

# Reproductive Justice

## ISSUE STATEMENT

Women's reproductive issues are a matter of women's health. However, women's bodies have become battlegrounds on which ideological battles are waged. Rather than a simple matter of physical and emotional health, the fight over women's reproductive capabilities represents a larger ideological struggle over the role and rights of women. For example, states have adopted 334 abortion restrictions since 2010, while adopting only 22 measures aimed at expanding access to reproductive health services or protect reproductive rights (Nash, Gold, Ansari-Thomas, Cappello, & Mohammed, 2016). It is vital that the social work profession keep abreast of the constantly changing policy landscape of reproductive issues and take an ethical and evidence-based position on behalf of our clients and communities.

## *Reproductive Justice: A New Framework*

In the 1960s and 1970s the women's rights movement made reproductive rights a cornerstone of organizing and advocacy. However, reproductive rights were often narrowly defined as the right to choose an abortion, often termed being "pro-choice." Women of color critiqued this narrow focus and, in contrast, developed an intersectional analysis termed "reproductive justice" (Ross, 2007). Largely through the efforts of such groups as SisterSong Women of Color Reproductive Health Collective and the Asian Communities for Reproductive Justice (ACRJ), the reproductive justice lens is now the preferred lens for looking at women's health and reproductive issues (Cook, 2007). *Repro-*

*ductive justice* is "the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Ross, 2007, p. 4). The lens is consistent and compatible with NASW's focus on social and economic justice for all.

This analysis seeks to join multiple social justice movements together to address structural inequalities across race, gender, generations, and class. The expanded agenda seeks to end the isolation of abortion and contraception from other related issues, such as immigration, incarceration, disability, spirituality, and the environment. Alzate (2009) presented 20 health concerns, other than abortion and contraception, including infertility, drug use during pregnancy, child sexual abuse, menopause, forced marriages, child birth, assisted reproductive technologies (ART), and lactation, to name a few, that fall under the larger umbrella of reproductive justice. This framework includes not only pregnancy prevention and termination, but also the right and support to have children, including health insurance, affordable and quality child care, a living wage, and paid family leave and sick leave.

In addition to the expansion of topical areas and structural injustices, the reproductive justice framework includes paying special attention to a range of populations, including sexual minorities, trans men and trans women, women of color, and incarcerated and immigrant women (Roth, 2007; Wellek & Yeung, 2007). This expanded focus includes three main frameworks: (1) reproductive health, which deals with service provision; (2) reproductive rights, addressing legal issues; and (3) reproductive justice, which focuses on movement

building (Ross, 2007). The reproductive justice framework embraces activism and coalition building with diverse groups with interrelated agendas.

Furthermore, the reproductive justice movement highlights the unique concerns of women of color. For instance, black and Latina women have higher rates of abortion, often because of lower incomes and limited access to preventive health care, including birth control. Women of color have also been targets of coercive government policies that attempt to regulate their child-bearing through a range of policies including sterilization, family caps on public assistance, prosecution for using drugs while pregnant, and the criminalization of pregnant women (Roberts, 2015). Although it is beyond the scope of this policy statement to address the complete myriad of topics and structural inequities that fall under the reproductive justice umbrella, an attempt is made to expand the conversation.

## Abortion

**Brief History.** Until the later years of the 19th century, abortion was legal before *quickening*, defined as when fetal movement could be felt, at approximately the fourth month of pregnancy (Reagan, 1998). Over time abortion began to be criminalized due to multiple factors including concern over the safety of women who were dying due to self-induced abortions; the medical profession's attempt to establish supremacy over midwives; and anti-immigration, anti-Catholicism, and anti-feminist movements. The criminalization of abortion did not stop abortion, but, rather, led to illegal abortions and more self-induced abortions often resulting in injury and death (Pollitt, 1997). Women used an assortment of methods to self-induce abortion including inserting knitting needles or crochet hooks into their uteruses or ingesting gunpowder and whiskey (Reagan, 1998). The estimated numbers of illegal abortions in the 1950s and 1960s ranged from 200,000 to 1.2 million a year (Gold, 2003).

In 1973 the Supreme Court decision in *Roe v. Wade* affirmed women's right to an abortion, attributed to the constitutional rights of privacy and liberty. Justice Blackmun created a

three-tiered framework, tied to the three trimesters of pregnancy, which gave the state greater power to regulate abortion as the pregnancy advanced and fetal viability increased (Masci, Lupu, & Davis, 2013). Three years after the passage of *Roe v. Wade*, Congress passed the Hyde Amendment, which banned federal funding of abortion (Poggi, 2007). Because of the racialized nature of poverty, these prohibitions on abortion funding disproportionately affect low-income women of color. Poggi (2007) reported that as many as one in three low-income women who would have had an abortion if it were covered by Medicaid are instead obliged to continue the pregnancy. In 1979, the United Nations Commission on Human Rights stated that unimpeded access to family planning and reproductive health services, including abortion services, is a fundamental human right that contributes to the advancement of women worldwide.

