SISTERSONG WOMEN OF COLOR REPRODUCTIVE HEALTH COLLECTIVE

COLLECTIVE VOICES

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Ningún ser humano es ilegal
Immigration Reform, Human Rights and Reproductive Justice

By Laura Jiménez, Deputy Coordinator, SisterSong
May 13, 2006

Ningún ser humano es illegal, **no human being is illegal.** This is one of the declarations made by immigrant communities and their allies at the protests, rallies, and marches throughout the United States in the last two months. In response to the proposed immigration reform measures being debated in both Houses of Congress, millions of people have participated in these actions, voicing their opposition to increased militarization of the border, as well as the more stringent and repressive enforcement of current immigration laws and harsher penalties for breaking them.

Although this newest set of legislation targeting immigrants appears to have set off the events and activities of the last two months, it is really only the most recent in a long history of attacks against immigrant communities in the United States. These recent protests are also linked to the 500-year history of social justice activism by Latinos and other immigrants that are ignored by the mainstream media. The real catalyst for the people's outrage is the everyday tension and indignity of having to survive under what amounts to blatant (and legally sanctioned) human rights violations.

SisterSong's Reproductive Justice framework understands that women make their reproductive health decisions within the context of their family's and community's life and circumstances. This is a perfect example of how an issue, such as immigration reform, will not only affect immigrant women of color, but also their families and their whole communities.

If Congress passes any repressive legislation, then we can expect that women will experience this debate played out on their bodies and in their realities. As stated in ACRJ's Reproductive Justice Agenda: "During a war, a woman's body is treated synonymously to the land: as a battleground where women and resources are exploited, and as a site where victors establish dominance by reproducing themselves in the population through women's bodies, as well as reproducing their values, culture, religion, language, and traditions." [i]

Immigrant women already have less access to reproductive health services for various reasons, including cultural and linguistic barriers, lack of health care coverage, poverty or low formal educational levels (which have been associated with under-use of medical services).[ii] If legal barriers are also erected, there would be the systematic, institutionalized and deliberate denial of the humanity of the people who are affected. In addition, other barriers include lack of economic resources to access medical services, and legislation that has already been enacted, such as the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, which prohibits the states from using federal funds to provide Medicaid coverage for immigrants who have resided in the country for less than five years.

All of the immigration reform legislation currently being proposed in both Houses of Congress include tighter restrictions on services and benefits that could be accessed by immigrants. States including Arizona, Georgia and Virginia have already enacted such laws. It is critical to understand that, as this legislation is pending approval, the amount of public debate that is created by these proposals also trigger different types of behaviors from different groups of people:

• Undocumented immigrants who fear removal from the country stop trying to access services, causing medical conditions to go untreated, become emergency situations and create gaps in preventive strategies;

• Pregnant women do not access pre-natal services, causing poorer birth outcomes; and

• US citizens who work in institutions such as schools, hospitals, and banks among others, feel empowered to request immigration documents inappropriately, without guidelines and without legal authorization. This was the case immediately after California voters authorized the passage of Proposition 187 in 1994 (a law that denied social services, health care and public education to illegal immigrants and was subsequently struck down by the federal court).

In addition, we are concerned about the women who will continue to make risky attempts to enter the United States. According to the Committee of Indigenous Solidarity, "Rape has become so prevalent that many women take birth control pills or shots before setting out to ensure they won't get pregnant. Some consider rape 'the price you pay for crossing the border.'"[iii] More women than ever are attempting such crossings with the full knowledge that rape and death are possible consequences. What will be their fate with the new beefed-up border security and the proposed 700-mile wall between the US-Mexico borders? What about the women who make the perilous journey in their last weeks of pregnancy with the desperate hope that their child will be born a US citizen? And what about the children and families that they leave behind who are depending on them for economic support?

These are all issues of extreme concern to the Reproductive Justice movement. SisterSong has supported and will continue to support the great numbers of immigrant communities and their allies that have come out in these recent events, and we support the movement for fair comprehensive immigration reform that recognizes and respects the human rights of all people. This recent public outcry has been a perfect example of an instance in which a unified Reproductive Justice movement has aligned itself with allies of other social justice and reproductive health movements to

Continued On Next Page >>

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 politeness is killing us."

Cherrie Moraga

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declare, "Citizenship, reproductive health, and the benefits that accompany it are not privileges; they are human rights!"

Most importantly, SisterSong encourages the communities of Indigenous women and women of color across the United States to stand together with our immigrant sisters in opposition to these repressive immigration measures. The key to winning this fight is to do collectively what we cannot do individually.

[i] ***Asian Communities for Reproductive Justice. A New Framework for Advancing a Social Justice Movement for Reproductive Health, Reproductive Rights and Reproductive Justice, 4-5 (2005).***

[ii] ***Foulkes R., Donoso R., Fredrick B. Opportunities for Action: Addressing Latina Sexual and Reproductive Health Outcomes. American Journal of Obstetrics and Gynecology, S37-42 (2003); Vines A, Godley P. The Challenges of Eliminating Racial and Ethnic Health Disparities, NC Medical Journal. 341-349 (2004).***

[iii] ***Committee of Indigenous Solidarity. "Mexico Week in Review". April 27, 2005.***

The following documents were also of great assistance in writing this piece:

National Asian Pacific American Women's Forum (Chappell, C).Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women. 2005.

National Latina Institute for Reproductive Health. The Reproductive Health of Latina Immigrants. December 2005.

HISTORY MATTERS
MISSISSIPPI THEN AND NOW

By Joyce Follet, Sophia Smith Collection, with research assistance from Kelly Anderson

Uses and Abuses of the Past

The race is on to become the first abortion-free state in the country, and Mississippi is definitely in the running. The state legislature has imposed numerous restrictions that undermine *Roe v. Wade*, and in the last session, lawmakers nearly passed a bill that would ban almost all abortions. The bill died in March after House and Senate leaders failed to reach a compromise on specific provisions, but reproductive rights advocates consider this a temporary reprieve and are gearing up for the same fight next year.

For now, the immediate struggle is taking place outside the legislative chambers. It centers on the Jackson Women's Health Organization, run by Susan Hill, the last remaining facility in the state to openly provide abortion. Pro-Life Mississippi, an influential group that has helped close five other clinics, is pressuring the Jackson clinic to shut its doors. Operation Save America (formerly Operation Rescue) is directing national attention to Jackson by holding its week-long annual meeting in the city in July.

The racial undercurrent in this confrontation is strong. Clinic staff and the 3000 women who rely on the Jackson clinic each year for health care are predominantly African American, as are Michelle Colon and most leaders of the community coalition defending the clinic.

Anti-abortion activists, on the other hand, are predominantly white, and they presume to speak for the staff and clientele. Playing to longstanding fears that associate abortion with genocidal intent, they wrap themselves in the mantle of the civil rights movement to claim the moral high ground of protecting endangered black lives. On Martin Luther King Day in 2004, anti-choice Mississippians installed 2000 crosses on the grounds of the state capitol as "a memorial to the unborn." Terri Herring, the lobbyist and spokeswoman who serves as president of Pro-Life Mississippi, routinely invokes Martin Luther King's "dream" of a thriving African American community. By presenting herself as the keeper of King's dream, Herring in effect accuses African Americans of betraying it when they support women's exercise of control over their own fertility.

Dreams are all to the good, Michelle Colon readily agrees, but the reality is that 49% of women in Mississippi live in poverty. Mississippi has the second-highest rate of child poverty, the third-highest rate of infant mortality, and one of the highest rates of teen pregnancy in the country. Colon observes that anti-abortion activists turn little of their political passion into efforts to address the systemic conditions in which women make their reproductive decisions.

Colon is president of Jackson NOW and member of a progressive coalition that stands for "social justice, moral agency, and the ability of a woman to make educated, compassionate decisions regarding birth control, pregnancy, and abortion." The coalition is fighting for women's health, comprehensive sex education, and access to birth control, as well as for access to abortion. In May, progressives helped defeat the Health Insurance Marketplace Modernization and Affordability Act, which would have allowed insurance companies to disregard state laws requiring coverage of contraception. Today, progressives are up against a petition drive calling for a statewide vote on a human life amendment to the Mississippi constitution, and they are holding clinic defense trainings in preparation for the July arrival of Operation Save America.

However, the media are not giving progressive voices the attention Herring and anti-abortion leaders command. To a certain extent this bias is merely an expression of Mississippi's racial politics. But it is also true that there is widespread neglect of the long tradition of African American women's reproductive health activism in Mississippi, and that neglect is not benign. The ignorance creates a vacuum that conservatives can fill with distortions, and leaves progressives without an empowering

counter-narrative woven out of the actual truths of women's lives.

A Century of Health Activism

As Susan Smith, Jennifer Nelson and other historians have documented, African American women have organized continually for more than a century to provide and demand health education and medical services, including birth control and abortion. In the early years of the twentieth century, club women in the National Association of Colored Women — which was larger than the NAACP or the Urban League — countered official neglect of black communities by creating hospitals and mobile clinics and petitioning for public health services. During National Negro Health Week, which ran from 1915 to 1930, local women in Mississippi and around the country organized lectures and health screenings for millions of people. In the 1940s, Negro Home Demonstration Clubs distributed birth control information through the rural South as one component of a general program of health, education, and economic development. In these same years, six itinerant black public health nurses, working out of headquarters in Jackson, were traveling around Mississippi and forming popular local women's health clubs, conducting clinics, collecting data on the incidence of disease, and working with thousands of midwives.

Until the mid-twentieth century, midwives were the primary reproductive health providers. In Mississippi, most were African American. There were some 4000 registered black midwives in the state and no telling how many unregistered lay "granny" midwives, whose traditional knowledge extended back to slavery. They delivered the vast majority of black babies. Community members themselves, midwives practiced in homes, conducted birthing demonstration projects, offered mothers' clinics for pre-natal and post-natal care, and negotiated poor families' links with the larger medical system. Registered midwives risked losing their permits to practice if they performed abortions, and official records are silent on the subject, but unofficial accounts leave little doubt that abortion was part of midwifery practice and understood as an essential element of personal, family and community strategies.

Also in the 1930s and 1940s, Dr. Dorothy Ferebee, who taught obstetrics at Howard University, directed the Mississippi Health Project of the Alpha Kappa Alpha Sorority. As sorority president, Ferebee led teams of medical volunteers and AKA members to the Delta each summer to deliver basic health services to sharecroppers. Wording her reports carefully to avoid jeopardizing the program by targeting "white power" as the root of the problem, Ferebee nonetheless made it clear that general conditions undermined community wellbeing. "The standard of health is indissolubly linked to all the socio-economic factors of living," she reported. There was national awareness of a health crisis in black communities at the time — *Time* magazine identified "Negro Health" as the "No. 1 public health problem" in 1940, and the AKA project received considerable national press. Eleanor Roosevelt expressed interest and met with Ferebee. Ferebee lobbied Roosevelt to encourage the federal government to adopt the AKA project as a model for a comprehensive public health program.

Black women were disappointed in their efforts to win government support for their health needs. At the same time, the number of registered midwives was decreasing rapidly; there were only 600 left in Mississippi by 1966. This reduction in providers may have contributed to the prevalence of sterilization abuses that civil rights workers observed in the 1960s. Beginning in 1958, the state legislature considered punitive sterilization measures aimed at reducing "illegitimate" births. In 1964, SNCC produced a pamphlet entitled "Genocide in Mississippi" that reported on proposed legislation that would force women who gave birth to more than one "illegitimate" child to choose between sterilization and prison. Describing her own 1961 experience of being sterilized without her knowledge, Delta sharecropper and civil rights leader Fannie Lou Hamer claimed that 60% of black women who entered her local hospital for medical care came out sterilized, many involuntarily. The procedure was so common it was known in medical circles as a "Mississippi appendectomy."

With racial tensions running high in the mid-1960s, women from Jackson appealed to Dorothy Height, president of the National Council of Negro Women (NCNW), to bring northern women to Mississippi to serve as "a ministry of presence among us" simply by bearing witness. Height launched *Wednesdays in Mississippi*, a plan that dispatched interracial teams each week to transport resources, stand alongside civil rights workers in Freedom Schools and voter registration projects, and take home word of the daily realities and explosive conditions in Mississippi. The NCNW later established the Fannie Lou Hamer Day Care Center in Ruleville, and Height brought a delegation of South American, African, and Caribbean women to Mississippi to meet with rural women.

Height's experience in Mississippi no doubt informed her response to *Roe v. Wade* in 1973. She maintained that legalization of abortion is necessary but insufficient. Height was one of six prominent black women leaders who issued a statement endorsing Medicaid coverage for abortion, contending that women of color were disproportionately poor and that "the vast majority" of women "who died at the hands of incompetent practitioners in the days before abortion was legal were Black and Brown." At the same time, Height pointed to the "bitter experience" of sterilization abuse as proof that "choice" is a feeble foundation for women's empowerment as long as class and race inequities persist.

Terri Herring would probably be surprised to learn that Martin Luther King was not deaf to the message of this long line of club women, physicians, public health nurses, community organizers, midwives, extension agents, and sorority sisters. He wrote in 1966 that family planning was "a special and urgent concern" for African Americans and "a profoundly important ingredient in [our] quest for security and a decent life." His wife kept up the drumbeat. In her opening remarks to the 20,000 women at the National Women's Conference in Houston in 1977, Coretta Scott King noted, "Despite some gains made in the past 200 years,…man-made barriers, laws, social customs and prejudices continue to keep a majority of women in an inferior position without full control of our lives and our bodies." She went on to advocate a bold social justice agenda including gay and lesbian rights and universal health care.

Perhaps if Herring understood the history of women's organizing for health and reproductive rights in Mississippi, she would pause before posing as King and condemning the reproductive decisions of poor and young women and women of color. Perhaps if that history were widely known, she would be less likely to get away with it. It's worth a try.

Putting History in Action: The Voices of Feminism Project

The conviction that history matters motivates the Voices of Feminism Project at the Sophia Smith Collection (SSC) at Smith College. The SSC is the oldest women's history archive in the country and already home to major reproductive rights collections, including the archives of Planned Parenthood Federation of America, the International Women's Health Coalition, the Midwives Alliance of North America, the National Women's Health Network, the YWCA, Catholics for a Free Choice, Choice USA, and anti-sexual violence organizations such as Have Justice Will Travel and Stop It Now! The personal papers of Margaret Sanger, Harriet Pilpel, and other key players in struggles over contraception and family planning are at the SSC, along with an ambitious oral history project documenting the international reproductive health movement.

With support from the Ford Foundation, the Voices of Feminism Project has made a priority of preserving under-documented stories and perspectives. On the topic of sexuality and reproductive health among women of color, the Project has videotaped oral histories and/or saved personal papers and organizational records of Byllye Avery and the National Black Women's Health Project, Luz Alvarez Martinez of the National Latina Health Organization, Charon Asetoyer and the Native American Women's Health Education Resource Center, Mohawk midwife Katsi Cook and the Mother's Milk Project, Loretta Ross and the SisterSong Women of Color Reproductive Health Collective, the National Latina Institute for Reproductive Health, Fran Beal, Linda Burnham, Barbara Smith, Cherríe Moraga, Betty Powell, Peggy Saika of Asian and Pacific Islanders for Choice, Marlene Fried and the National Network of Abortion Funds, Graciela Sanchez of Esperanza Peace and Justice Center, Nkenge Toure of the Black Panther Party, Carmen Vazquez of the LGBT Community Center, and many involved in the fight against HIV/AIDS in Latino communities of western New England. Luz Rodriguez formerly of the Latina Roundtable on Health and Reproductive Rights and Brenda Joyner formerly of the Federation of Feminist Health Centers will be interviewed soon.

