Secondary Source Materials

(Materials about the Right)
Enter the glass doors at 222 West 14th Street in New York City, and the chaos of traffic horns and tire-screeches, jackhammers, and concentrated humanity recedes into a hush. In the serene offices of Elizabeth Seton Childbearing Center, surfaces are awash in blue hues, the lighting is dim and the women at the desk are friendly and concerned. A receptionist is telling a nurse about a delivery the day before. The mother-to-be was getting a due-date manicure and facial and began having contractions during the appointment, the receptionist explained. “She said she wanted to look fabulous when she came in here to have the baby!”

At Elizabeth Seton, women are meant to feel fabulous, too. Oven mitts adorn the cold stirrups of the exam table. Clients are encouraged to labor wherever they like — each suite of birthing rooms contains a queen-size bed, a whirlpool bath and comfy chairs. Partners can assist the mothers or wait with family inches away in a room equipped with a kitchen where they can cook or have a party after the baby is born. Women giving birth have access to La Leche League (for breast-feeding support) and doulas (experienced mothers who assist new mothers), along with a midwife, a nurse and an acupuncturist. Other services include sibling preparation, infant massage and postpartum yoga. Gay mothers are welcome and make up a small percentage of Seton’s clientele. In short, Seton is a feminist’s dream.

Unless, that is, you need a tubal ligation after your childbirth, which is the best time to do the procedure. Or any sort of contraception, even family-planning counseling. Why? This birthing center, founded in 1996, receives funding from St. Vincent’s, a Catholic hospital. And Catholic hospitals do not condone these services.

Elizabeth Seton—a midwifery clinic built on the principles espoused by Our Bodies, Ourselves and which claims to offer “full scope, woman-gynecology[al] services”—is not alone in its restrictive practices. Catholic HMOs, hospitals and affiliates, which together play an ever-larger role in healthcare delivery, are effectively eliminating virtually every health-related feminist victory of the past thirty years. The “Ethical and Religious Directives”—Catholic healthcare’s seventy commandments, drafted by the Church’s American Bishops—prohibit abortion, birth control, most vasectomies, tubal ligation and the morning-after pill even for rape victims. The result is a healthcare system that effectively bypasses not just Roe v. Wade but Griswold v. Connecticut, the 1965 Supreme Court decision that allowed married couples to seek contraception.

Legislative tolerance of such restrictions is growing. The 1997 Balanced Budget Act applies the "conscience clause"—which originally meant that individuals would not have to perform procedures (such as abortions) to which they have moral objections—to the institution of managed care. As a result, health plans for federal employees may opt not to include reproductive care on religious or moral grounds. In South Dakota pharmacists are legally allowed to deny a woman a prescription if they have reason to believe it will be used to terminate a pregnancy.

Yet, to understand why midwifery clinics like Elizabeth Seton choose to play dumb when asked about birth control, one has to look beyond the antifeminist legislative climate to the changing face of our healthcare system. Hospitals fall into three categories: federal (such as Veterans Affairs hospitals), for-profit and nonprofit—including religious-affiliated and secular institutions. According to the records of the Catholic Health Association, 10 percent of nonfederal hospitals and 15 percent of nonfederal hospital beds are Catholic. And Catholic hospitals are the largest nonprofit healthcare provider. The Catholic Church currently owns five of the ten largest hospital corporations—amounting to more than 800 hospitals and healthcare systems and caring for more than 70 million patients.

Most significant, more and more hospitals are merging in an effort to cut costs, and when one of the two joining forces is Catholic, its practices frequently become the new standard. In the past few years, 40 percent of some 5,200 nonfederal hospitals have either merged or entered into an agreement to do so. Catholic hospital networks are expanding the most rapidly through mergers, with one survey observing a 12 percent growth rate among participating systems in 1997. According to a study by the nonprofit social justice group Catholics for a Free Choice, in the past eight years nearly one hundred mergers have occurred in which a non-Catholic hospital has aligned with a Catholic hospital. In half of those instances, reproductive health services have remained largely unchanged (that is, intact at the formerly non-Catholic facility, and still nonexistent at the formerly Catholic one), while in the other half such services have been either cut back or wiped out completely.

"This is stealth elimination," says Susan Berke Fogel, legal director of the California Women's Law Center, a nonprofit spearheading an aggressive campaign to bring attention to Catholic encroachment on reproductive freedom. She is most galled by the Catholic Church's assertion that because its hospitals are nonprofits rather than businesses, they are exempt from antidiscrimination law. A recent California Supreme Court decision ruled in favor of a Catholic hospital that was sued for not complying with fair employment laws. "Look, I don't argue with the importance of allowing hospitals to be nonprofits so that the communities will reap the benefits rather than shareholders," says Berke Fogel. "But that shouldn't be license to discriminate, either in the types of services they provide or in hiring based on race or gender."

Berke Fogel also points out that Catholic hospitals, far from being autonomous, are drawing much of their funding from federal sources such as Medicaid and Medicare. "The reality is that they are accumulating huge amounts of money that is exempt from taxation," she says. "We, the taxpayers, are subsidizing their expansion. Their revenues aren't required to go back into healthcare but can go into religious institutions. The public is simply not benefiting from these transactions." For example, the nuns who operate the Daughters of Charity, the largest owner of Catholic hospitals, commanded a pot of $2 billion in cash and investments as of March 1998. A reproductive health ideology that would work only for a celibate (or for the barefoot and pregnant) seems rather out of touch with women's needs. But low-income women disproportionately depend on Catholic hospital care, and as Catholic HMOs proliferate, they are serving a growing number of Medicaid patients—a "very frightening prospect for low-income women," says Berke Fogel.

Whether poor women should be subject to the morals of the Vatican was the question put forth on a recent crisp fall morning in Manhattan, as New York City hustled forward with its rollover into mandatory managed care for 1.2 million Medicaid beneficiaries, two-thirds of whom are women. Pro-choice advocates and reporters gathered at City Hall on October 27 to give testimony in support of a bill to protect women on Medicaid from being auto-assigned (if the beneficiary doesn't choose a plan within a given time frame) into plans that don't directly provide contraception and family-planning services. Unfortunately the bill—opposed by the mayor as well as by Fidelis, a major Catholic HMO that wouldn't be able to comply with its provisions—is unlikely to pass.

When advocates talk of the merger crisis, they often remark on the dangerous blurring of the line between church and state. Yet groups such as the California Women's Law Center and New York's Center for Reproductive Law and Policy have not found such constitutional arguments very effective. Although there have been gains in the courts in some states—as in the recent New Mexico Supreme Court decision that medically necessary abortions for Medicaid recipients must be covered because of the state's Equal Rights Amendment—there is no legal precedent for protesting denial of access on the basis of the US Constitution. "Look, the law is not on our side," says Frances Kissling, president of Catholics for a Free Choice. "No hospital—Catholic or non-Catholic—is required to perform an abortion, and most of them don't. They're not required to provide contraception or reproductive healthcare. The only thing a hospital has to do is treat a patient who comes in through the door in a life-threatening situation."

Leaving aside for a moment that denial of reproductive care can have catastrophic consequences, what if a woman's situation is life-or-death, in conventional terms? When Elliot Hospital in Manchester, New Hampshire, went Catholic in May 1998, Dr. Wayne Goldner was refused permission to perform an emergency abortion to a patient after her water broke at fourteen weeks. She was forced to ride eighty miles in a taxi to Hanover.
to have the procedure. Goldner, who has spoken out on the issue and for whom abortion is a small fraction of his practice, has had his house picketed and lost his teaching position, and there was a bomb threat at his young daughter’s school. And last September Michelle Lee, a 26-year-old awaiting a heart transplant, was denied an emergency abortion in Louisiana, amid disagreement over whether she faced the 50 percent chance of death required for the procedure by state law. The Louisiana State University hospital that turned her down is not Catholic but has a conservative religious culture. “At a lot of hospitals,” says Maureen Britell of the National Abortion Federation, “whether they’re Catholic or not, the board of directors has a strong link to a Catholic or religious organization.”

Catholics for a Free Choice has been tracking the mergers for years and has perhaps the most comprehensive analysis of how activists should respond. The CFFC approach is pragmatic: Mergers are a trend that will continue. Therefore, people concerned about women’s healthcare should either try to block the mergers or make sure that access to abortion and contraception is mandated in the deal structure. Services are preserved when the community and the doctors stand firm, Kissling says. A CFFC report also cites ways in which doctors and administrators have worked the system by creatively interpreting the Church’s Directives. Strategies include setting aside an area of the facility for reproductive health services or having a “virtual merger”—“a close collaboration that does not merge assets or establish one governing body.”

CFFC’s approach takes into account an often overlooked nuance of the merger issue, which is that there can be a flip side to glorifying procreation: At some Catholic hospitals, a woman having a baby is treated like the Virgin herself. Staffers at Elizabeth Seton stress that they want the center to be aligned with St. Vincent’s, emphasizing its thoughtful, pro-mother care. “This is a besieged profession,” adds Pat Burkhardt, the former clinical director of Elizabeth Seton, now director of New York University’s Nurse-Midwifery Program, “and St. Vincent’s is consciously pro-midwife,” whereas many secular hospitals are not. She believes that pro-choicers in Catholic institutions simply become adept at working the system. “There are hospitals out there that quietly make referrals,” says Burkhardt. “You don’t want to get the news out because that would get them shut down, but, you know, Catholic women have for years chosen to ignore the Pope and the Catholic hierarchy’s stance on birth control.”

There is still the question of why, in at least half the Catholic/non-Catholic mergers, the secular hospitals roll over so quickly, observes Catholics for a Free Choice’s Kissling, who opened the first abortion clinic in New York’s Westchester County nearly thirty years ago. “I would expect the Catholic hospital to get its values, as bad as they are, visible in the merged institution,” she says. “But where is the non-Catholic hospital in standing up for women’s rights?”

Bring up women’s rights, and many defenders of the hospitals in question respond with a blank stare. It isn’t about sexism, they say, it’s about cost. Reproductive care is just too expensive.

Obviously that’s not the right question—we are talking about access to basic health services—but for the sake of argument, are contraception, tubal ligation, vasectomy and abortion profitable?
Like any medical treatment, in and of themselves, they’re not. But according to a 1997 study by Planned Parenthood of New York City, the money saved in terms of prevention is enormous. Among the findings are that for every 1,000 members who receive contraception, the managed-care organization will save $1.2 million annually for pregnancy-related care averted. A 15 percent increase in the number of oral contraceptive users in a health plan would produce enough savings in pregnancy costs alone to provide oral contraceptives for all users in the plan. Birth control pills and exams cost between $285 and $804 per patient per year, while the average cost of delivering an unintended pregnancy is $3,200.

Even so, some question whether reproductive care is “medically necessary,” the sine qua non of insurance reimbursement. “About 60 percent of women access healthcare through these services,” responds Alice Berger at Planned Parenthood of New York City in an “Is the Pope Catholic?” tone. Furthermore, she says, it’s ultimately quite costly for the insurance companies if women don’t get the services. “The sequelae are unintended pregnancy, STDs, later-term abortions, cancer that’s not detected early enough—very serious stuff that translates into big dollars,” Berger says.

Yet the majority of commercial plans do not provide reversible family-planning methods in their benefits, which means millions of women are paying out of pocket for diaphragms, the pill and condoms. In fact, women spend 68 percent more on healthcare per year than men do—this, while symmetrically making around 70 cents to the male dollar. And then there’s the fact that just five weeks after the erection-helper Viagra became available, nearly half of the 270,000 very expensive prescriptions sold were paid for by some form of insurance. Meanwhile, although Congress forbids abortions in military hospitals even if the servicewoman pays for the procedure out of pocket, the Washington Feminist Faxnet reported in early October that the Pentagon earmarked $50 million to bankroll Viagras for US troops and military retirees. Is potency a medical necessity? I guess God knows, because according to Brian Mulligan at the Catholic Healthcare Network, even the Vatican supports Viagra.

The bright spot in the bleak landscape: A proposed merger in Kingston, New York, between a Catholic and a secular hospital fell apart, largely due to community-based resistance to the threatened loss of reproductive services. Citizens held rallies, wrote hundreds of letters to the editor, signed petitions and decorated the town with lawn signs that read “PEOPLE OF ALL FAITHS USE OUR HOSPITAL!” Lois Uttley, director of the Merger Watch project, which coordinated community efforts, was thrilled with the victory. But it drove home the lesson that advocates of reproductive freedom, who are accustomed to focusing on legal rights, now have to fight in new arenas. “New York is a pro-choice state—on paper,” says Uttley, who, in alliance with the California Women’s Law Center, was awarded a Ford Foundation grant to expand her community organizing efforts nationally. “But we have four regions in this state where access is in peril right now. We can no longer focus purely on legislation.”

After Dr. Barnett Slepian, an OB-GYN who performed abortions, was slain in his Buffalo-area home by a sniper with a high-powered rifle, representatives from various reproductive rights organizations tossed around the scary facts and figures. Two-thirds of all OB-GYNs who perform abortions are over the age of 65 and will soon be retiring; in 84 percent of US counties, there are already no providers. The precedent has been set to treat abortion and related services as unseemly and therefore marginalized to easily targeted women’s clinics. Doctors who perform abortions are picked out of their crowd of peers and terrorized. An OB-GYN at the Cleveland Clinic told me that while he is personally pro-choice, he wouldn’t have a public profile as such, because he believes that the atmosphere in his community (medical and otherwise) would not defend a doctor who supported reproductive freedom. “I am counting on others to take the risk,” says the doctor, who asked not to be identified. “And I fear that I am part of the problem by not standing by this procedure that I want to have available, but won’t do myself.”

As abortion opponents focus on providers, so must abortion rights supporters. “Most of the people in my school now were born at or around the time of Roe v. Wade,” says Kiersta Kurtz-Burke, a student at Tulane who is also the national coordinator for the Southeast region of Medical Students for Choice. Besides pushing medical schools to include training in the very simple abortion procedure, MSC also raises historical consciousness by screening the Dorothy Fadiman documentary When Abortion Was
Illegal and bringing in older doctors to recount tales of the days when fifty women might be in the septic ward due to botched illegal abortions. MSC also tries to bridge the fact that most medical students are pro-choice and yet few want to take on what they see as a harrowing life as a provider. “Providing abortions can be integrated as a small part of your family practice,” says Kurtz-Burke. “You might have a regular patient who at some point doesn’t want to be pregnant.” In the next couple of years, the first waves of some 5,000 doctors belonging to MSC will be setting up family and OB-GYN practices across the country. Meanwhile, doctors aren’t the only hope for women needing abortions. The National Abortion Federation reports that in New York, which has no “physician only” law, physician assistants (PAs) are providing abortions. Vermont has a long history of PAs doing abortions with as good an outcome, if not better, as those performed by doctors. Nurse practitioners can also be trained in the procedure in Vermont, and just a few months ago, the first modern midwife was trained in surgical abortion. With nonsurgical “medical” abortion on the not-so-distant horizon (RU 486 is due here in late 1999), even more midlevel healthcare providers will be able to terminate an unwanted pregnancy.

