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# The War on Drugs and the War on Abortion: Some Initial Thoughts on the Connections, Intersections and Effects <sup>☆</sup>

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**Abstract** While many people view the war on abortion and the war on drugs on the part of state and federal governments in the USA as distinct, there are in fact many connections and a great deal of overlap between the two. Their histories, the strategies used to control and punish certain reproductive choices and those to control the use of certain drugs, the limitations that are placed on access to abortion and other reproductive health care and drug treatment, and the populations most harmed by those limitations are remarkably similar. These similarities are particularly apparent where the issues coalesce in the regulation and punishment of pregnant, drug-using women [1]. Efforts to control reproduction and drugs are rooted in forms of bigotry and prejudice that are essentially the same; African-American women are particularly harmed by them [2]. These efforts reflect a common political agenda and draw attention away from real underlying issues, including poverty, race discrimination and lack of a coherent national health care policy. Those who fight against each of them must recognize that they have a common cause and need a comprehensive strategy to address both as fundamental issues of social justice. © 2001 Southern University Law Review. Published by Elsevier Science on behalf of Reproductive Health Matters.

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**T**HROUGHOUT history, women have sought to control their reproduction regardless of cultural, religious or family proscriptions against contraception, abortion and childbearing [3]. Similarly, people have always sought to alter their state of consciousness through a wide range of mind-altering experiences and drugs, some of them associated with religious rites [4]. Thus, a primary connection between the two subjects is that both relate to what people do and have always done, with or to their own bodies, even in the face of severe restrictions. This similarity, and the others discussed in this article are initial observations

intended to stimulate further exploration and discussion.

Other similarities include the fact that both reflect the extremes of the human experience. On the one hand, sex and drugs can give people mind expanding, life affirming, ecstatic experiences [5]. Each, however, can be associated with violence, abuse, and despair. A woman's relationship to her sexuality and her ability to reproduce may be affected deeply and permanently by experiences of incest, molestation and rape, all far too common in the lives of American women [6]. Similarly, for those who turn to drugs to numb the pain of such experiences [7], drug use frequently becomes chaotic, dangerous and out of control [8]. Thus, efforts to address sexuality, reproduction and drug use all require responses that take into account an extremely broad range of experience and the disparate needs that emerge from that experience.

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## Prohibition: justifying control and punishment

Both abortion and certain drugs have been outlawed at various times in American history. Yet women continue to have abortions and people continue to use those drugs that have been outlawed. The criminalization of these activities results in flourishing illegal markets, and a deeply ingrained cynicism toward the government authority that attempts to enforce the law.

Control of both reproduction and drug use have been justified by various forms of stigma and prejudice, including but not limited to those based on race, ethnicity, and gender. For example, abortion became illegal in the USA in part based on appeals to xenophobia and nativism [9]. As Carole Joffe summarizes:

*“The drive to criminalize abortion, which started in mid-[19th] century and peaked by the early 1880s, when all the states had enacted anti-abortion statutes, stemmed from a variety of motivations, including societal anxiety about the declining birth rates of Anglo-Saxon women in comparison to those of newly arriving immigrants.”* [10]

Similarly, efforts to sterilize certain populations have been justified by various forms of stigma and prejudice, including but not limited to those based on class and race [11]. With respect to laws aimed at drug use, they too have been based on appeals to racist fears, in many instances unambiguously so:

*“... Racism was called into play at the end of the 19th century. Among other things, the notion that using cocaine would heighten the desire of black men to rape white women was widely proclaimed. The same was held to be true with regard to the use of opium by Chinese men. Despite the fact that, at the time, the majority of addicts were actually those white housewives hooked on patent medicines.”* [12]

Original efforts to outlaw abortion were led by physicians of the newly formed American Medical Association who wanted to establish their professional status by taking “control [of] the terms under which ‘approved’ abortions were performed” [13]. By taking abortion out of the control of women and away from the physicians’ business competitors

– healers, homeopaths and midwives – doctors could monopolize this area of medical practice. Among the arguments the doctors used to justify this campaign was that abortion represented a threat to male authority over women. Carrying these views forward, doctors in the 1930s claimed that “if women know they can destroy the fetus very easily, they become lax in their sexual morals” [14].