The purpose of saving these stories is to ensure that lessons learned are not lost to future generations. Materials at the SSC are preserved for the ages, but they don't rest in peace. The SSC is open to the public, publishes a newsletter, holds public programs to showcase new collections, and posts a website: http://libraries.smith.edu/libraries/libs/ssc. Faculty from area colleges build courses around these primary sources, and travel grants make it possible for scholars from around the world to access them. Reference archivists assist visitors to the reading room, field questions by phone and email, and help journalists, activists, filmmakers, and high school students explore women's history and acquire copies of original materials for their own projects.

Many Voices of Feminism oral histories are completed, and the rest will be available by the end of 2006. Some manuscript collections are ready for research. However, sorting, cataloging, and attending to the preservation needs of fragile items is a labor-intensive process, so it will be a while before all these records can be opened.

In the meantime, the SSC is working with advisors, including the authors of *Undivided Rights*, to develop a historical documentary that puts history into action by placing women of color at the center of today's volatile confrontations around reproductive and sexual politics. The goal is a film that both educates the general public and functions as a tool organizers can use to strengthen community-based groups. SisterSong members will hear more about the documentary in the months ahead.

For information on the Voices of Feminism Project, contact Joyce Follet at jfollet@email.smith.edu. For information about the Sophia Smith Collection or copies of materials, contact a reference archivist at ssc-wmhist@email.smith.edu or (413)-585-2970.

History does matter – just look at Mississippi.

Look Before You Lick

By Kai Gurley,
SisterSong Development Coordinator

One evening earlier this year, I found myself in a room full of mostly lesbian-identified women staring at a power point presentation full of pictures of STD-infected vaginas. Being a queer person myself, I'd spent a good amount of time with the vagina, but I'd never seen anything like this before. Picture a 10-foot-tall vagina covered with genital warts (HPV) or Herpes and/or leaking some gray or yellowish discharge. NOT SEXY! I began to have the feeling that if I looked at someone long enough, I might catch Herpes. While my personal vow that evening to never have sex ever again did not last long, I did leave with a new and lasting understanding of STDs, high risk behaviors, and safer-sex practices.

In honor of African-American HIV/AIDS Awareness Day, ZAMI (Atlanta's premiere organization for lesbians of African descent www.ZAMI.org) sponsored an event on "Lesbian Sex in the Age of STDs." ZAMI brought together three local experts on HIV and STD transmission to educate and dispel myths about STDs in the lesbian community.

A quick note about language and gender: As a person who does not identify as either a lesbian or a woman, I feel compelled to clarify some things from the beginning. While the information provided in the presentation was catered to lesbian-identified women, all of the information also applies to any female-born person (a person assigned a female identity at birth) having sex with any other female-born person, and would not necessarily apply to a male-born person in spite of their current identity. In other words, this information could apply to transmen (if he is having sex with another female-born person) and female-born genderqueer folks (who are having sex with other female-born people), but not transwomen (even if she identifies as a lesbian and is having sex with other lesbian-identified women). For more information about trans health and/or gender language, see www.callen-lorde.org or www.srlp.org.

The Facts:

Dr. Miriam Phields, from the Centers for Disease Control and Prevention, began the evening by presenting the following WSW (women who have sex with women) statistics: *There are no statistics, because this group is not being studied.* According to the federal government, to fall into the WSW category, a woman must never have been or have ever had sex with an injectable drug user, must not be a hemophiliac, and must not have had sex with a man since 1979. Given these criteria, studying this population is difficult, if not impossible, and so there is very little data about WSW transmission. This lack of data presents a huge problem because, according to Dr. Phields, data "is a cornerstone of prevention of HIV and STDs," and without data we're each left to determine our own risk.

Unfortunately, this often leaves WSW believing they aren't at risk for STDs, and engaging in high-risk sexual behavior without protection. According to Dr. Edith Biggers, "We think of ourselves in terms of risk groups, as opposed to risky behaviors," and so we aren't getting tested for HIV and STDs and practicing safer-sex like we should. "As lesbians, we really have not been studied adequately," she stated, and so there is little information about potential transmission of STDs through oral sex, sex toys, etc. We all need to stop and "look before we lick."

The Danger:

Here's what we do know: Information about WSW transmission is based largely on case reports, not studies, and can be divided into three risk categories: definitely, probably, and completely unknown.

Definitely: Trichomoniasis, Pubic Lice, Scabies, Herpes, HIV, Hepatitis A, and Hepatitis B can definitely be transmitted between female-born people through sexual activity. The first documented case report of WSW transmission of HIV was in 1986.

Continued On Next Page >>

Dying Babies: Infant Mortality Rates and People of Color

By LaToya Rogers, SisterSong Intern

I saw an edited version of the CDC report on Infant Mortality Rate (deaths per 1,000 live births) by Race/Ethnicity 2000-2002 in an email sent out by the Kaiser Family Foundation State Health Facts website (http://www.kaisernetwork.org/). Upon first glancing at the data, I wondered why African Americans have the highest IMR compared to Whites and Hispanics. Then, I began to ask where are the other ethnic groups listed in this report? While scrolling down the email I noticed a link to the *National Vital Statistics Reports* published by the CDC about this particular information. The report pulled data from birth and infant death certificates from White, Black, American Indian, Asian/Pacific Islander (broken down into sub-groups), Hispanic (broken down into sub-groups), Non-Hispanic White, and Non-Hispanic Black.

The birth and death certificates of the infants were taken from all states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam. Each state provided the CDC and the National Center for Health Statistics matching numbers on the certificates for each infant less than one year of age who died in the state during 2002.

In order to find more information about the definition of Infant Mortality Rate and what deaths are included in the calculations, I went to the Office of Minority Health website, which also retrieved some information from the CDC report. According to the Office of Minority Health, the definition of Infant Mortality Rate is the "sudden death of an infant less than one year of age that cannot be explained by information collected during a thorough investigation." An investigation should include a complete autopsy, examination of the death scene, and a review of the clinical history. SIDS, Sudden Infant Death Syndrome, is associated with this definition. They go on further to state that, although the overall rate of infant mortality/SIDS in the United States has declined by more than 50 percent since 1990, rates have declined less among African American and American Indian/Alaska Native infants. Moreover, infant mortality/SIDS is still the third leading cause of infant deaths in the United States and the leading cause of death among infants 28–364 days. The cause of infant mortality/SIDS is unknown. Several factors have been identified that increase an infant's risk for SIDS:

Tummy (prone) or side sleeping - Infants who are put to sleep on their tummy or side are more likely to die from SIDS than infants who sleep on their backs.

Soft sleep surfaces - Sleeping on a waterbed, couch, sofa, or pillows, or sleeping with stuffed toys has been associated with an increased risk for SIDS.

Loose bedding - Sleeping with pillows or loose bedding such as comforters, quilts, and blankets increase an infants risk for SIDS.

Overheating - Infants who overheat because they are overdressed, have too many blankets on, or are in a room that is too hot are at a higher risk of SIDS.

Smoking - Infants born to mothers who smoke during pregnancy are at increased risk of SIDS. Also, infants exposed to smoke at home or at daycare are more likely to die from SIDS.

Bed sharing - Sharing a bed with anyone other than the parents or caregivers and with people who smoke or are under the influence of alcohol or drugs, increases an infant's risk for SIDS.

Preterm and low birth weight infants - Infants born premature or low birth weight are more likely to die from SIDS.

The United States has made substantial improvements in infant mortality, but disparities still exist. In 2002, the infant mortality rate for African American infants was more than twice the rate for non-Hispanic White infants (13.8 deaths per 1,000 live births for African Americans vs. 5.8 for non-Hispanic Whites). In American Indian and Alaska Native populations, the death rate is 48 percent higher than in non-Hispanic Whites. American Indian/Alaska Natives Sudden Infant Death Syndrome (SIDS) mortality rate is 2.2 times the SIDS mortality rate for non-Hispanic Whites. Although the infant mortality rate for Hispanic infants is less than the rate for non-Hispanic White infants, within the Puerto Rican subgroup, the infant mortality rate was 41% higher than non-Hispanic Whites.

Quick Facts

- African American mothers were 2.8 times as likely as non-Hispanic White mothers to begin prenatal care in the 3rd trimester, or not receive prenatal care at all.
- American Indian/Alaska Natives have 1.5 times the infant mortality rate as non-Hispanic Whites.
- Among Asian/Pacific Islanders, the infant mortality rate ranges from 3.1 per 1,000 live births for Chinese Americans to 9.3 per 1,000 live births for Native Hawaiians.
- Puerto Rican infants were 2.2 times as likely to die from causes related to low-birth weight, compared to non-Hispanic White infants.

Upon looking at this information one has to wonder why are mothers of color are late in beginning prenatal care or not receiving prenatal care at all? Why are the "minorities" listed in the Quick Facts not receiving adequate care to prevent the causative factors of SIDS? According to popular myths, the welfare system is overpopulated with minorities seeking assistance for healthcare for themselves as well as their children, so why aren't more of us seeking prenatal care for our families? Could it be that people of color are using Medicaid and other insurance programs to go see the obstetrician/pediatrician, but the providers are not giving culturally appropriate pre-natal and postpartum education to their clients? Could it be that there are not sufficient programs geared towards people of color to identify and prevent factors that are related to the death of their children less than one year of age?

According to the *National Vital Statistics Reports* study in 2002, the mortality rate for infants of mothers who began prenatal care after the first trimester of pregnancy, or not at all, was 9.0 per 1,000.

Continued From Page 4 >>

Probably: Human Papillomavirus (HPV)/Genital Warts, Bacterial Vaginosis (BV), Gonorrhea, Pelvic Inflammatory Disease (PID), and Chlamydia are probably all transmitted between female-born people, but there is no research documenting prevalence and risk.

Unknown:

Syphilis, Yeast, and Hepatitis C are all theoretically transmittable between female-born people, but none have been studied. Yeast is not considered an STD in heterosexual sex.

While there is little concrete information available based upon the ways these STDs are transmitted in heterosexual and gay-male sex, it makes sense that all of these STDs can be transmitted between female-born people. Virtually any time bodily fluids are exchanged (vaginal fluid, blood, saliva, urine, feces, breast milk), there is a risk for transmission. It is up to each of us to monitor our sexual partners for STDs regularly as well as ourselves. We must all take the time to learn what our bodies look like, so we can know when something looks abnormal on our sexual partners or ourselves.

The most up-to-date and comprehensive information about WSW transmission of STDs can be found at www.lesbianstd.com.

The Good Stuff:

To end the evening's presentation, Tonia Poteat, from Grady Health System led a conversation about healthy, erotic, lesbian sex. "It's healthy for lesbians to realize that we have full and robust sexual lives," Tonia stated. "Often when people talk about lesbian sex they talk about oral sex like that's all that two women can do together, but clearly that's not the case."

In a room of approximately 75 women, the following lesbian sex acts were identified in less than three minutes – fingering, frottage, grinding, rimming (anal licking), oral sex, fisting, toys (dildos, vibrators, nipple clamps, anal plugs, blindfolds, handcuffs, etc), kissing, strap-on sex, biting, S/M, tit-fucking, spanking, tying-up, and golden showers/water sports. According to Tonia, WSW must recognize that there is a "continuum of risk" with sex acts, and we must make choices about the level of risk each of us is willing to take. Once we identify the risk involved with our favorite behaviors, we can then take action to make them safer. Condoms on toys, gloves or finger-cots on the hand, and dental dams on the vagina can all greatly reduce the risk of WSW transmission of STDs.

For more information on ways to make WSW sex safer, check out www.lesbianstd.com.

The Moral of the Story:

First, this is an appeal to health care providers to get better educated about WSW sex acts and potential transmission of STDs. While the statistics are not available, common sense and caring are. WSW are engaging in every type of sex that heterosexuals and gay men are engaging in, minus the semen. Women's health clinics, in particular, owe it to their clients to have all the information and ask all of the appropriate questions in a way that feels informed, not voyeuristic. Butch-identified women and transmen are significantly less likely to obtain regular gynecological exams; primarily due to the shame and embarrassment we feel when our gynecologists interrogate us as if we're aliens from another planet. Health care providers can serve as the first source of STD information for WSW, but more information and training is needed.

Secondly, this is not a "what you don't know can't hurt you" situation. In this case, what we don't know can, will, and certainly already is causing our community great harm. As women, queers, lesbians, people of color, trans, and gender-variant people, we already know that we cannot count on the government for protection, and this situation is no different. We cannot wait for the CDC or the federal government to decide our lives and our health are worth protecting. We must begin to protect ourselves. We can celebrate our fabulous, beautiful, sexual, selves with safety. We are worth protecting.

Continued From Page 4 >>

This rate was 45 percent higher than the rate for infants of mothers whose care began in the first trimester.

Overall, the infant mortality rates for women who began care in the third trimester were lower than women who began care in the second trimester. This is because women who began prenatal care in the third trimester had to have a gestation period of at least 7 months, thus reducing the probability that the infant would be born preterm or of low-birth weight. It has been suggested that when certain pregnancy complications are especially present (e.g., post-term pregnancy, pregnancy-induced hypertension), infants of both black and white women who do not obtain prenatal care are at increased risk of post-neonatal deaths.

SisterSong readers, you must wonder what is happening with healthcare providers, education and facilities for people of color in our communities. Now we must think about what we can do as a Collective to reduce these numbers in our communities. What tactics can we develop that will protect the children of our future?

Sister Sucker Punches

By Loretta Ross , SisterSong National Coordinator

"*It's particularly hard to take being stabbed in the back close to home. There's always a feeling of betrayal when people of your own group oppose you. It's mainly a few elite women who benefit greatly from standing with the forces that keep women down.*"

—Catherine MacKinnon

As women of color in the reproductive justice movement, we often find that fighting battles within our movement are even more exhausting than fighting people outside. In SisterSong, we call this phenomenon *Sister Sucker Punches*. It is so hard to fight personalities, corruption and opportunism within our movement that many good people leave the work, not willing to compromise their principles for a paycheck. SisterSong sponsored a workshop at our membership meeting in October 2005 in Oakland, California on the topic of **Demystifying Conflict: Dealing with Sister Sucker Punches** featuring Merina Sapolu of Kokua Kalihi Valley Comprehensive Family Services; Juanita Williams, an individual member; and Loretta Ross, National Coordinator.

We organized this workshop because many of us had difficult stories to share about how hard it can be to work with women of color who practice internalized oppression on each other. We decided to share a summary of that workshop with other sisters who may be blindsided by the surprising ruthlessness, cynicism, and personal ambitiousness of some of our colleagues. While we cannot permanently avoid Sister Sucker Punches, we wanted to identify some patterns and learn how to minimize the toxic damage.

Sometimes conflict arises because there are genuine political disagreements. Political disagreements are okay within a movement because when many different people think the *same* thing and move in the *same* direction, that dynamic could be called a cult. When many people think *different* things and move in the *same* direction, that intellectual diversity is movement building.

