

A National Latina Agenda for Reproductive Justice

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Executive Summary

Latinas stand at a unique historical juncture in the reproductive justice movement. A new wave of Latinas are coming of age, changing the political and social landscape of this country. Without question, Latina civic and political influence will grow exponentially over the next decade, making their involvement and leadership in the reproductive rights movement a prerequisite for success.

The need for reproductive justice for Latinas has never been greater. Latinas continue to face serious health care access barriers and consequently poorer health outcomes, especially in the area of reproductive health. By all measurable standards, Latinas are faring far worse than other groups in numerous areas of reproductive health, including breast and cervical cancer, HIV/AIDS, sexually transmitted infections and teen pregnancy. For example, the rate of cervical cancer among Latinas is twice the rate of white women, the rate of HIV infection for Latinas is seven times higher than white women, and Latinas have the highest teen birth rate of any racial/ethnic group. A number of factors contribute to Latinas' reproductive health problems, such as lack of health insurance, language barriers, institutional challenges in the public health care system, and poverty.

Most certainly, Latinas are facing a serious health care crisis that threatens to undermine the reproductive health and overall well-being of themselves, their families and their communities. Despite the growing number of uninsured Latinas and the significant health disparities they face, health policy makers have paid little attention to the reproductive health needs of Latinas. Against this backdrop, we are also witnessing an onslaught of attacks on the reproductive freedom of women in this country that will no doubt disproportionately impact Latinas. For example, the increase in federal funding for abstinence-only programs will have a serious effect on Latino teen pregnancy, STI and HIV/AIDS rates.

In an effort to highlight these problems and provide concrete steps toward change, the National Latina Institute for Reproductive Health (NLIRH) proudly presents the National Latina Agenda for Reproductive Justice (Agenda). The first part of the Agenda provides an analysis of the most salient reproductive health and rights issues impacting Latinas, followed by a set of policy recommendations and action strategies to address Latinas' specific reproductive health needs. The seven-point policy action program is intended to guide efforts to affect policy change at the federal, state and local level. The Agenda is framed from a social justice perspective that takes into account the intersection of race and ethnicity, class, gender, sexual orientation, and immigration status, among others. The seven policy action priorities identified by NLIRH include:

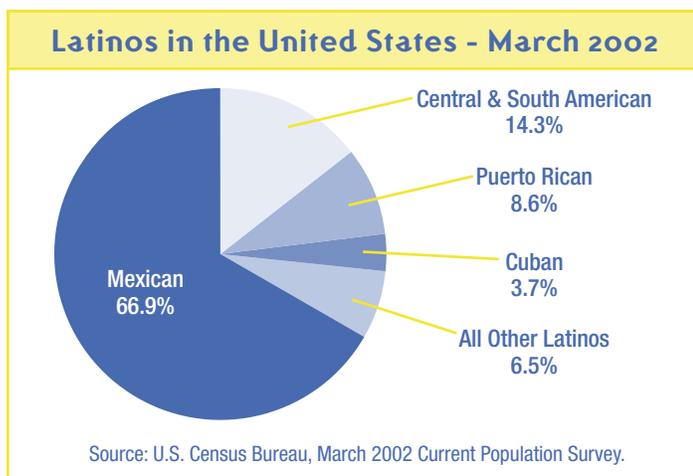
- Expanding Access to Health Care
- Demanding Culturally Competent and Linguistically Appropriate Services
- Ensuring Access to Family Planning and Contraceptive Equity
- Promoting Comprehensive Sexuality Education
- Protecting and Enhancing the Reproductive Rights of Latinas
- Fostering a Pipeline of Latina/o Health Professionals
- Generating Accurate and Unbiased Latina Focused Public Health Research

Undoubtedly, Latinas are and will continue to play an increasingly pivotal role in the fight to increase health care access and the struggle to protect and enhance the reproductive rights and freedom of women. We recognize and applaud efforts that are occurring throughout the country to develop Latina reproductive health and rights strategies founded on the real life experiences of Latinas and their communities. It is our hope that the National Latina Agenda will contribute to this unique Latina dialogue on reproductive justice and serve as a blueprint for action and a catalyst for change.

An Overview of Latinas in the United States: A Diverse and Growing Community

A Profile of Latinos in the United States

The United States has witnessed a tremendous growth in the Latino population across the nation. There are now 40 million Latinos residing in the U.S., representing a 58% increase from 1990-2000.¹



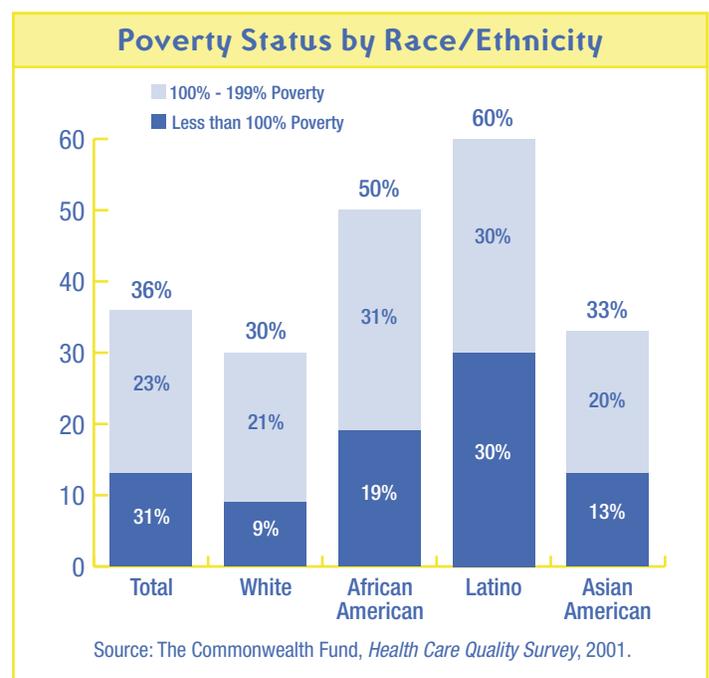
Latinas account for 18.3 million of the total Latino population and 13% of all women in the U.S.² It is estimated that by the year 2050, one out of every four women in the U.S. will be a Latina.³

In addition to being a significant portion of the female population in the United States, Latinas are the youngest sector of the female population. In fact, 40% of Latinas are under the age of 21.⁴ Reproductive health and rights are especially important issues for Latinas given that almost half of all U.S. Latinas are of childbearing age (9 million), and Latinas represent 15% of all women of reproductive age in the United States. Moreover, since the median age of Latinas is 27 years of age as compared to 37 years for whites and 30 years for African-Americans, a substantial number of Latinas face more than 18 years of reproductive capacity.

Latinas/os make extraordinary contributions to the social and economic well-being of this country. Despite their valuable contributions, Latinas often face formidable challenges to their own social and economic well-being, including racial, ethnic and gender discrimination. Latinas/os continue to be concentrated in the lowest paying jobs, have the second highest rate of unemployment (8.1%) and the lowest

rate of home ownership and asset accumulation.⁵ It is estimated that at least 23% of Latinos live in poverty. The rate is even higher among Latino children, who represent nearly 31% of children living in poverty.⁶

A survey conducted by the Commonwealth Fund paints an even bleaker picture with 60% of Latino respondents living below or near the poverty line. One of the contributing factors to the high poverty rate is that close to 25% of Latino households are headed by single Latinas who are the lowest paid wage earners of any group.⁷ Latinas earn only \$383 per week as compared to \$522 for white women and \$667 for white men.⁸



Inequities in wages contribute to the devaluation of Latina's hard work. For example, for every dollar earned by white men in 1998, white women earned 78 cents, African-American women earned 67 cents, and Latinas earned 56 cents.⁹ There is also a significant wage gap between Latinas and Latino males. The median wages for Latinas in 2001 was \$15,671 as compared to \$21,073 for Latino males, \$20,376 for African-American women and \$21,975 for white women.¹⁰ Another contributing factor is lack of educational opportunities and access to quality education, which leads to lower educational attainment. For

example, 6.7% of Latinas have less than a ninth grade education, only 30% of Latinas are high school graduates, and less than 22% have secured a bachelor's degree or higher.¹¹ Educational achievement, however, does not fully explain the earning gap or the higher rates of poverty among Latinas; a Latina with a college degree earns less than a white woman with a high school diploma.¹²

Top Ten States with the Largest Latino Populations

State	Total Population	Latino Population	Latinos as a Percentage of State Population
California	35,116,000	11,937,000	34%
Texas	21,780,000	7,314,000	34%
New York	19,158,000	3,073,000	16%
Florida	16,713,000	3,019,000	18%
Illinois	12,601,000	1,681,000	13%
Arizona	5,456,000	1,477,000	27%
New Jersey	8,590,000	1,221,000	14%
Colorado	4,507,000	818,000	18%
New Mexico	1,855,000	796,000	43%
Georgia	8,560,000	517,000	6%

Source: U.S. Census Bureau, Population Division, July 1, 2002.