Similarly, assertions that white women would be raped by men of color on drugs perpetuated racist views of men of color, mythologized the effect that certain drugs have and simultaneously portrayed white women as vulnerable and in need of protection. In addition, drug policy itself has been used to reinforce stereotypes about different groups of women. The control of both drug use and reproduction have thus been justified by resort to popular prejudices and particular fears about certain populations and in turn used to reinforce deeply embedded stereotypes about those populations.

## Controlling speech about drugs and reproduction

Indirect methods of control, including restrictions on free speech concerning the beneficial uses of contraception, abortion and those drugs deemed illegal are also remarkably similar. In 1873, the Comstock law labelled advice on contraception and abortion “obscene, lewd, lascivious, and filthy” [15]. Among other things, this law made it a crime to transport by public mail material about:

*“... every obscene, lewd, or lascivious, and every filthy book, pamphlet, picture, paper, letter, writing, print, or other publication of an indecent character, and every article or thing designed, adapted, or intended for preventing conception or producing abortion, or for any indecent or immoral use; and every article, instrument, substance, drug, medicine, or thing which is advertised or described in a manner calculated to lead another to use or apply it for preventing conception or producing abortion, or for any indecent or immoral purpose”. [16]*

Until 1965 it was still illegal for Connecticut doctors, in the privacy of their offices, to advise married couples that contraception could prevent unwanted pregnancy and the health risks associated with it [17]. Until 1977 restriction on the sale and

advertisement of contraception were still on the books in New York State and elsewhere [18]. Even today, US Supreme Court doctrine permits speech restrictions on the provision of information on abortion by doctors in certain government programs. As recently as 1991, the US Supreme Court upheld "the Gag Rule" which, prohibits a project funded under Title X – the federal program that funds family planning programs across the country – from engaging in activities that encourage, promote or advocate abortion as a method of family planning [19].

Similarly, the federal government, in response to passage of California's Compassionate Use of Marijuana Act, threatened doctors with criminal prosecution, loss of Medicaid and Medicare payments and revocation of their federal prescription drug licenses if they advised their patients about medical benefits of marijuana [20], despite extensive evidence of the beneficial effects of marijuana [21]. Thus, even when it is clear that certain drugs or contraceptive devices could improve people's health, the government has used control over medical practice as a mechanism for preventing dissemination of that knowledge and information.

### Access to reproductive health care and drug treatment

In both arenas, the US government not only restricts information about medically safe and useful procedures, it also restricts access to them. In the case of reproduction, access to abortion, contraception and other reproductive health care is deliberately blocked or limited. Even though abortion is now legal [22], access is extremely limited as the result of a wide variety of restrictive laws. As Joffe explains:

*"Some 84% of all US counties are without abortion facilities. The number of US hospitals where abortions are performed decreased by 18% between 1988 and 1992, and less than one-third of the nation's hospitals with the capability to perform abortions (defined as hospitals that offer obstetrical services) do so [23]. The majority of ob/gyns presently in practice do not perform abortions, and most residents in this specialty are not routinely being trained in abortion procedures."* [24]

All sorts of restrictions exist in the abortion context for procedures that are safe and medically ap-

proved – from mandated counselling unrelated to the patient's needs to unnecessary waiting periods and notification requirements designed to delay and intimidate [25]. Similarly, access to safe and effective treatment for drug addiction is deliberately limited in the USA today [4]. Methadone, for example, is the most effective treatment for opiate addiction, yet government regulations largely block its prescription by primary care physicians and its sale by pharmacies, limiting it to special clinics, which tend to be poorly staffed and inconveniently located [26]. Collectively, methadone programs can accommodate fewer than 15% of those whom methadone treatment might help [27].

Likewise, abortion services are largely limited to free standing clinics. Although this was not the result of specific federal legislation, as in the case of methadone treatment [28], the isolation of abortion services from mainstream medical care similarly leaves patients and staff without adequate access to services. In addition, patients and staff are easily targeted for violence and harassment [29], and there are harrowing stories of both methadone patients and abortion patients having to travel hundreds of miles to the nearest clinic to meet their basic health care needs [30].

