncertain about how to prevent heart disease using methods like diet alteration, hormones and supplements. Lori Mosca, study co-author and director of preventive cardiology at New York-Presbyterian Hosptial, said it's important to target women who need the information the most. She also stated that although there has been an increase in awareness of heart disease, there is still a "challenge to reduce ethnic disparities and maximize knowledge among all racial and ethnic groups." *Reuters* reported that heart disease is the leading cause of death among women in the United States, with Black women having the highest mortality rate.

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HAMPSHIRE COLLEGE

Mapping Our Rights: Navigating Discrimination Across the United States

By Leila Hessini
SisterSong Middle Eastern/
Arab American/North African Community

A short quiz: In which country

- is HIV/AIDS the leading cause of death for Black women between the ages of 25 and 34?
- do more than 84 percent of lesbian, gay, bisexual or transgendered students report verbal harassment at school?
- are recipients of public assistance who give birth denied public health coverage?
- did states consider 614 anti-choice measures in 2005?

Answer: The United States of America

Americans hold their ability to choose their sexual partner and whether to have a child among their most fundamental freedoms. The statistics above show the extent to which these rights are undermined on a daily basis.

Core democratic values are embedded in both sexual and reproductive concerns: the right to privacy; the right to self-determination; the right to form a family with the partner of one's choice; and the right to choose if, how, when, and with whom to have a child. The presence or absence of these rights affects individuals' sense of physical and emotional security, socioeconomic status, and ability to make decisions in all other areas of their lives. These rights affect whether people can continue their education, if they are able to lead healthy lives, and if they can create families.

These are universal human needs.Yet, surprisingly, our ability to act on these rights is contingent on where we live.

Where a person lives in the United States determines her rights as well as her geography. And our rights — be they sexual or reproductive — are inherently linked, as is demonstrated by a new interactive website**,** Mapping Our Rights**.** The project scores and ranks all 50 states and Washington, D.C on key sexual and reproductive rights legislation. The map uses a penalty-points system to determine whether a state's laws and policies support or undermine sexual and reproductive rights.

The policies analyzed in the map have enormous impacts on individual lives. If you are an African American woman, for example, you are four times more likely to die in childbirth and pregnancy than if you are white. If you are a woman in Missouri, you cannot use your employer's health insurance to pay for a medically necessary abortion. If you are a gay man in Massachusetts, you and your partner can enjoy the same legal benefits as a heterosexual couple — as long as you don't move to one of the more than 40 other states that have passed laws or amended their constitutions to define marriage as a male-female, opposite sex union.

By linking policy analysis with economic data, the map illustrates the dismal state of sexual and reproductive rights across our nation. We cannot ignore the fact that states with the highest unintended pregnancy rates also require abstinence-only sex education in their schools — preventing teens from receiving any education about effective birth control. Or that the states with the most discriminatory legislation toward gays, lesbians, bisexuals, and transgendered people also teach curricula that demonize any relationship beyond a "traditional" heterosexual marriage. And that states with the least childcare assistance also have the most restrictive abortion laws.

This map is the result of a partnership between Ipas, the National Gay and Lesbian Task Force, and the SisterSong Women of Color Reproductive Health Collective. Our complementary missions span the areas of abortion rights and safety; lesbian, gay, bisexual, and transgender (LGBT) concerns; and reproductive justice. This partnership reflects our overall vision that the right to plan a pregnancy and carry a pregnancy to term, the right to end a pregnancy, and the right to choose a life partner are ultimately the same human rights.

By connecting these issues in this way, we can begin to see the patterns of discrimination that run through our lives and forge alliances that make us stronger in our fight for full equality and dignity. Healthy, loving families should know no boundaries.

The map was launched at a press conference on May 31, 2006 at the Center for American Progress.

Check out the map at www.mappingourrights.org and let us know what you think.

Leila Hessini is an American of Algerian origin. She works for Ipas, a global reproductive rights organization. She is currently based in Rabat, Morocco.

Midwives Honor the Sensuality of Pregnancy and Birth

By Shafia Monroe,
President/CEO International Center for Traditional ChildbrearingCTC

People have often said to me, "You must really love babies to be a midwife and "Wow how you can stand all that blood!"

Well the truth is, midwives do love babies. We work hard to provide care to ensure that a woman has a healthy pregnancy, and thus, a vigorous baby. In actuality, midwives love women. We love to see them happy during their pregnancy, supported during their labor, honored in birth, sustained while breastfeeding, and nurtured as new mothers. Pregnancy has been mystified as being a nasty, ugly, shameful and an unclean event. My role as a midwife is to help a woman and her partner celebrate her magnificence and embrace her sensuality. Western culture has taken birth from our view and put it in a place that is hard to find. On television we see birthing women mostly in hysteria, sweating profusely, out of control and not looking pretty. But birthing women are beautiful and birth is physical. As a society we must reclaim birth as normal, stunning, sacred, sexy and exotic.

When the female hormone estrogen comes alive during pregnancy, a woman's nipples darken to beautiful hues, her breasts grow globular preparing to make milk, her hips and buttocks become inviting to give birth while her hair and nails grow and her skin glows. She truly becomes a unique creation. These physical changes are healthy, expected and normal developments during pregnancy. I remind the expecting woman of this transformation. And though I can't prove the anthropological rationale, I believe that the sexuality of pregnancy had a protective purpose. Perhaps in the topless hunting and gathering societies expectant women elicited a certain spell of protection.

I struggle with the current societal de-ranking of the pregnant female body and its replacement with a male version. Many women no longer desire to look pregnant. They work hard to stay lean, restrict calories, and sometimes, even develop eating disorders. Our society teaches being round and softly firm during pregnancy is not considered attractive or sexy.

I am not advocating that pregnant women need to put on excessive weight, but there are physiological benefits for having small stores of fat on the body. These stores of fat provide natural energy during the birthing process. The body needs calories at this precious time and if there is a famine, the extra fat is a protection for a woman's milk supply. In addition, these stores of fat can help a women recuperate quicker in the postpartum period. Oftentimes, many new mothers are busy bonding with their babies and they don't always have time to eat. Fat provides extra calories for the mother to use. It is so critical that midwives remind pregnant women that they are sexy and attractive in order to counteract the poor self-image that many women experience while pregnant.

