

Family Planning and Reproductive Choice

BACKGROUND

Women and men have attempted to practice family planning since the beginning of human history. 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 had to be legalized to free women from poverty, dependence and inequality" (Planned Parenthood Federation of America, 1998b, p. 2). Many social workers have participated in the birth control movement in the United States.

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. At that time, studies showed that the rate of unwanted childbearing among poor people 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 poor women. By 1965, with bipartisan support, federal funds were made available to support family planning services for low-income women as a way of alleviating poverty, expanding economic independence, and decreasing dependency on welfare (Planned Parenthood Federation of America, 1998b).

Title X of the Public Health Service Act of 1970 provided the majority of public funding for family planning services until 1985. Because of political factors, such as the right wing and religious assaults on women's reproductive rights, and fiscal pressures, Congress has not formally reauthorized Title X since 1985. Appropriations have continued, but without congressional support funding has been lower (Planned Parenthood Federation of America, 1998b). Government funding has been significantly reduced for family planning services in general in the United States and internationally, resulting in a two-tiered system of reproductive health care.

A vocal and well-organized minority of the population has been able to wield undue influence in the area of reproductive choice. However, public opinion polls continue to show that a large majority of Americans support a woman's decision in seeking contraception, abortion, and other reproductive health services. The public also supports sex education and continued government funding for research and development of birth control methods (Planned Parenthood Federation of America, 1998a).

The World Health Organization (WHO) has four program goals in the area of reproductive health. WHO (1999) holds that people should exercise their fundamental "sexual and reproductive rights" in order to:

- (1) experience healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfillment

(2) achieve their desired number of children safely and healthily, when and if they decide to have them

(3) avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed

(4) be free from violence and other harmful practices related to sexuality and reproduction. (p. 1)

These areas of concern make clear how comprehensive services must be in order to achieve sexual and reproductive health for all.

There are numerous economic and social benefits to good public family planning policies. Public funding for family planning prevents 1.2 million pregnancies in the United States each year. Of that number, 509,000 are prevented unintended births and 516,000 are prevented abortions. Each dollar spent on prevention saves more than four dollars in other medical costs and welfare. Women who use family planning services are more likely to use prenatal services and thus have reduced infant mortality, have fewer low-birthweight babies, have reduced mortality, and have decreased health problems for themselves (Alan Guttmacher Institute, 1998a, 1998b). The infant mortality rate is two times higher for a sibling born within two years of another child, a rate that is constant throughout the world (Planned Parenthood Federation of America, 1998c).

Maternal Death

Effective family planning policies prevent maternal mortality and morbidity. Mortality declines significantly with better and safer contraceptives. For example, "maternal mortality fell by one-third in a rural area of Bangladesh following a community project that increased contraceptive use prevalence to 50 percent" (Keller, 1995, p. 4). Worldwide there are approximately 585,000 pregnancy-related deaths each year. Ninety-nine percent of these deaths have occurred in developing countries (Alan Guttmacher Institute, 1998c). According to UNICEF, "no public health problem shows greater disparity between rich and poor countries than maternal mortality" (UNICEF, 1998).

Adolescents and older women are at the greatest risk of maternal death. In the United States between 1987 and 1990, there were 1,459 deaths that were pregnancy related, representing 9.2 deaths per 100,000 live births. The death rate for African American women was three to four times higher than for white women. The pregnancy-related death rate for women with no prenatal care was 7.7 times higher than for the group who had "adequate" prenatal care (Koonin, MacKay, Berg, Atrash, & Smith, 1998). Overall, the health and well-being of all family members improve when women are able to control the number and spacing of their children.

