

**OUR BODIES, OUR LIVES, OUR VOICES**



The State of Black Women &  
Reproductive Justice



# I. Writing Our Own Narrative: Black Women's Vision For The Future

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June 27, 2017

Dear Colleagues,

*In Our Own Voice: National Black Women's Reproductive Justice Agenda* produced *Our Bodies, Our Lives, Our Voices: The State of Black Women and Reproductive Justice* to put forward a policy, leadership, and movement-building agenda for Black women's Reproductive Justice organizations and activists.

As a national-state partnership, *In Our Own Voice* focuses on lifting up the voices of Black women leaders at the national, regional, and state levels in our ongoing policy fight to secure Reproductive Justice for all women and girls. Our strategic organizational partners, representing more than 500,000 Black women, are 8 Black women's Reproductive Justice organizations: Black Women for Wellness, Black Women's Health Imperative, New Voices for Reproductive Justice, SisterLove, Inc., SisterReach, SPARK Reproductive Justice NOW, The Afiya Center, and Women With a Vision.

Our goals, based on a vision of self-autonomy and empowerment, are:

1. To establish a leadership voice for Black women on reproductive rights, health, and justice policy at the national level;
2. To build a coordinated grassroots movement of Black women in support of abortion rights and access, including ending onerous funding restrictions, contraceptive equity; and comprehensive sex education;
3. To lay the foundation for ongoing policy change at the national and state levels that impacts the lives and well-being of Black women and their families; and
4. To engage and motivate Black women as a traditionally underrepresented group to use their voting power in the American electorate.

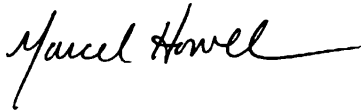
When we started writing this report in mid-2016, we were optimistic about our ability to shape the future for ourselves, our children, and our communities. The Affordable Care Act provided health care insurance for millions of Black families; the United States Supreme Court, in *Whole Woman's Health v. Hallenstadt*, reaffirmed a woman's right to abortion care; and Black Lives Matter started a youth-led movement to confront the over-policing of Black communities. And, although the national presidential election was still in process, Black women voters had clearly solidified behind a candidate we felt carried a progressive agenda that addressed income inequality, reproductive health and rights, educational opportunity, criminal justice reform, and the political advancement of Black women and other women of color.

Today, we find ourselves in a new reality. A man who ran one of the most bigoted campaigns since George Wallace is now in the White House. Worse yet, 53 percent of white women, a group we considered as allies, helped put him there.

Just the few short months of his administration tells us that voting rights, reproductive rights, educational opportunity, workers' rights and environmental advances are all threatened. Additionally, the Justice Department, now under the control of an avowed racist, has targeted communities of color with increased policing, draconian sentencing mandates, and decreased supervision of police departments.

Consequently, our collective new reality is one of RESISTANCE.

But resistance is nothing new for Black women. We have always lived at the intersections of resistance and survival. Moving forward, we will rally our leadership to speak out against any attempts to turn the clock back. We will train Black activists to rally against repressive policies. And, we will mobilize Black women voters to come out and vote for progressive policies that will better the lives of Black women, men and children. We invite you to join us!

A handwritten signature in black ink that reads "Marcela Howell". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Marcela E. Howell  
Founder and Executive Director  
In Our Own Voice: National Black Women's Reproductive Justice Agenda





# Introduction

In the aftermath of the 2016 presidential election, many politicians, especially those who speak for the so-called left, have attacked Black women voters as being part of a failing “identity politics” strategy. In its place, these politicians have advocated for an economic equality message that focuses on class to the exclusion of race and gender. In short, their premise for winning elections is no different than Trump’s – promise white males you will turn the clock back to when laws and policies favored only them. When society mandated their control of all things “American.” A time when there were no safeguards for people of color when it came to voting, housing, employment, rights to credit or mortgages, rights to simply walk down the

street or ride on a bus free from racist attacks.

Consequently, our resistance to turning the clock back is not just about the Trump Administration’s disastrous policies. It is also against the white politicians on the left who think that we, Black women, are expendable to their egotistical base-building.

These political machinations by both political parties tell us that we must take the protection of our rights into our own hands. For more than 20 years, Black women have approached our work using a Reproductive Justice frame that acknowledges the intersectionality of our lives. It is this frame that will support our resistance and propel our vision moving forward.

## Reproductive Justice Worldview

Reproductive Justice (RJ) is the human right to control our bodies, our sexuality, our gender, our work, and our reproduction. This right can only be achieved when all women and girls have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives. Because the Reproductive Justice framework encompasses bodily integrity and autonomy, our use of the term “Black women” includes cis women, femmes, trans\*, binary and gender non-conforming individuals.

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\* “Trans” is an umbrella term that refers to all of the identities within the gender identity spectrum (e.g., transgender, transsexual, etc.).

*“Black women” includes cis, femme, trans, binary and gender non-conforming individuals.*

Too many reproductive health and rights advocates see Reproductive Justice is a womb-centric world view that focuses only on a woman’s rights to have or to not have a child. That interpretation consistently places the lives of Black women and other women of color into silos that may fit well into the framework for policy wonks, but has little to do with the everyday intersectionality of our lived experiences.

But, those of us who work within a Reproductive Justice vision know that the lives of Black women are complex, encompassing educational opportunities; economic stability; housing access; safety from violence, including state-sponsored violence; clean water; fresh food, and the ability to live the life we want for ourselves and our families.

*Those of us who work within a Reproductive Justice vision know that the lives of Black women are complex, encompassing educational opportunities; economic stability; housing access; safety from violence, including state-sponsored violence; clean water; fresh food, and the ability to live the life we want for ourselves and our families.*

## Structure of the Report

*Our Bodies, Our Lives, Our Voices: The State of Black Women and Reproductive Justice* examines the impact of policy on the health and well-being of Black women.

The report is divided into four sections.

- **Part One: Writing Our Own Narrative** examines the current political climate and the leadership from Black Women’s Reproductive Justice organizations in writing our own narrative for the future.
- **Part Two: Our Bodies** examines some of the issues that impact the lives of Black women and girls. These issues cover sexual and reproductive health issues, including the Affordable Care Act; abortion rights and access; contraceptive equity; comprehensive sex education; family planning; maternal health; reproductive cancers; sexually transmitted infections, including HIV; violence against women; and LGBTQQ rights.
- **Part Three: Our Lives** examines the other intersections of our lives, including the criminal justice system; the intersections of faith; economic justice and leadership development.

- **Part Four: Our Voices – An Agenda for Action** delineates recommendations for shifting policies, actions for Black RJ organizations and activists in leadership development, movement building and voter education and mobilization.

Throughout the writing process, we also conducted interviews with Black women in Atlanta, Los Angeles, Memphis, New Orleans, and Pittsburgh about their experiences in accessing reproductive health care. Summaries of those “listening sessions” are featured throughout the report. We want to thank these women for sharing their lived experiences with us.

Our goal is to provide a snapshot of how national and state policies impact our lives and what steps we can take, as organizations and individuals, to shift those policies. But, beyond just policy change, our goal is to provide a clear agenda for our Agenda for Action for Black women’s Reproductive Justice organizations and activists.

Overall, we hope that this report will provide discussion points for Black women as we develop strategies for working with policymakers, community leaders, faith leaders, young activists, and other justice movements.



# Strategic Partners



*Janette Robinson  
Flint – Executive  
Director*

**Black Women  
for Wellness,  
(BWW),** started

by a group of Black women who were concerned about the health and wellbeing of Black babies, is a Los Angeles-based, woman centered, community-based organization offering a multi-generational approach to building health and wellness for our communities. We stand on the history of our experience and envision a future that includes empowered Black women and girls. We are on a mission to create new realities and visions for Black women that highlight the resiliency and strengths of our culture. We address health disparities impacting Black women and girls by influencing policy and regulations; conducting community research and validating our experience; implementing programs and services that are responsive to our health and life challenges; building capacity of our leadership to direct resources; and modeling good health and well-being. Visit us at [www.bwwla.org](http://www.bwwla.org)



*Linda Goler  
Blount – President  
& CEO*

**Black Women's  
Health Impera-  
tive (BWHI)** is

based in DC and is the only national organization dedicated to improving the health and wellness of our nation's 21 million Black women and girls—physically, emotionally, and financially. We identify the most pressing health issues and

invest in the best of the best strategies, partners, and organizations that share our goal: ensuring Black women live longer, healthier, more prosperous lives. Our mission is to lead the effort to solve the most pressing health issues that affect Black women and girls in the U.S. Through investments in evidence-based strategies, we deliver bold new programs and advocate health promoting policies. Our bold goal is to increase the number of healthy Black women in the U.S. from 9.5 million to 12.5 million by 2020. Visit us at [www.bwhi.org](http://www.bwhi.org)



*La'Tasha D. Mayes  
– Founder &  
Executive Director*

**New Voices  
for Reproduc-  
tive Justice** is a

multi-state organization dedicated to the health and well-being of Black women, femmes, and girls. It promotes a holistic approach to health measured by the complete physical, emotional, spiritual, cultural, political, economic, environmental, and social well-being of Black women, femmes and girls, our families and communities. Our mission is to build a social change movement dedicated to the health and well-being of Black women and girls through leadership development, human rights, and Reproductive Justice. New Voices advocates for Reproductive Justice at the local, state, and national level with offices in Pittsburgh, Cleveland, and Philadelphia. We celebrate 13 years of having served over 75,000 Black women, femmes and girls, women of color, and LGBTQ+ people of color with our leadership

development, community organizing, policy advocacy, and culture change work. New Voices is building a bold and powerful movement for Reproductive Justice in Pennsylvania and Ohio. Visit us at [www.newvoicespittsburgh.org](http://www.newvoicespittsburgh.org).



*Dazon Dixon  
Diallo – President  
& CEO*

**SisterLove, Inc.**  
is a 28-year old,  
Atlanta-based,

Reproductive Justice organization with a focus on sexual health and prevention/care, including HIV, sexually transmitted infections, unintended pregnancy, and violence. As a founding member of SisterSong, Trust Black Women Partnership, and the 30 for 30 Campaign, SisterLove has continued its commitment to ensuring that the human rights framework of liberty, justice, and dignity is the core element of any movement-building effort to protect and advance the sexual and reproductive health and rights of women and their families. We work at the intersections of Black women's lives and we work to change the policy frame from defending women's choices to asserting women's agency to make decisions that are best for themselves and their families. Visit us at [www.sisterlove.org](http://www.sisterlove.org)



*Cherisse Scott –  
Founder & CEO*

**SisterReach,**  
founded in October  
2011, is a Memphis-  
based non-profit

organization supporting the reproductive autonomy of women and girls of color, poor women, and ru-

ral women as well as their families through the framework of Reproductive Justice. The organization's mission is to empower women and girls to lead healthy lives, raise healthy families, and live in healthy communities. SisterReach provides comprehensive reproductive and sexual health education to women and teens, and advocates at local and state levels for public policies that support the reproductive health and rights of all women and youth. SisterReach utilizes community dialogues, civic engagement, and inter-faith community engagement strategies to expand new relationships among stakeholders. Visit us at [www.sisterreach.org](http://www.sisterreach.org)



*Krystal Redman  
– Executive  
Director*

**SPARK Reproductive Justice NOW** is a Re-

productive Justice organization based in Atlanta that advocates for policies that protect and expand access to the full range of comprehensive sexual and reproductive health care and services, abortion, and sexual health education for Black women, women of color, and LGBTQ youth of color in the state of Georgia. Importantly, SPARK ensures that these voices are included and centered in the Reproductive Justice movement. Our mission is to build new leadership, change culture, and advance knowledge in Georgia and the South to ensure individuals and communities have resources and power to make sustainable and liberatory decisions about our bodies, gender, sexualities, and lives. We fulfill our mission by maintaining the following strategies: developing the

political leadership of our constituency through timely skill-building workshops, outreach and advocacy, issue-based education, and conferences that incorporate our advanced racial and gender justice analysis, and mobilizing our base and social justice allies to respond to immediate political threats and develop long-term proactive strategies for social justice. Visit us at [www.sparkrj.org](http://www.sparkrj.org)



*Marsha Scott –  
Executive Director*

**The Afiya Center** is a Dallas-based organization established in a re-

sponse to the increasing disparities of HIV incidences and prevalence among Black women and girls in Texas. We are extremely unique in that we are the only Reproductive Justice organization in North Texas founded by, directed by, and unapologetically focused on the existing disparities among Black women. Our mission is to serve Black women and girls who are transforming their relationship with their sexual and reproductive health. We envision a world where women and girls will have full achievement of social justice and human rights, ending reproductive oppression. Additionally, The Afiya Center believes that Reproductive Justice serves as a platform for creating advocacy that is informed, self-actualized, and protects women's reproductive health, rights, and justice. Our programs utilize an economic justice framework to center the experiences of marginalized Black women affected by health disparities and poverty. The Afiya Center seeks to decrease HIV risk and other health disparities, working at the intersection of race, class, and gender. Visit us at: [www.theafiyacenter.org](http://www.theafiyacenter.org)



*Deon Haywood –  
Executive Director*

**Women With a Vision, inc. (WWAV)** is a New Orleans-based non-profit,

founded in 1989 by a grassroots collective of African-American women in response to the spread of HIV/AIDS in communities of color. The mission of WWAV is to improve the lives of marginalized women, their families, and communities by addressing the social conditions that hinder their health and well-being. WWAV accomplishes this through relentless advocacy, health education, supportive services, and community-based participatory research. Major areas of focus include Sex Worker Rights, Drug Policy Reform, HIV Positive Women's Advocacy, and Reproductive Justice outreach. WWAV envisions an environment in which there is no war against women's bodies; in which women have spaces to come together and share their stories; in which women are empowered to make decisions concerning their own bodies and lives; and in which women have the necessary support to realize their hopes, dreams, and full potential. The populations WWAV works with are often not visible within the health system and kept from services and access to the things they need to lead healthy lives. WWAV provides navigator services connecting women in its community to women's health, sexual, and reproductive services. Visit us at [www.wwav-no.org](http://www.wwav-no.org)

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## II. Our Bodies







## CHAPTER 1

# The Affordable Care Act and Black Women

**I**n 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law and, with a stroke of the pen, enabled millions of Americans to access health insurance for the first time.<sup>1</sup> This historic legislation expanded both private and public insurance coverage for a significant portion of the population, controlled health care costs, and introduced new standards for coverage.

The ACA had several key components. It reduced individuals' health care costs by capping out-of-pocket expenses and mandating access to preventive care without cost-sharing (like co-pays or deductibles). It established competitive Health Care Exchanges (also called Marketplaces) for those without existing coverage. It expanded

Medicaid and provided funds for states to expand Medicaid eligibility requirements and cover a larger number of low-income residents. It enabled parents to maintain their children's coverage up to age 26. And, critical for women's health, the ACA prohibits insurers from charging women more than men, and required the provision of 26 preventive services — including contraception — without excessive cost-sharing (see box.)<sup>2</sup>

By 2016, more than 20 million people had enrolled in the ACA, including both Medicaid and Marketplace enrollments. By 2017, the number of Americans who lack health insurance had “fallen from 41 million to 27 million.”<sup>3</sup>

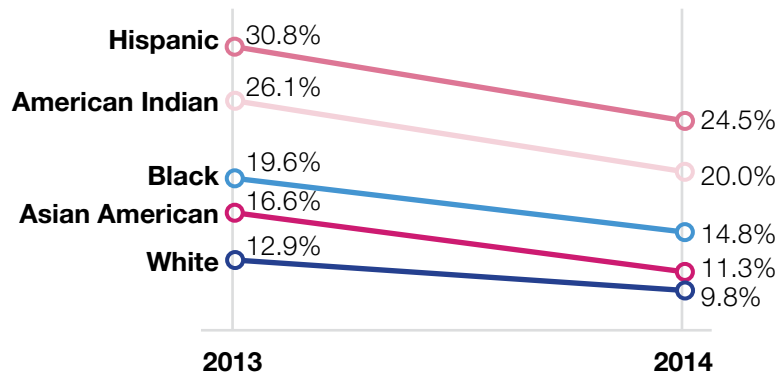
For the first time, many low and moderate income people, including women of color, young people, and

individuals with preexisting conditions, have health insurance. In most states, more than 80 percent of women of color now have health insurance, thanks to the ACA.<sup>4</sup>

Since ACA enrollment began in 2013, the uninsured rates for Black people has declined by more than 50 percent.<sup>5</sup> Fifteen million Black women got coverage through the ACA, and the uninsured rate for Black women fell by nearly seven percent.<sup>6</sup> In a majority of states, more than 80 percent of women of color ages 18-64 now have health insurance; and 3 states and the District of Columbia (DC) have achieved almost universal coverage (95 percent or greater) among women of color.<sup>7</sup>

The ability to get needed care on a regular basis is a huge benefit for Black women's health. Black

## PERCENT OF UNINSURED WOMEN BY RACE AND ETHNICITY (2013-2014)



Austin A, *Obamacare Reduces Racial Disparities in Health Coverage*, Washington, DC: Center for Global Policy Solutions, no date, page 7. Online: <http://globalpolicysolutions.org/resources/obamacare-reduces-racial-disparities-in-health-coverage/>

## ESSENTIAL HEALTH BENEFITS

Ambulatory patient services  
[outpatient care]

Emergency services

Hospitalization

Maternity and newborn care

Mental health and substance  
use disorder services, including  
behavioral health treatment

Prescription drugs

Rehabilitative and habilitative  
services and devices

Laboratory services

Wellness and preventive services

Pediatric services

women have significantly benefited from the ACA's prohibition against insurance companies denying coverage or raising rates based on pre-existing conditions. Given on-going health disparities, Black women are disproportionately likely to suffer from a chronic health condition that qualifies as a pre-existing condition, including diabetes, hypertension, obesity, cancer, and STD/STIs (including HIV/AIDS).<sup>8</sup> And, access to

women's preventive services helps address Black women's disproportionate risk of these conditions, by expanding their ability to access timely counseling, screening, and treatment.

## Expansion vs. Non-Expansion States

One of the ACA's key provisions was to require Medicaid expansion

on the state level, to broaden eligibility and get more people covered so they can access needed care. The Federal government funds the vast majority of the associated spending. Medicaid expansion has been the subject of several lawsuits brought by ACA opponents, which the U.S. Supreme Court ruled upon in 2012. The Court held that the Federal government could not require states to participate in the expansion program; states thereby gained the right to choose whether or not to expand Medicaid. By 2017, 32 states and DC had chosen to expand their Medicaid programs, with a far-ranging and positive impact on their residents.<sup>9</sup> Expansion efforts have decreased the probability that individuals go without needed medical care by up to 25 percent, and have increased the likelihood that people have a "usual place of care" (an important component in accessing services) by up to 86 percent.<sup>10 11</sup>

But, millions of Americans live in the 19 states that refused to expand Medicaid. These individuals fall into what's called the "coverage gap" — their incomes are lower than the minimum needed to qualify for Marketplace premium tax credits, but too high to qualify for (non-expanded) state Medicaid coverage.<sup>12 13</sup> The resulting health-insurance costs are significant. Overall, Black people are twice as likely to be in the coverage gap and be without insurance, compared to whites. The risk is particularly acute for those who live in Southern states, which comprise more than half of the non-expansion states.<sup>14</sup> The states with the largest number of people in the coverage gap — North Carolina, Georgia, Texas, Florida, and North Carolina — are home to a significant number of Black women.<sup>15</sup> (Texas alone accounts for 26 percent of all individuals in the coverage gap.<sup>16</sup>) Black women and low-income women

in non-expansion states are more likely to be uninsured, contributing to on-going health disparities, or to suffer financial hardships in the pursuit of needed care.<sup>17</sup>

It should be noted that having access to health insurance and services is not enough to ensure that the care received is high-quality and culturally effective. And, racism, sexism, and provider bias remain challenges that hamper women of color's access to care that is delivered in a respectful and appropriate manner. A wealth of evidence shows that "members of socially disadvantaged groups perceive that they receive inferior or biased treatment within the health care setting."<sup>18</sup> Black women are less likely to receive timely and aggressive medical treatment, compared to their white counterparts.<sup>19</sup> The negative impact on their long-term health is significant, and is clearly seen in Black women's outcomes on indicators including breast cancer, hypertension, and maternal death, among others. The impact of racism, sexism, and provider bias runs deep and specific efforts are needed to improve the health care system above and beyond mere access to health insurance.<sup>20 21</sup>

## The Threat from the AHCA

The American Health Care Act (AHCA), the Republican version of health care reform, would have the opposite effect on Black women's

health than the ACA. If enacted, the AHCA would eliminate access to affordable, timely care and reverse the recent gains in health outcomes. It would double the number of people without health coverage to a level above even pre-ACA numbers: 51 million Americans under age 65 risk losing coverage.<sup>22</sup> Women, low-income individuals, those with disabilities and pre-existing conditions, and older American will be particularly impacted.

In general, the AHCA contains a host of dangerous provisions. It would repeal the ACA's mandates for individuals and employers coverage and reduce the tax credits and cost-sharing components that made health care affordable to low- and moderate-income individuals. The ACA's tax credits were adjusted by income and geographic location, but the AHCA only takes into account the person's age; the result will be significantly higher out-of-pocket costs for most consumers, and a correspondingly reduced ability to afford coverage. It also lets insurers charge older people up to five times more than younger people, threatening to make health care unaffordable just when people need it most. Supporters of the AHCA pretend that it maintains protections for the 133 million Americans with a pre-existing condition. But it doesn't. Instead, it allows insurers to charge higher deductibles and co-pays, enabling them to set rates for those with pre-existing conditions at levels so

high that coverage will be unaffordable to most people.

The AHCA also has numerous provisions that are specifically harmful for women. First, states would be allowed to opt out of the "essential benefits" that were required to be covered under the ACA.<sup>23</sup> Women's preventive care, prenatal and maternity care, chronic disease management, and access to mental health treatment could all be jeopardized as a result. Second, the AHCA would prohibit people who receive tax credits from buying an insurance plan that includes abortion care, which may cause insurers to drop the coverage completely.<sup>24</sup>

Third, the AHCA defunds Planned Parenthood and prevents it from participating in the Medicaid program. This would eliminate a critical source of reproductive and preventive health care for Black women who have no other provider. More than half (54%) of Planned Parenthood centers are located in under-served communities. "In 21 percent of counties with a Planned Parenthood health center, Planned Parenthood is the only safety-net family planning provider, and in 68 percent of counties with a Planned Parenthood health center, Planned Parenthood serves at least half of all safety-net family planning patients."<sup>25</sup> Without this option for reliable and accessible health care, many low-income women of color will have nowhere to get needed reproductive health care.

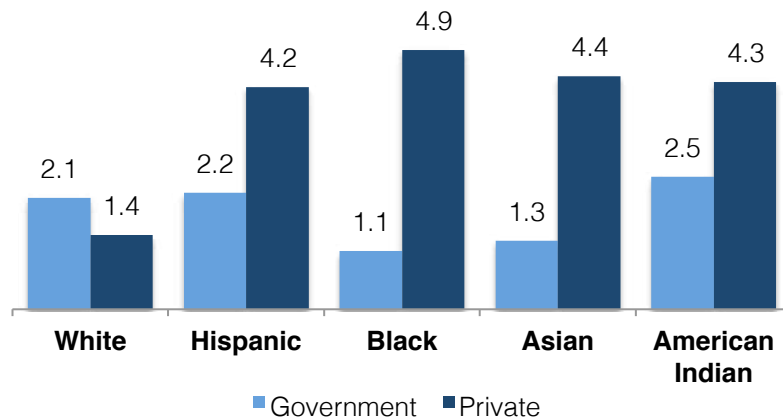
*The impact of racism, sexism, and provider bias runs deep and specific efforts are needed to improve the health care system above and beyond mere access to health insurance.*



And, last but not least, the AHCA essentially guts Medicaid by ending state expansion efforts, changing how states receive Federal funds, and drastically cutting the Medicaid budget.<sup>26</sup> The impact on women of color will be immediate, and dire. “Medicaid finances over half of all births in the United States, and accounts for 75 percent of all public dollars spent on family planning. One in five women of reproductive age, and nearly half (48 percent) of all low-income women of reproductive age, are enrolled in the Medicaid program.”<sup>27</sup> Almost one-third (31 percent) of Black women of reproductive age are enrolled in Medicaid.<sup>28</sup> Most women of color under age 64 who gained health insurance through the ACA provisions did so as a result of state Medicaid expansion.<sup>29</sup> Hence, ending support for Medicaid expansion would have a direct impact on low- and moderate-income women, who are disproportionately women of color.

The combined effect of these provisions will be a sharp decrease in coverage, increase in costs, and erosion of women’s health. According to the U.S. House of Representatives, “on average, 360,200 individuals in each congressional district stand to lose access to free preventive care if the ACA is repealed.”<sup>30</sup> There isn’t a single reputable public health organization or women’s health organization that supports this travesty of a bill. This new administration-backed bill is dangerous to Black women and our families and would have a devastating, long-term impact on women of color’s health, economic security, and progress. It is an attack on Reproductive Justice.

## PERCENTAGE CHANGE IN GOVERNMENT AND PRIVATE INSURANCE COVERAGE BY RACE AND ETHNICITY (2013-2014)



Austin A, *Obamacare Reduces Racial Disparities in Health Coverage*, Washington, DC: Center for Global Policy Solutions, no date, page 8. Online: <http://globalpolicysolutions.org/resources/obamacare-reduces-racial-disparities-in-health-coverage/>

*Despite its flaws, the ACA has successfully made health insurance more secure, reliable and more affordable for millions of vulnerable Americans, including a large number of Black women.*

## Summary

The ACA is not perfect; its weaknesses include the coverage gap, fluctuating and unpredictable costs, lack of awareness about essential benefits, and continuing barriers to care for residents of non-expansion states. There are still too many communities that are under-served and under-resourced with respect to the number of available health care providers. This is particularly true in rural communities. The solution is not to completely discard the system,

however. Despite its flaws, the ACA has successfully made health insurance more “secure, reliable and more affordable”<sup>31</sup> for millions of vulnerable Americans, including a large number of Black women. Under normal conditions, complex Federal legislation like the ACA is adjusted and improved over time; for example, the government tweaks the Medicare and Medicaid programs at least annually. The same should be done with the ACA in order to maintain and expand the far-reaching and positive gains for women’s health.



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# Health Care for All

## LISTENING SESSION, PITTSBURGH

*Nearly 40 percent of mothers of color have post-partum depression, compared to 19 percent of new moms overall; 60 percent of mothers of color do not receive mental health services for depression and post-partum depression.*

A key goal of the Affordable Care Act (ACA) is to increase Americans' access to health care, especially low- and moderate-income families. It was immediately apparent that the ACA had the potential to benefit Black women, who experience higher-than-average uninsured rates. New Voices for Reproductive Justice, based in Pittsburgh, Pennsylvania, mobilized in a successful effort to support state Medicaid expansion and ensure the largest possible number of Black women could benefit from increased access to health care services.

"Thank God for Barack Obama!" exclaims Carmen, 39, who is enrolled in Pennsylvania's Medicaid program, Gateway Health Plan. "It's good for all of us, especially for women's health." Carmen grew up in a single-parent home with several siblings. Although her mom had a full-time job, she couldn't afford health coverage for the entire family. Growing up, Carmen knew many people who opted out of insurance prior to the ACA because, even when their jobs offered health coverage, the costs consumed a large portion of people's paychecks.

Janice, 62, also expressed delight over her ACA coverage, although she had a hard time getting en-

rolled. When she became ill and needed to see a doctor, she was initially turned away at the Medicaid enrollment office. "I just cried like a baby," Janice explained. "The next day I went back, and they put me on Gateway. I thank the Lord I got it."

Most of the women said that prior to the ACA, the emergency room (ER) was their only option for health care. It was expensive, however, so they often didn't seek care unless the situation was dire.

LaQuesha, 26, who is now enrolled in Gateway, explains: "Before insurance was an open market, you only got insurance if you worked. So, if you didn't have a job when you were coming out of high school or college, you [wouldn't be able to] look into Blue Cross Blue Shield or the University of Pittsburgh Medical Center (UMPC)... because you're not even sure what insurance is." LaQuesha didn't go to the doctor regularly when she was growing up, and didn't know where to turn for health services, so she mainly relied on word of mouth information for her health and the local Planned Parenthood for care. LaQuesha's parents couldn't afford to keep her on their insurance plan and she couldn't afford health insurance until she had her first child and enrolled in Medicaid. Now she

has access to preventive care at health centers.

Daesha, 23, was in a similar situation before the ACA. She left her mother's health insurance as a teenager and was unable to afford her own health care, using the emergency room as her only health care option. A few years ago, not knowing she was two months pregnant, Daesha went to the ER for care, was misdiagnosed with a sexually transmitted infection, and ended up with an expensive bill. "I couldn't pay it then and I still can't pay it...it cost a few thousand [dollars]".

Daesha is extremely thankful for the coverage she now receives through the ACA, because it enabled her to get regular prenatal visits during a recent pregnancy. It was particularly helpful when she experienced pain during her pregnancy, as well as when she needed post-natal care. "The care I received when I was pregnant with my children was really accessible; they wanted you to come in. They did everything they could to get you to come in. They'd give you transportation, and call to make sure you know your appointments. It was really accessible."

Despite the ACA's expansion of access to care, costs remain a problem for many women, as do

inadequate family leave policies. Krystle, 29, has insurance through her workplace, but the cost is still a financial struggle. “Even though I have insurance, I gotta take a pick: do I get my medication or do I pay my bills?” Nonetheless, having insurance was essential when her son was born at 25 weeks and had to spend 9 months in the hospital. Although she had coverage, the experience put financial and emotional stressors on Krystle, because she couldn’t take time off from work to be with her son. She also had few pregnancy accommodations at the hospital where she works. “The workforce isn’t built for females,” she says, explaining that she had to walk long distances daily at her job. “Nobody understands. Nobody cares.”

LaQuesha, who is currently pregnant, is happy with her health care, also says there are still barriers to accessing services. “A lot of doctor’s offices don’t make it easy.” LaQuesha works from 9:00 in the morning until 5:30 in the evening, which overlaps with her doctor’s office hours. She recently started a new job and is currently on a three-month probation period, so she can’t request time off or leave work early for doctors’ appointments. Combined with having her other children on the weekend, it makes it difficult for her to go in for prenatal blood work and check ups. “Regardless, we get hit on what choice we make,” she comments.

The ACA also gives women access to mental health care. Nearly 40 percent of mothers of color have post-partum depression, compared to 19 percent of new moms overall; 60 percent of mothers of color do not receive mental health services for depression and post-partum depression.<sup>1</sup> However, in many cases, women who ask for support fear that doing so could lead to issues

with state authorities and separation from their children.

Krystle’s mother — not her providers — recognized that Krystle was experiencing post-partum depression after her son’s birth. “I didn’t know; I thought I was just sad because my baby was in the hospital...I love my child. Please understand, I love my child — but I need something. I am stressed. I am working. I’m trying to go to school. I need some help. And you basically have to scream for it.” Krystle’s experience is not unusual.

When Daesha had a mental health breakdown and needed inpatient care, her midwife helped her make appointments immediately with a therapist and psychiatrist and she was able to get treatment for post-partum depression and bipolar disorder. “They really seem like they care about me,” she says.

LaQuesha also says she was glad her providers asked her questions and screened her for post-partum depression, but cautions that this has to be done appropriately. “If you ask a 16-year-old, she might not answer those questions because she might be scared and think, ‘They’re gonna take my baby if I answer this properly.’” Daesha, who was hospitalized during a mental health crisis, says she was afraid to talk to her doctors about her experience because she didn’t want anyone to think she was a bad mother.

The women believe there’s a racial and economic difference in the options available to them and the care they receive from providers, which impacts everything from access to abortion care to family planning services. Daesha noticed that all of the Black women in her life were on Depo-Provera, and that it was the only contraception her provider offered her. Carmen’s

provider tried to give her a form of contraception she didn’t want. “That’s not what I asked you for,” Carmen responded. Carmen also educated her friends about the contraception’s side effects so they could make informed decisions for themselves. She says it’s on her to do her own research, find all of her options, and fight stigma that impacts her access to contraceptive services. “If you’re living in a more ‘thriving’ area, [emergency contraception,] the before-and-after pill is available. White communities have more access to things like that.”

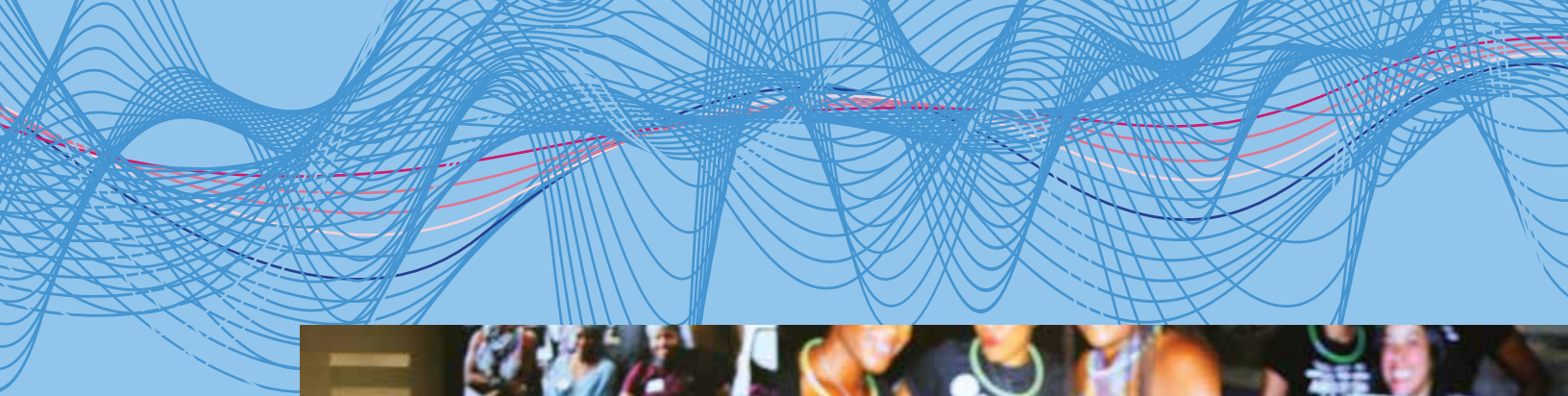
Krystle was thankful that her mother was there to educate her about all of her pregnancy options, but said that not everyone has access to the same level of education. She says that, no matter what she would decide to do if she got pregnant, it made her feel comfortable to know there are options and people who would help her with funding. In reality, however, the general lack of access to services makes the decision for many women. “They’re forcing your hand. Keep the baby, stay broke.”