Feminists of the second wave declared that women would never be free unless they could control their own bodies, a fierce belief that became law in 1973. But Congress doesn’t have to ban abortions if the American Medical Association treats the procedure as beyond the bounds of medical training. The Catholic Church doesn’t have to bother swaying the opinion of the majority of Americans who believe in a woman’s right to choose if it owns the hospital they go to. Strategies for attaining reproductive human rights have changed with the times, shifting away from a focus on legislation and the courts and toward community organizing and consciousness raising. But after all the years of feminist struggle, we face a grim and familiar reality: Women are getting screwed.
ELLEN GOODMAN

RU-486 – still stalled

It’s been stuck on the tarmac for so long that now RU-486 sounds like the flight number of a plane taken hostage. And that’s not far from the truth.

RU-486, otherwise known as mifepristone, is the drug developed in the 1980s by a French doctor so women could choose a nonsurgical abortion very privately and very early in pregnancy.

In the past dozen years, 500,000 French women have used it safely and effectively. It’s been distributed to 20 other countries, ranging from the United Kingdom and Finland to Greece and Israel. But RU-486 remains grounded in America.

For a while, everyone blamed the weather. RU-486 couldn’t take off because of “the climate.” During the Reagan and Bush years, the political turbulence was so great it was simply banned.

But when Clinton was elected the slides became friendly. In 1993 the new president promised to bring the pill here. Yet it took years to complete the required clinical trials, however redundant, and more years to find a manufacturer.

During this time, the pro-life movement changed tactics. It went from trying to make abortion illegal to trying to make it impossible. The number of clinics performing abortions shrank to 2,000. Today, 86 percent of counties have no providers at all.

Clinton has come and almost gone, and just months before the scheduled approval date the FDA has apparently come up with yet another set of restrictions that could keep the drug off the runway. In a recent meeting in the endless negotiating process, we are told, it added some doozies:

Only doctors who perform surgical abortions will be allowed to use mifepristone. And only doctors who have privileges at hospitals less than an hour away.

Caution is fine. I don’t want an FDA that’s blase about health risks for women. But the new restrictions for this drug are out of all proportion.

RU-486 is meant to provide an early medical alternative to surgical abortions. And to increase access for many women, especially in rural counties.

Today, one-quarter of women travel 50 miles or more to obtain an abortion. A recent Kaiser study said that one in three gynecologists who don’t currently perform abortions would prescribe mifepristone but the more restrictions the FDA adds, the fewer doctors would sign on.

Under these restraints the pill would be available only at the same facilities by the same providers. Women would have to travel to the same distant clinics, run the same prolific gantlets. So much for the privacy of a doctor’s office.

There is no medical reason for such limits. The FDA does not normally determine which doctors can provide which drugs. You can get Viagra from your ophthalmologist.

As for the requirement that the doctor be near a hospital? Mifepristone is a safe drug with very few side effects. Only 5 percent of the women who take this pill need further treatment. In essence, it produces a miscarriage. Yet no one makes location rules for doctors who deal routinely with miscarriages.

“It’s very reasonable for the FDA to be concerned about safety, but they go way overboard in regulating the practice of medicine,” says Dr. Eric Schaff, who conducted some of the trials.

Why? He says, bluntly: “I suspect the FDA people are positioning themselves to retain their jobs depending on who becomes the next president.”

In short, the motives are not medical but political. Indeed, the FDA approval deadline for RU-486 — up or down — is Sept. 30, right in the middle of the presidential campaign.

After seven years, the Clinton administration hasn’t come through on one of its earliest promises. Meanwhile, Bush the Second will be running on a Republican platform that in essence labels abortion a capital crime.

Ironically, for almost two decades RU-486 has been the best hope of running the endless public and political struggle over abortion. It offers women the possibility of making a decision early and privately with their own doctor.

The entire argument has been stuck way too long. It’s time for the traffic controllers at the FDA to let RU-486 off the ground.

Ellen Goodman is a Globe columnist.
Physicians’ Statement on Late-Term Abortion

by Seymour Romney and Jodi Magee

The Society of Physicians for Reproductive Choice and Health urges state legislatures and Congress not to ban an abortion procedure known medically as dilation and extraction. As physicians, we are concerned by any inappropriate government efforts to intrude in the confidential patient-doctor relationship. By limiting medical options, legislation banning dilation and extraction can result in physical harm to our patients.

Legislation banning this procedure shifts the focus from an effective therapeutic procedure, in what are frequently tragic personal circumstances, to a contentious political debate. We agree with the American College of Obstetricians and Gynecologists that any legislation that criminalizes a medically established procedure is unwarranted. The resulting laws would pre-empt a recognized surgical treatment choice that only skilled physicians, in consultation with their patients, are qualified to make.

In complex obstetrical situations, dilation and extraction is the safest procedure to use. It carries the least risk of bleeding, perforation, infection or trauma to the birth canal, potential post-surgical complications that a physician must consider to preserve a woman’s ability to have future healthy pregnancies.

The decision to recommend this medically indicated procedure depends upon expert medical judgment and therapeutic assessment. These decisions require a careful evaluation of the patient’s physical and emotional health and recuperative abilities; knowledge of proven therapeutic alternatives and their risks; and the woman’s informed consent.

Legislators are not qualified to make clinical decisions about the medical management of complicated obstetric conditions. Such decisions are a physician’s responsibility within the privacy of the confidential doctor-patient relationship. Legislation that censors therapeutic options will undermine and compromise the quality of medical care and may result in needless injury and death.

No thoughtful woman or doctor makes the decision to have or perform an abortion — or any surgical procedure — lightly. There is no justification in this difficult personal health decision for interference by legislators. As physicians, we are professionally obligated to assure the health of our patients. We are also ethically bound to speak out against any efforts by legislators to limit medical options for non-scientific reasons.

Seymour Romney, M.D., is Chair and Jodi Magee is Executive Director of The Society of Physicians for Reproductive Choice and Health, a national organization that believes physicians have an ethical and moral responsibility to ensure that everyone has the knowledge, access to quality services, and the freedom of choice to make their own reproductive health care decisions.

For information, contact PRCH at 212-673-1118, fax 212-724-2270.
Abstinence-only Programs Get the Big Bucks

By Annya Shin

Teens all over the U.S. are about to be inundated with the message that abstinence from sexual activity is “the only certain way” to avoid pregnancy and sexually transmitted diseases (STDs), thanks to a little-known provision of the 1996 Welfare Reform Act. The provision, originally dreamed up by folks at the Heritage Foundation, a conservative “think” tank, and attached to the welfare bill with almost no debate, guarantees that federal and state governments will shell out a combined total of $78 million a year for the next five years on education efforts that promote abstinence exclusively. The provision’s supporters also made sure that states can’t use a dime of the new money to mix the strict abstinence message with information about contraception and STD/HIV prevention, an approach that research indicates is effective in preventing teen pregnancy.

The provision’s teeth come in the form of a rigid eight-point definition of abstinence education. Programs that receive the new funds must teach “abstinence from sexual activity outside marriage as the expected standard for all school-age children,” that “a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity,” and that “sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects.” The fact that there’s no conclusive evidence that abstinence-only education has any effect on teen pregnancy rates was of little concern to the statute’s drafters.

The eight guidelines for abstinence education have put state Maternal and Child Health Bureau (MCHB) officials, who are in charge of allocating the new funds, in a bind. “MCHB officials are doing their best to make lemonade out of lemons,” said Daniel Daley, director of public policy for the New York City-based Sexuality Information and Education Council of the United States (SIECUS). Fortunately, state officials got a break from the federal MCHB. The agency has allowed states to emphasize different portions of the abstinence education definition as long as the result doesn’t contradict any other part of the definition. Given this leeway, many state officials have chosen to focus on the least controversial planks of the definition, such as encouraging teens to abstain from sexual activity until they’re self-sufficient. Voilà! Lemonade!

State officials, in dealing with the new law, have to come up with hefty state matching funds. Some public health experts worry that cash-strapped states may shift funding for comprehensive sexuality education to abstinence-only initiatives in order to get the federal money. It’s too soon to tell whether the money will provoke more school districts to adopt fear-based abstinence education curricula such as “Choosing the Best,” published by an Atlanta company that promotes abstinence-based sex education programs. Comprehensive sexuality education advocates have criticized such curricula for terrorizing teens with images of advanced STDs and advising them to wash their genitals with Lysol after intercourse.

The family values crowd has criticized the way several states are using their abstinence education funds. The conservative group Focus on the Family is spearheading an effort by an assortment of right-wing groups, including Phyllis Schlafly’s Eagle Forum, to pressure state health officials into following all eight federal guidelines for abstinence education. If conservatives succeed, MCHB officials could find themselves in hot water. The House Ways and Means Committee is considering holding hearings in the next few months looking into how the abstinence education money is being spent.

Annya Shin is a freelance writer based in Washington, D.C.
AFRICAN-AMERICAN WOMEN FOR REPRODUCTIVE FREEDOM

Choice is the essence of freedom. It's what we African Americans have struggled for all these years. The right to choose where we would sit on a bus. The right to vote. The right for each of us to select our own paths, to dream and reach for our dreams. The right to choose how we would or would not live our lives.

This freedom—to choose and to exercise our choices—is what we've fought and died for. Brought here in chains, worked like mules, bred like beasts, whipped one day, sold the next—244 years we were held in bondage. Somebody said that we were less than human and not fit for freedom. Somebody said we were like children and could not be trusted to think for ourselves. Somebody owned our flesh and decided if and when and with whom and how our bodies were to be used. Somebody said that black women could be raped, held in concubinage, forced to bear children year in and year out, but often not raise them. Oh, yes, we have known how painful it is to be without choice in this land.

Those of us who remember the bad old days when Jim Crow rules and segregation were the way of things know the hardships and indignities we faced. We were free, but few or none were our choices. Somebody said where we could live and couldn't, where we could work, what schools we could go to, where we could eat, how we could travel. Somebody prevented us from voting. Somebody said we could be paid less than other workers. Somebody burned crosses, harassed and terrorized us in order to keep us down.

Now once again, somebody is trying to say that we can't handle the freedom of choice. Only this time they're saying African-American women can't think for themselves and, therefore, can't be allowed to make serious decisions. Somebody's saying that we should not have the freedom to take charge of our personal lives and protect our health, that we only have limited rights over our bodies. Somebody's once again forcing women to acts of desperation, because somebody's saying that if women have unintended pregnancies, it's too bad, but they must pay the price.

Somebody's saying that we must have babies whether we choose to or not. Doesn't matter what we say, doesn't matter how we feel. Some say that abortion under any circumstance is wrong, others say that rape and incest and danger to the life of the woman are the only exceptions. Doesn't matter that nobody's saying who decides if it was rape or incest, if a woman's word is good enough, if she must go into court and prove it. Doesn't matter that she may not be able to take care of a baby, that the problem also affects girls barely out of adolescence, that our children are having children. Doesn't matter if you're poor and pregnant—go on welfare or walk away.

What does matter is that we know abortions will still be done, legal or not. We know the consequences when women are forced to make choices without protection—the coat hangers and knitting needles that punctured the wombs of women forced to seek back-alley abortions on kitchen tables at the hands of butchers. The women who died screaming in agony, awash in their own blood. The women who were made sterile. All the women who endured the pain of makeshift surgery with no anesthetics and risked fatal infection.

We understand why African-American women risked their lives then and why they seek safe, legal abortion now. It's been a matter of survival. Hunger and homelessness. Inadequate housing and income to properly provide for themselves and their children. Family instability. Rape. Incest. Abuse. Too young, too old, too sick, too tired. Emotional, physical, mental, economic, social—the reasons for not carrying a pregnancy to term are endless and varied, personal, urgent, and private. And for all these pressing reasons, African-American women once again will be among the first forced to risk their lives if abortion is made illegal.

There have always been those who have stood in the way of our exercising our rights, who tried to restrict our choices. There probably always will be. But we who have been oppressed should not be swayed in our opposition to tyranny of any kind, especially attempts to take away our reproductive freedom. You may believe abortion is wrong. We respect your belief and we will do all in our power to protect that choice for you. You may decide that abortion is not an option you would choose. Reproductive freedom guarantees your right not to. All that we ask is that no one deny another human being the right to make her own choice. That no one condemn her to exercising her choices in ways that endanger her health, her life. And that no one prevents others from creating safe, affordable, legal conditions to accommodate women, whatever the choices they make. Reproductive freedom gives each of us the right to make our own choices and guarantees us a safe, legal, affordable support system. It's the right to choose.

We are still an embattled people beset with life-and-death issues. Black America is under siege. Drugs, the scourge of our community, are wiping out one, two, three generations. We are killing ourselves and each other. Rape and other...
unspeakable acts of violence are becoming sickeningly commonplace. Babies linger on death’s door, at risk at birth: born addicted to crack and cocaine, born underweight and undernourished, born AIDS infected. An ever-growing number of our children are being abandoned, being mentally, physically, spiritually abused. Homelessness, hunger, unemployment run rife. Poverty grows. Our people cry out in desperation, anger, and need.

Meanwhile, those somebodies who claim they’re “pro-life” aren’t moved to help the living. They’re not out there fighting to break the stranglehold of drugs and violence in our communities, trying to save our children or moving to provide infant and maternal nutrition and health programs. Eradicating poverty isn’t on their agenda. No—somebody’s too busy picketing, vandalizing, and sometimes bombing family-planning clinics, harassing women and denying funds to poor women seeking abortions.

So when somebody denouncing abortion claims that they’re “pro-life,” remind them of an old saying that our grandmothers often used: "It’s not important what people say, it’s what they do." And remember who we are, remember our history, our continuing struggle for freedom. Remember to tell them that we remember!

