The way things have been going since Trump took office, maybe we need trigger alerts for good news. Anyway, here it is: Teen pregnancies in New York City have dropped a stunning 60 percent since 2000.

This dramatic decrease is due to smart programs and effective birth control. It’s also due to the leadership of dedicated public servants, like Estelle Raboni, whom we’re proud to have as the first Latina board chair of Population Connection. (See interview on page 10.) Estelle is the Project Director of New York City Teens Connection. She provided the spark for this issue’s coverage of reproductive justice.

While Trump’s tortured tweets mock and malign so many, we highlight vital work that’s being done despite this administration’s woeful words and dastardly deeds.

What do you think the Trump administration did in light of the stunning success of Raboni’s federally funded program, which saves taxpayers vast sums of money and transforms the lives of so many New York teens in disadvantaged neighborhoods? Did it increase funding or reduce it? Neither, actually. The administration flat-out cancelled all funding, effective at the end of June, for this and all such programs across the nation — programs that reach 600,000 at-risk teens. Thankfully, New York officials have stepped in to provide needed support.

Here’s what one young participant, Danesha from Staten Island, had to say about teens and sex, “If you don’t give them proper information, then something is going to happen, especially if they don’t know how to protect themselves." The program works wonders in 138 public high schools in New York City.

The Trump administration plumbs new dismal depths daily with decisions as mean as they are just plain stupid. We all pay the price for teen pregnancy.

The annual cost of teen pregnancy to U.S. taxpayers is $9.4 billion, according to a 2010 study by The National Campaign to Prevent Teen and Unplanned Pregnancy. That price tag doesn’t even take into account the enormous loss of productivity, which results when pregnant teens drop out of school, not to mention missed opportunities for them to have a better life.

We know that, “The modern plague of overpopulation is soluble by means we have discovered and with resources we possess.” Those are the words of Dr. Martin Luther King, Jr. In the same 1966 speech, Dr. King emphasized, “There is scarcely anything more tragic in human life than a child who is not wanted.” That’s still true today. He also once said, “Every man must decide whether he will walk in the light of creative altruism or in the darkness of destructive selfishness.”

Every woman, too, of course. The theme at a rally I attended recently was “Girls Lead the Way.” We can help by making sure they have access to the information and services they need so they can become leaders. Dawn will follow darkness. In the meantime, all of us at Population Connection are inspired by our friend Estelle Raboni and all those who will never back down.

John Seager
john@popconnect.org

2018 marks our 50th anniversary! Fifty years of advocating for reasonable, voluntary solutions to achieve zero population growth. We owe it all to the 250,000 donors who have enabled us to educate millions of young Americans and to be strong, effective advocates for population stabilization. Thank you!
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Editor’s Note

This was the most challenging issue of Population Connection’s magazine that I have overseen in my eleven years as editor. It was challenging to my brain in terms of learning everything I didn’t know I didn’t know about the Reproductive Justice (RJ) framework. It was challenging to my psyche in that much of that framework is suspicious, at best, of the intentions of programs that work toward population stabilization. And it was challenging to my sanity because there was so much content we wanted to include that we expanded this issue by eight pages right before the print deadline.

My hope in tackling reproductive justice in Population Connection magazine is that our readers will learn something new, as I did; that you will read the articles with an open mind; and that you will reassure yourself that we all just want to do and support what’s best for people, and the planet.

It can be difficult to come to grips with the mistakes and misdeeds that were done in the name of “population control” in the twentieth century. But the unfortunate reality is that they are part of the population movement’s history, and the people who were affected by forced sterilization, coerced acceptance of long-acting contraceptives, and non-consensual medical experimentation are still hurting today.

For nearly three decades now, population programs have been rooted in a dedication to voluntarism, informed consent, and the upholding of human rights. Family planning is shared with marginalized communities as a tool of empowerment, not oppression.

I interviewed Loretta Ross, the person who coined the term reproductive justice and who co-founded the RJ movement and the organization SisterSong. An article about her life, her recent publications, and our differences when it comes to our outlook on population issues begins on page 20.

Jamila Perritt, MD, contributed an original article about extending the RJ framework to her work with her OB/GYN patients. Dr. Perritt was the keynote speaker for Capitol Hill Days 2017 and her stories about racial inequities in the healthcare system were so moving that she was the first person I thought of when I was looking for article authors for this issue.

Our new Board Chair, Estelle Raboni, discusses the teen pregnancy prevention program she runs for vulnerable youth in New York City, and what the impending cut in federal funding will mean for the program. An article about a similar program in Nevada follows. Finally, we have an article by a member of our Population Education staff and another by three members of our Field team who led a session together at SisterSong’s twentieth anniversary conference last fall.

This issue is a bear, but if you can get through it, I’m confident you’ll come out the other end a more informed and empathetic advocate for reproductive health and rights — in all its forms — for everyone, everywhere.

Marian Starkey
marian@popconnect.org

Reproductive Health and Rights + Social Justice = Reproductive Justice
Letters to the Editor

Congratulations on a gripping December 2017 issue of Population Connection magazine. I was especially impressed with the program aimed at middle schools.

Jerry Brand

I was somewhat amazed by the treatment of men in the December 2017 issue of Population Connection.

Let’s start with the cover picture showing a man passively waiting for his planned vasectomy with his back slouching and his hands held between his legs. Not exactly a strong image of masculinity. It makes one wonder if he’s trying to protect his privates.

Next, look at the picture on page 15. Again, the man is pictured in a subservient position with his hands between his legs. This time, the vasectomy he is discussing is in the past. He’s still looking like he has something he wants to protect.

But what most offended me was the cartoon on page 32. In your President’s Note you rightly condemn coercion. But what’s going on in the cartoon, if not coercion?

Let’s switch things around. Make the cartoon of a man leading his pregnant wife into an abortion clinic blindfolded and announcing the same thing, “We’re almost there. Happy anniversary, dear.”

You treat men as so stupid that their wives can make them happy by scheduling a vasectomy for them?

The articles on male contraceptives were interesting. I don’t think many men will ever accept hormonal contraception for the same reason many women won’t — the side effects and risks are so severe and our love for children will many times win out. But there is a double standard. That’s why there are no hormonal contraceptives for men currently, and women are often bearing that burden.

Jean Crocco
Pro-Life Action League

Jean Crocco is an anti-choice crusader.

Anyone who has ever had a significant medical procedure can tell you it’s not a trip to Disney World. Even the most positive surgical interventions rarely provoke wide grins.

Regarding that cartoon, longtime Population Connection supporter Dr. Amy Gilbert also didn’t like it, commenting that, “Your publication needs to stick to your own values and moral principles and not discount them to be funny.”

Humor is subjective, and it’s wise to consider how people react to it. We do try to poke fun at the powerful — not those who lack power.

Ms. Crocco doubts “many men will ever accept hormonal contraception.” Time will tell as new methods come online. Millions of men, however, use testosterone replacement. It’s our view that the more FDA-approved, thoroughly-tested birth control methods the better.

Her reference to the “love of children” is bewildering. Decent, caring people the world over plan their families precisely because they love their children and want to make sure they have the resources to be responsible parents.

John Seager
The rate of black infant deaths is more than double the rate of white infant deaths.

### Infant deaths per 1,000 live births

- **White**: 43.5
- **Black**: 14.4
- **Women of other races**: 12.7

### Infant deaths per 1,000 live births

The rate of black infant deaths is more than double the rate of white infant deaths.

### Preterm Births (%)

- **White**: 9.0
- **Non-Hispanic White**: 8.9
- **Black**: 13.2
- **Non-Hispanic Black**: 13.4
- **Hispanic**: 9.1
- **Asian or Pacific Islander**: 8.6
- **American Indian or Alaska Native**: 10.5

### Babies with Low Birth Weight (%)

- **White**: 7.0
- **Non-Hispanic White**: 6.9
- **Black**: 13.0
- **Non-Hispanic Black**: 13.3
- **Hispanic**: 7.2
- **Asian or Pacific Islander**: 8.4
- **American Indian or Alaska Native**: 7.5

### Total Fertility Rate

- **White**: 1.86
- **Non-Hispanic White**: 1.75
- **Black**: 1.85
- **Non-Hispanic Black**: 1.86
- **Hispanic**: 2.12
- **Asian or Pacific Islander**: 1.65
- **American Indian or Alaska Native**: 1.26

### Median Income

- **White**: $60,349
- **Non-Hispanic White**: $65,041
- **Black**: $40,065
- **Non-Hispanic Black**: $39,490
- **Hispanic**: $47,675
- **Asian or Pacific Islander**: $72,709
- **American Indian or Alaska Native**: NA

### % Below Poverty

- **White**: 9.9
- **Non-Hispanic White**: 7.8
- **Black**: 22.7
- **Non-Hispanic Black**: NA
- **Hispanic**: 19.4
- **Asian or Pacific Islander**: 10.1 (Asian alone)
- **American Indian or Alaska Native**: NA

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Income and poverty data (2016): United States Census Bureau
All other data (2015): Centers for Disease Control and Prevention

Note: Because Hispanics may be any race, data for Hispanics overlap with data for racial groups. The vast majority of births to Hispanic women are reported as white. In tabulations that include Hispanic origin, data for non-Hispanic persons are classified according to the race of the mother, due to substantial differences in fertility and maternal and infant health characteristics between Hispanic and non-Hispanic white women.
The risk of pregnancy-related deaths for black women is 3 to 4 times higher than for white women.
California Population Growth Increases Wildfire Threats

California’s wildland-urban interface (WUI) is naturally prone to fires. But the intensity, frequency, and destructiveness of fires these past few years have got officials rethinking the state’s plans for future development.

The human population in the WUI in the western United States has grown by 300 percent in the past 50 years. The number of homes located in the WUI has grown by nearly 25 percent since 1990; as of 2012, 46 million homes were located in the WUI.

“If you look historically at Southern California, the frequency of fire has risen along with population growth,” says Jon Keeley, a senior scientist with the U.S. Geological Survey.

California has the highest number of housing units in WUI areas of all 50 states — about one-third of Californians live in the WUI. That figure could rise unless sprawl is contained (84 percent of the state’s private wildlands are still available for development). With housing in short supply and a population currently growing by nearly 300,000 people a year, sprawl has become an accepted reality in California — and one that people are willing to risk even if it means losing their homes, or their lives.

