

The Role of Sexual and Reproductive Rights in Social Work Practice

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The understanding and promotion of sexual and reproductive rights are essential in the social work profession, not only to improve the health status of affected populations but to advocate effectively for social justice and to respond to globalized realities. This article highlights the relevance of sexual and reproductive rights in the philosophical foundation and practice of social work, emphasizes the impact of reproductive health and rights on women's lives, and proposes a social work agenda that will embrace and promote sexual and reproductive rights. It uses policy statements from the International Federation of Social Workers as well as a human rights framework focused on sexual and reproductive rights that stems from the global feminist movement.

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Social work has both pioneered human rights causes (Steen, 2006) and promoted the development of human rights (Healy, 2008; Sewpaul & Jones, 2004). Consequently, there has been a steady movement to "integrate human rights into social work teaching, research and practice" (Reichert, 2003, p. 9). According to the International Federation of Social Workers (IFSW), some international declarations and conventions are specifically relevant to social work practice and action. IFSW strongly supports the International Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). It also endorses the Platform for Action issued during the United Nations Fourth World Conference on Women, held in Beijing in 1995. The general agreement of this conference was guided by the conviction that such a platform is necessary to achieve global gender equality and gender-sensitive development. As a result, IFSW's Policy Statement on Women specifically highlights 6 of the 12 areas of critical concern identified in the Platform for Action, given their relevance to social work internationally. One of these areas, in particular, is health and its impact on women's development and contribution to society (IFSW, 1999).

The 1995 Beijing conference recognized the importance of mental health, along with physical, social, and sexual and reproductive health. Correspondingly, IFSW sees women's ability to control their own fertility as the foundation for the enjoyment of other rights. IFSW believes that when women's reproductive rights are neglected, women's opportunities in public and private life, education, and economic and political participation are severely compromised (IFSW, 1999).

Using the IFSW policy statements and a human rights framework focused on sexual and reproductive rights that stems from the global feminist movement, this article highlights the

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relevance of sexual and reproductive rights in both the philosophical foundation and practice of social work, emphasizes the impact of reproductive health and rights on women's lives, and proposes a social work agenda that respects and promotes sexual and reproductive rights as the arena that intersects with health, development, and human rights (Petchesky, 2003). Social workers should, at the least, know and understand such rights, regardless of whether the rights are legally recognized where they live and work. This understanding is essential not only to improve the health status of affected populations but also to advocate effectively for social justice and to "respond to [the] realities of global interdependence" (Hokenstad & Midgley, 1997, p. 4). As Ife (2005) stated, human rights go beyond the legal system and the reach of the law; they link macro- and micropractice and "touch every aspect of our humanity and our interaction with other humans" (p. 56). Human rights are cross-cultural and transcend national boundaries (Reichert, 2003). As a human rights profession, social work is an international discipline and field of practice.

Despite the universality, indivisibility, and inalienability of human rights, women have been at the margin of their applicability with severe consequences for their lives (Bunch & Frost, 2000). For this reason, in 1993, the UN World Conference on Human Rights (the Vienna Declaration) reassessed the status of human rights and ignited a global campaign for women's human rights. From a global feminist perspective, women's rights as human rights are revolutionary and transformative because they "accord women the human dignity and respect that they deserve simply as human beings" (Bunch & Frost, 2000, p. 1078). The analysis presented here focuses mainly on women's reproductive rights, considering (a) the particular effect that reproductive health and rights have on women's lives (Fourth World Conference on Women, 1995), (b) the greater incidence of poverty among women that hinders their access to health care (Reichert, 2003), (c) the fact that reproductive health and rights are essential to achieve gender equity (UN Millennium Project, 2005), and (d) the fact that women's health care constitutes a major aspect of social workers' practice, including maternal and child health and sexual and reproductive health care (IFSW, 1999). For a summary of the history of human rights, women's rights, and reproductive rights, as well as a description of the different UN conferences on women and human rights, see Pillai and Wang (1999) and Wronka (2008). Healy (2008) described the history of social work as a human rights profession. The next section presents an overview of the role of social work in health and reproductive health, followed by a sexual and reproductive rights framework.

