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From Abortion Rights to Reproductive Justice: A Call to Action

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Abstract

As aggressive cultural and legislative attacks on abortion rights and access continue, we call upon social workers to pursue the liberatory aims of the reproductive justice (RJ) movement. We argue that the RJ framework, rooted in feminist theory, aligns with social work's social justice ethos and goals, appropriately guiding advocacy and intervention. After outlining the central aims and tenets of the RJ movement, we consider policies that impair RJ and those that could promote RJ, focusing on enhancing body sovereignty, childbearing, and parenting. We conclude with concrete recommendations for how social workers can pursue RJ professionally and personally.

Keywords

reproductive justice, abortion, advocacy, social justice

Introduction

Between 2014 and 2019, the U.S. states enacted a staggering 227 abortion restrictions or bans (Jones et al., 2019). As we write, S.B. 8, a Texas law banning abortion after about 6 weeks' gestation, was rescinded and then reinstated. The Supreme Court heard arguments deriving from a Mississippi law banning abortion after 15 weeks of pregnancy, actively threatening *Roe v Wade* (1973), with a decision expected by Spring of 2022. Over the past year and a half, the COVID-19 pandemic provided opportune cover for hostile states to propose additional abortion bans (Tanne, 2020). Since January 2021, 10 abortion bans were approved, with 28 new restrictions enacted in seven states in just 4 days (April 26–29, 2021) (Nash & Cross, 2021). These restrictions are sordid, impede people's right to choose by limiting their access to reproductive health care, and pose health and mental health risks for those seeking abortion care, especially for women of color, queer people, those with disabilities, and those living in poverty (Ross, 2006; Ross & Solinger, 2017). Moreover, the anti-choice movement's misleading and contentious rhetoric has continued to stigmatize abortion care,

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increasingly endangering the lives of people who seek it and of those who provide it (National Abortion Federation, 2020). What then is the role of social work in response to the legislative and cultural attacks on abortion care and how can reproductive justice (RJ) inform social workers' response?

The profession is relatively silent. It appears that only a handful of social work scholars focus on topics related to abortion within the classroom or in scholarship (Beddoe et al., 2020; Begun et al., 2016; Begun & Walls, 2015; Ely et al., 2018; Ely & Dulmus, 2010; Gómez et al., 2020; Hansford et al., 2017; Liddell, 2019; McCoyd, 2010; Younes et al., 2021). Furthermore, few social workers are on the front lines advocating for RJ despite social work's code of ethics, which promulgates self-determination, dignity, worth, and equity for the communities we serve. In this article, we call upon social workers to respond to the systemic and ideological injustices found in reproductive health care and we argue that a RJ framework, rooted in feminist theory, is essential to social work's social justice ethics and praxis aims, and is critical to meeting the moment. We first provide historical background on the development of the RJ framework and outline how this framework has shifted the abortion discourse. We then review the three central tenets of RJ and consider how structural and legislative policies limit or enhance rights to body sovereignty and the ability to make choices about childbearing and parenting. Finally, we identify how social workers can apply and promote the tenets of RJ in response to threats to reproductive freedoms.

A Brief History of the RJ Movement

The United Staes has a centuries-long history of regulating sexuality and reproductive freedoms. Although a full historical review is beyond the scope of this article, situating the current assaults against reproductive freedoms within the differing eras of reproductive movements is important to understand the impact and aims of RJ. Historian Linda Gordon theorized four pivotal eras of birth control politics in the United States: the first was the voluntary motherhood movement beginning in the 1870s to the early 1900s when white women began to claim the right to choose motherhood rather than submit to it, a right women of color and enslaved women could not assert; the second era took place from 1910 to 1920 as the birth control movement evolved in tandem with eugenics; and then further evolved into the third era, labeled the family planning movement of the 1920s–1960s, led by male medical professionals deliberately focused on future family planning and less on women's autonomy, equality, and population control; the 1970s–1980s reproductive rights movement was encapsulated by the right to choose (Gordon, 1990). Each era was shaped primarily in the interest of elite heterosexual white women. At the time of her writing, Gordon suggested 1990 began a fifth era, in which we currently find ourselves, concerned primarily with individual rights, freedoms, and citizenship (Gordon, 1990, p. 473). The efforts of the current movement are directed toward preserving privacy and rights for contraceptive access and abortion choice.

