An Examination of Oppression Via Anti-Abortion Legislation

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AN EXAMINATION OF OPPRESSION VIA
ANTI-ABORTION LEGISLATION

by

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ABSTRACT

This thesis utilizes a reproductive justice framework to discuss the impact of anti-abortion legislation and the anti-abortion movement on women of color and low-income women, arguing that reduced access to abortion is oppressive to minority women. Chapter 1 outlines the theoretical framework of this thesis, focusing on feminist Marxism, Intersectionality, Critical Race Theory, and radical and third wave feminist perspectives. Chapter 2 provides an overview of the anti-abortion movement and the major state and federal laws and court cases that have defined women’s access to abortion in the United States, including Roe v Wade, the Hyde Amendment, Planned Parenthood v Casey, and TRAP laws. Chapter 3 discusses the oppressive effects of these laws by connecting anti-abortion legislation and the anti-abortion movement to larger historical systems of oppression and examining the effect of reduced access to abortion on women’s reproductive choices and socioeconomic status. This chapter argues that reduced access to abortion is oppressive because it encourages sterilization among minority women who may have chosen other birth control options given the choice, and funnels minority women into an oppressive and exploitative US welfare system. Chapter 4 discusses minority women’s potential to overcome this oppression and examines some real-world examples of reproductive rights activism. This thesis expands the current discussion on abortion access by centering the discussion on minority women and arguing that reduced access to abortion is systematically oppressive rather than simply discriminatory.
DEDICATION

Dedicated to Diana Carson and Jeanne and George Tiller
ACKNOWLEDGEMENTS

Writing in general feels like a very solitary task but it is impossible without the support of the people around you. Quite literally, I would not have been able to write this paper had it not been for the tireless support and assistance from Dr. Kenicia Wright and Dr. Anne Bubriski. Their criticisms and encouragements shaped this thesis and shaped me as a writer, and I am truly grateful to have had these women as my thesis chairs. I would also like to thank the professors from the Interdisciplinary Studies Honors track at Valencia College, who helped me get to the point where I felt confident enough to write a paper about race and gender oppression.

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INTRODUCTION

The Guttmacher Institute classifies both Alabama and Louisiana as hostile to abortion (State Abortion Policy Landscape 2019) because they limit abortion access for low-income women in a manner that also frequently discriminates against women of color. For example, in June 2019, a Jefferson County grand jury in Alabama indicted 28-year old Marshae Jones for the manslaughter of her unborn fetus (Brown 2019). While pregnant, Jones instigated an argument which led to the death of her fetus and supposedly justified the charge of manslaughter put against her (Brown 2019). A conviction could have subjected her to up to 20 years in prison (Simon & Scutty 2019). Luckily, an Alabama district attorney dismissed the charges (Brown 2019). In Louisiana a woman named Dominique was still $30 short for her abortion, despite using all her savings, picking up extra shifts at work, and getting financial assistance from her abortion clinic (Shah 2019). Because both Alabama and Louisiana are hostile to abortion, Marshae Jones’ and Dominique’s predicaments are, unfortunately, not surprising.

Louisiana and Alabama are not alone in their hostility toward abortion. Abortion is consistently a contentious issue in US political debates. In the first half of 2019, 19 states passed 58 abortion restrictions and 12 states passed an abortion ban, 5 of which banned abortion at 6 weeks gestational age (Nash, Mohammed, Capello, Naide, & Ansari-Thomas 2019). Many contextual factors likely contribute to these bans, however limits to abortion access are not new and have increased across states since the passage of the Hyde Amendment in 1976. Scholars note that reduced access to abortion disproportionately affects women of color and low-income women (see Gerber Fried 1998, Ross 1998, and Shaw 2016). Scholars often focus on the impact
of the Hyde Amendment on low-income women because it is one of the clearest examples of how reduced access to abortion has a disproportionate effect on a disadvantaged group. More recent work incorporates race, arguing that the cumulative effect of several decades of anti-abortion legislation disproportionately impacts women of color because of systemic issues of institutional racism that lead to poverty and poor sex education for minority women. However, important questions remain unexplored. For example, what are broader, negative consequences of reduced access to abortion on minority women? How are these consequences different for white women or women with higher incomes?

In this thesis, I use a reproductive justice framework to understand the effect of anti-abortion legislation on minority women. Within this framework, I employ several different theories that structure my research and conclusions including third-wave feminist and Marxist theories of oppression and privilege, Critical Race Theory, and Intersectionality. I examine the history of the anti-abortion movement and argue that it influences politics and political opinion such that subsequent anti-abortion legislation has racialized effects. I then argue that those effects constitute oppression and point to three specific sites of oppression to support that claim. Thus, this thesis argues that reduced access to abortion is a form of reproductive oppression affecting women of color and low-income women. This introduction briefly defines and discusses reproductive oppression and summarizes the following chapters’ main points.

In this thesis I argue that reduced abortion access is a form of reproductive oppression that disproportionately and negatively impacts women of color and low-income women. Reproductive oppression describes “‘the controlling and exploiting of women, girls, and individuals through our bodies, sexuality, labor, and reproduction (both biological and social) by families, communities, institutions and society’” (Manes 2017 para. 3) and is frequently
associated with larger systems of oppression such as slavery and population control (Soomer 2000, Mass 1977). I argue that reduced access to abortion is a form of social control that reduces women of color and low-income women’s reproductive autonomy and exploits their labor. Thus, I build on existing literature by arguing that reduced access to abortion constitutes reproductive oppression for minority women and low-income women.

Chapter Summary

In Chapter 1 I discuss the theoretical framework for this thesis. I argue that it is necessary to incorporate multiple frameworks given the multifaceted nature of reproductive oppression, therefore the first chapter centers on four different theories. First, I discuss feminist perspectives on oppression and privilege to help me examine intersecting dynamics of power. Second, I rely on Marxist feminism to motivate my argument that reduced access to abortion contributes to the exploitation of low-income women of color’s labor. Third, I incorporate Critical Race Theory in order to examine institutionalized racism, which is the systematic suppression and exploitation of people of color via institutions such as global capitalism, political structures, and mass media (Collins 2004). Finally, I discuss Intersectionality as an important way to understand the ways individuals comprised of multiple disadvantaged social identities face overlapping systems of social inequality.

I apply this theory to examine whether reduced access to abortion disproportionately affects women of color and low-income women in Chapter 2. I provide an overview of the anti-abortion movement and argue there is a connection between this movement and racist
movements in the US. I build on this by outlining several pieces of important anti-abortion legislation and present my argument that these examples of abortion-related legislation are most likely to impact minority women and low-income women. I support this argument by examining population demographics of abortion hostile states, demographic disparities in abortion rates, and observed impacts of reduced access to abortion. I conclude that anti-abortion laws negatively affect minority women and low-income women by drawing on Intersectionality and Critical Race Theory which focus on how power structures impact individuals (as opposed to other theories which blame individuals for their misfortunes).

Chapter 3 presents my argument that limits to abortion access constitute a form of oppression for women of color and low-income women. I include three major sites of study – political connection to broader forms of oppression, reduced reproductive autonomy, and economic exploitation – which I argue constitute reproductive oppression. First, scholars tie reproductive oppression to broader, historic systems of oppression such as slavery and colonization. I argue that the limited attention to women’s reproductive health – specifically, abortion access – is a shortcoming of the existing literature and therefore examine ways in which anti-abortion legislation and reduced access to abortion connect to current systems of broader oppression. Specifically, I focus on the War on Drugs and militaristic anti-immigration enforcement at the border between the US and Mexico because, I argue, these are two important sites of oppression that influence the political and social world we live in today. This allows me to examine my argument that reduced access to abortion and anti-abortion legislation are forms of reproductive oppression. I then examine the relationship between abortion access and the rates of sterilization and sterilization regret among women of color. Finally, I suggest that low-income women, who are disproportionately women of color, face a double bind (Frye 1983) when
deciding whether to get an abortion. They can either spend a lot of money for a procedure and risk missing a monthly payment or have the child and enter into a family welfare system that exploits their labor and restricts their chances for economic advancement.

