The Movement: Reproductive Health and Rights in 2024

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Article

Abstract

Women's sexual and reproductive health (SRH) encompasses several topics, including but not limited to sexual expression, pregnancy, childbirth, contraception, and diseases of the reproductive system. The use of legal authority and power, as well as political influence, have long been factors used to regulate women's SRH. In the United States (U.S.), examples of state and national legislation have been undertaken to impact SRH and medical treatment and decision-making related to SRH. Several national and international organizations engage in sexual and reproductive health rights (SRHR) activities. The activities of these national and international organizations in SRH often include policy formulation, data collection, monitoring, reporting, and other functions.

While definitions of sexual and reproductive health rights vary, there are commonalities and core issues that can be identified. These include issues related to the LGBTQ population, immigration, and reproductive health rights among minoritized groups, which are leading topics wrapped around SRHR and of debate in recent history. This article aims to discuss sexual and reproductive health in promoting population health and societal well-being, recent policy decisions impacting SRH, and the role nurses play in shaping research, practice, and policies. For this paper, sexual and reproductive health rights (SRHR) are defined as an extension of human rights relating to an individual's autonomy, sexuality, sexual expression, reproduction, and access to information and resources on SRH. SRHR also includes freedom from violence, discrimination, and mistreatment. While a comprehensive review of these areas is beyond this article's scope, historical and recent examples are illustrated.

Key Words: childbearing, laws, coercion, family planning, threat, nursing, academics

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Women's health, particularly during reproductive age, is a critical component of the health and economy of a community. Unhealthy women face significant challenges in terms of giving birth to healthy babies and caring for families. Additionally, unhealthy women cannot be active and efficient contributors in the workplace (Ford et al., 2023). Understanding and improving women's health, particularly those of reproductive age, is essential to a thriving U.S.

With data from the Commonwealth Fund 2020 International Health Policy Survey and the Organization for Economic Co-Operation and Development, the health of women of reproductive age in eleven of the high-income countries of the world was examined (Gunja et. al, 2022). These eleven countries included the U.S., Sweden, Canada, Netherlands, France, United Kingdom, Germany, New Zealand, Australia, Norway, and Switzerland. U.S. women of reproductive age were found to have the highest rates of avoidable death at 198 deaths per 100,000 females, which is significantly higher than the United Kingdom (146 deaths per 100,000 females) as the next highest and Switzerland (90 deaths per 100,000 females) at the lowest rate (Gunja et al., 2022; Hoyert, 2024).

When looking closer at reproductive health status, the U.S. has the highest maternal mortality rate (22.3 deaths per 100,000 live births) in comparison to the other ten high-income countries (Gunja et al., 2022;Hoyert, 2024). France has the next highest rate at 7.6 deaths per 100,000 live births. Conversely, Norway has 0.0 deaths per 100,000 live births (Gunja et al., 2022). In a deeper dive examining the U.S. maternal mortality rate, differences between racial and ethnic groups are seen. The maternal mortality rate for Black women was 49.5 deaths per 100,000 live births and for White (19.0), Hispanic (16.9), and Asian (13.2) women in 2022 (Hoyert, 2024).

A myriad of reasons exist for why the U.S. maternal mortality rate is high, including high rates of cesarean sections, inadequate or lack of prenatal care, pay models, social determinants of health, racism, and elevated rates of chronic disease. For example, the U.S. (20%) and Canada (20%) had the highest percentage of women of reproductive age having two or more chronic conditions in comparison to other high-income countries, with Australia (17%) and Norway (17%) being the next highest (Gunja et al., 2022;Hoyert, 2024). Almost half of U.S. women (49%) reported delaying or skipping needed healthcare due to costs; Australia (32%) was next highest, while Netherlands (12%) was lowest (Gunja et al., 2022). Lack of access to reproductive and sexual health services is a problem that contributes to the high rates of maternal mortality as well as poor reproductive and sexual health outcomes in the U.S. (Adler et al,, 2023; Sutton et al., 2021). While the Affordable Care Act improved access to care for women in the U.S. (Sutton et al., 2021), approximately ten million still lack health insurance (Gunja et al., 2022).

