

A BROADER VISION OF THE REPRODUCTIVE RIGHTS MOVEMENT: FUSING MAINSTREAM AND LATINA FEMINISM

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INTRODUCTION

While our country remains bitterly divided over the issue of abortion, many women struggle to exercise their right to abortion in a political climate that is increasingly hostile toward reproductive rights.

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For women of color, however, abortion access is only one battle in a much larger fight for reproductive justice.¹ Women of color disproportionately suffer from inadequate reproductive health care, and, as a result, reproductive health disparities between women of color and white women remain an intractable problem.² The difficulties women of color confront in exercising their rights and securing basic reproductive health care illustrate how the mainstream reproductive rights movement may not be effectively addressing the reproductive health needs of communities of color.

Latinas in particular face a number of obstacles to accessing important health care services, and, consequently, improving their reproductive health status. For example, lack of health insurance, cultural and linguistic barriers, high rates of poverty, immigration status, unequal treatment by providers, and lack of information all contribute to the reproductive health problems facing Latinas.³ Thus far, the mainstream movement has failed to adequately address these issues for Latinas, despite the fact that Latinas, as members of the largest minority group,⁴ represent an important constituency. Recognizing the difficulties Latinas face in accessing comprehensive reproductive health information and services, Latina activists are renewing a national movement that seeks reproductive justice for Latinas.⁵

This paper explores the limitations of mainstream feminist theory in the context of the reproductive rights movement as it applies to Latinas. Section II provides a brief history of the reproductive rights movement, as well as the critiques of the movement by women of color. Section III presents a description of Latinas' reproductive health issues from a historical and contemporary perspective, as well as an overview of the current efforts by Latinas to address their unique

1. See Melanie M. Lee, *Defining the Agenda: A New Struggle for African-American Women in the Fight for Reproductive Self-Determination*, 6 WASH. & LEE RACE & ETHNIC ANCESTRY L.J. 87 (2000) (detailing the historic inequities in reproductive rights for African-American women).

2. See *id.* at 93 (identifying economic factors and racist social policies as factors contributing to this persistent problem).

3. See generally Roberto R. Ramirez & G. Patricia de la Cruz, *The Hispanic Population in the United States* (U.S. Census Bureau, Washington, D.C.), June 2003, at 4-6, available at <http://www.census.gov/prod/2003pubs/p20-545.pdf> (last visited Jan. 17, 2005).

4. See *id.* at 1-2 (reporting that in 2002, there were approximately 38 million Latinos living in the United States, which represents approximately thirteen percent of the United States population).

5. See NAT'L LATINA INST. FOR REPROD. HEALTH, A NATIONAL LATINA AGENDA FOR REPRODUCTIVE JUSTICE (on file with author); NAT'L LATINA REPROD. HEALTH POLICY AND JUSTICE ADVOCATES, PRINCIPLES OF UNITY AND EQUAL PARTNERSHIP (on file with author).

reproductive health needs. Section IV concludes the paper by examining the lessons that can be learned from Latina feminists and by offering recommendations for creating a movement that is more responsive to women of color.

I. BACKGROUND

A. The Mainstream Reproductive Rights Movement

The mainstream reproductive rights movement has roots in a broader women's rights movement that advocated for women's equality, articulating reproductive and sexual freedom as the means to self-determination, full participation in society, and emancipation from patriarchal control.⁶ During the 1960s and 1970s, feminists advocated for women's right to control their reproductive lives through increased access to contraception and abortion. They brought attention to the deaths of women who, in desperation, were forced to resort to illegal, back-alley abortions,⁷ and they secretly provided underground access to such services.⁸ These women strategically lobbied state legislatures to expand the availability of birth control and safe, legal abortions.⁹ Where that strategy failed, they used the courts to argue that women have a constitutional right to determine whether and when to have a child.¹⁰

The early movement peaked with *Roe v. Wade*,¹¹ the famous 1973 Supreme Court decision legalizing abortion. The Court held in *Roe* that "the right of personal privacy includes the abortion decision, but

6. See, e.g., Rachel Pine & Sylvia Law, *Envisioning a Future for Reproductive Liberty: Strategies for Making the Rights Real*, 27 HARV. C.R.-C.L. L. REV. 407, 423, 455 (1992) (arguing that, historically, opposition to choice was more concerned with control of women than with fetal life).

7. See Lee, *supra* note 1, at 89 (stating that many women joined the reproductive rights movement because of their direct or indirect experiences with dangerous illegal abortions).

8. See Cheryl Ter Horst, *Abortion in the Underground: Before Roe vs. Wade, the Group 'Jane' Gave Women a Choice*, CHI. TRIB., Sept. 15, 1999, § 8, at 1 (describing the most well known of such underground abortion referral services, "Jane," officially known as the Abortion Counseling Service of the Chicago Women's Liberation Union, a network of women in the Chicago area who assisted thousands of women in obtaining abortions from 1969 until 1973).

9. See Jon Merz et al., *A Review of Abortion Policy: Legality, Medicaid Funding, and Parental Involvement, 1967-1994*, 17 WOMEN'S RTS. L. REP. 1, 4-5 (1995) (reporting that states began to liberalize their abortion laws in the late 1960s and early 1970s).

10. See, e.g., *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (granting unmarried individuals access to contraception); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (striking down Connecticut law making it a crime for a married couple to access contraception).

11. 410 U.S. 113 (1973).

that this right is not unqualified and must be considered against important state interests in regulation.”¹² Accordingly, during the first trimester of pregnancy, the doctor, “in consultation with *his* patient,” could decide to terminate a pregnancy free from state regulation.¹³ After this point in pregnancy, the state could regulate abortions so long as the regulations “reasonably relate[d] to the preservation and protection of maternal health.”¹⁴ Once the fetus reached viability, the State could prohibit abortion except when necessary to save the life or health of the mother.¹⁵

The impact that *Roe* has had on the reproductive rights movement cannot be understated; *Roe* has shaped the movement’s focus from both a practical and theoretical standpoint. On a practical level, the movement has dedicated most of its energy and resources toward keeping abortion legal.¹⁶ Although *Roe* was a major victory for the movement, it elevated the controversy around abortion to the national level, provoking an intense backlash.¹⁷ As a result, the movement has had to spend most of the last thirty years defending the right to choose against attempts by the “pro-life” movement to erode or abolish it.¹⁸

On a theoretical level, *Roe* has heavily influenced the mainstream movement’s approach to advancing reproductive rights. Mainstream feminist theoretical messaging behind the movement has become rooted in a traditional, individual rights-based framework, which is consistent with how the Supreme Court has interpreted reproductive rights under the Constitution. Specifically, the Court has held that an individual has a right to make personal decisions about procreation as a function of the right to privacy, which is in turn embedded in the substantive due process right to liberty.¹⁹ Textual support for the right to privacy is expressly negative—the right to be free from state

12. *Id.* at 154.

13. *Id.* at 163 (emphasis added).

14. *Id.*

15. *See id.* at 163-64.

16. *See Merz, supra* note 9, at 5-6 (stating that following the victory of *Roe*, it was immediately necessary to defend against efforts to undermine the essential holdings of the case).

17. *See id.* (describing legislative efforts and legal decisions in the wake of *Roe* designed to “erode” the constitutional right of women to choose to have an abortion).

18. *See* Marlene Gerber Fried, *Abortion in the United States: Legal but Inaccessible*, in *ABORTION WARS: A HALF CENTURY OF STRUGGLE, 1950-2000*, at 219 (Rickie Solinger ed., 1998) (noting that the movement narrowed its agenda from broad reproductive freedom to safe, legal abortion in the 1980s).

19. *See, e.g., Roe*, 410 U.S. at 152-54 (detailing the line of cases which define the scope of “the right of privacy”).

interference.²⁰ The movement has co-opted this language and developed an individual rights-based framework to guide the theoretical arguments it advances for reproductive rights.²¹ The framework is based on four, highly inter-related, theoretical principles: 1) choice (i.e., women must have a choice about whether and when to bear a child); 2) privacy (i.e., personal decisions about sexual intimacy and childbearing are private); 3) freedom from governmental interference (i.e., the government should not interfere with a medical decision that is made by an individual in consultation with her physician); and 4) personal autonomy (i.e., the freedom to make decisions about one's body is an essential component of autonomy).²²

In 1992, the Court came precariously close to overturning *Roe* in *Planned Parenthood v. Casey*.²³ Although there have been many important reproductive rights cases decided in the thirty years since *Roe*, *Casey* arguably has had the most significance in terms of dictating what types of legal arguments can be made today in defense of the right to choose. In *Casey*, the Court gave states the right to regulate abortion at any point prior to viability provided that the state did not "unduly burden" a woman's right to choose.²⁴

As a result of the decision in *Casey*, reproductive rights organizations must challenge anti-choice legislation under the nebulous "undue burden" standard. Anti-choice legislators have used their legislative powers to implement many requirements that restrict abortion access. For example, twenty-six states now require counseling and/or mandatory delays before abortion procedures,

20. See, e.g., U.S. CONST. amend. XIV, § 1 ("No state shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

21. See Pine & Law, *supra* note 6, at 431 (noting that, after *Roe*, litigators relied on the privacy doctrine to advance reproductive rights).