Chapter 4 concludes this thesis by addressing an objection and discussing spaces for resistance to this system of reproductive oppression. Some point to Margaret Sanger and the historic connection between birth control and eugenics to argue that abortion is a form of racist population control carried out by white liberals (Ross 1998, and Dehlendorf, Harris & Weitz 2013). Those who adopt this view interpret restricting access to abortion as “freeing” for women of color. I disagree and argue that increasing access is not the same thing as coercion and population control. Women of color are, and have historically been, central actors in the fight for reproductive justice and abortion access, so I conclude my thesis by focusing on examples of how women at the margins are fighting to increase abortion access.

The negative impact of current abortion restrictions demands a closer examination of the origins of anti-abortion legislation and the potential effects of that legislation on women of color and low-income women. Therefore, I use a reproductive justice framework to examine the current and historical state of abortion access. I explore three major sites of study – historical and contemporary connections to broader systems of oppression, connections to sterilization abuse, and relationship with poverty – to understand the effect of reduced abortion access on minority women and low-income women, and conclude that reduced access to abortion is a form of reproductive oppression for women of color and low-income women. Despite the difficulties reduced access to abortion places in front of these women, they are not completely disempowered; indeed, they are uniquely placed to come up with creative solutions to the issues that they are confronted with to achieve reproductive justice.
CHAPTER 1

This thesis uses multiple theoretical frameworks to argue that lack of access to abortion is oppressive to low-income women and women of color by limiting their choices for birth control and reproductive autonomy, thereby encouraging sterilization and trapping them in poverty. Studying abortion access is one important avenue towards a broader examination of the oppression of low-income women and women of color. Reproductive oppression is historically tied to broader systems of oppression, and reduced access to abortion is a current expression of that pattern. Lack of access to abortion is oppressive to low-income women and minority women and these limitations affect them more harshly than higher-income women, particularly higher-income white women (Gerber Fried 2000, Shaw 2016). Reducing access to abortion forces low-income and minority women towards more extreme forms of birth control such as sterilization, contributes to these women being in poverty by trapping them in exploitative family welfare, and is a current manifestation of the long history of reproductive oppression.

It is necessary to present my theoretical motivation so that my argument about the complex ways this oppression disproportionately impacts low-income women and minority women, specifically, is clear. First, I employ third-wave feminist perspectives on oppression and its converse privilege in order to clarify the dynamics of power that have created the current system of reproductive oppression. Second, I discuss theories of economic oppression. Here, I employ feminist interpretations of Marxism to demonstrate how the reproductive oppression of women is connected to larger systems of economic inequality and the exploitation of the working class. Third, I discuss critical race theory to explain how systems of racism are institutionalized.
Finally, I conclude this chapter with a discussion of intersectionality, which explains how intersecting identities can confer oppressions and privileges.

I begin with a general theory of oppression. Radical and third wave feminist theories are useful here because they often center on examining multiple oppressions with a specific emphasis on gender and race. Marilyn Frye (1983) argues that oppression imposes barriers and forces that are systematically related and inhibit certain groups of people from moving freely in society. She stresses that it is important to look at these systems from a macroscopic level, comparing oppression to a birdcage; if one examines just one bar of the birdcage it seems obvious that the bird could just fly around the bar, but looking at the whole birdcage it becomes apparent that the bird is trapped by multiple barriers that are systematically linked (p. 4-5). This creates an experience of oppression that is characterized by the feeling of being in a double bind (p. 2). Bailey (1998) expands on this by arguing that for many women the bind is more than double due to their intersecting identities, and that “the strength of the bind depends upon which of these oppressive conditions are present in a person’s life, how many conditions are present, how long they are present, and whether the individual is privileged in ways that might weaken or mediate the binds” (p. 106).

I argue that lack of access to abortion is oppressive in this sense for low-income women and women of color – it places this group in a double (and often triple or more) bind wherein they have few options both for their reproductive health and for their economic wellbeing. For example, I argue that low-income women who are unable to obtain an abortion due to reduced access are funneled into family welfare where they are then frequently exploited and unable to advance economically. Additionally, reduced access to abortion for many women of color, combined with reduced access to other kinds of birth control, reduces their options for birth
control in a manner that forces them to choose between two “extremes” – potentially becoming pregnant, or entirely ridding themselves of their reproductive abilities. Because of this double-bind I argue that restricting access to abortion is a key aspect of the systematic oppression of minority women. Finally, I tentatively suggest that if lack of access to abortion is a key aspect of systematic oppression, perhaps gaining access to abortion could be the key to reducing the oppression of low-income women and women of color. In other words, gaining abortion access could unlock the birdcage that traps this group.

Oppression does not exist by itself, so I discuss it in terms that include its converse, privilege. Bailey (1998) describes privilege as “unearned advantages or assets conferred systematically” (p.110). The words “unearned” and “systematic” are important to stress here. Privilege is the result of structural and systematic advantages granted by society and can “exist” within characteristics such as the family one is born into, or being white, male, or upper-class (Matthews 2013). Society systematically rewards people that hold these identities by giving them advantages or removing barriers from their path (Bailey 1998). For example, it is possible for those who are not privileged to gain a college education, however it is much easier for someone who is privileged (perhaps through their financial stability or social connections) to go to college (Matthews 2013). Many note that these gains often occur with limited “hard” work on the part of the privileged individual as the advantages are woven into the systems that make up our society and confer systematically.

In addition, people are often oblivious to their own privilege. Peggy McIntosh (1988) describes it as an “invisible weightless knapsack of special provisions” and notes that she consistently forgot each of the ways she is privileged until she wrote them down (p. 87, 89). Another useful analogy that reveals the invisibleness of privilege is Jona Olsson’s comparison of
privilege to a user-friendly word processing program (Bailey 1998). Just as the word processor does most of the work of making the document look professional, making it easier for the user to succeed in presenting themselves and their work in a good light, so too does privilege make it easier for, say, white, upper-class men to succeed in life. Both are *created* to be difficult to see by others and by the person immediately affected.

Those who are privileged reinforce their privilege by creating categories of being that are less privileged. The idea that privilege is created is important to stress because it has greater connotations; privilege is created by society and with it comes the power to create other categories (Bailey 1998). For example, Bailey describes how white men in power introduced the distinction between white people and black people into 17th century America to define who had rights and benefits in society (1998 p.107). Today, political arguments over which bathroom transgender people should use or if they should be allowed to work in the military demonstrate how those who hold cisgender privilege are creating categories of people who are deemed unfit for the allocation of certain rights and benefits. I argue that reducing access to abortion for low-income women and women of color is a process implemented in the United States by primarily privileged groups, such as upper-class white Christian men and women, that helps maintain their own privilege through oppression, while systematically disadvantaging low-income women of color. These examples demonstrate the relationship between privilege and oppression; both involve unearned assets or barriers that are systematically related and imposed on certain categories of person, but one has the power to create and control those categories while the other must work inside the confines of the category created by the first.

I build on these third-wave feminist theories of oppression and privilege with other theories of oppression that specifically factor in economics and race. The above theories provide
necessary tools to discuss oppression in general, however they lack discussion on the specifics of oppression, namely, race and class oppression. First, I address class oppression through the lens of feminist, intersectional Marxism. Shahrzad and Carpenter (2019) argue that social relations such as race, gender, class, etc. are integral aspects to the rise and success of the capitalist mode of production (p. 278). In other words, the capitalist system exploits social identities and relations by creating meanings for those identities that benefit those in power (Shahrzad and Carpenter 2019). Nicole Rousseau (2009) concurs, specifically arguing that black women and their reproduction have historically been manipulated to fulfill the labor needs of the economy. In other words, black women’s labor and reproduction have been commodified depending on the shifting needs of the US economy ever since the time of slavery (Rousseau 2009).

These ideas are useful because they illuminate how control of women’s reproduction can confine women to lower socioeconomic statuses and thus act as an oppressive force. Many scholars agree that much, including economic stability, is at stake for women when deciding whether to get an abortion (Rhodes 2014). I concur, arguing that reducing access to abortion disproportionately affects low-income women and women of color and is oppressive to that group in part because the cost of such scarce abortion, or alternatively the cost of raising children within the US welfare system, make it incredibly difficult for these women to escape poverty. In this position they are exploited for their labor which often takes the form of low-paid reproductive labor such as cooking, cleaning, or child or elder care (Glenn 1990). In other words, privileged elites control the reproduction of low-income women of color such that they are trapped in poverty and are only able to trade their reproductive labor for survival.