Traditionally, services in the U.S. have focused on specific diseases such as HIV/AIDS rather than viewing sexual health in a holistic and integrated approach (Ford et al., 2023). For women, a holistic and integrated approach is needed; for example, sexual expression is related to pregnancy, including unplanned pregnancy, as well as sexually transmitted infections and sexual dysfunction (Ford et al., 2023). For women from racial and ethnic minoritized populations, in particular, underlying conditions such as stigma, poverty, and structural, cultural, and interpersonal racism warrant a comprehensive approach that recognizes these conditions when addressing sexual and reproductive health (Ford et al., 2023; Sutton et al., 2021). Unfortunately, limited work has been done to gather data systematically to demonstrate the implementation and effectiveness of holistic and integrated sexual and reproductive health services in the U.S. (Hall et al., 2023; Sutton et al., 2021).

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The overturning of Roe vs. Wade by the U.S. Supreme Court in 2022 brought the issues of reproductive health and reproductive rights to the forefront of the intersection of health and legal arguments (Carvajal et al., 2024; Poehling et al., 2023; Schott et al., 2023). Laws related to abortion care have long varied from state to state, with some states prohibiting specific types of reproductive health care services and others now moving to safeguard the full range of reproductive health care services (Blazina, 2022).

Framework of Reproductive Justice

The framework of reproductive justice (Ross & Solinger, 2017) was developed to express the context and experience in which women from majority populations, as well as racial and ethnic minoritized populations, live and give birth. Ross and Solinger define reproductive justice as going "beyond the pro-choice/pro-life debate and [having] three primary principles: (1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments (2017). The framework recognizes and advocates for sexual autonomy and gender freedom for every human being (Poehling et al., 2023; Ross & Solinger, 2017). Reproductive justice expands the concepts of reproductive health and rights by incorporating intersectionality, human rights, reproductive oppression, and population control (Ross & Solinger, 2017).

Suppose the reproductive justice framework is thought of as scaffolding. In that case, other concepts and theories can be the building material that provide pathways for research, practices, and policies for addressing issues that all people experience around reproduction. For example, environmental justice can fit within the framework of reproductive justice when examining exposures to hazards that can affect the health of a pregnant person and/or the child (Liddell & Kington, 2021; Lochotzki et al., 2022). Social determinants of health provide specific constructs that can influence the economics of reproduction and the family structure (Carvajal et al., 2024). The implementation of reproductive justice dictates the particular use of other concepts and theories within a context and/or population.

Legislative Landmarks in SRHR

In the United States, SRHR has been the focus of several historic and impactful judicial decisions. In the classic case known as "Griswold versus Connecticut" (1965), the United States Supreme Court heard the case of the director of a Planned Parenthood clinic and its medical director, a licensed physician, who were convicted as accessories for giving married persons medical advice on how to prevent conception and providing a prescription for a contraceptive. At the time, a

Connecticut statute made it a crime for any person to use any drug or article to prevent conception. The court ruled that a right to privacy can be inferred from several amendments in the Bill of Rights, and this right prevented states from making illegal the use of contraception by married couples.

In 2010, the landmark legislation, the Affordable Care Act (ACA), was signed into law. This comprehensive healthcare reform law had three primary goals. These included 1) making affordable health insurance available to more people, 2) expanding the federal Medicaid program to cover all adults with income below 138% of the federal poverty line, and 3) supporting innovations to lower the costs of health care. Other benefits covered by the ACA included breastfeeding equipment and support, birth control methods, and counseling. The law also furthered regulation of health insurance companies by requiring insurance plans to cover people with pre-existing health conditions, including pregnancy, without charging more (Jones & Sonfield, 2016). Further revision of the original ACA, "Women's Health Amendment," included coverage for several family planning services, including contraception and screening for sexually transmitted infections (Witkop, 2023; HRSA, 2024).