22. See Fried, *supra* note 18, at 219 (arguing that the movement began to use "the more euphemistic notions of *choice*, *personal freedom*, and *privacy*" during the Reagan-Bush era as a counter to the intense anti-abortion movement); see also Pine & Law, *supra* note 6, at 415 ("The idea that 'my body belongs to me,' not to the state, expresses a fundamental value of self-determination: that people require autonomy in the decisions that affect their bodies and their persons in order to be able to participate fully in society."); see also Antoinette Sedillo Lopez, *A Comparative Analysis of Women's Issues: Toward a Contextualized Methodology*, 10 HASTINGS WOMEN'S L.J. 347, 367 (1999) (comparing the abortion issue in Mexico and the United States and concluding that U.S. abortion policy is based on a strong value of autonomy while the Mexico anti-abortion policy is based on its religious and family values).

23. 505 U.S. 833 (1992).

24. *Id.* at 876-77 (explaining that "undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus").

forty-four states have enforceable restrictions on minor's access to abortion (i.e., requiring parental or adult consent), and twenty states have passed laws that impose burdensome regulations on abortion providers and clinics (known as Targeted Regulation of Abortion Providers ("TRAP") laws).²⁵ These laws have proven difficult to challenge under the undue burden standard because courts have significant discretion to determine what constitutes an "undue burden."²⁶

In addition to fighting limitations placed on the right to choose, the mainstream movement has also worked to curb the growing fetal rights movement. In an effort to undermine the premise in *Roe* that fetuses are not full human beings with the same rights as born persons,²⁷ anti-choice advocates have been systematically establishing legal support for fetal personhood by advocating for laws that define the beginning of life at conception or pre-viability.²⁸ For example, many states, as well as the federal government,²⁹ have passed fetal homicide laws, which make killing a fetus during the commission of a crime against the mother a separately punishable offense.³⁰ At least fifteen of these fetal homicide laws define human life from the moment of conception.³¹ It is not clear whether such laws can be

25. NARAL PRO-CHOICE AM., WHO DECIDES? A STATE-BY-STATE REPORT ON THE STATUS OF WOMEN'S REPRODUCTIVE RIGHTS (Jan. 2004) [hereinafter WHO DECIDES?], available at <http://www.naral.org/yourstate/whodecides/index.cfm> (last visited Jan. 17, 2005).

26. See Hilary Guenther, Note, *The Development of the Undue Burden Standard in Stenberg v. Carhart: Will Proposed RU-486 Legislation Survive?*, 35 IND. L. REV. 1021, 1033 (2002) (discussing claims that the undue burden standard is vague and affords judges ample discretion).

27. See *Roe*, 410 U.S. at 156-62 (noting that if fetal personhood is established, the fetus would have a right to life guaranteed under the Fourteenth Amendment).

28. See Kirk Johnson, *Harm to Fetuses Becomes Issue in Utah and Elsewhere*, N.Y. TIMES, Mar. 27, 2004, at A9 (reporting on efforts to establish a separate crime in cases where a fetus is harmed in a violent attack on the mother); see also NARAL PRO-CHOICE AM., ISSUE BRIEF: FETAL RIGHTS (Oct. 2002) (detailing the strategy of bestowing more rights to fetuses in order to diminish women's right to an abortion), available at http://www.naral.org/facts/im_fetal-rights.cfm (last visited Jan. 17, 2005).

29. See, e.g., Unborn Victims of Violence Act of 2004, Pub. L. No. 108-212, 118 Stat. 568 (1996).

30. See Johnson, *supra* note 28, at A9; Sandra L. Smith, Note, *Fetal Homicide: Woman or Fetus as Victim? A Survey of Current State Approaches and Recommendations for Future State Application*, 41 WM. & MARY L. REV. 1845 (2000); Nikki Katz, *Fetal Homicide Laws-What You Need to Know* (explaining that supporters believe this legislation justly recognizes legal rights of both mothers and fetuses, and rightly criminalizes attempts to infringe upon those rights), at <http://womensissues.about.com/cs/parentingfamily/a/aafetalhomicide.htm> (last visited Jan. 17, 2005). Opponents suggest that these laws could create an adversarial relationship between the mother and the fetus, and worry that they could be interpreted to apply to the mother's behavior during pregnancy. *Id.*

31. NAT'L CONFERENCE ON STATE LEGISLATURES, FETAL HOMICIDE (Nov. 2004) (summarizing current fetal homicide statutes), at <http://www.ncsl.org/programs/>

successfully challenged.

Finally, the movement has been involved in efforts to increase the number of pro-choice legislators, prevent the packing of courts with anti-choice justices, reduce clinic violence, fight abstinence-only education policies, and expand access to contraception.³² Women's rights organizations use a range of tactics, including litigation, lobbying, campaigning, and public education to achieve these goals.³³

*B. Critiques by Women of Color*³⁴

Women of color have critiqued the movement since its inception on a number of grounds, each relating to the central ideas that women of color have been excluded from the movement and that the movement does not speak for them.³⁵ First, women of color argue that pro-choice messaging does not resonate with certain communities of color because many women of color have never had real choices.³⁶ As shorthand to describe the position that abortion should be a choice available to women, the term "pro-choice" carries an assumption that having children is a default option for women. The term does not adequately reflect the fact that many poor women of color have been limited in their ability to bear children through coercive reproductive policies. For example, forced sterilization,³⁷

health/fethom.htm (last visited Jan. 17, 2005).

32. See Pine & Law, *supra* note 6, at 441 ("The impending demise of *Roe* has . . . revitalized the pro-choice movement.").

33. See *id.* at 443-55 (detailing the various strategies adopted by pro-choice groups to preserve and expand access to legal abortion).

34. I use the term "women of color" to refer to women who identify as Latina, African-American, Asian, and Native American, recognizing that this is a broad and diverse group of women who do not necessarily share the same experiences or perspectives.

35. See, e.g., Darci Elaine Burrell, *The Norplant Solution: Norplant and the Control of African-American Motherhood*, 5 UCLA WOMEN'S L.J. 401, 405-07 (1995); Lee, *supra* note 1, at 95-96 (stating that "most minority women view the abortion rights movement to be 'white woman-led and white woman-defined'"); Lopez, *supra* note 22, at 348; Daisy Hernandez & Pandora Leong, *Feminism's Future: Young Feminists Take the Mic*, IN THESE TIMES, Apr. 21, 2004, available at http://www.inthesetimes.com/comments.php?id=703_0_1_0_C (last visited Jan. 17, 2005); see also Angela P. Harris, *Race and Essentialism in Feminist Legal Theory*, 42 STAN. L. REV. 581, 585 (1990) (critiquing feminist legal theorists' reliance on gender essentialism, which she defines "as the notion that a unitary, 'essential' women's experience can be isolated and described independently of race, class, sexual orientation, and other realities of experience").

36. See Charlotte Rutherford, *Reproductive Freedoms and African-American Women*, 4 YALE J.L. & FEMINISM 255, 258, 273-75 (1992) ("The reproductive rights and choices of poor women of color are fairly limited and sometimes non-existent."). See generally Pine & Law, *supra* note 6, at 453-54; Dorothy Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1461, 1464 (1991).

37. See, e.g., Luz Alvarez Martinez, *Major Latina Health Issues: 500 Years After*

family caps under state welfare laws,³⁸ and a history of racism that devalues women of color and portrays them as undeserving mothers,³⁹ have had profound effects on the ability of women of color to fulfill their reproductive choice to have children.

The term “pro-choice” is also problematic because it presupposes an ability to exercise a choice once it has been made and that women have the resources to execute their choices.⁴⁰ Poor women of color have not always been able to carry out their choice to prevent an unwanted pregnancy or terminate a pregnancy because of financial constraints and the limited availability of public funding.⁴¹ Women of color, who are disproportionately impoverished, often rely on Medicaid, Title X clinics, and other publicly funded sources for their healthcare.⁴² Title X clinics, which provide family planning services to low-income women,⁴³ have been systematically underfunded at the state and federal level⁴⁴ and subjected to restrictive federal policies.⁴⁵

Colonization, in TIME TO RISE: U.S. WOMEN OF COLOR—ISSUES AND STRATEGIES 78 (Maylei Blackwell et al. eds., 2001).

38. See, e.g., *id.* at 79.

39. See, e.g., Catherine Albiston, *The Social Meaning of the Norplant Condition: Constitutional Considerations of Race, Class, and Gender*, 9 BERKELEY WOMEN'S L.J. 9, 16-19 (1994) (describing the racist and sexist stereotypes of black women and the devaluation of black motherhood); Lisa Ikemoto, *The Code of Perfect Pregnancy: At the Intersection of the Ideology of Motherhood, the Practice of Defaulting to Science, and the Interventionist Mindset of Law*, 53 OHIO ST. L.J. 1205, 1220 (1992) (noting the racial component of the devaluation of motherhood and the regulation of pregnancy); Lee, *supra* note 1, at 90-95 (discussing the history of reproductive oppression of African-American women).

40. See Lopez, *supra* note 22, at 368 (“Allowing absolute individual autonomy . . . can help women in a position to exercise choices to make those choices. However, autonomy theory does not help women (e.g., women of color and those who are poor) who are not in a position to exercise choices.”); see also Roberts, *supra* note 36, at 1478 (noting that “the abstract freedom to choose is of meager value without meaningful options from which to choose and ability to effectuate one’s choice”).

41. See Lee, *supra* note 1, at 93 (noting that financial limitations hinder poor women, a disproportionate number of which are minorities, from obtaining abortions); see also Julie F. Kay, Note, *If Men Could Get Pregnant: An Equal Protection Model for Federal Funding of Abortion Under a National Health Care Plan*, 60 BROOK. L. REV. 349, 365-66 (1994) (discussing geographic and financial restrictions on access to abortion).

