Reproductive Justice is the human right to control one's body, sexuality, gender, and reproductive choices. That right can only be achieved when all women and girls have the complete economic, social, and political power and resources to make healthy decisions about our bodies, our families, and our communities in all areas of our lives.

CONTRACEPTIVE EQUITY FOR BLACK WOMEN

Every person has the right to make informed decisions about their reproductive health and to plan their family without coercion or interference by doctors, the government, or anyone else.

Access to contraceptives is critical so people can be healthy. Access to contraceptives may help some people "complete their education, get and keep a good job, support themselves and their families financially, and invest in their children's future."[1] Every person should be able to choose which contraceptive method(s) to use (if any), based on their own health needs and unique circumstances.

Ideally, this means that people can plan whether or when to start or add to their family without outside interference. Yet, contraceptive choices are unduly influenced by structural racism, gender discrimination, and socio-economic barriers. These factors influence whether Black women have health insurance, what types of contraception are covered by their insurance, and how accessible contraception—and health care itself—are in their community.[2]

CONTRACEPTIVE ACCESS AND USE

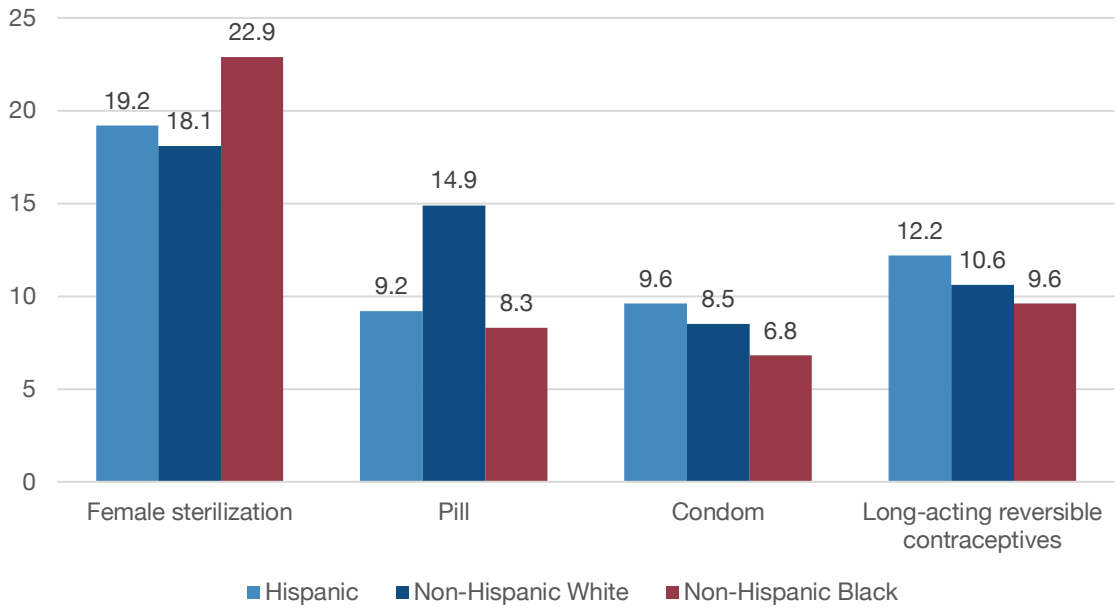
Because contraception is expensive, it is most accessible to people who have insurance. The Affordable Care Act (ACA) mandated that private insurance cover all 18 contraceptives approved by the Food and Drug Administration (FDA), including: barrier methods (e.g., diaphragms, sponges); hormonal methods (e.g., birth control pills, vaginal ring); implanted devices (e.g., intrauterine devices); Emergency Contraception; and tubal ligation. The ACA also required private insurers to cover contraception without excessive cost-sharing like deductibles and co-pays. The Trump-Pence administration has been trying to chip away at access to contraception and other vital health care services; in 2019, it issued regulations that allowed a broad array of employers to exempt themselves from the ACA's contraceptive coverage rules.[3]