Abortion Rates and Unintended Pregnancies

Among the 190 million women who conceive each year in the world, there are 20 million abortions. These abortions usually occur under unsafe conditions, increasing the mortality rate and subsequent health problems (UNICEF, 1998). In 1996 there were 1.37 million abortions performed in the United States, according to the Centers for Disease Control and Prevention. This represented a decrease of 4.5 percent over the preceding year ("Morbidity and Mortality Weekly Report," as cited in American Medical Association, 1998). Women who have access to contraceptives are less likely to be faced with unwanted pregnancy and to face the decision to have an abortion or carry to term. What common sense and research show, however, is that the most effective means of reducing abortion is preventing unintended pregnancies in the first place (Alan Guttmacher Institute, 1998b). In fact, the use of contraceptives reduces the incidence of abortions by 85 percent (Alan Guttmacher Institute, 1998b). The average heterosexual woman must practice contraception for approximately 27 years of her life to protect against unwanted pregnancies (Monson, 1998). However, contraception, even under the best circumstances, cannot end the need for abortion entirely. Contraceptive methods will never be perfect, and women and men will never be perfect users of them. For example, about 1 in 10 women in the United States using contraception experiences an accidental preg-

nancy within 12 months of beginning to use a specific contraceptive method (Alan Guttmacher Institute, 1999). Thus, the use of contraception reduces but will never eliminate the need for access to emergency contraception and to abortion services. Therefore, women must have the right to decide for themselves, with the advice of qualified medical service providers, to determine whether or not to carry a pregnancy to term.

Since 1973 and the landmark *Roe v. Wade*, U.S. Supreme Court decision granting women in the United States the right to an abortion, access to safe and legal abortion services has been gradually restricted. Some of this erosion has been in the form of discontinuing government funding for abortions for poor women and of allowing states to bar use of public facilities for abortion. Some of it has taken the form of imposing restrictions and conditions on abortion services—such as requiring counseling, waiting periods, and/or notification and consent procedures, restrictions related to the circumstances of the pregnancy, or restrictions on the specific surgical or medical procedures that can be employed.

Men and Contraception

Prior to the advent of oral contraception for women, men had a greater part in taking responsibility for birth control. The primary methods of birth control at that time were abstinence, withdrawal, and condoms, methods that depended on the cooperation of men. After the pill, men have been largely left out of the area of reproductive choices (Ndong & Finger, 1998). Men are important to reproductive health because they benefit from limits in family size, are intimately involved in child rearing, are concerned with the spread of sexually transmitted diseases (STDs), and are interested in the health and welfare of their partners and children (Population Reports, 1998). The only effective way to prevent STDs is abstinence or condom use, which involves the cooperation of men.

More research on methods of birth control that involve men is being done (Ndong & Finger, 1998). Contraceptive use needs to be seen in the larger context of gender equality

and the involvement of men and women in roles and responsibilities that serve both sexes, not sex at the expense of one over another. One gender should not have the ultimate responsibility for contraception, procreation, and child-bearing.

Violence and Reproductive Health

The World Health Organization (1996) stated that “the most pervasive form of gender violence is violence against women by their intimate partners or ex-partners, including the physical, mental, and sexual abuse of women and sexual abuse of children and adolescents” (p. 1). In addition, violence has been associated with greater sexual risk taking among adolescents and the development of sexual problems in adulthood. Studies conducted in a range of countries suggest that from 20 percent to 50 percent of women experience being victims of physical abuse by their partners at some time in their lives and that on average from 50 percent to 60 percent of women abused by their partners are raped by them as well. The reproductive health consequences of gender-based violence include unprotected sex, STDs including acquired immune deficiency syndrome and human immunodeficiency virus, unwanted pregnancy, miscarriage, sexual dysfunction, and gynecological problems (WHO, 1998).

In the United States in recent years increasing incidents of violence, intimidation, and harassment of providers and users of legal abortion services have been curtailing the availability of abortion services (National Abortion and Reproductive Rights Action League [NARAL], 1999a). Since 1991, a number of physicians and other clinic staff have been murdered, and there have been over 200 reported acts of violence, including bombings, arsons, and assault, and 28,000 reported acts of disruption directed against abortion providers. The 1994 Freedom of Access to Clinics Entrances was passed but has not eliminated acts of violence of this kind. Unfortunately, “physicians and other clinic workers daily face the possibility of anti-choice terrorism and violence in order to provide women with essential reproductive health services” (NARAL, 1999a,

p. 4). These are health care professionals and their support staff engaged in providing legal medical services to clients who choose to receive them. This situation has contributed to the growing shortage of abortion providers in the United States; in 1999, 86 percent of counties in the United States had no abortion providers. When abortion services are safe and legal, the risk of complication and harm to women from the procedure is much lower than that of childbirth (Allan Guttmacher Institute, 1998c). The statements made by opponents of abortion that abortion leads to later problems with infertility, infant problems at birth, or breast cancer are not supported by any scientific evidence (NARAL, 1997).