A 1992 Supreme Court decision, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, affirmed the *Roe v. Wade* decision, while also allowing states greater regulatory powers if abortion restrictions did not pose an "undue burden" on a woman's right to terminate her pregnancy. After the Casey decision, antiabortion activists at the state level proposed and passed numerous restrictions on women and abortion providers, termed Targeted Regulation of Abortion Providers (TRAP) laws. The laws included mandatory sonograms, extended waiting periods, requiring doctors to have local admitting privileges, and requiring abortion clinics to meet the strict standards of ambulatory surgical centers (Guttmacher Institute, 2016b). In 2016 the Supreme Court decision in *Whole Women's Health v. Hellerstedt* reaffirmed women's constitutional protection for abortion rights while also finding that many of the TRAP laws constitute an undue burden on women (Liptak, 2016). The latest ruling sets a standard that abortion regulations must demonstrate evidence-based health and safety reasons to meet constitutional standards.

**Statistics.** Since the 1970s the overall trend of abortion has been a gradual decrease in number each year, often attributed to greater birth control education and access. However,

despite a gradual decrease, in 2011 approximately 1.06 million abortions were performed (Guttmacher Institute, 2016a). Almost half of all pregnancies in the United States in 2011 were unintended, and about four in 10 of these resulted in abortion. Women of all races have abortions: 39 percent white, 28 percent African American, and 25 percent Latina. Women who seek abortions are disproportionately poor, with 49 percent in 2014 with incomes 100 percent less than the federal poverty level (\$11,670 for a single adult with no children) (Guttmacher Institute, 2016a). Women provide multiple reasons for having an abortion, including concern or responsibility for another individual; unable to afford a child; having a baby would interfere with work, school, or the ability to care for others; did not want to be a single parent; and having problems with their partner.

**Abortion Misconceptions.** According to the Pew Research Center (Liptak, 2016), 56 percent of U.S. adults say abortion should be legal in all or most cases, compared with 41 percent who say it should be illegal. Support for abortion varies by age, party, and religious affiliation; young people, Democrats, and the religiously unaffiliated are more likely to support abortion rights.

The people and organizations that actively oppose abortion often resort to campaigns of misinformation (U.S. House of Representatives, 2006). For instance, they may claim that abortion increases a woman's chances for breast cancer, future infertility, and mental health problems. However, each of these claims is false as demonstrated by empirical studies (American Congress of Obstetricians and Gynecologists [ACOG], 2015; Biggs, Upadhyay, McCulloch, & Foster, 2017). In fact, the risk of death associated with childbirth is more than 12 times higher than that for an abortion (ACOG, 2012). Also, a recent longitudinal study of women's mental health five years after being denied or receiving an abortion found that there were no greater risks of adverse psychological outcomes after having an abortion; to the contrary, being denied an abortion was associated with greater risk of initially experiencing adverse psychological outcomes (Biggs et al., 2017).

One way misinformation is given is through so-called crisis pregnancy centers (CPCs). There are approximately 2,500 such centers in the United States (Belluck, 2013). CPCs are often religiously based and attempt to deter women from having abortions, often by giving misinformation. They often provide pregnancy tests and ultrasounds, but no further medical services, and they might not even have trained medical staff. CPCs may try to confuse women by geographically locating themselves close to an abortion provider and also pay for Internet service optimization services to bring the center's name up when people search for "abortion" online (Belluck, 2013). Some of the centers are state funded, and other governmental organizations have tried to regulate them, requiring them to post signs stating that they do not provide abortion or contraception and disclosing whether medical professionals are on-site (Belluck, 2013). CPCs attempt to impose their values on women, which goes against social work's principle of self-determination.

**Stigma.** *Abortion stigma* is defined as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to the ideals of womanhood" (Kumar, Hessini, & Mitchell, 2009, p. 628). In their review of the literature, Norris et al. (2011) found that abortion stigma can be transitory or episodic and that it increases adverse emotional outcomes, is worse when the abortion is categorized as undergone for "bad" reasons (for example, later gestational age or repeat abortion), and may increase if a woman has received misinformation about the physical and psychological risks of abortion. Even though one in three women in the United States has had an abortion (Guttmacher Institute, 2016a), the silence around the procedure also adds to the stigma.

Abortion stigma can also affect individuals who work in abortion provision, including social workers. The stigma is increased due to the harassment and violence at abortion clinics and may result in staff feeling stress, fears about disclosing one's work in social situations, and burnout (Norris et al., 2011). Abortion providers counter the stigma with positive beliefs, such as that their work is "valuable and

it contributes to patients' well-being in a profound way" (Norris et al., 2011, p. S51).

## Contraception

**A Brief History.** Abortion became necessary for some women because they did not have access to family planning methods to control their childbearing (Poggi, 2007). The modern history of family planning in the United States is often attributed to Margaret Sanger, a nurse and the founder of Planned Parenthood. In 1916 she opened the first birth control clinic to provide women with education and information, but was arrested under New York's obscenity laws (Centers for Disease Control and Prevention, 1999).