Role of Social Workers in Health

In the United States, social workers make up the majority of mental health professionals (Substance Abuse and Mental Health Services Administration, 2007). Thirteen percent of social workers work in health care settings (not including mental health); more than half of health care social workers are employed in hospitals, and 14% work in health clinics (National Association of Social Workers [NASW], 2008b). They are "significant, well-trained provider[s] of services to clients in healthcare settings" (Whitaker, Weismiller, Clark, & Wilson, 2006, p. 7). In addition, health is the third most common practice field among all social work professionals in the United States and the second among social workers with master's degrees (Whitaker et al., 2006).

Although worldwide statistics are not available, it is known, from the academic literature, mass media, technical reports of international agencies, and professional

conferences, that social workers in different countries are involved in diverse health care areas, depending on the needs of the population and the resources of their societies. Practice environments vary from technologically advanced health care facilities to social services centers to hospices to nongovernmental organizations to neighborhood clinics to clients' homes and to improvised tents in places that are torn by natural or human made disasters, including war. The work of social workers may be individual or a part of an interdisciplinary team, and the level of intervention ranges from micro- to macropractice (Dziegielewski, 2004; Kitchen & Brook, 2005). In the United States, social workers' activities may be specialized in certain health fields (e.g., nephrology), may be limited to specific departments within a hospital (e.g., the emergency room), and may focus on one population (e.g., children) (Dziegielewski, 2004). Some social workers in developing countries have similar employment, whereas others focus on macroproblems, such as poverty, deprivation, or scarcity (IFSW, 1984).

Social Work and Sexual and Reproductive Health

The World Health Organization's (WHO, 2008) view of reproductive health is as follows:

Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Reproductive health also includes the rights of men and women to timely and accurate information and to have access to contraceptive methods of their choice and to appropriate prenatal, delivery, and postpartum health care services. Reproductive health care involves all methods, techniques, and services that are needed in matters associated with reproductive health. According to the Fourth World Conference on Women (1995), reproductive health also includes sexual health whose purpose goes beyond counseling and the treatment of sexually transmitted diseases; it involves the enhancement of life and personal relations. Petchesky (2000), a feminist scholar and activist, argued that the notion of sexual rights entails negative rights (freedom from violence or abuse) and positive rights (the capacity to seek pleasurable experiences in different ways, such as diverse forms of sexual orientation). Sexual rights have not been explicitly recognized by any international treaty; nevertheless, the language of the Programme of Action (POA) of the International Conference on Population and Development (ICPD), held in Cairo in 1994, includes the concept of sexual pleasure, and this language may be the starting point for acknowledging these rights (Petchesky, 2000).

Great differences exist between and within countries with regard to sexual and reproductive rights, but according to WHO's definition of *reproductive health*, human beings' needs in terms of sexuality and reproduction are similar. In 2001, sexual and reproductive health problems accounted for 32% of the global burden of disease among women ages 15 to 44 and 18% of the total burden of disease (WHO, as cited in Alan Guttmacher Institute, 2003). Similarly, unsafe sex is the second most important risk factor

