

## Restricted Access

### *The Intersections of Reproductive Health, Rights and Policy for Minors and Native American Women*

*Since the landmark ruling of Roe v. Wade, some restrictions to abortion access have been upheld as constitutional by the Supreme Court of the United States. This paper focuses on the ways in which mandatory parental involvement laws and funding restrictions, such as the Hyde and Vitter Amendments, disproportionately limit access for specific women. For example, mandatory parental involvement laws specifically target young women, and the Vitter Amendment solely targets Native American women. By centering the analysis on citizenship, it is possible to examine the complex relationship between the state and women's bodies, while simultaneously underscoring the fact that not all women are treated equally under the law. Consideration of both pregnant teens' and Native women's restricted access to abortion services reveals how the reproductive rights of specific women are targeted under the current political climate, as well as the material impacts that result from the constricted access to safe and affordable reproductive healthcare. The legal right to obtain an abortion is still protected in the United States, but as the two case studies reflect, the issue at stake is not only the legality of abortion, but also importantly, equal access. Thus federal policies which limit access for only some women while leaving the access of other women essentially unrestricted (at least in terms of federal policy) serve as institutional instruments that perpetuate a system of advantages and disadvantages based on race, class, and age and further place those who are most vulnerable at risk.*

As the United States advances into the twenty-first century and a new administration enters the White House, it is essential for feminist scholars and activists to continue to extend our interrogation of the complex ways in which legal policies impact women's reproductive healthcare experiences, especially for those women whose access to particular kinds of care is strikingly restricted. A close examination of the intersections of abortion policy, race and class reveals

disproportionate access to reproductive healthcare, including access to safe and affordable abortion services and counseling, for differently located women. This article therefore examines the growing restrictions on women's access to abortion services and counseling as a form of healthcare while paying particular attention to Native American women and pregnant minors. By centering our analysis on the complex intersections among reproductive policy, citizenship, and women's bodies, this paper focuses on the ways in which mandatory parental involvement laws and funding restrictions, such as the Hyde and Vitter Amendments, disproportionately limit access for specific women.

We begin with a discussion of mandatory parental involvement laws as a form of abortion restriction, interrogating the social and political construction of teen pregnancy and the impacts of this construction on young women seeking access to abortion services. Teenaged women under 18 are legally understood to be minors, and thus are restricted from accessing certain citizenship rights available to women 18 and older. As this article reveals, parental involvement laws are enacted upon the bodies of these "minor citizens" in particular ways that increase their vulnerability while pregnant, and limit the options available to them.

The second half of this article examines the intricate matrix of gender, race, class and citizenship identities that inhibit Native American women's access to reproductive healthcare, particularly in the form of abortion. The unique set of constraints placed on Native women seeking to defer childbearing reflect larger social and political discourses around regulating women's bodies, and particularly their reproduction, while denying the intersections of violence and poverty in Native women's lives.

We conclude with a discussion of the foundational idea of citizenship as it shapes and maintains exclusionary, marginalizing practices around reproductive healthcare. Ultimately, as Lynn Staeheli and Eleonore Kofman argue, citizenship as a concept "describes the construction and meaning of political subjectivities" (2004: 7). Young women, poor women, and women of color experience these subjectivities in strikingly restrictive ways, particularly as compared to the political subjectivities experienced by white, economically privileged, and legally adult women.

Consideration of both pregnant teens' and Native women's restricted access to abortion services reveals how the reproductive rights of specific women are targeted under the current political climate, as well as the material impacts that result from the constricted access to safe and affordable reproductive healthcare. This analysis enables us to better understand the mechanisms which criminalize abortion for poor, racialized, and underage women, leaving access only for more privileged women. Federal policies which limit abortion access for only some women while leaving the access of other women essentially unrestricted (at least at the level of federal policy) serve as institutional instruments that perpetuate a system of advantages and disadvantages based on race, class, and age and further place those who are most vulnerable at risk.