In the 1970s, the National Council of Negro Women (NCNW) and the National Black Women's Health Project (NBWHP) were instrumental in highlighting the limits of a "choice" framework that focused solely on the rights to prevent conception and motherhood. But it was through the organizing of feminist Black, Latina, Native American, Asian, and Queer people during the late 1990s and the subsequent formation of SisterSong Women of Color Reproductive Justice Collective that the abortion discourse was transformed into a broader social justice claim (Ross & Solinger, 2017). Loretta Ross, a founder of the SisterSong Women of Color Reproductive Justice Collective, wrote,

One of the key problems addressed by Reproductive Justice is the isolation of abortion from other social justice issues that concern communities of color: issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns. These issues directly affect an individual woman's decision-making process (2004, p.4).

Historically, for those with fewer resources, abortion restrictions pose insurmountable barriers, while a privileged few retain access to safe terminations. Although *Roe v. Wade* (1973) seemingly assured a person's right to abortion, increasingly restrictive legislation, political maneuvers, and stingy social safety nets have ensured that poor and marginalized groups are disproportionately excluded from "choice." The Hyde amendment (1976), which banned Medicaid funding for abortions, and the limited coverage of children's needs under Temporary Assistance to Needy Families (1996) are obvious examples of the ways laws restrict true reproductive freedom.

The RJ activism of the 1970s emerged almost in tandem with critical race theory in legal scholarship. Crenshaw's (1989) groundbreaking legal work on intersectionality illustrated how interacting identities (e.g., being both female and Black) results in compounding detrimental consequences: this aligned with RJ activism, highlighting the need for social justice for women of color across systems. Over time, legal scholars have increasingly used an RJ framework to highlight the constitutional limits of *Roe v Wade*, acknowledging that narrowly focusing on judicially protecting the right to choose, a passive right, hinders the reproductive movement's broader progressive aim to actively expand access (Ratelle, 2018). Indeed, Ruth Bader Ginsberg made this point repeatedly: she worried that premising *Roe vs. Wade* on the right to privacy rather than the affirmative right to gender equity (which abortion bans would impede) made the decision more vulnerable to attacks (Gupta, 2020). RJ framing presents the opportunity for social work to move praxis away from the neoliberal drives of individualism, privacy, and decision-making to attend to core professional values; seeking to build community, resources, supports, and to center the collective experiences of people of color, queer people, people with disabilities, and poor people (Kendall, 2020; Ross, 2006; Silver, 2020).

A RJ Framework for Social Work

Soon after *Affilia's* founding in 1986, feminist scholar Barbara G. Collins wrote:

> …women's capacity to reproduce has been used throughout history as a method and rationale for the oppression of women in society, feminists have consistently demanded that the reproductive needs and desires of women be respected. This strong feminist commitment to policies guaranteeing reproductive freedom is based on the fundamental belief that women must be able to manage their bodies. (Collins, 1987, p. 7)

We build on Collins (1987) appeal and amplify Liddell's (2019), Gómez et al. (2020), Younes et al. (2021), and other feminist scholars' claims that social workers are called to support RJ. RJ's core framework aligns with social work's ethical foundations and moves us away from the narrow focus on individual "choice" about contraception or abortion and "rights" as the end game in reproductive health. Instead, we adopt the RJ framework which is focused on access, resources, and the centering of the collective experiences of Black, Indigenous, and People of Color (BIPOC), LGBTQIA+, people with disabilities, and people who are marginalized and disenfranchised (Kendall, 2020; Ross, 2006). We challenge readers to commit to the three pillars of RJ, assuring *all* people can make the reproductive choices that fit their lives.

Pillars of RJ

Here, we discuss the overarching pillars of RJ, which include (a) the right not to have a child; (b) the right to have a child; and (c) the right to parent children in safe and healthy environments (Ross, 2006). Legal scholar Donofrio writes, "access to reproductive care is under siege throughout the United States, from restrictive state statutes that make it extremely difficult to find an abortion provider, to doctors who refuse to perform in vitro fertilization for lesbians, to welfare laws that punish

women for having children" (Donofrio, 2018, p. 223). Dismantling legislative restrictions while simultaneously addressing social justice issues is crucial to assuring body sovereignty, self-determination, and ultimately integral to the liberation of marginalized people. In juxtaposing the three central tenets of RJ against an American political system that dangerously maintains the subjugation of marginalized people, we illustrate how legislative advocacy and other interventions can be used to promote RJ.