Table 1
Some Sexual and Reproductive Health Concerns in Social Work Practice

<p>*Contraception for individuals, regardless of their marital status and age, including emergency contraception, forced sterilization, or forced contraception.</p> <p>*Abortion (surgical or medical) at different stages of gestation among women of all reproductive ages and in countries or jurisdictions where it may be prohibited, highly restricted, or where services do not exist or are difficult to obtain.</p> <p>*Diverse sexual orientations as well as family and societal reactions toward disclosure.</p> <p>*Assisted reproductive technologies used by heterosexual and homosexual couples and single women.</p> <p>*Infertility and its psychological consequences.</p> <p>*Sexually transmitted infections (including HIV/AIDS), from prevention to treatment, as well as sociocultural and economic factors that surround them.</p> <p>*The sexuality of individuals who are HIV-positive, issues of disclosure, protection of their partners, and prevention of greater risk.</p> <p>*Mother-child transmission of HIV during pregnancy and after delivery.</p> <p>*Drug use during pregnancy and lactation.</p> <p>*Prosecution of women accused of harming their newborn children during pregnancy with illegal drugs, as well as child custody issues of such women.</p> <p>*The sexuality and reproduction of certain populations, such as individuals with disabilities and those who are imprisoned.</p> <p>*Intimate partner violence, including rape within marriage/cohabitation/dating and coercion of women's contraceptive choices.</p> <p>*Rape in diverse circumstances, including war, natural disasters, and prostitution, particularly of minors.</p> <p>*Sexual trafficking, especially of young immigrants, refugees, and internally displaced populations.</p> <p>*Child sexual abuse.</p> <p>*Female genital mutilation.</p> <p>*Breastfeeding practices.</p> <p>*Cervical cancer and breast cancer of both men and women.</p> <p>*Chemotherapy and radiation during pregnancy.</p> <p>*Pregnancy-related diseases, such as anemia and diabetes (mainly as a result of poverty), as well as pregnancy-related disorders and postpartum depression.</p> <p>*Menopause (as a result of age or hysterectomy) and menarche and the physical and psychosocial effects of both.</p> <p>*Underage marriage and forced marriages, among others.</p>	<p>Each one of the aforementioned situations is suitable for social work interventions with individuals who need direct services, with families who face these situations, and with groups, organizations, institutions, and legislative bodies that provide, advocate, promote, control, and/or regulate needed services.</p>
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for disability and death in the poorest communities and the ninth in developed countries (Glacier, Gülmezoglu, Schmid, Garcia Moreno, & Van Look, 2006). Whether health is the social worker's main field of practice and depending on the social context, a practitioner may encounter clients with different needs, concerns, or particular situations that affect their sexual and reproductive health (see Table 1).

One common field of social work practice in the United States is maternal and child health (Combs-Orme, 1990); thus, it is seen as a critical area of training for social workers (Public Health Social Work, 2007). As a result, a few schools of social work have developed concentrations in maternal and child health for master's-level social work students, thanks to a grant from the U.S. Maternal and Child Health Bureau. The aim of maternal and child health social work is to train social workers to practice in this field in the United States; it focuses on domestic aspects of direct services and has historically emphasized children's health over maternal health (see Maternal and Child Health Bureau, 2007). Maternal health is viewed as important mainly to achieve children's health but not as a goal in itself. Policy

issues, advocacy, and community awareness of health disparities in maternal and child health in a social work context are rare, despite gaps among ethnic groups in maternal and infant morbidity and mortality (“Infant Deaths Climbing in South After Decline,” 2007; Kantrowitz & Wingert, 2007; Northup, 2007).

Maternal morbidity and mortality in developing nations are not generally the targets of study, intervention, or research by social work programs in maternal and child health (see Pecukonis, n.d.), even though situations of poverty, war, political unrest, laws, and cultural practices that violate women’s fundamental rights are to blame for the 529,000 maternal deaths that occur worldwide every year (WHO, 2006). As Kristof (2006) contended, the fact that the number of women who die in pregnancy worldwide has not decreased for a quarter of a century should be the cause of international outrage. In addition to deaths, at least 10 million women per year, mainly in the developing world, are victims of maternal morbidity—that is, injuries, infections, and disabilities related to pregnancy and childbirth (United Nations Children’s Fund, 2000).