Civic and Political Participation

Undoubtedly, Latinos are becoming a formidable civic and political force in this country. Not only do Latinos represent the largest ethnic group at nearly 14% of the total U.S. population, it is projected that by the year 2050, one of every four U.S. residents will be a Latino.¹³ Latino buying power now surpasses \$580 billion,¹⁴ and there are more than 1.2 Latino businesses employing 1.3 million people and generating more than \$186 billion in revenue.

The U.S. Census Bureau reported that Latinas are now the fastest growing segment of small business owners.¹⁵ As of 2002, approximately 470,344 majority owned, privately-held firms were owned by Latinas employing nearly 198,000 people and generating \$29.4 billion in sales. The growth in Latina-owned small businesses is recent; the number of Latina owned businesses increased by 39% in only five years (1997-2002).¹⁶ It should be noted that Latinos are not just contributing to growth in the private sphere. According to the Gallup-Independent Sector survey of giving and volunteering, Latino voluntarism is on the rise, reaching 46% in 1999.¹⁷

In addition to Latinos' contribution in the civic sphere, Latino political participation has significantly increased over the last three decades. The number of Latino registered voters grew from 2,495,000 in 1972 to 7,546,000 in 2000.¹⁸ In the year 2000, Latinos represented 7% of voting age citizens and had the third largest voter turnout (45%) among all racial/ethnic groups.¹⁹

Latinas/os have a strong political presence in many of the states with the highest concentrations of Latinos: California, Texas, New York, Florida, Illinois, Arizona, New Jersey, Colorado, New Mexico and Georgia. Moreover, Latina/o presence is increasing well beyond these states as Latinos continue to migrate to other states. The Latino population more than doubled in 23 states during the 1990s.²⁰ For example, North Carolina and Tennessee experienced, respectively, a 394% and 278% increase in the number of Latino residents from 1990-2000.²¹

In the near future, Latinas/os will become a formidable voting bloc capable of influencing major elections throughout the country. A new wave of second-generation Latinos reaching voting age, as well as higher rates of political participation among newly naturalized Latinos, will fuel Latino civic and political participation over the next decade.

Latinas are already beginning to realize their political power. For example, 75% of Latinas voted in the last presidential election as compared to 68% of Latino men.²² In New York City, Latinas accounted for 58% of registered Latinos.²³

Political Participation Trends

- More than 7.5 million Latinos voted in the 2000 elections
- 81% of Latino citizens are registered to vote
- 72% of registered Latinos voted in the last presidential election
- 58% of Latinas are registered Democrats as compared to 48% of Latino men
- 75% of Latinas voted in the last presidential election as compared to 68% of Latino men
- A net increase of 1.9 million Latinos are expected to vote in 2004 elections
- 2.8 million Latino young adults will be eligible to vote by 2008

Interestingly, a significantly higher number of Latinas are registered Democrats (58%) than Latino men (48%), although the gap may be narrowing.²⁴ Exit poll data from the 1996 national election showed an 18% point gender gap in party identification among Latino voters; 69% of Latinas claimed affiliation to the Democratic Party as compared to 51% of Latino men.²⁵

Even in the short term, the potential for increasing Latina/o voter turnout is extraordinary. The National Council of La Raza estimates that there will be a 1.9 million net increase in Latino voters in 2004, a growth rate of nearly one-third of the Latino voting population. Moreover, another 2.8 million Latino youth will be old enough to vote by November 2008.²⁶ In light of recent trends showing higher rates of Latina political participation, Latinas will undoubtedly form a large and pivotal component of this extraordinary Latino political and civic force.

Dangerous Health Trends

The last section provided a demographic overview of Latinos living in the United States in order to provide context for the following sections. This section, which highlights the dangerous health trends among Latinas and other Latino sub-populations, demonstrates the urgency of the state of Latina reproductive health,

Lack of Health Insurance

Widespread lack of health insurance is arguably the most urgent health problem facing Latinas today. Latinas not only have the highest uninsured rate of women from any racial/ethnic group (37%), but the number of uninsured continues to rise and shows no signs of abating.²⁷ For example, in 1994, 46% of low-income Latinas reported having no health insurance. By 1998, the number of uninsured, low-income Latinas had climbed to 51%.²⁸

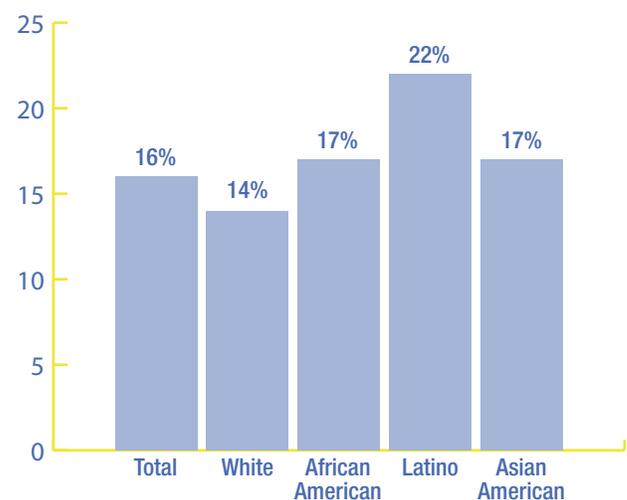
Uninsured Latinas often have no other recourse but to delay or forgo needed health care services because they simply cannot afford to pay for health care. Inadequate health care coverage also affects one's ability to sustain a continuous relationship with a health care provider. Approximately 31% of Latinas do not have a regular health provider as compared to 14% for whites and 17% for African-Americans.²⁹

Welfare and immigration reform have also severely impacted the ability of low-income Latinas to access safety-net programs such as Medicaid. A study commissioned by the Kaiser Family Foundation found that the percentage of Latinas receiving Medicaid decreased from 29% to 21% between 1994 and 1998. The study also found that, overall, women in their childbearing years were the most likely to lose Medicaid and become uninsured.³⁰ The loss of Medicaid coverage is especially concerning from a reproductive health standpoint. Medicaid is an important source of reproductive health care coverage for low-income Latinas. In fact, Medicaid is the largest source of public funding for contraceptive services and supplies, providing one of every two public dollars spent on family planning in the U.S.³¹

The difficulties Latinas' face accessing healthcare coverage and providers affect the overall health and well-being of Latinas. It is not surprising that 29% of Latinas report being in fair to poor health as compared to 14% of white women and 24% of African-American women.³² Moreover, Latinas in general report higher incidence of fair or poor health than any other racial/ethnic group (see Figure 6).

Self-Rated Health Status by Race/Ethnicity

Percent of adults rating health as fair or poor.



Source: The Commonwealth Fund, *Health Care Quality Survey*, 2001.

Cervical and Breast Cancer Incidence and Mortality

The consequences of lack of health insurance coverage are especially salient when we examine breast cancer mortality rates. For example, uninsured Latinas with breast cancer are 2.3 times more likely to be diagnosed at a later stage.³³ Although Latinas have a lower rate of breast cancer (69.8 per 100,000) as compared to white women (111.8 per 100,000), breast cancer remains the leading cause of cancer deaths among Latinas.³⁴ The five-year survival rate for Latinas with breast cancer is only 76% as compared to 85% for white women. The higher rate of mortality can be attributed in part to lack of breast cancer screening leading to delayed diagnosis and treatment. Only 38% of Latinas age 40 and older have regular mammograms that could detect cancer at its earliest stage before clinical symptoms develop.

Latinas also have significantly higher rates of cervical cancer (15.8 per 100,000 cases) as compared to white women (7.1 per 100,000 cases), and cancer has become one of the leading causes of death for Latinas ages 25-54.³⁵ Cervical cancer is ranked the third most common

cancer among Latinas.³⁶ Despite the fact that the cervical cancer rate for Latinas is more than twice that of white women, 33% of Latinas reported not having obtained a pap smear in the preceding three years.³⁷ Lower Pap smear rates results in Latinas being diagnosed at a more advanced stage of the disease when fewer treatment options are available.

HIV/AIDS and Sexually Transmitted Infections

Latinas are shouldering an increasingly larger portion of the HIV/AIDS epidemic than ever before. HIV infection is 7 times higher in Latinas than in white women, and HIV/AIDS has become the third leading cause of death for Latinas between the ages of 25 and 44.³⁸ Moreover, Latinas now account for more than 20% of the total AIDS cases among women although they represent only 13% of the female population. Despite the life threatening nature of this disease, only 33% of Latinas reported ever talking to a health provider about HIV/AIDS. Even fewer Latinas have specifically discussed the risks of being infected with HIV (23%) or getting tested for HIV (22%) with a provider during their lifetime.³⁹

Latinas also encounter higher prevalence rates for other sexually transmitted infections. The rate of primary and secondary syphilis among Latinas is twice the rate of non-Latino women, and congenital syphilis is nine times greater for Latino infants as compared to white infants. In 1998, the rate of gonorrhea was three times higher for Latinas (69.4 per 100,000) than for white women (26.0 per 100,000), and among Latina teens (15-19), the rate of gonorrhea has reached staggering proportions (251.6 per 100,000).⁴⁰ Overall, the rate of Chlamydia among Latinas has risen to 599 per 100,000 as compared to 161.9 per 100,000 among white women.⁴¹ Latina teens, particularly Mexican-Americans, also experience a higher rate of Chlamydia (6%) as compared to white female teens (4%).⁴²

Left untreated, Chlamydia and gonorrhea can lead to infertility and life threatening ectopic pregnancies.⁴³ Additionally, Chlamydia and gonorrhea increase the risk of becoming HIV infected upon exposure to HIV, leaving Latina teens, a group that is less likely to receive reproductive health or family planning services, at higher risk for HIV infection.

