

Family Planning and Reproductive Choice

BACKGROUND

The modern history of family planning in the United States began in 1916 when Margaret Sanger, a public health nurse in New York City, opened the first birth control clinic. She and two of her associates were arrested and sent to jail for violating New York's obscenity laws by discussing contraception and distributing contraceptives. Ms. Sanger argued that birth control must be legalized.

Government support of family planning in the United States began in the 1960s when President Kennedy endorsed contraceptive research and the use of modern birth control methods as a way to address the world's population growth. It was under President Johnson and the War on Poverty that family planning services became more widely available. The rate of unwanted childbearing among people living in poverty was twice as high as it was among the more affluent population. This difference was attributed to the lack of available family planning services for women living in poverty.

By 1965, with bipartisan support, federal funds were made available to support family planning services for low-income women.

Title X of the Public Health Service Act of 1970 provided the majority of public funding for family planning services until 1985. Because of fiscal pressures and political factors, such as the growing power and influence of the religious right (mobilized in opposition to the 1973 Supreme Court decision legalizing abortion), Congress has not formally reauthorized Title X since 1985. Appropriations have continued, but inflation-adjusted funding for Title X services decreased by 58 percent from 1980

over the next two decades. More recently, other federal sources—including Medicaid, social services, and maternal and child health block grants; state children's health insurance programs; and Temporary Assistance for Needy Families—as well as state and local funds—have become available to subsidize family planning. Nonetheless, Title X remains central to the national effort (Gold, 2001).

As a result of Title X funding, contraceptive use among American women increased considerably between the early 1980s and the mid-1990s, and the country's unintended pregnancy rate—and the abortion rate—declined. But as Title X funding decreased, the decline in the number of unintended pregnancies slowed sharply. According to research by the Guttmacher Institute in 2006, this progress has ground to a halt:

The newest data paint a disturbing picture of two very different Americas—one in which middle- and upper-class women are continuing decades of progress in reducing unplanned pregnancy and abortion, and the other in which poor women are facing more unplanned pregnancies and growing rates of abortion. (Gold, 2006, p. 3)

Although progress on universally accessible family planning in the United States has stalled, international family planning efforts are also challenged. The World Health Organization (WHO) defines *family planning* as "the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is

achieved through use of contraceptive methods and the treatment of involuntary infertility" (WHO, 2007b, p. 1). WHO estimated that more than 120 million couples worldwide do not use contraception, despite wanting to space or limit their childbearing.

There are numerous economic and social benefits to good public family planning policies. In the United States, public funding for family planning prevents more than a million pregnancies each year. It has been estimated that each federal and state tax dollar spent on family planning saves three dollars in Medicaid costs for pregnancy-related and newborn care (Gold, 2001). Women who use family planning services are more likely to use prenatal services and thus have reduced infant mortality and fewer low-birth weight babies, in addition to reducing their own risk of death or health problems. Family planning also reduces infant deaths by helping women space pregnancies. The infant mortality rate is two times higher for a child born within two years of a sibling, a rate that is constant throughout the world (Pichler, 2007).

Emergency Contraception

The "morning after pill," or emergency contraception (EC), is a form of contraception that can be used shortly after sexual intercourse to prevent unintended pregnancy. Offered as a "second chance" for individuals who did not use contraception before intercourse, EC is equally valuable as a safeguard against method failure. EC pills are estimated to reduce the risk of pregnancy by up to 89 percent (Rodrigues, Grou, & Joly, 2002). When offered in a timely manner to victims of sexual assault, EC almost eliminates the fear of pregnancy resulting from this criminal act, helping to restore a sense of control to the victim.

Although this form of fertility control is safe, inexpensive, and easy to use, EC generates opposition by groups who oppose all forms of birth control or believe that it is an abortifacient. These arguments among policymakers threaten the accessibility of emergency contraception to those who might benefit from its protection.