Contraception can also be covered by state regulation of insurance companies. As of 2019, 29 states required insurance plans that cover prescription drugs to "also cover prescription contraceptives."[4]

As a result of the ACA, rates of uninsurance among women aged 15–44 dropped 41% from 2013 to 2018, from almost 20 percent (19.9%) to 12 percent nationwide.[5] Black women's uninsured rates fell 9 percent during this time.[5] These improvements occurred before 2017, however, and there was a slight increase in the proportion of uninsured women of reproductive age between 2017 and 2018. It appears that "progress has stalled under the hostile policies of the Trump administration."[5]

For those who lack private insurance, family planning and contraceptive services may be available through Federal programs. These include Medicaid, which provides health care for women with low incomes and other specific groups of people; Title X, the Federal family planning program currently under attack by the Trump-Pence administration; and programs managed by state and local health departments, and non-profit providers.

CONTRACEPTIVE USE BY RACE/ETHNICITY[6]

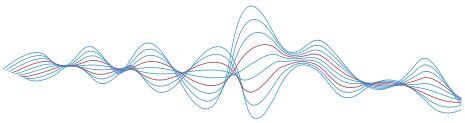


Although more women have coverage as a result of the ACA, there are still wide variations in the type of contraception women use and have access to. Women may choose (or be encouraged to choose) different methods depending on a number of factors, including having private vs. public insurance (an indicator of socio-economic status) and race/ethnicity.[2] Statistics indicate that Black women use contraception at lower rates than women of other racial/ethnic backgrounds, due to a number of structural barriers.[6]

CONTRACEPTIVE USE BY RACE/ETHNICITY[6]

A HISTORY OF COERCION AND MISTRUST

The U.S. has a long and troubling history of reproductive oppression on the part of physicians, government agencies, and medical institutions—which have sought to control and limit the fertility of marginalized communities, particularly Black women, women of color, women with low incomes, immigrant and Indigenous women, uninsured women, women with disabilities, and women whose bodily autonomy and sexuality was not respected.[7]



In the 1990s, coercive state policies attempted to force women with low incomes to accept sterilization or the Norplant implant in order to receive public benefits or avoid incarceration.

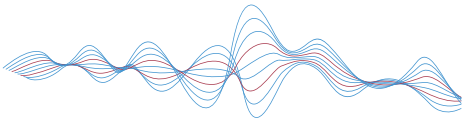
For decades, Black women have faced coercive contraceptive practices and policies, misinformation about contraceptive side-effects, and unethical testing of new contraceptive methods (e.g., the Pill, Norplant, Depo-Provera).[8] Family planning decisions were often made *for* Black women, not *by* Black women, with the goal of either controlling Black women and their reproduction or to advancing contraceptive research at Black women's expense.[9 10 11] This history includes both sterilization and administration of contraceptives without women's knowledge or permission, as occurred in many states well into the 1970s.[8 12] Such practices are not part of the country's distant past. For example:

- In the 1990s, coercive state policies attempted to force women with low incomes to accept sterilization or the Norplant implant in order to receive public benefits or avoid incarceration.[12] As one example, the South Carolina legislature introduced a bill requiring women "with two or more children to have a Norplant inserted as a condition of being able to receive welfare benefits."[12]

- Between 2006 and 2010, the California Dept. of Corrections and Rehabilitation sterilized nearly 150 female inmates. Although the sterilizations violated prison rules and state laws, the state paid doctors $147,460 to perform these operations.[13]
- In 2017, a Tennessee judge was reprimanded for offering to reduce convicted women's jail sentences if they got sterilized, a coercive practice that violates both personal liberty and bodily autonomy.[14] The judge claimed the offer was made to repeat offenders so they could "make something of themselves ."[15]
- To this day, South Dakota's Medicaid program refuses to cover removal of contraceptive implants, stating in the billing manual that the state "will not reimburse for the removal of the implant if the intent is for the recipient to become pregnant.'"[16 17]

When *In Our Own Voice* conducted "listening sessions" on reproductive health, women shared about times when they were not listened to or trusted by their providers. One woman, who had previously suffered side effects from birth control pills and developed ovarian cysts while using a NuvaRing, said she had to do her own research and fight her provider in order to try different birth control pills.[18]

Both historically and today, medical racism has resulted in experiments on, exploitation of, and mistrust of Black women's sexual and reproductive health.