I employ critical race theory (CRT) in this analysis to demonstrate the ways in which racism is rooted in historical contexts and institutions. This bolsters my argument that the
reproductive oppression of women of color is rooted in history and in today’s institutions such as state and federal governments, the courts, and the US system of capitalism. CRT originated in the works of black female abolitionists during the anti-slavery movement (Johnson 2015). These women influenced W.E.B. Du Bois who would later be credited as the father of CRT (Johnson 2015). Critical race theorists argue that racism is created by society, functions to allocate privilege and status to some of society, and is rooted in historical contexts (Delgado and Stefancic 2001). It serves as a critique of color-blindness and the neutrality of the law, by arguing that since racism comprises the foundation of American society, it is impossible for the law to be blind to race; the legal scholars and theories that created the laws were racist and so are the laws (Delgado and Stefancic 2001). In other words, according to CRT race and racism are integral parts of the way society was built and thus the way individuals interact with society at large. This is necessary in my discussion of abortion access because it prioritizes the role of race and racism in discussions of US history and US institutions. If one accepts the premise that racism is part of the fabric of the US it becomes clear that racism could influence how governments and the courts legislate abortion access, and how the reproductive rights of minority women can be manipulated to serve individuals with more power in society. CRT is central to the theory in this thesis however CRT only covers one social identity – race.

Intersectionality is critical to my argument as it explains how social identities interact to form overlapping forms of social inequality and privilege for individuals existing within multiple disadvantaged social identities such as low-income, minority women. Stemming in part from CRT and theories on privilege, feminists of color such as bell hooks, Kimberlé Williams Crenshaw, and Patricia Hill Collins apply intersectionality to explain how the experiences of black women are unique from white women, with whom these women share a gendered identity,
and black men, with whom these women share a racial identity. Put simply, intersectionality is the idea that individuals reside in multiple identities and that these identities interact in unique ways to create an experience of the world that is wholly distinctive to the individual (Crenshaw 1989). Three points highlight the importance of intersectionality to my theory: the specificity of oppression, the interaction between privilege and oppression, and marginality as strength.

First, intersectionality provides the foundation for my argument that oppression can disproportionately impact disadvantaged subgroups in society. Reducing access to abortion is a specific type of oppression that affects primarily women of color and low-income women - this oppresses these women while simultaneously contributing to the maintenance of privilege for other groups. Crenshaw (1989) explains that “the intersectional experience is greater than the sum of racism and sexism” (p.140). In other words, black women, for example, don’t experience simply both racism and sexism; they experience a type of racism that is specifically sexist, or conversely, a type of sexism that is specifically racist. This is applicable in my theory because I argue that lack of access to abortion is oppressive in multiple ways, some of which will affect all groups and some which will affect just a few groups depending on their identities and how they overlap. For example, low-income white women might experience the economic effects of oppression more acutely, while Native American women might experience the coercion to get sterilized due to lack of access to abortion and other birth control methods most prominently. Each group of women experiences oppression that is specific to the identities they reside in. In this way reducing access to abortion is a specific type of oppression that primarily affects a group of people who are at the intersection of multiple systems of oppression, while upholding privilege for others.
Second, intersectionality highlights the importance of social identities in shaping both oppression and privilege. I include this aspect of intersectionality to avoid the potential for ranking oppressions that could easily be interpreted from this thesis. I discuss the different ways reproductive oppression manifests for different groups of women however it is important to stress that one is not necessarily worse than another – all oppression is harmful. Collins (1993) argues that “there are few pure victims or oppressors…each one of us derives varying amounts of penalty and privilege from the multiple systems of oppression that frame our lives” (p.72). Individuals live in a complicated web of oppression, privilege, and power, so it is impossible to argue that one person is inherently more oppressed than another. Therefore, Collins argues we must reject additive analyses of oppression that rely on dichotomous thinking that ranks oppressions (1993 p.72-73). It is important to stress that many different groups reside within the broad “women of color” terminology and that each group has experienced the negative effects from lack of access to abortion differently because of the multiple identities they inhabit. One is not necessarily worse or better than another.

Finally, a critical component of intersectionality is putting forth “solutions” or ways of improving the inequality that disadvantaged groups face. This is crucial to my theory because it provides a potential solution to the systems of oppression I discuss in my thesis. May (2012) argues that intersectionality reconceptualizes marginality by focusing on the politics of location, placing marginalized groups as subjects with agency that have the potential to disrupt systems of domination via their place at the bottom of society (p. 81). Thus, women that I argue are oppressed by race, class, and institutional manipulation of their reproductive abilities have the potential to see the systems that oppress them clearly due to their place at the margins of society, allowing them to devise creative solutions and produce knowledge that helps them escape from
the systems that oppress them (hooks 1984, May 2012). In the conclusion to this thesis I offer
some potential solutions to the systems of oppression I describe – this discourse on marginality
and the production of knowledge will be particularly important in that discussion.

This thesis is theoretically grounded in intersectionality, critical race theory, and radical
and third-wave feminist theories of oppression and privilege. Each of these theories provides a
perspective that helps tease apart the many overlapping issues and identities that are important in
this discussion of abortion access. I argue that anti-abortion legislation and the subsequent lack
of access to abortion disproportionately affects women of color and low-income women, and that
this constitutes a form of reproductive oppression. Chapter 2 establishes the first aspect of this
thesis, arguing that anti-abortion legislation reduces access to abortion for minority women and
is influenced by an anti-abortion movement that has ties to racist movements and encourages
racialized fears. In other words, a racialized anti-abortion movement influences legislation that
has disproportionate effects on women of color and low-income women.

Chapter 3 builds on the theory presented in Chapter 2 by incorporating discussions of
oppression. First, I argue that reproductive oppression is consistently connected to larger systems
of oppression seen throughout history, and that reduced access to abortion is the current
manifestation of that recurring theme. This argument build’s on CRT’s position that racism is an
entrenched, historical fact of American society. Second, I argue that reduced access to abortion is
connected to an ongoing project of population control by encouraging minority women, who
have few other options for birth control, to sterilize themselves. Finally, I argue that the
increasing financial burden placed on women attempting to access abortion and the financial
burdens of childcare placed on women in the welfare system unable to access abortion,
effectively keep these women in perpetual poverty and lock them in a lower-class status. I draw
on the feminist approaches to Marxism discussed above to support this argument. Thus, each of the theories discussed in this chapter are integral to my theory of reproductive oppression through reduced access to abortion.
CHAPTER 2

Current abortion legislation is influenced by a history of conservative politics and anti-abortion activism. The moral panics and rise in conservative sexual politics that characterized the late 20th century influenced political attitudes and legislation in the US including most major federal decisions surrounding abortion (di Mauro & Joffe 2007). This led to a decline in abortion access and the current state of harsh restrictions surrounding abortion we see today. This chapter begins with a brief discussion of the anti-abortion movement to clarify the context of subsequent anti-abortion legislation. I argue that racism characterizes the anti-abortion movement, and thus influences much of the anti-abortion legislation in place today. I support this claim by examining major pieces of anti-abortion legislation and case law and highlight the disproportionate and negative effect on women of color and low-income women. In short, this chapter argues that reduced access to abortion disproportionately affects women of color and low-income women.

The Anti-Abortion Movement

Extreme individual level activism in the anti-abortion movement has historically had close ties with white supremacist groups like the KKK and neo-Nazis (Ross 1994). As Ross (1994) explains “[r]eligious zealotry, nostalgia for a more culturally ‘pure’ America, and a frightening rhetoric that encourages violence in the name of deeply held ideals fuels white supremacists and many anti-abortionists alike”. The sharing of ideals between the two movements extends to the sharing of individual members.
Relatedly, it is important to note that important leaders of anti-abortion organizations in the 1980s and 90s held close ties with white supremacist groups (Hughes 2006, Ross 1994). Two figures stand out as prominent connections between white supremacist groups and the anti-abortion movement: Randall Terry, leader of the influential anti-abortion activist group Operation Rescue, and John Burt, former regional director of pro-life group Rescue America. Burt was a former Klansman and, in a nod to practices originated by the Klan, Terry and other leaders of Operation Rescue would issue Wanted posters against doctors who performed abortions (Ross 1994). In other words, leaders of some of the most important anti-abortion movements in the late 20th century held close ties with and were influenced by the KKK.

