SISTERSONG WOMEN OF COLOR REPRODUCTIVE HEALTH COLLECTIVE

COLLECTIVE VOICES

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Reproductive Justice: Towards a Comprehensive Movement

By Eveline Shen, Asian Communities for Reproductive Justice
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On the 33rd anniversary of *Roe v. Wade*, reproductive rights activists, the media, and legislators are focusing on how the confirmation of Samual Alito will affect reproductive rights of women in the United States. Indeed, Alito's previous record raises serious concerns for those who support reproductive rights and civil rights. Historically and currently, many reproductive rights leaders and activists have viewed *Roe v. Wade* as being at the center of the fight for reproductive rights and abortion access.

However, a constitutional right to abortion is not enough to protect the reproductive health of women, or even abortion access for all women. In fact, even with *Roe* on the books, many women currently have limited, if any access to abortion services. The majority of poor and low-income women in the United States are denied access for a variety of reasons including abortion funding bans, bans on the provision of abortion services by government health care facilities, a shortage of abortion providers, and parental involvement laws.

We must cultivate a more comprehensive analysis and strategy to protect reproductive rights because women of color and poor women's reproductive options and self-determination are restricted in so many ways beyond abortion. For example, Asian women who live in low-income neighborhoods with high levels of environmental contaminants such as dioxins are disproportionately affected by these chemicals. Dioxins are linked to endometriosis and Asian women have some of the highest rates of endometriosis, which can lead to infertility. Of further concern is the cervical cancer rate among Asian women in California, which is 10% higher than women overall. In fact, the highest incidence of cervical cancer of all ethnic groups is among Vietnamese women, which is five times higher than in White women. While the best way to prevent cervical

cancer is through regular screening, Asian women have the lowest rates of Pap exams of all ethnic groups. Limited English proficiency, mistrust of the US medical system, immigration status, and cultural taboos prevent necessary early detection and diagnosis.

This variety of challenges demands a multi-dimensional approach to fight reproductive oppression and advance the well-being of women and girls.

Currently, there are three main frameworks for fighting reproductive oppression: 1) Reproductive Health, 2) Reproductive Rights, and 3) Reproductive Justice. Although the frameworks are distinct, together they provide a complementary and comprehensive solution. The Reproductive Health framework emphasizes the necessary reproductive health services that women need. The Reproductive Rights framework is based on Constitutionally-framed legal protections for women, such as *Roe v. Wade*. And the Reproductive Justice framework stipulates that reproductive oppression is the result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights.

The Reproductive Justice framework envisions the complete physical, mental, and spiritual well-being of women and girls. It stipulates that reproductive justice will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives.

Reproductive Justice is an intersectional theory emerging from the experiences of women of color. The concept of intersectionality has a long history, beginning with the writings of Fran Beale and Toni Cade Bambara in the 1970s, and re-articulated by Kimberle Crenshaw in the 1990s. They argue that the experiences of women of color vis-à-vis race, class and gender are not additive but integrative, producing a different paradigm called Intersectionality. What is fresh about SisterSong's approach is that we have applied theories of Intersectionality to the human rights framework, made a strong connection between

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Imagining Lives: Childcare And Reproductive Justice

By Benita Miller Johnston, Brooklyn Childcare Collective

I stay up late most nights thinking about the girls that I work with. I wonder whether they rub their bellies and hum quiet prayers meant for God to hear and answer. I did these things when I carried my babies. I marveled as my belly wriggled into humps and moved toward my touch. My babies and I knew each other well before we made our in-person acquaintance!

I wonder whether the girls that I work with worry about whether they will have enough. Enough love to keep them happy; enough energy to keep them going; enough time to get the things they want.

I worry, I worry and then I worry some more.

I look at their smiling brown faces and imagine my mother. Like them, she once wedged a protruding belly into a desk meant for teen girls that scrawled the football stars name on their sneakers and had no reason to worry about hard-bottom shoes. She was 16 in 1969 when she gave birth to my brother, and I quickly followed 13 months later. Today, I tease her, reminding her that I'm that dreaded and pesky too-soon subsequent birth. My mother is far removed from the day when she was pushed out of school and into a marriage that, in the last 36 years, has resulted in four children and nine grandchildren. Nowadays, she's a registered nurse. I look at my girls tangling their arms around young boys on the brink of fatherhood – nervous, sly smiles turning up the corners of their mouths when they greet one another. They have so much work to do. These boys' lives will not be like my father's as there are no auto factories brimming with jobs paying a wage high enough to head a household. But, they see me and know that for my girls I want what my mother got from my father, my grandmothers and our extended community. She had love, support and guidance.

Two years ago, I started the Brooklyn Childcare Collective to provide legal information and social services support to pregnant and parenting girls after working as an attorney at Legal Aid Society. I mostly enjoyed the experience of trying to use my law degree to positively affect the lives of children, but as I grew older, I watched the parents flowing into the courthouse to answer criminal charges appear younger. Mostly, they were black and brown girls with their mothers, other female relatives or friends. Being nudged toward the table where decisions would be made about their family's life, they always tried to figure me out – bewildered, afraid and very much in love with their children they often thought that the law guardian was the person that literally took their children in. Explaining my role often added another confusing layer of disruption to their lives. I wanted to be something different in relationship to them, not just be their child's attorney. I broke rules. Did things lawyers aren't supposed to do. I held hands with these young mothers, listened to them, gave comforting smiles and encouraged them in their mothering.

I knew that I had to move on so I started the Collective, believing that I could use the best tools I learned in the courtroom and wed them to my organizing experiences to create a dynamic community-based program. I started small with my own child strapped to my chest. I talked things up in Brooklyn Family Court and in the schools, and then was given an opportunity to launch a school-based program. The young mothers that I met at Brooklyn's P932K, helped me deepen my vision and together we questioned everything. Through questioning we are making personal and environmental changes. We are doing work in our schools, we are working in the courthouse, we birth in ways that honor our personal choices and ancestors. We are rearing our children in a woman-centered circle. We hold our babies to our breasts. We do our homework. We share our love in a way that affirms our dignity. We celebrate multi-ethnic and intergenerational friendships. We search for ways to get enough.

As young mothers on the verge, juggling school and good, safe childcare is a major challenge. While the New York City Department of Education provides childcare placements for student/parents, often these slots are not convenient or situated in a good educational setting. Moreover, young mothers often report that because there are so few slots, many quickly fill up. We struggle around this issue of trying to create enough slots because we know that childcare is a critical component to ensuring that these young women have the time and mental energy needed to explore their own academic and personal possibilities.

While we expect that the school system and local government respond to the needs of young mothers – we also seek out the support and guidance of our elders. We know that healthy mothering never happens in isolation. We consciously develop relationships that broaden our understanding of our experiences as women. We never can get enough of these types of relationship and as young mothers these relationships are critical, especially when we talk about baby-making. When a 13-year-old mother in foster care asked me to define ovulation, I needed to connect to women more knowledgeable. When two 17-year-old expectant mothers said with a level of authority that shocked me that if you jump up and down following intercourse you can get all of the sperm out of your body and prevent pregnancy, we huddled around a blackboard and quickly did our best to dispel this myth. Outside of the rudiments of academia, my girls need knowledge that will literally save their lives. One can never get enough of these types of connections.

I've learned not to underestimate the power of their love. Love for their children. Love for the partners. Love for themselves and each other. Often, the force of this love is lost to anger, frustration, envy and lack of understanding. We make an effort to strengthen these bonds for the benefit of the babies and for the sustenance of the girls. They need to be touched, they need smiles, and they need to be told that they are amazing. I tell them these things. I touch them. I know that this telling and touching matters because over time I see them do it with each other.

Last Sunday, my baby girl burned with fever and we were stuck indoors. I stared out of the window at Brooklyn (my adopted home, I'm a Detroiter) and listened to the cold wind whip against the concrete. I felt alone. I had work piled on my desk but it went untouched. Instead while cradling my daughter I was deep in thought about my girls. I thought about those waiting for babies to arrive. I thought about those struggling through math problems, fighting with boyfriends, or simply feeling overwhelmed. I wanted them in my living room with me. I wanted to talk and share. I wanted to listen to them plan their lives. I needed to connect to someone that would understand my yearning and I reached out to a sister/mentor in Detroit. She's been doing this work as a school principal for quite awhile. I wanted her to tell me that I was right and that the work I had chosen was worthwhile. Even before I asked, she moored me, told me stories – reminded me that this is my life's work.

Benita Miller Johnston is a mother and founder of the Brooklyn Childcare Collective, an organization that empowers young women to build strong peer networks, to rear healthy children and to move out of poverty. The Collective organizes young mothers around issues of education equity/access, reproductive health, child welfare reform and financial literacy. Our website is

www.brooklynchildcarecollective.org

individual and group rights, and built a growing movement for Reproductive Justice. Reproductive Justice is a positive approach that links sexuality, health, and human rights to social justice movements by placing abortion and reproductive health issues in the larger context of the well-being and health of women, families and communities. Reproductive Justice stresses both individuality and group rights. We all have the same human rights, but may need different things to achieve them based on our intersectional location in life - our race, class, gender, sexual orientation and immigration status. The ability of a woman to determine her reproductive destiny is directly tied to conditions in her community. The emphasis is on individuality without sacrificing collective or group identity. As with the human rights framework, it does not grant privileges to some at the expense of others.

We need a movement with a vision of addressing women comprehensively so that we do not single out pieces of a woman's body but see our bodies as whole. Similarly, we cannot focus solely on one aspect of a woman's life, whether at work, at school, at home, or on the streets. We need to understand how reproductive oppression may exist in all arenas of her life and recognize that she may have to walk through all of these arenas in a single day.

Reproductive Justice aims to invigorate the movement by:

• Addressing the needs and issues of a diverse group of women while acknowledging the layers of oppression that our communities face, particularly those who have little access to power and resources;

• Encouraging women and girls to be active agents of change and realize their full potential;

• Creating opportunities for new leaders to emerge within our communities and increase the sustainability of our movement;

• Integrating the needs of grassroots communities into policy and advocacy efforts;

• Infusing the movement with creativity, innovation, and vision;

• Providing opportunities to work at the intersection of many social justice issues while forging cross-sector relationships; and

• Connecting the local to the global by integrating the human rights framework.

As we are currently experiencing an escalated assault on women's rights as well as a shrinking of the mainstream reproductive health and rights movement, it is critical that we include a Reproductive Justice framework in our collective work. By integrating the reproductive justice needs of our communities at local, state, national, and international levels, we will be able to activate and mobilize larger constituencies. Furthermore, working in alliance with other social justice movements will infuse freshness and relevance into our own movement.

Reproductive Justice calls for integrated analysis, holistic vision, and comprehensive strategies that push against the structural and societal conditions that control our communities by regulating our bodies, sexuality, and reproduction. This is the time to come together across issue areas, across separate change efforts, and across identities to achieve the vision where all women, girls, and our communities can truly transform our world.

Eveline Shen is the Executive Director of Asian Communities for Reproductive Justice (ACRJ). ACRJ works for the liberation of Asian women, girls and our communities through the lens of Reproductive Justice.