Even as the women have complicated feelings about their health care, and continued challenges in accessing services, they are still glad they are covered through the ACA and Medicaid expansion. Overall, they feel happier and healthier, and their families are better off. With the support of New Voices for Reproductive Justice, these women are committed to challenging the system to ensure everything in society works better for Black women.

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## CHAPTER 2

# Abortion Rights and Access and Black Women

Every woman has the right to make fundamental decisions concerning her body, sexuality, and reproductive health. There are many reasons, both personal and medical, why a woman might decide to terminate a pregnancy. Only the woman seeking an abortion can fully understand the complex factors informing that decision. Despite the intensely personal factors that may motivate a woman to obtain an abortion, there are many forms of oppression—economic, social, and political—that prevent women from exercising that constitutional right.

Black women, in particular, have been systematically denied the resources, services, and information they need to make these important and personal health decisions. The

consequences for Black women have been profound: they are disproportionately likely to become pregnant unintentionally, to experience pregnancy-related health complications, and to become gravely ill or die in childbirth.

In June 2016, the United States Supreme Court ruled 5-3 in a Texas case, *Whole Woman's Health v. Hellerstadt*, affirming a woman's constitutional right to make her own decisions about abortion. By striking down the Targeted Regulations of Abortion Providers (TRAP) laws in Texas, the Court sent a message to policymakers that there were limits to the barriers they could set up to prevent a woman from accessing abortion services.

While Black women, young women, immigrant women, and low-income

women in Texas will benefit from this decision, there are 12.5 million other Black women in more than 20 states with similar laws who still face barriers to accessing abortion care. The *amicus brief* filed by *In Our Own Voice* outlined the impact that these TRAP laws and other abortion restrictions have on Black women of reproductive age.<sup>1</sup> The *brief* highlighted a “history of discrimination, economic disadvantage, and other factors” that disproportionately denied Black women access to reproductive health care services.

States are increasingly ramping up their own efforts to block access to abortion care, to the detriment of Black women's health. Between 2009 and 2014, states enacted almost 300 new abortion restrictions, the majority of which conflict



with medical best practices.<sup>2 3 4</sup> Common restrictions include onerous waiting periods; medication abortion bans; requirements that patients be given misinformation about abortion or be forced to have an ultrasound; and mandating that clinics meet the same standards as ambulatory surgical centers and for their clinicians to have hospital admitting privileges.<sup>5</sup> States have also banned coverage of abortion care in insurance purchased through state Exchanges, in public employees' health plans, and even in private insurance plans.<sup>6 7 8 9 10</sup>

In just the first three months of 2017 alone, legislators introduced 1,053 provisions related to reproductive health. Of these measures, 431 would restrict access to abortion services and 405 are proactive measures seeking to expand access to other sexual and reproductive health services.<sup>11</sup>

Today, abortion rates are declining, and are lower than they have been since legalization. But, there is a clear connection between poverty and lack of access to contraception that puts low-income women at higher risk for unintended pregnancy. Low-income women experience unplanned pregnancies at a rate five times that of women with higher incomes, making abortion “increasingly concentrated among this group.”<sup>12</sup> Three-quarters (75%) of abortion patients are low-income, and almost two-thirds (64%) are women of color.<sup>13</sup>

Black women account for 27.6 percent of all U.S. abortions, although they make up just 14.9 percent of the U.S. female population.<sup>14</sup> This disproportionate abortion rate is driven by factors that include Black women's greater likelihood of being poor, unemployed, or working in low-wage jobs without insurance coverage.<sup>15 16 17</sup> These factors create barriers to accessing high-quality reproductive health care, includ-

## U.S. ABORTION PATIENTS, 2014

### INCOME

75% poor or low-income

### RELIGION

62% religiously affiliated

### FAMILY SIZE

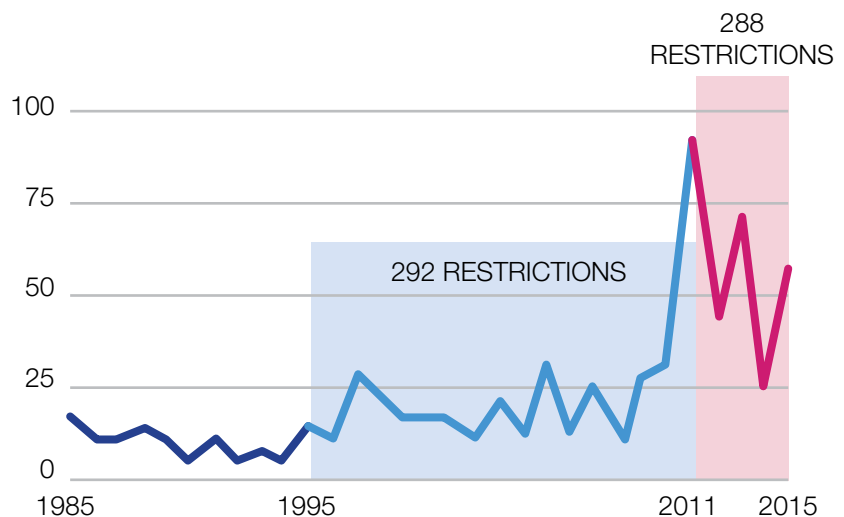
59% already have a child

### AGE

60% are in their 20s (only 12% are teens, of which 4% are minors)

Jerman J, Jones RK and Onda T, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, New York: Guttmacher Institute, 2016. Online: <https://www.guttmacher.org/infographic/2016/us-abortion-patients>

## STATES ENACTED NEARLY AS MANY NEW ABORTION RESTRICTIONS IN THE LAST 5 YEARS AS IN THE PREVIOUS 15 YEARS



Nash E, Benson Gold R, Rathbun G, and Ansari-Thomas Z, *Laws Affecting Reproductive Health and Rights: 2015 State Policy Review*, New York: Guttmacher Institute, 2016. Online: <https://www.guttmacher.org/laws-affecting-reproductive-health-and-rights-2015-state-policy-review>

ing contraceptive information and other family planning services.<sup>18 19 20</sup>

For many Black women, having the legal right to abortion does not necessarily translate into being able to access that right. Low-income women, including Black women, are more likely to rely on publically funded health care, which often restricts coverage of abortion care. On the Federal level, the Hyde Amendment restriction,

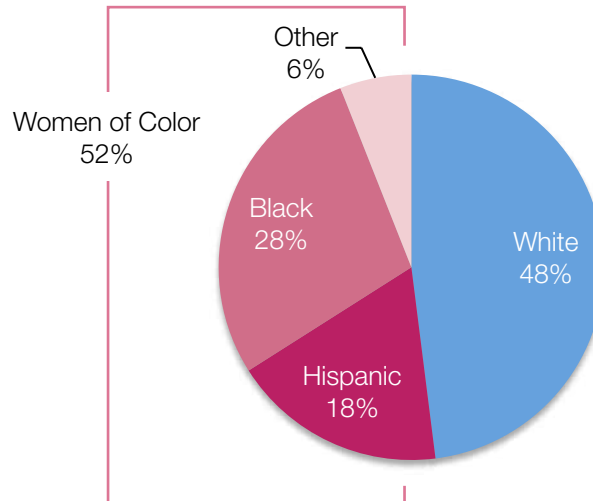
which has been attached to annual funding bills since 1977, specifically prohibits the use of Medicaid funds for abortion care except in the most extreme cases.<sup>21</sup> More than half (52%) of the women who were denied access to needed abortion care by Hyde Amendment are women of color, and almost one-fifth (18%) are Black.<sup>22</sup> While states can decide to use their own Medicaid funds to cover abortion

## WHO IS HURT BY HYDE?

**Because of social and economic inequality, women of color are disproportionately likely to be insured by Medicaid.**

**60%** of reproductive-aged women on Medicaid live in states that do not cover abortions with state dollars.

**Just over half of the seven million women subject to the Hyde Amendment are women of color.**



Boonstra H, "Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters," *Guttmacher Policy Review* 2016; 19: 46-52. Online: <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>

care for low-income women, and 17\* have done so,<sup>23 24</sup> 58% of women of reproductive age enrolled in Medicaid live in states that ban Medicaid coverage for abortion. Just over half of those enrollees – 51% - are women of color.<sup>25</sup>

Beyond Hyde, restrictions also prohibit Federal abortion care funding for military personnel and their dependents; Federal employees and their dependents; Native American and Alaskan Native women who get care through the Indian Health Service; women in Federal prisons; and Peace Corps volunteers.<sup>26</sup> And,

when President Obama signed the Affordable Care Act (ACA) into law in 2010, he also signed an Executive Order maintaining the Hyde restrictions in the ACA, dealing another blow to women's reproductive rights.<sup>27</sup>

These laws and regulations disproportionately harm Black women, who comprise a significant portion of Medicaid beneficiaries, Federal employees, and military personnel. Hyde and these other restrictions impede women's reproductive rights; it is long past time to repeal these restrictions and allow all

women access to the full range of reproductive and sexual health care.

The restrictions specifically harm Black women, who are likely to live in states with both coverage restrictions and other legal barriers. Women living in states that have the largest percentage of Black residents (i.e., Alabama, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina) face numerous barriers to exercising their right to abortion.<sup>28</sup> These states, where Blacks comprise 20 percent or more of the population, each have four to six abortion restrictions^ that hamper access to abortion care.<sup>29</sup>

As a result of these restrictive laws, the number of abortion clinics is declining and clinics are closing at record levels. Since 2011, more than 150 providers have either shut their doors or stopped providing abortion care.<sup>30</sup> Ninety percent of U.S. counties lack an abortion clinic.<sup>31</sup> This essentially puts abortion care out of reach for any woman who cannot travel the often significant distance to her nearest provider.

Another threat to reproductive rights is presented by the expansion of health care facilities that are owned and operated by religiously affiliated organizations that oppose reproductive rights. Catholic hospitals now provide one in six U.S. hospitals bed, a 22 percent increase from 2001.<sup>32</sup> These facilities explicitly deny access to many reproductive services, including abortion care, even when the procedure is needed to save the woman's life.<sup>33</sup> Religiously affiliated hospitals are often the only local health care provider, particularly in rural states, and are likely to be the provider of last resort for uninsured women. This is particularly important for Black women, who are more likely not to have health insurance.

\* These states are: Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New Mexico, New York, Oregon, Vermont, Washington, and West Virginia.

^Alabama has 5 restrictions; Georgia has 4; Louisiana has 5; Mississippi has 4; North Carolina has 4; and South Carolina has 6.

The combination of Federal, state, and facility-specific restrictions is creating a situation where abortion may remain technically legal, but the lack of providers and onerous restrictions makes it inaccessible for many women. A racial and economic divide is emerging: on one side are white and wealthy women, for whom abortion is rarer and paradoxically more accessible, and on the other side are women of color and low-income women, who are more likely to need an abortion and less likely to be able to afford or access one. “When a woman lives paycheck to paycheck, denying her coverage for an abortion can push her further into poverty.”<sup>34</sup>

Abortion restrictions explicitly seek to control women’s reproductive freedom and clearly oppress Black women and their communities. Access to abortion care cannot be separated from other human and reproductive rights. It is essential to empowering women to make their own best decisions about whether, and when, to have children; build healthy families; and foster sustainable communities.<sup>35</sup>

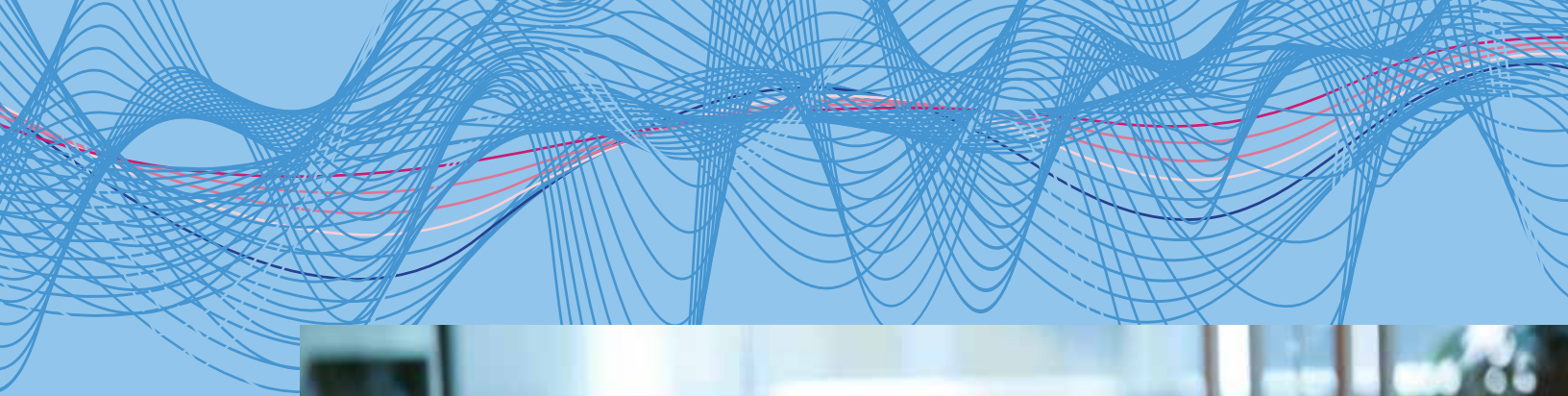
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*Abortion restrictions explicitly seek to control women’s reproductive freedom and clearly oppress Black women and their communities.*

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## CHAPTER 3

# Contraceptive Equity and Black Women

Access to contraceptives helps women “complete their education, get and keep a good job, support themselves and their families financially, and invest in their children’s future.”<sup>1</sup> Every woman has the right to make informed decisions about her fertility and to plan her family without coercion by either her doctor or her government. She should be able to choose her contraceptive method based on her own living conditions and circumstances. This should mean that she can plan whether or when to start or add to her family without outside interference. Yet, a woman’s choice of contraceptive method is largely influenced by whether she has health insurance, the types of contraception her insurance covers, her income, and how accessible health

care and contraception are where she lives.<sup>2</sup>

Contraception can be expensive, so it is most accessible to women whose insurance covers it. As of 2016, 28 states require insurance plans that cover prescription drugs to “also cover prescription contraceptives.”<sup>3</sup> Low-income women receive assistance with contraceptive costs through Federal and state programs including Title X and Medicaid. Women may choose (or be encouraged to choose) different methods depending on whether they have public vs. private insurance. Women who have public insurance are more likely to choose sterilization, and less likely to use the Pill, than women with private insurance.<sup>4</sup>

Although Black women take full advantage of available contraceptive options to plan their families, they use contraceptive at lower rates than women of other racial and ethnic backgrounds.<sup>5</sup> In fact, only 83 percent of Black women use contraception compared to 90 percent of Asians, and 91 percent of Latina and white women.<sup>6</sup> Black women are also more likely to use Depo-Provera than oral contraceptives, which are primarily used by white women.

When the Affordable Care Act was signed into law, it mandated coverage of all 18 contraceptives approved by the Food and Drug Administration (FDA), including: barrier methods (e.g., diaphragms, sponges); hormonal methods (e.g., birth control pills, vaginal ring); im-

## AFRICAN AMERICANS SUPPORT AVAILABILITY OF BIRTH CONTROL

Publicly-funded health services should include birth control for low-income women

All African Americans 94%

I consider birth control part of basic health care that should be covered by health insurance

Millennials 90%

0% 20% 40% 60% 80% 100%

Advocates for Youth and the National Black Women's RJ Agenda, *African American Voices on Sexual Health: Summary Analysis of Surveys and Focus Groups among African Americans*, Washington DC: Advocates for Youth and the National Black Women's RJ Agenda 2013. Online: <http://blackrj.org/resources/polling-research/>

planted devices (e.g., intrauterine devices); Emergency Contraception; and tubal ligation. It also addressed the challenge presented by the lack of insurance coverage by requiring private insurers to cover contraception, and to do so without excessive cost-sharing such as deductibles and co-pays.

As a result of the ACA mandate, the most effective forms of contraception — called long-acting reversible contraceptives (LARCs) — are now covered, and more women are using them. LARCs' use has increased almost fivefold over the past decade among women aged 15 to 44 (from 1.5 to 7.2 percent).<sup>7</sup> Between 2002 and 2010, the use of LARCs tripled among white women and increased four-fold among Black women (rates declined ten percent among Latinas). The use of LARCs increased at a similar rate among Latinas and white women from 2006 to 2013 (129 and 128

percent, respectively); rates among Black women increased 30 percent during this time.<sup>8 9 10</sup>

While the ability to get contraceptive information, services, and devices has improved due to the Title X, the ACA mandates, and Medicaid expansion programs, access is still limited and the demand for publicly-funded contraceptive coverage remains high. While the ACA has made access easier, an additional barrier still exists for Black women.

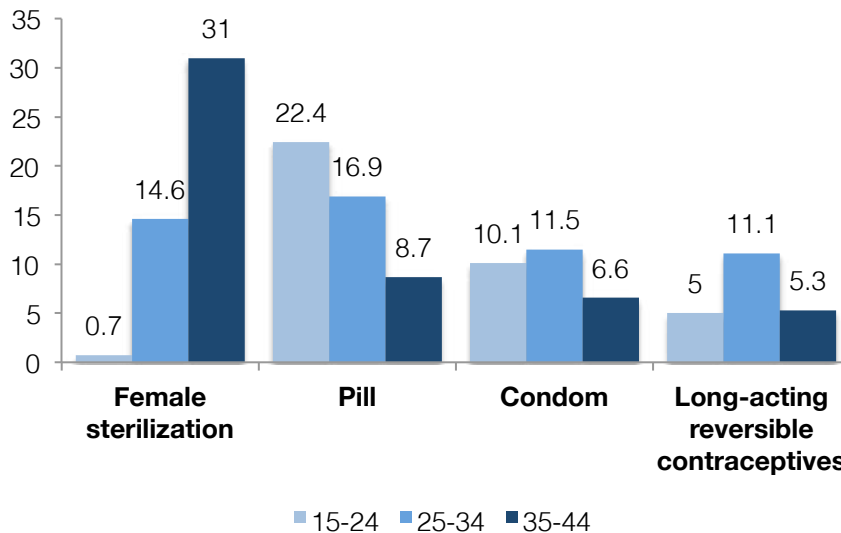
The U.S. has a long and troubling history of reproductive oppression that sought to control and limit the fertility of socially marginalized women — particularly low-income women, women of color, immigrant and Indigenous women, uninsured women, women with disabilities, and women whose sexual expression was not respected.<sup>11 12</sup>

This history includes using women as guinea pigs to develop and test new forms of contraception, often without informed consent, as occurred with Black women during the development of oral contraceptives. Participants in the early trials in Massachusetts did not know they were taking a potential contraceptive, or what the risks might be; some were patients locked in a mental hospital.<sup>13 14</sup>

It includes policies, popular among the states in the 1990s, to coerce Black women into accepting sterilization or the Norplant implant in order to receive public benefits and/or avoid incarceration. For example, South Carolina introduced a bill that required women “with two or more children to have a Norplant inserted as a condition of being able to start receiving welfare benefits.”<sup>15</sup> Other states considered requiring the use of Norplant in order for women to receive public

*The U.S. has a long and troubling history of reproductive oppression that sought to control and limit the fertility of socially marginalized women.*

## CONTRACEPTIVE METHOD USED BY U.S. WOMEN AGED 15-44 (2011-2013)



Daniels K, Daugherty J, Jones J. "Current contraceptive status among women aged 15–44: United States, 2011–2013," *NCHS Data Brief Number 173*, Hyattsville, MD: National Center for Health Statistics, 2014. Online: <https://www.cdc.gov/nchs/products/databriefs/db173.htm>

benefits at all, or in exchange for a reduced prison sentence.<sup>16</sup>

It includes sterilization and administration of contraceptives without women's knowledge or permission, as occurred in many states well into the 1970s.<sup>17 18</sup> Most recently, California Department of Corrections is said to have authorized sterilizations of nearly 150 female inmates between 2006 and 2010. Although these tubal ligations were done in violation of prison rules, the state paid doctors \$147,460 to perform the operations.<sup>19</sup>

This history has led to deep-seated distrust of medical science and government-sponsored health care. So, while medical professionals and family planning advocates applaud the expanded availability of LARCs, many in the Black community view the new drugs and devices with suspicion. LARCs are now being promoted for use by

young women, low-income women, and uninsured women — exactly the same marginalized communities that have experienced abuse and reproductive oppression by both health care providers and politicians.<sup>20</sup> In response, a joint statement of principles on LARCs, written by SisterSong: National Women of Color Reproductive Justice Collective and the National Women's Health Network addresses the past history of contraceptive abuses and provides recommendations to avoid these abuses in the future. To date, this statement has been signed onto by more than 115 organizations and individuals.<sup>21</sup>

Enthusiasm for the use of any form of contraception must not infringe upon women's reproductive autonomy. Efforts to advance the use of LARCs must not repeat past practices that coerced women into accepting a specific method,

or discouraged them from choosing a different family planning method (or none at all).<sup>22</sup> Women must be empowered and enabled to make their *own* assessment and decision about what methods are best for their unique circumstances. "Only affordable coverage of all options and a comprehensive, medically accurate, and culturally competent discussion of them will ensure treatment of the whole human being and truly meet the health and life needs of every woman."<sup>23</sup>

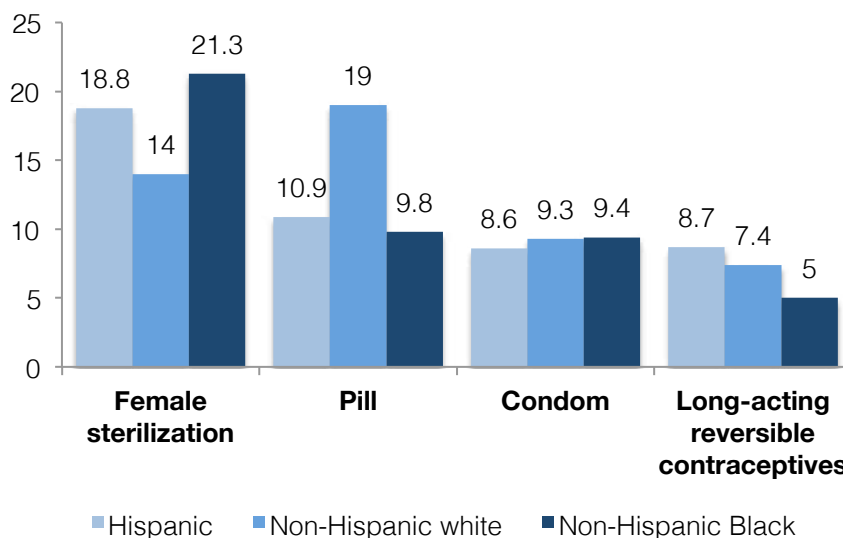
Yet, women—"particularly young women, elderly women, women of color, LGBTQ individuals, and low-income women—frequently report that clinicians talk down to them, do not take their questions seriously, and treat them as though they do not have the basic human right to determine what happens with their bodies."<sup>24</sup> For example, one study found that IUDs were recommended more often to low-income women of color than to low-income white women.<sup>25</sup> And, a recent study in Wisconsin found that "women reported that their preferences regarding contraceptive selection or removal were not honored."<sup>26</sup> They described experiences in which providers undervalued the woman's contraceptive preference; minimized LARCs' side effects; dismissed patients' concerns about LARCs; disrespected or patronized their patients; and were unsupportive when women wanted to stop using LARCs.<sup>27</sup>

Many RJ advocates who are knowledgeable of past history are concerned about the "variety of ways LARC methods might be promoted or practiced in socially unjust ways."<sup>28</sup> "We see this coercion play out when a program funds the insertion of a free IUD but not its removal, when a clinic must meet a quota for LARC use or risk its own funding, or when a doctor tells a woman she's not re-

sponsible enough for a method she can control herself. We see it when state poverty relief is tied to LARC use — as California was until 2017. And when state Medicaid programs refuse to cover removal — as South Dakota does even now, stating in its 2016 billing manual that it ‘will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.’<sup>29,30</sup>

Access to contraceptive information and services is important. But, it is not sufficient, in and of itself, to ensure women’s reproductive freedom. Reproductive Justice recognizes that the primary challenges facing young, low-income, and uninsured women stem not from unintended pregnancy — but from social disparities that disproportionately impact these groups of women.<sup>31</sup> Women must have access to the full range of safe and effective methods to plan whether and when to have children, along with patient-focused information. But they must also receive all the information about their options, including the benefits and risks, so that they can make informed decisions about what contraceptive method is best for them, given their own unique circumstances.

## CONTRACEPTIVE METHOD AMONG U.S. WOMEN BY RACE AND ETHNICITY (2011-2013)



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*Women must have access to the full range of safe and effective methods to plan whether and when to have children, along with patient-focused information.*

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# Provider Bias and Accessing Reproductive Health

## LISTENING SESSION, NEW ORLEANS

*What these women want to see is simple: better access to culturally competent and affordable health care for themselves and their families.*

Access to family planning and other health care services for Black women in the South is challenging and frustrating. Struggles to access affordable health care and find a provider who will honor women's wishes are exacerbated by a history of distrust in both the medical profession and the government that runs deep through generations. Women With A Vision, a Reproductive Justice organization based in New Orleans, Louisiana, addresses this situation by empowering women in the community and beyond.

Many Black women don't earn enough in their low-wage jobs to feed their families, but make slightly too much to qualify for public benefits like food stamps — leaving them in a constant state of instability that can threaten their overall health. “I only make \$8 an hour, [I'm a] single parent, I go to work bustin' my butt,” said Tenesha, 41. “And when I need assistance, nothing comes through...I can't even get food stamps making \$8 an hour.” She was initially turned down for Medicaid due to her income level, until Women With a Vision helped her navigate the complicated paperwork.

Like Tenesha, Dinara, 31, says that if she makes too much money, she becomes ineligible for the public assistance benefits she depends on. The mother of 5 children, Dinara feels caught because, although she and her children qualify for Medicaid benefits, she cannot afford to feed her children. Dinara says she often resorts to begging people to babysit them so she can find work. “Even if she did find a job, who's going to watch her kids?” She has three kids under the age of five,” her friend Cynthia, 32, chimes in. “I wanna get straight so I don't need that [public assistance], but it's hard,” Dinara says.

“It's just the way the system is,” says Tenesha. “It's set up to fail me. It's ridiculous. It's a white man's world, that's the way I feel about it.” The women swap stories about friends who got pregnant but are unable to receive benefits because they are enrolled in school full-time, or of caseworkers who try to shame them because of their family size. “How much are ya'll really trynna support us?” Arnisha, 21, asks. “They're not trying to support ya'll at all,” Cynthia, 32, replies coolly. “They don't care.”

In 2016, Louisiana chose to expand Medicaid under the Affordable Care

Act (ACA), but the program still has challenges. “The Affordable Care Act, why is it called that?” asks Dinara, who tried to enroll in the ACA prior to state Medicaid expansion. “I swear it's not affordable at all. I've tried to get just dental and vision, and it was \$157 a month, but I don't have a job...It's over \$300 for the whole family.”

Even with Medicaid coverage, Dinara says that seeing preventive and prenatal care providers is nearly impossible. During her most recent pregnancy, only one doctor in her area was accepting new Medicaid patients, and she experienced a delay in getting care. She attributes much of it to racism and her economic status. “With this skin, I don't get prenatal care.”

Rather than providing treatment, Dinara feels that her providers simply try to make sure she doesn't have any more children, and offer her birth control methods that have harmful side effects on her. “I'm one of those very few people who has side effects with any kind of pills. Always have.” Dinara used a NuvaRing but developed ovarian cysts. Dinara feels that her health care providers failed to work with her to find a method that worked for her body and lifestyle. Instead,

she says, she had to do the research on her own and fight her providers to try different birth control pills.

The challenges Dinara experienced in getting the type of care she desired continued throughout her pregnancies. She was sent home from the emergency room although she was experiencing an ectopic pregnancy that later burst, and was pressured into having a cesarean section. “My experience is that we’re not given all the options that other people are given...I’ve heard some really ugly stories. And it’s scary,” Dinara comments. Dinara has given up on going to the doctor altogether, “I’m gonna be hurting when I leave and then they gonna give me a \$1,000 bill. Nope.”

Arnisha was able to get on Medicaid when she became pregnant, and to meet with a nurse during her pregnancy. When she began to have pains, however, she went to the hospital several times, but the staff there told her she was fine and sent her home. Arnisha later miscarried at four and a half months.

The women believe more and better health education is key. Because her mother is the executive director of Women With A Vision, Cynthia learned about sex and reproductive health, and has received regular gynecological checkups since she was 15. Naturally, she shared the information she learned with her friends, commenting, “I was dumbfounded that nobody knew these things. When you have education, you can make better decisions.” She relates fond memories of making condom packets for distribution in the community when she was younger.

But health education wasn’t enough when she stepped into the doctor’s office. Cynthia says she

has always had reproductive health issues, which culminated in massive bleeding when she exercised. She knew this wasn’t normal. It turned out that her uterine walls were contracting and causing constant pain. Despite her symptoms, her doctors told her she was fine. “Are you not listening to me?” she asked them. “That was the last time. I can’t have a male doctor. I know my body. Me and my body have been together for a long time.” To Cynthia, and many other Black women in New Orleans, sexism and racism clearly impact their ability to receive competent care from a provider who listened to them.

The women shared personal stories about going into a hospital for gynecological care and being told there wasn’t a health issue, or that a hysterectomy was the only answer to their problems. Dinara’s mother was talked into a partial, and later, a full hysterectomy that she didn’t want. As a result, she ended up with a punctured bladder and multiple organ failure. Francis, 59, starts to cry when she recalls her 1988 hysterectomy: “I felt like the doctor I was seeing at the time, a white doctor, kept telling me that I have to do this, that I have to have the hysterectomy because I had fibroid tumors. I didn’t know.” Francis went to a second doctor for another opinion, who said the same thing. Years later, she found out that many Black women with fibroids had been pressured into undergoing unnecessary hysterectomies leading to sterilization, particularly in the 1970s and 1980s. “There are so many of us who wound up doing it because we didn’t know,” she says.

The women say that being denied the full range of reproductive options and sexual health educa-

tion is the norm in Louisiana, particularly around abortion care. The state forces women to navigate a myriad of barriers and laws designed to discourage them from seeking abortion care at its two remaining clinics. These include a 24-hour waiting period, state-mandated anti-choice counseling, a ban on telemedicine, and prohibition against ACA insurance coverage for abortion care. “Abortion is like a four-leaf clover, you’re lucky if you can find one; there’s no place. Even if, down the line, you don’t want to have one, you at least want the option. You don’t know what anybody’s situation is at the end of the day,” explains Cynthia. Arnisha says she considered having an abortion, but does not believe in it for herself. She has supported a friend who had one, though, adding, “Nobody should be able to govern anybody’s body but that person.” And yet, that simple fact isn’t reality for these Black women’s family planning decisions in Louisiana.

What these women want to see is simple: better access to culturally competent and affordable health care for themselves and their families. They want real choices in their communities that does not involve choosing between feeding their families and buying needed medication. They are cynical about the future and whether their situations will improve. Until then, they’ll continue to support each other and build community through Women With A Vision. Explains Dinara, “I would like for Black women to be allotted the exact same everything as everybody else. We matter too.”







## CHAPTER 4

# Comprehensive Sex Education and Young Black Women

By Janette Robinson Flint, Executive Director, Black Women for Wellness

**F**rom a Reproductive Justice framework, sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs and values. It encompasses sexual development, sexual and reproductive health, interpersonal relationships, affection, intimacy, body images and gender roles. Most sex education happens in the home with parents, trusted adults and siblings. Young people learn about sex from books, television, the Internet, and their friends. They also learn from planned sessions in their churches and in classes in their schools. According to the Sexuality Information and Education Council of the United States (SIECUS) “school based sexuality education should be designed to complement and augment the sexu-

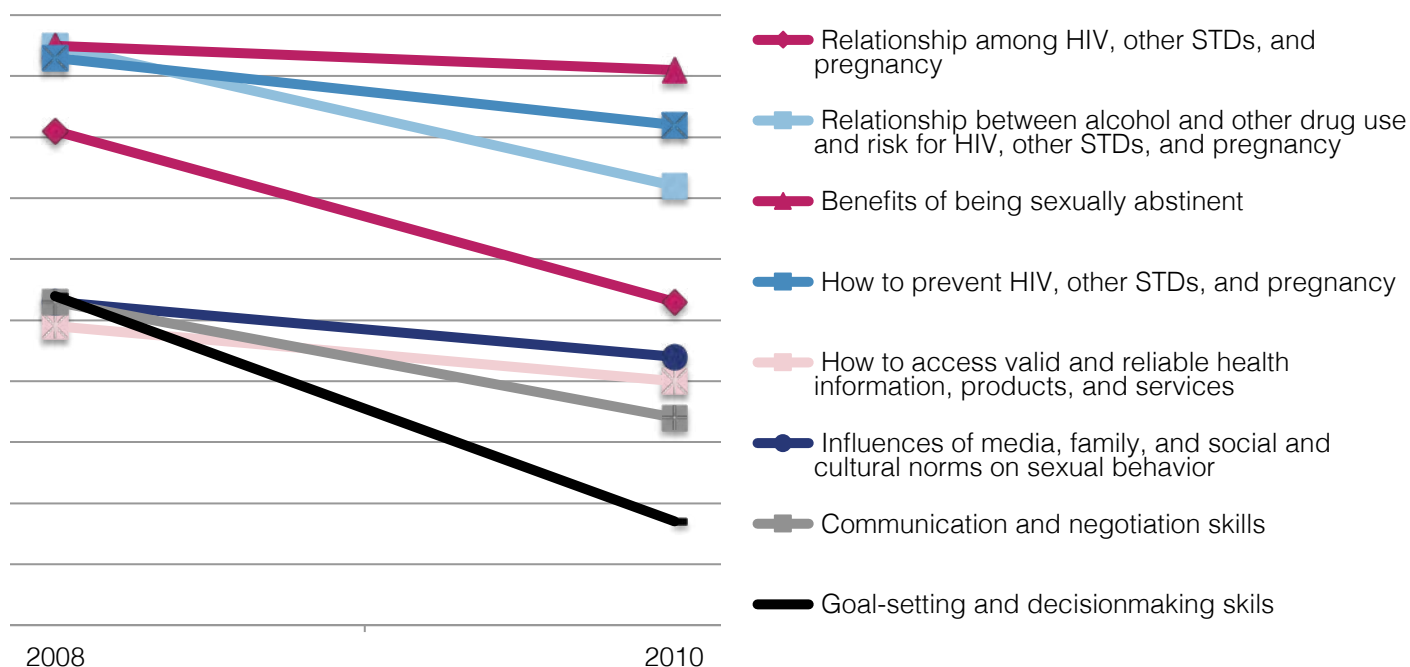
ality education children receive from their families.”<sup>1</sup>

The changing landscape of comprehensive sexual education has acutely impacted Black teens and youth. Currently, Federal dollars spent on pregnancy prevention and sex education, including abstinence-only-until-marriage programs total approximately \$280 million with the vast majority going towards evidence based programs like comprehensive sex education. This effectively serves approximately 2 percent of all teens.<sup>2</sup> This gap between funding and need, coupled with the refusal of many states to accept sex education funding,<sup>3</sup> compounds the challenge of Black teens obtaining the information and care they need to protect their health.

