

Center for American Progress



Separate and Unequal

The Hyde Amendment and Women of Color

Jessica Arons and Madina Agénor December 2010

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Preface

More than a report about the impact of the Hyde Amendment upon the lives of women of color, “Separate and Unequal: The Hyde Amendment and Women of Color” masterfully provides us with an in-depth analysis of how U.S. reproductive and sexual health policies have directly targeted women of color.

There is a direct connection between the present state of women of color’s reproductive and sexual health and restrictive U.S. policies around reproductive and sexual health. The U.S. government’s claim of economic stake and authority over women of color’s bodies spans a history that includes the slave master’s ownership of black women and their offspring, the forced sterilization of black and Latina women during the 1960s and 1970s, and the forced and coercive use of contraceptive technology during the 1980s through today. Much of this has been accomplished through punitive state and national policies that target women of color, and black women in particular.

This report details in a broader political context how policies such as welfare reform, access to contraceptives and other family planning services, the debate on abortion, the war on drugs, and the criminalization of black women who use drugs serve to further an agenda that is still very much intent upon controlling the childbearing of black women and other women of color. When we understand these issues not individually but rather as part of a larger concept of reproductive justice it becomes even more apparent that women of color have an even larger role to play in the fight for social justice.

The Hyde Amendment is, perhaps, the most punitive and inhumane regulation imposed upon the reproductive lives of low-income women. Each day, scores of low-income women are forced to make a choice between using scarce resources to take care of themselves and their families or use those dollars to pay for an abortion. The landmark decision in *Roe v. Wade* may have held that women have the constitutional right to determine whether to carry a pregnancy to term, but the Hyde Amendment stripped that right away from low-income women, espe-

cially low-income women of color. Left to make tough economic decisions that often put their own lives and that of their families at risk, low-income women in the United States are forced to either carry an unwanted pregnancy to term and survive off of meager amounts of public assistance or jeopardize their basic life necessities to pay for an abortion.

Fortunately, the National Network of Abortion Funds and its member organizations have stepped up to help women with the vital economic support they need to realize some semblance of reproductive autonomy. From direct financial assistance for abortion procedures to help with transportation and housing, the network has made it possible for millions of low-income women across the United States to continue on with their dreams of a better life for themselves and their families.

The Network is a recognized leader in framing abortion funding as an issue of racial and economic justice, as well as an issue of women's freedom. This approach is critical because it sets the stage for advocacy strategies, direct services, and public education that can meet the needs of the women most affected by lack of access to abortion. The Network has also risen as a leader in spearheading the work to create a long-term strategy for expanding access for low-income women and women of color and eventually repealing the Hyde Amendment.

This report highlights the fact that low-income women, women of color, and young women are not silent victims in the midst of their oppression. In fact, they have risen as a mighty force to be reckoned with as they seek to stake their rightful claim over their own bodies and reproductive lives. By telling their stories of resourcefulness and self-determination and working with allies in the fields of women's rights, civil rights, and human rights, they will prevail over discriminatory policies like the Hyde Amendment and reclaim their dignity.

— *Toni M. Bond Leonard, president and chief executive officer of Black Women for Reproductive Justice and a board member of the National Network of Abortion Funds*

Introduction and summary

The Hyde Amendment was “designed to deprive poor and minority women of the constitutional right to choose abortion.” — Justice Thurgood Marshall¹

Abortion policy in this country does not treat all women equally. Even before *Roe v. Wade* was decided in 1973, affluent women were usually able to access abortion safely through a network of private doctors or by traveling to other states or countries where it was legal, while poor women risked their health, fertility, and often their lives to end a pregnancy.² Unfortunately, because of a policy known as the Hyde Amendment, similar disparities and injustices still exist today—nearly 40 years after the Supreme Court declared that *all* women have a constitutional right to abortion.

The Hyde Amendment prohibits Medicaid, the joint federal-state health care program for the poor and indigent, from covering abortion care in almost all circumstances. Most people think of abortion as a “woman’s issue,” which of course it is. But the Hyde Amendment intentionally discriminates against poor women, who are disproportionately women of color. In this way, the Hyde Amendment is a policy that not only violates reproductive rights and principles of gender equity but one that undermines racial and economic justice as well.

Former U.S. Rep. Henry Hyde (R-IL), the law’s sponsor, admitted during debate of his proposal that he was targeting poor women because they were the only ones vulnerable enough for him to reach. “I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman,” he said. “Unfortunately, the only vehicle available is the ... Medicaid bill.”

The Supreme Court—shortsightedly, callously, and inconsistently—upheld this policy of discrimination against poor women, observing:

Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains 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.*³

We do not subject other fundamental constitutional freedoms—voting, free speech, freedom to worship, the right to a fair trial, the right to counsel—to poll taxes or income requirements. But a woman’s ability to act on her constitutionally protected decision to have an abortion is subject to the whims of a fickle legislature and what is (or is not) in her pocketbook.

And because of the overlap among class, race, and ethnicity in our country, the Hyde Amendment is especially harmful to women of color. According to the most recent Census data, 25.8 percent of African Americans and 25.3 percent of Hispanics are poor, compared to 12.3 percent of whites and 12.5 percent of Asians.⁴ These differences hold true for women of reproductive age (15 to 44 years old) living in poverty as well. While 28.5 percent are African American, 27.2 percent are Hispanic, and 27.0 percent are Native American, 15.8 percent are white and 13.3 percent are Asian.⁵

The upshot: Women of color are more likely to rely on government health programs and therefore more likely to be directly affected by abortion funding restrictions such as the Hyde Amendment.

The Hyde Amendment was the original restriction on federal funding for abortion, but it has since spread to numerous other government-run or government-managed health programs, including Medicare, the military’s TRICARE program, the Federal Employees Health Benefits Program, federal prisons, Indian Health Service, the Peace Corps, and the Children’s Health Insurance Program.⁶ (see pages 7 to 9) Most of these programs only allow abortions in cases where the pregnancy physically endangers the life of the woman or results from rape or incest. Some laws are even more restrictive, for example, protecting only women whose lives are endangered by a pregnancy. Not one includes an overall exception to protect the health of the pregnant woman.