Framework of Sexual and Reproductive Rights

Petchesky (2003) argued that the ICPD has serious “fault lines,” such as its “failure to address macroeconomic inequities and the inability of . . . market oriented approaches to deliver reproductive and sexual health for the vast majority” (p. 36). Nevertheless, the ICPD included a paradigm shift when pressed by the transnational women’s coalition (Petchesky, 2003). Adopted by 179 countries in 1994, the POA of the ICPD states that women have the right to control their sexuality, including the right to make autonomous decisions free from violence, discrimination, and coercion (Cabal, Lemaitre, & Roa, 2001). This is one of the major contributions of the global feminist movement to the UN community.

Inspired by the different UN Women’s Conferences from 1975 to 1995 (see Petchesky, 2003), particularly by the ICPD, Cabal et al. (2001) developed a sexual and reproductive rights framework of 10 rights to analyze the treatment of matters of reproduction and sexuality by the highest courts of five Latin American countries. Four of these rights that are most applicable to social work intervention and to the profession’s ethical principles are explored here.

Right to Health and Reproductive Health

This right involves access to health services, particularly to sexual and reproductive health services. Reproductive services may be designed, administered, and accessed from either a demographic and biomedical paradigm or from a reproductive health paradigm. Although the former focuses on achieving a programmatic goal (i.e., lower fertility rates), the latter’s intention is to empower clients to make informed choices that are safe and healthful and to understand reproduction not only from its biological but also from its “social, economic and psychological context” (Freeman, 1999, p. 171). The reproductive health paradigm acknowledges the social forces (e.g., racism, poverty, and patriarchy) that affect individuals’ choices in reproductive matters (Freeman, 1999).

Worldwide, the right to reproductive health is threatened by several factors: (a) laws that prohibit or restrict certain reproductive health services (e.g., emergency contraception and abortion), (b) insufficient public investment in health care, (c) inadequate health insurance coverage (i.e., the exclusion of contraceptive methods and treatment of HIV/AIDS),

(d) adolescents' parental authorization requirements, (e) husbands' authorization requirements, (f) the lack of services to unmarried women, (g) myths and misinformation that penalize women (e.g., punishment of pregnant drug users), and (h) the lack of enabling conditions, such as freedom (legal or socially sanctioned) to make choices, sufficient money to afford services, transportation to access services, and the availability and adequacy of services where populations in need reside to exercise this right (Petchesky, 2000). The lack of enabling conditions explains the fact that only 5% of pregnant women who have malaria receive effective interventions, increasing the health risks to them and their children (WHO, 2007).

In the United States, the reproductive health of women of color is worse than that of White women, particularly in relation to maternal mortality, sexually transmitted infections, and unintended pregnancies (Northup, 2007). This situation may be due, in part, to the for-profit nature of the U.S. health care system, which restricts poor people's, particularly minority groups', access to health care (Pillai, Gupta, & Jayasundara, 2005). Consequently, in addition to recognizing the right and providing enabling conditions, health as a human right must be viewed in connection with people's social conditions, such as discrimination (Freeman, 1999). Social workers can enforce, promote, and advocate for this right through the profession's principles of challenging discrimination and unjust social policies and practices and of solidarity work (IFSW, 2004).

Right to Decide the Number and Interval of Children

The capacity to make decisions about one's body and fertility is a condition for equality between women and men in society (Cabal et al., 2001). Furthermore, access to adequate reproductive health services is one of the means by which women can empower themselves to decide whether to have children and, if so, how many and when (Cabal et al., 2001). This sense of empowerment and promotion of gender equity is one of eight Millennium Development Goals defined by the United Nations in 2002 to improve global development by 2015 (UN Millennium Project, 2005). The IFSW (1996) adheres to women's right to decide on the number of children as follows:

IFSW endorses women's self-determination in all healthcare decisions as a core professional value, including all decisions regarding sexual activity and reproduction. Social workers understand that women have the right to receive competent and safe reproductive and sexual healthcare services free from government, institutional, professional, familial, or other interpersonal coercion.