An often-untold story in social work is the support for birth control at Hull House in Chicago, a settlement house viewed as a vital part of the social work profession's founding and history. Two long-time Hull House residents, physicians Alice Hamilton and Rachelle Yarros, supported sex education and birth control education, provision, and activism. Yarros (cited in Haslett, 1997) described her predicament this way: "No matter what your ideas of the sacredness of human life and the criminality of performing abortions, your heart aches while you send a woman out of your office, knowing that she is surely going to a quack" (p. 266). Rather than seeing abortion as a single issue, Hamilton and Yarros connected birth control to poverty, classism, and the role and status of women and rejected the eugenics argument popular at that time—the racist idea that birth control should be offered to poor and immigrant women for the sake of white race preservation (Haslett, 1997).

In 1965 the Supreme Court decision in *Griswold v. Connecticut* legalized birth control for married couples by acknowledging the implied right to privacy in the U.S. Constitution; unmarried women gained the right in 1972. In 1960 the first birth control pill was approved by the Food and Drug Administration (FDA). Today numerous forms of birth control for use by women exist, each with different advantages and disadvantages, including implants, intrauterine devices, injections, pills, patches, and rings.

**Statistics, Legislation, and Public Funding.** Three million pregnancies in the United States, almost half of all pregnancies each year, are unintended (Guttmacher Institute, 2016a). In 2014, 38 million women needed contraceptive care and of those, 20 million needed publicly funded services and supplies because they had income below 250 percent of the poverty level or were younger than 20 (Guttmacher Institute, 2016a). Public funding for birth control services totaled \$2.37 billion in fiscal year 2010 (Guttmacher Institute, 2016a). Public funds for contraceptive care come from Medicaid (75 percent), state appropriations (12 percent), Title X (10 percent), and other state and federal sources (3 percent). One in four women who obtained birth control in the years 2006 to 2010 did so at a publicly funded center. There are great disparities in contraceptive use by women with low income. These women have an unplanned pregnancy rate five times higher than high-income women (Sonfield, 2013). In addition, transgender men who have sex with men may also be at risk for unintended pregnancy (National Center for Transgender Equality [NCTE], 2012).

The benefits of family planning are multiple and well documented (Frost & Lindberg, 2012; Sonfield, Hasstedt, Kavanaugh, & Anderson, 2013). Women state that planning their families allows them to take better care of themselves and their families, finish school, and obtain a job that enables them to support themselves and their families (Sonfield et al., 2013). The disadvantages of an unplanned pregnancy are also well documented and are associated with more conflict and less relationship satisfaction, physical and sexual abuse, depression, and anxiety (Sonfield, 2013).

The Patient Protection and Affordable Care Act (ACA, also widely known as "Obamacare") was enacted by Congress in 2010 and included the requirement that most private plans include coverage of contraceptive methods and services. Earlier, the Equal Employment Opportunity Commission determined that health plans that covered other preventive services but excluded contraceptive coverage were guilty of sex discrimination (Sonfield, 2017). However, as soon as the ACA passed, some conservative lawmakers and employees

objected to the mandatory contraception coverage. These employers asserted a “conscience clause” that would allow employers with religious or moral objections to birth control to not provide birth control to their employees in the name of religious freedom. Conservative lawmakers at the state and federal levels have also attempted, and at times been successful, in blocking Planned Parenthood clinics from receiving federal or state funds for birth control services. These conservative lawmakers claim that any provider affiliated in any way with abortion should not receive public dollars, whether they provide abortions or even refer clients for abortions (Hasstedt, 2016). State legislators have also been creative in finding ways to decrease contraceptive funding, including 15 states that tried to limit family planning providers’ eligibility for reimbursement under Medicaid (Hasstedt, 2016).

In fact, in January 2016 antiabortion lawmakers in Congress nearly forced a government shutdown over funding for Planned Parenthood. Contraception accounts for 34 percent of Planned Parenthood services, sexually transmitted infections (STIs) screening and treatment accounts for 42 percent, cancer screenings and prevention account for 10 percent, and abortions account for only 3 percent of Planned Parenthood services (Goldschmidt & Strickland, 2017). Planned Parenthood also serves 36 percent of all clients obtaining care from publicly funded family planning centers.

**Emergency Contraception.** Emergency contraception is birth control used after a sexual encounter in instances in which no birth control was used, the birth control failed, or a sexual assault occurred. Emergency contraception can be a woman’s own birth control pills in higher doses, or the specialized pill, termed “Plan B,” often called “the morning-after pill.” The pills are highly effective, especially if taken within 72 hours of unprotected sex (U.S. Department of Health and Human Services, Office of Population Affairs, 2014). After a protracted and highly politicized process, the FDA approved emergency contraception for sale over the counter to any person 17 years of age and older.

**Male Contraception.** In many instances responsibility for reproductive decisions and

consequences is primarily borne by women. For instance, women often bear the brunt of obtaining, buying, and using birth control. Many of the most effective forms of birth control require women to take a pill, get an injection, or have an implant inserted. Numerous side effects can result, including mood swings, weight gain, blood clots, and irregular bleeding (American Sexual Health Association, 2013).

