Author accepted version. Accepted for *Critical and Radical Social Work* 17 September 2021. For publication March 2022.

Reproductive justice, abortion rights and social work

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Abstract:

Reproductive justice is essential in the struggle to remove health inequalities. Currently escalating threats to reproductive rights are rarely discussed in contemporary social work literature. Discomfort in the profession about addressing challenges to abortion rights exposes a lack of courage to treat abortion as essential healthcare. A case study of several abortion focused articles and chapters reveals a strand of ambivalence about taking a progressive stance on abortion. Recent trends demonstrate that reproductive rights cannot be taken for granted. Even when law reform removes some of the barriers to safe legal abortion, abortion stigma and anti-choice harassment remain potent threats to reproductive autonomy. A case is made for reproductive justice to be central in our drive for health equality. This requires a feminist perspective, moving away from seeing women as merely the object of the social work gaze, too often the focus of scrutiny and judgment.

Keywords: abortion • reproductive rights • reproductive justice • social justice • social work

It is well established that social work practice and education is numerically dominated by women and often held that men dominate in leadership positions although it is often difficult to provide accurate statistics (Jones et al, 2018). As far back as the 1970s a potential for gender related content in social work education to be minimised was recognised as a challenge to social work to be addressed at professional body level (Greubel, 2019). In their recent literature review of the contemporary dynamics of gender in Australian social work, Jones et al (2019) conclude that gender is under researched in Australian social work and that feminist literature is largely siloed in specialist journals such as Affilia.

There are many significant issues of concern for women that are compelling and preoccupy social work: violence against women and its impact on safe housing (Zufferey et al, 2016), women with disabilities (Muster, 2020) surviving disasters (First et al, 2017) and the terrible toll on women of child protection interventions (Broadhurst and Mason, 2019) Morriss, 2018) amongst them. In the large and ever-growing literature on these social problems it is rare that fertility and in particular reproductive rights are mentioned. For women caught up in child protection systems pregnancy is often problematised as not in women's best interests, may be seen as an impediment to their case and is a time of uncertainty and distress because "their hopes about the unborn baby belonging within the family were not necessarily shared by child protection professionals" (Critchley, 2019:141). In some programmes set up to support women who have children in care accepting long-acting contraception is a requirement (Broadhurst et al, 2015; Morriss, 2018) and contraceptive prescribing may be shaped by racist assumptions and biases of health professionals (Grzanka and Schuch, 2020; Higgins et al, 2016). Morriss notes that such policies are framed as producing financial outcomes: "controlling the reproductive lives of working-class mothers in ways which curtail future claims upon the state is construed as a policy solution to the imagined (moral) problem of their 'failed parenting' and 'welfare dependency'." (Morriss, 2018: 821).

Coercive control is well understood as a feature of intimate partner violence but less prominent in the literature is the role of control over fertility in such dynamics. In Aotearoa New Zealand two studies have made the links between seeking an abortion and intimate partner violence. Recently Burry et al (2020) reported findings from an Aotearoa New Zealand survey and interviews that outlined the way agency in reproductive decision making was diminished by coercive control actions by violent partners. This action included controlling access to contraceptives, sabotage of contraception usage, pregnancy coercion, and controlling access to abortion services.

In 2005 Whitehead and Fanslow found that the reported lifetime prevalence of physical or sexual abuse in a survey of women attending an abortion service was 50.8% (Whitehead and Fanslow, 2005: 321). The reported lifetime prevalence of physical abuse was 43.3% and that of sexual abuse was 32.2%. The reported prevalence of physical abuse within the last year was 13.3%, and of sexual abuse within the last year was 8.5%. Of women reporting a lifetime history of physical abuse, 69% reported that her partner was the perpetrator or one of the perpetrators of abuse (Whitehead and Fanslow, 2005). In a UK sturdy the prevalence of

lifetime abuse was 16% (Mott et al, 2014, p.130). The prevalence of physical abuse in the past year was 11% and sexual abuse in the past year was 4% 9 (Mott et al, 2014:130). The prevalence of DV in the current pregnancy was 4%. There was a higher rate of both lifetime and past-year DV with increasing number of terminations, although this was not statistically significant (p=0.196).