A more detailed description of the reproductive health, rights, and justice frameworks is given in ACRJ's new paper, *A New Vision for Advancing our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice*. To download a copy of *A New Vision*, please visit www.reproductivejustice.org.

Reclaiming Choice, Broadening the Movement:
Sexual and Reproductive Justice and Asian Pacific American Women, A National Agenda for Action

By Courtney Chappell, NAPAWF

Abortion, teen pregnancy, and comprehensive sex education are among some of the topics that inform the national dialogue about reproductive rights in this country. Yet, what often gets left out of this discussion is the intersection of reproductive rights with other issues such as immigration, health care, welfare reform, and environmental justice, many of which have an intimate impact on the reproductive health care experiences of Asian Pacific American (APA) women and other women of color.

Asian Americans and Pacific Islanders represent over 4% of the total U.S. population, or nearly 12 million people. By the year 2050, it is estimated that 33.4 million, or 8% of the total population will be APA. Approximately 60% of APAs are foreign-born, representing one-fourth of the nation's total foreign-born population. Of the 139 million females in the U.S., 4% are APA. And, 50% of APA women are of reproductive age.

The APA population is extremely diverse, comprising over 30 ethnic subpopulations and more than 200 languages and dialects. Yet, there are very few studies that specifically document the reproductive and sexual health trends of APA women and girls, and even fewer that disaggregate the data collection by ethnic subpopulation. Moreover, stereotypes such as the model minority myth create the public perception that all APAs are healthy and prosperous, and don't encounter any reproductive health care problems.

By contrast, the few studies and reports that include APA women present a very different and alarming picture. For instance, the incidence of cancer is steadily increasing for particular APA ethnic subpopulations: Vietnamese American women have a rate of cervical cancer that is five times higher than for white women, representing the highest rate for any racial or ethnic group. In addition, although Asian Pacific Americans comprise less than 1% of all reported HIV-positive cases in the U.S., the number of reported cases is steadily increasing, particularly among certain ethnic subpopulations.

APA women also encounter adverse reproductive health care problems in the workplace. Over 40% of nail technicians nationwide are of Asian descent, and 80% of the industry workers in California are Vietnamese immigrant women. Studies have found that prolonged exposure to phthalates, chemicals used in many cosmetics with the highest concentration found in nail polish, poses a serious occupational hazard to workers. For instance, phthalates have been linked to cancer, birth defects, and spontaneous abortions.

Finally, abortion remains an important option for APA women when making childbearing decisions. National data reveals that 35% of pregnancies end in abortion for APA women, the second highest percentage for all racial groups. Between 1994-2000 abortion rates fell for all groups *except* APA women. Teen pregnancy is also a critically important concern for the APA community, particularly for Laotian American teens who have the highest teen birth rate in California.

Why do APA women have poor health outcomes and suffer from health disparities? One of the primary reasons depends on whether they have the ability to access the health care system. Currently, 36% of APA women under age 65 lack health insurance, and Korean Americans are the most likely racial/ethnic group to be uninsured. Current immigration restrictions, the financial inability to purchase private health insurance, and lack of employment-based health benefits are among some of the reasons that explain their high uninsured rates.

In addition, even when APA women have the ability to access the health care system, language differences and lack of culturally competent services create huge barriers to receiving quality and effective care. The U.S. Census Bureau found that 79%, or four-fifths, of Asian Pacific Americans speak a language other than English at home, and 40% are limited English proficient (LEP) or speak English less than "very well." Further, studies have also found that the cultural stigmatization of disease and cancer prevent many APA women from seeking preventive reproductive health care services.

Lastly, insufficient and inadequate research on APA women and girls limit the public's and health care providers' understanding of the sexual and reproductive health care issues that shape APA women's lives. Of the total number of published reproductive and sexual health care articles, only 2% include APA women, the lowest percentage for all racial/ethnic groups, and far below their overall percentage in U.S. society.

Inspired by other women of color organizations that have been mobilizing around reproductive justice for years, the National Asian Pacific American Women's Forum (NAPAWF) developed a national agenda for action that discusses in more depth the above sexual and reproductive health care issues, concerns, and barriers that APA women and girls face. In addition, our agenda for action outlines the eight legislative priorities that will form the basis of our advocacy at the national and grassroots levels, and offers recommendations for policymakers, advocates, allied organizations, and community leaders to address these issues.

Our eight priorities include: providing access to health care for all; promoting linguistic and cultural competence in health and human services; demanding community-relevant sexual and reproductive health data and research; protecting and expanding sexual and reproductive rights; eliminating all forms of violence against women; increasing comprehensive sexuality education; linking women's reproductive health to environmental justice; and ending gender discrimination and the promotion of sex selection

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technologies.

By promoting a broad sexual and reproductive justice framework, NAPAWF seeks to reclaim the pro-choice terminology from opponents who have historically defined the debate as one single issue. Broadening the notion of choice beyond the constitutional right to access abortion gives APA women real choices when it comes to making decisions about their sexual and reproductive health. For what is choice really if you can't understand your doctor's instructions or you are unable to seek preventive care because of immigration restrictions? We hope to join with other national and grassroots organizations to create a community so that every woman and girl's life, including Asian Pacific Americans, is lived in dignity and equality.

To learn more about these issues or to receive a copy of *Reclaiming Choice, Broadening the Movement: Sexual and Reproductive Justice and Asian Pacific American Women, A National Agenda for Action*, please visit out website at www.napawf.org.

THE POWER OF SISTAH-HOOD
Something You Can't Get from a Grant

By Juanita Williams, SisterSong Membership Committee

As an original member of SisterSong, I have seen our Collective go through the birthing pains of creating a collective, to joys, successes, as well as welcoming new life and coping with death. As a woman, mother, grandmother and activist who is HIV+ I know it's a lot to deal with. When you are blessed to be surrounded by a beautifully-quilted fabric of women of all ages, colors, and experiences you've got something special. It's "The Power of Sistah-hood." There's power when you have sistahs banded together on the same accord. Whether we're in communion on our work together or dealing with our own personal issues, we're there for each other.

We are very sincere and dedicated to our work. Not only do we work with our heads, we also work with our hearts. We also respect each other by honoring our feelings. The love and respect I receive gives me the strength to carry on. It's about RESPECT! News flash Sistahs, that's something we are not getting in most grants.

Having a voice with a Collective of sistahs is more rewarding then anything you can get from a grant. The camaraderie and knowledge we gain from each other after business is conducted is more enriching and valuable. Spending time after hours together gives us a chance to shed the numbers and statistics. We connect in a way that saves each other's lives and the lives of our mothers, daughters, sisters and our friends. These things don't come in a grant. Grants are so uniform and generic with their list of criteria and demands that have to be fulfilled in order to get monies. It doesn't consider two real needs that are essential in order to be effective in our work: love and respect.

Grant monies are drying up and are more difficult to obtain than ever. Maybe we need to go back to the way things were when there wasn't any money. Remember the times of grassroots organizing? This was a time when women relied on each other. They financed their own causes and moved mountains by banding together and sharing talents and sistahs did it without writing grants. This is the power of Sistah-hood! Don't get me wrong; I give "Thanks" for grants and grant writers. But with all of the restrictions placed on funding, we need to start collaborating with each other again.

SisterSong is filled with so many beautifully talented experienced sistahs. We are mothers, daughters, sisters, cousins, best friends, homemakers and so much more. Being a part of SisterSong has been a very enriching experience for me. For most of us, I'm sure being a part of SisterSong has been an experience that I would have never gotten from a grant. Keep up the good work sistahs!!!!

Brother Beat: Being a Male Ally

By Rus Ervin Funk, Center for Women and Families

Within the social justice and human rights efforts, an "ally" is a person that works alongside and on the behalf of a particular group or affinity. Below are specific characterizations of men who work as allies for women. Allies:

Listen

Seek the perspective and listen to the voices of women in leadership as they say what they need and want from men. An ally also listens to women in general to learn more about what the forms and expressions of sexism are and how it affects women's lives.

Be open to feedback. Respond to criticisms without defensiveness.

Accept Responsibility

It is not women's responsibility to educate men; it is men's responsibility to educate themselves.

Respond when acts of sexism occur. Allies don't wait for women to tell them to do something; they take the initiative.

In accepting the responsibility to speak out, allies speak for themselves. Allies don't speak out against sexism on behalf of women. Male allies speak out on their own behalf because sexism is wrong.

Open Doors

Rather than accepting opportunities for themselves, male allies strive to advance opportunities for women.

Male allies challenge sexism and male entitlement.

Take Chances

There are few road maps for what it means to be a male ally. Much of what male allies do is learned as they go. Even though men may be afraid of "doing the wrong thing" or "stepping out of line," it is important that they do so anyway. Sometimes allies make mistakes. It is important to learn from those mistakes, be open about the process, and not allow making mistakes to keep men from trying.

Seek Support

Men can't be effective allies on their own – they need and deserve support in order to continue the hard work of being an ally. It is not the responsibility of women to support men who are acting as allies, it is men's responsibility to seek the support they need and deserve.

Seek out and create means to gather support from other men.

Earn Trust

It is men's responsibility to earn women's trust when working on issues of men's violence. Women are not obligated to trust men. It is up to men who act as allies to act in ways that demonstrate to women they are trustworthy.

Act Reliably

Male allies act in a consistent manner. It is a key way to earn trust, but it is also an important activity in its own right. Being reliable means that men follow through and that women know that they can depend on men to do what men say they're going to do, and to do what men need to do.

Take the lead (at times)

There are times that male allies need to take the lead in response to sexism or for other reasons. Acting as an ally means knowing when to take charge. There are also times when male allies need to be sure they don't assume a leadership role. Being an ally means knowing the difference and knowing both when and how to take the lead.

"Check in"

Male allies have a way of "checking in" with the local feminist leadership to make sure that what they are doing supports the goal of the organization.

Male allies also check in with other men and women to make sure their behavior (personally and politically) follows their stated beliefs and attitudes.

Are Accountable

Most importantly, male allies are accountable. Being accountable means doing what one says they are going to do. Accountability also means acting in a manner that is consistent with one's stated beliefs and attitudes. It also means recognizing when one makes mistakes, coming forward in a straightforward manner to accept responsibility for those mistakes and making amends.

Being accountable is more of a process than a position. Male allies are accountable when they create processes and accept the responsibility to ensure that their actions are aligned with the goals of the feminist leadership.

Being accountable does not necessarily mean doing what women think men should do. This is often one form of accountability, but there are ways that men can act accountably and still disagree with women – including feminists.

The Other Side of Pharmacy Refusal: Pharmacy Access

By Belle Taylor-McGhee, Executive Director
Pharmacy Access Partnership

You've heard the stories. A woman fearing she might be pregnant goes to a local pharmacy to fill a prescription for emergency contraception. She understands that if she takes it within 72 hours, she could avoid an unintended pregnancy. When she presents her EC prescription, she's stunned and confused by the pharmacist's reaction. The pharmacist tells her emphatically and unequivocally, "I don't believe in this medication, and I won't fill the prescription."