Similar restrictions were also attached to the Patient Protection and Affordable Care Act, or ACA, the new health insurance reform law that passed earlier this year. Under the ACA, women who receive subsidies from the federal government to help them purchase private health insurance through state-based insurance exchanges will have to pay two premiums for their health insurance—one to pay for the cost of the plan related to covering abortion, regardless of whether it is ever utilized, and one to cover all the other costs of their health plan.

The ostensible reason for all these restrictions is that citizens who object to abortion should not have to have their taxes pay for abortion. But, as Rep. Hyde himself admitted, his larger goal was not to protect taxpayer's money. Rather, it was to make abortion as inaccessible and unpopular as possible, with the ultimate objective of banning abortion altogether.

With attacks on abortion funding, abortion opponents have patiently pursued an incremental approach to eroding abortion rights and access that affects wider swaths of women each time. But they started doing so with the most vulnerable and marginalized groups of women in our society. It is on their bodies that abortion funding policy has been forged, and they are the ones who pay the harshest prices.

It is poor women and women of color who have to scrape together money for an abortion—foregoing rent or utilities, pawning dear items, taking food out of their children's mouths, or sometimes worse.⁷ It is they who consider suicide or self-harm in moments of desperation. It is they who risk inducing an abortion on their own. It is they who continue a pregnancy against their will and better judgment because they cannot find the money or get to a clinic in time. And it is they who are continually ignored by policymakers but who must live with the consequences of political fights in Washington over which they have little control.

The Hyde Amendment and its progeny are a travesty. And the implications for communities of color are far reaching. Women who lack the ability to plan the timing and spacing of their children are limited in pursuing their educational and economic goals, providing the kind of home they want for their children, and sustaining the relationships they desire—in short, in determining the course of their own lives.

As long as these unjust provisions remain a part of our laws, the rights of women in this country will continue to be treated according to two different standards—whether you can afford to pay for your rights or not. That is not equality.

The Hyde Amendment and related abortion funding restrictions should be repealed, but that is unlikely in the near term. A more conservative Congress and the new health reform law, which further restricts the use of federal funds for abortion care, are clear setbacks for women on the margins of society who face policies that simultaneously discourage them from having children *and* from having abortions—leaving them with no choices whatsoever.

As long as these unjust provisions remain a part of our laws, the rights of women in this country will continue to be treated according to two different standards—whether you can afford to pay for your rights or not. That is not equality.

But there are steps to be taken. As we begin to implement health reform and evaluate what does and does not work in our health care delivery system, we should examine the consequences of abortion funding bans on the physical, emotional, and financial well-being of women and their families. And we should be vigilant in seeking opportunities to improve access to quality, timely, and affordable abortion care.

Repealing the Hyde Amendment and related restrictions will not, by itself, ensure full equality for women of color and low-income women. But doing so is a necessary precondition. We must heed Dr. Martin Luther King Jr.'s admonition that injustice anywhere is a threat to justice everywhere. Ending abortion funding restrictions will improve the lives of all women, but none more so than the women who have shouldered much more than their fair share of injustice.

Overview of the Hyde Amendment and related abortion funding restrictions

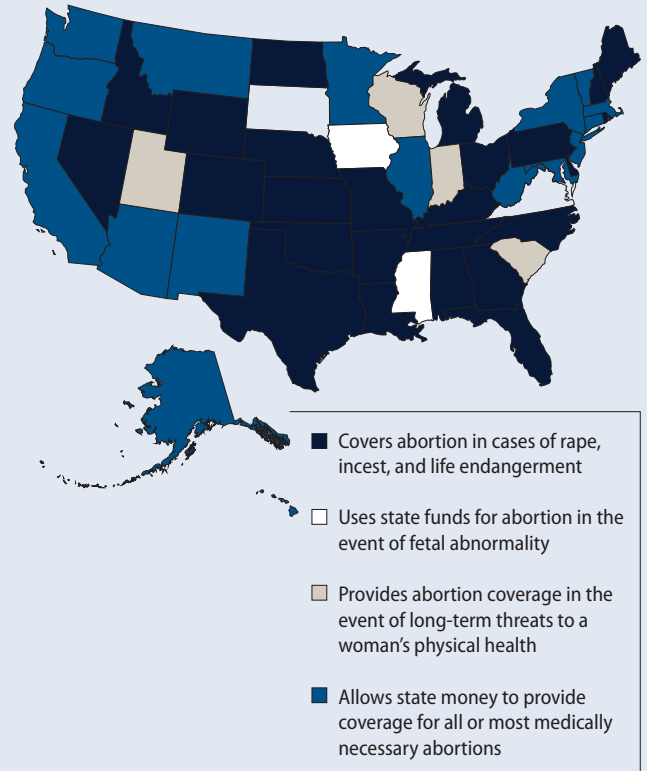
In 1976, three years after *Roe v. Wade* was decided, Rep. Henry Hyde (R-IL) introduced an amendment to restrict the use of federal funds for abortion.⁸ The legislation was immediately challenged, and the Supreme Court in 1980 upheld the restrictions on the use of federal funds for abortion in *Harris v. McRae*.⁹ Since then, the Hyde Amendment has been reenacted every year through the annual appropriations process.¹⁰

The Hyde Amendment currently prohibits all Department of Health and Human Services programs—including Medicaid, which serves over 20 million low-income women¹¹—from using federal funds to cover abortion except in the case of incest, rape, or life endangerment.¹² The limited exceptions to the Hyde Amendment, however, have changed over time.¹³ The original ban only included an exception for life endangerment,¹⁴ but in 1978 Congress added exceptions for “promptly reported” rape or incest, as well as “severe and long-lasting physical... damage” to a woman’s health.¹⁵ The narrow physical health exception was then removed the very next year.¹⁶ Congress discarded the rape and incest exceptions in 1981, but reinserted them in 1993.¹⁷

Most recently, in 1997 lawmakers narrowed the life endangerment exception to apply only to physician-certified cases where a woman is in danger of dying as a result of a physical disorder, injury, or illness unless she obtains an abortion. This is how the life exception is defined today.¹⁸

