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## TRANSCRIPT<sup>o</sup>

### CONVERGE! REIMAGINING THE MOVEMENT TO END GENDER VIOLENCE

# Panel on Beyond the Rape Exception: Using Law and Movement Building to Ensure Reproductive Health and Justice for All Gender Violence Survivors

UNIVERSITY OF MIAMI SCHOOL OF LAW

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**GONZÁLEZ-ROJAS:** Thank you for having me. My name is Jessica González-Rojas. I am the Executive Director of the National Latina Institute for Reproductive Health (NLIRH). I want to give a special thanks to Dian Alarcon, our local Field Coordinator here in

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<sup>o</sup> This transcript has been edited from its original transcription for clarity.

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<sup>†</sup> Original remarks from the CONVERGE! conference omitted.

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Florida who has been doing amazing work organizing across social justice movements. I am going to share a bit about the reproductive justice framework, how it intersects with work around gender violence and how we bring diverse theories together. I will talk a bit about reproductive oppression, provide a couple of examples, and then provide a snapshot of work that NLIRH is doing in Texas that highlights some of the human rights abuses that has happened in that part of the country. Often a place like Texas, which is led by ultra-conservative politicians who are anti-choice, anti-woman and anti-LGBTQ, ends up being a training ground for bad policies that are replicated in other parts of the country.

The first thing I would like to explain is “what is reproductive justice?” I will also share the difference between reproductive justice and reproductive health, and why the justice frame is really critical in our work. We see reproductive justice as a movement dedicated to ensuring that everyone, regardless of age, race, ability, national origin, income, religion, immigration status, sexual orientation or gender expression, has equal rights and access to reproductive health services, as well as a right to make informed decisions about whether or when to have children. Often it is about whether people can create the families they wish to create and are able to parent those families. For example, the criminal justice system, including detention centers, has torn families. Those who have chosen to create families are often unable to parent the children they have because the children have been placed in foster care or under the care of other family members. The reproductive justice framework acknowledges the systemic barriers that multiple communities face and brings movements together to advance the health and dignity of women and families, rooted in human rights. It offers a strong framework around which to do organize in impacted communities, rooted in “intersectionality.” Intersectionality refers to the way that different identity factors intersect to form an individuals’ reality and lived experience. It recognizes that individuals and groups are shaped by multiple and intersecting identities and that these must be taken into account when doing organizing work.

Reproductive oppression is the controlling and exploiting of women and girls’ bodies, sexualities, and reproduction by families, communities, governments, institutions, and societies. Coercive sterilization, in particular, has been an issue in the Latino community. There have been cases around coercive sterilization in institutions like prisons and public hospitals. In Puerto Rico, between the 1930’s and the 1970’s, there was an island-wide campaign to promote smaller families because of high rates of poverty and agricultural displacement. This was rooted in a racist and sexist notion of overpopulation, placing blame on low-income Latino

families for degradation of the land and characterizing people of color as wasteful, unclean, and uncaring. The campaign also sought to reduce childbirth to encourage women to enter the workforce. The fears of overpopulation targeted women's childbearing and reproductive decision-making. This campaign was a federally-funded effort to coerce women into sterilization and was marketed it as a means out of poverty. There were deceptive advertisements across Puerto Rico of white people with two children, describing the "ideal family" as a small one and encouraging women to seek "la operación" (publicly funded sterilization). By 1968, approximately a third of all women in Puerto Rico were sterilized. The campaign was so "successful" that in towns like Barceloneta, in the northwest part of Puerto Rico, the government was forced to close down elementary schools because there were not enough children to fill those schools. In the 1950's, scientists in the United States mainland were looking for a place for human trials to test contraceptives. They targeted women in Puerto Rico, describing them as poor, uneducated, and eager to reduce their family size. These women faced high dosage rates, sustained awful side effects, and were treated as guinea pigs, without adequate informed consent. While that existed several decades ago, we still see reproductive coercion happen now in the criminal justice system. There has recently been an investigation in California's women prison regarding charges of coercive sterilization, without informed consent.