Although there are no hard numbers about the extent of the problem, women with valid prescriptions for EC are being turned away at pharmacies – mostly in red states and rural communities where anti-choice conservatism runs amuck, but sometimes in major urban cities like Chicago.

In some cases, advocates have confronted the objecting pharmacy and pharmacist head on – staging protests and waging letter-writing campaigns. As was the case in Chicago, Planned Parenthood successfully targeted the pharmacy where the refusal occurred, forcing the pharmacy to reevaluate its policy. Last August, the state's Governor has issued an emergency rule requiring Illinois pharmacists to fill all prescriptions for EC.

Ensuring patient access to EC and ongoing contraception has become a new battlefront in the fight for reproductive justice. Abortion opponents have shifted their focus from late-term abortion to what they see as a threat to the beginning of life. They willfully ignore accepted medical science that EC does not cause abortion and that it is not the same as the abortion pill – RU-486. Once again, the woman becomes secondary to their mission of advancing an anti-choice agenda.

But let's not make a woman's right to obtain birth control about the radical right. It's a distraction we can't afford. It's about women's lives and what women want – access to affordable reproductive health services and supplies when they need them, and the respect from medical professionals with the duty to ensure a patient's access to care.

Moreover, women need the power to make personal, responsible decisions about their own health.

Yet, I sometimes worry that these values are buried in our struggle to fight the good fight. In our resolve to right a wrong, do we explore what happens to women when they don't get what they need? What happens to the woman who is turned away at Wal-Mart – sometimes the only pharmacy is rural communities – because the company's policy is to not stock Plan B, the dedicated product for EC?

No, we can't afford to allow pharmacists anywhere to deny access to birth control. And we can't allow drug store chains to hide behind refusal clauses. What we need is a comprehensive approach to the problem of pharmacy refusal that not only includes legislation and political action, but pharmacist and pharmacy participation as well. Indeed, many pharmacists and pharmacies are stepping up to the plate to provide women with the services and supplies they need.

In fact, in California alone, Pharmacy Access Partnership has supported and facilitated the training of nearly 3,400 pharmacists who have voluntarily stepped up to the plate to provide pharmacy access to EC – meaning the pharmacist initiates the prescription rather than the physician. For example, 100% of Walgreens stores in San Francisco stock EC; and in over 75% of the chain's San Francisco stores, pharmacists initiate the EC prescription, thereby alleviating the need for women to visit a doctor or clinic first.

Pharmacy access to EC is available in 85% of the California's 58 counties. Currently, seven other states – WA, NM, AK, HI, ME, NH, MA – allow pharmacists to provide direct EC access under collaborative agreements with licensed prescribers (doctors, nurse practitioners).

Yet many women, particularly women who could benefit the most – young women, women of color and low-income women – don't know about this option. And there are still too many women who don't know that EC can prevent an unintended pregnancy up to five days after unprotected sex, although it is most effective when taken in the first 24 hours. While timely access to EC to prevent pregnancy has been the driving force behind pharmacy access, the model offers promising opportunities to give women more of what they want and need.

In 2004, Pharmacy Access Partnership commissioned a national Field Research Corporation random digit-dial survey of 811 American women crossing all demographic lines – race, ethnicity, income, education, age and religion. We asked women if they were interested in directly accessing prescription birth control in pharmacies if it was available – namely, pills, patches and rings. An overwhelming majority of women (68%) reported that they would support and use pharmacy access to hormonal contraception, and two out of three women (63%) agree that pills, patches and rings should be available without a prescription if a pharmacist screens a woman first. And pharmacists are ready to meet this demand, as indicated by the 85% of pharmacists nationally who said they would be interested in pharmacy access to hormonal contraception.

Still, major gaps exist between what women want and need, and what the healthcare system provides. Women need expanded options to reproductive healthcare services, including pharmacy access. They need affordable contraception and better information about where they can go to get it. Women need universal healthcare.

In the meantime, Pharmacy Access Partnership is working to build stronger alliances between the pharmacy, medical provider and women's advocacy communities to improve awareness of and access to reproductive health services – at the community level and within pharmacy settings. Imagine how many more women can be served.

It's the other side of pharmacist refusal.

For more information about pharmacy access, visit www.GO2EC.org and www.PharmacyAccess.org. For a listing of EC pharmacies, visit www.EC-HELP.org.

Against the Grain: U.S. Abortion Policy from a Global Perspective

By Leila Hessini, IPAS

In 1973, the United States was part of a global trend to reform restrictive abortion laws that resulted in the unnecessary deaths and injuries of millions of women. After the Supreme Court decision in *Roe v. Wade* secured the right to abortion, access to safe abortion care dramatically reduced maternal deaths and injuries. Despite this healthy trend, right-wing conservatives immediately began a crusade to undermine women's health and self-determination, promoting conservative ideology over public health interests and significantly limiting women's access to safe abortion services.

While things are bad in the United States, they are much worse globally. Nearly one-quarter of all adult women in developing countries suffer illness or injury related to pregnancy and childbirth. One hundred-twenty million couples want to delay childbearing but do not have access to modern contraceptive methods. Many more lack access to essential obstetric care, which leads to 515,000 maternal deaths each year. And not coincidentally, approximately 70,000 women die each year due to unsafe abortions and millions more are temporarily or permanently disabled.

So how has the Bush Administration shown compassion for these women? On his second day in office, President George W. Bush reinstated the global gag rule. It prohibits foreign nongovernmental organizations that receive U.S. funds for family planning from providing abortion services, including referrals, even when these activities are supported by their non-U.S. funds and are lawful under their own legal system. While freedom of expression remains a constitutional right in the United States, our foreign assistance is used as a vehicle to impose an ideological agenda that undermines that right around the world. Through the gag rule, the U.S. government is proclaiming that women outside the United States should not benefit from a right that American women, at least theoretically, enjoy.

While proponents of the gag rule maintain that its imposition is necessary to reduce the number of abortions, research shows that it accomplishes just the opposite. The restrictions cause more unplanned pregnancies, more unsafe abortions, and more deaths and injuries of vulnerable women and girls. In addition, it makes no distinction between the varied and sometimes tragic circumstances that lead women to seek an abortion. Whether women and girls are rape victims, HIV positive or simply too young to have a child, the policies of the United States give them only one choice: to continue an unwanted and potentially deadly pregnancy or risk their lives by self-induced or otherwise unsafe abortions. The underlying message of the gag rule is that women's lives simply do not matter.

While the United States exports this archaic, unscientific and undemocratic policy, the world is moving in a different direction. In 1994, 179 countries agreed to address the public health impact of unsafe abortion at a key United Nations event. In its 1996 post-apartheid constitution, South Africa guaranteed a woman's right to abortion. In the past five years, both Ethiopia and Nepal have greatly liberalized their abortion laws.

In the Muslim world where I am based, the parameters of the abortion debate, and the language and strategies used, differ substantially from the United States. The fervor, absolutism and sometimes violent tactics that characterize the U.S. anti-abortion movement are completely absent. Efforts are made to limit the number of abortions by understanding the circumstances that lead women to experience unplanned and unsafe pregnancies. While the sanctity of life is critical to all Muslims, debates do not focus on fetal rights or when pregnancy begins, but what is best for women, existing children and their families.

In Egypt, Iran and Saudi Arabia, Muslim leaders have issued religious proclamations about the acceptability of abortion. Laws permitting abortion have been expanded in several countries including Bahrain, Turkey and Tunisia. These efforts are part of a global trend — ignored or opposed by the United States — of abortion law reform in more than 15 countries during the past decade.

In the time that it has taken to read this article, 88 women will have had an abortion, close to half of them under unsafe conditions. By contrast, thousands of lives have been saved in the U.S. since abortion was legalized 33 years ago. The struggle for reproductive justice continues, in Kansas as well as in Kenya. As we recognize the anniversary of *Roe v. Wade*, let us pause and scrutinize the real impact of our national and international policies. Unless we do, millions of women around the world will continue to suffer and die as a result of our misguided and morally bankrupt policies.

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

The Meth Baby Myth

By Lynn Paltrow,
National Advocates for Pregnant Women

Signatories from leading hospitals and Research Institutes in US and abroad agree that term lacks scientific basis as does the claim that treatment does not work. On July 25, 2005 more than 90 leading medical doctors, scientists, psychological researchers and treatment specialists released a public letter calling on the media to stop the use of such terms as "ice babies" and "meth babies." This prestigious group agrees that these terms lack scientific validity and should not be used.

Motivated by news coverage using alarmist and unjustified labels and new legislative proposals suggesting punishment rather than treatment, these leading doctors, researchers, and specialists collaborated to write a consensus statement requesting that media coverage of the subject and legislative proposals addressing it be "based on science not presumption or prejudice." Members of the consensus group agree "The use of stigmatizing terms, such as 'ice babies' and 'meth babies' lack scientific validity" and that the use of "such labels harms the children to which they are applied" by "lowering expectations for their academic and life achievements, discouraging investigation into other causes for physical and social problems the child might encounter, and leading to policies that ignore factors, including poverty, that may play a much more significant role in their lives. Members also agree that "the suggestion that treatment will not work for people dependent upon methamphetamines, particularly mothers, also lacks any scientific basis." The letter calls on the media to stop the use of pejorative terms and also urges the media to stop its practice of relying on people who lack scientific experience or expertise for their information about the effects of prenatal exposure to methamphetamine and about the efficacy of treatment. In order to receive a copy of the complete list of signatories, please visit

http://www.jointogether.org/y/0,2521,577769,00.html

Should Kirsten Johnson Be Allowed To Have Kids?

By Katie Watson

Vera Howse thinks her 26-year-old niece Kirsten Johnson wouldn't be a good mother, so she's asked the Cook County Probate Court for authorization to sterilize her niece against her will. Johnson is cognitively impaired, and her aunt is her legal guardian. This case has broad significance because Illinois, unlike other states, hasn't established when a court should grant a guardian authority to have a ward permanently sterilized.

Most cases like this are resolved in the doctor's office. Physicians at one Chicago hospital system estimate that it receives one to three guardian requests to sterilize their wards per month, usually from parents of disabled adolescents. After counseling, most eventually opt instead for long-term reversible birth control.

But in this case Howse continued to insist that her niece be sterilized permanently, and her internist and psychiatrist did not object. Johnson countered by contacting Equip for Equality, a disability rights organization that represented her in court. Johnson, who lives with her aunt in south suburban Matteson, is sexually active. She has always used birth control (her aunt currently helps her use the patch), but says if she were to marry a man who could help her parent someday, she would like to have a child.

Historically speaking, Johnson's situation isn't unique. State programs forced up to 70,000 disabled and poor Americans to be sterilized between the early 1900s and the 1970s. These programs, now ended, were driven by a belief that social eugenics would both "improve the gene pool" and save the taxpayers money by reducing the number of children born to parents who couldn't support them.