Prenatal Care, Maternal and Infant Mortality

Latinas have the highest fertility and birth rates of any racial/ethnic group. Latinas account for 18.6% of U.S. births, with more than 70% of these occurring among Mexican-American women.⁴⁴ Despite the high number of Latino births, Latinas are less likely to secure prenatal care during the first trimester. In fact, only 72% of Latinas, in comparison to 87.4% of white women, secured prenatal care within their first trimester.⁴⁵ In 1998, 6.3% of Latinas received delayed or no prenatal care as compared to only 2.4% of white women.⁴⁶ This poses a serious problem since late or lack of prenatal care can increase the risk of low birth weight, as well as infant and maternal mortality. In 1997, the Latino infant mortality rate (per 1,000 live births) was 6.0 as compared to 7.5 for non-Latinos. Among certain Latino subpopulations, however, the rate was much higher. For example, among Puerto Ricans, the infant

mortality rate was 14 per 1,000 live births.⁴⁷ Additionally, the maternal mortality rate was higher for Latinas (8.0 per 100,000) as compared to whites (5.8 per 100,000).⁴⁸

Sexuality Education and Teen Pregnancy

Latinas have the second highest teen pregnancy rate (17%), a rate that is almost twice as high as that of white teens. Factors leading to higher teen pregnancy rates among Latinas include lower rates of contraception use and limited knowledge concerning sexuality issues and birth control methods.⁴⁹ The consequences of teen pregnancy for young Latinas can be considerable; few teen mothers are able to earn a high school diploma or find a job that pays a living wage. Thus, teen pregnancy often sets into motion a chain of events that leads to lower educational attainment, welfare dependency and persistent poverty.

A study conducted by the National Campaign to Prevent Teen Pregnancy on sexuality and HIV education programs revealed that skills based sexuality education – those programs which teach contraceptive use and communications skills – are effective in helping youth delay the onset and/or frequency of sexual intercourse and the number of sexual partners while increasing the use of contraception.⁵⁰ Yet, as of 2001, only 19 states require schools to provide sexuality education, and only 9 of those states require schools that teach abstinence to also teach about contraception.⁵¹ The lack of comprehensive sexuality education in the schools is particularly detrimental to Latinos given the lower levels of contraception use and higher rates of HIV/AIDS, STIs, teen pregnancy and teen birth rates among Latino teens.

Family Planning and Contraception

The amount of available information on Latinas' contraceptive use is minimal. The studies that have examined family planning practices among Latinas have identified some troubling trends. For example,

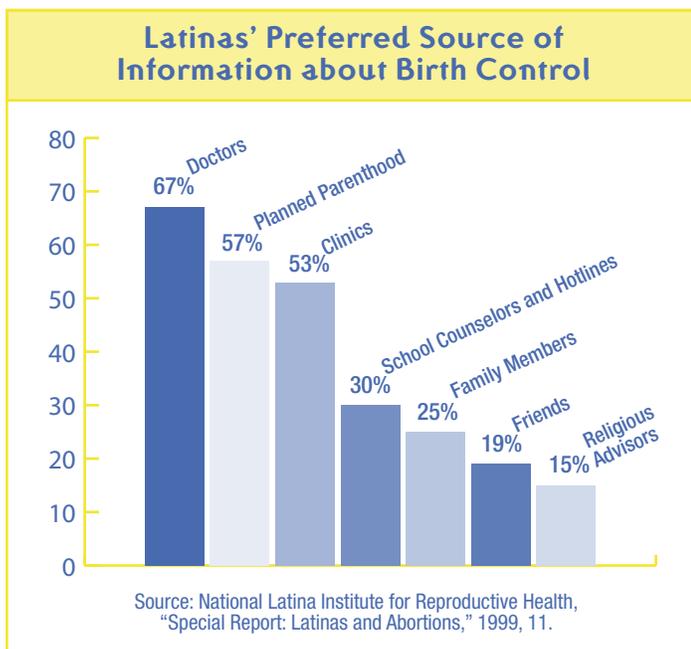
Percentage of Contraceptive Users Aged 15-44, by Current Method, Race and Ethnicity; 1995

Method	Latino	White	African American
Female Sterilization	37	25	40
Male Sterilization	4	14	2
Pill	23	29	24
Implant	2	1	2
Injectable	5	2	5
IUD	2	1	1
Diaphragm	1	2	1
Male Condom	21	20	20
Other	6	7	5
Total	100	100	100
Number (in thousands)	3,957	28,120	5,098

SOURCE: Stanley K. Henshaw, "Unintended Pregnancy in the United States," *Family Planning Perspectives* 30.1 (1998).

only 59% of Latinas between the ages of 22 and 44 reported using some form of contraception,⁵² highlighting the need to increase access to family planning and contraception for Latinas. Another troubling trend is that Latinas are relying heavily on sterilization as a form of contraception (illustrated in Table 3). Sterilization among Latinas has increased from 23% in 1982 to 37% in 1995 and is the predominant form of contraception among Latinas, followed by the pill (23%) and male condom use (21%).⁵³ This trend may indicate that Latinas cannot afford the costs of ongoing family planning services and contraception supplies. It may also reflect a lack of information about family planning options.

Finally, Latinas are not visiting family providers as frequent as they should be to maintain their reproductive health. The National Survey of Family Growth (NSFG) of 1995 indicated that only 32.7% of Latinas aged 15-44 reported seeing a family planning provider within the prior twelve month period.⁵⁴ This is especially problematic given that according to a 1998 NLRH Survey, Latinas indicated that health providers were their preferred source of information on birth control as contrasted with religious advisors, friends and family.



Rape/Sexual Assault and Intimate Partner Violence

In 2002, more than 247,730 cases of rape or sexual assault were reported in the United States,⁵⁵ placing victims at risk of sexually transmitted infections and unwanted pregnancy. Among Latinas/os, 13,810 cases of rape/sexual assault were reported in 2000,⁵⁶ and 18% of Latinas under the age of 16 reported that their first sexual intercourse was not voluntary.⁵⁷

For many Latina/o victims of violent crime (i.e., simple assault, robbery, aggravated assault and rape/sexual assault), the assailant is a known

party. For example, during the period of 1993-2000, 47% of reported violent crimes against Latinas/os were perpetrated by an intimate (i.e., current or former spouse, boyfriend or girlfriend), relative or friend/acquaintance.⁵⁸

A recent article notes that less than half of women injured as a result of intimate partner violence (IPV) seek health care services for their injuries.⁵⁹ This is especially disconcerting given the evidence suggesting that IPV may escalate during pregnancy. Research also indicates that Latinas are less likely to disclose intimate partner abuse to health providers unless directly asked, and Latinas tend to underutilize domestic violence services partly due to language barriers and the lack of culturally competent services.

The health care costs associated with IPV are estimated at 67 billion per year.⁶⁰ However, the human costs are far more devastating: homicide, depression and other debilitating mental health problems, serious injury, disability and family disruption, among others.

Dangerous Trends among Specific Sub-Populations

Immigrant Latinas

Fifty-three percent of Latino adults in the U.S. are foreign born, including more than 8 million Latinas.⁶¹ Foreign born Latinas/os are substantially more likely to be uninsured; for example, in 1997, 49% of foreign born Latinos were uninsured as compared to 24% of U.S. born Latinos. Even more alarming, an estimated 56% of low-income Latina immigrants lack health insurance. Latina immigrants are also more likely to live in poverty and less likely to access higher education than other immigrant groups and native-born Latinas.⁶²

Against this backdrop, it is not surprising that Latina immigrants have higher pregnancy related mortality rates than white women and U.S. born Latinas, or that children born to Latina immigrants are at a higher risk for low birth weight and premature delivery in comparison to whites.⁶³ Lack of health insurance also impedes access to preventive health care and screening for cervical and breast cancer, HIV/AIDS and sexually transmitted infections. In addition, growing anti-immigrant sentiment, coupled with the lack of culturally and linguistically competent services, serve as formidable barriers to accessing care, making it imperative that programs be designed and funded to serve the distinct needs of immigrant Latinas.