This is why addressing poverty and other conditions that impact women's lives is so important. We have such amazing partnerships here in Florida where we work across gender justice, immigrant rights, LGBTQ rights, economic justice and labor rights to lift up how various policies impact a person's ability to make and exercise decisions about their health, family and future. The work of NLIRH sits at an intersection of multiple movements. We are often the ones in the women's rights and reproductive rights movements bringing the Latina or immigration lens, and we are often in the Latino civil rights and immigrant rights movements bringing the gender lens. We are working together because the reproductive justice framework allows for that intersection.

The "reproductive justice" term was created by and for women of color. It was coined in 1994 by the Black Women's Caucus after the International Conference on Population and Development in Cairo, Egypt, and was born out of a need to address intersectionality. The term "pro-choice" did not resonate with women of color because it was too limiting. Many women of color are not able to actualize "choices" in their life due to systemic and institutional barriers. Obtaining the legal right to an abortion may not exist if you are poor, if you are an immigrant, if you do not speak the language, or if you live in rural

community with a nonexistent reproductive health system. That “choice” is out of reach for many women. Thus, a focus solely on rights does not address a person’s ability to actually exercise that right. Pro-choice is the view that a woman should have control over her fertility, to continue or terminate a pregnancy, but women of color found that choice is relative to the options that exist in a person’s life.

In terms of other frameworks, the term “reproductive health” often focuses on service provision and ensuring actual services in healthcare. Often the policy advocacy strategies to focus on improving and expanding services, research, and access are more within a legal context. Protecting women’s rights and reproductive healthcare services with a focus on keeping abortion legal and increasing access to family planning services is generally limited to a legislative, rather than an organizing strategy. By contrast, the reproductive justice framework is largely focused on movement building. We view reproductive oppression as a result of the intersections of multiple oppressions and connected to the larger struggle for social justice and human rights. Reproductive justice puts women of color and communities affected at the center of the work and it supports their leadership, it builds their power, it integrates other social justice and human rights issue.

Community mobilization strategies include organizing, leadership development, civic engagement, grassroots advocacy and culture shift. We are doing work to highlight Latina voices to change the conversation and shift the narrative. I am going to show a short video on our work in Texas, but first I will provide a bit of context about that community. NLIRH has been doing work in the Rio Grande Valley since 2006 to 2007. The Valley is home to 1.3 million people, largely Latino including many immigrants; urban, rural and suburban communities. The communities that we work with are mostly very rural. There is a high concentration of colonias. Colonias are unincorporated communities that often do not get basic services—they do not get transportation, electricity, or water. There are a lot of trailer homes and not a lot of resources. Most of the community members are low income and uninsured. As outlined in our report, “Nuestro Texas: The Right to Women’s Reproductive Health in the Rio Grande Valley,”<sup>1</sup> the state of Latina health in Texas is really dismal. Women in Texas consistently rank lower in terms of health. Latinas are the most likely racial ethnic group to report being in fair or poor health conditions; they are less likely to have a doctor. Half of Latinas of reproductive age in Texas are uninsured. Hidalgo County, where we are doing a lot of our work, has

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<sup>1</sup> See THE WOMEN OF RIO GRANDE VALLEY, [www.nuestrotexas.org/](http://www.nuestrotexas.org/) (last visited May 22, 2015).

the highest rate of uninsured women in any urban county in this country. When it comes to diseases like cervical cancer, which is almost 100% preventable, Latinas in the Rio Grande Valley have the highest incidences in the country and many are dying from it. The health conditions are really dismal and the disparities are really stark.

We partnered with the Center for Reproductive Rights to conduct a human rights investigation of the impact of the 2011 cuts in the Family Planning Program in Texas. We talked to 188 women. Their stories were hard and difficult, but what I want to share in the end is their resiliency, their sense of power, and that they are on the front lines of fighting for justice. This is just a snapshot of one of the stories: “It’s \$60 for a health checkup. I thought I would either pay \$60 or buy food for my children. Either I pay the rent and get my children a place to live or I have a mammogram, a pap test or contraception. It’s one or the other, not both.” These are the kind of predicaments that women face. Oftentimes they are going to choose to put food on the table and then their health is sacrificed. What we did in the report is document what kind of human rights violations are happening in the Rio Grande Valley. This as a form of reproductive oppression and it includes violations of the right to health, the right to life, the right to privacy and reproductive autonomy, and the right to nondiscrimination and equality and freedom from ill treatment. We include strong policy recommendations in the full report. The website is [NuestroTexas.org](http://NuestroTexas.org), so please check it out. Now, I am going to show a quick video from that campaign.

