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Preterm Premature Rupture of the Membranes (PPROM), Pregnancy Loss, and the Choice of Motherhood

Preterm premature rupture of the membranes (or preterm prelabour rupture of the membranes, PPROM) refers to the amniotic sac breakage of a pregnant woman before the gestational week of thirty-seven. It serves as the major cause of fetal and neonatal complications despite recent medical advances. This article argues that PPROM, which has almost exclusively been discussed in the medical community, should be examined as an important topic of reproductive justice and motherhood studies. In doing so, it reveals that PPROM has been overlooked in feminist conversations because of its marginalized status at the intersection of class and race, the lack of reliable resources, the successful birth of a child as the social norm, and the possible affirmation of fetal personhood if loss is involved. This article argues for the concept of "relational choice" to process PPROM-affected women's experience of loss beyond the limited boundary of fetal viability. Based on the considerations to validate women's experience of pregnancy loss, the "relational choice" perspective combines choice feminism, which enables pregnant women to take a stance through ambiguous boundaries, with relational autonomy, which acknowledges the multiple ways social forces influence individual agency. The relational choice model offers a way for women to interpret the unique meaning of pregnancy loss to each woman and choose to recognize themselves as mothers while they challenge the various social issues around PPROM and pregnancy loss. Overall, this article advocates for women's agency during and after pregnancy and the active inclusion of PPROM within feminist discourses.

PPROM (preterm premature rupture of the membranes in the United States [US] or preterm prelabour rupture of the membranes in the United Kingdom and Canada) refers to the symptom of a pregnant body's amniotic sac breaking and leaking fluid prematurely before the gestational age of thirty-seven weeks.

Although PPROM complicates about 30 to 40 per cent of preterm births in the US (Feduniw et al.), PPROM discussions are almost exclusively produced in the medical community.

Advances in the medical sciences have greatly increased the survival rates of infants affected by PPROM for the past few decades. However, many preterm births caused by PPROM still result in a negative prognosis; it is a major contributor to perinatal morbidity and mortality (Borna et al). Perinatal mortality, largely defined as fetal demise during the gestational weeks of twenty to twenty-eight or infant death that occurs around seven to twenty-eight days (Barfield et al.), blurs the notion of fetal viability when PPROM causes it. Although fetal viability as a legal concept was an important point of consideration to construct a time frame for *Roe v. Wade*, the US Supreme Court deliberately does not specify a certain gestational week for fetal viability; viability is a matter of medical judgment (Romanis). It is generally assumed that a fetus can be viable from twenty-three to twenty-four weeks with contemporary medical intervention. However, medical studies still show varied results of PPROM-affected fetus survival around twenty-two to twenty-four weeks (Lorthe et al.; González-Mesa et al.; Qattea et al.), demonstrating that fetal viability is a fluid concept further complicated by PPROM.

Moreover, PPROM significantly affects pregnant women's perception of motherhood. Sarah Earle et al. point out that most pregnancy discourses focus on positive outcomes and rarely acknowledge losses (259). Since many preterm births caused by PPROM result in perinatal morbidity or mortality, pregnant women who experience PPROM are isolated from these dominant discourses. When pregnancy loss is involved, the uncertainty of fetal viability at the time of delivery confuses them in processing their experience. Understanding the pregnancy loss as the loss of a viable fetus—a baby loss—without careful consideration risks affirming the antiabortion rhetoric of fetal personhood. However, accepting the loss of a nonviable fetus—a nonloss, as there was no baby—not only detaches pregnant women from their lived experience but reiterates the common medical and social response of brushing the experience off and saying, "Never mind—better luck next time" (Letherby 165). Lost in these two options, pregnant women who are diagnosed with PPROM and experience pregnancy loss are marked as the other in m/others or simply as nonmothers.

Based on this context and my personal experience, I argue that PPROM is an important issue of reproductive justice and motherhood studies and reveal that PPROM is situated at the intersection of gender, class, and race. From a feminist perspective, I also reclaim the rhetoric of choice within the context of choice feminism and relational autonomy and argue for the concept of "relational choice" to validate pregnant women's experience of PPROM and their perception of motherhood. In doing so, I share my own experience of PPROM and the subsequent pregnancy loss as an example and evidence to my argument. Studies on motherhood and pregnancy loss are often inseparable from the researchers' firsthand experience; in this sense, sharing one's personal experience can serve as a political act of speaking up and making the underexplored topic of PPROM visible.