The courts were no help. In Virginia, for example, the Lynchburg Colony for the Epileptic and Feeble Minded, which sterilized 8,300 people from 1927 to 1972, was a model of empty due process. The disabled and poor teens forcibly brought to the institution were given a perfunctory hearing, after which a judge would always find it was in the "best interests" of the patient and society that the ward not reproduce. In 1927 the Supreme Court upheld this Virginia statute in the case of *Buck v. Bell*.

Six years later, the Nazi regime in Germany modeled its new eugenic program on U.S. sterilization statutes. They began with the sterilization of disabled individuals in 1933, later executing thousands of persons with disabilities and millions from other "unfit" populations.

Whose 'best interest'?

But things are different now, right? States have formally apologized for their eugenics programs. The Americans with Disabilities Act ushered in a new era of accommodation and respect, and the disabled person's right to medical self-determination is implemented by his or her guardian, who is usually a family member concerned with the disabled person's "best interests." At least that's the standard Illinois law tells guardians to use.

The problem is that childbearing is one decision in which what's best for the ward and what's best for the guardian might conflict. While some cognitively impaired people might enjoy parenthood, their guardians may fear a new baby will become the guardian's responsibility. Or, in the case of congenital disability, guardians may fear the ward will "pass on their genes" and bear another disabled family member. Ironically, these criteria — resources and eugenics — are exactly those used by the now-discredited state programs.

What standard should Illinois courts use to resolve cases like Johnson's? To be blunt, families give up a lot to care for a cognitively impaired child. Is it so wrong to ask the disabled individual to give up the right have children in return? Might this be a fair exchange?

Absolutely not. The law says no person's reproductive options are contingent on the needs, desires or judgment of another. Why should persons with disabilities be the exception? No parent is allowed to control whether their child bears a grandchild, even when they're a minor (legally "incompetent").

Wives can give birth and have abortions against their husband's wishes. And the Supreme Court has ruled that criminals can't be sterilized as part of their punishment.

Reproductive freedom holds such a cherished place in our society that even the welfare of the potential child does not trump it. The state cannot prevent an abusive, drug-addicted person who has lost eight children to foster care from procreating. But Judge James Riley sees this case differently. In his Aug. 11 decision, he ruled that it is in Kirsten's best interest "to have a permanent form of birth control." Why? Because several people testified that she would not be able to care for a child alone. This sounds like a "parental litmus test" to me. I'm not applauding irresponsible parenting, but making people with disabilities the only group in America that must prove they'll be good parents before they are "allowed" to reproduce is intolerable discrimination. The second reason Riley gave for his decision was Johnson "would suffer irreparable psychological damage" if she had a child and the child was removed from her because of her inability to care for that child.

She can read, not drive

No one, including Johnson, disputes she'd need training and support to be a good parent. She's high functioning in some ways, but her IQ is in the borderline to low average range. She can dress, bathe and feed herself, but she can't drive. She can read, but she can't handle financial affairs, and she needs some assistance with household chores. But information and services for disabled parents is available at places like Community Support Services. Parenting support for the cognitively impaired is like ramps for those in wheelchairs — small modifications that ensure the only limitations are those caused by disability itself, not our society's response to it.

This case highlights the deep chasm that separates the able-bodied from the disabled. To prove it, try a thought experiment: Who in this essay have you identified with so far? I know I imagine myself in the position of the well-intentioned, overwhelmed guardian. If I stretch, I can imagine what it might be like to be raised by a cognitively impaired mother. Both sound hard.

But it's telling that I don't imagine myself in the shoes of the disabled person. It's also foolish. Johnson's brain was injured in childhood when she was hit by a car, something that could happen to me tomorrow. And if it did, I'd want to live my life to its fullest. I'd want "the dignity of risk" — the option to try difficult things and live with the consequences — and the support I'd need to maximize my potential and happiness. That's my "living will" for the social care I'd want after an accident.

Johnson's case isn't over. Riley has ordered that Johnson be evaluated to see whether she's a medical candidate for Implanon (the new Norplant) or an IUD that lasts 5 or 10 years, and he deferred his final ruling on Ms. Howse's petition for tubal ligation. On January 17, 2006, Judge Riley ruled that "birth control" is in the best interest of Johnson.

In this precedent-setting case, Riley says he's following a Pennsylvania court that adopted a "discretionary best interest standard." But his application of the specified best interest criteria is misguided and incomplete, because the standard the Pennsylvania court used is intended to focus the court on what's best for the person with a disability, and away from the best interest of the guardian, family, society or potential children.

Persons with disabilities in Illinois deserve better than this. Tubal ligation is a safe, effective form of contraception many women — including some with cognitive deficits — freely choose. But allowing guardians to permanently block their ward's reproductive desires with the muscle of the courts and the knife of medicine is a discriminatory step back toward a shameful era to which we should never return.

Katie Watson is lawyer and a lecturer in the Medical Humanities and Bioethics Program of Northwestern University's Feinberg School of Medicine. "Should Kristen" was originally posted on Minivanmom.com

New & Renewed Member Organizations Since 10/06

Organization Name	City	State	Website
African American Women Evolving	Chicago	IL	www.aaweonline.org
Asian Communities for Reproductive Justice	Oakland	CA	www.reproductivejustice.org
Asian Women's Health Project of T.H.E. Clinic	Los Angeles	CA	
Black Women for Wellness			www.bwla.com
Black Women's Health Council	St. Louis	MO	www.morcrc.org/index_page0010.htm
Black Women's Health Project, NE New York	Albany	NY	
California Black Women's Health Project	Los Angeles	CA	www.cabwhp.org
California Latinas for Reproductive Justice	Los Angeles	CA	
Catholics for a Free Choice	Washington	DC	
Dominican Women's Development Center	New York	NY	www.dwdc.org
Feminist Majority Foundation	Arlington	VA	
Grupo Pro Derechos Reproductivos	San Juan	PR	
Indigenous Peoples AIDS Task Force	Minneapolis	MN	www.indigenouspeoplestf.org
Institute for Women and Ethnic Studies	New Orleans	LA	www.iwes.org
International Center for Traditional Childbearing	Portland	OR	www.blackmidwives.org
Khmer Girls in Action	Los Angeles	CA	http://socal4youth.org/story.php?story=3
Kokua Kalihi Valley Comprehensive Family Services	Honolulu	HI	www.kkv.net
Los Angeles Indigenous Peoples Alliance	Los Angeles	CA	www.laipa.net
Mujeres Latinas En Accion	Chicago	IL	www.mujereslatinasenaccion.org
National Asian Pacific American Women's Forum	Washington	DC	www.napawf.org
National Latina Health Organization	Oakland	CA	www.latinahealth.org
National Latina Institute for Reproductive Health	New York	NY	www.latinainstitute.org
New Voices for Reproductive Justice Pittsburgh	Pittsburgh	PA	
Organization for Black Struggle	St. Louis	MO	www.obs-onthemove.org
Pro-Choice Public Education Project	New York	NY	
Project AZUKA Women's AIDS Project	Savannah	GA	www.azuka.org
Sakhi for South Asian Women	New York	NY	www.sakhi.com
Sistas on the Rise	Bronx	NY	www.sistasontherise.org
SisterLove, Inc.	Atlanta	GA	www.sisterlove.org
Sisters of Color United for Education	Denver	CO	www.sistersofcolorunited.org
The Praxis Project	Washington	DC	www.thepraxisproject.org
Tewa Women United	Santa Fe	NM	www.tewawomenunited.org
Virgin Islands Perinatal, Inc.	Christianhead	VI	
Wise Women Gathering Place	Green Bay	WI	www.wisewomengp.org
Women of Color Building Project	Minneapolis	MN	

For a complete list, contact SisterSong at info@sistersong.net

COLAGE CALL FOR SUBMISSIONS!

JFU is the only publication dedicated to the words, thoughts, opinions, and experiences of children, youth, and adults with lesbian, gay, bisexual, and/or transgender parents - and we want to hear from YOU.

Our first issue of 2006 will focus on reproductive justice and our families. When most people hear the term 'reproductive justice' they think first of abortion. Yet, the issue is actually much, much larger.

For someone who does not want a child, reproductive justice might mean information about contraceptives, access to abortion, or freedom from gender stereotypes that pressure them into parenthood. For someone who does want to have a child, reproductive justice might mean access to health care, ways to create a family through donor insemination or adoption, and protection from oppression or discrimination by state agencies, health care professionals, and other institutions.

One reason that COLAGErs might be concerned about reproductive justice is because of the huge diversity of ways that our families are created.

In 2006, several states are expecting proposals to ban same-sex couples from adopting or being foster parents. In Virginia, Delegate Bob Marshall has introduced a bill that would prohibit doctors and other licensed health professionals from assisting unmarried women with becoming pregnant. As people with LGBT parents, we want OUR voices to be a part of these debates as we talk about our true experiences and the right of our families to exist and for families like ours to be created.

In the next issue of JFU, we hope to explore these connections more deeply, and we invite you to tell us YOUR take on reproductive justice and LGBTQ families. Here are some questions to consider:

- How was your family formed? Was reproductive justice important to how your family came to be?
- Do you think reproductive justice is an LGBTQ issue? Why or why not?
- Were you raised by a single parent? How has this affected your outlook on marriage, family, and reproductive justice?
- If you were adopted, fostered, or created through donor insemination or surrogacy, did your parents have any difficulty carrying out their choice to have a child? What happened, and what is it like for you now?
- What does family mean to you? Why is it important for people to choose whether and how to make a family?

Submissions can take any form - art, poetry, and essays are all welcome and encouraged! Your article can be autobiographical, editorial, or informative in nature. Please limit your piece to 750 words or less and include a short bio, your contact information, and a digital picture with your submission. If you would like to contribute and need assistance planning or writing your article, please contact the COLAGE office.

Email questions or submissions to:
jfu@colage.org, call us at
415-861-5437, or send us a letter: 3543 18th St. #1 San Francisco, CA 94110.

Expand the **Pro-Choice** Dialogue

By Dinushika Mohottige

DURHAM, N.C. - President Bush's Supreme Court nomination of conservative Samuel Alito has reignited discussions over whether a woman's legal right to choose an abortion is under a serious threat.

The pro-choice movement continues to face the challenges of rallying reproductive rights supporters and defining and defending the term "choice." But has it really stopped to consider how "choice" applies to the options and resources available to low-income and minority women?

The pro-choice movement has long established its cause as defending a woman's right to choose. Yet for many women, that choice is nonexistent. The cost of raising a child in the United States today is nearly $200,000. With an egregious lack of affordable healthcare, housing, and educational opportunities, many poor women of color may simply opt out of bringing a child into the world.

The numbers bear this out: Minority women are more likely to live in poverty than other women in their states and in the nation as a whole, according to 2001 US Census figures. Further, women having abortions have become increasingly likely to be poor, nonwhite, and unmarried, and already have one or more children; two-thirds say they cannot afford to have a child, half say they do not want to be a single parent, according to a 2005 Alan Guttmacher Institute report.