[Video:] Two years ago I became pregnant because they closed the clinic in Mission [Texas]; there wasn’t enough funding to take care of me. Unfortunately, two years ago [government] funding was cut for women’s reproductive health. We were all affected: working women, women with their immigration documents, and it was especially those women without their papers in order that were most affected by the cuts in funding for women’s reproductive health. I’m fighting against cancer and I don’t have health insurance. They ask that I become a citizen in order to be seen [by a doctor] in Houston. Funding for women’s health has been cut. Grants have been cut and women who used to before have access to going and getting a mammogram, a pap smear, getting checked, they have no income and they have no access to those funds. The barriers that I see in the community where I work . . . transportation is one of them. Sometimes women miss their appointments because of this. There are no longer the same benefits;

they ask you for a lot of paperwork. We fear demanding from the government that we have rights. Nothing is going to stop us. We will continue fighting. This is just the beginning of the fight. We will need to forge ahead with more battles and struggles, holding more protests, using our voices, speaking with political representatives, holding an endless amount of things like meetings, whether they're small or large, uniting ourselves. As women of these communities, we have the power to make all of this change. We are not going to surrender; we are going to continue this fight so that the funding will come back and stay with us. Some of these women don't leave their houses. They don't leave the four walls of their homes. They don't even go outside because of fear. They also have many emotional problems and struggles with domestic violence. It's within this reality that we reach out to these women and we see that even within all these difficult situations, we can bring out the most beautiful in them . . . their power. Good morning neighbor. Women living in the lower Rio Grande Valley have struggled for years to obtain affordable healthcare in the face of numerous barriers including cost, immigration status, and the lack of transportation. Despite these barriers and the daily risk to their lives, they continue uniting under one cause – a right to healthcare and a more just Texas. Our Texas! For our Texas! Because we are Texan! Because this is where my children were born. Our Texas! For the health of our women! Because I don't want to be another number here in Texas. Our Texas! For our families, our state, our country!<sup>2</sup>

Those women in Texas are going to create social change. Dian here in Florida is going to create social change. That's how we are changing society. I want to leave you with a quote referring to a bill that would have expanded the prohibition on the use of federal funding for abortion:

Here's another problem: Calling HR7 “the rape audit bill” may have grabbed headlines and stirred the passions of the pro-choice base, but it came with a cost. This bill isn't primarily about rape. It's about abortion.

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<sup>2</sup> LATINA INSTITUTE, *Nuestro Texas: The Fight for Access to Reproductive Health Care in the Rio Grande Valley*, YOUTUBE (Nov. 11, 2013), [https://www.youtube.com/watch?v=kWL4\\_M2LFY0&feature=youtu.be](https://www.youtube.com/watch?v=kWL4_M2LFY0&feature=youtu.be).

And whenever the need for safe, legal abortion for all women is justified only by the most extreme cases, we risk obscuring many women's experiences behind a poster child façade.

This “rape audit” frame, for a bill about abortion and poor women, also creates a convenient excuse for some feminists to avoid conversations about privilege, poverty, and institutional racism—conversations which feminism is desperately in need of having (hello, #solidarityisforwhitewomen).

Defending women's reproductive autonomy is hard work, and our opposition is frequently strident, relentless, hyperbolic and even duplicitous. But while the heat of political scrutiny may tempt us to shield our views from behind seemingly unassailable, sympathetic avatars like rape survivors, justice demands more of us.

I say this as a woman who has never needed an abortion, but has experienced sexual assault. As a survivor, I start to worry when the discussion of rape becomes a political ploy for anybody—including those whose politics I generally agree with.

Justice demands that those of us who defend reproductive autonomy do so for all women, without placing the same judgments upon them as those who seek to deprive them of their rights. And while we're at it, justice demands that mainstream feminism stop avoiding conversations about racial and economic inequality, however uncomfortable or long-overdue those conversations may be.<sup>3</sup>

Thank you.

