REPRODUCTIVE JUSTICE & HARM REDUCTION

Sister Song defines reproductive justice as "the human right to **maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities**."[1]

An emphasis on "safe and healthy environments" for raising children encompasses **access to clean air, water, and safe and healthy food** as well as **health care, housing, education, employment, and other social determinants of health**.[2]

Reproductive justice involves a "**rededication to radical politics,**" shifting from the narrower focus on legal access and individual choice to **broader analysis of racial, economic, cultural, and structural constraints on power**.[3]

Access to health care is therefore defined not just in terms of a "right to choose" contraception or abortion, but as a matter of the **general affordability, availability, and cultural appropriateness of a wide range of health services for families**.[2]

There is an urgent need to further integrate principles of reproductive justice within harm reduction interventions, because it brings attention to:

- PWUD have higher rates of unintended pregnancy, pregnancy-related mortality, and lower rates of contraceptive use when compared with the general population.[4]
- Stigma driven by the criminalization and stigmatization of pregnant PWUD undermines service provision and family support for these populations and exacerbates health disparities.[5]
- Opioid use and associated overdoses have increased across gender demographics, including among pregnant women.[6, 7]
- About 20% of individuals take prescription opioids while pregnant, and women experience unique vulnerabilities for opioid addiction due to higher prevalence of chronic pain and provider tendencies to prescribe higher doses to women.[6, 8]
- Pregnant individuals who use illicit substances tend to decrease their substance use during pregnancy.[9]

GLOBAL HEALTH JUSTICE PARTNERSHIP

Research and practice frequently overlook maternal health outcomes, and deny principles of bodily autonomy associated with a reproductive justice framework

- Given associations between opioid use during pregnancy, risk for cesarean deliveries, and neonatal respiratory needs, the majority of research and evidence-based interventions that address intersections for maternal health, pregnancy, and opioid use, frequently address risks associated with (illicit) opioid use during fetal development, considering, e.g.: neonatal opioid withdrawal syndrome (NOWS), buprenorphine vs. methadone treatment on fetal outcomes, brain morphology and early childhood development, and universal screenings.[6, 10]

Engagement with maternal health outcome and bodily autonomy highlights, for example, how dynamics of care may misalign with harm reduction:

- The threat and/or direct involvement of child protective services, especially through mandated reporting, frequently affects the treatment modalities available to pregnant individuals, further limiting considerations for bodily autonomy among individuals with histories of substance use.
- Criminalization of and stigma associated with sex work may increase rates of untested sexually transmitted diseases, further increasing the risk of complications during pregnancy and in neonatal outcomes.[11]

GLOBAL HEALTH JUSTICE PARTNERSHIP

Reproductive Justice helps frame issues in access and outcomes and responses:

- More men than women are actively receiving treatment for substance use.[5]
- Many who are pregnant or who care for young children do not seek treatment or drop out of treatment early because they are unable to take care of their children, or fear that authorities will remove children from their care.[5]
- Involvement of child protective services and/or separation of a parent from their children results in interruptions of childcare, and severe psychological distress for parents and their child/ren.[11]
- Additional barriers include social stigma, and physical distance/time away from co-parents, family, and other children while in treatment.[11]
- Pregnant women are more likely to stay in outpatient treatment if these programs provide childcare, parenting classes, and vocational training.[12-14]
- Consistent medication assisted treatment is associated with a 47% decrease in hospitalization rate and 37-46% decrease in emergency department visits for pregnant individuals with histories of substance use disorder.[15]