Despite the international commitment made by adopting the ICPD POA and the Millennium Development Goals and well-documented studies that have established the medical, personal, and economic benefits of providing sexual and reproductive health services, about 14 million adolescent girls, more than 90% of them in developing countries, become mothers every year (Alan Guttmacher Institute, 2003; WHO, 2007). In addition, more than half the women of reproductive age in the developing world are at risk of unwanted pregnancies (Alan Guttmacher Institute, 2003). Nevertheless, unintended pregnancies occur not only in developing countries but also in developed countries. Finer and Henshaw (2006) found that in the United States from 1994 to 2001, the rates of unintended pregnancies increased among poor and less educated women, as did the unintended birth rates, but the rates of unintended pregnancies decreased among adolescents, college graduates, and the wealthiest women.

According to the CEDAW, the right to decide on the number of children and the timing of births is violated when the means to exercise it are hindered (Cabal et al., 2001). It appears that poor and less educated women in the United States do not have the means to exercise the same right as do other women in their country. This situation demonstrates that in the wealthiest country in the world, social workers have a particular responsibility to ensure equal access to public services and provisions for all women (see IFSW, 1996) and they have the ethical obligation to challenge unjust policies and practices that create disparities in health.

Right to Physical Integrity and Life Free From Violence

For many women around the world, violence in their homes is a frequent experience with consequences that go beyond the immediate result of their assault, such as the risk of mental health problems, susceptibility to HIV/AIDS, and preterm deliveries (Carter, 2006). Rather than a private family matter or a fact of life, violence against women is a social problem and a risk factor for women's ill health, as well as a human rights concern. "It is both a consequence and a cause of gender inequality" (WHO, 2005, p. vii), whether the perpetrator is an intimate partner, another relative, acquaintance, or stranger. It is estimated that

between 15% and 71% of women around the world have suffered physical or sexual violence committed by an intimate male partner at some point in their life, [and] some studies show that up to 1 in 5 women report being sexually abused before the age of 15. (WHO, 2007)

As a response to this situation, international conventions and courts have declared that women have the right to live free from sex- or gender-based violence and that violence against women violates their human rights and fundamental liberties (Cabal et al., 2001).

In a multicountry study on women's health and domestic violence against women, the WHO (2005) found that women with experiences of partner abuse are more likely than are nonabused women to have suicidal thoughts and to have attempted suicide, which is consistent with findings in other industrialized and developing nations. The WHO study also confirmed the association shown by previous research between early sexual initiation (before age 15) and coercion in the context of both violence by acquaintances or strangers and early marriage. Sexual violence contravenes women's rights to corporal integrity and controls women's sexuality and reproductive capacity. Furthermore, any kind of violence against women has a direct impact on their sexual health and reproductive autonomy (Cabal et al., 2001). For example, the high rate of forced sex found in several countries, particularly Ethiopia, increases women's vulnerability to HIV infection (WHO, 2005). It is no surprise that of all people living with HIV in Sub-Saharan Africa in 2006, 74% were young women (WHO, 2007).

The prevalence of violence against women varies not only from country to country but within countries (WHO, 2005). Some minority women are also more vulnerable to certain kinds of violence. This is the case of Native American and Alaska Native women, who are more than 2.5 times more likely to be raped or sexually assaulted than are other women in the United States (U.S. Department of Justice, as cited in Amnesty International, 2007). Although the statistics of the U.S. Department of Justice show that perpetrators are mostly non-Native, there is a lack of sufficient data on the ethnic origins of perpetrators, which complicates jurisdictional issues (federal, state, or tribal) to punish crimes of sexual violence (Amnesty International, 2007). Meanwhile, indigenous women in the United States do not have access to justice because of their gender, local identity, and socioeconomic

marginalization (Amnesty International, 2007). Thus, the plight of Indigenous women in the United States reminds social workers that their duty to end discrimination and to promote well-being is not limited to their workplace or field of practice. Rather, it is a part of the profession's commitment to social justice.