42. See KAISER FAMILY FOUND. (“KFF”), RACIAL AND ETHNIC DISPARITIES IN WOMEN’S HEALTH COVERAGE AND ACCESS TO CARE: FINDINGS FROM THE 2001 KAISER WOMEN’S HEALTH SURVEY 2 (Mar. 2004) [hereinafter DISPARITIES], available at <http://www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=33087> (last visited Jan. 17, 2005).

43. Title X clinics provide a range of family planning services, including contraception, gynecological exams, pregnancy testing, screening for HIV, STDs, cervical cancer, breast cancer, diabetes, and health education. Twenty-one percent of Title X clinic users are African-American, and twenty-one percent are Latino/a. See NAT’L FAMILY PLANNING AND REPROD. HEALTH ASS’N (“NFPRHA”), TITLE X, THE NATIONAL FAMILY PLANNING PROGRAM, ESSENTIAL HEALTH CARE FOR LOW-INCOME WOMEN OF COLOR 1-2 (Oct. 2003) [hereinafter ESSENTIAL HEALTH CARE].

44. NFPRHA, TITLE X, NATIONAL FAMILY PLANNING PROGRAM, CRITICAL WOMEN’S

The Hyde Amendment, which Congress first passed in 1977, prohibits the use of federal Medicaid funding for abortion except in the case of rape, incest, and life endangerment.⁴⁶ In 1980, the Supreme Court upheld the Hyde Amendment and found that the denial of Medicaid funding for medically necessary abortions did not violate the Due Process or Equal Protection Clause.⁴⁷ Twenty-seven states currently impose the full Hyde Amendment restrictions, limiting public funding for abortions to cases of rape, incest, and life endangerment, with no exceptions for medically necessary abortions that are not life threatening.⁴⁸ Relying on public health care programs thus limits the ability of poor women of color to exercise certain reproductive choices.

The second connected criticism suggests that the mainstream movement is too narrowly focused on keeping abortion legal rather than ensuring that women have the ability to access the full range of reproductive health care services free from governmental coercion.⁴⁹ As one commentator explained:

HEALTH PROGRAM STRUGGLES TO MEET INCREASING DEMAND 1 (Oct. 2003); see also Rachel Benson Gold, *Nowhere But Up: Rising Costs for Title X Clinics*, THE GUTTMACHER RPT. ON PUBLIC POL'Y, Dec. 2002, at 6.

45. See NAT'L ABORTION FED'N, ABORTION AND TITLE X: WHAT HEALTH CARE PROVIDERS NEED TO KNOW (2003) (discussing the federally regulated gag rule prohibiting discussion of abortion as a family planning option, which was upheld by the Supreme Court in *Rust v. Sullivan*, 500 U.S. 173 (1991)), available at http://www.prochoice.org/about_abortion/facts/abortion_title_x.html (last visited Jan. 17, 2005).

46. Consolidated Appropriations Act of 2004, Pub. L. No. 108-199, 118 Stat. 3 (2004). It should be noted that while the federal government will not reimburse for abortion, sterilization services are covered under the Medicaid program. Roberts, *supra* note 36, at 1443.

47. See *Harris v. McRae*, 488 U.S. 297 (1980).

48. See WHO DECIDES?, *supra* note 25, at 21.

49. See, e.g., Lee, *supra* note 1, at 96 ("Critical race feminist scholars have long petitioned for a broader definition of reproductive freedom that includes the ability of women to bear children, to conceive, to carry a fetus, to have an abortion, to deliver a baby, and to care for a child."); Roberts, *supra* note 36, at 1461 ("The primary concern of white, middle-class women are laws that restrict choices otherwise available to them, such as statutes [restricting abortion access]. The main concern of poor women of color, however, are the material conditions of poverty and oppression that restrict their choices."); Rutherford, *supra* note 36, at 258-59 ("Reproductive choice for African-American women must encompass a broad definition of reproductive health issues, rather than focus only on the issue of access to abortion services."). The mainstream movement has also been criticized for failing to fight for low-income women's abortion access:

[The pro-choice movement]'s focus has too often been on maintaining the legal right to abortion, while the unequal ability of different groups of women to exercise that right is slighted. The mainstream and predominately white middle-class pro-choice movement has always responded weakly, if at all, to restrictions on low-income women's abortion rights.

Fried, *supra* note 18, at 211.

[A] broad definition of reproductive freedoms must include access to adequate prenatal care; access to sex education and appropriate contraceptives; access to infertility services, including early diagnosis and proper treatment for preventable causes of infertility, concern about surrogacy and the potential exploitation of poor women of color; freedom from coerced or ill-informed consent to sterilization; freedom from reproductive hazards in the workplace; and last, but not least, the option of abortion.⁵⁰

For women of color, the range of reproductive health issues extends well beyond abortion.

Third, many women of color feminists argue that mainstream reproductive rights groups have failed to adequately address the intersectionality of race and gender in the reproductive health context.⁵¹ Women of color have criticized the movement for not fully acknowledging the historical role that race has played in the birth control movement in the United States and abroad.⁵² These feminists argue that for women of color, the line between helping women control their reproductive lives and coercing them to reduce their number of children has never been very clear. Not enough attention has been paid to the history of coercive sterilization and contraceptive testing, or the current use of long-term contraception methods,⁵³ all of which disparately affect communities of color. Women of color have emphasized the need for mainstream groups to develop a stronger critique of reproductive technologies in terms of their impact on poor women and women of color.⁵⁴

50. Rutherford, *supra* note 36, at 259.

51. See, e.g., Burrell, *supra* note 35, at 405-07; Roberts, *supra* note 36, at 1424.

52. See *Birth Control or Race Control? Sanger and the Negro Project*, 28 MARGARET SANGER PAPERS PROJECT 1 (2001) (discussing Margaret Sanger's campaign to increase birth control use among African-Americans in the South in 1939 and describing the "Negro Project" as "largely indifferent to the needs of the black community and constructed in terms and with perceptions that today smack of racism"); see also Burrell, *supra* note 35, at 420-22; Ikemoto, *supra* note 39, at 1225 ("Contraception restrictions state a preference for motherhood that is white, married, and probably middle class."). See generally Lee, *supra* note 1.

53. See, e.g., Burrell, *supra* note 35, at 402 (noting the story of a judge requiring a woman convicted of child abuse to use Norplant as a condition of her probation, and mentioning movements to mandate long-term birth control as a condition for obtaining welfare benefits); Sonia Correa, *Norplant in the Nineties: Realities, Dilemmas, Missing Pieces*, in POWER AND DECISION: THE SOCIAL CONTROL OF REPRODUCTION 287-309 (1994) (discussing the controversy around Norplant between feminists); Martinez, *supra* note 37, at 79 (highlighting problems associated with Depo-Provera and Norplant).

54. See, e.g., Burrell, *supra* note 35, at 408-09; Dorothy Roberts, *Race and the New Reproduction*, 47 HASTINGS L.J. 935 (1996) (applying a critical race analysis to new reproductive technologies, including in vitro fertilization and surrogacy); see also Roberts, *supra* note 36, at 1450 (analyzing the prosecution of pregnant drug addicts who are predominately African-American women).

Finally, feminists have critiqued the reliance on traditional privacy doctrine to advance reproductive rights, especially with respect to poor women.⁵⁵ Although the privacy argument was effective in securing certain reproductive rights under the Constitution, it has provided the Supreme Court a doctrinal justification for denying low-income women equal access to reproductive rights.⁵⁶ Despite these drawbacks, the mainstream movement continues to emphasize privacy exclusively as a right to be free from state interference. Recognizing that many poor women of color have limited privacy with respect to the government, and in fact rely on government programs to access reproductive health care services, women of color feminists have argued that the movement has not demanded enough pro-active involvement from the government to facilitate reproductive choice.⁵⁷

II. REPRODUCTIVE RIGHTS: THE LATINA PERSPECTIVE⁵⁸

A. A History of Limited Choices

Latinas have a long history of fighting against coercive practices and for basic reproductive health services.⁵⁹ Latinas fought for their reproductive rights independently of white feminists, as well as within the mainstream movement.⁶⁰ Despite their involvement, Latinas have not been afraid to criticize the movement. Specifically, Latinas have questioned the movement's "pro-choice" messaging and its abortion-focused platform.⁶¹ Latinas have argued that they have never had a full range of choices about whether or not to have a child and that other reproductive health issues are just as or even more important to

55. See Roberts, *supra* note 36, at 1476 (discussing the feminist critique of the privacy doctrine).

56. See, e.g., *Harris*, 448 U.S. at 317 (finding that "the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all").

57. See Albiston, *supra* note 39, at 38 ("Poor women of color experience greater governmental intrusion on their privacy because they rely on welfare agencies for economic support and public health facilities for health care."); Roberts, *supra* note 36, at 1461 (noting that the choices of poor women of color "are limited not only by direct government interference with their decisions, but also by the government's failure to facilitate them").

58. For purposes of this paper, I refer to Latinas as one group, but I recognize that Latinas represent a diverse group of individuals from different countries of origin, cultures, and races, and that there is not one universal "Latina" perspective or history.

59. See Jael Silliman et al., *UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE* 218-30 (South End Press, ed. 2004).