The Hyde Amendment only pertains to federal funding, but many states have followed suit and implemented bans on using state Medicaid funds to cover abortion care.¹⁹ In order to be compliant with the exceptions to Hyde, however, states must cover abortion in cases of rape, incest, and life endangerment.²⁰ Twenty-six states cover abortion services only in these instances.²¹ South Dakota, though, only covers abortion care when a woman’s life is in danger, in violation of the rape and incest exceptions to the Hyde Amendment.²²

Although states are required to meet this minimum floor, they are allowed to provide abortion coverage in additional circumstances.²³ Two states (Iowa and Mississippi) use state funds for abortion in the event of fetal abnormality, and four others (Indiana, South Carolina, Utah, and Wisconsin) provide abortion coverage in the event of long-term threats to a woman’s physical health.²⁴ The laws of 17 states and the District of Columbia go further, allowing state money to provide



coverage for all or most medically necessary abortions (five voluntarily and 13 under court order based on state constitutional requirements).²⁵ Even so, Arizona and Illinois are legally required to cover abortion under their state Medicaid programs but do not in practice.²⁶

Other federal abortion funding bans

Other women who receive their health care through the federal government also are affected by abortion funding restrictions similar to the Hyde Amendment, including women with disabilities enrolled in Medicare, adolescents enrolled in the Children’s Health Insurance Program, Native Americans receiving care through the Indian Health Service, military personnel and their dependents, federal employees and their dependents, Peace Corps volunteers, and women in federal prisons.²⁷ Let’s look at each of these programs’ restrictions in turn.

Medicare

Since 1998, Congress has applied the Hyde Amendment to Medicare, which, unlike the hybrid federal-state Medicaid program, is funded only with federal dollars.²⁸ Although Medicare primarily provides health care for Americans age 65 and older, the program also serves

certain individuals below this age, including people who have been entitled to Social Security disability benefits for at least two years.²⁹ Thus, in accordance with Hyde, women with disabilities who are enrolled in Medicare can only receive coverage for an abortion in the event of rape, incest, or life endangerment.³⁰

Children's Health Insurance Program

The Children's Health Insurance Program, jointly financed by the federal and state governments and administered by the states, provides health care to millions of uninsured children, including adolescents.³¹ Subject to federal guidelines, states can individually tailor the program to meet the needs of their populations, including eligibility groups, benefit packages, and payment levels for coverage.³² But the statute prohibits federal funding for abortion services or abortion coverage except in the cases of life endangerment, rape, or incest.³³ While the federal funds are restricted, the statute does not prohibit a state, locality, or private entity from expending funds to pay for any abortion or for health benefits that cover abortion.³⁴

Indian Health Service

Native Americans who live on or near reservations receive health services through the Indian Health Service, or IHS.³⁵ Between 1988 and 1993, Native American women were prohibited from receiving abortion care at any of the IHS health clinics or facilities except in the event of life endangerment.³⁶ In 1993, the IHS abortion ban was modified to cover abortions for rape and incest as well in order to comport with the Hyde Amendment.³⁷ Even with the exceptions, Native American women face considerable barriers in obtaining an abortion, including a lack of IHS clinics that provide abortions under the allowable exceptions and long distances to health care facilities that provide abortion care under all circumstances.³⁸

Military

Members of the military, veterans, and their dependents receive health insurance through the TRICARE program (formerly the Civilian Health and Medical Program of the Uniformed Services or CHAMPUS), which is funded through the annual Department of Defense appropriations bill.³⁹ In 1979, Congress prohibited TRICARE from paying for abortion except when a woman's life is in danger. This ban became permanent in 1985.⁴⁰

In 1988, the Department of Defense issued an executive order denying women access to abortion care in military facilities, even if paid for with nongovernment funds, except in instances of rape, incest, or life

endangerment.⁴¹ President Bill Clinton repealed the facilities ban by executive order in 1993,⁴² but Congress reinstated the policy in 1995.⁴³ This ban places severe constraints on women serving overseas who often lack access to health services other than those provided by the military system, especially in countries where abortion is illegal. It also ignores the high rates of sexual assault and coercion that take place in the armed services. An amendment that would repeal the ban on abortions in military facilities is currently pending in Congress, but even if it succeeds, the TRICARE coverage restrictions would remain.⁴⁴

Federal employees

Similarly, the Federal Employees Health Benefits Program, a network of health plans funded through the Treasury, Transportation, Housing and Urban Development, and Judiciary appropriations bill, provides insurance coverage to federal employees, retirees, and their dependents.⁴⁵ In 1983, Congress prohibited FEHBP plans from covering abortion except when a woman's life is in danger.⁴⁶ Congress lifted the ban in 1993, thus permitting federal employees to enroll in health plans providing abortion coverage in all circumstances. Unfortunately, Congress reinstated the ban in 1995, with exceptions for life endangerment, rape, and incest, and the law has remained that way ever since.⁴⁷

Peace Corps

The Peace Corps program is funded through the Foreign Operations appropriations bill. Peace Corps volunteers, 60 percent of whom are women,⁴⁸ receive medical insurance that fully covers the costs of primary care, hospitalization, medical evacuation, and prescriptions including birth control throughout the tenure of their service.⁴⁹ Since 1979, Congress has enacted abortion funding restrictions for Peace Corps volunteers under all circumstances, even in the case of life endangerment.⁵⁰ When a volunteer decides to have an abortion, the Peace Corps requires two levels of counseling before the volunteer is able to obtain the procedure with her own funds.⁵¹ The Peace Corps, however, will pay for medical evacuations to a location where medically adequate facilities for obtaining an abortion are available and legal.⁵²

Federal prisons

Since 1987, Congress has barred payment for abortions obtained by women incarcerated in prisons operated by the Federal Bureau of Prisons, which receives funding through the State, Commerce, Justice, and Science appropriations bill, except in instances of life endangerment or rape.⁵³ The ban was briefly repealed in 1993 but was re-imposed in 1995.⁵⁴ Prisoners must seek abortion services off

prison grounds using their own funds.⁵⁵ While they are supposed to be entitled to an escort free of charge, a “conscience” clause added in 1989 allows federal prison employees to refuse to serve in this role,⁵⁶ and often women must pay for the time a guard spends accompanying the woman, in apparent violation of Bureau of Prisons policy.⁵⁷

The effects of abortion funding bans

Abortion funding bans affect women’s health and lives in a number of ways. In particular, low-income women enrolled in the Medicaid program face considerable difficulties securing the money needed to obtain an abortion.⁵⁸ As a result, some women experience delays in undergoing the procedure, which not only increases its costs but also its related health risks.⁵⁹

Low-income women who are able to collect the funds necessary for an abortion often do so by diverting money from other essential needs, including housing, electricity and other utilities, and clothing and food for themselves and their children; pawning items or taking risky loans; and sometimes pursuing extreme measures, such as sex work, in search of funds.⁶⁰ They also seek financial assistance from the National Network of Abortion Funds and other private, charitable funds. The Network’s member groups help over 20,000 women and

girls each year who would not otherwise be able to obtain an abortion without this assistance.