Alexandra Syphard, a senior research scientist at the Conservation Biology Institute, puts it bluntly: “The problem is not fire. The problem is people in the wrong places.”

Notre Dame Ends and Then Resumes Birth Control Coverage for Faculty and Students

Notre Dame, the Catholic university in Indiana, announced in November that birth control coverage by university-sponsored insurance plans would end on December 31 for faculty and August 14 for students. A week later, the university announced that it would continue offering no-cost birth control coverage in health plans after all.

Notre Dame was one of the entities that had filed suit against the federal government during the Obama administration for what it deemed an affront to its religious liberty — the university didn’t want to provide birth control coverage and also didn’t want to sign the form that would allow a third party insurer to provide said coverage. When the Trump administration expanded exemption from the birth control benefit in October to any employer with a religious or “moral” objection, the university did the obvious thing and announced that it would stop providing coverage.

The reasons for the reversal a week later aren’t clear, but are likely due, at least in part, to the bad press the university got when it made its initial announcement.

Massachusetts Protects Birth Control Benefit

Although the Trump administration’s reversal of the birth control benefit is on hold, thanks to an injunction by two federal judges, it’s unclear what the final outcome will be. To make certain that state residents continue to have access to no-cost birth control regardless of what happens at the federal level, Massachusetts has encoded the ACA birth control benefit into state law. And the state went even further, expanding the benefit to include a 12-month supply of birth control after a successful 3-month trial with the method, and coverage for emergency contraception.

Gov. Charlie Baker signed the bill into law in November, after it received overwhelming support in the state legislature.

California CPCs Are Headed to Supreme Court

The Supreme Court has agreed to hear a case brought by California’s anti-choice crisis pregnancy centers (CPCs). The National Institute of Family and Life Advocates, which represents 110 CPCs, claims that California’s Reproductive FACT Act violates their freedom of speech. The Reproductive FACT Act requires CPCs to disclose whether they have a medical license and have medical professionals available, and to post a notice in the waiting room that says,
“California has public programs that provide immediate free or low-cost access to comprehensive family planning services, including all FDA-approved methods of contraception, pre-natal care, and abortion.”

The act went into effect in 2015 to counteract CPCs’ “intentionally deceptive advertising and counseling practices that often confuse, misinform, and even intimidate women.”

Justice Department Moves to Investigate Fetal Tissue Report

The Justice Department’s Office of Legislative Affairs sent a letter to the Senate Judiciary Committee in December, requesting unredacted copies of its 2016 report “Human Fetal Tissue Research: Context and Controversy.” The Justice Department has not revealed any plans to pursue legal action on the basis of the findings in the report, but says that at this time it wants to “conduct a thorough and comprehensive assessment of [the] report based on the full range of information available.”

In response to the letter, Senate Judiciary ranking member Sen. Dianne Feinstein (D-CA) said, “Multiple congressional committees, thirteen states, and a grand jury in Texas all investigated Planned Parenthood, and all of them found the organization did nothing wrong.”

Prince William Delivers Speech About Wildlife and Human Population

The Duke of Cambridge gave a speech at the Tusk gala in London in November, addressing issues negatively affecting Africa’s wildlife. One of those issues, as he described, is population growth.

“Africa’s rapidly growing human population is predicted to more than double by 2050 — a staggering increase of three and a half million people per month. There is no question that this increase puts wildlife and habitat under enormous pressure. Urbanization, infrastructure development, cultivation — all good things in themselves, but they will have a terrible impact unless we begin to plan and to take measures now. On human populations alone, over-grazing and poor water supplies could have a catastrophic effect unless we start to think about how to mitigate these challenges.”

The total fertility rate for the entire continent is 4.43 children per woman; for sub-Saharan Africa, where the large game animals live, the rate is 4.75.

Last summer, Prince William’s wife, Kate Middleton, made comments indicating that the couple planned to have more children (they already have two). Having Kids, a family planning organization in Tucson, AZ, wrote an open letter to the couple in response. The gist of the letter can be summed up in this quote: “All of us — especially public figures — should plan our families with the future environment in mind, producing a smaller and more resilient populace capable of thriving in that environment.”

The Duke and Duchess of Cambridge gave no response to the letter and are expecting their third child in April.

Teresa Manning Steps Down and Valerie Huber Takes Her Place

Teresa Manning resigned in January from her position as deputy assistant secretary for the Office of Population Affairs — a position she had only held since May.

Manning’s job was to oversee Title X, the federal family planning program that serves 4 million low-income Americans. The anti-abortion activist is on record saying that contraceptives don’t work.

The circumstances of Manning’s departure are unclear, but sources inside the building say that all staff on her floor were ordered to leave and bring their computers with them so they couldn’t record evidence of her being escorted away from the premises.

Manning was immediately replaced by Valerie Huber, a prominent abstinence-only advocate. Huber had been serving as the chief of staff in the Office of the Assistant Secretary of Health since June.
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Where did you grow up and attend school? Do you have any coming of age stories that especially affected your experience of being Latina?

I grew up in Manhattan and the Bronx, daughter to a Dominican mother and an American-born father. My mother had me when she was 20 years old — barely an adult. My parents separated when I was a child, which created a great deal of economic hardship for my mother when I was growing up. Had my mother been able to finish her education when she was a teenager, things might have been different, but she had to leave school when she was 16 when her father died.

My family was poor and worked in clothing factories in lower Manhattan making coats. I attended public elementary, middle, and high school. As a child I suffered from a terrible stutter and spoke no English. My paternal aunt, who was born and raised in NYC, attempted to enroll me in Head Start but found that the program was full. Because she felt that I really needed early education — due to my disadvantages — she made a financial sacrifice and enrolled me in a private nursery school in Westchester, New York — an affluent suburb of New York City. The difference between the environment around my mother’s apartment and my nursery school was dramatic. My mother’s pest-infested apartment was in a dangerous and noisy neighborhood — there was no playing outside there. My nursery school environment was bucolic — clean, bright, quiet — they even had farm animals on the property that were part of their programming.

My first sense of being different and learning that in the larger context being Latina was somehow disadvantageous happened as early as kindergarten. One afternoon during story time, my kindergarten teacher read a book about “brotherhood” that involved an African American child, a white child, and a Latino child. One student in my mostly-white kindergarten class interrupted the reading saying, “The black kid is yucky, the Spanish kid is yucky. Only the white kid is okay.” The children then walked off to play. That was my first experience of racism, but I didn’t understand it at the time. I only noticed the horrified...
expression on my aunt’s face (she was a class volunteer), and how she intentionally arranged for me to become friends with the two other Latino students who remained to hear the rest of the story.

There was no bilingual education when I was a child. You either learned English or you didn’t. If you didn’t, you were left behind until you mastered the language. As a result, I didn’t become English-dominant until second or third grade. At that time, NYC schools tracked students. There were classrooms for the “slower” kids, average kids, and advanced kids. I was put into the slower-paced class, which I noticed contained mostly kids of color. As I became more fluent in English, I was able to do better in school. I became an avid reader, and by fifth grade was in the advanced class for my grade. The difference in the classroom experience and resources was remarkable. I noticed that the expectations of students in the advanced class were so much higher than in my previous classes. Our teacher allowed us to run the school garden, learn about organic gardening, put on plays, and do other project–based work that other classes did not have access to. I saw how inequity manifests in different ways at a very early age — from the quality and amount of resources available, to the atmosphere of support and encouragement.

I graduated high school in the Bronx, and after a few years of working, completed a BA in Women and Gender Studies at Columbia University. My interest in social justice was encouraged at Columbia, and while I was also completing a concentration in pre-med (with the intent of going on to medical school to focus on women’s health), I ultimately chose to focus on population health. At the time I didn’t have words for what I was interested in, but I recognized that physicians have a very small influence on the health of large populations. I wanted to make an impact on the social determinants of health that impact women not just in New York City, but around the world.

After Columbia, I began working at Planned Parenthood Federation of America as the Manager of Education, working with the then 100 Planned Parenthood affiliates to coordinate professional development, training, and resources. I loved my work and I loved the organization. In many respects, I felt I had come home, and delved further into my interest in social justice and equity. Here I determined that, instead of pursuing medicine, I would pursue studies leading to a master’s degree in public health. I graduated in 2007 from Hunter College at the City University of New York with a focus on community health.

How did your background influence your interest and work in adolescent health, teen pregnancy, and reproductive justice?

While I was at Planned Parenthood, I worked with the group that launched the first Get Yourself Tested campaign in 2009. The idea for the campaign was — and is — to increase awareness about STIs and HIV. It’s a partnership between several high-profile health organizations and MTV. It was an exciting new campaign, but I felt that the campaign materials did not reflect the population that was most affected by STIs and HIV at that time — young men of color. As the Director of Latino Outreach, I worked to develop complementary campaign materials that took into account the stigma of STI and HIV infection in the Latinx community. After the campaign, we found that testing among Latinx clients increased by 20 percent as a result of our efforts to speak directly to the needs of this population.

Being Latina has always informed how I see the world — who has resources, who doesn’t, and why. While teen pregnancy rates have been dropping dramatically across New York City, and the country, there is still a large gap between the drops in pregnancy among white teens versus African American and Latina teens. Much of this gap comes down to wealth discrepancies. The literature in the field indicates that a young person growing up in poverty is three times more likely to become pregnant and drop out of school, making that young person less likely to continue to college and subsequently to higher-paid employment. The community that I work in — where 98 percent of the population is African American or Latinx and where 39 percent of youth are growing up in poverty — currently reflects this data sharply. The Bronx has the highest teen pregnancy rate and the lowest levels of high school graduation in all of New York City, and it consistently ranks #62 out of 62 New York State counties — dead last — in health and economic outcomes. Unintended teen pregnancy is a watershed event — if not provided with sufficient support, a teen mother will have negative health, academic, and economic outcomes.

Please talk a bit about your current job and why it’s important, and describe any challenges.