At the institutional level, there is a history of politicians using anti-abortion rhetoric to support their broader agendas, for example, hiding the War on Drugs and supporting anti-immigration sentiment. For example, Ronald Reagan published a book entitled Abortion and the Conscience of the Nation in 1984 that linked the sanctity of the life of slaves with the sanctity of fetal life to gain support among anti-abortion activists (Hughes 2006 p.10). The book’s message caught on with anti-abortion organizations and comparisons were made between Reagan and Abraham Lincoln who were both, according to anti-abortion rhetoric, emancipators of oppressed peoples (Hughes 2006 p.10-11).

The rhetorical success of Reagan’s book in making him appear emancipatory hid his broader political agenda. Ironically, at the same time as Reagan was hailing the emancipation of slaves and being compared to Lincoln, he was increasing funding to federal law enforcement agencies’ antidrug departments in the first steps of his War on Drugs (Alexander 2012). This “war” would eventually lead to the mass incarceration of millions of black and Latino men and women and the creation of a racial underclass (Alexander 2012). Reagan was skilled at using
language that hid his true intentions; he was never openly racist and “[t]he absence of explicitly racist rhetoric afforded the racial nature of his coded appeals a certain plausible deniability” (Alexander 2012 p.48). Thus, appropriating abolitionist era rhetoric in his arguments against abortion made his anti-abortion message seem more appealing while simultaneously clouding the fact that overall his policies were explicitly racist in nature. In this way, the anti-abortion movement and its rhetoric is tied to a larger movement against people of color.

Anti-abortion activists have also tied their rhetoric to anti-immigration sentiment. Dubow (2011) notes that “[i]n November 2006, the Missouri House of Representatives issued a report concluding that abortion was a factor in the rise of illegal immigration because it created a shortage of American-born workers” (p.156). Others have drawn on post-9/11 fears to argue that since “Muslim countries” don’t allow abortion they have higher birthrates than “Aryan” countries that do allow abortion, and are immigrating to the latter so that eventually they will overtake white people as the majority population (Dubow 2011 p.156). These explicitly racist arguments against abortion for white women prey on the fears of some Americans regarding their job security and the potential threat of terrorism. When encouraged in this way, these fears often lead to anti-Latino and Islamophobic sentiments. This is critical to my argument because it suggests that politicians use anti-abortion legislation and rhetoric as tools to accomplish racialized political agendas.

These racialized political arguments draw on the fear that the white race will go extinct, the assumption that abortion is the reason for lower birthrates among white women, and the assumption that banning abortion will automatically lead to higher birthrates among white women, despite evidence to the contrary for all of these fears. In doing so, these political arguments against abortion place the supposed problem in the reproductive systems of women of
color and the supposed solution in the reproductive systems of white women. I continue by arguing that this rhetoric and accompanying negative public opinion towards women of color has led to legislation that reduces access to abortion with an underlying aim of making upper- and middle-class white women reproduce more. To deal with the anticipated increase in babies of color that would accompany this, I argue that anti-abortion legislation works in tandem with other policies that encourage women of color to seek other forms of birth control such as sterilization, and policies that trap low-income mothers of color in poverty to exploit their labor.

Legislation

The United States government and various state governments have been relatively hostile towards abortion in the 46 years since Roe v. Wade. I start with an explanation of the precedent Roe v. Wade (1973) (Roe) establishes. Roe challenged the Texas criminal abortion law that outlawed all abortions except to save the life of the mother. The State made two major arguments against abortion, however only one argument is important enough to mention here, namely, the State’s argument that it had an interest in protecting pre-natal life (Roe v. Wade p. 150). The Court agreed with the State, however they noted that many of the state laws criminalizing abortion protected the life of the mother rather than the unborn fetus and were therefore not applicable under that reason for abortion restriction (p. 151). Additionally, they qualified that this interest only becomes “compelling” after the first trimester (p. 163). This State interest in pre-natal life would be a key aspect in subsequent Court decisions that would eventually erode abortion access.
The Court ruled in favor of Roe, citing the right to privacy\(^1\) despite this initial prioritization of state’s rights (p. 125). Significantly, the Court ruled that regulation of abortion in the first trimester was illegal, but that the state could regulate abortion in the second trimester for the purpose of maternal health, and that states could ban abortion after viability if they chose to do so (p. 163). Importantly, restrictions to abortion access would have to pass the “strict scrutiny” test before legalization (p. 170). Subsequent court decisions weakened Roe, however the basic right to privacy still applies to abortion.

The Hyde Amendment is the first major piece of legislation to reduce access to abortion after Roe. Initially passed in 1976, it removes federal funding for abortions under Medicaid except in cases where the life of the mother is endangered, or in cases of rape or incest (Engstrom 2016 p. 452). Ensuing renewals extended the amendment to cover federal funds directed towards Native Americans, federal employees, people with disabilities, veterans, prison inmates, children funded under the Children’s Health Insurance Program, and insurance plans that are federally subsidized under the Affordable Care Act (Adashi and Occhiogrosso 2017 p. 1523). In other words, it essentially eliminates all federal funding for abortions. To put this in perspective, should the Hyde Amendment be repealed more than 14.5 million women of reproductive age would be eligible for federal assistance for their abortion procedures (Salganicoff, Sobel & Ramaswamy 2019).

This reduction disproportionately limits abortions for Native American women by defunding abortions provided through The Indian Health Service (IHS). The IHS is a federally funded program that provides healthcare to Native Americans living on reservations (Lawrence

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\(^1\) While there is no explicit right to privacy written into the Constitution it is generally interpreted from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments.
2000) and is the primary provider of reproductive health care for many Native American women (Arnold 2014). The IHS currently serves roughly a third of the Native American/Alaska Native population (Donovan 2017). Medicaid insures many Native American women who are not insured by the IHS because of high rates of poverty among Indigenous populations, thus restricting abortion access for many Native women not living on reservations (Donovan 2017). Additionally, IHS facilities are often the only easily accessible local healthcare provider for many Native Americans meaning that even if an Indigenous woman is not federally insured, she may not have access to a non-federally funded healthcare provider, and thus has limited access to abortion services (Donovan 2017).

Since Native American women face a disproportionately high risk of sexual assault and teen pregnancy, they have a higher demand for abortion (Arnold 2014 p. 1892). Indigenous women are 2.2 times more likely than white women to have experienced forced penetration (Rosay 2010) and Native American teens have the third highest teen pregnancy rate behind black and Latina teens (Wiltz 2015). Despite this higher demand, the IHS performed only 25 abortions from 1981-2001 and many IHS facilities lack basic abortion services such as Mifeprex² (Arnold 2014 p. 1892). Although the Hyde Amendment allows federal funding for abortion in cases of rape, the extremely low number of IHS abortions performed suggests that the IHS is potentially unable to comply with this stipulation. In other words, Native American/Alaska Native women frequently lack insurance coverage for and easy physical access to abortion services. This suggests that the Hyde Amendment’s restrictions on federal funding for abortions provided through the IHS results in reduced access to abortion services for Native American women.

² Mifeprex (mifepristone) is a pill that blocks the hormone progesterone that is needed to continue pregnancy and, when taken with another pill (misoprostol), aborts an early pregnancy (USFDA 2019).
The Hyde Amendment also directly affects low-income women by denying abortion funding for people insured through Medicaid. A first trimester abortion can cost an average of $470 while a second trimester abortion can cost an average of $1,500, depending on the type of abortion and the abortion provider (Engstrom 2016). Thirty-four states and the District of Columbia currently comply with the Hyde Amendment’s specifications, restricting funding for abortion through Medicaid except in cases of rape or incest, or life endangerment (Salganicoff et al 2019). South Dakota restricts access further by only paying for abortions in cases of life endangerment (Salganicoff et al 2019). The Guttmacher Institute considers most of these states hostile to abortion (State Abortion Policy Landscape 2019). According to the US Department of Labor the average minimum wage is roughly $8.93 per hour, or about $1,547 per month. Therefore, a second trimester abortion for a single income family living on the average minimum wage may cost a few dollars less than a month’s wages. The impact of this expense is clearly visible in one study which reported that many women needed to divert money from living expenses such as rent (14%), food (16%), or bills (30%) to pay for their abortions (Boonstra 2013 p. 6). Coupling this with the fact that low-income women have higher rates of unintended pregnancy than upper- and middle-class women (Engstrom 2016 p. 455) provides the foundation for my argument that the Hyde Amendment disproportionately and negatively impacts low-income women.