In the past several years, legislative efforts impacting the topics of contraception and the reversal of Roe vs Wade have been evident (Haines, 2024). In 2022, the United States Supreme Court heard the Dobbs versus Jackson Women's Health Organization case, known as the Dobbs decision (Haines, 2024). The case intended to ask the court to consider the constitutionality of Mississippi's Gestational Age Act—a law banning most abortions after 15 weeks of gestation with rare exceptions. In a divided opinion, the Court not only upheld the Mississippi law but ruled on the broader issue of federal versus state determination of pregnancy termination laws. The court ruled that such control should revert to the states. Thus, the court overturned the hallmark 1973 case Roe v. Wade and a related 1992 case, Planned Parenthood vs. Casey. These two prior cases had set and reinforced the legality of —the right not to have a child, the right to have a child, and the right to parent children in safe and healthy environments (Haines, 2024; Schreiber et al., 2023).

Even before Dobbs, several states had restricted SRHR in various ways, including regulating insurance coverage, imposing waiting periods requiring counseling, requiring ultrasounds and requirements for parental consent for minors, and regulating clinics providing pregnancy termination and the regulation of providers performing the procedures. Since the Dobbs decision was passed, several states have introduced or enacted legislation, including state constitutional amendments to politicize — the right not to have a child, the right to have a child, and the right to parent children in safe and healthy environments at the state level. As of 2024, Dobbs' political influence and impact are still unknown (Hill et al., 2023). The 2024 election cycle will include several state ballot initiatives that include language on abortion access.

As noted above, within the United States, each state has different laws impacting SRH, including laws impacting termination of pregnancy. Sometimes, these include unclear and confusing language for practitioners and patients (Haines, 2024). The United Nations (U.N.) Office of the High Commissioner for Human Rights discusses SRH (U.N. Human Rights, 2020). The U.N. discussion includes clarity—writing women's sexual and reproductive health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination. The U.N. has indicated that women's rights to health include their sexual and reproductive health. Many policy-influencing organizations have developed definitions of SRH. Examples are shown in Table 1.

Table 1. Definitions of SRHR

The World Health Organization (WHO) notes that the definition does not represent an official WHO position, but rather is "a contribution to ongoing discussion about sexual health.	The fulfillment of sexual health is tied to the extent to which human rights are respected, protected, and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws."
U.S. Dept of Health and Human Services	refers to "ensuring women can make their own decisions about their own bodies, and preserving the FDA's authority to make science-based determinations about what medications are safe and effective." (DHHS, 2024)
Guttmacher-Lancet commission on sexual and reproductive health and rights (Starrs et al., 2018).	SRHR are defined as being based on human rights of individuals to have their bodily integrity, privacy and personal autonomy respected.

The Department of Health and Human Services (DHHS, 2024) does not define reproductive rights on its Reproductiverights.gov website. However, the DHHS site contains information on emergency care, birth control, medication, abortion access, and other preventive health services. The 2018 Guttmacher-Lancet report (Starrs et al., 2018) based human rights of individuals to:

- freely define their sexuality, including sexual orientation and gender identity and expression,

- decide whether and when to be sexually active,
- choose their sexual partners,
- have safe and pleasurable sexual experiences,
- decide whether, when, and whom to marry,
- decide whether, when, and by what means to have a child or children, and how many children to have,
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

In the U.S., health care is an example of a positive right. The implications of having the ability to obligate another to service without compensation or to obligate one or more other persons to taxation to confer a right to another is at the crux of the argument of whether healthcare, including any positive rights related to SRH, should be considered a human right, rather than recognizing it as an entitlement or another related term (U.S. 1776).