The right to make choices about one's fertility is fundamental to full participation in society. Reproductive autonomy describes someone's ability to make free, voluntary and informed decisions about their reproductive health and wellbeing (Moore et al, 2010). Reproductive coercion is thus any act that overrides the views and wishes and undermines the reproductive autonomy of another person. Freedom to choose if and when to become pregnant and become a parent is a fundamental right and an essential element in health and well-being of both women and non-binary people using women's health services (Gomez et al, 2020a; Gomez et al, 2012). The International Federation of Social Workers promotes the right to participate in health decisions as a human right: 'Social workers should promote the full involvement and participation of people using their services in ways that enable them to be empowered in all aspects of decisions and actions affecting their lives' (IFSW, 2004: 4.1 Human Rights and Human Dignity section, item 2). Furthermore, Gezinski (2011) argues that 'Full reproductive freedom, including access to family planning services such as abortion, is necessary for women to retain total control of their own automomy' (p.838). In social work reproductive justice is relatively invisible in social work scholarship research and most likely very marginally addressed in social work education (Gomez et al, 2020 b).

This article explores contemporary literature on reproductive rights and social work and, in particular, abortion rights. A case is made for a more central consideration of women's reproductive rights in social work. This requires centreing a feminist perspective, moving away from seeing women as merely the object of the social work gaze, the focus of scrutiny and judgment. A group of abortion focused articles and responses in the social work literature will form a case study to illustrate social work ambivalence and how this blinds us to essential rights. Ambivalence in the profession about the ongoing challenges to reproductive freedom in so many countries and jurisdictions reveals our lack of courage in failing to treat abortion as an issue of health care equality and social justice (Younes et al, 2021).

Literature

The concept of reproductive justice is of core significance to women's health but it is also closely aligned to broader challenge faced by social workers to work to reduce health inequalities (Liddell, 2018; Smith, 2017). In its more fulsome acknowledging this, the profession in the United States is visibly further ahead on this than social work in Australasia or Europe. One motivating factor for this visibility is the inclusion of a focus on health inequality as one of the 'Grand challenges for social work' (Spencer et al, 2016). The grand challenges, led by the American Academy of Social Work and Social Welfare (n.d.), were developed to encourage social work educators, researchers and practitioners to confront persistent social problems with solid evidence and innovative approaches. Referred to as 'Closing the health gap' refers to intervention at macro, meso and macro levels to improve access to health care, and address the social determinants of health inequities— "the avoidable, unfair, and unjust differences in health status that persist along racial, class, gender, and other social categories" (Gomez et al 2020b:1). Reproductive health underpins gender equality and well-being, on health and wellbeing across the life course (Starrs et al, 2018).

Reproductive justice is rooted in intersectional feminism when on the 1990s African American women rejected the narrow focus of white middle class women on abortion rights. Family planning services developed in the 1960s and 70s and primarily served the needs of middle-class women. The underlying premise for these services was choice and agency - freedom to choose - but as Grzanka and Schuch (2020) note this did not take into consideration the ways poverty and discrimination impacted on communities subject to racism, stereotypes about fertility and parenthood, and bias in service providers (Higgins et al, 2016).

Reproductive justice is much more than access to safe, legal abortion, although abortion rights are always going to be fairly central and most vulnerable to attack. An intersectional approach positions reproductive health as a dimension of health in which multiple intersecting identities and social locations – gender, race, class, sexualities, geography, culture, health, and disabilities – situates some people in a precarious position (Luna and Luker, 2013; Ross, 2017). Eaton and Stephens (2020:209) argue that neither traditional feminist theories, 'which problematize gender,' nor traditional critical race theories, 'which

problematize race,' provide on their own an adequate framework for understanding the multiple locations that shape reproductive health: 'bridging this gap, reproductive justice provides a more critical lens … by exposing oppression and power dynamics in an attempt to address the reproductive challenges diverse marginalized women face'.