*Planned Parenthood v. Casey (Casey)* is another major step towards erosion of abortion access. In the 1992 decision the Supreme Court upheld the right to abortion granted in *Roe* while simultaneously undermining some of the most important aspects of that case. First, it removed the “strict scrutiny” standard that had previously applied to laws meant to restrict abortion access and replaced it with an “undue burden” standard (*Planned Parenthood v. Casey* p. 837). *Casey*
defined a law as unduly burdensome if “its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability” (p. 837). This contrasts with the “strict scrutiny” standard which only allows a potentially restrictive law to pass if the law furthers a “compelling government interest” (LII 2019) and means that the burden of proof shifts from the government to the citizen. This also means that the bar was lowered for restrictive legislation, allowing states to pass more restrictive legislation (discussed below).

Second, the Court rejected the trimester framework established in *Roe*, arguing instead that the state has an interest in potential life throughout pregnancy (*Planned Parenthood v. Casey* p. 837). This differs radically from *Roe*’s stipulation that the first trimester be free from restrictions.

Finally, the *Casey* decision abandoned the principle of government neutrality regarding abortion. This allows states to incentivize childbirth over abortion on the grounds that it does not technically restrict a woman’s access to abortion (Benshoof 1993b p. 2253). However, Benshoof (1993a) argues that this stipulation effectively allows states to discourage women from choosing abortion (p.163).

Together, these stipulations made it much easier for states to pass legislation that reduced access to abortion. For example, when a court is analyzing a potentially restrictive law it often looks at the law in isolation. The problem with this is that while a law may not be unduly burdensome by itself, it may be extremely burdensome in combination with the various other state laws it interacts with (Young 2014). Additionally, a law may not restrict access to abortion for a pregnant woman at its face, but it could regulate abortion clinics so much so as to effectively remove any easy options for abortion for women (Young 2014). This loophole has led to a slew of state laws restricting abortion access called “Targeted Regulation of Abortion Providers” or “TRAP” laws (Young 2014).
TRAP laws work to close abortion clinics by placing extraneous and unnecessary requirements on abortion providers. These requirements include mandating that clinics meet personnel and facility guidelines usually reserved for ambulatory surgical centers, forcing abortion providers to have admitting privileges in a nearby hospital, and demanding abortion facilities to have transfer agreements with a nearby hospital (Austin & Harper 2019). All of these have been shown to be unnecessary – abortion is an extremely safe procedure and does not require surgery standard facilities or personnel (Austin & Harper 2019). This suggests that the real purpose of these requirements is reducing abortion access.

Indeed, legislatures write the laws under the guise of protecting maternal health but often explicitly intend to reduce abortion access (Greasley 2017). For example, one Texas bill (HB2) intended to impose admitting privileges and surgical center requirements on Texas abortion clinics, supposedly to protect women’s health (Whole Woman’s Health v. Hellerstedt p. 1). After the Texas Senate passed HB2, the Republican Lieutenant Governor “tweeted a photo of a map that showed all of the abortion clinics that would close as a result of the bill, accompanied by the caption: ‘We fought to pass [HB2] thru the Senate last night, & this is why!’” (Greasley 2017 p. 327). This suggests that HB2’s real goal was closing abortion clinics, not protecting women’s health. Fortunately, the Supreme Court struck down HB2 as unconstitutional under Casey in Whole Woman’s Health v Hellerstedt. Pro-choice activists generally viewed the decision as a success because the Court took a broader, more holistic approach to examining the effect of the law, rather than simply examining the individual effect it would have (Greasley 2017). However, some argue that the decision acts to further perpetuate the idea validated in Casey that abortion is dangerous to women’s physical and mental health (Goodwin 2017, Greasley 2017). The Whole
Woman’s Health decision kept with Casey’s stipulations for finding undue burden (Greasley 2017) and rooted the flawed undue burden framework deeper into precedent (Goodwin 2017).

Indeed, the broader effect of Whole Woman’s Health is still uncertain. As of mid-2017, 25 states have enacted TRAP laws while 21 states have enacted and enforced those laws (Austin and Harper 2019). In June 2019 CNN reported that six states – Kentucky, Mississippi, Missouri, North Dakota, South Dakota, and West Virginia – have only one abortion clinic (Yan 2019). And the ACLU notes that “judges on lower courts who disagree with Roe v. Wade, are already starting to ignore the Whole Woman’s Health ruling” (Arons n.d.). Thus, there are still a multitude of legislative barriers to abortion access despite the Whole Woman’s Health ruling.

Effect of Legislation

Most US states are hostile to abortion. The Guttmacher Institute classifies a state as hostile based on six limitations on abortion including an abortion ban that violates constitutional protections, restriction of Medicaid coverage, and any unnecessary abortion clinic requirements (State Abortion Policy Landscape 2019). Twenty-nine states meet the Guttmacher Institute’s definition of hostile. This means that 58% of women of reproductive age live in states that are

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3 Each limitation garners a score of -1. There are also six protective policies that hold a score of 1. A state’s score is found by adding or subtracting depending on how many hostile or protective policies a state has. Thus, a state must have at least a score of -2 to be defined as hostile to abortion (State Abortion Policy Landscape 2019).
hostile towards abortion and therefore have limited access to abortion (State Abortion Policy Landscape 2019).

There are several reasons I expect hostile abortion policies to have a greater effect on women of color and low-income women. First, anti-abortion policies have a greater effect on women of color simply because the states where they are active house more women of color, particularly black and Indigenous women. Abortion hostile states hold 52% of the women of color\(^5\) in the US (US Census Bureau 2017). Specifically, 61% of Native American women and 69% of black women live in abortion hostile states, however 53% of Hispanic/Latina women and 69% of Asian American/Pacific Islander women live in states that are protective of abortion (US Census Bureau 2017). This suggests that black women and Native American women feel the effects of anti-abortion legislation more harshly simply because of where most of them live\(^6\). Thus, the demographics of abortion hostile states, which provide a partial picture of who is affected by anti-abortion legislation, suggest that black and Native American women potentially feel the effects of that legislation more than other groups because of their location in the US.

Second, women of color and low-income women have higher rates of abortion than do white women and higher income women. In 2008, white women had a rate of 12 abortions per 1000 reproductive age women, Hispanic women had a rate of 29 per 1000, and black women had a rate of 40 per 1000 (Dehlendorf et al 2013). Native American women get abortions at twice the rate of white women (Urban Indian Health Institute 2010). Women with incomes less than 100%

\(^5\) Women of color being defined here as women who identify on the Census as African American, American Indian/Alaska Native, Asian/Pacific Islander, Hispanic/Latina, or two or more races.

\(^6\) This is not to say that Hispanic/Latina and Asian American/Pacific Islander women are not disproportionately affected by anti-abortion legislation. State demographics are just one measure of who is affected by legislation, and other ways will be discussed below. However, the fact that most black and Native American women live in abortion hostile states is significant and therefore worth mentioning.
of the federal poverty level (FPL) have an abortion rate of 52 per 1000, compared with 9 per 1000 among women with incomes greater than 200% of the FPL (Dehlendorf et al. 2013 p. 1772). In general, Asian women (11 per 1000) have lower rates of abortion than white women, however Indian (26.5 per 1000) and Japanese (14.7 per 1000) women experience higher rates of abortion (Population Association 2016). In other words, women of color and low-income women in general have a greater demand for abortion than white women and higher-income women. I argue, therefore, that restricting access to abortion has a greater impact on minority women because they are the primary users of abortion services.

Finally, limited access to abortion disproportionately affects low-income women because they have fewer financial resources to pay for the procedure. Numerous studies show that the cost of getting an abortion is a major hurdle for many women. For example, Margo et al. (2016) found that many women frequently cited paying for their abortions as a major challenge because insurance did not cover any of the procedures. Many of the women resorted to borrowing funds from family and friends and utilized clinic discounts whenever possible (Margo et al. 2016 p. 205). Quantitative data concurs, finding that a majority of participants not using health insurance to pay for their abortions found it somewhat or very difficult to pay for their procedures, which ranged in price from $485-$3,500 (Jones, Upadhyay & Weitz 2013 p. 175).