While communities across the USA have been using zoning laws to keep abortion clinics from opening, similar laws have long been used to prevent the establishment of methadone programs [31]. Moreover, efforts in both arenas, to give people greater access to health care through private physicians face serious hurdles. For example, it was hoped that the availability of mifepristone for early medical abortion would enable a significant number of women to get the procedure from private physicians, but abortion restrictions on the books may make the delivery of such services illegal [32].

Access has also been blocked to many "harm reduction" techniques that have proved effective both in terms of public health and cost savings [33]. Making clean needles available to injection drug users through needle exchange programs [34] and permitting their sale at pharmacies [35] has proved highly effective in curtailing the transmission of HIV/AIDS and hepatitis [36]. Public health groups, including the American Medical Association, the National Institutes of Health, the Centers for Disease Control and Prevention and the Institute of Medicine, have endorsed needle exchange programs [37], and government-sponsored research has shown that such programs do not lead to increased

drug use and have numerous positive health effects. Yet federal policy prohibits use of its funds for this measure [38].

The common governmental orientation toward control and punishment in both drug policy and reproductive health care policy is reflected in the funding priorities of each. The \$16 billion dollar budget for drug law enforcement, interdiction and supply reduction represents two-thirds of the total federal budget addressing drug use in this country [39]. Similarly, the government refuses to fund abortion services for poor women [40], while ensuring that funding is available for sterilization services for the same population of women [41]. The government has failed to increase adequately funding for the Title X family planning program, and fails to require private insurers to provide adequate coverage of contraceptive services and supplies [42].

*“In stark contrast to the situation in other developed nations, where contraceptives are easily affordable under universal health insurance systems, contraceptive supplies and services are expensive in this country and American women must rely on a variety of fragmented systems and programs to help them cover these costs”.* [43]

The federal government has also permitted the states to deny increased welfare payments to a woman who conceives and bears another child while she is on welfare [44], and state funding for a range of women’s reproductive health care – including screening and treatment for cervical cancer, sexually transmitted diseases, HIV prevention for women and obstetric and gynaecological care for low-income women – reflect a policy of extreme neglect [45].

In addition, numerous states have passed what have been labelled “TRAP” regulations – Targeted Regulation of Abortion Providers [46]. TRAP laws regulate the medical practices or facilities of doctors who provide abortions by imposing burdensome and unnecessary requirements that are not mandated for comparable medical services [47]. Examples of these regulations are rules permitting state agencies to copy and remove patient records, jeopardizing patient confidentiality, or mandating unique structural or administrative specifications that are not medically warranted and that increase costs so significantly that doctors are dissuaded from providing abortion services [48].

As the medical marijuana example discussed earlier demonstrates, drug laws in the USA also interfere with doctors’ ability to provide the care deemed most appropriate for a patient. Moreover, according to Mike Gray, as a result of drug law enforcement, doctors are extremely limited in their ability to prescribe narcotic pain medication to patients who need it and have largely “abandoned” patients with chronic pain who need ongoing narcotic painkillers just to get out of bed [49].

Despite these and other intrusions on medical practice, however, Carol Joffe argues that: “It is the medical community itself, and not [anti-abortion groups like] Operation Rescue, that bears chief responsibility for the present marginalization of abortion provision” [50]. Today, education in medical school about both abortion and addiction remains extremely limited. Only 12% of US residency programs in obstetrics and gynaecology require routine training in first trimester abortions [51]. Less than 1% of the curriculum in US medical schools is devoted to drug abuse and addiction [52].

### “Epidemics” of drugs and pregnancy

Very often, identical language is used to describe and define the terms of the public discussion about both drugs and reproduction. In the recent past, both the use of cocaine and pregnancy by teenagers have been reported and decried as “epidemics”. Virtually everyone has heard about the crack epidemic of the 1980s. Government data and research into actual use patterns, however, reveal that overall cocaine use was in fact down during this period and that there has never been an epidemic of crack addiction (or even crack use) among the vast majority of Americans [53]. As authors Reinerman and Levine explain, a more proper use of the word “epidemic” would be to describe the extensive use of alcohol and tobacco [54].