In their 2020 article Gomez et al (2020 b:1) argue that reproductive justice is an essential aspect of addressing health inequalities. Reproductive justice— "the right to have children, to not have children, to parent with safety and dignity, and to sexual and bodily autonomy—has not been a signature area of scholarship and practice" for social work. It is apparent that this relative silence – compared say to the plethora of social work literature on family violence and mental health – is also reflected in social work activism and the gaze of professional bodies.

In 2019 Beddoe et al posed some challenges to social work professional bodies about their relative silence on abortion law reform, using Australia, Ireland and Aotearoa New Zealand as case examples. Case-studies of social work action on abortion law reform in Ireland, Australia and Aotearoa New Zealand demonstrated that activism was variable and that abortion care social workers working were few in numbers and so the issue was often of low visibility. It was noted however that most social workers work with many people who experience unplanned pregnancy and may need support and unbiased information (Beddoe et al 2019). Since the writing of that article there have been several calls to action (Gomez et al. 2020; Younes et al, 2021). Among the challenges to reproductive rights identified by Gomez et al (2020) is the criminalisation of pregnancy where people are punished for behaviour deemed potentially harmful to their pregnancy which can be interpreted quite broadly. That social workers in both health and child protection services might be party to such ever-widening policing of pregnant persons, illustrates how reproductive justice highlights "the tension between participation in disciplinary surveillance and advancing social justice" (Gomez et al, 2020: 5). In failing to engage with reproductive justice social work and remaining relatively silent on this fundamental rights issue for women social workers may be unaware of how fertility control and family interventions so frequently hold women at the centre of systematic surveillance.

One commentary article, (Thyer 2018), published in a social work journal, provides a window on the politics of abortion in the social work realm and the extent to which ethics can

be expendable when anti-abortion politics are legitimised by publication. The following section offers as a case study a brief analysis of the commentary article, and some responses to it.

Ambivalence or fence-sitting? Contrasts and contradictions in the treatment of abortion rights in the social work values and ethics sphere

Conservative anti-choice rhetoric in social work is demonstrated in an 'opinion' piece in the *Journal of Social Work Values and Ethics* (JSWVE) in 2018 by Thyer a senior US social work academic. Entitled '*Aborting abortions: How you can reduce abortions in your community'*, this article proposes an action that 'pro-life' people could take to delay abortions and waste clinics appointments in the hope that such delaying tactics might lead to some patients changing their minds about having an abortion (Thyer,2018). Putting aside the incredulity I experienced when seeing such a proposal in a social work journal (which purports to include 'examples of good practice that clearly highlight ethical and values considerations)' (JSWVE website), the article illustrates how weakly observed the foundational social work principle of client self-determination can be.

Thyer's proposal was that:

> Pro-Life churches … recruit young women from among the faith-based community and ask them to volunteer to appear at the local abortion clinic requesting counseling and a pregnancy test.… Some of these women volunteers could actually be pregnant, and upon learning of the positive results of their test, take this effort to the next level and, after very lengthy discussions, schedule an abortion. At the appointed time she could simply not show up, or she could appear (perhaps with a burly companion), get completely prepped for the procedure, and just before being taken to the operating room, say she changed their mind, verbally withdraw her informed consent, and refuse to proceed. The staff might get angry, but pseudo-patients would smile serenely, get dressed and leave…Every time slot dedicated to performing an abortion on a patient who backs out at the last minute is one less abortion that clinic could perform that week, representing one baby potentially saved. (Thyer, 2018:93-4).