### Restricting access for pregnant minors

In 1973, the Supreme Court ruled in *Roe v. Wade* that abortion is legal under the right to privacy protected by the Fourteenth Amendment. Although minors have consistently been placed within a separate category from “adults” in legal policy, *Roe v. Wade* did not maintain such categories. As a result, almost immediately following the implementation of this landmark decision, individual states began to implement parental involvement laws that required consent from, or notification of, at least one parent in order for a minor to obtain an abortion. The first state to enact a parental consent law was Missouri in 1974, and after numerous Supreme Court hearings and appeals, mandatory parental involvement laws have been deemed constitutional.

Although no state explicitly requires that a parent be notified if a pregnant teen is seeking prenatal care (Guttmacher Institute, 2008a), forty-four states in the U.S. currently have parental involvement laws for accessing abortion on their books; of these, thirty-five actually implement such laws (Guttmacher Institute, 2008b). All of these thirty-five states offer some “alternative” or “compromise,” usually in the form of judicial bypass. While the language and implementation of these laws differ by state, the judicial bypass procedure offered by most requires a young woman to appear in court for a private hearing for which she is provided with free representation. She is granted bypass if the judge feels that she is “mature” enough to have an abortion. The concept of maturity is of course ambiguous, and is ultimately left up to each individual judge to decide. Judges are not always objective, and sometimes they use the hearing as an opportunity to share their moral opposition to abortion (Silverstein, 2007).

Further complicating teenagers’ access to abortion is the ignorance of many courts concerning judicial bypass. Not every court that offers a judicial bypass provision even knows that they have that power, which speaks to the rarity of the procedure being utilized in certain regions. In a study done in Alabama, Pennsylvania and Tennessee, inquiries about accessing the judicial bypass procedure received responses similar to the following: “I don’t know, you probably need to come in. I don’t think the judge would do that.... Let me get your name and number” (Silverstein, 2007: 74). This also brings to the surface the issue of trust. A pregnant teenager who doesn’t want her parents to know she is pregnant might not feel safe confiding in a government agency, which leaves her with very few alternatives depending on her level of privilege and access. In worst case scenarios, the lack of alternatives might result in running away, suicide, getting an unsafe “back alley” abortion, or attempting a self-induced abortion that might result in death (Ehrich, 1998).

Pro-parental involvement activists argue that mandatory notification/consent laws benefit teens by requiring that parents be a part of the decision making process (see, for example, <http://www.yeson73.net>). However, studies reveal that the majority of young women already do involve their parents when making decisions regarding their reproductive health (Guttmacher In-

stitute, 2006a). The most recent estimate for the national teen pregnancy rate is seventy-five pregnancies per one thousand teens aged fifteen to nineteen. Two-thirds of these are among eighteen and nineteen year olds (Guttmacher Institute, 2006b), who are legally defined as adults and are therefore not only excluded from parental involvement laws, but may also have a different set of resources available to them than younger teens.

Therefore, laws requiring parental notification actually put vulnerable teens at risk. Many scholars suggest that parental involvement laws endanger young women whose parents are abusive and/or addicts, and jeopardize their health by delaying access to appropriate medical and legal care (see, for example, Silverstein, 2007; Henshaw and Kost, 1992). Restrictions to abortion access can negatively impact teens where incest, mistreatment, violence, or substance abuse among parents, exist in the home (NARAL, 2007; Planned Parenthood Federation of America, 2004). Moreover, the requirement of parental notification or judicial bypass slows down the process of accessing an abortion, which puts the health of the young woman at greater risk since abortions are safer the earlier they occur.

Historically, teenage pregnancy became something to regulate once it was identified as a “social problem” among policy makers and social institutions in the 1970’s (Ojeda, 2003: 64). According to mainstream American opinions today, teen pregnancy is often deemed a result of promiscuity, failure to properly take contraceptives, and an inability to control sexual urges (Luker, 1984: 171-174). Additionally, teen pregnancy is frequently framed as an economic burden to society. For example, it is claimed that early childbearing is an “epidemic” (Ward, 1995) that costs society “millions of tax dollars each year” (Ojeda, 2003: 64). In ways strikingly similar to the stigma associated with welfare mothers, teenage pregnancy is seen as a social and financial encumbrance, especially when the young woman decides to give birth and remain unmarried.