Latino Men

Latino males encounter numerous sexual health problems including a disproportionately higher incidence of sexually transmitted infections. For example, the rate of new gonorrhea cases among Latino men is 67 per 100,000 as compared to 20 per 100,000 among white men.⁶⁴ Latino men account for 77% of the AIDS cases among Hispanic adults and adolescents, and HIV/AIDS has now become the second leading cause of death for Hispanic males aged 35-44.⁶⁵

Many Latino men lack basic access to prevention services and health screening. For example, while prostate cancer is emerging as a serious health problem for Latino men, a recent study among Latino men age 40 and older showed that only 40% of Latino men received a blood test or exam for prostate cancer as compared to 50% of white men and 49% of African-American men.⁶⁶

Finally, closer attention must be paid to the role Latino men can play in promoting the use of birth control. A study of men's perceptions concerning their roles and responsibilities regarding sex, contraception and childrearing indicated that Latino males were more likely to believe that men and women shared equal responsibility for contraception.⁶⁷ Additionally, Planned Parenthood Federation of America (PPFA) polling data indicates that Latinas are primarily influenced by their spouse or partner with respect to their views on birth control, followed by their doctor or health provider.⁶⁸ These findings confirm the need to outreach and educate broad sectors of the Latino community on reproductive health and rights issues and to engage Latino men as allies in the struggle for reproductive justice.

Women Who Have Sex with Women (WSW)

The amount of research on the specific reproductive health needs of Latina lesbians and bisexuals, as well as transgender individuals, is miniscule. What limited research has shown is that Latina lesbians and bisexual women face multiple barriers to health care access, and they may be at higher risk for certain reproductive health problems. For example, a recent study of self-identified lesbian and bisexual women of color living in Los Angeles, California, revealed that Latina lesbians and bisexuals were less likely to have a regular source of care, had lower rates of preventive care and higher rates of health risk behaviors (i.e., obesity, alcohol and tobacco use) than Latina heterosexuals.⁶⁹

Several studies about lesbian reproductive health suggest that lesbians and bisexual women may be at greater risk for breast and gynecologic cancers.⁷⁰ There is mounting evidence that breast and uterine cancer may be associated with nulliparity, the state of not having given birth. In addition, ovarian cancer is more prevalent among women who have never used oral contraception. Therefore, Latinas with a same sex partner history are potentially at greater risk for these cancers.⁷¹ In fact, a report published by the Institute of Medicine identified the potential for double to triple the risk of breast cancer among Lesbians in comparison to heterosexual women.⁷²

The higher rates of breast and cervical cancer among Latina lesbians compared to heterosexual Latinas are also related to inadequate preventative care. For example, one study found that only 67.9% of Latina lesbians reported having a pap test in the last two years as compared to 80.6% of Latina heterosexuals. Similarly, 66.2% of Latina lesbians reported receiving a clinical breast exam within the past two years as compared to 75.7% of Latina heterosexuals.⁷³ Institutionalized homophobia, gender, racial and ethnic discrimination, as well as low socio-economic status also serve as powerful barriers to health care access for Latina lesbians.

Youth

Currently, Latinos account for 16% of the U.S. youth population. It is estimated that by the year 2025, Latinos will comprise one quarter of the youth in the U.S.⁷⁴ As the future leaders of the Latino community and the nation as a whole, the health and well-being of Latino youth should be of concern to all of us. Unfortunately, not enough has been done to reduce the health disparities facing Latino youth. For example, 17% of Latino youth lack a regular source of health care and 25% of Latino children (under 18) are uninsured.⁷⁵ Research indicates that Latino youth experience higher rates of teen pregnancy and sexually transmitted infections (STIs) than non-Latino youth. Moreover, it is estimated that 45% of Latinas in the 9th-12th grade are sexually active,⁷⁶ and six out of ten Latina youth will become pregnant by the age of twenty.⁷⁷ While Latina teen pregnancy rates have declined over the last ten years, the Latina teen birth rate remains the highest among all racial/ethnic groups. The Latina teen birth rate (83.4/1,000) is well above the rate of African-American teens (66.6/1,000),⁷⁸ non-Latino white teens (28.5/1,000), and the national teen average (43.0/1,000).⁷⁹

Data from the Youth Risk Behavioral Survey (1997) shows that Latina high school students are less likely to use contraception than non-Latina high school students. For example, only 9.5% of Latinas reported using birth control pills as compared to 11.9% of black female teens and 20.6% of white female teens. Similarly, only 40% of Latina high school teens reported condom use during their last sexual encounter as compared to 58.9% of blacks and 49.2% of whites.⁸⁰

Unprotected sexual activity can lead to numerous health problems. Each year, one in four sexually experienced teens is diagnosed with an STI. This presents a dangerous trend given that untreated STIs can lead to reproductive cancers and infertility, as well as increase the risk of HIV infection.⁸¹ Among teens age 15-17, the rate of Chlamydia for Latinas was more than twice the rate of white females (2,757 versus 1,229 per 100,000), and the rate of gonorrhea among Latino male teens was more than three times the rate of white males (161 versus 39 per 100,000).

Latino teens are also disproportionately burdened by HIV/AIDS. In 2001, Latino teens (aged 13-19) accounted for 21% of new AIDS cases among teens, although they represented only 15% of U.S. teenagers.⁸² Another alarming trend is the number of Latino youth who reported unwanted sexual encounters. For example, in 2001, 12% of Latina teens and 6% of Latino male teens reported forced sexual encounters.⁸³

Structural and Institutional Barriers to Reproductive Health Care

Lack of health insurance and high poverty rates, described in the previous sections, are major contributing factors to poor health outcomes for Latinas. Many of the dangerous health trends discussed in the preceding section can also be attributed to structural and institutional barriers to quality reproductive health care. This section provides an overview of the daunting obstacles many Latina/os must overcome to access quality health care. In addition to lack of health insurance and poverty, the health care access barriers faced by Latinas/os include:

- Dependence on a financially distressed public health system;
- Lack of linguistically appropriate and culturally competent health care services;
- Discrimination in health care delivery and public health policies;
- Insufficient health research on Latina/o populations; and
- Limited pool of Latino healthcare personnel.

A Crippled Public Health Care Delivery System

Latinos rely heavily on public hospitals and publicly funded health centers for their care. Latinas in particular often rely on hospital clinics, health centers (38%) and emergency rooms (7%) for their care.⁸⁴ For the most part, these institutions are located in medically underserved communities that are composed of poor and immigrant populations. Public healthcare centers provide health care to an increasingly disproportionate share of the uninsured.⁸⁵ For example, according to the Bureau of Primary Health Care, the number of uninsured patients at community health centers increased by 49 percent from 1990 to 1997.⁸⁶ Not surprisingly, these institutions often operate under a climate of financial distress, posing serious challenges to the provision of quality health care.

These same institutions have also been impacted by recent health and social policy changes. According to a report issued by the Urban Institute, the implementation of managed care and changes in public benefits programs have had a substantial impact on public hospitals and publicly funded health centers. For example, commercial managed care organizations seek to maximize their cost savings by recruiting an insured, healthier patient base that regularly seeks preventive and primary care. Public health care institutions are therefore more likely to carry the burden of providing costlier treatment services to an ailing, uninsured population.

Federal welfare reform and changes in immigration laws have also contributed to the growth in the ranks of the uninsured by decreasing the number of persons receiving Medicaid in certain states.⁸⁷ For example, between 1995 and 1999, New York City witnessed a 12% decline in the Medicaid rolls, resulting in the loss of Medicaid for 200,000 persons including 105,000 children.⁸⁸ Thus, diminishing revenue streams due to competition from private hospitals and commercial managed care organizations, an increase in the number of uninsured, and the decline in the number of patients receiving Medicaid threatens the very survival of public hospitals and publicly funded health centers upon which so many Latinas/os rely.

Lack of Linguistically and Culturally Appropriate Services

Recognizing that the provision of culturally competent health services is an essential step towards the elimination of racial/ethnic health disparities, the DHHS Office of Minority Health has developed Recommended Standards for Culturally and Linguistically Appropriate Health Care Services (CLAS). These standards provide health care institutions and providers with guidance for achieving cultural competence. Cultural competency in health care delivery requires providers to have an understanding of the beliefs, values, traditions and practices of a cultural group. Comprehensive cultural competency care also includes knowledge about culturally based beliefs regarding the etiology of illness and disease, as well as health and healing practices.⁸⁹

The provision of culturally competent health care can enhance health outcomes for individuals and communities, increase levels of patient satisfaction and improve cost efficiency. According to the Health Resources and Services Administration (HRSA), culturally competent practices enable providers to: 1) obtain more specific and complete information to make a diagnosis; 2) facilitate the development of treatment plans that are more likely to be adhered to by the patient and supported by the family; and 3) enhance overall communication and interaction between patient and provider.⁹⁰

A key component of providing culturally competent services is to ensure the delivery of linguistically appropriate services. In a recent study conducted by the Commonwealth Fund, 43% of Spanish dominant Latinos reported communication difficulties with their health providers.⁹¹ Another 16% of Latinos reported not following the doctor's advice simply because they didn't understand it. Latino patients with

language discordant doctors are also more likely to omit medication, miss office appointments and rely on the emergency room for care, which often leads to poor health outcomes.⁹²

By contrast, language concordance between physician and patient has a positive impact on health behaviors. A study conducted at the General Medical Practice of the University of California, San Francisco found that Spanish monolingual patients whose physicians spoke Spanish had better recall of their physician's recommendations and asked more questions during their visit than their counterparts seen by non-Spanish speaking clinicians.⁹³

Service providers who fail to provide meaningful access to individuals with limited English proficiency (LEP) may be in violation of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.⁹⁴ Nevertheless, many Latinos are not receiving important language interpreter services. It is estimated that only half of Latinos needing interpreter services actually receive such services. This is especially problematic in the area of reproductive health because sensitive, private issues are often discussed between provider and patient.