One way this unequal burden on pregnancy prevention can be shared is by developing additional methods of male birth control. A recent study assessed the safety and efficacy of an injectable combination hormonal contraceptive for men. Although the injection showed great promise in being a reversible and effective form of birth control, the study was ended early due to a high frequency of reports of mild to moderate mood disorders (Behre et al., 2016).

### *Birthing and Parenting*

When viewed through the framework of reproductive rights, women’s reproductive issues most often began and ended with pregnancy prevention or termination. However, the reproductive justice framework expands the conversation into affording women the right to have or not have children, and the necessity of aiding women and men who are parents so that they may raise their children in safe, healthy, and supportive environments.

The decision whether to have a child is often viewed as an emotional decision, but clearly it is also an economic one. For instance, the annual cost of raising a child from birth to age 17 by high-income parents is \$372,210, by middle-income parents \$233,610, and by low-income parents \$174,690 (U.S. Department of Agriculture, 2017). Women’s ability to economically support a family depends on many larger structural issues including, but not limited to, the gender wage gap; child care costs; health insurance coverage; early childhood education; the minimum wage; discrimination in the workplace, including pregnancy discrimination; the availability of family leave and paid sick days; and access to reproductive health care.

In the United States about one in three births happens by cesarean section (C-section), and that rate has risen dramatically over the past few decades. The U.S. C-section rate is higher than that in most industrialized nations and does not lead to better birth outcomes (Thielking, 2015). One study of maternal mortality conducted in 48 states found that it increased from 18.8 in 2000 to 23.8 in 2014, which represents an overall 26.6 percent increase (MacDorman, Declercq, Cabral, & Morton, 2016). In the United States, half of all households with children under the age of 18 years have a breadwinner mother (Institute for Women's Policy Research [IWPR], 2016a).

Correll and Benard's (2007) foundational research was the first to empirically document the often-suspected motherhood penalty for mothers in the workplace. Mothers were judged as significantly less competent and committed than women without children, were rated as less promotable, were less likely to be recommended for management, and were recommended for a starting salary that was \$11,000 less than those salaries offered to women who were not mothers.

In 2015, women as a group working year-round and full-time earned only 80 cents on the dollar compared with men as a group (IWPR, 2016b). When analyzed by race and ethnicity, white women earned 75 cents for each dollar earned by a white man compared with 63 cents for black women, 84 cents for Asian American women, and 54 cents for Latinas. The U.S. Census reported that the poverty rate in 2015 varied by family type, with 5.4 percent of married couples, 14.9 percent of families headed by a man, and 28.2 percent of families headed by a woman living in poverty (Proctor, Semega, & Kollar, 2016).

ART, including egg donation, and pregnancy surrogacy can create new ethical dilemmas for women, families, and health providers. In some cases the risks of participation in some of these new technologies are not well described. For instance, older women should be informed of the probability of getting pregnant with the specific ART, and surrogates and egg donors should receive an explanation of the risks and rights inherent in their roles and

protected from exploitation and commodification of their reproductive capacities.

Transgender individuals may face unique challenges to their fertility due to feminizing and masculinizing hormone therapy or surgeries that may remove or alter their reproductive organs. The World Professional Association for Transgender Health (WPATH) Standards of Care (WPATH, 2012) recommended that mental health and health care professionals discuss reproductive options with clients before initiation of such medical treatments. Reproductive options can include sperm and egg freezing. In some cases fertility can be restored by stopping hormonal treatments, but that can depend on the patient's age and the duration of hormonal therapies (WPATH, 2012). The more recent use of hormonal blockers for prepubescent children may also affect fertility. Transgender and gender-nonconforming individuals often have been reluctant or prohibited from pursuing such options due to stigma, discrimination, insurance coverage restrictions, and lack of knowledge by medical professionals (National Women's Law Center, 2015).

### *Reproductive Coercion*

Feminist activism in the reproductive rights arena proclaims the principle that women have the right to control their bodies and their reproductive decisions. However, in many cases that autonomy is usurped by others, from an intimate partner to the government that increasingly regulates access to reproductive services. Reproductive and sexual coercion involves "behavior intended to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent" (Committee on Health Care for Underserved Women, 2013, p. 1). This behavior includes actions to pressure someone to get pregnant, continue a pregnancy, or terminate a pregnancy. Controlling behaviors include threats and physical violence, including homicide (Committee on Health Care for Underserved Women, 2013). Specific actions might include sabotaging contraceptive methods, forcing sex without a condom, or intention-

ally exposing a partner to an STI. A small qualitative study by Canadian social workers found that intimate partner violence influenced women's abortion decisions due to fear of the perpetrator and fear for the life of the baby (Cote & Lapierre, 2014).

**Forced Sterilization.** As mentioned earlier, reproductive coercion can occur as a result of an individual or government action. A very tragic but often untold chapter in American history is the story of how mostly poor women of color were sterilized, often by deceit or coercion (Krase, 2014). Instead of gaining access to reversible contraception, the United States promoted a policy of permanent sterilization in Puerto Rico. Some states set up Eugenics Boards that targeted poor, unwed, or mentally disabled women, children, and men for sterilization. This nationwide sterilization effort was institutionalized in U.S. laws and policy using government and private funds. Latinas in Puerto Rico, New York City, and California were targeted as well as black women in the South and Native American women in the West. The practice of forced sterilization is not just a tragic history lesson, but continues today. In 2013, investigative reporting revealed that female inmates in California had been illegally sterilized (Krase, 2014).