While journal editors are not assumed to agree with every item they publish there is surely at least a duty of care to publish material that is aligned to the core ethical principles of the profession. This ethics journal presents as 'opinion' a proposal for actions that are clearly not aligned to basic professional values of honesty, integrity and respect. Rather the author promotes dishonesty and interference in the safe functioning of a legal health service, and in doing so takes a somewhat contemptuous disregard or any impact on the volunteers of carrying out such an action.

By way of justification for his proposal Thyer (2018:5) parrots common anti-choice stigmatising viewpoints, for example, in this particularly misogynist comment: "...the sad reality is that many women seeking an abortion do so purely for methods of birth control, for convenience, being unwilling to bear the burden of nine months of pregnancy." The literature on the reasons underlying a choice to have an abortion provides myriad reasons (Ely et al, 2017; Finer et al, 2007; Sperlich, 2020). Ely et al, 2017 cite economic distress, limited access to contraceptive health care, current parenting responsibilities, requiring public assistance, rape and intimate partner violence, abusive unwilling or unsupportive partners (Chibber et al, 2014), criminal justice involvement, health, mental health and disabilities, lack of social and emotional support and insecure housing. Other studies have highlighted concerns over ability to cope emotionally and or financially with additional dependents, satisfaction with family size, pursuing further education as reasons for seeking abortion (Bankole et al., 1998; Finer et al, 2007).

Further on Thyer (2018:95) ignores the structural realities of racism and poverty facing stigmatised and marginalised populations when he claims his idea is necessary for "the love of human life, or babies, of women, love to prevent the needless deaths of tens of thousands of African-American babies". Love, does not pay the rent or put food on the table. Love alone does not heal the wounds of abuse and violence. It is one of the deepest hypocrisies of the anti-abortion movement that it's zealots, purporting to stop abortions, are the least likely to have fought for free, safe, accessible contraception. Rather they would actively prevent such access, even to the extent of blocking funding to health services that include reproductive care both at home and abroad (see for example, Gezinski, 2012 on the 'Global Gag' rule).

This opinion piece did not go unchallenged and is the subject of a long running editorial correspondence published in the journal. In a letter to the editor feminist scholar Goldblatt Hyatt (2019) takes Thyer to task for numerous assertions made in his opinion piece. She notes that he did not base his work on an evidence base but rather 'presents multiple uninformed assumptions about the reasons why women have abortions, avoiding our profession's acknowledgement of social justice and access issues. His words further stigmatize women and minority/underserved populations' (Goldblatt Hyatt, 2019: 4). In a subsequent letter to the editor in the JSWVE, Ely et al. (2021) systematically refute Thyer's arguments, using the substantial research base to illustrate point by point his lack of an evidence informed position.

In 2019 the handbook the *Routledge Handbook of Social Work Ethics and Values* was published edited by the editor of JSWVE (Marson, 2019). This handbook contains three chapters on abortion. These have clearly been chosen to represent a range of views but it can be argued that in doing so, again client self-determination and reproductive justice are cast as expendable and women's rights subject to moral policing by male social work academics. Most social work journals and edited works strive to avoid inclusion of material that is sexist or racist or which promotes stigma and oppressive practice. Providing 'balance' is not achieved by the inclusion of outdated and discredited material.

In the first of these three chapters, 'Self-Determination and Abortion Access: A Pro-Choice Perspective on the International Statement of Ethical Principles' Witt, Goldblatt Hyatt, Franklin, and Younes set out an argument for a pro-choice position based on core ethical principles of social work. This chapter clearly identifies an ethical stance of reproductive justice based on the following values: the right to self-determination, the treatment of people as whole persons, and the right to participation. Witt et al's conclusion provides a clear guidance for social workers:

> social workers are compelled to practice from a value-neutral stance when working with pregnant individuals. Social workers must honor the unique cultural and social contexts influencing client decision-making – including supporting a client's decision to carry to term or end a pregnancy. Imposing one's beliefs regarding abortion onto a client instead of seeking supervision, referral, and/or working to put the client's needs first seriously violates multiple codes of ethics. Remaining value-

> neutral, social workers act in the best interests of clients by referring them to appropriate private and community organizations for assistance continuing or ending a pregnancy (Witt et al, 2019: 106).