I am the Director of New York City Teens Connection, the New York City Department of Health and Mental Hygiene’s program to decrease teen pregnancy rates in areas of the city where they are higher than the national average. We work to build capacity in schools by training teachers to provide teen pregnancy prevention programs in ninth or tenth grade, before

1 Gender-neutral term for Latina/Latino
most young people become sexually active, and linking those students to high-quality, teen-friendly healthcare. Because not all youth are engaged in schools, we also work with partners to implement evidence-based teen pregnancy prevention programs in foster care agencies, youth-serving organizations, colleges, and clinics.

Last year we were able to reach nearly 7,000 New York City youth with evidence-based programming, while also linking them to quality healthcare. This year we project that we will reach approximately 15,000 youth in 20 percent of the city’s high schools. We also build capacity among our clinical partners to provide the latest in contraceptive technology — including Nexplanon and IUDs — so that teens have access to the most effective methods of contraception on the market. These methods take out the human error implicit in methods that depend on the person to take a pill or insert a ring. Colorado, for example, has been able to decrease its teen pregnancy rate by 40 percent as a result of increased use of the most effective methods.

One of the challenges in this work is funding. The current administration has shortened the grant cycle for the Teen Pregnancy Prevention Program, which provides federal dollars to organizations and health departments across the country to decrease teen pregnancy. By shortening the grant cycle by two years, we are less able to support the efforts and inroads we have made. This means that fewer young people will receive the information and services they need to navigate adolescence safely and pregnancy-free.

**What are you seeing in the field? How are your programs serving different populations?**

What we are seeing is an increase in sex trafficking. According to the report “America’s Prostituted Children,” at least 100,000

**Above: NYC Department of Health public awareness campaign to increase the practice of dual protection, encouraging youth to use both condoms and female contraceptives**
children are used in prostitution every year in the United States. The most common age of entry into the commercial sex industry in the U.S. is 12–14 years old. As a result, we’ve been working with organizations that help train teachers and clinicians to recognize signs often present when someone is a victim of sex trafficking. We are also providing training to partners on trauma-informed care, as well as inclusivity training to appropriately address the needs of LGBTQ+ youth. We don’t provide direct service; rather, we build on the capacity of existing networks to provide education and services to youth. Ultimately, we want to make this work sustainable within existing institutions. Still, we hear through our partners how youth react to the programming or services they receive — they are often incredulous that they get to have access to high-quality medical care without their parents’ permission, and at low or no cost. I have the good fortune of working in New York City, within New York State — we have progressive laws such as Minors’ Rights to Confidential Reproductive and Sexual Health Care, which allows minors who meet certain criteria to consent to medical treatment without involving a parent, and the Family Planning Benefit Program, which extends family planning coverage to low-income New Yorkers who aren’t covered by Medicaid.

As the new chair, how do you hope to influence the direction of the Population Connection Board of Directors?

I would like to increase and diversify the membership of the board. The mission of Population Connection is critical, particularly given the current administration’s disregard for women and the environment. We need younger generations of leaders to become engaged in this work so we can promote future policies that will protect the environment and women’s health and rights.
Probably the last thing a high schooler wants to be doing on a Friday afternoon is practicing unrolling a condom onto a styrofoam penis as part of a three-hour sex ed class.

And yet that’s exactly what nine 11th-grade boys were doing on a Friday afternoon in early November while attending a sexual health class in downtown Las Vegas put on by a local non-profit organization. There were the requisite bouts of uncomfortable giggles, but also frank conversations about risky behaviors, sexually transmitted infections, and birth control methods. The goal: destigmatize conversations about sexual health, whether or not you are planning to have sex anytime soon.

“Oh, I love that analogy. I’ve never heard that before,” said class instructor Jessi Dorn, praising the way one of the boys framed purchasing condoms. “It’s like
buying Band-Aids and cotton balls. It should be just part of your routine, and putting on a condom should be like brushing your teeth. It happens every time. You brush your teeth every day. You’re preventing cavities.”

Dorn patiently and matter-of-factly answered their questions: Plan B isn’t a routine form of birth control, it’s emergency contraception. STI stands for sexually transmitted infection, the preferred way to talk about what were once known as STDs, or sexually transmitted diseases. Yes, herpes can be transmitted just through skin-to-skin contact. No, you can’t get HIV through French-kissing.

Where kids of generations past might have been subject to decades-old public service announcement videos in their sex ed classes from teachers who adamantly insisted they were representative of teenage interpersonal relationships, Dorn acknowledged the cheesiness of the videos she showed them. As she passed out condoms for the demonstration, Dorn told them, “Shake it out, get the wiggles out, while I pass it out, get your giggles, I mean,” before descending herself into laughter along with the group.

“Half the kids I teach don’t know how to put a condom on properly. I watch them struggle,” Dorn said in an interview before the class. “I know that they’re learning on their own or they’re not learning from anyone. So to watch them struggle and feel embarrassed, I’m almost like, ‘Good, I’m glad you’re a little embarrassed so you’re more receptive how to do it appropriately or the correct way.’”

That Friday afternoon was Dorn’s first session teaching students from the Core Academy after school program, which provides mentoring, tutoring, and character development programs for underserved youth in Clark County. Dorn, an educator with the non-profit SAFY (Specialized Alternatives for Families and Youth), typically teaches sexual health classes to kids in juvenile detention centers and on probation, as well as to homeless and foster youth.

The work Dorn does educating kids about healthy sexual choices is made possible through a federal grant, administered by the Southern Nevada Health District, aimed at reducing teen pregnancies. But earlier this year, the Trump administration decided to cut the $214 million in federal grants that pay for Dorn’s classes and other pregnancy prevention efforts and research across the country.

What was supposed to be a five-year grant program will abruptly end after three, in June, leaving the local organizations who relied on the federal government for teenage pregnancy prevention funds in a lurch, scrambling to think of creative alternatives and look for private funding sources that might be able to sustain their work. Teen pregnancy rates are on the decline in Nevada as they are nationally, but local health officials worry that cutting the funds means taking a step backwards when the United States still has higher teen pregnancy rates than most other developed nations.

“Although people can say, ‘Well these rates are going down, so there’s not a need,’ that’s exactly why there is a need — because we have proven that by providing these services, it does provide a positive change and a positive impact,” said Southern Nevada Health District health education supervisor Xavier Foster, adding that cutting the funds “will put us in danger of reversing this trend.”

An “Evidence-Based” Approach

The federal Teen Pregnancy Prevention Program, established in 2010, is the result of a congressional mandate to fund medically accurate and age-appropriate programs to prevent teen pregnancies across the United States. (It’s one of six federal evidence-based initiatives aimed at tackling various social issues.)

The Southern Nevada Health District and the 101 other recipients of the first round of funding, which spanned 2010 to 2014, helped reach nearly half a million kids in 39 states and Washington, D.C., trained 6,100 program facilitators, and created more than 3,800 community partnerships, according to the U.S. Department of Health and Human Services. The program also funded 41 evaluation studies to figure out which sexual health curricula were most effective where, when, and with whom.

The second round of funding, from 2015 to 2020, awarded 84 grants to implement evidence-based teen pregnancy prevention programs, build the capacity of existing programs, support technology- and program-based innovations to prevent teen pregnancy that need further development, and rigorously evaluate new approaches to reducing teen pregnancy. The goal of the second round of funding was to reach 1.2 million teens in 39 states and the Marshall Islands by 2020.

The Southern Nevada Health District used its first round of funding to gear up its evidence-based teen pregnancy prevention efforts, and has been using its second round $750,000-a-year award to build capacity in its existing system. The Nevada Primary Care Association, based in Carson City, also received a roughly $572,000-a-year award in the second round of funding to implement for the first time a teen pregnancy prevention
program in community health centers statewide.

But then, in July, the Department of Health and Human Services abruptly announced that grant funding would not be renewed for the fourth or fifth year, citing the “poor evaluation results” from the program.

“The very weak evidence of positive impact of these programs stands in stark contrast to the promised results, jeopardizing the youth who were served, while also proving to be a poor use of more than $800 million in taxpayer dollars,” the department said in a statement to CNN.

“The poor evaluation results were the reason that the Trump administration, in its FY 2018 budget proposal, did not recommend continued funding for the TPP program and HHS hit the pause button on it,” the statement said. “This action gives the Department time to continue its review of the program and the evidence, to ensure that should Congress continue it, the program provides positive reinforcement of the healthy decisions being made by a growing majority of teens.”

But part of the goal of the Teen Pregnancy Prevention Program was to test the effectiveness of the programs and observe how well different curricula worked in different communities. Advocates for the program say that cutting off funding next year is tantamount to ending a five-year experiment two years early.

“These programs were designed to test programs and strategies. The current round of grants was building off of the success of the first round,” said Lauren Ranalli, director of the Adolescent Health Initiative at Michigan Medicine. “Cutting these programs is counterintuitive and flies in the face of good public health data and policy. We need to invest in the scientifically sound ways to help young people make healthy decisions.”

Teen pregnancy rates are at an all-time low. Between 2010 and 2015, Clark County saw a 33-percent decrease in teen birth rates, down to 26.3 births per 1,000 teenage girls. That’s higher than the national teen birth rate of 20.3 per 1,000, but slightly lower than Nevada’s teen birth rate, 27.6 per 1,000.

“Why mess with success? One of the nation’s great success stories over the past two decades has been the historic declines in teen pregnancy and childbearing. Teen pregnancy is down better than 50 percent since peaking in the early 1990s. Teen births are down 67 percent,” said Bill Albert, chief program officer of The National Campaign to Prevent Teen and Unplanned Pregnancy. “There have been declines in all 50 states, that includes Nevada, and among all racial and ethnic groups. Truly historic progress on an issue that experts in the field considered intractable.”

Dr. Joseph Iser, district health officer for the Southern Nevada Health District, wrote a letter in July with 19 other health officials from across the country to then-Health and Human Services Secretary Tom Price voicing concern about the administration’s decision to slash funding to the program.

“Ending what was intended to be five-year TPPP grants two years early is highly disruptive to ongoing work in localities across the country,” Iser and the other officials wrote. “These cuts will negatively affect the lives of young people currently participating in these programs, and will mean fewer project

Albert says the Teen Pregnancy Prevention Program hasn’t been solely responsible for the decline — “not by a long shot.” But he says it would be “folly” to think the program had nothing to do with the historic drop in rates of teen pregnancies.