**Original Signers:**
Byllie Avery (National Black Women’s Health Project)
Rev. Willie Barrow (Operation Push)
Donna Brazile (Housing Now)
Shirley Chisholm (National Political Congress of Black Women)
Representative Cardiss Collins (U.S. Congress)
Romona Edelin (National Urban Coalition)
Jacqui Gates (National Association of Negro Business and Professional Women’s Clubs, Inc.)
Marcia Ann Gillespie (Ms. Magazine)
Dorothy Height (National Council of Negro Women)
Jewel Jackson McCabe (National Coalition of 100 Black Women)
Julianne Malveaux (San Francisco Black Leadership Forum)
Eleanor Holmes Norton (Georgetown University Law School)
C. Delores Tucker (DNC Black Caucus)
Patricia Tyson (Religious Coalition for Abortion Rights)
Maxine Waters (Black Women’s Forum)
Faye Wattleton (Planned Parenthood Federation of America)

**Additional Signers in 1994:**
Tony M. Bond
Sen. Carol Moseley-Braun (D-IL)

Rep. Corrine Brown (D-FL)
Rep. Eva Clayton (D-NC)
Rep. Barbara-Rose Collins (D-MI)
Rev. Alma Crawford
Evelyn S. Field
Rev. Catherine Godbolt
Rev. Dr. Claudia Hightbaugh
Beverly Hunter
Rev. Elenora Giddings Ivory
Bernice Powell Jackson
Terri James
Rep. Eddie Bernice Johnson (D-TX)
Bisola Marigny
The Rev. Dr. Joan Martin
Cassandra McConnell
Rep. Cynthia McKinney (D-GA)
Rep. Carrie P. Meek (D-FL)
Mary F. Morten
Cynthia Newbille
Mary Jane Patterson
Loretta Ross
Jerald Lillian Scott
Beverly W. Stripling
Elizabeth Terry
Mable Thomas
Winnette P. Willis
Kim Youngblood

Note: Organizations are given for identification purposes only.

Human Life International: Promoting Uncivilization

By Sandi Dubowski

Human Life International, the anti-choice movement’s largest international network with 84 branches in 56 countries, is a leading trainer ofactivists, and certainly the largest distributor of literature and paraphernalia. HLI’s “millions of brochures, flyers, booklets, books, posters, films, videos, cassette tapes, newsletters, postcards, fetal models, and rosaries” are not only ubiquitous, but “almost all given gratis.” These materials include the graphic “Freedom of Choice??” postcard, which features the mutilated head of a fetus held over a petri dish. In 1994 alone, HLI trained thousands of activists in the U.S. (California, Ohio, and cities that include Detroit, Minneapolis, Philadelphia, Orlando, St. Louis, and Tampa) and cities and countries worldwide including Auckland, Brisbane, Chile, Dublin, Moscow, Paris, and Winnipeg. Thus HLI is a pivotal if not always obvious force in the anti-choice movement.

Led by Fr. Paul Marx since its founding in 1981, HLI has become a vehicle for extremism—threatening constitutional democracy, as well as the rights of women, gays and lesbians, Muslims, Jews, and people with HIV/AIDS worldwide.

Unsurprisingly, a wake of controversy has always followed HLI and Fr. Marx. Marx was ousted from the Human Life Center he had founded in 1980 at St. John’s University and Abbey in Minnesota. Parishioners have walked out of Marx’s homilies, and he has been banned from some Catholic schools. HLI’s application for official recognition was rejected by the United Nations for “attacks on Islam,” its stance “against the purposes of the United Nations,” their “aggressive language,” and the “issue of tolerance.” Even Catholic leaders have denounced HLI.

Although Marx has stepped down from the Presidency, he remains Chair of HLI, and the organization goes on headed by Fr. Matthew Habiger. Here is a list of concerns about HLI that have arisen over the past year:

- Anti-Semitism: “The same segment of the Jewish community that accuses the Pope of insensitivity to the Jewish Holocaust,” claims Marx, “is using a typical distribuee, ‘not only condones but has more or less led the greatest holocaust of all time, the war on unborn babies.’” In light of the suffering chronicled in Jewish history, such as the anti-Semitic blood libel that blames Jews for the murder of Christian babies, “alleged to use their blood in Passover matzo” such statements are more than merely disturbing. When criticized for singling out Jews, HLI’s response was “such Jews [the pro-abortion ones] are disloyal to the teachings of Judaism.” “Real Judaism is pro-life and all pro-lifers are ‘spiritual Semites,’” said Marx.

- Abortion and Rape: HLI believes there “can never be any justification” for abortion “even in so-called ‘hard cases.’” (rape or incest). “(Y)ou lose the ballgame,” says Marx, “because every woman is going to say she was raped.”

- Exporting Anti-Abortion Extremism: HLI advocates militant “rescue” tactics, including blocking women’s health clinics, and supports Operation Rescue. “ ‘Rescue’ militants Joseph Scheidler and Bishop Austin Vaughan are among HLI’s USA advisors. Convicted felon Joan Andrews has taught “Rescue Tactics” at HLI World Conferences. HLI helped mount Canada’s first major clinic blockade in connection with its 1988 World Conference in Toronto. Forty people, including Fr. Marx, were arrested when “150 pro-lifers from Canada and the United States” “effectively closed down” a clinic by “blocking both front and rear entrances.” There were thirty-one arrests in connection with HLI’s 1989 Conference in New Orleans, and 29 arrests related to HLI’s 1990 conference in Miami.

- Non-violence: Although HLI is sometimes explicit in its statements of non-violence, its actions and statements are contradictory. “Just as a military force needs dozens of different kinds of personnel to wage one war,” says Marx, “so also our war against the anti-life demons calls for many kinds of combatants.” He continues, “We need militant groups such as the Pro-Life Action League of Chicago’s incomparable Joe Scheidler, which shuts down abortion mills with picketing.” As far back as 1983, Fr. Marx refused to leave a Toledo, Ohio clinic and feigned taking photos of patients along with Marjorie Reed, who then had been arrested four times and is now serving 10 years in jail for fire-bombing a clinic in that city. HLI President Fr. Matthew Habiger, while denouncing anti-choice violence, recently spoke at an anti-Koe v. Wade rally in Washington, DC sponsored by the American Coalition of Life Activists, whose leaders, Andrew Burnet, David Crane, Joseph Foreman, and Michael Dodds, have deemed killing abortion providers “justifiable homicide.”

- John Salvi and Conspiracy Theories: Prior to John Salvi’s violent rampage in Brookline, Massachusetts, which left two clinic staff dead and five wounded, Salvi distributed gory color photos of fetuses that he obtained from HLI. Rev. Sviokla of Immaculate Conception Church in Everett, MA, said Salvi had “wanted to distribute these hideous pictures” at his church. He refused, “They provoke disgust and violence,” he said. HLI claims that Salvi is “a stranger to us.” Interestingly, Salvi released a statement from jail alleging Masonic persecution of the Catholic church. “Why do the Freemasons persecute the Catholic people?” asked Salvi. “Because their [sic] good at it.” Where did he get such ideas? He may very well have gotten them from HLI, which publishes and distributes conspiracy literature about the Masons. Fr. Marx himself warns that bishops, health ministers, cardinals, and presidents have been Masons.

- Homosexuality and AIDS: HLI supports anti-gay bigotry in the person and work of Paul Cameron, who has been denounced by the American Sociological Association and dropped from membership by the American Psychological Association.
for violating the preamble to it's ethical principles. HLI distributes Cameron's literature, and has featured him as a speaker at its conferences. Fr. Marx himself is on the Advisory Board of Cameron's Family Research Institute. Cameron is notorious for having advocated branding "AIDS victims on the face" with a letter A and proposing "elimination of the carrier" as a solution to the AIDS epidemic. He has also said, "The No. 1 public health threat in the world today is homosexuality, not AIDS. Either we destroy homosexuality, or we will die." 

- Family Planning and Sexuality Education: HLI opposes every form of family planning and sex education that does not conform to its peculiar notion of Catholic doctrine. One HLI book, for example, declares, "Sex Education is by nature and by design intrinsically evil...and seeks to undermine the teaching authority of the Church...." However the book also claims that the principal promoter of classroom sex education in the United States is the U.S. Catholic Conference!

- Islam: "Moslems will take over Western Europe," declares Fr. Marx, and "if you're not a follower of Mohammad you are an enemy...they will kill you to please Allah." Unsurprisingly, HLI's 1995 conference features a talk titled "The Moslem Threat to the World."

- Democracy: HLI's featured speaker at its 1994 conference was Randall Terry, who received standing ovations for his demagogic challenge to rise up and make America a "Christian nation" under "Biblical law."

All this might be dismissed as the ravings of a fringe group, except that HLI has built a formidable international network. Its leaders and literature have a significant and profoundly divisive influence. HLI has also recently embarked on a $2.9 million fundraising campaign to build a new headquarters on 82 acres in Front Royal, VA. Their capacity to distribute literature and media designed to attack civil discourse with conspiracy theories, scapegoat Jews and Muslims, demonize gays and lesbians, and roll back the gains of women—needs to be taken seriously by all those who believe in reproductive health, religious tolerance and freedom, and a pluralist democratic society. 

3. $40,000 worth of material was shipped to Ireland in a campaign to prevent the legalization of abortion in that country, "HLI boasts Irish efforts," HLI Report, these guy posters were used by Youth Defenders, the shock troops of the anti-abortion movement in Ireland, who picked the bones of pro-choice politicians. See "Irealist young men see shock troops of the anti-lobby," The Daily Telegraph, October 26, 1992, Mairead Robinson, "Rise of the milities," The Times, October 12, 1992.
8. "Moslems get NGO status, HLI is shut out," HLI Reports, December 1993 UN Press Release, Dept. of Public Information, March 26, 1993
21. Why Don't You Join with Other Pro-Life Groups? (Or: What HLI Does That No One Else Can)" by Fr. Paul Marx, pamphlet, HLI.
34. Fr. Paul Marx, speech at HLI World Conference, Irvine, California, April 1994.
Armed and dangerous

CHIP BERLET

Many people assume that John C. Salvi 3d must be unbalanced -- after all, what other explanation can there be for a person who allegedly sprays health clinics with bullets leaving death and destruction? Salvi’s other reported actions add to this public assumption. He quotes the biblical book of Revelations; he meets with a Catholic priest and demands to distribute lurid photographs of aborted fetuses, charging that the Catholic Church is not doing enough to stop abortion; he confronts his parish on Christmas Eve for failing to live up to his interpretation of the Catholic faith and its obligations; he embraces violence while participating in a movement that calls itself profile.

The courts will decide if Salvi is competent to stand trial, but each of his actions and statements can be traced to specific theological and political arguments promoted by organizations in the Boston area and nationwide.

The photographs of fetuses distributed by Salvi come from Human Life International, a right-wing Catholic antiabortion group with a chapter in Massachusetts. HLII promotes a highly didactic vision of Catholicism that is critical of liberal Catholics around the issues of abortion, sex education, homosexuality and feminism. HLII distributes books with titles such as “The Feminist Takeover,” “Ungodly Rage: The Hidden Face of Catholic Feminism,” and “New World Order: The Ancient Plan of Secret Societies.”

The last book promotes the longstanding conspiracy theories of ultraconservative and far-right groups. Under the umbrella of the little-known “Patriots” movement, groups that fear a “New World Order conspiracy” held a meeting in November at Burlington High School. Speakers included John Birch Society stalwart Samuel L. Blumenfeld, Sandra Martinez of Concerned Women for America and leading antiabortion organizer Dr. Mildred Jefferson. Both the Birch Society and CWA are active in the antiabortion movement. Jefferson is in leadership roles in both the National Right to Life Committee and Massachusetts Citizens for Life. Salvi attended at least one meeting of Massachusetts Citizens for Life and met with several of its leaders.

While Jefferson spoke, attendees browsed three tables of literature brought by Den’s Gun Shop in Lakeville. One book offered instruction in the use of the Ruger .22 rifle, the weapon allegedly used by Salvi. Other books contain diagrams on how to build bombs and incendiary devices. One title was “Improved Weapons of the American Underground.” You could even purchase the book “Hunter” by neo-Nazi William Pierce of the National Alliance. “Hunter” is a book about parastic Jews destroying America and the need for armed civilians to carry out political assassinations to preserve the white race. Leaflets from the National Alliance attacking the New World Order and “minority parasites” have been appearing in Cambridge, Somerville and other Boston-area communities.

One speaker, Ed Brown, runs the Constitutional Defense Militia of New Hampshire. Brown passed out brochures offering “Firearms Training, Combat Leadership, Close Combat, and Intelligence Measures.” Brown is part of the growing armed militia movement, which is the militant wing of the Patriots movement. Several months ago Planned Parenthood held a press conference in New York, where it released information about a Patriots meeting in Wisconsin, where antibortion activists and armed militia proponents shared the podium.

A key figure in training armed civilian militias was the featured afternoon speaker at the Burlington meeting, Robert K. Spear, the author of “Living Under the New World Order” and “Surviving Global Slavery.” According to Spear, we are living in the “end times” predicted in the book of Revelations.

True Christians will be asked to make sacrifices to defend their faith and prepare the way for the return of Christ. Spear’s plan is the formation of armed Christian communities.

The idea that we are in the end times is growing in right-wing Christian evangelical circles. While predominantly a Protestant phenomenon, there are small groups of doctmatic and charismatic Catholics that also are embracing end times theology. Like Salvi, they point to the book of Revelations. Spear cited Revelations 13, the prophecy that in the end times, Christians will be asked to accept the Satanic “Mark of the Beast” and reject Christ. These views are hardly marginal on the Christian Right. Pat Robertson, a leading figure in the religious right whose Christian Coalition is credited with helping elect many Republican congressmen, has been emphasizing end times themes on the TV program “700 Club.”

On the fringes of the antibortion movement are groups that argue that it is morally justifiable to kill abortion providers. In recent years the most militant antibortion groups have been influenced by the theology of Christian Reconstructionism or dominion theology, which argue that true Christians must physically confront secular and sinful society and return it to God. Through predominantly composed of right-wing Protestants, a similar movement among doctrinaire Catholics has emerged. The trajectory of Philip Lawler from the editorship of the Catholic publication The Pilot to the Catholic League for Religious and Civil Rights to Operation Rescue is one example of this drift toward militancy. Last spring Salvi joined 800 antibortion demonstrators outside the Planned Parenthood clinic in Brookline, where pamphlets were circulated citing Operation Rescue estimates that 18,000 abortions were performed annually at the facility.

There is no evidence that Salvi attended the Patriots meeting in Burlington or that the rhetoric or ideas of any of the groups or individuals mentioned directly influenced his actions. The fact remains, however, that there is a growing right-wing social movement that uses theological arguments to encourage direct confrontation of its targets and tolerates discussions of armed resistance. Its adherents scapegoat abortion providers, gays and lesbians, feminists, even environmental activists. Some have called feminists who support abortion rights “femi-Nazis” and argued that abortion is a genocide worse than that of Hitler. One slogan is “If you really think abortion is murder, then act like it.”

For some who hear this message, all that’s left is to pull the trigger.

Chip Berlet is an analyst at Political Research Associates.
Anti-Choice, Anti-Child

One of the favorite tactics of pro-lifers—especially ones who are self-described "progressives"—is to accuse abortion rights supporters of being anti-child, hyperindividualistic, unwilling to protect the vulnerable and generally in favor of "death." The truth is almost the opposite.

