Assessing Knowledge of Reproductive Justice Among Family Medicine and OB/GYN Providers

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INTRODUCTION

Reproductive Justice (RJ), a term that combines "social justice" with "reproductive rights," is a framework that connects reproductive health to larger political, social, racial, and class movements. It was developed by organizations for women of color and other marginalized groups, and goes beyond reproductive rights—it believes that focusing solely on a woman's right to an abortion does not address the systemic inequities, oppression and lack of access that minority women have faced throughout history[1].

This framework is centered around four basic tenants:

1. The right to maintain personal bodily integrity
2. The right to have children
3. The right to not have children
4. The right to parent children in safe and sustainable communities [1]

The term Reproductive Justice was coined by a group of Black women in Chicago in 1994 who called themselves Women of African Descent for Reproductive Justice. They came together after recognizing that the women's rights movement, led and represented primarily by middle class and wealthy white women, could not defend the needs and rights of women of color, other marginalized women, and trans folks[1].

RJ goes beyond focusing solely on a woman's right to an abortion.[2] It is an important framework for physicians who engage in family planning conversations with their patients. By approaching family planning discussions using an RJ lens, providers can work towards ensuring that all patients have equal access to high quality reproductive health resources. Thus, the goal of this project is to assess healthcare practitioners understanding of and use of an RJ framework in practice.

METHODS

1. Electronic surveys, distributed via email and Twitter were used to collect data regarding provider knowledge of RJ. Respondents were entered into a raffle for an Amazon gift card.
2. A qualitative analysis using open coding was performed to develop themes.

REFERENCES & SUPPLEMENTAL MATERIALS

RESULTS

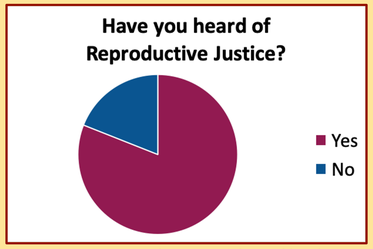

Fig. 1. Survey respondents specialty and level of training (n=43).

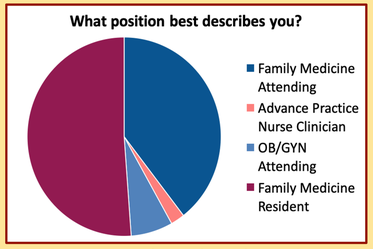

Fig. 2 Survey respondents who endorse prior knowledge of RJ (n=43).

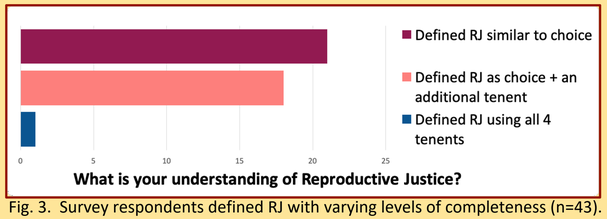

Fig. 3. Survey respondents defined RJ with varying levels of completeness (n=43).

- **How do you use RJ in your practice?**
  - Most providers practice RJ through patient-centered care and patient empowerment
  - Some providers had never heard of RJ but reported the framework already aligns with their practice
    - *"I have lived with this idea for my entire career."*
- **What barriers do you face in using RJ?**
  - Structural barriers (lack of time with patients, high costs of contraception and abortion services, and lack of training about non-hormonal birth control)
  - Providers struggle using RJ with populations whose cultures they perceive to be patriarchal
    - *"I work with women from cultures where in some cases they are not in control of their reproduction because of expectations from their husbands/partners or their families."*
  - Many providers felt that they did not have the tools to address larger systemic social justice issues their patients face
    - *"[There is] lots of systemic inequality that's hard to address in the confines of a medical clinic."*
- **Does the population you work with effect how you use RJ?**
  - Many participants use RJ differently depending on the patient population (historical injustice, patient culture)
    - *"[Persons of Color] feel (rightfully) that their reproductive health/choices have been unjustly controlled by politicians and physicians"*
  - Other participants said they use the same framework regardless of patient background
    - *"It's of value to everyone."*
- **What resources would you like to learn more about RJ?**
  - Providers requested resources (pamphlet, web-based) as well as more formal training (CME, residency training, employee-based training)

DISCUSSION

IMPLICATIONS & NEXT STEPS

1. Providers had an incomplete understanding of the RJ framework, demonstrating the need for increased RJ education to be able to integrate it into clinical practice.
2. Respondents were primarily interested in having opportunities for Continuing Medical Education or employee trainings focused on reproductive justice. As discussed above, this CME should adopt a structural competency-focused approach
3. Some providers requested physical resources as a way to learn about RJ and implementation. These can include physical handouts, web-based resources, podcasts, or webinars.
4. Integrate men, patient families and community leaders into RJ discussions in an effort to understand how patriarchal cultural traditions may influence patients' ability to make choices centered around bodily autonomy.