Women's susceptibility to violence, particularly to sexual violence, increases under certain circumstances, such as war or natural or development-induced disasters (Snyder, Gabbard, May, & Zulcic, 2006). These women may subsequently become refugees, internally displaced, or victims of human trafficking (London School of Hygiene and Tropical Medicine, 2003; Women's Commission for Refugee Women and Children, 2006). Even though protocols, an international convention, and many countries' laws try to guarantee people's freedom from human trafficking (Cabal et al., 2001), sexual exploitation remains unchecked, especially among the young, the poor, and women (Hodge & Lietz, 2007). Social workers face a great challenge to promote the principle of social justice where violence has become normal in people's lives, whether in societies that are torn by conflict or in industrialized countries with high concentrations of marginalized and socially excluded populations.

Right to Education

International treaties recognize that the right to education is indispensable to exercise other rights, particularly in the context of reproductive rights (Cabal et al., 2001). Education promotes the empowerment of women at home and within their communities and helps them to make free, informed, and responsible decisions about their fertility. Therefore, education is of the essence, given the strong correlation between high fertility rates and poverty in many developing nations (Cleland et al., 2006). Furthermore, delaying motherhood through the use of contraceptives contributes to women achieving higher education (Alan Guttmacher Institute, 2003), and when women are educated, they understand the overall importance of their reproductive rights and want fewer children (German Foundation for World Population, n.d.).

Social workers need to advocate for and promote the right to education to comply with one of their core professional purposes. This core purpose is to facilitate the inclusion of marginalized, dispossessed, vulnerable, and at-risk groups of people (Sewpaul & Jones, 2004). After all, the biggest obstacle to exercising any right is the lack of knowledge, for no one can claim a right if she or he does not know it exists.

Implications for Social Work

Different international conferences, resolutions, and conventions that have been adopted not only by many countries but also by the IFSW provide social workers with sufficient tools, background information, principles, and a solid philosophical foundation to identify social work as a human rights profession. It follows, then, that sexuality and reproduction should be included within a human rights framework to view individuals holistically in accordance with common social work approaches, such as the social systems, empowerment, and feminist perspectives.

Although social work areas of practice and educational requirements differ from country to country, there are common values and principles that unite the profession, as identified by the IFSW's ethical principles and policy statements. These principles and statements reflect the thought process of social workers from around the world who contribute

knowledge, expertise, and experience gained through local practices. A similar process applies to the development of international declarations and conventions. The knowledge of this macroframework increases social workers' sensitivity and competence when working with or researching clients, especially women, whose equity and development have been compromised by denying or curtailing their sexual and reproductive rights. At the microlevel, practitioners may encounter a broad range of situations that deal with sexual and reproductive health (see Table 1); consequently, a sexual and reproductive rights framework strengthens their ability to serve under these circumstances.

Social workers' skills are enhanced not only by the awareness and understanding of international declarations that pertain to sexual and reproductive health and rights but also by establishing the compatibility between these declarations and the profession's ethical principles (see Healy, 2008). This knowledge empowers social workers to be active in social justice and policy-related efforts that are necessary to bringing about permanent changes in peoples' lives. For example, in the past few years, HIV/AIDS has been at the forefront of social work practice and advocacy in the United States (see Curiel & Land, 2006; Natale & Baker, n.d.). Today, women's reproductive health in developing nations, and even in some industrialized countries, is an area that is in extreme need of just as much attention. This field of care would greatly benefit from social work interventions at all levels. Thus, promoting knowledge of sexual and reproductive rights, as well as their connection with social work professional values and principles, would support a professional mobilization that could dramatically reduce the preventable deaths and morbidity of thousands of women around the world.