**AINSWORTH:** Hi everybody. First, I want to thank Angela and Jessica and Lillian for agreeing to come together to do this. I am finding it very thrilling first of all to be with these wonderful allies, but also to get to have the conversation in the context of a conference focused on gender violence. Just to give you a little context of the work I do, I started my law practice as a legal services lawyer representing survivors

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<sup>3</sup> Kimberly Inez McGuire, *Feminists Should Have Never Called it the “Rape Audit” Bill. It’s Much Worse Than That.*, POLICY.MIC (Jan. 28, 2014), <http://mic.com/articles/79881/feminists-should-have-never-called-it-the-rape-audit-bill-it-s-much-worse-than-that>.



of domestic violence. The majority of the people I worked with were immigrants facing domestic abuse and immigration status issues. I work in the Seattle area, which is very different from the Miami community, but the same issues are there for the people who are there facing immigration issues and other issues of marginalization. I then worked at a legal organization where I worked on reproductive rights and health issues, eventually learning to incorporate the reproductive justice frame into my work. I learned a lot of that from the Latina Institute and other organizations.

What I am going to talk about today are some of the issues in individual perpetration of intimate partner violence and sexual violence, what those incidents of violence do to women's reproductive health and autonomy, and some of the barriers to healing, recovery, and safety. And then I wanted to pick some examples of legal advocacy or other remedies. I am going to also just touch briefly on medical violence and the intersection of child birth interventions for survivors of intimate partner violence and sexual assault. I will try to touch on what are the limits of these legal responses, who is leading them, and how are we mobilizing communities to work together.

We know that the majority of rapes are perpetrated by intimates or acquaintances, and we know that victims of domestic violence experience high rates of sexual violence. We also know that sexual violence is hard to talk about. Those of us who work in the field as lawyers often find ourselves talking about the physical violence and not asking our clients to relive the sexual assaults with us in an interview room or on paper to a judge. I support those decisions to keep that private, but I also see that it makes the problem more hidden and it is harder for all of us to realize how pervasive rape is. We also know that approximately 5% of rape victims will become pregnant as a result of the rape. This probably substantially undercounts the number of people that get pregnant as a result of rape because we know rape is underreported and because this study did not account for intimate partner violence at all. So, plenty of children born into marriages are born as a result of rape and are not included in this kind of statistic. And none of those statistics account for reproductive coercion—the kinds of techniques that abusive partners use to control birth control, sabotaging birth control, preventing their partner from using any birth control, and forced and coercive pregnancy. And we know that this is a real problem for teenagers across racial demographics and this is not accounted for in this 5% figure.

It is completely obvious that a rape survivors' primary concern immediately after a rape is likely to be avoiding pregnancy if the rape victim is a person of reproductive age. There are several studies that confirm that this is so. If you do not avoid the pregnancy, we also know

that in the context of intimate partner violence, pregnancy is a very risky proposition for women. There is a higher incidence of severe abuse in pregnancy and homicide is the third leading cause of death for pregnant women in the United States—and that is across demographics.

When someone is facing reproductive coercion, their decision making is hampered by a lot of barriers. They have probably already been prevented from preventing the pregnancy by their partners' coercive acts, and then if they do become pregnant, there are a host of things that limit their ability to get what they need, whether they want to have the child or whether they want to have an abortion. Many barriers come from the partners' conduct in preventing them from accessing healthcare. We know that when women become pregnant as a result of rape, more than half (just a little more than half) choose to have an abortion.

I want to talk now about some barriers that limit survivors' options: poverty, immigration status, and batterer abuse generate risks. If you cannot get to a pharmacy to get emergency contraception because you are not allowed to leave the house, if you have to account to your abuser for every dollar that you spend, you are not going to be able to get to the services that you need.

So, these posters went up all around New York on subways and at bus stations. The posters showed children who were either African American or mixed race. They were targeted at teenagers to try to make them feel that having a baby is a bad decision. I am particularly struck by how these messages completely ignore the fact that a lot of teenagers become pregnant because of reproductive coercion and intimate partner violence. It is not a decision that teens are making in order to flout societal norm. In addition, there is lack of access to healthcare; many immigrants are excluded from Medicaid. So, there are so many ways in which people that need reproductive healthcare in the context of intimate partner violence cannot access it.