Over the last three decades, I have taught other midwives, expecting couples and communities to entrust normalized birth and breastfeeding as sexual functions. During my personal journey to become a midwife, I remember certain midwives showing me that birth was sensual and sexy; they taught me to see pregnant women as eye-catching. They said birthing was normal and pretty and that midwives must separate the women from the birth. By protecting her identity and individuality it is a strategy to honor the sensuality of pregnancy and birth. And though the mother may not feel nice-looking, it was probably never mentioned to her that she could be sexy while pregnant or while birthing.

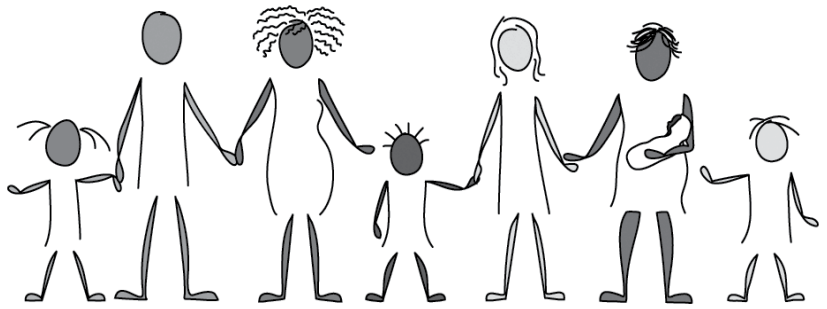
To support women-led births we must admit to the beauty, sacredness, and sexuality of pregnancy. Midwifery has taught me that birth is beauty in its most primal and intimate form. And during the birthing process, in its nudeness, with shining breasts and the human smell of life emerging, there is no shame on my part, only wonder and awe. After each birth, I see women transformed as goddesses. But maybe only a midwife can see this.

For more information, contact Shafia Monroe at shafiammonroe@comcast.net

CONNECT THE DOTS

Indian **Health** Service Stops Funding for California **Health Center**

The Fresno Native American Health Center closed in Fresno, California. The federal Indian Health Service did not renew its $330,000 contract in order for it to continue to serve approximately 13,000 American Indians living in the area. According to the *AP/San Luis Obispo Tribune*, the Indian Health Service stated that the center had too few patients and lacked a public health nurse. Yet, the center's executive director, Virginia Sutter, stated that the center had 5,000 clients, which met IHS' expectations. Sutter also stated that the center hired a public health nurse, but IHS' disapproved the hire. The health center counseled American Indians on diabetes, substance abuse, nutrition and other health issues. Paul Redeagle, deputy director of IHS in California, said eligible patients could obtain care at Central Valley Indian Health Clinic, a tribal clinic in Clovis, California.



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Great Demand for Prenatal, **Maternity Care** in New Orleans for **Hispanic** Immigrants

CONNECT THE **DOTS**

According to a report released by the Louisiana Recovery Authority, New Orleans has increased in its Hispanic immigrant population to the tune of 4,000 since Hurricane Katrina. From 2005 to 2006, there have been 35 percent more births whereas patients with insurance decreased from 57 percent to 30 percent, according to East Jefferson General Hospital in Metairie, Louisiana. Although Tulane-Lakeside Hospital in Metairie saw few births before Katrina, now it averages 30 to 50 Hispanic births a month. In 2005, the Louisiana Office of Public Health reported that 1,522 Hispanic women sought pregnancy and childbirth-related services, and in 2006, it has increased to 3,868 women. Local doctors stated that the influx of Hispanic births has created other challenges like immigration issues, language barriers and lack of healthcare insurance, forcing women to neglect prenatal care, reported the *Times-Picayune*.

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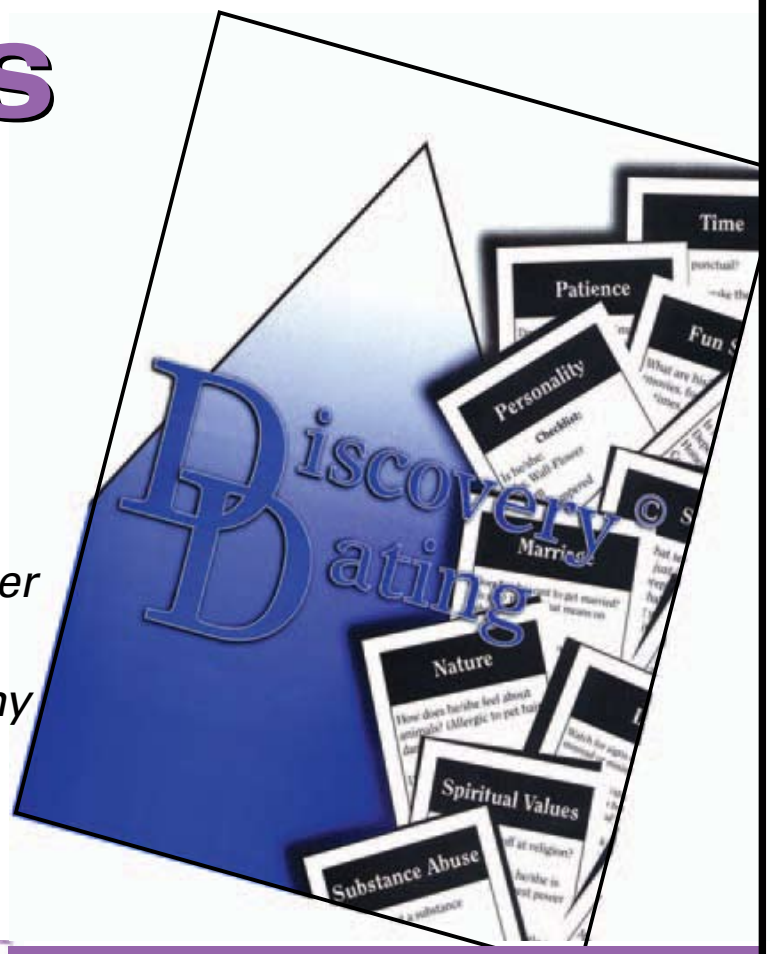