The Marginalization of PPROM and PPROM-Affected Women's Experience

PPROM covers various issues in reproductive justice and motherhood studies. When pregnant women experience PPROM, considering their gestational week and the physical and physiological conditions, medical professionals suggest termination of pregnancy or expectant management (i.e., the close monitoring of a patient's condition without treatment until symptoms change) that involves bed rest. Sometimes, women request expectant management even though their medical team suggests abortion; if they cannot afford to stay in the hospital for a prolonged period, they are advised to pursue expectant management at home. PPROM, as such, encompasses issues in the definition of fetal viability, the right to continue or terminate pregnancy, miscarriage, stillbirth (pregnancy loss after twenty to twenty-eight gestational weeks), access to healthcare, and the emotional wellbeing of pregnant women during and after their pregnancy.

Nevertheless, PPROM is almost entirely discussed in the medical domain, except for a few private awareness organizations and social media pages founded by those who experienced PPROM. One main reason for this underexplored area comes from its rarity. Multiple medical sources indicate that PPROM complicates about 1 to 3 per cent of pregnancies in the US (about 150,000 pregnancies each year) and that it occurs more frequently among African Americans and people of low socioeconomic status, as well as among people in developing countries (Jazayeri; Dayal and Hong; Abebe et al.). These studies particularly demonstrate that the environmental conditions—that is, a matter of social status—in which pregnant women live are an important factor of PPROM. At the same time, they also demonstrate that most PPROM-affected women are marginalized by social class and race in addition to gender. It is common knowledge that most clinical research in the West is conducted for and around white middle-class males and that even in maternity care, more patients of colour report discrimination or mistreatment than their white counterparts (Jacewicz; Mohamoud et al.). PPROM, then, is isolated from the major discourses in reproductive justice and motherhood studies not only because it is a rare condition but also because it is a marginal issue at the intersection of class and race.

The marginalization of PPROM is problematic as PPROM-affected women can easily be confused regarding their treatment plans. The internet has made many online resources available for different health conditions, including PPROM, but these sources vary widely in terms of accuracy, quality, readability, and credibility. Indeed, in a 2023 study, Megan Hall et al. analyze information on PPROM online and reveal that most online resources discussing PPROM are either inaccurate or inaccessible to most readers (1300). Even in the case of medical journal articles that are fairly accessible to college-educated nonprofessional readers, the results of these articles vary because of the nature of clinical research and thus further confuse the readers to discern which study they may refer to for their situations. The lack of credible and accessible information on PPROM hinders pregnant women from making informed decisions in seeking suitable post-PPROM treatments, eventually rendering them feeling lost and isolated.

I had PPROM at the gestational week of twenty-one and lost all my amniotic fluid. When I was admitted to the hospital, my obstetricians (OB) told me that they would not take any action because I would deliver in two days. When I did not go into labour after two days, both my OB and maternal-fetal medicine (MFM) teams suggested an abortion because the fetus would have no chance to survive outside the womb at twenty-one weeks. I thought about the time when I lost a significant amount of amniotic fluid in week fourteen. My doctors did not discuss PPROM back then, although in retrospect, it could have been the first sign of PPROM, according to one of my MFM doctors. No matter what it was, there was just enough water, and the fetus was fine. I was discharged from the emergency room that day. I hopefully believed the same thing could happen: It was fine at week fourteen, so it could be fine this time, too. However, my medical team did not tell me of an alternative to an abortion. I desperately sought a second opinion, talking to a family member who was a medical professional from another hospital and reading about other PPROM cases on social media with positive outcomes (newborns with fairly treatable health conditions), and based on the information I acquired from these sources, I demanded antibiotic treatment and expectant management. I did not request these based on the belief that I had full control over my body—what Linda L. Layne would call a “side effect” of the women’s health movement, an idea I will explain below. I was hopeful but realistic as well, and I knew I could control only a few things. I just thought that even if the fetus would have to go eventually, I should have the right to request some medical attention from my doctors to prolong my pregnancy and see what could happen. At least I was fortunate to have an insurance plan that would cover most of the expenses for what was going to be a long hospital stay.