The Right Not to Have a Child

Contraception is key to preventing unplanned pregnancies just as abortion is critical for contraceptive failure, rape, and other situations where pregnancy starts and is not desired and/or feasible for the pregnant person. Title X was established in 1970 to cover contraception costs for people (including teens) who did not have insurance coverage for contraception. The contraceptive mandate under the 2010 Affordable Care Act ("Obamacare" or ACA) was also part of ensuring that people who rely on public health insurance or who are uninsured would have access to contraception, but this has been more aspirational than practical, failing to truly provide contraceptive access to all who need it. The Trump administration's "gag" rule limited providers from discussing abortion and meant that Planned Parenthood, the provider of reproductive health care for 41% of Title X recipients, lost funding (Villavivicencio et al., 2020). The ACA contraceptive mandate was legislatively chipped away until recently when the Biden administration began to affirm ACA tenets and signed a memorandum to overturn the gag rule (Planned Parenthood, 2021).

The Hyde Amendment (1976) was the first, but not the last, of many examples targeting low-income and minoritized populations, restricting access to abortion care by prohibiting federal funding for abortions. It meant that people on Medicaid, serving in the military, or covered under federal insurance policies could not have abortion coverage. Since *Roe v. Wade* (1973), more than 1,300 abortion restrictions have been enacted; since January 1, 2021 (to June 7, 2021), 561 more restrictions across 47 states have been introduced (Nash & Cross, 2021). The assault on the right to not have a child is tenacious and dramatic, making the passing of proposed legislative remedies such as the EACH Woman Act (Equal Access to Abortion Coverage in Health—H.R.1692/S.758, 2019) and the Women's Health Protection Act (WHPA—S. 510/H.R. 1322, 2017) priorities for action. The EACH Woman Act would overturn the Hyde Amendment assuring more equity in health services for pregnant people trying to access abortion (All Above All, 2021). The WHPA would prohibit restrictions to abortion care that do not apply to other medical care and prohibit restrictions that interfere with individuals' personal choices or block access to abortion care.

The Right to Have a Child

Choice discourse has primarily focused on dealing with choices to end pregnancies with complications (whether due to psychosocial or medical circumstances), rather than the choices involved when one has full bodily sovereignty. This means that white second-wave feminists have largely ignored the long, continuing history of state violence that strips marginalized people of their right to have a child through forced or coerced fertility impairment [whether sterilizing people against their will or implanting long-acting reversible contraceptives (LARC) like Norplant or IUDs]. The right to have a child is also impaired by the removal of children from their families, legal restrictions on parenting for people with disabilities or LGBTQIA + families, and through the lack of response to disparities in maternal health and mortality (Ross & Solinger, 2017).

American policies have allowed the nonconsensual sterilization of Native Americans, poor women in Puerto Rico, those deemed mentally "unfit" (Schickler et al., 2021), and, most recently, asylum-seeking women at the U.S. border detention centers. Women on Temporary Assistance for

Needy Families (TANF) have been coerced into using LARC without a clear pathway for their removal. A legacy of violent removal of children from families began under slavery and of Indigenous children relegated to "reform" schools. That legacy can be seen in the current foster care system that primarily targets and polices parenting in minoritized poor communities and it can be seen also in the removal of children from families at the U.S. border. Similarly, intersex, transgender, and gender-nonconforming people face steep barriers to accessing assisted reproductive health services and/or adoption and face overt discrimination in their attempts to create families (Silver, 2020). People with disabilities have also been historically challenged when trying to conceive, or having, children as recently showcased in the conservatorship case involving Britney Spears (considered disabled by mental illness): though recently freed from her father's conservatorship, Spears' desire to remove an IUD required court approval. These limits on the ability to have a child are explicit, yet there are less obvious and persistent examples.