Responding To Politicization of Women's Health

State action is inconsistent when responding to the politicization of women's health. Sexual and reproductive health champions are incorporating SRH into legislative agendas. SRH champions promote research-supported evidence, ethics, and best practice guidelines. For example, the Emergency Medical Treatment and Labor Act (EMTALA) guidelines specify that stabilizing care must be provided, even if this means performing an abortion. However, EMTALA is being resisted in many courts (Chernoby & Acunto, 2024). Fear of litigation leads to an undue burden on patients and delays in care (Hill et al., 2023). There are current cases where emergency room physicians have not provided stabilizing care due to the politicization of health care, which has led to loss of fertility or life (Chernoby & Acunto, 2024).

Another unintentional consequence of unclear policies and fear of litigation is the presence of maternity care deserts, leaving women not only with a lack of reproductive access but also a lack of early care for such specialties as oncology (Hill et al., 2023). The maternal mortality rate was 32.9 deaths per 100,000 live births in 2021 and 22.3 deaths per 100,000 live births in 2022, significant increases over 2018's rate of 17.4 deaths per 100,000 live births (Hoyert, 2024). In 2022, the maternal mortality rate for Black women in the U.S. was 49.5 deaths per 100,000 live births, a decrease from 69.9 in 2021, yet significantly higher than rates for white (19.0), Hispanic (16.9), and Asian (13.2) women (Hoyert, 2024). As a developed country struggling with high maternal mortality rates, policies blocking evidence-based care will increase maternal mortality rates and health disparities. The current partisan climate on providing evidence-based care for women does not, in some cases, align with practice guidelines or medical protocols. States where there is a total ban on certain reproductive care services are exacerbating an already taxed system (Hill et al., 2023). Lack of essential care for women can lead to increased morbidity and mortality in women and may lead some to access unregulated health care (e.g., lay people offering abortion services), increasing their risk for poor outcomes (Burdick et al., 2024). Skilled practitioners must be allowed to provide life-preserving care using research-based evidence and practice guidelines (ACOG, n.d.).

Health care policy is intended to protect access to care, not create barriers driven by political motivations or personal ideology.

Responding to politicization in the treatment of the full scope of reproductive healthcare services includes protecting the rights of patients (ACOG, 2023a). Providers should have the right to practice within clinical guidelines and provide care to the full extent of the law (ACOG, 2023b). This includes the right to disseminate evidence-based information and maintain private patient records (ACOG, 2023b; Chernoby & Acunto, 2024). This also implies transferring care to an appropriate provider with "real-time" information when necessary to meet the needs of patients (ACOG, 2023b). This is a pivotal and controversial time in history for providers and recipients of women's health care because access to specific types of care provided to women are viewed as unlawful or limited. When problems with access to care negatively impact gender equality and health equity, it undermines social determinants of health goals, mission, and vision (Hill et al., 2023). The outcomes of providing care in a way that is contrary to science and evidence-based practice are adverse effects on vulnerable populations, including the LGBTQ community, minorities, adolescents, and individuals with fertility concerns.

Health care policy is intended to protect access to care, not create barriers driven by political motivations or personal ideology. The National Partnership for Women and Families (2016) made the following recommendations to guide lawmakers and the medical community: "1) Lawmakers and policymakers should reject legislative and regulatory proposals that interfere in the patient-provider relationship or force providers to violate accepted, evidence-based medical practices and ethical standards. 2). The medical community, patients and advocates should speak out against government actions that inappropriately infringe on the relationship between patients and their healthcare providers, including mandates or

restrictions that require providers to violate their professional standards or provide care that does not align with accepted, evidence-based medical practices. 3) Laws that are based on politicians' ideology and not sound medical evidence — such as ultrasound requirements, biased counseling laws, mandatory delays, restrictions on medication abortion and TRAP laws — should be repealed. 4) Lawmakers should take steps to protect the patient-provider relationship and affirm the importance of individualized care and providers' ability to further the best interests of their patients. This includes advancing legislation prohibiting interference with licensed health care providers' ability to exercise their professional and clinical judgment so that patients can receive care based on medical evidence, not politics." Following these guidelines can ensure equitable access to care for all seeking services.