Changing teen behavior when it comes to sex is “not for the faint of heart,” Albert said. “It’s hard to do. He noted that somewhere close to 40 percent of the programs funded through the grant were successful in changing teen sexual behavior, which is “remarkably successful” when similar public health interventions are typically considered successful at a 10-percent success rate.

“The entire Teen Pregnancy Prevention Program was based on evaluation. What worked among a relatively well-to-do white population in New England is not working with relatively poor Black African American kids in Mississippi,” Albert said. “That’s what the Teen Pregnancy Prevention Program has done. It is committed to evaluation. It has expanded the menu of options that communities can choose from.”
jobs, fewer trained professionals, and reduced community partnerships.”

Nevada’s Efforts
The Southern Nevada Health District’s goal with the Teen Pregnancy Prevention funding was to target specific zip codes in Las Vegas and North Las Vegas with the highest rates of teen pregnancy, with the goal of reducing teen pregnancy rates in the two cities by 15 percent by 2020.

The grant to the health district currently funds two programs for teens: Be Proud! Be Responsible! and Sexual Health and Adolescent Risk Prevention (SHARP), both of which focus on communicating skills to prevent sexually-transmitted infections, HIV, and pregnancy. A third program, called Families Talking Together, helps parents talk about sex with their kids.

Much of the focus of the health district’s grant is on reaching kids in juvenile detention centers and foster homes, as well as homeless youth, though the health district and its community partners will occasionally work with after school programs to teach the curriculum to kids there. It is the responsibility of the community partners, in this case SAFY and Planned Parenthood of Southern Nevada, to actually teach the programs in the community, while the health district staff ensures the classes are taught appropriately and evaluating how much kids are learning through the classes.

The health district is responsible for community outreach about the program, from handing out condoms outside high schools with a card with a number that kids can text to get sexual health information or ask for the closest clinic where they can go to receive services to putting up advertisements in bus shelters near some of the target high schools. A Youth Leadership Council, also funded under the grant, teaches high schoolers leadership skills while training them to become peer educators for sex education.

But all that could change starting next year. Foster said that when the health district received the notice from the federal government in July indicating the Teen Pregnancy Prevention Program funding for the third year of the grant had been formally approved, they also received notice that it would be the last year of funding.

“I mean there’s always been talk with the election and the new administration that their focus could be something different that would not be as open to what we are doing and the focus might switch from prevention to abstinence,” Foster said.

Unless Congress takes action to specifically fund the Teen Pregnancy Prevention Program when it approves its budget in December, the funding for the programs will officially expire at the end of June. That’s why the health district is trying to look at other possible funding sources, such as private foundations, to continue to fund the pregnancy prevention efforts. Foster and other officials involved with the program presented to the Southern Nevada Health District board last month in an effort to raise community awareness about what the program does and what the community stands to lose if it ends.

“The purpose of the presentation to the board of health last week was to kind of like, ‘Let’s use your connections and your leverage to get all these systems and institutions and cities to sit together and let’s find some funding from somewhere where everybody can chip in so we can continue providing these services,’ ” Foster said.

2 The budget still had not been approved at our print deadline in February.
Up north, the health district’s sister grantee based in Carson City, the Nevada Primary Care Association, is grappling with the possibility of winding down a program that has barely just started. The association, which aids federally qualified health centers and other community health providers across Nevada, received an implementation grant to ramp up their pregnancy prevention efforts in the state’s community health centers in both southern and northern Nevada by 2020.

It took time for the association to ramp up its program. First, it had to reach out to various community health centers across the state to see if they had the time and space to run sexual health programs and pick out which evidence-based curricula they wanted to teach. Once they figured that out, the staff at the health centers had to be trained, and the association had to coordinate outreach to get kids into the programs.

Since the program launched in July 2016, they have reached 390 kids and families in Clark and Washoe counties at eight community health centers. The initial grant included Elko, Lander, Nye, and Eureka counties, as well as Carson City, but hasn't expanded to health centers in those communities yet.

But now, the association is grappling with how to ensure the program is sustainable and low cost so that community health centers can continue to provide sexual health education to the community even after the funding ends in June. All that on top of the fact that federally qualified health centers, nonprofit health centers, and clinics that serve medically underserved areas and provide services regardless of a patient’s ability to pay have yet to receive funding reauthorization for Congress for the next year.

“So far we’ve been focusing most of our efforts on making the program sustainable because they are set up and people have been trained so they have everything they need to run the evidence-based curriculum,” said Jim Godwin, communications coordinator for the Primary Care Association. “We’re trying to work on ways to have it still be there.”

Godwin emphasized that even though the numbers of teen pregnancies are going down, they’re still “alarmingly high.”

“These programs do work, and it is important to promote safe and supportive sexual and reproductive health education that helps reduce those unplanned pregnancies and STIs,” Godwin said. “I think now with the way technology is and social media the teen pregnancy prevention programs or adolescent health and wellness programs take on an added urgency.”

What Happens Next

Albert, from The National Campaign to Prevent Teen and Unplanned Pregnancy, said there is a “very, very small” but “not zero” chance that the Teen Pregnancy Prevention Program will be funded, depending on what Congress decides to do with the budget. He said that there are private and regional foundations or local businesses that might be able to step in to help grantees continue operating their teen pregnancy prevention efforts.

“Many will seek private funding, perhaps, some may appeal to state government to replace the lost federal money, and I think some will be successful,” Albert said. But my concern — and I’m not trying to be cynical here — I think the concern is many will not be successful in replacing that money and will subsequently go dark.”

Foster, with the Southern Nevada Health District, said he has had some conversations with the state, which operates two pregnancy prevention programs, about how to hand off the district’s relationships with its community partners should the funding dry up with no viable alternatives in place.

The Nevada Adolescent Health and Wellness Program already works with Planned Parenthood, one of the health district’s community partners, through its State Personal Responsibility Education Program (PREP) funded through the Department of Health and Human Service’s Administration on Children, Youth, and Families. The state also receives a federal grant through the
Abstinence Education Grant Program (AEGP). Both programs are under consideration for reauthorization at the federal level, but are funded through 2019 and 2018, respectively.

Through the PREP program, the state has focused on implementing a Spanish-language based program called ¡Cuidate!, which aims to use Latinx cultural beliefs to talk about abstinence and condom use. Planned Parenthood has used that curriculum to go out into homes and community centers to educate the community about sexual health, said Vickie Ives, Maternal, Child, and Adolescent Health Section manager at the state’s Division of Public and Behavioral Health.

The state’s efforts also include focusing on teen pregnancy prevention education in the rural communities. Through its abstinence-based program, the state works with the Nye Communities Coalition in Nye County, and both the AEGP and PREP funds are used to facilitate trainings at the Family Resource Centers of Northeastern Nevada in Elko.

“We actively try to serve and create linkages and share best practices with our more urban and more rural sites,” Ives said.

But when it comes to the impact of what eliminating the Teen Pregnancy Prevention Program funding might have on the state’s efforts as a whole, Ives said she couldn’t be sure.

“We try to do outreach to others working in the state to increase capacity and create relationships,” Ives said. “But in terms of just capacity to serve as many youth as possible? That’s always something we’re looking at and concerned about.”

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Loretta Ross: Reproductive Justice Pioneer, Co-Founder of SisterSong Women of Color Reproductive Justice Collective

By Marian Starkey and John Seager

The following article is based on a phone conversation with Loretta Ross in December and quotes, ideas, and information from the two most recent books that Ross co-authored: Reproductive Justice: An Introduction (March 2017) and Radical Reproductive Justice: Foundation, Theory, Practice, Critique (November 2017).

To understand the life and work of Loretta Ross you need first know this: She was brutally raped by a stranger when she was eleven years old. Just three years later, a distant cousin raped her and she became pregnant. It was 1969, so abortion was not yet a legal — or safe — option. The son she birthed at age fifteen would be her only child, because at 23 she had a hysterectomy due to an infection from the infamous Dalkon Shield.¹

Ross was the sixth of eight children, born in small-town Texas. She was a star student, who earned a scholarship to Radcliffe College. The scholarship was revoked, however, when the school learned of her pregnancy, and she ended up going to the historically black Howard University in Washington, D.C., instead. She started college young, at only 16. She soon found herself pregnant again, this time from consensual sex with her first boyfriend. Fortunately, abortion was legal in D.C. by then, and she had a safe procedure without issue.

After her abortion, Ross got the Dalkon Shield inserted, at no charge, at the health clinic at Howard University. She soon developed pelvic inflammatory disease — caused, she believes, by the IUD — which she lived with for six months. She had been told dismissively during those six months that she had a rare STD from having sex with GI soldiers who had been in Vietnam (she didn’t know any GIs). She finally fell into a coma brought on by the severe infection, and when she woke up in the hospital, she had “no plumbing” anymore — the doctor had performed a total hysterectomy, removing even her ovaries.

She says, “By the time the sterilization happened, I was pissed off. The fact that the Dalkon Shield was freely distributed at Howard University — years after it had been proven dangerous — made me feel that it was a strategy of population control.”

Ross was the victim of horrific crimes with roots in the monstrosity of slavery, along with greed, arrogance, and willful stupidity. It’s not surprising that she is wary of population control. From the late nineteenth century well into the second half of the twentieth century, it was a gathering point for the pseudoscientific eugenics movement populated by nativists, racists, and xenophobes. The decades that shortly followed the eugenics craze were a turning point, however; a new generation emerged, dedicated to upholding reproductive rights while recognizing the critical connection to population issues.

After many years of involvement in feminist causes, Ross, along with others, started advocating for a more holistic approach to reproductive rights that included social justice and human rights: the right not to have children, the right to have children under the conditions parents choose, and the right to parent the children one has in a safe and healthy environment.
These organizing principles became what she and eleven other women of color — they called their alliance Women of African Descent for Reproductive Justice — coined “reproductive justice” in 1994 at the Illinois Pro-Choice Alliance Conference in Chicago. The 1994 International Conference on Population and Development (ICPD) in Cairo, a few months later, emphasized the importance of prioritizing human rights and of understanding the development situations of countries participating in population programs. No longer would targets, quotas, or coercion be tolerated — the new narrative demanded a focus on individuals and the choices they had a right to make for themselves.