Comprehensive, culturally sensitive sex education is a proven method for reducing reproductive and sexual health disparities as well as providing the rights tools and information for young people to be better equipped to make decisions about their bodies. For sex education to be effective, however, it needs to be able to reach the most vulnerable teens, and be coupled with strategies to address health access issues and stigma.

Comprehensive sexual education has long played a role in helping teens (ages 13-18) and young adults (ages 19-24) make critical decisions regarding their sexual health, healthy relationships, and normal biological changes that come with maturing from adolescence to adulthood.<sup>4</sup> Unlike abstinence-only-until-marriage education, com-

## PERCENTAGE OF PUBLIC SECONDARY SCHOOLS IN WHICH SPECIFIC HIV, STD, OR PREGNANCY PREVENTION TOPICS WERE TAUGHT IN A REQUIRED COURSE IN GRADES 9, 10, 11, OR 12 — 45 STATES, 2008 AND 2010



Source: Centers for Disease Control and Prevention, "HIV, Other STD, and Pregnancy Prevention Education in Public Secondary Schools — 45 States, 2008–2010," *MMWR* 2012; 61(13): 222–228.

prehensive sex education teaches teens about bodily development, sex, sexuality, contraception, sexually transmitted diseases and infections (STD/STIs), unintended pregnancy, and informed decision making. Ideally it also includes culturally competent information about puberty and reproduction, sex, sexuality, gender identity and expression, media literacy, contraception, gender based violence, and sexual orientation.<sup>5</sup>

Evidence-based programs not only promote agency for youth throughout their formative years, they have been proven to help delay first time sexual activity; declines in unintended teen pregnancy and STI

rates; and increase the use of more effective forms of contraception earlier.<sup>6</sup> Curricula during the K-12 experience have also been proven to help teens better communicate about sex and reproductive health with their partners and parents, value and understand their own bodily autonomy, respect sex and sexuality, and make informed decisions about their reproductive and sexual health.

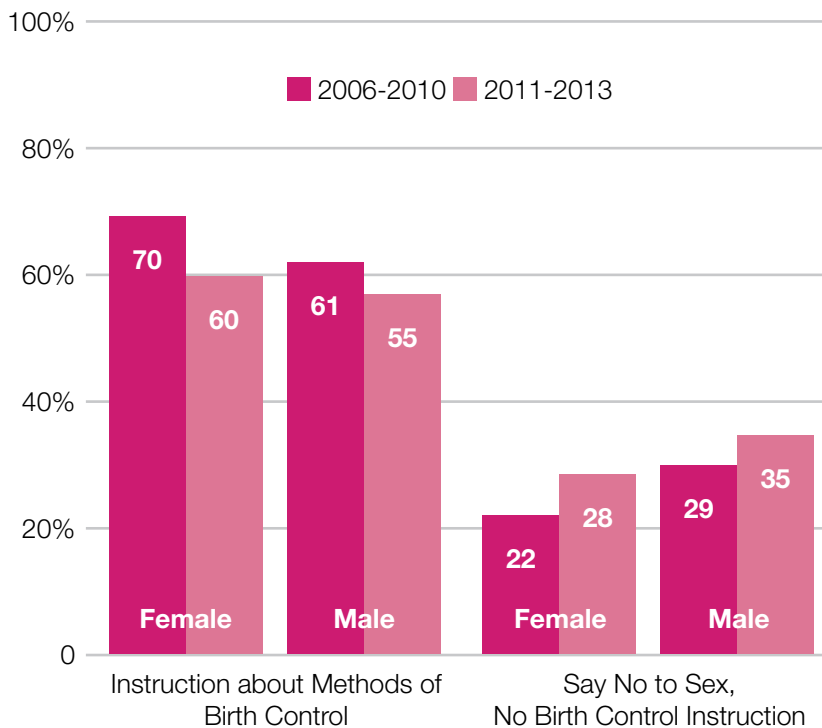
Black teens and youth make up a disproportionate amount of reproductive and sexual health disparities. Though unintended pregnancy rates of all U.S. teens are down across all ethnicities, Black teens still have unintended pregnancy

rates more than double that of white teens.<sup>7</sup> Furthermore, nearly one-third of all HIV infection rates occur among Black youth between the ages of 14–24.<sup>8</sup> Black teens are six times more likely to be infected with HIV than non-white Hispanics and twenty times more likely than white youth.<sup>9</sup> Over the last 20 years, chlamydia, syphilis and gonorrhea rates of Black teens between 15–19 years of age vary from five times higher to 16 times higher than that of white teens.<sup>10</sup> For most public health advocates, this would suggest a simple lack of education around safer sex practices and access to contraception, however this is not the whole story. Although there is tremendous need



## DECLINES IN BIRTH CONTROL EDUCATION

Fewer teens are learning about birth control from formal sex education programs; more teens are being taught to say ‘no’ to sex without getting any birth control instruction



Guttmacher Institute, Fact Sheet: *American Teens' Sources of Sexual Health Education*, New York: Guttmacher Institute, April 2016. Online: <https://www.guttmacher.org/fact-sheet/facts-american-teens-sources-information-about-sex>

to increase funding for sexual education, the needs of Black teens, in particular, have been missing in most curricula.

A 2011 survey by *Essence Magazine* and the National Campaign to Prevent Teen and Unplanned Pregnancy found that 90% of Black youth said they didn't want to get pregnant at this point in their lives, but over 67% have had sex without using contraception.<sup>11</sup> One in three Black females said they had unprotected sex because their partner didn't want them to use contraception. Of the teens who have had sex, almost half (45%) said they

were pressured to have sex. Seven in ten Black youth believed that the media sends the message that Black females' most important quality is their sex appeal. These numbers tell us that good sex education needs to include information and strategies to address social pressures, self-esteem and stigma that contribute to the decision-making process of many young Black teens in wanting to protect themselves and their partner from sexually transmitted infections.

In addition, sexual harassment, sexual assault and intimate partner violence (IPV) are a crucial part of

sex education for Black girls. In a study looking at sexual victimization of Black girls, 60% reported being sexually assaulted by the age of 18.<sup>12</sup> Black young women are more likely to experience and die from IPV.<sup>13</sup>

## Foster Youth

Young Black people are disproportionately in the foster care system, currently making up 23% of youth in foster care.<sup>14</sup> These young people have major obstacles in obtaining comprehensive sex education from their school. Almost one third of foster youth do not attend the same school for the full school year<sup>15</sup> thus, they are more likely to miss sex education classes. Furthermore, foster youth who are in juvenile detention centers, group homes or live in non-related placement foster homes face additional barriers for accessing sexual education. Young women in foster care are more than twice as likely to become pregnant by the age of 19, and even more likely to have a repeat pregnancy before the age of 19, making up 46% of repeat pregnancies.<sup>16</sup> A national study looking at children in the child welfare system, which includes foster youth, found that almost 20% engaged in consensual sexual activity before the age of 13.<sup>17</sup> Comprehensive age appropriate sex education for foster youth, which starts at a younger age, and is geared to the unique barriers of foster young people is essential to addressing the health disparities of Black foster youth.

## Abstinence-Only Education

Abstinence only programs put teens, particularly in marginalized and rural communities, at more risk, with less tools available to them to make the best decisions about their bodies. In an evaluation

of six abstinence only programs, three found no differences between the youth in the program and the youth outside of the program; two evaluations found that there was an increase in rates of sexual activity by youth in these programs. In addition, in an analysis of the abstinence-only programs nationwide, over 80% of the curricula contained false information about the risk of abortion, the effectiveness of contraception, and expressed religious beliefs as science facts. Finally, when it comes to “virginity pledges,” a popular abstinence-only-until-marriage component, a study found that although the programs resulted in a slight delay in teens initiating sex, the majority (88%) initiated sex before marriage, had the same rates of STD/STIs as those who did not take the pledge, but were more likely to delay treatment for the STD/STI.<sup>18</sup>

Additionally, the majority of abstinence-only programs are in the South, where 55% of the Black population in the United States resides.<sup>19</sup> Federal funds for abstinence-only education, coupled with a divestment in Title X funding and refusal to expand Medicaid, puts the health and well-being of Black teens in jeopardy. In the Deep South, states tend to have the least expansive Medicaid program and the most rigid requirements for families to apply, making it that much harder for underserved communities to receive treatment for STD/STIs. In 2015, many southern states ranked highest in the nation in rates of gonorrhea, chlamydia, and syphilis.<sup>20</sup>

Teen pregnancy rates in Arkansas and Mississippi are ranked number one and number three respectively<sup>21</sup> with Louisiana and Alabama among the top ten and South Carolina, Georgia, Tennessee among the top twenty.<sup>22</sup> Many of the states in the South with the highest rates of STD/STIs and

## NATIONAL SEXUALITY EDUCATION STANDARDS

**Anatomy & Physiology:** provides a foundation for understanding basic human functioning.

**Puberty & Adolescent Development:** addresses this pivotal milestone that impacts individuals’ physical, social, and emotional development.

**Identity:** addresses several fundamental aspects of people’s understanding of who they are.

**Pregnancy & Reproduction:** provides information about how pregnancy occurs and builds decision-making skills to avoid unwanted pregnancies.

**Sexually Transmitted Diseases and Infections (STD/STIs), including HIV:** provides both content and skills-building to understand STD/STI transmission and prevention, including signs, symptoms, testing, and treatment.

**Healthy Relationships:** offers guidance on how to successfully navigate changing relationships among family members, peers, and partners. Special emphasis is given to technologies’ impact on these relationships.

**Personal Safety:** emphasizes the need to create and maintain safe environments for all students.

unintended teen pregnancy do not provide students with the opportunity to receive comprehensive, evidence-based education about reproductive and sexual health. For example, Alabama, Arkansas, and Louisiana, have no requirement for sex education to be taught,<sup>23</sup> even though these states have rates of sexual activity by teens that are higher than the national average.<sup>24</sup> Mississippi, Alabama, and Arkansas have the highest rates of teens having sex before the age of 13.<sup>25</sup>

Black parents and students overwhelmingly support (90%) comprehensive sex education.<sup>26</sup> Despite

these numbers, Federal, state and local policymakers regularly try to prevent the implementation of evidence-based comprehensive sex education as the standard. The Federal government traditionally funded only abstinence-only programs until recently.<sup>27</sup> In his FY2010 budget, President Obama included funding for the Personal Responsibility Education Program (PREP) and Evidence Based Teenage Pregnancy Prevention Initiative (TPPP) to reduce teen pregnancy.<sup>28</sup> PREP, authorized as part of the Affordable Care Act provides grants for states that teach both abstinence and contraception and is specifically

## *Much like the Medicaid expansion battle raging at the state level in many conservative states, comprehensive sex education has also become a political football.*

meant to target vulnerable communities to reduce teen pregnancies. TPPP funds medically-accurate and age-appropriate programs to reduce teen pregnancy. Additionally, in 2013, the Centers for Disease Control and Prevention (CDC) began offering grants to State Education Agencies (SEAs) and Large Municipal Education Agencies (LEAs) to implement Exemplary Sexual Health Education (ESHE) and evidence based approach that emphasizes continuous learning from K-12.<sup>29</sup>

States can apply for these programs as well as the Abstinence-only and Title V funding (Title V money is abstinence education funding that does not have to be evidence based nor medically accurate) but many have opted not to do so. Much like the Medicaid expansion battle raging at the state level in many conservative states, comprehensive sex education has also become a political football. In the absence of Federal legislation regarding comprehensive sex education, like the pending Real Education for Healthy Youth Act (H.R. 1706, S. 2765), states can determine the fate of this issue. In FY 2016 Florida, Indiana, North Dakota, South Dakota, Texas, Virginia and Kansas opted not to use their PREP funding and 14 states decline Title V money.<sup>30</sup>

More than half of all the states in the US, including the District of Columbia, have sex education policies. Because there is no Federal mandate, the types of policies in place vary by state and are shaped by the various political structures. Thirty-four states and the District

of Columbia mandate at least HIV education.<sup>31</sup> Only 13 states require medically accurate information and only 8 states require sex education to be culturally appropriate and unbiased.<sup>32</sup> Thirty-seven states require abstinence be taught as a part of the curriculum. Thirteen states require that sexual orientation be a part of the curriculum, however of that, 3 states included this issue in a negative way. Twenty-two states require information about healthy decision making, 21 states and the District of Columbia require information about coercion, and 11 states require family communication be taught.<sup>33</sup> Finally, 44 states require some type of parental involvement take place in sex education, such as notification that sex education is being provided, requiring parental consent for this education, or enabling students or parents to opt out of sex education.<sup>34</sup> As advocates push forward to promote sex education at the Federal, state, and local level, the baseline for information should be the national sexuality education standards (see box).<sup>35</sup> However even these standards could go further and should include cultural competency around race and class and information about sexual orientation, gender expression and identity, and information about abortion.

*Black Women for Wellness* (BWW), based in Los Angeles, CA, is a woman centered, community-based organization offering a multi-generational approach to building health and wellness for Black communities. The organization addresses health disparities impacting Black

women and girls by influencing policy and regulations; conducting community research and validating our experience; implementing programs and services that are responsive to our health and life challenges; building capacity of our leadership to direct resources, and modeling good health and well-being.

BWW has been instrumental in developing sexuality education programs in Los Angeles. Their “Get Smart, B4U Get Sexy” is a comprehensive sex education program that provides prevention and intervention resources for youth and young adults ages 12-30, that supplements sex education in the school system. The program specifically targets Black young people, including programs specifically looking at foster youth.

An overwhelming body of evidence exists that details the long-term benefits of evidence-based, sexual education. Comprehensive approaches help young people to have healthy, responsible, and mutually protective relationships when they become sexually active, and contribute to increased condom or contraceptive use, and reduced sexual risk-taking. Sexual education cannot be taught in a vacuum, however. When it comes to Black youth, it is essential to pair good sex education with programs that look at media literacy, self-esteem, empowerment, and access to services. If young people do not feel that they are worthy enough to respect their bodies, education alone will not decrease sexual health disparities. Sexual

education policies also need to meet youth where they are, including young people outside the traditional school system. Black youth are more likely to be homeless, in foster care, in juvenile detention centers, or in alternative public schooling, like continuation schools. Black youth also need sex education that addresses sexual harassment, sexual assault, and intimate partner violence. Black youth need sex education that affirms their identities, uses real world barriers as learning opportunities and provides an inclusive framework that examines the impact of race, gender, gender expression, and orientation. Real comprehensive and culturally sensitive sex education is a crucial tool for Black women and girls to achieve full autonomy of their bodies.

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# Comprehensive Sex Ed

## LISTENING SESSION, LOS ANGELES

*Even in states like California, which has good mandates for school-based, comprehensive sexual health education, students still don't get all the information and skills they need to make healthy decisions.*

Thanks to better sexual health education and access to contraception and disease-prevention services, U.S. rates of teen pregnancy, birth, and abortion have all fallen to historic lows.<sup>1</sup> Yet, while rates have dropped significantly for all racial and ethnic groups, clear disparities exist that hurt Black youth. Even in states like California, which has good mandates for school-based, comprehensive sexual health education, students still don't get all the information and skills they need to make healthy decisions. To fill in the gaps, teens rely on television, the internet and community organizations like Black Women for Wellness, a Reproductive Justice organization based in Los Angeles, California.

"The society is restricting us from knowing information," says Josie, a 17-year-old high school senior. "They're not really teaching us. They're not giving us the tools or teaching us the right thing to do. They're restricting us from know-

ing stuff." Josie's first sexual health education class was in 9th grade, which she attended until she was pulled out, at her mother's request, when her classmates learned to put a condom on a banana. She says 9th grade felt early to get that information, but now she feels this information should be taught earlier, at age-appropriate levels, and on an on-going basis.

Although Josie isn't interested in having sex at the moment, she wants the ability to get comprehensive health information so she can share it with friends and be ready later, when she decides to have sex. "I just feel like, every year there needs to be a refreshing of what we need to know because a lot of things change, and a lot of rules change in the sex world, and young adults just need to use the right tools," she explained.

"What?! I wish I could have learned to put on condoms!" exclaimed Tressel. "I would have learned so much more." The 17-year-old high school senior agreed with Josie

about the lack of sexual health education in schools. "The last time I learned about sex was in the 8th grade. They taught [sic] us in 8th grade but, it's like, we need to learn again. We need reminders," she said. "As soon as we're having sex, we're gonna be forgetful; you want to hurry up and do it, but you need to think before you do it." Tressel believes adults need to be realistic about teenagers and sex, and make contraceptives easier to access.

DeKendra, 17, also a senior in high school, says it would be helpful for teens if protection (like condoms) were less expensive, or even free. Tressel says that young people don't have disposable income, and therefore can't afford condoms and birth control. They can also be difficult for teens who are under 18 years old to purchase. "Grown folks tell us to use condoms, but they don't ever give us none," Tressel explains. "So, it's like, how do you want us to not have sex but if we do want to have sex, we don't have no protection to do it?"



*Similarly, Josie says she and her friends learn about sex from doctors' and clinics' social media accounts, and from YouTube videos, including a video on giving birth and how to put on a condom correctly.*

She also explained that several students were pregnant in junior high and high school, and many students thought it was funny and judged the young women for becoming pregnant, yet the school didn't offer additional information about protecting oneself from pregnancy or sexually transmitted diseases and infections (STD/STIs). "In school, they don't tell you about birth control or sex anymore, they just see us get pregnant. They don't talk about sex or anything."

"When I learned about sex, it was just nasty. I didn't really know why they were telling me this about sex," describes Shanelle, an 18 year-old student. "But 8th grade wasn't our first time learning about sex. We know about sex before we turn 14 or 13. We know about it even as a kid. You know something is going on. You probably don't know about the stuff that's going out, or the eggs and that you're ovulating, but you know how you do 'do it' or whatever. You know what's going on." Shanelle says she turned to Planned Parenthood for contraception and condoms because it was close to her house, offered confidential services and privacy from her parents, and, "They have condoms for days!"

Josie feels comfortable asking her mother about sex and reproductive health care, but Shanelle and Tressel do not. Tressel explains, "My mom, she says I can tell her stuff but if I do tell her stuff or say, 'Mom, I have sex,' it's gonna blow up." While she hasn't been to the Planned Parenthood health center

herself, Tressel says her friends frequent it often, and she likes to know that it's there for her if she needs it. Teens value the ability to access sexual health care confidentially, and the assurance of privacy from parents and peers; this enables them to avoid both awkward conversations and slut-shaming at school. "If you have an STD or something is wrong with you, everybody is going to know about it, it's not gonna be a secret, and you're gonna get clowned," Tressel says. She adds that many teens experience STD/STIs, but don't pursue treatment for fear of being judged by their doctors and friends. "Sometimes you don't know what you have and it will just progress and progress." And, because of the lack of comprehensive sex education, male students are often unaware that they can contract and spread STD/STIs.

The teens also feel that race plays a factor in their ability to access health care, how they dress, and how they express their sexuality. Tressel notes that when she wears ripped-up jeans, people assume she's a "hussie," but she's noticed that white girls can wear the same thing to school and it's considered acceptable. "I think race does play a big part of it." Josie, who attended both predominantly Black and white schools during junior high school, feels this also affects how teachers present sexual health information. About the predominantly white school, Josie says, "I remember being in 8th grade, they didn't give us a lot of information

because they said everyone was smart enough not to do it; 'Don't worry about it, you're fine.' But, when I went to school with [mostly] African American students, it was very protective. They were looking out for us and they wanted us to know that using a condom is the best thing. They want us to know about getting abortions and what else to do." Josie says she was surprised by the assumption that Black students would have sex and white students wouldn't.

While she got some sexual health education, Josie felt that it wasn't comprehensive, so she and her friends sought out older students and turned to pop culture for more information. The teens say they turn to television, social media, and older, more experienced friends to fill in the gaps. "We learn a lot from TV and music videos, explains Tressel. "We'll learn about famous people who talk about sex, and from TV." Similarly, Josie says she and her friends learn about sex from doctors' and clinics' social media accounts, and from YouTube videos, including a video on giving birth and how to put on a condom correctly. Tressel says she isn't always sure the information she's getting is accurate, but verifies it by trial and error. She says that she had been worried about the impact of contraception on her future fertility, but says she looked information up on the Internet or asked her brother for more information.

What are the teens' suggestions to make sure teens are better informed about sexual health? Every

city should give away “goody bags” with sexual health information and contraception, says Shanelle. She likes the way Planned Parenthood and Black Women for Wellness make free condoms available for young people to take. “We’re gonna have sex. Period,” Tressel said pointedly. “But the thing about it is, if they tell us about the tools we need to be protected while having sex, then we won’t have problems today.” Josie wants organizations like Planned Parenthood and Black Women for Wellness to teach sex education in schools. Tressel would like her health classes to include mannequins to show the human body visually, so she could learn more about ovulation, eggs, and other changes during puberty.

Mostly, the teens just want consistent and on-going health education. “Just like how they want us to learn math and geometry, you need to keep teaching us this stuff, because people are gonna forget,” says Josie. She says that most students don’t know where to go, and are ashamed to ask for help.

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## CHAPTER 5

# Family Planning and Black Women

**R**eproductive Justice is the human right to control our bodies, our sexuality, our gender, our work, and our reproduction. That right can only be achieved when Black women have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives. Access to family planning services is essential to ensuring this right.

Although often considered synonymous with contraception, the full range of family planning services includes the myriad preventive services that are critical to women's reproductive lives. Family planning includes health care services that women need to effectively prevent pregnancy, plan childbearing, and

protect their sexual health (see box).<sup>1</sup>

The Women's Preventive Services Initiative recommends that women "receive at least one preventive care visit per year beginning in adolescence and continuing across the lifespan to ensure that the recommended preventive services include preconception, and many services necessary for prenatal and inter-conception care are obtained."<sup>2</sup> Quality family planning services are essential to ensuring that Black women experience healthier pregnancies and improved post-natal health outcomes for both mothers and their infants.<sup>3</sup> Family planning's screening services are also life-saving for early detection and treatment of STD/STIs (including HIV/AIDS) and reproductive cancers,

both of which disproportionately impact Black women.<sup>4 5</sup>

Black women, like all women, need these essential family planning services so they can plan their pregnancies, ensure their health, and safeguard their futures. But, Black women face a variety of obstacles in exercising their right to these services, both due to lack of access to health insurance and health care, and the legacy of racist family planning efforts. As a result, Black women experience significant health disparities, which result in their higher rates of negative health outcomes — including STD/STIs, unintended pregnancy, preventable reproductive cancers, and maternal mortality.<sup>6 7 8 9</sup>

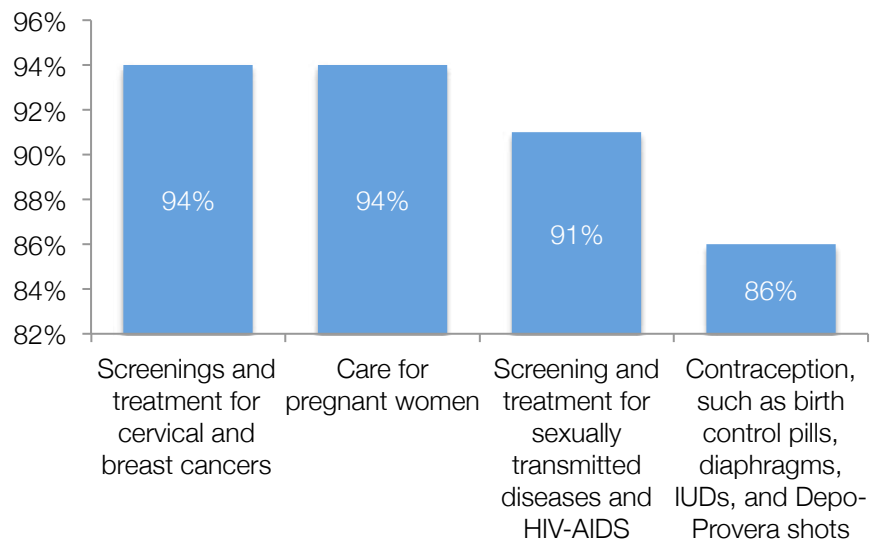
Black women are 55 percent more likely to be uninsured, compared to



## FAMILY PLANNING SERVICES

Pre-conception health care  
Contraception  
Pregnancy counseling and testing  
Infertility counseling  
Screening and treatment for sexually transmitted diseases and infections (STD/STIs)  
Reproductive cancer screenings

## MORE THAN EIGHT IN TEN BLACK WOMEN AND MEN SAID EACH OF THE FOLLOWING ITEMS ARE “PART OF BASIC HEALTH CARE SERVICES FOR WOMEN”



white women.<sup>10</sup> The lack of private health insurance means that Black women are more likely rely on publically funded insurance. This lack of access to high-quality care jeopardizes Black women’s access to family planning services and their overall health.

Federal family planning programs play an essential part in Black women’s health care and access to contraceptives and other reproductive health services. The Affordable Care Act (ACA) guarantees coverage of all forms of contraception approved by the Food and Drug Administration (FDA) without cost sharing. The ACA also requires that women’s preventive health services be covered without costs, including essential family planning

services such as breast and cervical cancer screenings and prenatal care. Nearly one-third (31 percent) of Black women of reproductive age are enrolled in the Medicaid program.<sup>11</sup> A large number of Black women, however, live in states that refused to expand Medicaid under the ACA and face significant financial challenges to getting health coverage and, hence, family planning services.

Title X, the largest Federal family planning program,<sup>12</sup> funds the provision of family planning services

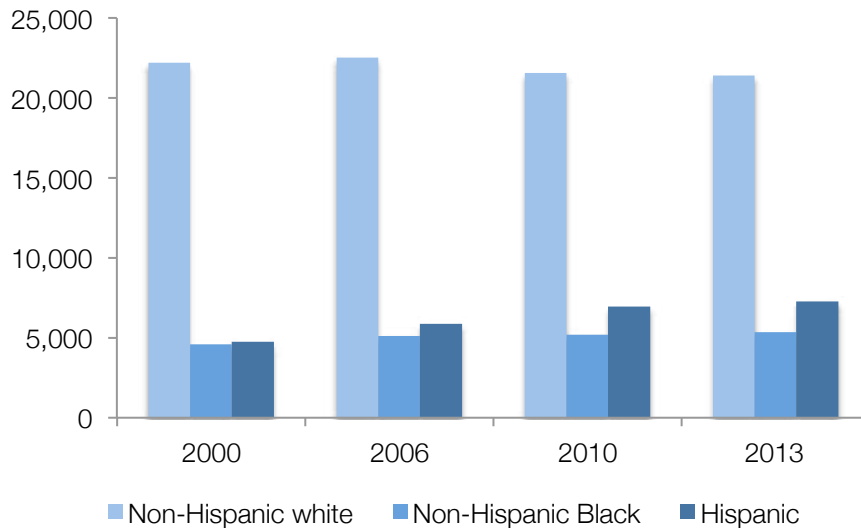
to low-income individuals by health departments, community-based health centers, Planned Parenthood clinics, school-based health clinics, hospitals, and private non-profits.<sup>13</sup> Of the 4.2 million people served through Title X, 92 percent are women and more than 20 percent are Black.<sup>14</sup>

Federal funding for health coverage and essential family planning services is at risk of severe cuts under the Trump Administration. Any reduction of funds directed

Belden-Russonello Strategists, *African-American Attitudes on Abortion, Contraception, and Teen Sexual Health*, Washington DC: Belden-Russonello Strategists LLC, 2013. Online: <http://www.blackrj.org/wp-content/uploads/2015/01/media-memo.pdf>

*A commitment to empowering and ensuring Black women make their own family planning decisions, access contraceptives, and safeguard their sexual health is fundamental to ensuring their reproductive health and rights.*

## WOMEN IN NEED OF CONTRACEPTIVE SERVICES AND SUPPLIES, BY RACE AND ETHNICITY



Barry D, Esenstad A, *Ensuring Access to Family Planning Services for All*, Washington, DC: Center for American Progress, 2014, page 6. Online: <https://www.americanprogress.org/issues/women/reports/2014/10/23/99612/ensuring-access-to-family-planning-services-for-all/>

to family planning services will disproportionately impact the health and lives of Black women, and must be opposed.

Another barrier to accessing family planning services is the legacy of racist and discriminatory policies that specifically targeted women of color for sterilization and other forms of population control.<sup>15</sup>

Black women have a long and complicated history with contraception that is marked by coercive policies that prevented Black women from making their own family planning decisions.<sup>16 17 18</sup> These historic injustices include doctors withholding accurate information needed to make fully informed family planning decisions, sterilizing women of color without their knowledge and/or consent, and pressuring Black women not to have children. These injustices also include legislators forcing women to accept the Norplant contraceptive implant to

avoid prison sentences; researchers engaging in unethical contraceptive testing on women of color; and public insurers paying for insertion of Norplant, but not its removal.<sup>19</sup>

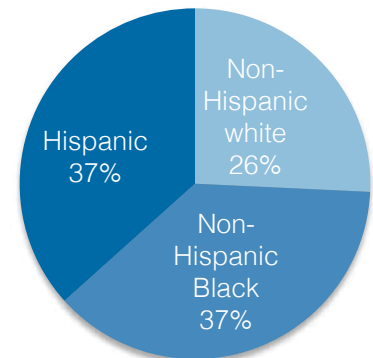
<sup>20 21 22</sup> The result is a deep-seated mistrust of the health care profession that acts as a barrier to Black women's access to family planning services.

This history may be one driver of the slow update of Long-Acting Reversible Contraceptives (LARCs), the most effective forms of birth control.\* Some evidence suggests that providers are more likely to recommend LARC to women of color and low-income women, compared to white women and women of means.<sup>23</sup> Access to care

\* LARCs include intrauterine devices (IUDs), injections (i.e., Depo Provera), and subdermal =contraceptive implants.

^ "Trans" is an umbrella term that refers to all of the identities within the gender identity spectrum (e.g., transgender, transsexual, etc.).

## WOMEN IN NEED OF PUBLICLY FUNDED CONTRACEPTIVE SERVICES AND SUPPLIES, AS A PERCENTAGE OF POPULATION BY RACE AND REPRODUCTIVE AGE



Source: Barry D, Esenstad A, *Ensuring Access to Family Planning Services for All*, Washington, DC: Center for American Progress, 2014, page 6. Online: <https://www.americanprogress.org/issues/women/reports/2014/10/23/99612/ensuring-access-to-family-planning-services-for-all/>

that is culturally effective is critical in supporting Black women's reproductive rights and choices. It is particularly important with respect to family planning visits, when providers are helping their patients to make intimate and very personal decisions about their lives and futures.

Lesbian, gay, bisexual, trans,<sup>^</sup> queer, and questioning (LGBTQQ) individuals also face barriers from homophobia and transphobia that can impede their access to care.<sup>24</sup> This is particularly true in rural communities with shortages of health care providers and facilities. Yet, this community has significant

needs for family planning services, including STD/STI and cancer screenings; one study found that lesbians are less likely to get preventive services for cancer or to receive mammograms.<sup>25</sup> In another study, more than half of LGBTQQ people surveyed reported that they had been denied health care, been treated harshly by providers, or had providers blame an illness on the patient's sexual orientation or gender identity.<sup>26</sup> For trans individuals, negotiating reproductive and sexual health care is particularly challenging when faced with providers who do not understand their lived experiences and health care needs.

In order to achieve true Reproductive Justice, Black women must have access to the full range of family planning services — without coercion by her doctor or her government. A commitment to empowering and ensuring Black women make their own family planning decisions, access contraceptives, and safeguard their sexual health is fundamental to ensuring their reproductive health and rights. Family planning can play a critical role in the lives of Black women when providers and policies center women's rights and decision-making.

