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Editorial

Race, reproductive politics and reproductive health care in the contemporary United States

To paraphrase Leo Tolstoy, who famously wrote that all unhappy families are unhappy in their own way, we can say that all nations confront the thorny issue of demographics, but each in its own, typically controversial, way. Various European countries, for example, have anxieties about a "demographic winter," which is a below replacement birth rate of the native population, which has led to corresponding fears about rising birth rates among Muslim immigrants. China, driven by worries about overpopulation, has instituted coercive reproductive policies that many observers find unacceptably harsh. The United States, a country marked by extreme stratification on both racial and economic grounds, is a particularly interesting case to consider from a demographic lens because there has been a history both of targeting the birth rates of people of color *and* at the same time deep political divisions about the provision of reproductive health services — particularly abortion but increasingly, as the current election season reveals, contraception as well.

We, a sociologist and physician, respectively, write here of our dismay about the contemporary state of reproductive politics in the United States and particularly the cynical manipulation of racial themes by the opponents of abortion and birth control. However, we are acutely aware of the mixed legacy of the United States with respect to demographic issues. To name but a few examples, in 1905, President Theodore Roosevelt warned of "race suicide" because of his concern about falling birth rates among white Anglo-Saxon women and the higher rates among immigrants [1]. In the 1927 Supreme Court case, *Buck v Bell,* the Court upheld a statute instituting compulsory sterilization of the unfit, including the mentally retarded, "for the protection and health of the state" [2]. In the 1960s, impoverished African-American and Latina women, along with some poor whites, were subjected to coerced sterilizations, often without these women fully understanding to what they had ostensibly agreed [3]. When the first federally funded family planning centers were established in the early 1970s, as a result of the passage of Title X, they were disproportionately located in African-American communities, although the language of the legislation did not mention race but rather the income status of the intended recipients [4].

Co-existing with these events, however, has been a longstanding reproductive freedom movement in the United States, made up of clinicians and lay activists alike. Starting in the early 20th century, doctors and nurses, along with lay allies, fought for the legalization of first, birth control, and, later, abortion, seeing the particular damage done to the most vulnerable women in the absence of such services. In the 1960s and 1970s, feminist health activists raised an outcry about the sterilization abuses mentioned above; indeed, among the most prominent of the reproductive rights organizations to emerge from the "second wave" feminism of that era was CARASA, the Committee for Abortion Rights and Against Sterilization Abuse, providing a template for the principle that abortion rights should ideally be considered in a broader context that includes the right to *have* children [5]. That generation of feminist activists also severely criticized the then-common practice of testing new contraceptive methods on Third World women. Today, there are numerous reproductive rights/reproductive justice groups hard at work in the United States, a number of them specifically concerned with the situation of women of color.

In short, this very brief recapitulation of reproductive struggles in the United States reveals the truism that the world of sexual and reproductive health services is a complex terrain, always containing both liberatory and coercive possibilities, and always with particular implications for people of color in a white-dominated society. But with respect to present-day conflicts, no figure's legacy has been more contested than that of Margaret Sanger, the founder of the organization that eventually became Planned Parenthood. Anti-abortion forces for years have accused Sanger of being a racist and a eugenicist. Currently, these groups have pounced upon the high rate of abortion within the African-American community — black women have abortions at nearly four times the rate of white women — and have joined forces with some conservative groups within that community to mount a vigorous campaign against Planned Parenthood in particular and abortion provision more generally. Starting in Atlanta, and spreading to other cities, these groups have sponsored controversial billboards — some proclaiming that "black children are an endangered species" and others comparing abortion to slavery.