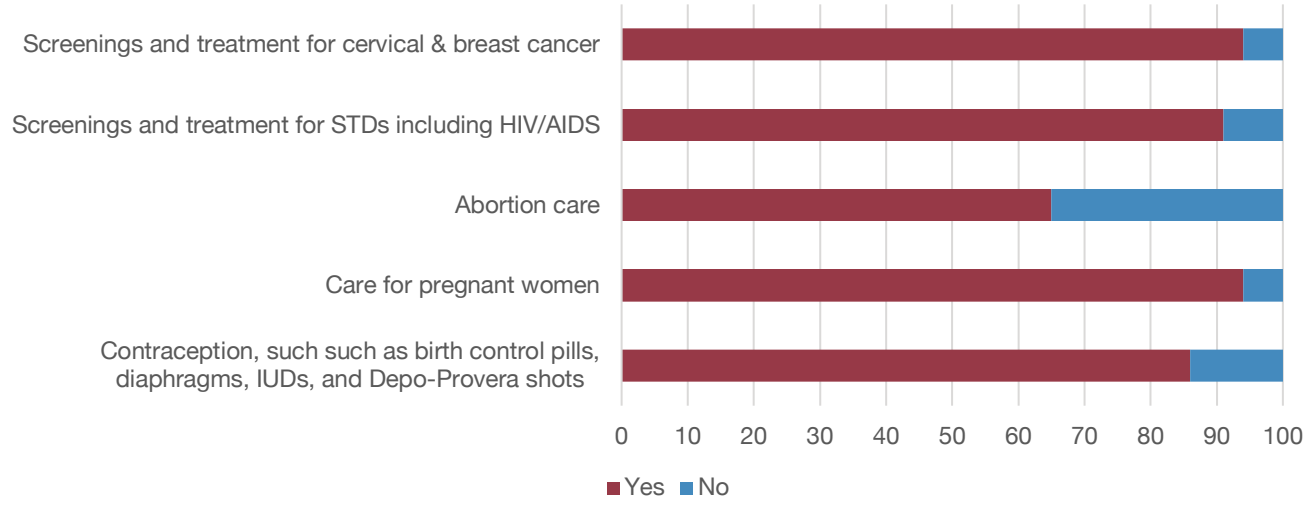


In response to concerns about these issues, *In Our Own Voice* became a signatory on an important "Statement of Principles on LARCs," co-written by SisterSong: National Women of Color Reproductive Justice Collective and the National Women's Health Network (NWHN). The Statement, which addresses past contraceptive abuses and makes recommendations to avoid abuses in the future, has been signed by 115 organizations and individuals (see: https://nwhn.org/larc-statement-of-principles/).

Myriad barriers make health care systems difficult to navigate for Black women and people. Both historically and today, medical racism has resulted in experiments on, exploitation of, and mistrust of Black women's sexual and reproductive health. The result is a culture of fear and mistrust of health care institutions, which makes it more difficult for Black women to access contraceptive coverage and care.

Awareness about this risk is deeply important. Women—particularly those who are the most impacted by racism, economic injustice, and gender discrimination—"frequently report that clinicians talk down to them, do not take their questions seriously, and treat them as though they do not have the basic human right to determine what happens with their bodies."[9] They may be encouraged or pressured to accept LARCs based on their race; for example, one study found that IUDs were recommended more often to low-income women of color than to low-income white women.[19] They may be unable to access a preferred birth control method, or to remove LARCs and regain control of their bodies; in one study, "women reported that their preferences regarding contraceptive selection or removal were not honored."[20] They described experiences in which providers undervalued the woman's contraceptive preference; minimized LARCs' side effects; dismissed patients' concerns about LARCs; disre-

DO YOU CONSIDER EACH OF THE FOLLOWING THINGS PART OF BASIC HEALTHCARE SERVICES FOR WOMEN, OR NOT?