Disinformation is a hallmark of the anti-abortion movement. The promulgation of misleading information in a scholarly publication is a concerning feature of the social work 'debate' on abortion. The second chapter, Rainford and Thyer's contribution to the Routledge handbook is titled 'Preventing and Ending Abortion: The Role of Social Workers in Protecting Unborn Children'. Rainford and Thyer's argument is that social workers should all be anti-abortion because we are:

> professionally bound and obligated to act on behalf of the human being from point of conception, enlisting social work knowledge, skills, and experience in protecting the life of the unborn human being from conception forward and facilitating its growth in dignity toward full human potential. Further, as in all social work practice, it is not enough to merely serve the un-born human being; the professional social worker must advocate for the end of the legality and practice of abortion as an atrocity and affront to the life and dignity of all human beings. (p.109).

It is not the intention in this present article to debate such assertions, except to note that they represent opinions that are rarely reflected in professional codes of health and human services professions. Rather my concern is with the positioning of such extreme positions in social work literature. However, the invisibilising of the pregnant person's rights in such discourse in this chapter is flagrant. All adult women and pregnant people, or children pregnant from rape and abuse have no agency in this discourse but are merely the carriers of a romanticised 'sentient' embryo, and these authors suggest that pregnant people are to be policed and constrained by a self-proclaimed judge and jury social work profession.

Goldblatt Hyatt (2019) notes also that the disinformation promulgated by Thyer in 2018 continues in this chapter. Thyer and Rainford (2019) for example 'argue that fetuses are "pain-capable" at fourteen weeks and beyond (p.112), and erroneously cites scholarly literature, when in fact, there is no scientific evidence' for this (Goldblatt Hyatt 2019: 5, citing Lee et al, 2005). Goldblatt notes that Thyer and Rainford cite a long since discredited anti-abortion "documentary", The Silent Scream, to suggest that fetuses attempt to "escape

the physician's tools" (p. 112). Use of extremely dubious but inflammatory sources to promulgate disinformation is a trait of right- wing conservative activists and surely has no place in the scholarly literature, and even less so in a publication that is devoted to professional ethics.

The third chapter on abortion in the Routledge handbook by Sheridan is 'Mercy or Murder: Social Work and Ambivalence over Abortion'. While Sheridan's intention is to find a middle ground for social workers, the implications of this position are worrying. Rights are rights and not expendable. Social workers either believe fully in bodily autonomy or they don't.

> Ambivalence among social workers is seldom discussed, and ambivalence, in general, is viewed negatively. But social workers are people too, and people may not be able to embrace either a pro-life or pro-choice policy position without reservations. However, one need not hold a firm position to work productively with clients or client groups or at the macro level. Taking a middle position is a reasonable approach to complex topics and may bring benefits. To be true to one's conscience (p.122).

I have always found it helpful to frame arguments around bodily autonomy by using the example of organ donation. No state can require an individual to give up an organ or bone marrow, even when doing so would save another's life. Similarly, in current debates about vaccination, although we would want people to vaccinate, we cannot physically force the vaccine. And yet restrictive abortion laws would force women, even when their lives are at risk, to bear children against their will. Irish novelist Sally Rooney captured the heart of the argument beautifully in this passage in a short essay in the *London Review of Books* (2018):

> Pregnancy, entered into willingly, is an act of generosity, a commitment to share the resources of life with another incipient being. Such generosity is in no other circumstances required by law. No matter how much you need a kidney donation, the law will not force another person to give you one. Consent, in the form of a donor card, is required even to remove organs from a dead body. If the foetus is a person, it is a person with a vastly expanded set of legal rights, rights available to no other class of citizen: the foetus may make free, non-consensual use of another living person's uterus and blood supply, and cause permanent, unwanted changes to

> another person's body. In the relationship between foetus and woman, the woman is granted fewer rights than a corpse.