Sterilization also can affect the transgender population. Some policies require transgender people to undergo masculinizing or feminizing surgeries before changing their gender markers on government documents. NCTE (2012) charges that such policies violate the reproductive rights of transgender individuals and can result in forced sterilization.

## ***NASW Code of Ethics and Reproductive Justice***

The NASW (2015) *Code of Ethics* states that "social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (p. 5). Self-determination related to reproductive health means that without government interference or reproductive coercion by an intimate partner, friend, family member, or professional, people should make their own

decisions about sexual activity and reproduction. As social workers, we support the right of individuals to decide for themselves, without duress and according to their own personal beliefs and convictions, when they want to become parents, if they want to become parents, how many children they are willing and able to nurture and support, the opportune time for them to have children, and with whom they choose to parent. All social work services, ranging from abortion to adoption to contraception to parenting, should be provided safely and competently in a nonjudgmental atmosphere based on evidence-based practice rather than the imposition of another's personal beliefs. The right to parent should not be denied to individuals because of class, disability, race, gender or sexual identity, or any other category.

The ability to control one's own sexual and reproductive life leads to increased educational and career opportunities and the ability to care for oneself and others. All people deserve to make these decisions with dignity and autonomy and to have access to the services that support their decisions.

According to the NASW (2015) *Code of Ethics*, one of social workers' ethical responsibilities to clients is informed consent, which includes clear language to inform the client of the purposes, risks, and limits to services. Informed consent should be based on empirical evidence and the social work values of competence and integrity (NASW, 2015). These values require that social workers act honestly, responsibly, and "continually strive to increase their professional knowledge" (p. 4). Therefore, providing misinformation to dissuade women from having an abortion violates the social work code of ethics.

## ***POLICY STATEMENT***

NASW supports the following:

### ***Public Awareness and Advocacy***

- public health campaigns that attempt to destigmatize abortion and other reproductive services while providing evidence-based infor-

mation so that each person has a solid foundation on which to base their decision

- coalitions that share the intersectional analysis of reproductive justice; for example, law enforcement killing of unarmed black men falls under the umbrella of reproductive justice because killing black youths violates the rights of mothers to raise their children in a healthy and humane environment (Roberts, 2015)
- a requirement that advertisements and notices seeking women to supply donor eggs state that long-term health risks of egg harvesting procedures are unknown

### *Availability and Access of Services*

- increasing families' access to affordable, high-quality child care and early childhood education
- expanding Medicaid programs to cover those with incomes up to 138 percent of the federal poverty level
- increasing public expenditures for family planning services
- reproductive justice for incarcerated individuals, including access to abortion, quality prenatal care, and routine preventive health services; incarceration geographically close to their children to preserve relationships; prohibition of shackling during labor and delivery; diverting from jail or prison to mental health and addiction services where possible; and removing restrictions on people with felony convictions that make it difficult to obtain public housing, food stamps, Temporary Assistance for Needy Families, student loans, and jobs or to vote
- efforts to objectively educate individuals on the range of options available to them when facing an unplanned pregnancy, including abortion and adoption services, based on evidence and the beliefs of the client
- efforts to provide safe, competent, non-judgmental, and confidential reproductive health services to trans women and trans men who may be in need of services that do not align with their current gender identification

and expression, for example, transgender men who need annual pelvic exams or transgender women who require a prostate exam

- a full range of reproductive options available to trans men and trans women, including preventive health screenings, prenatal and pregnancy care, infertility assistance, STI screening and treatment, and contraceptive services
- training for medical social workers and other health professionals on transgender-appropriate care, nondiscrimination, and inclusivity
- school-based, age-appropriate, culturally informed sexuality and reproductive health education programs that include information about the roles of personal beliefs, culture, and values in individual and family decision making on these issues; prevention of STIs; range of reproductive health services and contraceptive methods; skills for making healthy personal choices about sexuality and reproduction; and information about sexual consent and violence prevention
- efforts to mandate insurance coverage for infertility treatments
- efforts to monitor the ethical dilemmas and health risks of current and future ART, including egg donation and surrogacy, which have the potential to increase the possibility of the commodification of reproduction and the potential exploitation of poor women, in the United States as well as internationally

### *Policy*

- opposing the repeal of the ACA while continuing key requirements of the ACA for private health plans including coverage of contraceptive methods with no out-of-pocket costs and opposing any effort to exempt employers who would impose their religious beliefs on their covered employees
- opposing the repeal of *Roe v. Wade*
- repealing the harmful Hyde Amendment and other restrictions on insurance coverage of abortions