The need, however, is far greater than private resources can ever provide. The Network and its member funds received over 89,000 calls for help over the past year.⁶¹ And that number does not include the women who found assistance from other sources as well as those who never discovered the funds.

Anecdotal evidence also suggests some women turn to self-induced abortion, in part due to the cost and distance, as well as to avoid the stigma that surrounds abortion.⁶² Finally, several studies indicate that the Hyde Amendment prevents a substantial number of women from obtaining an abortion altogether. While estimates vary, the most well-regarded study concludes that a third of women who would have obtained an abortion if funding were available were forced to carry their pregnancy to term instead because they did not have the financial resources to secure an abortion.⁶³ The fact that two-thirds of these women do manage to overcome funding barriers simply demonstrates the determination, if not desperation, they have to terminate their pregnancies once they have decided that it is what they need to do.

The paradox of abortion funding

Women of color have a greater need for abortion but fewer means to pay for it

Women of color are more likely to rely on government insurance, and they are at higher risk for adverse reproductive health outcomes, including unintended pregnancy, due to less access to a trusted health care provider, less contraceptive use, more birth control failures, and inadequate access to family planning and sex education programs. This means that they are more likely than the general population to need abortion services but less likely to have them covered by their insurance program. Because many of these women qualify for government-based health care due to their low-income status, this also means they are less likely to be able to afford to pay for an abortion out of pocket.

Whites are more likely than all other racial and ethnic groups to obtain health insurance through their employer—about 162 million out of 204 million carrying some kind of insurance in 2009. In contrast, African Americans are the most likely to be covered under Medicaid or another public insurance program, such as Medicare, the Children’s Health Insurance Program, or military-related insurance.⁶⁴ Of the 30 million African Americans with health insurance in 2009, 15 million had coverage through Medicaid and Medicare, and 1.6 million were insured through Veterans Affairs, the military’s TRICARE program, or other military care.⁶⁵

While 12 percent of whites and 10 percent of Asians and Pacific Islanders have government insurance, 28 percent of African Americans, 23 percent of Hispanics, 23 percent of Native Americans, and 26 percent of multiracial people rely on public programs for their coverage.⁶⁶ Racial and ethnic minorities also comprise a greater portion of Medicare’s disabled population, which includes people of all ages, than they do of its elderly population.⁶⁷ And Indian Health Service, by its mission, serves only Native Americans. Approximately 57 percent of all American Indians and Alaska Natives in the United States, about 1.9 million people, obtain health care services through IHS.⁶⁸

Health insurance coverage helps people obtain health care in a timely fashion, but not all health plans are created equal, and Medicaid is far from perfect. “While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a negative impact on health care access and quality among its beneficiaries,” concluded the Committee on the Elimination of Racial Discrimination Working Group on Health and Environmental Health, a coalition of experts in the fields of health policy and environmental justice that submitted a “shadow report” to the U.N. Committee on the Elimination of Racial Discrimination in 2008. The CERD Working Group also found that Medicaid’s per-patient expenditures varied greatly along racial and ethnic lines, especially when higher rates of illness among minorities were taken into account.⁶⁹

Differential access to treatment, lower levels of respect and competency from health care providers, lack of trust in the medical establishment, lack of accurate information, and a host of other socioeconomic factors (discussed in more detail below) lead to poorer outcomes along racial and ethnic lines for overall health indicators and with regard to reproductive health specifically. Women of color face higher rates of reproductive cancers, HIV and other sexually transmitted infections, maternal and infant morbidity and mortality, and unintended pregnancy and abortion.

While overall rates of unintended pregnancy and abortion have declined in recent decades, these data mask underlying divergent trends. According to The Guttmacher Institute, “unintended pregnancy is becoming increasingly concentrated among poor women.”⁷⁰ Among women living in poverty, 16 percent are “at risk” for unintended pregnancy—meaning they are sexually active, of reproductive age, and do not wish to be pregnant—but they account for 30 percent of unintended pregnancies. From 1994 to 2001, the rate of unintended pregnancy rose 29 percent for women living in poverty and 26 percent for women living between 100 and 200 percent of the federal poverty level. During the same period, the rate fell 20 percent for women at higher incomes.⁷¹

Unsurprisingly, given our country’s interrelationship between race, ethnicity, and poverty, similar trends surface for women of color. Black and Hispanic women each comprise 14 percent of women at risk for unintended pregnancy but make up 26 percent and 22 percent of unintended pregnancies, respectively. While the unintended pregnancy rate fell slightly among African Americans through 2001, it is still nearly twice the national average (98 versus 51 per 1,000 women). And because the intended pregnancy rate has dropped for Latinas while the unintended pregnancy rate stayed constant, their unintended pregnancy rate is now 75 percent higher than the non-Hispanic rate.⁷²

These higher rates of unintended pregnancy lead almost inevitably to higher rates of abortion for these groups of women, despite the government's efforts to throw obstacles to abortion in their way. In fact, the abortion rate for African-American women is more than twice the national rate. And while one-third (34 percent) of women of reproductive age live below 200 percent of the poverty line, they have 57 percent of all abortions.⁷³ These trends stem from lower levels of contraceptive use and higher rates of contraceptive failures, which result in part from less health insurance coverage and a decline in real dollars for the Title X federal family planning program.⁷⁴ Unequal access to quality sex education⁷⁵ also likely plays a role.