60. See *id.*

61. NAT'L LATINA INST. FOR REPROD. HEALTH ("NLIRH"), *LATINAS AND ABORTION ACCESS* 1 (Jan. 2004) [hereinafter *ABORTION ACCESS*].

them than abortion. As the National Latina Institute for Reproductive Rights explained,

Pro-choice language is often difficult to translate and many immigrant Latinas are not too familiar with the American political context. The reproductive rights of Latinas have been threatened by a range of coercive and punitive policies, all of which have denied Latinas access to basic health care services. Consequently, for many women of color, the fight for abortion rights is broader and the term “pro-choice” is too limiting.⁶²

A closer look at the history of reproductive rights for Latinas demonstrates how their choices have been limited. Latinas have a long history of forced sterilization in the United States and Puerto Rico.⁶³ Thousands of Latinas, specifically Puerto Rican, Dominican and Mexican-American women, suffered from forced or coercive sterilization from the 1950s until the late 1970s.⁶⁴ Many of these women were sterilized in public hospitals immediately following childbirth.⁶⁵ Evidence indicates that some women were not aware that the procedure was happening or that it would be permanent.⁶⁶ For example, one of the most egregious sterilization practices occurred at the Los Angeles County Medical Hospital, where Mexican-origin women were sterilized during or immediately following childbirth, without adequate information or necessary

62. *Id.*

63. See Elena R. Gutiérrez, *Policing “Pregnant Pilgrims”: Situating the Sterilization Abuse of Mexican-Origin Women in Los Angeles County*, in *WOMEN, HEALTH, AND NATION, CANADA AND THE UNITED STATES SINCE 1945*, at 380 (Georgina Feldberg et al. eds., 2004) (describing the sterilization abuse Mexican-origin women suffered at the Los Angeles County Medical Hospital and contextualizing the practice within the prevailing “social concerns about increasing Mexican immigration”); Iris Lopez, *Agency and Constraint: Sterilization and Reproductive Freedom Among Puerto Rican Women in New York City*, in *SITUATED LIVES: GENDER AND CULTURE IN EVERYDAY LIVES* 157 (Louise Lamphere et al. eds., 1997); see also Jenny Rivera, *The Violence Against Women Act and the Construction of Multiple Consciousness in the Civil Rights and Feminist Movements*, 4 *J.L. & POL’Y* 463, 480 (1996) (noting that, globally, Puerto Rican women have the highest rate of sterilization).

64. Gutiérrez, *supra* note 63, at 380; Loretta Ross et al., *The “SisterSong Collective”: Women of Color, Reproductive Health and Human Rights*, 17 *AM. J. HEALTH STUD.* 2, 79-81 (2001) (citing Princeton University’s national fertility study, conducted in 1970, that found that twenty percent of all Chicana women and thirty-five percent of Puerto Rican women of childbearing age had been sterilized).

65. Stephen Trombley, *Exporting Sterilization*, in *THE RIGHT TO REPRODUCE: A HISTORY OF COERCIVE STERILIZATION* 214-34 (Weidenfeld & Nicolson eds., 1988); CHI. COMM. TO END STERILIZATION ABUSE (“CESA”), *STERILIZATION ABUSE: A TASK FOR THE WOMEN’S MOVEMENT* (Jan. 1977) [hereinafter *STERILIZATION*], at <http://www.cwluherstory.com/CWLUArchive/cesa.html> (last visited Jan. 17, 2005).

66. See Carlos G. Velez, *The Nonconsenting Sterilization of Mexican Women in Los Angeles*, in *TWICE A MINORITY: MEXICAN AMERICAN WOMAN* 235-40 (1980) (providing accounts of physical abuse or withholding pain medication in order to secure the woman’s signature on a consent form). See generally Lopez, *supra* note 63.

translation.⁶⁷

In California, some judges ordered female defendants to undergo sterilization as a condition of probation.⁶⁸ In all of the recorded forced sterilization cases the defendants were either Latinas or African-Americans.⁶⁹ In one particularly notorious case, a twenty-one year old Latina was given the choice between jail time or probation conditional upon her sterilization.⁷⁰ The crime, a misdemeanor, was being present in a room where her boyfriend was caught smoking marijuana.⁷¹ In addition to probation sentences, some women were coercively sterilized in order to obtain welfare benefits.⁷²

During the 1970s, Latinas actively resisted coercive sterilization practices by demanding new standards for informed consent procedures.⁷³ One of the most influential Latinas spearheading the movement was Dr. Helen Rodriguez-Trias, a Puerto Rican physician who fought for access to abortion and prenatal care and against forced sterilization in New York and Puerto Rico.⁷⁴

The history of sterilization provides an example of how Latinas have been unable to fulfill their reproductive choice to bear children.⁷⁵

67. See, e.g., Gutiérrez, *supra* note 63, at 386 (noting that “doctors often took advantage of their patients’ inability to understand English to manipulate them into consenting to sterilization”); Martínez, *supra* note 37, at 78 (discussing a 1975 lawsuit filed on behalf of twelve Latina patients who had been forcibly sterilized by the USC Medical Hospital); Stephen Trombley, *Sterilization and Informed Consent, the 1960’s*, in *THE RIGHT TO REPRODUCE: A HISTORY OF COERCION* 175-213 (Weidenfeld & Nicolson eds., 1988) [hereinafter *Informed Consent*]; Pamela Bridgewater, *Connectedness and Closeted Questions: The Use of History in Developing Feminist Legal Theory*, 11 *WIS. WOMEN’S L.J.* 351, 365 (1997); Ikemoto, *supra* note 39, at 1233 (stating that for many years involuntary sterilization was federally funded).

68. *Informed Consent*, *supra* note 67, at 176.

69. See *id.*

70. See *id.*

71. See *id.*

72. See Roberts, *supra* note 36, at 1443; see also Trombley, *supra* note 65, at 176 (referring to a case in which three unmarried women were arrested when they applied for welfare, and the judge threatened to remove their children if they had any more children).

73. See SILLIMAN, *supra* note 59, at 225-28.

74. See Helen Rodriguez-Trias, *Sterilization Abuse*, in *BIOLOGICAL WOMAN—THE CONVENIENT MYTH* 147 (1982); NAT’L LIBRARY OF MED., *CHANGING THE FACE OF MEDICINE, BIOGRAPHY: DR. HELEN RODRIGUEZ-TRIAS*, at www.nlm.nih.gov/changingthefaceofmedicine/physicians/biography_273.html (last visited Jan. 17, 2005).

75. See KFF, *ORLANDO SENTINEL EXAMINES ‘BITTER FEELINGS’ OF SOME PUERTO RICAN PARTICIPANTS IN EARLY ORAL CONTRACEPTION STUDIES* (Apr. 6, 2004) (noting that abusive reproductive control techniques were not limited to sterilization), at http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=23056 (last visited Jan. 17, 2005). In the 1950s and early 1960s, Puerto Rican women were used as test subjects for new oral contraceptives. *Id.* Participants in the study were not provided full information about the study and as a result, many suffered serious side effects. *Id.* Researchers used the results of the study to improve the pill for

Latinas have also been constrained in their ability to prevent or terminate unwanted pregnancies because of financial barriers. Historically, Latinas have had a high rate of poverty and limited access to public health programs. The Hyde Amendment exacerbated the problem of abortion access for Latinas.⁷⁶ In fact, the first woman to die from a back-alley abortion after the Hyde Amendment became law was Rosie Jimenez, a young, Latina single-mother who had recently enrolled in college to build a better life for herself and her daughter.⁷⁷ Without Medicaid funding, Rosie could not afford to go to a licensed physician. She died from an infection within a week of her illegal abortion procedure.⁷⁸ Low-income Latinas who could not obtain contraception or an abortion were effectively denied the choice not to have children.

B. Reproductive Health and Rights Issues Facing Latinas Today

In addition to the continuing difficulties accessing abortion, Latinas face a number of obstacles to improving their reproductive health status, including: lack of health insurance; limited access to providers; cultural/language barriers; high rates of poverty; restrictive immigration policies; unequal treatment by providers; and lack of information. This section will briefly explore each of these barriers, followed by an overview of Latinas' most alarming reproductive health disparities, in order to illustrate how broad and urgent these issues are for Latinas.

The most pressing concern is the low rate of health insurance coverage among Latinas of reproductive age. It is estimated that over one-third (37%) of Latinas in the United States do not have health insurance, the highest rate of uninsured among any racial/ethnic group.⁷⁹ Research has found that nearly half of the Latina population lacks health insurance for at least part of the year.⁸⁰ Without health insurance, Latinas are less likely to visit their health care providers and obtain important health screenings.⁸¹ According to a recent

women in the United States. *Id.*

76. See, e.g., SILLIMAN, *supra* note 59, at 218.

77. See *id.*

78. See *id.*

79. See, e.g., DISPARITIES, *supra* note 42, at 2; CTRS. FOR DISEASE CONTROL & PREVENTION, MORBIDITY AND MORTALITY WEEKLY RPT., ACCESS TO HEALTH-CARE AND PREVENTIVE SERVICES AMONG HISPANICS AND NON-HISPANICS—UNITED STATES, 2001-2002 (Oct. 15, 2004) [hereinafter MORBIDITY AND MORTALITY], available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5340a2.htm> (last visited Jan. 17, 2005).