When Sheridan promotes the middle ground, she is effectively saying to social workers 'it's Ok to be anti-choice but just be nice and provide a half-hearted referral'. But the 'ambivalent' social worker is free to vote for anti-choice politicians, to support anti-choice laws, and feels no obligation to fight for reproductive justice for their clients. They can centre their conscience as taking precedence over broad conceptions of universal human rights. The ambivalent social worker can carry on while disguising their barely marginal support for women's agency over their own bodies. Cowley (2019) argues against conscientious objection to abortion using the dimension of place to explore the issue. He notes that when a pregnant person visits their primary health care service to request an abortion and meets conscientious objection, they can retreat back into the public or private space. In contrast, when a social worker visits their home "it is much easier to see [them] as an invading force", even if their intention is benign. The social worker is in the client's life-world and there is no further place to retreat [and] brings with [them] vague powers of coercion, and that influences the dynamic" (Cowley, 2019:2095). Reproductive coercion takes many forms.

Law reform and enduring problems

The last decade has seen many changes to abortion legislation. Across the globe in developed and developing countries, battles are being waged in courts and in the streets to ensure basic rights for safe legal abortion (Chesney-Lind and Hadi, 2017). In some contexts, this has seen liberalisation where abortion has been decriminalised through legislation – several states in Australia, Aotearoa New Zealand and Ireland for example. However, in other jurisdictions previous protections have been severely challenged. In the United States many attempts to overturn the Roe v Wade which decriminalized elective abortion in the US and which is expected to be tested in the next 12 months. At the time of writing, the supreme court has failed to block a Texas law which bans abortion as early as six weeks, before most people will be aware they are pregnant. The Texas law allows and incentivizes any abortion opponent to sue any person who assists a woman seeking an abortion, invoking the grim likelihood of abortion bounty hunters and avoiding the need for public officials to police the law which contravenes Roe V Wade. Kathryn Kolbert and Julie F Kay, long-standing

abortion rights campaigners and authors of '*Controlling Women: What We Must Do Now to Save Reproductive Freedom*' (Kolbert and Kay, 2021), write in the Guardian that the campaigns to follow the supreme court inaction must increase innovations to support women's equality and reproductive justice grounded in the reproductive justice movement, "led by women of color, [which] has successfully exposed the link between systemic racism and the denial of reproductive freedom" (Kolbert and Kay, Guardian , 1 September 2021).

This legislative assault on rights directly contravenes The World Health Organisation (WHO) statement that

> Every individual has the right to decide freely and responsibly – without discrimination, coercion and violence – the number, spacing and timing of their children, and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health … Access to legal, safe and comprehensive abortion care, including post-abortion care, is essential for the attainment of the highest possible level of sexual and reproductive health. (WHO Abortion overview, nd)

The WHO notes that the barriers to accessing safe abortion include restrictive laws, poor availability of services, high cost, stigma, the conscientious objection of health-care providers and unnecessary requirements, such as mandatory waiting periods, mandatory counselling, provision of misleading information, third-party authorization, and medically unnecessary tests that delay care. (WHO Abortion overview, nd). Much is written about these infringements of rights, even when abortion is legal component of health care, but the focus of the remainder of this article is a brief survey of stigma and safe access.

Stigma

'These are your personal opinions they don't belong on a professional page. This quote is from a comment made on a post I made about abortion law reform in Aotearoa New Zealand on a closed social work Facebook page. I was castigated by religiously motivated social workers almost every time I posted on social work social media. Apart from the absurdity of expecting personal opinions not to feature in the discussion of social work concerns - after all isn't that really the main point of social work on social media- my critics revealed a

somewhat hypocritical position. Their personal opinions, being against abortion rights, if acted on professionally or at the ballot box, were directly limiting the rights of pregnant people to access an essential health care. Mine, would rather enable choices.