Anti-abortion measures also affect women of color more harshly. For example, the participants in Jones et al’s (2013) study were mostly women of color, with 73% of the study participants identifying as black, Hispanic, or “other” (p. 176). Additionally, women who are seeking abortion but are nearing or past the gestational age limits for abortion in their state are more likely to be multiracial or some race other than white (Upadhyay, Weitz, Jones, Barar, & Foster 2014 p. 1689). This was generally due to broader systemic issues associated with
institutional racism such as poor sex education and ineffective governmental support systems for childcare (Upadhyay et al 2014 p. 1689). Altogether, this evidence indicates that legislation that restricts access to abortion disproportionately affects women of color and low-income women.

This chapter argues that anti-abortion legislation disproportionately effects women of color and low-income women. An examination of major anti-abortion court decisions and federal regulations reveals that reduced access to abortion disproportionately effects women of color and low-income women. I contextualize this phenomenon within the anti-abortion movement, arguing that this movement is both influential in US politics and connected to racist movements and political ideologies. Chapter 3 expands on this discussion and argues that such a disproportionate effect on women of color and low-income women functions as reproductive oppression.
CHAPTER 3

In this chapter I make three major claims. First, anti-abortion legislation is connected to larger systems of oppression such as the war on drugs and militaristic immigration enforcement. Systems of reproductive oppression have historically been tied to broader systems of oppression. *Reproductive oppression* describes the idea that anyone, but specifically women and girls, are oppressed when their bodies, sexuality, labor, and reproduction are controlled, exploited, or suppressed for others’ gain (Manes 2017). For example, the common practice of raping women enslaved on Southern plantations and then selling the resultant child into slavery was reproductively oppressive because, among other reasons, it violated the enslaved woman’s autonomy and used her reproductive capacities for the plantation owner’s gain (Ross 1998). Thus, the connection between anti-abortion legislation and broader systems of oppression suggest that anti-abortion legislation is oppressive. Second, I argue that reduced access to abortion, in combination with reduced access to other forms of birth control, contributes to higher rates of sterilization and sterilization regret in minority groups. Finally, I argue that pro-life states encourage childbirth for welfare recipients thus funneling them into a family welfare program that is exploitative and oppressive. These three claims support my broader argument, suggesting that the disproportionate effect reduced access to abortion has on low-income women and women of color is a form of reproductive oppression.
Historical Context

Reproductive oppression has historically been connected to broader systems of oppression such as colonization and slavery. For example, European colonizers manipulated and suppressed the reproduction and cultural reproductive systems of Native American women as part of their larger project of settler colonialism (Smith 2005). Prior to colonization, Native American women were considered autonomous persons, held positions of power and esteem, and were often leaders in matriarchal societies (Ralstin-Lewis 2005). Christian colonization disrupted much of the gender equality in Native communities by introducing patriarchy and attempting to force Native family structures to conform to Western structures that emphasized male-domination (Ralstin-Lewis 2005). As the project of settling the American West became an important political goal in the nineteenth century, reproduction among white settlers was encouraged, while Indigenous reproduction was actively discouraged (Jacobs 2017). For example, the 1850 Oregon Donation Land Act allowed white married couples to claim twice as much land as a single white male settler, thus encouraging marriage and inevitably reproduction among white settlers. Conversely, the 1887 Dawes Act severely decreased the amount of land available to Native peoples. This, combined with unreliable government support for Native Americans on reservations, led to rampant malnutrition and disease leading to a steep decline in the Indigenous population (Jacobs 2017). The manipulation of Indigenous reproductive systems served a larger purpose – by controlling and manipulating Native bodies and gender constructions European settler colonizers were able to justify and achieve colonial domination of the Americas (Cremer 2008).
Institutionalized slavery in America was also characterized by rampant reproductive oppression. The American slave trade stripped African mothers of their role as mother, destroyed African family structures, and reduced African women to laborers and reproductive machines. In many places in Africa, mothers were important members of their communities, transmitting knowledge, culture, and values to their children (Bush 2010 p. 69). The slave trade reduced and commodified this role. For example, African mothers were usually stripped of their important religious belongings before being transported across the ocean and were therefore unable to perform many of the rituals associated with childbirth (Bush 2010 p. 79). Thus, the slave trade reduced African women’s abilities to fully connect with the role of mother by alienating them from their communities and limiting their ability to participate in their traditions of motherhood.

Slave traders were simultaneously commodifying the reproductive capacities of African women. Women often comprised a majority of the slave population due to their ability to bear children (Soomer 2000). They were dehumanized as breeders and whores to justify the rampant practice of rape, and the children of those unions were frequently sold into slavery (Soomer 2000). Enslaved women would sometimes abort their offspring in a simultaneous act of mercy for their unborn child and rebellion against their designated role as breeder (Schiebinger 2005 p. 318). Thus, plantation owners sought to restrict enslaved women’s knowledge about birth control and abortion in order to avoid this rebellion and maximize their profits (Ross 1998). These are just a few examples of the ways in which enslaved women’s reproductive capacities were manipulated and commodified for other’s gain, but they demonstrate the important role of reproductive oppression in the broader system of slavery.

These historical connections between reproductive oppression and more general oppression unveil a pattern on which my argument centers: systems of domination manipulate
women’s reproduction to maintain control over the dominated peoples at large. The following two examples of anti-abortion legislation connected to current examples of oppression suggest that modern forms of domination are using reduced access to abortion to maintain control. I argue that this suggests that reduced access to abortion is a form of reproductive oppression because it aligns with the historical pattern identified above.

First, some scholars link the war on drugs with the anti-abortion movement and anti-abortion legislation. At a superficial level, there are many similarities between the anti-abortion movement and the War on Drugs. For example, Ferraiolo (2014) argues that marijuana usage and abortion are both “morality policy” issues used to garner support for one political party or alternatively to malign the other political party. Paltrow (2001) finds eight distinctive similarities between the War on Drugs and what she calls the “war on abortion”: control and punishment justified by illegality, restrictions on speech, limited access, the language of “epidemics”, lack of education surrounding both sex and drugs, choice rhetoric, child protection as justification for illegality, and disproportionate harm for African American women (Paltrow 2001). These similarities indicate a broader political agenda that acts to reduce civil liberties and social mobility for women and people of color. They also suggest that the anti-abortion movement may overlap with the War on Drugs.

Beyond these similarities however, the political agendas of both movements actively reinforce one another. For example, the anti-abortion argument in support of giving fetuses rights actively supported, and was supported by, efforts to imprison black women. Dubow (2011) describes how the “crack baby epidemic” in the late 1980s and early 1990s helped to support the anti-abortion argument for fetal rights while simultaneously supporting racist stereotypes about black mothers as drug addicts lacking maternal instincts (p.141-142). In other words, the rhetoric
that pregnant black women were dosing their unborn children with cocaine symbolically supported both the anti-abortion movement’s push to define viable fetuses as humans with rights, and the War on Drugs’ argument that black women were all drug addicts without maternal instincts. However, the interaction between the two movements was more than just symbolic and extended to physically imprisoning mothers who used crack cocaine during their pregnancy (Dubow 2011). For example, many South Carolina hospitals would test babies and pregnant women for cocaine when they entered the hospital and report any positive findings to law enforcement (Dubow 2011 p. 145-146). The charges varied depending on the specific circumstances from drug possession, delivering drugs to a minor, child neglect, and, in an extreme case, homicide, but often ended in incarceration for the mother, who was usually black (Dubow 2011 p. 145, 151). This is despite evidence that suggests that cocaine has few adverse health effects on children exposed in the womb via their mother, especially when compared to the effects of substances that are used far more commonly such as tobacco and alcohol (Chavkin 2001). While many of the cases prosecuting these women have fortunately been overturned in higher courts, South Carolina still defines a viable fetus as a person and has recently introduced a bill to ban abortion when a fetal heartbeat is detected (SC Fetal Heartbeat Protection from Abortion Act 2019). Thus, the anti-abortion movement contributed to the oppression of women of color within the War on Drugs.

Finally, reduced access to abortion has recently been used to police immigrant women and Latinas who live near the US border with Mexico. Gomez (2015) describes how reduced access to abortion in Texas makes immigrant and US born Latina women in the Rio Grande Valley at risk of being detained and potentially deported as illegal immigrants. The Rio Grande Valley is home to numerous checkpoints along major highways that work to find potentially
illegal immigrants (Gomez 2015 p. 94). The Valley has extremely limited access to abortion – it has been classified as a “medically underserved area” and is lacking in options for primary healthcare (Gomez 2015 p. 98). Thus, Latina immigrant women must either travel to the nearest US abortion clinic on highways riddled with immigration enforcement checkpoints, or risk going to Mexico for their abortion and being denied access back into the US (Gomez 2015). This restricts their physical movement, literally confining them to a small area of Texas that is lacking in necessary healthcare services. More recently, The Washington Post reported in June 2019 that the Trump administration had instituted a ban on abortion for minors detained in immigration custody. Fortunately, an injunction on the policy has allowed all women affected to proceed with their abortions, but the effort highlights the continuing struggle that pregnant immigrant women must face (Marimow 2019).