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CONNECT THE DOTS: HOW OTHER INJUSTICES AFFECT REPRODUCTIVE RIGHTS

Senate Bill **Criminalizes Pregnant Women** Using Meth

Sen. Benton Darrington (R-Idaho) reintroduced Senate Bill 1337, which makes methamphetamine or any other drug use by pregnant women a felony, reported the *AP/Twin Falls Times-News*. The bill states that the crime is punishable by up to five years in jail with a $50,000 fine. According to the Kaiser Daily Women's Health Policy Report, Darrington introduced SB 1337 last year that gave permission to authorities to obtain custody of infants if their mothers tested positive for drugs at birth. The bill received flack from a number of pediatricians whose concerns included an increase in abortions and less prenatal care. Darrington met with State Rep. Jim Clark (R), chair of the state House Judiciary, Rules and Administration Committee in order to alleviate the growing concerns surrounding the bill. "I haven't decided what I'm going to do. I don't know how much I can change it," Darrington said to the *AP/Twin*.

SISTERSONG CREATES **HISTORY**

AFTER TEN YEARS OF MOVEMENT-BUILDING, SISTERSONG PREPARES FOR THE 2008 ELECTIONS AT THE "LET'S TALK ABOUT SEX" CONFERENCE

By Yaminah Ahmad,
Managing Editor, Collective Voices

SisterSong Creates **History**

It's been a long time coming, but we are finally here! Ten years ago, an idea emerged, where sisters from autonomous organizations – African American, Latina, Asian, Arab American, and Indigenous – would gather together to organize, strategize and advocate for reproductive health and sexual rights on the behalf of women of color. What only began as a three-year initiative to report reproductive health issues for women of color for the Ford Foundation, has now developed into an internationally recognized organization that is the architect of and foremost expert in the Reproductive Justice movement.

While "choice" has dominated the mainstream women's movement since the decision of *Roe vs. Wade* in 1973, women of color have always been and are currently fixated on one choice – survival. Without choices, women of color have not been able to go to the doctor, pay for daycare, educate their children, afford adequate housing, as well as exercise control over their bodies. And before the inception of SisterSong Women of Color Reproductive Health Collective, the mainstream movement didn't connect a woman's body with her community and environment. Now with SisterSong's Reproductive Justice analysis, civil rights, immigration and environmental organizations, as well as mainstream women's rights organizations, understand that social injustices affect women's reproductive rights. We believe in the mental, physical, spiritual and economical empowerment of women of color. During SisterSong's first national conference, in November 2003, over 600 women from all walks of life gathered to substantiate this new movement and its continued mission to uplift the voices of women of color.

Ten years is a milestone, for no other women of color coalition has been able to maintain our existence since the National Black Women's Health Project (NBWHP), the first women of color reproductive justice organization was established in 1983. Over the years SisterSong has sustained funding in order to expand our infrastructure, build capacity, and simply, do the work. And while "working," five women of color communities (African American, Latina, Asian/Pacific Islander, Arab American, Indigenous) represented by 19 board of directors who advocate for thousands of members and millions of women of color across the nation, have successfully (miraculously) worked through our internal disagreements in order to become the only multi-cultural national coalition for women of color by women of color, advocating for reproductive health and sexual rights in the United States. And what better way to celebrate than sex!

Although just about everybody is having sex (those who aren't, eventually will, and definitely want to), it is such a taboo subject matter in our society. Even this year's conference theme, "Let's Talk About Sex," made some board members nervous. *"How will our funders respond? "Will people show up?"* It is this very reason SisterSong chose to tackle the stigmatism behind sex and sexuality through workshops and plenary sessions focused on safety, health, well-being, and our human right to positive sex and sexuality. These dialogues ultimately will create a healthy attitude towards sex and encourage healthy sexual practices. With a sex-positive environment, we can begin to create a society that supports women's sexual rights. Our funders agreed and women from around the country signed up to make this conference a historical moment in time.

Among the many highlights throughout the three-day weekend is keynote speaker, former U.S. Surgeon General Dr. Joycelyn Elders, the first African American woman to hold the post. Dr. Elders didn't have her first doctor's visit until she was in college. As a pediatric endocrinologist, she is committed to providing quality healthcare for the poor and powerless. In 1994, she was attacked, and subsequently fired, for speaking candidly about sexuality. At the World AIDS Day conference, she stated that masturbation is "something that is a part of human sexuality." Today, she is a high-profiled speaker advocating for women's health. It is only befitting for her to not only impart her wisdom with "Let's Talk About Sex" attendees, but also movement-build with SisterSong.

The conference also has the support of over 60 sponsors – the first time in history where major corporations and organizations finance an event organized by women of color dedicated solely to address our reproductive health issues. With substantial sponsorships, SisterSong established the Mother-Daughter Scholarship Fund and provided $75,000 in scholarships for mothers and daughters and others to attend the conference. We

COVER STORY

Cover story continued from page 19

anticipate at least 1,200 women to come celebrate and strengthen the voices of women of color.

There will be plenty of fun activities throughout the weekend like a Sister's Village of alternative activities, spoken word, belly dancing, and youth-organized events, but there is a methodology behind this conference. In anticipation of the upcoming 2008 presidential election, "Let's Talk About Sex" will provide some guidelines to establish an advocacy agenda on reproductive justice and sexual rights and an opportunity to movement-build among activists and advocates.