Research Evidence and Nurse Advocacy to Impact Policy

Violence against women, sometimes also referred to as gender-based violence, is a manifestation of gender inequality as it typically situates women and girls in subordinate positions (Grace & Anderson, 2018). Violence has devastating consequences for women's lives, including their sexual and reproductive health and human rights. Reproductive coercion, a behavior that is designed to interfere with the autonomous decision of women about their SRH, is a specific type of gender-based violence that disproportionately affects women and girls, especially when gender inequity intersects with other forms of oppression such as those experienced by racial and ethnic minoritized women and immigrants (Grace & Anderson, 2018).

Nurses play a vital role in contributing to the research evidence on reproductive coercion and health. Nurse-informed research data has helped to classify the ways that interference with autonomous decision-making is evident in pregnancy coercion, abortion coercion, and birth control sabotage (Grace et al,, 2022; Grace & Anderson, 2018). Nurse advocates helped to elucidate the prevalence and context of political interference among diverse populations such as bisexual and heterosexual minority women, college-age women, and Latinas. Researchers have documented political interference co-occurrence with other forms of violence, such as physical intimate partner violence, and health and social consequences, such as post-traumatic stress disorder and unplanned pregnancies (Alexander et al., 2016; Grace et al., 2022; Sutherland et al., 2015).

There are several ways that nursing organizations have informed policies on reproductive coercion. For example, research provides evidence for policy recommendations directed at policymakers. This has included consensus studies completed by the National Academies of Sciences, Engineering, and Medicine (NASEM) and other non-partisan groups, policy briefs generated through professional organizations such as the American Nurses Association (ANA), American Academy of Nursing (AAN), and the National League of Nursing (NLN). Other exemplar reports using evidence-based policy recommendation include the Essential Health Care Services Addressing Intimate Partner Violence Consensus Study Report (NASEM, 2014), which included three nurse scientists on the committee, and an American Academy of Nursing position statement on SRH Health Rights (Olshansky et al., 2018), which provided comprehensive, evidence-based policies with applicability to reproductive coercion.

Expert testimonials from nurse scientists can also be influential, especially when research evidence is combined with clinical evidence from nurses who communicate the human experience of reproductive coercion and recommended policies, such as the lived experience of women experiencing reproductive coercion and lack of access to needed services such as health screening, childbirth, birth control, and abortion. Finally, nurses in leadership positions have direct roles in policymaking at the organizational (e.g., executive in a healthcare organization) or governmental level (e.g., state senator; U.S. congressperson). One exemplar is Dr. Lauren Underwood's (D-IL) work with the Momnibus Act, which is designed to address the maternal health crises, in part by capitalizing on improving investments in addressing the social determinants of health, which include violence and reproductive coercion (Underwood & Booker, 2020).

While these examples highlight a solid foundation for clinical practice recommendations for screening and addressing reproductive coercion and its consequences, this evidence can also promote the creation of policies that can prevent and address reproductive interference and further enhance the availability of services for individuals experiencing gender-based violence. The end goal is policies and laws that support the sexual and reproductive health of women, their partners, and their families, which are the foundation of our communities and nation.

Conclusion

Having autonomy over their bodies, people should unquestionably have access to the sexual and reproductive health services of their choice. SRH rights protect everyone's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination (WHO, n.d.). Because access to certain SRH services has become regulated by policy and law, women are faced with having to seek access through non-traditional means. While many important improvements have occurred over the past several decades, access to full SRH

remains limited for many U.S. women. Legislative and policy actions to protect existing and reinstate limited access to full-service SRH are urgently needed. A call to cease the politicization of reproductive health and a respect for science that drives policy change is advantageous for the greater mass of providers and recipients of reproductive health care services.

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