80. See DISPARITIES, *supra* note 42, at 2.

81. See *id.*; see also MORBIDITY AND MORTALITY, *supra* note 79, at 938, 946.

survey, almost one quarter of Latinas had not visited a physician in the last year,⁸² and slightly less than one-third of Latinas had not had a clinical breast exam.⁸³ Thirty-one percent of Latinas reported not having a regular health care provider, compared to seventeen percent of African-American women and fourteen percent of white women.⁸⁴ Without a regular doctor, detecting diseases early and effectively managing chronic illnesses are difficult, if not impossible. In addition to lack of insurance, Latinas have also reported that problems finding childcare and transportation have impeded their access to providers.⁸⁵

For Latinas who are able to access providers, language and cultural barriers account for some of the problems they encounter when trying to obtain basic reproductive health care. Differences in language and culture between the provider and the patient can hinder communication and affect the quality of care that patients receive.⁸⁶ Recent census reports indicate that twenty-eight percent of Spanish-speakers speak English “not well” or “not at all.”⁸⁷ For these limited English proficient Latinos, language has proven to be a significant barrier to effective communication with their physicians.⁸⁸ When sensitive issues are involved, as is often the case in the area of reproductive health, poor communication can leave Spanish-speakers feeling uncomfortable and dissatisfied with their treatment.⁸⁹

82. See DISPARITIES, *supra* note 42, at 3.

83. See *id.* at 5.

84. See *id.* at 4.

85. See *id.* at 3.

86. See, e.g., Lisa Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 ST. LOUIS U. L.J. 75, 83-86 (2003) (describing studies demonstrating how language barriers can impede a patient’s access to care and reduce quality of care); LEIGHTON KU & TIMOTHY WAIMANN, KAISER FAMILY FOUNDATION, HOW RACE/ETHNICITY, IMMIGRATION STATUS AND LANGUAGE AFFECT HEALTH INSURANCE COVERAGE, ACCESS TO CARE AND QUALITY OF CARE AMONG THE LOW-INCOME POPULATION 9, 17-18 (Aug. 2003) (“[O]ne-fifth of Spanish speaking Latinos reported they did not seek medical care when it was needed either because the doctor did not speak Spanish or because there was no language interpreter available.”), available at http://www.kf.org/uninsured/upload/22103_1.pdf (last visited Jan. 17, 2005).

87. See U.S. CENSUS BUREAU, LANGUAGE USE AND ENGLISH-SPEAKING ABILITY: 2000, at 4 (2003), available at <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf> (last visited Jan. 17, 2005).

88. See KU & WAIMANN, *supra* note 86, at 9; see also MICHELLE M. DOTY, THE COMMONWEALTH FUND, HISPANIC PATIENTS’ DOUBLE BURDEN: LACK OF HEALTH INSURANCE AND LIMITED ENGLISH 8-20 (Feb. 2003) (explaining that the problems associated with language barriers are likely to worsen in regions that are experiencing new immigrant populations, such as Georgia and North Carolina); see also U.S. CENSUS BUREAU, HISPANIC POPULATION 2000, at 5 (2003).

89. See DOTY, *supra* note 88, at 12 (stating that one in four Hispanics with limited English proficiency felt that their doctor had listened to them “somewhat” or “a little” and said they only understood “some” or “a little” of what their doctor told them).

Connected to the difficulty Latinas have accessing health insurance, providers and linguistically appropriate care is the overarching problem of poverty. Poverty is a strong indicator for reproductive health status because one's resources affect one's ability to access reproductive health services. Latinas are faring worse than other racial and ethnic groups in terms of poverty level, income, and labor force participation. While the overall poverty rate for single mothers in 2002 was 28.8%, 36.4% of Latina single mothers lived in poverty.⁹⁰ The overall mean income of Latinas was \$17,846 in 2001, as compared to \$21,215 for black women and \$23,837 for non-Hispanic white women.⁹¹ The median income for Latinas in 2001 was only \$12,583, compared to \$16,282 for black women and \$16,652 for non-Hispanic white women.⁹² Part of the income disparity can be explained by the fact that Latinas are less likely to have graduated from high school and less likely to be in the labor force than are white and black women.⁹³ In 2000, only fifty-seven percent of Latinas were in the labor force.⁹⁴ This reflects the overall employment trend of Latinos, who have a higher unemployment rate and earn less than non-Hispanic white workers.⁹⁵ Immigrant Latinas specifically are even less likely to have participated in the labor force (forty percent participation rate), and more likely to earn lower wages when employed than immigrant Latinos and native workers.⁹⁶ As a result of their financial situation, many Latinas rely on public health care programs for their reproductive health care services.⁹⁷ These programs, as previously noted, are not well funded and may not offer the full range of reproductive health care services that one could obtain on the market with sufficient resources.

Not surprisingly given their high rate of poverty, Latinas are also over-represented on the welfare rolls. Latino families comprise twenty-six percent of the current Temporary Assistance to Needy

90. U.S. CENSUS BUREAU, SINGLE PARENTS BY SELECTED CHARACTERISTICS (2000).

91. U.S. CENSUS BUREAU, HISTORICAL INCOME TABLES; RACE AND HISPANIC ORIGIN OF PEOPLE BY MEAN INCOME AND SEX: 1947 TO 2001 (2002), available at <http://www.census.gov/hhes/income/histinc/p03.html> (last visited Jan. 17, 2005).

92. *Id.*

93. DEP'T OF HEALTH AND HUM. SERV., 2002 WOMEN'S HEALTH USA 20 (2002).

94. *Id.*; see also U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES (2001).

95. Ramirez & de la Cruz, *supra* note 3, at 5-6.

96. RANDY CAPPS ET AL., URBAN INSTITUTE, IMMIGRANT FAMILIES AND WORKERS: A PROFILE OF THE LOW-WAGE IMMIGRANT WORKFORCE 5-6 (2003).

97. See DISPARITIES, *supra* note 42, at 2 (stating that twelve percent of Latinas rely on Medicaid for basic health care); see also ESSENTIAL HEALTH CARE, *supra* note 43, at 1 (noting that over twenty-one percent of Latinas obtain family planning services at Title X clinics).

Families (“TANF”) population, even though Latinos represent only thirteen percent of the total United States population.⁹⁸ Welfare policies can affect a Latina’s reproductive choices through state family cap laws, which limit welfare benefits regardless of whether a woman has additional children.⁹⁹ Twenty-three states have some version of a family cap law in place,¹⁰⁰ and studies have shown that these tend to be states with higher minority populations.¹⁰¹

Immigration status is another important indicator for Latinas’ reproductive health. With 52.2% of the Latino population in the United States foreign-born,¹⁰² the reproductive health status of Latinas is dependent in part upon whether immigrants have access to basic reproductive health services. Immigrant Latinas are presently facing a health care coverage crisis; fifty-six percent of low-income immigrant Latinas lack health insurance.¹⁰³ Immigrants frequently lack health insurance because they are less likely to find employment opportunities in industries that provide employer-based health care coverage.¹⁰⁴ Immigrants are also systematically excluded from certain public health programs. Under the 1996 welfare law, legal immigrants who arrived after August 22, 1996 do not have access to federal Medicaid or State Children’s Health Insurance Program (“SCHIP”) funding for their first five years in the United States.¹⁰⁵

98. DEP’T OF HEALTH AND HUM. SERV., 2003 ADMIN. FOR CHILDREN AND FAM., ANN. TANF REP. TO CONG. (2003). Low-income Latina welfare recipients are heavily concentrated in three states: California, New York, and Texas. The percentage of Latinas on welfare in these three states is staggering: in California and in Texas, forty-nine percent of welfare recipients are Latina, and in New York, thirty-nine percent of recipients are Latina. *Id.* Although Latinos make up a larger share of the population in all three of these states (32% in California, 15% in New York, and 32% in Texas), they are still drastically over-represented on the welfare rolls. See U.S. CENSUS BUREAU, UNITED STATES LATINO POPULATION, VOTING AGE POPULATION, AND CITIZEN VOTING AGE POPULATION COMPARISON TABLE (2000).

99. See Martínez, *supra* note 37, at 79.

100. See JODIE LEVIN-EPSTEIN, CTR. FOR LAW AND SOC. POL’Y, LIFTING THE LID OFF THE FAMILY CAP: STATES REVISIT PROBLEMATIC POLICY FOR WELFARE MOTHERS 2 (Dec. 2003).

101. Joe Soss et al., *Setting the Terms of Relief: Explaining State Policy Choices in Devolution Revolution*, 45 AM. J. POL. SCI. 378, 386 (Apr. 2001); see also LEVIN-EPSTEIN, *supra* note 100, at 3 (noting that studies found family cap laws do not actually reduce out-of-wedlock births).

102. U.S. CENSUS BUREAU, CURRENT POPULATION SURVEY: FOREIGN BORN POPULATION IN THE UNITED STATES (March 2002).

103. NLIRH, FORGING NEW PARTNERSHIPS: IMPROVING ACCESS TO REPRODUCTIVE HEALTH CARE FOR LATINA IMMIGRANTS 1 (Feb. 2004).

104. KAISER COMM’N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUNDATION, IMMIGRANTS’ HEALTH CARE COVERAGE AND ACCESS 1 (Aug. 2003) [hereinafter COVERAGE]; see also RANDY CAPPS ET AL., URBAN INSTITUTE, A PROFILE OF THE LOW-WAGE IMMIGRANT WORKFORCE 1 (Nov. 2003) [hereinafter PROFILE].

105. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), 42 U.S.C.A. § 1601 (1996).