It is imperative for women of color to establish an agenda because, for so long, we have been misrepresented. In the past, too few women of color have been invited to the table to discuss our issues concerning sexual rights. And before the voices of women of color were heard, our sexual rights issues were thought to be abuses. The real "abuse" was the marginalizing of our issues in the mainstream women's movement and our homes, churches and communities. Women don't have the social support they need in order to be sexually responsible. Women, for example, are reluctant to require their male partners to wear condoms because of society's attitudes towards sex. There is a general belief that condoms counteract sexual pleasure, and therefore, are an undesirable form of contraception. This belief not only burdens a woman with the responsibility and makes sexual pleasure for him a priority, but it also puts her health at risk for STDs.

Now more than ever women of color need an agenda for reproductive health and sexual rights because there is a continued attack on women through public policies and legislation. Title V abstinence education grant program – a federally-funded program, which distributes $50 million in funds to states based on the percentage of low-income children, bars any discussion about contraception and teaches "sexual activity outside the context of marriage is likely to have harmful psychological and physical effects" – has updated its guidelines to target unmarried women ages 19 to 29. California, Maine, New Jersey, Pennsylvania, Wisconsin and Ohio, however, rejected the grant. SisterSong believes abstinence-only education is ineffective and inhumane. Public health policies should provide *all* information on sex, including pleasure and responsibility in order to empower individuals to make well-informed decisions for their lives. Legislation (HB 2553 and SB 368) was introduced March 22nd, which promotes a sex-positive society. The REAL act (Responsible Education About Life), authored by Rep. Barbara Lee (D-CA), Rep. Christopher Shays (R-CT) and Sen. Frank Lauterberg (D-NJ), introduces a grant program for comprehensive sexuality education that provides states with federal funding through the Department of Health and Human Services. Hopefully, this is the beginning of accurate and effective programs. But, when we are having discussions about sex, we need to know what to say. An advocacy agenda on reproductive justice and sexual rights provides this information.

The advocacy agenda must include SisterSong's three core principles, which are: (1) the right to have a child; (2) the right not to have a child; and (3) the right to parent our children. These principles move us beyond identity and pleasure. They marry social justice and human rights. This new reproductive justice framework will create a society where women are able to exercise self-determination. She would be socially supported with institutions that provide economic empowerment for whatever decision she makes and adequate and culturally-comprehensive healthcare. She would also have the support of an environment that understands and respects the fact that her body is connected to her cultural practices.

Once the conference produces a clear and concise agenda as well as bring more members to the organization, SisterSong is strengthened enough to influence national conversations about sex and sexuality. We are able to communicate our beliefs and guidelines to the 2008 presidential candidates that speak to our immediate needs, other than the end of the war and universal healthcare. While the CEDAW treaty (Conversation on the Elimination on all forms of Discrimination Against Women) did not pass in the House of Representatives and isn't on the Democrats' agenda, SisterSong believes that our government is obligated to use our tax dollars to support women's private decisions by eliminating the Hyde Amendment. For example, an individual is empowered to choose any airline. The government is responsible to make sure the airline is safe, affordable and accessible. Likewise, we believe the government is obligated to make sex safe and healthy for all people, including teens. SisterSong charges the government with the responsibility to take care of all children because children are the future. Incidences like Deamonte Driver should never occur. Driver, a 12-year-old homeless African American boy from Washington D.C., had an infection in his tooth. His family had difficulties finding a doctor who would accept their Medicaid coverage. The infection spread to his brain, killing him. Children shouldn't die because of poor healthcare.

There is strength in numbers. We are now 80-plus organizations. Together, with diverse races, classes, sexualities, and cultures working on one collective vision with comprehensive strategies, SisterSong is able to ensure the complete physical, mental, spiritual, political, social, and economic well-being of women and girls around the country.

Let's Talk About the Power of SisterSong!

NARAL Pro-Choice America congratulates SisterSong on the upcoming "Let's Talk About Sex!" conference.

SisterSong's decade-long movement to protect and defend reproductive freedom has enhanced the lives of indigenous women and women of color.

We look forward to working in partnership for many years to come.

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CONNECT THE **DOTS**

Georgia Bill Requires Doctors to Offer Pregnant Women **HIV Tests**

According to the *Atlanta Journal-Constitution*, the Georgia House Health and Human Services Committee approved House Bill 429 with a unanimous vote, which require doctors to offer pregnant women an HIV test. The Department of Human Resources' Division of Public Health reported that between 20 to 30 infants are born HIV-positive annually in the state, with treatment costing approximately $600,000 per infant. Rep. Sharon Cooper (R), the bill's sponsor, stated that many Georgia physicians don't test their pregnant patients because they don't believe the women are at a high risk of transmission. The bill requires doctors to refer their HIV-positive pregnant patients to counseling and treatment assistance. Women who refuse testing will have their objection recorded on their medical record. The *Journal-Constitution* also reported that a number of committee members expressed concerns about patient confidentiality and doctor liability, yet, numerous physician organizations, including American Academy of Pediatrics, supported the bill.

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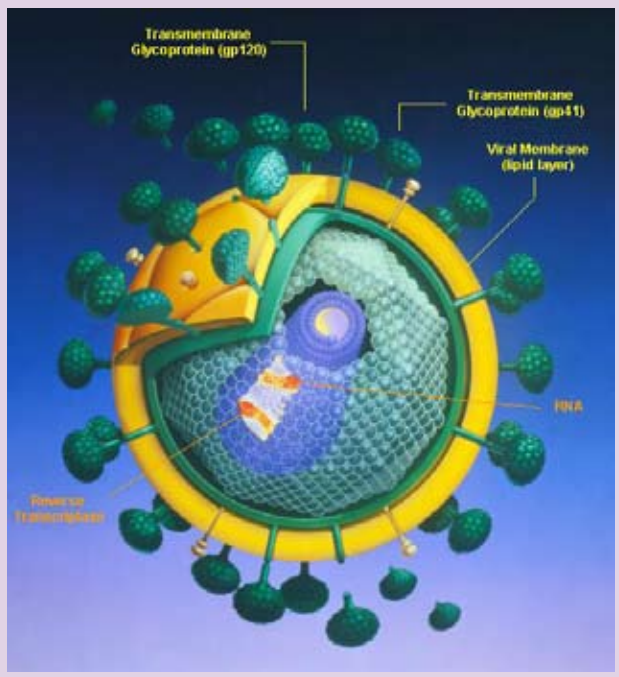
LIVING POSITIVELY: SEX AND CHILDBEARING AFTER AN HIV DIAGNOSIS

Guttmacher Institute policy brief underscores sexual and reproductive health needs of people living with HIV

Despite the enormous challenge that AIDS still poses to global health, for many people able to access antiretroviral treatment, HIV infection can now be managed as a chronic disease. Against this backdrop, a new policy brief from the Guttmacher Institute, entitled "Meeting the Sexual and Reproductive Health Needs of People Living With HIV," emphasizes that people living with HIV do not lose their desire to have sex and bear children, and outlines both the challenges and benefits of better meeting these needs.