One of the problems we've observed is that people sometimes take political disagreements personally. They cannot separate disagreement from personal dislike. Women's organizations actually may suppress political conflict because we are sometimes uncomfortable with the intense passions generated by discussing differences. Often we believe we are creating safe spaces. In fact, we are creating *silent spaces*. As Audre Lorde says, "Your silence will not protect you." What frequently emerges from these settings is a form of "group-think" that quashes marginalized voices and is impervious to alternative viewpoints.

But many times conflicts are based on other issues such as personalities, hidden agendas, power dynamics, competition, and passive/aggressive behavior. These can be complicated to decipher and much more challenging to counter. Our ability to pro-actively identify and change these destructive patterns frequently determines if we do this work with joy or cynicism.

SisterSong uses Self-Help to have difficult dialogues and address conflicts as well as to celebrate ourselves and our delight in being together. Self-Help is a process by which the telling of personal stories creates bonds of understanding and unity. It explores internalized racism, sexism, homophobia and class oppression, while it breaks down patterns of isolation that we have been taught through societal institutions. It allows us to peel back layers in a conflict to understand the underlying causes.

While the many cultures within SisterSong practice Self-Help in diverse ways, we collectively recognize its ancient wisdom in creating unity among women. As SisterSong reaches our 10th anniversary of working together, we are thankful we have a process inherited from the National Black Women's Health Project and the National Latina Health Organization with which to resolve our conflicts. This does not mean we never "argue, fuss and fight," as the song goes. Instead, we know that disagreements should not be used as excuses to attack, gossip about, or disrespect each other.

New women join SisterSong all the time so we explain Self-Help to them. Often they are wary, assuming it is "touchy-feely" stuff that takes away from the REAL work. But once they experience it, they often wish they had it or a similar process with which to deal with conflicts in a healing way in their own organizations. We use it in all our meetings, so the next time you're asked to engage in Self-Help at a SisterSong gathering, remember it serves a larger pur-

Continued On Next Page >>

pose than simply making you feel good.

Presentation Summaries:

Merina: We first have to understand that no one is an expert on everything. My experience is based on dealing with different Asian and Pacific Islander groups in Hawaii who all have a way of looking at things differently. In looking at conflict, we need to find out where it is coming from and what are the causes within the organization?

In my experience, the reason why conflicts erupt within an organization is because of misunderstandings of culture and age. Sometimes it's younger women against older women. Older women look to younger women with the idea that they should respect their elders. Sometimes people who come later into the organization have conflicts with people who have been there longer because of resistance by the older people saying, "I've been here before, so I know more than you." Also, I get the feeling that older people are problematic when they say, "You must do it my way and I don't welcome changes." The problem is that we begin to feel comfortable about what we've been doing for so long that we try not to accept new ideas.

In terms of culture, we often look for a person that people from dominant cultures feel comfortable working with instead of looking at all the different cultures within the organization and accepting them as equally valid. We have to become willing to learn and to respect each other.

My most recent Sister Sucker Punch occurred when co-workers were talking about a supervisor, stating she's not teaching anything and talking about the supervisor behind her back. My decision was to sit down and discuss the problem. I told the supervisor what was going on and stated that she needed to chat with her co-workers. The supervisor became confrontational when she approached them, and then the story became "Merina gossips." I explained to the supervisor that when I brought the problem to her I was looking for her help in finding a solution. I realize that all cultures have their own way of solving their problems. Instead of confronting and blaming, we need to discuss what our problems are with each other.

Gossip is one of the worst things that can happen and causes a lot of conflict in the workplace. We also suffer from the "Crab Syndrome," in which crabs in a barrel try to get out by dragging each other down. A supervisor must really look at the causes of the conflict and see if there is anything that can be done within a little setting or in a larger group, rather than using confrontation and power to silence people.

Resolving conflict can be tiring at times for both parties. We all have to be clear about what we want, what the root cause is, and the route we will take to arrive at a solution. I usually suggest to people to look at yourself because unconsciously you may be the cause. We need to ask ourselves: What is the conflict? What is your idea of the conflict? Your idea of the conflict may be different from mine. How do I resolve a conflict within the workplace? We also need to ask, is the person bringing in conflict from their home?

Juanita: The purpose of this workshop is to help us realize that we are not alone in this battle and that we can pull together. Sometimes we sucker punch each other and we're not aware of it. Until we understand the problem and how to resolve it, these things will continue and women of color will continue to victimize each other.

Founders and CEOs have the "My Baby Syndrome" a lot of times. They see their agency as their "baby," and feel that no one else can understand it and that no one else can help them do the work because they keep a lot of vital information only in their heads. It is understandable, but when you're talking about an agency that is serving 200 women and 100 children, you can't do it alone. This was my experience as a woman with AIDS on the board of directors of an AIDS service organization.

Mistake #1: Be careful who you put on your board of directors. Sometimes we want our friends on the board and we begin to protect them. Instead of them serving the organization, the organization ends up serving them. I worked with an organization in which the founder unexpectedly died and no one on the board or the staff knew how to run the organization because a leadership transition was never discussed. The founder's family became

Continued On Next Page >>

Surgeon General David Satcher Calls for Open Discussion About Sex with Teens

In a report released June 2006, titled, "The Surgeon General's Call to Action to Promote Sexual Health and Responsible Behavior," Surgeon General David Satcher urged parents, schools and communities to have open discussions about sexuality with teens and to provide "thorough and medically accurate sex education," the *New York Times* reported. The report also calls for respect for "diversity of attitudes, beliefs, values and opinions" and encourages finding common ground. Satcher proposes the "benefits of abstinence" be discussed, but teens should also receive pregnancy and disease prevention information. In the U.S., 39 percent of ninth graders and 65 percent of twelfth graders have had sex. Forty percent of girls become pregnant before the age of 20. Sixty percent of HIV-positive Americans became infected in their teens. According to the *Associate Press*, the report makes the following recommendations:

- Provide adequate training in sexual health for health care providers;
- Ensure the availability of programs that aim to prevent sexual abuse;
- Encourage stable and committed adult relationships to strengthen families;
- Increase scientific research on sexual health throughout life;
- Develop and distribute education materials for sex education classes that cover the "full continuum of human sexual development" for parents, teachers, clergy and others.

Satcher also stated that more research must be done on abstinence-only programs before a conclusion can be reached on its effectiveness. The report found "no scientific support" showing that sex education classes causes teens to engage in sexual activity. In fact, the report shows that students who are taught comprehensive sex education are more likely to use contraception once they are sexually active. The first step, he states in the report, must be a dialogue between parents and teens. But he also says the schools "play an important role," referring to them as "great equalizers" in healthy sex education.

involved because they felt it was their organization now since their daughter launched it and was overly-identified with it. Needless to say, that organization has now folded and the women it served have been abandoned.

It is important to pick your battles and to know when to walk away. Know your willingness and how far you want to go and when to let go. As women, it is sometimes hard to let go, especially in terms of abusive relationships, but sometimes we hurt each other so viciously it's crazy. Women are being beaten, robbed, raped, killed, and infected every two seconds while we are fighting with each other. While we are fighting, nothing gets done. We need to learn to work with each other and respect each other.

It is not glamorous to do this work. When we volunteer for leadership, we need to have on full armor because it will sometimes be a battle, both inside and outside. Leaders sometimes feel like they have a red target on their chests. Women who have suffered trauma sometimes have serious issues with authority. They sometimes act out their issues with authority on other women perceived as re-creating their feelings of powerlessness.

We have to look at ourselves and ask why we are battling each other like this. What is the real reason? How can we stop this? If we look past ourselves and center our attention on the women we need to serve, then some of us can come back to reality. But until we take the evil out of ourselves and stop fighting over the little money in this work, we'll be in trouble. Instead of constantly criticizing other sisters about what they should or should not do, we need to be self-critical first, examine ourselves to see if we're being positive and giving all that we can towards moving forward.

These poisonous situations affect our families as well when we're sucker punched. I have to be healthy emotionally, physically and spiritually in order to help people. That's why it's important to know your battles and understand that it's okay to walk away when the battle is killing you and your loved ones. As women we hate to give up because we're nurturers of the world. When we walk away we feel like we're giving up a lot of power, but in fact, we're giving ourselves power by refusing to be abused.

Loretta: All sucker punches do not have to be bad. Once when I was organizing a women of color conference on rape and domestic violence in 1980, Latina women accused the black women of oppressing them because there were many more black women than Latinas visible. This conflict lifted the voices and perspectives of Latinas in the anti-rape movement and led to increased sensitivity for everyone about practicing politics of inclusion.

Another sucker punch situation that was painful though, was speaking out to a supervisor about things the staff was saying behind her back. Like Merina, not only did the supervisor not appreciate hearing these things, but also the staff denied they had said them, leaving me in the lurch because their issues were not my issues. I now measure how I represent the voiceless now. I want to make sure that they have my back when I have their back, and I won't engage in discussions with folks who won't confront the source of their distress.

It's sometimes hard not to be judgmental about the work people do. I've learned that there is plenty of oppression to go around and everyone does not have to do the work the same way. Some of us prefer to work in the mainstream; some are more comfortable in the margins. Some of us want to build bridges to work with white women; some of us prefer not to. Either way is okay. When I criticize others, I try to criticize destructive behaviors and not personalities or people. I tend to think the best of others until proven otherwise. This can make me appear naïve and too trusting and I have been burned a couple of times by trusting the wrong people. But I choose to live with hope and optimism rather than with dread and fear. I figure karmic justice will take care of negative folks – in other words, what comes around, goes around. The key task for me is to not spread my own negative energy that will rebound exponentially.

As an older woman in the movement, I have a special responsibility to ensure that space for the leadership of young women is provided. This can have mixed results. I have met and worked with many young women deserving of leadership because they put their lives on the line and work in a principled and collegial way. These are the ones I probably identify with most because I began my political work when I was 15 years old. I had wonderful mentors who helped – and continue to help – me. Many of my mentors were old enough to have actually worked with Mary McCleod Bethune, founder of the National Council of Negro Women. In my twenties, these blue-haired soft-voiced Black women were kind enough to help me navigate the murky waters of politics and they now serve as my role models for working with younger women. They helped me understand that how you do the work is as important as the work you do. You can't do principled work in an unprincipled way.

I have also encountered some younger women who believe they have learned all they need to know in a women's studies course. These are the ones who believe leadership is something that is owed to them simply because they are young, degreed and new, not because they have earned it or paid their dues. They see leadership as a throne, not an opportunity to serve. They are disrespectful of others who don't have college degrees or their privileges. They are patronizing to those they see as their subordinates, but they can be personally charming and completely phony.

Often their role models for leadership are older women who practice the worse kind of competitive backbiting. Young women sometimes learn from these role models in successful mainstream organizations and they replicate these destructive tendencies in the women of color movement. The real sucker punch happens when they want to promote their own leadership by putting someone else down.

I've coined a term for something negative I've experienced: Management-by-clear-cutting. The fastest way to be the tallest tree in the forest is to cut everybody else down and only allow shrubs and bushes to grow. I've seen women of color use this tactic to hide their own mediocrity. They tend to only hire people who won't challenge their lack of competence, and fire or process out people they fear. They place a higher value on personal loyalty rather than competence. They have little tolerance for disagreement, taking it very personally, and surround themselves with sycophants. When a new idea works, they claim it. When an idea fails, they blame it (on someone else). The quality of the entire agency always goes down under their leadership,

Continued On Next Page >>

but I am often surprised at how long they hold on before they are exposed.

Another symptom is that people visit assumptions on you, which are the things they would do themselves. For example, I once had a co-worker who assumed everyone was a potential thief, if given the opportunity. She was very distrustful and always assumed the worst about others. She locked up office supplies and installed individual locks on office doors. Not surprisingly, she was the one who was caught embezzling funds.

What most people seeking leadership don't understand is that leadership, most of all, is an opportunity to serve others. It's not about fame, glory, or celebrity. It's about hard work and constant self-examination to see if one is worthy and doing the best you can. It's about creating the space for everyone to be a star. When lots of stars shine together, the skies are ablaze!

What can we do?

It is probably impossible to avoid all negative and destructive behaviors in our work. We are engaged in ameliorating the horrible things people do to each other. In the human rights movement, we call this looking at humanity's vomit. Despite the fact that we are engaged in fighting oppression, we have to remember that being oppressed is not fun, but fighting it should be. We have to do this work with joy, compassion, and honesty.

There are practical steps offered from the workshop that may help you identify Sister Sucker Punches and protect yourself and your agency from them. The most important thing to remember is that you are not alone and others may be experiencing the same things without being able to identify and name them.

Following are a few suggestions:

- **Learn techniques and processes to identify why we practice internalized oppression on each other.**
- **Create a safe space for people to talk about how they feel and how they feel in relationship to each other.**
- **Separate behaviors from the person to whom we offer criticism. We should not offer criticism in a way that makes the person feel humiliated, belittled, disbelieved.**
- **State honestly how we feel and take responsibility for our own feelings, not blame others.**
- **Discuss feminist ethics and determine what is – and is not – acceptable among women of color and offer guidance to others.**
- **Identify tangible tools that help us recognize the class, race, color, homophobic, ageist, and ableist issues to challenge.**
- **Recognize that we compete for funding because of the way foundations and donors work. We should try to share resources, not get in each other's way, and not put each other down because we want a grant.**
- **Acknowledge the class and color issues divides within ourselves, such as dark skin vs. light skin or East Asian vs. Southeast Asian, etc.**
- **Learn to work together in humility. We need to pull each other up when we are working on the same issues.**
- **Write articles about coalition building. Work with people who have expertise about these issues and share the knowledge.**
- **If we see other sisters sucker punch someone, we need to let them know this is unacceptable and we're willing to work with them to find a way to be healthier in the movement.**
- **Continue this discussion within our organizations and help identify those behaviors for others in a way that is useful for people coming after us and for the people with whom we are currently engaged in work.**

Unfortunately, all the advice in the world does not help sometimes. Some people don't know they are hurting and the only thing they know is how to spread pain to others. Some people are just malicious. Unfortunately you don't get to choose who you work with and you may have to struggle with all types. Please understand that no matter what you do, there are some people you cannot work with. These are people you have to work around.

The question is how can you protect yourself from people who are trying to steal your joy, and keep you from being happy and successful? The best way is to be able to surround yourself with people who are not going to offer you Sister Sucker Punches. This may not be possible, so consider organizing a peer support group outside of your organization to create a safe space to vent, find support and solidarity, and discuss helpful ways to resolve conflicts.

There are resources both in print and on the internet that can help you learn more about resolving conflicts. Among the best recommended is *The Mediator's Handbook* by Jennifer Beer or you can check out the Conflict Resolution Information website at http://www.crinfo.org/.

For information on practicing self-help, contact SisterSong at info@sistersong.net.

Mad at Birth Control?

Most people understand that if you want to reduce the likelihood of unwanted and unplanned pregnancies, people should have access to and use birth control. It's basic biology most of us learned in high school. However, many people in the anti-abortion movement seemed to have missed classes that day because they have widened their attacks on abortion rights to include attacks on birth control, including emergency contraception and conscience refusals by pharmacists. The war on abortion + the war on contraception = a war on women.