Significantly, during almost exactly the same period, the press and activists coined the phrase “epidemic of teen pregnancy”. By the early 1980s Americans had come to believe that teenagers were becoming pregnant in epidemic numbers [55], yet births to teenagers actually declined in the 1970s and 1980s [56]. In fact, in the 1980s older women and white women were slowly replacing African-Americans and teens as the largest population groups of unwed mothers [57].

Kristin Luker observed that “pregnant teenagers made a convenient lightening rod for the anxieties and tensions in American’s lives. Economic fortunes were unstable, a post-industrial economic order was evolving, and sexual and reproductive patterns were mutating. Representing such teenagers as the epitome of society’s ills seemed one quick way of making sense of these enormous changes” [58]. More specifically, poverty could be blamed on the “sexual and reproductive decisions that poor [teenaged] women make” [59].

Luker’s research demonstrates that early child-bearing was not a widespread phenomenon and that it would not impoverish women who were not already poor [60]. As she concluded: “Child-bearing among teenagers has relatively little effect on the levels of poverty in the United States. But income disparities have become a pervasive fact of American life, and it is scarcely surprising that when experts ... labelled ‘teenage pregnancy’ a fundamental cause of poverty, Americans were willing to listen” [61].

Thus, both drug and pregnancy epidemics have been used to redirect attention to “individual deviance, immorality, or weakness” [62] and away from fundamental, pervasive problems like unemployment, poverty, racism and sexism that drastically reduce individuals’ ability to exercise choice and maintain control over their lives [63].

### **Just saying “no” to comprehensive sex and drug education programs**

Similarities also exist in government endorsement of and funding for prevention programs. Candid and comprehensive education programs that distinguish between the use and abuse of drugs, and that accept the inevitability that some young people will experiment with drugs and engage in sexual activity, can help prevent unwanted pregnancies and harmful drug use [64]. Nevertheless, our government has chosen, in both arenas, to limit support exclusively to programs based on abstinence only – fear-based models that have proven to be at best ineffective and possibly counter-productive [65].

Despite evidence that abstinence only models did not work in the drug arena, the US government chose to support comparable abstinence-only models in sex education [66]. The welfare laws of the 1990s committed: “... nearly \$850 million in pub-

lic funds over five years ... to promote abstinence for anyone who is not married and to reward states that reduce out-of-wedlock births and abortions among all women in the state” [67].

Similarities between drug abstinence and sex abstinence programs are not accidental. The extent to which the same abstinence-only philosophy underlies both drug and sex education programs is demonstrated in the government’s Girl Power! Campaign. Originally conceived as an anti-drug program, it was repackaged as a teen pregnancy prevention program in response to welfare reform laws that directed the Secretary of the Department of Health and Human Services to implement an abstinence-based “strategy for preventing out-of-wedlock teenage pregnancies” [68].

### **The mythology of choice: reproduction and drug addiction**

The term “choice” is often applied to both reproductive decision making and to drug use. Women have a right to “choose” to have an abortion and drug addicts make a “choice” to use drugs. This language, however, obscures the lack of choice that many people have and the larger economic and institutional barriers that deny people, particularly low-income women of color, the ability to make consumer-like choices.

This similarity is best exemplified in efforts to control both reproduction and drugs through the punishment and prosecution of pregnant, drug-using women. Since the late 1970s, approximately 200 women have been arrested based on their status as pregnant, drug-using women. Thousands of others and their families are being affected by state laws that equate a pregnant woman’s drug use with evidence of civil child neglect. New calls for sterilization of drug-using women are receiving significant media attention and private financial support [69]. These laws, policies and practices combine the seemingly unrelated arguments that fetal rights should be recognized under the law [70] and the argument that the war on drugs should be expanded to women’s wombs.