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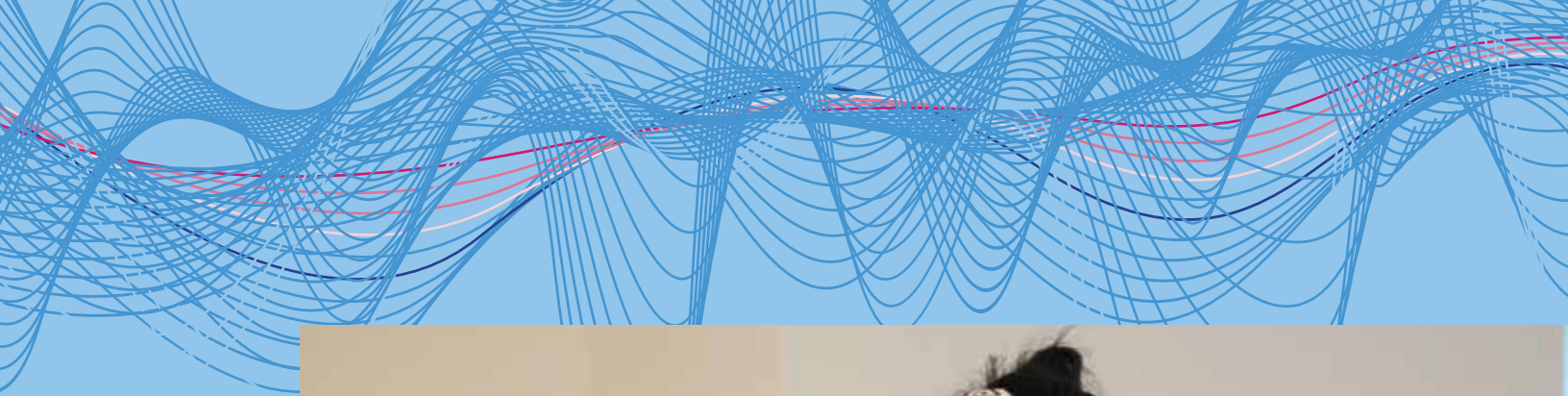
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*This community has significant needs for family planning services, including STD/STI and cancer screenings; one study found that lesbians are less likely to get preventive services for cancer or to receive mammograms.*

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## CHAPTER 6

# Maternal Health and Black Women

By Linda Goler Blount, MPH, President & CEO, Black Women's Health Imperative

All countries have a human rights obligation to provide women and children with equal access to quality health care. Nowhere is this more important than at the nexus of pregnancy and childbirth, when high-quality health care is critical to ensuring healthy outcomes for mothers and their children. Yet, while the United States spends more on health care than any other country, it has among the worst disparities in maternal health outcomes. “During recent reviews of the U.S. human rights record, independent human rights bodies have highlighted the persistent racial disparities in maternal health as a form of racial and gender discrimination and called on the U.S. to improve access to quality maternal health care.”<sup>1</sup>

Over the last few decades, maternal health has improved vastly worldwide; as a result, maternal mortality rates plummeted 44 percent from 1990 to 2015.<sup>2,3</sup> Yet, the U.S. is on the *opposite* track; alone of industrialized countries, maternal health in the United States is deteriorating, with mortality rates increasing between 1990 and 2013.<sup>4,5</sup> The U.S. failed to meet its global commitment to decrease maternal deaths by 75 percent by 2015 and its rate — 28 maternal deaths for every 100,000 live births — is now on par with rates in Afghanistan and El Salvador.<sup>6</sup>

But, these high rates do not occur by accident; maternal health challenges are clearly linked to disparities in women's access to high-quality health care and other needed resources before, during, and after pregnancy. These disparities particularly affect Black women, who are up to four times more likely to die from pregnancy-related causes, and more than twice as likely to experience severe maternal morbidity,\* compared to white women.<sup>7</sup> From 2011 to 2013, Black women experienced 40.4 deaths per 100,000 live births, compared to 12.1 deaths per 100,000 live births for white women.<sup>8</sup> These deaths have devastating

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\* “Maternal mortality” occurs when a woman dies either during pregnancy or in the following year due to pregnancy-related causes; “severe maternal morbidity” occurs when a woman experiences a life-threatening complication during either pregnancy or childbirth.

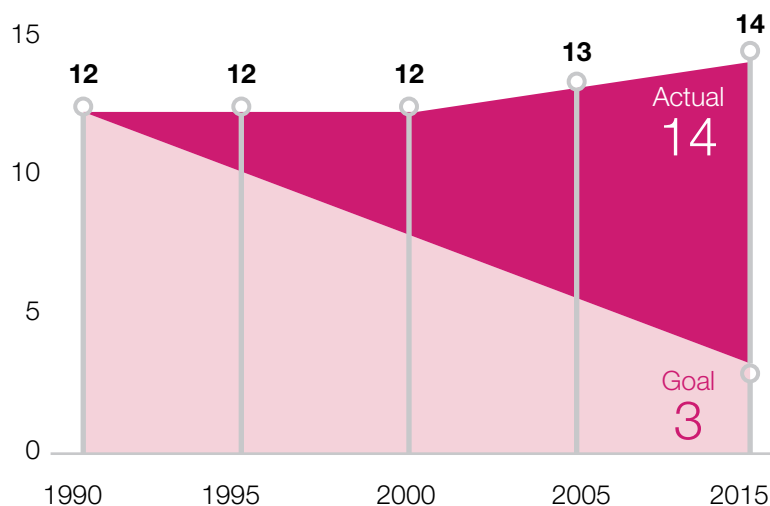
effects on Black women's children and families, and the vast majority is entirely preventable.

The root causes of poor maternal health among Black women are complex and multi-faceted; they include challenges in accessing high-quality health care, personal health risks, and social disparities such as racism and poverty.

Black women's challenges in accessing health care are a factor in their higher rates of maternal injury and mortality. Regardless of educational level, Black women are less likely to receive timely and consistent prenatal care, and more likely to experience a pregnancy-related injury or death, compared to women of other races and ethnicities.<sup>9 10</sup> Inadequate health care infrastructure, high costs, and lack of insurance are all factors that impede Black women's ability to access timely care. Additionally, the lack of Black health care providers, including OB-GYN and nurse midwives make culturally competent care difficult. In fact "only 6 percent of physicians are Black; 4 percent of OB-GYNs are Black; and fewer than 4 percent of certified nurse midwives are Black."<sup>11 12</sup> Assertive efforts are needed to ensure that Black women can access information, services, and supports to make their own health care decisions, particularly around pregnancy and childbearing.

Personal health factors also contribute to maternal injury and death, including obesity, diabetes, hypertension (a risk

## U.S. FAILS TO MEET THE MILLENNIUM DEVELOPMENT GOAL TO REDUCE MATERNAL MORTALITY BY 75% BY 2015



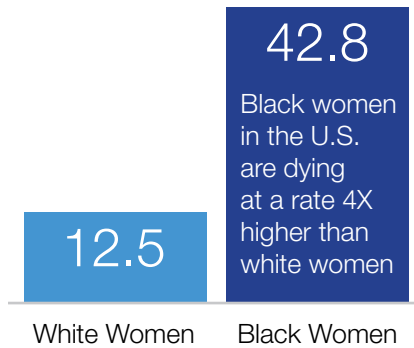
Maternal Health Task Force, *Maternal Health in the United States*, Boston: Harvard T.H. Chan School of Public Health, no date. Online: <https://www.mhtf.org/topics/maternal-health-in-the-united-states/>

factor in heart disease and kidney failure), and cesarean deliveries.<sup>13</sup> Black women have above-average rates of all of these conditions, placing them at significant risk for poor maternal health outcomes.<sup>14, 15, 16 17</sup> Equitable access to prevention, early identification, and effective treatment services that are delivered in appropriate care settings are all vital to improve Black women's chronic health conditions and maternal health.

Research also suggests that poor health — including poor maternal health — can result from social determinants of health, such as poverty and racism, which have a cumulative impact on Black women's bodies before, during, and after pregnancy.<sup>18 19 20</sup> (As just one example, racism has been linked with hypertension, which is a known risk factor for maternal death.) "To prevent pregnancy-related deaths and sustain-

*Research also suggests that poor health — including poor maternal health — can result from social determinants of health, such as poverty and racism, which have a cumulative impact on Black women's bodies before, during, and after pregnancy.*

## RACIAL DISPARITIES IN HEALTH OUTCOMES



Maternal Health Task Force, *Maternal Health in the United States*, Boston: Harvard T.H. Chan School of Public Health, no date. Online: <https://www.mhtf.org/topics/maternal-health-in-the-united-states/>

ably improve maternal health, states must make transformative investments in the health and well-being of Black women and girls throughout the life course, including in the areas of housing, nutrition, transportation, violence, environmental health, and economic justice.”<sup>21</sup>

The impact of these social determinants of health is particularly harsh for Black women living in the South, who are likely to bear the cumulative brunt of poverty, racial inequality, poor service delivery, and lack of health insurance.<sup>22</sup> For example, maternal mortality rates in Texas, Georgia, Mississippi, and Alabama all exceed the U.S. national average. Tellingly, these states have also rejected efforts to provide essential prenatal and reproductive care by expanding their Medicaid programs.<sup>23</sup>

Good health care is essential in order to identify pre-existing conditions and/or other factors that lead to maternal mortality and other negative outcomes. The dire sta-

*Fundamental human rights are violated when pregnant and birthing women endure preventable suffering, including death, illness, injury, mistreatment, abuse, discrimination, and denials of information and bodily autonomy.*

tistics around maternal health can only be reversed by ensuring that Black women have access to affordable, high-quality health care before, during, and after pregnancy so they can determine when to become pregnant and ensure they have a safe pregnancy and healthy baby.<sup>24</sup>

The Affordable Care Act (ACA) made considerable strides in increasing women’s health care access by including maternity care as a no-cost “essential health benefit” that all insurance companies are required to cover.<sup>25</sup> In addition, Medicaid expansion has played a critical role in improving the health of low-income mothers by covering the cost of prenatal care, labor, delivery, and post-partum care.<sup>26</sup> Millions of Black women have also gained access to free breastfeeding support and gestational diabetes screenings directly through the ACA and associated Medicare expansion efforts.<sup>27 28</sup> These benefits are threatened by Republican efforts to repeal the ACA, limit Medicaid funding through the use of block grants and/or *per capita* caps, and implement a new health care system that neither prioritizes nor protects maternal health. Millions of Black women risk losing coverage for vital prenatal and pregnancy care, and more will die.<sup>29</sup>

For more than 30 years, the *Black Women’s Health Imperative* (BWHI) has maintained a singular focus on promoting the health of Black women as a top priority for our community, service providers, policymakers, and researchers. In short, Black women are our priority.

Ensuring Black women’s right to access high-quality, affordable health care before, during, and after pregnancy is a critical component of their human rights.<sup>30</sup> “Fundamental human rights are violated when pregnant and birthing women endure preventable suffering, including death, illness, injury, mistreatment, abuse, discrimination, and denials of information and bodily autonomy.”<sup>31</sup> Efforts to identify barriers to Black women’s maternal health and expand access to high-quality, culturally effective care are equally critical to decrease the alarming rates of maternal mortality in the U.S. and to safeguard women’s rights to healthy pregnancy and childbirth.<sup>32</sup>



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## CHAPTER 7

# Reproductive Cancers and Black Women

By Linda Goler Blount, MPH, President & CEO, Black Women's Health Imperative

**J**ust like any other health condition, surviving cancer depends on several factors, having access to good health care, being diagnosed early, and receiving effective treatment. The social and economic disparities that drive health care in the U.S. show up in Black women's experience of cancer, and particularly in their experience with reproductive cancers.\* Black people in the U.S. experience cancer at significantly higher rates than other U.S. racial and ethnic groups. Black women are more likely to receive a cancer diagnosis at a later stage, and have lower survival rates at each state of diagnosis.

These negative outcomes result from a variety of interconnected factors that include lack of health insurance, barriers to accessing high-quality care (including cancer screening services), harmful differences in how aggressively Black women's cancer is treated, and specific variations in the types of cancer Black women are more likely to experience. Challenges to accessing nutritious food and opportunities for exercise, and the stress caused by social disparities like poverty and racism, are also factors in Black women's cancer experience.<sup>1</sup>

## Health Policies Impact Treatment and Outcomes for Black Women

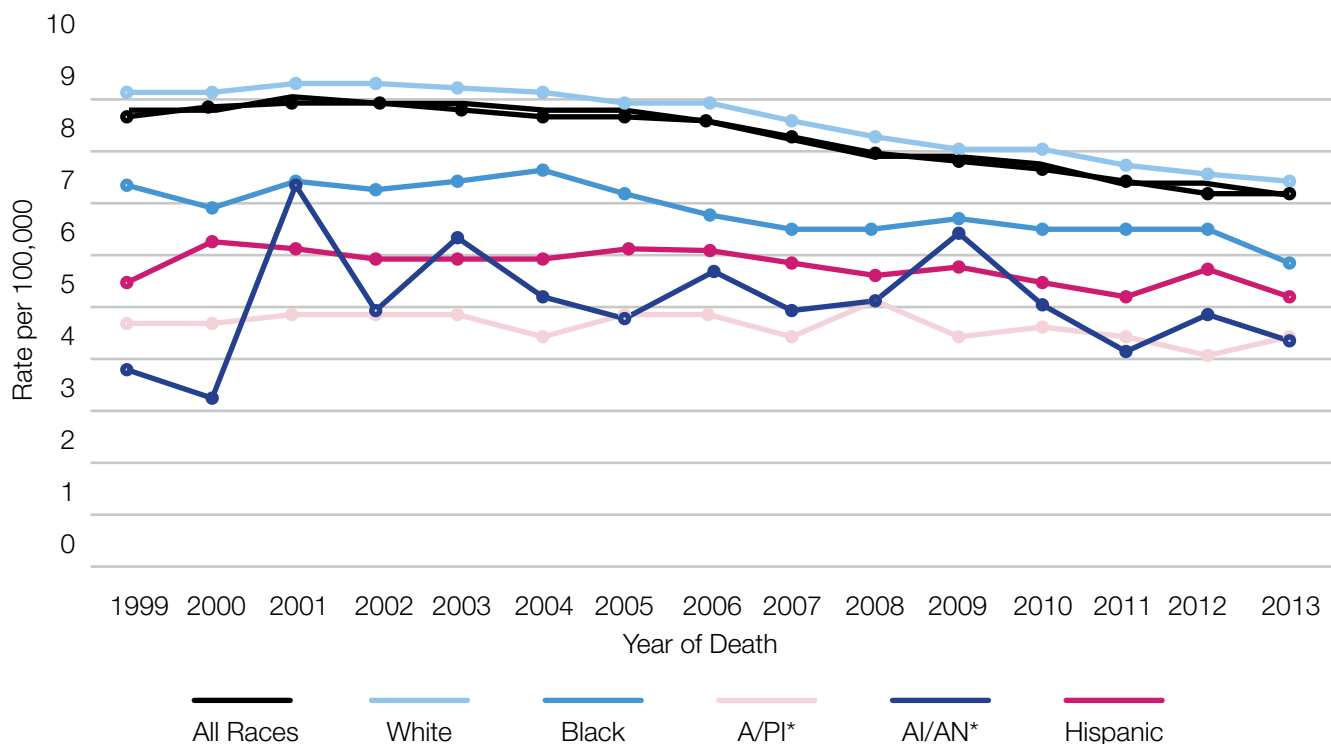
Early screening and access to treatment are critical to surviving cancer. Black women's cancer morbidity and mortality rates are so high partly because of the challenges they face in accessing high-quality, culturally effective health care. For this reason, the Affordable Care Act's (ACA) mandated coverage of preventive services (including HPV tests, mammograms, and cervi-

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\* Cancer is a disease in which abnormal cells in the body grow out of control; it is always named for the site where it originated, regardless of whether it later spreads elsewhere in the body. Women's reproductive cancers are due to an overgrowth of cells in the breasts, ovaries, and cervix.



## U.S. OVARIAN CANCER DEATH RATES BY RACE AND ETHNICITY, 1999-2013



\*A/PI: Asian/Pacific Islander, AI/AN: American Indian/Alaska Native

Centers for Disease Control and Prevention (CDC), *Ovarian Cancer Rates by Race and Ethnicity*, Atlanta: CDC, 2016. Online: <https://www.cdc.gov/cancer/ovarian/statistics/race.htm>. Rates are the number of cases per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130).

*Improving Black women’s access to health insurance as well as to high-quality, culturally effective health care is critical to reversing these disturbing facts.*

cal cancer screening) is helping improve Black women’s health. Those benefits are now in jeopardy as Republicans attempt to repeal the ACA and its women’s health benefits.

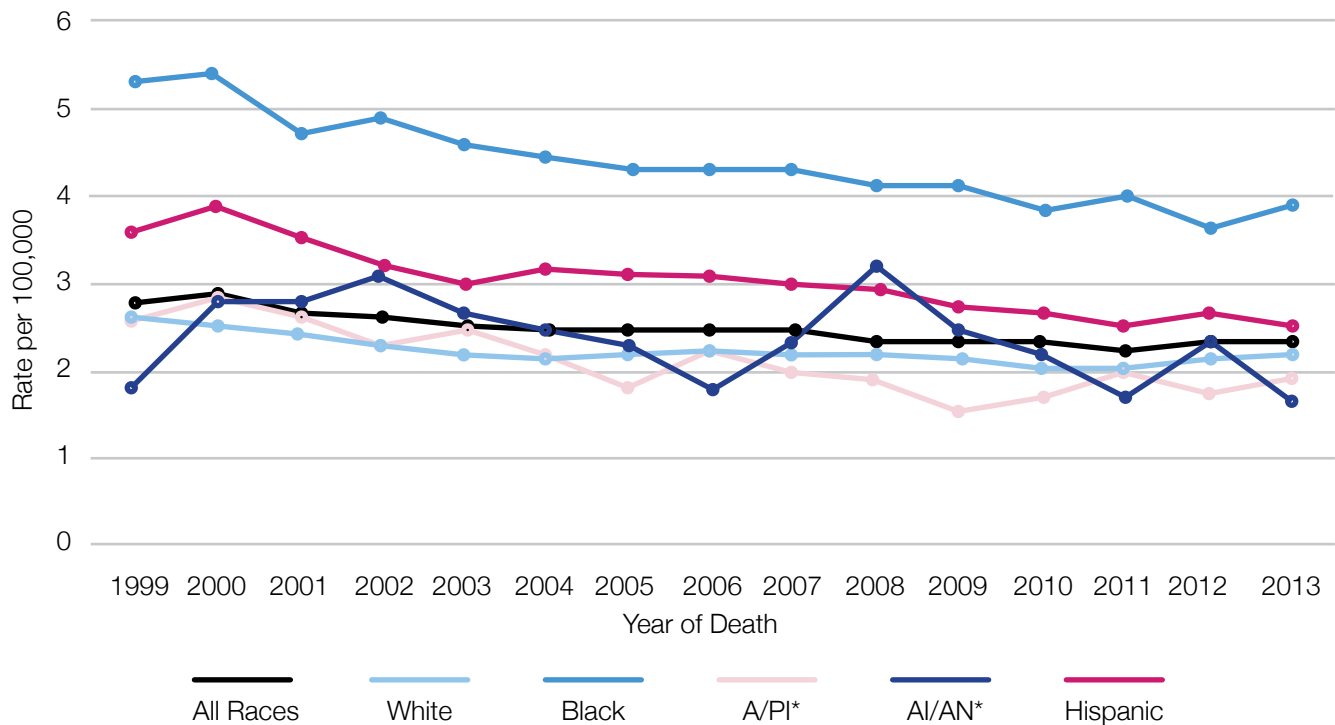
Another factor may be the adoption of health policies that inadvertently limit Black women’s access to screening and diagnostic services for reproductive cancers. For example, in late 2016, the Federal Health Resources and Services

Administration (HRSA) approved changes to the guidelines on preventative screenings for certain reproductive cancers.<sup>22 23</sup> The HRSA guidelines, which were developed by an expert panel named the “Women’s Preventive Services Initiative,” are followed by many health insurers. Under the new guidelines, women at average risk are only recommended to have Pap tests to screen for cervical cancer every 3-5 years between the ages of

30-65, and mammograms every 1-2 years starting by at least age 50.<sup>24 25</sup> (See chart.) If implemented, these screening guidelines have the potential to severely jeopardize Black women’s health and lives.

Screening guidelines should prevent cancer-related deaths, not increase them. Yet, these new guidelines could prove to be life-threatening for Black women. When detected early, cervical cancer is one of the most success-

## U.S. CERVICAL CANCER DEATH RATES BY RACE AND ETHNICITY, 1999-2013



\*A/PI: Asian/Pacific Islander, AI/AN: American Indian/Alaska Native

Centers for Disease Control and Prevention (CDC), *Cervical Cancer Rates by Race and Ethnicity*, Atlanta: CDC, 2016. Online: <https://www.cdc.gov/cancer/cervical/statistics/race.htm>. Rates are the number of cases per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130).

fully treatable cancers.<sup>26</sup> But Black women are consistently diagnosed with cervical cancer later than women of other racial and ethnic backgrounds. They also tend to be diagnosed with aggressive strains of breast cancer at a younger age, compared to other women.<sup>27</sup> For this reason, reducing the recommended frequency of cancer screening will delay early detection of reproductive cancers and result in the preventable death of thousands of Black women.<sup>28</sup>

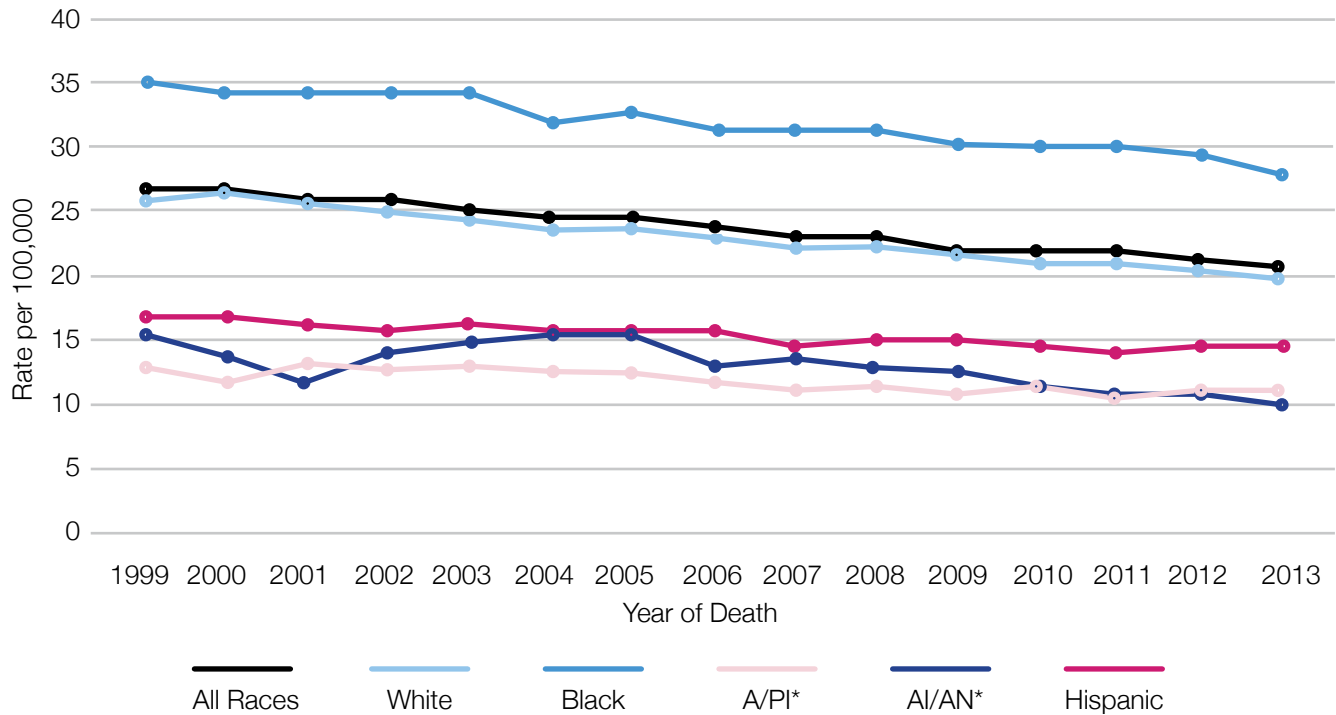
The breast cancer guidelines call for women at higher risk for breast cancer to receive “periodic mammography screening,” the text notes that “recommendations for additional [breast cancer screen-

ing] services are beyond the scope of this recommendation.”<sup>29</sup> The cervical cancer guidelines are specifically directed at women at average risk of the disease. The guidelines’ ambiguous wording could result in health insurers (including state Medicaid plans) limiting access to breast and cervical cancer screenings for women of *all* backgrounds and risk levels. This would force Black women to wait until their next covered mammogram or Pap test, delaying both screening and access to life-saving treatment.<sup>30</sup> Black women do not need generalized guidance that could potentially delay a diagnosis and life-saving treatment. They need guidelines that reflect the lived experiences

of Black women as they relate to reproductive cancers.

It is well-established that Black women experience health disparities that lead to worse outcomes when they are diagnosed with cancer. We also know that providers are significantly less aggressive in treating cancer among Black women compared to white women. The result is that Black women have lower five-year cancer survival rates, compared to white women, even when cancer is detected early. Improving Black women’s access to health insurance as well as to high-quality, culturally effective health care is critical to reversing these disturbing facts.

## U.S. BREAST CANCER DEATH RATES BY RACE AND ETHNICITY, 1999-2013



\*A/PI: Asian/Pacific Islander, AI/AN: American Indian/Alaska Native

Centers for Disease Control and Prevention (CDC), *Cervical Cancer Rates by Race and Ethnicity*, Atlanta: CDC, 2016. Online: <https://www.cdc.gov/cancer/cervical/statistics/race.htm>. Rates are the number of cases per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130).

## Reproductive Cancers

### BREAST CANCER

Breast cancer is the most common cancer among Black women and is the second leading cause of death for Black women. It is the leading cause of death among Black women, aged 45-64 years. Each year, an estimated 230,000 women are diagnosed with breast cancer, and more than 40,000 die from the disease.<sup>2</sup>

<sup>3</sup> While survival rates from breast cancer have generally increased over the past 20 years, Black women are less likely to receive recommended treatment for breast

cancer, and their survival rates are far lower than white women's.<sup>4</sup> They are 43 percent more likely to die from breast cancer than white women, according to recent data.<sup>5</sup> Black women are the only U.S. racial or ethnic group that experienced an increase in the incidence rate of breast cancer from 2010 to 2014.<sup>6</sup> Moreover, Black women are twice as likely to be diagnosed with aggressive subtypes of breast cancer than white women, and are more likely to be diagnosed under age 40.<sup>7</sup>

### OVARIAN CANCER

Ovarian cancer is known as the "silent killer" because there is no effective screening for detection.

Ovarian cancer is also the fifth-leading U.S. cause of cancer-related death, and causes more women's deaths than any other reproductive cancer. Each year, about 20,000 women are diagnosed with ovarian cancer in the U.S. and more than 14,000 die from the disease.<sup>8</sup> <sup>9</sup> For this reason, detecting ovarian cancer during its earliest (and most treatable) stages is critical to a woman's survival. Although Black women experience fewer new cases of ovarian cancer annually, their 5-year survival rates are much lower.<sup>10</sup> Because of health disparities, they are more likely to be diagnosed at a later stage of the disease, which hampers their overall health and increases their risk of death.<sup>11</sup>

## Recommended Cervical Cancer Screening Guidelines

Age	Have a Pap Test (Cytology)	Have both HPV and Pap Tests
21-29	Every 3 years.	Not recommended in this age range.
30-65	Every 3 years if not also having an HPV test. Every 5 years if also having an HPV test.	Every 5 years.
65+	Not recommended in this age range.	Not recommended in this age range.

## Recommended Breast Cancer Screening Guidelines

21-39	Not recommended for average-risk women
40-74	Initiate screening between ages 40-50; screening annually or biennially.
75+	May continue screening. "Age alone should not be the basis to discontinue screening."

## CERVICAL CANCER

Every year, more than 11,000 women are diagnosed with cervical cancer, and about 4,000 women die from the disease.<sup>12 13</sup> Cervical cancer is the most preventable form of cancer, however. With regular screenings, changes in the cervix can often be detected before they become cancerous. The clear majority of cervical cancers are caused by the Human Papilloma Virus (HPV), a very common sexually transmitted infection (STI).<sup>14</sup> <sup>15</sup> For this reason, Pap tests, which screen for HPV, are essential to identifying HPV and preventing cervical cancer's development. Black women experience higher rates of HPV-related cervical cancer, and lower 5-year survival rates, compared to other racial and ethnic groups.<sup>16 17</sup> (Hispanic women have higher incidence of cervical cancer, but lower death rates.) Further, a 2017 study indicates that cervical cancer deaths have been greatly underestimated in the past, due to

the exclusion of information on women who had a hysterectomy.<sup>18</sup> Black women are more likely to have a hysterectomy than white women and, when the calculations were adjusted to include women who had had hysterectomies, the racial disparity in mortality rates between Black and white women increased by 44 percent.<sup>19</sup>

Because of the history of medical experimentation in Black communities, Black women were slow to support the HPV vaccine, especially in the South. The HPV vaccine has been effective in curtailing rates of cervical cancer;<sup>20</sup> since 2006, rates of the specific HPV types affected by the vaccine have plummeted 56 percent among girls aged 14-19. But, young women and girls in the South are far less likely to get vaccinated, compared to girls living elsewhere. According to a study, vaccination rates in the South lag behind other regions with respect to in the percentage of girls who receive all three doses of the

vaccine: 23 percent in the Northeast have all three doses, compared to about 19 percent in the Midwest and West, and just 6 percent in the South. The reasons for this include social disparities, lack of access to health care, and lack of health insurance. As a result, HPV rates are much higher in the South, and nearly half of all U.S. cervical cancer deaths occur in the South.<sup>21</sup>

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## CHAPTER 8

# Sexually Transmitted Diseases & Infections, including HIV/AIDS, and Black Women

By Dázon Dixon Diallo, MPH, DHL, Founder and President, SisterLove, Inc.; Melanie Medalle, JD  
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**M**any complex and inter-related factors impact Black women's health, including their disproportionate burden of HIV/AIDS and other sexually transmitted diseases and infections (STD/STIs). Addressing these factors requires a Reproductive Justice (RJ) framework focused on persistent barriers to the empowerment, resources, and support necessary for Black women to make decisions about their bodies, health, and futures. This work is critically important when it comes to Black women's experience with HIV/AIDS.

In their early stages, most STD/STIs either produce few symptoms, or have symptoms so mild that people may not know they have been infected. As a result, many STD/STIs are undiagnosed, with

long-term health consequences for both the individual and their sex partners. This is the reason that the Institute of Medicine has described STD/STIs as “a hidden epidemic of tremendous health and economic consequence in the United States.”<sup>1</sup>

The Centers for Disease Control and Prevention (CDC) notes that “[i]nequities in social and economic conditions are reflected in the profound disparities observed in the incidence of STDs among some racial and ethnic minorities.”<sup>2</sup> These social and health disparities — including poverty, racism, provider bias, and lack of access to health care — place Black women at significant risk for STD/STIs and resulting negative health outcomes.<sup>3</sup> Addressing these health disparities is essential to achieve sustainable

changes in Black women's health in general, and in their HIV/AIDS experiences in particular.

Ending the epidemic of HIV and other STD/STIs requires an RJ framework that explicitly addresses the structural drivers of both individual and community health. These efforts must involve several components. First, they must address social determinants of health and focus on race- and class-based economic inequities. Second, they must ensure access to comprehensive sexual and reproductive health information and care, including prevention education and technologies, treatment, and support services. Third, they must address gender and racial inequities that restrict Black women's access to effective biomedical treatment and prevention interventions. Finally,

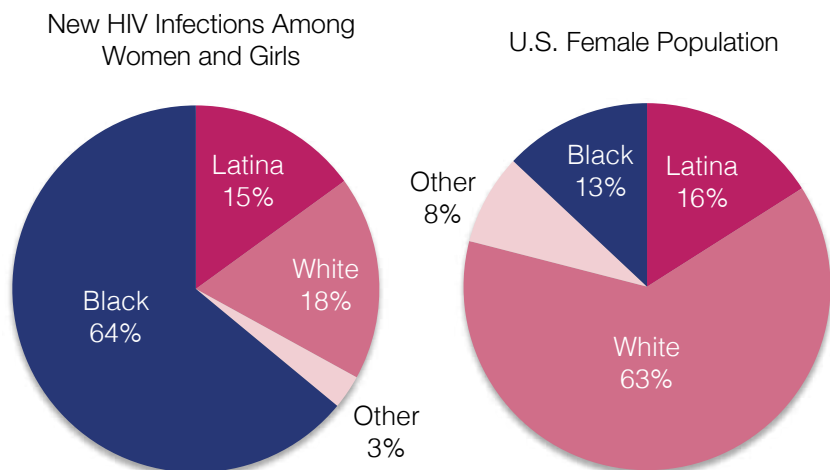


they must ameliorate rampant HIV stigma by overturning restrictions that criminalize HIV and police both gender and expressions of sexuality.

Social determinants of health are conditions in the places where people live, learn, work, and play that affect their individual health outcomes.<sup>4</sup> Black women are profoundly impacted by social and cultural attitudes and practices that shape their individual opportunities, quality of life, health risks, and health outcomes. Social determinants of health include racism, poverty, and discrimination based on health status (including HIV infection).<sup>5 6</sup> Resource-related social determinants of health include access to education; healthy food; and employment, wealth, and assets. The HIV/AIDS epidemic will never end until the nation adopts proactive policies and programs to address social determinants that drive specific populations' higher infection rates.