In a report released by the Guttmacher Institute in March 2006, the *Washington Post* reported that growing rates of unplanned pregnancies nationwide can be linked to several laws that reduce funding for family planning services and restrict access to contraception. The report, which is the first to survey all 50 states, stated that three million of the six million annual pregnancies in the U.S. are unplanned and half of those pregnancies end in abortion. According to Sharon Camp, CEO of Guttmacher Institute, 21 out of 1,000 women ages 15 to 44 obtained an abortion in 2002 – the lowest rate of abortions since 1974. The abortion rate decline makes Camp worried that policymakers are not concerned with the primary cause of unplanned pregnancies. The *Post* also reported that reproductive health barriers like lack of education and money, as well as access to birth control predominately affect the nation's estimated 17 million adolescent girls and low-income women. The study reports that California, Alaska, South Carolina, Alabama and New York ranked top five for states "serving women in need of contraceptive services, allocate public funding to family planning and adopt laws and policies that promote access to contraceptive information and services." Alabama, Alaska and South Carolina, in particular, have taken steps to make family planning services available to low-income women. Nebraska, Utah, Ohio, Indiana and North Dakota, however, ranked at the bottom of the survey primarily because of lack of access to reproductive health clinics. Camp said, "When effective contraceptive use rises, abortion rates go down."

In a related story, in March 2006, the Missouri House of Representatives banned state funding of contraceptives and prohibited state-funded programs from referring women to other programs, reported the *Kansas City Star*. Rep. Susan Phillips of Kansas City, the amendment's sponsor, stated, "If doctors want to give contraception privately or personally, they, can. But we don't need to pay for contraception with taxpayer funds." The ban calls for the elimination of infertility treatments and contraception. It also restricted how state agencies can spend $9.23 million earmarked for public health programs, which are primarily for low-income people. Rep. Melba Curls (D) responded to Phillips' amendment by stating, "Not all the low-income women who will get pregnant will have abortions." She continued, "If you have the baby, you're still low-income. And if you're poor and you have a baby, who takes care of the baby? The State of Missouri. You're setting up poor women once more not to have services." Rep. Kate Meiners (D) is an abortion opponent who said Phillips' amendment was meant to be a statement against abortion, but will, instead, create more unplanned pregnancies. Phillips, however, cites that the support of Missouri Right to Life and the Missouri Catholic Conference makes her satisfied with the contraceptive ban.

We in the reproductive justice movement cannot let these attacks on our lives go unchallenged. Our most vulnerable are young women and poor women who need access to contraception and abortion in order to be self-determining about their lives. First we are accused of being irresponsible for having "too" many babies and now they want to deny us the contraceptives and abortion services that women need to be actually responsible for their lives. Do contraception and abortion opponents really care about babies or controlling our sexual behavior? You decide.

Florida State Grant Program Starts Call Center to Reduce Abortion

Many reproductive justice advocates are concerned about crisis pregnancy centers that deceptively advertise that they help women make their own decisions – such as whether or not to continue a pregnancy – but in reality steer women towards gruesome lectures to discourage them from having abortions. The state of Florida is now funding such operations with taxpayer dollars.

CareNet announced, in February 2006, its new 24-hour call center to help find alternatives for pregnant women considering abortion. The *Christian Wire Service* reported that The State of Florida allocated $2 million to a new program, which is jointly owned and operated by CareNet and Heartbeat International. The Florida Pregnancy Care Network (FPCN) retained the Option Line call center to serve as the official call center for the new state program. They report that the Option Line receives more than 10,000 calls, e-mails, and instant messages per month from women facing unplanned pregnancies. Kurt Entsminger, president of CareNet, stated, "CareNet is enthusiastic about this new program, which allows meaningful participation by faith-based organizations." CareNet is a non-profit organization that supports a network of 900 crisis pregnancy resource centers in North America. Among the services provided by these centers are free pregnancy tests, peer counseling and post-abortion support. In addition, qualified pregnancy centers offering counseling services and that abide by Florida's faith-based initiative guidelines will receive reimbursement by the Florida program. The FPCN will allocate the state funds to pregnancy centers that have been trained, approved by the FPCN and participate in the counseling services.

The irony is that while state funds are drying up for contraception coverage to prevent pregnancies, such as in Missouri, somehow taxpayer money can be found to support these problematic centers that encourage women to continue an unwanted and/or unplanned pregnancy.

Making the Silent Heard and the Invisible Visible

Reproductive Justice for Women in Prison

By Robin Levi

Reproductive Justice is three-fold: the right to have – and to not have – children and the right to parent the children we have. —- SisterSong

Overview

Justice Now welcomes the invitation of SisterSong to share the experiences of women inside prison in accessing Reproductive Justice. Women in prison are often forgotten when discussing the need for Reproductive Justice. They are forgotten by society; they are forgotten by social justice activists; they are forgotten by reproductive rights activists. They are forgotten because their voices are rarely heard. This is because women in prison are predominantly poor and of color, a population that in the best of circumstances is marginalized and invisible. Prison drastically increases that isolation.

Justice Now, a California-based organization dedicated to ending imprisonment as a purported solution to social ills, works collaboratively with women inside prisons, including women who are imprisoned in men's prisons, to document violations of their human right to Reproductive Justice and to find ways to remedy these abuses.

Through listening to women inside, we have learned how women in prison face numerous violations by the prison system to their right to Reproductive Justice, in particular, their efforts to build their families. While the right to have an abortion is critical and is often unavailable to women inside, most of the women we work with wanted to highlight their right to have a family. In this article, we will focus on abuses related to women's ability to give birth; however, the majority of women in prison are already mothers and they also want to retain custody and support their families when they leave prison, rights which are also embattled. We gathered the information contained in this article through working collaboratively with women inside prison to document abuses inside through direct and written testimony.

Background

Women of color are disproportionately imprisoned in the United States (Baldwin & Jones, 2000; Greenfield & Snell, 1999). There are approximately 170,000 women imprisoned in California. As of December 2005, the racial distribution of women in California prisons was approximately 28% African American, although respectively, they only comprise 6.7% of the population, 26% Latina, 39% white and 5% other (CDCR, 2005). The majority of people in California's women prisons are between 25 and 34 years, the prime childbearing years.

International Human Rights Principles

Similar to SisterSong, Justice Now uses the international human rights framework because it more fully encompasses the rights and responsibilities necessary for full Reproductive Justice. It provides a broader framework to discuss the intersections of discrimination that lead to reproductive oppression, as well as the intersections of rights, such as the rights to health, family, information, and freedom from discrimination that are needed to achieve full Reproductive Justice. A human rights framework both speaks to the need to demand rights, not ask for privileges and the need to connect with other women and struggles worldwide through using a universal, internationally agreed upon framework. It also highlights the government's role and responsibility in committing these abuses, a role that is often obscured.

Limitations on ratification and when the U.S. government fails to ratify human rights treaties (as it has failed to do so on most treaties) prevent individuals in the United States from securing these human rights through legal claims. Nonetheless, as activists we continue to use the human rights framework as our standard which should hold governments accountable.

Because women inside most often speak of their desire to have and maintain a family, we start with the right to family. The right to family is recognized in several treaties, in particular, Article 23 of the International Covenant on Political and Civil Rights (ICCPR) ratified by the United States in 1992. Article 23 states, "the family is the natural and fundamental group unit of society and is entitled to protection by society and the state." General Comment 19, expanding on this right, stated "the right to found a family implies, in principle, the possibility to procreate and live together." In addition, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which the US government has not ratified, protects the right of women to "decide freely the number and spacing of their children and to have the access to the information, education, and means to enable them to exercise these rights" in Article 16(1)(e).

The right to health is also a critical pillar for Reproductive Justice. Sadly, the right to health carries little weight in the United States. We challenge that position as a racist, sexist and classist construction, since it is those who are marginalized by such discrimination who most need their right to

Continued On Page 12 >>

From Welfare Queens to Gay Marriage

The Path to Compulsory Heterosexual Marriage?

By Suzanne Pharr

Since the federal government passed the Deficit Reduction Act in February 2006 with $1.5 billion dollars for marriage promotion, Wade Horn, Assistant Secretary for Children and Families at Health & Human Services under the Bush Administration, has developed a travelling road show promoting marriage in conferences with thousands of entrepreneurs and consultants called "marriage practitioners." These folks are making mucho dollares from the Bush Administration in what can be described as a marriage-promotion cult sweeping America. One of the marriage conferences with 2,000 participants was held in Atlanta June 20-26, 2006 during which the participants were instructed how to apply for marriage-promotion funding from the government. This is notably the same government that underfunds family planning, child welfare, health care and domestic violence programs. SisterSong participated in a protest organized by LIFETIME, a low-income mothers' organization in Oakland, CA. SisterSong joined this direct action because we are opposed to the government forcing marriage on those who don't want to be married (such as low-income women) while preventing those who do but can't because they are gay or lesbian.

A major icon of the Reagan era was the welfare queen, developed carefully in the media by conservative leaders to evoke taxpayer disgust and resentment. This icon was female, Black, unmarried, drove a Cadillac, and had gangs of children whose very existence brought her great financial benefits from the government. A major icon of the 21st century is the gay couple, developed carefully in the media by gay leaders to evoke sympathy and compassion. This couple is male/male or female/female, white, wants a wedding, drives a Subaru, and seeks benefits from the government. Both stand historically at the center of a swirling, culture-changing controversy about morals, values, money and power.

The welfare queen arose from the 1980s, a decade dedicated to globalization, corporatization, the trickle-down theory of economics, union-busting, deregulation, anti-taxation, and privatization. It was a forceful, and ongoing, agenda to bring more wealth to the powerful and to destroy the social contract that was created following the Great Depression. The idea that we pay taxes because we live in a community and must provide care for each other was replaced by the myth of scarcity and meanspiritedness: the idea that there is not enough to go around and someone is

Continued On Page 12 >>

U.S. Social Forum

Another America is Possible

By Titilayo Ihesinachi,, SisterSong Administrative Coordinator

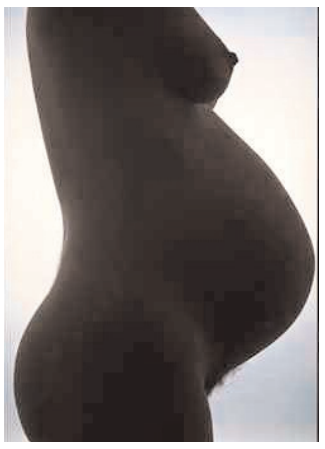
Atlanta will be the site of the U.S. Social Forum June 27-July 1, 2007 hosted by Project South and supported by SisterSong. A Southeast Regional Forum was held June 16-17, 2006 in Durham, N.C. which drew more than 550 activists from across the South. More than 20,000 people are expected at the 2007 U.S. Social Forum. SisterSong is working to ensure that many women of color participate in the U.S. Social Forum and that gender issues will be fully integrated in the event. For more information, go to www.ussf2007.org/ .

The World Social Forum (WSF), held annually since 2001, was created by members of the alternative globalization and anti-imperialist movements to coordinate campaigns, share and refine organizing strategies and inform each other about other movements and issues around the world. Attendees to the annual event consist of social movements, networks, non-governmental organizations (NGOs), and other civil society organizations opposed to neo-liberalism and a world dominated by capital or any form of imperialism. Since the first world forum in 2001, the WSF has become a permanent course of action, intentional about its international dimension, which seeks and builds alternatives to neo-liberal policies. The Charter of Principles, the WSF's guiding document, defines it as an "open meeting place" that is "plural, diversified, non-confessional, non-governmental and non-party." It proposes to facilitate decentralized coordination and networking among organizations engaged in tangible action towards building another world, at any level from the local to the international, without intending to be the body representing world civil society. The WSF is a global, multi-issue movement; it is not a group or an organization.

The World Social Forum has a tendency to meet in January when its "greatest capitalist rival," the World Economic Forum is meeting in Davos, Switzerland. The World Economic Forum is an alliance of business and political elites who mainly support and promote financial capital and the interest of transnational corporations. The WSF is intentional about its meeting date because of the logistical difficulty of organizing a mass protest in Davos and it seeks to overshadow the worldwide media coverage of the World Economic Forum. The WSF emerged from the alternative globalization and anti-imperialist movements against the Multilateral Agreement of Investments (MAI), which was signed by the richest countries of the world in 1998. This agreement was first discussed secretly by Organisation for Economic Co-operation and Development (OECD), presently comprised of 30 developed nation-states, including the United States, the United Kingdom, Japan, Spain, Germany, France, and Canada. The first critique of the MAI was made in the United States by the Public Citizens

Continued On Page 14 >>

Midwife Pleads Guilty to Practicing Medicine Without a License



Jennifer Williams, a Shelbyville, Ind., midwife, pleaded guilty in June 2006 to practicing midwifery without a license, the *AP/Louisville Courier-Journal* reports (*AP/Louisville Courier-Journal*, 6/16). Williams in June 2005 conducted the home birth of an infant who died. Williams faced charges of practicing medicine and midwifery without a license but did not face criminal charges of causing or contributing to the infant's death. Indiana prohibits the practice of midwifery by individuals other than licensed doctors or nurses with specialized training in obstetrics (*Kaiser Daily Women's Health Policy Report,* 5/25). Williams will serve one year on probation and, upon completion, could petition to have the felony conviction changed to a misdemeanor, Shelby County prosecutor Kent Apsley said. Williams will not be allowed to practice medicine or midwifery during the probation, Apsley added. "It is my hope that my case will illuminate the problems with the archaic midwifery laws in Indiana," Williams said, adding that she will spend time supporting attempts to revise the state's midwifery laws. According to Mary Ayres, president of the Indiana Midwives Association, Williams' case will allow Indiana to focus on removing laws that are "nonsensical and don't promote anyone's safety" (*AP/Louisville Courier-Journal*, 6/16).

The state of Indiana, along with nine other states, prohibits the practice of midwifery by non-licensed doctors and nurses. This case is part of an examination by *The New York Times* of whether the practice of midwifery by non-licensed doctors and nurses pose significant medical risks. The National Center for Health Statistics reports that 99 percent of all births occur in hospitals. Nurse midwives assist about eight percent of these births. According to the Midwives Alliance of North America, there are approximately 3,000 practicing midwives without formal medical training and about 1,100 are certified by the North American Registry of Midwives, which is a private agency recognized by 20 states. Kevin Burke, president of the Indiana State Medical Association, told *The Times* the hospital is the best place for labor and delivery because, "routine things sometimes become very un-routine." Annually, Indiana has about 1,000 home births. Reproductive Justice means determining your own birth options.

African Americans Underrepresented in Anti-Abortion Movement

In January 2006, the *St. Louis Post-Dispatch* reported on the low representation of African Americans in the anti-abortion movement. Black women make up only twelve percent of the female population in the United States; however, one-third of abortions are performed on Black women. Currently, federal and state data show that Black women have about three times as many abortions as white women. Although statistics show that a growing number of Black and Latino men are opposed to abortion, few people of color (especially women) are active participants in the anti-abortion movement. According to Rev. John Ensor of Heartbeat International, Blacks believe the pro-life movement is "a white, Republican, conservative movement." The *Post-Dispatch* also reported that some anti-abortion supporters recommend that organizations position minorities in leadership roles and make a serious effort to diversify its membership in order to strengthen the movement. *(Sound familiar?)*

photo by yaminah ahmad

Somebody in Virginia was apparently reading the St. Louis story. A month later, during the 2006 Pro-Life Conference held at Mount Gilead Full Gospel Church in Chesterfield County, Va., Black churches were urged to end abortion in the Black community. The two-day event, which took place in March 2006 and was attended by a reported 400 people and 20 organizations, encouraged pastors to join the anti-abortion movement. In 2003, the Virginia Department of Health data reported Black women had a rate of 30.2 abortions per 1,000 women ages 15 to 44, compared with white women who had a rate of 12 abortions per 1,000 women. Mira Signer, director of statewide organizing for Planned Parenthood Advocates of Virginia told the *Richmond Times-Dispatch*, "There is a real disparity in the health care system, in who can obtain preventive health care services." While organizers considered the conference a successful event, Day Gardner, director of Black Americans for Life admitted, "Many pastors are afraid they will offend women if they talk about it." In the opinion of SisterSong, they should be afraid – very afraid.