"Because sex and childbearing are central to the lives of almost everyone, including those living with HIV, effective programs must take into account the sexual and reproductive health needs and aspirations of people living with HIV," said Heather Boonstra, senior public policy analyst at the Guttmacher Institute, who wrote the policy brief. Where sexual and reproductive health services tailored to the needs and circumstances of people living with HIV are in place, Boonstra notes, "not only do the lives of people with HIV stand to benefit,



but global HIV prevention efforts will benefit as well."

The policy brief was published jointly by the Guttmacher Institute and the Joint United Nations Programme on HIV/AIDS (UNAIDS) in collaboration with EngenderHealth, the Global Network of People Living with HIV/AIDS (GNP+), the International Community of Women Living with HIV/AIDS, the International Planned Parenthood Federation, the United Nations Population Fund (UNFPA) and the World Health Organization.

The policy brief examines a range of sexual and reproductive health needs and aspirations of people living with HIV as well as factors that can limit access to such health care services, including:

- Weak health care systems, where staff may not have been trained about HIV and sexual and reproductive health, and

Living Positively continued on page 34

CELEBRATING **10 YEARS**

Racial Discrepancy in Breast Cancer Partially Attributed to Tumor Biology

CONNECT THE DOTS

According to *The New York Times*, a study published in the December issue of the journal, *Cancer*, Black women living with breast cancer are more likely to have estrogen receptor-negative cancer, which is more difficult to treat and have larger tumors at the time of diagnosis than white or Hispanic women. The *Houston Chronicle* reported that Wendy Woodward, assistant professor of radiation oncology at the University of Texas' Anderson Cancer Center, along with her colleagues, studied tumor biology among 2,140 women of different races in the Houston area. Diagnosis among white women averaged at the age of 49, 47 for Hispanics and 50 for Blacks. All participants had breast surgery before the study and were followed approximately 10 years. Twenty-four percent of Black participants had later-stage breast cancer and tumors larger than five centimeters, compared with 14 percent of whites and 18 percent of Hispanics, the *Chronicle* reported. Researchers stated that although Blacks and Hispanics in Houston have similar demographics, the survival rate of Hispanic patients was equal to or higher than white participants. "This doesn't mean every African American woman is going to have a sad outcome," Woodard told the *Times*. Researchers stated that the best way to investigate the effects of tumor biology and race has on treatment outcomes are to factor in socioeconomic status. Peggy Porter, a researcher at Seattle-based Fred Hutchinson Cancer Research Center, told the *Chronicle*, "This study adds to the growing body of evidence that both tumor biology and access to care and other important socioeconomic factors are involved in lower survival rates seen among African-American women with breast cancer."

TEENS SPEAK OUT!

Sex, Etc.'s new campaign, I'M TABOO, calls on teens to "make the unspeakable, speakable" and gives them a platform for self-advocacy, so they can spread the word about their need and right to comprehensive sex education.

ARE YOU TABOO?
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Thank you

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CONNECT THE DOTS

Harvard University Discovers Life Expectancy among Eight Americas

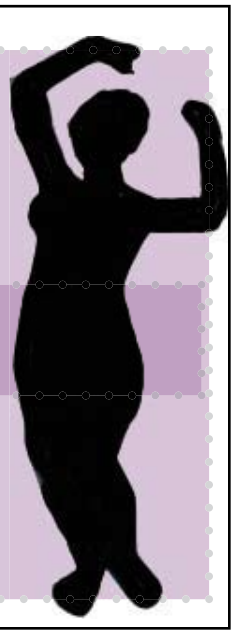
According to researchers at Harvard University, there are Eight Americas in terms of life expectancy:

• 84.9 years for Asian Americans with a per capita income of $21,566 (*Neergaard, AP/Detroit Free Press*, 9/12);
• 79 years for low-income rural whites in Minnesota, North Dakota, South Dakota, Montana and Nebraska with a per capita income of $17,758 (*USA Today*, 9/12);
• 77.9 years for middle Americans with a per capita income of $24,640;
• 75 years for low-income whites in Appalachia and the Mississippi Valley with a per capita income of $16,390;
• 72.9 for Black middle Americans with a per capita income of $15,412;
• 72.7 years for western American Indians with a per capita income of $10,029;
• 71.1 years for southern, low-income, rural blacks with a per capita income of $10,463 (*AP/Detroit Free Press*, 9/12); and
• 71 years for urban blacks in counties with homicide rates that exceed the 95th percentile and a per capita income of $14,800 (*USA Today*, 9/12).

Among the eight groups, there is a "life expectancy gap of almost 14 years, similar to gaps between economically developed and emerging countries, note the researchers."