As a feminist of color, I am often frustrated by feminists and pro-choice activists who consistently engage in a two-sided reproductive rights dialogue void of discussions of race and class. Where are the reactions to the fact that although blacks constitute only 13 percent of the US population, they account for nearly 36 percent of abortions, according to Centers for Disease Control and Prevention 2001 figures?

It is time the national pro-choice movement - which aligns itself with women's empowerment and autonomy - widens the conversation to include and advocate the numerous issues faced by women whose daily needs and concerns remain largely neglected and marginalized.

It is easy to become engrossed in today's divisive reproductive rights jargon without realizing the fuller historic context of women of color and the American pro-choice movement.

For example, consider the opinions of Margaret Sanger, a white 1920s birth-control advocate and the founder of the American Birth Control League (later to become Planned Parenthood).

In her 1920 publication "Women and the New Race," Sanger claimed "every jail, hospital for the insane, reformatory and institution for the feebleminded cries out against the evils of too prolific breeding among wage-workers." Sanger's advocacy of birth control extended to support eugenics - a movement that promoted selective breeding and genetic engineering to advance the human race, later criticized as a form of scientific racism.

This approach of "managing" poor minority populations extended well into the modern era. A 1975 report published by the Health Research Group revealed how sterilization had been abused by clinicians seeking to prevent poor, disabled, or minority women from bearing children or having repeat abortions. And often limited income meant poor women who did seek abortions were forced to endure unsanitary, sometimes fatal, "back alley" procedures, according to a 1977 report by the Committee to End Sterilization Abuse.

Another view held by Sanger that I do firmly support says, "[N]o woman can call herself free until she can choose consciously whether she will or will not be a mother." But providing little in the way of access to affordable healthcare, prenatal care, housing, and education is hardly creating an environment of choice. The lives and freedom of American women depend on all of those things, but also on upholding *Roe v. Wade* and expanding affordable access to safe abortions.

A revitalized pro-choice movement must remain vigilant against the subtlest drift toward imposed birth control, abortion, and the reduction of fertility among "socially undesirable" women. At the same time, our generation must revamp the discourse of reproductive freedom to address the varied experiences of women.

Pro-choice advocates can begin by acknowledging and working to eliminate resource and access disparities in all areas of women's lives throughout the nation. But that is only a preliminary step. Women of color need to become fully embraced by and engaged in the pro-choice movement. We must demand a new framework for understanding "choice" and more comprehensive solutions for women's empowerment and reproductive liberty. Only then will the pro-choice mission ultimately benefit from expanding to include the often muffled "different" voices that extend beyond shared gender.

• *Dinushika Mohottige is a Robertson Scholar at Duke University and codirector of Dialogues on Race Relations, a campus forum.*

WHAT IS TRUE SELF-DETERMINATION?

HOME BIRTH = SELF DETERMINATION

You decide how, when, where and with whom to give birth, using your own resources.

BREAST-FEEDING=SELF DETERMINATION

Your own body is the “nest” for your baby. Your own body makes all the food, medicine and water that your baby needs according to the combined rhythms of you and your baby. Your milk is the PERFECT food for your baby.

MOTHER-TENDED CHILDREN=SELF DETERMINATION

You are worry-free because you know for sure how your baby is treated, fed and cared for. You are in complete control of what your baby is exposed to. You are your baby’s first teacher.

INDIGENOUS FOOD=SELF DETERMINATION

Your most healthy food is created and offered as gifts to you by the homeland.
No artificial one-size-fits-all food pyramid

MIDWIVES=SELF DETERMINATION

You are the perfect helper. You are available, nearby, concerned, experienced, able and willing.

HOME SCHOOLING=SELF DETERMINATION

You teach your own child according to your child’s unique way of learning, thus assuring continuation of your own cultural beliefs.

ABSTINENCE FROM KNOWN HIGH RISK CHOICES=SELF DETERMINATION

You protect your own body’s sovereignty by choosing healthy habits including avoiding alcohol, tobacco, drugs, unhealthy foods and sedentary lifestyles and by thoughtfully choosing a safe, loving, committed life-mate before investing everything you have into an intimate relationship.

FAMILY-TENDED ELDER CARE=SELF DETERMINATION

You are worry-free because you know for sure how your elder is treated, fed and cared for. You are able to make sure that the wishes of your loved elders are respected and fulfilled.

Insurance Rates of Asian and Pacific Islander Children Vary Widely

According to a report published by the UCLA Center for Health Policy Research, six out of 10 Asian American and Pacific Islander (AAPI) children have employer-based health insurance. Over 90% have insurance all year, but children's coverage differs across AAPI ethnic groups. The California Health Interview Survey data reported that Korean and Vietnamese children had the lowest rates of continuous job-based coverage in 2001/2003, at 40.5% and 42.6%, respectively, compared to 71.9% of Filipino children and 62.7% of AAPI children overall. In spite of their low rate of employment-based insurance coverage, Vietnamese children are protected by Medi-Cal and Healthy Families. Korean children, however, have half the rate of public coverage enrollment and consequently, twice the rate of uninsurance. Nearly 60% of AAPI children who were uninsured all or part of the year are members of families with a least one full-time employee. Among AAPI children with Medi-Cal or Healthy Families, over three-fourths are in families with at least one working parent. Data from the CHIS 2001-R and 2003 has been averaged to provide more stable estimates for health insurance and uninsured eligibility rates among Asian subgroups. Family work status data is only available from CHIS 2003.

For a complete copy of the fact sheet, visit http:/www.healthpolicy.ucla.edu under "What's New."

Bribing Low-Income Families to Ignore Environmental Hazards

In January 2006, the *Seattle Times* reported that the Environmental Protection Agency launched a two-year investigation, partly funded by the American Chemical Council, based on how 60 children in Duval County, Fla., absorb pesticides and other household chemicals. The chemical-industry funding initially prompted some environmentalists to question whether the study would be biased. Now, some rank-and-file agency scientists are questioning whether the plan will exploit financially strapped families.

In exchange for participating for two years in the Children's Environmental Exposure Research Study, which involves infants and children up to age 3, the EPA will give each family using pesticides in their home $970, some children's clothing and a camcorder.

Willingness of Minorities to Participate in Health Research

Researchers at the National Institutes of Health conducted a study which shows that minorities participate in health research studies at the same rate as non-Hispanic whites when they are informed about the study and meet the medical requirements. The findings also report that minorities are more likely to participate when there is more access. The study was led by researchers in the Department of Clinical Bioethics at the National Institutes of Health Clinical Center, the hospital at NIH. The work was published online December 6, 2005 in the medical journal "PLoS Medicine," published by the Public Library of Science. The research team did a comprehensive search of the medical literature to identify published trials that reported consent rates by race and/or ethnicity. The team identified and reviewed 20 studies that involved more than 70,000 patients. Most of studies were conducted in the United States and most of participants from minority groups were African Americans or Hispanics. Given that research was based on the enrollment decisions of more than 70,000 people over two decades in a variety of different types of research studies, from epidemiology to drug to surgical studies, the authors say they believe their findings are robust.

"In order to improve the health of our population, we must make health research accessible to all groups," says Raynard Kington, NIH Deputy Director. "This NIH-supported study is a good example of research on how we do our research that can help us in making sure we have the best scientific knowledge base possible for eliminating health disparities." As one of the authors of the report, Kington focused on the relationship between social factors, such as race and economic status, and health.

According to the study, it is widely claimed that racial and ethnic minorities are less willing to participate in health research because of past research abuses. The Tuskegee Experiment, which took place in 1932 and lasted forty years, was a syphilis study conducted by the Public Health Service. Hundreds of poor African American men in Alabama were followed for decades without being told they had syphilis and were prevented from getting penicillin to treat it.

But the data from this new study finds that when minorities are given the opportunity to participate in health research, they do so at the same rate as non-Hispanic whites.

"The big take home message here is that the main barrier probably is not the attitudes of African Americans and other minorities," Emanuel says. "The main barrier is access, knowledge that these studies exist, eligibility criteria that ensure minorities can participate, and overcoming logistical barriers that exist," such as the location of the study or the need for child care.

For more information, visit http://clinicalcenter.nih.gov/

Montana American Indian Population Expected to Double Because of Birth Rates

The *AP/Billings Gazette* reports that in the next 25 years, Montana's American Indian population is expected to double with an "explosive" birth rate. On the Rocky Boy's Reservation, about 90 miles northeast of Great Falls, the birth rate is about 29 births per 1,000 residents, more than twice the state's rate of 12 births per 1,000 residents. According to tribal health board records, the birth rate accounts for at least 100 infants for each of the last five years, not including infants born off the reservation. Reservation populations also tend to be younger, which means fewer deaths and more births, according to the *AP/Billings Gazette*. A 2005 survey conducted by the Center for Disease Control and the Montana Office of Public Instruction on high school students reports that reservation teens are having sex earlier, more frequently and with more partners, compared with off-reservation teens. The study reveals that reservation teens also are less likely to use contraceptive methods than teens who do not live on a reservation. According to the data, 70% of reservation high school students reported having had sex and 10% of sexually active reservation students surveyed reported using birth control pills. Zella Nault, a counselor at Rocky Boy High School, said some families discourage birth control because it conflicts with Indian values or Catholic teachings. "A lot of older people don't believe in birth control because it goes against nature," Nault said. In 2000, the Rocky Boy's Reservation population was estimated to be 2,676; however, a private study by the Chippewa-Cree Business Committee estimates the actual population to be 4,200 - a 54% increase from census figures 10 years ago.

Model Prenatal Care in New York Prison

NPR's "Weekend Edition Saturday" profiled the prenatal care program for female inmates at Bedford Hills Correctional Facility in Westchester County, NY. The state sends all of its pregnant inmates to Bedford Hills, a maximum security prison, where they receive prenatal care and parenting classes. Inmates are also permitted to keep their infants at an in-house nursery for up to 18 months after birth. The program was created to cultivate relationships between mothers and their newborns, as well as give the women a reason to "stay straight," according to NPR. Mary Byrne of Columbia University, who is evaluating the success of the nursery program, said the infants at Bedford Hills "do as well as babies in any other setting" and are "not challenged at all in any negative way." Her research is expected to be completed in 2007. Critics of the program say it is "soft on crime" and that inmates should lose their parental rights. The U.S. is one of four countries that routinely take infants away from their incarcerated mothers (Wertheimer, "Weekend Edition Saturday, " NPR, 11/5).

Black Women With Breast Cancer More Likely To Die of Disease Study Shows

In a study published in the October 2005 issue of the *Journal of the American Medical Association*, the *News Daily Press* reports that black women who have breast cancer have a lower survival rate than white women with the disease. The findings state that black women are more likely to die from co-infections of other chronic diseases, such as diabetes, heart disease, lupus and AIDS. Martin Tammemagi, an associate professor of epidemiology at Brock University in Canada, and colleagues examined the medical records of 264 black women and 642 white women diagnosed with breast cancer in Detroit's Henry Ford Health System between 1985 and 1990 (Tammemagi et al., JAMA, 10/12). Almost 23% of black women with breast cancer were diagnosed with four or more diseases, compared with an 18% co-infection rate of four or more diseases among white women, according to the study. About 37% of black breast cancer patients in the study died from those illnesses, compared with 32% of white patients. John Kessler, a physician with Virginia Oncology Associates, said drugs used to treat other diseases could interfere with surgery and chemotherapy, rendering them less effective, or possibly create complications. Kessler recommends to other physicians to monitor all conditions.