Ross says, “The previous population conferences had all talked about fertility management and reduction. The Cairo conference, by adding the term ‘development,’ pointed out that the ability of any individuals to control their fertility was directly related to what was going on in their community. It wasn’t just an individual woman’s problem whether she had access to birth control or not. Making that connection between an individual’s decision-making options and the systematic underdevelopment of the communities that we were talking about — that’s the paradigm shift that needed to happen. There’s no way to address with any ethics the question of managing people’s fertility if you’re not addressing the reasons that fertility is not already being managed.”

A generation has elapsed since the Cairo conference. It was, without question, a major turning point. The euphoria that accompanied the groundbreaking agreement was, however, short-lived. Within a month, Republicans — a party that had become bound by a shared hostility to reproductive freedom — won control of the U.S. House for the first time in more than 40 years. The funding promised to meet the Cairo agenda didn’t materialize, and family planning efforts stagnated.

Three years after the Chicago and Cairo conferences, Ross co-founded SisterSong Women of Color Reproductive Justice Collective, whose mission is “to strengthen and amplify the collective voices of indigenous women and women of color to achieve reproductive justice by eradicating reproductive oppression and securing human rights.”

Rights, Race, and Poverty
The feminist movement, according to Ross, has been led by white women with a single-issue agenda: reproductive choice in the form of abortion rights. (White feminists also placed strong
emphasis on voting rights, equal pay, educational opportunity, and access to birth control, among other things.) Ross insists that social issues — such as the mass incarceration of reproductive-aged people, pressure to accept long-acting contraceptive methods, and pervasive poverty — are components of reproductive choice as well. She argues that these issues, which disproportionately affect minorities, are examples of the racism embedded in our country’s culture.

Some of the racisms Ross describes are overt (e.g. Trump’s outrageous comment, “Why are we having all these people from shithole countries come here?”). Others are subtler, often in the form of condemnation for safety net programs. “Every social program that is seen through a white lens as benefitting people of color comes under assault,” Ross says. This happens, she explains, through “dog whistling” — using language that’s not explicitly racist but seeks to subtly play on racial stereotypes. Many advocates point to a recent comment by Sen. Orrin Hatch (R-UT) about the Children’s Health Insurance Program (CHIP) as an example of this. “I have a rough time wanting to spend billions and billions and trillions of dollars to help people who won’t help themselves — won’t lift a finger — and expect the federal government to do everything.”

The Hyde Amendment is another implicitly racist policy, according to Ross, because people of color experience poverty at higher rates than white people and therefore must rely on government forms of health insurance at higher rates than whites. Ross says, “White people think they do all the hard work and they think people of color are the unfair beneficiaries. So you can’t isolate Hyde from that overall narrative.” America’s history, Ross argues, is full of examples of the racialization of “every pregnant woman and every baby born,” from the genocide of Native Americans, to the breeding of African slaves, to the suppression of African American fertility once there was no profit to be made from Black offspring, to the use of Puerto Rican women as guinea pigs in early trials of the birth control pill. She points out that abortion was a legal and acceptable practice up to the point of “quickening” in early America — and that its prohibition in every state by the end of the nineteenth century was due to early leaders’ concerns with “populating the white nation.” She argues that poor people have just as much right to “sexual citizenship” as anyone, and that wealth should have nothing to do with sexual autonomy or fulfillment. People who make comments about women needing to “control themselves” or “close their legs” if they’re not prepared to raise a child are saying that poor people shouldn’t have the right to enjoy sex — even with their spouses.

When asked how she stays optimistic in the face of all this, she says, “As an African American woman, I know that ‘at times like these it’s always been times like these.’ The difference is more white people are waking up. I think November 9 was a big alarm clock. Everyone thought we had reached this post-racial moment and then on November 9 the sky fell.”

**Sound Science**

Ross and her co-author, Rickie Solinger, write in *Reproductive Justice: An Introduction*, “There’s never been a situation where women — if offered educational and economic opportunities — have not done everything in their power to control their fertility.” On the phone, Ross expanded on this point, saying that programs to slow population growth are unnecessary because with the right programs and policies (girls education, female employment opportunities, adequate healthcare, and an end to the structural adjustment policies of the World Bank and IMF that have often been so damaging to countries’ self-sufficiency and sustainable development) in place, lower fertility and slower population growth would result naturally. Population Connection fully supports greater investments in these areas, but not at the expense of meeting the unmet need for contraception.

Ross is also wary of connecting population growth to environmental challenges, since it’s the wealthy who have done the most damage to wildlife habitats, consumed the most natural resources, and put the most carbon into the atmosphere. But we believe — and the data supports our view — that the enormous impact we humans have on our living Earth grows with every thousand, million, or billion people we add to the planet.

We certainly agree that those of us in the developed world, who tend to have smaller families, have an outsized
ecological footprint due to our much higher rates of consumption. But that’s not the whole story. People need to eat, and food is grown and raised on land. That land is often former wildlife habitat, native forest, or coastal flood barrier. The water needed for irrigation is diverted to crops regardless of whether it leaves enough for individual consumption. Deforestation (land-clearing for agriculture or wood removal for biofuels) is responsible for nearly one-third of global carbon emissions. To ignore the impact of rapid population growth is to ignore sound science.

There are an estimated 214 million women in developing countries who don’t want to be pregnant, yet face any number of barriers to using modern contraception. Eliminating those barriers will dramatically improve their lives while also reducing the short term and long term impacts of population growth on the environment. The willful failure to provide access to the family planning services women need is the defining reproductive coercion of today. It is being driven by some craven political leaders in countries around the world, including our own. Nobody should be denied the power to determine her own reproductive future. And it is in defending human rights that we will ultimately address the very real challenges that population growth still poses.

As we continue to do good work with SisterSong and the collective’s associated organizations, we urge them not to write off those who work to address population challenges because of the movement’s troubled past. We are committed to reproductive rights, social justice, and, yes, reproductive justice. And we recognize the inextricable link to voluntary population stabilization of all three movements.

Ross is a visiting associate professor this year at Hampshire College in Amherst, Massachusetts, where she’s teaching a course called “White Supremacy in the Age of Trump.” In her free time, she plays competitive pinochle, joining tournaments around the country. She enjoys watching tennis, football (a Cowboys fan), and college basketball (“Georgetown Hoyas all the way”).

Endnotes

1 The earliest intrauterine device (IUD); available in the early 1970s, the Dalkon Shield caused injury, infection, and/or infertility in 200,000 American women, and death in 18.

2 See the story, beginning on the next page, about SisterSong’s conference where our field staff presented a session on advocacy in the Trump era.

3 A policy, in place since 1977, that prohibits federal funding of abortion. It excludes Medicaid recipients, government employees, people with disabilities on Medicare, and Indian Health Service recipients from insurance coverage of abortion services — care that, if they weren’t poor, or employed by the government, might be covered by their private health plans. This is especially problematic as people of color and people living in poverty experience unintended pregnancy at higher rates than the general population.

4 A phrase that Dr. Willie Parker, author of Life’s Work: A Moral Argument for Choice, is known to say
SisterSong has provided a voice for reproductive justice for over 20 years. Last October, our Field Team had the opportunity to attend its celebratory conference, *Let’s Talk About Sex*, and see firsthand the powerful ways in which the collective’s partner organizations strategize and organize to advance reproductive justice (RJ).

*Let’s Talk About Sex* offered a unique opportunity for our team to learn about the impacts of multiple systems of oppression — including gender, sexual orientation, and social class disparities — on the health and lives of indigenous people and other people of color in the United States. We participated in sessions led by women of color, for women of color. From sex worker justice to abortion access to black liberation to trans rights, the conversations explored how reproductive justice is crucial to all progressive movements.

Most importantly, the SisterSong conference pushed us to reflect as an organization and consider how we can be a better ally to the RJ movement. As we explored the reproductive justice framework with hundreds of advocates, we found a collective strength in our mission to extend voluntary family planning education and services to people around the globe, at countries’ request, through U.S. foreign assistance.

Reproductive justice highlights the ways that healthcare choices look different for different groups of people. Those from marginalized communities often face disproportionately high rates of violence (including state violence) and poverty, and unreliable access to quality education, childcare, healthcare, and stable jobs. Reproductive justice demands that we never make judgements about or seek to influence the reproductive choices of others. Each individual must have the right to make choices that are best for themselves, their families, and their circumstances, and to parent in the way that they choose.

In many ways, the reproductive justice movement is a direct response to a history of the state using the bodies of people of color for its benefit and otherwise controlling their reproductive futures. It stands in stark opposition to the shameful history of forced sterilization policies in the United States and around the world. Federally funded forced sterilization programs took place in 32 states throughout the twentieth century, with the most recent claims of unauthorized sterilization occurring in California from 2005–2013 (see sidebar). These programs oppressed those with “undesirable traits” or deemed unfit to parent: people of color, immigrants, poor people, unmarried mothers, incarcerated people, and people with disabilities.

The eugenics movement, other junk science, and thinly veiled racist fears provided the justification to sterilize over 65,000 people, often without their consent or even their knowledge. These programs were used specifically to curb the populations of communities of color and were an abhorrent violation of reproductive freedom, completely robbing victims of reproductive choice. Today, the voices of the victims are too often sterilized as well, leaving little room for recognition and retribution.

As a population organization, we cannot talk honestly about reproductive justice without first acknowledging the dark history of forced sterilization policies in the United States. As we discuss the impacts of our growing population on the world’s resources, we must be mindful of the association vulnerable communities draw between “population control” and the violation of bodily autonomy. While Population Connection never supported forced sterilization or any other form of involuntary family planning, coercive population control is undoubtedly a ghost that haunts the population movement, even today. We cannot right the wrongs of the past, but we can recognize the pain these unjust policies have caused. We need to listen to and lift up the voices of victims and survivors.
Only with our humble recognition of past injustices can we move forward in the fight to ensure access to reproductive healthcare for everyone, everywhere. Through our grassroots outreach and advocacy work, we continue to promote rights and justice-based approaches to advancing access to voluntarily family planning for women, girls, and all people around the world. As a team, we work to start conversations in communities across the country in an effort to advance global reproductive rights. We seek to make the connections between population growth, the planet’s resources, and human health and wellbeing. Population control has no place in our mission. We do not seek to control anyone — rather, we advocate for each individual to have the resources to make choices that make sense for them.