Black women are the backbone — foundation, whatever you want to call it — of the Black church. It may not be entirely wise for mostly male Black church leaders to tell their majority-female congregations what to do with their bodies and for their families. Women are not blinded by their faith, and they understand the connection of abortion to other critical issues such as economic justice, the environment, racism, and caring for Black children. In fact, as one SisterSong member put it, "Jesus died to save us from our sins, not to save us from our minds."

Stories such as these highlight the urgency of SisterSong's work to ensure that the African American community understands how the spectre of forced breeding (like during slavery) in the Black community is resurrected by the anti-abortion and anti-birth control agenda of conservative Republicans and Democrats. The Black community must also understand that attacks on abortion and birth control are cynically used to mobilize a conservative base of voters who are hostile to civil rights, human rights, LGBTQ issues, women's rights and immigrants' rights. But mostly, they are hostile to our Black children, pushing them out of schools and into jails.

On the other hand, the Black Church Iniative of the Religious Coalition for Reproductive Choice, led by Rev. Carlton Veazey, sponsored its 10th Annual National Black Religious Summit on Sexuality in Washington, DC July 11-14, 2005 with hundreds of participants (www.rcrc.org/). The Summit brought together religious leaders to discuss critical issues such as teen pregnancy, sexuality and religion, domestic violence, HIV/AIDS and other issues of reproductive health. Their Clergy for Choice Network maintains a national registry of clergy of all faiths who are dedicated to preserving reproductive rights and freedom for all. SisterSong is thankful that these religious leaders stand on the frontline against those religious leaders who would return women to the "barefoot & pregnant" days.

For more information on the history of the 400 years of activism by African American women on reproductive justice issues, please visit www.sistersong.net/publications.html for an article on African American women and abortion. Knowing our history helps us understand why there are so few Black women in the anti-abortion movement. Hopefully, there never will be.

Study Reports on Black Women in Low-Income Neighborhoods and Cervical Cancer Screenings

In a study published in the Feb. 1, 2006 edition of the journal *Cancer,* Black women living in low-income neighborhoods are less likely to regularly schedule cervical cancer screenings, *Reuters* reported. A team from the Harvard School of Public Health reviewed records of approximately 40,000 Black women registered in the Black Women's Health Study. Researchers examined participants' occupation, education, neighborhood, and the percentage of individuals living in poverty within those neighborhoods. With a working definition of regular screenings as within the last two years, researchers discovered that 8.3 percent of women did not have regular cervical cancer screening. It also reports that high school or lower education, old age, obesity and smoking are linked to lack of cervical cancer screenings. According to the report, neighborhoods with a 20 percent or higher rate of poverty are related to low rates in recent cervical cancer screenings. Geetanjali Datta from the Harvard School of Public Health told *Reuters,* "We can only speculate that [the disparities] might be due to a lack of resources, such as transportation, day care or health centers in deprived areas. There might be some benefit in neighborhood-level interventions focusing on high-poverty areas."

Women in Prison Continued >>

health protected. The right to health is enshrined in the Universal Declaration of Human Rights, the International Covenant of Economic, Social and Cultural Rights (ICESCR) and CEDAW. The first is not legally binding but carries authoritative weight in interpreting other rights. The latter two treaties have not been ratified by the United States. This right to healthcare states that all persons are entitled "to the enjoyment of the highest attainable standard of physical and mental health." Article 12, ICESCR. Although it does not include the right to be healthy, the right does encompass the right "to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation." ICESCR, General Comment 14.

We also found violations to the right to privacy (Article 17, ICCPR), the right to information (Article 19, ICCPR), and the right to be free from torture and cruel, inhumane and degrading treatment that is enshrined in Article 7 of the ICCPR and the Torture Convention, both which have been ratified by the United States.

Destruction of Reproductive Capacity

While imprisoned, abysmal health care has led a significant number of women to face destruction of their ability to conceive or give birth biologically, creating the modern equivalent of forced sterilization of women of color. For example, although women prisoners are at high risk for cervical cancers, annual Pap smears are performed erratically and follow-up is often nonexistent, thus permitting cancers to progress undiagnosed and unaddressed. In addition, we have spoken with several women who report having been coerced into full hysterectomies or the removal of their ovaries, including being asked to consent without full information. We also had a case of a woman with a cyst having the *wrong* ovary removed, even though removal for a cyst is rarely required.

These practices may violate Article 2 of the Convention on the Prevention and Punishment of the Crime of Genocide, which states in part:

Article 2: Genocide means any of the following acts committed with intent to destroy, in whole or in part, a national ethnical, racial or religious group, as such: (d) Imposing measures intended to prevent births within the group, and (e) forcibly transferring children of the group to another group.

One of the most obvious ways in which the California prison system fails to provide Reproductive Justice is through its abusive and negligent provision of Pap smears. Over the past 50 years, the Pap smear test has been an effective and inexpensive tool for the screening and early detection of cervical cancer that, combined with treatment, reduces mortality rates and complications associated with late treatment. Studies have shown that people in women's prisons are more likely to have risk factors for cervical cancer such as human papilloma virus, HIV, diets low in fruit and vegetables, and low socioeconomic status, than the population as a whole. *National Commission on Correctional Health Care, "Women's Health Care in Correctional Settings" (1994, revised 2005).* But despite this clear need for monitoring, the California prison system does not provide consistent or timely Pap smears and results. Rather, Pap smears are conducted in an unprofessional and inhumane manner, with little information or follow up.

When describing the Pap smears, women told us that they were painful and there was no privacy. One woman said, "You leave the office in pain. You can feel him scraping the side of your cervix." Others told us how the exams felt sexually abusive, "He pulled it in, pulled it out, pushed it out, pushed it in, pulled it out." And, "I felt disgusted and dirty. It took me back to having a sexual experience with a man that I didn't want to have." These negative experiences lead women to refuse later Pap smears — a potentially fatal decision. One woman told us, "I would refuse another Pap by him. I just couldn't do it, couldn't go through that again."

Many women do not need to refuse a Pap smear; they are never allowed to get a Pap smear. Some women went five years without being called for a Pap smear. Other women go through the process of submitting a co-pay of five dollars, and still face difficulty seeing a doctor and receiving a Pap smear. The co-pay itself is an excessive charge for a woman making 7-10 cents per hour, often forcing women to forego basic necessities such as toiletries.

In addition, very little information is provided to the women about the procedure. They are told what to do but not why they need the examination, what is being done during the examination, or what will happen after the examination. The results are not timely, nor are they confidential. Finally, follow-up care is often haphazard leading to devastating results. One woman told us, "I had a couple [of Pap smears] that weren't right. No one said anything until a year later." Another woman said, "I had to lose my reproductive system because I didn't get the care I needed."

Another way in which women's reproductive capacity is damaged is through the overly aggressive use of hysterectomies. Too often hysterectomies (or sterilization) appear to be the first choice solution to medical problems that may have more effective and less drastic cures. We have spoken with many women who have had partial and full hysterectomies (removal of the uterus, cervix, fallopian tubes, and ovaries), which were later deemed unnecessary, including two women who learned after their complete hysterectomies that they did not have the cervical cancer that was the purported reason for the hysterectomy. In another case, a woman received no follow-up care after receiving a hysterectomy for cervical cancer, putting her at risk for recurrence and death.

We also have heard from women who did not sign consent forms or were not fully aware when they signed the forms. In one case, the woman was sedated. Another woman at Central California Women's Facility (CCWF) was suffering from abdominal pain and was sent to a local hospital. While at the hospital, she was given a hysterectomy although there were no orders for the procedure. In addition, while performing the operation, the doctor punctured her bladder and she was unable to hold urine for four

Continued On Next Page >>

Welfare & Gays Continued >>

going to take "mine" from me. The social contract was broken when human needs were successfully portrayed as racialized problems that people of color had somehow wilfully created. The welfare queen was created by Reagan (and many conservatives before him) to represent the immorality, greed, and tax burden that are destroying our culture: a Black woman, under the authority of no man, who takes the money of good honest people who pay their taxes. The way to stop her and to save America was to eliminate those taxes and cut those benefits right out from under her.

The marriage-seeking gay couple arose from the culture wars of the past three decades in which sexuality outside of marriage was bad, family was narrowly defined as married couples with children, and allegiance to country was blended with belief in heterosexual, monogamous two-parent families. Good gay people increasingly became identified as those who passed and who sought ways to mainstream into a culture whose norm was white and middle-class. By the 1990s, not many LGBT organizations were taking on the broken social contract that was fracturing our society; instead, they were for the most part seeking equality in a vastly unequal world. It was then that the path of the welfare queen and the good gay couple began to merge. And the Right figured out how to combine racism and homophobia in its strategies to move both its economic and social agenda.

Their common road was displayed in 1992 in the two landmark ballot measures in Oregon and Colorado. These constitutional amendments called for prohibiting "minority status" and "quotas" for lesbians and gay men—that is, prohibiting something that no one in the LGBT community had ever called for. In their campaigns, they argued that "gay rights are special rights" and that only "deserving minorities" should receive civil rights, i.e., special rights. What they successfully accomplished in these campaigns was to redefine this country's understanding of civil rights to be special rights (as opposed to civil rights being constitutionally granted to all) and to make people think that one had to be deserving in order to receive them. And who became defined as not deserving? Why, of course, LGBT people, depicted by both the mass media and our own as white, and the Black welfare queen. These amendments, defeated in Oregon and passed in Colorado, prepared the groundwork for the Right to attack affirmative action as a special right and to take to Black communities the message that white gay men and lesbians are challenging both their morality and their civil rights gains.

These cultural, religious, and economic wars continue. The welfare reform act has virtually demolished welfare; no elected official dares to support increased taxation despite an enormous national debt, impoverished state governments, and diminishing human services. Churches have become a major force in politics, and gay rights, abortion, and immigration remain the hot button issues of the media and elections. These conditions are the landscape for another shared path of the welfare queen and the gay couple.

This time, there are two seemingly separate but connected agendas, and both promote marriage. The Rightwing's "pro-marriage" agenda comes with $300 million from Bush for marriage promotion for those who receive welfare, initiating a distinction between good families (married) and single parents (welfare queen). For the last decade, the Right's web pages have been filled with concern about the breakdown of marriage, the need to keep gay marriage from weakening it further, and more importantly, with definitions of healthy families. They are set on a course to define narrowly what a legitimate family is and what support it can receive through church-based initiatives that deliver government benefits. This path leads to compulsary marriage granted by the state, delivering the benefits to small social units held under the authority of men and easily identified and controlled. Such units fit in nicely with the massive identification and surveillance of Homeland Security, whereas loosely woven, broadly defined families do not.

The "gay marriage" agenda seeks the full benefits of marriage at the moment when these benefits are disappearing through the loss of the social contract. The fight is for access to one's partner's insurance coverage at a time when insurance is dwindling, for access to one's partner's social security benefits at a time when social security is in complete jeopardy, for tax benefits when taxes are not the issue but services are. Framed as a civil right, this course seeks equality in a world that daily destroys economic justice and creates a fractured society. As does the Right's pro-marriage agenda, it calls for benefits, however few they might be, to be tied to legality and legitimacy, determined by the state.

LGBT engagement in the battle for marriage as a single focus risks missing the larger issue that surrounds it: how family is defined and, through that definition, who is determined to be legitimate in this society, who has standing, privileges, benefits. A narrow definition is based on state-determined legal status and includes who can adopt, who can provide foster care, who can retain custody, who can have in vitro fertilization, who is eligible for benefits—and ultimately, who has legitimacy as a full person in society. The Right's effort to restrict the definition of family far overshadows the agenda to enforce heterosexual marriage.

Because the relentless constitutional amendment campaigns have opened every door for discussion of marriage, we now have a chance to use the marriage debate to move toward a larger goal. We as LGBT

Continued On Next Page >>

Women in Prison Continued >>

months until she had surgery to repair the fistula. Another woman was told that the hospital would schedule a radical hysterectomy although they did not have her medical charts. When she said she might not consent, she was told that she had to. Justice Now got her released from prison in order to have her surgery elsewhere.

The medical abuse and neglect of women's reproductive health are not limited to hysterectomies. One woman received radiation treatment for cervical cancer 9 months after diagnosis that permanently damaged her ovaries, as well as her intestines and digestive tract, and she was left unable to have children. We have seen several cases with women with yeast infections and or prolonged periods of vaginal discharge and bleeding who go several months without any treatment. In these cases, the chances of infertility were dramatically increased through the prison's neglect.

Finally, gender discrimination also limits access to care; a woman at CCWF sought medical treatment for symptoms of pelvic inflammatory disease. The doctor told her that she could not have that disease because she was a lesbian. We also have received reports of women in men's prisons not receiving mammograms and Pap smears when they are medically necessary.

Another way that women in prison's right to Reproductive Justice is obstructed is through the disproportionately long terms of imprisonment that many of them have received, either through mandatory minimums for drug crimes or because of receiving a third strike, which is a California law requiring life sentences for a conviction if she already has two previous serious felony convictions. These sentences leave many women imprisoned through their reproductive years, the years when they could conceive and give birth to children, especially since most of these women will not have access to assisted reproductive technology when they are released from prison.

Violation of Right to Safe Motherhood

Pregnant women in California prisons, many of whom are high risk due to past histories or poverty or malnutrition, face rampant violations of their human rights. Doctor visits for pregnant women are infrequent and erratic. In some cases, prison medical staff has ignored obvious warning signs of complications, such as extensive bleeding and cramping. Special dietary requirements are not met and despite recent changes in the California state law, some, if not many, women are still shackled during labor and after delivery. And post-natal care is virtually nonexistent.

Underlying this abysmal care is a complete lack of respect for the humanity of pregnant women in prison and their real and legitimate desire to build their families. When interviewing women in California about their doctor-patient relationship, all responded that they did not have a relationship with their doctor. One woman was told by her doctor, "If you wanted better care, you shouldn't have gone to prison."

This disregard for women leads doctors to ignore obvious signs of complications. Another woman told us that when she went to the doctor with complaints of bleeding heavily, he told her the problem was pulled ligaments and sent her back to her cell. Her premature daughter died shortly after birth.

Every woman we speak to raises concerns about her prenatal diet. Despite clear medical advice, there is no special diet for pregnant women. They do not receive extra food; the fruits and vegetables are often inedible, they only get an extra 4 oz. carton of milk and occasionally folic acid/iron supplements.

In addition, the California prison system is slow in transporting women in labor to the hospital and disrespectful in the process. One woman was told, "Shut the fuck up, you're not a baby, stop screaming." Another woman said that it took them an hour and a half of her screaming before they transported her to the hospital, "they don't rush, they never rush." A nurse made another woman check her own amniotic fluid and then sent her to the hospital in her underwear, which her ambulance attendant said was "ridiculous."

In all cases we researched, women are shackled during labor and after giving birth. Thus, they cannot walk around, although walking has been shown to promote labor and post-birth healing. Women have to request permission from prison staff to use the bathroom.