In one of these cases, a young African-American woman who used cocaine while pregnant was charged under a statute that made it a crime to “deliver” drugs to a minor [71]. The state argued successfully at trial that the statute could be applied to the delivery of drugs through the umbilical cord.

Although this conviction was ultimately reversed, the woman was initially sentenced to 15 years of probation. At sentencing the judge justified the verdict on two separate but interdependent grounds: she deserved punishment both because "the defendant . . . made a choice to become pregnant and to allow those pregnancies to come to term" and because the "choice to use or not to use cocaine is just that – a choice" [72]. In making these pronouncements, the judge assumed that the intercourse that resulted in the pregnancy was voluntary. He assumed that she had "chosen" not to use contraceptives, assumed that despite their imperfections she would not have become pregnant if she had used them, and assumed that contraceptive services were easily accessible to her. The judge also assumed that she made a choice not to have an abortion and clearly believed that was the wrong decision. Yet Florida, where she lived, does not fund abortion services – thus making an abortion inaccessible even if she had sought to terminate the pregnancy. Using the language of "choice" the judge felt justified in punishing a low-income African-American woman for having a child [73]. Similarly, he felt justified in treating her drug use as a "choice" despite the fact that the US Supreme Court [74] and the health community [75] have long recognized that drug addiction is an illness, not simply a matter of willpower.

### Child protection

In both the reproductive rights and drugs arenas, calls for prohibition and punishment are often justified by the claim that they are necessary to save the children. A primary reason given during the Clinton administration for not funding needle exchange programs was that that such programs would send a message to children that drugs are acceptable [76]. Recently, when asking for the largest budget in history for federal drug control, \$19 billion, the Office of National Drug Control Policy under George W. Bush justified this predominantly law enforcement budget by saying: "The President's budget will allow us to better protect our youth and our safety" [77].

In the case of reproductive rights, the "children" are embryos and fetuses who must be saved from abortion and even contraception. Claims that abortion is child murder are simply too numerous to cite, but there is a recent notable example of apply-

ing child abuse rhetoric to contraceptive services. In May 2001, US Rep Chris Smith called the Planned Parenthood Federation, a voluntary family planning organization, "Child Abuse Incorporated" [78].

The claim of child protection is particularly apparent in the case of pregnant, drug-using women. In the United States, individual prosecutors have tried to treat fetuses as persons, arguing that existing child abuse laws could be used to punish pregnant women who engage in behaviors that might be harmful to the fetus. In *Whitner v. South Carolina* [79], the Supreme Court of South Carolina agreed with this approach and declared that viable fetuses are "persons", and as a result, the state's criminal child endangerment statute applied to a pregnant woman who used an illicit drug [80]. In *Ferguson v. City of Charleston*, city and state officials in South Carolina argued that a hospital policy of secretly searching pregnant women for evidence of drug use and then turning that information over to the police did not violate the Fourth Amendment's prohibition on unreasonable searches, because the search served the special need of protecting children [81]. Although the US Supreme Court recently rejected this argument, finding that the policy was in fact about criminal punishment, not providing treatment to children or women, a draconian program of dragging pregnant and newly delivered mothers out of their hospital beds in chains and shackles had nevertheless been in effect for five years based on such claims of children's rights.

Child protection has also been the rationale for an increasing number of states to pass laws that treat a pregnant woman's drug use as evidence of parental neglect and unfitness [82]. "While bills proposing criminal penalties have failed, 18 states have amended their civil child welfare laws to address the subject of a woman's drug use during pregnancy" [83]. Some of these statutes treat a single positive drug test as the basis for presuming parental unfitness [84]. Some recent state court decisions, relying on medical misinformation, have also expanded the scope of their civil child welfare laws to reach the conduct of pregnant women [85]. In fact, research has found no significant difference between addicted and non-addicted mothers in childrearing practices and addicted and drug-using mothers have been found to look after and care adequately for their children [86]. Thus, these cases and statutes permit significant state intrusion on

certain women's lives and families without protecting children from actual harm [87].