spected or patronized their patients; and were unsupportive when women wanted to stop using LARCs.[20]

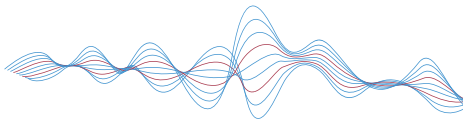
BLACK PEOPLE SUPPORT CONTRACEPTIVE EQUITY

In 2017, *In Our Own Voice* sponsored polling on Black people's views about a variety of issues, including contraception. The poll indicates that an overwhelming majority of Black people (92%) agree that contraception is a part of women's basic health care; the same percentage agree that "a woman should be able to get birth control through her health insurance, even if her boss disagrees with the idea of birth control."[21] The large majority (88%) agree that, regardless of whether a woman has private or government-funded health coverage, coverage should include "the full range of pregnancy-related care, including prenatal care and abortion."[21]

Almost two-thirds of respondents (61%) believe that racism affects the Black community's ability to access affordable contraception.[21] Almost all respondents (94%) agree that school sexual education topics should include pregnancy prevention using contraception, and the vast majority (85%) agree that this education should cover pregnancy outcomes, including childbirth, adoption, and abortion.[21]

NEXT STEPS

Access to contraceptive information and services is essential, but not enough to ensure Reproductive Justice. Many challenges facing Black women—and other communities most impacted by racism, economic injustice, and gender discrimination—stem not from unintended pregnancy, but rather from social and economic disparities.[22] It is critical that advances in contraception not repeat practices that risk coercing or pressuring women into accepting or rejecting any specific contraceptive method—or none at all.[20]



Many challenges facing Black women—and other communities most impacted by racism, economic injustice, and gender discrimination—stem not from unintended pregnancy, but rather from social and economic disparities.

Women must have access to patient-focused information and services for the full range of safe and effective methods, so they can be healthy overall and plan whether and when to have children. They must also receive all the information about all of their options, including the benefits and risks, so that they can make informed decisions about which contraceptive method is best for them, given their own unique circumstances. Furthermore, more comprehensive, patient-centered research and recourse to address provider bias is needed.

There are several pieces of Federal legislation that would help advance this goal, both of which have been endorsed by *In Our Own Voice:*

The Affordability is Access Act (H.R.3296/S.1847): requires health insurance plans to cover FDA-approved over-the-counter (OTC) oral contraceptives without any cost-sharing. The ACA requires health plans to cover all FDA-approved forms of contraceptives, including those available OTC. But, the U.S. Department of Health and Human Services (HHS) allows insurance companies to require a prescription in order to access these OTC methods without any fees. This bill would eliminate this requirement and the resulting barrier to accessing contraception without cost-sharing or fees. This applies to any methods that are approved by the FDA in the future, including any daily OTC pill. It also prohibits retailers that stock FDA-approved oral contraception from interfering with consumers' access to, or purchase of, the contraception.[23]

The Access to Birth Control Act (H.R.2182/S.1086): ensures that people can access contraception in a timely manner by prohibiting pharmacies from refusing to fill a customer's valid prescription for birth control or Emergency Contraception. The bill seeks to address the fact that some pharmacists refuse to fill birth control prescription (and some go as far as refusing to return the prescription to the customer). Some states even allow pharmacists to refuse to fill a contraception prescription, under "refusal laws."

People must have accurate information, access, and provider trust in order to make their own best decisions about their bodies and lives. To accomplish this goal, it is essential that women have affordable health insurance coverage of all contraceptive options, as well as comprehensive, accurate, and culturally competent information and delivery of services.[9]

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In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national Reproductive Justice organization focused on lifting up the voices of Black women at the national and regional levels in our ongoing policy fight to secure Reproductive Justice for all women and girls. Our eight strategic partners include Black Women for Wellness, Black Women's Health Imperative, New Voices for Reproductive Justice, SisterLove, Inc. SisterReach, SPARK Reproductive Justice Now, The Afiya Center and Women With A Vision.

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