The law also established “deeming” requirements whereby an immigrant sponsor’s resources can be attributed to the immigrant when determining his or her eligibility for Medicaid and SCHIP.¹⁰⁶ There is no exception in the law for prenatal care, and only nineteen states currently use state Medicaid funds to cover low-income pregnant immigrants during their first five years of residency.¹⁰⁷

In addition to problems obtaining health care coverage, immigrant Latinas suffer from language barriers, geographic isolation, and discrimination from providers.¹⁰⁸ Undocumented immigrants fare even worse; in many states, public funding is only available to undocumented Latinas for emergency medical services, which include labor and delivery but not prenatal care.¹⁰⁹ In a political climate that is increasingly hostile toward immigrants, some undocumented immigrants avoid seeking medical attention for fear of deportation.¹¹⁰

Another factor contributing to disparities in health outcomes for Latinas was recently brought to light by a number of studies, most notably a report issued by the Institute of Medicine in 2002.¹¹¹ These studies demonstrate that even when insurance status, income level, and age are taken into account, racial and ethnic minorities generally receive lower quality care from healthcare providers than whites.¹¹² Researchers have found that providers may not be aware of the biases that they hold about racial and ethnic minorities, and that these views may nevertheless affect the quality of care minority patients receive.¹¹³ Exacerbating the unequal treatment problem is the dearth of Latino health professionals.¹¹⁴ Until providers commit to eliminating racial bias and greater diversity in the health professions is achieved, Latinas and other racial and ethnic minorities will struggle to achieve health outcomes on par with whites.

106. *Id.*

107. *See* COVERAGE, *supra* note 104, at 2.

108. *See id.*

109. *See* PRWORA § 1611; Emergency Medical Treatment and Active Labor Act (“EMTALA”), 42 U.S.C.A. § 1395dd (2003).

110. *See* Ross, *supra* note 64.

111. INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (Sept. 2002) [hereinafter INST. OF MED.]; *see also* NAT’L ALLIANCE FOR HISPANIC HEALTH & THE NAT’L PHARMACEUTICAL COUNCIL, GENES, CULTURE AND MEDICINE: BRIDGING THE GAP IN TREATMENT FOR HISPANIC AMERICANS (March 2004) (documenting the disparities Latinos face in pharmaceutical therapy); PHYSICIANS FOR HUMAN RIGHTS, THE RIGHT TO EQUAL TREATMENT (2003), *available at* http://www.phrusa.org/research/domestic/race/race_report/report.html (last visited Jan. 17, 2005).

112. INST. OF MED., *supra* note 111.

113. *See id.*

114. DEP’T OF HEALTH AND HUM. SERV., HEALTHY PEOPLE 2010 (2000).

Finally, many Latinas are not receiving comprehensive reproductive health information in their schools or in the home.¹¹⁵ Abstinence-only education policies fail to adequately educate teenagers who choose to become sexually active.¹¹⁶ Without such information, Latina teenagers who are sexually active will be unprepared to protect themselves against sexually transmitted infections (“STIs”) and unwanted pregnancies. For many Latinas, lack of information in schools is exacerbated by religious and social beliefs that prevent open dialogues about sexuality.¹¹⁷ Focus groups conducted in California found that Latinas listed lack of education and information on reproductive health issues to be the most pressing issue for their communities.¹¹⁸ They expressed the need for more open dialogue in the family and community about reproductive health issues.¹¹⁹

The compounded effect of these multiple barriers is a host of disparities in Latinas’ reproductive health status, some of the most significant of which are in the area of STIs. In recent years, HIV/AIDS has spread rapidly among Latinas. Latinas account for sixteen percent of new AIDS cases among women, although they only represent thirteen percent of the entire female population in the United States.¹²⁰ The AIDS case rate is six times higher among Latinas than white women,¹²¹ and AIDS is the fourth leading cause of death among Latinas ages twenty-five to forty-four.¹²² Latinas, especially Latina teenagers, also have a higher infection rate of syphilis, gonorrhea, and Chlamydia than white women.¹²³

In addition, Latinas have a higher prevalence of and mortality from

115. NAT’L LATINA INSTITUTE FOR REPROD. HEALTH, *LATINAS AND ABORTION*, SPECIAL REPORT (1999) [hereinafter *LATINAS AND ABORTION*] (finding that most Latinas rely on doctors, Planned Parenthood clinics, and community health clinics to obtain birth control information as opposed to school advisors).

116. NAT’L LATINA INST. FOR REPROD. HEALTH, *THE REPRODUCTIVE HEALTH OF LATINAS IN THE U.S.* (March, 2002) (arguing that comprehensive “sexuality education is essential considering that 45% of 9-12th grade Latinas have had sex”), available at <http://www.latinainstitute.org/facts.html> (last visited Jan. 17, 2005).

117. Ross, *supra* note 64.

118. LATINO ISSUES FORUM, *OUR HEALTH, OUR RIGHTS, REPRODUCTIVE JUSTICE FOR LATINAS IN CALIFORNIA* 28-29 (Sept. 2003) [hereinafter *LATINO ISSUES*].

119. *See id.*

120. KFF, *WOMEN AND HIV/AIDS IN THE UNITED STATES* (Dec. 2004).

121. *Id.*

122. KFF, *WOMEN AND HIV/AIDS* 8-9 (Oct. 2003).

123. *See, e.g.*, Aida L. Giachello, *The Reproductive Years: The Health of Latinas*, in *A PUBLIC HEALTH READER: LATINA HEALTH IN THE U.S.* 119-21 (Marilyn Aguirre-Molina & Carlos W. Molina eds., 2003); NARAL FOUND., *THE REPRODUCTIVE RIGHTS AND HEALTH OF WOMEN OF COLOR* (2002); *LATINO ISSUES*, *supra* note 118, at 13; Anamary Pelayo, *Three Things Your Gyno May Not Tell You: Latinas Face a Number of Startling Health Risks that Doctors Don’t Even Know About*, *LATINA*, Dec. 2003/Jan. 2004, at 90.

certain deadly cancers. The cervical cancer rate among Mexican-American and Puerto Rican women is twice as high as it is for white women.¹²⁴ Latinas are more likely to die from breast cancer than white women despite the fact that Latinas have a lower rate of breast cancer.¹²⁵ Both disparities are attributed in part to problems accessing health care providers for preventative screenings such as Pap smears and mammograms.¹²⁶

Another area of serious concern for the Latino community is teen pregnancy. The Latina teen pregnancy rate has not declined as much as it has for other groups in the last ten years;¹²⁷ Latinas presently have the highest teen birth rate of all major ethnic groups.¹²⁸ In 2002, the Latina teen birth rate was 83.4 per 1,000, almost double the national average of 43 per 1,000.¹²⁹ It is estimated that fifty-one percent of Latinas become pregnant at least once during their teens, compared to thirty-five percent of girls in the entire United States population.¹³⁰

Young Latinas are not the only ones experiencing high rates of unintended pregnancy; approximately fifty percent of all pregnancies among Latinas are unintended.¹³¹ Lack of information and access to birth control options contribute to the high rate of unintended pregnancies among Latinas. National data has shown that contraceptive use among Latinas is not as widespread as it is among other racial and ethnic groups. Only fifty-nine percent of Latinas between the ages of fifteen and forty-four reported using some type of contraception in 2002,¹³² and less than half of Latinas (46%)

124. INTERCULTURAL CANCER COUNCIL, HISPANICS/LATINOS AND CANCER (May 2001), available at <http://iccnetwork.org/cancerfacts/cfs4.htm> (last visited Jan. 17, 2005).

125. *See id.*

126. *See id.*; *see also* MORBIDITY AND MORTALITY, *supra* note 79, at 938.

127. THE ALAN GUTTMACHER INST., U.S. TEEN PREGNANCY STATISTICS, OVERALL TRENDS, TRENDS BY RACE AND ETHNICITY AND STATE-BY-STATE INFORMATION 2 (Feb. 2004), available at http://guttmacher.org/pubs/state_pregnancy_trends.pdf (last visited Jan. 17, 2005).

128. THE NAT'L CAMPAIGN TO PREVENT TEEN PREGNANCY, TEEN SEXUAL ACTIVITY, PREGNANCY AND CHILDBEARING AMONG LATINOS IN THE U. S., FACT SHEET 2 (May 2004), available at <http://www.teenpregnancy.org/resources/reading/pdf/latinofs.pdf> (last visited Jan. 17, 2005).

129. *Id.*

130. *Id.*

131. Stanley K. Henshaw, *Unintended Pregnancy in the United States*, 30 FAM. PLAN. PERSPECTIVES 24, 26 (Jan. 1998).

132. Giachello, *supra* note 123, at 116; William D. Mosher, et al., *Use of Contraception and Use of Family Planning Services in the United States: 1982-2002*, 350 ADVANCE DATA FROM VITAL AND HEALTH STATISTICS 19 tbl.7 (Dec. 10, 2004) [hereinafter *Use of Contraception*]. Notably, female sterilization continues to be the most popular form of birth control among Latinas. *Id.*

reported using any method of contraception at first premarital intercourse, compared to sixty-seven percent of white women and sixty percent of black women.¹³³

Latinas' high fertility rate translates into high birth and abortion rates. Latinas have the highest birth rate of any racial or ethnic group.¹³⁴ In terms of abortion, studies estimate that twenty percent of women having abortions are Latina,¹³⁵ and Latinas are two and a half times more likely to have an abortion than white women.¹³⁶ It is not clear whether some Latinas are unable to obtain desired abortions for social or economic reasons. Based on the socio-economic constraints that a disproportionate number of Latinas face, however, it is assumed that Latinas "are among that group of poor women most likely to suffer from lack of access to safe abortions."¹³⁷

Finally, Latinas are less likely to receive prenatal care during the first trimester than white women (74.4% compared to 88.5%, respectively).¹³⁸ Over six percent of Latinas did not receive prenatal care until the third trimester or received no prenatal care at all in 2000, compared to 3.3% of white women.¹³⁹ Prenatal care reduces the risk of infant and maternal mortality. Overall, Latinas have a low infant mortality rate.¹⁴⁰ However, among specific sub-populations, such as Puerto Ricans, the infant mortality rate is alarmingly high.¹⁴¹ The maternal mortality rate among Latinas is also 1.7 times the rate among white women.¹⁴²

133. *Use of Contraception*, *supra* note 132, at 6.