This article also includes a summary of ratings according to state:

23. North Carolina: 75.8 years
24. Georgia: 75.3 years
25. Arkansas: 75.2 years
25. Kentucky: 75.2 years
25. Oklahoma: 75.2 years
26. Tennessee: 75.1 years
26. West Virginia: 75.1 years
27. South Carolina: 74.8 years
28. Alabama: 74.4 years
29. Louisiana: 74.2 years
30. Mississippi: 73.6 years
31. Washington, D.C.: 72 years

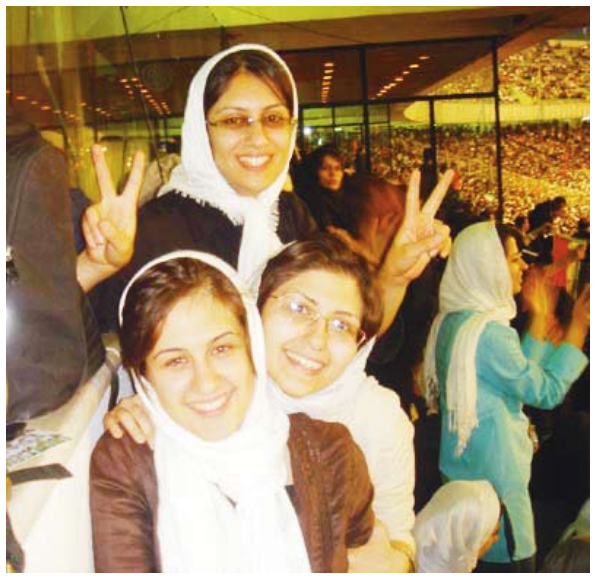


Strategies of Resistance
Women Rising in the Arab World

By Leila Hessini
SisterSong Middle Eastern/
Arab American/North African Community

Indigenous demands for political change and democratic reform are permeating the Arab world. Pictures of women climbing through voting station windows to cast their ballots in last year's Egyptian elections were widely published as were photographs of long lines of Kuwaiti women casting the first votes of their lives. Women have lobbied for quota systems to ensure a certain percentage of women candidates in Egypt, Jordan and Morocco. In several countries, they occupy key ministerial positions and serve as judges. Another central component of democratic processes is the proliferation of independent, nongovernmental feminist and women's organizations.

Women scholars and activists argue that democracy is not solely about elections but includes a more equitable distribution of resources and the overturning of *de jure* and *de facto* gender discrimination. Efforts to promote gender equality in the context of the increased politicization of Islam incorporate four interrelated strategies: i) breaking the monopoly on patriarchal religious interpretation; ii) challenging legal discrimination; iii) defying taboos on issues such as violence against women and iv) working to address social and economic disparities. This article focuses on defying taboo issues and addressing social and economic disparities.



DEFYING TABOOS

As few reliable statistics exist on gender-based violence in the Arab world, women's groups have documented harmful practices toward women. One in three women have been victims of violence in Egypt; 51 percent and 43 percent of Moroccan women believe that violence is justified if a woman argues with her husband or refuses to have sexual relations with him. These studies demonstrate that violence is deeply rooted in societal norms—including gender roles and expectations—and codified in legal systems that discriminate against women.

Violence is often sanctioned by patriarchal interpretations of the Quran, including the belief in male authority over women. In addition to researching and analyzing the types, magnitude and consequences of domestic violence, advocates and programs are assisting women through legal aid projects; providing shelters and employment for survivors of violence and training law enforcement agents, health professionals and educators to recognize the signs of violence.

Creating programs that do not treat "women" as a homogenous category but seek to respond to their different realities and needs is critical. In the Occupied Territories of Palestine, the Women's Center for Legal Aid and Counseling addresses both gender-based violence and the effects of increased militarization and occupation on women's lives. Groups working in Sudan have documented the systematic and deliberate abuse of women, including the use of rape during times of war. Algerian organizations link the atrocities that were committed during the civil war to the general culture of violence that makes gender-based violence so endemic in that country. In Egypt, the organization Shumuu (meaning candles) has launched a campaign against sexual violence and discrimination of women with mental and physical disabilities.

Several innovative projects are being conducted in Morocco. Women's groups work together with a woman-headed publishing house to research and disseminate landmark studies on violence against women. Jargon-free and easy-to-read books and guides have been written by groups such as the Moroccan Association of Democratic Women and the Centre FAMA on sexual harassment in schools and universities, legal discrimination and women's testimonies of violence. Building on these efforts is Anaruz, a Moroccan national network of 20 legal aid and counseling centers for women.

ADDRESSING SOCIAL AND ECONOMIC INEQUITIES

Islamists have been successful in the political arena because they present utopian visions of societal cohesion and provide services in marginalized and underdeveloped areas where the government is absent. Women's groups counter Islamists' conservative vision by developing programs to alleviate poverty, improve maternal and preventative health and increase access to education and labor-saving technologies. The Palestinian Development Society is developing innovative programs to address women's economic, social and psychological conditions in refugee camps. In Egypt,

Strategies of Resistance continued on page 37

reproductive
health
access
project

The Reproductive Health Access Project (RHAP) is a non-profit organization dedicated to preventing unintended pregnancy and promoting high-quality reproductive health care. RHAP provides training and support to family physicians working in medically underserved communities so that they can provide reproductive health care to their patients. Only when women at all socioeconomic levels have access to birth control and abortion services in secure primary care settings will they truly have the right to choose.

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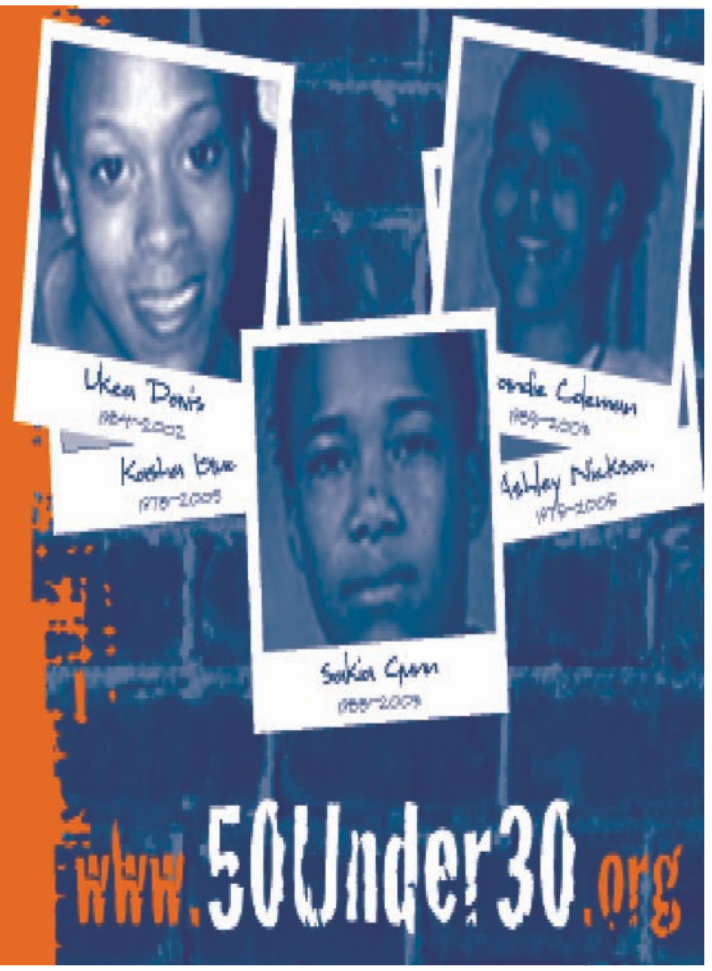