Discrimination in Health Care Delivery and Public Health Policies

Recent reports, most notably by the Institute of Medicine, on racial and ethnic disparities in health care have highlighted the continuing problem of unequal treatment by health providers and institutions. Discrimination in health care delivery settings can range from overt and intentional to subliminal and sub-conscious. Today, patients of color are more likely to experience subtle and indirect forms of discrimination and unequal treatment. One example of less overt institutional discrimination is when hospitals separate their privately insured postpartum patients on different floors or wards from their uninsured and Medicaid patients who are primarily people of color.⁹⁵ Another form of discrimination includes disparities in health care spending. For example, in 1996, \$1,428 was spent on the average Latino Medicaid recipient compared to \$4,074 for the average white recipient.⁹⁶

Studies indicate that Latinas suffer from various forms of discrimination by their health care providers. For example, Latinas are more likely to report that doctors did not usually take the time to answer all their questions (14%) as compared to white (9%) and African-American women (8%).⁹⁷ Additionally, recent survey findings indicate that 18% of Latinos have felt disrespected by a health provider because of an inability to pay for services, language difficulties and/or their race/ethnicity.⁹⁸ Perhaps even more telling, 13% of Latinos reported believing they would receive better health care if they were of a different race or ethnicity.⁹⁹

Insufficient Research and Data Collection

Behavioral and biomedical research plays a powerful role in shaping health care delivery and public health policies. The National Insti-

tutes of Health (NIH) recognizes that research provides the scientific basis and legitimacy necessary to support efforts aimed at improving standards of care, formulating better public health policy, changing the individuals' health related behaviors, improving health care delivery systems and creating strategies for overcoming cultural and economic barriers to health care.¹⁰⁰ In addition to research, health data collection allows for the identification of health trends in a given population so that more targeted health interventions can be utilized to ameliorate health problems.

Despite the importance of research and health data collection in addressing the health needs of a population, the first comprehensive Hispanic health survey, known as the Hispanic Health and Nutrition Survey (HHANES), was not implemented until 1982-1984. In addition, the leading causes of death for all Latinos were not published by the Department of Health and Human Services in its annual report to Congress until 1993.¹⁰¹

A review of Healthy People 2010 illustrates that there are still substantial research gaps for Latinos in many health areas. Most significant is the lack of baseline data on Latinos by which to establish benchmarks for the year 2010.¹⁰² Despite these glaring omissions, it is estimated that only 1% of the NIH research funding has been allocated to conduct research on Latinos.¹⁰³

Moreover, data collection and surveillance systems are not keeping up with the rapidly changing demographics and characteristics of the Latino population.¹⁰⁴ Most national data sets do not have significant sample sizes by which to analyze Latino health needs by subgroup populations.¹⁰⁵ Without specific data, health problems experienced by various subgroups are often overlooked, and trends in a leading subgroup are incorrectly generalized to other subgroups. For example, further research by subgroup population could shed light on whether acculturation or other factors are the reasons why Puerto Ricans with low socioeconomic status (SES) appear to have significantly poorer health status than low SES Mexicans.¹⁰⁶

Additionally, as noted by the Midwest Latino Health, Research, Training and Policy Center, there is a real need to re-frame the Latino research agenda:

Research on Latinos and other minorities traditionally has included methods of observation and criteria for validating facts and theories that intentionally or unintentionally justify stereotypes about these populations. . . This often has resulted in a number of biases that reinforce the social, economic and political disadvantages of these groups in society.¹⁰⁷

Crucial to the effort to eliminate bias in research is the recruitment and training of bilingual/bicultural Latino researchers who can help to deconstruct some of the biases contained in present day research paradigms and develop new frameworks.

Health Care Personnel

The number of Latino health providers is abysmally low. This is especially disconcerting considering that several studies have indicated that patient satisfaction is highest when the patient and doctor are of the same race or ethnicity, and that minority physicians tend to care for minority patients in greater numbers and to work in medically underserved areas.¹⁰⁸

Although Latinos account for almost 14% of the total U.S. population, they comprise only 4.6% of physicians in the United States. Latino representation in the field of nursing is even smaller (2.4%), and Latinos account for only 2.8% of pharmacists.¹⁰⁹ Although more people of color applied to medical school in 2000, fewer were accepted than in 1998 and 1999. In 2000, 17,546 of the 37,137 minority applicants were accepted to medical school, and only 545 of those accepted identified as either Mexican-American (415) or Puerto Rican (130).¹¹⁰

The recruitment of Latino health personnel is an important vehicle to increase access and quality of care for Latinas. Latino health personnel are more likely to be able to bridge the language gap that often deters Latinos from seeking prompt care or interferes with patients' ability to understand and follow through on health care instructions. Latino health professionals are also more likely to understand cultural belief systems and to work within this context to support health promotion, disease prevention and early medical intervention when needed.

Reproductive Rights Challenges Faced by Latinas

Punitive, Coercive and Discriminatory Policies and Practices

Prejudice and discrimination based on race/ethnicity, class, gender, sexual orientation, language and immigration status often work to undermine the self determination and reproductive freedom of Latinas. Thus, the development of a Latina reproductive rights strategy must include pro-active efforts to expose and systematically dismantle discriminatory, coercive, punitive and otherwise disempowering policies that infringe upon the rights and ability of Latinas to effectively exercise their reproductive freedom and gain access to quality reproductive services.

The United States has a long history of infringing upon women of colors' reproductive rights. For example, during slavery, African-American women in bondage were treated as breeders and denied the rights of motherhood. Another egregious example includes the massive sterilization campaign of Puerto Rican and Mexican-American women. More recent examples of coercive, discriminatory and/or punitive policies and practices that differentially impact Latinas and other women of color include: welfare and immigration reform; prohibitions on publicly funded abortion; mandatory HIV testing of pregnant women or their newborns; policies penalizing pregnant, substance using women involved in the criminal justice system; and, finally, the use of coercion and/or "incentives" to promote use of long-term contraceptives (e.g. Norplant and Depo-Provera) by women of color. While the tactics and subterfuge may vary, these policies contain one central ingredient—placing the locus of control for reproductive health decisions outside of Latinas' hands, thereby violating the fundamental human right to self-determination.

One of the most notorious, coercive programs in existence today is Children Requiring a Caring Kommunity (C.R.A.C.K.). C.R.A.C.K. opened its doors in 1994 with the explicit purpose of offering vulnerable, substance using women \$200 in exchange for their consent to long-term birth control or sterilization.¹¹¹ Another recent example of a coercive, public health policy was the participation of a public hospital operated by the Medical University of South Carolina in the collection of evidence used to criminally prosecute pregnant addicted mothers. The majority of women taken into custody as a result of the hospital's actions were African-American women. The Supreme Court struck down the hospital's drug-testing policy in *Ferguson v. City of Charleston* (2001).¹¹² Undoubtedly, at the center of these policies lies the deeply

racist notion that the sexuality and reproduction of poor women of color is the source of many of the social problems we face today.

It should also be noted that although these policies do not single out Latinas or women of color exclusively, they disparately impact women of color because women of color are disproportionately poor, politically disenfranchised and experience multiple barriers to accessing quality health services.

The Legacy of Sterilization Abuse

Historically, Latinas and other women of color have been targets of population control policies. During the 1940s and 1950s, the United States engaged in a massive sterilization campaign in Puerto Rico, resulting in the sterilization of almost 40% of Puerto Rican women of childbearing age. The sterilization campaign continued as Puerto Rican women migrated to the United States mainland.¹¹³ Throughout the 1950s, 1960s and early 1970s, public hospitals in New York City sterilized thousands of Latinas, primarily Puerto Rican women, without proper counseling or safeguards to insure informed consent.¹¹⁴ During the same time period, Latinas in California were subject to coercive sterilization practices at the Los Angeles County hospital. The coercive practices at this hospital included asking Mexican-American women to sign untranslated consent forms during labor.¹¹⁵

The coercive sterilization practices were not limited to hospital settings. In 1966, Nancy Hernandez, age 21, charged with a misdemeanor, was given the choice by a California judge of six months in jail or probation conditioned upon sterilization. She chose prison.¹¹⁶ Other women were coerced into sterilization out of fear that they would lose their welfare checks. Although many women of color suffered from these coercive sterilization practices, Latinas fared far worse than any other group. During this time, Latinas had a sterilization rate seven times the rate of white women and twice the rate of African-American women.¹¹⁷