Throughout the Let’s Talk About Sex conference, a quote by Assata Shakur was referenced many times.

*It is our duty to fight for our freedom.*
*It is our duty to win.*
*We must love each other and support each other.*
*We have nothing to lose but our chains.*

The scope of our mission is so important — for the people we fight for, and for the sake of the planet. It is our duty to insist on reproductive justice, to remember the wrongs of the past, and to strive to be better. It is our duty to fight, and when the fight is this important, it is our duty to win.

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**Sterilization Abuses in the United States**

The sterilization policies of twentieth-century America were aimed at people who were incarcerated, disabled, or deemed “promiscuous.” Indigenous, Black, and Latinx people were especially vulnerable to state-sanctioned sterilization abuses.

In 1927, the U.S. Supreme Court ruled in *Buck v. Bell* that a Virginia law mandating the sterilization of the “feebleminded” did not violate the Constitution (a ruling that has never been overturned). In Justice Oliver Wendell Holmes, Jr.’s delivery of the opinion of the Court, he wrote, “It is better for all the world if, instead of waiting to execute degenerate offspring for crime or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.”

Upwards of 65,000 Americans who were judged to have mental illnesses or developmental disabilities were sterilized between the 1920s and the 1970s. Many of them were perfectly healthy and sound of mind. Carrie Buck, the plaintiff in *Buck v. Bell*, is one such example. Her mother was living in an asylum due to “feeblemindedness,” and Carrie herself had been committed by her foster parents after she had given birth to a daughter — who happened to be the result of a rape by her foster mother’s nephew. All three generations of women were deemed mentally deficient — even Carrie’s baby, who was one year old at the time.

Elaine Riddick was a 14-year-old African American girl living in small-town North Carolina in 1968. She was sterilized without her consent after giving birth to a baby who was conceived through rape by an older man. The state’s Eugenics Board decided that she was “feebleminded” and “promiscuous” and went forward with the operation on a signature (the letter X) from her illiterate grandmother. Riddick didn’t know that she had been sterilized until she was having trouble getting pregnant with her husband, years later. According to state records, between 1964 and 1968, 65 percent of sterilizations were performed on Black women.

In the 1960s and first half of the 1970s, the Indian Health Service (IHS) sterilized at least 25 percent of Native American women ages 15–44, many forcibly, and many more without consent. Special emphasis was placed on sterilizing “full-blooded” Indian women. Women were sterilized after C-sections and during unrelated surgeries, and, once consent forms were required starting in 1973, they were often signed by patients while they were sedated or in severe pain.

Data from a 1965 health survey revealed that over 34 percent of Puerto Rican women ages 20–49 who had ever been married and had at least one child were sterilized (46.7 percent of women ages 35–39). According to *Latino(a) Research Review,* “By 1980, Puerto Rico had the highest rate of female sterilization in the world.”

The most recent U.S. sterilization scandal was reported by The Center for Investigative Reporting in 2013. Prison records show that between 2005 and 2013, doctors working for the California Department of Corrections and Rehabilitation performed unauthorized tubal ligations on 144 female inmates. California law mandates that inmate sterilizations be approved on a case-by-case basis by a medical committee. None of the 144 procedures were approved, and patient interviews revealed that many were repeatedly pressured to consent, some while in labor or undergoing C-sections.
Women of color, and particularly Black women, have been, at best, relegated to the sidelines in the reproductive rights movements of the last century. But the contributions Black women have made in the past two-dozen years through the reproductive justice framework have transformed the way we discuss reproductive rights today.

Black women have demonstrated that the right to abortion isn’t the be-all and end-all when it comes to reproductive rights, despite being the most visible part of the women’s movement since anti-choice forces began trying to dismantle Roe v. Wade. Reproductive rights through a reproductive justice lens include affordable access to family planning (threatened by bans on Medicaid reimbursements to Planned Parenthood and cuts to the nation’s Title X program); comprehensive sex ed that’s appropriate to students’ cultural identity (threatened by the premature canceling of Teen Pregnancy Prevention Program grants); access to safe maternity care (Black women are 3-4 times more likely to die from pregnancy-related causes than white women); and yes, the right to safe abortion without unnecessary delay (the Hyde amendment prohibits Medicaid funding of abortion, and TRAP laws disproportionately affect poor women and women of color who may have more difficulty with waiting periods and traveling long distances to clinics). Reproductive justice insists that there are many components to reproductive choice, including the right to have children, and to deliver and raise them in safe environments.

In the early twentieth century, with the advent of the first modern contraceptives, Black women joined white feminists in advocating for birth control as a means to escape the financial and physical stresses of multiple pregnancies. But it was during this time that...
eugenics became acceptable public policy. The racist and unscientific theories behind eugenics led the United States government to wield anti-natalist policies targeting vulnerable communities — most horrifically, through state-sponsored coercive sterilization. In response, Black women broadened their family planning activism to include fighting the government’s attempts to control their bodies.

African American women’s fight for bodily autonomy continued during the Civil Rights movement and the subsequent Black Power movement. Throughout this time, reproductive rights for Black women came under attack from two fronts: the U.S. government and Black movements themselves.

In 1965, the provocative study “The Negro Family: The Case for National Action” concluded that, “The breakdown of the Negro family has led to a startling increase in welfare dependency.” The report identified a rise in male unemployment, marital dissolution, female-headed households, and “illegitimate births” as the primary components of “the deterioration of the Negro family.” The report gave rise to the notion that government involvement in Black women’s reproductive decision-making would reduce welfare spending.

Within the African American community, Black liberation movements struggled to adequately address reproductive rights for Black women. The Nation of Islam, for example, protested against the eugenics-inspired agenda of forced sterilization, but also argued that women’s sole responsibility was to procreate. The Black Panther Party’s leadership, while intimately aware of the inequities Black women faced within their communities, nonetheless struggled to rein in their sexist and chauvinistic inclinations.

That changed when Elaine Brown, a prominent figure in the Black Panther Party, was able to overcome the party’s deep-seated misogyny and become chair of the party in 1974. Brown added reproductive rights for Black women to the party’s platform. She said, “I would support every assertion of human rights by women — from the right to abortion to the right of equality with men as laborers and leaders. I would declare that the agenda of the Black Panther Party and our revolution to free Black people from the oppression specifically included Black women.”

In the mid-1990s, a group of Black women convened in Chicago and coined the term “reproductive justice.” Calling themselves the Black Women’s Caucus of the Illinois Pro-Choice Alliance, these women went to work ensuring that women of color and women of limited means be empowered and defended, in national and international declarations and action plans.

Now, more than twenty years later, the mainstream feminist movement still struggles to adequately address issues affecting women of color within their ranks, and Black women still struggle to maintain bodily autonomy. But it’s getting better, and that’s thanks to countless Black women over the past century who demanded to be heard.
“Don’t Let Them Put Anything Inside You”

The Complex Family Planning Considerations of Women from Marginalized and Disenfranchised Communities

By Jamila Perritt, MD, MPH, FACOG
It was the end of a very long day in the office when I picked up her chart. I had already seen twenty patients and she was my last of the day. I recognized her name — Anna. I’d seen Anna before, about a year earlier; she was returning to the office for her annual checkup. She was healthy and didn’t have any concerns or complaints, so we chatted a bit while I performed her exam. We talked about her work and how her two small children were doing. She had recently started a new job as a waitress and was attending school at night.

When the conversation turned to her plans for pregnancy prevention, she told me that, although she knew that she didn’t want to have another baby “anytime soon,” she wasn’t interested in using anything for birth control.

She had used birth control pills in the past, but she experienced side effects that she didn’t like. We discussed other methods that might work for her given her preferences and past experiences. Her new job didn’t provide health insurance, so the birth control patch and the ring were financially out of reach for her. Given her new job and her school schedule, she was worried about being able to get to the office every three months, which is required for the Depo-Provera shot. When we got to the discussion about long-acting reversible contraceptive (LARC) methods — the implant or the intrauterine device (IUD) — she replied with a resounding, “No! My mom always told me, ‘Don’t let them put anything inside you.’ ” She told me about her mother’s experience with the IUD and about an older cousin who had an implant placed years earlier. Both women advised Anna not to use these methods or anything similar.

Anna went on to tell me that she preferred to use condoms, even though she understood that they “may not work as well” as some of the methods I mentioned. At least, in her words, “I know what I’m getting.”

We talked a bit longer about condom use and I gave her a prescription for emergency contraception, just in case she needed a back-up. She told me she would follow up if needed, and we wrapped up her visit.
Complex Lives, Complex Decisions

As an OB/GYN physician, with subspecialty training in family planning, my work is often laser focused on reproductive health. From contraceptive counseling to abortion services, I take care of women every day who are working to manage their reproductive lives. Some are planning a pregnancy. Others are trying to avoid one. But all of my patients share one thing in common: They are not making decisions about family planning in a vacuum. Contraceptive use, pregnancy, and abortion happen like everything else: within the context of one’s life and lived experiences.

When patients show up to see me with a pregnancy, planned or unplanned, they are often dealing with a myriad of other issues as well. Like Anna, some lack insurance coverage. Many are unemployed or under-employed. Others have concerns about their immigration status or violence in their homes or communities. All of these things factor into their decision-making process and cannot be separated from the way they seek or obtain care.

The influences of personal and community experiences with contraception decision-making and attitudes around pregnancy and abortion are complex. This is especially true for communities that have been historically marginalized and disenfranchised, such as communities of color. From government supported and sanctioned eugenics programs, to abusive and coercive sterilization practices in Black, Latinx, and Native American populations, to birth control trials without informed consent in Puerto Rico, to the linking of birth control implant placement to obtaining or maintaining...
public welfare benefits, when we look back at the history of reproductive healthcare in the United States, we see a pattern of stratified reproduction.

The fertility of women of color has often been devalued and intentionally suppressed. This has contributed to a legacy of suspicion and distrust of the medical system. Studies show that people of color, and African Americans in particular, are more likely to report a general distrust of the healthcare system. They often express concern about being experimented on during the course of routine medical care and about receiving substandard care due to their race or income, and they often report dissatisfaction with the patient-provider relationship.