During the four weeks of my bed rest, one of the MFM doctors gave me a copy of a medical journal article about the negative prognosis of periviable

PPROM (between twenty-two and twenty-six weeks of gestation) and encouraged me to read more about it. I found more journal articles about PPROM online and kept reading them, but they often seemed to be irrelevant to a common reader like me. Some articles were published decades ago, and many articles were based on international research. I was not able to tell what articles would best explain my situation. I felt isolated and marginalized in my hospital room, listening to the newborns crying outside in the Labour and Delivery Department, just like when Layne remembers her miscarriage: "I remember thinking at the time that it wasn't fair that the women who got the babies were also those who got all the support and attention" ("Breaking the Silence" 293). I was told that my OB and MFM teams had different opinions about administering more antibiotics to me. When the fetus showed intrauterine growth restriction (IUGR) at twenty-four weeks, they also had different opinions over fetal heart monitoring: My OB doctors wanted to avoid an unnecessary cesarean section to minimize the harm to my pregnant body, whereas the MFM team wanted to take any necessary measures for the fetus in the slim chance it survives. I was lost between these two opinions, with no reliable resources to help me understand the situation more clearly. In the meantime, the fetus's heart eventually stopped at week twenty-five, and I was induced. As my nurses put it, the decision was made by the fetus while I was lost and unable to make an informed decision for my own body.

When I came home from the hospital, no one mentioned the pregnancy loss to me. I tried to take it as a thoughtful gesture to give me enough time to process, but I found it disappointing when my family looked noticeably uncomfortable talking about my pregnancy loss. Some outright told me to stop thinking about the loss and move on. Most of my colleagues and other people around me acted as if nothing had happened. When I saw my OB doctors after a few weeks, they reassured me the fetus had no chance of living even with an emergency cesarean section and that I should focus on recovering and trying again. The more I was silenced, however, the more I wanted to share my experience. I decided to share my experience with some of my friends, and when I did, a surprising number of them shared various experiences of pregnancy loss.

Another reason for the marginalization of PPROM comes from the stigma attached to pregnancy loss. Many narratives of pregnancy loss explore pregnant women's experience of loss being made taboo and silenced, although they later realize the commonness of their experience. Masha Sukovic and Margie Serrato explain that their miscarriages were "akin to experiencing a stigmatized illness" (21). They later shared their experience and learned that many people had similar experiences; they had to go through a long time of feeling shameful and guilty because "uncomplicated fertility and natural motherhood are not just expected but taken for granted, and are often perceived as the norm rather than the fortunate exception" (25). Pregnancy loss as a stigmatized illness demonstrates once again that only the successful delivery of a healthy child is considered as the dominant view in pregnancy discourses. Layne argues this dominant discourse is rooted in the culture of meritocracy that promotes individual control. According to Layne, although biomedical obstetrics and the women's health movement since the 1960s have brought about significant medical advances and self-awareness of the female body, they also created the idea that pregnancy and childbirth are something pregnant women can control when most issues in pregnancy and pregnancy complications are uncontrollable. This idea, in turn, portrays successful childbirth as the norm, a "natural womanly talent" ("Unhappy Endings" 1888–89). More problematically, it reinforces the neoliberal rhetoric that individual control is a self-conscious and neutral decision unaffected by any surrounding influences. This neoliberal rhetoric is even more problematic in the case of PPROM, since it disproportionately affects people of colour with lower socioeconomic status.

What is equally problematic is that the emotions of pregnant women experiencing pregnancy loss are not properly addressed or acknowledged. In the medical professionals' eyes, most pregnancy losses are relatively unimportant medical events, as they are natural reactions of the body and are not evidence of any pathological issues (Layne, "Breaking the Silence" 292). That is, these women at the risk of pregnancy loss are not sick—they will be physically fine once the fetus is removed. They are neither patients nor mothers to these professionals, and with the stigma of pregnancy loss, their emotions are largely ignored by the people around them. In the case of early miscarriage, the social lack of awareness of its emotional aspect is even more serious because the fetus is not pronounced. Marie Allen and Shelly Marks explain that there used to be a clear distinction between miscarriage as the "loss of a dream" and stillbirth as the "death of a baby," at least until the 1980s (3). In a more recent narrative, Nancy Gerber recollects a similarly frustrating experience of being told that miscarriage is not the loss of a baby—it is the "loss of a nameless, formless mass that would never grow into a living being" (49). Regardless of what trimester the loss has occurred, however, the once-pregnant women who lost their pregnancy are collectively put in an ambiguous space of motherhood and deemed a nonmother or the other in m/others because the once-expected child is not present. As such, pregnant women who experience PPROM and the subsequent pregnancy loss are multiplicatively marginalized by the intersection of class, race, and gender, the lack of reliable resources, the stigmatized feelings they have lost control over their bodies, and the surrounding environment in which their emotions are not validated or welcome to be shared.