Racism and provider bias are additional social determinant that affect Black women's experience and outcomes for HIV and other STD/STIs. Researchers have found that providers treat Black and white patients differently; the result is worse health outcomes for Black individuals. A growing body of evidence shows that "racial bias and discrimination in health care as well as outside of medicine contribute to poor health for African-American patients and other racial and ethnic minorities."<sup>7</sup> With respect to the provision of family planning services, racism and sexism results in delayed access to STD/STI counseling; screening to detect STD/STIs; and access to treatment in the early stages of infection when it is most effective. For Black girls, lack of access to sex education and condescending attitudes and assumptions about sexually active youth present additional challenges.<sup>8 9 10</sup>

## NEW HIV INFECTIONS AMONG WOMEN & GIRLS AND THE U.S. FEMALE POPULATION, BY RACE/ETHNICITY, 2010

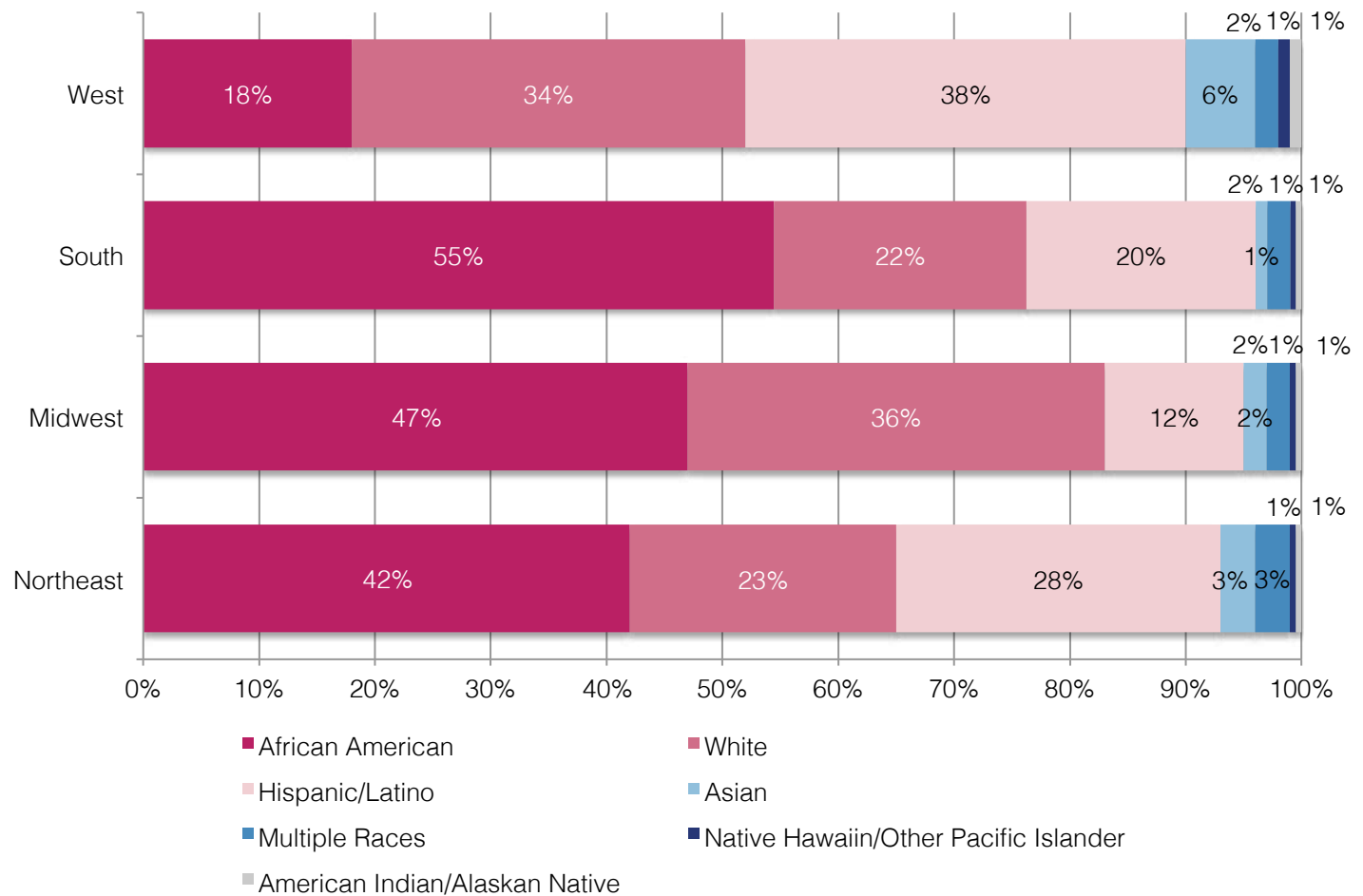


Henry J. Kaiser Family Foundation, *Women and HIV/AIDS in the United States*, Palo Alto (CA): Henry J. Kaiser Family Foundation, no date. Online: <http://kff.org/hivaids/fact-sheet/women-and-hivaids-in-the-united-states/>

## JUANITA'S STORY

On a hot summer day in Atlanta long ago, Juanita, a bright-eyed young woman with an enormous smile, disclosed her HIV status to me. We were the only two people in the room as Juanita shared her story, through painful pauses and long stretches of sobs and tears. Her experience began in South Carolina, when she decided to get a no-cost tubal ligation that was being advertised by a local hospital. Juanita described that what she thought was going to be a routine visit for a routine procedure turned into a terrifying and unconscionable event when she was told that she had tested positive for HIV. The hospital clinicians refused to complete Juanita's procedure that day or any other day — and refused to provide any care at all due to her health status. Juanita was promptly ushered down the hospital's back staircase and out the door without any more information, services, or support. Devastated, Juanita went through a journey of depression, fear, and suicidal ideation before she found the support she needed and moved to Atlanta. (Juanita's name is used with her permission.)

## DIAGNOSES OF HIV INFECTION IN THE U.S. IN 2015, BY RACE/ETHNICITY AND REGION OF RESIDENCE



Centers for Disease Control and Prevention (CDC), "Diagnoses of HIV Infection in the U.S. in 2015, by Race/Ethnicity and Region of Residence," *HIV Surveillance Report* 2015; 27:1-114. Online: <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>

Black women and girls' ability to access comprehensive sexual and reproductive health education, screening services, treatment, and associated support services directly affects their health status.<sup>11 12</sup> Achieving equity begins by implementing RJ-focused efforts to ensure that communities affected by HIV and other STD/STIs are empowered with affirming, comprehensive health information and access to preventative measures,

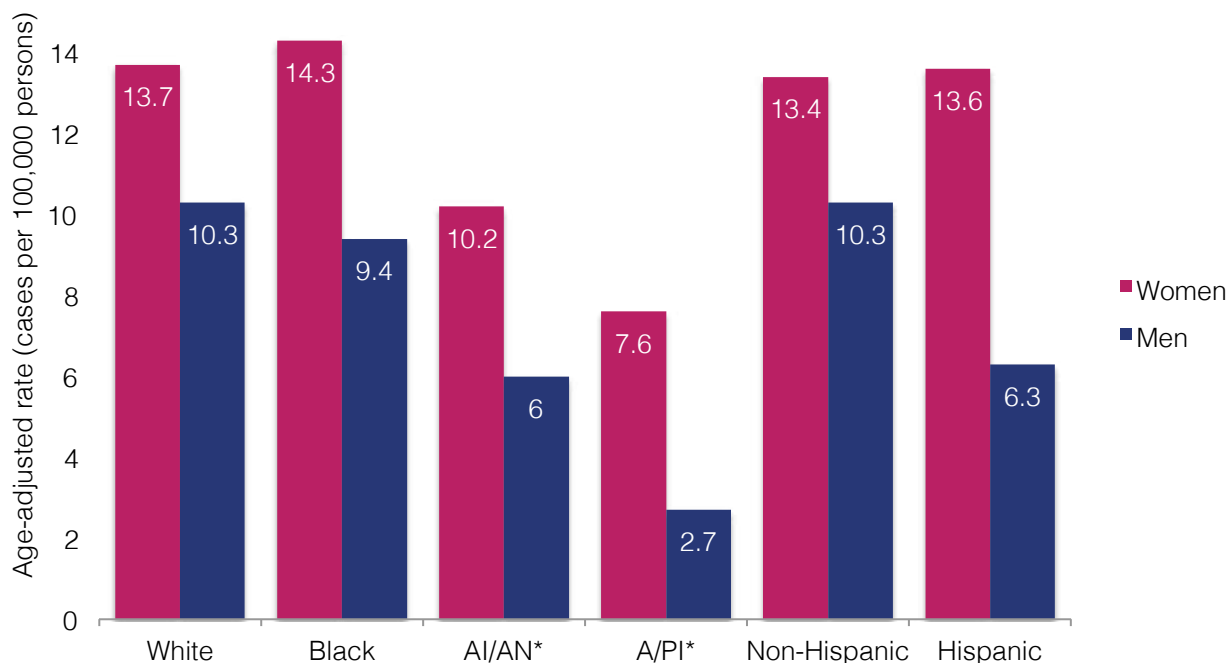
medical care, and support. These efforts must include equal access to prevention information, STD/STI vaccines, and pre- and post-exposure prophylaxis by those at higher risk for HIV and other STD/STIs.<sup>13</sup> It also requires better efforts to link women living with HIV and other STD/STIs to active treatment. Currently, less than three-quarters of HIV-positive women have been linked to care and fewer than half receive regular care.<sup>15</sup> Enhancing

the services Black women already receive from their established providers (i.e., family planning clinics, schools, and social services) can be effective in these efforts, by meeting people where they are and facilitating access to HIV prevention and care services.

For this reason, the Affordable Care Act's (ACA) guaranteed coverage of essential benefits\* has the potential to significantly improve

\* The STD/STI-related preventive care health services required to be covered without cost sharing (i.e., co-pays, co-insurance, or deductibles) include: HPV testing, HPV DNA testing, annual STI counseling, annual HIV counseling, chlamydia screening for sexually active women under 25 as well as older women at higher risk, gonorrhea screening for all women at higher risk, Hepatitis B screening at pregnant women's their first prenatal visit.

## HPV-ASSOCIATED CANCER RATES BY RACE AND ETHNICITY, UNITED STATES, 2009–2013



\*A/PI: Asian/Pacific Islander, AI/AN: American Indian/Alaska Native

Centers for Disease Control and Prevention (CDC), *HPV-Associated Cancer Rates by Race and Ethnicity, United States, 2009–2013*, Atlanta: CDC, 2017. Online: <https://www.cdc.gov/cancer/hpv/statistics/race.htm>

the health of Black women, who have high rates of poverty and lack of insurance coverage.<sup>16 17</sup> The ACA's inclusion of STI prevention and risk reduction counseling is particularly critical for sexually active young women, who have higher rates of many STD/STIs compared to older women. Early detection is particularly important for treating conditions like HPV before they result in life-threatening cancers. Yet, many Black women live in states that refused to expand Medicaid as part of the ACA (these states, not surprisingly, also have among the nation's highest STD/STI rates).<sup>18</sup> And, while the ACA reduced the number of people who lack insurance to 10.4 percent in 2014, 12 percent of Black people still remain uninsured, compared to 8 percent of whites.<sup>19</sup>

Gender and racial inequities in the accessibility and coverage of biomedical treatment and prevention interventions are just as stark. At-risk HIV-negative Black women are less likely to receive pre-exposure prophylaxis (PrEP), which can reduce the risk of HIV transmission by 90 to 99 percent. PrEP has enormous potential to reduce perinatal HIV transmission; and to protect sex workers, women experiencing interpersonal violence, and those whose partners are living with HIV. Yet, while an estimated 460,000 U.S. women could benefit from PrEP, fewer than 20,000 have been prescribed it, with life-threatening consequences.<sup>20</sup>

PrEP's efficacy for preventing HIV varies by sexual practices; the regimen must be initiated at least

seven days before anal sex, and even earlier for vaginal sex. PrEP must also be taken at the same time every day to be effective during vaginal sex. These factors increase the risk that PrEP is not used effectively, heightening the risk of HIV transmission. Another challenge is that PrEP's efficacy may be reduced by the presence of a specific vaginal bacteria that is more prevalent among people of African descent (*Gardnerella vaginalis*).<sup>21</sup> Cisgender women, trans men, and people of African descent who engage in vaginal sex may need to follow different prevention regimens and/or take special precautions when using PrEP.

Despite its disadvantages, PrEP is an essential option that allows women to control their sexual and

reproductive health. Yet, too many health care providers are uninformed about PrEP and the need for rigorous adherence to prevent vaginal transmission of HIV. One-third of health care providers either do not know about PrEP or do not prescribe it to their at-risk patients.<sup>22</sup> At the same time, there is a need to develop prescription protocols to ensure that patients receive accurate information about PrEP's availability and use, particularly for those who are at risk of vaginal HIV transmission.

HIV criminalization restricts Black women's sexual autonomy and self-determination, dehumanizes people living with HIV (PLHIV), and feeds the stigma that has long fueled this epidemic. "HIV-specific criminal laws single out and punish PLHIV for non-disclosure of HIV status, HIV exposure, HIV transmission, or some combination of these acts."<sup>23</sup> HIV criminalization is not an effective disease prevention strategy; these efforts discriminate against people based solely on their sero-status and invasively regulate and control PLHIV's sexual lives and autonomy. HIV criminalization also disrupts the safety and health of our families, neighborhoods, and communities — making it clearly an issue of reproductive oppression.

HIV stigma against PLHIV interferes with Black women's ability to exert their full bodily autonomy. It hampers robust and effective responses to HIV/AIDS and other sexual and reproductive rights challenges affecting Black women. HIV stigma is based, in large part, on entrenched misogyny and homophobia, and must be replaced by narratives that support greater sexual and reproductive self-determination.<sup>24</sup>

*SisterLove*, a Reproductive Justice organization based in Atlanta,

focuses on HIV's intersections with all forms of sexual and reproductive oppressions, especially among Black women and their communities. SisterLove's programs and projects — HIV and AIDS education, prevention, support services, and advocacy — are conceived and implemented through the prism of fighting the myriad sexual and reproductive oppressions that lead to HIV acquisition, and the subsequent challenges of living with HIV and AIDS.

SisterLove's Healthy Love workshop (HLW) is a group-level STD/HIV prevention program that makes "house calls." SisterLove's HLW facilitators typically go to locations requested by the participants and provide the women with prevention information on their own turf. As a result, the workshops are often conducted in familiar and safe settings which make it easier to dispel racial and social identities that are sometimes subtle barriers and obstacles to practicing safer sex.

Ending sexual and reproductive injustices that exacerbate the impact of HIV/AIDS and other STD/STIs on Black women and girls requires a concerted and long-term policy response grounded in a Reproductive Justice framework. This is the only way to ensure that individuals can exercise their human right to culturally affirming, affordable, and nondiscriminatory health resources and care. This effort includes support for community mobilization, activism, and advocacy efforts that are grounded in intersectionality.

## Common STD/STIs

### HIV / AIDS

One-quarter of U.S. people living with HIV is a woman, and women make up one in five new infec-

## STDs IN THE U.S.

The Centers for Disease Control and Prevention (CDC) estimates that 19.7 million new STD/STIs occur each year in the United States.<sup>25</sup> STD/STIs are very common, and more than half of all people in the U.S. will have an STD/STI at some point during their lifetime.<sup>26</sup> STD/STIs are usually acquired through sexual contact, and are spread through bodily fluids (i.e., blood, semen, or vaginal fluids).<sup>27</sup> Some STD/STIs can also be transmitted non-sexually, such as through maternal transmission in pregnancy or childbirth, from blood transfusions, or by sharing needles.

tions.<sup>28</sup> Black women shoulder a disproportionate burden of the HIV/AIDS epidemic; they comprise the majority of U.S. women living with HIV/AIDS, experience the largest number of new HIV infections, and have the most HIV-related deaths.<sup>29</sup> Almost two-thirds (61%) of new HIV infections in 2015 were among Black women, an infection rate 20 times that of white women.<sup>30 31</sup> Rates of new HIV infections are highest in the South, due to health disparities, inadequate health care infrastructure, and high health care costs.<sup>32</sup> This is another factor driving Black women's increased risk of HIV infection, since many Black women live in that region. In Atlanta, for example, a Black woman's chances of contracting HIV is 14 times higher than a white



*Black women shoulder a disproportionate burden of the HIV/AIDS epidemic; they comprise the majority of U.S. women living with HIV/AIDS, experience the largest number of new HIV infections, and have the most HIV-related deaths.*

woman's.<sup>33</sup> There are some signs of progress, however; new HIV diagnoses have declined overall during the last decade, and Black women saw the most significant decreases among all racial and ethnic groups.\*

### **HUMAN PAPILLOMAVIRUS (HPV)**

There are 37 different types of human papilloma virus (HPV), the most common STD/STI in the United States. While many types of HPV go away on their own, 14 types are considered to be “high risk” because of their role in the development of cancer, if left untreated.<sup>34</sup> Almost all cases of cervical cancer are caused by specific types of HPV.<sup>35</sup> Black women are at particular risk for getting HPV-associated cervical cancer, and of dying from cervical cancer, due to their lack of access to timely HPV screening services and treatment.<sup>36</sup> Black women have a HPV-associated cervical cancer rate of 9 per 100,000 women, compared to 7 cases per 100,000 for white women.<sup>37 38 39</sup> Cervical cancer has declined significantly since the introduction of the HPV vaccine in 2006. The vaccinations are proving to be less effective in preventing Black women's cervical cancer, however, because they do not cover the HPV types most commonly seen in Black women.<sup>40</sup> And, both

barriers to health care and a legacy of suspicion of the medical field have hampered vaccination uptake for Black girls, particularly in the South.<sup>41 42</sup> As a result, HPV rates are much higher in the South, and nearly half of all U.S. cervical cancer deaths occur in that region.<sup>43</sup>

### **CHLAMYDIA**

Chlamydia is the STD/STI that is most frequently reported to the CDC.<sup>44</sup> Left untreated, it is a major cause of Pelvic Inflammatory Disease (PID), which is a leading cause of infertility, ectopic pregnancy, and chronic pelvic pain.<sup>45</sup> Chlamydia also makes it easier to transmit and acquire HIV. Chlamydia is usually asymptomatic; the Centers for Disease Control and Prevention (CDC) recommend annual STD/STI screening for sexually active women under age 25, and for women over age 25 at increased risk of infection.<sup>46</sup> In 2015, more than 1.5 million cases of Chlamydia were reported, the highest number of any condition ever reported. Black women and girls have the highest infection rates of all ethnic and racial groups, and are more than five times more likely to be infected with chlamydia than white women.<sup>47</sup> Rates are highest among Black girls aged 15-24. Rates were either stable or increased for all racial and ethnic groups except Black people, from 2011 to 2015.

### **GONORRHEA**

Gonorrhea is the second most frequently reported STD in the U.S., with almost 400,000 reported to the CDC in 2015.<sup>48</sup> Gonorrhea can be cured with medication but, left untreated, results in infertility, ectopic pregnancy, PID, and long-term pain.<sup>49</sup> Gonorrhea also makes it easier to transmit and acquire HIV. Alarming, the disease is increasingly resistant to treatment with standard regimens.<sup>50</sup> A large percentage (42%) of U.S. gonorrhea cases occur among Black people, and Black women have infection rates more than 9 times higher than white women.<sup>51</sup> Young Black women are particularly at risk. In 2015, Black women aged 20–24 years had a gonorrhea rate 9 times higher than their white peers; 15–19-year-old Black women had a gonorrhea rate more than 11 times that of their white peers.<sup>52</sup> Rates have decreased among Black people to a greater extent than other racial and ethnic groups, however, between 2011 and 2015.

### **SYPHILIS**

Syphilis' symptoms are often painless and can mimic a host of other conditions, so many people do not know they are infected at the time when it is most effectively treated. Untreated syphilis can affect the heart, brain, and other organs.<sup>53</sup> Syphilis also makes it easier to transmit and acquire HIV. Congenital syphilis, which occurs when a woman transmits the infection during pregnancy, can result in still-

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\* New HIV diagnoses declined 35% among Latina women, and 30% among white women.

^ The U.S. government requires certain diseases and medical conditions to be reported to the CDC by states and localities to facilitate disease prevention and treatment; other conditions are voluntarily reported to the CDC.

birth and high rates of infant mortality.<sup>54</sup> More than 74,000 cases of syphilis were reported in the U.S. in 2015. Compared to white women, Black women are 8.8 times more likely to acquire syphilis, and have congenital syphilis rates 8 times higher for live births. While syphilis rates increased for all racial and ethnic groups between 2011 and 2015, Black people had the smallest rate of increase.

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# Being HIV-Positive

## LISTENING SESSION, ATLANTA

*Even as public education about HIV increases and medical prevention advances are featured on public education campaigns and other media, a lot of misinformation remains about how HIV spreads and is treated.*

Significant gains have been made in HIV prevention and treatment over the last few decades, with the result that people are now living longer and more healthily with the disease. But, there is still a significant need for improved access to health care and supportive services for Black women who are living with HIV. SisterLove, a Reproductive Justice organization based in Atlanta, Georgia, helps create community and meets women's needs by offering programming and support services for Black women.

“Grady Baby” is an identity worn proudly in Atlanta. Generations of Georgians born at Grady Memorial Hospital refer to themselves as “Grady Babies”, and continue to go to the hospital for all of their ailments, check-ups, and to give birth. It's a family tradition. At the SisterLove office, Liz\* smiles as she introduces herself: a ‘Grady Baby’, mother of 7, and grandmother of 21. Liz, who is in her early 50s, has only ever been to Grady Memorial Hospital for her health care, including her HIV treatment. Liz was diagnosed as HIV-positive in 1996 and says that, other than receiving her diagnosis, her experience at Grady was “awesome,” because she

received so much support from the hospital and counselors.

Valencia, a mother of three in her 50s, had her youngest daughter in April, 1993. Around that time, everyone in her family experienced flu-like symptoms; everyone except Valencia got better a few days later. So, in May, 1993, Valencia went to a Grady health center for a check-up and after several blood tests, learned she was HIV-positive. “I was confused. I wasn't a sex worker, wasn't a drug addict...was heterosexual.” Valencia walked out of the health center unsure of her future. A week later, she attended her first HIV education class. “It's not a death sentence. You not gon' die. You gon' be around for about 70 years,” the counselor told Valencia. “And I'm looking at her like, ‘Okay that's gonna make me 92.’ Thing is, I need to be around for my kids,” Valencia recalls.

Like Valencia, Steph, didn't think she was susceptible to HIV because of stereotypes and misinformation about who could contract the disease. “You know, I wasn't the gay, sex worker, drug addict they said had to look out,” explained Steph, who was diagnosed 20 years ago. “I wasn't one of those, so I wouldn't have taken a test” for HIV. Steph

happened to go to the hospital for other health issues and was offered an HIV test. “My concern was, how much is it? And he said free, so I was like ‘Yeah, give me anything for free!’ A couple of days later when it was time for me to go home, they came back and said my test came back positive.”

Kay, was diagnosed in 2012. She'd been celibate for 2 decades, and was rushed to the hospital with kidney failure and a 35-pound weight loss. “I was near death when I was diagnosed.” Kay didn't believe it when the doctors diagnosed her with HIV, because she'd been celibate for so long; she still hasn't accepted it. Phyllis, another Grady Baby, was diagnosed at Kaiser Permanente. She comments, “I worked in the medical field, but I didn't really know anything about HIV.”

Phyllis experienced many challenges in accessing sustained treatments. When she was first diagnosed, she was told she would begin receiving care within 72 hours, but actually had to wait 2 weeks, which impacted her mental and physical health. “You're waiting two weeks and every kind of thought comes into your mind.” In Steph's opinion, HIV care has become less personal over time.

Some names have been changed.



## *Stigma is another factor keeping Black women from getting the health care they need. The stigma against HIV/AIDS breeds silence and isolation for some women.*

“Twenty years ago, they was wrapping their arms around you.” Now, she says, HIV is treated like HPV; the initial compassionate care she received is gone. “You’ve got diabetes. Take a pill and you’ll be all right. That’s how they treat HIV now and they’re not giving people the support they need initially.”

“When I was first diagnosed, I was kinda scared,” Liz explains. “I had mixed feelings. I didn’t have any insurance, but the counselor walked me through it. I stayed on the Ryan White Program until I got Medicaid.” The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, created in 1990, provides primary medical care and support programs for uninsured and underinsured people living with HIV/AIDS. In Atlanta, this program is a lifeline.

All of the women are enrolled in HIV treatment and health insurance programs like the CARE Act, the Federal AIDS Drug Assistance Program (ADAP), and the Affordable Care Act (ACA). Kay says the ACA enables her to afford to see a doctor. In 1997 and 2007, Kay had major surgery and the bills bankrupted her. But things have changed dramatically under the ACA, she says. “I’m able to get medication in order for me to live. It’s an awesome thing. The price of 1 pill is over \$1,000...who could ever pay for a month’s supply?”

While these programs are designed to make treatment affordable, the

cost of health care continues to be a major barrier to care. Steph says monthly payments and co-pays required by her insurance make health care too expensive for her to afford to use. “When I didn’t have any [private] insurance, I could go to the doctor as much as I wanted to...now that I have insurance, every time I go to the doctor, I have to pay. I get a bill in the mail. So now, emotionally, I’m in a place where I could stand to do therapy once a week, but I can’t afford it.”

Phyllis, who was diagnosed in 1996, was re-diagnosed in 1998 during an incarceration. She received medical reprieve and was enrolled in ADAP, enabling her to have regular appointments at Grady Memorial Hospital and see a therapist. But once Phyllis was released from prison and no longer covered by ADAP, she couldn’t afford to go to the hospital or see a therapist regularly. She was forced to forgo her medication for two years, which negatively impacted her health. “I have to pay if I want to go see my therapist once a week, I have pay every time I go there, but I can barely make it so I can only go one time a month. And if I’m lucky I can make it twice. But that’s it.” Even now, Phyllis says because of lapses in coverage and bureaucratic mistakes, she’s forced to go months without medication, leaving her scrounging for leftover pills. “I managed it okay, but I’m still off the wire because that whole month I didn’t get to take all my medicine.

Am I still undetectable? Am I still suppressed?”

Stigma is another factor keeping Black women from getting the health care they need. The stigma against HIV/AIDS breeds silence and isolation for some women. Valencia waited nearly three months before telling her mother, with whom her family lived, about her status. Liz went off of her medication while she was incarcerated for fear of disclosing her HIV-positive status to the jail staff. As a result, Liz missed treatment for over two weeks.

Kay hasn’t shared her status with anyone in her family because of the way she’s heard them discuss other family members with HIV. Because of the things she’s heard her best friend say about HIV-positive people, Liz also hasn’t yet disclosed her status to her friend; she has, however, talked about her older sister’s death from AIDS to create a teachable moment. Similarly, Phyllis recalls sitting at a bus stop with a woman who began to talk about “people with the nasty disease.” “She talked too ugly about it,” Phyllis remembered, and decided to disclose her HIV status and touch the woman as she got up to catch the bus.

After Valencia’s children learned about her status, she sought out educational programs to help them be more comfortable speaking about HIV to their classmates and other family members. Valencia



beams as she shares a story about one of her daughters, who complained that her high school health teachers weren't giving enough information about HIV, and stated that she should teach the section herself. "I did my job," Valencia says with satisfaction.

Even as public education about HIV increases and medical prevention advances are featured on public education campaigns and other media, a lot of misinformation remains about how HIV spreads and is treated. Most of the women interviewed say men are unwilling to take Pre-Exposure Prophylaxis (PrEP), a prevention drug for high-risk HIV-negative individuals. The men's reasons include not wanting to have sex with an HIV-positive person, not wanting to take medication, and preferring to use condoms as protection against HIV. Steph says that area billboards have information about PrEP, but don't include many details. She adds that PrEP is hard to get, expensive, and not always covered by insurance. Steph doesn't want to encourage her partners to take PrEP because she doesn't know what the long-term effects are on someone who is HIV-negative, and the drug can cause liver damage among those who are living with HIV.

Steph feels hindered by the need to disclose to those she is intimate with, even when using a condom. "It puts me in a place to make deci-

sions at a particular time," explains Steph. Liz isn't okay disclosing her serostatus to a new partner, so she either goes back to her previous partners who are aware of her status or uses adult toys. As Liz laughs about her newest toy, Steph giggles and says it's time for her to go to the store, too. "I love living life. Love living life. And being a full sexual being, and I enjoy life, and I'm a horny girl," Steph exclaims. It is clear that a healthy sex life is still a priority for several of the women.

HIV-positive women often have to be their own advocates, even with health care providers. When the once-a-day pill Atripla came out, Steph wanted to take it, but her providers refused to give her a prescription unless she also took birth control pills, because the medication causes birth defects. Steph, who was already 50, felt that she was being denied treatment and questioned why her providers didn't trust her to prevent pregnancy on her own. Liz and Kay were both told they "had to have" a hysterectomy, but refused. "They're giving a lot of Black women hysterectomies that don't need them," Liz recalls a friend telling her.

When asked about their work with SisterLove, all of the women cite the benefits of fellowship and support from other Black women. Steph explains, "If it wasn't for a place like this, I would be at home basically doing it by myself. It keeps me from saying 'Why me?'"

Valencia loves the people, camaraderie, and the safe place where she can "broaden her horizons" with an inner circle of friends, and not have to worry about others judging her based on her serostatus. "People call in and they ask questions, like where they can find a place to live with HIV... It's just the thought of helping somebody get to where they need to be," says Phyllis, who loves helping others who are newly diagnosed.

The ability to give back is the biggest motivation for Valencia. "As far as our human rights, reproductive health, equal justice, sexual rights, we are women here working for the purpose of the greater good," Valencia explains. "To educate one another as well as our community on HIV/AIDS and everything else that they might want to incorporate too."

Steph says she truly enjoys seeing women coming in for their first meeting, often scared and worried, and seeing how they grow over time. Kay says the ability to see Black women living with HIV well into the double digits was what gave her hope. She describes SisterLove as a place where she can come for information and to cry, especially when everyone else in her life has no idea why she is crying.





## CHAPTER 9

# Violence Against Black Women

**T**he United Nations' *Declaration on the Elimination of Violence Against Women* states that “violence against women is a manifestation of historically unequal power relations between men and women... violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.”<sup>2</sup> Violence is a pattern of behaviors “directed at achieving and maintaining power and control”<sup>3</sup> over another person. Violence against women includes a host of behaviors, including sexual assault, stalking, intimate partner violence (IPV), and murder.

U.S. society is extraordinarily violent in comparison to other high-income countries. However, as a society, we are too often desensi-

tized to violence, especially when it is perpetrated against Black women and girls. Over the years, Black women have been stereotyped as overly domineering, assertive, and masculine, and viewed as paradoxically both not at risk for — and to blame for — any victimization.<sup>4</sup> This mischaracterization contributes to a lack of visibility and concern about Black women's experiences of violence.

Black women live at the intersection of gender and race.<sup>6, 7</sup> As such, the interconnections between racism and sexism cannot be separated or ignored when Black women experience violence. Black women are at increased risk for IPV and other forms of sexual violence (e.g., rape, sexual assault, stalking by someone other than a

current or past partner).<sup>8</sup> They are also at increased risk of experiencing institutionalized violence within educational, criminal justice, and law enforcement systems.

Violence perpetrated against a Black woman based solely, or in part, on the offender's bias is a hate crime, as defined by the Federal Bureau of Investigation (FBI).<sup>9</sup> Yet, when Black women experience violence, it is rarely officially classified as a hate crime. For example, the Oklahoma City police officer who raped and battered more than 18 Black women, who were chosen specifically based on race, is clearly engaging in hate crimes, but the assaults were not classified as such.<sup>10</sup>

The impact of violence on Black women's lives is significant and far-reaching. Women who experi-

ence IPV and sexual violence face a significant number of health problems, including chronic conditions, suicide, depression, and post-traumatic stress disorder (PTSD).<sup>11</sup> Compared to women who have not experienced IPV, “Black women who are battered have more physical ailments, mental health issues, are less likely to practice safe sex and are more likely to abuse substances during pregnancy.”<sup>12</sup> The trauma caused by violence and IPV increases the risk of HIV and hampers women’s access to needed treatment. Victims of IPV are also more likely to experience unemployment, poverty, food insecurity, and housing insecurity.<sup>14</sup>

Beyond issues of sexual violence, Black women are also at heightened risk from institutionalized violence due to their relative lack of power.<sup>15</sup> For example, educational settings often jeopardize Black girls’ safety. While Black girls are only 16 percent of female students, they comprise almost half (45%) of girls with “at least one out-of-school suspension, 42 percent of girls who receive corporal punishment and are expelled, 34 percent of girls arrested on campus, and 31 percent of girls who are referred to law enforcement.”<sup>16</sup> The harmful results include academic failure and dropping out, with long-term economic consequences.

Often, victimization by sexual violence feeds into victimization by institutional violence. Sexual abuse survivors are more likely to become involved with the criminal justice system as a result of the “sexual abuse to prison pipeline.”<sup>17</sup>

## SEXUAL VIOLENCE & INTIMATE PARTNER VIOLENCE

Nearly 20 percent (19%) of U.S. women have been raped, and 15% have been stalked in their lifetime.<sup>33</sup> Black women and girls experience higher rates of rape and sexual assault compared to women of other racial and ethnic backgrounds.<sup>34</sup> About 40 percent of Black women report having experienced coercive sexual contact,<sup>35</sup> and 18 percent of Black women report being raped in their lifetime.<sup>36</sup> Lesbian and bisexual women are at greater risk for sexual violence;<sup>37</sup> more than 80 percent of murdered trans\* people are women of color.<sup>38</sup>

According to the National Coalition Against Domestic Violence, every year, 1.3 million women suffer intimate partner violence (IPV).<sup>39</sup> This type of abuse starts tragically early: two-thirds (69%) of female IPV survivors first experienced this abuse between the ages of 11 and 24 (22% between 11-17; 47% between 18-24).<sup>40</sup> Although Black women are 8 percent of the population, they comprise 22 percent of reported instances of IPV. Compared to white women, Black women are twice as likely to be killed by a spouse and four times more likely to be killed by a boyfriend or girlfriend.<sup>41</sup> IPV is, in fact, among the leading causes of death for Black women between the ages of 15 and 35. While a few high-profile IPV cases make the headlines, like the nauseating video of former Baltimore Ravens running back Ray Rice battering his then-fiancée into unconsciousness,<sup>42</sup> most IPV involving Black women are unreported and unnoticed.