Around the world, there's a general correlation between the availability of abortion and social concern for the well-being of children, as an upcoming publication from the Center for Reproductive Law and Policy vividly suggests. The fifty nations that permit abortion regardless of a woman's reason for wanting one include countries with the world's most extensive social provisions for children—Norway, Denmark, Sweden, the Netherlands, Canada. The anti-choice camp is full of countries with astronomical infant mortality rates, no free schooling and no commitment to poor kids. Cuba, the only country in Latin America that permits abortion without restriction, has universal free healthcare and education, and the lowest infant mortality rates in that region. In anti-choice Egypt, Haiti, Guatemala, Indonesia, Paraguay and Brazil children live on the street.

In Europe, Poland restricts abortion while simultaneously embracing free market policies that consign ever more children to poverty. Ireland, which bars abortion except to save the mother's life, included in its Constitution the comment that women serve the state from within the home but didn't institute free secondary schooling until 1967. As for "death," the list of anti-choice nations dovetails nicely with the list of countries with capital punishment. Unfortunately, few Americans know or care what goes on outside God's own country, so the fact that the Republican platform calls for replicating the abortion laws of such child-friendly nations as Afghanistan and El Salvador gets little attention.

Now comes Jean Ruth Schroedel, associate professor of political science at Claremont Graduate University, whose findings test whether opposition to abortion in the United States is motivated by concern for children or by a desire to restrict and control women. In her forthcoming book, *Is the Fetus a Person? A Comparison of Policies in the Fifty States*, Schroedel sets out three criteria. If states that restrict abortion care about protecting children, born and unborn, she theorizes, one would expect them to treat the fetus as a "person" in other areas of the law; to be more likely than pro-choice states to adopt policies to combat prenatal drug use and third-party killings (physical violence by someone other than the woman that results in fetal death); and to support wide-ranging benefits for children. If, on the other hand, their stance relates to antipathy toward women's equality, one would expect to find that abortion states do not consistently treat the fetus as a person in other areas of the law; that women's political, social and economic status is lower than in pro-choice states; and that they are not more likely to have policies benefiting children.

"The data," Schroedel writes, "showed that anti-abortion states do not consistently value fetal life." (Surprise!) They are far more concerned with drug use by pregnant women than with the battering and killing of pregnant women—the main way men harm fetuses. Schroedel finds that even states with weak pro-choice policies are more likely to criminalize third-party fetal killings than states with either weak or strong anti-choice policies. In six of the most stringent anti-choice states, it is not even a crime for a third party to kill a fetus—but drug users can be prosecuted for murder if the pregnancy goes awry.

Is there a relationship between the abortion laws of a given state and the status of its women? "The evidence was quite clear," Schroedel writes. The lower women's status—as measured by education levels, ratio of female to male earnings, percentage of women in poverty, percentage of female legislators, and state mandates that insurers cover minimum hospital stays after childbirth—the more stringent the abortion laws. This follows the global pattern. As in Iran (no abortion even to save the mother's life) or in Louisiana, the state with the most restrictions (twenty-three).

What about kids? Despite much anti-choice rhetoric about the need to protect the weakest and most vulnerable, Schroedel found that anti-choice states are "far less likely than pro-choice states to provide support for the poorest and most needy children." They spend less money per child on a range of services, from the adoption of special needs children to foster care to welfare to education. This follows the oft-noted pattern in Congress, where pro-choice legislators tend to support measures benefiting children, and anti-choice legislators tend to support tax cuts for rich people.

 Schroedel's findings also support the pro-choice quip that anti-choicers' concern for children begins with conception and ends with birth, as well as the pro-choice contention that retrograde views of women—for example, that only mothers are responsible for children—shape the ways anti-choicers seek to "protect" the fetus. While Schroedel is careful not to deny the sincerity of pro-life lawmakers (I'm more cynical—too many anti-choice politicians were pro-choice before the Christian right got going), she finds "virtually no support" for the antiabortion claim that opposition to abortion is all about caring for kids.

Empirical research is a wonderful thing.

***

*Unjust in the Much: The Death Penalty in North Carolina*, edited by Calvin Kytle and Daniel H. Pollitt (my uncle), collects talks from a 1998 symposium of North Carolinians involved in fighting the death penalty. You don't often hear grassroots voices like these in the death penalty debate—local lawyers, clergy and activists talking simply and from their own experience about poverty and racism, about police who persuade retarded people to make false confessions and about court-appointed lawyers who show up drunk to trial. Such abuses have caused the American Bar Association to call for a moratorium on the death penalty, but *Unjust in the Much* (the title is from Luke 16:10) also argues for opposition on principle. Order the book from Geoffrey Mock, 1008 Lamond Avenue, Durham, NC 27701 (geoff@dukenews.duke.edu).
A LETTER FROM RELIGIOUS LEADERS

A Letter to Pro-Life Religious Leaders from the Religious Coalition for Reproductive Choice

January 1995

As religious leaders who support abortion rights, we applaud the Archbishop of Boston’s recent call for a moratorium on protests at reproductive health clinics as a strong first step in de-escalating violence. As we commit ourselves to dialogue marked by mutual respect, we hope that all religious people who oppose abortion will carefully examine the language they use and condemn rhetoric that dehumanizes abortion providers and pro-choice advocates.

We do not wish to silence religious leadership. Indeed, it is the sacred duty of all religious people to speak out against that which their religious traditions inform them is immoral and unjust. Yet leadership demands responsibility. To speak out forcefully and passionately against actions or policies one believes to be unjust and immoral is at the core of being American. But to dehumanize and demonize those with whom one disagrees is to set the stage for violence.

For example, when leaders compare abortion to the Holocaust, abortion providers to Nazis, and anti-clinic terrorists to resistance fighters, they cross the line that separates passionate debate from inciting violence. Those who have used such rhetoric have actively contributed to a climate and a culture that views anti-abortion violence as righteous resistance and retribution.

Pro-life leaders must now call to task those among their movement (Continued on page 6

This article was originally published in the Winter, 1994/1995 edition of ProChoice IDEA, the newsletter of the PorChoice Resource Center, which provides trainings, publications, and other resources to the pro-choice grass roots – www.prochoiceresource.org.
Continued from page 5
whose dehumanizing rhetoric has encouraged violent and unstable individuals to harm God’s children. We strongly encourage anti-abortion leaders and followers to protest in ways that affirm all life—not only potential life but also the lives of women and their health care providers. Responsible action and language on all our parts can begin to restore civility to the nation’s debate on abortion and end the violence that has come to surround this issue.

Dr. Thom White Wolf Fassett
General Secretary
General Board of Church and Society
United Methodist Church

The Reverend Dr. Paul Sherry
President
The United Church of Christ

The Reverend Elenora Giddings Ivory
Director, Washington Office
Presbyterian Church, USA

Rabbi David Saperstein
Director
Religious Action Center of Reform Judaism
Union of American Hebrew Congregations

The Reverend Dr. John Buehrens
President
Unitarian Universalist Association

The Most Rev. Edmond L. Browning
Presiding Bishop
The Episcopal Church


My name is Katherine Hancock Ragsdale. I am an Episcopal priest and the national president of the Religious Coalition for Reproductive Choice, a 21-year-old organization that is proud to call itself prayerfully pro-choice.

Who speaks for religious America?

Is it Randall Terry, or Pat Robertson, or Jerry Falwell? No. It’s the United Methodist Church, and they’ve been pro-choice since 1976. It’s the Episcopal Church—we’ve had a policy since 1967. It’s the Presbyterian Church of the United States of America. The United Church of Christ, the Union of American Hebrew Congregations, the Unitarian Universalist Association, and even the Reorganized Church of Jesus Christ of the Latter Day Saints—Mormons—with a policy dating to 1974. These are the voices of religious America and they are pro-choice.
Your Most Valuable Ally May Be Your Local Clergy

by Ann Thompson Cook

...let us witness that the Holy One continually sets before us life and death, and that choosing life is a much more complex and conscious undertaking than unquestionably accepting pregnancy. Let us bear witness that choosing to carry a pregnancy to term can be heroic, and choosing to terminate a pregnancy can be likewise heroic. She who must make the decision needs the support of her community.

—Dr. Paul Sherry and Dr. Mary Sue Gast, the United Church of Christ, in a statement responding to the murder of Dr. David Gunn.

Faced with continuous opposition, harassment, and even violence by Bible-quoting anti-abortion activists, pro-choice activists are hard pressed to realize the level of support for abortion rights in the religious community. The truth is that many of the most popular religious groups—including Presbyterian (USA), United Metho-
dist, Episcopal, United Church of Christ, Christian Church (Disciples of Christ), and a range of movements within Judaism—have official pro-choice positions.

Nevertheless, religious opponents to abortion rights have succeeded in framing the debate. Seldom are pro-choice religious organizations offered an opportunity to refute religious based anti-abortion arguments. Even our pro-choice allies perpetuate the perception that this is a battle between the religious and secular communities. Yet to label religion as the enemy is to ignore the reality—and history—of religious support for reproductive rights.

Clergy Leadership

The clergy has provided vital leadership by counseling those in the community. Because of their experience with referring women to health services, many members of the clergy were drawn to political action to legalize abortion. Indeed, they were some of the most active voices and most-quoted media sources for the pro-choice movement during those years.

Shortly after the Supreme Court ruled on Roe v. Wade, an interfaith group of religious activists founded the Religious Coalition for Abortion Rights to challenge the Catholic bishops' and religious right's attacks on legalized abortion. The Coalition has grown to 34 national religious organizations representing 14 denominations, each of which has an official pro-choice position. They are joined by 55 state and local affiliates across the country that lobby state legislatures, conduct peaceful presence at clinics, and provide all-options clergy counseling. In order to reflect a concern with a broader range of reproductive health concerns, the Coalition recently changed its name to the Religious Coalition for Reproductive Choice.

Refusing To Be Silent

For the 90's, the Coalition's top priority is to reclaim the religious ground on reproductive freedoms, including abortion. To do that, we're designing a nationwide media campaign—getting religious voices heard in local, national and denominational media. This past summer, for example, during Operation Rescue's Cities of Refuge campaign, the Religious Coalition placed op-eds in the Dallas Morning News and the San Jose Mercury News and was featured in an article in the Philadelphia Inquirer. Our board president, the Reverend Katherine Hancock Ragsdale, appeared on NBC Nightly News condemning Operation Rescue's tactics as blasphemy.

The emergence of religiously identified pro-choice activists has, of course, fueled further opposition by those who would prefer that religious progressives remain silent. Rabbis, ministers, and pro-choice congregations have been targeted for anti-abortion harassment. To protest clergy's pro-choice stance, anti-abortion activists around the nation have picketed clergy homes, issued death threats, disrupted worship services, targeted congregations which have abortion providers as members, and condemned pro-choice educational programs held inside religious facilities.

Refusing to back down in the face

Continued on the next page
of the opposition, congregations are getting more and more creative in expressing their pro-choice commitment. For example, an Iowa synagogue held an interfaith service to unite religious people in opposition to anti-abortion harassment of their rabbi. A Baptist congregation in Denver opened its doors for clinic defense training in preparation for the Pope’s visit. A Philadelphia Unitarian Universalist congregation provides weekly defense of a clinic. And during 1992, seven prominent African American clergy proclaimed their support for a woman’s right to choose in the Coalition’s national newsletter.

Reach Out!

How can you tap the pro-choice religious energy in your community?

• Call the Coalition’s national office: 202-628-7700. We can direct you to an affiliate or contact persons in your area.

• Contact faith groups that you have heard are strongly pro-choice, such as Jewish reform synagogues and Unitarian Universalist congregations. They are likely to know pro-choice clergy and laity from other denominations as well, and the Christian clergy—who are always under pressure not to be vocal on the issue—may be more willing to join their peers than to go out on a limb by themselves.

• Find out who in your network attends a synagogue or church. You may be surprised how many do. As we travel around the country talking to religious people, we find that many of them are already active in local chapters of NOW, NARAL and Planned Parenthood, and/or have worked on an IDEA project.

Once you’ve developed your pro-choice religious contact list, consider these suggestions:

• Respect clergy as professionals and make it easy for them to participate. While they may not have time to sit on boards, they are often available to sign on to statements of support and to attend press conferences.

• Social action committees of local congregations are often available to mobilize volunteers. Often these committees are more progressive than the congregation as a whole and are already active in many progressive causes. (And are prime candidates for participation in an IDEA project.)

Perhaps the most important consideration in joining hands with religious people is to understand that, like most Americans, religious people have mixed feelings about abortion itself. And of course, religions have various points of view about when abortion is right or wrong. It is precisely because of such differences that the Religious Coalition is committed to leaving the decision to the woman. People of faith work on this issue because a genuine commitment to justice and to religious liberty demands that abortion remain legal.

To counter the opposition’s false and punitive claims on religion, religious people—perhaps you are one—must speak out, in the name of religion, and in support of women choosing whether and when to have children.

Ann Thompson Cook is National Director of the Religious Coalition for Reproductive Choice in Washington, D.C.

We apologize for the following errors in the appendix of our recent publication ProChoice IDEA: How Grassroots Pro-Choice Groups Fought the Opposition—and Won:

The work of Missourians for Choice was incorrectly attributed to the Reproductive Health Clinic.

Also, the work of South Carolina Voters for Choice/Spartanbug was incorrectly attributed to a different Spartanburg group.

For a complete listing of these, and 62 other projects, send for a copy of An American IDEA: An Anthology of ProChoice IDEA Projects.
Cracking open CRACK: Unethical sterilization movement gains momentum

By Judith M. Scully

"We don’t allow dogs to breed. We spay them. We neuter them. We try to keep them from having unwanted puppies, and yet these women are literally having litters of children." These are the words of Barbara Harris, a 47-year-old homemaker from Stanton, California, who has started an organization called Children Requiring a Caring Kommunity (CRACK). Despite its benevolent name, CRACK's primary goal is to promote population control by paying $200 to women with substance abuse problems who can document that they have been sterilized or are using long-term birth control such as Norplant, Depo-Provera or an IUD.

Since its founding in November 1997, Harris' nonprofit organization has reached 158 women, 91 of whom were permanently sterilized by tubal ligation. To solicit "clients," CRACK has placed large billboards in Black and Latino communities in Los Angeles. The billboard advertisements offer to pay $200 to drug users in exchange for their sterilization. Some of the billboards simply say, "Don't Let A Pregnancy Ruin Your Drug Habit." Others read, "If You Are Addicted To Drugs, Get Birth Control—Get $200 Cash." To promote its sterilization campaign, CRACK plans to place more billboards in dozens of other cities nationwide.

In addition to its headquarters in Fresno, California, CRACK opened a chapter in Chicago in July 1999 and Houston in January 2000. The organization is planning to open chapters in Seattle, Las Vegas, Dallas, St. Louis, Denver, Pittsburgh, Atlanta, San Diego, Cleveland, and Florida. Women in Rhode Island and the Lakes Region of New Hampshire have also been introduced to CRACK.