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As Ellen Chesler, Sanger's premier biographer, has argued, such accusations are a distortion of Sanger's record [6]. Although Sanger did receive some support from eugenicist organizations (at a time when eugenics was a far more mainstream movement than it is currently), her record cannot be construed as "racist." Among her supporters were numerous black ministers, leading African-American intellectuals such as W.E.B. Dubois, and prominent community leaders such as Mary McLeod Bethune, founder of the National Council for Negro Women. In 1966, when Dr. Martin Luther King accepted the first Margaret Sanger award from Planned Parenthood, he praised Sanger for "her courage and vision," comparing her struggle for birth control to the civil rights movement. One of the most effective critiques of the billboard campaign, and against the larger agenda of demonizing Planned Parenthood, has come from Sistersong, a coalition of reproductive justice groups of women of color. As Loretta Ross, the executive director of the group told the *New York Times*, "The reason we have so many Planned Parenthoods in the black community is because leaders in the black community in the '20s and '30s went to Margaret Sanger and asked for them. Controlling our fertility was part of our uplift out of poverty strategy, and it still works" [7].

This manipulation of the history of race and reproduction by those involved in the billboard campaigns and similar efforts obscures the contemporary facts of life faced by the most vulnerable black women. These women experience high rates of unintended pregnancy, low use of the most effective forms of contraception, deep poverty, inadequate educational opportunities, unacceptable levels of intimate partner violence and, very often, lack of support from their churches. It should come as no surprise that these same women would have the highest rates of abortion in this country. Given the conditions, these women need — among many other services — access to comprehensive health care that includes both family planning and abortion. Yet, abortion has long been excluded from most mainstream health care institutions and sources of public funding, and during the current political season, we have watched with dismay the severe attacks on contraceptive coverage as well. The isolation of abortion, in particular, from the rest of health care has contributed to its stigmatization and has helped the development of conspiracy theories, such as we see in the billboard campaign. We decry the inflammatory, false rhetoric of "black genocide" that has been used in this campaign by anti-abortion extremists, and we are hardly the first to point to the hypocrisy of those who oppose contraception and abortion, yet just as fervently oppose any spending for social services.

One of us (WP), speaking from my perspective as a member of the African American community and as a women's health provider, asserts that this attempt to manipulate my community is made possible by our unresolved issues regarding gender roles and sexuality in a modern context. The failure of our community to promote the agency of our mothers, sisters and partners, and to deal forthrightly with sexual matters, leaves us treating abortion and HIV-related issues as "open secrets." This evasion results in exorbitant rates for both. To truly confront these issues, our community desperately needs medically accurate sexuality education, improved health literacy and a constructive engagement of religious and spiritual leaders, given the central importance of religion in the African-American community. This type of empowerment effort towards shared reproductive health responsibility is the only effective rebuttal to the mischief occurring with race and reproduction in our community. To paraphrase Dr. King, just as individual wealth is always a function of the commonwealth, thus it too holds true that compromising the reproductive health and rights of individual black women results in jeopardizing the collective well-being of black communities.

If to know is to become responsible, my awareness of black women's unmet reproductive health needs requires me to provide family planning and abortion care to those most in demand for them. Doing so represents a dual sense of responsibility that I feel as both a women's health provider and as a member of the African-American community. I join with those in my community who have articulated a vision of reproductive justice, defined as creating a society that enables all women and families to have the children they want, the resources needed to raise them, and the ability to prevent or end the pregnancies that they do not want. I call on my fellow health care providers, of all races, to trust women to make the good and tough decisions about when and whether to expand their families. A fundamental respect for fairness necessitates it, and a respect for human rights demands it.

In conclusion, as already noted, we write in a period of unprecedented political attack on women's health issues — not just abortion, but also contraception and a range of other reproductive health services. Even the seemingly long settled issue of the importance of programs to combat domestic violence is now being resisted by conservative forces [8]. This "war on women," as it has come to be known, has galvanized a countermovement of health activists, both women and men, who have effectively and creatively protested these developments in a variety of ways. We are greatly heartened by this mobilization, although its eventual impact on elections and restrictive measures is unclear at this time. We close by reminding our readers of what is perhaps obvious: the stakes in this "war" are inevitably the highest for the most vulnerable in our society — those poor women of color about whom we have written in this editorial.

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