In the 1970's, the Committee for Abortion Rights and Against Sterilization Abuse (CARASA) was formed in New York City in response to the numerous cases of Latinas and African-American women who had been sterilized without consent or under coercion. Despite the success of CARASA and other reproductive health advocates in establishing informed consent practices and publicizing egregious sterilization practices, the history of sterilization abuse has fostered a deep sense

of distrust of the health system within the Latino community. Moreover, sterilization rates among Latinas remain high despite the availability of other forms of contraception. Sterilization is the predominant form of contraception among Latinas (37%), followed by the pill (23%) and male condom use (21%).¹¹⁸

Welfare and Immigration “Reform”

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) contained numerous measures aimed at controlling the sexual behavior and reproductive decisions of poor women, particularly women of color who are over-represented among the poor. These measures include: 1) the imposition of family caps intended to dissuade women from bearing additional children; 2) the illegitimacy ratio bonus which provides states with financial incentives to reduce out-of-wedlock pregnancy; 3) abstinence-only education aimed at lowering the rates of teen sexual activity, and; 4) eligibility restrictions for immigrants intended to deter further immigration of poor immigrants and discourage childbearing among immigrants in the U.S. Latinas are disparately affected by all of these policies because Latinas are disproportionately poor and foreign-born.¹¹⁹ In fact, more than 40% of the Latino population in the U.S. is foreign born, and a very substantial number of Latino families are of mixed-status (citizen, undocumented and legal permanent resident family members residing in the same household). Latinas are also disproportionately represented on the welfare rolls and have high birth and teen pregnancy rates.¹²⁰

Latina immigrants were especially affected by PRWORA’s punitive immigration reform measures. While certain restrictions have been lifted, the original 1996 legislation barred several categories of immigrants from a wide array of assistance including Food Stamps, TANF (Family Assistance), Medicaid, and Social Security Income (SSI). The consequences of these changes were devastating. For example, within the first year after the passage of PRWORA, 940,000 immigrants lost their eligibility for Food Stamps.¹²¹

The combined effects of welfare and immigration reform policies have also worked to decrease the percentage of Latinas eligible to receive Medicaid benefits. Between 1994 and 1998, the percentage of Latinas receiving Medicaid fell by 8% from 29% to 21%. Moreover, among non-citizen immigrant women, the percentage of uninsured reached 56%, a 10% increase from 1994 to 1998. During that same period Medicaid coverage for non-citizen immigrant women decreased from 26% to 17%.¹²²

The extreme, anti-immigrant movement that is sweeping the country did not end with welfare reform. The post-September 11th climate and the passage of the USA Patriot’s Act have fanned the flames of xenophobia and the anti-immigrant sentiment that is deeply embedded in our society. The result is that many immigrants, especially undocumented Latinas/os, are fearful of seeking out basic services or demanding fair treatment. Since September 11th, the Latino community has witnessed a rise in racial profiling, abuse of power by law enforcement officials, civil rights violations, loss of jobs and diminished labor protections.¹²³

Undocumented immigrants in particular have experienced an unprecedented loss of rights. For example, a recent case that will have a resounding impact upon the Latina/o immigrant community is *Hoffman Plastics v. NLRB*, in which the U.S. Supreme Court ruled that undocumented immigrants using false documents in order to obtain work were no longer entitled to back-pay even if they were fired illegally.¹²⁴ Another example is the continual erosion of prenatal care access for undocumented immigrants. In 2001, a federal appeals court reversed a 1987 ruling requiring the government to provide prenatal care for undocumented immigrants. The ruling had the effect of denying 13,000 undocumented immigrants prenatal care in New York State that year.¹²⁵ Other states are threatening to cut prenatal care services for this vulnerable population, despite the fact that it is poor public policy.¹²⁶ Actions such as these have a chilling effect upon Latina/o immigrants, creating a climate of fear and distrust that discourages Latina/o immigrants from seeking out the services they need to ensure their health and well-being.

Lack of Access to Abortion

The reproductive rights of Latinas are imperiled not only by coercive policies intended to curb Latina birth rates, but also by lack of access to safe, legal abortions. Latinas have paid with their lives when a safe, legal abortion was unavailable to them. For example, Rosie Jimenez, a Latina college student who was unable to pay for a legal abortion, became the first woman to die from a back alley abortion after the passage of the Hyde Amendment in 1977. The Hyde Amendment restricts public funding for abortion under the federal Medicaid program. Currently, public federal funding for abortion is only available in cases of life endangerment, rape, or incest.

States are not required to limit public funding for abortion to the narrow Hyde Amendment exceptions so long as the state pays for abortions through state-funded programs. Nevertheless, public funding for abortion at the state level is extremely limited—only 16 states provide public funding for abortion in “all or most circumstances.”¹²⁷ A total of 28 states provide public funding for abortion in the limited cases of life endangerment, incest or rape. Some states with high concentrations of Latinos, such as Texas and Florida, have limited public funding for abortion in accordance with the Hyde Amendment.¹²⁸ Thus, many Latinas are left on their own to try to find ways to pay for an abortion. Often, low-income Latinas find it difficult to raise the money quickly enough to have the procedure performed during the first trimester, placing them at a higher risk of health complications from later term abortions.

These funding restrictions have had a long-lasting, chilling effect on the ability of low-income Latinas to access abortion. Financial barriers faced by many uninsured Latinas make abortion as inaccessible as if abortions were still illegal. Thus, for some Latinas, especially those who are poor and uninsured, *Roe v. Wade* is nothing but an abstract concept with little bearing on their reality.

Lack of public funding for abortion will continue to be a major obstacle for poor Latinas until the Hyde Amendment restrictions are lifted.

Unfortunately, constitutional challenges to the law have been unsuccessful. In 1980, the Supreme Court held in *Harris v. McRae* that under the U.S. Constitution, the federal and state governments have no obligation to provide funds for abortion services even though they pay for prenatal and maternity care for poor women.¹²⁹

Latinas who are insured or otherwise can afford to pay for health care services have an abortion rate that is similar to other groups. According to the National Survey of Family Growth (1995), approximately 50% of all pregnancies to Latinas were unintended, and of these unintended pregnancies, approximately half ended in abortion.¹³⁰

Parental consent and notifications laws have also made it difficult for Latina teens to access abortion in some states. These laws may be a contributing factor to the significantly lower abortion rates among Latina teens (27.5%) as compared to white teens (32%) and African-American teens (40.8%).¹³¹

Political Threats to Reproductive Health and Freedom

The anti-choice movement has continually sought to undermine the hard fought gains of the reproductive rights movement achieved over several decades of labor and sacrifice. The threat to reproductive rights, however, has never been greater than it is today.¹³² Conservative policy-makers in Congress and the Bush Administration have successfully pushed the anti-choice agenda in recent years. For example, upon his election, President Bush proceeded immediately to reinstate the global gag rule on international family planning programs. President Bush then appointed abortion opponents John Ashcroft and Tommy Thompson to U.S. Attorney General and Secretary of the Department of Health and Human Services (HHS), respectively. In terms of domestic legislation, anti-choice advocates were able to celebrate the passage of a number of anti-reproductive rights measures during the 108th Congress. For example, Congress passed and Bush signed into law the so-called Partial Birth Abortion law and the Unborn Victims of Violence Act. In addition, rather than increasing funding for family planning to prevent unwanted pregnancies and HIV/STDs, which disproportionately impact Latinas, Congress and the Bush administration chose to favor ideology over science by appropriating 87.5 million dollars in funding per year for ineffective abstinence-only programs.¹³³

The recent onslaught of anti-choice policy has by no means been limited to the federal government. As of 2004, state legislatures have passed nearly 400 anti-choice laws, and approximately 560 anti-choice laws were considered by state legislatures in 2003.¹³⁴ Examples of state anti-choice legislation include so-called partial-birth abortion laws, biased counseling and mandatory waiting periods, targeted regulation of abortion providers, and parental notification/consent laws.

The Role of the Judiciary: What is at Stake for Latinas?

In a poll conducted by PPFA, the majority of Latinas believed the Supreme Court played a very important role in protecting a woman's right to an abortion. Latinas aged 36–50 were most likely to emphasize the

important role the court plays in preserving this fundamental freedom.¹³⁵ While this is a promising trend, altogether too many Latinas remain unaware of the Supreme Court's critical role in establishing and preserving the right to a legal abortion and other reproductive rights. In fact, 39% of Latinas participating in the NLIIRH Abortion Survey of 1998 were unable to identify *Roe v. Wade* as the source of authority for the legalization of abortion.¹³⁶ These findings underscore the urgent need to educate Latinas about the crucial role of the judiciary in preserving reproductive freedom, especially given the likely retirement of several Supreme Court Justices over the next few years.