Post-natal care is also substandard. We spoke to one women who did not have the staples from her C-section removed until several weeks later. Most of the women we spoke to, including a woman in remission from cancer, never received the customary 6-week post- natal appointment. Women routinely have their hospital-prescribed pain medications taken from them when they return to prison and are often unable to receive more, even through the pharmacy.

Conclusion

Because most of these abuses arise from the fundamental disrespect of women in prison, legal reforms have had little impact. For example, in October 2005, California passed AB478, which requires the California Department of Corrections to establish minimum standards of care for pregnant women and to transport pregnant women in the least restrictive way possible, including a presumption against shackling. Nonetheless, we have seen little, if any, change in the care and treatment that pregnant women receive. In fact, in April 2006 while on a visit to a hospital that houses women prisoners, one of our staff attorneys saw an official notation that a laboring woman was in shackles.

Consequently, to truly remedy these abuses we need to begin to address the root of the problem and end the use of prison and policing to address social ills, a policy that disproportionately affects black and brown people and our communities. The first step is to radically reduce the number of people in prison through simple, cost-saving decarceration strategies. In addition, while working to lower the number of people in prison, as advocates for Reproductive Justice for women of color, we need to ensure that we hear and amplify the voices of women in prison and their desire to build healthy families.

Welfare & Gays Continued >>

people do not want to contribute to a more restrictive, authoritarian society, especially one that particularly targets African American single mothers. We can take this moment to move the debate from marriage to the definition of family and the social contract.

What, then, are some ways the LGBT community can move in concert to achieve common goals in a time in which the focus by the Right and our own people is on marriage? We can seize the moment and use it to shape what we want. Because the television sits at the center of most homes, this discussion of marriage is going on everywhere. There is no more silence or denial about the existence of LGBT people. Now is a rare moment of great opportunity to talk about every issue of importance to us.

Those issues are many, but I would place family high among them. This is not an argument for saccharine images of couples and children or for nostalgic images of two adults and children in a small house with a picket fence. Instead, it is recognition that our strongest social formations are small and are found in the ways we are bound to one another by commitment, love, loyalty, responsibility, and sometimes, but not always, biology. Worldwide, these formations are called family, tribe, clan—one's people. What we have called family in the U.S. has been fluid over time. Today, what we know as family (but is not necessarily legally recognized) includes many configurations: blended families of married couples and their children and relatives from other marriages; LGBT couples, with or without children; grandparents raising children; single parents and their children; unmarried people and their chosen families of committed friends; nuclear families; unmarried people living together; unmarried individuals and their children; old people living together for companionship and economics; married or single people with adopted or foster children—families who always have room for one more, whether blood related or not.

What we have in common is that we all want recognition and respect for our relationships, the means to take care of each other, freedom from unjust authority, a legitimate place in our communities. To achieve these goals, we will have to develop some strategies such as these:

•Use our skills, born of necessity, for creating chosen families (we are experts);
•Broaden the definition of family within state agencies;
•Gain legal recognition of a wide range of relation
ships;

Continued On Next Page >>

Welfare & Gays Continued >>

•Separate benefits and privileges from marital status;
•Work to establish a strong social contract that protects human rights and guarantees universal healthcare, genuine disaster relief, affordable housing, etc.
•Build new cultural traditions for honoring relationships in ways that are not controlled by either the church or state;
•Join with others who face state opposition to their family composition and/or rights: immigrants, old people, single parents, former prisoners, battered women, poor people.

It makes sense that so many of us seek marriage because of our deep longing for public commitment or because of economic need. While a marriage strategy meets some of our individual short-term goals, we have the opportunity now to build a movement strategy that includes everyone and gives us much more. As Kay Whitlock (*In a Time of Broken Bones*) says,"We can follow a strategy that permits us to build bold, new relationships across many constituencies struggling for the integrity, stability, and security of many kinds of families and households. Far from being a tactical retreat, this approach stakes out new ground that permits us to forge new approaches to shattering the power of homophobic and racist 'wedge' politics. And it creates new terrain on which to engage countless faith communities that care passionately about economic justice. By its very nature, it deconstructs the lethal sense of 'us' and 'them' that have stalked the marriage wars."

Our efforts for recognition of our lives and our right to be free and fully human are intimately connected with others who suffer injustice and who struggle for fairness and human dignity. Why not take this moment to go for what we want for all of us: a free and just society that is inclusive and provides broadly defined human rights based on equality and justice. Why not include it all in our vision: our individual and collective rights to food, clothing, shelter, education, health, a clean environment, a living wage, safety, and relationships of our choice.

U.S. Social Forum Continued >>

Movement, led by Ralph Nader and Lory Wallach, and was published by the French newspaper, *Le Monde Diplomatique*. The article sparked intense debates, which led to France's withdrawal from signing the agreement. These alternative movements, composed of activists, economists, environmentalists, sociologists, workers, peasants, and human rights activists, work against the neo-liberal paradigm and the foundation of Davos, including drawing international attention to effective movement building that counters this paradigm.

The first World Social Forum was held from January 25-30, 2001, in Porto Alegre, Brazil, organized by many groups involved in the alternative globalization movement. The WSF was sponsored, in part, by the Porto Alegre government, led by Partido dos Trabalhadore (PT), the Worker's Party. The town of Porto Alegre was experimenting with an innovative model for the local government that combined traditional representative institutions with the active participation of open assemblies of the people. Also at that time, Brazil was in a moment of transformation that would later lead to the electoral victory of the PT candidate Luiz Inácio Lula da Silva. More than 15,000 delegates came from 131 countries, representing 4,909 organizations. They attended more than 24 plenary meetings, 100 seminars and 700 workshops. Furthermore, there were 3,000 journalists from 48 countries and between 50,000 and 60,000 people came without delegates' credentials. Among the delegates were 2,300 campesinos (peasant farmers) and 2,600 trade unionists. The WSF website was visited by half a million people daily during forum.

The 2002 World Social Forum, also held in Porto Alegre from January 31 to February 5, had over 12,000 official delegates representing people from 123 countries, with more than 60,000 attendees and 652 workshops. The third WSF was again held in Porto Alegre, January 23-28, 2003, with more than 100,000 attendees. There were many fascinating workshops, including, for example, the *Life after Capitalism* workshop, which proposed focused discussion on non-communist, non-capitalist, participative possibilities for different aspects of social, political, economic, and communication structures. The 2004 WSF was held in Mumbai, India, from January 16 to 21. The attendance was expected to be 75,000, but according to the organizers in Mumbai, an estimated 120,000 people took part in WSF activities from 130 countries around the globe. The fifth WSF in 2005 was held in Porto Alegre, January 26 to 31, with more than 150,000 participants.

In 2006, the sixth World Social Forum was polycentric, where decentralized, simultaneous meetings occurred in different places around the world in January and March. The decision to hold a polycentric WSF in 2006 was made during the 2005 WSF International Council (IC) meeting. The three cities that held the WSF were Bamako, Mali (January 19 to 23); Caracas, Venezuela (January 24 to 29); and Karachi, Pakistan (March 24 to 29). In addition, there was a social forum event held in the United States: the Boston Social Forum, July 23-25, 2004, with 5,000 participants and 575 workshops. Additionally, there is an increasing demand to have more of these forums in the United States, with movement building towards a WSF-type social forum held in the U.S. in 2007. Why would we need a social forum in the United States?

The **U.S. Social Forum (USSF)** comes at a significant time in American history. The conservative political Right dominates the legislative, executive, and judiciary branches of government. The military is consumed by the questionable occupation of Iraq and Afghanistan as public support for these invasions erodes. The Hurricane Katrina disaster and the inexcusable failure of the federal government to respond to the people's needs illuminated the race and class divisions in the U.S. These interrelated events provide the impetus for the USSF to provide a process for movement building in this country based on the organized voices and experiences of those on the grassroots most affected by the U.S. and global injustices.

The U.S. Social Forum enables progressive forces to mount an effective national response to issues such as the Gulf Coast tragedies; corporate scandals; government corruption; privatization of public resources; a deteriorating education system; a widening gap between the rich and the poor; deregulation; corporate welfare; government corruption; monopolization of the media; a ballooning federal deficit and attacks on our civil liberties. Despite these challenges, the progressive movement remains disconnected and fractured along geography, gender, race, class, and issues. The fragmentation of the largest labor federation, the scandals within the Catholic church and mega-churches, and the backlash against several politicians of color clearly demonstrates the lack of political strength. There is a rising need for greater convergence among progressive activists and an intention to create a space for alternative movement building in the United States for these activists to articulate a conceivable vision for "another world." At its conclusion, the USSF will communicate effectively and confidently the values and strategies of progressive civil society in the United States. Those who participate in the USSF are no longer interested in stating what social justice movements oppose; rather we are part of movements that transcend national boundaries, practice democracy on all levels, and convey the world we want.

Now that we understand the need for the U.S. Social Forum, how do we decide on where it will be held? The USSF will be more than a conference, a networking event, or a "strong" anti-war response; the USSF is the next most important step in our struggle. Movement building for social justice demands disruption and transformation of the status quo. To revolutionize the nation, we must revolutionize the South. The southern site of the USSF marks a new movement in the United States for social and economic justice. Oppression, injustice, exploitation, and social control have deep, entangled roots in Southern soil. The South has also cultivated significant battles for indigenous self-determination, black freedom, working class emancipation, and human liberation. Hosting the USSF in the South builds political potency for a powerful movement to challenge white supremacy, imperial domination, worldwide genocide, ecocide, and all other manifestations of global capitalism.

After gathering 150,000 people in Porte Alegre, Brazil earlier this year, it was decided there would be regional social forums to culminate for a World Social Forum in 2007. The WSF committee delegated Grassroots Global Justice (GGJ) to coordinate a U.S. Social Forum that represents those most adversely affected by the ravages of globalization and neo-liberal policies. GGJ is an alliance that grew out of people-of-color-led grassroots groups and organizations who participated in the first WSF. These grassroots leaders initiated a process to create a U.S. Social Forum Planning Committee, and Atlanta, Georgia, was selected as the host city for the 2007 USSF.

How relevant is the U.S. Social Forum to your work or activism? If you fight against social injustice and challenge the consequences of neo-liberalism, capitalism or any form of imperialism, you should come to the 2007 USSF. We call on you to reflect on the potential of our positions and the power of our connections. Although movement leaders have built organizations that embark on integrated, multi-issue, multi-racial strategies, we have yet to build our movement on a scale relative to our brothers and sisters in the global South. The first USSF offers a historic opportunity to advance our collective work to build grassroots leadership, develop collective vision, and formulate strategies to grow a strong movement in the United States that mirrors and works collectively with the alternative globalization and anti-imperialist movements of the global South.

For more information about the 2007 U.S. Social Forum, please contact Project South at (404) 622-0602. For more information about the World Social Forum, you may visit the following websites:

http://www.worldsocialforum.org,http://www.wsf2006karachi.org,

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LAS OLVIDADAS/THE FORGOTTEN ONES
Latinas and the HIV/AIDS Epidemic
Hispanic Federation

While Latinos account for 14% of the U.S. population, they account for 20% of new AIDS cases and 18% of the cumulative AIDS cases in the United States. HIV/AIDS has had a devastating impact on Latino communities and is responsible for the death of more than 92,000 Latinos in the United States through 2003. The Centers for Disease Control estimates that more than 80,000 Latinos are currently infected with AIDS, signaling that the HIV/AIDS epidemic will continue to devastate Latino families and communities well into the future. [1]

Latinas have been especially hard hit. The rate of infection among Latinas as a proportion of all Latino AIDS cases has climbed from 15% in 1990 to 23% in 2002.[2] This change represents a 53% increase in the number of Latinas with AIDS since 1990. Latinas now account for 21% of all AIDS deaths among women,[3] with AIDS becoming one of the leading causes of death for Latinas between the ages of 25-44.[4]

Despite these facts, Latinas remain virtually ignored by health policy makers and are one of the most underserved HIV-affected populations. For instance, in New York, the epicenter of the HIV/AIDS crisis, there are only a handful of Latina-centered HIV programs to meet the needs of thousands of Latinas who are HIV positive or at risk of HIV.[5]

Not surprisingly, HIV/AIDS continues to disproportionately impact Latinas, their families and communities. Latinas are more likely to be unaware of their positive HIV status, to learn of their HIV diagnosis at later stages of disease progression, and face numerous obstacles in accessing health care services. They are also more likely to experience considerable discrimination and patient-provider communication barriers that affect the quality of care they receive.

Latinas are most certainly *"Las Olvidadas" — the Forgotten Ones*. The price of such neglect has been the unacceptable loss of many Latina lives that have left Latino families and communities fractured and vulnerable.

This report is a Call to Action! The report and action agenda provides an analysis of key factors fueling the HIV/AIDS epidemic among Latinas and offers policy recommendations and action strategies to address Latinas' priority needs. The analysis and recommendations provided are framed from a social justice perspective that takes into account the intersection of race, ethnicity, class, gender and immigration status, among other factors. The report concentrates on the experiences of Latinas in New York, the state with the highest AIDS case rate and the largest concentration of Latinos living with AIDS. However, similar trends are occurring across the country and the action agenda is designed so that it can be easily adapted to the needs and circumstances of other states, as well as national advocacy efforts.

Creating an Engine for Latina Activism and Leadership

The Latina HIV/AIDS crisis will only worsen without aggressive action from key legislators, public health officials and institutions, the media and community-based organizations. Latina advocates must be front and center in articulating Latina-centered strategies and solutions and successfully advocating for their adoption. Towards this aim, the following steps must be undertaken:

1. Building Capacity: The Need for a Latina HIV/AIDS Advocacy Coalition Efforts to address the HIV/AIDS crisis among Latinas will require that we galvanize our best thinkers, community leaders, heath care providers and strategists under a single, unified and powerful advocacy umbrella consisting of a Latina HIV/AIDS Advocacy Coalition. By bringing together health experts, health providers, researchers, advocates, civic leaders, consumers and health policy makers, the Latina HIV/AIDS Advocacy Coalition can garner the nec essary expertise and strategic insight necessary to articulate cutting-edge strategies and solutions to address the rising tide of HIV/AIDS among Latinas. An investment in the development of a permanent infrastructure will enable the Latina HIV/ AIDS Advocacy Coalition to regularly pool the advocacy resources of its organizational partners, establish early credibility and enhance its negotiating position and leveraging power in support of its goal.

2. Development of a Latina AIDS Agenda and Advocacy Campaign

One of the coalition's initial steps must be to build broad-based consensus concerning the top priorities for strategic action that will most effectively address the prevention barriers and health access problems faced by Latinas. Towards that aim, sponsorship of a Latina AIDS Summit (the "Summit") to develop agreement on priority needs and strategies would generate a shared vision and advance coordinated action. The Summit would serve to galvanize and facilitate dialogue among diverse sectors of the Latino community in order to work cooperatively to establish an agenda for action and map out a Latina AIDS Advocacy Campaign with measurable goals and objectives to achieve strategic impact.