These examples of the connection between the anti-abortion movement, anti-abortion legislation, and larger systems of racial oppression suggest that current systems of domination are using reduced access to abortion as a method of control. Historically, scholars classify manipulation of women’s reproduction within larger systems of oppression such as colonization and slavery as reproductive oppression. Thus, I suggest that reduced access to abortion functions as a form of reproductive oppression because of its connection with larger systems of oppression such as the war on drugs and anti-immigration policy enforcement.
Minority communities have historically experienced sterilization abuse. While blatant sterilization abuse is uncommon today, I argue that reduced access to abortion and other forms of birth control contribute to higher rates of sterilization and sterilization regret in minority communities. This would qualify reduced access to abortion and birth control as a form of subtle coercion (Clarke 1994, discussed below) which I argue is oppressive because it restricts women’s ability to make autonomous decisions regarding reproduction.

Eugenic sterilization programs in the mid-20th century led to thousands of sterilizations of Black and Native American women, and Latinas, and that trend has continued through to today. Estimates indicate that up to 70,000 Native American women (out of 100,000-150,000 women of childbearing age) underwent coerced sterilization from the early to mid-1960s to 1976 (Ralstin-Lewis 2005 p. 71-72). Puerto Rico’s aggressive population control policies resulted in the sterilization of roughly one third of women of child-bearing age by 1965 (Mass 1977). Social Darwinism and eugenics politics heavily influenced these high rates of coerced sterilization among women of color (Mass 1977, Ralstin-Lewis 2005, Shreffler, McQuillan, Greil & Johnson 2015). This historical trend has had impacts on current sterilization trends.

Today, women are less likely to experience coercion when getting sterilized, but women of color and low-income women still have the highest rates of sterilization and importantly sterilization regret (Shreffler et al 2015). Black and Native American women are more likely to have undergone sterilization than non-Hispanic white women (Volscho 2010). This remains true for black women even when controlling for partner vasectomy status (Borrero et al 2009). Shreffler et al (2015) found that Hispanic women were less likely to undergo surgical
sterilization when controlling for socioeconomic status (p. 14). However, they, along with Native American women, were more likely to see their sterilization as preventing them from having desired children (Shreffler et al 2015 p. 15). Shreffler et al (2015) found that black women were not likely to regret their procedure, however Eeckhaut et al (2018) found that black women were likely to regret their sterilization. Asian women were not more likely than white women to have undergone sterilization (Shreffler et al 2015 p. 14). Ultimately, this suggests that the historically high rates of sterilization for black, Hispanic, and Native American women has continued to today, and that many women eventually regret their procedure.

Women of color’s higher rates of sterilization can be partly explained by reduced access to impermanent birth control methods, such as abortion. This functions through a process which Clarke (1994) calls ‘subtle coercion’, defined in relation to sterilization as “situations in which a woman or man legally consents to sterilization, but the social conditions in which they do so are abusive – the conditions of their lives constrain their capacity to exercise genuine reproductive choice and autonomy” (p. 341, emphasis in original). For example, Gurr (2011) argues that the high rates of sterilization on Native American reservations can be traced back to limited birth control options, including abortion. Birth control pills are dispensed to Native American women living on reservations only once a month, frequently from IHS facilities that are difficult to reach, access to emergency contraception is patchy, and abortion access is limited due to the Hyde Amendment (Gurr 2011 p. 72-80). Conversely, less effective birth control options such as condoms, and long-term birth control options such as Depo-Provera, Norplant, and sterilization are more easily available and more widely promoted (Gurr 2011 p. 74-77).

Reduced access to impermanent birth control and abortion is also common among other racial minorities. Despite an overall increase in the number of young women using sexual and
reproductive health (SRH) services, black and Hispanic women are still less likely to effectively use contraception (Murray Horwitz et al 2018). However, they are just as likely as white women to use long-acting reversible contraceptives (LARC) and condoms, in similar fashion to the Native American women discussed above (Murray Horwitz et al 2018). These low rates of contraception use, combined with women of color’s higher rates of sterilization, suggest that social conditions wherein birth control and abortion are difficult to access contribute to increased usage of permanent birth control methods.

This becomes problematic when women begin to regret their sterilizations. As discussed above, women of color are more likely to regret their sterilizations and see them as preventing them from having desired children (Eekhaut et al 2018, Shreffler et al 2015). Additionally, there has been a 41% increase in sterilization regret, from 18% in 1995 to 25% in 2006-2010 (Eekhaut et al 2018). This suggests that had these women had better access to impermanent birth control options, such as abortion, prior to sterilization they might have been able to delay or avoid the procedure which they now regret. Women who have more options for birth control have more nuanced control over their reproductive capacities and are therefore not as easily subject to subtle coercion. More options for birth control, such as abortion, could prevent women from getting sterilizations which they later regret. Since women of color have higher rates of sterilization regret and have less access to abortion (due to reasons discussed throughout this thesis such as restrictive federal funding and limited physical access), I suggest that reduced access to abortion is oppressive to these women – it limits their reproductive options, subtly coerces them into getting sterilized, and prevents them from having children that they want.
Poverty

Poverty is feminized and racialized (Elmelech & Lu 2004) and while the reasons for this are nuanced and historically situated, I posit that reduced access to abortion is one factor that supports the feminization of poverty. The feminization of poverty thesis argues that women and their children are disproportionately represented in the population of individuals in poverty (Elmelech & Lu 2004). In the 1980s, scholars revised the feminization of poverty thesis to more accurately reflect the racialized nature of the problem, renaming it the racial feminization of poverty (Elmelech & Lu 2004). The issue continues today – women were 38% more likely than men to live in poverty in 2016 (Patrick 2017). However, women of color and women with disabilities are more likely than white women to be in poverty: in 2016, 9.7% of white, non-Hispanic women were in poverty while 10.7%, 18.7%, 21.4%, and 22.8% of Asian, Latinx, black, and Native American women were in poverty, respectively (Patrick 2017). Thirty-one percent of women with disabilities were in poverty in 2016 (Patrick 2017). This trend persists despite “comparable human capital and positive work ethic attributes and characteristics” at least among black women (Ezeala-Harrison 2010 p. 149), but potentially among other groups of women as well. This suggests that high rates of poverty are unrelated to labor market reasons and have more to do with institutional sources of inequality (Ezeala-Harrison 2010). I argue that reduced access to abortion is one of those institutional sources.

Abortion is expensive, especially for women in poverty who are disproportionately women of color. As discussed in previous sections, women frequently cite cost as one of the most difficult aspects of obtaining an abortion (Margo et al 2016). A single mother working for
minimum wage could potentially have to spend a month’s wages or divert money from rent, food, or bills to pay for her abortion (Boonstra 2013). While clinics frequently offer financial support to women, they often have limited resources and thus cannot completely remove the financial burden of abortion. The high cost of abortion places women in poverty in a double-bind situation where they are forced to choose between an expensive abortion that could potentially remove their access to food, basic utilities such as water, or housing, or have children and qualify for family welfare, usually Temporary Assistance for Needy Families, that is oppressive and exploitative.

Temporary Assistance for Needy Families (TANF) provides time-limited financial assistance to low-income families and is the primary financial welfare system covering women in poverty with children. TANF proclaims that it works “to prevent and reduce the incidence of out-of-wedlock marriages” and encourage two-parent homes (HHS.gov 2012), suggesting that it is hostile towards single mothers. A work first ideology characterizes TANF, and penalties, financial sanctions, and restrictive eligibility enforce this ideology (Bowie and Dopwell 2013 p. 178). TANF also enforces a five-year lifetime maximum limit for financial assistance, with several states stiffening limits to four, three, or two-year maximums (Bowie and Dopwell 2013 p. 178). It is within this context that low-income women and especially low-income women of color face a multitude of barriers to upward mobility.