Chicago Doulas for Low-Income Pregnant Teens

In October 2005, the *New York Times* profiled the work of Chicagoian Loretha Weisinger, an advocate who provides "doulas" – women who serve as mentors and coaches – to low-income pregnant teenagers during childbirth. Doulas often charge $1,000 per birth and are usually hired by upper-middle class pregnant women. Now Weisinger is providing this service to teenagers on the West Side of Chicago. A University of Chicago study conducted by psychologist Sydney Hans found that the work of doulas increases rates of breastfeeding and has other, less tangible benefits. Supporters of doulas are mimicking Weisinger's work around the country, with similar programs appearing in Phoenix, Indianapolis, Denver, Atlanta and Albuquerque, N.M., and burgeoning plans to launch programs in San Francisco, Cleveland, New York, Milwaukee and Washington, D.C. (Wilgoren, *New York Times,* 9/25).

Three Federally Funded Abstinence Programs Instill 'Fear' Not Information in Students

In its third annual "Back to School" briefing, the Sexuality Information and Education Council of the United States (SIECUS) reported that three federally funded abstinence-only sex education programs spread messages of "fear and shame" among students. The findings state that the programs also teach medical misinformation on issues such as the effectiveness of contraception and the risks of contracting sexually transmitted diseases. The council reviewed the "Passion and Principles," "Worth the Wait," and "Navigator" curricula, which have been taught in more than 12 states and used in programs that have received more than $4 million since fiscal year 2001. According to SIECUS, the "Passions and Principles" program states; "one in five times condoms will fail for pregnancy," promoting bias and providing inaccurate information. The group also lists statements in the three curricula it says are religious and inappropriate for public school, use negative messages or offer false information. According to their findings, abstinence-only sex education programs have received more than $600 million in federal funds since 2000. For FY 2006, the Bush administration requested $206 million for such programs, an increase from about $170 million in FY 2005. The Responsible Education About Life Act (HR 2553, S 368), co-sponsored by Rep. Barbara Lee (D-Calif.) and Sen. Frank Lautenberg (D-N.J.) and supported by SIECUS, would provide $206 million annually in grants to states to provide comprehensive sex education programs. According to the group, "no federal funding stream currently exists for this type of education."

Proposed Bills To Limit Reproductive Procedures for LGBT People Dropped

A controversial bill proposed by Sen. Patricia Miller (R-Indianapolis) prohibiting the LGBT community and single people from using medical procedures to produce a child was dropped by its legislative sponsors in October 2005. Under her proposal, couples who needed assistance to become pregnant through intrauterine insemination, the use of donor eggs, embryos and sperm, in vitro fertilization and embryo transfer, would have to be married to each other. The bill, which also required married couples to go through the same rigorous assessment as parents who want to adopt, received harsh opposition from the Indiana Civil Liberties Union and Planned Parenthood of Indiana. "The issue has become more complex than anticipated and will be withdrawn from consideration by the Health Finance Commission," says Sen. Miller.

In January 2005, the *Richmond Times-Dispatch* reported that the Virginia House Health, Welfare and Institutions Committee without debate rejected a bill (HB 187) that would have banned unmarried women from becoming pregnant through assisted reproductive technologies such as in vitro fertilization. A subcommittee of the state House health committee heard testimony on the bill — sponsored by Delegate Robert Marshall (R) — and voted not to recommend it. Virginia House rules state that subcommittee recommendations on legislation stand unless the full committee votes to consider a rejected bill. Marshall said he will attempt to add language from HB 187 as an amendment to another measure on the state House floor. The health committee also did not reconsider the subcommittee's rejection of another bill sponsored by Marshall that would have required physicians providing abortion services in Virginia to have residency and hospital privileges in the state.

Survey Shows Half of 15-19 Years Olds Have Had Oral Sex

The CDC's National Center for Health Statistics released a study in September 2005, which reported that about 55% of U.S. boys ages 15 to 19 and 54% of girls the same ages have engaged in oral sex, while 49% of teenage boys and 53% of teenage girls have engaged in sexual intercourse. William Mosher and colleagues from NCHS presented national estimates for several measures of sexual behavior using data from the 2002 National Survey for Family Growth, a survey of 12,571 U.S. men and women ages 15 to 44 (Lewin, *New York Times*, 9/16). The data from the survey show that the proportion of teens engaging in oral sex increases to approximately 70% with 18 and 19 year-olds. In addition, about 12% of 15 to 19-year-old boys and 10% of girls the same age said they engage in oral sex but avoid having intercourse. The percentage of people who said they had oral sex but not intercourse dropped to 3% among people ages 22 to 24 (Heslam, *Boston Herald*, 9/16). However, nearly all teenagers who reported having had sexual intercourse also have engaged in oral sex — 88% of teen boys and 83% of teen girls (*New York Times*, 9/16). According to

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the survey, only 9% of teens said they used condoms during oral sex.

Kristin Moore, president of the not-for-profit research organization Child Trends, responded to the findings by stating, "If a substantial number of young people are having oral sex, as these numbers indicate, this is a big concern." Jennifer Manlove, director of Child Trends' fertility research, said some teens might view oral sex as a way to maintain their virginity, but are not aware of its health risks. "What's disturbing about these findings is that many teens seem unaware of the health risks associated with oral sex, such as the possibility of contracting sexually transmitted infections, including HIV," said Manlove. The National Campaign to Prevent Teen Pregnancy also conducted an analysis of the data. Communications director Bill Albert said that parents must improve their communication about sex with their teenage children. "If they want their teens to abstain from sex, they need to say exactly what they want their kids to abstain from."

Cervical Cancer Screening Rates Law Among Asian Women

Health providers working to reduce the rates of cervical cancer among Asian women say cultural traditions are preventing women from undergoing screenings and seeking treatment for the disease, the *Philadelphia Inquirer* reports. Health workers say that many Asian women avoid seeking testing and treatment in part because of the cultural tradition of modesty that teaches them to be uncomfortable exposing their bodies to male gynecologists. Other factors include the possible discomfort of undergoing a Pap test, mistrust of the U.S. health care system, language barriers and limited access to medical treatment. According to the National Cancer Institute, the cervical cancer rate among Vietnamese women is five times the rate among white women, and surveys show Asian women overall have lower cervical cancer testing rates. Currently, the CDC is operating a program in areas with large Asian populations in order to prevent breast and cervical cancers. The program's message is: "If you don't take care of yourself, you can't take care of your family."

African American Women Evolving

Call For Abstracts:
2006 Black Women: Loving the Mind, Body, & Spirit Health Conference
October 27-28, 2006
Malcolm X College
Chicago, Illinois

African American Women Evolving, Inc. (AAWE) invites health care service providers, community organizers, policy makers, health researchers, and public health advocates to submit abstracts for presentation at our 2006 Black Women: Loving the Mind, Body, & Spirit Health Conference. The conference themes focus on the intersections between women and girls being healthy, having healthy families, and living in healthy communities. Help make this conference an important step forward for Black women's and girl's health!

Email Submissions
You can submit your abstract via email to AAWEin2006@aaweonline.org An email will be sent to you acknowledging receipt of your abstract.

Mail submissions
AAWE
2006 Black Women: Loving the Mind, Body, & Spirit Health Conference
220 South State Street, Suite 1330
Chicago, Illinois 60604

Emergency Funds for Hurricane Victims

The National Network of Abortion Funds has established an emergency fund for abortion care for women and girls affected by the hurricanes. Our national case manager, Lynn Jackson, will coordinate this funding for women affected. Lynn will take calls from the women needing help, from member funds, and also from clinics working to help women from the hurricane region. WRRAP has also set up a special fund to assist women affected by the hurricane. Together, the Network and member funds will work to help as many women and girls as possible.

We believe that the abortion funding needs of women and girls from the hurricane region will grow substantially over the next weeks and months. Many women may have to delay their abortions as they deal with other survival issues and will likely seek second-trimester abortions that require increased funding.

If you know people interested in making a donation to help with this effort, tax-deductible donations for abortion care for hurricane victims can be sent to NNAF at the following address. Please earmark gifts: Hurricane Victims Abortion Fund.

NNAF
42 Seaverns Avenue
Boston, MA 02130

Donations can also be made online at www.nnaf.org by clicking on the "donate now" button. Please specify that donations are for hurricane victims. Donors can also call the NNAF office for more information at: 617-524-6040.

Here is a list of free and reduced-fee services from clinics near the hurricane region (compiled by Ann Rose, Abortion Clinics OnLine, http://www.abortion-clinic.com). We understand that women are really scrambling to get both abortion and contraceptive services (in addition to help dealing with sexual assault). Also, all of the states in the region have a 24 hour waiting period, causing another huge problem for women who have no place to "wait."

If any funds have additional information about clinics in the affected states, or about where women are going for help once leaving the hurricane states, please let me know (Stephanie Poggi at spoggi@nnaf.org). Also, if your fund is able to negotiate lower-fee procedures for Katrina refugees from clinics you're working with, that information will also be helpful.

LOUISIANA

As far as we know all New Orleans clinics are CLOSED. We've had trouble getting through on the phone to Baton Rouge, but they're supposed to be OPEN.

Hope Medical Group in Shreveport, Louisiana is OPEN. Call 800-448-5004 http://www.hopemedical.com

Bossier City Medical Suite in Bossier City Louisiana is OPEN. Call 800-749-7267 http://www.abortion-bossier-city.com

Delta Women's Clinic in Bossier City is OPEN Call 225-923-3242

ALABAMA

Mobile clinic will be open as of September 6 for consents, then Wednesday/Thursday next week for procedures. Center for Choice. Call 251-476-2404 http://www.gynpages.com/ACOL/alabama.html

ARKANSAS

FREE abortions for hurricane victims available in Little Rock at Little Rock Family Planning Services 800-272-2183 http://www.lrfps.com Abortion assistance available at Fayetteville Women's Clinic in Fayetteville AK 479-442-8166

MISSISSIPPI

Jackson Women's Health Organization (the only clinic in the state) in Jackson MS is OPEN. Help is needed because women are coming in for sevices with just the clothes on their backs. Financial assistance will be available to patients on an individual basis, as well as clothing and other necessities. The clinic has been closed all week but is open Friday/Saturday and Monday through Saturday next week. Call 800-532-5383. http://www.gynpages.com/ACOL/mississippi.html

TEXAS

Most Texas clinics will make special arrangements for hurricane victims. Call them for more information. http://www.gynpages.com/ACOL/texas.html

Planned Parenthood of Houston & SE Texas offering FREE Emergency Contraception and Birth Control

http://www.plannedparenthood.org/pp2/portal/files/portal/webzine/insidepp/ipp-050826-hurricane.xml

New Orleans' Women's Health Clinic and Apothecary Need Help

By Thea Patterson, Women's Health Clinic and Apothecary

In the aftermath of Hurricane Katrina huge gaps have been left in care provision for low-income and working class community members who may not have access to insurance but still need affordable health care.