Funded by private donations, CRACK distributes its literature to foster parents, police, social workers, probation officers, hospital workers, church leaders and others who "may know someone who is
taking drugs.” In addition to the $200 cash incentive, CRACK offers an extra $50 for referrals of other substance-abusing women.

So far, CRACK has received an enormous amount of publicity. In 1999 alone, CRACK has been the focus of thirty television interviews, four magazine articles and several newspaper articles. Unfortunately, most of the publicity has painted the group in a positive light. George Annas, chairman of the health law department at Boston University School of Public Health, has stated, “If the state of California was doing this, then people would be beside themselves, but because a private nonprofit organization is doing this, then it doesn’t seem quite as scary.” Annas’ comment leads one to question why it is that private institutions are not held accountable to rights issues in the same way as public ones. Should the public be contemplating mechanisms of democratic control which subordinate the interests of private groups to human rights concerns, now that social welfare and charitable programs are increasingly carried out by private, non-profits?

Like earlier sterilization movements in the United States, CRACK’s program is based in eugenic philosophy. In CRACK’s own words, its primary goal is to “put an end” to “drug babies.” CRACK vows to eliminate children born with drug addictions from the population because, according to CRACK, these kids cost the taxpayers too much money when they wind up in special education classes, foster care and/or state sponsored nurseries. But one has to wonder what really is the difference in terms of the cost to society between a disabled child born to a drug-addicted woman and a disabled child born to a physically or mentally disabled woman? If the cost to society is really the issue, as CRACK claims it is, the “logical” extension of this argument would be to expand the sterilization campaign to all of society’s “burdens” — the poor, the disabled, the homeless, as well as the drug addicted. Does society really need to be reminded of the consequences of such thinking?

Reminiscent of the eugenic sentiments of birth control advocate, Margaret Sanger, who sought “to assist the race toward the elimination of the unfit” (Sanger, Margaret, *The Birth Control Review*, Vol.3, No.2, pg.11), CRACK seeks to diminish the number of “undesirables” from the overall population. Although its goal is to eliminate the segment of the population born addicted to drugs, CRACK claims that it is saving children.

CRACK claims that its agenda is not racist because it will “serve” any woman who has a substance abuse problem — but the facts speak for themselves. The statistics produced by CRACK itself indicate that a disturbingly disproportionate number of women of color have been affected by CRACK’s sterilization campaign. Of the 158 women who were either temporarily or permanently sterilized, approximately 60% of them were Black or Latina. And if $200 is a sufficient incentive for them to take the drastic action of becoming sterilized, these women are obviously earning low or no incomes. Thus, CRACK’s program also has a disproportionate effect on women in poverty.

The fact of the matter is that CRACK’s strategy is specifically designed to entrap low-income women of color and to eliminate their “problem children.” Like William Shockley, the notorious eugenicist and scientific racist, CRACK promotes the concept of offering cash bonuses to women who “agree” to be sterilized. Shockley’s proposal would have based the amount of cash a woman could receive on so-called “scientific” estimates of disadvantaged hereditary factors such as heroin addiction, diabetes, epilepsy, and low IQs. Like Shockley, CRACK seeks to eliminate the disadvantaged rather than eliminating the social conditions which cause disadvantage.

CRACK’s sterilization campaign, like the sterilization campaigns of the not-so-distant past, poses a serious threat to the reproductive rights of all women, not just those who are currently targeted.
In the 1930’s, twenty-seven states enacted compulsory sterilization laws targeting the mentally and physically disabled as well as those who were convicted of committing crimes. An estimated 60,000 Native-Americans, African-Americans, mentally and physically disabled, and poor persons were sterilized as a result of these laws. Although these laws were successfully challenged by the end of the 1930’s, by the 1940’s private organizations and foundations became the main force behind the sterilization movement. Among these private donors were the American Eugenics Society, Hugh Moore (of Dixie Cup Corporation) and the Rockefeller Foundation.

By the 1970s, it was estimated that between 100,000 and 150,000 low-income women were sterilized annually under federally funded programs. Many of these women were improperly coerced into accepting a sterilization operation under the threat that their welfare benefits would be withdrawn. In 1974, the United States District Court in the District of Columbia ruled in the Relf v. Weinberger case that such practices would no longer be tolerated. The court declared that “federally assisted...sterilizations are permissible only with the voluntary, knowing and uncoerced consent of individuals competent to give such consent.” The court further noted that “Even a fully informed individual cannot make a voluntary decision concerning sterilization if he has been subjected to coercion.”

In the CRACK sterilization program, women are improperly coerced by cash incentives during a time in their lives when they are addicted to drugs and therefore clearly vulnerable. Consent obtained through cash coercion does not constitute voluntary or informed consent. Consequently, CRACK’s program is not only unethical but it may be illegal in so far as it has decimated the foundation for informed consent.

Currently, individuals who receive free sterilizations under Medicaid sponsored programs must give their “informed consent” to the sterilization. Such consent must be evidenced by a written and signed document indicating that the patient is aware of the benefits and costs of sterilization. In addition, these sterilizations are permissible only with the voluntary, knowing and uncoerced consent of the woman. It is difficult to imagine how anyone can honestly claim that informed consent exists in a sterilization scenario where cash incentives are being offered to low-income drug-addicted women.

In addition to the informed consent problems raised by the CRACK sterilization program, one must question how anyone can support a program that endorses a structure in which the economically privileged can and do dictate who will and who won’t have children. Who among us is entitled to purchase the elimination of a particular segment of the population? One has to wonder why is it that CRACK is being praised rather than admonished for its sterilization program. Have we reached a point in our society, where eugenics is once again an acceptable practice?

CRACK’s troublesome social engineering agenda also imposes substantial health risks and obstacles to substance abuse treatment.

In its drive to “protect” the as yet unconceived children of women with substance abuse problems, CRACK places its targeted population at risk from potentially serious health conditions. CRACK offers an extremely limited “choice” of contraceptives for which it is willing to pay cash. Tubal ligation, Norplant, Depo-Provera and the IUD are either permanent or semi-permanent methods that do not protect against HIV. By promoting Norplant and Depo-Provera, CRACK encourages women on drugs to put even more chemicals, which are associated with strong side effects, into their bodies. Women addicted to drugs and on low incomes are likely to already suffer from poor health conditions, inadequate access to health care, and risks of exposure to HIV and other STDs. The
high-tech, birth control “options” compensated by CRACK require health care screening for contraindications, and monitoring for side effects, which poor women are unlikely to receive. The fact that these methods provide no protection against HIV and STDs is especially worrying given the intersection between substance abuse and HIV exposure. 20 percent of the approximately 890,000 people infected by HIV in the US are women, and a major subset of them are Black and Latina women. By promoting methods that do not protect against STDs, CRACK’s activities may actually increase a woman’s risk of contracting HIV or other STDs.

In addition, CRACK impedes the goals of substance abuse treatment by assuming that the women it targets will be perpetually addicted and that treatment options are not worthy of being pursued. Instead, they should be the priority. CRACK should examine some of the socio-political factors that have driven women to substance use. Why not support the creation of options that empower women? Why not help women find health care that will supply them with HIV cocktail options that will cut maternal-fetal transmission risk to 1%? Why not find ways to make women whole instead of violating their most basic reproductive freedom?

Judith M. Scully is an Associate Professor at the West Virginia University College of Law. Prior to becoming a law professor, she was a civil rights and criminal defense lawyer in Chicago. She is also a trained gynecological health care worker and has been a reproductive rights activist for 15 years. This article was written with the assistance of Rajani Bhatia and the Dangerous Contraceptives Task Force of the Committee on Women, Population and the Environment.

Further Resources
Committee on Women, Population and the Environment (CWPE)
c/o Population and Development Program (CLPP)
Hampshire College
Post Office Box 5001
Amherst, MA 01002-5001 USA
tel 413/559-5506
fax 413/559-6045
email: cwpe@hampshire.edu
www.cwpe.org

Lynn M. Paltrow, JD
Program Director
National Advocates for Pregnant Women
45 W. 10th Street #3F
New York, NY 10011
tel 212/475-4218
fax 212-254-9679
email: lmpnyc@aol.com

Sheila Clark, MSW
Public Policy Associate
National Black Women’s Health Project
600 Pennsylvania Avenue SE, Suite 310
Washington, DC 20003
tel 202/543-9311
fax 202/543-9743
email: Sheilac@nbwhp.org
Ethical Concerns by Ellen H. Chen and Charon Asetoyer

In addition to concerns about Depo-Provera's health hazards, women's health and human rights advocates have pointed out Depo-Provera's potential for unethical use. In U.S. history, birth control has always been used to limit the fertility of the disadvantaged—low-income women, immigrant women, and women of color [Powderly 1995]. Depo-Provera, however, with its side effects and its non-reversible, provider-controlled injection, presents a larger threat as part of the new contraceptive technology controlled by manufacturers, population control advocates, and healthcare practitioners.

Historically, Depo-Provera's potential for coercion and population targeting has already been realized. Beginning in the 1960's, before any long-term effects were known, the drug was used on millions of women in at least 80 countries. In many developing nations, it became a primary weapon for population control advocates. In the U.S., in 1967, one year before the Upjohn Company began long-term animal studies, Grady Memorial Family Planning Clinic of Atlanta began the 11 year "Hatcher Study," in which thousands of primarily African-American women where given Depo-Provera without informed consent [Branan and Turnley 1984].

Other testimonies in the 1980's indicated similar abuses. In 1986, investigative reporters found that the IHS had been giving Depo-Provera to Native American women, many who were mentally retarded, for 10 years without informed consent [Materson and Gutherie 1986]. In New Zealand, poor white and Maori women were found to be the preferred recipients for experimental use of the drug. In Australia and Canada, reports of mentally retarded women receiving Depo-Provera were also made [Swenson 1987].

One study in France indicated that while only 4% of French women used Depo-Provera, 15% of Algerian women living in France and 20% of sub-Saharan African women used the drug. Records reveal that African women initially requested a method other than Depo-Provera more than twice as often as French women [National Black Women's Health Project in NWHN 1995].

When determining who should use Depo-Provera, some policy makers have documented reasons of what can only be called "social control." In the 1983 Submission to the Public Hearing on Depo-Provera, British researchers of the Coordinating Group on Depo-Provera and Independent Witnesses listed

categories of women for whom Depo-Provera was recommended. The following are listed as medical indications:

- Women who have refused sterilizations
- Unmotivated women
- Unreliable or irresponsible women
- Stupid women
- Less competent or incompetent women
- Retarded women or women of low intelligence
- Illiterate women
- Problem women with problem families
- Psychiatric patients, mentally ill or disturbed women
- Promiscuous women
- Young women at risk of participating in sexual activity unwillingly or unknowingly
- Women who cannot understand English
- To aid in population control" [Swenson 1987].

These categories blatantly reveal the unethical intent and negative assumptions which allow the targeting of certain populations of women without regard for their health or human rights.

Other advocates of Depo-Provera targeting do not use such labels as basis for use, but rather argue that the drug can improve the health and economic status of disadvantaged groups through fertility control. Here, many population control advocates argue that Depo-Provera is necessary to fight maternal and infant mortality rates. Instead of presenting Depo-Provera as a potentially life-threatening drug to be given to healthy, normal people, these arguments depict the targeted populations as if they are ill and will be put at risk if they do not take the drug. Ethicists note that the literature about Depo-Provera frequently adapts the tone which "suggests that if women did not receive the drug they might die in childbirth, a shocking misrepresentation of their true risks" [Swenson 1987]. In addition, these arguments ignore the realities of unequal economic distribution in the U.S. and around the globe which leads to the poor health of many disadvantaged groups. Ironically, this advocacy for Depo-Provera also ignores the lethal threat of STDs in high risk communities.

Today, arguments for the targeting of adolescents for Depo-Provera use and pregnancy prevention may grow in popularity. As exemplified in current debates about welfare reform, teenage pregnancy, particularly when out-of-wedlock, has become a scapegoat for all kinds of social problems. Social policy writers like Charles Murray, author of The Bell Curve which links IQ to race, have labeled out-of-wedlock births "the single most important social
problem of our time—more important than crime, drugs, poverty, illiteracy, welfare, or homelessness because it drives everything else” [Woodman 1995]. To address these problems, some are turning to teenage pregnancy prevention programs which may include Depo-Provera.

To “face the issue of teen pregnancy head-on,” however, politicians would need to fight “sexual predators, violence and incest at home”. One 1992 study has shown that “among young women who became pregnant during adolescence, a significant number have been physically or sexually abused at home” [Woodman 1995]. Depo-Provera would not only expose these teenagers to the threat of its side effects and STDs, but also make them more susceptible to abuse, “without even the possibility of protesting that they might become pregnant” [Swenson 1987].

Regardless of their argued justifications, both policy makers and practitioners who advocate Depo-Provera use within specific populations often take on patronizing and paternalistic attitudes toward these women. In the effort to better women’s lives and solve social problems, they assume that they know better than women themselves how to choose a contraceptive. They assume they know what is best for these women’s bodies and lives. The following excerpt from a Hastings Center report illustrates such an attitude.

[It] can be appropriate and responsible to use different techniques to influence a woman to consider long-term contraceptive use, even if she is not immediately inclined to do so.... Accepting the possibility of justifiable influence requires appreciating the limits of any single individual’s knowledge, perspective, and life circumstances.... Possessing greater maturity than adolescents, adults can be a prudent and ethically appropriate source of guidance.... The possibility of justifiable influence is not limited to adolescents. Occasionally, an adult will also be unprepared to make a contraceptive choice that furthers her interests and satisfies her responsibilities based solely on a nondirective, seemingly value-neutral approach: In some cases she too will benefit from the more involved aid and guidance of others” [Moskowitz et al. 1995].

Here, in the name of women’s “benefit,” these writers support “techniques of influence” which can easily become coercion in the context of unequal provider-patient relations.

Women’s health and human rights advocates have recognized that often “providers act according to their own personal values and beliefs. Indeed,
studies have shown that many practitioners assume poor and young women are incapable of using methods that require high user compliance. Despite the fact that such assumptions are not grounded in reality” [Scott 1994]. In order to prevent coercion and medical practice based upon preconceived notions, women’s advocates have continuously stressed the importance of nondirective counseling and informed consent.

Because Depo-Provera is a provider-controlled, long-acting contraceptive which cannot be counteracted once in the body, nondirective counseling and informed consent are crucial to protect contraceptive users. Unbiased information about Depo-Provera and other contraceptive options must be given. A woman must know of the drug’s three month irreversibility, lack of STD protection, contraindications, side effects and long-term health risks. This information should be accessible in both oral and written forms before injection. The lack of informed consent and nondirective counseling create situations of coercion in which a woman may make a choice she normally would not. Only after knowing all the basic facts about Depo-Provera and its alternatives can women make their own informed choices.