Instead of reducing the abortion rate, what the Hyde Amendment and similar policies accomplish is a delay in when many lower-income women, especially black women, manage to finally obtain the abortion services they seek. The average woman takes approximately 16 days from when she decides to have an abortion to when she obtains her procedure. But a woman living below 200 percent of the poverty line takes six more days and on average ends up having her procedure 10 days later in her pregnancy.⁷⁶

Sixty percent of economically disadvantaged women said they would have preferred to have their abortion sooner and over one-half reported delays due to making arrangements, including raising money. A quarter of women who experienced a delay in obtaining an abortion said it was because they needed time to raise money, and the need to raise money was the most frequently reported reason for delay in in-depth interviews.⁷⁷ While abortion remains one of the most common and safest of medical procedures, delays increase both its costs and health risks.

Sexual and reproductive health disparities in context

Opponents of abortion recently launched a pernicious campaign aimed at the African-American community, using the tag line “Abortion Is Genocide.”⁷⁸ Through billboards, films, community events, and legislation, they are trying to drive a wedge among African Americans over sexual and reproductive justice issues by propounding the myth that African-American women obtain abortions at much higher rates than the general population because they have been targeted by abortion providers in a discriminatory fashion.

This strategy cynically plays on the distrust of the medical establishment among many people of color. But it completely ignores the structural racism and economic inequality in our society that create health disparities for women of color across the board. It also treats women of color as pawns in the alleged self-destruction of themselves and their own community rather than as agents of their own self-determination.

The disparities observed for unintended pregnancy and abortion rates among women of color do not exist in a vacuum. In fact, they are repeated in almost every measure of health and well-being that gets tracked. Profound racial and ethnic disparities persist across a range of health outcomes, including diabetes, cardiovascular disease, hypertension, obesity, and some forms of cancer.⁷⁹ People of color bear a disproportionate burden of disease as a result of chronic exposure to racism,⁸⁰ alongside deeply entrenched inequities in the areas of health insurance coverage, health care, income and wealth, access to healthy foods, transportation, education, and employment, all of which influence access to health-promoting resources.⁸¹

These inequities translate into stark disparities across a number of sexual and reproductive health indicators. In addition to higher rates of unintended pregnancy and abortion, women of color fare significantly worse than their white counterparts with regard to HIV/AIDS and other sexually transmitted infections, birth outcomes, and maternal mortality.⁸² Each of these inequities requires careful examination.

HIV/AIDS and other sexually transmitted infections

A black woman in our nation is 15 times more likely to become infected with HIV than a white woman.⁸³ And HIV/AIDS is the leading cause of death for black women between the ages of 25 and 34.⁸⁴ While black and Latina women only comprised 12 percent and 13 percent, respectively, of all U.S. women in 2008, the last year for which complete data are available, they represented 65 percent and 17 percent, respectively, of new AIDS diagnoses among women.⁸⁵

Black women also have the highest rates of chlamydia, gonorrhea, and syphilis, followed by Native Americans, Hispanic, white, and Asian and Pacific Islander women.⁸⁶ There are also notable racial and ethnic disparities for human papillomavirus, or HPV, infection and cervical cancer rates.⁸⁷ The prevalence of HPV among women ages 14 to 59 was 39.2 percent for blacks, as opposed to 24.2 percent for whites.⁸⁸ And African-American and Hispanic women have cervical cancer incidence and mortality rates that are 1.3 times to 2 times higher than white women.⁸⁹

Birth outcomes

Perhaps one of the most tragic areas of health disparities is seen in infant mortality rates. In 2005, the infant mortality rate (the number of deaths among children under 1 per 1,000 live births) was about 2.5 times higher among African Americans than whites.⁹⁰ Moreover, although the U.S. infant mortality rate generally declined throughout the 20th century (and is currently at a record low) the gap between African Americans and whites has remained unchanged or has increased in the past 40 years.⁹¹

Investigators attribute nearly two-thirds of the infant mortality disparity between blacks and whites to higher rates of pre-term birth delivery, which means delivery at less than 37 weeks of gestation, and low birth weight (weighing less than 5 lb. 8 oz. at birth) among blacks.⁹² Indeed, while the prevalence of low-birth-weight babies is 7.2 percent among white women, it reaches a high of 13.8 percent among black women.⁹³

Much about the stark racial and ethnic health inequalities in poor birth outcomes is still not understood,⁹⁴ but researchers point to the role of maternal socioeconomic status; prenatal care; maternal infection; exposure to chronic sources of stress, including poverty and racism; poor maternal health behaviors such as ciga-

rette smoking; and contextual factors such as residential segregation in determining the risk of low-birth-weight babies, pre-term birth, and infant mortality.⁹⁵

Consider that women who received no or delayed prenatal care were three times more likely to have a low-birth-weight baby compared to women who received timely, comprehensive prenatal care.⁹⁶ Further, a study showed that if black and Latina women who obtained an abortion to terminate an unwanted pregnancy had instead carried the pregnancy to term, they would have delayed the initiation of prenatal care,⁹⁷ which suggests that an inability to obtain a desired abortion may contribute to poor birth outcomes.

Maternal mortality

Equally disturbing are the substantial disparities for maternal mortality. While the maternal mortality rate is on the rise among women of all racial and ethnic groups,⁹⁸ black women are almost four times more likely to die from pregnancy-related causes (embolism, hemorrhage, and pregnancy-induced hypertension) than white women.⁹⁹

In a recent report released by the New York City Department of Health and Mental Hygiene and the New York Academy of Medicine, researchers noted that between 2001 and 2005, black women living in New York City were seven times more likely to die during pregnancy than white women.¹⁰⁰ Additionally, Latina and Asian women were twice as likely to die from pregnancy-associated causes as their white counterparts.¹⁰¹

Causes of reproductive health disparities

Perhaps it should go without saying, but a primary reason for these reproductive health disparities is a lack of access to regular, timely, and high-quality health care for many women of color. Indeed, women of color and poor women face several barriers to accessing reproductive health services such as their contraceptive method of choice, comprehensive prenatal care, and quality care during childbirth.¹⁰² Such barriers include:

- A lack of health insurance
- A lack of access to primary care and a routine and trusted primary care provider