Women particularly have been ignored by mainstream health care structures. Being the carriers of children a.k.a the future it is imperative that this gap be filled. We are seeking to provide health care for women that promote a holistic approach to health and understand that surrounding social realties affect physical health.

As we provide actual services, we will be promoting community based educational and preventative health programs in the forms of workshops, story circles, support groups, peer counseling, peer education, and all around self-involvement of the community in it own health. Though many women lack access to prescription medicines, integrated health strategies, such as herbal medicines and preventative care may be able to provide people with alternatives. We do not believe that specialization, licensure and credentials should stop people from living healthy lives. That kind of community self-involvement is a necessity for people to lead self-determined lives.

We have been offered space. Now we need everything else. Due limited access to the most basic resources, including power and near grocery stores, we understand that providing adequate care will involve some form of mobility and flexibility. We also know that eventually we will need lab capacity. However, at this point, we feel that this list covers the basic needs we have to get a health center up and running.

OFFICE NEEDS

Car
Website
Cell phone
Clipboards
Pens
Business Cards
Folders
File Cabinet (locked)
Computer
Printer
Couches and comfy chairs
Art and other decorative items
Stapler
Paper Clips
Rubber Band
Food (for gatherings/workshops)

EDUCATIONAL MATERIALS

Self-health
Vaginal Health
Reproductive Health

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Diabetes
Hypertension
STDs
Drug abuse
Children's health
Prenatal health
Mental health/self help
Basic Herbal remedies
Healthy Cookbooks
Intimate Partner Violence
Nutritional Information
Lactation Information

CLINIC NEEDS

Staff /Personnel

Exp Health Educator to train others from the community in how to take vitals, blood sugar samples etc., can coordinate broad community health promotion program that promotes a holistic approach to health and understands that surrounding social realties affect physical health.

Exp. Mental Health Counselor (possibly licensed) has experience with rape counseling. dv counseling, grief counseling, stress counseling, etc. Can also train others from the community to lead support groups, peer counseling, story circles etc.

Volunteer base to do intake, staff the clinic, take calls, do outreach, childcare, cook, and run emergency ride service.

Nurse Practitioner
Doctor
Herbalist
Masseuse

Supplies

BASIC NEEDS

Hand Sanitizer
Latex Gloves/ Non-Latex Gloves
Soap
Tongue depressors
Alcohol preps
Sterile water
Saline
Privacy Screen
Bandage Scissors
Thermometers,
Gloucometers
Stethoscopes
Otoscope
Blood pressure cuffs
Pearl cover 4 thermometer
Flu shots

WOMEN'S CARE

Speculums
Table
Stirrups
Lamp
KY Jelly

WOUND CARE

Band-aids,
Ace bandages,
Gauze,
Antibiotic ointment,

OVER THE COUNTER MEDICATION

Hepatitis Shots
Tetanus Shots
Vitamins
(calcium, iron, B complexes, vitamin E)
Tissues
Clinic staple
Pregnancy tests
Needles
Syringes
Over the counter yeast infection medication
Condoms/contraceptives
Keepers/Diva Cup/other alternatives to tampons and pads
Herbs

PRESCRIPTION MEDS

Emergency Contraceptives
Diabetes meds
Hypertension
Heart medication
Asthma medications and inhaler
Antibiotics (broad spectrum)
Hormones (esp. Thyroid)
Estrogen supplements
Birth control pills

BABY SUPPLIES

Baby bottles
Diapers
Formula
Bottles water
Breast pumps
Baby wipes
Blankness
Toys
Scale
Eye chart
Tuning Fork
Rubber Hammer

DIAGNOSTICS

Urine Dip Sticks
Hem occult Tests
Fetal Heart Monitor (portable)
Heart Monitor

Spare Money to supplement other people's workshop ideas and projects (such as a salve workshop, cooking workshop, self-examination workshop, etc.)

Donations can be sent to:
Mayaba Leibenthal
100 Bourbon St.
New Orleans, LA 70130

(Please use Mayaba's name when addressing the package, but enclose a slip specifying that it's for the Women's Health Clinic.)

A collective of community organizers, health professionals, and students organizes this project. Our work is supported and informed by Incite! Women of Color Against Violence, and the Peoples' Hurricane Relief Fund.

Vaginal Gel Trials Start in Africa

By Clare Nullis, *Associated Press*

CAPE TOWN, South Africa (AP) - Researchers in Africa have started what they describe as the largest trials ever held of a vaginal gel that could help women protect themselves against HIV in countries where men are notoriously reluctant to use condoms.

About 10,000 women in South Africa, Uganda, Tanzania and Zambia. are expected to take part in the trial of PRO 2000, which could provide a physical barrier that prevents HIV from reaching target cells during sexual intercourse. It is one of a number of microbicide products in various stages of clinical development around the world. The first nine volunteers were enrolled in Johannesburg this week, said Sibongile Walaza of the University of Witwatersrand Reproductive Health Research Unit.

HIV infection is rising more rapidly among women than men in many parts of the world. Half of all adults living with the virus that causes AIDS are female, according to U.N. figures.

In sub-Saharan Africa, home to more than 25 million of the nearly 40 million people infected globally, the figure is nearly 60 percent, with most new infections acquired through heterosexual intercourse. Yet strong taboos exist on the continent against the use of condoms.

"If there is any other mechanism for women to protect themselves using their own power, then that is absolutely critical," Health Minister Manto Tshabalala-Msimang said at a news briefing Thursday.

Other microbicides under development enhance the natural vaginal defense mechanisms by maintaining an acidic pH, kill pathogens by stripping them of their outer covering, or prevent replication of the virus after it has entered the cell.

PRO 2000 has already been tested on small numbers of women to rule out serious side effects. Clinical trials funded by the British government and coordinated by the Clinical Trials Unit of the British Medical Research Council will take place over three to four years in South Africa, Uganda, Tanzania and Zambia.

Researchers hope to enroll 50 new HIV-free participants a month and ensure that all receive proper counseling and clinical monitoring.

The women will be assigned at random to receive a placebo or the microbicide. They will be asked to use it for one year but can drop out at any time if they are unhappy, Walaza said.

The volunteers will all be counseled to continue using a condom during intercourse, she added. But past experience has shown this advice is frequently

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Building a 21st Century Transnational **Women's Movement:** A Collective Statement of Shared Vision

This statement reflects the discourse and thinking of a group of women activists from around the world who met for three days in early September 2005 at Sarah Lawrence College in New York. The gathering was catalyzed by the growing concerns voiced by women from outside the United States about the grave and detrimental impact of increasing militarism, globalization, religious and political fundamentalism, and U.S. foreign policy on their communities. Almost a year prior to the meeting, a planning group came together to conceive of a gathering that could share the voices of international activists with their potential allies within the United States, and take the first steps in building effective transnational alliances.

The 83 activists who came together represented a diverse group of local, regional, and national leaders in the U.S. women's movement, international women's rights activists from about 20 countries, policy makers, scholars, and a few progressive and feminist donors. Our meeting not only coincided with the anniversary of the attacks on the World Trade Center in 2001, but also came on the heels of a more recent tragedy – the devastation wreaked by Hurricane Katrina in New Orleans and much of the Gulf Coast of the United States. Thanks to the efforts and networks of the Planning Committee, Black, Latina, Asian and Native women, immigrant women and young women were well represented among the 50 participants based in the United States. We engaged in spirited, sometimes painful dialogue informed by our different life experiences, identities, perspectives and core concerns.

Our charge over the course of our time together was to deepen our understanding of how the conditions facing women worldwide are directly related to the unequal and unjust exercise of power by a few over the many. In particular, we used feminism as a lens through which to analyze and critique structures of power, whether at home, in local institutions, or in global governance mechanisms. We also explored our shared experiences of discrimination, violence, and exploitation and debated how we might begin to exploit the potential of transnational organizing for women's rights.

In many international gatherings, the distance between those who live in the so-called "developed world" and those who come from the so-called "developing world" is so great that it requires much time and effort to overcome. But in the immediate aftermath of Hurricane Katrina – which was widely covered in the international media – the historic realities of race and class oppression in the United States were vividly highlighted, enabling many international participants to see for the first time how closely U.S. domestic policy mirrors its foreign policy. We were able to jointly critique the delayed and narrowly militaristic response to the crisis, ignoring local wisdom and networks, and the rapidly deteriorating conditions of life that face the world's women.

For many international participants the gathering offered a rare opportunity to listen to U.S. activists working with farm workers, prisoners, recent immigrants, and factory laborers in the United States. This proved pivotal to their ability to look beyond their most prevalent image of the United States as a wealthy, white, dominant superpower. We quickly arrived at a basic level of agreement about how women, even within the wealthiest nations, often lack sufficient access to the most basic conditions of life: food, water and shelter. They stagger under the burden of unending, undervalued and underpaid work. They experience devastating violence, inflicted upon them by intimate partners, by strangers, and by their communities, as well as by state actors, the military and occupation forces. Discrimination on the basis of sex and sexual orientation undermines women's right to self-determination and to full and free expression of their humanity. Women are unable to secure their own health and that of their families. Their decisions about whether, when, and in what circumstances to bear children are too often not their own. Despite decades of conferences, declarations, international conventions and determined organizing, human rights and human security remain distant goals for far too many of the world's women.

In our collective conversations, we came to unanimous agreement about the leading role the United States has played in undermining and distorting local and national economies, monopolizing access to resources, imposing its political will, and initiating devastating wars and invasions. We were clear that these are issues of critical importance and immediate concern to women in the current political climate, as the world's most powerful nation fuels a global descent into a state of permanent war. While international activists called on their U.S. sisters to identify and assume a leadership role in fashioning a more effective resistance movement to U.S. policy, we were reminded by U.S. activists that multiple challenges within the United States continue to subvert the emergence of a well-organized, dynamic transnational, transformational anti-racist and anti-imperialist women's movement.

Our reflections on the state of the world and our critique of the United States were grounded in workshops and sessions that provided a strong historical context for the current crisis. Our indigenous sisters from North, Central and South America reminded us that the global theft and exploitation of land and resources, and the destruction of peoples, dates back hundreds of years, having shaped the modern system of nation states. These processes have generally been interwoven with militarism and justifying religious ideologies. But the particular forms of economic, social, and cultural globalization of the past several decades has led to the aggressive privatization of social and environmental resources and resulted in the subjugation of peoples, objects, processes, and

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Listen Up!

New Voices for Reproductive Justice, a documentary film on the 2004 March for Women's Lives, will be available for sale starting April 2006. Check out the official website at www.ListenUpFilm.com When completing the order form for Listen Up! use the promotional code SSNET and the SisterSong Collective will receive $5.00 from each purchase.

In this compelling new documentary, women of color activists refuse to sit on the back of the Women's Movement bus and take a stand for their reproductive issues.