- resisting any restrictions to abortion access that do not meet the Supreme Court’s *Whole Woman’s Health v. Hellerstedt* decision that such restrictions offer evidence-based medical or safety benefits sufficient to justify any burdens
- opposing all efforts to deny federal and state funds, including Medicaid reimbursements, to Planned Parenthood and other providers associated with abortion
- increasing enforcement and oversight by state and federal agencies of the ACA birth control benefit
- the U.S. Department of Health and Human Services revising program guidelines for Title X family planning grants to prohibit discrimination on the basis of gender identity and sexual orientation and to address the cultural and clinical needs of transgender patients
- enacting the Pregnant Workers Fairness Act (2015–2016) and similar state legislation, which would require employers to make the same sorts of accommodations for pregnancy, childbirth, and related medical conditions that they do for disabilities
- passing the Reproductive Health Non-Discrimination Amendment Act of 2014, to ensure that employment discrimination based on reproductive health decisions is prohibited
- assisting working families by enacting the Schedules That Work Act (2015–2016) and similar state legislation to curb employers’ abusive scheduling practices and give working people the right to request schedule predictability and flexibility
- passing the Healthy Families Act (2017–2018), which would establish a minimum, earned paid sick and safe days standard, and the FAMILY Act (2017–2018), which would establish a paid family and medical leave insurance program
- eliminating public policies that require surgeries that often result in sterilization, for people undergoing gender transitions to procure gender marker changes on government documents
- eliminating discretionary funding for abstinence-only-until-marriage programs
- passing the Real Education for Healthy Youth Act (2015–2016), legislation that would provide young people with the comprehensive sexuality education they need to lead sexually healthy lives
- passing the Military Access to Reproductive Care and Health for Military Women Act (2013–2014), which seeks to undo restrictions that prohibit women from obtaining an abortion in military facilities except in cases of rape, incest, and life endangerment, even though those women use their own funds
- opposing legislation that attempts to criminalize pregnancy by drug testing and prosecuting individuals for using drugs while pregnant

### *Professional Development and Continuing Education*

- social work education that focuses on reproductive and sexual coercion (including birth control sabotage, pregnancy pressure and coercion) and harm-reduction strategies and safety planning
- inclusion of content on the reproductive justice paradigm in social work programs
- social work education efforts that address the evidence-based risks of pregnancy, birth control, and abortion

### *Research*

- investigation to better understand the troubling recent increase in the U.S. maternal mortality rate to prevent maternal deaths and improve maternity care
- evaluation of the business case for paid family leave and sick days
- addressing racial disparities in reproductive health access including examining the structural issues that individuals of color face, such as less income and education, and limited access to preventive health care, including regular birth control, which can contribute to their higher rates of abortion

- development of a safe, effective, and reversible form of birth control for cisgender men to share the burden of pregnancy prevention
- investigation to better understand the risks of donor egg extraction, particularly with respect to the impact of drugs used for both suppression and stimulation of the ovaries.

## REFERENCES

- Alzate, M. M. (2009). The role of sexual and reproductive rights in social work practice. *Affilia, 24*, 108–119.
- American Congress of Obstetricians and Gynecologists. (2012). *2011 women's health stats & facts*. Retrieved from <https://www.acog.org/-/media/NewsRoom/MediaKit.pdf>
- American Congress of Obstetricians and Gynecologists. (2015). *Induced abortion and breast cancer risk*. Retrieved from [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Gynecologic\\_Practice/Induced\\_Abortion\\_and\\_Breast\\_Cancer\\_Risk](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Gynecologic_Practice/Induced_Abortion_and_Breast_Cancer_Risk)
- American Sexual Health Association. (2013). *Birth control methods comparison chart*. Retrieved from <http://www.ashasexualhealth.org/pdfs/ContraceptiveOptions.pdf>
- Behre, H. M., Zitzmann, M., Anderson, R. A., Handelsman, D. J., Lestari, S. W., McLachlan, R. I., et al. (2016). Efficacy and safety of an injectable combination hormonal contraceptive for men. *Journal of Clinical Endocrinology & Metabolism, 101*, 4479–4788. doi:10.1210/jc.2016-2141
- Belluck, P. (2013, January 4). Pregnancy centers gain influence in anti-abortion arena. *New York Times*. Retrieved from <http://www.nytimes.com/2013/01/05/health/pregnancy-centers-gain-influence-in-anti-abortion-fight.html>
- Biggs, M. A., Upadhyay, U. D., McCulloch, C. E., & Foster, D. G. (2017). Women's mental health and well-being 5 years after receiving or being denied an abortion: A prospective, longitudinal cohort study. *JAMA Psychiatry, 74*, 169–178. doi:10.1001/jamapsychiatry.2016.3478
- Centers for Disease Control and Prevention. (1999, December 3). Margaret Sanger. *Morbidity and Mortality Weekly Report, 48*(47), 1075. Retrieved from <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4847bx.htm>
- Committee on Health Care for Underserved Women. (2013). *Reproductive and sexual coercion* (Committee Opinion, No. 554). Washington, DC: American College of Obstetricians and Gynecologists, Women's Health Care Physicians.
- Cook, K. (2007). Environmental justice: Woman is the first environment. In *Reproductive justice briefing book: A primer on reproductive justice and social change* (pp. 32–33). Atlanta and New York: SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project.
- Correll, S. J., & Benard, S. (2007). Is there a motherhood penalty? *American Journal of Sociology, 112*, 1297–1339.
- Cote, I., & Lapierre, S. (2014). Abortion and domestic violence: Women's decision-making process. *Affilia, 29*, 285–297.
- FAMILY Act, S. 337, 115th Cong. (2017–2018). Retrieved from <https://www.congress.gov/bill/115th-congress/senate-bill/337>
- Frost, J. J., & Lindberg, L. D. (2012). Reasons for using contraception: Perspectives of U.S. women seeking care at specialized family planning clinics. *Contraception*. Retrieved from <http://www.guttmacher.org/pubs/journals/j.contraception.2012.08.012.pdf>
- Gold, R. B. (2003, March 1). *Lessons from before Roe: Will past be prologue?* Retrieved from the Guttmacher Institute Web site: <https://www.guttmacher.org/gpr/2003/03/lessons-roe-will-past-be-prologue>
- Goldschmidt, D., & Strickland, A. (2017, January). Planned Parenthood: Fast facts and revealing numbers. CNN. Retrieved from <http://www.cnn.com/2015/08/04/health/planned-parenthood-by-the-numbers/>
- Griswold v. Connecticut, 381 U.S. 479 (1965).
- Guttmacher Institute. (2016a). *Induced abortion in the United States* [Fact sheet]. Retrieved from <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states>
- Guttmacher Institute. (2016b). *Targeted Regulation of Abortion Providers*. Retrieved from <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers>