This discourse is intertwined with, and relies upon, racist and elitist stereotypes, which construct the image of the young, poor, black mother on welfare and ignore statistics that show otherwise. As Dorothy Roberts (1997) explains, “The problem of teen pregnancy, too, is intertwined with issues of race and welfare policy. Although most teen mothers are white, the teen birthrate among Blacks is more than double that among whites.... The gap, however, is rapidly narrowing.... Many Americans nevertheless see unwed teen pregnancy as a Black cultural trait that is infiltrating white America” (113). The “epidemic” of teen pregnancy is thus socially viewed through a racialized lens which, in fact, understands it as an epidemic among non-whites. In this racialized discourse, it is Black and Latina teens who are irresponsibly reproducing and relying upon public funds. This view of teen pregnancy as a social ill inserts all pregnant teens into a public discourse which homogenizes their lived experiences to reflect a social and political agenda that de-values the reproductive experiences of *some* women.

Implied in the assumptions underlying mandatory notification laws is the valorization of “family values,” in which the nuclear heterosexual family is idealized. Dorothy E. Smith (2004) describes this ideal family type as the “Standard North American Family,” “a conception of The Family as a legally married couple sharing a household” in which “(t)he adult male is in paid employment; his earnings provide the economic basis of the family-household. The adult female may also earn an income, but her primary responsibility is to the care of husband, household, and children” (159). The standardization of this family type through social, political, and legal discourse creates an ideological code which stigmatizes all “other” structures. What is not specifically noted by Smith is the racialization of the Standard North American Family in which families of color are socially and politically constructed as deviant (see, however, Smith, 2005; Neubeck and Cazenave 2001; Collins, 1999; Roberts, 1997). Clearly, unmarried teens engaging in sexual activity do not conform to the Standard North American Family ideal, and are thus deemed a ‘social problem’ situated within racist discourses that assume the majority of teen pregnancies are among young Black and Latina women (Roberts, 1997).

As Nira Yuval-Davis (1997) suggests, “racism occurs when the construction of ‘otherness’ is used in order to exclude and/or exploit the immutable ‘other’” (49). The social construction of “the pregnant teen” defies the normalized and idealized mother; the pregnant teen becomes identified as a racialized “other” who is marginalized within the legal system when she seeks abortion services. This marginalized location marks as uniformly deviant the pregnancy experiences of all teens.

For pregnant teenagers seeking an abortion, age entwines with a racialized, class discourse to produce a category that is then used to block access for the most vulnerable teens: those who do not feel safe seeking parental involvement in their reproductive health. As the following section further reveals, class is implicated in this racial discourse and combines with citizenship categories in multiple ways to prevent equal access to abortion as a form of reproductive healthcare.

### **Restricting access for Native American women**

Native American women can access healthcare services in a way glaringly dissimilar from that of any other population in the United States: their dual status as citizens of the United States and members of sovereign Native nations entitles them to healthcare through the federally funded Indian Health Service (IHS). This provision of healthcare is mandated in several ways, most notably in the treaty negotiations between the United States and Native nations throughout the eighteenth and nineteenth centuries. The legal right to access this healthcare is thus based on an exclusive formulation of what it means to be “Indian,” a formulation with historic roots in acts of separation from other U.S. citizenship categories, as many Native peoples were removed from their homelands and confined to reservations throughout the nineteenth century.

A claim to Native identity is essential in order to receive services from IHS, in every case except when a non-Native woman is carrying a Native child (in which case the non-Native woman is entitled to prenatal and neo-natal care).

Additionally, because Native people are statistically the poorest in the United States (Ogonwole, 2006), IHS is often the only way many Native Americans can access medical care, which was originally intended to be available regardless of income. Under the current IHS funding structure, however, a Native woman must apply for and utilize Medicaid if she is eligible, before she can access IHS services. Native American women are thereby formally raced and classed when they seek healthcare, including reproductive healthcare.

The Official Mission of the Indian Health Service is

to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level; to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people; (and) to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes. (U.S. Department of Health and Human Services, 2007)

While IHS exists solely for the purpose of promoting and maintaining Native health and well-being, its structural location in the United States Public Health Service renders it ultimately accountable not only to the Native nations it serves, but also to the United States Congress which determines its budget, appoints its Director, and guides the shape and form of its policies. Therefore, despite the stated objective of IHS to work with Native communities, often its decisions and policies are based on the demands of multiple constituents at the national level rather than the needs of Native people in their local communities.