134. U.S. CENSUS BUREAU, 2000 FERTILITY OF AMERICAN WOMEN 3 (Oct. 2001).

135. PHYSICIANS FOR REPROD. CHOICE AND HEALTH AND THE ALAN GUTTMACHER INST., AN OVERVIEW OF ABORTION IN THE UNITED STATES, (Jan. 2003), *available at* http://www.guttmacher.org/presentations/ab_slides.html (last visited Jan. 17, 2005).

136. THE ALAN GUTTMACHER INST., FACTS IN BRIEF: INDUCED ABORTION 1 (2003), *available at* http://www.agi-usa.org/pubs/fb_induced_abortion.html (last visited Jan. 17, 2005).

137. SILLIMAN, *supra* note 59, at 218.

138. Joyce A. Martin et al., *Births: Final Data for 2000*, 50 NAT'L VITAL STAT. RPT. 1, 66 tbl.34 (Feb. 12, 2002). In particular states, the disparity in first trimester prenatal care is even greater. For example, in Arizona, only 66.7% of Latinas received prenatal care in the first trimester during 2002 compared to 87.2% of white women. See KFF, PERCENT OF MOTHERS BEGINNING PRENATAL CARE IN THE FIRST TRIMESTER BY RACE/ETHNICITY, 2002, *available at* http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&category=Women%27s+Health&subcategory=&topic=&link_category=Health+Status&link_subcategory=Prenatal+Care&link_topic=Prenatal+Care+by+Race%2fEthnicity&welcome=0&area=Arizona (last visited Jan. 17, 2005).

139. Martin, *supra* note 138, at 66 tbl.34.

140. KAREN SCOTT COLLINS ET AL., THE COMMONWEALTH FUND, U.S. MINORITY HEALTH: A CHARTBOOK 98-99 (1999).

141. *Id.*

142. NARAL, RACIAL DISPARITIES IN MATERNAL AND INFANT HEALTH 1 (Feb 2002), *available at* <http://www.prochoiceamerica.org/facts/loader.cfm?url=/commonspot/>

The difficulties that Latinas, especially those who are low-income, immigrant and/or Spanish-speaking, have in accessing care contribute to many of Latinas' negative reproductive health outcomes. Equality for Latinas in the area of reproductive health will be impossible without significant reforms at the institutional, community, and personal level.

*C. Shortcomings of the Mainstream Movement in
Addressing the Needs of Latinas*

Examining reproductive health issues from a Latina perspective demonstrates how the mainstream movement is not adequately addressing the needs of Latinas. The mainstream movement's messaging around the term "pro-choice" does not sufficiently capture the history of coercive policies that have limited the choices of Latinas or the breadth of reproductive health issues that Latinas confront today. Nor is the mainstream movement's abortion-focused platform comprehensive enough to achieve reproductive justice for Latinas. The emphasis on privacy solely as a right to be free from governmental interference is also problematic given the fact that many Latinas are dependent on the government for cash assistance, childcare support, healthcare, and other essential services.

From a practical standpoint, some tactics used by the mainstream movement may not be the most effective approach to ensure increased access to the full range of reproductive services for Latinas. For example, mainstream groups have focused on expanding access to prescriptive contraception by advocating for equity in private insurance coverage. Research shows, however, that Latinas do not use oral contraceptives as often as white women,¹⁴³ and less than forty-five percent of Latinas have private health insurance.¹⁴⁴ Thus, while this approach might work well for white women who lack coverage for contraception under private insurance plans,¹⁴⁵ Latinas are less likely to benefit.

The mainstream movement's position on other issues may actually conflict with the best interests of Latinas. One potential conflict is in the area of prenatal care for immigrants. In 2002, the Centers for Medicare and Medicaid Services issued a rule regarding SCHIP that

security/gefile.cfm&PageID=1855 (last visited Jan. 17, 2005).

143. *Use of Contraception*, *supra* note 132, at 19 tbl.7 (showing that thirteen percent of Latinas currently use the pill compared to twenty-two percent of white women); Giachello, *supra* note 123, at 117.

144. DISPARITIES, *supra* note 42, at 2.

145. *Id.* at 2 (stating that two-thirds of white women have employer-based insurance).

would allow state use of federal funds to provide prenatal care to women not otherwise eligible for Medicaid.¹⁴⁶ Instead of expanding coverage directly to the mother, the rule redefined the definition of child to include an “unborn child.” In states that adopt this policy, undocumented women and lawfully present immigrants who have resided in the United States for less than five years could qualify for prenatal care because they are carrying citizen-fetuses now covered by the SCHIP program as children.¹⁴⁷ The federal government has already approved some states to cover fetuses under this new rule.¹⁴⁸ Six of these states, however, previously provided coverage to these populations through state funds.¹⁴⁹

Women’s rights organizations have been very critical of this policy because it creates another precedent establishing fetal personhood.¹⁵⁰ The policy is also problematic from a feminist perspective because it elevates the health status of the fetus above that of the mother; the mother’s right to access health care is contingent upon her connection to her fetus. This sends a symbolic message that the mother’s health is less important than that of the fetus. Also, it threatens to undermine the availability of comprehensive care for this population of women because states may narrow the range of services previously offered under the state program. Moreover, because funding is tied to the fetus, once the child is born the mother does not necessarily have coverage for important post-partum care.¹⁵¹

Despite these concerns, the SCHIP policy may be one of the only ways in the current political climate to expand prenatal care coverage for a group of low-income, Latina immigrants who are effectively excluded from basic reproductive health care services.¹⁵² Although

146. State Children’s Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children; Final Rule, 67 Fed. Reg. 61,956 (Oct. 2, 2002) (codified at 7 C.F.R. pt. 457) [hereinafter Prenatal Care].

147. NAT’L IMMIGR. LAW CTR., PRENATAL COVERAGE FOR IMMIGRANTS THROUGH THE STATE CHILDREN’S HEALTH INSURANCE PROGRAM 1-2 (June 2003).

148. See NAT’L WOMEN’S L. CTR., UPDATE ON IMPLEMENTATION OF “UNBORN CHILD” SCHIP REGULATIONS 1 (Feb. 2004) [hereinafter UPDATE] (stating that as of February 2004, Massachusetts, Rhode Island, Minnesota, Illinois, Michigan, and Washington received approval to provide prenatal care under SCHIP); see also Nell Smith, *State Will Pay Alien Prenatal Services: Medicaid Change to Begin on July 1*, ARK. DEMOCRAT GAZETTE, Apr. 25, 2004, at 19 [hereinafter *State*] (declaring that Arkansas will begin paying for the prenatal care of non-citizens).

149. See UPDATE, *supra* note 148, at 1 (noting that Massachusetts, Rhode Island, Minnesota, Illinois, Michigan, and Washington already provided prenatal care through state programs).

150. See *id.*

151. See NAT’L HEALTH LAW PROGRAM, SCHIP COVERAGE FOR “UNBORN CHILDREN” (Dec. 2003) (explaining that funding is tied to the fetus and does not necessarily include post-partum care).

152. A bill introduced in the 108th Congress, the Immigrant Children’s Health

advocates for both immigrant and women's rights agree that the coverage for prenatal care should go directly to the mother, and that this particular policy is unlikely to help immigrant women in many states, it nevertheless provides an example of how the mainstream movement's abortion rights-focused platform may conflict with the broader goal of increasing Latina immigrants' access to reproductive health services.

D. The Latina Reproductive Rights Movement

Latina feminists are currently re-energizing and re-mobilizing a national reproductive rights movement that incorporates the diverse needs of Latinas. To that end, Latinas have been developing a set of principles to guide the movement. Those principles include promoting leadership and participation by women of color in the reproductive rights movement and providing resources and support to organizations led by and working on behalf of Latinas. Other goals include holding Latino organizations and politicians accountable on reproductive issues, educating and mobilizing the Latino community around reproductive health issues, and advancing a reproductive health and sexual rights policy agenda that is centered in a broader social justice and human rights framework.¹⁵³

The movement's agenda ranges from comprehensive health care proposals to specific reproductive health policies. For example, Latinas are demanding universal health care for all immigrants (universal health care would cover the range of reproductive health services, substance abuse treatment, domestic violence, and alternative healing). Latinas are also demanding the repeal of the Hyde Amendment and other policies that impede abortion access, protection of Medicaid and Medicare, and an increase in Title X funding for family planning clinics. Other goals include ensuring that Latinas have access to linguistically and culturally competent health care and reducing racial and ethnic disparities in health care outcomes and among health care professionals.

The agenda calls for advocacy on behalf of the most marginalized Latinas. For example, Latinas are advocating for minors'

Improvement Act ("ICHIA"), authorizes states to use federal Medicaid funds to provide prenatal care coverage to lawfully present pregnant immigrant women and children during their first five years of residency in the United States. ICHIA would not apply to undocumented immigrant women or children. The bill has not been voted on in either the House or the Senate.