The Choice of Motherhood for PPROM-Affected Women Who Experience Pregnancy Loss

The real emotional struggle and confusion did not come from sharing my experience with others; they came from interpreting the experience for myself. I went through the same frustrating course of processing my experience as many other feminists did. Just like Kate Parsons, I used to draw strict and clear lines among an embryo, a fetus, and a baby. An embryo and a fetus are not viable, and a fetus should only be recognized as a baby outside the womb, breathing and crying. I even called my embryo the "lump of cells" in the first trimester because the embryo at that point was exactly what it was—a lump of cells. Now, my pregnancy loss has complicated my beliefs and practices. If it was not something of value (an actual baby), what did I lose? Why am I grieving? The fetus I had passed at the gestational week of twenty-five, when it was supposed to be viable. Can I grieve the loss, then, because it was viable? However, the fetus was nonviable because it was having IUGR after my PPROM. Should I not grieve its loss because it was nonviable? Had I had an abortion following my doctors' suggestion, would I not have been allowed to grieve my loss because I decided to terminate my pregnancy? Does this mean that those who had an abortion cannot grieve their loss because they chose to terminate their pregnancy for whatever reason? Does this mean that only those who had a stillbirth at the point of "clear" fetal viability—if there is such a thing, since the fetus's heart can stop at any point—can grieve? This section examines the problems of grieving and accepting motherhood in the case of PPROM-related pregnancy loss and finds an answer to these questions in the model of relational choice.

Layne argues that feminists have carefully disregarded discussions on pregnancy loss: "Because anti-abortion activists base their argument on the presence of fetal, and even more important, embryonic personhood, feminists have studiously avoided anything that might imply or concede such a presence" (*Motherhood Lost* 240). That is, the idea of fetal viability, which largely overlaps with the issues in pregnancy loss, has been deliberately silenced in feminist discourses because it risks being oversimplified as "fetal personhood" and then "life" in the moral and religious senses by antiabortionists—although in reality, as explained above, fetal viability is a fluid and ambiguous concept both in legal and medical domains. Nevertheless, Layne explains that an anthropologically informed view of cultural personhood can reconsider embryonic/fetal personhood beyond the antiabortionist view. According to Layne's model of cultural personhood, pregnant women can establish a social relationship with a desired child during their pregnancy. This model also explains the processing of loss from nonembryonic pregnancies, such as anembryonic pregnancy (i.e., a fertilized egg not developing into an embryo) and molar pregnancy (i.e., the formation of tumours in the uterus) because a protoperson has been expected and can be mourned even if an embryo has never existed in the first place (*Motherhood Lost* 240).

Developing Layne's idea further and briefly drawing upon French feminists and posthumanism, Parsons suggests a relational model in processing pregnancy loss. The relational model of pregnancy loss is based on the premise that personhood is not an abstract and absolute concept but a social category (12). According to Parsons, pregnant women are interrelated to their embryos and fetuses on a physical level while they are separable at the same time, and this interrelatability and severability enables individual women to give meaning to their relationships to their embryos and fetuses. When pregnant women lose their pregnancy, the loss serves as an emotionally significant event as they lose both their embryonic/fetal tissue and other parts of their bodies (such as blood and tissue) as "developing beings" together (12–15). Although Parsons takes a reserved approach not to use the term "baby" to refer to the lost embryos and fetuses, her relational model offers another tool for pregnant women to acknowledge their different emotions resulting from pregnancy loss as they interpret their experience.