ISSUE STATEMENT

The NASW Code of Ethics (NASW, 1999) states that "social workers promote clients' socially responsible self-determination" (p. 5). Self-determination means that without government interference, people can make their own decisions about sexuality and reproduction. It requires working toward safe, legal, and accessible reproductive health care services, including abortion services, for everyone.

As social workers, we believe that potential parents should be free to decide for themselves, without duress and according to their personal beliefs and convictions, whether they want to become parents, how many children they are willing and able to nurture, and the opportune time for them to have children. For the parents, unwanted children may present economic, social, physical, or emotional problems. These decisions are crucial for parents and their children, the community, the nation, and the world. These decisions cannot be made without unimpeded access to high-quality, safe, and effective health care services, including reproductive health services.

Reproductive choice speaks to the larger issue of quality of life for our clients. It "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so" (Hardee & Yount, 1998, p. 4). As social workers, we cannot address reproductive choice without addressing the larger

issue of discrimination and the empowerment of women. "How, when and whether to have a child involve different issues for women than for men; yet they do so in ways that vary depending on a woman's class, age, and occupation, as well as the time and culture in which she lives. . . . Unequal access to abortion and birth control perpetuates existing systems of discrimination" (Rudy, 1996, p. 92). The lack of funding for abortion for poor women, decreased availability of family planning services, and our current system of welfare reform with financial disincentives to pregnancy and childbearing with no mention of family planning or abortion services or the responsibilities of men in contraception and child rearing clearly work to the disadvantage of women.

The United Nations' Fourth World Conference on Women adopted a platform statement in 1995 recognizing the importance of women's sexual and reproductive health (along with physical, social, and mental health) (United Nations, 1995). The International Federation of Social Workers (IFSW) has adopted a policy statement on women endorsing the platform statement and identifying women's health issues, including sexual and reproductive health, as an area of critical concern to social work (IFSW, 1999).

Population development, the environment, and social and economic stability are integrally linked. Worldwide, 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. 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 Commission for Human Rights, 1979). A total approach to population policy must include not only family planning and reproductive health care services but improvement of socioeconomic conditions, including the provision of income, food, and other essential goods and services that are basic to meeting family needs. Without such planning and development, individual self-determination in reproduction and sexuality

cannot be realized and the full benefits resulting from family planning and reproductive health services cannot be achieved.

A continuing partnership between the private and the public sectors is necessary to assist families to plan for children. Adequate financing 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 potential parents 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, with their underlying emphasis on and particular methods for enhancing self-determination, have a special responsibility.

Social workers should take professional responsibility to assist clients in obtaining whatever help and information they need for effective family planning and for safeguarding their reproductive health. Because social workers are knowledgeable about family and community resources, they have many opportunities to help clients obtain desired services. Social workers also have a professional obligation to work on local, state, national, and international levels to establish, secure funding for, and safeguard family planning and reproductive health programs, including abortion providers, to ensure that these services remain safe, legal, and available to all who want them.

POLICY STATEMENT

The social work profession's position concerning abortion, family planning, and other reproductive health services is based on the principle of self-determination:

- Every individual (within the context of her or his value system) must be free to participate or not participate in abortion, family planning, and other reproductive health services.
- The use of all reproductive health care services, including abortion and sterilization services, must be voluntary and preserve the individual's right to privacy.

- Women of color, women in institutions, and women from other vulnerable groups should not be used in the testing and development of new reproductive techniques and technologies.

- The nature of the reproductive health care services that a client receives should be a matter of client self-determination in consultation with the qualified health care provider furnishing them.

- Current inequities in access to and funding for reproductive health services, including abortion services, must be eliminated to ensure that such self-determination is a reality for all.

- We believe that client self-determination and access to a full range of safe and legal reproductive health care services without discrimination will contribute to an enhancement of the individual and collective quality of life, strong family relationships, and population stability.