- Haslett, D. (1997). Hull House and the birth control movement: An untold story. *Afillia*, 12, 261–277.
- Hasstedt, K. (2016). Recent funding restrictions on the U.S. family planning safety net may foreshadow what is to come. *Guttmacher Policy Review*, 19, 67–72. Retrieved from <https://www.guttmacher.org/gpr/2016/12/recent-funding-restrictions-us-family-planning-safety-net-may-foreshadow-what-come>
- Healthy Families Act, H.R. 1516, 115th Cong. (2017–2018). Retrieved from <https://www.congress.gov/bill/115th-congress/house-bill/1516?r=8>
- Institute for Women’s Policy Research. (2016a). *Breadwinner mothers by race/ethnicity and state* [Quick Figures, IWPR #Q054]. Retrieved from <http://www.iwpr.org/publications/pubs/breadwinner-mothers-by-raceethnicity-and-state>
- Institute for Women’s Policy Research. (2016b). *The gender wage gap: 2015. Annual earnings differences by gender, race, and ethnicity* [Fact sheet]. Retrieved from <http://www.iwpr.org/publications/pubs/the-gender-wage-gap-2015-annual-earnings-differences-by-gender-race-and-ethnicity>
- Krase, K. (2014). *History of forced sterilization and current U.S. abuses*. Retrieved from Our Bodies Our Selves Web site: <http://www.ourbodiesourselves.org/health-info/forced-sterilization/>
- Kumar, A., Hessini, I., & Mitchell, E. M. (2009). Conceptualising abortion stigma. *Culture, Health, & Sexuality*, 11, 625–639.
- Liptak, A. (2016, June 27). Supreme court strikes down Texas abortion restrictions. *New York Times*. Retrieved from <http://nyti.ms/298q4o8>
- MacDorman, M. F., Declercq, E., Cabral, H., & Morton, C. (2016). Recent increases in the U.S. maternal mortality rate: Disentangling trends from measurement issues. *Obstetrics & Gynecology*, 128, 447–455.
- Masci, D., Lupu, I. C., & Davis, E. (2013). *A history of key abortion rulings of the U.S. Supreme Court*. Retrieved from <http://www.pewforum.org/2013/01/16/a-history-of-key-abortion-rulings-of-the-us-supreme-court/>
- Military Access to Reproductive Care and Health for Military Women Act, H.R. 1389, 113 Cong. (2013–2014). Retrieved from <https://www.congress.gov/bill/113th-congress/house-bill/1389>
- Nash, E., Gold, R. B., Ansari-Thomas, Cappello, O., & Mohammed, L. (2016). *Laws affecting reproductive health and rights: State trends at midyear, 2016*. Retrieved from <https://www.guttmacher.org/article/2016/07/laws-affecting-reproductive-health-and-rights-state-trends-midyear-2016>
- National Association of Social Workers. (2015). *Code of ethics of the National Association of Social Workers*. Retrieved from <https://www.socialworkers.org/pubs/code/default.asp>
- National Center for Transgender Equality. (2012). *Transgender sexual and reproductive health: Unmet needs and barriers to care*. Retrieved from <http://www.transequality.org/issues/resources/transgender-sexual-and-reproductive-health-unmet-needs-and-barriers-to-care>
- National Women’s Law Center. (2015). *If you really care about reproductive justice, you should care about transgender rights!* [Fact sheet]. Retrieved from <https://nwlc.org/resources/if-you-really-care-about-reproductive-justice-you-should-care-about-transgender-rights/>
- Norris, A., Bessett, D., Steinberg, J. R., Kavanaugh, M. L., Zordo, S. D., & Becker, D. (2011). Abortion stigma: A reconceptualization of constituents, causes, and consequences. *Women’s Health Issues*, 21(Suppl. 3) S49–S54.
- Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).
- Poggi, S. (2007). The Hyde Amendment violates reproductive justice and discrimination against poor women and women of color. In *Reproductive justice briefing book: A primer on reproductive justice and social change* (p. 34). Atlanta and New York: SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project.
- Pollitt, K. (1997). Abortion in American history. *Atlantic*. Retrieved from <http://www.theatlantic.com/magazine/archive/1997/05/abortion-in-american-history/376851/>