Building upon these two models, I borrow the rhetoric of choice and reclaim it as an effective way to process pregnancy loss, especially when PPROM is involved. To be more specific, I situate the word within the contexts of choice feminism and relational autonomy to develop my idea of "relational choice" and argue that it is up to the pregnant women to choose how to make sense of their experiences of loss. As Layne discusses, the topic of pregnancy loss has been avoided in US feminist discourses because of the choice vs. life dichotomy generated and intensified after *Roe v. Wade*. Scholars have noted that the word "choice" in this framework is highly influential for activism (i.e., "My body, my choice"), but it problematically carries the negative connotations of "individual decision" in the neoliberal sense; in fact, I have argued in my previous work that feminists should move beyond the rhetoric of choice and see the overarching biopolitical ideology regulating the female body. Nevertheless, years later, in this article, I argue that the word "choice" still holds powerful meaning, as the rhetoric is easy to use and understand in interpreting pregnancy loss; now that *Roe v. Wade* has been overturned, I also believe reclaiming choice for the discussion of pregnancy loss is imperative.

"Choice feminism" is a term coined by Linda Hirshman in 2006. Embracing self-determination and respecting individual women's choices, the term celebrates individualism as a source of empowerment. Scholars have criticized it for being a form of neoliberal feminism—that is, it does not take the social, economic, and cultural structures that affect individual women into account and reduces these forces into individual concerns (Budgeon 304). However, Claire Snyder-Hall argues in support of choice feminism that it can be an important tool to "determine [individual women's] own path through contradictory discourses" among diverse and intersectional identities or experiences (259). In other words, choice feminism's commitment to pluralism welcomes all women's choices specifically placed within ambiguous or contradictory boundaries. In the context of processing PPROM-affected pregnancy loss, choice feminism opens up the possibility for all women to choose what their loss or lost embryo and fetus means to each woman without accepting fetal personhood as life, particularly because the boundary between the pregnant women and the fetus is fluid and the concept of fetal viability is ambiguous.

Additionally, choice feminism combined with the feminist philosophy of relational autonomy can effectively separate itself from the neoliberal rhetoric of choice. Catriona Mackenzie defines relational autonomy as a perspective that understands autonomy "through the lens of feminist work on social groups and social oppression" and "brings into focus the importance of developing concepts of autonomy that are sensitive to considerations of social justice" (146). Fully examining the various means that social forces influence individual agency, relational autonomy differs from the neoliberal model of the "maximal choice conception of autonomy" that promotes consumer sovereignty and noninterference from the state entities (146). Relational autonomy considers autonomy as both status (i.e., exercising self-determining authority over their lives) and capacity (i.e., making decisions and acting based on one's values) (147); in the context of pregnancy loss, autonomy as status explains the women's right to understand what their pregnancy loss means to them without being affected by outside influences, whereas autonomy as capacity explains their right to accept, express, and share their emotions with others if they choose to do so. Mackenzie further elucidates that relational autonomy "[draws] attention to … a wide range of emotional, imaginative and critically reflective skills, such as capacities to interpret and regulate one's own emotions, to imaginatively envisage alternative ways of acting, and to challenge social norms and values" (149). In other words, women can choose to process their emotions and the meaning of their loss in the manner that is suitable for them while they can also criticize the stigma of pregnancy loss. The pregnant women who experience PPROM and the subsequent pregnancy loss can likewise recognize the ways that PPROM is marginalized and their loss is silenced as important issues in feminist discourses.

Compared to Layne's cultural personhood that centres upon the formation of a social relationship with the embryo and fetus as the once-expected child and Parsons's relational pregnancy loss that revolves around the personal relationship between the pregnant women and the embryo and fetus during and after the pregnancy, the model of relational choice focusses on the women's agency and their active interpretation of what to make of their pregnancy loss while they recognize and even challenge social conventions and systems. The individual meaning of what these women have lost from their pregnancy does not need to align with the blurry definitions of fetal viability in the legal, medical, moral, or religious senses. Relational choice also significantly refuses the hierarchy between miscarriage and stillbirth and embraces the women's right to grieve after an abortion. Whether the loss was from a miscarriage or a stillbirth, whether an embryo existed or not, or whether the loss was caused by an abortion or a miscarriage, the experience of loss is unique to each woman. These women define what the loss was—if they have lost a "lump of cells" or a baby, or if they wanted to lose it in the first place or not—and they may perceive themselves as mothers if they choose to do so.