The restrictions that result from structuring healthcare in this way are particularly pertinent to Native women seeking reproductive care. Control over reproductive health is removed from Native women and located in other, fractured sites; the federal government, IHS policies, even individual IHS personnel. Charon Asetoyer, Executive Director of the Native American Women's Health Education Resource Center (NAWHERC), explains that "(o)ur reproductive choices are decided . . . by the federal government through the Health and Human Services—the Indian Health Service. And it's up to them as to whether or not they want to provide various services" (Arons, 2007). This has very real material consequences for Native women seeking reproductive healthcare. For instance, IHS lists only four types of contraception under its official protocol: Depo-provera, Norplant, the pill, and sterilization (NAWHERC, 2003), thus limiting the number of options that can be accessed through their facilities. Emergency contraception is not available at IHS facilities despite the high

rates of sexual violence against Native women (NAWHERC, 2003; Smith, 2005; Asetoyer, 2008), although following the work of NAWHERC and other Native activists, condoms have been made anonymously available (Arons, 2007). Many Native activists attribute the lack of contraceptive options directly to physician preference (NAWHERC, 2003; see also Arons, 2007). Additionally, NAWHERC notes that many Native women are not fully informed by IHS personnel about their reproductive health, including the short and long term implications of contraceptive choices, sexually transmitted diseases, therapeutic treatment, and abortion (1999; see also Smith, 2005).

Prior to 2008, legal restrictions on abortion access for Native women of limited income were enacted through the Hyde Amendment just as they are for all women who rely on state and/or federally funded healthcare, such as Medicaid. The Hyde Amendment forbids the use of federal funding for abortion procedures and counseling. However, individual states can and have chosen to provide funds for abortion under a slightly broader spectrum of reasons (including cases where either the physical or mental health of the woman is threatened by the pregnancy). Therefore women relying on Medicaid may in fact have a slightly greater opportunity to access abortion services in these individual states. However, Native women who rely on IHS for their care have not even this limited flexibility. Because IHS is funded at the federal level, Native women across the United States can access abortion through IHS only under the three circumstances allowed in the most recent (1997) modification of the Hyde Amendment: rape, incest, and endangerment of the mother's life.

Native women's access to abortion services and counseling is further complicated by an additional amendment passed by the Senate in early 2008. The Vitter Amendment, attached to the *Indian Healthcare Act* of 2008, further restricts access to abortion services specifically and solely for Native American women. The Amendment has been widely critiqued by feminist and Native activists for its redundancy, as the Hyde Amendment has been effectively limiting access to abortion services for Native women since 1976 (see, for instance, Planned Parenthood, 2004; Lillis, 2008; Chen, 2008; NIHB, 2008; also Asetoyer, 2008).

However, there are important differences. While the Hyde Amendment works in similar ways for economically limited women across the country, the reliance of Native women on IHS for their healthcare enforces an additional set of restrictions based on race and citizenship status; as Asetoyer notes, "(i)t's a very racist amendment ... it puts another layer of restrictions on the only race of people whose health care is governed by the federal government. All women are subject to the Hyde Amendment, so why would they put another set of conditions on us?" (Lillis, 2008). The Hyde Amendment must be renewed by Congress every year, often after significant debate (although it has never failed to renew); however, the Vitter Amendment renders funding restrictions permanent to Indian Health Service. Additionally, while both Amendments

make allowances for survivors of incest and rape, the Vitter Amendment limits these allowances to minors. The Vitter Amendment is also more expansive than the Hyde Amendment in that it applies not only to the use of federal funds, but also limits how individual Tribal Nations can use IHS funds to support the purchase of private health insurance. In this sense, the Vitter Amendment conflates a particular citizenship category with economic class to exclude Native American women on the basis of race.

Asetoyer asserts, however, that despite the difficulties, “Native women have abortions ... and anyone who tells you differently is out of touch with their community” (Lillis, 2008). In fact, according to the South Dakota Department of Health, in 2000 10.6 percent of abortions sought through non-IHS providers were sought by Native women (cited in NAWHERC 2002). Only 8.3 percent of the state’s residents are Native (U.S. Census Bureau, 2000), indicating a relatively high incidence of abortion among Native women. Yet none of the abortions were performed through IHS; virtually all were performed outside of IHS’s own or contracted facilities (NAWHERC 2002).