153. NAT'L LATINA INST. FOR REPR. HEALTH, A NATIONAL LATINA AGENDA FOR REPRODUCTIVE JUSTICE (on file with author); NAT'L LATINA REPR. HEALTH POL'Y AND JUSTICE ADVOCATES, PRINCIPLES OF UNITY AND EQUAL PARTNERSHIP (on file with author).

reproductive rights, including comprehensive sex education, confidential care, and the repeal of parental consent laws. The agenda also seeks to address the reproductive health needs of lesbian, bisexual, and transgender Latinas.

Finally, the Latina movement calls for a new understanding of reproductive rights.¹⁵⁴ Latinas are articulating a comprehensive, holistic approach to reproductive health that frames the reproductive rights movement as a fight for social justice and equality. Most importantly, the Latina reproductive justice movement is advancing a platform that has the necessary components to address the broad range of obstacles facing Latinas today.

III. LOOKING TO THE FUTURE: REPRODUCTIVE RIGHTS AS A SOCIAL JUSTICE ISSUE

Looking toward the future of the reproductive rights movement, one pioneer activist stated the following:

We need a vision based on the understanding that the denial of control takes different forms. Activists must as strenuously oppose coercive contraception and the denial of social services needed to support childbearing as they do the policies that restrict abortion. Only then will we be able to create a movement capable of fighting for and winning reproductive freedom for all women.¹⁵⁵

In order to diversify its following, the movement needs to broaden its platform, both in terms of theory and practice. First, the movement must continue to expand its agenda, beyond abortion, while reinforcing the idea that the right to abortion is one part of a broader reproductive rights agenda. This is not to say that it should cease fighting for greater abortion access, rather it cannot be the sole mission of the movement. The mainstream movement should use the comprehensive agenda put forth by Latina feminists as a model to ensure coverage of the broad range of reproductive health issues.

Second, the movement needs to digest critiques of the term “choice” that are based on the historical experiences of poor women of color. For Latinas in particular, the mainstream pro-choice message may not resonate.¹⁵⁶ Without a relevant message, fewer Latinas will be inspired to join the “pro-choice” movement, even

154. See generally NAT'L LATINA HEALTH ORG., HEALTH AGENDA FOR 2002-2003, available at <http://www.latinahealth.org/healthagenda.html> (last visited Jan. 17, 2005); NAT'L LATINA INST. FOR REPR. HEALTH, MISSION, VALUES, AND GUIDING PRINCIPLES, available at <http://www.latinainstitute.org/mission.html> (last visited Jan. 17, 2005).

155. Fried, *supra* note 18, at 212.

156. See ABORTION ACCESS, *supra* note 61, at 1.

though a majority of Latinas believe that abortion should be legal.¹⁵⁷

Third, the movement needs to redefine the principle of privacy to encompass a definition that extends beyond the traditional, legal interpretation of the privacy right. The movement's reliance on the right-to-privacy argument is essential insofar as it can be employed to protect an individual's autonomy against unwarranted interference or coercion by the government.¹⁵⁸ However, the traditional interpretation of privacy alone will not bring reproductive freedom to all women, especially those who rely on the government for reproductive health services. The privacy principle should be articulated in a way that reaffirms an individual's right to make decisions with moral independence, free from unjustified governmental interference. At the same time, it should demand that the government develop policies that support an individual's ability to exercise choice. Dorothy Roberts has eloquently described this new conceptualization of privacy as one that "includes not only the negative proscription against government coercion, but also the affirmative duty of government to protect the individual's personhood from degradation and to facilitate the processes of choice and self-determination."¹⁵⁹

Finally, the movement should not rely solely on the logic and legal arguments that the Supreme Court has used when extending constitutional protection to reproductive rights. The movement is free to explore and demand a more expansive vision of reproductive justice from state and federal legislatures than what is currently accepted by the Court.¹⁶⁰ Many feminists have offered new ways of framing reproductive rights to encapsulate a broader set of principles.¹⁶¹ Latina feminists are describing reproductive freedom as

157. *See id.* (noting one study conducted by the National Latina Institute for Reproductive Health found that fifty-three percent of Latinas identify as "pro-choice," and a large percentage believe that women should have liberal access to abortion); *see also* SILLIMAN, *supra* note 59, at 218.

158. *See* Roberts, *supra* note 36, at 1469 (arguing that the right of privacy can be especially helpful to protect the reproductive rights of women of color, including their right to bear children).

159. *Id.* at 1479; *see also* Fried, *supra* note 18, at 220 ("The [reproductive] rights movement must emphasize women's right to make their own decisions while advocating public policies that expand opportunities for all women.").

160. The Supreme Court would not likely accept an argument for expanding the reproductive rights of poor women if it would require affirmative government action. *See, e.g., Harris*, 448 U.S. at 330 (Brennan, J., dissenting) (noting that the Court's jurisprudence on reproductive rights do not impose "an affirmative obligation to ensure access to abortions for all who may desire them").

161. Lee, *supra* note 1, at 99 (arguing that the feminist movement should advocate for reproductive self-determination as a human right, which "will benefit women regardless of race and will establish an agenda around which all women can rally"); Roberts, *supra* note 36, at 1476-82 (arguing for a broader definition of privacy that

a social justice and human rights issue. One of the central principles guiding the Latina reproductive rights movement is the concept of “affirmative reproductive liberty,”¹⁶² premised on the theory that the “government has the obligation to ensure that people can make reproductive decisions freely.”¹⁶³ The time has come for the mainstream movement to listen to, and embrace, some of these alternative theories. By expanding and redefining its current messages, and opening itself to new ones, the movement is more likely to resonate with different ethnic and racial communities.

Although the battle over messaging continues, important changes in the movement at the organizational level have affected its focus on a practical level. After years of pressure from women of color, mainstream reproductive rights organizations have begun to diversify both their staff and their areas of advocacy.¹⁶⁴ Mainstream women’s rights groups are advocating for equal access to reproductive health care, over-the-counter access to emergency contraception, and comprehensive sex education—all of which will improve the reproductive health of women of color.¹⁶⁵ Women’s rights lawyers are challenging laws that restrict abortion access for low-income women and infringe on the rights of pregnant women.¹⁶⁶ Mainstream groups are also trying to reach out to and advocate on

requires “an affirmative guarantee of personhood and autonomy” from the government).

162. Pine & Law, *supra* note 6, at 421-22 (describing the feminist concept of reproductive freedom as an affirmative liberty). A society with reproductive freedom would be one “in which all people can make decisions regarding their reproductive lives and futures.” *Id.* at 421.

163. *Id.* at 421-22. These authors explain that affirmative reproductive liberty “requires subsidies for those who cannot afford the means of exercising choice; protection from the hostile acts of private parties seeking to interfere with choice; and educational, medical and social services to facilitate true choice.” *Id.* This theory recognizes the constraints on individual choice that are created and imposed by one’s socio-economic context and cultural norms and advocates for changes at a cultural and economic level. *Id.* The theory also “rejects the notion that parenthood is a privilege reserved to people who are married, heterosexual, physically and mentally unchallenged, and biologically fertile,” as well as the notion that “no woman is complete without motherhood.” *Id.* at 423.

164. *See generally* Hernandez & Leong, *supra* note 35 (noting that executive directors and senior staff of most women’s rights organizations are predominately white women).

165. *See, e.g.*, NARAL Pro-Choice America, at <http://www.naral.org/> (last visited Jan. 17, 2005).

166. For example, the Center for Reproductive Rights based in New York has litigated a number of cases challenging states bans on abortion funding, drug testing of pregnant women, and restrictions on minor’s rights. More information about the Center’s docket can be found at <http://www.crlp.org/> (last visited Feb. 7, 2005) and the ACLU Reproductive Freedom Project’s website at <http://www.aclu.org/ReproductiveRights/ReproductiveRightsMain.cfm> (last visited Feb. 7, 2005).

behalf of women of color specifically.¹⁶⁷ Despite these changes, many organizations still have a long way to go before women of color will feel fully involved and that their issues are adequately represented.

In order to eliminate racial and ethnic disparities in reproductive health, advocates from outside the traditional women's rights community must also participate. Groups that advocate for civil rights and for specific communities of color should include reproductive rights as part of their organizational agendas.¹⁶⁸ Foundations should also support organizations led by women of color to work on these issues.

If the goal is to build and strengthen a reproductive rights movement that seeks reproductive justice for all women, the mainstream movement should pay serious attention to the innovative approach Latina feminists are using to fight for reproductive and social justice. Latinas can educate mainstream feminists working in the reproductive rights movement about the need to address reproductive rights issues from a broader social justice framework. By building on the fundamental principles and rights established by the mainstream movement, Latinas have created a national agenda that reflects the diverse needs of Latinas today. In many ways, the future vitality of the movement depends on its ability to embrace this broader agenda and support a more diverse constituency.

167. NARAL Pro-Choice America Foundation recently released a new report that provides information and policy-oriented solutions for reducing racial and ethnic disparities in reproductive health care, promoting cultural and linguistic competence, and expanding access to family planning and abortion services for low-income women. See NARAL PRO-CHOICE AM. FOUND., *BREAKING BARRIERS: A POLICY ACTION KIT PROMOTING THE REPRODUCTIVE HEALTH OF WOMEN OF COLOR AND LOW-INCOME WOMEN* (Jan. 2003).

168. See Rivera, *supra* note 63, at 471-74 (noting that civil rights organizations have not paid significant attention to issues that are of particular concern to women of color); Rutherford, *supra* note 36, at 256 (stating that traditional civil rights groups and women's rights organizations have ignored the reproductive rights issues of women of color).