Conspiracy theories regarding coercive birth control practices, and even genocide, are often pervasive in communities of color. Not surprisingly, these suspicions are negatively associated with attitudes toward modern contraception, and they particularly impact a woman’s likelihood of using methods that require the involvement of or are controlled by a healthcare provider. In other words, the more effective LARC methods like IUDs and implants are not trusted by many women of color. They are often likely to prefer short-acting methods like the pill or patch, despite a higher likelihood of failure — because they, not the healthcare provider, control the stopping and starting of these methods.

This distrust is not unfounded. Provider based bias has been identified as a contributor to disparities in healthcare outcomes overall. There has been a good deal of work examining the impact that biases play in contraceptive counseling
on the provider side. Many studies have shown that providers are more likely to sterilize women of color and low-income women, and also that providers are more likely to recommend LARC methods to low-income women of color than to low-income white women. Women of color and low-income women are also more likely than more affluent white women to report being pressured to use birth control and limit their family size.

When we examine disparities in unintended pregnancy in this context, it becomes clear that those communities that are impacted the most by unintended pregnancy are also those that have been traditionally marginalized. Although almost half of all pregnancies in this country are unintended, we have made significant progress in reducing the overall rate of unintended pregnancy. The United States has also experienced significant declines in teen pregnancies.

But when we take a closer look, we find that these declines don’t occur uniformly. Women of color are roughly twice as likely to experience an unintended pregnancy as compared to white women. And Black women have the highest unintended pregnancy rate of any racial or ethnic group. At 79 unintended pregnancies per 1,000 women aged 15–44, the rate is more than double that of non-Hispanic white women (33 per 1,000). This remains true even when controlling for income.

One factor that may contribute to these disparities is contraception non-use. Couples who do not use any method of contraception have an 85-percent chance of experiencing a pregnancy over the course of a year. Black and Latina women are more likely to report not using any contraception at all, and to report using less effective methods.

About half of unintended pregnancies are experienced by women who were not using contraception at the time that they became pregnant; the other half are experienced by women who became pregnant despite reported use of contraception (though they may not have been using it consistently or correctly). According to a study by the Guttmacher Institute, only 5 percent of unintended pregnancies are experienced by women who report using contraception consistently and correctly. The evidence clearly shows that contraception works.

Reproductive Justice in Theory and Practice

The incorporation of a reproductive justice framework into clinical care provision creates a unique opportunity for healthcare providers to examine the ways that the systems and circumstances in our patients’ lives influence their health. This is distinctly different from the way many of us were taught to provide reproductive healthcare.

Reproductive health most commonly refers to the reproductive process — diseases, disorders, and conditions that affect the functioning of the male and female reproductive systems during all stages of life. This is different from reproductive rights, a term that is sometimes incorporated into the reproductive health framework. The World Health Organization (WHO) defines reproductive rights as the recognition of the basic right of all individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information to do so. The reproductive rights framework has historically focused on protecting everyone’s legal rights to abortion and contraception, and their freedom to make reproductive choices.

In contrast, reproductive justice places reproductive rights within a social justice and human rights framework. This framework was developed by a group of Black women who wanted to address the limited attention paid to diverse communities in the reproductive rights movement. Reproductive justice has its origins in grassroots mobilization and public policy change. It draws attention to the importance of changing the structural inequalities that impact women’s reproductive health and their ability to control their reproductive lives. Structural change is critical because
individual and community experiences with abortion, contraception, and unintended pregnancy are influenced by the social, political, and historical context in which we work, live, and play.

For many, the healthcare system serves to reinforce the already existing inequities in their lives. Anna’s story is demonstrative, but not unique. As a healthcare provider, I’ve had these interactions many times. Although Anna was sure that she didn’t want to become pregnant, her decision to use condoms was not based on the contraceptive efficacy of the method. There were other considerations and preferences that influenced her decision.

Without considering the ways structural barriers, historical influences, and lived experiences impact the receipt of care, it might be difficult to understand the way individuals make decisions around reproductive healthcare. If we, as healthcare providers, don’t take these influences into account, we will continue to struggle to provide the care for our patients that they need.

This is what reproductive justice looks like in practice. It means considering the context of the patient’s life and lived experience when providing care. It means asking our patients how the other structural barriers in their lives impact the way they experience the healthcare system in general, and contraceptive care specifically. And finally, once a patient has chosen a method, it means incorporating the reproductive justice framework into her continuing contraceptive care, and obtaining the desired method that same day, if possible.

The Case for Intersectionality
The lives of our patients are complex. So are the systems in which we live and practice. One way to account for these complexities through the reproductive justice framework is to incorporate the concept of intersectionality. The term, coined in 1989 by scholar and critical race theorist Kimberlé Williams Crenshaw, is grounded in the notion that our individual identities are not separate, just as our oppressions are not. The multiple layers of our identities combine to create unique experiences in our lives and unique oppressive existences for certain individuals.

Despite the intersectionality of our lives, we operate within a health framework that urges us to collapse individual identities into neat boxes for our own ease, comfort, and simplification. This can result in separate and unequal care. For Anna, this means acknowledging that, as a person of color in the United States, her willingness to use contraception may be impacted by the history of contraceptive and reproductive coercions experienced by her community. Additionally, as a woman of color, the structural racism and sexism that she experiences in larger systems result in a greater likelihood that she will be under-educated and under-employed. Intersectionality highlights the concept that oppressions that people of color, immigrants, low-income people, and trans people experience are often not additive, but multiplicative.

It is important to note that reproductive oppression doesn’t only occur in obvious ways, such as forced sterilization or lack of consent for care. It also occurs in more subtle ways that contribute to inadequate access to quality healthcare in low-income communities and communities of color. One obvious example is the Hyde Amendment, which prohibits the use of federal Medicaid funds to pay for abortion — the policy essentially makes abortion unaffordable for the people who are already struggling the most.

Considering the Context
When we evaluate our patients using the reproductive justice framework and taking into account the intersectionality of their lives, it’s clear that considering the political, social, and racial contexts in which they live is necessary to fully understanding their sexual and reproductive health decision-making. Acknowledging, addressing, and confronting systemic injustices and oppressions can help us better care for our patients and, most importantly, help them care for themselves.
The end of 2017 and the beginning of 2018 felt uncannily familiar. Just like a year earlier, there were unexpected election results, millions of outraged women marching through the streets, and, of course, a Congress that just couldn’t get it together.

No Moore
In a surprising turn of events, Democrat Doug Jones won the December 12 special election to fill the Alabama U.S. Senate seat vacated by Jeff Sessions, who resigned in order to become Trump’s attorney general.

Jones is the first Democrat to win a Senate seat in Alabama since 1992, and the first to win any statewide office since 2008. He is also, especially for Alabama, quite progressive. He was open throughout the campaign about his pro-choice views and his belief that healthcare is a human right.

His opponent was disgraced former judge and long-time (alleged) sexual predator Roy Moore, who is on the record saying that Muslims should not be allowed to hold elective office in the U.S., and that we don’t need any constitutional amendments after the first ten (which do not include the amendments banning slavery, granting women the right to vote, or guaranteeing equal protection under the law to anyone who isn’t a straight, white, Christian male).

Moore refused to concede the race, even filing multiple lawsuits alleging irregularities. Despite these efforts, Jones was sworn in on January 3. His win leaves Republicans with a thin 51-49 majority in the Senate.

Rollback Hits Roadblock
In our last issue, we reported that the Trump administration had announced a rollback of the Affordable Care Act’s birth control benefit, which had required that insurers offer prescription birth control methods without copays. We also reported that the attorneys general of several states planned to sue to stop the rollback.

Several such suits were filed, and in mid-December, two federal judges — one in Pennsylvania and another in California — issued temporary injunctions preventing the rollback from going forward until litigation is finished. The Trump administration plans to appeal the rulings, so it may be quite some time before we know the final outcome.

A Tax Bill with a Healthcare Twist
Desperate to record a legislative win by the end of the year, in late December Republican leaders dragged a poorly understood and shoddily drafted tax bill through Congress and sent it to Trump’s desk. He signed it on December 22.

The law included cuts to both the corporate and individual tax rates. But while the corporate cuts are permanent, a number of the cuts for the middle class are set to phase out over the next ten years. The bill also included, as a “cost-cutting” measure, a provision eliminating the Affordable Care Act’s individual mandate.

It’s true that the individual mandate cost the government money. The mandate required people to carry health insurance, and other parts of the ACA offered subsidies to help offset the cost for people who couldn’t afford it. If eliminating the mandate leads to people dropping their coverage altogether, then the government won’t have to spend the subsidy money.
But at what ultimate price? Experts disagree about the effect of the mandate’s removal. Some argue that the number of people who drop their insurance as a result of the change will be low, meaning there won’t be much of an impact. Others believe that the move could be catastrophic, sending the individual insurance market into a “death spiral.” Because the rules requiring insurers to cover people with pre-existing conditions are still in place, anyone can now elect not to carry health insurance and still get covered later if they become ill. Of course, only healthy people are likely to make that decision. Sick people will want to keep their coverage. That means a sicker insurance pool, which means higher premiums, which would mean more healthy people decide to drop their coverage (because of course they know they can jump back in if they get sick), which leads to... you get the picture.

**Changes at HHS**

On January 12, Teresa Manning, the anti-choice activist Trump appointed to head the Office of Population Affairs (OPA) at the Department of Health and Human Services (HHS), abruptly resigned her position. Manning, who has written that “contraception doesn’t work” and that it is “anti-family,” had been in charge of overseeing the Title X program, which provides family planning funding for 4 million low-income Americans. There has been no public explanation for her departure.

Her resignation might seem like cause for celebration, but the reality, as is so often the case under this administration, is disappointing. Valerie Huber, former head of Ascend (previously known as the National Abstinence Education Association), and Manning’s Chief of Staff, has stepped into the role on an interim basis. Whether Huber or someone else, when it comes to reproductive health, it’s a safe bet that the new OPA head isn’t going to be an improvement over the old one.

In other HHS news, in mid-January the Trump administration announced the establishment of a new “Conscience and Religious Freedom Division” within the agency. The administration says its aim is to protect healthcare “providers who refuse to perform, accommodate, or assist with certain healthcare services on religious or moral grounds.” The broad, nonspecific language and lack of details in the announcement is worrying.