According to NAWHERC (2003) and Asetoyer (2008), many of the Native women who seek abortion services outside of IHS do so later in their pregnancies, due to many reasons including shame, lack of information, and lack of funds. Seeking abortion services or counseling outside of IHS requires Native women to step outside of the healthcare system that has been legally guaranteed them through their unique relationship with the federal government, and with which they may have the most familiarity and readiest access. Stepping outside of this institutional relationship also requires the resources to negotiate class and economic structures that restrict Native women’s access to private funding. Thus for Native women, access to abortion services becomes not a private decision between a woman and her doctor (as intended for women citizens of the United States in *Roe v. Wade*) but rather a very public negotiation between a Native woman and the Federal government.

Native women are thereby inserted into a public discourse similar to that which shapes the experiences of pregnant teens. Like pregnant teens, Native women’s full citizenship rights are abridged by political and social assumptions about the Standard North American Family (Smith, 2004), a racialized, heteronormative, and classed ideal which exists in opposition to the racialized lives of economically disadvantaged “others.” The numerous policies, Supreme Court decisions, and legislative acts that define Native identity as something essentially different from idealized U.S. citizenship categories further maintain the normal/other binary that is inherently linked to the restrictive economic structures under which the majority of Native people live, and which circumscribe Native women’s ability to access healthcare outside of the IHS system. Thus, similarly to pregnant minors, Native women are positioned within a complex social, political, and economic location, and consequently seek reproductive healthcare at the intersection of federal policies based on social constructs which ultimately restrict the type of care they can receive as women.



## Conclusion

The intersection of federal policies with social constructions of race, class, and gender within the context of the United States reveal exclusionary practices that target individuals constructed as “other” in order to reproduce the image of the ideal family (Roberts, 1997; Ordover, 2003; Collins, 2000). At the foundation of this systemic targeting is the idea of citizenship. Citizenship, generally speaking, is usually thought of as a relationship between an individual and a nation state that consists of rights and responsibilities (Marshall, 1964; Cantu, 2009). Although citizenship is frequently thought of in relation to foreign versus not foreign constructs, the lived experiences of citizenship are much more complex and very much gendered, raced, and classed (Cantu, 2009), and therefore directly related to sexuality. Citizenship is thus a systemic identity that exists within “relations of ruling” (Smith, 1990) and enacts social regulation, while simultaneously producing knowledge constructions that perpetuate power relations.

In considering abortion restrictions, it is therefore necessary to examine the relationship between women and the state. As many feminist theorists have suggested, the state is an inherently patriarchal institution (Abromovitz, 1996), and the very construction of the state is directly connected to the reproductive roles of women (Yuval-Davis, 1997). This in turn influences and defines the ways in which women are perceived and valued within a given nation. They become the “bearers of the collective” and the reproducers of “people power” (Yuval-Davis, 1997: 27-29). However, race, age, and class mediate the relationship that women have with the state in accordance with state interests. Therefore, the idea of “motherhood” is of particular interest to the state and is socially constructed in terms of what is deemed as good or bad. This evaluation of worthiness has differential material consequences for women’s access to reproductive healthcare, as revealed by this examination of pregnant teenagers and Native American women.

As we consider the meaning of twenty-first century citizenship in the United States, it is imperative that we explicitly consider the implications and consequences for women’s reproductive lives. The granting of full citizenship rights must no longer rely on gendered, racialized, aged and classed constructs which limit access to reproductive healthcare for certain categories of women. While this analysis has focused specifically on abortion as one aspect of reproductive health, policy makers and legislators can no longer be allowed to pretend that full and equal access to reproductive healthcare can be extricated from the complexities of women’s lives, which are multipliciously and simultaneously socially and politically bounded and include the material consequences of ideological constructions of race, class, gender, and sexuality. As feminist scholars and activists continue to interrogate these consequences, it is imperative that we concurrently insist on a continuing public dialogue that explicitly acknowledges women’s multiple locations and needs. All women must be guaranteed truly equal and unrestricted access to the complete range

of reproductive healthcare, including but never limited to the right to abortion services and counseling on demand.

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