- Long geographic distances to the nearest medical facility compounded by limited access to transportation
- Constrained economic and social resources
- Poor provider-patient communication as a result of both cultural and linguistic divides¹⁰³

Equally important factors in adverse health outcomes are root causes such as income, racial, and gender inequalities, which contribute in significant ways to the health disparities that exist among different racial and ethnic groups in the United States.¹⁰⁴ Researchers have identified, for instance, a steep gradient between socioeconomic status—a composite measure of income, educational attainment, and occupation—and health. Those at any given level of socioeconomic status have better health outcomes, on average, than those at any level below that given level.¹⁰⁵

In short, the poorer you are, the worse your health is. Poverty and socioeconomic status shape women’s reproductive health outcomes by influencing not only their access to health insurance but also:¹⁰⁶

- Their access to accurate information
- Their susceptibility to sources of chronic stress, which undermine their ability to take medication like oral contraception regularly and may cause detrimental birth outcomes¹⁰⁷
- Their exposure to various barriers such as limited transportation that hinder their ability to access services¹⁰⁸

Racism, both interpersonal and institutional, also can play a role in negative health indicators, including birth outcomes.¹⁰⁹ One study, for example, indicates that low-income African-American women who reported experiencing racial discrimination during pregnancy may have a higher risk of bearing very low-birth-weight infants than those who did not report such experiences.¹¹⁰ Also, given the legacy of racism, coercion, and abuse that people of color have endured in the realms of medicine and public health over time, many people of color have a high level of mistrust toward the health care system. A 2002 Institute of Medicine report noted that this factor, too, plays an important role in shaping their willingness to access and use available health services.¹¹¹

On a structural level, sociologists David R. Williams and Chiquita Collins showed in a seminal paper that racialized residential segregation has important consequences for health disparities. By shaping individuals’ educational and employment opportunities, as well as the physical and social environment in which they

live, residential segregation determines people's access to health-promoting social and economic resources such as healthy foods and safe housing, as well as their exposure to health hazards such as targeted tobacco and alcohol advertising and violence, which can have deep physical and emotional consequences.¹¹²

Similarly, as a result of segregation into neighborhoods that are disproportionately affected by environmental degradation, people of color and poor individuals face an increased risk of being exposed to health-damaging toxins.¹¹³ Reinforcing these findings, a contextual analysis that examined the social, environmental, political, and economic circumstances that influence health outcomes found that the black infant mortality rate was higher in highly segregated cities.¹¹⁴

Considerably less research has been conducted on the effects of gender inequality on women's reproductive health outcomes, but academic analysis of the role of gender in shaping women's mental and physical health and well-being has grown in recent years. Because women earn less on average than men for the same jobs,¹¹⁵ they are more vulnerable to poverty—a known risk factor for adverse health outcomes.¹¹⁶ Additionally, because women are more likely to be caregivers of children, the elderly, and the ill and disabled, they are at increased risk for the adverse health outcomes that accompany caregiving, such as coronary heart disease.¹¹⁷ To compound matters, they also may forego their own self-care because they are too busy caring for others.¹¹⁸

Intimate partner violence, which is rooted in unequal gender relations and which occurs at disproportionately higher rates in the African-American community, also has negative effects on women's health and well-being. Reproductive health outcomes include a risk of birth control sabotage, unintended pregnancy, and violence during pregnancy. In fact, a 2005 study found that homicide ranked second, after auto accidents, among injury-related deaths for pregnant women and new mothers.¹¹⁹

Abuse also leads to poor birth outcomes. In reviewing the existing literature, one researcher found that women who are exposed to intimate partner violence while pregnant are significantly more likely to give birth to a low-birth-weight child and have a pre-term birth than their counterparts who did not experience violence during pregnancy. Similarly, violence toward pregnant women also increased the risk of neonatal mortality (the death of an infant in the first month after birth) and affected women's postpartum breastfeeding practices.¹²⁰

The interplay of reproductive health disparities and the Hyde Amendment

As should be clear, abortion is but one of many health disparities that women of color currently endure. Yet it is because of these disparities that women of color and low-income women obtain abortions at higher rates—in spite of funding restrictions. It is inequality that drives the trends of higher abortion rates among poor women of color, not conspiracies to perpetrate genocide. While health reform ought to improve these circumstances by increasing access to insurance and care, enabling women to establish trusted relationships with medical providers through more routine care, and decreasing the cost of family planning services, focusing only on unintended pregnancy and abortion rates among women of color is a myopic approach that overlooks the numerous health disparities they face that must *all* be addressed.

Against this backdrop of persistent health disparities, the Hyde Amendment should be seen as yet one more barrier that poor and low-income women of color must overcome in order to access reproductive health care and ensure their reproductive health and well-being. Our government has taken a group of women who have little access to health care generally, a heightened incidence of disease and injury, and an increased risk of unintended pregnancy, and then walled off abortion care.

This leaves them in the horrible position of not having the institutional supports necessary to plan wanted pregnancies and carry healthy pregnancies to term and yet unable to end pregnancies that they do not want or feel unprepared to handle. Our government does little to address and prevent the serious health disparities that women of color experience and then denies them services they need when those disparities emerge.

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A legacy of reproductive discrimination

The Hyde Amendment is not the first U.S. policy to target the reproductive decisions of poor women and women of color. A long line of policies and practices throughout our nation's history took away women's ability to determine whether, when, and with whom to have children. Many of these "population control" policies were designed to deny or discourage procreation by women on the margins of society. And it is important to see this broader context in which the Hyde Amendment operates.

Population control policies undermine the ability of women of color and poor women to bear and raise children. Abortion funding restrictions undermine their ability to end a pregnancy. At first blush these strategies may seem at odds, but they both stem from the same motivations:

- A desire to control women's fertility
- Mistrust of their judgment
- A vilification of their sexuality

Both population control policies and abortion funding restrictions deny women the opportunity and autonomy to make decisions about their own fertility, including whether to carry a pregnancy to term. Rep. Hyde admitted he targeted poor women with his amendment because it was the only way the federal government could deny abortion rights to any woman, but the result is the same—poor women of color are the targets.