Abortion

Research indicates that half of all pregnancies of American women are unintended and that four in 10 of these end in abortion (Guttmacher Institute, 2008). The correlation between high levels of unintended pregnancy and abortion cannot be discounted. As stated by Sharon Camp of the Guttmacher Institute (2006), "behind almost every abortion in the United States is an unplanned and unwanted pregnancy . . . [Abortion] . . . is a last resort for a woman who is faced with a crisis pregnancy" (p. 1). The United States has one of the highest abortion rates in the developed world, and it is estimated that 35 percent of women will have an abortion by 45 years of age. Although women of all backgrounds have abortions, abortion in the United States is increasingly likely to occur among single women, racial or ethnic minority women, low-income women, and women who have had at least one child (Boonstra, Gold, Richards, & Finer, 2006).

Abortion is a controversial medical procedure, but it has been performed over an average of a million times each year since 1973. The right of American women to terminate their pregnancy is founded on the Supreme Court decision in *Roe v. Wade* (1973) that has been under assault since the ruling was pronounced. A July 2007 national poll affirms, however, that a small majority of Americans, despite their ambivalence, still support the legal status of abortion. Looking at polls spanning the decade before, the percentages for all abortion questions have only fluctuated a few points over these 10 years, perpetuating an uneasy, but relatively stable tension (Polling Report, 2008).

Abortion rhetoric has always been highly charged, but only a tiny fraction of opponents have dedicated their lives to fight abortion on every level—from political activism to physical violence against abortion providers and patients. During the 1980s and 1990s, violence and physical, emotional, and social harassment forced many providers to abandon their practices. In addition, restrictions and regulations at every level of government have made it harder for women who need abortion services to access them. Consequently, one-third of

American women live in counties with no source of abortion services (Guttmacher Institute, 2003).

Men and Contraception

The primary methods of birth control before the 1960s were abstinence, withdrawal, and condoms, methods that depended on the cooperation of men. After the pill revolution, men have been largely left out of the area of reproductive choices (Ndong & Finger, 1998). However, men are important to reproductive health (Population Reports, 1998). The only effective ways to prevent sexually transmitted infections (STIs) are abstinence or condom use, both involving the cooperation of men. As research continues on male methods of contraception, fertility control and reproductive health are coming to be viewed through the wider lens of gender equality and shared responsibility.

Violence and Reproductive Health

Physical consequences of sexually violent acts may include STIs, HIV/AIDS, unwanted pregnancy, miscarriage, gynecological problems, sexual dysfunction, and injury. These wreak havoc on the victim's reproductive and emotional health (WHO, 1998).

ISSUE STATEMENT

Although contraceptive coverage in private insurance plans has improved in recent years, many women still lack coverage or have plans that do not cover the specific contraceptive they would like or face a prohibitive co-pay for their method of choice. As of 2004, only 20 states had comprehensive contraceptive coverage mandates, and employer self-insurance plans are generally not covered by these mandates (Moore, Finer, & Darroch, 2003).

The NASW *Code of Ethics* (2000) states that "social workers promote clients' socially responsible self-determination" (p. 5). Self-determination related to reproductive health means that without government interference, people can make their own decisions about sexuality and reproduction. As social workers, we sup-

port the right of individuals to decide for themselves, without duress and according to their own personal beliefs and convictions, whether they want to become parents, how many children they are willing and able to nurture, the opportune time for them to have children, and with whom they may choose to parent. Caring for children presents challenges for all parents, but for unwilling or unprepared parents, the economic, social, physical, or emotional challenges may be too great. Conversely, the right to parent should not be denied to capable people, regardless of gender or gender identity and expression.

Decisions about parenthood are crucial for individuals, their families, and their local communities, and multitudes of individual decisions even bear significant implications for the global community. Resolving personal issues of such importance should not be undertaken without access to reproductive health services that are based on the most current science and address the needs of a diverse population.