This term describes the fact that survivors often engage in behaviors that involve them with the juvenile and criminal justice systems. The most common reasons that girls are arrested (running away, substance abuse, and truancy) are also common reactions to sexual abuse.<sup>18</sup> These “victims of early

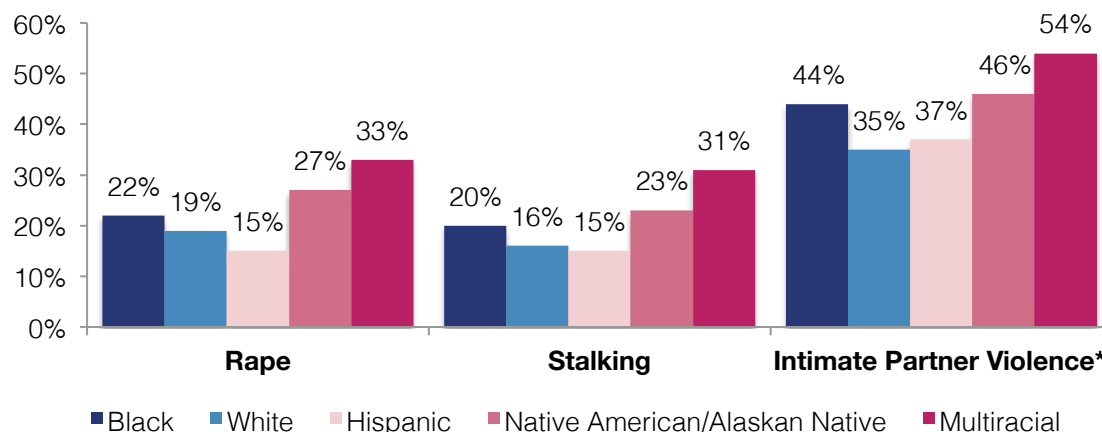
sexual abuse are more likely to fail in school, which can lead to sexual exploitation, which can lead to prison.”<sup>19</sup>

In fact, prior abuse is a key predictor of involvement in the juvenile justice system.<sup>20</sup> Between “77% and 90% of incarcerated women report

*Sexual abuse victims are more likely to become involved with the criminal justice system as a result of the “sexual abuse to prison pipeline.”*



## WOMEN'S LIFETIME PREVALENCE OF RAPE, STALKING, AND INTIMATE PARTNER VIOLENCE



\*Intimate partner violence includes rape, physical violence, and/or stalking by a current or former intimate partner

Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, Chen J, Stevens MR, *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report*, Atlanta: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011. Online: <https://www.cdc.gov/violenceprevention/nisvs/>

extensive histories of emotional, physical, and sexual abuse.<sup>21</sup> Among female inmates in the criminal justice system, nearly 60 percent had experienced physical or sexual abuse in the past. Black women are disproportionately represented in the criminal justice system, where they comprise nearly half of the female prison population.<sup>22 23</sup> Once in the system, Black women are likely to experience additional sexual violence. According to the U.S. Department of Justice, “allegations of staff sexual misconduct were made in all but one state prison, and in 41% of local and private jails and prisons.”<sup>24</sup>

Black women’s experiences of violence is gaining more exposure, and creating pathways for the issue to be discussed and the stories of brave survivors to be shared. Yet, many women do not

report experiences with violence for a host of reasons, including financial dependency on an abuser; expectations of cultural roles; concern about their children; fear of isolation, stigma, judgment, and alienation from their family or community; anxiety that they will not be believed; and concerns that service providers will not be effective at safeguarding their health and providing culturally competent services.<sup>25</sup> These factors are compounded by social disparities that make it harder for Black women to access the medical, mental health, and social supports they need to heal, including medical care, social services, and battered women’s services.<sup>26 27 28</sup>

It is particularly important to note that Black women may also be reluctant to report IPV and sexual victimization because they distrust

law enforcement. State policies that mandate police to make an arrest whenever they respond to a domestic violence call are one example of policies that foster distrust and deter women from seeking help. This is particularly true for women of color. For example, in New York City, two-thirds of the IPV survivors who were arrested were Black or Latina women.<sup>29</sup>

And, Black women’s risk are often overlooked with respect to concerns about violence committed against people of color by law enforcement representatives.<sup>30</sup> Assessing Black women’s experiences with police violence is challenging, because “there is currently no accurate data collection on police killings nationwide, no readily available database compiling a complete list of the cases of Black women’s lives lost at the hands of police, and no data collection on sexual or other forms of gender and sexuality based police violence.”<sup>31</sup> The

\* “Trans” is an umbrella term that refers to all of the identities within the gender identity spectrum (e.g., transgender, transsexual, etc.).



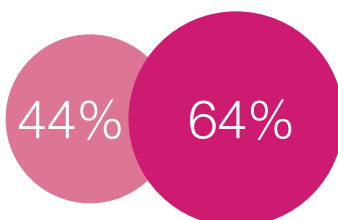
reality is, while they comprise just 7 percent of the nation's overall population, Black women and girls "account for 20 percent of unarmed individuals killed by police in the U.S. since 1999."<sup>32</sup> Black women have good reason to fear that police might react unsympathetically to a report of violence. In cases of IPV, Black women may also fear that law enforcement's involvement may result in harm to their Black male partner.

Reproductive Justice includes the right to exist and parent in environments that are safe, nurturing, and free from violence of all forms. Stopping the cycle of violence that harms so many Black women and children requires a Reproductive Justice-guided and intersectional approach that addresses the profound underlying systemic issues—including issues of race, class, and gender—that drive women's experience with violence at the hands of both individuals and institutions.

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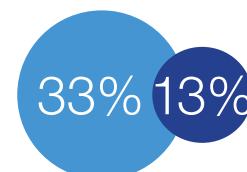
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## BLACK WOMEN ARE KILLED BY POLICE IN DISPROPORTIONATE NUMBERS



White women make up 64% of women in the U.S., but are 44% of fatal police shootings

Black women and girls are only 13% of the U.S. female population, but they account for 33% of all women shot to death by police

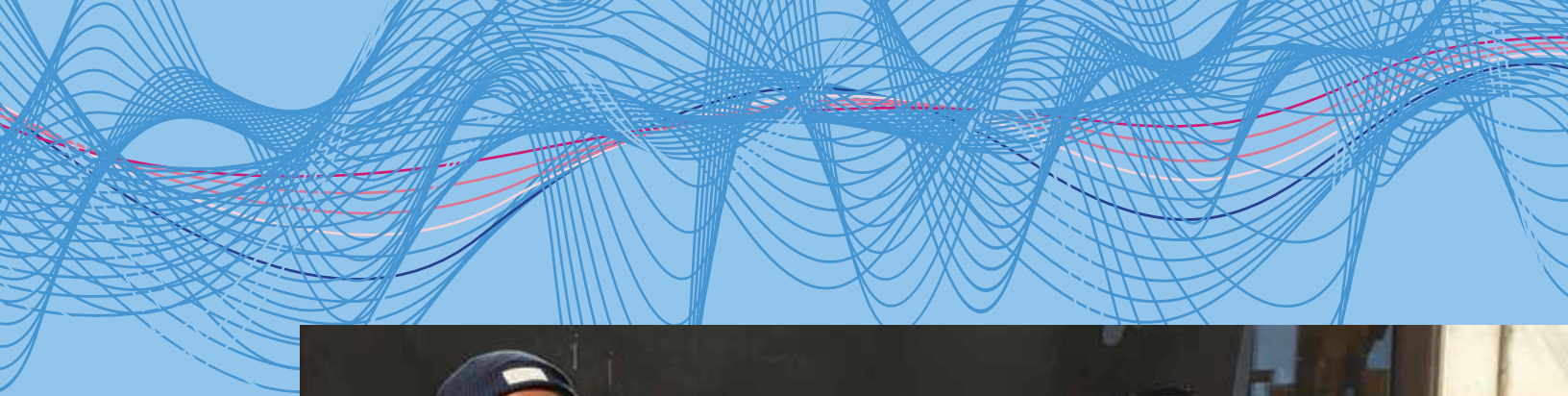


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## CHAPTER 10

# Reproductive Justice and Lesbian, Gay, Bi-sexual, Trans, Queer, and Questioning Black Youth

By Dr. Krystal Redman, DrPH, MHA, Executive Director, SPARK Reproductive Justice NOW!

**T**he broad Reproductive Justice (RJ) conceptual framework addresses barriers to sexual health and resources, particularly those experienced by marginalized groups. It includes an explicit focus on the disparities experienced by Black communities; other communities of color; and lesbian, gay, bi-sexual, trans,\* queer, and questioning (LGBTQQ) individuals. The RJ approach is particularly critical to understanding the interconnected nature of challenges faced by LGBTQQ youth of color with respect to their sexuality, gender identity, and reproductive and sexual

health. These barriers include pervasive racism and homophobia; a lack of access to health insurance and high-quality, culturally effective health care; stigma-based policies and laws; and non-inclusive health education that denies their existence. These challenges have a debilitating effect on both health and life outcomes for Black LGBTQQ youth.

As a result of these interconnected challenges, Black communities suffer from the heaviest burden of poor health outcomes in the United States. Black youth experience even more disparate impacts, and LGBTQQ communities even more.<sup>1</sup> As a result, LGBTQQ Black youth — who combine these three communities — are one of the most at-risk and marginalized popula-

tions in the nation, and experience significantly worse health outcomes compared to their white, heterosexual peers.<sup>2 3 4</sup>

Addressing the dual impact of systemic homophobia and racism, plus society's condescension toward youth, is essential to ensure that LGBTQQ Black youth have the resources and power to make sustainable decisions about their bodies, genders, sexualities, and lives.<sup>5</sup>

Endemic racism and homophobia leads LGBTQQ Black youth to experience significantly worse health outcomes, including depression, suicide, and substance abuse. This puts them at higher risk of experiencing STD/STI, including HIV/AIDS, and unintended pregnancy.<sup>6</sup>

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\* "Trans" is an umbrella term that refers to all of the identities within the gender identity spectrum (e.g., transgender, transsexual, etc.).



<sup>7</sup>In fact, LGBT youth\* of color are two to three times more likely to attempt suicide, compared to their white heterosexual peers. Homophobia puts LGBTQQ individuals, including Black youth, at risk for violence and sexual assault.<sup>8</sup> As many as one-quarter of LGB students have been threatened or injured on school property in the previous year. As a result, these youth drop out of high school at a rate three times higher than the national average, hampering their future earning potential.<sup>9</sup>

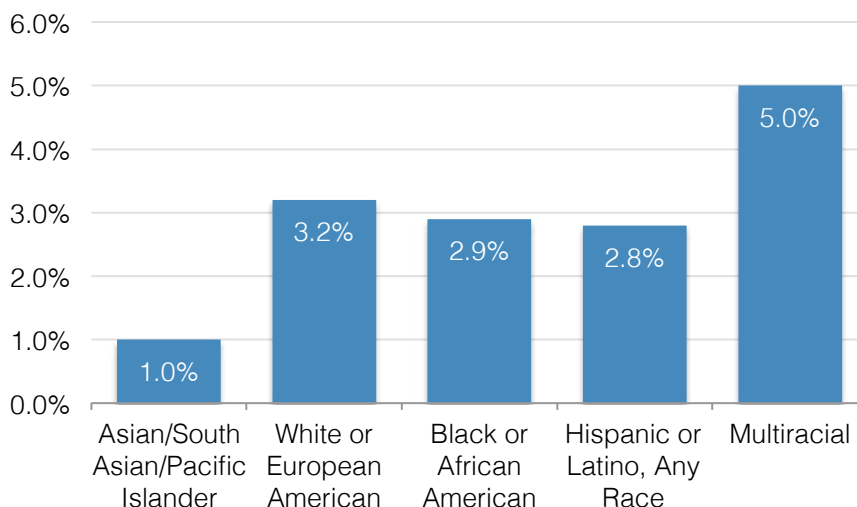
LGBTQQ youth of color are more likely to be poor and at much higher risk for experiencing homelessness, compared to white, heterosexual youth.<sup>10 11</sup> They are often forced to engage in commercial sex work for survival, trading sex for food, shelter, and other necessities.<sup>12</sup> This increases their risk for sexually transmitted diseases and infections (STD/STI), unintended pregnancy, rape, and other forms of violence.

Systematic inequalities and disparities, compounded by homophobia, hamper Black youth's access to health insurance and high-quality, culturally effective care in general.<sup>13 14 15</sup> As a whole, regardless of age, they are more likely to have unmet health needs due to lack of insurance, shortage of providers, and high costs. They are less likely to have a regular health care provider, compared to heterosexual individuals, and are more likely to experience discrimination and stigma from their medical providers. More than half of LGB people reported that providers had denied health care, spoken harshly to them, or blamed an illnesses on the person's sexual orientation or gender identity.<sup>16</sup>

\* There are little to no data specifically on Queer and Questioning youth of color.

## RACE/ETHNICITY AND DROPPING OUT

Percentage of LGBTQ students not planning to complete high school or not sure if will complete



Palmer NA, Greytak EA, Kosciw JG, *Educational Exclusion: Drop Out, Push Out, and the School-to-Prison Pipeline Among LGBTQ Youth*, New York: GLSEN, 2016, page 26.

The impact of the lack of access to culturally effective, high-quality health care is evident in health outcomes for LGBTQQ Black youth. Eighty-one percent of new HIV infections in 2015 were among Gay or Bisexual males aged 13 to 25; more than half of these youth (55%) were Black.<sup>17</sup> The teen pregnancy rate for youth who identify as Lesbian or Bisexual is 2 to 10 times greater than for their heterosexual peers.<sup>18 19</sup>

Among trans youth, the health outcomes are even worse. This community has a higher prevalence of HIV/AIDS, STD/STIs, and victimization; they are far less likely to have health insurance and access to health care.<sup>20</sup> These outcomes provide clear evidence that the nation has failed to meet its human rights obligations to provide equity and equal access to comprehensive and inclusive reproductive health care, education, and resources for all.

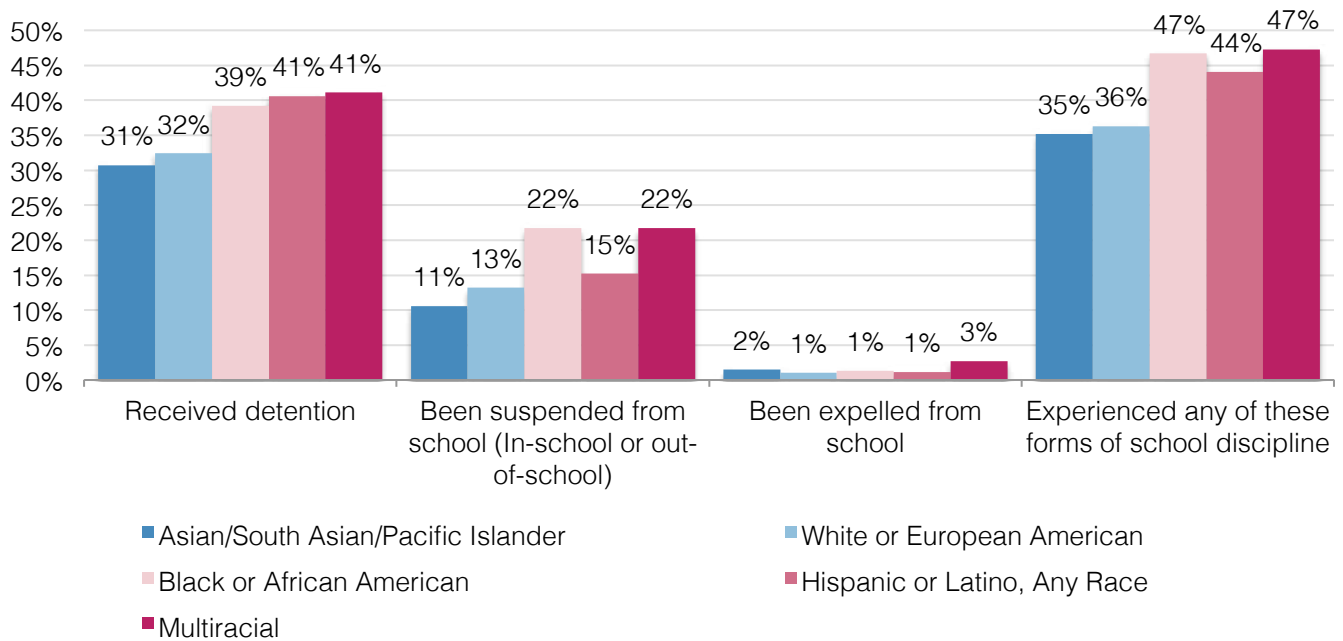
Despite the progress made in creating a more equitable society, laws criminalizing aspects of LGBTQQ lives continue to be introduced and supported across the nation. These laws attempt to control LGBTQQ individuals and disproportionately impact LGBTQQ Black youth. These cycles of criminalization perpetuate poor life and health outcomes and push vulnerable populations to the margins of society.

More than 30 states have laws requiring people living with HIV (PLWH) to provide prior notification of their sero-status to partners before engaging in sexual activity.<sup>21</sup> These laws penalize consensual sex, institutionalize HIV-stigma, and conflict with effective disease prevention strategies. PLWH risk conviction under these laws regardless of whether any disease transmission occurred; the risk of exposure alone is grounds for a felony conviction and carries a po-



## RACE/ETHNICITY AND EXPERIENCES OF SCHOOL DISCIPLINE

Percentage of LGBTQ students



Palmer NA, Greytak EA, Kosciw JG, *Educational Exclusion: Drop Out, Push Out, and the School-to-Prison Pipeline Among LGBTQ Youth*, New York: GLSEN, 2016, page 26.

tential 20-year sentence. Such laws disproportionately target LGBTQ youth and PLWH, and send the inaccurate message that attempting to avoid sexual partners with HIV is an adequate prevention strategy.

Laws targeting commercial sex workers also often impact LGBTQ Black youth. As noted, LGBTQ youth are often forced to engage in commercial sex work to survive, trading sex for food or shelter. LGBTQ individuals can be detained and/or imprisoned for violating laws against carrying condoms, which target commercial sex workers. Likewise, regulations aimed at preventing homelessness also disproportionately impact people of color, including LGBTQ Black youth. As noted, LGBTQ youth suffer from extremely high rates of homelessness, and are disproportionately affected by regulations against loitering and against

sitting or lying on sidewalks and other public places.

LGBTQ youth also face discrimination in our nation's schools. Perhaps the most notorious discrimination comes from the laws known as the "bathroom bills" which have been introduced in several states in the last few years. These laws force individuals to use the restroom that conforms to the sex listed on their birth certificate. These unconstitutional laws clearly seek to harass trans individuals, and result in an increased risk of discrimination and violence. Last year North Carolina and South Dakota faced boycotts and demonstrations over their controversial laws. Despite these controversies, five states – Alabama, Missouri, South Carolina, Texas, and Washington — filed bathroom bills this year.<sup>22</sup>

Additionally, other national, state, and local educational policies stigmatize LGBTQ youth by providing inaccurate, misleading, and incomplete information about LGBTQ lives, sexuality, reproduction, and identities. The Federal government and many states promote "abstinence-only-until-marriage" education that explicitly discriminates about LGBTQ individuals.<sup>23</sup> These ineffective programs also fail to provide medically accurate information about contraception, STD/STI prevention, and LGBTQ individuals.<sup>24</sup> These programs are particularly dangerous for sexually active and LGBTQ youth who are not only stigmatized but also denied vital information that can protect their health.<sup>25</sup>

Eight states go further, and have adopted so-called "no promo homo" laws that prohibit teachers from discussing LGBTQ issues

(including sexual health and HIV/AIDS prevention) in a positive light. Some state laws\* require teachers to actively portray LGBTQ individuals in negative and/or inaccurate ways.<sup>26 27</sup> For example, Alabama requires classes to “emphasize, in a factual manner and from a public health perspective, that homosexuality is not a lifestyle acceptable to the general public and that homosexual conduct is a criminal offense under the laws of the state.”<sup>28</sup> Although these laws are generally written to apply only to sexual health education, they are often so vague they can be used to limit other aspects of the school curricula, events, programs, and extra-curricular activities.

These laws foster an unsafe school atmosphere and promote medically inaccurate health information, which interfere with LGBTQ youth’s right to full information, services, and support to make healthy decisions about their lives and futures. They discriminate against individuals simply for identifying as LGBTQ, and perpetuate both unequal treatment and health disparities that affect these individuals’ life outcomes. Not surprisingly, the majority of LGBTQ youth of color report that they had been victimized at school due to either their race or their sexual identity; half had been victimized due to both their race and sexual identity.<sup>29 30</sup>

The lack of awareness about LGBTQ Black youth’s need for reproductive services — including contraception and abortion care — hampers their access to needed care and deepens their health disparities.<sup>31</sup> Yet, despite the enormous challenges faced by LGBTQ Black youth, not enough is known about

this community. There are almost no racial- and ethnic-specific data on either LGBTQ youth’s health disparities or the combined effects of racism, ageism, homophobia, and transphobia on their health outcomes. Further, due to history of oppression and the lack of trust in the public health community (including researchers), LGBTQ Black youth may be reluctant to engage in the few research efforts that exist. Studies that do explore this community’s experiences too often group disparate populations together (i.e., “LGBT adults,” “LGBT youth,” and “youth of color”), thereby compounding the problem and complicating any meaningful analysis.

Addressing LGBTQ Black youth’s sexual and reproductive health needs from a Reproductive Justice framework begins with understanding the history of oppression and discrimination this community has faced. *SPARK Reproductive Justice NOW*, a Reproductive Justice organization based in Atlanta, GA, advocates for policies that protect and expand access to the full range of sexual health education and services youth of color in the state of Georgia. Importantly, SPARK ensures the voices of women of color, young parents, and LGBTQ youth of color living in the South are included in the Reproductive Justice movement. Their mission is to collaborate with individuals, communities, and organizations to grow and sustain a powerful

Reproductive Justice movement in Georgia and the South.

Social determinants that affect the health of LGBTQ Black youth are correlated with systems of oppression, racism, and discrimination; gaps in access to health care; legal discrimination; and denial of their existence in health education. Without the implementation of effective policies, LGBTQ Black youth will not have equal access, fair treatment, and equity in resources.

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*Without the implementation of effective policies, LGBTQ Black youth will not have equal access, fair treatment, and equity in resources.*

\* States with these laws are: Alabama, Arizona, Louisiana, Mississippi, Oklahoma, South Carolina, Texas, and Utah

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# Sex Education and LGBTQQ and Gender Non-Conforming Black Youth

## LISTENING SESSION, ATLANTA

*None of the young people felt they could talk to their parents about sex, and particularly about their queer identity, because the conversations were steeped in stigma, negative religious teachings, and misunderstandings.*

Access to comprehensive sexual health education and culturally effective health care can be a challenge for young people, particularly for lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) Black youth. SPARK Reproductive Justice NOW, based in Atlanta, helps these youth by providing information, services, and support.

Nigel said, “They never talked about sexual health in school,” as the others burst into laughter. Nigel says he may have received a few days of sex education in the 7<sup>th</sup> grade, however, some of the students were already pregnant or experiencing syphilis and HIV. Angel, 19, a sex worker who identifies as a non-binary femme and uses the pronoun ‘they,’ describes their sex education as “a joke” They said, “I went to high school in a small rural place in Georgia, and in 5<sup>th</sup> grade we were told, ‘Probably next year, folks with vaginas, you’ll start bleeding.’ and we were like ‘What?’”

Katie, who uses the pronoun ‘they’ and identifies as non-binary, outlines similar experiences. In grade school, Katie’s class was separated by sex and students were told about menstruation; in middle school, students were shown internal condoms (also known as “female condoms”) and told these items were only for use “if you’re getting adventurous.” In 8<sup>th</sup> grade, Katie’s health teacher used metaphors about hot dogs and old shoes to talk about sex and promiscuity. Angel said that a school they attended in Birmingham, Alabama, used an abstinence-only-until-marriage education curricula; promoted crisis pregnancy centers, which provide biased anti-choice information; and refused to teach students about condoms, despite the high sexually transmitted disease and infection (STD/STI) rates among local teens.

Adonis, 23, who also uses the pronoun ‘they’ and identifies as a transboi, said their 5<sup>th</sup>-grade sexual health education program was “flawed.” Students were separated by sex to learn about puberty, al-

though many students had already experienced it and there were rumors about students who had begun to have oral sex. They watched a video about sperm swimming up to meet an egg without a clear context being provided. Consequently, students were forced to supplement their sexual health education with information from television and from friends. Adonis noted that they learned about LGBTQQ sex and relationships from shows like *Queer As Folk* and *The L Word*; they learned about HIV when singer John Legend came to their college campus and spoke about their city having the state’s highest HIV rates. Adonis was not surprised by the news about HIV rates; many of the students they went to grade school with had already experienced pregnancy, childbirth, or STD/STIs before entering high school.

Although Adonis was glad they could supplement their sex education through the media, the queer sex they learned about often focused on white, cisgender people. Adonis rarely saw characters who looked like themselves.



None of the young people felt they could talk to their parents about sex, and particularly about their queer identity, because the conversations were steeped in stigma, negative religious teachings, and misunderstandings. “I think, especially being queer, your parents aren’t helpful,” said Nigel. Much of their internalized stigma around their bodies, sexuality, gender identity, and virginity stemmed from their parents’ insistence that they would be “dirty” if they had sex, particularly if they did so with partners of the same sex. “Parents don’t realize...how you are really fucking with your kids when you don’t really bring in the holisticness [sic] of sex,” added Angel. “When you’re just bringing in fear all the time — when sex is so much more radical and better than that.”

Katie said they began having a lot of sex with cisgender men in college to try to regain autonomy over their body that had been denied by their mother, and to try to force themselves out of a queer identity. Katie ended up being raped and contracting an STI. They found it difficult to get gynecological care because their mom believed they were a virgin and they didn’t feel like they could disclose what had happened to their mom.

Angel also ended up having several STIs because they weren’t receiving information to protect themselves. “I just kept getting burned... nobody is telling me what to do so I can stop dealing with this issue.” It was not until near the end of high school that Angel found organizations like AIDS Alabama and Advocates for Youth that provide comprehensive and medically accurate sexual health information so

teens can protect themselves and others. Angel shares the information they’ve learned with their friends and fellow sex workers to ensure that everyone is informed about reproductive and sexual health. Angel said many of their friends are keenly aware of the history of contraceptive trials and sterilization perpetrated upon communities of color. They also said that some providers are unwilling to treat Black youth who engage in sex work. “A lot of us don’t feel comfortable going to doctors and nonprofits because they’re run by white people, and white people already think that our bodies are experiments,” Angel commented.

The intersections of being young, Black, queer, and disabled makes accessing health care particularly treacherous. Most do not have insurance coverage and even when they do seek health care from nonprofit clinics, they are made to wait for hours. Both Angel, who has sickle cell anemia, and Adonis engage in sex work to pay their bills and buy food. They say they are unable to maintain other jobs due to their physical and mental illnesses, and they can’t afford medication because they lack insurance. Adonis said that they hadn’t been tested for HIV in almost a year.

Being undocumented is another challenge. Some of the youth are afraid to go to the nearest hospital because Immigration Customs Enforcement (ICE) patrols the facilities in search of undocumented immigrants. Angel, who is undocumented, says they recently drove three hours from Georgia to Alabama, while bleeding after a miscarriage, because they were afraid to go to the nearest hospital in Atlanta.

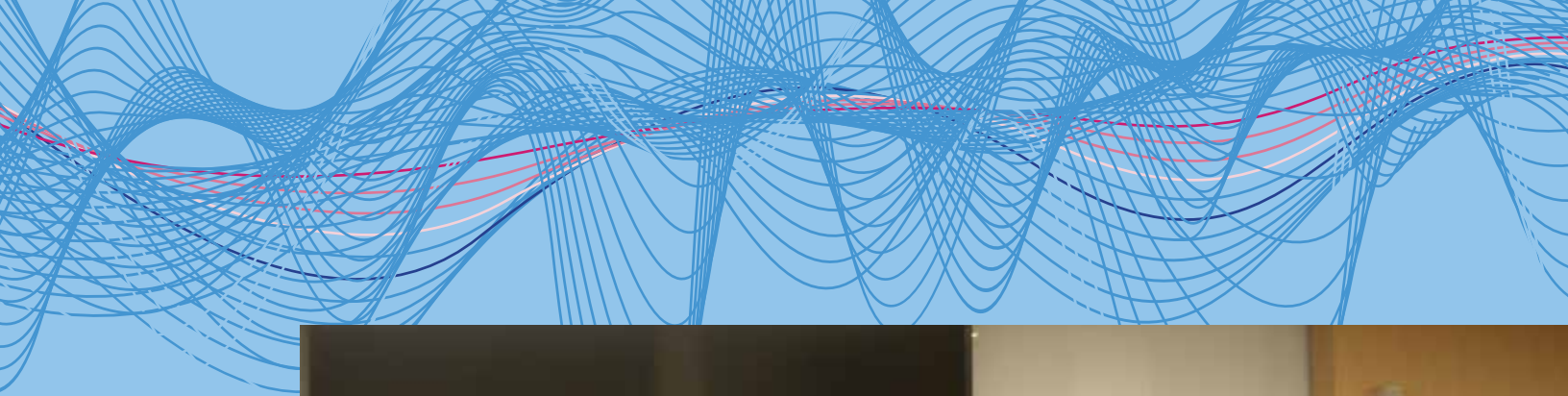
All four of the young people said they were reluctant to receive care from nonprofits without Black staff because they did not trust the clinics. They also rarely saw themselves represented in LGBTQQ-focused reproductive health care advertisements except for those about HIV. “Black faces are attached to disease warnings,” Nigel noted about a bus ad. “Why is it that our people are the face of the terminal stage [of AIDS]?” questioned Adonis.

The young people aren’t short of ideas on how to improve health care access for themselves and their peers. First and foremost, they would love health care to be free, and to have more options for care — particularly natural options. They’d like more healers and health providers of color who are culturally competent about the needs of LGBTQQ youth, gender non-conforming youth, and sex workers.

They are thankful that organizations like SPARK Reproductive Justice NOW exist so that they can receive accurate information and ask honest questions without fear of repercussions. While they wait for systems to change, they will continue to create better access for themselves and their peers. “My people are resilient. My people are hurting. My people are innovating. My people are fighting a battle that will be won with this generation,” declares Angel. As they left the SPARK office, the young people stocked up on internal and external condoms, and hugs from SPARK’s program manager, who told them to be safe. It was clear, after years of searching, they had found the affirming space they were looking for.



# III. Our Lives







## CHAPTER 11

# The Criminal Justice System and Black Women

On July 10, 2015, Sandra Bland, a 28-year-old Black woman from Naperville, Illinois, was arrested for allegedly assaulting a police officer during a traffic stop in Waller County, Texas, and three days later died in police custody. Her death served as a mobilization moment for Black women and highlighted the lived experiences of Black women with law enforcement. The African American Policy Forum (AAPF) developed a campaign #SayHerName to emphasize the need to focus on the plight of Black women's encounters with law enforcement.<sup>1</sup> The reality is that the criminal justice system is not, and never has been, a source of protection or recourse for Black women.

Black women's interactions with the criminal justice system affect our ability to live in community

without fear of violence from individuals or the government. The U.S. female prison population has increased nearly eight-fold since the 1980s, and there are now 1.2 million women involved in the criminal justice system.<sup>2</sup> Black women represent 44 percent of those incarcerated women.<sup>3</sup> Compared to white women, Black women are twice as likely to be incarcerated, and are more likely to serve longer sentences for the same crimes.

The over-policing of Black female bodies starts young, and is often severe. We are all aware of school security officers "slamming" teenage girls to the ground or an armed police officer dragging a 15-year old across the round by the hair as she called out for her mother.<sup>4</sup> According to a report by AAPF nationally, "Black girls were suspended six

times more than white girls,"<sup>5</sup> and they are three times more likely to be arrested or referred to law enforcement than white girls are.<sup>6</sup> Zero tolerance policies, which mandate suspension or expulsion for student misconduct also disproportionately affect Black students and feed the country's school-to-prison pipeline.<sup>7 8</sup>

Laws that penalize pregnant women for their behavior also disproportionately affect Black women, particularly those who live in the South. These laws seek to punish pregnant women for drug-related behaviors; for not following doctors' orders; or for engaging in behaviors that might affect the health of the fetus.<sup>9</sup> According to the National Women's Law Center, these laws are unconstitutional, because they *only* apply to specific

*The injustices perpetrated on Black women occur at every stage of the criminal justice system, from racial and gender profiling, to unfair and biased sentencing, to incarceration in a system designed for men that is unable to meet women's needs.*

people — pregnant women — and thereby violate these women's right to equal protection under the law.

Interactions with the criminal justice system impact Black mothers' ability to parent their children with necessary social supports in safe environments and healthy communities. The majority of women who are involved with the U.S. criminal justice system are either mothers of young children (79 percent) or are pregnant when they arrive (5 percent).<sup>10</sup> As former U.S. Attorney General Loretta Lynch said, "Put simply, we know that when we incarcerate a woman we often are truly incarcerating a family, in terms of the far-reaching effect on her children, her community, and her entire family network."<sup>11</sup>

Incarcerating a Black woman for even a short period of time has the potential for long-lasting impact on both her and her children. The National Resource Center on Children & Families of the Incarcerated (NRCCFI) notes, "parental incarceration significantly increases the risk of children living in poverty, experiencing household instability, and dealing with behavioral issues."<sup>12</sup> Parental incarceration is considered an Adverse Childhood Experience (ACE) with long-lasting effects on early childhood brain development and the child's future outcomes.