Packing the courts has been a core strategy of the anti-choice movement. For example, almost all of the 50 nominees put forth by President Bush to the federal courts of appeals hold positions that pose a fundamental threat to privacy rights, and fifteen nominees are considered to have extreme or activist anti-choice records.¹³⁷ Moreover, the Bush Administration's approach has employed tactics to achieve its court packing goals that defy democratic ideals. Never before has a president appointed a judge to the federal bench during a congressional recess when the Senate had expressly refused to confirm the nominee. Yet President Bush appointed both Charles Pickering and William Pryor to the federal bench during a congressional recess after the Senate had filibustered and refused to confirm these nominees because of their extreme positions. William Pryor has been attributed with saying abortion is "murder" and that the decision in *Roe* was the "worst abomination in the history of constitutional law."¹³⁸ Charles Pickering is credited with playing an instrumental role in promoting the development of the Republican Party plank calling for an amendment to the U.S. Constitution banning abortion.¹³⁹

Lessons Learned From the Nomination of Miguel Estrada

Last year, the Bush administration nominated Miguel Estrada, a conservative Latino, to the Washington, D.C. Circuit Court of Appeals. The D.C. Circuit Court of Appeals is widely viewed as the second most powerful court, presiding over cases involving federal agencies, which set numerous policies affecting Latinos throughout the nation. Furthermore, the D.C. Circuit Court is considered a possible stepping stone to the United States Supreme Court. Three of the current U.S. Supreme Court Justices sat on the D.C. Circuit prior to ascending to the highest court in the land.¹⁴⁰

While vocal opposition to his nomination forced Estrada to eventually withdraw from consideration, his nomination illuminated political efforts to court the Latino vote and to use Latinas/os as a wedge on reproductive rights issues. This lesson underscores the need to ensure the Latino community is well represented by progressive sectors of our community in all branches of government. Given the important role of the judiciary in preserving reproductive freedom, it is crucial for Latinas to demonstrate their support for keeping abortion legal and accessible to all women.

The Fabrication of Fetal Rights

Bestowing legal rights upon embryos and fetuses is a keystone strategy in the overall campaign to overturn *Roe v. Wade*. For example, in 2002, HHA amended the State Children's Health Insurance Program (S-CHIP) to allow for health insurance coverage for fetuses but not pregnant woman. Not only does this policy fail to address the problem of insufficient health insurance among low-income pregnant women, especially immigrant women, it also lays the foundation for granting an embryo or fetus "personhood" with separate legal rights.¹⁴¹ Most recently, passage of the Unborn Victims of Violence Act establishes a separate criminal offense for causing the death or injury of a fetus from the moment of conception. These policies erode the foundation of *Roe* and directly threaten a woman's right to choose.

Another recent fetal rights measure is the so-called "Partial-Birth" Abortion Ban Act of 2003. This law prohibits safe and medically appropriate abortions for women in their second trimester (as early as 13-15 weeks),¹⁴² without providing an exception for the woman's health. The American College of Obstetricians and Gynecologists (ACOG) characterized the law as "inappropriate, ill-advised and dangerous." The 2003 federal law is so fundamentally flawed that it has been held unconstitutional by three federal district courts across the U.S.

Latinas' Views on Reproductive Health Issues

Dispelling the Abortion Myths

Contrary to popular belief, and despite its continued status as a taboo subject within the Latino community, Latinas in the United States do access abortion services. In fact, many Latinas had abortions when abortion was illegal and dangerous. For example, a 1965 survey showed that 80% of deaths due to illegal abortions in New York City occurred to Latina and African-American women.¹⁴³ Today, approximately 50% of all pregnancies to Latinas are unintended, and of these unintended pregnancies, half end in abortion.¹⁴⁴ A study by the Centers for Disease Control (CDC) conducted in 24 states, the District of Columbia and New York City showed that Latinas accounted for over 17.3% of abortions in 1999.

Reported Legal Abortions in the United States, 1999

Characteristics	Hispanic		Non-Hispanic		Total	
	No.	%	No.	%	No.	%
Age Group (yrs)						
<15	454	0.6	2,543	0.7	2,997	0.7
15-19	13,640	17.6	66,927	18.2	80,567	18.1
20-24	26,607	34.4	116,146	31.6	142,753	32.1
25-29	18,814	24.3	84,987	23.4	104,801	23.6
30-34	10,680	13.8	52,562	14.3	63,242	14.2
35-39	5,494	7.1	31,991	8.7	37,485	8.4
>40	1,640	2.1	10,923	3.0	12,563	2.8
Total*	77,329	100	367,079	100	444,408	100
Marital Status						
Married	15,806	21.0	66,406	18.4	82,212	18.9
Unmarried	59,524	79.0	293,578	81.6	353,102	81.1
Total†	75,330	100	359,984	100	435,314	100

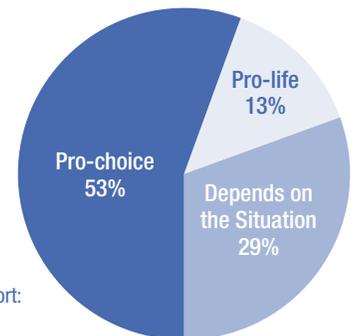
Source: US Department of Health and Human Services. Centers for Disease Control. (1999). Abortion Surveillance—United States, 1999. *Morbidity and Mortality Weekly Report*, 51(SS-9).

* Data from 24 states and New York City; excludes 13 states where ethnicity was reported as unknown for >15% of women. Percentages might not add to 100.0 because of rounding.

† Data from 23 states and New York City; excludes 13 states where ethnicity or marital status was reported unknown for >15% of women.

Another related myth—that Latinas don't support the legal right of women to choose an abortion—must also be challenged. In a non-random survey of NLIRH constituency conducted in 1998, the majority of Latinas (53%) self-identified as "pro-choice," 29% reported their stance on abortion would "depend on the situation," and only 13% identified as anti-choice or "pro-life." Moreover, 68% of Latinas surveyed supported liberal access to abortion.¹⁴⁵

Latina Attitudes Toward Abortion



Source: National Latina Institute for Reproductive Health, "Special Report: Latinas and Abortions," 1999, 7.

Interestingly, Latinas aged 26-50 were more likely to identify as pro-choice or support liberal access to abortion as compared to younger Latinas.

In a recent poll conducted by PPFA, 51% of Latinas surveyed supported the right of women to have an abortion.¹⁴⁶ Support for legal abortion is even greater in certain key states. For example, in a poll of Latinas living in the state of Florida, two-thirds of Latinas indicated that they agreed with the landmark Supreme Court decision to legalize a woman's right to obtain an abortion.¹⁴⁷

Latinas Support Family Planning, Contraception and Sexuality Education

Limited research has been conducted concerning the perceptions and opinions of Latinas regarding family planning, contraception and sexuality education. However, recent polling data suggests there is support among Latinas for family planning and sexuality education. Polling data commissioned by Planned Parenthood indicates that among pro-choice Latinas, 84% believe that information about all methods of birth control should be available to teenagers.¹⁴⁸ Additional polling data on Latinas in Florida indicated that Latinas are supportive of providing medically accurate sex education in the schools, and they overwhelmingly support requiring hospitals to provide emergency contraception to victims of rape and incest.¹⁴⁹

A Blueprint for Action

By all measurable standards, Latinas are faring far worse than other groups in numerous areas of reproductive health, including breast and cervical cancer, HIV/AIDS, sexually transmitted infections and teen pregnancy. For example, the rate of cervical cancer among Latinas is twice the rate of white women, the rate of HIV infection for Latinas is 7 times higher than white women, and Latinas have the highest teen pregnancy birth rate of any racial/ethnic group. Latinas' reproductive health disparities can be attributed in large part to low rates of health insurance, limited health care access, language barriers, lack of accurate information, and anti-immigration policies.

Reducing the reproductive health disparities that exist in the Latino community must be a top priority for every policymaker who is concerned about the future of our country. Latinas comprise a significant segment of America's future workers and leaders, accounting for one fifth of U.S. women by the year 2030. Consequently, the economic and social prosperity of this nation will largely depend on their health and well-being. Improving health outcomes for Latinas will require a much greater commitment and infusion of funds from all levels of government. It will also require leadership from the Latina/o community, and support from women's rights organizations.

The National Latina Institute for Reproductive Health presents this Blueprint for Action as the model for a national policy agenda that will address the reproductive health challenges facing Latinas today. The policy agenda is framed around the following priority issues for Latinas: access to affordable healthcare, culturally and linguistically competent health care services, family planning and contraceptive equity, comprehensive sexuality education, reproductive rights, Latino health professionals and accurate and unbiased research on the health status of Latinas.

1 Access to Health Care

Lack of health insurance and health care access pose serious health risks to the reproductive health of Latinas. The number of uninsured, low-income Latinas has climbed to a staggering 51%, and the number of Latinas receiving Medicaid has declined from 29% to 21%. Without health insurance, many Latinas are forced to delay or forgo health care altogether. For example, approximately 25% of Latinas have not visited a physician in the last year, and almost one-third of Latinas do not have a regular health care provider. Latinas who cannot access important preventative care services are less likely to detect diseases at early stages. For example, the fact that almost one-third of Latinas have not had a clinical breast exam may explain why Latinas have a higher morbidity rate from breast cancer.

Immigrant Latinas have even less access to health care as result of recent changes in the Medicaid eligibility rules and the lack of employer-based health insurance in industries that employ the majority of immigrants. Approximately 56% of low-income Latina immigrants lack health insurance.