Synopsis

Listen Up! New Voices for Reproductive Justice takes a socially conscious look inside the 153-year-old Woman's Movement.

Atlanta based filmmaker, N'Dieye Gray Danavall, travels to Washington, D.C. to follow several feminists groups as they work to organize and prepare for the groundbreaking 2004 March for Women's Lives.

Intense with desire, "Listen Up!" punches away at the over-insinuated identity of the Woman's Movement by giving ear to the voices of women of color who have been in the trenches all along. Danavall works to put a new face on the movement as female activists express their struggles, frustrations and hopes for its future.

Interviews with Feminist Leaders and Activists:
Loretta Ross, March Co-Director and SisterSong Coordinator
Dazon Diallo, SisterLove, Inc Director, Atlanta, GA
Eboni Barley, NARAL Pro-Choice GA
Nkenge Toure, Pacifica Radio, Washington, DC
Malika Redmond, National Center for Human Rights Education, Atlanta, GA
Beckie Rafter, NARAL Pro-choice GA
Camryn Manheim, Actress/Activist, The Practice

FOR MORE INFORMATION PLEASE VISIT THE OFFICIAL WEB-SITE AT: WWW.ListenUpFilm.com

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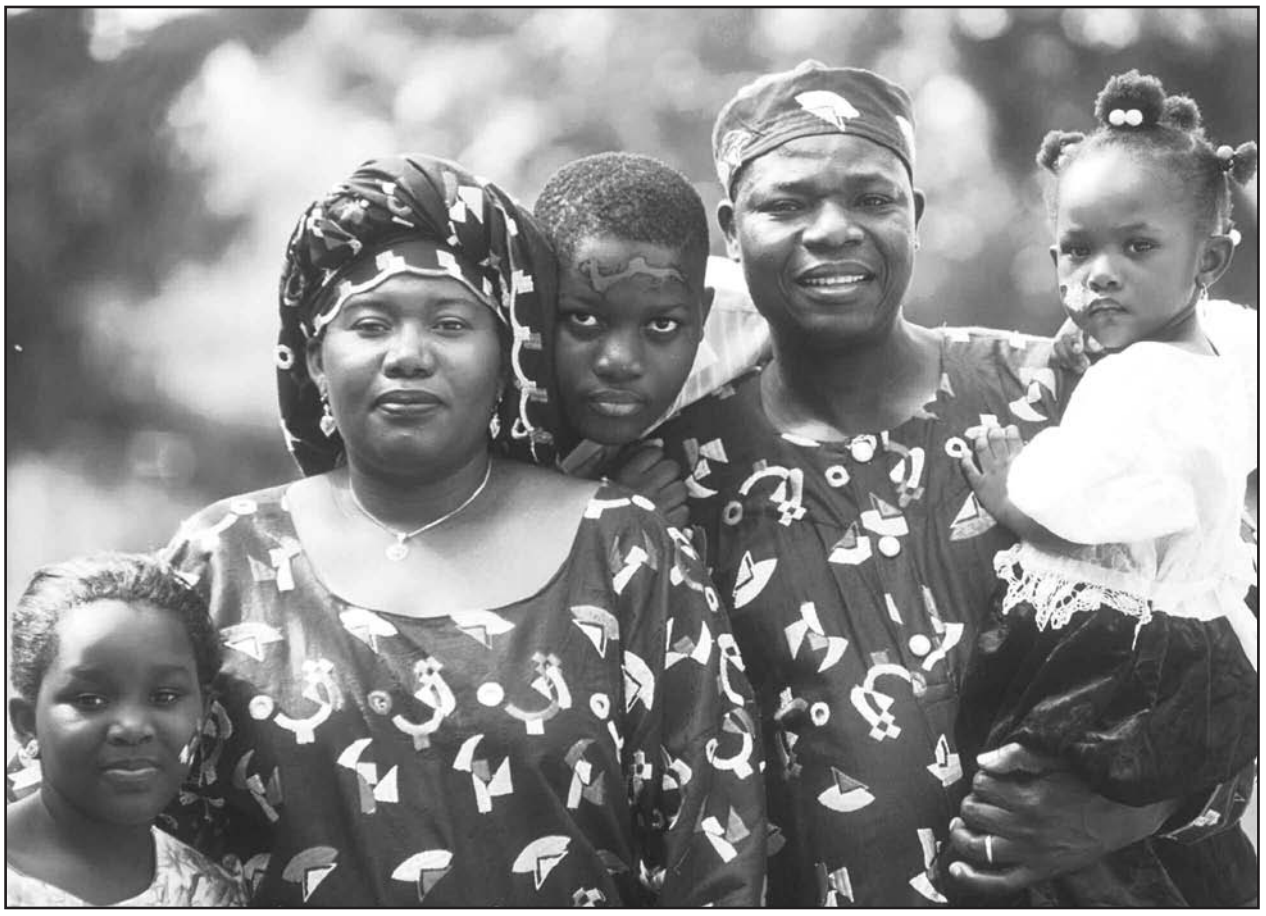

ignored, so the trial has been designed to determine whether the gel offers additional protection.

UNAIDS welcomed the microbicide trials, which officials said offer some of the best hope of curbing the deadly pandemic in the absence of a vaccine.

The London School of Hygiene and Tropical Medicine has calculated that a microbicide that is 60 percent effective against HIV and used by only 20 percent of women in 73 developing countries over three years could prevent 2.5 million infections.

"We are very much in favor of this research going forward and it is good to test the product in a real world setting where it is likely to have most application," said UNAIDS' chief scientific adviser, Catherine Hankins.

Researchers hope the first generation of microbicides with 50 percent to 60 percent effectiveness will be available over the counter in five years. By 2012, second generation microbicides that are between 70 percent to 90 percent effective could be on the market, the University of Witwatersrand Reproductive Health Unit said.

Male condoms, if used correctly, can reduce the risk of HIV infection to less than 1 percent.

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relationships to the demands of capital. Women around the globe are acutely aware of the massive power accumulated by transnational corporations and international finance institutions that erode the powers of both civil society and governments. These factors continue to undermine the gains women have made through decades of struggle.

A few core themes emerged from our conversations: the challenges facing indigenous peoples as they seek to protect the earth itself, defend their collective rights to self-determination and sovereignty over lands, resources and territories, and address violence both within communities and from external forces:

• the continued persistence of racial injustice and inequity at global, national and local levels, and their intimate interconnection with economic globalization and militarism

• gender-based violence, including rape by military and occupying forces, domestic violence, and the trafficking of women as a systemic and structural concern for women everywhere in the world

• the links among cultures of conquest, religious domination, heterosexism and women's subjugation

• the failure of current economic systems to achieve any semblance of equal opportunity or justice, while both absolute and relative poverty persist as the reality for most women

• issues of migration, national identity, language and culture, hierarchies of citizenship rights, criminalization, and the exploitation of especially vulnerable populations

• the experience of occupation and its impact on women and their families

• the emergence of various forms of religious extremism and fundamentalism, and their impact on women, our organizations and movements

• the growing influence of militarism as the only approach to conflict resolution, and its dangerous effects on the wellbeing of communities

The group emphasized that current U.S. administration rhetoric on militant Islam needs to be contextualized by the historical fact of U.S. support for militant Islamic factions in Afghanistan and other parts of the world during the Cold War, as part of the U.S. effort to counter the perceived threat of global communism. The current trend towards conflation of church and state in the United States exacerbates extremist trends in all religions in different regions of the world. The re-emergence of such extremism has the effect of reinforcing misogyny, homophobia, xenophobia and aggression, while narrowing secular space. At the same time, some participants urged us not to forget the potential of faith and religious traditions to play a more progressive role in women's own liberation efforts and their resistance to multiple forms of oppression.

Our collective analysis of the post-9/11 world led us to a blistering critique of the current U.S. administration's decision to wage a permanent war around the world. We are deeply concerned by the ways in which militarism shapes the lives of women, our children and communities worldwide. Around the globe, armed actors, from supra-national forces to village and neighborhood thugs, forcibly impose their will on women's bodies, their families, and communities. Women both participate in militarism and are victims of its processes. They are forced to serve soldiers in occupation armies and become tragic victims of brutal sexual assault. The logic of militarism desensitizes and dehumanizes soldiers to the pain and suffering of others, whether armed combatants, or innocent civilians. Military violence both creates and fuels a culture of violence that is widely disseminated by corporate mass media. Militarism is hugely profitable for corporations based in the United States and Western Europe which are cornerstones of a permanent war economy.

Collective Call for Change:

The activists gathered in New York expressed unanimous resistance to the forces of violence, coercion, and inequality that mark current relations between the so-called developed and developing world, and that define women's continued status as second-class citizens in every society. Our vision is one of a shared world that is free of poverty and violence, in which everyone's rights are realized and where diverse cultures and creativities are cherished and nurtured, as is the environment that sustains us.

Towards this end we call for efforts to continue and sustain transnational dialogues between and among women. These forums enable us to share and learn and build alliances that can help us to take both immediate actions on specific concerns as well as to take the first steps towards crafting longer-term strategies to bring peace and justice to our world. We believe that women in the United States must continue to have oppor-

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tunities to hear from and learn from their sisters in other parts of the world, so that they can better understand the impact of their government and the corporate actors based in this country. Similarly, women from other countries need to be able to count on U.S.-based groups and movements to actively resist the imperial policies and practices of the United States.

Our goal is to strengthen the connections between and among women activists, such as those represented at this meeting. Such expanded linkages would enable women to mobilize and transform their local or regional initiatives into broader and more visible platforms for social change, and to take the first steps towards organizing a vibrant and visible transnational women's resistance movement to current U.S. domestic and foreign policy. As this discourse deepens, it will yield more strategic interventions that truly transcend the barriers between women of the Global North and those of the Global South.

Members of the Planning Committee:
Maha Abu-Dayyeh Shamas, Women's Centre for Legal Aid and Counseling, Palestine
Christine Ahn, Women of Color Resource Center, U.S.A. Monica Alemán, MADRE, U.S.A.
Charlotte Bunch, Center for Women's Global Leadership, U.S.A.
Linda Burnham, Women of Color Resource Center, U.S.A.
Mirna Cunningham, Center for Indigenous Peoples' Autonomy and Development, Nicaragua
Asha Khalil Abdalla Elkarib, ACCORD International, Sudan
Terry Greenblatt, Global Fund for Women, U.S.A. Sonali Mohapatra, Network for Asian Pacific Youth, India Margo Okazawa-Rey, East Asia-U.S.-Puerto Rico Women's Network against Militarism and Fielding University, U.S.A. Kavita Ramdas, Global Fund for Women, U.S.A. Julia Sudbury, Mills College, U.S.A. Jurema Werneck, Criola, Brazil

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Want to bridge the race and class divide in the pro-choice movement?
Want to know how to bring new activists into the movement?

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404-344-9629

SisterSong
P.O. Box 311020
Atlanta GA 31131

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- Support capacity-building partnerships
- Increase leadership visibility on a local, national and international level
- Mentor grassroots organizations
- Partner with an activist for support and guidance

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