1. Sister Song. Reproductive Justice. Sister Song. Accessed June 28, 2023. https://www.sistersong.net/reproductive-justice
2. Wiley LF. “Health Law as Social Justice. *Cornell J. Law & Public Policy* 2014: 24(1): 47. https://scholarship.law.cornell.edu/cjlpp/vol24/iss1/2/ (citing, in part, Sister Song)
3. Rebouché R. “Reproducing Rights: The Intersection of Reproductive Justice and Human Rights.” *UC Irvine Law Review* 2017: 7: 579. https://scholarship.law.uci.edu/ucilr/vol7/iss3/4/ (citing Mason C. “How Not to Pimp out Reproductive Justice: Adventures in Education, Activism, and Accountability.” Frontiers: J. Women Stud. 2013: 34: 226. https://muse.jhu.edu/article/530614/summary).
4. Baca-Atlas MH, Nimalendran R, Baca-Atlas SN. Applying Harm Reduction Principles to Reproductive Health. *Am Fam Physician*. 2023;107(1):10B-10C.
5. Weber A, Miskle B, Lynch A, Arndt S, Acion L. Substance Use in Pregnancy: Identifying Stigma and Improving Care. *Subst Abuse Rehabil*. 2021;12:105-121. doi:10.2147/SAR.S319180
6. Cook JL. Epidemiology of opioid use in pregnancy. Best Pract Res Clin Obstet Gynaecol. 2022 Dec;85(Pt B):12-17. doi: 10.1016/j.bpobgyn.2022.07.008. Epub 2022 Aug 6. PMID: 36045026.
7. Tobon AL, Habecker E, Forray A. Opioid Use in Pregnancy. Curr Psychiatry Rep. 2019 Nov 16;21(12):118. doi: 10.1007/s11920-019-1110-4. PMID: 31734808; PMCID: PMC10296780.
8. Sanjanwala AR, Lim G, Krans EE. Opioids and Opioid Use Disorder in Pregnancy. Obstet Gynecol Clin North Am. 2023 Mar;50(1):229-240. doi: 10.1016/j.ogc.2022.10.015. PMID: 36822706.
9. Fielding-Miller R, Hatcher AM, Wagman J, Swendeman D, Upadhyay UD. Gender, justice and empowerment: creating the world we want to see. *Cult Health Sex*. 2020;22(SUP1):1-12. doi:10.1080/13691058.2020.1736843
10. Rizk AH, Simonsen SE, Roberts L, Taylor-Swanson L, Lemoine JB, Smid M. Maternity Care for Pregnant Women with Opioid Use Disorder: A Review. J Midwifery Womens Health. 2019 Sep;64(5):532-544. doi: 10.1111/jmwh.13019. Epub 2019 Aug 12. Erratum in: J Midwifery Womens Health. 2020 Jan;65(1):176. PMID: 31407485; PMCID: PMC7675450.
11. Daley M, Argeriou M, McCarty D, Callahan JJ Jr, Shepard DS, Williams CN. The costs of crime and the benefits of substance abuse treatment for pregnant women. J Subst Abuse Treat. 2000 Dec;19(4):445-58. doi: 10.1016/s0740-5472(00)00138-0. PMID: 11166509.
12. Chen X, Burgdorf K, Dowell K, Roberts T, Porowski A, Herrell J. Factors associated with retention of drug abusing women in long-term residential treatment. *Eval Program Plann*. 2004;27:205-212. doi:10.1016/j.evalprogplan.2004.01.010
13. McMurtrie C, Rosenberg KD, Kerker BD, Kan J, Graham EH. A unique drug treatment program for pregnant and postpartum substance-using women in New York City: results of a pilot project, 1990-1995. *Am J Drug Alcohol Abuse*. 1999;25(4):701-713. doi:10.1081/ada-100101887
14. Volpicelli JR, Markman I, Monterosso J, Filing J, O’Brien CP. Psychosocially enhanced treatment for cocaine-dependent mothers: evidence of efficacy. *J Subst Abuse Treat*. 2000;18(1):41-49. doi:10.1016/s0740-5472(99)00024-
15. Ahrens KA, McBride CA, O'Connor A, Meyer MC. Medication for Addiction Treatment and Postpartum Health Care Utilization Among Pregnant Persons With Opioid Use Disorder. J Addict Med. 2022 Jan-Feb 01;16(1):56-64. doi: 10.1097/ADM.0000000000000827. PMID: 33675606; PMCID: PMC8417138.