To address the crisis in health care coverage among Latinas, the following recommendations are offered:

Policy Recommendations

- Move towards universal health care by expanding health care coverage to uninsured Latinas through publicly funded programs and incentives for employer-based insurance, especially small-business owners.
- Restore federal Medicaid and SCHIP eligibility for lawfully present immigrants, protect Medicaid as a safety net program, and remove Puerto Rico from the Medicaid cap.
- Increase federal and state funding for comprehensive reproductive health care services, including health screenings for cervical and breast cancer, HIV/AIDS and STIs, and family planning and abortion access.
- Develop an Office on Latina Health within DHHS to coordinate Latina health initiatives, collect data, develop cultural competency materials and provide training and technical assistance in order to coordinate Latina health initiatives.

2 Demanding Culturally Competent and Linguistically Appropriate Services

The provision of culturally competent health care can dramatically improve health outcomes, increase levels of patient satisfaction and improve cost efficiency. The Health Resources and Services Administration (HRSA) notes that culturally competent practices enable providers to: 1) obtain more specific and complete information to make a diagnosis; 2) facilitate the development of treatment plans that are more likely to be adhered to by the patient and supported by the family; and 3) enhance overall communication and interaction between patient and provider.

A key component of providing culturally competent services is the delivery of linguistically appropriate services. In a study conducted by the Commonwealth Fund, 43% of Spanish dominant Latinos reported communication difficulties with their health providers. Another 16% of Latinos reported not following the doctor's advice simply because they did not understand it. Latino patients with language discordant doctors are more likely to omit medication, miss office appointments and rely on the emergency room for care, which often leads to poorer health outcomes. Service providers who fail to provide meaningful access to individuals with limited English proficiency (LEP) may be in violation of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.

To address the lack of culturally competent and linguistically appropriate reproductive health services, the following recommendations are offered:

Policy Recommendations

- Promote the adoption and implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards in all health care institutions.
- Increase funding to the Office of Civil Rights to provide training and technical support, and improve enforcement of Title VI of the Civil Rights Act.
- Increase the rate of federal matching funds for language services through Medicaid and SCHIP, and provide federal matching funds for language services through Medicare.
- Allocate funding to train Latina peer health educators to become qualified interpreters.

3 Ensuring Access to Family Planning and Contraceptive Equity

Latinas, who have the highest fertility and birth rates of any group, account for 18.6% of U.S. births. Approximately fifty percent of all pregnancies to Latinas, however, are unintended, and of these unintended pregnancies, half end in abortion. The 1995 National Survey of Family Growth (NSFG) indicated that only 32.7% of Latinas aged 15-44 reported visiting a family planning provider within the prior twelve month period. Furthermore, only 59% of Latinas between the ages of 22 and 44 reported using some form of contraception, highlighting the need to increase access to family planning and contraception for Latinas.

One of the options that must be made fully available to Latinas is emergency contraception (EC), especially over the counter (OTC) emergency contraception. EC can help reduce the number of abortions and sterilizations and enable Latinas to exercise a greater level of reproductive freedom.

To increase access to family planning and contraception for Latinas, the following recommendations are offered:

Policy Recommendations

- Allocate federal and state funding for the development of public education campaigns about family planning and contraception targeting both Latinas and Latinos.
- Fund initiatives to increase access to free and low cost family planning services for uninsured and underinsured Latinas.
- Ensure Medicaid coverage for emergency contraception in all states and advocate for FDA approval for OTC emergency contraception.
- Support local and statewide campaigns to fight the refusal to administer emergency contraception to sexual assault victims in religiously affiliated institutions.

4 Promoting Comprehensive Sexuality Education

Forty-five percent of Latina teens in grades 9-12 report being sexually active. It is critically important to provide sexuality education in the schools to prevent teen pregnancy and improve teen reproductive health. A study conducted by the National Campaign to Prevent Teen Pregnancy on sexuality and HIV education programs revealed that skills based sexuality education – those programs that teach contraceptive use and communications skills – are effective in helping youth delay the onset and/or frequency of sexual intercourse and the number of sexual partners while increasing the use of contraception. Yet, as of 2001, only 19 states require schools to provide sexuality education, and only 9 of those states require schools that teach abstinence to also teach about contraception. The lack of comprehensive sexuality education in the schools is particularly detrimental to Latinos given the lower rates of contraception use and higher rates of HIV/AIDS, STIs, teen pregnancy and teen birth rates among Latino teens.

To address the need for comprehensive sexuality education among Latino teens, the following recommendations are offered:

Policy Recommendations

- Support efforts to re-direct funding at the state and federal levels from abstinence-only programs to comprehensive sexuality education programs.
- Allocate funding for Spanish language parent training on teen sexuality and health in order to facilitate parent-child communication and healthy sexual development.
- Support efforts to increase funding for Latina/o peer programs on health and sexuality, including outreach and education on HIV/AIDS, STI's, teen pregnancy, sexual assault and intimate partner violence.

5 Protecting and Enhancing the Reproductive Rights of Latinas

Since 1995, the onslaught of attacks on reproductive freedom has been relentless. State legislatures have passed nearly 400 anti-choice laws, and approximately 350 anti-choice bills are currently under consideration. The Bush Administration, in particular, has sought to undermine the hard fought gains of the reproductive rights movement achieved over several decades of labor and sacrifice. Anti-choice zealots have been working especially hard to pass laws that bestow legal rights upon embryos and fetuses and to pack the bench with anti-choice judges as part of their overall campaign to overturn *Roe v. Wade*. The effect of their strategy is a continual erosion of a woman's right to choose.

Moreover, coercive, discriminatory and/or punitive policies and practices are differentially impacting Latinas and other women of color. For example, welfare family caps, prohibitions on publicly funded abortion, court mandated use of Norplant, mandatory HIV testing of pregnant women or newborns, and policies that criminalize pregnant substance users have disparately impacted women of color. While the tactics and subterfuge may vary, these policies all seek to place the locus of control for reproductive health decisions outside of Latinas' hands, thereby violating the fundamental human right to self determination and undermining the health and well-being of Latinas.

To protect and enhance the reproductive rights of Latinas, the following recommendations are offered:

Policy Recommendations

- Demand Congressional Action to repeal the Hyde Amendment.
- Support laws that protect and enhance the right of Latinas to accessible and affordable abortion services.
- Oppose the ability of states to impose family cap provisions in their welfare laws.
- Oppose the confirmation of federal judges who will not uphold the law and protect a woman's constitutional right to choose.

6 Increasing the Latina/o Health Professional Pipeline

Although Latinos account for almost 14% of the total U.S. population, they comprise only 4.6% of physicians in the United States. Latino representation in the field of nursing is even smaller (2.4%), and Latinos account for only 2.8% of pharmacists. Although more people of color applied to medical school in 2000, fewer were accepted than in 1998 and 1999. In 2000, 17,546 of the 37,137 minority applicants were accepted to medical school, and only 545 of those accepted identified as either Mexican-American (415) or Puerto Rican (130).

The recruitment of Latino health personnel is an important vehicle to increase access and quality of care for Latinas. Latino health personnel are more likely to be able to bridge the language gap that often deters Latinos from seeking prompt care or interferes with the patients' ability to understand and follow through on health care instructions. Latino health professionals are also more likely to understand cultural belief systems and to work within this context to support health promotion, disease prevention and early medical intervention when needed.

To increase the number of Latina/o health and allied health professionals, the following recommendations are offered:

Policy Recommendations

- Support efforts to create federal and state funded scholarships, tuition reimbursement and loan forgiveness programs, and other incentives aimed at increasing the number of Latinas/os in medicine, health and the sciences.
- Support efforts to fund health career mentoring programs for Latina/o youth in order to develop a larger cadre of future Latino health professionals.
- Support efforts by the Health Careers Opportunity Program, Hispanic Centers of Excellence, and the Agency for Healthcare Research and Quality to expand the pool of Latino health researchers.

7 Generating Accurate and Unbiased Research

Behavioral and biomedical research plays a powerful role in shaping health care delivery and public health policies that affect Latinas, their families and communities. The National Institutes of Health recognizes that research provides the scientific basis and legitimacy necessary to support efforts aimed at: improving standards of care, formulating better public health policy, changing individuals' health related behaviors, improving health care delivery systems and creating strategies for overcoming cultural and economic barriers to health care. In addition to research, health data collection allows for the identification of health trends in a given population so that more targeted health interventions can be utilized to ameliorate health problems.

To address the need for accurate and unbiased research on Latina reproductive health issues, the following recommendations are offered:

Policy Recommendations

- Allocate funding for a Five Year National Demonstration Project on Latina Reproductive Health that will seek to research and document new approaches and successful strategies for reducing Latina reproductive health disparities with the purpose of replicating model programs in Latino communities.
- Support efforts to increase spending on Latina/o health research from 1% to 15% of the NIH budget and hold other federal and state institutions with research divisions to the same standard.
- Support efforts by national scholarship and fellowship programs to recruit, train and retain Latina/o researchers, particularly in the areas of sexual and reproductive health.

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