There is a profound need for programs that actively strive to keep families together and focus on rehabilitation and treatment, rather than on time served. Diversion programs can provide mothers,

infants, and children with opportunities to establish and sustain their familial ties. One example is a Cook County (IL) Sheriff's Office program for pregnant and post-partum mothers, which allows women to stay with their children through preschool age.<sup>13</sup> Preliminary results indicate that it has reduced recidivism and helped maintain mother-child relationships. The alternatives to such programs can be harrowing: a study of mothers in the Cook County Jail found that women whose children were placed in foster care upon the mother's incarceration were half as likely to reunite with their children after release, compared to non-incarcerated mothers with children in foster care. Both the criminal justice and foster care systems "thrive on the punishment of Black mothers and have significant injurious effects on Black families and communities."<sup>14</sup>

Incarcerated women often face specific challenges in meeting their sexual and reproductive health needs, including access to menstrual hygiene products, contraception, and abortion care if they become pregnant while incarcerated. Prenatal care is not consistently provided to pregnant women, increasing the risk for miscarriages, stillbirths, and ectopic pregnancies. Some incarcerated women are forced to have abortions against their will, violating their reproductive rights. And, too many criminal justice systems continue the practice of shackling pregnant inmates. Shackling is inhumane and has been condemned by the American College of Obstetricians and Gynecolo-

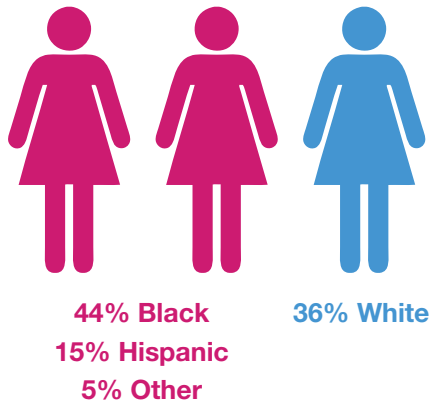
gists, the American Civil Liberties Union, and the American Public Health Association. Although the severe harms caused by shackling pregnant women are well-known, only 24 states and D.C. prohibit this practice; some of these laws have harmful loopholes, however, which put women at risk of shackling even in states with anti-shackling laws.<sup>15</sup>

Black women who are involved with the criminal justice system are often coping with significant challenges, including poverty, mental illness, substance abuse, and/or histories of abuse. Violence within the criminal justice system compounds these challenges; at least 15 percent of incarcerated women have been the victim of prison sexual assault, either from staff or other inmates.<sup>16</sup> Yet, there is a shortage of programs to assess and meet these women's disparate needs. They have little or no viable support or relief prior to incarceration — and are unlikely to find support or relief after incarceration and/or release. And, the experience of incarceration can be re-traumatizing for Black women and can exacerbate their existing physical and mental health issues, such as substance abuse. Many leave prison or jail in poor health, and with few prospects for improving their economic, mental, or physical well-being.<sup>17</sup>

Deon Haywood, the executive director of *Women With a Vision* (WWAV), a Reproductive Justice organization based in New Orleans, believes "it is important that for-

## RACIAL AND ETHNIC DISPARITIES OF WOMEN IN JAILS

**2/3** of the women in jail are women of color



Swavola E, Riley K, Subramanian R, *Overlooked: Women and Jails in an Era of Reform*, New York: Vera Institute of Justice, 2016, page 12. Online: <https://www.vera.org/publications/overlooked-women-and-jails-report>

merly incarcerated women stand at the forefront of the work being done to address the social justice, economic justice, and structural health issues that hamper their well-being.” WWAV seeks to give voice to women who have been incarcerated in working with public policy entities, including the court systems and law enforcement, to reform laws and programs to better help formerly incarcerated women rebuild their lives.

In the past five years, WWAV has helped to launch a legal campaign and diversion program to help sex

workers caught up in the criminal justice system avoid jail. The Racial Justice Improvement Project, an initiative of the American Bar Association in collaboration with WWAV, specifically works with women caught up in the criminal justice system.<sup>18</sup> WWAV staff estimates that the group has helped more than 120,000 women since its grassroots beginning nearly 30 years ago. Its work has focused mostly on “harm reduction” — reducing negative consequences of drug use—as well as improving awareness of health issues.

The injustices perpetrated on Black women occur at every stage of the criminal justice system, from racial and gender profiling, to unfair and biased sentencing, to incarceration in a system designed for men that is unable to meet women’s needs. To rectify the problem, changes must be coordinated and simultaneously implemented at all levels of the many systems that impact the lives of Black women.

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*Although the severe harms caused by shackling pregnant women are well known, only 24 states and the District of Columbia prohibit this practice.*







## CHAPTER 12

# Economic Justice and Black Women

**O**n average, a Black woman, working full-time, year-round, make \$0.63 for every dollar a white man makes doing the same job. This means that if a white male makes an annual salary of \$57,204, a Black woman makes only \$36,203 — \$21,001 less a year.<sup>1</sup> While this figure is a clear example of economic inequality, what it means is that a Black woman who starts working full-time, year-round at the age of 20 loses \$840,040 over a 40-year career, compared to a white man.<sup>2</sup> And, when a white male retires at age 60 after 40 years of work, a Black woman would have to keep working until she is 83 years old - 23 more years - “in order to close this lifetime wage gap.”<sup>3</sup>

Most advocates will immediately focus on economic inequality or,

more specifically, equal pay, as the answer to this problem. They will demand policies that address paycheck fairness or increases to minimum wage, all of which are important to this one immediate problem. But for Black Reproductive Justice advocates, equal pay is only one component of a multi-dimensional, ongoing fight for empowerment and self-determination. We recognize that a debate about economic inequality that fails to also address racial inequality and gender inequality is a meaningless exercise that ignores the fact that “the impacts of race, class, gender and sexual identity oppressions are not additive but integrative”<sup>4</sup> to the lived experiences of Black women and other women of color.

Historically, Black women have been profoundly impacted by social

and cultural attitudes and practices that shape their individual opportunities, quality of life, and health risks and outcomes. We know that Black women are the head of households (defined by the Census as having a female head and no spouse present)<sup>5</sup> for 29 percent of Black households with young children.<sup>6</sup> Like with any parent, their families depend on women’s wages to pay the bills – rent, utilities, clothing; pay medical bills if they are uninsured or underinsured; buy school supplies; cover transportation to and from work or school; and still put food on the table.

A Black woman’s ability to contribute to the economic productivity of her family and/or community, that is, to achieve economic justice, depends on an articulation of all the integral aspects of her daily



## EQUAL PAY DAYS, BY GENDER, RACE, AND ETHNICITY (2014 DOLLARS)

Comparison	What a woman makes for every dollar a man makes	Equal Pay Day	How many months a woman has to work to make what a man makes in a year
<b>Women overall v. men overall</b>	<b>78.6¢</b>	<b>April 8th</b>	<b>More than 15</b>
Asian American Women v. White, non-Hispanic Men	83.5¢	March 12th	More than 14
White, non-Hispanic Women v. White, non-Hispanic Men	75.4¢	April 28th	Nearly 16
Black Women v. White, non-Hispanic Men	60.5¢	August 26th	Nearly 20
Native American Women v. White, non-Hispanic Men	58.6¢	September 14th	More than 20
Latinas v. White, non-Hispanic Men	54.6¢	October 30th	22

“What a woman makes for every dollar a man makes” is the ratio of women’s and men’s median earnings for full-time, year-round workers. Earnings are in 2014 dollars. NWLC calculations based on U.S. Census Bureau, Current Population Survey, 2015 Annual Social and Economic Supplement and 2014 American Community Survey (for Native Americans).

Robbins KG, *NWLC Blog: Equal Pay Days, by Gender, Race, and Ethnicity*, Washington, DC: National Women’s Law Center (NWLC), 2015. Online: <https://nwlc.org/blog/equal-pay-days-gender-race-and-ethnicity/>

life. Her opportunity to attain a decent education; her capability to obtain a job that pays a living wage; her access to reproductive health care, including affordable, effective contraceptives and abortion to help her determine the size of her family;<sup>7</sup> her right to raise her children in safe, decent housing; her right to live her true gender identity; and her human right to move within a society free from racism, sexism, and homophobia are all critical components for her overall quality of life and advancing the economic welfare of her family and community.

Black women can only economically sustain their families when they can also plan those families. This means access to reproductive health care services, including family planning and abortion health care. The United States Supreme Court concurred in 1992, when

it stated, as part of the ruling in *Planned Parenthood of Southeastern Pennsylvania v Casey*, that “the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.”<sup>8</sup>

Another barrier to economic justice, however, is the fact that women of color are severely underrepresented in leadership positions across the board, from political office to corporate boardrooms. A new report analyzing the conditions for women of color in the corporate world shows, that, even at the “best” companies for women of color, their advancement has completely stagnated for the past half-decade.<sup>9</sup> According to a *Working Mother* report (which did not divide “multicultural women” by race) women of color comprised 22 percent of the workforce at

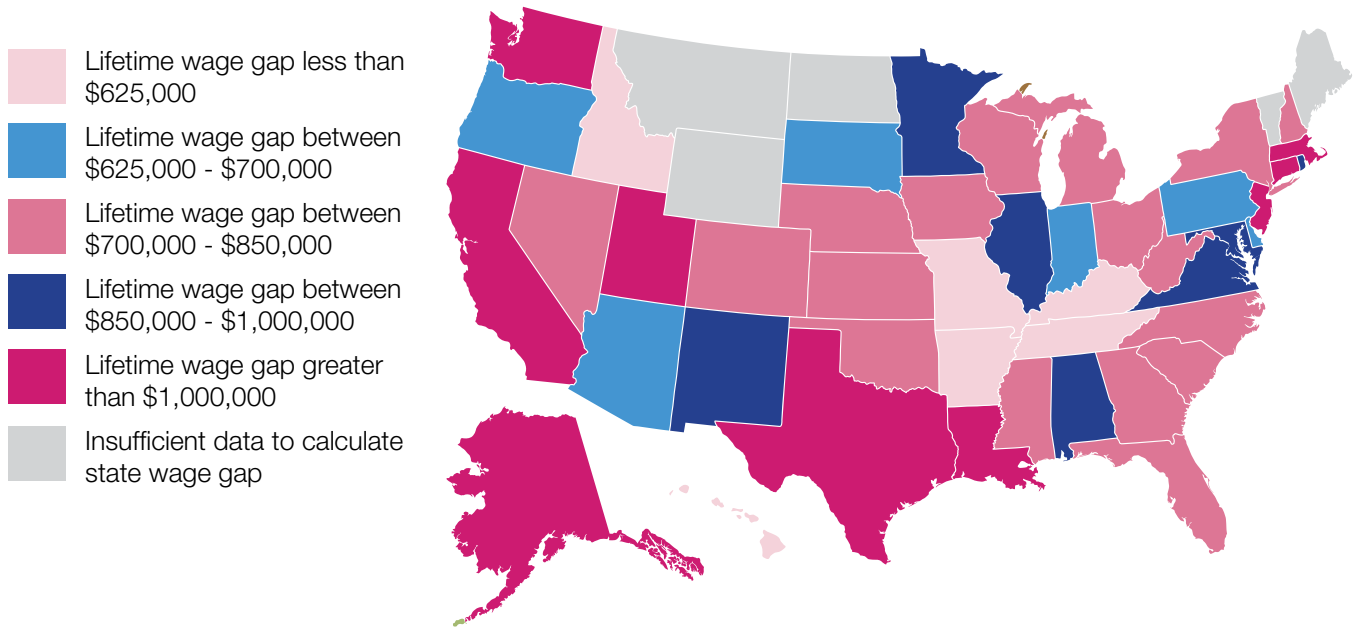
the companies studied — at face value, that might not seem so bad. However, women of color also represented 26 percent of the people who left those companies, and only 14 percent of the employees who received promotions to management and higher levels.<sup>10</sup>

Clearly, with abysmally low percentages of women of color in senior positions — 14 percent of managers, 8 percent of senior managers and only 4 percent of corporate executives — there’s plenty of room to improve. Not to mention that these percentages haven’t changed for the past four years, and women of color, compared to white women and all men, represent the lowest proportion for both new hires and promotions, by far.

Leadership, rather than mere employment, is critical to changing systems and processes that rein-

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## LIFETIME WAGE GAP FOR BLACK WOMEN COMPARED TO WHITE, NON-HISPANIC MEN



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National Women's Law Center (NWLC), *NWLC Resource: Lifetime Wage Gap, State by State*, Washington, DC: National Women's Law Center (NWLC), 2015. Online: <https://nwlc.org/resources/the-lifetime-wage-gap-state-by-state/>

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force discrimination and oppression. It's a lot harder to imagine the systematic mistreatment of women of color at Fox News happening with a Black woman as CEO — not because installing female leaders is the magic answer, but because investing in leadership by women of color can foster an environment in which our voices are heard and our grievances are taken seriously, leading to standardized change.

Corporations also need a real plan to address racism and sexism. The only way to develop and execute an effective plan is to listen to Black women and include us at all levels — from planning to implementation. And we can't just address racism and sexism in the boardroom; corporations must look at all levels of their operations and eliminate systemic prejudices and barriers to success from the bottom up. We know that women of color par-

ticipate in networking events and career counseling more than other groups, but for some reason we're less likely to engage in mentorship programs.

It is not happenstance that the vision for Reproductive Justice is a world where Black women and other women of color have the "economic, social and political power and resources"<sup>11</sup> to make the important, personal decisions that are best for ourselves and our families. It is difficult to achieve that vision when we take five steps forward and politicians push us three steps back.

Over the last year, politicians have spent an extraordinary amount of time lamenting the status of "working class Americans" as code for white males, while ignoring the needs of working class people of color. While this is something we

expect from the Trump campaign, the media has also picked up this false narrative and continues to promote it today. The reality, however, according to the Pew Research Center, is that "[B]lacks and Hispanics have far less wealth than their white counterparts."<sup>12</sup> Part of this "racial wealth gap"<sup>13</sup> is the bigoted perception that Black "working class Americans" are "considered underclass as opposed to working class and "lazy" instead of hardworking."<sup>14</sup>

On average, white families have roughly "13 times more wealth"<sup>15</sup> than Black families, with \$11, 200 for Blacks and \$144,200 for whites. Blacks also have less equity in their homes, fewer savings, and less disposable income. Plus, Black employees with "more experience and education are still paid less than their white counterparts."<sup>16</sup> The resulting wealth gap is only

worsening. At this rate, Black families won't "accumulate the same amount of wealth as whites" until the year 2245.<sup>17</sup>

Reproductive Justice plays an important role in the economic stability of Black families, as well as in addressing the many systemic factors that drive the economic inequality experienced by Black women and other women of color. Only by working on many levels will we be able to successfully mitigate and reverse the factors that hamper Black women's educational and economic opportunities, success in the work world, and reproductive health outcomes.

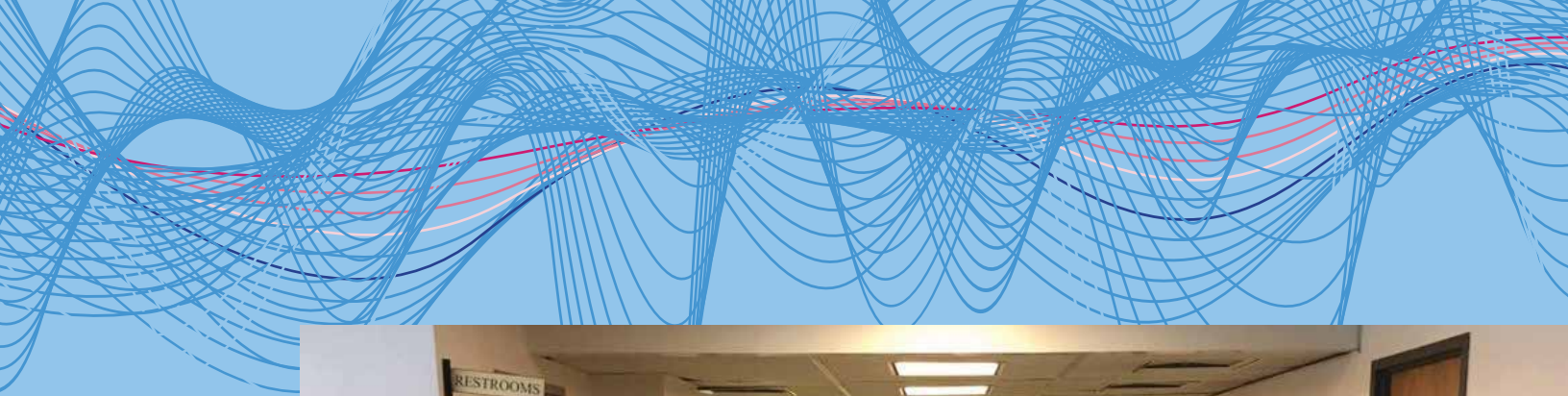
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## CHAPTER 13

# The Intersection of Reproductive Justice and Faith

By Cherisse A. Scott, Founder & CEO, SisterReach, and  
Rev. Faye London, Interfaith & Outreach Coordinator, SisterReach

**N**ow, more than ever, it is important to center the overlap of faith and RJ. It is crucial to expand beyond the single-issue RJ focus on abortion care and center the whole person and their full human rights, once and for all. The RJ, health, and rights movements no longer have the luxury to disengage from the progressive faith community. At the same time, justice-seeking faith leaders no longer have the luxury of ignoring the hostile political climate that their congregants are forced to navigate daily. It is past time to invite progressive leaders of faith to the table, particularly those for whom Womanist or liberation theologies are integral to their ministries. It is critical for these leaders to assist RJ efforts to shift the culture so that we priori-

tize individuals' bodily autonomy and empowerment. It is time to redefine religious freedom and exemption - and reclaim Jesus, whose ministry aligns perfectly within the human-rights-based RJ framework.

### Rev. Faye London

**Rev. Faye:** By now, it is no secret among reproductive health, rights, and justice advocates when, and how, the religious right became intimately connected to the Republican party. For those who want a refresher on this history, we recommend this entertaining and concise segment from night-time news show host Samantha Bee ([www.youtube.com/watch?v=Yz4AmUaLbUQ](http://www.youtube.com/watch?v=Yz4AmUaLbUQ)). This piece explains that most Evangelical Christians were relatively

apolitical until the 1970s, when the Federal government began to require their institutions end racially discriminatory rules and practices in order to maintain tax-exempt status. In response to these rulings, white fundamentalist Christians rallied... and the Republican party met them with rhetoric and policy that aligned with their core beliefs.

Recognizing that the preservation of segregation was unlikely to garner broad-based support, conservative leaders focused on issues that could be framed as moral imperatives from a Christian perspective — including abortion. Borrowing from conservative Catholic tradition, these leaders engineered a new movement by framing women who seek abortion care as irresponsible and selfish, and by placing a woman's ability to

*As Reproductive Justice (RJ) advocates and organizers, we know that the greatest potential for powerful change lies in the ability and willingness of the people who are most impacted by the policies created by this toxic environment to speak up for themselves and demand better from their leaders.*

make decisions about her body autonomously into direct (and grossly oversimplified) opposition to the broad concept of “life.” In this way, conservatives effectively locked many Evangelicals into a circular narrative that cast unintended pregnancies as moral failures and compulsory parenthood as an appropriate consequence—for the woman.

This strategy — shaming people for the “moral failings” that lead to unintended pregnancies — has become seemingly unbeatable among Evangelical Christians, and even among non-Evangelicals who are influenced by the ideological leanings of Evangelical Christians around them.

The work of faith organizing — particularly in Southern states and other “red” states where Christian rhetoric is ubiquitous — is absolutely necessary. The language of the most oppressive policies that impact people’s lives with respect to their bodies and sexuality is built on a foundation of shaming devices that were first employed during the early marriage of religious and political conservatism that spawned the Religious Right.

If we look closely, we can recognize that 2017 is not that different from 1972, when Bob Jones University entered the national spotlight by challenging the Federal government’s ruling that it could no longer both discriminate against Blacks

and be tax-exempt. In the 1970s, a segment of the white population became angry and afraid about their perceived loss of rights resulting from Black people’s gains in the Civil Rights movement. Today, those same segments of the population are responding to the progressive accomplishments made in eight years of a Black president and to the massive gains in LGBTQQ rights. In each case, people claimed it was their right to discriminate against, or limit the rights of, others based on their own religious beliefs.

This is where we stand now. Politically-motivated power-monsters, whose only real concern is continuing to amass wealth and power, are using faith speech that resonates with so many people to distort what it means to be an American and what freedom of religion entails. The oversimplified messages that create a false parallel between conservative ideology and religious piety dominate the political conversation. This makes many people feel that they have no choice but to align themselves with the death-dealing policies created by these leaders, or risk being inconsistent with their own faith proclamation.

As Reproductive Justice (RJ) advocates and organizers, we know that the greatest potential for powerful change lies in the ability and willingness of the people who are most impacted by the policies created by

this toxic environment to speak up for themselves and demand better from their leaders. This change necessitates work that functions primarily to shift the culture. If we are to be true to our core strategy of elevating the voices and experiences of people at the margins, we must acknowledge and commit to changing the cultural forces that silence them. The misuse of faith speech is one of the most powerful of these cultural forces.

People of faith have been an integral part of all movements for reproductive health, rights, and justice, working on behalf of the human right to bodily autonomy. As a movement, we have come to trust and rely heavily on the faith voices who have always been loyal to this cause. We know who we can call upon to speak up with moral authority in defense of our rights. This has been an impactful strategy for many years and must continue.

If we are to fully live into the strength of RJ, however, more is required of us than this. To truly live into what we *say* we believe is the winning strategy, we must be prepared to meet the individuals we serve where they are. For some, this means addressing problematic anti-human rights ideologies that masquerade as theologies in some of our faith spaces. SisterReach’s faith programming occupies this space, does this work, and has learned many valuable lessons.



The very first thing anyone who seeks to engage people of faith in RJ work on more than a cursory level must do is to evaluate whether this work is truly for them. Any organizer worth their salt can pull together already-friendly faith leaders to “collar up and show up.” It takes a different sort of patience and commitment to walk the long, sometimes treacherous, road of new understanding with someone in order to help them shift a culture that opposes their own flourishing. Assuring one’s own ability to remain emotionally safe while doing this work is paramount. It is perfectly acceptable to decide not to participate if faith communities are active sites of trauma.

## Cherisse A. Scott

**Cherisse:** March 2017 marks 20 years of me being an ordained Christian minister. Most of the ministerial work I have done has been outside of a brick-and-mortar church building, however, and is centered among those whom the “respectability politics” of church behavior wrote off a long time ago. My ministry has been informed by several factors, including my personal understanding of Biblical scripture and other texts, and my analysis of the person and character of Jesus and how His ministry centered those living on the margins of society or those altogether invisibilized. It has also been informed by my own lived trauma, mistakes, and navigation of life during and after those experiences — with the assurance that I serve a Savior who is eager to extend

compassion and forgiveness.

It was almost an effortless transition for me to become an activist who is charged to work on behalf of myself and others who are also marginalized, invisibilized, misunderstood, and often vilified. One of the most admirable aspects of serving Jesus, especially as a Reproductive Justice (RJ) advocate, has been the assurance that I also serve a Savior who promoted self-determination, bodily autonomy, and does not force His love, nor His promise of life eternal on me. My belief in Him is made optional and I have been granted full autonomy to receive God’s love, make choices informed by that love, and to interpret and apply God’s love to every aspect of my life. Within that autonomy is the justice of God. The equity in God.

Though my commitment to God has not wavered, I have struggled over these 20 years to hold some of those who profess to be Christian to the same regard of respect and honor in my heart. This is especially true of some of our elected officials, who claim they are Christian, yet, in justifying their political behavior, have reduced Jesus to a racist, classist, sexist, homophobic, and xenophobic deity who leads with shame and respectability over love and compassion. In the South, many of our elected officials are pastors, deacons, and Sunday school teachers, who have been able to co-opt and redefine “religious freedom” to be only for the wealthy, respectable and racially privileged. Everyone else be damned — literally.

For me, these are our modern-day Pharisees who, along with their supporters, have hijacked the life and ministry of a liberation-based Jesus within their limited scope and misguided interpretations.<sup>1</sup> They have politicized the Bible and made it into a weapon to manipulate, segregate and destroy all people — not just Believers. Their Jesus is a fascist, so it is not hard to believe that white Evangelicals and the alt-right fled to the polls to elect their ‘golden calf.’ This demagogue Jesus is their justice and the swift actions of a dictatorship-based administration are steadily moving toward what many believe is a totalitarian world government — the New World Order. Everything about the new presidential administration speaks to this as more truth than a falsehood. Let’s be clear, though: this culture and practice far precedes Donald Trump’s election. It is only emboldened by the reality of a Trump Administration.

Black women of faith helped create the RJ framework, and faith has always informed these efforts. I was introduced to the RJ movement during my ministry journey. One of the reasons I was recruited into this work was because of my ministry work and my relationships with the leaders of various Black church denominations. What I realized in my attempt to build relationships with clergy and organize them around RJ issues was that there was a lot of hurt for both ministry leaders and advocates. Ministry leaders had already grown weary of advocates who were only willing to engage them when the advocates

*Black women of faith helped create the RJ framework, and faith has always informed these efforts.*

needed faith voices around inflammatory policies, like abortion or LGBTQ rights. Advocates had — and continue to have — a nasty taste in their mouths from being force-fed the dictator-based, anti-woman, anti-human-rights Jesus. We still recognize the power and significance in those faith voices speaking to justice from a place of spiritual authority, however.

Nevertheless, the disconnect for true partnership is real and, in this current climate, has become a barrier in bridging collective power to evoke true culture change, internally as co-laborers in the service to humanity, and externally to mobilize against harmful personal piety narratives that restrict our human and spiritual rights.

In the meantime, the white Evangelical right wing is building a stronger following promoting a Christian dictatorship-culture

informed by a perverted interpretation of my Jesus. It is time that Believers call this behavior out and be intentional in promoting a loving, compassionate and justice-extending Jesus over a racist, misogynist, and xenophobic savior. The white Evangelical right wing narrative of Jesus is a terrorist, a capitalist, an abuser, and a narcissist who is only willing to bless those who are prosperous and respectable. They are no longer interested in the Jesus who sacrificed His life for the poor and disenfranchised so that those who believe and those who don't would always have unconditional access to His love.

At *SisterReach*, our attempt to reconcile this void, especially being based in the Bible-belt South, is to center faith-based and -focused organizing as a key strategy in building power on behalf of Southern women, teens, families, and gender non-conforming people. We recent-

ly produced *RJ & Faith Curricula* that are designed for advocates, clergy, and lay people who are interested in faith-informed justice and in working together to improve the lives of the most vulnerable.

Our hope is that this will strengthen our own work and arm the reproductive rights, health movement and other social justice movements with messages, tools, and strategies that have been tried and tested, that will help us bridge the divide between our servant communities, and that can help us create synergy that achieves justice for all of us.

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# RJ and Faith

## LISTENING SESSION, MEMPHIS

*Although faith traditions have been at the forefront of civil rights efforts, they have also perpetuated attitudes that disempower individuals particularly around reproductive and sexual health.*

Faith communities are tremendously important to nurturing people spiritually and physically, and building skills that are carried throughout life. Although faith traditions have been at the forefront of civil rights efforts, they have also perpetuated attitudes that disempower individuals particularly around reproductive and sexual health. These attitudes and restrictions are particularly damaging for women and gay, bisexual, transgender, questioning, and queer (LGBTQQ) individuals. Efforts to address this challenge and promote faith-based Reproductive Justice education are being led by organizations like SisterReach, a Reproductive Justice organization based in Memphis, Tennessee.

“Sex was not a topic for Sunday sermon or Sunday school,” recalls Roslyn Robinson, 54. Raised in South Memphis, “Roz Tee,” as her friends call her, is a deacon at her church. She can’t recall learning about sex or reproductive health from her faith community; she got it at home and, even then, it was a taboo subject. “Just say no,’ from my mom...that was the sex talk, you know, you just don’t do it,” she explained. “You just don’t have sex

until you’re married. There was nothing else to talk about. But I got the impression that it was something dirty or nasty within those ‘no’ guidelines.”

Lauren, 29, a SisterReach volunteer, says the lessons she received about sex and reproductive health were based in her faith and left her with negative impressions. Lauren first learned about sex during her Catholic school’s 5<sup>th</sup>-grade Family Life class, where she and her best friend read the glossary of definitions. “That’s how I discovered where body parts go during sex, through my religion group,” she explains. “We weren’t supposed to be looking at the definitions...I remember my friend said, ‘This goes here’, and I looked at him like ‘What?’ That was my revelation, I had no idea.” Later, Lauren questioned what she’d been taught after learning that masturbation was forbidden. “Sex was a negative. Abortion was a negative. Any type of body talk was in a negative light. We never talked about health, like going to the doctor.”

While sex wasn’t specifically discussed much in these women’s churches, they did experience lessons shaming Black women’s

sexuality and behaviors. As a child, Ziara, 28, distinctly remembers the pastor using stories about “fast-tailed girls;” a shaming term for Black girls who were presumed to be sexually active, to teach “church girls” how to behave. “If you don’t want the attention, don’t wear certain things. You’re a woman of God and you’re supposed to dress a certain way, and carry yourself a certain way if you want to be respected,” Ziara recalls the pastor explaining. Not knowing what he was referring to specifically, she felt confused and worried she’d do the wrong thing. “They’re teaching you stuff out of context and beating around the bush when you just want the information. Tell me what I’m supposed to do so I don’t end up being chastised in a sermon.”

Lauren learned similar lessons from sermons. Stories about “other girls” who became pregnant, or who went away for their first year of college and came back pregnant, described the ultimate failure. “Using those girls’ stories and lives as a marker for what you *don’t* want to be and *don’t* want to be labeled, and you don’t want to have to sit in the back of the church.” Years later, after her freshman year of college, Lauren became pregnant.

*However, the lack of positive discussion about sexual and reproductive health leaves many young women in the dark about their own bodies and health care.*

She sought an abortion at the very Planned Parenthood she had been taught to slut-shame women for going to for health care. She felt a lot of shame, particularly for having an abortion two short years after attending the March for Life with her high-school classmates. Now she turned out to be one of the women she had been warned about.

Although some families don't talk openly about sex, it doesn't mean their perspectives are negative. In middle school, Roslyn Regina, now 52, a pastor for the last 15 years, received a weekly health magazine addressed to her, which taught her about puberty and adolescence. She graduated to *The Joy of Sex*, perfectly perched at eye-level on her family's bookshelf. Years later, Roslyn's mother claimed she'd ordered the magazine to teach her daughter about puberty and avoid having uncomfortable conversations about sex. "I think she bought [the magazines] for herself, but she took pride in feeling like she had bought them for me; so I read them, cover to cover, pictures and all." Her mother took her to the local Planned Parenthood.

Roslyn's mother, a schoolteacher, also stood up to the administration when it tried to remove a girl from school after her pregnancy began to show. Roslyn says her mother "made it possible for that girl to finish high school, graduate, and go to college." She questioned that underlying sexism: "I always wondered, what about the guys? Do they get kicked out? That burden was always put on the girl and not the guy."

In church, Roslyn witnessed this same double-standard when pregnant young women were forced to apologize for their actions. "There was not one young man who was called out, and I learned that women could speak up for themselves and have voices."

Ziara also said that her mother told her stories about pregnant girls being walked to the front of the church and apologize for becoming pregnant. "She saw [the church] as a place of severe judgment. It breeds insecurities in young girls, especially if they make a mistake like that." Roslyn recalls a young pregnant woman in her church who refused to go to the front of the church and threatened to share private information about the trustees if they forced her. She was left alone. "What I learned was, if you had the courage to speak up for yourself, then they'd leave you alone," said Roslyn.

Roslyn says her mother's lessons helped her learn to view her own body in a positive light, to negotiate sexual consent with her first partner, and to educate him on her menstrual cycle. "Your parents are the first image of God that you have in your life. My mother was the first image of God...she did inform my faith, my sense of womanhood, my authority of my own body."

However, the lack of positive discussion about sexual and reproductive health leaves many young women in the dark about their own bodies and health care. When "Roz Tee" became pregnant after college, her mother pressured

her to have an abortion. She didn't want to, and often cried because her mother was ashamed the community and churchgoers would learn her daughter was pregnant out-of-wedlock. "Marriage is no guarantee that the child will be raised properly," Roz Tee tried to explain to her mother, to no avail. "I didn't cross that last 't.' I wasn't married therefore, I was called all kinds of things." Her mother didn't let up until "Roz Tee" got married and then, "It was like [the fight] never happened." She realized it had nothing to do with what she'd wanted, just her mother's stature within the community.

Ziara recalls learning about Pap tests from a friend who described the speculum as being "like a duck" and painful. She asked her mother about it, who told her that she didn't need a Pap smear until she was having sex, something that would happen after marriage. Ziara was confused and began to search for information on-line and from friends. "After a while, you hear about stuff from the 'fast girls' in school, you just live vicariously through them until you experience it for yourself." Lauren also turned to friends to learn where to get condoms and other reproductive health care in private. "Our friends knew [Planned Parenthood] was a place you could go without your parents knowing."

Stigma around sex cause many families to keep these conversations on the down low. As a child, Ziara's mother took her to "Friends for Life" classes to learn about how

to support a family member who was sick and ensure he didn't feel ostracized. All Ziara knew was that her relative was ill; she didn't learn he had HIV until after he died. Ziara wondered, "Is it a nasty word? Is it nasty? Maybe it is a word you don't say out loud. Maybe you don't put it in the obituary, but no one ever talked about sex or condoms." Roslyn says her family often talked about family members who had "cancer." Later, she realized they actually had HIV, not cancer. As someone who came of age during the AIDS epidemic, Roslyn had to adjust her entire way of thinking about sex, health, stigma, and protection.

Patty, 52, remembers her father giving the "birds and the bees" talk, and making it clear she should remain abstinent. "When I first got my period, my father talked to me about it. He sat me down and said, 'Your body is changing, now you're able to do things and there are consequences,'" she recalled. Her father gave her this "whole entire talk, half of which I didn't understand, but I knew my dad; if he sits me down to talk to me, and it's just me and him... it's serious. I took it very seriously, even though I didn't understand. He basically said, 'Boys are gonna want to do things to you'." The talk left Patty

nervous, scared, and worried that sex would hurt and cause boys to dislike her.

When Patty was 18, shortly after she began having sex, she experienced a series of stomach pains. Her father rushed her to the emergency room where they learned she had an ectopic pregnancy and would need an abortion. Neither the hospital nor local Planned Parenthood provided abortions, so her father took Patty to Newark, New Jersey. "There was a whole bunch of young women who looked like me in this big room, and you filled out paperwork. And I just remember my dad being disappointed but supportive," Patty shared. "I felt ashamed, because I never knew anybody who was having sex among my close friends. I never knew anybody who had gotten pregnant, and I didn't know anybody who had ever had an abortion. When they called my name, my dad couldn't go with me, and I had to go back there by myself...at that time, I felt so ashamed. I never told any of my friends. I don't feel that way now, because of grace...If my dad wasn't there, I don't know what I would have done." Her father's support taught Patty how men should treat her, and what grace and unconditional love looks like.