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OUT IN SCRIPTURE
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Living Positively continued from page 24

where supplies are often lacking;

• Parallel programs separately focused on HIV services and on sexual and reproductive health services;

• Taboos around sex, which impede the development of policies and programs addressing the sexual health needs of all people, particularly young people;

• Gender inequalities, which may lead to women's lack of individual autonomy and control over sexual experiences; and

• HIV-related stigma and discrimination, including that among health care providers.

"People living with HIV continue to have satisfying sexual lives and make plans to have families," explained Kevin Moody, International Coordinator of GNP+. "However, stigma and discrimination; lack of access to health workers trained in the sexual and reproductive health of people living with HIV; and the inability for people to even talk about sex make it difficult for people living with HIV to enjoy satisfying sex lives or to plan to exercise reproductive choices that are meaningful to them in their lives. The Guttmacher policy brief describes these challenges and describes how involving people living with HIV can help overcome them."

The brief underlines that people living with HIV may require specific sexual and reproductive health services. For example, compromised immune systems may leave people living with HIV particularly vulnerable to some sexually transmitted infections. Also, couples where one partner is HIV-positive face special challenges in trying to become parents and need help preventing transmission of the virus, and all HIV-positive women considering pregnancy need counseling and services to prevent perinatal transmission.

Nevertheless, the evidence shows that HIV infection need not prevent men and women from safely having sex, bearing children, using most modern contraceptives or accessing abortion services where legally available.

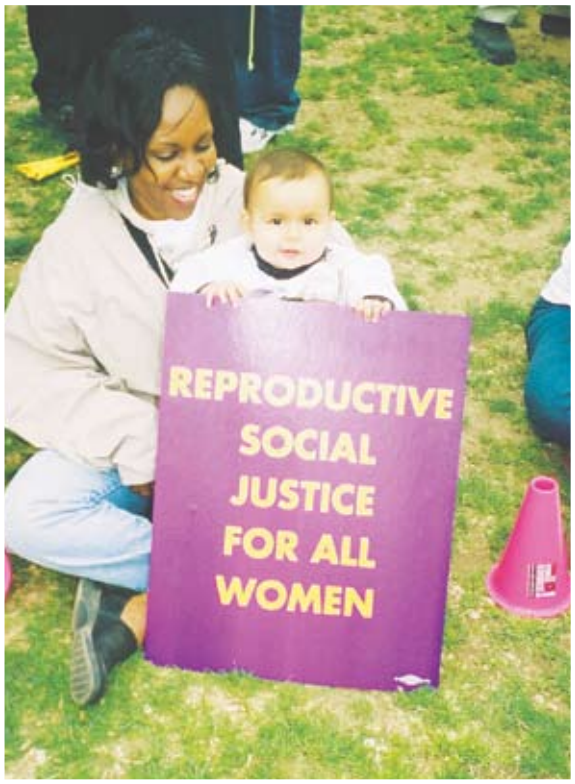
The policy brief stresses that in designing policies and programs to address the sexual and reproductive health needs of men and women living with HIV, policymakers, public health experts and national-level program planners must, of course, consider the best available scientific data. To be successful, they must also take advantage of the perspectives, expertise and accumulated experiences of people living with HIV.

"Associations and networks of HIV-positive people and community-based organizations run by and for people with HIV have a key role to play at all stages in the process—from program and policy design to the delivery and evaluation of sexual and reproductive health services," said Dr. Purnima Mane, UNAIDS' director of policy, evidence and partnerships.

The issue brief is available on the Guttmacher Institute's Web site at www.guttmacher.org, on GNP+'s Web site at www.gnpplus.net and on the UNAIDS Web site at www.unaids.org. For more information, email info@guttmacher.org.

CELEBRATING **10 YEARS**

CELEBRATING 10 YEARS



Strategies of Resistance continued from page 30

the Association for the Development and Enhancement of Women (ADEW) supports women's empowerment programs, including microcredit and women's equality in financial matters. And the Zakoura foundation has developed a network of home-based classrooms as a solution to the school drop-out rates among Moroccan girls.

Women's groups have also advocated for the protection of female workers; as a result, labor codes have been introduced which are often more progressive than those in the United States. Laws mandate the provision of maternity leave in the public sector (two months in Tunisia, three in Algeria and Egypt) and on-site daycare and nursing rooms are required if a company hires more than 50 employees. Sexual harassment in the workplace is a criminal offense in Morocco.

GLOBAL INFLUENCES

While demands for democratization and gender equality in the Arab world are indigenous, they are also influenced by global politics. The region has been at the epicenter of recent geopolitical changes that have affected the world: the fall of communism, the entrenched Israeli-Palestinian conflict, 9/11 and its aftermath and the invasion of Iraq. In this context, the success of the Islamists is no surprise. Seeds were planted during the Cold War when the US colluded with ruling Arab elites to support Islamists to counter communist and socialist opposition. It is the logical result of post-Cold War politics where the absence of an overarching "enemy" has resulted in incoherent policies that create "otherness" where it doesn't exist and where we wage wars today against our allies of yesterday. The inversion of reality is indispensable for US strategies: war is peace, occupation is liberation and Islam is oppression. The war on terrorism is framed in language of support for "democratic reform." The paradox of the US simultaneously encouraging democracy in the Arab world while illegally invading one country and supporting the illegal occupation of another is lost on no one—and certainly not the Islamists whose social and financial base is only strengthened as a result.