Although men also have an important stake in access to family planning and reproductive health services (Ndong & Finger, 1998; Population Reports, 1998), because women bear and nurse children their right to these services has been recognized internationally. The Convention to Eliminate All Forms of Discrimination Against Women asserts that women internationally have the right to "decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" (United Nations Commission for human Rights, 1979, p. 8).

If an individual social worker chooses not to participate in the provision of abortion or other specific reproductive health services, it is his or her responsibility to provide appropriate referral services to ensure that this option is available to all clients.

Availability of and Access to Services

In addition, the profession 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 safe

and legal family planning services regardless of the individual's income, marital status, race, ethnicity, sexual orientation, age, national origin, or residence

- Access to the full range of safe and legal reproductive health services for women and men including (and not limited to) contraception, fertility enhancement, treatment of sexually transmitted diseases, and emergency contraception, prenatal, birthing, postpartum, sterilization, and abortion services
- The provision of reproductive health services including abortion services that are legal, safe, and free from duress for both patients and providers
- The provision of reproductive health services, including abortion services, that are confidential, comprehensive, available at reasonable cost, and covered in public and private health insurance plans on a par with other kinds of health services (contraceptive equity)
- Improvement in access to the full range of reproductive health services, including abortion services, for groups currently underserved in the United States, including the poor and those who rely on Medicaid to pay for their health care; adolescents; 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 as abortion (NARAL, 1999b)
- Empower women through public policies that incorporate women's rights, reproductive health, and reproductive choices; condemn all forms of discrimination; and increase the economic and social supports for women and families who choose to have children
- The provision of reproductive health services to include access, protection, and supportive services to people with special challenges and needs.

Only by eliminating barriers to services based on finances, geography, age, or other personal characteristics will self-determination for all be achieved.

Legislation

Recent years have seen many initiatives at the state and federal level to erode the privacy and reduce the freedom granted by the Supreme Court to women seeking abortion, contraceptive, and other reproductive health services. In particular, national and state legislative bodies have acted to restrict funding, even internationally, to family planning and other health care programs that include abortion among the services they offer. Therefore, NASW:

- supports a woman's right to seek and obtain a medically safe abortion under dignified circumstances
- opposes government restrictions on access to reproductive health services, including abortion services, or on financing for them in health insurance and foreign aid programs
- opposes any special conditions and requirements, such as mandatory counseling or waiting periods, attached to the receipt of any type of reproductive health care
- opposes legislative or funding restrictions on medically approved forms of birth control, including emergency contraception
- opposes limits and restrictions on adolescents' access to confidential reproductive health services, including birth control and abortion services, and the imposition of parental notification and consent procedures on them
- supports legislative measures, including buffer zone bills, to protect clients and providers seeking and delivering reproductive health services, including abortion services, from harassment and violence.

Education and Research

In order for people to exercise their right to freedom in making sexual and reproductive choices for themselves and their families and to choose their own reproductive health care services, NASW supports:

- funding for research into medically safe and effective methods of birth and fertility control for women and men that includes attention to the needs of minority women
- inclusion of content on the provision of effective, safe, and high-quality family planning and reproductive health services, including abortion services, in the training of physicians and other relevant medical professionals
- comprehensive, age-appropriate, culturally competent sex education programs that include information about sexuality and reproduction; the role of personal attitudes, beliefs, and values in individual and family decision making on these issues; how gender roles and stereotypes can harm the reproductive health of women and men; the prevention of sexually transmitted diseases; the range of reproductive health services and technologies available; and the development of skills to make healthy personal choices about sexuality, reproduction, and reproductive health care
- funding for sex education programs without restriction on the content of the information provided
- development and funding of programs to prevent the spread of sexually transmitted diseases, to prevent unwanted pregnancies, and to reduce all forms of sexual violence and coercion from which many unwanted pregnancies result
- education of social workers, in degree-granting programs and through continuing education, about human sexuality, emerging reproductive technologies, and effective practice with people making choices about their reproductive behavior and reproductive health care services.

Support, including governmental support, should be available to develop and disseminate improved methods of preventing, postponing, or promoting conception.

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