Another issue regards crisis pregnancy centers. Crisis pregnancy centers target young people and low income people, people who lack insurance, and they do a variety of things to obstruct people's access to reproductive healthcare. One of the things that is more insidious about them is that they have started to indicate that they take referrals from domestic violence programs and they are trying to serve domestic violence survivors. In fact, what they are doing is tricking those survivors into not accessing abortion services by telling them things that are not true, including delaying them by saying their pregnancies are not as far along as they are, or convincing them that they have to come back to the crisis pregnancy center for an ultrasound in twelve or thirteen weeks to get the pregnancy confirmed, this delaying access beyond the

first trimester. An Oklahoma doctor refused to provide emergency contraception to a rape victim in the emergency room. She was twenty-four years old, her mother brought her there. Her mother talked on camera in a news report about the fact that he refused not only to give her birth control, but to treat her *at all* because there was no trained nurse examiner to collect a rape kit at the hospital. So she was sent in an ambulance to another hospital across town and traumatized by that action. Similarly, some pharmacists refuse to provide over the counter emergency contraception.

So, just to touch on one organization that is doing amazing work in Seattle: Open Arms Perinatal Services trains people to serve as birth doulas. We know that the Somali immigrant community in Seattle has a higher rate of C-sections and other birth interventions than the comparable population of other communities, but they also do not want those interventions. They speak out very strongly against those interventions. So, Open Arms is organizing Somali immigrant women to train them as doulas and they now have five people serving the immigrant community. They also help with language access issues.

In Washington State, we tried to deal with the pharmacist problem of refusing to fill prescriptions for Plan B by encouraging the Pharmacy Board to create a rule that all pharmacies have to fill prescriptions. This work was initially led by Planned Parenthood and Legal Voice. But then in December of 2010, the Board changed their mind. When that happened, we decided that we had to do reproductive justice work *for real*. We went into everybody's community. And so at the Board's hearing, we had many communities of color and the disability advocacy community, standing up and saying this rule making process is not accessible, there is no language access, there are no notices provided in people's languages. So we challenged not just the rule, but the process to show why it was exclusive of communities. We had rape survivors and intimate partner violence survivors speak. And so lessons learned: we should always start from the beginning to do this work *together* because we need to work in partnership. And it was not easy. There was a lot of tension at the table because the table was set initially by mainstream white reproductive activists and that was wrong. Good things can come from working together, those of us that did work together on this project liked working together so much that we started our own reproductive justice collaborative. We are holding a forum on immigrant access to reproductive healthcare on March 1st with immigrant communities and immigrant rights activists (not reproductive rights activists—they can come to the next table.)

**HEWKO:** We know that the United States incarcerates more individuals than any other nation in the world, but less known is that

more and more of the nation's incarcerated population are women.<sup>4</sup> The rate of incarceration for women is now increasing at nearly double the rate of men.<sup>5</sup> As racism exists on every level of criminal justice involvement from arrest, conviction, sentencing, women and girls of color are disproportionately represented.<sup>6</sup> Incarceration has unique and shattering effects on women, their families, and their communities. Reproductive justice demands a focus on the needs of those who have faced the greatest harms, and an end to systems that foster these harms. Extremely troublesome is the fact that statistics show the pathways that lead individuals into prison are often rooted in sexual and physical violence.<sup>7</sup> Instead of being treated for trauma, depression, addiction and other injuries of violence, women are displaced into our criminal justice system. We have an obvious public health problem to which we are applying a criminal justice approach. If we really wanted to help people, we would give them access to mental health services, treatment services, education and healthcare. Instead we are putting individuals behind bars which is actually the perfect way to break communities down. And, by communities, I am referring to communities of color.<sup>8</sup>

Our "incarceration solution" fails to address the underlying issues of abuse that led people to prison. The prison by its very nature is set up to inflict power and control over women. For example, incarceration places women at risk of widespread sexual and physical violence at the hands of correctional officers.<sup>9</sup> These women are survivors, have high rates of depression, are working to overcome substance abuse and addiction and once they are in these spaces, they have little access to healthcare, prenatal healthcare services are nonexistent, and an inability to choose

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<sup>4</sup> The speaker noted in her introduction that she uses "women," "mother" and "female" in this talk, but wants to recognize and highlight the fact that many individuals housed in female prisons may identify as gender-queer, gender-nonconforming, or transgender.