3. Investing in Public Education and Strategic Communications

For the most part, Latino/as and non-Latinos alike remain unaware of the serious HIV prevention barriers and health access problems affecting Latinas. As a result, Latinas public health needs are fre quently and more readily overlooked by public officials. A wide-scale public education and strategic media campaign must be developed that educates the general public about the HIV prevention and health care needs of Latinas. The campaign would also serve as a strategic vehicle by which to hold elected officials accountable for adopting sound public health policies and promoting increased HIV/AIDS funding and services for Latinos. Since many laudable advocacy campaigns have been lost not on their merits but based on public perceptions, it is imperative that the Latina HIV/AIDS Advocacy Coalition develop the capacity to continually assess and influence public opinion. Conducting periodic assessments is an important step in developing a program of communication and action that promotes the publics' understanding of the issues and generates appropriate levels of support.

4. Promoting Grassroots Organizing and Leadership Development

Most importantly, the Latina HIV/AIDS Advocacy Coalition must also be able to build a vocal, sophisticated and diverse constituency base with the capacity to mobilize quickly and efficiently and to continually inform policy positions through regular dialogue and active participation in a wide range of advocacy activities. This effort could entail focusing on developing Latina leadership through the development of local community advocacy networks, peer leadership programs, sponsorship of community meetings and HIV/AIDS advocacy "teach-ins", as well as providing technical assistance to local groups engaged in AIDS policy and advocacy activities.

In summary, the Hispanic Federation and the LUCES coalition believe it is crucial that Latino communities across the nation take bold, proactive steps to demand that increased health funding and services be directed to Latinas. The strategies described above represent a first step in this effort. We hope the report will serve as one of several vehicles by which to generate discussion and strategic action to address the HIV prevention and service needs of Latinas in our communities.

The Hispanic Federation published this report. In order to read the entire report, please visit www.hispanicfederation.org

[1]Centers for Disease Control and Prevention (CDC), "Combating HIV/AIDS: Protecting the Health of Latino Communities," CDC Website 2000, 1 Oct. 2004 <http://www.cdc.gov/hiv/pubs/brochure/latino-report.pdf>.

[2]Sonia Ruiz, Jennifer Kates and Claire Oseran, HIV/AIDS Policy Fact Sheet: Latinos and HIV/AIDS (Washington, DC: KFF, 2003) Publication No. 6007.

[3]Cynthia Guaba, "Latinas, The New Face of AIDS: Su Salud, The First Part of a Two Part Series," The Dominican Times Mar./Apr. 2004, 20-1.

[4]Guaba 20.

[5]Guaba 20.

Parental Notification of Abortions Will Hurt California's Latinos

By Dolores Huerta & Rocio Cordoba,

Nov 04, 2005

Proposition 73, a parental notification ballot initiative, was defeated in California in November 2005 by a coalition of grassroots activists despite the wishes of Governor Schwarzenegger. Dolores Huerta, co-founder of United Farm Workers, and Rocio Cordoba, Executive Director of California Latinas for Reproductive Justice and a SisterSong member, write about why they successfully worked to defeat this initiative.

In speaking out against Proposition 73 throughout California, we're often asked: "Why should Latino families oppose Proposition 73?" "Aren't they much too traditional or religious to get involved with this controversial issue?" "What difference will it make?" It's clear that public perceptions about Latinas and Latinos continue to remain fueled by myths that bear no resemblance to the real conditions facing our community.

The reality is Proposition 73 would have an overwhelmingly detrimental effect on the Latino community by limiting Latino youth's access to safe, confidential health services thereby endangering our most vulnerable young women. Proposition 73 seeks to amend the California Constitution to require parental notification and a 48-hour waiting period when teens seek an abortion. While Proposition 73 will place all California teens in danger, this initiative would have a unique effect on the health and well-being of the state's Latino community.

While the overall teen birth rate in California has decreased during the past decade, the birth rates of Latina teens in the state are three times higher than those of white teens. According to a recent study by UCLA's Center for Health Policy Research, California Latinos also continue to have the highest uninsured rates among all racial and ethnic groups. Nearly one-third of California's Latina women are uninsured, representing 56 percent of the state's uninsured women.

Clearly, Latino families need more access to health care and information, not less. Forcing young Latinas to tell their parents that they are having an abortion will make them less likely to seek critical health care services. Research shows that the guarantee of confidentiality is a key factor influencing whether teens will seek access to health services. In fact, according to a study published in the *Journal of the American Medical Association*, 47 percent of teenage girls seeking reproductive health care would completely stop seeking these services if parental notification were mandatory. Leading medical, public health and youth-serving organizations uniformly support minors' right to confidential care, even as they urge health care providers to help teens talk with their parents about sex and reproductive health.

Most teens talk to their parents about important decisions. In states without parental notification laws, a study by the Guttmacher Institute found that in more than 61 percent of young women who had abortions, one or more of their parents knew about them. Young women who don't tell their parents have real fears of physical harm by family members -- being kicked out of the house, or worse. Proposition 73 could force the most vulnerable Latina teens to take matters into their own hands instead of getting the care they need. That's why doctors, parents and nurses opposed Proposition 73, because in the real world, mandatory notification laws put teens in danger.

La Opinión, the leading Spanish-language daily in California, agrees, noting in a recent editorial: "There are certain special circumstances which demand that our daughters' privacy be kept to protect their safety – circumstances involving violence or sexual abuse at home."

The so-called "judicial bypass" procedure written into the measure -- which permits a young woman to obtain a court order waiving parental notification based on evidence of her maturity or best interests -- would not help. It would force young Latinas to face an overcrowded, overburdened and complicated court system. A scared, pregnant teen will have the additional burden of explaining the most intimate details about her pregnancy and home situation to strangers – including court officials, a legal guardian and a judge. Teens who may be new to this country, or whose home language is not English, will face additional hurdles. Teens in rural communities may not have transportation to reach a courthouse in the first place. These teens don't need a judge; they need a counselor and safe access to medical care.

In our conversations with Latino parents, we've discovered that they need and want real solutions, like programs to promote voluntary family communication about sexuality, enforcing comprehensive sex education in our schools, access to confidential and culturally appropriate reproductive health services, and positive programs to promote teens' future opportunities. Proposition 73 does nothing to provide the kind of support Latino families are looking for.

Finally, Latino families don't need a law that would raise barriers to their rights to self-determination and privacy. The California Supreme Court already ruled in 1997 that a parental consent law was unconstitutional because it violates a minor's right to privacy. This law was never enforced because it endangers teens' lives.

Latina women, communities of color and poor women historically have experienced governmental attempts to regulate their reproductive lives – from forced sterilization to coerced use of long-lasting contraceptives to forced childbearing when it was against their best interests. We can't let this type of oppression take place in California. We must resist forces that are seeking to deny women and teens the right to make informed choices about their reproductive health and self-determination.

We urge Latino families to seriously consider the negative effects Proposition 73 would have in our communities. As the largest growing segment of our state, we must demand that California's laws promote the health and well-being of families rather than placing our most vulnerable young women in danger. We can't let public perceptions of Latino families be used as an excuse to keep us silent.

Dolores Huerta, co-founder of the United Farm Workers Union, and Rocio Cordoba, Executive Director of California Latinas for Reproductive Justice, are statewide co-chairs of the Campaign for Teen Safety. Reprinted from Pacific News Service.

THE REPRODUCTIVE HEALTH OF LATINA IMMIGRANTS

By National Latina Institute for Reproductive Health

Fact Sheet • December 2005

Introduction

Over the past 20 years, the United States has experienced one of the largest waves of immigration in its history. Unlike the early 1900s, when the majority of immigrants came from Europe, the bulk of immigrants in the United States in 2000 were born in Latin America.[1] It is estimated that 40% of Latinos in the United States are foreign born.[2]

Without a doubt, Latinos are the fastest growing minority group in the U.S. Latinas already account for one in every seven U.S. women of reproductive age.[3] As a result of the growing number of Latinas and their contribution to the overall health of the nation, the health status and needs of Latina immigrants should be a matter of great concern to advocates and policy-makers.

Barriers to Access

Several studies indicate that Latina immigrants are less likely to receive adequate reproductive health care, including annual Pap smears, contraceptives, HIV treatment, and sex education, than white women. Immigrant women are less likely to receive appropriate reproductive health care as a result of significant barriers. Specifically, Latina immigrants often lack access to health care coverage, basic information, and culturally and linguistically appropriate services.

Health Insurance Coverage and Socioeconomic Conditions

Lack of health insurance and overall poverty are significant obstacles that may jeopardize the reproductive health and well-being of Latina immigrants. Nearly 32% of all immigrants are uninsured, compared to only 12% of those who are U.S.-born.[4] In fact, low-income Latinas are less likely than low-income African-American and white women to have health insurance; 43% of low-income Latinos were uninsured in 2002, in contrast with 25% of low-income whites and 26% of low-income African-Americans.[5] Latina immigrants who lack health insurance coverage are more likely to delay treatment, not fill prescriptions and go without important preventative medical procedures such as a Pap smear.

Access to health insurance often depends on two key factors–employment and socioeconomic conditions. However, according to studies, Latina immigrants are more likely than U.S.-born individuals to be uninsured even when taking a number of factors into account, such as employment, education and health status. Many Latina immigrant workers do not have employer-based coverage because they work in industries that do not provide health insurance. Low-income and unemployed Latina immigrants may not know that they are entitled to publicly funded health coverage or they may fear that their immigration status would be jeopardized if they seek health care.

Medicaid

Medicaid provides low-income women with funding for necessary reproductive health care services, such as family planning, prenatal care and testing for sexually transmitted infections (STIs). However, eligibility varies across states and is often linked to stringent requirements. Thus, many low-income women do not qualify for Medicaid and medical providers are often reluctant to accept Medicaid patients.[6]

As a result of the 1996 Personal Responsibility and Work Opportunity

Continued On Next Page >>

Reconciliation Act (PRWORA), Latina immigrant women face even more barriers to accessing Medicaid benefits. Under PRWORA, states are restricted from using federal funds to provide Medicaid coverage for immigrants who have resided in the U.S. for less than five years. Not surprisingly, studies have found that Latina immigrants with less than five years in the U.S. display significantly higher rates of non-insurance. Lack of health insurance among Latina immigrants is arguably the result of restrictive Medicaid eligibility rules. By restricting eligibility in this arbitrary manner, the federal government is currently limiting Latina immigrants' reproductive health choices and preventing low-income Latina immigrants from receiving appropriate and needed care.

Information and Education

A high percentage of Latina immigrants who reside in the U.S. are natives of developing countries. These women come to the U.S. to escape poverty in hopes of improving their families' futures. Some Latina immigrants have only a few years of formal education. Lack of formal education has been found to be associated with poverty, unemployment, and limited basic health knowledge.[7] One study found that lack of basic health education and information among Latina immigrants may deter them from using available medical services.[8] Community health education programs must be emphasized and incorporated into the reproductive health agenda in order to improve Latina immigrants' understanding of the health care system and its services. Health education and information may potentially help Latinas play a more active role in their reproductive health care.

Cultural and Linguistic Barriers

Language and cultural differences between Latina immigrants with limited English proficiency and their providers is another factor that can have a detrimental effect on women seeking reproductive health care. Only 5% of U.S. physicians and 2% of nurses are Latino/a.[9] Many clinicians do not speak Spanish and do not have on-site interpreters. Studies have found that, as a result, some Latina immigrants are forced to use their children as translators, suffer physical harm from misinformation or a misdiagnosis, and are often not satisfied with their visits to reproductive health care providers.[10] A provider's ability to communicate in a culturally and linguistically appropriate is especially important in the reproductive health care context.

Statistics on Health Disparities

Latina Immigrants and HIV/AIDS

HIV/AIDS is one of the leading causes of death for Latinas. Moreover, Latina immigrants living with HIV/AIDS in the United States are disproportionately poor and lack the necessary resources to obtain proper treatment.[11] Experts believe that Latina immigrants new to the U.S. lack knowledge about reproductive health issues and are less likely to negotiate condom/contraceptive use, making them extremely vulnerable to HIV/AIDS infection.[12]

- Among women, the AIDS case rate for Latinas is more than 5 times the rate for white women (12.9 per 100,000 compared to 2.4).[13]
- Latinas represent 20% of women diagnosed with AIDS in the U.S.[14]
- In 1991, Latinas represented 15% of new AIDS cases reported among all Latinos in that year: by 2001, Latinas represented almost one-quarter (23%) of new cases reported among all Latinos.[15]
- AIDS cases among Latinos vary by place of birth. Latinos born in the U.S. account for 43% of AIDS cases reported among Latinos, followed by Latinos born in Puerto Rico (22%) and Mexico (14%).[16]
- About one quarter of Latinos with HIV/ AIDS (24%) are uninsured compared to 17% of whites.[17]
- Migrant Latina immigrants are at high risk for HIV in part due to the risky behaviors of their male sex partners, which include IV drug use, sex with prostitutes without condoms, and sex between men and needle sharing.[18]

One study found that 75% of female migrant Latina immigrants reported never carrying condoms because they believed that carrying a condom would be perceived as a sign of promiscuity.[19]

Latina Immigrants and Cervical Cancer

Cervical cancer is almost 100% preventable through detection and treatment of precancerous cells. However, cervical cancer survival rates among Latinas are relatively poor. Cervical cancer screening is very low among Latina immigrants.[20] This is due to the lack of access to preventive health services, concerns about cost, and limited knowledge about the importance of a Pap smear.[21] Latina immigrants are often diagnosed with cervical cancer, which is caused by human papillomavirus (HPV), at the late stages of cancer.

- The cervical cancer incidence rate is twice as high among Latinas as non-Latina whites.[22]
- A study found that low-income Latina immigrants displayed significantly less knowledge regarding cervical cancer and were less likely to receive a Pap smear than low-income non-Latinas.[23]

Latina Immigrants:
Sex Education and Teen Pregnancy

Reproductive health knowledge is low among Latina immigrants regardless of sexual experience or age. Studies have demonstrated that the lack of reproductive health knowledge is primarily due to a combination of low educational attainment and lack of sex education among Latina immigrants.[24] Studies have also indicated that Latino immigrant families choose not to talk to their children about premarital sex.[25] Not surprisingly, pregnancy rates are consistently high among Latina teens.

- Latina immigrant teens currently have the highest birth rate in the U.S., with teens of Mexican origin having the highest rate and teens of Cuban origin having the lowest rate.[26]
- Latino immigrants are more likely to talk about parenting responsibilities with their children than about premarital sex.[27]
- The birth rate for Latina teens ages 15 to 17 was more than twice as high as the birth rate for all teens ages 15 to 17 (49.7 versus 22.4), and the birth rate for older Latina teens (aged 18 to 19) was more than 85% higher than the birth rate for all teens ages 18 to 19 (131.9 versus 70.8).[28]
- In 2003, only 12% of Latina high school females reported using birth control pills during their most recent sexual experience, compared with 21% of high school females overall.[29]

Conclusion

In order to reduce the reproductive health disparities among Latina immigrants, including the incidence of HIV/AIDS, cervical cancer and teen pregnancy, Latina immigrants need increased access to reproductive health care services, reproductive health information, and culturally and linguistically appropriate services. Advocates and policymakers concerned about Latina immigrants' reproductive health disparities must support national initiatives to promote reproductive health equity through policy and advocacy, public education, research and service delivery.

Although reducing reproductive health disparities among Latina immigrants is a challenging goal, it represents an opportunity to improve the health of one of the largest ethnic groups in the United States.