As the "lump of cells" embryonic stage was over, my partner and I started to think about a nickname for the fetus. It was not meant to be a real name but a fetal nickname. Giving the fetus a nickname has become a popular custom in South Korea since the new millennium. Although Hui-suk Kang argues that fetal nicknaming demonstrates Korean people's perception of fetus as lives with personality (33), the fact that fetal nicknames are informal and almost always never resemble real human names was a more interesting and appealing point to me; fetal nicknaming seemed to me that instead of accepting fetal "life," Korean people would rather ambiguously recognize the fetus as something that was not a human being yet but could develop into one after a while. We decided to call the fetus "Huckleberry" after our summer trip to Montana.

When I was admitted to the hospital, I thought if Huckleberry could survive PPROM, I would name him Phoenix. He did not survive, however, and was recorded as "Huckleberry" on his death certificate. I learned later that issuing death certificates in the case of stillbirth was a relatively new practice in the US and that there was no proof of the loss given to the once-pregnant women before (Cacciatore and Bushfield 379); it was as if these women were coerced into believing that nothing had happened. After I decided to write about PPROM, I learned more frustrating facts in the process of research. For one thing, there is a higher risk of recurrence after the first PPROM (Heyden et al.). For another, pregnant women who experience loss from PPROM and other complications suffer from posttraumatic stress disorder (PTSD) symptoms, including avoidance, hyperarousal, and fear of reexperiencing the complications (Stramrood et al.; Schwerdtfeger and Shreffler). The PTSD related to pregnancy loss is often resolved after the birth of a healthy baby (Turton et al.); if these women remain involuntarily childless after their loss, it is reported that they can suffer from PTSD for a prolonged period of seven years (Schwerdtfeger and Shreffler). Nevertheless, on a more positive note, I also learned that the legal community had been working to expand on the meaning of reproductive justice–based rights to include miscarriage and stillbirth and protect pregnant women's rights to appropriate prenatal preventive care, the choice of treatment options, and the claim of motherhood in the case of loss (Lens 1059).

These studies reflect my own experience, as I was afraid of getting pregnant again for fear of experiencing another PPROM. I had never realized just how many television commercials painfully portrayed normal or normative pregnancy and childbirth before I experienced PPROM. I even had to change the channel whenever a sick child was shown on television for a while. It took a time of deliberation and consideration until I decided to take Huckleberry as my baby, my first son. I have not yet dared to look at the reminders of Huckleberry—the blanket that had covered him right after he was taken out of my body and his death certificate—even after two years, but it does not matter as I have already decided how I should interpret my loss. Whether I have physical reminders or not, whether my family and friends acknowledge Huckleberry as my baby or not, I can choose to remember him as my baby and myself as his mother. It is not because Huckleberry was viable in the legal and medical senses or because his was a life in the moral and religious senses, but because he is our first son to my partner and me.

Conclusion

About a month before this article was accepted by the *Journal of the Motherhood Initiative*, I gave birth to a healthy baby without having another PPROM. My pregnancy loss-related concerns, which I had for the whole period of pregnancy, have largely been resolved with this delivery; the aftermath of PPROM as I experience it, however, is more long-lasting than what studies suggest. The problematic normativity of many television commercials in which heterosexual couples easily establish nuclear families still stands out to me; I now process news of disasters and untimely deaths with more difficulty than before. Ironically, it is the act of remembering the commonness of pregnancy loss—knowing that the loss is as natural as childbirth and that I am not alone on this issue—that has significantly relieved my anxiety over another pregnancy and general uncertainty in life. To properly address and acknowledge women's experiences of PPROM and pregnancy loss-related PTSD, more social awareness of pregnancy complications as common incidents and the changes in the perception of pregnancy loss are essential.

PPROM is indeed more commonly felt than what the incidence rate may indicate. Two weeks into my hospitalization, another patient was admitted to the Labour and Delivery Department with symptoms of second trimester PPROM, just like me. She was also of South Korean descent. I tried to connect with her, but she and I were never able to meet as I was discharged two weeks later. Although PPROM only complicates about 1 to 3 per cent of pregnancies in the US each year, that is 150,000 pregnant women. Based on where I live, New Jersey (the most densely populated state in the US), that number is as big as its third most populated city in 2023. It is not just a coincidence to have another patient with PPROM in the same hospital. Ultimately, my lived experience reiterates why it is crucial to consider PPROM as an important issue of reproductive justice and motherhood studies and to advocate for women's relational choice in processing their pregnancy loss: these 150,000 women in the US should not feel isolated or marginalized anymore.

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