Today, that same desire to preach grace and support informs Roslyn's sex-positive pastoral outlook. She recognizes this is rare, particularly as a Black church leader. "My faith personally is grounded in grace, but I represent a community that, for many people, has felt little to no grace. And, that's embarrassing. It saddens me greatly, because my faith has been my rock," she explains. "As a clergywoman, I want [my congregation] to feel that same grace...I'm fighting uphill to undo what others in my community have done." Roslyn counsels young people using a sex-positive lens, telling them about using contraception and condoms correctly and explaining that sex can change a relationship, so they should wait until the time is right for them. She didn't feel ashamed about having sex until, in her 20s, she heard an anti-abortion sermon, which caused her to weep and feel she had done something wrong by having sex. Roslyn never wants her congregation to have that feeling.







## CHAPTER 14

# Building the Next Generation of Black Reproductive Justice Activists

By La'Tasha D. Mayes, Founder and Executive Director, New Voices for Reproductive Justice

**N**annie Helen Burroughs, an early 20<sup>th</sup> Century civil rights leader and Black feminist said, “We specialize in the wholly impossible,” and so does the leadership of the Black Reproductive Justice (RJ) movement. This quotation captures the indomitable spirit of Black women during volatile political times and has inspired efforts to develop new voices of leadership across the nation. The statement’s legacy calls on the leadership of Black women – both cisgender and transgender – femmes, and girls to create change for the benefit of all Black people.

Black women have been rulers over thriving civilizations in ancient Africa. We have preserved our cultural traditions and reverence

for matriarchy. We were warriors for the liberation of Black people to defeat the scourge of slavery, lynching, and Jim Crow. Black women, femmes, and girls continue to tell our own stories, publish our own newspapers, produce our own songs, create our own distinct culture, and shape our own narratives about our lived experience through both traditional and social media. We have led every social movement from women’s suffrage to civil rights to gay liberation to women’s rights to environmental justice and reproductive rights.

It was a Black woman who was the first Black person to run as a major-party candidate for President of the United States, and it is true indeed that “Black women were the only ones trying to save the world”<sup>1</sup>

on election night in 2016. Black women sent astronauts to the moon and traveled time and space ourselves to shine among the stars. In every sector, Black women have carved out space in this world for ourselves — catching our breath as oppression works diligently to snatch it away. We set trends, blaze trails, and lead with passion and an insatiable pursuit of justice. This is an inheritance from our ancestors and the promise for our Black RJ future.

Now, Black women, femmes, and girls are making Black Lives Matter. And, we are making Reproductive Justice matter.

Leadership development as a value means that we invest in the potential of multiple leaders, not just invest in the charismatic nature of

## *Leadership development means the difference between liberation and defending our right to exist.*

one leader. New Voices for Reproductive Justice values leadership from those most affected by any issue we seek to address and we prioritize these individuals' leadership in our work. We tell our constituents that they are leaders right now, and do not have to wait for anyone else to identify them as leaders. We believe that — if young Black women, femmes, and girls make decisions in our community, create our own spaces that center our unique voices and experiences, and organize for Reproductive Justice — we can begin to dismantle race and gender oppression.

Leadership development means the difference between liberation and defending our right to exist. Yet, it is often challenging to understand leadership development in a tangible way — it is neither linear nor predictable. We simply know it when we see it, or we experience it as it is happening. Cultivating those sparks of brilliance and affirming the genius instinct is both an art and a science that can transform social justice movements.

The leadership development strategies of the Black RJ movement reflect enduring practices found in all social justice movements. Yet, Black women, femmes, and girls also build upon our lived experiences and use both long-standing strategies and new tactics to cultivate powerful leadership and advance the Black RJ movement. We create organizations, formations, and collectives; disrupt mainstream ideas; posit our own theoretical frameworks; serve on Boards of Directors and governing bodies; and lead organizing campaigns

on our interests and issues. We run for elected office and serve in appointed positions; participate in leadership fellowships and training programs; refine our skills through leadership coaching; win policy victories at the national, state, and local levels; dominate social media platforms; mentor our peers to leverage our collective knowledge; and host spaces at our conferences and convenings to stoke our #BlackGirlMagic. For each of us, there is that first spark — something that urges us to step forward into leadership.

For so many of us, *SisterSong: Women of Color Reproductive Justice Collective*, a multi-faceted, human-rights centered organization based in Atlanta, provided the opportunity for indigenous women and women of color activists to mark their entry into the Reproductive Justice movement. Headed by the brilliant leadership of Loretta J. Ross, SisterSong created spaces that spoke to the heart of indigenous women, Black women, and women of color to do “collectively what we could not do individually” through an intergenerational, multi-cultural and intersectional lens to challenge white supremacy. For me, the March for Women's Lives, co-chaired by Loretta, created a watershed opportunity to found New Voices and fill the leadership vacuum for Black women in Pittsburgh and ultimately Pennsylvania and Ohio.

There was a notable gap in Pittsburgh between the “reproductive rights” leadership and organizing of Black women during the mid-1980s to the turn of the millennium.

New Voices picked up where they left off and we invited our elders to participate in what had evolved into the Reproductive Justice movement. We understood that the gap or absence of Black Reproductive Justice as leaders could never happen again because it undermined the health and well-being of Black women, femmes and girls without our leadership as a political and policy safeguard.

The development of dynamic leaders who are anchored by integrity and intersectionality has accelerated the RJ movement's trajectory. This leadership development process is a powerful vehicle that creates a pipeline of fierce organizers, advocates, and culture change agents who will continue our struggle for Reproductive Justice for generations to come. It is imperative for Black women, femmes, and girls to lead the Black RJ movement. We can speak, act, and organize in our own voice. This practice is paramount. The current political climate makes it evident that the leadership of Black women must be nurtured, preserved, and trusted.

*In Our Own Voice: National Black Women's Reproductive Justice Agenda* does just this as a national/state partnership comprised of seven Black-led Reproductive Justice organizational partners. The mission of *In Our Own Voice* is to lift up the voices of Black women leaders on national policy issues that impact the lives of Black women and girls. Our strategic partnership enables us to operate on the cutting edge of leadership development.

*Black Women for Wellness*, based in Los Angeles, engages its constituents with Sisters in Control, their civic engagement and voter education programs, designed to increase the electoral and political power of Black women. They also organize and mobilize young Black women to understand reproductive health through their “Get Smart Before You Get Sexy” sex education program.

*Black Women’s Health Imperative*, based in Washington, DC, created My Sister’s Keeper (MSK), an advocacy and leadership development initiative focused on keeping female college students on track for graduation at Historically Black Colleges and Universities (HBCUs).

*New Voices for Reproductive Justice*, based in Pittsburgh and operating in Cleveland and Philadelphia, has developed a variety of leadership programs based on our key issue areas, identity groups and methodology. The SistahSpeak! Youth Project™ (SYP!) is training the next generation of Reproductive Justice leaders in Pittsburgh by focusing on sexual & reproductive health education, mentoring, cultural enrichment and community organizing for young Black women, femmes and girls ages 12-24. Our *Reproductive Justice Leadership Network*™ (RJLN) develops Black

women and women of color as state-level policy advocates across Pennsylvania and Ohio and our *Patients to Advocates* fellowship engages patients at Preterm Clinic in Cleveland, Ohio to become state and Federal policy advocates. Our Integrated Voter Engagement program, the *Voice Your Vote! Project*™ (VYV!), graduates our constituents from marginal voters to active voters, supporters and members of New Voices.

*SisterLove*, based in Atlanta, educates youth ages 13-24 through its Healthy Love Youth Leadership Network (HLYLN), which brings awareness to policies that effect youth who are living with HIV and those who are at high risk for HIV and other sexually transmitted infections (STIs).

*SisterReach*, based in Memphis, develops leaders through its interfaith advocacy program – Faith – which serves as the hub for outreach that provides resources to help ministry leaders and laity alike learn more about Reproductive Justice.

*SPARK Reproductive Justice Now*, based in Atlanta, develops the civic leadership of queer and trans youth of color living in the Southeast through its Fierce Youth Reclaiming & Empowering (FYRE) program and its FYRE Media Justice Camps.

*The Afiya Center*, based in Dallas, created the Young Black Women for Choice (YB4C), a project designed to develop young community leaders as ambassadors for the organization. YB4C aims to amplify Black women’s voices and shift the current narrative about Black women and the abortion care movement to one where Black women can own their power and are no longer made to feel ashamed.

*Women with a Vision*, based in New Orleans, started its Young Women with a Vision (YWWAV) weekly afterschool program to focus on high school-aged Black youth and provide more opportunities for leadership development. Their work with formerly incarcerated and high-risk women provides an opportunity for community leadership on key criminal justice reform issues.

And, *In Our Own Voice* is piloting our Next Generation Leadership Initiative, a two-year fellowship project to connect students at Historically Black Colleges and Universities (HBCUs) with our movement through work with Black RJ organizations in each of their respective cities and regions.

This work to build a national infrastructure to harness Black women’s political power and leadership potential is critical. Higher

*“Black women are leading efforts to promote positive social change, preserve and improve their communities, and prevent the perpetuation of violence and inequality... Despite these efforts and advancements, new research finds that Black women’s voices are the most likely to be overlooked in governmental policy-making.”*

Heights asserts that “Black women are leading efforts to promote positive social change, preserve and improve their communities, and prevent the perpetuation of violence and inequality... Despite these efforts and advancements, new research finds that Black women’s voices are the most likely to be overlooked in governmental policy-making.”<sup>2</sup>

A survey conducted by The League of Black Women to identify Black women’s views about leadership experiences and help eliminate the challenges they face in fulfilling their leadership potential<sup>3</sup> identified three key factors that increase Black women’s self-reported fulfillment and satisfaction levels with their personal and professional lives. These measures include: 1) *Engagement*, defined as connections with institutions and people that have the greatest impact on Black women’s lives; 2) *Cohesion*, the quality of Black women’s relationships with each other; and 3) *Bicultural Leadership*, the circumstances in which Black women lead or exude authority over others in the workplace.

While this survey focused on Black women in corporate settings, it is applicable in non-profits and social justice organizations as well. The findings speak to the critical need to address under-representation of

Black RJ organizations across the country; center opportunities for Black women, femmes, and girls to foster closer relationships and work together over the long-term; and end the isolation of Black women in white-led, mainstream, and/or allied organizations.

The voices of Black women are essential and our leadership is inherently intersectional. *In Our Own Voices*’ strategic partners create multiple points of entry for Black women, femmes, and girls who want to lead and serve as a pathway to advancing the broader Black RJ movement. The strategy of leadership development is intentional and includes opportunities for campaign organizing, media training, community outreach, board leadership, event planning, mentoring, coaching, and fundraising. Our leadership strategies are fundamental to achieve the desired impact of our community organizing, policy advocacy or culture change. It is vital for the Black RJ movement to foster the skills and talents of visionary leaders who are grounded in our collective herstory. At the same time, we must ensure that they have an arsenal of both skills and self-care methods to sustain our energy over the long-term, as well as systems of personal and professional support.

Black women, femmes and girls assert our leadership for all Black lives, and our movement boldly protects Reproductive Justice against acute threats to our human rights. Our presence and strategies here are examples of transformative leadership practices that are successfully shifting political power towards Reproductive Justice and increasing the representation of Black women in political leadership.

Our Black RJ movement has to build for the future across movements and sectors while we also address the urgency of now. Supporting the leadership of Black women – both cisgender and transgender – requires meaningful relationship-building. RJ organizations must be prepared to both meet the basic needs of those who desire to lead and connect them to resources that help them stay active within the movement in a holistic manner that affirms self-care. Our vision must extend twenty (20) years into the future to avoid cracks and gaps in the intergenerational leadership pipeline. The Black RJ movement must be bold and fearless in asserting our leadership in movements and a society that would prefer us to be silent. We must view our voice, our organizing, and our leadership as a revolutionary act to achieve Reproductive Justice and make the impossible possible.

*Our presence and strategies here are examples of transformative leadership practices that are successfully shifting political power towards Reproductive Justice and increasing the representation of Black women in political leadership.*

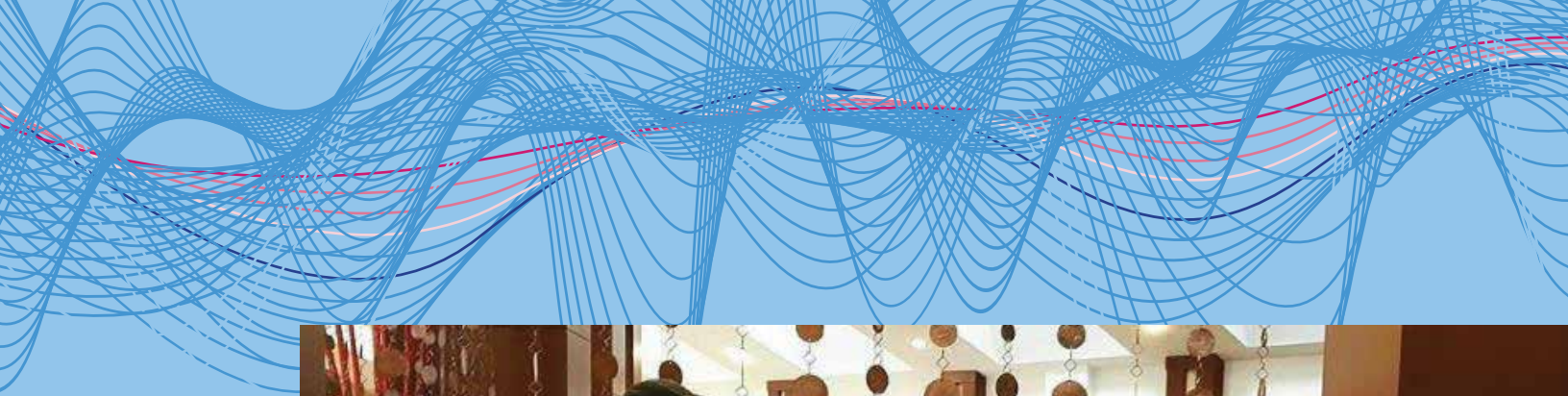


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# IV. Our Voices: An Agenda for Action







## CHAPTER 15

# Recommendations

**F**or two long years, we listened as Donald Trump used racism, religious intolerance, sexism, and xenophobia to win an election—never caring about the millions of Americans his bigotry hurt along the way. During that time he elevated white nationalists,<sup>1</sup> the Aryan Brotherhood, and the Klu Klux Klan to a national profile they have not had since the 1940s and, more problematic, he ushered in a new era of Jim Crow. Embedded in his slogan “Make America Great Again” is the implication that America’s multicultural, multiracial, and religiously diverse population has somehow destroyed our country.

Much has been made of his first 100 days in office, where he attempted much but achieved little. But for those of us in the Reproductive Justice Movement, it is the many months beyond the first 100 days that concern us. Trump’s budget threatens programs and services essential to Black communities. His cabinet appointments to the departments of Education, Health, Labor and Justice all share a commitment to roll back the many gains Black people have won over the years. All of us must stand up — resist attempts to turn the clock backward — and write our own narrative that will protect and enhance the lives of Black women and girls in the United States.

## Policy Recommendations

### THE AFFORDABLE CARE ACT AND BLACK WOMEN

- Protect and expand access to health coverage, particularly essential benefits, without cost-sharing.
- Ensure that low-income individuals and their families have access to tax credits and other cost-sharing reduction options that make health care affordable for those who are not eligible for subsidies.
- Maintain guaranteed access to contraceptive information, services, and devices for all Americans, regardless of where they live or work.

- Ensure that all women have access to the full range of reproductive health and family planning services, including abortion care.
- Fund research on health disparities and determinants of health that harm Black women's health outcomes, particularly around reproductive health.
- Ensure that people who have pre-existing conditions can access health care coverage without massive increases in their insurance premiums and/or other fees.

### **ABORTION RIGHTS AND ACCESS AND BLACK WOMEN**

- Ensure that Black women, especially those who live in underserved and rural communities, have access to culturally-appropriate reproductive health providers who listen to our concerns and treat us with respect and dignity.
- Expand access to medical abortion and telehealth services to increase access to abortion care, particularly for rural women.
- Eliminate restrictions that deny insurance coverage for abortion care at the state and Federal levels.
- Prohibit states from enacting anti-choice regulations that are designed to make abortion less accessible, including enacting legislation that erects barriers for abortion providers.
- Ensure medical students and health care professionals receive professional training to provide abortion care to women who need it.
- Expand access to abortion care

by training Nurse Practitioners, Certified Midwives, and Physician Assistants to provide these services.

### **CONTRACEPTIVE EQUITY AND BLACK WOMEN**

- Defend women's reproductive autonomy from coercive provider and family planning program practices.
- Ensure that all women are provided with complete information about contraceptive methods' safety, efficacy, risks, and benefits in order to guide their informed decision-making.
- Fund reproductive health and family planning programs and services on the local, state, and national levels.
- Eliminate financial, regulatory, and provider-based challenges to accessing contraception, including LARCs.
- Reject policy targets, goals, and other incentives that promote LARCs over other methods and/or restrict women's choice of contraception method.
- Safeguard women's reproductive autonomy by providing explicit resources and support for both initiation and discontinuation of LARCs (including device removal).
- Provide training and skills-building in delivering culturally effective care, so providers can recognize and eliminate bias and ensure provision of patient-focused contraceptive information, counseling, and services.

### **COMPREHENSIVE SEX EDUCATION AND YOUNG BLACK WOMEN**

- Adopt evidence-based, comprehensive sex education programs that empower Black youth with the knowledge, skills, and tools needed to safeguard their reproductive and sexual health throughout adolescence into adulthood.
- Ensure that educational content meets the National Health Education Standards, at a minimum, and is taught by a qualified teacher or other health professional.
- Implement age-appropriate, medically accurate, and LGBTQQ-inclusive HIV/AIDS and STI/STD health literacy and education programs in schools and communities.
- Ensure that sex education content includes and reflects the needs of LGBTQQ and gender non-conforming youth.
- Increase funding for comprehensive sex education programs and resources, and expand comprehensive sexual education in schools and communities.
- Develop and implement trainings for foster youth caregivers (including probation department and juvenile justice system staff) on sex education content, and youth sexual and reproductive health rights.
- Require sex education to be provided within the juvenile system, group homes, and other facilities where large numbers of youth reside.
- Support parental opt-out (vs. opt-in) policies for students to participate in sex education classes.

- Eliminate funding for harmful, ineffective abstinence-only-until-marriage programs.

## **FAMILY PLANNING AND BLACK WOMEN**

- Ensure that health care prioritizes a rights-based, self-determination approach for all women.
- Ensure that Black women are aware of and have access to the full array of high-quality family planning information and services, free from provider bias.
- Implement and support family planning programs that address Black women's experiences with and exposure to intimate partner violence and other forms of violence.
- Increase funding and support for research on racial, ethnic, and gender-preference health disparities, to guide development and delivery of evidence-based health care services that meet Black women and LGBTQQ individuals' needs.
- Expand the number and diversity of health care providers who serve Black women, to increase access to culturally effective care.
- Fund and support development of "multi-purpose prevention technologies" that protect women simultaneously from unintended pregnancy *and* STD/STIs, including HIV.
- Ensure that all health care providers have the education, training, and professional development needed to provide culturally effective care to Black women and LGBTQQ individuals.

## **MATERNAL HEALTH AND BLACK WOMEN**

- Expand programs that protect women's health throughout their lifetime and foster healthy pregnancy and post-partum outcomes for Black women and their babies.
- Support access to programs that identify and treat social disparities and other conditions that increase maternal mortality risks, including hypertension, diabetes, and obesity.
- Ensure that low-income women have access to health care that fully covers maternal health care.
- Support efforts to reduce the rate of cesarean delivery.
- Enable women who have given birth via cesarean to choose Vaginal Birth After Cesarean (VBAC); this choice should not be made by women's insurers or hospitals.
- Improve medical and family leave policies and support resources for young parents and other caregivers.
- Fund data collection and reporting on maternal morbidity and mortality across the country, including state-level maternal mortality data.
- Fund and support state maternal mortality review teams that assess all pregnancy-associated deaths in order to identify commonalities and possible solutions.
- Fund research that incorporates Black women's lived experiences into maternal health research and clinical trials to fully understand how our bodies respond to inter-

personal and environmental stressors during pregnancy and childbirth.

- Support educational efforts to improve the delivery of culturally effective care and ensure that Black women receive timely and accurate diagnosis and treatment for all conditions.
- Ensure that more Black health care professionals, including OB-GYNs, Certified Midwives and doulas, are trained to provide maternal care to Black women.

## **REPRODUCTIVE CANCER AND BLACK WOMEN**

- Ensure access to no-cost screening for breast and cervical cancers and HPV vaccines as part of overall health care coverage.
- Ensure access to breast cancer screening starting at age 40 with no cost-sharing or other barriers to access.
- Ensure access to cervical cancer screening every 3 years with no cost-sharing or other barriers to access.
- Expand education and programs that foster healthy lifestyles, including access to nutritious food, physical activity opportunities, and smoking cessation programs.
- Increase funding and support for research focused on prevention and treatment for ovarian, breast, and cervical cancers among Black women.
- Include more Black women in clinical trials and other cancer-related research efforts.
- Increase the number and diversity of health care providers who serve Black women.

## **REPRODUCTIVE JUSTICE AND LESBIAN, GAY, BI- SEXUAL, TRANS, QUEER, AND QUESTIONING (LGBTQQ) BLACK YOUTH**

- Fund research and data collection on the experiences of Black LGBTQQ youth in order to address barriers to care and foster patient-centered care, including sexual and reproductive health services.
- Create and promote materials that facilitate increased school programming on LGBTQQ sexuality, identity, and sexual health issues.
- Repeal laws and policies that specifically target LGBTQQ communities and increase the probability of over-policing, harassment, and unnecessary interactions with the juvenile and criminal justice systems.
- Support programs that help address poverty, disenfranchisement, and homelessness among LGBTQQ Black youth.
- Develop and support medical curricula that are based on Reproductive Justice principles for training of public health professionals in order to foster culturally effective health care.
- Expand the number and diversity of health care professionals who serve LGBTQQ Black youth.

## **SEXUALLY TRANSMITTED DISEASES AND INFECTIONS AND BLACK WOMEN**

- Ensure that routine screening for STD/STIs occurs as part of annual physical examinations and well-women check-ups.
- Support prevention options that enable women and girls to protect their sexual health without negotiating with, or getting permission from, others.
- Ensure full access to sexual and reproductive health care, including HIV/STD/STI prevention, screening, and services; contraception; and abortion care.
- Increase access to integrated sexual and reproductive health care that includes HIV prevention, treatment, and care services; gender-based violence, sexual violence and other trauma; and mental health and well-being services.
- Expand research efforts that include women across the spectrum of gender identity who are at-risk for HIV, in order to identify effective prevention, screening, and treatment methods.
- Improve gender equity in biomedical, social, and behavioral research efforts.
- Ensure that all health care providers have the education, training, and professional development needed to provide culturally effective care of HIV-positive women.
- Expand the number and diversity of health care providers who serve Black women, to increase access to culturally effective care.

## **BLACK WOMEN AND THE CRIMINAL JUSTICE SYSTEM**

- Demilitarize the educational system by removing police officers from schools and abolishing zero tolerance policies, which disproportionately affect Black students.
- Ensure that drug possession policies focus on higher-level distribution sources rather than low-level offenders.
- Implement effective treatment programs rather than using criminal sanctions against women who use drugs during pregnancy.
- Increase investments and support for substance abuse prevention and treatment programs, and provide additional options for community substance abuse treatment rather than incarceration, particularly for pregnant women.
- Implement and support correctional and diversion programs that sustain family ties among incarcerated mothers and their children, and prioritize family stability and rehabilitation over incarceration.
- Provide female- and gender-nonconforming-specific programs and services at each stage of the justice system, including sexual and reproductive care and mental and physical health services.
- Ban the practice of shackling pregnant women during transport, labor, delivery, and post-partum care.



## ECONOMIC JUSTICE AND BLACK WOMEN

- Support equal pay and closing the wage gap, in order to ensure that Black women receive equitable pay when doing the same job as white men.
- Provide working Americans with a living wage and increase the minimum wage.
- Support paid maternal/paternal and family leave policies for all employees.
- Support access to educational opportunities for low-income Black women, including scholarships and loan forgiveness.
- Provide opportunities for women to engage in mentoring, networking, and career counseling activities in the workplace.
- Implement management training, workplace policies, and advancement programs that foster Black women's participation and representation at the highest corporate levels, including senior management and Boards of Directors.
- Support policies that eliminate race and gender-bias in accessing capital, including bank accounts, loans, mortgages, etc. to promote economic stability.
- Reform the tax code so that it benefits all Americans, not just the wealthy.
- Invest explicitly in Black communities, including investments in housing, education, and employment.

## VIOLENCE AGAINST BLACK WOMEN

- Establish U.S. Department of Justice training for all Federal law enforcement officials, including all state and local law enforcement agencies that receive Federal funds, to focus on and address crisis interventions, mediation, de-escalation tactics, implicit bias, community relations and appropriate engagement with youth, women, people of color, LGBTQ individuals, non-English speakers, and people experiencing mental illness.
- Ensure that school officials and staff have training and skills on “trauma-responsive interventions”<sup>2</sup> that identify and address young victims of physical abuse, sexual abuse, and sexual exploitation.
- Fund advocacy programs and support services for victims of domestic violence or intimate partner violence to reduce the stigma attached to seeking help.
- Ensure that survivors of physical abuse, sexual abuse, and sexual exploitation have access to sexual and reproductive health care, including preventive care, mental health services, and abortion care services.
- Enable minors to receive sexual and reproductive health care (including abortion care services) without parental permission.
- Support research on violence's long-term impact on survivors, family members, and perpetrators.

- Implement strong standard of care guidelines for comprehensive sexual, reproductive, and mental health care for all incarcerated people to increase awareness of, and treatment for, histories of abuse, trauma, and violence.

# Black Reproductive Justice Organizations and Activists

## Call to Action

To make real policy change requires an engaged electorate that is committed to improving the lives of Black women and girls everywhere. For more than 20 years, Black women's Reproductive Justice organizations and activists have fought for an intersectional approach to changing the cultural narrative around Black women and girls.

To truly effect change, we must write our own narrative — setting forward our own principles — our own vision for the future. Following are some of the collective actions Black Reproductive Justice organizations and activists can implement within their states to protect the sexual and reproductive health, rights, and justice of Black women and girls.



## Organizational Actions

- Form partnerships with organizations across movements that work on economic justice, environmental justice, criminal justice and other social justice issues.
- Participate in local and state legislative visits or community events, to ensure legislators and decision-makers are aware of the needs of Black women and the larger community.
- Coordinate with relevant local advocates to develop legislation or resolutions that promote Reproductive Justice values.
- Support public information campaigns to raise awareness about how common, safe, and necessary abortion care is.
- Promote and endorse legislation that prohibits religion being used to discriminate and inhibit reproductive and sexual health choice
- Partner with faith-based organizations to educate faith leaders and communities about Reproductive Justice and its connection to spiritual and political lives.
- Engage in education, advocacy, training, and organizing with communities of faith on critical issues that impact the lives of vulnerable populations.
- Build authentic relationships that honor both the specific faith traditions and the lived experiences of the people in the pews.
- Within Black communities, meet our people where they are, across different stages of life, without judgment, to effectively organize them while maintaining accountability.
- Design opportunities for Black women, femmes and girls to lead through culturally relevant programs, convenings, trainings, workshops and experiences.
- Intentionally end the exploitation, tokenization, and transactional interactions of Black women, femmes, and girls for political gain in our Reproductive Justice work.
- Financially invest in the leadership of young Black activists in order to pursue new ideas and create new pathways to Reproductive Justice.
- Give young Black RJ leaders the time and space they need to develop their leadership voice, accepting that for some people, leadership comes naturally while for others, it takes intentional cultivation through trial and error and steadfast support.
- Create safe healing spaces where Black women and girls can access resources that promote dialogue, knowledge exchanges, and sharing personal and communal histories.
- Create and respect spaces that promote Black joy – the life force of our work and our movement.
- Utilize social media to call-out and/or thank Federal, state, and local legislators as they vote or introduce legislation that affects Black women and the larger community.
- Establish multi-faceted and interactive social media platforms within your organization that engage Black youth with accurate, non-judgmental health education that respects community cultural norms.
- Foster efforts to dismantle stereotypes and negative beliefs about individuals of different backgrounds and faiths.
- Work with teachers' associations in your state to support continuing education for elementary, middle school, and high school educators to ensure they are informed about research and best practices that support positive sexual and reproductive health education
- Repeal and reject school policies that marginalize and/or victimize victims of physical or sexual abuse and perpetuate the abuse-to-prison pipeline.
- Work with community advocates, residents, police and legislators to identify and implement efforts other than criminalization to address community problems.
- Foster coordinated responses across systems and agencies (e.g., corrections, community health centers, schools) to expand access to prevention information, testing and screening services, and early access to treatment.

## Individual Actions

- Follow In Our Own Voice on social media (Twitter: @Black-womensRJ, Facebook: *National Black Women's Reproductive Justice Agenda*).
- Sign up for In Our Own Voice's policy alerts and monthly newsletters (<http://blackrj.org/get-involved/rj-and-policy-change/>).
- Contact Black women's RJ organizations in your region to find out how you can support and become involved with the efforts to improve Black communities.
- Become educated and informed about the current policies and regulations in your city, county, and state that promote or restrict access to comprehensive, bias-free reproductive and sexual health for all.
- Identify your Federal, state and local legislators, and sign up for updates from their offices so that you are aware of their position on issues, how they vote, and legislation that they promote.
- Tell your story – Reproductive Justice is about the lived experiences of Black women and other women of color.
- For Black Reproductive Justice and social justice leaders, guard your health and well-being by any means necessary to sustain yourself over this lifetime struggle.

## References

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2. U.S. Department of Justice (DOJ), *The Impact of Incarceration and Mandatory Minimums on Survivors: Exploring the Impact of Criminalizing Policies on African American Women and Girls*, Washington, DC: DOJ Office on Violence Against Women, 2017. Online: <https://www.justice.gov/ovw/page/file/926631/download>.

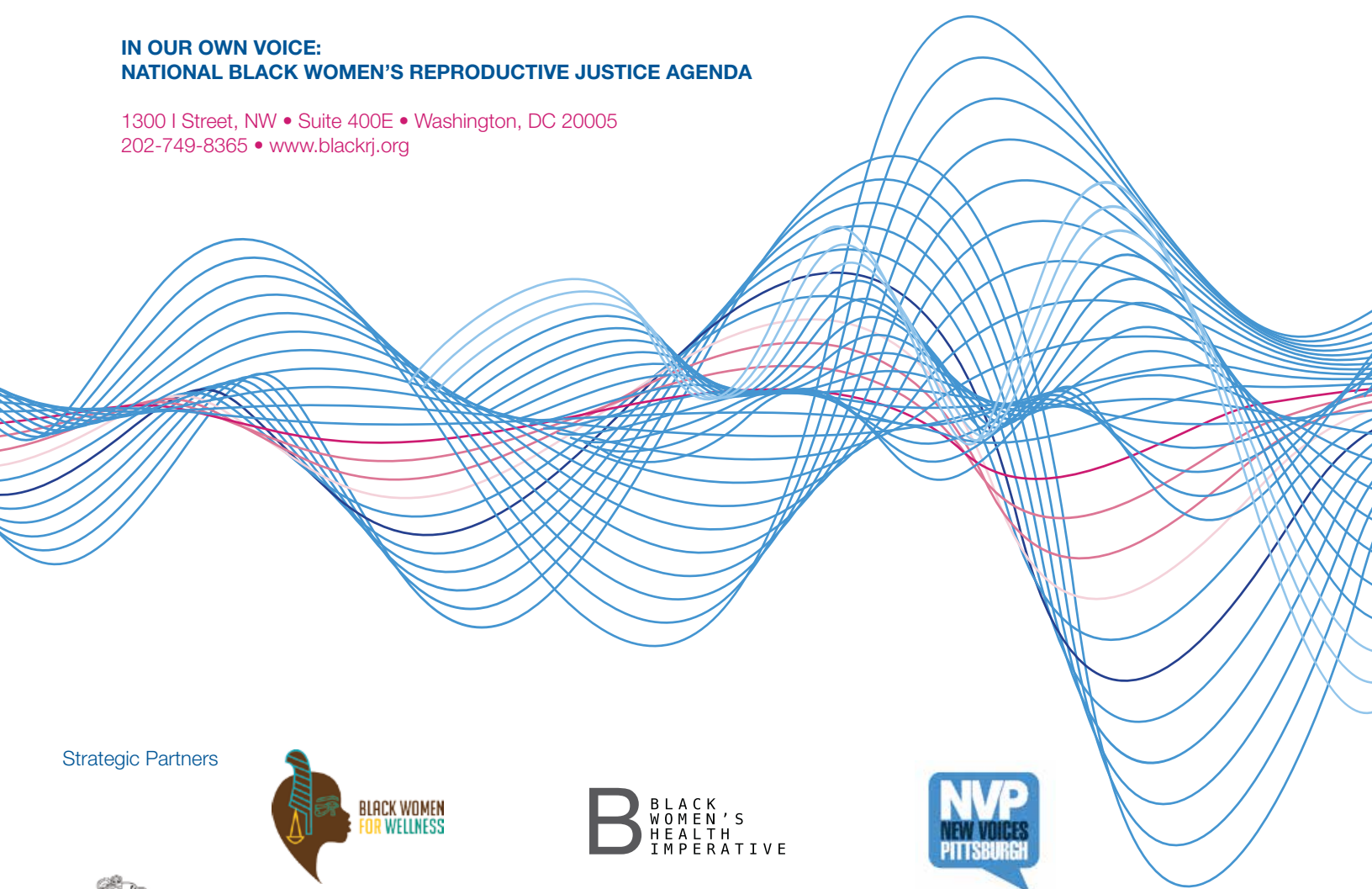
# voice

IN OUR OWN

National Black  
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## IN OUR OWN VOICE: NATIONAL BLACK WOMEN'S REPRODUCTIVE JUSTICE AGENDA

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