How far does the administration mean for the rule to go? Which workers are included? Can a nurse with a moral objection to single parenthood refuse to care for someone who is unmarried and pregnant? What about a lab technician? We don’t have the parameters yet, but we know from past experience that women seeking reproductive healthcare and members of the LGBTQ+ community will be the ones most impacted.

**Budget Showdown = Shutdown**

The fiscal year 2018 budget process, which in theory should have been completed back in September 2017, instead dragged on well into the new year. As the end of the fiscal year came and went, Congress passed two continuing resolutions, the second of which expired at midnight on Friday, January 19, causing the government to briefly shut down. On Monday, January 22, Congress passed — and Trump signed — a third continuing resolution, re-opening the government and moving the new target date for a longer term budget deal to February 8. The print deadline for this issue is before that, so I can’t tell you how the story ends. Hopefully, by the time you read this in March, there will be some sort of resolution.
It’s been just over a year since Trump’s Inauguration and the first Women’s March. So much has happened in the world of family planning and reproductive health since then. Donald Trump imposed his expanded Global Gag Rule, cutting off aid to health providers around the world. He eliminated funding for UNFPA, denying the agency United States support for critical maternal health and family planning programs in more than 150 countries. With the support of Congress, he’s moved to defund Planned Parenthood at every turn, and he has led the charge to dismantle the Affordable Care Act, which would leave millions of Americans without access to lifesaving healthcare. Despite all evidence proving him wrong, he’s an active climate change denier. And the list goes on and on.

In the face of these constant challenges, the progressive resistance movement, and reproductive rights activists like you, have maintained the fight. We’ve marched, rallied, protested, called, emailed, petitioned, and been relentless in our efforts to stand tall against attacks on our reproductive health, our civil liberties, and the environment.

One year in, we’re honored to stand side by side with you to speak up for international family planning, reproductive rights, and our planet, and to make our elected officials listen to what matters to us, their constituents. Thanks for all you did last year. We look forward to resisting with you this one!

Clockwise, from top:
- Kit Sperl brings the #Fight4HER to the Women’s March Ohio: Power to the Polls
- #Fight4HER activist Nick Youngblood at the Women’s March Ohio: Power to the Polls
- Protesting can be fun!
Clockwise from top:
- Population Connection staff and supporters get ready to hit the streets for the Women’s March on Washington: March On The Polls
- Marian Starkey at Maine Women’s March 2.0 in Augusta, Maine
- Annick Adams brings her creative spirit to the March on Washington
- Population Connection development staff at the Women’s March San Diego: Hear Our Vote
Reproductive choices hinge on women’s status in society. That’s why PopEd devotes sections of our middle and high school curricula to understanding the inequities that exist for girls and women around the world, mostly in less developed countries — places where few opportunities exist for girls outside of marriage and motherhood; where many girls are considered a burden to their parents, are married off as teens, receive inadequate healthcare, and are tasked with the lion’s share of domestic work; and where women have few opportunities to own property or be financially independent.

This might seem very far removed from the realities of teens in the United States, where girls are told they can be anything they want and have equal opportunities to their male counterparts. And, indeed, there has never been a better time for women in American history than the present moment. Yet, if the news of recent months is any gauge, we still have a long way to go. The #MeToo and #TimesUp movements shined lights on sexual discrimination and harassment in movie studios, newsrooms, and halls of Congress — probably just a tiny fraction of what goes on in workplaces large and small.

In terms of numbers, the share of women in leadership roles — corporate CEOs and legislative representatives — is still embarrassingly low for a country that prides itself on equal opportunities. Personal freedoms for women, including reproductive health choices, still aren't settled matters in the U.S. It’s fair game to ask high school students this: “If men were the ones who got pregnant, would there be any controversy surrounding reproductive choices?”

March is Women’s History Month, a time when schools explore the contributions of women since America’s founding. Yet, women’s history isn’t just about notable women who fought for suffrage, flew airplanes, and made medical discoveries; it’s also about the history of women’s role in society and the uncomfortable truths of sexism and gender discrimination yesterday and today.

In the soon-to-be-released fifth edition of our high school curriculum, Earth Matters: Studies for Our Global Future, we’ve included a new activity, “American HerStory,” to facilitate students’ exploration of women’s role in American society since 1900. Students participate in two short exercises about their own perception of gender roles, and then examine primary source materials that illustrate society’s views on women throughout six periods in American history. Here’s a condensed version of the activity.

**Part 1: Gender Stereotypes**

1. Have students fold a blank sheet of paper into six sections. Provide them with a list of six professions (e.g. doctor, firefighter, nurse, elementary teacher, engineer, scientist, police officer, fighter pilot) and ask them to quickly draw what they picture when they think of people who work in these professions. Through a show of hands, tally the number of men vs. women represented for each of the professions. As a class, discuss why these professions might be seen as more “male” or “female.” Does this say anything about our larger society? If so, what?

2. Have students complete one of the following statements on a sticky note based on their gender identity. These should be anonymous.

   (a) Because I am a woman, I must ___. If I were a man, I could ___.

   (b) Because I am a man, I must ___. If I were a woman, I could ___.

3. Ask students to stick the notes up on a wall in the classroom. Allow them a few minutes to walk around and read
their classmates’ answers. Lead a discussion, asking if they agree with all of the statements posted (why or why not?). Did they have any trouble deciding what to write? Would their parents or grandparents at their age have filled out the statements differently? Would they have filled out the statements differently if they lived in another place in the world?

Part 2: The Past Informs the Present

1. Ask students where our perceptions of men and women come from. (Observing others, our family members, multimedia, etc.)

2. Divide students into six groups and assign each group a time period (1900–1919, 1920–1939, 1940–1959, 1960–1979, 1980–1999, 2000–present). Using a variety of materials (historical records, song lyrics, print ads, TV ads, video clips, etc.), students will research the role of women in the home and workplace during that time period. Have each group prepare a presentation summarizing their findings. Allow two class periods for the research and presentations. The following questions should guide their research:

- Were women employed outside the home during this time period? If so, what were the most common professions for them at that time?
- What was the average number of children women had during the time period? How do you think this impacted women’s lives?
- How did the role of women change over the 20-year span? What improved for women? What stayed the same or got worse?
- What, if any, differences did you find in women’s role in the home and workplace based on race, ethnicity, and socioeconomic status?
- What similarities do you see between this era and today?

The full activity includes links to over a dozen reference sites for finding materials for students’ research, including the U.S. Library of Congress, the National World War II Museum, the National Women’s History Museum, PBS, and several university collections.

3. Follow up with a short essay assignment: How do you think the role of women in the United States might change in the next 20 years? (Include evidence you see in the home, workplace, politics, media, and entertainment.)
ENVIRONMENTAL JUSTICE IS
GENDER IDENTITY IS
BUILDING FAMILY ON YOUR
OWN TERMS IS
RACIAL JUSTICE IS
ENDING INCARCERATION IS
SUPPORTING TEEN PARENTS IS
FREEDOM FROM VIOLENCE IS
FOOD SECURITY IS

IMMIGRATION JUSTICE IS
ACCESSIBLE ABORTION IS
SUPPORTING BIRTHPARENTS IS
PAID LEAVE IS
DISABILITY JUSTICE IS
QUEER FAMILIES ARE
SAFE COMMUNITIES ARE
DECOLONIZATION IS

REPRODUCTIVE JUSTICE.

Artist: Megan J. Smith | repealhydeartproject.org | facebook.com/RepealHyde/photos_stream
Under Obamacare, employers had to provide contraception coverage to women with no out-of-pocket costs. The law carved out exemptions for churches and religious groups. And after the arts-and-crafts chain Hobby Lobby took its case to the U.S. Supreme Court in 2014, the exemptions were expanded to include small, family-owned companies that oppose the birth control mandate on religious or moral grounds.

Now, in the name of “religious liberty,” the Trump administration has issued regulations allowing companies to end birth control coverage without having to seek a government waiver. All they have to do is notify their employees that their benefits have changed.

Many practicing Catholics oppose the mandate on religious grounds, for church teachings say it’s a sin to use contraceptive pills and devices that interfere with the divine plan for new life. Church leaders also have argued that contributing to an insurance pool, which includes others covered by the mandate, is tantamount to being forced to sin.

By contrast, evangelical Christians, a voting bloc that helped put President Trump in the White House, generally do not discourage the use of birth control. In many Protestant and evangelical congregations, contraception — including sterilization — is viewed as a normal and responsible practice for married Christian couples.

Most Americans support the birth control mandate. A 2015 Washington Post/Kaiser Family Foundation poll found 77 percent of women and 64 percent of men support laws requiring health plans to cover the cost of birth control. This is not surprising given that in 2013 alone, it helped women save an estimated $1.4 billion, according to the National Women’s Law Center.

– October 19, 2017

There are few things more profoundly important to a woman than controlling when and if she has children. Almost all sexually active women have used at least one type of birth control in their lifetimes. One of the hallmarks of the 2010 Affordable Care Act is that it promised women comprehensive preventive care at no out-of-pocket cost if they were covered by employer-sponsored health insurance plans. Under regulations adopted under the Obama administration, that care included 18 methods of contraception.

Then, in October, the Trump administration put into place — without the required advance notice or opportunity for public comment — far-reaching new rules offering full exemptions to employers who claimed a religious objection to contraception and also to those who claimed a “moral objection.” The exemptions would be available to private companies of all sizes as well as nonprofits. And those companies would not be required to offer the workaround that guaranteed contraceptive coverage for their female employees at no cost to the employer.

In the tortured history of birth control coverage under the ACA, the government has made change after change to placate employers who objected on religious grounds to covering birth control. Now, the Trump administration has essentially neutered the mandate entirely, allowing any employer with any religious or moral objection to refuse to offer birth control coverage — without any requirement that they allow their insurance company to make an accommodation.

It is unjust and un-economical to deprive women of easy and affordable access to birth control. The issue here should not be an employer’s religious or moral beliefs but the needs, beliefs, health, and safety of the employee.

The new rules should be permanently rolled back. The Trump administration should not impose its wrongheaded moral principles on the rest of us by denying birth control coverage to women.

– January 2, 2018
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