The inclusion of a sexual and reproductive rights agenda will most likely face resistance in many societies where the laws and/or cultural norms are antagonistic to such a proposition, particularly to rights that empower women. In those contexts, it is vital for social workers to (a) belong to or form professional social work organizations, (b) actively participate in coalition building with other professions, (c) reach out to policy makers and educate them, and (d) create alliances with like-minded organizations and agencies that provide services, conduct research, lobby, or educate about issues that directly and indirectly affect the exercise of sexual and reproductive rights. Examples of such issues are the reduction of poverty; the prevention, treatment, and prosecution of violence against women; participating in micro- and macroeconomic activities and human and social development programs; engaging in political leadership; and in general participating in activities that empower women.

Regardless of whether the climate is favorable to sexual and reproductive rights, social workers need to educate themselves about international treaties that their countries have and have not ratified and apply pressure to implement them at the national, regional, and local levels if these treaties benefit women's empowerment. The fact that several U.S. state and local governments—in such states as California, Iowa, and Vermont—have passed resolutions in support of CEDAW demonstrates how local initiatives can champion what has been a nationwide failure (the United States has not ratified CEDAW; Center for Reproductive Rights, 2004). Furthermore, in developed and powerful countries, social workers have the potential to influence how their governments' foreign policies affect populations in developing nations. Such policies may range from free trade agreements and military interventions to restrictions on aid to reproductive health services, such as the U.S. Gag Rule (see Buncombe, 2005), which has affected the provision of family planning programs in developing countries. Social workers may do so by writing or telephoning their public officials, signing letters in favor of certain measures, and making public statements as individuals or through their local organizations.

In the United States, social workers have the opportunity to participate in Social Work Day at the United Nations every year and to present their views to international leaders. Likewise, most local chapters of the NASW organize a Legislative Day in the legislatures of their respective states. This activity allows social workers to discuss with legislators certain laws or bills that concern the profession and have particular relevance in their states. Social workers may also create coalitions with women's organizations inside and outside their countries, and those who consider themselves feminist may act as liaisons between their social work and feminist organizations. Finally, social work academics, particularly feminist social workers, are in a unique position to bring sexual and reproductive rights to the forefront of the profession through their teaching, service, and research activities.

Sexual and reproductive rights may be as controversial as, or may be more controversial than, issues such as the social rights of nonheterosexuals, interracial marriage and adoption, or even some political and cultural practices that vary from culture to culture. It is possible that some social workers, guided by their upbringing and social context, may be reluctant to take the position promoted in this article. In this case, they may find the resolution of their practice dilemma by applying these concepts: cultural competence, particularly in regard to cross-cultural and service delivery skills (see NASW, 2001), and evidence-based practice (see NASW, 2008a). The latter concept is probably more challenging for professionals who live in poor nations with no or limited access to research findings that could guide their approach to sexual and reproductive health issues (see Table 1). This limitation may be mitigated by attending conferences, networking, advocating for greater access to the Internet, obtaining grants, and engaging in professional and student exchanges, agreements between universities, paid internships in more developed countries, and any other kind of cooperative agreements that may strengthen evidence-based practice capabilities.

Sexual and reproductive rights support Ife's (2001) promotion of social work as a human rights profession. Each one of the four rights explained in this article underscores social workers' need to be informed about the "broader political, historical, social and cultural contexts within which social work practice is taking place" (Ife, 2001, p. 50). Likewise, sexual and reproductive rights show a clear connection between the personal and the political dimensions of human rights (see Ife, 2001). As individuals, women endure a great deal of suffering, disease, and even death when these rights do not exist, are not enforced, or cannot be exercised. Consequently, the ability to control one's own sexuality and reproduction—particularly for women—is at the core of being a full human being (Freeman, 1999). This fact is important not only for the individual but also for society in general, for without the enjoyment of sexual and reproductive rights, a large part of the population cannot contribute to the development of the communities in which they live. As Ife (2001) affirmed, human rights are for the benefit of both individuals and humanity.

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