A number of policies and practices throughout our nation's history have undermined women's reproductive options, including forced sterilization, pressure to use long-acting contraception, and coercive childbirth practices.¹²¹ These policies affect all women but have had a disproportionate impact on women of color and poor women, as they are more likely to rely on government-subsidized sexual and reproductive health services.¹²²

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Such practices are a legacy of gender-based racism that has persisted over centuries. Black women were forced to reproduce during slavery through rape and by being punished for not bearing children or rewarded for becoming pregnant.¹²³ Chinese women were characterized as “prostitutes” by politicians as justification to exclude them from U.S. immigration through the 1882 Chinese Exclusion Act and prevent them from joining their spouses. And Native Americans were subjected to a range of tactics used to control and exterminate them, including the intentional distribution of smallpox-infected blankets during the French and Indian War in the 18th century and the forcible removal of Native American children from their homes to attend white-run boarding schools in the 19th and 20th centuries.¹²⁴

In more recent times, sterilization abuse was a primary tool for controlling the reproduction of disfavored groups of people. At the beginning of the 20th century, a number of states passed involuntary sterilization laws aimed at preventing reproduction among people deemed “socially inadequate,” including those with a mental illness, developmental delays, alcoholism, a criminal record, those living in poverty, and those who were gay or lesbian.¹²⁵ These laws were rooted in eugenic theory—the idea that intelligence and other characteristics are determined solely by one’s genetic makeup—and the belief that certain groups of people should not bear children because “socially undesirable traits,” such as poverty and “welfare dependence,” were hereditary.¹²⁶

Involuntary sterilization laws were widely promoted by government officials and validated by the judiciary. The 1927 Supreme Court case *Buck v. Bell*, involving a poor woman deemed an “imbecile” for getting pregnant out of wedlock, is the infamous decision in which the Court upheld the constitutionality of a Virginia involuntary sterilization law.¹²⁷ In the Court’s opinion, Justice Oliver Wendell Holmes noted that sterilization was necessary “in order to prevent our being swamped by incompetence,” and to “prevent those who are manifestly unfit from continuing their kind.”¹²⁸

Blatantly coercive uses of sterilization—sometimes colloquially referred to as “Mississippi Appendectomies”¹²⁹—continued into the 1960s and 1970s.¹³⁰ In 1974, a federal district judge found that 100,000 to 150,000 poor women were sterilized every year under the auspices of federally funded government programs, often subject to the threat of losing welfare benefits.¹³¹ Similar violations occurred in the Indian Health Service, where hysterectomies were performed on young Native American women without their informed consent.¹³²

Similarly, Medicaid physicians in that era agreed to deliver babies or perform abortions for black women only if they “consented” to being sterilized afterward.¹³³ And in Puerto Rico, where the federal government imposed a population control policy in the 1940s,¹³⁴ sterilization reached its peak in 1965, with one-third of never-married women ages 20 to 49 having been sterilized.¹³⁵ Other more subtle forms of sterilization abuse included withholding information about sterilization, providing misleading or inaccurate information about sterilization, or seeking “consent” for sterilization while a woman was in the midst of a stressful situation such as labor and delivery.¹³⁶

In response to these abuses, women of color leaders in the 1970s formed the Committee for Abortion Rights and Against Sterilization Abuse and the Committee to End Sterilization Abuse, both of which fought against coercive and forced sterilization. Their efforts resulted in national reforms implemented in 1979 mandating that hospitals receiving federal funding wait 30 days prior to performing any sterilization and provide counseling and information about the procedure in the woman’s language of choice. The reforms also required that women, their physician, and an interpreter (if applicable) sign informed consent forms.¹³⁷

More recently, private groups such as CRACK, an acronym for Children Requiring a Caring Kommunity, have offered cash payments of \$200 to \$300 to drug-addicted women if they agree to be sterilized.¹³⁸ CRACK now goes by the more beneficent name, “Project Prevention,”¹³⁹ but the aim is the same: to “save our welfare system and the world from the exorbitant cost to the taxpayer for each drug addicted birth.”¹⁴⁰

Fighting back

In light of the assaults on women of color's reproductive rights, many of them are justifiably distrustful of family planning programs and initiatives. Even so, and contrary to the conventional wisdom that depicts women of color as uninvolved or uninterested in issues of reproductive freedom and autonomy, African-American, Latina, Asian and Pacific Islander, and Native American women boast a long legacy of not only resisting coercive population control policies but also fighting for access to safe and voluntary reproductive health services, including contraception and abortion.

Using a dynamic framework known as reproductive justice that highlights the intersection of race, ethnicity, class, gender, nationality, sexuality, and disability, women of color organizations have led the way in connecting the dots between women's social context, the economic circumstances in which they live and work, and their sexual and reproductive health and rights. The term "reproductive justice" was coined in 1994 by the Black Women's Caucus at the Illinois Pro-Choice Alliance conference. Responding to the International Conference on Population and Development in Cairo and the debate around the Clinton administration's health reform proposals, these activists saw the need for a broader analysis that acknowledged the everyday lived experiences of women and better claimed the right to be a parent as well as the right not to be a parent.¹⁴¹

Groups such as the SisterSong Women of Color Reproductive Justice Collective can be credited with bringing this new framework to the organizing around the 2004 March for Women's Lives. And Asian Communities for Reproductive Justice later expounded upon the definition in its seminal report, "A New Vision for Advancing Our Movement for Reproductive Health, Reproductive Rights and Reproductive Justice."¹⁴²

As documented largely by the groundbreaking work, *Undivided Rights: Women of Color Organize for Reproductive Justice*, groups such as Asian Communities for Reproductive Justice (formerly Asian and Pacific Islanders for Reproductive Health), the Black Women's Health Imperative (formerly the National Black Women's Health Project), the National Asian and Pacific American Women's Forum, the National Congress of Black Women (formerly the National Political Congress of Black Women), the National Latina Institute for Reproductive Health, the National Latina Roundtable, Native American Women's Health Education Resource Center, SisterSong, and many others are shifting the debate about reproductive rights in this country and inspiring a new generation of activism.¹⁴³