Reproductive Rights Abuses within IHS

Sterilization:

The IHS has a sordid history of Native American reproductive rights abuse. One example of such abuse occurred with the massive sterilization of Native American women in the 1970’s. It was discovered that 25,000 women had been sterilized at IHS facilities in 1975 alone. Upon investigation, data from 1973-1976 in four IHS areas showed that women had been coerced, through misinformation and threats, to have unnecessary and permanent tubal ligations. Other women underwent the procedure unknowingly. Case examples show that procedures were done directly after childbirth when women were still affected by medication. Relatives were told that healthy young women would die if they had anymore children. Unofficial reports gave accounts of entire communities without any fertile women due to this practice [Krust 1993].

Presently, though there is extensive IHS protocol and informed consent for tubal ligations, Native American women are still subject to coercion. According Cora Flying Hawk, former employee of the local Wagner IHS unit,
women labeled "uncooperative" or "alcoholics" are pushed to have tubal ligations. The IHS field nurses go to women's homes and "basically try to convince" them to get sterilized. Flying Hawk noted, "I would call it coercion myself — that's how I would understand it" [Flying Hawk 2/2 1995].

Depo-Provera:

The history of Depo-Provera use within the IHS provides another example of abuse. In 1986, before FDA approval, it was discovered that for at least ten years, profoundly mentally retarded Native American women in Arizona, New Mexico, Utah, Nevada, Oklahoma and southern California had been injected by IHS doctors with Depo-Provera. These clinics used the drug, in some cases without any informed consent, as a contraceptive and as a means "to eliminate menstruation, thereby improving hygiene and making life more convenient for their custodians" [Materson and Guthrie 1986]. Given the chaotic effect of Depo-Provera on bleeding patterns, the purpose of reduced staff attention is questionable. Furthermore, the Upjohn Company itself does not recommend use with mentally retarded women. After a campaign by news journalists and a Senate subcommittee investigation, the IHS instituted and amended its procedures specific to Depo-Provera.

Every woman should have the right to make informed choices about the drugs she takes. To ensure that women are fully informed about Depo-Provera and other options, women's health groups have advocated for written informed consent forms. David Kessler, Commissioner of the FDA, agrees that "all long-acting birth control methods should be used by women only after a written consent process. He compared long-acting methods to surgery, for which written consent forms are always required, even when the surgery is simple, safe, and effective" [NWHN 1995].

As mentioned before, however, the IHS has no uniform required protocol for the distribution of Depo-Provera. Thus, informed consent and follow-up tracking and care depend upon the policy of each individual clinic. Without required procedure and informed consent forms like those now implemented for sterilization, there is no guarantee that women are making informed choices about Depo-Provera.

For example, at the Wagner IHS unit, clinic staff member Alice Easterling stated that there is no consent form for Depo-Provera. She added, "The fact that
they are there is implied consent” [Easterling 2/24 1995]. This reasoning is highly questionable. A woman may be present at the clinic for any number of reasons, including a general request for contraception. Mere presence by no means ensures that basic consent, much less informed consent for Depo-Provera is given.

Not only is there no written consent form, but local women’s testimonies also indicate that important information about the drug is not given before injection. Cora Flying Hawk stated that in her experience as an IHS employee, women do not receive the informational patient insert and booklet which the Upjohn Company distributes with Depo-Provera. Instead, women are given a general pamphlet on all contraceptives, which lists a few of Depo-Provera’s most common side effects. Flying Hawk also stated that it was difficult to obtain additional information about the drug. When two clients wanted more facts after experiencing side effects from Depo, she asked nurses about it but was ignored when they discovered she was requesting information on the behalf of patients and not herself. Flying Hawk said she never saw the patient insert, the only material which includes all the risks of Depo-Provera. “Before I asked (for information), I never knew there was an insert.... If you ask once and they don’t answer, you know not to ask again.... So I never really really pursued getting an insert” [Flying Hawk 2/2 1995].

The lack of written consent and accessible information for Depo-Provera users illustrated here creates a situation in which Native American women are once again vulnerable to coercion. The Wagner unit is but one example of the lack of suitable delivery systems within IHS.

In addition to issues of informed consent, other subtly coercive measures also demand attention. In the 1993 study of Depo-Provera and Norplant use within IHS, the NAWHERC found that of the responding providers, 40% recommended Depo-Provera to clients over other contraceptives. This push for Depo-Provera, often based upon assumptions about race, economic status and age, is highly disturbing.

Another specific concern about the push of Depo-Provera within IHS involves a model code which Aberdeen Area doctors Thomas Welty and Lyle Best drafted and sent to all health care providers “At All IHS and Tribal Locations in South Dakota” [Appendix A] in October 1994. This model code,
which "could be presented for consideration by local Tribal councils," "would enable providers to dispense contraceptives to minors without parental consent." The methods authorized in the model code are listed as "non-surgical means including oral contraceptives, condoms, foam, depo-provera, and IUD's."

Present South Dakota law prohibits the distribution of contraceptives to minors without parental consent. A federal resolution, however, passed in 1991 to prevent the spread of STDs as well as unplanned pregnancies mandated that Native American minors have free and unquestioned access to condoms. The model code presented by the IHS doctors is misleading in that it does not acknowledge current access to condoms. It thus strives to make hormonal methods including Depo-Provera available to adolescents of all ages without parental consent. Promotion of non-barrier contraceptives, particularly IUDs which are contraindicated for women at risk of STDs, for teenagers is detrimental health policy.

When asked upon interview if he thought the drafted resolution was contradictory to HIV and STD prevention, Dr. Welty said he did not. "We've made every effort to promote condom use. We've bought thousands of condoms and have made them available to people in places where they can pick them up without being self-conscious. But many people simply do not prefer using condoms [Welty 2/8 1995]." He later added that after pregnancy, more options should be available to minors [Welty 2/13 1995].

The suggested resolution gives the impression that its primary intent is to reduce the Northern Plains Native American infant mortality rate by providing contraceptives and preventing teenage pregnancies. Infants of adolescent mothers, however, are not the primary risk group for infant mortality. When asked about the intent of the model code, Dr. Welty did not mention infant mortality rates at all. He did state that the intention was to make contraceptives available to older minors who may live in circumstances in which they should be able to make reproductive choices independently. "What we've seen is situations where a 17 year old who has had a child, maybe two, who's not married, requesting contraceptives and we have to tell them they need parental consent.... It causes problems. Some may not be close to their families, some may not be able to get consent." Dr. Welty added that this resolution would enable "prevention of unwanted pregnancies in a rational manner. There are a lot of social problems involved with some of these pregnancies— difficulties in raising children, disruption of the mother's education" [Welty 2/8 1995].
When asked what would prevent a 13 year old girl from receiving a dangerous contraceptive like Depo-Provera, Welty replied that "it would have to be tailored to each case by the physician." He also said "I don't see Depo-Provera as a major form of contraceptive here. It's not the main form" [Welty 2/8 1995]. But figures show that Depo-Provera is rising in popularity among adolescents. Ultimately, if this measure created by IHS staff were passed by tribal councils, there would be no guarantee that young girls without parental advocates were not placed on drugs like Depo-Provera without being told about the possible side effects and long-term health hazards.

For Native American women, the unethical use of Depo-Provera is by no means limited to Indian Health Services. Issues of coercion, targeting and informed consent are critical to investigate in any federal agency which provides long-lasting contraceptives. Institutionalized and incarcerated women are particularly vulnerable. For instance, during interviews, girls reported receiving Depo-Provera without informed consent and under persuasion of staff at a Job Corps site; their testimonies are included in the interview findings.

In general, a reevaluation of this contraceptive and its delivery systems is necessary. Reviewers must not only look into the health hazards of the Depo-Provera, but also ask whether true informed consent is possible to guarantee for the vulnerable populations which have been targeted. They must recognize who controls the birth control and stop the unethical use which leads to the violation of human rights.
RCRC Publications

WORDS OF CHOICE
Countering Anti-Choice Rhetoric

The Power of Language
Language is a powerful tool for advocacy. It shapes how people think about issues and creates the context in which public policy is defined. A single word, slogan, or phrase can symbolize an entire movement and influence more people than thousands of background papers and appeals. Nowhere has this been truer than in the often-contentious debate about reproductive choice. Women’s reproductive health and freedom are being damaged through choice of topics, choice of words, and choice of positioning. Anti-choice language has become so entrenched that the media, legislators, and even many pro-choice people accept and use it.

Opponents of choice employ false, misleading, and inflammatory language as a key tool in their campaign to erode all reproductive options—including family planning and sexuality education. Anti-choice language, whether on Capitol Hill or in pulpits, stigmatizes women who have abortions and dehumanizes health care professionals who provide abortion. Inflammatory rhetoric has been a barely concealed invitation to violence. Those who commit acts of violence are responsible for their own actions, but anti-abortion leaders know the power of their words to make violence thinkable to their followers.

The notion that human life or personhood begins at the moment of conception is the foundation of anti-choice language. Although theologians have addressed the question of the beginning of life for centuries without reaching agreement on the answer, opponents of choice promote their belief as the one and only truth.

To opponents of reproductive choice, the word “baby” is a synonym for fetus and women who choose abortion are “baby killers.” While women who terminate late-term pregnancies may also refer to their fetus as a baby, opponents of choice often add emotional modifiers such as “innocent baby” and “unborn baby” or “unborn child.” Terms such as “abortion as birth control,” “abortion for convenience,” and “abortion on demand” imply that abortion is a casual choice. Anti-choice images trivialize and devalue women. Gory pictures of late-term fetuses foster the misconception that late-term abortion is common, when in reality less than 1 percent of abortions are performed after 21 weeks of gestation. Despite the claims of some anti-abortion activists, abortions are extremely rare in the third trimester and they are generally provided only in cases of severe fetal abnormalities or situations when the life or health of the pregnant woman is seriously threatened. (A full term pregnancy lasts about 40 weeks. Pregnancy is divided into three trimesters, each approximately 12-14 weeks long.)

The political process and the press have been used to introduce anti-choice terms into the mainstream. The term “partial-birth abortion” is a striking example of how language can be manipulated to suit a particular need. As health professionals know, there is no such thing as “partial-birth abortion” and the term will not be found in any medical text. The term was introduced by anti-choice groups to push their agenda. The groups worked with anti-choice legislators to write legislation using this term—a political term created to incite and confuse. The Christian Coalition has acknowledged that use of the term “partial-birth abortion” was an explicit strategy to undercut the primacy of the woman and make her secondary to the fetus. The media—who assume legislative language is neutral—picked it up immediately as a good sound byte and headline word. Through cagey political maneuvers and the seemingly automatic response of the press, half-truths, distortions, and deceptions are perceived as truth and shape what millions of Americans think.

Newspapers carry such misleading headlines as “Mother’s Right Upheld Over Fetus’s” and “Bill Would Ban Use of Abortion as Birth Control.” A woman is labeled a “mother” whether she has—or wants—children. Banning abortion as a “method of birth control” implies that women in general are irresponsible about sex and reproduction. The evening news reports that “the Supreme Court handed down a decision today on a matter of life and death,” equating abortion with death.

While the divisive issue of abortion diverts the nation’s attention, vital reproductive health care needs go unmet. The United States lags far behind many other countries in the development of new methods of contraception and has one of the highest rates of unintended pregnancies, unwanted children, infant mortality, and abortion among developed nations. Not until a woman’s constitutional right to reproductive freedom is secure—facing no threats, requiring no defense—can we work solely and aggressively to solve our nation’s numerous reproductive health care problems.

Clarifying the language used to talk about reproductive choice and reproductive health will help clarify our needs. Reproductive choice is not a euphemism for abortion. Reproductive choice means women having control over their bodies, without government interference, and an equal place in all aspects of national

http://www.rcrc.org/pubs/words.html

Reprinted by permission of the Religious Coalition for Reproductive Choice.
decision-making. It means being able to consider all medical and moral options in decisions about bearing children. Reproductive choice includes accurate, complete information about and access to contraception, comprehensive sexuality education, and quality health care and child care. It means truly valuing children and families and having government policies that support family well-being. It means respecting a diversity of religious beliefs.

The Religious Coalition for Reproductive Choice hopes Words of Choice will encourage honest, respectful discourse. We must move beyond the bitter abortion debate to ensure that every child is wanted; that every pregnant woman has quality, affordable health care; that all parents—male and female—understand their responsibilities and have the support they need; that children are educated about sexuality so they can make responsible choices; and that freedom of choice—basic to our way of life—is preserved.

Countering Anti-Choice Rhetoric

Abortifacient

The term "abortifacient" is used loosely to refer to any contraceptive method that prevents implantation of a fertilized egg, including birth control pills, emergency contraception, intrauterine devices (IUDs), and hormonal injections.

Combined oral contraceptives contain the hormones estrogen and progestin. They suppress ovulation, thicken the cervical mucus (preventing sperm penetration), change the endometrium (making implantation less likely), and reduce sperm transport in the upper genital tract (fallopian tubes). Other methods work in similar ways. They do not disrupt an existing pregnancy.

Anti-choice groups continue to spread misinformation about contraception despite the fact that contraception is a proven way to reduce abortion.

Abortion as Birth Control

Opponents of choice claim that more than 90 percent of abortions are a form of contraception. Underlying this vague, unsubstantiated claim is the notion that women are irresponsible in their sexuality. In fact, 58 percent of women having abortions in the mid-1990s used a contraceptive method during the month they became pregnant. This high rate of contraceptive failure indicates that available contraceptive methods do not meet the health, economic, and social needs of many women.

According to the National Academy of Sciences, women in the United States have less access to contraceptive methods and fewer choices of methods than women in Western Europe and some less developed countries. Pressure from anti-abortion groups has been a major obstacle to contraceptive development and approval. In stark contrast to the situation in other developed nations, where contraceptives are easily affordable under universal health insurance systems, contraceptive supplies and services are expensive in this country, and American women must rely on a variety of fragmented systems and programs to help them cover these costs.

Abortion for Convenience

Women are charged with having abortions for frivolous reasons. Anti-choice rhetoric depicts women who have an abortion as impulsive or careless.

There is nothing "convenient" about having an abortion. It is socially stigmatized and personally wrenching. Women who have abortions often do so because they care about others—they want to bring children into the world under positive circumstances. The decision to have an abortion often is made because of poverty, concern for the well-being of existing children, and lack of commitment and support by the prospective father.

Since each person’s situation is unique, reasons for abortion vary. Forty-nine percent of all pregnancies are unintended; of these, half are terminated by abortion. Among those who report having an abortion, three-quarters say they are not ready to have a child because of responsibilities related to work, school, family, and other demands. About two-thirds say they cannot afford to have a child. Half do not want to be a single parent or are having problems with their husband or partner. Each year, about 14,000 women have abortions because they have become pregnant as a result of rape or incest.