I have chosen to discuss this under the theme of stigma because it is patriarchal religiosity that creates, inflames and maintains abortion stigma. Judgements are quickly and easily made. When my social work colleagues attempted to police my comments about abortion law reform, a current live issue before the Aotearoa New Zealand government at the time, they were reinforcing abortion as a dirty, private secret, a source of shame and guilt. They may not have consciously intended to shame colleagues on the page who had had abortions but how could they be unaware that shame might be a response. Abortion is uncomfortable for social workers as an enduring and painful example of the intersection of private troubles and public issues.

Anti-choice beliefs require stereotypes based on patriarchal notions of womanhood and antic-choice activism is bound up in rigid conceptions of gender roles. Swank (2020) undertook a study of pro-life activism by analysing data from the web-based Evaluations of Government and Society Study addressing the variable political behaviours as well as gender norms, social contexts, and sociodemographic social statuses. Swank found that "pro-life activism was connected to a person's perception of proper gender roles within a family … pro-life activists seem to idealize the notion of a stay-at-home mother who can be a full-time caretaker, cook, and maid for other family members" (2020: 9) Furthermore Swank reports that anti-choice activists were more likely to minimise discrimination and misogyny and downplay economic inequalities, and would challenge the prevalence of violence against women.

Media stories of personal troubles that are designed to support personal campaigns for change or access to health care are often framed in thematic style, for example stories of parents struggling to access surgery or expensive medications for their child. The 'case' is used to elicit emotions and to reflect the experiences of others and to draw attention to the problem with a structural health justice lens. In abortion care stigma means it is much less likely that named individuals will feature in such stories. Countering abortion stigma has thus become a tool in the struggle for change. Telling individual abortion stories has been a powerful tool in the campaign to personalise the issues, in the hope of invoking reasonable, empathic reactions. One prominent example is found on the tragic death of Savita Halappanavar in

Ireland which galvanised support for abortion law reform, (Holland, 2018). Interestingly in an Indian news outlet the headline was “Ireland Murders Pregnant Indian Dentist” (Agrawal, 2012). This tragic case where fear of religiously motivated legal sanction prevented medical professionals from saving a young life, became a watershed moment in Irish law reform. All life is precious except for adult women.

In Aotearoa New Zealand pro-choice activists used media stories to address stigma head on. Many articles were anonymous but some were published where the identity was known. Politicians, other public figures and journalists provided personal accounts that directly addressed both issues of access and abortion stigma. All those who told their stories were brave but as Duff (2019) notes in her article ‘we lay our pasts out for public scrutiny in the hope of one thing – achieving change’. Cullen and Korolczuk (2019:8), writing about such campaigns in Ireland and Poland note that campaigns to break the silence around abortion through these personal abortion stories “made individual women responsible to provide their testimony to end abortion stigma”. Furthermore, by emphasising the emotional aspects, poverty, family violence and other social factors, may be obscured, along with simple personal choice.

Unmolested access

While decriminalisation and law reform are very important advances in the availability of safe legal abortion, there remain in place significantly barriers. Mandatory waiting periods, meeting disinformation or refusal of care, arbitrary gestational limits, limited-service provision and enduring abortion stigma can all delay or prevent someone from accessing an abortion and pockets of criminalisation can lead to cross- border travel (Mecinska et al, 2020). The cumulative effect of these barriers is felt most keenly by those already marginalised.