Welfare, especially welfare in pro-life states, is oppressive because it encourages mothers of color into low-wage reproductive labor that has few prospects for advancement, effectively trapping minority mothers in poverty. Glenn (1992) and Duffy (2007) argue that reproductive labor, defined as work that is needed to sustain everyday life such as cooking, cleaning, and kin care, has historically been divided along gender and racial lines. Women of color have a history
of being confined to the service sector, first in the homes of wealthy whites, and now in institutional settings in the public sphere (Duffy 2007). The changing needs of the capitalist market motivated this change, demonstrating how capitalist forces have varying effects depending on a woman’s intersecting identities (Glenn 1992).

Many states have historically used welfare as a tool to maintain this systemic confinement of women of color to the service sector (Boling 2015). Current examples suggest that this historic trend has continued to today. Bowie and Dopwell (2013) argue that TANF overlooks and disregards the various metastressors women in poverty, specifically women of color in poverty, face. The harsh time limits, penalties, and emphasis on a work first ideology compound the already intense life stressors – such as physical/mental health issues, housing issues, and interpersonal violence – many of these women face, making it even more difficult for them to rise out of poverty (Bowie and Dopwell 2013). This is evidenced by the data that shows that TANF recipients disproportionately work in low-wage, unstable, and temporary jobs, and recidivism is worse for black welfare leavers than for whites (Banerjee and Ridzi 2008). Women of color are compelled to comply with TANF guidelines by the harsh penalties and find themselves in low-wage jobs that don’t cover basic financial needs and have little or no options for advancement (Banerjee and Ridzi 2008). As one woman put it, “It’s creating a workforce of slave laborers” (qtd. in Banerjee and Ridzi 2008 p. 106).

This process involves “encouraging” women in poverty to avoid abortion. Hussey (2010, 2011) found that welfare recipients were less likely to utilize abortion services in pro-life states. This was evident independently from other factors which might influence the abortion decision, such as women’s sensitivity to the cost of abortion (Hussey 2011). This suggests that pro-life state legislators promote childbirth and discourage abortion indirectly via non-abortion related
state programs such as welfare. Women with children are then eligible for TANF, since TANF is in general only available for parents. Thus, pro-life states that encourage women of color in poverty to have children are effectively funneling these women into jobs with no upward mobility through participation in TANF. I argue that this is exploitative and oppressive because it uses minority women for their labor while keeping them trapped in poverty with few routes to upward mobility.

This chapter expands the current discussion surrounding abortion access by arguing that reduced access to abortion is oppressive rather than simply coincidental or even discriminatory. I make three major claims which suggest that the effects of reduced access to abortion for low-income women and women of color are oppressive. First, I argue that the anti-abortion movement and anti-abortion ideology and legislation support current systems of oppression, namely, the war on drugs and militaristic immigration enforcement. Second, I argue that reduced access to abortion and birth control contribute to higher rates of sterilization and sterilization regret in minority populations. Finally, I argue that welfare in pro-life states encourages childbirth and thus participation in family welfare that is exploitative and oppressive. All three of these claims involve women of color and low-income women, and thus argue that the form of reproductive oppression described is racialized and classed. In other words, reduced access to abortion is specifically oppressive to minority women.
CHAPTER 4

I argue that reduced access to abortion is oppressive to women of color and low-income women. There is an extensive line of feminist research where scholars argue that anti-abortion legislation disproportionately affects minority women. I expand on this by arguing that this disproportionate effect functions as a site of oppression for minority women and low-income women. I examine historical and contemporary connections to supposedly unrelated oppressive systems, rates of sterilization and sterilization regret, and exploitative family welfare as major sites where reduced access to abortion functions as oppression. Recognizing that this is a controversial topic, I use this concluding chapter to discuss one main objection to the argument I present in this thesis. Simply explicating another site of oppression for minority women and low-income women does little to resolve the issues these women face. Highlighting avenues for improving the condition of disadvantaged groups is a key component to intersectionality so I conclude this chapter with theories of resistance through marginality, and examples of effective, contemporary resistance to reduced access to abortion.

Addressing a Concern…

One could object to my argument that reduced access to abortion is oppressive to low-income women and women of color by pointing to the history of birth control in the US. Margaret Sanger, an early birth control activist and founder of what would eventually become Planned Parenthood, popularized the term “birth control”. She espoused views that closely
aligned with the eugenics movement of her time, arguing for birth control as a method to rid the world of “human weeds [who] clog up the path, [and] drain up the energies and the resources of this little earth” (qtd. in Sanger 2007). This, combined with the historic suppression of women of color and low-income women’s reproduction (see Chapter 3), could lead one to argue that increasing access to abortion for minority women would be just another effort to eliminate minority people. In other words, one could object to my thesis by arguing that abortion is just another form of racist population control.

However, improving access to abortion is not the same thing as coercing women into getting abortions. While it is important to avoid eugenic notions and misguided population control policies, reducing access to abortion does not help in that endeavor. Quite the opposite, I argue that attempts to control women’s reproduction and reproductive labor motivate anti-abortion policies. For example, politicians have used xenophobic and racist fears about white women reproducing less than women of color to support their arguments against abortion access (Dubow 2011). This argument also ignores women of color’s reproductive autonomy and ability to make responsible reproductive choices for themselves. Women of color have been and continue to be important contributors to reproductive justice movements that include and highlight abortion access (Ross 1998). Access to a full range of reproductive options afford women true reproductive freedom that is not coerced – conversely, removing access in a misguided attempt to “save” women of color from population control is paternalistic and does more harm than good.
I conclude this thesis, which focuses so heavily on oppression, with a brief theoretical framework for resistance and some practical examples of resistance. I rely heavily on a Marxist theory of oppression and feminist theories of oppression and privilege that stem from Marilyn Frye’s *The Politics of Reality* (1983). A critique of these frameworks is that they are “discouraging [and] demoralizing” (Lugones 1990 p. 502) because they are not liberating. To remedy this, Lugones (1990) proposes a theoretical framework that positions oppressed individuals, those who feel their intersecting identities most viscerally, as most capable of liberation. Their positions in the liminal spaces of society and their ability to cross back and forth between being both oppressor and oppressed, grant them epistemological insight into structures of power (Lugones 1990). This insight aids in collective struggle and can result in imaginative solutions to complex problems.

It is important to note that women of color and women in states that are hostile to abortion are frequently central actors in reproductive justice advocacy. Despite the oppression they face, we should take care not to view women of color as passive (Roberts 1999). To this point, I conclude with a discussion of several contemporary organizations and their efforts at reducing the reproductive oppression disadvantaged women face. “SisterSong” is a coaltional education and awareness organization that focuses on reproductive justice issues for women of color. They have headquarters in Atlanta, Georgia, a long-time anti-abortion state. They formed in 1997 when 16 smaller organizations for Native American, African American, Latina, and Asian American women joined forces. They take a broad view of reproductive justice and focus
on issues most pertinent to women of color, including but not limited to abortion access (SisterSong 2019).

Choices Memphis Center for Reproductive Rights is more narrowly focused on issues of abortion, but also centers its work on the needs of underserved populations, specifically women of color and low-income women. Choices is an abortion clinic in Tennessee that aims to avoid getting shut down by TRAP laws by diversifying their services. By providing services such as transgender healthcare, adoption referrals, and midwifery care and births along with abortion they hope to avoid shutting down completely when adjusting to new TRAP laws. These additional services ensure a revenue stream during adjustment periods which allows the clinic to continue providing reproductive healthcare and restart abortion services more quickly than at clinics that focus simply on abortion (Memphis Choices 2019). These two examples demonstrate how women at the margins use their place of liminality and epistemological insight to come up with creative solutions and resistance methods to anti-abortion measures.

This thesis argues that reduced access to abortion functions as reproductive oppression for women of color and low-income women, however I acknowledge certain objections. Along those lines, I address some misleading ideas about increased abortion access as a site of oppression. These ideas hide the important contributions of women of color in the fight for abortion and general reproductive justice. I also discuss a theory of oppression and marginality as places for resistance; all too often, theories of oppression fail to provide a way to improve the experiences of the oppressed and, thus, can be disempowering. The organizations working for reproductive justice from places of marginality that I discuss in this chapter offer promising avenues for using creative strategies to address the reproductive oppression minority women and low-income women face. Despite the oppression they face, it is my hope that new strategies can
develop to assist minority women and low-income women in the fight for, and ultimately the attainment of, reproductive justice.


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