Abortion for Gender Selection

Opponents of choice advocate for legislation barring abortion for the purpose of gender selection.

By seeking legislation banning abortion for gender selection, opponents of choice create the impression that abortion is done for this purpose. There are no statistics or records indicating this to be the case in the United States. This claim is intended to inflame public opinion against abortion and cast doubt on the motives of all who seek to have an abortion.

Abortion on Demand
The term "abortion on demand" implies that a pregnant woman can walk into an abortion provider's office at any time in her pregnancy and have an abortion.

Pro-choice supporters have been charged with promoting "abortion on demand," without any qualification or restriction. This charge is used to insinuate that those who are pro-choice hold unreasonable views and are pushing abortion. It also obscures the wide variety of pro-choice views on when abortion should be available and whether restrictions are acceptable.

Legally, "abortion on demand" is a fiction. The Supreme Court's 1973 Roe v. Wade decision recognized a state's valid interest in potential life. The Court rejected arguments that the right to choose is absolute and always outweighs the state's interest in imposing limitation. After viability—the time at which it first becomes realistically possible for fetal life to be maintained outside the woman's body—the state may ban any abortion not necessary to preserve a woman's life or health. However, few women obtain abortions late in their pregnancies. Eighty-eight percent of all abortions occur in the first 12 weeks of pregnancy (the first trimester). Less than 1 percent of abortions are performed at the 21st week and later.

The term "abortion on demand" also suggests that abortions may be obtained anywhere, anytime. In fact, a woman's ability to terminate unplanned pregnancies has been steadily undermined since 1973. The procedure has been put out of reach for thousands of low-income women by the Hyde Amendment, which cut or severely restricted Medicaid funding for abortion.

State legislatures throughout the country, under pressure from right-wing groups, have enacted numerous obstacles to abortion. Since informed consent and mandatory parental notification and consent laws were ruled constitutional in 1992, state-mandated lectures, waiting periods, and laws that require minors to tell their parents or go to court for a special hearing have been put in force in many states. Legislatures continue to attempt to impose onerous restrictions on clinics.

Mergers of Roman Catholic hospitals with community hospitals have reduced or eliminated abortion services and other reproductive health care services in a growing number of communities. Merged hospitals must adhere to Catholic directives for health care, which forbid tubal ligation, vasectomy, in vitro fertilization, and the provision of contraceptive services in addition to abortion services.

Anti-choice violence and lack of training for physicians have also resulted in fewer providers. In 1996, 86 percent of U.S. counties, where 32 percent of women of reproductive age lived, had no identified abortion provider. The number of abortion providers declined by 14 percent from 1992-1996, with the greatest decline among hospitals and physicians' offices rather than clinics. (In the same period, the number of abortions fell from 1,529,000 to 1,366,000 a year, in part due to reduced availability although other factors, including a reduction in unintended pregnancy, may have been more important.)

Abortion Pill
RU-486 has been called the "death drug" and a "human pesticide." Opponents of choice claim that "the abortion pill" is difficult to take and has many inherent risks and dangers.

Mifepristone, formerly known as RU-486, in combination with a prostaglandin is an effective non-surgical (medical) method of early abortion that has been in use since 1981. More than 500,000 women have safely used mifepristone in Europe. U.S. clinical trials have found that mifepristone is effective and has a very high patient satisfaction rating.

The use of mifepristone requires a woman to make up to three visits to a clinic or doctor's office. Studies in France and the United States have shown that women prefer a non-surgical method of abortion because it provides greater privacy, is less invasive, and avoids anesthesia.

Adoption
To opponents of reproductive choice, there are only two options for pregnant women: keeping the child or putting the child up for adoption. Adoption is portrayed as virtually problem-free, once the mother-to-be reconciles herself to the loss of her child.

Adoption is a wise option for some women faced with unintended or problem pregnancies. However, in promoting adoption, opponents of choice ignore or minimize the emotional and social trauma of adoption and the health risks of pregnancy. It is simplistic and cruel to imply adoption is a problem-free alternative to abortion.

American Holocaust
Some fringe groups have equated abortion with the Nazi Holocaust. These extremists refer to reproductive health care clinics as "death chambers" and the health care professionals who perform abortions as "Nazi butchers."

The comparison is unconscionable; it trivializes the immensity of the Nazis' deliberate and systematic attempt to annihilate the entire Jewish population and other groups deemed "undesirable." Governmental
murder of entire populations cannot—and must not—be equated with the thoughtful, individual decision of whether or not to carry a pregnancy to term.

**Baby, or Unborn Child**
Opponents of reproductive choice refer to a fetus as a "baby," an "unborn child," "innocent unborn life," or "pre-born." They encourage the use of humanizing terms such as "this little guy." They call abortion "infanticide."

The purpose of these terms is to manipulate the public to think of a fetus as a cute, cuddly infant. The fetus is equated with an actual human being.

The use of these terms to refer to an embryo or fetus is a propaganda device called prolepsis, which Webster's Dictionary defines as "an anticipating, especially the describing of an event as if it had already happened" when in fact it may be months away or it may never happen.

**Beginning of Life**
Opponents of choice assert as fact their belief that human life begins at the moment of conception. They try to enshrine this religious belief into secular law, in direct violation of the constitutional guarantee of the separation of church and state.

For centuries, theologians and scientists have argued the question of the beginning of life without reaching consensus. There is no single answer to this question.

Nevertheless, the common belief is that life begins at birth, when the baby begins to breathe on his/her own and is not dependent on oxygen from the mother. Therefore, Jewish and biblical tradition defined a human being with the word "nephesh"—the breathing one. Modern science has reminded us that the brain is the essence of our existence and no human person can exist without a brain, which does not begin to take shape until the formation of the neocortex, or no earlier than the second half of gestation.

The Supreme Court, in Roe v. Wade, stated: "We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer."

**Clinic Rescues/Sidewalk Counseling**
To "rescue the babies," anti-abortion demonstrators from groups such as Operation Rescue harass women and medical personnel entering clinics. Sometimes they call this harassment "sidewalk counseling," "Rescue" groups compare themselves to the non-violent protesters of the civil rights movement.

Better called "clinical harassment," so-called rescues have included anthrax threats, bombing of clinics, and murder of clinic personnel. In 1998, almost one-quarter of abortion clinics faced severe anti-abortion violence, characterized as murder, death threats, stalking, bombing and arson as well as bombing and arson threats, blockades, trespassing, and chemical attacks.)

The comparison to the civil rights movement is invalid. "Rescues" are generally violent because they are intended to intimidate, unlike non-violent civil rights protests that used boycotts, peaceful marches, and demonstrations. Civil rights activists preferred to be subjected to violence rather than to inflict it on others. The civil rights movement struggled to end racial discrimination and ushered in a new era of equal rights. Clinic "rescuers" try to rescind and restrict individual rights.

When brought to trial, "rescuers" use the "necessity" or "choice of evils" defense. They claim their violence is necessary to prevent the "murder of unborn children." Women exercising their constitutional right to reproductive choice are participating in an act of health care, not violence.

**Conscience Clause**
The term "conscience clause" is used in legislation to permit health care providers to refuse to provide reproductive health services, including family planning, because of religious or moral beliefs.

This deceptive term implies that one belief—that of those who are anti-choice—is the standard. It ignores the consciences of those who believe children should be planned and wanted and who believe abortion can be a moral choice.

Efforts in Congress and in state legislatures are underway to expand conscience clauses to health care insurers, health maintenance organizations, and pharmacists and to include contraception and information and referrals for abortion as well as services. A clause that permits an insurance company to restrain providers from offering patients information regarding the full range of medical options is qualitatively different from a clause that permits an individual to decline to perform medical services to which that person is religiously or morally opposed.
Crisis Pregnancy Counseling Centers

Centers that offer “crisis pregnancy counseling” have proliferated since the mid-1990s. These centers purport to assist women in crisis by providing free pregnancy tests, caring and confidential counseling, medical referrals, abortion and adoption information, information about medical insurance or government assistance, and temporary shelter.

Under the misleading title of “center,” these privately funded, volunteer-run storefront operations or websites seek to attract women who are dealing with unintended pregnancy by offering free services, support groups, and material assistance. These “centers” are run by anti-choice, anti-abortion Christian churches and agencies whose intent is to talk women out of having an abortion. They are usually not staffed by trained health care workers, are not truthful about their particular political or religious leanings, and propagate misinformation about abortion and contraception. Many of these centers locate themselves near abortion and family planning clinics (sometimes even choosing closely similar names) in order to confuse, lure, and harass patients and employees. The centers do not offer medical assistance and all medical referrals are to anti-choice physicians.

Family Values

Abortion is abhorrent, according to opponents of reproductive choice, in part because it is an affront to family values and undermines the traditional family.

The ideal life, according to many opponents of choice, is conducted within the bounds of “the traditional family,” consisting of a mother, father, and children living under the same roof, with the father as economic support and final decision-maker. The Bible is often used to justify this view and criticize any other idea of family, especially if it involves women’s self-determination. To many Americans, however, there are many kinds of families, each of which is cherished just as much as the narrow idea of family promoted by opponents of choice. Many clergy and people of faith object to the misuse of the Bible to justify one particular point of view.

Fetal Personhood/Fetal Rights

By asserting that the fetus is a person, opponents of choice claim that fetuses have rights and that these rights are equal to the rights of women.

The primary theological issue in the abortion debate centers on the personhood of the fetus, an issue on which there is no unified position. The equation of “fertilized egg” with “person” equates a cluster of cells with a human being that has capacities of reflective choice, relationship, response, social experience, moral perception, and self-awareness. Both the person and the fertilized egg have life but the fertilized egg does not embody the qualities of personhood.

Fetal rights and fetal protection legislation punishes women for their behavior during pregnancy. Prosecuting women for illegal drug and alcohol use during pregnancy opens the way to prosecuting any behavior by a pregnant woman, such as smoking, drinking caffeine, jogging late in pregnancy, or failing to follow a doctor’s orders.

Fetal Tissue/Human Embryo Experimentation

The claim that fetuses are being aborted for purposes of scientific “experimentation” is made by Focus on the Family and other right-wing groups. The alleged experimentation includes parthenogenesis (manipulating the woman’s egg to produce a one-parent pregnancy) and chimeras (humans who would also have animal genes). These groups contend that fetal tissue and human embryo research will encourage women to become “baby machines” and have abortions for profit.

These claims demean women, clinics, scientific researchers, and government bodies that support research using fetal tissue. In making these claims, anti-choice groups are attempting to create a climate of fear and suspicion about the purposes of medical and scientific research. Anti-choice groups oppose research using fetal tissue despite its possible success in treating Parkinson’s disease, spinal cord injuries, epilepsy, diabetes, and Alzheimer’s disease. The research and scientific communities and organized groups of people suffering from these diseases strongly support research using fetal tissue.

Fetal Viability

Advances in reproductive technology have lowered the point of fetal viability, enabling the anti-choice movement to mount a credible public relations and legislative campaign centered on the small fraction of abortions performed around the point at which the typical fetus is capable of living outside the woman’s body.

Contrary to popular opinion, the decline in the point of fetal viability has been slight, only a few weeks, since the 1973 Roe v. Wade decision. In a long line of decisions since then, the Supreme Court has repeatedly stated that determinations of when a particular fetus is viable, what constitutes a threat to the health of a particular woman, and the appropriate manner in which to perform an abortion, as a procedure must be left to the attending physicians.
Genocide
The claim that abortion—and even family planning—is genocide of people of color has been espoused by anti-choice groups seeking to discredit reproductive health services. Some contend that medical personnel, many of whom are white, coerce people of color into obtaining abortions and using contraception against their will.

Webster's New World Dictionary defines genocide as "the systematic killing or extermination of a whole people or nation." While abortion abuses have been perpetrated against people of color, an individual woman's decision to have an abortion does not constitute genocide. This argument of reproductive choice opponents is intended to make a pregnant woman of color believe that if she chooses abortion, she is guilty of participating in the annihilation of her race. According to the Women of Color Partnership of the Religious Coalition for Reproductive Choice, this type of propaganda may dissuade women of color and their families from making wise, judicious, and responsible decisions.

Human Being
Opponents of reproductive choice support their position by asserting that a human being exists from the moment of conception. They back up this position by claiming that the fetus can feel pain from the earliest moments of life. If a fetus is considered a human being, abortion is murder.

The assumption that human life begins at conception implies that a human being is created at a specific moment instead of by a process that takes about nine months. We count age from the date of birth, not the date of conception. Legally, a human being is one who is born. Biblically, a human being is one who breathes.

There is no consensus among experts about the point in a pregnancy at which a fetus can feel pain. However, medical experts from the American College of Obstetricians and Gynecologists have stated that a fetus cannot perceive pain prior to the seventh month of pregnancy when the cerebral cortex is ready to function continuously.

Informed Consent
So-called "informed consent" or "women's right to know" laws require physicians to provide women with standard state-prepared anti-choice materials at least 24 hours prior to the abortion procedure, regardless of the woman's individual needs and the physician's ethical obligation to provide the best medical advice.

These laws are more appropriately called "biased counseling." They force physicians to recite false and misleading information that is intended to discourage the procedure, even if not having an abortion is ultimately harmful to a woman's health.

The standards of the medical profession, as well as state laws, ensure that health care practitioners provide women with accurate and unbiased information regarding the risks and benefits of various treatment options—in all cases, not only abortion—and obtain their informed consent. Biased counseling laws single out abortion from all other medical procedures. They imply that women do not adequately think through their abortion decision and that the state must think for them. This assumption reflects a lack of respect for women's moral decision-making. In fact, virtually all women have carefully considered their decision to have an abortion by the time they arrive for the procedure. Doctors routinely refer for additional counseling the small number of women who remain ambivalent.

Judicial Bypass
Judicial bypass provisions are often included in legislation that mandates parental notification or consent of a minor's decision to have an abortion. The term "judicial bypass" suggests a routine procedure.

Judicial bypass procedures pose formidable obstacles to young women facing crisis pregnancies, especially to the poorest, youngest and least experienced teens, who are the most likely to become teen parents or victims of unsafe, illegal abortion.

Bypass procedures often delay abortions, thus increasing the risk and sometimes the cost. Young women may not understand the complex legal system or be able to attend hearings scheduled during school hours. Others fear they will be recognized at the courthouse. Many are frightened and do not want to reveal intimate details to strangers. Some do overcome their fear and obtain a court appearance only to have their petitions denied by anti-abortion judges.

Medical Necessity
Some opponents of choice deny abortion is ever a medical necessity.