In both the drug and reproductive arenas punitive policies do not benefit real children. To the contrary, they increase public costs related to incarceration and foster care, and do so at the expense of drug treatment and other more cost saving forms of health care [88]. As Jean Schroedel documents, states most protective of "fetal rights" are the ones least likely to support health, education and welfare programs that actually benefit children [89]. Similarly, drug prohibition has by and large failed to reduce drug use by young people [90].

### Controls hurt everyone, but especially African-American women

Laws criminalizing and unnecessarily controlling illicit drug use and reproduction hurt a wide expanse of the population. As many commentators have noted, the war on drugs in particular has "shattered" numerous lives, placing hundreds of thousands of non-violent drug offenders into a criminal justice system that destroys families and fails to reduce drug use [91]. And, increasingly, people who do use drugs are not only at risk of arrest, but also subject to loss of a wide array of government support including welfare [92], housing [93] and federal college loans [94]. Perhaps most obvious is the unprecedented rate of incarceration in the USA. Today, more than two million people are behind bars [95]. By the end of 1998, there were 5.9 million adults in the "correctional population"; a rubric that encompasses people who are incarcerated, on probation or on parole [96]. The increase in prison population is directly linked to the war on drugs [97].

More than 70% of the imprisoned populations are people of color [98]. And while women continue to represent a minority of those behind bars, in recent years their numbers have increased at nearly double the rate for men [99]. This dramatic and disproportionate increase also has a great deal to do with the war on drugs [100]. "From 1986 to 1991, the number of black female drug offenders in state prison rose by 828%, Hispanic women by 328%, and white non-Hispanic women by 241%" [101].

Imprisonment has profound effects both on women and the children for whom they are responsible. Two-thirds of the women in prison are mothers of children under the age of 18 [102]. A 1991

survey found that 10% of the women prison inmates reported that their children were living in a foster home or children's agency [103]. Unnecessary separation of children from these mothers is not only enormously expensive in fiscal terms but is traumatic and harmful for all involved, and bodes ill for the next generation [104].

The harm that results from refusing to fund public health measures such as needle exchange also falls most heavily on African-American women and children, who are now the fastest growing population of people becoming infected with HIV [105]. Again, there is a direct parallel with restrictions on reproductive health care, which also disproportionately affect African-American women. As Dorothy Roberts explains:

*"This connection between denying reproductive choice and oppression will necessarily be the hardest for poor women and women of color. Because of poverty, these women have fewer real options and are dependent on government funds to realize the decisions they make. Because the government is more involved in their lives through their use of public facilities and bureaucracies, they are more susceptible to government monitoring and supervision. Because it is harder for them to meet the ideal middle-class standard of what a woman or mother should be, society is more likely to approve of, or overlook, punishing them for making reproductive decisions. Because they have less access to lawyers, the media and advocacy organizations, and because society has convinced many that they are powerless, they are less likely to challenge government restrictions of their rights. Reproductive freedom is a right that belongs to all women; but its denial is felt the hardest by poor and minority women".* [106]

### Conclusion

Those who are concerned about fundamental issues of social justice may be losing ground, missing opportunities to build coalitions and strengthen their respective arguments by refusing to recognize the relationship between drug policy and reproductive rights issues. By combining claims of fetal rights with the war on drugs, our opponents are making significant gains. For example, the holding in the South Carolina *Whitner v. State* case goes to the heart of the abortion debate in the USA, lending support to the anti-abortion position that fetuses

have rights and that pregnant women's health and freedom may be subordinated to those rights. Indeed, *Whitner* has been seized upon as the long-awaited chance to undermine and potentially overturn *Roe v. Wade*, the US Supreme Court decision recognizing a woman's right to choose to have an abortion. The opinion has provided grounds for the South Carolina State Attorney General's office to assert that it now has legal authority to make all post-viability abortions murder and to put to death women who have them, as well as the doctors who perform them [107]. At the same time it allows women to be punished merely for having a disease – the disease of addiction.