To support self-determination, these reproductive health services, including abortion services, must be legally, economically, and geographically accessible to all who need them. Medical research has advanced the prevention and treatment of HIV/AIDS and other STIs, the development of effective male contraceptives, wider choices of female contraceptive methods, and safer childbirth practices. Denying people with low income access to the full range of contraceptive methods, abortion, and sterilization services, and the educational programs that explain them, perpetuate poverty and the dependence on welfare programs and support the status quo of class stratification.

The United Nations' Fourth World Conference on Women adopted a platform statement in 1995 recognizing the importance of women's sexual and reproductive health (United Nations, 1995). The International Federation of Social Workers (IFSW) has adopted a policy statement on women's health issues, including sexual and reproductive health, and has identified this as an area of critical concern to social work (IFSW, 1999). WHO confirms that, despite tremendous advances in the development and accessibility of family planning services, there are still millions of individuals around

the world who are unable to plan their families as they wish. In addition to lack of access, poor quality of services, and technological issues, the utilization of family planning practices is hampered by power imbalances within couples and families and broader social, cultural, and religious issues (WHO, 2007a).

In 1979, the United Nations Commission for 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 (United Nations, 1979). Women who defer childbearing have the chance to further their education, develop work skills, acquire broader life experiences, have fewer children, provide better for the children they do have, and improve the well-being of their families. Family planning and access to a full range of reproductive health services are basic to meeting family needs, as well as allowing individual self-determination in reproduction and sexuality to be realized. Adequate financing through a continuing partnership between the private and the public sectors is necessary to make family planning programs and professional services available to all, regardless of the ability to pay. Government policies and medical programs, as well as medical programs under private auspices, should ensure that individuals have full access to the technical knowledge and resources that will enable them to exercise their right of choice about whether and when to have children.

As part of the professional team operating these programs, social workers must realize their professional duty to promote self-determination and assist clients in obtaining whatever help and information they need for effective family planning and for maintaining their reproductive health. Social workers also have a professional obligation to work in local, state, national, and international arenas to establish, secure funding for, and safeguard family planning and reproductive health programs, including abortion services and HIV/AIDS prevention and treatment, to ensure that these services remain legal, increasingly more effective, and available to all who need them.

POLICY STATEMENT

The NASW position concerning family planning, abortion, and other reproductive health services is based on the bedrock principles of self-determination, human rights, and social justice:

- Every individual, within the context of her or his value system, must have access to family planning, abortion, and other reproductive health services.
- The use of all reproductive health services, including abortion and sterilization services, must be voluntary and preserve the individual's right to privacy.
- Women (in particular women of color, women in institutions, and women from other vulnerable groups) should not be unethically used in the testing and development of new reproductive techniques and technologies.
- The nature of the reproductive health services that a client receives should be a matter of client self-determination in consultation with the qualified health care provider furnishing them.
- Public policies and legislation, nationally and internationally, must support a woman's authority over her sexual life and reproductive capacity, free from coercion, violence, and discrimination.
- Lesbians, gay men, and both male-to-female and female-to-male transgender people, as well as those who feel more comfortable living androgynously, are as capable as any other people of being good parents and should have equal access to parenting support services.
- Social workers who choose to restrict their services to clients and the community in a way that deprives their clients or community of a comprehensive consideration of all legal reproductive health options have a responsibility to disclose the limited scope of their services and to assist clients in obtaining comprehensive services elsewhere.

Availability of and Access to Services

NASW supports

- the fundamental right of each individual throughout the world to manage his or her fertility and to have access to a full range of effective family planning and reproductive health services, regardless of the individual's income, marital status, age, race, ethnicity, gender, sexual orientation, national origin, or residence; these services include, but are not limited to, contraception; and emergency contraception; fertility enhancement; prevention and treatment of HIV/AIDS, STIs, and the human papillomavirus (HPV); prenatal, birthing, and postpartum care; sterilization, abortion services, and adoption rights.
- a woman's right to obtain an abortion, performed according to accepted medical standards and in an environment free of harassment or threat for both patients and providers.
- reproductive health services, including abortion services, that are confidential, available at a reasonable cost, and covered in public and private health insurance plans on a par with other kinds of health services (contraceptive equity).
- improved access to the full range of reproductive health services, including abortion services, for groups currently underserved in the United States, including people with low income and those who rely on Medicaid to pay for their health care, adolescents, individual challenges and needs, sex workers, single people, lesbians, people of color and those from nondominant ethnic and cultural groups, those in rural areas, and those in the many counties and municipalities that currently do not have providers of such services.
- public and private adoption services that better address the needs of birth parents and that invite women and men, regardless of sexual orientation or gender expression, to consider adoption as a genuine alternative to abortion or parenting, contributing to a broader range of options.