A number of health conditions are exacerbated by pregnancy. These include epilepsy, diabetes, malignant tumors, hypertension, kidney disease, sickle cell anemia, and heart disease. Pregnancy in these cases increases the severity of the disease and can lead to permanent damage or death.
Mother/Motherhood

In the anti-choice lexicon, all pregnant women are "mothers," regardless of whether they have or want children. Motherhood is considered to begin with the genetic tie between the woman and the fetus.

Calling a pregnant woman "mother" creates images of babies and suggests that abortion is murder. According to Webster's Dictionary, a "mother" is not only "a woman who has borne a child" but also one who nurtures that child. A woman can be a biological, adoptive, foster, or surrogate mother. The meaning of "mother" is being expanded by new reproductive technologies and evolving beliefs about lifestyles such as gay/lesbian partnerships. Motherhood is far more than a biological act; it is the continuing commitment to loving, supporting, and caring for a child.

Murder

Based on their position that a fetus is a human being, opponents of choice describe abortion as "murder" and "infanticide" and call women who choose to terminate their pregnancy "murderers."

If these notions were carried to a logical conclusion, then women who have an abortion would be charged with murder and could face the death penalty or life imprisonment. The partner who participates in the decision, the clergy who counsels, and the health professional who performs the abortion would be charged as accessories to the "murder."

Parental Notification/Consent

Laws mandating parental notification or consent for a minor's abortion are said to strengthen family communications and parental rights. Opponents of choice say parents should know or be involved in this important decision so they can help their daughter.

Intended supposedly to "improve communications" between parents and their daughters, notification and consent laws have in fact caused much fear and confusion among young women and made it more difficult and stressful for them to get abortions. In some states, minors whose parents are divorced or do not live together may have to notify or get the consent of a mother or father they have not seen or talked to in years. Normally honest young women must lie or forge notes to get out of school for clinic appointments or judicial bypass hearings. In some areas where judges deny all bypass requests or simply refuse to hear the cases, minors who cannot tell their parents are routinely advised to find a clinic out of state.

Parental involvement laws are largely unjust and unnecessary. Most teenagers voluntarily seek out the love, support, and guidance of their parents when faced with such a difficult decision as abortion. About 60 percent of teens tell at least one parent, and others often ask for help from another responsible adult, such as an older sister, aunt, teacher, or clergy.

Teenagers who cannot talk to their parents about having an abortion often have compelling reasons—they may be victims of emotional or physical abuse, pregnant as a result of incest, or have feelings of shame and guilt from being raped. Some do not want to disappoint or hurt their parents with the reality of sexual activity and unplanned pregnancy. Among minors who did not tell a parent of their abortion, 30 percent had experienced violence in their family or feared violence or being forced to leave home. The American Medical Association noted that minors may be driven to desperate measures to keep their pregnancies confidential. The desire to maintain secrecy has been a leading reason for deaths from illegal abortion since 1973.

Those proposing mandatory parental notification note that even ear piercing requires parental involvement. This trivializes the serious consequences of an unintended pregnancy, including the possibility of death or permanent physical damage from an illegal abortion.

Partial-Birth Abortion Bans

Abortion opponents are on a crusade to ban what they call "partial-birth abortion."

"Partial-birth abortion" is a political term coined by anti-choice strategists who want to make all abortions illegal. This term has no meaning other than the shifting definitions given to it by anti-choice organizations intent on provoking legislators and tricking the public. Doctors do not identify any procedure by this name.

Proponents of so-called "partial-birth abortion" bans claim that the bans will prohibit only a single, rare "late-term" procedure called intact dilation and extraction, used largely in cases of severe fetal anomaly incompatible with life. In effect, however, "partial-birth abortion" bans are nothing but bans on abortion. As medical experts have testified and courts across the country have found so far, these bans could outlaw the safest and most common abortion procedures used throughout pregnancy. Such bans put women's health and lives at risk and violate the constitutional right to reproductive choice.

Person

Opponents of choice define a fertilized egg as a person because it contains 46 chromosomes, the full
genetic blueprint for a human body.

Just as a blueprint for a house is not a house, a genetic blueprint for a human body is not a person. Scientists have estimated that only one-third to one-half of all fertilized eggs develop in even the most favorable medical circumstances. A person is the collective result of a process of growth, not merely a collection of genes or a fertilized egg.

The U.S. Constitution defines a person as one who is "born." The Supreme Court ruled in Roe v. Wade that the Constitution's "use of the word (person) is such that it has application only postnatally."

Post-Abortion Syndrome
The term "post-abortion syndrome" (PAS) is used to describe what opponents of choice claim is a form of post-traumatic stress disorder that has long-term symptoms, which include nightmares, feelings of guilt, and attempted suicide. Anti-choice groups claim that "post-abortion syndrome" is widespread among women who have had an abortion as well as men and parents of minors involved in the decision.

The American Psychological Association found that severe negative psychological reactions to abortion are rare and that this "syndrome" is not scientifically or medically recognized. The association concluded that the vast majority of women experience a mixture of emotions after an abortion, with positive feelings predominating. The American Psychiatric Association also studied the psychological impact of abortion on women. A panel of six leading psychiatrists concluded that "government restrictions on abortion are more likely to cause women lasting harm than the procedure itself." A 1997 longitudinal study concurred about the effect of abortion, showing that the experience of abortion has no independent effect on the psychological well-being of a woman.

Pro-Abortion
Abortion opponents refer to supporters of reproductive choice as "pro-abortion," as if they are actively promoting abortion.

To be pro-choice is not to be "pro-abortion." Those who are pro-choice believe that abortion must remain legal and that the decision to have an abortion must remain with the woman and her physician and be based on her own beliefs, free of government interference. It is possible to consider an individual incident of abortion or even all abortion personally and religiously immoral and still be pro-choice.

The term "pro-abortion" distorts the meaning of reproductive choice: the ability to make deliberate decisions about bearing children, considering all medical and moral options.

Pro-Life
By calling themselves "pro-life," opponents of choice imply that those who support a woman's right to choose abortion are "anti-life."

The pro-life movement would be more accurately called pro-fetus. The pro-choice position is really pro-woman. Those who are pro-fetus define the woman in relation to the fetus. They assert the rights of the fetus over the right of the woman to be a moral agent or decision-maker with respect to her life, health, and family security. To be truly pro-life is to have concern and compassion for all life—the woman, her existing children, and her husband or partner.

Rape and Incest
Some opponents of choice make exceptions in cases of rape and incest. They send the message that fetal life is valuable sometimes—but not always. They imply that a woman who has an abortion is not immoral if she is a victim of violence.

Unfortunately, the rape and incest exception is moot for many victims who cannot comply with the strict reporting requirements necessary to be granted an abortion under these circumstances.

Opponents of choice walk a fine line when they condone any abortion. Based on their own definition, they are guilty of being accessories to "murder" by allowing abortion in cases of rape and incest.

Sacredness or Sanctity of Life
Opponents of choice try to claim the moral high ground by asserting the "sacredness" or "sanctity" of human life to defend their position. By implication, those who are pro-choice become immoral, irreligious, and unconcerned about human life.

The terms "sacredness of life" and "sanctity of life" do not appear in the Bible. Instead, there is an emphasis on "love of neighbor" in the sense of caring, concern, and respect for persons.

Anti-choice concern for the "sacredness of human life" typically either ignores the life of the pregnant woman and her existing family or considers these as secondary to the fetus. When Focus on the Family,
for example, calls "unborn children" "the most vulnerable and victimized members of our culture today," they ignore the millions of children who live in poverty and are true victims. Those who are pro-choice support comprehensive sexuality education, family planning services and contraception, affordable childcare and health care, and adoption services as well as safe, legal, and affordable abortion services. Medical, economic, and educational resources are necessary for healthy families and communities that can nurture children in peace and love.

**Unsafe Abortion/ Abortion and Breast Cancer**

Opponents of choice create fear among women with their unsubstantiated claims that abortion is unsafe and increases a woman's chance of developing breast cancer and other health risks.

The most important effect of the legalization of abortion on public health has been the near elimination of deaths from the procedure. By 1990, the risk of death from legal abortion was 0.3 deaths per 100,000 procedures. To put that number in perspective, the mortality rate associated with childbirth is ten times higher. Medical studies in 21 countries clearly demonstrate that: 1) abortion does not increase the risk of major pregnancy complications during future pregnancies or deliveries, 2) there is no added risk in future pregnancies or deliveries of infant mortality or having a low birth weight infant, and 3) the risk of infertility, ectopic pregnancy, and miscarriage following an abortion does not increase.

The largest and most comprehensive investigation of the potential link between abortion and breast cancer, of 1.5 million Danish women, concluded that "induced abortions have no overall effect on the risk of breast cancer." Experts from the National Cancer Institute, the U.S. Department of Health and Human Services Office of Public Health and Science, the National Breast Cancer Coalition, the American Cancer Society, and the American College of Obstetricians and Gynecologists have concluded that a link between abortion and the development of breast cancer has not been established.

**Waiting Periods**

Mandatory "waiting periods" prohibit a woman from obtaining an abortion until a specified period of time has passed and she has received a state-mandated lecture or materials. Many abortion-specific "informed consent" laws require that women receive state-mandated lectures and state-prepared materials on fetal development, services available to help the woman if she continues the pregnancy, and adoption.

Mandatory waiting periods imply that women will consider their decisions thoughtfully only under state mandate. These requirements impose an emotional burden on pregnant women by increasing the time, the potential health risks, and the cost involved in obtaining an abortion, especially in geographic areas with few or no providers.

The health risk to pregnant women from legal abortion rises as gestational age increases. The American Medical Association has concluded that mandatory waiting periods "increase the gestational age at which the induced pregnancy termination occurs, thereby also increasing the risk associated with the procedure." Although a first- or second-trimester abortion is far safer than childbirth, after eight weeks the risks of death or major complications significantly increase for each week of delay. Moreover, abortion after the first trimester is available at fewer than half the locations that offer first-trimester abortion services.
KATHA POLLITT

Secrets and Lies

on Fitzsimmons’s dramatic statement that he "tied through his teeth" fifteen months ago when he said, in a never-aired comment for Nightline, that only 450 "partial-birth abortions" are performed annually in the United States, always for serious medical reasons, has the press in one of its favorite tizzies. Once again, it’s beating its breast for being too liberal, in this case for having followed a pro-choice bias and trusted pro-choice numbers in last year’s debate over the procedure. Lazy maybe, forgetful definitely—both The Washington Post and the Bergen Record carried stories last September suggesting the procedure was performed several thousand times a year, mostly in the late second trimester of pregnancy, and mostly not as a matter of life and death. But biased? If the media are so pro-choice, how come we’re all talking about “partial birth” instead of “intact dilation and extraction,” the proper medical term? It isn’t often that the insurgents define the language of the debate. You are not likely to open your Boston Globe or your Time and find a story about events in “the country that opponents call the “Zionist entity” but supporters refer to as Israel.” As for lies, how come journalists aren’t furious over the constantly repeated anti-choice lie that Roe v. Wade allows a woman to have an abortion up to the minute she gives birth? Or that five-month-old fetuses are viable?

Actually, the National Coalition of Abortion Providers’ executive director, Fitzsimmons (who, for the record, is neither “prominent,” as the media sloppily anointed him, nor “an abortion provider,” as Katharine Seelye described him in The New York Times, but a lobbyist), had it right the first time. I.D.E.’s performed on women carrying theoretically viable fetuses—i.e., after twenty-four weeks—are extremely rare and performed only for grave medical cause. The anti-choice claim that large numbers of viable fetuses are aborted, almost always for frivolous reasons (such as fitting into a prom dress, as the Catholic bishops claimed), is false. Roe v. Wade permits states to criminalize abortion after twenty-four weeks for any reason except the mother’s life and health; and forty states and the District of Columbia have done so. New York State, as a matter of fact, does not even have a health exception, and requires a second doctor’s attendance on abortions performed after twenty weeks, to provide medical attention to the fetus—both of which strictures are in flagrant violation of Roe, not that this seems to matter. In other words, in the third trimester, abortion on demand by any method is already illegal—and almost no doctors will perform abortions then, even when they are medically advisable.

The big anti-choice lie was obscured by the consistent merging of third-trimester abortions, which, as I’ve just said, are already illegal under almost all circumstances, with second-trimester abortions, which are protected by Roe, describing both with the brilliant propaganda term “partial birth”—as in live-baby-who-could-survive-if-not-murdered-by-doctor, and also as in, Gross! Much hay was made of the gory details of I.D.E.—as if the anti-choice would approve of the other available methods (dismember the fetus in the womb, for instance, or poisoning it with a saline solution). By banning a procedure, performed at whatever stage of pregnancy, anti-choice forces seek to undermine the legality of second-term, i.e., pre-viability abortions, which are constitutionally protected by Roe—and undermining Roe is what this fight is really about.

In response to this onslaught of propaganda, pro-choice groups made a decision to focus on third-trimester medical tragedies that a ban would only have exacerbated. This was understandable—the anti-choice claimed their however-many thousands of frivolously aborted fetuses were as good as born, so why not challenge them on the numbers and the reasons for these very late abortions that the anti-choice claimed to be talking about (but really weren’t)? But the failure to discuss openly and to defend second-term procedures helped create the circumstances in which Fitzsimmons’s “revelation” could do its immense damage.

This whole mess shows that the pro-choice movement needs to reclaim the debate and start aggressively setting its terms. We wouldn’t be forced into this ridiculous corner, having to deny that women who are seven and eight months pregnant resort to abortion as a quick weight-loss method, had we not conceded a lot of ground already by failing to defend abortion as an essential—indeed, normal—aspect of women’s reproductive lives: every kind of woman, including anti-choice ones, in every social class. Since the anti-choice talk about abortion as if it were never justified, we’ve fallen into the trap of talking only about what philosophers call the “hard cases,” the extreme situations in which the woman is clearly a tragic figure: a molested child, a rape victim or, as in the debate over intact dilation and extraction, a woman whose much-wanted pregnancy has gone horribly awry. It’s right that we insist on those cases, but not in a way that helps to further delegitimize the vast majority of abortions—including, Fitzsimmons reminds us, the majority of pre-viability I.D.E.’s—which are performed for social, economic and personal reasons. We need to defend women’s freedom to choose when and if to become mothers—not just the right of women to choose abortion over serious injury or death.

Instead of brushing those second-trimester abortions to the side, we should talk about the women who have them and why they have them so late. We need to talk about sexual ignorance, about shame and denial, about lack of access to good information and consistent health care, about why the United States has the highest rate of teen pregnancy and unwanted pregnancy in the West, about the crippling and cumulative effects of state and local abortion restrictions—those supposedly not-undue burdens permitted by the Supreme Court. We need to talk about poverty and isolation: what it means not to be able to scrape together $250, or a ride to a distant clinic, in time for an early abortion.

Those circumstances—not the use of one particular abortion method, as the anti-choice disingenuously suggest—are the real abortion scandal.