<sup>5</sup> Allen J. Beck, *Prison and Jail Inmates at Midyear 2000*, BUREAU OF JUSTICE STATISTICS 5 (2001), available at <http://zimmer.csufresno.edu/~haralds/govdocs/prisonandjailinmates2000.pdf>; see also Paul Guerino, *Prisoners in 2010*, BUREAU OF JUSTICE STATISTICS 7 (2011), available at <http://www.bjs.gov/content/pub/pdf/p10.pdf>. Washington, DC: Bureau of Justice Statistics.

<sup>6</sup> Paul Guerino, *Prisoners in 2010*, BUREAU OF JUSTICE STATISTICS 7 (2011), available at <http://www.bjs.gov/content/pub/pdf/p10.pdf>.

<sup>7</sup> Caroline Wolf Harlow, *Prior Abuse Reported by Inmates and Probationers*, BUREAU OF JUSTICE STATISTICS 1 (1999), available at <http://www.bjs.gov/content/pub/pdf/parip.pdf>.

<sup>8</sup> DRUG POLICY ALLIANCE, *The Drug War, Mass Incarceration and Race* (2014), available at [http://www.drugpolicy.org/sites/default/files/DPA\\_Fact\\_Sheet\\_Drug\\_War\\_Mass\\_Incarceration\\_and\\_Race\\_Feb2014.pdf](http://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Drug_War_Mass_Incarceration_and_Race_Feb2014.pdf).

<sup>9</sup> Allen J. Beck, *PREA Data Collection Activities*, BUREAU OF JUSTICE STATISTICS 1 (2012), available at <http://www.bjs.gov/content/pub/pdf/pdca12.pdf>.

birthing options.<sup>10</sup> At the prison I work at, we had a doula services program where numerous women had worked with a doula up until the point of their birth, and at their labor, the prison guards refused to call the doulas to attend the actual delivery. Women have told me stories where they were forced by prison medical staff to consider abortion. When they did not consider abortion, they were given “protection pills” for their health that then led to miscarriage. As lawyers and law students in the room, we must recognize that there is little we can do when there is really no trail of records; in the end it is a woman’s voice against the prison system. Even with the passage of a law in 2010 that ended the practice of shackling pregnant women prisoners during labor and during transport in Washington State, I spoke to a woman, S, who was shackled.<sup>11</sup> When I asked her if she wanted to try and fight, she stated that she was too exhausted, and that her most important concern was that the state was now moving to terminate her parental rights—her baby would be permanently separated from her. The imbalance of power created by prisons leads to laws on the books being ignored without consequence.

When the law is not always enough, what can we do? As reproductive justice advocates, we can listen to the needs of the women we are working with to make systemic change, not just address their legal problems at hand. In S’s case, after being shackled, the state fast-tracked her case and terminated her parental rights after only six months. The state usually gives parents twelve months. Federal law demands that the state terminate parental rights when a child is out of home care for fifteen of the last twenty-two months.<sup>12</sup> Here, the grandmother was available to parent the child, but since the child had special needs and the grandmother was not very wealthy, the state said that the child was better off in foster care.

So, when speaking of reproductive rights and choices, what kind of choice is being offered to parents like S? We know from social science research and from the voices of youth, that although their parents may be less than perfect, the love that they have for their parents is as real and strong as any other child’s. The loss experienced by these children when their relationships are severed is real. I want to just share a quick poem that was written to a mother I worked with:

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<sup>10</sup> LEGAL ACTION CENTER, *After Prison: Roadblocks to Reentry: A Report on State legal barriers Facing People with Criminal Records*, 16 (2004), available at [http://www.lac.org/roadblocks-to-reentry/upload/lacreport/LAC\\_PrintReport.pdf](http://www.lac.org/roadblocks-to-reentry/upload/lacreport/LAC_PrintReport.pdf).

<sup>11</sup> *Id.*

<sup>12</sup> Adoption and Safe Families Act, 42 U.S.C.A. § 675 (5)(E)(2010).

Now Mom, this is only a poem, do not think anything bad from it, okay? I love you with all my heart and I know all the answers to all these questions but I was just making a poem out of them, okay? I love you so much. We have only 129 days left to go and I am 100% sure we can make it. Mom, why did you have to leave? Why did you go so far away? Why did you have to go somewhere we couldn't? How come you haven't come home? When will these things be normal again? Will they ever? I miss you. Why are so many people hurt? Whose fault is this? Was I doing something wrong? I miss you!—Carina Perry, age 14.