- national, state, and local public awareness campaigns and educational programs relating to reproductive health and choice.

Legislation

Recent years have seen many initiatives at the state and federal levels to challenge and thereby overrule or undermine the rights granted by the Supreme Court's *Roe v. Wade* (1973) decision and subsequent high court decisions. Federal and state legislative bodies have sought to restrict funding for abortion and other reproductive health care services and research and impose restrictions to impede the use of services, while Congress has restricted or eliminated funding to developing countries.

Therefore, NASW

- supports legislation to facilitate a woman's access to contraceptives and emergency contraception.
- supports legislation to ensure that women who have been sexually assaulted have access to emergency contraception.
- supports legislation that ensures privately and publicly funded health insurance coverage includes access to all forms of reproductive health technologies, contraceptives, vaccinations, and medication equally for men and women.
- supports legislation to permit women and couples to donate human tissue and frozen, living, or deceased embryos to legitimate research projects.
- opposes government restrictions designed to limit access to reproductive health services, including abortion services.
- opposes government restrictions on financing reproductive health services, including abortion services, in health insurance and foreign aid programs.
- opposes any special conditions and requirements imposed on reproductive health care providers, such as the prescribed warning of unsubstantiated health risks resulting from abortion or mandatory waiting periods, which are not based on medical standards.

- opposes legislative or funding restrictions on medically approved forms of contraceptives and emergency contraception.
- opposes limits and restrictions on adolescents' access to confidential reproductive health services, including contraceptive and abortion services, and the imposition of parental notification and consent procedures.
- opposes legislative restrictions limiting access to parenting for lesbian, gay, bisexual, and transgender individuals.

Education and Research

For people to exercise self-determination in making choices related to sexuality and reproductive health care for themselves and their families, NASW supports

- public and private funding for research to develop and disseminate medically safe and effective methods of preventing, postponing, or promoting conception (including antiretroviral therapy), appropriate for women and men;
- academic and clinical education for students in the medical and health professions relating to the physical and psychological consequences of pregnancy and pregnancy loss and education for appropriate specialties on pregnancy termination techniques, postabortion care, contraceptive methods, and appropriate contraception counseling;
- school-based age-appropriate, culturally informed sexuality and reproductive health education programs that include information about the role 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; and introduction to skills for making healthy personal choices about sexuality and reproduction;
- funding for the development of sexuality education curriculums, as described earlier;
- development and funding of education and research programs to prevent the spread of STIs, to prevent unwanted pregnancies, and to reduce all forms of sexual violence and coer-

cion from which many unwanted pregnancies result; education that informs students, social workers, or others, about the normally occurring diversity of sexuality and of gender identity and expression, including the equal ability of all people to have their family planning and reproductive health care needs met.

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Policy statement approved by the NASW Delegate Assembly, August 2008. This policy statement supersedes the policy statement on Family Planning and Reproductive Choice approved by the Assembly in 1999 and referred by the 2005 Delegate Assembly to the 2008 Delegate Assembly for revision, the policy statement on Family Planning approved by the Assembly in 1967 and reconfirmed in August 1990, and the policy statement on Abortion approved by the Assembly in 1975 and reconfirmed by the Assembly in 1990. For further information, contact the National Association of Social Workers, 750 First Street, NE, Suite 700, Washington, DC 20002-4241. Telephone: 202-408-8600 or 800-638-8799; e-mail: press@naswdc.org