For more information on the Reproductive Health of Latina Immigrants, please visit www.LatinaInstitute.org

Sister Song
Women of Color Reproductive Health Collective

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Women's Reproductive and Sexual Rights and the Offence of Zina in Muslim Laws in Nigeria

By Ayesha M Imam

Amina Lawal was convicted of adultery in March 2002 and sentenced to be stoned to death in Nigeria. In the wake of a new Sharia Penal Code in Katsina State, religious right vigilantes instigated a case against her for having a child after divorce without remarrying. The alleged father swore that he had not had sexual relations with her and was released. These events occurred during a heated controversy in Nigeria about the nature and desirability of Sharia, rights in Muslim laws, constitutional rights, international human rights and their relationships to each other. Ms. Lawal's case was immediately adopted by a coalition of Nigerian non-governmental organizations (NGOs) that provided her with lawyers, safe houses, medical care, and emotional support over the eighteen-month ordeal. She also became the object of world attention, media and protest campaigns, many of which excoriated "Islamic Law" as brutal and called on Nigeria's president to pardon her and repeal the Sharia Acts. In September 2003, Amina Lawal won her appeal in the state Sharia Court of Appeal and was acquitted (*Lawal Kurami v. the State*).

Ms. Lawal's is perhaps the best known of the five cases involving adultery and stoning since the passage of Sharia Penal Codes in several Nigerian states beginning in 2000. The offence of zina or unlawful sexual intercourse includes both adultery, punished by stoning to death, and fornication, punished by whipping. In some states, men may be imprisoned also. Two earlier defendants, Safiya Tungar-Tudu and Hafsatu Abubakar who were convicted in October and December 2001 respectively, had both appealed successfully, again with the assistance of Nigerian women's and human rights NGOs. The conviction of Fatima Usman and Ahmadu Ibrahim two months after Ms.Lawal's was still on appeal at the time of writing (March 2004), as was the last case, in Jigawa State. So far, no sentences of stoning have been upheld or carried out. However, over a score of fornication cases have led to convictions, with sentences of whipping carried out, and some men imprisoned as well as whipped.

These cases have opened up issues that are relevant to ensuring and developing women's reproductive and sexual rights in a way that recognizes and respects both local cultures and contexts and international rights agreements. Rising religious right identity politics in Nigeria and around the world, including the United States, on the one hand, and crude anti-terrorism policies which are often blatantly Islamophobic on the other, must both be considered-along with romanticizing practices that oppress women in the name of culture. Local cultures can be micro-cultures in small communities. Most often, local cultures are complicated mixtures of many ideologies and social practices structured by power relations, with the common factor of being part of the daily practices of life in a given community.

In order to respect the belief, tenets, and practices of both local cultures and international human rights agreements, it requires a double "claim and critique"strategy. This is claiming ownership of both local cultures and of international human rights discourses (including the right to participate in defining the content of each), while privileging neither local nor international as automatically superior, and thus being able to critique both. Strategies for promoting rights in particular situations are not mechanically given by either local or international tenets, but are necessarily contextual to specific history, politics, and place. They frequently involve interplay between local and international discourses.

There are two premises for claiming and critiquing both local and international discourses. The first is that the point of espousing human rights principles is to ensure that people actually enjoy rights as part of their mundane day-to-day lives. This requires, especially for reproductive and sexual rights, that they are claimed and respected by local cultures of understanding and ways of living and are not merely written texts. Celestine Nyamu-Musembi refers to Mahmoud Mamdani's insight that "wherever there (is) oppression, there must come into being a conception of rights… {thus} human rights are both universal and particular; universal because the experience of resistance to oppression is shared among subjugated groups the world over, but also particular because resistance is shaped in response to the peculiarities of the relevant social context" (Nyamu-Musembi 2002). If particular formulations of rights are perceived as imposed, whether by foreigners or national elites, they are less likely to have local legitimacy and be respected. Women's human rights activists must work, moving between local, national, and international levels, to develop resonances between local, national, and international understanding of rights.

The second premise is that international human rights understanding are also social and historical products, which are affected by the power politics and of the cultural and historical traditions of the dominant groups in their contexts. Although some international human rights agreements may be more advanced than particular local cultures on some issues in some places and times, they may also lag behind on other issues, in other places, at other times.

The dominant understanding of what human rights are at any particular time depends on the power of the various people involved to assert their definitions over those of others. Understanding this makes it possible to recognize Western European influences on the construction of rights today, but to accept, nonetheless, the universality of the notions of rights, even when they differ in particulars. Furthermore, human rights cannot be static, but must be continually reconstructed by women and men whose lives are affected by them. Universalizing human rights means not simply asserting that they are universal, but constructing rights that speak to peoples of different cultural, historical, gender and class backgrounds. Universalizing international constructions of rights requires recognizing diversity and including ideas and principles that may not hitherto have been part of the dominant language of human rights. Here the struggle for the recognition of women's rights as human rights and the development of international reproductive and sexual rights provide good examples.

Human rights approaches need to move beyond the notion of culture (including religion) as a static barrier to human rights and toward a notion of culture as constantly re-made historical constructions containing potential resources as well as obstacles-as Amilcar Cabral (1973) elucidated long ago. Human rights "outreach" should not mean simply "bringing the message to the grass roots" as, revealed in existing treaties etc. This denies the influence of Western cultural constructs on dominant rights definitions and locates all obstacles to the realization of rights in an unchangeable and monolithic "other" culture or religion. Thus, developing international and universalizing human rights must be seen as a multi-way process.

The proposed approach requires strategically drawing from and negotiating both local cultural-religious norms and traditions (which may be simultaneously transnational and are always complex and multiple) and formal national and international rights regimes. Women's groups have often been extremely creative in this process, framing and drawing upon and improving international covenants in ways that make sense in local contexts. For example, the rights of rural women in the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) or the rights of the girl child in the Beijing Platform of Action were due largely to the efforts of African and other non-Western women. Other examples include using CEDAW as the basis for mock tribunals and test cases, adopting it as local law, and highlighting the similarities between it and progressive constructions of religious, customary, and secular national laws and practices.

Typically women's rights are posed in opposition to family, religious or ethnic community rights. For instance, Muslim women are often accused of being "Westernized" and traitors to the Muslim community if they demand rights. Such oppositions ignore asymmetrical gender power relations and assume current male-dominant constructions of cultural norms as static and unchangeable. This, thereby, legitimates the power of beneficiaries of the status quo. However, women are as much part of the family and community as men are. What is challenged is not necessarily the community itself, but the current definitions of the culture and norms of that community and the powers of cultural gatekeepers to maintain their definitions in the face of demands from other community members. Thus, women may be asserting their right to participate in defining the norms of their communities as well as, or sometimes rather than, their rights to leave that community and choose another.

The net effect of the Sharia Acts and the politics around them has been to give increased power and authority to conservative religious essentialism and identity politics. Many vigilantes have reacted by assuming that the Acts justify their imposition of practices that have no legal basis at all, such as conservative dress codes for women, controls on women's movements and use of public transport, or prohibiting music and dancing at private social ceremonies, including at single-sex events. Women's rights activists and those women who refuse to abide by the religious right's notions of how they should dress, or who work outside the home, or who refuse to sit in the back seat in taxis and buses have been threatened and sometimes physically attacked. The staff and volunteers of women's organizations that provide sex education and contraceptive information, as well as drivers, who carry women in their taxis, buses, and motorcycles, have also been intimidated or beaten up. To criticize Sharianization, even mildly, was regarded as anti-Sharia, anti-northern Nigeria, and anti-Islam, even by some convicted under the new Acts, who were, therefore, unwilling to appeal their convictions.

The new Sharia Penal Codes created some new offences in Nigerian law, mostly around sexuality, like the zina laws and the prohibition of lesbianism. The Codes also recognize stoning, retributive punishments, and blood fines. In theory, these laws apply to Muslims only, thereby evading the charge that the Sharia Acts constitute the imposition of a state religion. It remains an open question whether Muslims have the right to choose to be governed by general Nigerian law without having to renounce their religious identity.

Organizing in Nigeria

The first group to be active on Sharianization's potential to violate women's rights was BAOBAB for Women's Human Rights. BAOBAB's work rests on recognizing the historicity and specificity of all discourses of rights and the need for their continual reconstruction. For instance, BAOBAB has been active in a comparative study of women's rights under customary, general (secular) and religious laws in the Muslim world. BAOBAB produces legal literacy leaflets, including on divorce, child custody, and women's protection from violence in all Nigerian systems of

Continued On Next Page >>

law and in international human rights. They are used widely in legal consciousness workshops that focus not just on knowledge of current law, but also on demystifying law and on strategies for changing it when necessary. BAOBAB collaborates with other women's and human rights groups in Nigeria, including the Women's Rights Advancement and Protection Alternative (WRAPA), which took the lead in defending Amina Lawal. The approach BAOBAB pioneered has three components: 1) defense of those convicted under the new Sharia Penal Codes, 2) demystifying the notion of Sharia laws, and 3) working to build common platforms to defend and promote women's rights across diverse communities.

It is important, in a diverse multi-ethnic and multi-religious state like Nigeria to work across communities, as well as within Muslim communities. Hence, the Coalition for Protection of Women's Rights in Secular, Customary and Religious Laws and the Sharia Stakeholders Group include national NGOs and smaller regionally based NGOs from different parts of the country; women's and human rights NGOs and activists; Muslims, Christians, and secularists, who work together on the zina cases.

Demystifying Sharia

Demystifying Sharianization in Nigeria also involves critiques of the current class- and gender- bias in content and implementation. The poor have been the most subjected to harsh punishments. There have been fewer convictions of men than of women for adultery or fornication. Moreover, men convicted of violent sexual offenses, like rape and sexual assault, have received less severe punishments (usually fines, imprisonment, or acceptance of pleas of illness and insanity), despite the stronger punishments available in the Sharia Penal Codes that are routinely meted out for consensual sex outside marriage. Women have clearly been discriminated against. Judges have ignored or dismissed women's allegations of rape and coercion in zina cases. Charges of adultery/fornication brought against women used different and discriminatory standards of evidence than those used for men -- that of pregnancy outside marriage.

Developments since 1999

The judgment in Ms. Lawal's case is important, adding to the prior successful appeals. Although it sets a precedent only in Katsina State, the definitions of zina are exactly the same in the twelve states with new Sharia Penal Codes, which should make it difficult to ignore. The majority position was sweeping, accepting every single ground of the appeal. The Katsina State Sharia Court of Appeal expressly departed from the dominant view of the Maliki School by holding that pregnancy outside of marriage is not evidence of zina, thus, confirming the arguments of the activists on the existence and permissibility of diversity in Muslim jurisprudence. The court also upheld standard Muslim jurisprudence that confessions need to be voluntary and repeated and that they can be withdrawn at any point right up to the commencement of the sentence. In so doing, the court implied that the prosecution needed to provide proof in the form of four witnesses of good character to the act of intercourse for women also, which is a standard position in Muslim jurisprudence and a difficult criterion to achieve.

The judgment undercuts the religious right and vigilantes who routinely report women with children born outside of marriage, and their partners, to the police and insist that the police charge them on this ground alone. It also restores the onus of proof to the prosecution, and thus, removes the discrimination against women that was evident in the prosecution of the cases. Although zina remains on the books, the overturn of Ms. Lawal's conviction should make new zina charges less likely and extremely unlikely that prosecutions will be successful.

National & International Meetings and Conferences 2006-2007

AUGUST 2006

August 13-18 – AIDS 2006: XVI International AIDS Conference – Toronto, Canada
http://www.aids2006.org
August 21-25 – 11th World Congress on Public Health – Rio de Janeiro, Brazil
http://www.saudecoletiva2006.com.br/
August 30-September 1 – Geneva Forum: Towards Global Access to Health - Geneva, Switzerland
http://www.hcuge.ch/genevahealthforum/index.htm l

SEPTEMBER 2006

September 14th - 16th – A Decade of Building: Power Justice Community – Los Angeles, CA
www.napawf.org
September 16th – SisterSong Reproductive Justice Training – Los Angeles, CA
www.sistersong.net
September 17th – SisterSong National Membership Meeting – Los Angeles, CA
www.sistersong.net
September 18th – SisterSong Ethnic Mini Communities Meetings – Los Angeles, CA
www.sistersong.net
September 21-24th – International Seminar on "Ethical Issues in Reproductive Health" Wassenaar, Netherlands
http://www.iussp.org/Activities/scc-rep/rep-call06.php

OCTOBER 2006

October 15-20th – 2nd International Conference and General Assembly Meeting of the African Network for Strategic Communication in Health and Development "3rd Generation HIV and AIDS Communication: The Key to Prevention, Care and Treatment" - Nairobi, Kenya
http://www.africomnet.org/cms/index.php
October 25-27th – The World Congress on Communication for Development
Rome, Italy
http://www.devcomm-congress.org/world-bank/macro/2.asp
October 27-28th – African American Women Evolving: Black Women: Loving the Mind, Body & Spirit 2006 Health Conference and 10th Anniversary Gala http://www.aaweonline.org/events.html

NOVEMBER 2006

November 4-8th – American Public Health Association 134th Conference
Boston, MA
www.apha.org
November 5-10th – XVIII FIGO World Congress of Gynecology and Obstetrics
Kuala Lumpur, Malaysia
http://www.figo2006kl.com/marketroot/figo2006kl/index.htm
November 18th – SisterSong Reproductive Justice Training – Albuquerque, NM
www.sistersong.net

2007 CONFERENCES

JANUARY 2007

January 18-21st – National Advocates for Pregnant Women & SisterSong: The National Summit on Pregnant Women and State Control: Ensuring the Health and Humanity of Pregnant and Birthing Women – Atlanta, Georgia
www.advocatesforpregnantwomen.org/

APRIL 2007

April 15-19th – XVIII Congress of the World Association for Sexual Health
Sydney, Australia
http://www.sexo-sydney-2007.com

MAY 2007

May 31-June 2nd – Let's Talk About Sex! SisterSong's 10th Anniversary National Conference on Reproductive Justice
Chicago, Illinois
www.sistersong.net

JUNE 2007

June 27-July 1st – United States Social Forum
Atlanta, Georgia
www.ussf2007.org

SisterSong
P.O.Box 311020
Atlanta GA 31131

Postage Here

COLLECTIVEVOICES

Let's Talk About Sex!

SisterSong 2nd National Conference And 10th Anniversary Celebration

May 31 – June 2, 2007
Wynham Rosemont Hotel
Chicago, IL

The SisterSong Women of Color Reproductive Health Collective intives you to our 10th anniversary national conference on women of color and reproductive justice called *Let's Talk About Sex!* The conference will be held May 31 - June 2, 2007 in Chicago, Illinois hosted by African American Women Evolving and more than 1,200 people are expected to attend.

Since the right to have sex is a topic rarely discussed when addressing reproductive health and rights issues, SisterSong believes that sexual prohibitions are not only promoted by moral conservatives in this country, but also by reproductive rights advocates who fail to promote a sex-positive culture. Sex is not for pro-creation and sexual pleasure – sex is a human right. We would like to create a pro-sex space for the pro-choice movement and we hope you will join us.

SisterSong is a membership-based organization. We invite all organizations and individuals to become members to receive reduced conference registration dates. Conference registration information is on the website at **www.sistersong.net**

SisterSong is also soliciting organizational co-sponsors and individual donors for this important conference. If your organization is interested in becoming a major co-sponsor with special benefits and opportunities for our partners, please contact us at **documentation@sistersong.net**. If you are interested in joining SisterSong's electronic listserve for future announcements, please send an email to **listserve@sistersong.net**