- Pregnant Workers Fairness Act, H.R. 2654, 114th Cong. (2015–2016). Retrieved from <https://www.congress.gov/bill/114th-congress/house-bill/2654>
- Proctor, B. D., Semega, J. L., & Kollar, M. A. (2016). *Income and poverty in the United States: 2015* (Report Number P60-256). Washington, DC: U.S. Census Bureau.
- Reagan, L. J. (1998). *When abortion was a crime: Women, medicine, and law in the United States, 1867-1973*. Berkeley, CA: University of California Press.
- Real Education for Healthy Youth Act, S. 2765, 114th Cong. (2015–2016). Retrieved from <https://www.congress.gov/bill/114th-congress/senate-bill/2765/titles>
- Reproductive Health Non-Discrimination Amendment Act of 2014 (Act 20-593) (Dec. 2014). Retrieved from <http://go.nationalpartnership.org/site/News2?page=NewsArticle&id=47642>
- Roberts, D. (2015, Fall). Reproductive justice, no just rights. *Dissent*. Retrieved from <https://www.dissentmagazine.org/article/reproductive-justice-not-just-rights>
- Roe v. Wade, 410 U.S. 113 (1973).
- Ross, L. (2007). What is reproductive justice? In *Reproductive justice briefing book: A primer on reproductive justice and social change* (pp. 4–5). Atlanta and New York: SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project.
- Roth, R. (2007). Incarcerated women and reproductive justice. In *Reproductive justice briefing book: A primer on reproductive justice and social change* (pp. 22–23). Atlanta and New York: SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project.
- Schedules That Work Act, S.1772, 114th Cong. (2015–2016). Retrieved from <https://www.congress.gov/bill/114th-congress/senate-bill/1772/text>
- Sonfield, A. (2013). What women already know: Documenting the social and economic benefits of family planning. *Guttmacher Policy Review*, 16(1), 8–12. Retrieved from <https://www.guttmacher.org/gpr/2013/03/what-women-already-know-documenting-social-and-economic-benefits-family-planning>
- Sonfield, A. (2017). What is at stake with the federal contraceptive coverage guarantee? [Reproductive health in crisis: A special series]. *Guttmacher Policy Review*, 20, 8–11. Retrieved from [https://www.guttmacher.org/sites/default/files/article\\_files/gpr2000816\\_0.pdf](https://www.guttmacher.org/sites/default/files/article_files/gpr2000816_0.pdf)
- Sonfield, A., Hasstedt, K., Kavanaugh, M. L., & Anderson, R. (2013). *The social and economic benefits of women's ability to determine whether and when to have children*. New York: Guttmacher Institute. Retrieved from <https://www.guttmacher.org/pubs/social-economic-benefits.pdf>
- Thielking, M. (2015, Dec. 1). Sky-high C-section rates in the US don't translate to better birth outcomes. *Stat*. Retrieved from <https://www.statnews.com/2015/12/01/cesarean-section-childbirth/>
- United Nations Commission on Human Rights. (1979). *Convention for the elimination of all forms of discrimination against women*. Geneva: Author.
- U.S. Department of Agriculture. (2017). *2015 expenditures on children by family report*. Alexandria, VA: Center for Nutrition Policy and Promotion.
- U.S. Department of Health and Human Services, Office of Population Affairs. (2014). *Emergency contraception: The facts*. Retrieved from <https://www.hhs.gov/opa/sites/default/files/emergency-contraception-fact-sheet.pdf>
- U.S. House of Representatives. (2006). *False and misleading health information provided by federally funded pregnancy resource centers*. Retrieved from <http://www.chsourcebook.com/articles/waxman2.pdf>
- Wellek, A., & Yeung, M. (2007). Reproductive justice and lesbian, gay, bisexual, and transgender liberation. In *Reproductive justice briefing book: A primer on reproductive justice and social change* (pp. 38–39). Atlanta and New York: SisterSong Women of Color Reproductive Health Collective and the Pro-Choice Public Education Project.

World Professional Association for Transgender Health. (2012). *Standards of care for the health of transsexual, transgender, and gender nonconforming people*. Retrieved from <http://>

[www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=3926](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926)

*Policy statement approved by the NASW Delegate Assembly, August 2017. This policy statement supersedes the policy statement on Family Planning and Reproductive Choice approved by the Delegate Assembly in August 2008. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 800, Washington, DC 20002-4241. Telephone: 202-408-8600; e-mail: [press@socialworkers.org](mailto:press@socialworkers.org)*