Other forms of reproductive coercion have come through the welfare and criminal justice systems. The 1996 welfare reform law, for example, included caps on the size of families, which punished women for having additional children by denying them public benefits for those children.¹⁴⁴ Some government officials and judges in the 1980s and 1990s pressured poor women and women of color to use Norplant, long-acting hormonal contraceptive capsules implanted in the arm, in exchange for receiving welfare benefits or avoiding jail time.¹⁴⁵ And low-income women, particularly African-American women, have been targeted for arrest and prosecution for using drugs while pregnant rather than offered substance abuse treatment.¹⁴⁶ Not surprisingly, women of color are fighting back. (see box above)

Unfortunately, these practices are not entirely a thing of the past. Just this year, a woman was sent to prison for becoming pregnant while on probation, which was a violation of the terms of her halfway house. Her complaints of illness were ignored by prison guards, and she died of untreated pneumonia.¹⁴⁷ Other modern-day policies and practices that carry echoes of population control include shackling women in prison during childbirth, terminating the parental rights of prisoners without adequate due process, and denying adoption and foster care rights to gays and lesbians. A movement to take away birthright citizenship from the children of undocumented immigrants is only the latest example. (see box below)

Targeting immigrant women

Recently, talk of legislation and constitutional amendments targeting the U.S.-born children of undocumented immigrants—offensively called “anchor babies” by some who think immigrant women travel to the United States to give birth just so that their children’s citizenship will “anchor” them in our country—is sadly gaining momentum. These measures would withhold birth certificates from babies whose parents cannot document their U.S. citizenship or legal permanent resident status. This would directly violate the 14th Amendment, which guarantees citizenship to any person born in the United States.

The person behind this proposal in Arizona is state Sen. Russell Pearce (R-Mesa), who also sponsored the controversial Arizona Senate Bill 1070. That bill would allow law enforcement officials to ask individuals for their immigration papers if “reasonable” suspicion exists about their status. Combining the two measures could easily result in racial profiling of pregnant women.

Immigrants also are being excluded from health care services. Undocumented immigrants will not be allowed to use even their own

money to purchase health plans in the insurance exchanges being set up under the Patient Protection and Affordable Care Act passed earlier this year. And since 1996, even immigrants with legal status have been barred from receiving Medicaid coverage for the first five years of their residency.¹⁴⁸ This ban prevents them from obtaining:

- Prenatal and postpartum care
- Contraceptive services and devices
- Testing and treatment for HIV and other sexually transmitted infections
- Breast and cervical cancer screening, diagnosis, and treatment services¹⁴⁹

These punitive measures undermine the sexual and reproductive health and rights of poor and low-income recent immigrant women, who already face a number of barriers to accessing quality health care, including a lack of economic resources and language barriers.¹⁵⁰

More broadly, factors that rendered (and continue to render) poor women and women of color particularly vulnerable to reproductive abuse and coercion include:

- Poverty and economic insecurity
- Institutionalized discrimination on the basis of race, sex, and class
- A lack of access to health care, including sexual and reproductive health services and information
- Biased government-funding for reproductive health services

In order for the government to justify such policies, politicians and the media often depict women of color and poor women as morally inferior, their behavior as irresponsible, and their sexuality as “out of control,”¹⁵¹ whether it be in the form of the “oversexed Jezebel,” “the lazy welfare queen,” or the immigrant women who “drop [their babies] and leave.”

These ideas arise from and contribute to the stereotypes that poor women of color are “unfit” to parent their children, engage in “excessive childbearing,” and are unable to use contraception effectively.¹⁵² Similarly, fears of population explosion and overpopulation by people of color that featured prominently in conversations around family planning in the mid-20th century and welfare reform in the 1990s continue to shape today’s debates pertaining to reproduction.

Add all of this up, and it is clear that the Hyde Amendment is one egregious policy among many that substitutes the government’s judgment about reproductive decision making for the judgment of women who, by virtue of the fact that they must rely on the government for assistance, lose the power to make those decisions for themselves. Taken together, these policies simultaneously discourage marginalized women from having children *and* from having abortions, leaving them with no choices whatsoever.

Instead, such policies should be neutral. Our government should provide women with the resources they need to obtain the reproductive health services they want, not drive them toward services they do not want but will use because it is the only option they have.

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Conclusion

Women of color experience higher rates of poverty and unintended pregnancy, and they are more likely to be enrolled in government health care programs. As a result, they are disproportionately affected by the Hyde Amendment, which raises the financial, physical, and emotional costs associated with abortion and impedes their ability to participate as full and equal members of society. This situation is exacerbated by the stark health disparities that women of color experience.

The Hyde Amendment and similar abortion funding restrictions are part and parcel of a history of discriminatory policies that have tried to control the fertility of women of color and denied them the power to decide for themselves whether and when to bear and raise children. Abortion funding restrictions, on their own, violate the constitutional, civil, and human rights of women of color. But funding bans also interact with other policies and conditions that violate their rights to health and life, to equality and nondiscrimination, and to self-determination.

Ultimately the Hyde Amendment and related abortion funding restrictions must be repealed. Unfortunately, in the current political climate—with an increasingly conservative Congress and a recent health reform debate that did much to cement the idea that government should not fund abortion care—such changes in the law are unlikely in the near term. But as we begin to implement health reform and evaluate what does and does not work in our health care delivery system, we should be mindful of the impact abortion funding bans have on the physical, emotional, and financial well-being of women and their families. And we should be vigilant in seeking opportunities to improve access to quality, timely, and affordable abortion care.

Repealing the Hyde Amendment and related restrictions will not, by itself, ensure full equality for women of color and low-income women. But doing so is a necessary precondition. Anyone who cares about fighting racism and poverty must realize that attacks on abortion, and especially on abortion funding, are first and foremost attacks on poor and low-income women of color, as Justice Marshall elo-

Anyone who cares about fighting racism and poverty must realize that attacks on abortion, and especially on abortion funding, are first and foremost attacks on poor and low-income women of color.

quently pointed out and as Rep. Hyde himself admitted. These attacks must not go unanswered. We must heed Dr. Martin Luther King Jr.'s admonition that injustice anywhere is a threat to justice everywhere. Ending abortion funding restrictions will improve the lives of all women, but none more so than the women who have shouldered much more than their fair share of injustice.

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