For those who want to raise children in the United States, the threats of maternal morbidity and mortality loom large; rising rates especially affect women of color, most profoundly Black women. As Villavivicencio et al. (2020) note: "Through the hard work of organizations like SisterSong, Black Mamas Matter Alliance, and the National Birth Equity Collaborative (among many others), the ugly truth of racism and white supremacy within the U.S. health care system has been unearthed" (2020, p. 409). Access to compassionate prenatal and maternity care is scarce in many areas, and midwifery care has been shown to decrease maternal mortality globally (Nove et al., 2021). Pregnancies for people of color are also more likely to end in premature births (Davis, 2019), likely due to the weathering and stress of long-term discrimination, oppression, and inattentive care. Current legislation to help reduce maternal mortality primarily consists of H.R.1318—the Preventing Maternal Deaths Act of 2018—which directs the Centers for Disease Prevention and Control to monitor maternal deaths using maternal mortality review boards but does not intervene directly to change the material conditions that contribute to these high mortality rates. Some states are working to expand health coverage from 8 to 12 weeks after birth to a year after the birth in an effort to support healthy pregnancies and outcomes. Finally, it should be noted that many individuals who struggle with infertility are dependent on insurance coverage to proceed with interventions such as intrauterine insemination (IUI) or in vitro fertilization (IVF), and many insurers do not cover these services in full. Although New York state will cover three rounds of fertility medication on public assistance, no state Medicaid programs provide coverage at all (Wegel et al., 2020).

While some pregnant people may feel compelled to not have a child when they learn of a life-threatening fetal anomaly or very impairing diagnosis, some might elect to have the child. Others assess whether they believe they have enough support to enable parenting a child with a diagnosis and when such support is limited, they decide against continuing the pregnancy based on resource scarcity (McCoyd, 2008). Pregnant people assess whether they can both *have* the child and be able to *parent* that child safely and with supports to enable the child's health. The right to have a child is intimately tied to material conditions and access to competent and compassionate reproductive care.

The Right to Parent Children in Safe and Healthy Environments

Freedom to choose to have a child is inextricably linked to the environmental conditions that shape children's lives (Kendall, 2020; Ross, 2006; Ross & Solinger, 2017). The third pillar of RJ emphasizes children's needs for safe and healthy housing, nutrition, education, medical care, and clean water, air, and environment. Housing and food instability, lack of consistent health care, environmental racism, stigmatization of people with disabilities, racism, transphobia, sexism, and paternalism in medical care, all limit choice and increase health and social risks for parents and children. The most recent census data shows that one in seven children live in poverty, with half of those classified as

living in extreme poverty and a staggering 71% of those children being children of color (Children's Defense Fund, 2021). Parenthood, like pregnancy, is precarious for those who have little access to economic, educational, medical, or social resources and limited social safety nets. Parenthood requires major sacrifices to work well. Electing to avoid or end pregnancy to avoid poverty for oneself and for a child is a rational choice, as is assessing access to resources that enable raising a child in a safe and healthy environment (see Liddell and Kington (2021) for ways pollution and toxic environments affect the reproductive health of Indigenous people). While many countries support parenting through extended paid parental leave after a birth or adoption and also make quality daycare and other economic supports for children a hallmark of their social safety net, the United States is still trailing behind these areas of support.

The American Families Plan recently introduced by the Biden Administration (2021) aims to support low and middle-income families through measures that limit the amount of income spent on childcare, provide a comprehensive national paid family medical leave program, and increase access to healthy, nutritious food in areas disproportionately affected by food scarcities. Importantly, the plan also includes tax modifications under the American Family Act of 2021 (H.R. 928) such as dependent care credits for working families with children, while extending health insurance tax credits originally introduced in the American Rescue Plan (ARP-borne of the Coronavirus pandemic). The ARP made the child tax credit fully refundable, meaning that it was not just a return on taxes paid, but an approximately $300/month payment made outright to families, envisioned to cut child poverty by about 40%, with children of color finally receiving the benefit of the tax credit they often did not receive because their parent had not made enough to get the full refund (Marr et al., 2021). At the time of this writing, the child tax credit rollout has begun and may be enshrined within the Build Back Better legislation if it is passed. Social workers must advocate for legislative policies that support families and children, while ensuring individuals' self-determination and ability to make reproductive decisions with clear support and access to needed resources.

Toward RJ and Liberation: A Social Work Call to Action

What can social workers do? Understanding the pillars of RJ and countering normative reproductive discourse is important but taking action to enact transformational change is vital. Here, we include a list of practical actions for social workers.