The need to respond simultaneously and forcefully against both claims of fetal rights and the failing war on drugs is clear. Drug policy reform efforts to destigmatize drug users and to shift emphasis from punishment to treatment cannot succeed if myths regarding “crack babies” and “crack mothers” destroying a generation of children are left unchallenged. Similarly, efforts to protect reproductive freedom cannot succeed as long as the rhetoric of the drug war is able to pit fetal rights against women's legal status as autonomous persons. Without a comprehensive strategy to undo decades of misinformation and political posturing about both pregnancy and drug use, an ever-widening circle of women will be caught in increasingly punitive, intrusive, and coercive government controls that hurt rather than help women and their families.

Taking on these issues in a coherent manner, however, affords a unique opportunity to develop the support of a broad coalition of organizations and communities in the struggle for reproductive freedom, drug policy reform and a more just society. We also have the opportunity to develop pro-

grams and institutions that recognize the ways in which intersecting issues and identities create barriers to treatment, recovery and well-being. Following Mari Matsuda's advice, it is by listening to the actual experiences of those people who “experience life on the bottom” that we can have a basis for “defining the elements of justice” [108].

By recognizing the similarity in the issues concerning reproductive rights and the drug war there is an opportunity not only for a deeper understanding of each issue, but also a basis for developing analysis and action that can counteract the dominating forces of punishment and prohibition and begin to build coalitions and movements toward preserving and expanding those social programs that can in fact empower women, preserve families, and create a more just society.

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References have not been included due to limitations of space. Reference numbers included in the text above are those relating to text in the original paper. The full text of the paper is posted on the website: <[www.advocatesforpregnantwomen.org](http://www.advocatesforpregnantwomen.org)>.



## Résumé

Nombre de gens pensent que la guerre contre l'avortement et la guerre contre la drogue menées aux Etats-Unis par les autorités fédérales et des Etats sont distinctes; pourtant, les deux se chevauchent et sont liées. Leur histoire, les stratégies employées pour contrôler et sanctionner certains choix de reproduction et celles qui contrôlent l'emploi de certaines drogues, les mesures qui limitent l'accès à l'avortement et à d'autres soins de santé génésique et au traitement des toxicomanes, et les populations les plus pénalisées par ces limitations sont remarquablement similaires. Ces ressemblances sont particulièrement apparentes quand on aborde la réglementation et les sanctions imposées aux femmes enceintes toxicomanes. Les initiatives pour maîtriser la reproduction et la drogue s'inspirent de formes de bigoterie et de préjugés qui sont essentiellement les mêmes. Elles lèsent tout particulièrement les Africaines-Américaines. Ces efforts reflètent des priorités politiques communes et détournent l'attention des véritables questions, notamment la pauvreté, la discrimination raciale et le manque d'une politique nationale cohérente de soins de santé. Il faut que les individus engagés dans chacune de ces luttes reconnaissent qu'ils ont une cause commune et qu'ils requièrent une stratégie globale pour mener ces deux combats comme des questions fondamentales de justice sociale.

## Resumen

Mucha gente piensa que no hay ninguna asociación entre la guerra en contra del aborto librada por los gobiernos estatales y federal en los Estados Unidos y la guerra en contra de las drogas, pero en realidad hay múltiples conexiones y mucha coincidencia entre ellas. Sus historias son similares. Las estrategias que se usan para controlar y sancionar ciertas opciones reproductivas se parecen a aquellas que se aplican para controlar el uso de ciertas drogas. Las restricciones que se imponen al acceso al aborto y a otros servicios de salud reproductiva se parecen a las limitaciones al tratamiento de la adicción a las drogas. Por último, las poblaciones más perjudicadas en ambos casos son similares. Estas similitudes son especialmente aparentes cuando se trata de la regulación y sanción de mujeres embarazadas que consumen drogas. Los esfuerzos por controlar la reproducción y las drogas están enraizados en los mismos prejuicios y formas de intolerancia; las mujeres afro-americanas resultan especialmente perjudicadas por ellos. Dichos esfuerzos reflejan una agenda política común y distraen la atención de las causas reales subyacentes, que incluyen la pobreza, la discriminación racial y la falta de una política nacional de salud coherente. Quienes luchan en contra de la una o la otra deben reconocer estas causas compartidas y comprender que se precisa una estrategia integral que las aborde como asuntos fundamentales de justicia social.