The resilience of women scholars and activists and their ability to continually adapt homegrown models of feminism and activism to new global and local challenges is admirable. Women's organizations are situating their demands in a historic, cultural and religious framework that presents an alternative to the Islamists' model of what it means to be a Muslim woman. They are holding their governments accountable to universal standards and working to oppose global policies—ranging from neo-liberal models of development to US interventionism that undermines human rights. Recognition and support for independent women's groups as the bearers of some of the most progressive changes in the region could go a long way toward building true democracy—a democracy built on gender equality, redistribution of resources and a more just future for all.

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Abortion and the Politics of Prevention

By Betsy Hartmann
Population and Development Program at Hampshire College

On November 7, voters in South Dakota voted to defeat a referendum whether to adopt the state's draconian law banning abortion. Reproductive rights activists from all over the country converged on the state to help mobilize pro-choice voters in an impressive grassroots effort. The stakes for women's health and human rights were very high indeed.

In the corridors of power, however, the liberal conversation about abortion has taken a different turn. In order to woo anti-abortion voters to the Democratic Party, prominent democrats like Hillary Clinton are engaged in re-framing the abortion debate in terms of prevention. Clinton and Senate Minority Leader Harry Reid, an opponent of abortion, collaborated together on the Putting Prevention First Act. The act's central premise is that most unintended pregnancies and abortions can be prevented if we eliminate barriers that prevent women from having access to affordable and effective contraception. According to Clinton, abortion is "a sad, even tragic choice to many, many women."

What is wrong with the abortion prevention framework?

Clearly, women should have access to affordable and effective contraception. But when you add women's health, safety and rights into the equation, abortion remains vital to the exercise of real contraceptive choices. It's not about preventing abortion, but instead about ensuring that abortion services are widely available and accessible.

For example, when used with the backup of legal abortion, barrier methods of contraception such as the condom, diaphragm and cervical cap, are the safest by far of all reversible contraceptives. They do not cause any delay in or risk to fertility and they help protect against sexually transmitted diseases and cervical cancer. They do not raise your risk of cancer or circulatory problems, or cause the so-called "minor" side effects of many hormonal methods – weight gain, loss of libido, depression.

Many women might choose to use barrier methods as their main form of birth control over so-called more effective methods with substantial side effects – the IUD, Depo-Provera, implants, the patch – if they knew they could get an abortion without difficulty in case they got pregnant. Access to emergency contraception (EC) is clearly vital too, but EC is only useful when you know you are at immediate risk of pregnancy and take action right away.

We need to return abortion to its status as a birth control method rather than as a tragic, traumatic event laden with guilt. Surgical abortion is one of the safest types of medical procedures; less than one percent of all women having legal abortions in the U.S. experience a major complication. We have to challenge American exceptionalism when it comes to the politics of abortion. In most other countries where abortion is legal, it is a question not only of women's rights, but also of public health.

Women have had abortions throughout history and will continue to have them. Today, almost a quarter of pregnancies worldwide end in abortion. The question is not about the morality of abortion, but its safety. Illegal and unsafe abortions claim the lives of nearly 70,000 women worldwide every year and leads to untold medical complications. Don't get me wrong -- this does not mean abortion should be the only or main form of birth control, as was the case in the former Soviet Union where the state neglected women's need for contraceptive methods. But we need to move away from abortion as the last line of defense against unwanted pregnancy and view it as a necessary component of contraceptive choice.

In the U.S., the increasing lack of access to abortion because of restrictive laws provides shortages, with expenses putting pressure on family planning providers to push the most effective contraceptives in terms of preventing pregnancy. The primary targets are young and poor women. The scarcity of abortion services, thus, skews the contraceptive calculus and encourages a cavalier attitude toward side effects and safety.

As the injectable Depo Provera loses favor because of its links to bone density loss and possible connection to an increased risk of acquiring HIV/AIDS, providers are starting to turn to other methods like the IUD. Locally, we are hearing reports of college students being prescribed the IUD even though it is contraindicated for young, sexually active women who have not have children because it is associated with a greater risk of pelvic inflammatory disease and future infertility.

Meanwhile, contraceptive manufacturers, eager to market their products, are waging a low intensity war against condoms as a form of birth control. For example, the former distributor of Depo Provera, Pharmacia Corporation, put out promotional materials suggesting that it was irresponsible for women only to use condoms since they are less effective than Depo in preventing pregnancy. Drug companies are also pushing a perverse notion of 'pharma-spontaneity' on young women. The message is that it is wonderful and liberating for young women not to worry about birth control when they have sex -- why negotiate with your partner to put on a condom when you can get a shot or implant in your arm, an IUD in your uterus, or even a hormonal method that lets you miss your periods.

This notion of sexual spontaneity is disastrous in terms of women taking action to protect themselves against sexually transmitted diseases. By contrast, we need to say condoms and other barrier methods are a good, safe contraceptive choice, and even more so in combination with access to EC and abortion.

We also need to acknowledge that sometimes we are not all good girls. When we screw, we sometimes screw up, or at least our partner does, and thank God for EC and abortion, and please, Hillary Clinton, don't make us feel guilty for failing to be perfect. We should put women's health and safety first, and that means defending abortion not only as a fundamental woman's right, but as an important tool of contraceptive choice. We need to challenge the discourse of prevention with a positive, proactive language of our own.

Betsy Hartmann is director of the Population and Development Program at Hampshire College in Amherst, MA and a longstanding activist in the women's health movement. She is the author of Reproductive Rights and Wrongs: The Global Politics of Population Control (Boston: South End Press, 1995)

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