- Learn the history of reproductive rights in this country well enough to make this a fluent talking point. Show up and speak up at discussions with a factually correct, informed perspective on the concrete ways the United States has exerted injustice over women's bodies.
- Listen to the people who are most negatively affected by reproductive injustice. Centering their stories and experiences is essential to inform scholarship, policymaking, program creation, and as advocacy work is directed toward new legislation that supports RJ. Are you partnering with community organizations to support low-income parents and provide low-cost supportive services? Start by gathering the input of the people directly affected before proposing research, policies, or programs.
- Get active and join grassroots organizations like SisterSong, All Above All, National Institute for Reproductive Health, National Advocates for Pregnant Women, and support local reproductive health clinics. Join the movement.
- Contribute to National Abortion Funds. These provide funding for abortions for those needing care but who are unable to pay; they subsidize or cover care.
- Contact your state senators, congresspeople, and federal representatives regularly. Make it clear that issues of RJ matter to you. Whenever a state or federal piece of legislation is

proposed, write to weigh in. Staffers keep track of what constituents care about enough to write a letter or place a call to the office. Provide positive feedback when elected officials vote for legislation that supports RJ ideals (e.g., American Families Act).

- Contact the editor at your local newspapers or blogs that support RJ tenets and tie social justice aims to current legislation in your state. Support efforts to overturn the Hyde Amendment and to support subsidized, quality childcare. Help to interpret RJ principles and change cultural norms of exclusion and stigmatization. Help build local capacity (and motivation) to help families.
- Vote for politicians who state a clear commitment to anti-racist practices, RJ tenets, and concern for people, particularly those who are minoritized in any way.
- Promote social work scholarship focusing on RJ to build awareness of the connections among abortion, contraceptive access, and a supportive environment for raising children. If you are an academic, does your scholarship include critical theory that questions norms of power and privilege? Acknowledge historical systems of oppression that work to limit power and access at various intersections of identities as people work to plan their families.
- Advocate for the Council of Social Work Education (CSWE), Society for Social Work and Research (SSWR), National Association of Social Workers (NASW), Society for Social Work Leaders in Health Care (SSWLHC), and other social work entities to ensure adequate education, so students recognize RJ as part of the social justice mission of social workers. Encourage social work entities to lobby to promote RJ.
- In your personal life, consciously work to uplift voices of people of color, LGBTQIA + those with disabilities, and/or poorly resourced people. Acknowledge how systems of oppression work to minoritize, marginalize, and stigmatize people to silence. How are you promoting and centering voices that have been previously silenced in this fight? Whose stories are you narrating when you stand before lawmakers who would restrict RJ? Lend your voice when asked. Turn up and show up.

Conclusion

As aggressive legislative attacks on abortion rights and access continue, we call upon social workers to pursue the liberatory aims of the RJ movement, support its tenets in practice, and become politically active. Listening to and centering clients' experiences allows social workers to help make compelling personal connections to macro aspects of practice. Moreover, social work has a critical role in developing programs and local policies that meet the needs of people often ignored in the realm of reproductive services.

The ability to exercise reproductive agency is dependent on both the removal of structural barriers and ensuring the opportunity to make reproductive decisions free of constitutional and human rights violation, coercion, or scarcity. There is no RJ when children do not have enough food to support optimal growth and development; there is no RJ when parents are without supports or entitlement to basic survival resources; there is no RJ without health care for all; there is no RJ when Black women die at geometrically greater rates during pregnancy, delivery, and postpartum; there is no RJ when people do not have body sovereignty and are instead treated as incubators; there is no RJ when congress cuts funding for contraception, SNAP, WIC, and CHIP; there is no RJ when children are removed from their parents because of a lack of affordable safe housing; there is no RJ when children are exposed to environmental toxins; there is no RJ when children with developmental and other disorders are merely warehoused instead of nurtured and taught. These are injustices that can be remedied, unlike the

existential injustice of a life-changing genetic or other condition affecting a fetus. We challenge you to commit to RJ as central to social justice work.

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Author Biographies

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Judith L. M. McCoyd, Ph.D., MSSW, LCSW (PA) is an associate professor at Rutgers University's School of Social Work. Her research lies at the intersection of perinatal health care, medical technologies, end of life decision making and bereavement, with attention to the inequities and access issues related to such decisions. Her clinical work is with "end of life care at both ends of life," with foci on prenatal decision-making, perinatal loss, and hospice work. She is co-author of Grief and Loss across the Lifespan (Springer, 2021) and Social Work in Health Settings (Routledge, 5 ed. forthcoming) and teaches in the Masters, PhD and DSW programs.

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