In 1996, we passed “welfare reform.” Just like our current immigration reform-it did not reform anything, instead it took more away, gutted more resources, and completely cut the social safety net for low income women in the United States. At the same time, the war on drugs was ramped up, and more and more low-income people were racially profiled and arrested for low-level drug offenses. Then, in 1997, we passed the Adoption and Safe Families Act which created financial incentives for adoption and made it easier and quicker to terminate parental rights by adding the arbitrary timeline I mentioned before. States could “free up” children in the foster care system and make it easier for them to be adopted.<sup>13</sup> As a result, incarcerated parents in the child welfare system are now losing their children at twice the rate of those parents not involved in the criminal justice system.<sup>14</sup> What message is this sending? The message is that these women are not valued as mothers and that their struggle and attempts at survival of poverty and violence are not supported. In some cases, adoption is needed, and thankfully there are loving families to step in, but we cannot at the cost of destroying certain families. The state gets a “bonus” if they complete enough adoptions, whereas there are no incentives for reunifying families. As Professor Dorothy Roberts says, “Adoption often provides to children a loving home and to capable adults a chance to parent, but there’s a reality that this is a political institution that reflects social

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<sup>13</sup> *Id.*

<sup>14</sup> Marilyn C. Moses, *Correlating Incarcerated Mothers, Foster Care and Mother-Child Reunification*, CORRECTIONS TODAY (2006) (Illinois study showed incarcerated parents in the child welfare system are now losing their children at twice the rate of those parents not involved in the criminal justice system).

inequities, including race, class, and gender hierarchies, and in serving powerful ideologies and interests.”<sup>15</sup>

Reproductive justice advocates in Washington State—with the direction and leadership of formerly and currently incarcerated parents—changed our child welfare law, modeled off of 2010 changes in New York.<sup>16</sup> Specifically, we amended our law to include an exception to the current timeline for incarcerated and formerly incarcerated parents.<sup>17</sup> We used positive rights language that would get women the resources and contact with their children that they need in order to be successful—such as rights to attend hearings via videoconference or teleconference, and rights to visitation and protections at the termination stage that forces the court to analyze and recognize the barriers of our current system.<sup>18</sup>

I work from a prison abolition framework, so for those of you that are struggling with what that can look like, knowing that prisons will not be gone tomorrow, we must do our work in a manner that does not make the criminal justice system stronger. The parent’s rights bill is an example of this prison abolition framework. We must begin to imagine a different system and change the institutional structures and underlying belief systems that drive that system. We can use structures already in place. Through the Affordable Care Act, the basic health and mental health services, resources, and reentry support available to women is unprecedented. Our courts lag behind these social movements. We can talk about race, and use social science research that show disproportionate racial or poverty effects. It will take creative solutions to find ways to support marginalized populations that are invisible. However, as reproductive justice advocates, if we start with supporting women in prison, all of the situations that we have been talking about this weekend in getting women in the general population access to reproductive health care will be possible.

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<sup>15</sup> Dorothy E. Roberts, *Adoption Myths and Racial Realities in the United States*, in *OUTSIDERS WITHIN: WRITING ON TRANSRACIAL ADOPTION* 50 (Jane Trenka et. al eds., 2006).

<sup>16</sup> Substitute H.B. 1284, 63rd Leg., Reg. Sess. (Wash 2013).

<sup>17</sup> See Wash Rev. Code Ann § 13-34-145(4)(a)(iv).

<sup>18</sup> Wash Rev. Code Ann § 13-34-067(3) (requiring that a parent unable to participate in a hearing in person, must have the option to participate through use of teleconference or videoconference); Wash Rev. Code Ann § 13-34-136(2)(b)(i) (requiring state social workers to assess an incarcerated parent’s ability to participate in meetings, the treatment available in the facility where they are confined and provide visitation unless it is deemed contrary to the best interest of the child); Wash Rev. Code Ann § 13-34-180 (stating that for parents who did not receive services, experienced delays and barriers to visitation and other meaningful contact, the court may consider this as evidence of rebuttal to any presumption established pursuant to § 13.34.180(1)(f) and § 13.34.180(2)).