Harassment by religiously motivated anti-choice activists often continues if there is no legal impediment to their activity. Male dominated legislatures frequently place the free speech of protestors above the rights of pregnant people to safely access essential health care without harassment. Lowe and Hayes (2018: 336) note that anti-abortion activity takes place in a realm “already governed by relations of power, and where the meaning of abortion is often

negatively culturally defined". Women seeking abortion services must negotiate the public space around the health service and except to encounter people who will subject them to stigmatisation: "As a form of public witnessing, anti-abortion activism outside clinics can thus be understood as a specific interaction whose purpose is for strangers to look at and/or address women" (Lowe and Hayes, 2018:336).

Some recent research reports that religiously motivated harassment is ineffective in preventing abortions (Fiala et al 2020; Foster et al 2020). While the evidence that protests deter people seeking abortions is weak (Fiala et al 2020) activity may continue with other motivations - 'witnessing' encouraged by church leaders (Swank, 2020), causing emotional distress, and targeting health professionals to try to persuade them not to participate. While anti-abortion protests may not be that effective in changing people's minds about seeking an abortion, Fiala et al (2020: 229) found that people encountering protests experienced "profound emotional stress caused by the actions of the demonstrators. They felt harassed, threatened and insecure". Similarly, Foster et al (2020) reported that "seeing and interacting with protesters was at times unsettling, stigmatizing, and frustrating" (p.308). Clinic patients who were struggling with their decision, those who made the decision for health reasons, or people experiencing intimate partner violence found these encounters particularly distressing. Earlier research by Ostrach and Cheyney (2014) found that for low-income people seeking abortion care, the protests were extremely stressful and created another layer of obstacles to accessing the support they needed. During this study research participants reported that they felt the need to cancel or reschedule abortion appointments, "citing a reluctance to walk through the gauntlet of yelling, shoving protesters as their reason" (Ostrach and Cheyenne, p.1015).

Conclusions

Where to from here? Social work must situate the ongoing struggle for abortion rights within a broad health disparities approach based on the right to good health care for all (Gomez et al, 2020b). Kolbert and Kay (2021) advocate a 'menu of reforms' including removing barriers to contraception, address the unequal rates appalling rates of infant and maternal mortality, which are experienced by Black and Indigenous people; and providing fertility treatment for all. Social workers in health settings can advocate for providing gender-inclusive and gender-affirming reproductive health care healthcare for LGBTQ+ people (see for example,

Gomez et al, 2020 a and 2021). Social workers are in a good position to aggregate stories, with a focus on social justice (health inequities, racism, poverty) and human rights (bodily autonomy, choices about fertility and parenthood) to avoid the need for some people to be brave and lay out their private decisions.

There is work to be done in social work ethics and social work education for practice. It is timely to ensure that the anti-choice and ambivalent positions outlined above do not act as deterrents to educators promoting a reproductive health lens (Younes et al, 2021). There is a minimum ethical position for social work as outlined by Witt et al (2019) and the literature consulted for this article suggests urgent attention to improving social worker knowledge about reproductive justice via social work education.

To achieve the goals of reproductive justice requires an intersectional feminist perspective, moving away from seeing women as merely the object of the social work gaze, too often the focus of scrutiny and judgment. The last word goes to the authors of this speculative ethnography, imagining a healthcare system in 2039 that was good for all, where holistic, relational practices in health care makes safe spaces for reproductive health to flourish:

> …wāhine Māori (Māori womxn) and other Indigenous sisters talked about bringing well established traditional knowledges into mainstream health care. I use this term deliberately, because with such a shift of how we understand ourselves, our (her)stories, our environment and the wisdom tuku iho (handed down) will change 'mainstream' into a space for all of us to focus on Indigenous female wellbeing. With this shift comes holism, collectivism, and relationality. This shift represents an opportunity for everyone to flourish.
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> A people-centred health system would have resourced space for woman's and whānau (family) health, for being proactive, being personal and providing holistic care. There is better education around sex, pleasure and our bodies. There is free access to, and accurate education about, birth control and abortions. (Came et al, 2021: 7)

Conflict of interest: The author declares that there is no conflict of interest
Funding: No funding was gained for this project.

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